Child Fatality and Near Fatality External Review Panel

Kentucky Chamber of Commerce
464 Chenault Road
Frankfort, Kentucky 40601

Tuesday, October 15, 2024

MINUTES

Members Present: Hon. Benjamin Harrison, Chair; Commissioner Lesa Dennis, Department for Community Based Services; Dr. Christina Howard, Child Abuse Pediatrician, University of Kentucky; Judge Libby Messer, Fayette Family Court; Hon. Olivia McCollum, Boone County Assistant Attorney; Jan Bright, State Child Fatality Review Team; Dr. Elizabeth Salt, Citizen Foster Care Review Board; Detective Jason Merlo, Kentucky State Police; Heather McCarty, Regional Program Manager, Family Resource and Youth Service Center; Rep. Samara Heavrin, House of Representatives; Dr. Melissa Currie, Chief, Norton Children's Pediatric Protection Specialist; Dr. Danielle Anderson, MAT Provider; Dr. Jaime Pittenger Kirtley, Prevent Child Abuse Kentucky; Allison Motley-Crouch, LCSW; Dr. William Ralston, Chief Office of the Medical Examiner; Steve Shannon, KARP, Inc.; Victoria Benge, Executive Director, CASA; Geoff Wilson, LCSW, Practicing Addiction Counselor; and Olivia Spradlin, ZeroV.

Welcome and Introductions ***Hon. Benjamin Harrison, Chair***

Chair Harrison welcomed everyone to the October panel meeting and thanked them for joining in-person and those joining virtually. Chair Harrison introduced himself to the group and then welcomed the newest panel member from CASA, Victoria Benge. Panel members and guest in the room introduced themselves to the group. Chair Harrison welcomed the panel's newest case analyst, Cynthia Hildebrandt. Panel member, Allison Motley-Crouch introduced her guest, Alicia McCauley.

Next on the agenda is to approve the Minutes and Case Review Summaries from the September panel meeting. Steve Shannon made a motion to approve, which was seconded by Jan Bright. Hearing no objections, those are approved as submitted.

Next item of business is scheduling the meeting dates for the 2025 calendar year. We are currently meeting virtually every third Tuesday from 1:00 p.m. – 4:30 p.m. Does anyone have any thoughts on changing that date? Does anyone have any objection to at least one in-person meeting a year? Members expressed their desire to meet a couple times a year in person. Hearing no objections, the panel will continue to meet every third Tuesday of the month virtually, with an in-person meeting quarterly throughout 2025.

Community Response Presentation *Dana Fryman, Branch Manager and Jennifer Woods, Social Service Specialist*

Dana thanked everyone for having them today. Dana was a former Systems Safety Analysts but now she's with the Division of Prevention and Community Well Being.

Quickly, this probably isn't anything you haven't already heard regarding the historic challenges within DCBS. There is an increase in numbers in, unmanageable caseloads, inadequate funding, high use of residential placement and a disproportionality and disparate outcomes; mandatory reporting and seeing DCBS as the one stop shop. Recently, I've talked to providers in the community, and they've said we don't know what else to do to help this family, so they call DCBS. Additionally, there is a lot of stigma related to DCBS involvement and try putting yourself in that person's shoes. DCBS has done a lot of work differentiating between safety and risk and poverty versus neglect. How those are two different things. We've seen these were historic challenges. We as a state do not do the best job of raising these children and when it's safe, we need to keep them with their families.

Historically, we would have to wait for something bad to happen in order to engage these families. We would have to receive a report that would meet our acceptance criteria in order to help these families. What if the first response was to really support these families rather than to police them. What is there was no poverty? Truly think about that. How often would neglect occur? Poverty and neglect are two separate things, but when you're living in poverty and struggling to meet your daily needs its difficult. What if communities were adequately resourced to meet the needs of families. We know across Kentucky; all our communities look different. Culture is different across Kentucky; families look different across Kentucky. But what if each community could meet the needs of those families. What would it look like if there were no disproportionality in the child welfare system? I used to do the annual child fatality and near fatality report for our team and we seen there was a high percentage of children of color being called in the child welfare system compared to the population percentage. They are being reported to our agency at a higher rate. It starts at that first call.

With all that said, in January of 2023 the Division of Prevention and Community Well Being really took off trying to meet families upstream. There are currently three branches within this division, Primary Prevention Branch, Community Response and Well Being, and Tertiary Prevention Branch. The secondary prevention is really a new world for us and we're learning every day about how to engage families. Due the stigma associated with being involved with DCBS we've really started to partner with community services.

A community response occurs when reports made to DCBS do not meet criteria for assessment or services and referred to a community-based agency to offer supports or resources to the family. The overall goal is to strength the families, prevent child abuse and neglect, and reduce future reports to DCBS. Connecting families to community-based resources and supports before maltreatment occurs prevents trauma of maltreatment and family separation. We want to reduce future reports to DCBS and allow staff to focus on those most critical safety issues. We talked about staff with unmanageable caseloads, and they are just triaging and doing the best that they can. We know small things get missed. It's not humanly possible for our staff to have high caseloads and manage all of their needs. We are learning from other states that are utilizing partnerships with Family Resource Centers or other community-based agencies for this purpose.

We have a pilot that was officially finalized in the summer, and we are waiting for an evaluation from our office of data and analytics. There are several things that we are learning. Historically, families have

not been referred for other services in a meaningful or structured way. We did have the availability to do resource linkages but those were managed through central intake, and they may not be aware of all the resources available. This builds a structured way to connect that family to a resource. Mandated reporters may falsely assume that the family's need has been addressed because of their report. If it does not meet criteria for assessment, that need is not addressed. It is the greatest missed opportunity for true prevention of child maltreatment. Services are voluntary but also intended to "plant the seed" and make families aware of services available within their own community. The work is centered around meeting families where they are and to prevent involvement with the child welfare system. I'll turn it over to Jennifer Woods to discuss some of our new work around the Plan of Safe Care Community Connector.

Our program we are calling the Plan of Safe Care Community Connector will be taking those screened out calls from Centralized Intake regarding pregnant and postpartum moms. Those referrals that do not meet the acceptance criteria that involve a pregnant and postpartum parent will be referred to the KY Moms MATR program. CI staff will send the intake information to the Secondary Prevention Branch team who will then review and send to the local community mental health centers. Some risk factors include unmanaged mental health, housing, food, clothing insecurity, victims of intimate partner abuse, tobacco use, lack of prenatal care, learning/intellectual disabilities, substance use by mom, partner, father of another household member and simply a mom seeking assistance. We've made contact with the fourteen Community Mental Health Centers across the state to introduce them to this program. Once our branch receives the referral, we will have 48 hours to notify these centers and help them make connect.

Dana: As you can see there, we are not off the ground and running yet. We're still in design, development, and data sharing agreements at this time. This work came out of the work from this panel. We had a subcommittee developed to discuss cases reviewed here that did not meet criteria for assessment but saw issues that developed later in that family. Especially when substance use is in the home. We saw this as a gap and basically how can we bridge that gap. Historically, we had providers call us and report mom was using while pregnant and we could not accept those referrals. Now this is a way for us to take those referrals and link mom with assistance. We really want to see mom's better prepared at the time the baby comes, at least the basic needs. I'm really excited about this program. We're really hoping we have some great engagement and feedback from moms.

Really quick, we are in ten counties currently with the community response pilot. We work with Gateway (Bath, Montgomery, Clark, Powell, and Rowan counties), Brighton (Kenton, Campbell, and Boone counties) in Northern, and two FRYSC in Barren and Perry County. We do have a one-pager that we can share with everyone. Those are our partners, and we meet once a month. We have an advisory council and steering community to learn how we can continue to improve our programs.

Joel: Real quick, I want to add that recommendation did come out of our subcommittee, but I want to add that the Commissioner completely supported the recommendation and you have hit the ground running with this. It has been exciting to see a huge gap and there's really a concrete plan around addressing it now. So, thank you for your leadership in that. (*round of applause)*

Dana: Thank you for that. Real quick the last slide here discusses KY Moms MATR, and you can reach out to Katie Stratton if you have any questions. She has been wonderful in trying to figure out how we can partner together and do this work. Thank you all so much for your time.

Chair Harrison: The prevention work is so important, and we greatly appreciate the work you are doing and continue to do. Next on the agenda, is the Recommendations and Responses from the 2023 Annual Report. Elisha shared a PowerPoint presentation with everyone, and we need have a discussion on each of those. Additionally in your folders, you will find our updated data analysis.

Recommendation #1: IJC on Families and Children should convene a workgroup with KBML to discuss amending KRS 311.601 to require at least 1 hour of mandatory training be dedicated to educating all professionals providing services in a medication-assisted treatment setting.

KBML stated they would participate in the recommended workgroup and recommended additional associations join this workgroup.

Rep. Heavrin: Part of being a chairwoman is also trying to learn the role and this wasn't brought to me by my staff. I've had a conversation with my staffers that if something like this comes in, it gets brought my attention. I would be happy to convene this workgroup and have the conversations with the KBML. In the future these things shouldn't slip through the cracks. I had a great conversation with the Secretary the other day about ensuring that DCBS turns in their information, but I have to be honest that I didn't do my part.

Dr. Anderson: It might also be prudent to involve the Kentucky Society of Addiction Medicine who can provide the education. As someone who is required to do these trainings there is a wide breadth of educational materials that can be used to do this and it's a pick and choose. Which is great so that providers can select where they need more education. This could be really a simple fix saying this one hour is mandatory of the 12 hours already required. The Kentucky Society of Addiction Medicine might be able to provide that education or the materials to the committee.

Rep. Heavrin: That sounds good. I'll probably also bring in Chairwoman Moser, that medical licensure is more under her purview rather than mine.

Geoff Wilson: In regard to the mandatory reporting duties when a caregiver drug testing relapse, having DCBS involved in that, that would be great. That's going to be a major educational piece for providers.

Dr. Currie: I was just going to echo having a provider as part of the workgroup is critical. I know from previous experience getting KMA on board with mandatory training is difficult but doesn't mean it can't happen. I think we need to be brainstorming, if that takes time, are there way to incentives providers to take this training.

Rep. Heavrin: Generally, in my workgroups, I bring everyone from both sides together and tell them we're going to come up with something. So, let's work together. If there are people who we think would be against it, I want to include them. If you would provide that information, that would be fantastic.

Dr. Salt: As part of my role now, I am responsible for continuing education for our College of Nursing. I get emails all the time requesting CE's. So, I think making them available through mechanisms in which people seek, such CE Central would be advantageous. I can provide those contacts for those who work with CE Central at UK.

Rep. Heavrin: Is this something that needs to be done immediately or can it be pushed in 2026?

Dr. Anderson: I think to Dr. Salt's point, I think this is something that can be created and made available in a couple months' time, but the mandatory aspect of this training will be what's harder to push. So, I think we can make it available first and then work on the mandatory aspect.

Rep. Heavrin: Ok, so we will make it available and then continue the conversation. I'm just trying to be realistic to my bandwidth.

Chair Harrison: Next recommendation, KBML should provide additional continuing medical education on their website regarding the signs and symptoms of opioid ingestions in children and the administration of naloxone. They responded saying they can do something and ask if we could provide any additional specific training.

Dr. Anderson: I think this is something that can be addressed in that same workgroup.

Dr. Currie: I wonder if it might make more sense to have two separate workgroups, one working on the content and one working on the legislative piece making it mandatory. The content part could be ongoing now and not interfere with your bandwidth. Whereas the mandatory piece can be on at a different timeframe. Does that sound reasonable?

Rep. Heavrin: Yes, and that was my question. How you laid it out is perfect.

Steve Shannon: Having the content, makes the mandatory piece a little easier.

Chair Harrison: Next recommendation, KBML should ensure proper training to medical marijuana prescribers regarding safe storage of medication and safe sleep practices. You can see the response, KBML does not have the authority to regulate the proper and safe storage of medicinal cannabis and would defer to the Cabinet.

Dr. Anderson: I worked with the Kentucky Society of Addiction Medicine on recommendations for these very things that we're mentioning here. I know the KBML has reached out to some of the addiction specialist at UK to start creating some of this content. So, I think there is something in the works, but we probably need to designate someone to follow up with what's occurring and what will be implemented. I know at least the content piece is in the works right now.

Dr. Currie: I'm wondering too if there could be some interim interventions like creating a poster to post where people who are going to get their medical marijuana. Something that says if you have kids in your home beware of these dangers. Some sort of public service announcement they will see. Again, sort of a stop gap measure.

Rep. Heavrin: Is this something Department for Public Health could do?

Elisha: That was one of our recommendations last year and we will get to that response in the next couple of slides.

Chair Harrison: Next recommendation, DCBS should develop training specific to providers of MAT regarding their intake criteria and required information for mandatory reporters. DCBS said they are updating their training videos, and they will develop a specific training for MAT providers.

Commissioner Dennis: Yes, we are working on that. Vanessa Hunter retired, and she was leading this work. Cliff is new in her position, but we are in progress of that training development and will have it available soon. It will be available online and we will communicate to providers that it's available and how to access it.

Dr. Anderson: Part of that training needs to be included in the workgroup and could be used as part of their required CE's. If that could be approved for training credits, more providers are more likely to take it. The approval process is not that complicated. It will increase the likelihood that people will do the training.

Geoff Wilson: A lot of MAT providers, it's the counselor that's seeing the client that really knows what's going on. Social workers, professional counselors, all of those folks in the practice really need that training. They are the ones that really know what's going on and usually on the fence about what needs to be reported. Really getting that information to clinical folks that work with those clients would be huge.

Chair Harrison: Next recommendation, DPH should partner with Kentucky healthcare systems to integrate a screening for medication or illicit substance safe storage into the standard electronic health record intake for all pediatric encounters. Response, the Division of Maternal and Child Health can offer expert guidance on safe storage of medications. This is covered through the work of the division's injury prevention program.

Dr. Anderson: I'll just pose a larger question that I think we will all be experiencing as we see cases in the future. The recommendations are currently for providers to provide this information to their patients about safe storage of medication but are the dispensaries and provider's offices going to have access to the things we're going to need for safe storage. It's great if we suggest it but where are the consumers going to obtain these bags. The availability of that is going to be extremely important.

Dr. Currie: It may be important as a first step to link those community resources that do have those boxes and bags available, but I think that's a really good point.

Chair Harrison: Next recommendation, the Department for Public Health should do a public service campaign targeting retailers that distribute THC containing products or Kratom about safe storage and the dangers of co-sleeping while under the influence of these product. DPH said they are currently working with staff in DBHDID to develop a training for retailers of hemp-derived cannabinoid products. The suggested addition of safe storage and the dangers of co-sleeping can be included in this training. It sounds like that is in the works for when those facilities open.

Dr. Anderson: Also, this recommendation grew out of the current Delta-8 products that are on the market that are marketed towards children. We've had several cases of ingestions of gummies that look like nerds' candy or glow worms and there have been some fatal ingestions in children. This seems very

important but a huge undertaking considering all the companies we import this from in Kentucky. I wonder if there are other ways to expand on this.

Dr. Currie: I will say we are seeing kids weekly in our ICU with THC ingestions. It is not getting better, it's getting worse. Part of my concern is the hemp-derived products are legal to begin with, but I also know any efforts to make that illegal is counter to the direction everyone is going. My thought at least is regulating it eventually. Part of the problem with these products right now is there is absolutely no regulation, we have no idea what is actually in them. It's usually toddlers getting into their parent's gummies. There are definitely kids buying it themselves and using it but those aren't the kids that end up in the ICU. Having regulations in place makes more sense to me regarding safety, in addition to educating the people who sell it. The other thing is about having some rules on who can sell it. I mean who's going to look at a posted about safe storage at a gas station.

Judge Messer: I echo what Dr. Currie is saying. I've been doing this work for 10-15 years on the prosecution side, I never used to see marijuana or THC ingestions positive for kids in petitions and now I think I get 2 or 3 a month at this point. I agree, it's our toddlers getting into things. One of my big concerns from the CHFS perspective is included in these folks lots of education about the safety. I feel like our workers come in and don't know what to say because it's legal or they're allowed to get it. Then when I tell the parents, you recognize that that's not regulated, and you have no idea what's in that right? So, you're taking that risk for yourself that's fine. Sometimes that gets a parent's eyes open and they're a little more comfortable when they realize it's a risk to their child. I think that could be some really good education to workers and frontline folks. So, at that initial meeting with parents, when you realize they're a medical marijuana user or Delta-8 user those conversations can happen right away. Cause people think it's safe and it's not. People act shocked when I say it at court, and I got it the information from you all at these meetings. So, its important frontline workers are having these conversations.

Dr. Salt: I completely agree with Judge Messer, and I have a couple of FDA links about the risks and also have an expired NIH funding announcement about the effects of cannabinoids on fetal brain development. I also want to say that on the Citizen's Foster Care Review Board we see the use of cannabinoids is minimized by the workers. I think really emphasizing the risks of these to the workers is a step that should be made.

Joel: I will add it's not just the workers minimizing the risks, it's the judiciary as well. We will talk about that in a case today. They will say refer to parent education unless it's just marijuana. It's a little concerning.

Jan: From a public health model, you also have to think about how you're forming your message. We talk about at the dispensaries with a lockbox and so on, but you go to the gas station and it's just hanging on a tab. Parents don't see it in the same light and just throw it in the seats or on the coffee table because it looks like candy and doesn't look harmful.

Dr. Anderson: And the availability in the gas stations, sends the signal that this is not a controlled substance and safe.

Dr. Kirtley: It's the same concept with ibuprofen or Tylenol. People think because it's not behind the pharmacy counter they're not dangerous.

Judge Messer: True but at least those are in a child safe bottle. So, I think people understand the danger a little more in those products because of the packaging.

Rep. Heavrin: I will say from a legislative perspective, you know we had legislation to get this stuff behind the counter. I had someone come into my office the other day and say we didn't do enough. Sometimes in policy, you have to do a first step because we can't get everything that we want. I would encourage you all to look at the lobbying groups that were against it and have conversations with them. I think you have one sector that are saying it's your right to have that. I think if you all can educate people and have conversations with these people who believe differently on the issue that is always helpful. I do think it's important to hear about the kid perspective and the health and safety risks.

Dr. Anderson: We're seeing an increased number of adults coming into the emergency department with psychosis from these products. Again, seemingly that they're safe and we know what's in the product but that also puts children at risk when parents are using. I think it's a huge public safety campaign.

Chair Harrison: I will say our conversation has kind of covered our next recommendation as well. The Department for Public Health stated they filed an emergency amendment which requires products be in packaging that would not be appealing to children. That brings me to ask what's the enforcement mechanism from DPH. What's that look like? The regulation may be in place but what's the enforcement. Any other thoughts?

Jan: I assume it's the same as those who monitor our other things. They're doing so much with a very limited bandwidth. It's like Kentucky State Police trying to pull over speeders. You pull over one and there's 50 more that drive by. I know someone who works at gas station who is constantly carding underage individuals trying to buy these products, but they'll just find a 21-year-old to come in and buy it for them.

Dr. Currie: I didn't know there were even age restrictions on these products.

Rep. Heavrin: I believe that was something we passed last session.

Chair Harrison: We're now to the Plan of Safe Care recommendations, this recommendation was to the Governor's Office recommending they convene a task force with goal of developing and implementing a robust Plan of Safe Care. The Governor's Office response was basically, thank you. I think that would show the executive branch's commitment to this, their concern for it, but the response was disappointing.

Rep. Heavrin: Could we ask the AG's office to do this?

Elisha: Sure, the legislative branch could convene the task force as well. We specifically asked the Governor's Office because of what we saw working in other states. Specifically, in Michigan, their Governor's Office convened a task force, and they have an incredible plan of safe care program. I'd be more than happy to share some of our research.

Joel: Their response said they'd welcome any additional feedback. Should we reach back out to them?

Dr. Currie: Can we do both? I think there's benefit in educating both branches about the support DCBS will need just for their current plan of safe care program. So, I'd advocate for both.

Steve: The AG's office has the Child Abuse Prevention Board that could help with funding this initiative.

Chair Harrison: The CHFS, in conjunction with the KHA, should identify barriers to reporting SEI/NAS cases to the DPH NAS Reporting registry and implement compliance by February 1, 2025. CHFS responded that many, if not all the improvements will be in place by the recommended deadline. Any feedback from members?

Jan: You know they moved that reporting from paper reporting to the Redcap survey and part of the issues we're hearing is bandwidth of the hospital staff. There are also several educational pieces we are working on to ensure accurate reporting through technical support.

Chair Harrison: The KMCCSA and the OAG should examine the feasibility and make a proposal to the Judiciary Committee to amend KRS 431.600 to require multidisciplinary teams to review all fatal or near fatal child physical abuse investigations. The OAG intends to implement this recommendation. The KMCCSA will be conducting a feasibility survey and will provide a copy to the Panel. Any comments? Next recommendation the KMCCSA shall amend their protocol to include all fatal and near fatal child physical abuse cases. The Commissioner will communicate directly with local teams to announce the feasibility study and encourage teams to consider adding fatal and near fatal physical abuse cases. KBN agrees with this recommendation. It will be tough to get that implemented locally without a statutory change.

Dr. Currie: I will just add in Jefferson County, the MDT's that review the physical abuse cases are not the same people that review the sexual abuse cases. Lumping it all together may be ominous considering all the people that would need to sit around the table. My suggestion would be to break it up into two different teams and we can talk more offline. Does it have to be the same?

Commissioner Dennis: It doesn't have to be, some of our small counties, it will be the same people. Having two separate meetings might become a barrier in those smaller counties. Maybe having the option to create two teams is the answer.

Dr. Currie: As it is setup now the sexual abuse MDTs are more or less run by DCBS. The physical abuse ones don't necessarily have to be.

Dr. Howard: I did talk with the CAC about this as well because I think that there are similar concerns, especially from the medical portion for the fatalities and near fatalities and who the medical provider may be on those teams. A lot of the CACs are not equipped with medical providers that would be ideal for being involved with these cases.

Chair Harrison: Ok, next recommendation was to the KBML and KBN should encourage all primary care providers who care for children to complete an Intimate Partner Violence screening safely with their caregivers, to refer to resources for those with a positive screening, and to securely document those results. KMBL will share this recommendation with licensees on its web site and in a targeted email

blast. They have asked the panel to provide a brief summary of its recommendation and links to model screening tools. KBN stated they will provide its licensees a list of screening instruments for IPV for licensees on its web site and in a targeted email blast.

Dr. Salt: I think Medicare is now requiring some of these screens. The problem I've been hearing from providers is the lack of resources.

Olivia Spradlin: This is now something the Cabinet is tracking as part of that mandate. There have been multiple working groups ZeroV has met with from the Cabinet. We have some concerns about confidentiality and how this is being documented. We are aware of some incidents where victims received referrals and the perp was made aware because they're on the same insurance. We've also had some reports of doctors doing these screenings while their partners are in the room. There is definitely space for more conversation and recommendations around this and resources are absolutely an issue.

Dr. Salt: Yea, I think we need to focus on executing this safely and effectively and getting more resources in those areas where it's needed.

Dr. Currie: I share the same concerns as Olivia. We see it in the children's hospital, they're screening mom but documenting it in the child's record where the perp may have access to that record. On the flip side if they're screening children, they're doing that in front of the caregivers too. Again, maybe identifying or developing content for CEs around safe documentation and safe screening, not necessarily mandatory but available may be more effective.

Olivia: You and I have talked about that before and perhaps it's time for us to start those meetings again.

Dr. Currie: Agreed and what I hear from other providers is they want very practical points about how to do this the right way. I think having an online module they can do for credit is a great first start. I'll just add to the resource part, it's not ethical to screen for something if we're not able to respond to a positive screen.

Olivia: Agreed and there are some things that need to be worked out for that referral system.

Chair Harrison: Next recommendation is for the CHFS recommending an educational handout for those individuals who screen positive for IPV. They responded stating they are providing some when it is safe to do so. They are using the "Help is Here" brochure but it does not include risk factors to children. KBN agrees with this recommendation. Any thoughts on these?

Olivia: There's already that mandatory referral law, if anyone discloses or screens positive you have to give education that includes all these things. We have those on our website, in at least six different languages. What they don't include is the social determinants of health information, which is noted there.

Chair Harrison: The next recommendation is regarding Family Recovery Court and that AOC should comply with the law and provide the panel a response to their 2022 recommendation. They responded stating that after the implementation of Family Recovery Court in Jefferson, Volunteers of America took on the leadership role in expanding in eight other counties.

Dr. Currie: I could be wrong but last I heard the Family Recovery Court was funded by a private funding source and not state funded. So, saying we have it in Jefferson County is a little disingenuous given that it's not being funded. We know how to do Family Recovery Court; we don't need to convince people that it needs to be done. It's how do we convince people it's worth funding statewide.

Judge Messer: That's 100% correct Dr. Currie. I have been saying for six years in Fayette County, I'll do it. When you look at how Jefferson County is doing it, it's a Judge working with private grant providers and entities. It's not part of AOC or state funding and it won't be implemented statewide until we have that funding piece.

Chair Harrison: The next recommendation requested AOC to prepare and present information regarding the barriers that may prevent the full implementation of Family Recovery Court. Their response to that was they established an executive board to maintain structure for FRC and future sites.

Rep. Heavrin: In Grayson County we don't have Family Court, but we do in Hardin County. Do you think this Family Recovery Court would have to be in Family Court?

Judge Messer: Absolutely not. The Judge itself does not have to be a certain jurisdiction. Additionally, if you have neighboring counties, you could run it out of one county or regionally. It doesn't have to be county by county.

Chair Harrison: On the DCBS recommendations, we talked about this earlier, they should explore changes to their practice to ensure referrals from professional reporting sources, the age of the victim, and prior involvement be a weighted consideration in Central Intake decision making. Their response stated they are considered. Commissioner Dennis, anything else?

Commissioner Dennis: Again, those factors are considered, and we've done some recent retraining of our Central Intake staff to ensure they are fully considering all those factors. We are currently working with an outside entity to help us assess the current intake policies and practices and make some recommendations for improvement.

Chair Harrison: Next recommendation, DCBS should continue to expand iTWIST improvements, as well as data collection efforts, to identify screened out CPS referrals which were ultimately accepted after further review and/or reports accepted within 60 days containing similar allegations. DCBS shall update the Panel on iTWIST changes and data collected. Their response states they are continuing to work on improving TWIST and the data collection piece.

Commissioner Dennis: We are continuing to make improvements to our case management system. We have implemented some changes already to help connect those referrals that do not meet referrals back into those counties. There are some additional changes that will be implemented this month and future enhancements that will be implemented in 2025.

Chair Harrison: Next recommendation is that DCBS should share information with the Panel regarding any data they currently have on wait times and potential improvement plans to address high volume call times. So where is that information available?

Commissioner Dennis: Yes, I just realized you all had not received that yet, but we are putting that together currently as we speak. Elisha, we will need to speak about what frequency you want that on, but we'll get that to you very soon.

Chair Harrison: Next recommendation is DCBS should revise Central Intake practice to ensure referrals received after hours undergo a thorough supervisory review within the two-to-four-hour timeframe. They state reports/referrals do undergo a timely supervisory review. For referrals received during normal business hours, 95% are reviewed by supervisors. During afterhours and holidays, they partner with Seven Counties who contacts the supervisor. Any comments? Next recommendation, DCBS should implement a process to ensure the Systems Safety Staff receive timely notification of all fatal and near fatal referrals, regardless of the designation applied to the report. DCBS stated currently, staff are required to notify the SSR team when a fatality occurs on an active case, regardless of the designation. Central Intake is required to notify the System Safety staff.

Commissioner Dennis: Previously, if the report did not meet criteria the Systems Safety team was not notified. We are making a change in practice and Central Intake will notify the System Safety Review Team of a fatality or near fatality to ensure those are tracked.

Chair Harrison: Great. Next recommendation, DCBS should explore creating a specialized branch or other processes within Centralized Intake to focus on handling referrals made by a professional reporting source. DCBS stated most referrals received are from professional reporting sources (79% in 2023). The provisions in HB 271 fulfill the intent of this recommendation. Next recommendation we are also waiting for the information from DCBS. Under Child Access Prevention Laws, the Kentucky General Assembly, through the Judiciary Committee, should research national legislative models pertaining to Child-Access Prevention and Safe Storage Laws with the goal of developing legislative action to encourage and support safe storage practices. We did not get a response. Regarding Youth Suicide Recommendations, the panel recommended that if DBHDID does not believe they are the appropriate entity to implement the psychological autopsy, they should identify the recommended agency. They responded again they are not the appropriate agency but did not state which agency would be.

Dr. Currie: We need to know who is answering this question and ask some follow up questions.

Steve Shannon: I'm reaching out to Commissioner Marks.

Chair Harrison: The last recommendation the panel recommended DBDID, complete the offered assessment of best practices in other states and present that information, along with any recommendations to the panel by September 2024. They responded stating they submitted requests to representatives in all 50 states about the use of psychological autopsies in youth suicides. As to date, 20 entities responded, with two reporting they use the psychological autopsy. Any thoughts on their response?

Dr. Currie: Have we thought about mandating suicide reviews? I mean like we do physical abuse and sexual abuse or fatality reviews. Just a thought. Similar to child fatality review teams but a specialized team to conduct those.

Jan: Currently, when the CFR teams have a suicide reported they bring DCBS to the table. That forensic piece is something we'd like to take on, but we only receive surface level records.

Joel: I think to do this statewide there would be a significant funding piece because you need to train people statewide and obtain the records. It's not like the basic CFR, it's deep dig into what happened and interviewing families and children.

Jan: The only funding for our current CFR is the federal Title V block grant, there is no state funding supporting that program. Funding is a big piece to build that bandwidth to have that expertise and ability to do that.

Joel: Even if we could start piloting that in a specific county would be a good starting point.

Dr. Howard: Is Jefferson County not currently piloting this project? (No confirmation)

Rep. Heavrin: This would be a really good conversation to have with Sen. McDaniel and Representative Petry. They're both Chairman in their respective chambers in the A&R and if you're going to do a pilot, I'd suggest a rural and an urban county. I think it's important to show it happens in both and not a rural or urban problem.

Jan: It's really hard to know the real number of child suicides in Kentucky.

Chair Harrison: Thank you everyone for all your input. I do want to point out in your folders, the panel data from FY 2018 until 2023. That gives a good overview of what we're looking at on a monthly basis and I did want to ask if anyone has any specific recommendations for next year. Maybe something we can talk about next meeting, but does anyone have anything they'd like to share now?

Rep. Heavrin: I do have a quick follow-up, it was HB 11, and it goes into effect January 2025 and in a nutshell, it gets stuff off the shelf that's not approved by the FDA. The feds implemented the 21-year age requirement. So, hopefully we will see some change.

Chair Harrison: Thanks for that follow-up. Any specific recommendations for the 2024 report?

Heather McCarty: I would like to see something regarding homeschooling. I don't know what that would look like, but it seems to be prevalent in a lot of the cases we review.

The Face It movement is looking at making some recommendation for legislative change regarding homeschooling as well. So, they might be a good resource to talk too.

Dr. Currie: I think this is an area where Rep. Heavrin's approach would be beneficial, get everyone in the room and discuss it. I wonder if just convening a workgroup could resolve this issue.

Rep Heavrin: Having a conversation with Chairman Tipton would be a good point of contact.

Dr. Currie: Something we are seeing a lot of, but I don't know how to address it, we are seeing a substantial increase of medically complex children coming in with fatal or near fatal neglect. I'm going

to meet with the Commissioner soon to talk about this, but it appears there have been several previous reports made to DCBS in these. Those reports are unsubstantiated but it's not clear that a medical provider was part of that discussion. I'm proposing that one of the pediatric forensic medicine teams are involved if we have medically complex kid that's reported to DCBS for medical neglect. There are more layers that need to go in there to keep these kids safe.

Joel: Quickly I want to follow-up on the ALTE\BRUE discussion regarding EMS response from last month's meeting. We reviewed a case where a kid experienced a BRUE event and the mother refused medical transport and I was asked to contact Morgan Skaggs to find out about their policy. Currently their protocol for when a person refuses transport, they encourage them to contact the hospital they would have been transported to for treatment. They need to do some definitional work and some updated training, but she did provide some data and there was only one that refused. So, there doesn't seem there's a bunch of these kids.

Dr. Currie: I wonder if part of it is how they code their data. When I look at EMS code sheets it almost never says BRUE on there. It will say respiratory distress or unresponsive and I don't know that those are getting coded as BRUEs. I do think it would be helpful if when they're updating their policies to involve one of the pediatric forensic teams just to offer some perspective.

Joel: I'll pass that along to her and ask her to dig into the data a little more as well.

Pending Cases:

F-005-23-C – We had some questions regarding genetic testing and Dr. Howard was curious if the ME does genetic testing when there are other kids in the home this could affect.

Dr. Ralston – We do genetic testing but it's pretty specific not for just general genetic disorders. We do retain a blood sample as well if the parents decide that they want to do the genetic testing. We inform the coroner that the family needs to be made aware of the situation.

Joel: So, the communication is on the coroner to tell the family. That was the question, how does the family find out.

Dr. Ralston: Right, that's generally how it works on all death investigations. Which points to the next case, the medical examiners communicate all the information to the coroners to distribute it to the appropriate authorities.

F-050-23 – The next case is where the kid was positive for fentanyl at the autopsy and there was a significant delay in reporting to those findings to DCBS. Dr. Ralston will consult with legal staff on their policy to ensure statutory compliance.

Case Reviews:

The following cases were reviewed by the Panel. A case summary of findings and recommendations are attached and made a part of these minutes.

Group	Case #	Analyst
1	NF-131-23-C	Joel Griffith
3	NF-124-23-C	Joel Griffith
2	NF-020-23-C	Joel Griffith
4	NF-155-23-C	Joel Griffith
2	NF-149-23-C	Lori Aldridge
3	F-021-23-NC	Lori Aldridge
1	F-007-23-C	Lori Aldridge
4	NF-022-23-C	Lori Aldridge
2	NF-038-23-C	Cindy Curtsinger
4	F-022-23-NC	Cindy Curtsinger
3	NF-045-23-C	Cindy Curtsinger
1	NF-125-23-C	Joel Griffith
2	NF-084-23-C	Joel Griffith
1	NF-062-23-C	Joel Griffith
3	NF-017-23-C	Lori Aldridge
2	NF-061-23-C	Joel Griffith
3	F-048-23-NC	Joel Griffith
4	NF-012-23-C	Joel Griffith
3	NF-128-23-NC	Joel Griffith
2	NF-066-23-C	Cindy Curtsinger
1	NF-001-23-NC	Cindy Curtsinger
4	NF-069-23-C	Cindy Curtsinger

***The following cases from the October agenda will be reviewed during the November meeting: NF-042-23-NC; F-049-23-C; F-024-23-C; NF-129-23-NC; NF-40/41-23-C; F-001-23-C; F-027-23-C; NF-142-23-C; F063-23-PH; and F-036-23-NC**

Due to the number of remaining cases to be reviewed, the Panel agreed to extend their November and December from 11:00 a.m. – 4:30 p.m.

Additional Discussion:

Potential Recommendation: Lack of testing for xylazine and fentanyl across the state.

Meeting adjourned.

Next meeting Tuesday, November 19, 2024, at 11:00 a.m.