PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE

Minutes

July 12, 2019

Call to Order and Roll Call

The Program Review and Investigations Committee met on Friday, July 12, 2019, at 10:00 AM, in Room 131 of the Capitol Annex. Representative Rob Rothenburger, Chair, called the meeting to order, and the secretary called the roll.

Present were:

Members: Senator Danny Carroll, Co-Chair; Representative Rob Rothenburger, Co-Chair; Senators Tom Buford, Perry B. Clark, Reginald Thomas, Stephen West, Whitney Westerfield, and Phillip Wheeler; Representatives Lynn Bechler, Chris Fugate, Al Gentry, Ruth Ann Palumbo, and Walker Thomas.

Guests: Judge Roger Crittenden, Chair, Child Fatality and Near Fatality External Review Panel. Elisha Mahoney, Executive Staff Advisor, Justice and Public Safety Cabinet. Elizabeth Caywood, Deputy Commissioner; Lesa Dennis, Chief of Staff; Christa Bell, Director, Division of Protection and Permanency; Melanie Taylor, Assistant Director, Division of Protection and Permanency; Laura Begin, Staff Assistant; Department for Community Based Services.

LRC Staff: Greg Hager, Committee Staff Administrator; Chris Hall; Van Knowles; Jean Ann Myatt; Sarah Ortkiese; Jeremy Skinner; William Spears; Shane Stevens; Susannah Stitzer; Joel Thomas; Tanner Rife, Graduate Fellow; and Christy Young, Committee Assistant.

Minutes for June 7, 2019

Upon motion by Representative Fugate and second by Representative Thomas, minutes for the June 7, 2019 meeting were approved by voice vote without objection.

Staff Report: *Kentucky Child Fatality And Near Fatality External Review Panel, 2018 Update*

Ms. Stitzer said the panel is compliant with statutory requirements except that its annual report was not published on December 1, 2018. As the deadline approached, a number of cases for review had yet to be received from the Department for Community Based Services (DCBS). The panel decided to delay the annual report until February 1, 2019. Recommendation 1 of the Program Review report is that the General Assembly may wish to change the due date of the panel's annual report to February 1 to provide the panel with enough time to review all cases from the previous fiscal year.

Under its governing statute, the panel is required to destroy copies of case files and has been regularly destroying paper copies. Case files stored in the electronic information system are nearing the end of the 5-year retention period. Recommendation 2 is that the panel should establish a policy for the destruction of electronic documents.

Ms. Ortkiese said the panel is concerned that it is not reviewing all child fatalities and near fatalities that occur within the state. The panel receives its cases primarily from DCBS. The Department for Public Health also forwards cases to the panel, including from its local child fatality review teams that are under the jurisdiction of coroners. Not all localities have review teams, many existing teams may not have a quality review process, and some are new. The department is working to assist local teams on the review process.

Nationally, child fatality review cases are underreported. States have differing statutes for reporting cases and information to state review panels. Depending on the state and the agency, agencies may be mandated to report to the panel or may be allowed to provide information to panel if requested. The Kentucky panel has expressed concern about the number of Sudden Unexplained Death of Infants (SUDI) cases that have not been referred to the panel for its review.

Ms. Ortkiese summarized two statistics for Kentucky and other states for the period 2008 to 2017. In Kentucky, there were 2.10 fatalities per 100,000 children, nearly identical to the national rate of 2.21. In Kentucky, 0.13 percent of reports of child abuse involved a fatality, which was lower than the national rate of 0.23 percent. She showed comparisons of key characteristics of the Kentucky panel to panels in five selected states.

Ms. Stitzer summarized the recommendations the panel made from 2014 to 2018 in seven categories: DCBS, substance abuse, courts, medical providers, law enforcement, coroners, and general. The panel has made several recommendations regarding DCBS, most related to increased funding for the department or the department's protocols and internal review processes. DCBS is implementing significant changes initiated by state and federal legislation and its new model for internal review of errors, the Culture of Safety. Eventually, Program Review staff and the panel will be better able to determine how the changes relate to recommendations of the panel. The panel recommended DCBS review its protocols for screening out cases. The panel reviewed 27 cases from FY 2017 that were initially screened out by DCBS. The number of screened out cases has increased significantly; nearly one half of referrals to DCBS in 2017 were screened out. DCBS' position is that more calls should be screened out, which it argues would be workable with a proposed full differential response system that would enable DCBS to provide different services based on the assessed level of risk.

Substance abuse is another frequent subject of the panel's recommendations. Examples are recommendations related to neonatal abstinence syndrome and medication

assisted treatment. The panel's most frequent recommendation pertaining to substance abuse is full implementation of family drug courts throughout the state. Kentucky previously had family drug courts, but funding for the program ended in 2008. Jefferson County has made efforts to reinstate its family drug court and in 2018 opened the Jefferson Family Recovery Center with funding from a nonprofit.

The panel's recommendations have frequently centered on using medical providers to educate parents on safe sleep practices and abusive head trauma. The Kentucky Hospital Association and Prevent Child Abuse Kentucky recently developed a video on safe sleep and abusive head trauma that is being distributed to birthing centers in the state.

Ms. Ortkiese said the panel twice recommended open court proceedings for dependency, neglect, and abuse proceedings. In 2016, the General Assembly authorized an open court pilot project, which began in 2018. The Administrative Office of Courts issued a 3-month status report that identified positives and negatives of the pilot and recommended further study.

The panel's recommendations on law enforcement relate to processing of child death scenes and drug testing of caregivers. The panel wants law enforcement to treat every child fatality or near fatality under the premise that the child may have been a victim of neglect or abuse. The Department for Criminal Justice Training has provided child death scene training for law enforcement and has requests for additional training.

The panel's recommendations involving coroners relate to their role in child death investigations. According to the panel, coroners' involvement varies by county. Child death notifications have increased, which the panel partly attributes to the use of pocket cards that are on scene guides. Use of the Sudden Unexplained Infant Death Form has increased, but often is incomplete according to the panel.

General recommendations relate to the education and awareness of child abuse and neglect. The General Assembly has enacted three statutes dealing with the panel's recommendations. The statutes cover education, training, and background check requests by parents on their children's caregivers.

Ms. Ortkiese said that the panel's recommendations are in its annual reports. It is not always apparent whether a recommendation is being made and the wording of some recommendations is unclear. Recommendation 3 of the Program Review report is that recommendations in the panel's annual reports should be easily identifiable and clearly stated.

Representative Palumbo asked how SIDS [Sudden Infant Death Syndrome] cases are related to SUDI cases. Ms. Ortkiese said that SIDS cases are included in SUDI cases.

In response to Representative Palumbo's question about why only 10 of 88 SUDI cases were reviewed by the panel, Ms. Ortkiese said that only 10 were referred to the panel. DCBS and panel officials could possibly explain further.

In response to Representative Palumbo's request for clarification of the 27 panel cases that were screened out, Ms. Stitzer said that DCBS uses specified criteria to determine whether further investigation of a referral is warranted. If the determination is no, the referral is screened out. DCBS does not investigate further but keeps a record of the referral.

In response to a question from Senator Wheeler about national underreporting of child fatalities, Ms. Ortkiese said that staff did not have access to data to indicate what the percentage would be for Kentucky.

Representative Bechler said that he is skeptical of estimates such as this that are widely accepted. He asked whether KRS 199.466 or any other statute requires that a background check on an individual caring for a child be completed after a parent or guardian requests it. Ms. Stitzer responded yes; the cabinet provides the results of the check to the individual who requested it.

Judge Crittenden introduced Ms. Mahoney and gave a response to the Program Review staff report. Regarding its Recommendation 1, he said that as of November 2018, the panel still had 60 cases from FY 2017 to review. The designated recipients of the panel's annual report were notified that it would be published on February 1, 2019. The panel will not provide an incomplete report even if the due date is not changed in statute.

Regarding Recommendation 2, the panel has now established a policy for destruction of electronic documents. The Commonwealth of Technology will delete documents with identifying information. The panel will maintain general data.

Regarding Recommendation 3, he said that he understands the concern with how recommendations are presented in the panel's reports. There is time pressure to produce the report and it is not always clear to whom a panel's recommendation should be addressed.

Judge Crittenden reiterated that the Department for Public Health suspected abuse or neglect in only the 10 SUDI cases that were referred to the panel. The panel has reviewed more than 600 cases in its history. Near fatalities are severe injuries, in some cases life altering, such as a brain injury. The panel disagrees with DCBS about screening out. Cases in which children are under 4, the referral is from a professional, or there have been previous referrals for the child should not be screened out.

Representative Rothenburger asked about the typical scenario of when there is a call to emergency medical services for a child that appears to involve abuse. Judge Crittenden said that once the child is at the hospital, staff should make a report to DCBS and law enforcement immediately. There should be a joint investigation. If abuse is found, DCBS should take action to determine whether the child should be removed from or returned to the home. After the investigation, the DCBS report is uploaded to the panel for its review.

In response to a question from Representative Rothenburger, Judge Crittenden said that the panel reviews cases from the previous fiscal year. Contract analysts review case materials and prepare summaries. Panel members also have access to original case materials.

Representative Rothenburger asked, given the delay in reviewing cases, about the mission of the panel. Judge Crittenden said that the purpose of the panel is to make recommendations related to system breakdowns to prevent future fatalities and near fatalities.

In response to a question from Representative Palumbo, Judge Crittenden said that the 27 fatality and near fatality cases that the panel reviewed in FY 2017 that were screened out should not have been. Representative Palumbo suggested that the committee look further into screening out.

In response to a question from Senator Wheeler about the delay in getting cases, Judge Crittenden said that he cannot say why it takes 10 months to do an investigation. Sometimes a criminal case is ongoing. The delay in uploading cases to the panel's file sharing system is because of a lack of staff.

In response to questions from Senator West, Judge Crittenden said that reports are retained 5 years, which is a requirement in statute or regulation. Paper materials are destroyed soon the after the panel meeting at which they are reviewed. The panel's reports are not used in criminal justice proceedings and the panel is not subject to open records requirements. The cabinet and law enforcement maintain their own records. One of the reasons the panel has asked for open courts is because it gives the public greater confidence in the judicial system.

In response to a question from Senator Thomas about the common themes in near fatality cases, Judge Crittenden cited substance abuse, especially opioids, as the most common theme. It is often a factor in head trauma caused by caregivers and neglect of care. He also cited family violence and young parents as themes.

Senator Carroll, commenting on the delay in records getting to the panel, said that integrity of the criminal investigation is paramount, so it must be thorough. He said the

intake process used to be local and is now done via regional call centers. He has not always been pleased with the response when he has made a report.

Judge Crittenden said that DCBS could respond to the call center issue. A law enforcement representative is on the panel. The panel may receive the report while criminal justice proceedings are taking place. The relationship between the cabinet and law enforcement is good.

In response to Senator Carroll's question, Ms. Dennis said that calls go to a centralized regional system. There is no plan to return to local intake. Calls are managed within the central office for consistency. Central office staff in Frankfort review a sample of screened-out calls. There is a plan to record calls to better assess the intake process. The system will allow supervisors to join intake calls when needed.

In response to Senator Carroll's questions, Ms. Dennis said that there is a set process for taking a call. Intake decision criteria are in statute, regulation, and standards of practice and should be applied consistently across regions. Intake workers are trained to identify families who could use additional services and to refer them to community resources to prevent future problems. Ms. Caywood described this as a differential response system. Ms. Bell said that the preference is to have experienced intake workers, but this is not always possible. The call centers are adopting a safety model.

In response to Senator Carroll's question as to whether DCBS is comfortable with regional call centers as the best approach, Ms. Bell said that the regional approach is better for consistency across the state and allows for more central guidance and the use of more experienced staff. There is a need for a better balance with identifying community resources.

Senator Clark made a motion to adopt the staff report; Representative Palumbo seconded. The report *Kentucky Child Fatality And Near Fatality External Review Panel, 2018 Update* was adopted by roll call vote.

Update: Implementation of HB 1, Response to Recommendations in 2018 Program Review Foster Care Report

Ms. Caywood summarized provisions of HB 1, enacted in the 2018 regular session. As part of the child welfare transformation process, there were workgroups within DCBS as the legislation was being considered. The process incorporates consideration of recommendations in the 2018 Program Review foster care report. The three main goals of child welfare transformation are to safely reduce the number of children entering foster care, improve timeliness to appropriate permanency, and reduce caseloads. There have been 81 planning sessions as of May 1, 2019.

Ms. Bell described implementation of HB 1 by DCBS and trends in the number of foster care homes and adoptions. She also covered the status of two recommendations from the Program Review foster care report. DCBS is addressing Recommendation. 1.4 that the department should use existing data to calculate a more accurate "percent of need met" figure in its recruitment report. Each region now develops a targeted diligent recruitment plan that reflects its children in care. DCBS also considers how many children have to be placed outside a region to meet a child's needs. She said that DCBS has implemented Recommendation 1.5 that the department should indicate disruptive, neutral, and positive reasons for placement changes in its reports. The data are used to develop performance-based measures that are included in agreements with private child-care providers and child-placing agencies. A video on recruitment of foster care parents was shown. Ms. Dennis summarized the implementation of the HB 1 provision related to reporting of caseloads. She described the trend, mostly upward, in the number of children in custody of the cabinet. Ms. Begin said that HB 1 required the creation of a study group of public and private child welfare leaders, stakeholders, and advocates to make recommendations on performance-based contracting for licensed child-caring facilities and child-placing agencies and the feasibility of privatizing all foster care services. The group's report on performance-based contracting, which includes 20 recommendations, was submitted in November 2018. The group's report on privatization, which has four recommendations, was submitted in June 2019.

Ms. Caywood summarized the federal Family First Prevention Services Act of 2018. Kentucky will be one of the first states to implement its provisions. She concluded by saying that DCBS will focus on biological families in its priorities for the 2020 legislative session.

In response to questions from Representative Bechler, Ms. Bell said that it has taken 4 to 5 months to upload a case to the system used by the panel because of the old system involving regions sending photocopied documents to the central office for further work. The time to upload a case will get shorter with a new system and a full staff of four in the fatality unit. Ms. Taylor said that she hopes to reduce the time of the process by 2 months.

Senator Carroll said that he is concerned that the panel can review a case in an open meeting in which there is an ongoing criminal investigation. Ms. Caywood said that this is the way the statute sets up the panel. She said no identifying information is presented at panel meetings. Senator Carroll said that someone might be able to figure out such information anyway.

Representative Rothenburger said that care should also be taken in regard to open meetings and privacy provisions of HIPAA [Health Insurance Portability and Accountability Act of 1996].

The meeting was adjourned at 10:06 AM.