Child Fatality and Near Fatality External Review Panel

Virtual Meeting

Tuesday, June 18, 2024

MINUTES

Members Present: Hon. Benjamin Harrison, Chair; Commissioner Lesa Dennis, Department for Community Based Services; Dr. Christina Howard, Child Abuse Pediatrician, University of Kentucky; Dr. Elizabeth Salt, Citizen Foster Care Review Board; Hon. Olivia McCollum, Boone County Assistant Attorney; Dr. Danielle Anderson, MAT Provider; Steve Shannon, KARP, Inc.; Dr. Jaime Kirtley, Prevent Child Abuse Kentucky; Catherine Frye, State Child Fatality Review Team; Olivia Spradlin, Policy: Leadership, ZeroV; Allison Motley-Crouch, LCSW; Ashley Evans-Smith, Executive Director, CASA; and Dr. William Lohr, Medical Director, Cabinet for Health and Family Services.

Welcome and Introductions ***Hon. Benjamin Harrison, Chair***

Chair Harrison welcomed everyone to the June meeting. First thing on the agenda, we have a few introductions, two new members have been appointed to the panel. First, Ashley Evans-Smith is the new Court Appointed Special Advocate. I will let Ashley introduce herself to the team.

Ashely Evans-Smith – Ashley introduced herself as a director with CASA Ohio Valley. Ashley has a background in social work prior to becoming a CASA director. She has a passion for this work and is excited to join the team.

Chair Harrison – Thank you, Ashley. We are glad to have you here. The second new appointment that we have is Allison Motley-Crouch. She is a licensed clinical social worker who serves as the practicing social work clinician on the panel. Allison if you would like to introduce yourself, we'd appreciate it.

Allison Motley-Crouch – I'm Allison, I own a private practice, but I've been a social worker since the dinosaurs have been on the Earth it feels like now. I've worked in a variety of different roles, most of it clinical, but I also do supervision for other social workers who are trying to obtain autonomous functioning. I have served on a child review panel before in Montgomery County. I'm sure everything is different, and it was years ago but I'm looking forward to brushing up my skills. Hopefully, we can be a team that can prevent some really bad things. I'm excited to be here.

Chair Harrison – Thank you. We're glad to have both of those appointments and I think, Elisha correct me if I'm wrong, but we now have a full panel.

Elisha - We do, the first time in many years.

Chair Harrison – Glad to finally get that done. Again, we appreciate the service of the two new member and all the members of the panel. Next time on the agenda is the approval of the minutes and case review summaries of the May 2024 meeting. Elisha sent those out last week for everyone to review.

Motion made by Steve Shannon for approval, which was seconded by Dr. Salt. With no objections, the Minutes and Case Review Summaries from the May meeting stand submitted. Next item on the agenda is the financial update. I'll turn that over to Elisha.

Elisha – Here is our quarterly budget review, the majority of the expenditures are personnel cost. There was a slight increase in our COT cost. That is due to having a new employee and additional equipment cost. Our total operating cost for FY 2024 is $330,565.21, our budget June expenditures is $48,500, which leaves a remaining budget of $41,334.79. Our restricted funds for the epidemiology contract have not changed. Casey will be giving an update today and we expect to have another invoice after today's meeting. Does anyone have any questions regarding the budget update?

Next, we will move on to the LOIC Annual Review. I've sent that to all members for review. If we want to issue a response, we have until June 21st. I sent some potential response but please let me know how you would like to proceed. We are scheduled to testify on July 11th. Chair Harrison has agreed to testify that day. If any other panel members are interested in joining us, please let me know. Any questions about the LOIC review?

Chair Harrison – If anybody is in Frankfort on July 11th, feel free to join us. We'd love to have you there and fill that table up. I probably won't be able to offer too much information since I'm fairly new as well. So, we'd appreciate any of the panel members that want to participate in that with us, we'd be glad to have you. So, our next item on the agenda is the epidemiologist data presentation. Casey Reed is the epidemiologist assigned to the panel and she's going to give us a mid-year data presentation. I'll turn it over to Casey.

Casey Reed – I'm a Maternal Child Health epidemiologist but I've been helping with the external panel. This will be a review of data from SFY18 through 23. The first slide represents an overall of all the cases reviewed by the panel. You will note the SFY 23 shows a decreased number, that's just the number reviewed to date. The total for SFY23 is approximately 215 but for clarity I wanted to keep just the cases that have been reviewed. Next slide, here you see two different graphs. The graph on the left shows the percentage of cases that had a positive parental CPS history identified. The graph on the right shows of the percentage of cases by perpetrator. These are not going to total 100% because some cases might have multiple people listed. The other category consisted of babysitters, other family members such as aunts, uncles, grandparents. As you can see the numbers are fairly consist that it's primarily the mother or father identified as the perpetrator. Next slide, this slide represents the top categorizations of cases. As you see here, the overwhelming majority had neglect listed as a category. This makes sense as the majority of the other types of cases listed here typically have an element of neglect involved. As you can see a little bit further broken down, abusive head trauma is large one, overdose/ingestion which has been increasing of the past few years, and physical abuse was a top contender as well. The next few slides breakdown each fiscal year by the top categories. All other categories not listed affected less than 10% of the cases. So, you can see overdose/ingestion was the top contender in SFY18 but then decreased slightly in SFY19. Next slide represents the top categories from SFY20 and SFY21 with neglect as the top categories, then overdose/ingestion. SFY20 list SUDI cases because they accounted for more than 10% of the cases that year. Next slide, here we have the most current fiscal year and SFY22. Again, SFY23 is such a reduced number of cases that have been finalized, so this will change when all 215 have been reviewed. Again, neglect is the highest with overdose/ingest and then physical abuse. Next slide, here I broke down the category by age. I was trying to show the different categories

affect different ages differently. So, as you can see almost all abusive head trauma cases were found in cases of children 4 years old or younger. You'll notice on the graph there's one case listed in the 5–9-year-old range. I've spoken with Elisha about this case and technically they passed when they were 5-9 years of age, but it was directly attributed to an abusive head trauma that happened while they were an infant. As you can see neglect affects all ages, but overdose/ingestion has really affected the 1–4-year-old range. That makes some sense as far as children don't know what they're looking at and are finally starting to walk and be more autonomous and getting into things. You see that number drop off as they get older. Physical abuse was also higher in the less than one-year range and of course SUDI is going to be less than one year old based on the definition. Additionally, drownings affected the 1–4-year-old range at a higher rate than any other age range. This next slide focuses more on the types of cases affecting older children. It's interesting to see the gunshot (accidental) category mainly affected the younger children and as they age the accidental aspect decreased. Cases in which firearms were intentionally used are more likely to affect older ages. Suicide primarily affects older children, but there is a worrying trend of younger children dying by suicide. This is statewide and not just specific to the external panel cases. I do know there's been a lot of push to focus on mental health, especially youth mental health. Next slide, this table shows the top family characteristics identified in the external panel cases. I could not list all of them, but these are the largest percentages throughout the past few years. As you can see these stay fairly consistent throughout the fiscal years. DBCS history was overwhelming the top category, with financial issues, criminal history, mental health, and substance abuse all in the top characteristics. I will note environmental neglect significantly increased over the years. I will get more into some of the increasing and decreasing trends in the next slides. Next slide, here I was trying to identify characteristics that were increasing. You can see here that education/childcare issues increased from SFY18 from 4% to 15% of cases affected in SFY23. As well as environmental neglect increased from 15% to 57%. I did not make a specific graphic for this finding, but MAT involvement also saw a slight increase from SFY18 – SFY23, from 12% of cases affected to 15%. I identified that one in particular because we've been interested in tracking overdose/ingestion cases, and I thought that might have some type of affect on those rates. There is nothing conclusive and I'm still digging into that data. The "Other" characteristic has also increased from 16% in SFY18, to 34% in SFY23. I think that is attributing to the complexity of these cases and not having a definitive category to list these cases in. Next slide, this is the same but opposite showing a decrease in these findings. It's hard to determine what exactly is the cause of this decrease, it could be the way we define these categories has changed. We are still looking into that change as well. Family violence has decreased a lot, from 49% in SFY18, to 13% in SFY 23. That's why we were wondering if it was our reporting that changed, or the actual data changed. Neglectful entrustment and Impaired caregiver have also decreased over the years. This is the last slide, and it gives a general what the panel has determined for each case. These findings are not going to equal 100% because each case may have multiple determinations. Overwhelming, neglect in any form was part of the determination of the panel. You can see the different colors represent each fiscal year and how they varied year to year. With this most recent fiscal year, neglect general has been the most common determination. Again, all data points related to SFY23 are going to fluctuate until all cases have been reviewed. That is all I have, if there are any questions, please let me know. If anyone has any specific data that they are noticing a trend and would like a deeper look, please let me or Elisha know, and I'm happy to dig into that data. I know we're already looking at firearms and overdose and ingestion cases but if you see anything of note, I'm happy to have a conversation about it. Thank you.

Chair Harrison: Thank you. Does anyone have any questions for Casey right now?

Joel: I don't have a question, more of an observation or comment. For this year we have 215 cases for SFY23, 75 of those cases are completed now. So, we've only reviewed 34% of the cases from last fiscal year, which is concerning because one of our goals this year was to get them uploaded and reviewed well before we started processing data. So, we're not processing data while we're trying to write the annual report. For that to happen, Lori, Cindy, and I are going to have to speed up the case reviews, but we have to have the cases available on SharePoint. Right now, we're pretty much keeping up with cases as they're being uploaded. So, we're going to need them uploaded within the next 2-3 months to achieve this goal.

Casey: I will add this is based on the finalized data as of June 1, so there may be more finalized since then that was not included.

Joel: That would only include cases reviewed today, which will be about 13 and that's still significantly less than where we need to be.

Commissioner Dennis: The DCBS team and I talked about this yesterday. We aware and working on ensuring those cases are uploaded as soon as possible.

Dr. Howard: I do appreciate this, Casey. It was very helpful and makes me think we need to be very cognizant about the family violence because that doesn't correlate with what we're seeing out of the child maltreatment reports. Kentucky tends to have some of the highest rates in the country of cooccurring child maltreatment and family violence and partner violence. So, I don't know why our numbers are so different from that.

Elisha: I think I know the answer to that. Around 2019, or maybe 2020, I'll have to go back and check the history, but we started tracking Domestic Violence and Family Violence as two separate categories and I think that is what caused that decrease in family violence. I really think it's purely a definitional issue. Casey, do you have the number of domestic violence as a characteristic? I'm wondering if we're seeing an increase or even a steady account of domestic violence and just the decrease in family violence. I don't think before we had it tracked separately.

Casey: Let me pull that up and I'll let you know.

Dr. Salt: I have a couple comments. I know we track criminal charges, but I think it would be interesting in those physical abuse cases to be trending whether criminal charges were filed and potentially any information related to that. Similarly, DCBS correct me here, but I think there's a new assessment with scores that are supposed to be predictive of various factors. It would be interesting if we have that data to look at those intake scores. Similarly, I know we track the substances in those ingestions cases and continuing to track that data is critically important to paralleling it with what we're seeing in the ED.

Joel: Are you talking about tracking the Structured Decision-Making intake tool or the risk assessment tool. I think it's a great idea, but we would have to think how we would access that and pull that data into the new system.

Melanie: For clarification, there's not an intake score. There is a risk assessment score, and it is specific to the probability of the family being rereported to the agency within 12-18 months. The research on that tool is designed to determine that probability. We probably have some data on those risk assessment scores that we could probably get. Just reminder, we have to create the data and that can take some time.

Joel: That data started in this fiscal year we're reviewing now. So, there's no old data for this and it's a whole new thing, which would be cool to do.

Dr. Howard: So, were you thinking about looking at the cases or the score prior to the near fatal/fatal event?

Dr. Salt: Right, we could potentially do that. I could think of a whole bunch of potential ways to use the data but without knowing all the data its hard to know all the possibility. Obviously, you have this number and if we could find a window that these children would be at higher risk you could potentially target those or have closer supervision or something like that, that could potentially preempt some of these issues. It could be a value if we understood its utility in predicting these events.

Dr Howard: So, it could be like a change in practice in maybe the screened-out process. I don't know. Lesa, what are you thinking?

Commissioner Dennis: It would not apply to the screened-out process because it did not meet criteria for acceptance and therefore would not receive that assessment.

Melanie: I think we'd have to be careful with our definition of "risk". That tool is specifically designed around the probability of a family being rereported to the agency within the next 12-18 months, not the probability of an event.

Joel: If I'm understanding that tool is based on a deep dig into the recidivism cases within DCBS which there was prior recidivism and then you looked at the those and said what were the predictive factors for recidivism, not predicting a serious injury.

Melanie: Exactly, I couldn't have said it better.

Elisha: I do think this is something we could start tracking when we develop the new data tool from a panel perspective. Does anyone have anything else?

Casey: I was just going to confirm with you, I believe you're correct because FY18 there's zero cases identified with domestic violence. As soon as you started identifying the domestic violence that family violence decreases. So, I think that new definition is exactly the reason why it decreased.

Allison Motley-Crouch: I have a quick question. I worked for the HANDS program for years in grad school and it's very helpful with some of these trends. The families or kids that don't meet the risk assessment for further CPS involvement, are they referred to any other programs like First Steps or HANDS? And my follow up question, if they are referred to these programs are there any requirements for them to upload any new information on that family?

Commissioner Dennis: If the reporting source leaves their name or calls, often times our central intake folks will say this doesn't meet our acceptance criteria but here are some other services in the community that you may want to connect an individual to. Additionally, the reporting source always gets a response back from centralized intake on whether it met acceptance criteria. We also have a pilot project right now in 10 counties, where we are piloting what we are calling community response. We look at those referrals that did not meet acceptance criteria but there's an identified need in the family. We are connecting them with a provider within those communities to conduct further outreach with the family and connect them with services. That is the pilot project right now in 10 counties and we are working with a couple of national partners to evaluate and hopefully expand that further.

Allison Motley-Crouch: Fantastic, thank you.

Melanie: I just want to clarify too since we're talking about the SDM tools, that's necessarily associated with that risk assessment tool. Generally, what that risk assessment tool should help a worker decide is if they have a higher probability of being rereported to DCBS. That helps us decide what services, what level of services, and whether to open a case or not. DCBS' mission is really to refer all kids who need early childhood services, whether it be HANDS, early childhood education, childcare services all of that, regardless of not necessarily associated with the risk assessment.

Allison Motley-Crouch: That's also a heavy load on a social worker. As a social worker myself, that's a lot to handle.

Chair Harrison: Anyone else have any questions or comments? That was a great discussion, appreciate everyone's input and questions. Joel, you ready for the 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-037-23-NC	Joel Griffith
2	F-045-23-NC	Joel Griffith
1	F-054-23-PH	Joel Griffith
3	F-056-23-PH	Joel Griffith
4	NF-013-23-C	Joel Griffith
3	F-053-23-PH	Lori Aldridge
4	F-030-23-C	Lori Aldridge
2	NF-091-23-NC	Joel Griffith
3	NF-120-23-C	Joel Griffith
4	F-055-23-PH	Joel Griffith
3	NF-123-23-NC	Joel Griffith
2	NF-144-23-C	Joel Griffith
4	NF-111-23-C	Joel Griffith

Additional Discussion:

Dr Howard: **Potential recommendation to develop a Torture Task Force that looks at the law in Kentucky and the criminal prosecution of it. What do we use to diagnosis torture? We need to make a clear definition of torture, how it's criminally prosecuted, and how our current laws regarding those cases.**

Dr. Salt: There is a document from the National Center of Statistics and Policy on Child Abuse and Child Torture, and they provided a definition, which Knox was part of it. They actually went state by state and evaluated the quality of the policy in each state and I think we're at a C. It's fairly prescriptive and it recognizes some of the deficiencies in the Knox article, specifically the exclusion of sexual abuse. I do think we need to look at our policies and child torture in the state of Kentucky. I do think we have a lot of guidance with that really excellent document. I definitely think this is something we should continue to consider. I am really concerned about, if the requirement to make the determination of torture requires the child to be verbal than what happens in medically fragile child or very young children. Are we limited in our ability to correctly classify the aggression nature of what has happened to these children. I have some hesitation there.

Dr. Howard: We have ways to gather that information in nonverbal children. For example, interviewing other children in the home and scene investigations can often find ties in the home. There are ways to determine torture in a nonverbal child.

Dr. Salt: I'll share the policy and statistics report and a torture checklist with the group.

Motion to adjourn made by Dr. Salt and seconded by Olivia McCollum. With no objections, meeting adjourned.

Next meeting Tuesday, July 16, 2024.