Child Fatality and Near Fatality External Review Panel
Virtual Meeting

Tuesday, August 19, 2025

MINUTES

Members Present: Hon. Benjamin Harrison, Chair; Commissioner Lesa Dennis, Department for Community Based Services; Senator Danny Carroll, State Senate; Rep. Samara Heavrin, House of Representatives; Dr Jaime Pittenger Kirtley, Prevent Child Abuse Kentucky; 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; Nicole Smith Abbott, LCSW; Steve Shannon, Executive Director, KARP, Inc.; Olivia Spradlin, ZeroV; Dr. Elizabeth Salt, Citizen Foster Care Review Board; Dr. Melissa Currie, Chief, Norton Children's Pediatric Protection Specialist; and Olivia McCollum, Boone County Assistant Attorney

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

Chair Harrison welcomed everyone to the August meeting. Everyone should have received an email from Elisha regarding the upcoming September 16th meeting. That meeting will be held in conjunction with the Kids Are Worth It! Conference at the Central Bank Center in Lexington. Please let Elisha know if you plan on attending in person. Elisha informed members the meeting will be held in meeting room 10 at the conference center. Next item of business is the approval of the Minutes and case reviews from the July meeting. Dr. Bada made a motion to approve the Minutes and Case Review Summaries, which was seconded by Commissioner Dennis. With no objections, the July Minutes and case review summaries stand as approved. I'll now turn it over to Casey Reed for the Firearm/Suicide Data presentation.

Firearm/Suicide Data Presentation ***Casey Reed, Epidemiologist***

Casey greeted the members and reminded everyone her presentation will be available on SharePoint if anyone would like to review it after the meeting. Firearm and suicides account for a small number of overall panel cases. Next slide shows Gunshot (accidental) cases are typically the leading type of firearm case reviewed by the panel. However, it does fluctuate with gunshot (homicide) and all types were equally accounted for SFY23. Handguns are the most common type of firearm used in these types of cases (65%). Homicide cases have the highest rate of unknown firearm types. Rifles are the second most common type of firearm in suicide cases. Biological fathers are the most common firearm perpetrator in these cases at 54%. Switching to suicide cases by mechanism, firearms are used more than any other means. Males tend to use firearms more often than females and this is also seen statewide with our CFR team and the data they review. Females use substances and poisons more often than males do; this is also the same at the state level. The majority of the firearm cases are either fatal or become fatal at some point, same is true for the majority of suicide cases reviewed. Children aged 1-4 years old are at a higher risk of accidental firearm use compared to other age groups. 46% of all gunshot (homicide) cases were

involving children ages 10-14 years old. Gunshot (suicide) cases primarily effected older age groups; 56% of cases were 15-17 years old. It is important to note, 39% of gunshot (suicide) cases involved children ages 10-14. When reviewing gunshot (homicide); 46% were children 10-14 and the vast majority of perpetrators were fathers. Fathers are the perpetrator of cases more than any other relationship combined. Suicides primarily effect the older age groups. As seen in SFY22, acts of suicide are occurring in younger age groups. Regarding firearm cases, the majority of those cases are white, male, non-Hispanic children. The majority of suicide cases are to white, non-Hispanic children, with both males and females experiencing suicide at the same rate. The maps indicate the number of suicide and firearms cases reviewed by the panel for each ADD. We did want to note, it's interesting Kentucky River region had zero cases reported for suicide but a relatively higher reporting on firearm cases.

Dr. Howard – I was just going to add to that sometimes that is the determination of the coroner, and some coroners may be very different in how they classify a suicide. For example, some coroners require a letter to classify it as a death by suicide.

Casey – That's a great point; we do suspect that some of the differences in rates is how they are reported and classified by the coroner. It should be noted; a suicide has not been reported in this region for over ten years. That's note just panel cases, that's statewide.

Dr. Howard – Regarding the firearm cases, I want to stress here these are firearm cases reported to the panel. Meaning there's concern for some type of abuse or neglect. I'm curious if some of these areas have a higher threshold for reporting these cases than other areas in the state.

Casey – That's a great point too. We do know depending on the area and who is reviewing the case they might have a different conclusion and determination. We do suspect that's probably what we're seeing here. As Elisha said, it's very interesting that Kentucky River is the *only* ADD with zero reported suicides. We are still doing some research into that region and going to dig deeper into the cause behind that. I know Elisha has a meeting scheduled with that region if you want to talk about that.

Elisha – I will just add that Kentucky River region is also the only region that did not have any overdose/ingestion cases listed in our last presentation. Dana Fryman has setup a meeting in that district to dig a little deeper into the data.

Dr. Howard - It's either they're missing a lot, or we need to replicate what they're doing in that area.

Elisha – We're hoping it's really good prevention work because we know their NAS numbers are really high in that area.

Chair Harrison – Why are we looking at Area Development Districts? It's clear they vary in number of counties and population.

Casey – Basically the data itself when we're getting into counts of 1 or 2 cases, it's not significant to look at one case one year in one county. To share the data, we typically have to do it by Area Development District because there are so few cases spread-out statewide. That's the rationale for this particular breakdown. We could do a different type of map, per county, but I think it would just show less helpful information because it's so few cases. That was the rationale, but we can always break it

down in other ways. If anyone has any suggestions, please let me or Elisha know, I'm happy to present the data in whatever way works best for the group.

Dr. Howard – So, these are public health regions, and our panel looks a lot at DCBS Service Regions which they do not directly correlate with each other. From the public health perspective, I think it makes sense to use their divisions.

Rep. Heavrin – A few years ago, I passed legislation on getting data about maternal mortality and I requested it be reported on a county level. However, CHFS said they could not do that because it was reported by Area Development Districts, so it would not point out one specific case. I think it's important to have county specific data. So, if there is a county experiencing something at a higher rate, we can look at policy specific to that area. I understand both sides of that and it would be helpful to see the county level. That could help us determine if we need additional funding or policies in that particular county.

Dr. Salt – I will say whenever I do this for research purposes, sometimes you will get it honed down to as small of an area as possible. It would be interesting in the areas with higher numbers, KIPDA and Bluegrass, if we could break it down to specific zip code areas where you could target community engaged activities where there is an increased need. However, you have to do that with an ethical consideration that you're not being able to identify the individuals involved.

Casey – Everyone has made great points. I will work with Elisha, and we can brainstorm how to best convey this while also highlighting those counties with higher rates. I really like the zip code data in those higher rated areas. I will go back and break those out so we can see which of those areas are being primarily affected. Those are great suggestions, if anyone has anymore, please let me know.

Dr. Howard – I have one more question, is there a way to compare it to the statewide public health data? Do we need a MOU or what?

Casey – That's a great idea and actually Elisha and I are in the works of having a MOU between, at least MCH and the external panel so we can do those comparisons. We are hoping to get that up and going soon. This next slide list the top family characteristics for firearms cases. Which includes unsafe access, DCBS history, and environmental neglect as the top three risk factors. Statutory issues and domestic violence occur at a higher rate in these cases than all other panel cases. Homicide cases were more likely to identify mental health issues (caregiver). The rate of mental health issues (caregiver) was similar between firearm cases and all external panel cases. Criminal history (caregiver) is slightly more prevalent in all external case vs firearm cases. Homicide cases are more likely to have a criminal history of the caregiver identified. Homicide cases had the highest rate of domestic violence. Financial issues primarily affect gunshot accidental cases. Regarding suicide cases, mental health issues (child) is vastly prevalent in these types of cases. Education and childcare issues were also very prevalent in the suicide cases with 80% of SFY23 cases being impacted. Regarding the panel determination for firearm cases, neglect general and neglect due to unsafe access are very prevalent in this population. Other things to note are the higher rates of neglect medical, impaired caregiver, and physical abuse. Physical abuse is not one of the top determinations for all panel cases. This slide shows the most common panel determinations for suicide cases; to note supervisory neglect and no abuse or neglect occur at higher rates in this population. Aside from that, neglect general and unsafe means continue to be the most

prevalent in this population. This last slide contains a few key facts from the presentation. These include the average time to submission, 91% of firearm cases were potentially preventable, 94% if suicide cases were potentially preventable and most of these cases were in the KIPDA and Central Kentucky regions. I will go back and break these cases down to a county level and maybe even zip code area, if I can. Thank you all and let me know if you have any additional ideas.

Dr. Howard – I just want to say how thankful I am that we've added Casey to this work. I think it makes a big impact.

Chair Harrison – Yes, thank you Casey. As she said that presentation will be available on SharePoint if you want to take a closer look at that data. Next up is the Kentucky Department of Education presentation, and I'll turn it over to Matthew Courtney, Policy Advisor with the department.

KDE Presentation ***Matthew Courtney, Policy Advisor***

Good afternoon, everyone. I'm Dr. Matthew Courtney. I'm a Policy Advisor for the Kentucky Department of Education and I'm here today for the first of what might be a couple of presentations in response to the request you sent us at the end of your last year's reporting cycle. The request we received was broad in terms of policies across the agency. So, in conversations with Elisha, we decided the best first steps to facilitate this conversation was for me to come and provide some information to you around the big picture policy landscapes surrounding your requests and really engage in more of a conversation than a presentation. Then I can refer you to specialist who can come speak at future meetings and assist you with digging deeper into those topics you are interested in exploring. Your request included information regarding homeschooling, virtual education, medically complex youth, mental health issues with youth, truancy and chronic absenteeism. I will try to hit on each of those buckets. It seems like from the work that you do, that mental health and medically complex youth is a theme that runs throughout all the other policy areas you asked about. I'm going to start with homeschool and non-public school policy. That's the easiest one to handle because there really isn't much. The Kentucky constitution enshrines the parents' rights to choose what type of school they send their kids too. In Kentucky they have three options: the public school, the non-public school, or the homeschool. In Kentucky statutes, non-public schools and homeschools are treated as one entity and KDE is not allowed to regulate them. The only thing we do is certify non-public schools in collaboration with the non-public schools' commission. So, if you wanted additional information about that process, we would need to do a joint presentation with the commission. If you did want to make recommendations related to homeschooling or non-public schools, those would need to be directed towards the legislators. Before we move on, does anyone have any questions.

Dr. Howard – We often see cases where the child was in public school, the school reports concerns for the child's living environment, then the parents remove the child from public school and the child has a fatal event because there were no outside eyes on the child. In that scenario, how would we develop a solution to prevent that and ensure someone is checking on this child?

Dr. Courtney – Thank you for that. That is definitely something we see and hear about at the Department. Where homeschool is viewed as an escape route from various responsibilities, monitoring, and accountability but it's something that we continually bump up against. It would require some sort of legislative action for us to be able to move into that space.

Dr. Salt – Another issue we've ran into, was there was some requirement for parental engagement or documentation that was not met, and the child was supposed to return to public school. At what point is that truant and the school has some responsibility for reaching out to the child regarding truancy. What are the opportunities to intervene in that situation?

Dr. Courtney – Again, that's a hard one for us because we don't have any kind of enforcement authority. Parents are required to keep an attendance log and curriculum and the local Director of Pupil Personnel (DPP) for that school district has the authority to request those records. However, the record review process is really the extent of their authority. There would need to be a statutory change that would give the department more authority to follow up on those records. You could work with the local DPP who could refer them to the truancy pathway. In making recommendations to the legislature, you don't want to eliminate options that may be working for some kids but a higher level of oversight or a more direct path for DPP to review that information and take a homeschool kid to the truancy track might be a worthwhile recommendation.

Cynthia – In regard to the kids we review that are enrolled in public school, there is a great deal of variability in how school systems are handling attendance issues. We also see these issues at a higher rate in kids with medical issues. There may be an extended period of absenteeism with no follow-up because they have a medical issue but it's really medical neglect. Is there any communication with their medical providers?

Dr. Courtney – Sure, happy to talk about a little bit. There are a couple routes districts can use for those kids in medically complex situations. The first one is what they call home hospital instruction. That's reserved for kids that cannot attend school for five or more days together. That may be for physical health issues or mental health issues. Home hospital is exempted from attendance rules because those kids require so much flexibility in order to see to their health. We also have alternative education programs which are attached to the regular public school. They're really for kids that need an environment different than the normal in-person school environment. That may apply to children with special medical needs, mental health issues, youth pregnancy and may be use as a disciplinary pathway. Instruction for that type of school is typically a mix of virtual and in-person depending on the school and needs of the child. Those are really the two pathways that schools should be using for students with ongoing medical concerns. Every district manages the truancy pathway a little different but there's supposed to be a committee that would intervene after a child misses 10 unexcused days. The committee should be engaging with the family to identify the issue or needs of the child. More recently, full-time enrolled virtual programs have been utilized. That is beneficial for those kids with extreme anxiety.

Dr. Howard – It sounds like the next best step is recommend statutory changes that allow increased authority in certain situations. I think we get a lot of push back when we say increased authority across the board because again there are a lot of parents that are doing a good job. So maybe that's where we approach it from a statutory perspective.

Dr. Courtney – The statutory route is the only viable route; there's nothing we can do at the agency. The more narrow and specific circumstances, the more successful that recommendation could be. Last session there was a bill that would prevent a child from going to homeschool once truancy was identified. That bill did not make it across the finish line.

Dr. Courtney – Virtual school is a relatively new format that has really taken off post pandemic. These kids are still attached to a regular public school, but they work in a full school day. They are tracking attendance, most of the time, in the same way they track in-person. They do have an option to work on a performance-based program. Participation in these programs are voluntary only. We've had a lot of success in this environment. That hits on all the pieces you all had asked us about but I'm happy to field anymore questions you may have.

Jennifer- In at least one county I'm familiar with, kids placed in those alternative schools are all place together regardless of the reason why they were placed there. So, you may have kids with violent behaviors placed in the same facility as kids with high anxiety. Is that like that in all counties?

Dr. Courtney – It really is a locate issue and comes down to what resources are available in that area. We know resources are not as equally distributed as they have been in the past. It really is a resource management issue across the state. We would love to see a recommendation to boost funding for alternative education resources across the state. Unfortunately, it really does vary district to district.

Elisha – In a prior meeting, Dr. Salt or Dr. Howard, had made the recommendation for a special health care needs advocate for students that are enrolled in virtual education. Is that something currently happening?

Dr. Courtney- To my knowledge, there is not any special advocacy program. There are non-profit advocates that work with IEPs and 504 plans. Medically engaged students should have a 504 plan that helps dictate where they are with their education plan, but we don't have anything from the department. There's no official person assigned in a school district to do that kind of outreach. I think that's definitely a conversation we can have about who that might be or what that might look like.

Chair Harrison – If no one else has any questions, Dr. Courtney thank you for being here and giving that presentation. This has been extremely helpful, and we appreciate you being here. I'm sure we will be in touch and have you come back here again.

Dr. Courtney – Absolutely, I'll be happy to come back anytime

Pending Cases:

F-036-24-C – Law enforcement issues added for lack of drug testing; lack of coordination with DCBS and coroner; and failure to pursue criminal charges. Lack of scene investigation should be added as a coroner issue.

F-017-24-C - Law enforcement issues for lack of drug testing in a motor vehicle fatality and recommend all fatal motor vehicle accidents should include accident reconstruction investigations.

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-049-24-C	Cynthia Hildebrandt
2	NF-096-24-C	Cynthia Hildebrandt
3	NF-108-24-C	Cynthia Hildebrandt
1	F-054-24-C	Cynthia Hildebrandt
2	NF-175-24-C	Jennifer Burke
1	NF-046-24-C	Jennifer Burke
3	NF-162-24-C	Jennifer Burke
4	NF-146-24-C	Jennifer Burke
1	NF-105-24-C	Cynthia Hildebrandt
2	NF-075-24-C	Cynthia Hildebrandt
3	NF-073-24-C	Cynthia Hildebrandt
4	F-053-24-C	Jennifer Burke
4	F-061-24-PH	Jennifer Burke
1	NF-106-24-C	Jennifer Burke
1	NF-104-24-C	Cynthia Hildebrandt
2	NF-116-24-C	Cynthia Hildebrandt

* Due to time constraints the following cases will be reviewed during the September 16th meeting: NF-118-24-C, NF-133-24-C, NF-127-24-C, NF-124-24-C, F-042-24-C and F-056-24-C.

Additional Discussion:

Dr. Howard – Potential recommendation, having a child abuse pediatrician on staff at burn centers that treat pediatric patients. If we're sending a lot of our kids to a burn center out of state, we need to support the presence of a child abuse pediatrician to be available for those as well.

Commissioner Dennis will follow-up on F-053-24-C at the September meeting. Remind next month's meeting will be in conjunction with the Kids Are Worth It! Conference. With no further discussion we can entertain a motion to adjourn.

Heather McCarty made a motion to adjourn, which was seconded by Dr. Kirtley. With no further discussion we will stand adjourned. Thank you.