Child Fatality and Near Fatality External Review Panel
Virtual Meeting

Tuesday, January 18, 2022

MINUTES

Members Present: Judge Melissa Moore Murphy, Chair, Hon. Dawn Blair, Assistant Hardin County Attorney, Co-Chair; Judge Libby Messer, Fayette Family Court; Dr. Melissa Currie, Chief, Norton Children's Pediatric Protection Specialist, University of Louisville; Commissioner Marta Miranda-Straub, Department for Community Based Services, Lori Armstrong, State Child Fatality Review Team; Lori Aldridge, Executive Director, Tri County CASA; Dr. William Ralston, Chief Medical Examiner; Dr. David Lohr, Medical Director, Department for Community Based Services; Betty Pennington, Family Resource and Youth Service Center; Isela Arras, Kentucky Coalition Against Domestic Violence; Dr. Henrietta Bada, Department for Public Health; Dr. Christina Howard, Child Abuse Pediatrician, University of Kentucky; Dr. Elizabeth Salt, Citizens Foster Care Review Board; Dr. Jaime Pittenger Kirtley, Prevent Child Abuse Kentucky; Steve Shannon, Executive Director, KARP; and Detective Jason Merlo, Kentucky State Police.

Welcome: ***Judge Melissa Moore Murphy, Chair***

Judge Murphy welcomed everyone to the first meeting of the year. Judge Murphy asked if anyone had any changes to the minutes or case summaries. With no changes, Judge Libby Messer made a motion to approve the minutes and case summaries which was seconded by Betty Pennington. Minutes and Case Summaries stand as submitted.

REDCap Survey and Analyst Binder Update:

Judge Murphy: In order for the REDCap survey to go live we would like to take a vote to be sure that we are all on the same page with the final edits. Elisha did receive some updates from panel members and those have been incorporated. Does anyone have any other things they want to add? I am going to entertain a motion to approve the REDCap Survey and Analyst Binder update so that can go live. Motion to approve from Commissioner Straub and seconded by Dawn Blair. With no objections, the REDCap Survey and Analyst Binder stand approved.

Annual Report Update:

Judge Murphy: As you all know the statute requires us to file the annual report by December 1. We did send our letter out saying that we would have it turned in by February 1. Elisha, Joel, and Cindy have been working really hard to get that done. They believe they will have one for us to review by this Thursday. We should have it in our email boxes on the 20th. With that being said, I am asking that everyone on the panel have notes, questions and edits to Elisha by Tuesday the 25th. And I say the 25th with the hopes that everyone has it back by the 27th. Tuesday, the 25th should be the deadline in your

head to get it back to Elisha so we can send it off to be printed in time by the February 1st date. If everyone would make note of that we would appreciate that so much.

Proposed 2022 Legislation:

Judge Murphy – I saw lots of good edits that went back and forth to Elisha for us to send to Senator Carroll's office. There were little questions here and there and I think Elisha has reached out to the Senator's bill writer in his office. We have not heard back from them at this time. We have sent what we believe should be the final language for those changes. There will be proposed legislation that should be beneficial or at least legislation that we all have had the opportunity to have input on as it affects us and our work. Hopefully that will be presented at some point, we just have not heard back from their office for any follow ups.

Elisha: As soon as we get the proposed legislation and the bills filed, I will put those in an email to all the panel members to review. This does include a mandate for drug testing for law enforcement officers during child fatality and near fatality investigations.

Judge Murphy: So, with that being said, I think we are ready to start case reviews.

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-012-21-C	Joel Griffith
2	F-013-21-C	Joel Griffith
4	F-019-21-C	Joel Griffith
1	F-039-21-C	Joel Griffith
2	F-046-21-C	Joel Griffith
2	F-060-21-C	Joel Griffith
3	NF-106-21-C	Joel Griffith
4	NF-001-21-NC	Joel Griffith
1	NF-002-21-C	Joel Griffith
3	NF-139-21-C	Joel Griffith
4	F-050-21-C	Joel Griffith
3	F-027-21-C	Cindy Curtsinger
1	F-029-21-C	Cindy Curtsinger
3	NF-004-21-C	Cindy Curtsinger
2	NF-011-21-C	Cindy Curtsinger
4	NF-019-21-C	Cindy Curtsinger
2	F-037-21-NC	Cindy Curtsinger
4	NF-003-21-C	Cindy Curtsinger
1	F-003-21-C	Joel Griffith
3	F-020-21-NC	Joel Griffith
3	NF-041-21-NC	Joel Griffith
4	NF-103-21-NC	Joel Griffith

1	NF-009-21-NC	Joel Griffith
2	NF-114-21-C	Joel Griffith

Additional Discussion:

Caseload Data: Commissioner Miranda-Straub said she can get the caseload data to the panel for review. Now they look at caseloads by the region. They are trying to recruit workers with more experience to handle the highly complex cases.

Coroner and DCBS issues regarding Children with complex medical issues, disabilities/special needs and communication:

Dr. Currie: This is what happens when the coroner does not notify DCBS of the unexpected death of a child. They can't then know that there is an active, ongoing case. This is yet another example of a frankly, pervasive problem, when children with complex medical needs die, it is automatically assumed that it is natural without any investigation. This is one of the most egregious cases of that that I have ever seen. We worked so hard to get this child safe and failed at every juncture. I think what concerns me the most, is that this case would not have even been on our radar as a panel and won't get included as a fatality in DCBS's fatality reports, even though she died of what I'm convinced is medical neglect. To me, that's a huge problem and we need to brainstorm how to make sure this doesn't happen anymore.

Steve Shannon: I agree, Dr. Currie. People with disabilities are marginalized in a variety of ways and again here's a child who was marginalized as well.

Commissioner: What would be the next steps since this is a pervasive issue. What would be the next steps or the conversation that needs to be had on what appears to be a pattern that is disturbing indeed?

Dr. Currie: I think its time we start talking about abolishing the coroner situation in Kentucky because coroners are not necessarily medically trained. They are elected. They may or may not have adequate training to make these incredibly important decisions that they are making. Many other states do not have coroners any longer for this reason. We have had ongoing recommendations from a coroner's standpoint at this panel for years now and we've had no success to get them to happen because there is no accountability for coroners with the system we currently have. As long as we have that system, this is going to continue to be a problem. From the Cabinet's perspective I would like to better understand on how decisions are made about not investigating it as a fatality when we know that coroner's findings are not necessarily reliable in the setting. Perhaps we shouldn't hang our hat on their findings in making decisions about whether or not to investigate it as a fatality. I am interested in hearing from others.

Lori Aldridge: I agree with you 100%.

Commissioner: Its interesting to see where the coroners sit in professional accountability space. Noted and important for us to figure out what we can do to help.

Joel: This case clearly met DCBS' criteria for acceptance. I struggle with PFM and the PCP both reporting to DCBS that this was medical neglect, and the child should not have died in their sleep. You

have a deputy coroner stating no autopsy this is a result of the child's medical condition. How can the Cabinet go with the coroner over the medical providers? That's the piece I struggle with.

Lori: Is that the Cabinet's policy to go with what the coroner says? Is that something that can be changed?

Mary Carpenter: I think this goes to show we have front-line workers out there trying to make decisions when there's a coroner and medical professionals with mixed recommendations. We don't have a policy about whose recommendation to take but they're hearing from different professionals and it's very complex. This case resulted in a pilot to improve communication between medical providers and DCBS.

Dr. Salt: Should coroners being doing what they're doing? Should DCBS be put in the position of who do I follow and that's not really a policy level issue. I think we can try to mitigate it, but it doesn't really address the overall problem. Maybe we need to think about working with our other partners on large policy issues.

Dr. Howard: One additional thing, my team has spent hours to days before trying to get something accepted as a fatality or near fatality. And that's even after a direct quote saying, I suspect this near fatality is secondary to maltreatment. I've had more trouble with medical neglect since we have redone the fatality/near-fatality protocol. I don't know if we need to relook at that as far as medical neglect. I've had a lot of trouble with them saying if physical abuse isn't a concern, we're not going to accept it. What is the resistance from CPS to accept these? Is it the case worker load or what?

Mary: It's definitely not because of case load, it has to meet the criteria. If your spending days on this, you can certainly reach out to me or Melanie.

Dr. Howard: I feel like Dr. Currie, and I are probably some of the most familiar physicians in the state with the acceptance criteria. I've been to the point of asking who is making this decision. I keep getting the response it's above me. I've asked to talk to them directly and cannot get anywhere. I want those conversations to happen.

Joel: I will just note in this case, the front-line staff noted the case was not accepted by central office. This was not a decision made by front-line staff.

Melanie Taylor: It is important to note centralized intake, who screens referrals and who makes all these determinations, they have a statewide branch manager who is in central office. So that note stating they consulted with central office, could indicate their branch manager who is in a different division than us. The folks on my team do not consult on intakes and most of the time when we do, the determination has already been made. Centralized Intake makes all the determinations on all intakes.

Joel: Maybe that's a systemic issue. I'm sure the branch manager is extremely knowledgeable, but they may not have the knowledge regarding the fatality or near fatality acceptance criteria. Maybe centralized intake should not make those decisions without consulting the child fatality/near fatality team.

Commissioner: This is really troublesome and what I can say to the panel, is the team will go and evaluate this process. We will engage Dr. Currie and Dr. Howard in that conversation to help our staff to make those decisions.

Meeting adjourned.