

State of Utah

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Division of Child and Family Services



Child Abuse Prevention and Treatment Act (CAPTA) Plan

June 30, 2011

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INTRODUCTION

In compliance with the CAPTA Reauthorization ACT of 2010, Public Law 111-320, this document presents the Child Abuse Prevention and Treatment Act (CAPTA) Plan for the State of Utah, Department of Human Services, Division of Child and Family Services (DCFS). In it, DCFS identifies program goals and objectives as well as future initiatives that will aid the division as it strives to increase the safety and wellbeing of children and families in the State of Utah.

This plan integrates and is consistent with goals and objectives outlined in the 2009-2012 Child and Family Services Plan (CFSP) and the FFY 2011 Annual Progress and Services Report (APSR), the year-two report outlining achievements relating to goals and objectives outlined in the CFSP. The CAPTA Plan has also been coordinated with, and is consistent with the 2009-2011 Family Violence Prevention and Services Act (FVPSA) Plan, the FFY 2011 Community-Based Child Abuse Prevention Plan, and the agency's Program Improvement Plan (PIP), which is being developed to respond to conclusions resulting from the agency's Child and Family Services Review (CFSR), held the week of June 21, 2010.

To provide data support to staff, DCFS operates and maintains the SAFE Management Information System (its SACWIS database) that tracks client identifying information as well as services delivered to children and families. Data presented in this plan were obtained through the SAFE database.

Involvement of Agencies, Organizations, and Individuals in Planning

The development and sharing of goals, objectives, and activities included in this plan took place at the Annual Quality Improvement Committee Summit (held December 1, 2010). During that meeting, participants discussed the agency's progress toward meeting former goals and objectives and voiced their support for activities currently taking place or that will take place in the future. A sample of agencies involved in that summit is listed below.

Agencies Represented at the 5th Annual Quality Improvement Summit		
Administration on Children and Families (ACF)	ACYF Region VIII Regional Office	Carbon County School District
Casey Family Programs	Christmas Box House International	Court Appointed Special Advocates Office (CASA)
Department of Human Services Executive Director's Office	Department of Human Services Office of Services Review	Department of Human Services Division of Child and Family Services
Fostering Healthy Children's (FHC) Program	Foster Parents	Department of Human Services Division of Juvenile Justice Services
Northern Region Quality Improvement Committee	Office of the Guardian Ad-Litem	Primary Children's Hospital Safe and Healthy Families Program
Salt Lake County Division of Youth Services	Sevier County	State of Utah Administrative Office of the Courts
Statewide Quality Improvement Committee	South Main Foster Care Clinic	University of Utah
Utah Foster Care Foundation	Utah House of Representatives	Utah Juvenile Court
Utah Pride Center	Western Region Quality Improvement Committee	

Distribution

This document will be distributed to the following agencies or individuals:

- Executive Director-Department of Human Services
- Regional Administrator-Administration on Children and Families
- Child and Family Program Specialist for Utah-Administration on Children and Families
- Native American tribes located within the State of Utah

It will also be available to other interested parties at their request.

Description of Agency

The State of Utah Department of Human Services (DHS) is responsible for the administration of programs and services provided using funding authorized by Titles IV-B, IV-E, and XX of the Social Security Act. The department has designated the Division of Child and Family Services (DCFS) as the agency responsible for implementing and providing direct oversight of Title IV-B and Title IV-E programs and child welfare and domestic violence services delivered to Utah's children and families. As such, DCFS administers the federal CAPTA Plan.

The division, the lead child welfare agency for the State of Utah, provides services throughout the State of Utah. The division is responsible for agency planning, legislative matters, implementation and coordination of federally funded programs, policy development, information system development and maintenance, as well as overall management of division programs and services.

Vision, Mission, and Practice Model Principles

Vision

Safe Children, Strengthened Families

Mission Statement:

To keep children safe from abuse and neglect and provide domestic violence services by strengthening families and working with communities.

Practice Model

Practice Model Principles guide staff as they strive to achieve the agency's vision and meet its mission. They are consistent with child and family services principles specified in federal regulations [45 CFR 1355.25(a) through 1355.25(h)].

Principle One - Protection. Children's safety is paramount; children and adults have a right to live free from abuse.

Principle Two - Development. Children and families need consistent nurturing in a healthy environment to achieve their developmental potential.

Principle Three - Permanency. All children need and are entitled to enduring relationships that provide a family, stability, belonging, and a sense of self that connects children to their past, present, and future.

Principle Four - Cultural Responsiveness. Children and families are to be understood within the context of their own family rules, traditions, history, and culture.

Principle Five - Partnership. The entire community shares the responsibility to create an environment that helps families raise children to their fullest potential.

Principle Six - Organizational Competence. Committed, qualified, trained, and skilled staff, supported by an effectively structured organization, help ensure positive outcomes for children and families.

Principle Seven - Professional Competence. Children and families need a relationship with an accepting, concerned, empathetic worker who can confront difficult issues and effectively assist them in their process toward positive change.

Practice Skills

A set of key Practice Skills has been formulated from the Practice Model Principles and are designed to "Put Our Values Into Action." These basic skills are:

Engaging. The skill necessary to effectively establish a relationship with children, parents, and individuals that work together to help meet a child or family's needs or resolve child welfare related issues.

Teaming. The skill that workers use to assemble, become a member of, or lead a group or groups that supply needed support, services and resources to children or families and that help resolve critical child and family welfare related issues. Child welfare is a community effort and requires a team.

Assessing. The skill that enables workers to obtain information about salient events and underlying causes that trigger a child or family's need for child welfare related services. This discovery process helps children and families identify issues that affect the safety, permanency, or wellbeing of the child, helps children and families discover and promote strengths they can use to resolve issues, determines the child or family's capacity to complete tasks or achieve goals, and ascertains a family's willingness to seek and utilize resources that will support them as they try to resolve their issues.

Planning. The skill that workers use to identify and design incremental steps that help move children and families from where they are to a better level of functioning. During the planning cycle a worker:

- Helps children or families make decisions about what programs, services, or resources they want to use to meet their needs,
- Helps children and families evaluate the effectiveness of their decisions,
- Helps children and their families rework or revise their service delivery plan,
- Helps children and families celebrate successes when they occur, and,
- Helps children and families face consequences when their plan fails to achieve the desired results.

The outcome of the planning process is the development of a unique service delivery plan tailored to the needs of the individual child or family.

Intervening. The skill used to intercede when a child or family's interactions, activities, or behaviors fail to decrease risk, provide safety, promote permanency, or assure the wellbeing of a child. This skill is utilized when helping families find housing, when helping a parent change negative patterns of thinking about their children, or when helping members of a family change their relationship with each other.

Practice Standards

Following are general practice standards that cross program boundaries. Together with practice principles and skills these standards will help caseworkers understand their roles and responsibilities. Standards will give guidance to caseworkers as they provide services and strive to achieve safety and permanence for each child and family member they help.

A. Service Delivery Standards.

1. Children and families will receive individualized services matched to their strengths and needs as assessed by the Child and Family Team.
 - (a) Prevention services help resolve family conflicts and behavioral or emotional concerns before there is a need for the family to become deeply involved in the child welfare system.
 - (b) In a family where abuse has already occurred, interventions will be developed with the goal of preventing any future incidents of abuse. Services provided to children and families will respect their cultural, ethnic, and religious heritage.
2. Services provided to children and families will respect their cultural, ethnic, and religious heritage.
3. Services will be provided in the home-based and neighborhood-based settings that are most appropriate for the child or family's needs.
 - (a) Services will be provided in the least restrictive, most normalized setting appropriate.
4. Meaningful child and family participation in decision-making is vitally important, and all children and family members shall have a voice (as developmentally appropriate) in influencing decisions made about their lives, to the level of their abilities, even when specialized communication services are required.
 - (a) Children and families will be actively involved in identifying their strengths and needs, and in matching services to identified needs.
5. In whatever placement is deemed appropriate siblings should be placed together. When this is not possible or appropriate, siblings should have frequent opportunities to visit each other.
6. When an out of home placement is required, children should be placed in close proximity to their family with frequent opportunities to visit.
7. When children are placed in an environment outside of their parent's home, they must be provided with educational opportunities and, where developmentally appropriate, vocational opportunities with the goal of becoming self-sufficient adults.
8. Children receiving services shall receive adequate, timely medical and mental health care that is responsive to their needs.

B. Standards Relating to Child and Family Teams.

1. Working within the context of a Child and Family Team is the most effective way to identify and provide services to children and families.
2. Whenever possible, critical decisions about children and families, such as service plan development and modification, removal, placement, and permanency, will be made by a team to include the child and his or her family, the family's informal helping systems, out of home caregivers, and formal supports.
3. Child and Family Teams should meet face to face periodically to evaluate assessments, case planning, and services delivered, and also to track progress. When there are domestic violence issues, separate Child and Family Team Meetings may be held (refer to Domestic Violence Practice Guidelines [Section 600](#).)

C. Standards Relating to Assessments.

1. Strengths-based assessments should be produced with attention to:
 - (a) The family's underlying needs and conditions.

(b) Engaging the family in developing interventions that address the threats of harm, the protective capacities of the family, and the child's vulnerability.

D. Standards Relating to Planning.

1. Children and/or their family members shall be involved in the planning process. The plan will be adapted and changed as the case evolves. The Child and Family Plan:

- (a) Incorporates input from the family, formal, and informal supports.
- (b) Identifies family strengths.
- (c) Utilizes available assessments.
- (d) Identifies services that address the family's needs and includes specific steps and services that assist the family in achieving safety, permanency, and the child's wellbeing.
- (e) Anticipates transitions.
- (f) Addresses safety for both child and adult victims.
- (g) Identifies permanency goals, including a concurrent permanency goal and plan.

Management

The Division Director is the administrative head of the division and is physically located in the state administrative headquarters in Salt Lake City, Utah.

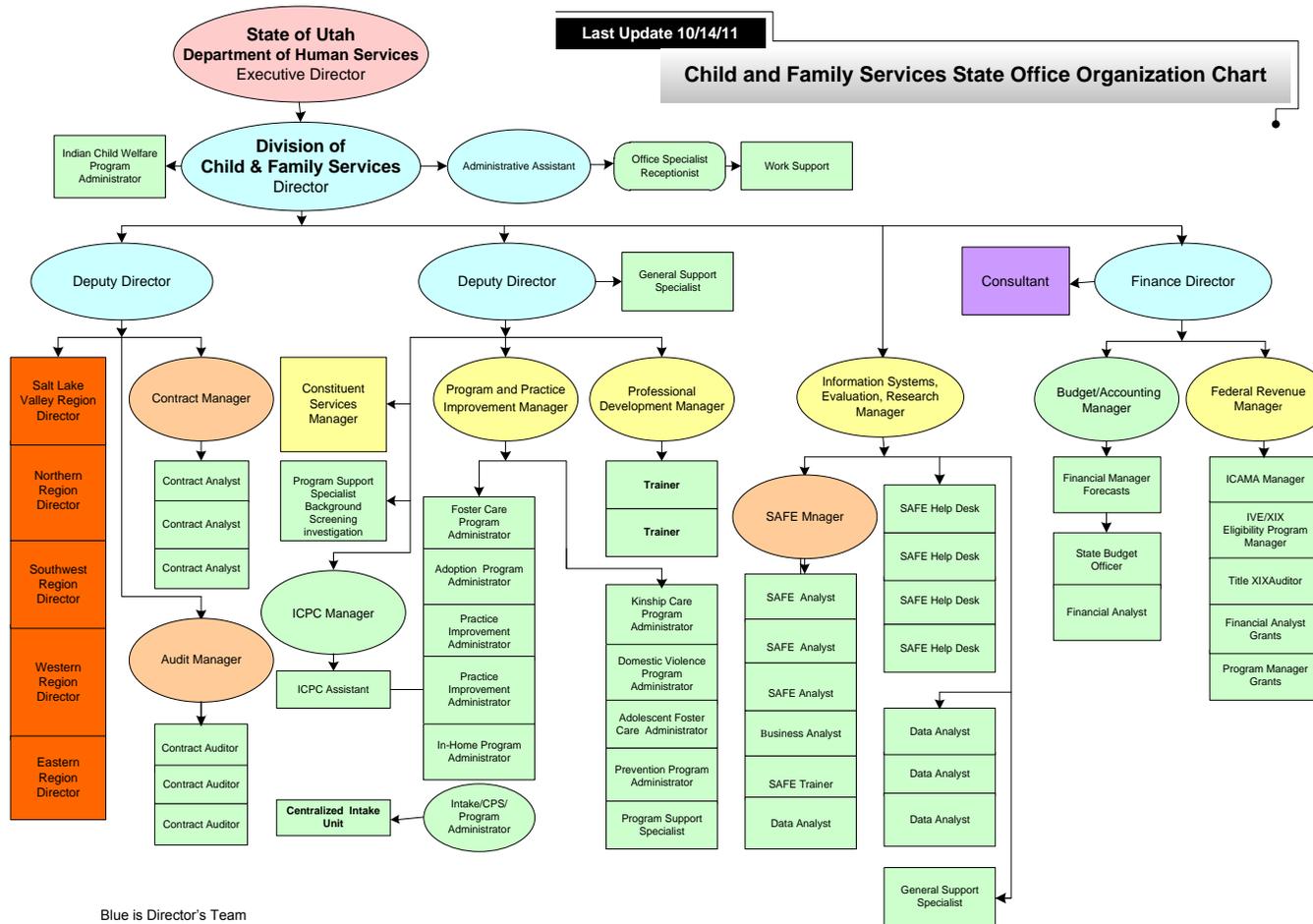
Three administrative teams coordinate activities and make policy decisions that guide agency programs and services. First, The Division Director is supported by and supervises the Director's Team, which includes the two Deputy Directors, the Finance Director and the Director's Administrative Assistant. This team meets weekly to review the division's financial status and coordinate state office activities with those being conducted through the regions.

Second, the DCFS Administrative Team is comprised of the Executive Team, the Information Systems, Evaluation, and Research Manager, Program and Practice Improvement Manager, Professional Development Manager, Federal Revenue Manager, and the Constituent Services Manager. It is the body that has primary responsibility for overseeing state office operations and for overall planning, budgeting, decision-making, and communications for the division. This group meets twice monthly to conduct the business of the division.

Third, the State Leadership Team (SLT) comprised of DCFS Administrative Team and the five Regional Directors, meets twice monthly and is responsible for oversight of statewide operations.

One Deputy Director directly supervises the Professional Development Manager who oversees all training activities and supervises state office staff that develop and deliver training. That manager also provides support to regional trainers that provide training to new and existing workers. The Professional Development Team also develops and provides training to community partners on their responsibility to report child abuse and neglect as well as the process partners should follow to report abuse and neglect.

Organization Chart

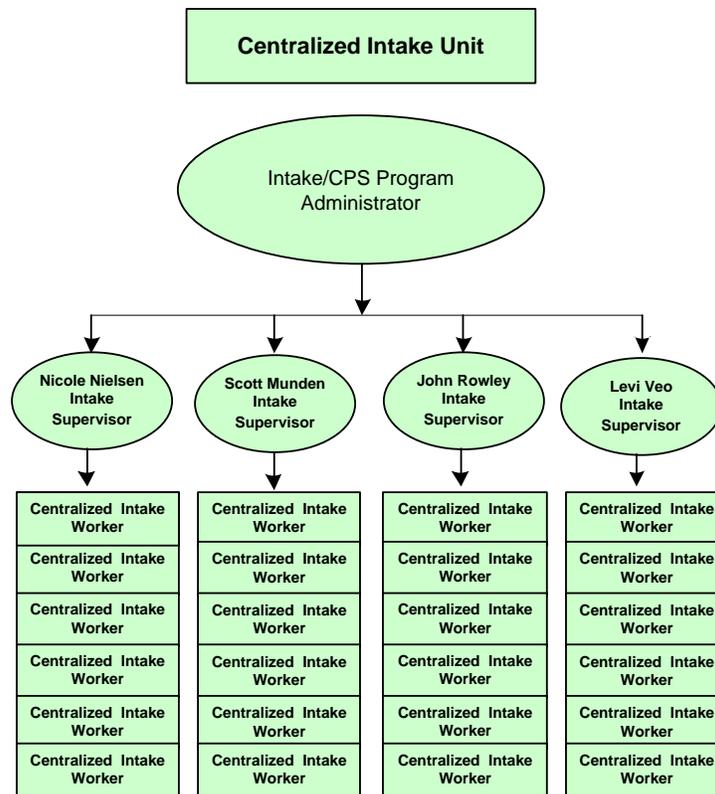


Blue is Director's Team
 Blue and Yellow and Tan Represent the State Office Management Team
 Blue, Yellow and Orange Represent the State Leadership Team
 Circles Represent Supervisors
 Arrow's define supervision path

Last Update 10/14/11

Child and Family Services State Office Organization Chart





The same Deputy Director supervises the Program and Practice Improvement Manager who in turn supervises the Intake/CPS Program Administrator. The Intake/CPS Program Administrator oversees the CPS Centralized Intake Unit and directly supervises four Intake Supervisors. Each Intake Supervisor manages the activities of six Intake Workers that provide 24-hour a day coverage.

Regional Directors, located in five geographically defined regions lead their regional administrative teams and are responsible for the region’s budget, personnel, inter-agency partnerships, and service delivery. Region Directors supervise Program Administrators that oversee services delivered to individual communities through one of several DCFS offices within each region. These Program Administrators direct CPS Supervisors who in turn manage CPS caseworkers that are responsible for researching and investigating allegations.

DCFS Regions and Counties They Serve	
Eastern Region	Carbon, Daggett, Duchesne, Emery, Grand, San Juan, Uintah Counties
Northern Region	Box Elder, Cache, Davis, Morgan, Rich, Weber Counties
Salt Lake Valley Region	Salt Lake, Tooele Counties
Southwest Region	Beaver, Garfield, Iron, Kane, Piute, Sanpete, Sevier, Washington, Wayne Counties
Western Region	Juab, Millard, Summit, Utah, Wasatch Counties

CHILD PROTECTIVE SERVICE-SERVICE DELIVERY PROCESS

During normal business hours the Intake Worker located in Centralized Intake assigns the case to a pre-identified supervisor located in an office within a region. That supervisor is then responsible for assigning the case to one of their caseworkers.

A Priority 1 response is assigned only if there is an imminent threat to the safety and wellbeing of a child as determined by the Intake checklist. Intake has no more than 30 minutes from the completion of the initial contact from the referent to gather additional information, staff the referral to determine the priority, notify law enforcement, and assign to the CPS caseworker.

For a Priority 1 response, the CPS supervisor or caseworker has a maximum of 60 minutes from the moment the Intake Worker notifies them to make face-to-face contact with an alleged victim. For a priority 1R (rural) referral, a CPS caseworker has a maximum of three hours if the alleged victim is more than 40 miles from the investigator assigned to make the face-to-face contact.

A Priority 2 response is assigned when physical evidence is at risk of being lost or the child is at risk of further abuse, neglect, or dependency, but the child does not have immediate protection and safety needs, as determined by the Intake checklist. In this case the Intake Worker has no more than 60 minutes from the completion of the initial contact from the referent to gather additional information, determine the priority, assign the referral to the CPS supervisor, and notify law enforcement.

For a Priority 2 response, the CPS caseworker has 24 hours from the moment Intake notifies the supervisor or caseworker responsible for making face-to-face contact with the alleged victim. A Priority 3 response is assigned when potential for further harm to the child and the loss of physical evidence is low. The Intake Worker has no more than one working day from the completion of the initial contact to gather additional information, research data sources, determine the priority, staff the referral, complete documentation including data entry, and notify law enforcement.

For a Priority 3 response, the CPS caseworker has until midnight of the third working day from the moment the Intake Worker assigns the case to make the face-to-face contact with the alleged victim.

Each region has on call workers that cover after hours and holidays. After business hours, if an Intake Worker determines a case is Priority 3, it is assigned as normal to the CPS supervisor. If the Intake Worker accepts a Priority 2 case that requires an immediate response, the intake worker calls the on call worker and provides them with the appropriate information.

To revitalize the division's safety model DCFS entered into a contract for the development of a safety decision-making model with the Children's Research Center (CRC). This model will

permeate the child welfare system. The model provides for greater safety by focusing on the decisions that affect immediate safety and longer term risk to children.

Intake begins the process by completing a safety-screening tool. This tool will most likely become the child abuse and neglect report document. This tool guides workers as they decide whether or not to accept the case, determine the allegation type, determine if there is imminent risk, and designate a priority assignment for each CPS case accepted.

CPS staff will be required to complete a safety assessment which ultimately determines whether the child is 1) Safe; 2) Conditionally Safe; or 3) Unsafe. Once those determinations have been made, the worker must take action (i.e. if unsafe, the child must be removed, or some alternative arrangement made, before leaving the site).

CPS staff will also be required to complete a risk assessment as part of their CPS case. The tool evaluates a variety of concerns and needs which are weighted to determine a risk "score." This assessment is used to rate (low, moderate, high and very high) the level of service needed. From those determinations, the worker will refer the family to either community services or to internal DCFS services. Based on the level of risk, this assessment also determines the level of contact required between DCFS and the family.

CHILD PROTECTIVE SERVICE-SERVICES

Population Served

The mission of the Child Protective Services Program is to prevent the occurrence or recurrence of child abuse, neglect, dependency, or exploitation of children in the State of Utah. Utah Code 78A-6-105 defines abuse and neglect as:

Abuse" means:

- (i) nonaccidental harm of a child;
- (ii) threatened harm of a child;
- (iii) sexual exploitation; or
- (iv) sexual abuse.

"Abuse" does not include:

- (i) reasonable discipline or management of a child, including withholding privileges;
- (ii) conduct described in Section 76-2-401; or
- (iii) the use of reasonable and necessary physical restraint or force on a child:
 - (a) in self-defense;
 - (b) in defense of others;
 - (c) to protect the child; or
 - (d) to remove a weapon in the possession of a child for any of the reasons described in Subsections (1)(b)(iii)(A) through (C).

"Neglect" means:

- (i) abandonment of a child, except as provided in Title 62A, Chapter 4a, Part 8, Safe Relinquishment of a Newborn Child;
- (ii) lack of proper parental care of a child by reason of the fault or habits of the parent, guardian, or custodian;
- (iii) failure or refusal of a parent, guardian, or custodian to provide proper or necessary subsistence, education, or medical care, or any other care necessary for the child's health, safety, morals, or well-being; or
- (iv)
 - (a) child at risk of being neglected or abused because another child in the same home is *neglected or abused*.
 - (b) The aspect of neglect relating to education, described in Subsection (25)(a)(iii), means that, after receiving a notice of compulsory education violation under Section **53A-11-101.5**, or notice that a parent or guardian has failed to cooperate with school authorities in a reasonable manner as required under Subsection **53A-11-101.7(5)(a)**, the parent or guardian fails to make a good faith effort to ensure that the child receives an appropriate education.
 - (c) A parent or guardian legitimately practicing religious beliefs and who, for that reason, does not provide specified medical treatment for a child, is not guilty of neglect.
 - (d) (I) Notwithstanding Subsection (25)(a), a health care decision made for a child by the child's parent or guardian does not constitute neglect unless the state or other party to the proceeding shows, by clear and convincing evidence, that the health care decision is not reasonable and informed.
 - (II) Nothing in Subsection (25)(d)(i) may prohibit a parent or guardian from exercising the right to obtain a second health care opinion.

Geographic Areas in Which Services are Provided

Staff members located in the agency's five regions deliver CPS services statewide.

Services Provided

CPS Allegations/Supported Cases							
	Number of Cases	Number of Supported Cases	Number of Unsupported Cases	Without Merit	False Report	Unable to Complete Investigation	Unable to Locate
FFY '07	20254	8460	10628	302	10	425	429
FFY '08	19902	8171	10604	284	29	421	393
FFY '09	20538	8473	11060	241	10	356	398
FFY '10	20046	8341	10715	267	20	350	353

Supported Cases by Age

Victim's Age	FFY '09 Number	FFY '09 Percent of Total Cases	FFY '09 Percent of Utah Population	FFY '10 Number	FFY '10 Percent of Total Cases	FFY '10 Utah Population
0-5 years	5263	41%	33%	5416	42%	39%
6-10 years	3440	27%	23%	3435	27%	27%
11-13 years	1763	14%	13%	1767	14%	16%
14-17 years	2285	18%	17%	2222	17%	18%
18+ years	15	0%	14%	23	0%	n/a
Total	12710	100%	100%	12823	100%	

Race of Victims

Race	FFY '09 Number	FFY '09 Percent of Total	FFY '09 Utah Population	FFY '09 Number	FFY '09 Percent of Total	FFY '09 Utah Population (Ages 0-17)
African American	519	4%	2%	524	4%	2%
American Indian/ Alaska Native	390	3%	2%	360	3%	2%
Asian				267	2%	1%
Pacific Islander	337	3%	3%	125	1%	1%
Caucasian	11607	90%	94%	11690	91%	94%
Other/Unknown	6	0%		20	0.00%	
Cannot determine	100	1%				
Total	12959	100%		12986		
Hispanic or Latino Origin	2955	23%	11%	2968	23%	21%

CPS is the most likely entry point for services that provide for the safety and wellbeing of a child and family. Child Protective Services (CPS) provides for the receipt of reports of possible abuse, neglect, or dependency, the investigation of such reports, determination of initial risk to a child, determination of need for ongoing in-home services or referral, and provision of an out of home placement when removal of a child from home is necessary. Specific activities performed by CPS caseworkers include:

- Intake and processing of initial allegations of abuse and neglect
- Completing assessments
- Conducting interviews
- Contributing to team consultations/staffings
- Coordinating services to children and caregivers including ensuring timely medical attention is provided when a child has experienced trauma caused from severe maltreatment, serious physical injury, recent sexual abuse, fetal addiction, medical neglect, or any exposure to a hazardous environment, including those involving illegal drug/chemical production
- Performing courtesy casework on behalf of another worker or another state
- Documentation of all casework activities.

GOALS AND OBJECTIVES RELATED TO PROGRAM AREAS SELECTED FOR IMPROVEMENT

Program Area 1-Intake, assessment, screening, and investigation of reports of abuse and neglect

In FFY 2010-2011 DCFS replaced its system of regional CPS referral units with a Centralized Intake Unit. The Centralized Intake Unit reports directly to the Intake/CPS Program Administrator in the State Office in Salt Lake City. In FFY 2011, a building was selected and all necessary data systems, telephones, and furnishings installed. Four intake workers were hired along with twenty-three Intake Workers. As of June 13, 2011 all regions had converted to the new system and the Centralized Intake Unit is now answering all calls.

Program Area	Inputs	Goal/Objective	Baseline	Process/Outcomes Measure	Time-Frame	Person(s)/ Group(s) Responsible	Achievements
1-Intake, assessment, screening, and investigation of reports of abuse and neglect.	CPS Team Administration Agency Partners Information Systems, Research, and Evaluation Team	A. Monitor and evaluate the CPS Central Intake system, which is expected to maximize agency efficiencies and provide better outcomes for children that are the subject of an allegation of child abuse or neglect.	90% of Intake referrals are completed within the prescribed timeframe	90 % success as reported in the CPS Priority Timeframe Report located in the DCFS Quarterly Report. Predominantly positive comments from surveys and focus groups.	Ongoing	Program and Practice Improvement Team	
		I. Develop data management tools, and collect data, and disseminate reports that outline Centralized Intake’s ability to meet requirements relating to their ability to meet timelines for delivery of allegations to region staff, completion of SAFE documentation, and other requirements that have a time restriction attached.					
		II. Develop and implement tools to survey administrators, supervisors and workers regarding their opinions regarding the efficacy of services provided through Centralized Intake					
		III. Hold focus groups to include Intake Workers, CPS Supervisor, other regional staff, and community partners to address further concerns, solutions, and next steps.					

Program Area 2-Creating and improving the use of multidisciplinary teams and interagency, intra-agency, interstate, and intrastate protocols to enhance investigations; and improving legal preparation and representation, including- procedures for appeals of substantiated reports of abuse and neglect; and provision for the appointment of an individual appointed to represent a child in judicial proceedings.

DCFS works with state legislators to develop legislation that results in new statutes, or revises exiting statutes that guide child welfare services in the State of Utah. In response to state or federal statutes and guidelines DCFS develops new, or revises existing, Administrative Rules, Practice Guidelines, and other policy and practice regulations that help the agency meet the changing needs of children and families.

Program Area	Inputs	Goal/Objective	Baseline	Process/Outcomes Measure	Time-Frame	Person(s)/Group(s) Responsible	Achievements
2-Creating and improving the use of multidisciplinary teams and interagency, intra-agency, interstate, and intrastate protocols to enhance investigations; and improving legal preparation and representation, including- procedures for appeals of substantiated reports of abuse and neglect; and provision for the appointment of an individual appointed to represent a child in judicial proceedings	State Legislators ACYF Program and Practice Improvement Team Administration Region Administration Legal Partners	B. Develop new, revise current, and publish Statutes, Administrative Rules, Practice Guidelines, and other policy or practice guidelines that support CPS intake, investigation, court proceedings, or other activities that assure the protection and wellbeing of children involved in the child welfare system.		Statutes, Administrative Rules, and Practice Guidelines are current and meet the needs of the children and families served.	Ongoing	DCFS Administrative Team	
		I. Revise the child abuse and neglect definitions in state statute so they are consistent with findings of supported allegations of abuse or neglect.	Current definitions		June 30, 2012		
		II. Develop or revise Practice Guidelines as needed that support Centralized Intake.	Current Practice Guidelines		Ongoing		
		III. Develop or revise Practice Guidelines or Administrative Rules to assure that seamless services are provided from the time a child or family enters the system through CPS to the time the child and family exits the system.	Current Practice Guidelines		Ongoing		

Program Area 4-Enhancing the general child protective system by developing, improving, and implementing risk and safety assessment tools and protocols

DCFS uses best practices and evidence-based program models to provide services to children and families. In FFY 2009, a workgroup (comprised of Child and Family Services staff, Directors of the Attorney General's Child Protection Division and the Guardian Ad-Litem's office, as well as a public defender) was formed to oversee the development and implementation of a Structured Decision-Making Model. In FFY-2010 DCFS signed a contact with the Children's Research Center (CRC) which requires them to collaborate with the workgroup in their effort modify the CRC model so that practices and tools are consistent with Utah statute and CPS Practice Guidelines.

Program Area	Inputs	Goal/Objective	Baseline	Process/Outcomes Measure	Time-Frame	Person(s)/Group(s) Responsible	Achievements
Program Area 4-Enhancing the general child protective system by developing, improving, and implementing risk and safety assessment tools and protocols		C. To assure that DCFS continues to provide the best quality services to children and families entering the system through CPS, DCFS will continue to utilize best practices and evidence-based models as it develops, revises, and implements those services.			Ongoing	DCFS Administrative Team	
	Casey Family Foundation, National Resource Center, Court Improvement Project, Decision-Making Model Workgroup	I. Implement Structured Decision-making tools throughout all division programs and services in an effort to enhance child safety and improve key outcomes for families including reducing <ul style="list-style-type: none"> The percentage of CPS substantiated victims with a subsequent supported CPS finding within 12-months The percentage of CPS substantiated victims with a subsequent supported finding The percentage of CPS substantiated victims with a subsequent supported finding 	<ul style="list-style-type: none"> -The percentage of CPS substantiated victims with a subsequent CPS supported finding within 12- months is 12.4% - The percentage of CPS substantiated victims with a subsequent supported finding is 10.78% - The percentage of CPS substantiated victims with a subsequent supported finding of case closure is 6.0% 	Structured Decision-making tools results in improved safety related outcomes for children as measured by a reduction in: <ul style="list-style-type: none"> The percentage of CPS substantiated victims with a subsequent supported finding within 12 months. The percent of home-based child clients who experience a subsequent supported CPS finding within 12 months of case closure. The percent of foster children who experience a subsequent supported CPS finding within 12 months of case closure. 	October 31, 2012	Katy Larsen	

Program Area	Inputs	Goal/Objective	Baseline	Process/Outcomes Measure	Time-Frame	Person(s)/Group(s) Responsible	Achievements
		a. Review and revise the plan to be used to implement the model.					
		b. Develop and disseminate Practice Guidelines that will guide workers' use of Structured Decision-making.					
		c. Identify and suggest modifications to State rules and statutes that will ensure maximum benefit from use of Structured Decision-making.					
		d. Develop or enhance data collection tools that will enable workers to utilize SDM on client outcomes.					
		e. Package, distribute and communicate to agency partners and service providers the value of, and ways to utilize Structured Decision-Making.					
		f. Integrate the application and use of Structured Decision-making into existing training and/or develop new training that will enable workers to effectively use Structured Decision-making tools.					

Program Area 5-Developing and updating systems of technology that support the program and track reports of child abuse and neglect from intake through final disposition and allow interstate and intrastate information exchange

DCFS operates and maintains the SAFE Management Information System (its SACWIS database), which tracks client identifying information as well as services delivered to children and families. The SAFE Team develops new and revises existing modules within SAFE to accommodate changing policies, procedures, practices, as well as the need for data to substantiate the quantity and quality of services delivered to clients. For instance, in FFY 2010, to allow workers to determine if a case had an interview completed through the Children’s Justice System, and to alert the worker that the interview may not be released in accordance with a 2010 state statute, the SAFE Team inserted an “interview location” into SAFE, which provides a notice when a worker tries to import or export the interview.

Program Area	Inputs	Goal/Objective	Baseline	Process/Outcomes Measure	Time-Frame	Person(s)/Group(s) Responsible	Achievements
Program Area 5- Developing and updating systems of technology that support the program and track reports of child abuse and neglect from intake through final disposition and allow interstate and intrastate information exchange		D. Develop new and revise existing modules within SAFE to accommodate changing policies, procedures, practices, as well as the need for data to substantiate the quantity and quality of services delivered to clients.	SAFE currently has approximately 25 modules The SAFE team typically publishes 4 or 5 SAFE releases a year, approximately 2 per year that affect CPS.	Modules in SAFE meet the needs of caseworkers, supervisors, administrators, data staff, and others that require verification of services delivered as well as data that supports the quantity of services delivered.	Ongoing	Information Systems, Research, and Evaluation Team	
	Program and Practice Improvement Team Safety Assessment Workgroup	I. Include recording and data modules that accommodate the new risk-assessment and safety assessment.			June 30, 2013	SAFE Team	

Program Area 6-Developing, strengthening, and facilitating training including training regarding research-based strategies to promote collaboration with the families, training regarding the legal duties of such individuals, and personal safety training for caseworkers, training in early childhood, child, and adolescent development

Training developed by the division’s training staff, acquired through purchase or agreement with an outside entity, or created through a contract for development is provided to CPS workers by DCFS trainers located in the state office or in each of the five DCFS regions.

Program Area	Inputs	Goal/Objective	Baseline	Process/Outcomes Measure	Time-Frame	Person(s)/Group(s) Responsible	Achievements
Program Area 6- Developing, strengthening, and facilitating training including training regarding research-based strategies to promote collaboration with the families, training regarding the legal duties of such individuals, and personal safety training for caseworkers, training in early childhood, child, and adolescent development		E. Continue to develop new training that presents new policies, procedures, practices and guidelines to CPS workers and community partners required to report child abuse and neglect.	CORE Training		Ongoing	Professional Development Team	
	Program and Practice Improvement Team Safety Assessment Workgroup	I. Revise CORE training to include specific training for CPS workers on the risk and safety assessments, as well as the decision-making model.	Existing CORE training	CORE training is updated and CPS specific training implemented.	June 30, 2013	Professional Development Team	
	Program and Practice Improvement Team CWLA	II. Implement the CWLA “Supervision to Success” training.	None	Supervision to Success training is incorporated into the training system.	June 30, 2013	Professional Development Team	

Program Area 7-Improving the skills, qualifications, and availability of individuals providing services to children and families, and the supervisors of such individuals, through the child protection system, including improvement in the recruitment and retention of caseworkers

Program Area	Inputs	Goal/Objective	Baseline	Process/Outcomes Measure	Time-Frame	Person(s)/Group(s) Responsible	Achievements
Program Area 7-Improving the skills, qualifications, and availability of individuals providing services to children and families, and the supervisors of such individuals, through the child protection system, including improvement in the recruitment and retention of caseworkers.	Division of Human Resource Management and DCFS Administrative Team	F. Incorporate new tools to aid in the effective recruitment and hiring of staff; specifically providing information that will increase an applicant's understanding of the nature of child welfare services, thereby assuring that the agency interviews applicants that are committed to providing quality programs and services to children and families.					
		I. Develop and disseminate a video that will help potential applicants for child welfare positions understand the nature of child welfare work as well as inform them of their responsibilities should they be employed by DCFS.	None	University and college candidates as well as other applying for DCFS casework positions are aware of current programs and services offered and report they have watched the video before being interviewed for a position.	TBD	DCFS Administrative Team	

Program Area 13-Supporting and enhancing interagency collaboration between the child protection system and the juvenile justice system for improved delivery of services and treatment, including methods for continuity of treatment plan and services as children transition between systems

To meet the needs of children and families CPS works in partnership with a variety of community-based education governmental, non-profit, faith-based, tribal, and other organizations that provide advocacy services for children, youth, families, and parents; after-school programs; crisis respite care; child abuse prevention education and advocacy; family resource and support services, parenting skills and training; protective day care; and work on community development initiatives.

Program Area	Inputs	Goal/Objective	Baseline	Process/Outcomes Measure	Time-Frame	Person(s)/Group(s) Responsible	Achievements
Program Area 13-Supporting and enhancing interagency collaboration between the child protection system and the juvenile justice system for improved delivery of services and treatment, including methods for continuity of treatment plan and services as children transition between systems		H. To meet the needs of children and families, DCFS and its CPS Program will continue to cooperate and collaborate with a variety of internal and external agencies and organizations that address or provide services that meet the needs of children that are the subject of a child abuse and neglect investigation and their families.					
	Utah Courts Decision-Making Workgroup Program and Practice Improvement Team Casey Family Foundation, National Resource Center	I. Continue to collaborate with the Court Improvement Project on the development, implementation, and evaluation of the Decision-Making Model.	None	DCFS and CIP report effective collaboration exists Decision-Making Model is implemented and evaluated.	Ongoing	DCFS Administrative Team	
	DJJS Program and Practice Improvement Team	II. Collaborate with the Division of Juvenile Justice Services to address issues related to children who are both abused and delinquent and who are dually adjudicated through DCFS and DJJS.	None	DCFS and DJJS report effective collaboration exists A Diversion Program is developed, implemented and regularly evaluated.	TBD	DCFS Administrative Team	
		a. Develop, implement, and evaluate a "Diversion Program" for dually adjudicated youth that have, or may in the future, commit offenses.	None				

TRAINING (CAPTA Subsection 106 (b) (2) (C))

Training developed by the division's training staff, acquired through purchase or agreement with an outside entity, or created through a contract for development is provided to CPS workers by DCFS trainers located in the state office or in each of the five DCFS regions.

All new caseworkers, including CPS workers, receive the 80-hour "New Employee CORE Practice Model Foundations" training module, which presents an Orientation to DCFS and Agency Mission, as well as identifies issues and casework practices that relate to Child Abuse and Neglect, the Safety Model, Worker Safety, Secondary Traumatic Stress, Trauma and Attachment, Effects of Trauma on Child Development, and presents a basic orientation to SAFE, the agency's SACWIS system. In addition, CPS workers receive training using the "New Employee CORE Practice Model-Applied" module, a 100-hour course that links knowledge and skills learned in the first module to work caseworkers will be performing as they provide Intake and CPS services.

Furthermore, CPS workers, and those who are required to report suspected cases of child abuse and neglect, receive CANS Assessment (Levels of Care) training that teaches students how to use the division's assessment tools as they assess the needs of children.

Other training delivered to CPS workers and/or those required to report suspected cases of child abuse and neglect are listed below.

Course Title	Course Description	Setting/ Venue	Proposed Provider	Approximate Number of hours/days	Audience	Frequency/ Duration	Title IV-E Administrative Functions
New Employee CORE Practice Model Foundations	Participants will learn about the foundations of Child Welfare including Practice Model Principles and Skills. They will receive the Orientation to DCFS and Agency Mission, and complete the Child Abuse and Neglect, Safety Model, Worker Safety, Secondary Traumatic Stress, Trauma and Attachment, Effects of Trauma on Child Development, SAFE basics training segments.	State Office or Regional Classroom	State Office or Regional Training Staff	80 Hours	New Caseworkers	2-4 times per year in each region	Development of a case plan, Case review, Case management
New Employee CORE Practice Model Applied	Participants will apply what they learned in CORE Practice Model Foundations to work assignments including Intake, CPS, In-Home and Out-of-Home casework.	State Office or Regional Classroom	State Office or Regional Training Staff	100 Hours	New Caseworkers	2-4 times per year in each region	Development of a case plan, Case review, Case management.
Legal-4th & 14th Amendments Web	Participants will study the legal history, including the 4th and 14th Amendments that builds the legal foundation for today's child welfare system. Located at http://hsemployees.utah.gov/dcf/4thand14thAmendments.htm	DCFS Web site	Self-Taught	2 hours	All Staff	As requested/Short-term	Preparation for and participation in judicial determinations
Child Interviewing	Workers will learn how children share autobiographical information and the effects and implications of sharing that information on the interviewing process. Workers will review audio recordings and will use various child-interviewing examples to complete practice scenarios.	State Office or Regional Classroom	State Office or Regional Training Staff	6 hours	All new caseworkers	2-4 times per year in each region	Referral to Services, Preparation and participation in judicial determination, Placement of children, Development of a case plan, Case review, Case management and supervision
Worker Safety	Participants will learn about risks to employees that may present themselves in their working environment. The course will give participant's tools and skills they can use to react to those situations in a professional and safe manner.	State Office or Regional Classroom	State Office or Regional Training Staff	4 hours	All Workers	2-4 times per year in each region	None
Developmental Screening	Participants will review the NDDS screening tool and learn how to implement it in their work with families. Participants will also learn about early intervention programs in their area. *Will be integrated into the revised New Employee training including Practice Model principles.	State Office or Regional classroom	State Office or Regional Training Staff	4 hours	CPS Staff. In the future will be applicable to all New Workers	1-4 times per year in each region/Short-term	Referral to Services, Placement of children, Development of a case plan, Case review, Case management and supervision
Domestic Violence Basic	Participants will identify state and federal law that pertain to domestic violence, will learn the definitions and characteristics of domestic violence, will study the cycle of abuse, and will learn skills used to intervene when serving victims, abusers, and their children. Participants will also receive information on community resources that serve or provide treatment to victims, abusers, and/or their children.	State Office or Regional classroom	Utah Domestic Violence Council	24 hours	All staff	1-4 times per year in each region/Short-term	Referral to Services

Substance Abuse Training Web-Based Training	Participants will explore their attitudes and beliefs about families with substance abuse problems and will receive information about the continuum of use, abuse, and addiction. They will learn how to identify signs of substance use disorders among families, the importance of screening for substance abuse with all child welfare clients, discuss the needs and experiences of people who become addicted, identify substance abuse treatment options and identify the stages of behavior change. Participants will learn means to explore the process of recovery, identify the role of lapse and relapse for clients who have been addicted, discuss children's needs and experiences related to having a substance abusing parent, talk about ways to enhance case planning, learn the benefit of teaming with substance abuse treatment providers, and identify Internet resources from which they can obtain information.	Self-Taught	Self-Taught	6 hours	All Staff	As requested/Short-term	Referral to Service
Legal Aspects of Child Protection (Legal Core)	Participants will learn about the Juvenile Court process and what the caseworker's role is in this process. Participants will also learn the legal definitions for abuse, neglect, and dependency.	State Office or Regional classroom	Attorney General's	3+hours	New Caseworkers	2-4 times per year in each region/ Short-term	Preparation and participation in judicial determinations, Case review, Case management and supervision
Advanced Intensive Sex Abuse Interview Skills	Participants build skills that will help them effectively interview children alleged to be victims of child abuse or neglect. They will develop skills that will enable them to conduct interviews in a manner that will decrease the traumatic effect of the interview on the child.	State Office or Regional classroom	State Office or Regional Training Staff	2-4 days	CPS staff, Law Enforcement	1-2 times per year/ Short-term	Case management, Case review
CANS Assessment (Levels of Care)	Participants will learn about assessing the needs of children. This will help the worker identify a child and family's treatment needs and will help the worker determine the most appropriate placement for a child when a child in the family is being followed by the child welfare system.	State Office or Regional Classroom	State Office or Regional Training Staff	6 hours	Direct Service Staff, Supervisors and Administrators	To be determined	Referral to Services, Placement of children, Development of a case plan, Case review, Case management and supervision
Audio-Import	Participants will review laws that require workers to keep audio records confidential. They will also learn how to import audio recordings of case information into the SAFE data collection system.	Under development as web-based	Under development as web-based	1 hour	CPS Staff	As needed	Preparation and participation in judicial determinations, Development of a case plan, Case review, Case management and supervision

ICWA Training Web-Based Training	Participants will review the main components of the Indian Child Welfare Act including its definitions and the rationale for complying with this legislation through the Diverse Utah Website. Participants will also learn how cultural frameworks impact interactions with people of other cultures as well as how those cultural frameworks impact the worker's decision-making. To direct the learning, participants will complete a worksheet.	DCFS Web-site	Self-Taught	1 hour	All staff	As needed/ Short-term	Placement of Children
Youth Safety 101	Participants will learn how to create a safe environment for LGBTQ youth currently in foster care.	State Office or Regional Classroom	Pride Center (regional trainers will be able to teach this course in the future)	3 hours	All Staff, Foster Parents	Annually in each region	None
Youth Safety 201	Advanced training for LGBTQ youth identity development and interventions to ensure youth safety and healthy development	State Office or Regional Classroom	Pride Center (regional trainers will be able to teach this course in the future)	3 hours	All Staff, Foster Parents	Annually in each region	None
Motivational Interviewing	Participants will learn how to interview clients to influence positive change.	State Office or Regional Classroom	Available from state or regional training staff	16 hours	Existing Caseworkers, Supervisors, and Administrators	Annually in each region	None
Secondary Trauma	Participants will learn the definition of STS and compare that definition with similar terms (especially "Burnout"). They will learn that STS is a normal human response and will identify the impact that STS has on individuals, groups, and organizations. Participants will learn how to recognize and manage STS in themselves and in others.	State Office or Regional Classroom	State Office or Regional Training Staff	4 hours for caseworkers, 5 hours for caseworkers	All Caseworkers and Supervisors	All Caseworkers and Supervisors	All Caseworkers and Supervisors
Newborn Exposure Cases	Participants will learn about issues related to newborn exposure to substances, including illicit and prescription drugs as well as alcohol. They will learn that safety planning and case planning is individualized to each case, particularly when removal from the mother is being considered.	Web-based under development	Web-based under development	2 hours	Direct service staff, supervisors and administrators	1-2 times per year	Case management, Case review
Car Seat	Staff are provided information about the proper installation and use of car seats.	Varies by region	Health Dept. Law Enforcement, CBH	30 minutes	Variable	None	
SAFE Training for New Employees	Participants will receive an introduction to the SAFE database management system. Participants will learn how to access and log into SAFE, will learn about components in SAFE including tabs, screens, reports, and be introduced to the various database modules.	State Office or Regional classroom	SAFE Trainer	12 hours	All Staff	Monthly in each region/ Short-term	Case management, Data entry and collection
SAFE New Release Training	Participants will receive updates and learn how to use new SAFE database modules.	State Office or Regional classroom	SAFE Trainer	Variable	All Staff	As needed/ Short-term	Case Management, Data entry and collection
Program Summit	Participants will attend a variety of workshops that will discuss current child welfare issues, identify new practice guidelines, principles or skills, and address new treatment or service delivery programs, services or models that may help workers address needs of their clients. Outside presenters may also speak on special matters relating to the work environment, employee motivation, or recruitment and retention.	State Office or Regional classroom, Outside facilities if needed.	Internal and guest speakers	1 day	Program related staff	Annually/ Short-Term	Case Management, Data entry and collection

In addition, the Professional Development Team is in the process of developing and implementing the following training models that are relevant to new or existing CPS workers.

Course Title	Course Description	Setting/ Venue	Proposed Provider	Approximate Number of hours/days	Audience	Frequency/ Duration	Title IV-E Administrative Functions
Traumatic Brain Injury	Participants will learn about potential causes of and the effects that brain trauma has on the children or adults they may serve. Participants will also gain skills that will enable them to more effectively serve clients with traumatic brain injuries.	State Office or Regional Classroom	State Office or Regional Training Staff	To be determined	Experienced Caseworkers	To be determined	Case review, Case management and supervision
Removal of children - still under development	This training will heighten a worker's awareness of a child's anxiety, fear and trauma when facing removal from the home of their parents or caretaker. It will provide staff tangible suggestions about how to make the process less traumatic for children.	State Office or Regional Classroom	State Office or Regional Training Staff	To be determined	Direct Service Staff, Supervisors and Administrators	To be determined	Referral to Services, Development of a case plan, Case review, Case management and supervision
Kinship Web-Based Training - still under development	Participants will review Federal regulations that require notification of all known relatives when a child enters care.	State Office or Regional Classroom	State Office or Regional Training Staff	1 hour	All Kinship Workers	As requested	Referral to Services, Placement of children, Development of a case plan, Case review, Case management and supervision
E-Warrant Web-Based Training	Participants will learn how to get a warrant through the ewarrant system	Self-Taught	Self-Taught	To be determined	TBD	TBD	TBD
SDM	Training for Screening Tool, Safety Assessment, Risk Assessment, Risk Reassessment			To be determined	TBD	TBD	TBD
Motivational Interviewing Refresher	Under development - Participants will bring difficult cases in and practice using motivational interviewing techniques, get feedback from the group.	State Office or Regional Classroom	State Office or Regional Training Staff	4 hours	TBD	TBD	TBD

INVOLVEMENT OF FAMILIES IN DECISION MAKING

DCFS has a long commitment to involving children and families in the decision-making process. Following are DCFS Practice Guidelines that support that commitment:

- Administrative Guideline 10.3 “Practice Principles, Skills, And Standards Practice Standards” A 4 states, “ Meaningful child and family participation in decision-making is vitally important, and all children and family members shall have a voice (as developmentally appropriate) in influencing decisions made about their lives, even when specialized communication services are required.
- Administrative Guideline 10.3 A 4 (a) also states, “Children and families will be actively involved in identifying their strengths and needs, and in matching services to identified needs.
- CPS Practice Guideline 200.2 “Philosophy Of Child Protective Services Investigations” suggests, “CPS caseworkers focus on five basic tasks in their daily work”
 - A. What must I do to reduce the threats of harm and the child vulnerabilities immediately and fin the future?
 - B. How can I increase the protective capacities so that the child remains safe?
 - C. How do I engage the child and family in a way that will allow me to understand the child and family’s needs and challenges beyond just those identified on the CPS case and provide enduring safety and permanence for the child?
 - D. How do I develop a trusting relationship with the family that will facilitate their use of community resources?
 - E. How do I assist the family in identifying its strengths, which will increase the possibility of the child remaining at home or returning home quickly?
 - F. What must I do to ensure that the family has a smooth transition from the CPS case to ongoing services?
- CPS Practice Guideline 202.8 “Medical Examination Of The Child-Serious Medical Neglect and Emergency Court Ordered Medical Treatment” section A “Procedure for Investigation of Serious Medical Neglect” states, “The CPS and ongoing caseworker will hold a Child and Family Team meeting to involve the family in planning and decision-making.”

COLLABORATIONS

A number of Practice Guidelines encourage and support collaborations between DCFS and community organizations including state courts and Native American tribes. Following are statements listed in those Practice Guidelines:

- Domestic Violence Practice Guideline 600.2 “Philosophy” states, “There is a high, positive correlation between domestic violence and child abuse and neglect. Domestic violence is not only an act of aggression against the adult victim in the home, but is also a dangerous act that places children at risk for abuse and neglect. Collaborative links with community partners should be developed and maintained to provide services to families experiencing domestic violence.
- Domestic Violence Practice Guideline 600.2 “Philosophy” also states “The goals of domestic violence services are (E) to maintain a cooperative relationship between law enforcement, prosecution, courts, legal aid, medical providers, treatment providers, social services and other community agencies, to coordinate the prevention and treatment of domestic violence.
- Domestic Violence Practice Guideline 600.3 “Child And Family Services And Worker Expectations” states, “Domestic violence interventions will...(D) Facilitate community collaboration.”
- Domestic Violence Practice Guideline 601.1 “Regional Domestic Violence Programs” states, “(A) The regional coordinator shall:
 - (7) Implement collaboration between child welfare and domestic violence staff and partners by providing case consultation and mentoring when appropriate,
 - (10) Participate and collaborate with the Utah Domestic Violence Advisory Council, the Domestic Violence Steering Committee, and other committees as necessary and
 - (15) Encourage and facilitate collaboration between domestic violence workers and allied agencies.”

To meet mandates outlined in Practice Guidelines CPS works in partnership with a variety of community-based education governmental, non-profit, faith-based, tribal, and other organizations that provide or address:

- Advocacy services for children, youth, families, and parents
- After-school programs
- Crisis respite care
- Child abuse prevention education and advocacy
- Family resource and support services
- Parenting skills and training
- Protective day care
- Community development initiatives

A sample of specific programs include:

- Allies for Families, which provides support to children with mental illness or other special needs.
- The Child Abuse and Neglect Council (CAN), which helps improve prevention services across all program areas.
- The Christmas Box House International, which provides emergency shelter for children taken into state custody.
- The Drug Endangered Children's Medical Advisory Team, which works to improve education programs (provided to professionals and the general community) relating to safety guidelines, as well as response to, and treatment of victims who have been in contact with a methamphetamine laboratory.
- Family Support Centers, which provide statewide community-based support services including counseling and education.
- The Indian Walk-In Center, which provides social services in a culturally appropriate manner to more than fifty separate tribes and other clients from numerous ethnic backgrounds.
- The National Alliance for the Mentally Ill (NAMI) Utah, which provides advocacy and education for youth.
- The National Indian Child Welfare Association, which provides training and technical assistance related to Indian child welfare services, provides information regarding the needs and problems of Indian children, and helps improve community-based services that work to improve and promote public policies for Indian children.
- The Parent Center for Educational Needs, which provides support to children with mental illness or other special needs.
- Public, private, and residential mental health agencies, which provide a continuum of mental health services to adoptive families and youth.
- The Utah Department of Health, which has assigned a Fostering Healthy Children Nurse to every DCFS office who facilitate Medicaid mental health and rehabilitation services exempt from the Public Mental Health Plan.
- The State of Utah Office of Indian Education, which ensures that the education system supports and empowers Indian/Alaska Native students, embraces positive native values, and honors and affirms students past, present, and future contributions.
- The State of Utah Office of Education, which coordinates special education services for children with special needs.
- The Utah Indian Substance Abuse Coalition, which encourages professional interaction, supports problem-solving efforts, and provides a forum for discussion of substance abuse issues among AI/AN youth in Utah.
- The Utah Pride Center, which is collaborating with Child and Family Services to develop training for caseworkers and foster parents.
- The Utah Sexual Violence Council, which supports and coordinates legal, treatment, and financial support services to victims of sexual violence.
- The Community Partnership to End Homeless Committee, supported by the State of Utah, Department of Community and Culture, Division of Housing and Community

Development, which hosts the Improving Discharge Planning Committee an interagency group that collaborates to prevent the discharge of clients to homelessness.

- The University of Utah and Utah State University, which contracts with DCFS to provide advanced social work education for DCFS employees and persons preparing for employment in child welfare.

Child and Family Services also works collaboratively with the Court Improvement Project (CIP) to improve the overall court process for children and families involved with child welfare. DCFS and the CIP are joint partners in the implementation of the Utah Safety Decision-Making Model, which outlines practices caseworkers follow as they assess a child's safety and potential risk of harm. Court improvement funds support the purchase of evidence-based assessment tools used by caseworkers to implement the model.

DCFS also works closely with the six federally recognized Native American Tribes in Utah including the Navajo Nation, Confederated Tribes of the Goshute Reservation, Skull Valley Indian Community (Goshute), Uintah and Ouray Tribe (Northern Ute), Paiute Indian Tribe of Utah, and Northwestern Band of the Shoshone Nation. Utah has negotiated Memorandums of Understanding (<http://hsemployees.utah.gov/dcfs/tribe-agreements.htm>) with each of the six federally recognized tribes.

The MOU with the Ute Tribe indicates they will deliver their own Child Protective Services (CPS) investigations and In-Home Services. DCFS has agreed to provide foster care services. The Ute Tribe has its own Tribal Court that hears child welfare cases.

The Confederated Tribes of the Goshute Reservation provide all child welfare services on their reservation but have an agreement with DCFS to provide services to tribal members living off of the reservation. They use their own courts (or coordinate with the Bureau of Indian Affairs) to adjudicate child welfare cases

The Paiute Tribe, Northwestern Band of the Shoshone Nation, Navajo Nation, and Skull Valley Goshutes rely on DCFS for the provision of child welfare services to their tribal members. They also use the Utah Juvenile Court and its attorneys to adjudicate child welfare cases. DCFS informs and involves each of these tribes in case planning and all court proceedings.

The DCFS ICWA Program Administrator coordinates DCFS activities with tribes at the quarterly Utah Tribal Leaders Meeting. During this meeting participants receive updates on the status of agreements, discuss tribal issues, connect with state ICWA specialists, discuss national policy and statutes, and collaborate to implement the Indian Child Welfare Act.

In addition, a Consultation Agreement has been executed between federally recognized Indian tribes in Utah and the Department of Human Services. This agreement provides a framework for the government-to-government relationship and outlines implementation procedures that help assure the process is executed as planned. In support of this agreement, The ICWA Program Administrator sits as a member of Department of Human Services Tribal and Indian Issues Committee and sits on other community coalitions that reinforce collaborative efforts between tribes, other ethnic minority communities, and DCFS casework teams.

Finally, DCFS collaborates with 16 domestic violence shelter programs in the State of Utah that provide shelter and support services to victims of domestic violence and their dependent children. Of the existing 16 programs, 13 are managed by private non-profit agencies and three are operated by the State. 12 of the 13 private non-profit shelters have contracted with DCFS to provide services and receive DCFS funding that at least partially supports programs and services delivered by those shelters. The other private non-profit shelter operates without funding from DCFS. The three State shelters are funded and managed by DCFS and utilize only state funding.

Domestic Violence Shelters in Utah (Urban Shelters Highlighted)				
Shelter	Location	Beds	Catchment Area	Population in Catchment Area
Canyon Creek Women's Crisis Center	Cedar City, Iron County	17	Iron, Beaver, Garfield Counties	48,985
Community Abuse Prevention Services Agency (CAPSA)	Logan, Cache County	32	Cache, Rich County	103,564
Center for Women in Crisis	Provo, Utah County	27	Utah, Juab Counties	403,352
Colleen Quigley Woman's Shelter (DCFS)	Price, Carbon County	12	Carbon, Emery Counties	30,148
D.O.V.E. Center	St. George, Washington County	25	Washington, Kane Counties	142,650
Gentle Ironhawk	Blanding, San Juan County	25	San Juan County	14,140
New Horizons Crisis Center	Richfield, Sevier County	45	Piute, Sanpete, Sevier, Wayne, Millard	59,529
Pathways (DCFS)	Tooele, Tooele County	11	Tooele County	51,311
Peace House (SPEACEHO)	Park City, Summit County	15	Summit, Wasatch Counties	51,982
Safe Harbor	Kaysville, Davis County	32	Davis County	268,187
Seekhaven	Moab, Grand County	9	Grand County	8,743
South Valley Sanctuary	West Jordan, Salt Lake County	57	Salt Lake County	948,172
Women's Crisis Center (DCFS)	Vernal, Uintah County	9	Daggett, Duchesne, Uintah Counties	43,292
Your Community Connection (YCC)	Ogden, Weber County	25	Weber, Morgan Counties	218,655
Your Community in Unity (YCU)	Brigham City, Box Elder County	11	Box Elder County	46,440
YWCA	Salt Lake City, Salt Lake County	160	Salt Lake County	948,172
Total Beds		512		

Shelter program services include 24-hour shelter care, shelter supervision, and a 24-hour hotline for victims/survivors of domestic violence and their dependent children. Domestic violence shelters are required to provide survivors with an overview of available supportive services including, but not limited to, medical resources, self-sufficiency, day care, and legal, financial, and housing assistance. When indicated, referrals are made for psychiatric consultation, drug and/or alcohol treatment, or other allied services.

DIFFERENTIAL RESPONSE

Rather than having five regional intake teams processing allegations of abuse and neglect DCFS now processes all reports through one Centralized Intake Unit. Referents now speak with a well-trained intake worker who determines if a referral meets guidelines requiring intervention, intervenes in the least intrusive manner, and determines the appropriate level of intervention in regard to intensity and duration. By implementing a 24-hour a day intake service, DCFS can be assured that a referent will always receive consistent, quality, 24-hour a day, 7-day a week service regardless of when they call.

When a referral comes to Child and Family Services through Centralized Intake a determination is made as to whether or not the minimum requirements for opening an investigation are present. If the referral does not rise to the level requiring a formal investigation the caller is referred to community services that may be able to support the child and family. In addition, in cases where an investigation is opened, and the caseworker determines that the child is not at risk for abuse or neglect, and also determines that the family could benefit from community services, the caseworker will refer the family to community resources available in their area.

CHANGES TO STATE LAW OR REGULATIONS THAT COULD AFFECT THE STATE'S ELIGIBILITY FOR THE CAPTA STATE GRANT

An Assistant Attorney General in the Utah Attorney General's Child Protection Division has indicated that no new legislation passed during Utah's 2011 Legislative Session will impact the state's eligibility to receive CAPTA funding. On the other hand, after reviewing the CAPTA Reauthorization Act of 2010, the Assistant Attorney General has indicated that several current statutes in the Utah State Code will need to be revised in order to comply with new regulations outlined in the new CAPTA legislation. A DCFS Deputy Director and the Assistant Attorney General will collaborate to identify current statutes needing revision and will work with state legislators who will present legislative amendments to the State Legislature for their approval.

CITIZEN REVIEW PANELS

In Utah, Quality Improvement Committees (QIC) act as Citizen Review Panels (CRP), required entities as legislated in the Child Abuse Prevention and Treatment Act (CAPTA). In accordance with provision specified in 107.c of that act, QICs examine policies, procedures, and practices proposed, developed, or implemented by the Division of Child and Family Services (DCFS).

QICs also have the ability to review specific Child Protective Service (CPS) cases and evaluate the extent to which the child protective services system is successfully discharging protection

responsibilities. QICs offer resolutions to unique problems and have independence to advocate for unique solutions to community needs.

Members have a stake in the outcome of services provided to children and families and are considered “informed evaluators” who give DCFS the best, most objective analysis of issues that face the state’s child welfare system. They have the knowledge and ability to identify organizational obstacles, have the ability to recognize system strengths, and have the authority to communicate those strengths to the community.

The DCFS state office maintains and supports a statewide QIC that responds to all recommendations, questions, and concerns delivered to it. The statewide QIC serves as the conduit for information and ideas presented by regional QICs. In addition, they develop, operate, update and maintain the QIC website which provides convenient access to information and data relevant to QICs.

In addition, each of the five DCFS regions maintain and support at least one QIC that is responsible for reviewing and supporting activities expected of CAPTA CRPs. Each committee is coordinated by a citizen chair and is composed of citizen and community partners living or practicing within a region’s jurisdiction.

At least quarterly, each QIC is required to review CPS related data and identify issues that affect CPS. At least yearly QICs invite the following agencies to a committee meeting and receive reports that relate to child welfare trends or the status of child welfare services:

- The Office of Services Review, which reports on Qualitative Case Review (QCR) and Case Process Review (CPR) outcomes
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- Data reviewed
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- CPS and domestic violence related issues

- Recommendations passed to region administration, the State QIC, and/or DCFS administration.

To communicate their recommendations DCFS has developed a [Recommendation Process](#) that defines how to prepare a recommendation as well as identifies to whom recommendations should be sent. The document states that DCFS region or state office administrators have 30-days to respond in writing to a recommendation and that once a response is made, both the recommendation and the response are to be posted on the QIC website.

The [Quality Improvement Committee Annual Report](#) is attached.

CHILD PROTECTIVE SERVICE WORKFORCE

Utah has a highly qualified cadre of CPS workers. Providing 24-hour a day coverage, they exercise independent judgment as they as they investigate abuse, exploitation and/or neglect, provide children and families with referrals to programs and services, recommend appropriate action affecting the client's wellbeing and social functioning including, when necessary, recommending appropriate substitute care for children and youth. In addition, they may directly provide counseling, education, and other related human services.

CPS workers support and document client progress by developing service plans, compiling case histories, and preparing other related reports and ensure the quality of services delivered to clients by coordinating provider services.

Due to time constraints DCFS is presenting demographics relating to its entire workforce. The agency will supply CPS specific data, including average number of years of education and their licensure type in subsequent yearly reports.

DCFS Workforce Demographics		
Race	Number	Percentage
American Indian/Alaska Native	8	1%
Asian/Pacific Islander	17	2%
Black	6	1%
Hispanic	45	4%
White	955	93%
Total	1031	1
Gender		
Male	243	76%
Female	788	24%

The average DCFC employee is 43 years of age and has worked for the agency an average months of 113 months (almost 9 years). All workers have at least a Bachelor's Degree in Social Work, Psychology, Sociology, or closely related field of study and must obtain at least a Social Service Worker (SSW) license within a year of being employed.

DCFS has not set a standard regarding average caseload for intake workers. Since the division only recently implemented its Centralized Intake Unit, no data is available relating to the average number of cases an intake worker accepts. That information will be collected and reported in subsequent yearly reports

The maximum number of cases a CPS worker should have open at any point in time has been set at 16. Currently, the average CPS worker has approximately 13 open cases.

JUVENILE JUSTICE TRANSFERS

Juvenile courts adjudicate cases regarding children and youth entering the custody of both DCFS and DJJS. In order for a child to be transferred from DCFS to DJJS custody a juvenile must commit a significant offense, have their case adjudicated in juvenile court, and meet DJJS sentencing guidelines before they can be placed in DJJS custody. Delinquency alone is generally not a sufficient reason for a child to be transferred from DCFS to DJJS custody. Sentencing guidelines are comprised of three fundamental parts: 1) The youth's criminal history as measured by the criminal episode history assessment, 2) The severity of the presenting episode, or most severe offense, and 3) a list of aggravating and mitigating circumstances. Sentencing guidelines promote uniformity while, at the same time, afford the juvenile court the flexibility to fashion a specific sentence to an individual juvenile offender.

Caseworkers track the transfer of children from DCFS to DJJS in its SAFE (SACWIS) system by entering "transfer to DJJS custody" as the reason for termination of foster care services.

	Number of Cases	Percent of all youth exiting custody
FFY '07	61	3.7%
FFY '08	52	2.7%
FFY '09	33	1.8%
FFY '10	46	2.2%

In FFY 2010, 46 children or youth were transferred from DCFS to DJJS custody.

STATE LIAISON OFFICER

The following individual is the primary contact regarding CPS related issues:

Marnie Maxwell-Intake/CPS Program Administrator
195 North 1950 West
Salt Lake City, UT 84116
Phone: (801) 809-7413
E-mail: MMAXWELL@utah.gov

ATTACHMENTS

Quality Improvement Committee Annual Report

State of Utah

Gary R. Herbert-Governor

Palmer DePaulis-Executive Director Department of Human Services

Brent Platt-Director Division of Child and Family Services

Division of Child and Family Services



Quality Improvement Committees Annual Report

June 30, 2011

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State of Utah Quality Improvement Committees Annual Report June 30, 2011

PURPOSE AND STRUCTURE

In Utah, Quality Improvement Committees (QIC) act as Citizen Review Panels (CRP), required entities as legislated in the Child Abuse Prevention and Treatment Act (CAPTA). In accordance with provision specified in 107.c of that act, QICs examine policies, procedures, and practices proposed, developed, or implemented by the Division of Child and Family Services (DCFS).

QICs also have the ability to review specific Child Protective Service (CPS) cases and evaluate the extent to which the child protective services system is successfully discharging protection responsibilities. QICs offer resolutions to unique problems and have independence to advocate for unique solutions to community needs.

Members have a stake in the outcome of services provided to children and families and are considered “informed evaluators” who give DCFS the best, most objective analysis of issues that face the state’s child welfare system. They have the knowledge and ability to identify organizational obstacles, have the ability to recognize system strengths, and have the authority to communicate those strengths to the community.

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the QIC website which provides convenient access to information and data relevant to QICs.

In addition, each of the five DCFS regions maintain and support at least one QIC that is responsible for reviewing and supporting activities expected of CAPTA CRPs. Each committee is coordinated by a citizen chair and is composed of citizen and community partners living or practicing within a region’s jurisdiction.

At least quarterly, each QIC is required to review CPS related data and identify issues that affect CPS. At least yearly QICs invite the following agencies to a committee meeting and receive reports that relate to child welfare trends or the status of child welfare services:

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employee complaint or concern, and are responsible for being informed evaluators who ask hard questions and make recommendations designed to improve agency processes and client outcomes.

To communicate their activities, each QIC produces a quarterly summary that includes a description of:

- Data reviewed
- Public relation activities
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To communicate their recommendations DCFS has developed a [Recommendation Process](#) that defines how to prepare a recommendation as well as identifies to whom recommendations should be sent. The document states that DCFS region or state office administrators have 30-days to respond in writing to a recommendation and that once a response is made, both the recommendation and the response are to be posted on the QIC website.

ANNUAL QUALITY IMPROVEMENT COMMITTEE SUMMIT

More than eighty-five participants attended the 5th Annual Quality Improvement Summit was held December 1, 2010 at the Airport Hilton in Salt Lake City, Utah. This year's summit not only meets the division's yearly goal to bring all QIC members together as a group, but since federal and community partners attended, serves as the Joint Planning Meeting as required by federal regulation 45 CFR Part 1375.15 (6).

Brent Platt, the Director of the Division of Child and Family Services welcomed all in attendance and thanked the division's federal partners as well as partners from the Casey Family Programs for attending the Summit.

Brent complemented all on the quality services they provide and stated that over the past several months he has had many states (seeking examples of innovative and effective programs, services, and systems) inquire about Utah's child welfare system. Specifically, many have been interested in the state's SAFE data management system and the child and family teaming process utilized by DCFS workers.

He stated DCFS is now in a position that it can be innovative and creative as it devises means to improve and fine-tune the child welfare system. He emphasized that citizen involvement enables the system to be more creative.

As a result of this process the division has identified three priority areas on which the division will focus future activities. These goals state that DCFS will:

- Implement (by July 1, 2011) a Centralized Intake system, which will bring consistency to the intake process
- Provide caseworkers and families they serve access to a broader array of child and family assessments including the Child and Adolescent Needs and Strengths (CANS) assessment. In addition the division will develop and implement assessments that will support the structured Decision-Making Model
- Assure placement stability by taking an in-depth look at which placement options work best.



Brent indicated that once Centralized Intake is implemented its effectiveness will be assessed on an ongoing basis. QICs, especially in rural areas, are encouraged to submit ideas for baseline measures to be used to track trends. He assured attendees that although intake will be centralized, regional CPS workers will still need to respond to the referrals.

In conclusion, Brent indicated that, in an effort to collect community member's ideas and identify their concerns about Utah's child welfare system, he intends to visit with each QIC over the next several months.

Rick Smith, the Statewide QIC chairman, was introduced and emphasized that QICs offer a forum where citizens can become involved in Utah's child welfare system and can provide critical feedback that will improve the child welfare system. To support that purpose, a Memorandum of Understanding between QICs and Child and Family Services (available on the QIC website <http://utahqic.utah.gov/>) outlines a formal process to be used by QICs to conduct business.

Rick indicated that the primary purpose of QICs is to examine data, review DCFS policies and procedures, and recommend means to be used by DCFS to improve services delivered to children and families in the State of Utah. He highlighted issues that many QICs are facing and stated it is unfortunate that many of the state's QICs still struggle to recruit and retain members with diverse backgrounds and from a wide array of community organizations. Budget constraints have been a major roadblock to maintaining committees and Rick asked that DCFS consider increasing its financial support of QICs, specifically asking for

funding that will allow QICs to provide lunch at monthly meetings.

Palmer DePaulis, Executive Director of the Department of Human Services (DHS) thanked everyone for their attendance and complemented members for the wonderful work they do as members of QICs. He indicated that the 2011 Legislative Session is coming up and hopes to get through the session without cuts to the department budget. He believes that informing legislators of the valuable service QICs are providing is a priority and encouraged participants to contact their legislators to inform them of their involvement.

Legislative committees, including the appropriations subcommittee that oversees Human Services, have been restructured and now have the responsibility to review activities and budgets of an increased number of state agencies. This means everyone will need to work more closely with legislators to stress the needs of agencies within the Department of Human Services (DHS).

He said that DHS recently completed an in-depth legislative review. The review presented a number of recommendations that administration hopes will help strengthen department programs and services. The department is currently seeking public input relating to these recommendations.

Marilyn Kennerson, Region Administrator for the Administration on Children and Families stated that Utah performed well on the CFSR. She is aware that Utah, like most states, is supportive of (but would like to fine-tune) the CFSR accountability process.

She said the CFSR does show that Utah is providing quality services. Likewise, the



CFSR shows that the community is involved, that the QICs are an integral part of the five-year plan, and that the accomplishments of QICs are reflected in the results. She indicated that there are a number of opportunities for QICs to be involved in the Program Improvement Plan (PIP) and activities outlined in that plan. Finally, to assure quality programs and services are provided, she encouraged QICs to remain involved in the quality assurance process.

QIC Chairperson Report

Julie Steele moderated a panel of QIC chairpersons. Each described what motivates them to serve on their committee and reported on QIC accomplishments.

Mike Hamlin, the Salt Lake Valley QIC chair stated that it is fulfilling for him to watch the child welfare system grow and improve, in part due to his committee's activities. He indicated that his committee implemented a client satisfaction survey to be given to clients reported to CPS.

Daryl Melton, the Northern QIC chair told the audience that he appreciates the opportunity to help children achieve permanency. He likes keeping committee members focused on the issues and enjoys coming up with recommendations that help improve programs and services. He stated his committee has focused on issues that relate to permanency. Specifically, his QIC is working with the Family Support Center to pilot a process to help the region conduct family searches through the Internet. Furthermore, his committee has been studying the utilization of the Christmas Box House as a transitional placement.

The Eastern Region's QIC in Carbon County is working on issues related to CPS and recidivism, especially as they pertain to

cases where there are repeat allegations of domestic violence related child abuse.

Colleen Cook, a Transition to Adult Living (TAL) coordinator stated that she appreciates her committee for their help with the Regional TAL Summit. She stated her committee made a proposal to use interns earning their Master's Degrees to address the needs of various victim groups.

Debbie Hofhines, the Southwest/St. George QIC chair stated her committee has focused on supporting caseworkers and held a potluck in recognition of the work done by caseworkers.

Rick Smith, the State QIC chair indicated his committee made recommendations that resulted in Child and Family Services adopting the Safety Decision-making Model. They recently sent a recommendation to administrators regarding foster parent licensing.

Matt Dinger, the Western QIC co-chair has enjoyed the opportunity to work directly with youth receiving help from child welfare programs and services. He stated that his committee focused on parent burnout and recommended providing relief home parent services to distressed parents. His QIC also implemented a mentoring program that matches community volunteers with youth in the foster care system.



Foster Parents Discussion

Jennifer Gardener moderated a discussion between foster parents.

When describing how Child and Family Services and the child welfare system has changed over the past few years, and how budget cuts have affected foster care providers, one panel member indicated that “the division has only gotten better over the last 10 years.” Panel members agreed that they like that a child and family team is “individualized” for every child and noted that working with biological parents is encouraging and fulfilling.

The panel indicated reunification is a greater priority than in the past. They also stated that caseworker support of foster parents has increased and that recommendations from foster parents about what services children and youth need are better received by staff.

On the other hand, panel members noted that child and youth behavioral issues are now more severe. Unfortunately, many foster families are not trained to deal with these behavioral issues. One member indicated that foster care reimbursement rates were higher 23 years ago and today it costs more to kennel a dog than is being paid to foster a child. One panel member stated that when there are cuts in the budget it feels as if there is no appreciation for the care they give. She stated, even marginal cuts cause foster parents to lose confidence, which in turn results in the formation of negative impressions of the child welfare system. Those impressions not only affect the retention of current foster parents but also affect the recruitment of potential foster parents. The panel indicated that foster families struggle on a daily basis to make ends meet and encouraged legislators to be

more sensitive when addressing funding for foster care.

The panel provided reasons they continue to be foster parents. One member likes the fact that being a foster parent gives them an opportunity to adopt. Most agreed that they feel their experience has helped them become the kind of parent children in the child welfare system need. All agreed that it is an amazing experience to care for a child in need, especially one that is not your biological child.

Relating to what foster parents need from the child welfare system, the panel asked that caseworkers be creative when identifying solutions to problems and be clear, consistent, and flexible with their expectations. They want caseworkers to remember that foster parents are part of the team.

One foster parent encouraged the system to provide more time to assess children and families before placing children in out-of-home placements. Furthermore, foster parents need help in accessing resources available to them. They noted that after-hours support is not currently available and would be helpful. Developing an on call crisis team or peer foster parent system may be a way to provide this support. All agreed that budget constraints are forcing DCFS and foster parents to seek lower cost solutions and asked that, despite budget cuts, QICs continue to work on solutions that meet the needs of foster families and do so by thinking outside the box.

Concerning foster care training, one foster parent suggested that UFCF make training and attendance at cluster group meetings mandatory, that UFCF review outside training opportunities to determine their benefit to foster parents, and limit the



amount of training that can be approved from sources other than that provided by UFCF. The panel suggested that UFCF make regional mandatory training consistent statewide and develop more training that allows foster parents to learn from each other.

They agreed that cluster groups have been helpful in crisis situations and indicated that, in an effort to provide immediate clinical support to families, it might be helpful to provide mentoring to new foster families, especially those in crisis situations. Finally, they all agreed that it would be helpful to provide childcare for current and potential foster parents attending training.

Placement Stability Panel

Carolyn Hansen moderated a panel where participants were asked to present ideas that will help facilitate placement stability.

One panel member suggested that caseworkers help children understand what a placement is and why the placement is needed. Another noted that it helps if foster parents get to know children before they are placed. Another participant stated she reviews the long-term view in the placement plan with the girls she works with, many of which have experienced placement disruptions. She also tries to help her girls understand why the disruption occurred. Another panel member stated she sees great success when the boys she works with feel a part of their decision-making team. A caseworker stated she not only works with foster families and other workers to prepare them for the placement of children in a foster home but also makes follow-up calls to determine how the placement is going.

Another caseworker explained the benefit of his region's two placement committees, one

for children needing levels I or II placements and the other for children needing level III and higher placements. He explained that the screening process has been effective in not only determining which placement is most appropriate but has helped preserve many placements. He also indicated that Resource Family Consultants (RFCs) have been helpful in preserving placements when problems occur.

Lastly, another panel member stated that being a contract grant analyst allows her to offer insight to her placement committee about the needs and abilities of providers. The panel agreed that it is beneficial when caseworkers are given information about potential foster families and have the opportunity to meet with families before the placement is made. They also agreed that it is beneficial to have mental health professionals and caseworkers as participants on permanency committees

Linda Winger, the DCFS Director of Program and Practice Improvement stated that as of December 2010, DCFS has fulfilled all of the requirements mandated in the David C. lawsuit as well as the Performance Milestone Plan developed as a result of that lawsuit. The formation of QICs, which were not in existence before the suit, was mandated in the Milestone Plan. She also mentioned that at this point QICs have far surpassed goals listed the Milestone Plan.

Linda reviewed the results of the Child and Family Service Review (CFSR) conducted in June 2010. Utah's QICs were key players in that process. The Executive Summary and Final Report are available on the Child and Family Services website: (http://www.dcfs.utah.gov/cfs_review.htm). She pointed out that the federal agency responsible for conducting CFSRs recently raised the minimum scores needed to



achieve a “successful” rating on many indicators measured during the CFSR. Since Utah did not achieve these higher ratings on several indicators, it may appear that Utah’s ability to meet child welfare standards is declining. While as in most states Utah is struggling to meet the new standards, it should be recognized that most of Utah’s scores improved from the previous CFSR.

Finally, she stated DCFS is in the process of drafting a Program Improvement Plan (PIP) to address indicators where Utah was below the standard. A PIP kickoff event was recently held and approximately 100 people attended.

Mike Scholl explained that Casey Family Programs is a foundation that provides services designed to improve permanency outcomes and prevent the need for foster care. Their vision statement states that by the year 2020 they plan to reduce the number of children in foster care by half. To achieve this vision, they have developed four strategic focus areas, Safe Reduction, Reinvestment, Wellbeing, and Self-sufficiency. They will utilize direct services, strategic counseling, and public policy partnerships to achieve goals that support the strategic focus areas.

Mike introduced the concept of permanency roundtables and stated they are designed to support a professional case consultation process that is designed to increase self-competencies, break systemic barriers, and strengthen systems integration. Permanency roundtables will help drive youth to legal permanence, improve their permanency status, reduce the level of restrictiveness, increase the number of permanent connections, and reconnect youth with parents and siblings.

Finally, he indicated permanency roundtables are currently being piloted in the Salt Lake Valley Region and may grow into other parts of the state. A follow-up presentation about permanency roundtables in Utah will be given at next year’s QIC Summit.

Heidi Valdez, the DCFS Prevention Specialist, explained the importance of involving parents and youth in the child welfare system and provided tips that can help increase the participation of parents and youth in QICs. She stressed that QICs will notice the difference in commitment between parents or youth whom they ask to “join a committee” versus those they ask to become “community partners.” She emphasized that to gain commitment from parents or youth it is important to explain why their participation is beneficial to not only the committee but to the community at-large. Furthermore, to maintain their commitment, DCFS and the QICs need to provide parents and youth with training and tools they can use to identify and assess the needs of their community. It is useful to provide parents and youth with a mentor that can guide them through the process. QICs need to provide parents and youth with opportunities to present their ideas to the committee and the community, and should allow time in their meetings for members to share information obtained through their participation on other committees or from attending meetings sponsored by other organizations.

Finally, she reminded participants of the benefit of parent and youth involvement by stressing the fact that legislators and members of their community hear the voices of parents and youth and take their ideas seriously.



Dr. David Corwin noted the fact that protecting children is a greater task than one single agency can accomplish. He complemented the work done by QICs and thanked them for their involvement in a process that is designed to support families and protect children from maltreatment. He relayed the belief that reducing abuse and/or neglect of children is central to improving the wellbeing and productivity of society and encouraged QICs to develop activities that support efforts to prevent child abuse and neglect. He noted several issues and encouraged QICs to address them. Those issues include the need to identify means to effectively screen cases at intake, the need to develop a process to effectively collaborate with Safe and Healthy Families' doctors and nurse practitioners, and the need to develop measures to educate the public as well as community leaders about the need for prevention services.

STATE QUALITY IMPROVEMENT COMMITTEE

MEMBERSHIP	
Rick Smith (Chair)-Guardian ad Litem	Carolyn Jensen-Director , Children's Justice Center
Jenny Arm, Ph.D. -Training Coordinator and Research Associate, Utah Pride Center	Lisa McDonald , Executive Director, The Christmas Box International
Trish Beck -Legislator	Leticha Medina , Operations Director, Colors of Success, Inc
Karen Buchi, M.D. - Professor Department of Pediatrics U of U	Karla Pardini , Child and Family Services Director, Jeene Wagner Lake Jewish
Chris Chytraus, R.N., BSN, CPM - Program Manager, Fostering Healthy Children	Julie Steele, FNP -Department of Pediatrics, U of U
Stephan Clark -Attorney	Staff Support
Jennifer Gardner -President, Utah Foster/Adoptive Families Association	Katy Larsen -DCFS Professional and Community Development Manager
Katie Gregory -Assistant Juvenile Court Administrator	Reba Nissen -DCFS Mentor Program Coordinator
Tina Groves -Indian Walk-in Center	Carol Miller -DCFS Program Support Specialist

Significant Activities

In FFY 2010, the State QIC concluded its inquiry into the relationship between the

Division of Child and Family Services (DCFS), the Office of Licensing (OL), and foster care providers. While their recommendation that DCFS take over all licensing activities for current and potential foster parents cannot be implemented, their study did result in a process that administrators believe will not only increase the ability of OL to process applications for licensing in a timely manner but will improve the relationship between foster parents, DCFS, and OL.

Other issues addressed by the State QIC include:

- Medicaid unbundling and its impact on residential placements
- Medicaid unbundling and its effect on children's mental health services
- Budget reductions and their effect on the child welfare system
- The inability of families caring for their grandchildren to obtain services unless DCFS becomes involved
- The need to develop a new In-home Services model designed to reduce the number of children removed from their homes
- Implementation of a Centralized Intake Unit
- The need to identify and support services delivered to Lesbian, Gay, Bisexual, Transsexual, and Questioning (LGBTQ) children.

Finally, the QIC heard a concern that foster parents and the children they care for are often not notified of court hearings. The QIC is in the process of formulating goals that will increase the participation of foster parents and children in the court process.

Recommendations and Responses

On May 21, 2010, the State Quality Improvement Committee submitted a



concerning the [recommendation letter](#) “interface between DCFS and the Office of Licensing.” It addressed the impact of the relationship between DCFS and OL on the licensing of foster parents.

The QIC noted that “there exists a general disconnect between the process of licensing foster parents and the needs, aims, and perceptions of the programs and personnel of both DCFS and the Foster Care Foundation.” A number of individuals stated they believe DCFS and OL have very different standards for certifying foster homes “and do not share a common perception of what foster parents should be and what foster homes should look like.”

Therefore, the State QIC recommended that DCFS develop and adopt practices and procedures necessary to license its own foster parents.

Due to transitions of both division and department directors, the response from Child and Family Services to this letter was delayed, which the chair of the committee was aware of. A [response letter](#) was sent from Child and Family Services to the chair of the committee on September 16, 2010.

The reply responded to seven concerns outlined in the recommendation. DCFS administration agreed there are issues surrounding the stability and permanency of out of home placements. Administration also agreed that there are licensing issues to be resolved. In the future, the DCFS and OL Directors will meet at least monthly to address licensing issues and identify solutions to be implemented that will resolve those issues.

EASTERN REGION/MOAB QUALITY IMPROVEMENT COMMITTEE¹

MEMBERSHIP	
Geri Winkler (Chair) – Utah Foster Care Foundation	Tom Nixon – Moab PD
Chris Blackmon – Juvenile Probation	Gen Numaguchi – Four Corners Behavioral Health
Cheryl Brand (Stewart) – Former Client	Sean Sasser - DCFS
Mike Gardener - Seekhaven	Kevin Webb – DV treatment
Connie Haycock – Children’s Justice Center	Teresa Wyatt-Hines – Family Support Center
Teri Nixon – DV treatment	

Significant Activities

The Eastern Region/Moab QIC researched the impact of drug-endangered children on the Moab community. They are probing issues related to the availability of drugs to youth in the community and are specifically trying to identify the types of drugs being offered and used by youth.

The committee invited the local Sheriff’s Office to one meeting and addressed a number of topics including how to maintain good working relations between DCFS and the Sheriff’s Office. DCFS and Sheriff’s Office staff recognize the differences between their agency’s definitions of “domestic violence” and indicated a desire to work together to develop a common definition. Similar meetings with local schools, the System of Care Committee (SOCC), and drug court, resulted in the identification of measures that will aid in solidifying the relationship between DCFS and those agencies.

¹ On Dec 1, 2010, in an effort to provide better support to members, the Eastern Region combined the Moab and Carbon County QICs and has structured that committee much like committees in the Northern, Salt Lake Valley and Western Regions.



In training designed to introduce QICs to the Safety Model, the committee used the model to review two CPS cases. In addition, the committee explored the need for, and costs associated with producing a “service guide” in the form a brochure. They hope to provide this guide, which includes an introduction to the scope and purpose of the QIC, to the community in the coming year.

Recommendations and Responses

The Eastern Region QIC/Moab did not submit a recommendation to Regional Administration, the State QIC, or the Division Director.

EASTERN REGION/PRICE QUALITY IMPROVEMENT COMMITTEE

MEMBERSHIP	
Lisa Branch -Local Interagency Council	Heather Ogden -Carbon School District
John Behn -Boy Scouts of America	Jeff Olinger -DWS
Patsy Buchmiller -Regional Healthcare Coordinator	Misty Olsen -Consumer
Kyle Elder -Four Corner 's Behavioral Health	Rhonda Peterson -Carbon County Fairgrounds
Missy Hamilton -Bruin Point Elementary Principal	Boni Seals -DCFS Community Service Manager
Keri Larsen -CASA Coordinator	Lisa Shook -DCFS Intake (minutes)
Reverend Huseby -Ecclesiastic Leader	Shelley Wright -Children 's Justice Center Manager
Kobi Marchello -Foster Care Foundation	

Significant Activities

While they addressed issues related to foster parent retention and stability, the CPS process and use of the Safety Model in that process, as well as substance abuse and the availability of treatment to substance abusers, the Eastern Region/Price QIC spent the majority of their time focusing on two issues.

First, the QIC spent a great deal of time researching domestic violence related child abuse and the rate of repeat child abuse allegations with domestic violence as the only complaint in the allegation. They found that while a child may enter custody due to the actions of a perpetrator of domestic violence, they often re-enter custody because of abuse and neglect at the hands of the victim. They met with staff from the local domestic violence shelter and discussed measures that might increase treatment options available to the victim of domestic violence. As a result, they developed a supporting treatment model (see “Recommendations and Responses” below) and have begun efforts to initiate a pilot test of the recommended treatment model.

Secondly, the QIC reviewed services delivered to youth transitioning from custody to independent living. They met with representative from the local Homeless Project in an effort to make that project aware of youth’s needs as well as to offer their support to Homeless Project programs that support homeless youth.

They identified activities the QIC will undertake to support the Transition to Adult Living (TAL) Summit and made plans to hold a DCFS Immersion Day in conjunction with the TAL Summit. During this immersion, youth receiving TAL services will learn more about how DCFS functions, what services are available, and how they can interact with the agency.

Finally, the QIC continues to focus on its membership. Last year, it added four new members that represent the community as well as clients served by DCFS.

Recommendation and Responses



A **recommendation letter** dated September 16, 2010 was submitted to Eastern Region Administration. It addressed domestic violence cases and high recidivism rates and stated that the QIC has been concerned with the number of CPS cases in their area as well as the rate of recidivism (repeat allegations) associated with past cases. Their research indicates that the largest number of children involved in a CPS case who are re-victimized are re-victimized by the victim of domestic violence and not the perpetrator of domestic violence.

They proposed that employees currently in the process of completing a master's degree in social work be allowed to, under the supervision of local therapists, provide domestic violence group therapy for children that witness domestic violence, or that the region be allowed to hire a CPS/Domestic Violence worker that will specifically handle domestic violence cases.

The **regional response** was sent on November 27, 2010 and stated that Regional Administrators support, and will allow, social work interns to provide group therapy to child victims of domestic violence.

As related to the second proposal to hire a CPS/domestic violence worker, the administrators felt that the proposal was an excellent recommendation but could not support the hiring of a new worker since the State of Utah has put a full-time employee cap on each region. Since the region has reached that cap they will be unable to hire any new workers.

NORTHERN REGION QUALITY IMPROVEMENT COMMITTEE

MEMBERSHIP	
Daryl Melton (Chair)- Community Volunteer/Foster Parent	Karen Kagie-Community Volunteer
Eileen Nicholas (Co-Chair)- Ogden School District	Sandra Kimber-Community Volunteer
Sandy Rice (Co-Chair)- Community Volunteer	Timothy Ledna-Foster Parent / USU
Susan Andersen-Foster /Adoptive Parent	Mindy Lundgreen-Utah Foster Care Foundation
Carol Baumann-DCFS Regional Director	Linda Melton-Community Volunteer/Foster Parent
Tami Baugh-Christmas Box House Club	Craig Monson-Community Volunteer
Joyce Booth-Paralegal - Office of Attorney General	Jean Marie Morris-Kinship Specialist – DCFS
Melonie Brown-Christmas Box House Director	Pam Nacario-Office Manager – DCFS
Pam Clark-Family Support Center	Stacey Newman-Community Volunteer
Sylvia Cobabe-Community Volunteer	Happie Patterson-Larson- Utah Foster/Adoptive Families Assoc (UFAFA)
Patty Conner-Rose- Community Volunteer	Virginia Pendleton- Community Volunteer
Brenda Durtschi-Utah Foster Care Foundation	Jed Platt-CBI Community Outreach
Sherri Engar-Christmas Box International	Sarah Pomeroy-DCFS – TAL Supervisor
Mary Francisco-Foster and Healthy Children-Nursing Supervisor	Art Rice-Community Volunteer
Jennifer Gardner-Utah Foster/Adoptive Families Assoc (UFAFA)	Pat Ropelato-Community Volunteer
Marie Grogan-Community Volunteer	Justine Stephenson-Weber Human Services
Landon Halverson-Weber Housing Authority-Executive Director	Stacey Snyder-Guardian ad Litem
Marty Hood-Davis County Behavioral Health	Jeff Tesch-Clinician-Headstart
Pam Hucie-Community Volunteer	Winnie Warren-Community Volunteer
Teresa Jones-Licensing Specialist – Office of Licensing	

Mission Statement

“As informed critics, the QI Committee will analyze relevant information, make recommendations for systemic improvements and be advocates for clients and staff.”

Significant Activities



The Northern Region QIC implemented three pilot projects last year. The Kinship Locator Project helps youth with few family connections locate and meet with their biological parents.

Under the Placement Disruptions Project, the committee surveyed caseworkers and foster family or kinship family members in an effort to determine what circumstances caused the disruption of the placement, what could have been done to prevent the disruption, and gathered suggestions on system changes needed to prevent further disruptions.

Finally, the Northern Region QIC developed, and are currently supporting, a Teen Support Group in which 12 youth aged 12-15 and in foster care receive supports designed to reduce the number of placement disruptions. These groups are designed to help youth “have fun, feel supported, and help them integrate their foster care experience into their lives in a productive, positive and meaningful way.”

The Northern Region QIC sponsored “Insight, the Whole Team” training. By listening to the experiences of foster parents and caseworkers, QIC members achieved a better understanding of what families and caseworkers experience as they work together to serve children placed in out-of-home placements. The committee also received Safety Model Training, which includes a segment on use of the Safety Assessment. They also reviewed guidelines that relate to safety decision-making, intervention, and safety tracking processes.

This QIC also sponsored an Immersion Day where 43 community members received an overview of child welfare services from caseworkers, consumers, and service providers.

The committee has also been involved in the development and implementation of the “Drug Endangered Children Conference.” A subcommittee has been formed that will develop a cost proposal and find funding to hold the conference.

Finally, eleven committee members signed up to shadow a lead reviewer in the upcoming QCR in March 2011.

Recommendations and Responses

In November 2009, the Northern Region Quality Improvement Committee issued [Recommendations](#) on how to boost foster parent support. They recommend that the Northern Region:

1. Develop a system to better support foster parents to include:
 - Providing foster parents with names and phone numbers of staff that can respond to a crisis and
 - Providing families with additional literature that addresses specific child welfare issues
 - Identifying and providing access to foster parent mentors who will provide support to foster parents experiencing difficulties.
2. Develop a process to help resolve relationship issues between caseworkers and foster parents when the relationship begins to deteriorate.
3. Have trainers evaluate and update Behavior Replacement Model Training (BMRT).

The response indicated that the Northern Region Administration used these recommendations to develop a forum where caseworkers, foster parents and families can meet to discuss issues that affect their relationship. In addition the region stated that staff will compile a list of community



agencies emergency contact numbers as well as telephone numbers for staff on call and will add those contacts to the out-of-home book. The region indicated that the CWA that supervises Resource Family Consultants developed and implemented a procedure to address relationship issues that surface between caseworkers, foster parents, or families. They also indicated that the Utah Foster Care Foundation is in the process of updating BMRT training.

month and are designed to obtain information relating to the client's feelings about their involvement with CPS.

They also continue to focus on worker recognition and conducted a worker recognition event on March 16th during World Social Worker's Day. In addition, they are planning a Nurse Recognition event where nurses scoring 100 percent on their CPR indicators will be recognized for their efforts. The QIC also reviewed:

SALT LAKE VALLEY REGION QUALITY IMPROVEMENT COMMITTEE

MEMBERSHIP	
Mike Hamblin (Chair)-Utah Foster Care Foundation	Carolyn Jensen -Tooele County, CJC
Carolyn Hansen (Co-Chair)-Christmas Box House	Marilyn Johnson-Community Member
Misty Butler -Administrative Office of Courts	Diane Moore -Region Director DCFS
Cheryl Dubach -UDOH~Fostering Healthy Families	Stephanie Steele -The Sharing Place
Sherri Engar -Christmas Box House International	Arn Stolp -Community Member
Kristin Fadel -Guardian ad Litem	Kristie Van Wagoner -DCFS
Karen Hansen -Safe and Healthy Families PCMC	Mary Wilder -DCFS
Annette Jan -Attorney General	Patricia Worthington -Community Member
Teresa Jacobs -Family Support Center	

- The Region's ability to staff essential staff positions, this in light of the loss of caseworkers and the increase in the caseload of remaining workers
- Cases where both the Division of Juvenile Justice Services (DJJS) and DCFS provide overlapping services or support
- The Fatality Review Report and Domestic Violence nationwide data

Finally, the QIC provided support during the Salt Lake Valley Region's QCR conducted in September 2011. It also supported the federal CFSR conducted in June 2010.

Recommendations and Responses

Salt Lake Valley Region did not submit a recommendation for review by Region Administration, the State QIC, or the Division Director in FFY 2010.

Significant Activities

The Salt Lake Valley Region QIC is in the process of developing a charter that will formalize the committee structure (to include the development of several subcommittees) and are revising the QIC handbook, which in the future will include information about the duties and responsibilities of those subcommittees. The Salt Lake Valley Region continues to review CPS surveys sent to all CPS cases once they are closed. Up to 300 surveys are sent each



**SOUTHWEST
 REGION/IRON COUNTY
 QUALITY IMPROVEMENT
 COMMITTEE**

MEMBERSHIP	
Amy Bates (Chair)-Foster Parent	Duane Jarvis -South West Center
Stephanie Furnival -Children's Justice Center	Gwen Knight -CASA Coordinator
Tyler Goddard -Paiute Indian Tribe of Utah Department of Behavioral Care	Destry Maycock -DCFS Supervisor
Susan Goodman - DCFS Supervisor	Shandra Powell -Family Support Center
Denny Heaton -Southwest Education Academy	Helen Rosso -Safety Solutions Coalition
Mark Hollingshead -DCFS Supervisor	

Significant Activities

The Southwest Region/Iron County QIC located in Cedar City, Utah welcomed their new chair Amy Bates, who takes over for Amber Perkins who resigned due to work conflicts. Southwest Region/Iron County QIC priorities centered around the need to support families that provide foster care as well as public affairs efforts that either inform the community of programs and services available to those involved with the child welfare system or that highlight events that support agencies providing child welfare services. The QIC also addressed the following:

- Repeat maltreatment cases and factors that influence whether a case is determined to be one that involves repeat maltreatment.
- The role and function of Resource Family Consultants
- The possible negative effect that Medicaid cutbacks will have on child placements and services.

During FFY 2010 the QIC:

- Developed and implemented a survey (provided to resource families attending UFCF cluster meetings) that allows resource families to provide feedback to the division
- Sponsored and produced a flyer that advertised the Drug Endangered Children Summit held in cooperation with the Utah Drug Endangered Children's Alliance
- Submitted an article to the St. George Spectrum that featured a local family who adopted a child through DCFS.

Recommendations and Responses

The Southwest Region/Cedar City QIC did not submit a recommendation to Region Administration, the State QIC, or the Division Director in FFY 2010.

**SOUTHWEST REGION/SEVIER
 COUNTY QUALITY
 IMPROVEMENT COMMITTEE**

MEMBERSHIP	
Karen Payne (Chair)-Office of the Guardian ad Litem	Susan Munk -Department of Workforce Services
Tammy Powell (Co-Chair)-Division of Juvenile Justice Services	Bill Pierce -Head Start
Alysa Bowling -Community Member	Chad Williams -Central Utah Counseling Center
Marissa Douglas -Utah Foster Care Foundation	Caron Withers -New Horizons Crisis Center
Shelley Haupt -Sevier County Attorney	DCFS Liason: Bruce Zylks -PA
Mandy Jensen -Family Support Center	

Mission Statement

"Our mission is to identify issues and make recommendations to improve the delivery of DCFS services for the purposes of strengthening families."

Significant Activities

The Southwest Region/Sevier County QIC located in Richfield, Utah developed a new mission statement that will guide its future



activities. The QIC participated in activities designed to support recruitment and training of foster care and foster to adopt families served by the Utah Foster Care Foundation (UCFC). They receive monthly updates from UCFC representatives and made recommendations based on those reports.

They also addressed issues that affect the Region's relationship with Juvenile Justice Services, the Family Support Center, and the Central Utah Counseling Center. As a result, at least one member was recruited as a liaison between the QIC and a committee reviewing the need for a local Children's Justice Center. Other issues addressed by the Southwest Region/Sevier County QIC include:

- Worker retention
- Medicaid restructuring
- Safety Model and In-Home Services
- Recruitment of new QIC members
- Peer Parent and Youth Advocate recruitment
- The community's perception of CPS.

The committee received training related to the new Safety Model and used a hypothetical case to determine the impact of budget cuts to services provided.

Recommendations and Responses

The Southwest Region/Richfield QIC did not submit a recommendation to Region Administration, the State QIC, or to the Division Director in FFY 2010.

SOUTHWEST REGION/ WASHINGTON COUNTY QUALITY IMPROVEMENT COMMITTEE

MEMBERSHIP	
Debbie Hoffhines (Chair)-Utah Foster Care Foundation	Chantel Markel -tolbert Nielsen Realty Group
Sara Boatright -Foster Parent	Madonna Melton -DOVE Center
Jenny Bonaudi -Community Volunteer	Trina McCoy -St. George Police Dept.
Diane Callister -Utah Foster Care Foundation	Jennifer Nichols -Washington County Justice Court
Sandy Cox -CASA Volunteer	Terry Ogborn -Principal Millcreek High School
Tami Fullerton -Division of Juvenile Justice Services	Armondo Parras -Community Member
Mikelle Haven -Washington County School District	Patricia Sheffield -CJC
Greg Loebel -Pilot Community Coordinator	Carolyn Washburn -USU Extension Services
Biff Lowry -Community Volunteer	Jeff Wilcox -Attorney
Beverly Lutrell -Community Volunteer	Lynda Whitlock -Community Volunteer

Mission Statement

“The Washington County Quality Improvement Committee (QIC), working in partnership with Division of Child and Family Services (DCFS), advocates for client well being by identifying areas of improvement, and promoting change within the child welfare system.”

Significant Activities

The Southwest Region/Washington County QIC recently developed and published their mission statement, which will be used to guide future activities.

This QIC formed a new Substance Abuse subcommittee, which will attempt to determine if DCFS needs to provide CPS services to children whose parents may have a substance abuse problem but where no other serious child welfare issues exist. Specifically, in light of recent budget cuts, the committee stated it will try to determine if drug screening is necessary, will review the cost to DCFS of repeated drug screenings ordered by the courts, and will try to determine whether drug screens ensure a parent is free of the abused substance. The committee will determine if it is feasible to advocate with courts in an effort to reduce the number of drug screens required, reduce the number of removals where drug use is



the only safety factor, and reduce the number of children currently in custody because of a parent's substance abuse.

The committee continues to focus many of its activities on employee retention. In association with National Social Worker Month in March, the committee organized an appreciation luncheon and potluck as well as provided a small token of appreciation to each employee at that luncheon.

The committee reviews CPS related data monthly and are currently awaiting Safety Model Training, which has been scheduled for FFY 2011.

The committee will also augment community education provided during Red Ribbon Week and will support training provided by the Drug Endangered Children's task force.

Finally, the committee recognizes the need to recruit more committee members from the community. In an effort to recruit new members, the committee obtained copies of the new QIC handbook and began distributing them to potential QIC members. This process resulted in the recruitment of two local clergy members to the committee.

Recommendations and Responses

The Southwest Region/Richfield QIC did not submit a recommendation to Region Administration, the State QIC, or to the Division Director in FFY 2010.

WESTERN REGION QUALITY IMPROVEMENT COMMITTEE

MEMBERSHIP	
David Bayles - Boys and Girls Club	Monica Hullinger – Nebo School District
Laura Blanchard –CJC	Martin Hurlburt -Wealth Management Systems
Barbara Blotter – Nebo	Ha Khong - Provo School

School District	District
John Bonnett – DCFS, Drug Court	Dee Knell – Casa Coordinator
Wendy Bunnell –Foster Care Foundation	Jared Landvatter – Summit
Renee Calkins – UFAFA	LoAn Lee – Community Action
Miriam Campbell - Provo School District	Barbara McCleary –AAG
Evelyn Cloward – Utah County Health	John Moody –GAL
Trish Coburn – DCFS	Richard Nance - Utah County Health
Matt Dinger - Boys and Girls Club of Utah County	Rebekah Olsen - United Way
Branden Duncan – Centro Hispano	Bert Peterson - DCFS
Jessi Duncan – Centro Hispano	Vicky Proctor – Provo PD
Sherri Engar - Christmas Box House	Betty Quinn - Christmas Box House
Stephanie Ellis - UFAFA	Marla Raff –Utah County Health
Rhonda Gates –Center for Women & Children	Judy Robertson -DCFS
Judee A Gillies -CJC	Brian Robinson - Summit (Alpine School District)
Dan Grinder -Community Partner	Teresa Tavares -Centro Hispano
Beverly Hart – DCFS	John Thill - Foster Care Foundation
Jennie Hall – The Summit (Alpine School District)	Elisabeth Williams -Christmas Box House

Significant Activities

The Western Region QIC conducted a SWOT analysis in an effort to identify priorities. They noted that one of the committee's strengths has been the commitment and capability of their past and present chair and co-chairpersons. Another strength is that agencies represented on the committee have a strong relationship and that many great ideas are presented by members. The committee noted that members are committed to meeting the needs of the children and families they serve and that they work as a team to meet those needs. Finally, they noted that the system gives them the chance to make suggestions and that those suggestions are taken seriously.

Relating to weaknesses, members were most concerned about the lack of funding available to support the committee, the lack



of a sufficient number of members to do the work, and the need of all members to invest significant time to implement projects developed by the committee.

In May the Western Region QIC conducted an Immersion Day for individuals and groups interested in learning about how child welfare services are delivered as well as the impact those services have on children and families served.

The Western Region QIC continued to deliver and evaluate their Mentor Program pilot project, which teams mentors with youth who are currently receiving support through the TAL program. The QIC partnered with the Boys and Girls Clubs in the area, partnerships that have enabled the QIC to provide more mentors to more youth.

The Western Region QIC has recruited and trained seven relief parents and is in the process of recruiting more relief foster homes that can provide temporary care for children in foster care when the foster parents become stressed or when care is needed because of a family emergency.

The QIC expressed their concern about fiscal constraints resulting from budget cuts. Members continue to monitor the rise in worker caseloads and are monitoring worker “burn-out” that results. In an effort to resolve this problem the QIC made efforts to increase its community awareness. It is currently planning an Immersion Day and will invite local government leaders, agency staff, and the general public to attend. Also the QIC is in the process of scheduling presentations that will introduce participants to the child welfare system to community groups including the PTA, the City Council, Chamber of Commerce, and other agencies.

Recommendations and Responses

On February 2, 2010, the Western Region Quality Improvement Committee submitted a letter to Child and Family Services Regional and State Administration. In that letter the QIC made suggestions that are designed to boost resources available to structured foster parents.

As the state is having fewer options for high cost placements, the committee made a proposal to implement, over a 12-month period, a cost saving pilot project that will support experienced structured families that will provide support to, and will help “fill in the gaps” when foster families have an emergency or feel stressed by caring for a child in custody.

As part of this proposal, the Western Region will:

1. Recruit and train relief home parents
2. Create crisis homes
3. Utilize interns as support aids
4. Recruit in-home therapists

The response letter from the Division Director was sent on March 2, 2010. In that letter, DCFS administration approved the project and recommended that the QIC take whatever steps are needed to initiate the pilot project. The Division Director also offered the help of State Office staff as needed.

DEPARTMENT OF HUMAN SERVICES

FATALITY REVIEW REPORT

FY 2010

**Compiled by
Department of Human Services
Office of Services Review
August 1, 2010**

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DEPARTMENT OF HUMAN SERVICES FATALITY REVIEW ANNUAL REPORT

JULY 1, 2009 – JUNE 30, 2010

EXECUTIVE SUMMARY

Department of Human Services (DHS) Fatality Review Policy requires a review of the deaths of all individuals for whom there is an open DHS case at the time of death or in cases where the individuals or their families have received services through DHS within the 12 months preceding the death. Information obtained from case reviews provides insight into systemic strengths and highlights areas in which changes or modifications could enhance systemic response to client needs.

During FY 2010, 159 deaths of current or past DHS clients were reported to the Office of Services Review (OSR). There were ten suicide deaths (6%) and one homicide (.06%). The reviews indicate that abuse and/or neglect were contributing factors in two (1.3%) of the 159 deaths. Two (5%) of the 40 child fatalities reported by the Division of Child and Family Services (DCFS) died as the direct result of abuse or neglect by their parents/caretakers.

Of the 40 fatalities reported by DCFS, 16 reviews were held (40%) with no reviews pending. Forty-three of the 64 reported DSPD fatalities were reviewed (67%) with no reviews pending. Four Division of Juvenile Justice Services (DJJS) fatalities were reviewed (100%). An on-site review was held for four (100%) of the four reported Utah State Developmental Center (USDC) fatalities with no reviews pending. Utah State Hospital (USH) conducted on-site reviews for three of four reported fatalities (75%). The fourth reported fatality was an employee who died while at work and for whom no review was conducted.

The deaths of 34 individuals who received services through the Division of Aging and Adult Services (DAAS) were reported, with all formal reviews (100%) being waived. The Office of the Public Guardian (OPG) reported the deaths of 13 individuals for whom they provided services. Three of these individuals (23%) were also receiving services through DSPD at the time of their deaths and one individual (8%) was receiving services through USDC at the time of her death. OPG provided the Fatality Review Coordinator with comprehensive written reports detailing services provided and information relating to the deaths of their 13 clients (100%).

There were 93 (58%) reported deaths of male clients and 66 (42%) reported deaths of female clients. Reported deaths included 15 infants (9.4%) under the age of one year; 29 individuals (18.2%) between the ages of one to 18 years; 50 individuals (31.4%) between the ages of 19 to 50 years; 43 individuals (27%) between the ages of 51 to 80 years; and 22 individuals (14%) between the ages of 81 to 97 years.

One DSPD case was referred to the Bureau of Internal Review and Audit (BIRA) and to DSPD administration to review a contract provider's possible misappropriation of funds in an individual's budget. Review of the budget indicated that the provider had provided all billed services and that the services were appropriate to the individual's needs.

BACKGROUND and METHODOLOGY

In November 1999, the Office of Services Review (OSR) assumed responsibility for reviewing all DHS client fatalities. OSR recognizes the fatality review process as an opportunity to acknowledge good case management, to identify systemic weaknesses, to propose training for Division staff in performance problem areas, to involve Division staff on a local level in the review process, and to make cogent recommendations for systemic improvements. During the 2010 legislative session, the Utah State Legislature passed House Bill 86 by which the DHS fatality review process was codified in statute (62A-16-101).

During FY 2010, the DHS fatality review committees consisted of the Attorney General or designee for the division, a member of management staff (supervisory level or above) from the designated division, and in the case of a child fatality, the Director of the Office of the Guardian ad Litem or designee. DHS Fatality Review Policy indicates that the committees may also include individuals whose expertise or knowledge could significantly contribute to the review process, e.g., a member of law enforcement and/or a physician, medical practitioner, or registered nurse. The Child Fatality Review Committee (CFRC) has been strengthened by the participation of two pediatricians from Primary Children's Medical Center, a representative from the Division of Substance Abuse and Mental Health, and by the Director of the DCFS Professional and Community Development Team. The Director of Professional and Community Development provides a vital link between the committee and DCFS as she and her team develop or strengthen training to address identified problematic patterns of practice.

The DSPD Fatality Review Committee has utilized the knowledge and expertise of two regional DSPD Registered Nurses who have on-going personal contact with many of the DSPD clients and who, in many cases, have first-hand knowledge of a decedent's medical history. The RNs' medical knowledge and insight into health and safety issues is of great value to non-medical committee members.

Notification of client deaths is received through Deceased Client Reports, Certificates of Death, the Office of the State Medical Examiner, newspaper obituaries, emails, etc. The Department of Health provides the Fatality Review Coordinator with Certificates of Death for every child in the State of Utah who dies between the ages of birth and 21 years. These certificates are reviewed against the child welfare database, SAFE, to determine if the child or his family has had services through DCFS within twelve months of the death. If services were provided within this time period, the Coordinator requests and reviews the family's DCFS case file, makes a written summary of the family's history of involvement with the Division, and makes analyses pertaining to case practice and agency culpability.

Prior to the bi-monthly DSPD and CFRC meetings, committee members receive copies of fatality review reports to review preparatory to discussion. When deemed appropriate, the committees invite division staff and/or contract providers to committee meetings to provide additional information. Following the committee review, the fatality review reports, with the addition of committee questions, concerns, and/or recommendations, are sent to the DHS Executive Director, the Director of the division under review, and the Director of the region in which the fatality occurred. The Region has fifteen days in which to formulate a reply and, if necessary, a plan of action for carrying out the committee's recommendations. Due to the low number of fatalities in the Division of Juvenile Justice Services, the JJS Committee meets on an as-needed basis.

In FY 2010 the CFRC and the DSPD committee utilized the process of waiving the formal committee review for cases in which there were no practice concerns or in which there was no indication that division practices contributed to the death of the client. The written report for waived cases follows the same format as that for reviewed cases with the addition of the Coordinator's recommendation that the formal review process be waived.

The full report is then reviewed by the chairs of the CFRC and DSPD committees and by the Director of the Office of Services Review. If the chairs and Director concur with the Coordinator's recommendation to waive the formal review, they sign off on the recommendation. CFRC and DSPD committee members are provided with the "Findings" and the "Systemic Analyses" of waived cases. Committee members can request a full review of any case for which the formal committee review has been waived.

Fatality review reports are classified as Private/Protected. The content of the fatality report, i.e., the summary of services to the individual and/or his/her family is classified as "Private". The Fatality Review Committee's analyses of concerns regarding practice and the Committee's recommendations to the Division are classified as "Protected". Requests for copies of fatality reports must meet GRAMA criteria for these classifications.

The DHS Fatality Review Coordinator represents DHS as a member of the Multidisciplinary Child Fatality Review Committee (MCFRC), which is coordinated by the Department of Health's Violence and Injury Prevention Program (DOH/VIPP). The MCFRC is a collaborative process that includes professionals from Primary Children's Medical Center's Safe and Healthy Families Team, the Birth Defects Network, the Office of the Medical Examiner, Emergency Medical Technician Services, law enforcement, the Office of the Attorney General, the Office of the Guardian ad Litem, the Children's Justice Division, the State Office of Education, the Department of Human Services, Valley Mental Health, the PCMC Child Advocacy Team, the Shaken Baby Foundation, and the Division of Child and Family Services.

The MCFRC meets with the Utah State Medical Examiners on an as-needed basis to review the deaths of children whose deaths occur under violent, suspicious, unattended, or unknown circumstances and to review the deaths of children who have committed suicide. Committee members pool information regarding prior services to and/or involvement with the decedent/decedent's family, identify causes of preventable deaths, make Child Protective Services referrals, make recommendations for follow-up services when appropriate, attempt to

identify interventions that could prevent future deaths, and provide information to law enforcement during child homicide investigations.

The MCFRC has been instrumental in creating a Suicide Task Force, in partnering to complete a six-phase Youth Suicide Study, in working toward more comprehensive child-restraint and seat belt legislation, and in developing news releases, public service announcements, and media events to address the most common injuries among Utah's children.

FINDINGS

The purposes for reviewing a Department of Human Services client death are to assess if the Department had any culpability in that death, to develop means for preventing future client deaths, and to improve Department services to children and adults. The review itself evaluates the system's response to protecting vulnerable clients. Committee members attempt to assess if "best practice" was followed during the provision of services to individuals and families.

During FY 2010, the DHS Fatality Review Committees received reports of the death of 159 individuals who had received services through the Department within twelve months of their deaths. The Committees determined that in all 159 cases (100%), DHS services provided to the clients and/or their families did not contribute to the clients' deaths. Of the 40 reported child fatalities two deaths (5%) were attributed to abuse or neglect by a parent or caretaker. The following children died as the result of abuse or neglect:

- An 11-year-old male, who was wheelchair bound due to extremely limited mobility in his trunk, died of scalding injuries incurred in the family bathtub. The boy, who prior to the incident had been hospitalized for several months, was home on a weekend visit. He was left unattended in the bathtub for several hours while his siblings watched a video. It was reported that the boy's parents were home but that they ignored his screams of pain. The child was transported to the hospital and died the following day.
- A two-month-old male died as a result of inflicted trauma. The infant's mother initially claimed that the baby had fallen from the sofa two days prior to his death. She later admitted to smothering the baby by placing him in a sleeping bag and "bear hugging" him. She then wedged the sleeping bag with the baby inside between the seat and back cushions of the couch and lay on top of the cushions for approximately two hours before putting the dead infant in a bouncer chair and calling for her husband.

The DHS Fatality Review Committee members identified numerous strengths in service-delivery systems that included noticeable improvement in child welfare's involvement of families in service planning; more aggressive seeking of appropriate kinship placements; and on the part of DSPD Support Coordinators, increased attention to the health and safety issues of their clients. Committee members also singled out several areas in which changes or modifications could enhance systemic response to the needs of Department clients that included better documentation of decision-making and case-management activities, more effective interviewing/questioning techniques, better supports and internal processes for workers who are dealing with difficult cases, improved incident reporting, and enhanced communication between contract providers and the Division. The reviewers also recognized several examples of outstanding case management conducted by Human Services staff.

DIVISION OF CHILD AND FAMILY SERVICES

SYSTEMIC STRENGTHS

In the majority of cases reviewed the quality of work conducted in Child Protective Services investigations and in providing on-going services to families continued to conform to DCFS Practice Guidelines. In the majority of cases reviewed workers saw the child within priority

timeframes, conducted appropriate interviews, collaborated with law enforcement when necessary, worked with service providers to meet the needs of their clients, and if removal was necessary, aggressively sought appropriate kinship or foster placements. Caseworkers are conducting Child and Family Team Meetings, are working closely with clients in an attempt to identify client needs and to plan appropriate services, and are conducting assessments of a caretaker's capacity to protect. Some examples of good casework include:

- Two sisters who were in foster care for three and five years respectively were provided with extensive mental health treatment, medication management, and comprehensive medical and dental care. The girls were given the opportunity to be adopted; but due to their behavior choices, adoption options were withdrawn in each case. A permanency worker provided case management for the girls for 2-1/2 and 4 years respectively. He held frequent Child and Family Team Meetings to review the effectiveness and appropriateness of services, to plan for important transitions, and to attempt to provide opportunities for the girls to gain skills they would need to live independently. The worker communicated frequently with mental health providers, school staff, and foster parents to monitor the girls' needs, behaviors, and safety. He demonstrated extraordinary patience in working with two young women who had multiple mental health issues, which contributed to their sabotaging their opportunities to be adopted.
- In a case where the same allegations of abuse and neglect were being repeatedly reported the DCFS Child Protective Services workers conducted thorough and exhaustive investigations of the allegations. One CPS worker interviewed numerous collateral contacts furnished by both the mother and the father. She offered reasonable and appropriate options to the GAL and to the parents for ways to provide a safe environment for the children. The worker gathered information from many sources and excellently documented the accounts given and the casework done. She based the disposition of the case on the evidence gathered during the investigation.
- DCFS and DSPD partnered well to provide the best possible care for a young man who suffered from mental retardation and whose aggressive behaviors were putting his mother and siblings at risk. Due to the parents' desire to care for their son, the young man remained in his parents' home until approximately six months prior to his death. For several years prior to the youth's being ordered into DCFS custody, DSPD provided in-home supports to the family. When the parents accepted the fact that they could not provide a safe environment for their son, their other children, or themselves, they agreed to allow DCFS to take custody of the boy in order to procure appropriate and necessary services for him.

While in DCFS custody the youth was placed in a living environment in which he could learn independent living skills and from which he could attend a school program designed to meet his individual needs. The long-range plan for the boy was to eventually place him in programs that would help him develop occupational skills in preparation for obtaining satisfying employment. While in foster care, the boy's behaviors continued to stabilize, and he was displaying less aggression and fewer self-injurious behaviors. Following the boy's death from pneumonia-induced septic shock, the Transition to Adult Living (TAL) worker assisted the family in obtaining financial and in-kind donations to cover funeral expenses. The TAL worker also coordinated a resolution of a funding problem that arose from the youth's final hospitalization.

SYSTEMIC WEAKNESSES

In FY 2010 a formal Child Fatality Review was held for 16 of the 40 reported DCFS fatalities. Twenty-four formal reviews were waived, as it was deemed by the Director of the Office of Services Review, the Child Fatality Review Committee Chair, and the Fatality Review Coordinator that the cases contained no practice concerns or any indication that Division practices contributed to the deaths of the children. In the cases reviewed the committee noted isolated systemic weaknesses but no pervasive patterns in case management. Deficits in documentation contributed to questions about corroboration of information, follow-through in providing services, investigation dispositions, and other case-management decisions. Many of the Committee's concerns were assuaged by additional information provided by the regions. However, good casework documentation remains a problem for some workers. It is recommended that during FY 2011, DCFS concentrate on improving case practice in the following area:

Documentation

Major deficits in documentation were noted in two of the 16 cases reviewed (13%).

- A parent/grandmother involved in 11 CPS investigations over a seven-year period of time was most recently the alleged perpetrator of Emotional Maltreatment – General and Physical Neglect. The CPS worker, although relatively new, was diligent in interviewing family members, the referent, and collateral contacts. She staffed the case three times with her supervisor and with a group of supervisors in order to gain direction. At the final staffing with several supervisors it was determined that the worker would hold a Child and Family Team Meeting (CFTM). If the family did not cooperate and comply with the Division's requests and recommendations, DCFS would file a petition for Protective Supervision Services (PSS).

The family did not attend the CFTM on either of the two scheduled dates, and the case was closed two days after the second scheduled date with no petition having been filed and with no explanation in the activity logs of the reason for the sudden case closure. There is no documentation stating that services were offered to the family. It was during this CPS investigation that a child in the family died, yet there is no mention in the activity logs of his death.

- A lack of documentation in an IHS case led the Committee to believe that the worker, an intern, had been poorly supervised, that she had failed to make an assessment of the family's needs, and that the family had not complied with court orders or had not received necessary services. No context was provided as to why the case had been opened. Documentation of case activities suddenly ceased, and the case was closed six months later. Additional information provided to the Child Fatality Review Committee by the region indicated that an assessment conducted by DJJS Observation and Assessment was presented to the court and that based on that assessment, the target child and her family had received extensive services under the direction of the Juvenile Probation case manager.

Miscellaneous

The Child Fatality Review Committee identified isolated best-practice weaknesses in several cases, but there was no repetitive pattern of poor casework in the cases reviewed in FY 2010.

DIVISION RESPONSES TO RECOMMENDATIONS

Regions have the opportunity to disagree with Committee recommendations and to explain their rationale for practice decisions. If Regions accept the Committee's recommendations, they are asked to submit an action plan outlining how they will implement the Committee recommendations.

At the close of Fiscal Year 2010 DCFS had responded to all concerns and recommendations made by the Child Fatality Review Committee. The Child Fatality Review Committee commends DCFS for the thoughtful and thorough responses the Regions and the Administrative Team have provided to the Committee's concerns and recommendations.

- In a case with an allegation of sexual abuse the County Attorney declined to prosecute the alleged perpetrator due to a lack of evidence. DCFS was under the impression that law enforcement would follow up with the alleged perpetrator and closed the case with the allegation supported. The alleged perpetrator and his parents were taken by surprise when they received the DCFS letter stating that there was a supported finding against the youth. Reportedly, law enforcement had not interviewed the youth but had pressed charges against him and had then dropped them.

In response to the committee's recommendation that CPS workers be trained on the process for conducting an investigation into an allegation of sexual abuse when law enforcement declines to conduct an investigation or to interview the alleged perpetrator, the region responded that they were working with the local AAG to help prepare and present a training on due process in cases such as this one.

- The Committee recommended additional training for in-take workers, case managers, and supervisors in the following areas:
 - Training for Intake/CPS workers on how to replace "unknown perpetrator" with the name of the perpetrator when that name is known before closure of a CPS case;
 - Training for CPS workers on the importance of speaking with as many collateral contacts as possible who have first-hand knowledge of the physical well-being and safety of a child(ren) named in a report of abuse, neglect, or dependency;
 - Training for CPS workers on the need to document clearly the reason(s) each allegation is supported or unsupported;
 - Training for all workers on the need to document decision-making and case management actions;
 - Training for Intake workers on including all children in a home on the CANR, not just the primary victim(s);
 - Training for CPS workers on how to conduct an investigation on an allegation of Sexual Abuse when law enforcement declines to conduct an investigation or to interview the alleged perpetrator;
 - Training for Intake and CPS workers on "asking the next question" or "going to the next level" in taking information and in conducting interviews (effective interviewing/questioning techniques).

In response to the Committee's recommendations Salt Lake Valley conducted the following staffings/trainings:

- Meeting with Intake supervisors and Administrators to discuss intake issues including adding all of the children to CANR and asking follow-up questions when taking a report of abuse or neglect;
- Discussion with case management regarding providing better supports and internal processes on difficult cases and on involving outside partners as needed;
- Training for supervisors on the need to document clearly the reason(s) each allegation is supported or unsupported;
- Training for supervisors and caseworkers on Domestic Violence.

In response to the Committee's recommendation that CPS workers to be trained on speaking with as many collateral contacts as possible who have first-hand information pertaining to the physical well-being and safety of a child(ren) named in a report of abuse, neglect, or dependency, Northern Region sent the recommendation to the entire region as an opportunity for practice improvement.

The Professional and Community Development Team recently implemented a one-hour web-based training, "Foundations for Youth: Supporting Foster Parents". During this training, participants receive the latest research relating to adolescent development, as well as learn about the impact of abuse and neglect, including trauma issues, on children. Participants learn about adolescent behavior, both normal and trauma-related, learn how to engage, how to provide appropriate interventions, and how to conduct planning with youth. Participants are introduced to the Ansell-Casey Life Skills Assessment (ACLSA), learn how to support youth through their transition to adulthood, and learn how to support foster parents who provide care to youth.

During FY 2010, the Division also implemented Foster and Adoptive Parent Levels of Care. During this training, participants receive information and learn techniques that help them build relationships with youth. They also develop skills to better serve youth 14 years of age or older who are currently in care. Participants receive Level III training, which prepares them to work with youth who have behaviors or conditions that need a higher level of care.

No changes were made or are in the process of being made to a law, rule, policy, or procedure in response to a fatality review that occurred in FY2010.

DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

COMMUNITY PLACEMENTS

SYSTEMIC STRENGTHS

Support coordinators act as advocates for individuals who are receiving services through the Division and through its contract providers. They verify and provide appropriate documentation necessary for ensuring an individual's eligibility for waived services, provide crisis intervention when necessary, monitor the delivery and appropriateness of contracted services, review monthly provider reports, and assess an individual's well-being through in-person visits in the home and at day program sites. The DSPD Fatality Review Committee recognized the

excellent work of several Support Coordinators and recommended that they be commended for their outstanding work.

- Following visits with a client, a support coordinator wrote clear and concise accounts of the visits touching on the client's health, safety, and wellbeing and on the condition of the home or day program environment. He asked day program staff to include documentation of changes in the client's mood and eating habits in her monthly summary, checked the medication log, noted missing signatures, and reminded the house manager of staffs' responsibility to sign each time a medication was administered. When the provider was tardy in notifying the support coordinator of the client's hospitalization, the support coordinator reminded the house manager of his responsibility to pass on that information within 24 hours of a hospitalization or other critical incident.
- Another support coordinator was described as her client's "biggest fan" and often expressed amazement and delight at the outstanding progress the woman made while receiving DSPD services. The support coordinator attempted to convince the client's parents of the importance of putting additional supports in place during the client's home visits, a plan, which if accepted, might have prolonged the client's life.
- A third support coordinator exhibited great care and concern for a client, especially while he was hospitalized. She instructed provider staff on the necessity of writing Incident Reports for individuals with seizure disorders and suggested that the provider provide additional training to staff on incident report writing.

Staff from several contract providers were recognized by the Committee for their excellence in caring for individuals and for their exceptional efforts to provide comfort to individuals suffering from terminal medical conditions. Staff from TKJ, Futures through Choices, JST, Work Activity Center, and Danville Services were commended for their outstanding work.

- A site manager for JST gave careful attention to a client's care by providing the support coordinator with reports on changes in the client's behavior, medical issues, medication changes, and concerns about the client's overeating while on home visits and the adverse affect that behavior had on the client's health and behavior.
- Over the course of many years WAC staff gave dedicated service to a client, and they expended valiant effort in their attempts to save his life. Over the years staff had taken the client on their family vacations and shortly before his death had taken him to a favorite restaurant to celebrate his 65th birthday. Staff expressed that the client's death was "especially devastating", as the man had been a participant of the Work Activity Center for over 43 years.
- Danville Services was commended for the care staff gave to a dying woman and for their honoring her desire to die at her home rather than in a care center. Staff provided a level of care above and beyond that for which they were paid. They made the woman comfortable and provided her with compassionate, loving care until her death.

- An individual showed symptoms of distress after, against the advice of staff, defiantly shoving four pieces of corn muffin into his mouth. Futures through Choices staff immediately began mouth sweeps and chest thrusts and continued to do so according to the instructions being given by the 911 dispatcher until the paramedics arrived. The FTC Program Coordinator arrived at the home shortly after the paramedics, spoke with staff about the incident, met the paramedics at the hospital, and immediately contacted the individuals' family. The paramedics reported that they were impressed with the quick response of FTC staff and indicated that staff had helped them in their efforts to resuscitate the patient. The Program Coordinator provided the doctor with the individual's medical history and with a list of his current medications and updated the individual's family when they arrived at the hospital.

The DSPD RNs continue to provide an excellent resource for Support Coordinators as they deal with the health and safety issues of individuals in service. Many of the individuals receiving services through DSPD and its contract providers are diagnosed with numerous medical and/or behavioral problems for which they receive treatment and prescription medication. Individuals who are immobile are subject to skin breakdown that can lead to serious, and even life-threatening, wounds. RNs visit with individuals in their homes, in hospitals, and in care centers to make assessments of their medical condition and to monitor their progress and the quality of care they are receiving. The RNs have knowledge of prescription medications, their uses, the signs of adverse drug interactions and possible side effects. They can monitor the effectiveness and/or appropriateness of these medications and alert medical personnel to potential medication-related problems. In some instances the RNs act as a liaison between medical professionals and providers, family, and DSPD, and they participate with hospital personnel in discharge planning. The Committee continues to recognize the excellent work of the DSPD RNs in all regions.

SYSTEMIC WEAKNESSES

In the majority of cases reviewed in FY 2010 the level of care for individuals appears to have been appropriate and to have been provided as contracted. Individuals were provided with multiple services, excellent medical, dental, and mental health care, and opportunities to participate in meaningful work and community and social activities. Provider staff worked with several individuals in planning and shopping for nutritious meals and in encouraging them to exercise in order to reach or maintain a healthy weight. With the help of respite and supported living services twenty-seven individuals (42%) were able to remain in their homes and to be cared for by family members.

During FY 2010, the DSPD Fatality Review Committee noted some isolated concerns related to the delivery of provider services and to other systemic issues.

Incident Reporting

The Committee noted problems related to incident-report writing in six (9%) of the 64 cases. There were concerns about missing and/or poorly written incident reports, about reports not being sent to the support coordinators within DSPD Practice Guideline timeframes, about incident reports not being filled out following the death of an individual, about incident reports being written by someone other than the person who was present at the time of the incident, and about support coordinators not signing incident reports to indicate that they have reviewed the document. Training was recommended for provider staff on writing incident reports with an emphasis on documenting "times", e.g., the time the incident began; the time that emergency

procedures were begun; the time that emergency calls were made; the time that emergency staff arrived, etc. Additional training was recommended for support coordinators pertaining to their responsibility to review and sign incident reports and to send incident reports back to the provider if they did not contain adequate information.

Communication of Information

The issue of communication of information between providers and support coordinators and between support coordinators and DSPD RNs was noted in three (5%) cases.

- The provider for an individual who fell at his home, who was hospitalized, and who underwent surgery failed to notify the support coordinator or her supervisor of these events. Five days passed before DSPD became aware of the incident, which was conveyed through a relative of the client.
- An individual was hospitalized, released, and hospitalized once again due to an infected sore. Although the provider kept the support coordinator apprised of the individual's condition and progress, the support coordinator did not inform the DSPD RN of the matter. After the individual aspirated while in the hospital, which led to his condition changing "dramatically", the DSPD supervisor requested that the DSPD RN make an assessment of the individual's medical condition.
- During an individual's final illness, the provider Program Coordinator obtained frequent updates on his condition, spent time with him at the hospital/care center, and provided information to the DSPD Support Coordinator regarding his progress. However, provider staff did not notify the DSPD support coordinator of the individual's death. It was only when the support coordinator contacted the provider for an update on the individual's condition that he was told that the individual had died two days prior to that time.

The Committee recommended that DSPD administration provide training for support coordinators on notifying DSPD RNs about individuals' hospitalizations, acute medical problems, or on-going medical issues and on keeping the RNs fully apprised of any changes in an individual's medical condition. It was also recommended that providers be reminded of their contractual obligation to notify the person's family, support coordinator, and DHS DSPDS Region Director within 24 hours of first knowledge of the death of a person receiving support services.

DIVISION RESPONSES TO RECOMMENDATIONS

The DSPD Regional Directors are to be commended for their prompt and serious consideration of committee recommendations, for the action they initiated to comply with recommendations, and for their formal written responses to the Fatality Review Committee. Following are examples of division responses:

- In response to the Committee's recommendation that DSPD develop a system or procedure to ensure that there is continuity of service delivery during periods of transfer or transition, e.g., an individual moves from one region of the state to another or there is a change in the support coordinator provider, Central and Northern Regions designated "transition" workers to oversee these transitions and to help prevent an interruption of services to the individuals involved.

- In response to the Committee’s concerns regarding poorly written or missing incident reports, the Region Director requested and received copies of missing Incident Reports, medication logs, and an outline of the training on Incident Reporting that the provider agreed to provide to its staff. The region also scheduled training for all private and State support coordinators concerning the expectations pertaining to their review of Incident Reports.
- A supervisor addressed with a support coordinator the steps to follow when reviewing provider monthly summaries and how to follow up with the information received. The worker was instructed that if she copied the provider’s reports directly into her activity logs, she would need to provide follow-up information on how the supports benefited the client. The supervisor also reviewed with the worker steps for responding to concerns addressed in the summaries and reports. The worker was instructed to follow up with the provider and to document comments and recommendations in the logs.

UTAH STATE DEVELOPMENTAL CENTER

During FY 2010, Utah State Developmental Center (USDC) reported the deaths of four individuals who were or who had been residents of that facility. Three of the four individuals died at American Fork Hospital, American Fork, Utah, and the fourth individual died in an extended care/rehabilitation facility. Formal death reviews were held at USDC for these individuals as well as for seven individuals who died in FY 2009.

“Natural Causes” is certified as the manner of death for each of the four individuals. Three died of aspiration pneumonia, and one individual died of sepsis/cardiac arrest. It appears that USDC staff followed practice guidelines and appropriate protocol when handling medical issues. No recommendations for practice improvement were made concerning these fatalities.

DIVISION OF AGING AND ADULT SERVICES

During FY 2010, the Division of Aging and Adult Services reported the deaths of 34 individuals who were or who recently had been the alleged victim in an Adult Protective Services (APS) investigation. FY 2010 was the first year in which the deaths of all known APS clients were reported. The individuals were reported as victims of alleged abuse or neglect, and the reports were investigated by Adult Protective Services (APS). APS investigators conducted thorough investigations into reports of Caretaker Neglect, Self-neglect, Financial Exploitation, and Emotional Abuse/Harm and made dispositions based on information gathered and assessments made. There was no evidence to suggest that DAAS or the APS investigations contributed to the deaths of the 34 individuals.

DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

UTAH STATE HOSPITAL

During FY 2010, Utah State Hospital reported the deaths of three individuals who were residents of USH at the time of their deaths and reported the death of one USH employee who took his

own life while on duty. The Utah State Hospital Clinical Director and the Clinical Risk Manager conducted an on-site Risk Management Fatality Review for each case. One of the three patients was on a day pass with his parents and died at his parents' home. Two patients and the USH employee died or were pronounced dead at Utah Valley Regional Medical Center (UVRMC) in Provo, Utah. The manner of death for one individual was "natural causes", with the cause of death being "pulmonary embolism". The manner of death for three individuals was "suicide" with two individuals dying of asphyxia due to hanging and the other dying of a gunshot wound to the head.

- An individual was admitted a second time to USH in March 2010 with diagnoses of major depression, alcohol dependence, and Type II diabetes. The individual's excess drinking had created a severe strain on her relationships with her husband and daughter. In the days prior to her suicide the woman indicated that she was being visited by an invisible friend and that she had been talking to her deceased mother.

At the time of her admission to the hospital the woman was placed on Direct Observation Status (DOS) for at least four days and was then placed on area restriction during the day with DOS continuing at night. She had not recently voiced suicidal ideation. On the day of her death the woman was permitted to leave the common area to take a shower. However, staff failed to set a required timer when the patient left area restriction, and the on-shift tech failed to tell his replacement that the patient had gone to take a shower. When techs missed the woman, it was thought that she had gone to rest in the dayroom. Failing to find her there, the techs searched the bedrooms and bathrooms and found the woman hanging by her shirt from the showerhead. CPR was started, and the RN called 911. However, staff failed to notify the hospital switchboard of the emergency, which caused a delay in the Code Blue response. This omission also left EMS searching for the correct location without an escort from USH Security.

Risk Management determined that although the hardware in the shower was a safety showerhead, it had been installed incorrectly, leaving a small space between the showerhead and the wall. The screw designed to secure the showerhead to the wall was loose, which created a hinge on which the patient could hang her shirt.

- After numerous hospitalizations and a suicide attempt, an individual was admitted to USH in May 2010. After being hospitalized for approximately a month the individual was cleared for day visits with his family, as he had had two prior successful off-grounds visits with his parents. When the individual's parents signed him out for an off-grounds day visit, they agreed to supervise him at all times. Prior to going fishing, the family made a stop at their home. The parents gave the individual permission to look at his grandfather's rifle, which they believed to be unloaded. After a period of time the family heard a gunshot and found their son in his bedroom with a fatal gunshot wound to the head.
- Another individual was committed to USH for his sixth admission due to a history of chronic mental illness and legal problems associated with his mental illness. The patient's psychosis was treatment resistive and persisted despite his being on three anti-

psychotics. The patient was sedated much of the time, and in the six and a half years since he had begun taking Clozaril, he had gained 160 pounds. Efforts were being made to taper the Clozaril and to substitute a combination of other medications. Although the patient lacked motivation for physical activity, he had attended physical therapy on a regular basis during the year preceding his death and had lost 33 pounds during that time. However, obesity and a sedentary lifestyle posed an increased risk for pulmonary embolism. While the RN was conducting an assessment of the patient's condition, the individual went into cardiac and respiratory arrest. Paramedics transported the patient to the hospital where resuscitation efforts failed.

Based on review findings, the fatality review committee made recommendations for improving service and for lessening the level of risk to patients residing at USH, which included:

- having medical staff, including the presenting psychiatrist and the attending medical services practitioner, meet on a regular basis to review challenging cases;
- establishing a pharmacology consult/review team to review patients who were on “large amounts of medication” if the attending psychiatrist was unsure as to where to go with treatment;
- having the Medical Executive Committee Leadership Group discuss the details of establishing a medical intervention protocol for extremely obese patients;
- improving campus-wide signage to facilitate EMS' ability to respond promptly to medical emergencies;
- conducting a literature review for guidelines on making decisions regarding home visits;
- researching the process by which gun dealers are notified of a person's commitment status;
- reviewing USH risk assessments for effectiveness;
- teaching staff to call the hospital emergency number first to announce Code Blue and then to call 911;
- having Risk Management create a mock Code Blue outline/form to make drills more meaningful;
- making CPR shields available in the OSHA cabinets on each unit for staff to carry on their person if desired;
- standardizing from unit to unit the meaning and understanding of different types of restriction and limits, including suicide precautions;
- having the Unit Small Management Teams tour the units on a monthly basis to look for anything that could be considered dangerous to patients.

USH Facilities personnel made a check of all shower heads and corrected those that were improperly installed. The Executive Staff agreed to determine training needs related to the Suicide Precautions and Seclusion/Restraints policies and related to the hospital's mood rating system/scale.

DIVISION OF JUVENILE JUSTICE SERVICES

The Committee received notification of four Division of Juvenile Justice Services (DJJS) clients who died during FY 2010. Three of the decedents had received service through both DJJS and

DCFS. The manner of death is certified as “Accident” in two cases with one youth dying from mixed drug intoxication and the other dying from blunt force injuries sustained in a motor vehicle accident. The manner of death is certified as “Natural Causes” for a youth who died of chronic renal failure as a result of Type I Diabetes. The manner of death for the fourth youth is “Could Not Be Determined”, and the cause of death is “Undetermined Causes”.

Three of the youth had been terminated from DJJS custody prior to their deaths. The fourth youth was in an independent living arrangement with a DJJS proctor family. He was scheduled to attend a court hearing a week following his death, at which time DJJS would have recommended his termination from the Division’s custody.

SYSTEMIC STRENGTHS

In the cases reviewed by the Fatality Review Committee, youth in DJJS custody received intensive assessments and services that included individual and group therapies, medication management, life skills training, substance abuse counseling and treatment programs, educational services, and tracking. Case managers and trackers were diligent in monitoring the well being and compliance of their clients.

SYSTEMIC WEAKNESSES

The DJJS Fatality Review Committee did not identify any practice concerns or systemic weaknesses in the DJJS cases reviewed.

OFFICE OF THE PUBLIC GUARDIAN

During FY 2010, the Office of the Public Guardian (OPG) reported the deaths of thirteen individuals for whom they had provided guardianship services. One client was also receiving services through the Utah State Developmental Center and three individuals were receiving services through the Division of Services for People with Disabilities and were in community placements. Seven individuals were hospitalized at the time of their deaths, and six individuals were in rehabilitation/care facilities. All deaths were certified as “Natural Causes” with causes of death being certified as dementia, debility, cerebrovascular accident, cardiopulmonary arrest, aspiration pneumonia, and cardiac arrest.

OGP provided the Fatality Review Coordinator with comprehensive summaries of the clients’ service histories and with an explanation of the causes of death. It appeared that all decedents received appropriate services and that their deaths were related to age and medical conditions.

**DEPARTMENT OF HUMAN SERVICES
FATALITY REPORT
SUMMARY
FY 2010**

DEPARTMENT/DIVISION	Number of Reported Deaths	Cases Open at Time of Death	Cases Reviewed	Committee Review Waived	Reviews Pending	Male	Female
DEPARTMENT OF HUMAN SERVICES	159	120	70	89	0	93	66
DAAS (Division of Aging and Adult Services)	34	28	0	34	0	17	17
DCFS (Division of Child and Family Services)	38	11	15	23	0	22	16
DCFS/DSPD (Division of Child and Family Services/Division of Services for People with Disabilities)	2	2	1	1	0	2	0
DJJS (Division of Juvenile Justice Services)	1	0	1	0	0	1	0
DJJS/DCFS (Division of Juvenile Justice Services/ Division of Child and Family Services)	3	1	3	0	0	3	0
DSA/MH - USH (Division of Substance Abuse/Mental Health - Utah State Hospital)	4	3	3	1	0	3	1
DSPD – COMMUNITY PLACEMENT (Division of Services for People with Disabilities)	61	59	43	21	0	39	22
DSPD/OPG (Division of Services for People with Disabilities/Office of the Public Guardian)	3	3	3	0	0	2	1
DSPD - USDC (Division of Services for People with Disabilities - Utah State Developmental Center)	3	3	3	0	0	1	2
OPG (Office of the Public Guardian)	9	9	0	9	0	3	6
USDC/OPG (Utah State Developmental Center/Office of the Public Guardian)	1	1	1	0	0	0	1

CHART I
FIVE-YEAR COMPARISON
FY 2006 – FY 2010

	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
DHS Reported Deaths	100	133	171	129	159
DAAS	0	3	3	2	34
DCFS	31	49	59	49	38
DCFS/DSPD	1	1	1	3	2
DJJS	2	3	2	3	1
DJJS/DCFS	1	1	2	4	3
DMH - USH	2	4	10	4	4
DSPD	57	57	75	49	61
DSPD/OPG	0	3	2	1	3
DSPD – USDC	3	3	4	7	4
OPG	3	9	13	7	9
Cases Open at Time of Death	79	101	124	106	111
Cases Reviewed	97	124	139	121	70
Abuse & Neglect Deaths	6	11	22	4	2
Accidental Deaths	8	15	10	12	18
Homicides	3	5	14	5	1
Motor Vehicle Accidents	3	5	9	1	6
Suicides	1	4	5	7	10
Undetermined	7	12	10	9	6

CHART II
AGE AT TIME OF DEATH
FY 2010

AGE IN YEARS	DHS	DAAS	DCFS	DCFS/ DSPD	DJJS	DJJS/ DCFS	DSPD	OPG	USDC	USH
< 1	15		15							
1 - 3	1		1							
4 - 6	5		5							
7- 10	4		4							
11 - 14	5		3				2			
15 - 18	14		8	2	1	1	2			
19 - 30	23	1	2			2	16			2
31 - 50	27	3					22	1		1
51- 65	25	5					16		3	1
66 - 80	18	8					4	5	1	
81 - 90	22	17					2	3		
TOTALS	159	34	38	2	1	3	64	9	4	4

CHART III
ABUSE/NEGLECT DEATHS
 FY 2010

CAUSE OF DEATH	DHS	GENDER	AGE	DIVISION
Suffocation and Blunt Force Injuries	1	Male	2 months	DCFS
Scalding	1	Male	11	DCFS
TOTAL	2			

CHART IV
ACCIDENTAL DEATHS
 FY 2010

CAUSE OF DEATH	DHS	GENDER	AGE	DIVISION
Asphyxia – Choking	2	Female	26	DSPD
		Male	65	DSPD
Aspiration – Food/Foreign Body	2	Male	10 months	DCFS
		Male	51	DSPD
Auto/Pedestrian Accident	2	Female	12	DCFS
		Male	61	DSPD
Drug Intoxication	3	Male	16	DCFS
		Male	18	DJJS/DCFS
		Female	28	DSPD
Fall	1	Male	4	DCFS
Motor Vehicle Accident	6	Female	5	DCFS
		Female	6	DCFS
		Female	15	DCFS
		Female	18	DCFS
		Male	19	DJJS/DCFS
		Female	19	DCFS
Scalding Injuries	1	Male	11	DCFS
Smoke Inhalation and Thermal Injuries	1	Male	10	DCFS
TOTAL	18			

**CHART V
HOMICIDE DEATHS
FY 2010**

MANNER OF HOMICIDE	DHS	GENDER	AGE	DIVISION
Inflicted Injuries	1	Male	2 months	DCFS
TOTAL	1			

**CHART VI
SUICIDE DEATHS
FY 2010**

MANNER OF SUICIDE	DHS	GENDER	AGE	DIVISION
Asphyxia (Hanging)	7	Male	10	DCFS
		Female	15	DCFS
		Female	17	DCFS
		Male	18	DCFS
		Male	19	USH
		Male	29	DCFS
		Female	54	USH
Drug Overdose	1	Male	14	DCFS
Gunshot Wound	2	Male	18	USH
		Male	30	USH
TOTAL	10			

CHART VII
MEDICAL EXAMINER'S DETERMINATION
MANNER OF DEATH
FY 2010

MANNER OF DEATH	DHS	DAAS	DCFS	DJJS	DSPD	OPG	USDC	USH
Accident	18		11	2	5			
Homicide	1		1					
Natural Causes	120	33	15	1	57	9	4	1
Pending	4		1	1	2			
Suicide	10		7					3
Undetermined	6	1	4		1			
TOTALS	159	34	39	4	65	9	4	4

**CHART VIII
DECEDEENTS' RACE
FY 2010**

RACE	DHS	DAAS	DCFS	DCFS/ DSPD	DSPD	DJJS	OPG	USDC	USH
AMERICAN INDIAN	3								
Navajo		1							
Paiute					1				
Ute			1						
ASIAN	2								
Indian					1				
Laotian					1				
BLACK/AFRICAN AMERICAN	1		1						
CAUCASIAN	140	32	27	2	60	3	8	4	4
HISPANIC	13	1	9		1	1	1		
TOTALS	159	34	38	2	64	4	9	4	4

CHART IX
FATALITIES BY REGION AND OFFICE
FY 2010

DIVISION OF AGING AND ADULT SERVICES

REGION	TOTAL	OFFICE	TOTAL
Central	15		
		Holladay	15
Northern	10		
		Bountiful	1
		Clearfield	1
		Logan	1
		Ogden	7
Southern	9		
		Cedar City	1
		Price	1
		Provo	2
		Richfield	3
		St. George	2
TOTAL	34		34

DIVISION OF CHILD AND FAMILY SERVICES

REGION	TOTAL	OFFICE	TOTAL
Eastern	3		
		Price	1
		Ute Family Services	1
		Vernal	1
Northern	16		
		Bountiful	7
		Brigham City	1
		Clearfield	3
		Logan	2
		Ogden East	3
Salt Lake Valley	13		
		Fashion Place	1
		Magna	1
		Metro	1
		Mid Towne	1
		Oquirrh Neighborhood	6
		South Towne	2
		TAL	1
Southwest	2		
		Manti	1
		St. George	1
Western	6		
		American Fork	1
		Orem	3
		Provo	2
TOTAL	40		40

CHART IX (Continued)
FATALITIES BY REGION AND OFFICE

DIVISION OF JUVENILE JUSTICE SERVICES

REGION	TOTAL	OFFICE	TOTAL
Region I	2		
		Logan	1
		Ogden	1
Region II	1		
		Salt Lake City	1
Region III	1		
		St. George	1
TOTAL	4		4

**DIVISION OF SERVICES FOR PEOPLE
WITH DISABILITIES
COMMUNITY BASED and
UTAH STATE DEVELOPMENTAL CENTER (USDC)**

REGION	TOTAL	OFFICE	TOTAL
Central	29		
		Salt Lake City	29
Northern	13		
		Clearfield	5
		Logan	4
		Ogden	4
Southern	22		
		Cedar City	1
		Price	2
		Provo	11
		Spanish Fork	3
		St. George	5
USDC	4		
		American Fork	4
TOTAL	68		68

FATALITIES BY REGION AND OFFICE

CHART IX (Continued)

OFFICE OF THE PUBLIC GUARDIAN

REGION	TOTAL	OFFICE	TOTAL
Central/Administration	9		
		Salt Lake	9
DSPD/OPG	3		
		Clearfield	1
		Spanish Fork	1
		St. George	1
USDC/OPG	1		
		American Fork	1
TOTAL	13		13

DIVISION OF SUBSTANCE ABUSE/MENTAL HEALTH UTAH STATE HOSPITAL

REGION	TOTAL	OFFICE	TOTAL
USH	4		
		Provo	4
TOTAL	4		4

