

Child Fatality and Near Fatality External Review Panel

Kids Are Worth It! Conference

Lexington Convention Center

430 W. Vine Street

Lexington, KY

Monday, September 9, 2019

MINUTES

Members Present: Hon. Dawn Blair, Assistant Hardin County Attorney, Acting Chair; Dr. Melissa Currie, University of Louisville, Pediatric Forensic Medicine; Dr. Jaime Pittenger, Prevent Child Abuse Kentucky; Commissioner Eric T. Clark, Department for Community Based Services, Cabinet for Health and Family Services (CHFS); Dr. Christina Howard, University of Kentucky, Department of Pediatrics; Betty Pennington, Family Resource and Youth Service Centers, CHFS; Dr. William Ralston, State Medical Examiner; Detective Isaac Waters, Kentucky State Police; Linnea Caldon, Citizen Foster Care Review Board; Dr. Henrietta Bada, Department of Public Health, CHFS; Elizabeth Croney, Board of Social Work; Steve Shannon, KARP; Judge Libby Messer, Fayette County Family Court Judge; Elizabeth Epperson, Association of Addiction Professionals; and Angela Yannelli, Kentucky Coalition Against Domestic Violence

Welcome:

Hon. Dawn Blair

Dawn Blair welcomed everyone to the meeting and introduced new members that were recently appointed to the panel. Minutes and Case Review Summaries from the June meeting stand approved. Members were reminded the next panel meeting will be October 21st at 9:00 a.m. till 4:00 p.m., at the Kentucky Coalition Against Domestic Violence at 111 Darby Shire Circle, Frankfort, Kentucky. The panel will discuss recommendations for the annual report at the next meeting. Members were advised all cases for FY18 have been uploaded to SharePoint and thirty-three (33) cases have been uploaded for FY19.

The panel has 136 cases to review for FY18, forty-eight (48) fatalities and eighty-eight (88) near fatalities. At the conclusion of today's meeting, the panel will have sixty-two (62) case reviews to complete. After further discussion, the panel decided to hold a special meeting on October 22nd at the KCADV.

Culture of Safety Presentation:

Dr. Scott Modell and Noel Hengelbrok
Collaborative Safety

Scott Modell explained the science of the model that will be implemented in Kentucky's DCBS and a quick review of the results from other states that have implemented a similar model. When you take a look at child welfare through the lens of the media, you will notice trends that emerge throughout the country. Headlines appear regarding budget cuts to the child welfare system. Followed by a high profile child death which results in public outrage. Subsequently, those in charge are terminated and more money is added back into the child welfare budget. If we follow the same pattern we are destined to do the same thing over and over again.

Who does safety better than anyone else? Some of those industries include aviation, nuclear power, some sectors of healthcare, military and the tech sector. These industries apply the science of Human Factors and System Safety. In Tennessee, they took this science and started to integrate it into how they investigated critical incidents in the child welfare system. People started to notice the change in how Tennessee responded to critical incidents. President Obama's Commission to Eliminate Child Abuse and Neglect Fatalities noticed and asked them to come and present their new process. If you look at how some of these industries who adopted safety science respond to a critical incident and how they treat their employees, it's distinctly different. The lens at which they view the incident is also distinctly different.

When comparing a critical incident response from an aviation incident to that of a child fatality in the welfare system, you notice the child welfare system places blame. The child welfare response discussed what didn't happen and the words "should have" are throughout the response. In safety science they say, "don't should on yourself or others" when looking back on a critical incident. The reason is because contemporary safety science directs us fully away from trying to explain what happened by what people didn't do. Rather they focus on what people did do and why they did it. That information gives you the best clues on how to learn and improve.

Can frontline child welfare workers and supervisors follow every policy and task in every case? Everybody answers no. If that is the case, why would you ever put a review system in place that the first thing you do is look back and determine if staff followed every policy and completed every task if we know on the front end they can't and then typically add more policies, forms, and procedures. In general, child welfare workers want to do a good job. The decisions people make at the time, make sense to them at the time they are making them. The science guides us to understand that if it makes sense to one person it will make sense to someone else.

Noel Hengelbrok explained the science behind the review process that transitions into changing the culture. The child welfare system does not have control of the entire situation that is afforded to other industries. Fundamentally, if you want to properly learn and improve as an organization you need to transition away from blame and into accountability. Research shows when you directly blame an individual you are not holding the organization accountable. After something goes wrong we want to look at the organization 5-10 years in the future, and not only did we learn something from the event, but became better because of it. That is true accountability.

The second transition typically involves quick fixes which implement additional policies, task, or disciplinary actions. When this occurs, it makes the employee feel like they are being criticized and don't have a choice or say in the matter. Science directs you move toward things that truly matter. For example, social workers have high caseloads and limited time. Regardless of what line of work you are involved, you must learn how to prioritize. Issues such as; limited resources, conflicting goals, being efficient yet still thorough, all require additional study. These individuals are going to work every day trying to be successful in very complex circumstances. If we want to adequately learn how our system works, if we want to put ourselves in the best position to improve as a system, you have to look for the second story.

The first story is the superficial way we try to understand the story and what went wrong. Which typically ends with someone not following the policy. We are all guilty of, "what you look for is what you find." As previously addressed, we already established social workers cannot follow every policy and procedure for every case. Then you apply, "what you find is what you fix." Which typically results in additional policies and additional procedures which they will not be able to follow. If you find people are the reason for the mistake than you are constantly trying to fix that. The second story takes you beyond that. When you figure out someone is not following policy or best practice, this is the beginning of the process. The second story reflects the resource constraints people may encounter. For example, a social worker was scheduled to do a home visit a month prior to a child fatality. He did not complete the visit because the family home was located in a rural area, hours from his office, and it was during the middle of winter. Due to the road conditions, the worker

would have put himself at risk because he did not have access to a four wheel drive vehicle. This does not excuse the worker for not completing his task, but it did make the agency aware of the need to acquire four wheel drive vehicles for their employees. It's an accountability process, they gained the point of view of the front line staff.

How do you build a culture of safety? Kentucky has a model that was specifically designed for Kentucky that matches the complexity of the work. It involves systematic critical incident reviews that serve as a structural artifact. It moves away from blame and seeks out the second story from the staff's perspective. This process is referred to as the human factors debriefing. The process must be voluntary, in a safe and blameless atmosphere, and seek access as to why decisions made sense to the staff at the time of the event. The information gathered gets processed to a systematic mapping team. Kentucky will have six mapping teams for the nine regions throughout the state. Mapping teams will consist of frontline workers, supervisors, managers, and staff from all levels of the system. These reviews will be put into a narrative. The model must have top to bottom alignment and engage all community partners. Social workers, SRA's, and SRAA's will be receiving training on the human factors debriefing process. Then they will begin to integrate it into their everyday work. The model must have accountability and sustainability that outlast every person in this room. Better retention has been associated with every organization that has implemented the culture of safety. Other states have seen improved communication with community partners and media. While you cannot, nor should you try and control what the media says or does, the way you talk about a critical incident can influence what they write.

Questions\comments:

Elizabeth Croney: She is excited to see this model being implemented in Kentucky but how do you sustain it? Is it a train the trainer model?

Response: First, they build the capacity for Kentucky to conduct their own reviews. It's not a classic train the trainer but it builds in the fundamental infrastructure for sustainability. The program is designed to engage with the agency for one to five years. The average time is three years.

Elizabeth Croney: When state agencies work with a lot of community partners, do they try and implement the same process with those partners?

Response: Yes, the better the engagement with outside partners the better the outcome. In one state they included the child abuse pediatricians in their mapping teams and it resulted in an improved relationship.

Commissioner Clark wants to practice some culture of safety with the panel. The timing of this is perfect, as you probably saw the articles recently published by reporter Debbie Yetter. Those articles discussed high profile child fatality cases and cases this panel deemed as torture. Hopefully, the panel is seeing a different way of communicating with the press and being alongside of them. Just last week, Commissioner Clark participated in a radio interview with Debbie Yetter and Dr. Currie. They even fielded questions from the public regarding those articles. DCBS is not going to shy away from having a voice in these matters. Historically, they would bunker down, say no comment, and refuse to release any records. Commissioner Clark commended Debbie Yetter for those articles. However, the Commonwealth of Kentucky leads the nation in child abuse year after year. Kentucky is second in the nation for child fatalities and near fatalities and we're not changing. Commissioner Clark wants to charge this panel to evaluate how they review cases and how they make recommendations to do something meaningful. We can do this work till the end of time but if these stats remain, what are we really doing here. This is not a criticism, but hopefully the comment will spark some critical thinking about how can we improve our work. Commissioner Clark would like to bring a recommendation forward giving the presentation just heard. He would like for the panel to consider extending an invitation to every worker and supervisor when their case is being reviewed. He would like to take this one step further and ask that they have a seat at the table. It would be completely voluntary. He thinks their voice and their participation in the review would make the panel's work richer. This has been approved through leadership in the Cabinet. Their workers over the years have desperately wanted a seat at the table.

Commissioner acknowledges this is only his second meeting. However, this panel has traditionally had a reputation of being adversarial with the Department and blame oriented on their workers. When this panel goes before a legislative committee and makes a recommendation that impacts our department and we're not sitting at the table with you on those recommendations that is not the type of culture we want to foster in Kentucky. Commissioner Clark is trying to advocate for his agency and request the panel's consideration.

Elizabeth Croney: Just recently she was reviewing a case and wondered why the agency did what they did in that case. She has a list of questions for that community partner but can only guess at the answers without speaking to them directly. She would like to see community partners present for their cases as well.

Steve Shannon: Steve thinks this is a great recommendation. When he reads the reports they are awful but he cannot figure out how they got to that place. He agrees the panel can be critical of the department at times and that's not useful. We have to foster an environment that will allow the worker to come forward and explain what actually happened. They can't be afraid to be honest and voice their concerns.

Commissioner Clark: It's going to take a change of culture from this panel that allows them to come and speak openly. Again, there's a reputation that this panel is adversarial to our workers and agencies. They want a voice here but if we honor that, we're going to have to be very intentional on how we receive them here. Not that the Department is beyond criticism but how do we make it beneficial to them to participate. This work is personal to the Commissioner as he was a victim of child abuse. The picture recently published in the Courier Journal was taken at the last meeting. Specifically, after discussing the worst case of child neglect that's been presented in front of this panel. Then he began to hear the "should haves" and "would haves" and smoke began to come out of his ears. That is when he piped up and said does anyone believe that the workers in this case wanted this outcome. No one thought that but then what are we doing here. We've got to change the way we look at this because the outcomes aren't getting better.

Betty Pennington: Betty agrees with the Commissioner and works under the umbrella of DCBS. She would like to work harder for the Department. She would like someone to sit at the table and tell them how to achieve that goal. She thinks they can work harder and smarter together.

Dr. Currie: This is a critical conversation that we have about the culture here in the panel. I think one of the pieces that's necessary, and Commissioner you have done this and I hope it continues, is in order to have the culture of safety we have to have the information. As you mentioned earlier in the meeting, the prior approach has been to stonewall and share no information. And not to sound defensive, but we are left with only the "would haves" and "should haves" when we have no information about what is happening in the agency. Having that exchange of information both ways is critical. Something else the panel needs to discuss, and she agrees we need to have the workers and community partners at the table, but practically speaking, the panel will not be able to review nearly as many cases. Which may be okay but we need to think about the effect on the panel's productivity if we do proceed in this matter. Personally, she would rather have a quality review on fewer cases than a superficial recommendation on numerous cases.

Commissioner Clark: There is definitely going to be value to having them here but they don't need to be here for every case.

Angela Yannelli: It is important to not just focus on the problems but focus on what is really working well in other states. She supports the Commissioner's recommendation as well.

Dawn reminded the panel members, do not mention any names, counties, or identifying information. The analysts are not going to reference the counties.

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.

<u>Group</u>	<u>Case #</u>	<u>Analyst</u>
1	F-005-18-C	Joel Griffith
4	F-006-18-C	Joel Griffith
4	F-007-18-C	Joel Griffith
2	F-020-18-C	Joel Griffith
3	F-022-18-C	Cindy Curtsinger
2	F-025-18-C	Cindy Curtsinger
3	F-026-18-NC	Cindy Curtsinger
1	F-023-18-NC	Joel Griffith
2	NF-030-18-NC	Joel Griffith
3	NF-034-18-C	Joel Griffith
1	NF-007-18-C	Cindy Curtsinger
4	NF-064-18-NC	Cindy Curtsinger

Additional Discussions:

Firearm Safety Discussion – The panel needs more information on how the Department determines whether or not to substantiate neglect when a child accesses a firearm that results in a fatal or near fatal event. The panel has noticed a lack of consistency regarding the substantiations on those cases. Additional discussion regarding talking to your children about gun safety is not an effective prevention.

Pool Safety Discussion – There seems to be more access to purchasing a pool with less safety restrictions. Should the panel explore recommending additional educational messages for families with small children?

Sleep Deprivation – The panel agreed to pull data and explore the risk factor of parents or caregivers working 2nd or 3rd shift and still being the primary caregiver after their shift. Panel members agreed they've seen parents who are sleep deprived and when awake are harming the child or they are asleep and neglecting the child. Parents getting adequate sleep may be a prevention effort. Should the panel consider recommending employers who utilize 2nd and 3rd shifts require an additional education piece for families of young children? It may be a financial issue or access to childcare issue which could result in a recommendation as well.

Special guest – A KSP detective who worked the child fatality case came to the table and informed the panel about the judicial process issues in that particular case. The detective presented his case to the county attorney and prosecution was declined. The family was involved with the court system for six months but the petition was dismissed without a judicial finding. Panel discussed the judicial process is to hold the individual accountable for their actions. It is possible prosecution was not pursued because the medical examiner could not determine neglect caused the fatality. *Commissioner Clark* asked for clarification on what is the role of the panel? How is asking why was this person not prosecuted the right question. *Elizabeth Croney* stated it's not fair to train the social workers on how to do an investigation and the outcome of that investigation vary depending on the county. *Dr. Pittenger* stated the panel has a rare opportunity to give

feedback on a multidisciplinary level. The panel consists of well suited professionals who can reach out to their counterparts throughout the state and provide them insight. From a medical standpoint, if a provider missed an opportunity, she can call them and provide an educational piece. *Dr. Howard* stated the criminal neglect charge is different throughout the state. It's important to track the trends and identify the issues in order to know if a policy change is required or if additional education would improve consistency throughout the state. *Commissioner Clark* thanked everyone for the insight and thanked the detective for his presentation. Commissioner Clark again advocated for his workers to be provided the same opportunity. *Dr. Currie* stated, it is important to recognize, bringing the workers to the table is not a big deal for the panel to allow them to do that, it's a big deal for the Cabinet to allow them to do that. *Commissioner Clark* apologized that it's not happened in the past but believes they deserve to be heard.

Meeting adjourned

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