Child Fatality and Near Fatality External Review Panel
Virtual Meeting

Tuesday, October 18, 2022

MINUTES

Members Present: Judge Melissa Moore Murphy, Chair; Judge Libby Messer, Fayette Family Court; Detective Jason Merlo, Kentucky State Police; Janice Bright, State Child Fatality Review Team; Dr. Elizabeth Salt, Citizens Foster Care Review Board; Dr. William Ralston, Chief Medical Examiner; Dr. Henrietta Bada, Department for Public Health; Lori Aldridge, Tri County CASA; Dr. Christina Howard, Child Abuse Pediatrician, University of Kentucky; Dr. Melissa Currie, Norton Children's Pediatric Protection Specialist, University of Louisville; Dr. Jaime Kirtley, Prevent Child Abuse Kentucky and Beth Workman, Kentucky Coalition Against Domestic Violence

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

Judge Murphy welcomed everyone to the October meeting of the Child Fatality and Near Fatality External Review Panel. We would like to welcome Beth Workman, who is acting as proxy for the KCADV today. Thank you for joining us.

Everyone should have the Minutes and Case Review Summaries from the September meeting. If everyone has had an opportunity to review those, we will entertain a motion. Dr. Currie made a motion to adopt the minutes and case review summaries which was seconded by Dr. Elizabeth Salt. With no objections, the September Minutes and Case Review Summaries stand as submitted.

Torture Definition Workgroup

Dr. Salt: We identified some definitional issues in a couple different cases regarding child torture determination. We started to take a deeper dive into this issue, as mentioned last time, we looked at the published literature and verified this with the reference library. We have those articles pulled that discuss child torture and then we looked at case law. Judge Messer and her colleagues conducted a legal review. We then contacted the National Center for Child Fatality Review and Prevention; we didn't get a response from them. As follow up to that, there's a list of contacts for every state's Child Fatality Program and we reached out to each of them with a REDCap questionnaire. We asked them if they make the determination of torture and if they do, what definition do they utilize. We had twenty states that responded and only two states make that determination. One of those states has a really nice checklist, which we might want to consider using if we want to apply that definition. There's a national center that looks at child torture and evaluates each states' statutes and policies and grades them. Which was very interesting. From what I've looked at, 19 out of 20 states do have a determination of torture in their state's statutes. That sums up the information we've gathered regarding the definitional problem of child torture. Our next steps are what do we do with this information. One option, I don't have listed is, we have this information, and we just don't do anything with it. Another option is a focus impact, we use this data to inform the panel's determination by comparing our current definition to other programs

and making necessary revisions. Then there is the potential for broad impact, since we have such a unique group, we can take the opportunity to write a consensus definition based on all the definition we've gathered. The long-term objectives being able to lobby for improving state statutes, not only in Kentucky but throughout the U.S. Like I said previously, this National Center for Child Abuse Statistics and Policy has graded each state's statutes on their identified areas that would be idea as far as addressing the issues of child abuse and neglect. Their determinations are supported by the American Bar Association. Judge Murphy, Elisha, and I all agree there needs to be some consensus on what we do with this information. We can open it up to questions, comments, voting, or however the panel decides.

Dr. Currie: I want to thank all of you for all your hard work on this project. This is a topic that is near and dear to my heart but unfortunately, I haven't had the bandwidth to engage with the subcommittee, but you've done a lot. I'm going to put my vote for the broader impact. I think we're a unique group and we have the potential to make a national practice change by changing this definition and getting it published. That's easy for me to say because I won't be the one doing the work. There's no rule saying it must be done next month. So, it will take the time that it takes but I would like to see us focus on a broad impact. I did want to suggest the American Professional Society for the Abuse of Children or APSAC, has a monograph on interfamilial child torture and they have their own definition, which I don't have in front of me, but you may want to add that to your research. Thank you.

Dr. Salt: I should also say, my thought on how the broader dissemination would move forward would be for me to draft that document and then share that with the group for everyone to provide feedback. I also think the documentation will have to be tailored for publication for each interdisciplinary area. I'm less versed in communicating in those other areas but I'm happy to start drafting it. Medical journals and that type of literature is more my background, but I think we need to consider dissemination in lay publications as well. I think it's important the public understands what this panel does and what the problem is and that might instigate policy change. If legislators know that our current policies are not really meeting the standards that other states are. Any other opinions on next steps?

Joel: I don't have an opinion but more of a question. Can we prioritize getting a working definition that we can integrate into our process in the next couple months? That would allow us to use the new definition on this year's cases, while the other broad impact work goes on.

Dr. Salt: Yes, I don't think they're mutually exclusive. Obviously, I think the broad dissemination would incorporate us reconsidering our current definition.

Dr. Bada: I don't think we've had that many cases in the past few years. Is it possible we review some of those cases and see what kind of information we have and compare it to those various definitions? Maybe that would be a start before we make our own definition.

Dr. Salt: I say make the definition, but it's really looking at the broader literature. The definitions are there, its just a matter of a consensus that this what we see as all encompassing of what child torture looks like. It is sort of philosophical and perfect for a consensus statement because it is sort of a philosophy of this is the threshold by which it crosses from physical abuse to torture. It isn't necessarily completely objective.

Judge Messer: During our review and I think part of the reason we need policy change, is the medical literature does a better job of describing and having a definition for medical providers to identify torture. The problem is the legal side does not. The reason this came up, we were seeing cases that to all of us look, feel, and smell like torture and may have met some of the medical definitions of torture but they are nowhere near what the Kentucky legal definition of torture is. So, we were getting things like law enforcement not being able to follow up and charge accordingly under the increased penalty statutes for torture. If we had a more consensus definition of what medical professionals and mental health professionals all say is torture to then present to ensure the criminal side is aligned. On the criminal side of it, we almost have to defer to the federal definitions applied to prisoner torture, we just don't have a good definition when it comes child abuse and neglect on the criminal side.

Dr. Salt: Yes, and I think the fact that it's mentioned in 19 state statutes, yet it's not defined is inherently a problem.

Dr. Currie: I will say, I think the Face It campaign in Louisville and Lexington would be happy to pick this up once we have language drafted from a policy standpoint.

Jan Bright: I think this will then present a good training opportunity for the CFR to take to the coroners. So, they can look for different nuances that they wouldn't typically think to ask, look for or document.

Judge Murphy: Are any panel members opposed to going forth with broad impact? With all members in agreeance, we will move forward with next steps. Dr. Salt will start the drafting process and we greatly appreciate her taking the lead on this project.

KY's Safety Model

Chelsea Harrod from the Department for Community Based Services presented information on Kentucky's new Safety Model Implementation. Panel members were provided all material from the presentation after the meeting.

Dr. Currie: I noticed that the terminology under the investigation track early on in the presentation was substance affected infant, as opposed to substance exposed infant and then I noticed the non-investigation categories included safe infant pathway. Can you explain how this new system is going to help us identify children who need plans of safe care and what the main differences will be, if any, on how those cases are handled.

Chelsea: The safe infant pathway for non-investigatory response is for infants with no identified perpetrator. So, this is an assessment, and we provide safety for that child and placement opportunities but there is not an identified perpetrator.

Melanie Taylor: Right, nothing about those assessments or even the terminology has changed. The Safe Infant Path is a path where a mother within 72 hours can relinquish a child or leave it at a safe place. We don't identify names in those cases and it's on a fast track for potential termination and adoption. All of that process is the same and nothing has changed. The substance affected infant terminology is the same term we used before; it just now has its own category. Everything about how we would have assessed or even if it meets criteria is the same but not it has its own category.

Chelsea: Another new piece on our ADT is the identification of a plan of safe care. This is a checkbox on our ADT that would be checked if plan of safe care occurred. That plan and collaboration for plan of safe care can be identified through a prevention plan. It can also be identified during our safety planning and ongoing case planning documentation. That now occurs in our service recordings.

Joel: Say the SDM tool is used to support reunification decisions in out of home care cases, when I think OOHC I think committed kid in a paid foster care placement or does that OOHC term count for kids in kinship care?

Chelsea: Yes, it applies to any child that is placed in DCBS custody.

Joel: So, if you're a direct placement in a kinship care and you're not in DCBS custody, do you do a SDM before the child goes home?

Chelsea: Yes, I believe we will.

Melanie: So, this tool has not been implemented yet. We're still working on that part, and we've done a lot of work around the relative service array. That probably is an entire other presentation. When we implement the risk reassessment and reunification tools, I believe it will apply to children with relatives as well. We haven't got that far yet.

Pending Cases:

F-38-21: No judicial missed opportunities after thorough review of all court documents and video. Case closed.

F-52-20: Update from the Kentucky Board of Nursing. Case closed.

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-054-21-C	Joel Griffith
2	F-038-21-C	Joel Griffith
3	F-042-21-C	Joel Griffith
4	F-022-21-C	Joel Griffith
1	F-061-21-PH	Joel Griffith
2	F-057-21-C	Cindy Curtsinger
3	NF-012-21-C	Cindy Curtsinger
4	F-018-21-C	Cindy Curtsinger
1	NF-016-21-C	Cindy Curtsinger
3	NF-052-21-NC	Cindy Curtsinger
4	F-058-21-C	Joel Griffith

1	NF-008-21-C	Joel Griffith
2	NF-027-21-C	Joel Griffith
3	NF-110-21-C	Joel Griffith
4	NF-142-21-NC	Joel Griffith

Additional Discussion:

Meeting adjourned.