

DEPARTMENT  
OF HUMAN  
SERVICES

2016



FATALITY  
REVIEW  
EXECUTIVE  
SUMMARY  
FY 2016

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## DEPARTMENT OF HUMAN SERVICES FATALITY REVIEW EXECUTIVE SUMMARY

JULY 1, 2015– JUNE 30, 2016

Department of Human Services (DHS) Fatality Review Policy requires a review of the deaths of all individuals for whom there is an open DHS case at the time of death or in cases where the individuals or their families have received services through DHS within 12 months preceding the death. Information obtained from case reviews provides insight into systemic strengths and highlights areas in which changes or modifications could enhance systemic response to client needs.

During FY2016, 218 deaths of current or past DHS clients were reported to the Office of Services Review (OSR). There were 15 suicide deaths (7%) and four homicides (2%). The deaths of 11 individuals (5%) were ruled accidental. The reviews indicate that abuse and/or neglect were contributing factors in seven (3%) of the 218 deaths. The Division of Child and Family Services (DCFS) reported five children who died as the direct result of abuse or neglect by their parents, caretakers, or family members. No child died of abuse or neglect while in the custody of DCFS. One individual receiving services through the Division of Services for People with Disabilities (DSPD) died as a result of complications after suffering an unexplained fall. The Division of Aging and Adult Services/Adult Protective Services (DAAS/APS) conducted an investigation on circumstances relating to an individual who experienced an unexplained fall that eventually resulted in death.

Of the 33 fatalities reported by DCFS, 30 formal committee reviews were held (91%) with no reviews pending. Fifty-four of the 79 reported DSPD fatalities were reviewed (68%), 25 reviews were waived (32%), with no reviews pending. One Division of Juvenile Justice Services (DJJS) fatality was reviewed (100%). On-site reviews were held for eight of the 10 reported Utah State Developmental Center (USDC) fatalities (80%) with two reviews pending. The Utah State Hospital (USH) conducted an on-site review for its one reported fatality (100%).

The deaths of 85 individuals who received services through the Division of Aging and Adult Services (DAAS) were reported. Two individuals (2%) were also receiving services through DSPD during the time they received services through DAAS.

The Office of Public Guardian (OPG) reported the deaths of 12 individuals for whom they provided services. One of these individuals (8%) was also receiving services through DSPD at the time of death. A full committee review was held for this individual. OPG provided the Fatality Review Coordinator with comprehensive written reports detailing services provided by that office and information relating to the deaths of their 12 clients (100%).

The Division of Substance Abuse and Mental Health (DSAMH) is no longer reporting fatality review numbers for Local Authorities to the Department of Human Services. At the conclusion of each fiscal year DSAMH will request Local Authorities report the number of fatality reviews they have completed.

UBHC Clinical Directors agree that fatality reviews should be completed for known deaths of all open clients and for clients who have been discharged within six months of death where the cause of death may have been related in any way to mental health or substance use. Formal fatality reviews continue to be conducted at the Utah State Hospital. There was one individual (.005%) who met the criteria for a formal review from that facility.

There were 100 (46%) reported deaths of male clients and 118 (54%) reported deaths of female clients. Reported deaths included 11 infants (5%) under the age of one year; 32 individuals (15%) between the ages of one to 19 years; 37 individuals (17%) between the ages of 20 and 49 years; 61 individuals (28%) between the ages of 50 and 69 years; 64 individuals (29%) between the ages of 70 and 89 years, and 13 individuals (6%) between the ages of 90 and 100 years. Included in the 218 reported fatalities was one (.005%) Asian, two African Americans (1%), 191 (88%) Caucasians, 18 (8%) Hispanics, one Pacific Islander (.005%), and four American Indians (2%).

**DEPARTMENT OF HUMAN SERVICES  
 DIVISION SUMMARY  
 FY 2016**

DEPARTMENT/DIVISION	Number of Reported Deaths	Cases Open at Time of Death	Committee Reviews Held	Committee Reviews Waived	Reviews Pending	Female	Male
DEPARTMENT OF HUMAN SERVICES	218	188	94	28	2	118	100
DAAS (Division of Aging and Adult Services)	83	81	N/A	N/A	N/A	49	34
DCFS (Division of Child and Family Services)	33	8	30	3	0	15	18
DCFS/DSPD (Division of Child and Family Services/Division of Services for People with Disabilities)	2	2	2	0	0	1	1
DJJS (Division of Juvenile Justice Services )	1	0	1	0	0	0	1
DSPD – COMMUNITY PLACEMENT (Division of Services for People with Disabilities)	74	73	50	24	0	39	35
DSPD/DAAS (Division of Services for People with Disabilities/Division of Aging and Adult Services)	2	2	1	1	0	1	1
DSPD/OPG (Division of Services for People with Disabilities/Office of Public Guardian)	1	1	1	0	0	0	1
OPG (Office of Public Guardian)	11	11	N/A	N/A	N/A	7	4
USDC	10	10	8	0	2	6	4
USH (Utah State Hospital)	1	0	1	0	0	0	1

CHART I  
 FIVE-YEAR COMPARISON  
 FY 2012 – FY 2016

	FY2012	FY2013	FY2014	FY2015	FY2016
DHS Reported Deaths	192	191	214	270	218
DAAS	54	57	73	87	83
DCFS	41	28	35	37	33
DCFS/DSPD	1	1	1	0	2
DCFS/DSAMH	1	0	1	0	0
DJJS	0	1	1	2	1
DJJS/DCFS	0	0	0	0	0
DJJS/DSAMH	1	0	0	1	0
DSAMH	15	18	32	47	0
DSPD	59	64	51	66	74
DSPD/DAAS	2	1	1	1	2
DSPD/DSAMH	0	1	2	1	0
DSPD/OPG	1	4	2	3	1
DSPD/OPG/DSAMH	0	0	1	0	0
OPG	13	11	7	13	11
USDC	3	3	0	6	10
USDC/DAAS	0	0	1	1	0
USDC/OPG	0	1	4	3	0
USH	1	1	1	2	1
USH/DSPD	0	0	1	0	0
Cases Open at Time of Death	157	157	173	238	187
Cases Reviewed	109	105	109	103	96
Abuse & Neglect Deaths	11	6	7	4	7
Accidental Deaths	15	9	16	17	11
Homicides	5	2	6	4	4
Suicides	5	13	7	18	15
Undetermined	11	4	11	10	5

CHART II  
 AGE AT TIME OF DEATH  
 FY 2016

AGE IN YEARS	DHS	DAAS	DCFS	DCFS/ DSPD	DJJS	DSPD	DSPD/ DAAS	DSPD /OPG	OPG	USDC	USH
<1	11		11								
1-3	8		8								
4-6	2		2								
7-10	6		3			3					
11-14	6		4	1		1					
15-19	10		5	1		4					
20-29	13				1	11	1				
30-39	12	2				8			1	1	
40-49	12	2				5			2	2	1
50-59	38	9				25				4	
60-69	23	12				10			1		
70-79	34	19				7	1	1	3	3	
80-89	30	26							4		
90-100	13	13									
TOTALS	218	83	33	2	1	74	2	1	11	10	1

CHART III  
 ACCIDENTAL DEATHS  
 FY 2016

CAUSE OF DEATH	DHS	GENDER	AGE	DIVISION
Asphyxia	3			
Choking		Female	52	DSPD
		Female	54	DSPD
Positional		Female	16 months	DCFS
Falls	3			
Ground-level Fall		Female	77	DAAS
		Female	87	DAAS
Fall from cliff		Male	58	DSPD
Conflagration/Smoke Inhalation - House Fires	2			
		Male	4	DCFS
		Female	57	DSPD
Vehicular Accidents	3			
Auto/Pedestrian		Female	20 months	DCFS
		Female	5	DCFS
Motor Vehicle		Male	54	DSPD
<b>TOTAL</b>	<b>11</b>			

CHART IV  
HOMICIDE DEATHS  
FY 2016

MANNER OF HOMICIDE	DHS	GENDER	AGE	DIVISION
Blunt Force Injuries	1			
		Female	2 months	DCFS
Dehydration due to Neglect	1			
		Female	1	DCFS
Gunshot Wound	2			
		Female	2 months	DCFS
		Male	2	DCFS
TOTAL	4			

CHART V  
SUICIDE DEATHS  
FY 2016

MANNER OF SUICIDE	DHS	GENDER	AGE	DIVISION
Asphyxia (Hanging)	10			
		Female	14	DCFS
		Male	14	DCFS
		Male	14	DCFS
		Male	15	DCFS
		Male	15	DCFS
		Male	15	DCFS
		Male	17	DCFS
		Male	20	DSPD
		Male	25	DSPD
		Male	47	USH
Drug Toxicity	2			
		Female	17	DCFS
		Male	33	DSPD
Gunshot Wound	2			
		Female	14	DCFS
		Male	20	DJJS
Train/Pedestrian	1			
		Male	36	DAAS
TOTAL	15			

CHART VI  
 ABUSE/NEGLECT DEATHS  
 FY 2016

CAUSE OF DEATH	DHS	GENDER	AGE	DIVISION
Asphyxia	1			
		Male	5 months	DCFS
Dehydration	1			
		Female	1	DCFS
Drug Intoxication	1			
		Female	1	DCFS
Falls/Broken Bones	2			
		Male	52	DSPD
		Female	82	DAAS
Gunshot Wound	2			
		Female	2 months	DCFS
		Male	2	DCFS
TOTAL	7			

CHART VII  
 MEDICAL EXAMINER'S DETERMINATION  
 MANNER OF DEATH  
 FY 2016

MANNER OF DEATH	DHS	DAAS	DCFS	DCFS /DSPD	DJJS	DSPD	DSPD /DAAS	DSPD /OPG	OPG	USDC	USH
Accident	11	2	4			5					
Can Not Be Determined	5	1	4								
Homicide	4	1	3								
Natural Causes	172	74	8	1		66	2	1	11	9	
Pending	11	4	5	1						1	
Suicide	15	1	9		1	3					1
TOTALS	218	83	33	2	1	74	2	1	11	10	1

CHART VIII  
 DECEDENT'S RACE  
 FY 2016

RACE	DHS	DAAS	DCFS	DCFS /DSPD	DIJS	DSPD	DSPD /DAAS	DSPD /OPG	OPG	USDC	USH
AMERICAN INDIAN											
Navajo	1		1								
Northern Arapaho	1								1		
Northern Ute	2	1	1								
ASIAN											
Vietnamese	1								1		
AFRICAN AMERICAN	2	1	1								
CAUCASIAN	191	74	23	2	1	70	1	1	8	10	1
HISPANIC											
Argentine	1		1								
Cuban	1		1								
Honduran	1	1									
Mexican	12	5	4			3					
Nicaraguan	2	1							1		
Puerto Rican	1						1				
IRANI/AFGHAN	1		1								
PACIFIC ISLANDER											
Tongan	1					1					
TOTAL	218	83	33	2	1	74	2	1	11	10	1

CHART IX  
 FATALITIES BY DIVISION AND REGION  
 FY 2016

DIVISION OF AGING AND ADULT SERVICES

REGION	TOTAL
Central	42
Eastern	2
Northern	16
Southeast	1
Southern	15
Southwest	7
TOTAL	83

DIVISION OF CHILD AND FAMILY SERVICES

REGION	TOTAL
Eastern	2
Northern	5
Salt Lake Valley	14
Southwest	4
Western	8
TOTAL	33

DIVISION OF SERVICES FOR PEOPLE  
 WITH DISABILITIES  
 COMMUNITY BASED and  
 UTAH STATE DEVELOPMENTAL CENTER (USDC)

REGION	TOTAL
COMMUNITY PLACEMENT	
Central	39
Northern	18
Southern	22
Western	0
TOTAL	
USDC	10
TOTAL	89

**DIVISION OF JUVENILE JUSTICE SERVICES**

REGION	TOTAL
Region I	
	1
TOTAL	1

**OFFICE OF PUBLIC GUARDIAN**

REGION	TOTAL
Central	
Office of Public Guardian	10
Guardianship Associates	1
TOTAL	11

**UTAH STATE HOSPITAL  
 DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH**

REGION	TOTAL
USH	
	1
TOTAL	1

## Chapter 16 Fatality Review Act

### Part 1 General Provisions

#### **62A-16-101 Title.**

This chapter is known as the "Fatality Review Act."

Enacted by Chapter 239, 2010 General Session

#### **62A-16-102 Definitions.**

- (1) "Committee" means a fatality review committee, formed under Section 62A-16-202 or 62A-16-203.
- (2) "Qualified individual" means an individual who:
- (a) at the time that the individual dies, is a resident of a facility or program that is owned or operated by the department or a division of the department;
  - (b)
    - (i) is in the custody of the department or a division of the department; and
    - (ii) is placed in a residential placement by the department or a division of the department;
  - (c) at the time that the individual dies, has an open case for the receipt of child welfare services, including:
    - (i) an investigation for abuse, neglect, or dependency;
    - (ii) foster care;
    - (iii) in-home services; or
    - (iv) substitute care;
  - (d) had an open case for the receipt of child welfare services within one year immediately preceding the day on which the individual dies;
  - (e) was the subject of an accepted referral received by Adult Protective Services within one year immediately preceding the day on which the individual dies, if:
    - (i) the department or a division of the department is aware of the death; and
    - (ii) the death is reported as a homicide, suicide, or an undetermined cause;
  - (f) received services from, or under the direction of, the Division of Services for People with Disabilities within one year immediately preceding the day on which the individual dies, unless the individual:
    - (i) lived in the individual's home at the time of death; and
    - (ii) the director of the Office of Services Review determines that the death was not in any way related to services that were provided by, or under the direction of, the department or a division of the department;
  - (g) dies within 60 days after the day on which the individual is discharged from the Utah State Hospital, if the department is aware of the death; or
  - (h) is designated as a qualified individual by the executive director.

Enacted by Chapter 239, 2010 General Session

### Part 2 Fatality Review

#### **62A-16-201 Initial review.**

- (1) Within seven days after the day on which the department knows that a qualified individual has died, a person designated by the department shall:

- (a) complete a deceased client report form, created by the department; and
  - (b) forward the completed client report form to the director of the office or division that has jurisdiction over the region or facility.
- (2) The director of the office or division described in Subsection (1) shall, upon receipt of a deceased client report form, immediately provide a copy of the form to:
- (a) the executive director; and
  - (b) the fatality review coordinator or the fatality review coordinator's designee.
- (3) Within 10 days after the day on which the fatality review coordinator or the fatality review coordinator's designee receives a copy of the deceased client report form, the fatality review coordinator or the fatality review coordinator's designee shall request a copy of all relevant department case records regarding the individual who is the subject of the deceased client report form.
- (4) Each person who receives a request for a record described in Subsection (3) shall provide a copy of the record to the fatality review coordinator or the fatality review coordinator's designee, by a secure method, within seven days after the day on which the request is made.
- (5) Within 30 days after the day on which the fatality review coordinator or the fatality review coordinator's designee receives the case records requested under Subsection (3), the fatality review coordinator, or the fatality review coordinator's designee, shall:
- (a) review the deceased client report form, the case files, and other relevant information received by the fatality review coordinator; and
  - (b) make a recommendation to the director of the Office of Services Review regarding whether a formal fatality review should be conducted.
- (6)
- (a) In accordance with Subsection (6)(b), within seven days after the day on which the fatality review coordinator or the fatality review coordinator's designee makes the recommendation described in Subsection (5)(b), the director of the Office of Services Review or the director's designee shall determine whether to order that a formal fatality review be conducted.
  - (b) The director of the Office of Services Review or the director's designee shall order that a formal fatality review be conducted if:
    - (i) at the time of death, the qualified individual is:
      - (A) an individual described in Subsection 62A-16-102(2)(a) or (b), unless:
        - (I) the death is due to a natural cause; or
        - (II) the director of the Office of Services Review or the director's designee determines that the death was not in any way related to services that were provided by, or under the direction of, the department or a division of the department; or
      - (B) a child in foster care or substitute care, unless the death is due to:
        - (I) a natural cause; or
        - (II) an accident;
    - (ii) it appears, based on the information provided to the director of the Office of Services Review or the director's designee, that:
      - (A) a provision of law, rule, policy, or procedure relating to the deceased individual or the deceased individual's family may not have been complied with;
      - (B) the fatality was not responded to properly;
      - (C) a law, rule, policy, or procedure may need to be changed; or
      - (D) additional training is needed;
    - (iii) the death is caused by suicide; or
    - (iv) the director of the Office of Services Review or the director's designee determines that another reason exists to order that a formal fatality review be conducted.

Amended by Chapter 343, 2011 General Session

**62A-16-202 Fatality Review Committee for a deceased individual who was not a resident of the**

**Utah State Hospital or the Utah State Developmental Center.**

(1) Except for a fatality review committee described in Section 62A-16-203, the fatality review coordinator shall organize a fatality review committee for each formal fatality review that is ordered to be conducted under Subsection 62A-16-201(6).

(2) Except as provided in Subsection (5), a committee described in Subsection (1):

(a) shall include the following members:

(i) the department's fatality review coordinator, who shall designate a member of the committee to serve as chair of the committee;

(ii) a member of the board, if there is a board, of the relevant division or office;

(iii) the attorney general or the attorney general's designee;

(iv)

(A) a member of the management staff of the relevant division or office; or

(B) a person who is a supervisor, or a higher level position, from a region that did not have jurisdiction over the qualified individual; and

(v) a member of the department's risk management services; and

(b) may include the following members:

(i) a health care professional;

(ii) a law enforcement officer; or

(iii) a representative of the Office of Public Guardian.

(3) If a death that is subject to formal review involves a qualified individual described in Subsection 62A-16-102(2)(c) or (d), the committee may also include:

(a) a health care professional;

(b) a law enforcement officer;

(c) the director of the Office of Guardian ad Litem;

(d) an employee of the division who may be able to provide information or expertise that would be helpful to the formal review; or

(e) a professional whose knowledge or expertise may significantly contribute to the formal review.

(4) A committee described in Subsection (1) may also include a person whose knowledge or expertise may significantly contribute to the formal review.

(5) A committee described in this section may not include an individual who was involved in, or who supervises a person who was involved in, the fatality.

(6) Each member of a committee described in this section who is not an employee of the department shall sign a form, created by the department, indicating that the member agrees to:

(a) keep all information relating to a fatality review confidential; and

(b) not release any information relating to a fatality review, unless required or permitted by law to release the information.

Enacted by Chapter 239, 2010 General Session

**62A-16-203 Fatality Review Committees for a deceased resident of the Utah State Hospital or the Utah State Developmental Center.**

(1) If a qualified individual who is the subject of a formal fatality review that is ordered to be conducted under Subsection 62A-16-201(6) was a resident of the Utah State Hospital or the Utah State Developmental Center, the fatality review coordinator of that facility shall organize a fatality review committee to review the fatality.

(2) Except as provided in Subsection (4), a committee described in Subsection (1) shall include the following members:

(a) the fatality review coordinator for the facility, who shall serve as chair of the committee;

(b) a member of the management staff of the facility;

(c) a supervisor of a unit other than the one in which the qualified individual resided;

(d) a physician;

(e) a representative from the administration of the division that oversees the facility;

- (f) the department's fatality review coordinator;
  - (g) a member of the department's risk management services; and
  - (h) a citizen who is not an employee of the department.
- (3) A committee described in Subsection (1) may also include a person whose knowledge or expertise may significantly contribute to the formal review.
- (4) A committee described in this section may not include an individual who:
- (a) was involved in, or who supervises a person who was involved in, the fatality; or
  - (b) has a conflict with the fatality review.

Enacted by Chapter 239, 2010 General Session

#### **62A-16-204 Fatality Review Committee Proceedings.**

- (1) A majority vote of committee members present constitutes the action of the committee.
- (2) The department shall give the committee access to all reports, records, and other documents that are relevant to the fatality under investigation, including:
- (a) narrative reports;
  - (b) case files;
  - (c) autopsy reports; and
  - (d) police reports, unless the report is protected from disclosure under Subsection 63G-2-305(10) or (11).
- (3) The Utah State Hospital and the Utah State Developmental Center shall provide protected health information to the committee if requested by a fatality review coordinator.
- (4) A committee shall convene its first meeting within 14 days after the day on which a formal fatality review is ordered under Subsection 62A-16-201(6), unless this time is extended, for good cause, by the director of the Office of Services Review.
- (5) A committee may interview a staff member, a provider, or any other person who may have knowledge or expertise that is relevant to the fatality review.
- (6) A committee shall render an advisory opinion regarding:
- (a) whether the provisions of law, rule, policy, and procedure relating to the deceased individual and the deceased individual's family were complied with;
  - (b) whether the fatality was responded to properly;
  - (c) whether to recommend that a law, rule, policy, or procedure be changed; and
  - (d) whether additional training is needed.

Amended by Chapter 445, 2013 General Session

### **Part 3 Reporting and Review**

#### **62A-16-301 Fatality review committee report -- Response to report.**

- (1) Within 20 days after the day on which the committee proceedings described in Section 62A-16-204 end, the committee shall submit:
- (a) a written report to the executive director that includes:
    - (i) the advisory opinions made under Subsection 62A-16-204(6); and
    - (ii) any recommendations regarding action that should be taken in relation to an employee of the department or a person who contracts with the department;
  - (b) a copy of the report described in Subsection (1)(a) to:
    - (i) the director, or the director's designee, of the office or division to which the fatality relates; and
    - (ii) the regional director, or the regional director's designee, of the region to which the fatality relates; and
  - (c) a copy of the report described in Subsection (1)(a), with only identifying information redacted, to

the Office of Legislative Research and General Counsel.

(2) Within 20 days after the day on which the director described in Subsection (1)(b)(i) receives a copy of the report described in Subsection (1)(a), the director shall provide a written response to the director of the Office of Services Review and a copy of the response, with only identifying information redacted, to the Office of Legislative Research and General Counsel, if the report:

- (a) indicates that a law, rule, policy, or procedure was not complied with;
- (b) indicates that the fatality was not responded to properly;
- (c) recommends that a law, rule, policy, or procedure be changed; or
- (d) indicates that additional training is needed.

(3) The response described in Subsection (2) shall include a plan of action to implement any recommended improvements within the office or division.

(4) Within 30 days after the day on which the executive director receives the response described in Subsection (2), the executive director, or the executive director's designee shall:

- (a) review the plan of action described in Subsection (3);
- (b) make any written response that the executive director or the executive director's designee determines is necessary;
- (c) provide a copy of the written response described in Subsection (4)(b), with only identifying information redacted, to the Office of Legislative Research and General Counsel; and
- (d) provide an unredacted copy of the response described in Subsection (4)(b) to the director of the Office of Services Review.

(5) A report described in Subsection (1) and each response described in this section is a protected record.

(6) (a) As used in this Subsection (6), "fatality review document" means any document created in connection with, or as a result of, a fatality review or a decision whether to conduct a fatality review, including:

- (i) a report described in Subsection (1);
- (ii) a response described in this section;
- (iii) a recommendation regarding whether a fatality review should be conducted;
- (iv) a decision to conduct a fatality review;
- (v) notes of a person who participates in a fatality review;
- (vi) notes of a person who reviews a fatality review report;
- (vii) minutes of a fatality review;
- (viii) minutes of a meeting where a fatality review report is reviewed; and
- (ix) minutes of, documents received in relation to, and documents generated in relation to, the portion of a meeting of the Health and Human Services Interim Committee or the Child Welfare Legislative Oversight Panel that a fatality review report or a document described in this Subsection (6)(a) is reviewed or discussed.

(b) A fatality review document is not subject to discovery, subpoena, or similar compulsory process in any civil, judicial, or administrative proceeding, nor shall any individual or organization with lawful access to the data be compelled to testify with regard to a report described in Subsection (1) or a response described in this section.

- (c) The following are not admissible as evidence in a civil, judicial, or administrative proceeding:
- (i) a fatality review document; and
  - (ii) an executive summary described in Subsection 62A-16-302(4).

Amended by Chapter 343, 2011 General Session

#### **62A-16-302 Reporting to, and review by, legislative committees.**

(1) The Office of Legislative Research and General Counsel shall provide a copy of the report described in Subsection 62A-16-301(1)(b), and the responses described in Subsections 62A-16-301(2) and (4)(c) to the chairs of:

- (a) the Health and Human Services Interim Committee; or
  - (b) if the individual who is the subject of the report was, at the time of death, a person described in Subsection 62A-16-102(2)(c) or (d), the Child Welfare Legislative Oversight Panel.
- (2)
- (a) The Health and Human Services Interim Committee may, in a closed meeting, review a report described in Subsection 62A-16-301(1)(b).
  - (b) The Child Welfare Legislative Oversight Panel shall, in a closed meeting, review a report described in Subsection (1)(b).
- (3)
- (a) Neither the Health and Human Services Interim Committee nor the Child Welfare Legislative Oversight Panel may interfere with, or make recommendations regarding, the resolution of a particular case.
  - (b) The purpose of a review described in Subsection (2) is to assist a committee or panel described in Subsection (2) in determining whether to recommend a change in the law.
  - (c) Any recommendation, described in Subsection (3)(b), by a committee or panel for a change in the law shall be made in an open meeting.
- (4)
- (a) On or before September 1 of each year, the department shall provide an executive summary of all fatality review reports for the preceding state fiscal year to the Office of Legislative Research and General Counsel.
  - (b) The Office of Legislative Research and General Counsel shall forward a copy of the executive summary described in Subsection (4)(a) to:
    - (i) the Health and Human Services Interim Committee; and
    - (ii) the Child Welfare Legislative Oversight Panel.
- (5) The executive summary described in Subsection (4):
- (a) may not include any names or identifying information;
  - (b) shall include:
    - (i) all recommendations regarding changes to the law that were made during the preceding fiscal year under Subsection 62A-16-204(6);
    - (ii) all changes made, or in the process of being made, to a law, rule, policy, or procedure in response to a fatality review that occurred during the preceding fiscal year;
    - (iii) a description of the training that has been completed in response to a fatality review that occurred during the preceding fiscal year;
    - (iv) statistics for the preceding fiscal year regarding:
      - (A) the number and type of fatalities of qualified individuals that are known to the department;
      - (B) the number of formal fatality reviews conducted;
      - (C) the categories, described in Subsection 62A-16-102(2) of qualified individuals who died;
      - (D) the gender, age, race, and other significant categories of qualified individuals who died; and
      - (E) the number of fatalities of qualified individuals known to the department that are identified as suicides; and
    - (v) action taken by the Office of Licensing and the Bureau of Internal Review and Audits in response to the fatality of a qualified individual; and
  - (c) is a public document.
- (6) The Division of Child and Family Services shall, to the extent required by the federal Child Abuse Prevention and Treatment Act, as amended, allow public disclosure of the findings or information relating to a case of child abuse or neglect that results in a child fatality or near fatality.