

Montana Department of Justice
Office of the Child and Family Ombudsman
Child Fatality Review Report
December 2016



**Office of Child &
Family Ombudsman**



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Background:

The Office of the Child and Family Ombudsman (OCFO) responds to requests to protect the rights of children and families by improving case outcomes and strengthening Montana’s child welfare system. Montana statute 41-3-1211 requires the OCFO to investigate circumstances surrounding child fatalities when the child was involved with the Montana Department of Public Health and Human Services (DPHHS) Child and Family Services Division (CFSD) within 12 months of the date of the child’s death.

DPHHS provides notification of child fatalities via email to the Chief Child and Family Ombudsman and the following processes are initiated:

- Review of CFSD actions, policies and procedures related to the child fatality case including:
 - Safety assessment of siblings
 - Report to law enforcement
 - Status of law enforcement investigation
- Collect the case file and confirm:
 - Documentation is the entirety of the information in the CFSD file.
 - Status of child protection investigation and law enforcement investigation.

The OCFO case reviews are initiated after the conclusion of a criminal investigation, but the judicial process may not be complete. Information about criminal cases including conviction and any sentencing is limited to media reports or publicly accessible databases.

Executive Summary:

- ***14 children died across Montana after reports of abuse were made to DPHHS/CFSD***
- ***12 cases included prior reports to CFSD on the child***
- ***8 out of 14 children died within 60 days of the last report filed by CFSD***
- ***11 fatalities involved children aged two or younger***
- ***11 fatalities involved allegations of drug use, 4 of which indicated meth use***
- ***12 out of 14 cases contained multiple neglect and/or abuse indicators***

As directed by state statute, the Children's Justice Bureau (CJB), which is part of the Montana Department of Justice's Division of Criminal Investigation, created the Child Fatality Review Team. The team reviewed child fatalities reported to the OCFO from July 1, 2015 through November 8, 2016. 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 and the Office of Victim Services.

The Child Fatality Review Team gathered in Helena November 9– 10, 2016 to review a total of fourteen child fatalities. Region IV reported five child fatalities, which was the highest number per region. Region IV includes Anaconda, Bozeman, Butte, and Helena.

Of the fourteen cases reviewed, eleven involved children two years old or younger; in nine of those cases, the children were one year old or younger. Eleven cases included allegations of drug use, four of which indicated methamphetamine use. Six cases indicated issues of domestic violence. Five other cases were unknown for domestic violence. Eight cases involved parents who received child protective services in Montana when they themselves were children.

Twelve cases included prior reports to child protection on the child. In eight of the fourteen cases, the child died within 60 days of the last report to Centralized Intake, or while the assessment was underway. Three cases did not involve siblings. Of the remaining eleven cases involving siblings, eight cases led to the removal of the siblings from the parent's care.

Three cases involved a paramour as the alleged perpetrator and all three had prior criminal records. Four cases resulted in criminal charges being filed. However, information about alleged perpetrators, cause of death, and resulting criminal investigations was often incomplete. In summary, twelve of the fourteen cases contained multiple neglect and/or abuse indicators.

Practice trends identified during the review included variations in how cases were handled once the fatality was reported and no consistent means for reporting a summary of the incident. Individuals or professionals contacted as collateral sources varied widely. The format of the family functioning assessment did not support a clear summary of a child fatality.

Cases with open reports revealed checks on the history of child protection involvement occurred after the fatality, was not reviewed thoroughly, or was not included in the assessment. Records on parents and children were often not linked or contained duplicates, which could complicate investigations. All assessments were missing supervisory documentation of safety determinations, case closures, or both.

Executive Recommendations Summary:

- ***DPHHS provide clarification on steps CFSD takes following a child fatality. DPHHS provide results of critical incident review committees to the OCFO.***
- ***DPHHS create a summary format created to assist in reviewing and determining whether child neglect or abuse is indicated. Summaries to include medical records and documentation supporting a cause of death by a medical professional.***
- ***Child Protection Specialists review and document child protection history and criminal history on all household members within 24 hours of receipt of the report.***
- ***CFSD provide enhanced support to Child Protection Specialists on investigating when multiple neglect and abuse indicators are present, as well as support in identifying early intervention services to high-risk families.***
- ***DPHHS implement a Child Fatality Review Board to collect more comprehensive data to support more thorough recommendations.***

Statutory Definitions and Requirements:

Montana Code Annotated 41-3-1211 requires the OCFO “to investigate circumstances surrounding reports that are provided to the ombudsman pursuant to 41-3-209.” The DPHHS Child and Family Services Division notifies the OCFO of critical incidents involving children in the CFSD system. Child fatalities are one type of critical incident reported to the OCFO. Child fatality notifications include children who:

- 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) had been in out-of-home care at the time of the child's death; or
- d) had received services from DPHHS under a voluntary protective services agreement.

Montana statute also requires the OCFO to report recommendations to DPHHS to promote best practices and improve procedures, practices, and programs. A review form is utilized to objectively capture the facts and circumstances of each child fatality. From the review forms, the team identified the findings and recommendations.

Philosophy and Limitations:

The objective of the required review is to strengthen Montana’s child welfare system, including the work of critical stakeholders and partners, such as law enforcement and medical and mental health resources to improve outcomes for Montana children. The CJB team adopted a philosophy mirroring that of the Montana Domestic Violence Fatality Review Commission. Each case that was reviewed was complex and often involved a number of variables, including inconsistent access to law enforcement reports, death certificates, and CFSD records.

The review team encountered limitations to making certain findings:

- ***Multiple and dated CFSD case management systems complicated child protection investigations, such as records that were duplicated or not linked;***
- ***Documentation was limited to the CFSD case file and public records;***
- ***CJB was prohibited from accessing to criminal justice information;***
- ***Information about alleged perpetrators and resulting criminal investigations was often incomplete;***
- ***CJB access to file documentation from medical/mental health providers, other service providers, child welfare partner agencies, and law enforcement was limited;***
- ***Ongoing legal matters with living siblings often took precedence to collecting information on the child fatality. This information became mixed into the same investigation or Family Functioning Assessment; and***
- ***Specific cause of death information was incomplete or missing.***

Review Findings:

Factors Identified:

1. The majority of the incidents involved children two years old or younger and involved assessing the safety of siblings.

Total cases reviewed	Child fatalities 0 – 12 months of age	Child fatalities 12 – 24 months of age	Cases with surviving siblings	Cases with CFSD removal of siblings
14	9	2	11	8

2. Drug use and domestic violence allegations and multiple indicators of abuse and neglect played a role in the majority of cases.

Total cases reviewed	Caregiver drug use identified	Caregiver methamphetamine use identified	Domestic violence in family identified	Multiple indicators*
14	11	4	6	12

* Multiple indicators include, but are not limited to these combinations: Prior CFSD history, prior criminal history, methamphetamine use, alcohol and drug abuse, domestic violence, housing instability or other financial insecurities.

3. Criminal history information was limited and approximately 50% of cases referenced criminal case information.

Total cases reviewed	Criminal history on alleged perpetrator	Criminal charges resulted from child fatality	Alleged perpetrators were paramour to mother*	Criminal history unknown
14	7	4	3	4

*Each of these three cases indicated the paramour had a criminal history.

4. The majority of cases included prior history with Montana child protection services.

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 parents when they were children
14	12	8	8

5. The Family Functioning Assessment is the CFSD tool used to determine child safety both immediate and impending. The completion of the Family Functioning Assessment is required within 60 days of the report to CFSD that initiated an investigation by CFSD. Family Functioning Assessment practices varied.

Total cases reviewed	Child fatality occurred within 60 days of 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	8	6	3	14

Additional Demographic Information:

Total cases reviewed	Female child fatalities	Male child fatalities	Caucasian children	American Indian children	African American children
14	4	10	9	4	1

Total cases reviewed	Region I	Region II	Region III	Region IV	Region V	Region VI
14	3	2	2	5	2	0

Recommendations:

The CJB review team recommends to DPHHS:

- Legislative action to create and support a Child Fatality and Near Fatality Review Board.
- Prioritize requirements to develop and support statewide and local partnerships between CFSD, law enforcement, medical providers, mental health and chemical dependency providers, juvenile justice, county attorneys, and victim advocates to improve information sharing and increase child safety.
- Improve organization and documentation of risk assessment and safety planning.
- Improve assessment and safety planning in cases with drug affected families and multiple child abuse risk factors.
- Develop an effective mechanism to increase consultation between CFSD and experts, including medical and law enforcement personnel directly involved in the care of the child or family in high-risk cases.

Appendix A:

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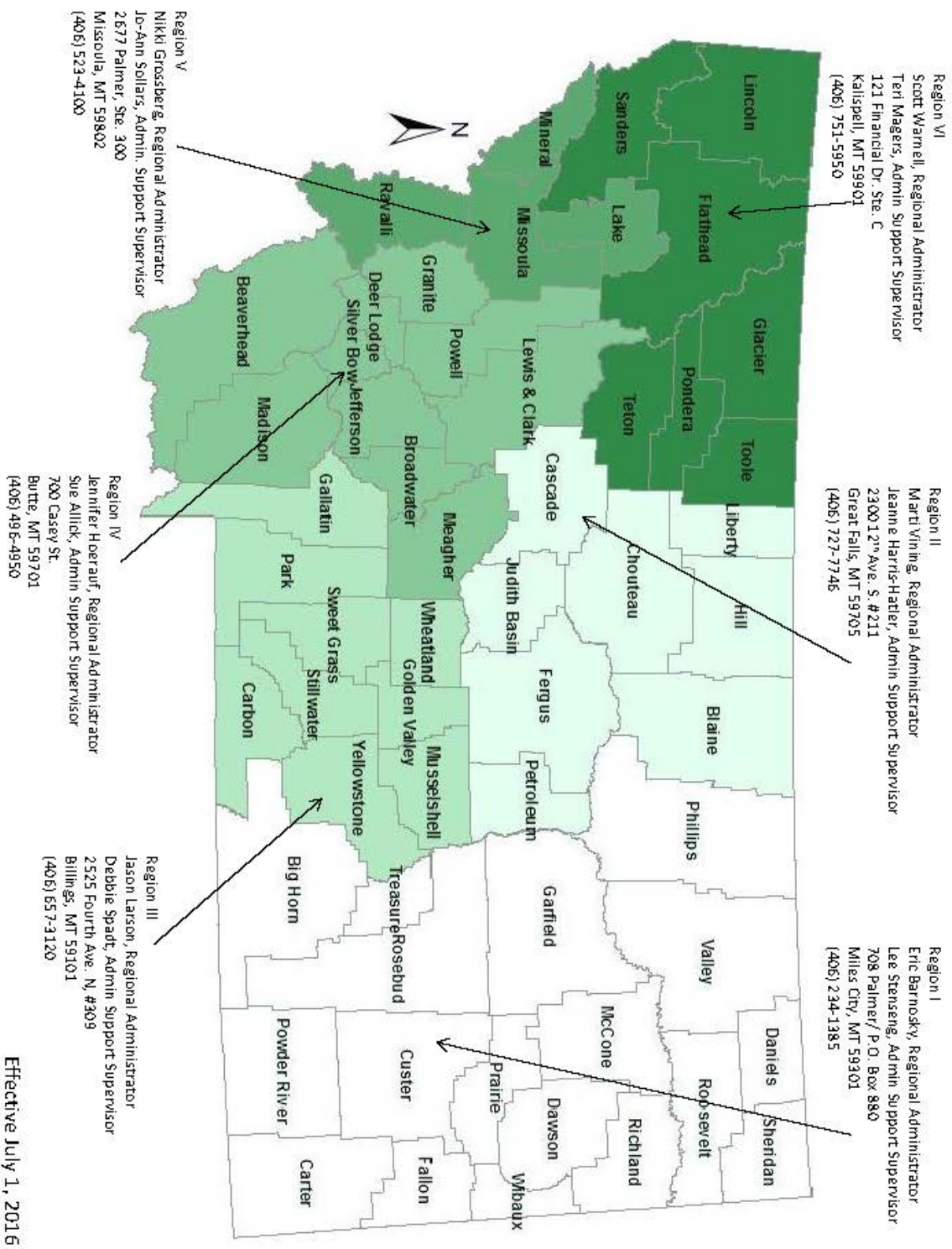
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