Kentucky Child Fatality And Near Fatality External Review Panel 2025 Update

Legislative Oversight And Investigations Committee

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Abstract

KRS 6.922 and 620.055(17) require the Legislative Oversight and Investigations Committee to conduct an annual evaluation of the Child Fatality and Near Fatality External Review Panel (panel) to monitor its operations, procedures, and recommendations. The panel, which has 17 voting and 5 ex officio members, is attached administratively to the Justice and Public Safety Cabinet. The independent panel's charge is to conduct comprehensive reviews of child fatalities and near fatalities reported to the Cabinet for Health and Family Services that are suspected to be a result of abuse or neglect. It is also required to submit annual reports discussing case determinations, as well as findings and recommendations for system and process improvements. The panel addressed two of the three recommendations adopted by the Legislative Oversight and Investigations Committee in its 2024 panel update. The panel implemented both recommendations by updating its notification letter. The panel did not develop written procedures as recommended, citing its intention to do so in tandem with the deployment of its new case management system which is currently in development. Panel staff were also concerned that written procedures could hinder panel members. However, a lack of documented processes can lead to internal control issues. Generally, the panel complies with statutory requirements in that it exceeds the required number of meetings, posts required information, and delivers required reports. Of the six agencies that received recommendations, four responded in a timely manner as required by statute. This report contains two recommendations for the panel.

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. Elisha Mahoney, executive staff adviser, and Benjamin Harrison, chairperson and Lewis County attorney, provided valuable information.

Jay D. Hartz
Director

Legislative Research Commission
Frankfort, Kentucky
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Contents

Tables

Figures

Summary

KRS 6.922 and KRS 620.055(17) require the Legislative Oversight and Investigations Committee (LOIC) to conduct an annual evaluation of the operations, procedures, and recommendations of the Child Fatality and Near Fatality External Review Panel (panel). The panel conducts comprehensive reviews of child fatalities and near fatalities resulting from abuse or neglect. The panel is required to publish its annual report by February 1 of each year. These reports consist of case reviews, findings, and recommendations for system and process improvements to help prevent child fatalities and near fatalities that are due to abuse and neglect.

Major Objectives

The major objectives for this study were to review

- the actions taken by the panel over the past year to address recommendations from LOIC's 2024 annual report;
- the panel's development of findings and recommendations to meet reporting and other requirements under KRS 620.055(10);
- the panel's progress in developing its new case management system; and
- the panel's operations and procedures.

Major Conclusions

- The panel addressed two of the three recommendations adopted by LOIC at its July 11, 2024, meeting. The panel did not act on the recommendation to develop written procedures. Panel staff expect that the new case management system will impact how procedures will be written.
- Agencies responsible for responding to the recommendations in the panel's annual reports have not consistently fulfilled the requirements of KRS 620.055(10). As of May 27, 2025, four of six agencies have responded to the recommendations made in the panel's 2024 report. These responses addressed 9 of the 11 recommendations in the report.
- The 2024-2026 executive branch budget included $200,000 for the panel in FY2025 for the purchase of a new case management system. The panel is working with the Commonwealth Office of Technology (COT) to design and build a new system. According to budget staff with the Justice and Public Safety Cabinet, unused funds would continue to be available after the end of the fiscal year through a capital funds budget account.
- 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, as well as case summaries and determinations.
- The panel's findings in its 2024 annual report were supported by analysis and data that were illustrated in the report. Recommendations were appropriately linked to the report's findings, and the recommendations were targeted and actionable.

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- The panel's operations and procedures have not been formalized into written standard operating procedures. Panel staff stated their intent is to write procedures in tandem with the development of the panel's new case management system. A lack of written procedures can be a risk to internal controls and may prevent the panel from operating as intended or prevent panel members from providing feedback on operations.

Recommendations

In the 2024-2026 executive branch budget, the panel received an additional $200,000 in FY 2025 for the procurement of a new case management system. The budget bill specified that the funds allocated to the panel for the purchase of the case management system will lapse to the budget reserve trust fund account if not expended in FY 2025. Panel staff expressed concern that it would not be able to access all appropriated funds because the project would extend past FY 2025. LOIC staff interviews found the Justice and Public Safety Cabinet could provide guidance for funds to be used past FY 2025.

Recommendation 2.1

Kentucky Child Fatality and Near Fatality External Review Panel staff should consult with the budget staff of the Justice and Public Safety Cabinet regarding how to use funds appropriated for the new case management system beyond FY 2025. If further clarity is needed regarding use of the appropriated funds, panel staff should contact the budget director of the Justice and Public Safety Cabinet.

In the 2024 panel update, LOIC staff recommended that panel staff develop written procedures. Panel staff have yet to develop written procedures and intend to develop them in tandem with the new case management system. The new procedures will represent how the new system operates. However, panel staff expressed concern that formal procedures would limit how panel members would operate. LOIC staff clarified that the recommendation was intended to address the administrative side of panel operations. The issues with a lack of procedures still remain, so a revised version of the written procedures' recommendation was issued.

Recommendation 3.1

Panel staff should develop written procedures for review and approval by the panel chair and members. The written procedures should document the administrative processes by which panel staff obtain, store, review, and analyze cases; assist with developing findings and recommendations; assist with developing annual reports; and comply with the reporting requirements mandated by KRS 620.055(10). Activities of the panel members should be left to the discretion of the panel chair and members.

Chapter 1

Kentucky Child Fatality And Near Fatality External Review Panel

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

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

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

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

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

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

The panel is required to publish its annual report by February 1 of each year. These reports consist of case reviews, findings, and recommendations for system and process improvements to help prevent child fatalities and near fatalities due to abuse and neglect.[4] The panel's annual report considers cases from the previous fiscal year regardless of whether investigations by the Department for Community Based Services (DCBS) substantiated allegations of abuse or neglect in each case.

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

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

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

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

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

The 2021 report, adopted on October 14, 2021, focused on the process the panel uses to request, receive, and analyze information to carry out its statutory responsibilities. It also focused on the process by which the panel requests and receives its funding. The 2022 and 2023 reports—adopted on November 10, 2022, and August 10, 2023, respectively—focused on the panel's implementation of the changes in Senate Bill 97 (2022 RS), the findings and recommendations in the panel's annual reports, updates to the panel's data tool and data dictionary, and the panel's budget procedures. The 2024 report, adopted on July 11, 2024, focused on the actions taken by the panel to address the recommendations from LOIC's 2024 report, with continued focus on the panel's findings and recommendations.

Major Objectives

This study had four major objectives.

The major objectives for this study were to review

- the actions taken by the panel over the past year to address recommendations from LOIC's 2024 annual report;
- the panel's development of findings and recommendations to meet reporting and other requirements under KRS 620.055(10);
- the panel's progress in developing its new case management system; and
- the panel's operations and procedures.

Methodology

LOIC staff conducted the following research tasks:

- Observed monthly panel meetings and followed up on information as needed
- Reviewed and analyzed child fatality and near fatality case information and data from the panel's annual reports from 2014 to 2024
- Reviewed and analyzed the panel's historic expenditure data from eMARS
- Reviewed and analyzed the panel's historic contract information from eMARS
- Interviewed panel staff about the panel's operations, procedures, recommendations, and development of a new case management system.

Major Conclusions

This study has six major conclusions

This report has six major conclusions.

- The panel addressed two of the three recommendations adopted by the Legislative Oversight and Investigations Committee at its July 11, 2024, meeting. Panel staff updated their notification letters to delineate the 90-day deadline by which a response is required and clearly indicated required elements of an agency response. The panel did not act on the recommendation to develop written procedures. Panel staff expect that the new case management system will impact how procedures will be written.

- Agencies responsible for responding to the recommendations in the panel's annual reports have not consistently fulfilled the requirements of KRS 620.055(10). As of May 27, 2025, four of six agencies have responded to the recommendations made in the panel's 2024 report. These responses addressed 9 of the 11 recommendations in the report.

- The 2024-2026 executive branch budget included $200,000 for the panel in FY 2025 for the purchase of a new case management system. The panel is working with the Commonwealth Office of Technology (COT) to design and build a new system. According to Justice and Public Safety Cabinet budget staff, unused funds would continue to be available after the end of the fiscal year through a capital funds budget account.

- 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, as well as case summaries and determinations.

- The panel's findings in its 2024 annual report were supported by analysis and data that were illustrated in the report. Recommendations were appropriately linked to the report's findings, and the recommendations were targeted and actionable.

- The panel's operations and procedures have not been formalized into written standard operating procedures. Panel staff stated their intent is to write procedures in tandem with the development of the panel's new case management system. A lack of written procedures can be a risk to internal controls and may prevent the panel from operating as intended or prevent panel members from providing feedback on operations.

Structure Of This Report

Chapter 2 provides statutory and background information related to the panel. It outlines statutory requirements, as well as administrative, budgetary, and staffing numbers. The chapter discusses case reporting, investigation, and referral; data collection and panel responsibilities to make case determinations and develop findings; and recommendations for system and process improvements. Chapter 2 presents one recommendation concerning funds allocated for the development of the panel's new case management system.

Chapter 3 provides a review of panel operations and focuses on the procedural changes made since LOIC's 2024 panel report was published. The chapter contains three major finding areas and one recommendation.

Chapter 2

Child Fatality And Near Fatality External Review Panel Background

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

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

Statute requires the panel to

- conduct "comprehensive reviews of child fatalities and near fatalities, reported to the Cabinet for Health and Family Services, suspected to be a result of abuse or neglect" and
- "publish an annual report … consisting of case reviews, findings, and recommendations for system and process improvements to help prevent child fatalities and near fatalities that are due to abuse and neglect."[5]

Membership

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

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

Table 2.1 reflects the panel's membership as of May 28, 2025. There are currently no vacant positions or expired terms; the previous year there were two vacant positions.[7]

Table 2.1
Membership Of The Child Fatality And Near Fatality External Review Panel
As Of May 28, 2025

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

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

Meeting Requirements

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

Statute requires that the panel meet at least quarterly.[8] The panel has exceeded this requirement in every year since its inception in 2013.[9] The panel has met monthly since July 2020 due to increased caseloads.[10] Table 3.1 in Chapter 3 provides more information.

Budget And Expenditures

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

The panel is attached to the Justice and Public Safety Cabinet for staffing and administrative purposes.[11] The panel does not have its own personnel and operating budgets, as its funding is included as part of the Office of the Secretary's baseline funding. In budget years when baseline funds were insufficient to meet the Office of the Secretary's needs, the panel's budget was also susceptible to cuts.[12]

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

According to a 2014 memorandum of understanding between the panel and the Justice and Public Safety Cabinet, the panel is required to provide its budget request during the fall prior to a budget session. The cabinet then operates as a pass-through to submit the panel's budget to the Office of State Budget Director without prioritization.[13]

The panel, through the cabinet, requested and received $420,000 annually in the 2014-2016 budget request. The 2024-2026 executive branch budget subsequently included $594,100 for FY 2025 and $592,900 for FY 2026 for the panel.

The panel, through the cabinet, requested and received $420,000 annually in the 2014-2016 budget.[14] Subsequent budgets did not include specific appropriations or allotments for the panel. Rather, the panel's expenditures for the biennia covering 2016 through 2022 were included as part of the baseline funding for the justice administration appropriation unit, under the Office of the Secretary.[15]

The panel worked with justice cabinet budget staff and submitted a budget request in the fall of 2021.[16] The 2024-2026 executive branch budget subsequently included $594,100 for FY 2025 and $592,900 for FY 2026 in the base budget of the justice administration budget for the panel.[17]

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

Table 2.2 details the panel's expenditures from FY 2015 through year-to-date FY 2025. Nearly 95 percent of the panel's expenses have been for personnel costs related to the compensation of full-time employees and contracted consultants/analysts. Operating expenses have typically been minimal and consist primarily of charges from the Commonwealth Office of Technology and, starting in FY 2023, rent for office space. Operating expenses related to food and travel have decreased since 2020 due to the panel's switch from in-person meetings to primarily virtual meetings.

Table 2.2
Kentucky Child Fatality And Near Fatality
External Review Panel Expenditures
FY 2015 To May 29, 2025

Fiscal Year	Personnel Expenditures	Operating Expenditures	Total
2015	$212,582	$6,946	$219,528
2016*	267,004	21,198	288,202
2017	213,259	56,289	269,547
2018	141,943	7,671	149,614
2019	185,345	3,611	188,955
2020	275,117	6,511	281,628
2021	245,261	2,206	247,467
2022	293,852	2,203	296,055
2023	320,547	13,269	333,816
2024	351,423	17,991	369,414
2025**	443,238	19,939	463,177
Total	$2,949,571	$157,834	$3,107,403

Notes: Expenditures for 2015 to 2025 do not sum to the total shown due to rounding. An additional $200,000 in capital outlays was allocated to the panel in 2024 for the development of a new case management system.
*An additional $7,983.75 was expended for part-time data consultants from Kentucky State University and the University of Louisville.
**Statewide accounting system data through May 29, 2025.
Source: eMARS, Expenditure Analysis Report-FAS Power BI.

Staffing

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

Panel staffing currently consists of one executive staff adviser, two social service clinicians II (case analysts), one contract pediatric forensic medical case analyst, and an administrative staff member who is shared with the Office of Drug Control Policy. Additionally, the panel has entered into an agreement with the Department for Public Health (DPH) for epidemiology services. The DPH epidemiologist assisted the panel with its 2024 annual report.[18]

Panel Funding In The 2024-2026 Budget

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

In its 2024-2026 budget request, the panel requested additional funding to hire additional full-time staff and to continue epidemiology support. The panel also requested one-time funding of $200,000 for FY 2025 for a new case management system.[19]

The 2024-2026 executive branch budget increased the panel's annual allocation to $594,100 in FY 2025 and $592,900 in FY 2026. The panel also received an additional $200,000 in FY 2025 for the procurement of a new case management system. The budget bill specified that the funds allocated to the panel for the

purchase of the case management system will lapse to the budget reserve trust fund account if not expended in FY 2025.[20] The increase in funding enabled the panel to hire an additional full-time case analyst in 2024.[21]

Case Referral

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

The panel reviews cases referred from the Department for Community Based Services and, to a lesser extent, DPH.[22] Table 2.3 details the number of cases reported by each agency. From 2019 to 2024, total referrals increased 61.03 percent.

Table 2.3
Kentucky Child Fatality And Near Fatality External Review Panel
Case Referrals By Agency
2019 To 2024

Referring Agency	2019	2020	2021	2022	2023	2024
DCBS	121	140	173	207	196	208
DPH	15	42	27	8	6	11
Total	136	182	200	215	202	219

Note: DCBS = Department for Community Based Services; DPH = Department for Public Health.
Source: Kentucky. Justice and Public Safety Cabinet. Child Fatality and Near Fatality External Review Panel: *2019 Annual Report*; *2020 Annual Report*; *2021 Annual Report*. *2022 Annual Report*; *2023 Annual Report*; *2024 Annual Report*. Web.

DCBS Referrals

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

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

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

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

KRS 72.025 and 72.405, the coroner shall "immediately" contact DCBS and law enforcement agencies for information.
Once a report is received, DCBS screens acceptance criteria for the alleged maltreatment "where the alleged perpetrator is in a caretaking role."[23] DCBS then seeks to identify a link between the alleged maltreatment and a child's fatal or near fatal condition. According to DCBS, once a link is established, "centralized intake staff will designate the intake in TWIST as a fatality/near fatality."[24]

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.[25]

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

If DCBS suspects that a child fatality occurred as a result of abuse or neglect, it investigates the case, which is ultimately referred to the panel for review. The same is true for cases involving a near fatality. However, if DCBS receives a report of abuse "other than a parent, guardian, or other person exercising control or supervision of the child," it notifies local or state law enforcement.[26]

DPH Referrals

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

DPH also refers cases to the panel from its local child fatality review teams.[27] 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.[28] Upon receipt, panel staff send the list of DPH referrals to DCBS to request available case information. According to DCBS officials, frontline staff from DCBS regional offices also participate on the local teams and provide information as needed.[29]

If DCBS is not involved with the case, panel staff may send formal requests for information to local entities requesting medical, education, law enforcement, and other records. DCBS may choose to investigate the matter as well, if it is not familiar with the circumstances surrounding a child's death.[30]

Panel Reviews

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

The panel uses information and records provided by the Cabinet for Health and Family Services to make its case determinations, as well as to support findings and recommendations for system and

process improvement. KRS 620.055(6) requires CHFS to provide the panel, within 30 days, numerous types of information and records in unredacted form. Appendix A summarizes the information to be provided to the panel.

Although statute authorizes the panel to request case records at any point, the panel has historically elected to wait until DCBS has finished its investigations before reviewing cases.[31] Panel staff stated that it is easier to obtain information and records for closed cases.[32]

The amount of time required by DCBS to complete investigations has decreased this year, but the majority of cases still require more than six months to complete. Investigations have an average completion time of eight months.

However, the significant amount of time required by DCBS to complete investigations has impeded the panel's ability to review cases in a timely manner. In its most recent annual report, the panel stated that the state-wide average length of time from receipt of a fatality/near-fatality case to completion of the investigation has decreased to eight months in FY 2024 in comparison to the average of nine months in FY 2022.[33] In FY 2023, DCBS completed 40.2 percent of its investigations in 5 months or less, 22.8 percent of its investigations in 6 to 11 months, and 28.3 percent of its investigations took a year or longer to complete.[34] The panel noted that Jefferson County staff have caseloads two to three times higher than other counties which results in longer average completion times than the rest of the state.[35] On average, Jefferson County takes four months longer than the rest of the state to complete investigations.[36]

Review Process

Panel staff use a document management and storage platform called SharePoint to upload information from CHFS to a secure online location. Staff copy information and records into separate SharePoint folders for analysts and panel members to use when reviewing cases.[37]

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

Due to the large number of records associated with each case, panel members elected to streamline the review process by having analysts provide panel members with case summaries and analysis.[38] Once CHFS uploads the case documents to SharePoint, panel analysts review the case information and document their findings and analyses into case summary and timeline templates, which are forwarded to panel members a week before each panel meeting. Each panel member is assigned four to five cases per meeting, depending on the number of cases and the number of panel members available for that month's meeting. Although each

panel member is assigned only a portion of the month's cases, all members have access to all cases.[39]

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

Analyst Binder. The panel has developed a manual called the *Analyst Binder* for analysts to reference when reviewing cases. It includes general instructions for accessing and using the two software platforms used by the panel. SharePoint provides a secure location for storing case files where they can be accessed by panel members and analysts for review. DCBS and panel staff use the Research Electronic Data Capture application (REDCap) for entering case information to provide to the panel prior to meetings and to record panel determinations after meetings.

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

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

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

The panel received $200,000 in FY 2025 for a new case management system. The panel is working with the Commonwealth Office of Technology to develop a new software system.

Updates To Panel's Software Platforms. The panel received $200,000 in FY 2025 funding for a new case management system in the 2024-2026 executive branch budget. The panel is working with the Commonwealth Office of Technology (COT) to develop a

new software system that will incorporate elements of both SharePoint and REDCap. According to panel staff, there is a formalized statement of intent with COT. Staff are meeting with COT weekly and sometimes biweekly to work on the new system. The new case management system is not expected to be finished by the end of FY 2025.[40]

Panel staff expressed concern that it would not be able to access all appropriated funds because the project would extend past FY 2025.[41] The budget language associated with the case management system allocation states, "Notwithstanding KRS 45.229, any portion of General Fund not expended for this purpose shall lapse to the Budget Reserve Trust Fund Account (KRS 48.705)." LOIC staff also interpreted this language to mean the panel would lose access to unspent funds on July 1, 2025, due to the budget period ending.[42]

Despite budgetary language suggesting the case management system funding would end in FY 2025, Justice and Public Safety Cabinet staff provided guidance on how the panel could continue accessing the dollars.

LOIC staff interviewed budget staff with the Justice and Public Safety Cabinet to determine how the panel could continue with the case management system update into FY 2026 without losing funding. Budget staff indicated that unused funds would be available after the end of the fiscal year through a capital funds budget account.[43]

Recommendation 2.1

Kentucky Child Fatality and Near Fatality External Review Panel staff should consult with the budget staff of the Justice and Public Safety Cabinet regarding how to use funds appropriated for the new case management system beyond FY 2025. If further clarity is needed regarding use of the appropriated funds, panel staff should contact the budget director of the Justice and Public Safety Cabinet.

Annual Reports And Recommendations

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

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

- Categorization

- Family characteristics
- Other qualifiers
- Panel determination

The panel's 2024 annual report summarizes 219 cases reviewed from the previous fiscal year—July 1, 2022, through June 30, 2023. The 219 cases represented 70 fatalities and 149 near fatalities. DPH referred 11 fatality cases to the panel.[44] Table 2.4 shows the number of cases reviewed by the panel from the last six years.

Table 2.4
Cases And Recommendations
From Child Fatality And Near Fatality External Review Panel Reports
2019 To 2024

Action	2019	2020	2021	2022	2023	2024
Total cases reviewed	136	182	200	215	202	219
Fatalities reviewed	54	85	80	69	68	70
Near fatalities reviewed	82	97	120	146	134	149
Findings	32	6	20	14	25	9
Recommendations	32	6	22	21	25	11

Source: Kentucky. Justice and Public Safety Cabinet. Child Fatality and Near Fatality External Review Panel: *2019 Annual Report*; *2020 Annual Report*; *2021 Annual Report*. *2022 Annual Report*; *2023 Annual Report*; *2024 Annual Report*. Web.

Agency Responses To Recommendations

KRS 620.055 requires the panel to send recommendations to agencies. Of the 11 recommendations forwarded to agencies on February 1, 2025, 9 received an agency response within the 90-day deadline.

KRS 620.055 requires the panel to send recommendations to the agency responsible for implementing the recommendations, and requires the agency to respond within 90 days of receipt with an explanation of implementation or why it will not implement the recommendation. The panel's 2024 annual report included 11 recommendations, which were forwarded to recipient agencies by February 1, 2025, the report's publication date.[45] A majority of recommendations received agency responses within 90 days as required by statute with 9 out of 11 recommendations receiving a response.[46]

Chapter 3

Review Of Panel Operations

The review of operations produced three major finding areas and one recommendation.

This evaluation of the Kentucky Child Fatality and Near Fatality External Review Panel focused on procedural changes made since LOIC's 2024 panel report was published and produced three major finding areas and one recommendation.

The Panel Has Acted On LOIC's 2024 Recommendations

The panel has acted on two of the three recommendations in LOIC's 2024 report.

On July 11, 2024, the Legislative Oversight and Investigations Committee adopted three recommendations and one matter for legislative consideration related to the following areas:

- Matter for Legislative Consideration 3.A: Development of procedures for filling the vacancy of a voting member of the panel when it cannot be filled as mandated by KRS 520.055(2).
- Recommendation 3.1: Delineation of the 90-day response deadline by which agencies are required to respond to panel recommendations.
- Recommendation 3.2: Updating the panel's agency notification letter to improve response rates and quality.
- Recommendation 3.3: Development of written procedures to document the processes by which the panel obtains, stores, reviews, and analyzes cases; develops findings and recommendations; develops annual reports; and complies with the reporting requirements mandated by KRS 620.055(10).[47]

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

Recommendations From LOIC's 2024 Panel Update

The panel has updated its notification letter to indicate required response elements and to clearly state the date of the 90-day response deadline by which agencies are expected to respond.

Two of the 2024 recommendations were tied to notification letters from the panel. The first recommendation was to establish an official deadline for responses, while the second was to implement more formal response templating. The goals of the recommendations were to improve responsiveness of agencies and to improve clarity of intended actions. Both recommendations were implemented through an updated notification letter. The two recommendations are provided in italics.

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

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

Panel staff have updated their notification letter to clearly delineate the 90-day response deadline by which a response from the receiving agency is required. Each notification letter mailed to agencies on January 31, 2025, clearly states, "Please respond by close of business Monday, May 5, 2025" and provides a mailing address and an email address.

Panel staff also updated their notification letter format to clearly indicate required elements of an agency response per KRS 620.055(10). Check boxes are now provided for agencies to indicate whether they agree or disagree with the recommendation. Spaces are provided for agencies to respond to one of two prompts. The first is labeled, "If you agree to implement the recommendation, please briefly explain how the recommendation will be implemented and approximate time frame below," while the second is labeled, "If you do not agree to implement the recommendation, please provide a detailed explanation of why the recommendation cannot be implemented."[48]

Panel staff have not developed written procedures because they anticipate changes associated with the new case management system

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

The development of written procedures is still in progress as of the publishing of this report. Panel staff stated that their intent is to write policies in tandem with the deployment of their new case management system which is currently in development with the Commonwealth Office of Technology and that doing so will allow for the written procedures to reflect operation of the new system. The continuing issues with a lack of written procedures is discussed in more detail in the section on internal controls.

Statutory Compliance

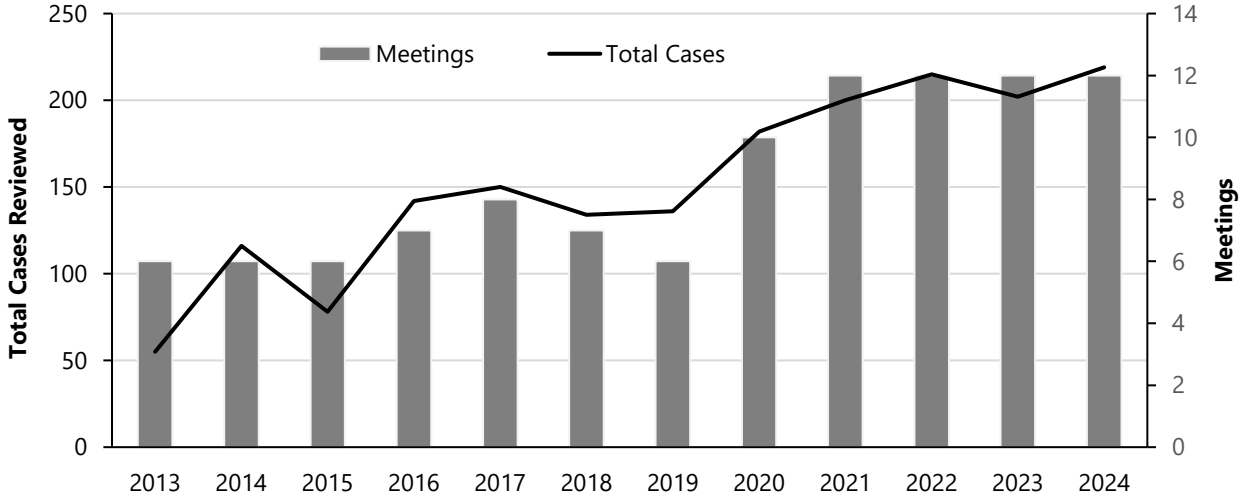
The panel is in compliance with its statutory requirements outlined in KRS 620.055 related to meeting frequency, reporting, and notification. However, not all agencies are responding to the panel's recommendations as envisioned by statute.

Meeting Frequency Exceeds Requirements

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

KRS 620.055(4) requires the panel to meet at least quarterly. The panel has exceeded this requirement since its inception in 2013.[49] Due to increasing caseloads, the panel began meeting monthly starting in July 2020.[50] The panel has 12 meetings scheduled for calendar year 2025.[51] Figure 3.A shows that the increase in meetings has corresponded with an increase in total cases. Reviewed cases increased 298 percent, from 55 in 2013 to 219 in 2024.[52]

Figure 3.A
Child Fatality And Near Fatality External Review Panel
Number Of Annual Meetings And Case Reviews
2013 To 2024



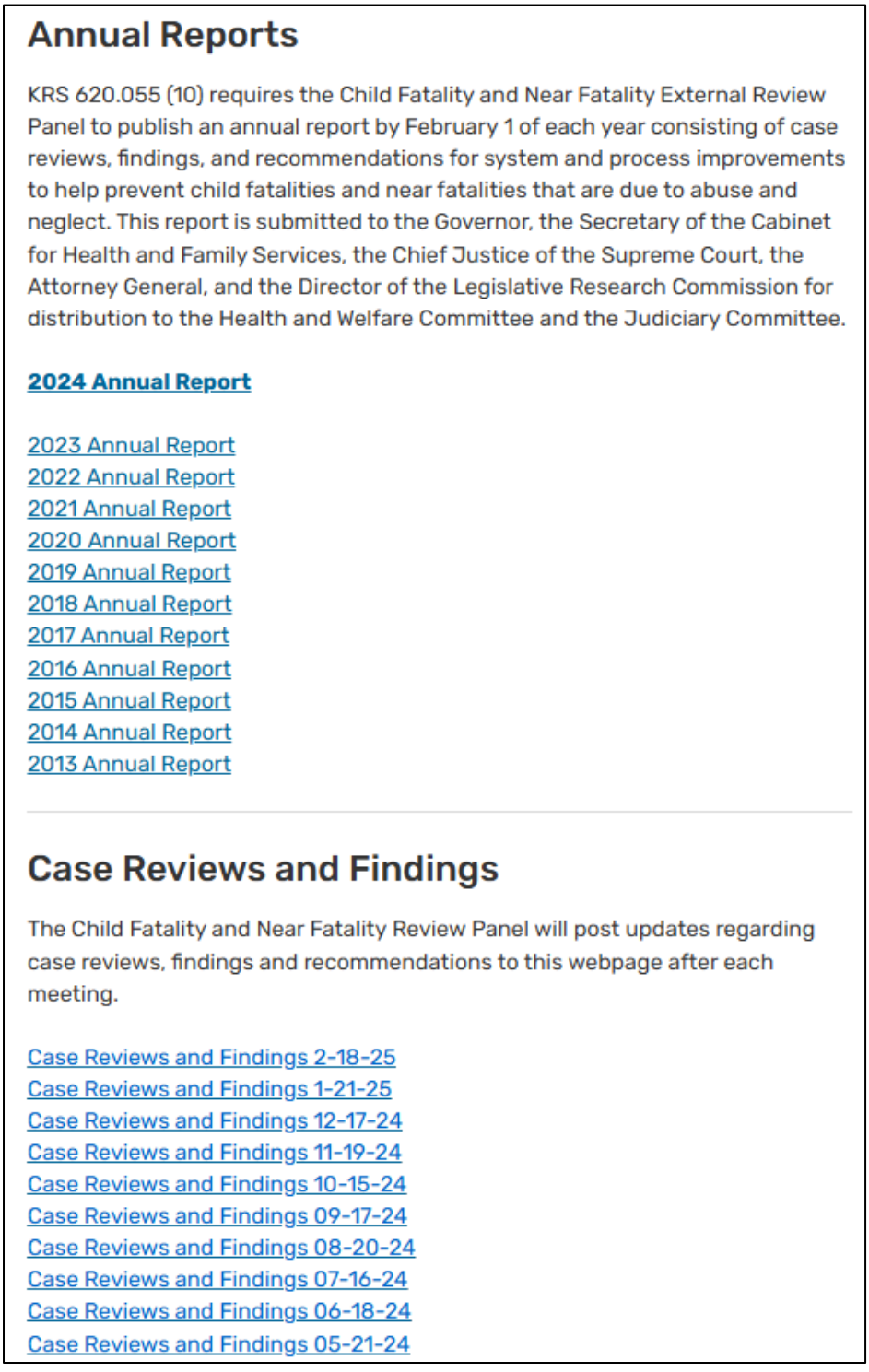
Source: Kentucky. Justice and Public Safety Cabinet. Child Fatality and Near Fatality External Review Panel: *2013 Annual Report*; *2014 Annual Report*; *2015 Annual Report*; *2016 Annual Report*; *2017 Annual Report*; *2018 Annual Report*; *2019 Annual Report*; *2020 Annual Report*; *2021 Annual Report*. *2022 Annual Report*; *2023 Annual Report*; *2024 Annual Report*. Web.

Panel Publicly Posts Required Information

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

KRS 620.055(8) requires the panel to post updates on the Justice and Public Safety Cabinet's website after each meeting. The updates must include case reviews, findings, and recommendations. The panel posts case reviews and findings to the cabinet's website following each monthly meeting. Although not required by statute, the panel also posts the minutes for its monthly meetings to the cabinet's website. The panel does not post its recommendations in a dedicated space on the website, but the panel's annual reports—which include the panel's recommendations—are posted to the website, fulfilling the requirement.[53] Figure 3.B demonstrates how the panel posts its required updates. The same page includes links to panel minutes.

Figure 3.B
Child Fatality And Near Fatality External Review Panel Website
Examples Of Annual Reports, Case Reviews, And Findings
April 29, 2025



Annual Reports

KRS 620.055 (10) requires the Child Fatality and Near Fatality External Review Panel to publish an annual report by February 1 of each year consisting of case reviews, findings, and recommendations for system and process improvements to help prevent child fatalities and near fatalities that are due to abuse and neglect. This report is submitted to the Governor, the Secretary of the Cabinet for Health and Family Services, the Chief Justice of the Supreme Court, the Attorney General, and the Director of the Legislative Research Commission for distribution to the Health and Welfare Committee and the Judiciary Committee.

2024 Annual Report

2023 Annual Report
2022 Annual Report
2021 Annual Report
2020 Annual Report
2019 Annual Report
2018 Annual Report
2017 Annual Report
2016 Annual Report
2015 Annual Report
2014 Annual Report
2013 Annual Report

Case Reviews and Findings

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

Case Reviews and Findings 2-18-25
Case Reviews and Findings 1-21-25
Case Reviews and Findings 12-17-24
Case Reviews and Findings 11-19-24
Case Reviews and Findings 10-15-24
Case Reviews and Findings 09-17-24
Case Reviews and Findings 08-20-24
Case Reviews and Findings 07-16-24
Case Reviews and Findings 06-18-24
Case Reviews and Findings 05-21-24

Source: Kentucky. Justice and Public Safety Cabinet. Child Fatality and Near Fatality External Review Panel. “Reports,” n.d. Web.

Summary Reports Are Appropriately Delivered

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

The panel is complying with KRS 620.055(9), which requires it to report a summary of its discussions, along with any proposed or actual recommendations, to the Interim Joint Committee on Families and Children monthly or at the request of the committee co-chair. The panel sends its meeting minutes—which include discussions of any proposed or actual recommendations—via email to the co-chairs and committee staff administrator of the Interim Joint Committee on Families and Children on a monthly basis.[54] Additionally, the co-chairs of that committee are current ex officio nonvoting panel members and receive updates during panel meetings.[55]

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

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

KRS 620.055(10)(a) requires the panel to publish an annual report by February 1 of each year consisting of case reviews, findings, and recommendations for system and process improvements to help prevent child fatalities and near fatalities that are due to abuse and neglect. Statute requires that the panel submit the annual reports to

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

The panel sent copies of its 2024 annual report to the parties specified by statute on January 31, 2025, thus fulfilling the requirements of the statute.[56] The report, along with all prior annual reports, is also posted to the Justice and Public Safety Cabinet website.[57]

All recommendations in the panel's 2024 report were actionable and targeted, and all addressed the concerns expressed within their corresponding findings.

Findings And Recommendations. In 2021, LOIC staff found that the findings in the panel's reports from 2014 to 2020 were often unsupported by evidence that could be identified within the report. Staff also found that recommendations in panel reports often failed to target a specific entity and did not address the concerns expressed within associated findings.[58] The panel's findings and recommendations have since been updated for clarity and accuracy.[59] All nine findings in the panel's 2024 report are

supported by evidence, data, or analysis identified within the report. Additionally, all 11 of the panel's recommendations were actionable and targeted, and all addressed the concerns expressed within their corresponding findings. Appendix B provides an overview of the findings and recommendations in the panel's 2024 report.

The panel's 2024 report addressed 11 recommendations to 6 state entities. As of May 23, 2025, four agencies had responded in writing. These responses represent 9 of the 11 recommendations.

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

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

The panel fulfilled its statutory notification requirement by mailing letters dated January 31 to the 6 state entities and their subdivisions responsible for implementing the 11 recommendations in the panel's 2024 report. The following agencies received notifications:

- Cabinet for Health and Family Services
    - Department for Behavioral Health, Developmental and Intellectual Disabilities
    - Department for Community Based Services
    - Department for Public Health
        - Division of Maternal and Child Health
    - Kentucky Office of Medical Cannabis
- Governor's Office
- Kentucky Department of Education
- Kentucky Hospital Association
- Kentucky Legislative Research Commission
- Office of the Attorney General
    - Child Abuse and Neglect Prevention Board[60]

Table 3.1 details the agency responses received as of May 14, 2025. Of the six agencies required to respond to the panel's recommendations, four responded in writing, addressing 9 of the 11 recommendations (82 percent) in the panel's 2024 report.

Statute requires agencies to respond within 90 days of receipt. In response to Recommendation 3.1 from LOIC's 2024 report on the panel, panel staff updated their notification letter to clearly delineate the 90-day response deadline by which a response from the receiving agency is required. Each notification letter mailed to agencies clearly stated that the response deadline was close of business on Monday, May 5, 2025.[61] All of the responding agencies responded within the 90-day window. The Kentucky Hospital Association and the Kentucky Legislative Research Commission did not provide written responses by the deadline.[62]

Table 3.1
Kentucky Child Fatality And Near Fatality External Review Panel
Responses To Recommendations By Agency
2024 Annual Report

Agency	Panel Recommendation	Response	Responded Within 90 Days	Intent To Implement
Cabinet for Health and Family Services	The Cabinet for Health and Family Services, including representatives from the Department for Behavioral Health, Developmental and Intellectual Disabilities; the Department for Public Health; and the Kentucky Office of Medical Cannabis should convene a workgroup to create a standardized safe storage guideline for all providers and the public.	Yes	Yes	Yes
Child Abuse and Neglect Prevention Board	The Child Abuse and Neglect Prevention Board should work collaboratively with community partners to fund and raise awareness regarding safe storage practices of firearms.	Yes	Yes	Yes
Department for Community Based Services	The department should educate staff on the need to request comprehensive drug screens for caretakers, especially if the child had a positive response to Naloxone.	Yes	Yes	Yes
Department for Community Based Services	The department should create a Practice Guidance Specific to Safe Storage of Medication available within SOP 2.11.	Yes	Yes	Yes
Department for Community Based Services	The department should examine and document existing practice involving use of virtual contacts by CPS staff (investigative, ongoing, foster care, etc.), to include use of phone, Zoom, or virtual formats. This examination should be included in all levels of the Continuous Quality Improvement (CQI) and the Case Review Process. Based on findings from the CQI reviews, amended SOP and/or practice guidelines should be issued to the field by January 2026.	Yes	Yes	Yes
Department for Public Health	The department should conduct an aggressive public safety campaign targeting proper medication safe storage, and saturating these critical tools throughout Kentucky communities. The campaign should also encourage the use of fentanyl and xylazine testing strips and Naloxone in pediatric ingestions.	Yes	Yes	Unclear*
Kentucky Department of Behavioral Health, Developmental and Intellectual Disabilities/ Kentucky Department for Public Health, Division of Maternal and Child Health	The two departments should convene a workgroup to identify the resources required to fully implement the Psychological Autopsy throughout the state. The goal of the workgroup should be to implement pilot projects in order to further identify the barriers for implementation (i.e. statutory authority, staffing, funding, etc.).	Yes	Yes	Yes

Agency	Panel Recommendation	Response	Responded Within 90 Days	Intent To Implement
Kentucky Department of Education	The department should coordinate a presentation with the panel regarding best practice standards for addressing truancy issues, and the use of virtual school or other non-traditional instructional formats, especially with high- risk children.	Yes	Yes	Yes
Kentucky Governor's Office	The Kentucky Governor's Office should convene a task force with the goal of developing and implementing a robust Plan of Safe Care to address the needs of substance exposed infants and their caregivers across the commonwealth. The task force should consist of House and Senate members, Executive Branch personnel, External Child Fatality and Near Fatality Review Panel members, and community stakeholders.	Yes	Yes	Unclear**
Kentucky Hospital Association	The association should encourage all hospitals to conduct comprehensive UDS, inclusive of synthetic opiates, when a child has a positive response to Naloxone.	No	N/A	N/A
Kentucky Legislative Research Commission	The Kentucky General Assembly, through the Judiciary Committee, should explore model legislative strategies to encourage and support safe storage of firearms. Recommended options for explorations include: 1) Child-Access Prevention and Safe Storage Laws, 2) funding for evidence-based preventions education, and 3) provision of gun locks with every firearm sold to give responsible gun owners the tools to securely store weapons.	No	N/A	N/A

Note: CHFS = Cabinet for Health and Family Services; DPH = Department for Public Health; UDS = Urine Drug Screen; SOP = Standard Operating Procedures; CPS = Child Protective Services; DBHDID = Department of Behavioral Health, Developmental and Intellectual Disabilities.
* While CHFS agreed to implement the first part of the recommendation, the agency disagreed with the last sentence pertaining to testing strips and naloxone but did not clearly state its declination to implement it.
** The Governor's Office responded, citing its response to an identical recommendation from the panel's 2023 report in which they asked the panel for more information concerning its recommendation but did not indicate intent to implement. It is unclear whether the Governor's Office intends to implement the panel's latest iteration of the recommendation.
Source: Staff analysis of information in the Kentucky Child Fatality and Near Fatality External Review Panel's *2024 Annual Report* and agency responses.

Failure Of Agencies To Meet Response Requirements

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

Agency notification and response requirements have existed for three of the panel's reports; for all three reports, agencies have not consistently fulfilled statutory requirements to adequately respond to the panel's recommendations. Only 48 percent of recommendations from the panel's 2022 report received appropriate agency responses by the deadline. Only 36 percent

of recommendations from the panel's 2023 report received a required agency response by the deadline. In addition, the 2023 recommendations that did receive responses often did not include statutorily required elements such as a clear statement of intent to implement the recommendation, a timeline for implementation, or a clear refusal to implement the recommendation with an explanation of why the agency does not intend to do so. Of the nine recommendations that received responses, only three received responses that included all elements required by statute. One of these recommendations received responses from two agencies, both of which were compliant.

In response to Recommendation 3.2 from LOIC's 2023 review of the panel, the panel updated their notification letter format to include all elements necessary to clearly indicate what is required to be included in each agency response per KRS 620.055(10). Check boxes are now provided for agencies to indicate whether they agree or disagree with the recommendation. Two spaces are also provided for agencies to provide their response to one of two prompts as shown in Figure 3.C.

Of the nine recommendations that received responses from agencies in 2024, four responses from three agencies did not provide a clear timeline of implementation. These agencies were the Cabinet for Health and Family Services, the Office of the Attorney General's Child Abuse Neglect Prevention Board, and Kentucky Department of Education. Some responses stated that the recommendation had already been implemented which is considered to satisfy the timeline requirement for the purposes of this report.

An additional two responses did not provide a clear indication of whether or not the agency intended to implement the recommendation at all. The Governor's Office responded, citing its response to an identical recommendation from the panel's 2023 report in which they asked the panel for more information concerning its recommendation but did not indicate intent to implement.[63] CHFS's response on behalf of the Department of Public Health also did not provide a clear indication of intent to implement due to a disagreement about recommendation phrasing.[64]

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

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

Date: January 31, 2025

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

Dear Secretary Friedlander:

Enclosed herein, please find the 2024 Annual Report of the Child Fatality and Near Fatality External Review Panel.

In accordance with KRS 620.055(10), the Panel is required to determine which agency is responsible for implementing each recommendation within this report. The agency that receives a recommendation shall respond to the Panel in ninety (90) days with a written notice of intent to implement, including how the recommendation will be implemented, and an approximate time frame ***or*** provide a detailed explanation of why the recommendation cannot be implemented. Recommendations pertaining to the Cabinet for Health and Family Services may be found on pages 5, 13, and 18.

Each recommendation is listed on the attached forms. Please mark the appropriate checkboxes regarding the recommendations to your agency and provide the additional required information on the enclosed forms.

Please respond by *close of business Monday, May 5, 2025,* to:
Elisha Mahoney
elisha.mahoney@ky.gov
Justice & Public Safety
125 Holmes Street, 2nd Floor
Frankfort, KY 40601

If you have any questions regarding the report, please let us know. We look forward to your response.

Sincerely,

Hon. Benjamin Harrison

Hon. Benjamin Harrison
Chair, Child Fatality & Near Fatality External Review Panel

CC: Commissioner, Lesa Dennis
Commissioner, Steven J. Stack
Commissioner, Katherine Marks
Encl

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

Panel Recommendation:

The Cabinet for Health and Family Services, including representatives from the Department for Behavioral Health, Developmental and Intellectual Disabilities, the Department for Public Health, and the Kentucky Office of Medical Cannabis should convene a workgroup to create a standardized safe storage guideline for all providers and the public.

☐ **Agree with implementation**

☐ **Do not agree with implementation**

If you agree to implement the recommendation, please briefly explain how the recommendation will be implemented and approximate time frame below:

If you do not agree to implement the recommendation, please provide a detailed explanation of why the recommendation cannot be implemented:

CC: Commissioner, Lesa Dennis
Commissioner, Steven J. Stack
Commissioner, Katherine Marks
Encl

Source: Elisha Mahoney, executive staff adviser, Child Fatality and Near Fatality External Review Panel. Email to Jacob Blevins, March 6, 2025. Attachment: *Annual Report Letters.*

Internal Controls

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

The panel has wide discretion in developing its standard operating procedures. The panel set out to develop procedures for its operations soon after its inception and has since developed standard operating procedures related to its meetings; case referral, storage, and review; and annual reports and recommendations.[65] However, these procedures have not been formalized into written standard operating procedures.[66]

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

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

Written, formal procedures can serve as internal controls for an entity. Internal controls address the risks related to achieving objectives.[67] *Risks* are any possibility that an event will occur and adversely affect the achievement of objectives.[68] The benefits of developing and maintaining written procedures include

- establishing and communicating the components of internal control execution to staff,
- retaining organizational knowledge and mitigating the risks associated with having organizational knowledge limited to a few personnel, and
- communicating organization knowledge as needed to external parties, such as external auditors.[69]

LOIC staff identified several areas during its 2024 review where the panel might benefit from having written policies and procedures, including

- procedures related to follow-ups with agencies that do not respond to panel recommendations in a timely manner,
- procedures related to follow-ups with agencies that do not clearly indicate whether they will implement a recommendation or how they plan to implement a recommendation, and
- onboarding of new staff or panel members.

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

Recommendation 3.3 from LOIC's 2024 review stated:

Panel staff should develop written procedures for review and approval by the panel chair and members. The written procedures should document the processes by which the panel obtains, stores, reviews, and analyzes cases; develops findings and recommendations; develops annual reports; and complies with the reporting requirements mandated by KRS 620.055(10).[70]

According to panel staff, the development of written procedures is still in progress. Panel staff stated that their intent is to write procedures in tandem with the development of the panel's new case management system, which is also currently in development through the Commonwealth Office of Technology. Panel staff also expressed concern that formally writing procedures would directly outline how the panel should operate. LOIC staff clarified that the recommendation is intended to apply to the administrative side of panel functions and not to how panel members conduct their analysis.[71] Given that members are appointed for their expertise, it is reasonable for panel members to have flexibility in operations.

However, the issues with a lack of procedures still remain. Without procedures, new staff do not have a resource to internalize standard operations of the panel. Written procedures also inform panel members of staff operations and allow panel members to provide feedback. Given the value of procedures and the requirement in KRS 6.922 to review procedures of the panel, a modified version of last year's recommendation has been issued.

Recommendation 3.1

Recommendation 3.1

Panel staff should develop written procedures for review and approval by the panel chair and members. The written procedures should document the administrative processes by which panel staff obtain, store, review, and analyze cases; assist with developing findings and recommendations; assist with developing annual reports; and comply with the reporting requirements mandated by KRS 620.055(10). Activities of the panel members should be left to the discretion of the panel chair and members.

Appendix A

Records Provided To Panel By Department For Community Based Services

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

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

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

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

(d) All records of services provided by the Department for Juvenile Justice regarding the deceased or injured child and his or her caregivers, residents of the home, and persons involved with the child at the time of the incident;

(e) Autopsy reports;

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

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

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

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

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

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

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

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

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

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

Appendix B

2024 Panel Report Findings And Recommendations

Table B.1 contains the findings and associated recommendations, grouped by subject area, from the Kentucky Child Fatality and Near Fatality External Review Panel's *2024 Annual Report*. As discussed in Chapter 3, all recommendations were supported by data and/or analysis. Multiple recommendations can be associated with a single finding.

Table B.1
2024 Panel Report Findings And Recommendations

Subject Area	Finding	Corresponding Recommendation
Overdose/Ingestion cases	(P. 3) Pediatric overdose/ingestion continues to rise at an alarming rate in cases reviewed by the Panel, from 16% of all cases reviewed in SFY19 to 35% in SFY23. Even more concerning, the rate of fatal pediatric ingestions has tripled in the last five years. (See Figure 1) Every fatal overdose/ingestion case reviewed by the Panel in SFY23 involved a child four years old or younger. Sadly, the Panel found 80% of those fatal ingestion cases were potentially preventable… Prior DCBS history was found in 74% of all overdose/ingestion cases reviewed by the Panel; this means DCBS was involved or received a report about the family prior to the fatal or near event.	(P. 5) The Cabinet for Health and Family Services, including representatives from the Department for Behavioral Health, Developmental and Intellectual Disabilities, the Department for Public Health, and the Kentucky Office of Medical Cannabis should convene a workgroup to create a standardized safe storage guideline for all providers and the public.
Overdose/Ingestion cases	(P. 4) Given the increasing rates of fatal fentanyl ingestions in young children, caregivers, bystanders, and first responders should be strongly encouraged to utilize Naloxone whenever an accidental ingestion is suspected... A new and emerging substance the Panel has recently started tracking is xylazine, which was found in 5% of the overdose ingestion cases... Substance abuse in the home was found in over 80% of the cases reviewed by the Panel. It is imperative to recognize the risks of a child living in an environment with a caregiver struggling with substance misuse issues. Caregivers in treatment for opioid use disorders should be educated on the importance of using Naloxone	• (P. 5) The Department for Public Health should conduct an aggressive public safety campaign targeting proper medication safe storage, and saturating these critical tools throughout Kentucky communities. The campaign should also encourage the use of fentanyl and xylazine testing strips and Naloxone in pediatric ingestions. • (P. 5) The Department for Community Based Services should educate staff on the need to request comprehensive drug screens for caretakers, especially if the child had a positive response to Naloxone.

Subject Area	Finding	Corresponding Recommendation
	when an ingestion by a child is suspected, and be provided access to fentanyl and xylazine testing strips...	
Overdose/Ingestion cases	(P. 4)Considering the surge of fentanyl in Kentucky, Child Protective Services (CPS) frontline staff and medical providers need additional training and encouragement to specifically request comprehensive drug screening that includes synthetic opioids. Similar conclusions were recently found in a study which noted the increase in opioid overdose in pediatric patients demands that all emergency physicians have an acute awareness and consider the unique features of an opioid overdose in a child. In addition, the study found early treatment may reverse the devasting consequences of an opioid ingestion in children.	(P. 5) The Kentucky Hospital Association should encourage all hospitals to conduct comprehensive UDS, inclusive of synthetic opiates, when a child has a positive response to Naloxone.
Overdose/Ingestion cases	(P. 3-5) Pediatric overdose/ingestion continues to rise at an alarming rate in cases reviewed by the Panel, from 16% of all cases reviewed in SFY19 to 35% in SFY23. Even more concerning, the rate of fatal pediatric ingestions has tripled in the last five years. (See Figure 1) Every fatal overdose/ingestion case reviewed by the Panel in SFY23 involved a child four years old or younger. Sadly, the Panel found 80% of those fatal ingestion cases were potentially preventable... Prior DCBS history was found in 74% of all overdose/ingestion cases reviewed by the Panel; this means DCBS was involved or received a report about the family prior to the fatal or near event.	(P. 5) The Department for Community Based Services should create a Practice Guidance Specific to Safe Storage of Medication available within SOP 2.11.
Plan of Safe Care	(P. 6-8) Holistically addressing the needs of the Substance Exposed Infant (SEI), and those infants diagnosed with Neonatal Abstinence Syndrome (NAS) or Neonatal Opioid Withdrawal Syndrome (NOWS), is an ongoing area of need in every region of the state. The Panel has repeatedly made recommendations aimed at enhancing the capacity to implement the Plan of Safe Care (POSC) as a tool to wrap services around SEIs, their parents, and caregivers. We again find ourselves facing another year in which the number of SEI cases have increased. See Figure 4. Year after year, the Panel has documented	(P. 9) The Panel recommends the Governor's Office convene a task force with the goal of developing and implementing a robust Plan of Safe Care to address the needs of substance exposed infants and their caregivers across the Commonwealth. The task force should consist of House and Senate members, Executive Branch personnel, External Child Fatality and Near Fatality Review Panel members, and community stakeholders.

Subject Area	Finding	Corresponding Recommendation
	these children are at significant risk of serious maltreatment. In SFY23, 17 of the 44 children identified as SEIs were fatality cases. Regrettably, and for another year, there has been no measurable progress in the Commonwealth's capacity to address this complex issue... In SFY 2023, the Panel identified 17 SEI cases lacking evidence of a coordinated POSC, representing over a third (36.9%) of all cases. This number is likely an underestimate.	
Department of Community Based Services	(P. 13) As previously documented in Figure 8, Phone/Virtual contacts has been a newly tracked concern noted by the Panel in SFY23. DCBS SOP 2.11, clearly states the social service worker is to conduct unannounced face-to-face interviews with all household members; including the alleged victim, other children in the home, and all adults living in the home. In 2021, DCBS updated their face-to-face service provision to ensure ongoing monthly home visits were occurring face-to-face and in-person. However, it was noted as a concern and outside of policy in several cases reviewed by the Panel.	(P. 13) The Department for Community Based Services should examine and document existing practice involving use of virtual contacts by CPS staff (investigative, ongoing, foster care, etc.), to include use of phone, Zoom, or virtual formats. This examination should be included in all levels of the Continuous Quality Improvement (CQI) and the Case Review Process. Based on findings from the CQI reviews, amended SOP and/or practice guidelines should be issued to the field by January 2026.
Child-access prevention laws	(P. 14) A critical area of similarity surrounds the presence of neglect related to unsafe storage of firearms. This risk factor was noted in 58% of the firearm incidents. Nine (75%) of the firearm cases were noted by the Panel to be potentially preventable. The premise behind this data is obvious, these tragedies can be prevented by increased safe storage practices (unload it, lock it, store it).	• (P. 15) The Kentucky General Assembly, through the Judiciary Committee, should explore model legislative strategies to encourage and support safe storage of firearms. Recommended options for explorations include: 1) Child-Access Prevention and Safe Storage Laws, 2) funding for evidence-based prevention education, and 3) provision of gun locks with every firearm sold to give responsible gunowners the tools to securely store weapons. • (P. 15) The Child Abuse and Neglect Prevention Board should work collaboratively with community partners to fund and raise awareness regarding safe storage practices of firearms.
Youth suicides	(P. 16, 17) An examination of characteristics identified within the Panel youth suicide cases provides some insight into the circumstances surrounding these tragic incidents. See Figure 16. Prior mental health issues were identified in all	(P. 18) The Kentucky Department of Behavioral Health, Developmental, and Intellectual Disabilities and the Kentucky Department for Public Health, Division of Maternal and Child Health should convene a workgroup to identify the resources required to fully implement the

Subject Area	Finding	Corresponding Recommendation
	cases. DCBS history was noted in nine of the cases, while educational issues (truancy, home school/virtual learning, behavioral issues, etc.) was found in eight cases... The Panel has recommended use of the psychological autopsy in Kentucky for several years, most recently directing this recommendation to the Cabinet for Health and Family Services, Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID). To date, there has been no discernable action taken toward the implementation of this recommendation.	Psychological Autopsy throughout the state. The goal of the workgroup should be to implement pilot projects in order to further identify the barriers for implementation (i.e. statutory authority, staffing, funding, etc.)
Educational issues	(P. 19, 20) When examining educational issues as a family characteristic in the overall context of all cases reviewed by the Panel, it was noted to be a concern in around 19% of the SFY 23 Panel cases... As shown in Figure 18, truancy occurs at two to three times the rate of all other possible concerns. During the 2024 session, the General Assembly implemented HB 611 which requires any student who misses 15 unexcused days to go before a judge... For example, when examining suicide cases reviewed by the Panel, 80% of those cases had an educational issue. Children with mental health issues and medically fragile children also had higher rates of educational issues, at 42.9%. These children were often enrolled in what the Panel refers to as virtual school.	(P. 20) The Kentucky Department for Education should coordinate a presentation with the Panel regarding best practice standards for addressing truancy issues, and the use of virtual school or other non-traditional instructional formats, especially with high-risk children.

Note: SEI = substance-exposed infant; NAS = neonatal abstinence syndrome; DCBS = Department for Community Based Services; CPS = Child Protective Services; DBHDID = Department for Behavioral Health, Developmental and Intellectual Disabilities; UDS = Urine Drug Screenings; NOWS = Neonatal Opioid Withdrawal Syndrome; POSC = Plan of Safe Care; CQI = Continuous Quality Improvement.
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