Child Fatality and Near Fatality External Review Panel

Virtual Meeting

Tuesday, May 20, 2025

MINUTES

Members Present: Hon. Benjamin Harrison, Chair; Commissioner Lesa Dennis, Department for Community Based Services; Rep. Samara Heavrin, House of Representatives; Dr Jaime Pittenger Kirtley, Prevent Child Abuse Kentucky; Olivia Spradlin, ZeroV; Matt Belcher, State Child Fatality Review Team; Dr. Christina Howard, Child Abuse Pediatrician, University of Kentucky; Dr. Henrietta Bada, Department for Public Health; Victoria Benge, Executive Director, CASA; Heather McCarty, Regional Program Manager, Family Resource and Youth Service Center; Dr. Danielle Anderson, MAT Provider, Nicole Smith Abbott, LCSW and Olivia McCollum, Boone County Assistant Attorney

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

Chair Harrison welcomed everyone to the May meeting. First item of business is the approval of the Minutes and case reviews from the April meeting. Dr. Danielle Anderson made a motion to approve the Minutes and case reviews, which was seconded by Nikki Abbott. With no objections, the April Minutes and case review summaries stand as approved.

Annual Report Responses

Before we start with the case reviews, I want to give a brief PowerPoint presentation regarding the Annual Report responses that we have received.

1.) In the Overdose/Ingestion section of the report we recommended that the Cabinet of Health and Family Services including representatives from the Department of Behavioral Health, Developmental and Intellectual Disabilities, the Department for Public Health, and the Kentucky Office of Medical Cannabis should convene a workgroup to create a standardized safe storage guideline for all providers and the public.

    a. The response to this recommendation was the cabinet recognizes the importance of establishing standardized guidelines and consulted with other states that have legalized medical cannabis. The Kentucky Office of Medical Cannabis has created a how to guide regarding safe storage of medical cannabis and it is on their website. Additionally, they have leveraged partnerships throughout the community of mental health centers to disseminate information on safe storage, and they have stated they will convene dedicated workgroups to develop standardized safe storage guidelines. I feel like that was a good response to that recommendation.

2.) The Department for Public Health should conduct an aggressive public safety campaign targeting proper medication, safe storage and saturating these critical tools throughout Kentucky

communities. The campaign should also encourage the use of fentanyl and xylazine testing strips and Naloxone in pediatric ingestions.

   a. DPH's response is that they will continue to engage families through the HANDS and WIC programs. Each local health department engages communities in the prevention of child's injuries including poisoning. DPH also provides education in the use of Naloxone in opioid poisoning. Fentanyl and xylazine can be ordered through a website or obtained through some local health departments and recovery centers.

3.) Still under the overdose/ingestion section there is a recommendation that the Department for Community Based Services should educate staff on the need for comprehensive drug screens for caretakers, especially if the child had a positive response to Naloxone.

   a. Their response is that they have implemented that recommendation.

4.) Under the same section there is a recommendation for the Kentucky Hospital Association that they should encourage all hospitals to conduct comprehensive UDS, inclusive of synthetic opiates, when a child has a positive response to Naloxone.

   a. The response is that they recall receiving the recommendation/report but have not responded yet. Our Justice staff has emailed them another copy of the recommendation/report, and we are hoping to hear back from them soon.

5.) Recommendation number 5 to DCBS to create a Practice Guidance specific to Safe Storage of Medication available within their SOP.

   a. DCBS has implemented that recommendation.

6.) Under the section of Plan of Safe Care there was a recommendation for the Governor's Office to convene a task force with the goal of developing and implementing a robust Plan of Safe Care to address the needs of substance exposed infants and their caregivers across the Commonwealth. The task force should consist of House and Senate members, Executive Branch personnel, External Child Fatality and Near Fatality Review Panel members, and community stakeholders.

   a. We did receive a response that this recommendation has not been implemented and this has been at least year two that this recommendation has been made to the Governor's Office and it not being implemented.

7.) Under the section of DCBS the recommendation that they should examine and document existing practice involving use of virtual contacts by CPS staff (investigative, ongoing, foster care, etc.), to include use of phone, Zoom, or virtual formats. This examination should be included in all levels of the Continuous Quality Improvement (CQI) and the Case Review Process. Based on findings from the CQI reviews, amended SOP and/or practice guidelines should be issued to the field by January 2026.

a. DCBS's response is that they are currently evaluating the use of virtual contact by CPS staff and will update the SOP accordingly by December 30th of 2025.

8.) Under Child Access Prevention Laws there is a recommendation to the General Assembly through the Judiciary Committee, they should explore model legislative strategies to encourage and support safe storage of firearms. Recommended options for explorations include Child-Access Prevention and Safe Storage Laws, funding for evidence-based prevention education, and provision of gun locks with every firearm sold to give responsible gunowners the tools to securely store weapons.

9.) And the recommendation to the Child Abuse and Neglect Prevention Board is to work collaboratively with community partners to fund and raise awareness regarding safe storage practices of firearms.

a. The Child Abuse and Neglect Prevention Board implemented the recommendation that the panel provided, and we have not received a response from the Legislative Research Commission. Chair Harrison and Elisha Mahoney are working with LRC to try and get a resolution.

10.) Under the Youth Suicide section, the recommendation was to the Kentucky Department of Behavioral Health, Developmental, and Intellectual Disabilities and the Kentucky Department for Public Health, Division of Maternal and Child Health should convene a workgroup to identify the resources required to fully implement the Psychological Autopsy throughout the state. The goal of the workgroup should be to implement pilot projects in order to further identify the barriers for implementation (i.e. statutory authority, staffing, funding, etc.).

a. Those agencies agreed to implement those recommendations.

11.) The Kentucky Department of Education (KDE) will coordinate a presentation with the Panel to identify an appropriate time and place to provide training related to truancy, virtual schools, and other non-traditional instructional formats as it relates to high-risk children (as defined by the Panel).

a. The Department of Education's response is that they will provide a presentation to the panel and that has been set for the August meeting.

We look forward to hearing that presentation from the Department of Education. If anyone wants a copy of those recommendations/responses, then just let us know and we can get a copy of that to you.

Seeing no additional business we will move onto the pending cases.

Pending Case Updates:

F-025-24-C – Jennifer Burke discussed the KVC records she had received after the previous panel meeting. Potential system issues identified include when referrals are made to in-home service providers and the family is on a "waiting list", if the DCBS case is closed, the referral is closed. Therefore, the

provider may never know the family was in need of services. Services can only be provided if there is an active DCBS case.

F-031-24-NC – Jennifer Burke provided an update to the panel regarding criminal prosecution. No additional findings were made or changed based on this information.

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
4	F-029-24-C	Cynthia Hildebrandt
1	NF-078-24-NC	Cynthia Hildebrandt
2	NF-067-24-NC	Cynthia Hildebrandt
3	NF-033-24-C	Cynthia Hildebrandt
1	NF-047-24-C	Jennifer Burke
4	F-033-24-C	Jennifer Burke
3	NF-052-24-NC	Jennifer Burke
2	NF-049-24-C	Jennifer Burke
4	F-024-24-C	Cynthia Hildebrandt
2	NF-030-24-C	Cynthia Hildebrandt
1	F-030-24-C	Cynthia Hildebrandt
3	F-37/38-24-C	Cynthia Hildebrandt
2	NF-060-24-C	Jennifer Burke
3	NF-070-24-C	Jennifer Burke
4	NF-064-24-C	Jennifer Burke
1	NF-076-24-C	Jennifer Burke
3	NF-045-24-C	Cynthia Hildebrandt
1	NF-102-24-NC	Cynthia Hildebrandt
3	NF-128-24-NC	Cynthia Hildebrandt
4	NF-090-24-NC	Cynthia Hildebrandt

Additional Discussion:

Dr. Anderson: This is the perfect example of someone who needs that education on safe storage of illicit and prescribed substances. I hope they are able to get that from DCBS and public health campaigns.

Dr. Bada expressed concern about how medical providers can assist with noncompliant parents. Should they notify law enforcement? I don't know of anyway to get them to come to the clinic. Sometimes we call and request assistance from DCBS but if they're noncompliant, I don't know what else to do to ensure the child is evaluated.

Jennifer: That is a question that has been posed to the panel. Is there a system that can be implemented to ensure these medically complex children are being seen for follow-ups? It's a reoccurring issue in these medical neglect cases.

Dr. Bada: They always have a reason they can't come to the clinic, or they move. It really is a big issue. At one point, if the child is left in the hospital, we could ask the police to go get the parents and ensure they come to the hospital. Once they're discharged, they're difficult to find. I just don't know what else we can do. We can't force them to treatment.

Motion to adjourn made by Commissioner Dennis and seconded by Heather McCarty. With no objections meeting adjourned.

Next meeting Tuesday, June 17, 2025, will be held in-person at ZeroV in Frankfort.