CHILD FATALITY NEAR FATALITY EXTERNAL REVIEW PANEL

September 8, 2014
Crowne Plaza Hotel, Louisville, KY

Members Present: Judge Roger Crittenden, Chair; Judge Brent Hall; Joel Griffith, Prevent Child Abuse Kentucky; Dr. Melissa Currie, U of L Division of Forensic Medicine; Dr. Tracey Corey, State Medical Examiner; Dr. Jaime Pittenger, Child Abuse Pediatrician, University of Kentucky School of Medicine; Dr. Kim McClanahan, CEO, Pathways, Inc.; Commissioner Teresa James, Department for Community Based Services, CHFS; Maxine Reid, Family Resource and Youth Service Centers, CHFS; Allison Taylor, designee for Dr. Stephanie Mayfield, Commissioner, Department for Public Health, CHFS; Dr. Blake Jones, University of Kentucky School of Social Work; Nicky Jeffries, CASA; Nathan Goins, ; and Sharon Currens, Kentucky Domestic Violence Association.

Members Absent: Senator Julie Denton, Representative Tom Burch, Dr. Ruth Shepherd, Dr. Carmella Yates, and Jenny Oldham. Detective Kevin Calhoon, Kentucky State Police, has retired and a replacement has yet to be appointed.

The meeting was called to order by Judge Crittenden who welcomed members and guests in attendance. The minutes from the previous meeting were approved. Judge Crittenden introduced Ms. Kerry Holleran as the new attorney hired by the Justice & Public Safety Cabinet to assist this panel as well as the Juvenile Justice Oversight Council.

Judge Crittenden asked Mr. Cannady to update the panel on the contract process for additional staff. Mr. Cannady noted there is currently a memorandum of agreement with the University of Louisville for up to six forensic medical analysts with a start date of October 1, 2014. Dr. Currie commented that she has expressed the need in getting them started as soon as possible.

Judge Crittenden noted that Ms. Holleran would be assisting with putting together the annual report. He remarked that panel members should submit to Mr. Cannady by email any recommendations that need to be included in the annual report to the legislature as the draft will need to be discussed at the next meeting. He commented that he had spoken with Dr. Currie about including the recommendation for some type of drug testing of caretakers for suspicious deaths of children. He noted the panel has discussed this previously and it has raised concerns. He noted that it seems to be an issue in a number of infant deaths even when there is co-sleeping involved and other issues. Judge Hall remarked that he is concerned that it is not being done already. Dr. Corey noted there was a case in Louisville where a judge would not sign a search warrant. Judge Crittenden noted that might happen but the panel should still make the recommendation and that would send a message. He also noted the last thing you want to do to parents is put them through a horrendous examination but if it is done for everyone as a matter of protocol that alleviates issues. Dr. Currie remarked that Ms. Holleran can assist with researching what other states do. She commented that the panel would be smart to have the recommendation included as part of a protocol, not something that is on the whim of the investigator because that is when the family reacts negatively and feels singled out. She noted that if it is done across the

board, it becomes standard procedure. Ms. Reid noted that eliminates discrimination by location as well. Mr. Griffith commented that as the panel moves forward to making this recommendation, work needs to be done to make sure it articulates the data. Dr. Corey noted the data is available in the medical examiner's annual report. Mr. Griffith also commented that the panel should determine how this can be done in a way that does not feel invasive to the family. He expressed that he has lost a child and it would be a bad time to go through a death and then have to be drug tested. He commented the panel must think through how this impacts families. He stated that he is okay with the concept but it must be done in a way that is respectful to families.

Judge Crittenden introduced Ms. Sandra Alexander who is with the Center for Disease Control in Atlanta, Georgia, and serves on the Atlanta Child Fatality Review Team. Ms. Alexander gave an overview of the Georgia Child Fatality Review Program. A copy of her materials is available upon request. Ms. Alexander specified the need to make actionable recommendations for prevention which include specifying who is to be responsible and how it is to be done as well as how it will be tracked to monitor progress. Judge Crittenden asked if Ms. Alexander's panel reviews all deaths. She noted there is a list of cases eligible for review which include the death of any child under eighteen that is unexpected or unexplained which included automobile accidents. Dr. Currie commented that the Jefferson County team would review those as well. Dr. Corey agreed the Jefferson County child review team is structured very similarly. Mr. Griffith inquired if the local teams in Georgia are required. Ms. Alexander indicated they are mandated. Mr. Griffith noted that Kentucky's local teams are permissive rather than mandatory. He noted they are required to coordinate investigations but there is not a mandate for local teams. Dr. Corey inquired about regional teams in Georgia. Ms. Alexander responded that the mandate states there will be a team in each county but the original legislation states they can recommend establishing a review committee for each alone or for all counties with a judicial district. She noted there are a few counties that are together but the larger counties have their own teams. Mr. Griffith noted that ninety percent of unexpected child deaths in Georgia are reviewed at a local level. Ms. Alexander remarked that if notification is received at the end of the year that there are cases that have not been reviewed, they hold a special meeting to do so. Judge Crittenden inquired about the number of local review teams in Kentucky. Dr. Currie indicated that there are over eighty local teams with a few more added every year. She noted the Department for Public Health is in charge and contracts with Dr. Pollack at the University of Kentucky to help run the local child fatality program. She noted there is not participation at a local level with 100% of our counties. Mr. Griffith commented the participation rate may have decreased slightly this year from approximately eighty percent. He also noted the teams that are established seem to be more focused on the joint investigation process than an in-depth review of cases. Dr. Currie commented that as far as making recommendations and compiling data for an annual report, that's not something that's consistently happening at a local level but happens at the state public health level. She stated the local teams report their numbers to the state level in most cases. Dr. Corey commented that the coroners are required to submit a child fatality form to public health in every child death. Dr. Currie noted that does not always happen but it does so in Jefferson County. Dr. Corey added that because those forms are required to be submitted, you should have the numbers reported, even for counties that do not have local teams. Mr. Griffith commented that he believes the compliance on that is actually very low. Dr. Currie stated that is one of the issues that the state public health team is reviewing. She inquired if there is a coroner system in

Georgia. Ms. Alexander confirmed there is as well as medical examiners in the larger counties. Dr. Corey noted Georgia's system is very different in that they have appointed medical examiners in larger metropolitan areas rather than coroners. She noted coroners are in the rural areas and they can send cases to the medical examiners. Dr. Currie inquired if local teams received any funding from the state level. Ms. Alexander indicated she was not aware of any funding received at the local level. Commissioner James inquired about any systemic changes seen in Georgia as a result of the reviews. Ms. Alexander responded that Georgia now has a safe sleep coalition which evolved from a smaller coalition in Fulton County. She also stated that while there have been campaigns, they are not seeing a significant decrease in related deaths. Commissioner James asked about recommendations they have put forward. Ms. Alexander noted there have been some traffic related changes at high risk intersections as well as graduated driver licensing. She noted agency level changes such as death scene investigations by the medical examiner's office, CPS staff requirement to actually see the children as well as better sharing of information are some recommendations and changes that have been made. She noted other changes are listed in the information provided. Judge Crittenden noted that a number of the co-sleeping deaths the panel has reviewed have involved substance abuse. He inquired if there had been any campaign on safe sleeping. Ms. Alexander stated there has been a campaign in Georgia and there is the national safe to sleep campaign that has many resources on their website. Judge Hall commented that the panel needs to consider a recommendation to mandate local review teams, if not county by county, at least for each judicial circuit. He also suggested recommending a penalty for coroners for non-compliance of submitting required reports. Mr. Griffith commented that even if the panel took the step to submit the annual report to include the coroners who submitted data as well as the coroners who did not, there is nowhere to find the data unless you start to ask questions. Dr. Corey noted that if the medical examiner's office gets the software they are requesting, they would be able to disseminate the information in real time as they sign out cases to the Department for Public Health. Judge Crittenden inquired if the medical examiner's office is waiting for funding for the software purchase. Dr. Corey stated they have received grant money to purchase the software for their offices. She explained they want to eventually have all coroners' offices linked as well. Judge Crittenden asked if the medical examiner's office gets a report of every death in the state. Dr. Corey explained that Kentucky has a dual death investigation system where the county coroners do their initial investigation and decide whether or not to have the body transported to their closest regional medical examiner office. If they decide not to send it, they are not required to do so. She noted there is a check and balance in that if the coroner decides not to send, law enforcement can go to their local commonwealth's attorney who can go get a court order for the case to go to the medical examiner. Dr. Corey noted there are very few cases, especially of infant deaths, that do not make it to the regional office.

Judge Hall asked whether juvenile court proceedings were open or closed in Georgia but Ms. Alexander did not know. Judge Crittenden mentioned a model system in Kentucky for open proceedings but Mr. Griffith commented that bill did not pass the legislature. Judge Hall noted the House and Senate could not agree on how it should be done. Judge Crittenden inquired if the panel had a recommendation on the issue. Judge Hall and Dr. Currie agreed it should be submitted as a recommendation. Dr. Currie noted that the panel has identified cases where it seemed that CHFS presented a case before the court and the judge ruled counter to the recommendation. Dr. Currie commented that having open courts provides a check and balance if

the judge rules against CHFS. Judge Hall commented that transparency is really needed. Mr. Griffith inquired if the panel would support total opening or the pilot project. Judge Crittenden commented that the panel should support the pilot project.

Judge Crittenden recognized Secretary J. Michael Brown who briefly addressed the panel. Secretary Brown commented on the memorandum of understanding which codifies that the panel is a separate and independent entity which serves the purpose of the panel to reestablish public confidence in the review process.

Judge Crittenden asked panel members if they had reviewed the conflict of interest disclosure form. He noted this was recommended and will be good to have on record if there is an area that could potentially raise a question. Dr. Currie noted that this is not meant to be a case specific conflict of interest but rather it is strictly about financial relationships. She suggested that if there were no proposed changes within the next week to finalize and send out to the panel members to complete.

Judge Crittenden asked Dr. Currie to update the panel on the case review tool. Dr. Currie remarked that Dr. Shepherd, Mr. Griffith and Mr. Walker had worked with her in developing this tool. She acknowledged the need for this tool for panel members to use to help make sure they are looking at issues that need to be looked at and also having consistency in the way that the panel is gathering information. She stated the front side is a revised version of what CHFS is already using and filling out part of page one for the panel. She noted the panel will go through and complete the rest of the information as the case is reviewed. She clarified that child risk factors on page one is a data gathering tool, not necessarily saying the factors contributed to the specific death but rather was it a factor that was present in the case overall. She remarked that when the panel is looking at risk factors that may have actually contributed to the death, those are listed again on the back of the form. She noted that all sections may not apply in all cases. She commented that this is a way for the panel to standardize data collection for information to include in the annual report. She remarked that as a panel you do not want to make recommendations based on one case; recommendations need to be based on objective data. She noted this is a working document created for the panel's use so as it is piloted recommendations can be made. She noted that parts of the form can be completed by the forensic medical analysts that will be summarizing the cases for the panel. She noted the idea would be to complete the categorization on the right of the form as a panel during case discussion so that there is consensus on those as they will be used in the annual report. She commented on the intentional use of the word categorization to make it clear that this is the panel putting the case in a category that is completely separate from any other entity such as the courts and/or CHFS. Dr. Corey suggested that if something is added to the tool at any point, the panel would have to go back and look at cases retrospectively to have accurate data for the annual report. She suggested leaving the form as is for a year and then revise. Dr. Currie agreed. Commissioner James suggested doing a tip sheet to assist panel members in understanding the categories on the form. She stated she would send that to Dr. Currie for review. Dr. Currie noted that is an area where assistance is needed with definitions, especially within the courts with the category of timely disposition. Judge Hall commented that timely hearings would be better language. Dr. Currie agreed that input would be helpful from Commissioner James and Judge Hall and others to make sure the right language is used. Dr. Corey commented that definitions are also needed with the section

for panel's categorization as well. Dr. Currie suggested the panel work on definitions and have a working document circulated within the panel by email for everyone to ask questions and add input. Dr. McClanahan noted that mental health is not included on the form as far as indicating if someone has been in treatment or followed through. Dr. Currie agreed that needed to be included. Dr. Currie noted that the box for panel referrals for further action is for those cases where the panel has identified a wrong that can be righted where some other entity can go back and look at a case and address issues that may still affect the outcome of that particular case. She stated that she anticipates the form will evolve over time and inquired if any panel members have used it in reviewing this case review. Judge Hall indicated that he liked the tool and Mr. Griffith commented that it helped him focus on the bigger picture. He also noted that the panel is still not getting records needed. Dr. Currie stated that the nurse analysts will help identify those missing records as they are compiling the cases and abstracting them and hopefully they can get those records in before the case summaries get to panel members. Dr. Pittenger inquired if the panel will ever make the recommendation that a case be reopened. Dr. Currie replied that would fall into the box for referral for further action to ask a particular agency to look at a case again. Judge Crittenden remarked about a letter received by some panel members regarding a particular case and asked for comment. Dr. Corey said that she did not believe the panel has a role in that. Judge Hall agreed as did Judge Crittenden. Judge Crittenden stated that he did not believe it was the panel's role to have any involvement in individual cases that are ongoing. Judge Hall remarked that would be another reason to open hearings. Dr. Currie stated that overall she agreed that it is not the role of the panel. She referred to a scenario where there has been a child's death in a local community, perhaps where they do not have a local review team, and a citizen has a concern about the determination in the death or how the death occurred. She noted that one of the things said in the beginning was that the panel would take referrals from different sources. If citizens have concerns about a fatality or near fatality, the panel should probably have a system by which that can be referred to the panel officially and vetted. Judge Hall agreed. Judge Crittenden noted some situations can be referred to the appropriate agency for action. Commissioner James noted that CHFS has an ombudsman's office which is a third party that anyone can contact to address concerns about a case. Mr. Griffith commented that if it is not a death or near death it does not meet the panel's statutory authority for review. Mr. Griffith also commented about the need for the review tool to have information about mental health assessments. Dr. Currie commented that it should be noted whether there is documentation of a formal assessment. Dr. McClanahan also stated it should be noted whether they were following their treatment plan and taking their medications. Dr. Currie added they can note the individual's adherence to mental health recommendations but it also needs to be noted if a formal mental health assessment and/or substance abuse assessment was completed. She remarked it is the *formal* assessment or lack thereof that has been an issue. Dr. Currie also commented that all panel members do not necessarily have to complete the form. She stated that the panel may decide to adjust the review process where one member reviews one particular piece of a number of cases but noted that she was not necessarily proposing it. Judge Hall stated that he has found a number of court discrepancies in cases he has reviewed and other panel members have found discrepancies within the medical treatment and determinations. He suggested that perhaps a better way to review cases would be to check compliance in a member's area of expertise to note on the case review tool. Dr. Currie noted the nurse analysts may be able to flag certain portions for panel members to look at specifically. Ms. Alexander commented that one of the categories on Georgia's review tool notes any services offered to the family as a

result of the death. Dr. Currie commented that was an interesting idea but one of the challenges this panel deals with is that the local teams are reviewing in real time whereas this panel is reviewing cases approximately a year out. She remarked that some of those types of things are much better addressed in real time by the local team. Mr. Griffith inquired if the panel needs to create a system that prompts to move out of the systems improvement piece which is very important but then also move to structured discussion regarding primary prevention/early intervention. Dr. Currie remarked that her hope was that having potential panel recommendations would be enough to remind the panel to do that but it can be more explicit and indicate particularly primary prevention. She also commented that the panel has done a good job during discussions in remembering to take a step back and talk about things such as education at the birth hospital, etc. She indicated the wording can be changed on the review tool as a reminder. Dr. Blake commented that he reviewed a case with cultural issues and inquired if that might be a risk factor to include. Dr. Currie replied that was a good suggestion. Dr. Corey noted the length of the review tool could increase as suggestions are added. Judge Crittenden remarked that it could eventually lead to separate pages for each area such as hospital/healthcare, social work, and law enforcement.

Mr. Cannady communicated that he would be meeting with the Commonwealth Office of Technology regarding SharePoint and has spoken with them regarding adding an element in SharePoint for recommendations. He suggested perhaps the summary pages could be put into SharePoint. Dr. Currie agreed and noted it is difficult to know how the mechanics with SharePoint are going to work until the nurse analysts are on staff.

Case Discussion:

Group 1
NF-71-13-C

- Thirteen year old Somalian boy; wheelchair-bound hemophiliac with PICC line
- Admitted to Kosair in June 2013 with severe infection in PICC line.
- Mother called and was advised to take child to hospital but waited two days to do so.
- Four previous contacts with DCBS due to neglect, not medical neglect; unsubstantiated.
- Mother with five children under the age of twelve along with a maternal aunt and uncle with children living in small home.
- Issues with housing; cultural barriers in terms of language; lack of education regarding child's medical care requirements.
- DCBS provided support and made referrals to Neighborhood Place.
- Workers interviewed children, a lot of collateral interviews.
- In-home nurse consultation also went with DCBS to home.
- Referred for housing; family did not want to break up extended family; cultural divide.
- Case of mother being overwhelmed.
- Different opinions from different social workers and doctor on what happened.
- Mother's explanation seemed that she was confused about the seriousness judging from similar past experience.
- Assumptions made about family; complaints made by neighbors possibly due to cultural differences.

- Parents traveled back and forth between countries.
- Father uninvolved.
- Medical neglect was substantiated in this case.

F-28-13-C

- Eight year old medically fragile, no muscle tone, seizures, non-verbal child in need of significant care living in very rural area.
- Was seen at hospital week before with A and B flu, strep throat and pneumonia; kept overnight and sent home.
- Mother and other children were also ill.
- Found unresponsive on the sofa next early afternoon.
- Coroner was originally concerned due to what was originally described as cuts on elbows of non-ambulatory child but later said to be bug bites.
- House was roach invested and dirty; children were dirty.
- Child had two prescriptions that had not been given but the doctor had said not to give.
- Mother took oxycodone night before.
- Coroner revised position stating child died from natural causes from pneumonia
- Family preservation had ongoing case and home visit had occurred within a week prior and said no environmental conditions with home.
- No indication that environment had any impact on child's death.
- Question was raised regarding child sent home with two types of flu, strep throat and pneumonia after an overnight stay. Dr. Pittenger noted hospitals do not keep patients until they are well necessarily, but rather until they are well enough.
- Dr. Currie inquired if medical records were included in case and also noted the lack of referral to medical examiner for an unexplained unexpected death of a child. She noted there seems to be an understandable response by some coroners that if a child is medically fragile, they do not view that as an unexpected death necessarily. She noted this was not a terminally ill child but rather a child with an acute illness who died.
- Dr. Corey was surprised it was not referred but they may have elected to do an external chart review, toxicology, etc. DCBS stated an autopsy was done and the cause of death was listed as bronchial pneumonia and medical records confirmed that the child's mother sought consistent medical care.
- Copy of autopsy should be available in SharePoint.
- Not substantiated for medical neglect.

Group 2
F-20-13-NC

- Third retrial; tabled for next meeting.

F- 40-13-C

- Murder suicide in Jefferson County
- Requested Jefferson County Domestic Violence Fatality Report; no report available.
- DVO issued in 2010.

- Visitation with children; complaints about nonsupport.
- No prior criminal record.
- Recommendation to invite domestic violence review team to address the panel regarding their work.
- Ms. Currens noted that when she was previously involved with the group, they were more focused on agencies involved and their response rather than risk factors, etc.
- Firearm involved; court should have been notified if recently purchased.
- Risk factor check sheet is required for domestic violence cases and should be available in court file.
- Mr. Cannady to request DVO court file.

NF-72-13-C

- Group of six children riding in car with adult female friend of family who was texting while driving and rear-ended a semi.
- Other than teen in front seat, none of the children were restrained including a four month old strapped into a car seat that was not strapped into the vehicle.
- Infant was the only biological child of the driver. Three of the other five were siblings.
- Six year old female twins, one of which (near fatality) started out in the back seat and was found in floor of front seat.
- Three of the children had closed head injuries with concussive symptoms. Near fatality also had pulmonary contusions and significant femur fracture requiring her to be transported to regional pediatric trauma center.
- Mother of main sibling group was incarcerated for drug related offenses. Children were in care of maternal aunt, mother's sister. Family friend offered to keep them overnight so that aunt could rest and mother was contacted in jail and approved. Children spent the night and were taken to a water park the next day.
- Driver had previous CPS history including substantiated physical abuse on her own biological child; significant mental health issues including bipolar; substance abuse issues.
- Driver positive for benzodiazepine and THC at time of accident on urine drug screen; no one interacting with her at hospital or at scene felt she appeared impaired or intoxicated; no prescription for benzodiazepine.
- Driver had neglect substantiated on her own infant and other child who was not even in vehicle; however, unsubstantiated neglect on near fatality and injuries to other children.
- Issues with previous CPS reports - was enough done to determine if mother was under the influence while caring for kids.
- Dr. Currie inquired why neglect was not substantiated for other children, particularly ones with severe injuries. Driver charged with six counts of wanton endangerment. Criminally charged for texting while driving, yet neglect was not substantiated.
- Substantiated neglect was based on positive drug screen.
- No issue made of fact that children were not restrained.
- Judge Hall stated under statute there could have been a finding of neglect.
- Not charged with DUI.
- Internal review completed by DCBS but not in file.

- Dr. Currie inquired if the finding could be revisited by DCBS. Commissioner James noted she has discretion to go back and look at the case and will report back at the next meeting.
- Dr. Currie remarked that it could very well have significant consequences for safety of the driver's own children but she also noted that the attention to child passenger safety in Kentucky and the lack of emphasis placed on that in the medical field, DCBS, and law enforcement is abysmal. She noted that when there is clear evidence that children were not restrained, to not substantiate neglect is a mistake.
- Commissioner James commented she would have CHFS legal staff review as technically they are not traffic police. She remarked that is a legal matter and they try to stay away from that. She noted they would be looking at the impairment piece in this case.
- Judge Crittenden remarked that it is understandable that she was not prosecuted for impairment but even so, you could have a finding that they should have been restrained which sounds like neglect. Judge Hall stated that it sounds exactly like neglect under the statute.
- Commissioner James inquired if every case of an unrestrained child should be referred to DCBS. Judge Crittenden commented that the panel is not recommending that; however, when you do have a case you might want to find neglect. Mr. Griffith noted that on this case there were multiple injuries, a positive toxicology screen, and texting while driving. He commented that this is one of those cases that clearly points out why the panel needs to be able to make findings that are different. He noted that Kentucky has a high incidence of traffic fatalities because of this.
- Panel found neglect based on no restraints.
- Clinical decision at DCBS to require drug screens based on safety and risk of harm; DCBS cannot afford across the board screens.

Group 3
NF-73-13-NC

- Four month old diagnosed with pediatric abusive head trauma.
- Seen by doctor on 6/18 for nausea and in emergency room that evening diagnosed with virus.
- Child in hospital on 6/20 for three days; released on 6/23.
- On 6/25 vomited at daycare; taken to hospital with life threatening event and diagnosed with subdural hematomas; discharged on 7/9 with safety plan with DCBS.
- All medical records not included in file.
- DCBS filed petition on 8/28; court refused to remove the child.
- Petition is still active with no finding; court is out of compliance.
- Family accepted services.
- Mother had been on maternity leave, went back to work and father had baby for couple of hours at a time around the time the baby is injured but daycare also began around the same time.
- Father had previous domestic violence in 2010.
- Cabinet substantiated neglect on both parents for risk of harm.
- Collateral interviews with daycare staff; thorough investigation by workers.

- Abusive head trauma not considered when child presented with vomiting but lots of children present with vomiting. Head injury should be on differential diagnosis when children present with vomiting in the absence of diarrhea but child did have diarrhea on one of the hospital visits.
- Cannot and should not do a head CT on every child for vomiting.
- No evidence of joint investigation.
- Hesitation to go into daycare; difficult to get DCBS and OIG to focus on daycares.

Group 4
NF-70-13-C

- Nine month old infant girl left with seventeen year old half-sister.
- Father was biological father of three older girls and infant; mother of infant was stepmother to older three girls.
- Father received call from seventeen year old saying she took out trash, was locked out and saw an intruder in the house and the baby was crying; later admitted story was a lie.
- Father found baby face down in crib with pillow on head.
- Father cleaned vomit off baby and gave CPR; told daughter to call 911 but then called as he was afraid she might not.
- Fatality; baby was on life support and died four days later.
- Maternal aunt indicated she had seen the older sister hitting the infant with open hand and being too rough; suspected jealousy due to grandmother paying more attention to the baby.
- Sentencing in October.

Group 3
F-41-13-C

- Impaired co-sleeping death of infant.
- Children left unsupervised while mother went to store.
- Alcohol and drug use that night by mother and boyfriend; mother went to sleep with baby; used bathroom on bed.
- Needed a warrant for drug test on mother.
- Court out of compliance regarding timeliness.

Judge Crittenden asked panel members to email Mr. Cannady within the next two weeks regarding any information and recommendations to be including in the annual report to Mr. Cannady. The next meeting of the panel is scheduled for November 17, 2014. Dr. Currie noted that Dr. Montgomery will be attending the meeting to speak to the panel regarding patient safety issues.

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