

Child Fatality and Near Fatality External Review Panel

ZeroV

111 Darby Shire Circle
Frankfort, Kentucky 40601

Tuesday, May 19, 2026

MINUTES

Members Present: Judge, Lauren Adams Ogden, Chair; Dr. Melissa Currie, Child Abuse Pediatrician, Norton Children's Pediatric Protection Specialist; Dr. Christina Howard, Child Abuse Pediatrician, University of Kentucky; Dr Jaime Pittenger Kirtley, Prevent Child Abuse Kentucky; Dr. Elizabeth Salt, Citizen Foster Care Review Board; Tisha Pletcher, CEO, ZeroV; Steve Shannon, Executive Director, KARP; Dr. Danielle Anderson, Practicing Medication-Assisted Treatment; Lesa Dennis, Commissioner, DCBS; Heather McCarty, Regional Manager, FRYSC; Victoria Bengé, Executive Director, CASA; Lt. Jonathan Murphy, Kentucky State Police, Post 9; Brittany Nichols, State Child Fatality Review Team; Dr. William Ralson, Chief Medical Examiner, OME; Rep. Samara Heavrin, Chair Families and Children, and Hon. Olivia McCollum, Practicing Local Prosecutor; Commissioner.

Welcome

Judge Lauren Adams Ogden, Chair

Judge Ogden welcomed everyone to the May meeting. A special thanks to Tisha Pletcher and ZeroV for allowing the panel to utilize their meeting space. First item of business on the agenda is the approval of the Minutes and Case Review Summaries of the April meeting. Steve Shannon made a motion to approve, which was seconded by Dr. Jaime Kirtley. With no objections, the April Minutes and Case Review Summaries stand as approved.

We would like to recognize Cindy Curtsinger, the panel's medical analyst, for her years of service and dedication to the panel. This will be Cindy's final meeting, and we cannot thank her enough for her expertise and work in this field. We wish you the best and will miss working with you.

Members, in your folders you will find a travel voucher. If you wish to be reimbursed for today's meeting, please complete the voucher and return it to Elisha by May 29th. Additionally, in your folder you will find the panel's updated financial report. If you have any questions, please let Elisha know.

Annual Report Responses

As required by statute, the panel submitted their annual report and has received responses from all agencies. We will quickly review those responses.

Recommendation: The Cabinet for Health and Family Services, Department for Public Health and Office of Medical Cannabis should amend the regulations pertaining to medical cannabis and hemp-derived cannabinoid products to ensure consistency pertaining to the child-resistant packaging requirements. Additional warnings should be required to inform the consumer that

“child-resistant” packaging does not mean “child-proof” and these products may be harmful or potentially fatal to children.

The Cabinet does not agree with implementation due to the ever-changing laws on the federal level. DPH is waiting to amend their regulations to comply with any changes to the federal requirements. That will be evolving as we move forward.

Recommendation: The Cabinet for Health and Family Services, Department for Public Health and the Office of Medical Cannabis should conduct an aggressive public safety campaign. The campaign should focus on educating caregivers, prescribers, and providing retailers with educational material for consumers regarding the dangers these substances pose to small children.

The Cabinet agrees with this implementation, a robust public safety campaign including social media posts, posters designed and printed, posting in retail establishments, and other settings will take place throughout the state in the next year.

Recommendation: The Department for Public Health, HANDS program should update their educational material to include safe storage of medical cannabis and hemp-derived cannabinoid products (i.e. Protecting Your Child from Harmful Substances).

The Cabinet agrees with this implementation and will update their material during the annual educational material review.

Recommendation: The Office of the Attorney General should work with law enforcement, medical providers, and prosecutors to create a toolkit focused on pediatric ingestions. The toolkit will assist law enforcement officers on how to investigate these types of cases, prosecutors on applicable criminal charges, and medical providers on proper toxicology testing and keeping a high index of suspicion for ingestion if a young child presents with altered mental status.

The OAG agrees with the implementation of this recommendation and that toolkit project is underway.

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It is the OAG’s understanding that the Council will be implementing this recommendation this fall.

Recommendation: The Kentucky Hospital Association should include training regarding pediatric ingestions at the 2026 Trauma and Emergency Medicine Symposium.

The KY Trauma Care System agrees with the implementation and anticipates pediatric ingestion training will be included in the 2026 Trauma and Emergency Medicine Symposium.

Recommendation: The Kentucky Multidisciplinary Commission on Child Sexual Abuse should provide an update on the feasibility study conducted based on the panel’s 2023 recommendation to expand the Commission’s capabilities to review all fatal or near fatal physical abuses in addition to sexual abuse cases.

The KMCCSA shared the outcomes of the feasibility study and the updated 2026 model protocol with the panel.

Recommendation: The Cabinet for Health and Family Services, in collaboration with Kentucky’s child abuse specialist teams, should develop and implement a comprehensive, standardized training curriculum on medical indicators of child physical abuse for both child welfare case workers and medical professionals. This training should include instruction on the American College of Radiology and American Academy of Pediatrics guidelines establishing that skeletal surveys—not single-image babygrams—are the required standard for evaluating suspected physical abuse in children 24 months of age and younger. The curriculum should incorporate additional training for identifying physical abuse indicators, including the Ten-Four FACES-P.

The Cabinet for Health and Family Services (cabinet), in collaboration with the University of Kentucky’s Child Abuse Pediatric Specialist, is finalizing a comprehensive, standardized curriculum that strengthens the identification and response to child physical abuse.

Recommendation: The Department for Community Based Services should implement a monitoring system to track caseworker and supervisor compliance with SOP G1.16 (Working with Families Affected by Substance Misuse).

DCBS does not agree with the implementation, as developing and maintaining a new system would require financial and staffing resources that are not currently available.

Dr. Currie: Can we keep this on the backburner for next year’s recommendation to the legislature to ensure DCBS has the financial resources that they need to address the cases we discuss here? I want to ensure when we hear that response, we are advocating for the resources that are needed.

Recommendation: The Department for Community Based Services should implement the practice of uploading supervisory consults into the TWIST system to assist in addressing gaps in services/contacts and reasons for these delays or gaps. This measure would also assist other staff, as well as newly assigned staff, in gathering information and needs for the case. In addition, the supervisory consults should be shared with the panel and included in the list of records provided to the panel under SOP C2.13.

The Department agrees to implement this recommendation which will take place in two phases. Phase one is expected to be completed in April 2027 and phase two in April 2029.

Recommendation: The Department for Community Based Services should add a separate guideline within SOP C2.8 to specifically address safe firearm storage assessments. A standardized checklist could assist CPS workers in completing these assessments consistently and should be

prominently incorporated into DCBS practice, rather than included merely as a supplemental resource within the SOP.

The Department agrees to implement this recommendation, and the project is expected to be completed by December 2026.

Recommendation: The Kentucky Board of Nursing through the Licensed Certified Professional Midwife (CPM) program, should develop a standardized protocol which includes the importance of vitamin K within parenting education and pre-natal medical visits.

The Board agrees to implement the recommendation by sending to its LCPM's periodic communications to the LCPMs' email to remind them of the importance of the administration of vitamin K and the responsibility to document refusals of its administration.

Recommendation: The Department for Community Based Services should include a parent's refusal of the vitamin K shot at birth as part of the medical neglect criteria in SOP C2.3.

The Department does not agree with this recommendation because vitamin K administration is not mandated, an informed parental refusal does not meet statutory criteria.

Recommendation: The Department for Community Based Services should enhance current Standards of Practice (SOP C7.21) to include the use of Regional Nurse Consultants, as well enhance current SOP C2.8 Investigation Protocol to include Practice Guidance for CMC. Practice Guidance should include, but not be exclusive of, Regional Nurse consultation and development of a resource for workers to reference for additional information.

The Department agrees to implement this recommendation, and it is expected to be implemented by December 2026.

Recommendation: The Department for Community Based Services should enhance current Standards of Practice (SOP C2.19) Pediatric Forensic Medicine Consultations to include cases involving medically complex children as a priority to pediatric forensics, following regional nurse consultation, to ensure reserving this specialty for necessary cases.

The Department agrees to implement this recommendation, and it is expected to be implemented by December 2026.

Recommendation: The Department for Community Based Services, in collaboration with the University of Kentucky Social Work Training Center (or other appropriate entity), should develop and implement a comprehensive, standardized training curriculum on medically complex children for child welfare workers. This training should include initial certification and annual continuing education, to include topics of defining medical neglect, caregiver burden assessments, distinguishing symptoms from abuse/neglect indicators, and working alongside medical care teams.

The Department does not agree to implement this recommendation due to lack of financial and staffing resources.

Dr. Currie: Add this recommendation for follow up. I will add if they're referring to the materials I provided to them, they've had them for six years now. There may have been subsequent materials submitted that they're referring to that I'm not aware of.

Elisha: Perhaps at the panel meeting where we discuss recommendations, we ask DCBS to provide us with an update on what material is currently available and how much financial cost are associated with each recommendation.

Recommendation: The Office for Children with Special Health Care Needs, in collaboration with the Department for Public Health, Department for Medicaid Service, and the Kentucky Hospital Association, should develop a statewide patient registry to enable coordinated care across systems and assist in early identification of at-risk families. This would include developing standardized criteria for identification based on diagnosis, creating data sharing agreements, and implementing flags in the registry to identify multiple risk factors for maltreatment. Implementation of such a system should require annual reporting on trends, child welfare involvement rates, and outcomes.

The Office for Children with Special Health Care Needs (OCSHCN) does not have the staff, funding, or technology to create or manage a registry.

*Add for discussion at next year's recommendation meeting.

Recommendation: The Kentucky Perinatal Quality Collaborative (KyPQC) should include a keynote address in the 2026 Kentucky Symposium for Maternal and Infant Outcomes on the Plan of Safe Care. The keynote should encourage prenatal care providers to participate in their local community's POSC and educate patients on the available community resources to support expecting mothers with substance use disorders.

Agrees with implementation, the 2026 Kentucky Symposium for Maternal and Infant Outcomes will include a presentation on Plan of Safe Care.

Recommendation: The Department for Behavioral Health, Developmental and Intellectual Disabilities, Plan of Safe Care program and DCBS should work with community treatment providers to develop a standardized release of information to reduce the burden on clients.

DCBS agrees to implement the recommendation and will work with partners to create a standardized form for release of information.

Recommendation: The Department for Community Based Services should encourage staff to continue to treat THC use as high-risk behavior and follow policy accordingly.

DCBS agrees with the implementation.

Recommendation: HANDS should work with the Kentucky Hospital Association to create a partnership that allows a HANDS representative to engage with the family at the birthing hospital.

HANDS agrees with the implementation and will meet with Kentucky Hospital Association by September 2026 to further strengthen their relationship with birthing hospitals.

Dr. Anderson: I would recommend we keep the medical cannabis and other THC containing products recommendations on the backburner so we can continue to monitor what's going on if the definition may change. We still have all the other products, like Delta 8, etc. being sold legally.

Elisha: We might want to consider having a representative from the Office of Medical Cannabis come and speak to the panel as well. There are limitations on how they can regulate those products based on how the statute is written. Perhaps having a discussion with that office can assist with future recommendations surrounding those products.

Implementation of HB 778

Lastly on the agenda, we need to discuss the recent changes to the panel's operations based on HB 788. Section 8 of HB 778 requires the panel to develop a procedure for discussion of cases that are being reviewed by the panel with the agency that was responsible for the investigation. The discussion would take place in a closed session after the investigative case has been closed. In addition, it gives the panel access to TWIST and iTWIST and all supervisory consults. We have discussed the access to TWIST would be for the paid staff only, not all members. We will need to talk to the Commissioner about how we will implement that, and any training required.

Commissioner Dennis: In regards to access to TWIST, Elisha and I just need to connect and discuss what permissions and IT needs are required to make that happen. Regarding the other section of HB 778 regarding having investigators come in and talk with the panel, we need to work together on what that would look like. Perhaps a workgroup to develop those procedures.

Judge Ogden: I agree, we should develop a subcommittee to recommend policies and procedures surrounding this piece. Steve Shannon, Dr. Melissa Currie, Commissioner Dennis, and Lt. Murphy will be part of the subcommittee that develops those policies. Elisha will set up that meeting via zoom.

Pending Case Update:

NF-124-25-C – Jennifer Burke provided an update on the in-home service provider and law enforcement records received. No missed opportunities for law enforcement, add in-home service provider to family characteristics and missed opportunity for lack of adequate services.

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.

<u>Group</u>	<u>Case #</u>	<u>Analyst</u>
1	F-009-25-C	Cynthia Hildebrandt
2	NF-002-25-C	Cynthia Hildebrandt
4	NF-008-25-C	Cynthia Hildebrandt
3	F-029-25-C	Cynthia Hildebrandt
1	NF-154-25-C	Jennifer Burke
3	NF-039-25-C	Jennifer Burke
2	NF-042-25-C	Jennifer Burke
4	F-013-25-C	Jennifer Burke
2	NF-035-25-NC	Emily Neal
3	NF-112-25-NC	Emily Neal
1	F-040-25-C	Cynthia Hildebrandt
2	NF-080-25-NC	Cynthia Hildebrandt
4	NF-085-25-C	Cynthia Hildebrandt
3	NF-092-25-C	Cynthia Hildebrandt
1	NF-169-25-C	Cynthia Hildebrandt
4	NF-144-25-C	Jennifer Burke
1	NF-130-25-C	Jennifer Burke
2	NF-095-25-C	Jennifer Burke
4	F-038-25-C	Jennifer Burke
3	F-045-25-C	Jennifer Burke
3	NF-126-25-NC	Emily Neal
2	NF-162-25-C	Emily Neal
4	NF-005-25-C	Cynthia Hildebrandt
1	NF-058-25-C	Cynthia Hildebrandt
3	NF-156-25-C	Cynthia Hildebrandt
4	NF-165-25-C	Cynthia Hildebrandt
2	NF-146-25-C	Jennifer Burke
1	NF-163-25-C	Jennifer Burke
4	NF-170-25-C	Jennifer Burke
2	NF-179-25-C	Jennifer Burke
3	NF-001-25-C	Jennifer Burke
1	F-060-25-C	Jennifer Burke
4	F-052-25-C	Jennifer Burke
2	NF-052-25-C	Emily Neal
1	NF-119-25-C	Cynthia Hildebrandt
3	NF-012-25-C	Cynthia Hildebrandt

Additional Discussion:

Potential recommendation regarding residential substance abuse treatment facilities lacking any protocol regarding evicting a parent with a child for noncompliance, especially if housing insecurity is a concern. At minimum a report to CPS should be made prior to release to ensure the safety of the child.

Is there a lack of understanding of the signs and symptoms of abuse on the educator's side. We know there was a reporting issue but is there also a knowledge deficit issue if we know these events are

happening and teachers aren't identifying them. Another concern reported by teachers previously was extended wait times when making a CPS report. Guidance counselors and support staff often assist teachers with making reports to help with long waiting times. KDE required child abuse and neglect prevention, recognition and reporting requirements were shared with all members via email. It seems the current training meets the letter of the law, but it may not meet the intent of the law. Some of the training courses are required annually and then required every four years. Perhaps we need to look at moving that to annual training. We could also talk to some of the preventative groups and see if they would be interested in speaking with school districts about providing additional in-person training. Recommend automatic acceptance of CPS reports by reporting professionals. Law currently states two professional reporting sources results in an automated investigation.

Potential recommendation that suboxone pills be distributed in blister packs. The panel has reviewed a substantial number of cases regarding accidental ingestions of fragmented suboxone pills. Perhaps we recommend those substances be dispensed in smaller milligrams in individual blister packs to prevent future ingestions. Perhaps we will have a discussion with the PILLS committee and the Board of Pharmacy regarding which entity would be responsible for implementing the recommendation.

Additional discussion regarding how homeschool and/or virtual school is allowed for a child who is receiving special services from a school (i.e. speech, language, etc.). Additionally, there appears to be no repercussions when you're not meeting the requirements for homeschool. Similarly, dismissing a child from mental health or other special services due to missed appointments is a major missed opportunity. Lastly, the current custodian, and multiple other custodians in this case, were an inappropriate placement. The panel needs to continue to explore recommendations regarding homeschool and virtual school. Should the school take more steps before approving virtual school. Perhaps a child's bill of rights. Additional discussion about formally inviting a KDE representative to act as an expert during panel meetings.

*NF-092-25 – Bring back for June meeting – DCBS will update the panel on the services offered by CCC and clarify any communication issues in this case.

*NF-001-25-C – Bring back for medical review.

Meeting adjourned.