CHILD FATALITY & NEAR FATALITY EXTERNAL REVIEW PANEL
September 14, 2015
Crowne Plaza Hotel, Louisville

Members Present: Judge Roger Crittenden, Chair; Joel Griffith, Prevent Child Abuse Kentucky; Commissioner Teresa James, Department for Community Based Services, Cabinet for Health and Family Services (CHFS); Allison Taylor, designee for Dr. Stephanie Mayfield, Commissioner, Department for Public Health, CHFS; Dr. Jamie Pittenger, Pediatric Hospitalist, University of Kentucky School of Medicine; Dr. Blake Jones, University of Kentucky School of Social Work; Ed Staats, Citizen Foster Care Review Board; Maxine Reid, Family Resource and Youth Service Centers, CHFS; Dr. Tracey Corey, State Medical Examiner; Dr. Ruth Shepherd, State Child Fatality Review Team; Jenny Oldham, Hardin County Attorney; Nicky Jeffries, Court Appointed Special Advocate (CASA); and Dr. Sabrina Jo Grubbs, Pennyroyal MR/MH Board.

Members Absent: Senator Julie Raque Adams, Representative Tom Burch, Judge Brent Hall, Ms. Sharon Currens, and Dr. Owen Nichols.

Judge Crittenden began by welcoming members and introducing new analysts, Karen Bremenkamp and Kindra Kilgore. Judge Crittenden noted the first item on the agenda was the draft of the legislative policy which was discussed at the last meeting. Mr. Griffith stated that he had comments that he can email but overall the panel needs to be very careful about the legislative process as he does not see it being a part of the panel's mission, especially when commenting on legislation that the panel has not specifically recommended. Ms. Oldham and Dr. Currie agreed. Dr. Currie noted the draft gives framework and tools to proactively go to the legislature to support things that are directly related to panel recommendations. Mr. Griffith commented that the draft seemed to be written in a way that opened the door to commenting on other legislation but it should be stated that the panel does not comment on legislation unless it is written in the annual report. Ms. Oldham and Judge Crittenden agreed. Judge Crittenden asked panel members to submit comments by email to Ms. Bruckner.

Judge Crittenden asked for members to serve on the annual report committee. Dr. Currie and Dr. Shepherd volunteered. Judge Crittenden asked if members have reviewed the draft letter regarding notification to hospitals on cases involving shaken babies and unsafe sleep. He noted that there are a couple of books available in the vendor area regarding these two issues. Dr. Shepherd gave an overview of the origin of the books and stated that they are encouraging birthing hospitals to use these resources. Ms. Oldham suggested sending the books along with the panel letter to the hospital so that hospitals could budget for the books. Dr. Shepherd stated that CHFS purchases the books for the HANDS program so they could work that out for the hospitals to purchase them as well. Mr. Griffith noted that Dr. Hutton will also send a web viewer of the book as well, so we could insert that link as well. Judge Crittenden stated that he liked Dr. Shepherd's idea of supplying the books for the hospitals if they agree to develop a certified program. Ms. Oldham inquired about the signature on the letter stating that she would like to sign the letters to the hospitals in her area to personalize it. Mr. Griffith suggested sending a copy to everyone on the panel so that they can also make contact. Judge Crittenden

commented on the need to make sure the right person receives the letter as well. Dr. Shepherd stated that they have a list of nursing directors and hospital administrators. Mr. Griffith suggested sending the letter to the nurse educators as well. Dr. Shepherd suggested making the person contact by copying to the panel members. Judge Crittenden asked panel members to email comments to Mr. Griffith to finalize the letter.

Judge Crittenden noted that training by medical professionals will start with him, Judge Hall and one additional person presenting to the family court college this month. He stated that it will be a 30 minute presentation on what the panel is doing and will try to get on the agenda for an hour next year to give some medical and social work background to judges. He noted it is important to have a doctor and one of the top line social workers present to the judges.

Dr. Shepherd gave an update on the public awareness campaign regarding bed sharing. She noted that October is SIDS awareness month and, while there is not funding for television advertising, there will be a lot of digital media with Facebook, Twitter, etc. Judge Crittenden commented that local cable air time can be inexpensive. Dr. Shepherd stated they are doing that as well as some audio news releases. She noted they will also be doing something each day for a week on a TV segment that many stations air called Moms Every Day.

Regarding the recommendation, assuring linkage of high-risk infants to a medical home and community services prior to discharge, Dr. Currie commented that there might be something to be gained by doing an article in the statewide KMA Journal or something that has a wide circulation to get this on the radar of at least one or two doctors at each hospital. She stated approaching this from a policy perspective would be extremely difficult; therefore, the education approach is most feasible.

Ms. Oldham updated on the protocol for sharing information during the investigative process. She commented that the appropriate approach might be to get training into law enforcement academies. Judge Crittenden agreed. Mr. Griffith stated that the National Association of Chiefs of Police recently came out with a protocol or book on assessing safety of children when making an arrest and working collaboratively with child protective services. He stated he would forward the link to Ms. Oldham. Dr. Currie noted the importance of communicating resources available to law enforcement officers also. Commissioner James noted that most issues occur on the local level. Mr. Griffith suggested including this information in the annual report to formalize into a more specific recommendation. Ms. Oldham also suggested merging some of the child fatality review teams with the multidisciplinary teams.

Judge Crittenden stated that he had not spoken to Senator Adams or Representative Burch about open courts legislation but is aware that others are working with them on the bill. Dr. Currie stated that the panel should stay away from the juvenile justice part of the bill again this year. Be clear that it is not a component related to its scope and not comment on that portion. She commented that it should also be made very clear in the annual report the reasoning behind the panel's support for open courts. Mr. Staats remarked that the transparency issue has to be front and center. Mr. Griffith suggested creating a one page outline so that every panel member is on the same page. Judge Crittenden stated that he would work on that with Ms. Bruckner.

Ms. Oldham updated the panel on the progress with the recommendation to provide training by medical professionals for prosecutors and stated she would contact the Prosecutors Advisory Council regarding a standing slot for training every year at their August conference.

Judge Crittenden asked if there were new recommendations to discuss for the annual report that have come from this year. Dr. Currie stated that she did not know enough about the data collected to know what evidence is available to make new recommendations. She commented that she is interested in knowing what the numbers will show regarding the issue of not properly restraining children in vehicles. She noted many near fatalities involving motor vehicle collisions involve children that were not properly restrained and drivers who were impaired. She commented that Kentucky does not do much, if anything, about the issue. She stated it is not uncommon for people to leave the scene and not even have a ticket, much less criminal charges, and there are issues of whether or not CPS substantiates neglect in those cases. She suggested making a new recommendation or area of focus regarding child passenger safety and what should be the most appropriate response. Dr. Shepherd noted that more data needs to be collected on the issue as that information is not always included. Ms. Oldham inquired about what the panel's current data indicates on child restraints. Judge Crittenden stated he was not certain there is a field of data on that issue. Ms. La'Quida Smith commented that information is not collected on the data tool but can be added. Dr. Shepherd indicated the data was not collected. Dr. Currie stated that she believes the vast majority of the cases have included inadequate restraint. Mr. Griffith suggested finding parallel data to use.

Mr. Griffith inquired about the caseload study for DCBS. Commissioner James stated that the costs associated have been a barrier but the department is working with CHFS leadership on the issue. She noted they are doing a monthly hand count in addition to the data collected from TWIST. She stated the Department has put into place a policy that after two weeks out of the agency, that social worker's cases must be transferred to the person who is actually working the case. She also noted they are prepared to make a significant budget request to the legislature for staffing and they are also looking at creating a separate job classification for DCBS workers. Mr. Staats commented that the workers he encounters seem to be disconnected from Frankfort and inquired about training and communication for workers in the field. Commissioner James responded that there is a policy for communication through the chain of command and the ability to move beyond that through service region administrators, as well as an ability to call anonymously thru a hotline. Judge Crittenden inquired about the ability to look at the experience level of a worker in a case with a systems breakdown. Commissioner James stated that can be provided on any case. He also inquired if any regional differences have been noted. Commissioner James they do have regional issues particularly where they have more competition in being able to hire. Dr. Currie stated the panel needs to have the data to provide as support before recommending more resources to DCBS. Commissioner James inquired about going back the last few years for every fatality and near fatality to look for the caseload for the worker and the average caseload for the county. Panel members agreed that would be helpful. Mr. Griffith noted that the experience is important as well as any exit interview data available. Dr. Currie stated that worker experience is important as it speaks to the salary issue and turnover rate as well. Dr. Shepherd commented that the acuity level of cases has an impact as well.

Judge Crittenden asked for any comments or corrections to the July meeting minutes. As there were none, the minutes were approved as submitted. Judge Crittenden then asked Mr. Cannady to give the financial report. Mr. Cannady noted a copy was included in the materials distributed and gave an overview. Judge Crittenden noted that Mr. Cannady and Ms. Bruckner will be traveling to Michigan this month to attend a meeting of the Michigan panel to get an idea of how they handle the process.

Judge Crittenden inquired about the current status of MOA's. Mr. Cannady stated that they will be reposting for additional analysts but may also want to reconsider having fulltime staff instead of contracting. Judge Crittenden commented that perhaps both. Commissioner James asked that DCBS be included in some of the funds for the upcoming year. She noted that none of the funds were allotted to help DCBS. Dr. Currie agreed and stated that the panel is asking for a lot of data from DCBS that is time-intensive for them to gather and it seems reasonable that if we pay the analysts to do summaries that the panel would at least allot some funds for DCBS. Judge Crittenden stated that could be a part of the budget request to add on and ask for funding to help support the data collection at DCBS. Commissioner James stated that the funding to hire a social work position would be very helpful. Judge Crittenden asked Mr. Cannady to include that in the budget request as well as adding a fulltime analyst on staff to work with the contract analysts.

Judge Crittenden asked Ms. Smith to update the panel on the data collection process. Ms. Smith stated that she has the first twenty-eight cases entered with descriptives and frequencies. She noted that other cases are missing some information and analysts are working to gather that data. Ms. Smith also remarked that she will need questions that the panel wants answered in order to pull data. Dr. Currie stated the need to prioritize cases that have been reviewed so that there will be a block of cases to describe for the report. She suggested beginning with the questions that were answered in the report last year and those can be expanded. Dr. Shepherd asked where the database is housed. Ms. Smith responded that the data tool is on SharePoint. Dr. Currie inquired about who has access. Ms. Smith explained that she used SPSS at Kentucky State University for those twenty-eight cases by pulling the data out of SharePoint into Excel.

Dr. Theresa Hayden gave an overview of her data collection process report prepared for the panel. Dr. Hayden noted that Dr. Shepherd recently informed of her of some misinformation contained in the report. Dr. Shepherd commented that on page nine of the report under evaluating the data tool, Dr. Hayden suggested looking at the National Child Death Reporting System and that is the data system currently used. She noted that data is not used to do the type of things this panel addresses in terms of looking at where are the system breakdowns, etc. She explained that is why we have developed a data tool which specifically identifies those issues. Dr. Currie agreed and commented that some of the background information in the report skips over the fact that the public health database and the national tool are referring to child deaths from *all* causes as opposed to those caused by abuse or neglect. She stated that what this panel is looking at is not at all what can be obtained from that national tool. There was some confusion regarding whether the data is currently in a sequel database. Ms. Smith explained that information has to be exported into Excel as it is currently stored.

Cases Reviewed:

F-20-14-C

- Thirteen year old female, previously healthy, died of dehydration from gastrointestinal illness
- Lived in home with mother who was on dialysis and three siblings
- EMS called to home, child was deceased, called police who notified coroner
- Coroner called CPS to respond
- Child reportedly became ill four days prior to death with vomiting and diarrhea, fever
- Child had asked to go to doctor; mother did not want to take the child to doctor and leave other children alone
- Lengthy CPS involvement beginning when mother was fifteen years old
- Mother had four children living in home with her and also had an adult son that was raised by her parents
- Mother died within a month and half of her child dying
- Mother uncooperative with CPS; previous reports of physical abuse, drug use, allegations of neglect, environmental neglect, mental health neglect of child, substantiated sexual abuse
- Law enforcement responded twenty-nine times to home regarding neighbor complaints of unruly/unsupervised kids, etc.
- CPS referral two months prior to death and mother had finally agreed to in home services on December 17. Child died less than two weeks later before that was set up.
- Children taking care of mother as her disease progressed
- Commissioner James will check to see if there was an internal review of case
- **Substantiated medical neglect**

F-28-14-C & NF–47-14-C

- Both children involved in motor vehicle collision
- F-28-14-C child was improperly restrained in a forward facing toddler seat
- NF-47-14-C six year old sibling was in critical condition but did not indicate if restrained at all but based on age probably should have been in booster seat
- Mother was driving and reported to be intoxicated
- Maternal grandmother reported to investigators that mom had come to her home earlier in day and appeared to be intoxicated. Mother was pregnant. Mother denied being high. Maternal grandmother asked mother to go to shelter and leave kids with her but was not allowing the mother to stay because of her drug use.
- Mother admitted to using non-prescribed Xanax and having recently gone to the methadone clinic.

- Mother reported using Xanax the day prior and the day of the accident and attributed the cause of the accident to reaching in the backseat to get a toy for child who was crying.
- Report indicated vehicle traveling at a high rate of speed on a roadway known to be curvy
- Three prior unsubstantiated CPS reports regarding drug use/abuse
- Mother involved with methadone clinic
- Two prior DUI guilty charges in KY and it was alluded to five DUI's in Indiana but the records were not provided
- Paramour was intoxicated upon arrival at hospital
- The six year old child was discharged from hospital to mother who had to stay with her mother for family supervision purposes
- Six year old's injuries included bilateral broken legs, liver laceration and significant facial trauma with facial bone fractures and was discharged to a rehabilitation hospital before being discharged home
- Indicated he was a back seat restrained passenger but did not mention if he was in a booster as he probably should have been based on his height, weight, etc.
- Mother was indicted for murder, assault 1st, possession of controlled substance 3rd and dui with aggravator.
- Six year old remained with maternal grandparents to attend school but was later placed in joint custody with mother and grandmother as mother was expecting to go to prison due to guilty plea to manslaughter 2nd, assault 2nd and DUI
- Infant remained with father
- Following accident, emergency custody order filed by cabinet and dismissed by judge, custody left with mother as long as she resided with her mother and compliant with court's order
- Case supports the recommendation for open courts; no basis for knowing why judge made this decision
- May have dismissed due to lack of drug screen results; why not continue case rather than dismiss?
- Mother held accountable for driving impaired but no mention or documentation of holding accountable for not properly restraining children in vehicle which resulted in a death
- Multiple previous reports; not a predictive factor but should be noted.
- No internal review
- Judge was closely monitoring case and kept calling them back in for review
- **Substantiated Neglect but not related to the death/near death due to no evidence that mother was intoxicated at the time of accident. Waiting for criminal court determination.**
- **Neglect due to lack of proper restraint and substance abuse**

NF-18-14C & NF-20-14-C

- Sibling cases involving 14 month old female presented to local ER with paternal grandparents for concerns of developmental delay.
- Described decreased activity, not walking like she had been, staring spell where unresponsive
- Head CT showed brain tumor; transferred to Kosair, had multiple surgeries and hospitalized for many days
- Allegation called in to CPS that mother did not seek care for the child and family alleged that child had these symptoms for about three weeks prior.
- Other two children, three year old male and two month old male, seen by doctor. Baby was found to be a case of extreme failure to thrive.
- Mother had significant relationship issues with everyone. Open case with CPS with numerous services in place. Had regular contact with CPS worker.
- Mental health concerns with mother; mother reported that she was diagnosed with bipolar and ADHD at age twelve. Mother stated she had trouble in school. Were there cognitive issues? Medical neglect of mother?
- Mother would call in concerns to pediatrician often but never went in
- Children placed with relatives
- **Substantiated near fatality neglect on both children; medical neglect for child with brain tumor and neglect not feeding baby**
- **Medical neglect for both**

The next meeting will be held on November 16, 2015. With no further business to discuss, the meeting was adjourned.