Child Fatality and Near Fatality External Review Panel

Kids Are Worth It! Conference
Crowne Plaza Louisville
830 Phillips Lane
Louisville, Kentucky

Monday, September 17, 2018

MINUTES

Members Present: Jenny Oldham, Co-Chair, Hardin County Attorney; Representative Addia Wuchner; Joel Griffith, Prevent Child Abuse Kentucky; Deputy Commissioner Elizabeth Caywood, Department for Community Based Services, Cabinet for Health and Family Services (CHFS); Dr. Melissa Currie, University of Louisville Pediatric Forensic Medicine; Dr. Jaime Pittenger, University of Kentucky School of Medicine; Dr. William Ralston, State Medical Examiner; Dr. Henrietta Bada, Department for Public Health, CHFS; Linnea Caldon, Citizen Foster Care Review Board; Shawna Kelly-Blair, CASA of Eastern Kentucky; Lieutenant Scott Lengle, Kentucky State Police; Steve Shannon, KARP, Inc.; Angela Brown, State Child Fatality Review Team, CHFS; Elizabeth Croney, KVC Behavioral Health and Dr. Christina Howard, University of Kentucky, Department of Pediatrics.

Welcome: ***Hon. Jenny Oldham, Co-Chair***

Co-Chair Oldham welcomed panel members and staff to the meeting and introduced the newest member, Shawna Kelly-Blair with CASA of Eastern Kentucky.

LRC Presentation:

The Panel is scheduled to present at the upcoming Health and Welfare and Family Services committee meeting on September 20, 2018. Dr. Jaime Pittenger, Judge Paula Sherlock, Lt. Scott Lengle, Dr. Bill Ralston, Steve Shannon and Deputy Commissioner Caywood will be present on behalf of the panel. The presentation will be a brief overview of last year's data and how the panel operates including case examples. All members were encouraged to participate if their schedule allows.

2018 Panel Update and Recommendations:

The panel has currently completed 51 case reviews from state fiscal year 2017. The data shows overdose/ingestion and abusive head trauma are the two leading types of fatal\near fatal events. The panel discussed MAT treatment and lack of communication with DCBS. Parents are routinely failing drug screens and that information is not being shared with the department. Additional training protocols need to be implemented. Dr. Currie suggested implementing blister packs for certain medications. Especially, clonidine which taste sweet and could be the reason behind children routinely ingesting that particular drug. Rep. Wuchner suggested meeting with the Board of Pharmacy and medical liaisons to initiate this process.

There was a brief discussion regarding the Cabinet's need to strengthen the internal review process as a part of an overall quality assurance.

Additional coroner and law enforcement training regarding child death scenes was also discussed. The panel would like to compile the data regarding the lack of information during a death scene investigation. It was noted that Dr. Ralston and Angie Brown have been traveling county to county educating coroners on the SUID forms. Coroners are now using the forms more consistently, but still lack completeness. The state SUID team has provided county coroner information with the panel. A suggestion was made to include a child death scene training as part of the coroners' continued education. The recommendations regarding the law enforcement and coroner issues need to be data driven and further discussed.

Family Drug Court should also remain on the panel's recommendations because it addresses the majority of the issues routinely seen during these reviews. The panel would like to review all past recommendations and the status of each recommendation to discuss possible alternatives for those recommendations not implemented.

The panel is still waiting for DCBS to upload 54 cases from state fiscal year 2017. DCBS informed the panel that at least five cases are still pending in one county. The panel discussed sending a letter to the LRC committee requesting a sixty-day extension to complete the annual report. The panel would like to schedule a special meeting for November 19th and requested the analysts start expediting their reviews.

Pending Case Reviews:

NF-100-16-C – Dr. Currie reviewed medical records from both medical hospitals and the panel determined medical issues to be a missed opportunity. The presence of a fever is what led the medical staff to determine the child had an infection. However, the blood work showed a significantly low hemoglobin count that should have triggered a trauma evaluation.

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.

Group	**Case #**	**Analyst**
1	F-011-17-C	Emily Neal
2	F-019-17-C	Cindy Curtsinger
4	F-036-17-PH	Cindy Curtsinger
3	F-041-17-PH	Cindy Curtsinger
2	NF-062-17-C	Cindy Curtsinger
1	NF-066-17-NC	Emily Neal
3	NF-070-17-C	Emily Neal
4	NF-080-17-NC	Emily Neal

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.