CHILD FATALITY & NEAR FATALITY EXTERNAL REVIEW PANEL
JULY 21, 2014

Members Present: Judge Roger Crittenden, Chair; Judge Brent Hall; Joel Griffith, Prevent Child Abuse Kentucky; Commissioner Teresa James, Department for Community Based Services, Cabinet for Health and Family Services (CHFS); Maxine Reid, Family Resource and Youth Service Centers, CHFS; Dr. Ruth Shepherd, State Child Fatality Review Team, CHFS; Allison Taylor, designee for Dr. Stephanie Mayfield, Commissioner, Department for Public Health; Dr. Blake Jones, University of Kentucky School of Social Work; Nicky Jeffries, CASA; and Sharon Currens, Kentucky Domestic Violence Association.

Members Absent: Senator Julie Denton, Representative Tom Burch, Dr. Tracey Corey, Dr. Jamie Pittenger, Dr. Kim McClanahan, Nathan Goins, Det. Kevin Calhoon, Jenny Oldham

Judge Crittenden began by welcoming panel members and introducing new members, Nicky Jeffries, CASA, and Dr. Blake Jones, University of Kentucky School of Social Work. He noted Dr. Pittenger has been reappointed to a two year term as well as Dr. McClanahan and informed the panel that Detective Calhoon was resigning due to retirement from the Kentucky State Police. The minutes from the previous meeting were approved with a minor word change on page seven.

Judge Crittenden announced the next meeting will be held in conjunction with the "Kids Are Worth It Conference" at the Crowne Plaza Hotel in Louisville, Kentucky. Mr. Griffith noted that Sandra Alexander will be addressing the panel at that meeting. She is a Subject Matter Expert in Child Maltreatment in the Division of Violence Prevention (DVP), National Center for Injury Prevention and Control (NCIPC) at the Centers for Disease Control and Prevention. He stated he would send registration information out to panel members. Judge Crittenden noted the panel will meet from 9AM-12PM on Monday, September 8, 2014.

Judge Crittenden stated he hoped to be starting on the report to LRC before the next meeting as it is due by December. Mr. Griffith suggested focusing on the report sent out by Dr. Shepherd at the next meeting. Dr. Currie noted that she had spoken with Dr. Montgomery from Kosair regarding speaking with the panel possibly in November.

Judge Crittenden noted the registration fees and costs for lodging at the conference and asked members to notify Mr. Cannady if their agencies are unable to cover the costs. Mr. Griffith abstained from discussion or decision making regarding Panel payment of conference registration costs.

Judge Crittenden said that he along with Ms. Oldham and Dr. Currie had been reviewing applicant resumes for the attorney position. He inquired with Dr. Currie regarding the

Request for Proposal (RFP) for nurse analyst positions. She replied that staff from the Justice & Public Safety Cabinet was assisting with answering questions regarding the process. Mr. Cannady noted the posting for the RFP ends on July 28, 2014.

Judge Crittenden stated that he attended the Legislative Program Review and Investigations Committee meeting along with Mr. Cannady and Ms. Oldham. He noted that Ms. Kennedy gave a report on the panel to the committee and that it was well done and accurately reflected the operations of the panel. He noted members of the committee were concerned about the authority of the panel to recommend changes and enforce those recommendations. He stated that he indicated on behalf of the panel that it was the panel's authority to recommend and the authority of the General Assembly to enforce. He reported the committee inquired about subpoena authority, but relayed to them that it has not been an issue thus far for the panel. He noted members of the General Assembly are anxious for the panel to make recommendations so the committee may evaluate the effectiveness of the panel's work.

Mr. Griffith suggested the panel have a formalized strategic plan regarding the panel's focus, budget and processes. He suggested setting aside some time to address those issues at an upcoming meeting. Dr. Currie agreed that there should be formalized policies but noted she has mixed feelings about strategic planning processes as they can take up time and energy. She noted she would like to see it be a very streamlined, focused plan. Judge Crittenden asked Mr. Cannady to put this on the agenda for September.

Judge Crittenden inquired if there are multi-disciplinary teams in every county or region. Dr. Shepherd stated there are multi-disciplinary teams which are different from the child fatality review teams. She commented that child fatality review teams in the public health system are contacted by the local coroner to help the coroner to define the manner and cause of death and not every coroner chooses to call his team when he has a child fatality. She noted it is at the discretion of the coroner and there are teams in seventy counties. Mr. Griffith noted that the team is discretionary but the coroner is required by statute to notify the health department, DCBS and law enforcement on every case. Dr. Currie noted the local teams sent information to the state team. She noted the state team can then refer those cases to this panel for review if desired. She commented that coroners are being notified currently so that they are aware of process for this panel to receive cases. Judge Crittenden inquired about the total number of child deaths per year. Dr. Shepherd noted there are approximately 350 infant deaths per year and those are looked at statistically. She noted the vast majority of those deaths are premature births and congenital anomalies which would not come to this panel for review. Judge Crittenden noted the Program Review Committee had inquired about how the panel works with other organizations for reviewing cases. Dr. Currie said that many of the local teams are reviewing cases that have just occurred while this panel is delayed until all information is available for review.

Judge Crittenden asked Dr. Shepherd for an update on the case review tool. Dr. Shepherd noted Dr. Currie has been working on that with her and Dr. Currie stated that they were close to having it ready for dissemination to the panel for input.

Case Discussion:

Group 2 **NF-9-13-NC**

- One month old child, lethargic, having trouble breathing, etc.
- Took hospital a few days to identify all injuries
- Presented with bruising which prompted skeletal survey
- Air found in soft tissue behind throat, traumatic perforation of the esophagus/larynx, grade two liver laceration.
- Diagnostic findings of physical abuse.
- No primary care records due to the child not being taken to the dr.
- Mother had history prior to pregnancy of prescription drug abuse, no formal treatment.
- No evidence of toxicology screen at birth.
- How do birth hospitals decide who gets toxicology screens?
- Excellent documentation by worker.
- IV heroin use by parents
- Father identified as having a temper, played a lot video games, put hand over baby's face when baby cried, referred to baby as crybaby, described as easily frustrated and irritable.
- Child healed physically and was placed with family members.
- DCBS acted quickly to get another biological child of the father's examined as well.
- Lack of law enforcement records and no knowledge if anyone was charged.
- There were issues with co-sleeping and unsafe sleep occurring in the home but did not directly contribute.
- Substance abuse, lack of treatment for substance abuse, and father's criminal history were risk factors.

Group 1 **F-13-13-C**

- Nine month old died of carbon monoxide poisoning in trailer with generator on back porch
- Home of 67 year old man, listed on birth certificate as child's father. Mother stayed overnight to care for him as he was ill then went to sleep and left him to care for the child.
- Coroner's office suggested that father's illness may have been caused by the carbon monoxide as well and if mother had been in the home as long as she stated, she should have been ill.

- Law enforcement officer would not release interview tapes to grand jury.
- Mother had history of substance abuse.
- Older child had been removed to grandparents.
- Law enforcement wanted to pursue but no indictment.
- No law enforcement records.
- Other sibling was a drug exposed newborn.
- DCBS did not believe the mother had been at the home as she stated and believe the baby went without care for several hours.
- Baby was found by the grandparents.
- No indication of drug testing at birth.
- Raises question of who is tested and establishing protocols for such.
- Public health working on recommendations for hospitals to develop protocol for screening for NAS. At least a verbal screening for everyone which would determine need for additional testing.
- Judge Crittenden noted the panel could develop protocol to be sent to the hospital associations and a year later we could have data on how many have adopted and are using it.

Group 3 **F-19-13-NC**

- Four month old left with father while mother worked at night
- Lesions on abdomen
- Older children had burns caused by furnace
- Medical neglect for not seeking treatment
- Mom checked upon arrival from work and found baby dead
- No criminal charges filed
- Baby had fluid in the lungs, could have been from bottle or positional asphyxia
- Untreated dermatitis, flea bites, poor hygiene/home conditions
- Court records were incomplete, did not meet statutory timelines
- Other kids were removed on neglect issues
- Chronically neglectful and low functioning family
- Previous history in Michigan indicated same issues
- Had there been screening on newborn, some issues would have become clear such as poverty and low level of functioning
- Isolated family, no daycare, no doctor visits, etc.
- Autopsy noted child was undernourished and in 5th percentile
- No food in home, no welfare benefits used.
- Undetermined cause of death
- Children were removed by DCBS within 48 hours

Group 4 **NF-22-13-C**

- 4 month old baby left in care of sitter (licensed daycare) overnight
- Left in car seat with blanket over head and found dead next morning
- Previous cps records on daycare worker found unsubstantiated and partner abuse in 2012 with no findings, another case where she was victim was substantiated.
- No previous history for the mother
- Small scar on baby's left thigh never explained
- Substantiated against babysitter

Group 1 **F-24-13-C**

- One month old co-sleeping death in hotel in TN
- Broken ribs caused by father's CPR efforts
- Baby and mother tested positive at birth for marijuana
- TN indicated if they had been contacted they would have done toxicology screen automatically on parents
- Living in homeless hotel?
- Grandparents came forward and reported abuse
- Family moved out of state and DCBS was trying to track them
- DCBS kept asking grandparents if they could pay for drug tests
- Statutory requirements must be met that define indigence
- New pilot program between DCBS and court for drug testing
- Case had been opened for ongoing services thru TAP program when baby was 7 days old as well as family preservation services after.
- Recommend mandatory drug testing for parents/caregivers
- Develop protocol to avoid over screening certain groups of people
- Helpful to research statutes from other states regarding testing/ task for new attorney
- How many of deaths are actually substance abuse issue rather than co-sleeping?
- How many die in co-sleeping deaths that this panel never sees?
- There is data to support that co-sleeping in the absence of substance abuse is still a dangerous practice.

Group 2 **F-15-13-NC**

- Eleven week old co-sleeping death
- No previous involvement, no suspected impairment.

Group 3 **F-26-13-C**

- Nine year old diabetic child
- Child sick for two days prior to being taken to hospital
- Staph infection in brain and lung.

- 2011 cabinet gave parents one week to get child's sugar levels under control and they did not.
- Mother told cabinet no drug history but she had two AI's and father had a drug history including trafficking.
- Mother's drug screen positive but no criminal charges filed.
- Poverty, lack of food, six dogs and four cats in home.
- Finding of neglect although neglect did not cause death
- Diabetes was secondary cause of death
- Important for medical staff to document instructions given to families of chronically ill children especially when cabinet previously involved regarding same issue
- Mother placed responsibility on child for his own care
- School nurse had spoken with father, referred to UK, father appeared more concerned than mother
- Had given prescription drugs not prescribed to child
- DCBS should seek help from medical community in these types of cases
- Helpful to DCBS when parents are asked to sign contract with medical providers regarding care for child
- History of non-compliance
- Occurred in Laurel County; ~~less~~ fewer resources
- Cabinet waited on coroner 's report; determined medical neglect

Group 4 **F-27-13-C**

- Children and dog left in car that rolled into lake
- 5 year old drowned
- Seventeen previous reports on family
- Emotional/behaviorally disturbed 7 year old sister
- Reports of sexual abuse unsubstantiated
- Teachers and neighbors reported bruises
- No collateral interviews in seventeen investigations
- Three adults in home when drowning occurred
- No criminal charges
- Some reports of alcohol use and possible drug use
- Chronic neglectful family
- Did not review TWIST history, cases were not merged in TWIST
- Poor documentation, lack of collaterals, lack of communication between multiple workers involved
- Should there be an additional level of review trigger by a certain number of reports?
- Compare average number of reports/make recommendation for trigger point

Group 1 **F-33-13-C**

- Five month old found unresponsive by parents
- Mother had two children removed prior
- Boyfriend caring for baby while mother was a work.
- Boyfriend indicated baby was fussy, gave meds, fed and put to bed.
- Mother found baby dead.
- boyfriend refused drug test
- Older children who visited reported domestic violence
- Medical examiner said it was not SIDS/believed baby was smothered with pillow.
- None of the medications said to have been given by boyfriend were on toxicology screen.
- Three cigarette burns on palm of baby, neck injury and bump on head
- Undetermined cause of death
- No criminal charges
- DCBS substantiated physical abuse
- Good case for nurse analyst to go thru records, note risk factors involved that might have been missed.
- no drug testing; need to have drug testing in unexplained deaths
- need for screening process at every birth

Group 2 **F-25-13-NC**

- three month old found unresponsive in crib with blood around nose and mouth
- 17 year old mother and 19 years old father
- Lived with her mother, throwing party when this occurred
- Cause of death undetermined
- Baby had broken arm that had not been treated
- Nurses contacted law enforcement
- Family members had advised to seek treatment for injury to arm but they did not.
- Neglect substantiated on parents for not seeking care for the arm injury and for not knowing how it happened, also substantiated for physical abuse on unknown perpetrator.
- Death was most likely positional asphyxia but could have been a smothering as well.
- History of family violence, substance abuse
- Baby had bruising on face identified by family members prior to death.
- Bottle-fed baby positive for caffeine
- Alcohol was purchased by the mother of under aged parent.
- No prosecution
- Separate referral/case re: mother who purchased alcohol for minors
- Good follow-up efforts by worker
- Was not referred to HANDS, missed opportunity

- Track HANDS eligible that do not get referred

Group 3 **F-31-13-NC**

- Five year old brother accidentally shot two year old sister
- Father took gun out of vehicle and left it out propped against a bookshelf
- Gun was purchased for the five year old a few months prior
- No prosecution, no substantiation.
- when does panel determine neglect vs cabinet determination
- cabinet can substantiate without providing services or involving the court
- lack of parental judgment
- Disservice to integrity of data as well as policy and procedure when judgment/sympathy makes determination. Demographics play a part in determination also.
- Should be consistency in all cases.
- Possibly create a new category to avoid inconsistency.

Group 4 **F-32-13-C**

- Fifteen year old committed suicide at state home.
- History of sexual abuse since 1999.
- Had been moved to different unit and placed on five minute checks after he was accused of assaulting another youth.
- May have been gap in checks as staff person claimed to have done checks but failed to log them. Found hanging at 7AM.
- Facility understaffed. Staff required to do cleaning as well as monitor patients.
- Previous history of suicidal.
- Substantiated neglect on individual caregiver
- Review last five years of licensing inspections for facility
- Did not have enough to substantiate neglect against the facility.
- If a facility loses license, Medicaid is pulled.
- Unknown if employee appealed decision.

Group 1 **F-39-13-C**

- Two and half year old ran over by minivan driven by mother's boyfriend.
- Child thought to be inside the home.
- Neighbors witnessed the accident.
- Mother had three other children removed previously due to child sexual abuse in NC. Natural father incarcerated.
- Mother had history of suicide, domestic violence, drug abuse.
- Numerous collaterals collected.

- Boyfriend refused Breathalyzer and would not take drug test. Prosecutor denied officer's request for warrant for blood test.
- Neighbors said it was accident but boyfriend was violent and had history of domestic violence in previous relationships.
- Lots of empty beer bottles in house and van as well as empty pill bottles.
- EMT's noted looking at boyfriend's eyes, he appeared to be under the influence.
- Mother filed for EPO two months later.

Group 2 **F-34-13-NC**

- One and half month old died from skull fracture and brain hemorrhage.
- Mother's boyfriend has been charged with murder. Case is pending prosecution.

Group 2 **F-40-13-C**

- Eight year old along with his mother killed by father in murder/suicide.
- Twelve year old and another adult escaped.
- Mother had three year DVO that may have just expired.
- Request file from Jefferson County fatality review board.

Group 2 **F-29-13-C**

- Seventeen year old overdosed.
- Had been placed with aunt who had refused to get mental health treatment for child.
- Aunt visited with another relative and was notified child had gone to stay with mother overnight.
- Alcohol, valium, Klonopin, and Suboxone found in her system.
- Mother and boyfriend charged with murder for allowing child access to drugs. Multiple drugs found at home.

Group 3 **36-13-C**

- Four year old drowned in family pool.
- In custody of maternal great aunt.
- Aunt went in to use restroom; child ended up in pool which was not completely fenced.
- Substantiated neglect.
- Six months prior, child was unsupervised at convenient store while under supervision of maternal great uncle.
- Prevention plan was in place with aunt that child would remain supervised at all times and not be left unsupervised with uncle.
- Second referral post death indicated child was unsupervised often.
- No drug test; aunt was using prescribed medications.

Judge Crittenden asked Mr. Cannady to assign four cases to be reviewed for September along with any cases from this meeting that were not discussed. He also asked Mr. Cannady to email information regarding conference attendance to panel members.

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