Report of the Office of the Child Advocate Child Fatality Review Panel

A Review of Seven Fatalities and Twenty-Three Near Fatalities

May 2025

Executive Summary

Purpose and Scope:

The intent of this report is to identify systemic strengths and weaknesses within the child welfare, children's behavioral health and juvenile justice systems, with a key focus on improving policies and procedures to support organizations serving children in Rhode Island. The OCA and the panel are cognizant of the hard work and dedication of frontline workers providing care and support to some of our most vulnerable children and families of Rhode Island. 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, children's behavioral health and juvenile justice systems. The panel aimed to identify inefficiencies within the system posing a risk to the children and youth of this state, and to better inform systemic change. The panel also recognizes that some of the recommendations provided involve various state agencies and private entities, in addition to the Rhode Island Department of Children, Youth & Families (hereinafter "DCYF"). While the OCA's authority for oversight extends solely to DCYF, the panel believed it was important to address all identified areas of change to ensure the safety and well-being of the children and youth we serve. It is our hope that as a State, there will be coordinated inter-agency collaboration to address all identified gaps.

This report analyzes the cases of seven (7) fatalities and twenty-three (23) near fatalities of children who had involvement with DCYF. These incidents occurred between 2019 and 2024.

Case Data Snapshot:

- Total Number of Cases Reviewed: 30
- Total Number of Child Fatalities: 7
- Total Number of Child Near-Fatalities: 23
- Age Range of Children:
    - Substance Exposure: 1 month to 4 years and 10 months
    - Substance Use: age 13 to age 20
- Contributing Factors to Critical Incidents: substance exposure, substance use, AWOL behavior, parental substance use

Key Findings and Trends:

The panel identified various areas of weakness and gaps in services to be strengthened or developed. The most significant findings that the panel determined during the case review process include, issues related to children's behavioral health and adolescent substance use treatment, care coordination and transition planning, AWOL youth and prevention strategies, trauma-informed practice, DCYF's Substance Use Coordinator, parental substance use treatment and prevention of substance exposure, parental access to substance use treatment, home-based services, harm reduction, critical event reviews, and transparency and accountability for the implementation of recommendations.

- **Common risk factors**: trauma history, youth with co-occurring diagnoses, parental substance use, lack of supervision, AWOL behavior
- **Missed opportunities for intervention**: fragmentation of services for youth – DCYF oversees children's behavioral health, BHDDH oversees substance use treatment for youth, lack of in-state placements for adolescents
- **Gaps in communication among agencies**: specifically, between DCYF and BHDDH requiring a closer look at intensive care coordination to better serve children and families

<u>Children's Behavioral health and Adolescent Substance Use Treatment</u>

The panel identified gaps in available resources throughout the review of all cases involving adolescent substance use. While the need for substance use treatment was a common theme throughout the cases, other critical services, which should be provided by DCYF, were also inaccessible. Our state lacks a comprehensive continuum of care as required by law. In ten (10) of these fatalities and/or near fatalities, the panel indicated there were gaps in the entire continuum of care impacting the youth's ability to access necessary supports and services, timely. The overarching crisis that continues to plague our child welfare, juvenile justice, and children's behavioral health systems is the lack of a comprehensive service array across all levels of care. The youth and young adults involved with DCYF deserve meaningful investment and coordinated efforts to develop a concrete plan to rebuild the crucial services supporting their needs. This includes investments in Mobile Response and Stabilization Services to support children and youth in crisis; prevention and home-based services; a robust array of foster homes serving varying populations; in-state Psychiatric Residential Treatment Facility (PRTF) and Residential Treatment to support the needs of acute populations; and step-down programming for children and youth who require additional time in a structured environment, prior to transitioning home or to a foster home, to promote expedient discharges from more restrictive settings. The impact of a disjointed and under-resourced continuum of care was well illustrated by the cases reviewed by the panel.

In addition to maintaining a full continuum of care to provide treatment services at all levels, the panel noted a consistently fragmented approach to the delivery of services. The lack of services available in-state, in combination with extensive waitlists for critical services and timely

access to services, remains a concern. When youth require an out-of-home congregate care placement to receive services, DCYF compiles documentation to include in a referral packet that is sent to each placement. Once received, the program reviews it, sets up an interview if appropriate, and then schedules an admission date. In cases where there is no appropriate in-state treatment option, this process can be lengthy, because DCYF must rely on out-of-state programs to prioritize Rhode Island youth. While this process is taking place, youth may be waiting at home, in a temporary congregate care setting, or in a hospital setting.

Care Coordination and Transition Planning

The panel identified a lack of clarity on how determinations are made regarding which community-based services are appropriate for the youth and families. There were instances when interventions put in place were not specifically recommended for that youth's diagnoses and presenting behaviors. For example, youth who were diagnosed with an intellectual disability or a developmental disability had services in place that did not support the youth's substance use disorder and co-occurring disorders. Additionally, one (1) allegation of a traumatic incident went unaddressed and unacknowledged during years of treatment because it was not included in referral information to placements and service providers. Currently, DCYF's Central Referral Unit makes referrals for community-based services for youth with information provided by the FSU team.

AWOL Youth and Prevention Strategies

In addition to the clear need for a substance use residential treatment facility in-state and a comprehensive continuum of care, a behavior that many of the youth and young adults engaged in was being AWOL. AWOL behavior is consistently observed among youth and young adults experiencing the child welfare, juvenile justice, or children's behavioral health systems. The current Department Operating Procedure (DOP) titled "Missing Children/Youth Absent from Care" outlines the action steps that staff are required to complete when a youth is identified as missing or absent from care. These immediate actions are taken to make every effort to locate the child as soon as possible. Of the youth who displayed AWOL behavior, some were missing for days and others were missing for up to four (4) months. The DOP specifically outlines action steps to be taken by DCYF's Special Investigations Unit (SIU). SIU is comprised of staff who have built critical relationships with police departments, community partners, and most importantly young people, which allows the SIU team to effectively and efficiently locate youth missing from care. The specialized and time sensitive work conducted by the SIU team is an invaluable and impactful resource supporting our youth.

Trauma-Informed Practice

The panel consistently elevated the importance of trauma-informed practice during case discussions of adolescent youth involved with the child-welfare, juvenile justice, and children's behavioral health systems. Adolescents who become involved with these systems experience trauma which requires professionals in this field to expand their knowledge through education

and training in order to stay current on trauma-informed best practices for high-quality service delivery.

DCYF's Substance Use Coordinator

The panel identified some gaps in using the resources provided by the Substance Use Coordinator. In several of the cases reviewed by the Panel it was evident that this position was not used as a resource to help identify and coordinate services, because referrals were either not made or inconsistent. The panel cited this gap in several cases and attributes this to the lack of knowledge by all DCYF staff of the role and the supports the Substance Use Coordinator can provide.

Upon review of DCYF Operating Procedures, the role of the Substance Use Coordinator is not specifically incorporated as part of the procedures that would be applicable to the responsibilities outlined. Integrating this role into DCYF's policies and providing staff with robust training on the role and responsibilities of the Substance Use Coordinator will increase the likelihood that this position is utilized to the fullest extent and consistent referrals are made to support youth with substance use issues. In cases where fatalities or near fatalities occur due to substance use or substance exposure, the Substance Use Coordinator should participate and play an active role in the Critical Event Review process.

Parental Substance Use Treatment and Prevention of Substance Exposure to Children

The stigma surrounding substance use among parents often leads to shame, isolation, and fear of losing custody, which can prevent them from seeking the help they need. To break this cycle, we must take a multifaceted approach rooted in education, policy, and compassionate support systems. Public education campaigns can shift harmful narratives by promoting understanding that substance use is a health issue, not a moral failing. Policy reforms should focus on harm reduction and prioritize keeping families together whenever safe and appropriate, rather than punitive responses. Expanding access to trauma-informed treatment services, peer support programs, and parenting resources tailored to those in recovery creates an environment where healing is possible. By combining these strategies, we can replace stigma with empathy and empower parents on their journey to recovery and family stability.

Parental Access to Substance Use Treatment

Residential treatment for parents with substance use issues who wish to remain with their children, is limited. For example, in Rhode Island, there is a twelve (12) bed facility, which provides intensive residential substance use treatment to mothers with children. This program provides a holistic and comprehensive approach to treatment, including parenting programs and services for children under the age of three (3). Exploring the need for additional residential treatment, which can support families, would prioritize family stability while addressing the critical needs of both the parents and children, in a supportive setting. Additionally, barriers were identified regarding the criteria for available programming. This

program model is gender specific and has criteria in place, such as a limit on the number of children, the age of the child(ren), and the type of substance utilized by the parent.

Home Based Services

Family visiting programs are home-based and voluntary programs, which provide critical support to pregnant women and families with young children. These programs are offered in every city and town in Rhode Island and link expectant parents and families with young children with additional resources and services in their community.

Family visiting programs collaborate with Peer Recovery Specialists working with parents struggling with substance use. Peer Recovery Specialists coordinate care, building relationships between the provider and the parents, and work to increase parent engagement with the services. Peer Recovery Specialists receive specialized training as peers with lived experiences to provide support to pregnant and parenting mothers. As noted, through the role of the DCYF Substance Use Coordinator, DCYF routinely connects parents with this service. However, it was noted the workforce providing this support has decreased over the past few years. Rebuilding and reinvesting in the workforce could help sustain and expand the provision of these services.

Harm Reduction

Furthering initiatives to decrease children's access to substances and medication by providing safe storage containers along with educational materials around the importance of safe storage, could decrease the risk of unintentional ingestion by younger children or limit access by adolescents. For example, one study conducted in 2020, found that despite widespread reporting on the opioid crisis, many caregivers remained unaware of safe medication storage practices and as well as the opioid crisis.[1] In their survey of fifty (50) caregivers of one-hundred twelve (112) children, only four percent (4%) reported that they stored their medications in a locked or latched place. Fifty-six percent (56%) of caregivers believed that it was unlikely or very unlikely that their child could gain access to medications. Thirty-eight percent (38%) reported that their main barrier to storing medications safely was access to locked storage. Fifty percent (50%) of the caregivers surveyed claimed to be unaware of the opioid crisis.[2] Providing medication lock boxes removes a commonly reported barrier to safely storing medications.

Critical Event Reviews

The Critical Event Review process is meant to serve as an internal administrative review to assess for systemic issues, including a review of applicable statutes, regulations, procedures, training, and practice. This should be scheduled within five (5) business days after DCYF receives

[1] Webb, A.C., Nichols, M.H., Shah, N. *et al.* Effect of lock boxes and education on safe storage of medications. *Inj. Epidemiol.* **7** (Suppl 1), 21 (2020). https://doi.org/10.1186/s40621-020-00257-y
[2] Webb, A.C., Nichols, M.H., Shah, N. *et al.* Effect of lock boxes and education on safe storage of medications. *Inj. Epidemiol.* **7** (Suppl 1), 21 (2020). https://doi.org/10.1186/s40621-020-00257-y

notification of the fatality, near fatality, or another critical incident referred deemed necessary to review.

Transparency and Accountability for the Implementation of Recommendations

The OCA acknowledges the recent efforts by DCYF to engage a wide range of partners in reviewing and analyzing all recommendations made over the past ten years in response to child fatalities and near fatalities, in a variety of forums. The work group is not just focused on the recommendations issued by the OCA Child Fatality Review Panels, but the recommendations of all partners in this work. This is an immense undertaking, and we applaud these efforts. However, as leadership changes, so can initiatives such as this. It is imperative that a requirement for a response and plan for implementation be formalized in law to ensure that expectations are clear, and this work is ongoing.

It is paramount to ensure that any opportunity for improvement related to child safety and well-being is urgently acted upon and done so efficiently and with transparency. Requiring DCYF to provide a response within a designated timeframe, identifying a plan for action, barriers to implementation, and funding needs, will inform advocacy efforts. This written response will provide our state with the opportunity to further support DCYF in their efforts to make necessary improvements. We recognize that there are recommendations that the Director, as the decision-maker for DCYF, may not support. By requiring a public written response within a designated timeframe, these issues can be identified, provide an opportunity for discourse and advocacy, but most importantly establishes a mechanism to keep the work moving forward. In addition, the Panel recognizes that the recommendations issued may extend beyond the scope of DCYF to other entities that are involved with child welfare or family services. We ask that DCYF engage with any and all entities identified and incorporate efforts to collaborate regarding inter-agency issues as a part of the written response.

Recommendations:

For a complete list of the panel's recommendations, please see Page 69 in the full report.

Conclusion:

The 30 cases reviewed reflect critical areas where our child welfare system must improve its ability to protect vulnerable children. Immediate action on the outlined recommendations is essential to prevent future harm.

We must work together to take proactive steps to prevent tragedies like these from occurring in the future. Our children and youth need a robust system to support them through a comprehensive continuum of care that is nimble and ready to support their complex needs in real time.

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PREFACE

On behalf of the Office of the Child Advocate (hereinafter "OCA"), I would like to extend our sincere appreciation and heartfelt gratitude to the members of the Office of the Child Advocate Child Fatality Review Panel (hereinafter "panel") for dedicating their time, expertise, and unwavering commitment to the review process. Thank you to our distinguished panel for your invaluable contribution to this important process:

- Captain Gregg Catlow
- Sarah Dinklage, LICSW
- Ken Fandetti
- Linda Hurley
- Michele Paliotta, LICSW
- Dr. Linda Shaw
- Rachel Weitz, DNP, PMHNP-BC

I would also like to acknowledge the hard work and dedication of my colleagues at the Office of the Child Advocate. Without the tireless efforts of this incredible team, this report would not have been possible.

- Diana Robbins, Esq.
- Kathryn R. Cortes
- Jacqueline Lafontant
- Jimmy Vilayvanh
- Kara A. Foley, MSW
- Taylor Camirand
- Anna Sheil, Esq.
- Peter Capalbo, JD.
- Siobhan Bogosian, Esq.
- Kristin Anslo

Thank you all for your commitment to improving the safety and well-being of children and youth in the State of Rhode Island.

Sincerely,

Katelyn Medeiros, Esq.
Child Advocate

Introduction

The intent of this report is to identify systemic strengths and weaknesses within the child welfare, children's behavioral health and juvenile justice systems, with a key focus on improving policies and procedures to support organizations serving children in Rhode Island. The OCA and the panel are cognizant of the hard work and dedication of frontline workers providing care and support to some of our most vulnerable children and families of Rhode Island. 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, children's behavioral health and juvenile justice systems. The panel aimed to identify inefficiencies within the system posing a risk to the children and youth of this state, and to better inform systemic change. The panel also recognizes that some of the recommendations provided involve various state agencies and private entities, in addition to the Rhode Island Department of Children, Youth & Families (DCYF). While the OCA's authority for oversight extends solely to DCYF, the panel believed it was important to address all identified areas of change to ensure the safety and well-being of the children and youth we serve. It is our hope that as a State, there will be coordinated inter-agency collaboration to address all identified gaps.

This report constitutes a public record under Rhode Island General Laws (R.I.G.L.) § 30-2-(d)(16). The names of the individuals involved in the cases reviewed have been omitted or altered to protect their identity to conform with the OCA's mandate for confidentiality outlined in R.I.G.L. § 42-73-1 et seq.

The panel reviewed thousands of pages of documentation and analyzed each case extensively. This comprehensive report is the result of countless hours of investigation, records requests, research, review and discussion of the cases, policies, statutes, and other relevant materials. The OCA also conducted informational meetings with other entities and agencies to collect additional information about the work underway, state-wide. Upon completing this review, the panel composed the recommendations included in this report with the intent of effectuating the critical systemic change necessary to ensure the safety and well-being of all children involved with DCYF.

The panel would like to acknowledge the statewide efforts currently underway to address the far-reaching impact of substance use and exposure on children and families throughout the community. We are deeply appreciative of the many government agencies and community partners who are working tirelessly—often with limited resources—to meet the complex needs of those affected. Sustained, coordinated collaboration at all levels will be essential in combating this pervasive issue. Throughout the course of our work, we were fortunate to engage with numerous dedicated partners, and we sincerely thank all who took the time to meet with our team and share their insights in preparation for this report. The OCA welcomes

continued partnership as we move forward together to assess and implement the panel's findings and recommendations.

OCA's Statutory Mandate and Overview of Cases

The OCA is responsible for reviewing any child fatality or near fatality under R.I.G.L. § 42-73-2.3(b):

> (1) The fatality or near fatality occurs while in the custody of, or involved with, the department[3], or the child's family previously received services from the department;
>
> (2) The fatality or near fatality is alleged to be from abuse or neglect of the child and the child or child's family had prior contact with the department; or
>
> (3) A sibling, household member, or daycare provider has been the subject of a child abuse and neglect investigation within the previous twelve (12) months, Including, without limitation, cases in which the report was unsubstantiated or the investigation is currently pending.

The OCA is notified by DCYF of all child fatalities and near fatalities, from birth to age twenty-one (21), and reviews the circumstances of each incident including the history of the family to determine if it meets the criteria for review under the above-referenced statute. If it meets the criteria, the OCA will convene a panel.

Pursuant to R.I.G.L. § 42-73-2.3 (e), "[t]he child advocate … [is to] publicly announce the convening of a child-fatality-review panel, including the age of the child involved." Panel members are chosen based on areas of professional expertise and their ability to exercise independent judgment. The team is tasked with reviewing the circumstances surrounding the death or near death of the child, identifying gaps in assessments and service provision, and recommending prevention strategies to improve the overall coordination of services to children and families involved in state care.

A press release was first issued on April 12, 2023, to announce the convening of a panel to review the fatality of a fifteen (15) year old youth, open to DCYF. A second press release was issued regarding this panel, on June 20, 2023, to announce the panel members and to note that three (3) additional cases would be added to the review. Throughout 2023-2024, there was an increase in the number of child fatalities and near fatalities related to substance use and substance exposure. Upon review of all fatalities and near fatalities that occurred between 2019 and 2024 that met the statutory mandate for review, the OCA made the decision to expand the scope of the initial review. The decision was made to include all fatalities and near fatalities related to substance use or substance exposure, as we had already impaneled experts

[3] R.I.G.L. § 42-73-2.3 refers to the Department of Children, Youth and Families as "the department".

to focus specifically on the needs of this population of children and youth. While there were additional fatalities and near fatalities that occurred during this timeframe, these cases will be reviewed in another report by a separate panel.

On February 21, 2024, the OCA began reviewing cases with the convened panel. In total, the panel reviewed twenty-three (23) near fatalities and seven (7) fatalities. There were fourteen (14) youth, ranging in age from one (1) month to four (4) years and ten (10) months old who were exposed to substances. Specifically, there were twelve (12) near fatalities and two (2) fatalities due to substance exposure. There were sixteen (16) youth ranging in age between thirteen (13) and twenty (20) who used substances. Specifically, there were five (5) fatalities and eleven (11) near fatalities due to substance use.

DCYF's Statutory Mandate

I. Notify the OCA

In accordance with R.I.G.L. § 42-72-8(c) DCYF is "…mandated to notify the OCA in writing and verbally within forty-eight (48) hours of a confirmed fatality or near fatality[4], when the child is the subject of a DCYF case." With only a few exceptions throughout 2019-2024, DCYF has consistently notified the OCA, once they became aware of a fatality or near fatality.

In accordance with R.I.G.L. § 42-72-8(c)(3), DCYF must also disclose information to the OCA "…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." The information that should be provided to the OCA following a substantiated finding of abuse or neglect that resulted in a fatality or near fatality, is further delineated in R.I.G.L. § 42-72-8(c)(4).

II. DCYF Public Disclosure

Pursuant to R.I.G.L. § 42-72-8(c)(2), "[t]he 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."

[4] DCYF's Public Disclosure of Child Fatality and Near Fatality Information Department Operating Procedure (DOP) 100.0265 defines a "Near Fatality" as a child in serious or critical condition as certified by a physician due to abuse, neglect, self-harm, or other unnatural causes. The child being placed in serious or critical condition must be classified by the treating and/or consulting physician and reflected in the medical chart. The treating physician's determination that the child is in serious or critical condition is accepted without further assessment by the Department.

III. Federal Reporting

a. Child Abuse Prevention and Treatment Act

The Child Abuse Prevention and Treatment Act (CAPTA), (P.L. 100–294), as amended by the CAPTA Reauthorization Act of 2010 (P.L. 111–320), retained the existing definition of child abuse and neglect as, at a minimum: "Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act, which presents an imminent risk of serious harm."

b. National Child Abuse and Neglect Data System

The National Child Abuse and Neglect Data System (NCANDS) is a centralized data collection system that gathers information on reports of child abuse and neglect from all 50 states, the District of Columbia, and Puerto Rico. Each state voluntarily provides data annually and the data are archived at the National Data Archive on Child Abuse and Neglect for researchers to use for statistical analysis. NCANDS collects data based on the Federal Fiscal Year which runs from October 1 to September 30.

According to NCANDS data from 2023, one (1) fatality occurred in Rhode Island due to maltreatment, a decrease from two (2) fatalities during each reporting period between 2020 – 2022, and three (3) fatalities in 2019. It is important to note that while NCANDS data includes child fatalities, near fatalities are not included in reporting.[5] This data also may not align with the data provided on a state level as the NCANDS accounts for the date the death was determined to be the cause of maltreatment, not the date of death. NCANDS data also does not account for near fatalities.

It is important to promote consistency but also have an understanding in the differences in data reporting both on a state and federal level. The more we can do to push for consistency and standardization in reporting and information sharing, will only further our work in assessing and addressing systemic need and formulating effective prevention strategies.

Cases Reviewed – Substance Exposure

I. Fatalities

Fatality Summary #1:

A report was made to DCYF[6] due to the fatality of a four (4) month old under the care of a legal guardian effectuated through probate court. DCYF completed an investigation. During the investigation, the legal guardian reported that she was not made aware of safe sleep best

5 Child Maltreatment 2023. (n.d.). U.S. Department of Health & Human Services; Administration for Children and Families. Retrieved April 4, 2025, from https://acf.gov/sites/default/files/documents/cb/cm2023.pdf.

6 "A report was made to DCYF" refers to a call to the DCYF's Child Abuse Hotline.

practices, and she did not speak with anyone in the hospital prior to caring for the newborn. The cause of death was a lethal dose of Benadryl, and this fatality was listed as a homicide. DCYF indicated[7] the legal guardian for Physical Abuse – Death, Physical – Poisoning/Noxious Substance, and Physical Neglect – Death.

This family initially came to the attention of DCYF due allegations made to DCYF regarding the subject child's sibling(s). The panel's review indicates that there may have been at least three (3) prior investigations completed and unfounded[8]. At least one (1) Family Care Community Partnership (FCCP)[9] referral was made during previous contact with DCYF. The panel did not review these records, as they were not in Rhode Island Children's Information System (RICHIST)[10], were not in the hard copy file provided by DCYF, nor was a Critical Event Review held for this case.[11] About seven (7) months after the last contact with DCYF, the fatality occurred. The legal guardian had no documented history with DCYF as an adult.

Fatality Summary #2:

A report was made to DCYF due to an unresponsive two (2) year old. Emergency services administered CPR; however, the child was pronounced dead at the hospital. There was evidence of narcotics manufacturing in the home. An eight (8) year old sibling tested positive for fentanyl. The other sibling tested negative. DCYF was informed the cause of death was acute fentanyl intoxication. The manner of death was homicide. DCYF completed an investigation. DCYF indicated mother for Physical Neglect – Death and Neglect – Lack of Supervision/Caretaker.

This family initially came to the attention of DCYF due to allegations of domestic violence with the subject child's sibling present in the home. Mother agreed to engage in anger management and FCCP services. DCYF spoke with family members who denied concerns for mother's parenting. Parents denied ongoing domestic violence. DCYF indicated mother for Neglect – Other Neglect. The family remained open to DCYF for a short period of time due to issues with the referral to FCCP. Once involved with FCCP, a referral was made for Early Intervention[12] and then FCCP closed to the Family. A review of RICHIST by the OCA indicates there was at least one (1) subsequent investigation that was unfounded, and one (1) report made to DCYF that was

[7] DOP 500.0025 defines indicated as "...a report, under RI General Law § 40-11-2, was assessed, and a preponderance of the evidence indicates that abuse or neglect exists consistent with the Rhode Island State Statutes."
[8] DOP 500.0025, defines unfounded, also referred to as "unsubstantiated" as "...a child abuse and neglect report, according to RI General Law §40-11-2, was assessed and that the preponderance of the credible evidence does not indicate that abuse or neglect exists consistent with Rhode Island State statutes."
[9] Family Care Community Partnership are a network of prevention-focused providers, that work with DCYF to deliver community-based services to children and families.
[10] Rhode Island Children's Information System (RICHIST) is the DCYF's automated information system to record work on behalf of children and families.
[11] Reports made to DCYF that are screened out and investigations where the allegations are unfounded are no longer documented in RICHIST after a period of time has passed. These were not available for review, they were not provided to the OCA in the DCYF hardcopy file, nor were they reviewed at the Critical Event Review. The OCA was able to obtain partial information from Case Activity Notes on RICHIST and Assignments of cases within RICHIST.
[12] Early Intervention is a program in Rhode Island providing developmental screenings and supportive services to to promote the growth and development of infants and toddlers who have a developmental disability or delay in one or more areas.

categorized as an Information/Referral.[13] The panel did not have access to the full records of these calls as they are not in RICHIST, nor were the records in the hard copy file provided by DCYF and were not reviewed during the Critical Event Review.

Another report was made to DCYF due to allegations that a sibling had inappropriate contact with a peer. No additional information was provided. DCYF made this an Information/Referral with no further involvement from DCYF. Another report was made to DCYF during the COVID-19 pandemic that mother's other child was not engaging in virtual learning and mother could not be reached by the school. DCYF requested a well-check by the local police department. A neighbor indicated that mother moved with no forwarding address. This report was screened out[14] with no further involvement from DCYF.

II. Near Fatalities

Near Fatality Summary #1:

A report was made to DCYF that a one (1) year old presented as lethargic and emergency services responded to the family home. It was reported that the child was potentially exposed to Suboxone. Emergency services administered Narcan. This did not seem to have any effect and there was a plan to give another dose. The child was admitted to the Pediatric Intensive Care Unit (PICU) and tested positive for buprenorphine, which is the active ingredient in Suboxone, and the child's medical evaluation was clinically consistent with opioid (partial) agonist intoxication. The child accessed the Suboxone pill, which was left unattended on a nightstand next to pieces of candy. DCYF completed an investigation and both parents were indicated for Neglect – Lack of Supervision/Caretaker. While this investigation was underway, an additional report was made to DCYF due to a domestic violence incident, which resulted in the child being struck by a family member. DCYF indicated the family member for Neglect – Domestic Violence.

The family initially came to the attention of DCYF when a report was made due to a domestic incident between father and a family member. DCYF completed an investigation and the allegations of Neglect – Domestic Violence were unfounded as to father.

Near Fatality Summary #2:

A report was made to DCYF that a four (4) year old ingested a sleeping pill and emergency services responded to the home. Emergency services administered Narcan, and police informed the family that the child had ingested an opioid. The father reported that he believed it to be fentanyl. The child was transported to the hospital and was admitted. It was discovered that the child had knowledge of where the pills were stored in a bag, in a drawer, which was accessible to the child. The child accessed the pills and ingested one. The child's toxicology

[13] An "Information/Referral" is the previous term used for the current "Screen Out."
[14] A "Screen Out" is a report made to DCYF's Child Abuse Hotline concerning a child's well-being that does not meet one of six (6) criteria for an investigation.

screen came back positive for fentanyl. DCYF completed an investigation and indicated father for Neglect – Lack of Supervision and Neglect – Neglect (Other Neglect).

This family first came to the attention of DCYF when there was a disturbance during a visitation exchange involving the fathers of the mother's children. DCYF completed an investigation and indicated both parents for Neglect – Lack of Supervision/Caretaker. Mother was offered an FCCP referral, which she declined. She reported that she could handle the situation on her own.

A report was made to DCYF due to allegations the children were left in the care of a thirteen (13) year old sibling. Two days later, a report was made to DCYF due to allegations that the children were residing in a home where a household member required emergency services due to an overdose. DCYF completed an investigation as to both reports made to DCYF and unfounded the allegations.

Another report was made to DCYF reporting the children were left in the care of a thirteen (13) year old sibling. DCYF requested a well-child check and there were no reported issues in the home. This call was made an Information/Referral, with no further involvement from DCYF.

A report was made to DCYF due to allegations that mother's oldest child was left at a shopping center and unable to reach their parents. One (1) day later, another report was made to DCYF alleging mother smelled like alcohol at a school meeting. DCYF completed an investigation for both reports and unfounded the allegations. Mother agreed to a referral to FCCP, and a substance use evaluation.

A report was made to DCYF when father was heard yelling and swearing at the children. This call was made an Information/Referral. A report was made to DCYF when one of mother's older children came to school with bruises and scratches. These were reportedly from the family dog. This report was screened out, with no further involvement from DCYF.

Near Fatality Summary #3:

A report was made to DCYF that a three (3) year old was brought to the hospital due to ingesting Clonazepam. The child was admitted to the hospital to monitor their respiratory status due to ingestion of medication causing altered mental status, lethargy, and difficulty walking. It was reported the child accessed a bottle containing the pills on a shelf in the parents' bedroom. Parents reported their medication was typically kept on a higher shelf, but they may have forgotten to put it back. During the investigation, numerous medications were observed in this location, as well as the wrong medications in the wrong bottles. DCYF completed an investigation and indicated the father for Neglect – Lack of Supervision/Caretaker.

This family initially came to the attention to DCYF due to mother testing positive for marijuana when the subject child's older sibling was born. DCYF completed an investigation and indicated the mother for Neglect – Other Neglect and Physical Abuse – Drug/Alcohol use. Mother was

referred for services and closed to DCYF following her engagement in substance use counseling and providing urine screens. Five (5) years later, another call was made to DCYF reporting the parents and grandparents were heard yelling and swearing at the child in their care. This call was made an Information/Referral, and no further intervention was provided. The near fatality occurred approximately one (1) year after this call.

Near Fatality Summary #4:

A report was made to DCYF that a 23-month-old was brought to the hospital when found unresponsive by mother. The child was admitted to the hospital, requiring Narcan, Epinephrine, intubation, and then was sedated in the PICU on a ventilator. The toxicology report was positive for fentanyl. DCYF completed an investigation and discovered the mother was engaged in substance use and left the drugs in a place accessible by the children. It was also reported mother had misplaced one of the bags of substances at one point, which both mother and father searched for until it was located. DCYF indicated the mother for Neglect – Lack of Supervision/Caretaker.

This family initially came to the attention of DCYF when mother moved to a different state leaving her first child with family in Rhode Island. Family expressed concerns regarding mother's substance use. DCYF completed an investigation and indicated the mother for Neglect – Other Neglect. The case opened to DCYF. Parents had sporadic engagement and subsequently, a legal guardianship with family was finalized and the case closed to DCYF.

Approximately a year and half after the legal guardianship was finalized, a report was made to DCYF indicating that mother had just given birth to another child and alerting DCYF to possible substance use by parents. DCYF investigated and found that both parents were actively engaged in treatment. DCYF unfounded the allegations, and no further intervention was provided. Six (6) months later a report was made to DCYF reporting concerns for substance use and domestic violence between parents. DCYF investigated and it was reported by mother that father was engaged in substance use and made him leave the home. DCYF confirmed that mother was still engaged in substance use treatment and was providing negative toxicology screens. DCYF unfounded the allegations. The following month, three (3) reports were made to DCYF reporting concerns for substance use and domestic violence. Mother and grandparents reported mother was substance free and engaged in treatment. Both parents denied domestic violence. Two investigations were conducted by DCYF within the same month, and DCYF unfounded the allegations. Four (4) months later, DCYF received a call from a hospital indicating that mother had given birth and tested positive for marijuana at birth. Mother had a medical marijuana card and was prescribed the treatment by a doctor. She was also engaged in a methadone maintenance treatment program. The information was confirmed, and DCYF unfounded the allegations. At this time DCYF reviewed safe sleep best practices and safe marijuana use with the parents.

Approximately three (3) months later, a report was made to DCYF noting father overdosed and went to the hospital and that mother assaulted father while she was under the influence. DCYF

completed an investigation and the allegations as to mother and father were indicated for Neglect – Lack of Supervision. The children were removed from the care of the parents and placed in foster care. The family remained open to DCYF for one (1) year and after mother graduated from drug court, DCYF closed to the family. Upon graduating from Family Treatment Drug Court, mother was receiving methadone treatment, monthly scheduled sessions with a counselor, and weekly toxicology screens were negative. Additionally, mother was meeting with a provider for a psychological evaluation. About six months following the family closing to DCYF, a report was made to DCYF by mother that she tested positive for marijuana, not opiates; she wanted DCYF to know her medical marijuana card expired and due to COVID, she could not get it renewed. This call was documented in a Case Activity Note in RICHIST. The near fatality occurred about three (3) weeks later.

Near Fatality Summary #5:

A report was made to DCYF that a ten (10) month old was brought to hospital because the parents observed the baby turn blue. The hospital administered Narcan due to unresponsiveness and the child was admitted to the PICU for monitoring. The toxicology report was positive for fentanyl. DCYF completed an investigation.

Father reported they were in a hotel room and the child picked up a piece of cotton and the child put it in their mouth. Mother was out with the other children at the time. Shortly after, the child was lethargic and nodding off. There was an active No Contact Order between the parents at the time. Parents denied substance use. Father agreed to submit to a drug screen but did not provide any results to DCYF. Mother later tested positive for fentanyl but denied use. During this investigation, it was also discovered a (12) year old sibling had smoked marijuana and accessed mother's methadone pills, taking the medication. The child disclosed that mother kept her methadone in a lock box, however, it was often left open. DCYF indicated both parents for Neglect – Lack of Supervision and Physical Abuse – Drug/Alcohol Abuse. DCYF also indicated the mother for Neglect – Lack of Supervision/Caretaker and Physical Abuse – Drug/Alcohol Abuse, as to the child's sibling.

The family initially came to the attention of DCYF two (2) years prior when a report was made to DCYF that mother gave birth to a baby and mother tested positive for marijuana and methadone at delivery. The methadone was prescribed as mother was actively engaged in Medication Assisted Treatment. Mother was reportedly using marijuana to assist with nausea and loss of appetite. DCYF completed an investigation and indicated the mother for Physical Abuse – Drug/Alcohol Abuse. DCYF did not remain open to this family, reporting mother was in treatment, providing negative drug screens, and the treatment provider had no concerns. Mother was also willing to engage in a family visiting program[15]. The child was also referred for a developmental evaluation. About nine (9) months later, a report was made to DCYF due to a

[15] "Family visiting programs" are home-based programs that provide guidance and support to families. There is a short-term program through First Connections and a longer-term program through Healthy Families America (HFA), Nurse-Family Partnership (NFP), and Parents as Teacher (PAT). Collectively, these programs are known as RIDOH's evidence-based Maternal, Infant, and Early Childhood Home Visiting (MIECHV) programs.

domestic violence incident in the car between mother and father. DCYF completed an investigation and indicated the father for Neglect – Domestic Violence. A No Contact Order was issued between mother and father. Mother was referred to FCCP services and was living in a motel, paid for by family. DCYF subsequently closed.

An out-of-state child welfare agency contacted DCYF when mother gave birth to another child, and they were unable to locate the family following discharge from the hospital. Mother tested positive for marijuana and methadone at the birth. DCYF provided the agency with the information from their previous contact regarding treatment. DCYF made several attempts to locate the family, including connecting with the children's school, pediatrician, father's probation officer, and local state assistance agencies. DCYF was finally able to locate mother and met with her and the children. There were no concerns identified during the visit and mom signed releases and DCYF referred the family to FCCP. DCYF contacted mother's substance use treatment provider, who reported that all random weekly drug screens were negative, and she is engaged in weekly dosing for methadone. They see the kids sometimes when they come with her and have no concerns. The out-of-state child welfare agency closed the case once the family was confirmed to be in Rhode Island. DCYF assisted in referring the children to the correct school and connected with FCCP. FCCP stated that mother denied services, as family is paying for her motel. DCYF spoke with mother about declining services, and she reports she already has the services, is looking for a job, and identified a daycare. DCYF spoke with father, and he stated he is not having contact with mother. The out-of-state agency provided their investigation which was indicated as the new baby tested positive for methadone and marijuana. Both the out-of-state agency and DCYF closed to the family. About six (6) months later, the incident which led to the near fatality occurred.

Near Fatality Summary #6:

Two (2) reports were made to DCYF reporting that an eleven (11) month old was found unresponsive. Emergency services administered two doses of Narcan, and the child responded immediately. Narcan was also administered at the hospital. The child was admitted to the PICU and the toxicology report was positive for fentanyl. DCYF completed an investigation. Mother denied any history of substance use. A review of the prior record showed mother had a lengthy substance use history. At the scene, police recovered heroin and illegal drug packaging consistent with fentanyl and/or heroin packaging. The bag of heroin appeared to be chewed with teeth marks on it. DCYF indicated the mother for Neglect – Lack of Supervision/Caretaker and Physical Neglect – Poisoning/Noxious Substances. The child was removed and placed in foster care.

This family initially came to the attention of DCYF when a sibling was placed with father in Rhode Island through an Interstate Compact on the Placement of Children (ICPC)[16], with DCYF

[16] The Interstate Compact on the Placement of Children (ICPC) is a statutory agreement between all 50 states, the District of Columbia and the US Virgin Islands. The agreement governs the placement of children from one state into another state. It sets forth the requirements that must be met before a child can be placed out of state. The Compact ensures prospective

providing monitoring. When the child who experienced the near fatality was born, an out-of-state hospital contacted DCYF alerting them that the mother did not have custody of her other children and has a history of substance use and is reportedly staying in Rhode Island. The hospital reported that mother's toxicology screen was negative upon admission, as well as her pre-natal screens. The hospital was planning to discharge the baby with mother as mother was compliant and there were no red flags indicating substance use. DCYF conducted an assessment. During this assessment, DCYF called mother and explained the process. DCYF obtained the history mother had with the out-of-state child welfare agency. The family had a lengthy history due to mother's substance use, including using substances while pregnant, failing to get pre-natal care during another pregnancy, and testing positive for substances. The agency closed when both children were placed in the guardianship of family. The family reopened with an out-of-state child welfare agency when another child was placed in the guardianship of a friend due to mother's substance use. Ultimately, father obtained custody of two of the children and one child remained with family.

DCYF connected with mother, who reported that the baby was doing well and discussed services. DCYF conducted a well-check observing that mother had the essentials to care for the newborn and discussed safe sleep with mother. Referrals were made for Early Intervention and DCYF considered making a referral to a family visiting program however it is not clear if this was made. The plan for the family was to remain with mother's friend. The case closed to DCYF. The near fatality of the child occurred about ten (10) months following the case closing to DCYF.

Near Fatality Summary #7:

A report was made to DCYF that an eighteen (18) month old child was transported to the hospital after mother called emergency services inquiring whether she could administer Narcan to her child, who ingested Percocet. Emergency services observed the child to be unresponsive upon arrival and administered three (3) rounds of Narcan. The child was admitted for monitoring as the child required an additional dose of Narcan at the hospital. The toxicology report was positive for fentanyl. Following an investigation, DCYF indicated the mother for Neglect – Lack of Supervision/Caretaker and indicated father for Physical Neglect – Poisoning/Noxious Substances.

This family initially came to the attention of DCYF when a report was made regarding a sibling of the subject child. The call was made an Information/Referral with an in-person response by a Child Protective Investigator (CPI). The child was living with family members and there were allegations of child-on-child sexual abuse with a cousin. DCYF spoke with the family members caring for the sibling and they reported that they were unable to get in contact with mother. DCYF determined that the family member was able to meet the needs of the child but could benefit from support of DCYF due to lack of involvement by mother. DCYF provided the family with the number for FCCP if they needed it in the future. There was another report made to

placements are safe and suitable before approval, and it ensures that the individual or entity placing the child remains legally and financially responsible for the child following placement.

DCYF indicating mother's boyfriend was incarcerated and there were concerns regarding her ability to care for her child. Mother was at the family member's home attempting to take the child. The police and family member could not identify a reason she could not leave with the child. This call was made an Information/Referral with no further involvement by DCYF.

Another report was made to DCYF that mother was drinking and smoking marijuana in front of her children. Additionally, it was reported mother's boyfriend was arrested by federal law enforcement and there were unknown men in the home. Family members and the children's daycare did not report any concerns with mother's ability to care for the children and reported they have not observed her under the influence. DCYF completed an investigation and the allegations were unfounded, with no further involvement by DCYF. Upon review of the full record by the panel, there was also documentation of a domestic incident requiring police response and the child was present. There was no corresponding call to DCYF.

A report was made to DCYF alleging mother had unknown males in the home, there was no furniture, the home was filthy, and there was marijuana smell/paraphernalia in the home. DCYF completed an investigation, noting mother just moved and this is why there was no furniture. The children were living with a family member. The children were observed to be well-cared for with the family member. Mother was pregnant during this investigation. DCYF unfounded the allegations.

A report was made to DCYF when the child who was the subject of this near fatality was born. Mother admitted to smoking marijuana for nausea during pregnancy, but her toxicology report was negative. The hospital reported that mother was seen about three (3) months earlier saying she fell down the stairs, however, told others father assaulted her. She tested positive for marijuana during this hospital visit. DCYF found an active No Contact Order between parents and father was asked to leave the hospital. DCYF spoke with a family member who stated the mother and children live with her. DCYF completed an investigation and unfounded the allegations and referred the family to FCCP and a family visiting program, with no further involvement with DCYF. A review of the full record by the panel showed mother had additional involvement with the police as a victim of domestic violence and due to substance use, however no corresponding calls were made to DCYF as the children were not present. About eighteen (18) months following the last report made to DCYF, the near fatality occurred.

Near Fatality Summary #8:

A report was made to DCYF that a one (1) year old was brought to the hospital by emergency services. The child presented tachycardic, with a fever and required intubation. The mother reported that the child was found earlier in the day with a pill in their mouth, nine (9) more next to them, and an open Unisom bottle. Mother reported the child presented as acting strange, could not walk straight and was trembling. The child was admitted to the PICU. The hospital reported the child was on seizure management; heart functions and seizure activity were being monitored. DCYF completed an investigation and found that the child accessed the bottle of pills from father's backpack, which was left on the couch. There was an active No

Contact Order between the parents at the time of the near fatality. DCYF indicated the mother and father for Neglect – Lack of Supervision/Caretake due to ongoing domestic violence and violating the No Contact Order. DCYF unfounded the allegations against both parents.

This family initially came to the attention of DCYF when a report was made due to concerns about mother's other children with a different father, who she shared custody with. Her child was sick, and the father brought them to the emergency department, but when mom attempted to pick up the children from father, she could not get ahold of him. A well-check was requested. DCYF referred the caller to the local police department. This report was screened out and the family had no further involvement with DCYF. Another call was made to DCYF that mother's home was full of trash, cigar wrappers, and clothing. There were concerns about mother having the children. DCYF referred the caller to address this in domestic court. This report was screened out with no further involvement from DCYF.

A call was made to DCYF requesting a hospital alert due to mother's mental health and history of domestic violence. Mother reported that she was depressed, had severe anxiety, and wanted to kill herself. The caller reported that mother was not engaging in treatment, refusing services for housing, and she was experiencing domestic violence. The child was born, and caller wanted DCYF to be aware prior to discharge. DCYF reviewed the family's history noting that the alleged father had signed direct consents for two of his children and was involuntarily terminated as to another child. He had a history of criminal charges for domestic violence, shoplifting, and substance use. DCYF made this a Prevention Response[17] and the case was transferred to the Support and Response Unit (SRU)[18]. Mother denied issues with mental health and domestic violence. DCYF spoke with a family member who reported no concerns. DCYF observed positive interactions with the child in the home. DCYF made a referral for a family visiting program, confirmed the intake took place, and then closed the family to DCYF. Another report was made to DCYF due to concerns about mother's older children with a different father. The allegations were made as to father and his wife due to reports of inappropriate consequences and withholding food. DCYF completed an investigation and unfounded the allegations.

Near Fatality Summary #9:

A report was made to DCYF due to a two (2) year old being brought to the hospital when mother found three (3) Clonidine pills in their mouth. At the hospital, the child was minimally responsive, lethargic, low heart rate, and shallow breathing. Narcan was administered twice, but the child's heartrate remained low, so the child was admitted to the PICU. The toxicology report was negative. The family was open to SRU when this incident took place. DCYF completed an investigation. Mother reported the medication was prescribed to her other child

[17] A prevention response prompts a referral to SRU. DOP 500.0015 and 700.0190 both mention a prevention response but neither policy defines this term.

18 DOP 700.0190 defines the Support and Response Unit (SRU) as the unit that assists families seeking help with navigating community services. The SRU conducts assessments where appropriate, provides community service referrals, and supports case transfers from Child Protective Services, Family Services Unit, and the Children Services and Behavioral Health Division, with or without legal involvement, when ongoing case management is required.

but had no explanation for how the two (2) year old was able to access the medication. DCYF indicated the mother for Neglect – Lack of Supervision/Caretaker.

This family initially came to the attention of DCYF when a report was made that mother's other child was heard discussing being hit by a belt and mother was late picking up the child, leaving another child in the car with no supervision. DCYF made this call an Information/Referral with no further involvement by DCYF. Another report was made to DCYF when mother's other child was heard talking to peers about their dad making inappropriate statements about harming others. The child also disclosed that mother hits their bottom with a belt. The school asked mother about these statements and she denied anyone was hurting the child. This report was screened out with no further involvement from DCYF. Another report was made to DCYF when mother's other child reported they do not like hanging out with dad because he hits and punches. The school did not inquire further. This report was screened out with no further involvement from DCYF.

Another report was made to DCYF when mother's other child reported they observed their father punch out his girlfriend's car window, go after her with a knife, and try to stab her in the stomach. The child noted their mother was present too. DCYF completed an investigation. They spoke with the girlfriend who stated there was an argument but nothing physical and no knife was involved. The mother and school noted that the child's behavior had been increasing. The police had no reports that confirmed the statements. DCYF unfounded the allegations with no further involvement from DCYF.

Another report was made to DCYF by mother's other child reporting that the mother threatened she would hit them, and the father would hit them too. There were no injuries observed. The reporter provided information about services that were involved, and that mother did not follow through with some services. This report was screened out. Following this call, DCYF followed up with mother, who reported that the child making the reports to DCYF was hard to control, with aggressive behaviors towards their sibling, often having to separate them. She reported that they had in-home therapy, but it was currently telehealth. She reported wanting more services and DCYF referred the family to SRU. DCYF provided mother with the phone number and mother stated she would call. There is no record that mother contacted SRU.

A report was made to DCYF alleging that mother was not doing well, experiencing domestic violence and had placed her child with a family member out-of-state. There were allegations that there was a very serious incident where mother was not allowed to leave, and the children were not cared for during this time. DCYF spoke with mother who stated that while there was a verbal argument between her and her partner, denied physical violence or being held hostage. While mother reported they were no longer together, DCYF observed mother's partner leaving the home. DCYF confirmed that mother was involved in Healthy Families America. Mother was visiting with the children, who were currently in the care of their father. DCYF also spoke with family members who reported that mother has a history of abusive relationships, and she could

benefit from services. DCYF completed an investigation and indicated the mother for Neglect – Lack of Supervision/Caretaker with no further involvement from DCYF.

Another report was made to DCYF alleging that mother was calling family members explaining she could not take care of the children. DCYF contacted the local police department for a well-check and the police reported the home was messy, but not unsafe. Mother reported that she would accept help from SRU. SRU began contacting mom right away, to no avail. DCYF finally reached father, who reported improvements, stating there was no need for additional services. Father and mother were not together. DCYF was unable to make contact with mother by phone. About three (3) weeks later, the near fatality occurred.

Near Fatality Summary #10:

A report was made to DCYF due to an unresponsive two (2) year old. Emergency services administered Narcan and transported the child to the hospital. The child was breathing when they arrived at the hospital. A subsequent report was made to DCYF regarding this incident due to the child going into cardiac arrest, regaining a pulse and blood circulation prior to arriving at the hospital. The emergency department administered Narcan again. The initial toxicology screen was positive for fentanyl. The child was admitted to the PICU. Mother noted the child had been fine all day but then observed the child to have a bloody nose, so she gave them a bath. When she took the child out of the bath, she observed the child to be lethargic and having difficulty breathing and then called 911. When police searched the home, they seized substantial amounts of cocaine and fentanyl, which were stored in diapers. A more comprehensive toxicology screen was completed for the child and revealed the child was positive for fentanyl, cocaine, cocaine metabolite, xylazine (an animal tranquilizer) and caffeine. DCYF completed an investigation and indicated the mother and her partner for Physical Abuse – Drug/Alcohol Abuse.

This family initially came to the attention of DCYF when a report was made to DCYF due to the birth of a sibling. The caller reported that mother admitted to smoking marijuana daily for medical and mental health needs. Mother was forthcoming about her marijuana use during the investigation. DCYF confirmed involvement with services by speaking to providers. DCYF completed an investigation and indicated the mother for Physical Abuse – Drug/Alcohol Abuse with no further involvement with DCYF. Another report was made to DCYF alleging that mother was using substances in front of the child, the home had an infestation, and mother was rough with the child and not practicing safe sleep. DCYF reported to the home and did not observe any conditions as described by the reporter and mother denied substance use. After reporting to the home, this report was screened out.

Near Fatality Summary #11:

A report was made to DCYF due to a nine (9) month old who was turning blue and wheezing. Emergency services regulated the child's breathing and transported the child to the hospital. A second report was made to DCYF that the child's toxicology report was positive for fentanyl. A

third report was made to DCYF that the child was brought to the hospital and was unresponsive. A fourth report was made to DCYF which confirmed that the child responded to Narcan and there were reports the child may have ingested a family member's Suboxone. Additionally, the child's sibling was also evaluated for drug exposure, however, there were no signs of this. The preliminary toxicology test at the hospital was negative for substances for the sibling, however, the comprehensive test was positive for metabolized cocaine. DCYF completed an investigation and found that the substances belonged to a family member living in the home. DCYF indicated the family member and their partner for Neglect – Lack of Supervision/Caretaker and unfounded the allegations as to parents.

This family initially came to the attention of DCYF when a report was made to DCYF, and an investigation was completed. DCYF unfounded the allegations. The OCA does not have the complete records for this call, as they are no longer in RICHIST, not in the hard copy record provided by DCYF, nor was this report reviewed at the Critical Event Review. Nine (9) months later, another report was made to DCYF due to mother being a victim of domestic violence and there was a child present in the home. Additionally, there was a report made to DCYF a few days later alleging that mother was not taking care of her child, there are no diapers, and the baby was dirty and smelled. There were also allegations that mother was using substances. DCYF completed an investigation. DCYF indicated the father for Neglect – Domestic Violence with no further involvement from DCYF. DCYF unfounded the allegations as to the mother. Prior to closing, DCYF made a referral for an Early Intervention screening.

DCYF was contacted when mother gave birth to her second child to see if the family was open to DCYF. The caller reported there were no issues with parents or baby and no action was taken by DCYF.

Another report was made by the police after mother called 911 because her heart was racing after sharing an edible with friends. It was reported that the child was in the care of a family member. This report was screened out with no further involvement from DCYF. A report was made to DCYF due to allegations that a family member living in the home was using substances and leaving paraphernalia around. Additionally, there were allegations that one of the child's caretakers was exposing the child to inappropriate individuals. The reporter stated this was third-party information. The reporter also stated that the family could live with them but chose not to. This report was screened out.

Near Fatality Summary # 12:

A report was made to DCYF regarding an unresponsive one (1) year old. The child was brought to the hospital by emergency services. The child was administered Narcan, intubated and admitted to the PICU. The child and a sibling tested positive for exposure to fentanyl. Parents were uncertain as to how the child could have been exposed to fentanyl. DCYF connected the family to home-based services, including Parent Support Network, FCCP, First Connections and Safe Care. DCYF completed an investigation and indicated mother and father for Physical Neglect – Drug/Alcohol Abuse and Neglect – Lack of Supervision/Caretaker.

The family initially came to the attention of DCYF when a report was made that the mother was refusing father access to this child's sibling due to fear the father would harm the baby. The father did not reside in the home. Mother denied any domestic violence in the relationship. Father was engaged in therapy for anger management. The call was made a Prevention Response and was referred to SRU. The social worker from SRU did visit the home, assessed for safe sleep, provided contact information for the domestic violence hotline and offered services through FCCP. The mother declined FCCP services. The case subsequently closed. There was no additional contact with DCYF until the near fatality occurred.

CASES REVIEWED - SUBSTANCE USE

I. Fatalities

Fatality Summary # 1:

A report was made to DCYF due to an unresponsive fifteen (15) year old. The police responded to the home and upon arrival, the youth was deceased from an apparent drug overdose. The autopsy report confirmed the youth died as a result of acute fentanyl intoxication. DCYF completed an investigation. DCYF unfounded the allegations as to the foster parent.

In the months leading up to this incident, the youth was absent without official leave (AWOL) for about a month and then placed with mother for five (5) days before transitioning to a relative foster home. For almost two (2) months, there was an improvement in behaviors and a significant decrease in AWOLs. Then an AWOL occurred, and the youth went to mother's home. The family planned to travel, and the youth was not permitted to travel with the family. The plan was for mother to return the youth to the foster placement prior to traveling. There was a lack of clear communication regarding the plan for the youth to return the foster placement. The youth remained AWOL until a report was made to DCYF that the youth was at the hospital due to intoxication. The foster parent brought the youth home, reporting they were still intoxicated. That day, the youth reported going to bed to rest. The foster parent checked on the youth at around 10:00 p.m. and the youth was not there. The youth met up with a friend, was drinking, and then was provided a pill by an adult male, which they took. This took place in the adult male's car. He was pulled over by the police for speeding around 1:00 a.m. with the youth in the back seat. It was reported that the police did not request identification from the passengers. They were let go by the police. The friend reported that the youth was no longer coherent and was taken to another friend's home, where they went to sleep. When they awoke, the youth would not wake up and they called 911.

The family initially came to the attention of DCYF when a report was made regarding allegations of corporal punishment as a form of discipline and alleged mother was emotionally abusive, not feeding the children, and leaving them at home overnight. DCYF completed an investigation. During the course of the investigation, the child admitted they made up the allegations and the

other children did not report physical abuse or lack of food. The family identified family members and peers that are resources to the family. DCYF unfounded these allegations.

A report was made to DCYF alleging that one of the children was being hit by their parents because they left the home without permission and refused to return. DCYF made this call a Prevention Response and assigned the case to SRU. The family was referred to FCCP for home-based services.

There were seven (7) subsequent reports made to DCYF, three (3) were screened out, two (2) were Prevention Responses, and two (2) met the criteria for investigation. The family was referred to Division of Family Services (DFS) following an investigation completed by DCYF indicated mother for Physical Abuse – Excessive/Inappropriate Discipline and Physical Abuse – Cut, Bruise, Welt, as to a sibling. DCYF created a safety plan with the family, including one (1) of the children moving to live with father.

FSU made an in-home service referrals for the family, referrals for evaluations for two (2) children, and services for clinical supports. During this time, the child was engaging in AWOL behaviors. There was a report to DCYF due to a physical altercation between two (2) of the siblings. The child was admitted to the psychiatric hospital due to this incident. After discharging home, there was another serious fight that led to injuries to the sibling. This altercation was reported to DCYF, and the allegations were screened out. The child was placed outside the home at an assessment and stabilization center[19] on an emergency basis. After five (5) days the youth was moved to another assessment and stabilization center.

DCYF made in-state referrals for the youth for residential support and services. DCYF identified a placement about five (5) weeks later and the youth was placed in a community-based residential group home. During this time, the youth struggled at school, however, was doing better in the group home. Although an in-state placement was identified, DCYF was court-ordered to keep the placement referrals open, due to the behaviors and mental health needs of the youth. The youth was accepted to an out-of-state placement. The clinical recommendation from the current team was that they could continue to meet the needs of the youth. Additionally, her current placement recommended additional substance use services to be implemented by DCYF. The youth did not transition out-of-state.

There were noticeable improvements with the youth's engagement in clinical supports and relationships with family. During a holiday, the youth's family traveled, and the youth went AWOL from the program. About a month later, the youth returned and went to mother's home. Mother identified a family member to provide foster placement. While there was a noted improvement during the next two months, the youth was not engaged in any clinical services prior to the fatality.

[19] DOP 700.0170 defines Assessment and Stabilization Center as "a short-term therapeutic group care program that provides comprehensive youth assessment and stabilization services and is licensed by the Department of Children, Youth and Families."

Fatality Summary # 2:

A report was made to DCYF that a fifteen (15) year old was found deceased in the family home from an apparent fentanyl overdose. At the time of the report, police and the medical examiner were on-site. While the initial report to DCYF was to be investigated, the allegations were screened out as the youth passed away due to an overdose, with no reports of abuse or neglect by the family.

The family first came to the attention of DCYF when the youth was one (1) month old and there was a report to DCYF regarding mother's substance use. DCYF completed an investigation and indicated the mother for Neglect – Lack of Supervision. The child was removed from the home and placed in foster care. Mother was connected with substance use and parenting services. The child was reunified with mother after about one (1) year and the family closed to DCYF.

About one (1) year later, a report was made to DCYF reporting that mother was a victim of domestic violence. DCYF completed an investigation and indicated the mother and her partner for Neglect – Other Neglect. The case was transferred to the DCYF Intake Unit. After speaking with mother and supportive family members, this family closed to DCYF.

About two (2) years later, a report was made to DCYF that mother and child were present at an event where there was a physical altercation, and illegal substances were present. DCYF completed an investigation and indicated the mother for Neglect – Other Neglect. The child remained in the care of mother; however, a petition was filed in Rhode Island Family Court. While open to DCYF, there was a report to DCYF that mother was entering an apartment that was not rented to her and staying there. DCYF spoke with family members who stated mother and child were staying with them. DCYF completed an investigation and indicated the mother for Neglect – Inadequate Shelter. Shortly thereafter, there was a report made to DCYF alleging physical abuse by mother and the child being unsupervised with inappropriate caretakers. DCYF completed an investigation and indicated the mother for Neglect – Lack of Supervision/Caretaker and Physical Abuse – Excessive/Inappropriate Discipline. Following this investigation, the child was removed from mother and placed in non-relative foster care. During this placement, there were multiple reports made to DCYF as the child was disclosing abuse and neglect by other people in mother's life. DCYF identified an appropriate relative foster home for the child and the child transitioned to be with family members. The child was placed in a legal guardianship with the identified family members.

About three (3) years later, mother gave birth to a baby. A report was made to DCYF due to mother's history and substance use during the beginning of the pregnancy. It was reported mother accessed treatment prior to giving birth and was negative for substances at the birth. The family reopened to DCYF. There were reports that mother's older child was alternating between staying with mother and the legal guardians, and the child was struggling. Following compliance with services and a period of stability, this family closed to DCYF.

About three (3) years later, a report was made to DCYF alleging sexual abuse regarding mother's older child against her younger child. Another report was made to DCYF that the older child was being evaluated due to a behavioral outburst. While this report initially triggered a Prevention Response, DCYF ultimately completed an investigation. DCYF indicated the older child for Sexual Abuse – Sexual Molestation and unfounded the physical abuse allegations against the mother. The family reopened to DCYF, and the older child returned to live with the legal guardians from mother's home. The behaviors started to increase, even with services put in place. DCYF referred the family to in-home services and outpatient therapy. Over the next eighteen (18) months, there were five (5) reports made to DCYF due to escalating behaviors by both siblings. The older child was ultimately placed in a community-based group home for the purpose of treating the behaviors following the incident with the sibling. The clinician at this placement recommended a higher level of care due to ongoing incidents of high-risk behaviors, such as AWOLs, physical aggression, and property destruction. The youth was placed at a residential treatment facility in-state to address these behaviors.

After about one (1) year, the team started to plan for reunification with intensive supportive services in the home. Following reunification, there was a delay in starting these services as it did not seem that there was a clear understanding by the family of the demands of the program. After almost two and a half (2.5) months, the in-home services began, and program goals and expectations were outlined. There were four (4) reports made to DCYF due to the child's behaviors in the home. Due to the child's escalating behaviors, DCYF decided to terminate the current service provider and make a referral for a more intensive service. It was clear that the current team had built a strong rapport with the family. Mother refused the new services that DCYF referred the family to. About three (3) weeks after the original services ended, they started again with the family. There were several recommendations throughout their involvement that a referral be made to a mentor program. The service was still in place with the family when the child passed away. A mentor was never involved with the youth.

Fatality Summary # 3:

The juvenile probation officer assigned to the youth received a call that their eighteen (18) year-old client had passed away due to an overdose. The youth was found by their friends and emergency services were notified.

The youth first came to the attention of DCYF two (2) years prior to the fatality due to an open wayward/truancy petition. Due to unsafe behaviors and suspected substance use, DCYF made referrals for home-based services, drug counseling, and drug screens. Parents accessed substance use treatment through their insurance and DCYF arranged home-based services. The reported concern at that time was marijuana use. Two (2) months later, the home-based provider closed out services due to the family's non-compliance.

Approximately two (2) months later, the Division of Community Services and Behavioral Health (CSBH)[20] received a referral for the youth seeking services. The referral indicated the youth had three (3) outpatient and two (2) inpatient hospital stays in the past eight (8) months. The referral stated the youth struggled with "anger control, high risk sexual behavior, oppositional, AWOL, school issues, and substance abuse." The referral also noted that at the time of the referral the youth had six (6) open juvenile petitions and a pending DCYF investigation after DCYF received several back-to-back phone calls alleging physical abuse of the youth and lack of supervision within the home. The OCA does not have the records for these calls, as they were not in RICHIST, not in the hard copy record provided by DCYF, nor was the record reviewed as part of the CER. The youth was referred to outpatient services.

A couple of weeks later, the youth was charged with Simple Assault for assaulting a family member. Prior to the youth's arraignment they were held at the Rhode Island Training School (RITS). An emergency assessment was completed for this youth. The youth disclosed struggling with the loss of their friend just a few months prior due to a drug overdose. The youth disclosed they were using cocaine and Xanax. The youth noted they were hospitalized after the loss of their friend and engaged in counseling for about six (6) weeks. The youth was arraigned and was ordered to have electronic monitoring/home confinement. The youth opened to juvenile probation. It was reported the youth was minimally compliant with the terms of electronic monitoring.

One (1) month later, the youth stole their parent's car and was located with a man who had just overdosed. Just a few days later, the youth assaulted their mother causing injuries. The youth was subsequently brought to the hospital after admitting to taking a bunch of pills. Once the youth was released from the hospital, they were put on home confinement and electronic monitoring. It was reported the youth was once again non-compliant. The youth was subsequently detained at the RITS and referrals for residential treatment were ordered. One (1) week later, the youth was allowed to return home with electronic monitoring. Approximately two (2) weeks later, the youth's juvenile probation officer was contacted by father indicated that the youth was caught smoking marijuana in their room and the father found messages that indicated mother's assistance in the youth going AWOL and sneaking an adult male into the home.

Approximately two (2) weeks later, the youth went AWOL again and failed to appear for court. The youth was missing for almost two (2) weeks before they were picked up and detained at the RITS. The youth was held at the RITS for almost seven (7) weeks while a residential placement was identified.

The youth was subsequently placed out-of-state. Five (5) days after the youth was placed a report was made to DCYF by a police department out-of-state to inform them that the youth

[20] The Division of Community Services and Behavioral Health (CSBH) is the division within DCYF responsible for developing a continuum of care for children's behavioral health services that supports children to live in family settings. CSBH encourages services to prevent hospitalization and reviews services to ensure proper matching of services to needs and to improve the quality of and access to services.

had overdosed on opiates and was found unresponsive. Emergency services were contacted. The youth was revived with Narcan. The youth spent several days at the hospital before returning to the residential placement. This incident was further investigated when video footage was obtained that the youth's mother had passed something to the youth during a visit, which was alleged to have been fentanyl pills. Both mother and the youth denied that mother provided pills. Mother reported she provided the youth with a cell phone, which was prohibited. DCYF indicated the mother for Neglect – Lack of Supervision/Caretaker and a petition was filed in court. Due to this incident, visitation with mother was terminated and mother was referred for services and a neuropsychological evaluation. This incident was a near fatality and a Critical Event Review was completed by DCYF.

Upon discharge from the hospital, the youth transitioned back to their prior residential placement. The youth remained in placement and had been making progress in their treatment. Approximately ten (10) months after the near fatality, the youth was referred for a neuropsychological evaluation. There were concerns regarding the youth's cognitive function. On the date of the appointment, a report was made to DCYF by program staff to report the youth went AWOL from the appointment. DCYF's Special Investigation Unit (SIU)[21], local law enforcement, and the National Center for Missing and Exploited Children were contacted.

Due to the length of time the youth was AWOL, their placement closed, as DCYF policy is to only hold the youth's bed open for four (4) days when a youth is AWOL.[22] Parents continued to work with law enforcement and DCYF to try to locate the youth.

Approximately four (4) months after the youth went AWOL, father discovered mother allowed the youth to use her car when father was not home, and the youth had two jobs in Providence. This was reported to police and DCYF. The youth was never located and two (2) weeks later, the youth was found deceased by friends.

Fatality Summary # 4:

A report was made to DCYF that an eighteen (18) year old was found deceased in their foster home. It was later determined that the youth ingested prescription medication with the intent to die by suicide. This report was screened out.

The family initially came to the attention of DCYF when a report was made alleging that mother and stepfather of three (3) minor children were arrested and held. DCYF completed an investigation. DCYF indicated both parents for Neglect – Other Neglect. The family opened to FSU. The children were placed with relatives. During this out-of-home placement, a report was

[21] DOP 700.0070 defines the Special Investigations Unit (SIU) as" the unit staffed by special investigators whom are available to assist all Department caseworkers and supervisors in situations requiring their expertise. The Special Investigations Unit may assist to gather evidence to support child safety and permanency decisions in civil proceedings, conduct kinship searches, locating missing and runaway children in Department custody, accompanying caseworkers on potentially volatile or dangerous situations, and conducting trainings."
[22] See DOP 700.0275.

made to DCYF alleging prior physical abuse by father. DCYF completed an investigation. DCYF indicated father for Physical Abuse – Excessive/Inappropriate Discipline. The children were still in the care of relatives at this time. After receiving supportive services, the children were reunified with mother. The case subsequently closed to DCYF.

Another report was made to DCYF that the mother left the home this morning and had not returned by dinner time. One of the children called the police to report mother missing. The police were unable to reach mother for about two (2) hours and then mother returned to the home. DCYF completed an investigation and indicated the mother for Neglect – Other Neglect. DCYF discussed a protective plan with mother to prevent this from happening again. The family was referred to FCCP for services, however mother reported this was an isolated incident and would not occur again.

A report was made to DCYF alleging mother was taking her child's Attention-Deficit/Hyperactivity Disorder (ADHD) medication. DCYF completed an investigation and indicated the mother for Neglect – Lack of Supervision/Caretaker. Mother admitted that she was taking the medication as her own prescription had run out due to taking more than one a day on a few occasions. Additionally, she reported that there were issues with insurance preventing her from filling the prescription timely. The child's prescriber confirmed this information. The child's prescriber made a decision to change the prescription for the child and reported to DCYF there were no concerns for abuse and neglect and there were not patterns or concerns for mother consistently taking the child's medications. DCYF offered mother FCCP services, which mother reported may be beneficial in order to obtain mental health counseling for herself and her son, as well as additional support in the home. DCYF confirmed with school and prescriber that they would check in on the family and DCYF closed to the family.

A report was made to DCYF when mother died of an overdose. An adult sibling was caring for the other two children and was requesting assistance from DCYF. The case was referred to SRU. The child's father was also contacted and reported he was not interested in caring for the child but could provide support. The family was referred for FCCP services and closed to DCYF a couple weeks later.

A report was made to DCYF that a family friend was caring for one of the children and required assistance. The case was initially opened to SRU and subsequently transferred to FSU. The child was engaged with supportive services, including counseling. The child only remained at the home for a short period of time before the placement disrupted. The child was then placed in non-relative foster care.

A few months prior to the fatality, substance use was identified as a concern. Alcohol was found in the child's room and a substance thought to be drugs was found in the child's belongings. The child denied substance use and refused treatment. The child remained engaged with counseling and was on track to graduate, however there were some concerns around recent educational engagement and lack of motivation. Placement referrals were being explored for independent living at the time of the fatality.

Fatality Summary # 5:

The child's Voluntary Extension of Care (VEC) worker was notified that their twenty (20) year old client was brought to the hospital by emergency services. The youth was unresponsive without a pulse upon arrival of emergency services. The youth's pulse was restored prior to arrival at the hospital and the youth was admitted to the Intensive Care Unit (ICU). The youth passed away hours later.

This family came to the attention of DCYF due to mother testing positive for marijuana following the birth of another child. DCYF completed an investigation and indicated the mother for Neglect – Other Neglect. The family was open to DCYF for monitoring. DCYF closed to the family after mother successfully engaged in services.

About eight (8) years following DCYF closing, the family came to the attention of DCYF again due to truancy concerns and juvenile charges for this youth. The youth moved out-of-state to live with family. The youth returned to Rhode Island and there was another report made to DCYF regarding wayward/disobedient petitions filed. DCYF made referrals for services. At this time, there were concerns for mental health issues, self-injurious behaviors, suicidal ideation, and high-risk behaviors, such as gang involvement and commercial sex trafficking. Due to these behaviors, the youth was hospitalized. Following discharge home, there were additional concerning behaviors, and the youth was placed outside of the home at an assessment and stabilization center. Due to the location of the group home and safety concerns for gang involvement, the youth was moved to a group home in a different location.

After a few days, the youth was transitioned to a different group home for long-term treatment. The youth continued to engage in AWOL behaviors, negative peer interactions, self-injurious behaviors, and required psychiatric evaluations. Additionally, the treatment team was concerned about substance use and the youth was referred for substance use treatment. The services engaged were drug screens and addressing substance use in the current clinical setting. The youth transitioned to a hospital step-down program due to ongoing safety concerns related to gang involvement. The youth engaged in AWOL behaviors at this program and during AWOLs would engage in substance use. One AWOL lasted a week and when the youth returned and went to DCYF, they were placed at another assessment and stabilization center. This was a short-term placement to identify the current needs, which were identified as a sexual abuse evaluation and clinical support, scheduled medical appointments, a psychiatrist, and individual counseling.

The youth transitioned to a staff secure group home setting. The youth continued to struggle requiring additional psychiatric evaluations and was ultimately hospitalized. DCYF made referrals to high-end residential placements out-of-state, and the youth was accepted to an out-of-state program. The youth discharged from the hospital to this program. After successfully completing treatment at this program, the youth stepped down to a semi-independent living program in Rhode Island. Upon arrival, the youth struggled with their

behavior, however, was engaged in supportive clinical services. There continued to be concerns in the program, however, the youth and mother wanted to work toward reunification. This took place with services in place.

Despite these services, the youth's behaviors continued, and mother was struggling to maintain the youth safely. After about four (4) months, the youth was placed again in an assessment and stabilization center. There were many AWOLs from this program, additional juvenile charges, and emergency department visits for psychiatric evaluations. After one of the AWOLs, the youth was medically cleared and transitioned to a different group home. DCYF made additional referrals for services to address the needs of the youth. The youth's number of AWOLs continued to increase. One service provider was unable to begin services due to lack of engagement and recommended substance use treatment for the youth. During the last AWOL at this program, the youth returned to the program and was told the bed had closed. After the unsuccessful attempt to return to the program, the youth remained AWOL for another one (1) month. DCYF made referrals for high-end out-of-state residential facilities. The youth eventually returned from AWOL to mother's home and was there for a short time before leaving.

During the last AWOL, additional juvenile charges were picked up out-of-state. The youth was placed at an assessment and stabilization center and then transitioned to the program's staff secure program. The youth experienced a period of stability during this time, however, there were additional charges brought against the youth when they assaulted staff. Following this incident, AWOL behaviors continued. Due to the youth's age, DCYF made referrals for independent living for the youth. DCYF reportedly exhausted all other options for the youth. The youth returned home temporarily while awaiting an apartment through independent living. After about four (4) months, the youth was evicted from the identified independent living apartment and DCYF requested the matter close to DCYF as the youth was not engaging in services.

About nine (9) months later, the youth came to the attention of DCYF again because the youth was pregnant. The youth was eligible for the VEC program and DCYF began working with the youth to identify housing. DCYF assisted the youth in identifying an apartment. The youth's baby was placed in foster care following the birth. After about four (4) months, due to successfully engaging in services, the youth reunified with their child. DCYF referred the family for services and continued to see positive engagement from the youth. The goals for the youth were to find a job or engage in a vocational program. DCYF visited with the youth and had a good home-visit with the youth and their child a few days before the accidental overdose.

II. Near Fatalities

Near Fatality Summary # 1:

Two (2) reports were made to DCYF due to a sixteen (16) year old overdosing over the weekend on Percocet and Xanax while also consuming alcohol. Multiple doses of Narcan were

administered at the time of the incident and the youth was transported to the hospital. The youth was open to DCYF at the time of the incident. These reports were screened out.

This family came to the attention of DCYF when mother had a child and there were concerns for substance use. DCYF completed an investigation and indicated the mother for Physical Neglect – Drug/Alcohol Abuse. The child was placed outside the home. There was one previous call during the pregnancy due to substance use. This was made an Information/Referral. The child was placed in a foster home from the hospital and adopted by that family.

The adoptive family came to the attention of DCYF due to truancy issues with a sibling. DCYF made an FCCP referral. While the family did not follow through with this specific referral, DCYF confirmed that the family connected with supportive services.

A call was made to DCYF reporting a young child was found wandering down a main road without adult supervision. DCYF completed an investigation and indicated the mother for Neglect – Lack of Supervision/Caretaker and Neglect – Other Neglect. The family was referred for supports and services and closed as to the family. Within the same year, there were two (2) additional reports made to DCYF reporting that a young child was unsupervised on the street. DCYF completed an investigation and indicated the mother for Neglect – Lack of Supervision/Caretaker and Neglect – Other Neglect. DCYF opened to the family and filed a petition in Rhode Island Family Court. This child was placed in foster care and DCYF asked the family to engage in services. The child was reunified with mother.

A report was made to DCYF reporting the child had gotten out of the home during the night and was found outside two nights in a row. DCYF completed an investigation and indicated the mother for Neglect – Lack of Supervision/No Caretaker. DCYF implemented a safety plan with the family to ensure the safety of the child, including that the child was to be appropriately supervised. While DCYF was open, there were reports made to DCYF that the child had eloped from the family home. These reports were made Information/Referrals and the primary social caseworker followed up.

DCYF remained open with the family and the child continued to struggle with behaviors requiring multiple hospitalizations and was ultimately placed at a residential treatment facility in-state. Following treatment, the youth was reunified with supports and services put in place. DCYF continued to monitor the family and received reports during this time about the child struggling with their mental health and requiring evaluations at the hospital. The family identified services, such as a clinician, a psychiatrist, therapeutic extracurricular activities, and an appropriate school setting. Due to this, DCYF closed to the family.

Two (2) months following the case closing, a report was made to DCYF due to concerns with the child's family. DCYF connected with the family, and they reported that the same services remained in place. DCYF did not reopen to the family at that time.

About one (1) month later, there was a report made to a DCYF social caseworker that there continued to be concerns regarding the child's behaviors, including assaultive behaviors to family members. The social caseworker requested that the reporter contact CSBH. The reporter contacted the unit referring the family for additional support and potentially residential treatment. The reporter was asked to contact DCYF, specifically the DCYF's Child Abuse Hotline, if there were any aggressive or assaultive behaviors. There was a report made to DCYF due to these behaviors shortly after the referral for services. The child continued to struggle with behaviors and ultimately was placed at the RITS. The youth was at the RITS for about two (2) months and then placed at an in-state congregate care[23] facility. During the time at this placement, the youth experienced periods of stability, while also engaging in AWOL behavior, another placement at the RITS, and multiple visits to the emergency department.

The youth returned to the RITS. DCYF was to identify a placement that could meet the needs of the youth. The youth was at the RITS for about three (3) months when DCYF identified a high-end residential treatment facility out-of-state. The youth started off doing well at the program, however, engaged in AWOL behavior when visiting family in-state and returned to the RITS. The youth went back to the out-of-state placement, however, engaged in assaultive behaviors and again returned to the RITS. DCYF identified a residential treatment facility in-state and the youth transitioned there. The youth had periods of stability, however continued to struggle to maintain this stability. The youth began struggling with substance use and noncompliant behavior. This resulted in an additional placement at the RITS. The youth returned to the in-state program. During a home pass, the youth engaged in AWOL behavior and returned to the RITS for two (2) months. The youth fully engaged in programming at the RITS, including substance use programming and clinical supports. The youth reunified with mother. The youth was able to maintain stability for a short period of time before engaging in high-risk behavior and substance use, leading to the near fatality.

Near Fatality Summary # 2:

A report was made to DCYF regarding an unresponsive sixteen (16) year old. The youth was brought to the hospital and intubated due to alcohol consumption. The family was open to DCYF at the time of the incident and was engaged in home-based services. This report was screened out. The youth was discharged from the hospital and was referred to a virtual substance use program. The youth was subsequently discharged from the program due to non-compliance.

The family first came to the attention of DCYF twenty-three (23) years prior to this incident. A report was made to DCYF that mother, who was a minor at that time, was engaged in high-risk behaviors and her child was with her. There were concerns mother was a victim of sex trafficking. The caller also reported significant concerns of domestic violence between the

[23] DOP 700.0170 defines congregate care as "any private or public facility where youth reside that provides youth with treatment in an on-site residential setting and is licensed by the Department of Children, Youth and Families as a Child Caring Agency. A congregate care facility may include in-house educational programming; in-patient or residential psychiatric treatment for mental illness; group home care; and assessment and stabilization as delineated in RIGL 42-72.1-2."

mother and the father of the child. DCYF completed an investigation. While the investigation was pending, another report alleging similar concerns was made to DCYF. DCYF indicated the mother for Neglect – Other Neglect. The case transferred to FSU for services and case management and remained open for the next few years. During this time, a report was made to DCYF due to concerns for physical and verbal abuse. DCYF completed an investigation. DCYF indicated the mother for Neglect – Other Neglect. After several years of services and supports, the case closed to DCYF.

Approximately one year after closure of the case, a report was made to DCYF due to a domestic disturbance and allegations of physical abuse. DCYF completed an investigation. DCYF indicated both parents for Neglect – Other Neglect. The case was transferred to FSU for ongoing case management. While open to FSU, a report was made to DCYF due to allegations of domestic violence and that parents were selling drugs with the children in the home. DCYF completed an investigation. DCYF indicated both parents for Neglect – Lack of Supervision/No Caretaker and Neglect – Other Neglect. The case was already open to FSU and remained open to DCYF for supports and services for a few more months before closing.

Five (5) months after DCYF closed the case, a report was made to DCYF because the parents were arrested. There were also reports regarding the condition of the home, the safety of the children, and mother's mental health. DCYF completed an investigation. DCYF indicated the mother and father for Neglect - Lack of Supervision/Caretaker. The case was transferred to DCYF's Intake Unit for service referrals and the family eventually closed to DCYF.

The family had no further involvement with DCYF for over a decade until a report was made to DCYF that mother was arrested due to driving under the influence with her child in the car. DCYF completed an investigation and indicated the mother for Neglect – Lack of Supervision/Caretaker. The family was referred to FCCP for services and the family closed to DCYF. A few months later, a report was made to DCYF with concerns regarding the behaviors of one of the children. The family was referred to additional services to support the child. A petition was filed in Rhode Island Family Court due to truancy and DCYF remained open to the family for supports and services. While DCYF was open, a report was made to DCYF due to this youth and a sibling threatening each other with weapons, however no injuries occurred. The report was screened out as the family was open to FSU. About two (2) months later, the near fatality occurred.

Near Fatality Summary # 3:

A report was made to DCYF that a fifteen (15) year old youth went AWOL from a congregate care placement and the youth remained AWOL for more than a week. While the youth was AWOL, the assigned DCYF casework supervisor was made aware that this youth was found unresponsive and observed to be blue. After administering multiple doses of Narcan, the youth responded and ran away from emergency services. Ultimately, the youth was located and transported to the hospital. The youth reported they were dared to inhale a substance for money. The youth reportedly was not aware that the substance was fentanyl. In the hospital, the youth disclosed

engaging in high-risk behaviors. The youth was discharged home with his mother with in-home services.

The family came to the attention of DCYF due to a report made to DCYF that mother was going to kick the child out of the home if they did not stop smoking. This report was screened out.

A report was made to DCYF due to the youth missing from the family home. The police returned the youth home. DCYF made this report a Prevention Response and the family opened to SRU. Prior to meeting with SRU, a wayward petition was filed by mother and all other services by DCYF were declined.

A report was made to DCYF that the youth was missing from the family home. The youth was missing for over a week. Mother engaged with DCYF and police to locate the youth. When the youth was located, the youth was seen at the hospital for a mental health evaluation. The family opened to DCYF and DCYF made referrals for out-of-home placements. While DCYF identified a placement, the youth returned home. DCYF responded to the family home to meet with the youth, mother, family and service providers to safety plan. While mother was engaged in safety planning, the youth was not open to discussing the presenting issues. There was a prior referral for a substance use evaluation requested by the youth's school. DCYF was going to help coordinate this evaluation and on-going services with providers. The report was screened out. This case transferred from SRU to FSU.

A report was made to DCYF that the youth was under the influence and brought to the hospital. Due to concerns about the youth's behavior, mother asked DCYF to place the youth outside the home. The youth was placed at an assessment and stabilization center. While placed at this facility, the AWOL behaviors, substance use, and interactions with police continued until the near fatality occurred.

Near Fatality Summary # 4:

A report was made to DCYF that a fourteen (14) year old fell and hit their head at home requiring intubation. The toxicology report noted a high blood alcohol level and was positive for cocaine. The youth was admitted to the PICU. The former neighbor was arrested and charged with distributing alcohol to minors. DCYF unfounded the allegations as to mother. DCYF indicated the mother's partner for Physical Abuse – Drug/Alcohol Abuse against both children.

This family initially came to the attention of DCYF due to a report regarding a family member who is a registered sex offender. DCYF completed an investigation and conducted a Duty to Warn[24] due to the criminal history of the family member to ensure they have no access to the minor children. Based on reports that there was no contact with this family member, DCYF unfounded the allegations of Neglect – Other Neglect.

[24] DOP 500.0025 defines Duty to Warn as "means to communicate a threat in cases of foreseeable act of perils."

A report was made to DCYF alleging that the youth was injured by an intoxicated family member. Based on the report of the child's behaviors and no documented injury, the report was screened out.

A report was made to DCYF that during an appointment with a provider, there were concerns regarding mother's presentation and a comment made by the mother about hitting the child. DCYF responded to the home and there were no concerns, therefore the report was screened out.

A report was made to DCYF due to allegations of physical abuse by the mother. The matter was open to DCYF for prior reports to DCYF, therefore, the report was screened out.

A report was made to DCYF due to allegations of physical abuse to the sibling by mother and concerns about the older youth's high-risk behaviors. This report was screened out.

A report was made to DCYF due to concerns regarding the youth disclosing suicidal ideation, substance use by the youth, parental substance use, and engaging in self-injurious behaviors. This was the fifth (5^{th}) report made to DCYF in two (2) months. DCYF completed an investigation. During the investigation, the youth denied the concerns except that they have smoked marijuana with mother. The provider working with the youth stated that mother initiated services for the youth. Family members living in the home reported no concerns and have no observed substance use by mother. They did report that the youth sometimes smoked marijuana with neighborhood kids. DCYF made referrals for in-home supportive services. Based on the investigation, DCYF unfounded the allegations.

A report was made to DCYF due to concerns regarding mother's partner and his substance use, and marijuana use by the youth. DCYF completed an investigation. During the investigation, mother and her partner denied the allegations and showed them the lockbox provided by the in-home supports to ensure the children cannot access any recreational substances. There were providers in the home almost every day that had no concerns. DCYF made recommendations for resources that offer grief counseling due to the passing of a family member. Based on the investigation, DCYF unfounded the allegations.

A report was made to DCYF due a domestic violence incident in which minor children were present, and mother was arrested. DCYF completed an investigation and indicated the mother for Neglect – Domestic Violence. The family denied the need for service referrals as the youth would continue with outpatient therapy.

A report was made to DCYF due to concerns regarding substance use by the youth at school and self-injurious behaviors. The youth was brought to the emergency department. This report was screened out. About one (1) month later, the near fatality occurred.

Near Fatality Summary # 5:

A report was made to DCYF due to an eighteen (18) year old young adult who engaged in self-injurious behaviors and ingested prescription medication in an attempt to die by suicide. The young adult called mobile crisis and was transported to the hospital requiring intubation. Initially, this information was provided to the DCYF casework supervisor by mother and mobile crisis. DCYF requested that mobile crisis contact the DCYF's Child Abuse Hotline. This report was screened out.

This family came to the attention of DCYF when a report was made to DCYF. This report was screened out. There was a report made to DCYF. DCYF completed an investigation and the allegations were unfounded. Another report was made to DCYF due to concerns that the child was being left alone. DCYF completed an investigation and mother admitted to leaving the child alone for a period of time. DCYF indicated the mother for Neglect – Lack of Supervision/No Caretaker. DCYF was made aware during this investigation that the child was in the legal guardianship of family members in another state but was residing with mother in Rhode Island.

About ten (10) years later, three (3) reports were made to DCYF within five (5) days due to allegations of sexual abuse by the father in childhood. The first (1st) report was screened out. The second (2nd) report was subsequently upgraded to an investigation, and the third (3rd) was included in the investigation The youth denied the allegations reporting a peer gave them the idea to make these reports. DCYF unfounded these allegations as to father.

A report was made to DCYF that a youth overdosed on prescription medication and was transported to the hospital for a psychiatric evaluation. DCYF completed an investigation. DCYF unfounded the allegations. During this inpatient hospitalization, a referral was made to CSBH for residential placement. After reviewing the referral, DCYF determined that due to being in the legal custody of family, the youth was a resident of a different state. While this may have been the legal status, the youth was physically living in Rhode Island and attending school here. The hospital attempted to access help from the out-of-state child welfare agency, however, the youth was not living in that state and did not have family there who were able to provide placement.

About four (4) months later, DCYF filed a dependency petition based on the complex mental health needs of the youth This youth required additional supports and services that the family was unable to provide. At the time of the arraignment, the youth was in the hospital for about six (6) months. DCYF made referrals for the youth for out-of-home placement, in-state and out-of-state. The youth remained in the hospital for an additional seven (7) months, awaiting placement. The youth discharged home with their mother with a safety plan in place. DCYF continued to search for an appropriate placement for the youth. About one (1) month after discharge, a report was made to DCYF that the youth was hospitalized for overdosing on medication. The youth was discharged home with mother with a referral of clinical supports. During this time, the youth successfully obtained a high

school diploma through online learning. About three (3) weeks after discharge, DCYF was notified that the youth was hospitalized due to ingesting medication and engaging in self-injurious behaviors. The youth was discharged home to mother with a safety plan. About two (2) weeks following discharge, the near fatality occurred.

Near Fatality Summary # 6:

A report was made to DCYF due to a thirteen (13) year old youth being admitted the week prior for an overdose due to ingesting prescription medication. There was an indication that this overdose was an attempt to die by suicide. The child required intubation at the hospital and was admitted due to medical and psychiatric needs. Initially, this report prompted a Prevention Response. Following additional reports to DCYF based on obtained information, DCYF completed an investigation and indicated the mother for Neglect – Emotional Neglect and Physical Abuse – Excessive/Inappropriate Discipline. DCYF indicated the family member that was also caring for the youth with Neglect – Emotional Neglect and Neglect – Medical Neglect.

This family initially came to the attention of DCYF due to a report that the identified caregivers for a sibling were no longer able to care for the sibling and required assistance. Mother reported that due to safety concerns, the child was unable to live with her. The sibling was placed in a foster home by DCYF. DCYF completed an investigation, and the caregivers and mother were indicated for Neglect – Other Neglect. DCYF filed a petition in Rhode Island Family Court as to this child only and monitored the other children that were residing with mother.

A report was made to DCYF alleging domestic violence between mother and her partner and that mother's partner was sleeping in the same bed as mother's child. This call was made an Information/Response and the assigned social caseworker responded to identify the needs of the family. Mother denied allegations of domestic violence, but the child and mother reported sometimes family or mother's partner would sleep in the child's bed. DCYF told mother that this cannot happen any longer. The child also reported domestic violence occurring in the home. DCYF provided mother with the contact information for a victim advocate. Based on this report, and additional reports to made to DCYF in a short period of time, one resulting in an investigation that was ultimately unfounded, DCYF filed petitions in Rhode Island Family Court for the children residing with mother. There were concerns that the children were being exposed to domestic violence. DCYF provided services to the family and ultimately closed to the children living with mother.

Two reports were made to DCYF alleging domestic violence between the mother and her partner. DCYF completed an investigation and indicated the mother for Neglect – Lack of Supervision. DCYF indicated mother's paramour for Neglect – Domestic Violence and Neglect – Other Neglect. DCYF reopened to the family to provide services. Following monitoring by DCYF, a few clinical options were provided to the family, and they closed to DCYF.

Several reports were made to DCYF when the youth was admitted to the hospital. One report was due to the youth being reported missing after they did not come home from school and

found to have been with a registered sex offender. The youth connected with this individual online. Other reports were due to allegations of physical abuse by mother and a family member. These calls prompted a Prevention Response and assigned to SRU. During the hospitalization, there were additional reports made to DCYF, including a report that the youth was sexually assaulted by a sibling. This was screened out, as the family was open to SRU. There was another report made that the youth was sexually assaulted by mother and a family member sexually assaulted a sibling. This report was screened out. This was subsequently upgraded to an investigation. Immediately after the report was upgraded, there was another report made to DCYF alleging that the youth was sexually assaulted by a peer. DCYF completed an investigation as to the last four (4) reports made to DCYF. During the investigation, while the allegations were reiterated, there were no corroborating details or additional information provided. The allegations as to mother and family member were unfounded. The allegations as to the sex offender were indicated for Sexual Abuse – Sexual Exploitation.

While the youth was experiencing a hospital level of care, which lasted about nine (9) months, additional reports were made to DCYF, including reports of physical abuse by mother, inappropriate behavior by staff, and physical abuse of a sibling by a family member. These reports were screened out. There were ongoing efforts to repair the relationship between the youth and family. DCYF made placement referrals for the youth. The youth was engaging in unsafe and self-injurious behaviors. DCYF made additional placement referrals for the youth, including high-end residential placements out-of-state. Ultimately, the youth returned home with outpatient clinical supports. This service terminated due to lack of engagement by the youth. About three (3) months after discharge, the family closed to DCYF services due to stability with the family and an identified aftercare plan including the youth utilizing coping skills, attending school, medical, mental health, dental, and psychiatric appointments, and mother to seek help when needed. About three (3) months later, the near fatality occurred.

Near Fatality Summary # 7:

The VEC casework supervisor was notified that a twenty (20) year old youth required medical attention due to ingesting ecstasy that was laced with fentanyl. The youth required Narcan and was discharged quickly from the hospital.

This family came to the attention to DCYF through an ICPC request from an out-of-state child welfare agency. The agency wanted to place the child with mother. The out-of-state agency provided a brief history for the family, including a history of substance use and experiencing a domestic violence relationship. There were investigations in the other state for physical abuse and lack of supervision. At the time of the request to place, mother was in substance use treatment.

A report was made to DCYF when the mother gave birth. The report was that the mother was engaged in substance use treatment and there were no concerns reported. The out-of-state agency was still requesting the home study to place mother's other child with her. DCYF completed the investigation and indicated the mother for Neglect – Other Neglect. DCYF

opened to the family to complete the home study and provide services. After monitoring and completion of the home study, DCYF closed to the family.

The out-of-state agency reached out to DCYF to request monitoring through the approved ICPC. Mother's child was reunified with her. During the monitoring period, DCYF had concerns regarding mother's follow through with service providers. There was a report made to DCYF due to concerns for mother relapsing. DCYF completed an investigation, and mother was indicated for Neglect – Other Neglect. The children were placed outside the home at an assessment and stabilization center. DCYF identified separate foster placements for the siblings. The youth who experienced the near fatality was with a foster family for over year when they started to struggle with their behaviors and understanding the permanency plan. There was a report made to DCYF regarding physical abuse allegations. DCYF investigated and these allegations were unfounded. DCYF requested an ICPC for another state to transition the youth to family members. While awaiting the ICPC to approved, the youth had to transition to a respite foster home for a short period of time. Once the ICPC was approved, the youth transitioned to live with family. The permanency plan was adoption with this family. As the adoption date was approaching, the foster family requested that the youth be placed somewhere else. This was due to personal matters within the home and the relationship with the child. The youth was able to remain with the family until a pre-adoptive family was identified. The transition to this family went well and the youth was adopted by this family.

About two and a half (2.5) years following the adoption, the parents reached out for assistance from DCYF due to the youth's behaviors. The parents were seeking out-of-home placement. While the family was being assessed, the youth was admitted to the hospital. The youth stepped down to a hospital step-down program before transitioning to a group home. After one (1) month, the youth was hospitalized again and following treatment, returned to the group home. After two (2) months, the youth was hospitalized again and DCYF identified a new group home for the youth. The youth was there for about three (3) months requiring another hospitalization. The youth returned to this group home and was able to stabilize.
During this time, the identified concerns were substance use, impulsive and dysregulated behavior, and suicidal ideation due to a history of physical and emotional abuse and neglect.

Once stabilized at the program, there were significant improvements in school, engagement with clinical supports, and in the residence. There was a recommendation that due to the improvement that the youth transition to a different location within the agency to better meet the needs of the youth. The youth agreed to this transition and was excited about it.
During this transition, the youth struggled in school and with compliance with program expectations. There were services in place, however, the youth was hesitant to engage in services. The youth's engagement in AWOL behavior increased and during one of the AWOLs, the youth reached out to a provider stating that they wanted to hurt themself. The youth was admitted to the hospital.

Following discharge, the youth transitioned back to the more secure group home through this agency where the youth had prior success. The youth agreed with this plan. While there were

still some struggles, the youth made improvements, and it was recommended that they return to the lower level of care through the same agency. The youth was aware of why the transition was unsuccessful the first time and recognized what was required to be successful this time. There were some concerns with marijuana use, but after a period of time, the program made a recommendation based on improvements to transition the youth to their independent living program. This transition to independent living was only maintained for a short period of time and they subsequently returned to their semi-independent living program. There was again a period of improvement and as the discussions began to transition to independent living, the youth started engaging in AWOL behaviors. The last AWOL lasted for an extended period of time. The youth reached out and asked that they be able to stay with friends that were identified.

The family was allowed to provide foster care to the youth. Over the next two (2) years, the youth remained in this home. While there were periods where the foster parents required additional support to maintain the youth; they were able to maintain the youth in their home successfully. The youth graduated from high school and DCYF made a referral to the VEC program. The youth remained in the foster home when they entered the VEC program, and the near fatality occurred shortly thereafter.

Near Fatality Summary # 8:

The case of this youth is outlined in Fatality #3. This youth experienced a near fatality due to opiate overdose while open to DCYF. Approximately one (1) year after the near fatality, the youth went AWOL. The youth was missing for four (4) months until they were found deceased due to a drug overdose.

Near Fatality Summary # 9:

A report was made to DCYF indicating that ten (10) days prior, a seventeen (17) year old was found unconscious in the bathroom of an assessment and stabilization center. Narcan was administered on site and in the ambulance, which was able to revive the youth. DCYF completed an investigation. The CPI built a timeline. Based on obtained information, it was discovered that the youth went AWOL. The AWOL was reported to DCYF. Two (2) days later, the youth returned to the program in the morning and was brought to the hospital to be medically cleared. The AWOL return was reported to DCYF. After returning from AWOL, the youth engaged in behaviors and staff inappropriately restrained the youth. Later that day, the youth reported feeling sick and was brought to the bathroom on the second floor by staff and the staff returned to the first floor. When staff went to check on the youth, they were unconscious. Earlier in the day, when the youth was medically cleared, the toxicology report was positive for marijuana. The youth also reported that they had taken acid when AWOL. DCYF unfounded the allegations as to the staff member with regards to the near fatality. Additionally, a report was made to DCYF regarding the allegations as to the inappropriate restraint. DCYF completed an investigation and unfounded the allegations as to the staff member.

This family came to the attention of DCYF when a report was made to DCYF that father was acting inappropriately while the youth was awaiting psychiatric services by the hospital. After speaking with the youth and father, DCYF unfounded the allegations and DCYF terminated involvement with the family with no further engagement. Another report was made to DCYF by the police that the youth received pictures of a naked male. The police addressed this. DCYF documented the report but did not investigate. A report was subsequently made to DCYF that the youth was being abused by father. There were additional concerns about high-risk behaviors of the youth. The family opened to DCYF, and the youth was placed at an assessment and stabilization center while DCYF identified an appropriate placement. While in placement, the youth's relationship her mother and father were strained and contact required supervision. The youth struggled with the rules of the program and peers.

An evaluation was completed for the youth and the recommendations included individual therapy, obtaining a neuropsychiatric evaluation, a mentor, and structured free time. DCYF made attempts to identify a foster placement for the youth, however, when DCYF identified a foster home, the youth did not want to go. DCYF made referrals for in-state community-based congregate care facilities. During the youth's time in the program, there were disclosures about additional traumatic incidents that occurred in childhood. There continued to be struggles in the program and in school, including AWOLs, noncompliance, and assaultive behavior towards peers. DCYF made referrals for higher levels of care in-state. The youth was accepted to a higher level of care in-state and successfully transitioned there. Upon discharge, the previous program did note improvements in some areas, such as interactions with peers. Another evaluation was completed, which recommended continuing with a consistent clinician to build a relationship, trauma focused therapy, addressing anger, and addressing behavioral issues.

While at the new program, there was initial improvement but then the youth began to engage in similar behavior patterns, such as AWOL behaviors, negative interactions with peers, and noncompliance. A neuropsychological evaluation was completed. In addition to many recommendations on how to support the youth at school, there were recommendations regarding ongoing mental health counseling, a structured routine, and identifying adult supports to work on peer relationships. The program did see some improvements, specifically in school, however the youth was struggling with the relationships with her parents, especially since other youth were able to go on pass and visit with their family and the youth could not do this with their parents.

A foster family was identified for this youth. DCYF, the program, the foster family and the youth spent a lot of time planning for this transition and building rapport. Prior to the transition, the foster family determined that they were unable to move forward due to the behavioral presentation and complexity of the youth. This was very difficult for the youth. The youth identified a former supportive adult that could be a resource and asked DCYF to find the person. DCYF was able to locate this adult.

The youth continued to struggle with the same behaviors and was advocating to leave the current program. DCYF facilitated a placement with the supportive adult through an ICPC in a

different state. After about a month, the foster parent was observing similar behaviors that the program had been observing. Additionally, the foster parent had difficulty obtaining the youth's prescribed medications. The foster parent's agency also observed behaviors that would be expected from a youth much younger than the youth. The foster parent requested that DCYF return the youth back to Rhode Island due to safety concerns for the family. The youth was placed at an assessment and stabilization center when they returned to Rhode Island. DCYF made referrals for high end out-of-state residential placements. At the assessment and stabilization center, similar behaviors continued, and the youth required a hospitalization. An out-of-state placement accepted the youth; however, they were unable to admit the youth for about four (4) months. The youth was at the hospital for five (5) months total before discharging to the out-of-state placement. The youth made a lot of improvements in this facility, and it was recommended that they discharge to a lower level of care. A community based congregate care setting in-state was identified and there was a transition plan developed. A discharge summary was created by the program and recommended the youth responds well to 1:1 instruction, clear expectations, plans for transitions, continue with all mental health treatment, identify a mentor, and family therapy.

Immediately following the transition, the same behaviors from before the out-of-state placement started again, including struggles with peer interactions, AWOLs, and indications for more high-risk behaviors. While there was a lot of discussion around what will be available to the youth upon discharge, some of the services were unable to start right away due to scheduling and insurance issues. Additionally, school was unable to start right away. These behaviors continued to escalate putting the youth's safety at risk. DCYF made referrals to out-of-state high end residential placements. Ultimately, the youth assaulted a peer in the program and was asked to the leave the program. The youth transitioned to an assessment and stabilization center. When this transition occurred, the youth wanted to change schools, as well. The new program set up a treatment plan, including individual and group therapy and additional services to target high-risk behaviors. DCYF continued to identify a high-end residential placement for the youth. The same behaviors were occurring at this program, such as noncompliance, AWOLs, negative peer interactions, and high-risk behaviors. This is the program in which the near fatality occurred.

Near Fatality Summary # 10:

A report was made to DCYF that a seventeen (17) year old youth had overdosed and was found unconscious outside. Emergency services administered multiple doses of Narcan and transported the youth to the hospital. The youth admitted to using heroin and stated that there were additional drugs in their bedroom, which was later identified as fentanyl.

This family came to the attention of DCYF when there were multiple reports made to DCYF regarding the youth's mental health, including homicidal ideation, and aggressive behaviors. These reports were screened out and DCYF completed an assessment. The youth had significant diagnoses and concerns for a substance use disorder. DCYF referred the family to

FCCP and there was also a referral to enhanced outpatient services, however the family was on a waitlist.

Approximately one (1) year later, there was a referral to CSBH seeking additional supports for this youth due to an increase in aggressive behaviors, AWOL behaviors, and concerns for gang involvement. The youth was not actively involved with clinical supports or school. The youth was connected with substance use treatment, had a recent hospitalization, however, was not taking prescribed medication. The discharge plan included referrals to additional services. The case remained closed to DCYF.

A report was made to DCYF due to an argument between the youth and their father. This report was screened out. A report was made to DCYF because the youth assaulted someone and was subsequently charged, and this report was screened out. DCYF opened to the family and was ordered to make placement referrals due to the seriousness of the juvenile charges and substance use.

DCYF identified an in-state residential treatment facility. The youth and family were engaged in treatment while the youth was placed here. A report was made to DCYF due to an argument between the youth and the father and allegations of physical abuse. This report was screened out. During this placement, the youth was placed at the RITS two (2) separate times. The youth was able to return to the residential treatment facility both times and the youth was successful and able to transition home with supportive services.

The youth was in placement for approximately eight (8) months before transitioning home with home-based services and individual counseling. Within a few months of reunification, the youth began struggling at school and was suspended. Due to the developmental disabilities that the youth was diagnosed with, the family was seeking supports and services related to this.

A report was made to DCYF that the youth was accessing inappropriate content on their cell phone at school. This report was screened out. The youth remained in the family home, experiencing one placement at the RITS due to behaviors. There were serious concerns regarding the youth's interest in guns, having non-operational guns, and having gun parts delivered to the home. In attempting to address these concerns, the youth required a psychiatric evaluation. During the hospital admission, DCYF made referrals for out-of-home placement. The youth transitioned home, however, struggled with their behaviors and returned to the RITS. During this admission to the RITS, the youth obtained mental health treatment, including evaluations at the RITS. The youth transitioned back to the in-state residential treatment facility. The youth quickly returned to the RITS. DCYF made referrals for placement, however, the youth ultimately returned to their father due to waitlists.

DCYF referred the family to supports and services. While there was some success, the youth was unable to maintain stability, struggling with school and compliance with treatment plans. The youth was home when the near fatality occurred.

Near Fatality Summary # 11:

A report was made to DCYF that a sixteen (16) year old youth placed in an in-state residential treatment facility was not making sense, spaced out, and shaking. A nurse was not available or on-call, emergency services was contacted, and the youth was transported to the hospital. When family was contacted, it was discovered that on pass, the youth may have had access to medication. The program found a significant amount of medication in the youth's bedroom. Based on the incident and the treatment, this was considered a near fatality. DCYF completed an investigation and unfounded the allegations as to the staff member.

This family came to the attention of DCYF when a report was made to DCYF regarding a domestic violence incident between the mother and a household member. Three household members, including the mother were indicated for Neglect – Other Neglect. DCYF made referrals for services. DCYF remained open as there were ongoing concerns regarding mother's compliance with the services. Ultimately, the child was placed in the legal guardianship of family members. This family closed to DCYF.

This family came to the attention of DCYF again when the youth was engaging in unsafe behaviors, even with in-home services and clinical services in place. Additionally, there were multiple hospitalizations due to suicidal ideation. DCYF made a referral to FCCP. Based on clinical reports that all services were in place, DCYF closed to the family.

There was a report made to DCYF due to physical abuse allegations by mother. DCYF completed an investigation and the allegations were unfounded. The youth was not engaging with the services in place and was experiencing suicidal ideation, as well as engaging in assaultive behavior towards family and providers. A safety plan was developed with the services open to the family and additional family members. Service providers started actively working with the family.

The youth was subsequently hospitalized. While the youth was in the hospital, the case transferred from FSU to CSBH and DCYF made referrals to out-of-state high end residential placement facilities. Several programs reached out to interview the youth and these interviews went very poorly. The youth, struggling with their mental health and upset about the idea of going to a residential placement, was unable to regulate during the interviews. The programs ultimately were not moving forward due to the interviews. Additionally, there were placements that the family felt were too far away to consider. After about five (5) months in the hospital, the youth returned home with in-home services. DCYF continued to explore residential placement for the youth. Following discharge, there were barriers to the youth returning to school. Residential placements reached out to interview the youth, but these interviews did not take place.

The youth continued to remain in the home. There were reports by the providers that they were concerned about self-injurious behaviors. There were continued recommendations that the youth be seen at the hospital for these injuries. There were also concerns with the youth's

phone and internet use. Based on these concerns and the lack of progress with current treatment, the case transferred back to FSU from CSBH. The recommendations from providers were that the youth required a higher level of care.

Following the transfer back to FSU, the family noted an improvement in behaviors and in school, although the youth was only in school part-time. The family decided that due to the improvements, they were no longer requesting residential placement. Following this decision, there were unsafe behaviors that prompted the family to reconsider residential placement. The unsafe behaviors presented as self-injurious behaviors and suicidal ideation. There were denials due to lack of engagement with the interview process. DCYF re-referred the youth to high-end residential treatment programs. When the interview process began again, the family determined that the youth's behaviors were manageable and were not interested in residential treatment. There continued to be concerns about the amount of time the youth was not attending school. The in-home services terminated services due to lack of engagement. Based on FSU's continued monitoring of this case, a dependency petition was filed. The youth's school attendance increased, however, there was also an increase in their access to sharp objects. The recommendation was that the youth's room be searched every day. There was a gap in clinical services following the termination of the previous service. The school continued to have serious concerns about self-injurious behaviors.

The youth was hospitalized and upon discharge there was a gap in services due to refusals by the youth and waitlists. There was increase in the number of days missed from school. Once services started, the providers worked to build a rapport. There was a subsequent hospitalization due to the youth overdosing and required treatment in the intensive care unit. The youth was visiting extended family and had access to medication. The youth was hospitalized for about two (2) months before returning home. The youth was discharged with a plan to attend a partial program and continue with the already established in-home services. While there was stability for a period of time, there continued be concerns about substance use and inappropriate use of internet.

Following discharge from the partial program, there were recommendations regarding clinical supports, coping strategies, and recommendations for in-person schooling. Due to concerning behaviors, the youth returned to the partial program. The youth was admitted to the hospital again due to ingesting medication. The recommendations from the clinical team were that the youth required residential placement. There continued to be unsafe behaviors during this time. DCYF continued to explore placement options for the youth. The youth was in some form of a hospital setting for seven (7) months before a placement was identified. The youth was discharged to an in-state residential treatment facility. While it took some time, the youth started improving and making significant progress. The youth was engaged with other youth in the home and started learning to advocate for themself. The youth was engaged in the clinical supports put in place. The youth was continuing to request passes to visit family. The recommendations were that this takes place after consistent family therapy. The near fatality took place following the implementation of off-ground passes.

Discussion and Findings

I. Children's Behavioral Health and Adolescent Substance Use Treatment

Pursuant to R.I.G.L. § 40-1-13, the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH) is responsible for substance use services, programming, and education in Rhode Island. This mandate is for all populations, including adolescents.

Pursuant to R.I.G.L. § 42-72-5, DCYF is responsible for establishing treatment programs, protective services, primary- and secondary-treatment programs, evaluate the services of DCYF, license and monitor all residential and nonresidential placements, and coordinate community resources.

Further, DCYF is responsible for delivering mental health services to "seriously emotionally disturbed children"[25] and "children with functional developmental disabilities".[26] More specifically, the mandate includes developing a comprehensive network of programs and services, promoting the development of new resources for program implementation, and to transition plan for these youth.

Additionally, pursuant to R.I.G.L. § 42-72-5.2, DCYF:

> "…shall cooperate to develop and design of a continuum of care for children's behavioral health services that encourages the use of alternative psychiatric and other services to hospitalization and reviews the utilization of each service in order to better match services and programs to the needs of the children and families as well as continuously improve the quality of and access to services."

In accordance with the statutory mandate set forth for both BHDDH and DCYF, it is important to note that the powers and duties outlined for both state agencies require collaboration and

[25] R.I.G.L. 42-72-5 defines "seriously emotionally disturbed" as "any person under the age of eighteen (18) years, or any person under the age of twenty-one (21) years, who began to receive services from the department prior to attaining eighteen (18) years of age and has continuously received those services thereafter; who has been diagnosed as having an emotional, behavioral, or mental disorder under the current edition of the Diagnostic and Statistical Manual and that disability has been ongoing for one year or more or has the potential of being ongoing for one year or more; and the child is in need of multi-agency intervention; and the child is in an out-of-home placement or is at risk of placement because of the disability."

[26] R.I.G.L. 42-72-5 defines "functional developmental disability" as "any person under the age of eighteen (18) years or any person under the age of twenty-one (21) years who began to receive services from the department prior to attaining eighteen (18) years of age and has continuously received those services thereafter…this includes autism spectrum disorders and means a severe, chronic disability of a person that: (A) Is attributable to a mental or physical impairment or combination of mental physical impairments; (B) Is manifested before the person attains age eighteen (18); (C) Is likely to continue indefinitely; (D) Results in age-appropriate, substantial, functional limitations in three (3) or more…areas of major life activity…"

coordination with other state agencies to carry out their responsibilities, specifically developing and maintaining a comprehensive continuum of care.[27]

The panel identified gaps in available resources throughout the review of all cases involving adolescent substance use. While the need for substance use treatment was a common theme throughout the cases, other critical services, which should be provided by DCYF, were also inaccessible. Our state lacks a comprehensive continuum of care as required by law.
In ten (10) of these fatalities and/or near fatalities, the panel indicated there were gaps in the entire continuum of care impacting the youth's ability to access necessary supports and services, timely. The youth and young adults involved with DCYF deserve meaningful investment and coordinated efforts to develop a concrete plan to rebuild the crucial services supporting their needs. This includes investments in Mobile Response and Stabilization Services to support children and youth in crisis; prevention and home-based services; a robust array of foster homes serving varying populations; in-state Psychiatric Residential Treatment Facility (PRTF) and Residential Treatment to support the needs of acute populations; and step-down programming for children and youth who require additional time in a structured environment, prior to transitioning home or to a foster home, to promote expedient discharges from more restrictive settings. The impact of a disjointed and under-resourced continuum of care was well illustrated by the cases reviewed by the panel.

Additionally, a critical need identified by the panel is the development of a full continuum of services to address adolescent substance use. Adolescents in Rhode Island require a "continuum of services to identify, treat, and maintain gains and support recovery for youth with substance use or substance use and co-occurring mental health disorder."[28] This continuum needs to include appropriate screening tools, assessments, outpatient treatment focused on individual, group and family therapy, intensive outpatient treatment, partial hospital programming, targeted case management, and recovery services and supports, including youth peer-to-peer coaching, parent/caregiver support, technological support services, and residential treatment, including an intensive residential treatment option for substance use and co-occurring disorders.[29] Identification of available state and federal resources that can be utilized for funding will be needed for developing these services.

A review of the cases illustrated a clear need for additional supports and services addressing substance use including community-based substance use programming and mental health treatment throughout the youth and young adults' involvement with DCYF. For some youth, these interventions were necessary in an attempt to prevent the youth from experiencing an out-of-home placement and, for others, there was a need for intervention to support transition

[27] See R.I.G.L. § 42-72-5 and R.I.G.L. § 40-1-13.
[28] Centers for Medicare & Medicaid Services (CMCS) & Substance Abuse and Mental Health Services Administration (SAMHSA). (2015). Joint CMCS and SAMHSA Informational Bulletin: Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions. cib-01-26-2015.pdf
[29] Centers for Medicare & Medicaid Services (CMCS) & Substance Abuse and Mental Health Services Administration (SAMHSA). (2015). Joint CMCS and SAMHSA Informational Bulletin: Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions. cib-01-26-2015.pdf

into a step-down program, foster home, or back home with family. Waitlists for critical substance use treatment and services created barriers to clinical progress for some youth. For youth at risk of out-of-home placement or youth who were attempting to succeed in the community after stepping down from a residential treatment facility, they can fail to make substantive clinical progress when there are gaps in service provision.

In-state community residential providers have been willing to incorporate existing substance use treatment into their programs. If appropriate community-based substance use programming is not available or accessible, youth are unable to remain in these community-based residential programs. When youth require an intensive level of care to address their substance use disorder, this level of treatment is not available in-state. To access the necessary supports and services, youth are often referred out-of-state. Of the cases reviewed, four (4) youth were placed in an out-of-state high-end residential treatment facility and five (5) additional youth were referred to out-of-state placements.

Often, youth with a substance use disorder diagnosis or youth who are utilizing substances as a coping mechanism, also have a co-occurring mental health diagnosis requiring treatment. While there are currently two (2) residential treatment facilities for males in-state, addressing substance use disorder requires additional planning and services. Our in-state providers review the information available to ensure they can provide treatment to both co-occurring disorders. Currently, there is a high-end residential treatment facility under construction specifically for females in-state, however, as of the release of this report, there are no other options available for females requiring a higher level of residential treatment whether they have a substance use disorder or a mental health diagnosis. Continuing to develop services to address substance use and the behavioral health needs of youth, regardless of gender, is critical.

While the OCA continues to advocate to build capacity in-state, there may be youth who presently require a higher level of care, at an out-of-state placement, due to their specialized and complex needs. To use these programs effectively, DCYF must develop placements and services youth can readily access as they step-down following intensive treatment. Whether the youth is able to return home, transition to a foster placement, or transition to a step-down congregate care setting, DCYF must ensure these levels of care are accessible. Two (2) of the four (4) youth who successfully discharged from an out-of-state placement, returned to Rhode Island and immediately began to struggle in their next setting. In these cases, there were discussions about making referrals to find another out-of-state placement following their return. While DCYF is responsible to plan for out-of-home placement, reunification, and behavioral health supports and services, BHDDH remains responsible for the procurement and delivery of substance use treatment, which may be necessary for a youth stepping-down to continue treating their substance use disorder. The coordination of these services is a necessity, to build a comprehensive transition plan for the youth. In DCYF's most recent procurement, home-based services for families and youth struggling with a substance use disorder were included and should be accounted for when further planning for the continuum occurs.

In addition to maintaining a full continuum of care to provide treatment services at all levels, the panel noted a consistently fragmented approach to the delivery of services. The lack of services available in-state, in combination with extensive waitlists for critical services and timely access to services, remains a concern. When youth require an out-of-home congregate care placement to receive services, DCYF compiles documentation to include in a referral packet that is sent to each placement. Once received, the program reviews it, sets up an interview if appropriate, and then schedules an admission date. In cases where there is no appropriate in-state treatment option, this process can be lengthy, because DCYF must rely on out-of-state programs to prioritize Rhode Island youth. While this process is taking place, youth may be waiting at home, in a temporary congregate care setting, or in a hospital setting.

The OCA has consistently advocated that all efforts are made to ensure that DCYF provides all levels of care in Rhode Island. Whenever possible, youth should remain with their families in Rhode Island in order to maintain ties to their school, family, friends, and community. The panel specifically identified that services for substance use disorders be provided in-state requiring significant coordination between DCYF and BHDDH and development of these services by BHDDH. The coordination between DCYF and BHDDH is critical to appropriate planning for youth and families whose needs include substance use treatment. DCYF's involvement in developing adolescent substance use treatment ensures that the approach is appropriate for this population. Adolescents require a specialized approach to substance use programming, due to the "biological development of the adolescent brain, the lack of adolescent-specific treatment services, and the need for evidence-based quality treatments"[30] unique to this population.

When a youth opens to DCYF and is struggling with a substance use disorder, DCYF is responsible for identifying the appropriate treatment for the youth. The panel noted that in cases with an identified issue with substance use, referrals were made to DCYF, not to services administered by BHDDH. DCYF is responsible for children's behavioral health, except for substance use treatment, which is the responsibility of BHDDH. As a result, youth requiring substance use treatment and treatment for co-occurring disorders, must navigate two separate systems causing fragmentation and inefficiency which negatively impacts our youth.

The panel also discussed timely access to comprehensive evaluations for youth and implementation of the recommendations outlined in such evaluations. While there were youth who received extensive evaluations with recommendations, it was unclear how the evaluations for one (1) youth were being utilized to support their clinical progress. For some youth requiring substance use evaluations or screenings, referrals for these services never occurred. Providers who can conduct more intensive evaluations, including neuropsychological evaluations, are scarce resulting in lengthy waitlists.

[30] Winters, K. C., Botzet, A. M., & Fahnhorst, T. (2011). Advances in adolescent substance abuse treatment. Current psychiatry reports, 13(5), 416–421. https://doi.org/10.1007/s11920-011-0214-2

Rhode Island needs a concrete plan with input from both DCYF and BHDDH to design and develop a continuum of care that addresses the spectrum of complex needs, behaviors, and diagnoses youth may experience. We also require further planning to develop coordinated systems that provide children and youth streamlined access to services and comprehensive treatment without barriers imposed by the structure of our systems.

II. Care Coordination and Transition Planning

The panel identified a lack of clarity on how determinations are made regarding which community-based services are appropriate for the youth and families. There were instances when interventions put in place were not specifically recommended for that youth's diagnoses and presenting behaviors. For example, youth who were diagnosed with an intellectual disability or a developmental disability had services in place that did not support the youth's substance use disorder and co-occurring disorders. Additionally, one (1) allegation of a traumatic incident went unaddressed and unacknowledged during years of treatment because it was not included in referral information to placements and service providers. Currently, DCYF's Central Referral Unit makes referrals for community-based services for youth with information provided by the FSU team. [31]

In addition to community-based services, the panel observed a disjointed process for placement referrals to congregate care. The current referral process requires the primary case worker to obtain treatment, hospital, school, and other records to provide a comprehensive overview of the current issues a youth is presenting along with historical information.[32] Inconsistencies in the information provided in the referral packet are due to information not being available or obtained timely by DCYF. In one (1) of the cases reviewed, placement referrals were delayed due to incomplete information in the youth referral packet. While there are certainly difficulties in compiling a complete record for youth, continuing to do this on an ongoing basis in order to make timely and appropriate referrals will ensure that transitions take place timely.

Once the information is obtained and the primary case worker requests a placement, CSBH is responsible to make the referrals. In multiple instances, there were referrals made to a wide range of residential treatment facilities including programs that offered different levels of care, types of services, and served different populations than the youth required. The panel noted that there was a lack of specificity in determining the most appropriate residential intervention for the individual youth and family, casting a wide net to any placement providers previously used by DCYF. The OCA also outlined this issue in the DCYF and St. Mary's Home for Children Investigative report released in December 2023.[33] This approach does not focus on the youth but focuses on the ultimate goal of identifying a placement. Simply finding any placement is not enough. The placement has to be able to meet all of the unique needs of the youth. The panel discussed whether a multi-disciplinary team would benefit this process, including the FSU team,

[31] See DOP 700.0225; 700.0170

[32] See DOP 700.0170.

[33] Rhode Island Office of the Child Advocate, DCYF and St. Mary's Home for Children Investigative Report, December 19, 2023.

current providers, the family, and the youth. Making decisions with youth and families at the table will ensure that their voices are centered in planning and decision making.

Currently, the FSU team, in coordination with the Substance Use Coordinator, are responsible to make referrals to community-based substance use treatment programs and out-of-state substance use residential treatment facilities. Specifically, this includes any program or facility that is funded by BHDDH or by private insurance. Due to the lack of a robust continuum of care for substance use treatment in-state, DCYF is limited to where referrals can be made.
Youth and families experiencing a substance use disorder require thoughtful and intentional decision making when it comes to accessing treatment. There are services and providers that may be appropriate for one youth, but not for another. In order to achieve this, resources must be readily available for DCYF to access.

Once services were in place for youth and families, the panel noted there were consistently gaps or disruptions with service providers. The OCA commonly receives feedback from older youth that they struggle with the number of times they have to restart treatment with a new clinician. Forcing youth to repeat their story or trauma history, and build new clinical relationships is extremely challenging. Youth requiring high end residential treatment, whether in-state or out-of-state, will work with clinicians, case managers, and direct service workers who will no longer work with the youth when they discharge to a lower level of care. There were instances when these services and relationships ended without the appropriate follow-up clinical services in place. In some cases, there were services or providers available to begin right away but the previous support ended without an appropriate transition or communication between providers. In one (1) case, a service provider nearing the end of treatment made attempts to connect with the new providers through DCYF in an effort to provide continuity of care, however it was unclear if this occurred. Additionally, there was little information provided to determine if placement providers who were discharging youth were put in contact with the new placement provider to support the transition. In order to effectively address substance use disorders and co-occurring mental health disorders, youth require consistency in treatment and appropriate transitions between placements and providers.

The availability of resources, programming, and appropriate levels of care is only the first step in setting up youth and families for long-term success. It is equally important to determine the appropriate services and levels of care, evaluate and assess progress, and continuously plan for the next step. The panel discussed throughout the cases, the need for intensive care coordination. Intensive care coordination the process of assessment and service planning, accessing and arranging for services, and coordinating multiple services, including access to

crisis services.[34] Additionally, it includes assisting the child and family to meet basic needs, advocating for the child and family, and monitoring progress.[35]

At the outset, the person who is tasked with facilitating intensive care coordination for the youth and family would assist in determining the appropriate services and placement. Transition and discharge planning would begin at intake or admission. This process would include communicating with all providers, the family, and most importantly the youth. The team would develop achievable, measurable outcomes that would show progress in treatment and allow the team to determine when discharge from services and placement are appropriate. During periods of transition, the intensive care coordinator would ensure that accurate treatment information and relevant historical information is available to new providers. This wraparound approach was identified as a need in six (6) cases that youth appeared to be moving from placements and transitioning between services without intentional decision-making and transition planning. Additionally, there were multiple youth who experienced multiple disrupted placements, repeated detentions at the RITS, and unsuccessful transitions to step-down facilities that may have been prevented with a coordinated, youth-focused, team-based approach.

III. AWOL Youth and Prevention Strategies

In addition to the clear need for a substance use residential treatment facility in-state and a comprehensive continuum of care, a behavior that many of the youth and young adults engaged in was being AWOL. AWOL behavior is consistently observed among youth and young adults experiencing the child welfare, juvenile justice, or children's behavioral health systems. The current Department Operating Procedure (DOP) titled "Missing Children/Youth Absent from Care" outlines the action steps that staff are required to complete when a youth is identified as missing or absent from care.[36] These immediate actions are taken to make every effort to locate the child as soon as possible. Of the youth who displayed AWOL behavior, some were missing for days and others were missing for up to four (4) months. The DOP specifically outlines action steps to be taken by DCYF's Special Investigations Unit (SIU). SIU is comprised of staff who have built critical relationships with police departments, community partners, and most importantly young people, which allows the SIU team to effectively and efficiently locate youth missing from care. The specialized and time sensitive work conducted by the SIU team is an invaluable and impactful resource supporting our youth.

Youth and young adults who are missing from their group home, foster home, or parents/caregivers are more likely to engage in high-risk behaviors. Of the youth reviewed in this report, there were specific concerns related to gang involvement, commercial sex trafficking,

[34] Centers for Medicare & Medicaid Services (CMCS) & Substance Abuse and Mental Health Services Administration (SAMHSA). (2013). Joint CMCS and SAMHSA Informational Bulletin: Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions. cib-05-07-2013.pdf

[35] Centers for Medicare & Medicaid Services (CMCS) & Substance Abuse and Mental Health Services Administration (SAMHSA). (2013). Joint CMCS and SAMHSA Informational Bulletin: Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions. cib-05-07-2013.pdf

[36] See DOP 700.0070.

injury or assault, criminal activity, and substance accessibility. The panel identified that when youth returned from being AWOL, there was an inconsistent approach to addressing the behaviors. Developing a clear procedure and effective interventions to disrupt this pattern of behavior will require input from DCYF, providers, parents, foster parents, and most importantly youth who engage in this behavior. Youth with lived experience can help us understand their needs and inform development of policies and protocols to support mitigation of AWOL behavior.

Collaborating with first responders, including local police departments, is important to strengthening the protocol for responding to AWOL youth. Educating police officers about when to call the DCYF's Child Abuse Hotline may help locate AWOL youth more quickly. A clear and uniform response will be beneficial to anyone who interacts with youth, including congregate care staff, DCYF, caregivers, and first responders.

While it is likely that some youth will be susceptible to engage in AWOL behavior or leave their home without permission, there are ways to ensure they are prepared to keep themselves as safe as possible. There were multiple youth reviewed by the panel who engaged in recreational substance use; however, the pill, powder, or substance was laced with fentanyl. The increased risk of death due to unknowingly ingesting fentanyl needs to be consistently reiterated to all youth, but specifically to youth who are frequently missing from care or showing signs that they are engaging in substance use. Implementing a curriculum that regularly provides this information is critical. Ensuring that youth who are missing from care know how to contact someone to help them and that they know someone will come to help them will provide them with an opportunity to leave an unsafe situation. Finally, prioritizing education on commercial sex trafficking for all youth is important so they can identify when they are at risk to be groomed or recruited in any setting, especially while AWOL.

Providing consistent and clear messaging to youth regarding ways to stay safe while AWOL is important, and it is equally important to provide training and psychoeducation to caregivers. Ultimately any youth, regardless of their placement in residential or foster care, can engage in AWOL or high-risk behaviors. Ensuring that primary caregivers are trained on appropriate supervision when youth return from being AWOL, when it is important to have the youth seen by a doctor, and what signs are important to look for to identify if a youth has experienced trauma or as been victimized. Additionally, it is important that when youth are referred for supportive services that caregivers are included in developing treatment goals and engaging in treatment. It is important that services are easily accessible to the youth's caregiver or parent, including in their native language or adapted if the parent is diagnosed with an intellectual disability. Any education provided to the youth's caregivers or family should take into consideration the specific needs of the youth and family.

Education for youth, family members, and community partners on obtaining and utilizing Narcan is critical for reducing harm for youth at risk for substance use. Direct care workers working with youth in congregate care settings should be trained to administer Narcan and should know where and how to access in case of emergency.

IV. Trauma-Informed Practice

The panel consistently elevated the importance of trauma-informed practice during case discussions of adolescent youth involved with the child-welfare, juvenile justice, and children's behavioral health systems. Adolescents who become involved with these systems experience trauma which requires professionals in this field to expand their knowledge through education and training in order to stay current on trauma-informed best practices for high-quality service delivery.

Trauma-informed practice is an approach in healthcare, education, social work, and related human service fields that acknowledges the widespread impact of trauma and integrates this understanding into policies, procedures, and interactions. Rather than focusing solely on symptoms or behaviors, trauma-informed care emphasizes safety, trustworthiness, choice, collaboration, and empowerment. It recognizes that trauma can affect individuals' ability to engage, learn, or heal and seeks to avoid re-traumatization by creating supportive environments.

Guidelines for trauma-informed practice are primarily set by organizations such as the Substance Abuse and Mental Health Services Administration (SAMHSA) in the United States. SAMHSA outlines six key principles of trauma-informed care: safety; trust and transparency; peer support; collaboration and mutuality; empowerment and choice; and cultural, historical, and gender considerations.

- Safety: Ensuring physical and psychological safety for all participants and staff.
- Trustworthiness and Transparency: Making decisions with transparency to build and maintain trust.
- Peer Support: Recognizing the value of mutual self-help and peer support.
- Collaboration and Mutuality: Emphasizing partnership and leveling power differences between staff and service participants.
- Empowerment, Voice, and Choice: Fostering a belief in the primacy of the people served to heal and promote recovery.
- Cultural, Historical, and Gender Issues: Offering culturally and gender-responsive services while moving beyond stereotypes and biases.

Best practices for professional development in trauma-informed care include ongoing training, reflective supervision, and fostering organizational culture that prioritizes staff well-being and trauma awareness. Professionals should be educated not just on recognizing signs of trauma, but also on strategies for building resilience and maintaining personal boundaries. Ultimately, trauma-informed development must be continuous, responsive to new research, and embedded into everyday practice rather than treated as a one-time initiative.[37]

[37] Substance Abuse and Mental Health Services Administration: Practical Guide for Implementing a Trauma-Informed Approach. SAMHSA Publication No. PEP23-06-05-005. Rockville, MD: National Mental Health and Substance Use Policy Laboratory. Substance Abuse and Mental Health Services Administration, 2023.

V. DCYF's Substance Use Coordinator

The Substance Use Coordinator works within DCYF to coordinate substance use treatment for both parents and youth. This grant funded position is part of the CPS unit. After reviewing several cases where this role was mentioned, the OCA met with the Substance Use Coordinator to learn more about the function of the position and how they support youth and parents with substance use issues.

When working with parents, the goal is to intervene as early as possible to avoid removal of children and support reunification. In addition to coordinating substance use treatment, this role is intended to fulfill a myriad of responsibilities. The Substance Use Coordinator reported that the CPS Call Floor Supervisor is to notify the Substance Use Coordinator when the DCYF's Child Abuse Hotline receives a call regarding a mother using substances while pregnant. After receiving this notification, a hospital alert is sent to all Rhode Island birthing hospitals using the hospital alert form, which was updated in October 2024. The hospital alert form indicates the alerts should be sent to Rhode Island hospitals and hospitals in the surrounding area. DOP 100.0060 indicates "…the hospital alert can be initiated by the Substance Use coordinator, a CPS worker, FSU worker, or Juvenile Correctional Services (JCS) worker. A Call Floor CPI supervisor may initiate an alert on a case not currently open with DCYF." However, the policy does not indicate the alerts should be sent to both hospitals in Rhode Island and hospitals in the surrounding area, to neighboring states. It is important there is clarity and consistency with the issuance of hospital alerts. The language within the policy should mirror the expectations outlined within the form. Supervision of hospital alerts should be provided to ensure the correct process is followed and all information is documented accordingly.

The Substance Use Coordinator works collaboratively with a certified Peer Recovery Specialist who connects directly with the mother to ensure they have all the supports and services necessary. The Peer Recovery Specialist monitors and tracks progress as the mother engages with substance use treatment. The goal is to safely plan to prevent removal through the continued support of a reliable peer with lived experience. Once the mother gives birth, DCYF is notified, and a CPS investigator is assigned to the case to meet with mother and coordinate with the hospital. If the mother has engaged in treatment, it is possible that the call to CPS can be screened out. Prior to discharge from the hospital, the healthcare team develops a Plan of Safe Care, which outlines a plan for postnatal treatment. This can include but is not limited to, aligning with additional supportive services, scheduling developmental screenings for the baby, and educating the parent regarding care of a substance exposed newborn. [38]

The Substance Use Coordinator reported they also work in consultation with FSU and CPS to coordinate substance use evaluations and services for youth. The Substance Use Coordinator indicated that they hold bi-weekly virtual meetings with the Congregate Care Unit to discuss and coordinate services. They also connect directly with youth when given consent by the parent(s). This position is also tasked with providing trainings to CPIs about best practices when

[38] See DOP 500.0080, Substance Exposed Newborns.

working with parents who are struggling with substance use. Specifically, the trainings address preferred language, preventing a punitive approach, and ensuring blame is not placed on parents struggling with substance use.

The panel identified some gaps in using the resources provided by the Substance Use Coordinator. In several of the cases reviewed by the Panel it was evident that this position was not used as a resource to help identify and coordinate services, because referrals were either not made or inconsistent. The panel cited this gap in several cases and attributes this to the lack of knowledge by all DCYF staff of the role and the supports the Substance Use Coordinator can provide.

Upon review of DCYF Operating Procedures, the role of the Substance Use Coordinator is not specifically incorporated as part of the procedures that would be applicable to the responsibilities outlined. Integrating this role into DCYF's policies and providing staff with robust training on the role and responsibilities of the Substance Use Coordinator will increase the likelihood that this position is utilized to the fullest extent and consistent referrals are made to support youth with substance use issues. In cases where fatalities or near fatalities occur due to substance use or substance exposure, the Substance Use Coordinator should participate and play an active role in the Critical Event Review process.

The Substance Use Coordinator position serves a vital function within DCYF, with a broad and complex scope, and duties that cross into multiple units within DCYF. Although the role is situated within the CPS unit, it involves coordination of services and placement for youth in need of substance use treatment. As such, the position should serve as a liaison between DCYF and BHDDH, which oversees substance use treatment services in the state.

A thorough assessment is recommended to determine whether one individual can reasonably manage the wide range of responsibilities currently assigned to the role. It is important to evaluate whether one individual has the necessary training and expertise to meet these expectations and support the unique needs of the complex populations served by DCYF. Increased staffing to support this function at DCYF with additional qualifications and specialized knowledge would greatly benefit the needs of our youth and families.

VI. Parental Substance Use Treatment and Prevention of Substance Exposure to Children

The stigma surrounding substance use among parents often leads to shame, isolation, and fear of losing custody, which can prevent them from seeking the help they need. To break this cycle, we must take a multifaceted approach rooted in education, policy, and compassionate support systems. Public education campaigns can shift harmful narratives by promoting understanding that substance use is a health issue, not a moral failing. Policy reforms should focus on harm reduction and prioritize keeping families together whenever safe and appropriate, rather than punitive responses. Expanding access to trauma-informed treatment services, peer support programs, and parenting resources tailored to those in recovery creates an environment where

healing is possible. By combining these strategies, we can replace stigma with empathy and empower parents on their journey to recovery and family stability.

In at least twelve (12) of the cases under review, parental substance use was identified as a risk factor and in at least seven (7) cases, the child, which is the subject of the review, or a sibling, were born exposed to substances prior to the fatality or near fatality. In most of the cases involving substance exposure during pregnancy, children were exposed to marijuana throughout the mother's pregnancy. Mothers cited the use of marijuana due to nausea or loss of appetite, to support mental health, or as a prescribed treatment by a doctor. Several parents were in active treatment for opioid use and were engaged in Medication Assisted Treatment, specifically methadone, while pregnant. This resulted in a child's positive screen at birth for methadone.

A. Parental Access to Substance Use Treatment

Pursuant to R.I.G.L. § 40.1-13, BHDDH is also responsible for substance programming for adults. An in-depth review of case records illustrated the challenges parents faced in accessing the appropriate level of treatment, in real-time. The panel identified gaps in available resources for adult services, across all levels of care. The services available do not always provide for childcare or options to continue to care for your children, which can be a barrier for treatment in some instances.

Residential treatment for parents with substance use issues who wish to remain with their children, is limited. For example, in Rhode Island, there is a twelve (12) bed facility, which provides intensive residential substance use treatment to mothers with children. This program provides a holistic and comprehensive approach to treatment, including parenting programs and services for children under the age of three (3). Exploring the need for additional residential treatment, which can support families, would prioritize family stability while addressing the critical needs of both the parents and children, in a supportive setting. Additionally, barriers were identified regarding the criteria for available programming. This program model is gender specific and has criteria in place, such as a limit on the number of children, the age of the child(ren), and the type of substance utilized by the parent.

Intensive residential treatment services for parents are just one part of the full continuum of services, which should be assessed. The Office of Management and Budget recently finalized an accounting of all substance use treatment services, to gain a comprehensive understanding of available resources. Coupling this knowledge with a state-wide needs assessment to determine whether our current resources are effectively meeting the needs of this population would be critical in moving this work forward. This process will also illuminate gaps in our service array and whether treatment options are readily available in all communities, in real-time.

B. Home-Based Services

Family visiting programs are home-based and voluntary programs, which provide critical support to pregnant women and families with young children. These programs are offered in

every city and town in Rhode Island and link expectant parents and families with young children with additional resources and services in their community.

The Rhode Island Department of Health (DOH) administers First Connections which is a short-term, state-wide program targeting support to families with children under age three. First Connections collaborates with DCYF to conduct home visits that address each family's unique needs. The provider engages directly with families in the home to mitigate identified risk factors. Services are based on family need and may include health education and connections to healthcare services, social services, and community resources. The program conducts child wellness screenings, administers developmental screenings for eligible children, and facilitates referrals to Early Intervention or other appropriate developmental services when needed. Additionally, First Connections offers support to foster parents and kinship guardians caring for children placed outside their homes by DCYF. When suitable, families may be referred to a long-term, evidence-based program, including Healthy Families America or Nurse-Family Partnership.

According to the Rhode Island Department of Health's Family Visiting Legislative Report[39], 649 children were referred to First Connections by DCYF during federal Fiscal Year 2024. Of the 649 children referred by DCYF, 572 children had an indicated case of child abuse or neglect, and 77 children were in families that were investigated by DCYF, but the case was unfounded. [40] Referrals to First Connections can be made by the hospital following the birth of a child. However, First Connections can engage earlier with parents during pregnancy. Since this is a voluntary program, the engagement rate for this service varies. Building relationships earlier, increases the likelihood of engagement after the birth of the child. This provides an opportunity to get into the home, make an assessment, and connect families with necessary support and connection to long-term services.

DOH also administers three evidence-based family visiting programs: Healthy Families America, Nurse-Family Partnership, and Parents as Teachers. These programs are longer term and can serve children up to the age of five (5). Each program works with families in the home, connects the family to additional services as needed, supports child development, and supports the goals of the family. These three (3) programs can work with parents who do not currently have custody of their child(ren) if reunification is the goal.

Family visiting programs collaborate with Peer Recovery Specialists working with parents struggling with substance use. Peer Recovery Specialists coordinate care, building relationships between the provider and the parents, and work to increase parent engagement with the services. Peer Recovery Specialists receive specialized training as peers with lived experiences to provide support to pregnant and parenting mothers. As noted, through the role of the DCYF Substance Use Coordinator, DCYF routinely connects parents with this service. However, it was

[39] Rhode Island Department of Health. (2025). *Family visiting legislative report*. https://health.ri.gov/sites/g/files/xkgbur1006/files/2025-03/Family-Visiting-Legislative-Report-2025.pdf
[40] Rhode Island Department of Health. (2025). *Family visiting legislative report*. https://health.ri.gov/sites/g/files/xkgbur1006/files/2025-03/Family-Visiting-Legislative-Report-2025.pdf

noted the workforce providing this support has decreased over the past few years. Rebuilding and reinvesting in the workforce could help sustain and expand the provision of these services.

In at least eight (8) of the cases under review involving young children exposed to substances, records showed families were referred to family visiting programs. However, records showed engagement in these services in three (3) cases. The panel recognizes in some cases, the family's referral and/or involvement with a family visiting program may not be reflected within the DCYF record.

The lack of referral to this critical service in some of these cases was a missed opportunity to provide home-based support to mitigate risk factors identified. Ensuring DCYF staff and members of the medical community have an in-depth understanding of when referrals to these programs should be made, along with the importance of a warm handoff and follow up to promote engagement may align families with these voluntary services during a time when the need for support is crucial.

In speaking with agencies engaged in this work, a consistent theme emerged regarding the need for additional funding and resources to adequately support the role and responsibilities of these programs. Further investment in these programs will provide opportunities to expand the workforce, increase program capacity, eliminate limits on the number of visits that can be provided, and expand the engagement in these services, with the goal of offering family visiting programs universally.

The voluntary nature of the program, coupled with the concern for further involvement in the child welfare system, may cause a barrier to family engagement. In Rhode Island, families are referred to family visiting programs if certain risk factors are identified. Providers reported that families are resistant to engage with these services in their home, especially when DCYF is involved. Universal home visiting programs have been implemented in several states as well as internationally, recognizing their significant benefits for all families and communities. For example, New Jersey has established a statewide universal home visiting program known as Family Connects NJ which offers all new parents, including those welcoming a child through birth, adoption, or foster care, a free home visit from a registered nurse within two weeks of the child's birth. The program aims to improve maternal and infant health outcomes, reduce healthcare costs, and strengthen family resilience by connecting families to necessary services and supports.[41] Visits are offered to families at no cost, regardless of income, insurance, or immigration status. Visits are offered to all families on a more limited basis to provide further assessment, education, and support within the home. Similar models have been implemented in other states including Oregon and North Carolina. The benefits of home visiting programs are well-documented. Research indicates that these programs can improve maternal and child health, enhance school readiness, reduce child abuse and neglect, connect families to essential community resources, and improve long-term outcomes for children and families.[42] By offering

[41] *Family Connects NJ*. (n.d.). Family Connects NJ. https://www.familyconnectsnj.org/

[42] (2025, March 19). *Home visiting programs – Casey Family programs*. Casey Family Programs. https://www.casey.org/home-visiting-programs/

universal access to home visiting services, families, regardless of background or income, will be eligible to receive the support they need during critical early childhood years.

C. Harm Reduction

Twelve (12) of the near fatalities and one (1) fatality under review were due to the unintentional ingestion of substances by the child. One (1) fatality was due to ingestion of substances intentionally given to the child. In one (1) case under review, a Suboxone pill was left on a nightstand within the reach of the child and the child ingested the pill. The child was admitted to the PICU and tested positive for buprenorphine, which is the active ingredient in Suboxone. In one (1) case under review, a child was aware of the location a parent kept pills in a bag inside a drawer. The child accessed the pills, which resulted in fentanyl exposure. In one (1) case, a parent left two Percocet pills unattended on a dresser where a child was watching television, and the child accessed the pills when unsupervised. In one (1) case, a child ingested a parent's Clonazepam, which were not locked away and proper storage of medication was addressed with parents in this case. These cases illustrate similar fact patterns where children could easily access substances within the home. In some cases, the substances were prescribed to parents and in other instances, the substances were attributed to substance use. In at least six (6) of the cases reviewed, substance use was identified as a risk factor prior to the critical incident.

Unintentional ingestion of substances, particularly opioid pain relievers, poses significant public health concerns in the United States. A study analyzing data from 2004 to 2011 found that emergency department visits involving accidental ingestion of opioid pain relievers by children ages 1 to 5 increased by 200.7%, from 1,437 visits in 2004 to 4,321 in 2011. The same study reported that 85% of these ED visits involved opioids alone, with hydrocodone, oxycodone, buprenorphine, and methadone being the most frequently implicated substances.[43]

In one study examining opioid exposures reported to poison control centers between 2016 and 2023, 34,632 cases were analyzed. The children in this study ranged in age from one month to six years. The study, which aimed to assess trends in opioid-related poisoning, found that 96.7% of the exposures were unintentional. Despite an overall 57.5% decrease in opioid exposures over the period, a disturbing trend emerged with a 300% increase in deaths and severe health effects. Buprenorphine was the most commonly involved opioid. [44]

Furthering initiatives to decrease children's access to substances and medication by providing safe storage containers along with educational materials around the importance of safe storage, could decrease the risk of unintentional ingestion by younger children or limit access

[43] Crane, E.H. *Emergency Department Visits Involving the Accidental Ingestion of Opioid Pain Relievers by Children Aged 1 to 5.* The CBHSQ Report: November 30, 2017. Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Rockville, MD.

[44] Perry E. Rosen, Christine Ramdin, James Leonard, Bruce E. Ruck, Lewis S. Nelson & Diane P. Calello (24 Sep 2024): Trends in opioid exposures among young children reported to United States poison centers from 2016 to 2023, Clinical Toxicology, DOI: 10.1080/15563650.2024.2401598

by adolescents. For example, one study conducted in 2020, found that despite widespread reporting on the opioid crisis, many caregivers remained unaware of safe medication storage practices and as well as the opioid crisis.[45] In their survey of fifty (50) caregivers of one-hundred twelve (112) children, only four percent (4%) reported that they stored their medications in a locked or latched place. Fifty-six percent (56%) of caregivers believed that it was unlikely or very unlikely that their child could gain access to medications. Thirty-eight percent (38%) reported that their main barrier to storing medications safely was access to locked storage. Fifty percent (50%) of the caregivers surveyed claimed to be unaware of the opioid crisis.[46] Providing medication lock boxes removes a commonly reported barrier to safely storing medications.

These findings, coupled with the fact patterns of the cases reviewed by the panel, highlight a critical need for continued vigilance and improved prevention strategies, especially in light of the growing opioid crisis. The cases illustrate the importance of safe storage practices and ongoing public education in addressing the risks associated with unintentional substance exposure to children. Arming community providers, treatment centers, primary care providers, health clinics, and agencies, such as DCYF, with the necessary resources and information to educate at-risk populations should be prioritized. Frontline workers are often the first point of contact individuals at risk for substance use or misuse, so equipping them with both knowledge and safe storage supplies—such as lockboxes, childproof containers, and clear instructions—can make a significant impact. This would break down barriers to access, ensuring that safe storage supplies and educational materials are distributed in a way that is accessible to people in underserved communities, those with limited resources, and individuals living in high-risk environments. By empowering these community touchpoints with the tools and knowledge to promote safe storage practices, reflects a shift toward a more pragmatic approaches, emphasizing safety and education. Safe storage of medications could also prohibit access by adolescents. In several of the cases reviewed, youth accessed medication prescribed to caretakers and strict adherence by parents to the use of lockboxes could have prevented a youth's access. The Panel recognizes this work is already underway by some providers. The goal would be to increase efforts and provide for widespread distribution of these materials.

VII. Critical Event Reviews

In accordance with DOP 100.0290, DCYF conducts Critical Event Reviews, which is a detailed case analysis, in the following situations:

1. The occurrence of a child fatality in which child abuse or neglect is suspected to be a contributing factor, regardless of whether the family is currently active or has ever received services from the Department.

[45] Webb, A.C., Nichols, M.H., Shah, N. *et al.* Effect of lock boxes and education on safe storage of medications. *Inj. Epidemiol.* **7** (Suppl 1), 21 (2020). https://doi.org/10.1186/s40621-020-00257-y
[46] Webb, A.C., Nichols, M.H., Shah, N. *et al.* Effect of lock boxes and education on safe storage of medications. *Inj. Epidemiol.* **7** (Suppl 1), 21 (2020). https://doi.org/10.1186/s40621-020-00257-y

2. The occurrence of a child fatality or near fatality of a child from a family that is currently active or has been involved with any division of the Department within the previous 12 months.
3. Any severe other situation as identified by the Department Director or designee.

In four (4) of the cases reviewed, two (2) fatalities and two (2) near fatalities, a Critical Event Review was not completed in compliance with this policy. In one (1) fatality and one (1) near fatality, the youth were open to the Voluntary Extension of Care (VEC) program at the time of the critical incident, which would have qualified the case for a review since the cases were active with a division of DCYF. One (1) near fatality occurred when the family was open to DCYF and one (1) fatality due to abuse and/or neglect and should have been reviewed in accordance with the policy.

The Critical Event Review process is meant to serve as an internal administrative review to assess for systemic issues, including a review of applicable statutes, regulations, procedures, training, and practice. This should be scheduled within five (5) business days after DCYF receives notification of the fatality, near fatality, or another critical incident referred deemed necessary to review. The policy notes:

…a uniform response to critical events allows the Department to:

- Review factors that impact the safety of children.
- Review factors that affect practice.
- Review the appropriateness of the Department's services to the child and family.
- Identify instances of exceptional service provision.
- Identify services provision that requires corrective action.
- Reflect on organizational or broader systemic change.
- Provide for professional growth.

This process provides an opportunity for an in-depth analysis of the critical incident and case history to assess whether there is a need for change within the individual case or systemic change, a need for training, or to identify any gaps in the provision of services. Failure to complete these reviews in accordance with DCYF's policy is a missed opportunity for DCYF to conduct a comprehensive review of the case alongside multi-disciplinary professionals.

In accordance with DOP 100.0290 (H)(2), indicates the final Critical Event Review report, which outlines the relevant findings and recommendations, is submitted to the deputy director. Additionally, DOP 100.0290 (H)(3), indicates that on an annual basis the Critical Event Review facilitator should also be providing a report with the findings for all Critical Event Reviews that calendar year. The Panel reviewed all Critical Event Reviews completed for the cases under review, finding that several issues and recommendations were identified in more than one case. For example, the need for adolescent substance use treatment was recommended in at

least seven (7) Critical Event Reviews, which remains a significant need within the current service array and a focus of this report.

A gap in the provision of peer support to DCYF workers following a critical incident, in accordance with DCYF policy, was identified in at least five (5), Critical Event Reviews. In accordance with DOP 200.0090, the Peer Support Team is to be activated in the following circumstances:

1. Death or serious injury to department staff.
2. Death or serious physical injury to a child or youth in care.
3. Any other incident that has a high emotional impact on the staff person beyond their typical experience that creates a heightened sense of vulnerability or an experience of lack of control over the situation.
4. Critical Event Review meetings.
5. Any department staff can initiate a self-referral to the PST.

This resource is in place to provide staff with the necessary emotional support after a critical incident and to limit the impact of secondary trauma. Per the DOP, the Director or Director's designee shall notify the Peer Support Team leaders following a critical incident and provide all relevant information. If this is not happening consistently, DCYF should review their current process and provide further oversight to ensure the Peer Support Team is contacted following every critical incident.

The Critical Event Review is a meaningful process, which provides invaluable insight into cases where critical incidents and tragedies have occurred. In an effort to prevent similar instances from occurring in the future, heightened internal oversight of necessary changes and implementation of recommendations is critical. Also, providing insight regarding the status of prior recommendations could further inform the process when similar issues arise in another case. In fact, in one review, it was recommended that a DCYF representative who can provide an update on the status of previous recommendations be available for every Critical Event Review. The panel concurs with this recommendation and recommend that the policy be updated to reflect this requirement.

The OCA has raised concerns about implementation of recommendations to DCYF Administration and we recognize efforts made internally to assess progress with prior recommendations. However, the panel recommends this update be provided on an annual basis. When providing an annual summary of Critical Event Review findings in accordance with the relevant policy, this report should also include a summary of all recommendations. The report should indicate whether a recommendation has been made more than once throughout the year and include an update on the status of the recommendation. This report should also include an update on the status of recommendations made in prior years. We recognize some recommendations pertain to other agencies, but the report should outline efforts made to coordinate with other entities to discuss potential strategies and implement changes. Formalizing a mechanism for tracking progress and the provision of annual updates provides the accountability necessary to create lasting change.

VIII. Transparency and Accountability for the Implementation of Recommendations

Nationally, child fatalities and near fatalities are a public health problem and often there is intersectionality with family involvement in the local child welfare agency. Agencies charged with child protection play a crucial role in preventing future tragedies and trauma. As such, child fatality reviews consisting of multidisciplinary teams of professionals and community members completing a comprehensive analysis of cases and authoring reports with substantive recommendations for systemic change are critical to improvement specific to child health and safety.

The intent of this report is to outline specific recommendations to improve systemic errors, gaps, and opportunities for intervention with the ultimate goal of preventing future fatalities and near fatalities of children and youth. The OCA upholds our statutory mandate to review child fatalities and near fatalities with the utmost care and attention at every step of the process. This includes carefully selecting Panel members, ensuring they have access to comprehensive and accurate information to effectively assess and analyze each case, and collaborating with the panel to develop thoughtful findings and recommendations aimed at driving essential systemic change. This process is a significant undertaking for the OCA and our panel members, and we approach this responsibility with the highest level of seriousness and commitment. What is needed, is a mechanism to ensure that a response and plan for implementation are met with the urgency they require.

The OCA acknowledges the recent efforts by DCYF to engage a wide range of partners in reviewing and analyzing all recommendations made over the past ten years in response to child fatalities and near fatalities, in a variety of forums. The work group is not just focused on the recommendations issued by the prior OCA Child Fatality Review Panels, but the recommendations of all partners in this work. This is an immense undertaking, and we applaud these efforts. However, as leadership changes, so can initiatives such as this. It is imperative that a requirement for a response and plan for implementation be formalized in law to ensure that expectations are clear, and this work is ongoing.

It is paramount to ensure that any opportunity for improvement related to child safety and well-being is urgently acted upon and done so efficiently and with transparency. Requiring DCYF to provide a response within a designated timeframe, identifying a plan for action, barriers to implementation, and funding needs, will inform advocacy efforts. This written response will provide our state with the opportunity to further support DCYF in their efforts to make necessary improvements. We recognize that there are recommendations that the Director, as the decision-maker for DCYF, may not support. By requiring a public written response within a designated timeframe, these issues can be identified, provide an opportunity for discourse and advocacy, but most importantly establishes a mechanism to keep the work moving forward. In addition, the panel recognizes that the recommendations issued may extend beyond the scope of DCYF to other entities that are involved with child welfare or family services. We ask that DCYF engage with any and all entities identified and incorporate efforts to collaborate regarding inter-agency issues as a part of the written response.

RECOMMENDATIONS

1. DCYF to develop an appropriate continuum of care to meet the needs of all youth at all levels of care, pursuant to R.I.G.L. § 42-72-5 and R.I.G.L. § 42-72-5.2. The panel recommends a multi-year procurement and investment plan be devised, addressing all levels of care. This plan should be made public and:
    a. Ensure that Mobile Response and Stabilization Services is adequately funded and accessible to all, in every community to support youth in crisis and maintain at home whenever possible.
    b. Ensure there is a robust array of prevention services and home-based services,
    c. Ensure there is a state-wide recruitment and retention plan, which includes provider input, to ensure there is an array of foster homes willing to meet the needs of various populations, including adolescents.
    d. Ensure that Psychiatric Residential Treatment Facility (PRTF) and Residential Treatment is accessible in real time to meet the needs of acute populations and a plan for step-down programming for children and youth who require additional time in a structured environment, prior to transitioning home or to a foster home.
    e. Ensure there are supportive services to meet the needs of our transition age youth.

2. BHDDH to develop a concrete plan to provide a comprehensive continuum of substance use treatment services for adolescents, pursuant to R.I.G.L. § 40.1-13. This plan should be made public and address the following:
    a. Appropriate screening tools and assessments for adolescent substance use.
    b. Intensive residential treatment for substance use treatment, which provides a comprehensive treatment approach, including trauma-informed treatment for co-occurring disorders.
    c. Outpatient treatment focused on individual, group and family therapy.
    d. Intensive outpatient treatment and partial hospital programming.
    e. Partner with community providers to develop family-centered, wrap-around and step-down services to support youth and families in the community.
    f. Targeted case management, and recovery services and supports, including youth peer-to-peer coaching, parent/caregiver support, technological support services.

3. DCYF and BHDDH to coordinate in the development of a continuum of substance use treatment options for youth, with a specific focus on the specialized needs of adolescents, pursuant to R.I.G.L. § 42-72-5 and R.I.G.L. § 40.1-13.

4. BHDDH and DCYF to develop a process to coordinate planning, funding, and service delivery between agencies for our children and youth and ensure all staff are trained on this process, pursuant to R.I.G.L. § 42-72-5 and R.I.G.L. § 40.1-13.

5. DCYF to review and revise DOP 700.0015, Delivery and Coordination of Support Services, to reflect any changes to the process developed with BHDDH to coordinate substance use treatment services.

6. EOHHS, BHDDH, and DCYF to continue to evaluate the administrative structure for children's behavioral health to determine if it is effectively meeting the needs of our children and youth. Specifically, having services for adolescent substance use and children's behavioral health administered by two different agencies.

7. DCYF to identify all providers who conduct assessments and evaluations for youth and explore funding allocation needs to retain providers for immediate service delivery for DCYF youth.

8. DCYF and BHDDH to develop or use an existing standardized substance use screening evaluation tool and train DCYF staff on utilizing the tool to immediately identify the substance use treatment needs of youth and families.

9. BHDDH to conduct a system-wide needs assessment to assess whether the current continuum of substance use treatment services meets the needs of all populations served, including an evaluation of existing programs.

10. DCYF to complete a system-wide needs assessment of all internal DCYF programming across child welfare, juvenile justice, and children's behavioral health and contracted services to ensure that the system is meeting the needs of the populations it serves. Funding has already been allocated for this assessment in FY 2025.

11. DCYF to coordinate a state-wide survey of children and youth experiencing the children's behavioral health, juvenile justice, and child welfare systems to collect data and feedback to inform policy and practice impacting youth and young adults.

12. DCYF to develop an intensive care coordination system, which will provide ongoing assessment and service planning, access and arrange for services, coordinate multiple services, including access to crisis services, assist and advocate for the child and family, and monitor the child or youth's progress.

13. DCYF to develop a formal process, mandatory documentation, and training for all staff to engage in consistent and effective transition planning, which must include active engagement with youth and families.

14. DCYF to prioritize youth and family voice at the center of care coordination, transition planning, and should be embedded in all areas of service delivery on an ongoing basis throughout involvement with DCYF.

15. DCYF to provide continuing education to all staff regarding trauma-informed care best practices, embedded into daily practice, and ensure trainings are in line with new developments in research.

16. DCYF to ensure that youth who have experienced trauma are aligned with the appropriate services to address it while in treatment.

17. DCYF to explore and implement ongoing professional development for front line staff regarding the impact of trauma and exhibited behaviors by children and youth. Specifically, frontline staff should be trained in recognizing signs of trauma, building rapport, and approaching children and families with patience, understanding, and compassion.

18. DCYF to assess the need for an additional allocation of funding into the Special Investigations Unit to ensure the unit has enough staff and resources to continue the critical work in locating missing youth or youth absent from care.

19. DCYF to develop a clear procedure and effective interventions to disrupt the pattern of AWOL behavior with input from DCYF, providers, parents, foster parents, and most importantly youth who engage in this behavior.

20. DCYF to develop, implement, and follow a protocol around heightened communication for youth with AWOL behaviors to ensure that all parties involved are on the same page about where at-risk children may be going, who they are communicating and spending time with, and strategies to support their return to placement.

21. DCYF to evaluate the services provided by the Substance Use Coordinator as part of the ongoing needs assessment, including assessment of data to determine the need, evaluate the number of children and parents served, develop outcome measures to track progress, and evaluate performance.

22. DCYF to evaluate the staffing, resources, training, and qualifications required to adequately carry out the expansive role and responsibilities of the Substance Use Coordinator position.

23. DCYF to integrate the Substance Use Coordinator as part of their plan to collaborate and coordinate care with BHDDH and serve as a liaison between agencies.

24. DCYF to coordinate monthly meetings between the Substance Use Coordinator and community providers to ensure all DCYF staff has the most up to date information regarding substance use treatment options and capacity within the programs.

25. DCYF to coordinate an all-staff training regarding the role and responsibilities of the Substance Use Coordinator, including ongoing continuing education, to include presentations at new worker trainings by the Substance Use Coordinator regarding best practice when working with parents and youth engaged in substance use.

26. DCYF to review and revise DOPs to include the role and responsibilities of the Substance Use Coordinator to ensure there is a clear understanding of the position's function. Specifically, we recommend reviewing and revising the following DOPs for this purpose:
    a. DOP 500.0080-Substance Exposed Newborns
    b. DOP 100.0290-Critical Event Reviews
        i. Specifically, when revising the Critical Event Review Policy, DCYF should mandate the Substance Use Coordinator to attend, participate, and review recommendations when a Critical Event Review is held due to the fatality or near fatality of a child as a result of substance use or substance exposure.
    c. DOP 500.0000- Child Abuse and/or Neglect Reports
    d. DOP 700.0015- Delivery and Coordination of Support Services

27. DCYF to develop a policy that requires social caseworkers to make a referral to the Substance Use Coordinator when a youth or family member on their caseload is engaged in substance use, to assist with the prompt coordination of services.

28. DCYF to update DOP 100.0060 – Issuing a Hospital Alert, to outline the procedure of sending alerts to out-of-state hospitals just over the Rhode Island state line.

29. DCYF and BHDDH to coordinate a state-wide campaign to educate the public about the resources and treatment options available to address substance use or a substance use disorder among youth and young adults.

30. DCYF to collaborate with community-based service providers to develop and disseminate educational materials specifically designed for youth, addressing personal safety in the community, the risks associated with ingesting or using unknown substances, warning signs of Commercial Sexual Exploitation of Children (CSEC), and clear guidance on how and where to seek immediate help, when needed.

31. DCYF to collaborate with service providers and coordinate in-depth training for parents, foster parents, caregivers, or staff members regarding the care of children and adolescents who have exhibited high-risk behaviors, including but not limited to, AWOL behavior, substance use, and CSEC involvement.

32. DCYF to review licensing regulations with respect to requiring all congregate care facilities to have Narcan available and for all staff members in the facility to be trained in harm reduction, where to access Narcan within respective placements, and how to administer Narcan.

33. DCYF to collaborate with DOH and BHDDH to develop education materials for parents, foster parents, caregivers, and youth on harm reduction, specifically when to have Narcan available in the home, where to obtain Narcan, and how to administer Narcan.

34. DCYF to explore whether a multi-disciplinary team approach would benefit youth and families in determining the appropriate placement referrals to be made, with participation from FSU, current providers, the family, and most importantly, the youth.

35. DCYF to strengthen the placement referral process, including developing a revised referral packet, to ensure that all referrals sent out on behalf of youth are based on their individual treatment needs, recommendations from their current clinical and provider team, and prioritize in-state placement whenever possible.

36. DCYF to ensure that all referral packets sent to agencies on behalf of youth include the most recent clinical and educational documentation, as well as relevant historical information, with a particular focus on the youth's strengths, and personal attributes.

37. The Governor's Council on Behavioral Health to explore the development of a subcommittee specifically focused on the substance use and behavioral health needs of children and adolescents. This subcommittee will be committed to the unique needs and experiences of this population. The membership of the task force should include but is not limited to, subject matter experts, community providers serving children and adolescents, and DCYF. The subcommittee should provide ongoing updates to the Governor's Council on Behavioral Health and the Children's Cabinet. The task force should prioritize the following:

    a. Ongoing assessments of systems serving children and youth.
    b. Data collection and evaluation regarding treatment and services for children and youth.
    c. An annual report outlining the findings and recommendations of the task force should be made public and provided to the Governor, General Assembly and the Rhode Island Family Court.

38. DCYF to collaborate statewide with all police departments to:
    a. Develop a uniform response protocol to provide guidance in the field when DCYF should be contacted. This provides the opportunity for consistent reporting to DCYF and an opportunity for earlier interventions for high-risk children and families. Include guidance on:
        i. Domestic violence in the presence of children;

ii. Substance exposure/unintentional ingestion of substances by children;
iii. AWOL youth

b. Uniform Response Protocol exists for Commercial Exploitation of Children (CSEC) cases. DCYF to collaborate with law enforcement and other cooperating entities to ensure that there is widespread distribution and training regarding these protocols, which should provide further consistency in reporting these cases to DCYF.

39. DCYF to identify a DCYF staff member who is dedicated to working with all law enforcement, providing ongoing guidance, training, sharing resources and collaboration on cases.

40. DCYF to collaborate with the American Academy of Pediatrics, Rhode Island Chapter, to provide ongoing trainings for local pediatricians and community healthcare agencies regarding mandatory reporting laws, identifying risk factors, available resources, and how to access necessary services.

41. DCYF to review and revise DOP 100.0290: Critical Event Reviews:
    a. To amend required participants and add a DCYF representative at every Critical Event Review who can provide an update on the status of previous recommendations.
    b. To revise the section regarding "CER Summary Reports" to include the following information in DCYF's annual summary report:
        i. A summary of all recommendations.
        ii. Whether a recommendation has been made more than once throughout the year.
        iii. An update on the status of the recommendation.
        iv. An update on the status of recommendations made in prior years.
            1. DOP 100.0290 requires the annual CER Summary Reports be provided to the Office of the Child Advocate. The panel recommends this practice occur, and include the additional information outlined in this recommendation.

42. DCYF to ensure Critical Event Reviews are scheduled within five (5) business days of DCYF's notification of the fatality or near fatality and complete a final report within sixty (60) days from the review, in accordance with DCYF policy.

43. DCYF to provide heightened oversight to the provision of peer support following a critical incident, in accordance with DOP 200.0090.

44. DCYF to collaborate with DOH to develop a plan to increase access to educational materials reinforcing the importance of the safe storage of substances. The written materials should be available in multiple languages.

45. DCYF and DOH to develop a plan to provide widespread access to lock boxes or locked storage bags to families for the safe storage of substances in collaboration with community providers.

46. DCYF to review and revise DOPs to ensure that DCYF staff are addressing the safe storage of recreational substances and prescription medication with families at all home visits and that DCYF staff are making lock boxes or locked storage bags available to families.

47. DCYF, DOH, and BHDDH to develop a plan to recruit and retain a robust perinatal peer workforce to support pregnant and parenting mothers struggling with substance use.

48. BHDDH to increase residential substance use treatment options for parents with children so families can remain together, including intensive treatment options for parents who have a family dynamic that does not fit within the parameters of existing programming.

49. DOH to develop and initiate a public health campaign regarding the risks of substance exposure to babies during pregnancy, including, but not limited to, cannabis.

50. DOH to develop and initiate a public health campaign regarding the risks of adolescent substance use, including, but not limited to, cannabis.

51. Additional funding to be allocated to family home visiting programs in Rhode Island. These investments should seek to:
    a. Increase and strengthen the current capacity of family home visiting programs.
    b. Eliminate limitations on the number of visits that can be provided. The number of visits should be based on the needs of the family and best clinical practice.
    c. Visits should also provide for in-depth coordination of care to ensure a warm hand off to other services deemed to be necessary.
    d. Explore universal delivery of family home visiting programs to provide services and supports to all families.

52. DOH and DCYF to coordinate with service providers to collect and evaluate data on referrals and the capture utilization rate of all family visiting programs to inform future investments and the need for programmatic changes.

53. DCYF to coordinate with service providers to provide ongoing training to DCYF staff regarding family visiting programs to ensure there is an in-depth understanding of when

referrals to these programs should be made and review their internal process to ensure referrals are made consistently.

54. DCYF, DOH, and medical providers to improve integration of family visiting programs in the development and implementation of Plans of Safe Care, including further investments to further support engagement with families prior to discharging from the hospital.

55. DOH and BHDDH to develop systemic partnerships between substance use disorder treatment programs who serve pregnant and parenting individuals and family visiting programs. This provides an opportunity to streamline services and collaboration on cases.

56. DCYF to issue a public report within six (6) months of the release of this report. The report should be made available on the DCYF website and outline the following:
    a. Plan and timeline to implement the recommendations outlined in this report.
    b. Barriers to implementation of any recommendations, including funding needs.
    c. Recommendations DCYF will not be implementing.
    d. Any efforts that have been taken to collaborate with other entities identified in this report.
        i. It is the recommendation of the panel that the requirement of a public response by DCYF be memorialized through legislative change. Specifically, changes to R.I.G.L. § 42-72 or R.I.G.L. § 42-73 should outline this requirement.

Respectfully submitted,

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APPENDIX A

Captain Gregg L. Catlow

Gregg L. Catlow is a Captain with Smithfield Police Department where he has served for 23 years. Currently his is assigned as the Patrol Division Commander. During his career Captain Catlow has held many roles in the Department, however much of that time was spent in the Detective Division as a Detective Sergeant. In that position he served as the Juvenile Officer, investigating crimes against children, and establishing important relationships in the child welfare and victim advocate communities. Captain Catlow holds a Bachelors Degree in Administration of Justice and a Masters Degree in Justice & Homeland Security, both from Salve Regina University. He is also a graduate of Session 92 of the Police Executive Research Forum's Senior Management Institute For Police.

Sarah C. Dinklage, LICSW

Sarah C. Dinklage, LICSW, is a recognized leader in youth mental health and substance abuse prevention, with a distinguished career spanning over four decades. As Chief Executive Officer of Rhode Island Student Assistance Services (RISAS) and Coastline EAP, she has been instrumental in expanding critical support services for young people struggling with substance use and mental health challenges.

Sarah's career began as a Clinical Social Worker at the Rhode Island Youth Guidance Center, where she provided direct counseling services to at-risk youth. She later became Director of Outpatient Services, overseeing clinical programs that addressed adolescent behavioral health needs. In 1986, she was appointed Program Director for Rhode Island Student Assistance Services under the former RI Department of Mental Health, Retardation, and Hospitals (MHRH), where she developed and launched the first statewide school-based substance abuse prevention and early intervention program. Under her leadership, this initiative grew from a small pilot program to serving over 80 schools in 32 districts.

As Executive Director of RISAS from 2003 to 2021, Sarah played a pivotal role in securing legislative support for student assistance programs, advocating for policies that expanded mental health and substance use treatment access for minors. She was also instrumental in establishing the first certification program for Student Assistance Counselors in the country. Throughout her tenure, Sarah has been a strong advocate for integrating mental health and substance abuse services into educational settings. Her leadership has helped shape policies and programs that ensure students receive early intervention and support.

Sarah holds a Master of Social Work from Simmons College and a Bachelor of Arts in Psychology from Smith College. She is a Licensed Independent Clinical Social Worker.

Ken Fandetti, MS

Ken Fandetti began his career as a social worker at the multi service center on Mystic Street in South Providence in 1969. He worked in both the Dept. of Corrections (DOC) and Dept. for Children Youth and Families (DCYF) for 28 years. At DOC he was the Assistant to the Director, and Superintendent of the Rhode Island Training School. The Training School was the first Juvenile Correctional Institution in the U.S. to be Accreted by the American Correctional

Association in 1981. In 1984 he headed the development of RI's Child Abuse and Tracking System (CANTS) which was recognized nationally for its expedited response and investigative techniques to child abuse and neglect allegations. Ken held the positions of Acting Director and Executive Director of DCYF until his retirement in 1997. Since then, Ken has worked in the private sector as both a corporate trainer and sea kayak instructor which allowed him to travel everywhere nationally and to many countries worldwide.

Linda Hurley

Linda Hurley has been an addictions professional for over 40 years. She has worked at CODAC Behavioral Healthcare since 1989 and became President/CEO in 2016. CODAC, RI's oldest, largest--and only nonprofit---provider of outpatient services for opioid use disorder (OUD), other substance use disorders (SUD), and behavioral health challenges, has grown exponentially under her leadership.

A trailblazer throughout her career, Ms. Hurley initiated the nation's first Opioid Treatment Program (OTP) within a state prison in 2019. Acknowledged by the Obama Administration as a "model for all states," this program, offering all three FDA-approved medications for OUD, has been adopted in prisons nationwide.

Under her guidance, CODAC launched the first licensed mobile medical unit in the US in 2023, providing all three FDA-approved medications for OUD under revised DEA regulations. Ms. Hurley's influence extends nationwide as she consults to replicate this groundbreaking model. Ms. Hurley's work is grounded in two core principles: ensuring that every person with a substance use disorder receives comprehensive, person-centered treatment, and emphasizing collaboration across the continuum of care. She will continue to fight for monitoring and compliance with existing mandates, as well as long overdue rate increases, and to help build on these to create a functional, supported infrastructure for the treatment of SUD.

Michele Paliotta, LICSW

Michele is a dedicated social worker with over 20 years of experience spanning clinical, community, and organizational settings. Her diverse expertise includes education, clinical practice, forensics, child welfare, and regulatory compliance. Michele provides specialized clinical consultation and training to corporate, educational, and community organizations, focusing on key areas such as LGBTQIA+ cultural competency, mental health and well-being in the workplace, de-escalation techniques, and trauma-informed care. Her practice is grounded in a strong commitment to social justice, advocating for the rights and dignity of all individuals. Michele holds a Bachelor of Science in Human Services from Northeastern University and a Master of Social Work from Rhode Island College.

Linda Shaw, MD, MSSW

Linda Shaw, MD, MSSW is a retired pediatrician who was board certified in Child Abuse Pediatrics. She previously chaired a fatality review board in New Jersey and served on another in Missouri. Her roles as a child abuse pediatrician included clinician and educator at University of Medicine and Dentistry New Jersey and at St. Louis University School of Medicine; numerous committee and board memberships related to child maltreatment and its prevention; court testimonies regarding suspected abused and neglected children; and presentations to legal, educational, and child welfare professionals, as well as foster parents, on medical issues of abused and neglected children.

Rachel Weitz, DNP, PMHNP-BC

Dr. Weitz is a board-certified advanced practice registered nurse who specializes in the assessment and treatment of adolescents and emerging adults who struggle with substance use and related mental health conditions. She has dedicated her career to advancing and delivering evidence-based behavioral health care for adolescents. For nearly two decades, Dr. Weitz has provided the highest-quality direct clinical care to youth and their families across a variety of settings in New York, Massachusetts, and Rhode Island. Dr. Weitz earned her doctorate in nursing from the University of Massachusetts in Amherst and completed her practicum training in May of 2020. Prior to her doctoral studies, Dr. Weitz was a registered nurse providing care in the child and adolescent psychiatric inpatient setting at Bellevue Hospital, as well as case management in the home-care setting for comorbid psychiatric and medical conditions. From both a professional and personal capacity, she is committed to lead with authenticity and integrity and to assess and evaluate clients and their families from a biopsychosocial lens. Importantly, Dr. Weitz is devoted to the implementation of evidence-based practice while inspiring hope and resilience.

In 2018, while completing her doctoral degree, Dr. Weitz joined the Bradley Vista team at Bradley Hospital where, with Dr. Miranda, she helps lead the treatment team for the intensive outpatient program.