CHILD FATALITY AND NEAR FATALITY EXTERNAL REVIEW PANEL

PANEL MEMBERS

- Chairperson of the House Health and Welfare Committee – Rep. Addia Wuchner
- Chairperson of the Senate Health and Welfare Committee – Sen. Julie Raque Adams
- Commissioner, DCBS – Elizabeth Caywood
- Commissioner, DPH – Dr. Henrietta Bada
- Family Court Judge – Hon. Paula Sherlock
- UK School of Medicine – Dr. Jaime Pittenger
- UofL School of Medicine – Dr. Melissa Currie
- State Medical Examiner – Dr. William Ralston
- Court Appointed Special Advocates – Shawna Kelly-Blair
- Kentucky State Police – Lt. Scott Lengle

PANEL MEMBERS

- Prevent Child Abuse Kentucky – Joel Griffith
- Practicing Local Prosecutor – Hon. Jenny Oldham
- KY Coalition Against Domestic Violence – Sherry Currens
- State Child Fatality Review Team – Angela Brown, RN
- Board of Social Work – Elizabeth Croney
- Family Resource and Youth Services Center – Betty Pennington
- Association of KY MHMR Centers – Steve Shannon
- Citizen Foster Care Review Board – Linnea Caldon
- UK PFM Expert – Dr. Christina Howard

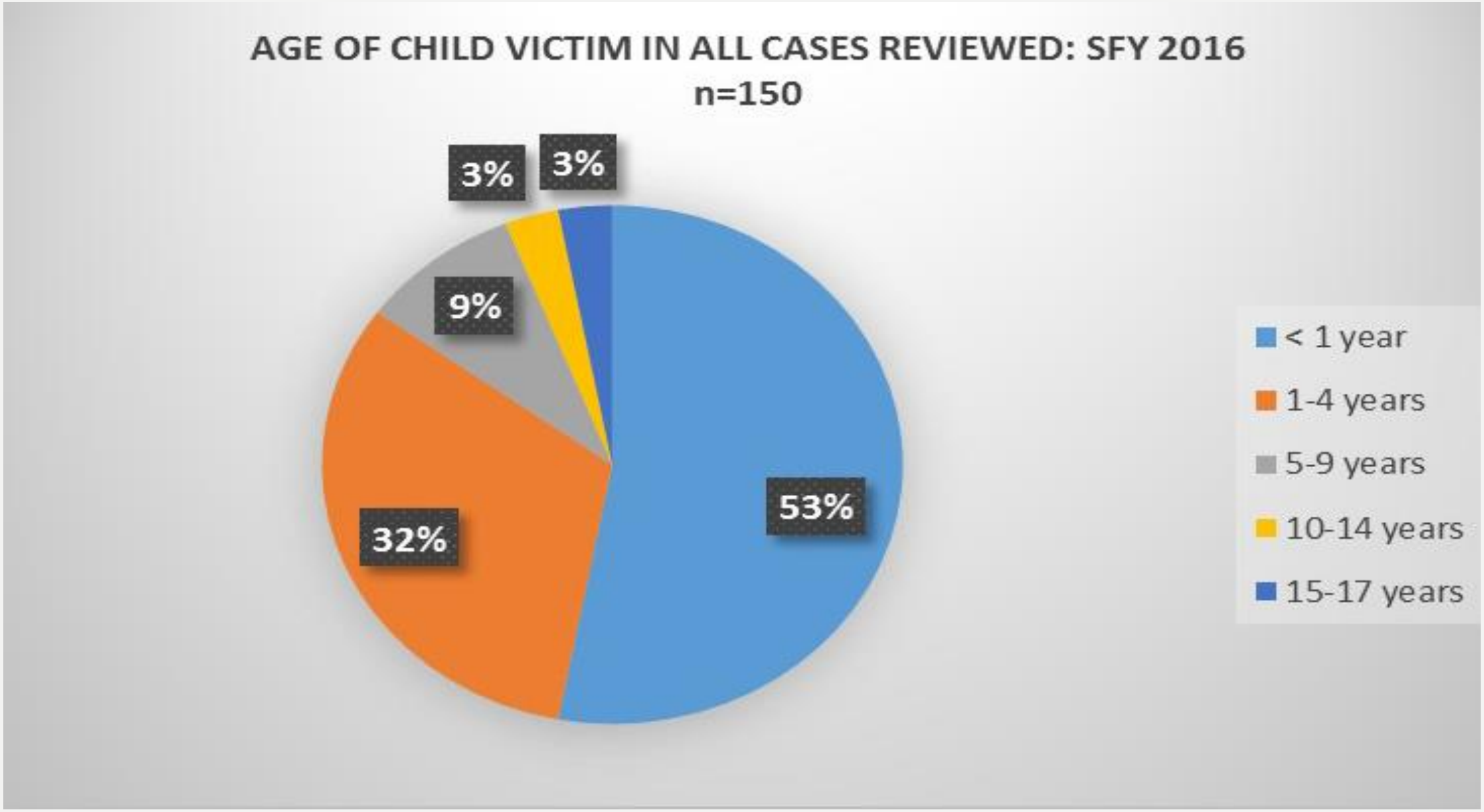
PANEL PROCESS

- Cases referred from DCBS and DPH
- SharePoint - Data Collection
- Analyst Summary
- Comprehensive in-depth discussion
- Category
- Family Characteristics
- Panel Determination

Cases Reviewed by County of Incident, 2014-2016

December 5, 2017
Data Source: Child Fatality Near Fatality External Review Panel
Shapefiles from Kentucky Geography Network.
Prepared by Emily Ferrell, MPH CPH
380 cases total for these years.

Note: Not adjusted for county population



- Data Source: Child Fatality and Near Fatality External Review Panel

2017 PANEL FINDINGS

- 85% of the cases reviewed had a prior history with child protective services.
- 75% of all cases are potentially preventable
- 41% of all cases with a panel determination of Abusive Head Trauma were found to be in the care of a substitute caregiver at the time of the incident.
- 39% of the fatalities reviewed were cases of Sudden Unexplained Death in Infancy (SUDI).
- 65% of the SUDI Cases involved an impaired caregiver who shared a sleep surface with their baby and the baby died from suffocation or asphyxiation.

CASE EXAMPLE

- *6 week old baby was found deceased in bed next to mother….*
  - The victim was born positive for multiple drugs and diagnosed with Neonatal Abstinence Syndrome.
  - There was an open CPS case at the time of the child's death due to the mother's ongoing substance abuse. From the time the child was released from the birthing hospital until it's death, CPS did not make a single home visit.
    - Mother had been non-complaint with drug screens requested by CPS and they had planned to file petitions in court but this did not happen prior to the child's death.
  - GPs' reported they were both suspicious that mother was using drugs but still allowed her to care for the children unsupervised. Neither had reported their concerns to CPS prior to the incident. GPs' did report they repeatedly told the mother not to sleep with the baby.
  - The child was seen by a pediatrician two days prior to the death and the doctor reported to the police the mother was under the influence. However, the doctor did not discuss it during the appointment and failed to notify CPS.
- On the day of the death, mom tested positive for amphetamine, benzodiazepine, marijuana, methamphetamine, and oxycodone – none of which were prescribed to her.
- The CPS worker assigned to this case had 9 months experience and 33 open cases.

PANEL REVIEW

- SUDI CASE
- Bystander Issues/opportunities
- Criminal History (caregiver)
- DCBS Issues
- Family Violence
- Impaired Caregiver
- Lack of Treatment
- Medical Issues/management
- Medically Fragile Child
- Mental Health Issues
- Substance Abuse
- Unsafe Sleep

- DETERMINATION
  - Neglect (general – unsafe caregiver)
  - Neglect (impaired caregiver)
  - Neglect (unsafe sleep)

CASE EXAMPLE

- *2 year old child presented to the hospital in full cardiac and respiratory arrest….*
  - Both parents of the index child had a history of substance abuse but were reportedly doing well in recovery.
  - Father of the child reported he was prescribed methadone but that it was kept locked and out of reach of the children.
  - Victim has a history of Neonatal Abstinence Syndrome as a newborn due to mother's participation in a methadone program during pregnancy
- Child was successfully resuscitated with CPR and responded to several doses of Narcan.
- Child's toxicology testing was positive for methadone. Hair testing revealed the child had also been exposed to methamphetamine and cocaine. Both siblings' hair testing was also positive for methamphetamine.

PANEL REVIEW

- OVERDOSE/INGESTION
- Criminal History (caregiver)
- Criminal History (in the home)
- Medical Neglect
- Substance Abuse (in home)
- Substance Abuse by caregiver

- DETERMINATION
  - Neglect (medical)
  - Neglect due to unsafe access to deadly/potentially deadly means

CASE EXAMPLE

- *6 week old baby was brought to ED by father with difficulty breathing and bruises on her face….*
  - The infant was born drug-exposed but did not have a formal diagnosis of Neonatal Abstinence Syndrome. The infant was placed with father due to the mother's substance abuse issues.
  - Father resided with his mother and both parties expressed concern to CPS about their ability to care for the infant. Both parents had other children who did not live with them.
- The victim was found to have bleeding inside the skull and brain injury that was diagnostic of abusive head trauma. The child had several broken bones, including in the legs and ribs.
- Father ultimately demonstrated to the police how he violently shook the baby out of frustration when she cried. Father was convicted of Criminal Abuse 2nd degree and is serving a 2-4 year prison sentence.
- The victim survived but is at high risk for developmental delay and other health problems as a result of her inflicted brain injury.

PANEL REVIEW

- ABUSIVE HEAD TRAUMA
- PHYSICAL ABUSE
- Bystander Issues/opportunities
- Criminal history (caregiver)
- DCBS history
- Lack of family support system
- Lack of regular childcare
- Medical issues/management
- Medically Fragile Child
- Substance Abuse (caregiver)

- DETERMINATION
  - Abusive Head Trauma
  - Neglect (medical)
  - Physical Abuse

POTENTIAL FOCUS AREAS OF PREVENTION

- Sleep Related Deaths
  - Modelling Safe Sleep Practices - Alone (A) Back (B) Crib (C) Danger (D)
  - Informing caregivers of the dangers of bed sharing, particularly when under the influence.
- Plan of Safe Care at birth – "Warm" hand off to Pediatricians and HANDS for high risk families.
- Drug testing caregivers at the time of an unexpected death.
- Additional law enforcement training regarding child death scenes.
- Coroners education and standardization of reporting child deaths to the appropriate authorities.
- Abusive Head Trauma – bruising in babies IS NOT NORMAL
  - Implementing hospital-based prevention education to the parents of all newborns.
- **Encourage reporting by family members, neighbors, and professionals**.

Thank You

Questions?