Child Fatality and Near Fatality External Review Panel
Virtual Meeting

Tuesday, June 16, 2026

MINUTES

Members Present: Judge, Lauren Adams Ogden, Chair; Dr. Christina Howard, Child Abuse Pediatrician, University of Kentucky; Dr. Elizabeth Salt, Citizen Foster Care Review Board; Hon. Olivia McCollum, Practicing Local Prosecutor; Victoria Benge, Executive Director, CASA; Nicole Smith Abbott, LCSW; Catherine Frye, State Child Fatality Review Team; Dr. William Ralson, Chief Medical Examiner, OME; Judge Libby Messer, Fayette Family Court; Lesa Dennis, Commissioner Department for Community Based Services; Steve Shannon, Executive Director, KARP and Representative Samara Heavrin, House of Representatives, District 18.

Welcome ***Judge Lauren Adams Ogden, Chair***

Chair Ogden welcomed everyone to the June meeting. First item of business on the agenda is the approval of the Minutes and Case Review Summaries of the May meeting. Victoria Benge made a motion to approve, which was seconded by Dr. Elizabeth Salt. With no objections, the May Minutes and Case Review Summaries stand as approved.

Next item of business is the LOIC Annual Review, I'll let Elisha update everyone regarding that update.

Elisha – Everyone should have received an email from me containing the draft of the report from the committee staff and a list of potential responses to their recommendations. I have not received any responses to date. The responses were due yesterday, but I have requested an extension until tomorrow. Please review the email and let me know as soon as possible if you have any suggested changes. Additionally, we are scheduled to testify on July 6th at 1:00 p.m. and I need some volunteers. If you're available to join me, please let me know. I will send a reminder email after today's meeting.

Judge Ogden – I do think resending the email is a good idea. I know a lot of people are traveling for the holidays and unfortunately, I'll be out of town that week as well. If you are available, please let us know and Elisha will have you well prepared. Next item on the agenda is the 2025 Annual Report Recommendations with Dr. Salt.

Dr. Salt – Yes, so regarding recommendation number 16 and 17 were two recommendations that questioned whether the resources would be available to fully actualize those recommendations from the respective offices. Both of them seemed to be reasonable and there might be some collaboration efforts that might make them feasible. One was for the training in collaboration with UK of College of Social Work, so I reached out to the Dean of UK College of Nursing to see if there were any opportunities for us to complete that work and develop the training using CE Central resources and I think that might be possible. I think that's something we can work with Commissioner Dennis on and move forward with implementation.

Dr. Howard – Real quick can you remind us of what that training was in regard to?

Elisha – DCBS in collaboration with UK Social Work should develop and implement a comprehensive standardized training curriculum for medical complex children for child welfare workers. The training should include an initial certification and annual CE.

Dr. Salt – It seems like a great fit for UK College of Nursing to develop considering the nurses are probably the ones developing the discharge plans and working with these families anyway. I think it lends itself very well and UK Healthcare is well poised to understand the gaps in parental understanding. The other recommendation was number 17. Elisha, do you have that one you can read to us really quickly as well.

Dr. Howard - Real quick, I'd like to add I think Melissa Currie does have some training already established that you might be able to work with her and get that information I know she's had a big push for that specific training too.

Commissioner Dennis – Yes, thank you Dr. Salt for your email and we've been discussing this at DCBS. I think Dr. Howard is correct, Dr. Currie already has some information put together, but we can enhance and build upon that. We do already have the foundation started but we can work together collaboratively and build onto that. So, we will reach and include Dr. Howard to create something that can be very helpful.

Dr. Salt – I think that's great, the more we can all jump in and work together the better. The other recommendation was a registry, Elisha?

Elisha – Yes, the other recommendation was to 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. Once the system is implemented it should require annual reporting on the trends of child welfare involvement rates and outcomes.

Dr. Salt – There's part of this that's obviously policies and layers of regulations at different institutions but that said, I do think we can use existing data to create predictive models for high-risk groups. I reached out Epic Cosmos, which is the academic side of Epic that allows for use of all Epic data across the US. I reached out to them and the data scientist, and they thought this would be possible that they had enough data to work on that first piece of developing a predictive model. So, I wrote a little proposal to pay for the data scientist but I'm not sure what that cost will be. I think we can at least do the part to look at predictive risk. The flag systems and the remaining parts are a regulatory barrier as to the impact of having that information available to us, but we can at least take that first step.

Dr. Howard – I spoke to some students at one point about a possible registry and they have started working on something like that. Let me see if I can find their information and I'll pass that along to you.

Dr. Salt - Great, that's all I have at this point, but I'll keep everyone updated as we progress through the implementation.

Judge Ogden – That sounds very promising! Thank you all. If there's nothing more on that, we will move on to pending cases.

Pending Cases

NF-192-25 – Cynthia Hildebrandt – case is being brought back from an update from DCBS. No changes to the prior findings.

NF-001-25 – Jennifer Burke – this case is being brought back for a medical evaluation.

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	F-022-25-NC	Jennifer Burke
2	NF-108-25-C	Jennifer Burke
2	NF-131-25-C	Jennifer Burke
2	NF-132-25-C	Jennifer Burke
3	F-046-25-C	Cynthia Hildebrandt
4	F-043-25-C	Cynthia Hildebrandt
1	NF-178-25-C	Cynthia Hildebrandt
3	NF-037-25-C	Cynthia Hildebrandt
4	NF-057-25-C	Jennifer Burke
2	NF-133-25-C	Jennifer Burke
2	NF-134-25-C	Jennifer Burke
3	F-025-25-C	Jennifer Burke
1	NF-098-25-C	Cynthia Hildebrandt
4	NF-129-25-C	Cynthia Hildebrandt
3	NF-145-25-C	Cynthia Hildebrandt
4	NF-103-25-C	Cynthia Hildebrandt

Additional Discussion:

Dr. Howard – This case reenforces our prior recommendation regarding education on drug testing across the state at every hospital. The lack of appropriate drug testing directly impacted the investigation in this case.

Dr. Howard - Do we really track data on lack of resources in particular areas in the state? I think that's a risk factor in this case.

Elisha – I don't think we do a great job of tracking that specific findings. Obviously, we track the county where the incidents occur and medical issues, but I can't recall a specific finding for lack of medical resources available in the area. I think we can currently track this issue under 'Other', and I'll ask the analysts to start identifying this issue for future case. We will need members to let us know

about these issues as well. I see Casey is on, and I'll get her opinion as well, but I think we currently say we see a higher rate of medical issues in a certain part of the state due to, for example, lack of UDS testing but I don't think it would identify lack of resources.

Dr. Howard – It is challenging for the analysts, especially since the members are not always area of the county information during the meetings. But I do think that's something important to start tracking and understanding the more geographical needs across the state.

Elisha – I think we might want to start at least mentioning what area of the state the incident occurred in without mention the county. For example, western Ky or Central Ky and that might help the members more during the presentation.

Recommendation to review all suicides which include interviewing family members and reviewing medical records. There needs to be more intensive statewide systemic review of all deaths by suicide and attempted suicides in youth.

Next meeting will be held virtually on July 21st. Motion to adjourn made by Steve Shannon and seconded by Dr. Howard. With no other business, the meeting is adjourned.