

CPS Citizen Review Committees
Annual Reports

Utah Department of Human Services
Division of Child and Family Services
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SOUTHWEST REGION CPS CITIZEN REVIEW COMMITTEE

Annual Report
June 1, 2003

In compliance with the Federal requirements of the Child Abuse Prevention and Treatment Act (CAPTA), DCFS Southwest Region submits the following annual report from their CPS Citizen Review Committee. The Committee meets monthly at the DCFS Southwest Region Office in Cedar City, Utah.

CPS Citizen Review Committee Membership:

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Committee History:

Southwest Region's CPS Citizen Review Committee, which also functions as Southwest Region's Quality improvement Committee, has been in operation since July, 1999. The group is comprised of volunteer members and is broadly representative of DCFS Southwest Region. The Committee was trained in the provisions of CAPTA and its reporting requirements shortly after its organization and has expertise in the prevention and treatment of child abuse and neglect. The CPS Citizen Review Committee has evaluated Southwest Region's child protection responsibilities since 1999.

Committee Focus:

Following their CAPTA training, Southwest Region's CPS Citizen Review Committee chose to focus on SEC. 106 (a) (3) [42 U.S.C. 5106a]: "case management and delivery of services provided to children and their families". In their review of CPS services, it became evident that CPS caseworker turnover was negatively impacting service delivery as clients and their families tried to adapt to repeated changes in caseworkers. This concern was supported by a review of turnover rates of 21% for CPS workers in Southwest Region. The Review Committee was also concerned that DCFS workers typically began their careers as CPS workers, putting the Region's least experienced workers in positions that require experience and judgment. Additional data from Southwest Region's first Qualitative Case Review yielded case stories that spoke repeatedly to the impact of worker change on service delivery to families.

The Review Committee implemented a written survey of Southwest Region CPS staff early in 2001 in an effort to pinpoint causes of the high turnover among these workers. Response rates were in excess of 90% and indicated high levels of burnout as measured by a standardized tool embedded in the survey. Since that time, the Committee has completed a second survey, which identifies the underlying causes of burnout and prioritizes the order in which CPS workers would like their concerns addressed. The Review Committee is working jointly with Southwest Region's Management Team to formulate solutions to those issues.

Future Direction of CPS Review Committee:

Southwest Region's CPS Citizen Review Committee plans to incorporate SEC. 106. (a) (5) "developing, strengthening, and facilitating training opportunities and requirements for individuals overseeing and providing services to children and their families through the child protection system" in their focus for the coming year. Survey data indicate CPS workers would benefit from training designed to focus on personal well-being and empowerment. The Committee plans to work closely with Southwest Region's Management Team to develop the type of training that will help workers keep job and personal aspects of their lives in balance. Members of the CPS Review Committee believe this will increase workers' abilities to cope with the high stress associated with CPS position clients and their families by retaining experienced CPS and ultimately enhance service delivery to workers.

The CPS Review Committee has chosen to track specific CPS trend data for DCFS Southwest Region. The Committee is particularly cognizant of Southwest Regions consistently high percentage of CPS referrals that are accepted for investigation (81% to 86%). The Committee also focuses attention on quarterly trend data for percent of CPS investigations initiated within the mandated time period for each of the four priority levels and focus on worker needs that underlie these trends.

Report for CAPTA
Northern Region Quality Improvement Committee
12 June 2003

The Quality Improvement Committee examined the relationship between the schools and the Division of Child and Family Services. The method of review for this project was a survey administered to every public school in the region. Each school in the region from elementary to high school was given enough surveys for every staff member of the school who might have some contact with the agency. The survey was designed to determine whether the respondent had contact with the Division of Child and Family Services and in what capacity and how satisfied the respondent was with the experience. There were several questions specifically designed to extract information about the professional conduct of agents of the Division of Child and Family Services. There were also questions pertaining to the respondents knowledge of the agency and what needs they had that were unmet by the agency. Certain demographic information was collected from each respondent such as position with the school, and the district and school at which they were employed. The survey questions were primarily set up with scaling the respondent's satisfaction. The survey concluded by giving respondents and opportunity to share specific detailed comments. These responses ranged from positive to dissatisfied experiences. They were also some general comments or questions made in some cases.

The results of the survey were collected and calculated by students from Weber State University. When the results were analyzed, the areas for needed improvement were identified. The areas that were targeted for improvement were:

- * Improved communication to the schools. There were several specific examples where improvements could be made. Workers returning phone calls promptly. Follow-up with schools regarding CPS reports being made by the school. Notification to the school when a child has been either removed from the home and cannot be released to a parent or when the child has been returned to the custody of the parent and the school is permitted to release the child to the parents.
- * Workers properly identifying themselves at the school.
- * Educating school personnel regarding the Child Welfare process and limitations.
- * Improved coordination between the schools and shelter staff for children in the shelters.
- * Improved efforts to include school personnel in the case planning process.
- * Agency staff treatment of school personnel in a professional manner.

Regional Community Service Managers designed plans targeting these areas. These plans were presented to the Quality Improvement Committee. Community Service Managers reported the on progress plans periodically throughout the school year. This will continue to be an area of focus.

Results from the survey, such comments or data are available upon request. The specific strategic plans targeting areas of improvement are also available.

**DEPARTMENT OF HUMAN SERVICES
FATALITY REVIEW ANNUAL REPORT**

JULY 1, 2001 - June 30, 2002

Department of Human Services (DHS) Fatality Review Policy requires a review of all deaths for which there is an open case at the time of death or where clients have received services through DHS within twelve months preceding their death. Information obtained from case reviews provides insight into systemic strengths and highlight areas in which changes or modifications could enhance systemic response to client needs. During fiscal year 2001 - 2002, one hundred fifty-nine deaths of current or past clients of DHS were reported to the Office of Services Review (OSR). The reviews indicate that abuse and/or neglect were contributing factors in nine of the one hundred fifty-nine deaths. The Division of Child and Family Services (DCFS) reported that four children died as the direct result of abuse or neglect. The deaths of four individuals receiving services through the Division of Services to People with Disabilities (DSPD) could be linked to the failure of contract providers to provide appropriate client supervision and the failure of provider staff to expeditiously access emergency medical treatment. A resident of the Utah State Development Center died of injuries inflicted by another resident and could be attributed to a high staff-to-patient ratio that resulted in a lack of appropriate supervision.

Fatality Review Committees for DCFS, DSPD, and the Division of Youth Corrections (DYC) reviewed eighty deaths and have five reviews pending. The fatality reviews included ten cases of suicide and six homicide deaths. Fatality review committees waived two case reviews for DSPD, as the case files were destroyed in a fire at the Payson DSPD office. Utah State Developmental Center (USDC) conducted three and Utah State Hospital (USH) conducted six on-site fatality reviews. The Division of Aging and Adult Service (DAAS) reported three deaths, the Division of Mental Health (DMH) reported forty-seven deaths, the Division of Substance Abuse (DSA) reported one death, and the Office of the Public Guardian (OPG) reported twelve deaths. No committee reviews were held on cases from these divisions.

BACKGROUND and METHODOLOGY

In November 1999, the Office of Services Review assumed responsibility for reviewing all DHS client fatalities. OSR recognizes the fatality review process as an opportunity to acknowledge good case management, to identify systemic weaknesses, to train staff in performance problem areas, to involve Division staff on a local level in the review process, and to make cogent recommendations for systemic improvements.

The fatality review committees consist of a board member of the Division under review, the Attorney General or designee, a member of management staff from the designated Division and from a region other than that where the fatality occurred, a member of DHS Risk Management, and in the case of a child fatality, the Director of the Office of the Guardian ad Litem or designee, a member of the Child Welfare Legislative Oversight Committee, and any individual whose expertise or knowledge could significantly contribute to the review process.

The Child Fatality Review Committee and the DSP Fatality Review Committee meet on a monthly basis. Prior to committee meetings, members are furnished with copies of fatality review reports, which they study and in which they note areas for discussion. When it is deemed appropriate, Division staff and/or contract providers are invited to committee meetings to clarify issues and to provide additional information to the committee.

The DHS Fatality Review Coordinator participates in two inter-disciplinary child fatality review committees. The Early Response Team, headed by a representative of the Department of Health examines the causes of death of all children throughout the State of Utah. Representatives from Primary Children's Medical Center, The Department of Health, and the Department of Human Services attend this meeting. Team members pool family information that is then used in compiling Health Department statistics pertaining to birth defects, congenital anomalies, suicides, abuse and neglect, and accidental deaths.

The Rapid Response Team, also coordinated by the Department of Health, meets bi-monthly with the State Medical Examiners. This team is made up of representatives from Primary Children's Medical Center, law enforcement, the Office of the Attorney General, The Office of the Guardian ad Litem, the State Office of Education, the Department of Human Services, the Shaken Baby Foundation and the Division of Child and Family. Medical Examiners discuss autopsy reports of children who have died under violent, suspicious or unknown circumstances, or who have committed suicide. When appropriate, the team makes a referral to the Home Health Nurse program requesting that a nurse visit the deceased child's family to provide them with information regarding support groups for grieving parents and siblings. The representative from the State Office of Education coordinates with school counselors and teachers to provide special support and counseling to children whose sibling has died. The representative from the Department of Human Services reports on the Child Protective Services history of families and makes CPS referrals to Child Protective Services when there is concern about the safety of siblings remaining in the home.

Sharing of information among community partners has been especially helpful to law enforcement officers who are conducting criminal investigations concerning child fatalities. During the past year, information obtained from the Rapid Response Team has aided law enforcement in gathering evidence and strengthening cases preparatory to filing criminal charges against several suspected perpetrators of child homicides.

FINDINGS

The reviewers identified numerous strengths in service-delivery systems and singled out several areas in which changes modifications could enhance systemic response to the needs of Department clients. The reviewers also recognized several examples of outstanding case management conducted by Human Services staff. In the cases reviewed there were several recurring themes in both systemic strengths and weaknesses. This report will list the most frequently identified issues for each Division.

During FY 2001 - 2002, the one hundred fifty-nine reported deaths of current or former DHS clients represents a twenty-seven percent (27%) in the number of reported deaths over FY 2000 - 2001 and an eighty percent (80%) increase in the number of reported deaths over FY 1999 - 2000. The increase in the number of reported deaths is directly attributable to more thorough reporting by the Division of Mental Health (47 cases) and the Office of the Public Guardian (12 cases). When numbers for DMH and OPG are extracted, there was actually a ten percent (10%) decrease from FY 2001 in the number of reported DHS fatalities. The DHS fatality review committees reviewed thirty-four (34) DCFS cases with four (4) reviews pending, forty two (42) DSPD cases with one (1) case pending, and four (4) DYC cases. A committee review was waived for two (2) DSPD cases due to the fact that the case files were destroyed at the Payson DSPD office. USDC held on-site reviews on three (3) client facilities, and USH staff reviewed six (6) client fatalities. No committee reviews were held for forty-seven (47) DMH, three (3) DAAS, one (1) DSA, and twelve (12) OPG client deaths.

DIVISION OF CHILD AND FAMILY SERVICES

Systemic Strengths

Of the thirty-four DCFS cases reviewed, ten families (29%) had extensive histories of involvement with the Division. Two families had received services for nineteen and eighteen years respectively, two families for fifteen years, one for twelve, and the remainder for eight or more years. These cases clearly demonstrated an extremely positive change in the way DCFS investigates Child Protective Services (CPS) referrals and in the ways it provides services to families. In these cases, early CPS investigations were frequently cursory. Investigative omissions included failing to interview both parent and/or the referent, not substantiating allegations in spite of a history of prior referrals with similar allegations, no substantiating allegations based on conditions that existed at the time of the referral, not requesting court-ordered services when families failed to comply with voluntary services, and not removing children from homes when it appeared that they were at risk of harm. Although these same omissions can be found in current casework, they do not appear to be as egregious or prevalent as they were ten to twenty years ago.

For example, in cases with DCFS involvement within the past five years, the majority of the cases examined by the Committee reflected more thorough CPS investigations than in earlier years. In most cases workers conducted appropriate interviews, collaborated with law enforcement when necessary, worked with service providers to meet the needs of their clients, and if removal was necessary, were aggressive in seeking appropriate kinship or foster placements. With the advent of the Practice Model, caseworkers are working more closely with clients in an attempt to identify client needs and to plan appropriate services. In the cases reviewed, workers appeared to be diligent in assessing child risk and in removing children when risk was deemed to be high.

The Child Fatality Review Committee recognized the excellent work of DCFS staff, Ryan Stark, Tracy Aguilar, Brett Dickison, Michelle Nelson, a Peer Parent, and Post Adoption workers for conducting thorough CPS investigations and for providing excellent In-home services. These workers coordinated their investigations and services with the Child Protection Team at Primary Children's Medical Center and with law enforcement and teamed with community partners in providing extensive services to families. The workers made accurate assessments of children's safety and of family needs, staffed cases with supervisors and when necessary, worked with the Assistant Attorneys General in filing petitions with the court.

Systemic Weaknesses

In the course of case reviews the Child Fatality Review Committee identified perceived systemic weaknesses and noted deviations from "best practice" casework. In the thirty-four DCFS cases reviewed, the following two issues raised the greatest concern among committee members. It is recommended that during FY 2003, DCFS concentrate on improving case practice in these two areas.

Assessment of Underlying Needs

In eight (24%) of the thirty four DCFS cases reviewed, it appeared that CPS workers did not adequately assess the family's underlying needs and did not offer appropriate services to meet those needs. During the course of several child abuse investigations, family members or third parties disclosed information that indicated the families were in need of services not directly related to the stated allegation. However, workers did not adequately address those underlying needs or offer adequate services to the families.

During the investigation of a physical abuse allegation, a mother and her daughter gave the CPS worker information that indicated family members were experiencing a high level of stress due to the negative emotional climate in the home created by the father. The worker failed to recognize and/or acknowledge the impact of that environment on family members and failed to acknowledge the family's need for mental health services. The worker did not discuss with the family community mental health resources and did not offer to assist them in obtaining needed services.

A case with a lengthy history of DCFS in involvement had numerous CPS referrals with allegations of Physical Neglect based on the fact that the house was dirty. Several CPS investigators documented third-party suspicions that drugs were being sold out of the house. However, the workers did not acknowledge that the dirty house could be a symptom of a deeper problem or need. The family was required to clean the house, but their underlying needs of mental health services and/or substance abuse treatment were ignored.

A third case involved a child who died from abuse perpetrated by his mother's paramour. The mother had been involved in two relationships in which domestic violence was an on-going issue. The child's siblings were returned to the mother with court-ordered services. The worker discussed mental health services and grief support with the mother. Although the mother stated that she would look into treatment, mental health services were not addressed in her service plan.

The Child Fatality Review Committee recommended that DCFS workers be reminded to take a holistic approach when working with families. CPS workers would do well to look at the safety risks to all members of the family rather than just the child(ren) named in the CPS referral. In accordance with Practice Model Principles, workers should make a thorough assessment of a family's underlying needs and based on that assessment, assist the family in developing a plan for services to meet identified needs.

DCFS/AAG Case Staffings

In five (13%) of the reported cases, the Committee had concerns regarding the opening of Voluntary Supervision Services (PSC) in cases where there is a history of chronic and/or serious domestic violence or substance abuse.

These cases do not appear to respond to voluntary services and should be staffed with the Assistant Attorneys General (AAG) as to the feasibility of filing petitions for court-ordered services (PSS).

In one case, numerous CPS referrals pertaining to a family had been made and the allegations investigated. The family had received extensive services through the Division but always on a voluntary basis. A careful study of the pattern of referrals would indicate that should the family be named in subsequent CPS referrals, the worker should staff the case with the AAG to determine if a petition needs to be filed.

In a case involving the sexual abuse of a child, the worker did excellent investigative work and with the assistance of a mental health therapist, made a thorough assessment of the child's needs. The assessment indicated that the child was considered a "significant risk" for further sexual abuse. However, the family declined counseling services. The worker closed the case without staffing with the AAG for possible court-ordered services.

Another case involved a succession of unsubstantiated referrals for Physical Neglect. Credible third-party sources observed and reported neglect, but workers continue to close their cases with the allegations unsubstantiated. None of the workers offered services to the family. The Committee recommended that CPS investigators be reminded that where appropriate, they should offer services to a family. If services are not accepted, workers should staff the case with the AAG concerning the appropriateness of filing a petition for court-ordered services.

DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

Community Placements

Systemic Strengths

DSPD Support Coordinators act as advocates for individuals receiving services through the Division and through its contract providers. They assist individuals in establishing and maintaining SSI and Medicaid eligibility, assess individual service needs, coordinate and monitor client services provided through contract providers and assist in developing Person Centered and Individual Service Plans and Support Strategies. Through the Division's contract providers, individuals are provided with supported living placements in the least restrictive setting. They receive training in communication and social skills, are able to have community access, and receive vocational, occupational, and physical therapies. Individuals living at home receive respite, family support, personal assistance, and Hospice Care services.

DSPD has strengthened its program through the addition of nurse consultants in all regions. Support Coordinators are able to staff cases with the nurses and receive valuable assistance in monitoring the appropriateness of placements and services for medically fragile individuals. Nurse consultants can be an invaluable resource by assisting Support Coordinators in the development of Health and Safety portions and Support Strategies of the Person Centered Plan. The nurse consultants also make home visits to individuals, coordinate individual services with medical and dental professionals, resolve service and billing problems with doctors, dentists, and health-care specialists, review medications for possible drug interaction problems, train DSPD staff on drug interactions, and act as a medical resource to DSPD staff located throughout the state.

The DSPD Fatality Review Committee commended Support Coordinator, Stephanie Duran, who worked with an individual for fourteen years and who provided him with a sense of continuity, stability, and friendship. The Committee also commended Support Coordinator, Sue Canton, who was diligent in providing emotional support and assistance to a family receiving respite services and Hospice Care for their terminally ill daughter. Staff of the contract provider, TURN, were commended for the extraordinary efforts they expended in receiving permission to allow an individual to receive Hospice Care in their group home rather than transferring her to a nursing home. Their efforts allowed the woman to die with dignity in a familiar setting surrounded by caring friends and staff.

Systemic Weaknesses

Monitoring of Contract Providers

In four cases (9%) lack of supervision or failure to access medical treatment in an expeditious manner appeared to be linked to the death of four individuals who were receiving services through contract providers for the Division of Services for People with Disabilities.

In one case a man suffering increasingly frequent seizures was left unsupervised in a bathtub while the staff member assigned to him left to assist another staff member in bringing in and putting away groceries. While the staff member was out of the bathroom the man had a seizure and suffered a near-drowning episode. He died several days later of complications associated with the incident.

A woman with a history of compulsive eating sneaked a ball of pizza dough from the refrigerator while she was helping put away groceries. The woman went into the bathroom to avoid detection, stuffed the dough in her mouth, and choked. Although the Division was paying for 1:1 staffing for this client, staff left the apartment for a brief time, during which the client died.

A member of line staff in a group home was left to care for a medically fragile individual. When the individual's condition worsened staff's calls to the Program Manager for assistance and direction were not regarded as important. The individual died later in the day without having received medical intervention. It was the consensus of the committee that individuals with life-threatening medical conditions need to be cared for where there are attendant medical personnel available.

Staff in a Prader Willi group home turned off the door alarm because the sound was annoying. A resident of the group home walked out the backdoor and was subsequently hit by a light rail train. The Committee recommended that the DSPD State Leadership Team conduct an administrative review of the Prader Willi group home and that the Region provide enhanced supervision of the facility to ensure that staffing ratios are appropriate, that alarms are armed at all times, and that staff are appropriately supervising individuals in the home.

In response to the fatalities and to the recommendations made by the Fatality Review Committee, the Division of Services for People with Disabilities has imposed sanctions on the contract providers involved that will remain until providers can demonstrate that they have corrected all violations of their contractual obligations.

Health and Safety Plans

In four cases (9%), the Health and Safety portion of The Person Centered Plan for individuals who are diagnosed with special medical needs did not address those needs.

The documentation logs, Individual Service Plan, of a woman who had a propensity to aspirate did not address these known risks or her special medical needs.

The Person Centered Plan for another medically fragile individual identified the medical issues but did not outline a plan for addressing these medical issues.

A man diagnosed with uncontrolled seizures who was uncooperative in taking his medication was allowed to self-chart his medication compliance. There was no behavioral medication plan and no behavioral plan for seizures in his file.

Although the Person Centered Plan of a man who was experiencing an increased frequency of seizure activity had recently been updated, it did not address the issue of seizures, did not contain Support Strategies addressing bath protocol, and did not outline an action plan to deal with the seizures.

The Committee recommended that Regional Directors initiate training for DSPD line staff on writing the Person Centered Plan with special emphasis on writing the Health and Safety portion of the plan. The Committee recommended that DSPD nurses present in-service training to Support coordinators on identifying potential health risks and dangers for medically fragile individuals. It was also recommended that support coordinators staff cases of medically fragile individuals with DSPD nurses in regard to the appropriateness of placements and services and include nurses in the development of useful Health and Safety outlines, behavior plans, action plans, and specific Support Strategies.

Utah State Developmental Center

Systemic Strengths

Individuals at the Utah State Developmental Center are served by dedicated, caring, and, generally, well-trained staff. They receive excellent on-going medical, dental, and mental health treatment, medication management, and close supervision. Developmental Center staff are trained to respond rapidly to emergency situations, and they have established a good working relationship with community medical providers.

Utah State Developmental Center administration consistently conduct thorough and productive fatality reviews. The decedent's service team attends the fatality review and reports on circumstances surrounding the death, answers questions, and clarifies information for committee members. The service team is then excused, and committee members note any irregularities in case practice, policy compliance, or systemic performance. The committee then makes recommendations for systemic improvement and for improved individual care. If warranted, Developmental Center staff members receive in-service training in policy, procedure, and service delivery. If necessary, administrative team members consider systemic changes.

Systemic Weaknesses

Two of the three deaths at the Developmental Center (67%) raised the question of whether or not clients were being appropriately supervised by staff and whether or not the staffing ratios, although in accordance with Medicaid standards, were adequate for all situations. The client deaths prompted the recommendation that USDC evaluate staffing needs based on the needs of each individual in each apartment. It was recommended that decisions on staffing ratio should take into consideration both the medical and behavioral issues of the individuals on the unit and, while always meeting Medicaid minimum standards, should be increased or decreased as patient needs dictate.

DIVISION OF MENTAL HEALTH

Community Placements

During FY 2001 - 2002, the Division of Mental Health reported the deaths of forty-seven clients, forty of whom had open cases at the time of death. DMH clients were receiving services that included individual and group therapies, medication management, inpatient evaluation, supported housing, substance abuse treatment, and case management. No fatality reviews were conducted for these clients.

Utah State Hospital

Systemic Strengths

Utah State Hospital is to be commended for taking immediate action to improve systemic problems identified in its fatality reviews. Medical staff appear knowledgeable about decedents, and they provide informative verbal reports pertaining to the patient's treatment history and death. The DHS Risk Management representative and the DHS Fatality Review Coordinator, as well as medical and professional hospital staff, are in attendance at the reviews.

Of the six reported USH fatalities, one patient receiving residential services hanged himself with a belt in his bedroom. Another patient, who had been discharged from the hospital by the court against medical advice, was receiving medication management and outpatient therapy. He died from a gunshot fired by a police sniper during a hostage situation at a Salt Lake City store. Three patients had been discharged to nursing homes or care centers, and one patient had been discharged to a family member. One of the nursing home patients was receiving Hospice Care. In all cases where patients were released to nursing homes or care centers, Utah State Hospital supplied the receiving facility with information concerning the patient's history and on going care needs.

Systemic Weaknesses

There were no recurring systemic weaknesses identified in the six cases reviewed by Utah State Hospital.

DIVISION OF YOUTH CORRECTIONS

Systemic Strengths

The Committee reviewed four DYC fatalities. Documentation in case files indicated that through psychological and psychiatric testing, the Division had conducted thorough assessments of clients' needs, had obtained diagnoses, and had referred clients to treatment programs. The Division has contracts with numerous treatment program providers and has a good system of step-down programs for clients as they require less restrictive placements and supervision.

Systemic Weaknesses

Lack of Documentation

In two cases (50%) there was a lack of documentation from case managers as to whether or not treatment procedures were meeting or accomplishing case goals for the clients. There was no documentation that contracted services were actually being provided. There were no service plans in the case file and little, if any, documentation detailing the course of treatment offered in the treatment program, the client's progress in treatment, or an on-going assessment of the client's needs.

Individualized Treatment Programs

The Committee expressed concern that in the cases reviewed, services built into system treatment programs did not always fit the individual needs of the client. In two cases (50%) a mentor might have been more effective than a smoking cessation class. The Committee recommended that case managers and contract providers individualize the services provided to DYC clients.

Emergency Contingency Plans

In one case (25%), a youth was allowed an unsupervised home visit during which he refused to return to the treatment program facility. Program staff were notified of the problem. However, the facility was understaffed, and there was no one who could provide intervention. The youth remained AWOL from the facility for several weeks until he was killed in a high-speed automobile accident. The treatment program did not have a contingency plan to deal with emergency situations and did not have sufficient staff to carry out a contingency plan.

DIVISION OF AGING AND ADULT SERVICES

Systemic Strengths

The Adult Protective Services (APS) case managers made home visits within priority time frames, made thorough and accurate initial assessments of the physical and emotional well being of clients and made assessments of their safety, linked families to appropriate services, and assisted clients in creating emergency plans for use in the event of future abuse or exploitation.

Systemic Weaknesses

There were no systemic weaknesses identified in the two Division of Aging and Adult Services cases reviewed by the Fatality Review Coordinator.

DIVISION RESPONSES TO RECOMMENDATIONS

Recommendations made by the Fatality Review Committees are sent to the Division Director and to the director of the region in which the death occurred. The Regional Director or designee is responsible for implementing the committee recommendations and for making a formal written response to the Fatality Review Committee outlining the steps the region has or will take to implement the recommendations or explaining why such implementation is not possible.

The DSPD Regional Directors are to be commended for their prompt and serious consideration of committee recommendations, for the action that they initiate to comply with recommendations, and for their formal written responses to the Fatality Review Committee.

The Director of the Division of Child and Family Services has assigned a member of his administrative team to track Fatality Review recommendations and to ensure that the regions are responding to the Committee. This process has greatly improved the Division's responsiveness to Committee recommendations.