Montana Department of Justice
Office of the Child and Family Ombudsman
Child Fatality Review Report 2018

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
Joan Eliel, SAKI Coordinator, Children's Justice Bureau

OCFO Contact Information: 1-844-25CHILD
DOJOMBUDSMAN@mt.gov

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. 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 third review and covers December 16, 2017 through December 31, 2018. All subsequent reports will cover the annual year or January 1-December 31st.

In compliance with MCA 41-3-209, OCFO created the Children's Justice Bureau (CJB) Child Fatality Review Team. 2018 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 Joan Eliel, Sexual Assault Kit Initiative (SAKI) Coordinator. The team met October 29, 2018. In total, twelve child fatalities were reviewed.

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. 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. 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/.

This report includes data collected from the reviews, findings based on the data, and recommendations. The CJB team recognizes the Department of Justice (DOJ) 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.

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[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

Table of Contents

Statutory Definitions and Requirements

Montana Code Annotated 41-3-209 requires 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:

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.

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 addresses the duties of the OCFO per statute. The information reviewed 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 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 locates in the electronic case management systems or 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.

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. Therefore, both reviews are required.

2017 Review Recommendations and Updates

The 2017 OCFO Child Fatality Review recommended:

1) The Child Abuse and Neglect Review Commission (CANRC) develop a process that requires review of all available resources and information related to child fatalities with suspected abuse and neglect factors.

Update: *The CANRC met and developed a process to collect, disseminate, and review all available resources and information in the cases under review.*

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.

Update: *DPHHS continues to work on their internal review process and report progress to OCFO. DPHHS did not provide completed reports on critical incident reviews for 2017 or 2018.*

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.

Update: *DPHHS invited OCFO to present issues regarding trends, including assessments to the DPHHS administration, CFSD management team, and to field staff as appropriate. OCFO reported improvements overall in recent assessment in the area of investigative collateral contacts. Discussions continue on how to address drug testing and training on safety plans and voluntary agreements with families and clients. CFSD incorporated prior recommendations on using experts in trainings, particularly as to domestic violence and trauma informed care and recently expanded the training for new workers on Family Functioning Assessments (FFAs). In addition, CFSD is moving toward a training model that includes more training in the field and ongoing training throughout the career of a child protection specialist.*

In the 2018 review of child fatalities, only two FFAs were noted to need further investigative collateral contact information. All the fatalities reviewed documented drug testing of parents and children when drug allegations were present.

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.

Update: *DPHHS informed OCFO that both the Centralized Intake categorization process and the category change form will be reviewed.*

5) DPHHS complete efforts to modernize the case management system. Complete revisions of the policy and procedure manuals for CFSD staff.

Update: *DPHHS and CFSD began training for the new case management system Montana Family Safety Information System (MFSIS). OCFO participated in a training. The initial roll out of the system occurred the first week of December 2018. Full replacement of the current system will not occur until 2024; however, the initial steps will improve searches for history and consistent application of the safety assessment model.*

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.

Update: *The DOJ launched the Aid Montana Initiative of which DPHHS was a partner. DPHHS began and continues to implement new services aimed at prevention and meeting the needs of mothers and very young children, including enhanced supervisory reviews, home visiting services, and addiction and recovery teams. In one 2018 case, an enhanced review provided improved information on questions investigated and decisions made.*

DPHHS held a conference on the federal Family First Act on November 2, 2018, seeking partners to apply evidence-based practices to prevention and family preservation. In addition, OCFO was notified in November 2018 that Centralized Intake will also hold enhanced reviews for children under two years old, which could improve response time and early access to services.

Review Findings

2018 Overview

Facts of each case 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.

2018 Fact Findings

1) The process of confirming each cause of death improved over the year as CFSD requested ten of twelve autopsies and documented receipt or communication with appropriate officials. The following depicts the information found:
    - Three deaths were deemed accidental. One involved co-sleeping where the parent did have a history of drug use. These fatalities demonstrate the importance of educating parents about sleeping and feeding practices with infants.
    - One death was charged as negligent homicide.
    - One death was charged as deliberate homicide.
    - Two deaths were due to medical complications for the child. The mothers did use illicit drugs while pregnant, causing the children to suffer from withdrawal. This may have contributed to the children's deaths.
    - Two deaths were ruled suicide.
    - One death was undetermined per the autopsy.
    - Two deaths are still being investigated for cause.

2) The majority of the incidents involved infants 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
12	7	2	3

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
12	8	5

4) Criminal history was known in only two cases.

Total cases reviewed	Criminal history on alleged perpetrator or caregiver to child.	Criminal history unknown	Criminal charges resulted from child fatality	Alleged perpetrators were paramour to mother
12	2	4	3 charged; 2 pending investigation	0

5) Multiple indicators for risk were identified in most 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
12	7	5*	4	8

**Of the seven cases where drug use was identified, five of those seven 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) The majority of cases involved some history on the family as to prior CFSD involvement.

Total cases reviewed	Prior CFSD reports on child or children in the home	CFSD history on parent or caretaker as a child
12	10	6

8) OCFO reviewed cases for effective use of the investigative tool, the Family Functioning Assessment. Improvements were evidenced by most of the 2018 FFAs being on time and complete.

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
12	3	3	1	1

9) Demographics may present more areas for review and assessment.
    - 5 children were female and 7 were male.
    - 6 children were reported as Caucasian.
    - 3 children were reported as American Indian.
    - 1 child was reported as Black.
    - 2 children were unidentified as to race. In each, the mother was reported as Caucasian. Father data was not reported.
    - There are six CFSD Regions. See Appendix B for Region information. Each Region reported at least one child fatality.
        - I- 2
        - II- 1
        - III- 2
        - IV- 3
        - V- 2
        - VI- 2

2018 Practice Findings

1) When an individual is entered in the electronic case management system, CAPS, the person is assigned a number.
    - In two of the cases reviewed, a parent or caretaker was assigned a number referred to as UNK MALE. In one of the cases, a parent was assigned a number referred to as UNK FEMALE.
    - This universal CAPS number prevents the person from being linked to any other person in the electronic CAPS case management system.
    - In each case, the person was not assigned an individual CAPS number even after their relationship was known. In both cases, the relationship was known at the outset of the case. It is unclear the usefulness of this universal CAPS number.
    - In addition, the Relationship List (RELL) screen shows the relationships between one person and another by name and CAPS number. In at least three cases, relationships were not linked.

2) In two cases, an Interstate Contract on the Placement of Children (ICPC) was required. ICPCs provide information on the placement as well as feedback on any safety issues when a child is coming to Montana from another state or going from Montana to a placement in another state.
    - In one case, the ICPC was not completed prior to placement of a child into Montana.
    - In one case, an ICPC was not completed and children were placed out of state for at least three months.

3) In two child fatality cases, the reports were evaluated by the Centralized Intake Bureau; neither an investigation nor Family Functioning Assessment was initiated.
    - One child fatality was categorized as Child Protective Services Information (CPI) or information only. This case could not be reviewed in its entirety.
    - Two child fatalities were categorized as Child Protective Services- Request for Services (CFS). There is no time frame for a Child Protection Specialist to respond to a CFS and a Family Functioning Assessment was not required.
    - In two cases under review, prior reports were also taken as CPI despite the reporter being law enforcement or a doctor or a report involving a child under age three.

4) After an investigation is completed, the Child Protection Specialist sends a letter to the parent to say the allegations were substantiated, founded, or unsubstantiated.
    - In one review, an unsubstantiated letter was sent seven months after an investigation closed and one month after the subsequent child fatality.
    - In one review, a letter was not dated.
    - In one review, a letter was sent two months after the investigation was closed.

- In one review, a letter was sent one day after the close of the investigation by certified mail.
- In seven reviews, no letter was located in the file and the investigation was closed.

5) In three cases, parenting plans were identified as in place between the parents. No copies of the parenting plans were found.

6) In three cases, medical records of the needs of the child were not properly documented or shared appropriately by service providers with other providers or with CFSD.

7) CFSD requested autopsy reports in ten cases. CFSD received three autopsy reports. In four fatalities, CFSD received verbal information on the cause of death from the medical examiner, doctor, or law enforcement.

8) CFSD has a policy on securing the case record in response to a child fatality. CFSD also has a policy to complete a Child Death or Near Death form to assess whether it meets federal criteria for a review per CFSD policy or by the Child Abuse and Neglect Review Commission.
    - Of the 12 cases reviews, only one case record was secured per policy.
    - Of the 12 cases reviewed, only three case records contained Child Death forms.\
    - One investigation was in the first weeks of assessment as of the publication of this report.

9) In at least two cases, collateral contacts knew of child abuse and neglect concerns but never reported those concerns to Centralized Intake. The concerns of the collaterals were consistent with how the child died. In at least one case, collaterals were also mandatory reporters.

10) When immediate safety concerns are not present, Child Protection Specialists can implement protection plans or safety plans among the parent, CFSD, and safety resources. These plans address any impending safety concerns and allow children to remain in the home.
    - In three cases, safety resources did not follow the protection or safety plan, which prevented CFSD from intervening.
    - In two cases, the communication by the Child Protection Specialist with the parent and safety resource was insufficient.

Recommendations

Based on the Fact Findings and Practice Findings from the review, the CJB Review Team recommends:

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.

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.

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.

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.

5) CFSD create a timeframe and assessment tool for responding to all CFS or request for services reports.

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.

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.

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.

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

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 includes when and how to apply ICPC rules.

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

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.

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

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

Region V

Courtney Callaghan, Regional Administrator

2677 Palmer, Ste. 300

Missoula, MT 59802

(406) 523-4100

Region VI

Angie Rolando, Acting Regional Administrator

121 Financial Dr. Ste. C

Kalispell, MT 59901

(406) 751-5950