Child Death Review

2015 Annual Report

Contents

Acknowledgement

The Tennessee Department of Children's Services Office of Child Health wishes 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; however, 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 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 is for this reason DCS designed a 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 and revised January 1, 2015.

Recent enhancements were made to the DCS CDR in order to increase its overall efficiency and effectiveness. First, the CDR process was redesigned so that available resources could be strategically focused on cases with increased complexity while maintaining expedient and thorough review of all child deaths and near deaths. Second, the CDR reports and key data are now managed in a web application hosted by Vanderbilt University's REDCap system. The system allows DCS to collect and examine important CDR data longitudinally with increased precision. This process is outlined in more detail in the Child Death Review Process section. Third, DCS has begun to use Spaced Education. Spaced Education is a learning system designed to quickly communicate important information from CDRs to DCS employees to ultimately increase favorable outcomes for children and families served by DCS.

This is the third Annual Report of the CDR process (the Report). The audience for this Report is broad, including DCS leaders and its many public and private partners. Tennessee's Child Death Review process to review child deaths and near deaths applies a Safety Science approach, which is a pioneering methodology used successfully in other industries such as aviation, nuclear power and health care to improve safety. This approach was recently featured in a federal report from the Commission to Eliminate Child Abuse and Neglect Fatalities (Appendix A). The Child Death Review Process section of this Report briefly explains the current CDR process. The remainder of the Report explains the findings of the CDR process, what was recommended and what action has been taken or will be taken to address those recommendations.

Beginning in 2014 the DCS 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 quarterly as it becomes available. This increased transparency means information that typically might be included in an Annual Report is made available to the public on an ongoing basis and before the CDR process Annual Report is complete and would be published. Therefore the focus of this Report is less on a compilation of demographic and descriptive data and instead emphasizes what was learned and how the understanding and knowledge can inform DCS practice.

It is important to note a death or near death of a child/youth that occurred in 2015 may not be reviewed until 2016 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 required to investigate and determine if an allegation of abuse or neglect was substantiated[1]. In addition, near deaths require additional time to establish 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.

[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.

This report covers deaths and near deaths reviewed in Calendar Year 2015. A total of 95 deaths were reviewed. This includes: 85 non-custody deaths and 10 custody deaths. During this review period, 28 near death cases were also reviewed. This includes one custody near death and 27 non-custody near deaths. Based on the 123 cases reviewed, 5 key areas of improvement were identified and acted on.

Key Areas of Improvement

- Increasing capacity building for Family Support Services (FSS).
- Strengthening the mentoring process for newly hired case carrying staff.
- Providing supports to decrease the likelihood case carrying staff will be affected by stress and fatigue.
- Expanding Situational Awareness, Self-Defense/De-escalation Tactics and Child-specific Engagement trainings for all case carrying staff.
- Exploring technology that will support case carrying staff while working in rural areas.

Introduction

As Tennessee's public child welfare agency, DCS is responsible for serving some of the state's most vulnerable citizens. 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. 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[2], information beyond that mandated by CAPTA is now provided publicly at: http://www.tennessee.gov/youth/childsafety/publicnotifications.html.

[2] 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.

Definitions

Custody Death: any child in the state of Tennessee who is in the custody of the Department of Children's Services at the time of his or her death.

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 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.

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 reporting system.

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 review process includes both a central office review and a "systems analysis" review that occurs in the field. The central office review occurs within 30 days after a child death or near death is recommended for review by the Office of Child Safety. The central office review team identifies any additional immediate concerns and determines which cases meet criteria for further review with systems analysis. If recommended for systems analysis, the case receives a systemic review by a regional multidisciplinary team within 90 days. This review also includes staff debriefings.

Staff debriefings are facilitated opportunities for staff involved in death or near death cases to share, process and learn. Debriefing opportunities typically include frontline staff and supervisors, but may include other positions as needed. During debriefings, staff share and process their experiences working the death or near death case and/or historical information specific to the child or family associated with the death or near death case. Debriefings explore critical decisions and interactions throughout the department's history with the subject child or their family (e.g., removal decisions, service provision, teamwork opportunities, record acquisition, etc.) and create a safe environment for staff to identify opportunities for learning and improvement. The debriefing information is provided to the regional systems analysis teams.

Regional systems analysis teams are comprised of representatives from different disciplines within DCS (frontline staff, frontline supervisors, health representatives, regional leadership) and from partner agencies (e.g., law enforcement, CACs, health providers). The team is supported to review the case using a systems analysis model. The systems analysis model challenges team members to analyze cases to identify systemic vulnerabilities (e.g., teamwork, staffing ratios and service array) and identify any case specific concerns.

In addition to the direct benefits of an improved system for tracking, reporting, and reviewing child deaths and near deaths, the Child Death Review Process is also a vehicle for identifying and analyzing systems issues and generating improvements. Findings and recommendations from reviews are provided monthly to Safety Action Group[3] consisting of the DCS Commissioner, Deputy Commissioner of Child Health; Deputy Commissioner of Child Safety, Deputy Commissioner of Juvenile Justice, Assistant Commissioner of Quality Control, General Counsel, Assistant Commissioner of Finance and Budget, Court Monitor, Director of Policy CQI, and Director of Safety Analysis. This group reviews information generated by the Child Death Review, as well as the Confidential Safety Reporting System and other Continuous Quality Improvement (CQI) activities, in order to develop and implement system improvements.

[3] The CO Safety Action Group is a team comprised of Central Office leadership. This group meets monthly to review considerations derived from CDR findings with the goal of developing and tracking recommendations.

Cases Reviewed

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 (CDRT) reviews deaths when:

a. A child was in DCS custody at the time of death;
b. DCS had contact with the child or family within three (3) years preceding the child's date of death;
c. The child's death has been substantiated for abuse; OR
d. The Commissioner, Medical Director or the Deputy Commissioner of the Office of Child Safety requests a review.

The CDRT reviews all confirmed near deaths. The near death confirmation process is outlined below:
All potential near death cases are considered preliminary until confirmed as a near death. When a Preliminary Near Death (PND) report is received, the Child Abuse Hotline marks the case with a PND indicator. Cases with a PND indicator are confirmed or excluded as near deaths following the closure of the case.

A case can be confirmed as a near death in two ways:

a. By meeting the statutory definition of a near death, or
b. By meeting criteria established by the Department of Children's Services (DCS).

A case meets the statutory definition of a near death if the child "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." (TCA 37-5-107).

If a case does not meet the statutory definition of a near death, it will be confirmed as a near death only if it meets ALL of the following DCS criteria:

a. The case receives a Substantiated classification,
b. The child did not pass away prior to case closure, AND
c. A physician reviewer answers Yes or Unable to Determine as to the question of whether the child was in a serious or critical medical condition.

All other cases with a PND indicator are excluded as near deaths.

Cases Reviewed

In this review period, a total of 123 deaths and near deaths were reviewed. This includes: 85 non-custody deaths, 27 non-custody near deaths, 10 custody deaths, and 1 custody near deaths. Cases are reviewed contingent upon meeting criteria for review. Cases are given priority for review by the order in which they meet criteria.

Table 1: Custody Status

Custody Status (n=123)	n	%
Deaths		
Custody	10	11
Non-Custody	85	89
Near Deaths		
Custody	1	4
Non-Custody	27	96

There were 95 total child deaths reviewed in 2015. 10 children (11%) were in DCS custody at the time of their death and immediately met criteria for review.

Of the 10 children who died in custody, 6 died as a result of medical causes. Another 3 children died of "suffocation/strangulation/asphyxiation" (2 of these were the result of suicide and 1 child was a medically-fragile 1 ½ year old male, who died as a result of getting wedged between the mattress and the wall of his bassinet). Lastly, 1 youth died from an accidental poisoning/overdose when he absconded from his foster home and consumed large quantities of alcohol with his peers.

There were 28 total near deaths reviewed in 2015. Nearly all (27 children; 96%) were children not in DCS custody at the time of their near death. One child (4%) was in DCS custody at the time of near death. In this case, the child nearly died as a result of non-accidental trauma. The incident of non-accidental trauma happened prior to the child's placement in DCS custody, but the life-threatening extent of the child's injuries was not fully known until the child was placed in DCS custody. For this reason, this child's near death was classified as happening in DCS custody.

Table 2: History Status of Non-Custody Cases

History Status of Non-Custody Cases (n=112)	n	%
Deaths		
History	76	89
No History	9	11
Near Deaths		
History	15	56
No History	12	44

Most reviewed deaths (85 children; 89%) involved children not in DCS custody at the time of their death and met criteria because there was relevant history with DCS. Of the 85 non-custodial child deaths reviewed, 89% (76 children) had either personal or family history with DCS within the 3 years preceding their death. The remaining 11% (9 children) had no personal or family DCS history within the 3 years preceding their death. These cases met criteria solely due to the child's death being substantiated for abuse.

Of the 27 non-custodial child near deaths reviewed, 56% (15 children) had either personal or family history with DCS within the 3 years preceding their near death. The remaining 44% (12 children) had no personal or family DCS history within the 3 years preceding their near death.

Regional Information

CDRTs are located within 4 regional groups: West, Middle, Plateau and East. Each regional group consists of 3 DCS regions. Cases are reviewed in the regional group where the child/family was being served. Regional groups are as follows:

1. **West**- Shelby, Northwest, Southwest
2. **Middle**- Mid Cumberland, Davidson, South Central
3. **Plateau**- Upper Cumberland, Tennessee Valley, East
4. **East**- Smoky Mountain, Knox, Northeast

Below are the cases reviewed by regional grouping:

Table 3: Regional Group Information

Regional Group Information (n=123)		
	n	%
Reviews Per CDR Regional Group		
West	27	22
Middle	33	27
Plateau	30	24
East	33	27

Cases were relatively equally distributed across regional groupings. East and Middle each held 33 cases (27%). Plateau had 30 cases (24%). West held 27 cases (22%). The appropriate Regional Group was determined based on the location where the Office of Child Safety (OCS) investigation was assigned.

Below are the cases reviewed by Region:

Table 4: Cases Reviewed by Region

Regional Information (n=123)	n	%
Reviews Per Region		
Davidson	15	12
East	13	10
Knox	8	7
Mid-Cumberland	10	8
Northeast	15	12
Northwest	2	2
Shelby	20	16
South Central	8	7
Southwest	5	4
Smoky Mountain	10	8
Tennessee Valley	12	10
Upper Cumberland	5	4

Of the 123 reviewed child deaths and near deaths, Shelby County had the largest number and percent of cases reviewed (16%, 20 children). Davidson and Northeast each had 12% of cases reviewed (15 children per region). East (10%; 13 children) and Tennessee Valley (10%; 12 children) held the 3rd and 4th highest number of cases reviewed, respectively. Southwest and Upper Cumberland had the fewest number of cases reviewed at 5 children (4%) per region. Northwest had the fewest number, with 2 cases (2%). For the purposes of this report, the appropriate region was selected based on the location where the Office of Child Safety (OCS) investigation was assigned.

Demographic Information

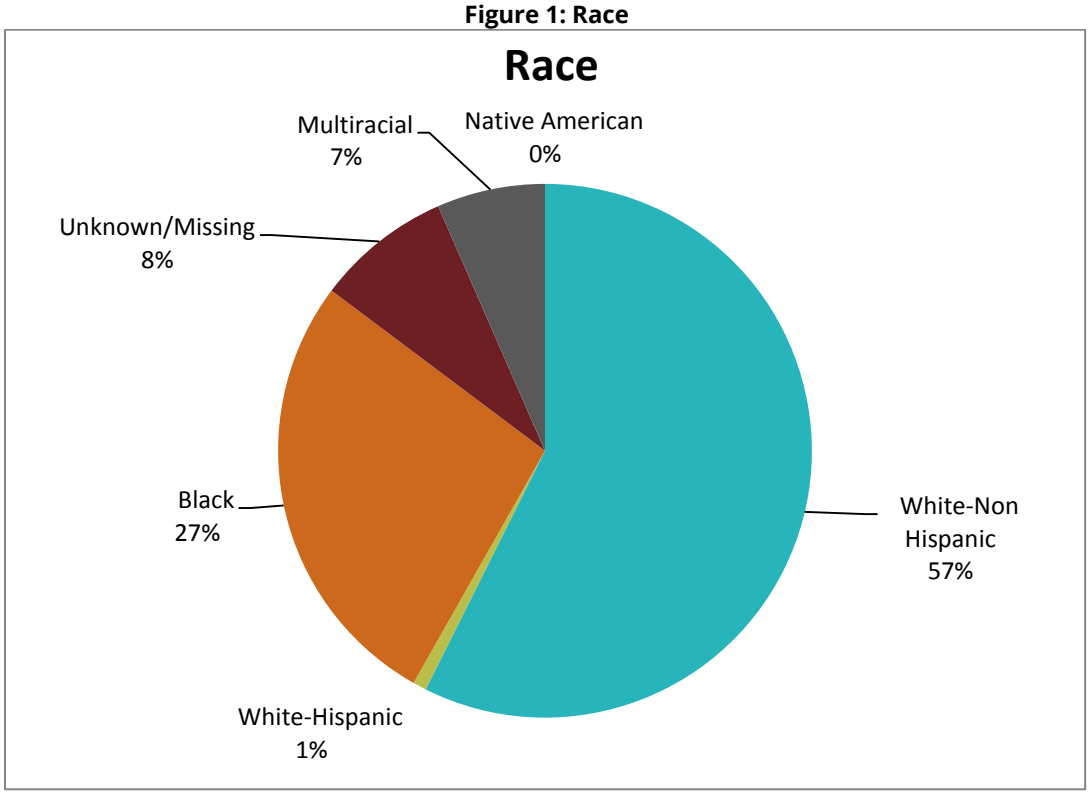
Demographic information is collected from children who have met criteria for a Child Death Review. This demographic information includes race, gender and age. The following table provides demographic information for all cases reviewed within 2015.

Table 5: Demographics

Demographics (n=123)	n	%
Race		
White-Non Hispanic	70	56
White-Hispanic	1	1
Black	33	27
Unknown/Missing	10	8
Multiracial	8	7
Asian	0	0
Native American	0	0
Other	1	1
Gender		
Male	70	57
Female	53	43
Age		
<6 months	62	50
6 to 11 months	17	14
1 to 5 yrs	27	22
6 to 12 yrs	6	5
≥13 yrs	11	9

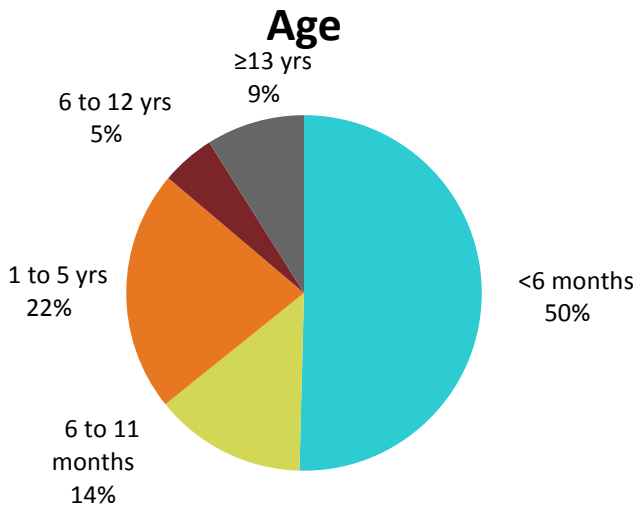
In addition to the demographic information listed above, the department publicly releases all elements designated by the Child Abuse Prevention and Treatment Act (CAPTA) for the child death and near death cases included in this report can be found at the DCS website at the following link: http://www.tn.gov/youth/childsafety/publicnotifications.html.

Figure 1: Race



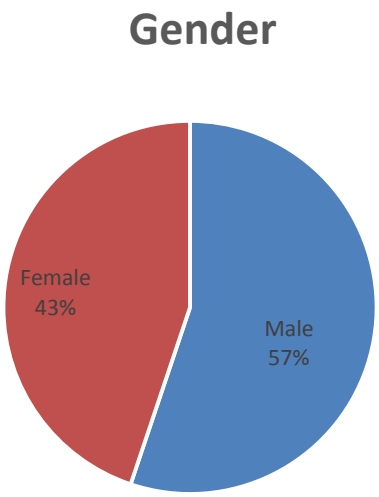
Of the 123 child deaths and near deaths, the primary identified race was White-Non Hispanic (70 children; 56% of total). Black was the next most common race, with 33 children (27%). 10 children (8%) did not have their race documented in medical records or CPS case documentation. This could be due to a lack of autopsy, extreme prematurity, inability to locate the parent for interview, etc. Eight children (7%) were identified as multiracial. Of the remaining 2%, 1 child was Hispanic and 1 child was categorized as Other, whose race was Pacific Islander.

Figure 2: Age



Of the 123 reviewed child deaths and near deaths, 62 children (50%) were less than 6 months old. Another 17 children (14%) were between 6-11 months of age. 27 children (22%) were between the ages of 1-5 years old. 6 children (5%) were between the ages of 6 and 12; 11 children (9%) were 13 and older.

Figure 3: Gender



Of the 123 reviewed child deaths and near deaths, 70 children (57%) were male; 53 children (43%) were female.

Table 6: Cause of Death

Cause of Death (n=95)	n	%
Medical	28	29
Child abuse/Non-accidental trauma	0	0
Motorized vehicle	4	4
Weapon	4	4
Drowning	1	1
Blunt Force trauma	6	6
Poisoning/Overdose	5	5
Fire/Burn	1	1
Inadequate care/Neglect	0	0
NAS	0	0
Acute Life threatening event	0	0
Suffocation/Strangulation/Asphyxiation infants	21	22
Suffocation/Strangulation/Asphyxiation age 1-18 years	5	6
Fall Injury	0	0
Other	4	5
Unable to determine	16	17

Of the 95 reviewed deaths, 28 children (29% of cases) died from medical causes (e.g. prematurity, genetic disease, etc.). Another 21 children (22%) were infants who died as a result of asphyxiation, often from unsafe sleep environments. 6 children (6%) died as a result of blunt force trauma. 5 children died from poisoning/overdose, and another 5 children (age 1-18 years) died from asphyxiation. 4 children died as a result of injuries sustained in motor vehicle accidents, and another 4 children died from either the accidental or intentional use of a weapon. 1 child died as a result of injuries sustained in a house fire, and 1 child drowned.

16 children (17%) died as a result of undeterminable cause. A child's cause of death may be undeterminable for a number of reasons, but often complex factors (e.g. drug-exposure, dehydration, prematurity, viral infections, unsafe sleep) prevent medical personnel from being able to identify a central cause of death. The remaining 4 children (5% of total cases) died as a result of "other" causes not well-captured in existing data selections. Each of these children received an autopsy. 2 of the children's cause of death was Sudden Unexplained Death of an Infant (SUDI), and the other 2 children's cause of death was Sudden Unexplained Infant Death (SUID). One of these children had a contributory factor of unsafe sleep, but asphyxia was not medically proven.

While no children died specifically from medically-documented child abuse/non-accidental trauma, it should be noted autopsy information rarely identifies “non-accidental trauma” as a cause of death. When children die as a result of abuse, the cause may be more accurately captured as blunt force trauma, gunshot wound (e.g. weapon), etc. While these designations do not hamper CPS classification, this report captured “cause of death” in a manner consistent with the autopsy findings whenever possible.

Table 7: Manner of Death

Manner of Death (n=95)	n	%
Natural	29	32
Accident	28	29
Homicide	6	6
Suicide	4	4
Unable to Determine	28	29

Of the 95 child deaths reviewed, the majority died natural (29 children; 32% of cases) or accidental (28 children; 29% of cases) manners of death. 6 children (6%) died as a result of homicide, and 4 children (4%) died as a result of suicide. 28 children (29%) died in a manner that could not be determined. In most cases, this is a reflection of the specific autopsy findings.

Table 8: Cause of Near Death

Cause of Near Death (n=28)	n	%
Medical	6	21
Child abuse/Non-accidental trauma	10	35
Motorized vehicle	0	0
Weapon	0	0
Near drowning	3	11
Blunt Force trauma	0	0
Poisoning/Overdose	4	14
Fire/Burn	1	4
Inadequate care/Neglect	1	4
NAS	1	4
Acute Life threatening event	0	0
Near Suffocation/Strangulation/Asphyxiation infants	0	0
Near Suffocation/Strangulation/Asphyxiation age 1-18 years	0	0
Fall Injury	0	0
Other	0	0
Unable to determine	2	7

Of the 28 near deaths reviewed, 10 children (35%) nearly died as a result of non-accidental trauma. 6 children (21%) nearly died from medical causes (e.g. prematurity, genetic disease, etc.). 4 children (14%) nearly died as a result of accidental or intentional poisoning/overdose. 3 children (11%) nearly drowned. One child (4%) almost died in a fire and another (4%) as a result of neglect. For the purposes of this report, Neonatal Abstinence Syndrome (NAS) was identified as a distinctive cause of death/near death. 1 child (4% of total cases) nearly died of complications directly stemming from NAS. In this case, the mother went into labor prematurely as a result of a drug overdose. Though the child had medical complications from prematurity, the NAS diagnosis was specifically causal to the child's near death.

Table 9: Cause of Death by Custody Status

Cause of Death by Custody Status (n=95)

	Custody	Non-Custody	Total
Medical	6	22	28
Child abuse/Non-accidental trauma	0	0	0
Motorized vehicle	0	4	4
Weapon	0	4	4
Drowning	0	1	1
Blunt Force trauma	0	6	6
Poisoning/Overdose	1	4	5
Fire/Burn	0	1	1
Inadequate care/Neglect	0	0	0
NAS	0	0	0
Acute Life threatening event	0	0	0
Suffocation/Strangulation/Asphyxiation infants	0	21	21
Suffocation/Strangulation/Asphyxiation age 1-18 years	3	2	5
Fall Injury	0	0	0
Other	0	4	4
Unable to determine	0	16	16

Table 10: Manner of Death by Custody Status

Manner by Custody Status (n=95)

Age	Custody	Non-Custody	Total
Natural	5	24	29
Accident	2	26	28
Homicide	0	6	6
Suicide	2	2	4
Unable to Determine	1	27	28

Table 11: Cause of Death by Age

Cause of Death by Age (n=95)

	<6 months	6 to 11 month	1 to 5 yrs	6 to 12 yrs	≥13 yrs
Medical	15	3	8	1	1
Child abuse/Non-accidental trauma	0	0	0	0	0
Motorized vehicle	0	0	1	3	0
Weapon	0	0	1	1	2
Drowning	0	0	1	0	0
Blunt Force trauma	1	0	4	1	0
Poisoning/Overdose	1	0	2	0	2
Fire/Burn	0	0	1	0	0
Inadequate care/Neglect	0	0	0	0	0
NAS	0	0	0	0	0
Acute Life threatening event	0	0	0	0	0
Suffocation/Strangulation/Asphyxiation infants	15	6	0	0	0
Suffocation/Strangulation/Asphyxiation age 1-18 years	0	0	2	0	3
Fall Injury	0	0	0	0	0
Other	2	2	0	0	0
Unable to determine	13	2	1	0	0

Table 12: Manner of Death by Age

Manner by Age (n=95)

Age	Natural	Accident	Homicide	Suicide	Unable to Determine	Total
<6 months	16	11	2	0	18	47
6 to 11 months	2	4	0	0	7	13
1 to 5 yrs	9	6	3	0	3	21
6 to 12 yrs	1	4	1	0	0	6
≥13 yrs	1	3	0	4	0	8

Table 13: Cause of Death by Manner of Death

Cause of Death by Manner of Death (n=95)

	Natural	Homicide	Suicide	Accident	Unable to Determine
Medical	27	0	0	0	1
Child abuse/Non-accidental trauma	0	0	0	0	0
Motorized vehicle	0	0	0	4	0
Weapon	0	1	2	0	1
Drowning	0	0	0	1	0
Blunt Force trauma	0	4	0	2	0
Poisoning/Overdose	0	0	0	3	2
Fire/Burn	0	0	0	1	0
Inadequate care/Neglect	0	0	0	0	0
NAS	0	0	0	0	0
Acute Life threatening event	0	0	0	0	0
Suffocation/Strangulation/Asphyxiation infants	0	0	0	15	6
Suffocation/Strangulation/Asphyxiation age 1-18 years	1	0	2	2	0
Fall Injury	0	0	0	0	0
Other	0	0	0	0	4
Unable to determine	1	1	0	0	14

Debriefings

In addition to the factual data collected specific to the case being reviewed, debriefings are conducted with frontline staff and supervisors involved with the subject case. These debriefings are intended to explain actions, understand decisions and provide a comprehensive assessment of case context. Additionally, debriefings promote a safe environment for staff to revisit cases and review their cases with Safety Analysts. This provides critical learning opportunities for all staff involved.

Debriefings 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 or constraints (situational, operational, and organizational) may have influenced their perception of a situation and subsequent actions.

In 2015, 140 debriefings were conducted. During these robust debriefings, 214 different findings were discussed. Each debriefing lasts a minimum of one hour; therefore, at least 140 hours of discussion with frontline workers and supervisors contributed to the Department's evaluation and analysis of practice through the Child Death Review in 2015.

Findings

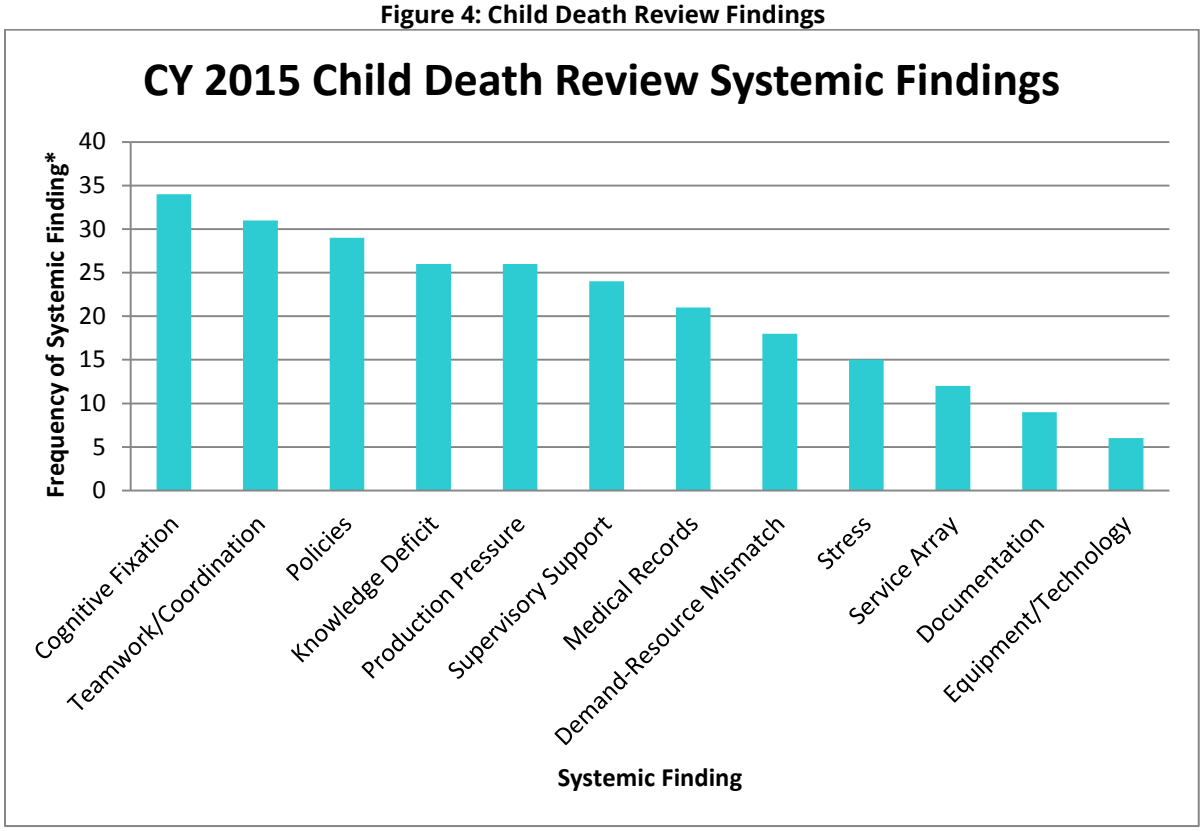
Represented below is this year's distribution of systemic findings. Systemic findings have specific definitions developed from relevant safety science literature. Using these definitions, systemic findings are identified within and across cases. The frequency of the systemic finding is determined by the amount of times it is identified across cases. The frequency of systemic findings informs further analysis designed to identify specific learning points. Below is the list of systemic findings with corresponding definitions.

Cognitive Fixation: A faulty understanding of a situation due to biases (e.g., confirmation bias, focusing effect, transference).
Demand-Resource Mismatch: A lack of resources (e.g., human, capital) to carry out safe work practices.
Documentation: Absent or ineffective documentation in connection with a particular case.
Equipment/Technology: An absence or deficiency in the equipment and technology utilized to carry out work practices.
Knowledge Deficit: An absence of knowledge or difficulties activating knowledge (putting it into practice).
Medical Records: Difficulties in obtaining, understanding and utilizing medical record or autopsy information.
Policies: The absence or ineffectiveness of a policy.
Production Pressure: Demands to increase efficiency, which are incompatible with safety assurance.
Service Array: The availability of a particular service which could support safe environments for children and families.
Stress: Unsafe work practices influenced by stress.
Supervisory Support: Ineffective support or knowledge transfer from a supervisor to those supervised.
Teamwork/Coordination: Ineffective collaboration between two or more entities (e.g., agencies, people and teams).

These systemic findings are identified within and across reviewed cases with the use of the Systems Analysis Tool. The Systems Analysis Tool is a multi-purpose information integration tool whose purpose is to support a culture of safety, improvement and resilience. Completion of the instrument is accomplished in order to allow for the effective quantifiable communication of influencing factors on a case at all levels of the system. Systemic findings found within cases are scored. These scores reflect whether a finding was present in a case and supported by evidence, which is captured by the label "actionable."

Below are findings from all cases:

Figure 4: Child Death Review Findings



*The frequency of each system level finding is determined by the amount of times it is identified as actionable across Child Death Review cases. A systemic finding cannot be counted more than once for any single case.

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 significant learning points from the review of deaths and near deaths in this review period:

1) Family Support Services (FSS) is one of DCS' strategic custodial prevention programs. FSS resources vary from county-to-county, based on the region's allocation for this service. Reviews highlighted the underutilization of FSS within CPS work, especially in circumstances where services were recommended but not yet in place (e.g., due to waiting lists, etc.), and when ongoing concerns were present but did not warrant removal. *Example: An investigator identifies a parent's pill abuse but feels the parent is not currently an unsafe caregiver. The parent is referred to services and is placed on a provider agency's waiting list, but due to the wait the investigator closes the case without ensuring the parent received services.*

   Supports: Teamwork/Coordination; Production Pressure; Cognitive Fixation

2) Current methods of mentoring oncoming staff appear insufficient. This is augmented by the fact that current staff are not supported to properly mentor new staff (e.g., time, experience, skill). There are two issues that have been noted to influence this issue. First, staff do not feel an incentive to mentor others. Second, staff do not feel as though they have adequate training or knowledge on how to mentor others. *Example: Investigation and assessment tasks are not completed by the case manager since they were not taught to do so.*

   Supports: Knowledge Deficit; Supervisory Support; Cognitive Fixation

3) Investigators and Family Service Workers were found to work 20-36 hours with minimal breaks which produces worker fatigue and may influence effective follow-up. This occurred primarily during on-call responses and during transport to/from various custodial placements. This workload influences fatigue and is a barrier to risk assessment which heightens the likelihood of harm to DCS employees and children. *Example: An investigator worked a standard business day and began her on-call shift. She had a high priority response and ultimately worked 36 hours before being relieved of duty, and this relief was at her request due to exhaustion and her concerns about transporting a child while affected by fatigue. Because the investigator was worked to the point of exhaustion, she did not participate in a meeting later that day to determine placement for the child. The investigator felt the placement decision made was unsafe.*

   Supports: Production Pressures; Policies; Stress

4) Child risk assessment and investigative evidence collection is hindered by case managers who feel intimidated by unsafe environments and believe further assessment may increase their personal likelihood of harm. In contrast, personal risk assessment is also hindered when case managers are unaware of the heightened risk of harm in specific environments (e.g. walking ahead of an Alleged Perpetrator down a narrow hallway during a home visit, being the sole supervisor of a custodial youth with a diagnosis of Conduct Disorder, etc.). *Example: A Juvenile Justice (JJ) staff was supervising a youth with whom the JJ team had contact for several years without incident. However, the youth had serious mental health diagnoses influencing assaultive/risk behaviors, and the staff was assaulted and injured by the youth. The extent of risk associated with the mental health diagnoses was not well understood by staff.*

   Supports: Cognitive Fixation; Policies; Stress

5) Case Managers have disclosed concerns with the timely availability of Law Enforcement and with accessing immediate aide when a situation becomes suddenly unsafe. This safety concern is exacerbated when a case manager is without cellular reception and/or is unable to provide their specific location. *Example: A Case Manager went out to a home on an allegation of Environmental Neglect. The mother was intoxicated and threatened the case manager with a knife. The case manager left the child in the home while she fled, called Law Enforcement and awaited assistance. The Case Manager remained within visibility of the home to reduce the risk of the mother escaping the home with the child, prior to Law Enforcement's arrival. Law Enforcement may also struggle to locate Case Managers due to rural, unnamed, dirt roads.*

   Supports: Teamwork/Coordination; Equipment/Technology

Recommendations

Recommendations are informed by what is learned from the Child Death Review process. With the support of the DCS Central Office Safety Action Group, recommendations are developed and tracked. Based on the findings, recommendations for improved practice are as follows:

1) Increase centralized oversight of Family Support Services with emphasis on strategic planning and capacity building to improve internal and external collaboration, data use and training needs.

2) Explore opportunities to improve the mentoring and coaching process for case carrying new hires within the Department of Children's Services in order to prepare staff for the complexities of their work which cannot be learned in a classroom setting.

3) Increase safety parameters regarding how many hours a case carrying staff may work within a 24-hour period to combat the effects of stress and fatigue.

4) Implement Situational Awareness, Self-Defense/De-escalation Tactics and Child-specific Engagement trainings for all case carrying staff.

5) Identify and implement multi-access (e.g. radio frequency, Wi-Fi, cellular), GPS-enabled communications devices for case carrying staff so they are able to consistently access crisis support when completing field work in rural areas.

Department Actions

The development of action plans for recommendations are completed outside of the CO Safety Action Group. Recommendations are presented to CQI teams comprised of content experts specific to the recommendation. These specific teams identify actions that will be implemented and tracked. These actions include:

1) To address recommendation 1, a workgroup was developed to study the FSS division. In order to have a better understanding of the practice and to analyze the workflow process, a case review was conducted in six regions across the state. Specifically, the workgroup studied influences that contribute to the length of time FSS is involved with the family, the internal collaboration, and coordination with courts. The workgroup also reviewed current policy and identified the need for a specific practice model to be developed that would provide a more consistent approach. Data elements were also identified that are critical to monitoring case activity and assessing performance and outcomes. Additionally, training needs were identified to enhance the skills of FSS case managers. A framework is being proposed based on the In Home Tennessee structure to address the practice. On April 14th, the FSS workgroup will convene to review the proposed framework, discuss ways to improve relationships with the courts and explore ways to enhance information sharing with the courts. Additionally, ongoing CPS workgroup meetings will focus on advancing and enhancing internal collaboration between CPS Investigations, CPS Assessment, FSS and DCS Legal staff.

2) To address recommendation 2, The Office of Learning & Development has revised the Pre-Service Case Manager Training Program. The updated training program is being piloted in Nashville in February, 2016. The content is better oriented to case practice and practical application for new hires. In order to help trainees connect the material in the classroom with what is required in the field, the Pre-Service training will include 4 weeks of On the Job Training (OJT). The trainee's progress or learning needs will be captured by the trainers and regional staff through an Individual Learning Plan that is updated weekly throughout the process. The Learning Plan will be used to identify tasks during OJT, assess strengths and needs during classroom training and OJT, identify action steps to enhance learning and serve as an overall assessment to determine if the new hire is ready to be assigned a training caseload. Another change is that the training program will consist of a case presentation where the new hire will present one of their training cases to a panel which consists of their OJT coach, a Team Leader, their mentor and other regional staff who may be invited to participate. There will then be a question and answer period followed by a determination on whether to certify the new hire or recommend additional OJT/Coaching.

3) To address recommendation 3, policy 31.15 was modified to update guidelines for how long and far staff can travel in prescribed timeframes. This update became effective on January 25th, 2016. The policy update allows for workers to stay overnight after transporting children or travel with a co-transporter if transportation of a child or travel back to the worker's home will require the worker to remain on the road after reaching the maximum number of 14 work hours in a single shift.

4) To address recommendation 4, the Department has expanded the Situational Awareness training for all case carrying staff. This training not only provides information on how to be aware of your surroundings and what employees should look for when visiting with families, it also provides information on de-escalation techniques. Previously, this class was only offered to CPS Investigators. The training was expanded in collaboration with the Tennessee Bureau of Investigation (TBI). The Situational Awareness course, delivered by the TBI, was made available to all DCS employees starting with the Shelby region on January 25, 2016. In calendar year 2016 each of the twelve regions will have three, four hour training sessions available to them.

5) To address recommendation 5, a statewide Continuous Quality Improvement group is discussing and assessing the need for alternative (non-cellular) communication devices across the state. The group has completed initial research on types of devices (e.g. satellite phones, digital radio and long-range walkie-talkies) and their associated costs. The tablets used by field staff are GPS-equipped, so further research may be done to see how supervisors can quickly access staff's location through their tablet. The group is currently considering actions steps to assess which regions, particularly which counties, are in greatest need of alternative communication equipment.

Ongoing Improvement Efforts

Based on findings and recommendations from the Child Death Review process, which are noted in Annual Reports published in previous years and with the support of Continuous Quality Improvement, the Department has made considerable progress. This progress includes the implementation and management for system wide changes that address underlying systemic issues affecting the ability of the Department to provide safe and reliable services to Tennessee's children and families. Below are notable updates:

Safe Sleep

One example of a notable improvement initiated by the Department to address safe sleep is the increased availability of, and a streamlined process for procuring, safe sleep furniture for families when an unsafe sleeping environment is identified. Through partnership with local health departments and acquisition of a stock of resources for local offices, the Department has increased the timeliness of providing safe sleep resources to families. These changes were prompted by the understanding from the CDR process of the risks to child death posed by the lack of safe sleeping practices for young children and challenges to obtaining safe sleep furniture for at risk families.

Medical Records

The Department has also made significant improvement to address the recurring issues related to acquisition of medical records. The Child Death Review identified challenges workers faced in obtaining medical records from various facilities. To address this, Safety Analysis and Continuous Quality Improvement (CQI) worked with DCS Legal staff and the Forms Committee to create a request form that explains clearly to medical providers the statutory authority pursuant to which the provider is permitted to provide records to DCS, with or without a Release of Information. Prior to development of this request form, some providers were unclear about what records the Department is able to obtain in the course of investigating abuse and neglect, specifically when a Release of Information cannot be provided. This led to inconsistent practice across the state related to obtaining medical records and created challenges for completing timely, complete investigations when facilities refused to provide records to investigators. Now, workers have a clear, consistent mechanism for communicating to medical facilities the statutory grounds granting DCS access to certain medical records.

Additionally, CQI, in collaboration with the Forms Committee and DCS Legal, is currently condensing DCS' Release of Information forms. Systems Analysis revealed these multi-page documents were being underused and not thoroughly completed, at least partially due to the complex format and instructions. As a result, some providers were hesitant to release records to DCS, even when an appropriately completed Release of Information was provided. Once completed, the revised Release of Information forms are projected to be only one page each, with simple instructions and a user-friendly format.

Teamwork between CPS and Health Unit Staff

In 2014, Child Death Reviews indicated case carrying CPS staff were unfamiliar with DCS nurses in their local region. To address this, DCS created a specific webpage[4] with information on the various DCS nursing positions and a description of the nurses' various responsibilities, including how they may assist CPS' casework. The webpage is intended to guide DCS staff regarding how and when DCS nurses can assist them. The site identifies the roles of three DCS nursing positions: Child Health Nurses, Child Safety Nurses and Youth Development Center nurses. The site explains how DCS nurses assist custodial cases (e.g. accessing medically-fragile waivers, explaining EPSD&T results, signing medical consent paperwork when a parent or guardian cannot, tracking psychotropic medications, etc.) and non-custodial CPS cases (e.g. offering consultation on medical disease and medical care needs, offering consultation on medical needs when children are initially placed in DCS custody, interpreting medical records, etc.). The site articulates the role of YDC nurses as well (e.g. convalescent care, primary medical care, administering medications, etc.).

[4] http://www.tn.gov/dcs/topic/child-health-nurses

Appendix A: Commission to Eliminate Child Abuse and Neglect Fatalities

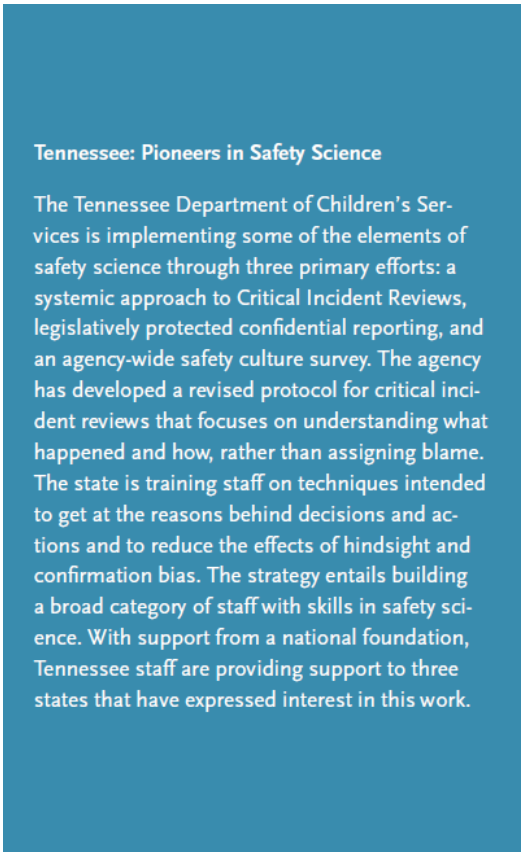
The federal Commission to Eliminate Child Abuse and Neglect Fatalities was established by Public Law 112-275, the Protect Our Kids Act of 2012, to develop a national strategy and recommendations for reducing fatalities across the country resulting from child abuse and neglect.[5] The Tennessee Department of Children's Services was asked to present to the commission on the Child Death Review Process and how Safety Science has been successfully applied. Based on the Department's input, the Commission developed the following Recommendation:

"Fund pilot programs to test the effectiveness of applying principles of safety science to improve CPS practice" (CECANF, 2016, p.78).

[5] The report can be found online at: http://www.acf.hhs.gov/programs/cb/resource/cecanf-final-report

In addition to making a recommendation based on the Department's contributions, DCS was recognized as "Pioneers in Safety Science" (CECANF, 2016, p. 78). The excerpt is included below.

"The Tennessee Department of Children's Services is implementing some of the elements of safety science through three primary efforts: a systemic approach to Critical Incident Reviews, legislatively protected confidential reporting, and an agency-wide safety culture survey. The agency has developed a revised protocol for critical incident reviews that focuses on understanding what happened and how, rather than assigning blame. The state is training staff on techniques intended to get at the reasons behind decisions and actions and to reduce the effects of hindsight and confirmation bias. The strategy entails building a broad category of staff with skills in safety science. With support from a national foundation, Tennessee staff are providing support to three states that have expressed interest in this work" (CECANF, 2016, p. 149).



Tennessee: Pioneers in Safety Science

The Tennessee Department of Children's Services is implementing some of the elements of safety science through three primary efforts: a systemic approach to Critical Incident Reviews, legislatively protected confidential reporting, and an agency-wide safety culture survey. The agency has developed a revised protocol for critical incident reviews that focuses on understanding what happened and how, rather than assigning blame. The state is training staff on techniques intended to get at the reasons behind decisions and actions and to reduce the effects of hindsight and confirmation bias. The strategy entails building a broad category of staff with skills in safety science. With support from a national foundation, Tennessee staff are providing support to three states that have expressed interest in this work.

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