Child Fatality and Near Fatality External Review Panel

Virtual Meeting

Tuesday, April 25, 2023

MINUTES

Members Present: Judge Melissa Moore Murphy, Chair; Lori Aldridge, Co-Chair, Tri County CASA; Lesa Dennis, Commissioner, Department for Community Based Services; Dr. Melissa Currie, Norton Children's Pediatric Protection Specialist, University of Louisville; Detective Jason Merlo, Kentucky State Police; Janice Bright, State Child Fatality Review Team; Dr. Elizabeth Salt, Citizens Foster Care Review Board; Steve Shannon, Executive Director, KARP, Inc.; Isela Arras, ZeroV; Dr. David Lohr, Medical Director, Department for Community Based Services, Dr. Christina Howard, Child Abuse Pediatrician, University of Kentucky; Geoff Wilson, LCSW, Practicing Addiction Counselor; Dr. Jaime Kirtley, Prevent Child Abuse Kentucky; and Dr. Henrietta Bada, Department for Public Health.

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

Judge Murphy welcomed everyone to the April meeting of the Child Fatality and Near Fatality External Review Panel. Everyone should have the Minutes and Case Review Summaries from the March meeting in their email. If everyone has had an opportunity to review those, we will entertain a motion. Steve Shannon made a motion to adopt the minutes and case review summaries which was seconded by Lori Aldridge. With no objections, the March Minutes and Case Review Summaries stand as submitted.

KCADV Presentation ***Isela Arras, COO***

For the last forty years we've been around, the Kentucky Coalition Against Domestic Violence was previously known as the Kentucky Domestic Violence Association. I'm really thrilled to introduce you to our newest iteration of our identity. As of last week, we rebranded and renamed ourselves. I'm going to play a brief video our CEO, Angela Yannelli, created to introduce us to the world.

Our new name is ZeroV and look for lots of exciting changes but still the same mission and goals. We hope you enjoy it as much as we have. We will have a new website and email addresses.

Case Updates:

Joel Griffith – F-049-22-NC – After reviewing additional records, it does not appear there was a missed opportunity regarding the mental health providers or the school counselors.

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	NF-001-22-C	Joel Griffith
2	NF-002-22-C	Joel Griffith
3	F-001-22-C	Joel Griffith
4	NF-056-22-C	Joel Griffith
1	NF-079-22-C	Joel Griffith
2	NF-066-22-C	Joel Griffith
3	NF-100-22-C	Joel Griffith
4	NF-078-22-C	Cindy Curtsinger
1	NF-135-22-C	Cindy Curtsinger
2	F-042-22-C	Cindy Curtsinger
3	NF-029-22-C	Cindy Curtsinger
4	NF-084-22-C	Cindy Curtsinger
4	NF-127-22-C	Cindy Curtsinger
3	NF-063-22-C	Joel Griffith
2	NF-027-22-NC	Cindy Curtsinger

Additional Discussion:

Law Enforcement discussion regarding a child that had a near fatal event due to the ingestion of fentanyl and there was no criminal investigation.

Dr. Currie confirmed, they have ongoing disagreements with the Crimes Against Children's Unit about their lack of investigation in these ingestion cases. They're asking medical providers to notify them within an hour of the child coming to hospital, which is extremely difficult to do given that the focus is on the child's wellbeing and not on the social situation. They won't accept ingestion cases unless the child's symptomatic within that hour. When we do notify them within that hour, there is usually another reason they won't investigate. We're really struggling to get these cases investigated and other jurisdictions do not respond that way. We've had some great successes with other law enforcement entities.

Dr. Salt: Was there a rational given for their one-hour response time?

Dr. Currie: They say that the family will clean up the scene if we take longer than that and then it's not worth going.

POSC- Dr. Bada – Regarding the POSC, when DCBS lets us know that the baby will be discharged to mom under supervision, we usually get whoever that supervisor is to come to the unit and stay with the child. We provide them with all the instructions and everything but after that we really don't know what happens. The other issue we have, it's really frustrating to know what's best to provide education to these families. There are times we ask mom to provide care and she's in there sleeping with the infant on her lap. It's really hard and I don't know how to reach these families. We communicate these concerns with DCBS but it's really difficult. Once they go home, I don't know what else you can do.
Joel: I feel like the missing piece is that whole collaborative piece. If there was a process in place when this baby was born that people from the birth hospital, DCBS, substance abuse provider, all got in a

room and laid out these circumstances and determined if it's safe for the baby to go home. If it is, what does that look like and what is everyone's role in ensuring the baby's safety. We need a multidisciplinary wrap-around services for these families. Absent, maybe a START team, I don't think you'll see in Kentucky.

Dr. Bada: I think DCBS does their best. When they determine who the caregiver is going to be, we ensure they receive all the instructions and training. The parents are even required to sign the Plan of Safe Care document and it's in the chart. So, there's still some kind of mandate with these families. The problem is, they're still going to do what they want to do when they go home. That's the problem.

Joel: The process that currently occurs as soon as they leave it's done. We need a team that when mom relapses, they come back together and discuss does this need to be reevaluated. Not a one and done team meeting but a long-term process that stays with the family to ensure the child's safety. And it can't just be DCBS. They can't provide the breadth of services these people need. They'll need employment services, mental health services, medical services.

Dr. Bada: No, I agree it's not DCBS' responsibility. As I said, I'm the baby's physician, I see what's needed and our social worker's see what's needed and there's communication with the families. To expect everyone to be in the huddle, it's a big issue. Then we have this pressure, even in the literature, that the quality of care is determined by the length of time of the baby is in the hospital. Which is the most ridiculous thing I've heard of. So, they discharge the baby as soon as possible and if you run out of beds you transfer them to the hospital nearest to the home but then you have a fragmentation of care. My dream is a place in the beginning of the record about the mother's treatment and compliance that every physician is aware. That the hospital and DCBS records are all in one and easily accessible to all physicians involved with the family.

Lori: I agree, because we're so close to the Tennessee boarder, we're just thankful that our moms go to a local hospital where people know them. We regularly have people that go out of state, so the Cabinet doesn't know they had the baby. I don't know that there is an answer. They purposely go to another hospital so they can fly under the radar.

Dr. Currie: I agree with Joel.

Isela: I think this is a much broader issue than a practical problem to solve. We can put all these steps in place but it's ultimately surveilling poor families. For me, in our report and advocacy, what financial investments are we making in families to be able to care for their families. We need more investment in housing, increase in benefits…that will translate into hopefully better outcomes for these families. So, anything we can do to implement or advocate for those are things that can help families prevent these circumstances or at least improve their chances. It's a longer-term solution.

Dr. Currie: I think multidisciplinary wrap-around services should be the goal, as Joel stated. I still maintain that the most appropriate entity to own the plan of safe care is not the birth hospital nor DCBS, but I think is public health. But public health needs to have funding in order to do that. I think in order for there to be true wrap around services multidisciplinary services that live within public health there needs to be state-wide funding for that program. I think it is very similar to START but we have to put

our money where our mouths are to make this happen. I think every family deserves a case manager that helps coordinate these wrap-around services. The case manager is where the funding comes into play.

Jan Bright: You would need many, many case managers by sheer volume and then you'd have to build a lot of infrastructure to get to those records. It's difficult to obtain records for these cases, there are many more infant exposed cases, and it would be very difficult to become part of that transition team. Then you have your community teams, such as HANDS, which is voluntary, and a lot of these families aren't inviting them in. There's more to that large problem than we've been able to bite off.

Dr. Currie: I understand it's a huge undertaking and the resources are not available to make it happen right now. But I think, if we're going to comply with the federal mandates of the plan of safe care, we need to fund it. It's not going to just condense out of the atmosphere into a program that's workable. It needs to be funded and built.

Joel: I think in our last annual report, we sent this issue to mental health and public health, so it will be interesting to see what the response is, but I think its unrealistic for us to develop the plan because we won't be the ones implementing. I think our role is to hold those account that received that recommendation about addressing this issue.

Dr. Bada: As Melissa said, we need some funding. We're doing our best. From an education standpoint, we're really doing our best. We're trying to educate all providers, not just nurses and physicians. We can only do so much, but we are doing more than we used to do. It's still a funding issue. If we're looking for case managers, which I think is the greatest thing that can happen, where are you going to find them? It's hard to hire individuals that are capable of knowing the resources, understanding these families, and they themselves are going to need some kind of education to handle these types of cases. They are difficult cases.

Dr. Currie: I think education is very important and should be a cornerstone but it's just one cornerstone. I don't think we can educate our way out of this problem. There needs to be monitoring and a safety net built. Each individual stakeholder needs to have their own set of responsibilities for what they do if they notice the family is not doing well. Just having MAT providers involved so DCBS is aware of relapse, would be huge.

Steve: I agree with everything, just in reality if a provider starts reporting missed appointments regularly with DCBS, that's going to get shared throughout the community and people will stop going there for services. In some ways you decrease access by doing that. I understand and I agree with it but that's just the reality and you'll see people shopping for providers who are less likely to report. You have to walk a thin line between encouraging people, motivating people and keeping them engaged in services versus chasing them away. You quite often see this in schools when kids are suddenly homeschooled because a schools reported. Again, I don't disagree with anything we've said here but we have to make sure the provider services are not perceived as an arm of the reporting mechanism.

Joel: Steve, I think you're right but if you look at model, like START, everyone is there to protect and mentor the family. If you define from the onset what the role is and the client understands they are there to help and the ultimate goal, you can do it without losing trust.

Steve: I'll disagree. I think at some point, some family is going to lose their child and that's going to be the message they share. I don't want to disagree with you but that's the reality of it. Furthermore, it's really hard to gather busy people on a regular basis and I don't disagree with the value but in the current environment it will be difficult. You rarely ever hear a primary care provider has participated in a planning meeting. You may get a report and occasionally they'll send a nurse. So, yes, we can build the system but let's figure out all those issues going forward to make sure people are engaged and that case manager has a reasonable caseload. It can't be 40, that's one hour a week. We can build it but are we going to fund it. If we don't fund it, we might as well not build it. It has to be more than pilot project and grant funding. I don't disagree but let's just be cognizant of those things that impact the service delivery that we want to take on.

Dr. Salt: Prior to discharge do parents have to identify a caretaker and does that have to be verified, that will happen in a situation of relapse? I mean we understand the nature of these conditions, we understand that relapse is definitely a potential option for these patients. So, is that person identified?

Dr. Bada: I don't think most of them have anybody. When you interview these moms and you ask them for any close friends or relatives, most of them don't. Their only support is really their boyfriend. In some cases, you have the grandparents. Most of our kids we always discuss with DCBS about what happens at home. DCBS usually lets us know who they've identified as a support for mom.

Isela: Again, I don't think we can ignore that those relationships are an economic resource. Especially where paramours are involved, those are economic choices. These people are struggling with poverty and can't make different choices for themselves.

Dr. Salt: I just think that not even having that fundamental piece in place, we're not even close to being able to provide wrap-around services.

Steve: If someone ask the person that question and they say they don't have anyone, what happens? If they go home anyway and something happens, then are you accountable for the action. I think it's a really complicated piece.

Dr. Salt: The community-based approaches we've used were the family needs alternative resources, have those services been considered in these types of cases? Leveraging the community resources.

Joel: I would say yes and if we look at national models, we can find models where plans of safe care are done effectively.

Lesa: I think we've had some of those conversations, but it was in previous years. I think this is an opportunity for a small group of us to come back to the table and work of this piece.

Dr. Bada: I think we should do that and include community mental health centers.

Lesa: Yes, we've talked about the maternal branch at the community mental health centers working with DCBS on those families that did not meet criteria and how we can connect those two agencies. Previously, we hit some roadblocks that may not exist today.

Steve: I can make that happen. I think this would be a conversation.

Elisha: I will set up a subcommittee meeting. If anyone wants to volunteer, please message me to add your name to the list. I have Dr. Bada, Steve Shannon, Dr. Salt, Dr. Currie, Commissioner Dennis, Jan Bright and Dr. Howard. If anyone else wants to be involved, please let me know.

Lesa: This is a really good discussion and it's all relevant, but I think it's time we revisit the conversation from prior years and see if there are some opportunities available now.

Next meeting will be held virtually on May 23rd.

Meeting adjourned.