Child Fatality and Near Fatality External Review Panel

Virtual Meeting

Tuesday, December 19, 2023

MINUTES

Members Present: Judge Melissa Murphy, Chair; Lori Aldridge, Co-Chair, Tri County CASA; Shannon Hall, as proxy for Commissioner, Department for Community Based Services; Dr. Christina Howard, Child Abuse Pediatrician, University of Kentucky; Janna Estep-Jordan, Prevent Child Abuse Kentucky; Dr. William Ralston, Chief Office of the Medical Examiner; Dr. Elizabeth Salt, Citizen Foster Care Review Board; Heather McCarty; Family Resource and Youth Service Center; Hon. Olivia McCollum, Boone County Assistant Attorney; Dr. Danielle Anderson, MAT Provider; Rep. Samara Heavrin, House Representative; Steve Shannon, KARP, Inc.; Sen. Danny Carroll, State Senator; Dr. Henrietta Bada, Department for Public Health; Dr. Melissa Currie, Chief, Norton Children's Pediatric Protection Specialist; and Olivia Spradlin, ZeroV.

Welcome and Introductions ***Judge Melissa Moore Murphy, Chair***

Judge Murphy welcomed everyone to the December meeting of the Child Fatality and Near Fatality External Review Panel. We do not have any new introductions this month, but it is good to see everyone again.

If everyone has had an opportunity to review the minutes and case review summaries from the November meeting, we will entertain a motion to approve. Steve Shannon made a motion to approve, which was seconded by Dr. Henrietta Bada. With no objections, the November Minutes and Case Review Summaries are approved.

Annual Report Discussion

It is time to compile and discuss all of our recommendations for the year. We present our annual report to those that can actually make a difference in what we're seeing throughout the Commonwealth. I'm going to turn it over to Elisha who has prepared a presentation on the year end data.

Elisha – First and foremost, this is preliminary data. We have not completed the case reviews for the year but we're hopeful this will help drive the discussion regarding our recommendations for this year's annual report. We did identify the top categories and compare them to previous years. As always, overdose/ingestion cases are probably again going to be the number one type of cases we have reviewed. Ninety percent of these cases involved children four years or younger. Upon initial review of the types of substances ingestion, fentanyl appears to be the most ingested substance with suboxone coming in second. Over the course of the year, we have discussed multiple recommendations. One being, MAT providers should make reports when parents of young children are using illicit substances. We know Kentucky is a mandatory reporting state. The question for the panel is, who oversees the MAT

providers? Who do we need to make these recommendations to ensure MAT providers are educating their clients and making referrals when necessary. Dr. Anderson, can you provide us some insight?

Dr. Anderson – I think the easiest way to get this information out would be to provide it in some of the House Bill 1 education that is required for providers. Perhaps include it in the four-hour required education which could reiterate the importance of discussing with the patients the proper storage of controlled substances, as well as reminding providers they are mandatory reporters. From my experience, in the last few months, I've made reports and those have not been accepted. I do think provider education is something we need to focus on but I'm not as familiar with criteria for cases to be accepted by DCBS.

Elisha - DCBS, correct me if I wrong, but you have a training specifically for medical providers on making referrals and information required to meet the acceptance criteria. Is that something we can add to House Bill 1 that CPS is providing the referral training to MAT providers?

Shannon Hall – Yes, I certainly think DCBS will come to the table. I will say that MAT providers are reluctant to have these discussions around mandatory reporting and what their role is in that. I have a lot of personal experience in that, and I think getting them to the table will be a challenge.

Dr. Salt – Would it be an approved continuing education unit for the providers that would be required? I guess, I'm confused.

Judge Murphy - I agree. I think we were asking where this would be housed, and you mentioned it through training and education but if it's not mandatory then it won't get to the people we need to reach.

Dr. Anderson – HB 1 is mandatory for all physicians to receive four hours of approved CME regarding substance use and opioid use disorder. So, if one of the four hours was required to be this, there's a variety of training that people can use for HB 1 on CE central this could be written in saying that one of the hours must be related to the safe prescribing of buprenorphine and all the regulations surrounding it including review of mandated reporter duties.

Dr. Salt – But who would own that? Kentucky Board of Nursing or KBML?

Dr. Anderson – The KBML would probably create or develop an approved course.

Dr. Currie – It's important to recognize, if we want one of those hours to be mandatory that will require a legislative change. That's not something KBML can do. If we're talking about a legislative change, that's fine but we have to recognize that requires significantly more effort on our part and other people's parts to get that to happen. What I'm hearing is number one, we need education about what should prompt a MAT provider to call CPS, but we also need education about what are the elements of a report that would be necessary for CPS to accept it. What are the key things that CPS is looking for in such report to decide whether or not to investigate.

Dr. Anderson – Agreed. I don't think I've ever received any training on the important aspects of a report. I think that could be very helpful because I'm often left thinking how could this not be accepted.

I don't know that most providers are aware of the elements that DCBS is looking for to initiate an investigation.

Judge Murphy – I am grateful for this conversation, and I think the first thing is, the recommendation of the panel would be to both of those agencies to say they want to have this type of training as one of their four types of trainings. There also needs to be conversations with our legislators as to why this needs to change but we also have to make sure our medical personnel are all on board, as well as the Cabinet. We're not saying we have some magic language that automatically gets picked up, but they need to know what CPS needs to hear for acceptance.

Dr. Bada – I think one thing when reporting to DCBS, when we are in the hospital and the mother is in a treatment program, they are not referred to DCBS. It's this fear of having CPS involvement that these mothers will not go for prenatal care. Maybe the other thing is not only education for the providers but more a part of the discharge planning when the babies are leaving the hospital. In addition to teaching the mother basic parenting skills, if they are currently in MAT treatment, they need additional information about safe storage of medication.

Dr. Salt – In a situation it takes a period of time to get legislation moved through, we could potentially talk to some of the major healthcare providers into requiring a continuing education unit within their healthcare system. I think that might be another option as well. They would have an incentive to do so because there's obviously a cost associated with each one of these poisonings that come through their unit. The other is there are community workers that we might be a source to allocating lockboxes and resources that may not reach out to DCBS. That might be another mechanism we could fully actualize the potential for.

Rep. Heavrin – I'm happy to convene any conversation too. Especially with the Families and Children's Committee, even if we have a listening session during committee while we're in session or convene a group of people if we need legislation. You all just let me know what you need from me on how I can be helpful in the legislative role.

Dr. Anderson – I wanted to point out what Dr. Currie said in the chat, it is passive illicit drug exposure for parents who are on MAT, but they are screening positive for illicit drugs. One of the highest risks for relapse and return to use is after a pregnant mother delivers. That is one of the highest risk times and I think we're failing to follow up or follow closely. We should be providing them with more resources and more support post-natal.

Dr. Currie – I completely agree and that takes us to our Plan of Safe Care discussion which I'm sure Elisha will get to. I think we're making good strides toward developing a much more robust Plan of Safe Care approach here in Kentucky. I won't say more about that now but thank you I appreciate those comments.

Elisha – Another educational piece to include with MAT providers is ensuring they are educating their clients on Safe Sleep practices. The panel also discussed the skyrocketing numbers regarding the ingestion of Delta 8. Is Kentucky doing enough to education caregivers about the risk of these substances if they are ingested by children? If not, what is the recommendation and who should we direct that too.

Dr. Howard – Something that has been upcoming up in our hospital, and I think Louisville does it as well, is dividing out the number of deaths we've had. I think the number of deaths is almost doubling from year to year and I don't know if that is happening this time. There's been some talk about that wide distribution of Narcan. If we want to prevent deaths, that might be something to consider. I think that's something that's being looked at.

Elisha – I will say, it does look like fatalities have increased within this category. Another potential recommendation for discussion is, does the panel need to recommend that medical providers at local ED's receive additional training on the symptoms of opioid ingestions and the administration of Narcan in pediatric patients? We've had a couple cases where the delayed administration of Narcan. Do we want to make that recommendation, and does it fall under KBML?

Dr. Currie – That's a great question. I do think we need to do a better job of educating providers, especially non-pediatric providers who are on the front lines in more rural or non-regional hospital settings about Narcan. I hesitate to make yet one more recommendation for required training. I wonder if we could have some conversation perhaps with the Kentucky Hospital Association or something like that about offering additional training without making it mandatory. Similar to what Dr. Salt said earlier, perhaps hospital systems would make it mandatory without a legislative change.

Joel – I had one additional thought about the training requirement under HB 1. It's my understanding that's for the doctors but will that information reach the counselors and social workers within the MAT providers program. Is that a different target audience?

Dr. Currie – That's a great question, Joel and I don't know how to effectively train that group of providers.

Dr. Salt – I'll reach out to the College of Social Work and ask how they could provider that information. I'm sure they have some sort of continuing education.

Steve – Yes, they have continuing education through the Board of Social Work and psychologist through the Board of Examiners of Psychology and family therapist. They all have Boards that require CEU's.

Joel – Is there a regulatory authority over MAT providers?

Dr. Anderson – The Kentucky Board of Medical Licensure. The buprenorphine regulations are done by state. So, the KBML has a set of buprenorphine regulations that govern how physicians can prescribe and what physicians are required to do to prescribe buprenorphine. That's where the changes would probably have to be made. Ours are actually pretty antiquated and require much more than most other states. In thinking of this and the next topic you are bringing up Elisha, the KBML is also responsible for creating the cannabis regulations for prescribers. I have been reviewing and there's a public hearing on Thursday at the KBML and they pale in comparison to the buprenorphine regulations. Which in my opinion, is quite scary because there is no specific education in that stating that we have to talk to people about proper storage of medical cannabis. There's no exact verbiage explaining the proper storage, the physician has a responsibility to let the patient know this but there's no actual required reading or information for those people. I think this is going to be a problem across the board and something to consider.

Dr. Currie –I will add to that and say that that's just medical cannabis. We're already seeing significant morbidity and mortality from ingestion of illicit cannabis or the legal form Delta 8 THC, which can still land a child in the ICU. So back to Elisha's question on how best to get that information out, I wonder about a public service campaign and targeting the kratom shops and smoke shops that sell these edibles and Delta 8. That's just my thought.

Elisha – Historically, we've requested public service campaigns be assigned to public health. Do you think is best to house that recommendation? Yes, ok. This was great discussion on overdose/ingestion, does anyone have anything else before we move on?

Dr. Howard – Face It has made some PSA regarding this. I think there are 4-6 made, they distributed some last year, and plan to distribute more this year. So, there are some already made, it's just getting the widespread distribution.

Elisha – The next category we are going to discuss is drownings and near drowning. We have seen a slight increase in panel cases. We have not seen the DPH data yet to compare it on a year-to-year basis. Regarding the panel cases, 5 of these cases involved a medically fragile child, 12 cases were from a swimming pool, 3 in a bathtub, 1 river, and 1 in a bucket. Around 71% of these cases involved children 4 years or younger. Any thoughts on prevention recommendations regarding drowning cases? Also, if any members have any specific questions on the data, please put it in the chat or let me know. Our epidemiologist Casey is online to assist and will take a deeper dive into our data.

Nothing on drownings, next we will move onto Abusive Head Trauma. Overall, you will see the trending line is down but there was a slight increase from last year. An interesting feature in both the abusive head trauma and physical abuse categories is the history of domestic violence in the home. In both of these categories, DV is present in over half of the cases. When you compare that to the overall neglect category, which is about 70% of our cases, DV occurs in only 30% of those cases. Is there a recommendation there to target specific education to those involved in domestic violence, to both the victim and the perpetrator? Are there any additional educational needs regarding pediatric abusive head trauma? Regarding the physical abuse cases, 60% of the caregivers had a mental health issue. Is this another area to target? The only specific recommendation regarding the physical abuse cases is all MDT should be reviewing all fatalities and near fatalities suspected of physical abuse in addition to sexual abuse cases. This could potentially alleviate those communication barriers. Do you think this would require a statutory change? Does this recommendation need to be made to the Attorney General's office?

Dr. Currie – My opinion is yes and yes. I do think that would require a statutory change and that would fall within the AG's office.

Elisha – On the physical abuse cases, 87% of these cases were kids under four.

Olivia Spradlin – You mentioned there was also a really big co-occurrence with mental health. I'm thinking about a needs assessment we did with ZeroV for survivors. Something that kept coming up was there wasn't enough access to mental health services for them and there weren't enough mental health providers that had a thorough understanding of domestic violence. I don't know what recommendation that could potentially lead to, but I felt it was significant to share that piece of information.

Elisha – Joel and I discussed this earlier this week that we track lack of treatment but due to the types of records we receive, it's very hard to understand. Is it lack of treatment because that type of treatment doesn't exist in the area, is it an access issue, or lack of coverage. I just feel like we have a missing component to relay too heavily on what we track on the panel side.

Olivia – So many of the cases that we review are folks that are living in extreme poverty and potentially on Medicaid. It looks different getting mental health treatment on Medicaid than it does on private insurance. So, I wonder if there's not a connection there as well.

Dr. Currie – I'm curious your thoughts about this – I have in my clinical experience – I feel like so many times when we've had a child whose been physically abused and there's domestic violence in the home I feel like I hear so many times the non-offending caregiver, the adult victim, making some kind of statement along the lines of, he hurt me but I never thought they would hurt the kids. So, I'm wondering about some kind of educational intervention with parent/victim/survivors about that, about the risks. I know we want to empower them and give them a sense of control and to recognize when they're safe but at the same time I feel like there's a real disconnect in their ability to recognize the risk this is posing to their children. What thoughts do you have on that?

Olivia – Off the top of my head, I don't know that this research is current but for awhile there was a statistic floating around out there that spoke to this in the sense that often times when a child became part of that abuse cycle that was the precepting factor for someone leaving. That was the bridge they couldn't cross. I think you're right on that is a factor for folks leaving. In terms of ways to do more educational campaigns around that, I'll have to think about what that looks like and where there might be space for that. I know we're getting ready to do a pretty big educational campaign and part of that, one of the taglines, is going to be talk to your kids about healthy relationships. Of course, how do you talk to your kids about healthy relationships, if you yourself don't have one. Going back to our needs assessment, something survivors identified coming out of that was that there are so many other types of abuse that weren't physical and until it got to become physical abuse, people weren't recognizing it was domestic violence. So, when we're talking about prevention, expanding the understanding of domestic violence to the psychological aggression or course of control factors or financial abuse is one that came up pretty big there again. So, thinking about is there a space there to do some prevention or campaign work around, how are all the ways domestic violence shows up and what does that mean for you and your decision making. I know we have a few communities that use what are called LAPs, which are lethality assessments. I don't believe those have questions about children in them. I also believe that is an instrument that is validated in a certain way that we couldn't just add that to it and have it work in the right way. That might be another thing to think about in terms of JC3s or safety planning. In that space building out or making sure anyone who is safety planning with victims is accounting for this. In terms of what are some of those red flag behaviors maybe before we get to physical abuse that we can talk about. Those are some ideas off the top of my head, but I don't know that any of those are policy related though. At least on the state level. I think too, us working with healthcare providers too in educating them on signs of abuse. Sometimes you all have different access to these populations than we do. What are some of those red flags in those kinds of situations that if these things are going on than potentially you might be at a higher risk for that. Maybe there's space for a collaboration there as well.

Joel – Since we're picking your brain here, Elisha and I talked about a recommendation around Batterer Intervention Program and is there evidence of efficacy around those programs? There is an access issue

statewide and the difference between that and anger management. I don't have the understanding of IPV to get into that but is there a recommendation we should or could be making around that issue?

Olivia – I would like to talk to our Chief Legal Officer and BIP team before I offer anything up around that specifically in terms of a policy related recommendation. Anger management and batterer intervention are absolutely different. Batterer's intervention does get into issues around power and control. It does talk about parenting. It is not the same as anger management. We certainly do still have judges who are referring to anger management instead of batterers intervention programs but again there is an access issue around the state. The number of providers and where they're located. In terms of the efficacy in batterers intervention, it really depends upon the program. Programs that have longer durations of course are doing better. Programs that have strong contacts with the victims about certain things are doing better. Programs that have a community response are doing better. There's an institute called Safer Together that was just at our conference and someone who I think might have some good information on this. I don't know if we're at the point with BIP if there's a particular legislative or policy fix, we'd be after. I know it's hard to get in with judges to train them. So, that's something we've been working on to train them on BIP and victim services. It's also a little horse and cart situation if we don't have the BIP providers available in those areas than that creates another set of problems. How do build them out. I don't know if that helps or just game myself more homework.

Joel - It does, in the sense it sounds like we're not ready to make a recommendation at this time, but it is definitely something we need. In reading cases, I almost wonder if people use anger management and batterers intervention terms almost interchangeably.

Olivia – They absolutely do.

Dr. Currie – I wonder if a recommendation – because I agree with Dr. Howard – the numbers are staggering as far as the overlap focusing on a IPV approach. I'm wondering if our recommendations could focus on primary care providers for children and the importance of screening for IPV safely with their caregivers. And by safely, I mean you never screen for it in front of a potential batterer. I still am amazed when I go through medical records how frequently the social history part of the medical record is completely blank. Or just says lives with mom, dad, and a dog but doesn't probe anything that's pertinent to the child's health. I'm wondering if we can have a recommendation from that standpoint. It may not be policy per say but it might increase the number of at-risk children that are identified.

Olivia – Also, I think if there are providers to target for that might be better places to start. I don't know if the folks that are doing dental, vision, and hearing are screening. Especially, since it's all head related. Or if it's just general primary care or emergency room care. And thinking about too with these screenings, not only for children but also for the adults that are in the relationships. So hopefully, the adult could get some level of intervention before the children were any more affected. I think the VA at one point had some interesting charting they were doing in regard to domestic violence. They had a different way of charting domestic violence on the victim so it would not be readily seen by the whole family if they were on the same insurance.

Dr. Currie – Yes, that's super common in children's hospitals. We usually have a very specific way of documenting domestic violence screening and results such that a potential batterer usually can't see the results of it. Usually, our hospital social work helps with that, but I don't know that primary care offices

separate out that information. From my perspective it's primary care providers for children, which doesn't just mean pediatricians. Most kids in the state have family practitioners as their primary care providers or what we call mid-level providers or nurse practitioners. Maybe we can craft our recommendation around those folks.

Olivia – Maybe we need to schedule a follow-up meeting and talk more about this so we can get a little further along and bring things back to the group.

Dr. Howard – I'm also curious if there can be some things in the court system. We've seen some determinations in certain regions that are not really focused towards a victim that's been through IPV, like requiring them to work with their perpetrator of abuse. I do think there's some things that can happen in the court system. I'm also curious, I think those social determinates of health screening is supposed to start in January for Medicaid patients, but I think it will be implemented system wide. So that does include intimate violence screening. I'm wondering if there couldn't be something provided to parents or adults that screen positive that we could put something on their handbook that included the safety of their children and recommendations on those.

Olivia – As you all know, when it's an adult it's a mandatory referral and so maybe there just needs to be a secondary piece of something that can be handed to that person. Or in the course of that screening with the provider, maybe there's a way to prepare that provider better to have that conversation in certain ways that are with those more social conditions. Including do you have this fear for your children.

Dr. Salt – If they are screened and identified in the rural communities, are there even resources for IPV victims with their families? There's a recent document coming out of the state talking about IPV and gives a list of all the different resources in different regions, but many regions only have one resource. So, if they have transportation or control issues or if they would even allow children in the resources.

Olivia – Are you referring to the CJSAC report? Also included in that report are the number of children we've served in all of our shelters. It's full families. I think there is absolutely a capacity problem. As part of that report there was a significant unmet need and it's because we don't have the bed space, or the workers, or transportation. We would love to be able to meet everyone's needs that come to us. We do have one program that is part of that state-wide network per area development district, there are some other programs that aren't necessarily part of our system that are also throughout the state that were not a part of that report. In terms of do we have enough resources to meet that need, I think that's a legitimate question. Regarding the court comment, one of the reasons why a lot of survivors stay is because they're worried about if they leave, who gets custody of their children. They feel like if they stay, at least they can be in the home when their children are in the home. That is absolutely something that is a deterrent for survivors leaving because Kentucky has a 50/50 presumptive joint custody law right now. So, they run the risk of leaving the child with nonprotective parents and that's really scary for them. I know we have some safe visitation, exchange sites throughout the state but I don't know that we have nearly enough of them to meet the need. I hope I have answered your questions.

Judge Murphy – I think you have and of course those lead to more questions. This has been fantastic discussion and we might want to consider having a special meeting just to discuss recommendations. I know Elisha has four more slides, so I'm going to turn it back over to her.

Elisha – Next, we'll briefly talk about SUDI cases, as you can see the numbers from last year are down. Again, we only see a small subset of these overall cases. We will do an overall comparison to see if this number has increased. 47% of these kids were medically fragile – more than likely it was NAS, but we will do a deep dive into that data. 80% had a prior history with DCBS and substance abuse in the home. We thought the Plan of Safe Care could be a preventative measure for SUDI cases to incorporate the safe sleep education in that piece. We had a Safe Sleep presentation a few months ago from Dr. Lohr, does the panel feel we need any additional recommendations regarding safe sleep? With the exception of building that into the MAT provider education and POSC.

Seeing none, we'll talk briefly about suicides. Again, we will do an overall comparison to the statewide data to see if there was an increase. Over half of these were suicide by gunshot. There were some educational issues in these cases and lack of treatment. Another interesting feature, over 70% of the caregivers had a mental health issue. We have discussed throughout the year about psychological autopsies. Last year we made the recommendation that DBHDID house the psychological autopsy. They do not feel like they are the entity that should be conducting those. Does the panel have an idea where that should be housed?

Judge Murphy – I think we make the suggestion again with a note that says, we understand you feel it's not appropriate to be housed with your department, however, where would you suggest?

Dr. Howard – Maybe it's not with their current capacity but with an increased capacity that could be it.

Judge Murphy – And that's one of things we put in there if you can't because of capacity that's an option that we give them to say. Again, I think we are all agreeing that is where it should go. So, they need to tell us where they think it should go or tell us no because they don't have capacity.

Dr. Currie – I think they need to explain why they are saying it doesn't fall under their department. Not just a suggestion for someone else but explain why they are declining. It's easy for anyone to decline.

Elisha – They stated in their response, *even though they do not believe they are the correct agency to administer this effort. The department would be pleased to assess best practices in other states to develop an appropriate implementation proposal that identifies needed resources and expenditures.* Do we want to ask them to do that and state the panel still believes you are the correct entity.

Judge Murphy – Definitely what they've already offered but also please who else would you recommend and if no give us further explanation as to why.

Elisha – Also under the suicide category, we have had multiple discussions throughout the year about the role of the school counselors. What role they play with the child's mental health providers and recommending a more extensive training for all school personnel. I think we keep coming back to what is the current training and guidelines. Joel and I were discussing this yesterday and thought it might be wise to make a recommendation for the Kentucky Department of Education to come give the panel members a presentation regarding current guidelines. That way panel members are educated and can make a best-informed recommendation. What's your thoughts on that?

Steve – I think there might be legislation this session that really focuses on that as well. Educating all school personnel with the objective of each kid in the school has a positive relationship with an adult in the environment. I don't know how realistic that is in terms of numbers. There are other people discussing student resiliency among the department of education. It's been drafted and I think we have a sponsor.

Dr. Currie – I have a quick question about our data, do we have the information among the suicides how many of them had essentially medical neglect? Where medical neglect needs had been identified but parents had not sought them out or not allowed the child to have access to mental health. I'm just wondering if there potentially is a recommendation for additional education for DCBS about why mental health neglect is just as serious and potentially fatal as physical health neglect.

Elisha – Yes, we do track that information, however I do not have that data in front of me. I have it on my to do list now. So, we will look into that, and I know we've talked about that in the years past about mental health treatment is just as important as physical health treatment. Moving on to firearm injuries, we saw a slight decrease from last year but still an overall increase in firearm injuries in our cases. I think we have to continue to advocate for safe storage and child access prevention laws. Dr. Howard, I know you brought up mass causality events in prior meetings. We pulled the murders/suicide cases in the past years and have definitely seen a major increase over the last two years. Historically, we would only review about one a year and have reviewed 4 for this year and 4 cases in the previous years. Does everyone agree with the safe storage recommendation? Anything else on firearms?

Some additional discussions we've had throughout the year, is developing a social work certificate for the management of medically complex children. We have also discussed the lack of law enforcement involvement in overdose/ingestion cases. When we broke down those cases, 70% fell in one county. How do we want to handle this issue regarding that county? (Chat – we will reach out to the Chief to discuss) We will discuss developing a task force for plan of safe care. We've had some discussions about missed opportunities with the medical examiners and coroners and that best practices recommend coroners request an autopsy on all children underage of 18.

Panel members developed a Plan of Safe Care subcommittee that has met several times over the last couple of months. The subcommittee includes community partners in addition to the panel members. We have discussed the federal requirements, what Kentucky's current plan of safe care looks like, and other states. DBHDID developed a plan of safe care workgroup that mainly focused on engaging community partners and educating providers that serve families. We've also discussed the Kentucky Mom's MATR program, which is a collaborative with the health departments, prenatal clinics, and community mental health centers. KY Mom's does provide case management and the program is currently eligible for Medicaid reimbursement for one year postpartum. Joel and I attended a National webinar by the National Center on Substance Abuse and Child Welfare which focused on Michigan's Family-Centered approach to implementing a POSC. Michigan's plan focuses on creating a POSC as early in the pregnancy as possible to maximize health outcomes and prevent family separation. The community piece of their plan allows the POSC to be initiated by healthcare teams, home visiting programs, treatment providers and other agencies. The parent must consent to the POSC before its developed and provide explicit informed consent to ensure providers are sharing information. If the family declines to voluntarily participate in the prenatal POSC, then the POSC must be developed by CPS.

During these meetings, we broke down KY's NAS Data report, which indicates 77% of moms are seen for at least one prenatal appointment within the 1st months of pregnancy. This is an ideal opportunity to assess and engage the family with the KY-Moms MATR program. As a result of these discussions, DCBS is working with KY-Moms to start referring substance exposed infant cases that do not meet acceptance criteria. However, in order to move this upstream, we'd like the panel to recommend a Governor's task force be developed that will focus on implement a robust POSC and educating providers statewide. Does the panel support this recommendation? Does anyone else have anything to add about that recommendation?

Joel – Elisha, the only thing I'd add is we didn't just make this up, most of the states that you look at that were model states started at the high-level policy maker process before it got implemented. That's where this idea came for us.

Elisha – Correct, and the task force in other states were able to develop and focus on the education to providers and community partners. Our small subcommittee doesn't have the time, funding, or authority to accomplish that task. Any other questions? And I apologize I have not been able to keep up with the chat and I'm rushing through this presentation.

Dr. Howard – I think we need some clarification on the recommendation regarding autopsies for children under 18. Dr. Ralston expressed some concern about it.

Joel – It is unexpected child deaths, not medical kids.

Dr. Ralston – OK, that makes more sense.

Dr. Currie – However, I do just want to point out, so we're super clear, we have a habit sometimes of kids with chronic medical illnesses not getting autopsies. It's being assumed they died as a result of their medical condition, when we have a number of cases that we know it was medical neglect. We can talk more about the specifics of that, but I think that's an area that needs to be flushed out.

Joel – I think you're absolutely right and those cases it's not like the kids were in hospice or receiving medical care at the time of death, but they had these chronic conditions.

Elisha – Maybe we need to recommend additional coroner's training around working with the medical providers of medically complex children. We will take a look at the data surrounding that issue.

Dr. Currie – Happy to be a part of that.

Elisha – Any additional recommendations or anything we missed? Please feel free to put any data request in the chat or email me directly. If not, I'm tossing it back to you Melissa.

Judge Murphy – Thank you. We will now move on to the pending cases, starting with Dr. Currie.

Pending Cases

NF-025-22-C – Dr. Currie – I have reached out to the Commonwealth Attorney; they are still working on trying to figure out what the status is. This was a young kid with a ton of injuries and our concern was there didn't appear to be criminal charges. The detective that had the case is no longer with the Crimes Against Children's Unit and it's taking them some time to adjust where the case sits but it is on their radar now. They will get back to me when it's sorted, and I will get back to the panel.

Judge Murphy – Thank you, Dr. Currie. Just a note, Lori had to jump off the meeting early and she was going to provide an update to NF-110. So, we will move that case to the January meeting. Cindy, you're up next.

F-034-22-C – Cindy Curtsinger – This case involved the 15-year-old child that shot himself and we had no information on the law enforcement investigation. Since then, we have received the file and both the local sheriff's office and KSP conducted a joint investigation. We can remove law enforcement issues.

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-038-22-NC	Cindy Curtsinger
1	F-039-22-NC	Cindy Curtsinger
2	NF-022-22-NC	Cindy Curtsinger
3	NF-115-22-C	Joel Griffith
4	F-050-22-C	Joel Griffith
1	NF-122-22-C	Joel Griffith
2	NF-138-22-C	Joel Griffith
3	F-023-22-C	Joel Griffith
3	NF-086-22-NC	Cindy Curtsinger
4	NF-123-22-C	Joel Griffith
1	NF-133-22-C	Cindy Curtsinger
2	NF-055-22-C	Cindy Curtsinger

Additional Discussion:

Panel members decided that prenatal exposure alone will not count as a near fatality for review purposes of panel cases.

Next meeting Tuesday, January 16, 2024.

Meeting adjourned.