Fiscal Year 2024

Fatality Review Summary

Utah Department of Health & Human Services

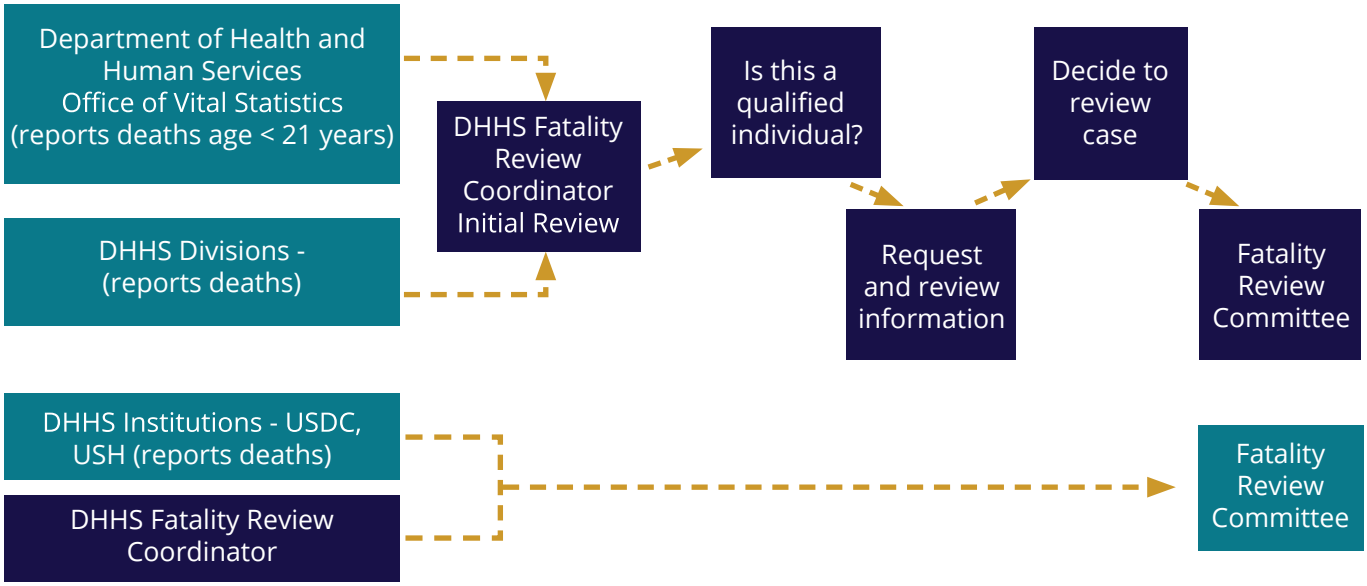
The Department of Health and Human Services (DHHS) Fatality Review Committees review cases of individuals who themselves, or a family member, had an open case with a DHHS division at the time of their death or, in some cases, within up to 12 months preceding the death.

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).

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)

Fatalities are reported and reviewed in the following manner:



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 2024
Process Improvements

During state Fiscal Year 2024, DHHS engaged systemic improvements to strengthen the fatality review process:

• Continued the case factors debriefing process 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 services to individuals.This process has been informative and has helped support recommendations for divisions.

• The case factors debriefing process has been implemented into the Division of Services for People with Disabilities.

• Continued the continuous quality feedback loop with agency partners by incorporating a quarterly collaboration meeting to review recent fatalities, demographics, and recommendation implementation.

• Implemented a quality feedback loop with committee members to improve the committee process and ensure a quality product.

• Reviewed, refined, and made all report templates uniform.

Data
and Findings

Important Note:

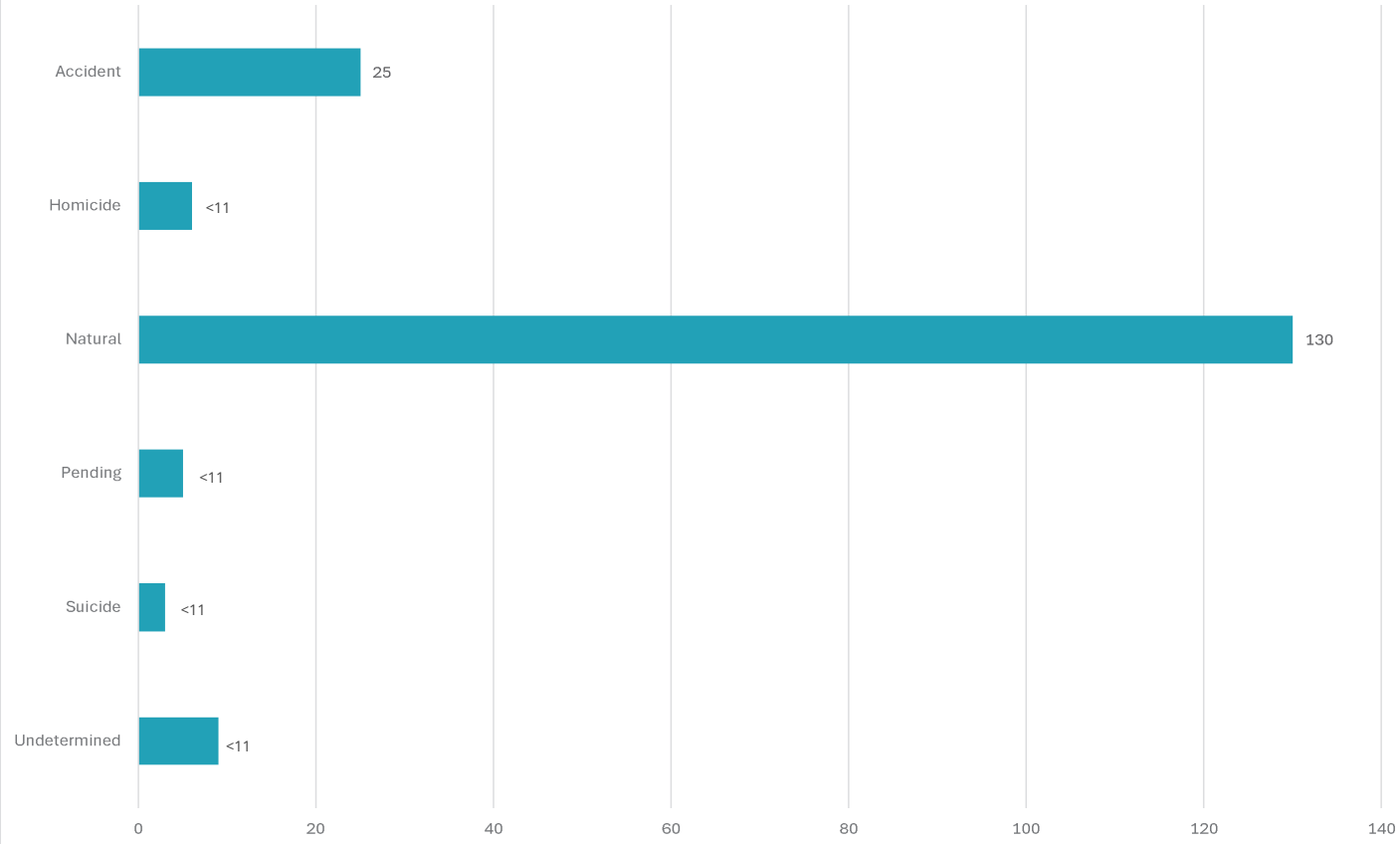
Data contained in this report reflects fatalities reviewed by the committee in FY24. However, actual deaths may have occurred in a previous fiscal year and were awaiting information.

FY 2024
Formally Reviewed Fatalities

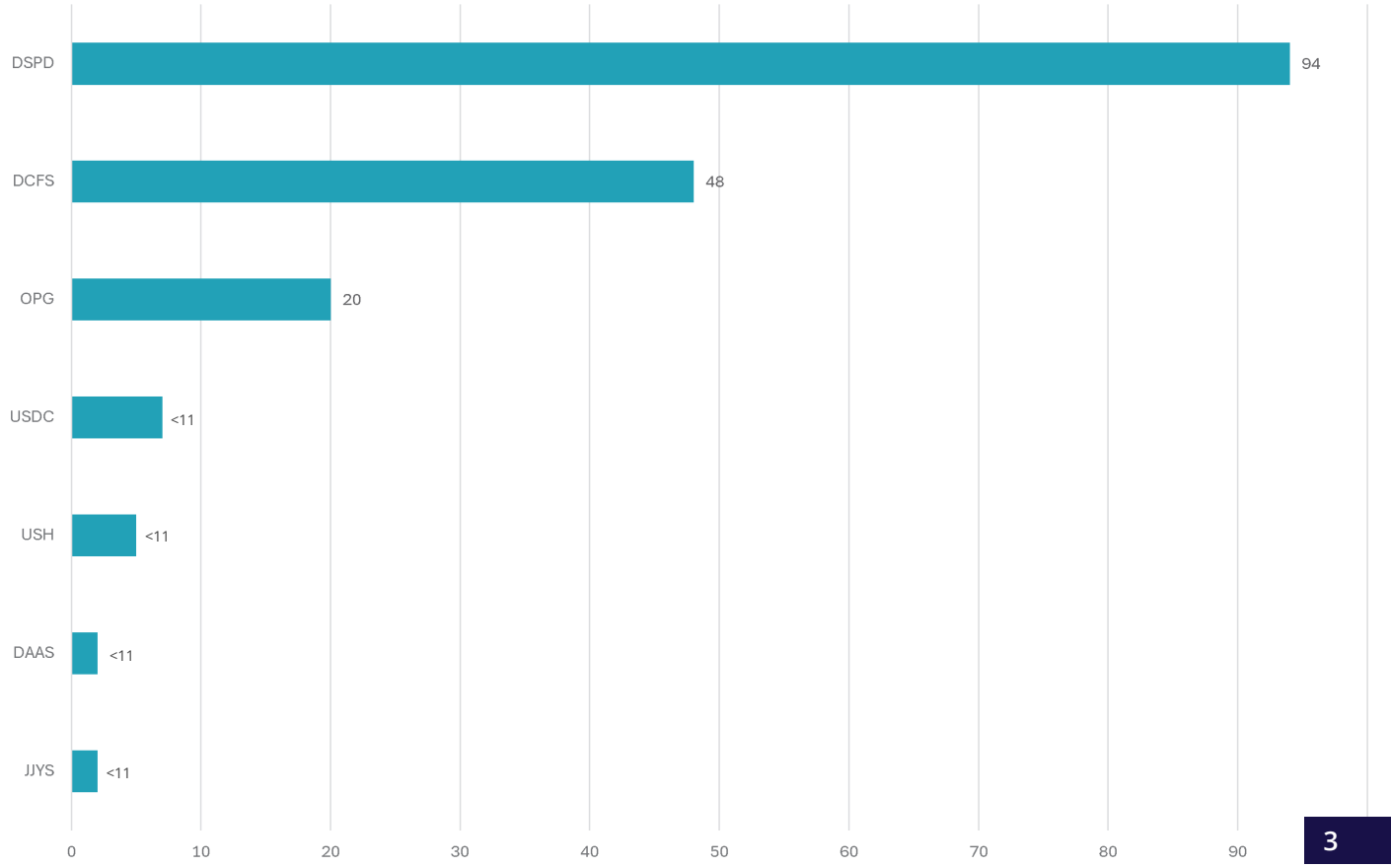
178 deaths were reported to OSR, as well as 10 near fatalities. The committee completed 124 formal reviews, including:

- 70 case factors debriefings held with case managers from DSPD, DCFS and JJYS
- All deaths 21 and younger who met statute criteria reviewed
- All DSPD-involved deaths
  - 34 DSPD formal reviews waived
- All OPG-reported deaths
- All individuals with multiple division involvement
- All USH deaths
- All JJYS deaths
- All USDC deaths
- All DAAS deaths

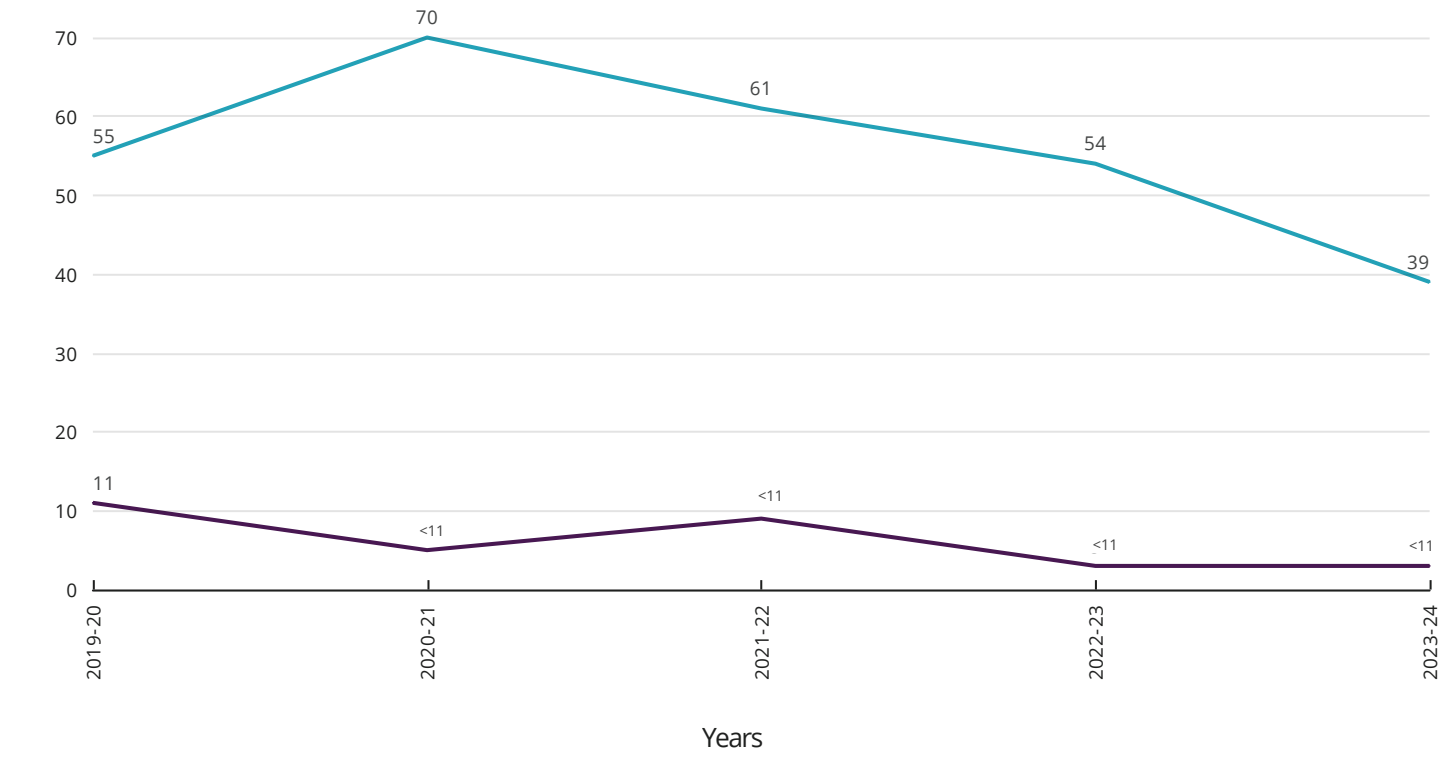
Reviewed Cases, Manner of Death Per Medical Examiner



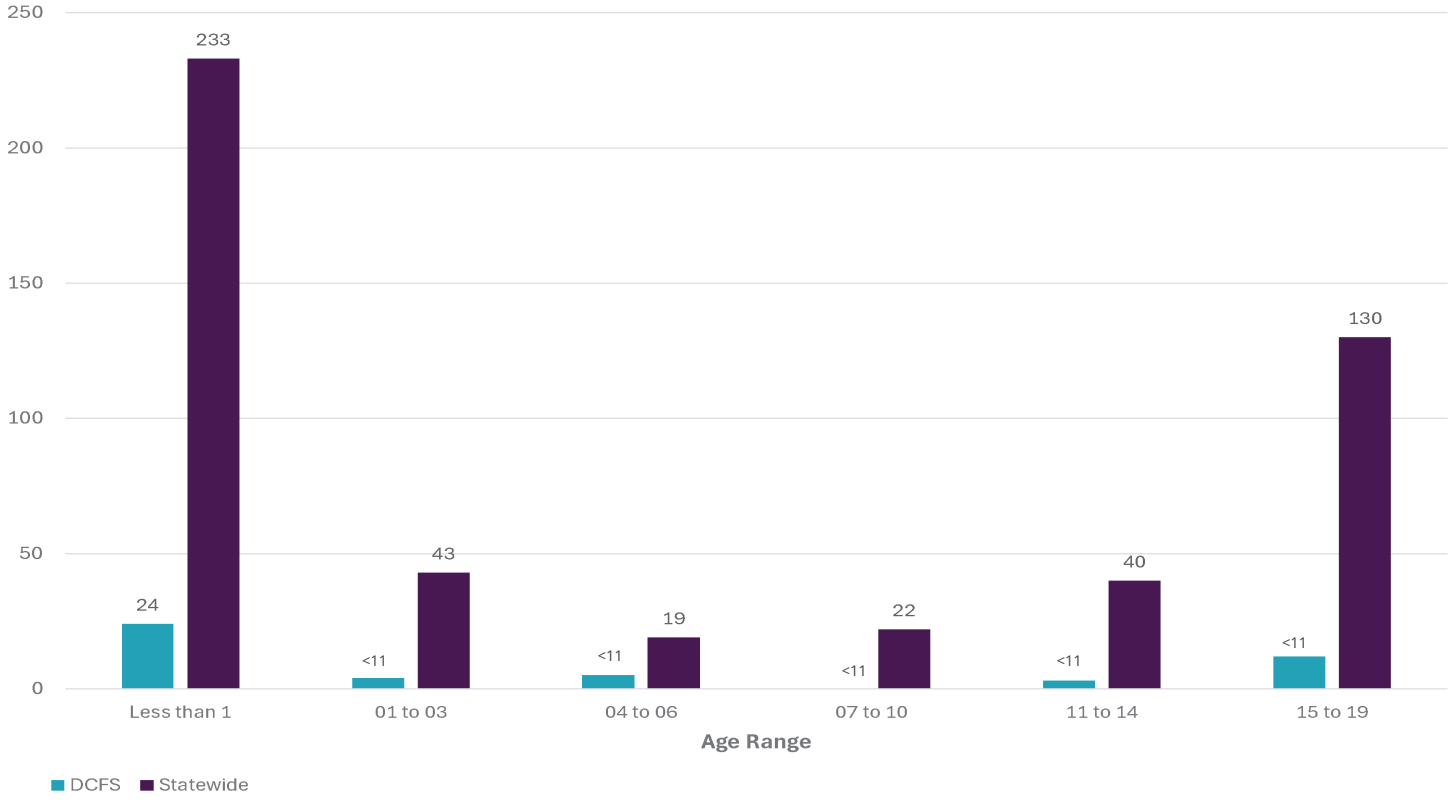
Report Deaths by Division, Total Reported Deaths: 178

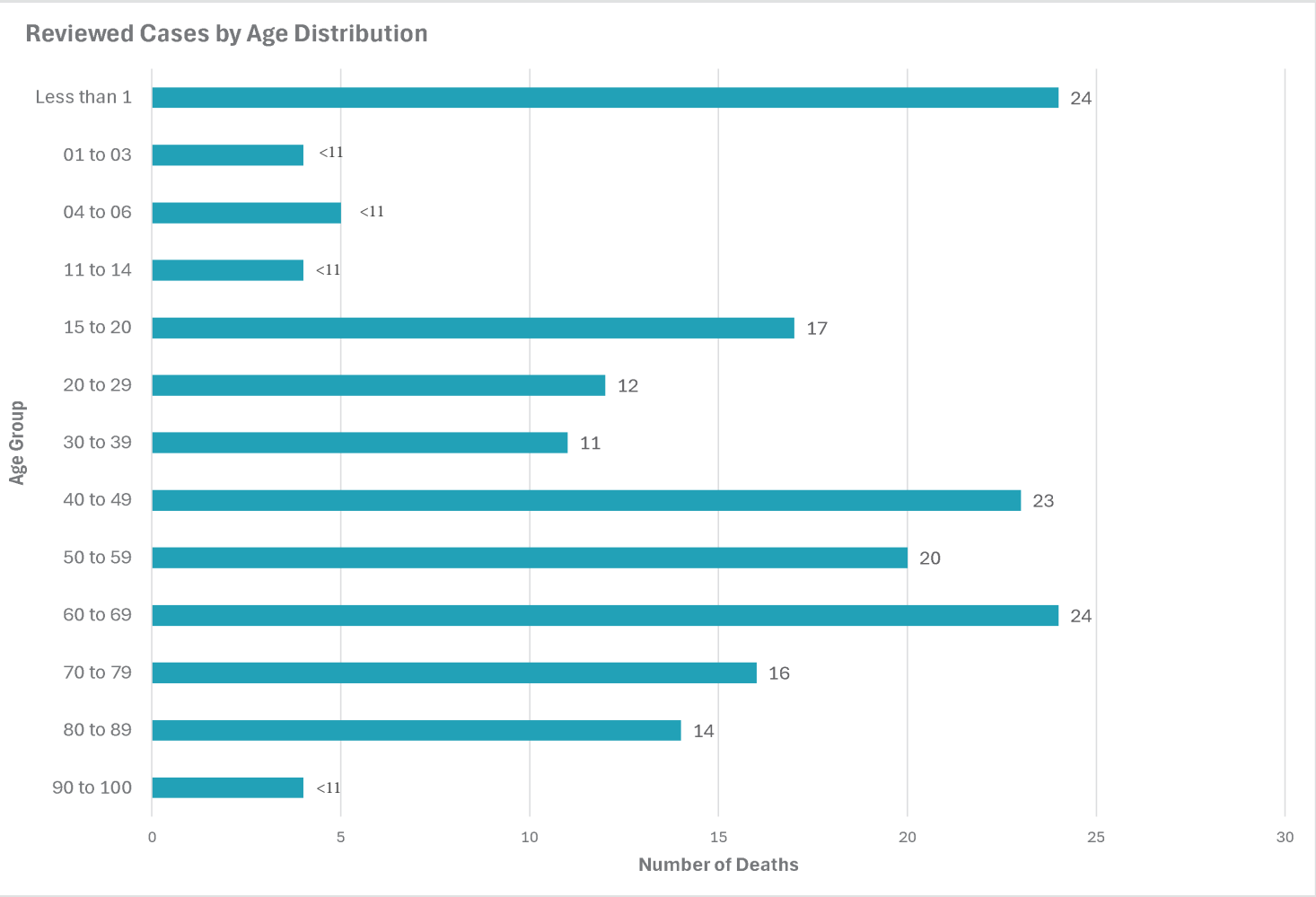


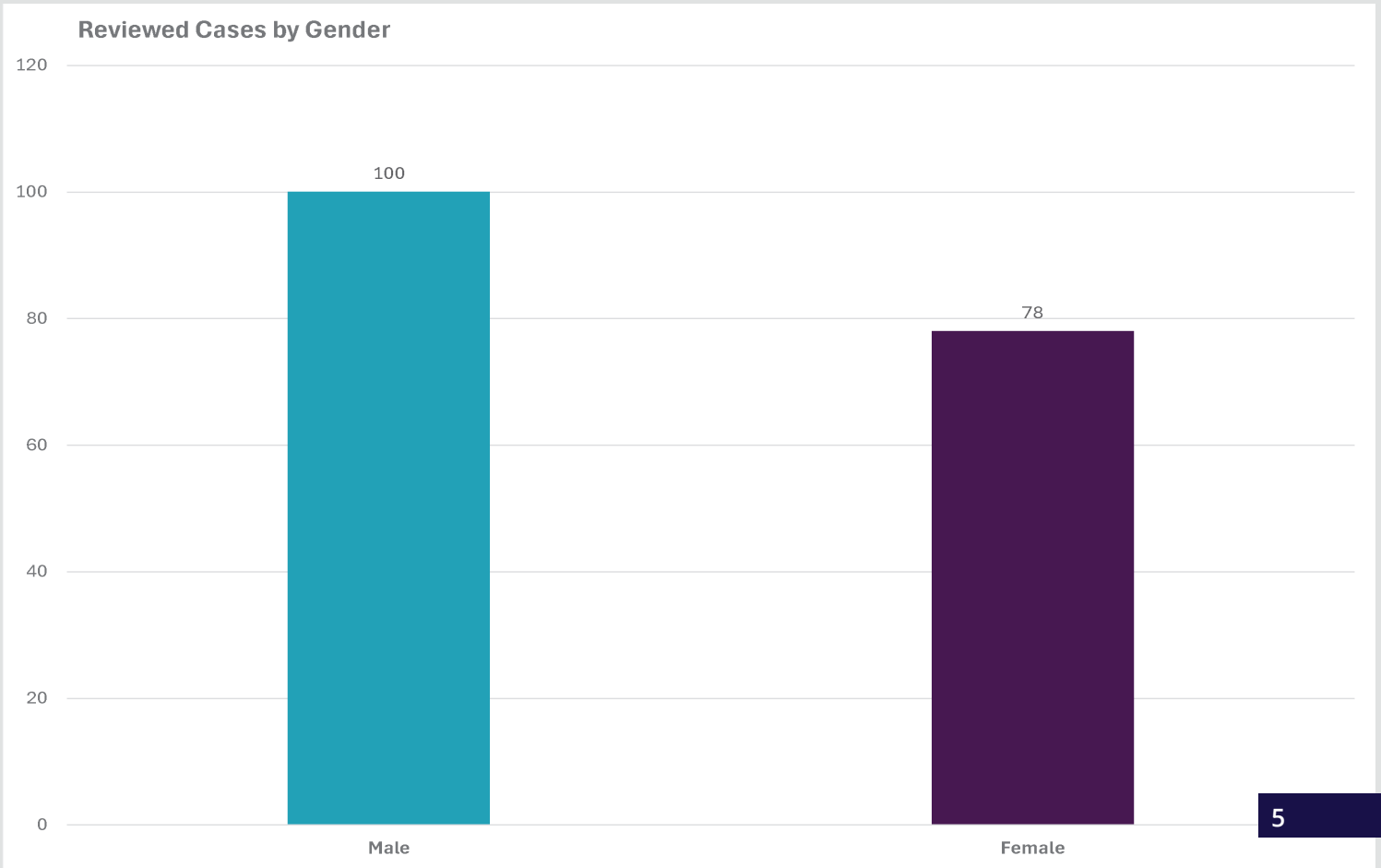
DHHS Involved and Statewide Youth Suicide Deaths for 11 - 19 Year Olds (2019 - 2023)



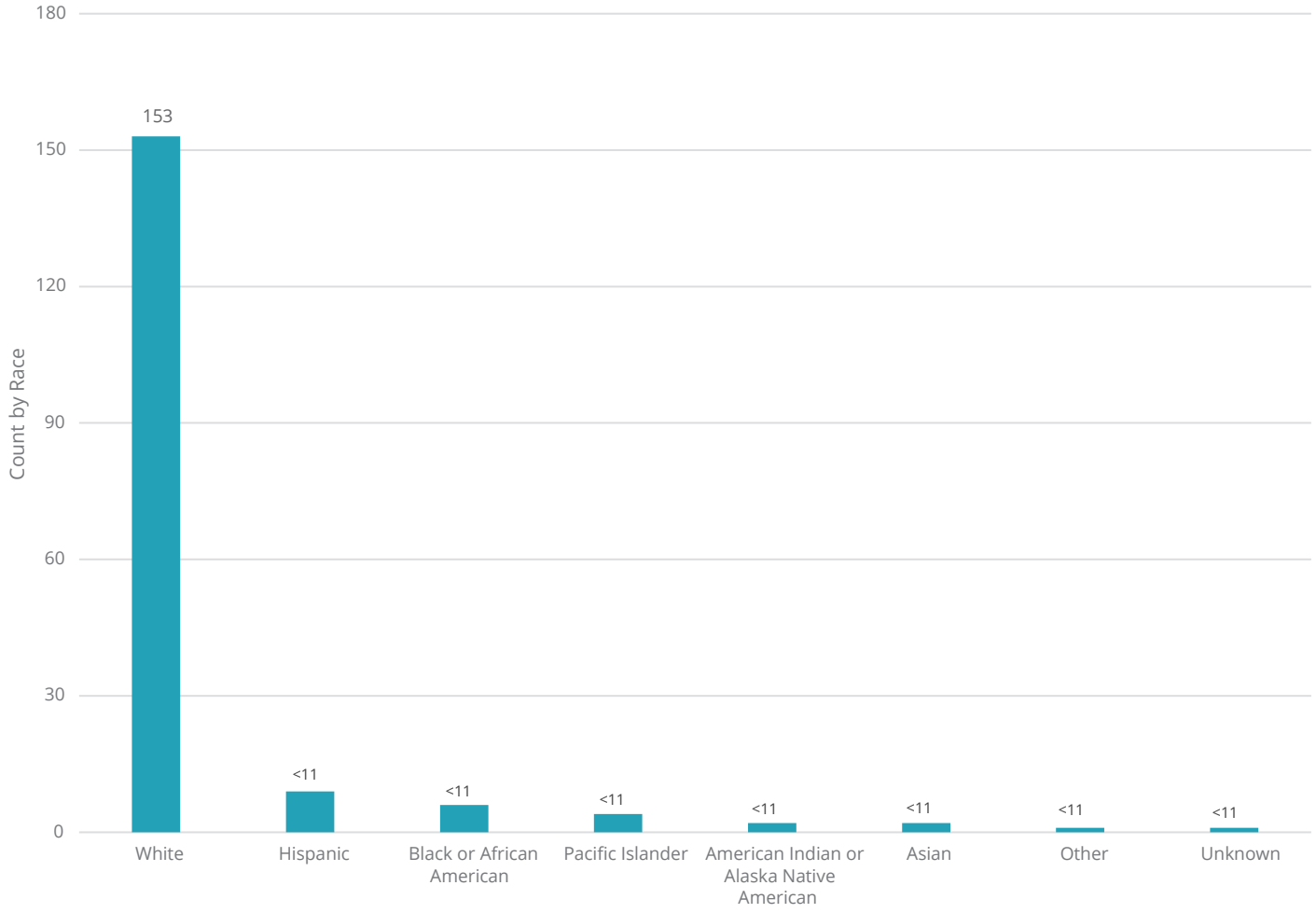
DCFS Fatalities Compared to Statewide Fatalities by Age Group




Reviewed Cases by Age Distribution
Less than 1
01 to 03
04 to 06
11 to 14
15 to 20
20 to 29
30 to 39
40 to 49
50 to 59
60 to 69
70 to 79
80 to 89
90 to 100
24
<11
<11
<11
17
12
11
23
20
24
16
14
<11
Age Group
0
5
10
15
20
25
30
Number of Deaths


Reviewed Cases by Gender
120
100
80
60
40
20
0
100
78
Male
Female

Reviewed Cases by Race



Reported COVID-19 Deaths

Recommendations for FY2024 report

1. **DHHS shall continue to develop the provider system to be able to support individuals with behaviorally complex needs.**

This was an area from one critical incident that resulted in a fatality of an individual with complex behavioral and mental health needs, as well as identified in several case factor debriefing interviews where case managers reported difficulty in finding appropriate placements due to lack of providers, or lack of experienced providers.

2. **DCFS should continue to support the voluntary case factors debriefing process as it is extremely informative.**

The case factors debriefing process is a way to help identify the systemic barriers department employees are facing. Workers are able to answer questions about the case, the critical incident and systemic barriers facing workers and service recipients.

DCFS caseworkers are currently participating at a rate of 80%, and the fatality review team would like to improve participation to at least 85%.

3. **DCFS will provide and train workers on sentinel injuries.**

This stems from one critical incident resulting in fatality. The division has recognized the need for this training and is currently developing and rolling out this training.

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Division of Continuous Quality and Improvement
Office of Service Review

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State of Utah

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Executive Director

NATE CHECKETTS
Deputy Director

DR. MICHELLE HOFMANN
Executive Medical Director

DAVID LITVACK
Deputy Director

NATE WINTERS
Deputy Director

July 31, 2024

TO: Jennifer Mendelson, Office of Services Review
FR: Tonya Myrup, DCFS Director

RE: Progress Update FY23 Fatality Recommendations

Recommendations from individual and systemic reviews include:

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.
    a. 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.

Progress update:

- DCFS is granting access to SAFE to liaisons in DSPD to further facilitate the transfer of information.
- DCFS is developing minimum communication requirements, guidance around when meetings should be held at critical junctures, and clarification on what information elements can be shared for cases that are served by DCFS and DSPD.
- The Interagency Agreement between DCFS and DSPD is being updated.

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

Progress update:

- DCFS met with Utah Foster Care to discuss the need for increased recruitment of foster homes willing to take medically fragile youth.
- Additional training will be provided to foster parents who are caring for medically fragile children.

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

Progress update:

- A consistent statewide ICPC process is already in place. All regions are working from the same expectations and administrative guidelines. Currently ICPC training for caseworkers and supervisors is optional. DCFS is making the training mandatory for all new workers and current foster care workers to help clarify the role of the region ICPC specialist, caseworker and state ICPC.
- DCFS is reinstating monthly meetings between state ICPC administrators and the region ICPC specialists to improve communication and provides regular opportunities to resolve concerns or barriers.

Sincerely,

Tonya Myrup
DCFS Director

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State of Utah

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Jul 29, 2024

DSPD is in the final stages of approval for the new inter agency agreement with DCFS. This agreement will clarify roles and improve communication between our agencies with youth in DCFS custody that enter DSPD services.

Let me know if you need additional information.

Thanks,

Marci Platt

Assistant Division Director of Programs

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