Child Fatality Near Fatality External Review Panel

Meeting Summary
January 25, 2016

- Meeting held at Kentucky Coalition Against Domestic Violence
- Newest panel member introduced, Adria Johnson, Commissioner, Department for Community Based Services. New contract analysts who were in attendance were introduced. The intern from the Association of Kentucky Independent Colleges and Universities, Aylissa Mattingly of Campbellsville University, was introduced.
- November 16 meeting minutes were approved by consensus.
- Financial report submitted by Lyn Bruckner summarizing remaining budget for FY16.
- Dr. Currie reported that the Data Tool that will be used for collecting FY15 case data will be completed for use prior to the March 13-15 meeting.
- Dr. Currie briefly discussed the completion of the contract for the new case analysts which includes one new medical analyst and three social work analysts. The Panel again expressed the need for a full time data person as staff to the panel.
- Judge Crittenden discussed the extended panel meeting in March. The first day will begin approximately at 3:00 p.m. on Sunday, March 13. The first day will be strategic planning and administrative matters. The Monday session will begin at 9 a.m. and start immediately with the case review. The Panel will meet to the end of the day Monday or as necessary. The Tuesday session will immediately begin with case review beginning around 9 a.m. It is anticipated that the meeting on Tuesday may end early to mid-afternoon depending upon the status of the case review. Lyn Bruckner and Cindy Curtsinger will work together to schedule the cases to ensure the best use of case analyst presentation times. The case assignments need to go out to the panel members as soon as possible so they may begin to read the cases in preparation for the March meeting.
- Panel members were reminded of the Legislative Policy. Any member who may be asked to testify before a legislative body should: 1) clearly state that although they are a member of the Child Fatality and Near Fatality External Review Panel, their testimony is as a representative of their respective agency, unless they are in fact testifying on a matter that the full panel has adopted and 2) Panel members were reminded that according to the MOU with the Justice Cabinet, if panel members are to testify before a legislative body, they should let Judge Crittenden, Chair know so that he may give courtesy notice to the Cabinet Secretary.
- Lyn Bruckner discussed the preliminary legal research into the Keeping Children and Families Safe Act of 2003 which amended the Child Abuse Treatment and Prevention Act. *Please note*: the research discussed was from statutory and case law and not through any published scientific literature from the social services, child welfare, or other arenas. The Panel and staff will continue to research this matter as a possible recommendation for its 2016 Annual Report.
- Dr. Ralston provided information regarding NF-44-14. It had been stated in the November 16 meeting that an autopsy had *not* been completed on the deceased sibling of the index infant in the near fatality case that was the subject of the case review. Dr. Ralston asked that the record be corrected as there was in fact an autopsy completed in the death of the sibling, the coroner

had acted appropriately and notified law enforcement, the Department for Community Based Services and the health department.

- Dr. Ralston reported on trend data for 2010-2015 of death certificates of SUDI cases. In every instance with the exception of one, an autopsy was completed by the coroner.
- Judge Crittenden went over the recommendations from the 2015 annual report. Members and staff were assigned to track the various recommendations.

Tasks for implementation of the recommendations:

- General Assembly - Open DNA proceedings

Joel Griffith will advocate for opening dependency, neglect and abuse cases before General Assembly.

- General Assembly - Require AHT and Safe Sleep before discharge from hospital

Joel Griffith and Dr. Ruth Shepherd assigned to this task. Possible look at legislative alternatives and other avenues for building support.

- Require AHT and Safe Sleep in Drug Courts, CDW. Family Court

Judge Hall and Judge Crittenden will follow this recommendation. Dr. Shepherd has provided Safe Sleep video to Administrative Office of the Courts. Lyn Bruckner will assist.

- Coroner notification to LE, DCBS, Health Dept. upon death <18

Dr. Ralston will assist in the implementation of this recommendation.

- MDTs to review physical abuse cases

Jenny Oldham and Lyn Bruckner to work with the Multidisciplinary Commission on Child Sex Abuse regarding the ability to survey local teams to determine which teams also review physical abuse cases.

- LE enhance enforcement of child safety seats

Sgt. Scott Lengle will assist in implementation. Continue study into restraint use and traffic report data.

- DCBS consider inadequate restraint as indicator of neglect
- DCBS Internal Review Process consistent w statute/quality improvement process
- DCBS timely completion of fatality/near fatality investigations - ID # of incomplete in annual report
- DCBS provide to the Panel caseload, training , experience of staff when fatal/near fatal incident

Commissioner Johnson will brief the panel on the four recommendations for the Department for Community Based Services at the next meeting.

- DCBS Internal Review Process was briefly discussed. It was reported that DCBS provided panel staff with an Excel spreadsheet that contained a list of all cases, date of incident, date investigation was completed and whether the cases was pending or not pending. La'Quida Smith will upload this data to the SharePoint website.

- **CASE REVIEW:**

NF-11-14-C

10 year old attempted suicide by ingestion of medication. Presented with bruising over body, rectal injury, failure to thrive. Was removed from grandmother's home where he had been placed due to prior sexual abuse by birth parents and paternal uncles.
Missed opportunities: physician, multiple reports from school regarding this child and siblings, multiple investigations by Cabinet

Categorization:	Suicide/Attempted Suicide
	Overdose/Ingestion
Panel Determination:	Neglect
	Physical Abuse
Contributing Risks:	Supervisional Neglect

NF-58-14-C
NF-59-14-C
NF-60-14-C

These three cases were combined as all were sibling group with multiple fathers. Mom and one of her paramours argued over paternity of youngest child. Domestic violence including threat of death in presence of children. Children kidnapped and involved in motor vehicle collision at 90 m.p.h. All three children were improperly restrained and sustained near fatal injuries.

Categorization:	Blunt force trauma, not inflicted: Motor Vehicle Collision
Panel Determination:	Supervisory Neglect
Contributing Risks:	Military access to mental health services, impaired caregiver at time of event, mental health issues – caregiver (perinatal depression), substance abuse in home, lack of treatment – mental health or substance abuse, family violence

NF-29-14-C

4 year old twin found non-responsive. Transported to hospital with skull fractures and brain bleeds after being in father's care. Other twin had bruising, no fractures.
Missed Opportunities: Records indicate paternal grandmother and mother had knowledge of father's violence. Initial court case was informally adjusted, no evidence of court supervision.

Categorization: Physical abuse/blunt force trauma with evidence of abusive head trauma
Panel Determination: Physical Abuse, Abusive Head Trauma, Supervisional neglect (mother)
Contributing Risks: Substance abuse Caregiver, Substance abuse in home

NF-52-14-C - Near fatality that later resulted in fatality
4 year old child accessed loaded gun and alleged accidentally shoot himself. Neither parent admits gun ownership. Final determination pending access to law enforcement records.

Categorization: *pending*
Panel Determination: *pending*
Contributing Risks: substance abuse in home, substance abuse caregiver, criminal history – caregiver, supervisional neglect, unsafe access to deadly means

- Obtain records from Jefferson Metro Police
- Discuss letter to providers at March meeting

F-23-14-C
One week old child presented at ER dehydrated and malnourished. Infant had lost weight prior to release from hospital and had lost additional weight when presented at ER. Both parents on methodone for ten years. Four older siblings in out of home care. Prior to release from hospital after birth, infant showed signs of withdrawal but was discharged none the less. DCBS was in home with services within hours of release.
Missed opportunity: hospital at discharge, not tests for substances

Categorization: Starvation, Failure to thrive
Panel Determination: Medical neglect
Contributing Risks: substance abuse – caregiver, substance abuse in home, medical neglect

NF-72-14-NC
Six month old infant. Father alone with child night prior. Next morning child taken unresponsive to hospital. No prior DCBS history.

Categorization: Blunt Force Trauma, with evidence of abusive head trauma
Panel Determination: Abusive Head Trauma
Contributing Risks: Substance abuse - caregiver, Criminal History - caregiver

NF-33-14-C
7 year old with cerebral palsy presented at ER with starvation. 7 year old was part of a sibling group that was adopted by foster mother where they had been placed. Missed Opportunities: Multiple reports to DCBS by school, referrals on family when in foster care yet foster parent allowed to adopt

Categorization:	Starvation, Failure to thrive
Panel Determination:	Supervisory Neglect, Medical Neglect
Contributing Risks:	mental health issues – caregiver, Supervisional Neglect, medical Neglect

NF-61-14-C

14 month old unresponsive, experiencing seizure. Presented at ER then flown to Vanderbilt

Categorization:	Physical Abuse/blunt force trauma, with evidence of Abusive Head Trauma
Panel Determination:	Physical Abuse with Abusive Head Trauma
Contributing Risks:	Mental health issues – caregiver, substance abuse - caregiver

Cases pending for review in March:

NF-31-14-C
NF-62-14-C
NF-46-14-C
NF-48-14-C
NF-64-14-C
NF-68-14-NC

Possible recommendations as evidenced through the case review:

Thorough mental health assessments
Notify health, mental health providers in fatal and near fatal cases
Education to professionals/public on detail necessary to report abuse

Cases to place on March agenda for review:

NF-31-14-C
NF-62-14-C
NF-46-14-C
NF-48-14-C
NF-64-14-C
NF-68-14-NC