CHILD FATALITY NEAR FATALITY EXTERNAL REVIEW PANEL

January 26, 2015
Kentucky Domestic Violence Association, Frankfort, KY

Members Present: Judge Roger Crittenden, Chair; Joel Griffith, Prevent Child Abuse Kentucky; Dr. Melissa Currie, U of L Division of Forensic Medicine; Sharon Currens, Kentucky Coalition Against Domestic Violence, Executive Director; Major Eddie Jonson, Kentucky State Police (KSP); Commissioner Teresa James, Department of Community Based Services (DCBS); Dr. Blake Jones, University of Kentucky College of Social Work Training Resource Center; Maxine Reid, Cabinet for Health and Family Services, Regional Program Manager, Senator Julie Raque-Adams; Dr. Sabrina Grubbs, Addiction Counsellor, Penny Royal MH/MR Board, Inc.; Allison Taylor for Dr. Stephanie Mayfield, Cabinet for Health and Family Services (CHFS), Commissioner, Public Health; Dr. Jaime Pittenger, University of Kentucky School of Medicine, Pediatric hospitalist and Assistant Professor of Pediatrics

Members Absent: Rep. Tom Burch; Dr. Tracy Corey, Kentucky State Medical Examiner; Nathan Goins, Citizen Foster Care Review Board Executive Committee, Chair; Judge Brent Hall, Hardin County Family Court; Nicky Jeffries, CASA of Kenton and Campbell Counties, Executive Director; Dr. Kim McClanahan, Pathways, Inc. CEO; Jenny Oldham, Hardin County Attorney; Dr. Ruth Shepherd, Kentucky Public Health State Child Fatality Review Team, Chair.

Chair Roger Crittenden called the meeting to order and welcomed the newest members of the Panel: Dr. Sabrina Grubbs, representing addiction counsellors, with Pennyroyal MH/MR Board, Inc., and Senator Julie Raque-Adams, Chair of the Senate Health and Welfare Committee. He also introduced an intern from the Association of Independent Kentucky Colleges and Universities, Justin Lawson, from Campbellsville University. Justin will be working with the Panel this semester. The Forensic Medical Analysts contracted by the Panel were introduced: Cindy Curtsinger, Ashley DeJarnette, Sue Hilburn, Christina Howard, Emily Neal and Vickie Zelko.

The Chair noted that the Panel has received good press on its annual report and various articles have been distributed to the panel as we became aware of them.

Regarding the 2015 session of the General Assembly, a recommendation suggested in the annual report concerning open courts was discussed. Two bills filed last session improving its changes this year. Joel Griffith added that the Prevent Child Abuse Kentucky board of directors has voted in concept for supporting open courts with judicial discretion, but they do not have a specific bill to respond to at this time.

Judge Crittenden noted there was an adjustment to the final report regarding some transposed data figures around page 17. Tom Cannady responded that staff sent corrected copies to archives and LRC and posted the corrected report to the Justice Cabinet website.

Minutes of the September and November meetings were emailed to panel members. A motion to accept the minutes was made and seconded.

Joel Griffith brought up discussion of tracking recommendations published in the annual report addressing this group's role in seeing panel recommendations reach their respective agencies; expectations regarding feedback; and the panel's role in monitoring recommendations for future reporting. Dr. Blake Jones proposed keeping a running status of our recommendations and providing an

update at all panel meetings on each recommendation. Specific individuals or agencies could address the panel regarding how specific recommendations affect their agency and what steps they have or have not taken in response. Judge Crittenden mentioned to Commissioner James that a number of the recommendations relate to the Cabinet (CHFS), in terms of the Cabinet taking the lead, on safe-sleep and the caseload time study that may be conducted this year. Commissioner James responded that there will costs associated with implementing those recommendations. She indicated they are looking at best practices other states utilize in terms of child welfare. They currently use supervisors to triage and keep up with case load. DCBS has a large consulting group working on other projects, and will consider their abilities for this task, or possibly inquire with the Casey family programs to determine who in the country may have the most expertise in making an assessment. She hopes this would be completed by the 2016 Session to present to the legislature and the Governor regarding the needs of the Department. She also indicated her department is attempting different management styles to manage caseloads. Staff are hand-counting case-loads, which changes the way we look at things. If a worker is off a case more than two weeks that case now has to be reassigned to the system in an attempt to provide caseload count accuracy and clarity. Additional positions are being hired in 5 of their 9 regions. Commissioner James stated that they now have a 35% turnover rate in one region and 25% in another. Applicants are not even going onto the registers for the positions posted. The Department is struggling to find competent individuals. The incoming pay has some challenges in urban areas. An applicant can go to work for hospice or other social work provider and do much better with a position that involves a lot less risk and personal liability.

Senator Adams added that she has heard frustration expressed relative to the Cabinet and caseworker loads. Part of the frustration relates to which cases receive priority treatment. Commissioner James responded that they are looking at intake very closely and actually have a workgroup of folks that answer the phones attempting to build some continuity in case assessment. She said she believes that there are varying degrees of report acceptance by area. They are also planning to perform quality assurance by monitoring the phone calls. Their staff performing quality assurance while listening to a worker at centralized intake, listening to a provider. We have conducted some education with the schools about what we need through the educational in-services in collaboration with the Kentucky School Board Association.

Judge Crittenden suggested looking at all the recommendations and having Kerry assign specific ones to various panel members to monitor. He said he discussed with Secretary Brown the recommendation on coordinating investigations. The Secretary agreed to take the lead on exploring investigative processes that could be shared between agencies including LINK and local law enforcement. The Chair then reminded the panel that we have the recommendations by agency/actor in the annual report, and suggested that we pick one or two of those for each meeting and report on its status.

Judge Crittenden asked who the contact would be as far as health care providers are concerned for fulfillment of requirements or discussions of the newborn's parents about safe sleep, etc.
Dr. Currie remarked that the whole education piece with regard to abusive head trauma, birthing hospitals and co-sleeping was going to require building an infrastructure to start. Joel Griffith mentioned that Dr. Shepherd has convened a group and called every birthing hospital in the state. She is asking them what program they are using, if they have a program. Their goal is to have an education program in place at the start of April. He added that this is an example of a recommendation follow-up they could report. Dr. Currie inquired if that group was only looking at the abusive head trauma, or also looking at co-sleeping and risk assessment? Joel replied they were just looking at pediatric abusive head trauma, so it's a partial to the status of a recommendation. Dr. Currie suggested tackling them all at once for better efficiency. Judge Crittenden noted some of the recommendations cross lines, but we should take a look at those and get something put together for discussion at the next meeting. He indicated he would check with the Supreme Court and General Assembly regarding authorization of the open courts. Senator Adams agreed to get the language from last year's session and pre-file a bill.

Judge Crittenden inquired about the contract for data analysts for 2014 and 2013. Tom Cannady replied we hope to to find someone who can tell us what data we need to collect; a professional in data analysis that could assess our data tool and our methods of data collection to ensure we are getting the best results. We may need to adjust the data tool to accurately collect those numbers, we want to do that in the beginning rather than later, and also apply it to the 2013 cases. Dr. Currie remembered we had a contact at the Kent school of Social Work at U of L, and suggested the possibility working with them. It was determined we need to start now to get that person, firm, or contract in place to have it by the end of the fiscal year. Dr. Currie stated the Analysts are doing the best they can with the resources they have, so getting a professional to sort through issues with us would be very helpful. Judge Crittenden asked if we were speaking of utilizing a contract for the data analysis portion. Tom indicated we wanted to set up the data collection with the ability to continue using it in the future. Then, we could focus on getting a person who could monitor the data collection and continue to collect and analyze the data as we go. Dr. Currie suggested that Dr. Shepherd may have qualified people in her area

A motion to spend up to $40,000 for data analyst services, on a contract basis, was made by Sharon Currens and seconded by Dr. Blake Jones.

Judge Crittenden asked that Mr. Cannady explain about expanding the medical analysts' budget for reviewing case summaries to include the 2013 cases. Tom referred to the financial report spreadsheet that noted almost $3,200 dollars for July-Dec 2014. He added it is costing approximately $10,000 to review the first 25 cases and projecting that figure over the remaining case load would spend all of the money that was designated in the MOA. Reviewing all of the approximately 100 cases will cost about $45,000. The panel needs to discuss expanding the dollar amount of the MOA. Dr. Currie stated she knew there were applicants that responded to the initial RFP for Forensic Medical Analysts recommended the panel pursue adding additional analysts. The amount of time required to review and prepare case summaries has been more than they anticipated. She suggested submitting another RFP. Judge Crittenden asked if under the current regulations, they need to submit another RFP or can they add to and expand the current MOA. Tom explained that Kerry and he thought it might work if they could both expand the Memorandum of Agreement to ensure the FY2014 cases would be competed, and then submit an RFP to fund additional analysts to cover the FY2013 cases. He added that the COT people were continuing to develop and improve the SharePoint site and were working with us to develop the data tool within SharePoint. The data tool is going to drive file establishment. When DCBS uploads case file information SharePoint will create a series of working documents for each case name including a data tool. COT is attempting to simplify the process but the panel must establish protocol.

Joel Griffith asked who was being paid out of the staff expenditures. Tom Cannady noted that it was him, part of Marlene and Kerry, who didn't start until September. He added that Kerry was about a 50-50 split between the Justice Cabinet and Panel duties and he was at 80% toward the panel. Judge Crittenden noted that they were sharing the costs of employees with the Justice Cabinet.

Judge Crittenden noted the financial report handout covered expenditures for the next six months, and that if they expand as Tom recommended, the $41,812 is the projected expenditure for the Medical Analysts, and that picks up the December charge. Tom said the figure included December and January and they have spent about $10,000 dollars. Judge Crittenden noted that he understood the $30,000 is to expand the MOA, but then asked about the $75,000 case reviews section. Tom said that is the cost to review FY2013, and it would be about the same number of cases as 2014.

A motion to accept the proposals that had been budgeted, was made by Sharon Currens and seconded by Dr. Blake Jones.

The next topic of discussion was case review process and the modified data tool. Dr. Currie said she and some of the other panel members had developed a data tool which seemed great until they started to use it. They realized it was very labor intensive. She added they have begun an overhaul on the data tool and it has become a lot more user friendly. She stressed that it was important to get all of the data so the tool could be as complete and accurate as possible. Judge Crittenden mentioned that he thought law enforcement records were a standard request. Joel Griffith said law enforcement records were not included in his case, and he added and Dr. Currie agreed, they should make a standard list of records to request when they receive a case. Dr. Currie stated they also need to gather all of the primary care records for the children, which include all pediatrician's records, birthing hospital, law enforcement, DCBS, and sometimes even the parent's records. She added, those are the people/agencies that were a safety net for kids because they could see how the parents were doing and seize the opportunity to call for services if they noticed any potential risk factors. Kelly Sherchock mentioned they had asked last year for DCBS staff to gather all of these records when opening a case as standard process. The 2014 cases should contain more records, but sometimes they have a hard time gathering records, particularly from law enforcement, because of pending investigations.

Commissioner James stated that DCBS was certainly open to the idea if the panel wanted to send a form out the day they get everything requesting all of the records, and then they could check to see what all came in. Judge Crittenden noted that was the concept we had planned, and he thought they should go back to that, because the department was a little more comfortable getting the letter from the panel since they have the legislative authority to request it. Tom Cannady noted that if it saved a step to come directly from his office, they could do that. Judge Crittenden said he thought they should ask for those records and should ask for all law enforcement records on all cases. If an agency doesn't provide a reason for not handing over records, the cabinet and panel would send another letter. Joel Griffith noted and Dr. Currie agreed that if the panel has in appropriations a significant amount of budget for staffing for the panel, then it's the Justice Cabinet's responsibility, not the task of DCBS. Senator Adams remarked that because the legislation states we are allowed to collect the information, agencies are compelled to give it over. She added that should be an aggressive component that does not get dropped. Kelly noted that when Kerry and she had the conversation about this her interpretation of statute, she believed the panel did have the right, not DCBS, on their own to request these records with the letter. Judge Crittenden said the panel has authority to obtain those records and they would work with Tom and Kerry to get a process ironed out for getting the information in the most efficient way. Commissioner James noted it would most likely be through Tom and the Justice Cabinet.

Dr. Currie requested input from panel members over the next couple of weeks concerning the data tool. She would like panel members' opinions.

Judge Crittenden mentioned the panel could plan on having Kerry give a report on the Michigan child fatality panel at the next meeting. Tom Cannady said Kerry will speak with Michigan team members about the possibility of some of this panel's members attending one of Michigan's meetings. He anticipates this will occur soon and we would have that information to share at the next meeting. Judge Crittenden added that if anyone was particularly interested in attending a Michigan panel's meeting to let Tom know.

Commissioner James noted she was able to attend the ninth and final meeting of the federal child fatality commission. The meeting covered predictive analytics for child welfare. She noted that at the end of the day, she was incredibly disappointed because she learned that predictive analytics really can't predict at this point.

Joel Griffith asked if there were anyone from Casey Family Services or somewhere else that could help inform the panel about their data tool, and maybe learn something from their process. Commissioner James noted that Eckard would come in and show the panel their tool, if they wanted to see it.
Joel added that he didn't mean for Eckard to change her practice, but maybe there are some pieces of the data collection tool they are using that could inform us. Commissioner James said she met with Will Jones, the CEO of Eckard, and they have really good outcomes with children and families. She is hoping they can have an ongoing dialogue with them about the potential of working in Kentucky at some point. Judge Crittenden noted their philosophy may be correct, but maybe the implementation of the panel's philosophy needs work. Commissioner James added that she received a call from another state that looks a lot like Kentucky. One of the other individuals from Casey family programs had referred that state to her because the START program had taken in some substance abuse patients. She noted that the 4E Waiver takes our largest funding string and allows us to diversify it for children who are not getting care. Kentucky's ability to diversify those dollars now will allow, even in conjunction with Senate Bill 200, a little bit of flexibility to attempt real prevention. These dollars can be used for in-home service delivery, additional in-home services for children, and keeping families together safely. The 4E Waiver is the ability to expand Kentucky's nationally ranked Sobriety, Treatment and Recovery Teams (START) program. She added she was at the Tennessee and Georgia Governors' mansions recently presenting these programs. She is hopeful that the 4E Waiver will be able to diversify dollars and expand the START program.

CASE REVIEW

Group 1
F-01-14-NC

- This baby was a 2 months, 22 day old little boy at home with his mother and older sister; who was two at the time
- Mother had been drinking a couple of cocktails before breastfeeding the child and lying down to nap on the couch. The child fell asleep next to her, and died of asphyxiation on the couch. There was some question whether the mother's drinking contributed to the death.
- Mother had previous DUI. Father had been in contact with police because of alcohol consumption. After the child's death the police conducted urine screens on the mother to calculate her blood alcohol level at approximately the time she fell asleep.
- There was no previous CPS involvement with the family.
- The parents were referred for a structured alcohol/addiction assessment, which yielded a good amount of information about the state of the home because there was another child.
- Action was taken to make sure the other child was taken care of.
- The child died of asphyxiation on the couch. There was some question whether the mother's breastfeeding while intoxicated had an effect on the child.
- Dr. Currie noted that it was actually a SUDI. They did not call it asphyxiation, because there was not clear evidence that his face was obstructed. She added that it ended up being no anatomic, toxicological, or metabolic cause. He was 2 almost 3 months old. So it's an unsafe sleep, but it wasn't actually a suffocation they could actually prove from a medical examiner's standpoint.
- Neglect was substantiated because of the alcohol use, but was not substantiated to have caused death or near death.

Group 2
F-02-14-NC

- This is a neglect and infant mortality case DCBS opened.
- It was originally brought to DCBS's attention after the Courier Journal reported on the incident.

- On August 12, 2013 Louisville metro police identified the mother of an infant found dead in the bathroom of Kohl's department store in Louisville. The baby was female, and appeared to be full term. Subsequently store surveillance video and interviews with other store employees helped to identify the mother within an hour of the incident.
- The case was assigned to a Bullet County DCBS investigator, where the mother lived, and LMPD homicide was assigned to the case, since the child was discovered in Jefferson County.
- The mother stated initially she was unaware that she was pregnant. Buy she thought she had only gained five pounds which she attributed to heavy alcohol intake.
- Law enforcement documentation actually said she concealed her pregnancy. She did later state to the DCBS investigator that she knew about a month ahead of time that she was pregnant when she felt the baby kick. She had no prenatal care whatsoever. She delivered the infant in the lady's restroom, placed the infant in the trash can, and then went home to clean up.
- At the time this incident occurred she was in the process of purchasing her own home separate from her parents. She had access to that home. That is where she went to clean up, and where subsequent evidence was found by LMPD.
- She went back to work and was greeted upon her return by homicide detectives. At the time she was gone, it was a janitor at Kohl's that actually found the infant in the trashcan. She said that she had planned to take the baby to the hospital on her return but it was too late. She said the umbilical cord was separated at the time of the birth, and the infant did not breath, did not open her eyes or make any sounds.
- She did go to University of Louisville hospital where she had a post-partum medical evaluation and treatment and then she was transferred to their in-patient psychiatric unit. Then she was taken into custody and charged with murder, tampering with physical evidence, and abuse of a corpse.
- She has a self-reported history of untreated substance abuse, up to thirty beers a night, including the months preceding the birth of this child.
- She did have a previous pregnancy and delivered a truly pre-viable infant in the bath-tub of the family home, in 2006. She was transported to the hospital and that was all verified.
- There was no CPS history on any adults in her home and no documented criminal history on anyone in the home. The autopsy findings were homicide by undetermined means. It did appear that this was a viable infant, and witnesses indicated having heard baby crying, grunting noises, and multiple toilet flushes in the bathroom.

Group 3
F-03-14-C Tabled until March Meeting

Group 3
F-07-14-NC

- This was a four month old child found in bed unresponsive with an 8 year old child and a 12 year old other child. I think a report was initially called in because they didn't think parents were initially in that home.
- The four month old's mom and dad's house had burned down a week prior to this event so they were working on renovations and they had the paternal aunt and uncle to care for this four month old child, paternal aunt got flu symptoms, and wasn't feeling well, so she called the 12 year old niece to come there for the weekend to help babysit.
- The aunt and uncle reported that the baby was fine the night before. They laid it in their bed to sleep, surrounded by pillows, and they fell asleep on the couch in the family room.
- Upon interview with the twelve year old, she remembers getting up around approximately 3 am, to feed the four month old child She fed her, burped her, and brought her into bed with her. Woke up about an hour later and said the child was fine, and woke up around 8 am, and the baby was face down on a pillow and unresponsive.

- The twelve year old picked the baby up, took her into the family room, and told the aunt and uncle about what had happened and they called EMS and resuscitation was attempted but unsuccessful.
- They got most of the information from the twelve year old, but they did find out that the aunt and uncle were in the home.
- There wasn't a whole lot of social history, and CPS has history with the mom, but she is young, she is only 17. I think her only previous CPS involvement was with her as a child and sexual abuse allegations. The father is 22 but he wasn't really in the system for anything either. It was called the paternal aunt and uncle's since they were the caregivers, they don't have any history.
- The case was actually unsubstantiated for both physical and neglect. Autopsy was consistent with being found face down on a pillow.

Group 4
F-04-14-C

- This is a case where the biological mom went to work around 7:30 pm and she left her 5 month old baby in the care of a babysitter.
- Mom reported that while she was at work she consumed a few alcoholic beverages. She returned around 3 o'clock in the morning with some of her friends from work. They stayed up and consumed more alcohol and all hung out. Around 5:30-6 o'clock in the morning everyone left. Mom went to the methadone clinic, received her dose, returned, got the baby from the babysitter.
- She decided to take a bath with the baby. Mom reports that he enjoyed kicking the water. She had been laying, his back was to her chest and she was going to let the baby play a little while and that was the last thing that she remembered.
- The mom's roommate went into the bathroom a few hours later and found the baby was drowning.
- It took a while for the roommate to wake up the mom, but then they immediately picked up the baby, he was already blue and unresponsive; they called EMS, and the child was taken to Cincinnati Children's Hospital and he was pronounced dead.
- The autopsy was consistent with accidental drowning.
- There was significant history of DCBS involvement with mom when she was a child, and also the previous older child, whose custody has been given to one of the mom's relatives. Also, mom had been struggling with substance abuse.

Group 1
F-05-14-C

- This is a 15 year old girl whose older brother was her custodian; she had gone to stay with her boyfriend, his mother, and some with her natural mother. Her brother originally said she had been checking in with him all weekend, but then reported that he had actually not spoken with her for several days.
- She had been removed from her mother's custody as a child, for neglect and educational neglect, and her natural mother had significant drug history.
- She was again found deceased in a creek. Her blood alcohol level was .049%. Her mother's paramour admitted to giving her alcohol before she went to her boyfriend's home, and there were pictures that were not given to us that confirmed that she was with her mother's paramour at the time of her disappearance.
- A local convenient store showed her on video at approximately 7 pm walking through a parking lot. On June 13, around 11 pm police were called in relation to an individual being on a bridge, wearing a white tank-top. The police responded, but did not find anyone.

- There was not a missing person's report filed, and this young girl was found on June 17 in a white tank top that she had been reported of wearing the last time she was with anyone.
- The police conducted an investigation and found that she was on the phone with her boyfriend at 11:17 pm when her phone reportedly went dead. Her boyfriend reported that he had tried to return her calls without success, and he had texted her brother on that Friday questioning her whereabouts. Her brother reported that she was asleep in bed, but his last phone call with her was on June 8th.

Group 2
F-06-14-C

- This case is a 5 week old infant whose death was consistent with overlay.
- The biological parents reported putting the baby infant in their standard adult bed with them about 11 pm; mother stated that she found the infant face down at 5:30 am the next day, unresponsive. Resuscitation efforts were unsuccessful.
- A neglect investigation was opened due to unsafe sleep conditions and failure to check on this infant for greater than six hours.
- There were drug use concerns, a significant CPS history of substantiations and removals in this family, and a current investigation.
- Mother admitted to drinking, smoking marijuana during her pregnancy, maternal grandmother already had custody of mother's older 3 biological children from previous relationships, ages 9,10, and 16 years.
- The day prior to finding the infant deceased, the mother self-reported that she drank four beers over 5 hour period. She denies being intoxicated.
- Father said he worked late and had a few beers, but he denied being drunk.
- Mom's 33, dad is 54; they are unmarried biological parents of this 5 week old infant. Mom was a stay-at-home, dad worked, farming; mother stated she reduced her drinking since this baby was born because she wanted to be a better parent than she had been with her previous children.
- She had 12 previously documented CPS referrals. CPS had been involved on and off with this family since July of 1998 until August of 2013 when this child died.
- There was a history of child abuse and neglect, domestic violence, alcohol and drug related charges involving the mother. The father had one DUI.
- The child's autopsy findings were consistent with overlay. This had been a premature baby, but it was a 34 week baby, weighed 4 pounds and 6 ounces and stayed in the hospital for a little over a week. According to the SUDI form that was completed, had been seen for normal checkups on 7/26 and 8/9, and appeared to be doing well. The baby died on 8/17.

Group 3
F-11-14-NC

- This 13 year old child was at his home with his family and he was eating at the table. He ran outside, chasing after his sister who was leaving the home with two of her cousins. Apparently he jumped on the sister's car to prevent her from leaving, and he fell of the car and hit his head.
- EMS and police were called immediately. He was taken to Kosair Children's hospital where he survived for about 48 hours and then brain death was determined.
- The mom didn't see the event. She was only able to relate what her grandchildren had told her happened. She had another small child. She had all the kids sitting at the table eating, and she had gone into another bedroom to breastfeed her infant when this kind of happened.
- CPS was able to interview the sister the following day. She was very shaken but tried to describe the best she could what had happened.

- There wasn't any previous CPS history and the school had never had any concerns. There were a few absences, but they were all excused absences with medical notes.
- Cause of death was multiple blunt force injuries to the head and torso.

Group 4
F-08-14-C

- This incident occurred in the foster home with 5 children, one biological child, two adopted children, and two foster children.
- This infant was about four and a half months old and was found in his crib, cold and unresponsive; autopsy results were most consistent with sudden unexpected death in infancy.
- Initially when the investigation started, the physical harm to the child was based on the fact that foster mom administered Dimetapp to the children to help with the cold symptoms. It is not indicated for anyone under the age of six.
- This infant was placed in this foster home in the middle of August and was found dead at the end of August so she only had him for like about three weeks.
- She did take him to the pediatrician's office for a checkup, and she reported to the investigator that she was advised by the pediatrician and the nurse in the pediatrician's office to administer Dimetapp. There was no indication of such instruction. It was clearly documented by the pediatrician that was not discussed.
- Foster mom recorded at a later time feared she would face some kind of consequences by giving the Dimetapp, and therefore lied about the pediatrician.
- The biological mother had significant history with CPS, and had a few children removed. This child was actually discharged to the maternal grandmother after birth and at a later point was placed in foster care.
- No active ingredients, including Dimetapp, were found on the autopsy toxicology screening.
- Foster mom placed him in the crib for a nap, with a light blanket. The mom came to check on him in about 15 minutes, and he was asleep. She went on doing some things with the other children. Then grandmother, the foster mom's mom came, because it had been a couple of hours to wake up the infant, and he was found in his crib with a light blanket over his face.
- There was documentation that foster mom did attend classes on abusive head trauma, safe-sleep environment and things like that.

Group 1
F-09-14-C

- This case involves a two year old who drowned in a swimming pool. Mother was 24, father was 36, and there was a 3 month old sibling at home at the time of death.
- Father works. Mother stays home Father got up that morning, put his clothes on and went to work. Mother had the children. She fed the two year old a pop-tart and gave the baby a bottle while they were lying in her bed watching a movie.
- Both kids fell asleep and mom moved both of them to their respective beds. She moved the infant to the bouncy seat, and moved the two year old to her room. There were two exits from the two year old's bedroom. One from the closet, where the dad kept his clothes, and he had left that door open. And there was a half door that opened into a regular door into her bedroom. That door had a spring latch that was not secured appropriately. After mom put her down in the bed, she went to clean up and wash some dishes. That would have according to the investigators, put her back to where the child would have had to pass her to get outside.
- The door that they usually keep closed was also ajar, and she got outside. Mom said after about thirty minutes she went to check on the baby. The baby was sleeping on the bouncy. She went to check on the two year old, and she was nowhere to be found.

- Mom starts looking, and calling her name, and looking, and finds the child face down in the swimming pool. It was an above ground type pool. They had tried to take precautions, because she had gotten out in the past, (nothing to involve CPS). They failed to move the ladder, and the ladder was accessible from the ground.
- Mom performed CPR. She ran into the house and called 911. EMS came and pronounced the child dead. This case was fairly interesting from a historical standpoint, because there was a lot of CPS involvement with the mother of the child. The mothers two older children were removed for domestic violence and serial domestic violence issues in the home on another family worker case plan.
- This mom had a lot of domestic violence and she had two home visits from DCBS prior to this child's death. This child died in September. They had been trying to open a case since January or February of that year, but couldn't find the family because they were crossing state lines.
- They had two home visits. The case was open for domestic violence. One of the things I noticed, was that her two older children (plus the children who were in the home at the time of death), had APS reports. But when the APS reports noted that there were children at the home who were present during the incident, there wasn't a concurrent CPS investigation.
- They found what they thought to be a marijuana cigarette in the bedroom.

Group 2
F-10-14-NC

- This child had been in a bean bag chair for several hours most likely, and then was placed in a crib with numerous other articles, including a can of Pepsi, and soft bedding.
- This child was found unresponsive by parents in her crib. According to the history they gave to the investigator, the parents had another couple over to spend the night with them the night before. Their older son spent the night with the maternal grandmother.
- The mother reports that the infant usually takes 4 ounces of formula every 2-3 hours. That night she took 6 ounces, and slept until 7 am. They're saying during the evening they wrapped the baby in the blanket about 7 pm, and put it into a bean bag chair. She said the baby woke up around midnight, they played with her until one am, and the father reportedly fed the baby. They took the baby into the bedroom, wrapped her back in the blanket, and put her back into the bean bag chair.
- So they took the bean bag chair from the living room, where the two couples had been, and they took, and wrapped her back up, and put her back into the bean bag chair. Parents had sex on their bed, after mother reportedly picked her up and put her into her crib from the bean bag chair. She said the baby's head moved so she thought she was alive, but doesn't indicate any other way, or checking on the infant in any other way; her having moved spontaneously or crying.
- Mother went back out into the living room and dad went back to sleep. Mother said she eventually went to bed for the night at 3:30 am. She said at that time, she told the DCBS worker, she kissed the baby on the head, before she got into bed, but when she talked to the coroner she said she never checked on the baby at 3 o'clock when she went to bed.
- When she and father woke up at 10:30 am the next morning the baby was dead. Mom called 911, father supposedly attempted CPR, but he couldn't even clear mucous from the baby's nose or mouth because she was so stiff. So she had been dead for quite a while.
- According to the coroner's report, the house was in deplorable conditions, no sheets on any beds, clothes, trash all over the floor. Old baby bottles were strewn throughout the house.
- According to the autopsy report, four paper bags containing contents of the infants crib, accompanied the body to the medical examiner's office. There were blankets, a Pepsi can, formula, a pillow, burping blankets, a stuffed giraffe, lotion, bibs, etc. Reportedly the one year old sibling usually slept in the bed with the parents.
- At the time of the DCBS visit on 9/9, (the baby died on 9/7), the house was all cleaned and packed up, and the bean bag chair had been disposed. The family was moving to a new home. In

an interview with mother at the new home, on 12/20, the environment of the new home was described as cleaned although cluttered. Mom agreed that at the time of the baby's death the home was quote "nasty."

- The people who spent the night there supported the history given by the parents. They did say they saw her sleeping in the bean bag chair in the living room while they watched a movie. They also saw her at midnight, and they said after they had played with the baby for a while, the parents did take the baby and the bean bag chair, into the bedroom. Then they awakened at 10:00 following dad, the biological father, saying the baby wasn't breathing. The only issue with that couple is that DCBS had also received a report on their own biological child. It said their four week old had thrush, and medication was prescribed but was not being given. Their child was not taken to physician appointments and he was not gaining weight.
- Their house was full of dogs and dog feces, and that the parents were selling food stamps to buy marijuana.

Group 3
F-15-14-NC

- This Fayette County case involved a two month old female that was found not breathing. The child was sleeping with him and he woke up and found her not breathing. He attempted CPR but couldn't find his phone to call 911 for at least twenty minutes.
- Mom tried CPR and told Dad to call 911. He laid the phone on the bed, and his brother ended up coming in and calling 911. EMS got there and continued CPR; the child was taken to UK and pronounced dead at UK.
- At the scene the father kept calling himself a baby killer. They continued to question him at the scene and he said that he put her down around 12 o'clock. He was up with her around 1:00 and gave her a bottle, then wrapped her back up and put her to sleep. He said she liked to fight sleep; she kept spitting out her pacifier, so his solution was to put the pacifier in her mouth and then wrap the blanket around her nose and mouth, and place her back in bed.
- He later on stated that he was angry when he did this and probably wrapped it too tight, although not intentionally. When he got up the next morning he relieved the tension and found her not breathing and cold to the touch.
- The baby didn't have a very significant medical history. She did have low oxygen at birth, but she was a C-section, and swallowed amniotic fluid.
- Social history, mom and dad are actually the mom and dad to all of the children. There is a seven year old, a four year old, a two year old, and a two month old. Mom does work at waffle house, mostly the evening shifts, so the dad is a stay-at-home father and takes care of the children. They do have a history of substance abuse. Both had last used marijuana the day prior to this child dying.
- No CPS history for either one of them. The dad has a criminal history of drug abuse and more criminal mischief, robbery, and running from the police.
- The autopsy was consistent with asphyxia and suffocation due to the child being wrapped. All of the other children were placed with a relative. The other interesting thing is that after that placement, mom actually had supervised visitation and was eventually granted unsupervised visits. But, then she posted bail for the dad and allowed him to visit the children during one of her unsupervised visits, and so those were revoked.
- Physical abuse on this child was substantiated on the father on the other 3 siblings because he used the same technique on all four children and then neglect was substantiated on the mother for all of the children, in this case.
- They substantiated neglect on the mother because she knew how the Dad wrapped the baby's nose and mouth, and also because of her drug use.
- The dad wasn't drug tested because he was arrested.

Group Four
F-12-14-NC

- This case involved a four month old female that was found unresponsive according to history provided by mother. She went to the home of the child's father that night, and she was playing with the child until about 3 am. Then she gave her some Tylenol, and the child went to sleep, and mother woke up the next morning and the child was unresponsive.
- She took the child downstairs to her, paternal grandmother and paternal uncle and they called 911.They were attempting to instruct him in CPR, but his phone died before they could give him directions. EMS took her to Jenny Stuart Medical Center where she was pronounced dead.
- The child was a twin sibling, and the twin brother had passed away from co-sleep, a co-sleep investigation about 3 months prior. There was no drug testing. It was just really hard to get in touch with this mom, Kentucky State Police investigation wouldn't release the records on the brother because it was still an ongoing case. It was ruled an accident, so the case was closed and unsubstantiated.
- Co-sleeping information was emailed to the mom.
- Father was incarcerated prior due to manufacturing methamphetamine. Marijuana was found in the room where the child expired. Mother denied any drug use.

Group 1
F-13-14-NC

- Jefferson County case involving a three month old, a 23 year old mother, a 23 year old father, and then an acquaintance of the mom who was 19 years old. She denied that this individual was a paramour at the time
- The child was reported to have been co-sleeping with mom and the acquaintance on a flattened futon, the acquaintance was against the wall, and then it was mom, then baby. When they went to bed, mom was holding the baby against her chest, and when she woke up the baby was in the position and not breathing.
- They called 911 and the child was pronounced dead at the home. Law enforcement was notified.
- Mom was an impaired caregiver. She reported on the evening before this incident she had drank two shots of liquor, on at approximately 11:30 pm, and another at approximately midnight. Both her and her acquaintance admitted to smoking marijuana during the night. The baby was last awakened at 3: 30 for breastfeeding. She said it took about an hour to feed him and get him back to sleep.
- She reported that she and her acquaintance went to sleep at approximately 7 am, and at 2 pm the afternoon of the 13th they found the child lifeless, when they woke up.
- The mom was tested positive for THC after the incident.
- The child's previous medical history was that she was a term newborn. There were no social red flags at birth. There was no drug testing on the child or the mother at the time. And they had been compliant with the well child checks. The child had been seen 40 days prior to the incident for the 2 month check-up and was to be seen approximately 3 weeks after the incident for his next check-up. He had a newborn screen.
- Criminal history with the family. Dad at the time said mom was at paternal grandmothers. He was at work and was not aware that mom was with this acquaintance at his home. Prior criminal for mom and dad was speeding violations and also charges of marijuana possession.
- Mom, dad, and paternal grandmother all said that when mom found out she was pregnant she stopped smoking marijuana at that time.
- The acquaintance of mom did have a charge of meth manufacturing the month before.

- There wasn't much beforehand that would have been a red flag, but afterwards mom basically admitted herself into the Rouge, got grief counselling, and was put on medication for anxiety and depression. But, she was not compliant afterward. She didn't like the group therapy, outpatient.
- Dad and she both had a domestic violence dispute between the two after the death of the child. He was placed on a diversion program for assault in the first degree and was ordered to attend DV classes.
- Grandmother said prior to the death she had no concerns with either the mom or the dad; they both loved this baby more than anything.
- The home was described as dirty and cluttered, and the baby only had a car seat to sleep in. They reported that the home mom and dad cohabitated together had pictures of the child all around. There was a crib, and the child's needs were met.

Group 2
F-14-14-NC

- This is a case involving a six day old male that was found unresponsive.
- Social history provided that the child was doing great the day before, picked up his newborn pictures the night before, was seen by multiple people, he was a little bit fussy. They contributed it to him being tired from having his pictures taken. He went to sleep. Dad fed him at 3 am, it was moms turn at 6 am, so she fed him, burped him, changed his diaper, and then they got back to bed around 7 am. He went to bed with her and she stated he had on his diaper and blanket at the time. The way that he was sleeping is that she sleeps on the side closest to the wall. So she scooted over, and he was sleeping perpendicular to her with his head towards the wall. She woke up around 8 am, and said that he just didn't look right. She said that he was pink and warm, but wasn't really breathing to her.
- She woke up the father, who did CPR at that time. EMS got there and continued CPR and he was transmitted to an outlying hospital.
- At the outlying hospital he appeared to be intubated by a tube that was too small, according to the transfer. He was intubated pretty far down, so I think he was intubated into just one lung. The helicopter team came out, saw him, repositioned his intubating tube, and brought him to UK. He was at UK for a couple of days, and then was pronounced dead at UK.
- There was a lot going on at the outlying hospital, that not necessarily would have prevented him from dying, but it definitely didn't help. There is quite a bit of history on his hospital visit there.
- As far as social history goes, his mom and dad are cohabitating. Mom does admit to Subutex being used during her pregnancy that was monitored by her OBGYN. She denies any mental health issues. She does have a history of methamphetamine use, but denies any current use of that. She does just use the Subutex Program.
- She does have a history with CPS, mostly with her older child that currently lives with the maternal grandmother and grandfather. But it's just because she did that when mom was in jail and she was used to it, and they never brought her back after mom got out of jail. So it's not that CPS required that, that's just what the girl was comfortable with.
- Mom's history of drug use and correlating conditions were reported, and a lot of them were unsubstantiated.
- Autopsy was consistent with cardio respiratory arrest of unknown ideology and astute co-sleeping infant with resuscitation. The odd thing was there was a presence of Hintos in the newborn urine screen, but it was recorded as a negative screen. From my view, if it was negative I'm not sure where the medical examiner got the positive drug screen. I didn't see that in my record. Postmortem was 74 and urine was 250. Other than that, I don't really have much else on them.

Group 3
NF-02-14-NC

Ms. DeJarnette noted that the number of the case she had was different than the number on the agenda, but Judge Crittenden and Joel Griffith said that they were the same case.

- This incident involved a two month old that had spontaneous bleeding from his nose and mouth. The family consisted of two married parents, age 24 and older siblings' age 5 years, 3 years, and 2 years.
- This family took an afternoon trip to Panera Bread, and on the way the baby was a little fussy, so they got the baby some formula. The five year old had been playing peek-a-boo with the baby. It was a rainy day so mom covered the car seat with a blanket.
- They take her into Panera Bread, and noticed there was blood coming from the baby's nose, the baby was gasping for air and obviously having some type of respiratory distress. So they screamed for someone to help mom had actually left her phone in the car, so they yell for someone to call 911, and dad runs out to the car and grabbed her phone and called 911; EMS arrived and took the child to Kosair Children's hospital where the child was ultimately intubated and taken to ICU.
- His hemoglobin was 8-2 on presentation, and dropped to 6-2 when he received a blood transfusion. He had some slightly elevated liver enzymes which was concerning for intro-abdominal trauma, so he had a head CT that was negative. He had an abdominal that was negative and he had an abdominal ultrasound, which was a little confusing. It was read as though there was hematoma clot material layering over the liver, but it also said that there was no lesion on the liver.
- Dr. Howard noted that this was one of her cases. She said there wasn't much concern for trauma, but we were looking for an AB malformation type of thing, which would not have necessarily been trauma. The reason I went to CPS was because we had an infant unresponsive from the beginning, and we would rather them be involved up front then wait to hear what happened. But then from all the work up that we did, we could not find any trauma on this child. I don't know if we ever really found out what happened to this child.

Judge Crittenden then thanked the analysts for their help and noted their assistance allowed the panel to review more cases than they had in the past. Ms. Curtsinger said they would also like to have feedback from panel members regarding documentation and case review processes. The Analysts are creating a summary and a timeline and documenting any particular issues with a case. Any concerns should be shared with Dr. Currie or Tom. Joel Griffith said that he thought the timeline was incredibly helpful. He then asked about a case for review at the next meeting, NF-07-14-C. This is case with a previous death prior to this one and there is nothing in the case file about the previous death. Obtaining the previous death records would be helpful to that case. Judge Crittenden noted this case is assigned to Ms. Zelko.

With no further business to discuss, the meeting was adjourned. The next meeting will be March 16th.