

**Child Fatality and Near Fatality External Review Panel**  
Kentucky Coalition Against Domestic Violence  
111 Darby Shire Circle  
Frankfort, KY 40601

Monday, July 9, 2018

**MINUTES**

**Members Present:** Judge Roger Crittenden, Chair; Representative Addia Wuchner; Jenny Oldham, Hardin County Attorney; Joel Griffith, Prevent Child Abuse Kentucky; Deputy Commissioner Elizabeth Caywood, Department for Community Based Services, Cabinet for Health and Family Services (CHFS); Dr. Jaime Kirtley, University of Kentucky School of Medicine; Betty Pennington, Family Resource and Youth Service Centers, CHFS; Dr. William Ralston, State Medical Examiner; Lieutenant Scott Lenge, Kentucky State Police; Steve Shannon, KARP, Inc.; Angela Brown, State Child Fatality Review Team, CHFS; Sharon Currents, Kentucky Coalition Against Domestic Violence; Elizabeth Croney, KVC Behavioral Health and Dr. Christina Howard, University of Kentucky, Department of Pediatrics.

**Welcome:**

*Judge Roger Crittenden*

Judge Crittenden welcomed panel members and staff to the meeting. The Panel approved the minutes and case review summaries from the May meeting.

**Data Tool Update:**

*Elisha Mahoney*

The data tool was updated to include coroner issues, language/cultural issues, environmental neglect, and MAT Involvement under section #19 Family Characteristics. In the event coroner issues, language/cultural issues, or MAT involvement is selected, a comment box will allow for further information. For the case analysts, under section #3, *Do one or more parents have a history with DCBS as a child*, if marked yes, a comment box was added to provide additional information, if available.

**Sudden Unexpected Infant Death Case Registry Grant Presentation:**

*Tina Ferguson, Principle Investigation and Emily Ferrell, Epidemiologist SUID Grant*

Sudden Unexpected Infant Death (SUID) is a death that occurs in the first year of life, in which the cause of death is not immediately obvious before an investigation. A case categorized as SUID includes: undetermined causes, Sudden Infant Death Syndrome (SIDS), and accidental suffocation and strangulation in bed (ASSB). Around 3500 SUID deaths occur nationally each year, which translates to nearly 1 in every 1000 live births. SUID deaths account for 22% of infant deaths in Kentucky, which is double the national average at nearly 2 in every 1000 live births. The CDC developed the SUID Case Registry in order to bring together detailed population-based data regarding the circumstances for all SUID cases and identify common characteristics and risk factors in order to develop data-driven practices and policies to reduce future deaths. Kentucky identified 103 SUID cases for 2016, 84 cases for 2017, and 24 cases have been identified thus far for 2018. The SUID case registry has established a mechanism to track all cases and a state team to review cases not reviewed at

the local level. The SUID Case Registry team has conducted 6 multidisciplinary trainings focusing on death scene investigations, case reviews and developing prevention activities. As part of the trainings, SUID kits were provided which include a weighted doll for re-enactment, protocols, and point and shoot cameras. The SUID registry team designed and conducted a study of the 2016 cohort that compared SUID cases to other live births from the same birth year. They were able to identify a few risk factors and found breastfeeding to be a protective factor. The Department found prevention efforts are needed beyond safe sleep messaging. A few existing interventions may also reduce SUID, including breastfeeding promotion, preterm birth prevention, and smoking cessation. The Department would like to work with the state Medicaid program to provide education on the risk factors to the high risk population. They also encourage safe sleep education be provided during all pregnancies, not just first-time mothers.

The SUID Registry team would like to partner with the panel members to dive deeper into the data and develop preventive measures. Representative Wuchner would like to conduct a workshop with the Department of Public Health, Medicaid, and Prevent Child Abuse Kentucky to brainstorm ideas and open communication on prevented services based on the data presented. A special thanks to Tina Ferguson and Emily Ferrell for sharing that information and their continuing efforts to prevent child fatalities.

**Pending Case Reviews:**

F-009-17-C – rib fractures found 2 days later, law enforcement was informed and then coroner held a meeting 2 months later. The rib fractures were not the cause of death.

F-32-17-NC – no SUID form was completed. However, EMS claimed the child had a rhythm at home and passed at the hospital.

NF-032-17-C, NF-083-16-C and NF-100-16-NC will be reviewed during the September meeting.

**Case Review:**

The following cases were reviewed by the Panel. A case summary of findings and recommendations are attached and made a part of these minutes. All cases were presented by analyst Cindy Curtsinger.

<u>Group</u>	<u>Case #</u>	<u>Analyst</u>
1	F-003-17-C	Karen Bremenkamp
2	F-025-17-C	Cindy Curtsinger
4	NF-010-17-NC	Cindy Curtsinger
1	NF-042-17-NC	Cindy Curtsinger
2	NF-058-17-C	Cindy Curtsinger
4	NF-087-17-NC	Cindy Curtsinger
1	NF-024-17-NC	Karen Bremenkamp
2	NF-040-17-C	Karen Bremenkamp
4	NF-079-17-C	Karen Bremenkamp
3	F-037-17-PH	Karen Bremenkamp
3	NF-093-17-C	Kindra Kilgore
3	NF-084-17-C	Karen Bremenkamp

## Meeting adjourned

### Items needing further study:

#### (Ongoing List)

1. **KASPER access for DCBS during investigations.** DCBS has limited access and they have to rely on other agencies to obtain that information. DCBS would like to have the legal ability to access KASPER for home placements and evaluations.
2. **DCBS Policy issue.** Anytime a fatal or near fatal event has a screened out referral there should be an internal review for quality assurance.
3. **Collect data on homeschooling of children known to the child welfare agency.** Case reviews revealed parent(s) removing children from school upon reports to DCBS by the school regarding possible abuse by the parent(s).
4. **Interstate collaboration.** Case reviews demonstrated a need for better interstate collaboration and communication.
5. **Fire Arm Safety.** Track issue to determine whether recommendation(s) needed.
6. **Medically Assisted Treatment.** Determine issues surrounding patient waivers, safety coaching by providers to patients, and other issues associated when treating patients with young children. Possible legislation to provide more counseling to families struggling with addiction.
7. **Tracking data on Criminal Diversion Programs used in child abuse cases.** Further study needs to be done to determine if allowing diversion programs in child abuse cases creates a loop hole in preventing further abuse.
8. **CAPTA appeals overturning the DCBS' findings of neglect or abuse.** More than half of the Department's findings of abuse and neglect get overturned during a CAPTA hearing. Further study needs to be done on the CAPTA process.
9. **Private Foster Care Providers.** Track issue to determine whether further recommendations are needed. Follow up on foster parent registry.
10. **Coroner Issues.** The Panel will start tracking which county coroner fails to notify the proper agencies and fails to complete the forms. Perhaps reaching out to the county attorneys could help facilitate coroners' cooperation.