Child Death Review

2018 Annual Report

Contents

Acknowledgement

The Tennessee Department of Children's Services Office of Continuous Quality Improvement 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

The Department of Children's Services (DCS or the Department) is charged with providing supports to vulnerable children and families in a complex social system affected by significantly challenging issues such as poverty and substance use. Using a Safety Science approach, the Department's Child Death Response and Review process (CDR process or Child Death Review process) thoroughly investigates interventions with children and families prior to and following deaths and near deaths in order to learn and ultimately improve the ability to support safe outcomes. In this report, the current process will be explained. And the report provides information about the findings, recommendations and actions taken as a result of the 2018 CDR process.

This report covers deaths and near deaths reviewed in Calendar Year 2018. A total of 135 deaths were reviewed. This includes: 127 non-custody deaths and 8 custody deaths. During this review period, 18 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 total 153 cases reviewed, **four key areas of improvement were identified and are being acted on.**

Key Areas of Improvement Identified

- Heighten workforce supports to safely and effectively assess domestic violence and help families experiencing such violence through a newly created Domestic Violence Partnership collaborative and accompanying position, and new training opportunities for staff
- Create reliable, expedient recovery efforts to locate runaway custodial youth, including a new unit focused on absconders
- Improve the assessment and support provided to children with complex healthcare needs, including developing and implementing new policies and oversight mechanisms
- Collaborate with multiple state agencies to improve families use of infant safe sleep practices

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 1,720 children died as a result of abuse or neglect in 2017 (U.S. Department of Health and Human Services, 2019). An important DCS responsibility is to review and learn from the tragedy of child deaths and near deaths in Tennessee focusing on children in state custody, children whose family had DCS history within 3 years, and children whose death or near death was the result of maltreatment.[1] 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.

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

See Appendix B for a table showing the number of cases by county.

[1] 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. [TCA §37-5-107© (4)].

[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.

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, detailed below.

The child death review process contains both a Central Office review and a Safety Systems Analysis. 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 purpose of the Central Office review is to identify any immediate concerns and to determine which cases would benefit from Safety Systems Analysis.

If recommended for Safety Systems Analysis, the case receives a systems-level review via voluntary interviews (i.e., debriefings) with internal and external professionals assigned to work with the family, a hard copy case file review (when applicable), and a review of system-level policies and procedures. The process is completed within 90 days and provided to senior leadership. On a quarterly basis, local multi-disciplinary review teams convene and discuss themes, "lessons learned," and brainstorm solutions to local and statewide issues highlighted during the Child Death Reviews.

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 his/her 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.

Local multidisciplinary review 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). In 2017, these review teams began meeting quarterly, so they could better ascertain regional trends and local, as well as statewide, systemic vulnerabilities affecting casework. Quarterly meetings have improved the review teams' functionality and efficiency.

Gathered information and recommendations from reviews are provided monthly to the Safety Action Group. This group is comprised of all existing senior leadership. The Safety Action Group meets quarterly 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, implement, and sustain system improvements.

Cases Reviewed

Child Death Review Criteria

The Child Death Review Team (CDRT) reviews deaths when:[3]

a. A child was in DCS custody at the time of death;
b. DCS had contact with the child or family within three 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 which are certified by the process below.[4]

- 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.

[3] See Appendix C for more information about terminology/definitions.

[4] See Appendix D for more information about the process for confirming near deaths.

Cases Reviewed

In this review period (calendar year 2018), a total of 153 deaths and near deaths were reviewed. This includes: 127 non-custody deaths, 18 non-custody near deaths, and 8 custody deaths. There were no custody near deaths. Cases are reviewed contingent upon meeting criteria for review.

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

Table 1: Custody Status

Custody Status (n=153)	n	%
Deaths		
Custody	8	6
Non-Custody	127	94
Near Deaths		
Custody	0	0
Non-Custody	18	100

The eight custody deaths have not resulted in any substantiated acts of abuse or neglect. One case is still pending classification at the time of this report.

There were six completed autopsy reports; one autopsy was still pending at the time of this report. One child did not receive an autopsy. Conducting an autopsy was declined by medical staff in that case, due to the child's medical condition at birth; the child had never left the hospital. The death with pending autopsy results appears to have resulted from a self-inflicted gunshot wound; the youth reportedly thought the weapon was not loaded. There was another youth death by firearm, and this death was a homicide. Both firearm deaths occurred while youths were on runaway. The remaining five deaths resulted from medical conditions children had prior to entering DCS custody; these children were designated as children with special healthcare needs.

Table 2: History Status of Non-Custody Cases

History Status of Non-Custody Cases (n=145)	n	%
Deaths		
History	105	83
No History	22	17
Near Deaths		
History	8	44
No History	10	56

Most reviewed deaths (105 children) involved children not in DCS custody and met criteria because of recent Departmental history. Of the 127 non-custodial child deaths reviewed, 83% (105 children) had either personal or family history within the 3 years preceding their death. The remaining 17% (22 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 18 non-custodial child near deaths reviewed, 44% (8 children) had either personal or family history with DCS within the 3 years preceding their near death. The remaining 56% (10 children) had no personal or family DCS history within the 3 years preceding their near death.

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 2018.

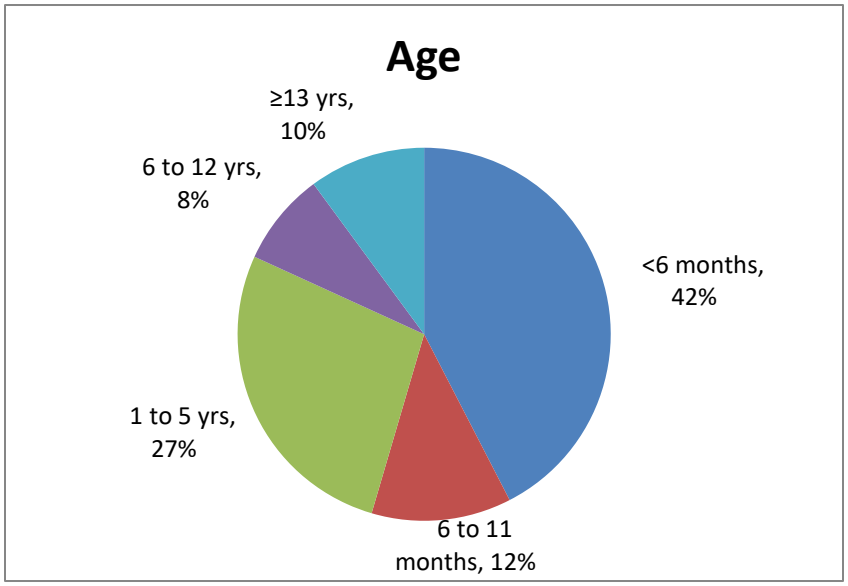
Table 3: Demographics

Demographics (n=153)	n	%
Race		
White-Non Hispanic	80	52
White-Hispanic	5	3
Black	58	38
Unknown/Missing	0	0
Multiracial	10	7
Asian	0	0
Native American	0	0
Pacific Islander	0	0
Gender		
Male	89	58
Female	64	42
Age		
<6 months	65	42
6 to 11 months	19	12
1 to 5 yrs	41	27
6 to 12 yrs	13	8
≥13 yrs	15	10

Of the 153 child deaths and near deaths, the primary identified race was White-Non Hispanic (80 children; 52% of total). Black was the next most prevalent race, with 58 children (38%). Ten children (7%) were identified as multiracial.

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 153 reviewed child deaths and near deaths, 65 children (42%) were less than 6 months old. Another 19 children (12%) were between 6-11 months of age. Forty-one children (27%) were between the ages of 1-5 years old. Thirteen children (8%) were between the ages of 6 and 12; 15 children (10%) were 13 and older.

Of the 153 reviewed child deaths and near deaths, 89 children (58%) were male; 64 children (42%) were female.

Table 4: Cause of Death

Cause of Death (n=135)	n	%
Medical	26	19
Non-accidental trauma	9	7
Motorized vehicle	4	3
Weapon	11	8
Drowning	8	6
Blunt Force trauma	11	8
Poisoning/Overdose	3	2
Fire/Burn	4	3
Inadequate care/Neglect	1	1
NAS	1	1
Acute Life Threatening Event	0	0
Suffocation/Strangulation/Asphyxiation infants	26	19
Suffocation/Strangulation/Asphyxiation age 1-18 years	4	3
Fall Injury	0	0
Other	1	1
Unable to determine	25	19
Pending	1	1

Of the 135 reviewed deaths, 26 infants (19% of cases) died from asphyxiation, often from unsafe sleep environments. Medical causes (e.g., prematurity, genetic disease, etc.) accounted for the deaths of 26 more children (19%). Eleven children (8%) died as a result of blunt force trauma, and another 11 children died from a weapon. Nine 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 often hamper CPS classification, this report captured “cause of death” in a manner consistent with the autopsy findings whenever possible.

Eight children died from drowning, and four children died from fire/burn. Four children died as a result of injuries sustained in motor vehicle accidents. Four children, ages 1-18 years died as a result of suffocation/strangulation/ asphyxiation, and 3 children suffered poisoning/overdose.

Twenty-five 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.

One child died as a result of "other" causes not well-captured in existing data selections. The child's cause of death was Sudden Unexplained Infant Death (SUID).

The cause(s) of one child's death is 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 5: Manner of Death

Manner of Death (n=135)		
	n	%
Natural	22	16
Accident	45	33
Homicide	28	21
Suicide	4	3
Unable to Determine	35	26
Pending	1	1

Of the 135 child deaths reviewed, the majority of the children died undeterminable (35 children; 26% of cases) or accidental (45 children; 33% of cases) manners of death. Twenty-eight children (28%) died as a result of homicide and 22 children (16%) died as a result of natural causes. Four children (3%) died as a result of suicide. In most cases, the manner of death is determined specifically from autopsy findings; in one case, 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 6: Cause of Near Death

Cause of Near Death (n=18)	n	%
Medical	2	9
Non-accidental trauma	7	30
Motorized vehicle	3	13
Weapon	1	4
Near drowning	1	4
Blunt Force trauma	0	0
Poisoning/Overdose	2	9
Fire/Burn	0	0
Inadequate care/Neglect	0	0
NAS	0	0
Acute Life Threatening Event	1	4
Near Suffocation/Strangulation/Asphyxiation infants	0	0
Near Suffocation/Strangulation/Asphyxiation age 1-18 years	0	0
Fall Injury	1	4
Other	0	0
Unable to determine	0	0

Of the 18 near deaths reviewed, seven children (30%) nearly died as a result of non-accidental trauma. The categories of medical near death and poisoning/overdose each contained 2 near deaths accounting for a total of 18% of the cases. Three children each experienced near death by motorized vehicle (17%). Registering one child each (totaling 16%) were near deaths by weapon, near drowning, acute life threatening event, and fall injury.

Table 7: Cause of Death by Custody Status

Cause of Death by Custody Status (n=135)

	Custody	Non-Custody	Total
Medical	6	20	25
Non-accidental trauma	0	9	9
Motorized vehicle	0	4	4
Weapon	0	11	11
Drowning	0	8	8
Blunt Force trauma	0	11	11
Poisoning/Overdose	0	3	3
Fire/Burn	0	4	4
Inadequate care/Neglect	0	1	1
NAS	0	1	1
Acute Life Threatening Event	0	0	0
Suffocation/Strangulation/Asphyxiation infants	0	26	26
Suffocation/Strangulation/Asphyxiation age 1-18 years	0	4	4
Fall Injury	0	0	0
Other	0	1	1
Unable to determine	1	24	25
Pending	1	0	2

Table 8: Manner of Death by Custody Status

Manner of Death by Custody Status (n=135)

Age	Custody	Non-Custody	Total
Natural	5	17	21
Accident	0	45	45
Homicide	0	28	28
Suicide	0	4	4
Unable to Determine	2	33	35
Pending	1	0	2

Table 9: Cause of Death by Age

Cause of Death by Age (n=135)

	<6 months	6 to 11 mos	1 to 5 yrs	6 to 12 yrs	≥13 yrs
Medical	12	3	4	4	3
Non-accidental trauma	3	4	2	0	0
Motorized vehicle	0	0	3	0	1
Weapon	0	1	2	4	4
Drowning	0	0	5	3	0
Blunt Force trauma	1	1	8	1	0
Poisoning/Overdose	0	0	1	0	2
Fire/Burn	0	1	2	1	0
Inadequate care/Neglect	0	0	1	0	0
NAS	1	0	0	0	0
Acute Life Threatening Event	0	0	0	0	0
Suffocation/Strangulation/Asphyxiation infants	21	5	0	0	0
Suffocation/Strangulation/Asphyxiation age 1-18 years	0	0	1	0	3
Fall Injury	0	0	0	0	0
Other	1	0	0	0	0
Unable to determine	19	3	3	0	0
Pending	0	0	0	0	1

Table 10: Manner of Death by Age

Manner of Death by Age (n=135)

Age	Natural	Accident	Homicide	Suicide	Unable to Determine	Pending	Total
<6 months	10	22	4	0	22	0	58
6 to 11 months	1	5	7	0	5	0	18
1 to 5 yrs	4	11	11	0	6	0	32
6 to 12 yrs	4	4	3	0	2	0	13
≥13 yrs	3	3	3	4	0	1	14
Total	22	45	28	4	35	1	135

Table 11: Cause of Death by Manner of Death

Cause of Death by Manner of Death (n=135)

	Natural	Homicide	Suicide	Accident	Unable to Determine	Pending
Medical	21	0	0	2	3	0
Non-accidental trauma	0	9	0	0	0	0
Motorized vehicle	0	0	0	4	0	0
Weapon	0	7	1	1	2	0
Drowning	0	0	0	7	1	0
Blunt Force trauma	0	6	0	3	2	0
Poisoning/Overdose	0	0	0	2	1	0
Fire/Burn	0	4	0	0	0	0
Inadequate care/Neglect	0	1	0	0	0	0
NAS	0	0	0	1	0	0
Acute Life Threatening Event	0	0	0	0	0	0
Suffocation/Strangulation/Asphyxiation infants	1	1	0	24	0	0
Suffocation/Strangulation/Asphyxiation age 1-18 years	0	0	3	1	0	0
Fall Injury	0	0	0	0	0	0
Other	0	0	0	0	1	0
Unable to determine	0	0	0	0	25	0
Pending	0	0	0	0	0	1
Total	22	28	4	45	35	1

Debriefings

Debriefings are conducted by Safety Analysts with frontline staff and supervisors involved with the subject case to explain actions, understand decisions, and provide a comprehensive assessment of case context. Additionally, debriefings promote a safe environment for staff to review their cases with Safety Analysts (i.e., facilitators of the CDR process) which provides critical learning opportunities.

Debriefings conducted as developed by Gary Klein (as cited in Dekker, 2006, pp. 94-95) are outlined below:

1. Participants tell the story from their point of view.
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 probes critical junctures to show how the situation was understood from the perspective of the participant;

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

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

Findings

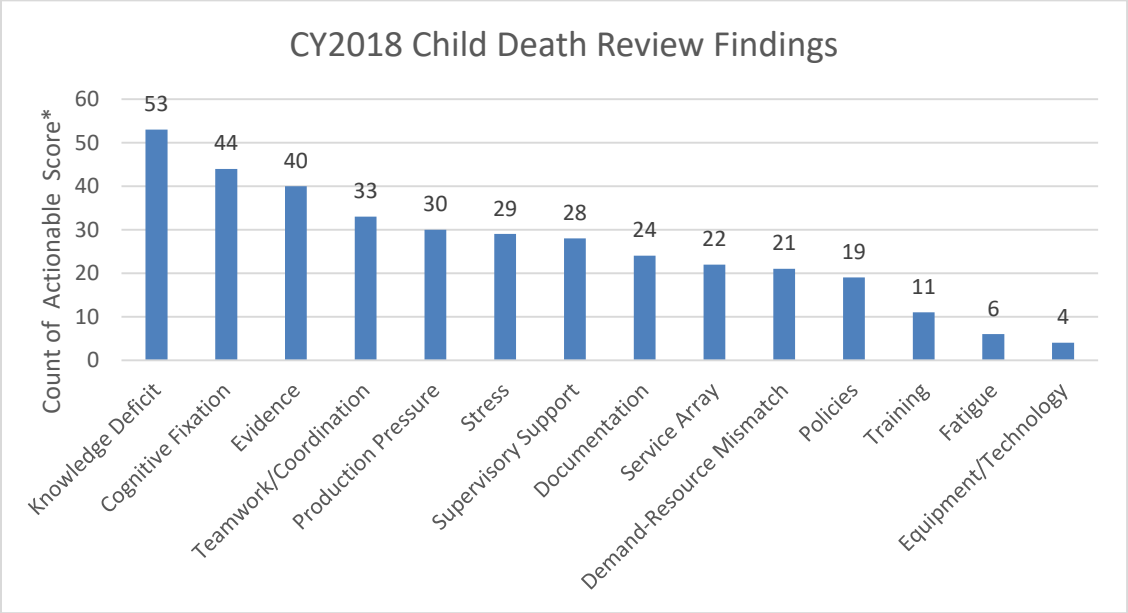
Represented below is this year's distribution of systemic findings. Systemic findings have specific definitions developed from relevant safety science literature. Using these definitions, systemic findings are identified within and across cases. The frequency of the systemic finding is determined by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

These systemic findings are identified within and across reviewed cases with the use of the Safe Systems Improvement Tool (SSIT).[5] 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."

[5] For a definition of each SSIT item, see Appendix E.

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 Bias, Knowledge Deficit, Teamwork/Coordination, Evidence, Policies, Service Array, Training

1) **Professionals struggle to assess domestic violence and to effectively help families experiencing this violence.** Even when professionals are aware of domestic violence, they have a hard time knowing how to safely and successfully intervene. As it relates to child deaths, the presence of domestic violence sometimes correlated to physical abuse and neglect later present at the time of a child's death or near death. In summary, domestic violence seemed an early indicator of maltreatment.

   During debriefings, staff sometimes shared their suspicions of domestic violence but were unaware of how to approach the issue, especially when there was no evidence of

child harm. For example, CPS may investigate a family due to concerns of substance abuse or environmental neglect but may also suspect domestic violence. Without evidence of child harm, professionals feel incapacitated to engage the couple in treatment; any treatment sought would likely be optional. Professionals thought families would generally refuse help and experienced grave concern that even bringing up the topic could initiate more violence and place lesser aggressive or non-aggressive family members at risk.

Professionals denied knowing much about domestic violence assessment. In some areas, service array was slim for victims who needed out of the home, especially those who wanted housing for children. Offender treatment programs were not present in many rural areas either.

Finding 2 Supports: Cognitive Fixation, Production Pressures, Teamwork/Coordination, Policies, Evidence, Supervisory Support

2) **When custodial youth abscond, efforts to locate them are inconsistent.** Reviews in 2017 and 2018 found an increased number of custodial youth who died while on runaway. Similar to 2017 findings, professionals were 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. Emergent needs on other cases often affected this as efforts to retrieve runaway youth was less prioritized. This prioritization, though not ideal, was rational—youth who runaway sometimes do so perpetually, in spite of diligent efforts and safety planning, and the Department takes every effort to prevent youth from being served outside their local area and/or being housed in more restrictive environments (e.g., congregate care, inpatient facilities). Preventing youth from running away can be exhausting and ineffective. Recovering youth on runaway can be even more tiring and unfulfilling; sometimes Law Enforcement and provider agencies seem slow or entirely absent in efforts to retrieve these youth.

Finding 3 Supports: Knowledge Deficit, Teamwork/Coordination, Policies, Production Pressures, Stress

3) **Custodial children with complex healthcare diagnoses need more specialized attention and increased support to help them achieve optimal well-being.** Children

with extremely poor, terminal prognoses sometimes died in foster care. While reviews did not indicate the Department's involvement was causal to the deaths of children, reviews did reveal opportunities to better support optimal well-being.

Reviews uncovered the Department does not have a reliable way of tracking this population (i.e., children with complex healthcare needs), and internal medical professionals do not always systematically review medical records and/or visit these children. Mostly only informal procedure dictated the role of internal medical professionals in assessing and coordinating care for these children, and these professionals have a barrage of workload pressures. They also serve in primarily consultative roles and often only heavily engage in specific cases upon request of the Child and Family Team (CFT). However, the CFT may not be educated enough on the child's condition to believe consultation with an internal medical professional is helpful to achieving optimal well-being. Furthermore, when internal medical professionals would review records, the recommendations were not always considered in the child's placement.

This population is nearly always served through contracts with provider agencies, so the foster family and foster child can receive increased monitoring and support. In many cases, these contracts did not uniquely identify the needs of the child though, so neither the agency nor the Department had a clear plan of who was responsible for what elements of the child's care.

Finding 4 Supports: Knowledge Deficit, Teamwork/Coordination

4) **Infants continue to die in unsafe sleeping environments, often as a result of co-bedding or improper items (e.g., fluffy bedding) being stored in a crib.** Nearly a fifth of all reviewed deaths were infants who died of asphyxiation—mostly as a result of unsafe sleeping. The Department routinely deploys immediate and free pack-n-plays to families in need of safe sleep furniture, and case managers are increasingly vigilant to educate caregivers on safe sleep practices. Last year, a Safe Sleep Educational Protocol was created, and new training curriculums were administered to case managers and foster parents alike. Nonetheless, this cause of death persists in child welfare work, and further action is needed to prevent these infant deaths.

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) **Heighten workforce supports to safely and effectively assess domestic violence and help families experiencing such violence.**
    - Ongoing Actions: The Office of Child Safety created a Domestic Violence Partnership with the help of the Office of Criminal Justice, Prevent Child Abuse Tennessee, and local domestic violence shelters. The Partnership is a multidisciplinary model for the prevention and safe intervention of families affected by intimate partner violence. The program houses a new position, a Domestic Violence Liaison, who co-locates among the Partnership offices and helps facilitate safe, coordinated, and supportive family intervention. The Partnership is not yet a statewide initiative but has successfully launched in Madison County.

      The Office of Training and Professional Development has partnered with the Safe and Together Institute to provide e-courses in domestic violence assessment and intervention strategies. These e-courses contain reality-based scenarios and interactive practice activities and will be available to all DCS staff as well as community partners. The first e-course is scheduled for availability in March 2019.

2) **Create reliable, expedient recovery efforts to locate runaway custodial youth.**
    - Ongoing Actions: An Absconder Recovery Unit has been created and has three employees strategically located across the state. The primary focus on this team is to locate runaway youth. This small unit mirrors a highly successful unit established in a prior DCS administration and should help provide the extra support, coordination, and accountability needed to find missing youth. In addition to the priority time investments these employees will be able to make to locate youth, this team will also have the added benefit of a more coordinated relationship with Law Enforcement and provider agencies—who also need to be taking effort to retrieve these youth.

3) **Improve the assessment and support provided to children with complex healthcare needs.**
    - Ongoing Actions: The Office of Child Health currently maintains a list of these children and conducts audits to ensure every child receives both quarterly medical record reviews and biannual face-to-face visits with the DCS Nursing Team. In addition, a policy has been created, and a new process better ensures the Nursing Team's recommendations are fulfilled in both the selection and monitoring of the child's placement. Though still in creation, a new section of the Contract Provider Manual will address this population, and contracts improvements are being drafted also.

4) **Collaborate with multiple state agencies to improve families' use of infant safe sleep practices.**
    - Ongoing Actions: The Department has partnered with its sister agencies, the Bureau of TennCare and the Department of Health, to start a new media campaign on safe sleep. While initial meetings are still ongoing, this multiagency collaborative intends to target a broader audience of caregivers, including fathers and grandparents of infants with a variety of media resources (e.g., commercials, infographics, billboards, press releases) and hopes to partner with local medical providers like obstetricians.

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Appendix A: Casey Family Programs 2018 Signature Report

Casey Family Programs recognized Tennessee's work in the *2018 signature report: Moving hope forward*.[6]

"So often in child welfare, we ask critical questions, especially when a tragedy occurs… In each of these cases, questions arise: How did that child die? Who is responsible? Who must be held accountable?

> Beyond fatalities, many more children experience maltreatment mostly as a result of neglect, often coming to the attention of child protection agencies, educators, physicians and other adults who play a role in a child's development. We know that these children will be at a much higher risk of poor health and well-being outcomes later in life. These facts lead us all to ask some fundamental questions: How can we keep more children safe from harm? And in particular, how can we keep more children safe with their own families? And finally, how can we help communities take the steps necessary to address the conditions that negatively affect children and families?

[6] This report can be found at the following address: https://www.casey.org/hope2018/

There are no simple answers to any of these questions. But there is tremendous progress taking place across America that is helping to point the way forward…

In Tennessee and Arizona, child welfare leaders are building a safety culture aimed at improving systems and, ultimately, outcomes for children and families.

Appendix B: National Center for Fatality Review and Prevention Report

National Center for Fatality Review and Prevention (CFRP) recognized Tennessee's work in the 2018 Report: *Child Maltreatment Fatality Reviews: Learning Together to Improve Systems That Protect Children and Prevent Maltreatment:*

"There are excellent examples of review systems that have developed hybrids of review models, focusing on both systems issues and individual behaviors, and incorporating safety science. For more detail on safety science, see page 15. Tennessee has a comprehensive CDR program based in their state health department, with multidisciplinary county teams reviewing all preventable deaths. They also have a review system called Children's Services Systems Analysis, administered by the Department of Children's Services (DCS). This model has four regional teams conducting analyses of deaths of children in state custody or with a DCS case within 3 years from the death, or whose death is substantiated for abuse or neglect. They also review some serious injuries from abuse or neglect. The process uses systems analysts to construct a case file and conduct the reviews. They are assisted when necessary by a team of nurse consultants. Following the systems analysis, a state Safety Action group discusses findings with leadership and does a formal hand-over to the state quality improvement office. Tennessee uses a *Safe Systems Improvement Tool* to summarize findings. This SSIT is now in use in other states as well. While this safety science system looks at individual performance, the objectives are to provide a safe and supportive environment for staff to process, share, and learn from child deaths and near-deaths in an effort to better support quality case management practices and influence safe outcomes for children.

In addition to maltreatment review models, many states conduct reviews of other types of deaths. These include fetal and infant mortality reviews, maternal mortality reviews, overdose, suicide and domestic violence reviews, and reviews of deaths of vulnerable adults. It can be helpful to work to improve coordination and collaboration across these systems in your state or community. Figure 2 presents how CDR can logically link to other reviews."

"Applying a safety science framework to child fatalities is a new and promising area. Safety science is an interdisciplinary science that draws on psychology, engineering, architecture/design and many other related fields. It is an approach that concerns itself with understanding how humans interact with and within complex systems so those systems can be made more safe and reliable. Safety Science began as an approach to understand the complex set of systems involved in plane crashes: from engineering, weather, pilot behavior, traffic control, etc. The model has expanded to the health care industry and is routinely used to systematically examine medical errors with "the aim to make it harder for people to do something wrong and easier for them to do it right … More commonly, errors are caused by faulty systems, processes, and conditions that lead people to make mistakes or fail to prevent them."

The Commission to Eliminate Child Abuse and Neglect Fatalities recommended in their final report that safety science be explored as an approach to better understand and prevent fatalities: “Child protection is perhaps the only field where some child deaths are assumed to be inevitable no matter how hard we work to stop them. This is certainly not true in the airline industry, where safety is paramount and commercial airline crashes are never seen as inevitable.”2

The approach systems take to reviewing and learning from critical incident can have an outsized impact on improvement and reliability. For example, when a child welfare system’s response to a high-profile death results in blame, as is commonly seen, professionals in that system can become more risk averse and fearful. The numbers of children removed increases and reunifications decrease. This can result in overwhelming workloads and high staff turnover. In addition, as other safety critical industries have recognized, a culture of fear and blame does not promote learning from error and can result in decreased organizational effectiveness and compromised safety.

Safety science gives systems a framework for review processes that: 1) Understand the inherently complex nature of child welfare work and the factors that influence decision-making; 2) Acknowledge staff decisions alone are rarely direct causal factors in a child’s death, but these decisions may affect the overall trajectory of well-being for a child or family and be an influence, among many influences, of poor outcomes; and 3) Provide a safe and supportive environment for professionals to process, share, and learn from child deaths in an effort to best support quality case management practices and influence increasingly safe outcomes for children.

For the past several years, Casey Family Programs has supported efforts to implement safety science principles in Child Welfare in several jurisdictions through peer visits to the TN Department of Children’s Services as well as through technical assistance and expertise from consultants at Chapin Hall at the University of Chicago and Collaborative Safety, LLC.

The interest in this approach is growing and a number of jurisdictions have embraced strategies and tactics from safety science, as adapted from other safety critical industries, in an effort to improve their systems. Among these strategies is the Safe Systems Improvement Tool (SSIT). Arizona, Wisconsin, and Tennessee use SSIT and the systems-focused approach developed in Tennessee to learn from child deaths and inform prevention strategies.

Although still in its infancy as a tool for fatality reviews, there is promise that safety science can be adapted to help teams better identify systems issues and develop solutions to better protect children.”

[1] Institute of Medicine. (1999). To err is human: building a safer health system.

[2] Commission to Eliminate Child Abuse and Neglect. (2015). Within our reach: a national strategy to eliminate child abuse and neglect fatalities. Government Printing Office, Washington DC. Page 11.

Appendix C: CDR Cases Reviewed by County

County (n=153)

County			
Anderson	3		
Bedford	3	Macon	2
Benton	1	Madison	2
Blount	4	Marion	1
Bradley	1	Maury	1
Carroll	1	McMinn	2
Carter	1	Monroe	1
Claiborne	2	Montgomery	7
Clay	1	Morgan	2
Cocke	5	Obion	1
Coffee	2	Rhea	2
Cumberland	2	Robertson	2
Davidson	26	Rutherford	4
Dickson	2	Sevier	2
Dyer	3	Shelby	24
Greene	1	Sullivan	2
Hamblen	2	Sumner	5
Hamilton	4	Tipton	3
Hawkins	1	Union	1
Henderson	3	Warren	1
Humphreys	1	Washington	3
Jefferson	2	Weakley	1
Knox	8	White	1
Lauderdale	3	Wilson	1

Appendix D: Definitions

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

Custody/Non-Custody Near Death: any child in the state of Tennessee who is/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 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).

Substantiated: In child abuse investigations, this classification is applicable to allegations when there is a preponderance of evidence to validate an allegation occurred and applicable to perpetrators when there is a preponderance of evidence that the alleged perpetrator is found to be responsible for the alleged acts.

Appendix E: Near Death Confirmation Process

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:
  d. The case receives a Substantiated classification,
  e. The child did not pass away prior to case closure, AND
  f. 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.

Appendix F: SSIT Definitions

Below is the list of systemic findings with corresponding definitions.

PROFESSIONAL DOMAIN

Cognitive Fixation: A faulty understanding of a situation due to inherent biases (e.g., confirmation bias, focusing effect, transference).

Stress: Unsafe work practices influenced by a psychological strain or tension resulting from adverse or demanding circumstances.

Fatigue: Unsafe work practices influenced by extreme tiredness.

Knowledge Deficit: An absence of knowledge or difficulties activating knowledge (i.e., putting it into practice).

Documentation: Absent or ineffective official records.

Evidence: Difficulties in obtaining and synthesizing (i.e., summarizing; combining multiple pieces of information into a coherent holistic assessment) externally-sourced information (e.g., medical records, criminal records, statements from key members, formal assessments).

TEAM DOMAIN

Teamwork/Coordination: Ineffective collaboration between two or more internal and/or external entities (e.g., agencies, people, teams).

Supervisory Support: Ineffective support, teamwork, availability, or knowledge transfer from an internal supervisor to those internally supervised.

Production Pressure: Demands to increase efficiency.

ENVIRONMENT DOMAN

Demand-Resource Mismatch: A lack of internal resources (e.g., inadequate staffing, limited access to drug testing supplies, insufficient funding for services) to carry out safe work practices.

Equipment/Technology: An absence or deficiency in the equipment and technology (e.g., communication devices, electronics, protective safety materials like gloves, vehicles, operability and usability of electronic records management system) used to carry out work practices.

Policies: The absence, poor clarity, or ineffectiveness of a written practice or procedure.

Training: The absence, poor clarity, or ineffectiveness of formal instruction.

Service Array: The unavailability of a particular service to support safe, healthy outcomes for clients (e.g., children and families) or staff.