

DEPARTMENT
OF HUMAN
SERVICES

2016



FATALITY
REVIEW
EXECUTIVE
SUMMARY
FY 2016

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DEPARTMENT OF HUMAN SERVICES FATALITY REVIEW EXECUTIVE SUMMARY

JULY 1, 2015– JUNE 30, 2016

Department of Human Services (DHS) Fatality Review Policy requires a review of the deaths of all individuals for whom there is an open DHS case at the time of death or in cases where the individuals or their families have received services through DHS within 12 months preceding the 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 FY2016, 218 deaths of current or past DHS clients were reported to the Office of Services Review (OSR). There were 15 suicide deaths (7%) and four homicides (2%). The deaths of 11 individuals (5%) were ruled accidental. The reviews indicate that abuse and/or neglect were contributing factors in seven (3%) of the 218 deaths. The Division of Child and Family Services (DCFS) reported five children who died as the direct result of abuse or neglect by their parents, caretakers, or family members. No child died of abuse or neglect while in the custody of DCFS. One individual receiving services through the Division of Services for People with Disabilities (DSPD) died as a result of complications after suffering an unexplained fall. The Division of Aging and Adult Services/Adult Protective Services (DAAS/APS) conducted an investigation on circumstances relating to an individual who experienced an unexplained fall that eventually resulted in death.

Of the 33 fatalities reported by DCFS, 30 formal committee reviews were held (91%) with no reviews pending. Fifty-four of the 79 reported DSPD fatalities were reviewed (68%), 25 reviews were waived (32%), with no reviews pending. One Division of Juvenile Justice Services (DJJS) fatality was reviewed (100%). On-site reviews were held for eight of the 10 reported Utah State Developmental Center (USDC) fatalities (80%) with two reviews pending. The Utah State Hospital (USH) conducted an on-site review for its one reported fatality (100%).

The deaths of 85 individuals who received services through the Division of Aging and Adult Services (DAAS) were reported. Two individuals (2%) were also receiving services through DSPD during the time they received services through DAAS.

The Office of Public Guardian (OPG) reported the deaths of 12 individuals for whom they provided services. One of these individuals (8%) was also receiving services through DSPD at the time of death. A full committee review was held for this individual. OPG provided the Fatality Review Coordinator with comprehensive written reports detailing services provided by that office and information relating to the deaths of their 12 clients (100%).

The Division of Substance Abuse and Mental Health (DSAMH) is no longer reporting fatality review numbers for Local Authorities to the Department of Human Services. At the conclusion of each fiscal year DSAMH will request Local Authorities report the number of fatality reviews they have completed.

UBHC Clinical Directors agree that fatality reviews should be completed for known deaths of all open clients and for clients who have been discharged within six months of death where the cause of death may have been related in any way to mental health or substance use. Formal fatality reviews continue to be conducted at the Utah State Hospital. There was one individual (.005%) who met the criteria for a formal review from that facility.

There were 100 (46%) reported deaths of male clients and 118 (54%) reported deaths of female clients. Reported deaths included 11 infants (5%) under the age of one year; 32 individuals (15%) between the ages of one to 19 years; 37 individuals (17%) between the ages of 20 and 49 years; 61 individuals (28%) between the ages of 50 and 69 years; 64 individuals (29%) between the ages of 70 and 89 years, and 13 individuals (6%) between the ages of 90 and 100 years. Included in the 218 reported fatalities was one (.005%) Asian, two African Americans (1%), 191 (88%) Caucasians, 18 (8%) Hispanics, one Pacific Islander (.005%), and four American Indians (2%).

DEPARTMENT OF HUMAN SERVICES
 DIVISION SUMMARY
 FY 2016

DEPARTMENT/DIVISION	Number of Reported Deaths	Cases Open at Time of Death	Committee Reviews Held	Committee Reviews Waived	Reviews Pending	Female	Male
DEPARTMENT OF HUMAN SERVICES	218	188	94	28	2	118	100
DAAS (Division of Aging and Adult Services)	83	81	N/A	N/A	N/A	49	34
DCFS (Division of Child and Family Services)	33	8	30	3	0	15	18
DCFS/DSPD (Division of Child and Family Services/Division of Services for People with Disabilities)	2	2	2	0	0	1	1
DJJS (Division of Juvenile Justice Services)	1	0	1	0	0	0	1
DSPD – COMMUNITY PLACEMENT (Division of Services for People with Disabilities)	74	73	50	24	0	39	35
DSPD/DAAS (Division of Services for People with Disabilities/Division of Aging and Adult Services)	2	2	1	1	0	1	1
DSPD/OPG (Division of Services for People with Disabilities/Office of Public Guardian)	1	1	1	0	0	0	1
OPG (Office of Public Guardian)	11	11	N/A	N/A	N/A	7	4
USDC	10	10	8	0	2	6	4
USH (Utah State Hospital)	1	0	1	0	0	0	1

CHART I
 FIVE-YEAR COMPARISON
 FY 2012 – FY 2016

	FY2012	FY2013	FY2014	FY2015	FY2016
DHS Reported Deaths	192	191	214	270	218
DAAS	54	57	73	87	83
DCFS	41	28	35	37	33
DCFS/DSPD	1	1	1	0	2
DCFS/DSAMH	1	0	1	0	0
DJJS	0	1	1	2	1
DJJS/DCFS	0	0	0	0	0
DJJS/DSAMH	1	0	0	1	0
DSAMH	15	18	32	47	0
DSPD	59	64	51	66	74
DSPD/DAAS	2	1	1	1	2
DSPD/DSAMH	0	1	2	1	0
DSPD/OPG	1	4	2	3	1
DSPD/OPG/DSAMH	0	0	1	0	0
OPG	13	11	7	13	11
USDC	3	3	0	6	10
USDC/DAAS	0	0	1	1	0
USDC/OPG	0	1	4	3	0
USH	1	1	1	2	1
USH/DSPD	0	0	1	0	0
Cases Open at Time of Death	157	157	173	238	187
Cases Reviewed	109	105	109	103	96
Abuse & Neglect Deaths	11	6	7	4	7
Accidental Deaths	15	9	16	17	11
Homicides	5	2	6	4	4
Suicides	5	13	7	18	15
Undetermined	11	4	11	10	5

CHART II
 AGE AT TIME OF DEATH
 FY 2016

AGE IN YEARS	DHS	DAAS	DCFS	DCFS/ DSPD	DJJS	DSPD	DSPD/ DAAS	DSPD /OPG	OPG	USDC	USH
< 1	11		11								
1 - 3	8		8								
4 - 6	2		2								
7 - 10	6		3			3					
11 - 14	6		4	1		1					
15 - 19	10		5	1		4					
20 - 29	13				1	11	1				
30 - 39	12	2				8			1	1	
40 - 49	12	2				5			2	2	1
50 - 59	38	9				25				4	
60 - 69	23	12				10			1		
70 - 79	34	19				7	1	1	3	3	
80 - 89	30	26							4		
90 - 100	13	13									
TOTALS	218	83	33	2	1	74	2	1	11	10	1

CHART III
 ACCIDENTAL DEATHS
 FY 2016

CAUSE OF DEATH	DHS	GENDER	AGE	DIVISION
Asphyxia	3			
Choking		Female	52	DSPD
		Female	54	DSPD
Positional		Female	16 months	DCFS
Falls	3			
Ground-level Fall		Female	77	DAAS
		Female	87	DAAS
Fall from cliff		Male	58	DSPD
Conflagration/Smoke Inhalation - House Fires	2			
		Male	4	DCFS
		Female	57	DSPD
Vehicular Accidents	3			
Auto/Pedestrian		Female	20 months	DCFS
		Female	5	DCFS
Motor Vehicle		Male	54	DSPD
TOTAL	11			

CHART IV
HOMICIDE DEATHS
FY 2016

MANNER OF HOMICIDE	DHS	GENDER	AGE	DIVISION
Blunt Force Injuries	1			
		Female	2 months	DCFS
Dehydration due to Neglect	1			
		Female	1	DCFS
Gunshot Wound	2			
		Female	2 months	DCFS
		Male	2	DCFS
TOTAL	4			

CHART V
SUICIDE DEATHS
FY 2016

MANNER OF SUICIDE	DHS	GENDER	AGE	DIVISION
Asphyxia (Hanging)	10			
		Female	14	DCFS
		Male	14	DCFS
		Male	14	DCFS
		Male	15	DCFS
		Male	15	DCFS
		Male	15	DCFS
		Male	17	DCFS
		Male	20	DSPD
		Male	25	DSPD
		Male	47	USH
Drug Toxicity	2			
		Female	17	DCFS
		Male	33	DSPD
Gunshot Wound	2			
		Female	14	DCFS
		Male	20	DJJS
Train/Pedestrian	1			
		Male	36	DAAS
TOTAL	15			

CHART VI
 ABUSE/NEGLECT DEATHS
 FY 2016

CAUSE OF DEATH	DHS	GENDER	AGE	DIVISION
Asphyxia	1			
		Male	5 months	DCFS
Dehydration	1			
		Female	1	DCFS
Drug Intoxication	1			
		Female	1	DCFS
Falls/Broken Bones	2			
		Male	52	DSPD
		Female	82	DAAS
Gunshot Wound	2			
		Female	2 months	DCFS
		Male	2	DCFS
TOTAL	7			

CHART VII
 MEDICAL EXAMINER'S DETERMINATION
 MANNER OF DEATH
 FY 2016

MANNER OF DEATH	DHS	DAAS	DCFS	DCFS /DSPD	DJJS	DSPD	DSPD /DAAS	DSPD /OPG	OPG	USDC	USH
Accident	11	2	4			5					
Can Not Be Determined	5	1	4								
Homicide	4	1	3								
Natural Causes	172	74	8	1		66	2	1	11	9	
Pending	11	4	5	1						1	
Suicide	15	1	9		1	3					1
TOTALS	218	83	33	2	1	74	2	1	11	10	1

CHART VIII
 DECEDENT'S RACE
 FY 2016

RACE	DHS	DAAS	DCFS	DCFS /DSPD	DJJS	DSPD	DSPD /DAAS	DSPD /OPG	OPG	USDC	USH
AMERICAN INDIAN											
Navajo	1		1								
Northern Arapaho	1								1		
Northern Ute	2	1	1								
ASIAN											
Vietnamese	1								1		
AFRICAN AMERICAN	2	1	1								
CAUCASIAN	191	74	23	2	1	70	1	1	8	10	1
HISPANIC											
Argentine	1		1								
Cuban	1		1								
Honduran	1	1									
Mexican	12	5	4			3					
Nicaraguan	2	1							1		
Puerto Rican	1						1				
IRANI/AFGHAN	1		1								
PACIFIC ISLANDER											
Tongan	1					1					
TOTAL	218	83	33	2	1	74	2	1	11	10	1

CHART IX
 FATALITIES BY DIVISION AND REGION
 FY 2016

DIVISION OF AGING AND ADULT SERVICES

REGION	TOTAL
Central	42
Eastern	2
Northern	16
Southeast	1
Southern	15
Southwest	7
TOTAL	83

DIVISION OF CHILD AND FAMILY SERVICES

REGION	TOTAL
Eastern	2
Northern	5
Salt Lake Valley	14
Southwest	4
Western	8
TOTAL	33

DIVISION OF SERVICES FOR PEOPLE
 WITH DISABILITIES
 COMMUNITY BASED and
 UTAH STATE DEVELOPMENTAL CENTER (USDC)

REGION	TOTAL
COMMUNITY PLACEMENT	
Central	39
Northern	18
Southern	22
Western	0
TOTAL	
USDC	10
TOTAL	89

DIVISION OF JUVENILE JUSTICE SERVICES

REGION	TOTAL
Region I	
	1
TOTAL	1

OFFICE OF PUBLIC GUARDIAN

REGION	TOTAL
Central	
Office of Public Guardian	10
Guardianship Associates	1
TOTAL	11

UTAH STATE HOSPITAL
 DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

REGION	TOTAL
USH	
	1
TOTAL	1