CHILD FATALITY & NEAR FATALITY EXTERNAL REVIEW PANEL

2014 ANNUAL REPORT

EXECUTIVE SUMMARY

In 2013, the General Assembly enacted KRS 620.055, which created the Child Fatality and Near Fatality External Review Panel. The statute tasks the independent, multi-disciplinary panel with reviewing official records and information relating to child fatalities or near fatalities and analyzing medical, psychosocial, and legal circumstances to recognize systemic defects and recommend systemic improvements.

The Panel consists of a diverse team of professionals from across the state, including members from medical, social services, mental health, legal, and law enforcement fields. The Panel's enabling statute requires quarterly meetings for case reviews and recommendation discussions, but the Panel has chosen to meet bimonthly in order to enhance its ability to review cases and documents. The Panel reports annually to the Governor, the Secretary of the Cabinet for Health and Family Services, the Chief Justice of the Supreme Court, the Attorney General, and the director of the Legislative Research Commission for distribution to the Health and Welfare Committee and the Judiciary Committee by December 1st.

There were more than 40 recommendations discussed and considered by the Panel for this year's report. The recommendations that follow were considered critical to include this year either because the Panel accumulated sufficient supporting data to support the recommendation or the recommendation was deemed a pressing systemic issue. The Panel fully recognizes this report is not inclusive of every concern or issue identified in Panel case reviews. On the contrary, there is much more to be done. The Panel is still early in its work and understands the need to be deliberate and thoughtful in its presentation of recommendations. The Panel members encourage all citizens to read this report and to visit the Justice Cabinet's website (http://justice.ky.gov/Pages/Reports.aspx) to read the Panel's meeting minutes for a greater understanding of its work. The Panel's 2014 recommendations are:

Bed Sharing/Unsafe Sleep

- The Panel recommends CHFS develop a state-wide public awareness campaign in collaboration with medical professionals, child care providers, parenting programs, early child home visiting programs, and other agencies. The information should provide tools for community professionals to discuss safe sleep with new parents, including the dangers of bed sharing, particularly when the caregiver may be impaired by exhaustion or sedating substances. When working with families of infants, staff of DCBS should include information on the dangers of bed sharing and impaired bed sharing—particularly during home visits with parents of infants;
- The Panel recommends all birthing hospitals develop policies and practices to model safe sleep in their newborn, Neonatal Intensive Care Units (NICU), and pediatric care areas;

Substance-Related Impaired Caregivers

- The Panel recommends development of a protocol for standardized, universal administration of drug tests of caregivers when children die unexpectedly in their care;

Mental Health

- The Panel recommends CHFS work to improve access to quality structured mental health assessments for caregivers of children in families found to be high risk, so mental health and substance abuse problems can be identified and addressed early in order to diminish the number of fatal or near-fatal events;

Abusive Head Trauma

- The Panel supports multi-tiered prevention programming for abusive head trauma to be provided to parents by birth hospitals, healthcare providers, and home-visiting programs that include:
  - the dangers of shaking an infant or young child;
  - how to deal with infant crying, including soothing techniques and permission for caregivers to step away and take a break when feeling frustrated;
  - choosing safe caregivers for infants and young children;
  - having an action plan for caregivers in the event of escalating frustration;
- The Panel supports ongoing education targeted to all professionals who work with children, as well as the community at large, about mandatory reporting requirements and recognition of early warning signs of child physical abuse, including specific education about bruising in infants;

Coordinating Investigations

- The Panel recommends law enforcement explore uploading information from family and district court protective and restrictive orders into the law enforcement database when those orders limit an adult's visitation opportunities with a child;
- The Panel recommends DCBS, law enforcement, and coroners (in fatality cases) conduct joint investigations in cases where a child suffered a fatality or near fatality and there is reasonable suspicion to believe the cause may have involved abuse and/or neglect;

Wrap-around Services

- The Panel recommends birthing hospitals assure linkage of high-risk infants to a medical home and needed community services prior to discharge;

Neonatal Abstinence Syndrome and Child Maltreatment

- The Panel recommends CHFS develop best practice guidelines for recognition of Neonatal Abstinence Syndrome (NAS), including discharge guidelines for affected infants, and distribute them to all birthing hospitals;

Open Courts

- The Panel supports the concept of opening dependency, neglect, and abuse court proceedings for purposes of transparency, accountability, and systems improvement; and

DCBS Workloads

- The Panel recommends CHFS conduct a workload study focusing on DCBS frontline workers, including weighting complexity of cases, and the impact of workloads on quality service delivery.

2014 IN REVIEW

As the Panel began drafting its first annual report in 2013, members recognized the need for data to support recommendations the Panel may propose. What began as the members' general observations culminated in a request for designated funding to support case review, data collection analysis. That funding request was fulfilled by the biennial budget as a $420,000 appropriation for FY 2014 and 2015. This appropriation has allowed the Panel to identify personnel priorities and plan for organized data collection.

A subcommittee of Panel members including Dr. Ruth Shepherd, Robert Walker (whose term ended June 30, 2014), Dr. Melissa Currie, and Joel Griffith was formed to develop a data collection tool that could be applied to all cases reviewed by the Panel. A final draft was presented to the Panel at its September meeting. The data collection tool will provide consistency in interpreting the volumes of data being

gathered. This data tool is also being loaded into the SharePoint website to facilitate Panel members' abilities to add information as they receive it. The tool is flexible with the opportunity for expansion as need dictates.

The SharePoint website, utilized by the Panel to review cases and exchange information, was upgraded by the Commonwealth Office of Technology to allow for more efficient establishment of case files, further development of categories of data, and better access to data extraction.

The Panel further defined its autonomy and addressed concerns of transparency with its proceedings in 2014. A memorandum of understanding (MOU) with the Justice and Public Safety Cabinet was instituted in May. As delineated in the MOU, the Panel operates as an independent entity attached to the Justice and Public Safety Cabinet solely "for staff and administrative purposes." This MOU sets forth the formal agreement governing the manner in which potential conflicts of interest and other problems that could arise within this structure will be avoided. There is also potential for real or perceived conflicts of interest within the Panel. Due to the unique composition and responsibilities of the individual members of the Panel, it is likely Panel members may have direct or indirect connections with one or more state agencies. All Panel members have agreed to sign Conflict of Interest disclosure forms. This form is designed to enhance the transparency of the Panel by publicly disclosing any relationship, financial interest, or business affiliation of Panel members that could be perceived to result in a conflict of interest.

Panel funding was first available July 1, 2014. Before the funding was procured, Panel members began preliminary work to initiate the hiring processes for the essential staff, including establishing a Panel staffing subcommittee consisting of the Panel chair, Roger Crittenden, Dr. Melissa Currie, and Jenny Oldham. As a result, the Justice Cabinet hired an attorney in September who was assigned to the Panel. A data analyst was another key position needed to fulfill the mission of the Panel, and the committee opted to craft a memorandum of agreement (MOA) with the University of Louisville to utilize forensic medical analysts on staff there to conduct preliminary case analysis work. Hiring contract staff is a first step that will provide the opportunity to better understand the volume of analytical work required before the Panel considers hiring a permanent position.

For review in 2014, the Panel received 115 FY 2013 cases and one case from FY 2010 from the Department of Community Based Services (DCBS). All information was un-redacted and was uploaded to the SharePoint website by DCBS. Although the Panel exceeded the number of statutorily required meetings in 2014, the Panel was only able to review a portion of the total cases provided by DCBS due to time and resource limitations. Approximately 20 cases (four to five per group) per meeting were assigned for discussion to the four groups of Panel review members. Time constraints, criminal court circumstances, or Panel requests sometimes tabled case reviews until subsequent meetings. Fifty-six cases were discussed in meetings this year. Two cases were assigned for all Panel members to allow the opportunity for everyone to engage in in-depth review of the same case. The Panel is confident that with the addition of forensic analysts, and by continuing to exceed the number of statutorily required meetings, the members will increase the number of cases reviewed in 2015.

Per statute, the Legislative Program Review and Investigations Committee conducted its first annual evaluation of the Panel in 2014. That report was presented to the Joint Health and Welfare Committee July 1 and proffered three major conclusions:

- the External Child Fatality and Near Fatality Review Panel is complying with its governing statutes;
- the Panel appears to be unique in terms of its organizational structure and mission; and

- the $420,000 annual appropriation to the Panel, to be used primarily for staff, should allow the Panel to review cases and make recommendations more effectively.

The Panel experienced a smooth transition at the end of the fiscal year as the statutorily required staggered terms of service necessitated replacement of some members. The Panel has also experienced some attrition as members have resigned or retired. By statute, many of the positions on the Panel require the member to be actively employed in a particular profession or with a specific organization or agency. The appointing agencies have been timely in supplying nominees for the vacant positions and naming individuals to serve. Current Panel membership is listed in Appendix A.

FOLLOW UP TO 2013 REPORT

In its inaugural report, presented in December 2013, the Panel reported several preliminary issues of concern for the children of Kentucky. In this year's review of the FY 2013 cases, the Panel found each of those preliminary issues of concern is still at issue in child safety. This year, the Panel has chosen to make specific recommendations on several of the issues first raised in the 2013 report and the 2013 meeting discussions. Last year's unresolved issues have been integrated into the Panel's priorities for this year:

- drug testing caregivers upon the unexpected or unexplained fatality or near fatality of a child in their care;
- educating the public on the dangers of bed sharing;
- sharing information between DCBS and law enforcement;
- requiring law enforcement scene investigations when children are found with fatal or near fatal injuries;
- the importance of administering mental health assessments;
- opportunities for prevention of abusive head trauma;
- the adverse effects of inadequate staffing numbers at DCBS; and
- the need for creating a system of wrap-around services for low-functioning and high-risk families.

One of the Panel's recommendations in the 2013 report was codified into statute by the General Assembly in HB 157, passed in 2014. This new law requires the State Board of Medical Licensure to include in its continuing medical education requirements training on the recognition and prevention of pediatric abusive head trauma for pediatricians, radiologists, family practitioners, and emergency medicine and urgent care physicians.

CASE REVIEW PROCESS

All cases from FY 2013 were uploaded, un-redacted by DCBS staff, onto the secure SharePoint website. Cases were loaded chronologically as DCBS investigations were finalized. The summary sheet for demographic data on each case, developed and implemented by the Panel last year, has been expanded to become the data collection tool. This tool has just been completed and is being adapted to the SharePoint site. The data tool is included as the first page of each case file.

The SharePoint site is continually being modified to better capture the data collected from case review and store it for more efficient analysis.

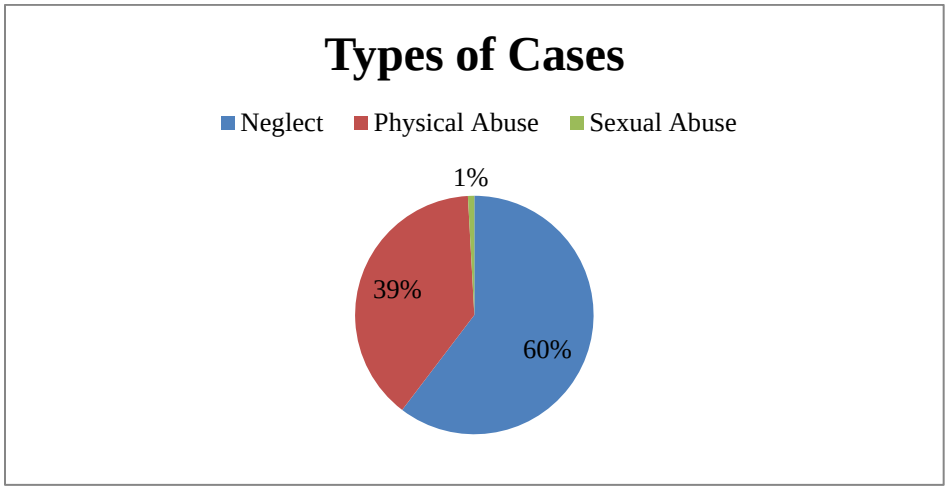
DATA COLLECTION

The Panel continued the focus on data collection to support the development of evidence-informed recommendations. Because the data tool was created after the vast majority of this year's cases[1] were reviewed and discussed, the Panel has limited data to report in support of its findings this year. Panel staff undertook a basic system of coding the FY 2013 cases and the data collected will be utilized in this report. The data serves as a guide, offering at least a glimpse of the issues found in the 2013 cases. By its 2015 annual report deadline, the Panel expects to have a more comprehensive set of data from the FY 2013 and 2014 cases. That data will be collected by the Panel members and/or staff throughout 2015.

The data proffered this year comes as a result of Panel staff's statistical review of all 116 cases made available to the Panel by DCBS, which are represented in the charts, graphs, percentages, and numbers that follow. These statistics include all cases provided to the Panel, including those substantiated and unsubstantiated by DCBS. The cases were coded for several factors, including cause of fatality or near fatality, whether impairment of a caregiver was an issue, age of victim, relationship of perpetrator to victim, and prior medical history.

Demographics

Of the 116 cases made available to the Panel, 43 were fatalities cases and 73 were near fatalities cases. Of these incidents, 39 had no prior DCBS history and 77 had prior DCBS involvement. Boys represented 63 cases and girls represented 53 cases. Seventy incidents were categorized as neglect, 45 were categorized as physical abuse, and one was categorized as sexual abuse. Eighty-eight of the children were Caucasian, 19 were African-American, seven were identified as of two or more races, and two were identified as Hispanic.



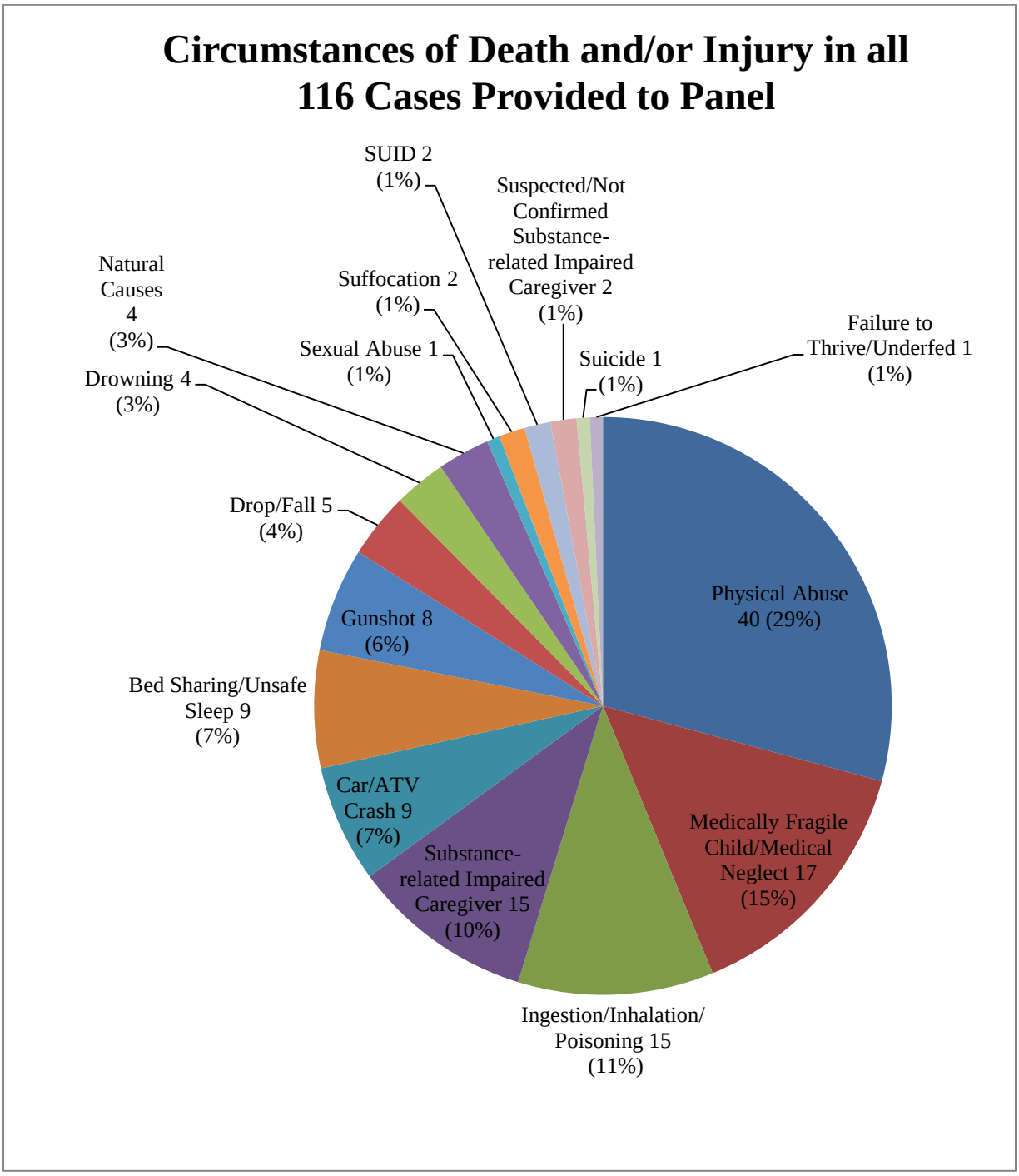
[1] The Panel chose to use the term "case" because many files involved more than one child. Not all children involved were "victims" in the generally recognized sense of the word. The Panel acknowledges the term "case" does not do justice to any individual child involved in this report, but was at a loss for a more respectful term.

Circumstances of Death and/or Injury in All 116 Cases Provided to Panel

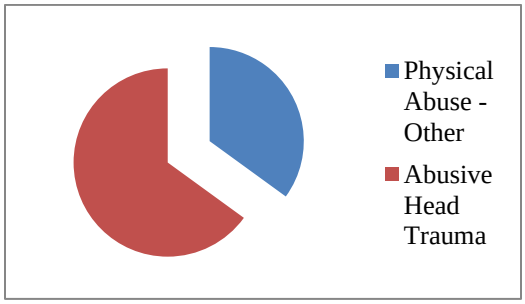
The following two charts portray the circumstances surrounding the death and/or injury in each of the 116 cases provided to the Panel for review. Each case is represented at least once in the charts below. Some cases are represented more than once. For example, several cases fall under the categories of Substance-Related Impaired Caregiver and Car/ATV Crash; likewise, several cases fall under both Bed Sharing/Unsafe Sleep and Substance-related Impaired Caregiver.

Circumstances Surrounding Incident	
Physical Abuse (including Abusive Head Trauma)	40
Medically Fragile Child/Medical Neglect	17
Ingestion/Inhalation/Poisoning	15
Substance-related Impaired Caregiver	15
Car/ATV Crash	9
Bed Sharing/Unsafe Sleep	9
Gunshot	8
Drop/Fall	5
Drowning	4
Natural Causes	4
Suffocation	2
Suspected/Not Confirmed Substance-Related Impaired Caregiver	2
Sudden Unexplained Infant Death (SUID)	2
Sexual Abuse	1
Suicide	1
Failure to Thrive/Underfed	1

Some cases are represented more than once.
Each case is represented at least once.



Twenty-six of the forty cases (65%) coded as "Physical Abuse" involved abusive head trauma. Below is a chart showing those numbers in proportion.



RECOMMENDATIONS

BED SHARING/UNSAFE SLEEP

BED SHARING/UNSAFE SLEEP				
	BED SHARING		UNSAFE SLEEP	
	Age Range	Number	Age Range	Number
TOTAL	7 days - 4 months	8	4 - 7 months	2
FATALITIES	7 days - 4 months	7	4 - 7 months	2
NEAR FATALITIES	2 months	1	n/a	0

Either bed sharing or unsafe sleep arrangements were factors in nine of the 22 fatalities (41%) involving children in their first year of life. Seven fatalities involved sharing a bed or other sleep surface; bed sharing resulted in one near fatality. Five of the seven (71%) bed or sleep surface sharing fatalities involved an impaired adult sleeping in bed with an infant. Substances included marijuana (two cases), oxycodone (one case), and alcohol (three cases). Other substances may have also been involved but were not confirmed. Unsafe sleep was a factor in two cases, which involved a seven-month-old medically fragile infant placed on a pillow in a bassinet and a four-month-old infant sleeping in a car seat.

Specific Recommendations Related to Bed Sharing and Unsafe Sleep

Panel members are concerned there is not sufficient adult education on safe sleep, and particularly the dangers of bed sharing. Healthcare providers should discuss safe sleep with parents of newborns, including the dangers of bed sharing, particularly when the caregiver may be impaired by exhaustion or substances with sedating effects. Parent education on safe sleep should be consistently provided in every birthing hospital; in addition, birthing hospitals should also develop policies to model safe sleep in their newborn and NICU care units. Education on safe sleep should take place in hospitals before newborns are discharged, and at key stages of the infant's development, e.g. during office visits with the child's healthcare provider, and encounters with other agencies such as child care, home visitors, parenting classes, and other community resources. The Panel recommends DCBS include information on the dangers of bed sharing and impaired bed sharing in any cases involving infants—particularly during home visits. Additionally, Panel members are concerned the general public is not aware of the dangers of bed sharing, especially when the caregiver is impaired. The Panel recommends a state-wide public awareness campaign, led by CHFS in collaboration with medical professionals, highlighting the dangers of bed sharing and bed sharing while impaired. The Panel endorses and recommends widely promoting the materials from the National Safe Sleep Campaign developed by the National Institute of Child Health and Human Development (NICHD), available at www.nichd.nih.gov. The NICHD document "What Does a Safe Sleep Environment Look Like?" is included as Appendix B.

SUBSTANCE-RELATED IMPAIRED CAREGIVERS

SUBSTANCE-RELATED IMPAIRED CAREGIVERS		
	Age Range	**Number**
TOTAL	7 days - 17 years	15
FATALITIES	7 days - 2 years	8
NEAR FATALITIES	8 months - 17 years	7

In determining the incidence of substance-related impaired caregivers, the Panel considered those who: a) were found to be under the influence of alcohol or drugs via an administered test at the time of the incident or b) admitted impairment. Substance-related impaired caregivers, as defined by those factors, were present in 15 of 116 cases provided to the Panel, or 13%. Eight substance-related impaired caregiver cases were fatalities. Seven were near fatalities. Five of the fatalities were the result of bed sharing. One involved abusive head trauma of an infant; one was Sudden Unexplained Death in Infancy (SUDI). Driving under the influence was found to be a substantial issue, with 35% of situations involving an impaired caregiver being related to vehicle crashes. All seven near fatalities in this category were caused by car crashes with impaired drivers. The following substances were involved in the caregivers' systems: alcohol (seven cases), marijuana/THC (five cases), benzodiazepines (four cases), methamphetamines (two cases), opiates (four cases), cocaine (one case), and amphetamines (one case). Some caregivers were under the influence of more than one substance.

The incidence of impairment among caregivers is presumably much higher than the Panel is able to document. Drug tests were not administered in at least 95 cases received by the Panel. In several of the cases mentioned above, no drug test was administered. Instead, the caregivers admitted substance abuse. Because there is no clear protocol for gathering data on substance-related impaired caregivers, the Panel is unable to report precisely how much of a factor substance abuse is for child fatalities and near fatalities in Kentucky.

The Panel anticipates a more accurate representation of Kentucky data would demonstrate a significantly stronger correlation between child death and near fatalities as related to substance-impaired caregivers. Data provided by the Cabinet for Heath and Family Services indicates 55% of all substantiated incidents of maltreatment involve substance abuse as a contributing factor (http://www.pcaky.org). The National Center on Substance Abuse and Child Welfare indicates up to two-thirds of families in the child welfare system are impacted by substance abuse (https://www.ncsacw.samhsa.gov). In a report from the Virginia State Child Fatality Review Team, 26% of all co-sleeping infant deaths involved substance-impaired caregivers (http://www.vdh.virginia.gov/medExam). Given the prevalence of substance impairment found in other data sources, it is reasonable to conclude the actual incidence in Kentucky is much higher than documented in the cases received by the Panel. More accurate identification of the actual incidence will involve the utilization of improved screening and investigation techniques at the time of the incident.

Specific Recommendation Related To Substance-related Impaired Caregivers

As substance abuse was among the most common factors identified, the Panel recommends the development of protocol for standardized, universal administration of drug tests of caregivers when children die unexpectedly in their care. This protocol should be included as an element in the thorough, timely and multidisciplinary investigation of all fatal or near fatal incidents. It will be necessary for the protocol to be crafted thoughtfully to assure consideration is given to the following issues: 1) the need to avoid racial, ethnic or economic bias in administration of drug tests; 2) recognition of and sensitivity to

the needs of the grieving family; and 3) the recognition that the ultimate goal is treatment for the potential chemically dependent family member.

The standardized administration of drug tests is a systems improvement effort aimed at enhanced investigation and assessment after an incident has occurred. It is also recognized by Panel members that public education, awareness, early intervention, and treatment are the solutions to the issue of substance-related impaired caregivers. The implementation of more prevention-focused recommendations will ultimately result in fewer child fatalities and near fatalities in the Commonwealth.

STRUCTURED MENTAL HEALTH AND SUBSTANCE ABUSE ASSESSMENTS

The fatalities and near fatalities reviewed typically involved not just a single episode of impairment, but recurring, ongoing patterns where the parent was too impaired to properly care for the child. "Impairment" in this context is referring to cognitive, mental health, and substance-related impairment. The Panel repeatedly discussed how such scenarios demonstrated the need for structured assessments for mental health issues and substance abuse issues in high-risk families, as well as the lack of resources available to perform those assessments. Particularly in cases involving very young children, early and accurate identification of mental health or substance abuse issues in the parents might have led to different management and/or monitoring of the case. Lack of professionals who are adequately trained to administer these structured assessments was common. In addition, even in situations where mental health and substance abuse issues were identified, there was limited ability to access or to afford treatment for these conditions, which might have improved the opportunities to stabilize the social situation without harm to the child.

While recent reforms made within the mental health delivery system and the expansion of Medicaid coverage for substance abuse treatment are encouraging developments, there needs to be diligent focus on increasing the capacity of the system to provide these critical specialized assessments.

Specific Recommendations Related to Mental Health and Substance Abuse Assessments

The Panel recommends CHFS take steps to increase the number of trained providers able to complete structured and comprehensive assessments for mental health and substance abuse. These assessments should be timely, accessible, and affordable. Further, the state should develop a centralized triage and access point to enroll persons who are identified as having mental health or substance abuse issues into appropriate treatment programs, prioritizing those who are parenting young children. This process should include structured protocol for case collaboration with DCBS child welfare staff when child safety is identified as a concern.

ABUSIVE HEAD TRAUMA

ABUSIVE HEAD TRAUMA		
	Age Range	**Number**
TOTAL	1 month - 4 years	26
FATALITIES	2 months - 1 year	5
NEAR FATALITIES	1 month - 4 years	21

Kentucky children suffering from abuse or neglect are more likely to die of abusive head trauma than from any other cause. Sixty-three percent of the cases coded as "Physical Abuse" involved abusive head trauma. Abusive head trauma constituted 22% of all fatalities or near fatalities made available to the

Panel this year. Children in their first year of life represented nineteen of the abusive head trauma cases (73%). Eighteen of the 26 perpetrators (63.6%) were either the child's father or the mother's paramour. Four perpetrators were unknown; one perpetrator was a very young parent; and two mothers reported drops and/or falls found inconsistent with the child's injuries by medical professionals. Evidence of previous physical abuse is often seen in children who are victims of abusive head trauma. Recognition of this evidence allows us to appreciate the long-term escalation of violence often present in such scenarios. As such, there is the need for comprehensive programming that helps prevent not only abusive head trauma, but all forms of physical abuse in infants and children. Published scientific data supports efforts to prevent child physical abuse, and specifically abusive head trauma, by educating parents and caregivers of infants and young children about a number of issues. Public health data suggests educational programming is most effective when provided in multiple "doses" by a variety of sources that are trusted by parents. Consequently, the Panel agrees such educational efforts are best undertaken by a variety of professionals who interface with families. The issues to be addressed in such educational programming were identified in varying degrees in the cases reviewed.

Specific Recommendations Related to Abusive Head Trauma

The Panel supports multi-tiered prevention programming for abusive head trauma/physical abuse to be provided to parents by birth hospitals, healthcare providers, and home-visiting programs, including a combination of age-appropriate information about:

- the dangers of shaking an infant or young child;
- coping with infant crying, including soothing techniques and permission for caregivers to step away and take a break when feeling frustrated;
- choosing safe caregivers for infants and young children;
- having realistic expectations for children's behavior at various developmental stages, specifically involving infant crying and toilet training in toddlers and young children;
- safe and effective discipline techniques for young children; and
- having an action plan for caregivers in the event of escalating frustration.

The Panel also supports ongoing education targeted to all professionals who work with children, as well as the community at large, about mandatory reporting requirements and recognition of early warning signs of child physical abuse, including specific education about bruising in infants.

Finally, the Panel recognizes many of its recommendations in other categories will indirectly help prevent abusive head trauma by addressing the underlying biopsychosocial contributors to violence against children, including substance abuse, neonatal abstinence syndrome, undiagnosed/untreated mental illness, and family violence.

COORDINATING INVESTIGATIONS

In its previous report, the Panel identified communication between law enforcement, DCBS, and the court system as an area of concern. The Panel reviewed cases this year in which law enforcement officers placed children with parents who DCBS had specifically mandated were not to have visitation rights. Kentucky statutes require DCBS and law enforcement to conduct child sex abuse investigations jointly; similarly, statutes require the sharing of information during unexpected child death investigations. However, the Panel reviewed cases where DCBS and law enforcement could have worked together to jointly investigate the scene, but did not.

Specific Recommendations Related to Coordinating Investigations

DCBS and the law enforcement entity in control of the LINK (Law Information Network of Kentucky) database should begin discussing the incorporation of information found in family and district court protective and restrictive orders into the law enforcement database. Document imaging may be unnecessary; DCBS could provide relevant portions of family and district court protective and restrictive orders to law enforcement so only the most pertinent information is entered into LINK.

The Panel has noted in several cases questioning performed by DCBS personnel days after a child fatality or near fatality has often revealed potential abuse or neglect in cases where no scene investigations were performed. Therefore, the Panel recommends implementation of an across-the-board scene investigation protocol requiring full law enforcement investigations at any scene of a child fatality or near fatality where there was reasonable suspicion to believe the cause may have involved abuse and/or neglect. The Panel recommends a law enforcement protocol requiring officers conducting those scene investigations to contact DCBS to coordinate investigations. Additionally, coroners should make appropriate contacts to DCBS and law enforcement in cases where they are involved. There were a number of cases reviewed by the Panel where interviews and investigations between law enforcement, DCBS, and coroners were undertaken collaboratively, and the communication produced clear benefits in those cases.

WRAP-AROUND SERVICES FOR HIGH-RISK FAMILIES

As the Panel reviewed cases, particularly infant deaths, it became apparent many families presented with identified risk factors but no community supports were in place to address their needs. If support services and follow-up were in place for high-risk families, some adverse events may have been prevented. While the Panel acknowledges the reviews were retrospective and the risks may not have been as obvious in real time, the lack of a system of services and supports for high-risk families of newborns, especially those who have risks but do not meet criteria for DCBS interventions, was repeatedly noted.

Specific Recommendations Related to Wrap-around Services

The American Academy of Pediatrics (AAP) recommends **all** newborns have a follow-up visit by a healthcare professional within 48-72 hours after discharge, but in Kentucky, most newborns are discharged with only instructions to call a doctor for an appointment. Families may have trouble finding doctors who are accepting new patients, will accept their insurance, or are accessible via their method of transportation. For newborns who have been identified as high risk for readmission (including those with feeding problems, elevated bilirubin levels, drug-exposed, family/social instability, and neonatal abstinence syndrome), the Panel recommends birthing hospitals assure the infants' linkage to a medical home (primary medical provider or office/practice) and needed community services prior to discharge. Such linkage includes actually making an appointment for the newborn's follow-up with a medical home, identifying and addressing any barriers to the family attending that appointment, and establishing communication protocol with the medical home so if a high- risk infant does not show for follow-up, the office will notify the hospital social worker to contact the family and make sure the infant is not in danger. Hospitals should link families with needed community services such as WIC, HANDS, and other services as indicated.

NEONATAL ABSTINENCE SYNDROME AND CHILD MALTREATMENT

Wrap-around services are particularly critical for infants suffering from Neonatal Abstinence Syndrome (drug withdrawal after birth when the mother takes addictive drugs during the pregnancy). Not only are these infants at high risk of readmission to the hospital, but they are also at high risk to die from child

abuse in the weeks after discharge from the hospital. In cases reviewed by the Panel, these infants showed up in the deaths as victims of abusive head trauma cases or infant death from bed-sharing, often with an impaired parent. These outcomes are not surprising, because infants who have experienced withdrawal continue to have irritability and feeding problems after going home, and are typically discharged at the peak time normal babies cry more (4-6- weeks of age).

Specific Recommendations Related to Neonatal Abstinence Syndrome and Child Maltreatment

Families must be prepared to care for these infants and must have training before leaving the hospital including abusive head trauma prevention, ways to calm an infant, and an appropriate safe sleep environment. It is also important the mother/caregiver get into treatment, as after the birth, the mother may be relapsing, have no coverage for treatment, or otherwise be unstable. The key to keeping the infant safe is to provide treatment and supports for the mother. Providers must be aware of these increased risks and be certain the transition from the hospital to community supports assures these infants get to their medical home. Providers must also assure the mother/family accesses follow-up from community services as planned. Emergency departments must be alert to the possibility any infant presenting with irritability has a high risk to be in a potentially dangerous situation, and they can now look up the prescription drug use history of the mother in the Kentucky All Schedule Prescription Electronic Reporting System (KASPER), which tracks controlled substance prescriptions dispensed within the state. The Panel recommends CHFS, in collaboration with medical professionals, develop best practice guidelines for recognition of Neonatal Abstinence Syndrome, including discharge guidelines for affected infants, and distribute them to all birthing hospitals.

OPEN DEPENDENCY, NEGLECT, AND ABUSE COURTS

The Panel endorses the concept of opening dependency, neglect, and abuse court proceedings to the public. Because the Panel's mission is to protect the children of Kentucky from death or serious injury at the hands of another, and because the Panel understands all government and court systems and personnel are fallible, the Panel supports opening these proceedings to increase public oversight of those adults tasked with protecting the most vulnerable citizens of this Commonwealth. Although many hold fast to the notion that closed proceedings are essential to the best interests of our children, as a result of its case review process, the Panel believes closed door hearings can mask systemic defects. Many states have opened child welfare proceedings. To the Panel's knowledge, no state that has opened child welfare proceedings has later chosen to close those proceedings as a result of a decrease in child safety. Our General Assembly has considered the issue of opening juvenile proceedings in multiple legislative sessions throughout the past few years. Most recently, in 2014, a bill that would have opened some juvenile proceedings passed both Chambers in different forms, but there was no final concurrence.

Specific Recommendations Regarding Open Courts

The Panel supports opening dependency, neglect, and abuse proceedings for purposes of transparency, accountability, and systems improvement. The Panel expresses no opinion on termination of parental rights proceedings, juvenile status offense proceedings, or juvenile public offense proceedings. The Panel agrees the Commonwealth will act in the best interests of the children of Kentucky by opening dependency, neglect, and abuse proceedings and believes increased transparency will provide useful information for process improvements.

Additionally, the Panel recommends the Administrative Office of the Courts develop and administer training, conducted by medical professionals, on abuse and neglect for Family and District Court Judges and County Attorneys and their staffs regardless of whether an open courts bill is passed.

DCBS WORKLOADS

A consistent theme throughout many of the Panel fatality and near fatality reviews was the impact of workload on DCBS staff. While quality case work was noted often, there were also concerns identified regarding the timeliness and quality of casework. This casework weakness generally led to discussion of high caseloads, staff turnover and burnout, worker inexperience, and lack of training. The issue of workload is complex and involves obvious factors such as the need to increase the number of child welfare staff. More subtle issues involve the changing nature of the child welfare caseload, specifically the increasing complexity of the families and children coming into the child welfare system. This issue is further exacerbated by an increase in the number of child abuse and neglect reports being received by the Cabinet.

In August 2014, the Colorado Department of Human Services released a Child Welfare County Workload Study conducted by their State Auditor. Select Panel members are aware that the Colorado study addressed issues of workload, not just caseload, and included the complexities of the cases, not just numeric caseloads. This type of study would be beneficial to addressing workload issues in Kentucky.

Specific Recommendation Related to DCBS Workloads

While the Panel has not documented a direct correlation between DCBS frontline worker workload and the incidence of child fatalities, it is clear the issue of workload does impact the quality of service delivery and deserves further review. The Panel will continue to study this issue, but additionally recommends the Cabinet undertake a workload study to better understand the correlation between workload and quality of service.

FUTURE FOCUS

Improved data collection will be key to honing future recommendations from the Panel. The forensic medical analysts now under contract from the University of Louisville will be providing case review summaries to the Panel members allowing them the opportunity to discuss more cases in greater detail at their regularly scheduled meetings.

The analysts' progress will be monitored closely to determine if contracting the initial case review is the best option versus hiring a fulltime case analyst. The contractual relationship between the Panel and the analysts is an effort to learn the actual scope of work involved in thoroughly reviewing and summarizing each case. The Panel may learn that conducting case reviews properly requires one full-time person, more than one person, or a combination of full time and contractual resources.

The Panel is taking advantage of a program available through the Association of Independent Kentucky Colleges and Universities (AIKCU) for the 2015 spring semester by providing a stipend to a student earning college credit who will work as an intern for the Panel. Anticipated duties of that student intern will be related to data collection and organization.

The SharePoint site is being updated and will be able to collect and manage case data to some extent throughout the next year. Panel staff will have the ability to run reports of the data collected. Once the Panel determines the extent of information SharePoint can produce, they will be better positioned to determine whether hiring or contracting for data analyst skills is necessary.

Initial projections are to complete all case reviews and data analysis by July 2015 for FY 2014. Once FY 2014 case information has been categorized via the newly developed data tool, the Panel hopes the

forensic analysts are able to begin to review FY 2013 cases and collect that data in the same format so the Panel may identify long-term trends related to child fatalities and near fatalities.

2014 RECOMMENDAITONS BY AGENCY/ACTOR

Administrative Office of the Courts

- Develop and administer training conducted by medical professionals to Family Court and District Court Judges on abuse/neglect.

Cabinet for Health and Family Services

- Develop, in collaboration with medical professionals, a state-wide public awareness campaign highlighting the dangers of bed sharing and impaired bed sharing.
- Include information on the dangers of bed sharing and impaired bed sharing in any home visits with parents of infants.
- Work to improve access to quality structured mental health assessments for caregivers of children in families found to be high risk.
- Develop best practice guidelines for discharge of infants with Neonatal Abstinence Syndrome and distribute them to all birthing hospitals.
- Develop a workforce study to look at workloads for DCBS workers.

Healthcare Providers

- Healthcare providers should discuss safe sleep with parents of newborns, including the dangers of bed-sharing, particularly when the caregiver may be impaired by exhaustion or sedating substances.
- Birthing hospitals should develop policies and practices to model safe sleep in their newborn and NICU care units.
- Birthing hospitals should assure linkage of high-risk infants to a medical home and needed community services prior to discharge. Make appointments for newborn's follow-up with a medical home, identify and address any barriers to the family's attendance at that appointment, and establish communication protocol with the medical home so that if a high-risk infant does not show for follow-up, the office will notify the hospital social worker to make sure the infant is not in danger.
- Hospitals should link families with needed services such as WIC, HANDS, and other community services as indicated.

Law Enforcement

- Develop a protocol to administer across-the-board drug testing of caregivers in cases where a child suffered an unexpected fatality or near fatality.
- Develop a process for Law Enforcement to upload District and Family Court preventive and restrictive orders into LINK.
- Conduct scene investigations in cases where a child suffered a fatality or near fatality and there is reasonable suspicion to believe the cause involved abuse and/or neglect.

General Assembly and Supreme Court

- Consider authorizing legislation and Supreme Court rule change to open dependency, neglect, and abuse cases in Kentucky Courts.

Prosecutors

- Develop and administer training conducted by medical professionals to County Attorneys and staff on abuse/neglect.

APPENDIX A

Current Panel Membership

Rep. Tom Burch, Kentucky House of Representatives, House Health and Welfare Committee, Chair

Dr. Tracey Corey, Kentucky State Medical Examiner

Roger Crittenden, Chair, Retired Franklin Circuit Judge

Dr. Melissa Currie, University of Louisville School of Medicine, Child Abuse Pediatrician

Sharon Currens, Kentucky Coalition Against Domestic Violence, Executive Director

Sen. Julie Denton, Kentucky Senate, Senate Health and Welfare Committee, Chair

Nathan Goins, Citizen Foster Care Review Board Executive Committee, Chair

Joel Griffith, Prevent Child Abuse Kentucky

Judge Brent Hall, Hardin County Family Court

Comm. Teresa James, Department of Community Based Services

Nicky Jeffries, CASA of Kenton and Campbell Counties, Executive Director

Maj. Eddie Johnson, Kentucky State Police Forensic Central Laboratory

Dr. Blake L. Jones, University of Kentucky College of Social Work Training Resource Center

Dr. Stephanie Mayfield, Kentucky Cabinet for Health and Family Services, Commissioner

Dr. Kim McClanahan, Pathways, Inc., CEO

Jenny Oldham, Hardin County Attorney

Dr. Jaime Pittenger, University of Kentucky School of Medicine, Pediatric Hospitalist and Assistant Professor of Pediatrics

Maxine Reid, Cabinet for Health and Family Services, Regional Program Manager

Dr. Ruth Shepherd, Kentucky Public Health State Child Fatality Review Team, Chair

Members who Left the Panel in 2014

Andrea Goin, CASA Greenriver, Executive Director

Dr. Carmella Yates, Chrysalis House, Addiction Counselor

Det. Kevin Calhoon, Kentucky State Police

Robert Walker, University of Kentucky College of Social Work Training Resource Center

What Does a Safe Sleep Environment Look Like?

Reduce the Risk of Sudden Infant Death Syndrome (SIDS) and Other Sleep-Related Causes of Infant Death

Use a firm sleep surface, such as a mattress in a safety-approved* crib, covered by a fitted sheet.

Do not use pillows, blankets, sheepskins, or crib bumpers anywhere in your baby's sleep area.

Keep soft objects, toys, and loose bedding out of your baby's sleep area.

Do not smoke or let anyone smoke around your baby.

Make sure nothing covers the baby's head.

Always place your baby on his or her back to sleep, for naps and at night.

Dress your baby in sleep clothing, such as a one-piece sleeper, and do not use a blanket.

Baby's sleep area is next to where parents sleep.

Baby should not sleep in an adult bed, on a couch, or on a chair alone, with you, or with anyone else.

*For more information on crib safety guidelines, contact the Consumer Product Safety Commission at 1-800-638-2772 or http://www.cpsc.gov.

NIH Eunice Kennedy Shriver National Institute of Child Health and Human Development

SAFE TO SLEEP®

APPENDIX C

Glossary

Abused or neglected child: A child whose health or welfare is harmed or threatened with harm when:

(a) His or her parent, guardian, person in a position of authority or special trust, as defined in KRS 532.045, or other person exercising custodial control or supervision of the child:

1. Inflicts or allows to be inflicted upon the child physical or emotional injury as defined in this section by other than accidental means;

2. Creates or allows to be created a risk of physical or emotional injury as defined in this section to the child by other than accidental means;

3. Engages in a pattern of conduct that renders the parent incapable of caring for the immediate and ongoing needs of the child including, but not limited to, parental incapacity due to alcohol and other drug abuse as defined in KRS 222.005;

4. Continuously or repeatedly fails or refuses to provide essential parental care and protection for the child, considering the age of the child;

5. Commits or allows to be committed an act of sexual abuse, sexual exploitation, or prostitution upon the child;

6. Creates or allows to be created a risk that an act of sexual abuse, sexual exploitation, or prostitution will be committed upon the child;

7. Abandons or exploits the child;

8. Does not provide the child with adequate care, supervision, food, clothing, shelter, and education or medical care necessary for the child's well-being. A parent or other person exercising custodial control or supervision of the child legitimately practicing the person's religious beliefs shall not be considered a negligent parent solely because of failure to provide specified medical treatment for a child for that reason alone. This exception shall not preclude a court from ordering necessary medical services for a child.

Biopsychosocial: A general model or approach stating that biological, psychological, and social factors all play significant roles in human functioning in the context of disease or illness.

Family and District Court Protective and Restrictive Orders: Orders promulgated by Family and/or District Court judges restricting or limiting, in any manner, an adult's visitation time or custodial privileges with a child.

Medical Home: Primary medical provider or office/practice.

Neonatal Abstinence Syndrome: A group of problems that occur in a newborn who was exposed to addictive opiate drugs while in the mother's womb.

Neonatal Intensive Care Unit: Hospital facility or unit staffed and equipped to provide continuous mechanical ventilatory support for a newborn infant.

Substance-Related Impaired Caregiver: For purposes of this report, a caregiver who either tested positive for any non-prescribed substance or admitted use of any non-prescribed substance soon after a scenario where a child was found to have received fatal or nearly fatal injuries while being cared for by the caregiver.

Sudden Unexplained Infant Death (SUID): Nearly 4,000 US infants die suddenly and unexpectedly each year. We often refer to these deaths as sudden unexplained infant death (SUID). Although the causes of death in many of these children can't be explained, most occur while the infant is sleeping in an unsafe sleeping environment.

Researchers can't be sure how often these deaths happen because of accidental suffocation from soft bedding or overlay (another person rolling on top of or against the infant while sleeping). Often, no one sees these deaths, and there are no tests to tell sudden infant death syndrome (SIDS) apart from suffocation.

To complicate matters, people who investigate SUIDs may report cause of death in different ways and may not include enough information about the circumstances of the event from the death scene.

Law enforcement, first responders, death scene investigators, medical examiners, coroners, and forensic pathologists all play a role in carrying out the case investigation.

A thorough case investigation includes

- An examination of the death scene.
- An autopsy (medical examination of the body after death).
- A review of the infant's medical history.

Most SUIDs are reported as one of three types of infant deaths.

Types of SUID

- Sudden Infant Death Syndrome (SIDS)

  SIDS is defined as the sudden death of an infant less than one year of age that cannot be explained after a thorough investigation is conducted, including a complete autopsy, examination of the death scene, and a review of the clinical history. SIDS is the third leading cause of infant deaths in the United States and the leading cause of death in infants one to 12 months old.
- Unknown Cause

  The sudden death of an infant less than one year of age that cannot be explained because a thorough investigation was not conducted and cause of death could not be determined.
- Accidental Suffocation and Strangulation in Bed Mechanisms that lead to accidental suffocation include
  - Suffocation by soft bedding—such as a pillow or waterbed mattress.
  - Overlay—when another person rolls on top of or against the infant while sleeping.
  - Wedging or entrapment—when an infant is wedged between two objects such as a mattress and wall, bed frame, or furniture.
  - Strangulation—such as when an infant's head and neck become caught between crib railings.

Even after a thorough investigation, it is hard to tell SIDS apart from other sleep-related infant deaths such as overlay or suffocation in soft bedding. While an observed overlay may be considered an explained infant death, no autopsy tests can tell for certain that suffocation is the cause of death.