Kentucky Child Fatality And Near Fatality External Review Panel 2023 Update

Research Report No. 483

Legislative Oversight And Investigations Committee

Kentucky Legislative Research Commission

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Kentucky Child Fatality And Near Fatality External Review Panel 2023 Update

August 10, 2023

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Abstract

KRS 6.922 requires that the Legislative Oversight and Investigations Committee conduct an annual evaluation of the Child Fatality and Near Fatality External Review Panel. The panel, which has 17 voting and 5 ex officio members, is attached administratively to the Justice and Public Safety Cabinet. The independent panel's charge is to conduct comprehensive reviews of child fatalities and near fatalities reported to the Cabinet for Health and Family Services that are suspected to be a result of abuse or neglect. It is also required to submit annual reports discussing case determinations, as well as findings and recommendations for system and process improvements. The panel uses SharePoint and REDCap to track various information and data related to child fatality and near fatality reports. Senate Bill 97, passed during the 2022 Regular Session, changed the panel's composition and reporting requirements, as well as the privileged nature of panel proceedings, records, opinions, and deliberations. The bill also included changes to law enforcement testing requirements and coroner notifications. This report makes five recommendations related to REDCap and software platforms, budgetary and expenditure procedures, reporting requirements, and the format of findings and recommendations in the panel's annual reports.

Foreword

Legislative Oversight and Investigations Committee staff appreciate all those who provided assistance with this report. The Kentucky Child Fatality and Near Fatality External Review Panel provided the benefit of its time, and its staff provided various data and other information. Additionally, the Cabinet for Justice and Public Safety provided budgetary and other information related to the panel's operations and funding.

Jay D. Hartz
Director

Legislative Research Commission
Frankfort, Kentucky
August 10, 2023

Contents

Tables

Figures

Summary

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

This year, LOIC staff evaluated the panel's actions in the following areas:

- LOIC staff recommendations from *Kentucky Child Fatality And Near Fatality External Review Panel, 2022 Update,* Research Report No. 478.
- Requirements of Senate Bill 97, from the 2022 Regular Session, regarding the panel's composition and reporting, as well as the privileged nature of the panel's proceedings, records, options, and deliberations. SB 97 also changed requirements related to law enforcement testing and coroner notifications.
- The panel's statutory requirement to submit annual reports related to allegations of dependency, neglect, and abuse. LOIC staff reviewed recommendations, the organization of information related to findings, and the inclusion of case reviews and supporting data.

This report includes an update on the software that the panel uses to store, review, and analyze case data. It also includes a summary of expenditures since 2015, as well as information on a recently filled administrative position and a memorandum of agreement with the Department for Public Health for epidemiologist services. The report discusses detailed reporting information related to determining and forwarding recommendations to responsible agencies as part of the panel's annual reports.

Findings And Recommendations

The panel has taken substantive actions to address the nine recommendations adopted by LOIC at its November 10, 2022, meeting.

In 2022, the panel revised its data tool using the web-based Research Electronic Data Capture Application (REDCap). The updated data tool replaced narrative text boxes with options more friendly to analysis, such as multiple choice. Panel staff and members also created an Analyst Binder, which serves as the panel's data dictionary in addition to being a step-by-step reference for analysts.

The REDCap software cannot store case information. Panel members and staff must use multiple platforms to store, review, and analyze cases. The panel is working with the Commonwealth Office of Technology and Justice and Public Safety Cabinet budget staff to explore options that may allow the panel to use a single platform for case storage and analysis.

Recommendation 3.1

The Child Fatality and Near Fatality External Review Panel should continue to work with officials from the Commonwealth Office of Technology as well as Justice and Public Safety Cabinet budget staff to explore options that will allow the panel to use one platform for case storage, review, and analysis.

The panel was directly appropriated $420,000 for each year in FY 2023 and FY 2024. Although the panel's 2022-2024 budget request included a request for funding for two full-time positions, panel staffing remained unchanged in FY 2023. As of July 2023, the panel had added an administrative staff member who will be shared with the Office of Drug Control Policy. Also, the panel entered into a memorandum of agreement with the Department for Public Health for epidemiologist services.

LOIC's 2022 evaluation of the panel recommended that the panel and the Justice and Public Safety Cabinet update a memorandum of understanding (MOU) outlining the panel's budget and expenditure procedures. At the panel's March 2023 meeting, panel staff indicated that the cabinet was "happy" to update the MOU, pending guidance from the panel. Panel members were given a copy of the MOU and were asked to provide feedback for possible changes, but as of July 2023, they have not submitted suggested changes to panel staff. The MOU is likely in need of an update to reflect changes resulting from the recent direct appropriation and the establishment of expenditure budget authorities in eMARS, as well as increased staffing needs to handle direct referrals from coroners, law enforcement agencies, and hospitals.

Recommendation 3.2

The Child Fatality and Near Fatality External Review Panel and the Justice and Public Safety Cabinet should update the existing memorandum of understanding (MOU) to reflect current budgetary and expenditure procedures to reflect changes resulting from the recent direct appropriation and the establishment of expenditure budget authorities in eMARS, as well as increased staffing needs. The MOU has not been updated since it was drafted in 2014.

The panel has taken action to implement the changes made by SB 97. Specifically, it has notified appointing agencies related to the panel's expanding membership and it has assisted in training law enforcement personnel and coroners on the new requirements. Additionally, the panel has met its reporting requirements by determining and forwarding recommendations from its most recent annual report to responsible agencies. However, less than half of the panel's recommendations had appropriate agency responses.

Recommendation 3.3

The Child Fatality and Near Fatality External Review Panel should develop procedures to follow up with agencies that do not comply with KRS 620.055(10)(c)2.

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

The panel's findings in its 2022 annual report were supported by analysis and data that were illustrated in the report, and recommendations were appropriately linked to the report's findings. The recommendations were targeted and actionable. However, the panel could better organize the information to make findings stand out more in its annual reports.

Recommendation 3.4

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

Recommendation 3.5

The Child Fatality and Near Fatality External Review Panel should organize information in each finding area so that each finding is clearly articulated related to corresponding recommendations.

Chapter 1

Kentucky Child Fatality And Near Fatality External Review Panel

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

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

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

The General Assembly amended KRS 620.055 through Senate Bill 97 of the 2022 Regular Session. The changes strengthened reporting controls with respect to how the panel makes annual recommendations to state agencies, and the bill also instituted requirements regarding the agencies' implementation of the panel's recommendations. Additional requirements were enacted regarding the testing of caregivers suspected of being under the influence, adjustments to panel membership, notification by coroners, and the panel's annual report.[3]

By February 1 of each year, the panel must publish a report consisting of case reviews, findings, and recommendations for improvements to its system and process.

By February 1 of each year, the panel must publish a report consisting of case reviews, findings, and recommendations for improvements to its system and process to help prevent child fatalities and near fatalities that are 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) conducts an annual evaluation.

KRS 6.922 and 620.055(17) require the Legislative Oversight and Investigations Committee (LOIC) to conduct an annual evaluation of the Child Fatality and Near Fatality External Review Panel.

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

- Panel organization, membership and independence
- Compliance with statutes
- Confidentiality and transparency
- Budget and staff
- Case review using SharePoint
- Case statistics
- National statistics
- Other states

Staff drafted and presented subsequent annual reports, which the committee adopted on December 10, 2015 (2015 update); December 13, 2016 (2016 update); August 9, 2018 (2017 update); July 12, 2019 (2018 update); and October 14, 2021 (2021 update). These evaluations continued the statutory compliance focus and a general description of processes by which the panel receives and analyzes case information and drafts its annual reports. LOIC staff's 2022 update, adopted on November 10, 2022, focused on the panel's implementation of the changes in SB 97 (2022 Regular Session), 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. Table 1.1 provides additional detail.

Table 1.1
Legislative Oversight and Investigations Committee Staff Evaluations
2014 To 2022

Committee Adoption Date	Major Conclusions	Recommendations
7/10/14 (initial)	• The Child Fatality and Near Fatality External Review Panel is complying with its governing statutes. • The panel appears to be distinctive in terms of its organizational structure and mission. • The $420,000 annual appropriation to the panel, to be used primarily for staff, should allow the panel to review cases and make recommendations more effectively.	None
12/10/15 (2015 update)	• The panel is in compliance with six of seven administrative requirements in statute. • The panel has addressed all recommendations made in its 2014 report. • The panel has determined that two of those recommendations would require action by the General Assembly.	• The panel may wish to create a formal policy for deleting cases stored in electronic form in SharePoint.

Committee Adoption Date	Major Conclusions	Recommendations
12/13/16 (2016 update)	• The panel adopted a 5-year retention schedule in accordance with the practice for similar data tracked by other Kentucky agencies and other states. • The panel expressed that it would like to have dedicated staff as follows: full-time director; full-time program coordinator; full-time data analyst; an intern; and contractors as needed.	None

8/9/18 (2017 update)	• The panel is in compliance with all but two statutory administrative requirements:
	  • The 2017 Annual Report was published on December 8 rather than December 1.
	  • A panel seat has been vacant since June 30, 2017. Nominations must come from the Kentucky Association of Addiction Professionals, which has not responded to requests for nominations from the panel and the attorney general's office.
	• Three of the nine recommendations in the panel's 2016 annual report resulted in actions by the General Assembly, the Kentucky Hospital Association, or the Administrative Office of the Courts during 2017.
		• The General Assembly may wish to specify a procedure for filling the vacancy of a voting member when it cannot be filled in the same manner as the original appointment.

7/12/19 (2018 update)	• The panel is in compliance with statute, except that its annual report was not published by the mandated time. • The panel could receive additional case referrals to increase the likelihood that all relevant near fatalities and fatalities are reviewed.	• The General Assembly should consider changing the due date of the panel's annual report to February 1 to provide sufficient time for the panel to receive and review all cases of the previous fiscal year. • The panel should establish a policy for the destruction of electronic documents stored in SharePoint. • Recommendations in the panel's annual reports should be easily identifiable and clearly stated.
10/14/21 (2021 update)	• The panel has met its statutory requirements to submit annual reports. • The panel's findings in its annual reports were often not supported by the analyses performed. Recommendations were not empirically linked to its findings. • The panel does not have a data dictionary to clearly define the variables it collects from case files. The data tool has not been updated since 2014. • The panel and the cabinet have not followed the requirements outlined in a May 2014 memorandum of understanding (MOU).	• The panel should reevaluate how it uses SharePoint and its data tool to collect and analyze case data. • The panel should formally review its data tool to ensure that it is capturing relevant data needed to make case determinations and to develop findings and actionable recommendations. • The panel should consider requesting assistance from the National Center for Fatality Review and Prevention to understand how it designed its data tool and data dictionary. • The panel and the cabinet should develop processes to ensure that the panel submits a formal budget request to the cabinet prior to each budget session.

Committee Adoption Date	Major Conclusions	Recommendations
		• The panel should consider creating a data dictionary. • The panel and the cabinet should develop processes for meaningful communication related to the panel's budgetary needs. • The panel and the cabinet should discuss with the Office of the State Budget Director the possibility of establishing a separate appropriation allotment for the panel.

11/10/22 (2022 update)	• The Cabinet for Health and Family Services has provided a full and final response to the Legislative Oversight and Investigations Committee's July 2021 request. The Department for Community Based Services (DCBS) appears to be appropriately using an internal tip sheet to identify near fatalities. DCBS completed internal reviews in accordance with KRS 620.050(12)(b) and its internal standards of practice/system safety manual.
	• The panel has met its statutory requirements to submit annual reports.
	• The panel's findings in its 2021 annual report improved markedly from those of previous reports. The findings were supported by analysis and data illustrated in the report, and recommendations were appropriately linked to the report's findings. The recommendations were targeted and actionable.
	• The panel has finalized a significant update to its data tool and the document it used to instruct users on each data element and related guidelines.
	• The panel is reviewing and developing processes related to SB 97's changes to the panel's membership and reporting requirements.
	• The panel is updating budget processes after the passage of HB 1 (2022 Regular Session), which directly appropriated $420,000 for each year in FY 2023 and FY 2024, but the 2014 MOU between the panel and the Justice and Public Safety Cabinet has not been updated.
		• The panel should address its concerns and ideas for improvement with DCBS through panel workgroups and/or annual report recommendations in the following areas:
		  • Intake of reports filed by the medical community under KRS 620.030(2)
		  • DCBS's use of the Near-Fatality Criteria and Determination Flow Chart
		  • Training for the medical community related to reporting allegations of abuse and neglect
		  • DCBS's internal review process
		• The panel should discuss the possibility of online training modules with the Kentucky Board of Medical Licensures in the following areas:
		  • Reports filed by the medical community pursuant to KRS 620.030(2)
		  • Documenting and reporting near fatalities as defined under KRS 600.020(40)
		• The panel should contact DCBS and discuss the feasibility of using existing pediatric forensic medicine contracts to provide additional training to the medical community.
		• The panel should follow through on its idea of holding a spring 2023 meeting to discuss the implementation of SB 97.
		• The panel should seek feedback from the courts, law enforcement, the medical community, and coroners related to the areas addressed in SB 97.
		• The panel should continue its positive efforts to ensure that findings are based on data presented in the report and that recommendations are actionable, targeted, and directly related to findings.
		• The panel should continue to update its data tool and data dictionary as needed.
		• The panel and cabinet should update the existing MOU to reflect current budgetary and expenditure procedures.
		• Panel staff should present financial updates to panel members on a regular basis.

Note: In December 2020, staff submitted a co-chair memorandum providing an update and additional detail on its initial and subsequent reports from 2015-2019, as well as identifying areas for further research in 2021. Generally, the areas suggested for additional review included the panel's operations, procedures, and recommendations. Source: LOIC staff review of previous evaluations.

Major Objectives

This study had three major objectives.

The major objectives for this study were to review

- actions taken by the panel over the past year to address recommendations from LOIC's 2022 annual report;
- the panel's implementation of the changes introduced in SB 97 (2022 Regular Session); and
- progress in developing findings and recommendations to meet reporting requirements and other requirements under KRS 620.055(10), as amended by SB 97.

Methodology

This report focuses on the panel's implementation of previous LOIC recommendations and statutory guidance from SB 97. 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 2022
- Reviewed and analyzed the panel's historic expenditure data from eMARS
- Reviewed and analyzed the panel's historic contract information from eMARS
- Followed up with panel's staff and members about various budget, training, and reporting processes

Major Conclusions

This study has six major conclusions

This report has six major conclusions.

- The panel has taken substantive actions to address the nine recommendations adopted by LOIC at its November 10, 2022, meeting.

- In 2022, the panel finalized a significant update of its data tool and the document it used to instruct users on each data element and related guidelines. The new data tool cannot store case

information. Panel members and staff must use multiple platforms to store, review, and analyze cases.

- The panel was directly appropriated $420,000 for each year in FY 2023 and FY 2024. The panel has taken a more active role in its budget and expenditure processes over the past 2 years. However, the 2014 memorandum of understanding (MOU) between the panel and the Justice and Public Safety Cabinet has not been updated since 2014.

- The panel has taken action to implement the changes made by SB 97. In addition to notifying agencies related to the panel's expanding membership and assisting in the training of law enforcement and coroners, the panel has met its reporting requirements by determining and forwarding recommendations from its most recent annual report to responsible agencies. However, less than half of the panel's recommendations received appropriate agency responses.

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

- Findings in the panel's 2022 annual report were supported by analysis and data that were illustrated in the report. Recommendations were appropriately linked to the findings and were targeted and actionable. However, the panel could better organize the information to make findings stand out more in the reports.

Structure Of This Report

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

Chapter 3 presents three major findings and five recommendations.

Chapter 2

Child Fatality And Near Fatality External Review Panel Background

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

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

- KRS 620.055(1) requires the panel to conduct "comprehensive reviews of child fatalities and near fatalities, reported to the Cabinet for Health and Family Services, suspected to be a result of abuse or neglect."
- KRS 620.055(10) requires the panel to "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."

Membership And Meeting Requirements

KRS 620.055(2) requires that the panel include 5 ex officio nonvoting members and 17 voting members. Table 2.1 shows that the voting members are 4 panel members based on their position, 11 appointed by the attorney general, 1 appointed by the chief justice of the Supreme Court, and 1 appointed by the secretary of state. Individual panel member names and affiliations are included in each annual report.

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

Ex Officio Members (5)		
Name	**Title/Appointing Authority**	
Vacant	Appointed by president of Senate	
Vacant	Appointed by speaker of House of Representatives	
Lesa Dennis	Commissioner, Department for Community Based Services	
Dr. Henrietta Bada	Commissioner, Department for Public Health	
Judge Libby Messer	Family court judge appointed by chief justice of Kentucky Supreme Court	
Voting Members (17)		
Name	**Title**	**Appointing Authority**
Judge Melissa Moore Murphy	At-large representative, serves as chair	Secretary of state
Dr. Christina Howard	Pediatrician from University of Kentucky Department of Pediatrics*	Attorney general** (appointed from three names provided by dean of University of Kentucky School of Medicine)

Name	Title	Appointing Authority
Dr. Melissa Currie	Pediatrician from University of Louisville Department of Pediatrics*	Attorney general (appointed from three names provided by dean of University of Louisville School of Medicine)
Dr. William Ralston	State medical examiner or designee	—
Lori Aldridge	Director of Court-Appointed Special Advocates (CASA)	Attorney general (appointed from three names provided by CASA)
Detective Jason Merlo	Peace officer**	Attorney general (appointed from three names provided by commissioner of state police)
Dr. Jaime Kirtley	Representative from Prevent Child Abuse Kentucky	Attorney general (appointed from three names provided by president of board of directors of Prevent Child Abuse Kentucky)
Vacant	Practicing local prosecutor	Attorney general
Olivia Spradlin	Executive director of Kentucky Domestic Violence Association	—
Janice Bright	Chair of State Child Fatality Review Team	—
Vacant	Practicing social work clinician	Attorney general (appointed from three names provided by Board of Social Work)
Geoff Wilson	Practicing addiction counselor	Attorney general (appointed from three names provided by Kentucky Association of Addiction Professionals)
Vacant	Representative from family resource and youth service centers	Attorney general (appointed from three names provided by Cabinet for Health and Family Services)
Steven Shannon	Representative of community mental health center	Attorney general (appointed from three names provided by Kentucky Association of Regional Mental Health and Mental Retardation Programs)
Dr. Elizabeth Salt	Member of citizen foster care review board	Chief justice of Kentucky Supreme Court
Mark Hammond	President of Kentucky Coroners Association	—
Vacant	Practicing medication-assisted treatment provider	Attorney General (appointed from three names provided by Kentucky Board of Medical Licensure)

Note: As of July 2023, the panel has six vacancies. Two are for ex-officio non-voting members, to be appointed by the speaker of the House and president of the Senate; the remaining four are for voting members, to be appointed by the Attorney General. — = serving according to position, not by appointment.
*Appointee must be licensed and experienced in forensic medicine relating to child abuse and neglect.
**Appointee must have experience investigating child abuse and neglect fatalities and near fatalities.
Source: KRS 620.055(2).

Meetings

The panel is required to meet at least quarterly.[5] According to its 2020 annual report, in July 2020 the panel began meeting monthly to complete yearly case reviews.[6] Since 2016, the panel has exceeded the requirement for quarterly meetings. Table 2.2 provides additional details.

Table 2.2
Number Of Panel Meetings And Number Of Cases Reviewed
2016 To 2023

Year	2016	2017	2018	2019	2020	2021	2022	2023
Number of meetings	7	8	7	6	10	12	12	12*
Fatalities reviewed	47	59	51	54	85	80	69	21**
Near fatalities reviewed	95	91	83	82	97	120	146	70**

*Includes meetings scheduled for July 25, August 22, September (date to be determined), October 24, November 28, and December 19, 2023.
**As of May 25, 2023.
Source: Staff analysis of information in the Kentucky Child Fatality and Near Fatality External Review Panel's webpage and annual reports.

The panel has twelve meetings scheduled for 2023—regular half-day Zoom meetings, and quarterly all-day, in-person meetings.

Administrative Attachment

The panel is attached to the Justice and Public Safety Cabinet for staffing and administrative purposes.[7] The panel does not have its own personnel and operating budgets; its funding is 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.[8]

According to an MOU 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.[9]

Budgets And Expenditures

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

The panel proactively worked with Justice and Public Safety Cabinet budget staff and submitted a budget request in the fall of 2021. The panel's funding request was included within the cabinet's biennial budget request as an additional budget request.[10] The 2022-2024 Budget of the Commonwealth included $420,000 in the base budget of the Justice Administration budget for the panel.[11]

The panel, through the cabinet, requested and received $420,000 annually in the 2014-2016 budget. [12] However, panel staff and members did not formally participate in any other budgets prior to the 2022 budget request. Rather, the cabinet approved the

panel's expenditures as part of the baseline funding for the Justice Administration appropriation unit, under the Office of the Secretary.[13]

The panel's annual personnel and operating expenditures have never totaled $420,000, though, which was the panel's initial appropriation in 2015. From 2015 through 2023, the panel expended only 60 percent of its appropriations.[a] Table 2.3 provides additional details on expenditures.

Table 2.3
Kentucky Child Fatality And Near Fatality External Review Panel Expenditures
FY 2015 To FY 2023

State Fiscal Year	Personnel Expenditures*	Operating Expenditures	Total
2015	$212,582.32	$6,946.05	$219,528.37
2016**	267,004.34	21,197.73	288,202.07
2017	213,258.51	56,288.95	269,547.46
2018	141,943.11	7,670.70	149,613.81
2019***	185,344.55	3,610.57	188,955.12
2020***	275,116.91	6,511.40	281,628.31
2021	245,260.94	2,205.67	247,466.61
2022	293,852.33	2,202.60	296,054.93
2023	320,547.17	13,268.84	333,816.01
Total	$2,154,910.18	$119,902.51	$2,274,812.69$2,274,812.69

*Staffing for the panel includes one executive staff adviser, one social service clinician II, and various contracts for a forensic nurse analyst and pediatric medical analyst.
**An additional $7,983.75 was expended for part-time data consultants from Kentucky State University and the University of Louisville.
*** For 2019 and 2020, baseline budget cuts of 6.25 percent were applied to 500A-Justice Administration. This calculates to $26,250 each year.
Source: eMARS, Expenditure Analysis Report-FAS3.

Staffing

The panel has never been fully staffed as originally envisioned.

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

- Administrative coordinator
- Internal policy analyst III
- Staff attorney III
- Paralegal consultant
- Administrative specialist III[14]

[a] $2,274,812.69 ÷ $3,780,000.00 = 0.602.

In addition to administrative and legal support, staff resources were needed to help review a high volume of cases, each of which involves analysis of hundreds of pages of information and records. Staffing currently consists of one executive staff adviser, one social service clinician II, one contract pediatric forensic medical case analyst, and a newly hired administrative staff member who is shared with the Office of Drug Control Policy (ODCP). The panel has also entered into an agreement with the Department for Public Health (DPH) for epidemiologist services.

Case Reporting, Investigation, And Referral

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

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

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

KRS 620.040(5)(e) requires law enforcement officers to request a test of blood, breath, or urine when a report includes a fatality or near fatality if the officer has reason to believe a caregiver was under the influence of drugs or alcohol at the time of the incident. If consent is not given for the test, a search warrant must be requested and may be issued by a judge. 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 the Department for Community Based Services and law enforcement agencies for information.

Once a report is received, DCBS screens acceptance criteria for the alleged maltreatment "where the alleged perpetrator is in a caretaking role."[15] 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."[16]

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.[17]

If the Department for Community Based Services 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.[18]

After investigations are completed, the panel receives case files from DCBS via SharePoint, which includes information from the Division of Protection and Permanency initial assessment (DPP-115). The DPP-115 includes the following information for each case:

- Calendar year
- Month
- State fiscal year
- Referral date (date DCBS received allegation)
- Approval date (date regional DCBS office sends file to panel)
- Case number
- Last name of child
- First name of child
- Investigation finding (substantiated, unsubstantiated, pending)
- Upload date of case file to SharePoint for the panel (email is generated automatically to panel staff to notify that an upload has occurred)[19]

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

The Department for Public Health also refers cases to the panel from its local child fatality review teams.[20] 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.[21] Upon receipt, panel staff send the list of DPH referrals to DCBS to request available case information. Panel staff also accesses DPH information via its SharePoint. According to DCBS officials, frontline staff from DCBS regional offices also participate on the local teams and provide information as needed.[22]

If DCBS is not involved with the case, panel staff may send formal requests for information to local entities requesting medical, education, law enforcement, and other records. Once it is provided, panel staff upload the information or records into the appropriate data field folder in SharePoint. DCBS may choose to investigate the matter as well, if it is not familiar with the circumstances surrounding a child's death.[23]

According to panel staff, DPH cases comprise 10 percent or less of the cases referred to the panel.[24]

Panel Review

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

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

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

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

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

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

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

(e) Autopsy reports;

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

(g) Medical records regarding the deceased or injured child, including but not limited to all records and documentation set out in this paragraph:
   1. Primary care records, including progress notes; developmental milestones; growth charts that include head circumference; all laboratory and X-ray requests

and results; and birth record that includes record of delivery type, complications, and initial physical exam of baby;
2. In-home provider care notes about observations of the family, bonding, others in home, and concerns;
3. Hospitalization and emergency department records;
4. Dental records;
5. Specialist records; and
6. All photographs of injuries of the child that are available;

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

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

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

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

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

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

(m) All law enforcement records and documentation regarding the deceased or injured child and his or her caregivers,

residents of the home, and persons involved with the child at the time of the incident; and

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

SharePoint

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

Panel staff use SharePoint to upload information and records from CHFS to a secure online location. Staff copy information and records into separate SharePoint folders for panel members to use when reviewing cases.

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

- Fatality and near fatality investigation (DPP-115, Investigative Assessment, Notification of Findings, Administrative Office of the Courts records, and Prevention Plans)
- Prior investigations
- Court records
- Medical records
- EMS records
- Autopsy records
- Law enforcement records
- Case plans and evaluations
- Service recordings
- Any other pertinent professional documents[25]

Panel members can also access case information through SharePoint outside of regularly scheduled meetings. After an annual report is published, hard and electronic copies of case information and records are destroyed. However, associated case review notes are maintained in SharePoint indefinitely.[26]

According to DCBS officials, regional offices provide agency records to the system safety review team for submission to the panel within 30 days of the fatality/near fatality investigative assessment approval. More specifically, the system safety review team is responsible for providing all records to the panel.[27]

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

Data Collection

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

The panel uses the Research Electronic Data Capture application (REDCap) survey response in conjunction with SharePoint to record certain details about each case. REDCap includes 22 screens, 19 of which are populated by panel staff before and after each board meeting.

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

Table 2.4 provides additional details.

Table 2.4
REDCap Screens And Detail

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

Screen	Detail
19. Family characteristics	Risk associated with the family such as substance abuse, unsafe sleep, unsafe access to deadly means, etc.
20. Categorization	Various case categories such as head trauma, blunt force trauma, etc.
21. Other qualifiers	Other information related to the case related to accidents, foul play, and prevention
22. Panel determination	Various categories of neglect and abuse an open response for missed opportunities

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

Annual Reports

Since 2013, the panel has met its statutory requirements to submit annual reports consisting of case reviews, findings, and recommendations for system and process improvements. The reports include contextual information, state and federal statistics, case summaries, and determinations.

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

- Categorization
- Family characteristics
- Other qualifiers
- Panel determination

The panel's 2022 annual report summarizes cases reviewed from the previous state fiscal year (July 1, 2020 through June 30, 2021). It summarized information related to 215 cases, which included 69 fatalities and 146 near fatalities. Eight fatality cases were referred to the panel from the Department for Public Health.[28]

Table 2.5 provides additional information.

Table 2.5
Panel Reports
2013 To 2022

Action	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Fatalities reviewed	0	43	31	47	59	51	54	85	80	69
Near fatalities reviewed	0	73	47	95	91	83	82	97	120	146
Findings	18	12	10	21	11	18	32	6	20	14
Recommendations	0	12	10	21	11	18	32	6	22	21

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

Chapter 3

Findings And Recommendations

This review produced three major finding areas and five recommendations.

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

Panel Has Acted On LOIC's 2022 Recommendations

The panel has taken substantive action related to all nine recommendations in LOIC's 2022 report.

On November 10, 2022, LOIC adopted nine recommendations related to the following areas:

- DCBS processes: intake of reports filed by the medical community under KRS 620.030(2); use of the Near-Fatality Criteria and Determination Flow Chart; training for the medical community related to reporting allegations of abuse and neglect; and DCBS's internal review process
- Online training modules with the Kentucky Board of Medical Licensure related to reports filed by the medical community pursuant to KRS 620.030(2) and documenting and reporting near fatalities as defined under KRS 600.020(40)
- Use of existing pediatric forensic medicine contract to provide additional training to the medical community
- Training and feedback regarding SB 97 (Regular Session 2022) requirements
- Annual report findings and recommendations to be based on data and analysis with actionable and targeted recommendations
- Implementing the panel's new data tool (REDCap survey) and analyst binder
- Budget and expenditure processes[29]

In the year following the adoption of LOIC's report, panel members and staff have taken substantive action related to all nine recommendations. Table 3.1 provides additional information.

Table 3.1
LOIC 2022 Update On The Kentucky Child Fatality And Near Fatality External Review Panel Recommendations

Recommendation Number And Text	Actions Taken
3.1 The Child Fatality and Near Fatality External Review Panel should more formally address its concerns and ideas for improvement with the Department for Community Based Services (DCBS) through panel workgroups and/or annual report recommendations in the following areas: intake of reports filed by the medical community under KRS 620.030(2); DCBS's use of the Near-Fatality Criteria and Determination Flow Chart; training for the medical community related to reporting allegations of abuse and neglect, and DCBS's internal review process.	At its March 2023 meeting, panel discussed its actions related to this recommendation. The recommendation regarding intake reports was addressed through recommendations in the panel's 2022 annual report. The Near Fatality Criteria and Determination Flow Chart was discussed during a 2021 meeting and later updated by DCBS. Panel members from the medical community have conducted training on the identification of near fatalities and shared the flow chart as part of the training. The panel continues to review DCBS's internal review process and discusses any concerns with DCBS staff at the monthly meetings.
3.2 The Child Fatality and Near Fatality External Review Panel should formally discuss the possibility of online training modules with the Kentucky Board of Medical Licensure in the following areas: reports filed by the medical community pursuant to KRS 620.030(2) and documenting and reporting near fatalities as defined under KRS 600.020(40).	This recommendation was discussed during the panel's March 2023 meeting. Panel members suggested adding a training module related to medical community reports and documenting/reporting near fatalities due to the statutorily required Abusive Head Trauma training.
3.3 The Child Fatality and Near Fatality External Review Panel should contact the Department for Community Based Services and discuss the feasibility of using existing pediatric forensic medicine contracts to provide additional training to the medical community, which may require a contract modification to increase the number of hours available for training.	This recommendation was discussed during the panel's March 2023 meeting.
3.4 The Child Fatality and Near Fatality External Review Panel should follow through on its idea of holding a spring 2023 meeting to discuss Senate Bill 97 implementation and other issues if needed.	The panel discussed implementation of SB 97 at its March 2023 meeting. *Note: Additional information is provided as part of this finding.*
3.5 The Child Fatality and Near Fatality External Review Panel should proactively seek feedback from courts, law enforcement, the medical community, and coroners related to the following areas addressed in Senate Bill 97: law enforcement testing; treating panel proceedings, records, opinions, and deliberations as privileged; and coroners' contact with the Department for Community Based Services and others upon notification of the death of a child. Feedback related to these areas could help the panel develop recommendations for system and process improvements in its annual reports.	Panel members are training coroners at annual trainings and new-coroner trainings about the changes included in SB 97. Coroners receive training on how to contact their local DCBS office and others. The local Child Fatality Review teams are getting feedback about the testing piece.

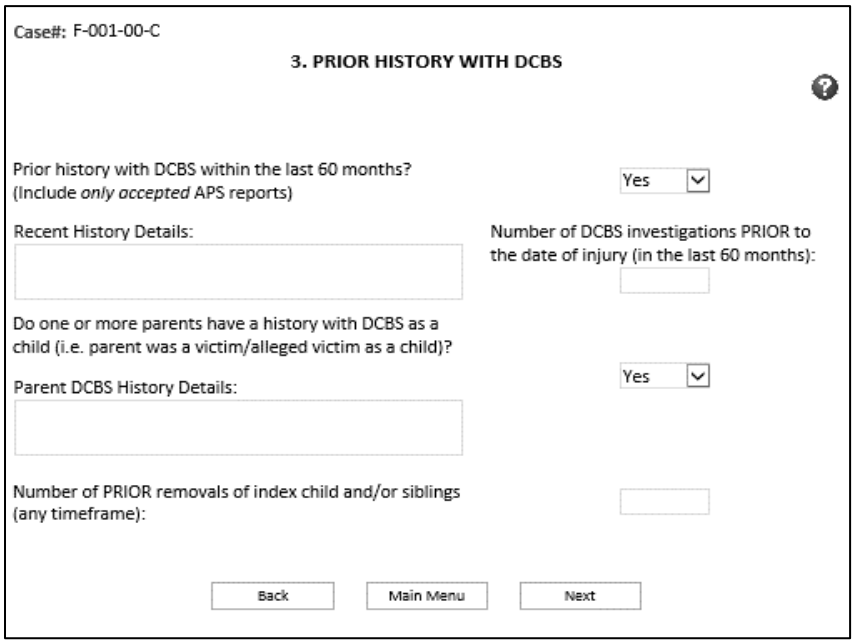
Recommendation Number And Text	Actions Taken
3.6 The Child Fatality and Near Fatality External Review Panel should continue its positive efforts to ensure that findings are based on data presented in the report and that recommendations are actionable, targeted, and directly related to findings.	The recommendation was discussed during the panel's March 2023 meeting. *Note: Additional information is provided as part of this finding.*
3.7 The Child Fatality and Near Fatality External Review Panel should continue to update its data tool and data dictionary, utilizing multi-disciplinary workgroups and the National Center for Fatality and Prevention; for example, to address factors that contribute to child fatalities and near fatalities such as resuscitation, naloxone, and torture. The panel should also periodically review entries in "Other" and comment text boxes to identify common entries that may be beneficial to add in its multiple choice data field options.	This recommendation was discussed during the panel's March 2023 meeting. *Note: Additional information is provided as part of this finding.*
3.8 The Child Fatality and Near Fatality External Review Panel and the Justice and Public Safety Cabinet should update the existing memorandum of understanding to reflect current budgetary and expenditure procedures. The memorandum of understanding should include written guidance related to the panel's biennial budget requests and expenditures**.**	The recommendation was discussed during the panel's March 2023 meeting. Panel members received a copy of the MOU and were encouraged to let staff know if they had suggestions for updates. No suggests have been received as of July 2023. *Note: Additional information is provided as part of this finding.*
3.9 The Child Fatality and Near Fatality External Review Panel and the Justice and Public Safety Cabinet should develop processes for meaningful communication between the panel chair and the cabinet secretary or the cabinet secretary's designee related to the panel's budgetary needs, as envisioned by the 2014 MOU (section 3). Such processes should include steps by which panel expenditures are approved and staffing requests are formally considered, as well as presentation of financial reports or updates to the panel.	Panel staff and Justice and Public Safety Cabinet budget staff presented financial updates to panel members during the March 2023 and June 2023 panel meetings. *Note: Additional information is provided as part of this finding.*

Source: Kentucky. Legislative Research Commission. Legislative Oversight and Investigations Committee. *Kentucky Child Fatality And Near Fatality External Review Panel 2022 Update*, Research Report No. 478, pp. 26-27, 29, 31, 37, 43; Kentucky. Justice and Public Safety Cabinet, Child Fatality and Near Fatality External Review Panel. *Panel Response To LOIC Questions*, Email from Elisha Mahoney, executive staff adviser, Child Fatality and Near Fatality External Review Panel to Gerald W. Hoppmann, July 10, 2023.

The panel revised its data tool in 2022. The updated data tool replaced narrative text boxes with options more suitable for analysis.

Data Tool And Data Dictionary. In 2022, the panel revised its data tool using REDCap. The updated data tool replaced narrative text boxes with options (such as multiple choice) that are more suitable for analysis.[30] Figure 3.1 illustrates that the panel's previous data tool for "Section 3. Prior History with DCBS" included two text boxes for additional information regarding prior DCBS history (child and parent). It also included two yes/no options.

Figure 3.1
Field 3. Prior History With DCBS, Previous Data Tool



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

In contrast, Table 3.2 shows how the updated data tool includes nonnarrative box data fields in sections that previously contained narrative boxes. This example illustrates how the panel replaced narrative boxes with more analysis-friendly multiple-choice options. This example includes seven yes/no questions with 13 multiple choice options containing 36 additional data points.[31]

Table 3.2
Prior History With DCBS, Updated Data Tool (REDCap Survey)

Question	Multiple Choice Options	Additional Data Points
1. Prior history with DCBS within the ast 60 months?	1. Result of involvement 2. Number of substantiated cases 3. Number of unsubstantiated cases 4. Number of FINSA/in need of services 5. Number of screened-out 6. Number of DCBS investigations prior to date of injury	1. Substantiated (1-10+) 2. Unsubstantiated (1-10+) 3. FINSA/in need of services (1-10+) 4. Screened out (1-10+) 5. DCBS investigations prior to date of energy (1-10+)
2. Does mother have a history with DCBS as a child?	7. DCBS history details	6. Parent identified as a child victim in CPS investigation 7. Parent removal from household 8. Parent identified in a screened-out referral 9. Parent in substantiated case was in household of CPS investigation 10. Unknown

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

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

Additionally, panel staff and members also worked to create an Analyst Binder, which serves as the panel's data dictionary in addition to being a step-by-step reference for analysts. The Analyst Binder/data dictionary expands on data fields/questions to ensure that data are consistently understood both on the input end and on the aggregate analysis end.[32]

The panel is working with Commonwealth Office of Technology and Justice and Public Safety Cabinet budget staff to explore software platform options.

Although the panel is currently using the REDCap survey for case analysis, staff use SharePoint to upload information and records from CHFS to a secure online location. Specifically, staff copy information and records into separate SharePoint folders for panel members to use when they review cases.[33]

The REDCap software cannot store case information. Panel members and staff must use multiple platforms to store, review, and analyze cases. The panel is working with the Commonwealth Office of Technology and Justice and Public Safety Cabinet budget staff to explore options that may allow the panel to use a single platform for case storage and analysis.[34]

There are plans to upgrade SharePoint, but the upgrade will be costly and time-consuming. The panel is considering buying off-the-shelf software or building its own software platform. The panel will consult with contracted DPH epidemiologists to determine the best course of action.[35]

The panel worked with the Justice and Public Safety Cabinet to submit a budget request in the fall of 2021. The 2022-2024 Budget of the Commonwealth included a $420,000 appropriation to the panel.

Panel's Budget And Expenditures. Related to the establishment of a separate appropriation allotment for the panel, the 2022-2024 Budget of the Commonwealth included a $420,000 appropriation for the panel for each fiscal year in the base budget of the Justice Administration budget.[36] Consistent with the initial annual appropriation of $420,000 in the 2014-2016 Budget of the Commonwealth, this appropriation appears to illustrate the legislature's intent to fully fund the panel each year.[37] The panel worked with the cabinet and submitted a budget request in the fall of 2021, which included funding for two additional full-time staff members.[38]

The communication between the panel and the cabinet has improved over the past 2 years. The cabinet typically approves the panel's expenditures as part of baseline funding for the Justice Administration appropriation unit, under the Office of the Secretary.[39] Panel expenses, such as salaries and fringe benefits, contract employee costs, and operating expenses, post to the panel's chart of accounts. It should be noted that the panel's annual personnel and operating expenditures have never totaled $420,000, which was the panel's initial appropriation in 2015. From 2015 through 2021, the panel has expended only 58 percent of its appropriations.[b] Table 3.3 provides additional information.

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

Table 3.3
Kentucky Child Fatality And Near Fatality External Review Panel Expenditures
FY 2015 To FY 2023

Fiscal Year	Personnel Expenditures*	Operating Expenditures	Total
2015	$212,582.32	$6,946.05	$219,528.37
2016**	267,004.34	21,197.73	288,202.07
2017	213,258.51	56,288.95	269,547.46
2018	141,943.11	7,670.70	149,613.81
2019***	185,344.55	3,610.57	188,955.12
2020***	275,116.91	6,511.40	281,628.31
2021	245,260.94	2,205.67	247,466.61
2022	293,852.33	2,202.60	296,054.93
2023	320,547.17	13,268.84	333,816.01
Total	$2,154,910.18	$119,902.51	$2,274,812.69

* Staffing expenditures include one executive staff adviser, one social service clinician II, and contracts for a forensic nurse analyst and a pediatric medical analyst.
** An additional $7,983.75 was expended for part-time data consultants from Kentucky State University and the University of Louisville.
*** For 2019 and 2020, baseline budget cuts of 6.25 percent were applied to 500A-Justice Administration, calculating to $26,250 each year.
Source: eMARS, Expenditure Analysis Report-FAS3.

The panel's FY 2023 staffing remained consistent with prior years, but the panel added an administrative staff member in 2023 and entered into an agreement with the Department for Public Health for epidemiologist services.

Staffing. The panel's 2022-2024 budget request included a request for funding for two full-time positions: a social service clinician II and an epidemiologist I.[40] In its justification for additional funding, the panel indicated increased caseloads resulting from its recent collaboration with DPH to encourage local child fatality review teams to refer cases suspected to stem from abuse or neglect.

Further increases in caseloads are expected due to continued collaboration with DPH along with a plan to request coroners, law enforcement agencies, and hospitals to refer cases directly to the panel. Further, the panel is "reevaluating and changing" its data tool, which may require additional data fields, thus increasing workload for staff. The panel also expressed the need for an epidemiologist for data analysis and quality assurance.[41]

As stated previously, the panel was appropriated $420,000 in the 2022-2024 Budget of the Commonwealth, a considerable increase from the panel's historical expenditures. However, the panel's staffing remained unchanged in 2023. As of July 2023, the panel had added an administrative staff member who will be shared with the Office of Drug Control Policy.[c] The position will use a payroll template in the Kentucky Human Resource Information System (KHRIS) that will split all costs associated with the new employee 50/50 between the budget allocated to the panel and ODCP.

[c] The panel anticipates using the $50,000 transferred from the Kentucky Agency for Substance Abuse Policy in 2022 to fund this contract.

Percentages can be adjusted if the employee is regularly working more than 50 percent of the time on tasks for one office or the other. The employee can also track work hours in real time, using the KHRIS timesheet allocation process.[42]

Also, the panel entered into a memorandum of agreement with the Department for Public Health for epidemiologist services.[43] CHFS is to send invoices for epidemiologist services to the Justice and Public Safety Cabinet, which is to process payment to CHFS through the use of Internal Transaction Initiator or Internal Transaction Agreement documents, unless CHFS indicates a preference for a different payment process in eMARS.[44] Tables 3.4 and 3.5 provide additional detail on both positions.

Table 3.4
Kentucky Personnel Cabinet
Position Description-Administrative Specialist III

Task	Duties
1	Provides professional support to the External Child Fatality and Near Fatality Review Panel by exporting, compiling, and analyzing complex data from SharePoint data tool. Responsible for researching extracted data and interpreting rules, regulations, and policies to provide guidance to local board members and agency staff.
2	Monitors, processes, and implements various complex requests submitted through departmental accounts, to include drafting requests to appropriate law enforcement agency based on case-analyst-submitted requests, budget modifications, public inquiries, etc. Responsible for processing Kentucky Agency for Substance Abuse Policy (KY-ASAP) budget modification requests received from local boards.
3	Reviews budget modification requests, evaluating that eligibility requirements are met, and implements in Intelligrants IGX. Communicates with board requesting modification and responds to questions and status update of request. Communicates final decisions.
4	Drafts and distributes correspondence to include statutorily required case information and correspondence to governing bodies regarding panel recommendations and programs. Distributes communications to panel members, boards, and public announcements. Serves as point of contact for KY-ASAP local boards on various complex matters throughout the year.
5	Serves as backup to Program Administrator for the Office of Drug Control Policy (ODCP) on the maintenance of the MethCheck Blocklist. Monitors Blocklist inbox for monthly conviction data upload as provided by the Administrative Office of the Courts, processes data into monthly Blocklist report, and uploads to National Precursor Log Exchange server.
6	Answers incoming phone calls, reviews and distributes incoming mail, schedules meetings and travel, transcribes meeting minutes, and conducts research upon request. Develops and maintains filing system for Child Fatality and Near Fatality Review and ODCP MethCheck Blocklist.
7	Other duties as assigned.

Source: Kentucky. Personnel Cabinet, Kentucky *Personnel Cabinet Position Description*, position number 31154007-Administrative Specialist III.

Table 3.5
Cabinet For Health And Family Services, Division Of Maternal And Child Health, And Justice And Public Safety Cabinet
Contract PON2 500 2300001857

Entity	Terms
Cabinet for Health and Family Services (contractor)	Provide expert data analysis and quality assurance pertaining to the evaluation of case files compiled for review pursuant to KRS 620.055 as requested by the Commonwealth.
	Be available to attend the External Child Fatality and Near Fatality Review Panel meetings in person or virtually in order to: a. Monitor data collection methods; b. Identify, interpret, and report data trends based upon analysis of collected data; and c. Assist in creation of prevention strategies and interventions to reduce the occurrence of fatal/near fatal child maltreatment.
	Be available to attend any additional meeting deemed necessary by the panel.
	Agree staff of the Commonwealth are permitted to monitor and evaluate services being performed by Contractor pursuant to this MOA.
	Perform remote services where feasible and as needed to comply with applicable federal, state, and local requirements and advisories pertaining to the COVID-19 pandemic or other states of emergencies.
	Provide own computer that meets Commonwealth Office of Technology requirements.
	Bill the Commonwealth for services rendered from the first to last day of each calendar month and provide all supporting documentation used to constitute the invoice.
	Provide all invoices to the Commonwealth no later than 30 calendar days after the end of the billing period.
Justice and Public Safety Cabinet (Commonwealth)	Provide direction and assistance to the Contractor for routine epidemiological functions which consist of data collection, analyzing data, and assisting with epidemiological investigations.
	Request periodic quality assurance of the data collection methods and written presentations of data trends via written correspondence with the Contractor.
	Monitor and evaluate the activities of the Contractor for the purposes of determining that the services provided are within the scope of this MOA.
	Approve all invoices submitted by the Contractor for payment.

Note: MOA = memorandum of agreement. The commonwealth is to pay the contractor a rate of $45 per hour, not to exceed $49,500 for the contract period, for services referenced in this MOA. The travel rate is per state policy, and the hourly rate does not apply during travel. The travel reimbursement is not to exceed $500 for the contract period. The total cost of services is not to exceed $50,000 for the contract period.
Source: eMARS.

The existing memorandum of understanding between the panel and the Justice and Public Safety Cabinet is likely in need of an update to reflect recent budget and expenditure changes.

Written And Other Guidance. At the panel's March 2023 meeting, panel staff indicated that the Justice and Public Safety Cabinet was "happy" to update the budget process in the memorandum of understanding as discussed in Recommendation 3.8, pending guidance from the panel. Panel members received a copy of the MOU and were asked to provide feedback for possible changes, but as of July 2023, panel members have not submitted suggested changes to panel staff.[45] Neither the panel nor the cabinet identify revising the MOU as a priority.[46] Nevertheless, the MOU is likely in need of an update to reflect changes resulting from the recent direct appropriation, the establishment of

expenditure budget authorities in eMARS, as well as increased staffing needs to handle direct referrals from coroners, law enforcement agencies, and hospitals.

Related to Recommendation 3.9 (see Table 3.1) that the panel and cabinet develop processes for meaningful communication related to budgetary needs, quarterly financial updates are being provided to panel members during their meetings. The panel's June 2023 financial update was presented by the Justice and Public Safety Cabinet's budget director.[47] The panel has also worked with cabinet budget staff on recent staffing decisions, and it is currently working on its upcoming budget request, which will more than likely address the following areas: hiring of a social services clinician and benefits, funding to continue the epidemiology contract, and one-time funding for the software update.[48] Draft baseline and additional budget requests are being developed by cabinet budget staff and are to be discussed at an upcoming panel meeting. After the panel's review, input, and approval, operating budget forms are to be produced.[49]

Recommendation 3.1

Recommendation 3.1

The Child Fatality and Near Fatality External Review Panel should continue to work with officials from the Commonwealth Office of Technology as well as Justice and Public Safety Cabinet budget staff to explore options that will allow the panel to utilize one platform for case storage, review, and analysis.

Recommendation 3.2

Recommendation 3.2

The Child Fatality and Near Fatality External Review Panel and the Justice and Public Safety Cabinet should update the existing memorandum of understanding (MOU) to reflect current budgetary and expenditure procedures to reflect changes resulting from the recent direct appropriation and the establishment of expenditure budget authorities in eMARS, as well as increased staffing needs. The MOU has not been updated since it was drafted in 2014.

The Panel Is Implementing Recent Legislative Changes

Table 3.6 shows that the panel is implementing changes made by SB 97 (Regular Session 2022), which amended sections of KRS Chapter 620 (Dependency, Neglect, and Abuse) and KRS Chapter

The panel is implementing changes to its composition; law enforcement testing requirements; panel reporting; records, opinions, and deliberations; and coroner notifications.

72 (Coroners, Inquests, and Medical Examinations).[50] Specific changes were made regarding the panel's composition; law enforcement testing requirements; panel reporting requirements; privileged nature of panel proceedings, records, opinions, and deliberations; and coroner notifications. The bill was passed as a result of findings and recommendations adopted by the committee, which are included in the LOIC staff report *Kentucky Child Fatality And Near Fatality External Review Panel 2021 Update,* Research Report No. 472.

Table 3.6
Panel's Actions In Response To Statutory Amendments
(2022 Kentucky Acts Chapter 139)

Statute Amended	Conditions Of Amendment	Panel Actions
KRS 620.040(5)(e)	Requires law enforcement officers to request a test of blood, breath, or urine when a report includes a child fatality or near fatality and the officer has reason to believe the child's supervisor was under the influence of drugs or alcohol at the time of the incident. If the individual does not consent, a search warrant must be requested and may be issued by a judge to the officer. Tests must be conducted pursuant to KRS 189.103.	Partnered with Prevent Child Abuse Kentucky to implement a checklist making law enforcement officers aware of legislative changes. The panel's 2022 report recommended that Kentucky State Police and Department of Criminal Justice Training ensure all officers receive training on the statutory changes.
KRS 620.055(2)	Expanded panel membership to 17 voting members, adding the president of the Kentucky Coroners Association and a practicing medication-assisted treatment provider selected by the attorney general from three names provided by the Kentucky Board of Medical Licensure. The chairs of the House and Senate Health and Welfare Committees were removed as ex officio nonvoting members. Two ex officio nonvoting members were added, to be appointed by the president of the Senate and the speaker of the House of Representatives.	Notified appointing agencies. The panel is working with appointing authorities to fill vacant positions.
KRS 620.055(10)(a)	Changed the requirement for the panel to publish its report by December 1 of each year to February 1.	The panel met this requirement by releasing its 2022 annual report prior to the deadline.
KRS 620.055(10)(b)	Introduced a new requirement for the panel to determine which agency is responsible for implementing each recommendation it makes in its annual report, and to forward that recommendation in writing to the appropriate agency.	Recommendations from the panel's 2022 annual report were forwarded to responsible agencies.
KRS 620.055(10)(c)	Recipient agencies must respond within 90 days with • written notice of intent to implement, an explanation of how they will do so, and an approximate time frame or • written notice that the agency does not intend to implement the recommendation along with a detailed explanation of why this cannot be done.	Responses were received for 10 of the 21 recommendations included in the panel's 2022 annual report.

Statute Amended	Conditions Of Amendment	Panel Actions
KRS 620.055(16)	Proceedings, records, opinions, and deliberations of the panel are now privileged, cannot be subject to discovery or subpoena, and cannot be used as evidence in any civil or criminal actions in a manner that would identify specific persons or cases reviewed by the panel.	No action taken. The panel is unaware of any challenges or concerns regarding this amendment.
KRS 72.410	Requires the coroner, upon notification of the death of a child which meets criteria defined in KRS 72.405 and 72.025, to immediately contact the local office of the Department for Community Based Services, law enforcement agencies with local jurisdiction, and the local health department to determine the existence of relevant information concerning the case. The language previously required the coroner to do so "as soon as practicable."	Panel members representing the State Child Fatality Review teams are educating coroners on this amendment at their annual training and new coroners' training.

Source: Child Fatality and Near Fatality External Review Panel. Question set responses, June 23, 2023. Email from Elisha Mahoney, executive staff adviser, Child Fatality and Near Fatality External Review Panel, to Gerald W. Hoppmann, July 10, 2023.

Reporting Requirements. The panel has met its reporting requirements by determining and forwarding recommendations to responsible agencies from its most recent annual report.[51] The panel's 2022 annual report included 21 recommendations, which were forwarded to recipient agencies on February 1, 2023, the report's publication date. Only 48 percent of recommendations received appropriate agency responses; the remainder received no responses. Tables 3.7 and 3.8 provide additional detail regarding agencies that did or did not respond to recommendations.

Table 3.7
Agency Responses To Recommendations,
2022 Report Of Kentucky Child Fatality And Near Fatality External Review Panel

Panel Recommendation	Response Within 90 Days	Written Notice Of Intent To Implement	Recommendation Implementation	Time Frame Of Implementation
1. The Department for Community Based Services should revise Standards of Practice and/or the SDM manual to allow for consideration of history of prior CPS involvement, age of victim, or professional reporting source as factors in decision making regarding acceptance of CPS reports by Central Intake staff.	Yes	Yes	Yes	Already implemented

Panel Recommendation	Response Within 90 Days	Written Notice Of Intent To Implement	Recommendation Implementation	Time Frame Of Implementation
2. The Department for Community Based Services should develop protocol for supervisory review of screened-out CPS referrals involving children under age four, history of prior CPS involvement, and referrals made by professional reporting sources.	Yes	Yes	Yes	Already implemented
3. Central Intake staff should consult with Systems Safety Staff on the first business day after receipt of a CPS referral regarding fatal or near fatal maltreatment to assure the correct designation has been applied.	Yes	Yes	Yes	Already implemented
4. The Department for Community Based Services should develop a process for professional reporters to seek timely supervisory review of a decision to screen out a CPS referral, including an opportunity to provide additional information, and a process to review referrals alleging fatal or near fatal maltreatment but not designated as such.	Yes	Yes	Yes	Already implemented
9. The Kentucky Board of Pharmacy should require that all pharmacists and/or pharmacy technicians provide face-to-face safe medication storage messaging to anyone receiving Medicated-Assisted Treatment pharmaceuticals. This messaging should strongly encourage recipients to obtain medication lockboxes to prevent unintentional ingestions	Yes	Partially agree	Partially yes, but stated that face-to-face messaging would require a statutory change	July 1, 2023
12. The Kentucky chapter of the American Academy of Pediatrics should encourage all primary care providers to educate their clients on proper medication storage. This messaging should be targeted to families with children under the age of six and older children who have documented mental health issues.	Yes	Yes	Yes	May 20, 2023
15. The Kentucky Department of Professional Licensing should ensure all mental health counselors are providing consistent messaging on safe storage of medication and firearms to the caregivers of children in their practice.	Yes	Yes	Yes	Within 18-24 months

Panel Recommendation	Response Within 90 Days	Written Notice Of Intent To Implement	Recommendation Implementation	Time Frame Of Implementation
19. The Kentucky Coroners Association and the Department of Criminal Justice Training should ensure all coroners and deputy coroners understand how to conduct a multidisciplinary investigation. This should include the purpose behind contacting the local DCBS and DPH and obtaining the proper medical history to determine if medical neglect could have played a role in the death.	Yes	Yes	Yes	2024 training program
20. The Department of Criminal Justice Training and the Kentucky State Police Academy shall ensure officers receive training on the recent changes in KRS 620.040(5)(e) and promote the utilization of the free training material offered by Prevent Child Abuse Kentucky.	Yes	Yes	Yes	2024 training program and free courses for officers by August 1, 2023
21. The Department of Criminal Justice Training and the Kentucky State Police Academy should convene a workgroup with representatives from DCBS, forensic pediatrics, and medical examiners to develop a specialized training focused on child fatality and near fatality investigations. This training should focus on the recognition of potential abuse or neglect cases, prompt drug testing when impairment is suspected, collaborative investigations, and pursuing criminal charges.	Yes	Yes	Yes	• Department of Criminal Justice Training: September 1, 2023 • KSP: 2024 Training Program

Note: The date the panel recommendations were published, February 1, 2023, is used as the date that all agencies received the recommendations. LOIC staff used "calendar day" to calculate timeframes. Of the 10 responses received, 4 were completed by DCBS (or CPS/Central Intake). SDM = structured decision making; CPS = Child Protective Services; DCBS = Department for Community Based Services; DPH = Department for Public Health.
Source: LOIC staff compilation of responses provided by the Kentucky Child Fatality and Near Fatality External Review Panel, 2023 Update, July 10, 2023.

Table 3.8
Recommendations Receiving No Agency Response,
2022 Report Of Kentucky Child Fatality And Near Fatality External Review Panel

Panel Recommendation
5. The House and Senate Committees on Families and Children should examine national best practices surrounding Alternative Response models and monitor the outcomes of the pilot efforts in Kentucky with the goal of providing support and resources necessary to rapidly expand the model.
6. The Administrative Office of the Courts should develop a budgetary proposal to expand Family Recovery Courts throughout Kentucky. The budgetary proposal should be presented to the Interim Joint Committee on Appropriations and Revenue, Budget Review Subcommittee on Justice and Judiciary, and the Kentucky Opioid Abatement Advisory Commission for appropriations.
7. The Department of Behavioral Health in conjunction with the Department for Public Health should accept full responsibility for implementing a comprehensive Plan of Safe Care. The Department for Community Based Services should ensure all notifications of substance-exposed infants are referred to the Plan of Safe Care program, regardless of whether the case is accepted for investigation.
8. The Health and Welfare Committee should review the Department's Plan of Safe Care Program for implementation and allocate necessary funding and any proposed legislative changes.
10. The Cabinet for Health and Family Services, Department for Community Based Services, and the Department for Public Health should apply for funding from the Kentucky Opioid Abatement Council, to purchase medication lockboxes that can be distributed during home visits.
11. The Department for Public Health, in collaboration with local partners, should launch a safe medication storage campaign. This campaign should include information on how families can obtain medication lockboxes free of charge.
13. The Department for Behavioral Health, Developmental and Intellectual Disabilities should develop a budget proposal to implement a statewide utilization of the Psychological Autopsy in youth suicides. The budget proposal should be presented to the Interim Joint Committee on Appropriations and Revenue.
14. The Department for Behavioral Health, Developmental and Intellectual Disabilities should explore grant opportunities to offset the initial implementation cost.
16. The Kentucky General Assembly, through the Judiciary Committee, should research national legislative models pertaining to Child-Access Prevention and Safe Storage Laws and develop legislation to implement Child-Access Prevention laws in Kentucky.
17. The Cabinet for Health and Family Services, Department for Public Health, Diabetes Prevention and Control Program should develop a workgroup consisting of, but not limited to, representatives from the Department for Community Based Services, Pediatric Forensics, a Pediatric Endocrinologist, Department for Public Health and a school nurse representative. This workgroup, at minimum, should be tasked with the following: • Research and develop a plan to implement a comprehensive case management system in Kentucky, similar to The Novel Interventions in Children's Healthcare. This plan should be presented to the Interim Joint Committee on Health, Welfare, and Family for funding and implementation. • Develop and disseminate a training with educational material for subspecialists to address when it is appropriate to make a referral to Child Protective Services (CPS) with allegations of medical neglect regarding a medically complex child. • Develop training for CPS staff on how to assess children with medically complex needs. This training should encourage social workers to consult with a pediatric forensics specialist at UK or UofL for expert analysis. • Develop a campaign for school-age children to destigmatize youth with medical conditions and mental health issues.
18. The Kentucky Society of Addiction Medicine should disseminate Safe Sleep material to all medication-assisted treatment providers and strongly encourage safe sleep education when serving parents and/or caregivers of infants. Education should emphasis the danger of co-sleeping while impaired, even on prescribed medications.

Note: According to panel staff, they have been in discussion with the Department for Public Health and a written correspondence is being provided regarding the safe storage campaign discussed in Recommendation 11.[52]
Source: LOIC staff compilation of responses provided by the Kentucky Child Fatality and Near Fatality External Review Panel, 2023 Update, July 10, 2023.

Although the panel has no formal procedures to follow up with agencies that do not respond to the panel's recommendations, staff does present information during panel meetings. For example, during the panel's June 27, 2023, meeting, recommendations and responses were presented to panel members. Nonrespondent agencies present provided verbal responses and/or notified staff that they were working on more formal responses.[53]

According to panel staff, panel members and staff have limited resources in both time and authority to follow up with agencies that do not respond.[54]

Recommendation 3.3

Recommendation 3.3

The Child Fatality and Near Fatality External Review Panel should develop procedures to follow up with agencies that do not comply with KRS 620.055(10)(c)2.

The Panel Is Meeting Its Statutory Requirements To Submit Annual Reports

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

In LOIC's 2022 evaluation of the Kentucky Child Fatality and Near Fatality External Review Panel, staff found that the panel met its statutory requirements to submit annual reports consisting of case reviews, findings, and recommendations for system and process improvements. Staff also found that the panel's reports included case summaries, determinations, contextual information, and state and federal statistics. Finally, SB 97 (2022 Regular Session) changed the deadline by which the panel is required to publish its annual report, from December 1 of each year to February 1. LOIC staff found that the panel met this statutory requirement in publishing its 2022 annual report.

In past years, LOIC staff found that the panel's findings were often unsupported by the analysis the panel performed and that the reports did not always present the information needed to link findings to data. Staff also found that the panel's past recommendations were not directly linked to its findings, nor were they consistently targeted, actionable, or able to address concerns in the findings.[55]

A review of the panel's most recent annual report, however, indicates that improvements continue in these areas. For example, in the 2022 report, all 14 findings were based on data or analysis identified in the report. All 21 recommendations in the report

addressed the concerns identified in the findings. All recommendations were both targeted and actionable.[56] Table 3.9 provides additional information on the panel's findings in its 2022 annual report.

Table 3.9
Child Fatality And Near Fatality External Review Panel
Findings Of 2022 Annual Report

Finding Number/Area	Finding
1. DCBS Processes	**Page 4:** "In FY 2021, the Panel reviewed 207 cases received from DCBS. Of those cases, 74 cases (26%) had prior screened-out CPS referrals. … 'This points to the importance of the initial decision to 'screen-out' certain calls. Screening out referrals leaves children unseen who may be at a high risk for later fatality.' … Based on SDM information provided to the Panel, it does not appear a history of prior CPS involvement, age of victim, or professional reporting source would trigger supervisory review of a decision to screen out referrals."
2. DCBS Processes	**Page 5:** "The determination of whether a CPS report is designated as a maltreatment related fatality or near fatality is made at the Central Intake level. The Panel has documented seven cases in which this designation was not made in a timely manner, or in some cases, not made at all. A common scenario is a case is accepted, the investigation is initiated, and days later it is correctly determined the fatality/near fatality designation should have been applied. At this point, a new worker is often assigned, second interviews are conducted and an already traumatized family may be confused by an unexpected change in the case. These scenarios raise concern that appropriate referrals are not identified and reviewed."
3. Family Recovery Court	**Page 7:** "As illustrated in Figure #2, 68% of all cases reviewed by the Panel had previous court history. … The judicial branch plays a crucial role in ensuring favorable outcomes for these families. Families with CPS involvement, substance misuse, mental health issues, and poverty issues require holistic services, delivered in a multidisciplinary and collaborative environment. Family Recovery Courts have been shown to improve collaboration while ensuring the safety of the children."
4. Plan of Safe Care	**Page 8:** "As noted in this report, 'Every infant, including those prenatally exposed to drugs or alcohol, should leave the hospital with an appropriate plan of safe care (POSC). A plan of safe care should include coordinated and integrated services needed for the affected child, parent(s), and caregivers.' This, unfortunately, is not the experience documented among NAS and substance exposed infant cases reviewed by the Panel."
5. Plan of Safe Care	**Page 9:** "The development of the POSC across Kentucky varies depending on the health-care provider and other agencies involved with the family. As stated in previous reports, the Department for Community Based Services should not be responsible for implementing and monitoring the POSC for every substance exposed infant. The Plan of Safe Care should be an individualized collaborative plan to support the caregiver(s) as well as providing services to promote the health and safety of the infant."
6. Overdose/Ingestion Cases	**Page 10:** "As shown in Figure #6, suboxone, buprenorphine, and methadone still rank among the top substances ingested in these types of cases. When analyzing cases involving those substances, 86% of these families were receiving Medicated-Assisted Treatment (MAT). MAT is a valuable resource utilized to combat Kentucky's opioid epidemic, but more must be done to educate providers and families about the potential lethality of these substance in children. Small children may mistake pills for candy and the source is usually a caregiver, parent, or home visitor. The exposure occurs most often in the child's own home."

Finding Number/Area	Finding
7. Youth Suicides	**Page 12:** "The Panel identified seven cases that illustrated the need for a psychological autopsy. These cases often included a child with a history of trauma, out of home placement, untreated mental illness, and bystander issues."
8. Youth Suicides	**Page 12: "**Youth suicides reviewed by the Panel were the result of self inflicted gunshot wounds and drug overdoses. Females accounted for 58% of all cases, including all overdose cases, with three of those cases identifying as LGBTQIA youth. … In over half of these cases (58%), the index child was either currently on medication or active in mental health treatments, while 33% had a history of previous mental health treatment."
9. Child Access Prevention Laws	**Page 13:** "The Panel reviewed a total of 24 firearm related injuries, seven cases were unintentional (accidental) and as previously mentioned, seven were suicide cases. … Deeper discussion of these cases during Panel meetings underscores the importance of limiting child access to and the safe storage of firearms. … Available research seems to strongly support CAP and Safe Storage laws as effective prevention strategies. • A 2020 study comparing states with stronger CAP laws to states with weaker CAP laws concluded states with stronger CAP laws had a 13% reduction in all shooting deaths among children under 15-years of age, specifically with reductions in homicides (15%), suicides (12%), and accidental deaths 13%. • While 70% of parents believe their adolescent child could not access firearms in the home, over a third of children report being able to quickly to access guns. • As reported in 2021, safe storage requirements could eliminate up to 32% of youth firearm-related deaths."
10. Medical Providers	**Page 14:** "In SFY 2021, the Panel reviewed 45 cases involving children with complex medical needs that were classified as 'medically fragile'. Of these cases, 27% were diagnosed with diabetes and an even more alarming trend, 37% of all medically complex children struggled with mental health issues. In several cases reviewed by the Panel, children diagnosed with diabetes struggled with depression and often stated they just wanted 'to be normal'. One case resulted in a suicide. Another alarming trend identified by the Panel was the number of repeated hospitalizations due to diabetes ketoacidosis (DKA). … Kentucky needs to develop a more comprehensive case management system around children diagnosed with diabetes. Often these families live in rural communities located hours from a subspecialist, struggle with lack of transportation and understanding of this disease and treatment. According to the American Diabetes Association, strategies for prevention of recurrent episodes of DKA include more intensive care coordination with the patient and family engagement. The Novel Interventions in Children's Healthcare is a comprehensive program that includes care coordination with families while incorporating telemedicine to engage youth with multiple hospitalizations for DKA. This program showed that daily communication via text messages and other forms of telecommunication decreased DKA readmissions in adolescents."
11. Safe Sleep	**Page 15:** "In addition, the Panel encourages all MAT providers address safe sleep education when serving parents and/or caregivers of infants. Due to the high rate of impaired caregivers, providers should educate their clients about the recent updates to KRS 620.040(5)(e), which requires law enforcement to drug test caregivers at the time of a child fatality or near fatality."
12. Coroners	**Page 16:** "[C]oroner issues were identified in 38% of all fatality cases reviewed by the Panel. … [L]ack of proper agency notification continues to be the most identified missed opportunity by coroners. … Of the SUDI cases reviewed by the Panel, a coroner issue was identified in 63%. These cases often lacked a proper doll reenactment, absent or incomplete SUIDI form, and/or lacked the proper notification to other investigatory agencies. As previously mentioned, the Panel reviewed 45 cases involving medically complex children; of those cases 13 were fatalities. Of those fatalities, 46% had documented coroner issues."

Finding Number/Area	Finding
13. Law Enforcement	**Page 17:** "In 2022, law enforcement issues were identified in 49 cases reviewed by the Panel. Law enforcement issues may include an agency's failure to conduct a thorough investigation, failure to drug test (despite probable cause), failure to seek criminal charges and/or a failure or delay to notify CPS. A third of these cases involved a child who ingested an illicit substance, yet there was either a lack of an investigation or lack of drug testing of the caregiver at the time of the event. A multidisciplinary investigation, including medical providers and DCBS, is critical in child abuse and neglect investigations. The Panel is hopeful the statutory changes implemented in SB 97 will support a more thorough investigation of these cases."
14. Law Enforcement	**Page 17:** "All law enforcement officers in basic training receive 4.5 hours of training focused on child abuse. The Department of Criminal Justice Training offers a 40-hour in-service training regarding child abuse investigations. However, law enforcement agencies struggle with staffing capacity and funding. Therefore, when the agency can permit an officer's absence for a week, the officer is limited to the trainings that are available at that time. The Panel continues to recommend that supervisors in the law enforcement field shall receive specialized training regarding the investigation of child death scenes."

Note: Finding 1 relates to 4 recommendations, finding 6 relates to 4 recommendations, and finding 7 relates to 2 recommendations. DCBS = Department for Community Based Services; CPS = Child Protective Services; SDM = structured decision making; NAS = neonatal abstinence syndrome; CAP = child-access prevention; MAT = medication-assisted treatment; SUDI = sudden unexpected death in infancy; SUIDI = Sudden Unexpected Infant Death Investigation.
Source: Kentucky. Justice and Public Safety Cabinet, Child Fatality and Near Fatality External Review Panel. *2022 Annual Report*.

Previous Annual Report Analysis

LOIC staff analysis found that all of the 14 findings in the panel's 2022 report were based on data/analysis identified in the report.

The marked improvement in the panel's 2022 report is best illustrated by revisiting LOIC's 2021 panel report, which determined that 49 percent of the 110 findings presented in the panel's 2014-2020 reports cited specific case data or analysis. Over that same period, 36 percent of the explanations explicitly mentioned case reviews but did not provide specific data or analysis. The remaining 15 percent of the finding explanations did not appear to link to any case data or analysis. These designations were determined by whether the relevant data or analysis could be identified within the report. In some cases where "yes" was indicated, the finding summary provided did not immediately include data or analysis, but relevant data or analysis was present in other parts of the report, such as appendices.[57]

Table 3.10 provides an overview of panel's findings and how the panel's annual reports have improved. Annual reports have improved by ensuring that findings are based on case data and analysis reflected in the reports. Since 2020, the percentage of findings based on case data and analysis has increased from 50 percent to 100 percent. LOIC staff also found that all findings mentioning case reviews were consistently supported by data.[58]

Table 3.10
Panel's Findings Based On Case Data/Analysis In Report
2014-2022

Annual Report Year	Were Findings Based On Case Data/Analysis Shown In Report? Yes	No	Unsure	Annual Total
2022	14	0	0	14
2021	19	1	0	20
2020	3	0	3	6
2019	27	3	2	32
2018	13	0	5	18
2017	2	4	5	11
2016	4	6	11	21
2015	1	1	8	10
2014	4	2	6	12
Total	87	17	40	144

Source: LOIC staff analysis of information in annual reports of Kentucky Child Fatality and Near Fatality External Review Panel

The panel could better organize information to make findings stand out more in its annual reports.

Better Organizing Information In Reports. Although the panel's findings have generally improved as noted above, the panel could better organize the information to make findings stand out more in their annual reports. LOIC staff had to thoroughly read the information prior to each set of recommendations to identify the critical condition associated with each topic area as noted in Table 3.1.

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

- Specific: Answers to "who, what, where, when, which, and why" are described.
- Measurable: A tangible plan for measuring impact is determined. …
- Achievable: Decide how important this activity is to your end goal and if it is possible.
- Realistic: Can this work be done with the resources available? …
- Time Sensitive: Identify a timeline and a due date.[59]

LOIC staff analysis found that all of the recommendations in the panel's 2022 report addressed finding concerns and were actionable and targeted.

Panel Recommendations Address Findings. To establish a base of comparison, LOIC's 2021 evaluation of the panel determined that 25 percent of recommendations presented in the panel's 2014-2020 reports addressed issues in corresponding findings. Nearly 72 percent of the panel's recommendations did not address finding concerns.[60] As shown in Table 3.11, however, all

recommendations in the panel's 2021 and 2022 reports addressed issues identified in the reports' findings.

Table 3.11
Panel's Recommendations Addressed Findings
2014-2022

Annual Report Year	Did Panel's Recommendations Address Findings?			Annual Total
	Yes	No	Unsure	
2022	21	0	0	21
2021	22	0	0	22
2020	0	6	0	6
2019	16	14	2	32
2018	3	15	0	18
2017	0	11	0	11
2016	1	19	1	21
2015	3	7	0	10
2014	4	7	1	12
Total	70	79	4	153

Source: LOIC staff analysis of information in annual reports of Kentucky Child Fatality and Near Fatality External Review Panel

Note that the panel's 2022 annual report presented and explained well-defined topic areas ahead of related recommendations.

Panel Recommendations Are Actionable And Targeted. In the panel's 2022 annual report, all 21 recommendations were actionable and targeted. This marks the second consecutive panel report in which LOIC staff determined that all recommendations were adequate, which is a significant improvement. *Actionable* indicates that the recommendation is realistic, is tangible, and specifies what should be accomplished to satisfy the recommendation. *Targeted* means the recommendation names the entity that is to carry out the recommendation. As discussed above, these terms are based on principles found in guidance from the National Center for Fatality Review and Prevention and represent best practices for developing recommendations.[61]

Recommendation 3.4

Recommendation 3.4

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

Recommendation 3.5

Recommendation 3.5

The Child Fatality and Near Fatality External Review Panel should organize information in each finding area so that each finding is clearly articulated related to corresponding recommendations.

Endnotes

[1] Kentucky. Governor Steven L. Beshear. Executive Order 2012-585, July 16, 2012. Secretary of State, Executive Journal
[2] KRS 620.055(1).
[3] Kentucky, General Assembly, *Acts Of The 2022 Regular Session,* ch. 139.
[4] KRS 620.055(10).
[5] KRS 620.055(4).
[6] Kentucky. Justice and Public Safety Cabinet, Child Fatality and Near External Review Panel. *2020 Annual Report*. 2021, p. 3.
[7] KRS 620.055(1).
[8] Kentucky. Office of State Budget Director. *2018-2020 Kentucky Branch Budget, Baseline Budget Request: Program Narrative/Documentation Record*. 2018, p. 44.
[9] Kentucky. Justice and Public Safety Cabinet. *Memorandum Of Understanding Between The Justice And Public Safety Cabinet And The Child Fatality And Near Fatality Review Panel*. May 23, 2014, pp. 3-4.
[10] Elisha Mahoney, executive staff adviser, Child Fatality and Near Fatality External Review Panel. Email to Gerald Hoppmann. Sept. 1, 2022. Attachment: *Question Set For The Kentucky Child Fatality And Near Fatality External Review Panel.*
[11] Kentucky. Office of State Budget Director. *2022-2024 Budget Of The Commonwealth*, Vol. I. N.d., p. 242. Web.
[12] Kentucky. Office of State Budget Director. *2014-2016 Budget Of The Commonwealth*. 2014, p. 214.
[13] Kentucky. Justice and Public Safety Cabinet. *Memorandum Of Understanding Between The Justice And Public Safety Cabinet And The Child Fatality And Near Fatality Review Panel*. May 23, 2014, pp. 3-4.
[14] Kentucky. Office of State Budget Director. *2014-2016 Kentucky Branch Budget, Additional Budget Request: Program Narrative/Documentation Record*. 2014, p. 54.
[15] Kentucky. Cabinet for Health and Family Services, Department for Community Based Services. "2.3 Acceptance Criteria And Reports That Do Not Meet." *Standards Of Practice Online Manual*. Jan. 14, 2020. Web.
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