Kentucky Child Fatality And Near Fatality External Review Panel 2026 Update

Research Report No. 503

Legislative Oversight And Investigations Committee

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Legislative Oversight And Investigations Committee

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Abstract

KRS 6.922 and 620.055(17) require the Legislative Oversight and Investigations Committee to conduct an annual evaluation of the Child Fatality and Near Fatality External Review Panel (panel) to monitor its operations, procedures, and recommendations. The panel, which has 17 voting and 5 ex officio members, is attached administratively to the Justice and Public Safety Cabinet. The independent panel's charge is to conduct comprehensive reviews of child fatalities and near fatalities reported to the Cabinet for Health and Family Services that are suspected to be a result of abuse or neglect. It is also required to submit annual reports discussing case determinations, as well as findings and recommendations for system and process improvements. During the 2026 Regular Session, the General Assembly passed House Bill 778 which amended KRS 620.055 and expanded the panel's access to records to include all "supervisory consult notes, documents, and information related to all fatal and near fatal cases." HB 778 also granted the panel access to The Workers Information System (TWIST), and the internet Workers Information System (iTWIST). The panel addressed one of the recommendations adopted by the Legislative Oversight and Investigations Committee in its 2025 panel update and is progressing on the second. Panel staff consulted with budget staff of the Justice and Public Safety Cabinet and resolved budgetary concerns with what originally appeared to be time-limited funding. The panel did not develop written procedures as recommended in 2024 and 2025, citing its intention to do so in tandem with the deployment of its new case management system which is currently in its testing phase. However, a lack of documented processes can lead to internal control issues. Generally, the panel complies with statutory requirements in that it exceeds the required number of meetings, posts required information, and delivers required reports. All five of the agencies that received recommendations responded as required by statute. However, two agencies responded after the statutory deadline. While agency responses to the panel's 2025 recommendations were improved, there is a risk that agencies in the future may not provide responses or provide responses that lack the clarity envisioned by statutes. LOIC staff conducted a survey of panel members to better understand the experience of serving on the panel and whether improvements could be made. The most common sentiments expressed by panel members included frustration with the case management system and the time commitment required of members to fulfil their duties on the panel. This report contains two recommendations for the panel and a matter for legislative consideration.

Foreword

Legislative Oversight and Investigations Committee staff appreciate all those who provided assistance with this report. The Kentucky Child Fatality and Near Fatality External Review Panel provided the benefit of its time. Elisha Mahoney, executive staff adviser, and Judge Lauren Adams Ogden, chairperson, provided valuable information.

Jay D. Hartz
Director

Legislative Research Commission
Frankfort, Kentucky
July 6, 2026

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

Major Objectives

The major objectives for this study were to review

- the actions taken by the panel over the past year to address recommendations from LOIC's 2025 annual report;
- the panel's development of findings and recommendations to meet reporting and other requirements under KRS 620.055(10);
- the panel's progress in developing its new case management system;
- panel members' experiences serving on the panel; and
- the panel's operations and procedures.

Major Conclusions

- The panel addressed one of the two recommendations adopted by the Legislative Oversight and Investigations Committee at its July 10, 2025, meeting. Panel staff consulted with the budget staff at the Justice and Public Safety Cabinet regarding how to use case management system funds beyond FY 2025. The panel did not act on the recommendation to develop written procedures. Panel staff intend to write written procedures but expect that the new case management system will impact how procedures will be written.
- In the past, agencies given recommendations in the panel's annual reports have not consistently fulfilled the requirements of KRS 620.055(10). All five agencies responded to the recommendations made in the panel's 2025 report, although two agencies responded late. These responses addressed all 21 recommendations in the report and satisfied statutory criteria.
- The 2026-2028 executive branch budget did not include a line item for the panel in the Justice and Public Safety Cabinet budget. Before the panel was included as a line item, the panel had not received resources to be sufficiently staffed. Panel staff are not concerned about potentially losing resources, but LOIC staff will monitor resources and expenditures as a precaution.
- The 2024-2026 executive branch budget included $200,000 for the panel in FY 2025 for the purchase of a new case management system. The panel is working with the Commonwealth

Office of Technology (COT) to design and build a new system. While the system is not complete and does not have an expected completion date, it has entered the testing phase.
- The panel has met its statutory requirement to submit annual reports consisting of case reviews and findings and recommendations for system and process improvements. The reports include contextual information, state and federal statistics, as well as case summaries and determinations.
- The panel's findings in its 2025 annual report were supported by analysis and data that were illustrated in the report. Recommendations were appropriately linked to the report's findings, and the recommendations were targeted and actionable.
- The panel's operations and procedures have not been formalized into written standard operating procedures. Panel staff stated their intent is to write procedures in tandem with the development of the panel's new case management system. A lack of written procedures can be a risk to internal controls and may prevent the panel from operating as intended or prevent panel members from providing feedback on operations.

Recommendations And Matter For Legislative Consideration

During the 2026 Regular Session, the General Assembly passed House Bill 778 which amended KRS 620.055 and expanded the panel's access to The Workers Information System (TWIST), and the internet Workers Information System (iTWIST).[1] TWIST and iTWIST are child welfare information systems managed by the CHFS Department for Community Based Services (DCBS). Allowing panel access to TWIST may be more difficult than envisioned in statute, based on difficulties encountered by other agencies. After the ombudsman for the Cabinet for Health and Family Services was moved to the office of the Auditor of Public Accounts in July 2024, the ombudsman did not initially have access to TWIST. Gaining access to TWIST required discussions through September 2024 and mediation between the two agencies. If the panel encounters issues with TWIST access, it may have more difficulties than the auditor's office. The panel has only two administrative staff and the panel conducts monthly meetings, limiting the amount of time available to discuss TWIST access. If panel staff cannot access the database, then it may deprive the panel members of information that may be useful in evaluating cases.

Recommendation 1.1

Staff of the Child Fatality and Near Fatality External Review Panel should request access to TWIST and any necessary training from the Cabinet for Health and Family Services as soon as possible. If panel staff encounter any difficulties, they should consult with other staff in the Justice and Public Safety Cabinet for assistance.

In the 2024 and 2025 panel updates, LOIC staff recommended that panel staff develop written procedures. According to panel staff, the development of written procedures is still in progress. Panel staff stated that their intent is to write procedures in tandem with the development of the panel's new case management system, which is also currently in development through the COT. According to staff, the new system is currently in its testing phase; however, it remains unclear when the system will be finished. The new procedures will represent how the new system

operates. The issues with a lack of procedures still remain, so a revised version of the written procedures' recommendation was issued.

Recommendation 3.1

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

While agency responses to the panel's 2025 recommendations were improved in comparison to past years, there is a risk that agencies in the future may not provide responses or provide responses that lack the clarity envisioned by statute. Even with the perfect response rate for the 2025 report, some agencies did not want to implement recommendations. There are reasonable justifications for refusing recommendations, such as a lack of authority or resources, but there may be panel recommendations that the General Assembly wishes to further investigate. The panel lacks any mechanism to seek additional information that could be provided to the General Assembly. In those cases, it may be beneficial for the General Assembly to request testimony from agencies to determine if barriers are legitimate or if legislative changes could be made.

Matter For Legislative Consideration 3.A

When agencies do not respond to or do not plan to implement recommendations, even with reasonable justification, from the Child Fatality and Near Fatality Review Panel, the General Assembly may wish to consider requesting testimony from the agencies if it believes additional information or further study of a recommendation is required.

Chapter 1

Kentucky Child Fatality And Near Fatality External Review Panel

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

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

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

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

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

From the 2026 Regular Session, HB 778 expanded the panel's access to case records, the Workers Information System (TWIST), and the quarterly System Safety Review Report. It also required the panel to develop a procedure for discussing cases with the agency that investigated the case.

During the 2026 Regular Session, the General Assembly passed House Bill 778 which amended KRS 620.055 and directly impacted panel operations. The bill expanded the panel's access to records to include all "supervisory consult notes, documents, and information related to all fatal and near fatal cases."[4] HB 778 also granted the panel access to The Workers Information System (TWIST), and the internet Workers Information System (iTWIST).[5] TWIST and iTWIST are child welfare information systems managed by the CHFS Department for Community Based Services (DCBS).[6] HB 778 additionally gave the panel access to the quarterly System Safety Review Report that is submitted to the Safety Action Group (SAG), along with any additional reports, minutes, and recommendations from the SAG meetings that are not part of the recommendations incorporated in the CHFS Annual Fatality Report.[7] Access to such records will provide the panel

additional information stemming from DCBS's own internal review of the cases reviewed by the panel.[8]

In addition to expanding the panel's access to the records and databases mentioned above, HB 778 created new operating requirements for the panel. The panel is required to develop a procedure for discussing reviewed cases with the agency that was responsible for the initial investigation of the case.[9] These procedures must include

- that any discussions about a case shall be held in a closed session;
- that anything said by an employee of the investigating agency shall not be used as evidence in any civil, criminal, or administrative hearing;
- that any employee of the investigating agency may attend with the employee or employees who investigated the case being discussed; and
- that the investigating agency shall not be asked to attend until after final judgment was entered by the court in that case or the commonwealth declined to prosecute the case.[10]

HB 778 was signed by the Governor on April 10, 2026, and takes effect 90 days after the adjournment of the legislative session on July 15, 2026.[11] During the panel meeting held on May 19, 2026, members of the panel discussed HB 778, aiming to have most of the new requirements implemented by August 2026.[12]

Potential Difficulties Of Accessing TWIST

In 2024, the ombudsman for the Cabinet for Health and Family Services encountered difficulty accessing TWIST after it was moved to the office of the Auditor of Public Accounts.

Allowing panel access to TWIST may be more difficult than envisioned in statute, based on difficulties encountered by other agencies. After the ombudsman for the Cabinet for Health and Family Services was moved to the office of the Auditor of Public Accounts in July 2024, the ombudsman did not initially have access to TWIST. Gaining access to TWIST required discussions through September 2024 and mediation between the two agencies.[13]

If the panel encounters issues with TWIST access, it may have more difficulties than the auditor's office. As discussed later, the panel has only two administrative staff and the panel conducts monthly meetings, limiting the amount of time available to discuss TWIST access. If panel staff cannot access the database, then it may deprive the panel members of information that may be useful in evaluating cases.

Recommendation 1.1

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Staff of the Child Fatality and Near Fatality External Review Panel should request access to TWIST and any necessary training from the Cabinet for Health and Family Services as soon as possible. If panel staff encounter any difficulties, they should consult with other staff in the Justice and Public Safety Cabinet for assistance.

Reporting And Oversight Requirements

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

The panel is required to publish its annual report by February 1 of each year. These reports consist of case reviews, findings, and recommendations for system and process improvements to help prevent child fatalities and near fatalities due to abuse and neglect.[14] The panel's annual report considers cases from the previous fiscal year regardless of whether investigations by the Department for Community Based Services substantiated allegations of abuse or neglect in each case.

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

KRS 6.922 and KRS 620.055(17) require the Legislative Oversight and Investigations Committee (LOIC) to conduct annual evaluations of the Child Fatality and Near Fatality External Review Panel to monitor its "operations, procedures, and recommendations." LOIC staff's first evaluation of the panel was adopted by the committee in July 2014 and focused on the panel's

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

Since 2014, LOIC reports have continued to evaluate statutory compliance while reviewing processes for panel funding, case reviews, and drafting annual reports and recommendations. The most recent LOIC update in 2025 focused on internal controls for the panel and funding for a new case management system.

Major Objectives

This study had five major objectives.

The major objectives for this study were to review

- the actions taken by the panel over the past year to address recommendations from LOIC's 2025 annual report;
- the panel's development of findings and recommendations to meet reporting and other requirements under KRS 620.055(10);
- the panel's progress in developing its new case management system;
- panel members' experiences serving on the panel; and
- the panel's operations and procedures.

Methodology

LOIC staff conducted the following research tasks:

- Observed monthly panel meetings and followed up on information as needed
- Reviewed and analyzed child fatality and near fatality case information and data from the panel's annual reports from 2014 to 2025
- Reviewed and analyzed the panel's historic expenditure data from eMARS
- Reviewed and analyzed the panel's historic contract information from eMARS
- Interviewed panel staff about the panel's operations, procedures, recommendations, and development of a new case management system
- Surveyed panel members to identify obstacles and investigate potential operational improvements

Major Conclusions

This study has seven major conclusions.

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- The panel addressed one of the two recommendations adopted by the Legislative Oversight and Investigations Committee at its July 10, 2025, meeting. Panel staff consulted with the budget staff at the Justice and Public Safety Cabinet regarding how to use case management system funds beyond FY 2025. The panel did not act on the recommendation to develop written procedures. Panel staff intend to write written procedures but expect that the new case management system will impact how procedures will be written.

- In the past, agencies given recommendations in the panel's annual reports have not consistently fulfilled the requirements of KRS 620.055(10). All five agencies responded to the recommendations made in the panel's 2025 report, although two agencies responded late. These responses addressed all 21 recommendations in the report and satisfied statutory criteria.

- The 2026-2028 executive branch budget did not include a line item for the panel in the Justice and Public Safety Cabinet budget. Before the panel was included as a line item, the panel had not received resources to be sufficiently staffed. Panel staff are not concerned about potentially losing resources, but LOIC staff will monitor resources and expenditures as a precaution.

- The 2024-2026 executive branch budget included $200,000 for the panel in FY 2025 for the purchase of a new case management system. The panel is working with the Commonwealth Office of Technology (COT) to design and build a new system. While the system is not complete and does not have an expected completion date, it has entered the testing phase.

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

- The panel's findings in its 2025 annual report were supported by analysis and data that were illustrated in the report. Recommendations were appropriately linked to the report's findings, and the recommendations were targeted and actionable.

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

Structure Of This Report

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

Chapter 3 provides a review of panel operations and focuses on the procedural changes made since LOIC's 2025 panel report was published. The chapter contains three major finding areas, a summary of the panel member survey, one recommendation carried over from the 2025 report, and one matter for legislative consideration.

Chapter 2

Child Fatality And Near Fatality External Review Panel Background

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

KRS 620.055(1) created the Kentucky Child Fatality and Near Fatality External Review Panel. Statute gives wide discretion to the panel in its activities. The panel must

- conduct "comprehensive reviews of child fatalities and near fatalities, reported to the Cabinet for Health and Family Services, suspected to be a result of abuse or neglect" and
- "publish an annual report … consisting of case reviews, findings, and recommendations for system and process improvements to help prevent child fatalities and near fatalities that are due to abuse and neglect."[15]

Membership

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

KRS 620.055(2) requires that the panel be composed of 5 ex officio nonvoting members and 17 voting members. Four of the voting members serve because of their positions, eleven are appointed by the attorney general, one is appointed by the chief justice of the Supreme Court, and one is appointed by the secretary of state. The member appointed by the secretary of state serves as chair of the panel. The names and affiliations of panel members are included in the panel's annuals reports and on the panel's webpage.[16]

Table 2.1 reflects the panel's membership as of May 4, 2026. There are currently no vacant positions, however one member is serving on an expired term. Panel staff have contacted the appropriate liaison to confirm that the member is to be reappointed.[17]

Table 2.1
Membership Of The Child Fatality And Near Fatality External Review Panel
As Of May 8, 2026

Name	Title/Appointing Authority		Term Ends
Ex Officio (Nonvoting) Members (5)			
Sen. Danny Carroll	Member appointed by president of Senate		N/A
Rep. Samara Heavrin	Member appointed by speaker of House of Representatives		N/A
Lesa Dennis	Commissioner of Department for Community Based Services		N/A
Dr. Lyndsey Neese	Commissioner of Department for Public Health		N/A
Judge Libby Messer	Family court judge appointed by chief justice of Kentucky Supreme Court		N/A
Voting Members (17)			
Judge Lauren Adams Ogden	At-large representative who shall serve as chair	Secretary of state	4/15/2028
Dr. Christina Howard	Pediatrician from University of Kentucky Department of Pediatrics	Attorney general*	6/30/2026
Dr. Melissa Currie	Pediatrician from University of Louisville Department of Pediatrics**	Attorney general*	6/30/2026
Dr. William Ralston	State medical examiner or designee	Position	N/A
Victoria Benge	Director of Court-Appointed Special Advocates	Attorney general*	6/30/2026
Lt. Jonathan Murphy	Peace officer***	Attorney general*	6/30/2027
Dr. Jaime Kirtley	Representative from Prevent Child Abuse Kentucky	Attorney general*	6/30/2026
Hon. Olivia McCollum	Practicing local prosecutor	Attorney general	6/30/2027
Tisha Pletcher	Proxy of executive director of ZeroV	Position	N/A
Brittany Nichols	Chair of State Child Fatality Review Team	Position	N/A
Nicole Smith Abbott	Practicing social work clinician	Attorney general*	6/30/2026
Geoff Wilson	Practicing addiction counselor	Attorney general*	6/30/2027
Heather McCarty	Representative from family resource and youth service centers	Attorney general*	6/30/2027
Steven Shannon	Representative of a community mental health center	Attorney general*	6/30/2026
Dr. Elizabeth Salt	Member of a citizen foster care review board	Chief justice of Kentucky Supreme Court	6/30/2025†
Mark Hammond	President of Kentucky Coroner's Association	Position	N/A
Dr. Danielle Anderson	Practicing medication-assisted treatment provider	Attorney general*	6/30/2027

Note: N/A = not applicable.
* Attorney general selects appointee from a list of three names provided by entities specified in statute.
** The appointee must be licensed and experienced in forensic medicine relating to child abuse and neglect.
*** The appointee must have experience investigating child abuse and neglect fatalities and near fatalities.
†Dr. Salt continues to serve until a replacement is appointed or she is reappointed.
Source: KRS 620.055(2); Elisha Mahoney, executive staff adviser, Child Fatality and Near Fatality External Review Panel. Emails to Jacob Blevins. May 4 and May 8, 2026.

Meeting Requirements

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

Statute requires that the panel meet at least quarterly.[18] The panel has exceeded this requirement in every year since its inception in 2013.[19] The panel has met monthly since July 2020 due to increased caseloads.[20] Table 3.1 in Chapter 3 provides more information.

Budget And Expenditures

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

The panel is attached to the Justice and Public Safety Cabinet for staffing and administrative purposes.[21] The panel does not have its own personnel and operating budgets, as its funding is included as part of the Office of the Secretary's baseline funding. In budget years when baseline funds were insufficient to meet the Office of the Secretary's needs, the panel's budget was also susceptible to cuts.[22]

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

According to a 2014 memorandum of understanding between the panel and the Justice and Public Safety Cabinet, the panel is required to provide its budget request during the fall prior to a budget session. The cabinet then operates as a pass-through to submit the panel's budget to the Office of State Budget Director without prioritization.[23]

The panel, through the cabinet, requested and received $420,000 annually in the 2014-2016 budget.[24] Subsequent budgets did not include specific appropriations or allotments for the panel. Rather, the panel's expenditures for the biennia covering 2016 through 2022 were included as part of the baseline funding for the justice administration appropriation unit, under the Office of the Secretary.[25]

The panel, through the cabinet, requested and received $420,000 annually in the 2014-2016 budget request. As of 2026, the panel no longer has a separate line item.

The panel worked with justice cabinet budget staff and submitted a budget request in the fall of 2021.[26] The 2024-2026 executive branch budget subsequently included $594,100 for FY 2025 and $592,900 for FY 2026 in the base of the justice administration budget for the panel.[27] As of 2026, the panel no longer has a separate line item in the justice cabinet budget.[28]

Table 2.2 details the panel's expenditures from FY 2015 through year-to-date FY 2026. Nearly 95 percent of the panel's expenses have been for personnel costs related to the compensation of full-time employees and contracted consultants and analysts.

Operating expenses have typically been minimal and consist primarily of charges from COT and, starting in FY 2023, rent for office space. Operating expenses related to food and travel have decreased since 2020 due to the panel's switch from in-person meetings to primarily virtual meetings.

Table 2.2
Kentucky Child Fatality And Near Fatality External Review Panel Expenditures
FY 2015 To April 27, 2026

Fiscal Year	Personnel Expenditures	Operating Expenditures	Total
2015	$212,582	$6,946	$219,528
2016*	267,004	21,198	288,202
2017	213,259	56,289	269,547
2018	141,943	7,671	149,614
2019	185,345	3,611	188,955
2020	275,117	6,511	281,628
2021	245,261	2,206	247,467
2022	293,852	2,203	296,055
2023	320,547	13,269	333,816
2024**	351,423	17,991	369,414
2025	478,791	22,287	501,078
2026***	342,489	62,416	404,905
Total	$3,327,613	$222,598	$3,550,209

Notes: Expenditures for 2015 to 2026 do not sum to the total shown due to rounding.
* An additional $7,983.75 was expended for part-time data consultants from Kentucky State University and the University of Louisville.
** An additional $200,000 in capital outlays was allocated to the panel in 2024 for the development of a new case management system but is not included in the table.
*** Statewide accounting system data through April 27, 2026.
Source: eMARS, Expenditure Analysis Report-FAS Power BI.

Staffing

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

Panel staffing currently consists of six staff: one executive staff adviser, two social service clinicians II (case analysts), two contract pediatric forensic medical case analysts, and an administrative staff member who is shared with the Office of Drug Control Policy. Additionally, the panel has entered into an agreement with the Department for Public Health (DPH) for epidemiology services.[29]

Panel Funding Increased In The 2024-2026 Budget

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

The panel's 2024-2026 budget request was notable because the panel requested new funding in two areas. The panel requested additional funding to hire additional full-time staff and to continue epidemiology support. The panel also requested one-time funding of $200,000 for FY 2025 for a new case management system.[30]

The 2024-2026 executive branch budget increased the panel's annual allocation to $594,100 in FY 2025 and $592,900 in FY 2026. The panel also received an additional $200,000 in FY 2025 for the procurement of a new case management system. The budget bill specified that the funds allocated to the panel for the purchase of the case management system will lapse to the budget reserve trust fund account if not expended in FY 2025.[31] The increase in funding enabled the panel to hire an additional full-time case analyst in 2024.[32]

Panel Now Lacks A Budget Line Item In The 2026-2028 Budget

The FY 2026-2028 budget for the Justice and Public Safety Cabinet did not include a line item for the panel. This lack of line item increases the risk that the panel will be underfunded, as discussed in prior panel updates.

The FY 2026-2028 budget for the Justice and Public Safety Cabinet did not include a line item for the panel.[33] In prior years, the panel had received a line item under the Justice Administration unit of the cabinet.[34] This lack of line item increases the risk that the panel will be underfunded, as discussed in prior panel updates. While the executive staff advisor for the panel indicated no concern with funding, the 2027 panel update will review expenditures to ensure the panel received resources.[35]

In the 2021 update, LOIC staff found that that the panel received $420,000 in the FY 2015-2016 budget but actual expenditures never approached $420,000 from FY 2015 to FY 2021.[36] The report found that the panel's budget concerns led to obstacles with focusing on legislation and following up on recommendations. The report recommended that the panel develop formal budget requests and be included as a separate appropriation allotment.[37]

The 2022 update found that a 2021 recommendation to include the panel as a separate allotment was fully implemented and two recommendations regarding improving the budget submission process were partially addressed. For the partially addressed recommendations, budget discussions between the panel and the Justice and Public Safety Cabinet occurred but there was not written documentation at the time.[38]

Since 2022, the panel has been able to expand staffing and improve services to the panel members. As of the 2022 update, staffing for the panel had consisted of one executive staff adviser, one social service clinician, and one contracted pediatric medical case analyst.[39] As discussed in the staff section of this update, the panel is currently staffed by six professionals.[40] If the panel begins to lose funding as a result of no longer having a line item, then services provided to the panel members could be impacted.

Case Referral

The Department for Community Based Services and, to a lesser extent, the Department for Public Health refer cases to the panel for review.

The panel reviews cases referred from the Department for Community Based Services and, to a lesser extent, the Department for Public Health.[41] Table 2.3 details the number of cases reported by each agency. Total referrals increased 82.4 percent from 136 cases in 2019 to 248 cases in 2025.

Table 2.3
Kentucky Child Fatality And Near Fatality External Review Panel
Case Referrals By Agency
2019 To 2025

Referring Agency	2019	2020	2021	2022	2023	2024	2025
DCBS	121	140	173	207	196	208	239
DPH	15	42	27	8	6	11	9
Total	136	182	200	215	202	219	248

Note: DCBS = Department for Community Based Services; DPH = Department for Public Health.
Source: Kentucky. Justice and Public Safety Cabinet. Child Fatality and Near Fatality External Review Panel: *2019 Annual Report*; *2020 Annual Report*; *2021 Annual Report*; *2022 Annual Report*; *2023 Annual Report*; *2024 Annual Report*; *2025 Annual Report.* Web.

DCBS Referrals

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

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

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

Additional expectations are placed on medical professionals, educational personnel, social workers, and police.

KRS 620.030(2) places additional expectations on medical professionals, educational personnel, social workers, and police who know or suspect dependency, neglect, or abuse. KRS 620.040(5)(e) requires law enforcement officers to request a test of blood, breath, or urine when a report includes a fatality or near fatality if the officer has reason to believe a caregiver was under the influence of drugs or alcohol at the time of the incident. If consent is not given for the test, a search warrant must be requested and may be issued by a judge. Also, KRS 72.410(a) requires that upon notification of the death of a child as defined in KRS 72.025 and 72.405, the coroner shall "immediately" contact DCBS and law enforcement agencies for information.
Once a report is received, DCBS screens acceptance criteria for the alleged maltreatment "where the alleged perpetrator is in a caretaking role."[42] 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."[43]

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.[44]

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

If DCBS suspects that a child fatality or a near fatality occurred as a result of abuse or neglect, it investigates the case, which is ultimately referred to the panel for review. 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.[45]

DPH Referrals

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

DPH also refers cases to the panel from its local child fatality review teams.[46] 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.[47] Upon receipt, panel staff send the list of DPH referrals to DCBS to request available case information. According to DCBS officials, frontline staff from DCBS regional offices also participate on the local teams and provide information as needed.[48]

If DCBS is not involved with the case, panel staff may send formal requests for information to local entities requesting medical,

education, law enforcement, and other records. DCBS may choose to investigate the matter as well, if it is not familiar with the circumstances surrounding a child's death.[49]

Panel Reviews

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

The panel uses information and records provided by the Cabinet for Health and Family Services to make its case determinations, as well as to support findings and recommendations for system and process improvement. KRS 620.055(6) requires CHFS to provide the panel, within 30 days, numerous types of information and records in unredacted form. HB 778 was passed in the 2026 Regular Session and added "All supervisory consult notes, documents, and information related to all fatal and near fatal cases," to the list of required information that CHFS must share.[50] Appendix A summarizes the information to be provided to the panel.

Although statute authorizes the panel to request case records at any point, the panel has historically elected to wait until DCBS has finished its investigations before reviewing cases.[51] Panel staff stated that it is easier to obtain information and records for closed cases.[52]

The amount of time required by DCBS to complete investigations has decreased since FY 2024, but the majority of cases still require more than six months to complete. Investigations have an average completion time of 7.6 months.

However, the significant amount of time required by DCBS to complete investigations has impeded the panel's ability to review cases in a timely manner. In its 2024 annual report, the panel stated that the state-wide average length of time from receipt of a fatality/near-fatality case to completion of the investigation had decreased to eight months in FY 2024 in comparison to the average of nine months in FY 2022.[53] The panel's report stated that FY 2025 case investigation times decreased to 230 days or approximately 7.6 months.[54]

In its 2024 report, the panel noted that Jefferson County staff have caseloads two to three times higher than other counties which resulted in longer average completion times than the rest of the state. Jefferson County took four months longer than the rest of the state to complete investigations.[55] According to the 2025 report, the Jefferson County average has increased to 395 days for case completion, which is 165 days more than the average in the rest of the state or approximately 5.4 months.[56]

Review Process

Panel staff use a document management and storage platform called SharePoint to upload information from CHFS to a secure online location. Staff copy information and records into separate SharePoint folders for analysts and panel members to use when reviewing cases.[57]

Panel members streamlined reviews by instructing analysts to provide case summaries and analysis. Each panel member is assigned four to five cases per meeting. Analyst findings and case summaries are provided a week before each meeting.

Due to the large number of records associated with each case, panel members streamlined reviews by instructing analysts to provide case summaries and analysis.[58] Once CHFS uploads the case documents to SharePoint, panel analysts review the case information and document their findings and analyses into case summary and timeline templates, which are forwarded to panel members a week before each panel meeting. Each panel member is assigned four to five cases per meeting, depending on the number of cases and the number of panel members available for that month's meeting. Although each panel member is assigned only a portion of the month's cases, all members have access to all cases.[59]

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

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

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

[a] The panel is currently in the process of developing a new software platform to perform the functions that SharePoint and REDCap currently fulfill.

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

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

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

Updates To Panel's Software Platforms. The panel received $200,000 in FY 2025 funding for a new case management system in the 2024-2026 executive branch budget. The panel is working with COT to develop a new software system that will incorporate elements of both SharePoint and REDCap. According to panel staff, there is a formalized statement of intent with COT. Staff meet with COT weekly and sometimes biweekly to work on the new system. The new case management system is not expected to be finished by the end of FY 2026, and the timeline for completion remains unclear.[60] Panel staff are currently working with COT to conduct the testing phase of the project.[61]

Annual Reports And Recommendations

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

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

- Categorization
- Family characteristics
- Other qualifiers
- Panel determination

The panel's 2025 annual report summarizes 248 cases reviewed from the previous fiscal year—July 1, 2023, through June 30, 2024. The 248 cases represented 72 fatalities and 176 near fatalities. DPH referred nine fatality cases to the panel.[62] Table 2.4 shows the number of cases reviewed by the panel from the last 7 years.

Table 2.4
Cases And Recommendations
From Child Fatality And Near Fatality External Review Panel Reports
2019 To 2025

Action	2019	2020	2021	2022	2023	2024	2025
Total cases reviewed	136	182	200	215	202	219	248
Fatalities reviewed	54	85	80	69	68	70	72
Near fatalities reviewed	82	97	120	146	134	149	176
Findings	32	6	20	14	25	9	19
Recommendations	32	6	22	21	25	11	21

Source: Kentucky. Justice and Public Safety Cabinet. Child Fatality and Near Fatality External Review Panel: *2019 Annual Report*; *2020 Annual Report*; *2021 Annual Report*; *2022 Annual Report*; *2023 Annual Report*; *2024 Annual Report*; *2025 Annual Report*. Web.

Agency Responses To Recommendations

KRS 620.055 requires the panel to send recommendations to agencies. All of the 21 recommendations forwarded to agencies by February 1, 2025.

KRS 620.055 requires the panel to send recommendations to the agency responsible for implementing the recommendations, and requires the agency to respond within 90 days of receipt with an explanation of implementation or why it will not implement the recommendation. The panel's 2025 annual report included 21 recommendations, which were forwarded to recipient agencies on January 31, 2026, before the statutorily required deadline of February 1.[63] All recommendations eventually received agency responses; however, only four received responses within 90 days as required by statute.[64]

Chapter 3

Review Of Panel Operations

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

This evaluation of the Kentucky Child Fatality and Near Fatality External Review Panel focused on procedural changes made since LOIC's 2025 panel report was published and produced three major finding areas and one recommendation.

The Panel Completed One Of LOIC's 2025 Recommendations And Is Progressing On The Second

The panel has acted on one of the two recommendations in LOIC's 2025 report. It plans to complete the second recommendation.

On July 10, 2025, the Legislative Oversight and Investigations Committee adopted two recommendations related to the following areas:

- Recommendation 2.1: Consultation with budget staff of the Justice and Public Safety Cabinet regarding how to use appropriated funds.
- Recommendation 3.1: Development of written procedures to document the processes by which the panel obtains, stores, reviews, and analyzes cases; develops findings and recommendations; develops annual reports; and complies with the reporting requirements mandated by KRS 620.055(10).[65]

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

Recommendations From LOIC's 2025 Panel Update

The panel consulted with budget staff of the Justice and Public Safety Cabinet and their concerns have been resolved.

Panel staff have consulted with budget staff of the Justice and Public Safety Cabinet and resolved budgetary concerns with what originally appeared to be time limited funding.

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

In the 2024-2026 executive branch budget, the panel received an additional $200,000 in FY 2025 for the procurement of a new case management system.[66] The budget bill specified that the funds allocated to the panel for the purchase of the case management system would lapse to the budget reserve trust fund account if not expended in FY 2025.[67] Panel staff expressed concern that it would not be able to access all appropriated funds because the project would extend past FY 2025.[68] LOIC staff interviews found the Justice and Public Safety Cabinet could provide guidance for funds to be used past FY 2025.[69] Panel staff have indicated that they have consulted with Justice and Public Safety staff about the use of funds appropriated for the case management system and that their concerns have been resolved.[70]

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

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

The development of written procedures is still in progress as of the publishing of this report. Panel staff stated that their intent is to write policies in tandem with the deployment of their new case management system which is currently in development with COT and that doing so will allow for the written procedures to reflect operation of the new system. Until written procedures are completed, potential concerns with internal controls will exist. The benefits of written procedures are discussed in more detail in the section on internal controls.[71]

Statutory Compliance

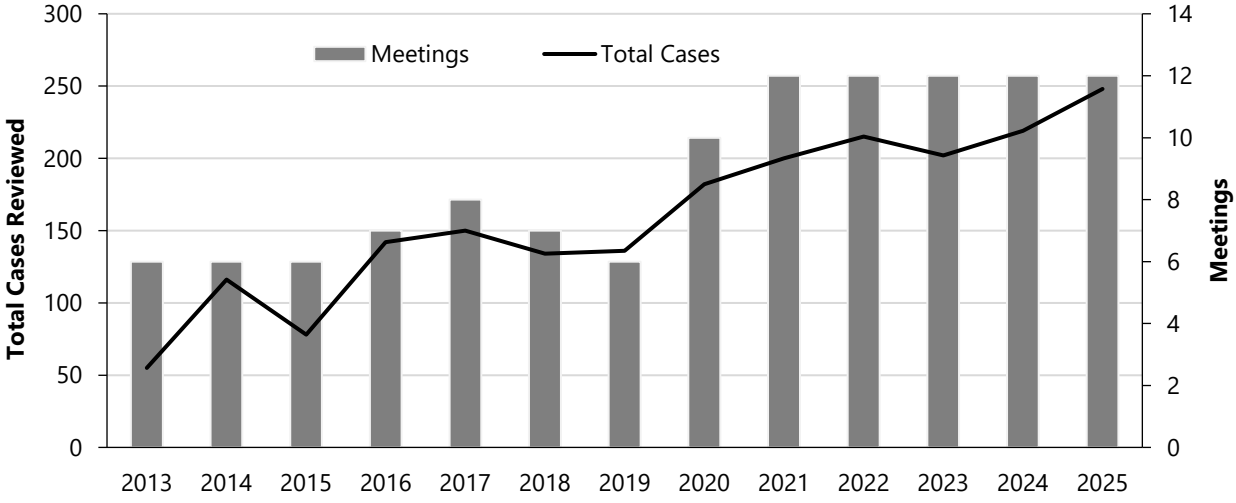
The panel is in compliance with its statutory requirements outlined in KRS 620.055 related to meeting frequency, reporting, and notification. However, not all agencies are responding to the panel's recommendations as envisioned by statute.

Meeting Frequency Exceeds Requirements

The panel has met monthly since July 2020, three times the statutory requirements.

KRS 620.055(4) requires the panel to meet at least quarterly. The panel has exceeded this requirement since its inception in 2013.[72] Due to increasing caseloads, the panel began meeting monthly starting in July 2020.[73] The panel has 12 meetings scheduled for calendar year 2026.[74] Figure 3.A shows that the increase in meetings has corresponded with an increase in total cases. Reviewed cases increased 350 percent, from 55 in 2013 to 248 in 2025.[75]

Figure 3.A
Child Fatality And Near Fatality External Review Panel
Number Of Annual Meetings And Case Reviews
2013 To 2025



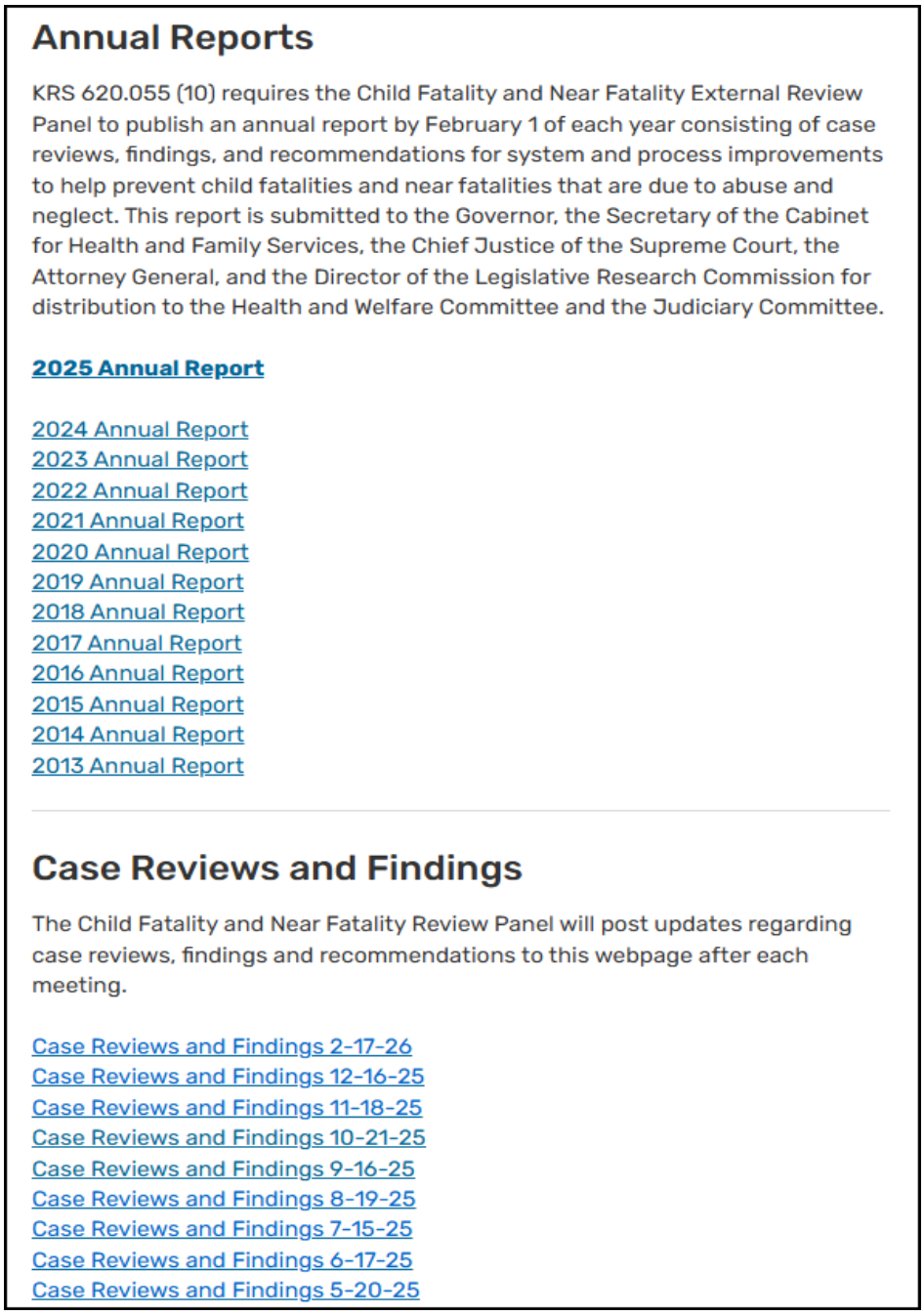
Source: Kentucky. Justice and Public Safety Cabinet. Child Fatality and Near Fatality External Review Panel: *2013 Annual Report*; *2014 Annual Report*; *2015 Annual Report*; *2016 Annual Report*; *2017 Annual Report*; *2018 Annual Report*; *2019 Annual Report*; *2020 Annual Report*; *2021 Annual Report*, *2022 Annual Report*; *2023 Annual Report*; *2024 Annual Report*, *2025 Annual Report*. Web.

Panel Publicly Posts Required Information

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

KRS 620.055(8) requires the panel to post updates on the Justice and Public Safety Cabinet's website after each meeting. The updates must include case reviews, findings, and recommendations. The panel posts case reviews and findings to the cabinet's website following each monthly meeting. Although not required by statute, the panel also posts the minutes for its monthly meetings to the cabinet's website. The panel does not post its recommendations in a dedicated space on the website, but the panel's annual reports—which include the panel's recommendations—are posted to the website, fulfilling the requirement.[76] Figure 3.B demonstrates how the panel posts its required updates. The same page includes links to panel minutes.

Figure 3.B
Child Fatality And Near Fatality External Review Panel Website
Examples Of Annual Reports, Case Reviews, And Findings
April 29, 2026



Annual Reports

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

2025 Annual Report

2024 Annual Report
2023 Annual Report
2022 Annual Report
2021 Annual Report
2020 Annual Report
2019 Annual Report
2018 Annual Report
2017 Annual Report
2016 Annual Report
2015 Annual Report
2014 Annual Report
2013 Annual Report

Case Reviews and Findings

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

Case Reviews and Findings 2-17-26
Case Reviews and Findings 12-16-25
Case Reviews and Findings 11-18-25
Case Reviews and Findings 10-21-25
Case Reviews and Findings 9-16-25
Case Reviews and Findings 8-19-25
Case Reviews and Findings 7-15-25
Case Reviews and Findings 6-17-25
Case Reviews and Findings 5-20-25

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

Summary Reports Are Appropriately Delivered

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

The panel is complying with KRS 620.055(9), which requires it to report a summary of its discussions, along with any proposed or actual recommendations, to the Interim Joint Committee on Families and Children monthly or at the request of the committee co-chair. The panel sends its meeting minutes—which include discussions of any proposed or actual recommendations—via email to the co-chairs and committee staff administrator of the Interim Joint Committee on Families and Children on a monthly basis.[77] Additionally, the co-chairs of that committee are current ex officio nonvoting panel members and receive updates during panel meetings.[78]

The Panel Publishes Reports And All Agencies Responded For The First Time

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

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

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

The panel sent copies of its 2025 annual report to the parties specified by statute on January 30, 2026, thus fulfilling the requirements of the statute.[79] The report, along with all prior annual reports, is also posted to the Justice and Public Safety Cabinet website.[80]

All recommendations in the panel's 2025 report were actionable and targeted, and all addressed the concerns expressed within their corresponding findings.

Findings And Recommendations. In 2021, LOIC staff concluded that the findings in the panel's reports from 2014 to 2020 were often unsupported by evidence that could be identified within the report. Recommendations in panel reports often failed to target a specific entity and did not address the concerns expressed within associated findings.[81] The panel's findings and recommendations have since been updated for clarity and accuracy.[82] All 19 findings in the panel's 2025 report are supported by evidence, data, or

analysis identified within the report. Additionally, all 21 of the panel's recommendations were actionable and targeted, and all addressed the concerns expressed within their corresponding findings. Appendix A provides an overview of the findings and recommendations in the panel's 2025 report.

The panel's 2025 report addressed 21 recommendations to five state entities. All five agencies had responded to all recommendations in writing.

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

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

The panel fulfilled its statutory notification requirement by mailing letters dated January 30 to the five state entities and their subdivisions responsible for implementing the 21 recommendations in the panel's 2025 report. The following agencies and their subdivisions received notifications:

- Cabinet for Health and Family Services
  - Department for Behavioral Health, Developmental and Intellectual Disabilities
  - Department for Community Based Services
  - Department for Public Health
  - Department for Medicaid Services
  - Health Access Nurturing Development Services
  - Kentucky Office of Medical Cannabis
  - Kentucky Perinatal Quality Collaborative
  - Office for Children with Special Health Care Needs
- Kentucky Board of Nursing
- Kentucky Hospital Association
- Kentucky Multidisciplinary Commission on Child Sexual Abuse
- Office of the Attorney General
  - Child Abuse and Neglect Prevention Board
  - Office of the Prosecutors Advisory Council[83]

Table 3.1 details the agency responses received as of May 18, 2025. Of the five agencies required to respond to the panel's recommendations, all responded in writing, addressing all 21 of the recommendations in the panel's 2025 report.[84]

Statute requires agencies to respond within 90 days of receipt. In response to Recommendation 3.1 from LOIC's 2024 report on the panel, panel staff updated their notification letter to clearly delineate the 90-day response deadline by which a response from the receiving agency is required. Each notification letter mailed to agencies clearly stated that responses were due by close of business on May 6, 2026.[85] [b] Four of the responding agencies responded by May 6, while CHFS responded on May 8. The Kentucky Board of Nursing provided its response on May 18. Agencies agreed to implement or stated that they had already implemented 16 of the panel's recommendations. CHFS declined to implement five of the panel's recommendations and provided explanations for doing so.[86]

Table 3.1
Kentucky Child Fatality And Near Fatality External Review Panel
Responses To Recommendations By Agency
2025 Annual Report

Agency	Panel Recommendation	Response	Responded Within 90 Days	Intent To Implement
Cabinet for Health and Family Services	The Cabinet for Health and Family Services, Department for Public Health and Office of Medical Cannabis should amend the regulations pertaining to medical cannabis and hemp-derived cannabinoid products to ensure consistency pertaining to the child-resistant packaging requirements. Additional warnings should be required to inform the consumer that "child-resistant" packaging does not mean "child-proof" and these products may be harmful or potentially fatal to children.	Yes	No	No
Cabinet for Health and Family Services	The Cabinet for Health and Family Services, Department for Public Health and the Office of Medical Cannabis should conduct an aggressive public safety campaign. The campaign should focus on educating caregivers, prescribers, and providing retailers with educational material for consumers regarding the dangers these substances pose to small children.	Yes	No	Yes

[b] Panel staff indicated this was a mistake and the intended due date was Monday, May 4, 2026.

Agency	Panel Recommendation	Response	Responded Within 90 Days	Intent To Implement
Cabinet for Health and Family Services	The Cabinet for Health and Family Services, in collaboration with Kentucky's child abuse specialist teams, should develop and implement a comprehensive, standardized training curriculum on medical indicators of child physical abuse for both child welfare caseworkers and medical professionals. This training should include instruction on the American College of Radiology and American Academy of Pediatrics guidelines establishing that skeletal surveys—not single-image babygrams—are the required standard for evaluating suspected physical abuse in children 24 months of age and younger. The curriculum should incorporate additional training for identifying physical abuse indicators, including the Ten-Four FACES-P.	Yes	No	Yes
Department for Community Based Services	The Department for Community Based Services should implement a monitoring system to track caseworker and supervisor compliance with SOP G1.16 (Working with Families Affected by Substance Misuse). This could be added to the already structured continuous quality improvement (CQI) system within the department. This system should offer a data dashboard accessible to supervisors and regional administrators to track key performance indicators including timeliness of substance abuse assessments, frequency of treatment provider contacts, and case plan integration of treatment goals, as well as regular feedback loops where findings are shared with frontline workers and supervisors to support practice improvement. This monitoring framework aligns with the National Center on Substance Abuse and Child Welfare's recommended six touchpoints for addressing substance use (screening, education, prevention strategies, referral to treatment, coordination with providers, and case management) and the Administration for Children and Families' emphasis on fidelity monitoring as essential to effective child welfare practice.	Yes	No	No

Agency	Panel Recommendation	Response	Responded Within 90 Days	Intent To Implement
Department for Community Based Services	The Department for Community Based Services should implement the practice of uploading supervisory consults into the TWIST system to assist in addressing gaps in services/contacts and reasons for these delays or gaps. This measure would also assist other staff, as well as newly assigned staff, in gathering information and needs for the case. In addition, the supervisory consults should be shared with the panel and included in the list of records provided to the panel under SOP C2.13.	Yes	No	Yes
Department for Community Based Services	The Department for Community Based Services should add a separate guideline within SOP C2.8 to specifically address safe firearm storage assessments. A standardized checklist could assist CPS workers in completing these assessments consistently and should be prominently incorporated into DCBS practice, rather than included merely as a supplemental resource within the SOP.	Yes	No	Yes
Department for Community Based Services	The Department for Community Based Services should include a parent's refusal of the vitamin K shot at birth as part of the medical neglect criteria in SOP C2.3.	Yes	No	No
Department for Community Based Services	The Department for Community Based Services should enhance current Standards of Practice (SOP C7.21) to include the use of Regional Nurse Consultants, as well enhance current SOP C2.8 Investigation Protocol to include Practice Guidance for CMC. Practice Guidance should include, but not be exclusive of, Regional Nurse consultation and development of a resource for workers to reference for additional information.	Yes	No	Yes
Department for Community Based Services	The Department for Community Based Services should enhance current Standards of Practice (SOP C2.19) Pediatric Forensic Medicine Consultations to include cases involving medically complex children as a priority to pediatric forensics, following regional nurse consultation, to ensure reserving this specialty for necessary cases.	Yes	No	Yes

Agency	Panel Recommendation	Response	Responded Within 90 Days	Intent To Implement
Department for Community Based Services	The Department for Community Based Services, in collaboration with the University of Kentucky Social Work training center (or other appropriate entity), should develop and implement a comprehensive, standardized training curriculum on medically complex children for child welfare workers. This training should include initial certification and annual continuing education, to include topics of defining medical neglect, caregiver burden assessments, distinguishing symptoms from abuse/neglect indicators, and working alongside medical care teams.	Yes	No	No
Department for Community Based Services	The Department for Community Based Services should encourage staff to continue to treat THC use as a high-risk behavior and follow policy accordingly.	Yes	No	Yes*
Department for Public Health	The Department for Public Health, HANDS program should update their educational material to include safe storage of medical cannabis and hemp-derived cannabinoid products (i.e. Protecting Your Child from Harmful Substances).	Yes	No	Yes
Health Access Nursing Development Services/ Kentucky Hospital Association	HANDS should work with the Kentucky Hospital Association to create a partnership that allows a HANDS representative to engage with the family at the birthing hospital.	Yes	No	Yes
Kentucky Board of Nursing	The Kentucky Board of Nursing through the Licensed Certified Professional Midwife (CPM) program, should develop a standardized protocol which includes the importance of vitamin K within parenting education and pre-natal medical visits.	Yes	No	Yes*
Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities/ Department for Community Based Services	The Department for Behavioral Health, Developmental and Intellectual Disabilities, Plan of Safe Care program and DCBS should work with community treatment providers to develop a standardized release of information to reduce the burden on clients.	Yes	No	Yes
Kentucky Hospital Association	The Kentucky Hospital Association should include a training regarding pediatric ingestions at the 2026 Trauma and Emergency Medicine Symposium.	Yes	Yes	Yes
Kentucky Multidisciplinary Commission on Child Sexual Abuse	The Kentucky Multidisciplinary Commission on Child Sexual Abuse should provide an update on the feasibility study conducted based on the panel's 2023 recommendation to expand the Commission's capabilities to review all fatal or near fatal physical abuses in addition to sexual abuse cases.	Yes	Yes	Yes

Agency	Panel Recommendation	Response	Responded Within 90 Days	Intent To Implement
Kentucky Perinatal Quality Collaborative (CHFS)	The Kentucky Perinatal Quality Collaborative (KyPQC) should include a keynote address in the 2026 Kentucky Symposium for Maternal and Infant Outcomes on the Plan of Safe Care. The keynote should encourage prenatal care providers to participate in their local community's POSC and educate patients on the available community resources to support expecting mothers with substance use disorders.	Yes	No	Yes
Office for Children with Special Health Care Needs	The Office for Children with Special Health Care Needs, in collaboration with the Department for Public Health, Department for Medicaid Service, and the Kentucky Hospital Association, should develop a statewide patient registry to enable coordinated care across systems and assist in early identification of at-risk families. This would include developing standardized criteria for identification based on diagnosis, creating data sharing agreements, and implementing flags in the registry to identify multiple risk factors for maltreatment. Implementation of such a system should require annual reporting on trends, child welfare involvement rates, and outcomes.	Yes	No	No
Office of Attorney General	The Office of the Attorney General should work with law enforcement, medical providers, and prosecutors to create a toolkit focused on pediatric ingestions. The toolkit will assist law enforcement officers on how to investigate these types of cases, prosecutors on applicable criminal charges, and medical providers on proper toxicology testing and keeping a high index of suspicion for ingestion if a young child presents with altered mental status.	Yes	Yes**	Yes
Office of Attorney General	The Office of the Attorney General, through the Prosecutors Advisory Council, should include a training focused on pediatric ingestions at the annual Kentucky Prosecutors Conference.	Yes	Yes**	Yes

Note: CMC = Children with Medical Complexity; CPS = Child Protective Services; CQI = Continuous Quality Improvement; DCBS = Department for Community Based Services; HANDS = Health Access Nursing Development Services; POSC = Plan of Safe Care; SOP = Standards of Practice; THC = Tetrahydrocannabinol; TWIST = The Workers Information System.
*Agency response indicated that the recommendation had already been implemented.
** Panel staff indicated that responses were due by Monday, May 6, 2026 in the notification letters addressed to agencies instead of the correct date of Monday, May 4. The May 6 response from the Office of the Attorney General is indicated as being within the 90-day deadline due to this miscommunication.
Source: Staff analysis of information in the Kentucky Child Fatality and Near Fatality External Review Panel's *2025 Annual Report* and agency responses.

Agencies Met Response Requirements In 2026

All agencies that received notifications responded to the panel's recommendations in their 2025 report and included all required statutory elements in their responses.

Agency notification and response requirements have existed for four of the panel's reports; for the first three reports, agencies did not consistently fulfill statutory requirements to adequately respond to the panel's recommendations.[87] All agencies that received notifications responded to the panel's recommendations in their 2025 report and included all required statutory elements in their responses. Figure 3.C shows an example of agency communication and the form provided for their response. Two agencies responded after the 90-day deadline; however, their responses satisfied all statutory criteria. CHFS and its subdivisions declined to implement five recommendations, but provided explanations that satisfy statutory criteria:[88]

- One explanation for declining cited shifting federal regulations around medical cannabinoid packaging and a lack of legal authority.
- Two explanations agreed with the recommendation but declined implementation due to a lack of funding.
- One explanation cited a lack of legal authority for implementation.
- One explanation cited a lack of staff, funding, and technology for implementation, and stated concern about the misuse of data. [89]

In previous years, response rates from agencies were lower and often lacked required elements.

In prior years, responses were lower and often lacked required elements for the agency responses. Agency notification and response requirements have existed for four of the panel's reports; for the first three reports, agencies did not consistently fulfill statutory requirements to adequately respond to the panel's recommendations.[90] Only 48 percent of recommendations from the panel's 2022 report received appropriate agency responses by the deadline.[91] Only 36 percent of recommendations from the panel's 2023 report received a required agency response by the deadline. In addition, the 2023 recommendations that did receive responses often did not include statutorily required elements such as a clear statement of intent to implement the recommendation, a timeline for implementation, or a clear refusal to implement the recommendation with an explanation of why the agency does not intend to do so. Of the nine recommendations that received responses, only three received responses that included all elements required by statute.[92]

Poor response quality continued in 2024. Of the nine recommendations that received responses from agencies in 2024, four responses from three agencies did not provide a clear timeline

of implementation. An additional two responses did not provide a clear indication of whether the agency intended to implement the recommendation at all.[93]

While response rates were improved this year, there is no guarantee that rates will remain at this level. There may also be times when agencies reject recommendations and the General Assembly wishes to further review why agencies did not implement the recommendation.

While agency responses to the panel's 2025 recommendations were improved in both response rate and required contents, there is a risk that agencies in the future may not provide responses or provide responses that lack the clarity provided by statutorily required elements. Even with the perfect response rate for the 2025 report, some agencies did not want to implement recommendations. There are reasonable justifications for refusing recommendations, such as a lack of authority or resources, but there may be panel recommendations that the General Assembly wishes to further investigate. The panel lacks any mechanism to seek additional information that could be provided to the General Assembly. In those cases, it may be beneficial for the General Assembly to request testimony from agencies to determine if barriers are legitimate or if legislative changes could be made.

Matter For Legislative Consideration 3.A

Matter for Legislative Consideration 3.A

When agencies do not respond to or do not plan to implement recommendations, even with reasonable justification, from the Child Fatality and Near Fatality Review Panel, the General Assembly may wish to consider requesting testimony from the agencies if it believes additional information or further study of a recommendation is required.

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

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

Date: January 30, 2026

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

Dear Secretary Stack:

Enclosed herein, please find the 2025 Annual Report of the Child Fatality and Near Fatality External Review Panel.

In accordance with KRS 620.055(10), the Panel is required to determine which agency is responsible for implementing each recommendation within this report. The agency that receives a recommendation shall respond to the Panel in ninety (90) days with a written notice of intent to implement, including how the recommendation will be implemented, and an approximate time frame ***or*** provide a detailed explanation of why the recommendation cannot be implemented. Recommendations pertaining to the Cabinet for Health and Family Services may be found on pages 5, 6, 8, 9, 12, 15, 16 and 19.

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

Please respond by *close of business Monday, May 6, 2026,* to:
Ms. Elisha Mahoney
elisha.mahoney@ky.gov
Justice & Public Safety
125 Holmes Street, 2nd Floor
Frankfort, KY 40601

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

Sincerely,

Hon. Benjamin Harrison

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

CC: Commissioner, Lesa Dennis
Commissioner, John R. Langefeld
Commissioner, Katherine Marks
Encl

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

Panel Recommendation:

The Cabinet for Health and Family Services, Department for Public Health and Office of Medical Cannabis should amend the regulations pertaining to medical cannabis and hemp-derived cannabinoid products to ensure consistency pertaining to the child-resistant packaging requirements. Additional warnings should be required to inform the consumer that "child-resistant" packaging does not mean "child-proof" and these products may be harmful or potentially fatal to children.

☐ **Agree with implementation**

☐ **Do not agree with implementation**

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

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

CC: Commissioner, Lesa Dennis
Commissioner, John R. Langefeld
Commissioner, Katherine Marks
Encl

Source: Elisha Mahoney, executive staff adviser, Child Fatality and Near Fatality External Review Panel. Email to Jacob Blevins, May 4, 2026. Attachment: *Annual Report Letters.*

Survey Of Panel Members

LOIC staff conducted a survey of panel members to better understand the experience of serving on the panel.

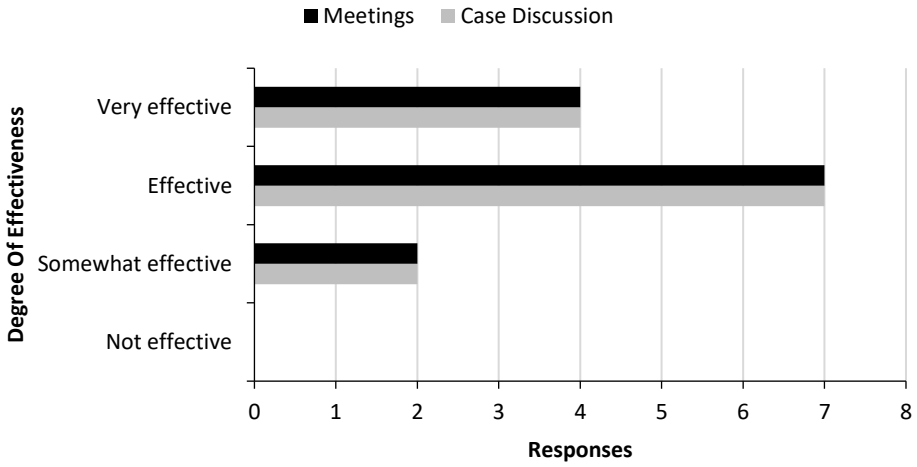
LOIC staff conducted a survey of panel members to better understand the experience of serving on the panel and whether improvements could be made. On March 17, 2026, the panel's executive staff advisor disseminated a survey link to panel members with a stated due date of April 7, 2026, which would later be extended to April 17, 2026. The survey included 15 questions designed to provide an understanding of the panel members' experiences in conducting their duties when serving on the panel. Thirteen of the twenty-two panel members provided responses. The full list of survey responses can be found in Appendix B.

Effectiveness Of Meetings And Case Discussions

Generally, panel members found meetings and case discussions to be effective.

Generally, panel members found meetings and case discussions to be effective. As shown in Figure 3.D, panel members were asked to evaluate the effectiveness of panel meetings. Two of the thirteen respondents felt that panel meetings are somewhat effective, while seven thought that meetings are effective and four indicated that they are very effective. No respondents indicated that panel meetings are not effective. Panel members were also asked how effective they feel that case discussion is during meetings. As also shown in Figure 3.D, results were identical to the first question.

Figure 3.D
Member Opinions On Efficacy Of Meetings And Case Discussion During Meetings



Source: LOIC staff analysis of survey results.

Almost all respondents indicated that cases were given an appropriate amount of time, with one respondent indicating more time may be needed.

Panel members were asked to evaluate the amount of time allotted to each individual case during meetings. No respondents indicated that far too little time, somewhat too much time, or far too much time is allotted. All but 1 of the 13 responses indicated that an appropriate amount of time is allotted to individual cases, with one member indicating that somewhat too little time is spent.

Open Response Questions

The remaining 11 survey questions asked panel members to respond to prompts in an open response format. Eight survey questions asked panel members to write any challenge or inefficiencies they have encountered and what changes to the panel's process they might recommend in four key areas of panel functions:

- Reviewing cases prior to meetings
- Reviewing cases during meetings
- Member participation during meetings
- Development of the panel's report and recommendations

The final three questions asked about obstacles members encountered when performing their roles, how the panel could improve agency responsiveness to recommendations, and whether they had additional comments or suggestions. Panel member responses were categorized by sentiments discussed in each response, resulting in 26 categories.

Respondents most commonly expressed frustration with the software used to review case materials.

Software Frustrations. The most common sentiment expressed by panel members was frustration with the software system, SharePoint, used to access confidential files in preparation for meetings. Ten of the thirteen respondents mentioned issues with using the platform. Most comments involved problems with logging into the software, in part due to security features that are necessary to share confidential information. Several comments cited problems related to whether the panel member uses a state email to login to the system.[94] Panel staff is continuing work with COT to develop a replacement system that panel staff believes will address these issues.[95]

Multiple panel members indicated that the time commitment of the panel was significant.

Time Considerations Or Constraints. Various time considerations when serving on the panel was also a common theme, with the second most common sentiment involving the time commitment required of panel members to fulfill their duties. Eight of the thirteen respondents indicated that the time commitment is an obstacle, with further explanation ranging from the time

required to prepare for meetings and attend, scheduling conflicts with their job, and a generally high caseload. Time constraints also extended to the process of developing and publishing the panel's report, with two members mentioning the tight timeframe in which the report must be published each year.

Two members indicated that the time between investigations being conducted by DCBS and the panel's ability to access case files and conduct case reviews is an obstacle to the panel's mission.[96] The panel regularly comments on this delay in its reports, with the average delay decreasing from 8 months in FY 2024 to 230 days or approximately 7.6 months in FY 2025.[97]

Virtual Meetings. Seven respondents mentioned difficulty with virtual meetings or a preference for an in-person format, although several admitted the impracticality of doing monthly in-person meetings, which typically last for 3.5 hours.[98] Two members wanted more engagement from panel members during panel meetings, which may be a result of difficulties using Zoom as a meeting platform for the up-to 22 panel members in attendance.

Lack Of Authority. Another common theme centered around the panel's lack of enforcement mechanisms after recommendations are made to agencies. Three members specifically cited a lack of enforcement authority as an obstacle to the panel's mission. Four members suggested that some form of legislative assistance may be necessary to encourage agency implementation, whether that includes legislative action or reporting agency implementation to the legislature. Other suggestions included establishing a working relationship with agencies through meetings or the establishment of liaisons that the panel can contact directly. If the General Assembly were to adopt Matter for Legislative Consideration 3.A, it may assist with establishing a working relationship.

Respondents were complimentary of staff's performance.

Appreciation For Panel Staff. Members were complimentary of panel staff. Seven respondents spoke positively of the staff and the work they do to support the panel. Members specifically mentioned the recent inclusion of a PowerPoint during meetings as very helpful.[99] Staff indicated that they began using a PowerPoint during case review during the February meeting in 2023.[100]

Other Comments Related To Panel Operations. Panel members also left specific comments about various aspects of the panel's operations. Sentiments that were only expressed one time are listed below:

- An appreciation for meeting dates being provided long in advance
- A desire for the presence of a clinical investigator at meetings
- A desire for more concise summaries being provided to panel members
- A desire for a way to submit comments, questions, or concerns prior to meetings to improve dialogue
- A desire for the panel to focus more on controversial cases
- A discussion about the sheer quantity of information needed to develop the panel's report as an obstacle
- An encouragement to members to review cases ahead of meetings
- A suggestion that members be encouraged to have case files in front of them during meetings
- A suggestion that the panel utilize polling during case review to arrive at determinations
- A suggestion that the panel develop a mechanism for tracking data in real time
- A suggestion that analysts use more safety science in their approach when presenting cases
- A suggestion that members complete a standardized form at the end of each case review, to be used in report development

Internal Controls

The panel has not completed written procedures for its operations. Panel staff have indicated they will implement written procedures once the new case management system is implemented. A lack of written procedures can lead to weaknesses in internal controls, so this finding will be repeated until policies are established.

LOIC staff recommended that panel staff develop written procedures to be approved by panel members in 2024 and 2025. Written procedures can serve as internal controls to ensure the panel is operating as intended and can allow panel members to better understand how staff work. While panel staff have yet to implement written procedures, they indicated a willingness to do so after the panel's new computer system is completed. Panel staff indicated that they have begun writing the standards and found the process useful.[101] Until written procedures are implemented, LOIC staff will reiterate the recommendation due to the importance of internal controls.

The panel has wide discretion to develop standard operating procedures.

The panel has wide discretion in developing its standard operating procedures. The panel set out to develop procedures for its operations soon after its inception and has since developed standard operating procedures related to its meetings; case referral,

storage, and review; and annual reports and recommendations.[102] However, these procedures have not been formalized into written standard operating procedures.[103]

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

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

Written procedures can serve as internal controls. Internal controls address risks related to achieving objectives.

Written, formal procedures can serve as internal controls for an entity. Internal controls address the risks related to achieving objectives.[104] *Risks* are any possibility that an event will occur and adversely affect the achievement of objectives.[105] The benefits of developing and maintaining written procedures include

- establishing and communicating the components of internal control execution to staff;
- retaining organizational knowledge and mitigating the risks associated with having organizational knowledge limited to a few personnel; and
- communicating organization knowledge as needed to external parties, such as external auditors.[106]

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

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

As discussed in Chapter 2, the panel has developed and maintained its *Analyst Binder* for analysts to reference while performing their case review duties. The binder includes general instructions for accessing and using the two software programs used by the panel, the completion of required case summary and timeline templates, and a dictionary of medical terminology. Although the *Analyst Binder* does include elements of policies and procedures, it is not

comprehensive enough to be considered a standard operating procedures manual. For example, it does not discuss the responsibilities of the executive staff adviser, procedures for budget requests, or policies for communicating recommendations to agencies. In addition, the panel's transition to a new case management system will result in the *Analyst Binder* being out of date in the future.

According to panel staff, the development of written procedures is still in progress. Panel staff stated that their intent is to write procedures in tandem with the development of the panel's new case management system, which is also currently in development through the Commonwealth Office of Technology. According to staff, the new system is currently in its testing phase; however, it remains unclear when the system will be finished.[107] Consequently, the issues with a lack of procedures still remain. Without procedures, new staff do not have a resource to internalize standard operations of the panel. Written procedures also inform panel members of staff operations and allow panel members to provide feedback.

Given the value of procedures and the requirement in KRS 6.922 to review procedures of the panel the following recommendation will continue to be issued until the new case management system is complete and the panel has developed procedures with consideration for the new system.

Recommendation 3.1

Recommendation 3.1

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

Appendix A

Records Provided To Panel By Department For Community Based Services

When HB 778 becomes effective on July 15, 2026, KRS 620.055 (6) will outline all information that the Department for Community Based Services must provide to the panel within 30 days:

(a) Cabinet for Health and Family Services records and documentation regarding the deceased or injured child and his or her caregivers, residents of the home, and persons supervising the child at the time of the incident that include all records and documentation set out in this paragraph:
   1. All prior and ongoing investigations, services, or contacts;
   2. 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 comply 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;

(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; and

(o) All supervisory consult notes, documents, and information related to all fatal and near fatal cases.

Appendix B

2025 Panel Report Findings And Recommendations

Table B.1 contains the findings and associated recommendations, grouped by subject area, from the Kentucky Child Fatality and Near Fatality External Review Panel's *2025 Annual Report*. As discussed in Chapter 3, all recommendations were supported by data and/or analysis. Multiple recommendations can be associated with a single finding.

Table B.1
2025 Panel Report Findings And Recommendations

Subject Area	Finding	Corresponding Recommendation
Overdose/Ingestion cases	(P. 4) The current regulations pertaining to the packaging and sale of medical cannabis and other hemp-derived cannabinoid containing products does require the product to be in a child-resistant package. However, the term child-resistant in the medical cannabis regulation is not defined, nor does it reference the definition for child-resistant packaging used in the regulations governing hemp-derived cannabinoid products. The definition in the hemp-derived cannabinoid products requires the package to maintain the child-resistant requirement through multiple openings for any products containing multiple servings. Additionally, the child-resistant requirements in the medical cannabis regulations require a two-step process for initial opening. This requirement is not included in the sale of other hemp-derived cannabinoid containing products. Considering the dangers both of these products pose to young children, the child-resistant requirements should remain consistent throughout all cannabinoid related products.	(P. 5) The Cabinet for Health and Family Services (CHFS), Department for Public Health (DPH) and Office of Medical Cannabis (OMC) should amend the regulations pertaining to medical cannabis and hemp-derived cannabinoid products to ensure consistency pertaining to the child-resistant packaging requirements. Additional warnings should be required to inform the consumer that "child-resistant" packaging does not mean "child-proof" and these products may be harmful or potentially fatal to children.
Overdose/Ingestion cases	(P. 4) In response to the panel's 2024 recommendations, the Kentucky OMC created a "how to" guide regarding safe storage of medical cannabis. The guide encourages the consumer to keep the product in the "child-resistant" packaging from the dispensary and provides the number for Kentucky Poison Control. However, it fails to mention these products may be harmful or even fatal to small children. The guide should encourage the consumer to obtain a medication lockbox to ensure safe storage of these products... For the third year in a row, the panel is recommending an aggressive public safety	(P. 5) CHFS, DPH and OMC should conduct an aggressive public safety campaign. The campaign should focus on educating caregivers, prescribers, and providing retailers with educational material for consumers regarding the dangers these substances pose to small children.

Subject Area	Finding	Corresponding Recommendation
	campaign regarding safe storage of medications and illicit substances, specifically targeting all cannabinoid containing products... These products are readily available at local retailers and gas stations for purchase without any forward facing public messaging about the dangers of these products.	
Overdose/Ingestion cases	(P. 4) It is the panel's understanding the DPH is educating families through various programs such as Health Access Nurturing Development Services (HANDS) and Women, Infants, and Children program (WIC). While educating those families is a commendable start, efforts must be more wide reaching. It is the panel's understanding the Department for Public Health is educating families through various programs such as Health Access Nurturing Development Services (HANDS) and Women, Infants, and Children program (WIC). While educating those families is a commendable start, efforts must be more wide reaching. These products are readily available at local retailers and gas stations for purchase without any forward-facing public messaging about the dangers of these products.	(P. 6) The DPH, HANDS program should update their educational material to include safe storage of medical cannabis and hemp-derived cannabinoid products (i.e. Protecting Your Child from Harmful Substances).
Overdose/Ingestion cases	(P. 5) An effective prevention effort must include enhancing enforcement of current laws surrounding these products. In the cases reviewed by the panel, 34% had a documented law enforcement issue. The most commonly identified missed opportunity for law enforcement was failing to investigate. It is important law enforcement agencies are considering applicable criminal charges, such as Endangering the Welfare of a Minor and Wanton Endangerment. Prosecutors should work collaboratively with investigating agencies to ensure the evidence required is properly obtained. If more of these cases were thoroughly investigated, it could potentially assist in identifying those retailers selling these products outside of compliance. Opportunities missed by medical providers were documented in 26% of all pediatric ingestion cases. The specific issue noted most often was failure to obtain a urine drug screen (UDS) on the child immediately upon arrival at the emergency department. Hospitals routinely use fentanyl when intubating a child and drug screens do not differentiate between fentanyl obtained on the streets or administered in a hospital setting. Therefore, it is imperative for medical providers to obtain the screening upon arrival. The second most commonly noted	(P. 6) The Office of the Attorney General (OAG) should work with law enforcement, medical providers, and prosecutors to create a toolkit focused on pediatric ingestions. The toolkit will assist law enforcement officers on how to investigate these types of cases, prosecutors on applicable criminal charges, and medical providers on proper toxicology testing and keeping a high index of suspicion for ingestion if a young child presents with altered mental status.

Subject Area	Finding	Corresponding Recommendation
	concern was the lack of timely reporting to Child Protective Services (CPS) and law enforcement. Medical providers should immediately report any suspected pediatric ingestions to authorities to ensure a timely investigation, although a delay in reporting should not preclude law enforcement investigation.	
Overdose/Ingestion cases	(P. 5) An effective prevention effort must include enhancing enforcement of current laws surrounding these products. In the cases reviewed by the panel, 34% had a documented law enforcement issue. The most commonly identified missed opportunity for law enforcement was failing to investigate. It is important law enforcement agencies are considering applicable criminal charges, such as Endangering the Welfare of a Minor and Wanton Endangerment. Prosecutors should work collaboratively with investigating agencies to ensure the evidence required is properly obtained. If more of these cases were thoroughly investigated, it could potentially assist in identifying those retailers selling these products outside of compliance. Opportunities missed by medical providers were documented in 26% of all pediatric ingestion cases. The specific issue noted most often was failure to obtain a UDS on the child immediately upon arrival at the emergency department. Hospitals routinely use fentanyl when intubating a child and drug screens do not differentiate between fentanyl obtained on the streets or administered in a hospital setting. Therefore, it is imperative for medical providers to obtain the screening upon arrival. The second most commonly noted concern was the lack of timely reporting to CPS and law enforcement. Medical providers should immediately report any suspected pediatric ingestions to authorities to ensure a timely investigation, although a delay in reporting should not preclude law enforcement investigation.	(P. 6) The OAG should work with law enforcement, medical providers, and prosecutors to create a toolkit focused on pediatric ingestions. The toolkit will assist law enforcement officers on how to investigate these types of cases, prosecutors on applicable criminal charges, and medical providers on proper toxicology testing and keeping a high index of suspicion for ingestion if a young child presents with altered mental status.
Overdose/Ingestion cases	(P. 5) An effective prevention effort must include enhancing enforcement of current laws surrounding these products. In the cases reviewed by the panel, 34% had a documented law enforcement issue. The most commonly identified missed opportunity for law enforcement was failing to investigate. It is important law enforcement agencies are considering applicable criminal charges, such as Endangering the Welfare of a Minor and Wanton Endangerment. Prosecutors should work	(P. 6) The Kentucky Hospital Association (KHA) should include a training regarding pediatric ingestions at the 2026 Trauma and Emergency Medicine Symposium.

Subject Area	Finding	Corresponding Recommendation
	collaboratively with investigating agencies to ensure the evidence required is properly obtained. If more of these cases were thoroughly investigated, it could potentially assist in identifying those retailers selling these products outside of compliance. Opportunities missed by medical providers were documented in 26% of all pediatric ingestion cases. The specific issue noted most often was failure to obtain a UDS on the child immediately upon arrival at the emergency department. Hospitals routinely use fentanyl when intubating a child and drug screens do not differentiate between fentanyl obtained on the streets or administered in a hospital setting. Therefore, it is imperative for medical providers to obtain the screening upon arrival. The second most commonly noted concern was the lack of timely reporting to CPS and law enforcement. Medical providers should immediately report any suspected pediatric ingestions to authorities to ensure a timely investigation, although a delay in reporting should not preclude law enforcement investigation.	
Physical abuse	(P. 6) The panel reviewed 55 physical abuse cases from SFY 24, comprising of 22% of all cases reviewed, and representing a 31% increase from the previous fiscal year (42 cases). The majority of physical abuse cases resulted in a near fatal event (76%).	(P. 8) The Kentucky Multidisciplinary Commission on Child Sexual Abuse should provide an update on the feasibility study conducted based on the panel's 2023 recommendation to expand the Commission's capabilities to review all fatal or near fatal physical abuses in addition to sexual abuse cases.
Physical abuse	(P. 8) Both medical and child welfare practitioners must understand proper diagnostic imaging protocols when investigating physical abuse. The use of a skeletal survey is considered best practice. The American College of Radiology (ACR) Practice Guideline for Skeletal Surveys in Children establishes that each anatomic region must be imaged with a separate radiographic exposure to ensure uniform image density and maximize sharpness. A single radiograph of the entire infant (babygram) must be avoided. Skeletal surveys are necessary when physical abuse is suspected in children under two years and in older children with developmental delays or limited verbal skills. The skeletal survey can identify characteristic injury patterns such as classic metaphyseal lesions ("bucket-handle" and "corner" fractures) and posterior rib fractures, which are highly indicative of abuse. A follow-up	(P. 8) The CHFS, in collaboration with Kentucky's child abuse specialist teams, should develop and implement a comprehensive, standardized training curriculum on medical indicators of child physical abuse for both child welfare caseworkers and medical professionals. This training should include instruction on the American College of Radiology (ACR) and American Academy of Pediatrics (AAP) guidelines establishing that skeletal surveys—not single-image babygrams—are the required standard for evaluating suspected physical abuse in children 24 months of age and younger. The curriculum should incorporate additional training for identifying physical abuse indicators, including the [TEN-4-FACESp].

Subject Area	Finding	Corresponding Recommendation
	skeletal survey approximately two weeks after the initial survey is recommended when clinical suspicion is high, as it increases detection of occult fractures not visible initially. Pennsylvania's child welfare training curriculum includes comprehensive instruction on medical indicators, including the "7 B's" of physical abuse (bruises, burns, bites, bones, brain, belly, brothers). Kentucky should adopt similar training to improve caseworker identification and assessment of physical abuse.	
Physical abuse	(P. 7) Substance abuse in the home was present in 67% of physical abuse cases, with impaired caregivers noted in 22%. Parents with substance use disorders are nearly three times more likely to physically abuse their children. The Administration for Children and Families identifies six critical touchpoints for addressing substance use: screening, education, prevention strategies, referral to treatment, coordination with providers, and case management. Kentucky's Sobriety Treatment and Recovery Team (START) and Kentucky Strengthening Ties and Empowering Parents (KSTEP) programs should continue expanding to reduce treatment wait times, and the SOP requirement for mental health assessment alongside substance use treatment reflects best practice for addressing co-occurring disorders... Of the 248 total cases reviewed, Department for Community Based Services (DCBS), Standards of Practice (SOP) issues were identified in 32 cases (13%). Kentucky's SOP G1.16 (Working with Families Affected by Substance Misuse) is comprehensive, requiring caseworkers to request substance use disorder assessments regardless of drug test results, increase contact frequency with treatment providers, and incorporate treatment plans into case planning. The policy appropriately prohibits punitive approaches to relapse and requires assessments to include the degree to which the parent is impaired in day-to-day functioning—not just caregiving while sober. However, these protocols are not consistently followed. Kentucky DCBS should implement enhanced training and supervision protocols, with regular quality assurance reviews monitoring compliance with treatment provider contact and case planning requirements.	(P. 9) The Department for Community Based Services (DCBS) should implement a monitoring system to track caseworker and supervisor compliance with SOP G1.16 (Working with Families Affected by Substance Misuse). This could be added to the already structured continuous quality improvement system within the department. This system should offer a data dashboard accessible to supervisors and regional administrators to track key performance indicators including timeliness of substance abuse assessments, frequency of treatment provider contacts, and case plan integration of treatment goals, as well as regular feedback loops where findings are shared with frontline workers and supervisors to support practice improvement. This monitoring framework aligns with the National Center on Substance Abuse and Child Welfare's recommended six touchpoints for addressing substance use (screening, education, prevention strategies, referral to treatment, coordination with providers, and case management) and the Administration for Children and Families' emphasis on fidelity monitoring as essential to effective child welfare practice.

Subject Area	Finding	Corresponding Recommendation
Department for Community Based Services	(P. 10) Timely completion of fatality and near fatality investigations remains a critical concern. These cases are complex and often take longer than typical investigations; however, timely resolution is essential for families and case outcomes. For SFY 2024, the average time to complete fatality and near fatality cases was 230 days statewide. While the statewide average time to completion slightly decreased, the time to completion increased in Jefferson County. Jefferson County, consistently has the highest caseload assignments in the state, averaged 395 days for case completion. Delays in case completion negatively impact families. Extended waiting periods can cause confusion, uncertainty, and disillusionment, particularly when casework halts or significantly slows. High caseloads and staff turnover directly contribute to these delays. When a CPS worker leaves the agency, cases may not be reassigned promptly, and reassignment often occurs without documentation or case notes, requiring the new worker to essentially restart the investigation. This leaves families in limbo and creates gaps in services and contact with no documented explanation. DCBS SOP G1.5 provides guidance for various consultations and specifically for Family Services Office Supervisor during investigations. This SOP requires at least monthly consults between worker and supervisor to be documented on the Investigative Consultation Form. Items to be addressed during these consults is completion of all identified tasks and/or actions and if not completed, to address barriers, strategies, and likely date of completion. The uploading of these forms to the TWIST system could assist in explaining gaps in services/contacts and the reasons for these delays.	(P. 12) The DCBS should implement the practice of uploading supervisory consults into the TWIST system to assist in addressing gaps in services/contacts and reasons for these delays or gaps. This measure would also assist other staff, as well as newly assigned staff, in gathering information and needs for the case. In addition, the supervisory consults should be shared with the panel and included in the list of records provided to the panel under SOP C2.13.

Subject Area	Finding	Corresponding Recommendation
Department for Community Based Services	(P. 11) In SFY24, the panel reviewed eleven cases involving firearm injuries to children, nine of which resulted in fatalities. While this represents a reduction from previous years, the reason for this decline is unclear. When comparing panel firearm cases to Kentucky's Statewide Child Fatality Review (CFR) firearm cases, the overall number of firearm injuries reviewed by the state CFR team has remained consistent. It should be noted the statewide CFR team reviews all child fatalities and firearm injuries to children not resulting in a fatality are excluded from this data. Despite these cases not being referred to the panel for review, firearm safety and safe storage remains a critical issue. Currently, DCBS SOP C2.8 requires CPS workers to assess homes for safe storage of medications; the panel recommends adding a separate guideline within this SOP specifically addressing safe firearm storage assessments. A standardized checklist could assist CPS workers in completing these assessments consistently. Additionally, the HANDS program guidelines contain relevant firearm safety information that should be prominently incorporated into DCBS practice, rather than included merely as a supplemental resource within the SOP. Elevating this guidance would ensure frontline staff are equipped to address firearm safety proactively during family contacts and safety planning.	(P. 12) The DCBS should add a separate guideline within SOP C2.8 to specifically address safe firearm storage assessments. A standardized checklist could assist CPS workers in completing these assessments consistently and should be prominently incorporated into DCBS practice, rather than included merely as a supplemental resource within the SOP.
Department for Community Based Services	(P. 11) A new and alarming issue that has come to the panel's attention is infant deaths related to Vitamin K Deficiency Bleeding (VKDB). VKDB occurs when an infant cannot stop bleeding because their blood does not have enough vitamin K to form a clot. According to the American Academy of Pediatrics (AAP), intramuscular administration of vitamin K for prevention of VKDB has been the standard of care since 1961. Healthcare professionals recommend all newborns receive a vitamin K injection at birth, as infants who do not receive this injection are 81 times more likely to develop late VKDB, which can occur without warning up to six months of age and may result in life-threatening brain hemorrhage or death. The panel reviewed cases in which parental refusal of vitamin K resulted in the infant's death or near death. Parental refusal has become increasingly common, often due to disinformation on social media and misunderstanding the risks involved. The panel recommends enhanced education	(P. 12) The Kentucky Board of Nursing through the Licensed Certified Professional Midwife program, should develop a standardized protocol which includes the importance of vitamin K within parenting education and pre-natal medical visits.

Subject Area	Finding	Corresponding Recommendation
	efforts across multiple fronts: CPS central intake staff should receive training on the risks associated with vitamin K deficiency to appropriately screen these reports; medical providers and midwives should be required to report parental refusal of vitamin K to CPS; and the importance of vitamin K administration should be incorporated into parenting education programs during prenatal medical visits. Increased awareness and education are essential to preventing future fatalities in this emerging area of concern.	
Department for Community Based Services	(P. 11) The panel reviewed cases in which parental refusal of vitamin K resulted in the infant's death or near death. Parental refusal has become increasingly common, often due to disinformation on social media and misunderstanding the risks involved. The panel recommends enhanced education efforts across multiple fronts: CPS central intake staff should receive training on the risks associated with vitamin K deficiency to appropriately screen these reports; medical providers and midwives should be required to report parental refusal of vitamin K to CPS; and the importance of vitamin K administration should be incorporated into parenting education programs during prenatal medical visits. Increased awareness and education are essential to preventing future fatalities in this emerging area of concern.	(P. 12) The DCBS should include a parent's refusal of the vitamin K shot at birth as part of the medical neglect criteria in SOP C2.3.
Medically complex children	(P. 15) During the panel's review of these cases there was documentation of DCBS workers reporting they did not feel they had the knowledge needed to perform their duties as it involved [children with medical complexity (CMC)] and maltreatment. Child welfare staff need education on the complex nature of CMC and their health care needs, including the importance of essential medications and follow-up care.	(P. 15) DCBS should enhance current Standards of Practice (SOP C7.21) to include the use of Regional Nurse Consultants, as well enhance current SOP C2.8 Investigation Protocol to include Practice Guidance for CMC. Practice Guidance should include, but not be exclusive of, Regional Nurse consultation and development of a resource for workers to reference for additional information.

Subject Area	Finding	Corresponding Recommendation
Medically complex children	(P. 15) During the panel's review of these cases there was documentation of DCBS workers reporting they did not feel they had the knowledge needed to perform their duties as it involved CMC and maltreatment. Child welfare staff need education on the complex nature of CMC and their health care needs, including the importance of essential medications and follow-up care. In some cases reviewed, DCBS did not obtain child abuse specialist consults despite the complexity of these cases. Child welfare investigators should be encouraged to consult with a child abuse pediatrician at either of Kentucky's pediatric forensic medicine programs when investigating cases involving medically complex children as best practice by DCBS and for the best outcomes.	(P. 16) DCBS should enhance current Standards of Practice (SOP C2.19) Pediatric Forensic Medicine Consultations to include cases involving medically complex children as a priority to pediatric forensics, following regional nurse consultation, to ensure reserving this specialty for necessary cases.
Medically complex children	(P. 15) Programs such as the Medically Complex Training Program at the University of Kentucky provide specialized training for foster and adoptive parents, nurses, and social workers caring for children with complex medical needs. These programs emphasize medically complex children require higher levels of commitment and care, with a focus on child safety. It is unclear if this resource is being utilized by DCBS for staff training regarding investigation and case management.	(P. 16) DCBS, in collaboration with the University of Kentucky Social Work training center (or other appropriate entity), should develop and implement a comprehensive, standardized training curriculum on medically complex children for child welfare workers. This training should include initial certification and annual continuing education, to include topics of defining medical neglect, caregiver burden assessments, distinguishing symptoms from abuse/neglect indicators, and working alongside medical care teams.
Medically complex children	(P. 14) The interface between child welfare and healthcare systems present both opportunities and challenges for protecting CMC. Medical providers serve as mandated reporters and often have frequent contact with these families, increasing the likelihood of identifying concerns. However, there are factors which complicate this intersection. The more medically complex the patient, the more elusive the diagnosis of maltreatment may be. Distinguishing between symptoms of underlying conditions and indicators of abuse or neglect requires specialized expertise. Effective care for CMC requires specialized training across multiple professional groups and settings.	(P. 16) The Office for Children with Special Health Care Needs, in collaboration with the DPH, Department for Medicaid Service, and the KHA, should develop a statewide patient registry to enable coordinated care across systems and assist in early identification of at-risk families. This would include developing standardized criteria for identification based on diagnosis, creating data sharing agreements, and implementing flags in the registry to identify multiple risk factors for maltreatment. Implementation of such a system should require annual reporting on trends, child welfare involvement rates, and outcomes.
Plans of safe care	(P. 17) The panel continues to collect data regarding the type of drug involved in the prenatal exposure. This data is based on the child testing positive for substance at delivery, drug screens administered to the mother, or through	(P. 19) The Kentucky Perinatal Quality Collaborative should include a keynote address in the 2026 Kentucky Symposium for Maternal and Infant Outcomes on the Plan of Safe Care (POSC). The keynote

Subject Area	Finding	Corresponding Recommendation
	self-report. Figure 11 shows the percentage of in utero drug exposure types documented in SFY24. It's important to note the panel is reporting an almost 30% increase of in utero cannabinoid exposure. It is often noted during case reviews, mothers using cannabis to treat nausea and vomiting during pregnancy. According to the American Academy of Family Physicians there is no known safe amount of cannabis use during pregnancy. Medical providers need to continue to counsel patients about the potential health effects of in utero exposure, which may include low birth weight. As documented in panel cases, 24% of substance exposed infants were premature.	should encourage prenatal care providers to participate in their local community's POSC and educate patients on the available community resources to support expecting mothers with substance use disorders.
Plans of safe care	(P. 18) DCBS SOP G1.16 Working with Families Affected by Substance Misuse procedure encourages the worker to request a signed release of information for treatment providers. However, this is not often obtained in cases reviewed by the panel. The release of information is imperative to ensure the parent's compliance with the program and to ensure the child's safety in the home. DBHDID and DCBS should collaborate with service providers during the monthly POSC meetings to create a standardized release of information for clients with ongoing CPS involvement. This will eliminate the burden from the client having to obtain the release, sign it, and return it to DCBS.	(P. 19) DBHDID, POSC program and DCBS should work with community treatment providers to develop a standardized release of information to reduce the burden on clients.
Plans of safe care	(P. 18) While the panel continues to advocate for a robust plan of safe care, Kentucky has made steps in improving their continuum of care. The Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID), POSC Initiative is a coordinated, collaborative approach utilizing the Regional Community Mental Health Centers. As part of this program, each region meets monthly with community partners to engage and support the specific needs of the families affected by substance use disorder. In addition, the DCBS has a comprehensive policy to address the plan of safe care regarding substance exposed infants reported to CPS. SOP C3.9 includes referring the family to services such as, KSTEP, START, HANDS and KY-Moms MATR (Maternal Assistance Towards Recovery). The policy requires the safety and/or prevention plan includes specific steps related to the caregiver's high-risk behaviors and encourages a release of information be obtained by treatment providers. Unfortunately, in the	(P. 19) DCBS should encourage staff to continue to treat THC use as a high-risk behavior and follow policy accordingly.

Subject Area	Finding	Corresponding Recommendation
	majority of the cases reviewed by the panel this policy is not consistently followed. As cannabinoid use has become more prevalent, concerns have been noted that THC use may not consistently be considered high-risk behavior. DCBS should ensure all substance exposed infants, regardless of the type of substance, are being referred to services in accordance with policy.	
Plans of safe care	Lack of HANDS referral continues to be an ongoing concern noted by the panel. The HANDS program is a voluntary home visitation program that provides services from pregnancy and up to three years of age. Prior to the pandemic, HANDS providers were meeting with families at the birth hospitals and educating them on services provided. Post pandemic, this practice does not appear to happen consistently across the state. Allowing HANDS representatives face-to-face contact with families may increase enrollment rates and ensure wrap-around services post discharge.	(P. 19) HANDS should work with the KHA to create a partnership that allows a HANDS representative to engage with the family at the birthing hospital.

Note: CHFS = Cabinet for Health and Family Services; DPH = Department for Public Health; OMC = Office of Medical Cannabis; HANDS = Health Access Nurturing Development Services; WIC = Women, Infants, and Children Program; UDS = Urine Drug Screenings; CPS = Child Protective Services; OAG = Office of the Attorney General; KHA = Kentucky Hospital Association; ACR = American College of Radiology; 7 B's = Medical indicators of physical abuse in Pennsylvania's child welfare training curriculum, which are bruises, burns, bites, bones, brain, belly, and brothers; AAP = American Academy of Pediatrics; TEN-4 FACESp = clinical screening tool used to identify potential child abuse by analyzing concerning bruises; START = Sobriety Treatment and Recovery Team; KSTEP = Kentucky Strengthening Ties and Empowering Parents; DCBS = Department for Community Based Services; SOP = Standards of Practice; TWIST = The Worker Information System; CFR = Child Fatality Review; VKDB = Vitamin K Deficiency Bleeding; CMC = Children with Medical Complexity; POSC = Plan of Safe Care; DBHDID = Department for Behavioral Health, Developmental and Intellectual Disabilities; KY-Moms MATR = Maternal Assistance Towards Recovery.
Source: Kentucky. Justice and Public Safety Cabinet. Child Fatality and Near Fatality External Review Panel. *2025 Annual Report*. Web.

Appendix C

Responses To Survey On Panel Meetings

LOIC staff conducted a survey of panel members to better understand the experience of serving on the panel and whether improvements could be made. On March 17, 2026, the panel's executive staff advisor disseminated a survey link to panel members with a stated due date of April 7, 2026, which would later be extended to April 17, 2026. The survey included 15 questions designed to provide an understanding of the panel member's experiences in conducting their duties when serving on the panel. Thirteen of the 22 panel members provided responses.

1. How effective are Panel meetings?
Not effective: 0 (0.0 percent)
Somewhat effective: 2 (15.4 percent)
Effective: 7 (53.9 percent)
Very Effective: 4 (30.8 percent)

Comments:
COVID forced meetings to be virtual, and monthly meetings necessitate virtual meetings. The case dialogue was more effective when meeting in person.
It is difficult to quantify the effectiveness of a panel meeting when the point of these meetings is to review information.
Investigators are often not clinical.

Note: Figures sum to 100.1 percent due to rounding.

2. How much time is allotted to individual cases during discussion?
Far too little time 0 (0.0 percent)
Somewhat too little time: 1 (7.7 percent)
An appropriate amount of time: 12 (92.3 percent)
Somewhat too much time: 0 (0.0 percent)
Far too much time: 0 (0.0 percent)

Comments:
It varies from case to case depending on what information is available at the time and how much discussion is needed for the case.

3. How effective is the case discussion process during meetings?
Not effective 0 (0.0 percent)
Somewhat effective: 2 (15.4 percent)
Effective: 7 (53.9 percent)
Very effective: 4 (30.8 percent)

Comments:
It varies but it can be very effective when there are things to discuss regarding the case.
I believe it is more effective during in-person meetings.
Zoom can be difficult

Note: Figures sum to 100.1 percent due to rounding.

4. What challenges or inefficiencies related to reviewing cases prior to meetings have you encountered while carrying out your responsibilities as part of the Panel? (Open-Ended Response)
Only issue I've found it having to do the "work around" to view some of the documents. It just slows you down having to download the documents prior to review.
The main issue has been accessing the documents. Without a state issued email address, there can be challenges in accessing Sharepoint. I understand that efforts are being made to resolve this issue.
I am not a state employee, so it is difficult for me to access cases. It has gotten better but is still challenging.
My experience with the case management system was not good as there were constant log in issues.
I have no concerns regarding the case review process. The information is upload and available for the reviews to be completed.
Some technology issues, but other than that the process to review cases prior to the meetings is good.
I have problems logging into the site almost every time I try.
The system can be difficult to manage at times - issues logging in. But other than that there have been no challenges.
The only challenge I have had is forgetting to reset my password, and then it takes time for me to get reset and get back into the system. Since I am only using once a month to review cases, and I am very busy, I always seem to forget to go in and reset my password.
My work computer blocks my access to Sharepoint, so during meetings if I am at my office which I usually am, I cannot access the case information. This also makes it impossible to review cases at the office prior to meetings and requires me to access them in my off time at home, which is limited.
None.
Can't access website to review!!

5. What changes in the process of reviewing cases prior to meetings would you recommend to improve Panel operations? (Open-Ended Response)
Other than a new work around where you don't have to download the files to review it. I heard the new system may fix this issue.
I do not have recommended changes.
Easier access to cases.
The case management system is being updated and will hopefully improve panel member access.

I think the current process works well and I don't have any suggestions.
They are currently working on a new system for us and that should help with the process.
None.
I believe it would be helpful if all members did review their assigned cases prior to the meeting.
A new system that worked with my [agency] access to allow me to review cases from my [agency] work computer using my [agency] email.
Simplified access.

Note: Information was removed from one entry to protect the respondent's identity.

6. What challenges or inefficiencies related to reviewing cases during meetings have you encountered while carrying out your responsibilities as part of the Panel? (Open-Ended Response)

None.
At times, there are request for documents that are pending at the time of review. We often revisit these cases when the documents are made available. I think this is an inherent challenge based on the charge of the panel. There are often a host of processes involving different cabinets involved with a case. The timelines are not always aligned.
It is difficult for me to maintain the level of engagement necessary when meeting virtually. It appears that there is less discussion.
I would prefer to have the case management system data in front of me while the analyst is speaking but the issues with the system prevents that from happening.
The case reviews would be more effective if the analyst use more safety science in their approach when presenting cases. There is a tendency to try to assign blame instead of looking at systemic issues. The purpose of the panel is to identify trends and help inform changes and make improvements within the system and not to assign blame.
N/A
Sometimes the summaries could be more concise.
None
There are no challenges that I can think of during the meetings.
Same issue as mentioned in reviewing prior. Access to Sharepoint is very difficult for me.
A clinical investigator would provide more context and understand the records better from the hospital, physician office etc.
None.

7. What changes in the process of reviewing cases during meetings would you recommend in order to improve Panel operations? (Open-Ended Response)

None.
I do not have recommended changes to the process. [Executive Staff Advisor] does an incredible job ensuring the Panel operations are efficient and effective.
It is not practical, but more in-person meetings would be beneficial.
Panel members should be encouraged to open up the case management system during the meetings so they can see and hear the particular case.

To continue to provide training and support to promote a culture of safety that prioritizes understanding systemic factors and the pressures affecting the system. Foster an environment where open dialogue and transparency are encouraged, supporting continuous quality improvement efforts focused on preventing future incidents. Strengthen the approach to balancing individual and system accountability to ensure both are addressed thoughtfully and effectively.
N/A
None
More engagement from panel members!
I don't have any recommendations during the meetings.
None. Believe the Powerpoint summaries are very helpful addition this year.
More member participation. With new legislation passed we will need discussion on possible meetings with investigating agencies.

8. What changes in the process of reviewing cases during meetings would you recommend in order to improve Panel operations? (Open-Ended Response)
None
There are challenges with holding a full-time job and participation. This said, the work of this panel is essential to creating a road map for improving the safety and well being of the children of the Commonwealth. The time spent is a statement to the value we place in caring for the vulnerable in our communities- no doubt every second is well spent.
Same issue - meeting in person is more effective, in my opinion.
None
Participating on this panel is important and I make every effort to prioritize the external panel. Having the dates set in advance is very helpful.
Sometimes I have other mandatory meetings scheduled at the same time as our panel meeting. I have to miss occasionally due to the schedule conflict but since I can review the cases prior to the meeting, that helps with knowing what will be reviewed at the panel meeting.
It is hard to have a 4-hour block of time without competing interests and needs
I think the nature of Zoom - people are trying to do 100 things at one time. But that is nothing that can be controlled.
During the Zoom meetings, it can sometimes be difficult to speak, or speak at the same time, but I believe that is just the nature of using Zoom, it is not always clear when someone will speak.
My own [position's] schedule is the only real obstacle. Monthly, 4-hour meetings are a difficult ask for many professionals to include with our other duties, but understand there are simply too many cases to go back to quarterly meetings.
None.

Note: Information was removed from one response to protect the respondent's identity.

9. What changes would you recommend in order to improve participation during meetings? (Open-Ended Response)
None.
I do not have recommended changes.

If there was an opportunity to submit comments, questions or concerns prior to the meeting might increase dialogue.

I believe there is sufficient participation in the meetings.

In-person meetings tend to prompt better dialogue and discussion. I know that is a challenge on a monthly basis, but there should be some in-person gatherings and individuals should be strongly encouraged to attend. Cameras on during virtual meetings for panel members. Continuing efforts to creating a safe space for discussions.

I like having an in-person meeting a couple times of year.

Maybe polling so that it is more interactive

I thoroughly enjoy the in-person meetings as there is more engagement and discussion regarding cases. I also realize the barriers to having more in-person meetings,

I don't have a recommendation for the participation during meetings.

None.

10. What challenges or inefficiencies related to developing the Panel's report and recommendations have you encountered while carrying out your responsibilities as part of the Panel? (Open-Ended Response)

None.

Often the timeline to produce the report limits my opportunity to provide feedback or for the feedback to result in meaningful change. Similarly, the Panel provides an annual report. Trending panel data real time might be useful to developing timely and incremental recommendations.

Although it cannot be helped, the amount of information required to develop the report is large.

The report and recommendations process is very effective; Chair and staff do an exceptional job.

The panel members contribute to the report and are able to provide feedback and input.

N/A

None.

None.

I haven't encountered challenges in developing the report.

None.

There should be a standardized form that is completed at the end of each review and recommendations listed with categories to make the report easier like the Maternal mortality review committee.

11. What changes to the process of developing the Panel's report and recommendations would you recommend? (Open-Ended Response)

None.

A collaborative discussion about the timeline report might be useful to ensure that all panel member recommendations can be captured.

None.

I do not recommend any changes.

More time for development, review and finalizing the report. The timeframe to have all cases reviewed, data compile and the report written can is tight.

N/A.

None.

None.

I do not have recommendations for developing the report.

None.

12. Are there any obstacles to you performing your role on the Panel? If so, please describe them. (Open-Ended Response)

None.

None.

The only obstacles are the time required for participation and accessing the Sharepoint. This said, panel participation is priority because of the value of the panel's work to address the health of children in our communities.

Besides the previously referenced case file frustration, I do not experience any obstacles.

No.

Just the occasional schedule conflict with other required meetings during the same time.

Just trying to juggle my schedule.

No.

Sometimes work responsibilities prevent me from being present at every meeting, but I try my best to attend.

Only those addressed above.

Large monthly time commitment.

13. How could the Panel improve agency responsiveness to recommendations? (Open-Ended Response)

This is a continuing issue. The only solution would be for the legislature to attach penalties to agencies that fail to respond.

I know we have a large number of agencies in the commonwealth however, it would be nice to establish a point of contact for the main agencies. This way we can have a person we can reach out to when we have issues. (We may already do this.)

To my knowledge the Panel does not have the authority to impact responsiveness. From my perspective, agency responsiveness is often related to available resources and the complexity of the situations that resulted in the death or near death.

The Panel makes recommendations to state agencies yet does not have the authority to enforce compliance. I think the pattern of reporting agencies' responses to the General Assembly may assist.

I'm not sure. I think they try their best at this.

Not sure that there is a way to speed it up.

I don't have any suggestions - I think the panel does a great job of trying to get responses.

Unsure.

I believe the panel does all in their power, without legislative teeth or some oversight there is little the panel can do to police their recommendations.

Huge delay in case reviews often over a year old.

14. Do you have any other comments or suggestions concerning Panel operations? (Open-Ended Response)
None.
No.
The work of the panel is critical to provide direction to the efforts of agencies and other entities in the community who support and facilitate the safety and well-being of children in the Commonwealth. It is a privilege to serve.
The Panel does important and difficult work. I commend the Panel members who work in the Pediatric Forensics on a daily basis.
N/A
None – [Executive Staff Advisor] does a phenomenal job and really helps this panel function!
No.
No.
Staff are amazing and do an amazing job!

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, pp. 875-880.
[4] KRS 620.055(6)(o)
[5] KRS 620.055(8)
[6] US Department of Health and Human Services, Office of Planning, Research, and Evaluation. *Case Study Report: The Kentucky Health Information Data Sharing Project: Sharing Healthcare Data with Child Welfare Workers to Improve the Well-being of Children in Foster Care.* Nov. 2023, p. 1. Web.
[7] KRS 620.055(9)
[8] Elisha Mahoney, executive staff advisor, Child Fatality and Near Fatality External Review Panel. Interview. May 26, 2026.
[9] KRS 620.055(14)(b)
[10] KRS 620.055(14)(b)
[11] Kentucky. Opinions of the Attorney General OAG 26-003.
[12] Elisha Mahoney, executive staff advisor, Judge Lauren Adams Ogden, chair, Child Fatality and Near Fatality External Review Panel. Meeting. May 19, 2026.
[13] Kentucky. Auditor of Public Accounts. "Auditor Ball Statement On Court Granting iTWIST Access To Ombudsman." September 18, 2024. Web.
[14] KRS 620.055(10).
[15] KRS 620.055(1); KRS 620.055(10).
[16] Kentucky. Justice and Public Safety Cabinet. Child Fatality and Near Fatality External Review Panel. *2025 Annual Report*, p. 34; Kentucky. Justice and Public Safety Cabinet. Child Fatality and Near Fatality External Review Panel. "Members," n.d. Web.
[17] Elisha Mahoney, executive staff adviser, Child Fatality and Near Fatality External Review Panel. Email to Jacob Blevins, May 4, 2026; Elisha Mahoney, executive staff adviser, Child Fatality and Near Fatality External Review Panel. Email to Jacob Blevins, May 8, 2026.
[18] KRS 620.055(4).
[19] Kentucky. Justice and Public Safety Cabinet. Child Fatality and Near Fatality External Review Panel: *2013 Annual Report*; *2014 Annual Report*; *2015 Annual Report*; *2016 Annual Report*; *2017 Annual Report*; *2018 Annual Report*; *2019 Annual Report*; *2020 Annual Report*; *2021 Annual Report*. *2022 Annual Report*; *2023 Annual Report*; *2024 Annual Report*. Web.
[20] Kentucky. Justice and Public Safety Cabinet. Child Fatality and Near Fatality External Review Panel. *2020 Annual Report*, p. 3.
[21] KRS 620.055(1).
[22] Kentucky. Office of State Budget Director. *2018-2020 Kentucky Branch Budget, Baseline Budget Request: Program Narrative/Documentation Record*. 2018, pp. 44-45.
[23] 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.
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[25] Kentucky. Office of State Budget Director: *2016-2018 Budget Of The Commonwealth*, vol. 1, pp. 228-229; *2018-2020 Budget Of The Commonwealth,* vol. 1, pp. 215-216; *2020-2021 Budget Of The Commonwealth*, vol. 1, pp. 221-222; *2021-2022 Budget Of The Commonwealth*, vol. 1, pp. 218-219. Web.
[26] Kentucky. Justice and Public Safety Cabinet. Child Fatality and Near Fatality External Review Panel, Oct. 19, 2021. Meeting minutes.
[27] Kentucky. General Assembly. *Acts Of The 2024 Regular Session*, ch. 175, p.1866.
[28] Kentucky. General Assembly. HB 500, Acts Of The 2026 Regular Session, p. 91-104.
[29] Elisha Mahoney, executive staff advisor, Judge Lauren Adams Ogden, chair, Child Fatality and Near Fatality External Review Panel. Interview. May 7, 2026.
[30] Elisha Mahoney, executive staff adviser, Child Fatality and Near Fatality External Review Panel. Email to Jeremy Skinner. March 6, 2024.
[31] Kentucky. General Assembly. *Acts Of The 2024 Regular Session*, ch. 175, p.1860.

[32] Kentucky. Child Fatality and Near Fatality External Review Panel. April 16, 2024. Meeting minutes.
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