Effective 5/3/2023

Part 5
Fatality Review

26B-1-501 Definitions.

As used in this part:

(1) "Abuse" means the same as that term is defined in Section 80-1-102.

(2) "Child" means the same as that term is defined in Section 80-1-102.

(3) "Committee" means a fatality review committee that is formed under Section 26B-1-503 or 26B-1-504.

(4) "Dependency" means the same as that term is defined in Section 80-1-102.

(5) "Formal review" means a review of a death or a near fatality that is ordered under Subsection 26B-1-502(5).

(6) "Near fatality" means alleged abuse or neglect that, as certified by a physician or physician assistant, places a child in serious or critical condition.

(7) "Qualified individual" means an individual who:

(a) at the time that the individual dies, is a resident of a facility or program that is owned or operated by the department or a division of the department;

(b)

(i) is in the custody of the department or a division of the department; and

(ii) is placed in a residential placement by the department or a division of the department;

(c) at the time that the individual dies, has an open case for the receipt of child welfare services, including:

(i) an investigation for abuse, neglect, or dependency;

(ii) foster care;

(iii) in-home services; or

(iv) substitute care;

(d) had an open case for the receipt of child welfare services within one year before the day on which the individual dies;

(e) was the subject of an accepted referral received by Adult Protective Services within one year before the day on which the individual dies, if:

(i) the department or a division of the department is aware of the death; and

(ii) the death is reported as a homicide, suicide, or an undetermined cause;

(f) received services from, or under the direction of, the Division of Services for People with Disabilities within one year before the day on which the individual dies;

(g) dies within 60 days after the day on which the individual is discharged from the Utah State Hospital, if the department is aware of the death;

(h) is a child who:

(i) suffers a near fatality; and

(ii) is the subject of an open case for the receipt of child welfare services within one year before the day on which the child suffered the near fatality, including:

(A) an investigation for abuse, neglect, or dependency;

(B) foster care;

(C) in-home services; or

(D) substitute care; or

(i) is designated as a qualified individual by the executive director.

(8) "Neglect" means the same as that term is defined in Section 80-1-102.

(9) "Substitute care" means the same as that term is defined in Section 80-1-102.

Amended by Chapter 113, 2024 General Session
Amended by Chapter 288, 2024 General Session

26B-1-502 Initial review.

(1) Within seven days after the day on which the department knows that a qualified individual has died or is an individual described in Subsection 26B-1-501(7)(h), a person designated by the department shall:
  (a)
    (i) for a death, complete a deceased client report form, created by the department; or
    (ii) for an individual described in Subsection 26B-1-501(7)(h), complete a near fatality client report form, created by the department; and
  (b) forward the completed client report form to:
    (i) the director of the office or division that has jurisdiction over the region or facility;
    (ii) the executive director;
    (iii) the director of the Division of Continuous Quality and Improvement; and
    (iv) the fatality review coordinator, or the fatality review coordinator's designee.
(2) Within 10 days after the day on which the fatality review coordinator or the fatality review coordinator's designee receives a copy of the near fatality client report form or the deceased client report form, the fatality review coordinator or the fatality review coordinator's designee shall request a copy of all relevant department case records, or electronic access to all relevant department case records, regarding the individual who is the subject of the client report form.
(3) Each person who receives a request for a record described in Subsection (2) shall provide a copy of the record, or electronic access to the record, to the fatality review coordinator or the fatality review coordinator's designee, by a secure method, within seven days after the day on which the request is made.
(4) Within 30 days after the day on which the fatality review coordinator or the fatality review coordinator's designee receives the case records requested under Subsection (2), the fatality review coordinator, or the fatality review coordinator's designee, shall:
  (a) review the client report form, the case files, and other relevant information received by the fatality review coordinator; and
  (b) make a recommendation to the director of the Division of Continuous Quality and Improvement regarding whether a formal review of the death or near fatality should be conducted.
(5)
  (a) In accordance with Subsection (5)(b), within 14 days after the day on which the fatality review coordinator or the fatality review coordinator's designee makes the recommendation described in Subsection (4)(b), the director of the Division of Continuous Quality and Improvement or the director's designee shall determine whether to order that a review of the death or near fatality be conducted.
  (b) The director of the Division of Continuous Quality and Improvement or the director's designee shall order that a formal review of the death or near fatality be conducted if:
    (i) at the time of the near fatality or the death, the qualified individual is:
      (A) an individual described in Subsections 26B-1-501(7)(a) through (h), unless:
        (I) the near fatality or the death is due to a natural cause; or
        (II) the director of the Division of Continuous Quality and Improvement or the director's designee determines that the near fatality or the death was not in any way related to

services that were provided by, or under the direction of, the department or a division of the department; or

(B) a child in foster care or substitute care, unless the near fatality or the death is due to:

(I) a natural cause; or

(II) an accident;

(ii) it appears, based on the information provided to the director of the Division of Continuous Quality and Improvement or the director's designee, that:

(A) a provision of law, rule, policy, or procedure relating to the qualified individual or the individual's family may not have been complied with;

(B) the near fatality or the fatality was not responded to properly;

(C) a law, rule, policy, or procedure may need to be changed; or

(D) additional training is needed;

(iii)

(A) the death is caused by suicide; or

(B) the near fatality is caused by attempted suicide; or

(iv) the director of the Division of Continuous Quality and Improvement or the director's designee determines that another reason exists to order that a review of the near fatality or the death be conducted.

Amended by Chapter 240, 2024 General Session
Amended by Chapter 288, 2024 General Session

26B-1-503 Fatality review committee for a qualified individual who was not a resident of the Utah State Hospital or the Utah State Developmental Center.

(1) Except for a fatality review committee described in Section 26B-1-504, the fatality review coordinator shall organize a fatality review committee for each formal review.

(2) Except as provided in Subsection (5), a committee described in Subsection (1):

(a) shall include the following members:

(i) the department's fatality review coordinator, who shall designate a member of the committee to serve as chair of the committee;

(ii) a member of the board, if there is a board, of the relevant division or office;

(iii) the attorney general or the attorney general's designee;

(iv)

(A) a member of the management staff of the relevant division or office; or

(B) a person who is a supervisor, or a higher level position, from a region that did not have jurisdiction over the qualified individual; and

(v) a member of the department's risk management services; and

(b) may include the following members:

(i) a health care professional;

(ii) a law enforcement officer; or

(iii) a representative of the Office of Public Guardian.

(3) If a death that is subject to formal review involves a qualified individual described in Subsection 26B-1-501(7)(c), (d), or (h), the committee may also include:

(a) a health care professional;

(b) a law enforcement officer;

(c) the director of the Office of Guardian ad Litem;

(d) an employee of the division who may be able to provide information or expertise that would be helpful to the formal review; or

(e) a professional whose knowledge or expertise may significantly contribute to the formal review.
(4) A committee described in Subsection (1) may also include a person whose knowledge or expertise may significantly contribute to the formal review.
(5) A committee described in this section may not include an individual who was involved in, or who supervises a person who was involved in, the near fatality or the death.
(6) Each member of a committee described in this section who is not an employee of the department shall sign a form, created by the department, indicating that the member agrees to:
(a) keep all information relating to the formal review confidential; and
(b) not release any information relating to a formal review, unless required or permitted by law to release the information.

Renumbered and Amended by Chapter 305, 2023 General Session

26B-1-504 Fatality review committees for a resident of the Utah State Hospital or the Utah State Developmental Center.
(1) If a qualified individual who is the subject of a formal review was a resident of the Utah State Hospital or the Utah State Developmental Center, the fatality review coordinator of that facility shall organize a fatality review committee to review the near fatality or the death.
(2) Except as provided in Subsection (4), a committee described in Subsection (1) shall include the following members:
(a) the fatality review coordinator for the facility, who shall serve as chair of the committee;
(b) a member of the management staff of the facility;
(c) a supervisor of a unit other than the one in which the qualified individual resided;
(d) a physician;
(e) a representative from the administration of the division that oversees the facility;
(f) the department's fatality review coordinator;
(g) a member of the department's risk management services; and
(h) a citizen who is not an employee of the department.
(3) A committee described in Subsection (1) may also include a person whose knowledge or expertise may significantly contribute to the formal review.
(4) A committee described in this section may not include an individual who:
(a) was involved in, or who supervises a person who was involved in, the near fatality or the death; or
(b) has a conflict with the fatality review.

Renumbered and Amended by Chapter 305, 2023 General Session

26B-1-505 Fatality review committee proceedings.
(1) A majority vote of committee members present constitutes the action of the committee.
(2) The department shall give the committee access to all reports, records, and other documents that are relevant to the near fatality or the death under investigation, including:
(a) narrative reports;
(b) case files;
(c) autopsy reports; and
(d) police reports, unless the report is protected from disclosure under Subsection 63G-2-305(10) or (11).
(3) The Utah State Hospital and the Utah State Developmental Center shall provide protected health information to the committee if requested by a fatality review coordinator.

(4) A committee shall convene monthly, unless this time is extended, for good cause, by the director of the Division of Continuous Quality and Improvement.
(5) A committee may interview a staff member, a provider, or any other person who may have knowledge or expertise that is relevant to the formal review.
(6) A committee shall render an advisory opinion regarding:
(a) whether the provisions of law, rule, policy, and procedure relating to the qualified individual and the individual's family were complied with;
(b) whether the near fatality or the death was responded to properly;
(c) whether to recommend that a law, rule, policy, or procedure be changed; and
(d) whether additional training is needed.

Amended by Chapter 288, 2024 General Session

26B-1-506 Fatality review committee report -- Response to report.
(1) Within 20 days after the day on which the committee proceedings described in Section 26B-1-505 end, the committee shall submit:
(a) a written report to the executive director that includes:
(i) the advisory opinions made under Subsection 26B-1-505(6); and
(ii) any recommendations regarding action that should be taken in relation to an employee of the department or a person who contracts with the department; and
(b) a copy of the report described in Subsection (1)(a) to:
(i) the director, or the director's designee, of the office or division to which the near fatality or the death relates; and
(ii) the regional director, or the regional director's designee, of the region to which the near fatality or the death relates.
(2) Within 60 days after the day on which the director described in Subsection (1)(b)(i) receives a copy of the report described in Subsection (1)(a), the department shall provide a written response, with only identifying information redacted, to the Office of Legislative Research and General Counsel, if the report:
(a) indicates that a law, rule, policy, or procedure was not complied with;
(b) indicates that the near fatality or the death was not responded to properly;
(c) recommends that a law, rule, policy, or procedure be changed; or
(d) indicates that additional training is needed.
(3) The response described in Subsection (2) shall include:
(a) a plan of action to implement any recommended improvements within the department; and
(b) the approval of the executive director or the executive director's designee for the plan described in Subsection (3)(a).
(4) A report described in Subsection (1) and the response described in Subsection (2) is a protected record.
(5)
(a) As used in this Subsection (5), "fatality review document" means any document created in connection with, or as a result of, a formal review of a near fatality or a death, or a decision whether to conduct a formal review of a near fatality or a death, including:
(i) a report described in Subsection (1);
(ii) a response described in Subsection (2);
(iii) a recommendation regarding whether a formal review should be conducted;
(iv) a decision to conduct a formal review;
(v) notes of a person who participates in a formal review;

(vi) notes of a person who reviews a formal review report;
(vii) minutes of a formal review;
(viii) minutes of a meeting where a formal review report is reviewed; and
(ix) minutes of, documents received in relation to, and documents generated in relation to, the portion of a meeting of the Health and Human Services Interim Committee or the Child Welfare Legislative Oversight Panel that a formal review report or a document described in this Subsection (5)(a) is reviewed or discussed.

(b) A fatality review document is not subject to discovery, subpoena, or similar compulsory process in any civil, judicial, or administrative proceeding, nor shall any individual or organization with lawful access to the data be compelled to testify with regard to a report described in Subsection (1) or a response described in Subsection (2).

(c) The following are not admissible as evidence in a civil, judicial, or administrative proceeding:
(i) a fatality review document; and
(ii) an executive summary described in Subsection 26B-1-507(4).

Amended by Chapter 288, 2024 General Session

26B-1-507 Reporting to, and review by, legislative committees.

(1) On or before September 1 of each year, the department shall provide, with only identifying information redacted, a copy of the report described in Subsection 26B-1-506(1)(b), and the response described in Subsection 26B-1-506(2) to the Office of Legislative Research and General Counsel and the chairs of:
(a) the Health and Human Services Interim Committee; or
(b) if the qualified individual who is the subject of the report is an individual described in Subsection 26B-1-501(7)(c), (d), or (h), the Child Welfare Legislative Oversight Panel.

(2)
(a) The Health and Human Services Interim Committee may, in a closed meeting, review a report described in Subsection 26B-1-506(1)(b).
(b) The Child Welfare Legislative Oversight Panel shall, in a closed meeting, review a report described in Subsection (1)(b).

(3)
(a) The Health and Human Services Interim Committee and the Child Welfare Legislative Oversight Panel may not interfere with, or make recommendations regarding, the resolution of a particular case.
(b) The purpose of a review described in Subsection (2) is to assist a committee or panel described in Subsection (2) in determining whether to recommend a change in the law.
(c) Any recommendation, described in Subsection (3)(b), by a committee or panel for a change in the law shall be made in an open meeting.

(4) On or before September 1 of each year, the department shall provide an executive summary of all formal review reports for the preceding state fiscal year to:
(a) the Office of Legislative Research and General Counsel;
(b) the Health and Human Services Interim Committee; and
(c) the Child Welfare Legislative Oversight Panel.

(5) The executive summary described in Subsection (4):
(a) may not include any names or identifying information;
(b) shall include:
(i) all recommendations regarding changes to the law that were made during the preceding fiscal year under Subsection 26B-1-505(6);

(ii) all changes made, or in the process of being made, to a law, rule, policy, or procedure in response to a formal review that occurred during the preceding fiscal year;
(iii) a description of the training that has been completed in response to a formal review that occurred during the preceding fiscal year;
(iv) statistics for the preceding fiscal year regarding:
(A) the number of qualified individuals and the type of deaths and near fatalities that are known to the department;
(B) the number of formal reviews conducted;
(C) the categories described in Subsection 26B-1-501(7) of qualified individuals;
(D) the gender, age, race, and other significant categories of qualified individuals; and
(E) the number of fatalities of qualified individuals known to the department that are identified as suicides; and
(v) action taken by the Division of Licensing and Background Checks in response to the near fatality or the death of a qualified individual; and
(c) is a public document.
(6) The Division of Child and Family Services shall, to the extent required by the federal Child Abuse Prevention and Treatment Act of 1988, Pub. L. No. 93-247, as amended, allow public disclosure of the findings or information relating to a case of child abuse or neglect that results in a child fatality or a near fatality.

Amended by Chapter 288, 2024 General Session