

Montana Department of Justice Office of the Child and Family Ombudsman Child Fatality Review Report 2017



Office of Child & Family Ombudsman

Traci L. Shinabarger, LCSW, MPA, BCBA, Chief Child and Family Ombudsman
Gala Goodwin, LCSW, ACSW, Deputy Child and Family Ombudsman
Dana Toole, LCSW, Children's Justice Bureau Chief
Matthew Dale, MA, Director, Office of Consumer Protection & Victim Services

Executive Summary

The Montana Department of Justice Office of the Child and Family Ombudsman (OCFO) responds to citizen requests to protect the rights of children and families by improving case outcomes and strengthening Montana's child welfare system. MCA 41-3-209 requires the Office of the Child and Family Ombudsman to investigate circumstances of child fatalities as specifically defined in the statute. This report marks the second review and covers December 16, 2016 through December 15, 2017.

In compliance with MCA 41-3-209, OCFO created the Children's Justice Bureau (CJB) Child Fatality Review Team. Team members included Dana Toole, Children's Justice Bureau Chief, Traci Shinabarger, Chief Child and Family Ombudsman, Gala Goodwin, Deputy Child and Family Ombudsman, and Matthew Dale, Executive Director of the Office of Consumer Protection & Victim Services. The team met October 31 & November 1, 2017. In total, fourteen child fatalities were reviewed.

The CJB team adopted the following philosophy from the Montana Domestic Violence Fatality Review Commission:

A no blame/no shame philosophy guides the work of the Commission. The purpose of the fatality review is not to identify an individual or agency as responsible for the deaths. These are complex cases, involving a number of individuals and variables.¹

The CJB team also considered the best practices recommendations for child fatality review teams issued by the Children's Bureau CANTASD and the National Center for Fatality Review and Prevention. Best practices include an objective, forward thinking, and nonpunitive approach to reviews. Best practices also include sharing data, addressing a broad array of systems, and focusing on action. Resources are found at <https://www.ncfrp.org/>.

Data collected from the reviews, findings based on the data, and recommendations are included in this report. The CJB team recognizes the Department of Justice for its support in conducting reviews and the Department of Public Health and Human Services for sharing information and considering recommendations for future system improvements.

¹ Dale, M. & Eliel, J. (2015, September). Report to the Legislature: Montana Domestic Violence Fatality Review Commissions. <http://leg.mt.gov/content/Committees/Interim/2015-2016/Law-and-Justice/Committee-Topics/Required-Reports/dvrc-2015-report-doj.pdf>

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Statutory Definitions and Requirements

Montana Code Annotated 41-3- 209 requires Child and Family Services Division (CFSD) to provide critical incident notifications to OCFO. Child fatalities are one type of critical incident reported to OCFO. Child fatality notifications must occur within one business day, on a death of a child who, within the last 12 months:

- a) had been the subject of a report of abuse or neglect;
- b) had been the subject of an investigation of alleged abuse or neglect;
- c) was in out-of-home care at the time of the child's death; or
- d) had received services from the department under a voluntary protective services agreement.

Montana Code Annotated 41-3-1211 requires OCFO to:

- a) “to investigate circumstances surrounding reports that are provided to the ombudsman pursuant to 41-3-209” and,
- b) “to periodically review department procedures and promote best practices and effective programs by working collaboratively with the department to improve procedures, practices, and programs”.

This review and report addresses the duties of the OCFO per statute. The goal of the report is to provide recommendations that include clear, measurable objectives to aid in the prevention of child fatalities due to neglect or abuse.

OCFO’s Review Process

Notification & Data Collection

DPHHS provides notification of a child fatality via email to the Chief Child and Family Ombudsman. An initial OCFO review of CFSD actions, policies, and procedures related to the child fatality case is conducted, including:

- Safety assessment of siblings
- Any reports to law enforcement
- Determination of an open law enforcement investigation

In every case, OCFO requests all documentation for each child and family member included in the report of the fatality. The primary responsibility of OCFO is to assess the process utilized by CFSD. All documentation available in the case management systems or provided by CFSD was reviewed.

OCFO reviews are initiated separate from a criminal investigation. No actions are taken to interfere with a criminal or judicial process. The OCFO review of child fatalities is limited to children reported to or in services with CFSD 12 months prior to their death.

Prior Review Recommendations

The 2016 OCFO Child Fatality Report recommended the creation of a Child Fatality Review Board. The 2017 Montana Legislature passed HB303 supporting this effort, creating the Child Abuse and Neglect Review Commission. The Commission is charged with educating the public, service providers, and policymakers about child abuse and fatalities, and strategies for intervention and prevention. The Commission will make recommendations that encourage collaboration to prevent fatalities and near fatalities.

The Commission is comprised of a cross-section of individuals, including representation from law enforcement, the judiciary, the Department of Public Health & Human Services, foster parents and former foster youth, providers, tribes, the legislature, and community organizations. The Chief Child and Family Ombudsman is a participant per statute. The Commission will hold its first meeting in February of this year.

In addition, DPHHS reports improving transparency of records to Legislators, participating in work groups such as the Department of Justice's Aid Montana Initiative, and implementing efforts to coordinate response to drug effected children through provider teams.

Review Findings

2017 Overview

The team reviewed eleven child fatalities. Three additional fatalities were reported after the team met and were reviewed by OCFO. A total of fourteen fatalities were reported as meeting OCFO criteria for review. These deaths occurred between December 16, 2016 and December 15, 2017.

Facts were identified and recorded in the review process. In addition to identifying and recording facts, the CJB Review Team assessed the facts for any information or trends that could inform recommendations for policy, procedure, and practice. The following sections summarize the CJB Review Team findings.

Fact Findings

1) Confirming cause of death remained difficult; however, the following depicts the information found:

- Four deaths were ruled accidental. Accidental incidents included three, which involved co-sleeping (infant sleeping with the mother) and drug use by the mother.
- Five deaths were deemed homicides.
- Two deaths were due to medical complications for the child. Both included drug use by the mother, which may have contributed to the child’s health.
- One death was confirmed as a suicide.
- Two deaths were unknown for cause or the investigation is ongoing.

2) The majority of the incidents involved children one year old or younger.

Total cases reviewed	Child fatalities aged one year or younger	Child fatalities aged one to three	Child fatalities aged four to seventeen
14	10	2	2

3) The majority of cases included siblings to the child under review.

Total cases reviewed	Cases with surviving siblings	Cases with removals of siblings following the fatality
14	10	4

4) Criminal history was present in many cases.

Total cases reviewed	Criminal history on alleged perpetrator	Criminal history unknown	Criminal charges resulted from child fatality	Alleged perpetrators were paramour to mother
14	6	6	6	1

5) Multiple indicators for risk were identified in the majority of the cases. Multiple indicators include, but are not limited to, combinations of the following:

- Prior CFSD history
- Prior criminal history
- Alcohol or drug abuse
- Methamphetamine use
- Domestic violence
- Housing instability or other financial insecurities

Total cases reviewed	Drug or alcohol use identified	Methamphetamine use identified	Domestic violence identified	Multiple indicators
14	9	3*	5	10

**Of the 9 cases where drug use was identified, three of those 9 cases included allegations of methamphetamine use.*

- 6) The majority of cases included CFSD history of reports on or involvement with the child under review.
- 7) Almost half of the cases included CFSD history of reports or involvement with the parents when they were children.

Total cases reviewed	Prior CFSD reports on child or children in the home	Open CFSD report at the time of the fatality	CFSD History on parent as a child
14	12	6	6

8) The timing of the child fatality in relation to any report or investigation was reviewed for areas of improvement in practice.

Total cases reviewed	Child fatality occurred within 60 days of the last report	Of reports less than 60 days old, number with active safety assessment at time of fatality	Cases past the 60-day due date for assessment closure	Assessments missing all or part of required supervisory reviews
14	6	4	3	3

9) When a call is taken by Centralized Intake, a report is generated and receives a category and priority. This directs the field office in what type of response is required. Primary categories and priorities are as follows:

- Child Protective Services (CPS)
 - Priority 1- Child Protection Specialist contacts child within 24 hours.
 - Priority 2- Child Protection Specialist contacts child within 72 hours
 - Priority 3- Child Protection Specialist contacts child within 10 days.
 - Priority 4- Investigation completed within 60 days from report.
- Child Protective Services-Request for Services (CFS)- Referrals for services made. No time requirement.
- Child Protective Information (CPI)-Information only. No response required.
- In four of the fatality reviews, the category and priority of the report from Centralized Intake changed. In three cases, the changes in category reduced the level of response to the report.
- Any report categorized as a CPS requires an investigation and completion of the Family Functioning Assessment (FFA). Eight reviews noted incomplete FFAs.

10) Demographic facts may present further areas for review and assessment.

- 8 children were female and 6 were male.
- 9 children were reported as Caucasian.
- 4 children were reported as American Indian.
- 1 child was reported as African American.
- There are six CFSD Regions. See Appendix B for Region information. Each Region reported at least one child fatality.
 - I- 1
 - II- 4
 - III-4
 - IV-1
 - V- 2
 - VI- 2

Practice Findings

- 1) Multiple and dated case management systems complicate child protection investigations.
 - CFSD records are in three different databases. Case records also include a paper file.
 - CFSD case investigation information is documented in one database system and information for open cases is documented in two additional database systems.

- 2) Family Functioning Assessment (FFA) practices varied. The Family Functioning Assessment is the tool used by CFSD to determine both immediate and future safety risk.
 - The FFA does not clearly include a section to describe the circumstances of a child fatality.
 - In cases involving siblings, the FFA information is focused on the living siblings and limits the information on the child fatality.
 - Individuals or professionals contacted as collateral sources in the investigation varied widely.
 - Cross reporting of the fatality was consistent; however, information sharing with law enforcement during an investigation or open case varied.
 - Medical records were often requested by CFSD but not received.
 - Follow up recommendations on drug effected infants varied.
 - FFAs were missing the required supervisory documentation of safety determinations, case closures, or both.
 - In many cases, missing information focused the FFAs on the incident and not the overall functioning of the family as the tool is designed.

- 3) Consistent checks of both child protection and criminal history on all adults in the home varied.

- 4) Of the four reports where the required response assigned by Centralized Intake was changed by the Regional Administrator or CFSD Administrator, two changes occurred prior to the child fatality. Procedures guiding changes and required documentation explaining changes is limited.

Recommendations

The CJB review team recommends:

- 1) The Child Abuse and Neglect Commission develop a process that requires review of all available resources and information related to child fatalities with suspected abuse and neglect factors.
- 2) DPHHS complete required internal reviews on critical incidents, reports on those reviews, and the annual report per CFSD policies and procedures. Provide OCFO with each report upon completion.
- 3) DPHHS review safety assessment protocols and improve fidelity to the safety model by ensuring Family Functioning Assessments are used to assess the whole family functioning instead of assessing specific incidents.
 - Consider the return to a Present Danger Assessment in addition to the Family Functioning Assessment.
 - Increase use of collateral contacts, including law enforcement, medical personnel, family, and friends of the family under investigation.
 - Enhance policies, procedures, and training on the use of safety plans and voluntary agreements.
 - Require drug testing information in every case where drug use is an allegation. Prioritize testing children under the age of five and when they are developmentally unable to be forensically interviewed.
- 4) DPHHS review policies and procedures for changing the Centralized Intake report category and required response time of the field.
 - Create policies that clarify the process and prevent the change in category without thorough and documented review of the history of the family.
 - Revise the category change form to include who reviewed, case specific information supporting the change, a place for a signatures and dates of reviewers.
- 5) DPHHS complete efforts to modernize the case management system. Complete revisions of the policy and procedure manuals for CFSD staff.
- 6) The State of Montana recognize the impact that lack of treatment and safety options have for pregnant and new mothers battling drug addiction through the following:
 - Legislative action to create and fund evidence based programs to treat and support mothers and their children.
 - Legislative or interdepartmental action to coordinate efforts to review, recommend, and act on recommendations of reviews.
 - DPHHS increase referrals and follow up with mothers reported to CFSD as needing or receiving treatment while pregnant or within one year of the birth of a child.

Appendix

A map and list are located on the DPHHS CFSD website:

<http://dphhs.mt.gov/CFSD/childfamilyservicescontacts>

Region I

Eric Barnosky, Regional Administrator

708 Palmer/ P.O. Box 880

Miles City, MT 59301

(406) 234-1385

Region II

Marti Vining, Regional Administrator

2300 12th Ave. S. #211

Great Falls, MT 59705

(406) 727-7746

Region III

Jason Larson, Regional Administrator

2525 Fourth Ave. N, #309

Billings, MT 59101

(406) 657-3120

Region IV

Jennifer Hoerauf, Regional Administrator

700 Casey St.

Butte, MT 59701

(406) 496-4950

Region V

Nikki Grossberg, Regional Administrator

2677 Palmer, Ste. 300

Missoula, MT 59802

(406) 523-4100

Region VI

Scott Warnell, Regional Administrator

121 Financial Dr. Ste. C

Kalispell, MT 59901

(406) 751-5950