STATE OF RHODE ISLAND
OFFICE OF THE CHILD ADVOCATE

Report of the

CHILD FATALITY REVIEW PANEL

A REVIEW OF FOUR CHILD FATALITIES AND TWO NEAR FATALITIES

MARCH, 2017

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PREFACE

The Office of the Child Advocate is tasked with the responsibility of reviewing the fatality or near fatality of a child, when the child was involved or recently involved with the Department of Children, Youth and Families I would like to express my great appreciation and gratitude for the hard work and commitment of the Child Fatality Review Panel who made the timely completion of this report possible, including:

Darlene Allen, MS

Kathryn R. Cortes

Molly Kapstein Cote, Esquire

Ken Fandetti, MS

Janet Gilligan, Esquire

Lisa Guillette

Detective Michael Iacone

Katelyn Medeiros, Esquire

Adam Pallant, MD

I would also like to acknowledge my dedicated and loyal employees, Kathryn Cortes and Katelyn Medeiros, who have worked so diligently over this last year to ensure that this office fulfills its statutory mandate. Thank you to all members of the panel for your continued commitment to improving the safety and well-being of children in the State of Rhode Island.

Sincerely,

Jennifer Griffith, Esquire
Child Advocate

INTRODUCTION

The Office of the Child Advocate (hereinafter "OCA") is tasked with the responsibility of reviewing any child fatality or near fatality where a child was in the care and custody of the Department of Children, Youth and Families or the child's family had recent contact with the Department of Children, Youth and Families (hereinafter "DCYF" or "Department"). The OCA may also complete a review of a fatality or near fatality when "[a] sibling, household member, or day care provider has been the subject of a child abuse and neglect investigation within the previous twelve (12) months…" The expectations of this office subsequent to notification of a child fatality or near fatality were delineated and expanded upon in the last legislative session. This was codified in *Rhode Island General Laws § 42-73-2.3* and *Rhode Island General Laws § 42-73-6*. This legislation was signed in to affect by Governor Gina Raimondo on July 6, 2016. Acting upon the authority granted by this legislation, the OCA initiated an extensive review of four (4) child fatalities and two (2) near fatalities, starting in October 2016.

Pursuant to *R.I.G.L. § 42-73-2.3* (e), which requires "[t]he child advocate … [to] publically announce the convening of a child-fatality-review panel, including the age of the child involved", the OCA issued its initial Press Release on October 27, 2016, announcing the convening of the child-fatality-review panel. The release disclosed that the fatality of a seven (7) month-old and near fatality of another seven (7) month-old child was under review. On December 28, 2016, the OCA issued another Press Release announcing the expansion of the review to include the fatality of a two (2) month-old infant. On January 5, 2017, the OCA issued a third Press Release announcing that the review would be expanded once again to encompass the near fatality of an eighteen (18) month-old infant. Unfortunately, the OCA issued a fourth and final Press Release on February 22, 2017, announcing that the review would be expanded upon again to include the recent fatality of a seven (7) month-old infant and the fatality of a two (2) month-old infant.

The intent of this report is not to denigrate the tireless efforts of the frontline workers at the Department of Children, Youth and Families or any other public or private organization that serves children in Rhode Island. The OCA and the child fatality review panel are cognizant of the hard work and dedication of those seeking to provide care and support to the children and families of Rhode Island who are in need. The OCA also recognizes the internal and external challenges these workers are faced with each day in the performance of their duties. The purpose of this report is to better inform the public of the challenges presented by the child welfare system, to identify

inefficiencies within the system posing a risk to the children of this state, and to better inform systemic change.

This reports constitutes a public record under Rhode Island General Laws 30-2-(d)(16). The names of the individuals involved have been omitted or altered to protect the identity of those involved and in in conformance with both the Office's confidentiality obligation mandated by Rhode Island General Laws 42-73-1 et seq.

The panel reviewed thousands of pages of documents and analyzed each case in great detail. This comprehensive report is the result of countless hours of investigation, research, review and discussion of the cases, policies, statutes and other relevant materials. Upon completing this extensive review, the Child Fatality Review Panel composed the recommendations included in this report with the intent of effectuating systemic change necessary to ensure the safety and well-being of all children involved with the Department.

THE CASES REVIEWED

The Child Fatality Review Panel reviewed six cases between October 12, 2016 and March 1, 2017. Four of the cases involved a child fatality and two involved near-fatalities, as defined by R.I.G.L. §42-42-8(c)(1) (*See Appendix B for full policy*). All six families were known by DCYF due to previous Child Protective Services (CPS) reports or prior case openings. In three cases, the parents and/or caretakers involved reported histories of CPS and/or DCYF involvement as children.

The cases reviewed included children ranging in age from two (2) months old to eighteen (18) months old. All four fatalities had a family history of involvement with DCYF and/or CPS Department. Both near fatalities involved cases of alleged child abuse and both had previous involvement with DCYF and the CPS Unit.

Although none of the cases were actively open at the time of the fatality or near-fatality, there were multiple risk factors present in each of the cases including but not limited to, previous DCYF contact, housing instability, inadequate housing, parental mental health issues, domestic violence and substance abuse. It is significant to mention that in all four of the cases involving child fatalities, CPS had been contacted regarding the families prior to the child fatality occurring, with concerns from either close family members, friends, hospital staff or police. Unfortunately, these calls were not investigated by CPS. The families resided in four separate communities in Rhode Island and were of diverse ethnicities and different genders. Four (4) out of twelve (12) of the parents involved had a prior criminal history, as adults.

I. FATALITIES

In the first case under review, an infant death was reported to DCYF after the infant was found unresponsive in bed with a caretaker. The infant was transported to the hospital where the baby was pronounced dead. This was the fifth report to CPS regarding the safety and well-being of this infant within six (6) months. One of the five reports made to CPS was investigated and indicated for Neglect after a caretaker admitted to drinking alcohol and dropping the baby. This case closed to DCYF one month later, despite on-going concerns, including struggles with mental health and substance abuse on the part of a parent. None of the reports made to CPS were investigated and instead were categorized as "Information/Referral Reports" (I/R). The allegations in all reports suggested parental substance use, and concerns for injuries due to the baby being dropped multiple times, neglect, possible failure to thrive and inappropriate/inadequate housing. Additional concerns surrounding depression and self-medication had been brought to the attention of the CPS Unit in this case, with little to no follow-up.

A second child death involving an infant was reported to DCYF after being found unresponsive in bed with a caretaker. The infant was transported to the hospital where the child was pronounced dead. This was the second CPS report on this child and the investigation was still pending as of February 27, 2017. The first report was initiated when the hospital reported mother admitted to smoking marijuana and using an anti-depressant/anti-anxiety medication throughout her pregnancy. A CPS investigation resulted in the findings being deemed unfounded, despite mother admitting to marijuana use during pregnancy, father admitting to regular marijuana use, and the newborn baby missing a follow-up medical visit. Additionally it is noted by the CPS Unit that mother has a history of depression, anxiety, cigarette use and marijuana use. Additionally, Mother was not actively engaged with or following up with a mental health provider as recommended.

In the third case under review, the death of an infant was reported to DCYF by the Medical Examiner's Office after the baby was transported to the Hospital. No further information was provided. DCYF did not initiate an investigation into this infant's death, and logged this matter as an I/R. This was logged as an I/R despite the family having a history with the CPS Unit and identified family risk factors including but not limited to, substance abuse, potential past domestic violence, inadequate housing and another child in the home under the age of eighteen (18) months. Additionally, this family had a recent CPS investigation involving their eighteen (18) month old child within the past eight (8) months due to concerns of parental neglect and/or abuse. The investigation was determined by the CPS Unit to be unfounded/unsubstantiated and the case was closed. There is no record or indication of any kind of support services or community service referrals offered to assist the family.

The fourth case under review involved an the death of an infant reported to DCYF by the Medical Examiner's Office after the baby was transported to the hospital and subsequently pronounced dead. This was the third CPS report involving this child. Two prior calls had been placed to the CPS Unit with concerns regarding drug abuse and parent's ability to properly care for the baby. The investigations were determined by the CPS Unit to be unfounded/ unsubstantiated and the case was closed. There is no record or indication of any type of support services or community services referrals were offered to assist the family.

II. NEAR FATALITIES

In one of the cases reviewed, a report was made to the CPS Unit informing DCYF that a baby presented at the hospital with suspicious bruises and injuries. The infant was evaluated and diagnosed with a Subgaleal Hematoma in addition to multiple skull fractures. Several skeletal

surveys were completed. The infant sustained complex branching skull fractures, traumatic head injuries, liver inflammation and other physical trauma affecting multiple organs, systems and body parts. The doctor reports the injuries and physical findings are consistent with child physical abuse and abusive head trauma. This was the second CPS report alleging concerns about the safety of the child. The first report, which was two (2) weeks prior, was not investigated and was categorized as an Information and Referral report.

In the second near fatality reviewed by the panel, a report was made to the CPS Department by the hospital after a child under the age of two (2) presented to the ER with extensive and suspicious burns on multiple areas of his body. The child received burns over sixteen percent (16%) of their body and required immediate surgery. A CPS investigation was initiated and is still pending as of March 8, 2017.

DISCUSSION AND FINDINGS

I. CHILD PROTECTIVE SERVICES (CPS)

The Rhode Island Department of Children, Youth and Families (DCYF) provides that their Child Welfare Services Program Mission is to,

> *"Ensure that each child and youth is protected from harm through the timely investigation of reports of child abuse and neglect. Maintain children and youth safely at home whenever possible through formal and informal supports and services, utilizing family and community partnerships, in order to mitigate risk and threats against safety. Safeguard the well-being of each child in a stable, permanent home in partnership with family, community and networks of care. Through these formal and informal resources, make certain that older youth are afforded optimal opportunities for successful transitions to adulthood."*

This mission is realized through the implementation of their Child Welfare Services Program, which is describe by DCYF as being,

> *"… comprised of several sub-divisions working in partnership with each other, family and community, and other divisions of the Department to ensure safety, permanency and well-being for each child. Child Protective Services (CPS) investigations received, screens and responds to reports of suspected child maltreatment. Investigations which result in the Department seeking legal status are assigned to Child Protective Services Intake in order to gather additional information before assigning the family to a Family Service Worker who works with the family toward a permanency goal in partnership with family and community in our networks of care. Child Protective Services also refers families whose children are at risk for maltreatment or who suffer from serious emotional or developmental needs to family and community supports such as the Family and*

Community Care Partnership (FCCP) in order to divert them from further DCYF involvement…"

The mission statement and the program model for the Department, indicate that the Child Protective Services Unit functions as the "gatekeeper" for child welfare services. All cases are initially reviewed, assessed and screened by CPS to determine what the most appropriate next steps are for the family. Does the case meet the criteria for an investigation? Will the family need additional supports or services? Or does the case warrant legal intervention? These crucial questions are initially answered by CPS. However, following an extensive review of current policies, protocols and actions taken by CPS it became evident that this system is not functioning properly, leaving children unattended to and at risk.

The Child Fatality Review Panel examined numerous case history files, police reports, medical records and other pertinent information associated with the six (6) cases under review. Additionally, the Panel reviewed extensive data and information regarding overall best practices within Child Protective Service Units. The Panel identified numerous questions and deep-rooted concerns regarding the current practices of CPS. To remediate the systemic issues currently plaguing CPS, the State of Rhode Island will need to complete an exhaustive review and assessment of the current system. Upon completion of this review, it is incumbent upon the State of Rhode Island to facilitate a complete overhaul of the current system to better align the model with national best practice standards and to ensure that our child welfare system delivers consistency when it pertains to the assessment of risk and protection of children.

a. Lack of Standardized Intake Process

In accordance with DCYF policies a CPS investigation is initiated when a report that meets the Investigation Criteria set forth in *DCYF Policy 500.0010* (*see Appendix C*) is made to the Child Abuse and Neglect Hotline. The Panel reviewed the criteria set forth in the DCYF Policies as well as the Rhode Island General Laws, which governs the Department in regards to child abuse and neglect. Upon careful review of the Investigation Criteria, and R.I.G.L. § 40-11-2 (*see Appendix C*) it was evident the CPS Unit does not consistently, adequately or judiciously follow the law or their own policies and associated procedures.

While the mission, definitions, criteria, policies and procedures are clearly identified and outlined by DCYF, it became evident these were not followed regularly or consistently and investigations were not initiated despite meeting the relevant criteria. Each of the six (6) cases under review presented with numerous risk factors for the victims and their families. Even though the allegations fit the criteria and standards for an investigation, many of the calls were placed in

the category of an Information/Referral (I/R). According to *DCYF Policy 500.0040*, *"[a] report made to the Child Protective Services (CPS) Hotline that contains a concern about the well-being of a child but does not meet the criteria for an investigation… may be classified as an Information/Referral (I/R) Report.*" (*See Appendix C for full policy*) The prior calls made regarding these families, which were categorized as an I/R involved reports such as inadequate housing and substance abuse by parents, which in accordance with DCYF policies and state law, should have prompted an investigation, not an I/R report.

It was apparent that each call into the hotline, was treated as a unique call, with little to no regard for the case history, prior family or individual involvement with DCYF. The family and case history, the age of the children involved and the presenting risk factors should be considered when determining the most appropriate subsequent response when a call is placed to the hotline. However, presently there is no identified risk assessment or standard practice followed by call floor workers when taking calls to determine the next steps, and each decision of whether to investigate or to categorize the call as an I/R appeared to be based on the opinions of the individual CPS worker. This has provided for inconsistent and inadequate results within CPS. This presented as a major concern for the Panel after numerous calls placed to the hotline, meeting the criteria for an investigation were categorized as an I/R Report and no further action was taken. Each of these calls relayed concerns which could jeopardize the well-being of the infants involved. When the calls were made an I/R there was no additional follow-up by CPS staff to ensure the well-being of these children. Many of these calls remained categorized as an I/R despite the fact that additional information and allegations regarding the families was provided to CPS, which should have prompted further action. Examples of information provided include, a new mother with a history of substance abuse, alcohol abuse, history of domestic violence, mother's admission to struggling with depression and possible failure to thrive of an infant.

Additionally, in some of the cases under review, there were prior calls to the Department where investigations were completed and indicated. Regardless, subsequent calls to the Hotline were still made an I/R, with no follow-up by CPS to ensure the well-being of the child, despite a past history with the Department and despite the call meeting the criteria for an investigation. Also, in the cases where the Department investigated and indicated parents for allegations of abuse or neglect they subsequently provided service referrals, however, there was little to no verification by the Department to ensure that parents were engaged in services or attending appointments as self-reported by parents. This was an issue cited by the March 2016 OCA Child Fatality Review Panel and remains an on-going issue to date. Furthermore, in some of the cases under review continued

concerns were reported by providers, including additional risk factors such as substance abuse and concerns with the mental health of the parents. Despite receiving this additional information, the Department closed cases instead of continuing their involvement to ensure the well-being and safety of the child or children.

Furthermore, in multiple cases under review, there was admitted drug use by mothers during their pregnancy and subsequent to the delivery of their child. Pursuant to *DCYF Policy 500.0125 (see Appendix C for policy)*, in any case where there is confirmed drug use by a mother during pregnancy, at a minimum, the Department should provide the family with services and complete legal consult to determine whether additional legal action should be taken. In the cases under review, this policy was not adhered to and the Department failed to take the appropriate steps on behalf of these families and children. Additionally, calls to the Hotline were unfounded although parents admitted to illegal drug and alcohol use while caring for their infants and children. An investigation that is unsubstantiated by the CPS Unit is closed and no further follow up is provided to the family or child.

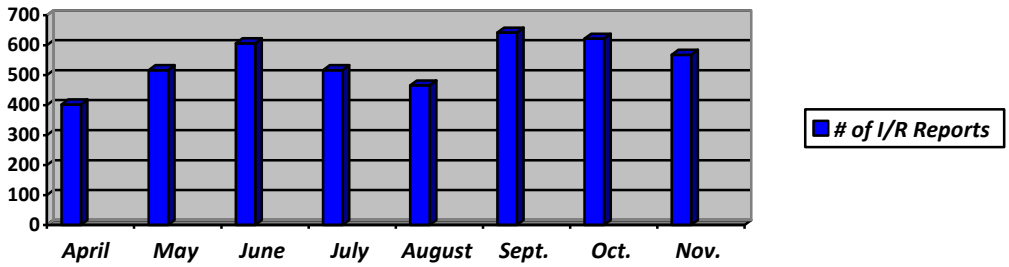
The inconsistencies between the calls and the response by the CPS Unit is extremely alarming and will require a comprehensive examination and overhaul of the practices and policies of CPS. During the March 2016 Child Fatality Review, the Panel cited similar concerns regarding the lack of a comprehensive and meaningful safety and risk assessment. When these concerns were cited in the previous review, CPS reported that they would be shifting towards the use of the evidence-based approach called the Structured Decision Making (SDM) Model. However, to date, there is no evidence that this model has in fact been implemented in its entirety or is being utilized by all CPS Workers. Moreover it has been reported that only a portion of the SDM will be or is being used, which would provide ineffective results as the entire evidence-based model must be implemented to be effective. Lack of utilization of a standardized risk assessment when evaluating each call has resulted in inconsistent responses by CPS, leaving many unknown variables, inadequate assessments of risk in the home and an inappropriate level of response by CPS. At the very least, in the cases under review, the potential victims identified were infants with little to no ability to protect themselves; these children should have been observed by a CPS investigator to ensure that the child is safe. It is reasonable to believe that had a standardized practice or evidence-based risk assessment been implemented and adhered to many of these calls would have become investigations.

This categorization of Information/ Referral was unquestionably over-utilized leaving many babies and children in high risk and detrimental situations. This prompted a more in-depth investigation by the OCA regarding the use of the Information/Referral policy.

b. Improper Application and Overuse of the Information/Referral Policy

The consistent over use and improper application of the Information/Referral Policy, including in the cases under review, prompted a more in-depth review of its utilization by CPS. According to *DCYF Policy 500.0040*, *"[a] report made to the Child Protective Services (CPS) Hotline that contains a concern about the well-being of a child but does not meet the criteria for an investigation… may be classified as an Information/Referral (I/R) Report."* (*See Appendix C for full policy*) Unfortunately, calls to the Child Abuse and Neglect Hotline have been routinely categorized as an I/R Report even though in accordance with DCYF policies, they should have been investigated. In many cases, this has left young children at risk, with no follow-up or "eyes on" the child to ensure their safety or well-being. In addition, this has skewed the data provided to various entities on both a state and federal level, specifically with respect to re-maltreatment rates.

In an effort to better illustrate the wide spread and negative impact this is having on the child welfare system, the OCA staff analyzed the use of this policy over an eight (8) month period. From April 7, 2016 through November 30, 2016, ***four thousand, three hundred and forty (4,340) calls*** to the Child Abuse and Neglect Hotline were classified as an Information/Referral (I/R) Report.



The OCA reviewed a sample of these calls from each month. In total, the staff evaluated two thousand and fifty-six (2,056) calls; a little less than half of the total I/R reports. The calls were assessed through the application of relevant DCYF policies, outlining the criteria for an investigation. In addition, the OCA staff reviewed other pertinent case information if there was prior contact with DCYF. Upon completion of this review, it was determined that four hundred and

eighty-six (486) or ***twenty-four percent (24%) of the sample*** should not have been categorized as an I/R Report; each of these cases met the criteria for an investigation. Each of these 486 missed investigations were further analyzed. When reviewing each call, the staff noted if the call was made by a professional reporter, which includes but is not limited to, medical professionals, law enforcement, judges, social workers, teachers and school administrators. Additionally, the staff determined whether the call involved a child under the age of six (6). This is of importance as children under six (6) lack the ability to adequately protect themselves, therefore, making them the most vulnerable population. Lastly, the cases were reviewed to determine whether the family had been previously indicated for abuse or neglect. It was determined that ***seventy-four percent (74%)*** of the 486 missed investigations involved calls made by a professional reporter. In ***fifty-nine percent (59%)*** of these cases, calls were made regarding families who were previously indicated for child abuse or neglect. Lastly, ***forty-six percent (46%)*** of these cases involved a child under the age of six (6) years-old. Callers reported cases involving physical abuse, sexual abuse and various forms of neglect.

Also, the CANTS system was originally created to separate the provision of service from the completion of investigations. The Panel strongly cautions against the practice often utilized by CPS of immediately diverting Hotline calls to other Units within DCYF. By utilizing this practice, it has the potential to keep children in unsafe situations and/or places without a proper assessment by CPS staff.

It was previously reported to the OCA by CPS Administration, that the Information/Referral Policy was developed to provide for more immediate action or additional oversight in cases that would not have previously been provided under the prior "Early Warning" policy. Under the Early Warning policy, CPS would be dispatched to a home to assess the safety and well-being of a child after receipt of three (3) calls regarding the same family, which may have not met the criteria for an investigation. However, after reviewing cases in which calls regarding the family were categorized as an Information/Referral, it was discovered that under the operation of this policy, there was less action and oversight by CPS, leaving children at risk. The accumulation of reports by multiple and professional reporters is a continued concern. In countless cases, numerous calls were made regarding a family, with each of the calls being categorized as an I/R Report, prompting no response by CPS or the Department to ensure the safety and well-being of the children involved. In some of these cases, under the Early Warning Policy, CPS would have responded to the home as many as four (4) times. To illustrate just how detrimental this practice is here is a synopsis of several cases:

Case Examples of I/R's with noted Risk Factors

Family A: Family with a lengthy DCYF history, had five (5) calls into the Hotline within three months. All calls were recorded as an I/R with no follow up. Calls placed to the Hotline came from various reporters, including but not limited to; family members, DCYF workers and family friends. Calls related to concerns regarding mother who was previously known to DCYF as a child. Mother has noted developmental disabilities and the concerns involved her five (5) children all under the age of seven (7) years old. Mother had another child that was adopted at birth and lives out of state. Callers identified issues of cleanliness with the children, cleanliness with the home, and mother's live-in boyfriend with a lengthy violent criminal history, substance abuse history, violation of No Contact Orders, and past reports of inappropriate sexualized behaviors with children. Five (5) calls were placed within a three (3) month period with no follow up to check on the children. Several months later, the local police placed a call to the Hotline after responding to the family home for a domestic disturbance. Police report numerous people in the home, including all five (5) children when a fight broke out. Mother's boyfriend was charged with domestic assault and all children were home at the time of the assault. DCYF investigated this latest call and it was indicated against mother's boyfriend. Mother agreed to not allow him around her children anymore, and DCYF closed the case.

Family B: Family has a lengthy history with DCYF. Mother and father were indicated for medical neglect several years ago for medical neglect of their infant child. The reporter was a medical provider for the family. At the time of this investigation the family was allegedly living in a hotel, but was also listed as living at Crossroads Homeless Shelter. Eventually the family was located and a current address identified. Father has a significant criminal history and mother has a significant history of untreated mental health issues. This family was indicated and the case was closed. Subsequently, four calls were placed within a four (4) month period by law enforcement personnel, hospital personnel, close family contacts and school personnel with concerns for the children and family, all of which were documented as an I/R. Calls made to the Hotline referred to concerns of warrants of arrest for both parents, deplorable living conditions, electricity being routed via an extension cord from an outdoor power box, which was subsequently unplugged, leaving the family without any electricity. Another call and I/R was from a local hospital reporting injuries of a child by another child, however no concerns of abuse were noted. The final and most recent I/R was by elementary school personnel reporting one of the children has missed more than twenty-five (25) days of school and is unable to locate the family. Again this report was made an I/R with no follow up to locate the children and or family.

Family C: Five (5) calls were placed to the Hotline, within a two (2) week period and all were recorded as an I/R. Calls to the Hotline were made by social workers, a doctor, a psychiatrist and a psychologist, with reports of alleged physical abuse, sexual abuse and a suicide attempt of a teenager. No investigations were initiated by DCYF as the teenager did not have physical marks of abuse. Additionally, a note in the file by the unit supervisor indicated the child made allegations of consensual sex then recanted and claimed it was forced. Furthermore, the note indicated that the child is described as having several mental health issues and is receiving treatment, therefore no investigation was needed. Once doctor described teenager's suicide attempt as a definite result of the physical abuse, and the family is in need of services. Still, no investigation was initiated and it is unclear if services were ever provided for this family.

These are just several examples of the hundreds of cases we have flagged involving families with multiple calls to the Hotline in a short period of time, relaying numerous risk factors and claims of abuse and neglect, with no follow through by CPS.

c. Classification of a Child Death as an Information/Referral

Highly concerning to this Panel was the categorization of an infant death as an Information/Referral. An infant death was reported to DCYF by the Medical Examiner's Office after being transported to the Hospital. While no outward signs of abuse or neglect were reported, it is disturbing that the Department did not initiate an investigation into the death of an infant despite the family being known to the Department. The CPS Unit has documented and identified risk factors for this family including but not limited to, substance abuse, domestic violence and inadequate housing. Additionally, this family has another young child in the home. The classification of a child death as an Information/Referral illustrates a blatant disregard of DCYF policies and Rhode Island General Law.

In accordance with DCYF Policy 500.0050, 500.0010 and R.I.G.L. § 40-11-3, the reported death of a child should prompt an immediate investigation. (*See Appendix C for complete statute and polices*) Unfortunately, this practice has been utilized in more than one case. In fact, the OCA discovered the categorization of two infant deaths as an I/R in the same day. One is the matter included in this review; the second did not meet the criteria to be reviewed by the Panel. The OCA requested, in writing, that the Department initiate investigations in both matters, in accordance with DCYF policies and state law. The Department prompted an investigation into one of the cases, however, they have failed to initiate an investigation into the child death recently incorporated into the Panel's review. This is despite the family's prior history with the Department and the presence

of another child in the home. The investigations of a child fatality prompt an immediate response, providing CPIs with the opportunity to be on scene directly after the incident occurred to collect pertinent information and make crucial observations. Even a delayed response will place the CPI at a disadvantage when completing their investigation.

Additionally, in other cases, past reports of child fatalities have been subsequently categorized as an I/R following the completion of an investigation. Although there may have been no substantiated findings of abuse or neglect, as a policy, these significant events should not be then cloaked as an I/R. When reviewing a case file in the RICHIST database, it should be readily apparent to anyone quickly reviewing the matter that a previous death has occurred within the family. Additionally, by categorizing such significant calls within this "catch-all" category, it is unclear whether this will in any way affect the reports or data generated by the Department regarding child fatalities.

II. SIDS and Other Sleep-Related Infant Deaths

All four of the infant fatalities occurred while the infant was in bed (co-sleeping) with one or more caretakers at the time of death. Although each of these cases involved prior involvement with DCYF and had regular visits with their pediatrician it is unclear if safe sleep practices and guidelines were discussed with these families.

The American Academy of Pediatrics recommends eighteen (18) recommendations to reduce the risks of SIDS and other sleep-related infant deaths. Some of these recommendations include:

a. Back to sleep for every sleep. Infants should be placed back to sleep in a supine position (wholly on the back) for every sleep, until the child reaches one year of age.
b. Use a firm sleep surface such as a mattress in a safety approved crib. This surface should be covered by a fitted sheet and no other bedding or soft objects.
c. It is recommended that infants sleep in the parents' room, close to the parents' bed, but on a separate surface designed for infants, ideally for the first year of life, but at least for the first six months.
d. Avoid smoke exposure during pregnancy and after birth.
e. Avoid alcohol and illicit drug use during pregnancy and after birth.
f. Continue the "Safe to Sleep" campaign, focusing on ways to reduce the risk of all sleep-related infant deaths, including SIDS, suffocation, and other unintentional deaths.

Pediatricians and other primary care providers should actively participate in this campaign.[1]

For the complete list of recommendations, please reference the article located at www./content/early/2016/10/20/peds.2016-2938.full.html.

Historically, the RI Department of Health has provided public education campaigns and public service announcements regarding the dangers of co-sleeping based upon recommendations from the American Academy of Pediatrics. The American Academy of Pediatrics publishes recommendations on best sleep practices to reduce the risk of SIDS and other sleep-related infant deaths. Unfortunately, due to a decrease in funding these programs have been discontinued. This Panel believes that it would be beneficial to re-implement and continue public education campaigns regarding co-sleeping. These services could be done in collaboration with DCYF, the OCA, local hospitals, pediatricians and any other entity providing assistance to infants and families.

III. STAFFING AND TRAINING

a. Inadequate Staffing and a High Rate of Staff Turnover

The four (4) child fatalities and two (2) near fatalities under review occurred August 2016-February 2017. During this period of time, the front line workers at DCYF continued to carry caseloads that were well above the national best practice standards. Unfortunately, this has been an ongoing issue, which has been discussed in numerous forums including the Senate Task Force for the Department, as well as in the report drafted by the previous OCA Child Fatality Review Panel in March 2016. Despite what has been reported by the prior administration in numerous forums including but not limited to, the Senate Task Force Hearings, the caseloads remain unconscionably high, front line workers are overworked and provided little to no support. It has been reported to the OCA by numerous DCYF staff members that staff morale is at an all time low while staff turnover has been cited as a continuous issue leading to minimally trained and inexperienced staff, inheriting massive and demanding caseloads. The front line workers are supporting children and families through unimaginable struggle, trauma and grief. DCYF will need to support its staff by hiring additional workers, reducing caseloads to a more manageable level and ensuring that each worker has the proper care and support to continue to perform their job duties. This will provide

[1] *SIDS and other Sleep-Related Infant Deaths: Updated 2016 Recommendations for a Safe Infant Sleeping Environment.* Official Journal of the American Academy of Pediatrics, Task Force on Sudden Infant Death Syndrome, October 24, 2016.

workers with the opportunity to deliver quality services and more positive outcomes for children and families involved with DCYF.

In January 2015, the RI Senate Task Force for DCYF released numerous recommendations regarding caseloads and inadequate staffing after hearing months of testimony. The recommendations of the Task Force were outlined and emphasized in the report completed by the March 2016 OCA Child Fatality Review Panel, however, due to ongoing issues, this report will reiterate some of the same information previously provided. Despite the comprehensive recommendations of the Senate Task Force and the placement of a "Strategy Team" at DCYF to implement the necessary changes, issues with staffing and unmanageable caseloads persist and in some units, have worsened. The DCYF Strategy Team focused on hiring at the administrative level, causing the Department to be "top-heavy". Many positions were created and filled by the Strategy Team, however most, if not all, were administrative positions or support staff for administrators, failing to address the vacancies in the Family Services Unit, Child Protective Services Unit and Intake/Monitoring Unit. Presently, the approximate cost for Central Management is $ 5,102,615 with twelve (12) vacancies to fill. There are approximately forty-nine (49) employees in Central Management; it is unclear exactly which employees are considered to be a part of Central Management.

Child Protective Services, Intake and Monitoring Units

The Child Protective Services, Intake and Monitoring Units are all supervised by an "acting" Assistant Director. As of February 2017, the Child Protective Services Unit (CPS) was composed of approximately thirty (30) Child Protective Services Investigators (CPI), which encompasses the staff that completes the investigations, as well as answers and assesses the incoming calls to the Child Abuse Hotline; approximately eight (8) CPI Supervisors and one (1) "acting" CPI Supervisor/Chief Casework Supervisor. In comparison, in early 2016, CPS was comprised of approximately forty (40) investigators, thirteen (13) supervisors and one (1) Chief Casework Supervisor. Staffing levels have decreased by approximately fifty percent (50%) in comparison to the nearly eighty (80) staff members the Child Protective Services Unit started with in the 1980's.

Currently, there is not enough staff within CPS to ensure that there is enough coverage for all three shifts, seven days per week. The inability to properly staff each shift has an adverse effect on the staff's ability to properly meet the demands and duties of the job. This is certainly a contributing factor to the plethora of inadequacies cited within the CPS Unit, however, once policies and protocols are adhered to, this will likely result in higher number of investigations causing a greater

demand on the current staff. It is worth noting, that numerous concerns have been raised regarding the level of expertise, qualifications and experience possessed by the current Child Protective Services administration. With numerous ongoing issues plaguing the CPS Department, this should be reviewed immediately.

In addition to the "acting" Assistant Director, there is also a Chief Casework Supervisor who oversees the Intake and Monitoring Units. As of February 2017, the Intake Unit was comprised of four (4) supervisors; nine (9) social case workers and one (1) call floor worker. The Monitoring Unit is comprised of one (1) supervisor and ten (10) workers. This supervisor is presently overseeing and supporting a staff that is double the national best practice standard. It is critical that both the Intake and Monitoring Units be provided with additional staffing to better serve the growing number of families assigned to these workers. At this time, CPS, including Intake and Monitoring, has eight (8) vacancies. However several staff members are on leave, which adds to the deficit in staffing. Furthermore, the number of available and approved full-time positions in CPS was decreased from one-hundred and nine employees (109) in 2016 to ninety-seven (97) employees in 2017. If the number of full-time positions had not been decreased they would have actually had twenty (20) vacancies within the CPS Department.

Family Services Unit

The Family Services Unit is facing similar staffing concerns. The Senate Task Force recommended that "DCYF should develop a continuous pipeline of recruitment and training of staff to address the high turnover of social workers, case managers, and supervisors, to ensure that caseloads remain at reasonable levels." This is a recommendation that the Child Fatality Review Panel echoes as inadequate staffing and high caseloads remains an ongoing issue. During the time period in which the child fatalities and near fatalities occurred, the Family Services Unit fluctuated from one-hundred and fourteen (114) social workers to one hundred and thirty-five (135) social workers with twenty-eight supervisors and four regional directors. Presently there are fifty-one (51) vacancies within the Family Services Unit.

b. Caseload Concerns

The report released by the Senate Task Force recommended that DCYF caseloads should target the national best practice standards. The Annie E. Casey Foundation cites the national best practice standards by service and caseload type, which is outlined in the chart below[2].

Service/Caseload Type	National Best Practice Standard
Child Protective Services (CPS) Caseloads/Investigation	No more than 8-10 cases per month; per 1 CPS Investigator
CPS- Ongoing Cases	Investigations to be completed within policy guidelines. For RI DCYF the policy is for investigations to be completed within 10 days
Social Caseworkers	12-15 cases, count each intact family as a case and each child in foster care as case
Supervision	1 supervisor per 5 social case workers or child protective services workers

In their final report, the Senate Task force noted that "[w]hen DCYF caseloads are too high, more children are removed from their families, since DCYF workers have too little time to assess whether a child is safe at home." Although we agree that having the proper amount of time to assess risk in the home remains an ongoing issue, this is now coupled with the aforementioned issues identified in the Child Protective Services Unit such as the failure to investigate, leaving more children at risk than ever before. The Panel reviewed and analyzed caseloads for CPS, Intake, Monitoring and the social workers in the Family Services Unit, during the period of time in which the fatalities and near fatalities occurred.[3]

CHILD PROTECTIVE SERVICES INVESTIGATOR CASELOADS

As of February 28, 2017, eighteen (18) of the twenty-two (22) Child Protective Investigators (CPI) that carry active caseloads are managing caseloads above the national best practice standard, which is an assignment of eight to ten (8-10) investigations per month. Eleven (11) CPIs possess

[2] The Annie E. Casey Foundation, 10 Practices: *A child welfare leader's desk guide to building a high performing agency*. Tracey Fields, 2015.

[3] All data regarding staff caseloads was pulled from the Department of Children, Youth and Families' database, *RICHIST*.

twenty (20) or more active investigations, which is double the national best practice standard. When state law and DCYF policies are properly adhered to regarding standards for an investigation, caseloads will continue to increase. It is imperative that CPS staff is increased in order to appropriately meet the demands of this Unit. Additionally, due to such demanding caseloads, inadequate staffing and support, the length of time investigations are pending is in violation of DCYF policy, which is that an investigation should be completed within ten (10) days. As of February 28, 2017, there were three-hundred and ninety-seven (397) active investigations. Two-hundred and ninety-eight (298) of these investigations or seventy-five percent (75%) have been pending for more than ten (10) days, in violation of DCYF policy. Prompt completion of an investigation is vital as oftentimes, the outcome of an investigation will dictate appropriate next steps for a family, including but not limited to, legal intervention or provision of necessary services. It is imperative that taking such action is not delayed.

Additionally, DCYF is required to maintain a high level of transparency with the OCA so the office can properly perform its duty as an independent and autonomous Rhode Island State agency responsible for protecting the legal rights of children involved with DCYF and charged with making recommendations for reforms in child welfare. It is worth noting that the reports generated by DCYF on their database, RICHIST did not accurately reflect the current caseloads for CPS. The OCA researched and manually calculated the caseloads of each individual worker to ensure accuracy in the data provided in this report. The reports generated by DCYF did not reflect the same data.

INTAKE AND MONITORING UNIT CASELOADS

As of March 1, 2017, ***every social worker*** within the Monitoring and Intake Units were carrying caseloads above the national best practice standard. Eight of the nine social workers in the Intake Unit are carrying caseloads equivalent to ***double*** the national best practice standard of 12-15 cases and three (3) of the nine (9) workers assigned ***triple*** the number of cases than what is recommended. With such demanding caseloads, it is extremely difficult to appropriately assess, monitor and support the needs of the families assigned.

CASELOADS OVER NATIONAL BEST PRACTICE: FAMILY SERVICE UNIT

Date of Statistic	Percentage of Social Workers with Caseloads Above the National Best Practice
August 7, 2016	94 out of 114 social workers (82%)

September 4, 2016	96 out of 120 social workers (80%)
October 2, 2016	101 out of 118 social workers (86%)
November 6, 2016	93 out of 116 social workers (80%)
December 4, 2016	91 out of 115 social workers (79%)
January 1, 2017	95 out of 119 social workers (80%)
February 5, 2017	89 out of 135 social workers (70%)

This table represents FSU social workers who carried a caseload of more than 14 ***families***, during the time period in which the child fatalities and near fatalities occurred. As previously mentioned, the national best practice standard for social workers is 12-15 ***cases,*** where intact families account for one case and each child placed out of their home is counted as an individual case. Based on this standard, a greater percentage of social workers at DCYF could be managing caseloads above national best practice standards, than the data provided above. This should be addressed immediately through filling vacancies for social workers and the redistribution of cases to ensure workers are provided with more manageable caseloads. This will provide social workers with a better opportunity to deliver quality care and services to the children and families they are working with.

c. Training and Addressing Secondary Trauma

Of equal importance to maintaining appropriate staffing levels to meet the demands placed upon the Department is ensuring that the staff serving the children and families of Rhode Island possess the appropriate education and training to fulfill their job duties and avoid secondary trauma. Pursuant to *R.I.G.L. § 42-72-5 (10)*, the employees of the Department of Children, Youth and Families must complete a minimum of twenty (20) hours of training per year. It is unclear as to whether the Department is in compliance with this statutory mandate as the DCYF report tracking this information has not been updated since 2012. The Department should provide adequate and ongoing trainings for their workforce. It is imperative that the staff tasked with supporting the most vulnerable population in this state are adequately equipped with the appropriate skills, education and training. It should be noted that some social worker vacancies have been filled through the "union bumping" process, placing former DHS workers within DCYF. As previously mentioned,

ensuring that the DCYF workforce has the appropriate experience and training is vital. It concerns the panel that this process, may place individuals within the Department who may not necessarily possess the knowledge, experience, training or desire to work with this vulnerable population.

During the period under review, the OCA met with DCYF staff to gain a better understanding of circumstances surrounding each of the child fatalities. The Department convened meetings with key child welfare employees at each meeting. During one of these meetings, the OCA staff were taken aback by the responses and explanations regarding the investigations that the CPS staff had conducted. The CPS staff did not display professional behavior and did not respond to questions with the sensitivity and knowledge expected by the OCA from CPS staff. The concerns the OCA and the Fatality Review Team have regarding the training, support, supervision and caseload size were all presented as needing attention during this meeting.

In March 2016, the OCA Child Fatality Review Panel cited concerns regarding the secondary trauma experienced by DCYF staff. The current Fatality Review Panel echoes these concerns as the Department still has a lack of supports and policies in place to address this matter. The front line staff at the Department of Children, Youth and Families work with children and families experiencing significant trauma, grief and various challenges. Although we believe that secondary trauma should be addressed for all staff at DCYF, our focus in particular for this report is on the CPIs assigned to investigate the cases encompassed in this review. While investigating a matter as traumatic as a child fatality or near fatality, these individuals still had to manage high caseloads, assigned additional incoming investigations and provided little to no time to process what they had experienced. When listening to each CPI discuss his or her experience while investigating a child fatality or near fatality one could hear the devastation in their voices. Just listening to these workers describe the experience, what they witnessed and the challenges they faced while completing these investigations was truly gut wrenching. The Department needs to establish and implement policies related to the care of their workforce, to ensure that each worker has access to appropriate, perhaps even mandatory, support services. The Department should also ensure that the administration within each unit has guidance on how to best support their workforce during the pendency of such a complicated matter. This will ensure the well-being of the work force, prevent compassion fatigue and prevent high rates of turnover.

Additionally, the Child Fatality Review Panel believes that the Department should draft a policy requiring the response of at least two (2) Child Protective Investigators when investigating a child fatality or near fatality. When responding to these calls, workers are met by families who are

struggling through unimaginable grief; the scene is often chaotic and emotionally charged. A lone CPI is expected to investigate the scene and speak with family members during this devastating time, while numerous law enforcement officers respond to perform a similar task. Requiring that at least two (2) CPIs investigate child fatalities or near fatalities, not only allows the Department to have two individuals review the case, providing varying perspectives on scene, but also provides the CPIs with the additional support and assistance they need to navigate such a difficult case. Current staffing levels make fulfilling such a policy nearly impossible, however, we are hopeful that based on the issues outlined in this report, the Department will ensure that CPS, as well as other units, are fully staffed.

IV. NON-COMPLIANCE WITH STATUTORY MANDATES

During the 2016 legislative session, one focus of the Rhode Island General Assembly was to establish greater oversight regarding child fatalities and near fatalities. The need for such scrutiny became increasingly evident and in response, the General Assembly passed a bill, which further delineated the responsibilities of relevant state agencies with regards to child fatalities and near fatalities, including the OCA, the Department and the Medical Examiner's Office. These important and impactful legislative changes were signed into effect by Governor Gina Raimondo on July 6, 2016.

This legislation implemented a comprehensive process for each agency to facilitate upon receiving notice of a child fatality or near fatality. In accordance with *R.I.G.L. §42-72-8 (c)(1)*, the Department of Children, Youth and Families is required to "[n]otify the Office of the Child Advocate verbally and electronically in writing within 48 hours of a confirmed fatality or near fatality that is the subject of a DCYF case. The department shall provide the Office of the Child Advocate with access to any written material about the case." The OCA applauds the Department with their strict adherence and compliance to the notification provision of this statute with respect to child fatalities. In fact, for each child fatality, the Department has provided notice to the OCA in less than forty-eight (48) hours, which is a drastic improvement from prior practice. However, until recently, the OCA was not receiving appropriate notification regarding near fatalities. In fact, for one of the near fatalities under review, the OCA never received notice from the Department; the case was discovered by an OCA employee. Subsequent to the release of the OCA's initial press release dated October 27, 2016, the Department notified the OCA that they were working to more concretely define what would constitute a near fatality with guidance from Hasbro Children's Hospital. It was later determined that any child suffering from injuries requiring an admission to the Pediatric

Intensive Care Unit, would constitute a near fatality. Since the development of this definition, the Department has consistently notified the OCA of each near fatality within the time parameters, as required by law.

In accordance with *R.I.G.L. §42-72-8 (c)(3),* the Department has compiled pertinent information in a rapid manner for the team's review pursuant to *R.I.G.L. §42-72-8 (c)(1),* "The department shall provide the Office of the Child Advocate with access to any written material about the case." Furthermore, the Department has coordinated timely reviews for each fatality and subsequent to the aforementioned policy improvements, for near fatalities as well. The OCA has received timely notification for each scheduled case review. The discussions are enlightening and productive. However, it is the understanding of the OCA that upon completion of a Critical Review by the various members of the Department and the OCA, the Department would author final reports summarizing findings and recommendations made by the group. The OCA has requested that a copy of the final report be provided to our Office upon completion of the reviews. Previously, OCA staff were informed that the release of this report to the OCA would need to be approved by the Chief Strategy Officer, Jamia McDonald. To date, the OCA has not received a copy of any of the reports completed by the Department following the numerous reviews that have occurred. It is the stance of the OCA and the Child Fatality Review Panel that pursuant to *R.I.G.L. §42-72-8 (c)(1)* and *R.I.G.L. §42-73-8,* the OCA should be provided with a copy of the final report generated by the Department upon conclusion of the review of a child fatality or near fatality.

Lastly, pursuant to *R.I.G.L. § 42-72-8(c)(2)*, the Department, more specifically, the director "…shall make public disclosure of a confirmed fatality or near fatality of a child that is the subject of a DCYF case within 48 hours of confirmation, provided disclosure of such information is in general terms and does not jeopardize a pending criminal investigation." Public disclosure of such information by the Department has yet to occur in any of the cases under review. Prior to the current Director, Dr. Trista Piccola, assuming leadership of the Department, the responsibilities of the Director were being filled by the Chief Strategy Officer, Jamia McDonald. Ms. McDonald and her administration failed to fulfill this statutory mandate. Unfortunately, there have been additional child fatalities during the transition of the administration. Two of these cases were added to this review. Public disclosure of these deaths has not occurred, however, the OCA is requesting that compliance with this statutory provision will occur in the future.

RECOMMENDATIONS

Subsequent to careful consideration of the six (6) cases before the Child Fatality Review Panel, the Panel has developed numerous recommendations, which we are seeking to have implemented in a timely manner. The panel's goal is to implement change to target systemic issues and ultimately improve the safety and well-being of children. It should be noted that in March 2016, the OCA completed a review of three (3) additional cases, also involving infants. This review was completed under the prior administration of the OCA. Although we commend the Department for implementing many of the recommendations made in the prior report just eleven (11) months ago, there are several vital recommendations, which have yet to be executed and remain relevant after analyzing the cases before the current Child Fatality Review Panel. The panel believed it was important to highlight each one to illustrate their importance and the necessity. After careful consideration, the Child Fatality Review Panel is proposing the following recommendations:

1. The Child Protective Services Unit (CPS) should shift from an incident-based system to a risk-based system. The Department is to adopt and integrate a comprehensive set of standardized, evidence-based investigation and risk assessment tools that address the needs of children and families at every level of their involvement. Particular attention to determining the best tools and process for children under age six with multiple reports to the Department. Explore investigation and assessment tools that utilize Structured Decision Making and screening tools for Adverse Childhood Experiences (ACES). However, this model would need to be implemented in its entirety. The Department has previously indicated that they would seek to implement a portion of this model, which would negatively impact the efficacy of this model. *This was a recommendation made by the March, 2016 Child Fatality Review Panel and is being recommended again by the current panel.* Realizing that implementing a change of this magnitude will take much research, planning, funding and most importantly time, the Child Fatality Review Panel would like the following changes to be implemented under the current system, effective immediately:
    a. Conduct a multi-state analysis and evaluate the systems/models utilized by other CPS Units in states that have comparable populations and have been deemed to be effective.
    b. Following the receipt of a call involving allegations of abuse or neglect of a child under the age of six (6), a Child Protective Investigator should be mandated to respond to the home and put eyes on the child, to assess potential risks and ensure the safety and well-being of the child.

c. That the Department develop a policy, which outlines in great detail the way in which a call made to the Child Abuse and Neglect Hotline, should be recorded into RICHIST, DCYF's electronic database. This policy should reflect that any and all calls made to the Hotline should be recorded in the "Intake" section so the system reflects the proper number of calls, which have been made regarding a specific family. The policy should also state that a call should never be recorded solely in the "Case Activity Notes". This will prevent a skew in the data regarding the number of calls that have been made to the Hotline, will provide a more accurate and readily available depiction of what has transpired with a particular family, and to provide workers and other entities an enhanced ability to rapidly assess the risks involved with a family.

d. Complete overhaul or repeal of *DCYF Policy 500.0040, Information/Referral (I/R) Reports*. A more strict procedure for the use of the category must be developed to prevent its misuse and overuse. Additionally, a more strict procedure with heightened oversight should be developed for the downgrading of any investigation to this category. Also, any call, which under the policies of DCYF, requires an investigation, should in fact be investigated by a employee of the CPS Unit and not categorized as an "Information/Referral". Additionally, should a call rise to the level of warranting an investigation under DCYF Policies, an investigation should in fact be completed by a CPS employee and should not be categorized as an "Information/Referral".

e. That the Department develop a policy, which mirrors the former "Early Warning" process. This will require a more prompt response from the CPS Unit after receiving numerous calls regarding a family. Under the "Early Warning" policy, after receiving three (3) calls regarding the same family, the Child Protective Services Unit (CPS) would respond to the home to ensure the safety and well-being of each child in the home. Although each call on its own may not rise to level of warranting an investigation under DCYF policies, CPS would still respond to the home to put "eyes on the child or children". Implementing a similar policy will prevent the continued trend of an extensive number of calls being made regarding a family, without prompting a response from CPS.

f. The Department should improve the verification of reports indicating participation in medical and other services, which are self-reported by families or foster families.

This information should be verified with the service provider or other relevant entities prior to closing a CPS investigation, termination DCYF involvement, or approving relative or other foster care licenses. *This was a recommendation made by the March, 2016 Child Fatality Review Panel and is being recommended again by the current panel.*

g. That the Department create an internal policy requiring the response of at least two (2) Child Protective Investigators to investigate any call reporting a child fatality.
h. That DCYF, more specifically CPS, should not categorize a child fatality or near fatality be categorized as an "Information/Referral", especially when the family has had prior involvement with DCYF. The Department should develop a specific policy and protocol when processing this information and develop an unambiguous category for this information. This will provide a more accurate depiction in the record of what has transpired within a particular case and will assist with the computation of accurate statistics regarding child fatalities and near fatalities for public reporting.
i. Training of CPS and Intake staff to ensure quality of information recorded and reports distributed. Ensure that all pertinent information is being recorded in RICHIST, in a timely manner, to provide subsequent users with all necessary information to properly assess each case. Enhance the quality of service provided to reporters and families. Provide extensive training to staff on any newly implemented model utilized by CPS in response to the recommendations provided in this report.
j. Re-evaluate administrative staff operating the CPS Unit to ensure that they meet the educational and experience requirements and to ensure that the qualifications of their administrative staff adhere to Rhode Island general law, specifically, R.I.G.L. § 42-72-6, which requires that, "…all assistant directors, associate directors or executive directors shall have a masters degree in social work (M.S.W.) or in a closely related field."

2. Reinstitute the use of "Legal Supervision" by DCYF, outlined in R.I.G.L. § 40-11-12. This will place the family under the supervision of the Family Court and DCYF to ensure that the family complies with community-based services, will mitigate the risks to the child or children, and potentially prevent the removal of the child or children from their home.

Should the family not comply with the necessary services, they will already be under the supervision of the Court and DCYF prompting immediate further action.

3. Following the expanded use of "Legal Supervision", if it is determined that Establishment of a Diversion Court through the Family Court, which will operate with the goal of overseeing cases under "Legal Supervision", to work with the family to prevent further involvement with the Department of Children, Youth and Families and the potential removal of children from their home while ensuring that the community-based services provided to the family mitigate the risks involved with the case.

4. The Department to develop a robust array of community based services to meet the complex needs of the children and families they serve. A focus on the needs of infants and young children with parental substance abuse, mental health, domestic violence and other risk factors, is recommended. *This was a recommendation made by the March, 2016 Child Fatality Review Panel and is being recommended again by the current panel.*

5. Coordination of medical records within the medical community to improve the exchange of medical information. Review and increase compatibility of different electronic record systems to enhance a health care provider's ability to review a patient's recent health history in real time.

6. That the use of medical marijuana by a primary caretaker, regardless of its legality, be assessed by the Department as a risk factor, similar to alcohol and prescription medication when determining risk and need for a family.

7. That the Department strictly adhere to *DCYF Policy 500.0125,* to ensure the appropriate level of DCYF involvement upon the confirmation of drug use by a parent during their pregnancy.

8. That when the Department receives a call reporting drug use during pregnancy and is verified by one of the forms of evidence outlined above, this should prompt an immediate hospital alert. This will ensure that the hospital is on notice to test the mother and baby

upon birth and subsequently alert the Department to provide the opportunity for further assessment for services or potential legal intervention.

9. Review of the statutory provisions of the Physician's Report of Examination (PRE) under Rhode Island General Laws § 40-11-4, § 40-11-5 and § 40-11-6, particularly to addressing concerns regarding chronic neglect. *This was a recommendation made by the March, 2016 Child Fatality Review Panel and is being recommended again by the current panel.*

10. Enhance the work of the Department of Health by dedicating resources for a new public education campaign to target the public, professionals who are in the child welfare system and foster parents regarding the dangers of co-sleeping. It is believed that to have an effective campaign that the Department of Children, Youth and Families, local hospitals, the Department of Health and the OCA, should be involved. Also, begin a pilot program in a high risk community to test any recommendations of the inter-agency collaboration.

11. Engage the Children's Cabinet to assist with the development and execution of a state-wide agenda to ensure safe sleeping practices, based upon the work of the agencies named in the previous recommendation.

12. That the Office of Vital Statistics reinstitute their previous Memorandum of Understanding with the OCA, to provide the OCA with notice of every recorded child death from ages 0-21. This will provide the OCA with the opportunity to ensure that there has been no previous involvement with the Department and assist the OCA with the necessary data to better inform policy and legislative change.

13. Ensure compliance with mandatory training requirements for all DCYF employees. In accordance with *R.I.G.L. § 42-72-5 (10)*, which requires the employees of DCYF to complete a minimum of twenty (20) hours of training per year. *This was a recommendation made by the March, 2016 Child Fatality Review Panel and is being recommended again by the current panel.* The Department should reinstitute their training unit to ensure that ample training is provided to incoming DCYF employees, as well as to provide ongoing training to current employees.

14. Ensure secondary trauma is addressed in the child welfare workforce and provide post trauma and grief services for the parents and foster families after the death of a child. *This was a recommendation made by the March, 2016 Child Fatality Review Panel and is being recommended again by the current panel.*

15. For the Department to strictly adhere to the statutory obligations delineated in R.I.G.L. § 42-72-8, including but not limited to R.I.G.L. § 42-72-8 (c)(2) which states "The director shall make public disclosure of a confirmed fatality and near fatality of a child that is the subject of a DCYF case within 48 hours of confirmation, provided disclosure of such information is in general terms and does not jeopardize a pending criminal investigation."

16. That upon completion of a Critical Event Review by the Department, the OCA shall be provided with a copy of the final report generated by the Department.

17. Fill vacancies for front line workers, including social workers, intake and CPS to ensure that caseloads are compliant with national best practice and to ensure that there is appropriate staffing on for each shift, every day of the week. *This was a recommendation made by the prior Child Fatality Review Panel and is being recommended again by the current panel.*

18. That the OCA be provided with advance notice of any policy change to take place within the Department to have the opportunity to be a part of the revision process in collaboration with the Department, as well as other relevant entities.

19. That the Department, in collaboration with the OCA, evaluate the methods utilized in other states to determine best practices for tracking data on child fatalities and near fatalities.

20. That the timely implementation of each of these recommendations be overseen by the Senate Task Force for DCYF and the OCA. Reports shall be provided to the Senate Task Force by both the Department and the OCA.

21. That the OCA be provided with appropriate staff and resources to have the ability to effectively monitor the Department and provide a heightened level of oversight, which has become increasingly necessary to ensure the safety and well-being of children in state care.

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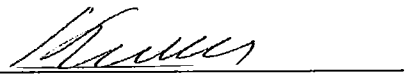

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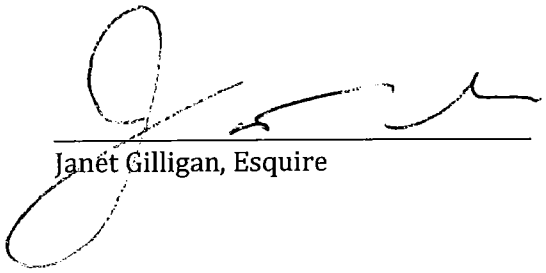

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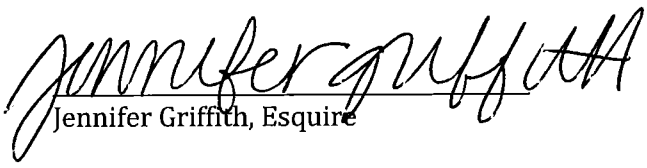

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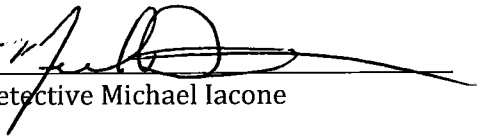
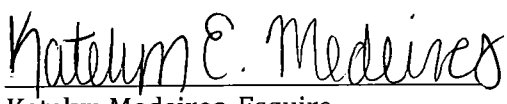


Detective Michael Iacone



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Adam Pallant, MD

APPENDIX A

Darlene Allen, MS Darlene joins the panel as a representative of the RI Coalition for Children and Families, an advocacy organization with 28 organizations serving thousands of children across the state. Darlene is an experienced child welfare leader who has dedicated her career to helping at –risk children and families. She has worked in both public and private organizations. Her focus has included child protective services, family preservation, permanency and adoption. For the past 16 years, Darlene has been the Executive Director of Adoption Rhode Island, a private non-profit organization that provides a range of trauma –focused and evidenced-informed services for foster and adopted children and their families.

Darlene is also a consultant for JBS International where she has participated in federal child and family service reviews in numerous states across the nation. Darlene is the Treasurer for the Adoption Exchange Association, the national non-profit that oversees the AdoptUSKids partnership, a member of the Family Builders Association Network, Vice-Chair of the Rhode Island Coalition for Children and Families and a member of the Healthy Youth Transition Subcommittee of the Governor's Council on Behavioral Health. Darlene has been a member of numerous workgroups that address safety, well-being and permanency for children and youth impacted by foster care over her many years in the field. She is a frequent presenter and public speaker on behalf of children in foster care. Darlene received her undergraduate degree at Providence College and her Master's Degree at the University of Massachusetts, Boston. Darlene has also participated in numerous non-degree conferring educational opportunities. She recently completed an executive education course in leadership at the Harvard Kennedy School of Government.

Kathryn Cortes Kathryn Cortes is currently the Senior Monitoring & Evaluation Specialist at the Rhode Island Office of the Child Advocate (OCA). Kathryn previously served as the Chief Field Investigator for the OCA from 2007 to 2013, until she was promoted. Kathryn has a Bachelor of Arts in Criminal Justice and Juvenile Justice from Salve Regina University located in Newport, RI. Prior to joining the OCA staff in 2007, Kathryn worked as the Senior Residential Counselor at Child and Family Services of Newport County in Newport RI. There, Kathryn worked to maintain a safe and therapeutic living environment for boys ages 6 through 12, which provided a structured program that promoted daily life skills, mental health services, and educational skills for the boys. Following her six years at Child and Family Services, Kathryn moved onto Civigenics, Inc. in Marlborough, MA where she spent four years as the Program Director of a therapeutic milieu program located in the Rhode Island Training School for Youth (RITS).

Kathryn remains an involved member of both the professional and personal community in RI. Her activities and volunteer positions include: serving as a Member of the Rhode Island Child Death Review Team, Member of the LGBTQQ Youth Committee, Executive Board Member of the RI Chapter of the American Foundation for Suicide Prevention (AFSP), Member of the JDAI Girls Work Group, Member of the Youth Suicide Prevention Subcommittee, and acts as the Legislative Field Advocate for AFSP. Kathryn is also very involved with the Smithfield High School Football team, where her son currently plays.

Molly Kapstein Cote, Esquire Molly earned her B.A. from the University of Michigan and her Juris Doctorate from Suffolk University Law School. Molly began her legal career as a law clerk for the Rhode Island Supreme Court from 2001-2002. Subsequent to working for the Supreme Court, Molly served as a state prosecutor with the Rhode Island Department of Attorney General from 2003-2010. During her career as a Special Assistant Attorney General, she was assigned to the Providence Trial Calendar where she handled a variety of cases ranging from child molestation to homicide matters. After working at the Department of Attorney General, Molly joined Lynch, Lynch & Friel in 2010 where she practiced for six years before opening her own office. Since leaving the Attorney General's office, Molly's practice has focused in the areas of criminal defense and domestic relations, including matters involving DCYF. In 2014, the Chief Judge of the United States

District Court for the District of Rhode Island appointed Molly to serve as an attorney to the H.O.P.E. Court Program in that court. The H.O.P.E. Court is a re-entry court program designed to prevent high-risk criminal defendants from re-offending upon their release from Federal custody. Molly continues to work in that capacity. Molly also serves as a Bail Commissioner with the Rhode Island District Court and is a member of the Rhode Island District Court Criminal Rules Committee which is tasked with advising that court on matters relating to the District Court rules of criminal procedure. Molly has presented at the annual Rhode Island Bar Association Meeting on the topics of resolving a criminal case by way of civil settlement and also about the consequences of a plea in a criminal case. Since 2010, in addition to her law practice, Molly has worked as an adjunct professor of law at Roger Williams University Law School where she teaches Trial Advocacy and is the director of the Prosecution Externship Program.

Ken Fandetti Ken earned his BA in Sociology from Providence College and a Master of Science in Social Services from the Boston University School of Social Work. Throughout his career, Ken served in a variety of public social service roles bringing a wealth of knowledge and experience to the team. Some of his past roles include, Social Caseworker for the Rhode Island Department of Children, Youth and Families; Family Court Liaison Worker for Child Welfare Services; Residential Services Coordinator Department of Corrections Juvenile Division; Assistant to the Director Department of Corrections; Superintendent Rhode Island Training School for Youth; Assistant Director of the Division of Direct Service of the Department of Children, Youth and Families; Project Director to establish the Rhode Island Child Abuse and Neglect Tracking System (CANTS); Assistant Director of the Child Protective Services Division at the Department of Children, Youth and families; the Executive Director of the Rhode Island Department of Children, Youth and Families and the Acting Director of the Rhode Island Department of Children, Youth and Families. Additionally, Ken served as an Ad Hoc Committee Member reporting on abusive treatment of children at the Rhode Island Children's Center, Rhode Island's State Liaison Officer to the National Center on Child Abuse and Neglect (NCCAN) and was the founding member of the New England Association of Child Welfare Commissioners and Directors. Ken has since become a certified sea kayak instructor for both the American Canoe Association and the British Canoe Union.

Janet Gilligan, Esquire Janet Gilligan is the Deputy Director of Rhode Island Legal Services and has been practicing law for 38 years. She received a BA from the University of Rhode Island in 1975 and her JD from the University of Maine in 1978. Janet began her legal career at Rhode Island Legal Services in 1978. Her practice was in Rhode Island‘s Family Court in both domestic and child welfare cases. In 1982, she directed a pilot project for the Rhode Island Public Defender’s Office that led to the establishment of its Parental Rights Unit. Janet went on to become a public defender in New Hampshire from 1983 to 1986. While in New Hampshire, she represented defendants in misdemeanor and felony cases before the New Hampshire District and Superior Courts. She returned to Rhode Island in 1986 and worked as legal counsel for the Rhode Island Department for Children Youth and Families for several years. She returned to Rhode Island Legal Services in 1990.

Most of Janet’s legal work has involved representing victims of domestic violence and families involved in the child welfare system. She has appeared in the Rhode Island Family and Supreme Courts. Janet frequently presents at Rhode Island Bar Association and Volunteer Lawyer seminars and has been a trainer with the national Center for Legal Aid Education, now the Shriver Center, since 1999. She has been a trainer at a variety of legal trainings in Massachusetts, Florida, South Carolina, Mississippi, Nevada, and the District of Columbia. Janet is a member of the Rhode Island Bar Association’s House of Delegates, the Rhode Island Supreme Court’s Committee on Women and Minorities, and is an adjunct faculty member at the Roger Williams University School of Law.

Jennifer Griffith, Esquire Jennifer Griffith was appointed by Governor Gina Raimondo on March 17, 2016 and received the advice and consent of the Rhode Island State Senate on April 7, 2016 for a five year term as the Child Advocate for the State of Rhode Island. She is a graduate of the College of the Holy Cross and Roger Williams School of Law. She is admitted to practice law in Rhode Island, Massachusetts and the United States Federal District Court of Rhode Island. Previously, she was a staff attorney at Rhode Island Legal Services for ten years handling all family law matters. She is a member of the Rhode Island Women's Bar Association, the Executive Board of the Rhode Island Family Inn of Court, the Rhode Island Family Court Bench Bar Committee, the Rhode Island Children's Cabinet, the Rhode Island Child Care Commission, the Rhode Island Child Support Advisory Committee, the Human Trafficking Task Force and the Rhode Island Juvenile Justice Advisory Committee.

Lisa Guillette Lisa Guillette is the Executive Director of Foster Forward, a statewide non-profit organization supporting foster families and children and youth in state care. Ms. Guillette has twenty-five years of professional experience in education and child welfare in Rhode Island, and has served in her current role for over thirteen years. During her tenure, Foster Forward (formerly the Rhode Island Foster Parents Association) has grown from being a small grassroots association to a recognized leader in child welfare practice: earning multi-million dollar competitive contracts and grant awards from the State of Rhode Island, the federal government and private funders.

Ms. Guillette served on the Rhode Island Joint Legislative Commission on the Education of Children and Youth in DCYF care and is an appointed representative to the Governor's Advisory Council on Homelessness. She is an active member of the United Way's Women's Leadership Council, chairing the Executive Committee and serving on the Membership Committee. Ms. Guillette was honored in 2005 with a United States Congressional *Angels in Adoption* Award, was recognized by the YWCA of Northern Rhode Island in 2007 as a *"Woman of Achievement"* and in 2011 was the recipient of the national Rama Ramanathan Commitment to Service Award from the Jim Casey Youth Opportunities Initiative. She holds a Bachelor of Arts Degree in Social Work and a Master's Degree in Business Administration from Providence College. Ms. Guillette resides in Providence with her husband and three children.

Detective Michael Iacone Detective Michael Iacone has been a police officer for the City of Cranston since 2002. He is currently assigned as a Detective in the Special Victims Unit where he handles all sexually-based crimes, as well as crimes against children and the elderly. In 2002, Detective Iacone graduated from Salve Regina University with a Bachelor's Degree in Administration of Justice. He went on to earn his Master's Degree in Administration of Justice and Homeland Security from Salve Regina University in 2009.

At this time, Detective Iacone is assigned to both the FBI and HSI Task Force dealing with the commercial sexual exploitation of women and children. Detective Iacone is the law enforcement representative for the Citizens Review Panel at Hasbro Children's Hospital/Aubin Child Protection Center. This multi-disciplinary team consists of physicians, as well as representatives from the Attorney General's Office, DCYF, Office of the Child Advocate, and Day One. The team meets weekly to discuss cases of child maltreatment and to determine appropriate measures for each case. Detective Iacone has shown a particular interest in the long-term mental health outcomes of his victims, and he has taken an active role by co-facilitating a support group for adolescent female victims of sexual abuse.

Katelyn Medeiros, Esquire Katelyn has worked as the Staff Attorney III for the Office of the Child Advocate since May 2014. Recently Ms. Medeiros was promoted to serve as the Staff Attorney IV in February, 2017. Ms. Medeiros graduated *summa cum laude* from Rhode Island College in 2010 with a Bachelor's Degree in Justice Studies and Sociology. She then pursued her Juris Doctorate at Roger Williams School of Law, graduating

magna cum laude in 2013. In addition, she was a member of the Roger Williams School of the Law Honors Program. She was admitted to the Rhode Island and Massachusetts Bar in November 2013 and the U.S. District Court of Rhode Island in 2014. Ms. Medeiros first worked for the OCA from 2012-2013 as a Rule 9 Intern. She worked in private practice prior to her career with the OCA. Presently, Ms. Medeiros serves as the program coordinator for Project Victim Services for the Office of the Child Advocate. Through this role, Ms. Medeiros advocates for children affected by physical and/or sexual abuse and assists them in accessing appropriate services and financial assistance.

Dr. Adam Pallant Adam has been the residency director at Alpert School of Medicine at Brown University in Providence, RI since 1998. He completed his graduate and medical training at the University of Rochester School of Medicine and Dentistry, receiving an MD/PhD with a specialty in immunology. He completed his pediatric residency and chief residency at the University of California, San Francisco. Dr. Pallant continues to practice and teach primary pediatrics and refugee health to residents and medical students in the primary care clinic at Hasbro Children's Hospital as an Associate Professor (Clinical). He was in a community pediatric practice for two years prior to being invited to work with the residency program at Brown University. Dr. Pallant has served to enhance medical education in both local and national committees. Dr. Pallant considers it a priority to bring a humanistic and family-centered focus to resident education and patient care. He received the Brown Pediatric Award for Outstanding Dedication to Patient Care in 2009 in addition to earlier receiving both the Teaching Recognition Award and The Dean's Teaching Excellence Award at Brown University. Previously he received the Neossi Award at the end of his chief residency at UCSF, given in recognition of caring interactions with medical staff while providing outstanding and humanistic medical care. Dr. Pallant is currently interested in fostering a meaningful and pragmatic educational approach to humanistic health care in the context of a busy residency training environment.

APPENDIX B

TITLE 42
State Affairs and Government

CHAPTER 42-72
Department of Children, Youth and Families

SECTION 42-72-8

§ 42-72-8 Confidentiality of records.

(a) Any records of the department pertaining to children and their families in need of service pursuant to the provisions of this chapter; or for whom an application for services has been made, shall be confidential and only disclosed as provided by law.

(b) Records may be disclosed when necessary:

(1) To individuals, or public or private agencies engaged in medical, psychological, or psychiatric diagnosis or treatment or education of the person under the supervision of the department;

(2) To individuals or public or private agencies for the purposes of temporary or permanent placement of the person, and when the director determines that the disclosure is needed to accomplish that placement, including any and all health-care information obtained by the department in accordance with the provisions of chapter 37.3 of title 5 of the general laws and applicable federal laws and regulations;

(3) When the director determines that there is a risk of physical injury by the person to himself or herself or others, and that disclosure of the records is necessary to reduce that risk;

(4) To the family court, including periodic reports regarding the care and treatment of children; provided, that if a child is represented by a guardian ad litem or attorney, a copy of the family court report will be made available to the guardian ad litem or attorney prior to its submission;

(5) To inform any person who made a report of child abuse or neglect pursuant to § 40-11-3, whether services have been provided the child as a result of the report; provided, however, that no facts or information shall be released pursuant to this subsection other than the fact that services have been, or are being, provided;

(6) To permit access to computer records relating to child-abuse and -neglect investigations by physicians who are examining a child when the physician believes that there is reasonable cause to suspect that a child may have been abused or neglected;

(7) To the office of the department of attorney general, upon the request of the attorney general or assistant attorney general, when the office is engaged in the investigation of, or prosecution of, criminal conduct by another relating to the child or other children within the same family unit;

(8) To the department of corrections in the case of an individual who has been transferred to the jurisdiction of that department pursuant to the provisions of §§ 14-1-7.3 or 14-1-7.1;

(9) To the office of the department of the attorney general, upon the request of the attorney general or assistant attorney general, when the office is engaged in the investigation of, or prosecution of, criminal conduct as defined in § 40-11-3.2;

(10) To individuals employed by a state or county child-welfare agency outside of Rhode Island when the director determines that the information is needed to ensure the care, protection, and/or treatment of any child; provided, however, any records relating to allegations previously determined to be unfounded, unsubstantiated, or not indicated shall not be disclosed;

(11) Whenever a person previously under the supervision of the training school becomes subject to the jurisdiction of the department of corrections as an adult offender, the director of corrections, or his or her designee, shall receive, upon request, the portions of the person's training-school records limited to the escape history, disciplinary record, and juvenile classification history;

(12) In an administrative hearing held pursuant to § 42-35-9, the records, or exact copies of the records, shall be delivered to the administrative-hearing officer pursuant to a written request by one of the parties, and shall be delivered to the party making the request or shall be reviewed in camera by the administrative-hearing officer for purposes of making a determination of relevancy to the merits of the administrative matter pending before the hearing officer, as the hearing officer may direct. If the records or a portion are relevant to the matter, those records may be viewed and/or copied by counsel of record, at the expense of the party requesting the records. The records shall not be disseminated in any form beyond the parties, counsel of record and their agents, and any experts, except as otherwise specifically authorized by the hearing officer, and provided further that at the conclusion of the action, the records shall be sealed; and

(13) In a criminal or civil action, the records, or exact copies of the records, shall be delivered to a court of proper jurisdiction pursuant to a subpoena duces tecum, properly issued by one of the parties, and shall be delivered to the party issuing the subpoena, or shall be reviewed in camera by the trial justice for purposes of making a determination of relevancy to the merits of the civil or criminal action pending before the court, as the court may direct. If the records or a portion are relevant to the civil or criminal action, those records may be viewed and/or copied by counsel of record, at the expense of the party requesting the records. The court shall issue a protective order preventing dissemination of the records in any form beyond the parties, counsel of record and their agents, and any experts, except as otherwise specifically authorized by the court, and provided, further, that at the conclusion of the action, all records shall be sealed.

(c) Disclosure required.

(1) The director shall notify the office of the child advocate verbally and electronically, in writing, within 48 hours of a confirmed fatality or near fatality of a child who is the subject of a DCYF case. The department shall provide the office of the child advocate with access to any written material about the case. For purposes of this chapter, "near fatality" shall mean a child in serious or critical condition as certified by a physician as a result of abuse, neglect, self-harm or other unnatural causes.

(2) The director shall make public disclosure of a confirmed fatality or near fatality of a child who is the subject of a DCYF case within 48 hours of confirmation, provided disclosure of such information is in general terms and does not jeopardize a pending criminal investigation.

(3) The director shall disclose to the office of the child advocate information, within five (5) days of completion of the department's investigation, when there is a substantiated finding of child abuse or neglect that resulted in a child fatality or near fatality. The department may disclose the same information to the office of the attorney general and other entities allowable under 42 U.S.C. § 5106a.

(4) The information that must be disclosed in accordance with subdivision (c)(3) includes:

(i) A summary of the report of abuse or neglect and a factual description of the contents of the report;

(ii) The date of birth and gender of the child;

(iii) The date that the child suffered the fatality or near fatality;

(iv) The cause of the fatality or near fatality, if such information has been determined;

(v) Whether the department of children, youth and families, or a court-appointed special advocate, had any contact with the child before the fatality or near fatality and, if so:

(A) The frequency of any contact or communication with the child or a member of the child's family or household before the fatality or near fatality and the date on which the last contact or communication occurred before the fatality or near fatality;

(B) Whether the department provided any child-welfare services to the child, or to a member of the child's family or household, before, or at the time of, the fatality or near fatality;

(C) Whether the department made any referrals for child-welfare services for the child, or for a member of the child's family or household, before or at the time of the fatality or near fatality;

(D) Whether the department took any other action concerning the welfare of the child before or at the time of the fatality or near fatality; and

(E) A summary of the status of the child's case at the time of the fatality or near fatality, including, without limitation, whether the child's case was closed by the department before the fatality or near fatality and if so, the reasons why the case was closed; and

(vi) Whether the department, in response to the fatality or near fatality:

(A) Has provided, or intends to provide and/or make, a referral for child-welfare services to the child, or to a member of the child's family or household; and

(B) Has taken, or intends to take, any other action concerning the welfare and safety of the child, or any member of the child's family or household.

(d) If a public panel is convened or established by the department to evaluate the extent to which the department is discharging its child-protection responsibilities, the panel, or any of its members or staff, shall not disclose identifying information about a specific child-protection case, nor make public any identifying information provided by the department, except as may be authorized by law. Any person who violates this subsection shall be subject to civil sanctions as provided by law.

(e) If a public panel is convened or established by the department, this panel, in the course of its evaluation, may review, but shall not investigate, any child fatality that is under the jurisdiction of the child advocate in accordance with the provisions of § 42-73-7(2).

(f) In the event records and information contained within DCYF records are shared with individuals or public or private agencies as specified in subsection (b) above, any such individual, and/or public or private agency, shall be advised that the shared information cannot be further disclosed, except as specifically provided for under applicable federal and/or state law and regulation. Any individual and/or public or private agency who or that violates this subsection shall be subject to civil sanctions as provided in chapter 37.3 of title 5, and any other federal or state law pertinent thereto.

History of Section.
(P.L. 1979, ch. 248, § 1; P.L. 1984, ch. 203, § 1; P.L. 1985, ch. 255, § 1; P.L. 1992, ch. 432, § 1; P.L. 1994, ch. 97, § 1; P.L. 1996, ch. 142, § 1; P.L. 1996, ch. 156, § 2; P.L. 1997, ch. 49, § 1; P.L. 1997, ch. 64, § 1; P.L. 1998, ch. 67, § 1; P.L. 1998, ch. 302, § 1; P.L. 1998, ch. 322, § 1; P.L. 1998, ch. 374, § 1; P.L. 1999, ch. 54, § 1; P.L. 1999, ch. 122, § 1; P.L. 2004, ch. 136, § 1; P.L. 2004, ch. 139, § 1; P.L. 2016, ch. 342, § 2; P.L. 2016, ch. 368, § 2.)

APPENDIX C

Criteria for a Child Protective Services Investigation

Rhode Island Department of Children, Youth and Families

Policy: 500.0010

Effective Date: July 7, 1984 Revised Date: February 24, 2014 Version: 6

The Department of Children, Youth and Families initiates a Child Protective Services (CPS) investigation when a report that meets Investigation Criteria is made to the CPS Hotline. Reports may involve families new to the Department, families actively being serviced by the Department, families previously active with the Department and incidents of institutional abuse and/or neglect. The report involves a child under eighteen years of age or under twenty-one years of age if the youth is residing in foster or institutional care or if the youth is in Department custody, regardless of placement.

Investigation Criteria 1 - Child Abuse/Neglect (CA/N) Report - RIGL 40-11-3 requires the Department to immediately investigate reports of child abuse and neglect. The circumstances reported, if true, must constitute child abuse/neglect as defined by RIGL 40-11-2.

Investigation Criteria 2 - Non-Relative Caregiver - RIGL 42-72.1-4 requires that no parent assigns or otherwise transfers to another, not related to him or her by blood or marriage, his or her rights or duties with respect to the permanent care and custody of his or her child under eighteen years of age unless duly authorized by an order or decree of the court.

Investigation Criteria 3 - Sexual Abuse of a Child by Another Child - RIGL 40-11-3 requires the Department to immediately investigate sexual abuse of a child by another child.

Investigation Criteria 4 - Duty to Warn - RIGL 42-72-8 allows the Department to release information if it is determined that there is a risk of physical injury by a person to himself/herself or others and that disclosure of the records is necessary to reduce that risk. If the Hotline receives a report that a perpetrator of sexual abuse or serious physical abuse has access to another child in a family dwelling, that report is classified as an investigation and assigned for investigation.

Investigation Criteria 5 - Alert to Area Hospitals – Safety of Unborn Child - RIGL 42-72-8 allows the Department to release information if it is determined that there is a risk of physical injury by a person to himself/herself or others and that disclosure of the records is necessary to reduce that risk. The Department issues an alert to area hospitals when a parent has a history of substantiated child abuse/neglect or a child abuse/neglect conviction and there is concern about the safety of a child.

A report made to the CPS Hotline that contains a concern about the well-being of a child, but does not meet the criteria for an investigation, may be classified as an Information/Referral (I/R) Report. Refer to DCYF Policy 500.0040, Information/Referral (I/R) Reports.

Related Procedure...

Criteria for a Child Protective Services Investigation

Related Policies...

Standards for Investigating Child Abuse and Neglect (CA/N) Reports (Levels 1, 2, 3)

Information/Referral (I/R) Reports

Processing and Notifications for an Alleged Institutional Abuse/Neglect Case

Kinship Care

Information/Referral (I/R) Reports

Rhode Island Department of Children, Youth and Families

Policy: 500.0040

Effective Date: July 7, 1984 ***Revised Date: May 29, 2015*** ***Version: 4***

A report made to the Child Protective Services (CPS) Hotline that contains a concern about the well-being of a child but does not meet the criteria for an investigation (refer to DCYF Policy 500.0010, Criteria for a Child Protective Services Investigation) may be classified as an Information/Referral (I/R) Report. If there is a history of Department of Children, Youth and Family (hereinafter, the Department) involvement, the CPS Hotline Child Protective Investigator (CPI) reviews the report with the Hotline supervisor to determine whether or not to initiate a CPS investigation.

When an I/R Report is received relating to an active Department case, all staff involved with the case are notified. The primary service worker/supervisor must review the information upon receipt and respond accordingly.

When an I/R Report is received relating to case that is not active with the Department, and it appears that there is a service need, a referral for services may be made to CPS Intake.

Related Procedure...

Information/Referral (I/R) Reports

Related Policy...

Criteria for a Child Protective Services Investigation

Drug Usage During Pregnancy

Rhode Island Department of Children, Youth and Families

Policy: 500.0125

Effective Date: January 22, 1990 ***Revised Date: December 9, 2011*** ***Version: 2***

The Department carefully considers all calls to the Child Abuse Hotline alleging drug and/or alcohol use by a pregnant woman. A call alleging drug and/or alcohol abuse may be received during the pregnancy, after delivery while the newborn is at the hospital or after a newborn is already home. An investigation is conducted if there is a specific allegation of abuse and/or neglect of the newborn and/or other children in the home. If, during the course of the investigation, the preponderance of evidence uncovered indicates that mother used drugs and/or alcohol during pregnancy, an allegation of drug/alcohol abuse is added to the investigation. Such evidence may include positive prenatal drug screen(s), positive toxicology screen on mother or newborn while in the hospital or admission by mother that she used drugs during pregnancy.

When a woman has tested positive for drugs and/or alcohol during prenatal treatment, there is good cause to test both her and her baby for the presence of drugs immediately after the birth. Babies born with drugs in their systems, as evidenced by a positive toxicology screen at birth or observable withdrawal symptoms, babies born to mothers who admit using drugs during pregnancy or who have been observed ingesting drugs and babies born with fetal alcohol syndrome must be reported to the Child Abuse Hotline. A Report of Examination is completed by the attending physician/nurse practitioner. If the method of use is known, such information is reported to the Department. All such reports are investigated by the Department.

If an investigation is founded and to ensure that these babies and their families are provided with necessary intervention, treatment and services, the assigned Child Protective Investigator (CPI) consults his/her supervisor and DCYF Legal Counsel as to the advisability of requesting an Order of Detention, Ex Parte, or a Straight Petition. Whether or not a Straight Petition is filed, the assigned Child Protective Investigator (CPI) refers the family to community services as appropriate.

Related Procedure...

Drug Use During Pregnancy

Related Policy...

Information/Referral (I/R) Reports

Standards for Investigating Child Abuse and Neglect (CA/N) Reports (Levels 1, 2, 3)

Rhode Island Department of Children, Youth and Families

Policy: 500.0050

Effective Date: July 7, 1984 **Revised Date: February 24, 2014** **Version: 7**

The Department of Children, Youth and Families (hereinafter, the Department) has established definitions and standards for investigating child abuse and/or neglect (CA/N) reports. These standards contain general directives for the handling of all investigations and designate different activities that are completed by the Child Protective Services (CPS) Hotline or Field Child Protective Investigator (CPI). Each investigative level (1, 2, and 3) is based on specific allegations prioritized in accordance with the severity of harm or threat of harm to the child. The assessment of the safety of a child is a critical component of a child protective investigation.

Rhode Island General Law 40-11-7 requires child abuse and/or neglect investigations to include personal contact with each child named in the report as well as any other children in the household or child care facility. In compliance with the statute, the Field CPI makes every effort to locate and interview each child residing in the household or present in the child care facility at the time the abuse and/or neglect took place, whether or not he or she is the alleged victim. When the alleged perpetrator is the parent or guardian of a child victim, the CPI makes every effort to confirm the past and present whereabouts of any child of that parent or guardian not residing in the household at the time of the alleged incident of abuse and/or neglect.

The Field CPI interviews the child, if the child is of the mental capacity to be interviewed, in the absence of the person responsible for the alleged abuse and/or neglect. In addition, the CPI has the right to question the child without the consent of the parent or other person responsible for the child's welfare. In the event that the CPI is denied reasonable access to the child, he or she may request the intervention of the local law enforcement agency or seek an appropriate court order to examine and interview the child.

Upon receipt of a CA/N report, the Hotline CPI initially sets the investigative standard (Level 1, 2, 3) based on the allegation of abuse and/or neglect. Each level has specific responsibilities that are performed by the Field CPI in the course of his or her investigation. The CPI Supervisor may upgrade the investigative level when circumstances warrant such a change. The Field CPI is then required to complete all responsibilities associated with the new investigative level.

The CPI or Supervisor may never downgrade the level of investigation. However, in certain circumstances, such as when the initial investigation proves the allegation to be false, the CPI may be allowed to omit specific tasks with administrative approval.

Related Procedure...

Definitions and Standards for Investigation Child Abuse and Neglect (CA/N) Reports (Levels 1,2,3)

Related Policies...

Criteria for a Child Protective Services Investigation

Removal of Child from Home

Police Involvement in Child Protective Investigation

Implementing the Indian Child Welfare Act

State of Rhode Island Regulations for Child Placing Agencies (Child Placing Regulations)

TITLE 40
Human services

CHAPTER 40-11
Abused and Neglected Children

SECTION 40-11-2

§ 40-11-2 Definitions.

When used in this chapter and unless the specific context indicates otherwise:

(1) "Abused and/or neglected child" means a child whose physical or mental health or welfare is harmed, or threatened with harm, when his or her parent or other person responsible for his or her welfare:

(i) Inflicts, or allows to be inflicted, upon the child physical or mental injury, including excessive corporal punishment; or

(ii) Creates, or allows to be created, a substantial risk of physical or mental injury to the child, including excessive corporal punishment; or

(iii) Commits, or allows to be committed, against the child, an act of sexual abuse; or

(iv) Fails to supply the child with adequate food, clothing, shelter, or medical care, though financially able to do so or offered financial or other reasonable means to do so; or

(v) Fails to provide the child with a minimum degree of care or proper supervision or guardianship because of his or her unwillingness or inability to do so by situations or conditions such as, but not limited to: social problems, mental incompetency, or the use of a drug, drugs, or alcohol to the extent that the parent or other person responsible for the child's welfare loses his or her ability or is unwilling to properly care for the child; or

(vi) Abandons or deserts the child; or

(vii) Sexually exploits the child in that the person allows, permits, or encourages the child to engage in prostitution as defined by the provisions in § 11-34.1-1 et seq., entitled "Commercial Sexual Activity"; or

(viii) Sexually exploits the child in that the person allows, permits, encourages, or engages in the obscene or pornographic photographing, filming, or depiction of the child in a setting that taken as a whole, suggests to the average person that the child is about to engage in, or has engaged in, any sexual act, or that depicts any such child under eighteen (18) years of age performing sodomy, oral copulation, sexual intercourse, masturbation, or bestiality; or

(ix) Commits, or allows to be committed, any sexual offense against the child as such sexual offenses are defined by the provisions of chapter 37 of title 11, entitled "Sexual Assault", as amended; or

(x) Commits, or allows to be committed, against any child an act involving sexual penetration or sexual contact if the child is under fifteen (15) years of age; or if the child is fifteen (15) years or older, and (1) force or coercion is used by the perpetrator, or (2) the perpetrator knows, or has reason to know, that the victim is a severely impaired person as defined by the provisions of § 11-5-11, or physically helpless as defined by the provisions of § 11-37-6.

(2) "Child" means a person under the age of eighteen (18).

(3) "Child protective investigator" means an employee of the department charged with responsibility for investigating complaints and/or referrals of child abuse and/or neglect and institutional child abuse and/or neglect.

(4) "Department" means department of children, youth and families.

(5) "Educational program" means any public or private school, including boarding schools, or any home-schooling program.

(6) "Institution" means any private or public hospital or other facility providing medical and/or psychiatric diagnosis, treatment, and care.

(7) "Institutional child abuse and neglect" means situations of known or suspected child abuse or neglect where the person allegedly responsible for the abuse or neglect is a foster parent or the employee of a public or private residential child-care institution or agency; or any staff person providing out-of-home care or situations where the suspected abuse or neglect occurs as a result of the institution's practices, policies, or conditions.

(8) "Law-enforcement agency" means the police department in any city or town and/or the state police.

(9) "Mental injury" includes a state of substantially diminished psychological or intellectual functioning in relation to, but not limited to, such factors as: failure to thrive; ability to think or reason; control of aggressive or self-destructive impulses; acting-out or misbehavior, including incorrigibility, ungovernability, or habitual truancy; provided, however, that the injury must be clearly attributable to the unwillingness or inability of the parent or other person responsible for the child's welfare to exercise a minimum degree of care toward the child.

(10) "Person responsible for child's welfare" means the child's parent; guardian; any individual, eighteen (18) years of age or older, who resides in the home of a parent or guardian and has unsupervised access to a child; foster parent; an employee of a public or private residential home or facility; or any staff person providing out-of-home care (out-of-home care means child day care to include family day care, group day care, and center-based day care). Provided, further, that an individual, eighteen (18) years of age or older, who resides in the home of a parent or guardian and has unsupervised access to the child, shall not have the right to consent to the removal and examination of the child for the purposes of § 40-11-6.

(11) "Physician" means any licensed doctor of medicine, licensed osteopathic physician, and any physician, intern, or resident of an institution as defined in subdivision (6).

(12) "Probable cause" means facts and circumstances based upon as accurate and reliable information as possible that would justify a reasonable person to suspect that a child is abused or neglected. The facts and circumstances may include evidence of an injury, or injuries, and the statements of a person worthy of belief, even if there is no present evidence of injury.

(13) "Shaken-baby syndrome" means a form of abusive head trauma, characterized by a constellation of symptoms caused by other than accidental traumatic injury resulting from the violent shaking of and/or impact upon an infant or young child's head.

History of Section.
(P.L. 1976, ch. 91, § 2; P.L. 1979, ch. 248, § 9; P.L. 1981, ch. 139, § 1; P.L. 1984, ch. 257, § 1; P.L. 1985, ch. 371, § 1; P.L. 1989, ch. 147, § 1; P.L. 1997, ch. 326, § 131; P.L. 1999, ch. 83, § 101; P.L. 1999, ch. 130, § 101; P.L. 2000, ch. 69, § 2; P.L. 2003, ch. 141, § 1; P.L. 2003, ch. 148, § 1; P.L. 2006, ch. 547, § 1; P.L. 2010, ch. 239, § 20; P.L. 2016, ch. 352, § 1; P.L. 2016, ch. 373, § 1.)

TITLE 40
Human services

CHAPTER 40-11
Abused and Neglected Children

SECTION 40-11-3

§ 40-11-3 Duty to report – Deprivation of nutrition or medical treatment.

(a) Any person who has reasonable cause to know or suspect that any child has been abused or neglected as defined in § 40-11-2, or has been a victim of sexual abuse by another child, shall, within twenty-four (24) hours, transfer that information to the department of children, youth and families, or its agent, who shall cause the report to be investigated immediately. As a result of those reports and referrals, protective social services shall be made available to those children in an effort to safeguard and enhance the welfare of those children and to provide a means to prevent further abuse or neglect. The department shall establish and implement a single, statewide, toll-free telephone to operate twenty-four (24) hours per day, seven (7) days per week for the receipt of reports concerning child abuse and neglect, which reports shall be electronically recorded and placed in the central registry established by § 42-72-7. The department shall create a sign, using a format that is clear, simple, and understandable to students, that contains the statewide toll-free telephone number for posting in all public and private schools in languages predominately spoken in the state, containing pertinent information relating to reporting the suspicion of child abuse, neglect and sexual abuse. This sign shall be available to the school districts electronically. The electronically recorded records, properly indexed by date and other essential, identifying data, shall be maintained for a minimum of three (3) years; provided, however, any person who has been reported for child abuse and/or neglect, and who has been determined not to have neglected and/or abused a child, shall have his or her record expunged as to that incident three (3) years after that determination. The department shall continuously maintain a management-information database that includes all of the information required to implement this section, including the number of cases reported by hospitals, health-care centers, emergency rooms, and other appropriate health-care facilities.

(b) The reporting shall include immediate notification of the department of any instance where parents of an infant have requested deprivation of nutrition that is necessary to sustain life and/or who have requested deprivation of medical or surgical intervention that is necessary to remedy or ameliorate a life-threatening medical condition, if the nutrition or medical or surgical intervention is generally provided to similar nutritional, medical, or surgical conditioned infants, whether disabled or not.

(c) Nothing in this section shall be interpreted to prevent a child's parents and physician from discontinuing the use of life-support systems or nonpalliative treatment for a child who is terminally ill where, in the opinion of the child's physician exercising competent medical judgment, the child has no reasonable chance of recovery from the terminal illness despite every, appropriate medical treatment to correct the condition.

History of Section.
(P.L. 1976, ch. 91, § 2; P.L. 1979, ch. 248, § 9; P.L. 1983, ch. 250, § 1; P.L. 1984, ch. 247, § 1; P.L. 1985, ch. 371, § 1; P.L. 1988, ch. 655, § 1; P.L. 1990, ch. 280, § 1; P.L. 1999, ch. 83, § 101; P.L. 1999, ch. 130, § 101; P.L. 2013, ch. 286, § 1; P.L. 2016, ch. 63, § 2; P.L. 2016, ch. 465, § 2.)

TITLE 40
Human services

CHAPTER 40-11
Abused and Neglected Children

SECTION 40-11-3.1

§ 40-11-3.1 Duty to report death of child due to child abuse or neglect.

Any person required to report under the provisions of this title, who has reasonable cause to know or suspect that a child has died as a result of child abuse or neglect shall immediately transfer that information to the department or its agent who shall cause the report to be investigated immediately. Upon receipt of the report, the department or its agent shall immediately transfer such information to the local law enforcement agency or the state police as well as to the office of the medical examiner. The office of the medical examiner shall investigate the report and communicate its preliminary findings, orally within seventy-two (72) hours, and in writing within seven (7) working days to the appropriate law enforcement agency, to the department and, if the person who made the report is an employee or a member of the staff of a hospital, to the hospital. Office of the medical examiner shall also communicate its final findings and conclusions, with the basis therefore, to the same parties within sixty (60) days.

History of Section.
(P.L. 1984, ch. 257, § 2.)

TITLE 40
Human services

CHAPTER 40-11
Abused and Neglected Children

SECTION 40-11-3.2

§ 40-11-3.2 False reporting of child abuse and neglect.

Any person who knowingly and willfully makes or causes to be made to the department a false report of child abuse or neglect shall be guilty of a misdemeanor and, upon conviction thereof, shall be fined not more than one thousand dollars ($1,000) or imprisoned not more than one year or both.

History of Section.
(P.L. 1996, ch. 156, § 1.)

TITLE 40
Human services

CHAPTER 40-11
Abused and Neglected Children

SECTION 40-11-3.3

§ 40-11-3.3 Duty to report – Sexual abuse of a child in an educational program.

(a) Any person who has reasonable cause to know or suspect that any child has been the victim of sexual abuse by an employee, agent, contractor, or volunteer of an educational program as defined in § 40-11-2 shall, within twenty-four (24) hours, transfer that information to the department of children, youth and families, or its agent, who or which shall immediately forward the report to state police and local law enforcement, and shall initiate an investigation of the allegations of sexual abuse. As a result of those reports and referrals, the department shall refer those children to appropriate services and support systems in order to provide for their health and welfare. In the event the department substantiates the allegations of sexual abuse against an employee, agent, contractor, or volunteer of an educational program, the department shall immediately notify the state police; local law-enforcement agency; the department of education; the educational program; the person who is the subject of the investigation; and the parent, or parents, of the child who is alleged to be the victim of the sexual abuse of the department's findings.

(b) The director is authorized to promulgate rules and regulations in order to carry out the intent of this section.

History of Section.
(P.L. 2016, ch. 352, § 2; P.L. 2016, ch. 373, § 2.)