Fiscal Year 2022

Fatality Review Summary

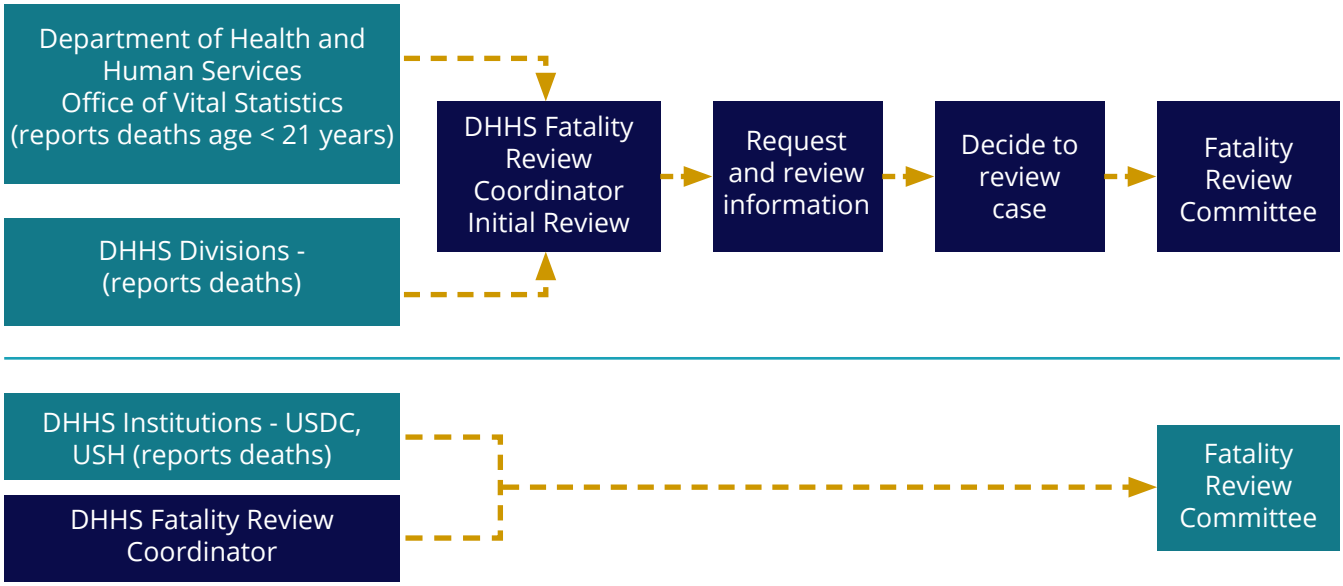
The Department of Health and Human Services (DHHS) Fatality Review Committees review cases of individuals who themselves, or a family member, had an open case with a DHHS division at the time of their death or, in some cases, within up to 12 months preceding the death.

Committee members are statutory appointees and professional partners whose expertise adds to the review findings. It includes representatives from the Guardian Ad Litem, law enforcement, medical profession (Safe and Health Families), Attorney General's Office, a Children's Justice Center representative, a Suicide Prevention and Crisis Services expert, risk management and DHHS division administration. The reviews are managed through a Fatality Review Coordinator in the DHHS Office of Service Review (OSR).

Fatalities are reported and reviewed in the following manner:

DHHS Divisions Included

- Aging and Adult Services (DAAS, Adult Protective Services (APS)
- Child and Family Services (DCFS)
- Juvenile Justice and Youth Services (JJYS)
- Office of Licensing
- Office of Internal Audit
- Office of Public Guardian (OPG)
- Services for People with Disabilities (DSPD)
- Utah State Developmental Center (USDC)
- Utah State Hospital (USH)



The Committee reviews include in-depth information from case logs, law enforcement, the Office of the Medical Examiner (ME) and Vital Statistics. Reviews identify issues in case practice and service delivery on specific cases, provide insight into systemic strengths and highlight areas in which changes or modifications could improve safety and response to client needs. The Committee reports detailed findings to the DHHS Executive Director, the legislative Child Welfare Oversight Panel and the legislative Health and Human Services Interim Committee and shares recommendations with the leaders of DHHS divisions and institutions with case oversight.

While case details are not public record, Utah Code 62A-16-302(5) requires that DHHS provide an annual aggregate summary of fatalities of qualifying individuals which includes:

- the number and type of fatalities
- the number of formal reviews conducted by the Committee
- the gender, age, race and other significant categories of individuals
- the number of deaths by suicide

FY 2022
Process Improvements

During state Fiscal Year 2022, DHHS engaged systemic improvements to strengthen the fatality review process:

- Worked with national experts to redesign and implement enhanced Human Factors Debriefing, further incorporating safety science principles into the fatality review process
- Expanded implementation of suicide screeners to identified youth and alleged perpetrators
- Developed an implementation plan for DHHS Fatality Review from the merger of the Department of Human Services and the Department of Health to increase collaboration and quality, and decrease duplication

Data
and Findings

Important Note:

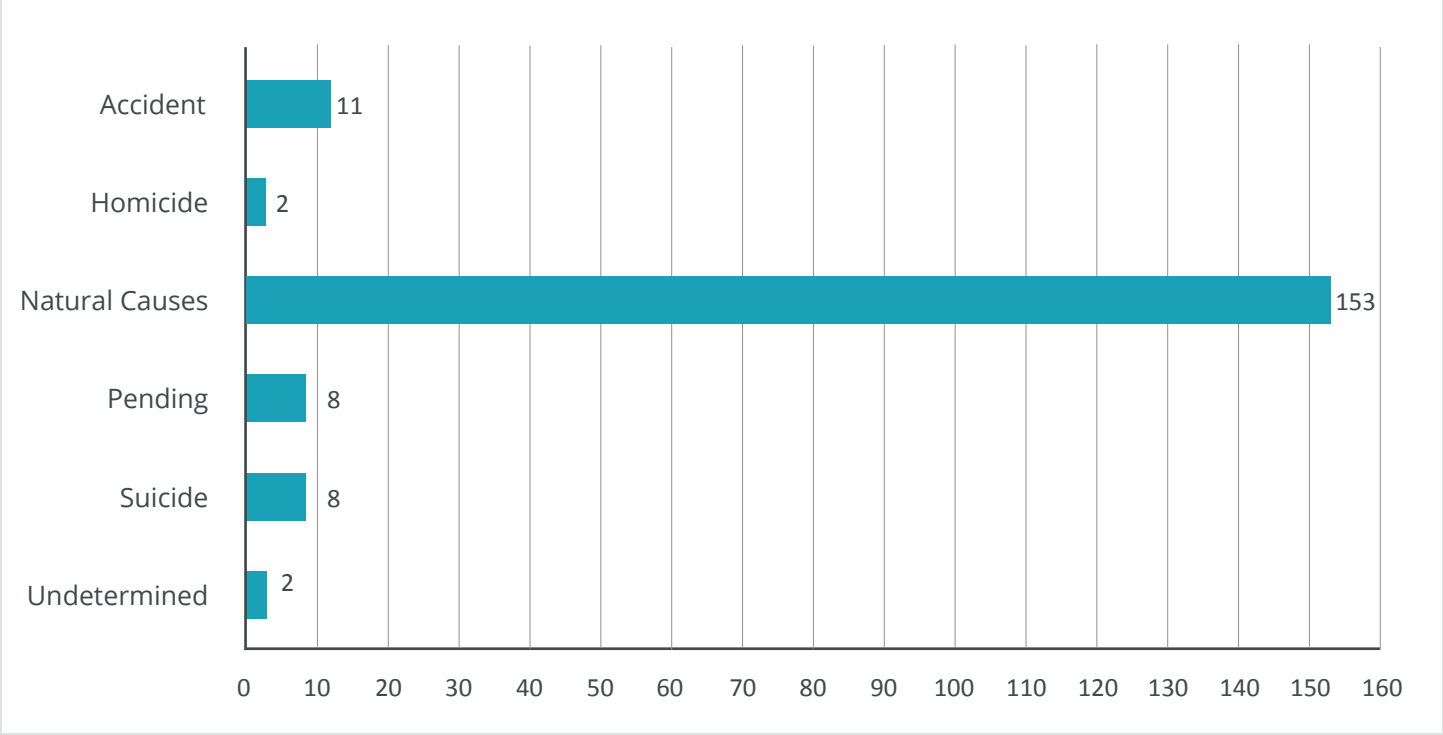
Data contained in this report reflects fatalities reviewed by the Committee in FY22, however actual deaths may have occurred earlier that were awaiting information for the review.

FY 2022
Formally Reviewed Fatalities

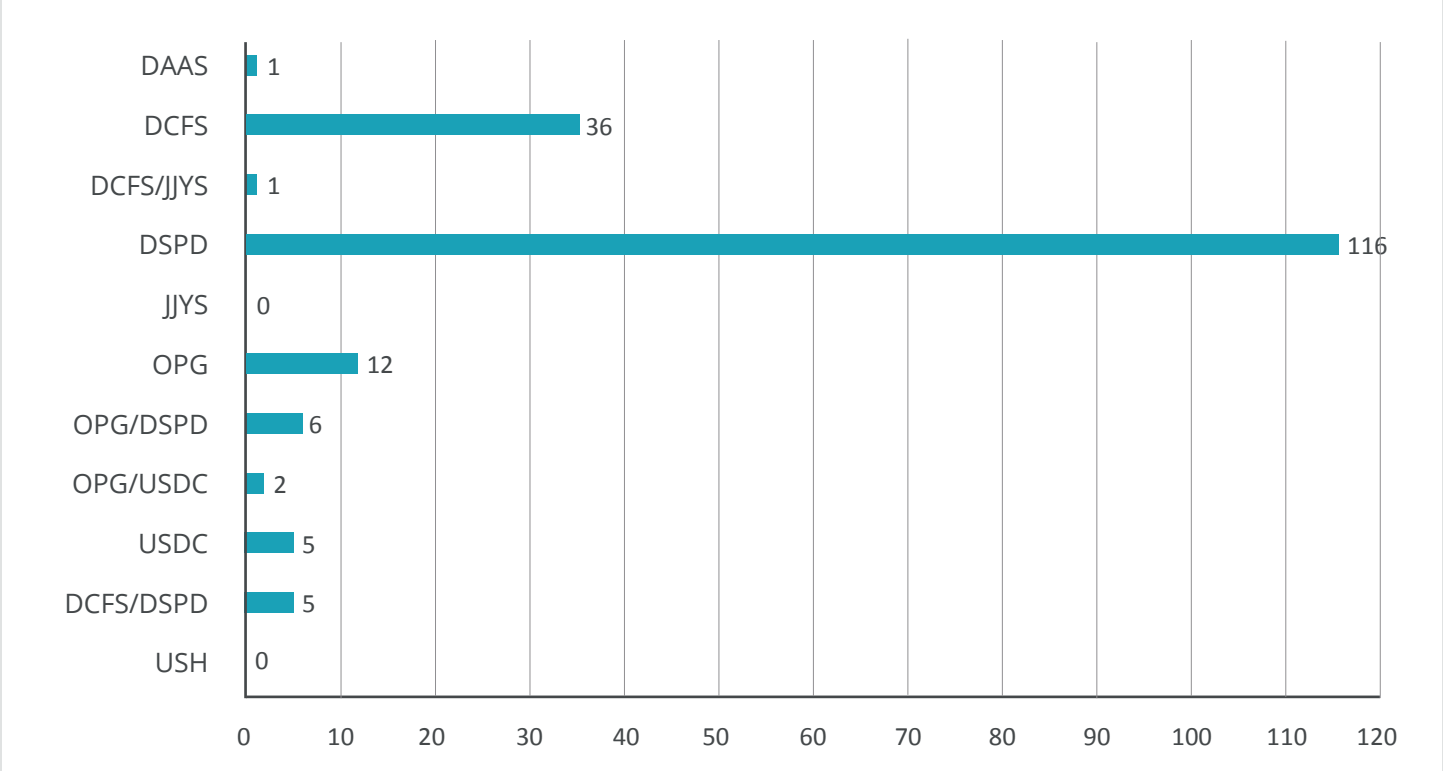
During FY22, 184 deaths were reported to OSR. The Committee completed 184 formal fatality reviews, including:

- All deaths 21 and younger who met the criteria
- All DSPD-involved deaths
- All OPG reported deaths that had more than one agency involved
- All individuals with multiple division involvement
- No fatalities met the formal review by USH

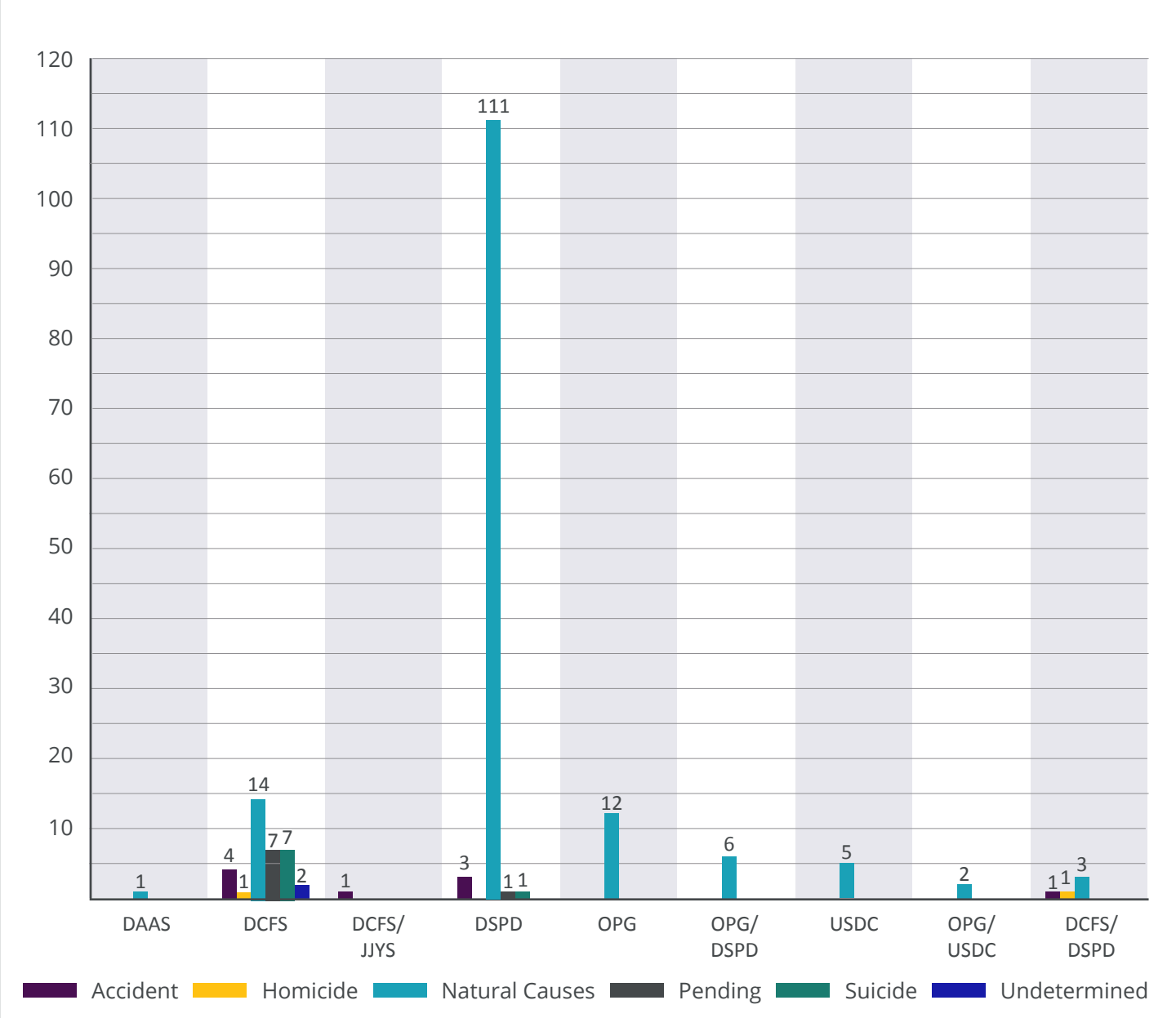
Reviewed Cases, Manner of Death Per Medical Examiner



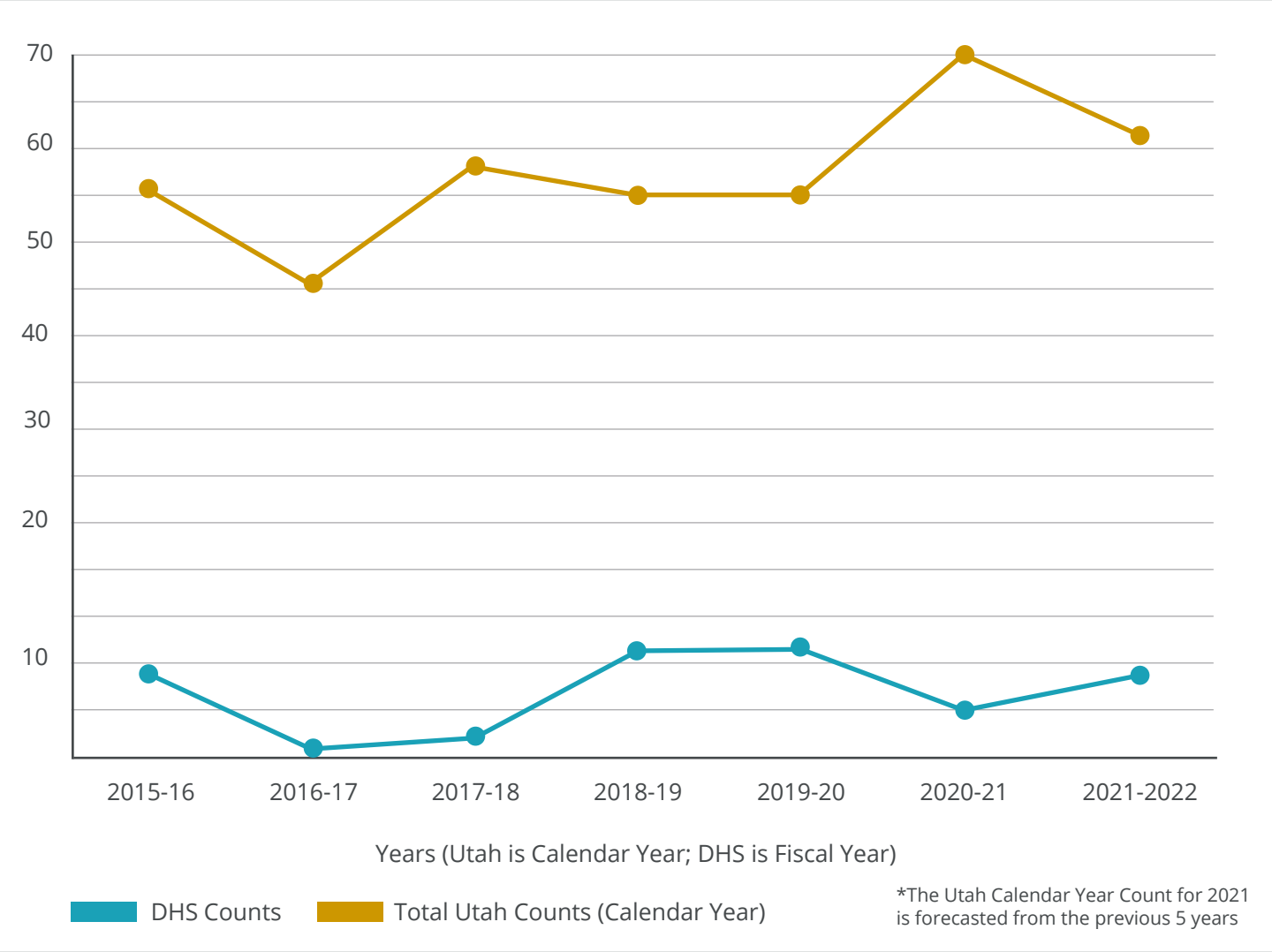
Reported Deaths by Division, Total Reported Deaths: 184



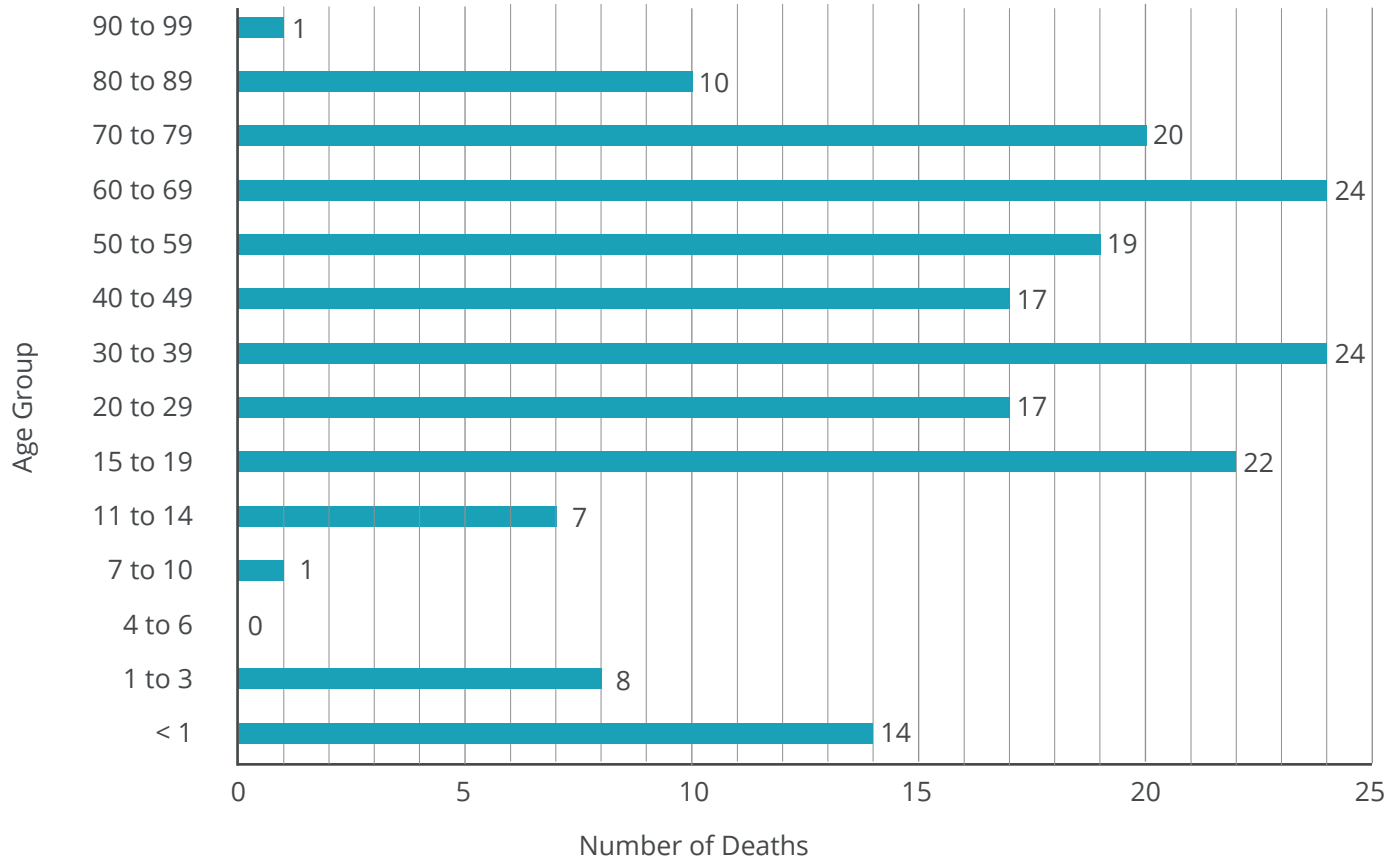
Reviewed Cases, Medical Examiner Manner of Death by Division



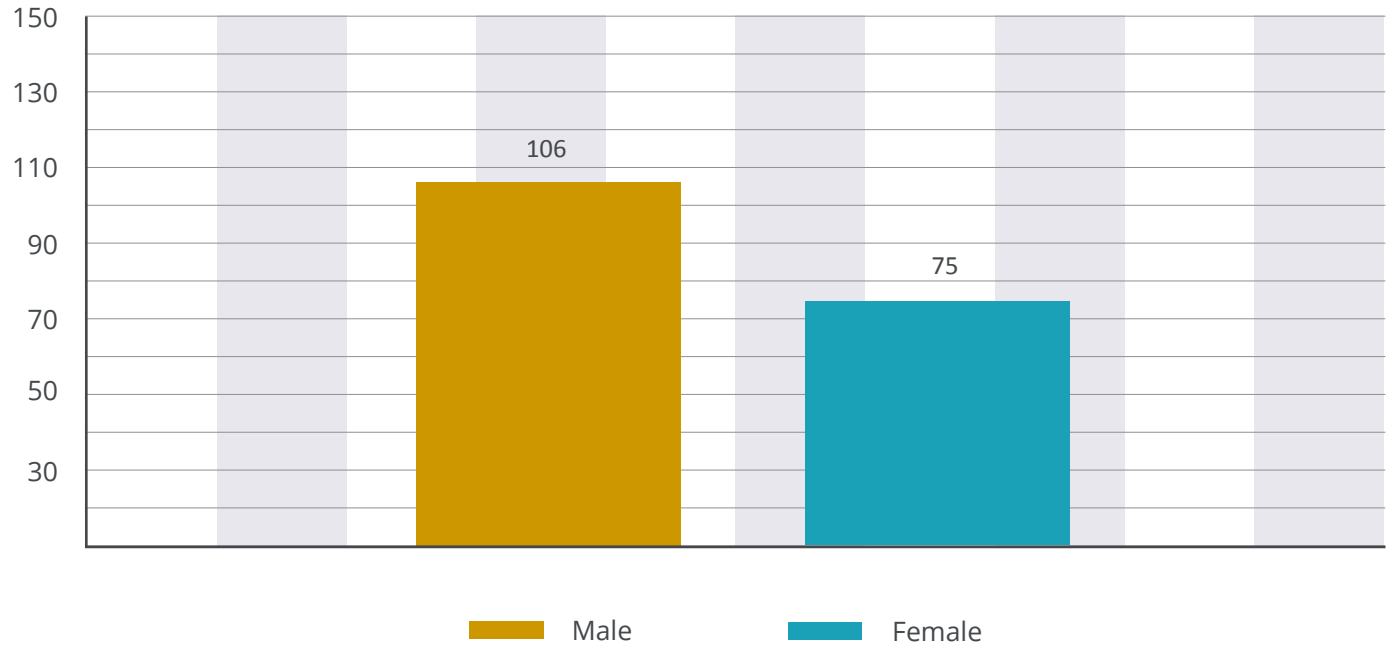
DHHS Involved and Statewide Youth Suicide Deaths for 11-19 Year Olds (2016-2022)



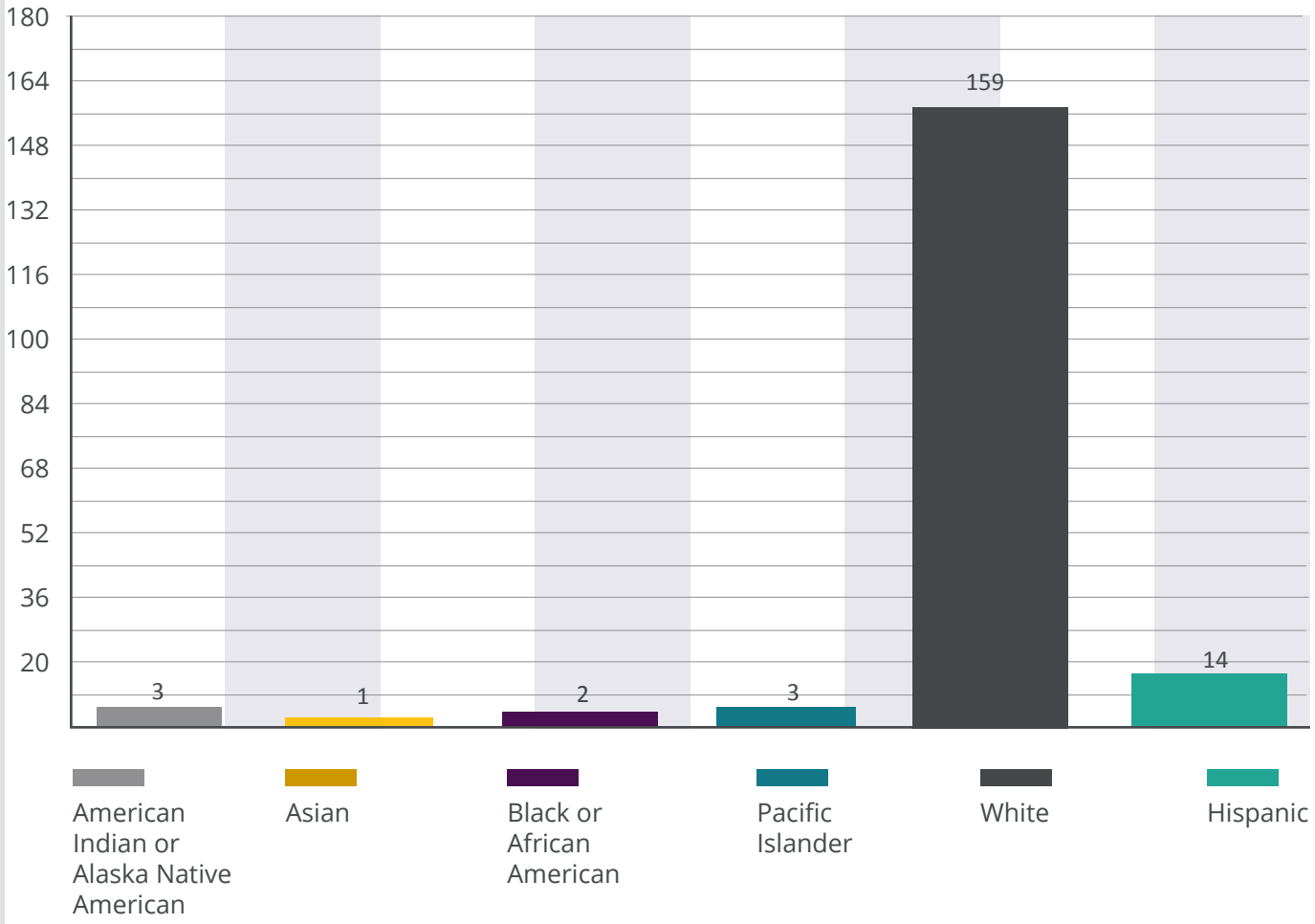
Reviewed Cases by Age Distribution



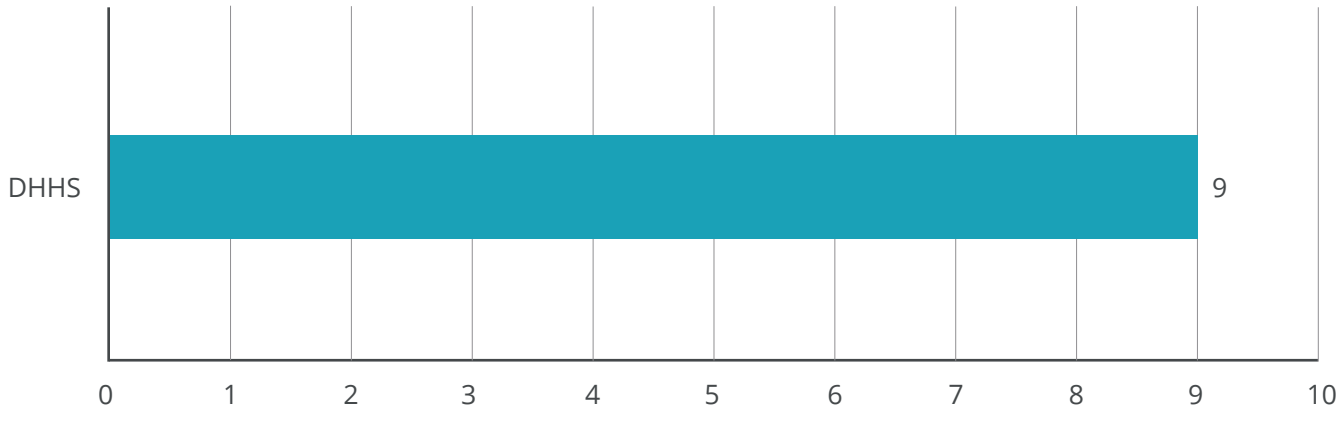
Reviewed Cases by Gender



Reviewed Cases by Race



Reported COVID-19 Data Deaths



- This data is limited to only those deaths reported to have been caused by COVID-19 during the period of this report.

Recommendations for FY22 Report

Recommendations from individual and systemic reviews include:

- We recommend that DSPD review policy, guidance, and contractual language to strengthen access to substance use and mental health services for individuals in the DSPD service system.
    - This recommendation is being rendered as the result of multiple fatality reviews which demonstrated significant effort in obtaining and maintaining a medication regimen for mental health concerns (primarily anxiety and depression), but accessing age appropriate therapies/mental health treatments was lacking in the individual's case record. The DHHS Fatality Review Committee recognizes that access to mental health services for individuals with disabilities has, historically, been difficult, but recommends that DSPD identify and execute efforts to increase access and encourage all service partners to seek age appropriate therapies as appropriate.
- We recommend that DSPD and the Division of Child and Family Services (DCFS) review policy and guidance to strengthen case record exchanges between DCFS and DSPD when transitioning an individual from DCFS to DSPD services.
    - This recommendation is rendered as a result of a single fatality review (2022-01) which highlighted concerns in the data exchange between the agencies. In this review it was identified that upon transition from DCFS to DSPD services, necessary information (behavioral and medical) was not relayed to appropriate DSPD staff and entities. The result of this lacking exchange was a backstep in the individual's progress and a delay in identifying the most appropriate services.
- We recommend that the Office of Service Review (OSR) research and implement a continuous quality feedback loop with agency partners.
    - This recommendation is rendered as a result of an informal internal review which focused on OSR customer feedback processes and recommendation follow-up. The DHHS Fatality Review system may be improved by implementing quarterly reporting on review demographics to agency partners and recommendation implementation from agency partners.

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