



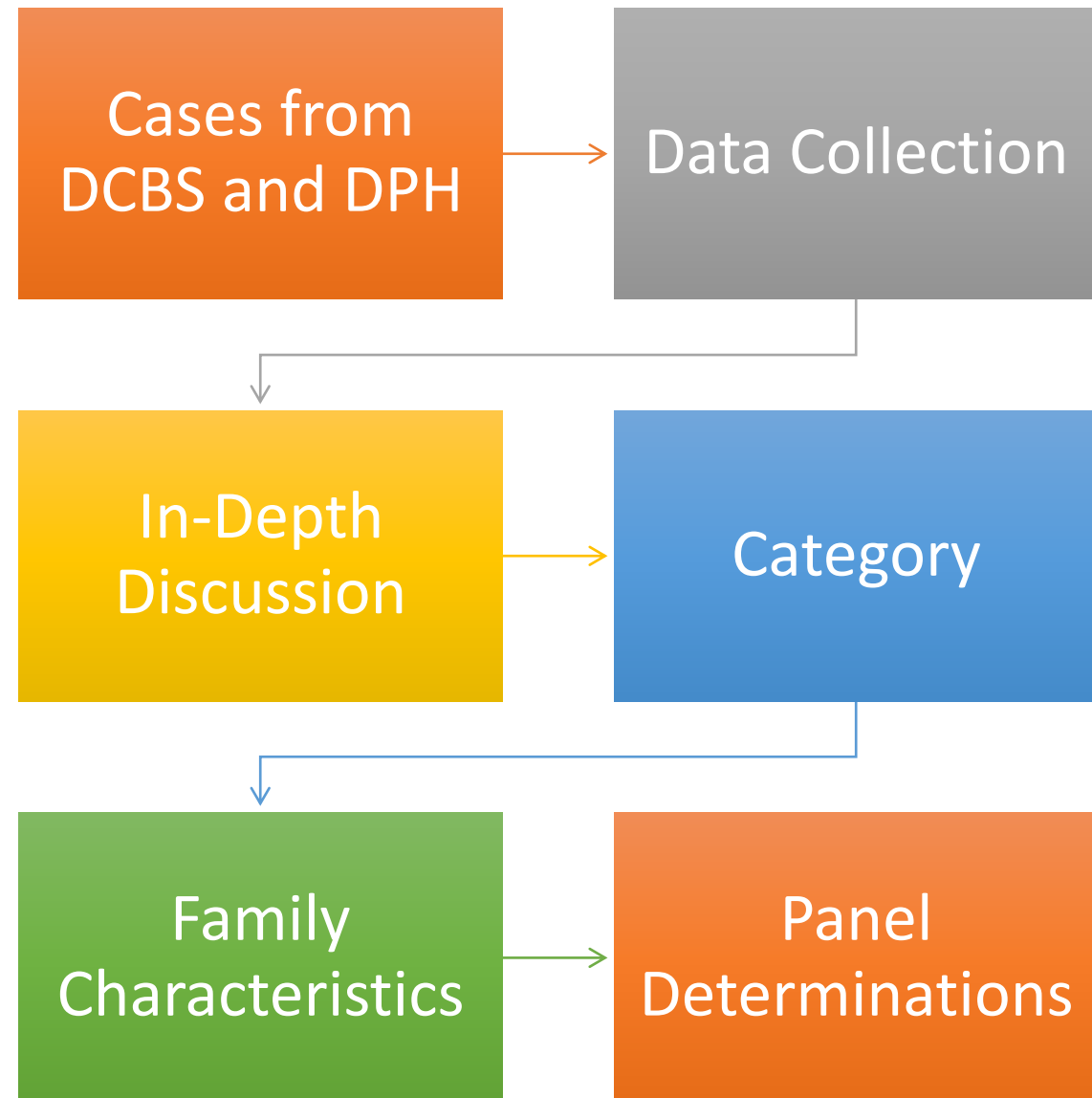
Child Fatality and Near Fatality External Review Panel

2024 Annual Report

Panel Members

- Chair - Hon. Benjamin Harrison, Lewis County Attorney
- Commissioner, DCBS – Lesa Dennis
- Commissioner, DPH - Dr. Henrietta Bada, proxy
- Family Court Judge - Hon. Libby Messer
- UK School of Medicine - Dr. Christina Howard
- UofL School of Medicine - Dr. Melissa Currie
- State Medical Examiner - Dr. William Ralston
- Court Appointed Special Advocate – Victoria Benge
- Kentucky State Police - Det. Jason Merlo
- Prevent Child Abuse Ky – Dr. Jaime Pittenger Kirtley
- Ky Coalition Against Domestic Violence – Olivia Spradlin
- Community Mental Health Centers- Steve Shannon
- Citizen Foster Care Review Board - Dr. Elizabeth Salt
- State Child Fatality Review Team - Janice Bright, RN
- President KY Coroner's Association - Mark Hammond, Boyd Co.
- Practicing Addiction Counselor – Geoff Wilson
- Kentucky House of Representatives – Samara Heavrin
- Kentucky Senate – Danny Carroll
- Practicing Prosecutor – Hon. Olivia McCollum
- Practicing Social Work Clinician – Nicole Smith Abbott
- Family Resource and Youth Service Center – Heather McCarty
- Practicing Medication-Assisted Treatment – Dr. Danielle Anderson

Panel Process



Annual Report

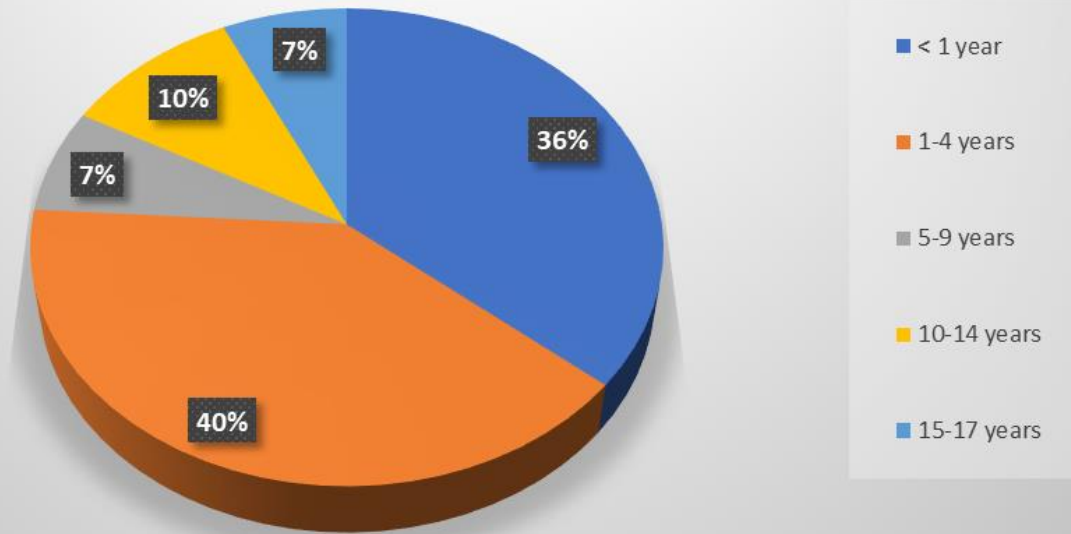
- Case Reviews
- Findings
- Recommendations



Findings

Children four years or younger are at the highest risk for maltreatment.

AGE OF CHILD VICTIM IN ALL CASES REVIEWED:
SFY 2023 n= 219



Data Source: Child Fatality and Near Fatality External Review Panel Data

Key Findings

- The most commonly found family characteristics in SFY23 included:
 1. Financial Issues (73%)
 2. DCBS Issues (68%)
 3. DCBS History (67%)
 4. Substance Abuse (in home) (54%)
 5. Substance Abuse (caregiver) (52%)
 6. Environmental neglect (51%)
- 95% of all Overdose/ingestion cases involved environmental neglect (unsafe access).
- 80% of all Suicide cases involved an educational issue.
- 50% of all cases with a Panel Determination of Neglect (medical) involved a medically fragile child.
- 56% of Abuse Head Trauma cases involved a caregiver with a mental health issue.
- 50% of all Physical abuse cases involved a caregiver with a history of domestic violence.

Trends

Overdose/Ingestion Categorization
FY 2015 - 2023

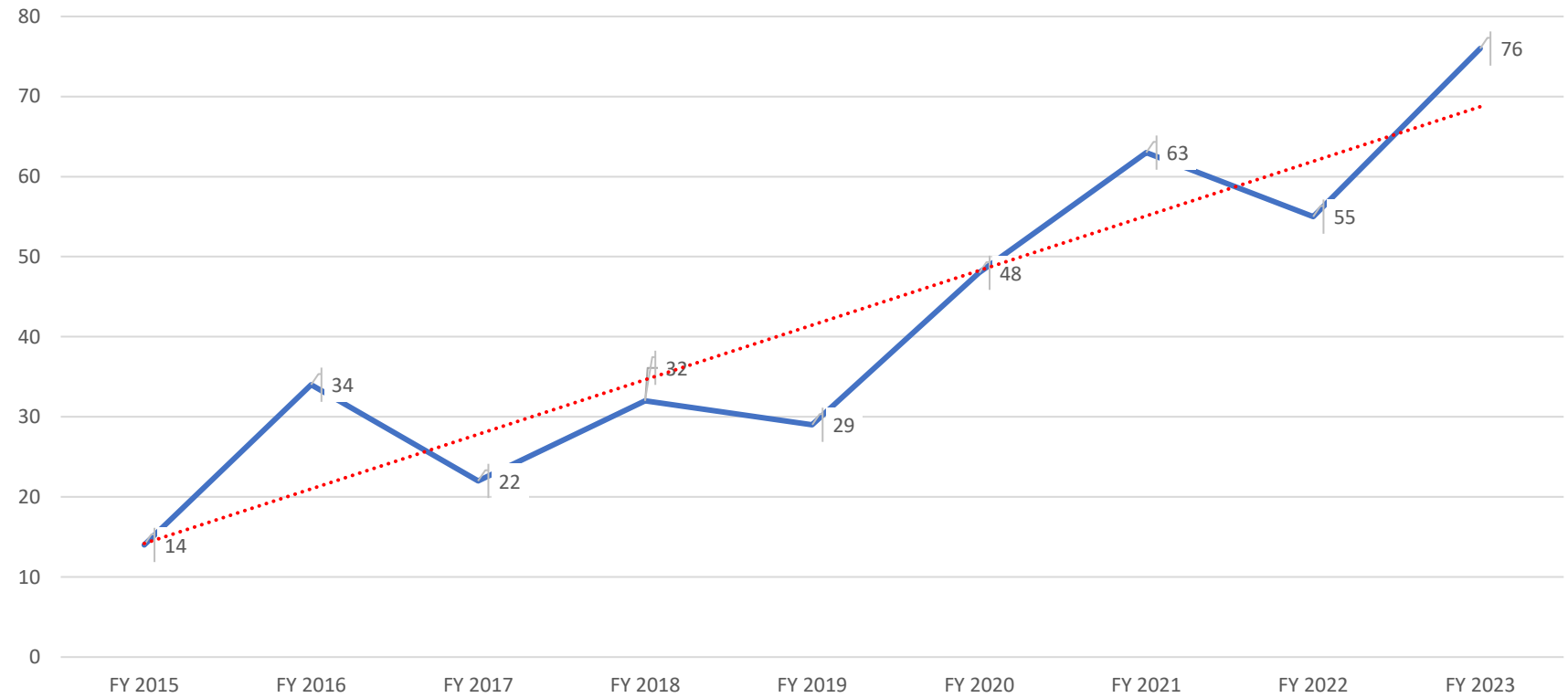
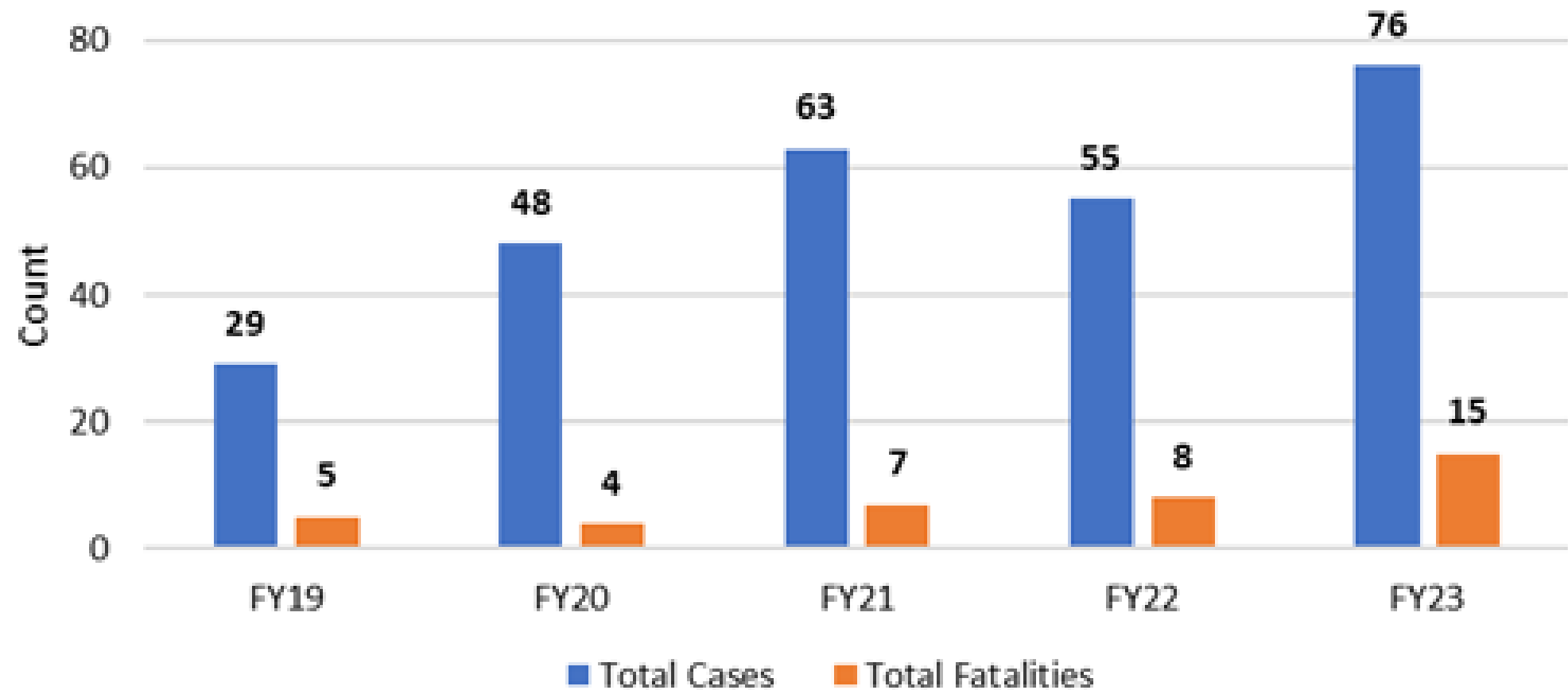
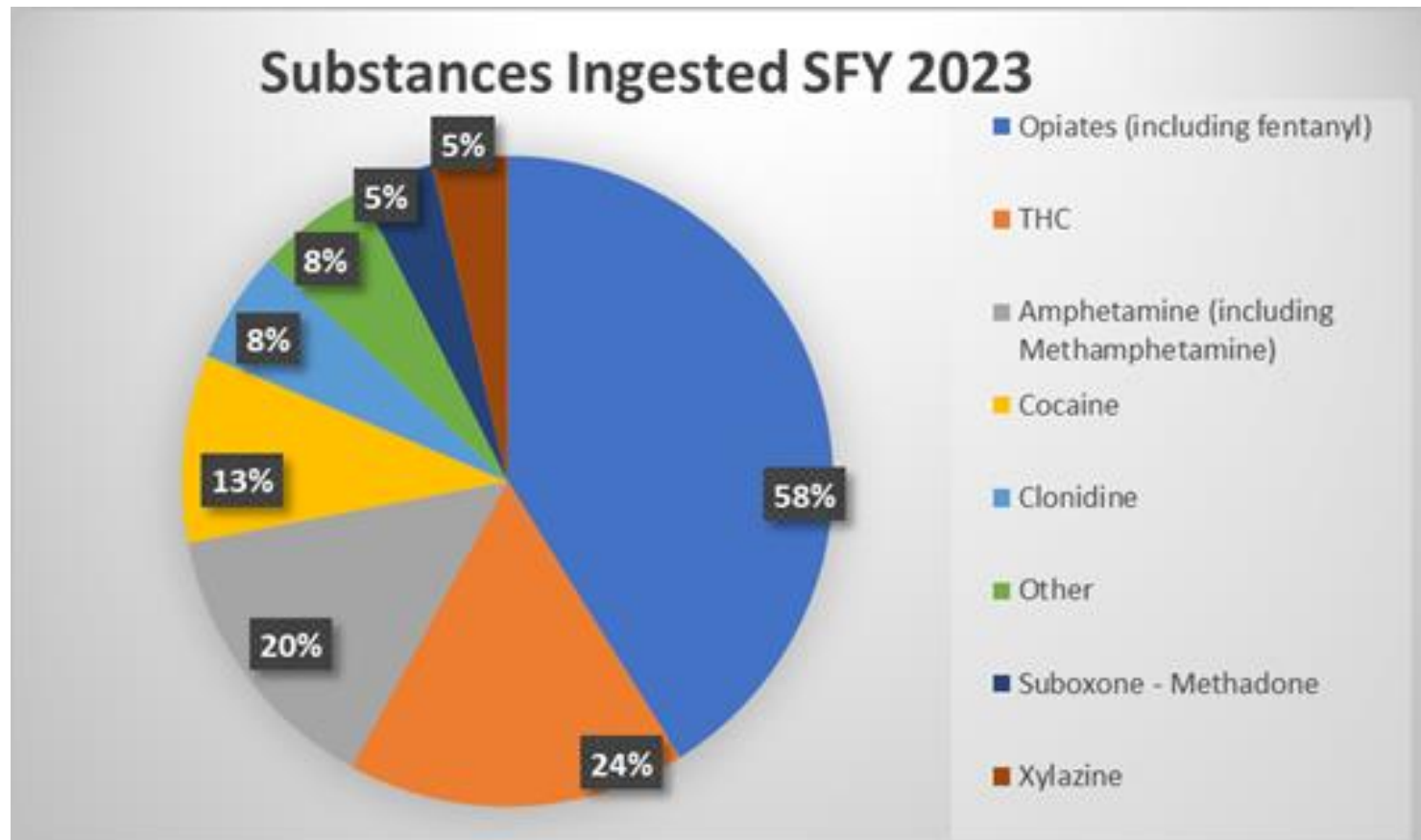


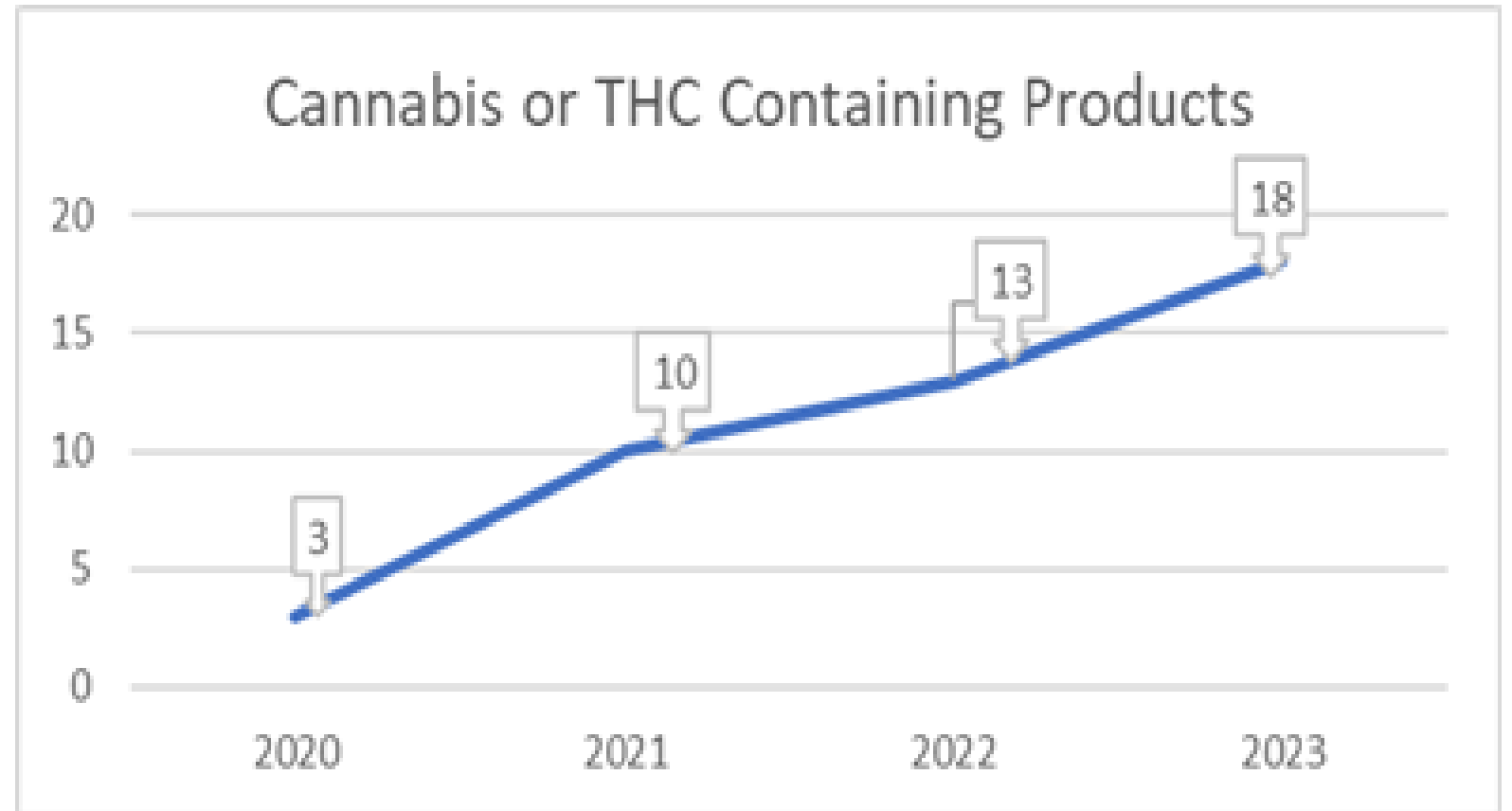
Figure 1. Overdose/Ingestion Cases



Types of Substances Ingested



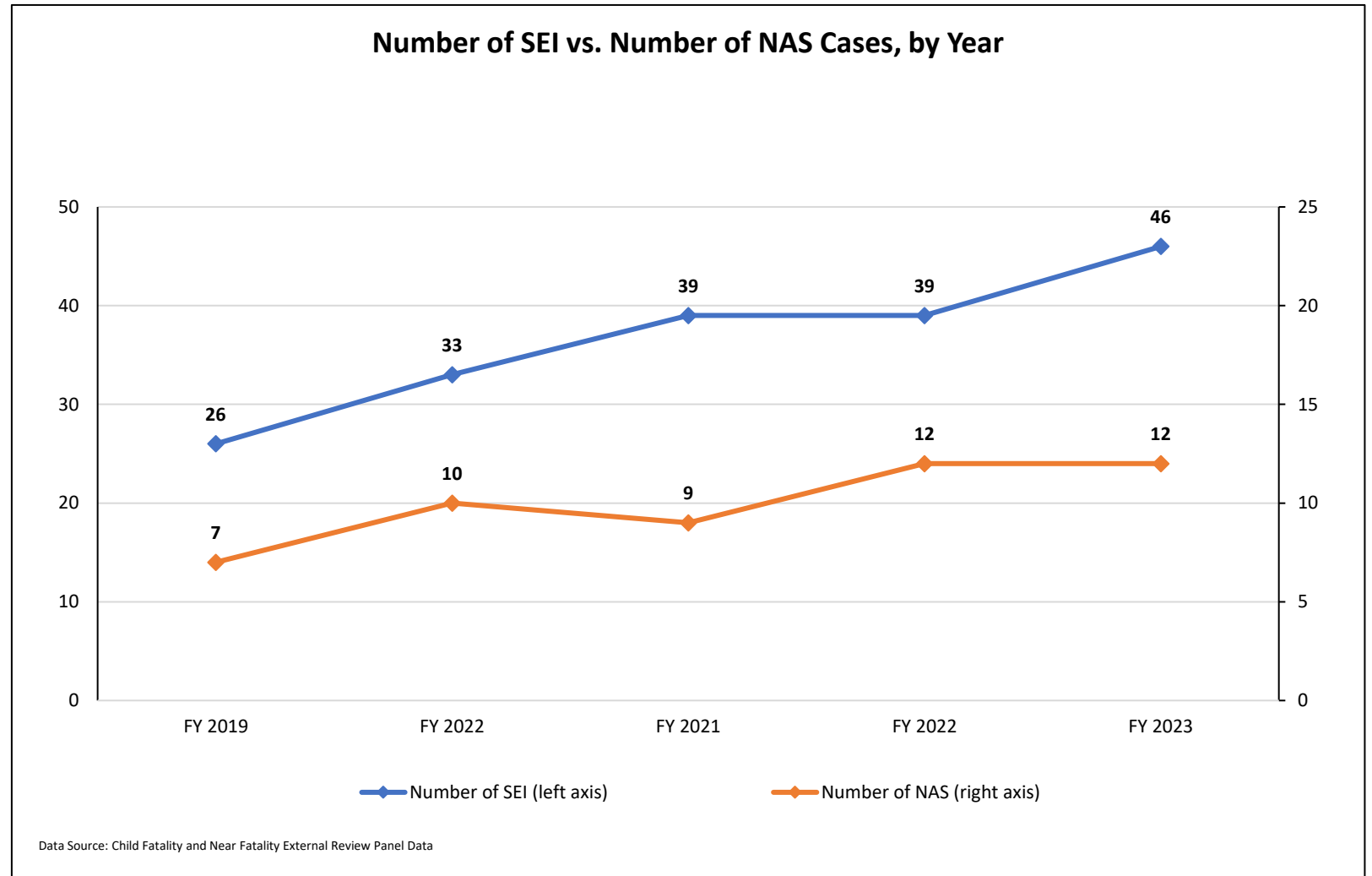
Trends



-
- An open aluminum carrying case for the ECG-1000. The case is open, revealing the internal compartments. The top compartment contains a black carrying case for the ECG-1000, which is shown in its closed position. The bottom compartment contains the ECG-1000 device, which is a small, rectangular, black device with a yellow and black striped strap. The device is shown in its open position, revealing the internal components. The case has a silver-colored metal frame and a black interior lining. The handle is made of silver-colored metal. The case is shown from a slightly elevated angle, highlighting its compact and portable design.

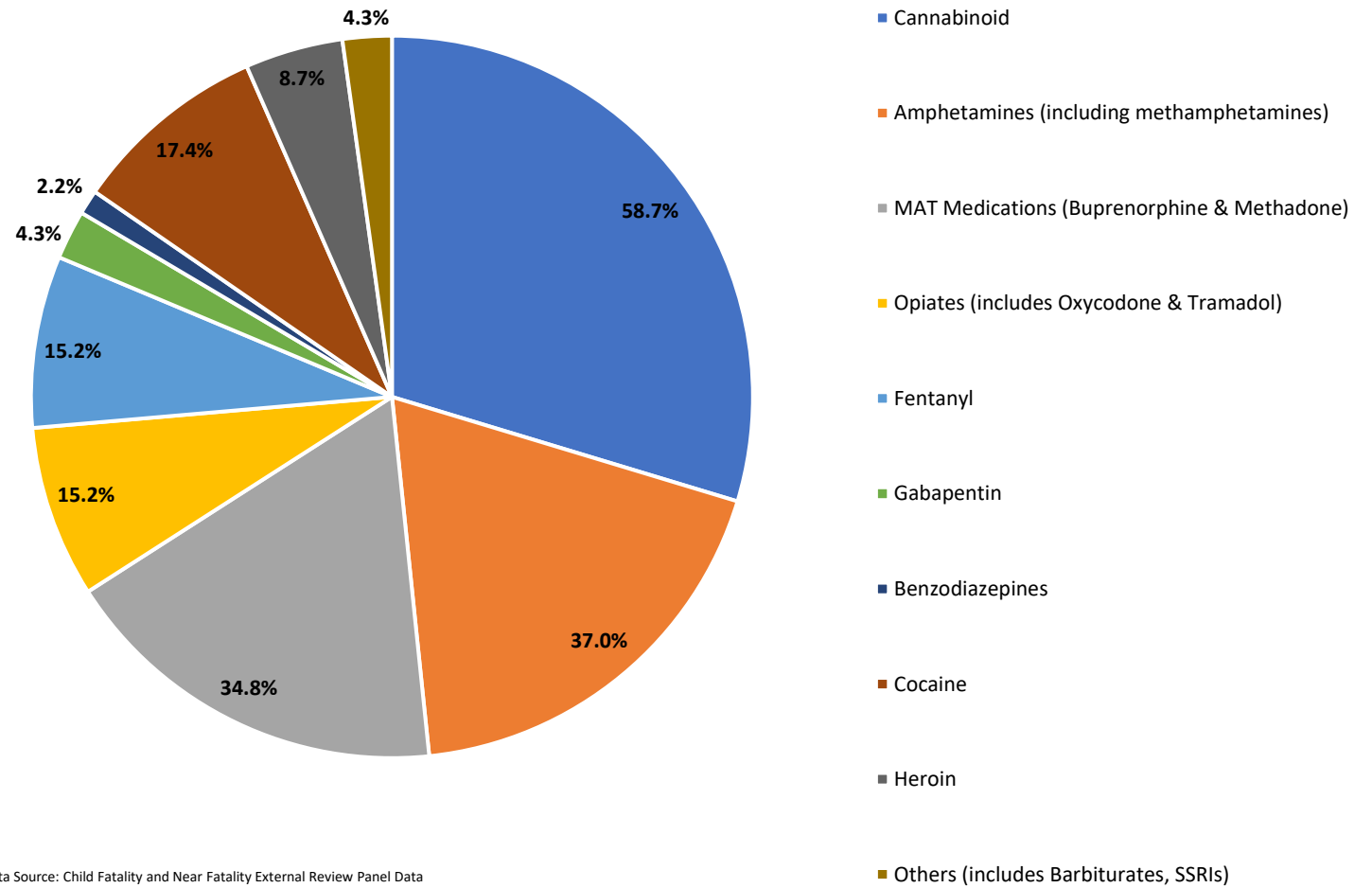


Plan of Safe Care



Plan of Safe Care

In Utero Drug Exposure Type FY 2023

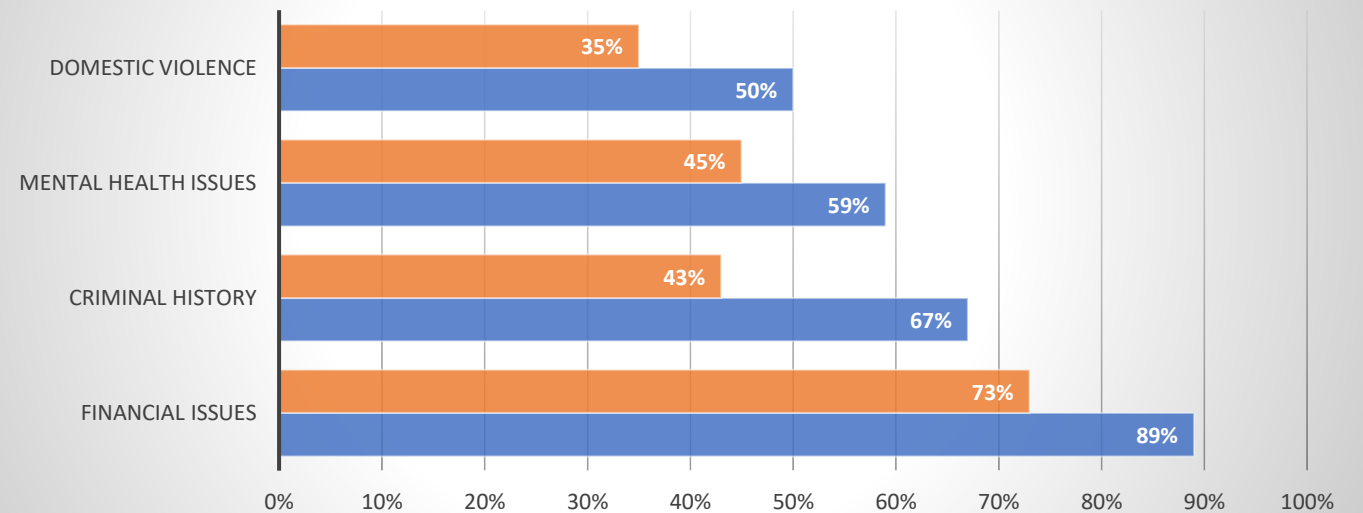


Plan of Safe Care

Co-occurring Case Characteristics

SEI Cases Compared to All Panel Cases

SFY 2023



Data Source: Child Fatality and Near Fatality External Review Panel Data

■ All Panel Cases %

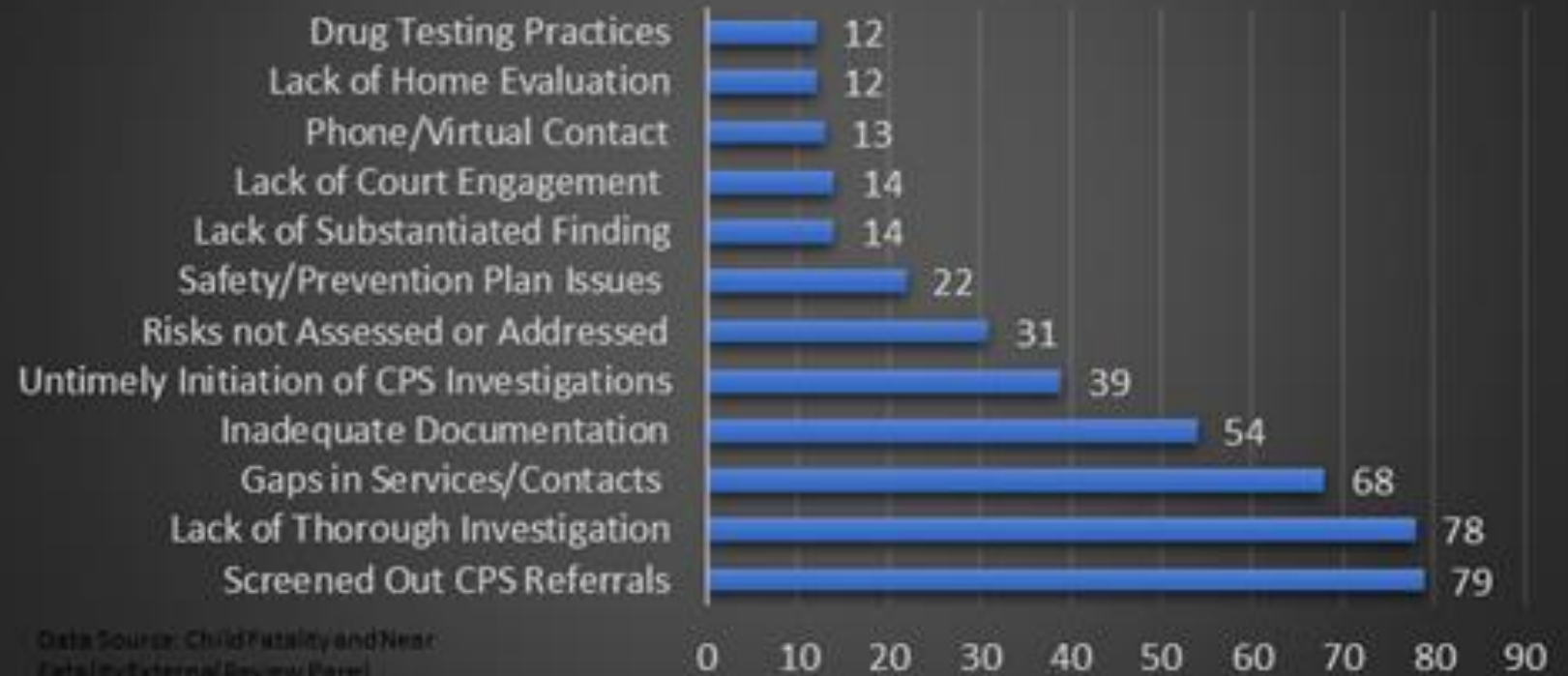
■ SEI Case %

Plan of Safe Care Recommendation

The 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, Child Fatality and Near Fatality External Review Panel members, and community stakeholders.

Department
for
Community
Based
Services

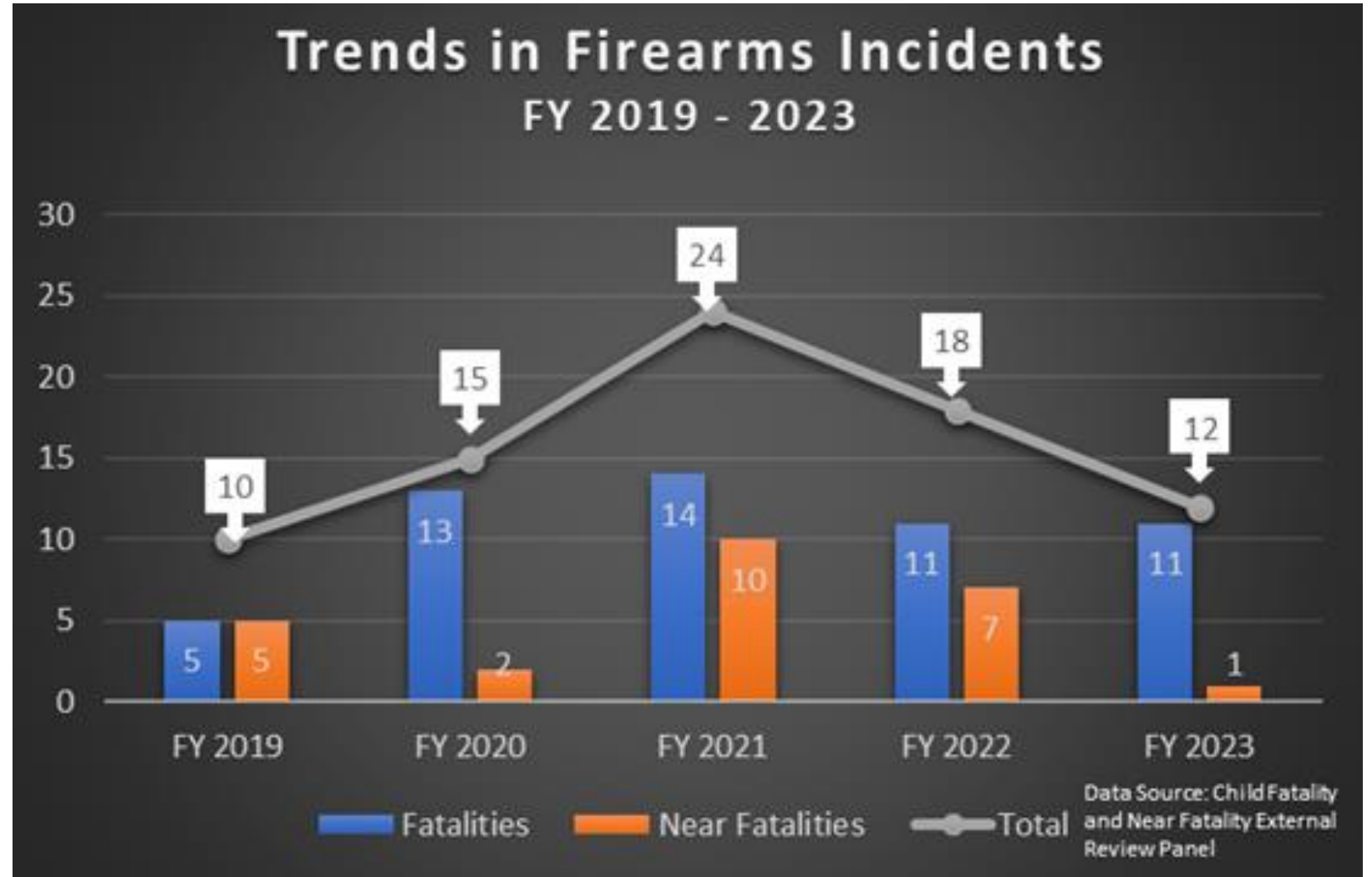
DCBS Issues: Incidence SFY 2023



DCBS Recommendation

The Department for Community Based Services should examine and document existing practice involving the 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 issues to the field by January 2026.

Trends

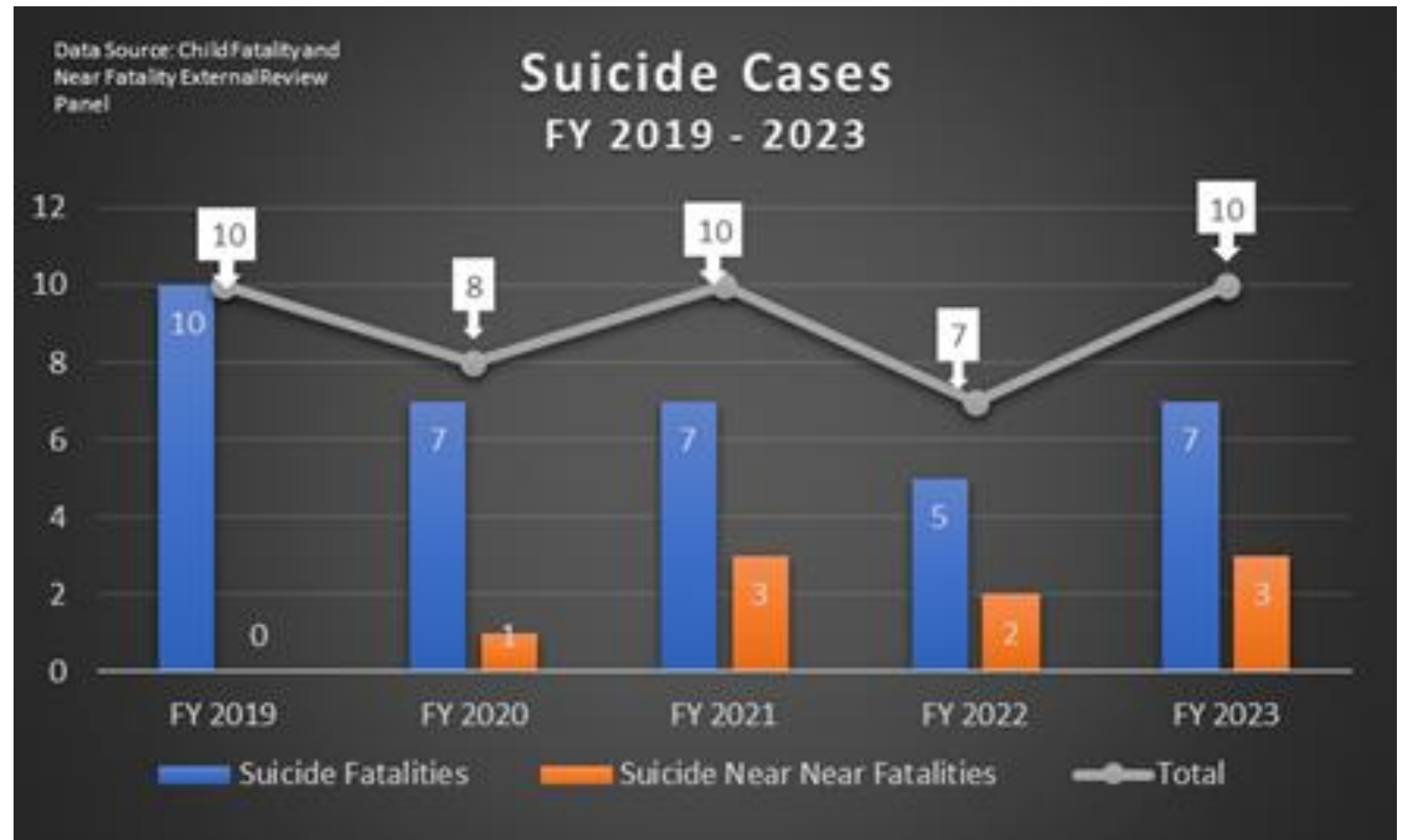


Child-Access Prevention Laws

The Kentucky General Assembly, through the Judiciary Committee, should explore model legislative strategies to encourage and support safe storage of firearms. Recommended options for exploration 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 firearms.

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

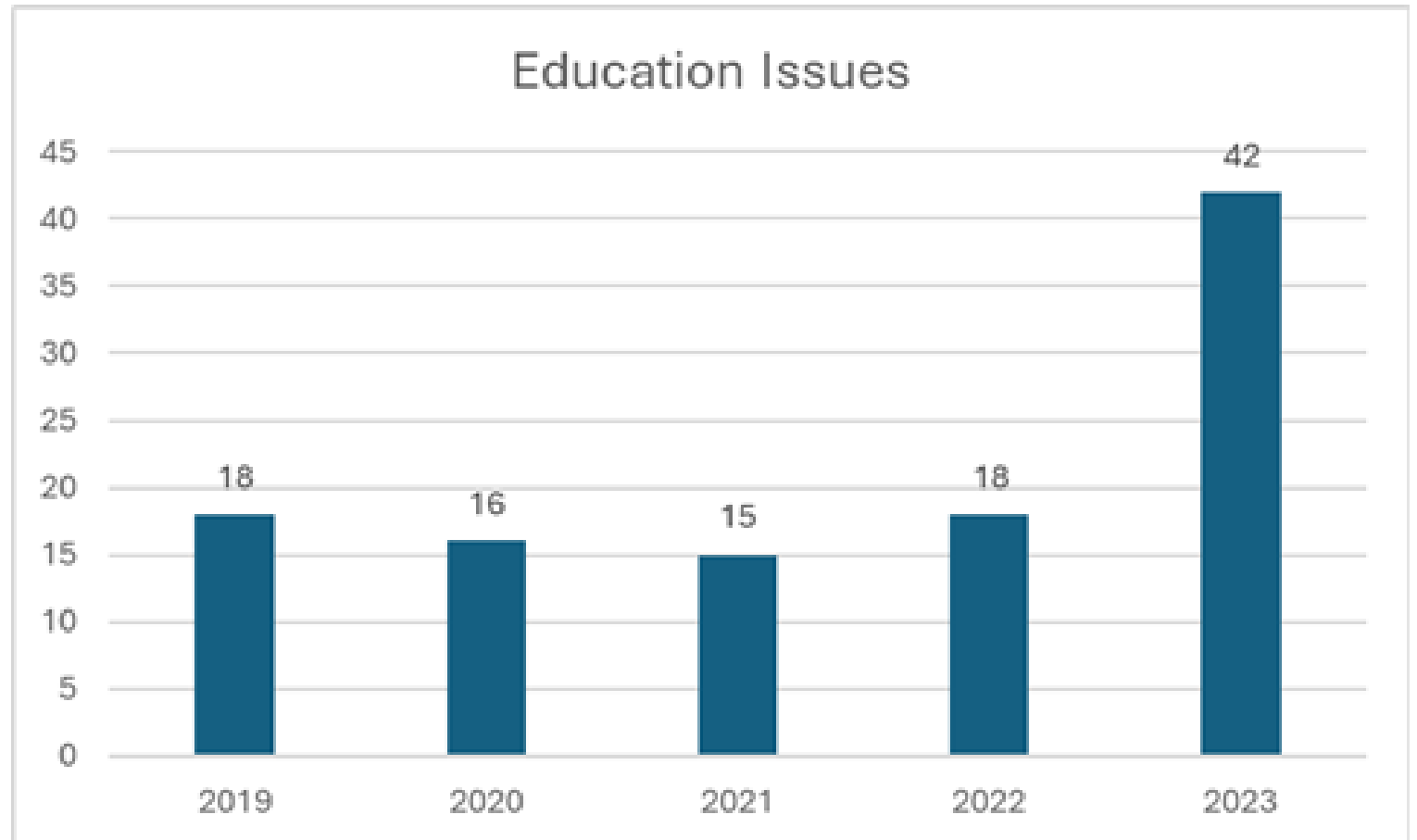




Youth Suicide Recommendation

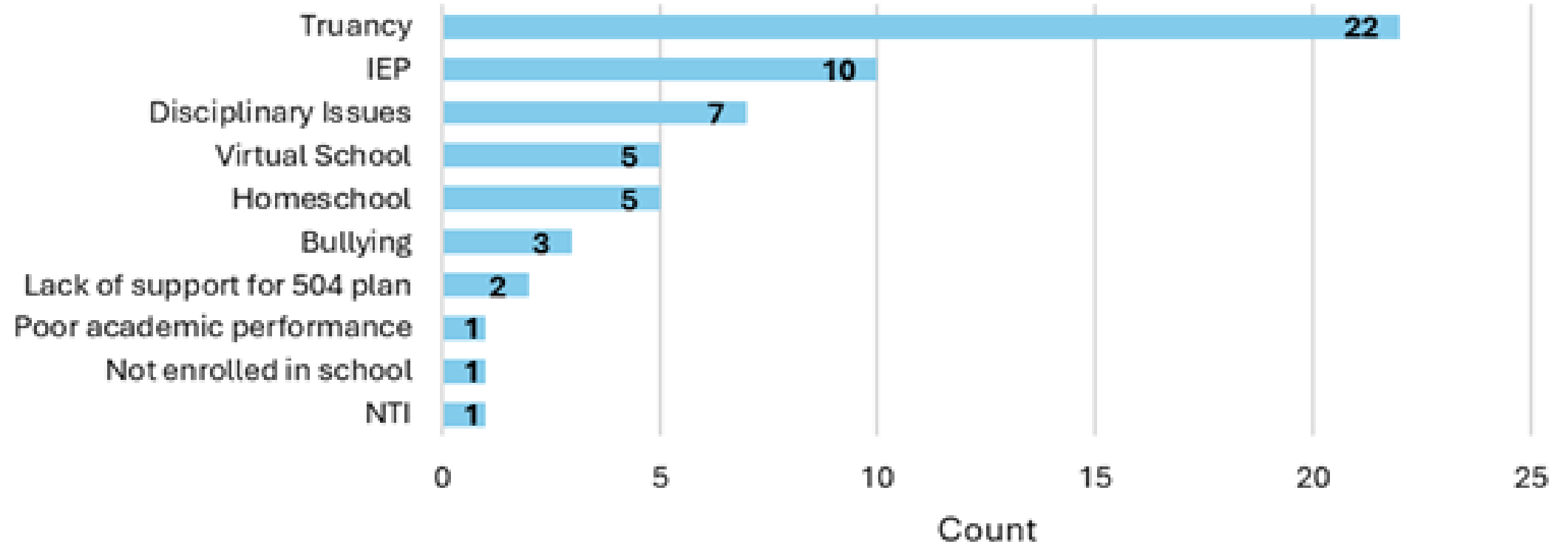
The Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) and the Kentucky Department for Public Health should convene a workgroup to identify the resources required to fully implement the Psychological Autopsy throughout the state.

Educational Issues



Education Issues, SFY23

n=42



Data Source: Child Fatality and Near Fatality External Review Panel

Education Recommendation

- The Kentucky Department of 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 regarding high-risk children.

Questions

Thank you!

