

# Fiscal Year 2020

## FATALITY REVIEW SUMMARY

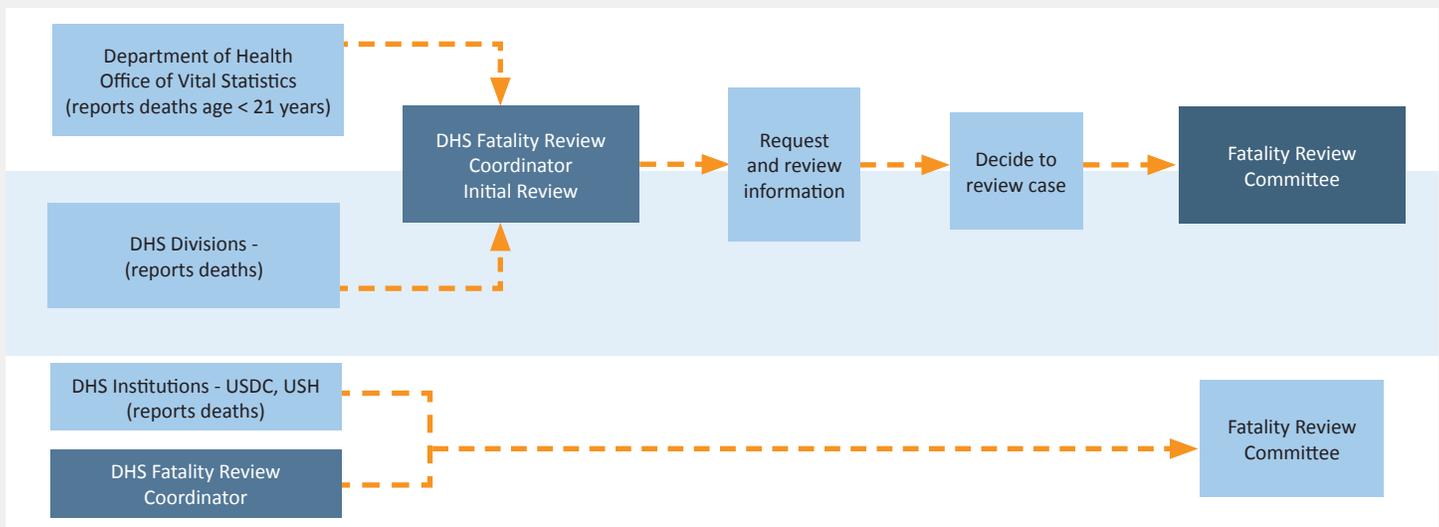
The Department of Human Services (DHS) Fatality Review Committee (Committee) reviews cases of individuals who themselves, or a family member, had an open case with a DHS division at the time of their death or, in some cases, within 2-12 months preceding the death.

Committee members are statutory appointees and professional partners whose expertise adds to the review findings. It includes representatives from the Guardian Ad Litem, law enforcement, medical profession (Safe and Healthy Families), Attorney General’s Office, Children’s Justice Center, Suicide Prevention and Crisis Services, risk management and DHS division administration. The reviews are managed through a Fatality Review Coordinator in the DHS Office of Quality and Design.

### DHS Divisions Included

- Aging and Adult Services (DAAS)
- Adult Protective Services (APS)
- Child and Family Services (DCFS)
- Juvenile Justice Services (JJS)
- Public Guardian (OPG)
- Services for People with Disabilities (DSPD)
- Utah Developmental Center (USDC)
- Utah State Hospital (USH)

Fatalities are reported and reviewed in the following manner:



Formal reviews include in-depth information from case logs, law enforcement, the Office of the Medical Examiner (ME), Vital Statistics and other sources. Reviews identify issues in case practice and service delivery on specific cases, provide insight into systemic strengths and highlight areas in which changes or modifications could improve safety and response to client needs. The Committee reports detailed findings to the DHS Executive Director and the Child Welfare Legislative Oversight Panel and shares recommendations with leaders of DHS divisions and institutions with case oversight.

While case details are not public record, Utah Code 62A-16-302(5) requires DHS to provide an annual aggregate summary of fatalities of qualifying individuals, which includes:

- the number and type of fatalities
- the number of formal reviews conducted by the Committee
- the gender, age, race and other significant categories of individuals
- the number of deaths by suicide

## FY20-21 PROCESS IMPROVEMENTS

During state Fiscal Year 2020-2021, DHS has been engaged in efforts to strengthen the fatality review process and systemic recommendations listed here:

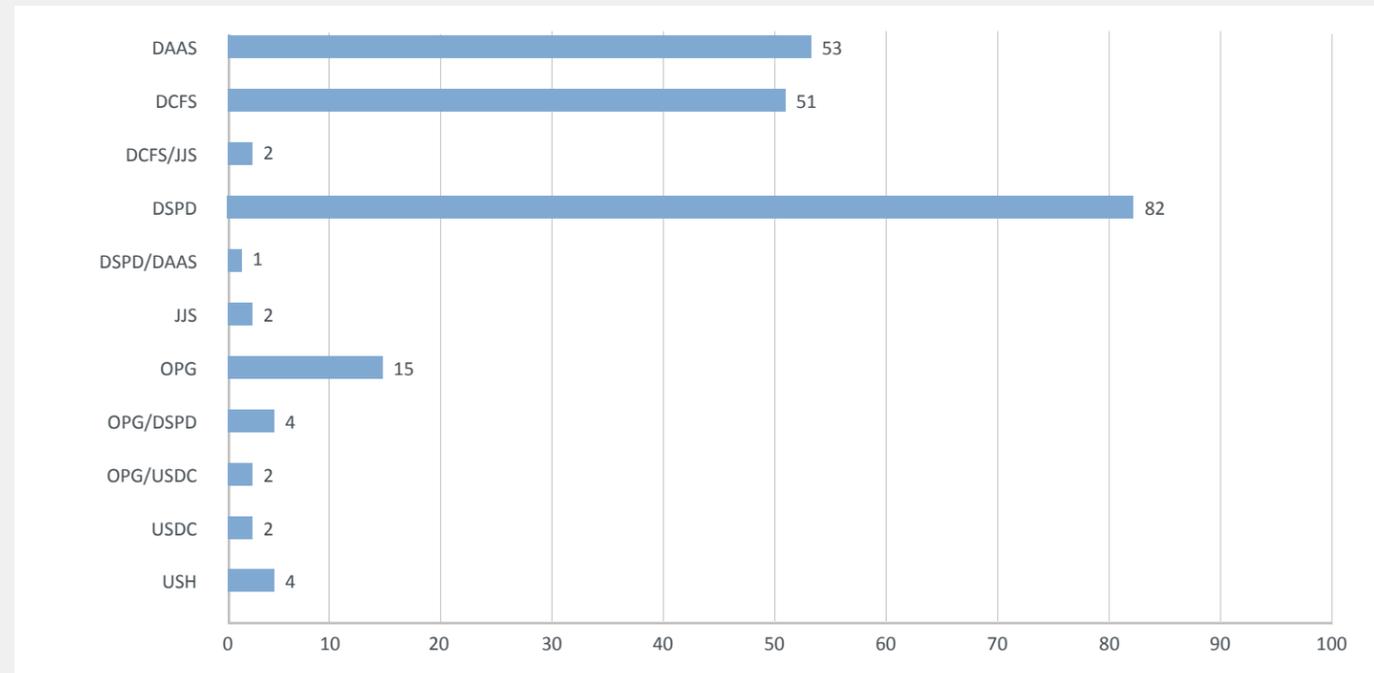
- Work with national experts to incorporate safety science principles into fatality review
- Included safety science processes such as Human Factors de-Briefing and System Mapping on recommended fatalities
- Initiated top-to-bottom alignment and education of safety science with administrators, supervisors and frontline staff

## DATA & FINDINGS

### Important Note:

Data contained in this report reflects fatalities reviewed by the Committee in FY20, however deaths that were awaiting information for the review may have occurred in the previous year.

### Reported Deaths by Division, Total Reported Deaths: 218

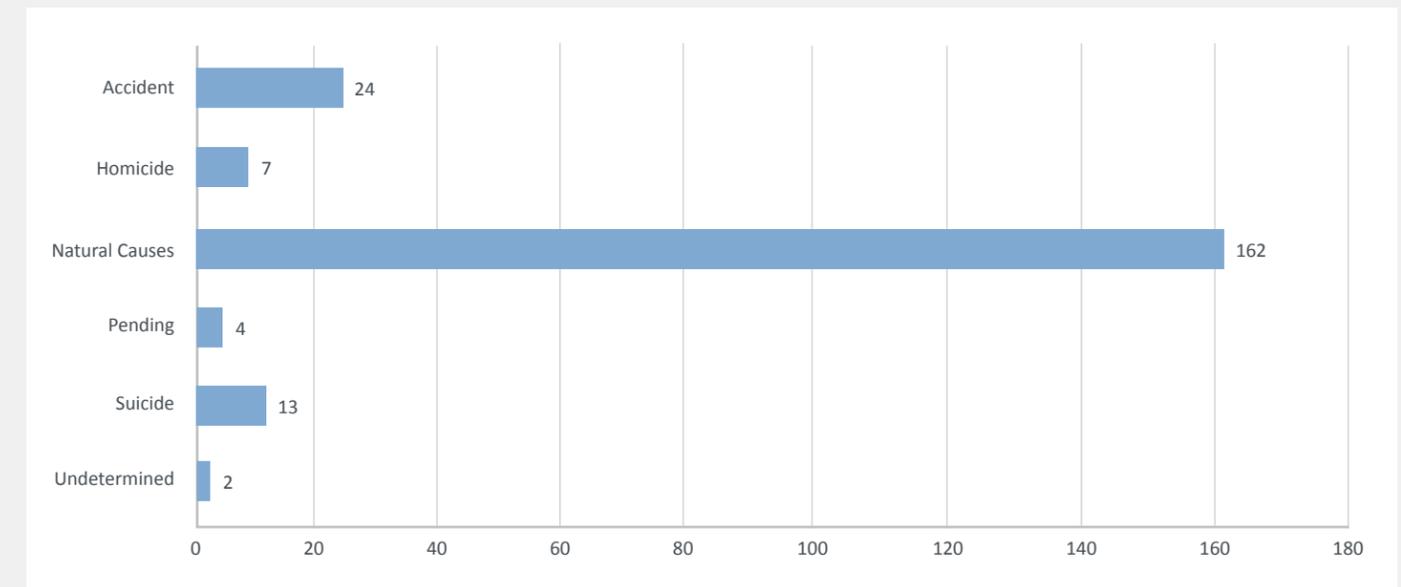


## FY 2020 FORMALLY REVIEWED FATALITIES

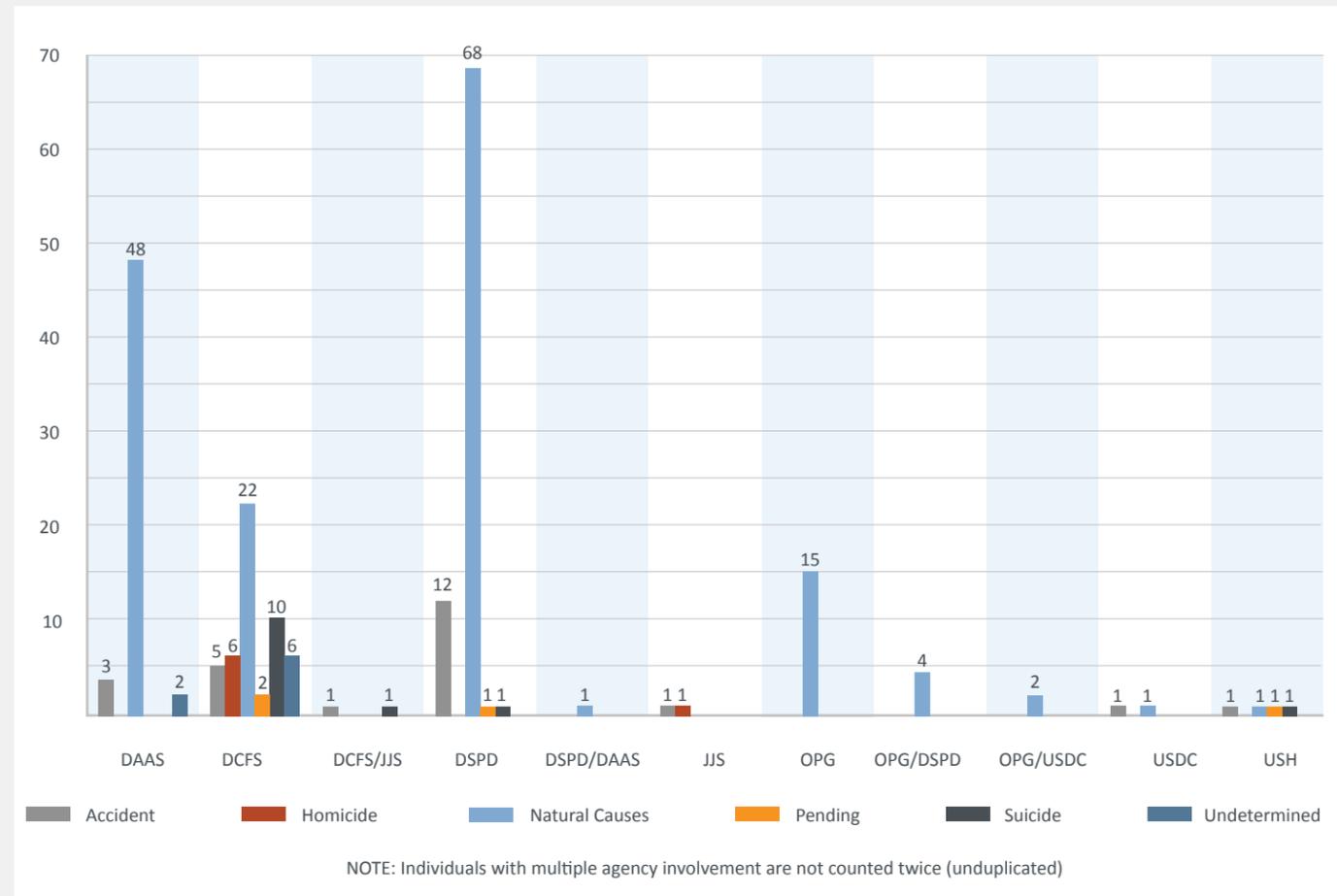
During FY20, 218 deaths were reported to OQD. The Committee completed 150 formal fatality reviews, including:

- All deaths 21 and younger who met the criteria
- All DSPD-involved deaths
- All OPG reported deaths that had more than one agency involved
- All individuals with multiple division involvement (9 total)
- No fatalities met the criteria for formal review by USH or APS

### Reviewed Cases, Manner of Death Per Medical Examiner

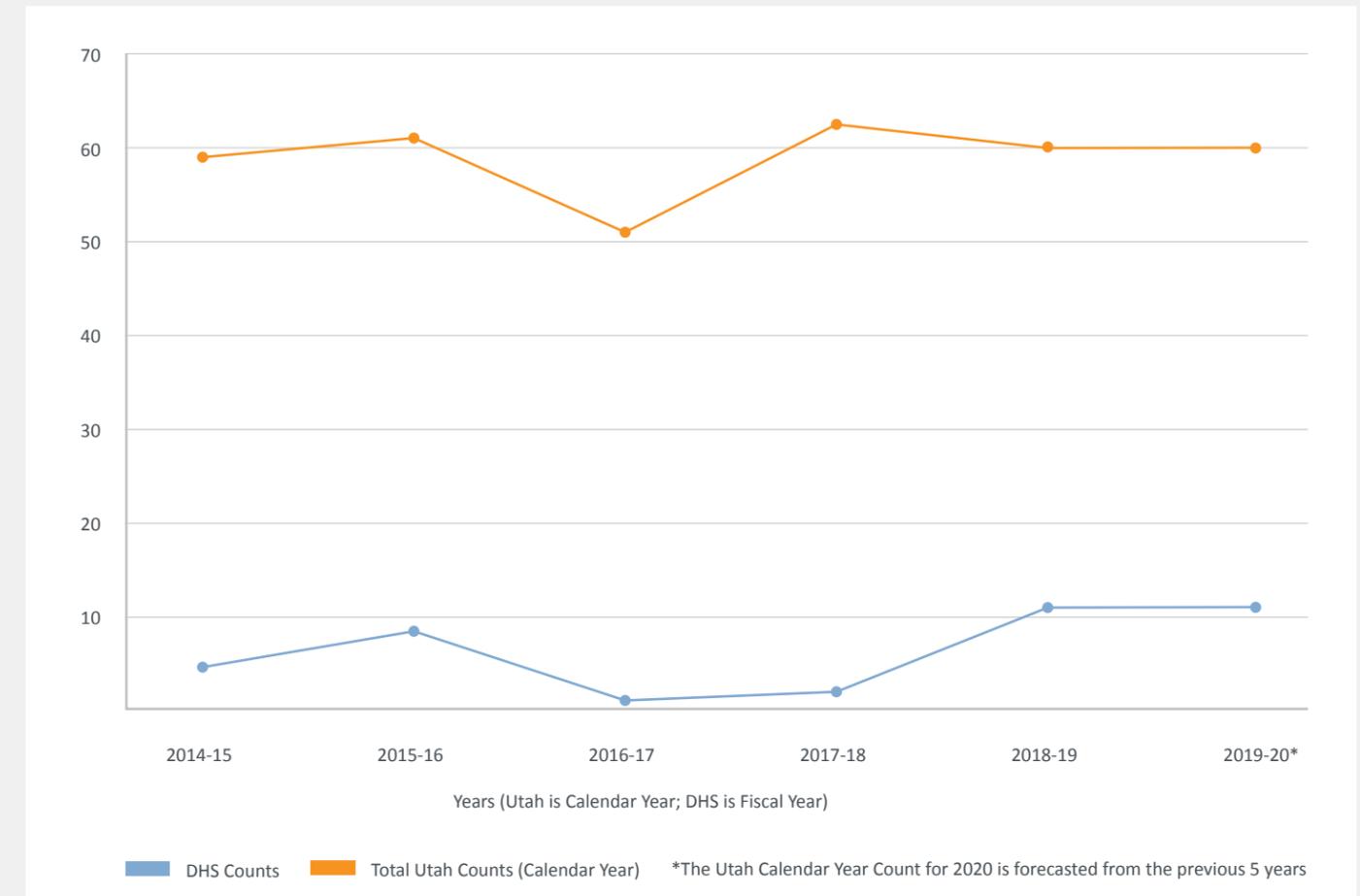


## Reviewed Cases, Medical Examiner Manner of Death by Division



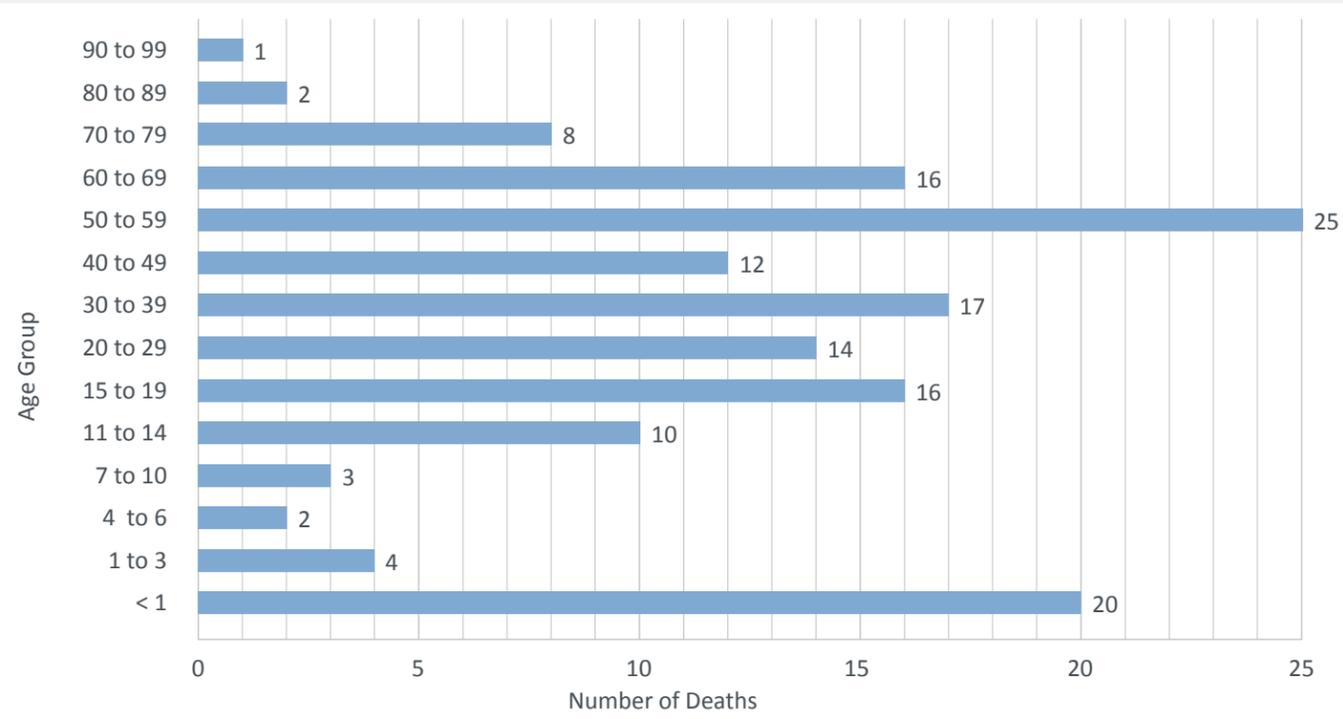
- DSPD reported the highest number of qualifying fatalities. DSPD provides home- and community-based services to individuals with disabilities of all ages, many of whom have complex medical needs.
- 4 fatalities were residents of USDC and received a formal review by the institution with representation by the Fatality Review Coordinator. Of these, 3 were determined by the medical examiner to be by natural causes and 1 was determined as accidental.
- Of the DCFS-involved fatalities:
  - 2 of the 4 JJS deaths had DCFS involvement
  - 17 had open cases at the time of the fatality; 36 had previous involvement within 12 months preceding the death, but not current open cases
  - 2 children were in foster care at the time of their death
    - 1 of these fatalities was determined by the medical examiner to be accidental and the other was determined to be by natural causes
  - 4 children were reported to have died as a direct result of abuse or neglect by their parents, caretakers or family members
    - 3 Child Protective Services investigations were opened as a result of the reported abuse which resulted in the fatality
    - 1 had previous involvement with the Division
    - 3 were younger than 1 years old and 1 was between 5-7 years old
    - These fatalities are of the utmost concern and received thorough reviews and resulted in multiple recommendations as well as a continued focus on safety assessment within DCFS

## DHS Involved and Statewide Youth Suicide Deaths for 11-19 Year Olds (2015-2020)



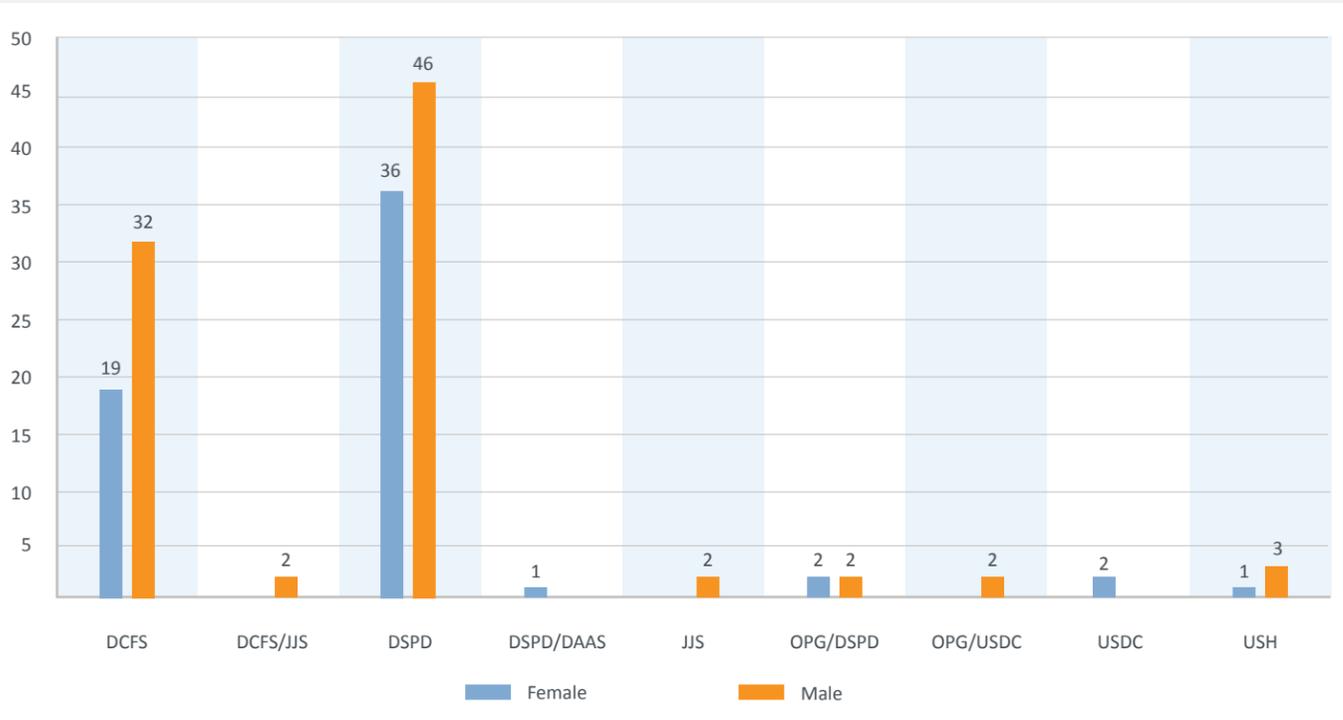
- 11 children died by suicide in FY20. This tragic number remained the same from FY19
  - 8 of these suicides were children ages 15-20 and 3 were children ages 13-14
  - All FY20 reviewed cases of youth suicide had current or previous involvement with DCFS. The Fatality Review Committee and the Division of Child and Family Services continues its resolve to implement measures to reduce the risk of suicide, such as suicide screeners to assess safety risk and referrals to mental health agencies.

## Reviewed Cases by Age Distribution

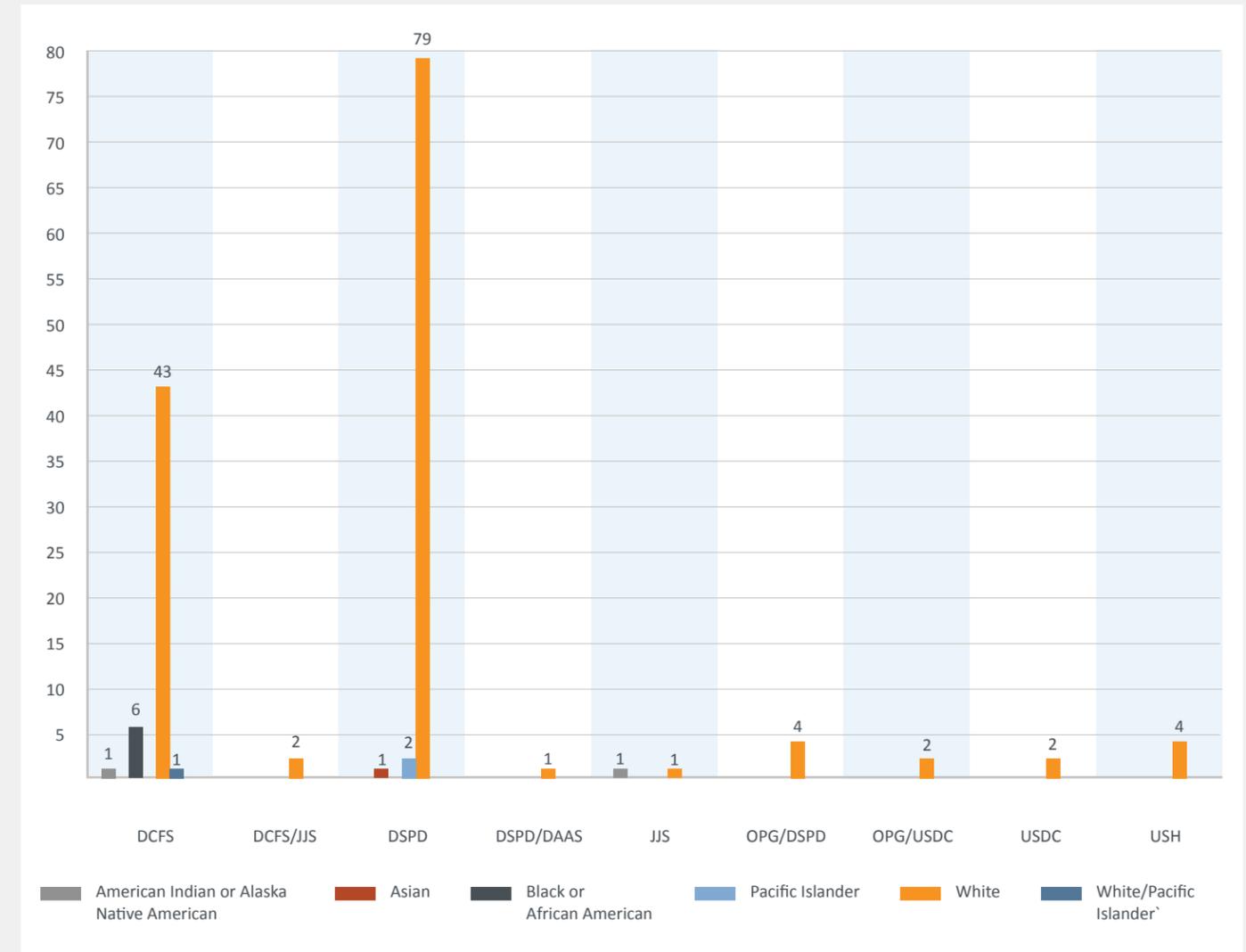


- 38.7% of qualified fatalities involved individuals 19 or younger

## Reviewed Cases by Gender and Division



## Reviewed Cases by Race and Division



## RECOMMENDATIONS

Recommendations from individual and systemic reviews included:

- Improving communication between caseworkers and medical providers
- Incorporating training in safety science and enhancing other formal and individual training for caseworkers
- Increasing the availability of supportive services for caseworkers, specifically interpreting resources and refugee services
- Continued tracking and data collection of fatalities of children with complex medical needs and fatalities where a caregiver was impaired due to the illegal misuse of substances

These recommendations were in addition to various specific recommendations on cases. The Committee issued no recommendations regarding changes to state law.

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