

Montana Department of Justice Office of the Child and Family Ombudsman Child Fatality Review Report 2019



Dana Toole, LCSW – Special Services Bureau Chief

Gala Goodwin, LCSW, ACSW –Child and Family Ombudsman

Marci Buckles, BSW - Child and Family Ombudsman

OCFO Contact Information:

1-844-25CHILD

DOJOMBUDSMAN@mt.gov

Introduction

The Montana Department of Justice (DOJ) 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. [Montana Code Annotated \(MCA\) 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 fourth review and covers January 1, 2019 through December 31, 2019 and includes a total of seventeen child fatalities that meet the legal requirements for an OCFO review.

In compliance with MCA 41-3-209, OCFO created the Special Services Bureau (SSB) Child Fatality Review Team. The 2019 team members included Dana Toole, Special Services Bureau Chief; Traci Shinabarger, Child and Family Ombudsman; Gala Goodwin, Child and Family Ombudsman; and Eric Parsons, Program Specialist DOJ Office of Victim Services.

The SSB Review 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 SSB Review Team also considered the best practice recommendations for child fatality review teams. Best practice includes an objective, forward thinking, and nonpunitive approach to reviews.

The Montana Department of Justice commends the Department of Public Health and Human Services (DPHHS) for releasing the [2019 Child Fatality Prevention Report](#). The 2019 OCFO Child Fatality Report and the DPHHS report each review a total of seventeen child deaths that occurred in 2019. The data analysis in each report differs as OCFO reviewed one child not included in the DPHHS report, and DPHHS reviewed one child that did not meet the legal requirement for an OCFO review.

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 the Department of Public Health and Human Services (DPHHS) 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:

1. Had been the subject of a report of abuse or neglect;
2. Had been the subject of an investigation of alleged abuse or neglect;
3. Was in out-of-home care at the time of the child's death; or
4. Had received services from the department under a voluntary protective services agreement.

[Montana Code Annotated 41-3-1211](#) requires OCFO:

- 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.

[Montana Code Annotated 41-31-1212](#) further states:

- a) After an investigation is completed, the Ombudsman shall provide to the department any findings, conclusions, and recommendations.
- b) At the Ombudsman's request, the department shall inform the Ombudsman in a timely manner about any action taken to address or any reasons for not addressing the Ombudsman's findings, conclusions, and recommendations.

This review and report address the duties of the OCFO per statute. The information reviewed for each child fatality is that which exists in the CFSD case record. 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 Montana Department of Justice, Office of the Child and Family Ombudsman.

In every case, OCFO locates in the electronic case management systems or requests all CFSD 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 is reviewed. It is important to understand that OCFO's review authority is limited to review of CFSD records and does not include all medical, law enforcement, criminal history, educational, mental health, medical examiner or coroner findings or other sources of documentation about the deceased child or his/her family.

OCFO reviews are initiated separate from a criminal investigation. No actions are taken to interfere with a criminal or judicial process.

OCFO reviews are also separate from the [Child Abuse and Neglect Review Commission](#) enacted in 2017. The Ombudsman is a statutory member of the Commission; however, the Commission's governing statute defines which cases are reviewed differently than OCFO's governing statute and expands the review to include additional system stakeholders and information. Currently, statute requires both reviews.

Prior Recommendations Including Updates

2018 Review Recommendations and Updates

The [2018 OCFO Child Fatality Review Report](#) recommended the following:

- 1) DPHHS collaborate with internal and external entities to develop a comprehensive public education campaign on safe sleep practices for newborns and infants. Include resources for obtaining additional training or assistance in high risk situations. Research the use of baby boxes and consider supplying them in high risk cases or upon completion of safe sleep training.

*Update #1: DPHHS worked with stakeholders to initiate the **First Years Initiative** to increase knowledge of safe sleep issues and to provide portable sleeping units to parents in need.*

- 2) DPHHS collaborate with internal and external entities to develop a comprehensive public education campaign on reporting child neglect and abuse. Include information for being a safety resource and assisting CFSD in safety planning to keep children in their homes. Include expectations for agencies or individuals serving as safety resources.
*Update #2: DPHHS released the statewide **Raise Your Voice** public service announcement campaign; provided presentations on reporting child abuse locally; and posted a document on its website to inform educators how to report child abuse.*
- 3) CFSD review the use of UNK MALE, UNK FEMALE, and relationship identifiers in the CAPS case management system to improve access to history in all cases.
Update #3: In December 2018, CFSD moved initial documentation of reports of child abuse and neglect into the Montana Family Safety Information System (MFSIS) system. This system does not use group identifiers.
- 4) CFSD create a procedure for supervisory review of all reports to Centralized Intake in which there is a child fatality and the initial assessment is a CPI or information only.
Update #4: All child fatalities are subject to a supervisory review, including all reports to CI containing an initial assessment of Child Protection Information (CPI) reports.
- 5) CFSD create a timeframe and assessment tool for responding to all CFS or request for services reports.
Update #5: CFSD is reviewing procedures for responding to CFS reports to the child abuse hotline.
- 6) CFSD create a timeframe and procedure for issuing letters, whether unsubstantiated, founded, or substantiated, notifying the parent or caregiver regarding the determination of the investigation in accordance with [Montana Code Annotated 41-3-202](#).
Update #6: CFSD timeline for issuing letters specific to investigation findings is 60 days.
- 7) CFSD require investigations include requests for court ordered parenting plans and review of parenting plans prior to the closure of the Family Functioning Assessment.
Update #7: CFSD will request court ordered parenting plans when relevant to the investigation or ongoing case.
- 8) CFSD work with health care providers to create a universal procedure for collecting medical records of children involved in investigations or children removed from their parent and placed in out of home care. Include provisions for streamlining the timely provision of medical records foster care providers and health care providers.

Update #8: DPHHS routinely requests medical records when relevant to open investigations and in each case of a child being placed in protective custody. Receipt of the records varies from provider to provider.

- 9) CFSD review [Montana Code Annotated 41-3-206](#) regarding mandatory reports in the case of a child's death with suspicion of child abuse or neglect and create policy and procedures in collaboration with medical examiners or coroners to improve timely receipt of the report per statute.

Update #9: DPHHS has convened an internal working group including the DPHHS early childhood programs, vital statistics, and county Fetal Infant Maternal Health Review (FICMR) representation to develop procedures for routine records collection pertaining to child fatalities. The DPHHS Child Abuse Neglect Review Commission is a stakeholder in this process.

- 10) CFSD review the application of ICPC rules and regulations. Enhance adherence to and documentation of all steps to placement out-of-state. Ensure training for all staff include when and how to apply ICPC rules.

Update #10: DPHHS Office of Legal Affairs provided detailed training on Interstate Compact on the Placement of Children (ICPC) rules and regulations for all CFSD supervisors.

- 11) CFSD improve adherence to or update policies on protection plans, securing case records, and completing all necessary forms for review of child fatalities.

Update #11: When DPHHS is notified of a child fatality, it produces a current hard-copy file of all records pertaining to the deceased child and his/her case. CFSD electronic records cannot be locked, thus a paper copy of the report is secured on the date of the child's death.

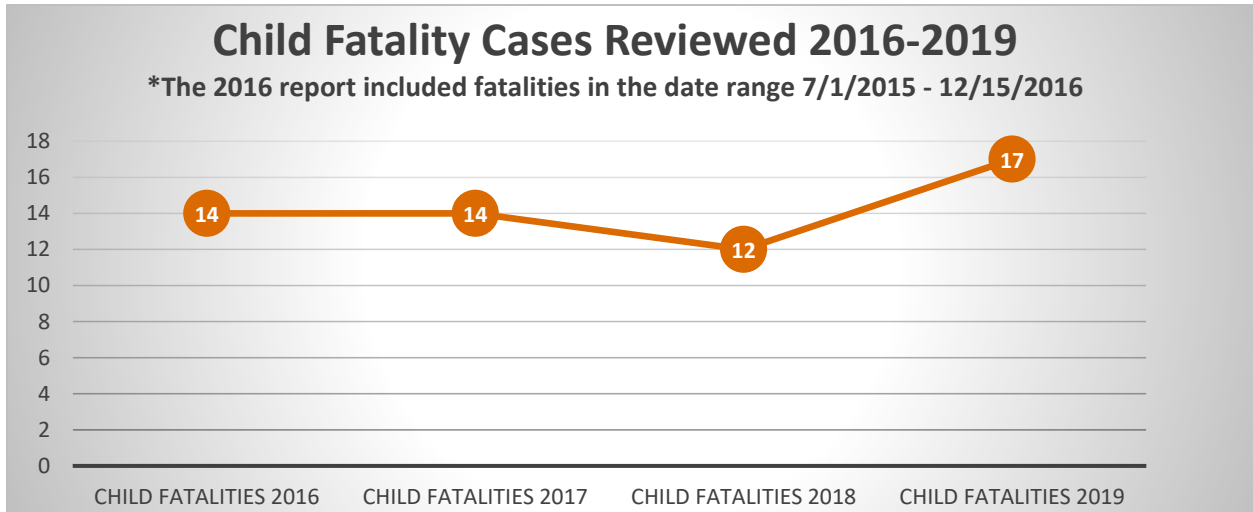
- 12) CFSD continue commitment to improving training, staffing times, enhanced case review for children under three, collateral contacts, complete assessments, and collaboration to increase access to services.

Update #12: Each of the six CFSD regions conducts supervisory review of any report to Centralized Intake pertaining to a child under the age of three.

2019 Overview

In 2019, OCFO reviewed 17 child fatalities reported by CFSD to OCFO as required by MCA 41-3-209. Facts from each case were identified and recorded in the review process. The following sections summarize the SSB Review Team findings.

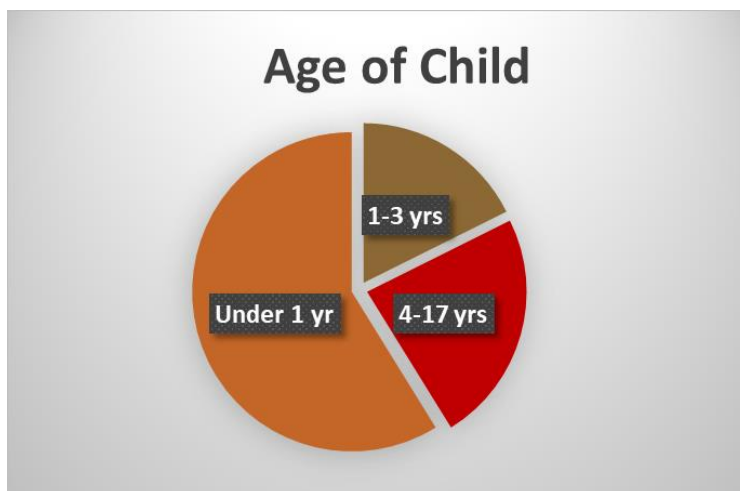
Child fatality cases have been reviewed by OCFO since July 1, 2015. The [2016 OCFO Child Fatality Report](#) reviewed 14 fatalities dated between July 1, 2015 and December 15, 2016 an eighteen-month date range.



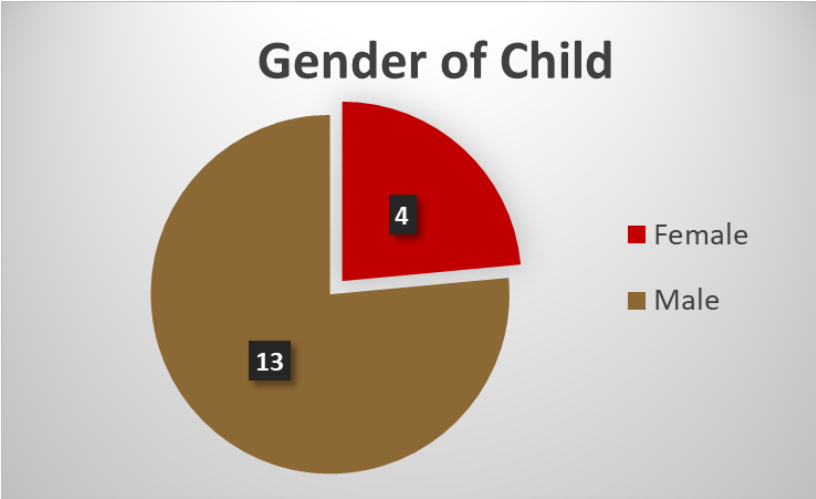
Fact Findings

Fact Number 1:

The majority of the incidents involved infants one year old or younger.



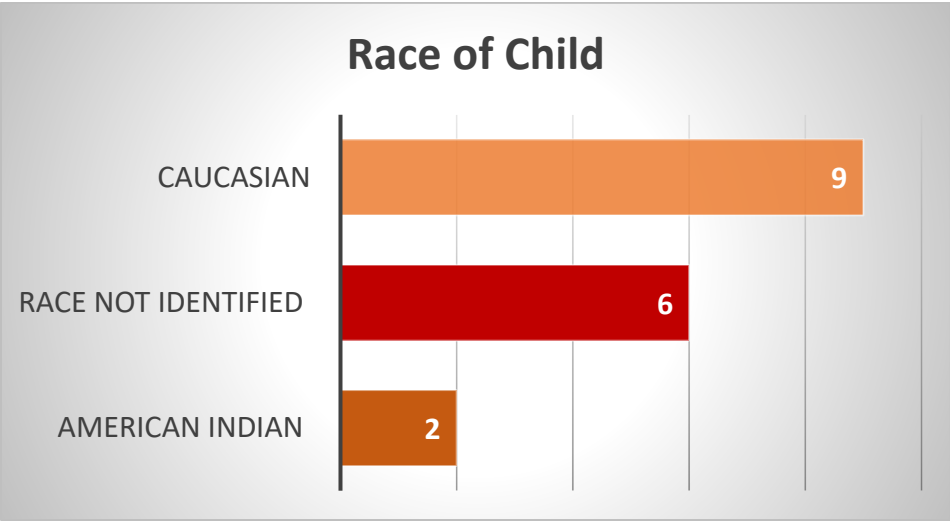
- 59% under age 1
- 23% ages 1 to 3
- 18% ages 4 - 17



76% of the fatalities were boys; 24% were girls

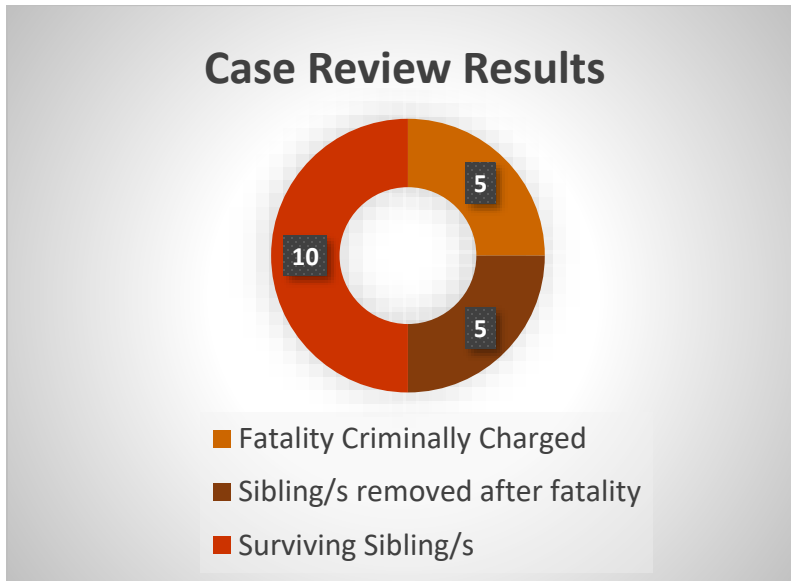
Fact Number 2:

In 2019, DPHHS CFSD records did not identify the child’s race in 35% of the cases.



Fact Number 3:

At the time of the 2019 OCFO review, five of the seventeen fatalities resulted in criminal charges.

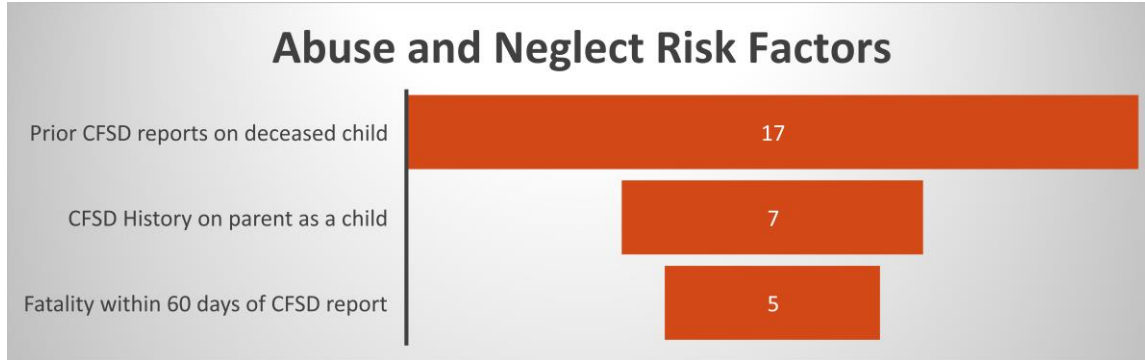


- Five of the seventeen child fatalities had surviving siblings.
- Ten of those siblings were put in protective custody or placed with a non-offending parent by CFSD at the time of the fatality.

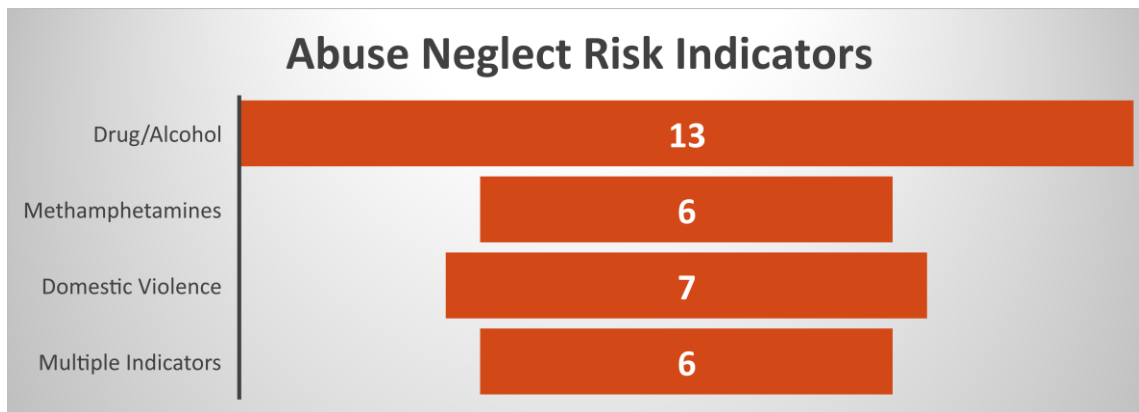
Fact Number 4:

Multiple risk indicators were identified in a majority of the cases.

Multiple indicators include, but are not limited to, combinations of the following:



- Prior CFSD reports on deceased child in all fatalities.
- CFSD history on parent/s as children in seven of the seventeen fatalities.
- Fatality occurred within 60 days of CFSD report in five of the seventeen fatalities.
- Drugs/alcohol use indicated in thirteen of the seventeen fatalities.
- Methamphetamine use indicated in six of the seventeen fatalities.
- Domestic violence indicated in seven of the seventeen fatalities.

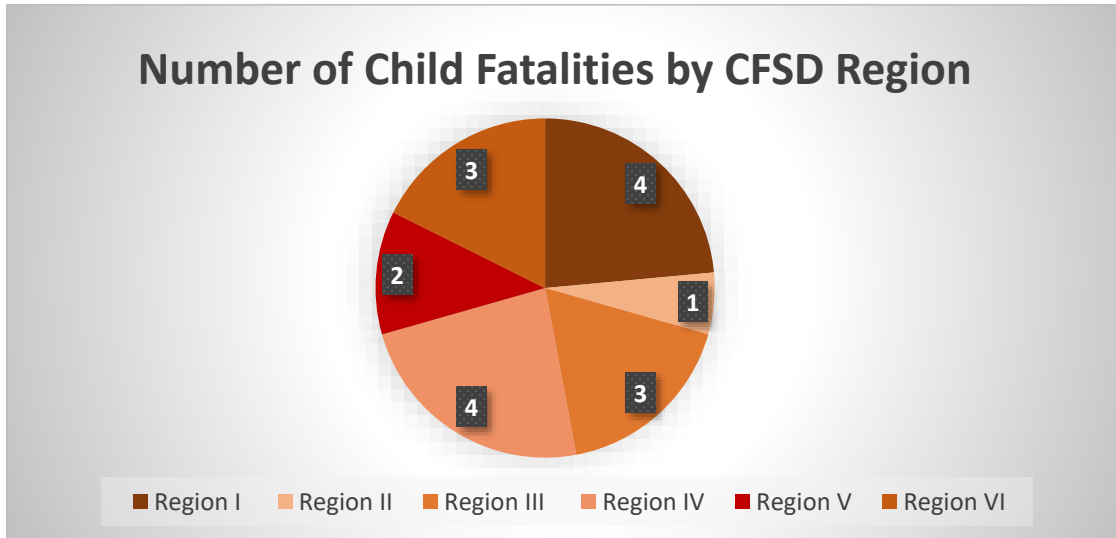


- Multiple risk indicators were indicated in six of the seventeen fatalities.

Fact Number 5:

Of the six CFSD Regions, each region reported at least one child fatality.

The OCFO review includes geographic information about each fatality; however, more detailed information and analysis is required before an accurate correlation between geography and number of fatalities can be stated.



See Appendix B for Region information.

2019 Review Recommendations

Based on the fact findings and practice findings from the review, the SSB Review Team recommends:

- 1) DPHHS continue to collaborate with internal and external entities to promote a comprehensive public education campaign on safe sleep practices for newborns and infants.
- 2) DPHHS continue to collaborate with internal and external entities to develop a comprehensive public education campaign on reporting child neglect and abuse.
- 3) CFSD continue commitment to improving training, staffing times, enhanced case review for all reports to Centralized Intake listing children aged three and under.
- 4) [Montana Code Annotated 41-3-206](#) requires medical examiners/coroners to submit written reports to CFSD following a child fatality. OCFO recommends CFSD coordinate with county attorneys and local law enforcement agencies, coroners, and medical examiners to improve timely receipt of those reports as per statute.

- 5) [Montana Code Annotated 41-3-123](#), which governs the Child Abuse Neglect Review Commission, be reviewed and clarified to allow CFSD to request and obtain all records related to a child fatality within 180 days of occurrence. Such records include medical, law enforcement, mental health, educational, childcare, medical examiner and coroner findings and any service providers engaged with the child prior to death.
- 6) CFSD complete the procedural review pertaining to timeframe and the assessment tool for responding to all request for services reports labeled as CFS. Additionally, CFSD should train its staff on the adopted procedure.
- 7) CFSD conduct training for staff to increase accurate reporting on the race of each child.
- 8) CFSD prioritize requesting and obtaining medical records of children involved in investigations or children removed from their parent and placed in out-of-home care. Include provisions for streamlining the timely provision of medical records to foster care providers and health care providers responsible for medically fragile or medically complex children.

Conclusion

The DOJ Special Services Bureau and OCFO recognize the impact child fatalities and case reviews have on citizens, communities, and professional stakeholders. Child abuse is a community problem; preventing and responding to child abuse requires strong collaboration among multiple agencies. We sincerely thank 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.

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

Sahrta Jones-Jessee, 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
Laura McCullough, Interim R/A for L&C County
111 North Jackson Street (Arcade Building)
Helena, MT 59601
(406) 841-2412

Region V

Courtney Callaghan, Regional Administrator
2677 Palmer, Ste. 300
Missoula, MT 59802
(406) 523-4100

Region VI

Angie Rolando, Regional Administrator
121 Financial Dr. Ste. C
Kalispell, MT 59901
(406) 751-5950