CHILD FATALITY AND NEAR FATALITY EXTERNAL REVIEW PANEL
July 22, 2013
KY Domestic Violence Association Building

Members Present: Judge Roger Crittenden, Chair; Senator Julie Denton; Detective Kevin Calhoon, Kentucky State Police (KSP); 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; Dr. Jaime Pittenger, Child Abuse Pediatrician, University of Kentucky School of Medicine; Dr. Camella Yates, Chrysalis House, Inc.; and Andrea Goin, Court Appointed Special Advocate (CASA).

Members Absent: Representative Tom Burch; Robert Walker, Social Work Clinicians, University of Kentucky, Dr. Kim McClanahan, CEO, Pathways, Inc.; Nathan Goins, State Chair, Citizen Foster Care Review Board Executive Committee; and Dr. Stephanie Mayfield, Commissioner, Department for Public Health, CHFS.

The meeting was called to order by Judge Roger Crittenden, Chair, who welcomed new members to the panel. Judge Hall was asked to swear in members. Judge Crittenden swore in Judge Hall. Judge reminded the panel of the statutory requirement to keep matters that are confidentially given to the panel confidential.

Judge Crittenden asked Glenn Thomas, Commonwealth Office of Technology (COT), to present information regarding the use of SharePoint for case reviews. Judge Crittenden inquired about the timeframe for setting up SharePoint for members. Mr. Thomas stated it would only take a couple of days to a week. Dr. Currie made a motion to go forward with the SharePoint plan. Senator Denton seconded the motion and the motion passed. Commissioner James questioned if the first 140 cases reviewed would need to be loaded into SharePoint. Judge Crittenden suggested loading future cases but not those the panel has previously reviewed. Dr. Currie indicated she would like to have the option to go back and select three or four previously reviewed cases that did not get the degree of discussion that she would have liked to have seen. Judge Crittenden said she could communicate those cases to be looked at again. Judge Hall noted there were a few cases that the panel did not receive records that were needed. Tina Webb indicated the panel did not receive some due to pending criminal cases; however some of those cases are now available. Dr. Currie suggested those cases be scanned into SharePoint for review. Ms. Webb inquired about how those cases should be listed on the master list sent to Tom Cannady. Judge Crittenden suggested continuing to use the same numbering system to identify cases. Ms. Webb suggested using the department's numbering system which includes the state fiscal year in which the death or near death occurred. Judge Crittenden agreed with that suggestion. Mr. Griffith suggested using a list which includes the case number, date of death, date referred to DCBS, and the date case was finalized.

Judge Crittenden asked Dr. Shepherd to explain the sample cover sheets she brought for the panel to review. Dr. Shepherd noted two suggestions were to have a summary and also to keep statistics. She stated the form covered demographics, what the incident was, agencies involved and also what risk factors were involved. She noted the form also listed family household information to keep a list of those involved in cases as well as family household risks. Dr. Shepherd also noted prior history with DCBS is listed with prior referrals chronologically on the front with the number of previous reports, substantiated or not, listed on the back. She noted that Dr. Currie sent her format for a timeline as well. Dr. Pittenger commented that psychiatric illnesses should be noted on the form. Mr. Griffith inquired if family risk factors could be pulled from TWIST. Dr. Shepherd stated the idea was to pull as much info as possible from TWIST to prefill the form. Ms. Oldham asked if the cabinet would fill out the form and scan into SharePoint with the cases. Dr. Shepherd remarked that it could be scanned as a cover sheet for each case. Commissioner James commented that it could not be prefilled but that it would be part of the agency's responsibility to coordinate getting them completed. Dr. Currie stated that she preferred the chronological version.

Ms. Webb commented that the panel should decide how they prefer to define risk factors for family in order to receive consistent information. Dr. Currie asked Ms. Webb to provide the criteria used by DCBS so that the panel can review for further discussion at the next meeting.

Group 1
FC8

Dr. Corey stated that this case involved a two month old little boy. She stated that she completed the autopsy in this case. She noted the case contained a lot of information; however, it did not contain the autopsy report. She commented that it was good that she reviewed the case as she could pull the autopsy file. She noted throughout the documents provided to the panel it states the mother reported the coroner said the death was consistent with SIDS. Dr. Corey stated the medical examiner's office has strict criteria for classifying sudden unexpected infant deaths. She stated she did not sign this case out as SIDS; she signed it out as undetermined. She noted her concerns with the baby being a co-sleeper, multiple people in the bed and other circumstances. Dr. Corey commented that she has reviewed the records in her autopsy file that were provided to her mainly through the coroner's office and noted she was not informed that both parents apparently admitted to being high on narcotics at the time that the child was discovered dead. Dr. Corey remarked that because of this case and several others it would be good to have some type of law requiring a drug screen if you are a custodian of a child and that child dies under your care. Dr. Currie agreed. Dr. Corey stated she had another case in Louisville a couple of years ago where the mother, who admitted to being high, left the child in the car and the child died from hyperthermia. She stated the detectives working the case tried to get a court order for a blood sample and it was denied. Senator Denton asked within what period of time would a blood sample need to be taken. Dr. Corey stated as soon as possible and within three hours. Ms. Currens commented that it seemed in this case that the child had died much earlier than realized. Dr. Corey noted that is not uncommon in sudden unexpected infant deaths as the child dies during a parent's sleep and that was the reason this case came in as a suspected SIDS. She stated this was not as this child, born opiate addicted, was placed face down on a pillow in a queen

sized bed with multiple individuals and that was even before she knew the parents admitted to taking Opana and Oxycodone. She noted that most of the babies who die suddenly and unexpectedly during sleep are in unsafe sleeping environments. Ms. Currens asked if Dr. Corey's findings should have been included in the case file. Dr. Corey stated she gets requests frequently from CPS for final autopsy reports. Ms. Currens noted there was nothing in the case that indicated social workers knew Dr. Corey's findings. Commissioner James commented it was documented that there were no injuries found on the autopsy so they may have called the medical examiner's office. Dr. Corey stated they did not speak with her as she would have noted it in her chart. Commissioner James indicated the worker must have known something from someone. Dr. Corey commented they may have spoken with the coroner's office or police but that she had no notation in the chart that a copy of the autopsy report was ever requested or sent anywhere. Commissioner James stated that may have been due to already having enough information to substantiate. She also commented that as the statute is now written, the cabinet will be gathering all the external information for cases to be reviewed. Judge Hall inquired about who was doing the drug testing on the family member. Commissioner James stated this was a START case which is for substance abuse children. She noted it is a nationally recognized program and that this was the first death in five years for these cases. She stated the cabinet was outside the visitation guidelines in this case. She noted the father was non-compliant with drug treatment and was not brought back to court in a timely manner and the mother had admitted during an unannounced home visit that she had taken a pain pill not prescribed to her. Dr. Currie inquired if a worker being outside policy guidelines is a training issue or an issue of having 100 cases when they were only supposed to have twenty-five. Commissioner James commented the volume frontline workers are under now is the most significant she has seen. Mr. Griffith remarked that for each case the panel needs to know the caseload, training, background and level of experience of that particular team. He stated having this information would help the panel address the issue for the cabinet from a broad perspective. Dr. Currie inquired about communication between DCBS and the coroner's office and medical examiner's office and the need to understand the difference between the two. She commented she has seen several examples where it appeared the medical examiner did not get significant information that was included in the DCBS file. She remarked that it may need to be a policy that communication has to occur with the medical examiner's office. Commissioner James inquired about the role of law enforcement in that communication. Detective Calhoon stated when he works a child fatality, he goes to Dr. Corey's office with crime scene photos and information he has obtained in the investigation. He commented that if there is a child fatality, a social worker is also needed there. Ms. Oldham commented she was concerned that if the right information is not given to the medical examiner, the prosecutor may not be able to rely on the medical examiner's determination for prosecuting the case. Mr. Griffith commented that there is an existing statute in place that requires the coroner to contact DCBS, the health department and law enforcement and pull the investigation together. He remarked that the panel needs to look closely at compliance with the statutes regarding local child fatality investigations. Dr. Currie agreed. Senator Denton inquired about the caseload for START program cases per worker. Commissioner James indicated the caseload was approximately nineteen to twenty cases per worker currently. She also noted the department is struggling to meet the mandate for the intensity of services that need to be provided. Judge Hall remarked that it is difficult to access care and inquired about the level of judicial involvement in this particular case. Kelly

Skerchock, CHFS, responded that non-removal petitions had been filed in court but it was unclear if it had been adjudicated.

Dr. Shepherd commented that in infant deaths, particularly post natal infant deaths after the first month of life, at least 70% of those involve a co-sleeping risk factor which is preventable. She noted it is seen particularly in substance exposed infants and the number of those is going up. She stated that almost a thousand babies were diagnosed with neonatal abstinence last year and that does not include those that go home without being diagnosed. She noted they are also at risk for abusive head trauma. She commented that Medicaid benefits cut off at sixty days and there are no programs that support families thru that period of time right after discharge.

Senator Denton commented that legislators are going to want to know if drug tests would be an automatic trigger for prosecution and at what level would it be determined to be a significant factor in the child's death. Mr. Griffith commented that it could be a hard sell to legislators. Dr. Corey commented that it would be a tool to further protect any other children still in the home.

Judge Crittenden suggested having a representative from the panel address the coroner's association regarding their role in child fatalities. Dr. Corey commented that in this case the coroner did a good job but there was a disconnect in knowing there was an ongoing investigation.

Group 4
FC7

Dr. Pittenger indicated this case involved a 9 month old little girl who drowned in a tub. She noted the mother gave several renditions of the story but originally said that she went to change her shirt and left her two daughters in the tub. Dr. Pittenger noted there were two prior referrals and there were apparently domestic violence and alcohol issues in the home. Dr. Currie commented that this case was another example of needing a blood test at the time of the child's death. Judge Hall noted there was some indication in the file that steps had been taken to mask drug screens in the past. Dr. Currie proposed tracking the number of cases where having the blood sample of the caregiver at the time of the fatality would have been potentially pertinent. Judge Crittenden agreed. Mr. Griffith commented that the panel should track the data for any potential recommendation. Dr. Pittenger remarked that she wished the panel had the autopsy for this case as well. She noted the child was transported to Cincinnati. Dr. Currie inquired about the older sibling. Ms. Skerchock responded that the older sibling was placed with the father against the recommendation of DCBS.

Group 2
NFC9

Judge Crittenden explained this case involved a 14 year old girl who overdosed on heroin with her mother in a gas station bathroom. He noted the mother was kept in the hospital and charged and the child was released to another relative. He commented the relative appeared to be the most stable of a twenty member family that was totally dysfunctional and using drugs. He remarked the relative the cabinet found probably did not understand what was going on to a great

extent. He noted the redactions in the case made understanding who the characters were almost impossible but the case had the same risk factors the panel has discussed such as substance abuse, domestic violence, poverty and lack of education. He noted there was a court history for truancy and the cabinet had been involved. Dr. Currie noted the complexity of the case due to the child's age and privacy rights. She stated one issue seen in the hospital is the challenge of discharging children who have a medical diagnosis or have just been traumatized to individuals that are not allowed to have that information. She commented that it is nearly impossible for them to appropriately take care of that child if they do not know what has happened to them. Dr. Currie stated that she frequently sees workers deem information not directly pertinent to the foster parents' ability to make decisions for the child and that it is a judgment call that she often does not agree with. Commissioner James commented that it is on a reasonable need to know basis but in terms of medical information she would want to be contacted if that happens. Judge Hall inquired about the court's involvement. Commissioner James responded there was some judicial involvement in Ohio. Ms. Skerchock commented the cabinet sought an emergency custody order from the judge at one point due to concerns about the grandmother's ability to take care of the child and it was denied.

Group 2
NFC10

Judge Crittenden stated this case involved a five month old who was transported from Marion County to Kosair with brain trauma. Dr. Currie commented it was acute and chronic subdural hematoma /abusive head trauma. Judge Crittenden stated there was an order from Dr. Currie that the child was not to be returned to the environment. He noted there were prior complaints about neglect that did not involve the person who did the abuse. He also noted the local hospital had the child in a couple of times before and did not identify the problem. Dr. Currie stated there is a need for more education in hospitals and there is clear data that abusive head trauma and child abuse are being missed far more often than they should be. She noted often children are being assessed at adult facilities staffed by physicians who are trained in adult medicine. Ms. Oldham asked if this was another issue that should be tracked as misdiagnosis or missed prior injuries. Dr. Currie agreed.

Mr. Griffith commented the panel has yet to define how the fatality review processes interact with each other in terms of recommendations. He noted the next meeting will be September 9th at the Lexington Convention Center and the panel will hear from Teri Covington of the National Center on Child Death Review. Dr. Currie suggested asking Ms. Covington for recommendations on how agencies interact. Judge Crittenden asked the panel to get information to Tom Cannady for the annual report to have a draft for the panel to review at the next meeting. Dr. Shepherd commented the panel needs to decide which recommendations to put forth and also to provide the background explaining why those recommendations are important. Judge Crittenden noted the report should include the number and types of cases reviewed the last twelve months and the panel's findings and recommendations.

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