Montana Department of Justice
Office of the Child and Family Ombudsman
Child Fatality Review Report 2020

Contact the Ombudsman:

1-844-25CHILD

1-844-252-4453

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 fifth review and covers January 1, 2020, through December 31, 2020, and includes a total of six 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. Review team members are:

Dana Toole, LCSW	Special Services Bureau Chief
Gala Goodwin, ACSW, LCSW	Child and Family Ombudsman
Marci Buckles, BSW	Child and Family Ombudsman
Kaci Gaub-Bruno, MA	Child and Family Ombudsman & Residential Investigator
Matthew Schubert	Justice for Montanans OCFO AmeriCorps Member
Joan Eliel	Director, Office of Consumer Protection and 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.

[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, the 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:

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.

An OCFO case review is an investigation of all the CFDS actions or omissions for a specific case. Each CSFD case may include records located in three different electronic databases:

- Child and Adult Protective Services or *CAPS*
- Montana Family Safety Information Systems or *MFSIS*
- Document Generator or *Doc Gen*

Additional case specific records may also be maintained in a county CFSD office hard file.

The CAPS database has been active since 2002 and MFSIS is in current development. At the time of this report the MFSIS module for case intake is active, but subsequent ongoing case management MFSIS modules have not been released. OCFO strives to conduct an accurate and comprehensive case review for each child fatality and for each citizen requestor.

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

Prior Recommendations Including Updates

2019 Review Recommendations and Updates

The 2019 OCFO Child Fatality Review Report recommended the following:

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.

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 continue to collaborate with internal and external entities to develop a comprehensive public education campaign on reporting child neglect and abuse.

Update #2: DPHHS sponsored a statewide “Raise Your Voice” public education and outreach campaign including radio, television and social media outlets in 2020. DPHHS and CFSD also offered CORE Training to the public and to child welfare stakeholders across the state. The CORE training provides information on how to make a report of suspected abuse and the CFSD procedures for responding to reports, conducting investigations, criteria for child removals, the required court timelines and more.

3. CFSD continue commitment to improving training, staffing times, enhanced case review for all reports to Centralized Intake listing children aged three and under.

Update #3: CFSD has instituted enhanced case reviews for reports of abuse of very young children in each CFSD Region statewide.

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.

Update #4: In 2021 the Montana Department of Justice will work with CFSD and the state crime laboratory to address this recommendation.

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.

Update #5: MCA 41-3-123 expires on September 30, 2021. The 2021 Montana Legislature did not extend the law thus the commission will disband.

6. CFSD complete the procedural review pertaining reports categorized as a Request for Service (CFS). Specifically, review the timeframe guidelines for a response to a CFS report.

Update #6: The DPHHS/CFSD review and revision of their policies is ongoing. Revised policy is being distributed and trainings on policy changes are offered as each policy section is completed. Responses for CFS reports will be addressed in policy. The OCFO staff are attending the trainings.

7. CFSD conduct training for staff to increase accurate reporting on the race of each child.

Update #7: In the 2020 OCFO Child Fatality Review the race of each child was reported in the CFSD record. CFSD Management Team worked with each Region and local CFSD office to improve race reporting practices.

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.

Update #8: CFSD is conducting meetings with hospitals, medical case management entities and providers to improve medical information sharing in cases with medically fragile and complex cases. In addition, CFSD continues to expand foster care health programs through the state Request for Proposal process.

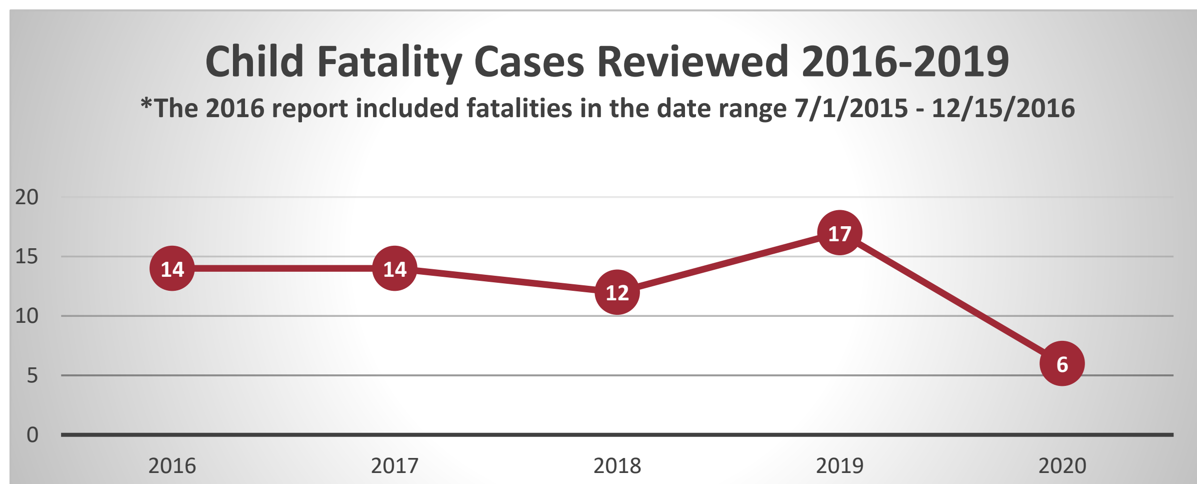
2020 Overview

In 2020, OCFO reviewed 6 child fatalities reported by CFSD to OCFO as required by MCA 41-3-209. Data points from each case were identified and recorded in the review process. The following sections summarize the SSB Review Team findings.

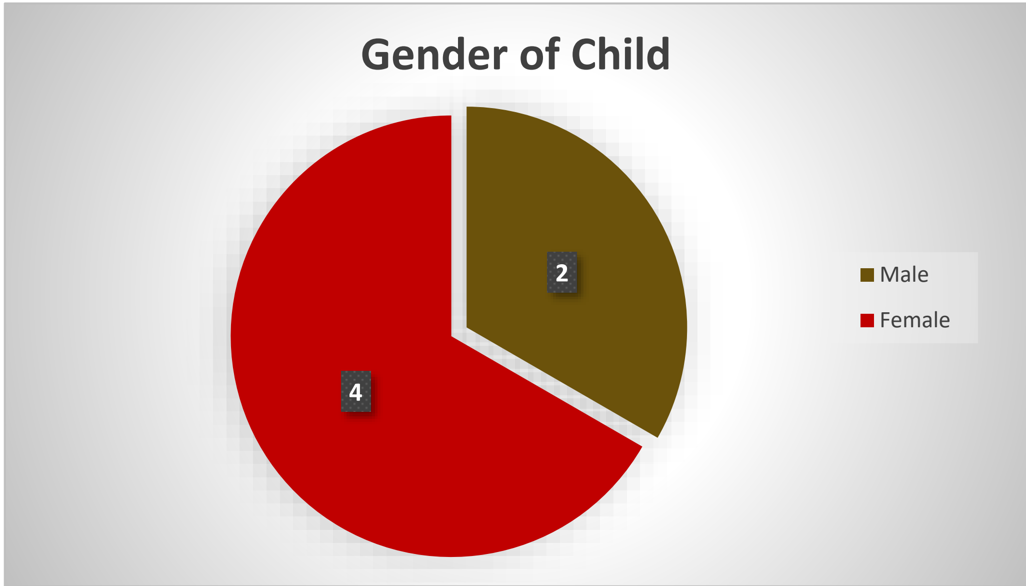
Child fatality cases have been reviewed by OCFO since July 1, 2015. The 2016 OCFO Child Fatality Report reviewed 14 fatalities dated between July 1, 2015, and December 15, 2016, an eighteen-month date range.

Findings:

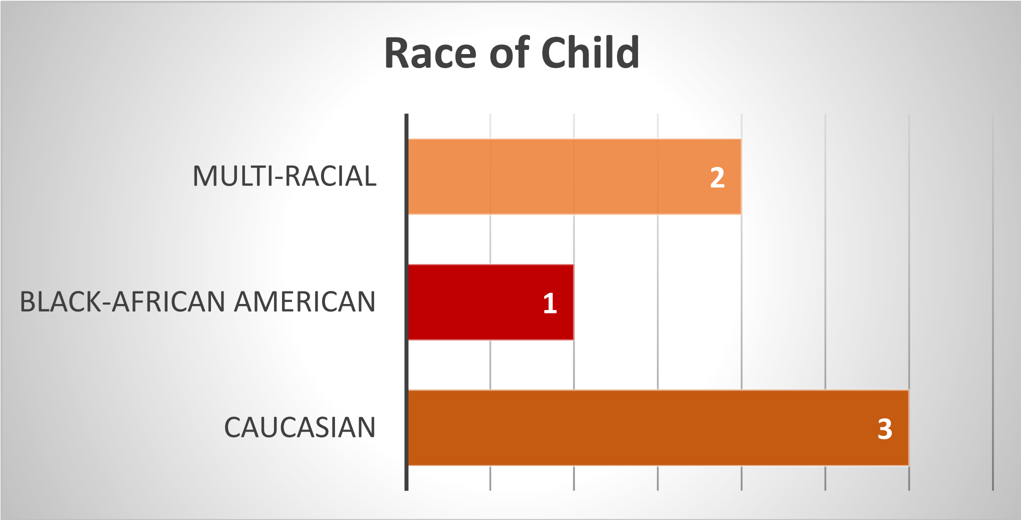
Finding #1: In 2020, half of the fatalities involved a child 1 year old or younger.



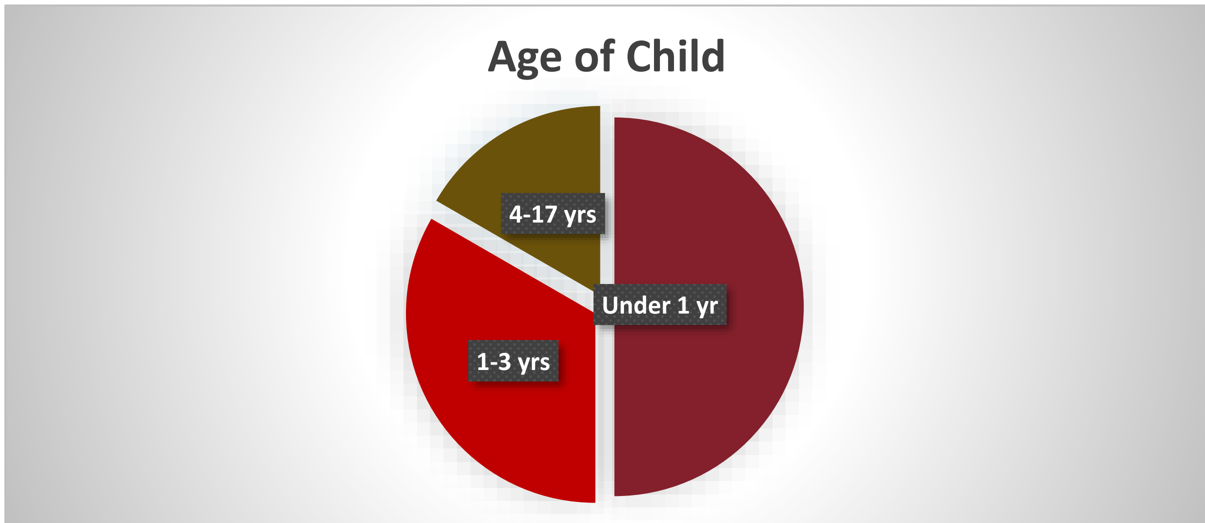
Finding #2: One third of the fatalities were male children and two thirds were female children.



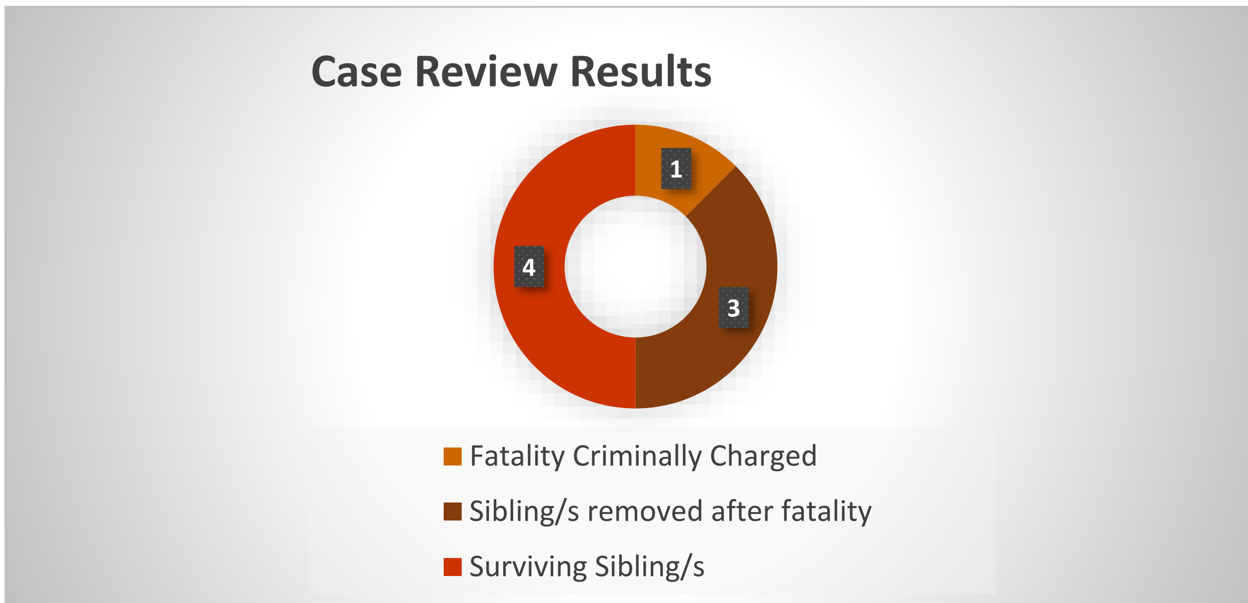
Finding #3: DPHHS CFSD identified the race of each child.



Finding #4: DPHHS CFSD identified the age of each child.

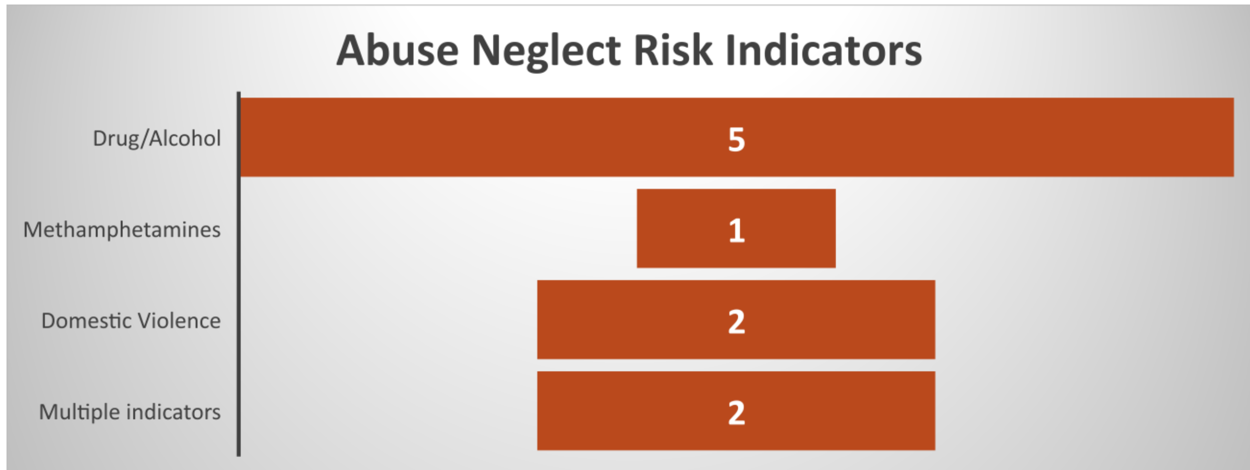


Finding #5: At the time of the 2020 OCFO Review, one of the six fatalities resulted in criminal charges.

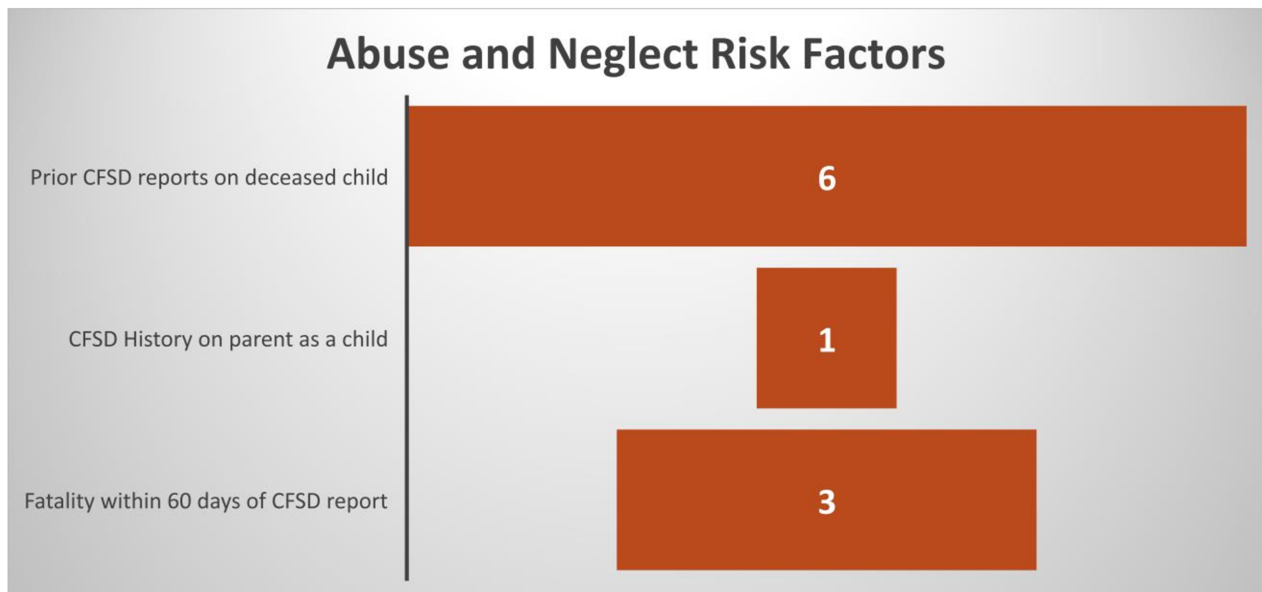


Finding #6: There were prior reports alleging abuse or neglect of all 6 children.

In one case, however, the young child was extremely medically fragile since birth and the prior reports were unrelated to the placement in which the child died.



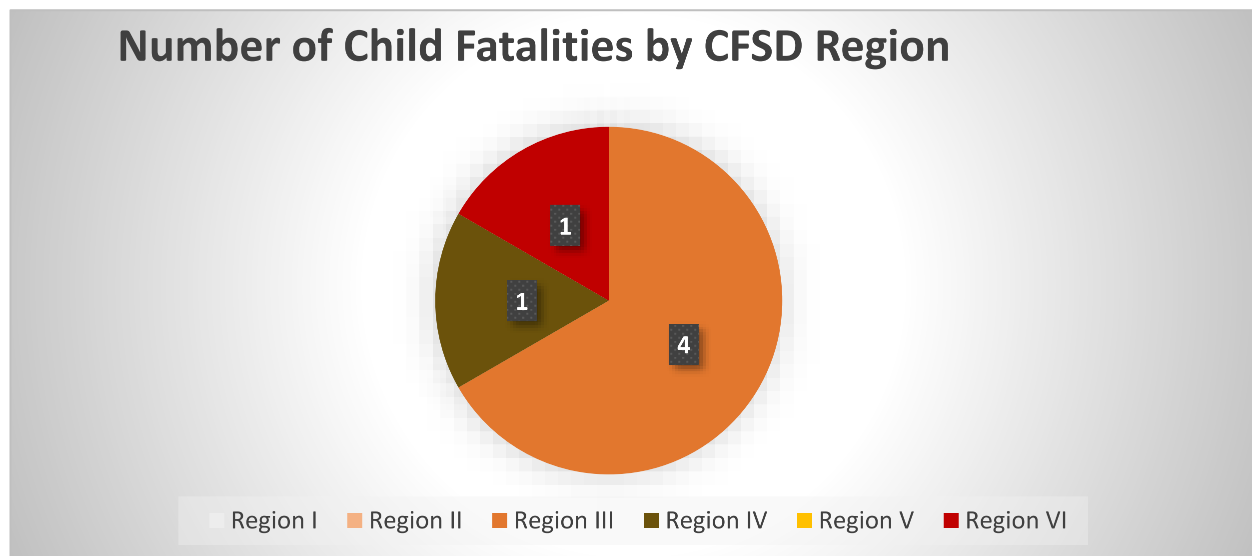
Finding #7: Five of the child fatality cases included multiple risk factors.



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 one of the six fatalities.
- Fatality occurred within 60 days of CFSD report in three of the six fatalities.
- Drugs/alcohol use indicated in five of the six fatalities.
- Methamphetamine use indicated in one of the six fatalities.
- Domestic violence indicated in two of the six fatalities.

Finding #8: Child fatalities occurred in three of the six CFSD regions.



See Appendix for CFSD Region information

2020 Review Recommendations

The 2020 recommendations are based on a thorough review of CFSD records for each child fatality reported to OCFO as per MCA 41-3-209. Sections 1 and 2 are specific to CFSD responsibilities. Section 3 is intended to increase interagency collaboration on behalf of vulnerable children.

The Office of Child and Family Ombudsman recommends DPHHS and CFSD provide staff training, and engage in collaborations as follows:

1. **Case record Training:**

    a. *Substantiations of child abuse/neglect are supported with accurate documentation and substantiation letters are provided to caregivers.*

b. *Case documentation is uploaded to the case management database in real time to assure a current case file;*

c. *Investigations are closed and closure is documented within the required 60-day timeframe;*

d. *Case records include a current comprehensive record of services provided to both caregivers and children;*

e. *Provide accurate documentation of the child and caregiver's relationships to other family and individuals relevant in the case;*

f. *Request, receive and review child protection history from other states;*

2. **Casework practice:**

a. *Child interviews are conducted in a neutral environment with the Child Protection Specialist and child separate from any other individuals;*

b. *respond to reports of child abuse and neglect within the required timeframe of P1, P2 and P3.*

c. *assess safety of any siblings or other youth in a home where a child fatality has occurred*;

d. *identify and provide appropriate services to caregivers and children in each case;*

e. *contact all collateral agencies and individuals relevant in response to reports of abuse and/or neglect*;

f. *complete Family Functioning Assessments in real time and maintain updated assessments in the case management database*.

3. Interagency coordination:

a. *Public education and outreach on reporting child abuse:*
DPHHS and CFSD establish a formal collaboration to develop a comprehensive public education campaign on reporting child neglect and abuse. Partners may include CASA, schools, service providers, medical providers, non-profit agencies dedicated to youth, law enforcement agencies, courts and faith communities and others.

b. *Partner with local and state law enforcement leadership to improve cross-reports of suspected child abuse from law enforcement to the child abuse hotline;*

c. *Partner specifically with local school districts to improve the mandatory reporting of suspected child abuse by educators.*

d. *Coordinate with county attorneys to maintain Child Protection Teams as per MCA 41-3-108 to increase interagency information sharing and improve child safety.*

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 of the DPHHS CFSD Regions and list of contact information 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

Sahrita 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, Regional Administrator
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

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