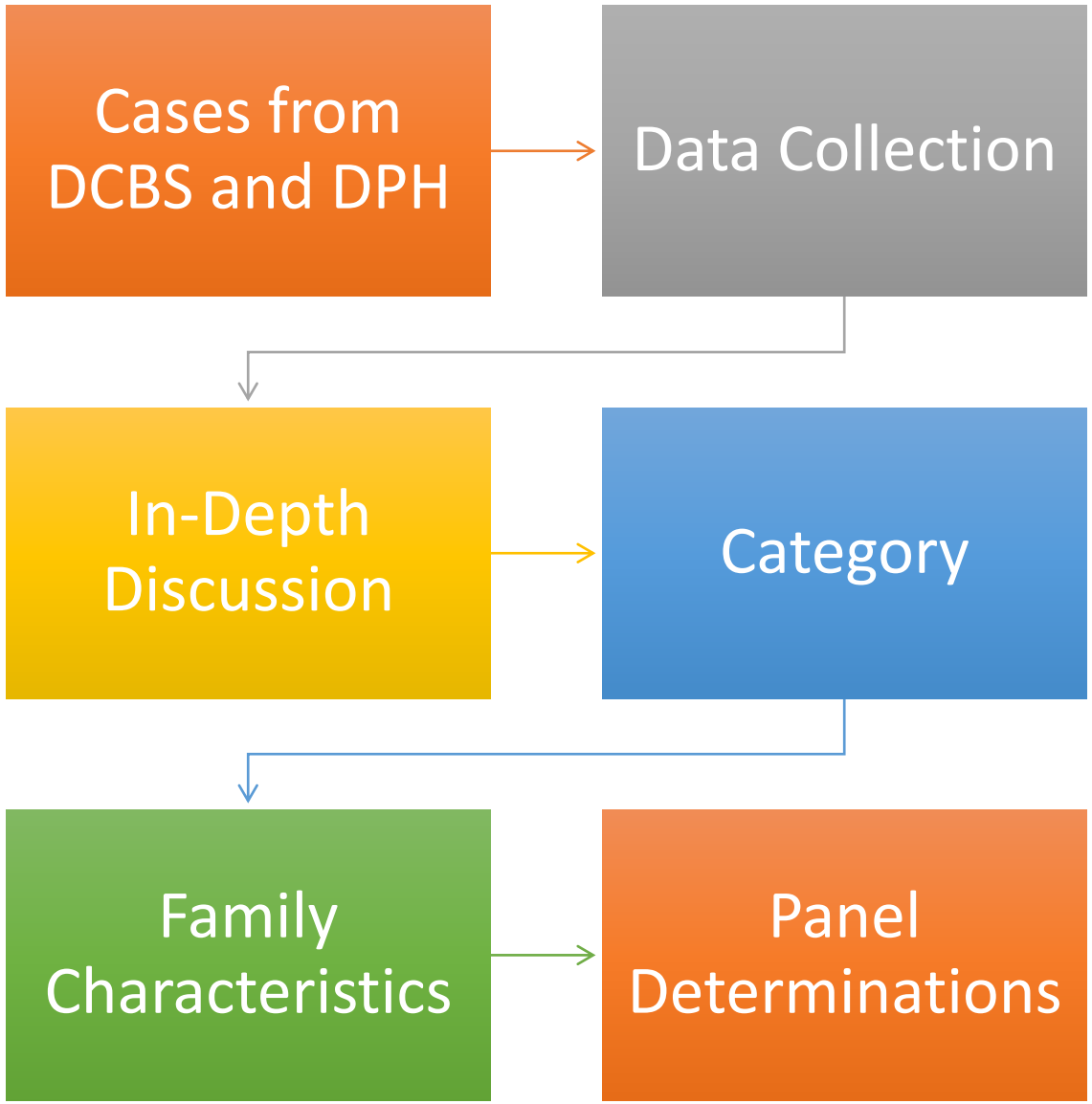
Child Fatality and Near Fatality External Review Panel

2025 Annual Report

Panel Members

- Chair - Hon. Lauren Adams Ogden, Family Court Judge, Jefferson
- Commissioner, DCBS – Lesa Dennis
- Commissioner, DPH - Dr. Lyndsey Neese, proxy
- Family Court Judge - Hon. Libby Messer, Fayette
- 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 – Lt. Jonathan Murphy
- Prevent Child Abuse Ky – Mike Bowling, Ret. KSP
- Ky Coalition Against Domestic Violence – Tisha Pletcher
- Community Mental Health Centers- Steve Shannon
- Citizen Foster Care Review Board - Dr. Elizabeth Salt
- State Child Fatality Review Team – Brittany Nichols
- 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

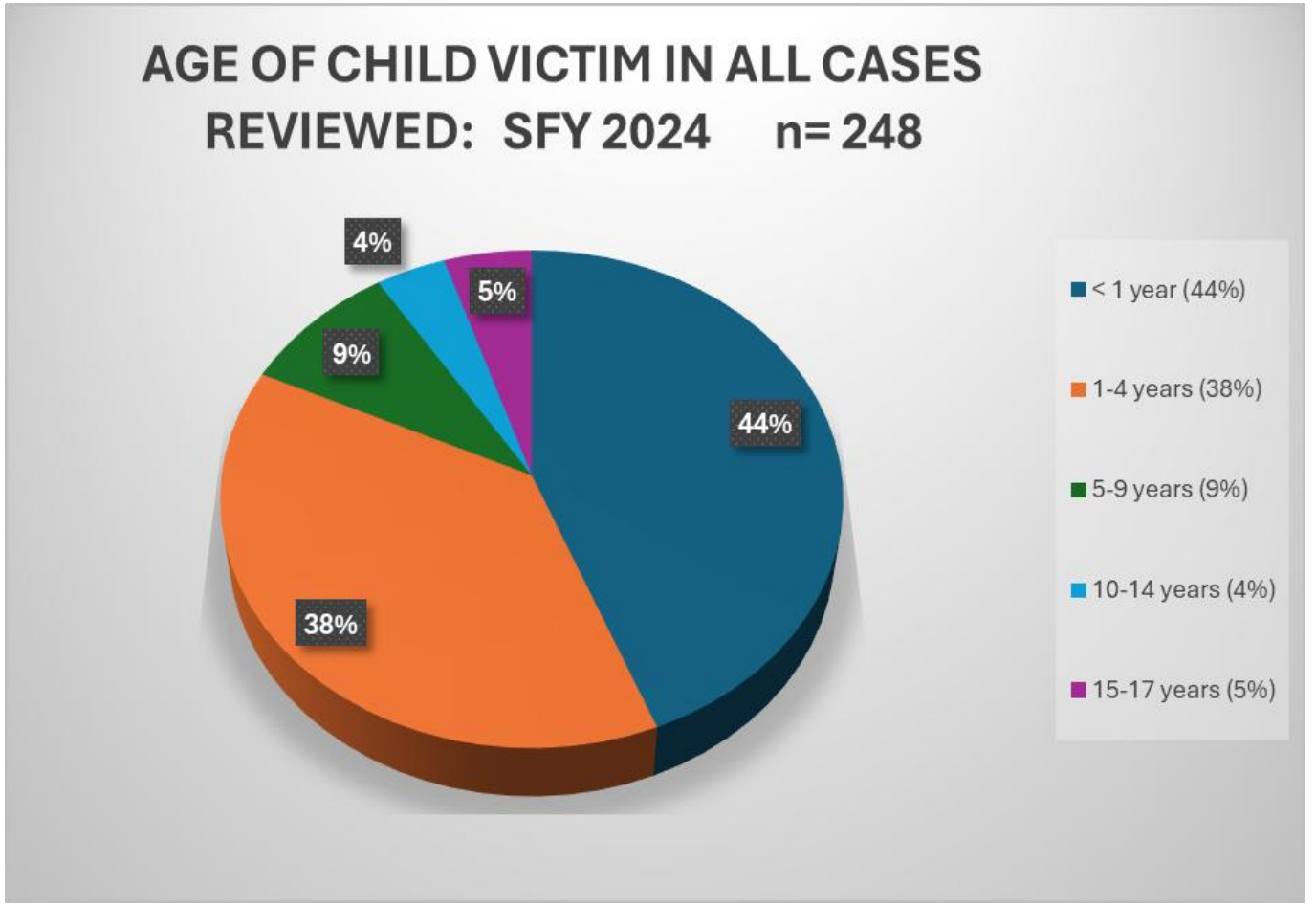


Annual Report

- Case Reviews
- Findings
- Recommendations

Findings

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

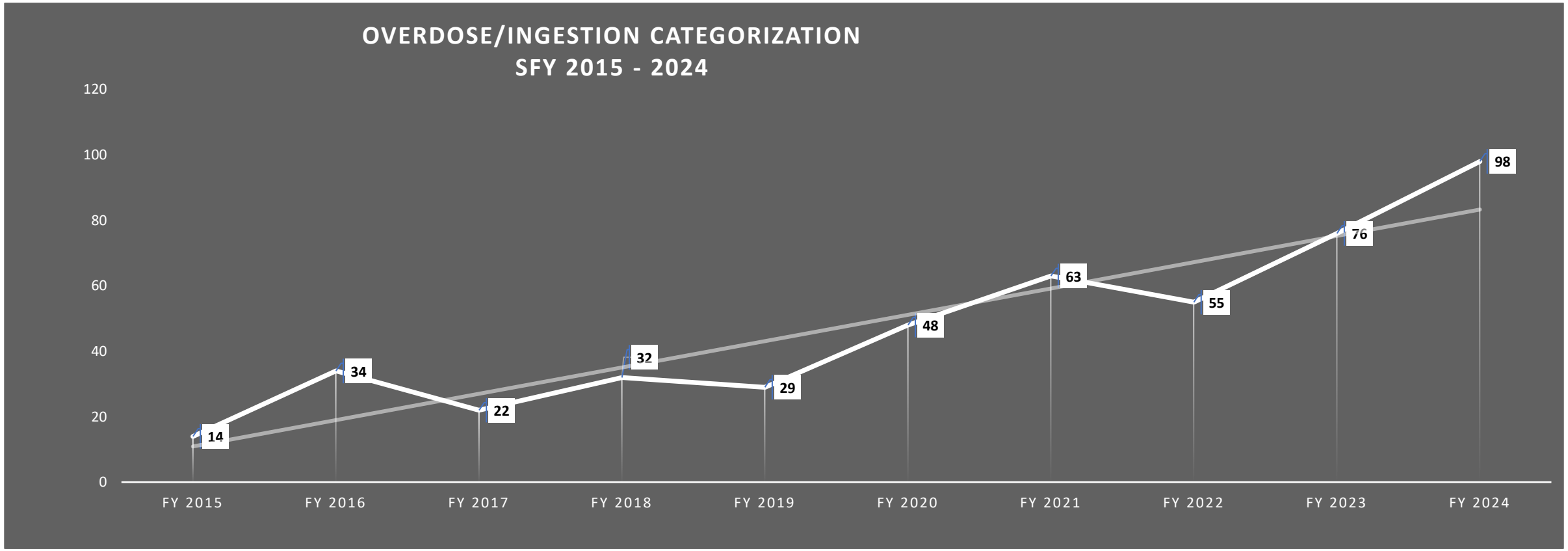


Data Source: Child Fatality and Near Fatality External Review Panel Data

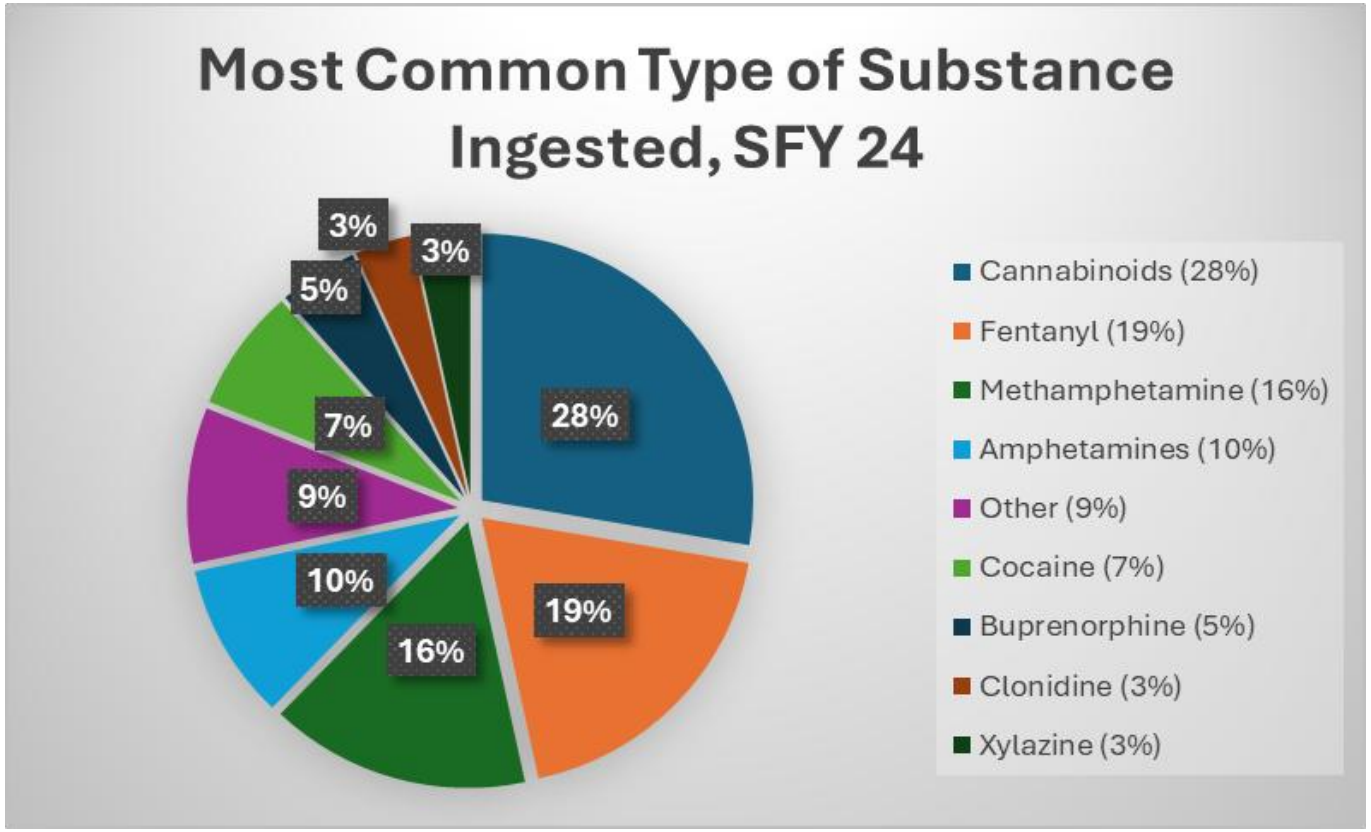
Key Findings

- The most commonly found family characteristics in SFY24 included:
    1. Financial Issues (75%)
    2. DCBS Issues (73%)
    3. DCBS History (63%)
    4. Substance Abuse (in home) (55%)
    5. Substance Abuse (caregiver) (54%)
    6. Environmental Neglect (52%)
- 91% of all overdose/ingestion cases involved environmental neglect (unsafe access).
- 82% of all physical abuse cases involved a family with financial issues.
- 71% of abusive head trauma cases involved substance abuse by the caregiver.
- 50% of sexual abuse cases reviewed by the panel involved a medically fragile child.

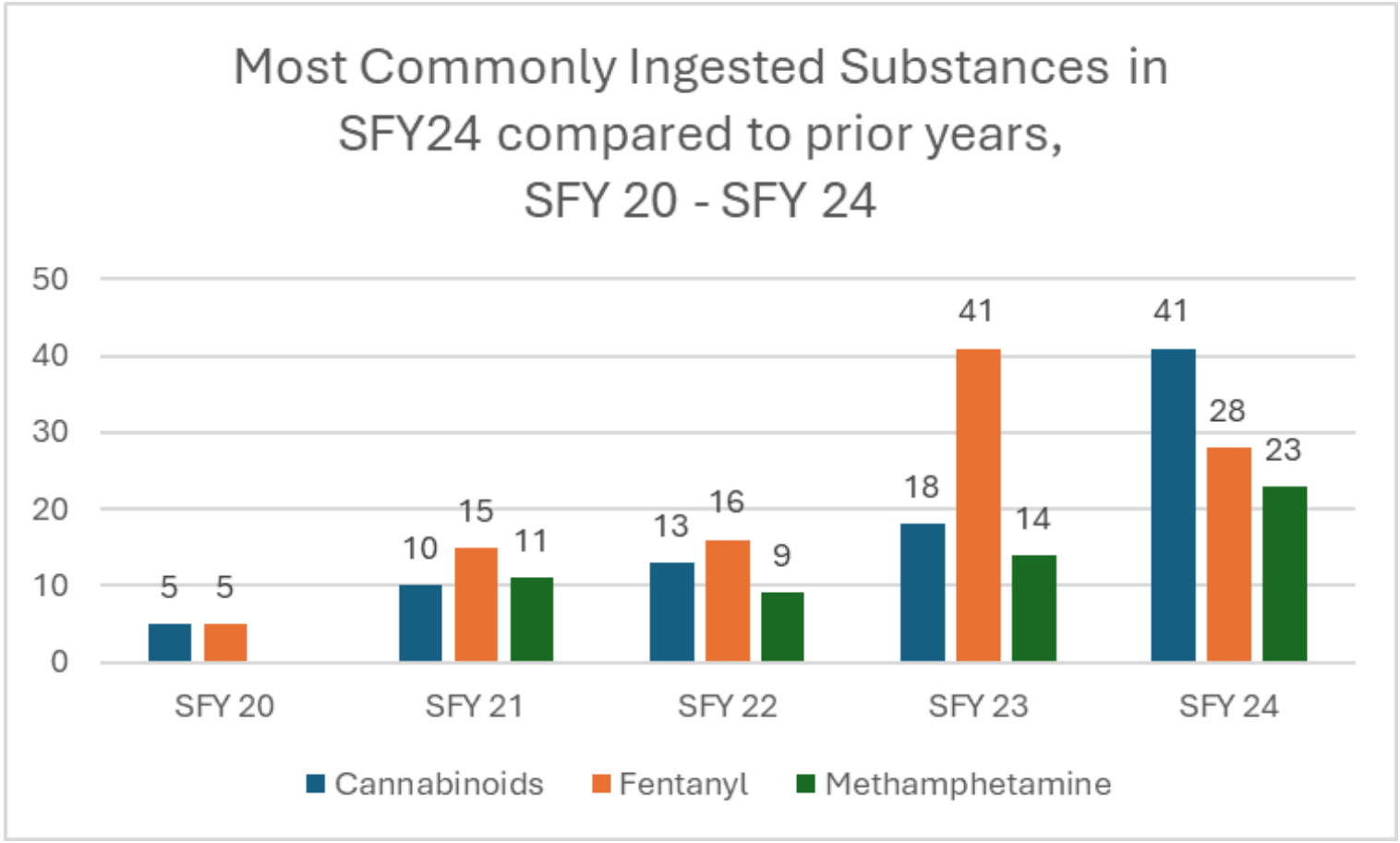
Trends


OVERDOSE/INGESTION CATEGORIZATION
SFY 2015 - 2024
120
100
80
60
40
20
0
14
34
22
32
29
48
63
55
76
98
FY 2015
FY 2016
FY 2017
FY 2018
FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024

Types of Substances Ingested



Most Commonly Ingested Substances



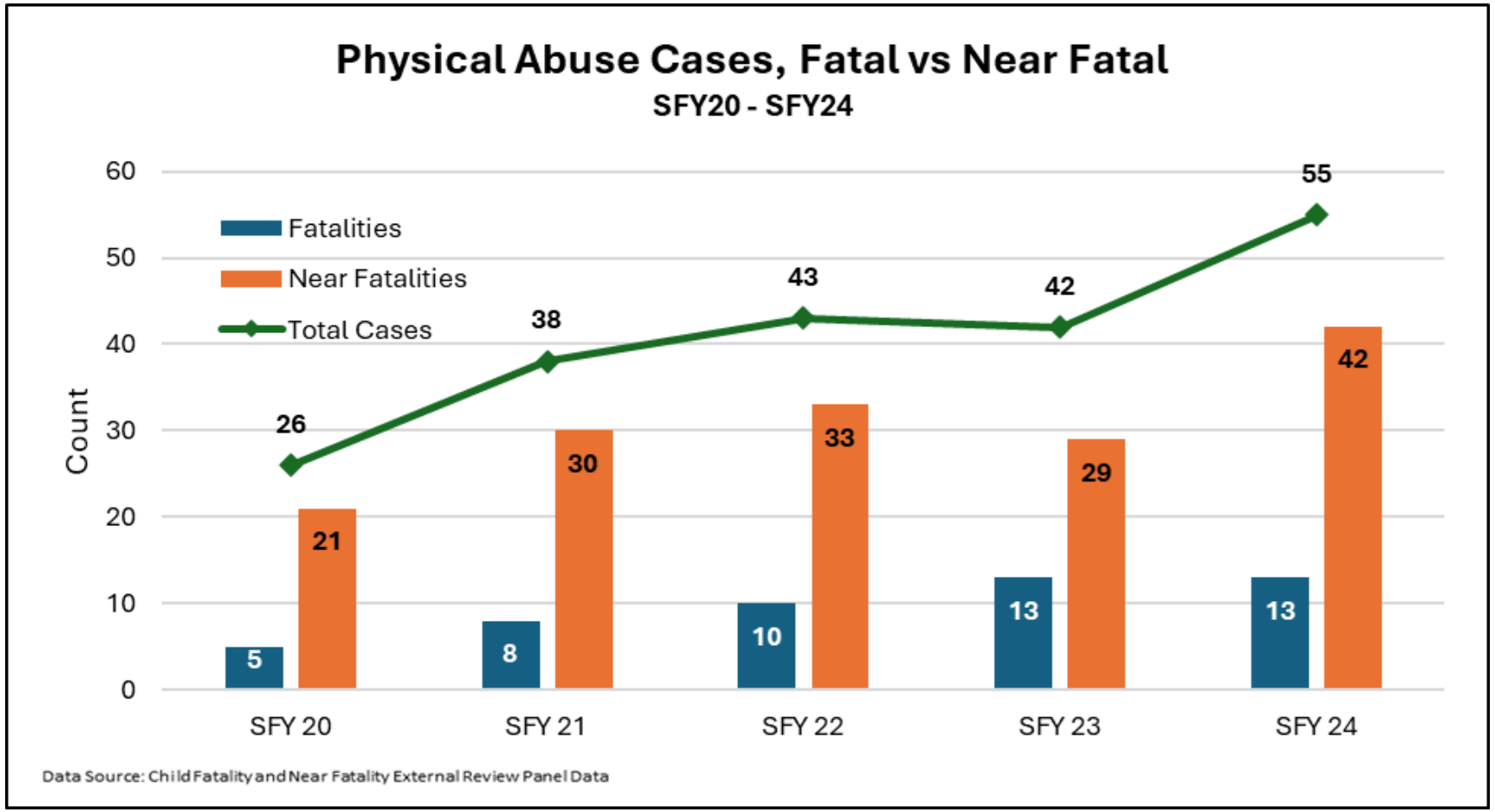
Case Example

- Case involved a near fatal ingestion of THC in a three-year-old child.
- Upon arrival to ED child received two doses of Narcan and was intubated for airway protection.
- After intubation, child developed frothy bloody secretions from the breathing tube and went into full cardiac arrest.
- Child was transported to a children's hospital and diagnosed with pulmonary hemorrhage and received a blood transfusion.
- Initial urine screen was positive for cannabinoids.
- Mother reported child had ingested the wax piece of a THC dab pen.
- The pen was newly purchased and reportedly contained 500mg of THC.
- The child remained in the PICU for eleven days and was released to an inpatient rehabilitation facility due to neurological deficits sustained from the ingestion.
- Law enforcement declined to investigate the case.

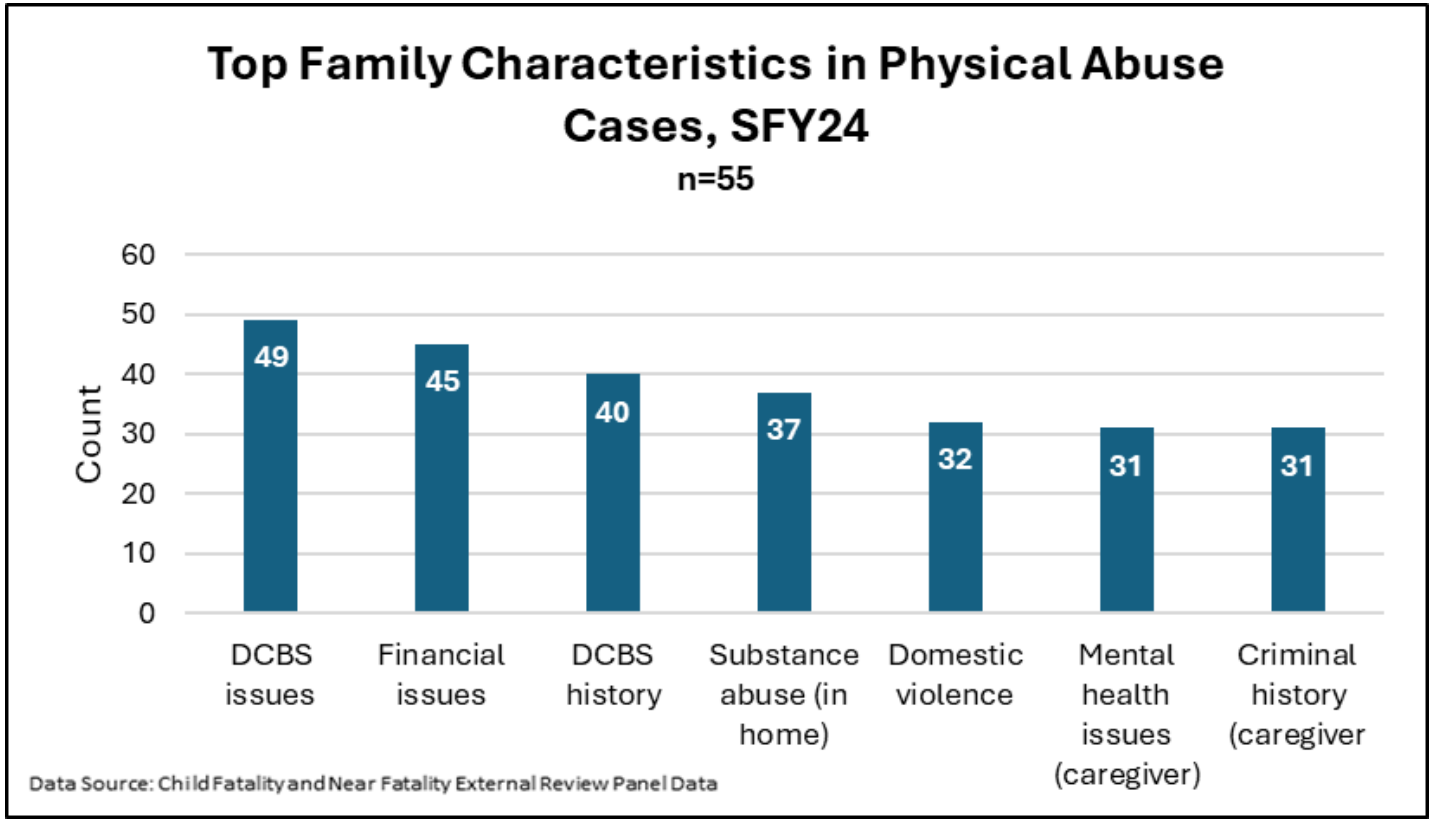
Overdose/Ingestion Recommendations

- Stronger, more consistent regulations pertaining to medical cannabis and hemp-derived cannabinoid products to ensure consistent child-resistant packaging requirements (DPH and OMC)
- Ensure consumers are aware that “child-resistant” does not mean “child-proof” and these products may be harmful or potentially fatal to children
- DPH and Office of Medical Cannabis to conduct an aggressive public safety campaign
- HANDS to update educational material to include safe storage of medical cannabis and hemp-derived cannabinoid products
- OAG to develop a toolkit focused on pediatric ingestions for law enforcement, medical providers, and prosecutors
- Increase education for law enforcement, medical providers, and prosecutors on pediatric ingestions via KHA and OAG conferences

Physical Abuse Cases



Family Characteristics in Physical Abuse Cases



Case Example

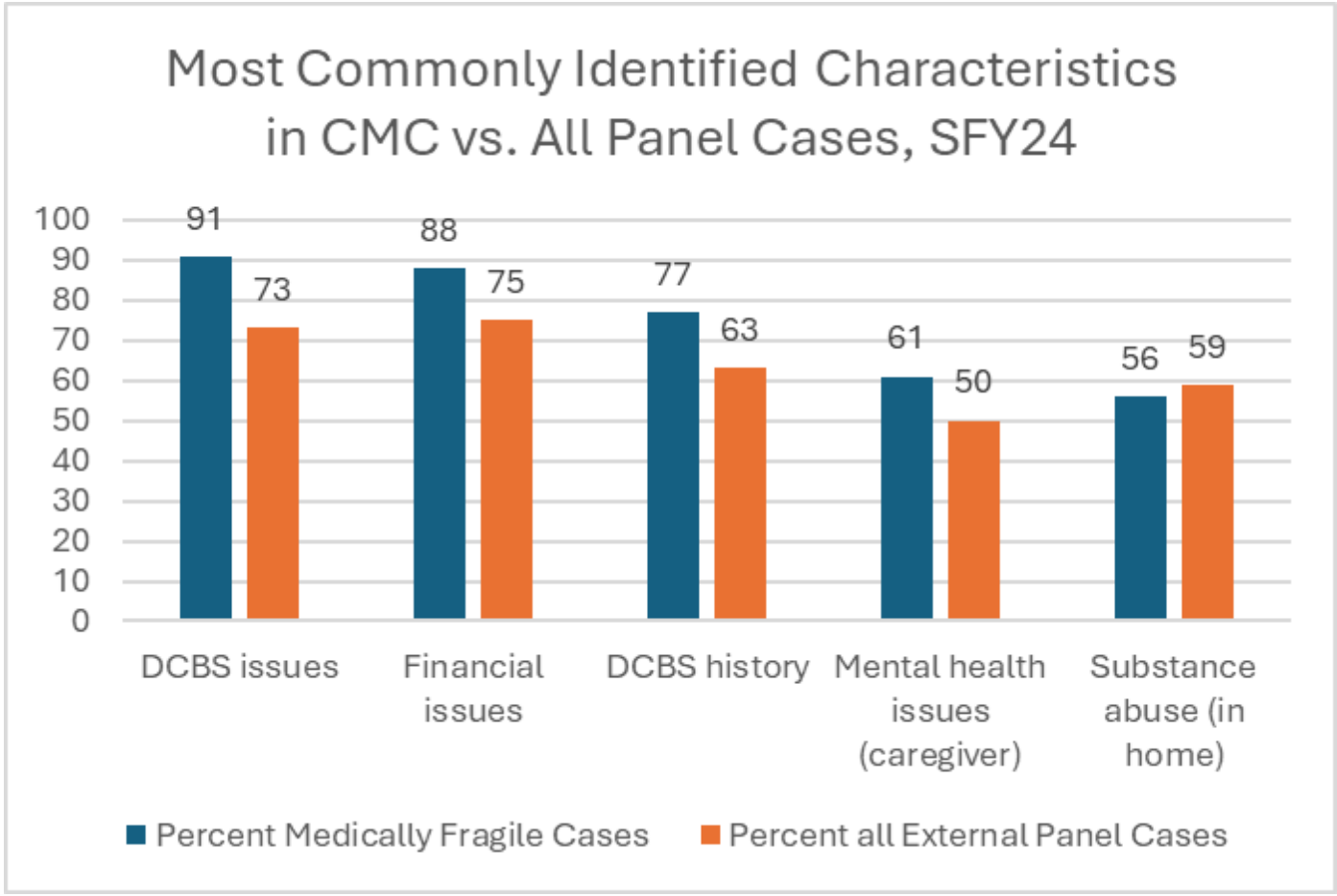
- Case involved a near fatality of a five-year-old child resulting from physical abuse, neglect, sexual abuse, and torture.
- Injuries noted included severe malnutrition, healing rib fractures, multiple bruises, pancreatic duct injury, and the child tested positive for fentanyl.
- Both parents had criminal histories including assault and drug offenses, substance abuse issues, history of intimate partner violence, and mental health issues.
- This case demonstrates how financial stress, substance abuse, mental health issues, and criminal history often co-occur and compound risk for severe child maltreatment.

Physical Abuse Recommendations

Additional training for child welfare staff and medical providers on the indicators of physical abuse. The training should emphasis the use of a skeletal survey, not single image babygrams, as best practice.

DCBS should implement a monitoring system to track case work compliance with SOP G1.16, Working with Families Affected by Substance Misuse.

Children with Medical Complexity



Case Example

- This case involved the near fatality of an eight-year-old child resulting from medical neglect, hygiene neglect, supervisory neglect, malnutrition, and sexual abuse.
- Child resided with mother and paternal relatives due to ongoing domestic violence issues with the father.
- Maternal grandparents reported being concerned for the care of the child due to the child's physical condition and mother's prior substance abuse issues. No reports were made to CPS.
- Injuries included severe starvation, the child weighed 22 pounds (the average weight of a 17-month-old), severe pressure ulcers that eroded to the bone, kidney stones, acute kidney injury, extensive dental decay, and severe joint contractures in all extremities.
- Child was later found to have chlamydia, pneumonia, pelvic abscess, and refeeding syndrome due to prolonged starvation.
- Mother and father were charged with Criminal Abuse 1st Degree. Father was charged with Rape 1st and Incest, Sexual Abuse 1st, 2 counts.
- According to medical records, child had not been seen by a provider in 18 months and had not received any in-home services since the child was 3 years of age.
- DCBS screened out a report with concerns for neglect and skin breakdown. The medical providers did not implement a follow-up mechanism when the child ceased to attend appointments.
- This case demonstrates the need for a monitoring system for medically complex children, as well as a need for training and improved coordination amongst professional providers.

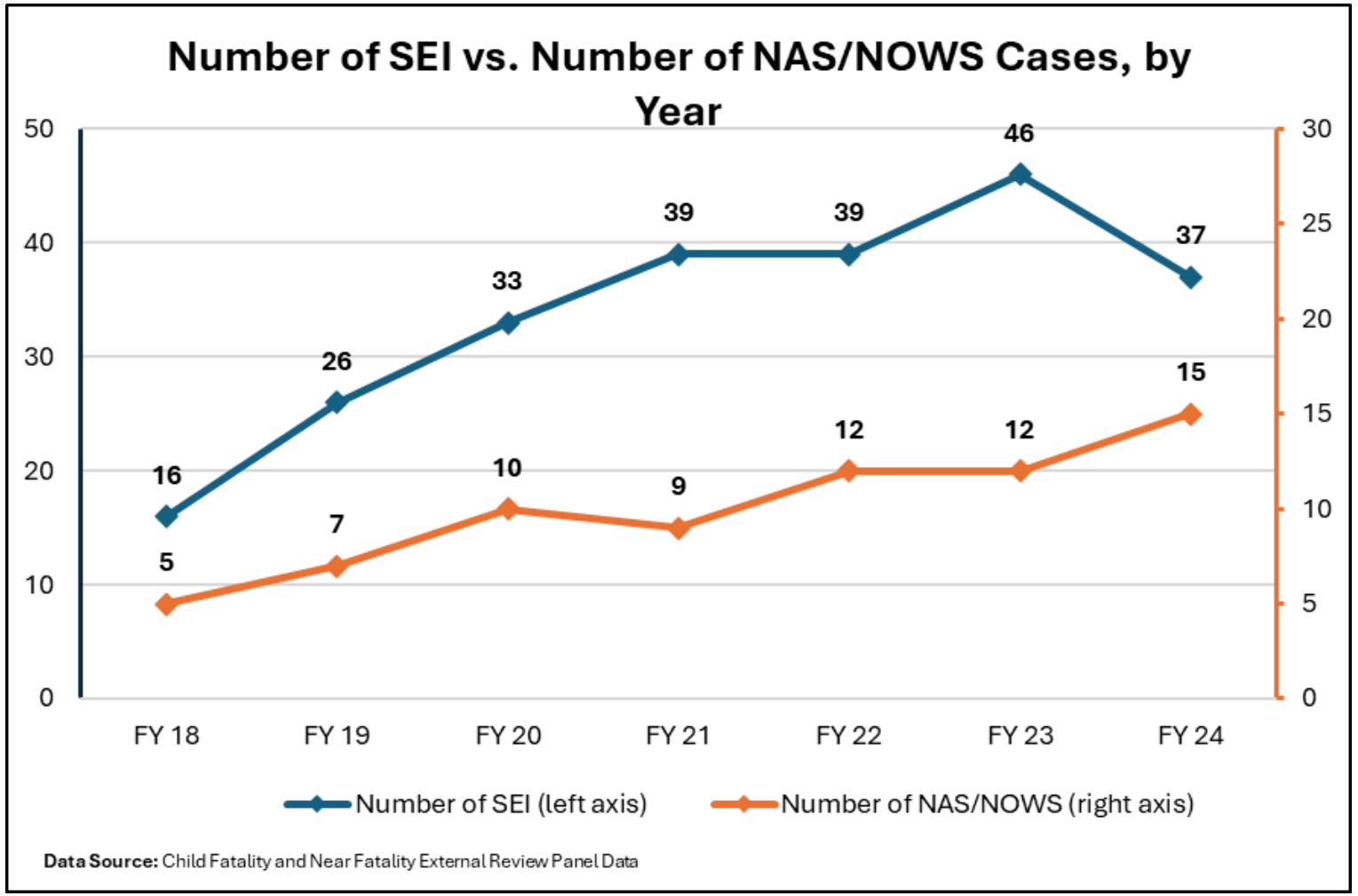
CMC Recommendations

Enhance current policies to ensure medical experts are available to assist CPS staff

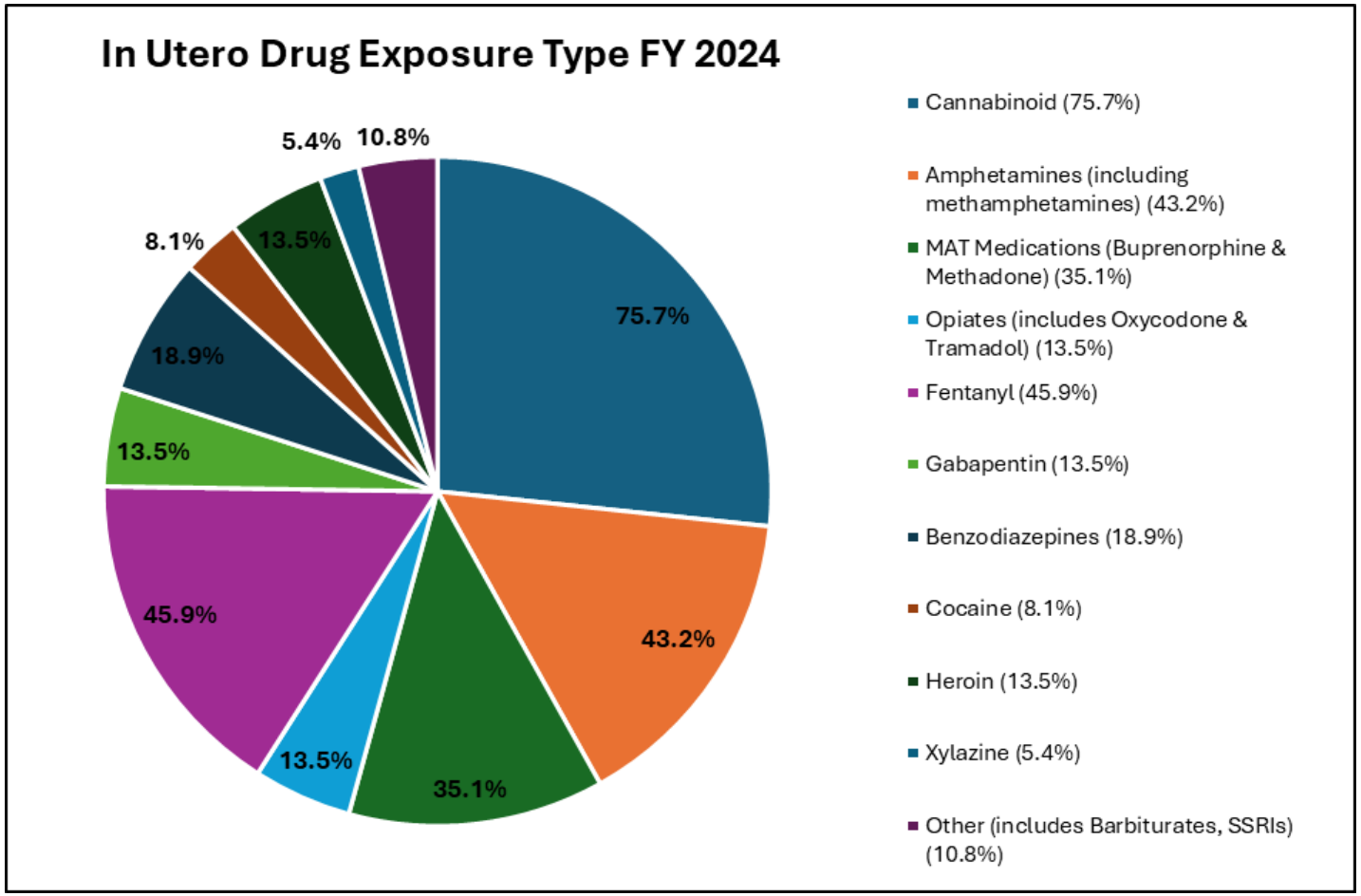
Develop and implement a comprehensive training curriculum on medically complex children

Develop a statewide registry to enable coordinated care across systems and assist in early identification of at-risk families

Plan of Safe Care



In Utero Drug Exposure Type



Case Example

- This case involved the fatal overdose/ingestion of fentanyl in a 13-month-old child.
- At the time of the event the child resided with mother and six siblings.
- The child's postmortem toxicology was positive for 4-ANPP, a metabolite of fentanyl.
- Due to the positive screen, child abuse specialist recommended the surviving siblings be screened.
- Three of siblings could not receive a hair toxicology due to not having enough hair to sample. The other three siblings all tested positive for fentanyl.
- All seven children had tested positive for an illicit substance at birth and were reported to DCBS.
- Four of the seven children were positive for THC at birth.
- There was an active CPS investigation at the time of the fatality due to the index child being born substance exposed.
- There was no Plan of Safe Care in place when this child was discharged from the hospital despite the mother's extensive substance use history.

Plan of Safe Care Recommendation

- Encourage prenatal care providers to participate in their local community's POSC and educate patients on community resources
- Stakeholders should collaborate with community treatment providers to develop a standardized release of information to reduce barriers
- CPS staff should be encouraged to continue to treat cannabinoid use as a high-risk behavior
- Hospitals should encourage prompt referral to HANDS to engage with the family at the birthing hospital

Questions

Thank you!