CHILD FATALITY AND NEAR FATALITY EXTERNAL REVIEW PANEL
May 13, 2013
KY Domestic Violence Association Building

Members Present: Judge Roger Crittenden, Chair; Sharon Currens, Kentucky Domestic Violence Association; Dr. Melissa Currie, U of L Division of Forensic Medicine; Dr. Tracey Corey, State Medical Examiner; Joel Griffith, Prevent Child Abuse Kentucky; Judge Brent Hall, Family Court Judge; 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; Robert Walker, Social Work Clinicians, University of Kentucky; Dr. Carmel Wallace, University of Kentucky Department of Pediatrics' Medical Home Clinic; Dr. Camella Yates, Chrysalis House, Inc.; and Andrea Goin, Court Appointed Special Advocate (CASA).

Members Absent: Detective Kevin Calhoon, Kentucky State Police (KSP); Senator Julie Denton and Representative Tom Burch.

The meeting was called to order by Judge Roger Crittenden, Chair. Judge Crittenden pointed out the legislation attached to the agenda indicating it was the final version passed by the General Assembly and signed by the Governor. He noted that the panel will continue to operate under the Governor's Executive Order until the new statute takes effect in June. He stated that Mr. Cannady sent out letters requesting names of new appointees be submitted by June 1, 2013, and shared that Chief Justice Minton has appointed Judge Brent Hall and Mr. Nathan Goins to the new panel. Judge Crittenden commented that Dr. Currie, as Chair of the State Child Fatality Review Team, would need to officially designate Dr. Shepherd to represent that team on this panel.

Judge Crittenden suggested a draft of the annual report be submitted to the panel prior to the September meeting as the report is due in December. He noted the new statute will require the Chair to report to the Health and Welfare Interim Joint Committee on a monthly basis. He also noted, beginning in 2014, the Legislative Program Review and Investigations Committee will conduct an annual evaluation of the panel and may require a report as well. Mr. Griffith pointed out there is also a requirement to post a report on the website after each meeting. Judge Crittenden mentioned having a summary of the minutes posted. Dr. Currie inquired about the focus of the annual report. Dr. Corey shared that annual reports would include statistical information followed by a summary stating conclusions of the panel.

Judge Crittenden remarked the statute says the panel was created for the purpose of conducting comprehensive reviews of child fatalities and near fatalities reported to the cabinet suspected to be the result of abuse or neglect. He commented that would include everything reported to CHFS whether substantiated or not and inquired about the how many cases that would be annually. Tina Webb, CHFS, indicated there are approximately 140 cases annually. Dr. Corey inquired about deciding a near fatality. Ms. Webb responded that it is defined by the federal

Child Abuse Prevention and Treatment Act (CAPTA) as a serious or critical injury as certified by a physician. She noted the state law mirrors that definition as well. Dr. Corey remarked that is open to subjective interpretation by a physician. Ms. Webb added that the certifying physician must be the treating physician at the time of the incident. Judge Crittenden inquired if the definition mirrored any legal definitions for assaults. Dr. Currie remarked the near fatality definition is not as specific as serious physical injury in the criminal statute. She explained that it is serious or critical injury which most interpret subjectively to be whether the child was ever in serious or critical condition or would the child have died without medical intervention.

Judge Crittenden inquired about developing a worksheet to use for reviewing each case. Dr. Shepherd indicated she could adapt an existing document. Mr. Griffith asked if DCBS could prepopulate a document that panel members could add additional information as needed. Dr. Shepherd stated she would work with DCBS to get the information. Mr. Walker inquired about having the ongoing list of recommendations available at each meeting. Judge Crittenden asked Mr. Cannady to provide the list for each meeting.

Dr. Currie asked about the status of SharePoint for the panel. Judge Crittenden communicated that he hoped SharePoint should be available for the new panel before September. Commissioner James expressed concern about SharePoint's ability to handle the volume of records. Judge Crittenden inquired with Mr. Cannady about having IT staff at the next meeting to discuss concerns. Dr. Currie suggested having a subcommittee to work on the SharePoint issue. Judge Crittenden asked Dr. Currie, Dr. Shepherd, Mr. Cannady and Commissioner James to serve on the subcommittee.

Mr. Walker suggested approaching Kosair and the University of Kentucky to provide funding for a staff person and offered to draft a proposal. He will work with Tom and circulate the draft for members to review. Judge Crittenden asked Dr. Currie and Dr. Corey to inquire with their contacts for any information on grants that may be available.

Judge Crittenden opened discussion on how to address requests to review specific cases. Mr. Griffith stated the statute was written to make sure the panel had the ability to look at cases even if they had not originally been referred to DCBS. He noted the legislation was written intentionally to include cases that came to the state child fatality review team thru the health departments. He specified that referrals should come thru the local fatality teams. Dr. Currie agreed and inquired how the panel should address near fatalities. Ms. Oldham suggested using the multidisciplinary teams. Mr. Griffith remarked they could be funneled thru the Child Advocacy Centers (C.A.C.'s). Ms. Oldham pointed out that the teams would need to be notified of the ability to refer cases to the panel for review. Judge Crittenden asked Ms. Oldham and Mr. Griffith to draft a protocol before the next meeting regarding case referrals, how they are chosen for review and any limitations.

Group 1 (Burch, Calhoon, Corey, Currens)

FC 3

Dr. Corey commented that this case may still be open to criminal prosecution. Ms. Currens noted it was clear the social worker was very concerned about the case as well as the person completing the autopsy. Dr. Currie stated she was consulted afterward but was uncertain if her report was included in the case. Dr. Corey stated it was a multi-volume case that involved a child with blunt head trauma who had a potential history of a crushing head injury from a television toppling over which was the initial history given. She noted that was initially signed out as undetermined manner by the medical examiner's office based on the injuries and the history. Ms. Currens commented that the case was confusing as it begins with information about another child and the alleged perpetrator. She noted the mother had domestic violence issues as well as the father of the child and possibly the alleged perpetrator. Dr. Corey pointed out that the child was transported across state lines. Judge Hall inquired about the outcome of the administrative appeal. Commissioner James indicated she would seek that information. Judge Hall commented there were many different stories with this case. Commissioner James pointed out that CASA and DCBS both were begging for someone to do something in this case. She also indicated there were threatening statements made to staff. She stated the other children were placed with the grandparents eventually under dependency. Mr. Griffith noted that the alleged perpetrator had been charged with choking his own seven month old child and the case was diverted. Ms. Currens stated that the police report was needed for review. Dr. Currie commented the communication between DCBS and law enforcement in this case is worth looking at further and suggested requesting more documents and revisiting the case. Judge Crittenden commented that the medical examiner could not specifically state the manner of death and, as a result, the prosecutor could not go forward with prosecution. Dr. Corey remarked the medical examiner cannot call the manner of death until they receive all of the information. Dr. Currie noted a key issue to perhaps include in the final report is the concept that the law enforcement investigation oftentimes informs what happens in family court; therefore, even if criminal charges are not filed, workers still need law enforcement to gather information that DCBS cannot such as good scene investigations, photographs, etc., in order to protect children. Dr. Corey commented that the child was pronounced in West Virginia which, along with Tennessee, does not autopsy Kentucky residents. She commented the death investigation should occur wherever a person dies but surrounding states do not agree. Dr. Currie noted that the issue of crossing state lines occurs often and perhaps a system could be implemented to have a designated team assist with coordination.

FNC 3

Dr. Corey stated this case involved a two year old that drowned in November in a neighbor's pond.

NFNC 1

Dr. Corey noted this case involved a two month old who was alone with the father and had findings consistent with abuse injury including a head injury and healing rib fractures. She stated this was also a child who was transported to West Virginia. She stated she is not aware of charges pending but assumes there will be. Ms. Currens inquired about the length of time before charges are filed as this occurred in 2011. Dr. Currie stated in her program the average is two years. Dr. Corey commented that these cases are difficult for law enforcement as they usually

begin with a call to 911, the child is transported sometimes across state lines as in this case, and the first call law enforcement receives is to the hospital rather than the scene which is generally gone by the time they realize there is a potential case. Judge Crittenden noted that it then becomes difficult to prosecute as evidence is lost.

NFC 1

Dr. Corey stated this case involved a three year old who ingested Clonidine prescribed for the child's hyper activity. She commented there were lots of potential social issues within the family which was said to be homeless. She noted the child had been taken to the emergency room twice since 2010 for drug ingestions with varying stories including the belief that the child was ingesting the medications to get attention. Ms. Currens remarked that there was some confusion regarding who was prescribed the medication. Dr. Currie commented that may have been an error in medical documentation. Dr. Corey noted the mother refused a drug test when the child was admitted and inquired if there should be a means to compel a drug test. Commissioner James remarked that there was a family history of concerns regarding substance abuse. Mr. Griffith noted the DCBS had lost contact with the family at some point and a resource had given the address a week before the incident but contact was not made. Ms. Oldham noted there were ten prior substantiated reports.

Group 2 (Currie, Crittenden, Denton, Goin)

FC 4

Judge Crittenden noted this case is an ongoing investigation involving a two year old child that was placed with an aunt and uncle. He explained the aunt went to work and left the child with the father who was not supposed to have the child and the child died. He noted that allegedly the birth mother took photos that were reported thru visitations but there are no photos in the file. Dr. Currie explained that the child was found dead with multiple injuries and it was clearly an abusive blunt force trauma related death. She stated the child had been taken by the worker to a pediatrician where the worker specifically requested a skeletal survey due to concerns for abuse and the pediatrician declined. Dr. Currie commented on an issue in this case that she sees often when a worker asks a parent or caregiver to take a child to the doctor for evaluation which then forces the doctor to rely on the caregiver for information. She stated there is a need for communication to doctors regarding the concerns so that they understand the seriousness. She noted that while it was difficult to tell from the medical records, if photographs had been taken of this child earlier to be evaluated by someone perhaps a physician could have intervened earlier. She also noted that the mother sent photos to the worker; however, it appeared the worker never looked at them. Dr. Corey commented that it is an unfair burden placed on private pediatricians when we expect them to have forensic training. She remarked that doctors are trained to analyze, document and interpret injuries to heal the patient, not to make the case for social services or the police. She stated that Dr. Currie's specialty and hers are the only two specialties trained to do those things for the purpose of answering legal questions. Mr. Griffith suggested recommending that a statewide network is needed to allow DCBS to access forensically trained specialists. Dr. Wallace commented that in his thirty years of private pediatric practice he never had a social worker contact him regarding a patient they were referring for suspected abuse. He

stated there was more information from his office to social services than from the agency to him. Mr. Walker commented that having access to behavioral health forensic providers is also critical. Ms. Currens asked if the C.A.C.'s could be expanded to include these providers. Dr. Currie stated that there would need to be a physician at the C.A.C. who is trained in the subspecialty of pediatrics. She noted it is a three year fellowship and not something that can be learned in a two or three day in-service training. Judge Crittenden asked if there was any legal reason prohibiting a social worker from contacting a pediatrician to refer someone. Dr. Currie noted that most social workers do not know their local pediatricians and that is a role of a multidisciplinary team, to establish those relationships. Dr. Corey suggested developing a protocol with the C.A.C.'s to get the children in for a standard workup including photographs and to make referrals for skeletal surveys when injuries are suspicious. Dr. Currie remarked that funding is an issue as the C.A.C.'s only have a medical provider available half a day once or twice a week.

Group 3 (Griffith, Hall, James, Reid)

FC 5

Judge Hall indicated that FC 5 was not received by the group.

NFC 3

Judge Hall stated that 1,335 pages had been redacted from NFC 3, 4, and 5. He remarked that some of the missing information changed the character of the case and the group wanted to wait until they had the information available for review.

NFNC 3

Mr. Griffith commented there was a central intake issue in this case. He noted the incident occurred in September but there had been a prior report in April which had been screened out at birth. Commissioner James noted that when there are significant concerns with a newborn being discharged from the hospital perhaps there needs to be something occurring in hospital discharge planning. She stated that in this case the mother had made plans for adoption which fell apart in the hospital and she took the newborn home. She noted there were significant bonding issues that occurred in the hospital. Mr. Walker remarked on the notations about the mother's mental health problems stating they were mostly mental retardation rather than mental health issues. He commented that it was difficult to know how much of her attachment issue was a function of low IQ versus lack of emotional engagement. He expressed that someone in the system should have realized this. Judge Hall noted this was intergenerational as the mother had been in the system as a child as well. Commissioner James noted that the mother's sister had an open case also. Mr. Griffith pointed out that the mother also had a two year old that had only received one immunization. He expressed the need for a system that wraps around low functioning high risk families other than the child welfare system as that is not its purpose. Dr. Currie suggested there be a requirement at discharge that a primary medical provider be identified by name in order to inform them to be expecting the child and require notification if the child is not seen within a week.

Group 4 (Oldham, Shepherd, Wallace, Yates, Walker)

FC 6

Ms. Oldham stated the case regarding Summer Adkins had many redactions and prior referrals. She commented that some of the investigations appeared incomplete and there appeared to be a lack of follow-up; however, the judge returned the child over objections from CHFS. She also noted there were telephonic interviews with the father which she expressed are a bad idea. She stated that a multidisciplinary approach with law enforcement involvement would have been helpful. Mr. Walker inquired about the degree of training for workers on court presentation of findings. Ms. Oldham remarked that workers are not trained to testify. Judge Hall commented that workers lack the ability to tell a story, have gaps in their presentations and are harassed by defense counsel regarding information that was not included in the petition. Commissioner James explained more training is being done with judicial staff and workers in an effort to meet judges' expectations and prepare staff.

Fiscal Year 2013 FNC Case

Judge Crittenden opened discussion on the newest case reviewed by the panel. Dr. Corey commented that a child left in a car is usually either an impaired caregiver or someone having a change in routine. Judge Crittenden commented on all the emphasis on campaigns such as if there is a car seat in the car, check it before you leave. Mr. Griffith noted there are concrete prevention strategies such as putting bottles up front and weight sensors that will alert you if you get too far away from the car. He also remarked these are relatively rare occurrences given the number of children riding in car seats. Dr. Corey stated this occurs more often in the southeast. Judge Crittenden commented again on the need for awareness campaigns that perhaps Kosair could sponsor.

Judge Crittenden stated that Mr. Cannady would send out the information for the next cases with each group reviewing three cases and as well as a review of one new case. Ms. Goin inquired about the process for dealing with the case files after reviewing. Judge Crittenden stated that, pursuant to the statute, the Justice & Public Safety Cabinet will destroy the files and that Mr. Cannady would notify members of the files to return for destruction. The next meeting was scheduled for July 22, 2013.

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

Meeting summary submitted by Marlene Mundine.