TENNESSEE
DEPARTMENT OF CHILDREN'S SERVICES

CHILD DEATH REVIEW
ANNUAL REPORT 2013

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Acknowledgement

The Tennessee Department of Children's Services Office of Child Health and Office of Child Safety wish to acknowledge the many professionals, volunteers and community partners whose commitment and support to Child Death Review has made this process possible.

It is important to note the CDR process does not exist to identify individual culpability in any death or near death event. The CDR process exists to best explain the inherently complex nature of child welfare work, and the many factors which influence decision-making. These decisions alone are rarely direct causal factors in a child's death or near death, but these decisions may affect the overall trajectory of well-being for a child or family and be an influence, among many influences, of poor outcomes. The CDR process makes every effort to be a safe and supportive environment for staff to process, share, and learn from child deaths and near deaths in an effort to best support quality case management practices and influence increasingly safe outcomes for children.

Executive Summary

A comprehensive and thorough child death review process is a critical component of any child welfare agency. The review provides an opportunity for agencies to examine their systems of safety. While typically there are assumptions that deaths and near deaths are caused by isolated failures of people or processes, it is largely not the case. Rather these tragic and usually unforeseeable events emerge from a complex social system comprised of society, communities, health agencies, cultures, public agencies and families working to support safe outcomes.

The Department of Children's Services (DCS or the Department) is charged with providing supports to vulnerable children and families in this complex social system affected by significantly challenging issues such as poverty and substance use. Child welfare agencies, such as DCS, are critical interfaces with vulnerable children and families; thus, it is imperative that the child death review process they implement thoroughly investigate such agencies' interventions with children and families prior to and following deaths and near deaths in order to learn and ultimately improve their ability to support safe outcomes. It was for this reason that DCS designed and has implemented a new, comprehensive system to examine and learn from the tragedy of the deaths and near deaths of Tennessee children who fall under the responsibility of DCS. With the input of many critical partners, DCS developed the Child Death Response and Review process (CDR process or Child Death Review process), which was implemented on August 29, 2013.

This is the first Annual Report of the CDR process (the Report). The audience for this Report was is broad, including DCS' many public and private partners. The Child Death Review process is a pioneering effort to apply a Safety Systems approach, which is used successfully in other industries such as aviation, nuclear power and health care to improve safety, to review child deaths and near deaths. As such, it is important for the reader to have a good understanding of the new process, both for this and subsequent years. Therefore, an early section of this Report is devoted to explaining the CDR process in detail. Then the Report moves on to explain what was found, what was recommended, and what action has been taken or will be taken to address those recommendations.

Several issues had to be operationalized as the system framework was implemented. For example, the definition of "near death" in statute (see p. 14) is difficult to apply because rarely does a physician record in the medical record that a child was in serious or critical medical condition as a result of abuse or neglect. DCS developed a process for specialist physician review to make that determination after the case has closed and the allegation has been substantiated. The process to determine near deaths involves additional steps and therefore takes more time to finalize. Moreover, as the CDR process was implemented, some cases were reviewed which later were found not to qualify for review (see p. 17 for review criteria); this issue is evident in the numbers reported on the next page. Not surprisingly, the CDR process has matured over the last several months and it remains a work in progress, with the goal of continuous improvement.

In addition to crafting and implementing the new CDR process, beginning in 2014 the Department began posting information on custody and non-custody deaths to its website generally within two business days of notification of a child's death. Once a case is closed, the full case file is added. Information on near deaths is posted to the website as it becomes available. This increased transparency means information that typically might be included in an Annual Report is made available to the public long before the CDR process annual report is complete and would be published. Therefore the focus here is less on demographics and, instead, more on what was learned and how the understanding and knowledge can inform DCS practice.

It is important to note that a death or near death that occurred in 2013 may not be reviewed until 2014 as a result of the timelines and operational requirements established in the CDR process. Factors that influence when a death is actually reviewed include the time to investigate and determine if an allegation of abuse or neglect was substantiated[1]. In addition, as noted above, near deaths require additional time since a physician must review medical records to determine whether the child was in critical or serious medical condition after a case has been closed and substantiated. Further, not all deaths and near-deaths meet criteria for review.

Custody Deaths

In calendar year 2013, no children in DCS custody died as a result of abuse or neglect. There was a total of 13 custody deaths:

- Ten children were medically fragile at the time they came into state care and died as a result of those medical issues.
- One child died of underlying medical conditions.
- One child absconded across state lines and subsequently died outside the state.
- One child died as a result of injuries sustained in a car accident that occurred in 2012.

There were 9 custody deaths reviewed for this report. As such, there are 4 cases remaining that will be reviewed and included in the next Annual Report.

Custody Near Deaths

As indicated above, finalizing near deaths is a more involved process that requires additional time and for this report only activity during Quarters 1 and 2 of 2013 was included. There was a total of 1 custody near death in Quarters 1 and 2 of 2013 which is currently awaiting review[2].

[1] To be more timely with release of the Child Death Review Annual Report, the Department elected to provide this report a month after the end of the first quarter of the calendar year following. The alternative would have been to significantly delay the Annual Report to include all cases from the previous calendar year.

[2] However, for this report there was 1 custody preliminary near death that was reviewed but this near death was later determined by our process to not be finalized as a near death.

Non-Custody Deaths

In calendar year 2013, there were 232 non-custody deaths (see p. 14 for definition of non-custody death). Of the total number of non-custody deaths, 75 were reviewed for this report[3]. In regard to the remaining 157 cases, 73 did not meet criteria for review, 70 have met criteria and are awaiting review, and 14 are pending classification.

Non-Custody Near Deaths

For 2013 Quarters 1 and 2, there was a total of 15 confirmed non-custody near deaths. There are 2 remaining confirmed non-custody near deaths to be reviewed and 4 non-custody preliminary near deaths pending physician review[4].

Summary of Findings

Learning is a primary focus of the Child Death Review. The Department conducts reviews in order to understand systemic and practice and policy issues that may have influenced how children and families were supported in order, if possible, to avoid these tragic outcomes in the future. The following were the significant lessons learned through the review of deaths and near deaths. Of note, there were no issues identified that were surprising, or that were of such seriousness that immediate action was required. In other words, there were no "eureka" moments. Based on the findings during this review period, recommendations for improved practice are as follows:

1. Workload Demands

Workload Demands included conflicts between conducting high quality casework while at the same time meeting myriad demands, including managing high caseloads, meeting set deadlines, adhering to accreditation standards, and entering case notes timely.

Recommendation: 1. Engage in efforts to reduce caseloads for case managers and supervisors. *Department Actions: The Department centralized CPS Investigations and allocated staff based on historical case load volume to ensure that caseload size was reduced. DCS leadership will continually evaluate workload demands. Additionally, 29 new CPS staff were added this fiscal year and 45 new CPS staff will be added next fiscal year.*

Recommendation: 2. Support efforts to improve case manager's timely entry of case notes. *Department Actions: The Department has initiated a tablet technology pilot. Deployment across case management staff is expected to occur over the following six months to nine months. The addition of tablets will increase the efficient and timely entry of case notes.*

[3] Of those 75, three cases were reviewed that ultimately were determined not to meet criteria because there was no history of contact with DCS and the death was unsubstantiated for abuse or neglect.

[4] For this report, 24 non-custody near deaths were reviewed; however, 11 of the 24 near deaths reviewed were preliminary near deaths which subsequently were determined not to be finalized near deaths after physician review. The result is that 13 out of the 15 confirmed near deaths were reviewed.

2. Supervisory Support

Reviews revealed the difficulties some direct supervisors have in supporting inexperienced staff and effectively transferring knowledge and experience to all staff. This difficulty was amplified by workload demands in the form of supervisors having caseloads as well as managing their supervisory responsibilities.

Recommendation: Reduce reliance on supervisors to carry caseloads. *Department Actions: The centralization and restructuring of CPS Investigations included changes to case management to promote all case managers who are investigators to Case Manager 3 (CM3) positions. In the centralization, CM3s no longer have supervisory responsibility and only carry caseloads. The Department is committed to continually evaluating supervisor support and staffing.*

3. Safe Sleep

Unsafe sleeping environments were noted to be present in many cases reviewed. This issue presented in different forms including; unsafe sleeping environments, lack of written materials regarding safe sleep provided to new mothers prior to hospital discharge and barriers to obtaining cribs for families.

Recommendation: Pursue expansion of the Department's Safe Sleep East Region Pilot to statewide implementation. *Department Actions: A Drug Exposed Infant (DEI) team from the East Region developed a process to reliably assess and train families, and deliver safe sleep materials (including cribs) to the point of care when needed. It is the intention of the Department to expand this project throughout the rest of the state.*

4. Safety Assessment Tools

Staff felt that the Structured Decision Making (SDM) Safety Assessment tool did not support case managers to be successful in assessing complex home environments.

Recommendation: Conduct a thorough review of the use and efficacy of the CPS safety and risk assessment and service planning tools. *Department Actions: The Department is revising the Structured Decision Making (SDM) tool used at the Child Abuse Hotline. Additionally, the Department has begun reviewing the safety and risk assessments used in the field. Finally, the Department collaborated with Vanderbilt University to review and revise the Family Advocacy Support Tool (FAST), which is the agency's service planning tool that will identify needed services for families during the course of a CPS investigation and assessment.*

5. Mental Health and Substance Abuse Assessment

Reviews surfaced the difficulty case managers have in adequately assessing families for mental health concerns and substance abuse.

Recommendation: Improve capacity of CPS Investigators and CPS Assessment Staff to respond to increased prevalence of mental health and substance abuse among client population. *Department Actions: The Department is developing a pilot project to train child protective services assessment track staff to use Structured Brief Intervention and Referral for Treatment (SBIRT) and Motivational Interviewing (MI). Additionally, courses have been added to the training academies to include substance abuse and mental health issues.*

6. Knowledge Sharing

The value of knowledge sharing was noted to be critical between case managers. Many case managers learn through experience and from peers, which may leave them with difficulties in managing the complexities of certain cases and their needing additional guidance from others in developing their ability to anticipate risks to children, families and to themselves.

Recommendation: Increase opportunities for case managers to share knowledge and experience. *Department Actions: The Department has begun a pilot of anticipatory team huddles. Anticipatory team huddles involve investigation teams meeting together each workday morning to discuss anticipated concerns or barriers to their work for that day, and then share strategies to overcome any foreseen issues. The Office of Child Safety intends to evaluate the effectiveness of this pilot and determine if it should be replicated across the state.*

Introduction

As Tennessee's public child welfare agency, DCS is responsible for serving some of the state's most vulnerable citizens. Commissioner Jim Henry was appointed interim Commissioner in February 2013 and permanent Commissioner in June 2013. Under his leadership, the mission of DCS is clear: to keep kids safe, get them healthy and get families and their children back on track.

It is estimated that nationally 1,640 children died as a result of abuse or neglect in 2012 (U.S. Department of Health and Human Services, 2013). An important DCS responsibility is to review and learn from the tragedy of child deaths and near deaths in Tennessee. By understanding the complex interplay of human factors and system factors we strive to learn from deaths and near deaths to improve the safety of all children in Tennessee.

Responsibility for review of all child deaths in Tennessee falls to the Department of Health. DCS has a narrower focus and reviews the death or near death of any child in state custody at the time of their death or near death, and deaths and near deaths of any child where there is an allegation of abuse or neglect. A near death is a condition which results from abuse that, as certified by a physician, places the child in serious or critical medical condition. [See TCA §37-5-107(c)(4)].

Moreover, data that are captured elsewhere are not duplicated here. For example, the federal Child Abuse and Prevention Act (CAPTA) requires states to report certain information on a case of abuse or neglect which results in a death or near death. With the posting of child death and near death information, including full case files on the DCS website[5], information beyond that mandated by CAPTA is now provided publicly at: http://www.tennessee.gov/youth/childsafety/publicnotifications.html.

[5] When the Child Death Review process was developed, the Department did not envision providing CAPTA case information online. By providing this information online, the Department is able to more completely and quickly provide the public this information than would be available in an annual report.

History

At the time Commissioner Henry was appointed, the public, the Legislature, and other stakeholders had expressed concerns about DCS' timely and accurate reporting of child fatalities. In addition, a court order issued in the Federal Brian A lawsuit required the Department to develop a revised internal process for investigating child deaths, subject to review and approval of the court monitor (the Technical Assistance Committee) within 90 days from January 24, 2013.

Given the opportunity to revise the child death review process, the Department considered its responsibility to all Tennesseans to be open and transparent about abuse and neglect related deaths and near deaths. Moreover, the Department recognized that transparency requires timely release of information to the public and the Legislature. Therefore DCS designed a Child Death Response and Review process (Child Death Review process or CDR process) that involves a comprehensive, multidisciplinary review of child death and near death cases utilizing a true systems approach to better understand the circumstances surrounding a child death or near death. The systems approach guides reviewers to analyze incidents as emerging from interactions of components and processes within systems. This approach contributes to organizational learning, addressing issues discovered in individual events, and understanding the underlying systemic issues that influence adverse outcomes. The Child Death Review process went live August 29, 2013 and included a structured process and the resources needed to review deaths and near deaths that occurred on or after January 1, 2013[6].

[6] An addendum to this Annual Report will forthcoming and will include the balance of child death and near death cases that were not reviewed for this report but occurred between January 1st, 2013 and August 28th, 2013.

Child Death Review Process

Review of a child death or near death begins with the report of the death or near death to the Child Abuse Hotline. Immediately following this report, DCS initiates its Rapid Response process. This protocol ensures that DCS takes immediate action to maintain the safety of other children and family members, notifies appropriate staff and initiates the process of collecting and protecting the integrity of information. As additional information becomes available throughout the investigation, actions or immediate adjustments to existing procedures or protocols may occur to ensure the safety of other children and family members. Specifically, the Department shall immediately take any necessary action so as to assure that children's safety is never taken for granted. Parallel to the rapid response process, the case is tracked to determine if it meets criteria for a death review.

The Child Death Review process has three stages: data collection; the Child Death Review Team (CDRT) meeting; and the development of findings. During the data collection stage, information is derived from factual information contained in records and from interviews of individuals involved in providing care for the subject child or family. The collected data is then presented to the CDRT that conducts a multidisciplinary analysis of the case to be reviewed. Following the CDRT meeting, findings are developed to highlight issues discovered in individual events and to understand the underlying systemic issues that may contribute to adverse outcomes.

Safety Analysts have a critical role in each of these steps. There are four Safety Analysts across the State of Tennessee, each responsible for one of the child death review regional groupings. The Safety Analyst is responsible for conducting the data collection, which includes technical data and interview data. The Safety Analyst is also responsible for compiling the collected data into a report, which is then presented to the CDRT. As facilitators of the CDRT meeting, the analysts present case information and guide the discussion. Following the CDRT meeting, the Safety Analyst develops findings that are utilized to inform recommendations.

Also instrumental in the child death review process are the Safety Nurses. Like the Safety Analysts, there are four Safety Nurses across the state of Tennessee, one in each of the child death review regional groupings. The Safety Nurse is responsible for collecting and reviewing all available medical records associated with the subject child. Following this review, a clinical summary is created and added to the report developed by the Safety Analyst. During CDRT meetings, Safety Nurses are a critical support for CDRT members to understand complex medical information.

Data Collection

The collection, processing and analysis of data is critical to understanding the complex interplay of human factors and system factors involved in a child's death or near death. For Tennessee's Child Death Review process, this consists of two broad categories of data: Technical Data and Interview Data.

Technical Data

Technical data consists of information that has been documented and is specific to the child or the family under review. Our guiding principle is to gather all of the relevant technical data (Dekker, 2006). Within any child welfare system, there are an abundant number of data sources, including among others:

a. Tennessee Family and Child Tracking System (TFACTS)
b. Hard-copy case files
c. Medical records
d. Records from state contracted service providers
e. Police reports

The collection of technical data reveals sequences of activities which include observations, actions, assessments, decisions and changes in processes or systems (Dekker, 2002), all of which provide an opportunity to understand the environment influencing the child and their family. This data collection provides a starting point to look further into the data to identify significant events and to inform subsequent interviews.

Interview Data

Interview data are referred to as human factors data in the field of Safety Science. Interview data are needed because people, social workers especially, do not operate within a vacuum. Rather, social workers operate while constantly interacting with the systems around them (Dekker, 2006). For this reason, the technical information may serve little purpose in trying to understand why systems designed to keep children safe have failed, if it is not understood from the perspective of frontline workers operating in these complex systems.

Interviews are conducted by the Safety Analysts to help reconstruct the situation that surrounded frontline workers while trying to provide services to children and families (Dekker, 2006). Gary Klein developed a method of interviewing (as cited in Dekker, 2006, pp.94-95), outlined below:

1. Have the participant tell the story from their point of view, without the Safety Analyst presenting any additional information that may distort their memory.
2. The Safety Analyst tells the story back to the participant, in an attempt to gain common ground.
3. The Safety Analyst along with the participant identify critical junctures in the sequence of events (this includes issues identified from technical data) if anything additional is detected.
4. The Safety Analyst progressively probes critical junctures to show how the situation was understood from the perspective of the participant; at this critical time, it may be appropriate to provide any necessary technical data to the participant.

At the critical junctures identified in numbers 3 and 4 above, the Safety Analyst identifies:

1. What cues may have prompted decisions or actions from the participant's perspective.
2. What knowledge (training, previous learning, experience, etc.) was utilized to inform these decisions or actions.
3. What the expectations were about how a particular plan was going to develop.
4. What other influences (situational, operational, and organizational) may have influenced their perception of a situation and subsequent actions.

After the technical data have been combined with the interview data, the information is compiled and arranged in a report for the CDRT meeting and system mapping process. The purpose of the report is to place the collected data in a useful format which will provide a clear and relevant picture of the case within context allowing for the CDRT to further explore any issues from a systems perspective.

Child Death Review Team Meeting

The primary purpose of having a team analyze child deaths from a systems perspective is that one person does not have adequate knowledge of an entire system. Rather, richness is provided from a collaboration of different disciplines and perspectives, each further shaping useful explanations and interpretations that can promote learning from adverse events, such as child deaths. Thus, teams are dynamic and comprised of individuals who can provide insight into the components of the system being reviewed.

Team Selection

The CDRT consists of members from the following areas:

a. Safety Analyst,
b. Safety Nurse,
c. Regional Administrator or designee representative,
d. Child Protective Services representative,
e. Special Investigations Unit representative,
f. Unrelated Resource Parent representative,
g. Independent Physician,
h. At least one interested community partner, which may include representatives from law enforcement, Child Advocacy Center, Department of Health, domestic violence specialist, child abuse prevention specialist, substance abuse specialist, disability specialist or other as deemed necessary.

Cases are reviewed by CDRTs in the regional group encompassing the county of venue where the child /family was being served. Regional groups are as follows:

1. Shelby, Northwest, Southwest
2. Mid Cumberland, Davidson, South Central
3. Upper Cumberland, Tennessee Valley, East
4. Smokey Mountain, Knox, Northeast

For the purpose of the child death review, an adapted AcciMap (Svedung & Rasmussen, 2002) tool called the Safety Systems Map is used to guide the discussion of the child death review team. The tool allows the CDRT to analyze a particular case while considering the complex systems in which the death or near death occurred.

Systems Mapping

The Safety Systems Map focuses on issues spread across 5 different levels. The first level is conditions, processes and actor activities, which can include use of technology, critical decisions, services and supports. The second level is DCS regional operations, which can include regional culture, management expectations, geography and demographics. The third level is DCS central operations, which can include executive decision making, policies and fiscal operations. The fourth level includes entities external to the DCS, such as law enforcement, healthcare providers and social services providers. The fifth and final level includes government and regulatory bodies, comprised of State and Federal legislation, resource allocation and mandates, or regulatory bodies such as accreditation agencies. The Safety Systems Map tool is provided below (Figure 1).

Figure 1. Safety Systems Map

Safety Systems Map- Child Death/Near Death	
Case No.:	
Government and Regulatory bodies	
External Factors	
Organizational Factors (Central)	
Organizational Factors (Regional)	
Conditions, Processes and Actor Activities	
Outcome	

Developing Findings

The review and development of findings are guided by the Safety Analyst. Starting with the pre-identified issues, the analyst will guide discussion from identified issues in order to explore all relevant influences throughout the system at each level. The next steps involve the creation of narratives and development of a conceptual description.

Narrative Creation

Following the systems mapping process with the CDRT, narratives are created using a language understandable by people who work within the child welfare system (domain specific language) neatly laying out how issues unfolded from influences within the system. Detailed narratives explain how identified influences were important in the case. These narratives are integral part of the process in developing Child Death Review findings.

Conceptual Description

Conceptual descriptions build an account of what happened in a way that does not utilize domain specific terms; rather, the language is of human factors and psychological concepts (Dekker, 2002). This account includes the language of production pressures, goal conflicts, tradeoffs, resource constraints, knowledge gaps and procedural adaptions. This allows findings to be set in a language that can be communicated to other domains and allows for the identification of common conditions across cases (Dekker, 2002).

Demographics

For purposes of the CDR process, DCS defines Deaths and Near Deaths as follows:

Custody Death: any child in the state of Tennessee who is in the custody of the DCS at the time of his or her death. All custody deaths will be investigated regardless of allegation of abuse or neglect.

Non-Custody Death: any child in the state of Tennessee who is not in DCS custody at the time of death and his or her death is investigated as an allegation of abuse or neglect by DCS.

Custody Near Death: any child in the state of Tennessee who is in DCS custody who has a serious or critical medical condition resulting from child abuse or child sexual abuse, as reported by a physician who has examined the child subsequent to the abuse. This is defined in TCA § 37-5-107. The Department has elected to exceed the statutory definition to include more situations as near deaths. As such, the Department will record a near death for a child in custody if the allegation of abuse or neglect is substantiated and a physician reviews the case and determines the child was in a serious or critical medical condition.

Non-Custody Near Death: any child in the state of Tennessee who is not in DCS custody who has a serious or critical medical condition resulting from child abuse or child sexual abuse, as reported by a physician who has examined the child subsequent to the abuse. This is defined in TCA § 37-5-107. The Department has elected to exceed the statutory definition to include more situations as near deaths. As such, the Department will record a near death for a child not in custody if the allegation of abuse or neglect is substantiated and a physician reviews the case and determines the child was in a serious or critical medical condition.

Previous History: any Tennessee DCS contact with a child or family occurring within 3 years of the child's death or near death, as documented in the Department's Statewide Automated Child Welfare Information System (SACWIS) reporting system (for DCS this is TFACTS).

The following tables provide demographic information on all child deaths investigated by DCS in 2013. However, it is important to recognize that not all of the child deaths listed occurred as a result of abuse or neglect. DCS is statutorily mandated to investigate any child who dies in the state of Tennessee when there is an allegation of abuse or neglect. Additionally, the Department investigates all deaths of children in custody. The percentages of those investigations that were substantiated for abuse or neglect are shown in the tables.

Table 1: DCS Custody Child Death Summary Data 2013

Calendar Year 2013 (January 1st – December 31st, 2013)			
Custody Deaths*			
Total Number	13		
In 2013, no children in DCS custody died as a result of abuse or neglect. There were a total of 13 custody deaths: • Ten children were medically fragile at the time they came into state care. • One child died of underlying medical conditions. • One child absconded across state lines and subsequently died outside the state. • One child died as a result of injuries sustained in a car accident that occurred in 2012.			
Classification**			
	Number	Percent	
Substantiated	0	0%	
Unsubstantiated	11***	100%	
Unable to Complete	0	0%	
Pending	0	0%	
		100%	
* A custody death is defined as any child in the state of Tennessee who is in the custody of the Department at the time of his or her death.			
** There are four types of classifications. Substantiated means that there is a preponderance of evidence that abuse or neglect occurred. Unsubstantiated means that there is not enough evidence to sustain the allegation. Pending classification refers to cases that have not yet closed. Finally, those classified as Unable to Complete still require additional information before the Department can classify a case.			
*** Following the arrival of Commissioner Henry in February 2013, a policy was adopted to investigate all custody deaths, regardless of whether there was an allegation of abuse or neglect. Two of the custody deaths in 2013 occurred before this policy was adopted. In accordance with policy in place at the time, these deaths were not investigated because there was no allegation of abuse or neglect.			

There were 9 custody deaths reviewed for this report. As such, there are 4 2013 cases remaining that will be included in the next Annual Report.

Table 2: DCS Non Custody Child Death Summary Data 2013

Calendar Year 2013 (January 1st – December 31st, 2013)			
Non Custody Deaths			
Total Number	232		
Allegations*			
	Number	Percent	
Neglect	210	91%	
Abuse	22	9%	
		100%	
Classification**			
	Number	Percent	
Substantiated	40	17%	
Unsubstantiated	142	61%	
Pending	48	21%	
Unable to Complete	2	1%	
		100%	
Historical Contact Information***			
	Number	Percent	
Previous History	124	53%	
No Previous History	108	47%	
		100%	

* Investigations into a child's death are opened for either allegations of abuse or neglect.

** There are four types of classifications. Substantiated means that there is a preponderance of evidence that abuse or neglect occurred. Unsubstantiated means that there is not enough evidence to sustain the allegation. Pending classification refers to cases that have not yet closed. Finally, those classified as Unable to Complete still require additional information before the department can classify a case.

*** Previous History is defined as any Tennessee DCS contact with a child or family occurring within 3 years of the child's death or near death, as documented in the Department's SACWIS reporting system.

Of the total number of non-custody deaths, 75 were reviewed for this report[7]. Of the remaining 157 cases, 73 did not meet criteria for review, 70 have met criteria and are awaiting review, and 14 are pending classification.

[7] Of those 75, three cases were reviewed that ultimately were determined not to meet criteria because there was no history of contact with DCS and the death was unsubstantiated for abuse or neglect.

Child Death Review Criteria

The Department has established criteria for review of child deaths and near deaths. As such, not all child deaths and near deaths receive a review. The Child Death Review Team reviews deaths and near deaths for:

a. any child in state custody who dies or experiences near death for any reason;
b. any child who has had contact with DCS within the three (3) years preceding their death or near death and their death or near death is being investigated for an allegation of abuse or neglect;
c. any child whose death or near death has been indicated (substantiated) for abuse or neglect regardless of previous contact with DCS;
d. any child death or near death at the direction of the Commissioner, on the advice of the Medical Director or Deputy Commissioner Office of Child Safety.

Cases Reviewed

In this review period, a total of 109 deaths and near deaths were reviewed. This includes: 75 non-custody deaths, 24 non-custody near deaths, 9 custody deaths, and 1 custody near death. Cases are reviewed contingent upon meeting criteria for review. Cases are given priority for review by the order in which they meet criteria. The review of any case using the CDR protocols typically is not complete until at least three months or more following the notification of the child death.

Of note, due to the Department's decision to exceed the statutory definition to include more situations as near deaths, the Department has not finalized 2013 near death data. The process of finalizing near deaths requires additional time for case closure and subsequent physician review. For 2013 Quarters 1 and 2, there was a total of 15 confirmed non-custody near deaths. There are 2 remaining confirmed non-custody near deaths to be reviewed and 4 non-custody preliminary near deaths pending physician review[8]. There was a total of 1 custody near death in Quarters 1 and 2 of 2013 which is currently awaiting review[9].

Number of Deaths and Near Deaths Reviewed in 2013 by CDR Regional Group:

Region 1	Region 2	Region 3	Region 4
30	24	24	31

[8] For this report, 24 non-custody near deaths were reviewed; however, 11 of the 24 near deaths reviewed were preliminary near deaths which subsequently were determined not to be finalized near deaths after physician review. The result is that 13 out of the 15 confirmed near deaths were reviewed.

[9] However, for this report there was 1 custody preliminary near death that was reviewed but this near death was later determined by our process to not be finalized as a near death.

Demographics of Child Death Cases Reviewed

Gender	Male: 54	Female: 30
Previous DCS History	Yes: 71	No: 13
DCS Custody	Yes: 9	No: 75

Demographics of Child Near Death Cases Reviewed

Gender	Male: 17	Female: 8
Previous History	Yes: 19	No: 6
Custody	Yes: 1	No: 24

All elements designated by the Child Abuse Prevention and Treatment Act (CAPTA) for the child death and near death cases included in this report can be found at the DCS website[10] at the following link http://www.tn.gov/youth/childsafety/publicnotifications.html. In addition, a summary of child death and near death data for 2013 is available at the same link.

Starting in 2014, the Department posts information concerning a child's age, gender, and previous history generally within two business days of a custody or non-custody child death. Following case closure, information concerning the case disposition, whether the case meets criteria for a child death review, and the full case file will also be posted.

[10] When the Child Death Review process was developed, the Department did not envision providing CAPTA case information online. By providing this information online, the Department is able to more completely and quickly provide the public this information than would be available in an annual report.

Findings

Learning and improving DCS's systems are a primary focus of the Child Death Review. DCS conducts reviews in order to understand how children and families can be better supported to eliminate or reduce the likelihood of these tragic outcomes. Through this understanding, the Department learns how it can support children and families in the future to keep children safe, healthy and ensure they are back on track. The following were the significant lessons learned through the review of deaths and near deaths in this review period. Findings include: Workload Demands, Supervisory Support, Safe Sleep, Safety Assessment Tools, Mental Health and Substance Abuse Assessment, and Knowledge Sharing.

Workload Demands

Workload Demands were noted by participants to be a constraint in many cases. Specifically, there were conflicts between conducting high quality casework while at the same time meeting myriad demands, including managing high caseloads, meeting set deadlines (e.g., priority response, case closure, face-to-face visits), adhering to accreditation standards, and entering case notes timely. These conflicts were noted to influence decisions, actions and stress levels of the case managers and their supervisors. *Example: Strong pressures to close a case prior to being overdue influenced a case manager to close a case without the opportunity to follow up on the effectiveness of the services put in place.*

Supervisory Support

Supervisory support for frontline case managers to adequately carry out tasks was a relevant issue. Reviews revealed the difficulties direct supervisors have in supporting inexperienced staff and effectively transferring knowledge and experience to all staff. This difficulty was augmented by workload demands in the form of supervisors having caseloads as well as managing their own supervisory responsibilities. *Example: A newly hired case manager was having difficulty following through with investigative tasks, which was influenced by limited support and coaching from the direct supervisor; ultimately, this created a situation where decisions in a complex case were made based on the case manager's skill level at that time.*

Safe Sleep

Unsafe sleeping environments were noted to be present in many cases reviewed. This issue presented in different forms. First, homes were found to be missing safe environments for an infant to sleep, such as a crib or a pack n' play. Second, co-sleeping was noted to have directly resulted in infant deaths due to positional asphyxiation. Third, hospitals, especially those serving populations for which there have been co-sleeping incidents and other high risk concerns, were noted to provide written materials regarding safe sleep without providing verbal instructions to mothers prior to their discharge. Lastly, case managers encountered barriers to obtaining cribs or pack n' plays for families who could not otherwise afford them. *Note: The Tennessee Department of Health's State Child Fatality Review Team recommended aggressively continuing the safe sleep campaign with an expanded emphasis on education for caregivers (grandparents, parents, and babysitters) and healthcare providers (pediatricians, family physicians, obstetricians, and nurse practitioners).*

Safety Assessment Tools

Reviews noted that many staff felt that the Structured Decision Making (SDM) Safety Assessment tool did not support case managers to be successful in assessing complex home environments. The tool was cited to be sometimes unreliable and contradictory to beliefs of the case managers using it. Because of this difficulty, the tool was sometimes used incorrectly, or not used at all. *Example: An SDM Safety Assessment tool indicated a safe environment and a FAST assessment scored low intensity of service needs; however the case manager noted that the family had many service needs. The case manager then felt conflicted on whether to provide services because the tool did not support that course of action.*

Mental Health and Substance Abuse Assessment

Reviews surfaced the difficulty of case managers to adequately assess families for mental health concerns and substance abuse. When trying to identify the presence of an issue, case managers were making decisions based on current knowledge without adequate education. This then influenced their ability to recommend and assess appropriate services based on need. *Example: a case manager did not feel they had the adequate knowledge of when a parent with a substance abuse issue was being successful with accepted services. Because of this, the case manager was left to make a decision to close the case or not based on limited knowledge support.*

Knowledge Sharing

The value of knowledge sharing between and among case managers was noted to be of critical importance. Given high turnover rates and difficulties with quickly accessing supervisory support, many case managers learn through experience and from their peers. The inconsistency of these valuable learning opportunities was seen to have left some case managers with difficulties in managing the complexities of certain cases and with limited ability to anticipate risks to children, families and to themselves. *Example: a case manager was having difficulty tracking down a family and was ultimately unsuccessful. The case manager later learned that the family in question was well known by other case managers who had experience in how to locate the family through established contacts; however, this information was never shared while the case was open.*

Recommendations

Recommendations are informed by what is learned from the Child Death Review process. With the support of a centralized Continuous Quality Improvement (CQI) Team, recommendations are developed and tracked. Based on the findings during this review period, recommendations for improved practice are as follows:

Recommendation 1
Engage in efforts to reduce caseloads for case managers and supervisors.

Recommendation 2
Support efforts to improve case manager's timely entry of case notes.

Recommendation 3
Reduce reliance on supervisors to carry caseloads.

Recommendation 4
Pursue expansion of the Department's Safe Sleep East Region Pilot to statewide implementation.

Recommendation 5
Conduct a thorough review of the use and efficacy of the CPS safety and risk assessment and service planning tools.

Recommendation 6
Improve capacity of CPS Investigators and CPS Assessment Staff to respond to increased prevalence of mental health and substance abuse among client population.

Recommendation 7
Increase opportunities for case managers to share knowledge and experience.

Department Actions

DCS already has undertaken and completed a number of actions to directly address some of the recommendations above. Additionally, DCS has begun or shortly will begin a number of activities that will address the remaining recommendations. These actions include:

DCS Action Item 1

In response to *Recommendation 1*, the Department has centralized CPS Investigations. As of March 17th, 2014, all CPS Investigations staff across the state report to central office. In the process of centralization, staff were allocated based on historical case load volume to ensure that caseload size was reduced. Finally, 29 new CPS staff were added this fiscal year (FY 13/14) and in the Governor's budget (FY 14/15) there is a recommendation to add 45 new CPS staff to support caseload reduction. DCS leadership will continually evaluate workload demands.

DCS Action Item 2

In response to *Recommendation 2*, the Department has engaged in efforts to improve the ability of case managers to enter information timely into TFACTS, the Department has initiated (October 2013 start date) a tablet technology pilot. Almost 70 investigators, assessment staff, special investigation unit staff, Brian A lawsuit staff and supervisors are participating in this pilot. Completion of the pilot is expected at end of April 2014. A decision will be made on the most appropriate type of tablet and it is anticipated that deployment across the case management staff will occur over the following six months to nine months.

DCS Action Item 3

The centralization and restructuring of CPS Investigations included changes to case management to promote all case managers who are investigators to Case Manager 3 (CM3) positions. Under the previous structure, CM3s had both caseload and supervisor responsibilities. In the centralization, CM3s no longer have supervisory responsibility and only carry caseloads. Supervision is provided by CM4s who do not carry caseloads and focus solely on supervision. As such, *Recommendation 3* has been addressed. However, the Department is committed to continually evaluating supervisor support and staffing.

DCS Action Item 4

In response to *Recommendation 4*, a Drug Exposed Infant (DEI) team from the East Region, in partnership with the Tennessee Department of Health and the Vanderbilt University Center of Excellence for Children in State Custody, developed a process to reliably assess and train families, and deliver safe sleep materials (including cribs) to the point of care when needed. Data were tracked from July 2013 to February 2014. During this period, the DEI team assessed and provided training to eighty-three percent of the families on their caseload. Family training and assessment was completed in the hospital and in the home. It is the intention of the Department to expand this project throughout the rest of the state.

DCS Action Item 5

In response to *Recommendation 5*, the Department has partnered with the Children's Research Center (CRC) to review and revise the Structured Decision Making (SDM) tool used at the Child Abuse Hotline with an anticipated completion date of August 2014. This revision ensures that the tool is aligned with policy and best practice.

The Department has additionally begun work in reviewing the safety and risk assessments used in the field. Recently, the Department received a proposal from CRC to support DCS in developing a review and revision plan for the use of SDM safety and risk assessments to inform decision making in child protection cases. The proposal includes reviewing the safety and risk assessments and meeting with workgroups to discuss ways to enhance and revive the SDM assessments and fully integrate these assessments into the Practice model in current use by DCS.

In addition, the Department collaborated with Vanderbilt University to review and revise the Family Advocacy Support Tool (FAST), which is the agency's service planning tool that will identify needed services for families during the course of a CPS investigation and assessment. A pilot of the FAST 2.0, which is the tool used for service planning with families, is currently underway in the Northeast region.

DCS Action Item 6

In response to *Recommendation 6*, the Department has engaged the Vanderbilt University Center of Excellence for Children in State Custody to develop a proposal for a pilot project that would train Davidson County region child protective services assessment track staff to use Structured Brief Intervention and Referral for Treatment (SBIRT) and Motivational Interviewing (MI), both of which are evidence-based procedures shown to effectively identify adults at-risk of having or who have substance use disorders and engage them in the change process. Taken together, SBIRT and MI are complementary approaches and training child protective services assessment track workers to use these strategies has face validity as a way of helping workers (a) identify children referred to the CPS assessment track who may have parents at-risk of or currently engaged in substance use and (b) intervene more effectively with these families. Given the magnitude of parental substance use among families involved with the child welfare system in general and our evidence suggesting the importance of this issue for Tennessee, this is a critical step in building capacity among our frontline staff around the identification and treatment of substance abuse. This project will begin in July 2014.

Additionally, the Department's Office of Child Safety has added the following courses to the CPS Investigator Training Academy: Drug Identification (Course focus: Recognition of drugs; paraphernalia and drug-related behavior during an encounter; common drug classification, their appearances and their effects; knowledge of the dangers of common drugs of abuse, and relationship to user and how users may react toward authority) and Recognizing and Documenting Impairment/Drug Use (Course focus: Recognition of when a person is impaired and how to respond). The first academy class graduated in March 2014. Roughly 400 investigative staff along with approximately 150 assessment staff and over 200 community partners will graduate from the academy by March 2016.

Further, the Department's Office of Child Safety has developed a CPS Investigator Post Academy. In light of this recommendation, the following courses have been added: Mental Health and Substance Abuse (Course focus: Identification of common mental health diagnoses seen by child protective service investigators; behavioral indicators of various diagnoses; common medications utilized and their side effects; and resources across the state will be highlighted which may assist with an investigation) and Drug Exposed Children (Course focus: Exploration of the medical and developmental effects neonatal exposure to various drugs and the impact of parental substance abuse on early childhood development). The first CPS Investigator Post Academy is anticipated to begin November 2014.

DCS *Action Item 7*

In response to *Recommendation 7*, the Department's Office of Child Safety and Safety Analysis Division along with Vanderbilt's Dr. Michael Cull, have begun a pilot of anticipatory team huddles. The pilot began on March 24th, 2014 with CPS investigation teams in Davidson County. The huddles involve investigation teams meeting each workday in the morning to discuss anticipated concerns or barriers to their work for that day, and then share strategies to overcome any foreseen issues. Anticipatory huddles have been utilized in healthcare settings and have shown to improve outcomes for patients by cultivating team work and increasing the ability to anticipate and mitigate risks. It is the intention of the Office of Child Safety to evaluate the effectiveness of this pilot and determine if it should be replicated across the state.

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