CHILD FATALITY & NEAR FATALITY EXTERNAL REVIEW PANEL
JANUARY 13, 2014

Members Present: Judge Roger Crittenden, Chair; Judge Brent Hall; Robert Walker, Social Work Clinicians, University of Kentucky; Detective Kevin Calhoon, Kentucky State Police (KSP); Dr. Melissa Currie, U of L Division of Forensic Medicine; Dr. Tracey Corey, State Medical Examiner; Dr. Kim McClanahan, CEO, Pathways, Inc.; Joel Griffith, Prevent Child Abuse Kentucky; Commissioner Teresa James, Department for Community Based Services, Cabinet for Health and Family Services (CHFS); Jenny Oldham, Hardin County Attorney; Maxine Reid, Family Resource and Youth Service Centers, CHFS; Dr. Ruth Shepherd, State Child Fatality Review Team, CHFS; Dr. Jaime Pittenger, Child Abuse Pediatrician, University of Kentucky School of Medicine; Dr. Carmella Yates, Chrysalis House, Inc.; Allison Taylor, designee for Dr. Stephanie Mayfield, Commissioner, Department for Public Health; and Sharon Currens, Kentucky Domestic Violence Association.

Members Absent: Senator Julie Denton, Representative Tom Burch, Dr. Corey, Nathan Goins, and Andrea Goin.

The meeting was called to order by Judge Roger Crittenden, Chair. Judge Crittenden introduced Allison Taylor who will be the designee for Dr. Stephanie Mayfield.

Judge Crittenden then began by reporting on testimony of panel members before the House Health & Welfare Committee. He noted the Committee was very receptive to the work of the panel and remarked there does not appear to be any resistance at the present time to the request for funding. He also mentioned that Dr. Currie spoke to the committee regarding a bill requiring training for physicians.

December minutes were approved as submitted.

Judge Crittenden asked Dr. Currie to report on the progress of the case review tool being developed for the panel. Dr. Currie explained the intent to combine Mr. Walker and Mr. Griffith's case review tools and that a list of different factors involved in a case that should be made note of when reviewing cases will be distributed to panel members. She indicated interest in knowing other factors panel members want to include in the list. She explained the case review summary form is a separate piece that is being used by the panel which is partially populated by DCBS. This form will continue to be used as the primary document while reading cases to summarize the case findings to discuss what issues were identified. Dr. Currie stated there will be a panel consensus determination at the end of each case discussed. She explained the point of having a final determination is to have one place where the findings of this panel have been documented so that it can been referenced and compared to numbers determined by other agencies such as law enforcement and DCBS. Dr. Currie also noted the findings should be based on the

panel's definitions of abuse and neglect. Mr. Walker pointed out that the panel is still missing records for some cases. Dr. Currie acknowledged the importance of receiving that information to tie up loose ends with those cases.

F-17-13-C

Judge Crittenden advised the panel would begin discussion of case F-17-13. Dr. Yates was excused from the discussion of this case due to a conflict of interest. Judge Crittenden noted this case involved the 2012 death of an infant. Commissioner James expressed one of her concerns in this case included not asking for substance abuse assessments. She noted the rural area where this family resided and the lack of resources available. She remarked that AOC records on the father were not reviewed thoroughly before making a placement choice. She also noted the father's alcoholism was not addressed. She commented that the mother's family history with the department was overlooked. Commissioner James also stated that the department should have filed a petition with the court in a more timely manner and the school was not contacted and engaged. Judge Hall remarked it should be noted in a case when the unsubstantiation is caused by the lack of cooperation with those being investigated. It was also noted that the finding by the department had to match the court's findings. Commissioner James remarked that once a case is unsubstantiated, the department has no standing. Judge Hall noted there was a petition filed in February 2011 but there was no filing against the biological father who was in jail at the time for a serious felony charge. He remarked that since there was no filing against the father, once he is released, the children go to him. Judge Hall also noted the court case went beyond the forty-five day requirement of state and federal law. He commented that in June the father was granted permanent custody with no finding by the court regarding how it was determined that the placement was in the best interest of the children. Ms. Oldham inquired about the caseload of the worker. Commissioner James stated the average caseload was nineteen. Ms. Taylor inquired about the policy regarding a mother testing positive for drugs. Commissioner James responded that while the mother tested positive throughout the pregnancy for various drugs, the discharge summary from the hospital did not indicate any referral for follow-up services. Commissioner James also noted the older children were out of the mother's custody until the infant was born. She stated the worker may have been relying on the grandparents to play a stabilizing role. Judge Hall commented that if in 2011 the judge had encouraged the Cabinet to file against the biological father, the grandparents would have had a tool to do something about the situation. Mr. Griffith inquired about options for the physician to contact DCBS and get any history of regarding a patient and establish communication. Commissioner James responded that occurred in years past but the number has increased drastically. She remarked the department can make changes in policies but the funds have to be available. Dr. Shepherd commented that in this case the physician noted in his chart that the mother was a drug user and was given suboxone. She also stated the number of babies born positive for drugs in Kentucky is between 5,000 – 10,000 per year.

Dr. Currie remarked that every time there is a budget cut, it must be made clear what that actually means. If you cut a certain dollar figure, that means 8,000 babies with positive drugs screens are going to go home with no investigation, no in home services, no home visiting nurse, no anything. She commented that we have not adjusted expectations to match the resources even though the policies may have been adjusted behind the scenes. Commissioner James remarked that the problem is that we have not adjusted the policy, so workers are still trying to keep up.

Panel members also discussed the failures of the judicial system and the need for accountability. Commissioner James asked Judge Hall what the Department could have done differently instead of trying to place with the grandmother under a prevention plan. Judge Hall indicated he does not like placement under a prevention plan as it relies on voluntary actions. Mr. Griffith also commented that in reviewing cases he believes there is an overuse of prevention plans when the courts need to be engaged. Judge Hall commented that prevention plans can be used when not removing children. Detective Calhoon noted that law enforcement cannot enforce a prevention plan.

Mr. Walker expressed the need for using the information gained in reviewing this case. Commissioner James suggested members submit written documentation on the issues noted to be compiled and categorized. Mr. Griffith suggested documenting the information on SharePoint. Judge Crittenden suggested panel members having computer issues can submit their information to Mr. Cannady to upload to SharePoint.

Dr. Currie inquired if members all agreed the determination on this case was neglect. Members were in agreement. Members discussed how the panel should define neglect and abuse. Dr. Shepherd commented that it is not hard to imagine that the panel might come to a different conclusion on cases other than the specific legal definition. The panel is looking at cases from a multi-agency point of view. Judge Hall suggested having a footnote in the annual report to address the difference in definitions of the panel versus the statute.

Mr. Walker expressed concern that the panel is thinking of the issue of substance abuse and assessing substance abuse too categorically. He suggested it needs to be looked at along with the overall parental capacities and caregiving responsibilities at the time.

Detective Calhoon suggested the panel request any records of law enforcement involvement in the case. Ms. Oldham noted the mother has a DUI for drugs with children in the vehicle (which occurred after this fatality) that is currently pending.

Group 1
NF-39-13

Ms. Currens stated this case was a near fatality in which the father had past issues of domestic violence. Detective Calhoon noted the alleged perpetrator had some behavioral issues as a child and had previous charges relating to domestic violence with the mother of his twin boys. He noted the victim was burned by a sippy cup of overheated liquid while in his care. He commented the child suffered burns on the outer body as well as inside. Detective Calhoon remarked that this case is currently before the court. Ms. Currens noted the time delay in the writing of the case report. Commissioner James remarked there is a forty-five day time limit for completing a report but there is an opportunity for extension. Mr. Griffith remarked that the delay causes inaccuracies in reports. Judge Crittenden inquired about the panel's finding in the case. Detective Calhoon stated it is a case of abuse that was inflicted. Ms. Currens noted the perpetrator had an anger issue that was identified in high school for which he received support at least through school. Dr. Currie inquired about the preventability of this case. Judge Crittenden commented that it was abuse but it was not preventable by the system. Ms. Currens agreed there was nothing in the record that indicated any problem in this situation prior to this. Detective Calhoon noted the mother cooperated with the investigation and was not at home when the incident occurred. Mr. Griffith noted that workers tend to hold women accountable for being in a violent relationship so that when something happens they revictimize the women by saying you should have known better. Commissioner James noted that sometimes you want to hold someone responsible and get overzealous.

Group 2
F-12-13-NC

Judge Crittenden stated this fatality involved a three year old that suffocated inside a beanbag while the father was in the shower. He noted the father called 911 when he could not locate the child and the fire department personnel found the child zipped inside the beanbag. Judge Crittenden noted the social worker had included in the report information from the internet regarding beanbag deaths. Dr. Currie noted one of the problems in this case is that police immediately defined it as an accident and there were no photos of the scene. Detective Calhoon commented that from his understanding social services called the police to ask them to be on standby and upon their arrival the coroner indicated they were not needed. He commented that the information from the autopsy on the death and where the child was found does not make sense from his perspective as an investigator. From his understanding, the first responder that found the child was not interviewed. Judge Crittenden noted the social workers were saying they wanted to be involved in the interview but were not informed of when the interview took place. Judge Crittenden remarked there was an allegation that there was a two or three hour interrogation and the worker was told the tape didn't work or was lost. Dr. Pittenger noted the medical examiner was not involved. Dr. Currie noted the coroner is allowed to make the call about how the scene is handled independently regardless of their background. Mr. Griffith inquired about the multidisciplinary team for Fayette County and whether they had reviewed this case. Detective

Calhoon noted they do have a team but he did not know if they had reviewed this case. He had inquired whether or not a case was opened by law enforcement and was told a case was not opened. Commissioner James noted this was a high profile case. Judge Crittenden remarked it was reported in the newspapers. Commissioner James commented that DCBS did not follow policy. DCBS does not have to depend on law enforcement to do its investigation. The family moved immediately after the death to another county. Mr. Griffith inquired if there are other children in the home. Commissioner James indicated there are now but there were not at that time. She noted that the way the situation went in the beginning made it difficult for the department to get any kind of future cooperation. Dr. Currie inquired about mechanisms by which special investigations can be recommended noting that it is not the role of the panel to conduct such an investigation. She stated that while it is outside the scope, the panel has an obligation to point out that this should be investigated by a neutral party. Judge Crittenden remarked that the panel can state there was a breakdown in communication and all policies were not followed. Dr. Currie commented that while it may be too late to investigate this child's death properly, it is not too late to investigate while this child's death was not investigated. Judge Crittenden noted the grandfather's involvement which made this a high profile case. He suggested the panel send a letter to the Lexington Fayette Urban County Police Department. He inquired if Dr. Currie had reviewed the autopsy and if there was any indication the child had ingested the contents of the beanbag. Dr. Currie responded that the material was aspirated. Dr. Currie inquired about the appropriate person to send a letter to and Ms. Oldham suggested the commonwealth attorney. Mr. Griffith suggested stating that the panel would like someone to review whether or not best practices were followed in this case. Judge Crittenden suggested the panel request information from law enforcement and the coroner. Mr. Griffith suggested requesting first responder records as well.

Group 3
F-9-13-NC

Mr. Griffith stated this case involved the death of a two year old. He indicated the child suffered head trauma and suffocation. The child was placed in a pack and play with gates over the top to prevent him from getting out. He indicated there was an open case on the mother in Tennessee but the mother was here with the child visiting her boyfriend. Commissioner James commented that DCBS reported this immediately to Tennessee authorities who removed the other children and placed them with their father with a no contact order for the mother. Panel members agreed this case was determined to be abuse. Detective Calhoon confirmed the boyfriend has been charged with manslaughter 2nd degree and criminal abuse 2nd degree.

Group 4
F-14-13-C

Dr. Shepherd stated this case involved a five-month-old baby. She noted the mother was nineteen and the father was twenty-one who were not married but stayed together through this. She noted the mother had a high school education and was taking college courses. She commented the baby was born fourteen weeks early at a hospital out of state and was hospitalized for five months. She noted the first contact with DCBS occurred when the hospital was looking for the mother to conduct discharge instruction, as she had been visiting frequently but had not been at the hospital for three days. She noted the nurses complimented the mother that she did very well with the care instructions for her baby. Dr. Shepherd indicated the baby had a trach which required regular suctioning as well as a feeding tube. She indicated they tried to set up home nursing for the baby but could not find an agency that would do it. She stated the mother took the baby home and the father was also present in the home as well as grandparents. She stated that DCBS was contacted when the family had not gotten the baby in with the primary care physician. Dr. Shepherd noted the mother had explained that she had arrived at the appointment late and the doctor refused to see the baby. She said the mother indicated she had difficulty finding a doctor under her coverage and some would not see an infant with these conditions. She noted the baby was seen by a pulmonologist who was planning to remove the trach the following month. Dr. Shepherd explained an alarm monitoring the baby's oxygen level began going off on a Thursday but when the company was contacted they were told they would not be able to do anything until Monday. She stated the baby was given children's Tylenol over the weekend and was found unresponsive Monday morning. She noted when the autopsy came back seven months later it indicated the baby had Benadryl in it's system and the family had not indicated they had given Benadryl. DCBS substantiated the case but she noted that at one point during the initial interview of the mother she indicated she had given the baby multi-symptom Tylenol. Dr. Shepherd noted the amount of Benadryl found was in the normal therapeutic range. Panel members agreed to determine this case non-neglect and system preventable.

Group 2
NF-06-13-NC

Dr. Currie explained this case involved a sixteen year old boy involved in a car accident with the his father. She noted the boy was in the care of his mother and there had been previous involvement with the Cabinet and drug use was indicated. She stated on the day of the accident the father refused to pick up the boy from his grandparents and had him meet him at the corner. She noted that witnesses indicated the father was under the influence of possibly multiple substances. She noted another child's caregiver reported she would not allow that child to get in the vehicle with this person. She stated the sixteen year old suffered a critical spinal cord injury. She pointed out that the father's blood was drawn upon arrival at the hospital and was positive for multiple drugs including methamphetamine; however,he was not charged with DUI or any other charge. She commented that DCBS substantiated neglect. She stated this case was potentially preventable due to a failure to report.

Judge Crittenden noted that F-16-13-C is to be reviewed for the next meeting. The next meeting is scheduled for March 10th at 10AM.

With no further business to discuss, the meeting was adjourned.