Fiscal Year 2023

Fatality Review Summary

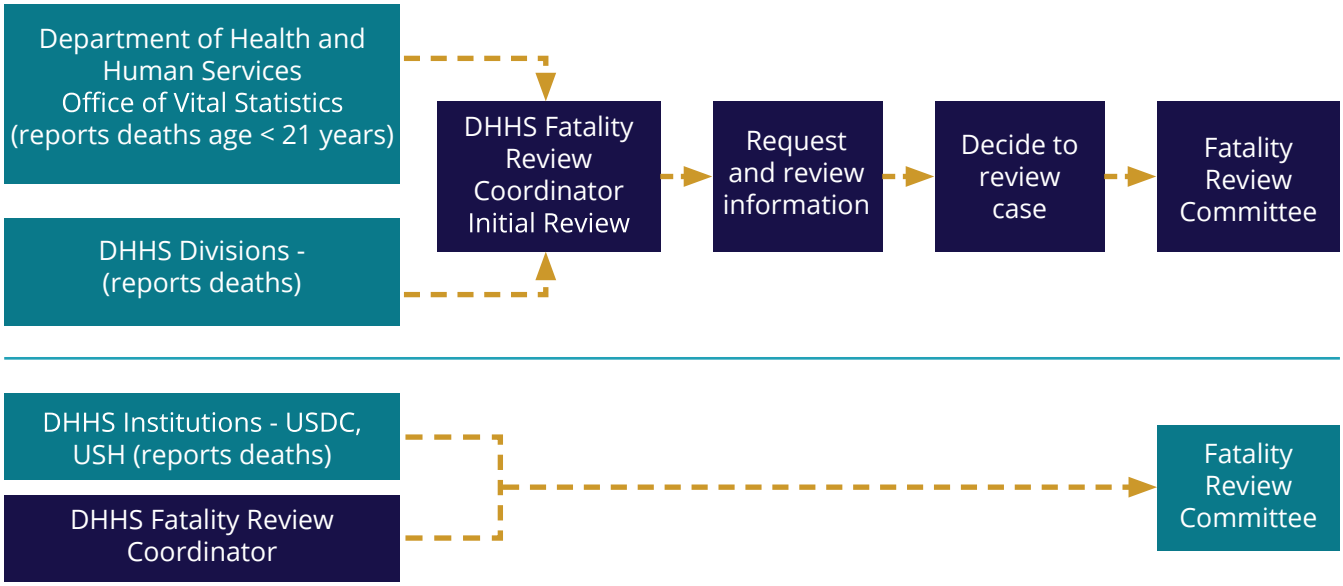
The Department of Health and Human Services (DHHS) Fatality Review Committees review cases of individuals who themselves, or a family member, had an open case with a DHHS division at the time of their death or, in some cases, within up to 12 months preceding the death.

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.

- Division of Services for People with Disabilities added language to the directive for youth that are transitioning to DSPD waiver services to **ensure that DSPD is consistently asking for complete case records** at the point of each transfer.

Data
and Findings

Important Note:

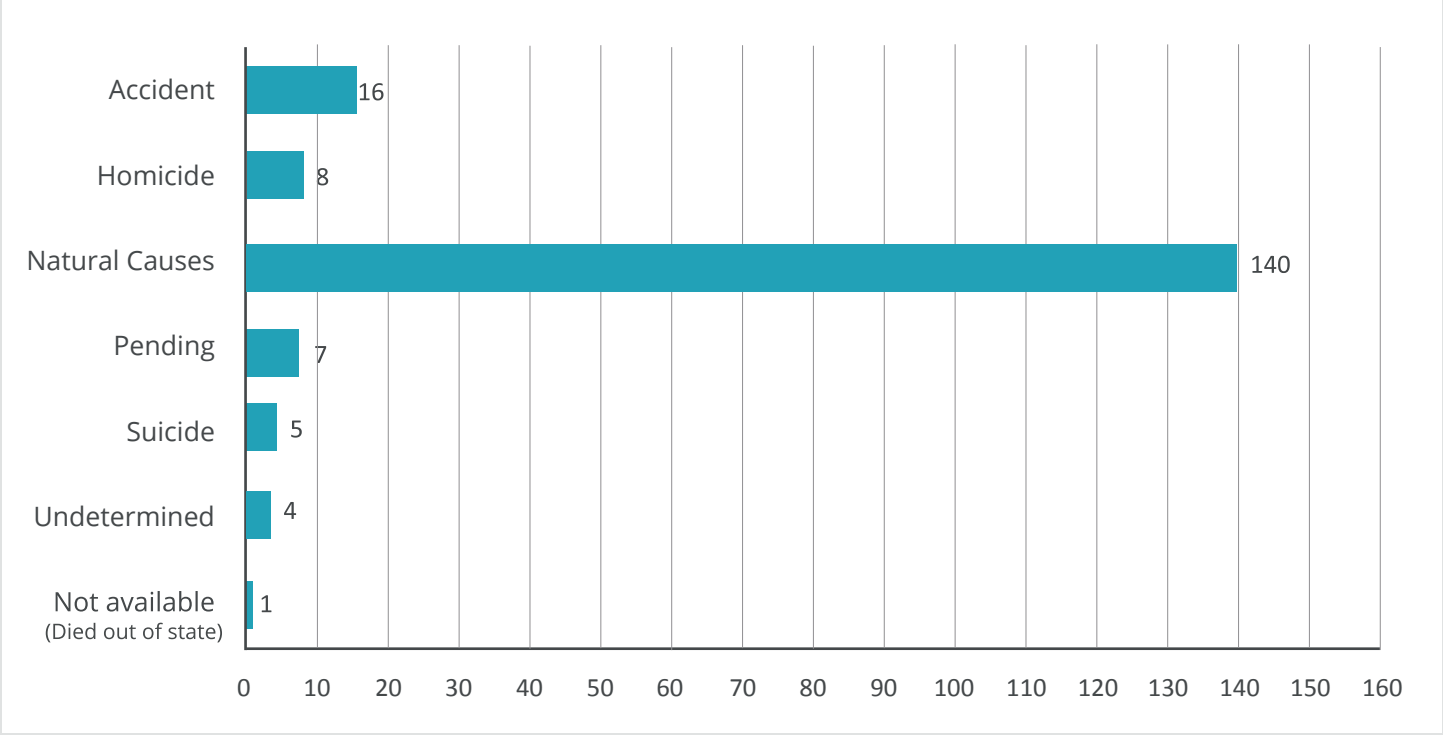
Data contained in this report reflects fatalities reviewed by the committee in FY2 3, however actual deaths may have occurred earlier that were awaiting information for the review.

FY 2023
Formally Reviewed Fatalities

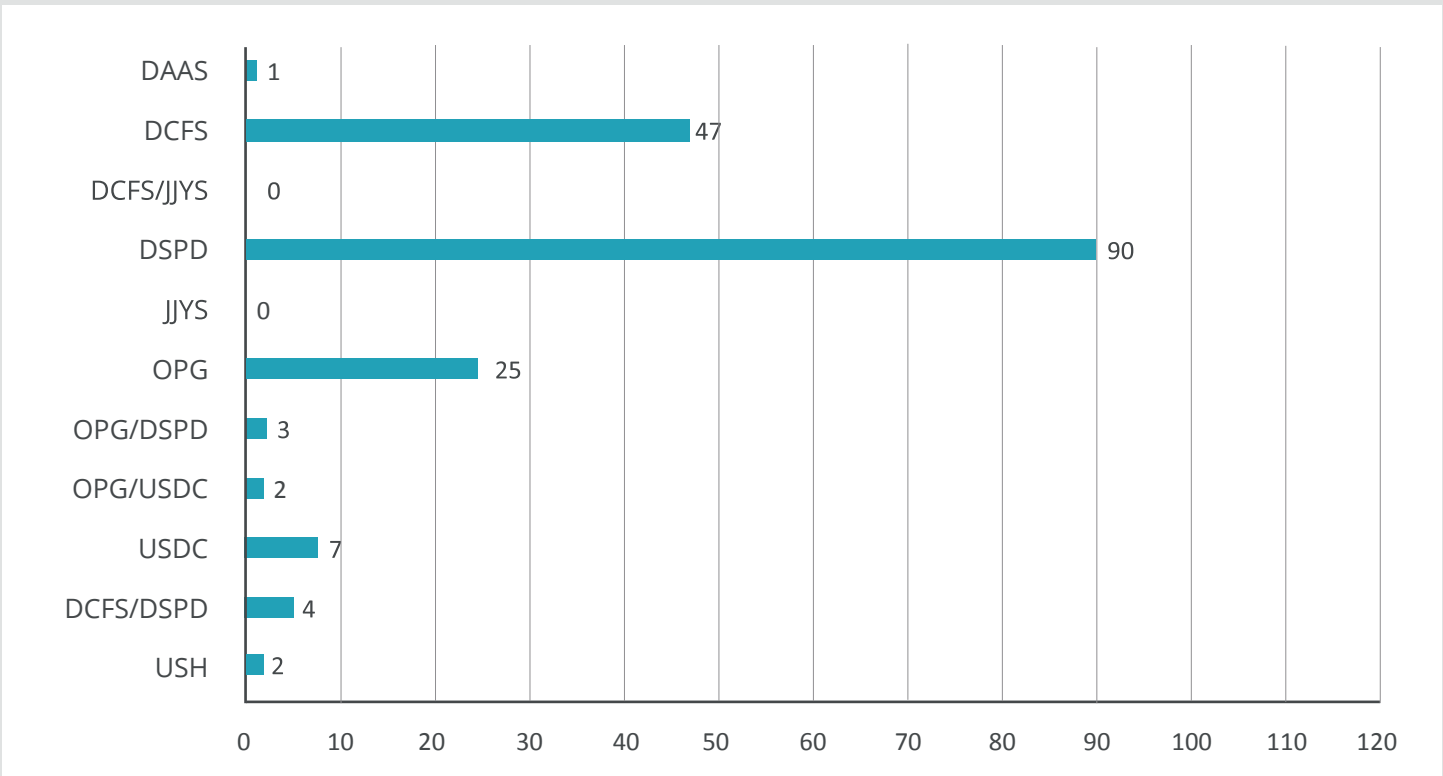
181 deaths were reported to OSR, and 10 near fatalities. The committee completed 191 formal fatality reviews, including:

- 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

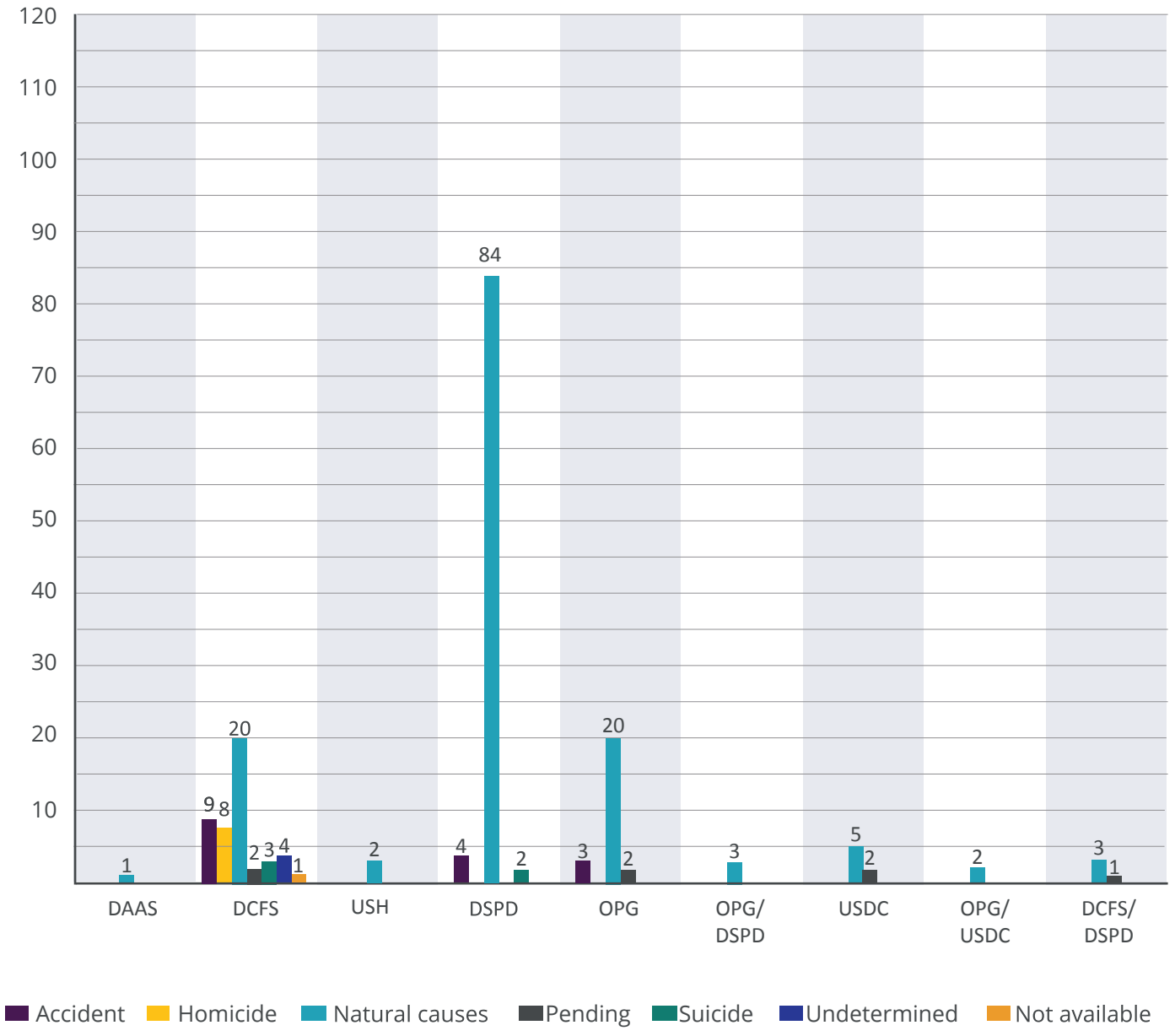
Reviewed Cases, Manner of Death Per Medical Examiner



Reported Deaths by Division, Total Reported Deaths: 181

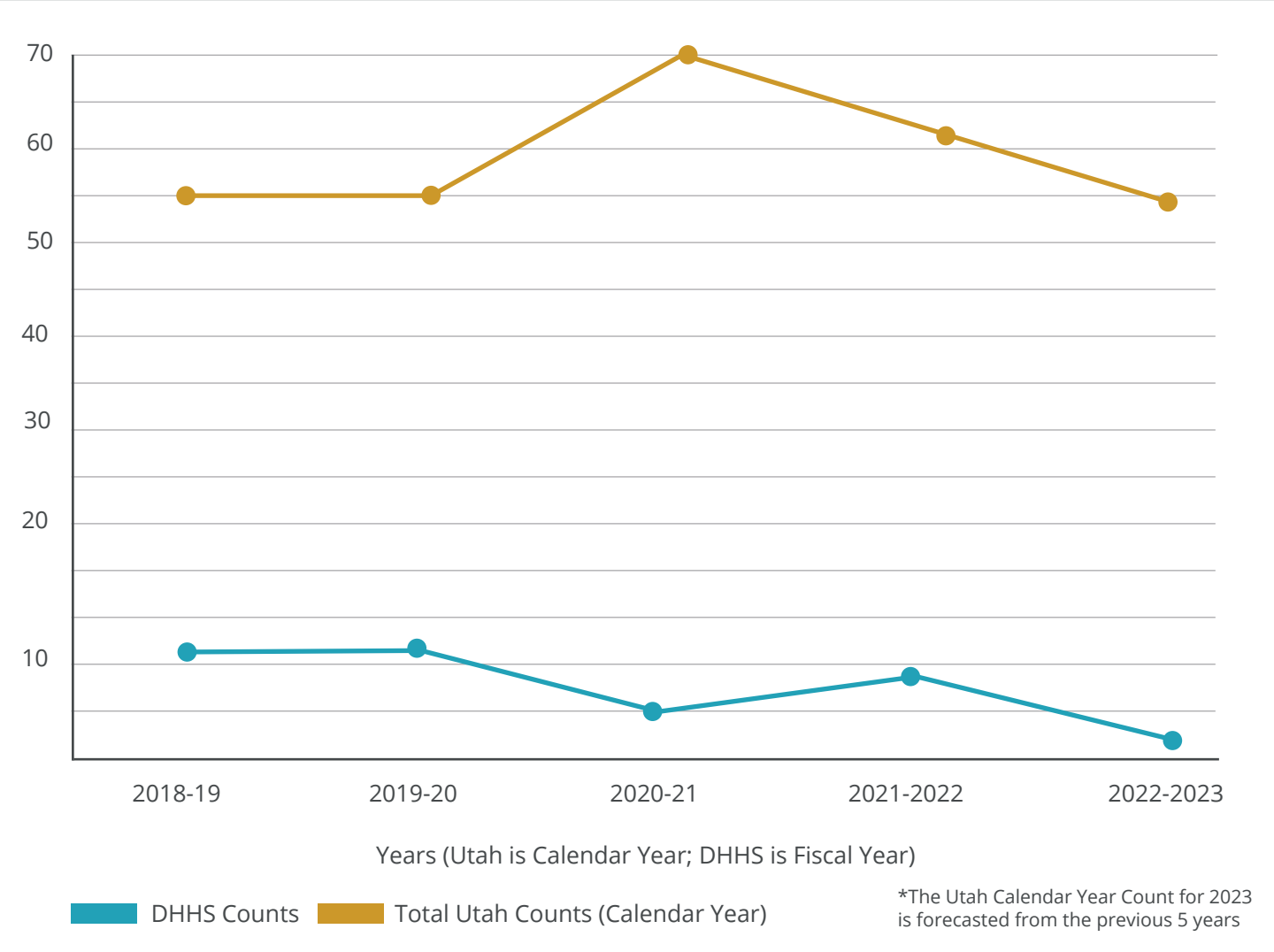


Reviewed Cases, Medical Examiner Manner of Death by Division*

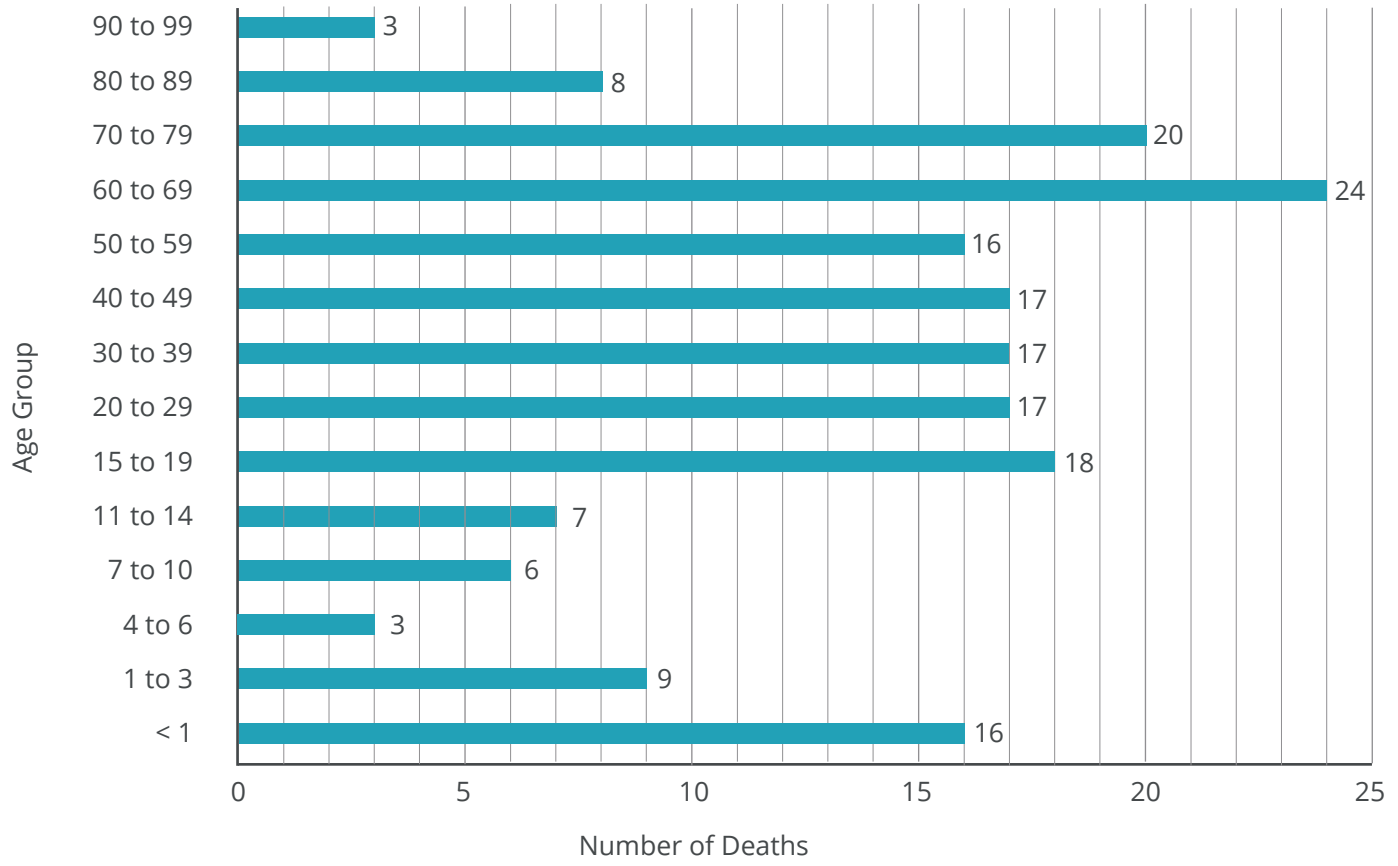


*JJYS had no cases reviewed by the Medical Examiner

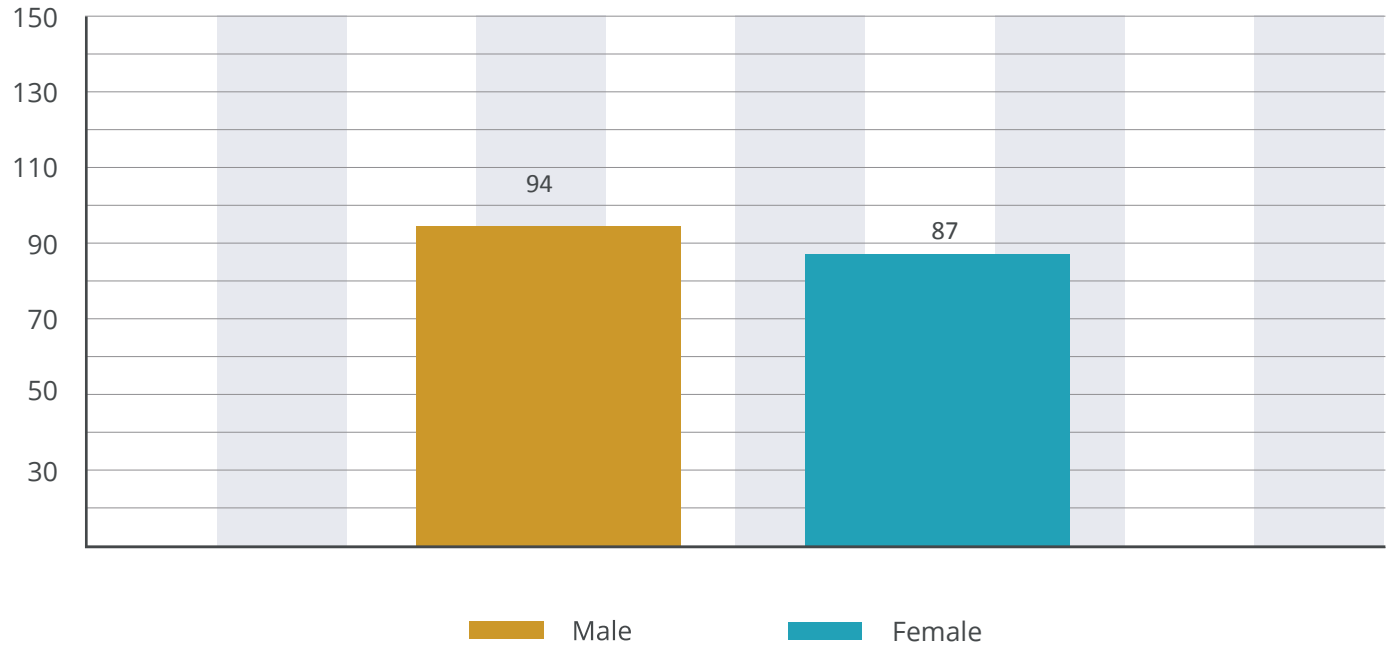
DHHS Involved and Statewide Youth Suicide Deaths for 11-19 Year Olds (2019-2023)



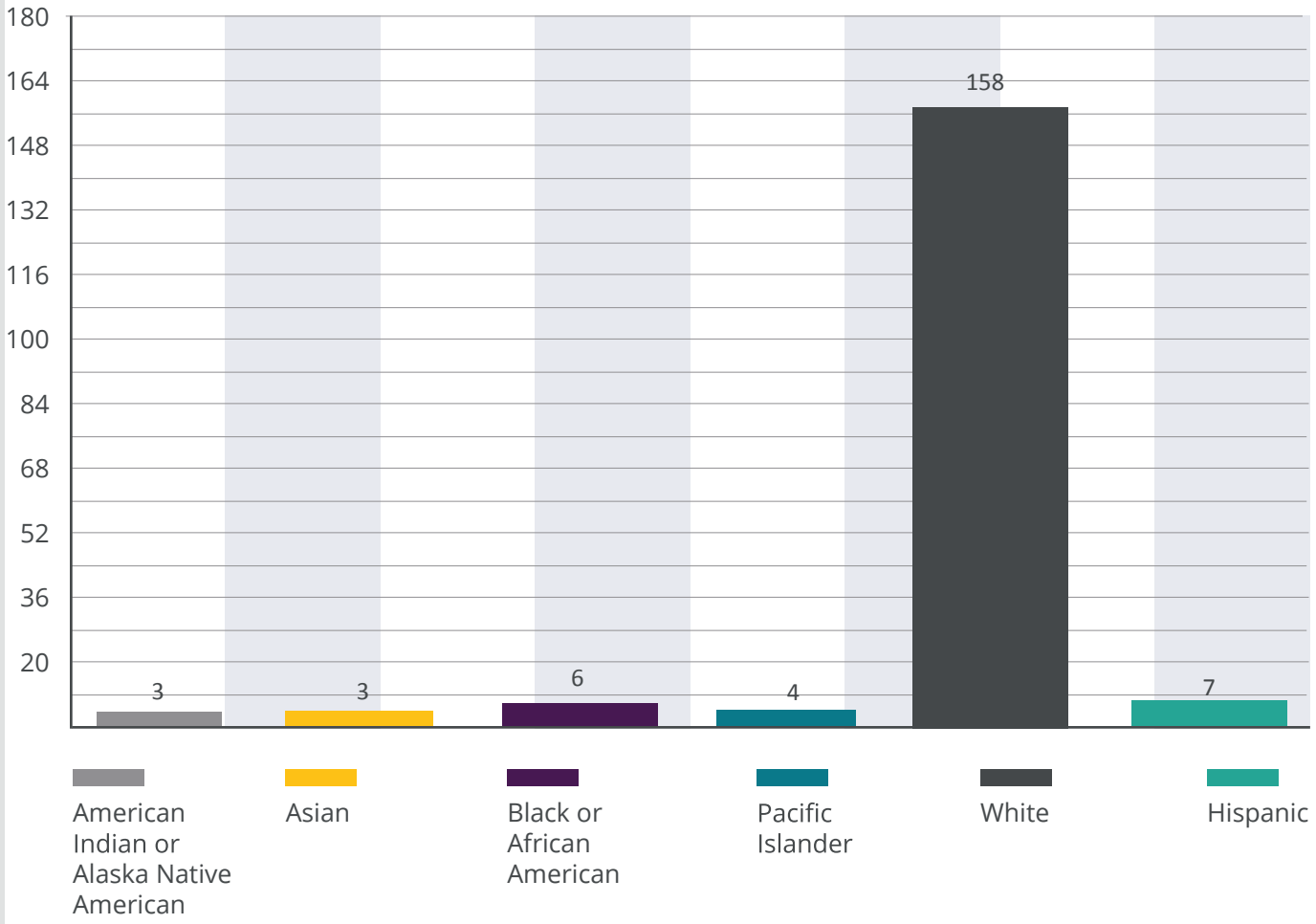
Reviewed Cases by Age Distribution



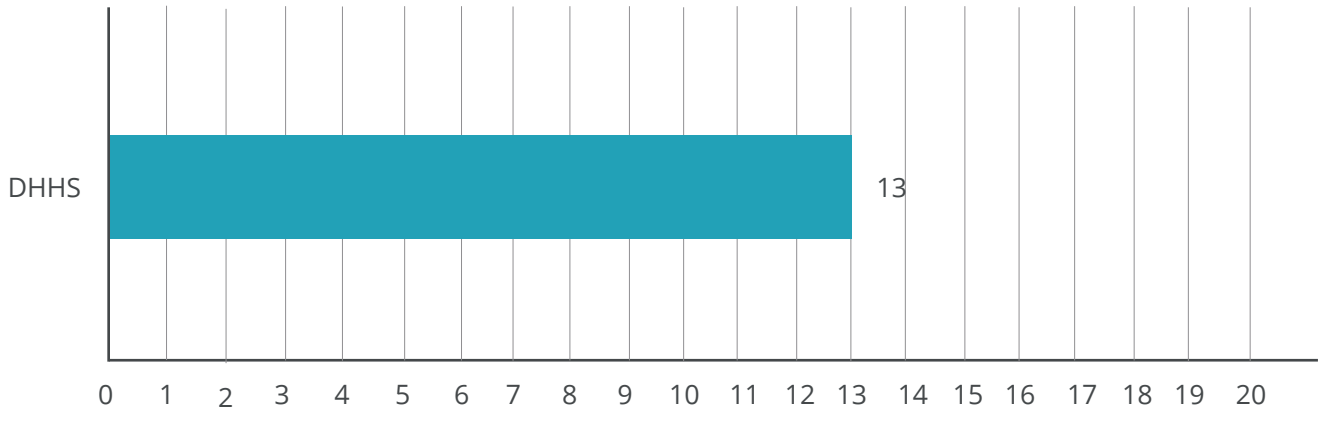
Reviewed Cases by Gender



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

Division of Continuous Quality and Improvement
Office of Service Review

195 N 1950 W
Salt Lake City, UT 84116

dhhs_cqi@utah.gov

Utah Department of Health & Human Services

State of Utah

SPENCER J. COX
Governor

DEIDRE M. HENDERSON
Lieutenant Governor

Department of Health & Human Services

TRACY S. GRUBER
Executive Director

NATE CHECKETTS
Deputy Director

DR. MICHELLE HOFMANN
Executive Medical Director

DAVID LITVACK
Deputy Director

NATE WINTERS
Deputy Director

To: Chandler Menteer, Office of Service Review Administrator
Jennifer Mendelson, DHHS Fatality Review Coordinator

From: Tonya Myrup, Division of Child and Family Services Director

Date: August 9, 2023
Re: DCFS Update on FY22 Fatality Review Recommendations

Thank you for the opportunity to provide an update on DCFS' progress in response to the FY22 Fatality Review Recommendation outlined below:

> 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.
> a. This recommendation is rendered as a result of a single fatality review (2022-01) which highlighted concerns in the data exchange between the agencies. In this review it was identified that upon transition from DCFS to DSPD services, necessary information (behavioral and medical) was not 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.

DCFS is actively working with DSPD on granting access to DSPD's USTEPS system to allow access to a limited number of DCFS designees. In return, DCFS is granting access to designated DSPD workers to access SAFE, DCFS' child welfare management information system. This will help streamline the flow of critical client-related information and allow for real time access to the DCFS and DSPD case records.

DSPD is developing and will be providing training to DCFS caseworkers who will serve as liaisons between DCFS and DSPD. Quarterly liaison meetings will be held to identify and resolve any barriers to effective communication and service.

DCFS and DSPD are creating a flowchart outlining the steps on how DCFS caseworkers can effectively coordinate with DSPD support coordinators once a DSPD case is opened. This will provide a quick reference to DCFS caseworkers who may go months or years without a case that has DSPD involvement. This will improve communication and help ensure important case information is communicated between agencies.

DCFS is also creating a case summary with pertinent information that can be provided to the Office of Public Guardian for youth exiting DCFS custody in need of an adult custodian.

Thank you again for the opportunity to improve the system to support quality outcomes for the children, youth and families DCFS serves.

State of Utah

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Deputy Director

To: Shannon Thoman-Black, CQI Division Director
Carrie Bambrough, OSR Office Director
Amanda Slater, DHHS Operations, Assistant Deputy Director
Tonya Myrup, DCFS Division Director
Charri Brummer, DCFS Deputy Director
Jennifer Mendelson, DHHS Fatality Review Coordinator
Chandler Menteer, Office of Service Review Administrator

From: Angella Pinna, DSPD Division Director

Date: March 8, 2023

Re: Fatality Review Recommendations

DSPD thanks the Office of Service Review and the Fatality Review Committee for the feedback and recommendations to improve our processes. We believe that some of the concerns have been at least partially addressed in a recent amendment, effective May 2022, to Directive 1.17 "Fatality Notifications." We are also currently reviewing relevant contract language that will further mitigate other concerns brought up in the memo. To respond in more detail, we would like to reply to each of the three formal recommendations separately below, even though only recommendations 1 and 2 name our division directly.

In response to the first recommendation, we appreciate that the memo recognizes the difficulty that exists in obtaining mental health services for people in services with DSPD. Indeed, the difficulty is not merely historical, but also systemic. It is extremely difficult to arrange substance use and mental health services for people with disabilities because treatment is often unavailable due to how few providers there are who specialize in dual diagnosis treatment. Additionally, many individuals who seek mental health treatment are turned away by clinicians who inaccurately attribute their mental health conditions to their disability. It is the expectation of DSPD that residential service providers will seek mental health services when an individual asks for treatment, or demonstrates a need for it, as their contracted provider is primarily responsible for their health and safety.

We are currently reviewing pending contract amendments in order to add language to strengthen and clarify that expectation in the "Health Support Policies and Procedures" section of the SOW. This change would help to ensure that the person receives needed

substance use and mental health treatment where appropriate and available. Current contract language already clearly stipulates proper record keeping requirements, and this is also reflected in the oversight laid out in the revised directive.

In response to the second recommendation, we would like to emphasize that the exchange between DCFS and DSPD, is in one direction only: people come into services with DSPD from DCFS, but they do not move in the opposite direction. This leaves DSPD at somewhat of a disadvantage in responding to the recommendation for improved records during transfer because we merely receive what has been sent to us. Nonetheless, in a forthcoming draft directive on State Match, we will add language that ensures that DSPD is consistently asking for complete case records at the point of each transfer.

Finally, we would like to provide feedback to the first informal area of attention, concerning accuracy of records, because it is also a concern that we share. We believe this concern can be addressed most effectively via recommendation number 3: by leveraging OSR's feedback loop process with DSPD as its agency partner. We share the memo's concerns about accurate record keeping and log notes, but especially regarding current medications. We also believe that updating medications at the point of fatality is after the fact, and simply too late. The accuracy of this list should be verified and maintained as part of the annual contract review by OSR. DSPD does not possess a mechanism internally to ensure accuracy because we can only confirm that notes on medications are present, but not that they are up to date and accurate. OSR can verify this accuracy during their annual contract review.

Thank you.