Child Death Review

2017 Annual Report

Tennessee Department of Children's Services| CDR Annual Report | 2017

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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 (CDR) 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 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 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 there can be assumptions deaths and near deaths are caused by isolated failures of people or processes, this is largely not the case. Rather these tragic and usually unforeseeable events emerge from a complex social system working to support safe outcomes (Dekker, 2006).

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 implemented 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. DCS developed the Child Death Response and Review process (CDR process or Child Death Review process) with the input of many critical partners. It was initially implemented on August 29, 2013, and revised January 1, 2015.

This is the fifth 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 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 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.

In 2014, 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 this 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 informs DCS practice.

DCS has demonstrated an ongoing commitment to the principles of Safety Science and has sought new ways to use the strategies of Safety Science to further learning at all levels of the Department. First, Spaced Education has been used since 2015. Spaced Education is a learning system designed to communicate important information from CDRs to DCS employees to ultimately increase favorable outcomes for children and families served by DCS. In 2017, Spaced Education was administered to DCS Case Managers in all regions, with approximately 800 Case Managers having participated in the entire curriculum. As of the writing of this report, Spaced Education is again being administered to DCS Case Managers as well as Training Coordinators. Based on themes and lessons learned in 2017 reviews, the 2018 Spaced Education curriculum features questions about finding and preventing runaway youth, custodial care coordination, and best practice uses of the Family Advocacy and Support Tool (FAST). Second, in 2016, Safety Notices began to be utilized by the Department. These notices serve as a prompt response to provide safety-critical information to DCS employees following CDRs. Third, leaders of the CDR process have begun facilitating Safety and Risk trainings for Child Protective Service professionals. These trainings focus on the same detection, response, and collaboration strategies found in the field of Safety Science and supported through learning opportunities in CDR. Fourth, in 2017, leaders of the CDR process were also collaborators in a Breakthrough Series Collaborative on Advancing a Culture of Safety in Child Welfare. This endeavor, in partnership with Casey Family Programs, created a venue for a multi-disciplinary cohort of Case Managers and supervisors across the state to learn and practice strategies consistent with a Safety Culture. The collaborative resulted in the creation of a Safety Culture Toolkit and a group of volunteers to serve as Culture Coaches across the state.

Several CDR-related projects that began in 2016 were completed in 2017. For example, in 2016-2017, all regional protocols for infant safe sleep assessments were gathered and cross-walked for similarities and distinctions. In collaboration with the Offices of Child Health, Child Safety, Child Programs, Professional Development, and Quality Improvement, a statewide safe sleep protocol is now active and in practice among the regions. In addition to the ongoing assurance of prompt delivery of safe sleep furniture to families who need it, the statewide protocol gave trainers substantial information to make a new curriculum. While the only former training was a computer-based training led by the Department of Health, the new training incorporates DCS

data around safe sleep, encourages more robust discussion and assessment about safe sleep practices, and includes the process of setting up a Pack-n-Play. In accordance with prior Quality Improvement initiatives, all regions continue to supply Pack-n-Plays in county offices, so safe sleep furniture is promptly delivered to families. Additionally, in previous years, Child Death Reviews have suggested the improved use of mentors within the Department may improve attrition and promote safe, quality casework practices. In 2017, a statewide mentoring program was created and features the values and strategies consistent with Safety Culture and the safety sciences. In the new program, regions formally identify experienced, quality, frontline professionals to serve as mentors for newly hired employees, and the mentors each receive in-person training and participate in coaching calls and activities through the Office of Professional Development.

It is important to note a death or near death of a child/youth that occurred in 2017 may not be reviewed until 2018 as a result of the timelines and operational requirements established in the CDR process. Factors influencing 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.

This report covers deaths and near deaths reviewed in Calendar Year 2017. A total of 134 deaths were reviewed. This includes: 117 non-custody deaths and 17 custody deaths. During this review period, 23 near death cases were also reviewed. This includes no custody near deaths; all were non-custody. Based on themes and items of interest from the 157 cases reviewed, **five key areas of improvement were identified and are being acted on.**

[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.

Key Areas of Improvement Identified

- Increasing the availability, consistency, and use of strategic tools in substance abuse assessment
- Furthering education and supports for engaging and assessing all caregivers (most notably fathers and other male caregivers)
- Cultivating supports and resources to prevent custodial youth from absconding and to recover them quickly when they do abscond (i.e. runaway)
- Creating improved accountability to best promote CPS Case Managers addressing new allegations from screened-out child abuse referrals occurring during open cases
- Developing a more trauma-informed protocol to better support Family Service Workers (FSWs) in the aftermath of a custodial child's death

Introduction

As Tennessee's public child welfare agency, DCS is responsible for serving some of the state's most vulnerable citizens. It is estimated nationally 1,520 children died as a result of abuse or neglect in 2013 (U.S. Department of Health and Human Services, 2014. 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 safety for all of Tennessee's children.

Responsibility for review of all child deaths in Tennessee belongs to the Department of Health. DCS has a narrower focus and reviews the death or near death of any child in state custody, any child whose family had history with the Department within three years prior to the death or near death, and any child whose death or near death was the result of maltreatment. 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 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 what is mandated by CAPTA is now provided publicly at:
https://www.tn.gov/dcs/program-areas/child-safety/cdnd-pn.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 DCS 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 (TFACTS).

Child Death Review Process

Review of a child death or near death begins with a report to the Child Abuse Hotline. This report initiates the Rapid Response process to ensure 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 immediately takes any necessary action to assure 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 includes debriefings with internal and external professionals assigned the case.

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 cases with the family and give 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 (e.g., frontline staff, frontline supervisors, health representatives, regional leadership) and from partner agencies (e.g., law enforcement, Child Advocacy Centers, 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, 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. Gathered information and recommendations from reviews are provided a minimum of quarterly to the Safety Action Group consisting of senior leadership. This group meets monthly and 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.

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 or 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 (calendar year 2017), a total of 157 deaths and near deaths were reviewed. This includes: 117 non-custody deaths, 23 non-custody near deaths, and 17 custody deaths. There were no custody near deaths. Cases are reviewed contingent upon meeting criteria for review.

Table 1: Custody Status

Custody Status (n=157)	n	%
Deaths		
Custody	17	13
Non-Custody	117	87
Near Deaths		
Custody	0	0
Non-Custody	23	100

There were 134 total child deaths reviewed in calendar year 2017. Seventeen children (13%) were in DCS custody at the time of their death and immediately met criteria for review.

Of the 17 custodial children, 5 died as a result of medical causes:

- A 4-month-old female was born drug exposed and died from extensive medical complications; she had congenital heart and chromosomal defects.
- An 8-month-old male with Downs Syndrome died after combined, recent hospital stays of 3 ½ months related to Tetralogy of Fallot. He had surgeries and procedures during the hospital stays, but they were ultimately unsuccessful in preserving his life.
- An 11-month-old male born prematurely and requiring 24/7 nursing care became unresponsive overnight while being attended by a nurse. He had been hospitalized most of his life but lived the last few weeks on a Trial Home Visit with his maternal, step-grandparents.
- A 15-year-old female who entered DCS custody as a result of the death of her adoptive mom, spent approximately 8 months in foster care before dying from complex medical issues including lung problems exacerbated by living in a foster home where she was exposed to cigarette smoking and pets. She was removed from that home but was hospitalized 10 days later, dying 3 weeks after hospital admittance.
- A 17-year-old male was wheelchair-bound with Duchenne Muscular Dystrophy and died after being found unresponsive during a Trial Home Visit with his parents.

A 9-year-old female hospitalized for a dental procedure, died 7 days later from respiratory complications. She also had complex medical issues and was deemed medically fragile by DCS because she required 24-hour nursing care due to a condition called Cerebellar Ataxia. She was non-verbal and required a wheelchair. An autopsy was declined by the medical examiner, but investigation is ongoing to ensure the child received appropriate care in the days leading up to her death. She likely died due to medical causes.

A foster father found his family's 3-year-old male foster child unresponsive one morning, and the autopsy revealed chronic bronchitis with mucous plugging exacerbated issues and caused asphyxiation (cause of death: accidental suffocation). The child had been exposed to methamphetamines prior to custody and had several medical and developmental needs.

Two children died a cause of death unable to be determined through an autopsy alone, but an explanation of the circumstances and investigative tasks revealed likely causes. The first child, a 3-week-old, was found unresponsive in a bouncy seat. Though the cause of death was unable to be definitely determined by autopsy, the child had been diagnosed with Neonatal Abstinence Syndrome and exhibited symptoms of a congenital medical condition that limited the adrenal glands ability to produce certain hormones. The second child, a drug-exposed 3-month-old born prematurely at 29 weeks, never left the hospital due to his medical issues.

Six teenage males died after having absconded from DCS custody, and 5 of them died of gunshot wounds. The sixth died after being struck by a vehicle in which he had earlier been joy-riding. Their time on runaway status just before their deaths ranged from 2 weeks to 4 ½ months, and 3 of the youths had multiple episodes of absconding. They were between 14 and 18 years old and only 2 investigations resulted in substantiation of perpetrators while 2 cases are still pending for classification. Three youth ran from facilities; two youth ran from foster homes. The remaining youth ran while being transported to a new placement.

An 8-month-old male died in an unsafe sleep environment; the cause of his death is currently unknown and waiting an autopsy. He was found unresponsive by the foster mother after she placed him on an adult bed with her 3-year-old son who was watching cartoons. The foster mother left the room briefly to prepare lunch. The child was born premature and drug-exposed. The investigation into this case is ongoing.

The remaining case involved a 2-years and 9-months-old female found unresponsive after a nap. She had been placed in another state with a family member through the interstate compact process. Investigation revealed the child had experienced at least 2 trips to the hospital for broken bones concerning for non-accidental trauma. An autopsy could not definitely determine the cause or manner of death, but an unknown perpetrator was substantiated for abuse death.

There were 23 total near deaths reviewed in 2016. All were children not in DCS custody at the time of their near death.

Note: Due to rounding, percentages in some tables and graphs below do not add up to 100%.

Table 2: History Status of Non-Custody Cases

History Status of Non-Custody Cases (n=140)		
	n	%
Deaths		
History	98	84
No History	19	16
Near Deaths		
History	13	57
No History	10	43

Most reviewed deaths (117 children) involved children not in DCS custody and met criteria because of recent Departmental history. Of the 117 non-custodial child deaths reviewed, 84% (98 children) had either personal or family history within the 3 years preceding their death. The remaining 16% (19 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 23 non-custodial child near deaths reviewed, 57% (13 children) had either personal or family history with DCS within the 3 years preceding their near death. The remaining 43% (10 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 generally 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=157)		
	n	%
Reviews Per CDR Regional Group		
West	34	22
Middle	51	32
Plateau	40	25
East	32	20
	157	100

Middle held the most cases, with 51 (32%). Plateau had the next highest with 40 cases (25%). West had 34 cases (22%), and East held 32 cases (20%). 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=157)	n	%
Reviews Per Region		
Davidson	25	16
East	6	4
Knox	10	6
Mid-Cumberland	15	10
Northeast	16	10
Northwest	9	6
Shelby	23	15
South Central	11	7
Southwest	2	1
Smoky Mountain	6	4
Tennessee Valley	23	15
Upper Cumberland	11	7
	157	100

Of the 157 reviewed child deaths and near deaths, Davidson had the largest number and percentage of cases reviewed at 25 and 16% respectively. Shelby and Tennessee Valley Counties tied for second highest number and percentage of cases reviewed (23 children each and 15%). Northeast had the next highest at 16 cases (10%). Mid-Cumberland had a similar number, with 15 cases. Southwest had the fewest number, with 2 children (1%). 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 2017.

Table 5: Demographics

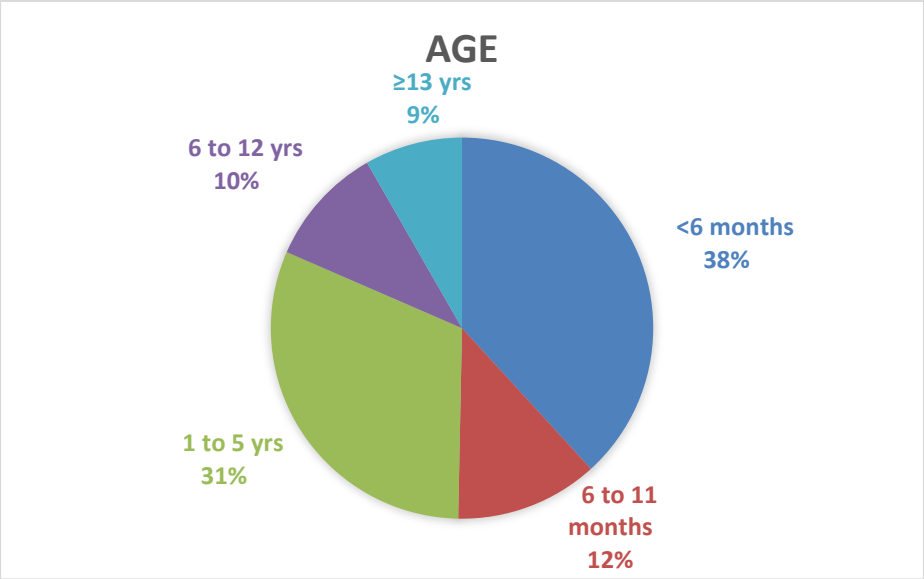
Demographics (n=157)	n	%
Race		
White-Non Hispanic	90	57
White-Hispanic	1	1
Black	60	38
Unknown/Missing	0	0
Multiracial	5	3
Asian	0	0
Native American	1	1
Pacific Islander	0	0
Total	*157*	*100*
Gender		
Male	93	59
Female	64	41
Total	*157*	*100*
Age		
<6 months	60	38
6 to 11 months	19	12
1 to 5 yrs	49	31
6 to 12 yrs	16	10
≥13 yrs	13	8
Total	*157*	*100*

Of the 157 child deaths and near deaths, the primary identified race was White-Non Hispanic (90 children; 57% of total). Black was the next most prevalent race, with 60 children (38%). Five children (3%) were identified as multiracial. Of the remaining 2%, 1 child was Hispanic and 1 was Native American.

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

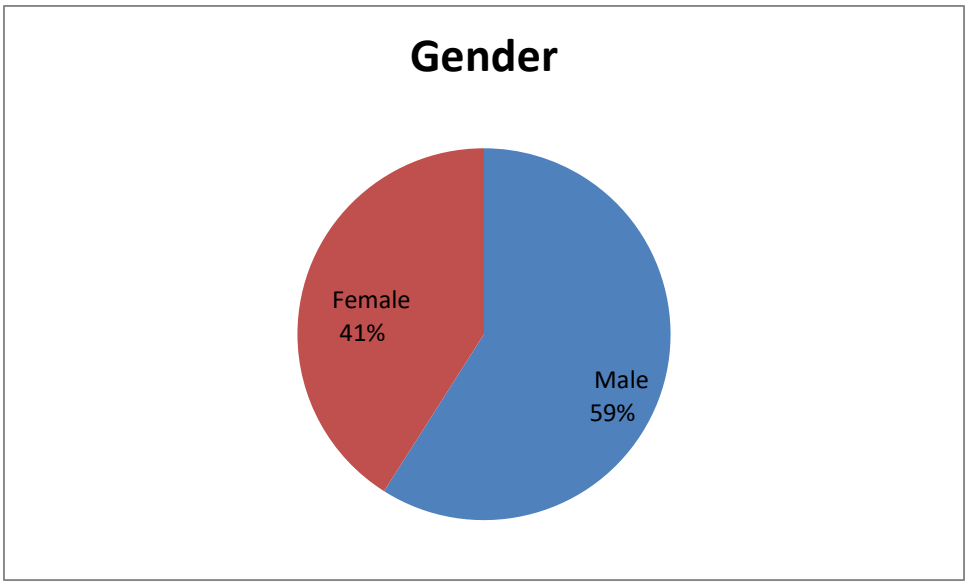
death and near death cases included in this report and can be found at the DCS website at the following link: https://www.tn.gov/dcs/program-areas/child-safety/cdnd-pn.html.

Figure 1: Age



Of the 157 reviewed child deaths and near deaths, 60 children (38%) were less than 6 months old. Another 19 children (12%) were between 6-11 months of age. Forty-nine children (31%) were between the ages of 1-5 years old. Sixteen children (10%) were between the ages of 6 and 12; 13 children (9%) were 13 and older.

Figure 2: Gender



Of the 157 reviewed child deaths and near deaths, 93 children (59%) were male; 64 children (41%) were female.

Table 6: Cause of Death

Cause of Death (n=134)	n	%
Unable to determine	26	19
Suffocation/Strangulation/Asphyxiation infants	21	16
Medical	16	12
Blunt Force trauma	12	9
Fire/Burn	11	8
Weapon	10	7
Motorized Vehicle	9	7
Other	9	7
Drowning	7	5
Suffocation/Strangulation/Asphyxiation age 1-18 years	4	3
Pending	4	3
Poisoning/Overdose	3	2
Non-accidental trauma	1	1
Inadequate Care/Neglect	1	1
NAS	0	0
Acute Life Threatening Event	0	0
Fall/Injury	0	0
	134	100

Of the 134 reviewed deaths, 21 infants (16% of cases) died from asphyxiation, often from unsafe sleep environments. Medical causes (e.g., prematurity, genetic disease, etc.) accounted for the deaths of 16 children (12%). Twelve children (9%) died as a result of blunt force trauma. Eleven children died from fire/burn, and another 10 children died from a weapon. Nine children died as a result of injuries sustained in motor vehicle accidents, and another 7 children died from drowning. Four children, ages 1-18 years died as a result of suffocation/strangulation/ asphyxiation, and 3 children suffered poisoning/overdose.

Twenty-six children (19%) 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.

Nine children (7% of total cases) died as a result of "other" causes not well-captured in existing data selections. Four of the children's cause of death was Sudden Unexplained Infant Death (SUID). Unsafe sleep was a contributing factor in the deaths of 5 of the 9 children. Of the remaining 4 children, 2 children experienced head trauma that could not be definitively

described as intentional. Another child died due to extreme prematurity with acute methamphetamine intoxication. Lastly, 1 child died due to an abdominal bleed caused by the rupture of an adrenal blood clot; it was ruled accidental by the medical examiner.

While only 1 child 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 often hamper CPS classification, this report captured "cause of death" in a manner consistent with the autopsy findings whenever possible.

The causes of 4 children's deaths are still pending final results; such findings (usually autopsy results) will be reviewed in the context of a Central Office Child Death Review Team meeting once available.

Table 7: Manner of Death

Manner of Death (n=134)		
	n	%
Natural	15	11
Accident	47	35
Homicide	19	14
Suicide	2	1
Unable to Determine	47	35
Pending	4	3
	134	100

Of the 134 child deaths reviewed, the majority of the children died undeterminable (47 children; 35% of cases) or accidental (47 children; 35% of cases) manners of death. Nineteen children (14%) died as a result of homicide and 15 children (11%) died as a result of natural causes. Two children (1%) died as a result of suicide. In most cases, the manner of death is determined specifically from autopsy findings; in 4 cases, final results (generally autopsy results) are still pending. Such findings will be reviewed in the context of a Central Office Child Death Review Team meeting once available.

Table 8: Cause of Near Death

Cause of Near Death (n=23)	n	%
Non-accidental trauma	8	35
Medical	3	13
Poisoning/Overdose	3	13
Motorized Vehicle	2	9
Acute Life Threatening Event	2	9
Blunt force trauma	1	4
Weapon	1	4
Near drowning	1	4
Fire/Burn	1	4
Unable to determine	1	4
NAS	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
Inadequate care/neglect	0	0
	23	100

Of the 23 near deaths reviewed, 8 children (35%) nearly died as a result of non-accidental trauma. The categories of medical near death and poisoning/overdose each contained 3 near deaths accounting for a total of 26% of the cases. Two children each experienced near death by motorized vehicle and acute life threatening events which were a combined total of 18%. One life threatening event was uncontrollable seizures of a 4-month-old child who was born drug exposed. The other life threatening event entailed a drug exposed newborn requiring chest compressions at birth. Registering one child each (totaling 20%) were near deaths by weapon, near drowning, blunt force trauma, fire/burn, and unable to determine. The unable to determine designation related to a 6-month-old child discovered having seizure-like activity and requiring hospitalization.

Table 9: Cause of Death by Custody Status

Cause of Death by Custody Status (n=134)

	Custody	Non-Custody	Total
Medical	5	11	16
Non-accidental trauma	0	1	1
Motorized vehicle	0	9	9
Weapon	4	6	10
Drowning	0	7	7
Blunt Force trauma	0	12	12
Poisoning/Overdose	0	3	3
Fire/Burn	0	11	11
Inadequate care/Neglect	0	1	1
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	1	3	4
Fall Injury	0	0	0
Other	0	9	9
Unable to determine	3	23	26
Pending	4	0	4
	17	117	134

Table 10: Manner of Death by Custody Status

Manner of Death by Custody Status (n=134)

Age	Custody	Non-Custody	Total
Natural	4	11	15
Accident	1	46	47
Homicide	4	15	19
Suicide	0	2	2
Unable to Determine	4	43	47
Pending	4	0	4
Total	17	117	134

Table 11: Cause of Death by Age

Cause of Death by Age (n=134)

	<6 months	6 to 11 mos	1 to 5 yrs	6 to 12 yrs	≥13 yrs
Medical	7	3	3	0	3
Non-accidental trauma	0	0	1	0	0
Motorized vehicle	1	0	2	6	0
Weapon	1	0	3	1	5
Drowning	0	1	4	2	0
Blunt Force trauma	3	0	8	1	0
Poisoning/Overdose	0	0	1	1	1
Fire/Burn	0	0	9	2	0
Inadequate care/Neglect	0	1	0	0	0
NAS	0	0	0	0	0
Acute Life Threatening Event	0	0	0	0	0
Suffocation/Strangulation/Asphyxiation infants	14	7	0	0	0
Suffocation/Strangulation/Asphyxiation age 1-18 years	0	0	3	0	1
Fall Injury	0	0	0	0	0
Other	6	1	2	0	0
Unable to determine	18	1	6	1	0
Pending	0	1	0	1	2
Total	50	15	42	15	12

Table 12: Manner of Death by Age

Manner of Death by Age (n=134)

Age	Natural	Accident	Homicide	Suicide	Unable to Determine	Pending	Total
<6 months	6	9	3	0	32	0	50
6 to 11 months	2	4	1	0	7	1	15
1 to 5 yrs	4	21	10	0	7	0	42
6 to 12 yrs	0	13	0	0	1	1	15
≥13 yrs	3	0	5	2	0	2	12
Total	15	47	19	2	47	4	134

Table 13: Cause of Death by Manner of Death

Cause of Death by Manner of Death (n=134)

	Natural	Homicide	Suicide	Accident	Unable to Determine	Pending
Medical	14	0	0	0	2	0
Non-accidental trauma	0	1	0	0	0	0
Motorized vehicle	0	0	0	9	0	0
Weapon	0	9	0	1	0	0
Drowning	0	0	0	5	2	0
Blunt Force trauma	0	8	0	3	1	0
Poisoning/Overdose	0	0	1	2	0	0
Fire/Burn	0	0	0	11	0	0
Inadequate care/Neglect	0	1	0	0	0	0
NAS	0	0	0	0	0	0
Acute Life Threatening Event	0	0	0	0	0	0
Suffocation/Strangulation/Asphyxiation infants	0	0	0	11	10	0
Suffocation/Strangulation/Asphyxiation age 1-18 years	0	0	1	3	0	0
Fall Injury	0	0	0	0	0	0
Other	1	0	0	2	6	0
Unable to determine	0	0	0	0	26	0
Pending	0	0	0	0	0	4
Total	15	19	2	47	47	4

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 (i.e., facilitators of the CDR process). This provides critical learning opportunities for all staff involved.

Debriefings are conducted by the Safety Analysts to help reconstruct the situation that surrounded frontline professionals while trying to provide accurate assessment and 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 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 (e.g., training, previous learning, experience) 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 (e.g., situational, operational, organizational) may have influenced their perception of a situation and subsequent actions.

In 2017, 229 debriefings were conducted. During these debriefings, 261different findings were discussed. Each debriefing usually lasts an hour or more; therefore, approximately 229 hours of discussion with frontline professionals, supervisors, and other internal and external professionals contributed to the Department's evaluation and analysis of practice through the Child Death Review in 2017.

Findings

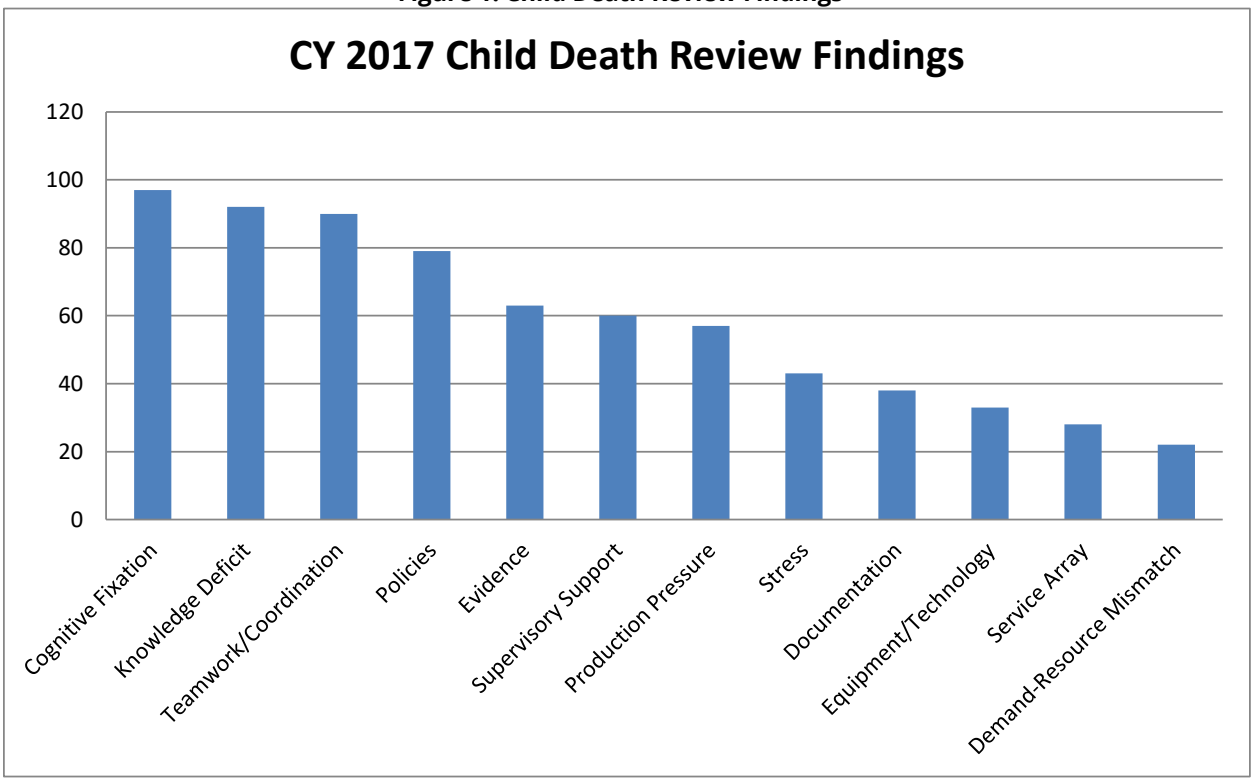
Represented below is this year's distribution of systemic findings. Systemic findings have specific definitions developed from relevant safety science literature. Using these definitions, systemic findings are identified within and across cases. The frequency of the systemic finding is determined by 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 (i.e., putting it into practice).
Evidence: Difficulties in obtaining and synthesizing externally-sourced information (e.g., medical records, criminal records, statements from key members, parent report).
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, teams).

These systemic findings are identified within and across reviewed cases with the use of the Safe Systems Improvement Tool (SSIT). The SSIT is a multi-purpose information integration tool that supports 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 1: 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' 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 back on track. The following were significant findings from the review of deaths and near deaths in this review period:

Finding 1 Supports: Cognitive Fixation, Knowledge Deficit, Teamwork/Coordination, Evidence, Policies, Equipment/Technology, Service Array

1) **Difficulty in accurately assessing substance abuse remains a struggle for frontline professionals.** Case Managers are sometimes suspicious of substance abuse but do not successfully engage caregivers towards honest disclosures of misuse or connect caregivers to an effective service array. Case Managers struggle to collect the evidence needed to best assess the family's needs and make appropriate service plans. In some cases, Case Managers have knowledge of substance misuse but struggle to determine the extent of any impact to caregiving and inaccurately assess the safety of children in the home. This is complicated by the experience of substance abuse—where impairment and sobriety can be in swing with one another and exist on a continuum.

   Case Manager practice varies in the use of drug testing and pill counting; also some Case Managers are quick to request for pharmacy and/or the caregiver's medical records while others are not. In cases under review, Case Managers often did not inquire of all household members about substance use practices in the home, and if services were recommended, cases sometimes closed without any knowledge the service had begun and was effective at meeting the family's needs. In several cases, Case Managers did not assess for collateral risk factors associated with substance abuse, like domestic violence, and this could become life-threatening as family violence went untreated and increased.

   While Case Managers appeared to have an increased knowledge of medication-assisted treatment (i.e., Subutex, Suboxone, Methadone), they sometimes reported frustration clinics prescribing such treatments were not offering more comprehensive services (e.g., individual/family counseling, parenting classes, group counseling). Current DCS policy does not expressly identify the boundaries and logistics of drug testing or pill counting, and different drug testing supplies are in use throughout the regional offices. Without a consistent drug test in use, no training is mandated, and regions are inconsistent in when and what training resources are offered to frontline staff on these topics. While the FAST is an intervention to guide family assessment, it does not expressly guide a case manager on how to ask about substance abuse.

Finding 2 Supports: Cognitive Fixation, Knowledge Deficit, Evidence

2) **The absence of privately interviewing and comprehensively assessing all household members was a common theme in reviewed cases**. Case Managers are diligent to interview and assess alleged perpetrators, but other household members

(especially adults) receive less attention. Child Protective Services is sometimes described as having an incident-driven culture, in spite of leadership's efforts, and this appeared an influencing factor. Case Managers describe leadership as wanting more comprehensive assessment strategies, but Case Managers report being uncertain of their legal parameters. They are uncertain what they can ask, and what they can share about the case with non-alleged perpetrators. Additionally, case managers often describe working closely with mothers in their cases, and—without a compelling reason—case managers worry about breaking positive rapport with the mother by engaging other potential caregivers (e.g., family friend, boyfriend) against the mother's request. Case Managers do contact collaterals in their casework, but sometimes these collaterals are simply those the alleged perpetrator requests and are not necessarily the best collaterals for quality assessment.

Finding 3 Supports: Cognitive Fixation, Teamwork/Coordination, Policies, Supervisory Support, Production Pressures

3) **Six teenage males died while absconding from DCS custody**. Their time on runaway status just before their deaths ranged from 2 weeks to 4 ½ months, and 3 of the youths had multiple episodes of absconding. Five of the 6 were either known to be involved or had some behaviors suspicious of gang affiliation. More youths absconded from facilities than other placements, but runaways during transport or from foster homes occurred too. Two youths absconded from foster homes, and one youth absconded while being transported. The remaining three youths absconded from facilities. In comparison to other annual child death review trends, this was an increase from historical yearlong child death review trends where only one youth died while on runaway status (2015 and 2016).

   Case Managers were generally inconsistent in their efforts to prevent runaway and to take quick, strategic efforts to recover runaway youth. Some of the time, policy and protocol were not followed in the aftermath of the youth's runaway, but even if it was—the most likely helpful actions (e.g., interviewing other peers in the facility, unannounced check-ins at relatives' homes) did not occur. Outside of calling Law Enforcement and DCS, there was little evidence provider agencies were diligently searching (e.g., searching the area, contacting nearby gas stations, interviewing peers) in the hours after a youth absconded from their facility.

Finding 4 Supports: Cognitive Fixation, Supervisory Support, Documentation, Policy

4) **Screened out referrals being timely addressed during open CPS casework was a concern in some cases**. Though not factors in investigating the death, historical cases with the family sometimes involved additional referrals made during the timeframes of the case. Unless a new investigation is opened, these referrals are generally screened-out and emailed to the assigned Case Manager and supervisor. The Child Abuse Hotline agent does not add any new allegations to the current CPS case and also does not link the intake to the case. This is done, at least in part, to avoid re-assigning a new priority response to the case, since CPS is already engaged with the family and can use their own judgement about when and how to address the concerns.

   In the midst of production pressures, Case Managers were inconsistent in how they assessed the merits of these referrals and did not formally address the allegations or comprehensively assess the household about the allegations and potential service needs. Sometimes the screened out referral was documented in a case recording (but not clearly labeled as such, so documentation was not obvious), and sometimes it was not documented at all—leaving future Case Managers to do extra work to recover the information. During debriefings, Case Managers sometimes felt they already knew what was going on with the family by the time of the screened-out referral, and they had decided the allegation was without evidence or merit. Supervisors, having only received the email, would not recall these emails during administrative reviews and did not double-check to ensure the allegation had been assessed.

Finding 5 Supports: Cognitive Fixation, Knowledge Deficit, Teamwork/Coordination, Supervisory Support, Policy

5) **In similarity to the deaths of children in custody reviewed from previous years, Family Service Workers (FSWs) are tasked with a majority of the notifications and service arrangements in the aftermath of a child's death while in the Department's custody.** Grieved and distressed, these professionals struggle to collect funeral home bids, collaborate with families and external partners (i.e., provider agencies, foster parents), and to determine what the Department can and cannot do and to understand what justifications are needed for payment or reimbursement to occur. During these cases, FSWs sometimes did not offer for the Department to pay for arrangements at all, and other times FSWs provided incorrect information about the

Department's processes or capabilities. In other times, FSWs paid for items out-of-pocket, never seeking reimbursement, because they were emotional, stressed, needed to make decisions quickly, and could not readily discern how the fiscal process worked. Regional leadership disclosed some confusion of the process also. For example, regions had questions about how and why certain people must authorize the release of the body, under what circumstances autopsies occur, what services/supports can be offered to provider agencies and/or foster parents after a child death, etc.

Recommendations and Actions

Recommendations are informed by what is learned from the Child Death Review process; they are developed and tracked with the support of the Safety Action Group. The development of actions stemming from recommendations is completed outside of the Safety Action Group. Recommendations are presented to CQI teams comprised of content experts specific to the recommendation. These specific teams identify actions to be implemented and tracked. Based on the findings, recommendations and subsequent actions to improve practice are as follows:

1) **Increase the availability, consistency, and use of strategic tools in substance abuse assessment through policy development, supplemental educational materials, standard drug testing supplies, and improved training.**
    - Ongoing Actions: An ongoing workgroup from the past year is now finalizing a drug testing policy, work aid, and supplemental materials. The workgroup diligently researched best practices and contains membership from frontline professionals, legal, fiscal, training, quality improvement, and others. Other states' policies were sought and reviewed as well as other internal state practices. The new policy will layout a process for confirmatory lab analysis of drug specimens likely to result in court action. DCS Fiscal and the workgroup have identified and approved the use of a single urine drug test to be used statewide. Such standardization will allow for improved access to training resources, and the vendor has also offered to provide training and prompt technical assistance to those administering the tests. The workgroup is also considering use of instant-result saliva drug testing, which could be contracted through the same vendor, with a similar process for confirmatory lab analysis when needed. Through Child Death Review, several one-page Safety Notices about substance abuse assessment have been created and address issues about interpreting pharmacy records, the differences between Subutex and Suboxone, and other substance abuse assessment strategies. Safety Notices are attached to applicable policies, distributed to regional leaders, and incorporated into existing trainings.

2) **Collaborate with DCS Legal to document and train on the legal parameters of engaging all household members. Find ways to empower Case Managers to collaborate with supervisors to better understand and feel comfortable navigating the assessment of these individuals.**

- Ongoing Actions: Leaders from Child Programs, Child Safety, Quality Improvement, and Legal have formed a workgroup to identify legal parameters and best practices for engaging and assessing all household members during non-custodial cases. While the workgroup will address other concerns as well (i.e., diligent search efforts, communications with birth fathers who live away from the child's primary residence), the team intends to create a document outlining best practices for the engagement and assessment of all household members. The Office of Child Welfare Reform, in conjunction with Vanderbilt Center of Excellence, is also conducting a project called Assessment Integration. Through face-to-face convenings and coaching sessions, Assessment Integration aims to empower frontline supervisors to coach Case Managers on the use of the FAST and CANS as part of a comprehensive family-based assessment and tool for communication with all case members in home visits, Child and Family Team Meetings (CFTMs), and other venues.

3) **Increase supports and resources to prevent custodial youth from absconding and especially to recover them quickly when they do abscond (i.e. runaway).**
    - Ongoing Actions: Executive leaders are consistently reviewing the count and circumstances of youth on runaway and are considering executing a pilot Absconder Recovery program. Similar to a team led under a previous DCS administration, small regional teams would be responsible for collaborating with provider agencies, Law Enforcement, and other internal and external partners to diligently search for and recover runaway youth. Also, an upcoming TFACTS build will place a "RUN" indicator beside the name of any custodial youth identified as a runaway in TFACTS, allowing all DCS employees to immediately know of the youth's status regardless of region or program area. Lastly, a workgroup is also considering ways to reach out to provider agencies about preventing and recovering runaways.

4) **Revise CPS process to create better documentation and accountability of screened-out referrals occurring during open CPS casework. Consider other resources (e.g., Child Abuse Hotline agents, regional personnel) that could assist with these accountability measures, rather than the assigned Case Manager.**
    - Ongoing Actions: Leadership has recently placed CPS "Readers" in every region. While these positions are still relatively new, the CPS Readers' primary responsibility is to review CPS referrals and make appropriate assignments. This alleviates substantial pressures from frontline supervisors, who used to be personally responsible for reviewing and assigning referrals. Under this new process, a CPS

workgroup is evaluating the possibility of CPS Readers receiving screened out referrals on open cases. Readers could contact the assigned Case Manager and supervisor, and can take extra steps (e.g., documenting the referral in TFACTS, adding any new allegations formally to the case) to better ensure objective assessment occurs. Cognitive bias seemed to be a strong influence to this finding; an in-depth, interactive training on bias is now being held at the CPS Academy and is intended to help professionals self-assess and evaluate how bias affects their work.

5) **Develop a more trauma-informed protocol to better support Family Service Workers (FSWs) in the aftermath of a custodial child's death.**
    a. Ongoing Actions: A workgroup is finalizing a revision to the custodial child death protocol. The new protocol is better organized, eliminates redundancies, adds improved clarity on important topics, and gives some responsibilities to the Fiscal Department regarding family engagement, collection of funeral bids, and coordination of burial arrangements. The new protocol is intended to take substantial pressure off FSWs, who will now be able to serve in a more supportive role, rather than trying to lead all the planning and death arrangements. Critical incident debriefing will systematically be offered on-site in the light of such tragedies, and a volunteer group of internal professionals are planning to make themselves available to provide technical assistance and compassionate care (i.e., care packages, handwritten notes, on-site office visits) during these sad and fortunately rare occurrences.

Appendix A: Commission to Eliminate Child Abuse and Neglect Fatalities

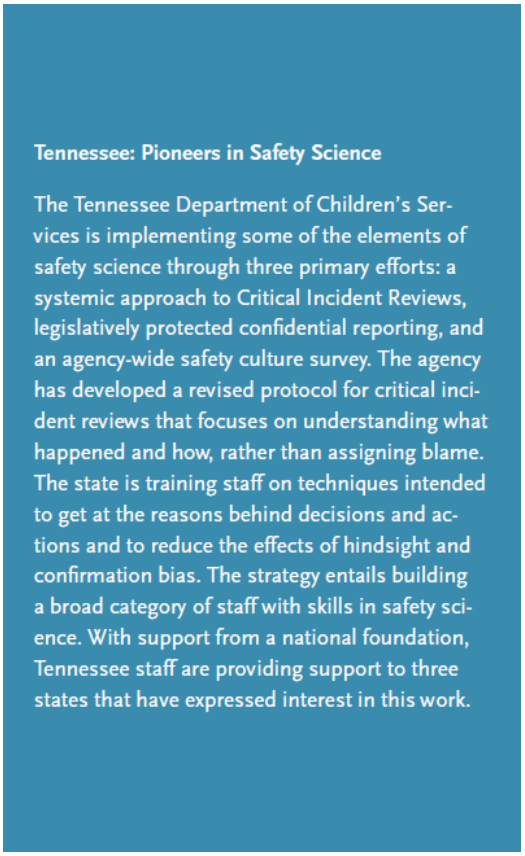
The federal Commission to Eliminate Child Abuse and Neglect Fatalities was established by Public Law 112-275, the Protect Our Kids Act of 2012, to develop a national strategy and recommendations for reducing fatalities across the country resulting from child abuse and neglect.[3] The Tennessee Department 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).

[3] 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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