Child Death Review

2019 Annual Report

Tennessee Department of Children's Services| CDR Annual Report | 2019

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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 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. This report will explain the current process and information about the observations, recommendations, and actions taken as a result of the 2019 CDR process.

This report covers deaths and near deaths that were reported to DCS and reviewed in calendar year 2019. A total of 109 deaths were reviewed. This includes: 102 non-custody deaths and 7 custody deaths. During this review period, 40 near-death cases were also reviewed. This includes 2 custody near deaths and 38 non-custody. Based on themes and items of interest from the total 149 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 medical records and assist in understanding of complex medical conditions as they relate to investigations, as well as education and support to families.
- Improve the response to child abuse and neglect allegations through the Child Protective Services Re-design, targeting a specialized approach to case assignment and response to alleged victims and their families.
- Create a distinct curriculum of Tennessee Department of Children's Services Critical Incident Review processes to model for other child welfare jurisdictions across the country and our staff.
- Continue to 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 that 1,770 children died nationally as a result of abuse or neglect in Federal Fiscal Year 2018 (U.S. Department of Health and Human Services, 2020). 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

[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 (c) (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 more completely and quickly provides the public this information than it could do 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 Child Death/Near-Death Rapid Response process (Policy 20.27) 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 certified 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 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 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.

Local multidisciplinary review teams are comprised of representatives from different disciplines within DCS (e.g., frontline staff, frontline supervisors, health representatives and 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 quarterly to the Senior Leadership Continuous Quality Improvement team (SLCQI). This group is comprised of senior leadership for the Department, along with other internal representatives as needed. The SLCQI, co-facilitated by the Directors of Safety Systems Analysis and Program Quality team, meets quarterly and reviews information generated by the Child Death Review, Confidential Safety Reporting System and regional Continuous Quality Improvement (CQI) activities, in order to develop, implement, and sustain system improvements.

Cases Reviewed

Child Death Review Criteria

The Child Death Review Triage (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 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 2019), a total of 149 deaths and near deaths were reviewed. These include 102 non-custody deaths, 38 non-custody near deaths, 7 custody deaths and 2 custody near deaths. Cases are reviewed contingent upon meeting criteria for review.

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

Table 1: Custody Status

Custody Status (n=149)	n	%
Deaths (109)		
Custody	7	6
Non-Custody	102	94
Near Deaths (40)		
Custody	2	5
Non-Custody	38	95

Six of the seven custody deaths have not resulted in a substantiated act of abuse or neglect. One case is still pending classification at the time of this report.

Six of the seven custody deaths received autopsies; however, two reports were not completed at the time of this report. One child did not receive an autopsy because it was declined by medical staff, due to the child's complex medical condition; furthermore, the County Medical Examiner declined jurisdiction. Two child deaths were medically related; one due to a preexisting medical condition prior to custody that was unknown. The four remaining child deaths involved gunshot wounds; one being self-inflicted. Two of the children were on runaway status and two were on Trial Home Visits.

Table 2: History Status of Non-Custody Cases

History Status of Non-Custody Cases (n=140)	n	%
Deaths (102)		
History	82	80
No History	20	20
Near Deaths (38)		
History	13	34
No History	25	66

Tennessee is a mandatory reporting state (TCA 37-1-403) and as such, all child deaths that are suspected to be the result of abuse or neglect must be reported to DCS via the Child Abuse Hotline. This information comes from many sources including law enforcement and the medical examiner's office, or any other referent with knowledge or suspicion of a child abuse related death. Most of the 109 reviewed deaths involved children not in DCS custody and met criteria because of recent Departmental history. Of the 102 non-custodial child deaths reviewed, 80% (82 children) had either personal or family history within the 3 years preceding their death. The remaining 20% (20 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 38 non-custodial near deaths reviewed, 34% (13 children) had either personal or family history with DCS within the 3 years preceding their near death. The remaining 66% (25 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 2019.

Table 3: Demographics

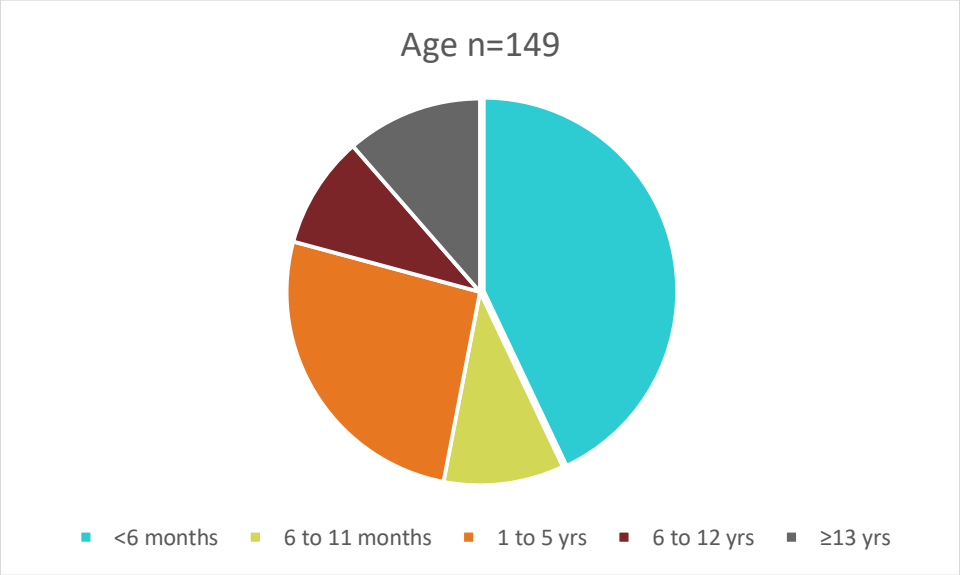
Demographics (n=149)		
	n	%
Race		
White-Non-Hispanic	90	61
White-Hispanic	3	2
Black	46	31
Unknown/Missing	2	1
Multiracial	8	5
Asian	0	0
Native American	0	0
Pacific Islander	0	0
Gender		
Male	87	58
Female	62	42

Age		
<6 months	64	43
6 to 11 months	15	10
1 to 5 yrs.	39	26
6 to 12 yrs.	14	9
≥13 yrs.	17	11

Of the 149 child deaths and near deaths, the primary identified race was White-Non-Hispanic (90 children; 61% of total). Black was the next most prevalent race, with 46 children (31%). Eight children (5%) were identified as multiracial. The remaining 3% were either unknown race or missing from documentation.

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. It can be found on the DCS website at the following link: https://www.tn.gov/dcs/program-areas/child-safety/cdnd-pn.html.

Figure 1: Age



Of the 149 reviewed child deaths and near deaths, 64 children (43%) were less than 6 months old. Another 15 children (10%) were between 6-11 months of age. Thirty-nine children (26%) were between the ages of 1-5 years old. Fourteen children (10%) were between the ages of 6 and 12; 17 children (11%) were 13 and older. Of the 149 reviewed child deaths and near deaths, 87 children (58%) were male; 62 children (42%) were female.

Table 4: Cause of Death

Cause of Death (n=109)	n	%
Medical	25	23
Non-accidental trauma	4	4
Motorized vehicle	0	0
Weapon	8	7
Drowning	7	6
Blunt force trauma	12	11
Poisoning/overdose	2	2
Fire/burn	1	1
Inadequate care/neglect	1	1
NAS	0	0
Acute life-threatening event	0	0
Suffocation/strangulation/asphyxiation infants	21	19
Suffocation/strangulation/asphyxiation age 1-18 years	4	4
Fall injury	0	0
Other	2	2
Unable to determine	20	18
Pending	2	2

Of the 109 reviewed deaths, 21 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 25 more children (23%). Though the presence of a medical condition is capture this does not rule out the presence of child abuse and neglect. Twelve children (11%) died as a result of blunt force trauma, and another 8 children died from a weapon. Four 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 listed on the autopsy report is captured as blunt force trauma, gunshot wound, 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.

Seven children died from drowning, and 1 child died from fire/burn. Four children, ages 1-18 years, died as a result of suffocation/strangulation/ asphyxiation, and 2 children suffered poisoning/overdose.

Twenty children (18%) died as a result of undeterminable cause. A child's cause of death may be undeterminable for several reasons, but often complex and/or multiple factors (e.g., drug-exposure, dehydration, prematurity, viral infections, unsafe sleep) prevent medical personnel from being able to identify a central cause of death.

Two children died as a result of "other" causes not well-captured in existing data selections. One child's cause of death was Sudden Unexplained Infant Death (SUID) and the other was an accidental onset of an acute medical condition due to an environmental cause.

The cause of two 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 Triage meeting once available. The circumstances of both deaths appeared to be gunshot wounds inflicted by others.

Table 5: Manner of Death

Manner of Death (n=109)		
	n	%
Natural	20	18
Accident	37	34
Homicide	15	19
Suicide	5	5
Unable to Determine	30	28
Pending	2	2

Of the 109 child deaths reviewed, the majority of the children died undeterminable (30 children; 28% of cases) or accidental (37 children; 34% of cases) manners of death. Fifteen children (19%) died as a result of homicide and 20 children (18%) died as a result of natural causes. Five children (5%) died as a result of suicide. In most cases, the manner of death is determined specifically from autopsy with investigative information; in two 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. The circumstances of both deaths appeared to be gunshot wounds inflicted by others.
The Alleged Preparators of the 15 homicide deaths were related to the children as parent, parent paramour, parent former paramour, extended relative, friend of parent, babysitter or unknown/undetermined.

Figure 2: Alleged Perpetrators of Homicide

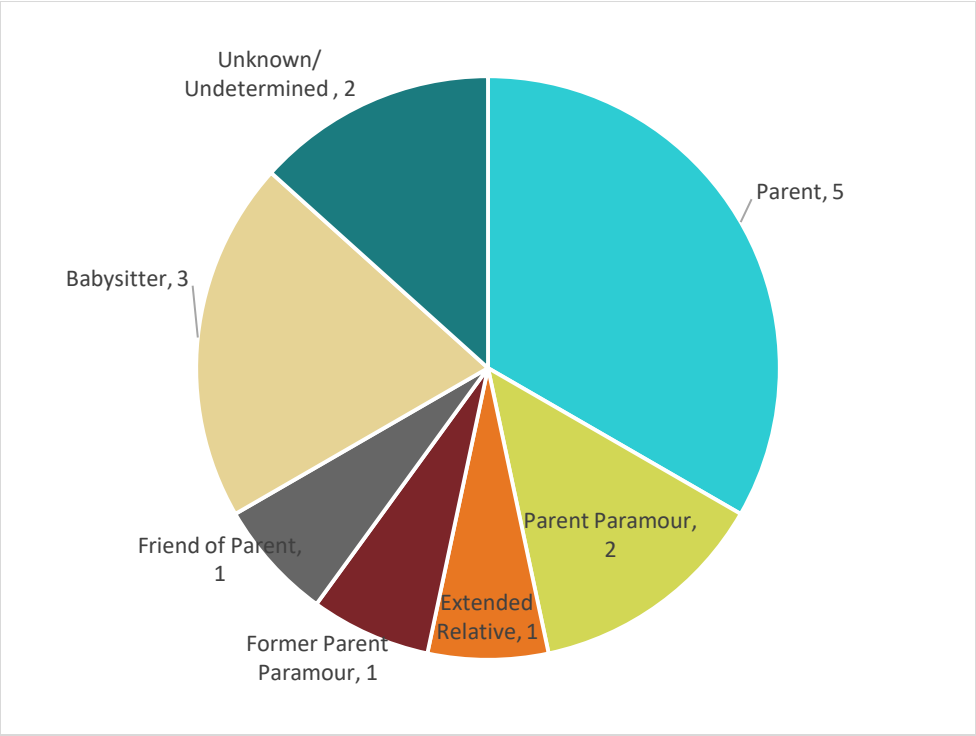


Table 6: Cause of Near Death

Cause of Near Death (n=40)	n	%
Medical	2	5
Non-accidental trauma	12	30
Motorized vehicle	5	13
Weapon	2	5
Near drowning	2	5
Blunt force trauma	4	10
Poisoning/overdose	5	13
Fire/burn	0	0
Inadequate care/neglect	6	15
NAS	0	0
Acute life-threatening event	1	3
Near suffocation/strangulation/asphyxiation infants	0	0
Near suffocation/strangulation/asphyxiation age 1-18 years	0	0
Fall injury	0	0
Other	0	0
Unable to determine	1	3

Of the 40 near deaths reviewed, 12 children (30%) nearly died as a result of non-accidental trauma. The categories of medical near death include 2 children and poisoning/overdose contain 5 near deaths, accounting for a total of 18% of the cases. Five children experienced near death by motorized vehicle (13%). Registering two children each (totaling 10%) were near deaths by weapon and near drowning. One child's near-death event was the result of an acute life-threatening event.

Table 7: Cause of Death by Custody Status

Cause of Death by Custody Status (n=109)

	Custody	Non-Custody	Total
Medical	3	22	25
Non-accidental trauma	0	4	4
Motorized vehicle	0	0	0
Weapon	2	6	9
Drowning	0	7	7
Blunt force trauma	0	12	12
Poisoning/overdose	0	2	2
Fire/burn	0	1	1
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	0	4	4
Fall injury	0	0	0
Other	0	2	2
Unable to determine	0	20	20
Pending	2	0	2

Table 8: Manner of Death by Custody Status

Manner of Death by Custody Status (n=109)

Age	Custody	Non-Custody	Total
Natural	2	18	20
Accident	1	36	37
Homicide	1	14	16
Suicide	1	4	5
Unable to determine	0	30	30
Pending	2	0	2

Table 9: Cause of Death by Age

Cause of Death by Age (n=109)

	<6 months	6 to 11 months	1 to 5 years	6 to 12 years	≥13 years
Medical	13	1	3	4	4
Non-accidental trauma	1	2	1	0	0
Motorized vehicle	0	0	0	0	0
Weapon	0	0	1	2	5
Drowning	1	1	4	1	0
Blunt force trauma	1	1	8	2	0
Poisoning/overdose	2	0	0	0	0
Fire/burn	0	0	1	0	0
Inadequate care/neglect	0	0	1	0	0
NAS	0	0	0	0	0
Acute life-threatening event	0	0	0	0	0
Suffocation/strangulation/asphyxiation infants	20	1	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	1	0	0
Unable to determine	15	3	2	0	0
Pending	0	0	0	0	2

Table 10: Manner of Death by Age

Manner of Death by Age (n=109)

Age	Natural	Accident	Homicide	Suicide	Unable to Determine	Pending	Total
<6 months	10	17	2	0	25	0	54
6 to 11 months	1	3	2	0	3	0	9
1 to 5 years	3	11	7	0	2	0	23
6 to 12 years	3	4	2	0	0	0	9
≥13 years	3	2	2	5	0	2	14
Total	20	37	15	5	30	2	109

Table 11: Cause of Death by Manner of Death

Cause of Death by Manner of Death (n=109)

	Natural	Homicide	Suicide	Accident	Unable to Determine	Pending
Medical	20	0	0	3	2	0
Non-accidental trauma	0	4	0	0	0	0
Motorized vehicle	0	0	0	0	0	0
Weapon	0	4	2	2	0	0
Drowning	0	0	0	6	1	0
Blunt force trauma	0	5	0	7	0	0
Poisoning/overdose	0	0	0	0	2	0
Fire/burn	0	0	0	1	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	16	5	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	1	1	0
Unable to determine	0	1	0	0	19	0
Pending	0	0	0	0	0	2
Total	20	15	5	37	30	2

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, 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:

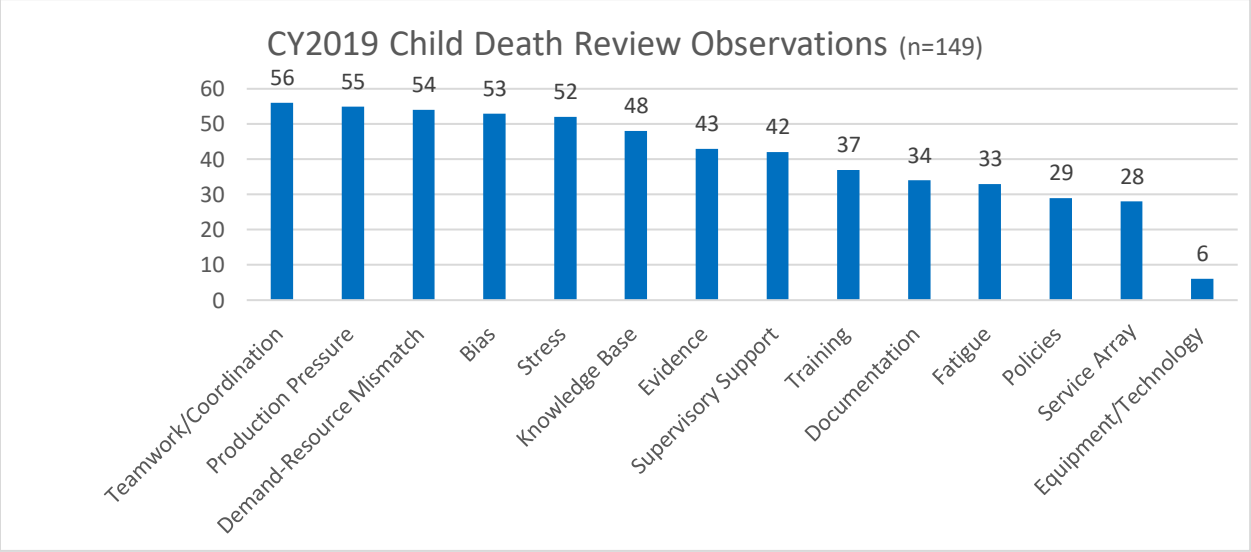
1) What cues may have prompted decisions from the participant's perspective.
2) What knowledge (e.g., training, experience) was utilized to inform these decisions.
3) What the expectations were about how a plan was going to develop.
4) What other issues (e.g., situational, operational, organizational)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

Observations

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

These systemic observations 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. The instrument is completed to allow for the effective quantifiable communication of influencing factors on a case at all levels of the system. Systemic observations found within cases are scored. These scores reflect whether an observation was present in a case and supported by evidence, which is captured by the label "actionable."
Below are observations from all cases:

Figure 1: Child Death Review Observations*



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

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

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 on track to permanency. The following are 4 significant observations from the review of deaths and near deaths in this review period:

Observation 1 Supports: Knowledge Deficit, Teamwork/Coordination, Evidence, Supervisory Support, Training, Production Pressure

1) **Obtaining medical records of children with health-related issues and consulting with Child Safety Nurses to ensure understanding of the records and the issues is inconsistent.** Although DCS Work Aids 2 and 3, supplemental to Policy 14.7, require obtaining medical records in severe abuse cases, it is sometimes difficult to acquire those records; harder to determine what is important in the voluminous information received; and almost impossible for non-medical staff to understand the significance of the information in relation to their casework. Consequently, medical records are not given priority, especially when caseloads are high, and pressure is exerted to close cases quickly. This results in a missed opportunity to provide effective supports to a child and their caregiver(s). Debriefings with staff confirm this narrative.

   Debriefings with staff, including casework professionals and supervisors, also revealed a lack of knowledge regarding resources to assist in changing the narrative: the DCS Regional or Child Safety Nurses. The nurses can help casework professionals not only request medical records, but also sift through the records, highlighting pertinent information, and explaining the significance.

Observation 2 Supports: Production Pressures, Teamwork/Coordination, Policies, Evidence, Supervisory Support, Demand-Resource Mismatch

2) **Since 2008, a multiple response system has guided the provision of Child Protective Services to families which creates the potential for lack of resources (staff), gaps in communication, casework redundancy, and varied approach to similar allegations.** Child Protective Services in Tennessee is split in two distinctive tracks: investigations and assessments. Since 2015, these tracks have been under separate management. Determining which cases are assigned to investigation and which are assigned to assessment is a source of contention and at times, subjective interpretation, even though policy attempts to delineate between the two. The two tracks approach have differing timeframes to complete their work. Staff debriefings

revealed many feel their education and expertise is not used to its greatest advantage in this 2-division system.

Shorter timeframes to complete casework in the investigation division leads to a sense of production pressure for staff who feel they are simply "checking the boxes" instead of effecting change. The assessment division has longer timeframes to complete casework, and while they see similar situations as investigations, their orientation is slightly different but feeling the same production pressure. Staff shortages contribute to the production pressure and demand-resource mismatch: not enough people to distribute the caseload leaves not enough time to adequately assess families.

Additionally, cases sometimes overlap, and multiple staff may be working with a family, whether it is assessment staff or investigative staff or both. Creating redundancy, this contributes to production pressure through limiting the time staff can devote to other cases, and it contributes to a lack of teamwork/coordination because multiple staff working with the same family may not communicate with each other.

Observation 3 Supports: Knowledge Deficit, Bias, Production Pressures, Policies, Supervisory Support

3) **With the evolution of the Child Death Review process, staff turnover, and inquiries from other jurisdictions, a gap in understanding the process was identified and needed to be addressed.** The Tennessee Child Death Review process was created in 2012. Since that time, the process evolved and adapted to better support leadership, staff, and the process of system-wide change. Through the reviews conducted in 2019, debriefings showed a trend in staff turnover and production pressure that ensued with experienced staff. Staff were forthcoming about their knowledge deficits regarding internal resources and processes influencing system change. The lack of program leadership's understanding of the relationship between Child Death Review and improved system outcomes affected their relationship with frontline staff, i.e., Safety Culture. The transparency the Department embraced was needed in the work conducted within our own internal reviews: staff needed to observe the process rather than simply be told about the process. In the same way, other jurisdictions seeking support from the Tennessee DCS to create their own influence of change and improvement were invited to observe our process and not simply hear about it.

Observation 4 Supports: Knowledge Deficit, Teamwork/Coordination

4) **Infants continue to die in unsafe sleeping environments, often as a result of cobedding 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 utilizing the Protocol for Safe Sleep Education and Delivery of Safe Sleep Furniture. 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 Senior Leadership Continuous Quality Improvement team. The development of actions stemming from recommendations is completed outside the Senior Leadership Continuous Quality Improvement team. Recommendations are presented to other CQI teams comprised of content experts specific to the recommendation. These content-specific teams identify actions to be implemented and tracked. Based on Observations, recommendations and subsequent actions to improve practice are as follows:

1) Heighten workforce supports to safely and effectively assess medical records and assist in understanding complex medical conditions as they relate to investigations and to education and support to families.

- Ongoing Actions: "Understanding Medical Records" training was developed to be available to all staff via webinar. It will assist staff in understanding the key components of a medical record and the type of information found in each of those components. The training provides information regarding the basic roles and responsibilities of the Safety Nurses and Regional Health Nurses. Finally, the training describes the process of requesting records and provides helpful forms needed to make those requests.

2) Improve the response to child abuse and neglect allegations through the Child Protective Services Redesign, targeting a specialized approach to case assignment and response to alleged victims and their families.

- Ongoing Actions: The CPS Redesign positions child welfare to more accurately respond to reports of abuse and neglect. This is achieved by creating a structure combining initial reports to the Child Abuse Hotline with information gathered directly from children and families coming to the Department's attention. Case decisions, including level of intervention and service planning, are then made with the family. The redesign replaces the two-track system with specialized teams to support the family through intentional transitions between case professionals. This allows staff to focus on specific sections of child protection: initial assessment and ongoing service planning. The CPS Redesign better serves children and families as key decision points are made with increased holistic information about the family's situation.

3) Create a distinct curriculum of Tennessee Department of Children's Services Critical Incident Review process to model for our staff and to other child welfare jurisdictions across the country.

- Ongoing Actions: The Tennessee Department of Children's Services is participating in the National Partnership for Child Safety (NPCS), a quality improvement collaborative. The NPCS collaborative was formed in partnership with Casey Family Programs and includes fifteen other states and jurisdictions in developing strategies in child welfare to improve safety and prevent child maltreatment fatalities. As a member of the collaborative, DCS will participate in safety science-derived quality improvement activities and data sharing. The participation in the data workgroup has focus on identifying which data points will be shared and the creation of the data dictionary. Beyond using the factors included in the dictionary, jurisdictions will be able to share other crafted resources, such as, educational resources and policy. The Executive Director for the OCQI serves on the Executive Committee for this Collaborative as well. The Executive Committee is tasked with monitoring the identified short- and long-term goals, obtain the assistance of technical advisors to advance the work and decide which recommendations are adopted to support the outcomes of the collaborative.

  In addition to the work with the Collaborative, the division of Organizational Culture and Workplace Safety focused on developing a concise presentation of the Tennessee Critical Incident Review process (Child Death Review). The curriculum consists of a half day presentation, followed by observation of the Child Death Review Triage and Grand Regional Systems Analysis. The curriculum has already been presented to leaders of the Missouri Department of Social Services and

guests. Opportunity for other jurisdictions, as well as DCS staff to participate and observe are being explored.

4) Collaborate with multiple state agencies to improve families' use of infant safe sleep practices.

- Ongoing Actions: The Department has continued partnering with its sister agencies, the Division of TennCare, all three of Tennessee's Managed Care Organizations, the Department of Health, and other private and state entities, to start a new media campaign on safe sleep, as well as, other avenues to educate a broader audience of caregivers, including fathers and grandparents, of infant safe sleep practices.

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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?
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.

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

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.

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."

[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: Definitions

Custody/Non-Custody Death: any child in the state of Tennessee whose 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 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 reported death or near death, as documented in the Department's Statewide Automated Child Welfare Information System (TFACTS).

Appendix D: Near Death Confirmation Process

The near-death confirmation process is outlined below[7]:

- 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.

[7] TN DCS Policies: https://files.dcs.tn.gov/policies/chap20/20.27.pdf and https://files.dcs.tn.gov/policies/chap20/20.28.pdf

Appendix E: SSIT Definitions

Below is the list of systemic findings with corresponding definitions.

PROFESSIONAL DOMAIN

Bias: A faulty understanding of a situation due to inherent bias(es) (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.