CHILD FATALITY AND NEAR FATALITY EXTERNAL REVIEW PANEL
March 11, 2013
KY Domestic Violence Association Building

Members Present: Judge Roger Crittenden, Chair; Detective Kevin Calhoon, Kentucky State Police (KSP); Sharon Currens, Kentucky Domestic Violence Association; Dr. Melissa Currie, U of L Division of Forensic Medicine; 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; and Andrea Goin, Court Appointed Special Advocate (CASA).

Members Absent: Senator Julie Denton, Representative Tom Burch, Dr. Tracey Corey and Dr. Camella Yates.

The meeting was called to order by Judge Roger Crittenden, Chair. Minutes from the previous meeting were approved with minor changes. Judge Crittenden asked for an update on the proposed legislation. Joel Griffith indicated the bill could pass the Senate today.

Judge Crittenden asked Tom Cannady for an update on establishing information sharing between members. Mr. Cannady stated technology staff indicated the best workable and economic solution would be to use SharePoint with a cost of approximately $2900 per year. Judge Crittenden stated that once the service becomes available he would meet with Secretary Brown and as well as staff from CHFS to ensure this could be used in a secure manner.

Judge Crittenden opened discussion regarding the process of reviewing cases by suggesting groups of four or five members take a set number of cases and report back to the panel. He noted that in the first meeting the panel agreed to look at all of the first fifty-five cases, but at some point the panel would need to break out numbers of cases for different panel members to look at specifically and report back. Dr. Shepherd suggested giving every panel member access to all reports but assigning certain members to do an in-depth review of specific cases for the purpose of reporting back to the panel. Mr. Walker noted that with the use of SharePoint each panel member could take certain cases. He also commented that it was important to keep all eyes on the cases. Judge Crittenden and Dr. Currie agreed. Dr. Currie commented that it would eventually become an efficiency issue making it necessary to divide cases among members with the ability to invite panel members who may not have been assigned a specific case to review regarding issues in their area of expertise. Joel Griffith commented that the internal review completed by DCBS might be useful to help with that. Judge Crittenden stated that the concept for the next two or three meetings will be to review four cases at a time and try to make a determination if there is anything consistent overall on the cases to advise on and make recommendations. Mr. Griffith inquired about the goal for the current year. He noted the current rate of four cases per meeting would require many meetings before September when the

report is due. Judge Crittenden commented that it would be difficult to review more than four cases between meetings. Detective Calhoon pointed out the need to review more recent cases as well. Judge Crittenden inquired about the end date of the cases currently being reviewed. Tina Webb, CHFS, stated the cases were from fiscal year 2012 and therefore ended the last day of June 2012. Judge Crittenden inquired about the number of cases CHFS has been involved in since that time. Ms. Webb stated monthly tallies are not kept of all reports received which include all child deaths associated with DCBS children or suspected abuse or neglect. She asked for clarification on which cases are being reviewed by the panel and indicated there would be lag time between when an allegation is received and when it is finalized and that some portion of those cases would have an internal review. Judge Crittenden inquired if the cases the panel is currently reviewing are all substantiated cases. Ms. Webb stated they were all substantiated and indicated that if the panel wished to review all abuse or neglect, including unsubstantiated and those without agency history, the number would be approximately 150 cases per fiscal year. Mr. Walker remarked that would be a great number to work with using a sampling from those for review to include some unsubstantiated cases. Mr. Griffith suggested using the 150 cases to look at trend data. Judge Hall noted that he had summarized all the cases the panel has received to date noting information such as ages, genders and cause of death and that he would provide that information to panel members. Judge Crittenden commented that would be beneficial information to put together with Mr. Griffith's spreadsheet. Ms. Oldham commented that Mr. Griffith had done a great job of showing the trends in his spreadsheet and that would be useful to the panel. Maxine noted the spreadsheet showed there are definite trends occurring. Mr. Griffith noted the new legislation will include all reported cases, not just those substantiated, so the panel will be able to expand information collected to see the larger picture. Dr. Currie remarked that the panel needed to be cognizant of not putting energy toward confirming known issues such as domestic violence, substance abuse, untreated mental illness, young parents, etc., but to rather focus more on the recommendations to address these issues. Judge Crittenden commented the panel would be looking at the data along with reviewing the next four cases and requested an additional fatality case from the current fiscal year. Commissioner James stated the investigation had to be complete and they sometimes have to wait on autopsy reports, etc. Judge Crittenden asked for a completed case with CHFS involvement. Dr. Currie noted that the panel has not reviewed any near fatality cases thus far. Ms. Oldham suggested assigning three sets of four cases to groups within the panel. Judge Crittenden stated that Mr. Cannady would email panel members with case numbers for groups to review along with a current fiscal year case.

Ms. Oldham inquired if this same group would be meeting after the legislation goes into effect. Judge Crittenden expressed that he thought it would be substantially the same members and the next meeting would occur on May 13th. Mr. Griffith commented that funding was being sought to pay for panel members who wished to attend the conference in Lexington where the September meeting has been scheduled.

Judge Crittenden then opened discussion on the following cases:

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Judge Crittenden commented he thought the cabinet was involved in this case. Dr. Currie noted that non-cabinet cases do not have previous cabinet involvement but most will have involvement

after the fatality occurs. She noted that the HANDS program mentioned in the case is a program through the health department rather than CHFS. Ms. Oldham pointed out there is a pretrial conference scheduled tomorrow and a trial later in the month and expressed concern about information being released. Judge Crittenden asked if there was communication between the health departments and CHFS. Commissioner James stated there is when appropriate. Judge Hall commented that the HANDS program is an educational program for new mothers and would not necessarily be a red flag to notify the CHFS for involvement. Commissioner James remarked the program is a great prevention tool. Mr. Griffith stated that when he read the notes documented by the HANDS worker, he noticed there may have been some red flags in that the mother stated she was not a good mom, admitted to drug use, depression and mentioned domestic violence. Dr. Currie agreed but remarked that she was not sure that would have been adequate to initiate an investigation by CHFS. She commented the same risk factors are present in many families but the resources do not exist to investigate all of those and questioned what can be done when those risk factors are identified other than contacting CHFS. Mr. Griffith noted that the HANDS program is voluntary and cannot be forced on the mother. Mr. Walker asked what should be done when you have some of the indicators. He inquired about screening processes that can carry further into other assessments. He noted the boyfriend was in drug court and but that drug courts do not assess for risk to children in the care of clients. He stated that if every case with an indicator of high risk was referred to CHFS, they would be inundated. Judge Hall stated it was not the drug court that raised a red flag to him but rather the prior conviction for assaults for child abuse but that he was uncertain the HANDS worker would have that information. Mr. Griffith noted the case mentioned his prior conviction but it was not seen on the AOC report and that it was noted he did not see his children but there was no report on him from CPS. Judge Crittenden stated that he only saw minor drug and traffic offenses. Judge Hall remarked that the prior conviction may not have been in Kentucky. Mr. Walker stated there are people in drug court that are very violent people that have not yet been convicted and again raised the question of whether there is a need for an assessment of child care giving as part of a drug court assessment. Judge Hall indicated there is a lack of funding. Ms. Oldham noted the lack of funding and the lack of qualification to make parenting assessments. Dr. Currie noted that the mother did not leave the child with the boyfriend; therefore, an assessment might not have identified him as someone in the role of caregiving. Dr. Currie also noted that when the incident occurred, at least according to the records, both were in the room with the child. She commented that her focus was on what could have been done to empower this mother to protect her child from the boyfriend. She remarked that the HANDS program was as close to an in-depth support of the mother as possible. Judge Hall remarked that the mother had admitted to the counselor that she was afraid of the boyfriend and his violent outbursts and those indicators never got to anyone that could do anything about it. Ms. Oldham commented that she was unsure anyone could do anything with that information. She noted that if reported to CHFS, being afraid is not enough information to investigate and the same with reporting to the police. She agreed the HANDS program was the best voluntary program we could have and yet it still happened. Mr. Griffith noted the mother's non-compliance. He commented that the panel may need to think about criteria for determining the difference between what are risk factors and what are predictive factors as a lot of cases may have all the same risk factors but there may be cases we could predict and do something different. Judge Crittenden remarked that was an important idea but Mr. Walker commented the whole issue of risk prediction is very delicate ground. Ms. Currens inquired if HANDS had referred the mother to a shelter or support services. Ms. Currie

noted that HANDS had referred her to counseling and tried to get her connected to other resources but she was noncompliant. Ms. Currens inquired if she had been referred to domestic violence services specifically. Dr. Currie stated it was not mentioned in the plan. She remarked that one thing she looks for as she reviews cases is missed opportunities by professionals to have done some differently and did not find any area in this case where that occurred. Ms. Oldham agreed. Mr. Walker noted the baby had been born premature and had been on a respirator for a few weeks and the mother had a drug history so perhaps more services intensively pursued earlier on might have been helpful. Dr. Shepherd pointed out the inconsistencies in the record regarding the baby being on a ventilator in the hospital for several weeks as it conflicted with pediatrician's records which indicated otherwise. Judge Crittenden expressed concern about inconsistencies in ages and dates within the case files. He commented that difference in ages in children makes a significant difference in what a child is capable of doing. Dr. Currie stated that is a chronic issue. She noted she checks the date of birth first when looking at cases. Commissioner James remarked that CHFS has a new document that will be out this year which will make it easier for workers to document information as well as easier to read and make a better assessment. Judge Crittenden commented that inaccurate information or mistakes in documentation can become an issue when testifying. Mr. Griffith noted difficulty in following dates and noted in some case the date of birth was redacted. He also commented on the change in workers involved and differences in what they've documented and suggested perhaps there should be a process for supervisor review to clean up those issues. Commissioner James stated the department is moving in the right direction by doing cleanup within the system and that the new document would alleviate some of the confusion. Dr. Currie stated that thought the investigation process after the death was a good example of law enforcement and CPS working closely together and it was a very high quality investigation. Detective Calhoon agreed. Ms. Oldham noted that sometimes it is the high profile fatality that gets the best joint investigation and others that might be prevented do not. She noted that while joint investigations are statutory but it is probably the biggest challenge.

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Judge Crittenden stated this case involved an eight month and twenty-three day old in Harlan County in which neglect was substantiated and commented that he thought it was a close call. He noted that the child ate medicine left out by the father. Judge Hall inquired about whether it was prescription medication. Judge Crittenden stated that one was prescribed. Dr. Currie commented that this is not the only case where children have died very rapidly from ingestion as the medicine is intended to be swallowed whole and break down slowly but children bite on them and absorb the medicine very quickly. Mr. Griffith expressed that he had no idea that kind of drug was so dangerous. Dr. Currie stated that pharmacists are supposed to put a sticker on the bottle and it should be dispensed in a child proof container but possibly there could be a more explicit warning on the bottle. Ms. Oldham asked Dr. Currie about the fact that the lab report did not show anything. Dr. Currie stated that it doesn't take much and their cutoff was clearly above the toxic level. Dr. Shepherd pointed out there was a comment in the file indicating a medical examiner was waiting on permission and funding to do a specialized drug screen. Ms. Oldham stated she thought that was the outside lab in Pennsylvania. Detective Calhoon commented that KSP relies on Commonwealth Attorneys' offices to pay for such expenses and also coroners sometimes offset some of the costs when sending to outside labs. Ms. Oldham commented that

this was also a very thorough and complete investigation by CHFS. Dr. Shepherd commented that their response time was good.

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Judge Crittenden noted this was a Christian County case where the child died in July 2011. He stated the main thing he noticed was that in June of the same year the child presented with a fractured arm and bruises and there was a finding of unsubstantiated physical abuse. Mr. Griffith stated that he did not understand the finding and the biggest concern to him was that a phone call was made to the father, no other services were provided by CHFS and the child is dead two weeks later. Ms. Oldham commented that the worker accepted the father's explanation without doing a face to face interview and it appeared there were lots of opportunities to do better. Commissioner James stated this case is probably one of the most egregious cases and there were multiple issues. She stated that there were multiple policy failures and that CHFS took very aggressive and immediate personnel action. She noted there were multiple opportunities to have prevented this death. She stated the policy for timeliness was not met, saying it was so long that they did not see the child face to face until the child was dead. She commented that there are multiple places that intervention even prior to the June incident could have prevented this child's death. She stated that CHFS took major aggressive action to see that this does not happen again. Judge Hall stated that he noticed through all of this that post death collateral interviews clearly painted the picture. Commissioner James commented that collateral contacts are the confirmation of an assessment. She stated CHFS is working with a young inexperienced staff to train them that you must be able to confirm statements. She pointed out that if the father said it happened on the slip and slide, the neighbor who he used to support his claim should have been contacted. Judge Hall commented the collateral interview part with staff is lacking and cannot be encouraged enough. Commissioner James remarked that it takes time to do investigations and collateral contacts as a part of that and staff is pushed hard to be able to do them. She stated that fatality investigations are done by seasoned investigators who have been with the agency for quite some time and that most regions have specific individuals. She noted that a different kind of quality in investigation is seen as you compare a case early on versus the quality visible in a near fatality. She commented on the difficulties faced by workers attempting to contact physicians and teachers. She stated that the cabinet went back and reviewed all open cases with the individuals involved in this case and conducted interviews and reinvestigated as needed on a regional level. She noted there were issues with the on call policy in this case where the worker contacted an additional supervisor to get a different directive than what was given by the first supervisor. She stated the 72 hour review did not happen as it should have in this case. She also noted the issue with crossing state lines. Judge Crittenden asked if that issue is being addressed because there was involvement with Tennessee. Commissioner James indicated CHFS is working on a border agreement with Tennessee now to better coordinate investigations. Detective Calhoon commented that it is a huge problem to get records outside the Kentucky border. He also noted that he did not see that law enforcement had ever been contacted until after the death of this child. Commissioner James inquired of Tina Webb who stated it was not documented whether or not law enforcement had been involved prior to the death. Mr. Griffith pointed out there were a number of neighbors and relatives that saw bruises on the child but did not report. He stated that he remains concerned that there still does not seem to be pulled into one place an internal review of the case of someone looking for and compiling policy issues

throughout the case. Commissioner James stated CHFS is doing that. Mr. Griffith noted that it is not visible. Commissioner James stated that it is not there yet but these cases were much of what promoted the change in the child fatality review. She noted one of the first things they are doing now is looking at policy violations. Mr. Griffith pointed out that the statute has been in place. Commissioner James stated that she could only tell what is being done moving forward. She stated there would be regional reviews that are in place and they are also monitoring all fatalities up front for policy violations and taking appropriate action when needed. Ms. Oldham inquired if she was referring to the prior injury for an internal review. Mr. Griffith commented it would be an internal review of all actions prior. He noted the statute refers to an internal review being conducted to identify policy violations, policy changes and personnel actions and that it is to be part of the annual report. Commissioner James commented that the meetings had not been as functional and did not solicit the outcome that she thought was needed or an action plan so there is a new coordinator at central office that will be trending all the information to be in future reports about policy changes and child review assessment. Mr. Griffith stated he would also like to see on cases with previous involvement the training levels of the staff involved, experience levels and caseloads as it directly relates to the quality of the investigations being done. Ms. Oldham commented that the potential for another FC-1 case happens weekly in Hardin County as there is a built in need to close cases quickly due to caseload. She noted a case with a broken bone on a four month old where she alienated several people at CHFS before it got to Dr. Currie. She stated they faxed for medical records and were going to wait three weeks to receive them and the child could have been dead. Commissioner James stated they have a difficult time getting records especially from hospitals. Dr. Currie commented that it helps to have someone involved who can have real time communication with those taking care of the child in the hospital. She stated the record is not where you want to get information; you want to get it from the person who is creating the record. She also noted that waiting for the record is waiting too long. Dr. Currie commented that her understanding of the purpose of a prevention plan is to come up with a way to ensure a child's safety until additional information can be gathered and pointed out the lack of a prevention plan in this case. She also commented that the medical professionals failed this child as well. She noted that at least one physician had expressed concerns about the father's explanations because the father requested to see someone else the next time but there was no evidence in the case that the physician contacted CPS. She stated that is an issue with not having medical records. She also commented that the child should have been placed on a 72 hour hold on June 14th when she went in for the evaluation of the elbow. Commissioner James commented that workers do not always feel comfortable challenging a finding of a physician. Ms. Oldham remarked that the investigators need to be empowered. Mr. Walker inquired about additional difficulties CHFS may be experiencing with military or ex-military. Commissioner James noted they are doing trauma based training with staff in those areas to include how to assess protective capacity or risk factors for children when there is post-traumatic stress syndrome in a home. Judge Hall commented that the military is ill-equipped to deal with such issues. Mr. Walker asked if the cabinet was able to get access to military records. Commissioner James was uncertain and indicated she would report back on that issue. Ms. Oldham inquired about Dr. Currie's caseload. Dr. Currie stated her office saw just over 900 children last year. Judge Crittenden asked Commissioner James if CHFS was supported in their disciplinary action. Commissioner James stated they were.

FC2

Judge Crittenden noted this was an Elliot County case of neglect and commented on the refusal of the district court to issue orders of cooperation without an order of removal. Judge Hall noted there is a need for better judicial training. Mr. Griffith commented on the overreliance of prevention plans in lieu of engaging the court. He stated that workers should be viewing the court and the county attorney as assistance. Judge Hall agreed the workers need to go to the county attorney and use the court system and not be hesitant to do so. Commissioner James commented that it should be decided what the system needs to look like and what is appropriate for investigation and that needs to be taken to the legislature. She also noted that along with that comes a financial commitment in order to expand the staff to provide the services to help support families. Ms. Oldham agreed that the funding is not there to have the appropriate caseloads for workers and provide and maintain appropriate training. Commissioner James also noted the lack of education on behalf of the general public as to the mandate for the department's investigations. Mr. Walker asked Commissioner James if workers have access to KASPER data. She stated they have not started routinely using that. Tina Webb commented that they have access to summary information only and it must be obtained through law enforcement. Judge Crittenden noted it was difficult to tell when the information became available to the social worker. Mr. Griffith commented that it seemed as though the worker was trying really hard to believe the mother even though a neighbor was being very specific about seeing the children left alone. He noted that law enforcement even said they believed she left the kid alone. Commissioner James noted the death did not occur while the child was in the care of the mother and there was a prevention plan in place. Judge Hall commented that it was a perfect storm that led to the child being placed with two of the worst people for the child. He also commented that he wasn't sure we even know what exactly happened. Dr. Walker noted there was a statement in the record about the child having difficulty walking yet had walked a considerable distance to the pond. Dr. Currie also noted the child had a seizure disorder for which the grandmother had given medication but did not send the medicine with him to the farm where this occurred. Judge Hall stated the grandmother should have known the child was not supposed to be with the grandfather-in-law. Detective Calhoon noted that the father never informed the troopers that the mother was not to have the child and questioned if prevention plans might need to be entered into LINK which is a state information network for law enforcement. He noted that if this had been in LINK, it would have been picked up when troopers ran a check on the mother. Judge Hall noted that if this had been a court order as opposed to just a prevention plan, this may not have happened. Ms. Oldham commented about whether or not law enforcement would have access to the court order either and KSP wouldn't have known to contact the cabinet. Detective Calhoon remarked that they wouldn't have known unless something was entered into LINK. Judge Hall noted there was also a June 15, 2011 referral that was still pending regarding the mother which there was not much information about in the case. Judge Hall remarked that the cabinet uses prevention plans to do a ten day petition to see what possibilities are for the family as opposed to immediately doing an ECO (Emergency Custody Order). Ms. Oldham commented they are also done to keep the child in the home after going to court and that it would be a good if the cabinet and law enforcement could share prevention plan information. Judge Crittenden agreed that it would be good to have the information available. Detective Calhoon noted he was not sure if there would be a way to have the prevention plans entered into LINK. Judge Hall also noted that sometimes the plans are very short lived and that could become a problem removing them from LINK. Ms. Oldham also mentioned tacking onto the eWarrants system. Mr. Griffith

commented that the bigger issue is how prevention plans are being used and if they are being overused is it due to judicial issues. He noted there are prevention plans in every case but perhaps there needs to be someone else involved in addition to DCBS workers and family. Judge Crittenden commented there needs to be more training at least with district and family court judges. Judge Hall commented that judges need training to hear from DCBS about how the components fit into the overall picture. Commissioner James stated the question then becomes how to make a determination about which cases go to the courts and the impact on court dockets. Judge Hall commented that he sees good prevention plans that work but he also sees some prevention plans that should have been an ECO. Ms. Oldham noted the multidisciplinary teams are where you can get more people involved in cases from CHFS, law enforcement, prosecutors, medical and school personnel. Judge Hall pointed out that the ability to deal with this on the front end is largely controlled by the legislature. He stated in order to adequately address the issues they need to know what we're dealing with. He commented that no one wants to acknowledge that this goes on but it is in every neighborhood, every school, every socioeconomic setting and until everyone is aware, we're going to have this problem. Ms. Currens commented that there are some great foster care families and some that are not so you are not necessarily keeping a child safe by placement although removing them may seem the appropriate alternative. Judge Hall commented there is a cost no matter what you do.

Judge Crittenden noted that the panel will be making reports, depending on the legislation, at least quarterly to the Health & Welfare Committee of the House and Senate and perhaps monthly to the Program Review Panel and also an annual report to the Governor, Chief Justice and various members of the legislature and, therefore, the findings and discussions will be made public. Dr. Currie inquired if a list was being compiled of ideas the panel has discussed. Judge Crittenden stated that the list would be distributed to members next week along with the case information for review for the next meeting scheduled for May 13th at 10AM.

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

Meeting summary submitted by Marlene Mundine.