CHILD FATALITY & NEAR FATALITY EXTERNAL REVIEW PANEL

2013 ANNUAL REPORT

EXECUTIVE SUMMARY

The Child Fatality & Near Fatality External Review Panel (The Panel) has met eight times beginning in November 2012 after being established by the Governor's Executive Order No. 2012-0585. Codified by the 2013 regular session of the Kentucky General Assembly, a seamless transition began with an expanded panel in July. Both the executive order panel and the statutory panel were required to meet at least quarterly. That the panel has chosen to meet twice as much as required is one indication of how seriously the members view their role as agents that could lead to reduced numbers of child fatalities and near fatalities in the Commonwealth.

Dedicated efforts were taken to ensure all panel members had access to and were able to review all case information available for FY 2012. Delving into these files (sometimes hundreds of pages of information) was a daunting task that each member performed. Sorting through these amounts of data and information proved to be challenging, and has led to the realization that the process of reviewing these cases is going to be as critical as the recommendations themselves.

Beyond the few hours of time required for the panel members to meet, the larger commitment of their time involves reading, comprehending and recording notes on each case file. A much more efficient use of the panel members' limited schedule would be providing them with case summaries put together by a professional that is dedicated to analyzing and interpreting child fatality and near fatality data. The work of the panel could then be focused on developing solutions for reducing child fatalities and near fatalities. Because of the sheer volume of information associated with each case a reviewer could summarize and provide analysis of the data to the panel members. Acquiring dedicated staff for the work of the panel specifically for case and data analysis is critical for the panel to achieve its goals.

Through the review of cases, the panel noted disturbing trends and missed opportunities to prevent tragedies to children. These findings were not limited to a specific individual or agency, but reflected a need for a multi-agency approach to prevention and systems improvement. Although the panel fully recognizes it is, at best, difficult to predict human behavior, and there is no definitive constellation of risk factors which accurately predict fatal or near fatal child abuse, these cases were potentially preventable. The review of these cases left panel members with the agonizing recognition that agencies, individuals and communities collectively are not doing everything possible to prevent these tragedies. Despite this uncomfortable recognition, the panel has chosen in this first report to focus on strengthening the panel's capacity to effectively review cases. The panel felt strongly about the importance of conducting more thorough reviews and fully analyzing data from a larger number of cases as a prerequisite to informed and effective recommendations for change. The panel is committed to making specific, evidence informed recommendations for systems improvement in future reports.

PANEL HISTORY

The Child Fatality and Near Fatality External Review Panel was initially created by Executive Order of Governor Steve Beshear on July 16, 2012. This independent, multi-disciplinary panel was charged to review official records or information relating to child fatalities or near fatalities and analyze medical, psychosocial and legal circumstances of the child to identify conditions that contributed to the death or serious injury. The panel was to recommend improvements to the Cabinet for Health and Family Services (CHFS), the Department for Community Based Services (DCBS) and to any other public or private

agencies involved with the family relating to protocols, practice, training or other protections to keep children safe.

Representation on this panel was a diverse, varied team of professionals from across the state including those in the medical, social services, mental health, judicial and law enforcement fields. They were tasked with meeting quarterly to review official records, case files, or information relating to child fatalities or near fatalities in the possession of any department, agency, organization or entity of state government; analyzing the medical, psychosocial and legal circumstances of the child to identify conditions contributing to child death or serious injury; recommending improvements to the Cabinet for Health and Family Services, the Department for Community Based Services, and any other public or private agency or entity relating to policy, practice, training or other protections for children; and publishing an annual report of case reviews, findings, and recommendations to be submitted to the Governor, the Secretary of the Cabinet for Health and Family Services, the Chief Justice of the Supreme Court, and the General Assembly.

At the panel's first meeting it was recognized that without legislation to codify its mission, the panel would run the risk of being dissolved. Legislation would provide the necessary support required to demonstrate Kentucky regards the reduction of child fatalities and near fatalities a critical issue. Legislation would also assist in meeting the necessary transparency the public needs regarding this issue.

Early meetings of the initial panel were dedicated to ensuring a properly worded bill would be passed legislatively. Senator Julie Denton and Representative Tom Burch advised the panel and took active roles in the crafting and passage of the legislation. Many panel members testified before legislative committees and informed legislators on the merits of providing the panel with the necessary statutory authority. Without these efforts the critical work being started may have foundered.

In the 2013 regular session of the Kentucky General Assembly the executive order panel was codified into KRS 620.055 through HB 290. With the same mission, the now 20-member panel continues the work of the previous group and submits its first annual report of findings and recommendations. In addition to the established representation on the panel, three new positions were created by the legislation adding additional perspectives to the case review. They are citizen foster care review, community mental health centers and the Commissioner of Public Health.

As a result of legislation the panel now has access to un-redacted case files from the Cabinet for Health and Family Services (CHFS). The panel may also request the records of many other agencies such as law enforcement, courts, medical providers, education, etc.

This is a critically important benefit of the legislation. Each panel member shall be provided copies of all information, including but not limited to records and information, upon request, to be gathered, un-redacted, and submitted to the panel within thirty (30) days by the Cabinet for Health and Family Services, from the Department for Community Based Services or any agency, organization, or entity involved with a child subject to a fatality or near fatality.

The panel is committed to maintaining transparency to the public while respecting the privacy and sensitivity of the materials it reviews. Notwithstanding any provision of law to the contrary, the portions of the External Child Fatality and Near Fatality Review Panel meetings during which an individual child fatality or near fatality case is reviewed or discussed by panel members may be a closed session and subject to the provisions of KRS 61.815(1) and shall only occur following the conclusion of an open session. At the conclusion of the closed session, the panel shall immediately convene an open session and give a summary of what occurred during the closed session.

There is also established legislative oversight of the panel's activity and processes. Beginning in 2014 the Legislative Program Review and Investigations Committee of the Kentucky General Assembly shall conduct an annual evaluation of the External Child Fatality and Near Fatality Review Panel established pursuant to Section 1 of this Act to monitor the operations, procedures, and recommendations of the panel and shall report its findings to the General Assembly.

CASE REVIEW PROCESS

All cases from fiscal year 2012 were initially distributed in hard copy form, with redacted information. These cases were difficult to read due to the inconsistent redactions, missing files and inconsistent format. The panel determined after the legislation allowed it to have un-redacted files that members would not go back and review the previous year. They would begin with FY 2013 and have those cases entered into the SharePoint software system. Cases were loaded chronologically as the investigations were completed. The panel determined it would prefer to review simpler cases first (particularly those that involved supervisory neglect). Those have been entered and are in the review process now. A summary sheet for demographic data on each case has been developed by a panel member to ensure all basic information is included up front. These summary sheets are included as the 1st page of each case file. The panel has also identified records it would like to have included with each file and requested that the Department for Community Based Services (DCBS) acquire those as part of the case upload process if they are not already included. That information consists of law enforcement, court, medical, medical examiner, mental health and assessments, substance abuse, and behavioral records.

Initially paper copies of the 55 known cases for FY 2012 were distributed to each panel member for review. Select cases were scheduled for review at specific meetings. As work progressed, the panel was divided into four work groups, each assigned cases for review for the next scheduled meeting. Each work group would report its findings at that meeting and open discussion with all panel members. Early on the panel recognized a need for a more efficient way to distribute cases to be reviewed from CHFS. There was also a need for a secure discussion forum among panel members to efficiently exchange information about cases outside of the relatively short meeting times available. SharePoint is an established software program that allows this type of exchange while respecting the sensitive nature of the information being exchanged.

SharePoint software was eventually adopted allowing for CHFS to upload case files as they are completed.

Panel members invited the Director of the National Center on Child Death Review (NCCDR) to speak to the group in a discussion forum at the September meeting. Among her recommendations for processing case reviews were hiring dedicated staff to conduct data analysis and prepare case summaries, tying panel recommendations to specific cases, and creating a standard template of information for all cases.

PROCESS FINDINGS

The panel is committed to strategies to prevent the tragedy of child death and serious injury as a result of abuse and neglect. Also, like many others when confronted with tragedy, the panel wants to see an immediate action taken to prevent future incidents. Sometimes there are immediate actions which can be taken; more often, a deliberate and thoughtful response is needed. Despite the panel's desire for immediate action, recommendations are best when fully informed by evidence, and not in response to a singular case.

The occurrence of child abuse and neglect is a complex issue, and there is not a simple single solution. Accordingly, the panel has tried to avoid making "quick fixes" driven by limited information. It is prudent to avoid systems change on the basis of a sole case. Panel members intentionally chose to look for trends in cases, which will lead to the most impactful prevention and systems improvement strategies.

Based on the limited number of cases read by the panel in its first year of existence, it has identified preliminary issues it feels are worthy of further study and review. These areas of concern are informed by actual occurrences in cases of death or near death in Kentucky. While these issues are not yet formulated into specific recommendations for legislative or policy change, these are the issues the panel will continue to explore over the coming year. The panel fully understands the responsibility for preventing child fatalities does not fall to a single government agency or entity within the community. These issues clearly reflect a broad, system-wide, multi-agency effort to transform organizational silos into systems of care and improve Kentucky's ability to strengthen families and children, and prevent child abuse and neglect.

Early in the panel's examination of records, several themes began to emerge that suggest need for more careful examination in future reviews. The panel was mindful of the need to not form premature conclusions from the first wave of case reviews but also noted the emergence of patterns that might ground future observations and recommendations. The patterns suggest areas of concern for more detailed exploration and for potential policy recommendations once a more systematic review of records is underway. In representing these patterns, the panel reflects a thoughtful and analytical approach to case findings as shown in the records under review. From these preliminary findings, it is clear that more definitive conclusions and recommendations will depend in part on having staffing support. Funding has been requested to lend greater systematic support to the review processes and findings in the records.

PRELIMINARY ISSUES OF CONCERN

- **COMMON RISK FACTORS**

Common risk factors identified in cases reviewed included issues of domestic violence, criminal history, and substance abuse by caretakers and family members. The issue of substance abuse was a commonly discussed theme, particularly in relation to deaths involving unsafe sleeping arrangements (co-sleeping by a caretaker under the influence of drugs or alcohol.) The need for consistent drug testing protocol of caregivers at the time of the child's death, particularly at the time of death, was discussed. The panel will continue to gather data from cases reviewed, and other sources, in an effort to develop best practice policy and/or statutory recommendations.

- **OPPORTUNITIES TO INCREASE AWARENESS**

Not surprisingly, the need to enhance general awareness and prevention activities was a common theme. The need to design and implement targeted awareness campaigns is manifest in the high number of children dying in unsafe sleeping arrangements, drowning incidents and less common but equally tragic incidents of infants being unintentionally left in hot cars. Failure to report suspected abuse and neglect is also an area in which increased awareness was identified as a critical need. It is not uncommon to find within the cases reviewed situations in which a neighbor, caretaker or relative had suspicions of abuse, but failed to make a report prior to the fatal incident. Utilizing ongoing trend data from panel case reviews, in combination with data from other injury surveillance systems, the panel will identify opportunities for enhanced prevention and awareness efforts.

- **LACK OF MENTAL HEALTH SERVICES**

The lack of affordable and readily accessible mental health services for families was a common theme. Often related to inadequate funding, this gap results in a critical lack of assessment and treatment services within communities, services which are particularly critical for the high risk families served by the child protective services system. Consequently, there is minimal capacity to provide the range of services needed, from even basic behavioral health services to high risk families and children, to much needed forensic-oriented behavioral health assessments for families (inclusive of child development and parenting capacity). The daily functioning of DCBS is contingent on access to competent behavioral health services and this emerges as a pattern for future study. The panel discussed the need for additional behavioral health representatives on the panel; a regional Mental Health CEO is now on the panel.

- **COMMUNICATION AND CAPACITY WITH INVESTIGATIVE RESPONSES (LAW ENFORCEMENT & COURTS)**

Multiple issues were found regarding process and communication in the "investigative" response to child abuse and neglect investigations. These were noted in the response to cases prior to a death or near fatality, and in the investigation of the suspected fatal or near fatal incident. In some cases, for example, law enforcement agencies were not aware of DCBS Prevention Plans or Family Court orders. Options to build such communication into law enforcement tools were discussed. The issue was frequently raised that Multidisciplinary Teams (MDT), statutorily authorized to coordinate investigations in child sexual abuse cases, are not authorized to address other forms of child maltreatment. Law enforcement officers often reported directly to the hospital when a child was found to have life threatening issues, sometimes resulting in the failure to conduct a scene investigation. In other cases, Child Protective Services had petitioned the Court for custody and had the petitions denied. The prevalence of these issues was difficult to assess due to the lack of inclusion of law enforcement records and court records in the vast majority of cases reviewed. The panel is implementing process changes to ensure law enforcement records and court records are made available. Each of the investigative issues identified were discussed by the panel, in the context of potential policy, regulatory and statutory responses. As further trends are noted, the panel may propose specific policy, regulatory or statutory changes.

- **COMMUNICATION AND TRAINING OF MEDICAL PROVIDERS**

In several cases critical opportunities to respond to high-risk families were missed within the medical system. These issues encompassed the sometimes untimely and ineffective communication between medical care providers and investigative agencies, the lack of adequately trained medical staff, and the lack of capacity of medical care providers to provide effective aftercare support to high-risk children in cooperation with other community providers. It would appear there needs to be enhanced training for medical care providers, better communication protocol between agencies (both investigative and service providers), stronger statewide capacity to provide forensic medical assessments for children, and enhanced provision of aftercare for high-risk families through a collaborative community based process.

- **COMMUNICATION, CAPACITY AND RESOURCES FOR CHILD PROTECTIVE SERVICES**

A recurring theme found in case reviews and subsequent discussions addressed the workload, training, experience level and supervisory support within Department for Community Based Services. While high quality casework, and particularly quick response times, was noted in panel discussions, case reviews prompted other discussions around the high worker caseloads, inexperience at the worker level, high turnover of front line workers, and increased need for supervisory support and consultation -- all issues that impact the capacity to fully address the needs of these families. Preliminary observations of the cases suggest a need for far more informed risk assessments of families. These assessments should demonstrate

competent assessment of child development, family violence, behavioral health and substance abuse problems. The panel intends to examine this need more carefully in subsequent reviews.

These issues were identified at various points in the system, including inconsistencies in acceptance of reports, screening out of reports, communication delays, provision of ongoing services, and handling of denials of court petitions. The Department, independent of the panel, has also identified these as agency needs. The panel will continue to review these issues, gather trend data and develop a process to receive caseload and staff training information from DCBS.

- **COORDINATION WITH OTHER RELATED PROGRAMS AND SYSTEMS**

There are a number of assets in existing Kentucky statutes and regulations which will enhance the panel in achieving its goal of prevention and systems improvement. This includes the statutory requirement for the coroner led multidisciplinary investigative response to unexpected child death, the State Child Fatality Team administered by the Kentucky Department for Public Health, and the completion of child fatality and near fatality internal reviews by DCBS on cases with prior child protective services involvement. These initiatives are not duplicative, but enhance the systemic response to fatalities and near fatalities. When carried out collaboratively, these initiatives can greatly complement the work of the panel. A protocol and process will be developed whereby cases from these efforts can be referred to the panel for review, as indicated in statute. As part of its review, the panel will assess existing practice and recommend system improvements when necessary. In addition, trend data that may be helpful in evaluating the impact of system changes may be available from the Kentucky Injury Prevention and Research Center, the Kentucky Violent Death Reporting System, Kentucky All Schedule Prescription Electronic Reporting, and the Kentucky Health Information Exchange. The panel will need to develop specific protocol for coordinating efforts and exchange of information between all these existing entities and effort.

FUTURE FOCUS

The upcoming year will require defining and expanding the panel's capacity with regard to administrative support, specifically identifying personnel dedicated to analyzing, sorting and summarizing large volumes of child fatality and near fatality data, and obtaining the resources necessary to provide that support.

Additionally, protocol for case discussion will be further developed including processes for documenting case reviews, tracking and monitoring case information, and "closed session" operation while meeting the public's expectation of transparency and maintaining the appropriate level of confidentiality.

The panel also wants to address the need for systems collaboration ensuring that all involved entities are sharing information as efficiently as possible and continue to enlist the assistance of national organizations involved with child abuse prevention and study.

The panel takes seriously the mandate to carefully examine all records available to it in order to identify the critical contributions to child fatalities and near fatalities. In order to carry out the full burden of this mandate, the members need funded administrative support. It is the panel's view that recommendations for changes in the various systems that interface with child protective services will require diligent data collection, systematic analysis, and consensus among panel members. Due diligence will more likely lead to supportable recommendations that can be implemented by state and other agencies.