

CPS CITIZEN REVIEW COMMITTEE

ANNUAL REPORT

June 2004

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OVERVIEW

Citizens review panels are mandated to examine policies, procedures, and to evaluate the extent to which agencies (state and local) are effectively discharging their child protection responsibilities in accordance with the state's CAPTA plan, child protection standards, and any other criteria that the members consider important to ensure the protection of children.

In Utah, Quality Improvement Committees were established as a part of the Milestone Plan and were designated to serve the function of CPS Citizen Review Panels (CRP). Four regions are represented. Members are comprised of volunteers that are broadly representative of their community in which they operate and includes individuals with expertise in the prevention and treatment of child abuse and neglect.

In addition, the Office of Services Review (OSR) assumes 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 the Division staff on a local level in the review process, and to make cogent recommendations for systemic improvements. The Fatality Review Report is attached.

We would like to take this opportunity to thank each individual who has taken the time to participate on these committees. We recognize your efforts and desire to ensure the protection of children.

Southwest Region

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JoAnn Bessee
Elaine Mullins

Trish Bumgardner
Karla Staheli
Steve Greenhalgh
Cathy Edwards

Bruce Zylks
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Salt Lake Valley Region

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Western Region

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Jim Beckstrand
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Margaret Pruitt
David Skougaard
Karen Wardle
Carma Swensen

In compliance with the Federal requirements of the Child Abuse Prevention and Treatment Act (CAPTA), DCFS submits the following annual report from their CPS Citizen Review Committees.

SOUTHWEST REGION

Southwest Region has focused on caseworker retention. An employee survey went out to the Southwest Region caseworkers and three concerns were identified: paperwork, renewal training, and compensation. Burnout scored very high in priority, but is considered to be a symptom, rather than a cause.

Since paperwork was identified as the number one concern, the committee gathered additional information regarding the DCFS computerized information system, SAFE. Discussion focused on the advantages of SAFE versus the documentation and accountability requirements it represents for workers. Committee members explored possible reasons staff feel overwhelmed by paperwork, noting that SAFE is a good system and is not likely the problem. There is, however; a perception that paperwork is a burden for caseworkers. One researcher presented to the committee after completing research on the Practice Model and SAFE requirements. Recommendations of possibly having secondary workers complete some of the paperwork requirements was made along with exploring the use of Palm Pilots as a time saver. A position paper offering solutions to reduce the stress of paperwork will be presented to staff. A self-monitoring plan will be included.

This information was shared at a DCFS Supervisor's Conference and a recommendation was made for a region-wide conference that focused on practice model skills by using games in a fun atmosphere. The Southwest Region Practice Improvement Conference was held following this recommendation with positive staff feedback resulting.

NORTHERN REGION

Northern Region began to evaluate how workers were doing in locating missing or absent parents. Data was reviewed regarding children in care and whether parents were identified in each case. The data appeared to be reflective of some data quality issues as well as data entry errors. This was given to the CSM's for resolution and the data was pulled several months later for a baseline. The committee discussed possibly doing a survey with caseworkers regarding attitudes of the importance of locating missing parents

Discussions were held with the Office of Recovery Services (ORS) to gather information on resources available to DCFS in locating absent parents. ORS has various sources to locate a non-custodial parent. A recommendation was made to improve communication and develop a partnership with ORS to increase resources to DCFS, possibly providing a liaison from ORS to facilitate this communication. As a result of this recommendation, discussions have begun with ORS to evaluate how the two departments can better serve each other.

A second focus for this committee has been looking at the relationship between caseworkers and foster parents. It was noted that Northern Region has the best record in the state for retention of foster parents. Data was gathered on why foster parents leave and the two highest reasons were adoption or because the dynamics of the family had changed. A recommendation of having a panel discussion between foster parents and caseworkers be held at the next Child Welfare Conference in the spring was made.

WESTERN REGION

Discussions regarding available resources for families were held. Concerns were raised over parents with a substance abuse history who have children in the home. A family drug court was discussed where immediate action takes place when the individual's drug test results were positive. Provo Juvenile Drug Court met with the committee and presented information on their program. Different areas of the region have specific concerns regarding drug issues and these were discussed. Discussions between DCFS, courts, and county attorneys will need to take place.

The efforts to support local foster parents were discussed. The Foster Parent Association shared information regarding resources that were available. In an effort to increase communication, the recommendation that the foster parents monthly newsletter be sent to the DCFS supervisors was made. The newsletter gives up to date information regarding respite care for children, when and where local cluster meetings are held, and who to contact with questions or concerns when caseworkers are unavailable. The Foster Parent Association is designed to give ongoing support to foster parents, who are new or who have situations that are uncommon.

SALT LAKE VALLEY REGION

Findings from the Qualitative Case Review were evaluated and discussed in order to determine a focus for this group. It was noted that permanence continues to be a struggle, specifically with kinships. It was determined that there was a need to provide more services in this area. As a region, this committee decided to focus on improving resources for in-home and kinship cases. Since all agencies working with children are considered to be ‘Child Welfare’, not just DCFS, a provider fair was discussed as a means for improved communication and resource connections.

Secondly, the committee discussed training issues around permanence and how proper training can decrease the time a child is in placement. It was noted that there appears to be an emphasis on caseworker training and this has impacted caseworker retention. It was also noted that ongoing training for caseworkers is a part of their continuing education. In addition to caseworkers, it was suggested that partners would also benefit from trainings specific to DCFS. It was suggested that juvenile court judges might benefit from being trained in the Practice Model Training since they already had some training in the family teaming process.

DEPARTMENT OF HUMAN SERVICES

FATALITY REVIEW REPORT

FY 2003

**Compiled by
Department of Human Services
Office of Services Review
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DEPARTMENT OF HUMAN SERVICES FATALITY REVIEW ANNUAL REPORT

JULY 1, 2002 - JUNE 30, 2003

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 highlights areas in which changes or modifications could enhance systemic response to client needs. During fiscal year 2002 - 2003, one hundred fifty-two deaths of current or past clients of DHS were reported to the Office of Services Review (OSR). There were fifteen suicide deaths and five homicides. The reviews indicate that abuse and/or neglect were contributing factors in six of the one hundred fifty-two deaths. The Division of Child and Family Services (DCFS) reported that four children died as the direct result of abuse or neglect by their parents. The deaths of two 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/or the failure of provider staff to expeditiously access emergency medical treatment.

DCFS, DSPD, and the Division of Youth Corrections (DYC) Fatality Review Committees reviewed eightythree deaths and have three DCFS reviews pending. Utah State Developmental Center (USDC) conducted one on-site review with four reviews pending, and Utah State Hospital (USH) conducted five on-site reviews with two reviews pending. The Division of Mental Health and Substance Abuse (DMH/DSA) reported forty-six deaths, and the Office of the Public Guardian (OPG) reported seven deaths. The Office of the Public Guardian wrote comprehensive reports covering services provided to the seven OPG clients, but no formal committee reviews were held on cases from that office or from DMH/DSA.

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 DSPD 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. Due to the low number of fatalities in the Division of Youth Corrections, that review committee meets on an as-needed basis.

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 Services. 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. Information provided to law enforcement aids in their criminal investigations of suspected child abuse fatalities.

FINDINGS

The reviewers identified numerous strengths in service-delivery systems and singled out several areas in which changes or 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.

DIVISION OF CHILD AND FAMILY SERVICES

Systemic Strengths

Of the fifty-two DCFS cases reviewed, sixteen families (31%) had extensive histories of involvement with the Division that spanned time periods ranging from at least ten years to over twenty years. These cases clearly demonstrated an extremely positive change in the way DCFS investigates Child Protective Services (CPS) referrals and in the way it provides services to families. In these cases, early CPS investigations were frequently cursory. Investigative omissions included failing to interview both parents and/or the referent, not using a prior CPS history involving similar allegations in making the determination to substantiate or unsubstantiated a report of abuse or neglect, not 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 as frequently as they were ten to twenty years ago. Cases with extensive histories of involvement with the Division are prime examples of how important it is for Child Protective Service and on-going workers to review a family's history when there is new agency involvement. The history can point to a pattern of abuse or neglect, to the family's willingness or unwillingness to comply with services, to whether or not there is a need for more intensive or court-ordered services, and can indicate if there is a heightened risk of harm to the child(ren).

In the cases the Fatality Review Committee reviewed, it appears that CPS investigators are currently conducting more thorough investigations than in those investigated five or more years ago. In most cases reviewed 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.

In several cases reviewed there were examples of casework excellence concerning the coordination of services between DCFS and community partners, e.g., mental health and medical providers, and Piute and Ute Tribal Social Services. One worker skillfully conducted a coordinated CPS investigation between two regions in the state. It appears that community agencies are demonstrating a willingness to work in concert with DCFS to provide services for children and families.

The Child Fatality Review Committee recognized the excellent work of DCFS CPS investigators, Mary E. Beam, for her thoroughness in investigating an allegation of educational neglect, and Betty Meyer, for the multiple case staffings, team meetings, and consultation with medical providers in her investigation of a medical neglect allegation. The Committee also recognized and commended foster care worker, Kristy DeGraaf, for her adherence to Practice Model principles, her excellent coordination with service providers, and her personal dedication to the welfare of the child.

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 fifty-two DCFS cases reviewed, the following three issues raised the greatest concern among committee members. It is recommended that during FY 2003, DCFS concentrate on improving case practice in these three areas.

Accessing Case Histories In some areas of the state, especially the larger metropolitan areas, there is some difficulty in accessing an entire case file. Older CPS files may be archived, incomplete, or lost, and in some regions files are destroyed after a five-year period. CPS files, which are listed under the mother's name, can be fragmented and filed in several locations if the mother has used different surnames, e.g., maiden name, married name, name of paramour(s), etc. If a family is transient, portions of the case file may be in different regions of the state. Files for on-going services, In-home and Foster Care, are usually kept in the office in which the services were offered. If a family has relocated, the files have to be obtained from each location in which the family received services.

Assessment of Underlying Needs/Continuum of Services

In twelve (23%) of the fifty-two 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 these underlying needs or offer adequate services to the families.

During the investigation of a domestic violence, related child abuse investigation, the investigator conducted a thorough investigation of the allegations. The worker closed his case with the impression that Family Preservation Services would be court ordered for the family. The court did not order such services, and the case was never staffed for ongoing services. The family, which was experiencing a number of high-stress situations including the introduction of a stepmother and more structured family rules, was left without any type of intervention. The target child committed suicide.

A mother of a family with a lengthy history of DCFS involvement left her three children with their maternal grandmother. The mother refused to see or talk with her two sons. A CPS worker, investigating an allegation of Physical Neglect in the grandmother's home, interviewed the boys and noted that the boys were dealing with abandonment issues. However, the worker addressed only the physical neglect issue and did not pursue mental health services for the boys. No ongoing services were opened for this family. The worker did not assess the needs of the grandmother as she fulfilled her kinship role. One of the boys committed suicide.

In a third case spanning a period of eleven years, there had been numerous CPS referrals, in-home services and even removal of children. The children were highly sexualized due to having been sexually abused at an early age, but no serious intervention was made until a pattern of behavior was so well established that it was impossible to change. At the time of the second referral it was apparent that the mother was not going to protect and that her children were extremely vulnerable to continuing abuse. At that time the daughters were young enough to have benefited from more intensive intervention, yet no intervention was made. Several years later, the two girls were killed in an automobile accident. The narrative in a CPS investigation recently conducted on the family indicated that the death of the two girls was having a profound, negative effect on the family's ability to handle stress and on their ability to cope with the loss of the children. However, the mother appeared to be unwilling to voluntarily work with DCFS in engaging in services to address the underlying emotional needs of her and her son. The case was not staffed for court-ordered services, and the young boy was left with no support and with no intervention at the closure of the most recently supported CPS investigation.

Another case file documented a pattern of intergenerational abuse, neglect, and nonsupervision. Some CPS investigations were closed with the allegations substantiated but with no services offered or in place. At one point there had been nine CPS investigations in which no voluntary or court-ordered services had been opened. After an unaccepted and an accepted referral were received involving the current generation of parents, voluntary services were opened. However, the in-home case manager merely furnished the mother with telephone numbers to community service providers. Before closing his case, the worker did not make collateral contacts to insure that services were in place and that the family was actually accessing those services.

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. When ongoing services are indicated, workers need to insure that there is a smooth transition /hand-off from one level of service to the next. Workers should also insure that services are actually in place and confirm through contacts with service providers that the family is participating in those services. If the family fails to comply with the agreed upon service plan, the case should be staffed with the Assistant Attorney General to decide if it is appropriate to file a petition for court-ordered services.

Sex Abuse Investigations

In four (8%) of the reported cases, the Committee had concerns regarding the investigation of sexual abuse issues and about the fact that sometimes services for sex abuse victims seem to be overlooked when the perpetrator is not in the home. The Child Fatality Review Committee recommended that workers pay particular attention to insuring that victims of sexual abuse receive mental health services, if appropriate, and that they pay particular attention to victims of out-of-home perpetrators to insure that they receive necessary services. The Committee also recommended that workers insure that law enforcement is involved in sex abuse investigations when appropriate.

- The CPS investigator interviewed the alleged victim of sexual abuse, assessed the family's need for services, and suggested possible resources. Although the worker supported the allegation of sexual abuse based on appropriate criteria, she did not involve law enforcement in the investigation. The worker appeared concerned that she had been unable to interview the alleged perpetrator, even though that task was the responsibility of law enforcement.

- A child was sexually abused at the age of seven by an "unknown" perpetrator, but she did not receive services to address the abuse. The child was placed with an aunt and uncle in a kinship placement. Several years later she disclosed that her uncle had repeatedly sexually abused her. The aunt obtained mental health treatment for the child, but after years of repeated abuse her mental health issues were so severe as to render the mental health services ineffective. It

appeared that there had been many opportunities through the years for the child to receive mental health therapy prior to the time she actually received it.

- A child, whose primary language was Spanish, reported sexual abuse. There was no indication in the case file that the worker attempted to provide an interpreter to assist with the child's interview. During the investigation, the child was explicit in her report of the abuse. However there was no follow through with an interview at the Children's Justice Center. Even though law enforcement declined to investigate the criminal aspect of this case, DCFS had the responsibility to investigate the sex abuse allegations. The Children's Justice Center has the ability to track treatment, which provides a mechanism for follow-up services through DCFS. There was no follow up regarding the child's obtaining counseling for her sexual abuse victimization.

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.

Regional nurse consultants are available to staff cases with Support Coordinators and provide valuable assistance in monitoring the appropriateness of placements and services for medically fragile individuals. Nurse consultants are an invaluable resource to Support Coordinators in the development of the Health and Safety portions and the 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.

Systemic Weaknesses

Monitoring of Contract Providers In two cases (7%) failure to access medical treatment in an expeditious manner appeared to be linked to the death of two individuals who were receiving services through contract providers for the Division of Services for People with Disabilities.

- A man sustained a broken leg when another individual in the group home ran into the man's wheelchair and caused him to hit the wall. Group home staff did not note the injury at the time it occurred and did not notice or did not acknowledge the swollen ankle the following morning while bathing and dressing the individual and while transferring him in and out of a van for transportation to his day training program. Day training staff notified the residential provider of the man's injury. However, without the insistence of the Support Coordinator, residential staff would not have taken the man to the doctor until the following day. The individual developed an infection, which doctors attempted to pinpoint through surgery. Medical personnel concluded that the man had developed a bone infection resulting from the broken bone. The infection weakened his immune system, he contracted pneumonia and died.

The Committee noted that the incident report concerning the broken leg incident was poorly written. It did not include the dates and times of events, and the events were not written in chronological order. The report was not written until three days after the incident, it did not state the facts pertaining to the accident, did not state if there were witnesses to the incident, was signed by only one staff member and was rewritten by an administrator.

- A woman experienced what was termed as a "quiet seizure" in the group home was taken to the hospital emergency room for treatment. Hospital staff refused to admit her and released her to contract provider staff who took her back to the group home. The morning following the "seizure", staff found the woman on the floor where she had fallen out of bed. She was injured and bleeding. The staff member and the contract Regional Director assisted the staff member in moving the woman into the bathtub to clean her, and then carried her back to her bed. No one called for medical assistance until the Support Coordinator arrived at the group home and insisted that staff call for an ambulance. At the hospital it was determined that the woman had a broken hip socket and a broken clavicle. According to medical personnel, the woman's chances of surviving surgery were slight. She remained in the hospital in pain, stopped eating, and died three days later admittance to the hospital. The Certificate of Death states that the woman died of pneumonia with the "significant condition contributing to death" being a "fractured left hip".

Of additional concern in this case is that the woman had a history of falling out of bed and had arrived at her day training program with bruises and cuts on several occasions. Day training staff and the DSPD Support Coordinator had not made an Adult Protective Services (APS) referral to investigate for the incidents for abuse or neglect. Also, no attempt had been made to insure that the woman had a safer sleeping environment by the installation of bed rails to prevent her from falling out of bed.

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.

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 administrative team members 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

During FY 2003, one fatality review was conducted and four reviews are pending the receipt of all medical information. No systemic weaknesses were noted in the completed review.

DIVISION OF MENTAL HEALTH/DIVISION OF SUBSTANCE ABUSE

Community Placements

During FY 2001 - 2002, the Division of Mental Health reported the deaths of forty-six clients, thirty-nine of whom had open cases at the time of death. DMH/DSA clients were receiving services that included individual and group therapies, medication management, inpatient evaluation, supported housing, payee services, hospice care, and case management. No fatality reviews were conducted for these clients. Local mental health centers conduct reviews on client fatalities.

DIVISION OF MENTAL HEALTH

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 to be knowledgeable about decedents' mental health and medical histories, and they provide informative verbal reports pertaining to treatment histories and to circumstances surrounding patient deaths.

During FY 2003, seven fatality reviews were held. Of the seven reported USH fatalities, one patient, who had been discharged from the hospital, died an accidental death from acute carbon monoxide poisoning caused by a faulty furnace in the building where she was living. Four former patients died of natural causes, one at home, one in a nursing facility, one in a hospital, and one in jail. Two patients who had been discharged from USH died of mixed drug poisoning. The Utah State Medical Examiner listed the manner of death as "Undetermined". In all cases where patients were released to nursing homes, hospitals, or correctional facilities, Utah State Hospital supplied the receiving facility with information concerning the patient's history and ongoing care needs.

Systemic Weaknesses

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

DIVISION OF YOUTH CORRECTIONS

Systemic Strengths

The Committee reviewed the fatalities of five DYC clients, three with open cases at the time of death and two with closed cases. Documentation in case files indicated that in all five cases (100%) the Division had obtained thorough assessments of their clients' treatment needs. Psychological and psychiatric testing provided mental health diagnoses and information for medication treatment. Based on these assessments, the Division made recommendations to Juvenile Court for placements and treatment programs.

The three youth with open cases were being provided with extensive and seemingly appropriate services. Two of the youth with open cases had transitioned home, and one was placed in a contract provider proctor home. Among the five cases reviewed, DYC case managers had done extensive planning to insure smooth transitions from residential/group home care to trial home placements for three of the four youth (75%) who had returned home. These clients were also provided with multiple wrap-around services to aid in stabilizing them after their transition home. The fourth youth was terminated from DYC custody when he reached the age of eighteen.

The Fatality Review Committee noted a high quality of service in the tracking services provided to the youth in the cases reviewed. Especially noteworthy was the trackers' thorough documentation of their work with their clients. The Committee commended DYC case managers Paul Gardner and Ed Conley for their excellent coordination of services, extensive transitional planning, and for their thorough reporting client progress and their making appropriate recommendations to Juvenile Court. The Committee also recognized and commended Sione T. for his intensive tracking and thorough documentation of his work with the client, and Steven Ha, Probation Officer, for his diligence in arranging for appropriate service providers and for his thorough reporting and appropriate recommendations to the court.

Systemic Weaknesses

In the five cases reviewed, the Committee noted two systemic weaknesses, neither of which was the direct responsibility of DYC. The Committee noted the juvenile court system's failure in one case (20%) to impose stringent enough sentencing and its lack of follow-through in assessing consequences when the youth failed to comply with court orders. Consequently, the youth openly expressed contempt for court orders and admonishments. In this case the court provided little deterrent to the youth's committing additional offenses.

In another case the youth and his family had an extensive history of involvement with the Division of Child and Family Services. Despite numerous Child Protective Services referrals throughout the child's life, DCFS had not opened any voluntary or court-ordered services to address the family's underlying needs. Although it is impossible to directly link the youth's behavior or his suicide to a lack of early intervention services, there is a high probability that all family members could have benefited from intervention services many years ago.

DIVISION OF AGING AND ADULT SERVICES

No fatalities were reported by the Division of Aging and Adult Services during FY 2003.

OFFICE OF THE PUBLIC GUARDIAN

The Office of the Public Guardian reported the deaths of seven clients. That office provided the Fatality Review Coordinator with a comprehensive summary of the client's service history and an explanation of the fatality. It appeared that all decedents had received appropriate services, and their deaths were related to age and medical conditions.

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.

**DEPARTMENT OF HUMAN SERVICES
FATALITY REPORT
FY 2003
DEMOGRAPHIC DATA**

DEPARTMENT/DIVISION	Number of Reported Deaths	Cases Open at Time of Death	Reviews Held	Reviews Waived	Reviews Pending ¹	Male	Female
Department of Human Services	152	109	89	0	9	81	71
DAAS (Division of Aging and Adult Services)	0	0	0	0	0	0	0
DCFS/DMH (Division of Child and Family Services/Division of Mental Health)	1	1	1	0	0	1	0
DCFS (Division of Child and Family Services)	50	19	47	0	3	28	22
DMH/DSA (Division of Mental Health)	46	39	0 ²	0	0	23	23
DMH (Division of Mental Health USH (Utah State Hospital))	7	5	5	0	2	5	2
DSPD (Division of Services for People with Disabilities) USDC (Utah State Developmental Center)	5	5	1	0	4	3	2
DSPD (Division of Services for People With Disabilities) Community Placement	27	26	26	0	0	13	14
DSPD/DCFS (Division of Services for People with Disabilities/Division of Child and Family Services)	1	1	1	0	0	1	0
DSPD/DMH (Division of Services for People wit Disabilities/Division of Mental Health)	1	1	1	0	0	0	1
DSPD/OPG (Division of Services for People with Disabilities/Office of the Public Guardian)	1	1	1	0	0	0	1
DYC (Division of Youth Corrections)	5	3	5	0	0	5	0
OPG (Office of the Public Guardian)	7	7	0	0	0	1	6
DCFS/DSPD (Division of Child and Family Services/Division of Services for People with Disabilities)	1	1	1	0	0	1	0

¹Reviews Pending – DCFS – 3, USH – 2, USDC – 4

² No fatality reviews are held for DMH/DSA cases.

CHART I

Reported Deaths by Division FY 2001, 2002, 2003

	FY 2001	FY 2002	FY 2003
DHS Reported Deaths	125	159	152
DAAS	2	3	0
DCFS	43	36	50
DCFS/DMH	0	1	1
DCFS/DSPD	1	1	1
DMH/DSA	16	48	46
DMH/USH	7	6	7
DSPD	42	43	29
DSPD/USDC	8	3	5
DSPD/DMH	2	2	1
DYC	4	2	5
DYC/DCFS	0	2	0
OPG	0	12 ¹	7

	FY 2001	FY 2002	FY 2003
DHS Reported Deaths	125	159	152
Cases Open at Time of Death	86	124	109
Reviews Held	96	89	89
Reviews Pending	5	5	9 ²
Reviews Waived	8	2 ³	0
Abuse & Neglect Deaths	10	9	6
Homicides	7	7	5
Motor Vehicle Related	10	7	14
Suicides	5	15	15

¹ First reporting Year – FY 2002.

² DCFS – 3; USH – 2; USDC – 4

³ Case file burned in Payson DCFS office fire.

Chart II -SERVICES OPEN AT TIME OF DEATH 2002 – 2003

Division of Child and Family Services

Adoption Subsidy (AAM) - 2. Child Protective Services (CPS) - 8
 Domestic Violence Services – I Court-ordered In-home Services (PSS) - 3
 Foster Care (SCF) – 6
TOTAL: 20* *Total includes services for one DCFS/DMH client.

Division of Mental Health/Division of Substance Abuse

Group Home – I Hospice - I
 Inpatient Unit for Evaluation – I Medication Management - 4
 Out-patient Individual and/or Group Therapy – 26 Payee Services - I
 Residential – I Supported Housing - 2
 Unknown - 2
 (Some DMH clients were open for more than one service. The Primary service is listed on the table.)
TOTAL: 39

Division of Mental Health - Utah State Hospital

Out-patient Treatment - 3
 Nursing Home/Rehabilitation - I
 Residential - I
TOTAL: 5

Division of Services for People with Disabilities - Community Placements

Cash Assistance – I Day Training - 3
 Family Support Services – 3 Fiscal Agent – I
 Group Home – 3 Home Health Care - I
 Hospice – 6 Nursing Home - I
 Personal Assistance Services – I Professional Parent Home - 2
 Respite – 2 Supported Living - 3
 Supported Employment - 3
 (Most DSPD individuals were open for more than one service. The primary service is listed on this table.)
TOTAL: 30* *Total includes services for one DSPD/DMH, one DSPD/OPG, and two DSPD/DCFS clients.

Division of Services for People with Disabilities - Utah State Developmental Center

Residential - 4
 Hospice Care/Rehabilitation Center – I
TOTAL: 5

Division of Youth Corrections

Proctor Home - I
 Group Home - I
 Tracker - I
TOTAL: 3

Office of the Public Guardian

Guardianship Services - 7
TOTAL: 7

CHART III – AGE AT TIME OF DEATH
2002 – 2003

AGE IN YEARS	DHS	DAAS	DCFS	DCFS/DMH	DCFS/DSPD	DMH/DSA	DMH/USH	DSPD	DSPD/USDC	DSPD/DMH	DSPD/OPG	DYC	OPG
Under 1 year	16		16										
1 – 3	7		7										
4 – 6	6		5		1								
7 – 14	17		9		1	2		5					
15 – 18	20		13	1				1				5	
19 – 21	2							2					
22 – 30	14					3	4	5	1		1		
31 – 50	35					25	1	6	2				1
51 – 65	24					14	1	6	1	1			1
66 – 80	6					2		2	1				1
81 – 93	3						1						2
94 – 102	2												2
Unknown	0												
TOTAL	152	0	50	1	2	46	7	27	5	1	1	5	7

CHART IV – CAUSE OF DEATH 2002 – 2003

	DHS	DAAS	DCFS	DCFS/ DMH	DCFS/ DSPD	DMH/ DSA	DMH/ USH	DSPD	DSPD/ USDC	DSPD/ DMH	DSPD/ OPG	DYC	OPG
Head Trauma	8		4			3			1				
Alcoholism	1					1							
ALS (Lou Gehrig's Disease)	2						1	1					
Asphyxia	5		4									1	
Aspiration	4							2			1		1
Bacterial Infection (Mixed)	1		1										
Blunt force Injuries	4		4										
Brain Injury	4		4										
Cancer	5					3	1						1
Carbon Monoxide Poisoning	1						1						
Cardiopulmonary Problems	4				1	1		2					
Cardiovascular Disease	1					1							
Cerebral Edema	1		1										
Closed Head Injury	4					2						2	
Colitis	1					1							
Cystic Fibrosis	1		1										
Dementia	2												2
Drowning	1											1	
Drug Intoxication	17		4			10	3						
Gunshot Wound	5		2	1		2							
Heart-related Problems	13		3			5		4		1			
Infarction of Small Intestine	1								1				
Iron Deficiency Anemia	1					1							
Malnutrition	2					1		1					
Massive Internal-External Injuries	4		3				1						
Meningeal Sayoma	1					1							
Neurologic Degeneration	1							1					
Pending	3					1	1	1					
Peritonitis	1					1							
Pneumonia	14		1				1	9	2				1
Premature Birth	6		6										
Renal Failure	2					1							1
Respiratory/Lung Problems	16		4		1	5		5					1
Sepsis	3		1			1			1				
SIDS vs. Positional Asphyxia	4		4										
Smoke Inhalation	1		1										
Stroke	1							1					
Thermal Injuries	1											1	
Unknown	5					5							
TOTALS	152	0	50	1	2	46	7	27	5	1	1	5	7

CHART V – MANNER OF DEATH
Medical Examiner's Determination
FY 2003

Manner of Death	DHS	DCFS	DMH/DSA	DMH/USH	DSPD	DSPD/USDC	DYC	OPG
Accident	26	16	5	1			4	
Homicide	5	4	1					
Natural Causes	89	18	27	2	30	5		7
Pending	1		1					
Suicide	15	8	4	2			1	
Undetermined	13	6	5	2				
Unknown	3		3					
TOTALS	152	52	46	7	30	5	5	7

HOMICIDES
FY 2003

AGE IN YEARS	DCFS	DMH/DSA	DSPD	DYC	USDC	USH	REGION	OFFICE
2 Months	1						Salt Lake Valley	Kearns
23 Months	1						Eastern	Vernal
4	1						Western	Payson
6	1						Northern	Clearfield
45		1					Western	Provo
TOTALS	4	1	0	0	0	0		

**SUICIDE DEATHS
FY 2003**

DRUG OVERDOSE

AGE IN YEARS	GENDER	DCFS	DCFS/DMH	DMH/DSA	DYC	USH
17	MALE	1				
28	MALE					1
46	FEMALE			1		
62	FEMALE			1		
TOTALS		1		2		1

GUNSHOT WOUND

AGE IN YEARS	GENDER	DCFS	DCFS/DMH	DMH/DSA	DYC	USH
13	MALE	1				
16	MALE		1			
17	MALE	1				
27	MALE			1		
TOTALS		2	1	1		

HANGING

AGE IN YEARS	GENDER	DCFS	DCFS/DMH	DMH/DSA	DYC	USH
12	FEMALE	1				
14	MALE	1				
16	MALE	1				
18	MALE				1	
TOTALS		3			1	

OTHER

AGE IN YEARS	GENDER	DCFS	DCFS/DMH	DMH/DSA	DYC	USH
13	FEMALE ¹	1				
23	MALE ²					1
TOTALS		1				1

¹Walked into path of on-coming traffic.

²Jumped off cliff.

CHART VI
MOTOR VEHICLE-RELATED DEATHS
FY 2003

AGE IN YEARS	GENDER	DCFS	DMH/DSA	DSPD	DYC	TYPE OF ACCIDENT	REGION
4	Male	1				Auto/Pedestrian Accident	Salt Lake Valley
9	Female	1				Motorcycle Accident	Southwest
11	Female		1			Motor Vehicle Accident	Western
12	Male	1				Motor Vehicle Accident	Eastern
13	Female	1				Auto/Pedestrian Accident	Southwest
13	Female	1				Motor Vehicle Accident	Salt Lake Valley
15	Female	1				Motor Vehicle Accident	Western
15	Male	1				Motor Vehicle Accident	Western
15	Female	1				Motor Vehicle Accident	Salt Lake Valley
17	Female	1				Motor Vehicle Accident	Western
17	Male				1	Motor Vehicle Accident	Salt Lake City
18	Female	1				Motor Vehicle Accident	Western
18	Male				1	Motor Vehicle Accident	Sale Lake City
37	Female		1			Motor Vehicle Accident	Western
TOTAL	14	10	2	0	2		