Fiscal Year 2023

Fatality Review Summary

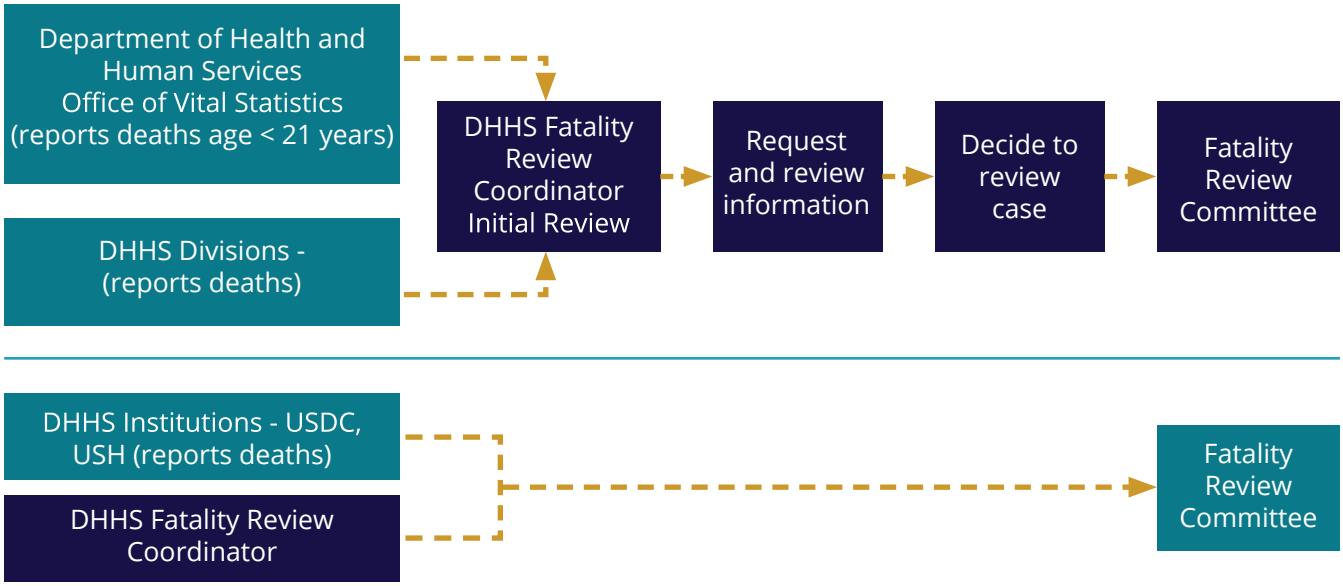
The Department of Health and Human Services (DHHS) Fatality Review Committees review cases of individuals who themselves, or a family member, had an open case with a DHHS division at the time of their death or, in some cases, within up to 12 months preceding the death.

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 Health Families), Attorney General's Office, a Children's Justice Center representative, a Suicide Prevention and Crisis Services expert, risk management and DHHS division administration. The reviews are managed through a Fatality Review Coordinator in the DHHS Office of Service Review (OSR).

Fatalities are reported and reviewed in the following manner:

DHHS Divisions Included

- Aging and Adult Services (DAAS) Adult Protective Services (APS)
- Child and Family Services (DCFS)
- Juvenile Justice and Youth Services (JJYS)
- Office of Licensing
- Office of Internal Audit
- Office of Public Guardian (OPG)
- Services for People with Disabilities (DSPD)
- Utah State Developmental Center (USDC)
- Utah State Hospital (USH)



The Committee reviews include in-depth information from case logs, law enforcement, the Office of the Medical Examiner (ME) and Vital Statistics. 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 DHHS Executive Director, the legislative Child Welfare Oversight Panel and the legislative Health and Human Services Interim Committee and shares recommendations with the leaders of DHHS divisions and institutions with case oversight.

While case details are not public record, Utah Code 26B-1-507(5) requires that DHHS 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

FY 2023
Process Improvements

During state Fiscal Year 2023, DHHS engaged systemic improvements to strengthen the fatality review process:

- **Implemented case factors debriefing for the Division of Child and Family Services**. This process allows for a deeper exploration into the events surrounding the fatality and helps identify any systemic barriers that case workers face in providing care to individuals. This is a voluntary process and an open discussion to talk about the case, discuss what caseworkers are facing right now, and identify system improvements.

- **Implemented a continuous quality feedback loop with agency partners** by incorporating a quarterly collaboration meeting to review recent fatalities, demographics, and recommendation implementation.

- DSPD added language to the directive on State Match to **ensure that DSPD is consistently asking for complete case records** at the point of each transfer.

Data
and Findings

Important Note:

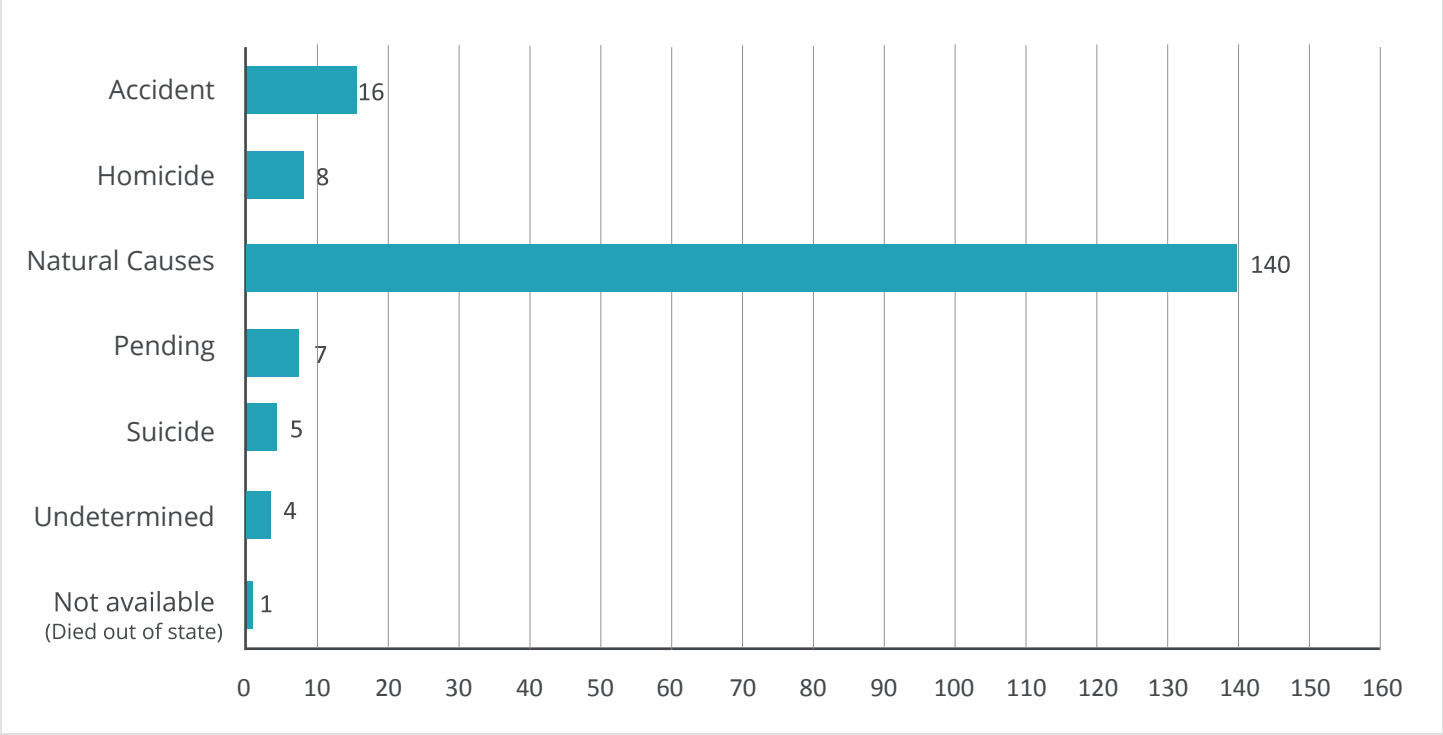
Data contained in this report reflects fatalities reviewed by the Committee in FY23, however actual deaths may have occurred earlier that were awaiting information for the review.

FY 2023
Formally Reviewed Fatalities

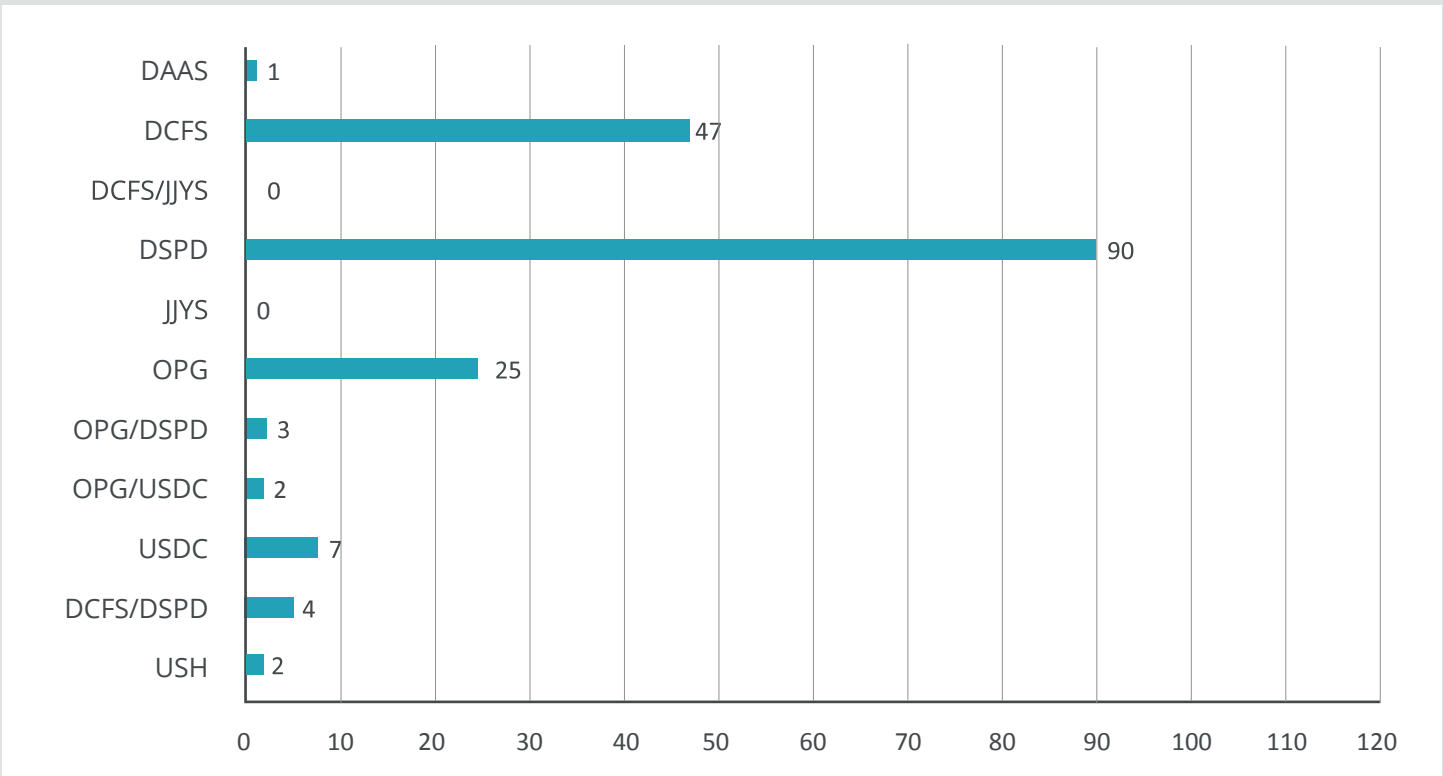
181 deaths were reported to OSR, and 10 near fatalities. The committee completed 191 formal fatality reviews, including:

- All deaths 21 and younger who met statute criteria
- 10 near fatalities
- All DSPD-involved deaths
- All OPG-reported deaths that had more than one agency involved
- All individuals with multiple division involvement
- All USH deaths
- No deaths met the formal review by JJYS

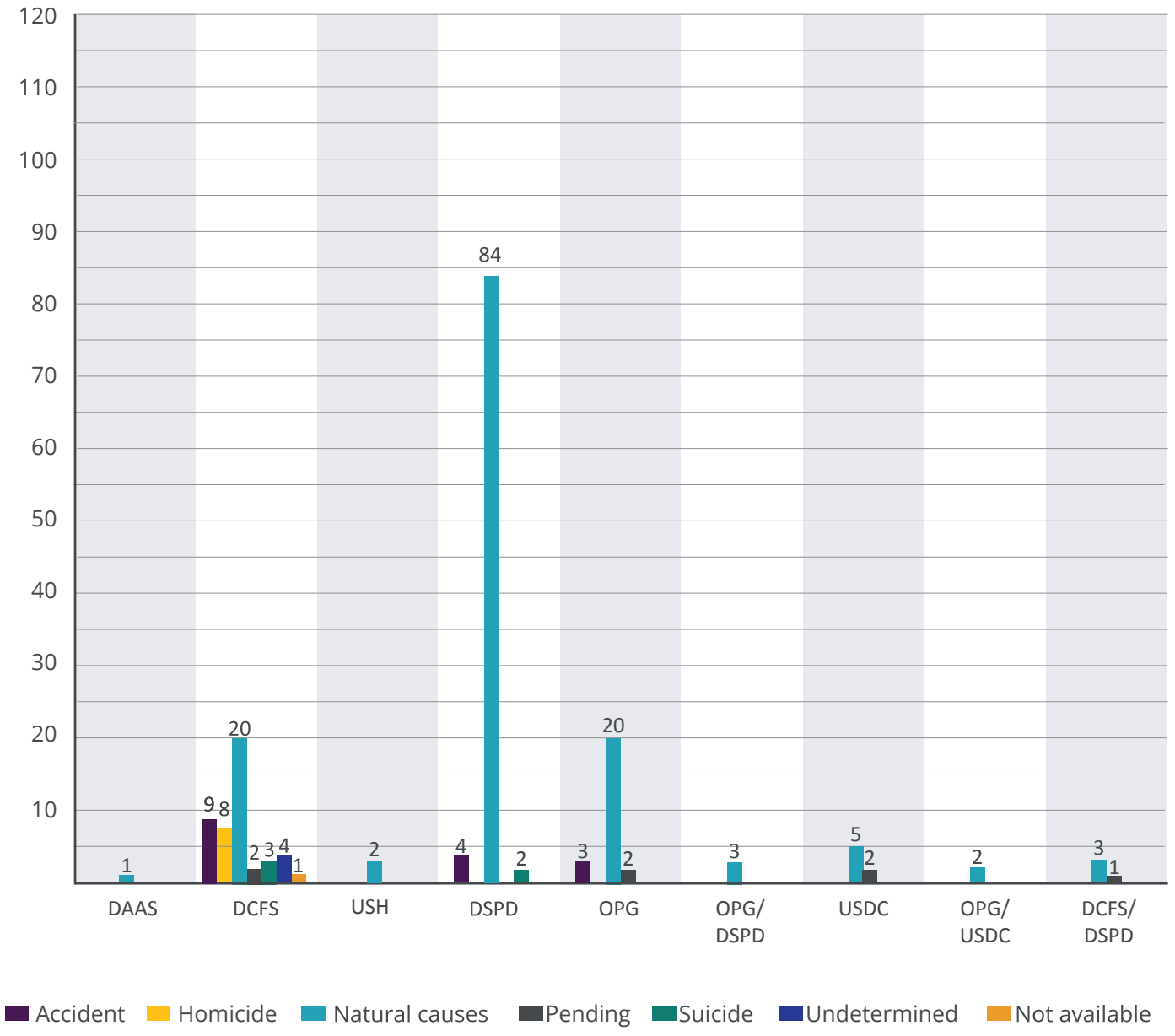
Reviewed Cases, Manner of Death Per Medical Examiner



Reported Deaths by Division, Total Reported Deaths: 181

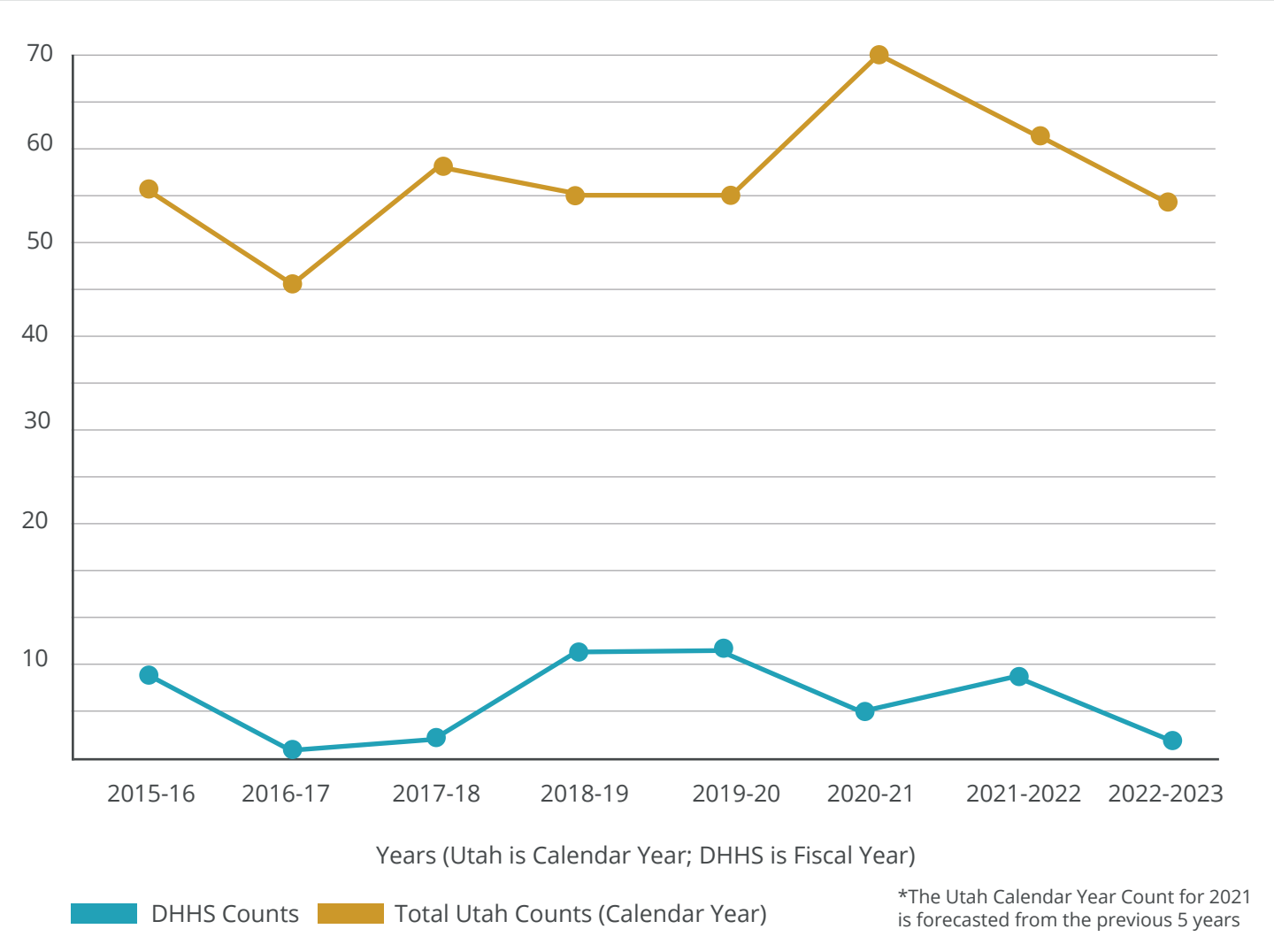


Reviewed Cases, Medical Examiner Manner of Death by Division*

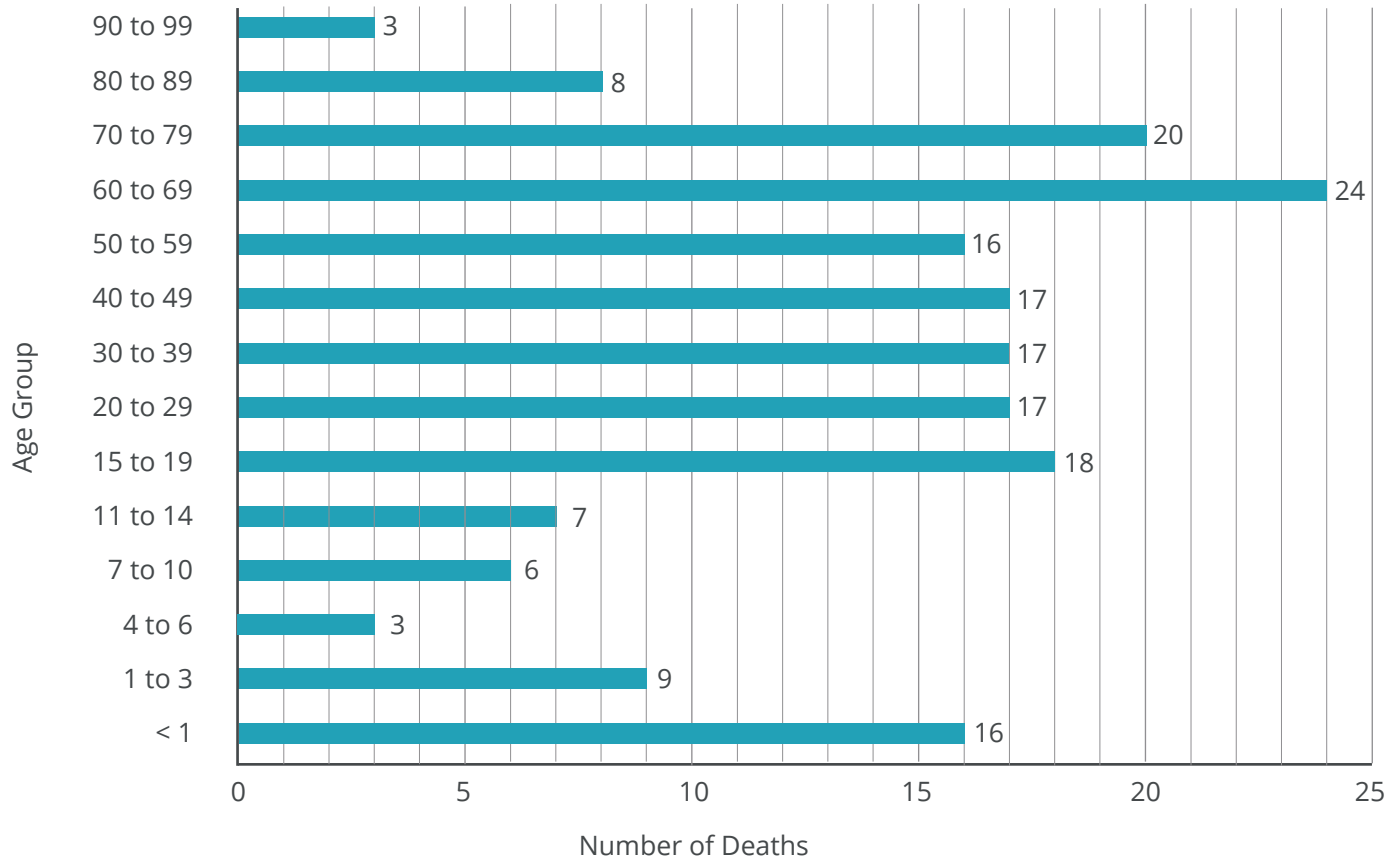


*JJYS had no cases reviewed by the Medical Examiner

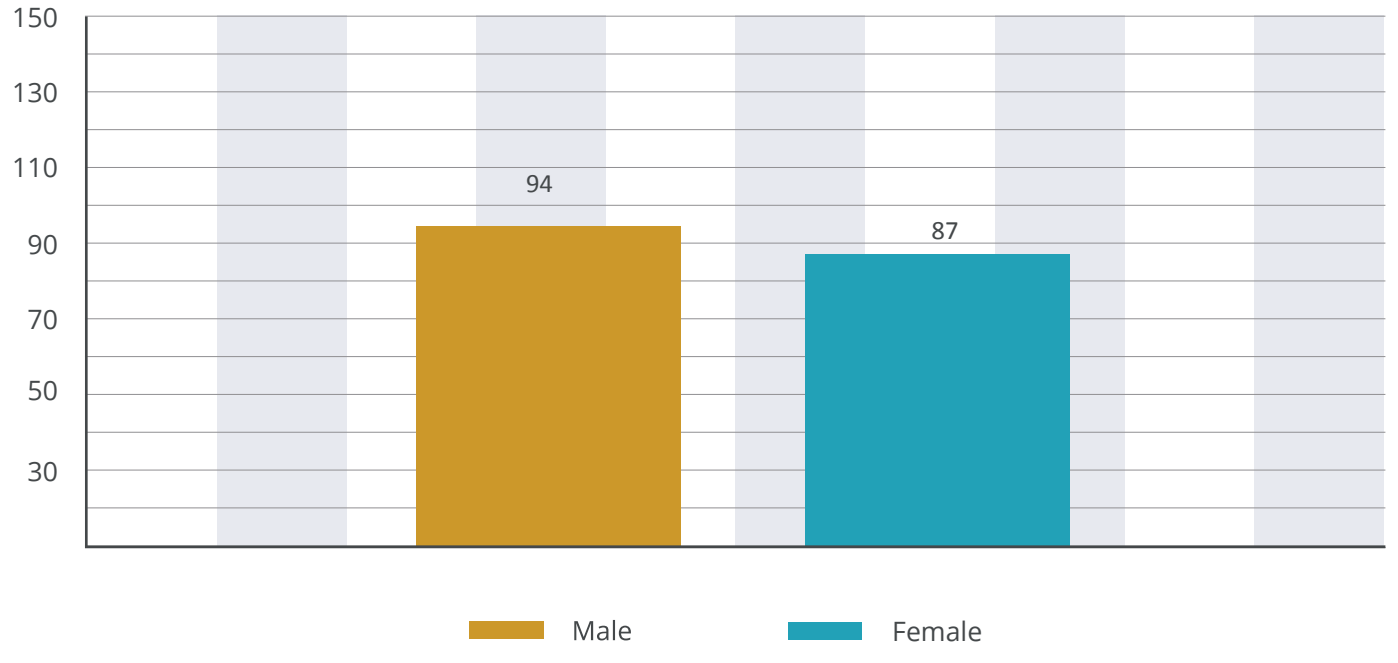
DHHS Involved and Statewide Youth Suicide Deaths for 11-19 Year Olds (2016-2023)



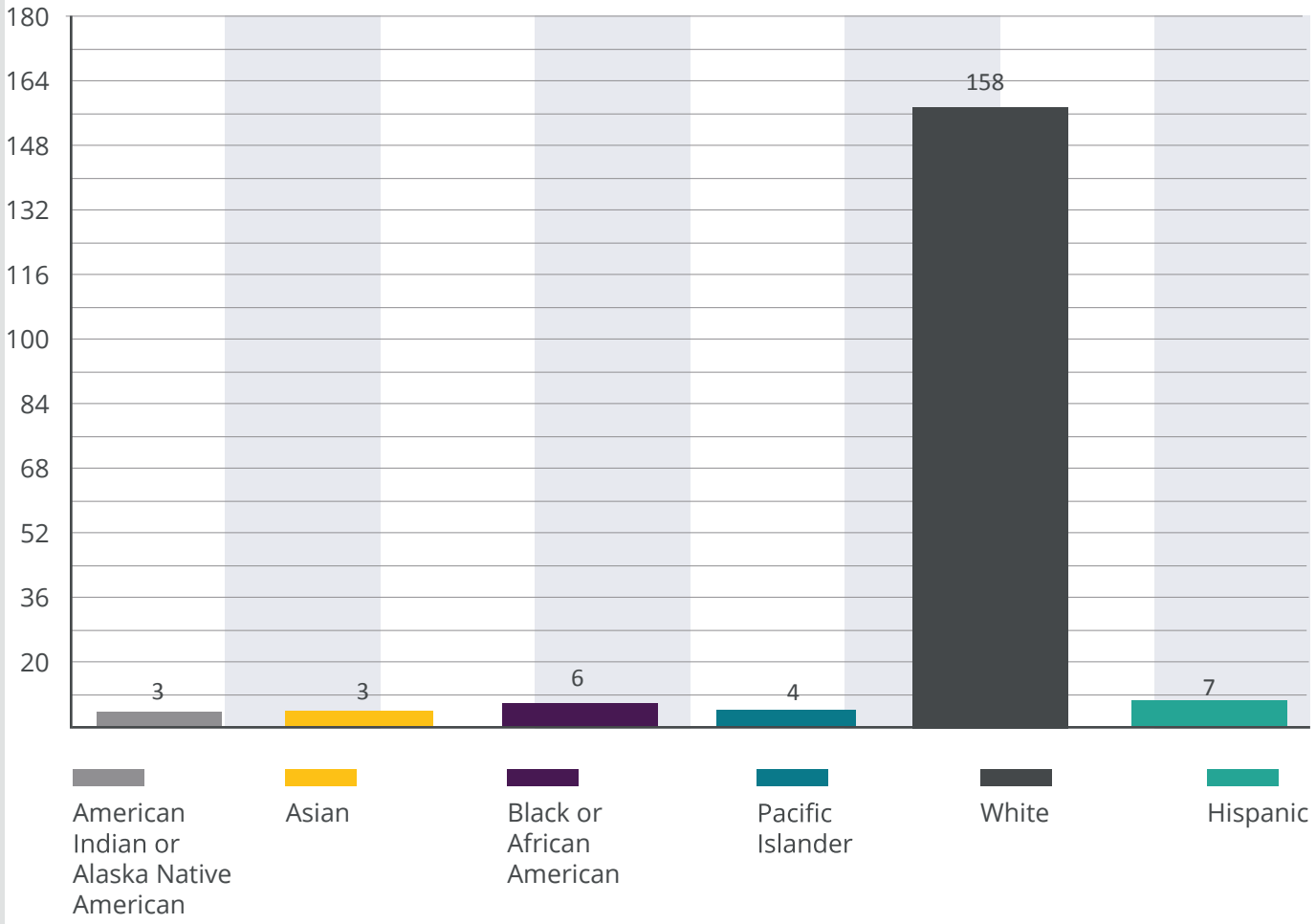
Reviewed Cases by Age Distribution



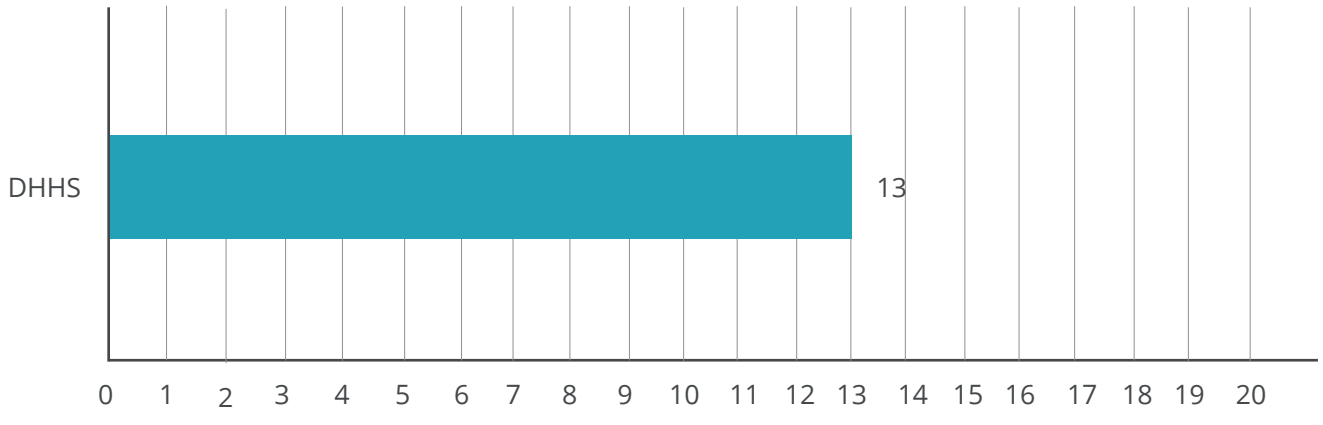
Reviewed Cases by Gender and Division



Reviewed Cases by Race and Division



Reported COVID-19 Data Deaths



- This data is limited to only those deaths reported to have been caused by COVID-19 during the period of this report.

Recommendations for FY2023 report

1. We recommend that DSPD and the Division of Child and Family Services (DCFS) review policy and guidance to strengthen the case record exchanges between the agencies when transitioning an individual from DCFS to DSPD based services.

This was an area identified in four fatalities reviewed over the last two years. In the reviews it was identified that upon transition from DCFS to DSPD services, necessary information (behavioral and medical) was not always relayed to appropriate DSPD staff and entities. The result of this lacking exchange was a backstep in the individual's progress and a delay in identifying the most appropriate services.

2. We recommend that DCFS recruit and train more medically specific foster homes for medically fragile service recipients

This recommendation is being rendered as a result of three separate fatalities where the foster home lacked training and experience to care for medically fragile service recipients.

3. We recommend that DCFS improve the Interstate Compact on the Placement of Children (ICPC) process

This recommendation is being rendered as a result of a single fatality (2023-19). While this finding did not have a direct impact on the fatality, it was identified during the case factor debriefing and mapping process as a system barrier. We recognize that the State of Utah DCFS has no control over the actions of other states or the Federal ICPC procedures, however, the following areas were identified that could strengthen ICPS processes within DCFS.

- The ICPC process varies from each region, having a consistent division wide process could streamline and simplify the process for caseworkers.

- It is recommended that timelines be tracked for when ICPC paperwork is submitted from the region to the state.

- ICPC office employees should communicate in a timely manner with the regions and other state entities and follow up regularly if the receiving state is not responsive to ICPC requests in a timely manner.

4. We recommend that the Office of Service Review (OSR) implement the case factors debriefing process in the DSPD system as has been implemented within DCFS.

The case factors debriefing process is a deeper exploration into the events surrounding the fatality and helps identify any systemic barriers that case workers face in providing care to the individuals. This is a voluntary process and is an open discussion to talk about the case, discuss what caseworkers are facing right now, and identify system improvements. This recommendation is a result of seeing the positive impact the case factors debriefing has had on the fatality review process in the DCFS system

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