



Utah Department of
Health & Human
Services

Fiscal Year 2025

Annual Fatality Review Summary
Division of Continuous Quality and Improvement
Office of Services Review

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FY2025 Overview

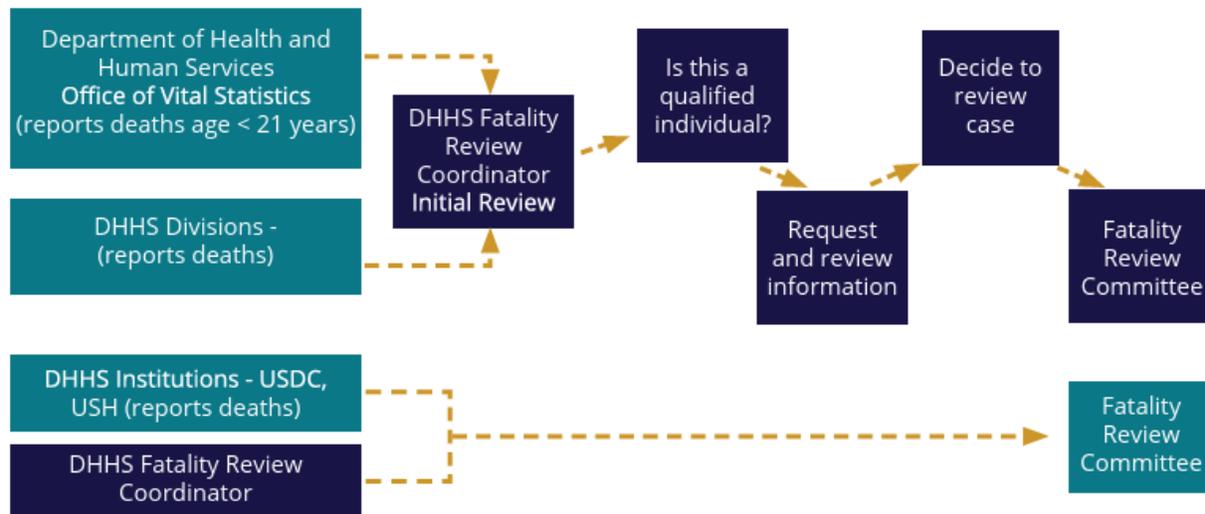
The Department of Health and Human Services (DHHS) Fatality Review Committees (Committee) review cases of individuals who had an open case with a DHHS division at the time of their death or, in some cases, within up to 12 months preceding the death.

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 Healthy Families), Attorney General's Office, 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 in review process

- **Aging and Adult Services (DAAS)**
 - **Adult Protective Services (APS)**
 - **Office of Public Guardian (OPG)**
- **Child and Family Services (DCFS)**
- **Juvenile Justice and Youth Services (JJYS)**
- **Division of Licensing and Background Checks (DLBC)**
- **Office of Internal Audit**
- **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 or modifications that could improve safety and response to client needs. The Committee reports detailed findings to the DHHS executive director, the Child Welfare Legislative Oversight Panel and the 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-1-506) requires DHHS 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

FY2025 Process Improvements

During state FY2025, DHHS engaged in systemic improvements to strengthen the fatality review process:

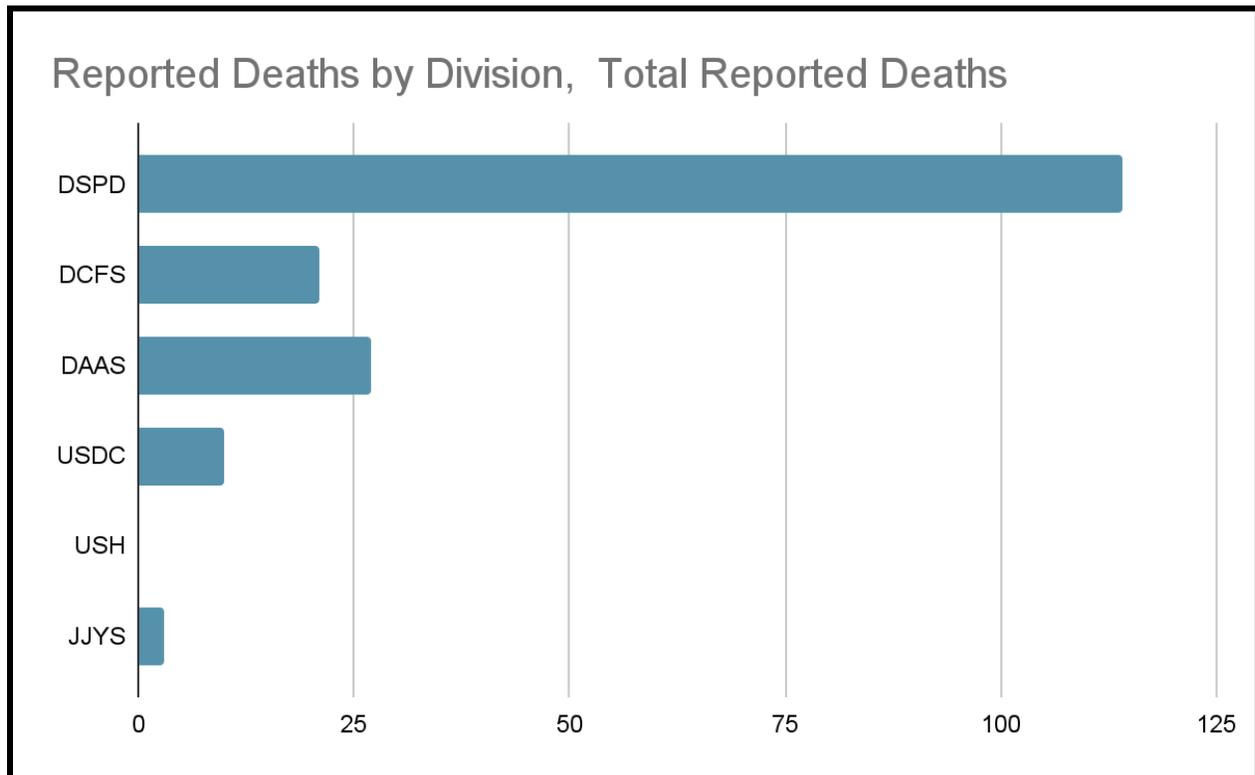
- USDC fatality review has been streamlined into one meeting, which has saved USDC staff time and improved timeliness for fatality review.
- Completed the first Office of Public Guardian (OPG) specific annual report.
- RedCap's single point fatality reporting system was refined and is in use by all department agencies.
- DSPD case factors debriefing process was refined and improved. The process was used during the entire fiscal year with 97% participation.
- Implemented plan for FY2026 to conduct case factors debriefing process with DSPD providers and guardians from the Office of Public Guardian (OPG).
- Recommendation to DSPD regarding Do Not Resuscitate Orders (DNR) was implemented and added to provider contracts by the agency.

FY2025 data and findings

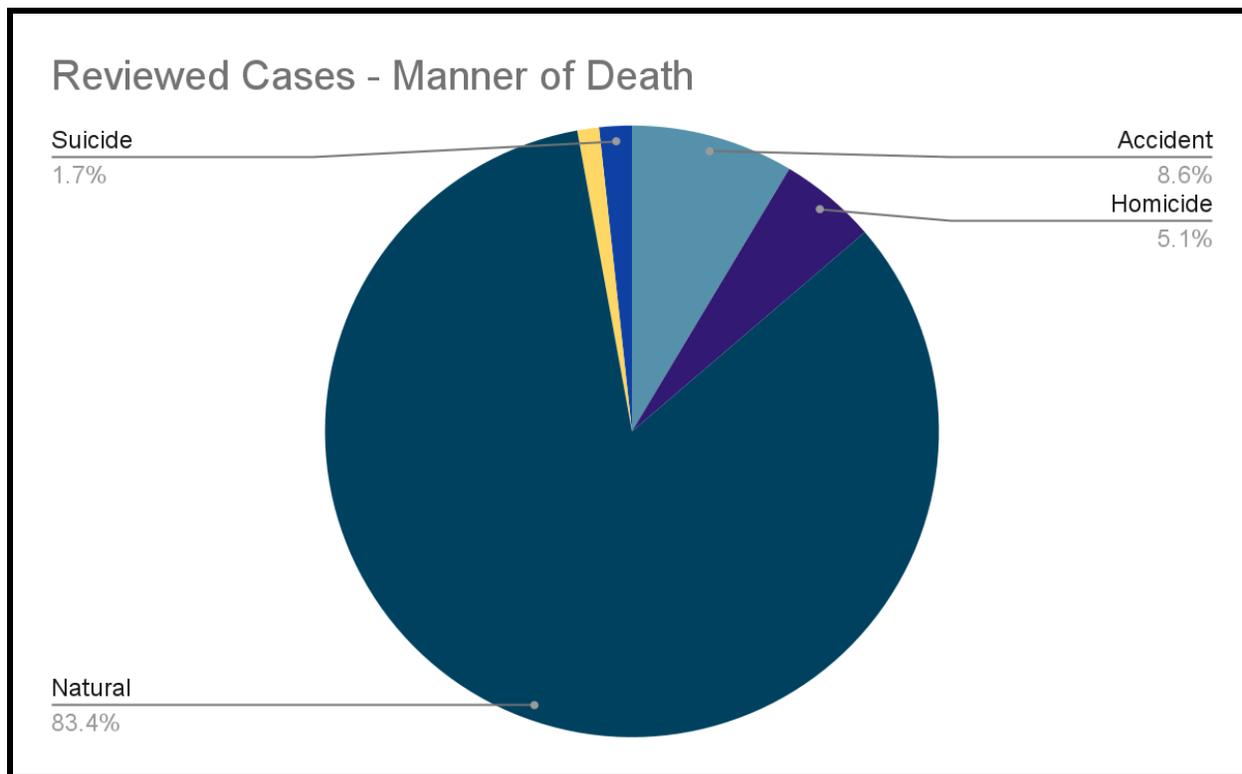
FY2025 formally reviewed fatalities

181 deaths and near fatalities were reported to OSR.

- The committee completed 116 formal fatality reviews.
- 102 case factors debriefings held with case managers from DSPD, DCFS, and JJYS
- All deaths for ages 21 and younger that meet statute criteria reviewed
- 75 DSPD-involved deaths formally reviewed
 - 39 DSPD formal reviews waived
- All individuals with multiple division involvement
- All USH deaths
- All JJYS deaths
- All USDC deaths
- All DAAS qualifying deaths

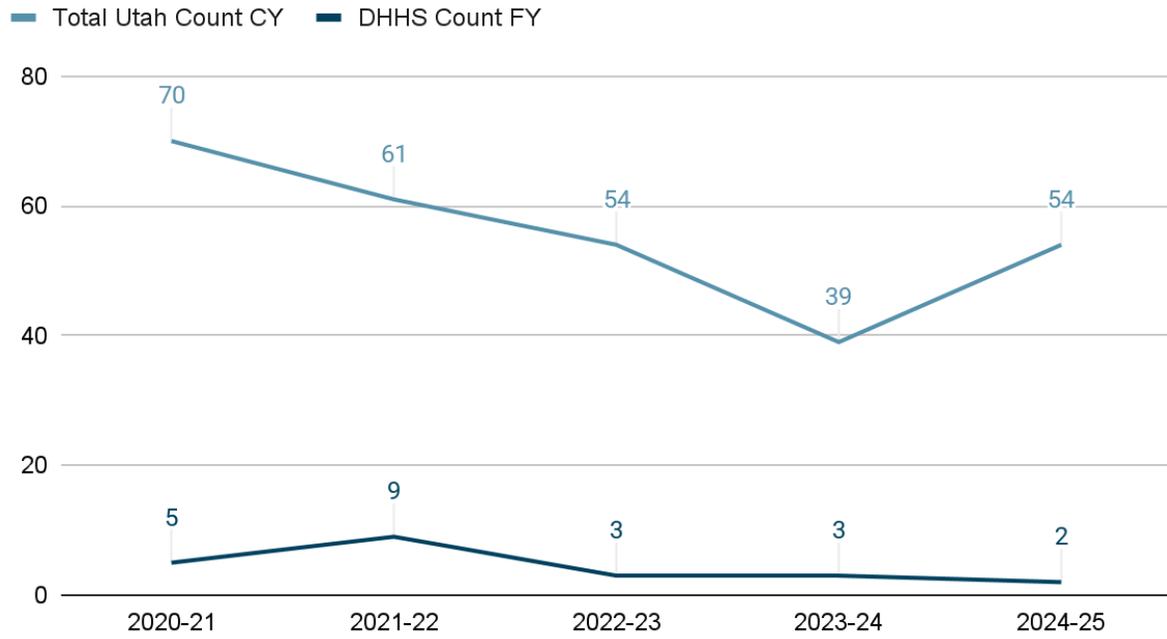


FY2025 fatality review graphs

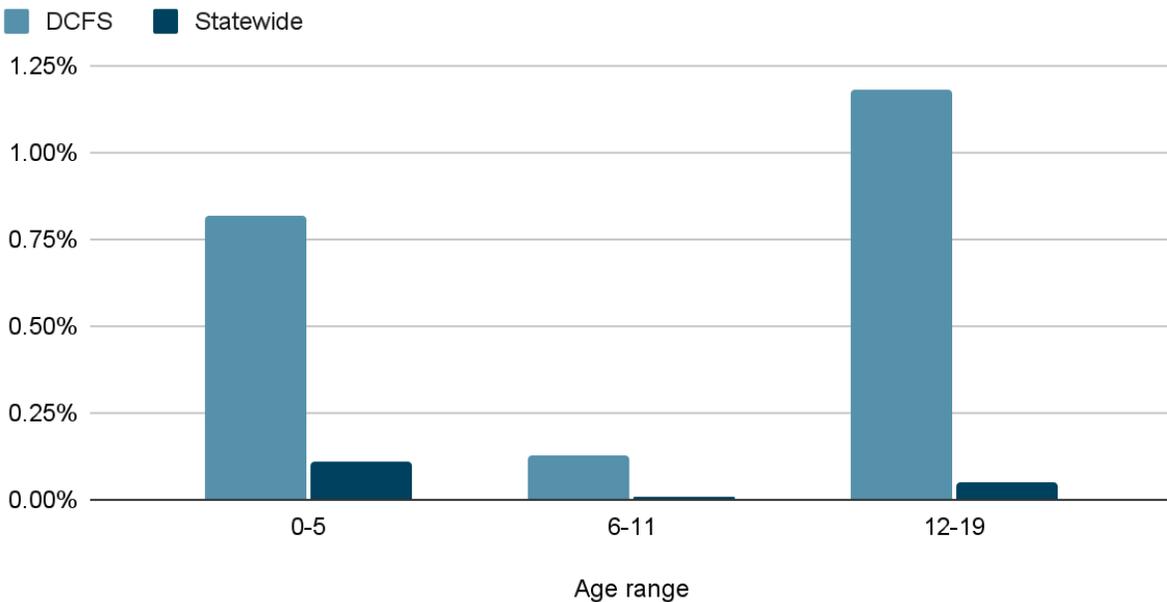


Pending/Undetermined >1%

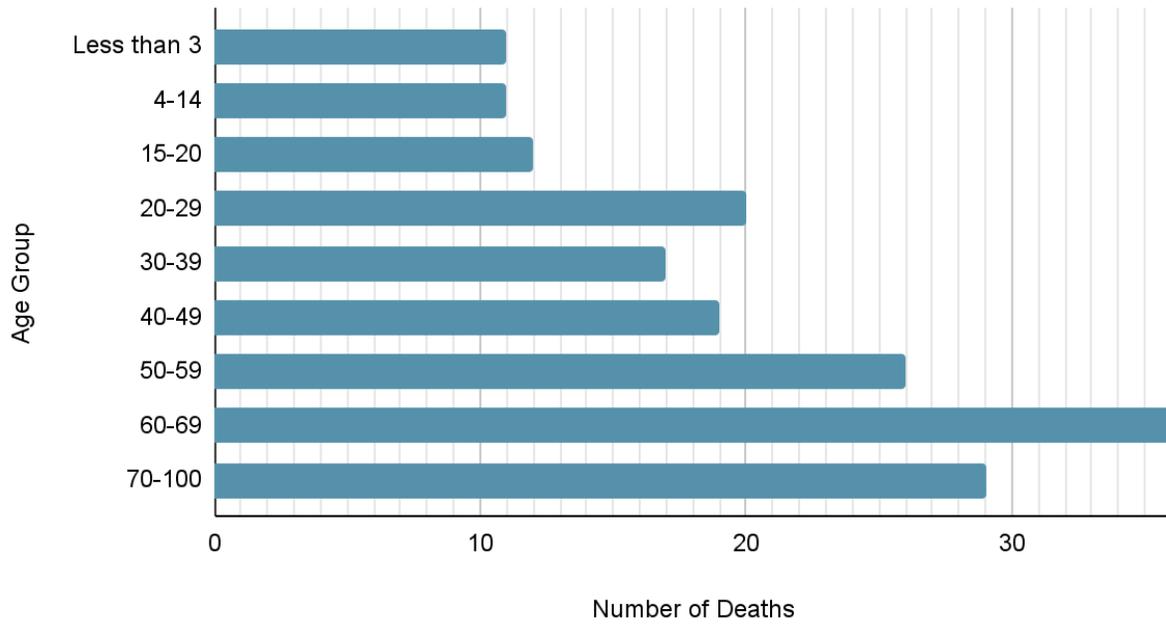
DHHS Involved and Statewide Suicide Deaths - juvenile (2020-2024)



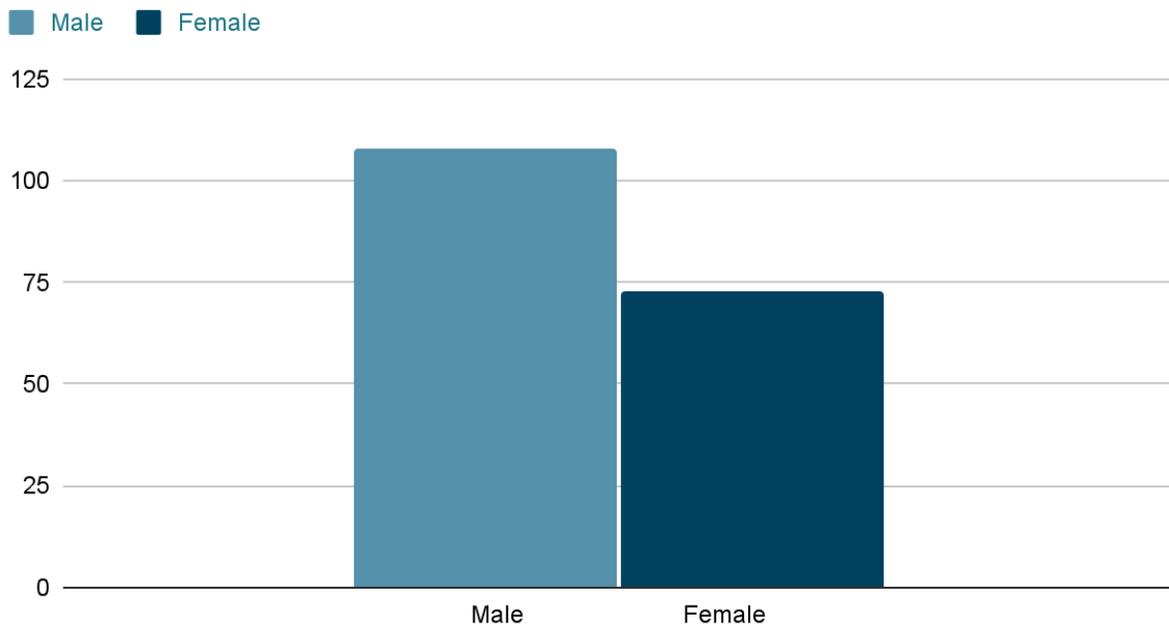
Child Fatalities in Utah: a comparison of DCFS served children (FY2025) and the General Child Population for calendar year 2024



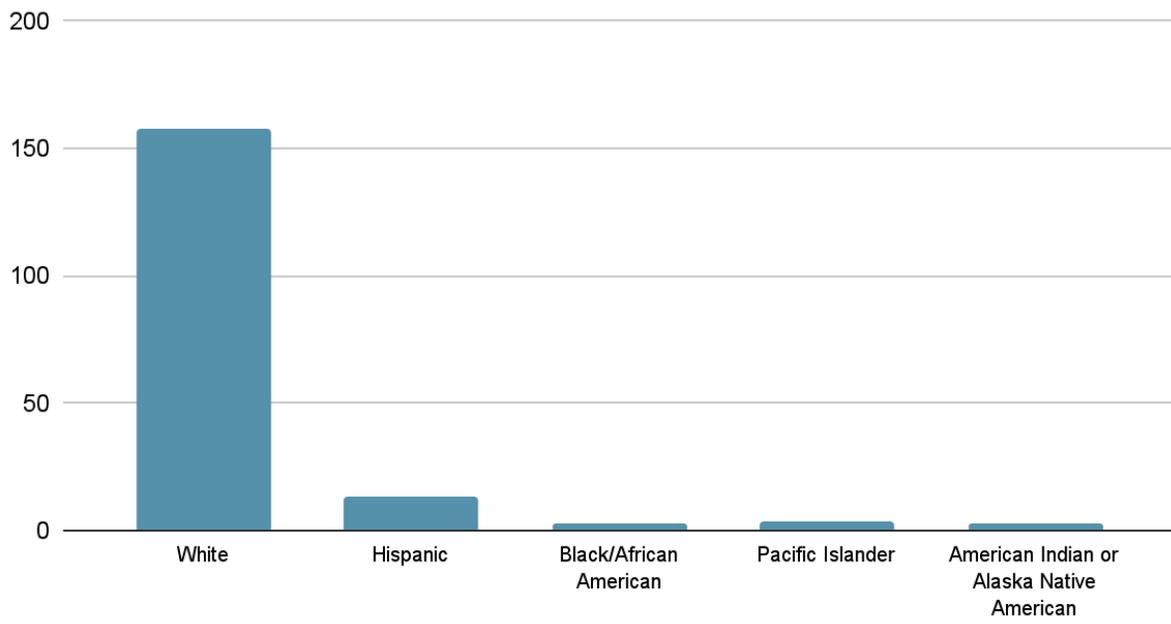
Reviewed Cases by Age Distribution



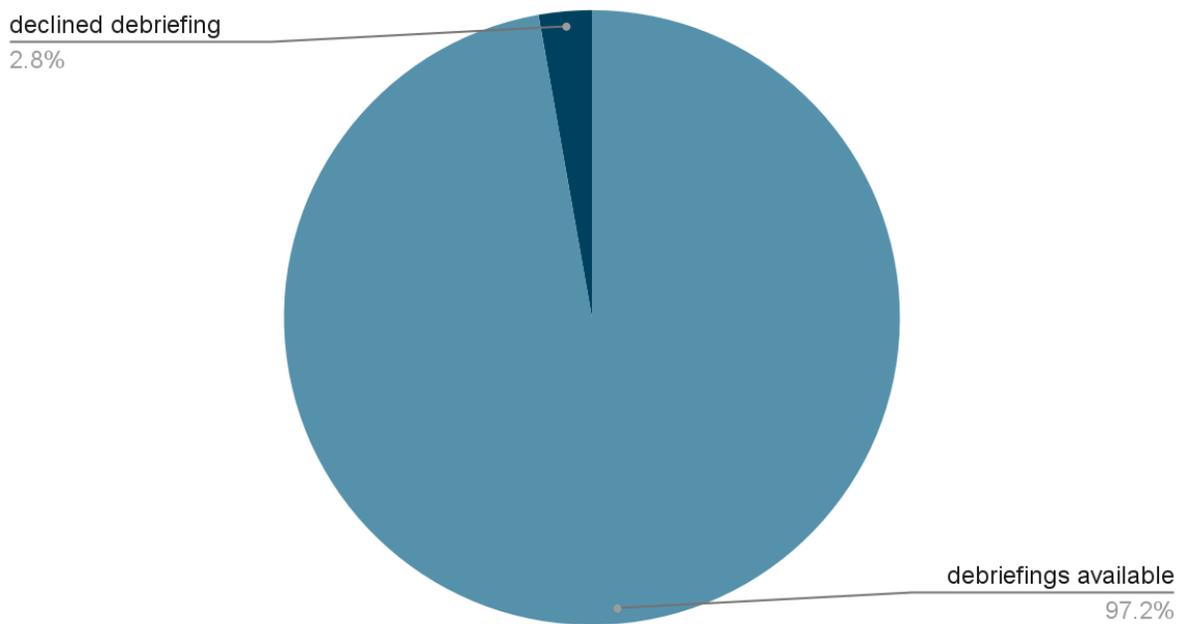
Reviewed Cases by Gender



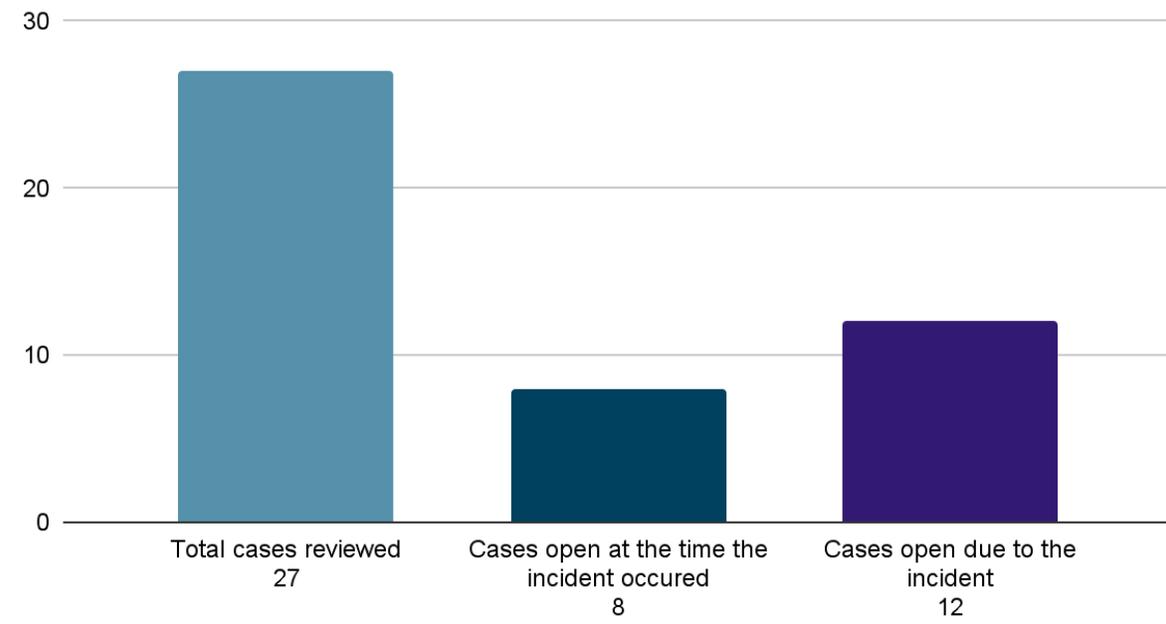
Reviewed Cases by Race



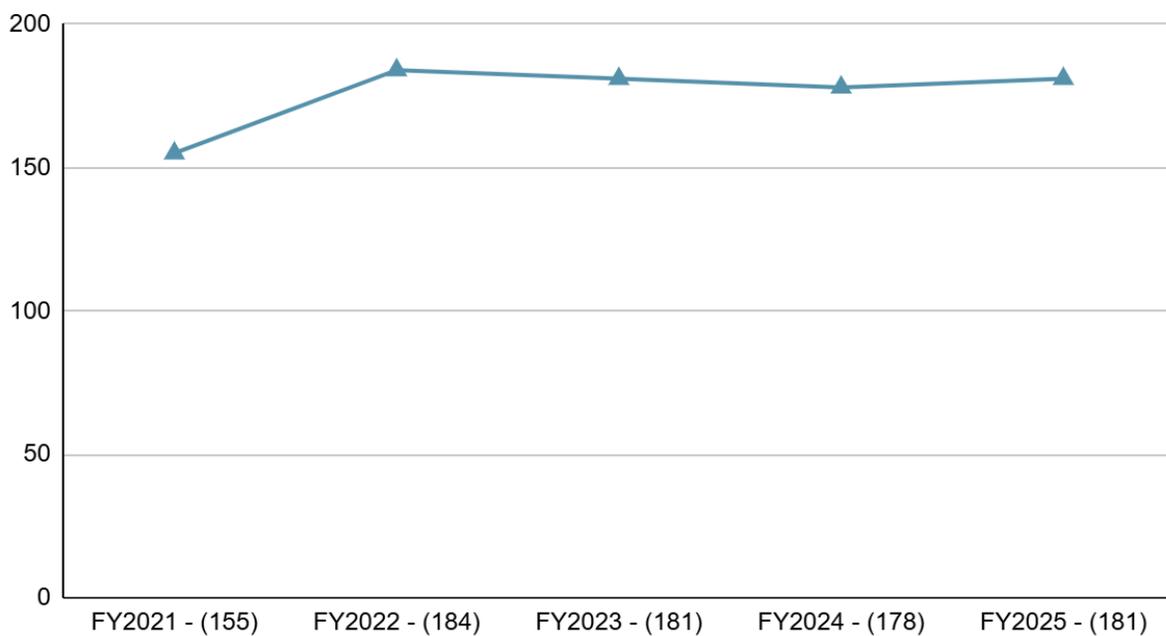
Case Factors Debriefing



DCFS involvement



Fatalities reviewed 5-year trend



Division of Licensing and Background Checks

Utah Code 26B-1-507, states that the fatality review executive summary shall include action taken by the Division of Licensing and Background Checks (DLBC) in response to the near fatality or the death of a qualified individual. The Division of Licensing and Background Checks investigates a fatality or near fatality of an individual if the individual was residing in a licensed site at the time.

- 34 fatalities in a licensed setting were reviewed by DLBC
- Action was taken against 2 providers in the form of having “non-compliance” issued to the facility.

FY2025 Recommendations

1. The fatality review committee has identified a gap in the oversight of online K-12 education services for students residing in Utah. While online learning has become an increasingly essential and viable option for many families across the state, current oversight mechanisms administered by the Utah State Board of Education (USBE) may not be sufficient to ensure child welfare protections for students enrolled in these programs. Many Utah students are now enrolled in full-time or part-time online educational programs offered through public school partnerships, and out-of-state providers. Teachers and school staff are often the first to notice signs of maltreatment and are trained to report suspected abuse to the authorities, however, the fatality committee found that there does not appear to be a standardized, comprehensive system for monitoring attendance and engagement tracking, and student well-being.

The committee respectfully recommends the Utah Legislature review the oversight requirements for online education programs serving Utah students, specifically, the fatality review committee recommends evaluating the following:

- A. Equitable access to support services, including special education, counseling, and intervention resources, regardless of a student's mode of instruction.
- B. Regular face-to-face check-ins between students and school personnel.

- C. Requirements for students to be present on camera during classroom instruction.
2. The fatality review committee recommends that DHHS review statute to bring USDC fatality review expectations into alignment with requirements for Utah State Hospital (USH) fatality reviews.
3. The fatality review committee recommends that DSPD strengthen protocol and contract to address situations where an emancipated adult becomes incapacitated and is unable to make end-of-life decisions.

Follow-up on FY2024 recommendations

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

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

Outcome:

DHHS continues to identify and recruit new providers for all levels of care.

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%.

Outcome: DCFS formed a committee to meet with the fatality review team and improve this measure. Case workers participated at a rate of 96.3%.

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.

Outcome:

DCFS implemented a training on sentinel injuries in conjunction with a training on safety planning that was provided to all employees in FY2025. In addition, DCFS is adding an additional sentinel injury training that will be added to the Results Based Accountability (RBA) plan in FY2026 for monitoring.