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

A Review of Thirty Fatalities and Eleven Near Fatalities

August 2026

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PREFACE

The Office of the Child Advocate (OCA) extends its sincere appreciation to the members of the OCA Child Fatality Review Panel (Panel) for their time, expertise, and steadfast commitment to the review process. Thoughtful analysis and dedication to advancing child safety were integral to the Panel's work and the development of this report. Thank you to our distinguished members for your invaluable contribution to this important process:

- Darlene Allen, MS
- Kristine Campagna, MEd
- Ken Fandetti, M.S.S.S
- Margaret Howard, PhD
- Detective Michael Iacone
- Margo Katz, MA
- Barry Lester, PhD
- Tosin Ojugbele, MD MPH
- Rebecca Silver, PhD

I would also like to acknowledge the dedication and hard work of my colleagues at the OCA, whose efforts were instrumental to the success of the Panel. The team compiled and reviewed thousands of pages of documentation and case records to develop the comprehensive case chronologies that informed the Panel's review and analysis. Their professionalism, diligence, and tireless commitment made this report possible.

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

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

This report is dedicated to the children whose lives were lost, the families, caregivers, and communities who continue to grieve, and the children and families navigating the trauma experienced as the result of near fatalities. It is important to acknowledge that the lives of children reviewed in this report hold immeasurable value and their loved ones have been forever changed. The impact of child fatalities and near fatalities reverberates far beyond the immediate family, affecting siblings, extended family members, schools, neighborhoods, service providers, and entire communities. The Panel recognizes the immense grief experienced by those who have lost a child, as well as the lasting trauma experienced by children, families, and professionals when system failures contribute to preventable harm. It is our responsibility to honor the experiences of the children discussed in this report with a steadfast commitment to learning from these tragedies with a goal of preventing future loss.

The findings and recommendations outlined herein identify both the strengths of Rhode Island's child-serving systems and identify opportunities to strengthen policy, practice, and collaboration among the child welfare and children's behavioral health systems. Following a multidisciplinary review process, the findings and recommendations outlined in this report are intended to better inform the public of the challenges presented by the child welfare and children's behavioral health systems. The Panel sought to identify inefficiencies within the system posing a risk to the children of this state, and to better inform systemic change. Some recommendations 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 determined it was important to address all areas in need of enhancement to ensure the safety and well-being of children and youth in Rhode Island. Stronger interagency coordination and collaboration is needed to comprehensively address all identified gaps and recommendations.

The Panel reviewed thousands of pages of documentation and analyzed each case extensively following countless hours of investigation, records requests, research, review and discussion of the cases, policies, statutes, and other relevant materials by OCA staff. The OCA also conducted informational meetings with other entities and agencies to collect additional information about ongoing statewide work related to the subject areas within this report. The Panel would like to thank everyone who met with OCA staff sharing valuable expertise, professional insights, and contributions during the drafting of this report.

It is important to acknowledge the dedication and hard work of child welfare workers who provide care and support to some of the most vulnerable children and families in Rhode Island. The OCA recognizes the substantial internal and external challenges faced by professionals in

carrying out their responsibilities on the frontline. These challenges include, but are not limited to, federal and state funding constraints, workforce recruitment and retention issues, staffing shortages, increasing caseloads and case complexity, limited availability of community-based services, housing and behavioral health resource shortages, competing priorities, cross-system coordination, and the cumulative effects of secondary traumatic stress, compassion fatigue, and burnout inherent in child welfare practice.

Meaningful reform requires honest and transparent assessment of the systems entrusted with protecting the safety of Rhode Island's children. This report is intended to promote accountability and a commitment to addressing difficult findings with transparency and purpose, prioritizing corrective action and systemic improvement rather than expending resources on justification or explanation of past shortcomings. Lasting improvement cannot be achieved through reactive responses to individual incidents, and requires deliberate, methodical, and sustained efforts to address the systemic issues identified throughout this review. The recommendations contained herein are offered in the spirit of continuous advancement and measurable progress that prioritizes the needs of the children and families served in Rhode Island. The children depending on state systems for safety and support, and the families impacted by these tragedies deserve impactful and enduring reform.

This report constitutes a public record under Rhode Island General Laws (R.I.G.L.) § 38-2-2(4). The names of the individuals involved in the cases reviewed have been omitted or altered to protect their identity to conform with the mandate of the OCA for confidentiality outlined in R.I.G.L. § 42-73-1 et seq.

OCA Statutory Mandate and Overview of Cases

Pursuant to R.I.G.L. § 42-73-2.3(b), "The child advocate, working with a voluntary and confidential child fatality review panel, whose members may vary on a case-by-case basis, shall review the case records of all notifications in accordance with subsection (a) of fatalities and near fatalities of children under twenty-one (21) years of age, if:

> (1) The fatality or near fatality occurs while in the custody of, or involved with, the department[1], 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

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

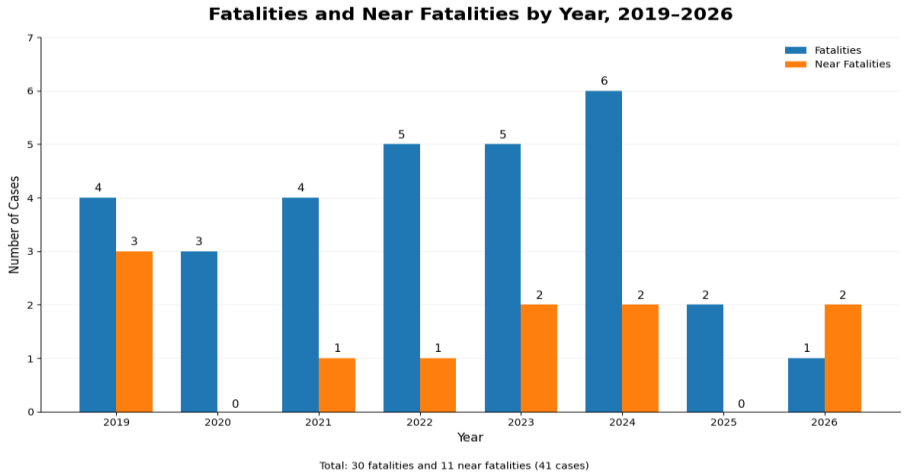
(3) A sibling, household member, or daycare provider has been the subject of a child abuse and neglect investigation within the previous twelve (12) months, including, without limitation, cases in which the report was unsubstantiated or the investigation is currently pending."

Upon receiving notification, the OCA reviews the circumstances of each incident including the history of the family to determine if the case meets the criteria for review under the statute referenced above. 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 shall 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 Panel reviews the circumstances surrounding the fatalities and near fatalities included in the review, to identify gaps in assessments and service provision, and recommend prevention strategies to improve the overall coordination of services to children and families involved in state care.

On September 30, 2025, the OCA issued a press release to announce the convening of a Child Fatality Review Panel to review twenty-nine (29) fatalities and nine (9) near fatalities of children from birth to age six (6) that occurred between 2019 and 2026 that met the statutory mandate for review. A second press release was issued on August 31, 2026 to announce that two (2) near fatalities and one (1) fatality of children from birth to age six (6) that occurred in 2026 were added to the cases reviewed in this Panel as they met the criteria. In total, the Panel reviewed thirty (30) fatalities and eleven (11) near fatalities. There were twenty-two (22) children under age 1, six (6) children age 1, six (6) children age 2, two (2) children age 3, three (3) children age 3, and two (2) children age 5. There were no children reviewed who were age 6.

Of the thirty (30) fatalities, there were four (4) in 2019, three (3) in 2020, four (4) in 2021, five (5) in 2022, five (5) in 2023, six (6) in 2024, two (2) in 2025, and one (1) in 2026. Of the eleven (11) near fatalities, there were three (3) in 2019, zero (0) in 2020, one (1) in 2021, one (1) in 2022, two (2) in 2023, two (2) in 2024, zero (0) in 2025 and two (2) in 2026. This breakdown is illustrated in the bar graph below.



Of the thirty (30) fatalities, twelve (12) were the result of sudden infant death syndrome (SIDS) or sudden unexpected infant death (SUID). Of these, ten (10) involved co-sleeping or unsafe sleep conditions. Seven (7) fatalities were the result of an unknown reason, or the autopsy report was not completed at the time of review by the Panel. While the cause of death was unknown, five (5) of the seven (7) fatalities, involved unsafe sleep conditions. Five (5) fatalities were as a result of drowning, five (5) were the result of a medical condition, and one (1) was the result of a violent crime.

Of the eleven (11) near fatalities, two (2) were the result of physical abuse, two (2) were the result of a motor vehicle accident, two (2) were the result of falling out of a window, one (1) was the result of a medical condition, one (1) was the result of an accidental shooting, one (1) was the result of unsafe sleep conditions, one (1) was the result of accidental strangulation by car seat straps, and one (1) was a result of malnourishment due to neglect.

Statutory Mandate of DCYF

I. Notify the OCA

In accordance with R.I.G.L. § 42-72-8(c) DCYF "shall notify the office of the child advocate verbally and electronically, in writing, within 48 hours of a confirmed fatality or near fatality[2] of a child who is the subject of a DCYF case." With only a few exceptions between 2019 and 2026, once a fatality or near fatality was reported to DCYF, the OCA was consistently notified.

[2] R.I.G.L § 42-72-8(c) defines near fatality as "shall mean a child in serious or critical condition as certified by a physician as a result of abuse, neglect, self-harm, or other unnatural causes."

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." R.I.G.L. § 42-72-8(c)(4) outlines the information that must be provided to the OCA following a substantiated finding of abuse or neglect that resulted in a fatality or near fatality.

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."

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. Annually, each state provides data voluntarily 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 spans October 1 to September 30.

According to NCANDS data from 2024, four (4) fatalities occurred in Rhode Island due to maltreatment, an increase from one (1) fatality[3] 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.[4] This data 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. While there is some overlap across data sources, each data set is determined by different federal and state statutes reporting requirements. That said, the fatalities and near fatalities statutorily required to be reviewed by the OCA are specific to R.I.G.L § 42-73-2.3 which may differ from other state agencies also tasked to report and review fatalities and near fatalities.

It is important to promote consistency while understanding the differences in data reporting at the state and federal levels. Ensuring consistency and standardization in data reporting and information sharing, is instrumental in assessing and addressing systemic issues and factors and formulating effective prevention strategies.

IV. National Partnership for Child Safety

The National Partnership for Child Safety (NPCS) is a national quality improvement collaborative of state, county, and tribal child welfare agencies that works to reduce child maltreatment fatalities and near fatalities using shared data, peer learning, and systemic reform. Rather than focusing on individual blame after a child death or near-fatality, NPCS promotes a learning organization approach that examines how organizational processes, decision-making, communication, and systemic factors can all contribute to critical incidents. NPCS was established in 2018 in response to recommendations from the federal Commission to Eliminate Child Abuse and Neglect Fatalities and seeks to improve child safety by identifying patterns across jurisdictions, strengthening workforce practice, and implementing evidence-informed prevention strategies.

In April 2025, DCYF became the first child welfare agency in New England to join NPCS. Through this partnership, DCYF is adopting a safety science framework with an emphasis on learning from child maltreatment fatalities and near fatalities to improve practice. Membership provides Rhode Island with access to a national repository of de-identified child welfare safety data, comparative analyses, peer learning collaboratives, and specialized workforce training

[3] 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.
[4] Child Maltreatment 2024. (n.d.). U.S. Department of Health & Human Services; Administration for Children and Families. Retrieved from https://acf.gov/sites/default/files/documents/cb/cm2024.pdf

opportunities designed to strengthen child protection decision-making and improve safety outcomes.

Rhode Island is participating in a nationwide effort to identify trends in child maltreatment fatalities, share promising practices across jurisdictions, and implement data-driven quality improvement initiatives. According to DCYF, participation in NPCS supports the Department's broader commitment to continuous quality improvement by enhancing its ability to analyze critical incidents, strengthen organizational learning, and implement evidence-informed strategies that prevent future tragedies.[5]

Cases Reviewed

I. Fatalities

Fatality Summary #1

A report was made to DCYF[6] due to an unresponsive two (2) year old. Emergency services responded and the child was pronounced deceased at the hospital. The report stated that the child was put to bed in the evening and around three (3) hours later, the parent went to check on the child and the child was unresponsive. Further, the parents explained that the child had multiple heart conditions, was diagnosed with autism, and had additional medical conditions. The cause of death was post-viral pneumonia with the child's significant medical conditions present. The manner of death was natural. DCYF screened out[7] this report as there were no allegations of abuse or neglect.

This family initially came to the attention of DCYF when a report was made due to allegations of domestic violence and homelessness at the time the baby was born. The baby was placed in relative foster care. While in foster care, the child was involved with skilled nursing, early intervention, and the Fostering Families program. Additionally, the baby was seen by medical providers regularly due to their medical conditions. The family was involved in Safe and Secure Baby Court allowing increased visitation and close monitoring of the case. After about five (5) months, the child was reunified with mother. Mother continued with in-home services and was monitored by DCYF until the matter closed to the court and to DCYF about two (2) months

[5] DCYF. (April 24, 2025). *Rhode Island Department of Children, Youth & Families Joins National Partnership for Child Safety* [Press Release]. RIDCYF_NPCS_Press Release_042425.pdf

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

[7] 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.

later. The family did not have any additional involvement with DCYF until the fatality thirteen (13) months later.

Fatality Summary #2

A report was made to DCYF due to an unresponsive four (4) month old. Emergency services responded and transported the child to the hospital where they were pronounced deceased. The report stated that the father consumed alcohol and then went to sleep in bed with the child. About five (5) hours later, the father awoke and the child was wedged under him with a blanket over their head. The child was unresponsive. The cause of death was SIDS while bed sharing, with other significant conditions. DCYF investigated and indicated[8] father for Physical Neglect – Death.

The family initially came to the attention of DCYF due to allegations of physical abuse by father toward his child with another mother. DCYF investigated and indicated father for Physical Abuse – Excessive/Inappropriate Discipline and Cut, Bruise, Welt. About thirteen (13) months later, the subject child was born and was referred to early intervention at time of birth by the hospital. There was no involvement with this child or mother prior to the fatality.

Fatality Summary #3

A report was made to DCYF regarding an unresponsive three (3) month old. Emergency services responded and the baby was pronounced deceased at the hospital. The report states that the child was put to bed on their stomach in a twin bed with pillows in a "v" shape around their head. Three (3) hours later, the baby was observed to be not breathing. The allegation of Physical Neglect/Death against father was unfounded[9]. The findings were as follows: lack of education of both parents regarding safe sleep practices, the baby was put to bed in a manner that the parent thought was best for the baby, insufficient evidence to suggest cannabis use contributed to the death. Asphyxia and SIDS may have been contributing factors, consistent with father's reenactment.

[8] 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."

[9] 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."

The family initially came to the attention of DCYF due to allegations of domestic violence that was perpetrated by father against mother while she was holding the two (2) month old sibling of the subject child. DCYF indicated father for Neglect – Domestic Violence. Within six (6) months, there was a report to DCYF alleging that mother was not abiding by the no-contact order. Initially, DCYF indicated mother for failing to abide by the no-contact order, but this was subsequently overturned and was unfounded.

About four (4) years later, mother gave birth to the subject child. A review of the record indicates that the family was offered First Connections family visiting but declined services.

Fatality Summary #4

A report was made to DCYF that a four (4) year old was involved in a near fatal accident by drowning and the prognosis was unknown. The child was later pronounced deceased at the hospital. The report states that the family was spending time at a pool and the child accidentally drowned. There was no evidence drugs or alcohol were involved, and video evidence showed no indication the child was left unsupervised as there were adults in the pool. DCYF unfounded this investigation.

The family initially came to the attention of DCYF due to mother leaving her children unsupervised with a family member whose children were just removed by DCYF. When the children were found with this family member, drug paraphernalia and an adult who appeared to be under the influence were present. DCYF indicated mother for Neglect – Lack of Supervision and DCYF informed her that her children could not be left alone with that family member. Approximately eighteen (18) months later, there was a call to DCYF regarding illegal substances found in the family home. The children were removed from the parents and placed in foster care. The family was open to DCYF's Family Services Unit (FSU)[10] for about two (2) years and then reunified with mother. The matter closed to DCYF about a month prior to the fatality.

Fatality Summary #5

A report was made to DCYF regarding the fatality of a three (3) year old child due to drowning. The report stated that there were ongoing concerns regarding the children leaving the home. DCYF completed an investigation and indicated the allegations as to the parents. The report

[10] The Family Services Unit (FSU) within the Division of Family Services, begins working with families after investigations have been completed and the determination is made that services are needed to support the family.

stated that there were significant concerns regarding the condition of the home, including animals in need of medical attention, windows with missing screens, strong cannabis and urine smells, trash and garbage strewn throughout the home, feces on the floor, and what appeared to be mold. Finally, there was a large cannabis production set up in the basement.

The family initially came to the attention of DCYF due to allegations of domestic violence reported to the DCYF Child Abuse Hotline (Hotline). The family was referred to Family Care Community Partnership (FCCP)[11]. There was an unfounded investigation around six (6) years later. Five (5) years after that, there were three (3) screen outs over the course of nine (9) months. The first report to DCYF by hospital staff was due to a sibling requiring a psychiatric evaluation and alleging physical abuse by mother. The child did not present with injuries. DCYF screened out this call. Eight (8) days later, a report was made to DCYF by a provider due to an argument between the sibling and mother. The sibling accused mom of hitting her. There were no injuries observed. DCYF screened out this call. Nine (9) months later, there was a report made to DCYF by a provider that the sibling disclosed that there was an argument with mother in the car and mother made her walk home alone. DCYF completed an investigation. The allegation of Neglect: Lack of Supervision/Caretaker against was unfounded. It was later documented in police records that during this investigation the Child Protective Investigator (CPI) did not enter the home, view the living arrangements for the youth, or assess the condition of the home. The fatality took place one (1) month later.

Fatality Summary #6

A report was made to DCYF regarding the death of a three (3) month old child. Emergency services transported the child to the hospital, and the child was pronounced deceased. The report states that mother, father, and child went to bed together in the same bed. The child's diaper was changed during the night. When the parents awoke the next morning, the child was unresponsive. The cause of death was determined to be SUID. DCYF unfounded this investigation as to the parents.

The family initially came to the attention of DCYF due to allegations of domestic violence. DCYF investigated and it was unfounded. There was a subsequent call to the Hotline about one (1) month later. There were concerns regarding attendance at pediatrician appointments, however, there was only one missed appointment, and it was already rescheduled. DCYF investigated and it was unfounded. The fatality occurred about two (2) months later.

[11] Family Care Community Partnerships (FCCP) are DCYF's primary prevention resource providing regionally situated services and supports to children and families.

Fatality Summary #7

A report was made to DCYF due to a four (4) day old who was at the hospital with trouble breathing. The hospital medical staff attempted to resuscitate the child and was unsuccessful. The child was pronounced deceased at the hospital. The cause of death was a congenital heart condition, and the manner of death was natural.

The family initially came to the attention of DCYF at the time the child was born due to allegations called into the Hotline regarding cannabis use by mother during pregnancy. DCYF investigated both reports made to DCYF at the time of the birth and the fatality of the child. DCYF unfounded the investigation as to the fatality, however, indicated mother for Physical Abuse: Drug/Alcohol Abuse.

Fatality Summary #8

A report was made to DCYF regarding the fatality of a three (3) month old. The cause of death was SIDS and the manner of death was undetermined. DCYF investigated the death of the child and unfounded the allegations as to the parents.

The family initially came to the attention of DCYF when a call was made to the Hotline regarding allegations of domestic violence and physical abuse by father. This incident occurred three (3) weeks prior to the fatality. The investigations were combined and based on this incident, father was indicated for Physical Abuse: Cut, Bruise, Welt, Neglect: Excessive and Inappropriate Discipline and Neglect: Domestic Violence. Following the initial report made to DCYF and the fatality of the child, the family was referred to home visiting programs, and the agency completed an in-person visit at a family member's home. They discussed how the baby was eating, how mom was doing since birth, and safe sleep. It was discussed that a referral for Healthy Families America was made but that they had not been in contact with mother prior to the fatality.

Fatality Summary #9

A report was made to DCYF from the police department that a one (1) month old was not breathing and transported to Hasbro Children's Hospital where the child was pronounced deceased. The cause of death was SUID, including significant conditions of an unsafe sleep environment and an acute viral infection. The manner of death was undetermined. DCYF investigated the death of the child and unfounded the allegations as to the parents.

The family initially came to the attention of DCYF about one (1) month prior due to allegations called into the Hotline regarding a positive drug screen for cannabis at the time of the child's birth. DCYF completed an investigation and determined that mother was under the care of her providers who were aware of her cannabis use due to a medical condition. DCYF unfounded the allegations of Physical Abuse: Substance Use as to mother. Mother was open to working with First Connections for in-home services. The fatality occurred one (1) month later.

Fatality Summary #10

A report was made to DCYF by the police department due to an unresponsive two (2) month old. The cause and manner of death were undetermined. DCYF completed an investigation and unfounded the allegation as to mother.

The family initially came to the attention of DCYF following a report to the Hotline due to mother reporting to the hospital with stomach pain. Mother was in labor and did not know she was pregnant. Mother admitted to cannabis use. Due to lack of knowledge of her pregnancy, she did not receive prenatal care. There was a subsequent report made to DCYF due to allegations of violence and substance use while pregnant. Mother was indicated for Physical Abuse: Drug/Alcohol Abuse and the case was closed as mother had moved into a transitional housing program for families at risk. There was a subsequent report made to DCYF alleging concerns about mother posting online and reporting a history of substance use and mental health problems. DCYF screened out these allegations. The fatality occurred about six (6) weeks later.

Fatality Summary #11

A report was made to the assigned DCYF social caseworker by father that their one (1) month old baby had passed away. The cause of death was SIDS with co-sleeping and the manner of death was undetermined. DCYF completed an investigation and indicated the parents for Neglect: Lack of Supervision/Caretaker.

The family initially came to the attention of DCYF due to allegations made to the Hotline regarding domestic violence. There was a subsequent call to the Hotline, and both calls were investigated by DCYF. DCYF completed an investigation and indicated mother for Neglect: Lack of Supervision and indicated father for Neglect: Domestic Violence. Mother agreed to engage with FCCP and abide by the safety plan. DCYF closed to the family. Around two (2) years later, there were allegations made to the Hotline regarding domestic violence and substance use. DCYF completed an investigation and unfounded the allegations as the parents. About nine (9)

months later, there was a call made to the Hotline regarding the family as they were living in a different state and there were concerns for abuse and neglect. Additionally, it was reported that mother was pregnant. DCYF contacted the family, and they reported they were going to return to Rhode Island. DCYF issued a hospital alert[12] to surrounding hospitals. When the family returned to Rhode Island about two (2) weeks later, there was a call to the Hotline regarding safety concerns for the children. DCYF completed the investigation and unfounded the allegations as to the parents and closed to the family with no further action. About one (1) month later, mother gave birth and there was a call to the Hotline as mother was positive for cannabis at birth. DCYF completed an investigation and unfounded the allegations. They referred the family to FCCP and safety planned. The fatality occurred about one (1) month later.

Fatality Summary #12

A report was made to DCYF that there was an unresponsive five (5) year old in the emergency room. The cause of death was acute inflammatory cardiac condition with other significant conditions including a viral infection, seizures, obesity, nutritional or behavioral health concerns, and a history of an elevated blood lead level. The manner of death was natural. DCYF completed an investigation and unfounded the allegations as to the parents.

The family initially came to the attention of DCYF due to allegations made to the Hotline that were made Information/Referrals.[13] About six (6) months later, there were allegations made to the Hotline due to domestic violence and other concerns for neglect. DCYF completed an investigation and indicated father for Neglect: Domestic Violence and indicated mother for Neglect: Other Neglect. The family was referred to FCCP. The family engaged with FCCP for several months. About one (1) year later there was a call to the Hotline due to a sibling arriving to school in dirty clothes. DCYF made this call an Information/Referral. About eight (8) months later, there was a call to the Hotline due to concerns about housing and the condition of the sleeping arrangements. Additionally, there were concerns about the welfare of the children, including lack of food. DCYF completed an investigation and observed no safety concerns, proper sleeping arrangements, and sufficient food. DCYF unfounded these allegations as to the parents. About one (1) week later, there was a call to the Hotline alleging concerns for mother's mental health. DCYF completed an investigation that was ultimately combined with the investigation of the fatality. DCYF unfounded these allegations.

[12] DOP 100.0060 titled Issuing a Hospital Alert states "Hospital Alert means a written notification issued by DCYF to Rhode Island birthing hospitals advising that DCYF has identified safety concerns requiring hospital staff to contact the CPS Hotline upon the birth of an infant. A hospital alert is issued for planning and safety purposes and does not, by itself, constitute an investigation."

[13] An "Information/Referral" is the previous term used for the current term "Screen Out."

Throughout the subject child's life, the child required medical follow-up regarding speech and developmental delays. The child was seen regularly by providers to receive follow-up medical care.

Fatality Summary #13

A report was made to DCYF by the police department due to an "almost non-responsive" ten (10) month old. The report stated that the child was left unattended in a bathtub. The child was transported to Hasbro Children's Hospital and was pronounced deceased. The cause of death was drowning and the manner of death was accident. DCYF completed an investigation and indicated parents for Neglect: Lack of Supervision.

The family initially came to the attention of DCYF through a call to the Hotline when the subject child was born due to mother testing positive for cannabis and lack of prenatal care. DCYF completed an investigation and indicated mother for Physical Abuse: Drug/Alcohol Abuse. DCYF made a referral to FCCP and First Connections. The family engaged with First Connections for several months and a referral was made for Early Head Start/Head Start services for the other children. The fatality occurred about one (1) year later.

Fatality Summary #14

A report was made to DCYF by the hospital that a two (2) month old was co-sleeping with father, who appeared to have rolled on him. The cause of death was SUID while bed sharing, with other significant conditions including prematurity and a congenital cardiac condition. The manner of death was undetermined. DCYF completed an investigation and unfounded the allegations as to father.

The family initially came to the attention of DCYF due to two (2) calls to the Hotline regarding alcohol use by mother. DCYF completed an investigation and unfounded the allegations as to mother. About seventeen (17) months later, there were two (2) calls to the Hotline alleging domestic violence and concerns regarding the condition of the home. DCYF completed an investigation and unfounded the allegations as to mother. The fatality occurred about one (1) year later.

Fatality Summary #15

Multiple reports were made to DCYF by the police and hospital staff due to an unresponsive twenty (20) month old. The cause of death was undetermined, with other significant conditions including chronic respiratory inflammation, viral infections, and head and neck injuries. The manner of death was undetermined. DCYF completed the investigation and unfounded the allegations as to the foster parent.

The family initially came to the attention of DCYF when concerns were brought to DCYF's attention regarding domestic violence and mental health concerns. DCYF completed an investigation and indicated the allegations of Neglect: Domestic Violence and Neglect: Lack of Supervision/Caretaker as to mother. About two (2) years later, additional reports were made to DCYF regarding physical abuse of a sibling. At the time of the report, mother was pregnant. DCYF issued a hospital alert. About five (5) weeks later, hospital staff notified the Hotline that the child was born. DCYF completed an investigation and indicated the allegations of Neglect: Other Neglect as to mother and father due to ongoing concerns with domestic violence and mental health. Following the baby's birth, DCYF safety planned with mother by including having her live with a supportive friend and putting intensive home-based services in place. Over the next two weeks, there were concerns brought to DCYF's attention by a provider and other adults in mother's life due to her mental health and alleged substance use. DCYF ultimately placed the child in foster care.

The kinship placement provider[14] had a history with DCYF prior to becoming a foster parent following a call to the Hotline alleging domestic violence in the presence of her own child. DCYF completed an investigation and she was indicated for Neglect: Domestic Violence. There was no other subsequent DCYF involvement. About three (3) years later, mother became a kinship foster placement for the subject child. The child was involved with daycare and virtual early intervention services, specifically occupational therapy and speech. Due to ongoing concerns with the child's behaviors at school and at home, early intervention was in the process of making a referral for appropriate mental health services at the time of the fatality

Fatality Summary #16

A report was made to DCYF by the police due to an unresponsive two (2) year old found in the family's pool. The child was transported to the hospital and was pronounced deceased. The cause of death was drowning, and the manner of death was determined to be an accident.

[14] DCYF's DOP: 700.0035 titled Kinship Care describes "kinship care" as, "the full-time care, nurturing, and protection of the child by a relative, member of a tribe or clan, godparent, stepparent, or any adult with a kinship bond with the child."

DCYF completed an investigation which cannabis was found in the home and improperly stored. DCYF indicated the parents for Neglect: Lack of Supervision/Caretaker due to the parents being previously warned due to improper storage of cannabis. DCYF unfounded the allegations as to the death of the child.

The family initially came to the attention of DCYF due to allegations made and a subsequent investigation by DCYF. The investigation was unfounded. Nine (9) months later there was a report to the Hotline due to allegations of sexual abuse by father. Father was indicated for Neglect: Other Neglect, but the allegations of sexual abuse were unfounded. Mother and father ended their relationship, and mother did not allow visitation with father. DCYF remained open for a year to support the family. About seventeen (17) months later, there was a call to the Hotline due to concerns regarding cannabis use and a child ingesting medication. DCYF completed an investigation. The child was medically cleared. DCYF unfounded the allegations. DCYF referred the family to FCCP and the child to early intervention. The family closed to DCYF. Four (4) months later there was a call to the Hotline that was made an Information/Referral. Seven (7) months later, there was a call to the Hotline due to the children smelling like cannabis at school. There was a subsequent call to the Hotline when mother gave birth, and she tested positive for cannabis. DCYF combined these investigations. DCYF unfounded the allegations of the children smelling of cannabis and indicated mother for Physical Abuse: Drug/Alcohol Abuse. DCYF monitored the family for about a month.

About eight (8) months later, there were a series of monthly calls to the Hotline. The first report made to the Hotline was due to a sibling having increased behaviors in the home and requiring a mental health evaluation. DCYF made this an Information/Referral. The second report to the Hotline was that a sibling was afraid to go home due to physical abuse. The child had no observable injuries and the reporter noted that this was a repeated statement by the child. DCYF made this an Information/Referral. The third report to the Hotline was that a sibling smelled like cannabis and was not acting like himself. DCYF completed an investigation and unfounded the allegations as to the parents, as the parents had medical marijuana cards and all cannabis plants were properly stored. The fourth report to the Hotline was due to a reported incident of domestic violence. DCYF completed an investigation. A sibling confirmed the verbal altercation and stated that mother told the child not to tell anyone. DCYF indicated the allegations of Neglect: Lack of Supervision/Caretaker as to mother. The fifth call was due to a report that mother was missing and reports that the house smelled like cannabis. DCYF completed an investigation and the allegations were unfounded as to mother and father. The sixth report to the Hotline was due to a sibling stating that he had been grounded and he took a gun from the family's gun safe and put it under his bed. DCYF completed an investigation and

responded to the home. The firearm was legally permitted and properly stored. DCYF unfounded the allegations as to parents.

About nine (9) months later, there was a call to the Hotline alleging physical abuse. DCYF completed an investigation. DCYF unfounded the allegations as to the parents. About two (2) months later, there was a call to the Hotline due to the children smelling of cannabis. DCYF completed an investigation and unfounded the allegations as to parents. The fatality occurred about two (2) months later.

Fatality Summary #17

A report was made to the Hotline by the police due to an unresponsive two (2) month old. The cause of death was SIDS while co-sleeping with other significant conditions including a viral infection. The manner of death was undetermined. DCYF completed an investigation. The child was in kinship care at the time of death. The parents were required to have supervised visitation. The foster family was allowing the parents to care for the child. The parents and child were co-sleeping at the time of death. DCYF indicated the allegations of Neglect: Lack of Supervision as to the foster parents. The allegations of Physical Neglect: Death as to the biological parents was unable to be completed due to the autopsy not being completed.

The family initially came to the attention of DCYF when a call was made to the Hotline with concerns regarding a sibling. The report stated that the child was coming to school smelling of cannabis. This call was made an Information/Referral. One (1) month later a call was made to the Hotline regarding a sibling. The report stated that the sibling had significant truancy issues and the reporter had additional concerns regarding substance use by parents. DCYF reported this to an out-of-state child welfare agency as the family was residing out-of-state. The out-of-state child welfare agency reported to DCYF that they completed an investigation and substantiated allegations of Neglect, and the sibling was now living with their other parent out-of-state. About three (3) weeks later, a call was made to the Hotline due to a child found unsupervised walking outside. DCYF completed an investigation and indicated the allegations of Neglect: Lack of Supervision/Caretaker as to mother. During this investigation, mother gave birth to a child, and a call was made to the Hotline due to concerns regarding substance use. DCYF completed an investigation and indicated the allegations of Physical Abuse: Drug/Alcohol Abuse and Neglect: Lack of Supervision/Caretaker. One child was placed into a guardianship with a family member. The other was placed in relative foster care. The family opened to FSU. About one (1) year later, a call was made to the Hotline alleging mother was seeing the child unsupervised. The call was screened out and the assigned social caseworker followed up. About four (4) months later, there was a call to the Hotline by an out-of-state child welfare agency

that they responded to a motor vehicle accident with two of mother's children and there were concerns that the driver was under the influence. This call was screened out. About one (1) week later, a call was made to the Hotline alleging concerns related to substance use and that the parents were having unsupervised contact with the child. The call was screened out. About two (2) months later, a call was made to the Hotline by an out-of-state child welfare agency alleging sexual abuse of one of mother's children by mother's paramour. This reportedly occurred out-of-state. The call was screened out. About two (2) months later, there was a call to the Hotline regarding the birth of a child by mother. The child was placed in kinship care with a sibling. The fatality occurred two (2) months later.

Fatality Summary #18

A report was made to the Hotline by police due to an unresponsive five (5) month old. The child was pronounced deceased at the hospital. The cause of death was SUID and the manner of death was undetermined. DCYF completed an investigation. It was determined that the child was put to sleep in the morning following a bottle feeding, after which they were found unresponsive. DCYF unfounded the allegations as to the father.

The family initially came to the attention of DCYF due to allegations of cannabis use. This call was made an Information/Referral with follow-up by DCYF's Intake Unit[15]. They observed the home, offered services, and early intervention. Mother declined services but accepted the referral for early intervention. About two (2) months later, there was a call to the Hotline due to allegations of a road rage incident with mother that ended in a motor vehicle accident. The child was in the car and was taken from the scene by a friend. DCYF completed an investigation and indicated the allegation of Neglect: Lack of Supervision/Caretaker as to mother. DCYF referred the family to FCCP and closed when mother engaged with FCCP. Seven (7) months later, there was a call to the Hotline due to concerns with substance use and father allowing mother to have unsupervised visits. DCYF completed an investigation and indicated the allegation of Neglect: Lack of Supervision/Caretaker as to mother. DCYF followed up with the family to ensure that there were no unsupervised visits with mother taking place.

About one (1) month later there was a call to the Hotline. About six (6) months later, there were three successive calls to the Hotline which led DCYF to complete an investigation. DCYF unfounded the allegations. Sixteen (16) months later, there was a call to the Hotline which led

[15] The Rhode Island Department of Children, Youth and Families (RI DCYF) Intake Unit was an operational division within the Child Protective Services (CPS) system responsible for receiving, screening, and processing initial reports, referrals, and non-abuse/neglect family service needs.
https://acf.gov/sites/default/files/documents/cb/ri-capta-2011.pdf

DCYF to complete an investigation. DCYF unfounded the allegations and mother started services with Healthy Transitions. Four (4) months later, there was a call to the Hotline which led DCYF to complete an investigation. DCYF unfounded the allegations. Two (2) and three (3) months later, there were two (2) calls made to the Hotline, respectively. These calls were made Information/Referrals. Around the same time, there was an additional call to the Hotline due to allegations that father was around mother despite a no-contact order. DCYF completed an investigation and indicated the allegation of Neglect: Lack of Supervision/Caretaker as to mother. DCYF followed up with service providers working with the parents and spoke with safety plan participants.

About five (5) weeks later, there was a call to the Hotline and DCYF made the call an Information/Referral. About three (3) weeks later, there was a call to the Hotline alleging concerns for substance use and domestic violence. DCYF completed an investigation and indicated the allegations of Neglect: Lack of Supervision/Caretaker as to mother. Due to this incident, one (1) of mother's children was placed with their father and the other was placed in foster care. The family opened to FSU and mother was provided case plan goals. After about six (6) months, mother resumed co-parenting with father with one (1) child and was reunified with the other. FSU remained open following reunification. Shortly following reunification, there was a call to the Hotline with concerns that mother was allowing father to violate the no-contact order. These calls were screened out. About eight (8) months later, there were two (2) calls to the Hotline regarding sexual abuse of mother's older child by a family member. DCYF completed an investigation and unfounded the allegations. Two (2) months later, there was a call to the Hotline regarding father violating the no-contact order but no reports of domestic violence. The call was screened out. About sixteen (16) months later, there was a call to the Hotline alleging mother was allowing father to have unsupervised contact with the child. The family remained open to FSU and there was a decision to place the child in kinship care. This child remained in kinship care and was ultimately placed in a guardianship with the family member. About fourteen (14) months later, there was a call to the Hotline due to mother being pregnant. This call was screened out. About four (4) months later, a call was made to the Hotline due to mother giving birth. No safety concerns were noted. The family was open to FSU at this time and the child remained with mother. The fatality occurred around five (5) months later.

Fatality Summary #19

A report was made to DCYF by the police due to an unresponsive five (5) month old. The child was pronounced deceased at the hospital. DCYF completed an investigation. It was reported that the child was co-sleeping in an infant lounger in an adult bed with both parents and a

sibling. The family's sleeping arrangements were tight due to staying in a motel with other family members due to housing insecurity. The family was open to FCCP at the time of the fatality. DCYF indicated the allegations of Physical Neglect: Death as to the parents.

The family initially came to the attention of DCYF when there was a call to the Hotline due to mother giving birth to a child and concerns regarding cannabis use. DCYF completed an investigation and indicated the allegations of Physical Abuse: Drug/Alcohol Abuse as to mother. DCYF made a referral for First Connections. About one (1) year later, there was a call made to the Hotline regarding a child's accidental ingestion of one (1) prescription pill accidentally left out. The family was open to FCCP at the time. DCYF screened out this call. About three (3) months later, there was a call to the Hotline due to the condition of home and an inquiry into the plan to assist the family. This call was screened out. There was a subsequent call made to the Hotline that the family was making progress in improving the conditions of the home. DCYF screened out this call. About two and a half (2.5) months later, mother self-referred to the Hotline requesting help with housing and mental health needs. Mother was connected to FCCP and DCYF made this a Prevention Response and referred to the Support and Response Unit (SRU).[16] The following day, there was a call to the Hotline by the police that father was damaging property at the motel where the family was staying. DCYF screened out this call and the family opened to SRU. The family remained open to SRU for one (1) month and when they closed, the family remained open to FCCP. About three (3) months later, the fatality occurred.

Fatality Summary #20

A report was made to DCYF due to an unresponsive two (2) month old. The child was pronounced deceased at the hospital. DCYF completed an investigation. It was reported that the family was living in temporary housing with additional extended family members due to housing insecurity. The family was working with FCCP. The child and their sibling were co-sleeping with when the fatality occurred. DCYF unfounded the allegations of Physical Neglect: Death as to the parents.

The family initially came to the attention of DCYF due to a call to the Hotline reporting concerns regarding cannabis use in front of one of mother's children. DCYF completed an investigation and indicated the allegation of Neglect: Other Neglect as to mother. The family was referred to

[16] DCYF describes the Screening and Response Unit (SRU) as The SRU provides assistance by identifying each family's needs and provides the necessary supports to help families thrive. The unit, which is located within DCYF's Division of Family Services (DFS), helps families navigate services in their own communities. Also, the unit is a resource families who are feeling overwhelmed or who need assistance with accessing home and community-based services for a variety of needs.

DCYF's Intake Unit, and a referral was made for First Connections. About four and a half (4.5) years later, a call was made to the Hotline due to concerns regarding cannabis use during pregnancy. DCYF completed an investigation and indicated the allegation of Physical Neglect: Drug/Alcohol Abuse as to mother. About six (6) months later, there were two (2) calls to the Hotline regarding mother leaving the children with family to care for the kids. DCYF completed an investigation. DCYF worked with a family member to help support mother in caring for the kids in their home. DCYF indicated the allegations of Neglect: Other Neglect as to mother and DCYF opened the family to FSU. Five (5) months later, services and supports were identified for the family and DCYF closed. Eight (8) months later, the Hotline received another call regarding this family, followed by an additional call four (4) months later.

About seven (7) months later, there was a call to the Hotline with concerns for medical neglect and not accessing social service assistance. DCYF made this a Prevention Response and referred the matter to SRU. SRU observed the home, spoke with collateral contacts, and offered mother services. She declined DCYF making a referral to FCCP. SRU closed about one (1) month following the Prevention Response. Following SRU closing, there was a call to the Hotline due to a police response to the home regarding an altercation between two males outside of the home. The children were not present. DCYF screened out this call. Three (3) months later, there was a call to the DCYF Hotline regarding a child missing school. The child was at home sick. A family member agreed to take the child to the doctor. DCYF screened out this call. Immediately following, there were three (3) calls to the Hotline regarding bruising on one of the children caused by a sibling, and allegations of physical abuse. DCYF screened out all three (3) calls. About five (5) months later, there was a call to the Hotline regarding the living conditions of the home and mother's mental health. Mother was working with First Connections. DCYF screened out this call. About one (1) month later, there was a call to the Hotline alleging physical abuse by mother's paramour. The child told the reporter mother's paramour does not do that anymore. There were no observable injuries. DCYF screened out this call. The fatality occurred two (2) months later.

Fatality Summary #21

A report was made to DCYF from a hospital due to a two (2) year old who was pronounced deceased. The cause of death was a respiratory infection, with other significant conditions including febrile seizures. The manner of death was natural. DCYF completed an investigation. It was reported that the child did have a fever before bed and was unresponsive in the morning. DCYF unfounded the allegations of Physical Neglect: Death as to mother.

The family initially came to the attention of DCYF when a call was made to the Hotline due to concerns for substance use in the home. DCYF completed an investigation and observed the home and a lock box[17] for cannabis. It was reported that no one was using cannabis in front of the children. DCYF unfounded the allegations as to the mother. About two and a half (2.5) years later, there were two (2) calls to the Hotline. The first call was alleging substance use and violence between family members. The second call was regarding domestic violence. DCYF investigated both calls and indicated the allegations of Neglect: Other Neglect as to mother and Neglect: Domestic Violence as to father. DCYF opened the family to FSU to receive support and services. About three-and-a-half (3.5) months later, there was a call to the Hotline that mother was allowing father around the children. FSU was still involved at this time. DCYF screened out this call and the assigned social caseworker followed up. The fatality took placed about six (6) weeks later.

Fatality Summary #22

A report was made to DCYF due to a four (4) month old choking. Emergency services transported the child to the hospital, and the child was pronounced deceased. The cause of death was SUID and the manner of death was undetermined. DCYF completed an investigation. The parents placed the child on a bed alone on a Boppy pillow. The family called emergency services when they observed vomit and thought the child was choking. DCYF unfounded the allegations of Physical Neglect: Death as to the parents.

The family initially came to the attention of DCYF when a call was made to the Hotline due to allegations of the parents engaging in criminal activity. DCYF indicated the allegations of Neglect: Lack of Supervision/Caretaker as to the parents and placed the sibling of the victim in foster care. The family opened to FSU and was engaged in services for five (5) months. The child was reunified with the parents. FSU continued to monitor for two (2) months and decided to close as the parents were involved in substance use treatment, counseling, and Healthy Families America home visiting. The fatality occurred four (4) months later.

Fatality Summary #23

A report was made to DCYF due to the death of a four (4) year old child. The cause of the death was a gunshot wound, and the manner of death was homicide. DCYF completed an investigation. Based on the history of domestic violence, DCYF indicated the allegations of

[17] Lock box means a secure, locked container designed and intended to keep medications out of reach of unauthorized individuals.

Neglect: Lack of Supervision/Caretaker as to mother. DCYF indicated the allegations of Physical Abuse: Death as to father.

The family initially came to the attention of DCYF when mother requested a home study to allow her husband to adopt her older child. DCYF completed the home study, and her husband was allowed to adopt the child. Two-and-a-half years later, there was call to the Hotline due to domestic violence in the home. DCYF completed an investigation and indicated the allegations of Neglect: Domestic Violence and Neglect: Lack of Supervision/Caretaker as to father. There was a no-contact order in place and father was required to relinquish his licensed firearm. Mother accepted a referral to FCCP. About two (2) months later, there were two (2) calls to the Hotline due to domestic violence. DCYF completed an investigation and indicated the allegations as to Neglect: Domestic Violence as to father and Neglect: Lack of Supervision/Caretaker as to mother. DCYF opened the family to FSU for support and monitoring. About eight (8) months later, mother had completed her goals and was ready for closure. Mother requested to stay open and remained open for nine (9) additional months. DCYF closed due to no further incidents of domestic violence or police responses. Mother was not residing with father nor planned to reconcile. Following DCYF case closure, the criminal petitions against father were dismissed and he was able to have his registered firearm returned to him. The fatality occurred seventeen (17) months later.

Fatality Summary #24

A report was made to DCYF by the police due to an unresponsive two (2) month old. The child was transported to the hospital and was pronounced deceased. The cause of death was SIDS and factors present were co-sleeping, and the child had a heart condition. DCYF completed an investigation and unfounded the allegations of Physical Neglect: Death as to the parents.

The family initially came to the attention of DCYF when a call was made to the Hotline due to mother giving birth and testing positive for cannabis. DCYF completed an investigation. During the investigation, it was determined that the family was residing with extended family, who also had their own open DCYF case, so the baby could not safely reside there. Due to this and mother's cannabis use, the child was placed in foster care. About six (6) months later, the family reunified due to obtaining appropriate housing and engaging in services. DCYF closed to the family about four (4) months later. About nine (9) months later, there was a call to the Hotline due to mother giving birth to another child. DCYF referred the matter to SRU. SRU met with the family in the home and discussed safe sleep and made a referral for FCCP. DCYF confirmed FCCP was involved prior to closing. The fatality occurred about three (3) years later.

Fatality Summary #25

A report was made to DCYF by the police due to the family finding a two (2) year old child in the pool. The child was transported to the hospital and following attempts to stabilize, the child was pronounced deceased. The cause of death was drowning, and the manner of death was accident. DCYF completed an investigation. During the investigation, it was reported that an adult sibling had been working on the pool and accidentally left the ladder down. The child was in foster care at the time. DCYF unfounded the allegations of Neglect: Lack of Supervision/Caretaker as to the foster parent.

The family initially came to the attention of DCYF due to a history with an older child, however the family ultimately moved out-of-state. The family became involved with the out-of-state child welfare agency and initiated an Interstate Compact on the Placement of Children (ICPC)[18] to a family member in Rhode Island. DCYF approved the placement of the two (2) year old with the family member in Rhode Island. DCYF monitored the placement of the child for the out-of-state child welfare agency. The fatality occurred six (6) months later.

Fatality Summary #26

A report was made to DCYF by the police due to a five (5) year old who had appeared to have a seizure. The child was transported to the hospital and was pronounced deceased. The cause of death was acute bronchopneumonia, and the manner of death was natural. DCYF completed an investigation. The condition of the home was described as deplorable. DCYF unfounded the allegations of Neglect: Medical Neglect as to mother and indicated the allegations of Neglect: Inadequate Shelter as to mother.

The family initially came to the attention of DCYF about seventeen (17) years prior due to concerns with another child and their father. Mother was not involved with this child at the time. The family opened to FSU and received services from DCYF. The father and child reunified and closed to DCYF.

[18] DCYF DOP 700.0040 titled Interstate Compact on the Placement of Children (ICPC) states ”The Interstate Compact on the Placement of Children (ICPC) i s an agreement among the states, the District of Columbia and the U.S. Virgin Islands that establishes standardized procedures for the placement of children across state lines. The ICPC offers services and provides protections to a child moved across state lines for purposes of placement in foster care, adoption or reunification with parents. The ICPC assigns legal and financial responsibility, details eligibility and home study processes and outlines requirements for termination and courtesy supervision.”

Mother had two additional children who had a different father. About seven (7) months following the birth of mother's first child, there was a call to the Hotline. DCYF completed an investigation and the allegations were unfounded. About one (1) year later, there was a call to the Hotline right before mother gave birth to her second child. DCYF referred the family for FCCP. About eighteen (18) months later, there was a call to the Hotline due to the older child falling out the window. There was a subsequent call to the Hotline due to the condition of the home. DCYF completed an investigation. It was described in reports as "deplorable". Mother was actively working with FCCP, and they were in the home regularly. During the investigation, it was determined that this incident was an accident and the family was engaged in services. DCYF unfounded the allegations. The fatality occurred seventeen (17) months later.

Fatality Summary #27

A report was made to DCYF due to a three (3) week old who was unresponsive. The child was transported to the hospital and pronounced deceased. It was reported that mother was holding the child and nodded off. The baby was unresponsive when mother woke up. DCYF completed an investigation and unfounded the allegation of Physical Neglect: Death as to the child.

The family initially came to the attention of DCYF due to mother being open to DCYF as a minor when pregnant with the child. Mother experienced out-of-home placement as a minor, however, was living with her mother when DCYF closed to the family. Prior to closing, DCYF determined that the family had appropriate supports and services in place. When mother gave birth, there were no safety concerns brought to the attention of DCYF. The fatality took place three (3) weeks after mother gave birth.

Fatality Summary #28

A report was made to DCYF by hospital staff due to an unresponsive three (3) day old. The child was pronounced deceased at the hospital. DCYF completed an investigation. During the investigation, there were inconsistent narratives provided on what transpired leading up to the child's death. There were concerns regarding co-sleeping and substance use. The cause of death was SUID, and the manner of death was undetermined. DCYF indicated the allegations of Physical Neglect: Death as to both parents.

The family initially came to the attention of DCYF when a call was made to the Hotline due to the birth of mother's child, mother's history with her older children being removed by an out-of-state child welfare agency, and concerns for substance use. DCYF completed an investigation. DCYF indicated mother for Neglect: Other Neglect and the baby was placed in

foster care and eventually a guardianship. About seven (7) years following the birth, there was one (1) call to the Hotline with concerns for mother's child who was a teenager having mental health concerns. The child went home with mother, and the family was referred for FCCP. DCYF closed to the family. About one (1) month later, there was call to the Hotline due to substance use and domestic violence concerns. DCYF screened out this call. About three (3) months later, there was a call to the Hotline due to concerns with substance use. DCYF screened out this call. Five (5) months later, there was a call to the Hotline due to the older child's presentation in the home with mom. There was also a concern for substance use. DCYF followed up with father who stated that he would bring the child to live with him. There was a subsequent call to the Hotline due to concerns for lack of follow-up on services by mother. SRU became involved and confirmed that the child was living with father. DCYF closed to the family. About eight (8) months later, there was a call to the Hotline that mother was currently pregnant and there were concerns for substance use. A hospital alert was issued. DCYF screened out this call. About four (4) months later, there was a call to the Hotline when mother gave birth to the child. DCYF completed an investigation. It was reported that while there were concerns for substance use, however since mother was in treatment, the hospital did not test mother for substances. DCYF created a safety plan with family members to safely discharge the baby home with parents. The fatality occurred three (3) days later.

Fatality Summary #29

A report was made to DCYF due to the fatality of a two (2) month old. Emergency services transported the child to the hospital. The child was pronounced deceased. DCYF completed an investigation. It was determined that the child was sick and was receiving medical care. Due to the child's illness, mother was co-sleeping with the child. DCYF unfounded the allegations of Physical Neglect: Death and Neglect: Other Neglect as to mother.

The family initially came to the attention of DCYF when a call was made to the Hotline with concerns for mother's mental health and substance use. DCYF completed an investigation. It was determined that mother was struggling with her mental health, had appropriately accessed treatment, and did not engage in any concerning behavior in front of the child. There were family members in the home who were able to assist mother. Mother was pregnant at the time of this investigation. DCYF unfounded the allegations of Neglect: Lack of Supervision/Caretaker as to mother. About (1) month after DCYF completed the investigation, there was a call to the Hotline that mother was psychiatrically certified at the emergency department and tested positive for cannabis. The report stated mom was six (6) weeks pregnant. DCYF screened out this call. About two (2) months later, there was a call to the Hotline that mother smelled of cannabis, did not have a medical marijuana card, and was pregnant. It was reported that

mother seemed to be consistent with prenatal care. DCYF screened out this call. The fatality occurred about seven (7) months later. During its review of this fatality, the OCA inquired whether a hospital alert had been issued following a prior investigation. DCYF advised that, due to an internal error, no hospital alert was issued and reported that the error had subsequently been addressed.

Fatality Summary #30

A report was made to DCYF due the fatality of a nine (9) week old. DCYF completed an investigation. It was determined that father put the child to sleep with soft items and blankets. There was also a delay in accessing emergency services for the child. DCYF indicated the allegations of Physical Neglect: Death and Neglect: Other Neglect as to father.

The family initially came to the attention of DCYF as father was open as a minor to DCYF at the time of the incident.

II. Near Fatalities

Near Fatality #1

A report was made to DCYF due to allegations of physical abuse related to the near fatality of a sixteen (16) month old. The report states that the child had a spinal fracture with bruising, fluid in their lungs, a large right-side pleural effusion, and a small left side pleural effusion. The child had a fever for two (2) to three (3) days, was refusing to walk, was vomiting, and had abdominal pain. DCYF investigated the allegations and indicated both parents for Physical Neglect and Physical Abuse.

The family initially came to the attention of DCYF due to allegations that mother was violating a no-contact order, concerns regarding medical needs of the child, and a lack of family supports. DCYF determined that this was an Information/Referral and assigned it for a family assessment response[19]. DCYF was unable to make contact with mother. A subsequent call was made to the Hotline within a few days alleging that mother was using cannabis in the presence of the child and allegations that mother was violating a no-contact order. DCYF determined that this was an

[19] DCYF's Glossary of Terms states "FAMILY ASSESSMENT: A comprehensive process for identifying, considering, and weighing factors that affect the child's safety and well-being. Assessment includes information obtained through investigation, as well as through a review of child and family needs, problems, strengths, capacities, and possible resources. The goal of the assessment is to develop, in partnership with the family, the plans and services needed to assure the child's safety, permanency, and well-being."

investigation and assigned a Child Protective Investigator (CPI). The CPI was unable to make contact with mother. There were two additional calls to the Hotline alleging cannabis use in front of the child. DCYF conducted an investigation. The CPI spoke with the pediatrician who had no concerns, and DCYF observed the home and the child with no concerns. Mother showed the CPI threatening messages from a former paramour. These three investigations were unfounded.

Around six (6) months later, there were two (2) calls to the Hotline alleging mother was leaving the child with other caretakers for long periods of time, concerns regarding medical needs of the child, and cannabis use. DCYF investigated and asked if the caretakers were able to continue to provide care for the child. They spoke with mother about signing a guardianship. The child was observed and there were no concerns. Mother confirmed the information and probate court granted temporary guardianship to the caretakers. DCYF developed a plan with the caretaker to contact the Hotline if the guardianship was not finalized and there were safety concerns. The investigation was unfounded.

A call was made to the Hotline about one (1) month later stating that mother was trying to take the child unsupervised. This was made an Information/Referral with no further action. A call was made to the Hotline about (1) month later stating that mother was requesting to terminate the guardianship and there were safety concerns. The call was made an Information/Referral with no further action. The probate court terminated the guardianship. About three (3) months later, there was a call to the Hotline that mother was losing benefits due to lack of compliance, and the child was not in her care. This call was made an Information/Referral. The near fatality occurred about two (2) weeks later.

Near Fatality #2

A report was made regarding a near fatality of a three (3) year old who fell out a third-floor window. The child was alert and awake when emergency services arrived. It was reported that the screen ripped and the child fell. Additionally, it was reported that a family member was watching the children and that a sibling had opened the window. DCYF investigated and this was unfounded as to the near fatality. During the investigation, it was reported that a grandparent watched the children every day because of the parents' work schedule. The grandparent struggled with their own mental health and there were three children, all with their own individual behavioral needs. The home had a lot of bags of trash, debris, and piles of clothes everywhere. This investigation was indicated as the family knew that the older child would open windows and this was not addressed by the parents.

The family initially came to the attention of DCYF due to calls to the Hotline alleging abuse or neglect. There was a call made to the Hotline that while in the care of a family member, the three (3) year old sibling was wandering in the street. DCYF made this an Information/Referral. Four (4) months later, there was a call made to the Hotline that the three (3) year old sibling reported to the school that his father hit him. The school did not note any injuries. DCYF made this an Information/Referral. Ten (10) days later, a call was made to the Hotline reporting that the three (3) year old sibling was very aggressive at school and stated that he smoked cannabis with his father. The report indicated that the child had a history of aggression and "blurting out" statements. DCYF made this an Information/Referral. About eleven (11) months later, there was a called made to the Hotline due to visible injuries to the now four (4) year old sibling. The child stated that father tied a toy around his neck. There were concerns for cannabis use by parents and the child being unkempt. DCYF initiated an investigation. During the investigation, the child showed the investigator how he wrapped the toy around his own neck and needed help to get it off by father. DCYF unfounded this investigation but referred the family to FCCP to assist with the child's behaviors. The family did not follow through with the referral. Three (3) months later, a call was made to the Hotline that a child was born, and the family was not following through with pediatrician appointments. DCYF initiated an investigation. During the investigation, it was reported that the child was hospitalized and did not attend the follow-up appointment. The child was seen by the pediatrician prior to the family meeting with the CPI. There were concerns regarding cannabis and drug use. DCYF indicated for Other Neglect as to father due to substance use and unfounded the allegations of Neglect: Other Neglect as to mother. The family opened to the FSU. Within a week, there was a call made to the Hotline due to the five (5) year old wandering outside alone. The CPI advised the family to install alarms and locks. DCYF indicated the parents for Neglect: Lack of Supervision. Two (2) months later, a call was made to the Hotline due to marks on the five (5) year old sibling. The child reported a family member shot him with bullets. DCYF initiated an investigation and the child reported that they were scratched by the family dog. CPI discussed the report with the family, and the child was referring to Nerf guns. The child also had a black eye, which a family member reported occurred when the child ran into a table. DCYF unfounded this investigation. One (1) month later, there was a call made to the DCYF Hotline regarding father being present in the home despite a court order, which restricted him from being in the home. DCYF was ordered to conduct tasks[20] at the home. About one (1) month

[20] DCYF indicates that "The TASK option is located within the SDM Hotline Screening and Response Priority/Assessment in RICHIST. Specifically, when completing the Final Screening Decision, if no maltreatment type is selected, the system provides the question Further Action Needed? Selecting this option provides a CPS Task selection. When CPS Task is selected, the CPS Supervisor is then presented with the available task options, including Well-Being Check, Courtesy Interview, Court Order, After Hours Request, Transportation of Child/Youth – ICJ, Gathering Additional Information, or Other/Specify."

later, there was a call made to the DCYF Hotline due to the five (5) year old sibling wandering along outside while in the care of a family member. DCYF initiated an investigation. The child had opened the window to escape. The family was advised to apply for childcare assistance and put locks on the windows. The allegations were unfounded as to the family member. About one (1) month later, a call was made to the DCYF Hotline that the child was wandering outside while in the care of a family member. The allegations were unfounded, but the family was advised the child should not sleep at the family member's home. About two (2) months later, there were two (2) calls made to the Hotline regarding the five (5) year old sibling wandering alone. DCYF initiated an investigation and mother reported she was planning to move. DCYF indicated the allegations of the Neglect: Lack of Supervision as to mother for both incidents. Later that month, there was a call made to the Hotline due to concerns of the home being deplorable. DCYF had conducted an unannounced visit that same day. This call was made an Information/Referral. Two (2) months later, a call was made to the Hotline due to the five (5) year old sibling wandering around outside. DCYF initiated an investigation. The family had recently moved. DCYF unfounded the allegations of Neglect as to the parents. FSU remained open for six (6) months prior to closing. The child who experienced the near fatality did receive early intervention services for a period of time. The near fatality occurred two (2) months after FSU closed.

Near Fatality #3

A report was made to DCYF due a near fatality of a two (2) year old. The call was made by an out-of-state child welfare agency because a Rhode Island DCYF youth was at the hospital due to injuries sustained. The child was unresponsive when emergency services arrived. DCYF completed an investigation. Based on the reports from the hospital, there were concerns that the injuries were inflicted on the child by another person. DCYF indicated father's paramour who lived in the home with Physical Abuse: Cut, Bruise, Welt and Physical Abuse: Excessive/Inappropriate Discipline.

The family initially came to the attention of DCYF due to a call to the Hotline by hospital staff when the subject child was born. There were concerns regarding mother's mental health and her history with a child welfare agency in a different state. DCYF completed an investigation and indicated mother for Neglect: Other Neglect. The child was placed into foster care. During the child's time in foster care, DCYF identified the biological father of the child and engaged with him in case planning. DCYF sent an ICPC referral packet to an out-of-state child welfare agency to determine if father and his home were suitable for his child in foster care in Rhode Island. The out-of-state child welfare agency denied the ICPC request to approve placement in father's home due to criminal background and untreated mental health. Following further case

planning with DCYF and a change in circumstances, about nineteen (19) months later, a second ICPC referral packet was sent to the out-of-state child welfare agency to determine if placement of the child with father was appropriate. It was determined that circumstances had changed and father and his home were appropriate for the child. Following this decision, there was a call to the Hotline alleging that the child had begun overnights too quickly. This was made an Information/Referral. Several days later, there was a call to the Hotline alleging that father had hit the child during a visit. There were no documented injuries nor disclosures, therefore DCYF made this an Information/Referral. The assigned DCYF social caseworker followed up on this call to the Hotline. The child was reunified with father a few weeks later. Directly following reunification, there was a call made to the Hotline that there was police involvement in the home. DCYF followed up with the out-of-state child welfare agency and the police department. This call was made an Information/Referral. Following reunification, the child was observed by DCYF in the home, at court, at the pediatrician's office, and by the out-of-state child welfare agency overseeing the placement. There were some concerns noted by the out-of-state child welfare agency due to observing the child having trouble with stability and reports from the family about these issues. A referral was made for early intervention. The near fatality occurred about two (2) weeks later.

Near Fatality #4

A report was made to DCYF due to the near fatality of a one (1) year old. The concern at the time of hospital admission was prolonged malnutrition. DCYF screened out this report due to an investigation already pending. During the eight (8) days prior, there were six (6) reports made to the Hotline. The first report alleged medical neglect, hygiene issues, and the children not having enough food. The main concern was safety and nutrition. DCYF initiated an investigation. On the same day, there was a subsequent call to the Hotline alleging hygiene issues, concerns with access to food, and physical abuse. This call was screened out. The following day, there was a call to the Hotline reporting that things were bad in the home. The reporter also requested multiple well-checks for the children. On the same day, there was a call to the Hotline reporting lice, feces in the apartment, and no appropriate clothing. Additionally, there were concerns for substance use and physical abuse. DCYF initiated an investigation. Six (6) days later, there were two calls to the Hotline. The first call reported that mother was arrested and there were concerns for who was going to care for the children. The second call was from a different reporter expressing concerns for who was going to care for the children. These two reports were combined in the same call record to the Hotline and not documented as two separate calls as required by protocol. The two (2) investigations were completed and DCYF indicated mother and father for the allegations for Neglect: Lack of Supervision/Caretaker, Neglect: Inadequate Food, Neglect: Medical Neglect.

The family initially came to the attention over twenty (20) years earlier and DCYF indicated mother and father for the allegation of Neglect: Medical Neglect. FSU opened to the family and provided services. DCYF closed to the family. Two (2) years after the family closed, there was a call to the Hotline that was made an Information/Referral. About seventeen (17) years ago, DCYF completed an investigation and unfounded the allegations as the parents. About fourteen (14) years ago, there were two (2) calls to the Hotline with no substantiated findings. About twelve (12) years ago, there was a call to the Hotline that was screened out. Starting about ten (10) years ago, the family had regular contact with DCYF. DCYF indicated allegations as to mother and father for Neglect: Medical Neglect, Neglect: Educational Neglect, Neglect: Inadequate Shelter, and Neglect: Lack of Supervision/Caretaker. Over the last ten (10) years, the family opened to FSU multiple times and the children were placed into foster care. One (1) year prior to the near fatality, the family was opened to FSU due to housing instability, parenting concerns, and case management services. About eleven (11) months prior to the incident, FSU closed to three (3) of the children, however, remained open to three (3) other children. The family was engaged in services and receiving support for education. DCYF was assisting the family with rent. About six (6) months prior to the near fatality, the entire family closed to DCYF. During the next six (6) months, there were no additional calls to the Hotline until around the time of the near fatality.

Near Fatality #5

A report was made to DCYF regarding the near fatality of a two (2) year old. The report stated that this occurred during a motor vehicle accident when mother was driving under the influence. DCYF completed an investigation and indicated mother for Neglect: Lack of Supervision/Caretaker.

The family initially came to the attention of DCYF due to a call to the Hotline by an out-of-state child welfare agency who was working with the family since the birth of a sibling. There was cannabis use during pregnancy. The family moved to Rhode Island and there were no concerns for safety. DCYF made this call a Prevention Response and assigned it to SRU. SRU met with the family to determine how they could assist, observed the sleeping arrangements, and discussed what supports DCYF could refer the family to. SRU made a referral to FCCP and confirmed the intake occurred and closed to the family. The near fatality occurred about fourteen (14) months later.

Near Fatality #6

A report was made to DCYF due the near fatality of a one (1) year old. DCYF completed an investigation. It was discovered that (2) children were left in the car alone for a short period of time, during which the one (1) year old was not fully restrained and was wrapped up in the car seatbelt and unable to breathe. DCYF indicated the allegations of Neglect: Lack of Supervision/Caretaker as to mother.

The family came to the attention of DCYF when a call was made to the Hotline due to allegations of domestic violence. DCYF completed an investigation. The report stated that mother's paramour was the perpetrator and mother acted appropriately. DCYF unfounded the allegation and referred mother to the domestic violence advocate. About eighteen (18) months later, there was a call to the Hotline due to allegations of physical abuse. It was reported that a child wrote to school staff reporting that mother hits them. The Hotline staff directed the school to message back and ask if the child was alright. No response was received. The reporter denied any prior concerns for abuse or neglect. This call was screened out and there was no further involvement from DCYF. The near fatality took placed ten (10) months later.

Near Fatality #7

A report was made to DCYF by the police due to the near fatality of a one (1) year old. It was reported the child fell out the window. DCYF completed an investigation. Based on the reports during the investigation, DCYF unfounded the allegations of Neglect as to the parents.

The family initially came to the attention of DCYF when a call was made to the Hotline regarding concerns of medical neglect due to missed doctor appointments. The call was screened out, however, DCYF responded in-person to the home to discuss barriers to getting the child to the doctor. Mother reported she was working on getting health insurance. Information regarding safe sleep was provided and a referral to FCCP was made. DCYF confirmed the child saw the doctor. About eight (8) months later, there was a call to the Hotline due to a domestic violence incident. DCYF completed an investigation and indicated the allegations of Neglect: Domestic Violence as to mother. The family was referred to First Connections. The near fatality occurred nine (9) months later.

Near Fatality #8

A report was made to DCYF regarding the near fatality of a four (4) year old. It was reported that the child was the victim of a gunshot wound to the head. DCYF completed an investigation. During the investigation, it was determined that father was storing a firearm for another person and when he moved it, the firearm fell, discharged, and hit the child. DCYF indicated the allegations of the Physical Abuse: Brain Damage/Skull Fracture as to father.

The family initially came to the attention of DCYF when a call was made to the Hotline due to allegations of domestic violence. DCYF planned to investigate, however, upon gathering additional information, the family was able to provide evidence that they were being harassed by someone. DCYF downgraded this to a Screen Out. Nineteen (19) months later, there was a call to the Hotline due to a disclosure by the child that a parent had hit them and left a mark. DCYF completed an investigation. During the investigation, the child and family members reported that the child fell. DCYF unfounded the allegations of Physical Abuse: Excessive/Inappropriate Discipline and Physical Abuse: Cut, Bruise, Welt. The near fatality occurred about six (6) months later.

Near Fatality #9

A report was made to DCYF by the police due to the near fatality of two (2) year old. It was reported that father, allegedly under the influence, was transporting the child unrestrained on a moped. When the moped hit another car, the child was thrown from the moped. DCYF completed an investigation. During the investigation, there were concerns regarding another child missing medical appointments. Due to the incident with the two (2) year old, the family was struggling to maintain appointments. DCYF unfounded the allegations of Neglect: Medical Neglect as to mother and indicated the allegations of Neglect: Lack of Supervision/Caretaker as to father. The family was referred to FCCP.

The family initially came to the attention of DCYF for two (2) reasons: 1. for a history with DCYF and 2. for being a licensed kinship provider. The mother was a kinship provider due to ongoing issues with her family members and their children. Additionally, there was a history from over ten (10) years ago in which there were no indicated investigations.

Additionally, the family came to the attention of DCYF due to a call by police to the Hotline indicating that a child was improperly restrained in a moving vehicle and concerns regarding mother's behavior during a traffic stop. DCYF completed an investigation. DCYF indicated the allegations of Neglect: Other Neglect as to mother. The family declined services at that time and DCYF closed to the family. About four (4) months later, there was an incident in which an older cousin was supervising mother's child in a bathtub and the child swallowed water and was taken to the hospital. About two (2) weeks later, concerns were reported to the Hotline regarding the well-being of the children living in the home, both mother's children and her nieces and nephews she was responsible for. The family declined services and mother stated she would contact a mentoring service for the children. About four-and-a-half (4.5) years later,

there was a call to the Hotline that a child overheard mother threaten father. DCYF screened out this call. The near fatality occurred five (5) months later.

Near Fatality #10

A report was made to DCYF due to the near fatality of a one (1) month old. Emergency services responded due to an unresponsive child and transported the child to the hospital. DCYF completed an investigation. DCYF determined that the child was unsupervised on a Boppy pillow for a short period of time. DCYF unfounded the allegations of Neglect: Lack of Supervision/Caretaker as to mother.

The family initially came to the attention of DCYF due to substance use. DCYF completed an investigation and indicated the allegations of Neglect: Lack of Supervision/Caretaker. A safety plan was put in place that mother and child would reside with family, and a referral was made to FCCP. DCYF closed to the family.

About twenty (20) months later, there was a call to the Hotline. About three (3) months later, there was a call to the Hotline due to mother relapsing. The family initially opened to FSU; however, father obtained orders in domestic court and was able to take the child. DCYF closed to the family. About ten (10) months later, a call was made to the Hotline. About two (2) months later, a call was made to the Hotline due to mom being pregnant. DCYF sent a hospital alert to hospitals. About three (3) months later, a request was made by an out-of-state child welfare agency to determine if mother's home would be safe for her oldest child as the child was removed from father. DCYF denied the ICPC request for the child to be placed with mother.

Following this decision, a call was made to the Hotline due to mother giving birth and concerns for substance use. DCYF opened the family to FSU, however, the child discharged home with mother. FSU worked with mother to engage in services and ensure that there were family supports in place. About one (1) month later, there was a call to the Hotline due to concerns for substance use. This call was made an Information/Referral and the assigned social caseworker followed up with the family. About two (2) months later, DCYF removed the children due to

substance use. The family engaged with Family Treatment Drug Court[21] and DCYF. About nine (9) months later, the children reunified with parents. The family closed to DCYF after three (3) months as parents were engaged in substance use treatment and there were active safety plan participants.

About four (4) months later, a call was made to the Hotline as mother gave birth to a child and there were concerns for cannabis use. The family opened to the Intake Unit and DCYF followed up with the family to assist with services and refer to early intervention.

About one (1) year later, there were two (2) calls to the Hotline regarding cannabis use by parents. DCYF completed two (2) investigations and unfounded the allegations as to the parents.

Ten (10) months later, there was a call to the Hotline regarding substance use. DCYF completed an investigation and indicated the allegations of Neglect: Lack of Supervision/Caretaker as to the parents. DCYF placed both children in foster care. About nineteen (19) months later, the children reunified with the parents as they were actively engaged in Family Treatment Drug Court. About six (6) weeks later, there was a call to the Hotline due to mother giving birth and concerns for cannabis use. DCYF was still open to the family, and the family was doing well. The baby discharged home with the parents. The near fatality occurred one (1) month later.

Near Fatality #11

A report was made to DCYF after a child in foster care presented to the hospital due to illness. During the week preceding the child's removal, the child had received routine vaccinations and subsequently became ill. The child's mother contacted the pediatrician and was advised to administer Tylenol. The morning after the child placed in a foster home, concerns arose regarding the child's condition, and the child was brought to the emergency department for evaluation. DCYF screened out this call. It was later determined that the child experienced a near fatality due to bacterial meningitis.

[21] The Rhode Island Judiciary defines the Family Treatment Drug Court also referred to as the Family Treatment Recovery Calendar is a "specialty calendar is a collaborative effort between the judicial officer, court social workers, DCYF, and other treatment providers. The calendar offers intensive court supervision, court ordered substance use treatment services, and other ancillary services, with the goal of allowing the participating adult mothers and fathers to address addiction challenges, keep the child(ren) in the home or work toward reunification, and learn the necessary skills to move on to a healthy, substance-free future."

The family came to the attention of DCYF when a call was made to the Hotline due to mother being pregnant. The father was open to DCYF at that time due to indicated allegations of abuse or neglect as to another child with another mother. Due to father being open, a hospital alert was sent to area hospitals. One (1) month later, there was a call to the Hotline when mother gave birth to the child. DCYF completed an investigation. The child was premature and required medical care at the hospital for a period of time. The child discharged home with mother and a family member due to ongoing concerns regarding father. During the investigation, there was a domestic disturbance incident involving father. Following this, it was determined that the safety plan in place for the living arrangements of the baby and supervision was not being complied with by mother and safety plan participants. The child was removed from mother and placed into foster care. The near fatality due to the medical issue occurred the following day.

Discussion and Findings

I. CHILD PROTECTIVE SERVICES (CPS)

Over the past several years, significant and persistent concerns have been identified regarding the overall functioning of the CPS unit. Recurring issues related to workload, staffing levels and staff turnover, training, administrative oversight, and compliance with statutory, regulatory, and policy requirements have raised serious concerns regarding the unit's capacity to consistently fulfill its mandate outlined in both statute and applicable policies.

As the primary point of entry for reports involving children and families, the CPS unit serves a critical role in identifying risk, initiating timely interventions, and protecting child safety and well-being. Decisions made at the initial intake and investigative stages determine whether allegations of abuse or neglect receive a protective response, making the accuracy, consistency, and timeliness of CPS decision-making fundamental to the safety of children and the integrity of the child welfare system. This responsibility requires adequate staffing, comprehensive training, strong supervisory oversight, and rigorous quality assurance processes.

Systemic challenges persist, despite repeated communications raising concerns to DCYF Administration. Ongoing deficiencies have resulted in inconsistent identification of risks to children, also impacting appropriate assessment and mitigation of risks. Leaving these longstanding issues unaddressed will continue to undermine the effectiveness of the child protection system and compromise outcomes for vulnerable children and families.

CPS serves as the gateway to Rhode Island's child protection system which means the consistency and quality of screening, assessment, investigation, and supervisory practices directly impact whether children receive timely and appropriate protective intervention. When

child safety concerns are not appropriately identified, assessed, or responded to, timely opportunities to mitigate harm can be missed, placing children at continued risk and eroding confidence in the child welfare system.

The Panel's review confirmed concerns previously identified through the OCA's internal oversight and monitoring process. Drawing the same conclusions through two separate review processes underscores the urgency of these critical systemic challenges. Through examination of these systemic issues, identified findings, and subsequent recommendations, systemic reform through stronger accountability, practice improvements, enhancement of administrative oversight, provision of support to frontline staff is vital to protecting the safety and well-being of children and families in Rhode Island.

a. Standardized Intake Process: Aligning Law, Regulations, Policy, and the Structured Decision Making Hotline Screening and Response Priority Assessment Tool

Pursuant to R.I.G.L. § 42-72-2(2), DCYF has a fundamental obligation to promote, safeguard, and protect the social well-being and development of children. In accordance with R.I.G.L. § 40-11-7, DCYF is statutorily responsible to "investigate reports of child abuse and neglect in accordance with the rules that DCYF has promulgated and in order to determine the circumstances surrounding the alleged abuse or neglect and the cause thereof."

When a report is made to the Hotline, DCYF utilizes the Structured Decision Making Hotline Screening & Response Priority Assessment (SDM) to guide decisions regarding the appropriate response. The SDM has been in use by DCYF for more than five (5) years and is designed to provide a standardized framework for determining the appropriate next steps following a call to the Hotline.

The SDM includes multiple decision points designed to guide Hotline screening decisions, including preliminary screening, identification of alleged maltreatment type, initial and final screening determinations, applicable overrides, and response priority assignment. Supervisory approval requirements are incorporated at designated decision-making points to support oversight and consistency in the screening process. For reference, the complete SDM is included in Appendix B.

Under the SDM framework, reports received by the Hotline are first reviewed to determine whether they meet criteria for an automatic Screen Out. If a report is not automatically screened out, the tool guides the Hotline worker through an assessment of the alleged maltreatment type and determines whether the allegations require an investigative response.

The SDM also provides limited circumstances for overrides when the identified SDM determination does not appropriately capture the circumstances of the report.

For reports requiring investigation, the SDM further establishes the response priority level based on the circumstances presented, including whether an immediate response is necessary to address child safety concerns.

While the SDM provides DCYF with a standardized screening framework, the OCA identified concerns regarding alignment between the SDM criteria, DCYF policy, and statutory requirements governing CPS investigations. Pursuant to DCYF DOP 500.0000 titled Child Abuse and/or Neglect Reports:

"Within 24 hours of receiving a report, the Department uses standardized decision-making criteria and supervisory/clinical consultation to determine if the report meets the state's statutory definition of child maltreatment. Based on this evaluation, the report is:

a. Screened in for a CPS assessment and investigation and assigned an investigation level and priority response.
b. Referred to law enforcement.
c. Screened out with a Department response.
d. Screened out with no follow-up."

The DOP then states that a report accepted for a CPS assessment and investigation must meet one (1) of six (6) criteria. These criteria do not fully align with the criteria contained within the SDM. Additionally, while DCYF policy references supervisory and clinical consultation as part of the screening determination process, the requirement for clinical consultation is not explicitly reflected within the SDM itself.

Additionally, both the DCYF Child Protective Services Regulations, 214-RICR-20-00-1, and DOP 500.000 require consideration of not only the reported incident, but also a "pattern of behavior or incidents" when assessing allegations of child abuse or neglect. However, the SDM does not appear to sufficiently include a prompt requiring the Hotline worker to review or incorporate prior DCYF history, including previous reports, findings, or patterns of concern. The identification and assessment of cumulative risk or a pattern of behavior is not explicitly established as a criterion within the SDM.

Thus, differing criteria between the SDM and DCYF policy has resulted in inconsistent application of DCYF's screening process. A standardized decision-making tool is only effective

when the criteria used to determine child safety responses are clearly defined, consistently applied, and aligned with statutory requirements.

As noted, if the information does not meet the criteria for investigation, the call is screened out with no follow-up from DCYF. Pursuant to DOP 500.0015 titled Screen-Out Reports Requiring a Response, when a report does not meet the criteria for a CPS investigation but contains a valid concern regarding the well-being of a child, the report may be designated as a Screen Out requiring further response from DCYF. In these circumstances, the CPI, with supervisory approval, determines whether additional DCYF intervention is warranted. This may include a referral to SRU for a Prevention Response. This will be further discussed in Section II of the report.

The Panel's review highlighted continued instances in which similar allegations received different responses, raising concerns regarding whether the current intake process is achieving the intended purpose of standardization and ensuring consistent assessment of child safety.

b. Inconsistencies with CPS Screening Practices

In March 2017, the OCA issued a report from the Child Fatality Review Panel which identified significant deficiencies in the Hotline intake process, including the absence of a standardized framework to assess reports of child abuse and neglect. Prior to implementation of the SDM, DCYF utilized the Information/Referral designation for reports that did not meet the criteria for a CPS investigation. DCYF DOP 500.0040 titled Information/Referral (I/R) Reports which is no longer in effect, defined an Information/Referral as a report that reflected "a concern about the well-being of a child but does not meet the criteria for investigation." The policy further required that, when a family had prior DCYF involvement, the CPS call floor worker to review the report with a supervisor to determine whether an investigation was warranted. The policy also permitted referrals to the CPS Intake Unit when families were determined to have service needs.

The same 2017 review determined that reports meeting the criteria for CPS investigation were frequently and improperly screened as "Information/Referral," resulting in no CPS response despite allegations warranting further investigation.

Additionally, historical information maintained by DCYF was not consistently reviewed or incorporated when evaluating new reports, undermining DCYF's ability to accurately assess child safety and family risk. The report stated that thorough intake decisions require consideration of the "family and case history, the age of the children involved, and the presenting risk factors" when reviewing subsequent reports to the Hotline.

The review concluded that the lack of a standardized risk assessment process contributed to inconsistent and inadequate CPS decision-making. Additionally, when families had a documented history of DCYF involvement, including prior indicated findings of abuse or neglect, DCYF conducted little to no verification that parents were engaged in recommended services or attending appointments, instead relying primarily on information self-reported by parents.

These findings echoed concerns previously raised by the OCA's March 2016 "Report of the Multi-Disciplinary Team: A Review of Three Cases That Involved Infant Deaths", which similarly stressed deficiencies in DCYF's ability to conduct comprehensive and meaningful safety and risk assessments. Collectively, the 2016 and 2017 reviews established a clear and consistent pattern of systemic shortcomings within the CPS intake process and underscored the critical need for a standardized approach to screening and assessing reports of child maltreatment.

The 2017 Report of the Child Fatality Review Panel accentuated significant concerns regarding the improper application and overuse of the Information/Referral designation.

These findings prompted the OCA to implement an internal review process for CPS reports that were not assigned for investigation. This internal review process remains in effect through the review of calls now designated as Screen Outs (formerly an Information/Referral). When reviewing the call, the OCA team reviews all relevant information and applies the SDM tool and DCYF policies to assess whether additional follow-up with DCYF is warranted.

In 2023, the OCA issued the St. Mary's Home for Children Investigation report. While this report issued findings and recommendations specific to this program, the report also outlined findings and recommendations for DCYF. Once again, the OCA identified concerns regarding the consistency of CPS screening practices by highlighting several calls pertaining to this program that met the criteria for investigation, with no investigations initiated and the calls were screened out. The OCA also raises concerns regarding the quality of investigations and the independent verification of information by DCYF in the next section of this report.

In 2023, the OCA also raised the need for additional staff training. In response, DCYF indicated that an additional position within CPS would be hired, tasked with the responsibility to conduct a daily review of Screen Out decisions, and to ensure fidelity to the SDM tool. Additionally, DCYF implemented an internal quality assurance process requiring Screen Out decisions to be reviewed by multiple CPS supervisors and the CPS Administrator. DCYF DOP 500.0000 requires supervisory approval for a Screen Out decision. The DOP states, "[i]f there is a history of involvement with the Department, the Hotline CPI reviews the report with the Call Floor supervisor to determine whether to initiate an investigation."

Despite these additional layers of review and the implementation of the SDM, the OCA continues to identify Screen Out decisions that warrant further intervention. As a result, the OCA routinely requests that these reports be reassessed for a CPS investigation. This practice is used to enforce fidelity to the SDM and comprehensive assessment of safety and risk in order to align families with appropriate interventions.

The current Panel identified many of the same concerns documented by the OCA in the prior reports referenced above. Significant inconsistencies remain in the application of the SDM, resulting in similar reports being handled differently, with some assigned for investigation while others are screened out. The review also identified continued reliance on unverified self-reporting by parents or household members and a persistent failure to consistently consider prior DCYF history, including indicated findings, prior investigations, and previous Screen Outs when assessing new reports made to the Hotline. In many cases, CPS assessments remained narrowly focused on the presenting incident, without adequately considering the family's prior history or the cumulative safety and risk factors necessary for informed decision-making. These systemic deficiencies persist ten (10) years later. The persistence of these concerns, despite implementation of both the SDM tool and enhanced supervisory review, demonstrates that standardization alone is insufficient without consistent application, meaningful supervisory oversight, and adherence to established law and policy.

The following cases are examples of specific calls to the Hotline that were screened out and followed up on by the OCA for further intervention:

CPS Case Summary #1:

A report was made to the Hotline by mother, reporting allegations of sexual abuse by father of their (6) year old child. Mother reported overhearing father performing sexual acts on himself in the presence of the child. A second report was made by a medical provider, providing the same information, but also noted that father admitted to the acts in writing. The child had not made any disclosure about abuse or witnessing these acts. Mother asked father to leave the home and was pursuing a restraining order. Both of these calls were made a Screen Out.

The OCA requested these calls be upgraded to an investigation and was denied by DCYF, stating the allegations did not meet the criteria for an investigation. For two weeks, the OCA, relying on the SDM and DCYF DOPs, insisted the case to be upgraded to an investigation, citing the specific qualifying criteria. This case had been referred to the police and the Rhode Island Office of the Attorney General for possible charges. Adamant that this case did not meet the criteria for investigation, DCYF did not open an investigation. Only after a Rhode Island Family Court Judge

ordered DCYF to investigate after the parent went to court seeking a restraining order did DCYF open an investigation.

In the OCA's correspondence in this matter, the OCA highlighted not only the concerns with this particular case but broader systemic concerns to DCYF Administration. Specifically, the OCA wrote: "As you are aware, the OCA functions as the oversight agency to DCYF and one of the roles of this office is to review DCYF's practices, policies, procedures and intervene when a child or children may require assistance from this office. While the OCA appreciates the offer to receive refresher training, our concerns are not with the OCA's understanding of the tool, but rather with the adequacy of DCYF staff training and the utilization of this tool to fidelity in this case. The mere fact that a case, with this set of facts, did not warrant an investigation and required judicial intervention for the screen out to be upgraded, is frankly alarming. That such extensive debate between our offices was even necessary in a matter of this nature underscores significant concerns about the effectiveness of current screening and decision-making processes."

CPS Case Summary #2:

A report was made to the Hotline by a local police department. Father was arrested for domestic disorderly conduct. According to the report, father threw chairs and objects around the home and prevented mother from leaving the home. Report noted concerns for a 4-month-old baby in the vicinity of chairs and objects being thrown.

The OCA applied the SDM to the information received through the report narrative and determined it met the criteria for an investigation. The OCA contacted DCYF and requested this Screen Out be upgraded for investigation. DCYF agreed it met criteria, upgraded to an investigation and the case was subsequently indicated.

CPS Case Summary #3:

A report was made to the Hotline by a local police department that a grandparent was arrested for domestic simple assault. An eight-year-old (8) and three-year-old (3) child witnessed the incident. This was a made a Screen Out.

The following day a school psychologist made a report to the Hotline that the 8-year-old child reported feeling sad and worried about his family because his mother was punched in the face a couple of times by his grandparent. This call was designated a Screen Out.

The OCA applied the SDM to the information received through the two report narratives and determined they both met the criteria for an investigation. The OCA contacted DCYF and requested this Screen Out be upgraded for investigation. DCYF agreed it met the criteria, upgraded to an investigation and the case was subsequently indicated.

CPS Case Summary #4:

A call was made to the Hotline by a special education teacher expressing concerns for an eight (8)-year-old child. Reporter stated that the child got into an altercation at school with another child and was told a parent would be contacted by the school. The child asked the school not to call because the child would be hit with a belt.

A few hours later a school social worker made a report to the Hotline after having a meeting with the parent. Parent admitted to hitting the child with a belt several months ago and making the child kneel for extended periods of time. The OCA applied the SDM to the information received through the report narrative and determined it met the criteria for an investigation. The OCA contacted DCYF and requested this Screen Out be upgraded for investigation. The OCA upgrade was denied twice by two different CPS Administrators.

The first CPS administrator stated "*the reporter provided no evidence of an Inflicted physical injury, nor a Suspicious physical injury, nor Physically excessive/inappropriate discipline "… "there was no evidence the parent struck the child to a degree it resulted in an injury to the child. While it is unfortunate that our society permits any form of corporal punishment as discipline, the reality is that is permitted within limits designated by law and policy."*

Additionally, this administrator stated, *"Further, information in the call stated that the father acknowledged that he made the child kneel for 'extended periods of time.' This information only comes to light because the father affirmed it and there is no evidence of the child being physically harmed*."

The OCA continued to advocate for an investigation based on the application of the SDM because the information met several criteria under application of the SDM. The OCA was again informed this case did not meet the criteria for an investigation by the second CPS Administrator. This administrator stated, "Based on Rhode Island General Laws 40-11-2 and DCYF CPS Intake and Screening policy, the information available at the time of the Hotline call did not establish reasonable cause to suspect that the child was currently experiencing abuse or neglect or was at substantial risk of harm requiring a CPS investigation. Accordingly, the threshold for investigation was not met at the time of screening."

The OCA remained adamant this case should be upgraded to an investigation, citing applicable criteria within the SDM. Two months later, after the DCYF Director was included on the email correspondence, the case was upgraded to an investigation. The CPS Administrator stated,

"CPS Administration has completed an additional review of this report with the Director, including the full information available at the time of intake and application of the Structured Decision Making (SDM) framework.

As you know, screening determinations require careful consideration of the information available at intake and whether that information establishes reasonable cause to suspect abuse, neglect, or risk of harm. These decisions are not always clear-cut, particularly in cases involving reported disciplinary practices and limited detail regarding timing or frequency.

Upon further review and considering the totality of the information—including the child's expressed fear of being physically disciplined and the caregiver's admission to prior use of a belt and **prolonged kneeling**—CPS has determined that this report meets the threshold for additional assessment. The report will be **upgraded for investigation** to better understand current conditions and ensure the child's safety.

We also recognize that this case reflects the type of scenario that benefits from continued alignment in how SDM criteria are applied, particularly with respect to emotional harm and the assessment of ongoing risk when historical conduct is reported. CPS is actively working to strengthen internal quality assurance processes and guidance to support consistency in screening decisions moving forward.

We appreciate OCA's engagement on this matter and our continued collaboration."

CPS Case Summary #5:

A school social worker placed a call to the Hotline with concerns for a nine (9)-year-old child. The reporter indicated that the medically fragile child, who had an IEP, was absent for 110 days. A sibling in the family had a developmental diagnosis, similar absences, and required specialized services in school including occupational, physical, and speech therapies.

This family was indicated a few months prior to the calls for medical neglect involving both children. The indicated Family Functioning Assessment (FFA)[22] noted parents were uncooperative with DCYF's interventions and minimized the treatment recommendations.

The OCA applied the SDM to the information received through the two report narratives and determined they both met the criteria for an investigation. The OCA contacted DCYF and requested this Screen Out be upgraded for investigation. DCYF agreed it met criteria, upgraded to an investigation and the case was subsequently indicated and opened to the FSU Division for further family assistance.

CPS Case Summary #6:

A call was placed to the Hotline by a local police department. Police reported three children ages four (4), six (6), and seven (7) witnessed an incident of domestic violence. According to the report, father came home intoxicated, yelled at everyone to move out, threatened to shoot everyone, and then began destroying objects in the home. The OCA applied the SDM to the information received through the report narrative and determined it met the criteria for an investigation. The OCA contacted DCYF and requested this Screen Out be upgraded for investigation. DCYF agreed it met criteria, upgraded to an investigation, and the case was subsequently indicated.

As of January 2026, the OCA's concerns regarding CPS screening practices became more dire due to the severity of allegations being screened out, coupled with delays in DCYF's response to concerns elevated by the OCA. The OCA raised significant concerns that the SDM was not being applied as intended and that calls involving significant allegations of abuse and/or neglect were being screened out contrary to the applicable criteria. The OCA repeatedly elevated these concerns to DCYF Administration and acknowledges that DCYF's timely responsiveness greatly improved, however, the concerns related to screening practices remain.

The OCA's concerns focused on statutory compliance, adherence to DCYF policy, and fidelity to the SDM. These requirements exist to ensure that allegations of abuse and neglect are assessed

[22] DCYF's Glossary of Terms states "The Family Functioning Assessment (FFA) is the first face-to-face assessment with a family for determining whether children are in Present or Impending Danger. A report that has been screened in for assignment is assessed by a child welfare agency. The FFA process includes interacting with a family for the purpose of assessing factors or conditions that are known to result in child abuse or neglect; to make a maltreatment determination or finding; to assess family conditions that create Present Danger and/or created Impending Danger; to identify family strengths; to evaluate enhanced and diminished Caregiver Protective Capacities; to reconcile information contained in the reports about alleged child abuse and neglect and alleged threats to child safety; to make a conclusion regarding the existence of Present and/or Impending Danger; to determine the need to open a case for ongoing FSU Services; and to establish the least intrusive, most effective Safety Plan."

consistently and that children are not placed at unnecessary risk because a report was screened out without appropriate consideration of all available information.

The OCA supports DCYF's goal to strengthen families and prevent unnecessary or further involvement with the child welfare system. However, that goal cannot supersede DCYF's obligation to comply with the law, follow internal policies and procedures, and consistently apply the SDM to fidelity. Appropriate and thorough screening is essential to achieving both family preservation and child safety.

The outcomes of cases reviewed by the OCA further validate the significance of these concerns. Many of the Screen Outs referred by the OCA for reconsideration are subsequently upgraded to investigations, and those investigations have often resulted in indicated findings. These outcomes reinforce the need for consistent application of the SDM and raise questions about whether the Hotline's screening process is reliably identifying reports that meet the threshold for investigation.

Although the OCA recognizes and appreciates DCYF's efforts to address the concerns raised in individual cases brought to their attention, this does not resolve the broader systemic concerns identified by the OCA. The OCA continues to find inconsistencies in the application of the SDM and DCYF DOPs. In addition to correcting individual decisions after they are challenged, a consistent screening process must be prioritized to ensure that CPS staff and supervisors are consistently applying the same decision-making framework at the point of intake.

Evident Change, the developer of the SDM model, assisted DCYF with its implementation in Rhode Island and provides technical assistance specifically designed to support fidelity to the model. The OCA recommends that DCYF reengage Evident Change to assess and strengthen implementation and use of the SDM by DCYF. Independent technical assistance would provide an opportunity to identify the source of inconsistencies, reinforce staff and supervisory expectations, and ensure that reports of abuse and/or neglect received by the Hotline are screened in a manner that is consistent, evidence-based, compliant with law and DCYF policy, and protects children.

In the 2017 report, the OCA cautioned that the SDM may not have been implemented in its entirety and emphasized that failure to implement the tool with fidelity could result in "ineffective results," because the evidence-based model must be implemented in its entirety to be effective. The OCA continues to observe concerns consistent with that finding. DCYF relies on the SDM model to screen and assess reports received through the Hotline, while utilizing the SAFE model (developed by Action 4 Child Protection) to conduct investigations and subsequent ongoing family functioning assessments. Since the implementation of these two distinct models, the OCA has repeatedly raised concerns regarding the use of different frameworks

across the child welfare continuum and the potential impact on consistency, continuity, and outcomes. The concern remains whether each model is being implemented as designed, applied and used to fidelity, and whether the transition between models supports a coherent, evidence-based approach to child safety, family assessment, and service delivery. The OCA recommends DCYF reengage with Action 4 Child Protection and Evident Change to evaluate whether the current implementation of both models is achieving the intended outcomes and whether additional technical assistance is needed to ensure that evidence-based practices are applied consistently and effectively.

c. Designating Calls to CPS as a Screen Out or Additional Information

It is important that calls to the Hotline be designated appropriately. Specifically, determining whether a report should be designated as a Screen Out or as Additional Information. Distinguishing between a Screen Out and Additional Information is critical because pursuant to 214-RICR-20-00-1(1.6)(H)(1)-(2):

> "All reports to the Hotline are electronically recorded and maintained for a minimum of three (3) years in a central registry.
>
> 1. Any person who has been reported for child abuse and/or neglect (CA/N) and who has been determined not to have neglected and/or abused a child, will have his or her record, relative to that incident, expunged three years after that determination.
> 2. Additionally, any report made to the Hotline that does not meet the criteria for a CPS investigation is expunged after three (3) years."

When reports providing Additional Information are made to the Hotline and are subsequently screened out during a pending investigation, the Additional Information provided will be deleted in the Rhode Island Children's Information System (RICHIST)[23] system after three (3) years, even if the allegations in the pending investigation are indicated.[24]

DOP 500.0030 titled Additional Information and Duplicate Reports, states that "[a]n Additional Information Report is used by a Call Floor worker when another report is received concerning the same incident of child abuse or neglect (CA/N). It is also used when an investigation is pending and a report is made to the call floor about an incident which happened prior to the

[23] DCYF's Glossary of Terms states "The Rhode Island Children's Information System (RICHIST) is the Department's automated information system to record our work on behalf of our clients and the state. It is the required method of documenting the Department's work. RICHIST includes information relating to: Individuals and families (services management), Client services (provider management), Finances (financial management) and Staff (staff management."

[24] 214-RICR-20-00-1(1.6)(H)(1)-(2)

date and time of the oral report on a pending investigation. For currently active investigations, a Child Protective Services (CPS) Report is generated to include the new reporter and/or allegation(s)."

According to the DOP, when Additional Information is reported to the Hotline it is: "assigned to the appropriate Investigative Unit for use in the ongoing investigation if:

a. The reporter and the allegations made are exactly the same as the previous report.
b. The involved subjects (perpetrator and victim) are the same as the previous report.
c. The same incident is being reported by a different reporter.
d. The same incident is being reported but new allegations are being made.
e. The same incident is being reported but new involved subjects (perpetrator/ victim) are being added.
f. An incident is reported which happened prior to the date and time of the oral report on the pending investigation.
g. The information provided alters the data currently on file in RICHIST.

2. For Additional Information Reports the CPS report is process as follows:

a. The report is linked to the existing case.

b. The case is assigned by the Call Floor Supervisor to the appropriate Investigative Unit for use in the ongoing investigation.

c. The assigned Child Protective Investigator (CPI) links the report to the pending investigation."

In addition to documentation concerns, when reports of additional information are designated as a Screen Out, it is unclear whether the same process outlined above would be followed allowing the assigned CPI to assess and address all pertinent information.

Proper designation and documentation of reports to the Hotline ensure that additional information provided to DCYF is received by the assigned CPI during a pending investigation and that this information is appropriately reviewed and followed up on during the investigative process. When calls are screened out, the applicable DOPs do not indicate that the current CPI is made aware of additional information pertaining to pending allegations under investigation. Therefore, there is a risk that the information will not be included in the completed FFA.

DOP 500.0030 also outlines that a Duplicate Report "is used only when a report is made alleging a similar incident to the one which has already been investigated and closed. For closed investigations, the same allegation must pertain to a previously investigated CA/N incident to

be considered a Duplicate Report." The DOP goes on to outline the procedure for addressing a Duplicate Report which states, "[a] Duplicate Report (which always pertains to a closed investigation) is processed as a CPS Report." It goes on to state that "if the report contains no new allegations or new involved subjects, the CPS report is processed as follows:

a. The CPS report is forwarded to the Call Floor Supervisor.
b. The Call Floor Supervisor reviews the CPS report for accuracy, accepts the report, and closes the case."

According to the SDM, Duplicate Reports are defined as "information received by DCYF is currently being investigated or has been investigated previously and there is no new information." The SDM prompts CPS to Screen Out these reports.

The SDM definition of a Duplicate Report directly conflicts with DOP 500.0030. The SDM prompt to screen out the report also conflicts with the more in-depth process outlined in DOP 500.0030, which states:

"1. A Duplicate Report (which always pertains to a closed investigation) is processed as a CPS report.

2. If the report contains no new allegations or new involved subjects, the CPS report is processed as follows:

a. The CPS report is forwarded to the Call Floor Supervisor.

b. The Call Floor Supervisor reviews the CPS report for accuracy, accepts the report and closes the case.

3. The Duplicate Report must be reviewed by the Call Floor Supervisor and if necessary, the Chief, Child Protective Investigator or his/her Administrative designee.

4. If the report contains new allegations which meet the criteria for investigation, a new CPS report is processed."

Ensuring that DOPs and the standardized tools being utilized are consistent is paramount, promoting standardized responses when staff are making decisions regarding calls to the Hotline and streamlines the process for supervisory review.

d. Screen Out Documentation for CPS

DOP 500.0000 provides that when a report does not meet the criteria for a CPS investigation, the CPI screens out the call and documents the decision in the DCYF's electronic case management system. DOP 500.0000 also outlines the requirement for call floor supervisory approval of screen-out decisions. Screen Outs must undergo multiple levels of review, particularly when there is a prior history with DCYF. This includes review and approval by the call floor supervisor and subsequent review by CPS Administration.

During the Panel's case reviews and the OCA's internal review process, it was consistently observed that documentation supporting screen out decisions was insufficient. In many cases, the RICHIST case notes contained only the notation "screen out" or "SO," with no explanation of the facts considered, the application of screening criteria, or the rationale for determining that the report did not warrant an investigation.

Documenting the basis for a screen out decision is a required component of the assessment for CPS staff completing the SDM. However, neither DOP 500.0000 nor related guidance establishes minimum documentation standards or clearly defines the information that must be recorded to support the decision. As a result, documentation practices are inconsistent and frequently fail to provide sufficient information for meaningful supervisory review or subsequent quality assurance.

Given that screen out decisions are subject to multiple levels of administrative review and may later be examined during critical incident reviews and oversight activities, complete and concurrent documentation of the screening rationale is essential. Without adequate documentation, reviewers cannot independently assess whether the SDM criteria were appropriately applied, whether the decision was supported by the available information, or whether supervisory approval was based on a complete understanding of the circumstances.

e. Inconsistent Application of Investigative Standards as Required by Rhode Island General Law, DCYF Regulations and DCYF Operating Procedures

Significant inconsistencies in how investigations were conducted were identified in multiple cases, raising concerns regarding the consistency and quality of investigative practices. R.I.G.L. § 40-11-3 requires “[a]ny person who has reasonable cause to know or suspect that any child has been abused or neglected as defined in § 40-11-2, or has been a victim of sexual abuse by another child, shall, within twenty-four (24) hours, transfer that information to the department of children, youth and families, or its agent, which shall cause the report to be investigated immediately. As a result of those reports and referrals, protective social services shall be made available to those children in an effort to safeguard and enhance the welfare of those children and to provide a means to prevent further abuse or neglect.”

In 2019, DCYF implemented the Safety Assessment and Family Engagement (SAFE) practice model, a "comprehensive, safety decision-making model and intervention framework." The SAFE model is a "strengths-based, family-centered, and trauma-informed model to inform child welfare agency decision-making." Further, the model utilizes "standardized tools and decision-making criteria to assess family behaviors, conditions, and circumstances, including individual child vulnerabilities and Caregiver Protective Capacities." When completing an investigation DCYF uses the FFA, designed by the SAFE practice model. In a number of cases, the Panel raised concerns about conducting investigations with fidelity to the SAFE model, specifically regarding interviewing relevant persons, verification of reported information, home observations, proper documentation, conducting comprehensive assessments, and timeliness of completed investigations.

During an investigation, the CPI is responsible for collecting, corroborating, and assessing information obtained from multiple sources and individuals to develop a comprehensive understanding of the family's circumstances and child safety concerns. R.I.G.L. § 40-11-7(a) requires that "the investigation shall include personal contact with the child named in the report and any other children in the same household... The interviewing of the child or children, if they are of the mental capacity to be interviewed, shall take place in the absence of the person or persons responsible for the alleged neglect or abuse." This requirement is also outlined in DCYF Regulations pursuant to 214-RICR-20-00-1, Section 1.9. Further, DOP 500.0025 titled Assessing Reports of Child Abuse and Neglect and Child Safety Determinations states that one of the objectives of the FFA is to "gather thorough information involving relevant family members."

The SAFE model has an Information Collection Protocol which states that "the Investigator conducts sufficient numbers of interviews of sufficient length and effort necessary to ensure that due diligence is demonstrated, and sufficient information is collected to assess Impending Danger. Diligence refers to conscientiousness apparent in all aspects of intervention with respect to thoroughness, timeliness, availability, and responsiveness." While the SAFE Model does not prescribe the exact number of individuals who must be interviewed or identify specific persons who must be contacted in every investigation, it clearly requires investigators to exercise due diligence in gathering sufficient information to conduct a comprehensive assessment of child safety.

However, DOP 500.0025 titled Assessing Reports of Child Abuse and Neglect and Child Safety Determinations, clearly outlines the expectations for investigative contacts and documentation when completing an FFA. Specifically, the DOP outlines in Section III. (D) which requires, in relevant part under Contact and Documentation:

> "d. Interview the victim face-to-face as soon as possible within the response priority timeframes.

e. Document attempted contact and contact with the victim in an investigative note within one business day.

f. Interview each involved adult, including the alleged perpetrator and caregiver, as soon as possible after the victim interview.

g. Interview individually all other children who resided in the household or were present in the childcare facility at the time of the alleged incident.

h. Confirm the whereabouts of any other child of the parent or guardian who did not reside in the household at the time of the alleged incident when the alleged perpetrator is the parent or guardian.

i. Interview other adult household members or facility staff.

j. Interview any known witnesses or individuals who may have knowledge relating to the incident.

i. If the witness is a minor and not a victim or related to the alleged perpetrator/victim, arrange contact through the child's parent or legal guardian unless it would cause immediate danger to the alleged victim

ii. The parent or legal guardian may be present during the interview, which should be conducted in an age-appropriate manner.

iii. If the parent or legal guardian is unavailable, the interview occurs in the presence of a familiar and comfortable adult.

k. Document all interview contacts in the Department's electronic case management system in accordance with DOP: 500.0065: Documenting Results of Child Protective Services Investigations in RICHIST."

Further the DOP continues to identify the professional contacts that should be made during an investigation, including:

"a. Interview at least two other individuals with first-hand knowledge of the incident or the family's circumstances.

i. For Level 1 investigations, these contacts must include two professionals

ii. For Level 2 investigations, these contacts must include two professionals."

In at least eight (8) of the cases reviewed by the Panel, critical issues were identified with investigations, which did not adhere to the Information Collection Protocol outlined in the SAFE model, R.I.G.L., DCYF Regulations or applicable DOPs. The Panel identified multiple investigative

deficiencies, including failures to verify information received during the investigation, interviewing all individuals with relevant knowledge of the events preceding the fatality, interviewing age-appropriate children residing in the household, and adequately documenting investigative activities, findings, and decision-making.

The SAFE model states that the purpose of the FFA is to "determine who the Department of Children, Youth and Families (DCYF) will serve, by assessing and reaching conclusions about caregivers who are unable or unwilling to protect their children from Impending Danger." The manual goes on to list the objectives of the FFA, which are:

- "To respond promptly according to content contained within the child abuse report;
- To inform reported individuals of a community concern for the safety of their children;
- To engage caregivers in a process that provides a picture of the family and reveals whether children are in danger;
- To meet emergency needs that are apparent at the onset or during the FFA;
- To conduct a structured, thorough information collection process that includes relevant family members;
- To keep caregivers informed and appropriately involved in case decision making;
- To reach a finding regarding the existence of child maltreatment consistent with DCYF policy and state statutes;
- To reconcile reported allegations;
- To conduct a family-centered assessment; and
- To establish a sufficient, least intrusive Impending Danger Safety Plan when children are determined to be in Impending Danger."

The SAFE Model requires investigators to complete a comprehensive, family-centered assessment to identify the needs of all household members and evaluate how those needs affect a caregiver's unwillingness or inability to protect their child from impending danger. However, the Panel found that this standard was not consistently met. In multiple investigations, particularly those involving families with complex and overlapping needs, the FFA was narrowly focused on the incident that prompted the report to the Hotline rather than a comprehensive assessment of overall family functioning.

Specifically, the SAFE model requires assessment and analysis across four areas when analyzing family strengths and child safety including:

1. "The extent of and surrounding circumstances accompanying the maltreatment;
2. Child functioning on a daily basis;

3. Adult functioning with respect to daily life management and general adaptation (including mental health functioning and substance usage);
4. The disciplinary and overall general parenting practices used by the caregiver."

The Panel identified investigations involving children with significant behavioral health needs, caregivers participating in anger management services, and caregivers with serious mental health concerns where the assessment failed to evaluate how these factors collectively affected caregiver protective capacity and child safety. Rather than assessing the family as an interconnected system, investigations frequently focused on resolving the specific allegation, after which the CPI concluded the investigation and rendered findings without fully considering the broader needs, risks, and functioning of the household.

As a result, the intended purpose of the family-centered assessment was not achieved in some cases, leaving significant needs and risk factors unidentified or insufficiently addressed. The Panel also found that, when subsequent Hotline reports resulted in new investigations, CPIs frequently completed new FFAs that focused solely on the new or repeated allegations without adequately reviewing or incorporating findings from prior FFAs. This fragmented approach prevented investigators from developing a complete understanding of family history, functioning, and cumulative risk factors, undermining the comprehensive assessment required by the SAFE model. The Panel found that, despite the implementation of the SAFE model, in some instances investigative practice remained incident-focused rather than evolving into the comprehensive, family-centered approach the model was intended to establish.

In two (2) cases, DCYF did not physically enter or observe the home during an investigation, which the Panel deemed to be a critical error in practice. In accordance with DOP 500.0025, a CPI must "...[m]ake an unannounced initial visit to the home or childcare facility unless the family is aware of the allegation and the Department's involvement, and the visit is planned.

i. The initial assessment should occur at the family's home as well as any other location where the abuse/neglect allegedly occurs..."

Visually assessing the household where the child lives is of the utmost importance to ensure thorough information collection and to adequately assess for safety and risk.

The SAFE model has been chosen by DCYF to conduct "strength-based, family-centered, and trauma-informed" assessments of families to ensure the safety of children in Rhode Island. It is imperative that staff are appropriately trained and supervised, the model be followed to fidelity, and that DCYF utilize all opportunities for technical assistance to support all staff, supervisors, and administrators in utilization while ensuring compliance with relevant statutes, regulations and policies.

In addition to identified issues with CPS screening and investigative practices, an in-depth review of CPS practices has identified other emerging patterns which are important to address, including:

1. Timeliness of completed investigations. A review of CPI caseloads illustrated a lack of compliance with investigative timelines outlined in DCYF regulations, DCYF policy and in accordance with the SAFE model.[25]
2. Reopening previously completed FFAs when information received meets the criteria for a new investigation. This practice is not outlined in the DCYF DOPs and does not seem to adhere to the applicable practice models. Failing to complete a full assessment could negatively impact the process with the family. This also raised concerns regarding the impact of this practice on federal re-maltreatment reporting requirements.
3. Inadequate supervisory and administrative oversight when approving pending investigations, specifically a lack of review to ensure compliance with applicable standards, policies and law.
4. CPI caseloads exceeding national best practice standards. DCYF achieved national accreditation through the Council on Accreditation (COA) on February 14, 2025. The COA's standard suggests that CPI caseloads "generally do not exceed 12 active investigations at a time, including no more than 8 new investigations per month."[26] As of August 27, 2026, seventeen (17) of the seventy (60) CPIs with active caseloads, or twenty-eight percent (28%), were carrying caseloads that exceeded the COA standard by a significant margin. The caseloads for these seventeen (17) CPIs were as follows:

CPI	TOTAL NUMBER OF ACTIVE INVESTIGATIONS
CPI #1	15 active investigations
CPI #2	20 active investigations
CPI #3	15 active investigations
CPI #4	19 active investigations
CPI #5	21 active investigations
CPI #6	19 active investigations
CPI #7	13 active investigations
CPI #8	20 active investigations
CPI #9	19 active investigations
CPI #10	18 active investigations
CPI #11	14 active investigations
CPI #12	24 active investigations

[25] See: 214-RICR-20-00-1, Section 1.9; DOP 500.0025; DOP 500.0070; DOP 500.0065.
[26] 90-day COA Maintenance Report 12.29.25.pdf

CPI #13	15 active investigations
CPI #14	20 active investigations
CPI #15	18 active investigations
CPI #16	14 active investigations
CPI #17	14 active investigations

Carrying caseloads above best practice standards may significantly impact the investigator's ability to complete thorough and timely investigations in accordance with relevant policies, regulations, best practice standards, and R.I.G.L.

5. CPS staffing on all shifts.
    a. Cases reviewed by the Panel illustrated that limited weekend staffing resulted in only one CPI being assigned to a child death investigation and back-to-back assignments of a CPI to child fatality investigations.
6. Qualifications and experience of CPIs at the time of hire. Given the complexity of the CPI's role and responsibilities, prior experience within the child welfare system of prior investigative experience should be explored as a required qualification. Further, it is important to assess whether the qualifications and experience of newly-hired CPIs may be contributing to the high rate of turnover within the unit.
7. Enhanced training and supervision to support CPS staff, particularly in light of varying levels of experience and the complexity of their responsibilities.

The Panel recommends that DCYF conduct an in-depth assessment to determine the impact of caseloads, staffing, supervision, and training.

f. DCYF Response to OCA Concerns

The OCA continues to express the need for urgent action to address systemic concerns impacting the safety and well-being of children with DCYF Administration. In May 2026, the OCA elevated these concerns further and requested that DCYF provide a written corrective action plan to address these concerns. On June 1, 2026, the OCA received a written response from DCYF Administration regarding the concerns about ongoing CPS practices, an overview of national screen out and screen in data, an overview of child fatality data, and how DCYF planned to address these concerns.

An overview of national data provided by DCYF describes that Rhode Island's current number of screened out and screened in calls is in line with national findings. However, as noted in DCYF's correspondence, screening percentages alone are not an indicator of child safety performance given the significant differences in state laws, policies, and screening practices.

Consistent with OCA assessments and affirmed in DCYF's response, the more relevant question is "whether a jurisdiction's screening decisions are consistent, legally grounded, evidence-informed, appropriately supervised, and paired with pathways to support families when formal CPS investigation is not the appropriate response." Foundational safeguards are lacking and urgent, systemic reform is needed in our state.

DCYF referenced the importance of distinguishing concern from causation noting that screening volume alone will not improve outcomes for children and families. The OCA agrees and also remains concerned about whether DCYF is consistently applying the relevant assessment tools, laws, policies, and regulations with fidelity when making screening and response decisions. The goal is to maximize child safety through sound decision-making, consistent practice, appropriate intervention, and meaningful access to services when a formal CPS investigation is not warranted.

The Panel and the OCA strongly support prevention efforts to limit unnecessary family involvement with DCYF. However, current approaches to prevention are falling short. While significant resources and public funds have been invested to develop and procure a robust array of prevention services, the state must prioritize appropriate assessment and meaningful opportunities to access services for families who can benefit. Ultimately, the issue is not whether DCYF conducts more investigations, but whether children and families are receiving the right response, at the right time, based on sound, consistent, and legally grounded decision making.

In response to the OCA's concerns, DCYF noted they would be taking the following action steps:

1. Daily CPS administrative review of screen-out decisions.
2. Executive level bi-weekly oversight meetings with CPS leadership.
3. National technical assistance and cross-jurisdiction learning. This was further explained as a request for a webinar with the National Partnership for Child Safety and Casey Family Programs.
4. DCYF to work with Casey Family Programs to develop a formal hotline quality assurance framework. It was noted that this would be in place no later than August 1, 2026. As of the date of this report, the OCA has not been notified that this has been implemented.
5. DCYF to work directly with Evident Change for technical assistance, staff development and enhanced quality monitoring.

6. DCYF to have the Division of Performance Improvement independently pull a random sample of investigations and Hotline decisions to provide "neutral review, feedback, and quality assessment outside of direct CPS operational supervision."
7. Additional call floor training and certification opportunities to strengthen practice consistency and decision-making quality.

DCYF indicated that they are committed to moving these action steps forward. While these action steps represent movement in the right direction, additional measures are necessary to establish greater clarity, consistency, and accountability within the system. Ensuring alignment with laws, regulations, and policy and assessment tools is critically important. The proposed plan does not specify whether DCYF intends to evaluate the appropriateness and effectiveness of the SDM tool itself; a critical step in determining whether the SDM tool is functioning as intended and effectively aligns with the SAFE model that guides CPS investigations. Although CPS Administration has conducted individual case reviews for years, the persistence of inconsistencies raises important questions about the effectiveness of this existing oversight process and why identified issues have not resulted in sustained practice improvements. Further examination of these underlying issues is imperative. Finally, the Panel recommends greater specificity regarding the proposed action steps, including clear expectations, timelines, accountability measures, and methods for assessing implementation and effectiveness. These issues are further addressed in the recommendations that follow.

II. THE SUPPORT AND RESPONSE UNIT (SRU)

a. Lack of Clear Standards Governing Prevention Responses and SRU Referrals

DCYF established SRU in 2020 to help connect children and families to necessary supportive services without having to engage in formal child welfare involvement.[27] The Panel fully supports these prevention efforts promoting the philosophy that children and families should, whenever safe and appropriate, receive supports and services within their homes and communities. Prevention interventions should strengthen family functioning and prevent unnecessary or continued involvement with the child welfare system.

Case reviews identified inconsistencies in the referral of screened-out families to SRU. While some families with identified service needs were referred to SRU for preventive supports, other similarly situated families were screened out without a referral, despite presenting with comparable needs. These inconsistencies suggest that referral decisions are not being made

[27] https://dcyf.ri.gov/programsinitiatives/support-and-response-unit-sru

consistently and may result in missed opportunities to connect families with available community-based services before concerns escalate.

DOP 700.0190 titled Support and Response Unit, notes that calls are referred to SRU when "reports are made to the CPS Hotline that do not meet the criteria for a CPS Investigation but do meet the requirements for a prevention response" and references that a caller requesting assistance or services from DCYF can also be referred to SRU. The policy refers the reader to DOP 500.0015 titled CPS Hotline Call Screen-Outs for additional information. However, DOP 500.0015 is not entitled "CPS Hotline Call Screen-Outs" it is entitled "Screen-Out Reports Requiring a Response".

DOP 500.0015 titled Screen-Out Reports Requiring a Response, notes that for cases that are "...not currently open with the Department, referrals may be made to the Support and Response Unit (SRU) to address the family's service needs. These cases typically involve families who would benefit from assistance in navigating community services and ensuring the child's or family's needs are met." This policy refers the reader to DOP: 700.0190: Support and Response Unit for additional details.

Although both operating procedures reference one another for additional guidance, neither policy defines what constitutes a "Prevention Response" or establishes the specific criteria, requirements, and procedures governing its use. This lack of policy direction creates a significant gap in practice and oversight, as critical screening and referral decisions are left largely to individual interpretation rather than guided by clear, standardized expectations.

As a result, families who may benefit from preventive services are not consistently identified and referred to SRU. The absence of clear standards also limits supervisory oversight and accountability, making it difficult to evaluate whether Prevention Responses are being appropriately utilized. The OCA raised concerns regarding the lack of clear eligibility criteria with DCYF Administration in February 2025.

The SDM, specifically refers workers to the SRU policy for eligibility criteria when deciding whether a Prevention Response is warranted. However, the eligibility criteria are not outlined within the policy.

The lack of consistent referral to SRU for families who may benefit from prevention services compounds the Panel's concerns regarding CPS screening practices when calls are screened out without an appropriate investigative response. When reports are screened out, including instances in which screening decisions may be inappropriate, there is no mechanism to ensure that families are consistently referred to SRU or connected with available community-based

supports. Consequently, opportunities for early intervention may be missed, family needs may remain unaddressed, and children may be placed at increased risk of harm and future involvement with the child welfare system.

In one 2024 case reviewed by the Panel, a call was made to CPS by a mother seeking help with housing and mental health supports. Documentation indicates that the call floor worker advised mother they would refer the case to SRU but there was a chance it may not be approved by the CPS Hotline Supervisor. This specific instance raised concerns for the Panel. Without clearly defined criteria, call floor workers do not have guidance on how to assess and determine whether a family should be referred to SRU. The DOP does not outline multiple layers of review before a family can be referred to SRU for assistance. In this instance, a parent self-reported to the Hotline, seeking help and connection with services, which is the very purpose of SRU.

The Panel also recognizes that opportunities to connect families with preventive services extend beyond screened-out Hotline reports. Families under CPS investigation may not ultimately require ongoing child welfare involvement because the allegations do not meet the statutory threshold for abuse or neglect. However, these families may have identified needs that could be effectively addressed through voluntary, community-based prevention services. The Panel encourages DCYF to evaluate existing referral practices to determine if they adequately identify and connect families to available prevention services, ensuring that families with identified needs are not overlooked simply because they do not meet the threshold for ongoing child welfare involvement. These families may benefit from a connection to SRU to help coordinate referrals and address service needs.

The OCA reviewed Hotline calls assigned a Prevention Response between January 1, 2026 and June 30, 2026 to better understand the trajectory of SRU referrals and assess response times, assessment practices, engagement, and documentation. The review was limited to the CPS daily call log and included an evaluation of every call identified as receiving a Prevention Response due to available information. DCYF does not maintain a daily call log specific to SRU, therefore the OCA was unable to identify and review all referrals actively being served by SRU during this period. Development of a centralized tracking and reporting system for SRU referrals is recommended to support ongoing monitoring, quality assurance, and program oversight.

The independent case review identified several instances in which, following a determination that a referral would receive a Prevention Response, there was no documented evidence of any engagement with the family. In these cases, there was no documentation to show that an SRU caseworker had been assigned. Furthermore, the case records contained no documentation

explaining the absence of a response, such as an administrative decision to discontinue or not pursue the referral as a Prevention Response.

SRU Case Summaries Identified

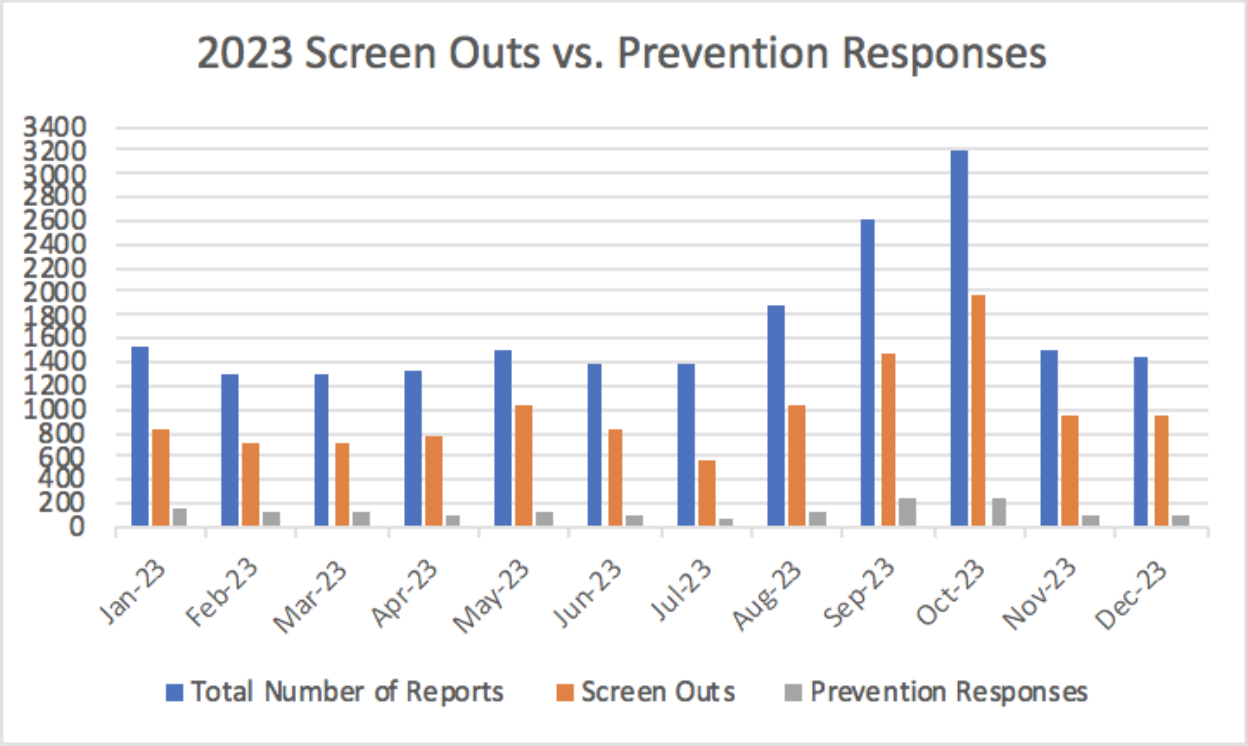
SRU Case Summary #1: A community provider working with a family contacted the Hotline with concerns regarding the safety of a child due to mother's ex-boyfriend breaking into the home numerous times. There was a documented history of domestic violence. Mother indicated she would not have otherwise contacted the police after these incidents.

SRU Case Summary #3-6: In February 2026, the Hotline received four (4) calls regarding families seeking assistance and support with housing, living in their vehicles with their children. All four (4) calls were assigned a Prevention Response by CPS and none of the cases were assigned to an SRU worker. There was no documentation to show that a formal assessment had been completed or supporting the determination that connecting these families with necessary services and supports was not needed.

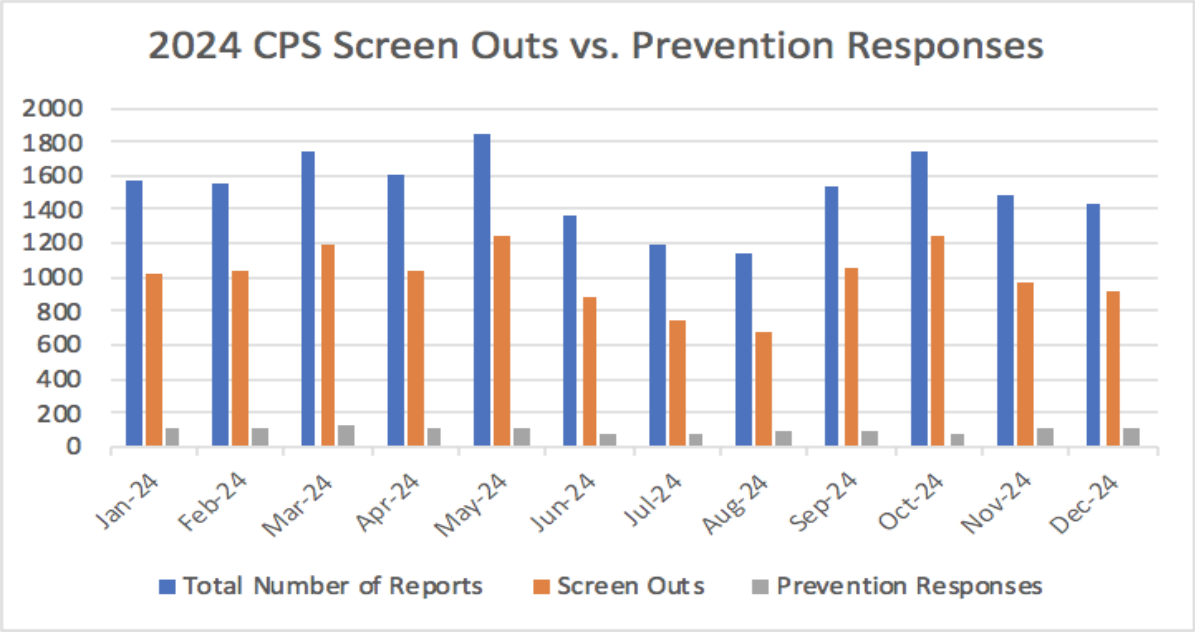
SRU Case Summary #7*:* Mother contacted the Hotline for assistance because she was living in a hotel with her child but was being evicted. There was an extensive write-up indicating mother had called previously, exhibited erratic behavior, and struggled with impulse control. Mother's parental rights for other children were terminated through a petition filed by DCYF. CPS referred the call for a Prevention Response. An SRU worker was not assigned. There was no evidence documenting how this determination was made and no additional follow up with the family.

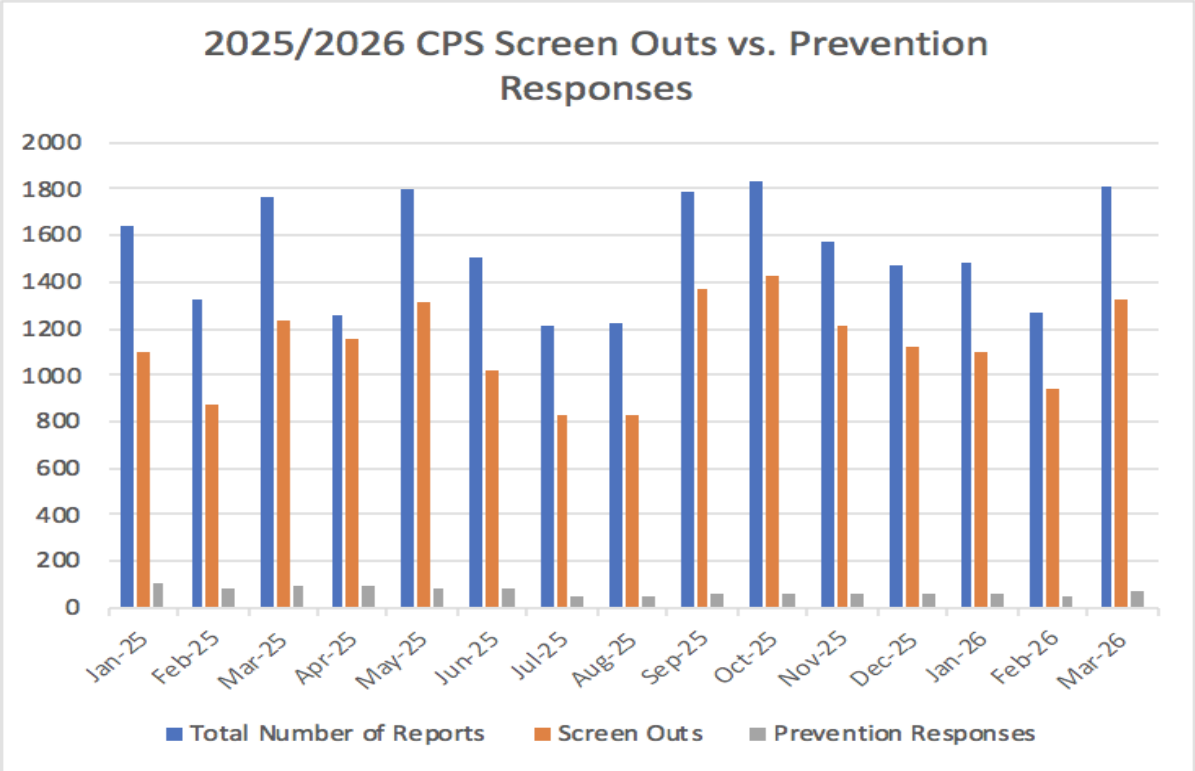
SRU Case Summary #8: A child welfare worker from another state called the Hotline to report allegations reported to their state a few months prior. The worker reported that mother's 8-month-old child had rolled off the bed and fallen onto the floor and had a mark on their head. Mother did not take the child to be medically evaluated until DCF became involved. The medical provider found mother's story about the injury to be inconsistent. Additionally, there were reported concerns about mother's partner and baby's father. It was reported that he had made mother's 6-year-old child stand outside in the cold for an unknown amount of time to "teach her a lesson." There were also reports that he would flick the 6-year-old in the head when words were said incorrectly due to the child's speech impediment. The DCF worker indicated that they filed a neglect petition against mother, however, mother moved to RI resulting in the closure of the petition in that state. This call was screened out by CPS and flagged for a Prevention Response, yet there was no further engagement between SRU and this family.

The OCA reviewed SRU referral data over the past several years. The data indicated that, while a substantial number of Hotline reports are screened out by CPS, only a small percentage are referred to SRU for a Prevention Response. While not all screened out reports warrant referral to SRU, the declining number of referrals highlights the absence of clearly defined Prevention Response criteria and/or an internal understanding of when cases should be referred for a Prevention Response.



****Note:** The data outlined in February 2023 and March 2023 is duplicated data as the data for February was reported two months in a row.





Note: The data presented are reported by DCYF in their monthly Strategic Metric Dashboard, which historically had been circulated monthly, and made publicly available on the DCYF website. This information is no longer available on DCYF website which states DCYF is redesigning the Strategic Metric Dashboard Report.

As previously noted, the OCA reviews calls to the Hotline to assess whether additional follow-up is required. When the OCA identifies a low rate of referrals to SRU, OCA staff further assess

whether a Prevention Response may be appropriate and follow-up with DCYF when necessary. Here are some examples of cases the OCA has followed up on for Prevention Response:

SRU Case Summary #1:

A call was placed to the Hotline by a school administrator. The reporter provided concerns for a 5-year-old child including poor hygiene, bug bite marks, child reporting they do not have a bed and a rash on their back. Reporter has provided the family with toiletries and clothing. This family has a lengthy history with DCYF.

Based on the history of the family and the concerns noted, the OCA requested this case be designated a Prevention Response and referred to SRU. DCYF agreed this family may require additional assistance and upgraded the call to a Prevention Response.

SRU Case Summary #2:

A call was placed to the Hotline by a doctor from a local hospital reporting concerns about a teenager with a significant history of hospitalizations and numerous documented mental health diagnoses. The youth recently pulled a knife on their parent, had recently been found unresponsive in the road, and reported being sexually assaulted. This family had recently closed to the DCYF and had multiple Screen Outs within a month. Based on the history of the family and the concerns noted, the OCA requested this case be designated a Prevention Response and referred to SRU. DCYF agreed this family may require additional assistance and upgraded the call to a Prevention Response.

SRU Case Summary #3:

A call was placed to the Hotline by a school psychologist stating mother recently called the school requesting help with her 15-year-old child who refuses to go to school. Mother told the school psychologist she hit the child with a stick the week prior to try and get them to go to school. Based on the concerns noted and mother requesting help, the OCA requested this case be designated a Prevention Response and referred to the SRU. DCYF upgraded the call to a Prevention Response.

SRU Case Summary #4:

A call was placed to the Hotline by a school social worker about a 5-year-old child. Reporter stated the child had developmental delays, was non-verbal, and in a specialized classroom. Reporter

further stated child comes to school with a bad smell, dirty, and the school bus driver reported seeing a bed bug and dead cockroach on the child's clothing. Based on the concerns noted, the OCA requested this case be designated a Prevention Response and referred to SRU. DCYF upgraded the call to a Prevention Response.

SRU Case Summary #5:

A call was placed to the Hotline by a teacher reporting a 10-year-old child always had a strong odor of urine and frequently urinates on themself in class, did not acknowledge when this happens and remained seated. The teacher also reported that the child's clothes are too small and the child reportedly has no friends, other than imaginary ones. This family has a history with DCYF, multiple Screen Out reports with concerns for the child's hygiene, and one call included child reporting being scared. Based on the history of the family and the concerns noted, the OCA requested this case be designated a Prevention Response and referred to SRU. DCYF upgraded the call to a Prevention Response.

Without established standards, it is difficult to assess whether families with identified service needs are being consistently considered for preventive services. This lack of guidance contributes to variability in referral practices and increases the risk that families may not be connected to available community-based supports and early intervention services creating missed opportunities for the provision of critical support.

While DOP 700.0190 governing the Support and Response Unit does not provide specific criteria for determining what constitutes a Prevention Response, DCYF regulations do outline a more specific process. DCYF Regulation 214-RICR-20-00-1(1.15)(A)-(D) outlines specifics for a Family Assessment Response using a "standardized screening tool to determine if a report made to the Hotline that contains a concern about the well-being of a child and does not meet the criteria for a child abuse/neglect investigation should be screened in for a family assessment."

The regulation identifies vulnerability factors and risk areas that alert a family assessment response may be necessary including,

1. "Child is age (6) six and under;
2. A caregiver or child's emotional, physical, or developmental condition;
3. Circumstances indicating that the caregiver's protective capacity may be compromised but not to the level of requiring an investigation.
4. A prior report within a twelve (12)-month period involving a family with a child age six (6) or under, or with two (2) or more children.

5. One or more prior reports received on a family within a three (3)-month period;
6. A prior indicated investigation or removal within the past twelve (12) months;
7. Any other risk factors that may compromise the well-being of the child; or
8. Whether the report was called in by a professional mandated reporter."

Although DCYF's CPS regulations were last updated in 2022, after the establishment of SRU, they are not aligned with the Department's current policies and practices for assessing and supporting families presenting with risk factors. The regulations continue to reflect the former Intake Unit model rather than the current SRU framework, resulting in inconsistencies and non-compliance with regulatory requirements. It is recommended that DCYF review and revise its policies and procedures to align with existing regulations or, where appropriate, amend the regulations to accurately reflect DCYF's intended practice and ensure compliance.

Additionally, as noted, the current SRU framework lacks a standardized assessment or decision-making tool to consistently determine whether a family would benefit from a Prevention Response. This absence has contributed to inconsistent decision-making and missed opportunities to identify and engage families who could benefit from early intervention and supportive services. The Panel recommends that DCYF adopt an evidence-based, structured assessment that aligns with the prescriptive criteria and assessment requirements set forth in CPS regulations to promote consistent decision-making and equitable access to prevention services.

Additionally, the adequacy of staffing within SRU should be evaluated to determine whether workforce capacity is affecting referral volume or the unit's ability to serve eligible families. It is recommended that DCYF conduct a comprehensive assessment of staffing needs and ensure that sufficient resources are allocated enabling SRU to effectively fulfill its prevention mission and provide timely support to all families who would benefit from a prevention-focused response.

Lastly, the concerns regarding consistency with SRU are compounded by the screening decisions outlined in the prior section. The Panel identified concerns regarding current CPS screening decisions and whether they are appropriately distinguishing between families who would benefit from a voluntary Prevention Response and families whose circumstances require a more formal child protection intervention. Cases referred to SRU must be carefully evaluated to ensure they do not present levels of risk that warrant a CPS investigation or a more structured response. The practice of screening out reports that may meet the threshold for investigation and referring them to an already resource-constrained prevention unit raises concerns about whether the current model appropriately balances child safety with family support. DCYF should evaluate referral criteria, screening practices, and resource capacity to

ensure families are receiving the level of intervention necessary to effectively address identified risks and protect children.

b. SRU Response Times

Throughout the review process, the Panel identified concerns regarding the timeliness of SRU's response to families. In addition to observations made during the reviews of child fatalities and near fatalities, Panel members reported experiences working with families who encountered delays in receiving outreach after referral, including unreturned telephone calls and prolonged wait times before being contacted by an SRU worker. These experiences raised concerns about the ability of SRU to provide timely engagement and connect families with necessary services during periods when early intervention is most critical. This prompted further examination of SRU response times and their potential impact on service delivery.

DCYF DOP 700.0190 titled Support and Response Unit states, "The SRU administrator, or designee, reviews the referrals daily and assigns the case to an SRU caseworker." Given SRU's operating hours, the Panel interprets this provision to mean that the SRU administrator will review all cases brought to the attention of the SRU each business day and assign those cases on the same business day. However, this section of the policy would benefit from additional clarification to ensure the intended process is clearly articulated.

In accordance with DOP 700.0190 titled Support and Response Unit, an SRU caseworker must contact the parents and child within three (3) business days of being assigned and must meet with the family face-to-face within five (5) business days of case assignment.

The data outlined below was compiled by the OCA from an internal review of screened-out reports referred for a Prevention Response between January 1, 2026, and June 30, 2026. It is important to note that the number of Prevention Responses documented each month in the CPS call log does not align with the number of Prevention Responses in the DCYF Strategic Metric Dashboard Reports.[28] This discrepancy is due to the CPS screening process. Screened-out reports are reviewed daily by CPS Administrators and based on this review, may be upgraded for a Prevention Response. These upgrades occur after the initial call log is generated; therefore, they are not reflected in the daily CPS call log reviewed by the OCA. As a result, the

[28] This data is no longer available on the DCYF website. The website states "DCYF is redesigning the Strategic Metric Dashboard Report to provide meaningful, well-defined measures presented in a reader-friendly format, making the data more accessible and more valuable to stakeholders. The new Strategic Metric Dashboard will be available here in Fall 2026."

Prevention Response totals in the CPS call log may differ from those reported in the DCYF Strategic Metric Dashboard.

January 2026

In January 2026, there were ***sixty (60)*** screen outs sent to SRU for a Prevention Response by the CPS Hotline call floor. Of those, ***six (6)*** cases had no further SRU engagement once designated for a Prevention Response. Of the ***six (6)*** cases, ***three (3)*** were referred back to CPS. In the remaining ***three (3)*** cases, once sent to SRU for assignment, there was no record of SRU assignment or engagement, no documentation to indicate reasoning for lack of assignment, and no documentation of any DCYF follow up with the family.

Of the ***fifty-four (54)*** cases assigned to an SRU worker, ***ninety-three percent (93 %)*** failed to comply with the assignment response times set forth in DOP 700.0190, via a call to the family, and/or a face-to-face visit.

Pursuant to DOP 700.0190, the SRU administrator or designee will review the cases daily for assignment. Based on the hours of operation for SRU, this excludes weekends. Seventy-six percent (***76%)*** of cases assigned to an SRU worker were not assigned within one business day in accordance with the DOP. The assignment timeframes for these cases were as follows:

- Within two (2) business days: ***Twelve (12) cases***
- Within three (3) to four (4) business days: ***Eighteen (18) cases***
- Within five (5) to seven (7) business days: ***Ten (10) cases***
- Within eight (8) to nine (9) business days: ***Zero (0) cases***
- More than ten (10) business days: ***one (1) case***

While most cases assigned to an SRU worker complied with the DOP requirement to reach out to the family within three (3) business days of assignment, ***three (3)*** of the ***fifty-three (53)*** did not comply. Of the ***fifty-four (54)*** cases, ***forty-eight (48%)*** of cases assigned to an SRU worker did not comply with the DOP requirement to conduct a face-to-face visit with the family within five (5) business days of assignment. Additionally, ***five (5)*** cases did not comply with the DOP timeframe of a face-to-face within five (5) business days of assignment, however, documentation described attempts to schedule with the family or rescheduled visits.[29] Additionally, there was ***one (1)*** case where the family declined services and a home visit before one could be scheduled. This case was also not accounted for.

[29] These cases were not accounted for in the ***twenty-six (26)*** cases that did not comply.

February 2026

In February 2026, ***fifty-nine (59)*** screen outs were sent to SRU for a Prevention Response by the CPS Hotline call floor. Of those, ***sixteen (16)*** cases had no further SRU engagement once sent to SRU for a Prevention Response, ***four (4)*** of which were referred back to CPS. ***Two (2)*** of the cases referred back to CPS were assigned to an SRU worker before the decision was made to transfer the case. In the remaining ***twelve (12)*** cases, once sent to SRU for assignment, there was no record of SRU assignment or engagement, no documentation to indicate reasoning for lack of assignment, and no documentation of any DCYF follow up with the family.

Of the ***forty-five (45)*** cases assigned to an SRU worker, ***ninety-six percent (96%)*** failed to comply with the response times for assignment, via a call to the family, and/or a face-to-face visit set forth in DOP 700.0190.

DCYF DOP 700.0190 indicates that the SRU administrator or designee will review the cases daily for assignment. Based on the hours of operation for SRU, this excludes weekends. ***Ninety-six percent (96%)*** of cases assigned to an SRU worker were not assigned within one business day in accordance with the DOP. The assignment timeframes for these cases were as follows:

- Within two (2) business days: ***Seven (7) cases***
- Within three (3) to four (4) business days: ***Eighteen (18) cases***
- Within five (5) to seven (7) business days: ***Fifteen (15) cases***
- Within eight (8) to nine (9) business days: ***Two (2) cases***
- More than ten (10) business days: ***One (1) case***

While most cases assigned to an SRU worker complied with the DOP requirement to reach out to the family within three (3) business days of assignment, ***five (5)*** of the ***forty-five (45)*** cases assigned did not comply with this requirement. Of the ***forty-five (45)*** cases, ***twenty-nine percent (29%)*** assigned to an SRU worker did not comply with the DOP requirement to conduct a face-to-face visit with the family within five (5) business days of assignment. An additional ***seven (7)*** cases that did not comply with the DOP timeframe of a face-to-face visit within five business days of assignment, however, documentation showed attempts to schedule with the family or the visit was rescheduled. Additionally, there were ***five (5)*** cases where the family declined services and a home visit before one could be scheduled.[30]

[30] These ***twelve (12)*** cases were not accounted for in the ***thirteen (13)*** cases that did not comply with the face-to-face requirement.

March 2026

In March 2026, there were ***seventy (70)*** screen outs sent to SRU for a Prevention Response by the CPS Hotline call floor. Of those, ***four (4)*** cases had no further SRU engagement once sent to SRU for a Prevention Response and ***two (2)*** of these cases were referred back to CPS. In the remaining ***two (2)*** cases, once sent to SRU for assignment, there was no record of SRU assignment or engagement, no documentation to indicate reasoning for lack of assignment, and no documentation of any DCYF follow up with the family.

Of the ***sixty-six (66)*** cases assigned to an SRU worker, ***ninety-five percent (95%)*** failed to comply with the response times set forth in DOP 700.0190 which indicates that the SRU administrator or designee will review the cases daily for assignment. Based on the hours of operation for SRU, this excludes weekends. ***Seventy-eight percent (78%)*** of cases were not assigned to an SRU worker within one (1) business day in accordance with the DOP. The assignment timeframes for these cases were as follows:

- Within two (2) business days: ***six (6)***
- Within three (3) to four (4) business days: ***Thirty-three (33)***
- Within five (5) to seven (7) business days: ***Thirteen (13)***
- Within eight (8) to nine (9) business days: ***Zero (0) cases***
- More than ten (10) business days: ***Zero (0) cases***

While most cases assigned to an SRU worker complied with the DOP requirement to reach out to the family within three (3) business days of assignment, ***one (1)*** of the ***sixty-six (66)*** cases assigned did not comply. Of the ***sixty-six (66)*** cases, ***thirty-eight percent (38%)*** of cases assigned to an SRU worker did not comply with the DOP requirement to conduct a face-to-face visit with the family within five (5) business days of assignment, however, documentation showed attempts to schedule with the family or the visit was rescheduled. In ***twenty-two (22)*** cases, the family declined services and a home visit before one could be scheduled, ***one (1)*** face-to-face event was conducted outside of compliance and there was never a documented initial phone call to the family, and ***one (1)*** case where both a phone call and face-to-face did not take place, only text messages at which point the family declined services.

April 2026

In April 2026, there were ***seventy-six (76)*** screen outs sent to SRU for a Prevention Response by the CPS Hotline call floor. Of the ***seventy-six (76)*** cases, ***eight (8)*** cases had no further SRU

engagement or follow-up. ***Five (5)*** of the ***eight (8)*** cases were referred back to CPS and in the remaining ***three (3)*** cases, once sent to SRU for assignment, showed no record of SRU assignment or engagement, no documentation to indicate reasoning for lack of assignment, and no documentation of any DCYF follow up with the family.

Of the ***sixty-eight (68)*** cases assigned to an SRU worker, ***sixty-five (65)*** cases or ***ninety-seven percent (97%)*** failed to comply with the response times set forth in DOP 700.0190. DCYF DOP 700.0190 notes that the SRU administrator or designee will review the cases daily for assignment. Based on the hours of operation for SRU, this excludes weekends. ***Ninety-seven percent (97%)*** of cases were not assigned to an SRU worker within one (1) business day in accordance with the DOP. The assignment timeframes for these cases were as follows:

- Within two (2) business days: ***Three (3) cases***
- Within three (3) to four (4) business days: ***Twenty-seven (27) cases***
- Within five (5) to seven (7) business days: ***Twenty-eight (28) cases***
- Within eight (8) to nine (9) business days: ***Six (6) cases***
- More than ten (10) business days: ***One (1) case***

In one case, there was no assignment to an SRU worker for eleven (11) business days. On day eleven (11), a CPI, instead of an SRU worker, made one (1) attempted contact to the family and closed out the case on the same day due to no contact with the family.

While most cases assigned to an SRU worker complied with the DOP requirement to reach out to the family within three (3) business days of assignment**, eight** ***(8)*** of the ***sixty-eight (68)*** cases did not comply.

Forty-seven (47) of the sixty-eight (68) cases assigned to an SRU worker did not comply with the requirements for a face-to-face visit outlined in the DOP. However, for ***Twenty-seven (27)*** of the cases that did not comply with the timeline outlined in the DOP, there were documented attempts to schedule with the family or the visit was rescheduled. In ***seven (7)*** cases, the family declined services and a home visit at the initial point of contact. In ***thirteen (13)*** of the ***sixty-eight (68)*** cases assigned to an SRU worker, the worker did not comply with the requirements for a face-to-face visit outlined in the DOP and there was no documentation outlining attempts to schedule the visit.

Also of note, there were ***two (2)*** cases in which an SRU worker/supervisor, reached out to the family prior to being formally assigned to the case.

May 2026

In May 2026, there were ***one hundred sixty-three (163)*** screen outs sent to SRU for a Prevention Response by the CPS Hotline call floor.

Of the ***one hundred sixty-three (163)*** cases reviewed, ***twenty-one (21)*** cases had no further SRU engagement once sent to SRU for a Prevention Response. Of the ***twenty-one (21)*** cases, ***eighteen (18)*** of the cases were referred back to CPS. In the other ***two (2)*** cases, once sent to SRU for assignment, there was no record of SRU assignment or engagement, no documentation to indicate reasoning for lack of assignment, and no documentation of any follow up by DCYF with the family.

Of the ***one hundred forty-two (142)*** cases assigned to an SRU worker, ***one hundred forty (140)*** cases or ***98%*** failed to comply with the response times set forth in DOP 700.0190. The DOP indicates that the SRU administrator or designee will review the cases daily for assignment. Based on the hours of operation for SRU, this would exclude weekends. The case review showed that ***one hundred thirty-six (136)*** cases or **96*%*** of cases were not assigned to an SRU worker within one business day. The timeframe for assignment for these cases was as follows:

- Within two (2) business days: ***five (5)***
- Within three (3) to four (4) business days: ***twelve (12)***
- Within five (5) to seven (7) business days: ***forty-two (42)***
- Within eight (8) to nine (9) business days: ***twenty-nine (29) cases***
- More than ten (10) business days: ***forty-eight (48) cases***

Of the ***one hundred forty-two (142)*** cases assigned to an SRU worker, ***five (5)*** did not meet the DOP requirement to reach out to the family within three (3) business days of assignment. **Seventy-one *(71)*** of the ***one hundred forty-two (142)*** cases or ***fifty (50%)*** of cases assigned to an SRU worker did not comply with the DOP requirement to conduct a face-to-face visit with the family within five (5) business days of assignment, however, in all ***seventy-one (71)*** cases the family declined services and a home visit before one could be scheduled.

Also of note, there were ***thirteen (13)*** cases in which an SRU worker/supervisor, reached out to the family prior to being formally assigned to the case. In all of these instances, there was no further engagement/family declined services. This was noted in a case activity note, however, there was no formal closing note added.

June 2026

In June 2026, there were ***eighty (80)*** screen outs sent to SRU for a Prevention Response by the CPS Hotline call floor. Of those, ***thirteen (13)*** cases had no further SRU engagement once sent to SRU. ***Eleven (11)*** of the ***thirteen (13)*** cases were referred back to CPS and the in remaining ***two (2)*** cases, once sent to SRU for assignment, there was no record of SRU assignment or engagement, no documentation to indicate reasoning for lack of assignment, and no documentation of any DCYF follow up with the family.

Of the ***sixty-seven (67)*** cases assigned to an SRU worker, ***ninety-nine percent (99%)*** failed to comply with the response times set forth in DOP 700.0190 which indicates that the SRU administrator or designee will review the cases daily for assignment. Based on the hours of operation for SRU, this excludes weekends. ***Eighty-seven percent (87%)*** of cases were not assigned to an SRU worker within one business day within one (1) business day in accordance with the DOP. The assignment timeframes for these cases were as follows:

- Within two (2) business days: ***eight (8) cases***
- Within three (3) to five (5) business days: ***twenty-five (25) cases***
- Within six (6) to seven (7) business days: ***sixteen (16) cases***
- Within eight (8) to nine (9) business days: ***Nine (9) cases***
- More than ten (10) business days: ***zero (0) case***

All of the cases assigned to an SRU worker complied with the DOP requirement to reach out to the family within three (3) business days of assignment. **Of the *sixty-seven (67)*** cases, ***twelve percent (12%)*** of cases assigned to an SRU worker did not comply with the DOP requirement to conduct a face-to-face visit with the family within five (5) business days of assignment, however, there were documented attempts to schedule with the family or the visit was rescheduled. In ***forty-one (41)*** cases, families declined services and a home visit before one could be scheduled.

In addition to the independent case reviews conducted for this report, in May 2026, the OCA was notified that ***seventy-seven (77)*** families were awaiting assignment to SRU. When reviewing SRU cases, the OCA noted that SRU received nearly twice the number of prevention referrals from CPS in May than prior months which caused a backlog of cases awaiting assignment. Collectively, these findings suggest that current SRU staffing levels are insufficient to support a more robust volume of referrals for prevention services and to provide timely engagement with families.

Although the backlog was reduced to approximately ***fifty (50)*** families by June 2026 by employees working overtime, the OCA found that service delivery and family engagement continued to deviate from the procedures outlined in DCYF policy. Reliance on overtime reduced the number of pending assignments but did not resolve the underlying capacity issues or ensure consistent adherence to established practice standards.

The OCA and the Service Employees International Union (SEIU) Local 580 raised concerns regarding inadequate staffing and delays in case assignment. The OCA raised concerns with DCYF specifically regarding delays in the assignment of SRU referrals and the use of an informal triage process that was not reflected in the DOP. The OCA acknowledged the significant staffing challenges facing the unit and emphasized that staffing shortages do not relieve DCYF of its obligation to comply with established operating procedures.

DOP 700.0190 establishes clear requirements governing the operation of SRU, including the daily review and assignment of referrals, timely family engagement following assignment, and case disposition within established timeframes. At the time of the OCA's inquiry, referrals had remained in the SRU referral cabinet[31] without assignment for extended periods, raising concerns that DCYF was consistently missing these policy requirements.

In its response, DCYF acknowledged several significant deficiencies in its current practice and confirmed that:

- DOP 700.0190 does not describe or authorize a referral backlog, waitlist, referral cabinet, or pre-assignment triage process.
- Referrals not immediately assigned are primarily the result of staffing capacity.
- The current administrative triage process, including outreach to determine whether families remain interested in voluntary services, is not expressly authorized by existing DCYF DOP.
- DCYF is reviewing whether written guidance should be issued to formalize the interim triage process and whether DOP 700.0190 should be revised to reflect the current service model and disposition timeframes.

DCYF further acknowledged that the current circumstances present both an operational and policy compliance concern.

While DCYF described administrative efforts to prioritize referrals, conduct limited outreach, and refer matters back to CPS when additional safety concerns were identified, these measures demonstrate reactive responses to capacity limitations rather than components of the

[31] SRU referral cabinet means a physical cabinet at DCYF where SRU referrals are kept.

established SRU model. The existing DOP describes a system in which referrals are reviewed, assigned to a caseworker, assessed, and connected to services in a timely manner. DCYF acknowledged that the current practice has diverged from that model.

DCYF's response demonstrates that the concerns identified during this review are not limited to staffing shortages or isolated delays. Rather, DCYF acknowledged that SRU is currently operating through informal processes that are not reflected in policy, and that existing policy no longer accurately describes how services are being delivered. This disconnect between policy and practice creates uncertainty regarding referral prioritization, documentation, supervisory oversight, accountability, and equitable access to prevention services for families.

The Panel recognizes efforts to stabilize staffing and improve operations, however, acknowledgment that DCYF is considering revisions to both the SRU DOP and service model further supports the Panel's conclusion that the current structure of SRU requires comprehensive review and reform. Addressing staffing shortages alone will not resolve the systemic concerns identified throughout this review. A broader overhaul is necessary to establish a clearly defined service model, standardized referral and assignment practices, consistent family engagement, effective oversight, and meaningful quality assurance to ensure that families receive timely and appropriate prevention services.

DCYF has acknowledged the need to strengthen SRU and has committed to adding one (1) Casework Supervisor and two (2) Caseworkers. While these additions are a positive step, once DCYF has evaluated the broader function and infrastructure of the unit, the OCA recommends that SRU undergo a comprehensive staffing and operational assessment to determine whether these positions are sufficient to meet service demands or whether additional resources are needed. The findings of this review indicate that current staffing capacity in SRU is insufficient to support an increased volume of prevention referrals and provide timely services. Without adequate staffing and consistent adherence to established operating procedures, families are likely to continue experiencing delays in receiving prevention services during a critical period when early intervention is intended to reduce risk, strengthen family functioning, and prevent future harm and involvement with the child welfare system.

While compliance with policy and procedure is an important measure of performance, it is one component of the broader prevention system effectiveness. Equally important is whether the SRU model is achieving its intended purpose by consistently identifying families in need, connecting them with appropriate services, and improving outcomes for children. The Panel believes that meaningful reform should extend beyond policy compliance and include a comprehensive evaluation of the SRU model to determine its effectiveness, identify gaps in implementation, and ensure it is meeting the needs of children and families as intended.

c. SRU Screening, Assessment and Family Engagement

The cases reviewed by the Panel and the in-depth internal review of cases referred to SRU by the OCA, raised concerns regarding the consistent and thorough assessment of the needs of the families referred to SRU. While many families were presenting with multiple risk factors and identified needs, coordination of the appropriate services and interventions to meet the needs of the family were inconsistent.

The review illustrated that SRU does not currently utilize a standardized assessment tool to consistently evaluate the needs of the family, identify the full scope of risk and protective factors, or guide service planning for families referred to the unit. Although SRU caseworkers document family contacts and provide referrals to community resources, the absence of a structured assessment tool results in considerable variability in how family needs are identified, assessed, and addressed across cases. Without a standardized framework, families presenting with similar risk factors may receive different levels of assessment and intervention depending on individual caseworker practice. Furthermore, the lack of a uniform assessment process limits supervisory oversight, making it difficult to ensure that all identified concerns have been comprehensively evaluated, and reduces the ability to measure practice consistency and outcomes across DCYF programs. Implementing a validated, standardized assessment tool would promote consistent decision-making, strengthen documentation, improve service matching, and help ensure that families with complex needs receive comprehensive and equitable assessments.

DOP 700.0190 indicates that SRU caseworkers are responsible for conducting an FFA when warranted due to elevated risk of harm to a child. The following definitions of risk of harm are outlined in the DOP:

"The following definitions of risk of harm below determine if the family should be assessed utilizing the FFA. (Refer to Family Functioning Assessment Intervention Manual).

a. Risk of physical abuse
    i. Circumstances where the child has not yet experienced harm, and it can reasonably be concluded that if the circumstances continue without change, physical abuse will likely occur.
b. Risk of sexual abuse
    i. Situations where, although the child has not yet experienced harm and there may have been no known sexually abusive actions, it can reasonably be concluded that the current circumstances represent a threat of sexual abuse. Examples of this type of situation include but are not limited to the following:

1) A person who previously sexually abused this or another child, including having prior or current child pornography charges, is a household member or has regained access to the child or other children in the residence.
2) There are indications that the child is being groomed. “Grooming” refers to a deliberate and escalating pattern of actions taken to lower a child’s inhibitions in preparation for sexual abuse (e.g. treating the child as “more special” than other children, talking about age-inappropriate sexual topics, exposing the child to pornography, deliberate self-exposure).

c. Risk of neglect
    i. Risk of neglect indicates the caregiver is demonstrating behaviors that are cause for concern; the behaviors indicate a trend or escalating pattern toward the potential inability to meet the child’s basic needs. This inability can reasonably be expected to produce a substantial and demonstrably adverse impact on the child’s safety, welfare, or well-being. Examples include but are not limited to the following:
        1) The caregiver appears to be suffering from mental health conditions and is unlikely to meet the child’s basic needs of food, clothing, shelter, or protection from harm.
        2) There are indications that the caregiver is not interested in caring for themselves or the children and that the children are vulnerable.
        3) One partner’s financial control appears to be preventing the other from purchasing items needed for the care of the child (e.g., the parent does not allow the other parent access to the bank account and only provides limited cash inconsistently, which prevents the parent from having funds to buy food, clothing, or medicine for the child as needed).
        4) Caregivers’ intellectual disability is likely to impair their ability to provide adequate care, supervision, or protection for a vulnerable child, and they are reluctant or refuse to allow extended family members or other supports to assist in caregiving. In accordance with Rhode Island General Law 42-71.12-3(a), a parent or prospective parent’s disability shall not be presumed to have a detrimental impact on a child.”

Without a standardized assessment tool, it is unclear how staff determine whether a case presents with the risk factors outlined in policy, what criteria are used to determine when an FFA is warranted, or how supervisors review and monitor those decisions. As a result, determinations are vulnerable to subjective interpretation and inconsistent application across staff and regions.

Compounding this concern, DCYF does not maintain a mechanism to systematically track FFAs completed by SRU or monitor whether assessments are conducted when required by policy. Without reliable data regarding FFA utilization, DCYF cannot effectively evaluate policy compliance, assess the consistency of practice, identify training or resource needs, or ensure that families presenting with elevated risk receive comprehensive assessment and appropriate intervention.

FFAs were completed in only a small number of SRU cases reviewed by the OCA. In numerous instances, the circumstances documented in the referral appeared to meet the criteria outlined in DCYF policy for completion of an FFA; however, no assessment was conducted. In some cases, FFAs were completed only after being ordered by the Rhode Island Family Court, rather than as the result of an independent assessment of the family's needs. These findings raise concerns that FFAs are not being utilized consistently or in accordance with DCYF policy.

The OCA further identified significant inconsistencies between DCYF regulations, departmental policies, and current practice. CPS Regulation 214-RICR-20-00-1 establishes a Family Assessment Response process for reports that do not meet the criteria for investigation but nevertheless raise concerns regarding a child's well-being. Pursuant to the regulations, CPS first completes a standardized assessment to determine whether a report that did not meet the criteria for investigation, is appropriate for a family assessment response.

While this process is voluntary, there is a meeting to assess risk if the family declines to participate. Based on that meeting, there is a decision whether to refer back to CPS. If the family agrees to participate, DCYF then "...conducts a thorough assessment of child safety and risk for all children in the home during the family assessment response, and develops a safety plan, if necessary."

If the family accepts services, DCYF is required to conduct a comprehensive assessment of child safety and risk for all children in the home, develop a safety plan when necessary, complete face-to-face contact within three (3) business days, conduct standardized safety and risk assessments within thirty (30) days, perform criminal background checks on household members and caregivers, and identify and coordinate services to address the family's needs.

Current practice does not reflect this regulatory framework. CPS does not utilize a standardized assessment tool to determine whether a family requires further assessment through SRU, and SRU does not use a standardized tool to evaluate safety, risk, or family functioning after a referral is received. Instead, eligibility for further assessment is left largely to individual judgment, resulting in inconsistent decision-making and limited oversight.

The SDM currently utilized by CPS is designed to determine whether allegations meet the threshold for a child protective investigation. When maltreatment criteria are not met, the SDM directs the worker to determine whether an alternative response, including referral to SRU, is appropriate. However, the tool instructs workers to apply SRU eligibility criteria that are not outlined in the DOP.

Furthermore, some of the definitions for risk of harm incorporated into SRU policy are derived from the SDM tool, where they are used to determine whether allegations of abuse or neglect meet the threshold for a child protective investigation. Risk of sexual abuse, risk of physical abuse, and risk of neglect are all qualifying criteria for a CPS investigation in accordance with the SDM. These criteria determine eligibility for an investigative response, not voluntary assessment and response.

The Panel found collectively that DCYF's regulations, DOPs, assessment tools, and operational practices are not aligned. The regulatory framework requires a standardized process for identifying families appropriate for a family assessment response and completion of comprehensive assessments of child safety and family risk. However, DCYF has not implemented policies, assessment tools, or oversight mechanisms that operationalize these requirements. Instead, critical decisions regarding whether a family receives further assessment are left to individual discretion without standardized criteria, consistent documentation, or meaningful supervisory review. These inconsistencies also create confusion regarding the roles and responsibilities for both CPS and SRU, including which unit is responsible to assess for safety and risk.

As a result, DCYF is not consistently implementing processes required under its own regulations. The absence of a standardized decision-making framework, coupled with conflicting policies and inconsistent practice increases the likelihood that families presenting with significant safety concerns will not receive the comprehensive assessment and intervention contemplated by the regulations. Ultimately, these systemic deficiencies place children and families at risk by allowing similarly situated families to receive markedly different responses based not on objective assessment, but on inconsistent and subjective interpretation and practice.

During the internal case review, the OCA identified a need for clearer practice guidance regarding case documentation, case duration, and supervisory oversight within SRU. Although case activity notes were generally maintained, the quality and level of detail varied significantly across cases. Documentation frequently focused on contacts and activities but did not consistently capture the assessment of family needs, the rationale for service decisions, or the specific actions taken to engage and support families. Limited documentation of assessment processes reduces transparency and makes it difficult to evaluate whether interventions were appropriate and responsive to identified risks. Utilizing and documenting a standardized assessment tool, should remedy some of these concerns.

Additionally, the OCA's review raised questions about whether the current 30- to 45-day case timeframe provides sufficient opportunity to meaningfully engage families and connect them with needed services. It is recommended that DCYF consider whether case closure should be based primarily on successful engagement, service linkage, and progress toward addressing identified needs rather than a prescribed timeframe alone. Finally, implementing a standardized supervisory review prior to case closure would strengthen oversight by ensuring assessments are complete, documentation is sufficient, and appropriate services and interventions have been provided before a case is closed. In response to the OCA regarding concerns about SRU, it is acknowledged that DCYF is reviewing timeframes in the DOP to better reflect the current service model and appropriate disposition timeframes. DCYF is reviewing whether longer timeframes are needed and noted that they are also "...reviewing whether court-ordered matters should be addressed separately, as return-to-court dates often extend beyond the current SRU disposition period and the Court may order SRU to continue working with the family."

The case review also raised questions regarding repeat engagement with families previously referred to the SRU who later re-enter the child welfare system. Many cases reviewed by the OCA involved families with prior SRU involvement that subsequently reconnected with DCYF through new child welfare reports. This suggests the need to better understand whether these repeat referrals represent unmet service needs or missed opportunities for intervention. At the time of the review, it was unclear whether DCYF systematically tracks or analyzes data on families who re-engage with child welfare following SRU involvement or conducts reviews to identify trends, contributing factors, or opportunities for practice improvement. Without ongoing monitoring of these cases, DCYF's ability to evaluate the effectiveness of SRU interventions, assess long-term family outcomes, and strengthen service delivery is limited.

The Panel identified a need to further examine how DCYF engages families who decline voluntary services or supports while experiencing significant challenges. Effective engagement with families who may be hesitant, overwhelmed, or distrustful of public systems requires

specialized skills and a consistent practice approach. It is recommended that DCYF assess whether staff working within SRU have access to the necessary training, tools, and ongoing coaching to effectively engage families, including the use of evidence-informed approaches such as motivational interviewing and other family engagement strategies. Strengthening these practices is critical to ensuring that families with identified needs receive meaningful support rather than disengaging.

III. DCYF Staffing and Resources

The Panel recognizes the significant challenges facing DCYF related to workforce capacity, recruitment and retention, and the increasing complexity of the needs presented by children and families served by DCYF. DCYF's ability to effectively fulfill its mission is directly impacted by having the robust staffing, resources, and infrastructure necessary to support quality service delivery, timely responses, and meaningful engagement with children and families.

In prior legislative testimony and interviews, DCYF leadership indicated that DCYF had the staffing and resources necessary to fulfill its responsibilities. However, the findings identified through the Panel's reviews demonstrate that current staffing levels, resources, and operational capacity have not been sufficient to consistently meet the needs of children and families or to ensure the effective implementation of DCYF initiatives. The Panel recognizes that resource needs must be continuously evaluated based on changing demands, case complexity, workforce capacity, and the outcomes being achieved. Assertions regarding available resources must be supported by ongoing assessments of whether those resources are adequate to meet statutory responsibilities and service expectations of DCYF.

It is recommended that an in-depth assessment of staffing and resource needs impacting service delivery to children and families be conducted and rigorously reviewed to ensure that identified needs are appropriately reflected in future budget requests. This assessment should include a comprehensive review of existing staffing structures, resources, and funding allocations to determine whether positions and available funding are being utilized efficiently and effectively, with a primary focus on improving outcomes for children and families.

As part of this review, DCYF should evaluate all positions, including both full-time equivalent (FTE) and contracted positions, to ensure resources are strategically allocated and aligned with the most critical operational needs of DCYF. This includes ensuring that public-facing positions responsible for direct service delivery have the necessary support, supervision, training, and resources required to effectively perform their responsibilities.

Additionally, continuous assessment of opportunities to maximize available federal funding will be essential to ensure DCYF is leveraging all available resources to support children, families, staff, and community partners. The Panel recognizes that budget constraints are an ongoing reality and that DCYF must balance fiscal responsibility with the need to provide effective and comprehensive services. However, DCYF must continue to advocate for the resources necessary to support its workforce, strengthen service delivery, and meet its responsibilities to the children and families it serves while ensuring responsible stewardship of available funding.

IV. Family Care Community Partnerships (FCCP)

FCCP agencies are DCYF's "primary prevention resource for the state."[32] Five (5) community agencies provide FCCP services for the State of Rhode Island.[33] FCCPs are a "formal collaborative structure for joint planning and decision making through which community partners take collective responsibility for development and implementation of system of care and the Wraparound process for families and youth who are at risk for child abuse and neglect, who have serious emotional disturbance (SED) and/or who are returning to the community after completing a sentence to the Rhode Island Training School."[34]

DCYF sends referrals to FCCP primarily from CPS, but also from SRU. Families referred to FCCP are at risk of opening to DCYF or struggling with meeting their basic needs. FCCP can assist with finding employment, securing basic necessities such as a bed for a child, accessing clinical services, and more. Any family can receive services through FCCP. In order to be eligible for FCCP, families cannot be open to DCYF's Family Services Unit.

Upon referral to FCCP, families are assigned to a staff person within twenty-four (24) hours to schedule an intake appointment. Initial contact ideally takes place within five (5) days; however, this can vary depending on the availability of the family. While the referral includes information regarding the family's needs, FCCP conducts an independent assessment with the family to determine and prioritize their needs. Once work with the family begins, FCCP is authorized to make referrals for the family through DCYF's Central Referral Unit (CRU)[35] which makes DCYF's service array accessible to families.[36]

FCCP utilizes the Wraparound Practice Model which approaches family work through the core principles of being family centered, team- and strength-based, collaborative, and flexible. FCCP

[32] Family Care Community Partnerships (FCCPs) | RI Department of Children, Youth & Families
[33] https://dcyf.ri.gov/media/3241/download?language=en
[34] Rhode Island Family Information System (RIFIS) | RI Department of Children, Youth & Families
[35] DCYF's Central Referral Unit (CRU) was developed following the reorganization of the Division of Community Services & Behavioral Health "in 2016 to resume the responsibility of processing all residential intervention and community-based service referrals."
[36] https://dcyf.ri.gov/media/4446/download?language=en

uses an evidence-based tool to conduct an assessment of families. One of the assessment tools helps the family share their story and identify their needs as a family. This assessment's questions aim to identify and elevate the family's needs and so staff can assist them in determining how they meet their current needs. This work is conducted during multidisciplinary team meetings which include, family members, providers, natural supports, and anyone else the family identifies as a support. Team meetings are used to ensure the family and their providers are on the same page, delegate tasks, and to prevent duplication of services or supports by participants.

Each family open to FCCP has a primary child that is assigned as the client for funding purposes. A staff clinician assesses the child to identify their needs and current diagnoses and to ensure there is a billing pathway for the family. Due to the billing structure of FCCP, when families are referred through CRU to a different but necessary service with a case management component, FCCP has to close, as it is a duplication of services. Despite this, FCCP could still play a critical role with the family in providing case coordination, especially if they have an existing relationship with the family. Recognizing the needs of the family and their provider relationships is important in maintaining service continuity during difficult periods of time when existing relationships are vital. The Family Support Partner and Family Service Care Coordinator are the primary FCCP points of contact for families. The Family Support Partner builds a relationship with the family and assists in helping them identify needs, obtain resources, and navigate state systems. The Family Support Partner has lived experience and can offer a more personalized perspective to families.[37] The Family Service Care Coordinator assists with scheduling and logistics, facilitating family/team meetings, delegating tasks to team members, and coordinating care between providers and the referral source.

CPS refers families with complex needs to FCCP. FCCP is voluntary and when families choose to opt out, they are no longer connected to DCYF or services. CPS becomes involved with families during some of the families' most stressful periods and there can be a stigma attached in utilizing FCCP services, even though FCCP is independent of DCYF. Additionally, when families are interacting with CPS, they are meeting different people and may have various people coming and going from their home. As a result, when FCCP initiates contact, the family may not engage, understand FCCP's role, or longer have the same contact information. Developing a process for a warm hand-off between CPS and FCCP may benefit families in understanding the role of FCCP and ensuring that they remain connected to services prior to DCYF case closure. While a warm handoff does not guarantee engagement with services, it can bridge the gap and help FCCP build rapport, and educate families about FCCP's role and services, including how they are independent of DCYF. When families decline FCCP services or FCCP is unable to

[37] Lived Experience | Child Welfare Information Gateway

connect with the family, FCCP alerts DCYF that they were unable to engage with the family. There is a misconception that referring a family to FCCP will automatically result in family engagement and provision of services. This is not the case for every family. DCYF would benefit from a clearly defined process that alerts them to the status of the referral and family engagement.

Recently, there has been a liaison from CPS assigned to each of the FCCP agencies to support the process of a warm hand-off and ensure that FCCP connects with the family prior to DCYF closing.

Fifteen (15) families reviewed by the Panel either had some contact with FCCP or a referral was made. While acuity of cases varied, families with individual needs that impacted caregiving in the home may have benefitted from the Wraparound Model FCCP utilizes. In multiple cases, that repeatedly came to the attention of DCYF, while the reported issue was addressed, it was evident from case history and investigation findings that families were presenting with multiple and interconnected complex needs. The Wraparound Model prioritizes the most critical issues while concurrently addressing the individual needs of each family member. Families need support while navigating state systems, specifically DCYF, while also managing trauma and other complex clinical needs. It is critical that warm, purposeful, and meaningful connections are made and every effort is made to support families in accessing necessary services. Every effort to engage the family should be exhausted, even with respect to voluntary services.

Historically, reliance on FCCP as a primary housing resource resulted in DCYF funding hotels for families to prevent formal involvement with the child welfare system. There has been a shift in practice and FCCP now assists families in navigating state systems, accessing resources, and completing applications to identify appropriate housing. The team is identifying the reasons that led to homelessness or risk of homelessness. There remain CPS referrals to FCCP for emergency housing required by the family. When this occurs, FCCP assists the family in identifying natural supports that can provide temporary shelter and explores any and all avenues to mitigate homelessness. If FCCP is unable to assist the family in identifying housing, the matter is referred back to DCYF. Currently, there is a housing crisis in the State of Rhode Island, which impacts individuals, youth, and families statewide. Investment in housing resources, including housing navigator positions, remains a critical component of FCCP and DCYF housing supports and service delivery. DCYF and FCCP should prioritize collaboration on these investments as a key prevention strategy to prevent formal child welfare system involvement due to housing insecurity.

The United States Department of Justice (DOJ) Consent Decree and the May 2025 report of the Office of the Child Advocate Child Fatality Review Panel which focused on substance use in adolescents and substance exposed newborns highlight the need for intensive care

coordination.[38] The Wraparound Model is a commonly used approach to intensive care coordination. The Wraparound Model appropriately "support children and youth whose needs exceed the resources and expertise of any one provider organization or child-and family-serving system."[39] In cases that may have benefitted from additional supports, services, and continued assessment, the Panel often discussed a form of this model for the entire family, similar to that of intensive care coordination for the child. The model relies on a team-based approach with a designated coordinator bringing the family, providers, and other supports together to develop a "comprehensive, individualized, and creative plan of care."[40] While FCCP is utilizing this evidence-based approach in their prevention work, and there is work underway to implement this approach for youth who require intensive care coordination, extending this model to families involved with DCYF, including those preparing to close their cases, could provide valuable continuity of support during a critical transition. As the Consent Decree work moves toward a Single Point of Access and Intensive Care Coordination,[41] it is important to consider how this approach may also be beneficial for nuclear families. A warm hand off to the Single Point of Access to ensure a family receives a comprehensive assessment and alignment with appropriate supports and services could help achieve this goal.

While DCYF continues to educate the public, strengthen community relationships, and build rapport with families, involvement with DCYF continues to be an intimidating and contentious experience for families. Establishing pathways to support entire families struggling to meet basic needs, combat mental health, and concerns of substance use, unstable housing, and childcare issues is critical. In New Jersey, Family Success Centers offer "one-stop" to provide "wrap-around[42] resources and supports for families before they find themselves in crisis." These primary prevention services are supported by New Jersey's Department of Children and Families, however, they are considered "gathering places where any community resident can go for support, information, programming, and resources as well as their skills and time to give back to the community."[43] In Rhode Island, families can self-refer to FCCP, but it is unclear how often this occurs. Increasing public education to make families aware of how to proactively access these supports prior to a crisis, can reduce entry into the child welfare system.

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[38] Intensive Care Coordination for Children and Youth with Complex Mental and Substance Use Disorders State and Community Profiles

[39] Intensive Care Coordination for Children and Youth with Complex Mental and Substance Use Disorders State and Community Profiles

[40] Intensive Care Coordination for Children and Youth with Complex Mental and Substance Use Disorders State and Community Profiles

[41] Implementation Plan__filed_2026.06.01.pdf

[42] In this quote, wrap-around is referencing putting services in place around the family for support and is not referring to the high-fidelity Wraparound Model.

[43] Family Success Center Program Manual.pdf

DOP100.0375 titled Family Community Care Partnership (FCCP) Referral, delineates when CPIs are authorized to refer families to FCCP, including considerations for family history with DCYF, protective capacity, and motivation to change. The Wraparound Model prioritizes youth and family voice, but the DOP does not include language regarding engagement with families. FCCP is available to any family at risk of DCYF involvement, which is a broad category that includes any family in Rhode Island. Rather than encouraging broad inclusion of families, the procedure emphasizes prioritization of families most in need. While prioritizing families who are already in crisis is important, assisting families prior to a crisis occurring is critical. The language in the DOP could be strengthened to align with fidelity of the Wraparound model used by FCCPs.

Similarly, in reviewing DOP 700.0190, titled Support and Response Unit, a clear protocol for referring families to FCCP is lacking. The Case Transfer and Closure section of the DOP refers to a referral to FCCP as a disposition and a means to case closure but does not define broader referral criteria or processes.

The DOPs for both FCCP referrals and SRU fail to outline an intentional process for educating all families about accessing these prevention services through self-referral. Family dynamics and circumstances can change rapidly. Equipping every family with the information on how to access FCCP at any time is critical to preventing families from opening to DCYF.

V. Family Visiting Programs

Family visiting programs are voluntary, home-based 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, connecting expectant parents and families with young children with additional resources and services in their community. The Report of the Office of the Child Advocate Child Fatality Review Panel report released in May 2025 reviewed fatalities and near fatalities related to substance exposure and adolescent substance use. The cases of children birth to age six (6) reviewed in that report highlighted the value of these programs and the Panel discussed them throughout the review process. The report included extensive discussion of the critical function of family visiting programs in supporting families with newborns and young children.

The Rhode Island Department of Health (RIDOH) administers the First Connections program which provides short-term, statewide 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. Family visitors conduct child wellness screenings, administer developmental screenings for eligible children, and facilitate referrals to Early Intervention or other appropriate developmental services when needed. Additionally, First Connections offers support to children involved with DCYF who are placed

outside of their home with foster parents and kinship guardians. When suitable, program staff may refer families to a long-term, evidence-based program, including Healthy Families America or Parents As Teachers.

According to the Rhode Island Department of Health's Family Visiting Legislative Report[44], 620 children were referred to First Connections by DCYF during federal Fiscal Year 2025. Of the 620 children referred by DCYF, 561 children had an indicated case of child abuse or neglect, and 59 children were in families that were investigated by DCYF, but the case was unfounded.[45] 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 be present in the family home, make an assessment, and connect families with necessary support and connection to long-term services.

RIDOH also administers two evidence-based family visiting programs including Healthy Families America and Parents as Teachers. These programs are longer term and can serve children up to age five (5). Each program works with families in the home, provides education about safe sleep, connects the family to additional services as needed, supports child development and the goals of the family. Both 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 when working with parents struggling with substance use. Peer Recovery Specialists coordinate care, build relationships between providers and parents, and work to increase parent engagement with appropriate services. Peer Recovery Specialists have lived experience and receive specialized peer training to provide support to pregnant women and parenting mothers. DCYF's Substance Use Coordinator routinely connects parents to this service. In recent years, the workforce supporting this service has decreased. Reinvestment to rebuild the workforce must be made to sustain and expand the provision of these critical services.

In at least five (5) of the cases reviewed involving newborns and young children who experienced a fatality or near fatality, records showed that families were referred to family visiting programs. As these programs are not administered by DCYF, it is likely that many other families were offered these services and the Panel did not have access to these records. Because First Connections and family visiting are voluntary programs, families may decline engagement.

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[44] Rhode Island Department of Health. (2026). *Family visiting legislative report*. https://health.ri.gov/sites/g/files/xkgbur1006/files/2025-03/Family-Visiting-Legislative-Report-2025.pdf

[45] Rhode Island Department of Health. (2026). *Family visiting legislative report*. https://health.ri.gov/sites/g/files/xkgbur1006/files/2025-03/Family-Visiting-Legislative-Report-2025.pdf

The Panel discussed how to increase engagement with family visiting programs acknowledging that there are a myriad of reasons not to, including feeling overwhelmed with a new child, having existing providers, and the stigma that comes with requiring assistance. The Panel repeatedly discussed the best timing to engage parents and how often to outreach families, noting that prenatal engagement is optimal. Some of the parents involved in the review were referred for services prenatally. Developing a universal strategy to reach out in multiple ways with the possibility to provide critical items for the child along with resources may be another way to establish a lasting connection. The Panel discussed opportunities for First Connections to co-locate at pediatric offices to provide an opportunity for face-to-face contact with families. Providing parents with the opportunity to learn about programming in a safe space outside their home may increase parental engagement.

First Connections is the foundation for initial short-term contact, providing one (1) to three (3) visits with families at no cost to the family. RIDOH provided the Panel with valuable contextual information regarding this programming. Families with children under age three (3), are eligible for First Connections, however, program guidance outlines certain risk factors that alert providers to make a referral. Between 60-65% of new parents have risk factors that would prompt a referral to First Connections.

In some cases reviewed, the Panel identified that the lack of referrals to home-based supports was a missed opportunity to mitigate identified risk factors. It is critical that DCYF staff and medical providers have an in-depth understanding of when program referrals should be made. Warm handoffs coupled with regular outreach may encourage families to engage in these supportive services at a crucial time of need.

In review of the cases in this report, similar to the findings in the May 2025 report, the Panel discussed the importance of ensuring adequate capacity and investment in these programs. Increased investment will allow for more visits for families and continue to expand engagement in these services. The ultimate goal would be to offer family visiting programs universally to all new parents, with discretion from the provider to continue engagement beyond the three (3) visits when necessary. Offering First Connections to all new parents, may support increased engagement, by decreasing the stigma that can be associated with asking for or accepting support and assistance.

A consistent theme emerged regarding the need for additional funding and resources to adequately support the role and responsibilities of these programs. Providers engaged in this work reported that further investment in these programs will provide opportunities to expand the workforce, increase program capacity, increase the number of visits, and expand engagement in these services, with the goal of offering family visiting programs universally.

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 due to the stigma of involvement with the child welfare system. 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.[46] 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.[47] By offering universal access to home visiting services, families, regardless of background or income, will be eligible to receive the support they need during critical prenatal and early childhood years.

Another barrier identified by the Panel for accessing these services is the time at which these referrals are made. Families may be overwhelmed in bringing a newborn home. Having new people in the home can add to this stress. The Panel discussed the importance of post-refusal follow-up by First Connections to ensure access if they change their mind. Additionally, the Panel discussed creative ways to engage the family such as dropping off items for the child, education materials for taking care of a newborn, or checking in with the family. Building relationships early and often was an ongoing theme throughout this Panel, including starting prenatal engagement.

VI. Safe Sleep

Sleep-related fatalities are among the leading causes of preventable deaths among infants in the United States and remain a persistent public health concern. According to the Centers for Disease Control and Prevention (CDC), approximately 3,400 infants die unexpectedly during sleep each year in the United States from causes that include SUID, which includes SIDS, accidental suffocation and strangulation in bed, and deaths from unknown causes.[48] Although the highest risk occurs during infancy, particularly during the first six months of life, the American Academy of Pediatrics (AAP) notes that unsafe sleep environments and inadequate supervision during sleep continue to contribute to fatalities and serious injuries among infants

[46] *Family Connects NJ*. (n.d.). Family Connects NJ. https://www.familyconnectsnj.org/
[47] (2025, March 19). *Home visiting programs – Casey Family programs*. Casey Family Programs. https://www.casey.org/home-visiting-programs/
[48] Moon RY, Carlin RF, Hand I; AAP Task Force on Sudden Infant Death Syndrome; AAP Committee on Fetus and Newborn. Sleep-Related Infant Deaths: Updated 2022 Recommendations for Reducing Infant Deaths in the Sleep Environment. Pediatrics. 2022;150(1):e2022057990
Centers for Disease Control and Prevention. (2024). Data and Statistics for SUID and SIDS. In *Sudden Unexpected Infant Death and Sudden Infant Death Syndrome*. https://www.cdc.gov/sudden-infant-death/data-research/data/index.html

and young children. Sleep-related deaths occur among all demographic groups and are often influenced by a combination of environmental factors, caregiver practices, social determinants of health, and barriers to accessing safe sleep education and resources. However, Black and Native American/Alaska Native infants death rates are twice that of white infants.[49] Research findings demonstrate that many of these deaths are preventable through adherence to evidence-based safe sleep recommendations and the implementation of trauma-informed, family-centered prevention strategies.[50]

Of the thirty (30) fatalities reviewed by the Panel, forty percent (40%) or twelve (12) cases, listed a cause of death of SUID. Of the twelve (12) SUID cases, ten (10) involved co-sleeping or unsafe sleep conditions. Of the thirty (30) fatalities, seven (7), had a final cause of death that was not determined because the autopsy report was either pending finalization or listed the cause of death as "Unknown". Of the seven (7) cases with an unknown cause of death, five (5) involved a form of unsafe sleep conditions.

The National Partnership for Child Safety (NPCS) emphasizes that multidisciplinary case review processes provide an opportunity to identify risk factor patterns and broader system-level prevention opportunities among social and environmental circumstances that impact child safety.

a. American Academy of Pediatrics Safe Sleep Recommendations

The AAP recommends that all infants be placed to sleep:

- On their backs for every sleep and in their own space without other people;
- On a firm, flat sleep surface with a fitted sheet;
- In their own crib, bassinet, portable crib, or play yard, avoiding sleep on a couch, armchair, or alternate seating device such as swings or care seats (except when riding in the car);
- Free of loose blankets, stuffed toys, pillows, bumpers, or other soft items; and
- Breastfeed when possible and avoid smoking.

The AAP further recommends infants sleep in the parents' room and close by the parents' bed and in a separate sleep surface for at least the first six (6) months and ideally the first year. Avoiding overheating and exposure to nicotine, alcohol, cannabis, opioids, and other substances is recommended to maintain caregiver responsiveness. The AAP also notes that

[49] American Academy of Pediatrics. (2023). Safe sleep. In *www.aap.org*. https://www.aap.org/en/patient-care/safe-sleep/

[50] Moon, R. Y., Carlin, R. F., & Hand, I. (2022). Evidence Base for 2022 Updated Recommendations for a Safe Infant Sleeping Environment to Reduce the Risk of Sleep-Related Infant Deaths. In *Pediatrics* (Vol. 150, Issue 1). https://doi.org/10.1542/peds.2022-057991

breastfeeding, routine immunizations, and offering a pacifier at sleep times are associated with reduced risk of SIDS.[51]

The AAP reports that room-sharing without bed-sharing may reduce the risk of sleep-related infant death by as much as fifty percent (50%). Infants under the age of one are particularly vulnerable because of developmental limitations in arousal, airway protection, and repositioning abilities. The CDC and the AAP have consistently found that prone sleep positioning, soft sleep surfaces, loose bedding, and bed-sharing are among the most frequently identified risk factors in sleep-related infant deaths.[52]

While most sleep-related fatalities occur during infancy, older infants and young children may also experience serious injury or death related to unsafe sleeping environments, inadequate supervision, entrapment hazards, or sleeping arrangements that are not developmentally appropriate. Accordingly, safe sleep education should be incorporated into broader injury prevention efforts throughout early childhood.

b. Harm Reduction and Safe Sleep

While the AAP does not recommend bed-sharing under any circumstances, research demonstrates that some families continue to practice co-sleeping because of cultural traditions, breastfeeding practices, caregiver exhaustion, housing constraints, or beliefs regarding bonding and infant safety.[53] Increasingly, researchers and healthcare providers recognize the importance of incorporating harm reduction principles into safe sleep education in acknowledgement of the realities of family life and seek to provide practical, nonjudgmental guidance while continuing to communicate that a separate sleep surface remains the safest recommendation.[54]

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[51] American Academy of Pediatrics. (2023). Safe sleep. In *www.aap.org*. https://www.aap.org/en/patient-care/safe-sleep/

[52] CDC. (2024). Providing Care for Babies to Sleep Safely. In *Sudden Unexpected Infant Death and Sudden Infant Death Syndrome*. https://www.cdc.gov/sudden-infant-death/sleep-safely/index.html

How to Keep Your Sleeping Baby Safe: AAP Policy Explained. (n.d.). In *HealthyChildren.org*. Retrieved August 20, 2026, from https://www.healthychildren.org/English/ages-stages/baby/sleep/Pages/A-Parents-Guide-to-Safe-Sleep.aspx?_gl=1

Moon, R. Y., Carlin, R. F., & Hand, I. (2022). Evidence Base for 2022 Updated Recommendations for a Safe Infant Sleeping Environment to Reduce the Risk of Sleep-Related Infant Deaths. In *Pediatrics* (Vol. 150, Issue 1). https://doi.org/10.1542/peds.2022-057991

[53] Bartick, M., Young, M., Louis-Jacques, A., McKenna, J. J., & Ball, H. L. (2022). Bedsharing may partially explain the reduced risk of sleep-related death in breastfed infants. *Frontiers in Pediatrics*, *10*. https://doi.org/10.3389/fped.2022.1081028

[54] Bartick, M., Young, M., Louis-Jacques, A., McKenna, J. J., & Ball, H. L. (2022). Bedsharing may partially explain the reduced risk of sleep-related death in breastfed infants. *Frontiers in Pediatrics*, *10*. https://doi.org/10.3389/fped.2022.1081028

Moon, R. Y., Carlin, R. F., & Hand, I. (2022). Sleep-Related Infant Deaths: Updated 2022 Recommendations for Reducing Infant Deaths in the Sleep Environment. In *Pediatrics* (Vol. 150, Issue 1). https://doi.org/10.1542/peds.2022-057990

Harm reduction approaches encourage providers to engage families in supportive conversations about actual sleep practices and discuss strategies that may reduce risk if bed-sharing occurs, including:

- Avoiding co-sleeping on couches, recliners, or soft surfaces;
- Avoiding bed-sharing when caregivers are smokers or have used substances including alcohol, cannabis, sedating medications;
- Avoiding bed-sharing with premature infants, infants with low birth weight, or infants under four months of age;
- Ensuring the sleep environment is free of pillows, blankets, comforters, and gaps where entrapment may occur; and
- Helping families identify safe alternatives for nighttime feeding and soothing practices.

Research suggests that caregivers are more likely to disclose actual sleep practices and engage in prevention efforts when approached through supportive, culturally responsive conversations that recognize family circumstances and avoid stigma or judgement.[55] The AAP further notes that repeated, consistent messaging from healthcare providers and community-based supports demonstrates promise in improving safe sleep practices and reducing disparities in sleep-related infant deaths.[56]

c. Community Education and Public Awareness Campaigns

Public awareness campaigns have played a significant role in reducing sleep-related infant deaths in the United States. The National Institute of Child Health and Human Development's (NICHD) *Back to Sleep* campaign, launched in 1994 and later expanded into the *Safe to Sleep®* campaign, is widely regarded as one of the most successful public health initiatives focused on infant mortality prevention.[57] According to the NICHD and the AAP, rates of SIDS declined by more than 50% following implementation of the campaign. The campaign has further expanded its messaging emphasizing a comprehensive safe sleep environment, including room-sharing without bed-sharing and the removal of soft bedding and other hazards.[58]

The AAP underscores that safe sleep recommendations are most effective when families receive clear, simple, and repeated messaging from multiple trusted sources throughout pregnancy and infancy. Research demonstrates that caregivers are more likely to adopt safe

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[55] Bartick, M., Young, M., Louis-Jacques, A., McKenna, J. J., & Ball, H. L. (2022). Bedsharing may partially explain the reduced risk of sleep-related death in breastfed infants. *Frontiers in Pediatrics*, *10*. https://doi.org/10.3389/fped.2022.1081028

[56] Moon, R. Y., Carlin, R. F., & Hand, I. (2022). Sleep-Related Infant Deaths: Updated 2022 Recommendations for Reducing Infant Deaths in the Sleep Environment. In *Pediatrics* (Vol. 150, Issue 1). https://doi.org/10.1542/peds.2022-057990

[57] Campaign History | Safe to Sleep®. (n.d.). In *https://safetosleep.nichd.nih.gov/*. Retrieved August 20, 2026, from https://safetosleep.nichd.nih.gov/campaign/history

[58] American Academy of Pediatrics. (2023). Safe sleep. In *www.aap.org*. https://www.aap.org/en/patient-care/safe-sleep/

Campaign History | Safe to Sleep®. (n.d.). In *https://safetosleep.nichd.nih.gov/*. Retrieved August 20, 2026, from https://safetosleep.nichd.nih.gov/campaign/history

sleep practices when education is reinforced across healthcare and community settings, including prenatal care, birthing hospitals, pediatric offices, home visiting programs, childcare settings, and community-based organizations.[59]

Evidence further suggests that educational campaigns are most effective when paired with practical supports, including access to approved sleep spaces and opportunities for caregivers to discuss barriers to implementation.[60] This approach is particularly important for families experiencing housing instability, financial hardship, caregiver fatigue, or other circumstances that may prevent adherence to safe sleep recommendations.

States across the country provide comprehensive safe sleep campaigns and initiatives providing useful models for prevention efforts. The Georgia Department of Public Health's *Safe to Sleep Campaign* utilizes the "ABCs of Safe Sleep" message—**A**lone**,** on their **B**ack**,** in a **C**rib—and combines public education with provider training, community partnerships, and resource distribution. Multiple states have also partnered with *Cribs for Kids®*, a national organization that provides hospital certification programs, caregiver education, and crib distribution initiatives. Evaluations of these programs have demonstrated improvements in caregiver knowledge and increased use of approved sleep environments, particularly among families experiencing socioeconomic challenges.[61]

Research demonstrates that effective prevention requires more than a single educational encounter. Families may encounter changing circumstances, sleep deprivation, economic stressors, and caregiving challenges that influence sleep practices over time. Public awareness campaigns that are culturally responsive, trauma-informed, and reinforced across multiple child-serving systems may increase opportunities to identify barriers and support safer sleep practices.[62]

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[59] American Academy of Pediatrics. (2023, August 21). *Safe sleep*. Www.Aap.Org. https://www.aap.org/en/patient-care/safe-sleep/
Erck, A. B., Shapiro-Mendoza, C. K., Parks, S. E., Cottengim, C., Faulkner, M., & Hauck, F. R. (2024). Characteristics of Sudden Unexpected Infant Deaths on Shared and Nonshared Sleep Surfaces. *Pediatrics*. https://doi.org/10.1542/peds.2023-061984

[60] Erck, A. B., Shapiro-Mendoza, C. K., Parks, S. E., Cottengim, C., Faulkner, M., & Hauck, F. R. (2024). Characteristics of Sudden Unexpected Infant Deaths on Shared and Nonshared Sleep Surfaces. *Pediatrics*. https://doi.org/10.1542/peds.2023-061984
Wilson, A. (2026, February 23). *Cribs for Kids Launches Professional Trainings to Strengthen Cross-System Safe Sleep Education - Cribs for*. Cribs for Kids. https://cribsforkids.org/cribs-for-kids-launches-professional-trainings-to-strengthen-cross-system-safe-sleep-education/

[61] Wilson, A. (2026, July 29). *How Cribs for Kids Understands Its Impact - Cribs for Kids*. Cribs for Kids. https://cribsforkids.org/cribs-for-kids-impact-statement/

[62] American Academy of Pediatrics. (2023, August 21). *Safe sleep*. Www.Aap.Org. https://www.aap.org/en/patient-care/safe-sleep/
Erck, A. B., Shapiro-Mendoza, C. K., Parks, S. E., Cottengim, C., Faulkner, M., & Hauck, F. R. (2024). Characteristics of Sudden Unexpected Infant Deaths on Shared and Nonshared Sleep Surfaces. *Pediatrics*. https://doi.org/10.1542/peds.2023-061984

d. Prevention Opportunities

The Panel identified several opportunities to strengthen preventative intervention with respect to safe sleep practices, processes, and collaborative strategies in Rhode Island. First and foremost, the Panel acknowledges the need for consistent and permanent funding to address safe sleep and fund the personnel to specifically address this critical issue. The Panel also elevated the need for a unified and consistent safe sleep language and messaging, including development of harm reduction messaging, education on the risks of substance use when co-sleeping, and accompanying materials available in languages of origin for Rhode Island families. Messaging should also clearly call out safe sleep practices when using highchairs, swings, Boppy pillows, car seats, and bouncy chairs, as well as how to practice safe sleep when parents are awake and sleeping.

Safe sleep messaging should be utilized across various disciplines including healthcare, child welfare, and any community systems that serve parents of newborns and infants. Safe sleep education messaging and assessments should be discussed early and often by all providers who interact with expectant parents during prenatal care and to parents of infants, including obstetricians, pediatricians, home visitors, clinicians, and providers.

In practice, the Panel recommends that DCYF expand the definition of safe sleep to include napping, the dangers of inclined sleep positions, use of Boppy pillows and swings, and provide physical and verbal resources about these risks to families. The Panel also recommends enhanced training and education of new and existing DCYF staff, with prescriptive steps for supervisors to reinforce the importance of safe sleep education and assessment in the field. The Panel recommends that CPIs should discuss safe sleep education and assess for safe sleep when responding to any calls for children under one year of age and any DCYF staff should put eyes on the sleeping environment as part of the safe sleep assessment when in a family's home. These instances should be documented in RICHIST in case notes.

The Panel recommends that in addition to collaborating with other state agencies serving and supporting parents of newborns and infants on safe sleep efforts, RIDOH should expand and enhance their Safe Sleep campaign to include self-disclosed lived experiences of Rhode Island families impacted by unsafe sleep practices to illustrate and emphasize the importance of safe sleep practices.

While education and assessment specific to safe sleep will not guarantee prevention of fatalities and near fatalities of infants, it is critical to provide consistent messaging and frequent discussion of safe sleep with the goal of prevention.

e. National Partnership for Child Safety – Support for States

The NPCS emphasizes that child fatalities should be viewed through a prevention framework aimed at understanding contributing circumstances and system opportunities rather than assigning individual blame. The multidisciplinary review team processes can identify patterns

and support upstream prevention strategies that address family stressors, housing instability, financial limitations, and barriers to implementing safe sleep recommendations.

The review team further recognizes that safe sleep practices are influenced by a broad range of individual, family, and systemic factors. Preventing sleep-related fatalities and near fatalities therefore requires coordinated efforts across public health, healthcare, child welfare, and community systems. Strategies that combine evidence-based education, public awareness campaigns, practical supports for families, and nonjudgmental, harm reduction approaches offer meaningful opportunities to reduce risk and prevent future tragedies. [63]

VII. Mobile Response and Stabilization Services

Behavioral health crises among children and adolescents require rapid, developmentally appropriate, and family-centered interventions. Nationally, children and youth experience rising rates of mental health disorders, suicidal ideation, self-harm, and substance use concerns, while families struggle to access behavioral health services. In the absence of appropriate community-based crisis intervention, behavioral health emergencies often escalate, resulting in unnecessary emergency department visits, involvement with law enforcement, child welfare involvement, and increased risk of serious injury or death. The Substance Abuse and Mental Health Services Administration (SAMHSA) emphasizes that children and youth require a specialized crisis continuum that is distinct from adult systems and designed to provide immediate access to developmentally appropriate interventions that prioritize safety, stabilization, and family preservation.[64]

Mobile Response and Stabilization Services (MRSS) is a nationally recognized best-practice model for responding to behavioral health crises among children and youth. MRSS provides immediate, community-based response to children, adolescents, and young adults experiencing emotional, behavioral, or psychiatric crises. The foundation of the model utilizes three interconnected components: a crisis access point for families seeking assistance, mobile crisis teams that respond rapidly to homes and community settings, and stabilization services that provide short-term interventions and connection to ongoing supports.[65]

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[63] American Academy of Pediatrics. (2023, August 21). *Safe sleep*. Www.Aap.Org. https://www.aap.org/en/patient-care/safe-sleep/
Erck, A. B., Shapiro-Mendoza, C. K., Parks, S. E., Cottengim, C., Faulkner, M., & Hauck, F. R. (2024). Characteristics of Sudden Unexpected Infant Deaths on Shared and Nonshared Sleep Surfaces. *Pediatrics*. https://doi.org/10.1542/peds.2023-061984

[64] SAMHSA. (2025). *2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care 2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care*. https://library.samhsa.gov/sites/default/files/national-guidelines-crisis-care-pep24-01-037.pdf

[65] Dunnigan, B. (2023, February 27). *Mobile Response & Stabilization Services | Innovations Institute*. https://innovations.socialwork.uconn.edu/mrss/

SAMHSA's National Guidelines for Child and Youth Behavioral Health Crisis Care and its 2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care identify MRSS as an essential component of an effective crisis system. Effective crisis systems are child-centered, family-focused, trauma-informed, culturally responsive, and designed to provide continuity of care from the onset of a crisis through stabilization and follow-up services. Evidence demonstrates that community-based mobile crisis interventions can safely de-escalate crises, reduce unnecessary hospitalizations and emergency department visits, prevent child welfare involvement, and improve engagement with ongoing behavioral health treatment and supports.

a. MRSS in Rhode Island

The implementation of MRSS in Rhode Island has proven success as a critical prevention strategy included in the comprehensive continuum of crisis services for children and youth. Initially launched as a statewide pilot, MRSS provides immediate, community-based behavioral health crisis intervention for children and adolescents experiencing emotional or behavioral health emergencies, with the goal of diverting youth from emergency departments, psychiatric hospitalization, law enforcement involvement, and out-of-home placements. Consistent with the national model developed by the Innovations Institute at the University of Connecticut, MRSS delivers rapid, in-person crisis response followed by short-term stabilization and family support services to children of all ages that are available where children live, learn, and play. In Rhode Island, implementation occurs through partnerships among community behavioral health providers, serving children and families throughout the state. During the 2026 legislative session, Rhode Island enacted legislation formally codifying MRSS in state law, establishing MRSS as a distinct, child- and family-specific crisis response service delivered by designated providers with demonstrated expertise in child and adolescent behavioral health and family systems.

b. Case Data

Case chronologies demonstrated opportunities for earlier intervention through MRSS for children in the home, including real-time assessment, safety planning, de-escalation, and timely connection to ongoing community-based services. Consistent with national evidence, children experiencing behavioral health crises often present with complex and intersecting needs that extend beyond psychiatric symptoms. These crises frequently occur within the context of trauma, family stressors, developmental disabilities, substance use concerns, child welfare involvement, or unmet social needs.

SAMHSA and the Innovations Institute emphasize that effective crisis response requires an integrated, cross-system approach that addresses both the immediate safety concerns and the underlying factors contributing to crisis recurrence within the family system. Stabilization

services, family peer support, and coordinated follow-up care are critical components of reducing future crises and promoting long-term well-being.

c. MRSS Codified in Rhode Island State Law

In June 2026, legislation sponsored by Senate President Valarie Lawson and Representative Julie Casimiro, codified MRSS in Rhode Island state law and the Rhode Island state budget provides for MRSS coverage by Medicaid through a $900,000 appropriation in FY 2027.[66] Codifying an effective program like MRSS ensures that trained clinicians can respond quickly to de-escalate crises in real time to keep children and youth safe and prevent emergency department visits, providing better outcomes for children and reducing stress on the healthcare system in Rhode Island. Legislation further requires that responding clinicians possess specialized training in serving children, youth, and families, reinforcing the state's commitment to developing an accessible, developmentally appropriate, and trauma-informed crisis response system for children and adolescents.

Expanding access to MRSS represents a critical strategy for improving overall family well-being and preventing deeper system involvement. A robust crisis continuum that provides immediate support, rapid response, and ongoing stabilization ensures that children and families receive the right care, in the right place, at the right time, and reduces the likelihood that behavioral health crises progress to preventable fatalities or near fatalities.

Following MRSS being codified in state law, it will be critical to enhance public education about the eligibility for MRSS for any child, from birth to age 21, when MRSS should be called, who can call in times of crisis, and expanding education on use of MRSS for young children.

VIII. Cannabis Use

Cannabis use among caregivers and during pregnancy presented in many of the cases reviewed by the Panel. While the parents were not necessarily indicated by DCYF for substance use, substance use was often discussed with families during the course of investigation. In fact, cannabis use was present in the case history for nineteen (19) cases, fifteen (15) fatalities and four (4) near fatalities. When DCYF was connecting with the family, harm reduction was most often discussed, as the presence of a medical marijuana card and the ultimate legalization of cannabis makes it increasingly difficult to indicate for allegations of drug/alcohol abuse for cannabis use. “Marijuana use among all adult age groups, both sexes, and pregnant women is going up. At the same time, the perception of how harmful marijuana use can be is declining.”[67] Cannabis use was not the central focus of investigations, calls to the Hotline, or caused the fatalities or near fatalities, however, cannabis use was present in many of the cases and had an indirect effect on outcomes.

[66] Senate Bill 3066 Sub B as amended sponsored by Senate President Lawson and House Bill 8180 Sub A as amended by Representative Casimiro.
[67] The Effects, Risks and Side Effects of Marijuana (Weed, Cannabis, THC) | SAMHSA

The AAP released guidance in 2018 regarding the increased use of cannabis for severe nausea associated with pregnancy and the long-term consequences for the infant or child.[68] The guidance made several recommendations including public education and counseling on the adverse effects of cannabis use for pregnant women and infant exposure to smoke from cannabis.[69] It also provided guidance that while cannabis is legal in some states, women who use cannabis while pregnant may be subject to child welfare investigations if they have a positive cannabis screen.[70] The Panel discussed the importance of ensuring that clear and accurate information is readily available to pregnant women and parents of the adverse of effects of cannabis use, especially with the amount of information and misinformation on the internet and social media.

Prior to legalization of cannabis in Rhode Island, cannabis use was weighed differently at the time of investigations concerning parents or caregivers of children. Now that cannabis is legal, it presents practice challenges pertaining to screening, investigation and risk assessment. It is recommended that DCYF work with RIDOH, in alignment with best practice recommendations, to determine how to approach legal cannabis use among caregivers who become involved with DCYF. Additionally, DOPs should be updated to reflect the legalization of cannabis in Rhode Island, and appropriate procedures staff should follow when assessing as a risk factor during investigations and in cases open to DCYF.

IX. Water Safety

The United States National Water Safety Program conducts education, community engagement, research and data collection, and implements evidence-based plans to promote water safety and prevent drowning across the country. This program connects initiatives from the United States Centers for Disease Control and Prevention (CDC) and United States Army Corps of

[68] Sheryl A. Ryan, Seth D. Ammerman, Mary E. O'Connor, COMMITTEE ON SUBSTANCE USE AND PREVENTION, SECTION ON BREASTFEEDING, Lucien Gonzalez, Stephen W. Patrick, Joanna Quigley, Leslie R. Walker, Joan Younger Meek, IBCLC, Margreete Johnston, Lisa Stellwagen, Jennifer Thomas, Julie Ware; Marijuana Use During Pregnancy and Breastfeeding: Implications for Neonatal and Childhood Outcomes. *Pediatrics* September 2018; 142 (3): e20181889. 10.1542/peds.2018-1889

[69] Sheryl A. Ryan, Seth D. Ammerman, Mary E. O'Connor, COMMITTEE ON SUBSTANCE USE AND PREVENTION, SECTION ON BREASTFEEDING, Lucien Gonzalez, Stephen W. Patrick, Joanna Quigley, Leslie R. Walker, Joan Younger Meek, IBCLC, Margreete Johnston, Lisa Stellwagen, Jennifer Thomas, Julie Ware; Marijuana Use During Pregnancy and Breastfeeding: Implications for Neonatal and Childhood Outcomes. *Pediatrics* September 2018; 142 (3): e20181889. 10.1542/peds.2018-1889

[70] Sheryl A. Ryan, Seth D. Ammerman, Mary E. O'Connor, COMMITTEE ON SUBSTANCE USE AND PREVENTION, SECTION ON BREASTFEEDING, Lucien Gonzalez, Stephen W. Patrick, Joanna Quigley, Leslie R. Walker, Joan Younger Meek, IBCLC, Margreete Johnston, Lisa Stellwagen, Jennifer Thomas, Julie Ware; Marijuana Use During Pregnancy and Breastfeeding: Implications for Neonatal and Childhood Outcomes. *Pediatrics* September 2018; 142 (3): e20181889. 10.1542/peds.2018-1889

Engineers, providing guidance on water safety resources, tools and strategies for individuals, communities, and organizations to prioritize safety in and around water.[71]

Children between ages one and four are more likely to die from drowning than any other cause of death, while drowning is the second leading cause of unintentional death after motor vehicle deaths among children between ages five and fourteen.[72] Drowning can occur at any time there is access to water and can happen to anyone. The CDC recommends various prevention strategies to prevent drowning including but not limited to learning basic swimming and water safety skills, building fences to fully enclose pools, close supervision, wearing a life jacket, and knowing the risks of natural occurring bodies of water.[73]

Prevention efforts targeting subpopulations at higher risk of drowning including young children and children with developmental disabilities, including autism spectrum disorder, are critical. Compared to the general population, drowning deaths are more than forty times as likely to be due to drowning among individuals with autism spectrum disorder (CDC). Various water safety prevention resources are available through Safe Kids Worldwide, Water Wise Kids, Healthychildren.org water safety advice, and the AAP.

The Panel reviewed five (5) fatalities due to drowning. While each of the cases had unique circumstances, the Panel discussed the value of continued public education with respect to water safety, including information regarding backyard pools, bodies of water, and public swimming areas. In Rhode Island, RIDOH uses a prevention block grant to promote water safety and fund community programs to provide youth swimming lessons. Ensuring that swimming lessons are affordable and accessible to all is invaluable to keep children safe in and around water.

X. Transparency and Accountability for the Implementation of Recommendations

The May 2025 Report of the Office of the Child Advocate Child Fatality Review Panel review cases related to substance exposure and adolescent substance use and discussed the importance of a written response from agencies named in the recommendations made by the Panel. While reports like these are publicly available on the OCA's website, there is no corresponding response requirement allowing the public to see how recommendation implementation is progressing in real time. The OCA recognizes the efforts by all state agencies to respond and address the recommendations, however, when leadership changes, priorities can shift and it is critical that a written response to the recommendations is issued to the OCA to monitor systemic reforms.

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[71] Centers for Disease Control. (2024, November 12). *U.S. National Water Safety Action Plan*. Drowning Prevention. https://www.cdc.gov/drowning/partners/usnwsap.html

[72] Centers for Disease Control. (2024, May 3). *Drowning Facts*. Drowning Prevention. https://www.cdc.gov/drowning/data-research/facts/index.html

[73] Centers for Disease Control and Prevention. (2024, October 16). *Prevention | drowning prevention | CDC*. Www.Cdc.Gov. https://www.cdc.gov/drowning/prevention/index.html

Connecticut General Statute § 46a-13l(f) requires “any state agency cited in a report issued by the Office of the Child Advocate, pursuant to the Child Advocate’s responsibilities under this section, shall submit a written response to the report and recommendations made in the report to the Governor and the General Assembly not later than ninety days after receipt of such report and recommendations.”

During the 2026 Legislative Session, Senate Bill 2976 was introduced by Leader de la Cruz, to require state agencies that receive recommendations from the OCA 's Child Fatality Review Panel to issue a formal written response within a specified timeframe, outlining planned actions, implementation progress, or barriers to implementation of recommendations. While the proposed legislation did not become law, it would build on Rhode Island's existing commitment to transparency by creating a structured accountability process similar to the process in Connecticut.

A new section titled The Office of the Child Advocate Fatality Review Panel Reports and Recommendations has been added under the Data and Analytics section of the DCYF website. In addition to a summarization of the purpose of OCA Child Fatality Reports, this section includes links to reports issued by former OCA Child Fatality Review Panels as well as a link to the DCYF Update on OCA Recommendations link, most recently updated as of May 2026.

However, requiring a more specific written responses will help the OCA monitor DCYF policy, procedure, and practice changes directly related to recommendations from OCA Child Fatality Review Panels. In order to better protect children in Rhode Island and prevent future fatalities and near fatalities, recommendations must lead to measurable action through stronger communication among agencies and policymakers, support the identification of resource or legislative needs, and promote continuous system improvement.

RECOMMENDATIONS

Child Protective Services

1. DCYF to conduct a comprehensive review of the SDM tool, DCYF DOPs, CPS Regulations, and applicable Rhode Island General Laws to identify and resolve any inconsistencies, gaps, or conflicts among these governing frameworks and ensure they are fully aligned. DCYF to develop a clear action plan to address identified issues, establish timelines and accountability for implementation, and track and publicly report on all resulting changes. DCYF to engage Evident Change to ensure the SDM tool is reviewed and modified in accordance with established standards and best practices.
2. DCYF Administration to assess and make any necessary changes to the CPS Administrative and supervisory review process for screening decisions to ensure this practice is both effective and reliable. DCYF to formalize any changes implemented to strengthen the process in a DOP.
3. DCYF to revise DOP 500.0000 to formally incorporate the Department's current practice requiring review and approval of Screen Out decisions by multiple CPS Administrators, in addition to the Call Floor Supervisor. DCYF to clearly outline expectations of assessment, review, and documentation prior to approval of a Screen Out.
4. DCYF to work with Evident Change to develop and implement a structured approach for assessing cumulative risk that incorporates prior history, recent CPS contact, and other relevant information. DCYF to ensure the approach supports consistent identification of patterns of behavior or incidents in accordance with CPS regulations and DOPs.
5. DCYF to reinforce investigative requirements and supervisory oversight to ensure that assigned CPIs conduct and document interviews with all individuals present at the time of incident, in accordance with DCYF DOPs and the Family Functioning Assessment Intervention Manual.
6. DCYF to establish and enforce clear documentation standards for screened-out reports, specifying the information that must be documented in RICHIST, including the allegations received, relevant risk and safety factors considered, application of the SDM criteria, and the rationale supporting the screen-out determination.
    a. DCYF to incorporate these requirements into the applicable DCYF DOP 500.0000 and, if feasible, embed them directly into the SDM prompts to promote consistency, accountability, and transparency in screening decisions.
7. DCYF to establish documentation standards for a Screen Out requiring an additional response, pursuant to DOP 500.0015, specifically, clear documentation standards for cases assessed by CPS for a Prevention Response.
8. DCYF to amend DOP 500.0000 and DOP 500.0015 to require a thorough review of Screen Out documentation by the Call Floor Supervisor and CPS Administration prior to providing final approval of the screening decision, including documentation

requirements for supervisors and CPS Administration regarding their review and approval of the screening decision.

9. DCYF to provide a comprehensive and public update regarding the development of a formal hotline quality assurance framework, including initial screening decisions and an assessment of CPS referrals to SRU for Prevention Response. This framework was to be established by August 1, 2026.
    a. DCYF to publicly report and utilize data collected through quality assurance and outcome monitoring to inform continuous practice improvement, including targeted training, supervisory coaching, policy revisions, and resource allocation to improve consistency and strengthen service delivery statewide.
10. DCYF to work directly with Evident Change to for technical assistance, staff development and enhanced quality monitoring.
11. DCYF to develop and implement a DOP that establishes a standardized process for responding to child fatalities and near fatalities. At a minimum, DCYF to include in the DOP:
    a. Notification requirements;
    b. Define roles and responsibilities for both administration and front-line staff;
    c. Expectations for information and data collection;
    d. Documentation standards;
    e. Key definitions;
    f. Intra-agency communication protocols;
    g. Investigative standards and documentation requirements consistent with applicable Rhode Island General Laws and regulatory requirements. The investigative standards should also include:
        i. Procedures for assigning investigations, including the assignment of two investigators to each child fatality investigation and measures to prevent investigators from receiving back-to-back child fatality assignments.
    h. Requirements for providing peer support to staff following the notification of a child fatality or near fatality.
12. DCYF to align the SDM and DOP 500.0030 regarding the documentation of Additional Information and Duplicate Reports. Ongoing training to be provided to staff on the proper documentation of this information. Supervisors and CPS Administration to assess this information when evaluating Screen Outs to ensure calls are not designated improperly as a Screen Out. DCYF to incorporate a review of consistency with this practice as part of the quality assurance process for CPS.
13. DCYF to reengage with Action 4 Child Protection and Evident Change to evaluate the implementation and effectiveness of the current models and determine whether continued use of both models or adoption of a single model would better promote

consistency and improve outcomes. DCYF to also explore whether additional technical assistance is needed to ensure that evidence-based practices are applied consistently and effectively.

14. DCYF to strengthen internal collaboration between CPS and CRU, in cases where formal FSU involvement is not warranted, to ensure families receive individualized, timely, and appropriate interventions based on their need identified through the FFA. A formal process should be outlined and memorialized in a DOP.
15. DCYF to strengthen CPS policies, protocols, training, and supervisory review practices to ensure fidelity to the SAFE model and that investigations result in a comprehensive assessment of the family's circumstances, including all significant safety, risk, and service needs. CPS should ensure identified concerns are thoroughly assessed, addressed, and documented before case closure and that families are connected to the appropriate level of intervention and services.
16. DCYF Administration to conduct a comprehensive review of all pending investigations and those completed within the past 90 days to assess compliance with investigative timelines established by DCYF regulations, policy, and SAFE model standards. DCYF should develop and publicly communicate a formal corrective action plan to address immediate safety concerns associated with delayed investigations.
17. DCYF Administration to reinforce SAFE model standards and monitor compliance by CPS Administration, specifically regarding the initiation of a new FFA when allegations are made to the Hotline. The practice of reopening closed FFAs is not in compliance with the SAFE model, does not promote comprehensive assessment of the family, and skews statistics regarding investigations.
18. DCYF to engage Action 4 Child Protection to retrain all CPS and SRU staff on the SAFE model, with specific instruction on the proper completion and application of the FFA. DCYF should establish an ongoing training schedule that provides continuous opportunities for staff to reinforce skills, address identified practice gaps, and maintain fidelity to the SAFE model.
19. DCYF to develop supervisory and administrative review and documentation requirements prior to approval of an FFA. The review is to include but is not limited to a review of:
    a. Timeliness of the investigation;
    b. Independent verification of information;
    c. Interviews with all relevant household members;
    d. Private interviews with children when developmentally appropriate;
    e. Adherence to documentation standards;
    f. Assessment of safety and risk;
    g. Development of a safety plan, when required

h. Strict compliance with relevant DOPs, SAFE model, RI General Law and CPS Regulations
    i. Robust reviews of completed investigations should inform future training and supervision needs for individual employees or CPS staff generally.

20. DCYF to require all CPIs to complete a nationally recognized Forensic Interviewing training.
    a. This was a prior recommendation of the OCA in the 2023 St. Mary's Home for Children Investigation report from 2023.
21. DCYF to develop a quality assurance framework to review completed FFAs to ensure strict compliance with the SAFE model, RI General Law, DCYF DOPs and CPS regulations.
    a. DCYF to publicly report and utilize data collected through quality assurance and outcome monitoring to inform continuous practice improvement, including targeted training, supervisory coaching, policy revisions, and resource allocation to improve consistency and strengthen service delivery statewide.
22. DCYF to evaluate CPS staffing levels on all shifts:
    a. To ensure there is adequate call floor staffing for each shift to provide for an opportunity for thorough engagement and information collection with each caller.
    b. To ensure adequate personnel are available for critical incidents, including child death investigations.
    c. To ensure screening practices are not influenced by the availability of CPS staffing.
    d. To ensure caseloads remain within COA standards.
    e. To ensure that lack of staffing does not impact DCYF's ability to conduct a comprehensive and timely response.
    f. To implement staffing strategies or surge-capacity protocols to ensure sufficient investigative coverage during weekends and other periods of reduced staff.
23. DCYF to evaluate its hiring practices and standards for CPS positions, including the requirement for prior child welfare and/or investigative experience. The importance of institutional knowledge should be given strong consideration when establishing qualifications for these positions, as this can support staff retention and help ensure a sufficiently experienced and knowledgeable workforce. DCYF to explore requirements for CPIs in other jurisdictions and align with best practice.
24. DCYF to review and clarify the definition of "caretaker" under Rhode Island law and policy, including its application to babysitters and other non-parent caregivers. DCYF should examine definitions and approaches used in other jurisdictions to determine whether changes are warranted.

25. DCYF to establish clear standards for assessment of risk when marijuana use is indicated.

Prevention and the Support and Response Unit

26. DCYF to develop and implement clear Prevention Response criteria. DCYF to revise DOP 700.0190 and DOP 500.0015 to specifically define what constitutes a Prevention Response.
27. DCYF to revise DOP 700.0190 and DOP 500.0015 to establish objective criteria and standardized procedures for referring screened-out CPS reports to SRU. Decision-making guidance, examples, and documentation requirements to be included in the changes to promote consistent application.
28. DCYF to revise DOPs and if possible, the SDM, to require documentation by CPS staff of rationale for SRU referral decisions, including decisions not to refer screened-out reports. Documentation must be sufficient to support supervisory review and quality assurance.
29. DCYF to revise DOP 700.0190 and applicable Child Protective Services DOPs to require the consideration and documentation of SRU or other prevention service referrals for families whose child protective services investigations result in unsubstantiated findings but identify service needs. Staff to document whether a referral was considered and, when appropriate, completed.
30. DCYF to provide training on Prevention Responses and SRU referral practices once criteria are further established. DCYF to provide initial and ongoing training to CPS staff, supervisors and administration regarding Prevention Response criteria, referral expectations, documentation requirements.
31. DCYF to provide ongoing training and accessible resources to ensure staff have current knowledge of available family and community-based services and can consistently connect families to appropriate resources statewide. DCYF to also engage provider agencies in these training opportunities to give staff direct information about available services, eligibility, and referral processes.
32. DCYF to comply with the regulations set forth in 214-RICR-20-00-1, Section 1.15, for a Family Assessment Response, or in the alternative, formally propose changes in accordance with the Administrative Procedures Act, to reflect the new model currently in practice. This will require a public comment period. The model outlined in the regulations does present solutions to many of the issues identified by the Panel with SRU.
33. DCYF to conduct a comprehensive assessment of SRU to identify and implement the infrastructure necessary to support its effective and consistent operation. The assessment is to include an examination of staffing, policies and procedures, assessment

tools, data collection, documentation standards, minimum requirements for ongoing supervision and related documentation, and quality assurance measures. The Panel recognizes that the findings of this assessment and any resulting restructuring of SRU may affect the specific recommendations and related policy changes outlined in this report. The findings of this assessment and corresponding action plan are to be shared publicly for full transparency and for future advocacy.

34. DCYF to develop a centralized tracking and reporting system for SRU referrals from all sources to support ongoing monitoring and quality assurance.
35. DCYF to establish and implement a standardized, evidence-based family assessment process for all families open to SRU, consistent with the existing requirement under 214-RICR-20-00-1, Section 1.15, including a standardized assessment tool and clear guidance to ensure consistent identification and documentation of family strengths, protective factors, risk factors, and service needs across all regions.
36. DCYF to develop and implement a standardized FFA decision-making process for families open to SRU when there is identified risk. The process must clearly define when an FFA is required under DOP 700.0190, establish objective criteria for identifying elevated risk, include documentation requirements to promote consistent decision-making and add strict requirements for supervisory review of this practice.
37. DCYF to develop and implement a mechanism to systematically track and monitor FFAs completed within SRU, including when an FFA is required under policy, whether it was completed, and the rationale for any exceptions. Utilize this data to monitor policy compliance, evaluate practice consistency, identify trends and training needs, and ensure that families presenting with elevated risk receive comprehensive assessments.
38. DCYF to revise *DOP 700.0190* to establish clear expectations regarding the timeframes for assigning referrals to an SRU caseworker from the date of receipt. DCYF to consider current assignment protocol to determine whether the current staffing structure supports compliance with timely assignment of cases and reflect any necessary changes in the policy. The policy must require timely notification to DCYF Administration when assignment timeframes cannot be met, including documentation of the reasons for the delay, the number of affected referrals, and the plan to restore compliance.
39. DCYF to revise *DOP 700.0190* to require clear documentation of administrative review of cases initially called in through the Family Support Line or designated for a Prevention Response and it is determined that SRU engagement is not warranted. The case record must include a documented assessment of the family's needs, the rationale supporting the decision not to proceed with SRU engagement, the identity of the individual making the decision, and the date of the determination. The policy is to outline heightened administrative review of these decisions as all families seeking support and services should be provided this assistance.

40. DCYF to implement standardized supervisory review requirements throughout the lifecycle of SRU cases, including review and approval of initial assessments, FFA determinations, and case closure decisions. Supervisors must ensure that identified risk factors have been comprehensively assessed, policy requirements have been met, documentation is complete and sufficient, and appropriate services and interventions have been implemented before approving case closure. All supervisory reviews are to be thoroughly documented.
41. DCYF to establish and implement a comprehensive quality assurance process for SRU that routinely reviews the quality, timeliness, and consistency of casework, including assessments, documentation, service planning, supervisory decisions, and reports. This process is to include regular case reviews at both the supervisory and administrative levels, identify trends and areas requiring corrective action, and ensure findings are used to strengthen practice, improve consistency, and promote compliance with policy and applicable standards.
42. DCYF to require SRU staff to receive training in motivational interviewing and other evidence-based engagement practices, with ongoing coaching and supervision to support consistent application and strengthen meaningful engagement with families.
43. DCYF to provide ongoing, standardized training for SRU staff on assessment practices, family engagement, risk identification, and service planning to promote consistent, high-quality practice.
44. DCYF to conduct and publicly report a comprehensive assessment of SRU staffing needs, including caseloads, workload demands, vacancies, turnover, and anticipated changes in work expectations pursuant to the recommendations outlined here, such as more in-depth family assessments and other changes that may increase the complexity of the casework. Based on the assessment, DCYF to develop and implement a plan to address staffing gaps and ensure sufficient frontline staffing to support timely and meaningful family engagement.
45. DCYF to establish standardized documentation expectations that clearly define the minimum information required in SRU case records, including family engagement efforts, assessment findings, service referrals, follow-up activities, barriers to engagement, and the rationale supporting case decisions and closure.
46. DCYF to review the current 30- to 45-day SRU case timeframe to determine whether it provides sufficient opportunity for meaningful family engagement and service connection. Outline case closure criteria that prioritizes successful engagement, completion of critical assessment activities, linkage to appropriate services, and progress toward addressing identified family needs rather than relying primarily on a prescribed timeframe.

47. DCYF to implement a process to monitor and analyze repeat child welfare involvement following SRU intervention, including tracking families who re-enter the child welfare system after SRU case closure, identifying trends and contributing factors, and using this information to evaluate program effectiveness and inform continuous quality improvement efforts.
48. DCYF to provide additional training, guidance, and supervisory oversight regarding the use of professional and language when documenting information about parents and children, particularly in court letters and case activity notes. Documentation to focus on objectively describing behaviors, circumstances, identified concerns, and actions taken.

DCYF Cross-Departmental Priorities

49. 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. DCYF 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.
            1. Whether a recommendation has been made more than once throughout the year.
            2. An update on the status of the recommendation.
            3. An update on the status of recommendations made in prior years.
                a. 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.
                    i. This recommendation was also made in the Report of the OCA's Child Fatality Review Panel from May 2025.
50. DCYF to provide heightened oversight to the provision of peer support following a critical incident, in accordance with DOP 200.0090.
    a. This recommendation was also made in the Report of the OCA's Child Fatality Review Panel from May 2025.
51. DCYF to conduct ongoing public education and establish sustained partnerships with local law enforcement agencies to strengthen communication, clarify roles and responsibilities, and ensure a consistent understanding of the appropriate steps to take when a case involves a child. DCYF to develop mechanisms for regular communication

and collaboration with police departments to promote consistent practices and timely coordination in cases involving child safety and protection.

52. DCYF to strengthen interdepartmental communication and coordination in the management of critical cases. Clear policies and protocols are to be established to ensure timely notification, consistent communication, and the prompt exchange of pertinent information among DCYF units. These protocols must clearly define roles, responsibilities, and expectations to ensure critical information is communicated across units and appropriate action is taken without delay.

Safe Sleep and Harm Reduction

53. DOH, DCYF, BHDDH, EOHHS, in consultation with the Rhode Island Chapter of the AAP, to develop and provide consistent messaging, resources, and documentation to be shared among the local medical community and community providers about safe sleep best practices when caregivers are awake or asleep, the risks of co-sleeping, and a harm reduction approach to bed-sharing when speaking to expectant parents or caregivers and with any parent or caregiver with a child under age one (1). The messaging is to include information about increased risks related to substance use, be culturally responsive and multilingual, incorporate lived expert testimonials, and include education about higher risk sleeping environments including Boppy pillows, swings, inclined sleep positions, and the like.
54. All child-serving state agencies, medical providers, and community providers to provide consistent information about safe sleep pre- and post-partum, early and often.
55. DCYF to develop procedural and practice training and process to ensure CPI and FSU workers have frequent and ongoing conversations about safe sleep pre- and post-partum, conduct safe sleep assessments, including putting eyes on the sleep environment when visiting in-home, with parents or caregivers caring for a child under age one (1). Procedures must incorporate a component for supervisory reinforcement and tracking in case notes.
56. EOHHS, DCYF, DOH, BHDDH, in consultation with the Children's Cabinet to assess and develop pathways for consistent and permanent funding streams to address safe sleep education, harm reduction for bed-sharing, and the positions needed to effectuate such work within state government.

Family Care Community Partnerships

57. DCYF to review billing structure for FCCP to allow for families to maintain involvement with FCCP even when incorporating additional, necessary services into the family through the Central Referral Unit, which may also have a case management component.

58. DCYF to establish a protocol within CPS and SRU to ensure that there is initial contact with FCCP and families prior to closing to DCYF.
59. DCYF to explore all funding opportunities to invest in housing resources and expertise to support families through FCCP and DCYF to identify and maintain stable housing.
60. DCYF to confer with the Federal Monitor for the DOJ Consent Decree regarding the use of the Single Point of Access to support comprehensive assessments and coordination of services for families to prevent child welfare involvement.
61. DCYF to increase public awareness of the availability of FCCP to all Rhode Island families who meet the eligibility criteria and how to self-refer to these services.
62. DCYF to amend DOP 100.0375 relating to Family Community Care Partnership (FCCP) Referral to align with the required Wraparound Model, including family and youth voice in considering a referral and also to remove language authorizing a referral to FCCP.
63. DCYF to review DOP 700.0190 to identify if the language can be strengthened to encourage referrals and education regarding FCCP, in addition to outlining a clearly defined process for when FCCP alerts DCYF that the family declined to engage in services or FCCP was unable to connect with the family.
64. DCYF to ensure that a review of FCCP is incorporated into the comprehensive needs assessment currently underway.

Family Home Visiting Programs

65. DOH to explore opportunities for First Connections to co-locate at pediatrician offices and other high-traffic areas for new parents to engage and educate parents on programming.
66. DOH to work with First Connections providers to identify and implement strategies to increase engagement with families who may be hesitant to participate in services, including additional follow-up and alternative methods of communication. DOH should also explore opportunities to support new parents by providing essential items and using these interactions to introduce families to First Connections services.
67. DOH to explore utilization data to determine the efficacy of co-locating at the hospital and pediatrician offices.
68. 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.
    i. ***This recommendation was also made in the Report of the OCA's Child Fatality Review Panel from May 2025.***
69. DOH to explore public education opportunities or a public awareness campaign on the importance of engaging parents through Family Home Visiting, early and often, starting prenatally.
70. 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 handoff to other services deemed to be necessary.
d. Explore universal delivery of family home visiting programs to provide services and supports to all families.
    *i. **This recommendation was also made in the Report of the OCA's Child Fatality Review Panel from May 2025.***

71. 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.
    *a. **This recommendation was also made in the Report of the OCA's Child Fatality Review Panel from May 2025.***

Mobile Response and Stabilization Services

72. DCYF, BHDDH, DOH, EOHHS and the RI Department of Education should collaborate with contracted MRSS providers on statewide public education efforts specific to MRSS eligibility for any child under age 21, and availability, including how and where to access.

Parental Cannabis Use

73. 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.
    *a. **This recommendation was also made in the Report of the OCA's Child Fatality Review Panel from May 2025.***
74. EOHHS, BHDDH, DOH and DCYF to explore the use of funds through the "marijuana trust fund" established through R.I.G.L. § 21-28.11-13 to support public education and service needs pursuant to subsection d. of this statute. A public report should be provided to report how funds were allocated and utilized by the identified agencies to support the initiatives outlined in subsection d.

Accountability and Funding

75. 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.
    c. Recommendations DCYF will not be implementing and why the recommendations will not be adopted.

d. Identify how FY 27 funding will be utilized to specifically address these issues and what additional funding will be required in FY 28.
e. Any efforts that have been taken to collaborate with other entities identified in this report.

76. The OCA to pursue legislative change to memorialize the requirement of a public response by all agencies who receive recommendations, to align RI with other states. The change sought is outlined in Senate Bill S2976 proposed by Senator de la Cruz during the 2026 legislative session.

Darlene Allen, MS

Kristin Anslo

Siobhan Bogosian, Esq.

Kristine Bouthillier

Kristine Campagna, MEd

Peter Capalbo, Esq.

Ashley Chiari

Kathryn R. Cortes

Ken Fandetti, M.S.S.S.

Kara A. Foley, MSW

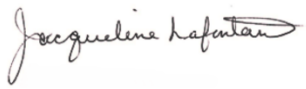
/s/ Margaret Howard

Margaret Howard, PhD

/s/ Det. Michael D. Iacone

Detective Michael D. Iacone

Margo Katz, MA

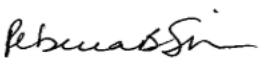


Jacquenline Lafontant

Katelyn Medeiros, Esq.

Tosin Ojugbele, MD MPH

Diana Robbins, Esq.



Rebecca Silver, PhD

APPENDIX A

Darlene Allen, MS, DHL

Darlene is an experienced nonprofit leader who has dedicated her 40+ year career to helping vulnerable children, youth, and families. She is a local and national advocate focused on legislation and resources to address the educational, housing, and mental health needs of children impacted by foster care. She has worked in both public and private organizations and her areas of focus have included adoption, child welfare, children's behavioral health, foster youth education, and preventing youth homelessness. For 26 years, Darlene has served as the CEO and Executive Director of Adoption Rhode Island, a private non-profit licensed and accredited organization that provides a range of trauma –focused and evidenced-informed services for foster and adopted children, transition age youth, young adults, and families. The agency also provides education, training, and technical assistance services for child welfare and other professionals who work with children, youth, and families impacted by trauma.

Kristine Campagna, MEd

Kristine Campagna is the Associate Director of the Division of Community, Health and Equity provides leadership, vision and policy direction to over 125 staff, including Center Chiefs, program leads, support staff and administrative staff. Ms. Campagna holds a Masters Degree in Education. She has worked passionately and tirelessly in the public health sector and at DOH for over 15 years. Ms. Campagna works closely with senior level department staff towards RIDOH's mission to eliminate health disparities and achieve health equity for all Rhode Islanders. Additionally, Ms. Campagna holds a strong commitment to engaging community members as key partners in public health and utilizing data to drive action. CHE's management team and grant management team have the requisite commitment, expertise, and experience to oversee, manage and evaluate the work for the Department of Health.

Ken Fandetti

Ken 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 Department of Corrections (DOC) and Department 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 Rhode Island's Child Abuse and Neglect 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.

Dr. Margaret Howard, PhD

Dr. Margaret Howard, Ph.D., is a Clinical Psychologist and Clinical Professor of Psychiatry and Human Behavior and Medicine at the Warren Alpert Medical School of Brown University, Providence, RI The Motherhood Center. Dr. Howard's primary clinical and research interests include perinatal mental health with particular focus on postpartum mood and anxiety disorders, trauma, and treatment models that support the mother-baby dyad. She has over 38 years of experience in clinical psychology, psychiatry, and women's mental health, with a career spanning inpatient, outpatient, and perinatal psychiatric services.

Detective Michael Iacone

Detective Michael Iacone, a 22-year veteran of the Cranston Police Department, who developed the department's therapy dog program, with Cali, believed to be the first comfort therapy dog in Rhode Island to serve as a police department member and hospital resident canine. Through his vision, Cali has supported victims of sexual assault and abuse and also participated in classroom visits and the creation of the "CALI Gives Back" program, which has evolved into CPD Cares, a charitable initiative that has donated over $10,000 to local organizations.

Margo Katz, MA

Margo is Chief of Program Development at the Rhode Island Department of Health. Her programmatic focus includes reducing sudden unexpected infant death (SUID) and improving the health and well-being of families affected by perinatal substance use. Margo came to the Department after a nearly 20-year career in hospital-based healthcare where she led programs in infectious disease and biodefense, cardiovascular disease and stroke, and graduate medical education. She has a bachelor's degree from Hampshire College and a master's degree from Smith College.

Barry M. Lester, PHD.

Dr. Lester, Professor of Psychiatry and Pediatrics at the Warren Alpert Medical School of Brown University and Women and Infants Hospital, has spent his career at the intersection of developmental psychology and pediatrics. As the Founding Director of the Brown Center for the Study of Children at Risk (BCC), Dr. Lester has built an interdisciplinary center that seamlessly integrates high-impact, clinically relevant research with evidence-based clinical services and professional training. The BCC was created to address the causes and manifestations of

neurodevelopmental disorders in children and provide innovative and effective interventions to promote neurodevelopment and behavioral health in high-risk populations. Under his leadership, the BCC has built a strong national and international reputation for conducting innovative, longitudinal, multi-center studies of infants at risk and their families.

Olutosin "Tosin" Ojugbele, MD, MPH

Dr. Ojugbele is the Medical Director of the Divisions of Community Health and Equity at the Rhode Island Department of Health. She is an Assistant Professor of Pediatrics at the Alpert Medical School at Brown University and practices primary care. Prior to joining the Rhode Island Department of Health, Dr. Ojugbele served as the Director of the Fostering Health Clinic at Hasbro Children's Hospital. She earned her medical degree and an MPH in Community Health Science from SUNY Downstate, completed her pediatric residency at Northwell Health/Cohen Children's Hospital, and pursued a post-doctoral fellowship in primary care research at Dartmouth Hitchcock Medical Center.

Rebecca Silver, PhD

Rebecca Silver, PhD is a clinical psychologist at the Early Childhood Collaborative of Bradley Hospital and an Associate Professor (Clinician Educator) in the Departments of Psychiatry and Human Behavior and in Pediatrics at the Warren Alpert Medical School of Brown University. Dr. Silver's professional interests focus on providing intervention, consultation, and professional development services for young children and their caregivers, supervising early childhood-serving professionals, and developing early childhood systems of care. She is the Director of SUCCESS, Rhode Island's infant and early childhood mental health consultation program in early care and education settings. She has also worked with other statewide systems to advance infant and early childhood mental health practice and principles, including the Rhode Island Family Visiting Network. She is involved in various efforts to evaluate the effectiveness of these services and systems via local program evaluation efforts and federal research funding. Dr. Silver is endorsed as an Infant Mental Health Mentor-Clinical by the Rhode Island Infant Mental Health Endorsement System.

APPENDIX B

Rhode Island Department of Children, Youth and Families
Department Operating Procedure

	DOP Number: **100.0060**	Effective Date: **July 02, 2026**	Page 1 of 5
	Version #: **1**	Revision History:	Director: **Ashley Deckert**
Section: **General Administration and Management**		Title: **Issuing a Hospital Alert**	

Legal Authority:

- R.I. Gen. Laws § 40-11-6 — Report by physicians and healthcare providers of abuse or neglect
- R.I. Gen. Laws § 40-11-7 — Investigation of reports — Petition for removal from custody
- R.I. Gen. Laws § 42-72-5 — Powers and scope of activities
- R.I. Gen. Laws § 42-72-8 — Confidentiality
- Child Abuse Prevention and Treatment Act (CAPTA), Pub. L. 93-247, as amended (42 U.S.C. § 5106a)
- Comprehensive Addiction and Recovery Act (CARA), Pub. L. 114-198 (amending CAPTA)
- 42 U.S.C. § 5106a(b)(2)(B)(ii) — Plan of Safe Care requirements for infants affected by substance abuse or withdrawal symptoms

Related DOPs:

- Child Abuse and/or Neglect Reports; DOP: 500.0000
- Assessing Reports of Child Abuse and Neglect and Child Safety Determinations; DOP: 500.0025
- Substance Exposed Newborns; DOP: 500.0080
- Plans of Safe Care Guidance Document
- Support and Response Unit: DOP: 700.0190

Related Forms:

- DCYF # 199, Alert to Area Hospitals – Infant Safety at Birth

I. PURPOSE

In accordance with state and federal law, the Department of Children, Youth, and Families (DCYF) may notify maternity hospitals when the Department identifies safety concerns requiring Child Protective Services (CPS) Hotline notification at the time of an infant's birth.

DCYF may receive reports to the CPS Hotline concerning suspected prenatal substance misuse or other safety concerns involving an expectant parent. A CPS investigation during pregnancy may be initiated when the report meets criteria for investigation and includes allegations of abuse or neglect involving a child who has been born. DCYF does not initiate CPS investigations of child abuse or neglect based solely on concerns regarding a pregnancy. When no child who has been born is alleged to be abused or neglected, an investigation is not initiated during pregnancy. However, DCYF may issue a hospital alert in accordance with this procedure when the

Department identifies safety concerns that may pose a potential safety risk to the infant after birth.

In compliance with state and federal requirements, DCYF identifies infants at risk of abuse or neglect due to prenatal substance exposure. The birthing hospital develops a Plan of Safe Care (POSC) for these infants and their caregivers. DCYF coordinates with the hospital and involved service providers, as appropriate, to support referrals and service connection. A POSC may be developed prenatally when appropriate and must be developed no later than discharge from the birthing hospital. When prenatal substance use concerns are identified before birth, the Department's Substance Use Coordinator may contact the expectant parent to offer support, provide information regarding available treatment and recovery resources, and assist with service connection before the infant is born.

II. TERMS DEFINED

Active / Open Case means a family or individual currently receiving DCYF services with an active case record in the Department's electronic case management system.

Caregiver means a parent, guardian, relative, or other person responsible for the care or supervision of a child or newborn. For purposes of this DOP, caregiver may include an expectant parent when discussing prenatal planning or hospital alerts before birth.

Designee means a person who has been formally authorized to act on behalf of the identified decision-maker for the specific responsibility described in this operating procedure. A designee must have the appropriate role, training, professional qualifications, supervisory authority, or clinical authority necessary to carry out the delegated responsibility.

Hospital Alert means a written notification issued by DCYF to Rhode Island birthing hospitals advising that DCYF has identified safety concerns requiring hospital staff to contact the CPS Hotline upon the birth of an infant. A hospital alert is issued for planning and safety purposes and does not, by itself, constitute an investigation**.**

Minimum Necessary means the least amount of information required to accomplish the intended safety purpose of the hospital alert, including identification of the expectant caregiver(s), the applicable alert reason category identified on DCYF #199, and instructions to notify the CPS Hotline upon the infant's birth. Minimum necessary disclosure excludes detailed allegations, case narratives, reporter/source identity, restricted information, and third-party records.

Plan of Safe Care (POSC) means a plan developed by the birthing hospital for an infant identified as affected by prenatal substance exposure and for the infant's caregiver(s), addressing the health and safety needs of the infant and the substance use disorder treatment and service needs of the caregiver(s), consistent with CAPTA/CARA requirements and Department guidance. DCYF coordinates with the hospital and involved service providers, as appropriate, to support referrals and service connection.

Protective Capacity means the behavioral, cognitive, and emotional characteristics of a caregiver associated with the ability and willingness to protect a child from harm and to meet the child's immediate safety needs.

Rhode Island Birthing Hospitals means the Rhode Island hospitals to which DCYF issues hospital alerts, including South County Hospital, Newport Hospital, Women & Infants Hospital, Landmark Medical Center, and Kent Hospital.

Substance-Exposed Newborn / Infant Affected by Prenatal Substance Exposure means an infant identified as affected by substance abuse, withdrawal symptoms resulting from prenatal drug exposure, fetal alcohol spectrum disorder, or other prenatal substance exposure, consistent with CAPTA/CARA requirements. Identification may be based on medical assessment, toxicology, withdrawal symptoms, diagnosis, hospital documentation, or the caregiver's self-disclosure of substance use during pregnancy.

III. PROCEDURE

A. Alerts to Rhode Island Birthing Hospitals Regarding Infant Safety at Birth

1. DCYF may disclose limited, minimum necessary information to Rhode Island birthing hospitals when necessary to protect the safety of an infant and to ensure an appropriate CPS response at the time of birth, consistent with R.I. Gen. Laws §§ 42-72-5 and 42-72-8 and applicable federal requirements (CAPTA/CARA).
2. Use of Standard Form and Minimum Necessary Disclosure
    a. All hospital alerts must be issued using the form DCYF #199 (Alert to Area Hospitals – Infant Safety at Birth).
    b. The Department may disclose only the minimum necessary information to:
        i. identify the expectant caregiver(s); and
        ii. instruct the hospital to contact the CPS Hotline upon the infant's birth due to identified safety concerns.
    c. Under no circumstances may staff provide detailed allegations, case narratives, reporter/source information, or third-party documents as part of a hospital alert.
3. Hospital alerts are confidential and are distributed only to designated hospital points of contact in accordance with Department protocols.
4. Reasons for issuing an alert may include, but are not limited to:
    a. Heightened-risk triggers (legal/child safety history):
        i. The parent has subjected another child to aggravated circumstances, including abandonment, torture, chronic abuse, or sexual abuse.
        ii. The parent has committed murder or voluntary manslaughter of another child.
        iii. The parent has aided, abetted, attempted, conspired, or solicited to commit murder or voluntary manslaughter of another child.
        iv. The parent's parental rights to a sibling of the child have been involuntarily terminated.
        v. The parent has inflicted excessive corporal punishment on a child resulting in physical injury.
        vi. The parent or caregiver has a history of indicated child abuse or neglect, a child abuse or neglect conviction, or other child safety history that may indicate risk of harm to the infant after birth.
    b. Current risk indicators requiring supervisory assessment:
        i. Concerns regarding the caregiver's protective capacity, as assessed through the Department's safety assessment, FFA process, SDM tool, supervisory consultation, or other available case information, as applicable.
        ii. Current substance use, misuse, self-disclosed prenatal substance use, untreated substance use disorder, or a history of chronic substance use when the available information indicates that the substance use may impair the caregiver's ability to safely care for the infant.
        iii. Untreated or unmanaged mental health concerns that may

impair the caregiver's ability to safely care for the infant.

iv. Domestic violence, intimate partner violence, or coercive control that may affect infant safety.

v. Unsafe or unstable housing, environmental hazards, or other home conditions that may affect infant safety.

c. Case context/coordination factors:

i. The Family Service Unit (FSU) is currently active with the family.

5. An alert concerning infant safety at birth may be initiated by the Substance Use Coordinator, a CPS worker, Family Service Unit (FSU) worker, or Division of Youth Development (DYD) worker.

6. A hospital alert must be reviewed and approved by the Administrator or designee prior to issuance. A designee may include a Chief Casework Supervisor or other supervisory staff designated by the Administrator.

a. A Call Floor Child Protective Investigator (CPI) supervisor may initiate an alert on a case not currently open with the Department.

b. The primary service worker initiating the alert documents the alert in a critical case activity note.

c. The critical case activity note must detail:

i. Alert reason category

ii. Approval

iii. Date/time sent

7. The alert instructs Rhode Island birthing hospitals to contact the CPS Hotline upon the infant's birth due to the Department's concerns regarding infant safety at birth.

a. If the family is currently open to FSU, the primary service worker meets with the Senior Case Work Supervisor to assess the caregiver's protective capacity with the newborn using the applicable Department safety assessment process, FFA process, SDM tool, and available case information.

8. For cases not active with the FSU, when DCYF receives a CPS Hotline report following the child's birth, the Hotline CPI reviews the report and determines whether it will be assigned for investigation, screened out with a Department response, or screened out with no follow-up in accordance with DOP: 500.0000, DOP: 500.0025, and DOP: 700.0190.

a. When a prenatal CPS Hotline report is screened out but includes prenatal substance use concerns or other information indicating a potential safety concern at birth, the report may be referred to the Substance Use Coordinator for review.

b. If the Substance Use Coordinator determines that a hospital alert is appropriate, the Substance Use Coordinator completes DCYF #199 and submits it for Administrator or designee approval prior to issuance.

B. Notice to Families Regarding Hospital Alerts

1. When it is safe and appropriate to do so, the primary service worker, Substance Use Coordinator, peer recovery coach, or other assigned Department staff informs the expectant parent or caregiver that a hospital alert has been issued.

2. When contact is made with the expectant parent or caregiver regarding prenatal substance use concerns, the Substance Use Coordinator may maintain ongoing contact, as appropriate, to offer support, encourage engagement in treatment or recovery services, and assist with referrals before the infant's birth.

3. Staff make reasonable efforts to provide notice, which may include telephone contact, in-person contact, written communication, or coordination with other involved Department staff or service providers, as appropriate. Notice must be provided in a manner the parent or caregiver can understand, including use of interpreter services, auxiliary aids, or other accommodations when required.

4. Staff document the contact or attempted contacts in a case activity note, including the date, method of contact, person contacted, information provided, and any reason notice could not be provided.

Family Care Community Partnership (FCCP) Referral

Rhode Island Department of Children,
Youth and Families

Department Protocol: 100.0375

Effective Date: January 3, 2014 Version 1

The Department of Children, Youth and Families promotes, safeguards and protects the overall well-being of culturally diverse children, youth and families and the communities in which they live through a partnership with families, communities and government. The Family Care Community Partnership (FCCP) assists the Department by implementing a wraparound approach at the community level for families that are referred for service. This protocol provides additional direction to Department staff in addressing the needs of families when the care giver is indicated in the current investigation and has had a previous indication within the prior 12 month period and/or there is prior legal status with the family and/or a prior removal of a child from home.

A. When the care giver is indicated in the current investigation and has had an indicated finding within the prior 12 month period and/or there is prior legal status with the family and/or a prior removal of a child from home, administrative review
is necessary before an FCCP referral can be made. The CPI forwards the case to a CPS administrator for review before making such a referral.

B. In considering whether to authorize an FCCP referral, the CPS administrator considers:

1. History of the case;
2. Similarity of the indicated instances of child abuse, neglect or maltreatment;
3. Progress in addressing the identified issue/in working with community resources, including the FCCP, since the last indication/case opening/removal of a child from home;
4. Protective capacity of the family;
5. Motivation to change;
6. Admission of the presenting issue; and

C. Presence of repeated instances of domestic violence, mental health needs and/or substance abuse needs/relapse.If the caregiver refuses to cooperate with the FCCP and/or does not demonstrate protective capacity, the case is not referred to the FCCP. The administrator advises the CPI:

1. To seek a straight petition if the child can be maintained at home with a safety plan or
2. To seek an ex parte if the child cannot be maintained safely in the home.

D. If the Department's Legal Counsel disagrees with the decision to file a straight or ex parte petition, the Deputy Director reviews and provides direction.

Rhode Island Department of Children, Youth and Families
Department Operating Procedure

	DOP Number: **500.0000**	Effective Date: **September 23, 2024**	Page 1 of 8
	Version #:**2**	Revision History: **July 1, 2018 V.1**	Director:  **Ashley Deckert**
Section: **Child Abuse/Neglect Investigations**		Title: **Child Abuse and/or Neglect Reports**	

Legal Authority:

- §RIGL 40-11-2
- §RIGL 40-11-3
- §RIGL 40-11-3.1
- §RIGL 40-11-3.2
- §RIGL 40-11-3.3
- §RIGL 40-11-4
- §RIGL 40-11-7
- §RIGL 40-11-7(b)
- §RIGL 40-11-7(g)
- §RIGL 42-72.1-4
- §RIGL 42-72-8
- Child Abuse and Prevention Treatment Act, Pub. Laws No. 98-457

Related DOPs:

- Issuing a Hospital Alert; DOP: 100.0060
- Prison Rape Elimination Act (PREA); DOP: 100.0185
- Critical Event Reviews; DOP: 100.0290
- Child Abuse and Neglect Definitions; DOP: 500.0005
- Screen Outs Reports Requiring a Response; DOP: 500.0015
- Assessing Reports of Child Abuse and Neglect and Child Safety Determinations; DOP: 500.0025
- Institutional Child Abuse/Neglect Case; DOP: 500.0035
- Police Involvement in Child Protective Investigation; DOP: 500.0040
- Support and Response Unit; DOP: 700.0190
- Structured Decision Making Hotline Screening & Response Priority System: Policy and Procedures Manual

Related Forms:

- DCYF # 199, Alert to Area Hospitals - Safety of Unborn Child

I. PURPOSE

The Department of Children, Youth, and Families (DCYF) operates a centralized Call Floor to efficiently manage child abuse and neglect reports. The Child Protective Services (CPS) Hotline is staffed by highly trained Child Protective Investigators (CPI), who are available 24/7 to receive and process reports of alleged child abuse and/or neglect. Reports can be made in person, by mail, online, or by other means. All reports must go through the Call Floor, where CPS Hotline staff receive the report and document the reporter's concerns and allegations.

According to **Rhode Island General Law 40-11-3**, anyone who suspects that a child has been abused or neglected must report this information to the DCYF Hotline within 24 hours. Additionally, all Rhode Islanders are required to report the following child abuse and/or neglect situations to the Hotline within 24 hours:

- Incidents of institutional child abuse and neglect by Department staff, foster parents, employees of residential childcare institutions, or any staff providing out-of-home care for children or youth, including the Youth Development Center. This also covers abuse or neglect resulting from a facility's practices, policies, or conditions.
- Suspicion or knowledge that a child has been sex trafficked, commercially sexually exploited, human trafficked, or subjected to any form of sexual abuse. This includes sexual abuse by another child, sexual abuse, sexual harassment, or voyeuristic behavior by any DCYF provider, vendor, contractor, volunteer, or staff toward a child/youth, or sexual abuse by an employee, agent, contractor, or volunteer of any educational program.
- Suspicion or knowledge that a child is being medically neglected or denied medically necessary treatment.

Reports may involve a child under 18 or under 21 years of age if the youth is residing in foster or institutional care or if the youth is in Department custody, regardless of placement.

Rhode Island General Law (RIGL) 40-11-4 protects anyone who reports child abuse or neglect in good faith from civil or criminal liability. However, **RIGL 40-11-3.2** makes it a misdemeanor to knowingly and willfully file a false report of child abuse or neglect. **RIGL 42-72-8** allows the Department to share records with the Office of the Attorney General when investigating or prosecuting false reports.

Reports made to the CPS Hotline are screened using a validated and standardized screening tool (refer to **Structured Decision Making Hotline Screening & Response Priority System: Policy and Procedures Manual**). The Department's electronic case management system provides instant information on previous child abuse or neglect (CA/N) reports and can monitor and track the progress of current investigations. The CPS Hotline Call Floor CPI (Hotline CPI) determines if the report meets the criteria for an investigation or a screen-out requiring a Department response.

If the Hotline CPI determines that a CA/N report meets the criteria to be for a CPS assessment, they set the investigation level (Level 1, 2, or 3) and response priority based on the allegation of abuse and/or neglect in accordance with the **Hotline Screening Tool**. Each level has specific responsibilities that the CPI must perform during their assessment. Before approving the CPS report, the Call Floor supervisor may adjust the investigative level when warranted. The CPI then completes all duties related to the designated investigative level.

The purpose of this operating procedure is to outline the steps taken by the Hotline CPI when a report of child abuse or neglect is received.

II. TERMS DEFINED

"Abused and/or neglected child" is a child whose physical or mental health is harmed or at risk of harm due to actions or neglect by a parent or caregiver, such as physical or sexual abuse, failure to provide basic needs or proper care, or exposing the child to dangerous situations.

"Medically Necessary Treatment" means treatment like nutrition, hydration, and medication that a doctor or nurse believes will improve or correct a child's life-threatening condition.

"Neglected Child" means a child whose physical or mental health is at risk because their parent or guardian fails to provide basic needs, proper education, or abandons them.

"Person Responsible for Child's Welfare" means a parent, guardian, or any adult who lives with the child, has unsupervised access, or works in child care or residential facilities.

"Youth Development Center" means Rhode Island's youth correctional facility and is often referred to as the Rhode Island Training School.

Refer to **DOP: 500.0005; Child Abuse and Neglect Definitions** and **§40-11-2** for further details regarding child abuse and neglect definitions.

III. PURPOSE

A. Child Protective Services (CPS) Hotline

1. The Department's Child Protective Services (CPS) Hotline provides a statewide, toll-free phone number (1-800-RI-CHILD) that receives child abuse and neglect (CA/N) reports 24 hours a day, seven days a week.
2. If a call comes in reporting that a child is in immediate danger and immediate police assistance is required, the Hotline CPI:
    a. Instructs the caller to notify the police and after terminating the call, notifies the police; or
    b. Puts the caller on hold and notifies the police; or
    c. Places a three-party call with the police and the reporter.
    d. The Call Floor supervisor follows up with law enforcement to ensure the immediate safety of the child.
3. When a report of suspected abuse or neglect is received, the Hotline CPI documents it in the electronic case management system using a structured decision-making tool to capture:
    a. An account of the alleged maltreatment, including any imminent risks that might require an immediate response or referral to law enforcement.
    b. A description of the child, including condition, behavior, and functioning.
    c. A description of the alleged perpetrator, including condition, behavior, functioning, and history.
    d. A description of the family, including family members, dynamics, functioning, and supports.
    e. Information regarding any other safety concerns or hazards.

f. Information needed to identify and locate the child and family.

4. Reporters of abuse and neglect are informed about:
   a. The Department's responsibilities, including the protection of reporters' identities.
   b. The process for screening and investigation.
   c. Whether reporters can have any ongoing role in the screening or investigation process.
   d. The result of the screening or investigation, unless prohibited by law or court order.
5. In accordance with **§RIGL 40-11-7(g)**, if a report is accepted as a valid allegation of abuse or neglect, the Department collects information concerning the military status of the parent or guardian of the child who is the subject of the report and shares information about the allegation with the appropriate military authorities.

B. Report Evaluation Process
1. Within 24 hours of receiving a report, the Department uses standardized decision-making criteria and supervisory/clinical consultation to determine if the report meets the state's statutory definition of child maltreatment. Based on this evaluation, the report is:
   a. Screened in for a CPS assessment and investigation and assigned an investigation level and response priority.
   b. Referred to law enforcement.
   c. Screened out with a Department response.
   d. Screened out with no follow-up.

C. CPS Criteria Required to Initiate an Investigation and Assessment Response
1. A report accepted for a CPS assessment and investigation must meet one of six criteria.
2. Criteria 1: Child Abuse/Neglect (CA/N)
   a. The Department assesses and investigates reports of alleged child abuse and/or neglect when there is reasonable cause to believe that abuse or neglect exists. CA/N Reports accepted for a CPS assessment and investigation contain the following elements:
      i. Harm or substantial risk of harm to the child (under 18 or under 21 years of age if in Department placement or custody) is present.
      ii. A specific incident or pattern of incidents suggesting child abuse and/or neglect.
      iii. A person responsible for the child's welfare (caregiver) has allegedly abused or neglected the child.
         1) The caregiver requirement does not apply to allegations of sexual abuse of a child by another child.
         2) The caregiver requirement does not apply to allegations of sexual abuse by an employee of a school or school district.
         3) The caregiver requirement does not apply for alleged child sexual exploitation and/or human trafficking, as the alleged perpetrator may be another individual under age 18 or, in the case of human trafficking, an individual not charged with the care of the child. The caregiver, as defined in **§RIGL 40-11-2**, may

be alleged to have placed the child in a harmful situation by failing to protect the child, and allegations of neglect or abuse may also be made against the caregiver.

b. The Hotline CPI completes a CPS report in the Department's electronic case management system for all reports alleging child abuse and neglect.

c. A report relating to the Youth Development Center (YDC), a foster home, or childcare program initiates a CPS investigation in conformance with **DOP: 500.0035; Institutional Abuse/Neglect**.

3. Criteria 2: Non-Relative Caregiver
   a. A CPS assessment and investigation are initiated when the Department receives a report that a parent has assigned or otherwise transferred to someone not related to them by blood or marriage their rights or duties concerning the permanent care and custody of their child under 18 unless an order or decree of the court authorizes the arrangement.
   b. The Hotline CPI completes a CPS report in the Department's electronic case management system.
4. Criteria 3: Sexual Abuse of a Child by Another Child
   a. The Department is required to investigate allegations of sexual abuse/molestation/exploitation between individuals under the age of 18 or when one individual is under age 18 and one is between 18 and 21 and in the care of the Department.
   b. The Hotline CPI completes a CPS report in the Department's electronic case management system.
5. Criteria 4: Duty to Warn
   a. The Department releases information if it is determined that there is a risk of physical injury by a person to themselves or others and that disclosure of the records is necessary to reduce that risk.
   b. In accordance with state law, a CPS assessment and investigation is initiated when the Hotline receives a report that a perpetrator who has been convicted, adjudicated, or indicated for the following categories of sexual abuse or serious physical abuse has physical access to other children in a family.
      i. Convictions:
         1) Murder (involving a child)
         2) First-degree child abuse
         3) Battery by an adult upon a child 10 years of age or younger - serious bodily injury
         4) First-degree child molestation
         5) Second-degree child molestation
      ii. Adjudications in Family Court
         1) Termination of Parental Rights based on a finding of conduct toward a child of a cruel and abusive nature
         2) Sexual abuse
      iii. CPS Indicated Abuse Findings
         1) Death
         2) Brain damage
         3) Subdural hematoma
         4) Internal injuries
         5) Intercourse
         6) Sexual exploitation
         7) Molestation

i. The Hotline CPI completes a CPS report in the Department's electronic case management system.

6. Criteria 5: Alert to Area Hospitals, Safety of Unborn Child
   a. The Department may release information if it is determined that there is a risk of physical injury by the person to themselves or others and that disclosure of the records is necessary to reduce that risk.
   b. In accordance with state law, the Department issues an alert to area hospitals when it is believed that there may be a risk of harm to a child born to a parent with a history of substantiated child abuse or neglect or a child abuse/neglect conviction. Refer to **DOP: 100.0060 Issuing a Hospital Alert.**
   c. The Call Floor CPI may initiate an alert on a case not open to the Department.
   d. When the Hotline receives a response to the alert upon the child's birth, the report is reviewed. A determination is made whether the report is assigned for investigation or assignment to the SRU. Refer to **DOP: 700.0190; Support and Response Unit**.
7. Criteria 6: Serious, Critical Injury, Child Near Fatality or Child Fatality
   a. The Department is required to investigate all instances of child fatalities or near fatalities 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. Refer to **DOP: 100.0290; Critical Event Reviews**.

D. Response Priorities and Investigation Levels
1. Response Priorities
   a. Priority 1 Response
      i. The Hotline CPI immediately notifies the Call Floor supervisor, who reviews and forwards the report to the Investigative Unit within 30 minutes after the call is terminated.
      ii. Criteria include:
         1) Child in imminent danger of physical harm.
         2) Child abandoned and in imminent danger.
         3) Child unsupervised and in imminent danger.
         4) Family may flee or child may disappear.
         5) Child at hospital for examination with parents present.
         6) Child fatality or near fatality due to alleged abuse or neglect.
         7) Child held by police/physician/nurse practitioner on a 48-hour hold.
         8) Other emergency circumstances.
      iii. If a child is left unattended, the Hotline CPI contacts local police to respond. If the police find a caretaker present and appropriate, the case may not be assigned for investigation.
   b. Priority 2 Response
      i. The Hotline CPI processes the CPS report within two hours after the call is completed.
      ii. Criteria include:
         1) Alleged abuse or neglect with no imminent danger but other risk factors present.
         2) Child abandoned but not in imminent

danger.
3) Child unsupervised but not in imminent danger.
4) Child hospitalized on a 72-hour hold.

c. Priority 3 Response
i. The Hotline CPI processes the CPS report within four hours after the call is completed.
ii. Criteria include minimal risk of harm to the child.
iii. Factors defining risk include:
1) Child's age.
2) Physical and mental condition of the child and caretaker(s).
3) Location and condition of the alleged perpetrator(s).
4) History of prior incidents/harm.
5) Need for medical attention.
6) Safety and health of the physical environment.

2. Investigation Levels
a. Child abuse and neglect reports accepted for assessment and investigation are classified as Level 1, 2, or 3, based on the allegation and information obtained.
i. Level 1 Investigations allegations include:
1) Death
2) Brain Damage/Skull Fracture
3) Subdural Hematoma
4) Internal Injury
5) Sexually Transmitted Infection
6) Sexual Intercourse
7) Sexual Exploitation
8) Sexual Molestation
ii. Level 2 Investigations allegations include:
1) Burn/Scalding
2) Poisonous/Noxious Substance
3) Wound
4) Malnutrition/Starvation
5) Bone Fracture
6) Excessive/Inappropriate Discipline
7) Cut/Bruise/Welt
8) Human Bite
9) Sprain/Dislocation
10) Tying/Close Confinement
11) Hazardous Drug or Alcohol use
12) Emotional Abuse
13) Lack of Supervision - Caregiver
14) Lack of Supervision - No Caregiver
15) Abandonment
16) Medical Maltreatment
17) Medical Neglect
18) Domestic Violence
19) Failure to Thrive
20) Corporal Punishment (Institutional)
21) Inappropriate Restraint (Institutional)
iii. Level 3 Investigations allegations include:
1) Other Abuse/Neglect
2) Inadequate Food
3) Inadequate Shelter

4) Inadequate Clothing
5) Educational Neglect
6) Emotional Neglect
7) Other Institutional Abuse/Neglect

3. Approval of Accepted CPS Reports and CPI Assignment
   a. The assistant director of the Division of Child Protective Services, or their designee, reviews all pending CPS reports accepted by the Hotline before assignment to a CPI.
   b. The administrator may request additional information or may upgrade, downgrade, or screen out reports that do not meet the criteria for the allegation and/or response priority initially determined by the Hotline CPI.
   c. The administrator documents any changes and the supporting rationale in the electronic case record.
   d. Once approved, the CPI is assigned to begin the assessment and investigation process in accordance with **DOP: 500.0025; Assessing Reports of Child Abuse and Neglect and Child Safety Determinations**.

E. Screen-Out Reports
1. When a report does not meet one of the six criteria for an investigation and is screened out, the Hotline CPI, with supervisory approval, determines if the report is screened out with a Department response or screened out with no follow up (refer to **DOP: 500.0015; Screen-Out Reports Requiring a Department Response**).
2. If there is a history of involvement with the Department, the Hotline CPI reviews the report with the Call Floor supervisor to determine whether to initiate a CPS investigation.
3. If additional Department support is necessary, the Hotline CPI refers the family to the Support and Response Unit (SRU). Refer to **DOP: 700.0190; Support and Response Unit.**
4. A screen-out report is documented in the Department's electronic case management system by the Hotline CPI.
5. CPS involvement is closed as the case was not identified as abuse or neglect.

F. Follow-Up and Monitoring
1. The assigned CPI establishes a plan for conducting the CPS assessment and investigation of the report, in accordance with **DOP: 500.0025; Assessing Reports of Child Abuse and Neglect and Child Safety Determinations**.

G. Report Documentation
1. All reports of child abuse and neglect (CA/N) are electronically recorded and maintained for at least three years in the Department's electronic case management system.
2. Any person reported for child abuse or neglect who is determined not to have neglected or abused a child will have their record for that incident expunged from the Department's electronic case management system three years after the determination.
3. Additionally, any report made to the Hotline that does not meet the criteria for a CPS investigation is expunged after three years from the Department's electronic case management system.

H. Routing of Child Abuse and Neglect (CA/N) Reports

1. All CA/N reports received must be routed through the Hotline. This includes reports on families new to the Department and families previously or currently active with the Department.
2. All CA/N reports received by Department personnel other than Hotline staff must be immediately forwarded to the Hotline. This includes in-person or written reports from any source.

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Department Operating Procedure

	DOP Number: **500.0015**	Effective Date: **September 23, 2024**	Page 1 of 3
	Version #: 3	Revision History: **July 7,1984 V.1 December 29,2006 V.2**	Director:  **Ashley Deckert**
Section: **Child Abuse/Neglect Investigations**		Title: **Screen-Out Reports Requiring a Response**	

Legal Authority:

- Public Law 96-272 (Adoption Assistance and Child Welfare Act of 1980)
- Rhode Island General Law §31-22-22
- Rhode Island General Law §40-11-3

Related DOPs:

- Child Abuse and Neglect Reports; DOP:500.0000
- Institutional Abuse and Neglect: DOP: 500:0035
- Support and Response Unit; DOP: 700.0190
- Structured Decision Making Hotline Screening & Response Priority System: Policy and Procedures Manual

Related Forms:

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I. PURPOSE

In accordance with DOP:500.0000; Child Abuse and Neglect Reports, all reports to the Child Protective Services (CPS) Hotline are screened to determine the appropriate Department response. The purpose of this operating procedure is to describe the steps taken in situations where a report made to the CPS Hotline does not meet the criteria for an investigation but does contain a valid concern about the well-being of a child. This type of report is classified as a Screen-Out with a Department Response.

II. TERMS DEFINED

"A case open to the Department" means a family involved with the Department with or without legal involvement within the Divisions of Child Protective Services, Family Services (including families and youth open to the Support and Response and the Voluntary Extension of Care units), Youth Development, Licensing and Resource Families, and Community Services and Behavioral Health.

"Resource Family or Resource Caregiver" means any home-based placement, inclusive of traditional foster home, fictive or relative kinship placement, and therapeutic foster home.

III. PROCEDURE

A. Screen-Out Reports Requiring a Department Response

1. A report made to the CPS Hotline concerning a child's well-being that does not meet the criteria for an investigation but contains a valid concern warranting follow-up may be classified as a screen-out report. Refer to **DOP: 500.0000; Child Abuse and Neglect Reports**.
2. A report made to the CPS Hotline concerning a child's well-being at a resource caregiver's home, residential facility or the Rhode Island Youth Development Center (YDC) that does not meet the criteria for an institutional investigation may be referred to the Department's Licensing Unit and/or Division of Family Services for a regulatory response due to a potential regulatory violation or safety concern.
    a. The Call Floor supervisor sends an email to the Licensing administrator and the assigned worker(s).
    b. No verbal or written notification of the report is required for the Office of the Child Advocate.
    c. If the child is placed in an actively licensed foster home and/or pending child-specific home, the Licensing administrator places the license/pending license on hold.
    d. For reports made to the CPS Hotline by a youth at the YDC, the Hotline Call Floor supervisor sends an email to the YDC superintendent and executive director.

B. Examples of Screen-Out Reports

1. Examples of reports that may be screened out include:
    a. Bruises with no suspicion of abuse/neglect and no history of abuse or neglect.
    b. A child not using a seat belt or car seat in accordance with **RI General Law 31-22-22**.
    c. A child aged 11 or older left unsupervised during the day or early evening with no clear and present danger.
    d. Custody issues related to domestic disputes.
    e. Reports of nuisances involving a family or child with no clear and present danger.
    f. Head lice and minor hygiene problems with no evidence of abuse/neglect.
    g. Physical or sexual abuse of an adult with no minor children in the home (refer to law enforcement).
    h. Overcrowded housing.
    i. Parent/child conflict without allegations of physical or sexual abuse.
    j. Previously investigated abuse reports with no new allegations or evidence.
    k. Truancy or lack of school attendance (refer to the appropriate agency).
    l. Abuse by an adult not responsible for the child's welfare with no evidence of parental negligence (refer to law enforcement).
    m. Vague or general information with no specific incident or credible reason to suspect abuse or neglect.
    n. Teenager beyond parental control (refer to community programs or law enforcement).
    o. General neglect of a teenager without a physical or developmental

disability.

p. Unsupervised teens disturbing the neighborhood (refer to law enforcement).

q. Allegations in a resource family home with no evidence of injury or potential risk of harm.

r. Caregiver is engaged with theft with no risk to the child.

s. Reports of slapping or spanking in a kinship resource family home.

C. Notifications for Screen-Out Reports

1. Open Cases

a. When a screen-out report is received relating to an open case, a notification email is automatically sent to the primary service worker, supervisor, and the licensing worker. The supervisor emails screen-out notifications to the Regional Administrator and any other line staff assigned to the case.

i. If immediate attention is required, the Call Floor supervisor will directly telephone the primary service worker/supervisor.

ii. The primary service worker/supervisor must review the information and respond within three working days, except in instances requiring immediate attention. They will document their response within the CPS Report.

iii. Any subsequent responses are documented as a Case Activity Note under "CPS Related Information."

2. Closed Cases

a. For cases not currently open with the Department, referrals may be made to the Support and Response Unit (SRU) to address the family's service needs. These cases typically involve families who would benefit from assistance in navigating community services and ensuring the child's or family's needs are met.

b. Refer to **DOP: 700.0190; Support and Response Unit for more** details.

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Rhode Island Department of Children, Youth and Families
Department Operating Procedure

	DOP Number: **500.0025**	Effective Date: **September 23, 2024**	Page 1 of 19
	Version #: **2**	Revision History: **July 1, 2018 V.1**	Director:  **Ashley Deckert**
Section: **Child Abuse/Neglect Investigations**		Title: **Assessing Reports of Child Abuse and Neglect and Child Safety Determinations**	

Legal Authority:

- RIGL§40-11-2
- RIGL §40-11-3
- RIGL §40-11-5
- RIGL §40-11-7
- RIGL §40-11-7(b)
- RIGL §40-11-7(c)
- RIGL §40-11-9
- RIGL §40-11-3.3
- Adoption and Safety Families Act of 1997
- Child Abuse Prevention and Treatment Act reauthorized in 2010
- Families First Prevention Act passed in 2017

- Issuing a Hospital Alert DOP; DOP: 100.0060
- Effective Communication with Persons of Limited English Proficiency; DOP: 100.0130
- Licensing of Resource Caregiver Homes; DOP: 300.0010
- Police Involvement in Child Protective Investigation; DOP: 500.0040
- Removal of Child from Home; DOP:500.0045
- Documenting Results of Child Protective Services Investigations in RICHIST; DOP: 500.0065
- Reasonable Efforts: DOP: 700.0005
- Implementing the Indian Child Welfare Act; DOP: 700.0145
- Clients with Disabilities; DOP: 700.0245
- Family Time; DOP: 700.0030
- Kinship Care; DOP: 700.0035
- Obtaining Custody via Dependent/Neglected/Abused Petition; DOP: 1100.0000
- Structured Decision Making Hotline Screening & Response Priority System: Policy and Procedures Manual
- Family Functioning Assessment Intervention Manual

Related Forms:

- Parents/Caregivers with Disabilities Notice.
- Early Intervention Form
- Safe Sleep Form and Pamphlet
- Client Rights and Responsibilities
- Guide for Parents and Caregivers Involved with Child Protective Services

I. PURPOSE

The Department of Children, Youth and Families (hereinafter, the Department) has established procedure for assessing child abuse or neglect reports and family functioning to make consistent and accurate determinations of child safety. This Department Operating Procedure contains general directives for handling all CPS assessments and designates tasks to be completed by the child protective investigator (CPI) using validated screening tools and best practices.

The CPI uses the Safety Assessment and Family Engagement (SAFE) practice model for safety assessments. The SAFE model is a criteria-based, family-focused approach that aims to identify children needing protection, implement minimal intervention plans to keep them safe, engage caregivers in developing behavior changes, and help caregivers return to their protective roles.

The standardized tool used during the assessment is the Family Functioning Assessment (FFA). This tool helps identify families where children are unsafe and need ongoing intervention. The FFA includes evaluating and managing present and impending dangers, as well as assessing the caregivers' abilities to protect their children (refer to the **Family Functioning Assessment Intervention Manual**).

The objectives of the FFA are to:

- Quickly respond to information from the CPS hotline report.
- Inform reported individuals of community concerns about their children's safety.
- Address emergency needs identified during the assessment.
- Engage caregivers in a family-centered assessment to determine if children are at risk of impending danger.
- Gather thorough information involving relevant family members.
- Keep caregivers informed and involved in decision-making.
- Investigate allegations and determine if child maltreatment occurred, following Department policy and state laws.
- Develop a minimally intrusive safety plan if children are found to be at risk.

The Department follows Rhode Island General Law **§40-11-7**, which requires personal contact with each child named in the report and all other children in the household or childcare facility. The law mandates that the Department provide such services necessary to protect the child and preserve the family. If, after the assessment and investigation, the Department determines that the child is being or has been abused or neglected but that the circumstances of the child's family or otherwise do not require the removal of the child for their protection, the Department may allow the child to remain at home and provide the family and child with preventative support and services. If serious harm or risk is determined that cannot be managed through in-home safety planning, the Department must seek court approval to remove the child from the care and custody of the parents. (Refer to **DOP: 500.0045; Removal of Child from Home**).

During the initial visit, the CPI explains the allegation to the alleged perpetrator and provides written information about the CPS process and their rights. Children and caregivers have rights that CPS must respect, including the child's right to safety, family, culture, and minimal trauma, and caregivers' rights to information, involvement, prompt responses, and

confidentiality. Children are provided this information in an age-appropriate manner.

The CPI conducts a present danger assessment during the first contact with the family (refer to the **Family Functioning Assessment Intervention Manual**). If safety threats are identified, the CPI works with caregivers to create a present danger plan. If, at the conclusion of the Family Functioning Assessment and investigation, the identified threats cannot be mitigated through an in-home safety plan, an out-of-home safety plan is developed, with priority given to placement with willing relatives. (refer to **DOP: 700.0230; Searching for Relatives and Natural Supports**). If necessary, the child is removed from the home following all procedures in **DOP: 500.0045; Removal of Child from Home**.

The CPI must consider the vulnerabilities of young children and children with disabilities when assessing safety. Understanding a child's unique needs helps in making appropriate decisions and connecting them with necessary support. Disabilities of caregivers and others involved must also be considered during interviews and assessments. Refer to **DOP: 700.0245 Clients with Disabilities**.

Effective communication is crucial for the CPI, especially when engaging with the child, caregivers, the alleged perpetrator, and other parties involved. Clear, respectful interactions are essential for accurate information gathering and ensuring everyone understands the process. Refer to **DOP: 100.0130; Effective Communications with Persons of Limited English Proficiency** for detailed guidelines when communicating with a child or family with limited English proficiency.

Research shows that families of diverse racial and ethnic backgrounds are significantly more likely to be subjected to a CPS investigation and substantiated for child abuse or neglect following a child maltreatment assessment. Effective engagement with the family is critical to understanding family functioning and cultural considerations. The FFA helps the CPI to remove biases from the decision-making process by applying a standardized assessment process. A culturally sensitive assessment recognizes that parenting practices and family structures vary due to ethnic, community, and familial differences. This diversity can result in different but safe and adequate care for children within the parameters of the law and this policy.

After the completion of the FFA, the CPI concludes with a safety determination and one of the following investigation dispositions:

- Indicated
- Unfounded
- Unable to Determine

II. TERMS DEFINED

“Caregiver protective capacities” means personal and parenting behavioral, cognitive, and emotional characteristics that are specifically and directly associated with being protective of one’s children. There are behavioral, cognitive, and emotional protective capacities.

“Conditions for return” means identified behaviors and circumstances that must exist within a child’s home for a child who has been removed to return. Conditions for return are discussed with the parent/primary caregiver when a child is removed.

“Duty to Warn” means to communicate a threat in cases of a foreseeable act of perils.

“Family Functioning Assessment (FFA)” means the function or process commonly referred to as investigation or initial assessment process. Completing the FFA utilizes safety concepts and decision-making methods concerned with reconciling information contained within a CPS report.

“Identified child in the Hotline assessment” means a child who has been reported to be maltreated

or potentially experiencing present or impending danger.

“Impending danger” exists when a child lives in a state of danger. Impending danger is not always active but can become active at any time or because of specific, stimulating events, circumstances, or influences. Impending danger is not necessarily obvious or occurring at the onset of the FFA or in a present context (e.g., initial contact) but can be identified after thoroughly evaluating individual and family conditions and functioning through the FFA. A child in impending danger without safety intervention reasonably could experience serious harm.

“Indicated” means that 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.

“Medical professional” means an individual duly licensed by the RI Department of Health (RI DOH), acting within the scope of practice defined by the RI DOH.

“Preponderance of Evidence” means to prove that something is more likely than not.

“Present danger” means an immediate, significant, and observable family condition that is actively occurring or “in the process” of happening or occurring at the point of contact with a family and will likely result in serious harm to a child. “In the process” of happening means it might have just happened (e.g., a child presents at the emergency room with an unexplained severe injury), is happening (e.g., a child is left unattended in a parked car), or happens all the time (e.g., young children were left alone last night and might be left alone again tonight.)

“Present danger assessment” means a judgment or process involving observation, interpretation, identification and a conclusion that a family condition, child condition, individual behavior or action or family circumstance places a child in immediate jeopardy. The judgment must involve supervisory consultation.

“Present danger plan” means an instantaneous *(*same day), short-term, sufficient strategy that assures a child is cared for, supervised, and protected by a responsible adult to allow for the completion of the FFA. The CPI must continue to collect information to develop a more comprehensive understanding of the family situation to evaluate Impending Danger.

“Safety assessment” means an evaluation that occurs after the FFA and identifies the existence of impending danger. The safety assessment applies danger threshold criteria to assess whether family conditions (i.e., circumstances, behavior, emotion, perceptions, attitudes, intentions, and motives) and determine the existence of impending danger.

“Safety intervention” means responding to and managing present and impending danger identified during the FFA and the services offered to reduce or eliminate impending danger and enhance caregiver protective capacities.

“Safety plan” means a written plan, developed with the caregivers, and implemented when a child is determined to be in impending danger upon the conclusion of the FFA process. The safety plan describes the impending danger within the family, the caregiver’s suitability to participate, and the safety services offered. The purpose of the safety plan is to ensure the protection of a child when impending danger is identified. The safety plan is adaptive and reflects the least intrusive management of impending dangers and diminished caregiver protective capacities.

“Safety plan determination” (SPD) means an analysis that occurs as part of decision-making required in the FFA when the safety assessment identifies impending danger and a child is unsafe. The SPD aims to determine the least intrusive approach to managing safety. The SPD results in deciding whether to proceed with an in-home or out-of-home safety plan. The SPD analysis is completed by the worker who completed the FFA. To determine a suitable safety plan, the worker in consultation with their supervisor, considers the caregiver’s willingness and capacity, the

calmness and stability of the environment, the suitability of the family residence, and necessary safety management resources.

"Standard of Proof" means the amount of evidence necessary to prove an assertion or claim.

"Unable to determine" means "inconclusive," which means there is some indication the abuse occurred. However, there is insufficient evidence to conclude that there is reasonable cause to believe that abuse occurred.

"Unfounded," also referred to as "unsubstantiated," means that 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.

"Unsafe child" means a child that is vulnerable to danger within the family where they reside due to diminished caregiver protective capacities.

"Unsubstantiated" means that a report, pursuant to RI General Law **§40-11-2**, was assessed and that the preponderance of the credible evidence does not indicate abuse or neglect exists consistent with Rhode Island State Statutes.

III. PROCEDURE

A. Child Abuse and/or Neglect Reports
   1. The Department receives, screens, and assesses reports that allege child abuse and/or neglect when there is reasonable cause to believe that abuse or neglect exists. Reports that are accepted for a CPI assessment and investigation are assigned by the CPS Hotline Call Floor Child Protective Investigator (Hotline CPI) to a CPI within designated timeframes. Refer to **DOP: 500.0000; Child Abuse and/or Neglect Reports**.

B. Case Assignment
   1. Review of Information
      a. The completed CPS report is reviewed by the investigative assignment supervisor.
      b. The referral is assigned to a CPI within the guidelines of the specific response priority.
      c. An investigation is initiated within the specified response priority time frames. Refer to Section C.
      d. Upon assignment, the CPI thoroughly reviews all relevant information in the electronic record. State BCI and national criminal background checks are conducted for all adult caretakers and alleged perpetrators, as per **DOP: 100.0215; Criminal Record Background Checks**.
   2. Completion of Tasks
      a. The CPI makes every effort to respond to each assigned investigation as quickly as possible, however, response priorities allow the CPI's and/or supervisor to triage assignments within the response priority categories when a subsequent report is assigned requiring a timelier response.
      b. All assigned investigations must commence within the timeframe of the designated response priority.
   3. Family Functioning Assessment
      a. For all investigation levels, the CPI completes the Family Functioning Assessment (FFA) to evaluate safety, caregiver protective capacities, and child and family functioning. Detailed protocols for the FFA process are available in the **Family Functioning Assessment Intervention Manual**.
   4. Planning and Consultation
      a. The CPI plans the most effective approach for conducting the FFA based

on the information reported in the Intake Assessment and consults with a supervisor as needed.

C. Priority Response Timeline Compliance
1. The CPI must make face-to-face contact with the identified child within the response time specified in the Hotline report to assess for present dangers and begin gathering information to complete the FFA.
   a. Priority 1 Response –The assigned CPI responds to the report within two hours of creation of the investigative protocol.
   b. Priority 2 Response – The assigned CPI responds to the report within 12 hours of the creation of the investigative protocol.
   c. Priority 3 Response – The assigned CPI responds to the report within 48 hours of the creation of the investigative protocol.
2. Response time is measured from the date and time the Hotline report is received until face-to-face contact with the alleged victim.
3. If the CPI cannot comply with the priority response time, the supervisor must approve the delay, and the justification must be documented in the Department's electronic case management system.
4. Exceptions to Response Times
   a. Exceptions can be based on verified content within the Hotline report indicating that the child is under the care and supervision of a responsible adult and that the current situation will not change until the CPI arrives.
   b. The supervisor must approve any exception to response times and may require the CPI to respond quicker than the allowed timeframe.

D. Investigation Procedures for Levels 1, 2, and 3
1. Contact and Documentation
   a. Contact the police (Level 1 only).
   b. Contact the reporter, if identified, for additional information.
   c. Make an unannounced initial visit to the home or childcare facility unless the family is aware of the allegation and the Department's involvement, and the visit is planned.
      i. The initial assessment should occur at the family's home as well as any other location where the abuse/ neglect allegedly occurs.
   d. Interview the victim face-to-face as soon as possible within the response priority timeframes.
   e. Document attempted contact and contact with the victim in an investigative note within one business day.
   f. Interview each involved adult, including the alleged perpetrator and caregiver, as soon as possible after the victim interview.
   g. Interview individually all other children who resided in the household or were present in the childcare facility at the time of the alleged incident.
   h. Confirm the whereabouts of any other child of the parent or guardian who did not reside in the household at the time of the alleged incident when the alleged perpetrator is the parent or guardian.
   i. Interview other adult household members or facility staff.
   j. Interview any known witnesses or individuals who may have knowledge relating to the incident.
      i. If the witness is a minor and not a victim or related to the alleged perpetrator/victim, arrange contact through the child's parent or legal guardian unless it would cause immediate danger to the alleged victim.
      ii. The parent or legal guardian may be present during the interview, which should be conducted in an age-appropriate manner.
      iii. If the parent or legal guardian is unavailable, the interview occurs in the presence of a familiar and comfortable adult.
   k. Document all interview contacts in the Department's electronic case

management system in accordance with **DOP: 500.0065; Documenting Results of Child Protective Services Investigations in RICHIST**.

2. Professional Contacts
   a. Interview at least two other individuals with first-hand knowledge of the incident or the family's circumstances.
      i. For Level 1 investigations, these contacts must include two professionals.
      ii. For Level 2 investigations, one of the contacts must be a professional.
3. Changing the Investigative Level
   a. The CPI, in consultation with their supervisor, may need to upgrade the investigative level of a case under certain conditions:
      i. Additional Allegations – If the Department is informed of an additional allegation that requires a higher level of investigation, the entire report is upgraded to that level.
      ii. Initiation of court action or 72-hour (physician or nurse practitioner) or 48-hour (police or Department CPI/Social Caseworker II) child protective hold.
      iii. Previous History of Abuse/Neglect – Although the present allegation may fall within a lower investigative level, a more intense investigation may be warranted if there have been prior agency contacts with the family.
      iv. Severity of the Injury – Although an allegation, by definition, falls within a lower level of investigation, the severity of the injury may warrant a higher level of investigation.
   b. The CPI or supervisor may never downgrade the level of investigation.

E. Locating Subjects of Report
1. Child Residing in the Household
   a. The CPI makes every effort to locate and interview each child residing in the household at the time of the alleged abuse and/or neglect, whether or not they are the alleged victim.
   b. If a child who resided in the household at the time of the alleged abuse and/or neglect is now living in another state, the CPI makes every effort to locate the child and arrange an interview through the child welfare agency in that state.
   c. All search efforts are documented as an Investigation Contact Note in the investigative record.
2. Child Not Residing in the Household
   a. The CPI makes every effort to confirm the past and present whereabouts of any child of the parent not residing in the household at the time of the alleged incident of abuse and/or neglect.
   b. If such a child is living in another state, the CPI makes every effort to confirm the child's whereabouts through communication with the current caregiver and/or the child welfare agency in that state.
   c. All search efforts are documented as an Investigation Contact Note in the investigative record.
3. Alleged Perpetrator
   a. Every reasonable effort is made to find and interview the alleged perpetrator.
   b. All search efforts are documented as an Investigation Contact Note in the investigative record.
   c. If a criminal investigation is in progress and law enforcement requests that the Department delay interviewing the perpetrator, the CPI and supervisor inform the administrator and legal counsel.
      i. The Department complies with the request to delay the interview for up to two weeks.
      ii. The decision to delay the interview for a specified time is

documented as an Investigation Contact Note in the investigative record.

iii. At the end of the delay period, the CPI contacts the police to check the investigation status and inform them of the Department's intent to interview the perpetrator.

iv. If law enforcement requests a further delay, the CPI and supervisor consult with the administrator and legal counsel.

4. If Face-to-Face Contact Cannot Be Made

a. If the CPI cannot make face-to-face contact with the alleged victim or household member by the end of their shift, supervisory approval must be obtained to determine if another CPI should be assigned to continue attempts. The supervisor must consult with their administrator if contact cannot be made by the following business day.

b. An allegation relating to a child participant in the investigation who cannot be seen or interviewed may be confirmed as "Unable to Complete" with CPS administrative approval.

i. If the report indicates the child could be experiencing present and/or impending danger and the child cannot be located, the CPI immediately notifies their supervisor and continues to make daily "persistent efforts" to locate the child.

ii. "Persistent efforts" may include continual actions to obtain information regarding the child and family and include, but are not limited to, the following:

1) Attempts to locate and meet with the child at school.

2) Contacting the school, district, or attendance officer for address information.

3) Reaching out to agencies that may have provided services to the family (e.g., Housing Authority, utility companies).

4) Communicating with individuals who may know the family, such as landlords, the reporting party, and/or neighbors.

5) Visiting the family's last known address and inquiring with neighbors about the family's new location.

6) Consulting law enforcement for any known information about the family's location.

7) Sending a registered letter (return receipt requested, deliverable to addressee only) to the last known address or the address of known relatives, friends, or employers.

8) Using internet directories and people searches.

9) Reviewing public assistance records (e.g., Medicaid, food stamps, child support).

10) Depending on the allegation, alerting area hospitals, the child's physician, the WIC program, or other relevant medical programs to notify the Department upon contact with the child or family. Refer to **DOP: 100.0060; Issuing a Hospital Alert DOP.**

F. Initial Contact and Present Danger Assessment and Plan

1. Introductions with Caregivers

a. The CPI must:

i. Identify themselves.

ii. Describe the Department and its role.

iii. Explain the reason for involvement.

iv. Provide a brief overview of the alleged child abuse or neglect.

v. Highlight any allegations that may indicate present or impending danger.

vi. Explain the purpose of and process for completing the Family Functioning Assessment (FFA).

vii. Enlist the caregiver's assistance in completing the assessment.

viii. Explain to the parent or guardian they have certain legal rights and advise them of those rights.

b. The CPI must provide the caregiver with written educational materials reinforcing the introductory information.

2. Child Information
   a. The CPI explains the circumstances and events that led to the Department's involvement to the child in a manner that is:
      i. Appropriate for the child's age and developmental level.
      ii. Clearly conveyed verbally and repeated as needed.
      iii. Provided in writing when suitable for the child's age and developmental level.
3. Child Interview
   a. The CPI interviews the child if they are mentally capable of being interviewed without the presence of the alleged perpetrator.
      i. Per **§RIGL 40-11-7(a)**, the CPI can question the child without parental consent.
      ii. If the caregiver refuses access, the CPI must immediately report this to the supervisor and administrator to determine the next steps.
      iii. Law enforcement may be involved or a court order may be sought to interview the child.
4. Medical Care
   a. The CPI must take immediate action to obtain medical care for the child if necessary to confirm abuse/neglect or if injuries require urgent treatment.
      i. The CPI must make every effort to help the parent/primary caregiver understand the need for medical care and gain their cooperation with accessing it.
      ii. The CPI must assist parents/primary caregivers in accessing medical care, including, if needed, accompanying them to a medical facility.
      iii. The CPI may seek a court order to obtain a medical exam or medical care if the parents:
         1) Are unavailable.
         2) Refuse to cooperate or give consent.
         3) Disagree with an attending physician's recommendations when medical care has been sought, and without continued care, the situation may become life-threatening.
      iv. To obtain a court order in these situations, the CPI can:
         1) File a petition requesting a court order which authorizes emergency medical care.
         2) File a petition giving DCYF the authority to consent to medical care.
         3) File a petition for legal temporary custody and request that DCYF be given authority to consent to medical treatment. Refer to **DOP: 1100.0000; Obtaining Custody via Dependent/Neglected/Abused Petition**.
   b. When an allegation of physical abuse is made, and a child discloses maltreatment and/or there is evidence to suggest physical harm, the child must be examined by a duly licensed physician or nurse practitioner in accordance with **§40-11-5**.
      i. Every effort is made to have a child examined by medical providers whose area of practice focuses on victims of child maltreatment.
      ii. When the maltreatment is such that a sexual or physical assault is involved or the neglect is such that the condition is deemed life-threatening, the CPI consults with their supervisor before contacting law enforcement.

iii. The CPI must notify the children's advocacy center of all suspected cases of child sexual abuse so that a forensic medical examination referral is made.
iv. The supervisor immediately notifies their CPS administrator or CPS on-call administrator of any complex or potentially high-profile cases (refer to **DOP: 100.0320; On-Call Administrators** and **DOP: 100.0265; Public Disclosure of Child Fatality and Near Fatality Information**.)

5. Present Danger Assessment and Plan
   a. The CPI conducts a present danger assessment and works with the family to create a present danger plan if the assessment indicates that a present danger safety plan is necessary.
   b. If a present danger plan is necessary, the CPI must:
      i. Inform the caregivers why a present danger plan is necessary.
      ii. Consult with their supervisor about options and the best course of action.
      iii. Identify with the caregivers what present danger plan options are available and acceptable to ensure child safety.
      iv. Work with the family to create the least intrusive present danger plan possible. The family must have a voice in identifying potential safety strategies and resources, including outside organizations and providers.
      v. Verify that the people participating in the present danger plan are responsible, available, capable, trustworthy, and able to protect the child sufficiently. This must include a home visit if the child will be staying in another residence.
      vi. Work with the family to establish the details of the present danger plan (e.g., how it will work, specific provisions, time frames, activities, child location, caregiver access), as well as the plan for communication with the family and safety resources, and how the CPI will oversee/manage the present danger plan.
      vii. The plan is developed in the community and signed by all parties who have a role in the plan. Plans are based on concrete tasks, are person-specific, and are time-limited.
      viii. The CPI, in collaboration with their supervisor, conducts background checks and an assessment of the participants' abilities and commitment to uphold the plan.
      ix. Implement the present danger plan before leaving the family or situation.
   c. The present danger plan includes the following details:
      i. The daily transportation needs of the child.
      ii. Arrangements for any medical or treatment needs.
      iii. Coordination for immediate service needs.
      iv. Daily supervision schedule and parameters around caregiver contact, if necessary.
      v. Potential results or consequences if the plan is not maintained.
   d. The present danger plan must not rely upon the caregivers who pose the threats to keep the child safe.
6. Reasonable Efforts to Prevent Removal
   a. The CPI must take actions to prevent or eliminate the need for removing a child from their home and to stabilize the family throughout the course of completing the FFA.
      i. The CPI makes reasonable efforts to prevent removal of the child by completing and documenting the process for the FFA and reaching conclusions about the appropriate, least intrusive safety plan to keep the child safe. Refer to **DOP: 700.0005; Reasonable Efforts**.

ii. Removal from the home may be necessary if a present danger plan cannot sufficiently prevent the danger with the child remaining in the home. Refer to **DOP: 500.0045; Removal of Child from Home**. If removal does occur as part of a present danger plan, the FFA process must continue to determine if the child is in impending danger. Refer to Section I.

G. Police Involvement

1. Immediate Notification

The Hotline CPI must immediately notify the police when a child is known or suspected to be at imminent risk of harm or when an emergency police response is necessary. Refer to **DOP: 500.0040; Police Involvement in Child Protective Investigation**.

2. Notification for Level 1 Allegations
   a. The local law enforcement authority must be notified of all Level 1 allegations of abuse and/or neglect before or during the investigation.
   b. If extenuating circumstances, discussed with a supervisor, lead the CPI to determine that police notification is not warranted, the CPI must document the reasons for this decision in an Investigation Contact Note in the investigative record.
3. Post-Investigation Reporting
   a. If, after completing the investigation and consulting with the Department's legal counsel, the CPI has reasonable cause to believe that a child has been subjected to criminal abuse or neglect, they must immediately report that information to the appropriate law enforcement agency.

H. Oversight of Present Danger Plan

1. Ensuring Plan Execution
   a. The CPI ensures that the present danger plan is being executed as agreed upon, that designated individuals are fulfilling their duties, that planned interactions between caregivers and children are occurring, and that all parties involved are maintaining their commitment to the agreed terms.
2. Weekly Contact
   a. The CPI must have personal contact with the plan participants at least once weekly.
   b. This contact can be face-to-face, by telephone, or electronically.
   c. The purpose of weekly contact is:
      i. To oversee the child's safety and the implementation of the present danger plan.
      ii. To continuously evaluate indicators that the child is safe under the present danger plan.
3. Supervisor Consultation
   a. The CPI must consult weekly with their supervisor on the status of the present danger plan.
4. Documentation
   a. The CPI must document all oversight contacts, supervisory consultations, approvals, and any actions taken in the electronic case record.

I. Impending Danger Assessment and Safety Plan Determination

1. Engaging Absent Parents
   a. When applicable, the Department must attempt to locate the child's absent parent and involve them in the FFA process. Refer to **DOP: 700.0140; Locating and Engaging Absent Parents**.
2. Impending Danger Assessment
   a. The impending danger assessment occurs after initial information has been collected and the situation is stabilized.
   b. This assessment involves making a safety decision to determine whether the child is safe or unsafe. If the child is deemed unsafe, an impending

danger safety plan must be implemented.

c. The impending danger safety plan aims to mitigate danger by identifying concrete safety actions, such as supervision, parenting assistance, crisis intervention, and transportation.

d. Safety actions can be provided by any responsible adult, including family members, friends, and professionals.

3. Effectiveness of In-Home Safety Plan

a. The assessment determines whether an in-home impending danger safety plan is likely to be effective, considering factors such as the family's willingness to participate, caregivers' abilities and capacities, available community resources, and the stability of the home environment.

4. Out-of-Home Safety Plan Determination

a. If an in-home safety plan is ruled out based on the safety plan determination assessment, and an out-of-home safety plan is required, the CPI will:

i. Discuss the conditions for return, specifying what must exist in the caregiver's home to establish an in-home safety plan.

ii. Develop a caregiver and child family time plan and document it in the safety plan. Refer to **DOP: 700.0030; Family Time.**

5. Discussion with Parents and Responsible Persons

a. Before implementing the safety plan, the CPI must discuss the following with the parent and persons responsible for protection:

i. All impending danger threats and diminished protective capacities in a language that all parties can understand. Refer to **DOP: 100.0130; Effective Communication with Persons of Limited English Proficiency**.

ii. The activities and frequency required and agreed upon by each person responsible for managing impending danger in the safety plan and who is responsible for monitoring each activity.

iii. The potential for using an out-of-home safety plan based on case circumstances, impending danger, and parent/caregiver response to safety interventions.

iv. The legal process, if removal is necessary, and conditions for return which may become part of the court order.

6. Documentation

a. The CPI must document the written safety plan in the electronic case record, including details of meetings and discussions with caregivers following the safety plan determination and the conclusion of the FFA.

7. Distribution of Safety Plan

a. The CPI must distribute copies of the safety plan to all participants on the same day the documentation is completed.

J. Additional Tasks Required for Non-Relative Caregivers (Criteria 2 Investigation)

1. During the assessment, the CPI evaluates the suitability of the home for the child. If the placement is appropriate, the Department licenses the caregiver if they meet the licensing standards and can fulfill the child's needs (refer to **DOP: 300.0010; Licensing of Resource Caregiver Homes**).

2. If the placement is unsuitable, the Department removes the child and arranges for an appropriate living situation. Before placing the child in out-of-home care, the Department must first consider potential relatives as placement resources (refer to **DOP: 700.0035, Kinship Care** and **DOP: 500.0045; Removal of Child from Home**).

K. Additional Tasks Required for Duty to Warn cases (Criteria 3 Investigation)

1. The CPI attempts to verify any prior adjudications related to Dependency/Neglect/Abuse petitions, criminal convictions in Family, District, or Superior Court, or CPS indicated findings of sexual abuse and/or serious physical abuse involving the alleged perpetrator.

2. The CPI attempts to confirm the identity of the individual previously adjudicated,

convicted, or subject to a prior CPS finding for charges/allegations of sexual abuse and/or serious physical abuse.

3. Before visiting the home, the CPI contacts legal counsel to determine what information can be disclosed to the primary caregiver under §42-72-8. After-hour inquiries are directed to the on-call administrator, who consults with the Chief Legal Counsel.
4. The CPI visits the home and interviews the child to determine if they have been a victim of abuse and/or neglect by the alleged perpetrator.
5. The CPI evaluates whether there is a substantial risk of imminent physical or emotional harm to any child residing in the same household as the alleged perpetrator or to whom the alleged perpetrator has frequent access. The CPI and supervisor consider the following factors in assessing risk:
    a. The time elapsed since the conviction, adjudication, and/or indicated finding.
    b. Whether the alleged perpetrator has undergone or is undergoing clinical treatment for issues related to prior sexual abuse and/or serious physical abuse.
    c. The age of the child(ren) in the household and any prior Department involvement with the child who is the subject of the current investigation.
    d. The family's willingness to accept services.
    e. Whether the child has disclosed any acts of abuse and/or neglect by the alleged perpetrator.

L. Additional Tasks Required for Serious, Critical Injury, Child Near Fatality or Child Fatality cases (Criteria 6)

1. CPS Investigative Response:
    a. Coordination with Other Divisions
        i. If the family is currently active with another division of the Department, CPS coordinates its assessment with the assigned staff from those divisions.
    b. Initial Contact and Information Sharing
        i. The CPI contacts other assigned Departmental staff to share information regarding the reported fatality/near fatality, review the family's current or recent history with the Department, identify potential safety concerns for other children in the home or placement, and explore available relative/kinship resources.
        ii. Contact is initiated by the CPI before the investigation starts, when possible. On weekends, holidays and after-hours, the CPI may contact the on-call administrator.
    c. Safety Assessment and Planning
        i. The CPI assesses the safety of any other children in the home or placement where the fatality or near fatality occurred, as well as any other children in the victim's family who may reside elsewhere and develops safety plans accordingly.
        ii. Safety plans are shared with other agency staff assigned to the case. Responsibilities for changes in placement, medical clearances, legal consults, and filing petitions, if necessary, are shared between CPS and other assigned divisions.
    d. Investigation and Interviews
        i. The CPI conducts required interviews, including those with family members, both immediate and extended.
        ii. The CPI serves as the primary agency contact with hospital/medical personnel, the Medical Examiner's office, law enforcement agencies, including police departments and the Office of the Attorney General.
    e. Review and Updates
        i. The CPI and supervisor participate in the Child Fatality/Near Fatality Review as scheduled.

ii. The CPI updates the Child Fatality/Near Fatality Reviewer on the outcome of the Department's investigation, findings from the Medical Examiner's office, and the status of any law enforcement investigations.

f. Support and Coverage

i. The divisional administrator assesses and arranges the initial level of support needed by the assigned CPI staff, unit, and division. Support can be accessed through the Department's Peer Support Team, the State of RI EAP, and the employee's medical benefits.

ii. The divisional administrator arranges for coverage of tasks associated with other cases assigned to the CPI and CPI supervisor handling the child fatality or near fatality and monitors work on those cases as needed.

2. FSU/JCS Responsibility

a. Primary Staff Assignment

i. FSU and/or JCS staff already assigned to the family at the time of the child fatality or near fatality remain the primary agency staff on the case.

b. Record Management

i. Once notified of the fatality or near fatality, the primary service worker assigned to the case does not enter any CANs or case information into the electronic case management system or alter the hard copy record until the Child Fatality/Near Fatality Review is completed or advised by the CF/NF Reviewer.

ii. Hard copy records are turned over to the CF/NF Reviewer.

c. Support and Casework Distribution

i. Casework responsibility for other cases assigned to the primary service worker/supervisor is redistributed for up to 7 business days if necessary to address the needs of the involved family and care for staff wellbeing.

ii. Management staff provide direct assistance and support to the assigned staff, assess the emotional wellbeing of the staff, unit, and division, and secure necessary supports.

d. Family and Child Support

i. The primary service worker, in consultation with the CPI, assists with identifying and determining the appropriateness of family/kinship placements if needed.

ii. The primary service worker assesses the wellbeing needs of any other children in the family and secures services and supports.

iii. The primary service worker and supervisor assess the needs of the parents and secure services, including emotional support, grief counseling, and financial assistance for funeral and burial arrangements.

e. Foster Care Assessment

i. If the fatality or near fatality occurred in a foster home, the primary service worker, in conjunction with the Licensing worker (and provider agency if appropriate), assesses the needs of the foster parents. The Licensing worker assists the foster parents.

f. Critical Event Review Participation

i. The primary service worker and supervisor participate in the Critical Event review as scheduled.

M. Additional Tasks for Domestic Violence Cases

1. When domestic violence is alleged, the Department coordinates the separation of children from their homes with a domestic violence unit or specialist.

2. The Department makes reasonable efforts to offer supports and resources to ensure the safety of the domestic violence victim.

N. Communicating with a Child or Parent/Guardian with a Disability

1. Attention to Disabilities
    a. The CPI should be particularly attentive to any indication that a child or parent/guardian might have a disability affecting their ability to communicate with the Department. In such cases, the CPI should refer to **DOP: 700.0245; Clients with Disabilities** and provide or utilize appropriate communication aids and services during the investigation to ensure effective communication with the family.
2. Responsibilities of the Child Protective Investigator (CPI)
    a. Gathering and documenting information regarding any disabilities, including physical, developmental, or intellectual disabilities, mental or behavioral health challenges, or substance misuse for the parent and child.
    b. Understanding how the disability may affect their ability to communicate with the Department.
    c. Providing the parent with a copy of the Parents/Caregivers with Disabilities Notice.
    d. Arranging for auxiliary aids and services promptly.
    e. Working with parents to implement necessary accommodations.
3. Documentation of Disabilities
    a. Any additional information regarding a parent/guardian or child's disability is added to the demographics section of the electronic case record.
4. Modified Interview Techniques
    a. Interviewing techniques may need to be adapted based on the unique needs of a parent, caregiver, or child with a disability.
    b. The CPI may consult with a specialist to determine the best approach for interviewing individuals with disabilities.
5. Fair and Individual Assessment
    a. The CPI must conduct a fair and individual assessment of a parent when evaluating child safety.
    b. If a parent has a disability, the determination of the disability's impact on their ability to provide for and maintain child safety must be based on objective facts and not stereotypes or generalizations.
6. Assessing Child Safety
    a. When assessing child safety, the CPI must consider the unique vulnerabilities of a child with a disability and evaluate how the parent's protective capacity can meet the child's individual needs.
7. Reasonable Efforts to Prevent Removal
    a. When making reasonable efforts to prevent removal, the CPI must consider whether providing reasonable accommodations or services to a parent with a disability will reduce or eliminate the risk.
8. Consultation with ADA and 504 Coordinator
    a. As needed, the CPI consults with the Department's ADA and 504 Coordinator to assist in interpreting observations and information and identifying necessary accommodations, supports, and services.

O. Cultural and Racial Considerations

1. Self-Examination and Objectivity
    a. The CPI should intentionally examine their thoughts and behaviors toward others. When conducting assessments, the CPI must rely on evidence, not personal thoughts, or feelings.
2. Strategies for Enhancing Equity in Investigations and Assessments
    a. Strategies to enhance equity in investigations and assessments include but are not limited to:
        i. Adopting a neutral perspective.
        ii. Understanding the context of the current situation.
        iii. Improving decisions by seeking input from a colleague.

iv. Using a trauma-informed lens to better understand the family's perspective.
v. Being aware of personal biases and prejudices and practicing cultural humility to work effectively in partnership with families.
vi. Clearly establishing the purpose of involvement with each family.
vii. Being consistent, reliable, open, transparent, and honest with families.
viii. Sharing information with families while respecting confidentiality requirements.
ix. Understanding families' experiences, current situations, concerns, strengths, protective capacities, and potential.
x. Validating the significant role of each family member's participation in the FFA process.
xi. Collaborating with the family to maintain connections with siblings, relatives, and fictive kin.
xii. Exploring and honoring the cultural, racial, ethnic, linguistic, and religious or spiritual backgrounds of children, youth, and families, and respecting differences in sexual orientation and gender identity by providing culturally appropriate resources and referrals as needed.

3. American Indian or Alaskan Native Heritage
   a. The CPI must inquire whether the child has American Indian or Alaskan Native heritage, refer to **DOP: 700.0145, Implementing the Indian Child Welfare Act.** When the case involves an American Indian child and family, the Department must:
      i. Ensure outreach and collaboration with tribal or local American Indian representatives to facilitate their participation in the investigation, safety planning, and assessment.
      ii. Consult with the DCYF Legal Office before taking any legal action regarding a child of Indian heritage.

P. Substantiation of Child Abuse and Neglect
1. Information Gathering
   a. To substantiate an allegation of child abuse and/or neglect, the CPI gathers information about the alleged incident(s) from various sources, including:
      i. The reporter (if not anonymous)
      ii. The alleged victim
      iii. The alleged perpetrator
      iv. Household members (adults and children)
      v. Neighbors, friends, and extended family members
      vi. Other professionals and service providers
      vii. Witnesses
      viii. Medical professionals specializing in the assessment of child abuse and neglect
      ix. Clinicians
      x. Law enforcement
2. Standard of Proof
   a. A preponderance of evidence must be demonstrated to meet the standard of proof for substantiating a finding of maltreatment.
3. Decision-Making
   a. The CPI and supervisors jointly decide whether child abuse or neglect occurred. The final decision must be approved by the supervisor.
4. Assessment of Multiple Caregivers
   a. If different caregivers are identified as responsible for maltreating their children, each caregiver is individually assessed, and their actions are

specifically described. For example, if a father physically abuses a child while the mother fails to supervise, each action is separately detailed.

5. Notification of Substantiated Sexual Abuse Allegations
    a. If the Department substantiates allegations of sexual abuse against an employee, agent, contractor, or volunteer of an educational program, it immediately notifies:
        i. The Rhode Island State Police
        ii. The local law enforcement agency
        iii. The Rhode Island Department of Education
        iv. The educational program
        v. The person who is the subject of the investigation
        vi. The parent of the child who is alleged to be the victim of the sexual abuse

Q. Legal Consult
1. Legal consult is required in the following situations:
    a. When it is determined that a child cannot safely remain in the home and the Department seeks temporary legal custody.
    b. When an in-home safety plan is in place, but a caregiver has been asked to leave the home, or conditions of contact with the child are imposed, to ensure the caregiver's due process and the child's safety.
    c. In circumstances involving a Duty to Warn.
    d. In any case, to determine if court action is warranted or advisable.
    e. Access to the home to investigate is denied.
2. Legal counsel is responsible for documenting the results of the consult in the Department's electronic case management system.

R. Conditions for Return
1. Identification of Conditions
    a. If the child is in impending danger and the safety plan involves out-of-home placement with relatives or a resource caregiver, the CPI must identify specific conditions that must be met for the child to return home.
2. Purpose of Conditional Statements
    a. These statements clearly outline the necessary conditions for the home environment and caregiver responsibilities that must be met to reduce the level of intrusiveness in safety management and to implement an in-home safety plan.
3. Explanation of Requirements
    a. The CPI provides a detailed explanation of:
        i. The conclusions about impending danger.
        ii. The conclusions about caregiver protective capacities.
        iii. The reasons why an in-home safety plan is unlikely to be effective, considering factors such as the family's willingness to participate, caregivers' abilities and capacities, available community resources, and the stability of the home environment.
        iv. The specific conditions that must exist within the child's home to establish an in-home safety plan and facilitate the child's return.

S. Timelines for Completion and Closing an Investigation
1. Safety Plan and Case Transfer
    a. Cases must not be transferred to the Family Services Unit (FSU) with an active present danger safety plan in effect.
    b. When a child is found to be unsafe due to impending danger, the case is transferred to FSU and remains open until the child is determined to be safe.
2. Completion and Documentation of Investigative Tasks
    a. All tasks corresponding to the assigned investigation level must be completed and documented in the investigative record.

b. In specific circumstances, such as when the initial investigation proves the allegation to be false, the CPI may omit certain tasks with administrative approval.
c. Administrative approval is required to end an investigation without completing all responsibilities outlined within the investigation level. The CPI or supervisor must document any such approval in the investigative record as an Investigation Contact Note.

3. Completing the FFA and Investigation
   a. The CPI must complete the FFA within:
      i. A maximum of 10 days when present danger exists unless there are extenuating circumstances.
      ii. A maximum of 30 days when there is no present danger unless there are extenuating circumstances.
   b. The CPI must complete the Investigation report within 30 days.
      i. If an extension of the 30-day timeframe for completing an investigation is necessary, a supervisor and/or administrator may grant an extension request for up to 15 additional days.
4. Documenting FFA Assessment Questions
   a. The CPI must thoroughly document the following FFA assessment questions to justify FFA decisions:
      i. What is the child abuse and neglect decision?
      ii. Is there a child that is unsafe due to impending danger threats?
      iii. If an unsafe child has been identified, what is the safety plan?
      iv. If an out-of-home safety plan is necessary, what are the conditions for return?
5. Supervisor/Administrator Review and Approval
   a. A supervisor must review and approve the completed FFA and the safe/unsafe conclusion.
   b. A supervisor must review and ensure that all collateral contacts were followed up on and documented.
   c. For cases involving a child aged 0-5, a closing consultation with the supervisor is required before administrator approval of case closure.
   d. An administrator must review and approve the closure of any case involving a child fatality or near fatality.
      i. The administrator must document this approval in an investigation contact note within the Department's electronic case management system.
6. Closing the FFA
   a. When the FFA findings determine that children are not in impending danger, the CPI completes the FFA as closed, with no transfer to ongoing monitoring unless court-ordered or there are other extenuating circumstances.
7. Community Resource Referrals
   a. The CPI is responsible for documenting any referrals to community resources in the electronic case management system.

Rhode Island Department of Children, Youth and Families
Department Operating Procedure

	DOP Number: **500.0030**	Effective Date: **July 1, 2018**	Page 1 of 2
	Version #:**1**	Revision History:	Director:  **Trista Piccola**
Section: **Child Abuse/Neglect Investigations**		Title: **Additional Information and Duplicate Reports**	

Legal Authority:

- Rhode Island General Law §40-11-3
- Rhode Island General Law §40-11-7

Related DOPs:

- Reporting Child Abuse and/or Neglect; DOP: 500.0000

Related Forms:

- N/A

I. PURPOSE

An Additional Information Report is used by a Call Floor worker when another report is received concerning the same incident of child abuse or neglect (CA/N). It is also used when an investigation is pending and a report is made to the Call Floor about an incident which happened prior to the date and time of the oral report on a pending investigation. For currently active investigations, a Child Protective Services (CPS) Report is generated to include the new reporter and/or allegation(s).

A Duplicate Report is used only when a report is made alleging a similar incident to one which has already been investigated and closed. For closed investigations, the same allegation must pertain to a previously investigated CA/N incident to be considered a Duplicate Report.

II. PROCEDURE

A. Additional Information Report

1. An Additional Information Report is processed on the Child Protective Services (CPS) Report Window and assigned to the appropriate Investigative Unit for use in the ongoing investigation if:
   a. The reporter and the allegations made are exactly the same as the previous report.
   b. The involved subjects (perpetrator and victim) are the same as the previous report.
   c. The same incident is being reported by a different reporter.
   d. The same incident is being reported but new allegations are being made.
   e. The same incident is being reported but new involved subjects (perpetrator/ victim) are being added.

f. An incident is reported which happened prior to the date and time of the oral report on the pending investigation.
g. The information provided alters the data currently on file in RICHIST.

2. For Additional Information Reports the CPS report is processed as follows:
   a. The report is linked to the existing case.
   b. The case is assigned by the Call Floor Supervisor to the appropriate Investigative Unit for use in the ongoing investigation.
   c. The assigned Child Protective Investigator (CPI) links the report to the pending investigation.

B. Duplicate Report

1. A Duplicate Report (which always pertains to a closed investigation) is processed as a CPS report.
2. If the report contains no new allegations or new involved subjects, the CPS report is processed as follows:
   a. The CPS report is forwarded to the Call Floor Supervisor.
   b. The Call Floor Supervisor reviews the CPS report for accuracy, accepts the report and closes the case.
3. The Duplicate Report must be reviewed by the Call Floor Supervisor and if necessary, the Chief, Child Protective Investigator or his/her Administrative designee.
4. If the report contains new allegations which meet the criteria for investigation, a new CPS report is processed.

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Department Operating Procedure

	DOP Number: **700.0035**	Effective Date: **November 15, 2023**	Page 1 of 6
	Version #: **3**	Revision History: ***April 28, 1986 V.1*** ***November 16, 2009 V.2***	Director: **Ashley Deckert**
Section: **Case Management**		Title: **Kinship Care**	

Legal Authority:

- Rhode Island General Law §14-1-27
- Rhode Island General Law §14-1-34
- Rhode Island General Law §40-11-12.2
- Rhode Island General Law §23-28.13-27 through §23-28.13-34.
- Rhode Island General Law §40-11-3
- Rhode Island General Law §40-11-7
- The Fostering Connections to Success and Increasing Adoptions Act of 2008 (PL 110-351)
- The Adoption and Safe Families Act of 1997 (PL 105-89)
- The Indian Child Welfare Act (ICWA) of 1978 (PL 95-608)
- The Adoption Assistance and Child Welfare Act of 1980 (PL 96-272)
- The Multiethnic Placement Act (MEPA) of 1994 (PL 104-188)
- Adam Walsh Child Protection and Safety Act of 2006 (PL 109-248)
- CAPTA Reauthorization Act of 2010 (P.L. 111-320)
- 214-RICR-40-00-3 Foster Care and Adoption Regulations for Licensure

Related DOPs:

- Complaints and Appeals; DOP: 100.0040
- Child Abuse and Neglect Registry Check; DOP: 100.0115
- Criminal Records Background Checks; DOP: 100.0215
- Licensing of Foster Care Homes; DOP: 300.0010
- Removal of a Child from the Home; DOP: 500.0045
- Interstate Compact on the Placement of Children; DOP: 700.0040
- Safety Assessment and Service Planning; DOP 700.0050Adoption Subsidy; DOP: 700.0060
- Respite Care Services; DOP: 700.0120
- Concurrent Planning; DOP: 700.0130
- Implementing the Indian Child Welfare Act; DOP: 700.0145
- Legal Guardianship and Kinship Guardianship Assistance; DOP: 700.0155
- Placement Determinations, Referrals, and Transitions; DOP 700.0170
- Family Search and Engagement; DOP: 700.0230
- Level of Need; DOP: 700.0240

Related Forms:

- Authorization to Obtain Confidential Information (DCYF #007B)

- Notice to Relative of Child (DCYF #029)
- Criminal Record Check (DCYF #034)
- Records Check (DCYF #035)
- Foster Care Application (DCYF #036)
- Preliminary Assessment of a Child Specific Home (DCYF #036A)
- Adoption and Foster Care Self-Assessment Questionnaire (DCYF #036B)
- Physician Reference (DCYF #037)
- Foster Care Boarding Home Agreement

I. PURPOSE

Child safety, permanency, and child and family well-being are the desired outcomes of our work with children and families. The Department of Children, Youth and Families (hereinafter the Department) maintains a child in their home whenever possible; however, certain events in a child's life may require a temporary or long-term placement outside the home. It is the policy of the Department to provide the child with an out-of-home placement that is least disruptive to the child and family, which offers the child the most familiar and family-like setting possible and encourages and promotes stability and permanency . Therefore, the Department must consider a kinship resource caregiver for the child before seeking a non-relative placement.

Kinship care is the full-time care, nurturing, and protection of the child by a relative, member of a tribe or clan, godparent, stepparent, or any adult with a kinship bond with the child. When it is determined that biological parents cannot safely maintain their child in the home , kinship care allows the child to to be cared for in a family environment, while the biological parents make the behavioral changes necessary to support reunification. Placement with a kinship resource caregiver, with whom the child has an established, supportive, caring relationship and by whom the child will be protected and provided for, can be of crucial importance to the child's future, the family, and the community. For this reason, identification of a kinship resource caregiver must be pursued during the initial family assessment. The kinship resource caregiver can be supportive in maintaining the child in the parental home and provide a placement for the child if it becomes necessary to place the child out of the home.

A child removed from the parental home experiences physiological and emotional trauma. Kinship care allows the child to remain within the protection and support of the extended family or community and can help mitigate this trauma. The child can maintain cultural and ethnic ties and identity. Kinship care provides a child more stability and less disruption than other placements. In most kinship care placements, a child can better remain in contact with their parent(s), and visits can often occur in a more natural manner and setting. The impact of being separated from both parents and siblings at the same time cannot be overstated. Kinship care can more often provide a home for a sibling group.

The need to identify and assess a kinship placement may come up more than once in the course of a case. If a child's placement must be terminated for any reason, the parents should again be consulted regarding potential kinship caregivers. If the parents are unavailable, a current kinship caregiver or other relative can indicate another caregiver within the family.

The Department, other state departments, and private social service agencies recognize the invaluable service that kinship caregivers provide to the children in their care and the community. Public and private agencies collaborate to offer support services to assist relative resource caregivers. Supports cover a wide range, including financial, training,

some forms of housing assistance, mentoring, and respite care. Eligibility for certain financial and supportive services may depend upon the degree of relationship between the resource parent and the child.

TERMS DEFINED

"Fictive Kinship Placement" means a placement for a child or youth with an individual who is not related by birth, adoption, or marriage to a child but who has a preexisting emotionally significant relationship with the child, such as a non-related godparent, caretaker, family friend, neighbor, clergy, or another adult who has a close and caring relationship with the child. For the purpose of this protocol, fictive kin is equivalent to kin or kinship. A fictive kinship home is a type of Resource Family Home.

"Kinship Placement" for the purposes of this Operating Procedure means both "Fictive Kinship Placement" and "Relative Kinship Placement."

"Relative Kinship Placement" means a placement in a living arrangement with a relative of the child or family. The home must meet all Department licensing requirements for out-of-home placement. Relative Kinship Placement is a type of Resource Family.

"Resource family" means any home-based placement, inclusive of traditional foster home, fictive or relative kinship placement, and therapeutic foster home.

"Traditional Foster Home" means one or more adults licensed directly by the Department to provide foster caregiving in a family-based home setting. A traditional foster home is a type of Resource Family.

II. PROCEDURE

A. Early Identification of Kinship Placements

1. Upon determination that a child requires out-of-home care in a resource home (Refer to **DOP: 500.0045 Removal of a Child from the Home)**, the primary service worker must investigate the possibility of placing a child with a fit and willing relative kin or fictive kin not residing with the parents.
2. At the time a child is removed from the parent's custody and throughout the time the case is open to the Department, the Department makes intensive efforts to identify and notify all relatives up to the third degree. Refer to **DOP: 700.0230; Family Search and Engagement** and **Implementing the Indian Child Welfare Act; DOP: 700.0145**.

B. Assessment of Kinship Homes

1. The Department conducts an assessment to determine the appropriateness of the placement of the child with the identified relative immediately, but no later than within 30 days, of the child's placement in the temporary custody of the Department.
2. Child safety and well-being issues are paramount in assessing a kinship care home. Careful and sensitive assessments must be made of kinship care homes with particular attention to the following areas:
   a. History of involvement with the Department or other child protective agency.
   b. History of criminal charges.
   c. The child's comfort level with the kinship caregiver.

d. The kinship caregiver's commitment to protecting the child's health and safety and willingness and ability to protect the child from abuse and neglect, whether by the parents or others.
e. The kinship caregiver's willingness to deny any unauthorized request by the parents for access to the child.
f. Ideally, a positive relationship between the caregiver and the parent. There are times, however, when a parent may object to the child's placement with a relative. If the placement appears to be in the child's best interest and will not interfere with the Department's efforts to work with the family, the worker may proceed. If the parent continues to object, they may petition the family court for a change in placement.
g. The kinship caregiver's understanding of the temporary nature of the foster placement.
h. The importance of permanency and willingness to care for the child as long as needed.
i. The kinship caregiver's willingness and capacity to keep siblings together or, at the least, allow them regular contact. Refer to **DOP: 700.0170; Placement Referrals**.

3. If the Department determines that the kin is a fit and proper person to have placement of the child, the child is placed with that kin unless the child's particular needs make the placement contrary to the child's best interests.
4. If the Department proposes to place the child with kin outside the state of Rhode Island, the Department notifies the parent, who can file an objection to said placement with the family court within 10 days of receipt of the notice.
   a. A hearing is held before the child is placed outside the state of Rhode Island.
   b. The Department must ensure compliance with the Interstate Compact on the Placement of Children before initiating an out-of-state placement. Refer to **Interstate Compact on the Placement of Children; DOP: 700.0040.**
5. If the Department denies the request of kin for placement of a child or children, that kin has the right, in accordance with RIGL 14-1-27, to petition the court for review.
   a. Within five days of the request, the court conducts a hearing on the suitability of temporary placement with said relative.
   b. The court will then issue orders regarding the suitability of temporary placement with the relative based on the information provided in the hearing.

C. Licensing of Kinship Homes Completed by Licensing Staff

1. A kinship placement is subject to the same licensing regulations as a non-kinship foster home. See **DOP 300.0010, Licensing of Foster Care Homes.** The Licensing worker is responsible for ensuring that all the licensing steps are completed for a resource home to be licensed.
2. All kinship care placements must be licensed and are subject to criminal records and clearance of agency activity checks and all foster care regulations promulgated by the Department.
3. Licensing workers conduct a child-specific home study with kinship providers that evaluates the relationship between the prospective resource family and the child, the child's relationship to individuals already living in the home, and the prospective resource family's commitment to the child.

4. Under certain circumstances, a waiver may be granted regarding licensing requirements. The licensing administrator may grant waivers on a case-by-case basis for conditions other than safety-related.
5. The Licensing supervisor or designee ensures that the following steps are completed within seven business days of receipt of the Preliminary Assessment Packet.
    a. The Licensing Application packet is sent to the kinship provider.
    b. The physician's reference is sent to the provider's physician.
    c. The child abuse and neglect registry check request is sent to each state's central registry that the prospective caregiver and any other adult (18 and older) living in the home have resided in the preceding five years.
    d. A review of the Preliminary Assessment packet (DCYF #036A, with attached DCYF #034, DCYF #035, DCYF #007B and, if applicable, a memo with details of criminal or Department history or physical or behavioral health issues of concern) for completeness.
    e. Initiation of the licensing process by creating a pending license and assigning the case to a licensing worker.
6. The Department may authorize the placement of a child in a kinship home pending licensure for a period not to exceed 180 days. This approval may be granted only after completing the DCYF records check, statewide criminal records check, and an approved DCYF #036A.
7. A resource caregiver license cannot be granted to a kinship home when the child's natural parent or legal guardian resides with the relative resource parent of the child unless an exempting condition is present. Specific exemptions may be granted with written documentation from a reliable professional that the biological parent or legal guardian is not capable of parenting the child due to having a condition that markedly restricts their ability to function physically, mentally, or socially.
8. If the kinship applicant does not meet the Department's required standards for licensing, is not granted a waiver, or refuses to cooperate in the licensing process, it may be necessary to terminate the child's placement and locate a placement that meets the Department's standards.
    a. The applicant is notified in writing of the Department's decision regarding licensing, the reason for denial if it is decided that the home will not be licensed, and the right to appeal.
    b. Refer to **DOP: 100.0040; Complaints and Appeals**.

D. Unlicensed Kinship Homes After 180 Days
1. If the Department is unable to complete the licensing process within 180 days of the child's placement in the kinship home and if the Department determines that continued placement of the child in the kinship home is in the child's best interest, the Department files a petition with the family court to seek authorization to allow the child to remain in the kinship home pending completion of the licensing process.
2. The Department's legal office provides notice of all such petitions to the Office of the Child Advocate, the child's parent/guardian, and the Court Appointed Special Advocate (CASA) attorney. The notice includes why the kinship caregiver has yet to be licensed and why the Department has determined that the continued placement is in the child's best interest.

E. Support Services

1. The Department is cognizant of the invaluable service that kinship caregivers provide to the children in their care and the community and provides support services to caregivers to assist them in their work.
2. If a child was eligible for Temporary Assistance for Needy Families (TANF) funding before coming into care, a relative kinship placement who is a blood relation may choose to continue to receive TANF payments and medical assistance for the child under TANF guidelines.
    a. The relative may be eligible to receive TANF and medical assistance for themselves if they meet the income guidelines established through the RI Department of Human Services.
3. Kinship caregivers who do not wish to receive TANF funds (or are not eligible for such funds) receive foster board payments from the Department. The amount of the foster board payment is based on the child's level of need. (Refer to **DOP: 700.0240 Level of Need**). A child receiving foster board also receives medical coverage through the Department.
4. There are resources available that may assist kinship caregivers to improve their property to conform to licensing standards. Additionally, some programs will help families move to more appropriate rented and/or subsidized housing if their residence does not comply with space requirements or other safety codes.
    a. This information is available to the kinship caregivers through the Department's designated providers and the Foster Parent Liaison.
5. The Department ensures that kinship caregivers are connected with other experienced kinship care providers who can provide information and support pertinent to the needs of kinship foster homes. The licensing division and primary service worker collaborate to create these connections.
6. Respite care is available to kinship caregivers when they must be absent and unable to care for the child for some time. Respite care may be required due to a family emergency, a planned vacation that cannot include the child, or situations where the primary service worker and the caregiver agree that respite may be necessary for the preservation of the placement (refer to **DOP: 700.0120, Respite Care Services**).

F. Permanency and Concurrent Planning
1. To support children's safety, well-being, and permanency, reasonable efforts to place a child for adoption or with a legal guardian may be made concurrently with reasonable efforts to reunify the child with parents.
2. Cases involving kinship placements are considered for concurrent planning based on the assessment criteria outlined in **DOP: 700.0130, Concurrent Planning**.
3. Adoption Subsidy or Guardianship Assistance may be available in accordance with **DOP: 700.0060, Adoption Subsidy** and **DOP: 700.0155, Legal Guardianship and Kinship Guardianship Assistance**.

G. Recruitment of Kinship Caregivers as Resource Families
1. When a kinship placement ends, the primary licensing worker discusses with the primary service worker whether the kinship caregiver may be a good fit for future resource caregiving of non-relative children.
2. If the caregiver is deemed appropriate to be a potential traditional foster care resource family, the licensing worker outreaches to the caregiver and provides education on traditional foster caregiving.
3. The licensing worker documents this conversation in RICHIST.

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	DOP Number: **700.0190**	Effective Date: **April 1, 2024**	Page **1 of 4**
	Version #: **2**	Revision History: **September 28, 2020 V.1** **April 15, 2021 V.2**	Director: **Ashley Deckert**
Section: **Case Management**		Title: **Support and Response Unit**	

Legal Authority:

- R.I. Gen. Laws § 42-72-5. Powers and Scope of Activities
- R.I. Gen. Laws § 42-72.12-3 Preservation of Families with Disabled Parent Act

Related DOPs:

- Residential Treatment for Youth without Legal Status; DOP: 100.0330
- Family Care Community Partnership (FCCP) Referral; DOP: 100.0375
- CPS Hotline Call Screen-Outs; DOP: 500.0015
- Transfer of Non-Legal Status Cases to FSU; DOP: 700.0215
- Early Childhood Referral Process for Children Involved with DCYF; DOP: 700.0285
- Filing a Straight Petition; DOP: 1100.0055
- Family Functioning Assessment Intervention Manual

Related Forms:

- N/A

I. PURPOSE

The Support and Response Unit (SRU) within the Department of Children, Youth, and Families (hereinafter, the Department) 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 (CPS) to the Family Services Unit (FSU) and the Children Services and Behavioral Health Division (CSBH), with or without legal involvement, when ongoing case management is required.

The SRU does not provide long-term case management. When the Support and Response Unit determines an assessment is necessary, its involvement is limited to the evaluation and referral period.

A Support and Response Unit worker processes all child welfare referral calls during standard working hours (8:30 AM to 4:00 PM on weekdays). Child welfare referral calls are processed through the Call Floor during non-standard working hours (4:00 PM to 8:30 AM on weeknights, and on weekends and holidays). An SRU worker follows up on a referral on the next business day.

The SRU performs the Department's referral function for child welfare matters involving families not active with the Department. A child welfare referral call regarding an active case (child and/or family) received by the Call Floor or the Support and Response Unit is directed to the assigned primary social caseworker in the Family Services Unit (FSU).

II. TERMS DEFINED

"Child welfare referral call" means phone or in-person contact with a family to assist them in navigating community services, conduct assessments where appropriate, provide community service referrals, and support transfers from Child Protective Services (CPS) to Family Service Unit (FSU) and Children's Services and Behavioral Health (CSBH).

III. PROCEDURE

A. Support and Response Unit Referrals and Case Assignments

1. A child welfare referral (telephone call, in-person contact) is directed to the Support and Response Unit's (SRU) Help Line during standard working hours (8:30 AM to 4:00 PM) if the Call Floor or another unit within the Department receives the request for information or assistance.
2. The following calls are referred to the Support and Response Unit:
   a. Reports made to the CPS Hot Line that do not meet the criteria for a CPS Investigation but do meet the requirements for a prevention response. Refer to **DOP: 500.0015; CPS Hotline Call Screen-Outs**.
   b. Callers requesting assistance or services from the Department.
3. Requests for service
   a. When a telephone services request is made, the SRU caseworker asks for the person's name.
   b. The caseworker conducts a Person Search in the electronic case record. If the person is found, a Case Search is conducted.
   c. If there is an active primary service worker, the caller is directed to the assigned worker. The client's call is documented in the family support call log located in the electronic case record.
   d. When there is no active case, the call is documented on the Call Log and opened to the SRU, if warranted.
4. Case Assignment
   a. CPS makes an electronic referral to the SRU.
   b. The SRU administrator, or designee, reviews the referrals daily and assigns the case to an SRU caseworker.
   c. Cases referred from the family court, or the family support line are prioritized for case assignment.

B. Support and Response Unit Caseworker Responsibilities

1. Refer the caller to the appropriate Department division or community provider for services.
2. Work with assigned families on a voluntary basis to ensure the child's needs are met and to assist caregivers.
3. Obtain from the caregiver or child the names of persons who can provide additional information about the child and family's needs.
   a. Encourage and assist the parents or legal guardians in contacting extended family members who may be able to support the family.
4. Contact the parents and child within three business days of being assigned to the case. Must contact them face-to-face within five business days cases assignment.
5. Conduct a Family Functioning Assessment (FFA) when warranted due to

elevated risk of harm to a child. The following definitions of risk of harm below determine if the family should be assessed utilizing the FFA. (Refer to **Family Functioning Assessment Intervention Manual).**

a. Risk of physical abuse
    i. Circumstances where the child has not yet experienced harm, and it can reasonably be concluded that if the circumstances continue without change, physical abuse will likely occur.

b. Risk of sexual abuse
    i. Situations where, although the child has not yet experienced harm and there may have been no known sexually abusive actions, it can reasonably be concluded that the current circumstances represent a threat of sexual abuse. Examples of this type of situation include but are not limited to the following:
        1) A person who previously sexually abused this or another child, including having prior or current child pornography charges, is a household member or has regained access to the child or other children in the residence.
        2) There are indications that the child is being groomed. "Grooming" refers to a deliberate and escalating pattern of actions taken to lower a child's inhibitions in preparation for sexual abuse (e.g., treating the child as "more special" than other children, talking about age-inappropriate sexual topics, exposing the child to pornography, deliberate self-exposure).

c. Risk of neglect
    i. Risk of neglect indicates the caregiver is demonstrating behaviors that are cause for concern; the behaviors indicate a trend or escalating pattern toward the potential inability to meet the child's basic needs. This inability can reasonably be expected to produce a substantial and demonstrably adverse impact on the child's safety, welfare, or well-being. Examples include but are not limited to the following:
        1) The caregiver appears to be suffering from mental health conditions and is unlikely to meet the child's basic needs of food, clothing, shelter, or protection from harm.
        2) There are indications that the caregiver is not interested in caring for themselves or the children and that the children are vulnerable.
        3) One partner's financial control appears to be preventing the other from purchasing items needed for the care of the child (e.g., the parent does not allow the other parent access to the bank account and only provides limited cash inconsistently, which prevents the parent from having funds to buy food, clothing, or medicine for the child as needed).
        4) Caregivers' intellectual disability is likely to impair their ability to provide adequate care, supervision, or protection for a vulnerable child, and they are reluctant or refuse to allow extended family members or other supports to

assist in caregiving. In accordance with **Rhode Island General Law 42-72.12-3(a)**, a parent or prospective parent's disability shall not be presumed to have a detrimental impact on a child.

6. Assess the family for the family court. The family court may request a DCYF family assessment before deciding on a juvenile matter or a domestic relations situation.
   a. The court may order a child who comes before the court on a wayward petition into placement.
   b. Both the court study request and placement order are carried out by the Department's SRU staff when the case is not active with the Department.
   c. If the child's case is open to the Department, the assigned primary service worker completes the court request for study or placement.

C. Case Transfer and Closure
1. A case disposition is made within 30 days of assignment to the SRU. The SRU caseworker supervisor may submit a request to the SRU administrator for a 15-day extension if necessary.
2. Assignment to the SRU concludes with one of the following dispositions:
   a. Referral to the CPS Hotline if there is information learned during the FFA regarding an allegation of child abuse and neglect.
   b. Case closure when no further Department involvement is necessary, and the reasons are documented in a case activity note.
   c. Referral to community-based service providers, including but not limited to Early Intervention services. (Refer to **DOP: 700.0285; Early Childhood Referral Process for Children Involved with DCYF** and **Family Care Community Partnership (FCCP) Referral; DOP: 100.0375**).
   d. Transfer to FSU without legal status in accordance with **DOP: 1100.0055; Filing a Straight Petition** and **DOP: 700.0215; Transfer of Non-Legal Status Cases to FSU** when children are determined to be in impending danger, but the Safety Plan Determination process indicates an appropriate in-home safety plan is in place. The SRU casework supervisor assigns the case to FSU if the FFA identifies needs warranting ongoing case management.
      i. The SRU caseworker contacts parents to inform them that the case has been assigned to an FSU worker and, when applicable, notifies them of the court date.
      ii. The SRU caseworker may gather additional information about the child that may be needed.
   e. Transfer to FSU with legal status if the FFA indicates impending danger and the SRU is unable to implement an appropriate in-home safety plan.
   f. Transfer to the Children's Behavioral Health Unit if the caller is seeking services to address a child's serious emotional disturbance (SED) or intellectual developmental disability (IDD) condition with significant functional impairments in multiple domains. (Refer to **DOP: 100.0330; Residential Treatment for Youth without Legal Status**).

Rhode Island Department of Children, Youth and Families

Family Functioning Assessment Intervention Manual

PREPARED BY ACTION FOR CHILD PROTECTION

October 7, 2018

Contents

Using the Intervention Manual

This Intervention manual is designed to assist Investigators and Supervisors in completing the Family Functioning Assessment. The information in the Intervention Manual supplements Rhode Island Statutes, Policies and Procedures. DCYF Staff should follow Rhode Island Statutes, Rhode Island Policies and Procedures if there is now or in the future conflicting information or directives.

Chapter 1. Family Functioning Assessment Purpose, Objectives, and Decisions

Purpose

The purpose of the Family Functioning Assessment (FFA) is to determine whom the Department of Children, Youth, and Families (DCYF) will serve, by assessing and reaching conclusions about caregivers who are unable or unwilling to protect their children from Impending Danger. The Family Functioning Assessment includes the assessment and management of Present and Impending Danger, and the assessment of caregivers with diminished Caregiver Protective Capacities.

Objectives

The objectives of the FFA are:

- To respond promptly according to content contained within the child abuse report;
- To inform reported individuals of a community concern for the safety of their children;
- To engage caregivers in a process that provides a picture of the family and reveals whether children are in danger;
- To meet emergency needs that are apparent at the onset or during the FFA;
- To conduct a structured, thorough information collection process that includes relevant family members;
- To keep caregivers informed and appropriately involved in case decision making;

- To reach a finding regarding the existence of child maltreatment consistent with DCYF policy and state statutes;

- To reconcile reported allegations;

- To conduct a family-centered assessment;

- To establish a sufficient, least intrusive Impending Danger Safety Plan when children are determined to be in Impending Danger.

Decisions

The FFA decisions are:

1. Is a child in Present Danger?
2. Has maltreatment occurred or is maltreatment occurring?
3. Is a child in Impending Danger?
4. Is this a family who should be served by the Family Service Unit due to a child being in Impending Dangers?
5. Which Impending Danger Safety Plan should be implemented?
6. If applicable, what are the Conditions for Return?

Chapter 2. Definitions

Abuse or Neglect of a Child

Insert Rhode Island's Policy Definitions for abuse/neglect. If policy further defines law, insert

Caregiver

A caregiver is an adult who has primary and/or daily responsibility for the supervision, care, and protection of a child in the family's home. This can include parents, stepparents, adoptive parents, relatives, companions of the child's parent, or any adult who is judged to have and continues to have responsibility for a child's supervision, care, and protection.

Caregiver Protective Capacities

Caregiver Protective Capacity refers to one's (personal and caregiving) behavioral, cognitive, and emotional characteristics that specifically and directly can be associated with caregiver performance. Protective capacities are personal qualities or characteristics that contribute to the presence or absence of vigilant child protection, influence safe environments, and impact the well-being of children.

Child

"Child" means a person under the age of 18 years.

Child Maltreatment

Child maltreatment refers to parenting behavior that is harmful or destructive to a child's cognitive, emotional, social, or physical development, and caregivers are unwilling or unable to behave differently.

Collateral Contacts

Collateral contacts refer to family members, professionals, and others who have knowledge of the family and the circumstances and events being evaluated during the Family Functioning Assessment (FFA). During the FFA, collateral contacts can occur to seek information beyond what is provided by family members, and to corroborate facts and information collected as part of the FFA. During FFA information collection, collateral contacts may consist of written documents, telephone calls, or an in-person communication with an individual to obtain information used to corroborate or dispute an allegation of child maltreatment or gather

information related to how the caregivers' parent, function as adults, or the functioning of children who reside with the caregivers.

Conditions for Return

Conditions for Return (CFR) refer to identified specific behavior and circumstances that must exist within a child's home, for a child who is placed to return home. The Conditions for Return are associated with what is necessary in order to establish an In-Home Impending Danger Safety Plan. Conditions for Return are established in conjunction with the results of the Impending Danger Safety Plan Determination Analysis. Conditions for Return are discussed with the parent/primary caregiver when children are removed.

Danger Threshold

The Danger Threshold is the point at which family functioning and associated caregiver performance becomes perilous enough to be perceived as a threat, or produce a threat to child safety. The Danger Threshold determines Impending Danger. The Danger Threshold is qualified by five criteria. In order for family functioning and associated caregiver performance to be an Impending Danger, all criteria must apply and be met.

- *Observable refers to family behaviors, conditions or situations representing a danger to a child that are specific, definite, real, can be seen and understood and are subject to being reported and justified. The criterion "observable" does not include suspicion, intuitive feelings, difficulties in worker-family interaction, lack of cooperation, or difficulties in obtaining information.*

- *Vulnerable Child refers to a child who is dependent on others for protection and/or is exposed to circumstances that she or he is powerless to manage, and susceptible, accessible, and available to a threatening person and/or persons in authority over them. Vulnerability is judged according to age, physical and emotional development, ability to communicate needs, mobility, size and dependence and susceptibility. This definition also includes all young children from 0 – 6 and older children who, for whatever reason, are not able to protect themselves or seek help from protective others.*

- *Unmanaged refers to family behavior, conditions or situations which are unrestrained resulting in an unpredictable and possibly chaotic family environment not subject to the influence, manipulation, or ability within the family's to manage. Such unmanaged family conditions pose a danger and are not being managed by anybody or anything internal to the family system.*

- *Imminent* refers to the belief that dangerous family behaviors, conditions, or situations will remain active or become active within the next several days to a couple of weeks.

This is consistent with a degree of certainty or inevitability that danger or severe harm are possible, even likely outcomes, without intervention.

- *Severity* refers to the effects of maltreatment that have already occurred and/or the potential for harsh effects based on the vulnerability of a child and the family behavior, condition or situation that is unmanaged. As far as danger is concerned, the safety threshold is consistent with severe harm. Severe harm includes such effects as serious physical injury, disability, terror and extreme fear, impairment, and death. The safety threshold is in line with family conditions that reasonably could result in harsh and unacceptable pain and suffering for a vulnerable child.

Diligence

Diligence refers to conscientiousness apparent in all aspects of intervention concerning thoroughness, timeliness, availability, and responsiveness.

Face-to-Face Contact

An in-person interaction between individuals that will allow for the Investigator to observe and assess the child, parents, and/or caregivers is face-to-face contact.

Family Functioning Assessment

The Family Functioning Assessment (FFA) is the first face-to-face assessment with a family for determining whether children are in Present or Impending Danger. A report that has been screened in for assignment is assessed by a child welfare agency. The FFA process includes interacting with a family for the purpose of assessing factors or conditions that are known to result in child abuse or neglect; to make a maltreatment determination or finding; to assess family conditions that create Present Danger and/or create Impending Danger; to identify family strengths; to evaluate enhanced and diminished Caregiver Protective Capacities; to reconcile information contained in the reports about alleged child abuse and neglect and alleged threats to child safety; to make a conclusion regarding the existence of Present and/or Impending Danger; to determine the need to open a case for ongoing FSU Services; and to establish the least intrusive, most effective Safety Plan. The FFA is conducted by an Investigator.

Family Functioning Assessment Information Collection Protocol

The FFA information collection protocol is a procedure which provides a uniform, systematic, and structured approach for interviewing and collecting information in family situations where a child may not be safe. Applying this information collection protocol creates a situation which controls the information collection process, increasing opportunities to

gather sufficient information to make decisions, determine with a higher degree of accuracy what is occurring, and ensure that all family members are seen and involved.

Four Assessment Areas

Four critical areas are used for assessing and analyzing family strengths and child safety. These are also referred to as the four assessment areas and the IA information standards. The four assessment areas address:

(1) the extent of and surrounding circumstances accompanying the maltreatment;
(2) child functioning on a daily basis;
(3) adult functioning with respect to daily life management and general adaptation (including mental health functioning and substance usage);
(4) the disciplinary and overall general parenting practices used by the caregiver

Household

The "household" is an association of persons who live in the same home or dwelling, and may be related by blood, adoption, or marriage or may be unrelated persons residing in the same home or dwelling as the child.

Impending Danger

Impending Danger refers to dangerous family conditions that represent situations/circumstances, caregiver behaviors, emotions, attitudes, perceptions, motives, and intentions which place a child in a continuous state of danger. They are unmanaged in the presence of a vulnerable child, and, therefore, likely to have severe effects on a child at any time in the near future. These dangerous family conditions exist within the child's home as a result of caregivers who possess diminished Caregiver Protective Capacities.

Impending Danger is not always active but can become active at any time or may become active because of specific stimulating events, circumstances, or influences. Impending Danger is not necessarily obvious or occurring at the time of the report, but can be identified and understood upon more fully evaluating and understanding individual and family conditions and functioning through the FFA. A child in Impending Danger without safety intervention reasonably could experience severe harm. As reported by a reliable source during the IA, Impending Danger refers to family conditions, situations, behaviors, emotions, intentions, perceptions, and motives that are out of control; are imminent with respect to the certainty as a direct threat to a vulnerable child; can likely result in severe harm; and are specific, observable, and describable.

Impending Danger Safety Plan

An Impending Danger Safety Plan is a written plan that is put into place at the conclusion of the FFA, when a child is determined to be in Impending Danger, (e.g., a Safety Plan is installed when Impending Danger is confirmed in the FFA conclusion.) The Impending Danger Safety Plan is developed through collaboration with the FF Supervisor and with caregivers. The purpose of the Impending Danger Safety Plan is to ensure protection of a child when Impending Danger is identified. The Safety Plan must be sufficient to manage and control Impending Danger based on a high degree of confidence that it can be implemented and sustained. The Impending Danger Safety Plan remains in effect as long as a child is in Impending Danger and Caregiver Protective Capacities are insufficient to provide protection. An Impending Danger Safety Plan describes how Impending Danger is occurring within the family; identifies Safety Actions, Safety Plan Participants, and their suitability to participate; and establishes how Impending Danger will be managed.

Impending Danger Safety Plan Determination

The Impending Danger Safety Plan Determination (SPD) is an analysis that occurs as part of the decision making required in the FFA, when the Impending Danger Safety Determination identifies Impending Danger and a child is unsafe. The purpose of the SPD is to identify the least intrusive approach to managing safety. The SPD results in a decision about whether to proceed with an In-Home Safety Plan or an Out-of-Home Safety Plan. The SPD analysis is completed by the Investigator. With respect to determining the suitable Impending Danger Safety Plan, the Investigator considers caregiver willingness; caregiver capacity; calmness and stability of the environment; suitability of the family residence; and necessary Safety Management resources.

Incident

An incident is an act of the caregiver or circumstance of a child reported to DCYF by the community, which, if true, would constitute abuse or neglect, Present Danger, or Impending Danger.

Initiation of the Family Functioning Assessment

Initiation refers to the DCYF Investigator contacting or attempting to contact the alleged child victim, siblings, caregivers, and other involved parties.

Present Danger

Present Danger is an immediate, significant, and clearly observable family condition that is actively occurring or “in the process” of occurring that is reported during the report, and/or occurring at the point of contact with a family, and will likely result in serious harm to a child.

"In the process" of occurring means it might have just happened (e.g., a child presents at the emergency room with a serious unexplained injury); is happening (e.g., a child is left unattended in a parked car); or happens all the time (e.g., young children were left alone last night and might be tonight.)

Present Danger Assessment

The Present Danger Assessment is a judgment or process involving observation, interpretation, identification, and a conclusion that a family condition, child condition, individual behavior or action, or family circumstance places or does not place a child in immediate jeopardy. The Present Danger Assessment is required at the initial contact with the identified child and caregivers at the onset of the FFA. The judgment must involve Supervisory consultation.

Present Danger Plan

The Present Danger Plan is an instantaneous (same day), short-term, sufficient strategy that ensures a child is cared for, supervised, and protected by a responsible adult, which allows for the completion of the FFA.

Priority Response Time

Priority Response Time is the time required to initiate the FFA with face-to-face contact, based on the screening determination.

Referral

A referral is information received from a reporting party alleging child abuse, neglect, Present Danger, Impending Danger, and/or requesting services.

Report

A referral becomes a report upon DCYF determination that information received constitutes an allegation consistent with Rhode Island Child Abuse and Neglect Allegation definitions, and/or indications of Present or Impending Danger.

Response Timelines/Timeliness

Refers to the time frame that is determined by the urgency of the report of child abuse or neglect.

Safe

Children are safe when there are sufficiently enhanced Caregiver Protective Capacities to ensure that there is no danger within the family where the child resides.

Safety Actions

Safety Actions are actions, activities, and/or direct services implemented to address the Safety Categories and achieve the purpose of the Impending Danger Safety Plan, which is to manage Impending Danger.

Safety Assessment and Family Evaluation

The Safety Assessment and Family Evaluation (SAFE) is the system of intervention that comprises all the assessments, activities, practices, and decisions that are intended to identify unsafe children; ensure unsafe children are protected; and restore caregivers to their protective roles. The Family Functioning Assessment is an intervention system within SAFE that is designed to identify which families the agency will serve due to children being in Impending Danger. The Ongoing Family Functioning Assessment and Caregiver Progress Evaluation and Safety Reassessment are the components in the intervention system that address the required changes and facilitate restoring caregivers to their protective role.

Safety Categories

Safety Categories are the functional objectives of an Impending Danger Safety Plan that are expected to sufficiently control Impending Danger and ensure child protection. The Safety Categories are: behavior management, crisis management, social connection, separation, and resource management.

Safety Determination

The Safety Determination, which is also known as the safety assessment, occurs as a conclusion at the completion of the FFA. The Safety Determination concludes a child is safe or unsafe, based upon identified Impending Danger. It is supported by an analysis of Caregiver Protective Capacities and documentation of the four assessment areas in FFA.

Safety Plan Participants

Safety Plan Participants are family network members, volunteers, paraprofessionals, professionals, and safety managers who are assigned to carry out Safety Actions as designated within a Safety Plan. Safety Plan Participants must be determined to be suitable to perform the duties and responsibilities identified within a particular Safety Plan.

Unsafe

Children are unsafe when they are vulnerable to danger within the family where they reside due to diminished Caregiver Protective Capacities.

Vulnerable Child

A vulnerable child refers to a child who is dependent on others for protection and/or is exposed to circumstances that she or he is powerless to manage, and susceptible, accessible, and available to a threatening person or persons in authority over them. Child Vulnerability takes into account according to age, physical and emotional development, ability to communicate needs, mobility, size and dependence, and susceptibility.

Chapter 3. Competency and Skills

The Foundation for Competency and Skills

The Investigator communicates and behaves in ways that engage the children, caregivers, and relevant family members interpersonally in the information sharing and collection exchange. The foundation for effectively engaging caregivers and family members is compassion and empathy. These emotional predispositions of an Investigator about people in general, and about reported families specifically, are profound in successfully connecting with and engaging family members in the FFA process. Expressions of kindness, understanding, caring, and acceptance, which are products of compassion and empathy, are more powerful influences than the skills and techniques the Investigator employs to involve family members in the FFA information collection process.

Compassion is a feeling of deep sympathy, pity, or sorrow for another who is stricken by misfortune, accompanied by a strong desire to alleviate the suffering. Empathy occurs when an FFA Investigator recognizes, and in some way personally experiences, the sad or happy feelings that are being experienced by a caregiver, child, or family member. Compassion and empathy are dynamic and personal, and can be developed. Having general compassion toward others at large predisposes the Investigator to experience empathy with caregivers and family members. The empathy the Investigator experiences with a specific family increases specifically the compassion he/she feels for that family.

Compassion is concerned with fairness and justice. Compassion is about caring enough to search for answers and solutions. Compassion differs from empathy in a distinct way. Compassion occurs in degrees of energy, commitment, effort, and passion to do something about the situation faced by the reported family.

Empathy is the capacity to recognize and, to some extent, share, feelings (such as sadness or happiness) that are being experienced by the caregiver, a child, or family members. Empathy is a conscious recognition of the experience of those encountered by the Investigator. The conscious recognition includes a vicarious experience of the feelings, thoughts, and attitudes of family members. Empathy influences understanding and promotes connection with others, but only if it is expressed or communicated to them. The Investigator is empathic when he/she emphasizes the desire to completely understand things from the caregiver's or family member's point of view.

The existence of compassion and empathy are essential to effectively connect with family members and engage them in the FFA information collection process. These dynamic qualities are more likely to be displayed when the Investigator's practice is grounded in commonality. Instead of recognizing the differences between themselves and reported caregivers and family members, Investigators try to recognize what they have in common. Commonality is rooted in identifying with others' humanity, common needs and

aspirations, and desire for attention, for success, for recognition and affection, and, above all, for happiness. As professionals, Investigators understand that the apparent differences between them and caregivers and family members reported to DCYF are likely a result of troubled history, trying circumstances, lack of opportunity, or other life situations that could beset anyone.

Once the Investigator is able to empathize with a caregiver, or child or, family member during the FFA process, he/she will more likely understand the person's humanity and suffering. The next step is to express that understanding to the person, understanding that the person wants to be freed from the challenges and difficulties he/she is facing. The Investigator who approaches the FFA process from the perspective of compassion and empathy knows how supportive and encouraging it feels when one human being (the Investigator) desires to understand and act upon the difficulties and suffering of another human being (caregivers and family members).

Family-Centered Approach

The FFA employs a family system, family-centered approach for interaction with all who are involved in the FFA information collection and decision-making process. This approach incorporates essential practice behaviors:

- Demonstrate respect and courtesy.
- Demonstrate genuineness and equity.
- Respond promptly.
- Constantly seek to engage.
- Act and respond with the family as the primary source of information.
- Provide support and encouragement.
- Demonstrate professionalism.
- Enable and promote participation and involvement.
- Provide necessary information.

Engagement

Engaging communication and behavior that should be evident at initial contact and should continue throughout the FFA information collection process include:

- Beginning where the caregiver is;
- Respecting the human and civil rights of all involved;
- Assisting the children, caregiver, and family members to purposefully express their emotions, thoughts, and concerns;
- Viewing the family and each of its members as unique and individual with respect to their perceptions, interests, concerns, and needs;
- Reinforcing that the family and its members are the best source for producing necessary FFA information and understanding;
- Dealing with the caregivers as the authorities and executives of the family through respect and deference, in regard to participation and involvement;
- Demonstrating a non-judgmental attitude and non-judgmental communication;
- Giving caregivers their right to self-determination and helping them understand the consequences of their choices; and
- Maintaining privacy and confidentiality, within clearly defined parameters.

Engaging communication and behavior are intentional, conscious, and purposeful. Engaging communication and behavior occur as a result of the application of pertinent interviewing skills and effective interview management.

The Investigator applies a neutral approach to the information collection and evaluation process. This means that the Investigator efforts to understand a family and the family's circumstances are objective rather than subjective. There is no intention to seek positive or negative information about the family. The Investigator intention is to exercise an intervention that results in a balanced and accurate reflection, depiction, or representation of the family, family dynamics, and caregiver performance.

Skills

The Investigator demonstrates interpersonal skills that facilitate information collection.

While personal style is encouraged, there are two interpersonal skill sets that Investigators use to promote involvement, encourage participation, generate information, and engage caregivers.

- Conversational Dialoguing

Conversational dialoguing is more of a strategy than a specific skill. This method of interviewing avoids an interrogation style of approach in favor of a "talking together." It requires communicating in a balanced and egalitarian manner. It works because the Investigator lowers his/her authority while seeking a common ground and interest. The person being interviewed is valued as the best source of information available. Conversational dialoguing is characterized by interest, curiosity, information sharing, empathy, support, and encouragement.

- Motivational Interviewing

Motivational Interviewing (MI) is a particular way to help people move forward in finding solutions to their present or potential problems. It helps resolve ambivalence. These methods are non-authoritarian, more persuasive, and less directive than other forms of interviewing.

Motivational Interviewing provides specific skills that guide the interview while encouraging participation and information sharing. The openness that is apparent in the Motivational Interviewing skill set is productive in "keeping the person talking." Additionally, MI provides a natural, effective means for probing more deeply into areas of information and emotions.

The Investigator understands that he/she is the most important variable in facilitating a successful FFA. The Investigator's effectiveness is directly associated with his/her beliefs and values, and the manner in which he/she conducts interaction with children, caregivers, family members, and collateral sources. The Investigator consciously uses himself/herself by employing interpersonal skills, yet does so in a way that feels more like a natural conversation than an inquiry.

Principles of Motivational Interviewing

- Express empathy
- Develop discrepancy
- Avoid argumentation
- Roll with resistance
- Support self-efficacy

Core Techniques:

There are long standing core interviewing techniques that facilitate information collection during the FFA.

- **Attending Behavior**

  Focus your attention on the caregiver rather than your agenda or your line of questioning. Attending behavior involves "matching" the caregiver's non-verbal behavior by consciously manipulating and controlling your own non-verbal skills and responses. Primary attending behaviors include: eye contact, facial expressions, body language, posturing and gesturing, following, reflecting, and vocal qualities such as tone and pace.

- **Open Questions**

  Typically, you want to begin each new line of questioning and/or transition in topic with an open-ended question. Open questions help to eliminate your responsibility for "carrying" the interview by establishing a conversational quality for the interaction. Open questions are questions that cannot be answered "yes" or "no" or in just a few words. Open questions require the adult caregiver to elaborate on their responses. Open-ended questions typically begin with words like what, where, how, and why. Open-ended questions can occur within a conversation as inquiries that are not really questions such as, "Tell me about what you were feeling when Bill said that," or "I'm wondering how you were feeling when Bill said that." Although not appearing in the form of a question, the effect is the same.

- **Paraphrasing**

  The primary intent of paraphrasing, as used during an FFA, is to facilitate the clarification of statements, issues, and concerns. Paraphrasing may involve selecting and using a caregiver's own words in your remarks. Paraphrasing allows you to judge whether what you heard from a caregiver was, in fact, accurate. Beyond your reuse of the caregiver's words, it is important to note that paraphrasing is not simply stating back the person's comments verbatim. Paraphrasing involves formulating the essential message that the caregiver is conveying and then stating that message back in your own words. When using this technique, you want to make sure that you always check out the accuracy of your statement by concluding the paraphrase with a simple question, such as, "Is that correct?" or "Does that sound accurate?"

- **Encouraging**

  This technique serves to keep people talking about a particular topic, issue, or concern. Encouraging may be as simple as using a slight verbal prompt such as: "Uh-huh"; "I see"; "Go on"; "Then what?" Encouraging may also involve using precisely chosen words or key

phrases stated by the caregiver in order to get the person to elaborate further, such as: “Angry?”; “Not the first time?”; “Always happens?”; “You screwed up?”

- **Reflective Listening Statements**

Reflective listening statements involve interpreting what a caregiver believes, thinks, feels, perceives, and understands. You then state your interpretation back to the caregiver. Your interpretation of what the caregiver is communicating is based on both verbal responses and non-verbal cues from the caregiver. As a technique and mental process, reflective listening statements begin with: 1) listening to what is being communicated by the caregiver (e.g., “I am really pissed off”); 2) processing the information and speculating as to the meaning of what the caregiver is saying (e.g., this parent appears to feel his independence is being taken away from him); and 3) “reflecting” the meaning back to the caregiver in the form of a statement (e.g., “It must feel like your life is being taken over by everyone.”) A statement is used rather than a question because a statement is less likely to produce caregiver resistance and, further, a statement triggers the caregiver to re-examine the accuracy of his/her perceptions and thoughts.

- **Conversational Looping**

Conversational looping is a skill for gathering information that first involves identifying some key general topic or area for discussion with the caregiver (e.g., relationships, education, employment history, etc.). Once you have identified a topic of discussion, begin the conversation with a broad non-threatening open-ended question. As the conversation progresses related to an identified topic, continue with a line of questioning (primarily open-ended) based on previous adult caregiver responses that progressively moves the discussion toward a more specific and intimate inquiry. A key to effective conversational looping is the ability of the interviewer to maintain a caregiver’s focus on a particular topic which will then enable you to gather more detailed information about the issue, concern, or topic of inquiry. Here is a table that provides the conversational looping process and examples of conversational looping. Keep in mind that the inquiry (questioning) is directly influenced by how a caregiver responds, what the caregiver shares.

Process of Conversation	Examples of Things You Might Say
Introduction of the Topic Explanation of a topical area.	*"Can we talk about your relationship with your husband?"*
First Inquiry Begin with non-threatening content. Use attending behaviors in order to prompt talking: direct expressions of specific interest including talking about yourself; generalizing to others with the same experience, and other ways that reveal your interest and responsiveness.	*"Tell me how you two met."* Or "*How would you describe your relationship?"*
Second Inquiry and Subsequent Inquiries Seek elaboration, more information; clarification. Widen to broader aspects of the topic/content. Move toward how the person feels or thinks about information shared.	*"Sounds like the years have matured your relationship."* *"What's the best part about being together now?"* *"Are there things that you'd like to change?"* *"How do you view the way you get along as influencing what's happening in the home?"* *"Does his traveling and you being alone bother you?"*
Sampling Consider similar related circumstances. Inquire about history. Consider application to other aspects of life, consistent in life, duration - been happening a long time.	*"I'm wondering if your independence in your relationship with your husband is unique to that relationship."* *"Have you always wanted lots of room in your relationships?"* *"How would you say your husband's need to be in charge works, say, with your kids, or in his work, or even with his own family?"*
Validation Identify your understanding. Use personal disclosure to demonstrate commonality.	*"It seems to me that you have a very close relationship, but one that allows room for others as well."* *"I know I feel the same way when someone close to me sort of encroaches on my privacy."*

<u>Verification</u> Reconcile variations and conflicts Qualify information that is concerning, illogical, irrational, biased, inappropriate, etc. Use reality testing, confrontation, interpretation or clarification.	*"I'm confused about how you can talk so highly of your relationship, but almost seem tearful."* *"Talk some more about how comfortable you are with your husband making all the decisions and how that is so."* *"You say that you and your husband don't really need any time for yourselves?"*

Chapter 4. Information Collection Protocol

The Investigator uses a protocol to ensure consistency in the approach to information collection and to maximize the amount and quality of information collected.

The Investigator uses the FFA Information Collection Protocol to collect information during the FFA process. The protocol is family-centered. The protocol begins with a preparation phase and continues through a series of interviews where information is collected and used to make the appropriate FFA decisions.

The protocol reinforces the importance of supportive interaction with individuals as pertinent and productive to effective information collection during the FFA.

The Investigator employs a family-centered approach when conducting the FFA. This approach seeks to support and involve children, parents, primary caregivers, and other individuals in all aspects of intervention. The Investigator makes every effort to constructively engage children, caregivers, and other persons involved with and knowledgeable of the circumstances surrounding the information within the FFA.

Essential Features

There are five essential features of the practice protocol.

1. Elevate the caregiver. Keep the caregiver at the center of attention and respect; reducing the use of authority and the profile of the Investigator produces an impartial, respectful climate.

2. Exhibit self-control. Remain calm, directed, professional, non-threatening, and non-judgmental.

3. Have an agenda. Enter the interviews with clarity about the purpose and the content that will be covered. This includes a sense of anticipated achievement in terms of understanding the person being interviewed and the family in general.

4. Anticipate challenges. Be prepared for both interpersonal and situational encounters that could de-rail the protocol.

5. Interview household members in a particular order. This provides structure and orderliness; provides more control over managing information collection; provides corroboration about facts and realities; and results in progressively building understanding of the family with each interview.

6. Preparation- The Investigator prepares for conducting the FFA prior to making initial contact with children, their families, and others pertinent to the assessment. Preparation includes, but is not limited to, the following: do they have time to do this for a Priority 1 response?

    - Reviewing all information collected during the Intake Assessment including DCYF case records and previous reports.
    - Contacting reporters, as needed, to clarify vague or inconsistent aspects of the intake information, or to obtain additional information needed before making initial contact;
    - Considering Present or Impending Danger that is contained within the Report;
    - Planning the location(s) and the order in which interviews will be conducted;
    - Identifying and securing necessary resources (e.g., child seat) and involvement of other needed individuals (e.g., law enforcement, other DCYF staff, mental health personnel);
    - Consulting with an Investigative Supervisor, as needed.

Interview Protocol Process

The Investigator begins the interview protocol by interviewing the child, identified within the report of abuse/neglect, at the location of the child. If the location of the child is other than at the child's home, the initial contact occurs where the child is located (i.e., school, day care, hospital, relative's home). If the child is at home, the Investigator begins the FFA by introducing the report to the caregiver, explaining DCYF's purpose, explaining the purpose of the FFA, explaining their rights to the caregivers, and then asking to interview the child first.

The Investigator judges whether to interview the child alone or in the company of a trusted adult, depending on the location of the interview. When in the child's home, the child should be interviewed privately (in a neutral location, typically not the child's bedroom).

Following the interview with the alleged victim child, the Investigator attempts to interview other children in the household, if they are available.

In two-caregiver households, the Investigator attempts to interview the non-maltreating caregiver next, if the report provides such information. Following these interviews, the Investigator interviews the caregiver identified within the report as responsible for the child abuse/neglect, Present Danger, or Impending Danger.

The Investigator conducts sufficient numbers of interviews of sufficient length and effort necessary to ensure that due diligence is demonstrated, and sufficient information is collected to assess Impending Danger. Diligence refers to conscientiousness apparent in all aspects of intervention with respect to thoroughness, timeliness, availability, and

responsiveness. (See Diligence in FFA Documentation section). During or following the interviews, protocol may be suspended if the Investigator observes the existence of Present Danger. Managing the Present Danger occurs immediately. When a Present Danger Plan is put in place, the Investigator begins an expedited FFA, which includes completing the protocol as fully and quickly as possible.

The FFA process allows for deviations from the FFA Information Collection Protocol. Certain case situations may require a deviation from the information collection protocol (e.g., access to people, emotional or aggressive reactions, location of people, and refusal of access). Deviations from the protocol can be considered with Supervisory consultation and approval and, of course, are documented.

The complete Information Collection Protocol was distributed to staff in training. The Information Collection Protocol should be understood and followed by investigators when completing the FFA.

Chapter 5. Practice Standards

Practice Standards are skills, motives, philosophies and ideas about families that Investigators must possess to complete the Family Functioning Assessment with fidelity. Each Investigator should review the Standards and strive to meet each Standard. Supervisors should be aware of the standards and assist their staff in meeting the standards.

Standard 1: Knowledge of Safety Intervention Concepts

The Investigator considers and possesses knowledge of Safety Intervention Concepts as the foundation for conducting FFA information collection and decision making.

Child safety is the operating concept applied during the FFA process. All assessments that form the Safety assessment and Family Evaluation (SAFE) assessment process are designed to evaluate the presence of danger to children and consider Caregiver Protective Capacities. The Investigator understands the importance of knowing and using essential Safety Concepts and practices that form SAFE and are necessary to perform effective practice and decision making.

The essential Safety Intervention Concepts applied during FFA are:

- Safe and unsafe
- Present Danger
- Impending Danger
- Danger Threshold
- Allegations of child abuse and neglect
- Present Danger Plan
- Impending Danger Safety Plan Determination
- Conditions for Return
- Reasonable efforts
- Impending Danger Safety Plan

Standard 2: Prompt Response

The Investigator meets face-to-face with children and caregivers promptly when there are indications in the report that children may not be safe.

The report results in the designation of a response time. The decision about the timing of a response to a report is based on a safety designated timeframe, content within the report, Supervisory consultation, and logical and reasonable judgment. The timeframe for response is contained within policy and procedure. Refer to Response Priorities DOP

The Investigator diligently attempts to make face-to-face contact with children named in the report as soon as possible and appropriate. The Investigator understands the rationale and importance for responding as soon as possible and within policy guidelines.

Standard 3: Engagement

The Investigator engages the caregivers and other family members in the information and assessment process.

The purposes of engaging a caregiver, children and collaterals for the FFA is to invest family members in information sharing and the process of information collection. The Investigator behaves and interacts in ways that encourage family members to "connect" with him/her, to join in accepting the task to share, and to provide information. Engaging caregivers and others during the FFA requires interpersonal skills and worker values, motivation, and intent.

Standard 4: Civil Rights

The Investigator acknowledges the caregiver's civil rights in general (e.g., right to privacy, due process, etc.), but specifically concerning informing the caregiver of the nature of the report and the role of DCYF.

The Child Abuse Prevention and Treatment Act requires that caregivers be advised of the reason for CPS/DCYFDCYF intervention. Traditionally, it has been accepted that good practice includes informing caregivers and family members of the concern that has been reported to the agency about their family. This standard goes further, though, by expressing a general attitude and expectation about the value and worth of the caregiver and the family. This expression is carried forth through the Investigator's behavior, communication, and interaction that demonstrate respect for privacy and due process as well as for basic human rights. Basic human rights are concerned with being informed, being heard, acceptance of individual and cultural uniqueness, being involved, and the right to have others involved according to personal choice (such as an attorney or some other advocate).

Standard 5: Confidentiality

The Investigator maintains the confidentiality of the reporter while conducting the FFA information collection process.

Confidentiality is a long-standing practice and an important value in SAFE and is required by law.

Standard 6: Present Danger Assessment

The Investigator assessed for Present Danger.

Present Danger refers to an immediate, significant, and clearly observable family condition that is actively occurring or "in the process" of occurring that is reported, and/or occurring at the point of contact with a family and will likely result in serious harm to a child.

The facts and evidence of Present Danger are usually being displayed in vivid and understandable ways. One often needs no more information than what is before him or her when evaluating Present Danger. Confirming information (from family members, collaterals, etc.) is often available to validate observations.

For DCYF, the Investigator, as the primary focus at initial contact, rules in or rules out Present Danger. When Present Danger is not apparent upon first encountering children, caregivers, or other family members in the home, the Investigator continues to be alert for any indication of Present Danger as interviews and interaction with family members proceed.

In identifying Present Danger, the Investigator observes the specific situation and/or behavior that represents the Present Danger, identifies the child who is vulnerable to the Present Danger, how the child is vulnerable, and what the potential effects the danger might have on the child. The Investigator considers all that can be understood about the Present Danger knowing that he/she must be prepared to manage the Present Danger through a Present Danger Plan.

Standard 7: Present Danger Safety Plan

When Present Danger is identified during the initial contact or anytime during the life of the case, the Investigator should perform reasonable efforts to prevent placement as part of the Present Danger Safety Plan.

The Present Danger Safety Plan is a stop-gap measure which essentially interrupts or places the family situation, family routines, and family functioning on hold, so that the FFA process can continue.

The Present Danger Safety Plan serves two purposes: 1) to control the Present Danger, and 2) to keep the children safe while the Investigator continues to collect information to further develop an understanding of the family and the family situation to evaluate Impending Danger.

Present Danger Plans may involve child placement. It is important to know that the Adoption and Safe Families Act (ASFA) requires Investigators to make reasonable efforts to prevent children from being placed. Reasonable efforts are defined as all that an Investigator does to keep a child safe without having to remove a child from his/her home. While the spirit of the ASFA requirement and good practice emphasizes reasonable efforts to avoid placing children, an exception exists when emergency circumstances exist. This applies to children who are in Present Danger. Avoiding placement is good practice and within the intention of ASFA, but realistically, in emergency situations, there may not be time and opportunity to expend reasonable efforts to prevent placement.

Even with this exception, (removing the child because of emergency) the Investigator can perform reasonable efforts to consider available options to keep a child safe without having to remove him/her. The Investigator consults with caregivers to identify resources within the family network that may be available for the Present Danger Safety Plan. The Investigator is informed of and considers Safety Actions that may be available and accessible. The Investigator pursues a least intrusive approach in selecting a Present Danger Safety Plan, with placement in foster care as the most intrusive.

Standard 8: Caregiver Involvement in Present Danger Safety Plans

The Investigator involves caregivers in creating the Present Danger Safety Plan to the extent possible based on ability and context.

When Present Danger exists, a Present Danger Safety Plan must be established the same day; caregivers do not have a choice about whether a Present Danger Safety Plan will be put in place. Caregivers can be involved in discussions about the Present Danger and the need for a Present Danger Safety Plan. The caregivers can identify what their concerns are, their interests for the plan, what they are willing to cooperate with, how they can participate, and who is available and accessible to participate in a Present Danger Safety Plan. The caregivers can be helped to understand that they are not accountable for the Present Danger Safety Plan. Oversight and accountability is the responsibility of the Investigator. If the plan is an In-Home strategy, the Investigator discusses the caregivers' willingness and capacity to allow

the plan to be implemented. If the plan is an Out-of-Home plan, discussion should occur about the level of caregiver-child contact that is acceptable and how that will be managed.

Standard 9: Arranging and Implementing Present Danger Safety Plans

When Present Danger is identified, the Investigator arranges and implements a Present Danger Safety Plan the same day.

The Investigator understands that Present Danger means that the child is in danger at the time. The Investigator knows that intervention must occur immediately. While taking the least intrusive approach possible, the Investigator rules in and rules out options in conjunction with consultation with the caregivers, other family members, his/her Supervisor, and others who may exist as prospective Present Danger Safety Plan participants.

"Arranges" means creating a specific plan that meets the criteria for an acceptable Present Danger Safety Plan. "Implements" means seeing and knowing that the Present Danger Safety Plan is operating and is managing the Present Danger.

Present Danger Safety Plans should consider:

- Transportation of child(ren) to school or daycare.
- Arrangements for any medical appointments scheduled or anticipated within the next ten days, and how those will be facilitated.
- Parameters around parental contact (i.e., texting, telephone calls, supervised or unsupervised visits, and location of visits) if acceptable, manageable and appropriate.

Standard 10: Evaluation of the Present Danger Safety Plan

The Investigator evaluates the Present Danger Plan by the next business day of implementation, including confirming the safety of the placement, if applicable.

The purpose of evaluating the Present Danger Plan by the next business day is to ensure that it is working according to the established guidelines. The point of prompt assessment is to ensure that it includes assessing a child's safety <u>because</u> the Present Danger Plan is sufficient and working.

Regardless of the details of the Present Danger Safety Plan, the Investigator is respectful of caregivers' feelings and perceptions about the Present Danger Plan and continues to provide them with information and updates concerning ongoing FFA activities and requirements.

Standard 11: Present Danger Plan Oversight

The Investigator monitors the Present Danger Safety Plan to ensure that the plan is actively working, throughout duration of the Plan.

The Investigator accomplishes this by having weekly personal contact with the participants of the plan, including individuals whom are responsible for caring for the child if the child is placed in their home, and the child if possible, confirming that those who committed to protect the child are doing so; that agreements about caregiver/child access are being carried out; that nothing associated with the Present Danger identified at first contact(s) is active or threatening the child; and that the child is safe with the plan in place. The contact may be face-to-face, by telephone, or electronically.

Communication with plan participants ensures understanding of responsibilities; development of an acceptable alliance with the Investigator in assuring that the child is not in danger; agreement with the need for the plan; implementation of the specific directives outlined in the plan; and any necessary clarification of the plan.

Standard 12: FFA Information Collection Process When Present Danger Is Identified

The Investigator expedites the FFA Information Collection Process when Present Danger is identified and completes the FFA within ten (10) days.

There are often occasions when there is both Present Danger and Impending Danger. It is imperative that the information collection process still occur for a multitude of reasons. The information collected will be essential for FSU to appropriately work with the family. Even more important, many times the Present Danger Safety Plan requires child removal due to the emergency nature of present danger. Once the emergency is over, a better understanding of family functioning will be learned through the FFA process the children can often be reunited with their parents on an In-Home Impending Danger Safety Plan.

Since the Investigator knows that even though Present Danger is of grave concern, it is not, in and of itself, a conclusive indicator that a child is living in Impending Danger. The need to reconcile whether Present Danger is symptomatic of Impending Danger compels the Investigator to act swiftly to fully understand what is going on in the family. Additionally, the Investigator knows that acting expeditiously is necessary because the Present Danger Safety Plan exists as an intrusion into the family's life, routine, and rights. The preferred course of action during the FFA is to reconcile the need for that intrusion as effectively and efficiently as possible.

To the Investigator, “expediting” means attempting to get back to the family after the initial contact as soon as possible to proceed with the FFA interview protocol (if the protocol was disrupted during the initial contact); this could mean commencing interviews the day after the initial contact or within the same week. “Expediting” requires the Investigator to be well organized and strategic about how to proceed, and intentional about scheduling the time and location of interviews.

Basic questions influence expediting information collection:

- Have variations and contradictions in information been reconciled?
- Has sufficient information been collected for each of the four assessment questions?
- Has a complete picture of the family been formed (family functioning, conditions, dynamics, characteristics)?
- Do I understand the family?
- Do I know enough to complete an informed and justifiable safety assessment?
- Do I know enough about the Caregivers and Potential Impending Danger Safety Plan providers to complete the Impending Danger Safety Plan Determination and if necessary, Conditions for Return?

Standard 13: Information Collection

The Investigator collects information in four areas of family functioning to understand the family and to evaluate impending danger and Caregiver Protective Capacities.

The four assessment areas (questions) are:

1. What is the extent and circumstances that surround the maltreatment?
2. How does the child function?
3. How do the adults (caregivers) function generally?
4. What are the disciplinary and general parenting practices?

The Investigator knows that when these four areas are fully explored, a description of family functioning results, which provides the basis and accountability for safety assessment and

Safety Management. The FFA decisions depend on sufficient information from these assessment areas.

The Investigator also understands that the information gathered from these four areas must documented and will be the official conclusion of DCYF gearding how the family functions.

Sufficient information, as represented by acceptable documentation, demonstrates the Investigator due diligence to collect the information, and is qualified by what reasonably could have been known from those diligent efforts.

By collecting sufficient information, Caregiver Protective Capacities should emerge and the investigator will be able to indicate if the Capacity is enhanced or diminished.

Standard 14: Emergency Needs

The Investigator identifies the immediate, critical, significant needs the family is experiencing and arranges for the provision of immediate emergency services.

At initial contact and during the FFA, when an Investigator recognizes that a family has emergency needs, he/she collaborates with the family to fully understand what the emergency needs are and how best to address the significant needs. Significant needs of an emergency nature may be physical or mental health-related; concerned with housing or other basic needs; or associated with transportation, utilities, or other basic financial deficiencies. Arranging and accessing services and resources to meet these needs often is necessary and facilitative with respect to successfully moving the FFA information collection along. There is a timeliness to the intervention issues in question in this standard; addressing emergency needs not only satisfies the significant need but encourages and facilitates engagement in the FFA process.

Standard 15: Child Safety Decision

The Investigator reaches a determination about child safety at the conclusion of the FFA.

Child safety is the governing concept in the FFA; child safety is the focus of the FFA and its mission is to enhance Caregiver Protective Capacities to ensure child safety in families. The Investigator understands that the single most important judgment that he/she makes is whether a child is or is not in Impending Danger.

Using all that he/she knows about a family, the Investigator rigorously employs the safety assessment instrument to rule in and rule out Impending Danger. The Investigator:

- evaluates Caregiver Protective Capacities and considers those which are diminished;
- qualifies family conditions as Impending Danger Threats by applying the Danger Threshold Criteria;
- reaches a conclusion as to whether a child is safe, which becomes the basis for determining whom DCYF will serve in FSU.

The Investigator knows that the fundamental responsibility at the end of the FFA is to make a judgment about the existence of Impending Danger.

Because Impending Danger is not necessarily obvious at the onset of DCYF intervention, the Investigator understands that it can be identified and understood upon more fully evaluating individual and family conditions and functioning. Therefore the safety assessment is justified by documentation of the four FFA areas, and why the official safety decision is at the conclusion of the FFA.

Standard 16: Substantiation

The Investigator substantiates allegations of maltreatment and reaches a finding of maltreatment at the end of FFA.

The Investigator considers the following to reach a determination about whether maltreatment has occurred or currently exists:

1. What is the extent of maltreatment?
2. Do the circumstances that surround the maltreatment indicate that the child's health or welfare has been harmed or threatened with harm?
3. Is there a preponderance of the evidence that abuse or neglect occurred?

The decision to indicate, or substantiate, the presence of maltreatment, is justified by specific, detailed information. The decision is based on information that complies with the preponderance of the evidence standard. Rhode Island policy and procedure should be followed in determining if substantiation should occur.

Standard 17: Impending Danger Safety Plan Determination

In cases where children are not safe due to impending danger, the Investigator completes an Impending Danger Safety Plan Determination through consultation with a Supervisor to inform the development of a sufficient Impending Danger Safety Plan.

The Impending Danger Safety Plan Determination is the final decision that completes the FFA when children are determined to be unsafe due to impending danger.

The Investigator knows that Safety Management options occur in a continuum from In-Home Safety Plans, to combinations of in-home plans where the child is sometimes outside of the home (child care, spending the weekend with grandparents) to Out-of-Home Safety Plans.

The Investigator understands that his/her responsibility is to think and plan flexibly to select the appropriate and most effective Safety Plan option. The Investigator also understands the importance of involving the caregivers in that process.

A dominant value is that the safety plan should be sufficient but not overly intrusive. This means the least interference in family life with respect to decisions, actions taken, and services provided that is necessary to ensure a child is safe. Ruling in or ruling out an In-Home Impending Danger Safety Plan requires a keen understanding on the part of the Investigator regarding how Impending Danger occurs within the family and the home. The Investigator considers seven SPD analysis questions to determine the least intrusive, appropriate safety plan. The Impending Danger SPD analysis questions are:

1. Does the child's primary caregiver(s) have a suitable place to reside where an In-Home Safety Plan can be considered?
2. Is there confidence in the sustainability of the Safety Plan in the current location of the caregivers?
3. Is the home environment consistent enough to allow Safety Actions in accordance with the Safety Plan, and for people participating in the Safety Plan to be in the home safely without disruption (e.g. reasonable schedules, routine, structure, general predictability of family functioning)?
4. Are the primary caregiver's cooperative with DCYF; and willing to participate in the development of the In-Home Safety Plan?
5. Are the primary caregivers willing to allow Safety Actions and Actions to be provided in accordance with the Safety Plan?
6. Do the primary caregivers possess the necessary ability/capacity to participate in an In-Home Safety Plan, and do what they must do as identified in an In-Home Safety Plan?

7. Are there sufficient resources within the family or community to perform the Safety Actions necessary to manage the identified Impending Danger Threats?

The Investigator must analyze the information he/she has collected; enlist family members in conversations about options; and think creatively about keeping a child safe. The Investigator uses the Impending Danger Safety Plan Determination to ensure the last plan is least intrusive.

Standard 18: Sufficient Impending Danger Safety Plan

The Investigator involves the caregivers in implementing the least intrusive Impending Danger Safety Plan that is sufficient to manage Impending Danger.

The Investigator knows that the final FFA responsibility prior to transferring a case to FSU is to implement Safety Plans when Impending Danger exists. A sufficient Impending Danger Safety Plan has several features:

- Those involved in the Impending Danger Safety Plan must be suitable and responsible to meet the requirements necessary to manage Impending Danger. (It is the responsibility of the Investigator to assess that suitability and responsibility.)
- Those involved in the Impending Danger Safety Plan must be accessible to a child in relation to timeliness and location.
- Those involved in the Impending Danger Safety Plan must be available at the level necessary to manage Impending Danger (i.e., frequency, intensity, associated influences, or stimulation).
- The Impending Danger Safety Plan must be sustainable for several weeks or months.
- The Impending Danger Safety Plan must manage the Impending Danger.

Standard 19: Conditions for Return

The Investigator establishes Conditions for Return for Safety Plans that involve child placement with relatives, fictive kin or foster care.

Conditions for Return are established when the Investigator and Supervisor reasonably anticipate the placement will last longer than 30 days.

Safety Management often requires an Out-of-Home Impending Danger Safety Plan. The placement may be with relatives, fictive kin or foster parents. The Investigator understands that caregivers want to fully understand the reasons for placement and to be well informed about the conditions required to return their child to them. At the time that a placement occurs, as all or part of the Impending Danger Safety Plan, the Investigator explains in detail his/her conclusions about Impending Danger; conclusions about Caregiver Protective Capacities; the process he/she went through to arrive at the conclusion that separating the child from the home is necessary; and what conditions must exist within the child's home for the child to be returned. While the Investigator knows that, in many instances, caregivers will not understand or agree with the need for an Out-of-Home Impending Danger Safety Plan, the Investigator is committed to full disclosure about these critical decisions that affect family life and caregiver authority.

The Investigator provides to the caregivers a written statement of the Conditions for Return. These conditions are based upon the Impending Danger Safety Plan Determination questions which are provided to caregivers as specific statements about exactly what circumstances must exist in relation to caregivers' involvement in the In-Home Safety Plan; what circumstances must exist in the home environment; and what behavior of responsible adults (e.g., other family members, or Safety Plan Participants) must be apparent and routine in the home before the child can be returned. The Investigator understands that when it is possible that it is good practice to have the Conditions For Return entered as part of the court order.

Standard 20: Impending Danger Safety Plan Oversight

The Investigator oversees the Impending Danger Safety Plan through weekly personal contacts with participants in the Impending Danger Safety Plan.

Depending on the timing of the Case Transfer to a FSU Caseworker, the Investigator's responsibility for managing the Safety Plan includes weekly oversight, which can be accomplished through personal contacts with those who are participating in and responsible for the Safety Plan implementation and actions.

Personal contact can occur in person, by telephone, or by email. The purpose of the weekly contacts is to ensure that the Safety Plan is being implemented according to plan; that those participating in the plan remain accessible, available, and committed; that accessibility between caregivers and children is occurring as planned; and that the Safety Plan is working.

Standard 21: Diligence and Timeliness

The Investigator is diligent and timely in completing the FFA.

The timelines for completion of the FFA are 10 days when Present Danger is identified at the initial contact and within 30 days when no Present Danger has been identified.

Prompt completion of the FFA should be influenced by respect for caregivers, intervention values, and good practice. The Investigator values the rights of caregivers and respects their interest and feelings. Diligence and timeliness related to completion of the FFA is influenced by its important to the caregivers in the case. The Investigator is concerned about the caregivers' feelings and perceptions of the time needed to complete the FFA. Operating from the perspective of the family, the Investigator understands the importance of expediency in providing information to the family in a timely way. Since a child's safety is involved, and since moving toward resolution of family conditions and caregiver behavior concerned with protectiveness is paramount, the Investigator manages his/her assignments and workload to achieve prompt completion of each FFA.

The Investigator understands that an FFA is not complete until it has been documented and decisions have been approved by a Supervisor.

Standard 22: Documentation

The Investigator finalizes the FFA by ensuring that documentation is complete, including the four assessment areas, Caregiver Protective Capacities decisions, Impending Danger Decision, Impending Danger Safety Plan Determination (if necessary), Condition For Return (if necessary), and the Impeding Danger Safety Plan (if necessary).

The Investigator understands that the FFA is not officially concluded until the record of the case has been documented.

- Documentation of the FFA can occur as the FFA process unfolds.
- The four areas can be documented as information is being collected.
- The impending danger decision can be completed when the Investigator believes he/she possesses enough information to complete the assessment and justify the assessment.
- When the Family Functioning Assessment in the identification of Impending Danger, the Impending Danger Safety Plan Determination and Impending Danger Safety Plan must be completed immediately, so that a Safety Plan can be installed promptly.
- Other documentation can then be finalized, such as identifying the maltreatment finding, or addressing other agency documentation requirements.

Standard 23: Case Transfer

The Investigator understands that the FFA is an entity within a larger system of intervention, and that the FFA contributes to the submission of the right cases forward for remedial assistance from an FSU Caseworker.

The Investigator sees him/herself as part of the larger process of intervention and knows that what he/she does contributes to the whole of intervention and to the mission of FSU Caseworker.

The Investigator understands that the work that he/she has done is not complete but remains a work in progress (unless the case is closed at the conclusion of the FFA). Because of those understandings, the Investigator prepares the case for transfer to FSU Caseworker in complete and thorough ways to produce as seamless a transfer as possible. This includes ensuring that the record is complete as set forth in previous standards and readying the caregivers and family members for the transfer.

Transfer is most effective when case movement is timely, and most smoothly achieved when Investigators and/or FSU Caseworker operate in tandem to transfer information and responsibility. The Investigator and Caseworker are committed to communication, and to methods for transferring responsibilities that are influenced by the knowledge, understanding, and perception of the family that is experiencing the process. The timeline for Case Transfer begins when the Investigator completes the FFA documentation (FFA, Impending Danger SPD, and Safety Plan), the Supervisor approves the FFA documentation, and the Supervisor confirms implementation of the Safety Plan. The timeline ends when the worker assigned to complete the Ongoing Family Functioning Assessment assumes full responsibility for the case. During the transfer process, the Investigator and FSU Caseworker staff the case to ensure that the FSU Caseworker has a clear picture of the family. The case transfer should occur as soon as possible.

Standard 24: Use of Supervision

The Investigator seeks out and uses Supervisory consultation throughout the FFA.

The Investigator consults with an FFA Supervisor at the point of case assignment to create a plan for conducting the FFA.

The Investigator consults with an FFA Supervisor during the initial contact when Present Danger is observed. The consultation includes discussion of the situation and conditions that appear to be Present Danger, and confirmation between the Investigator and the Supervisor about the existence of Present Danger.

The Investigator consults with an FFA Supervisor concerning the least intrusive, most sufficient Present Danger Plan option available, and confirms the successful establishment of the Present Danger Plan within 24 hours of the initial contact.

The Investigator consults with an FFA Supervisor, both spontaneously and in planned conferences, to consider the best approach to the completing the FFA; to determine effective use of interpersonal skills; to identify reliable sources of information; to report on progress; to overcome caregiver resistance; to address barriers that are preventing efficient and effective information collection; and to manage the FFA process.

The Investigator consults with an FFA Supervisor at the end of the FFA. The consultation includes discussion of and justification for substantiation and safety decisions and planning for the Impending Danger Safety Plan Determination, which may involve drafting Conditions For Return (if applicable).

The Investigator consults with an FFA Supervisor following the Safety Plan Determination to discuss and confirm the selected Impending Danger Safety Plan and finalize the Conditions For Return.

Chapter 6. Assessing Present Danger

The definition of Present Danger is immediate, significant, and clearly observable family condition or situation that is actively occurring or “in process” of occurring at the point of

contact with a family and will likely result in serious harm to a child. “In process” of occurring means it might have just happened (e.g., a child presents at the emergency room with a serious unexplained injury); is happening (e.g., a child is left unattended in a parked car); or reasonably will happen within hours if intervention does not occur (e.g., young children were left alone last night and probably will be tonight.)

Identifying Present Danger Situations

➢ Maltreatment

Occurring Now - refers to a child being maltreated when CPS makes contact with a child (e.g. being beaten, locked in a closet or basement, a vulnerable child unsupervised, living in a dangerous home setting, etc.).

Multiple Injuries - refers to serious, non-accidental injuries occurring on different parts of a child’s body and/or different kinds of injuries (e.g., bruising to a child’s back and upper legs indicating a beating, physical injuries, and cigarette burns, etc.). This situation suggests a caregiver is out of control and/or violent.

Face/Head - refers to a child who has non-accidental injuries to his face and/or head. This situation suggests a caregiver is out of control and/or violent.

Serious Injury - refers to a non-accidental injury that suggests a caregiver is out of control and/or violent. This would include bone breaks, deep lacerations, burns, malnutrition, etc.

Life-Threatening Living Arrangements - as a Present Danger, the danger apparent in the home is acute/immediate placing a child in immediate danger. This would include the most serious health circumstances: buildings capable of falling in, exposure to elements in bitter weather, fire hazards, electrical wiring exposed, guns/knives within reach of vulnerable children, unsanitary, etc.

Unexplained Injury - refers to a serious, likely non-accidental injury to a child in which caregivers cannot or will not explain. The lack of an explanation results in an inability of Child Protective Services to judge whether the injury is indicative of additional serious harm threatening the child.

Cruelty - refers to torture, tying a child up, keeping a child locked up and isolated, extreme scapegoating, etc. While this may be occurring in the present tense, it may also be occurring so frequently that it meets the Present Danger standard.

Several Victims - refers to the identification of more than one child who currently is being maltreated. "Several victims" suggests chaos, lack of control in behavior, and care that seems extreme. It's important to keep in mind that several children who are being chronically neglected do not meet the standard of Present Danger in this definition.

Maltreatment Premeditated/Intentional - refers to child maltreatment by a caregiver that indicates that the abuse was deliberate, a preconceived plan or intentional. This may include information that indicates that the caregiver's motive was to inflict harm on the child.

➢ Child

Unsupervised/Alone for Long Periods of Time - involves vulnerable children (more likely to be a younger child or an older child with special needs) who are unable to care for and protect themselves. Unsupervised refers to any amount of time that reasonably places a child in danger. This refers to children being left alone when CPS first makes contact and is also a Present Danger when children are unsupervised routinely.

Child Needs Medical Attention - refers to acute, immediate medical conditions which can result in severe effects if a child does not receive timely medical care. To be Present Danger, the medical care required must be significant enough that its absence could serious affect the child's health and safety. If children are not being given routine medical care, it would not constitute a present danger. This threat has an emergent quality.

Child is Extremely Fearful - refers to a child who is in terror, who is so afraid as to be at or near the level of panic or hysteria. The child's fear tends to be extreme, specific and presently active. The fear is directed at people and/or circumstances associated with the home situation, and it is reasonable to conclude there is a personal threat to the child's safety if the condition is currently active. Information would likely describe actual communication or emotional/physical manifestation from the child's knowledge or perception of their situation. Similar to the unexplained injuries, without other information, the fearfulness could represent a significant "red flag" concerning the danger that exists in the home.

➢ Parent

Caregiver is Unable/Unwilling to Perform Essential Duties - refers to caregivers who currently are not providing basic care to their children. To qualify as present danger, there must be reliable information that indicates caregivers are not providing child care necessary and the absence of care poses an immediate, significant, clearly observable threat to child safety. It also includes situations where caregivers are absent or abdicating their caregiving responsibilities to someone who is unable or unwilling to care for the child.

This Present Danger is focused on whether the primary caregiver's inability or unwillingness to provide basic care leaves the child in an immediate, clearly observable situation in which their physical and/or mental health is threatened with serious harm. It is not associated with whether the parent/caregiver is generally effective or situations in which other individuals in the home can provide basic care and protection.

Inexplicable Behaviors - refers to caregivers who are behaving in inexplicable ways; making no sense; possibly experiencing hallucinations, delusions, reactions to drugs or alcohol, etc. The person is likely out of touch with reality, unable to communicate or understand, certainly unable to provide basic care and protection to a vulnerable child.

Caregiver is Acting Dangerously - refers to caregivers and others in the home who are acting dangerously toward others, who are brandishing weapons, who are threatening others, who are known to be dangerous and to act on their impulses.

Caregiver is Unmanaged- refers to caregivers who are unable to manage their impulses, who may be emotionally immobilized, suicidal or dangerous to themselves or others, who may be bed-ridden or incapacitated, and who cannot or will not provide basic care or protection.

Caregiver is Under the Influence of Substances - refers to a caregiver who is drunk or high on drugs at the time Child Protective Services makes contact. It can also be situations in which there is credible information indicating the caregiver is under the influence of substances so frequently that a vulnerable child could be seriously harmed in the immediate future. For example, the caregiver is inebriated every night and vulnerable children are not supervised; however, the caregiver is sober the morning Child Protective Services Staff make contact. The inebriation is such that the person cannot provide basic care and protection. The state of the parent/caregiver's condition and how that condition poses an immediate, serious threat to a child is more important than the use of a substance (drinking compared to being drunk and unable to provide basic care; uses drugs as compared to being incapacitated by the drugs).

Caregiver Overtly Rejects Intervention - refers to caregivers who refuse access to the home and to the children. This is not about a lack of cooperation, emotional reactions, or

verbal assaults. It is the blatant refusal to allow access to the child. Like other Present Danger situations, overt rejection is not proof that a child is in danger, but the uncertainty and lack of information to the contrary makes this a Present Danger.

Caregiver's Viewpoint of the Child is delusional/distorted - refers to an extremely negative*, unusual or unrealistic* viewpoint of a child. This is not just a general negative attitude toward the child. The caregiver's perception or viewpoint toward a child is so skewed and distorted that *it poses a significant, clearly observable, immediate threat of serious harm to the child*. It is consistent with the level of seeing the child as *evil, deformed, or* demon possessed.

- **Family/Other**

Domestic Violence is Occurring - refers to domestic violence that is ongoing; happens with regularity; may or may not be predictable, but is imminent, given family functioning. This is an example of Present Danger being "in process."

Family Hides Child - refers to children who are not visible to the community and there are clearly observable, significant, immediate threats to the child based upon information collected. The implication is that something is vitally wrong if families hide their children from others.

Situation Will/May Change Quickly - In a pure sense, this is not a Present Danger, since moderate family functioning problems can change quickly. Normally speaking, this should be thought of in conjunction with other Present Danger situations, such as a family that avoids intervention and is highly transient, and the IA indicates a child is likely to be seriously harmed in the near future.

Family Will/May Flee - refers to situations where there are other possible Present and/or Impending Dangers and there is an indication that the family may flee DCYF intervention. This qualifies as a Present Danger if alleged child maltreatment, and/or situations in which serious harm is likely to occur to a child, is coupled with concerns about not having access to the children. This includes transient families or families where homes are not established as examples.

Unique Characteristics of Assessing for Present Danger

Assessing Limited Vivid Situations

Unlike other assessments, the Present Danger Assessment (PDA) is based upon limited vivid information. It is a judgment about what factually exists, with or without explanation or the

context of individual and family function. The assessment is based upon what the Investigator observes first hand, what is reported by eye-witnesses, and what is reported by others who have corroborative knowledge.

Assessing Without Explanation

The Investigator can conclude that Present Danger exists without an explanation beyond what he/she encounters first hand or "in process."

The Present Danger Assessment Requirements

The PDA is a field assessment, meaning the Investigator observes the Present Danger situation or process; consults with his/her Supervisor; and reaches a conclusion while in the home, school, etc. The PDA must be documented in Richest within **24 hours** of the PDA conclusion. The Investigator selects the Present Danger listed on the assessment that is closest to representing what he/she encountered when in the field. The PDA requires that the Investigator provides a specific, individualized description of the Present Danger in narrative:

- What was observed?
- Where was it observed?
- What exactly was happening (including within a process, if such exists)?
- How long had it been happening?
- Has it happened before? How often?
- What were the circumstances or context within which it was happening?
- Who was involved?
- What was the status/condition of the caregiver(s)?
- How was a child vulnerable?
- What was the condition of the child?
- Who else was eye-witness to or knew about it? How did they explain it?
- How was it explained by the child, by caregivers, by other family members?

Present Danger as an Isolated Family Dynamic

A Present Danger situation may exist within a family when the Investigator first encounters the family, but may not be evidence of or associated with Impending Danger. Present Danger can exist as a one-time- only situation, as an accident, as an isolated mistake. Alternatively, Present Danger can be an expression, symptom, and demonstration of Impending Danger gone active. The only way to rule in or rule out whether Present Danger is an extension of Impending Danger, or an anomaly, is to complete the FFA.

Example of Present Danger as an Isolated Family Dynamic

> *A mom was hanging laundry out in her back yard one day while her child played inside the house. The pre-school child was autistic. The mom may or may not have had a device for keeping the doors secured to keep the child inside. However, the child made his way outside the house and wandered off, despite the mom's normally watchful eye. The family lived in a rural area, and the child made his way along the road, and soon was meandering along a highway. A trucker noticed the child, picked him up, and delivered him to local law enforcement authorities. After some effort, law enforcement and DCYF located the mother who had become frantic upon realizing that her child had wandered off. The whole event happened within a relatively brief period. The completed FFA revealed that the mother was an excellent caregiver, well prepared to care for that special needs child, and was diligent about the child's care, supervision, and protection. This was an unfortunate mistake and an aberration in terms of this child's care.*

In this example, the circumstance meets the Present Danger definition. What was happening was in progress; it was happening in the "now." The autistic child was in Present Danger when the truck driver encountered him along the highway. The situation was observable, factual, specific and describable; the child was vulnerable; severe harm could have come to the child. Yet, the example demonstrates that while Present Danger was confirmed, Impending Danger was ruled out. A Present Danger Safety Plan would have been implemented to assure the child was safe until the FFA was complete.

Chapter 7. Establishing Present Danger Safety Plans

Definition

A Present Danger Safety Plan is an immediate (same day), short term, sufficient strategy that provides a child with responsible adult supervision and care to allow time for the completion of the FFA. A Present Danger Safety PLan is established any time Present Danger is identified as existing. The plan is an immediate protective action 1) because of its particular purpose, which is to suspend what is going on long enough to support continuing the FFA; and 2) in order not to confuse it with the formal, continuing Impending Danger Safety Plan, which is established at the conclusion of the FFA.

The definitions for immediate, short-term, and sufficient protective actions provide the criteria for the Present Danger Safety Plan:

Immediate - The plan must be capable of being in operation the same day it is created. Before the Investigator leaves the home, the plan must be active and confirmed.

Short-Term - The plan is very specific; planned to control the identified Present Danger threats; and sufficient to control Present Danger until adequate information can be gathered and analyzed, to determine whether Impending Danger exists and an Impending Danger Safety Plan is required. The plan should be sufficient to manage safety until the FFA is complete. The timeframe for the plan is 10 days or until the FFA is complete and a decision about Impending Danger is confirmed.

Sufficient - The plan must manage Present Danger and family conditions and behaviors associated with the Present Danger. The Investigator regularly confirms that the plan is working. The Investigator must verify that selected people are responsible, will be available, are trustworthy, and are capable. Additionally, the Investigator confirms that caregivers are willing to cooperate with the plan. Certainly, in many instances, caregivers will not agree with a plan, which results in placement as the plan and legal action. Even so, the Investigator remains concerned and encouraging about caregivers' ability/willingness regarding cooperation and considers the least intrusive means for managing child safety.

If the Present Danger Safety Plan includes the child residing outside his/her household, an evaluation of the safety of the environment where the child is to stay must occur.

Establishing and Implementing Present Danger Safety Plans

The following questions provide a guide for considering the establishment of immediate protective actions:

- Specifically, what Present Danger and related family behaviors and conditions are of concern? What danger must be controlled?

- Is the family network interested in and capable of carrying out a Present Danger Safety Plan?

- What potential present danger plan participants exist within the family network?

- What is known about these potential participants?

- Do resources and supports seem sufficient and available to address the Present Danger and associated family conditions and behaviors during the next few hours, up to ten days?

- What are the caregivers' and family's likely responses to the Investigator's concerns for Present Danger and implementing a plan to control the danger?

- What is the best approach to dealing with the caregivers and the need for the Present Danger Safety Plan?

- Does a crisis exist? Is the Present Danger associated with an individual or family crisis?

- How are family members responding to the crisis?

- Will the Present Danger Safety Plan stimulate a crisis? What are the implications of that?

- In addition to the Present Danger Safety Plan, is crisis intervention needed? What does that involve?

- Does the family have immediate needs that must be addressed (e.g., housing, food, some sort of care)? How does that affect decisions about the plan?

- Can an In-Home Present Danger Safety Plan be established? How can the caregivers/family network be involved? What roles and responsibilities will they have? What roles and responsibilities will be given to others? How independent are others in respect to exerting their protection role?

- What are the indications that the In-Home Present Danger Safety Plan will work?

- Does the child need a medical evaluation or immediate medical care? Why? How will this be communicated to the parents? How will the medical care be arranged?

- How will child get to and from school during the PDP?

- What are the immediate next steps? How will the next steps be explained to the caregivers and family? How will the Investigator know and have confidence about their responses, commitments etc. regarding the next steps?

- Is legal action necessary to help ensure the sufficiency of the PDP? What steps are necessary to carry this out?

Elements of the Present Danger Safety Plan

A Present Danger Safety Plan should contain certain elements, and documentation should reflect these elements.

- **Clear Description of Present Danger**

  The Present Danger should be identified and described, including the circumstances in which the assessment occurred. The Investigator describes what he/she observed that resulted in the conclusion to establish a Present Danger Safety Plan.

- **Consideration of Caregiver Involvement**

  It is desirable to involve caregivers and to seek willingness to cooperate. If the Present Danger Safety Plan involves other than child removal and legal action, the caregivers' attitudes and intent should be considered and confirmed as supportive. This does not mean the caregivers agree there is a need for a Present Danger Safety Plan, only that they agree for one to be established and to not interfere with its implementation.

- **Identification and Suitability of Participants**

  Often, little is known about the caregivers at the initial family encounter. Therefore, it is common for the Present Danger Safety Plan to involve someone outside the family home as the responsible person for protection. Regardless of who is involved in the Present Danger Safety Plan, it is necessary to identify the name(s) of the responsible/protective adult(s), their address, phone, and how they can be reached. Identify and explain the person(s)' relationship to family. Provide a full description of the process for determining suitability of the person entrusted to ensure protection (e.g., trustworthiness, reliability, commitment, availability). It is critical that the Present Danger Safety Plan is described in detail (e.g., how it will work, specific provisions, time frames, activities, child location, and caregiver access).

- **Oversight**

  The Present Danger Safety Plan must have a communication plan and oversight. Everyone involved in the plan must be informed at the onset that they are to call the Investigator immediately if the plan breaks down, or there are problems with implementation.

Instantaneous Protection

The Present Danger Safety Plan is an immediate plan which means the plan is set up and in operation within the same day that Present Danger is observed. The work that occurs during that same day involves considering:

- Assessing caregivers' willingness to agree to a Present Danger Safety Plan.
- Contacting and arranging for family network members or others to take responsibility.
- Assessing the suitability of prospective protective adults.
- Assessing the home environment, if the Present Danger Safety Plan involves a placement with a relative or in foster care.
- Resolving logistical issues (e.g., timing, transportation, child's belongings, school next day, etc.).
- Consulting with a Supervisor throughout.
- Implementing the Present Danger Plan.

Documenting the immediate Present Danger Safety Plan should occur in the field the day it is put into place. However, in the event circumstances do not allow for that, documentation of the plan must occur the next day.

Present Danger Safety Plan Options

The Present Danger Safety Plan options are:

- The threatening person will leave the home
- The protective parent and child will leave the home and go to a safe environment
- A responsible adult is in the home at pre-determined specific times
- A responsible adult will routinely monitor the home
- A responsible adult will move into the home seven days per week, 24 hours per day
- The child will be cared for outside the home periodically
- The child will live with someone in the family network part-time
- The child will live with someone in the family network for seven days per week, 24 hours per day
- The child will be placed in the temporary custody of the Department

Chapter 8. Substantiating Child Maltreatment

Substantiation is the decision-making concept used to determine whether reported alleged child maltreatment has occurred or is occurring, and, if it did occur, to determine if the maltreatment falls within the meaning and definition of child abuse or neglect outlined in Rhode Island Statutes, Rhode Island Policy, and Procedure. The information supporting the substantiation of abuse or neglect decision is found in the Extent and Circumstances Surrounding Maltreatment section of the FFA.

Documentation for this assessment area is concerned specifically with identifying the maltreatment typology (e.g., physical abuse) and describing the facts about the maltreatment (e.g., bruising, degree of injuries, time left unsupervised, effects on children, etc.).

Documentation for this assessment area is also concerned with explaining the circumstances that confirmed that maltreatment did not occur.

Frequently a report contains more than one allegation. Each allegation should be individually assessed in relationship to each child named as being affected. Furthermore, once an FFA has begun, additional forms of maltreatment can be discovered; these, too, become a part of the substantiation responsibility.

If different Caregivers are identified responsible for maltreating their children, each Caregiver should be assessed and how their actions were determined to be maltreatment should be individually described. Why is this so? Child maltreatment can be a complicated family dynamic with multiple forms of maltreatment perpetrated by different people. Consider this example: a father physically abuses a child, while the mother fails to supervise and protect the child. Additionally, as one pursues the analysis for determining substantiation, a crucial part of credible evidence is concerned with identifying who was involved in the events and their role.

Supervisors and Investigators should make the substantiation determination conjointly. Ultimately, the approval of the decision rests with the Supervisor.

The decision to substantiate is a ruling-in/ruling-out process. The same diligence to find proof that maltreatment has happened should be paralleled by a consistent diligence to determine that no maltreatment has happened. Being fair and equitable demands that reconciling allegations is no less or more important than exonerating those accused in reports. This tenet underscores the value of not jumping to conclusions, controlling bias, respecting those involved, and qualifying and clarifying your understanding of information that has a bearing on the determination.

Substantiated and Unsubstantiated Defined

“Substantiated” means that a report, pursuant to Rhode Island State Statute § 40-11-2 was assessed and a preponderance of the evidence indicates that abuse or neglect exists consistent with the Rhode Island State Statutes.

“Unsubstantiated” means that a report, pursuant to Rhode Island State Statute § 40-11-2, was assessed and that no credible evidence of the abuse or neglect exists.

Definitions of Child Abuse and Neglect Rhode Island Statute § 40-11-2.
The legal definitions of child abuse and neglect listed below should be the guiding factor on determining if a child has been abused or neglected. Rhode Island Statutes defining an abused and/or neglected child is found below.

TITLE 40 Human Services. CHAPTER 40-11 Abused and Neglected Children
SECTION 40-11-2 Definitions

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

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

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

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

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

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

(vi) Abandons or deserts the child; or

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

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

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

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

Necessary Evidence for Justifying a Substantiation of Maltreatment

The Investigator should look for evidence to:

- Identify the maltreatment typology (e.g., physical injury), describe the facts about the maltreatment (e.g., bruising, degree of injuries, time left unsupervised, effects on children, etc.), and identify the sources of information that justify the finding.
- Identify the person(s) responsible for the child's welfare and how he/she/they participated in the abuse or neglect or allowed abuse or neglect to occur.
- Identify and describe the circumstances surrounding the injury or neglect which indicate that the child's health or welfare is harmed or threatened with harm.

Terminology used when considering Substantiation of Abuse/Neglect

- **Evidence**: Something (including testimony, documents, and tangible objects) that tends to prove or disprove the existence of a fact.
- **Preponderance of the Evidence:** Evidence indicates that abuse or neglect is more likely to have occurred than not.
- **Credible Evidence**: Evidence that is worthy of belief.

- **"Allows"** abuse or neglect to occur. When a caregiver did nothing to prevent or stop the abuse or neglect when the caregiver knew or should have known that the child was abused or neglected using the reasonable person standard.

- **Threatened with Harm:** the child is subjected to conditions that would indicate they are likely to be severely harmed in the near future due to the caregivers (parent, guardian, or custodian) abusive or negligent actions or inactions.

- **Reasonable Person**: A Reasonable Person is a hypothetical person who exercises average care, skill, and judgment in conduct that society requires of its members for the protection of their own and of others' interests. A Reasonable Person standard serves as a comparative standard for determining reasonableness of judgment and believability. For example, in a 'allowing' abuse/neglect to occur substantiation decision, the Investigator must determine whether the conduct of the parent is abusive/negligent by comparing the conduct to whether or not a reasonable, prudent person under similar circumstances would have known that abuse/neglect was occurring or would occur.

- **Worthy of Belief**: Is related to credible evidence. To ensure that this idea does not become subject to values and bias, the Investigator should explain how he/she judged the belief to be worthwhile. The following criteria may be useful:

    - Personal revelation – admission; personal responsibility-taking
    - The source (collaterals, children) that formed the belief – personally observed; eye witness; expert opinion
    - Records – x-rays; videos; photography
    - Corroboration – confirming accounts from collaterals or children
    - Consistency – large numbers of facts or information which support worthiness
    - Patterns and history – previously confirmed beliefs that are consistent with current beliefs

Reconciling Information Discrepancies

The Investigator is often faced with competing stories and conflicting information that challenge accountability and justification related to the substantiation decision. Discrepancies about whether maltreatment occurred or is occurring can include information mismatches; lack of support for a particular rendition of what is happening; different

accounts from different sources; contradiction by single and multiple sources; and/or manipulation and misrepresentation by sources of information.

The Investigator must focus sufficiently to reconcile these discrepancies. It is important to avoid concentration on explanations of the allegations alone. This can produce tendencies to defend, deny, rationalize, or blame, among family members. Pressing family members can cause anxiety, defensiveness, anger, avoidance, manipulation, etc. Seeking to understand the family, in general, can be more productive in pursuing information of the allegation and in sorting out variations in people's accounts.

Credible Sources of Information

The question of credible sources of information is part of analyzing for credibility and determining if the information is "worthy of belief." The criteria the Investigator can use to judge credibility and believability of sources within and outside the family are:

- Relationship autonomy – Is the person free to speak his/her mind?
- Motive – Does the person have anything to gain or lose?
- Affect – Is the person's emotional presentation appropriate?
- Confidence – Does the person demonstrate certainty about what he/she knows?
- Openness – Is the person relaxed and comfortable while providing information?
- Agenda – Does the person appear to have an agenda or self-benefiting expectations?
- Specific – Is the person detailed in his/her account?
- Careful – Does the person acknowledge what he/she doesn't know?
- Position – Is the person in a particular special position or have special knowledge (includes family members and others)?
- Consistency – Does the person maintain the same account and conclusions over time?

Types of Evidence

Direct evidence is proof based on personal knowledge or observation, and proves a fact without inference or presumption. Evidence that stands on its own to prove an alleged fact,

such as testimony of a witness who saw a defendant pointing a gun at a victim during a robbery is direct evidence.

Indirect evidence and circumstantial evidence are the same thing. These terms refer to proof of facts offered as evidence from which other facts are to be inferred (contrasted with direct evidence).

Corroborating evidence is evidence which strengthens, adds to, or confirms already existing evidence.

Here are examples of the three types of evidence:

- **Direct** – a father admits beating his child; **direct** – a mother is an eyewitness to the beating.
- **Indirect/circumstantial** – the father demonstrates impulsive violent behavior; family members observe the father routinely handling the child roughly; the father has been substantiated for physical abuse on two other children.
- **Corroborating** – along with the mother, the children and grandmother also were eyewitness to the beating.

Determining Credibility

Credibility is the quality that makes evidence or an information source "worthy of belief." Determining credibility refers to the process of qualifying the information and the sources of information given to the Investigator.

When documenting substantiation to complete the FFA, the Investigator follows this analysis:

- Document what is known about allegations; events; facts; information provided about the maltreatment; and the circumstances surrounding the maltreatment in a specific, detailed manner.
- Categorize the information/evidence by type – direct, indirect/circumstantial, or corroborative.
- Identify sources of information – people, documents, personal observations, etc.
- Validate the veracity of people who are sources of evidence.

Excerpts from the FFA Information Collection Protocol delivered in training with a Focus on Allegations

The protocol is designed to guide information collection during the FFA in order to complete all the FFA decisions. The protocol is designed to provide a process of increasing the volume of information (what people reveal) in a progressive manner, which leads to corroboration of the information. This process can result in developing preliminary conclusions about allegations, and events and circumstances associated with the allegations, as final interviews with the identified maltreating caregiver occur.

The interview protocol follows this sequence:

1. Introduction with parent(s)/caregiver(s). The Investigator may first notify caregiver of the intent to interview the child, unless notification could compromise the child's safety. Initial contact with the child can occur at the child's school, if child safety may be compromised based on the allegations. While policy and statute allow the Investigator to contact a child without notifying the parent, FFA philosophy encourages notification unless exigent circumstances exist. If it is necessary to interview the child prior to notifying the caregivers, the caregivers must be contacted within the same day to inform them about the report, and then scheduled for an interview as soon as possible thereafter.
2. Interview identified child.
3. Interview other children living in the home.
4. Interview the non-offending caregiver (if there is one in families with two caregivers).
5. Interview the identified maltreating caregiver.
6. Interview collaterals who may have relevant information concerning the allegations or family functioning.

The sequence of interviewing is adjusted by specific case circumstances based on reported information, the location and condition of children, and the configuration of the family.

Introduction with the Parents/Caregivers

The Investigator must notify parents of their rights at the commencement of the investigation. The introduction includes: The Investigator, the role of DCYF, FFA purposes, the essence of the report, and the intention to help and understand. When introducing the report, the FFA Investigator probes into the parent(s)' perception about the reason for the

report. During the introduction, the Investigator allows the parent(s) to talk about the maltreatment issue, with plans to address it again at later times.

If the Investigator is nondirective about the maltreatment or allegations during the introduction, there will be less probability that the caregivers will immediately build defenses and arguments which will have to be overcome to proceed. In order to remain in the "here and now," it is important to allow caregivers to talk out their feelings and concerns about the allegations and to give their explanations. However, at a reasonable time, the Investigator should be prepared to move the interaction to broader concerns. The Investigator should take control by using appropriate questions or moving into assessment.

Interview with the Identified Child: Allegation Inquiry Focus

Here are examples of inquiry with the identified child about the alleged maltreatment:

> *"As I mentioned to you earlier, I have spoken to your school counselor, who told me about what you told her. I need you to tell me about it, or can you tell me about what happened?"*

While beginning the inquiry, the Investigator observes the child's condition and enquires into child's explanation; he/she evaluates the child's emotional state. If the child has told no one, it will be necessary to work from the reported allegation and seek the child's response and reaction.

> *"What else happened?"*

As a rule, the Investigator will often ask this type of question to fully explore with the child the extent of the maltreatment.

> *"Has anything like this happened to your other brothers/sisters?"*

> *"What did your other parent say, do, etc.?"* (if there is a non-alleged maltreating parent or any other adult or family member)

> *"When this occurred, how did it happen? What was happening around the home (situation) when this occurred? What else was occurring?"*

Interviews with Siblings – Other Children in the Home: Allegation Inquiry Focus

Here are examples of alleged maltreatment inquiry:

> *"I have spoken with your brother Alex and his school counselor about what happened to Alex. I need you to tell me about what happened."*

The Investigator observes the child's condition and enquires into child's explanation, evaluates the child's emotional state, and explores whether the child is also a victim. If helpful, the Investigator shares with this child what the identified child said and seeks this child's reaction. The Investigator reconciles differences in this child's explanation compared to the identified child. If the child is reluctant, the Investigator states the reported allegation and seeks the child's response and reaction.

> *"What else happened?"*

As a rule the Investigator will often ask this type of question to fully explore with the child the extent of the maltreatment.

> *"Has anything like this happened to your other brothers/sisters or you before?"*

> *"What did your other parent say, do, etc.?"* (if there is a non-alleged maltreating parent or another adult or family member)

> *"When this occurred, how did it happen? What was happening around the home (situation) when this occurred? What else was occurring?"*

Interview with Non-Alleged Maltreating Parent: Allegation Inquiry Focus

The Investigator shares the report in detail. Here are examples of alleged maltreatment inquiry:

> *"What are your initial thoughts, feelings, attitudes, and beliefs about what was reported*?"

Does the Investigator have any information which suggests the non-maltreating caregiver has been involved in maltreatment? If yes, the Investigator explores this with the caregiver in a direct, yet non-adversarial manner.

> *"Given what has been reported, I'd really like to hear what your version of what happened is? Can you provide me with details about what was reported?"*

Depending on the caregiver's beliefs, the Investigator explores variations in accounts, the need to deny or justify or defend, or the shock or anxiety the caregiver may be experiencing.

"You know I've talked with [the children]; what do you suppose they've told me about what happened? What would explain their versions, given your explanation?"

"The children told me this is what happened….what do you think about that?"

"What are your personal concerns about what has been reported and what I've learned?"

"Would you like to know what I think? What is your reaction to what I think about what happened?"

The Investigator explores with the non-alleged maltreating parent the alternatives to provide protection to the family.

Interview with the Alleged Maltreating Parent: Allegation Inquiry Focus

Here are examples of alleged maltreatment inquiry:

"As you know I've interviewed [children, other caregiver, or others, such as collaterals or family members], so I'm beginning to gain some understanding about what's going on, but, of course, I need to hear from you."

"Let's begin by allowing me to explain what was reported to our agency."

How does the person respond? The Investigator allows for denial and for emotional reactions.

"How about telling me what's going on in general with your family?"

By inquiring into more general topics, the Investigator seeks to reduce the alleged maltreater's emotion and focus on defending, in order to return to the alleged maltreatment inquiry.

When the Investigator begins to talk to the caregiver about the maltreatment, minimal information should be given. It is critical that the Investigator not engage in a battle of wills; the Investigator refocuses the caregiver to his/her own feelings and responses.

The Investigator allows the caregiver to provide his/her story:

"What happened?" "How did it occur?" "Has it happened before?"

"What were you doing?" "What were others doing?"

"When was this?" "What happened then?"

"How were you feeling?"

"How do you explain things [e.g., bruises, child's condition, etc.]?"

"How do you account for what others are saying, for differences in your story and others?"

"Tell me what has been going on. Sometimes things can happen without us really intending for it to happen. For instance a person can feel tired and worn out and it affects how they behave. Does this make any sense to you as far as what happened? Have you been under stress? What from? Drinking? Marital problems? Job related problems?"

The Investigator provides an opportunity for allowing the caregiver to provide a context for what occurred. At an appropriate time, the Investigator reveals what he/she believes.

"As you know I've been attempting to understand what is happening here in your family and home. I've been inquiring about what was alleged in the report with several who know about what happened. So…this is what I believe, based on what others have said and how you've responded. What do you think of what you've heard?"

Chapter 9. The Four Assessment Areas of the FFA – Key to Determining Child Safety

To make accurate Impending Danger Safety Decisions and implement least intrusive, sufficient Impending Danger Safety Plans, the Investigator must collect sufficient information related to the four assessment areas of the FFA. The Assessment areas are: Extent and Surrounding Circumstances of the Maltreatment, Child Functioning, Adult Functioning, and General Parenting and Discipline. The assessment areas are further described below.

Extent and Surrounding Circumstances of Maltreatment

The extent of maltreatment is a straightforward assessment area concerned with facts and evidence which support the presence of maltreatment which comes from worker observation, interviews, and corroboration. This includes making a conclusion about the type of maltreatment (sexual abuse, lack of supervision, etc.) and the specific symptoms and facts (injuries/constant hitting) which are consistent with the maltreatment.

The Surrounding Circumstances of the Maltreatment qualifies the maltreatment by placing it in a context or situation that (l) precedes, leads up to the maltreatment or (2) exists while the maltreatment is occurring. This includes the explanations given by the parties involved.

Extent and Surrounding Circumstances of Maltreatment and Impending Dangers

Impending Danger Threats associated with the assessment area concerned with the extent of maltreatment are considered in conjunction with the assessment area concerned with circumstances surrounding the maltreatment. This assessment area asks for conclusions about whether maltreatment occurred. Notably, maltreatment can occur and a child can be safe from Impending Danger. Substantiation of maltreatment usually is concerned with something that has already happened. Impending Danger is concerned with a threat of severe harm that is considered imminent. In some cases, severe maltreatment has happened, still exists, and will continue to occur, such as physical violence toward children or lack of supervision. In such cases, Impending Danger can also be identified in other assessment areas (i.e., adult functioning, parenting general, parenting discipline).

Surrounding circumstances accompanying the maltreatment address the “why” and “how” of the abuse or neglect. What was going on when the maltreatment occurred? This requires an explanation from caregivers, children, family members, and other witnesses to the circumstances. The circumstances surrounding the incident help the Investigator determine whether the person responsible for the welfare of the child could reasonably have expected the child to have been harmed as a result of their conduct.

Surrounding circumstances can be understood as the context that existed in general or leading up to maltreatment, or something specifically occurring at the time of the

maltreatment. For instance, a child may suffer a severe physical injury (physical abuse) as a result of a parent's conduct. The circumstances surrounding the incident will indicate whether the parent's conduct created a foreseeable risk of harm and whether the child's health or welfare is harmed or threatened with harm. For example, a toddler's broken arm may be a foreseeable injury when a parent allows a toddler to play on the stairs. The injury may therefore be considered non-accidental. However, the circumstances surrounding the incident will indicate whether the child's health or welfare was at harm or threatened with harm. If the circumstances surrounding the incident were that the parent was drinking heavily at the time of the incident, the circumstances would indicate that the child's health or welfare was threatened with harm because the parent was not able to care for the child appropriately. However, if the circumstances surrounding the incident fail to indicate that the parent was involved in any risky or inappropriate behavior, then it would be unlikely that the parent's conduct created a threat of harm to the child.

Extent of Maltreatment and Surrounding Circumstances and Impending Danger Threats

There are three Impending Danger Threats that can be indicated based on information within the extent of maltreatment and the surrounding circumstances assessment areas.

- **Living arrangements seriously endanger the physical health of the child(ren).**
- **One or both parents/caregivers intend(ed) to hurt the child and show no remorse.**
- **One or both parents/caregivers cannot or do not explain the child's injuries and/or conditions.**

Each of these Impending Danger Threats could have contributed to maltreatment. Living arrangements may have resulted in children being seriously injured. A child may have been seriously injured intentionally. Serious injuries may exist that a caregiver cannot or will not explain.

If any of the Impending Danger Threats are indicated, the information in the surrounding circumstances assessment questions must explain and justify the threat. That means the information must convincingly demonstrate how maltreatment and/or surrounding circumstances meet the Danger Threshold Criteria which are: out of control, severe, observable and specific, a vulnerable child, and imminent.

Child Functioning

This assessment area is concerned with how a child thinks, behaves, feels, socializes, and manages him/herself daily. It is concerned with physical health and development. It is concerned with normal, appropriate development and deviations from the normal.

This assessment area does not include documentation related to parenting; however, it does include documentation related to child behavior that is a management problem that provokes others, that is self-destructive, etc.

Focusing on the "daily" aspect of a child's behavior considers pervasive emotions, behavior, social interaction, performance, and physical health. In other words, the Investigator would only document that a child is sad if information sources (worker observation, reports from family members, reports from caregivers, reports from the child) indicate that the child is sad most of the time or all of the time.

The assessment area does not seek a snapshot of a child's functioning on the day the child is interviewed or on any specific single day. This is a challenge and is why an Investigator needs to interview multiple sources who know the child's daily behavior and functioning.

Among the areas you will consider in information collecting and "assessing" are trust, sociability, self-awareness and acceptance, verbal skills/communication, independence, assertiveness, motor skills, intellect and mental performance, self-control, emotion, play and work, behavior patterns, mood changes, eating and sleeping habits, and sexual behavior. Additionally, you consider the child's physical capabilities including vulnerability and ability to make needs known.

Child Functioning and Impending Danger

There are two Impending Dangers associated with child functioning is:

- **A child is extremely fearful of the home situation.**
- **The behavior of a child in the home threatens serious/severe harm to themselves or others in the home and the caregiver is unable to manage the child's behavior.**

If either of these Impending Dangers are selected, there must be information in child functioning to support the selection.

Adult Functioning

This assessment area is concerned with the functioning of a caregiver as a person, separate from being a parent or caregiver. Who is the adult and what is he/she like day-in and day-out?

This assessment area does not inquire into a person's parenting. The challenge is to collect information, analyze the information, and document the conclusions that relate solely to the functioning of the adult in the day-to-day management of his/her life. Again, "daily" encourages an assessment that considers pervasive physical and mental health, intellectual functioning, social interaction and connections, self-control, and substance use. In other

words, the Investigator would only document that an adult is having physical health problems if these problems are apparent consistently and not just the day the investigator interviewed the adult.

The Investigator must not overestimate the emotional reactions or behavior that is influenced by CPS intervention. It is quite easy to judge a person as volatile because of the person's reactions during the FFA due to specific stressors (e.g., feeling rights have been disrespected, removal of a child, feeling interfered with). These reactions can be understood within the context of the situation and must be assessed as to whether they are representative of functioning that is pervasive – regularly apparent beyond these situations.

Influence of Caregiver Protective Capacities on Information Collection

The Adult Functioning Caregiver Protective Capacities should prompt information collection by the Investigator. The Caregiver Protective Capacities that should be assessed are: controls impulses, takes-action, is self-aware, is intellectually able, recognizes threats, meets own emotional needs, and is resilient, tolerant, and stable. The Investigator must have a thorough understanding of Caregiver Protective Capacities. This understanding will allow the Investigator to guide interviews with caregivers, children and collaterals assuring that relevant information related to Adult Functioning and related Caregiver Protective Capacities. The Investigator will benefit by planning interviews and prioritizing information based on the Caregiver Protective Capacities that must be judged in this assessment area.

Adult Functioning and Impending Danger

There are four Impending Danger Threats associated with adult functioning:

- **A parent or caregiver is violent and no adult in the home is protective of the child(ren).**
- **One or both parents'/caregivers' emotional stability, developmental status, or cognitive deficiency seriously impairs their ability to care for the child(ren).**
- **One or both parents/caregivers cannot control their behavior.**
- **Family does not have resources to meet basic needs.**

When any of these Impending Danger Threats are selected, documentation in this assessment area must justify the selection. The selection of an Impending Danger Threat is determined by applying the Danger Threshold Criteria. The Investigator should remember that the selection of an Impending Danger Threat means that he/she has concluded that a child is unsafe and the case will be opened for Ongoing FSU.

A child is **unsafe** if there are Impending Danger Threats. To reach the conclusion that an Impending Danger Threat exists, the Investigator must ensure congruence in three areas of record keeping for this (or any) assessment area: 1) diminished Caregiver Protective Capacities are selected based upon the beliefs and understanding of the Investigator; 2) Impending Danger Threats are selected; and 3) documentation justifies and explains #1 and #2. For instance, the Investigator indicates that a mother has diminished impulse control and is unstable (diminished adult functioning Caregiver Protective Capacities); the Investigator indicates that the mother is violent and no adult in the home is protective of the child(ren) (Impending Danger Threat). The Investigator documents that the mother has a history of violence in her own family and in the community, has mental health problems which result in aggression and physical outbursts, does not take prescribed medication, and has been the domestic violence aggressor in her past two marriages. The Investigator goes on to document other relevant adult functioning information and identifies the information sources. By documenting this way, the Investigator has provided the congruence that justifies his/her judgments.

General Parenting and Discipline Assessment Area

It is imperative to understand how caregivers' discipline and how they typically parent to make accurate child safety decisions. Discipline techniques is often the focus, however how a parent generally and typically parents their child results in children being in danger far more than caregivers who inappropriately discipline their child.

To show the distinction between and importance of both General Parenting and Discipline, they are separated into two categories in the intervention manual.

Parenting – General

Parenting general is concerned with how a caregiver parents typically, based on how he/she was parented; how or why he/she became a parent; what he/she knows about parenting; what he/she knows about child development; how satisfied he/she is as a parent; and specific thinking, feeling, and behavior apparent as a parent.

The assessment considers how the person parents day-in and day-out: routines, habits, consistency in behavior from one day to the next, situations and circumstances that contribute to or distract the parent approach, the typical parenting style if one can be determined, and the nature of the parent - child relationship from day to day.

The Investigator knows that parenting is a complex human behavior and the parent - child relationship is complex, too. Therefore, documentation attempts to synthesize the

complexities into a cogent depiction that provides understanding about why and how certain parenting practices are occurring and the resulting parent - child relationship.

When considering this assessment question, it is important to keep distinctively centered on the overall parenting practices that are occurring and not allow the maltreatment effects or incident affect information collection. Among the issues for consideration within this question are: parenting styles and the origin of the style, basic care, affection, communication, expectations for children, sensitivity to an individual child, knowledge and expectations related to child development and parenting, reasons for having children, viewpoint toward children, examples of parenting behavior and parenting experiences. Regarding discipline, this should include the typical way the caregivers approach disciplining their children. The caregiver's methods, the source of those methods, purpose or reasons for, attitudes about, context of, expectations of discipline, understanding, relationship to child and child behavior, meaning of discipline should be considered.

Parenting Skills

The parenting skills of a caregiver are not necessarily very specific; some are broad in the sense of contributing to overall parenting responsibilities and objectives. For instance, a caregiver that provides for an adequate home, sufficient food, recreation, etc., must possess skills to make these things available. One might not necessarily consider providing these "quality of life" experiences to be parenting skills compared to teaching a child a specific behavior, skill, or concept. For reference, here is a list of common parenting skills:

- Providing clothing, food, shelter
- Teaching and ensuring personal hygiene
- Home management, including setting boundaries, rules, routines
- Acquiring and supporting education
- Acquiring routine and emergency medical care
- Providing love and affection
- Managing stress
- Developing relationship skills
- Communicating and behaving consistent with age/development
- Responding to uniqueness and needs
- Promoting independence
- Teaching
- Developing life skills
- Guiding moral development
- Providing a safe environment
- Protecting

Parenting – Discipline

This assessment area addresses how a caregiver thinks and behaves when disciplining his/her children. It includes the caregiver(s) definition of discipline, and what intentions exist when a child is being disciplined. The "daily" standard applies with this assessment area, since it is an important way to understand consistency in the application of discipline.

This assessment area is the most focused assessment since it is confined to a single topic – child discipline. However, the Investigator must not underestimate the complexity of the topic. The Investigator must consider all dimensions of child discipline.

The assessment should take a macro-view of child discipline. The overarching aspect of the macro-view is that the purpose of discipline is socialization. Fundamentally, socialization means methods and measures that develop throughout childhood to evolve an uncivilized person (an infant) to a civilized person (18-year-old young adult). Socialization is concerned with teaching, while discipline is concerned with learning. Discipline results in the development of self-expression, self-control, self-management, social responsibility, self-realization, and independence. This assessment area is concerned with judging the extent to which a caregiver approaches discipline from this point of view or a different one.

How discipline is applied "daily" encourages an assessment that considers how a person thinks about discipline in general; why the person disciplines; and the pervasive or inconsistent use of disciplinary knowledge, expectations, and methods. For instance, the Investigator finds significant meaning in a mother who professes to beliefs and commitments to discipline that is sensitive to the child's age and capacity and is directed at teaching. However, on a daily basis, the mother's inability to manage her own frustrations results in physical and verbal assaults upon the child. In other words, the daily "playing out" of disciplinary behavior is more profound than what the mother say she believes or wants to believe.

Disciplinary Methods

The methods that a caregiver uses should be age and situation appropriate. The Investigator should be well versed in disciplinary methods: their purpose, appropriate use, age appropriateness, timing and intensity, and situational appropriateness. For reference, here are some traditionally accepted disciplinary methods:

.

- Corporal punishment
- Placing a child in physically stressful positions
- Time outs

- Grounding
- Depriving food, privileges, favorite items
- Scolding
- Criticizing
- Guidance
- Offering alternatives
- Teaching
- Re-directing
- Providing choices
- Praise/reward
- Natural consequences
- Reasoning
- Positive reinforcement
- Negative reinforcement

Influence of Caregiver Protective Capacities on Information Collection

The FFA instrument should prompt information collection by the Investigator. Documentation of the parenting – general assessment area begins with judgments (selected boxes) about Caregiver Protective Capacities. The narrative documentation for this assessment area requires the Investigator to justify the judgments about Caregiver Protective Capacities. It follows that given those requirements, the Investigator will benefit by planning interviews and prioritizing information collection with adults, in relationship to parenting – general by the Caregiver Protective Capacities that must be judged in this assessment area.

Parenting and Impending Danger

There are six Impending Danger Threats associated with parenting – general and parenting - discipline:

- **No adult in the home will perform parental duties and responsibilities.**
- **One or both parents/caregivers have extremely unrealistic expectations.**
- **One or both parents/caregivers have extremely negative perceptions of a child.**
- **One or both parents/caregivers fear they will maltreat the child and/or request placement.**
- **One or both parents/caregivers lack parenting knowledge, skills, and motivation which affect child safety.**
- **Child has exceptional needs which the parents/caregivers cannot or will not meet.**

When any of these Impending Danger Threats are selected, documentation for this assessment area must justify the selection. The selection of an Impending Danger Threat is determined by applying the Danger Threshold Criteria (see Safety Determination). The Investigator should remember that the selection of an Impending Danger Threat means that he/she has concluded that a child is not safe.

To reach the conclusion that an Impending Danger Threat exists, the Investigator must ensure congruence in three areas of record keeping for this (or any) assessment area: 1) diminished Caregiver Protective Capacities are selected; 2) Impending Danger Threats are selected; and 3) documentation justifies and explains #1 and #2. The documentation explains and elaborates, fundamentally, to meet the definition of unsafe. For instance, the Investigator indicates that Holly has diminished recognition of Prince's needs (diminished Caregiver Protective Capacities); the Investigator indicates that Holly lacks parenting knowledge, skills, and motivation which affect child safety (Impending Danger Threat). The Investigator goes on to document other relevant parenting – general information and identifies his information sources. By documenting this way, the Investigator has provided the congruence that justifies his judgments.

Chapter 10. Concluding Children Are Unsafe = In Impending Danger

The Investigator must indicate a judgment about the safety of each child in a family at the end of the FFA. The decision is based on the definition for unsafe:

- **A child is unsafe when Impending Danger exists**

If the Investigator selects an Impending Danger while documenting the assessment areas in the FFA, he/she has concluded that the definition has been met: Impending Danger exists due to diminished Caregiver Protective Capacities. Selection of the Impending Danger Threat is non-specific with respect to a particular child. The selection means the Investigator is going on record that there is at least one child in the family who is unsafe.

The Investigator knows that only Impending Danger Threats that meet the Danger Threshold Criteria can be selected; those criteria are: unmanaged, severe, observable, a vulnerable child, and imminent.

At the conclusion of the FFA, the Investigator identifies each child in the family and indicates whether the child is safe or unsafe. The justification of the conclusion about each child is connected in documentation to facts that are recorded in each assessment area, clarification and explanation of a child's vulnerability in the child functioning assessment area, indication and justification of diminished Caregiver Protective Capacities, and selected Impending Danger Threats (that have been justified in the appropriate assessment areas).

Chapter 11. Documenting the 4 Areas of Assessment in the FFA

The Family Functioning Assessment is a business document and the official record of the case. It includes the assessment of Impending Danger and serves as the basis for determining if the family needs to be served by FSU. **It is a justification document and an accountability document**. As a professional document, it must be characterized by acceptable image, appropriate attitude, demonstrated depth and breadth of knowledge, ethics, maturity, reflection of acceptable conduct, and evidence of objectivity.

The cardinal rules for documenting the FFA are:

- Information is appropriate for the FFA in general and specific to each assessment area.
- All assessment areas are complete so that assessment areas are answered.
- Information is relevant to the FFA and the decisions that must be made.
- Information is substantial, assuming the Investigator has had reasonable access to family members and other sources of information.
- The entire FFA represents a comprehensive consideration of the family system.
- Facts contained within the FFA and conclusions reached by the Investigator are corroborated by sources, i.e., this is not a document for process recording (he said/ she said).
- Documentation is based on facts, and judgments that are supported by facts.
- Documentation is clear.

The Investigator documents the FFA assessment questions within 10 days when a Present Danger Plan is in place, and within 30 days when no Present Danger is in place. If, during the FFA process and prior to 30 days, the Investigator has gathered sufficient information to identify Impending Danger or determine that there is no Impending Danger, the information assessment questions should be documented.

The Investigator analyzes FFA information to complete the Family Functioning Assessment and reach FFA decisions.

General Instructions

While the FFA represents much more than a documented instrument (e.g., intervention values and philosophy, interpersonal skills, a process for collecting information, and a means for determining whom DCYF will serve in FSU), references to FFA in these instructions refer only to documenting the instrument.

Purposes of the FFA Form

The purposes of the FFA form are:

- To organize information for decision making.
- To assess the significance of information.
- To analyze case data.
- To document conclusions about FFA decisions.

The FFA form is used to organize information to assess Impending Danger based on the four assessment questions.

The FFA form is completed:

- at the time when enough information has been collected to make and justify decisions;
- within ten days when Present Danger has been identified; or
- within thirty days when no Present Danger has been identified.

When completed, the FFA results in a decision to substantiate or not substantiate child abuse or neglect; an assessment of Impending Danger; an assessment of Caregiver Protective Capacities; a Safety Determination; a decision to open a case for intervention by FSU; completion of the Impending Danger SPD when cases are open; and a Safety Plan.

Case notes are necessary during the FFA process to document the initial response, and for any other contacts that occurred during the FFA that were related to information gathering pertinent to assessing Impending Danger or related to the determination of substantiation. Case notes document sources of information, dates and times of interviews, and references to the subject matter of interviews.

Standards for Documentation

There are several principles that guide FFA documentation:

- Record facts, and support interpretation or judgment with facts.
- Record only relevant information and be concise.
- Use summary dictation whenever possible, not process recording of interviews.
- Identify information sources.
- Keep acronyms and abbreviations to a minimum.

Characteristics of Documentation

Appropriate - Documentation is appropriate when it is written within the proper FFA assessment area. Documentation must be related to and answer the assessment areas.

Complete - Documentation is complete when it is enough to answer an assessment area question and applicable Caregiver Protective Capacities.

Relevant - Documentation is relevant when it is pertinent to the caregivers, children, and family network, and can be specifically associated with the intention of the FFA, which is to assess child safety.

Substantial - Documentation is substantial when it shows reasonable diligence and effort to collect all the information necessary to provide details about circumstances in the case and to individualize the people in the case.

Sufficient - Documentation is sufficient when the depth and breadth of the information provides a reasonable understanding of individual and family functioning and the situations and circumstances in which the family lives.

Comprehensive - Documentation is comprehensive when information identifies, supports, reconciles, and justifies Impending Danger and the Safety Plans that result. The documentation addresses behavior, emotion, family conditions, perceptions, attitudes, motives, and intent that are consistent with a determination of a safe or unsafe environment.

Corroborative - Documentation is corroborative when all sources of information are identified by name, contact information, and relationship to the parties in the case, and when sources are cited with specific findings.

Factual - Documentation is factual when information is directly observed or from a reliable source, and then described without bias. Interpretation or other subjective information is

noted as such. Documentation is supported by conclusions and interpretations that are explained by factual examples.

Standardized - Documentation is a clear-based application of Standard English (correct grammar and spelling), and follows the guidelines for standard, formal, or technical writing: planned, clear, brief, simple, and appropriate language use.

Anchored – Documentation is anchored when an entry is placed at the end of each assessment area in the FFA, to indicate the information sources for the above information. Note the anchor at the end of the Child Functioning documentation in the example below:

> ***Child Functioning***
>
> *Taylor is an eleven-month-old girl who appears alert, upbeat, clean, and well-nourished. She has an infectious demeanor which causes everyone to want to hold her and play with her. She appears very comfortable with her mother, who dotes on her and appears genuinely "in love" with her baby girl, as stated by Sarah. Taylor has no health issues and appears to be satisfied with her bottle and is eating some cereal and fruits. Taylor is now walking with assistance and moves very well on her knees. She is very vocal and jabbers most of the time. She is currently up-to-date on all immunizations.*
>
> **(Social worker observation of Taylor, interviews with Mom, Dad, paternal grandmother, Christie Bennett, RN with Dr. Ervin's office) – <u>This is the anchor entry.</u>**

Conclusion and Belief

Documentation for an assessment area is not a reiteration of statements made by information sources. It is a conclusion about the beliefs of the Investigator that are based on the disclosures and statements made by the information sources, and what the social worker has observed.

Interpretation

Documentation for an assessment area can be based on a conclusion that is an interpretation of what information sources have disclosed. Consider this example:

> *A teacher indicates a mom's parenting satisfaction seems in question; a teenage daughter says that her mom said she wishes she had never become a parent; there are circumstances showing the mom looks for opportunities to shift her parenting responsibilities to others; BUT the mom says she loves being a parent.*

This kind of information, even with the contradiction of the mother, could result in an Investigator interpretation and a conclusion that the mother is not satisfied with being a

parent and looks for ways to avoid the responsibility. Discrepancies between what is said by the sources and what is observed or experienced by the Investigator should be noted.

Justification

The Investigator should provide justification for conclusions and beliefs in documentation. Consider this example:

> *Joan is emotionally immobilized (e.g., she seemed extremely sad during every interview; Joan's mother said Joan won't take her medication; she sleeps large amounts of time during the day; she said she has no reason for living; she complains of being constantly tired.)*

This example should not be thought of as the exemplar containing the right or preferred number of justifying facts. Justification does not require a certain number of supporting facts. Several significant or vivid facts can support the Investigator's judgment and belief.

Information Sources

Documentation of an assessment area should include the identification of information sources in conjunction with and specific to the conclusions and beliefs of the Investigator as represented by the documentation. Consider the example below:

> *Joan is emotionally immobilized. (e.g., she seemed extremely sad during every interview; Joan's mother said Joan won't take her medication; she sleeps large amounts of time during the day; she said she has no reason for living; she complains of being constantly tired.)*
>
> **(Worker Observation; Joan, Joan's mother Mrs. Grange)** - **Anchoring the documentation with information source.**

Sufficiency

The standard for sufficiency is concerned with the quantity of documented information necessary to support FFA decision making, and includes the topics and content prompted by the FFA assessment areas. Sufficiency includes the quality and adequacy of documentation, i.e., the depth and breadth required to provide a reasonable understanding of family members and their functioning, and to support and justify decision making. The information must be sufficient to identify, support, reconcile, and justify the presence of Impending Danger, and to inform and justify the kind of Safety Plan/Safety Management that occurs in the FFA process.

The Supervisor determines if the standard for sufficiency is met in terms of quality, adequacy, depth, breadth, etc. The length of the documentation is not necessarily a benchmark, since

documentation can be extensive, yet miss the point of the assessment area, be redundant, misdirected, or just wrong. (See Assessing Limited Information)

Diligence

Reasonable diligence and effort necessary for information collection and documentation refers to behavior that demonstrates thoroughness, conscientiousness, attention to and documentation of detail, repetitive attempts and exertion to get information, and inclusion of relevant people in the information gathering process. The Investigator can think of it as going the extra step, clearing up confusion, filling in the gaps, reconciling differences, and qualifying facts and opinions. “Reasonable” is a subjective standard to apply to diligence, but can be qualified by what seems sensible and logical; the level-headed thing to do; influenced by what is known; what is not known; what is important to know; what good practice, documentation, and decision making depend on.

Summarization

Documentation of an assessment area should be much more like a summary than a series of statements from information sources, or process recording. The summary represents the essential facts and conclusions that the Investigator reaches as a result of all information collection and all information sources that are relevant to a particular assessment area.

Unknown Information

Documentation of an assessment area should identify any significant information that is unknown for that question. For example, substance use is an important area of assessment for adult functioning. In some instances, the Investigator will conclude information collection and not be able to reach a conclusion about a person’s substance use. By documenting in the adult functioning assessment area that a person’s substance use is unknown, the document indicates that the Investigator considered this assessment area, but was unable to reach a conclusion.

The reasons that information is unknown can represent significant information in itself, and should be documented. For instance, the caregiver would not share information with the Investigator; the information source avoided the Investigator, therefore making it impossible to gather the information; the caregiver hides available information from the Investigator.

Objectivity

Documentation of an assessment area should always include both negative and positive information that has been gathered concerning caregivers, children, family members, and case circumstances.

Assessing Limited Information

In instances in which information is limited in quantity, the Investigator must make a judgment about the pertinence and relevance of that information with respect to its usefulness in supporting decisions. If one piece of information, or limited information, has major significance, the Investigator may be able to judge it alone.

Consider this example:

> *A father is unable or unwilling to share any personal information about his functioning; the Investigator has confirmed that the father is a serious alcoholic who is impaired weekly; the Investigator knows that this information, though limited, is pertinent and relevant, and reasonably justifies that the father's functioning is out of control.*

Two Households

If two households are involved in the FFA process, the Investigator should complete an FFA based upon the home in which the child is judged to be in Impending Danger. If there are screened-in reports about both homes, the Investigator completes a separate FFA on both homes, reaching independent judgments and conclusions about child safety for each home.

Multi-Family Households

Documentation of assessment areas and completion of the FFA should include only caregivers and family members that are identified in the Report as residing in the household, unless, during the FFA process, the Investigator identifies another family living in the household that appear to be a family with unsafe children. If there is reason to believe that both (or more) families are behaving in ways consistent with Impending Danger, then a separate report must be completed on each family. Whether the same Investigator conducts the FFA process with each family in a household is a Supervisory/Manager decision.

Who is Included in the FFA

Documentation of assessment areas concerned with adult functioning, parenting discipline, and parenting general must contain only information about primary caregivers that reside in the child's home, or are routinely involved in a caring capacity in the home. Other adults in the home are included in the FFA assessment, in the maltreatment and nature assessment areas, only if they are associated with the Impending Danger Threats. Other family members, in or out of the child's home, who are not in a primary caregiver role, are not included in the FFA.

Non-custodial parents are not included in the FFA. (See Two Households)

Caregivers' companions are considered in the FFA when they live in the home or frequent the home regularly, and when they assume some primary caregiver or supervision responsibility.

Documentation of assessment areas concerned with maltreatment and child functioning must contain only information on children who are subject to the caregiving of the primary caregivers in the home. This includes the caregiver's birth children, and children for whom the caregiver has come to be responsible in providing care and protection, and who reside in the home.

Extent and Circumstances Surrounding Maltreatment Documentation

This assessment area documents the substantiation decision. The standard for the decision to substantiate means that a child has been abused and/or neglected as defined by Rhode Island Statute, policy and procedures.

If maltreatment was not found, the Investigator justifies that determination in the assessment area concerned with surrounding circumstances. The Investigator justifies this conclusion after considering the conditions that existed and the family situation associated with (or surrounding) the alleged maltreatment that was documented in the IA. If maltreatment was not found, "Unsubstantiated" is checked and no other documentation is necessary for this assessment area.

If the Investigator documents that preponderance of the evidence of abuse or neglect exists, pursuant to Rhode Island Statute and Policy, and a finding of "Substantiated" is entered, then the following necessary evidence must be detailed in the Extent of Maltreatment and Circumstances Surrounding Maltreatment sections.

Documentation Pitfalls (Extent and Surrounding Circumstances of Maltreatment)

- Avoid documenting the process the Investigator went through to verify the existence of maltreatment and surrounding circumstances.
- Avoid a dated chronology of circumstances; rather, summarize the circumstances and provide examples that justify.
- Assess information about circumstances to judge what is most significant in defining the context in which the maltreatment occurred.
- Avoid "he stated," "she said," "he reported" references. The Investigator should consider all the information disclosed to him or her and what has been observed about the surrounding circumstances and arrive at a concise summary of the surrounding circumstances.
- Anticipate that this assessment area will typically be documented in half a page or less.
- Avoid "telling the story" of the events that led up to the maltreatment and the maltreatment itself.

- Follow other rules related to drawing conclusions and providing factual examples to justify; cite sources of information.

Examples of Documentation

- **Extent and Circumstances surrounding Maltreatment – Physical Abuse**

  Eighteen-month-old Jeremy had a puncture wound to his forehead. There were bruises on his right shoulder the size of a golf ball (round, 1 ½ inches in diameter, and greenish in color). He had bruising on the right side of his rib cage (a vertical bruise about 3 inches long from midway down his chest, greenish in color) and he had two broken ribs.

  Vera (mother) has a history of impulsive acting-out beginning when she was a teenager. She has conflicts with other family members and neighbors which include arguing and physical fighting. She has one arrest for disorderly conduct. Jeremy's injuries are non-accidental. Vera denies being abusive toward Jeremy and explains that the head injury occurred when she jerked a ballpoint pen out of Jeremy's hand. This explanation is highly questionable given the location of the injury and what appears to be a stab wound. Vera explained that she had no idea how the rib injury could have occurred, but suggested he was accident-prone. However, she could give no examples of accidents that were beyond normal toddler physical activity. (e.g., Vera said Jeremy falls a lot and rolls around on the floor where toys are.) The injuries occurred within the last two days. They were observed by Vera's mother, Janice Perl (reporter). (Sources: Vera; worker observation; Jeremy; medical exam; Dr. Janet Rogers; Janice Perl)

  There were multiple injuries to a very young child which required medical care. Mother cannot provide sufficient explanation for the cause of the injuries and fails to recognize that they were caused by more than just normal toddler activity. Mother is identified as one of only two persons who provide for child's care. The other care provider is the grandmother who reported the allegations against mother. Grandmother suspects her daughter of causing the injuries. Although mother denies causing the injuries and offers an explanation, her explanation is not consistent with the child's injuries. No examples of accidents were offered as possible explanation of injuries. Mother has history of being physically aggressive with other adults.

  (Sources: Worker observation; Jeremy; Vera; Dr. Janet Regen; X-rays)

Extent and Circumstances Surrounding Maltreatment – Sexual Abuse

Eleven-year-old Brianna has vaginal tearing and has tested positive for Chlamydia. Based on child's disclosure and the medical exam, Brianna's condition is consistent with sexual abuse.

The mother, Fran, has been involved in a relationship with Larry for nine months. On March 18, Brianna disclosed to her teacher, Brenda McGraw, that her mother's boyfriend had intercourse with her on February 14, and twice in March, most recently on Saturday, March 16. Brianna remembered the date of the first assault because it was on Valentine's Day. She doesn't remember the exact date of the second assault, but said it was on a Saturday afternoon. The most recent assault was on a Saturday. All abuse has occurred while Brianna's mother was out of the home. The first encounter occurred in the den. The other assaults occurred in Fran's bedroom. Larry denies the maltreatment and blames Brianna for being jealous and making up stories to get rid of him. Fran is distraught, but says she feels she must believe Larry. Fran cannot explain why Brianna would disclose sexual abuse. Neither Fran nor Larry can explain the injury or STD. Brianna disclosed because of fear of Larry and fear of reoccurrence. She has been distancing herself from others at school and appears very sad. She was fearful in all interviews. Physical injuries are explained as abnormal, not caused by normal childhood activity or problems. (Sources: Brianna, Brenda McGraw, Larry M., Fran T, Dr. Anna Blankenship; Det. Sarah Foster)

Detailed description of the abuse, times and dates is provided. Person responsible for child's care and causing the abuse is Larry, while mother was out of the home.

(Sources: Brianna, Brenda McGraw, Larry M., Fran T, Dr. Anna Blankenship; Det. Sarah Foster)

Note: In sexual abuse cases, you will **always** need to ask the alleged victim if they told anyone else (specifically the non-offending parent) about the abuse and, if so, document when, how, under what circumstances, and the outcome of the disclosure.

- **Extent and Circumstances Surrounding Maltreatment – Neglect**

Linda Salee does not provide necessary care for four-year-old Ryan and four-year-old Lily, including not feeding the children regularly, not providing nutritional food, failing to bathe and provide hygiene care, failing to ensure routine medical care including required vaccinations, and failing to provide dental care. Linda isolates the children frequently during the day, including keeping them locked in a bedroom. She hides the children from others. Both children are below the 50th percentile for height and weight. Socially and interpersonally, they are detached and developmentally delayed. They both have serious skin conditions related to lack of bathing and necessary hygiene.

Linda has suffered several losses during the past year (mother died; husband left her; lost her job). Linda is in extreme stress related to financial problems and a pending home foreclosure. She has become anti-social, having cut off all relationships she formerly enjoyed. Linda has no explanation for the children's conditions or the family situation. She denies not caring for the children. She has avoided providing information or involvement with the FFA. She has indicated that the children are fine and that she intends to continue raising them as she has been. She indicates no answers for her financial or housing problems.

Evidence of neglect includes collaterals and mandated reporters, who provided information about the children not being given adequate food regularly or daily. Children are isolated and kept locked in a bedroom. Both children are socially and interpersonally detached and developmentally delayed. Both children are below the 50th percentile in growth. Both also have serious skin conditions related to a lack of bathing and personnel hygiene. Mother does not see any fault in how she is caring for the children and intends to carry on in this manner.

(Sources: Worker observation; Linda, Ryan, Lily; physical exam; Carla Fisher RN; Ertha Madison – maternal grandmother)

Note: It would be important to ask the medical providers if they believe the lack of adequate food and lack of adequate hygiene is the cause of the growth and developmental delays and the serious skin condition.

Note: Of particular concern is the information re: the mother hiding the children from others.

- **Extent and Surrounding Circumstances of Maltreatment - Lack of Supervision**

Five-year-old twins Randi and Ronda and three-year-old Blair were unsupervised for 2 to 3 hours on April 7. The children were put out of the house to play in their yard. The front yard is unfenced in a residential neighborhood with moderate traffic. The children were unsupervised while an unnamed man visited the mother, Kathy. This situation occurs more than once weekly, including having occurred April 2 (the children were unsupervised outside in the afternoon) and April 5 (the children were unsupervised outside from late afternoon until after sunset. (Sources: Worker observation; Kathy; Randi; Ronda; John Barrett – neighbor/reporter; Bill and Jeanne Alford – neighbors)

Kathy explains that she allows the children to play outdoors most days when the weather is nice. She explains that she checks on them regularly, and that she has taught the twins to report in regularly. She denies that the children are unsupervised or in any danger. The front yard is unfenced in a residential neighborhood with moderate traffic. The children have access to the front yard (no gate on the back fence) and have wandered into the street and into neighbors' yards. Neighbors report high traffic at the house mostly at night, with men visiting regularly, less often during the day. On all occasions, when the children are unsupervised during the day, men are at the house. The identities of the men are unknown. Kathy is an unemployed waitress who says she currently is living off of savings. Kathy has been arrested three times for prostitution which she explains as "trumped up" and "bullshit." She denies prostituting now.

There is evidence of neglect due to the mother's failure to provide proper supervision. The children are too young to make appropriate decisions while left alone without any supervision for 2-3 hours a day in an unfenced or unsecured area. The children could easily wander off into traffic or with a stranger without the mother's knowledge. The lack of supervision is a result of the mother's habit, as evidenced by her admission, of leaving her children unsupervised. The circumstances surrounding the neglect indicate that the children's welfare is harmed or threatened with harm because of the mother's habit and belief that leaving young children without any supervision is appropriate parenting. The mother's conduct in continuing this behavior, her beliefs, and the likelihood that she is prostituting, create a significant risk of harm to the children. The mother fails to recognize the dangers and continues to repeat the same risky behaviors.

(Sources: Worker observation; Kathy; Randi; Ronda; John Barrett – neighbor/reporter; Bill and Jeanne Alford – neighbors)

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Child Functioning Documentation

Sufficient documentation exists when the Investigator provides a convincing picture of the child from day to day. At a minimum, such documentation should include the following:

physical health, emotion and temperament, intellectual functioning, behavior, ability to communicate, self-control, educational performance, peer relations, and development. Documentation about a child's development should specifically determine whether child is on target related to physical characteristics, mental characteristics, social characteristics, and emotional characteristics. For instance, a child between the ages of six months and a year will express the social characteristic of wanting his/her mother or mother-substitute above all others. The Investigator might document that the 6-month-old child being observed is rigid and non-responsive toward his mother on all observed occasions.

Documentation Pitfalls (Child Functioning)

- Avoid generalizations, such as documenting that a child is on target developmentally. The Investigator should document details about how a child is on target developmentally evidenced through daily functioning and physical health.

- Avoid seeing all children in a family as the same. Documentation should individualize each child seeking to demonstrate the uniqueness of the child, including how he/she is similar to and different from siblings. The Investigator knows that all the children in the home should be interviewed regarding allegations of abuse and neglect and the potential for Impending Danger.

- Avoid the "child is too young to interview" mistake. While it true that children possess different capacities related to verbal communication because of age or disabilities, the Investigator knows that, through observation and interaction, a great deal can be learned about a child's functioning and development. Additionally, others can report on a non-verbal child's daily functioning within the framework of child development.

- Avoid insufficient documentation which results from inadequate preparation for child interviews; the Investigator should gather age and developmentally related information going into an interview with a child. For instance, if the Investigator knows the child in the report is Jeremy, the 18-month-old toddler, interview preparation should include gaining knowledge and facility regarding the developmental capacities of normal 18-month-olds, and how to use that knowledge in observing and interacting with Jeremy.

Example of Documentation of Child Functioning

The following example documents the daily functioning of Brianna, whose case was introduced in the Extent of Maltreatment – Sexual Abuse section.

Brianna is 11 years old. She is 5'5" and weighs 102 lbs. She does not show secondary sexual characteristics of puberty. She is in good physical health with no problems with colds or recurring illness and no diagnosed physical health problems. Her hearing is good; she wears glasses. While reported to have been a calm and happy child, within the past months and continuing to the present she is sad and anxious. She seems preoccupied and hyper-alert to act and say the right thing. Her demeanor is downcast. She avoids eye contact. She clearly is unhappy. Brianna's school performance has dropped from good (B+-A) to below average (D-C-). She is a smart child and has performed well on both routine and special assignments in school until the last two months. She has difficulty concentrating during class and often appears to be daydreaming. She understands directions but doesn't follow through. Her school performance has been quite good up until recently. When she is able to focus herself, she performs above average. Brianna is withdrawn and non-assertive. She would rather observe what others are doing rather than get involved herself. She is reluctant to talk, but once encouraged and supported, communicates well; she is articulate for her age. She is less willing to talk about feelings, but is notably open about her discomfort with the home situation, her mother's relationship to Larry, and the fear that he will attempt to have sex with her again if she goes home. Despite this dread, Brianna wants to go home. Brianna never acts out in school, is compliant, responds to adults regarding expected behavior, and has become somewhat reclusive at school and in the foster home. She has a close friend at school. It was her friend who encouraged her to disclose the sexual abuse. She gets along well with her classmates. She has been shy with her foster family's children but gets along amicably. Developmentally, Brianna is much like other 11-year-old girls. Variations in Brianna's development appear to be most recently affected by her home environment, relationship to her mother, and the sexual abuse. (e.g., she is angry but unable to express it; shy around strangers; moody; often tearful and worried; not interested in age related activities and group activities.) (Worker observation; Brianna, Fran – mother; Brenda McGraw - teacher, Larry M – mother's boyfriend, Ron and Cheryl Ford – foster parents; Gretchen and Payton Ford – foster parents' children; Jenna Oliver – Brianna's best friend)

Adult Functioning Documentation Example

Sufficient documentation exists when the Investigator provides a credible picture of the adult and his/her daily functioning. To meet the sufficiency standard, minimum information is required. The topics of importance to document (and referenced in the FFA) are: current and recent history of mental and physical health, substance use, employment, criminal behavior, social relationships, current behavior, communication skills, intellectual functioning, problem solving, reality perception, and coping mechanisms and being able to answer most, if not all, of the Adult Functioning Caregiver Protective Capacities.

Documentation Pitfalls (Adult Functioning)

- Avoid being descriptive of the person rather than analyzing and documenting pervasive functioning. It is a common practice to document characteristics of the adult and his/her life rather than drawing conclusions about how the person is living their life and how effective his/her approach to their life is. For instance, a person's employment history and status is a way of describing the person. To consider the same information from a functioning standpoint, the Investigator should consider what the information has to say about stability, energy, self-control and self-management, independence, endurance, etc.

- Adults often are unable to articulate how they function. Some will be confused by the area of how they function since people don't normally think in those terms. Additionally, people misrepresent how they function. Documentation will meet the sufficiency standard when information sources beyond the adult are included for both corroboration and elaboration of how the adult functions.

- Although it has already been emphasized, a major pitfall in adult functioning documentation is to include information and references to the person's approach to parenting.

- Avoid documenting information about the adult in relationship to how he/she behaved or acted during the circumstances that surrounded the maltreatment. The exception to this is if the Investigator decides to reference something about the adult related to surrounding circumstances that provide justification for a conclusion about the person. For instance, Larry is highly deceitful (e.g., he lied about being in the home when the sexual abuse happened; he misrepresented his involvement to supervise Brianna; he lied about where he worked; he denied having a criminal record of sexual abuse of a minor.) These examples include circumstances that surrounded the maltreatment which are reasonable to include in documentation of adult functioning to justify the Investigator's belief, which is that Larry is not honest or truthful.

Adult Functioning and Caregiver Protective Capacities

Documentation for this assessment area must justify the judgments made about pertinent Caregiver Protective Capacities. It seems contradictory to warn against documenting information about parenting general and parenting discipline while at the same time requiring the Investigator to justify the Caregiver Protective Capacities in documentation. However, the personal characteristics identified at the beginning of this assessment area are specifically associated with adult functioning. The Caregiver Protective Capacities that are adult functions are:

1. Behavior
    a. Does the adult controls his/her impulses?
    b. Does the adult take-action?

2. Cognitive
    a. Is the adult is self-aware?
    b. Is the adult is intellectually able?
    c. Does the adult recognize threats to someone's safety?

3. Emotion
    a. Does adult meet his/her own emotional needs?
    b. Is the adult resilient?
    c. Is the adult tolerant?
    d. Is the adult emotionally stable?

The Investigator reaches a conclusion about each of these adult (personal) characteristics (protective capacities) and indicates the conclusion by selecting:

"Yes" which means the adult possesses the capacity;
"No" which means the adult does not possess the capacity, or the capacity is diminished;
"Unknown" which means the Investigator was unable to collect information to inform a conclusion.

- **Enhanced Caregiver Protective Capacity**

When indicating "Yes," the Investigator is concluding that the adult possesses and demonstrates the capacity and that the capacity is enhanced. These are two judgments to the conclusion: existence and the degree of effectiveness. "Enhanced" refers to a capacity that is heightened, which means it is effective; it serves the person's functioning; it contributes to role performance; the person recognizes the capacity in him/herself; and the capacity can be used, or performed, or have an effect proactively by the person. For instance, if the Investigator concludes that an adult emotional capacity of resilience exists, the Investigator has information to justify that the adult is able to solve problems,

bounces back from adversity, can marshal and mobilize action and energy, feels able and optimistic, and possesses emotional energy in daily adult functioning.

- **Diminished Caregiver Protective Capacity**

  When indicating "No," the Investigator is concluding that the adult does not demonstrate the capacity because there is no supporting information for the capacity, or there is evidence that the capacity is limited; it is, therefore, diminished. However, indicating a capacity is diminished does not necessarily equate to or prove that Impending Danger exists. "Diminished" qualifies a capacity as limited or weak, to not active. The idea of diminished capacity is a hopeful one, however, as it implies a potential for change, growth, and development. If the Investigator concludes that an adult capacity is diminished, then documentation should justify the judgment by indicating how the capacity is diminished and its affect. For instance, using the resilience capacity, the Investigator's documentation could explain the adult's limitations as: unable to generate energy to solve problems, lacks motivation and hope that situations can improve, lethargic, feels demoralized and pessimistic, etc. These characteristics about the adult can be elaborated upon and supported by specific facts, such as: when faced with stressful situations, the mother retreats to her bedroom rather than face the problem.

- **Unknown Caregiver Protective Capacity**

  Occasionally the Investigator possesses enough information to complete the FFA and reach a Safety Determination without having full knowledge of adult functioning in general and Caregiver Protective Capacities specifically. The general instructions have emphasized how limited, but vivid, information can result in reaching a decision. The Investigator may have limited, but vivid knowledge of Caregiver Protective Capacities, which still allows for the identification of Impending Danger Threats and the establishment of a Safety Determination. Given this reality, the standard of diligence requires the Investigator to persist in collecting information, and when information about Caregiver Protective Capacities is unknown, to document an explanation (see "Unknown Information" in General Instructions section).

Example of Documentation of Adult Functioning

George is 38 years old. He is physically and mentally healthy (i.e., no minor or serious illness, physically robust, very physically active, no mental health history or diagnosis). George manages his impulses and behavior (e.g., a moderate drinker, having wine daily; 15-year career in construction, advancing to foreman; same residence for over 10 years; minimum debt). He has supportive social relationships and is involved in the community (e.g., committee member of Homeowner's Association, member of Kiwanis, attends

church periodically, has several best friends dating back to high school, very attached to his family and his former wife's family). George is satisfied with his social situation (e.g., regular and extensive contact with others, good and rewarding relationships; he is single since his wife died 3 years ago, and has not gotten involved in a serious relationship since then). George has no criminal behavior. He behaves in a responsible, mature manner (e.g., maintains daily routines; manages his home and family as a single father while working 40+ hours a week; is involved productively in the community; has hobbies for himself as well as involving his children). George comes across as the "strong, silent type" (e.g., is shy about talking about himself, doesn't think of himself as a "talker," is straightforward in speech, does not elaborate, is articulate, but is less open about talking about his feelings). He is smart (e.g., deals with complex construction plans, participates in intellectual contexts like committee meetings, is logical, is reasonable (as in understanding why the report was called into DCYF), capable of discussing and understanding uncomfortable subjects, including able to challenge points of view rationally, has a college education. Hobbies include reading professional literature (architecture, construction, and building). George is an effective problem solver (e.g., reorganized his life after his wife died; manages financial commitments despite reduced income; manages life and family as a single parent; solves daily job-related problems). He believes that life is what is handed to you and you deal with it, which is his definition of reality. While he has experienced much grief and hardship because of his wife's death, he does not see himself as a victim, or his situation as unusual. His attitude about reality is "deal with it." His approach to coping is self-sufficiency. He doesn't ask for help or support; however, he is accepting of it. His general approach to life is evidenced by how he manages himself and his impulses. He is proactive in meeting the daily demands of his life. He denies that any danger ever existed in his home, but is able to describe what danger would be like for his children's ages. His resilience, tolerance, and stability are demonstrated in the management of his daily life, and how he has responded to his wife's death and the challenges it created emotionally and financially.

General Parenting and Discipline Documentation

General Parenting and Discipline are in a sense two separate assessment areas documented in one section of the Family Functioning Assessment form. For instance, a caregiver could appropriately discipline their child but not recognize how to safely care for their child. Both General Parenting and Discipline must be thoroughly understood and document in the FFA. Due to the importance of this area of study, topics to be covered in document for each is separated in the intervention manual.

Parenting – General Topics

Sufficient documentation exists when the Investigator provides a full and comprehensive view of how caregivers parent in general. Comprehensive refers to considering parenting from a broad perspective and the parent – child relationship which is the product of the parenting.

The parenting – general topics referenced in the FFA are: history of protective behavior, parenting style, sensitivity to a child's needs, expectations for children, self-satisfaction as a parent, knowledge of parenting/child development, demonstrated skills, and the parent – child relationship.

Parenting – Discipline Topics

Sufficient documentation exists when the Investigator provides a convincing explanation of how and why a caregiver approaches discipline as he/she does. At a minimum, such documentation should include the following as referenced in the FFA: the approach to discipline; purpose and intention; specific methods; ability to maintain self-control; parenting knowledge related to discipline and age appropriateness; routines, boundaries, rules; and caregiver's perception of effectiveness.

The Investigator should consider the "concept" of discipline that the caregiver has; the meaning discipline has for the caregiver in relationship to personal parenting responsibility. The Investigator should document discipline effectiveness and the caregiver's point of view about effectiveness.

Documentation Pitfalls (Parenting – General and Discipline)

- Avoid simplifying by generalizing documentation of this assessment area. For instance, an Investigator may be satisfied with documenting that the mother loves her child deeply and has a terrific relationship with her daughter. While this certainly may be true, it does not provide sufficient understanding of the quality and nature of the mother's parenting.

- Do not include documentation related to extent and surrounding circumstances of the maltreatment or adult functioning.

- Only include documentation about child functioning when it is in reference to, or an illustration of, parenting practices or parenting effectiveness.

- Avoid a limited perspective or view of discipline when collecting information.
- Avoid limiting documentation to methods of discipline (spanking, grounding, etc).
- Avoid documenting what caregivers say about their thinking and approach to discipline without corroborating from other sources. Documentation is only good if it represents

what the Investigator believes to be the truth, which means reconciling what caregivers say with what others say who know about the caregivers' disciplinary approach.

- Avoid documenting caregiver behavior associated with maltreatment. For instance, the Investigator would not put that the mother lost control and began whipping her daughter with an extension cord in this assessment area, but would in the Maltreatment assessment area.
- Remember that the meaning and intention of discipline is more important than the method.
- Remember to consider the connection between caregiver beliefs about discipline, methods, and situations requiring discipline, and caregiver self-control.

Parenting – General and Discipline Caregiver Protective Capacities

Documentation for this assessment area must justify the judgments made about pertinent Caregiver Protective Capacities. Notably, Caregiver Protective Capacities related to this assessment area provide clarity about the complexity of parenting – general, and can provide structure to information collection and documentation.

1. Behavior
    a. Does the caregiver set aside own needs for his/her child?
    b. Does the caregiver demonstrate adequate parenting skills?
    c. Is the caregiver adaptive?
2. Cognitive
    a. Does the caregiver recognize a child's needs?
    b. Does the caregiver understand his/her protective role?
    c. Is the caregiver able to plan, and articulate plans, for providing protection?
3. Emotion
    a. Does the caregiver express love, empathy, and sensitivity to the child?
    b. Is the caregiver positively attached to the child?
    c. Is the caregiver aligned with and supportive of the child?

The Investigator reaches a conclusion about each of these parenting (personal) characteristics (protective capacities), and indicates the conclusion by selecting either "Yes," which means the caregiver possesses the capacity; or "No," which means the caregiver does not possess the capacity or the capacity is diminished; or "Unknown" which means the Investigator was unable to collect information to inform a conclusion.

- **Enhanced**

The terms "enhanced," "diminished," and "unknown" are used in the same manner described in Adult Functioning.

When indicating "Yes," the Investigator is concluding that the caregiver possesses and demonstrates the capacity and that the capacity is enhanced. There are two judgments to the conclusion (or selection): existence and degree of effectiveness. "Enhanced" refers to a capacity that is heightened, which means it is effective; it serves the caregiver functioning as a parent; it contributes to role performance; the caregiver recognizes the capacity in him or herself; and the capacity can be used or performed or have an effect proactively behaving as a caregiver. For instance, if the Investigator concludes that a caregiver is adaptive, the Investigator has information to justify that the caregiver is flexible in parenting, looks for options that promote effective parenting, is adjustable in handling different parenting challenges, parents effectively with different-aged children and different child needs, and is able to use different skills and parenting approaches with comfort.

- **Diminished**

When indicating "No," the Investigator is concluding that the caregiver does not demonstrate the capacity because there is no information to support that he/she does, or that the capacity is limited; it is diminished. However, diminished capacities should not be considered equal to or proof of Impending Danger. "Diminished" qualifies a capacity as limited or weak, to not active at all. The idea of diminished is a hopeful one, however, as it implies the potential of change, growth, and development. If the Investigator concludes that a Caregiver Protective Capacity is diminished, then documentation should justify the judgment by indicating how the capacity is diminished and its affect. For instance, using the adaptive capacity, the Investigator's documentation could explain the limitations as: caregiver has limited parenting skills which are over-used, rigid in expectations of children and how to respond, unable to meet new or unusual demands as a parent, challenged by developmental changes related to a child's age and development, and is uncreative in his approach to parenting.

- **Unknown**

Occasionally, the Investigator possesses enough information to complete the FFA and reach a Safety Determination without having full knowledge of parenting - general and related Caregiver Protective Capacities specifically. The general instructions have emphasized how limited, but vivid, information can result in reaching a decision. The Investigator may have limited, but vivid knowledge of Caregiver Protective Capacities, which still allows for the identification of Impending Danger Threats and the establishment of a Safety Determination. Given this reality, the standard of diligence requires the Investigator to persist in collecting information, and when information about Caregiver Protective Capacities is unknown, to document an explanation (see "Unknown Information" in General Instructions section).

Example of Documentation of General Parenting and Discipline

Brandy Alvarado is a single parent of 3 children. She is responsible for all care giving duties and parenting responsibilities. She has CPS history dating back to 2011, much of which involves reports concerning neglect and improper care and supervision. While she demonstrates a basic understanding in terms of caring for children, she lacks knowledge around child development. For example, some of her expectations of the children are unreasonable given their ages and development, i.e., Tad, @ 8yrs. waking himself for school and getting to the bus stop on time, her younger child, age 2, to entertain himself front of the television for extended periods of time without getting into trouble.

Brandy's parenting style can be described as permissive and lacking structure. She seems to love her children and expresses the desire to parent them but doesn't always demonstrate this behavior. She's concerned when discussing each of her children's needs, but doesn't always recognize the seriousness of their needs, i.e. medical, dental, mental health. Additionally, she is inconsistent at delivery, i.e. follow through with medical, mental health counseling, medications, speech services and so forth. She's not adaptive as a caregiver and often seems paralyzed by her circumstances. The children (as well as their needs) do not appear to be the top priority. For example, school officials express frustration as to Brandy's lack of concern and/or action in terms of Tad's failing grades and poor school attendance. Family members, namely her mother and sister describe her as a negligent parent concerned primarily by her need to collect financial benefits for the children. Brandy struggles to understand her protective role and cannot always articulate a plan in favor of protecting her children. Brandy's unrealistic expectations coupled with her lack of knowledge and motivation create a state of impending danger for the children.

Tad has experienced significant absences from school. He's reportedly the victim of bullying, however Brandy's not been able to rectify the situation as she cannot seem to make it to a school meeting to address the concerns. She has failed to get Kenny's nebulizer machine, obtain medications for Trisha's mental health condition, or follow through with the counseling appointment for Trisha. Brandy does not appear to recognize Trisha's mental health as an issue, or she doesn't have the motivation to follow through with assuring she receives the mental health assistance that she needs. While Brandy is intellectually able to navigate life,

she lacks the organization necessary to keep appointments or maintain benefits all of which have implications for adequate parental role performance.

(information collected from interview with Brandy, Tad, Trisha, School Counselor Kayes, School Counselor Washington, and maternal grandmother Victoria, Brandy's sister Stephanie)

Chapter 12. Impending Danger and Caregiver Protective Capacities Definitions and Information

Investigators, Supervisors, Managers, and Leadership must have a thorough understanding of Impending Danger and Caregiver Protective Capacities to effectively provide least intrusive, family centered child safety practice to Rhode Island families.
Impending Dangers are dangerous family conditions that represent situations/ circumstances, caregiver behaviors, emotions, attitudes, perceptions, motives, and intentions which place a child in a continuous state of danger that are out of control in the presence of a vulnerable child and therefore likely to have severe effects on a child at any time in the near future.

These dangerous family conditions exist within the child's home as a result of those with caregiving responsibility that possess diminished Caregiver Protective Capacity.

Caregiver Protective Capacity refers to one's (personal and caregiving) behavioral, cognitive, and emotional characteristics that specifically and directly can be associated with caregiver performance. Protective capacities are personal qualities or characteristics that contribute to the presence or absence of vigilant child protection, influence safe environments, and impact the well-being of children.

Caregiver Protective Capacity Characteristics:

Behavioral refers to specific action, activity, performance that is consistent with and results in parenting and protective vigilance.

Cognitive refers to specific intellect, knowledge, understanding and perception that results in parenting and protective vigilance.

Emotional refers to specific feelings, attitudes, identification with a child, and motivation that result in parenting and protective vigilance.

Impending danger is often not immediately apparent and may not be active and threatening child safety upon initial contact with a family. Impending danger is often subtle and can be more challenging to detect without sufficient contact with families. Identifying impending danger requires thorough information collection regarding family/caregiver functioning to sufficiently assess and understand how family conditions occur. The information is collected through interviews with all the relevant family network sources and are categorized and documented in the Family Functioning Assessment (FFA).

The definition for impending danger indicates that dangerous family conditions that are out of control and likely to result in severe harm to a child are specific and observable, and the threat to child safety can be clearly understood and described in assessment content. All impending dangers that are identified within the family network must meet the safety threshold criteria.

Impending Danger and the Safety Threshold Criteria

The safety threshold criteria must be applied when considering and identifying any of the impending dangers. In other words, the specific justification for identifying any of the impending dangers are based on a specific description of how negative family conditions meet the safety threshold criteria.

The Safety Threshold is the point at which a negative condition goes beyond being concerning and becomes dangerous to a child's safety. Negative family conditions that rise to the level of the Safety Threshold and become Impending Dangers are, in essence, negative circumstances and/or caregiver behaviors, emotions, etc. that negatively impact caregiver performance at a heightened degree and occur at a greater level of intensity.

Danger Threshold Criteria and Definitions

Observable refers to family behaviors, conditions or situations representing a danger to a child that are specific, definite, real, can be seen and understood and are subject to being reported and justified. The criterion "observable" does not include suspicion, intuitive feelings, difficulties in worker-family interaction, lack of cooperation, or difficulties in obtaining information.

Vulnerable Child refers to a child who is dependent on others for protection and/or is exposed to circumstances that she or he is powerless to manage, and susceptible, accessible, and available to a threatening person and/or persons in authority over them. Vulnerability is judged according to age, physical and emotional development, ability to communicate needs, mobility, size and dependence and susceptibility. This definition also includes all young children from 0 – 6 and older children who, for whatever reason, are not able to protect themselves or seek help from protective others.

Unmanaged refers to family behavior, conditions or situations which are unrestrained resulting in an unpredictable and possibly chaotic family environment not subject to the influence, manipulation, or ability within the family's to manage. Such unmanaged family conditions pose a danger and are not being managed by anybody or anything internal to the family system.

Imminent refers to the belief that dangerous family behaviors, conditions, or situations will remain active or become active within the next several days to a couple of weeks. This is consistent with a degree of certainty or inevitability that danger and severe harm are possible, even likely outcomes, without intervention.

Severity refers to the effects of maltreatment that have already occurred and/or the potential for harsh effects based on the vulnerability of a child and the family behavior, condition or situation that is unmanaged. As far as danger is concerned, the safety threshold is consistent with severe harm. Severe harm includes such effects as serious physical injury, disability, terror and extreme fear, impairment, and death. The safety threshold is in line with

family conditions that reasonably could result in harsh and unacceptable pain and suffering for a vulnerable child.
There are 15 standardized impending dangers used to assess child safety. The identification of any one of the 15 impending dangers means that a child is in a state of danger. The impending danger and the caregiver protective capacities listed below are in the sequential order as they appear in the categorical areas of study within the FFA (the four areas).

Assessment Area 1 Extent of Maltreatment and Surrounding Circumstances Accompanying Maltreatment

There are no specific caregiver protective capacities associated with the Maltreatment categories of study.

1. Living arrangements seriously endanger the physical health of the child(ren).

This danger refers to conditions in the home which are immediately life-threatening or seriously endangering a child's physical health (e.g., people discharging firearms without regard to who might be harmed; the lack of hygiene is so dramatic as to cause or potentially cause serious illness).

Application of the Danger Threshold Criteria

To be unmanaged, this impending danger does not include situations that are not in some state of deterioration. The threat to a child's safety and immediate health is obvious. There is nothing within the family network that can alter the conditions that prevail in the environment.

The living arrangements are at the end of the continuum for deplorable and immediate danger. Vulnerable children who live in such conditions could become deathly sick, experience extreme injury, or acquire life threatening or severe medical conditions.

Remaining in the environment could result in severe injuries and health repercussions today, this evening, or in the next few days.

This danger is illustrated in the following examples:

- Housing is unsanitary, filthy, infested, a health hazard.
- The house's physical structure is decaying, falling down.
- Wiring and plumbing in the house are substandard, exposed.
- Furnishings or appliances are hazardous.
- Heating, fireplaces, stoves, are hazardous and accessible.

- There are natural or man-made hazards located close to the home.
- The home has easily accessible open windows or balconies in upper stories.
- Occupants in the home, activity within the home, or traffic in and out of the home present a specific danger to a child's safety.

2. One or both parents/caregivers intend(ed) to hurt the child and show no remorse.

This refers to caregivers who anticipate acting in a way that will result in pain and suffering. "Intended" suggests that before or during the time the child was mistreated, the parents'/primary caregivers' conscious purpose was to hurt the child. This danger must be distinguished from an incident in which the parent/caregiver meant to discipline or punish the child, and the child was inadvertently hurt.

Application of the Danger Threshold Criteria

This impending danger seems to contradict the criterion "unmanaged." People who "plan" to hurt someone apparently are very much under control. However, it is important to remember that "unmanaged" also includes the question of whether there is anything or anyone in the household or family that can manage the danger. In order to meet this criterion, a judgment must be made that (1) the acts were intentional; (2) the objective was to cause pain and suffering; and (3) nothing or no one in the household could or would stop the behavior.

Caregivers who intend to hurt their children can be considered to behave and have attitudes that are extreme or severe. Furthermore, the whole point of this safety threat is pain and suffering which is consistent with the definition of severe effects.

While it is likely that often this impending danger is associated with punishment and that a judgment about imminence could be tied to that context, it seems reasonable to conclude that caregivers who hold such heinous feelings toward a child could act on those at any time—soon.

This impending danger includes both behaviors and emotions as illustrated in the following examples:

- The incident was planned or had an element of premeditation, and there is no remorse.
- The nature of the incident or use of an instrument can be reasonably assumed to heighten the level of pain or injury (e.g., cigarette burns), and there is no remorse.
- Parent's/caregiver's motivation to teach or discipline seems secondary to inflicting pain and/or injury, and there is no remorse.

- Parent/caregiver can reasonably be assumed to have had some awareness of what the result would be prior to the incident, and there is no remorse.
- Parent's/caregiver's actions were not impulsive, there was sufficient time and deliberation to assure that the actions hurt the child, and there is no remorse.
- Parent/caregiver does not acknowledge any guilt or wrong-doing, and there was intent to hurt the child.
- Parent/caregiver intended to hurt the child and shows no empathy for the pain or trauma the child has experienced.
- Parent/caregiver may feel justified, may express that the child deserved it, and they intended to hurt the child.

3. One or both parents/caregivers cannot or do not explain the child's injuries and/or conditions.

Application of the Safety Threshold Criteria

Parents/caregivers are unable or unwilling to explain maltreating conditions or injuries of a child. An unexplained serious injury is a present danger and remains so until an explanation alters the seriousness of not knowing how the injury occurred or by whom. This impending danger is illustrated in the following examples:

- Parent/caregiver acknowledges the presence of injuries and/or conditions of the child but denies knowledge as to how they occurred.
- Parent/caregiver appears to be totally competent and appropriate but does not have a reasonable or credible explanation about how the injuries occurred.
- Parent/caregiver accepts the presence of the child's injuries and conditions but does not explain the injuries or appear to be concerned about them.
- Facts observed by child welfare staff and/or supported by other professionals (such as medical evaluations) that relate to the incident, injury, and/or conditions contradict the parent's/caregiver's explanations.
- The history and circumstantial information are incongruent with the parent's/ caregiver's explanation of the injuries and conditions of the child.

Assessment Area 2: Child Functioning

There are no specific caregiver protective capacities associated with this category of study.

4. A child is extremely fearful of the home situation.

"The home situation" includes specific family members and/or other conditions in the living situation (e.g., frequent presence of known drug users in the household).

Application of the Danger Threshold Criteria

Do you know when fear is unmanaged and out of control? Have you ever felt that way? Can you imagine a child being so afraid that his fear is unmanaged? Can you imagine a family situation in which there is nothing or no one within the family that will allay the child's fear and assure a sense of security? To meet this criterion, the child's fear must be obvious, extreme, and related to some perceived danger that child feels or experiences.

By trusting the level of fear that is consistent with the impending danger, it is reasonable to believe that the child's terror is well-founded in something that is occurring in the home that is extreme with respect to terrorizing the child. It is reasonable to believe that the source of the child's fear could result in severe effects.

Whatever is causing the child's fear is active, currently occurring, and an immediate concern of the child. Imminence applies.

This impending danger is illustrated in the following examples:

- Child demonstrates emotional and/or physical responses indicating fear of the living situation or of people within the home (e.g., crying, inability to focus, nervousness, withdrawal).
- Child expresses fear and describes people and circumstances which are reasonably threatening.
- Child recounts previous experiences which form the basis for fear.
- Child's fearful response escalates at the mention of home, people, or circumstances associated with reported incidents.
- Child describes personal threats which seem reasonable and believable.

5. The behavior of a child in the home threatens serious/severe harm to themselves or others in the home and the caregiver is unable to manage the child's behavior.

This refers to children whose behaviors are dangerous to themselves or other children in their home despite the caregivers' persistent and reasonable attempts to manage and address the behaviors. The Caregiver(s) may have gotten the child mental health counseling, addressed his behaviors using age appropriate discipline, or taken other reasonable actions to address the child's behaviors. (This should not be considered the same as caregivers who have not diligently attempted to manage or address the child's behavior. In situations where Caregiver(s) have not exercised due diligence to address their child's behaviors in an appropriate manner, examine parenting related impending dangers to determine if any child in the home is in impending danger).

Application of the Danger Threshold Criteria

The child's behavior must be unmanaged and nothing or nobody in the household can manage the behavior. The child's behavior is not just troublesome or incorrigible, but dangerous and severe effects to himself/herself or others in the home is the likely outcome.

This impending danger is illustrated in the following examples:

- Child is sexually acting out and placing vulnerable children who reside in the home in danger.
- Child is violent and other children in the home are likely to be physically injured.
- Child is abusing substances; may overdose and the caregiver is unable to manage the child's behavior.
- Child is acting bizarre and will likely harm himself or others in the household.

Assessment Area 3: Adult Functioning

Caregiver Protective Capacities Related to Adult Functioning

BEHAVIORAL

The caregiver demonstrates impulse control.	This refers to a person who is deliberate and careful; who acts in managed and self-controlled ways. People who do not act on their urges or desires (e.g., violence, addiction, or sexually). People who do not behave as a result of outside stimulation. People who avoid whimsical responses. People who think before they act. People who are planful.
The caregiver takes action.	This refers to a person who is action-oriented as a human being, not just a caregiver. People who are physically able to perform when necessary. Individuals possess adequate strength and mobility enabling an appropriate response to specific situations. People who are expedient and timely in doing things and discharge their duties accordingly. People who possess adequate energy. People who are alert and focused. People who are motivated and have the capacity to work and be active. People who are rested or able to overcome being tired. People who are assertive, convicted, and self-confident. People who demonstrate taking the necessary steps. People who get people to help them and their children. People who use community public and private organizations. People who will call on police or access the courts to help them. People who use basic services such as food and shelter.

COGNITIVE

The person is self-aware as a caregiver.	This refers to sensitivity to one's thinking and actions and their effects on others. People who understand the cause – effect relationship between their own actions and results upon others.

	People who are open to who they are, to what they do, and to the effects of what they do. People who think about themselves and judge the quality of their thoughts, emotions, and behavior accurately. People who see that the part of them that is a caregiver is unique and requires different things from them.
The caregiver is intellectually able.	This refers to information and personal knowledge that influences how a person is empowered to perform or function as an adult. People who possess adequate cognitive functioning (e.g., IQ levels or cognitive delays). People who know enough or have access to information related to what is needed in order to adequately perform daily or routine tasks. People who know what is needed, how to get it, and how to use it. People who possess the ability to learn and apply knowledge. People who have accurate perceptions of the world around them which considers their personal life experience; clarity (reality in its entirety); and comprehension (understanding, grasp, discernment). People who are able to integrate information and able to form appropriate beliefs, opinions, attitudes, and insight. People who, when presented with a scenario or live situation, are able to demonstrate appropriate behavior that is the direct result of the judgments or decisions they possess from their reality.
The caregiver recognizes threats.	This refers to mental awareness and accuracy about one's surroundings; correct perceptions of what is happening; and the viability and appropriateness of responses to what is real and factual. People who describe life circumstances accurately. People who recognize threatening situations and people. People who do not deny reality or operate in unrealistic ways. People who are alert to danger within persons and the environment. People who are able to distinguish threats to child safety.

EMOTIONAL

The caregiver is able to meet own emotional needs.	This refers to satisfying how one feels in reasonable, appropriate ways that are not dependent on or take advantage of others, in particular, children. People who use personal and social means for feeling well and happy that are acceptable, sensible, and practical. People who employ mature, adult-like ways of satisfying their feelings and emotional needs. People who understand and accept that their feelings and gratification of those feelings are separate from their child.
The caregiver is resilient.	This refers to responsiveness and being able and ready to act promptly. People who recover quickly from setbacks or being upset. People who spring into action. People who can withstand. People who are effective at coping.
The caregiver is tolerant.	This refers to acceptance, allowing and understanding, and respect. People who can let things pass. People who have a big picture attitude, who don't over react to mistakes and accidents. People who value how others feel and what they think.
The caregiver is stable and able to intervene to protect the child.	This refers to mental health, emotional energy, and emotional stability. People who are doing well enough emotionally that their needs and feelings don't immobilize them or reduce their ability to act promptly and appropriately. People who are not consumed with their own feelings and anxieties. People who are mentally alert, in touch with reality. People who are motivated as a caregiver and with respect to protectiveness.

Impending Dangers related to Adult Functioning

6. A parent or caregiver is violent and no adult in the home is protective of the child(ren).

Violence refers to aggression, fighting, brutality, cruelty and hostility. It may be regularly active or generally potentially active.

<u>Application of the Danger Threshold Criteria</u>

To be unmanaged, the violence must be active. It moves beyond being angry or upset, particularly related to a specific event. The violence is representative of the person's state of mind and is likely pervasive in terms of the way they feel and act. To identify this impending danger there must be specific information to suggest that a caregiver's volatile emotions and tendency toward violence is a defining characteristic of how he or she often behaves and/or reacts toward others. The caregiver exhibits violence that is unmanaged, unpredictable, and/or highly consistent. There is nothing within the family or household that can counteract the violence.

The active aspect of this sort of behavior and emotion could easily lash out toward family members and children, specifically, who may be targets or bystanders; vulnerable children who cannot self-protect—who cannot get out of the way and who have no one to protect them—could experience severe physical or emotional effects from the violence. This includes situations involving domestic violence whereby the circumstance could result in severe effects including physical injury, terror, or death.

The judgment about imminence is based on sufficient understanding of the dynamics and patterns of violent emotions and behavior. To the extent the violence is a pervasive aspect of a person's character or a family dynamic, occurs either predictably or unpredictably, and has a standing history, it is conclusive that the violence and likely severe effects could or will occur for sure and soon.

This impending danger includes both behaviors and emotions as illustrated in the following examples.

- Family violence involves physical and verbal assault on a parent in the presence of a child; the child witnesses the activity and is fearful for self and/or others.
- Family violence is occurring and a child is assaulted.
- Family violence is occurring and a child may be attempting to intervene.
- Family violence is occurring and a child could be inadvertently harmed even though the child may not be the actual target of the violence.
- Parent/caregiver who is impulsive, exhibiting physical aggression, having temper outbursts or unanticipated and harmful physical reactions (e.g., throwing things).
- Parent/caregiver whose behavior outside of the home (e.g., drugs, violence, aggressiveness, hostility) creates an environment within the home which threatens child safety (e.g., drug parties, gangs, drive-by shootings).
- Family violence is unmanaged and out of control due to nothing within the household to manage or mitigate the caregiver(s) behavior.

7. One or both parents'/caregivers' emotional stability, developmental status, or cognitive deficiency seriously impairs their ability to care for the child(ren).

Application of the Safety Threshold Criteria
The lack of the caregiver's ability to meet the immediate needs of a child may be due to a physical disability, significant developmental disability, or mental health condition that prevents adequate parental role performance. The disability or condition is significant, pervasive, and consistently debilitating to the point where the child's protection needs are being compromised. This refers to caregivers who CAN NOT perform their parental responsibilities due to a lack of fundamental deficiencies.

This impending danger is illustrated in the following examples:

- Parent/caregiver's mental, intellectual and/or physical disability prohibits his/her ability to adequately and consistently assure that a child's essential basic and safety needs are met.
- Parent/caregiver exhibits a distorted perception of reality and the disorder reduces his/her ability to manage his/her behavior (unpredictable, incoherent, delusional, debilitating phobias) in ways that threaten safety.
- Parent/caregiver exhibits anxiety/depressed behavior that manifests feelings of hopelessness or helplessness and is immobilized by such symptoms, resulting in a failure to protect and provide basic needs.
- Parent/caregiver is observed to be acting bizarrely and is unable to respond logically to requests or instructions.
- Parent/caregiver is not consistent in taking medication to control his/her mental disorder that threatens child safety.
- Parent/caregiver is emotionally immobilized (chronically or situationally) and cannot manage behavior.
- Parent/caregiver's intellectual capacities affect judgment in ways that prevent the provision of adequate basic needs.
- The parent/caregiver is significantly developmentally disabled and is observed to be unable to provide appropriate care for the child.
- Parent/caregiver is unaware of what basic care is required for the child. This example is likely identified in conjunction with other above examples.

8. One or both parents/caregivers cannot control their behavior.

This impending danger is concerned with self-control. It is concerned with a person's ability to postpone, to set aside needs; to plan; to be dependable; to avoid destructive behavior; to use good judgment; to not act on impulses; to exert energy and action; to inhibit; to manage emotions; and so on. This is concerned with self-control as it relates to child safety and protecting children. So, it is the lack of caregiver self-control that places vulnerable children in jeopardy. To identify this impending danger there must be specific information to suggest that a caregiver's impulsive behaviors, addictive behaviors, bizarre behaviors, compulsive behaviors, etc. cannot be controlled by the individual. The out-of-control behaviors result in the inability or unwillingness of the caregiver to provide for the basic needs and safety of the child.

This refers to caregiver's who WILL NOT perform their parental duties and responsibilities due to impulsive behaviors. (This should not be considered the same as caregivers with developmental issues, e.g., serious mental health or cognitive delays. Caregivers with these issues would be considered in Impending #7 of these definitions.)

<u>Application of the Danger Threshold Criteria</u>

This impending danger is self-evident as related to meeting the out-of-control criterion. Typically, application of the unmanaged criterion often leads to observations of behavior but, clearly, many of the self-control issues rest in emotional areas. In other words, a caregiver may be using substances as an escape for feeling sad or depressed. However, those who use substances may have become sufficiently dependent that they have lost their ability for self-control in areas concerned with protection.

Severity should be considered from two perspectives. The lack of self-control is significant. That means that it has moved well beyond the person's capacity to manage it regardless of self-awareness, and the lack of control is concerned with serious matters as compared, say, to lacking the self-control to exercise. The effects of the danger could result in severe effects as caregivers lash out at children, fail to supervise children, leave children alone, leave children in the care of irresponsible others, or sexually abuse/exploit children.

A presently evident and standing problem of poor impulse control or lack of self-control establishes the basis for imminence. Since the lack of self-control is severe, the examples of it should be rather clear and add to the certainty one can have about severe effects probably occurring in the near future.

This includes behaviors other than aggression or emotions that affect child safety as illustrated in the following examples:

- Parent/caregiver is chemically dependent and unable to control the dependency's effects.
- Parent/caregiver use of substances routinely leaves the children in precarious situations (e.g., unsupervised, supervised by an unreliable caregiver).
- Parent/caregiver makes impulsive decisions and plans which leave the children in precarious situations (e.g., unsupervised, supervised by an unreliable caregiver).
- Parent/caregiver spends money impulsively resulting in a lack of basic necessities.
- Parent/caregiver has addictive patterns or behaviors (e.g., addiction to gambling or computers) that are uncontrolled and leave the children in unsafe situations (e.g., failure to supervise or provide other basic care).
- Parent/caregiver cannot control sexual impulses.
- Parent/caregiver is not dependable related to the inability to delay gratifications and/or impulsive needs.
- Parent/caregiver does not demonstrate the use of good judgment and/or the ability to manage emotions, which negatively affects the quality and performance of daily life management.
- Parent/caregiver impulsive behaviors result in poor performance of daily life management (e.g., substance withdrawals, low energy, fatigue).

9. Family does not have resources to meet basic needs.

"Basic needs" refers to the family's lack of (1) minimal resources to provide shelter, food, and clothing or (2) the capacity to use resources if they were available. This Impending Danger is likely identified or dependent on selecting other impending dangers.

Application of the Danger Threshold Criteria
There could be two things unmanaged here. There are not sufficient resources to meet the safety needs of the child. There is nothing within the family's reach to address and manage the absence of needed protective resources. The second question related to management is concerned with the caregiver's lack of being able to manage their impulses regarding the use of resources or problem-solving concerning use of resources.

The lack of resources must be so acute that their absence could have a severe effect right away. The absence of these basic resources could cause serious injury, serious medical or physical health problems, starvation, or serious malnutrition.

Imminence is judged by context. What context exists today concerning the lack of resources? If extreme weather conditions or sustained absence of food define the context, then the certainty of severe effects occurring soon is evident. This certainty is influenced by the specific characteristics of a vulnerable child (e.g., infant, ill, fragile, etc.).

This impending danger is illustrated in the following examples:

- Family has no money.
- Family has no food, clothing, or shelter.
- Family finances are insufficient to support needs (e.g., medical care) that, if unmet, could result in a threat to child safety.
- Parents/caregivers lack life management skills to properly use resources when they are available.
- Family is routinely using their resources for things (e.g., drugs) other than their basic care and support thereby leaving them without their basic needs being adequately met.
- Child's basic needs exceed normal expectations because of unusual conditions (e.g., disabled child) and the family is unable to adequately address the needs.

Assessment Area 4: Parenting Discipline and Parenting General

Caregiver Protective Capacities related to Parenting Discipline and Parenting General

BEHAVIORAL

The caregiver sets aside her/his needs in favor of a child.	This refers to people who can delay gratifying their own needs, who accept their children's needs as a priority over their own. People who do for themselves after they've done for their children. People who sacrifice for their children. People who can wait to be satisfied.

	People who are internally motivated to vigilantly perform duties and responsibilities necessary to meet children's needs. People who seek ways to satisfy their children's needs as the priority.
The caregiver has/demonstrates adequate skill to fulfill caregiving responsibilities.	This refers to the possession and use of skills that are related to being protective. People who can feed, care for, supervise children according to their basic needs. People who can handle, manage, oversee as related to protectiveness. People who can cook, clean, maintain, guide, shelter as related to protectiveness. People who are in the home and available, accessible, and willing/able to perform parenting duties (e.g., Diminished = incarceration, abandonment, etc.). People who display concern for a child. This refers to a sensitivity to understand and feel some sense of responsibility for a child and what the child is going through in such a manner to compel one to comfort and reassure. People who show compassion through sheltering and soothing a child. People who calm, pacify, and appease a child. People who physically take action or provide physical responses that reassure a child, that generate security.
The caregiver is adaptive as a caregiver.	This refers to people who adjust and make the best of whatever caregiving situation occurs. People who are flexible and adjustable. People who accept things and can move with them. People who are creative about caregiving. People who come up with solutions and ways of behaving that may be new, needed and unfamiliar, but more fitting.

COGNITIVE

The caregiver recognizes the child's needs.	This refers to seeing and understanding a child's capabilities, needs, and limitations correctly. People who know what children of a certain age or with particular characteristics are capable of. People who respect uniqueness in others. People who see a child exactly as the child is and as others see the child.

	People who recognize the child's needs, strengths, and limitations. People who can explain what a child requires, generally, for protection and why. People who see and value the capabilities of a child and are sensitive to difficulties a child experiences. People who appreciate uniqueness and difference. People who are accepting and understanding.
The caregiver understands his/her protective role.	This refers to awareness…knowing there are certain solely owned responsibilities and obligations that are specific to protecting a child. People who possess an internal sense and appreciation for their protective role. People who can explain what the "protective role" means and involves and why it is so important. People who recognize the accountability and stakes associated with the role. People who value and believe it is his/her primary responsibility to protect the child.
The caregiver plans and articulates a plan to protect the child.	This refers to the thinking ability that is evidenced in a reasonable, well-thought-out plan. People who are realistic in their ideas and arrangements about what is needed to protect a child. People whose thinking and estimates of what dangers exist and what arrangement or actions are necessary to safeguard a child. People who are aware and show a conscious, focused process for thinking that results in an acceptable plan. People whose awareness of the plan is best illustrated by their ability to explain it and reason out why it is sufficient.

EMOTIONAL

The caregiver expresses love, empathy and sensitivity toward the child; experiences specific empathy with the child's perspective and feelings.	This refers to active affection, compassion, warmth, and sympathy. People who fully relate to, can explain, and feel what a child feels, thinks, and goes through. People who relate to a child with expressed positive regard and feeling and physical touching. People who are understanding of children and their life situation.

The caregiver is positively attached to the child.	This refers to a strong attachment that places a child's interest above all else. People who act on behalf of a child because of the closeness and identity the person feels for the child. People who order their lives according to what is best for their children because of the special connection and attachment that exists between them. People whose closeness with a child exceeds other relationships. People who are properly attached to a child.
The caregiver supports and is aligned with the child.	Supports - This refers to actual, observable sustaining, encouraging, and maintaining a child's psychological, physical, and social well-being. People who spend considerable time with a child filled with positive regard. People who take action to assure that children are encouraged and reassured. People who take an obvious stand on behalf of a child. Aligned - This refers to a mental state or an identity with a child. People who strongly think of themselves as closely related to or associated with a child. People who think that they are highly connected to a child and therefore responsible for a child's well-being and safety. People who consider their relationship with a child as the highest priority.

Impending Dangers related to Parenting Discipline and Parenting General

10. No adult in the home will perform parental duties and responsibilities.

This refers only to adults (not children) in a caregiving role. Duties and responsibilities related to the provision of food, clothing, shelter, and supervision are to be considered at a basic level, and the caregiver is not available to perform parental duties.

Application of the Danger Threshold Criteria

The caregiver who normally is responsible for protecting the child is absent, likely to be absent, or is incapacitated in some way or becomes incapacitated. Nothing within the family can compensate for the condition of the caregiver which meets the unmanaged criterion.

Duties and responsibilities are at a critical level that if not addressed represent a specific danger is posed to a vulnerable child. The lack of meeting these basic duties and

responsibilities could result in a child being seriously injured, kidnapped, seriously ill, even dying.

That the severe effects could occur in the now or in the near future is based on understanding what circumstances are associated with the caregiver's absence or incapacity, the home condition, and the lack of other adult supervisory supports.

This impending danger includes (1) absent caregivers from the home; or (2) caregivers with diminished Behavioral Protective Capacity which renders the caregiver as incapacitated for some reason that is not related to substance use, mental health, or developmental disabilities as illustrated in the following examples:

- Parent/caregiver is or has been absent from the home for lengthy periods of time, and no other adults are available to provide basic care.
- Parents/caregivers have abandoned the children.
- Parents arranged care by an adult, but the parents'/primary caregivers' whereabouts are unknown or they have not returned according to plan, and the current caregiver is asking for relief.
- Parent/caregiver is or will be incarcerated, thereby leaving the children without a responsible adult to provide care.
- Parent's/caregiver's physical incapacitation renders the person unable to provide basic care for the children (e.g. medical condition, hospitalization, physical health issue, unexpected illness or accidental trauma, etc.)
- Parent's/caregiver's physical incapacitation may be temporary or long term. Either way, a vulnerable child is subject to a state of danger that a caregiver is unable to perform basic parental duties to meet a child's basic needs.

11. One or both parents/caregivers have extremely unrealistic expectations.

"Extremely" is meant to suggest the caregivers' unrealistic expectations are apparently and overtly negative to a heightened degree that there are implications that the child is likely to be severely harmed.

<u>Application of the Danger Threshold Criteria</u>

The expectation of the child is totally unreasonable. No one in or outside the family has much influence on altering the caregiver's perception or expectations or explaining it away to the caregiver. It is unmanaged.

The extreme expectation places far too much responsibility on a child, is totally developmentally inappropriate, is psychological distressing, and may be physically dangerous.

The extreme expectation is in place, not in the process of development. It is pervasive concerning all aspects of the child's existence. It is constant and immediate in the sense of the very presence of the child in the household or in the presence of the caregiver.

This impending danger is illustrated by the following examples:

- A child is expected to take care of himself including feeding, clothing, and physical hygiene, yet the child is far too young or undeveloped to do so.
- A child is expected to stay alone or supervise other younger children.
- A child is expected to take care of household responsibilities or even care for adults which requires the child to be exposed to or use household items or appliances that endanger the child.
- Parent/caregiver does not respond to or ignores a child's basic needs.
- Parent/caregiver allows child to wander in and out of the home or through the neighborhood without the necessary supervision.
- Parent/caregiver allows other adults to improperly influence (drugs, alcohol, abusive behavior) the child and the parent/caregiver is present or approves.
- Parent's/caregiver's expectations of the child are totally unrealistic in view of the child's condition.

12. One or both parents/caregivers have extremely negative perceptions of a child.

"Extremely" is meant to suggest a perception which is so negative that, when present, it creates child safety concerns. In order for this impending danger to be applicable, these types of perceptions must be present and the perceptions must be inaccurate. The caregivers' negative perceptions toward the child are apparent and overtly negative to a heightened degree so that there are implications that the child is likely to be severely harmed.

Application of the Danger Threshold Criteria

This refers to exaggerated perceptions. It is unmanaged because their point of view of the child is so extreme and out of touch with reality that it compels the caregiver: to react to the child, avoid the child, mentally and emotionally terrorize the child, or allow the child to be in dangerous situations. The perception of the child is totally unreasonable. No one in or outside the family has much influence on altering the caregiver's perception or explaining it away to the caregiver. It is unmanaged.

The extreme negative perception fuels the caregiver's emotions and could escalate the level of response toward the child. The extreme perception may provide justification to the caregiver for acting out or ignoring the child. Severe effects could occur with a vulnerable child such as serious physical injury, extreme neglect related to medical and basic care, failure to thrive, etc.

The extreme perception is in place, not in the process of development. It is pervasive concerning all aspects of the child's existence. It is constant and immediate in the sense of the very presence of the child in the household or in the presence of the caregiver. Anything occurring in association with the standing perception could trigger the caregiver to react aggressively or totally withdraw at any time and, certainly, it can be expected within the near future.

This impending danger is illustrated by the following examples:

- Child is perceived to be the devil, demon-possessed, evil, a bastard or deformed, ugly, deficient, or embarrassing.
- Child has taken on the same identity as someone the parent/caregiver hates and is fearful of or hostile towards, and the parent/caregiver transfers feelings and perceptions of the person to the child.
- Child is considered to be punishing or torturing the parent/caregiver.
- One parent/caregiver is jealous of the child and believes the child is a detriment or threat to the parents'/primary caregivers' relationship and stands in the way of their best interests.
- Parent/caregiver sees child as an undesirable extension of self and views child with some sense of purging or punishing.

13. One or both parents/caregivers fear they will maltreat the child and/or request placement.

This refers to caregivers who express anxiety and dread about their ability tomanage their emotions and reactions toward their child. This expression represents a “call for help.”

Application of the Danger Threshold Criteria

Unmanaged is consistent with conditions within the home having progressed to a critical point. The level of dread as experienced by the caregiver is serious and high. This is no passing thing the caregiver is feeling. The caregiver feels out of control. The caregiver is afraid of what he or she might do. A request for placement is extreme evidence with respect to a caregiver’s conclusion that the child can only be safe if he or she is away from the caregiver.

Presumably, the caregiver who is admitting to this extreme concern recognizes that his or her reaction could be very serious and could result in severe effects on a vulnerable child. The caregiver has concluded that the child is vulnerable to experiencing severe effects.

The caregiver establishes that imminence applies. The admission or expressed anxiety is sufficient to conclude that the caregiver might react toward the child at any time, and it could be in the near future.

This impending danger is illustrated in the following examples:

- Parents/caregivers state they will maltreat.
- Parent/caregiver describes conditions and situations which stimulate them to think about maltreating.
- Parent/caregiver talks about being worried about, fearful of, or preoccupied with maltreating the child.
- Parent/caregiver identifies things that the child does that aggravate or annoy the parent/caregiver in ways that make the parent want to attack the child.
- Parent/caregiver describes disciplinary incidents that have become out of control and unmanaged.
- Parents/caregivers are distressed or “at the end of their rope,” and are asking for some relief in either specific (e.g., “take the child”) or general (e.g., “please help me before something awful happens”) terms.
- One parent/caregiver is expressing concerns about what the other parent/caregiver is capable of or may be doing.

14. One or both parents/caregivers lack parenting knowledge, skill, or motivation which affects child safety.

This refers to basic parenting that directly affects a child's safety. It includes parents/primary caregivers lacking the basic knowledge or skills which prevent them from meeting the child's basic needs or their lack of motivation resulting in the parents/primary caregivers abdicating their role to meet basic needs or failing to adequately perform the parental role to meet the child's basic needs. This inability and/or unwillingness to meet basic needs creates child safety concerns.

Application of the Danger Threshold Criteria

When is this family condition unmanaged? Caregivers who do not know and understand how to provide the most basic care such as feeding infants, hygiene care, or immediate supervision. The lack of knowledge is not because the caregivers are unable or unwilling to acquire it. This refers to caregivers who are first time parents, caregivers who are not able to recognize appropriate child development milestones to meet basic needs, or young/immature caregivers. Be cautious about identifying this impending danger when assessing caregivers that have a child that has exceptional needs or conditions that a caregiver does not understand or can comprehend. Skill, on the other hand, must be considered differently than knowledge. People can know things but not be performing or just don't perform. The lack of aptitude must be clear. The basis for ineptness may vary. Motivation is yet another matter. People may be very capable, have plenty of pertinent knowledge, but simply don't care or can't generate sufficient energy to act. Remember, any of these are unmanaged by virtue of the behavior of the caregiver and the absence of the internal family to manage the situation and ensure child safety.

This impending danger is illustrated in the following examples:

- Young or immature parents/primary caregivers have little or no knowledge of a child's needs and capacity.
- Parent/caregiver does not know what basic care is or how to provide it (e.g., how to feed or diaper or how to protect or supervise according to the child's age).
- Parent's/caregiver's knowledge and skills are adequate for some children's ages and development, but not for others (e.g., able to care for an infant, but cannot control a toddler).
- Parent/caregiver does not want to be a parent and does not perform the role, particularly in terms of basic needs.

- Parent/caregiver is averse to parenting and does not provide basic needs.
- Parent/caregiver avoids parenting and basic care responsibilities.
- Parent/caregiver allows others to parent or provide care to the child without concern for the other person's ability or capacity (whether known or unknown).
- Parent/caregiver does not know, denies the need for, or does not apply basic safety measures (e.g., keeping medications, sharp objects, or household cleaners out of reach of small children).
- Parents/caregivers place their own needs above the children's needs thereby affecting the children's safety.
- Parents/caregivers do not believe the children's disclosure of abuse/neglect even when there is a preponderance of evidence, and this affects the children's safety.

15. **Child has exceptional needs which the parents/caregivers cannot or will not meet.** "Exceptional" refers to specific child conditions (e.g., intellectual disability, blindness, physical health/disability, mental health) which are either organic or naturally induced as opposed to parentally induced. The key here is that the parents, by not addressing the child's exceptional needs, will not or cannot meet the child's basic needs.

    <u>Application of the Danger Threshold Criteria</u>

    The caregiver's ability and/or attitude are what is unmanaged. If you can't do something, you are unable to manage the task. If you do not want to do something and therefore do not do it but you are the principal person who must do the task, then you are not managing the situation.

    This does not refer to caregivers who do not do very well at meeting a child's needs. This refers to specific deficiencies in parenting that must occur for the "exceptional" child to be safe. The status of the child helps to clarify the potential for severe effects. Clearly, "exceptional" includes physical and mental characteristics that result in a child being highly vulnerable and unable to protect or fend for him or herself.

    The needs of the child are acute, require immediate and constant attention. The attention and care is specific and can be related to severe results when left unattended. Imminence is obvious. Severe effects could be immediate to soon.

    This impending danger is illustrated in the following examples:

- Child has a physical or mental condition that, if untreated, is a danger to the child's safety.
- Parent/caregiver does not recognize the condition.
- Parent/caregiver views the condition as less serious than it is.
- Parent/caregiver refuses to address the condition for religious or other reasons.
- Parent/caregiver lacks the capacity to fully understand the condition or the danger to the child.
- Parent/caregiver allows the child to live or be placed in situations in which harm is increased by virtue of the child's condition.
- Parent's/caregiver's expectations of the child far exceed the child's capacity thereby placing the child in unsafe situations.
- Parents'/caregivers' parenting skills are exceeded by a child's special needs and demands in ways that affect safety.

Chapter 13. Impending Danger Safety Plan Determination and Conditions for Return

Impending Danger Safety Plan Determination

When the FFA Impending Danger Safety Plan Determination indicates that there are children in the family that are unsafe, the case is always open for ongoing services. The next step is for the Investigator to conduct the Impending Danger Safety Plan Determination. Additionally, if it appears the Safety Plan is likely to involve child placement, the Investigator must collaborate with the Supervisor to identify Conditions for Return (CFR). Once the Impending Danger SPD, prospective Safety Plan, and CFR (if applicable) are approved by the Supervisor, the Investigator presents the prospective Impending Danger Safety Plan to caregivers and discusses CFR if the Safety Plan involves child placement.

Whether a Present Danger Safety Plan has been in place and remains in place as the FFA concludes, the Impending Danger SPD must be completed before the FFA can be finalized.

If there is Impending Danger and there is no Present Danger Plan in place, the Impending Danger SPD must be completed; the Supervisory consultation must have occurred; and the Impending Danger Safety Plan drafted for presentation to caregivers promptly. If the Impending Danger Safety Plan involves child placement, the Investigator must also draft Conditions for Return for consideration and approval by the Supervisor.

The Impending Danger SPD is completed by the Investigator for presentation to the Supervisor during consultation. The consultation involves discussion about the Safety Determination and the results of the Impending Danger SPD, including the Investigator's conclusion about, and/or along with, a draft Safety Plan. Once Supervisory consultation has occurred, and the SPD and the prospective Safety Plan have been approved, the Investigator meets with caregivers (sometimes referred to as the SPD visit or meeting) to discuss the prospective Safety Plan; seeks their participation in finalizing the Safety Plan; and seeks their cooperation with the final established Safety Plan.

Purposes of the Impending Danger Safety Plan Determination

The purposes of the SPD are:

- To create the least intrusive, sufficient Safety Plan that ensures child safety as FSU Caseworkers begin and continue their intervention; and

- To attempt to involve caregivers in the Safety Planning process as much as they are able and willing.

The result of the Impending Danger SPD analysis is to rule in or rule out the use of an In-Home Safety Plan.

Understanding Impending Danger

To accurately complete the Impending Danger SPD, the Investigator must have a precise understanding of Impending Danger. This cannot be emphasized enough. This understanding includes the quality, nature and intensity of specific threatening behaviors; frequency of demonstration of behavior or threatening circumstances; influences or contributors to threatening behavior or circumstances; what typically is going on when threatening behavior or circumstances occur; and who is around and who is involved. The Investigator must have this kind of detailed understanding of the Impending Danger to determine what actions and level of effort are necessary to manage the Impending Danger. This is the fundamental function of the Impending danger SPD.

The following chart provides a delineation of knowledge and understanding of how Impending Danger is occurring in a family that is necessary to effectively judge the SPD Analysis Criteria.

SPD Analysis Criteria: Conditions Required for Use of an In-Home Safety Plan	What Must Be Known and Understood to Judge Conditions Required for an In-Home Safety Plan
Does the child's primary caregiver(s) have a suitable place to reside where an In-Home Safety Plan can be considered? The child's primary caregiver(s) must reside in the child's own home which is a suitable, sustainable location.	One must know and be able to describe the physical and health conditions of the home, including whether such conditions were related to the Impending Danger that was occurring in the home and family. What has been the duration and the frequency of the Impending Danger related to threatening living conditions, and what are the influences that stimulated it? How predictable is a suitable living arrangement in relation to Impending Danger? (Refer to SPD Criteria for a fuller explanation.)
Is there confidence in the sustainability of the Safety Plan in the current location of the caregivers?	One must know and be able to describe the caregiver behavior, life style, and life management that contributes, or contributed, to the inability to maintain a

	safe home for the child. Impending Danger such as self- and impulse-control, cognitive functioning, and violence must be understood in relationship to the predictability of sustainability.
Is the home environment consistent enough to allow Safety Actions in accordance with the Safety Plan, and for people participating in Safety Plan to be in the home safely without disruption (e.g., reasonable schedules, routine, structure, general predictability of family functioning)?	One must know and be able to describe how the Impending Danger is occurring in the home and family, with respect to individual and family behavior, reliable life style as expressed through routine and habits, chaos and disruption resulting from activities occurring in the home, including individuals who frequent the home. What is the duration and the frequency of the Impending Danger associated with the home environment, and what are the influences that stimulate it? How predictable is the Impending Danger associated with the home environment? (Refer to SPD Criteria for a fuller explanation.)
Are the primary caregivers cooperative with DCYF, and willing to participate in the development of the In-Home Safety Plan?	One must know and be able to describe how the Impending Danger occurring in the home and family is associated with caregiver attitude, behavior, and tolerance of FFA intervention, which includes the nature and context of the relationship existing between the caregiver and the Investigator. Impending Danger that is associated with such caregiver personal characteristics as impulse control, self-management, trust, and openness are important to understand with respect to Impending Danger. How predictable is something such as a caregiver's cooperation and willingness to commit, as evidenced by what is known about the Impending Danger? (Refer to SPD Criteria for a fuller explanation.)
Are the primary caregivers willing to allow Safety Actions to be	One must know and be able to describe how the Impending Danger occurring in the

provided in accordance with the Safety Plan?	home and family is associated with violence, acting out, self-control and self-management. Understanding Impending Danger related to individual and family behavior includes the above, related to tolerance, intention, and trustworthiness to meet a commitment.
Do the primary caregivers possess the necessary ability/capacity to participate in an In-Home Safety Plan, and do what they must do as identified in an In-Home Safety Plan?	One must know and be able to describe how the Impending Danger, specific to caregiver functioning, occurs in daily living and family functioning. Understanding is necessary related to caregiver reliability, self-control and self-management, and cognitive and emotional functioning, related to common everyday matters which have been associated with Impending Danger.
Are there sufficient resources within the family or community to perform the Safety Actions necessary to manage the identified Impending Danger Threats?	Based upon a keen understanding of how Impending Danger is occurring, one must be able to identify what is required to control the Impending Danger in an In-Home Safety Plan. Impending Danger must be understood in relation to when it occurs, how often it occurs or exists, how long the danger persists, what influences occur in conjunction with the danger, what stimulates the danger, and what typically is happening when the danger is present. Knowing the dynamics of Impending Danger is necessary to knowing how to control the Impending Danger. One must specifically be able to identify what is required for necessary In-Home Safety Actions and Safety Actions related to: behavior management, basic parenting assistance, crisis management, supervision and observation, and resource acquisition. (Refer to SPD Criteria for a fuller explanation.)

Process for Completing the Impending Danger SPD

There is nothing more important that accurately completing the Impending Danger Safety Plan Determination Process. This process is the difference between children being left in danger or children being removed from their caregivers unnecessarily. Most instances the Investigator will know enough based upon the FFA process, information collection, and caregiver interaction and can confidently complete the Impending Danger SPD. The Investigator proceeds to complete the Impending Danger SPD and the draft Impending Danger Safety Plan, consults with the Supervisor, and then, based upon Supervisory approval, meets with caregivers to inform them of the results of the SPD, and discuss with them the Safety Plan options and Conditions for Return, if applicable. During this meeting, the Impending Danger Safety Plan can be signed by the Caregivers and Impending Danger Safety Plan Participants when available and appropriate.

There may be instances when the Investigator needs to collect additional information or discuss safety planning with the caregivers and potential impending danger safety plan participants. When he Investigator is unable to complete the Impending Danger Safety Plan Determination, one of three options must be decided by the Supervisor. The options for proceeding with the Impending Danger SPD are:

Option 1 - Based upon Supervisor Consultation, the Investigator is directed to gather more information from caregivers in order to confidently complete the Impending Danger SPD. This may require additional personal contact, phone calls with potential Impending Danger Safety Plan Participants, or other types of contact based upon Supervisor Consultation. This option results in the Investigator then completing the Impending Danger SPD, drafting a Safety Plan, and consulting with the Supervisor prior to facilitating a Impending Danger Safety Planning meeting with caregivers.

Option 2 - Although less common, this option may be necessary because of conflicts or other disruptions to the working relationship. The Investigator experiences the caregivers as highly resistant, in denial, possibly hostile, or refusing to cooperate for other reasons, such as being advised by an attorney to avoid cooperating (which may involve refusal to participate, or refusal to agree to anything). The Investigator proceeds to complete the Impending Danger SPD and the draft Impending Danger Safety Plan, and consults with the Supervisor. During consultation, the process of developing the Safety Plan will be determined. Given the nature of caregiver behavior and interaction, this option may best be accomplished through a meeting that involves the Investigator, the Supervisor, Caregivers, and others who have a stake in the case and in the Safety Plan. While the intention is to always involve caregivers and encourage participation, this option must result in an explanation of FFA findings about safety, the decision to open the case for FSU Services, and the Impending Danger Safety Plan that has been drafted. If placement is involved, Conditions For Return must also be discussed and explained. When caregiver resistance is such that he/she refuses to even participate in a meeting, the Investigator consults with the Supervisor to complete a plan for implementing necessary decisions and communication regarding the Safety Plan, including necessary legal action and communication.

Conditions for Return (CFR)

If the Impending Danger SPD results in a decision that an Out-of-Home Safety Plan is necessary to sufficiently manage child safety, the next immediate activity involves documentation by the Supervisor and Investigator of explicit statements detailing requirements for an In-Home Safety Plan to be established, so that the child can be returned home. These statements are based upon the Impending Danger SPD analysis questions and represent conditions that are necessary in order to answer the analysis questions in the affirmative (which justifies an In-Home Safety Plan.)

In other words, the requirements (i.e. conditions that must exist) in order to return children to their caregivers are directly connected to the specific reasons and justification from the Impending Danger SPD as to why an In-Home Safety Plan could not be put into place at the conclusion of the FFA.

Conditions For Return are the Investigator's written statements, approved by the Supervisor which identifies specific conditions and circumstances that were determined to be insufficient at the time of Safety Planning (to implement an In-Home Safety Plan) and must exist in order for 1) an In-Home Impending Danger Safety Plan to be installed, and 2) a child to be reunified with his parent/caregiver which the child was removed. Conditions For Return also include the behaviors of Safety Plan Participants which is required in order to install an In-Home Safety Plan.

Impending Danger SPD Questions and Example Conditions for Return

Impending Danger Safety Plan determination questions for ruling in or ruling out an In-Home Safety Plan consists of seven areas of analysis.

1. Does the child's primary caregiver(s) have a suitable place to reside where an In-Home Safety Plan can be considered?

2. Is there confidence in the sustainability of the Safety Plan in the current location of the caregivers?

3. Is the home environment consistent enough to allow Safety Actions in accordance with the Safety Plan, and for people participating in the Safety Plan to be in the home safely without disruption (e.g. reasonable schedules, routine, structure, general predictability of family functioning)?

4. Are the primary caregivers cooperative with DCYF; and willing to participate in the development of the In-Home Safety Plan?

5. Are the primary caregivers willing to allow Safety Actions to be provided in accordance with the Safety Plan?

6. Do the primary caregivers possess the necessary ability/capacity to participate in an In-Home Safety Plan, and do what they must do as identified in an In-Home Safety Plan?

7. Are there sufficient resources within the family or community to perform the Safety Actions necessary to manage the identified Impending Danger Threats?

Suitable Residence

1. Does the child's primary caregiver(s) have a suitable place to reside where an In-Home Safety Plan can be considered?

This is straightforward in the sense of making a judgment about where a caregiver lives and determining the suitability of the caregiver's residence in regard to implementing an In-Home Safety Plan. The critical issue has to do with physical existence of a location, place, structure, residence that is suitable. Suitable has to do with the structure or physical setting, physical safety, and physical health. Suitable, in relationship to an In-Home Safety Plan considers accessibility to others, neighborhood safety, physical accommodation of others in the place, adequate home arrangements to accommodate others being in the home (e.g., Safety Plan Participants who may be expected to be in the home for various lengths of time.) Even though the question refers to "the child's own home," it does not necessarily preclude a relative's or friend's home, or motels or shelters, from potential In-Home Safety Planning locations.

<u>Justification for Use of an In-Home Safety Plan Based on a Suitable Place to Reside</u>

(These examples would support selecting "Yes" on the Impending Danger SPD)

- The living place is established, known, can be located, has an address.
- It is confirmed that the caregivers are, and have been, residing in the living place.
- Caregivers may have had housing difficulties but there is no indication that repeated difficulties with maintaining housing is characteristic of larger Adult Functioning issues.

- Caregivers can be counted to continue residing in current location.
- No indication exists that caregivers will flee.
- The living place (e.g., home, trailer, apartment, hotel, shelter situation in specific cases) is suitable to support the use of an In-Home Safety Plan.
- The co-habitable situation (with friends, immediate, or extended family) is acceptable, and the people in the home co-habiting with the caregivers are known, and found to be suitable and reliable.
- The living place meets minimal standards for a dwelling in terms of space, conditions, utilities, physical safety, physical health, etc.
- The living place exists in a community that is reasonably safe, accessible to others, and can accommodate the physical requirements associated with an In-Home Safety Plan.

Conditions For Return and Use of an In-Home Safety Plan Based on a Suitable Place to Reside

CFR statements associated with the suitability of a caregiver's living place should reflect what needs to exist based upon Impending Danger, and the analysis of individual and family behaviors and conditions that justified an Out-of-Home Safety Plan.

See the previous examples related to the justification for an In-Home Safety Plan as a reference point for considering possible Conditions For Return related to permanent residence.

Following are examples of Conditions For Return related to the suitability of the caregiver's living place; this list is not exhaustive. Additionally, CFR should always reflect individualization of the caregiver and family circumstances. CFR should be tailored based upon the uniqueness of the family situation. Depending on the particular case situation, one or more of these types of Conditions For Return might be considered, along with others not on the list. The Investigator is encouraged to attempt to individualize the statements. Notably, some examples suggest providing specific descriptions. Certainly, Conditions For Return involving a person (i.e., caregiver, child, or someone else) should identify the person by name.

- Caregiver has a place to live which can be counted on as continuing and acceptable in which to put in place an In-Home Safety Plan.
- Caregiver maintains a permanent residence and there is confidence that the living situation is stable.

- Caregiver maintains a permanent residence for a minimum of **x** number of weeks [designate time period for specific cases where residence instability has been a chronic problem].
- The condition of the place to live is structurally adequate [describe what specifically about the condition of residence must be different] to safely put an In-Home Safety Plan in place.
- The condition of the living place meets community standards for cleanliness, order and organization, physical safety, and physical health.
- The living place has minimal acceptable requirements for space, utilities, access, and shelter.
- Caregiver is able to discuss having a reasonable plan for how he/she will use resources to maintain a stable residence.

Sustainability of location

2. ***Is there confidence in the sustainability of the Safety Plan in the current location of the caregivers?***

This analysis question amplifies the first question about a suitable place to live. It is separated from that analysis to ensure that sufficient attention is given to judging the sustainability of a living place, keeping in mind that an In-Home Safety Plan is implemented only if there is high confidence that it can be sustained. While there is no exact qualification as to what constitutes sustainability, consider the length of time until the next official case review, which occurs every 90 days. So, in other words, the judgment about sustainability reasonably could be that there is confidence that the living place will remain available for the next 3 months.

Justification for Use of an In-Home Safety Plan Base on the Sustainability of a Place to Live

(These examples would support selecting "Yes" on the Impending Danger SPD)

- Caregivers have lived in the place for a sustained period.
- Caregivers have a history of being able to maintain a place to live.
- Caregivers can be counted to continue residing in current location.
- No indication exists that caregivers will flee.

- When the living place involves living with others, those who have authority over the living place are committed to the co-habitable situation involving the caregivers and their children.

- Minimal adequacy of the dwelling in terms of space, conditions, utilities, etc.

Conditions For Return and Use of an In-Home Safety Plan Based on the Sustainability of a Place to Live

CFR statements associated with the sustainability of a caregiver's living place should reflect what needs to exist based upon Impending Danger, and the analysis of individual and family behaviors and conditions that justified an Out-of-Home Safety Plan.

See the previous examples related to the justification for an In-Home Safety Plan as a reference point for considering possible Conditions For Return related to a sustainable place to live.

Following are examples of Conditions For Return related to the sustainability of the caregiver's living place; this list is not exhaustive. Additionally, CFR should always reflect individualization of the caregiver and family circumstances. CFR should be tailored based upon the uniqueness of the family situation. Depending on the particular case situation, one or more of these types of Conditions For Return might be considered, along with others not on the list. The Investigator is encouraged to attempt to individualize the statements. Notably, some examples suggest providing specific descriptions. Certainly, Conditions For Return involving a person (i.e., caregiver, child, or someone else) should identify the person by name.

- Caregiver has a sustainable place to live in which to put in place an In-Home Safety Plan.

- Caregiver maintains a sustainable place to live and there is confidence that the living situation is continue.

- Caregiver resides in, and maintains, a living place for a minimum of **x** number of weeks [designate time period for specific cases where residence instability has been a chronic problem].

- Caregiver has a reasonable plan for how he/she will use resources to maintain a continuing residence.

Home Environment

3. Is the home environment consistent enough to allow Safety Actions in accordance with the Safety Plan, and for people participating in the Safety Plan to be in the home safely without disruption (e.g. reasonable schedules, routine, structure, general predictability of family functioning)?

Is it reasonable to expect and conclude that there would be no interference with or impediment to an In-Home Safety Plan and the Safety Plan Participants carrying out planned activities? To have confidence in establishing and sustaining an In-Home Safety Plan, the home environment should have some regular routine and predictability. The family and caregiver are predictable and reliable; family members have schedules that they attempt to maintain; schedules are associated with their daily activities which can be matched with In-Home Safety Planning.

The home environment should not have a high frequency of people coming and going; people are not aggressively arguing or physically fighting; there are not day-to-day crises that disrupt home life. There is some understanding about each day being somewhat the same, without uproar or circumstances that would impede the Safety Plan and Safety Plan Participants.

<u>Justification for Use of an In-Home Safety Plan Based on Home Environment</u>

(These examples would support selecting "Yes" on the Impending Danger SPD)

- The home environment may have aspects that are out of control, but the circumstances are consistent and calm enough to be amenable to being organized, and can be sufficiently controlled and managed by Safety Actions.

- Apparent situational crisis is acute, and Safety Actions are sufficient to address and reduce the crisis.

- The overall home environment is can be relied on and is consistently stable enough to accommodate Safety Actions at the required level and ensure the personal safety of Safety Plan Participants.

- Behavior and emotions may be out of control, but generally orderly and calm enough (not aggravated, extreme, or all-consuming) to be controlled and managed by Safety Actions.

- There is some appearance of overall family and individual family member routines, schedules, and daily life to support the ability to develop an In-Home Safety Plan targeting specific days and times.

- The family situation is generally predictable from week to week.

- While caregiver functioning may be out of control in certain areas affecting child safety, there is a reasonable understanding of how the family operates and manages on a routine basis to allow for Safety Actions.

- A reasonable level of reliability exists in the day-to-day dynamics of the home situation and interaction among family members.

- A reasonable level of reliability exists that people living in the home and day-to-day circumstances will not change without reasonable notice.

Conditions For Return and Use of an In-Home Safety Plan Based on Home Environment

CFR statements associated with the home environment should reflect what would need to be different compared to the conditions that justified an Out-of-Home Safety Plan. See the previous examples related to the justification for an In-Home Safety Plan as a reference point for considering possible Conditions For Return related to home environment.

Following are examples of Conditions For Return related to the home environment; again, the list is not exhaustive. Depending on the particular case situation, one or more of these types of Conditions For Return might be considered, along with others not on the list. The Investigator is encouraged to attempt to individualize the statements. Notably, some examples suggest providing specific descriptions. Certainly, Conditions For Return involving a person (i.e., caregiver, child, or someone else) should identify the person by name.

- The home environment is consistent from day to day [describe what would be different] enough for Safety Actions to be put into place.

- Specific individuals [identify and describe what was problematic about them being in the home] are no longer residing in the home, and the caregiver's commitment to keep them out of the home can be sufficiently supported by Safety Actions.

- The child no longer expresses fear of the home situation, daily atmosphere, and home environment.

- The home environment, dynamics of family interactions, and caregiver functioning (Impending Danger) are sufficiently understood, so that Safety Actions can supervise and monitor the situation, manage behavior, manage stress, and/or provide basic parenting assistance [describe specifically what Safety Actions would be necessary].

- The home environment is more structured, and a general routine exists that makes it possible to plan for the use of Safety Actions.

- There are no unknown, questionable, or threatening people in and out of the home which influence the home environment, climate, or atmosphere, or exist as a threatening influence.

- All individuals residing in the home are known to the agency, cooperative, and open to Safety Service intervention.

Justification for Use of an In-Home Safety Plan Based on Cooperation and Willingness to Participate in Development of the In-Home Safety Plan

4. Are the primary caregivers cooperative with DCYF, and willing to participate in the development of the In-Home Safety Plan?

Cooperating with DCYF typically should be no mystery by the time the SPD analysis question is considered. Reasonably, through the FFA process, there have been experiences, encounters, and sufficient time with caregivers to judge whether cooperation at the Safety Planning juncture is likely. This SPD question is concerned with involvement of caregivers in planning and understanding the Safety Plan being considered. Notice the analysis is about participation in developing the In-Home Safety Plan. Cooperation and willingness to discuss, consider, and even participate in development of ideas and resources for the In-Home Safety Plan is evidenced by the caregiver's interest and responsiveness during the SPD visit or meeting to address findings of the FFA, SPD analysis results, and the prospective Safety Plan. Cooperation and willingness can exist even when the caregiver does not agree with the FFA findings or the reasons identified for a Safety Plan. Cooperation has to do with the caregiver's attitude, demeanor, and responsiveness. Willingness is qualified by the caregiver's openness to understand the details of what will be required for an In-Home Safety Plan. This includes who will be involved, and the necessary frequency and intrusiveness into daily and weekly home life.

(These examples would support selecting "Yes" on the Impending Danger SPD)

- Caregiver agrees to and presents acceptable interest and openness to consider an In-Home Safety Plan.

- Caregiver understands what is required, and agrees to allow others into the home at the level required.

- Caregiver involvement related to Safety Planning does not include, or minimally includes, arguing, debating, rationalizing, or other avoiding

responses and demeanor when discussing Safety Planning in general and the requirements associated with an In-Home Safety Plan.

- Caregiver is open to exploring In-Home Safety options.
- Caregiver can participate in discussions.
- Caregiver does not reject or avoid involvement.
- Caregiver is willing to consider the steps it would take to keep the child in the home.
- Caregive is believable when communicating a willingness for cooperating in developing an In-Home Safety Plan.
- Caregiver is open to the parameters of an In-Home Safety Plan, arrangements, and Safety Plan Participants.
- Caregiver identifies him/herself as a caregiver for a child.
- Caregiver demonstrates an investment in having the child remain in the home.

Conditions For Return and Use of an In-Home Safety Plan Based on Cooperation and Willingness to Participate in Development

CFR statements associated with a caregiver's lack of cooperation and willingness should reflect what would be different compared to the caregiver's behavior, demeanor, and resistance to participate in developing an In-Home Safety Plan which justified an Out-of-Home Safety Plan. See the previous examples related to the justification for an In-Home Safety Plan as a reference point for considering possible Conditions For Return related to cooperation and willingness to participate in the development of an In-Home Safety Plan.

Following are examples of Conditions For Return related to cooperation and willingness to participate in developing an In-Home Safety Plan; the list is not exhaustive. Depending on the particular case situation, one or more of these types of Conditions For Return might be considered, along with others not on the list. The Investigator is encouraged to attempt to individualize the statements. Notably, some examples suggest providing specific descriptions. Certainly, Conditions For Return involving a person (i.e., caregiver, child, or someone else) should identify the person by name.

- Caregiver participates in candid discussion about the necessity for, and details of, a Safety Plan, and how the Safety Plan addresses the child's safety.

- Caregiver expresses a genuine interest in doing what is necessary to have the child returned to the home.

- Caregiver is willing to allow for Safety Actions in the home, and demonstrates openness to cooperate with the required level of involvement from Safety Plan Participants to ensure child safety.

Justification for Use of an In-Home Safety Plan Based on Allowing Safety Service and Actions to Be Provided

5. Are the primary caregivers willing to allow Safety Actions to be provided in accordance with the Safety Plan?

This analysis questions amplifies the previous question concerned with caregiver involvement in developing an In-Home Safety Plan. This judgment here is about "allowance." This crucial dynamic in Safety Determination respects caregiver self-determination and choice. While caregivers do not have a choice about whether there will be a Safety Plan, they do have latitude related to the Safety Management intervention or type of Safety Plan they will allow and commit to. Willingness to allow Safety Actions required by an In-Home Safety Plan is evidenced initially by the caregiver's participation in Safety Planning and then by his/her lack of interference with the Safety Actions and with others involved in the Safety Plan. For the caregiver to be in agreement with, and supportive of, an In-Home Safety Plan, the caregiver must demonstrate understanding related to the details of the Safety Plan; acceptance of who will be involved; the necessary frequency and intrusiveness into daily and weekly home life; and acceptance of the Plan and people involved with no intent to be disruptive. There must be confidence that caregivers are committed to permitting the expectations and requirements of the Safety Plan to be implemented as planned to ensure sustainability.

(These examples would support selecting "Yes" on the Impending Danger SPD)

- Caregiver agrees to and goes along with an In-Home Safety Plan.

- Caregiver's commitment to permit and support an In-Home Safety Plan is genuine and believable.

- Caregiver understands what is required, and agrees to allow others into the home at the level required.

- Caregiver does not interfere.

- Caregiver accepts and is open to involvement of others in the home.

- Caregiver understands the necessary steps required to keep the child in the home.

- Caregive is believable when communicating a willingness for cooperating with an In-Home Safety Plan.

- Caregiver is open to the parameters of an In-Home Safety Plan, arrangements, and Safety Plan Participants.

- Caregiver identifies him/herself as a primary caregiver for a child.

- Caregiver demonstrates an investment in having the child remain in the home.

- Caregiver demonstrates reasonable day-to-day intellectual functioning to sufficiently meet the requirements of the Safety Plan.

Conditions For Return and Use of an In-Home Safety Plan Based on Allowing Safety Actions

CFR statements associated with caregiver allowance of an In-Home Safety Plan should reflect what would be different compared to attitudes and behaviors that contributed to disallowing an In-Home option and justifying an Out-of-Home placement. See the previous examples related to the justification for an In-Home Safety Plan as a reference point for considering possible Conditions For Return related to willingness.

Following are examples of Conditions For Return related to allowing and supporting an In-Home Safety Plan; the list is not exhaustive. Depending on the particular case situation, one or more of these types of Conditions For Return might be considered, along with others not on the list. The Investigator is encouraged to attempt to individualize the statements. Notably, some examples suggest providing specific descriptions. Certainly, Conditions For Return involving a person (i.e., caregiver, child, or someone else) should identify the person by name.

- Caregiver participates in candid discussion about the necessity for and details of a Safety Plan, and how the Safety Plan addresses the child's safety.

- Caregiver expresses a genuine interest in doing what is necessary to have the child returned to the home.

- Caregiver is willing to allow for Safety Actions in the home, and demonstrates openness to cooperate with the required level of involvement from Safety Plan Participants to ensure child safety.

Caregiver Ability and Capacity to Participate

6. Do the primary caregivers possess the necessary ability/capacity to participate in an In-Home Safety Plan and do what they must do as identified in an In-Home Safety Plan?

Caregivers do not have to be problem free in order to participate in an In-Home Safety Plan, and to meet the expectations and carry out the responsibilities that are identified for them. This analysis question focuses only on the abilities and capacities that are basic and necessary to participate in, and be responsive to, the specific requirements set forth in the Safety Plan. The difficulties, challenges, and problems that have resulted in un-protectiveness may continue to present themselves in the caregivers. The analysis test is whether those emotions and behaviors are such that they reduce the caregiver from doing the most basic Safety Plan requirements to participate and not disrupt the In-Home Safety Plan.

Necessary ability and capacity is defined as the essential functioning that is required so that the In-Home Safety Plan can be implemented successfully, such as: caregiver can be trusted to comply with plans; be at the home; respond to phone and other kinds of contact as identified, related to the specifics of an In-Home Safety Plan; be sufficiently able and responsible for self-management consistent with required specifics in the In-Home Safety Plan; be tolerant of Safety Plan Participants, their schedules, identified expectations, and the role and behavior of Safety Plan Participants spelled out in an In-Home Safety Plan; set aside own choices and preferences which are contrary to specific requirements of the In-Home Safety Plan.

Justification for Use of an In-Home Safety Plan Based on Necessary Ability/Capacity

(These examples would support selecting "Yes" on the Impending Danger SPD)

- Caregiver demonstrates reasonable day-to-day intellectual functioning to sufficiently participate in an In-Home Safety Plan.

- Caregiver's limitations in intellectual functioning can be sufficiently compensated for, or controlled/managed by, necessary In-Home Safety Actions.

- Caregiver is emotionally stable enough to sufficiently participate in, abide by, and be trustworthy and reliable enough to be responsive to, the requirements

of an In-Home Safety Service, including being reality-oriented, able to generally track conversations, and not a danger to self or others.

- Issues associated with out-of-control caregiver emotional functioning can be sufficiently controlled and self-managed on a consistent basis by others who can Supervisor and monitor.

- Limitations in caregiver physical abilities and functioning can be sufficiently compensated for and managed by (identify specific Safety Actions and specific compensations and management needs).

- Attitudes, beliefs, and perceptions may be negative and out-of-control, BUT they are not extreme, AND can be sufficiently supervised and monitored (identify the specific condition that would be controlled and managed).

Conditions For Return and Use of an In-Home Safety Plan Based on Necessary Ability and Capacity

CFR statements associated with caregiver ability and capacity to participate in an In-Home Safety Plan should reflect what would be different compared to the lack of ability and capacity that contributed to disallowing an In-Home option and justified an Out-of-Home placement. See the previous examples related to the justification for an In-Home Safety Plan as a reference point for considering possible Conditions For Return related to willingness.

Following are examples of Conditions For Return related to acceptance, cooperation, and ability; the list is not exhaustive. Depending on the particular case situation, one or more of these types of Conditions For Return might be considered, along with others not on the list. The Investigator is encouraged to attempt to individualize the statements. Notably, some examples suggest providing specific descriptions. Certainly, Conditions For Return involving a person (i.e., caregiver, child, or someone else) should identify the person by name.

- Caregiver is trustworthy.

- Caregiver complies with the Plan without resistance, manipulation, rationalization, argumentativeness.

- Caregiver can be relied upon to be at the home and/or available as specified in the Safety Plan.

- Caregiver can be depended upon to respond to phone and other kinds of contact.

- Caregiver communicates responsively through self-initiation and as required by the In-Home Safety Plan.

- Caregiver is sufficiently able and responsible for self-management consistent with required specifics in the In-Home Safety Plan.

- Caregiver is tolerant of, and open to, Safety Plan Participants.

- Caregiver understand, respects, and meets required Safety Plan schedules, identified expectations, role and behavior of Safety Plan Participants spelled out in an In-Home Safety Plan.

- Caregiver sets aside his/her own choices and preferences which are contrary to specific requirements of the In-Home Safety Plan.

Sufficient Resources

7. Are there sufficient resources within the family or community to perform the Safety Actions necessary to manage the identified Impending Danger Threats?

Sufficient resources relates specifically to employing adequate Safety Actions and Safety Plan Participants at the level required to sufficiently manage Impending Danger in the home. Sufficient resources include having access to Safety Actions that are appropriate for addressing Impending Danger. This judgment requires Safety Plan Participants who are committed to participating in a Safety Plan and have been verified as acceptable. Safety Service resources (providers) must also be available and accessible at the specific times, and for the duration necessary, for managing child safety. Safety Plan Participants can be family members, people involved in the family network, friends, neighbors, volunteers, individual professionals, and/or professionals from agencies that provide various services, or are designed to provide Safety Actions.

The previous SPD questions are concerned with circumstances that must exist related to residence, environment, caregiver willingness, cooperation and ability (associated with participating in an In-Home Safety Plan). <u>This SPD question is about the behavior and participation of Safety Plan Participants in delivering Safety Actions</u> (e.g., professionals, family members, relatives, friends, volunteers, etc.) to manage Impending Danger. The analysis is concerned with whether there are sufficient resources (i.e., responsible people and their behavior) to manage Impending Danger, as it is understood to exist and occur within the home and family.

Justification for Use of an Impending Danger In-Home Safety Plan Based on Resources

(These examples would support selecting "Yes" on the Impending Danger SPD)

- There are adequate resources to consider planning for an In-Home Safety planning.

- The identified Safety Actions that are available match up with how Impending Danger is occurring.

- The Safety Actions and corresponding Safety Plan Particpants are logical choices, given family circumstances and what specifically must be controlled and managed to ensure child safety.

- There is confidence that Safety Plan Participants are open to, and understand, their role for participating in an In-Home Safety Plan.

- There is confidence that Safety Plan Participants will be committed to assisting with an In-Home Safety Plan.

- Safety Plan Participants can be verfied as acceptable.

- Safety Actions and Safety Plan Particpants are immediately available and accessible in time and proximity.

Conditions For Return and Use of an In-Home Safety Plan Based on Resources

CFR statements associated with the sufficiency of resources should reflect what would need to exist in comparison to what was determined to be the justification for an Out-of-Home Safety Plan. See the previous examples related to the justification for an In-Home Safety Plan as a reference point for considering possible Conditions For Return related to sufficient resources.

Following are examples of Conditions For Return related to resources; again, this is not an exhaustive list. Depending on the particular case situation, one or more of these types of Conditions For Return might be considered, along with others not on the list. The Investigator is encouraged to attempt to individualize the statements. Notably, some examples suggest providing specific descriptions. Certainly, Conditions For Return involving a person (i.e., caregiver, child, or someone else) should identify the person by name.

- There are sufficient Safety Service resources at the level of effort necessary to manage Impending Danger.

- There are sufficient Safety Service resources to address and manage threatening behavior or circumstances.
- Safety Actions are logically matched with quality and nature of Impending Danger at levels necessary to manage the Impending Danger.

- There are sufficient safety actions that are specific and relevant to the Impending Danger, diminished Protective Capacities, residence, ability of caregivers, and home and family routine.

- Safety Actions and Safety Plan Participants are available and accessible at the level required to manage safety.

- Safety Plan Participants meet the Safety Plan Particpant suitability criteria.

- Safety Plan Participants are acceptable to caregivers.

- Sufficient Safety Action resources are available and immediately accessible to compensate for a caregiver's cognitive limitations, and provide basic parenting assistance at the level required to ensure that the child is protected and has basic needs.

- Sufficient Safety Actions resources are available and immediately accessible to compensate for a caregiver's physical limitation, by providing basic parenting assistance to ensure that the child's basic needs are met.

- Specific Safety Actions needed to manage safety in the home are identified.

Chapter 14. Safety Management, Safety Categories, and Safety Actions

Safety Management refers to specific action the Investigator plans and implements in Safety Plans to control Impending Danger. Safety Management includes in-home, out-of-home, or a combination of in-home/out-of-home actions. Safety Management as an action refers to something specific that is done with energy and assertiveness to control an Impending Danger Threat to a child's safety. The action to achieve Safety Management can be a formal service from a professional provider, an informal activity performed by a relative or volunteer, or both.

Safety Management must have an immediate effect, be immediately available, be always accessible, and be sufficient to control the danger or threat of danger. Safety Management is concerned with controlling danger and threats of danger only. Safety Management is not concerned with changing caregiver or family functioning or circumstances.

Safety Categories

Safety Management includes five Safety Categories that can be applied alone or in combination. These are Behavioral Management, Crisis Management, Social Connection, Separation, and Resource Support. These are described below, followed by the Safety Actions that may be provided.

Safety Management Categories and Associated Safety Actions

Safety Management Category: <u>Behavioral Management</u>
Behavioral management is concerned with applying action (activities, arrangements, services, etc.) that controls caregiver behavior that is a threat to a child's safety. While behavior may be influenced by physical or emotional health, reaction to stress, impulsiveness or poor self-control, anger, motives, perceptions and attitudes, the purpose of this action is <u>only</u> to control the behavior. This action is concerned with aggressive behavior, passive behavior, or the absence of behavior – any of which threatens a child's safety.

Safety Action: Supervision and Monitoring

Supervision and monitoring are the most common Safety Action in safety intervention. It is concerned with caregiver behavior, children's conditions, the home setting, and the implementation of the In-Home Impending danger safety plan. The Safety Plan participant observes specific interactions, conditions, and/or behaviors within the home setting to assure

the identified dangerous situations are not occurring. This Safety Action includes oversight of people and the plan to manage safety. This Safety Action is often used to assure caregivers' assessed capacity to do what is necessary to support an In-Home Impending danger safety plan continues to be maintained or increased as the In-Home Impending danger safety plan continues. Supervision and monitoring is almost always occurring when other safety actions are employed.

Safety Action: Stress Reduction

Stress reduction is concerned with identifying and doing something about stressors occurring in the caregiver's daily experience and family life that can influence or prompt behavior that the In-Home Impending danger safety plan is designed to manage. Stress reduction as a Safety Action is not the same as stress management, which has more treatment implications. The Safety Action has to do with considering with the caregiver things that can be done to immediately reduce the stress the caregiver is experiencing and to then assure implementation of those stress-reduction strategies at key times within the day/week. Certainly, this can involve how the caregiver manages or mismanages stress; however, if coping is a profound dynamic in the caregiver's functioning and life, then planned change is indicated as a treatment/case plan goal.

Safety Action: Behavior Modification

Behavior modification as a treatment modality is concerned with helping a person internalize change in unwanted behavior using biofeedback or conditioning. Safety intervention uses the terms behavior modification differently than its use as a treatment modality. Behavior modification as a Safety Action is concerned with an immediate, supportive redirection of caregiver behavior that is associated with Impending Danger through monitoring and seeking to influence caregiver decisions to do certain things. The safety plan participant provider intervenes at key points in time to redirect caregiver behavior away from identified dangerous behaviors and towards alternative actions. This Safety Action limits and regulates caregiver behavior in relationship to what is required in the In-Home Impending danger safety plan. While the use of behavior modification as a Safety Action could have a secondary benefit for helping a person making internalized and self managed changes, its primary purpose is to control and assure caregiver behavior that must occur as part of the objectives for the In-Home Impending danger safety plan.

Safety Management Category and Safety Action: <u>Crisis Management</u>

Crisis is a perception or experience of an event or situation as horrible, threatening, or disorganizing. The event or situation overwhelms the caregiver's and family member's emotions, abilities, resources, and problem-solving. A crisis for families is not necessarily a traumatic situation or event in actuality. A crisis is the caregiver's or family member's perception and reaction to whatever is happening at a particular time. Many caregivers and families appear to live in a constant state of crisis because they experience and perceive most

things are happening their lives as threatening, overwhelming, horrible events and situations for which they have little or no control.

Keep in mind concerning safety management, a crisis is an acute, here and now matter to be dealt with so that the Impending Danger is controlled and the requirements of the In-Home Impending danger safety plan continue to be carried out. To be used effectively in an In-Home Impending danger safety plan, there must exist a level of confidence in the caregiver's ability to initiate the crisis intervention based on pre-determined triggers or circumstances. Crisis management is most typically used in the context of suicide prevention plans and relapse prevention/intervention plans.

The purposes of crisis management are crisis resolution and prompt problem-solving to control Impending Danger. Crisis management is specifically concerned with intervening to:

- Bring a halt to a crisis;
- Mobilize problem-solving;
- Control Impending Danger;
- Reinforce caregiver participation in the In-Home Impending danger safety plan; and
- Avoid disruption of the In-Home Impending danger safety plan.

Safety Management Category: <u>Social Connection</u>

Social connection is concerned with Impending Danger that exists in association with or influenced by caregivers' feeling or actually being disconnected from others. The actual or perceived isolation results in non-productive and non-protective behavior. Social isolation is accompanied by all kinds of debilitating emotions: low self-esteem and self-doubt, loss, anxiety, loneliness, anger, and marginality (e.g., unworthiness; unaccepted by others).

Social connection is a safety category that reduces social isolation and seeks to provide social support. This safety category is versatile in the sense that it may be used alone or in combination with other safety categories to reinforce and support caregiver efforts. Keeping an eye on how the caregiver is doing is a secondary value of social connection (See Behavior Management – Supervision and Monitoring).

Safety Action: Friendly Visiting

Friendly visiting (as a Safety Action) sounds unsophisticated and non-professional. It sounds like "dropping over for a chat." It is far more than "visiting." Friendly visiting is an intervention that is among the first in Social Work history. The original intention of friendly visiting was essentially to provide casework services to the poor. In safety intervention, friendly visiting is directed purposefully at reducing isolation and other disruptive emotional states (e.g., frustration, feelings of powerlessness, desperation, anxiety, feeling overwhelmed, etc.) and providing caregivers social support via connection and engagement with the Safety Action provider.

Safety Action: Basic Parenting Assistance

Basic parenting assistance is concerned with the presence or absence of specific, essential, parenting behavior that is threatening to a child's safety. This Safety Action is often focused on addressing deficits in essential knowledge and skill a caregiver is missing or failing to perform. Basic Parenting Assistance may be appropriate for socially isolated caregivers who do not have people within their natural support systems to help them with basic caregiver responsibilities. These are the caregivers whose emotional experience of social isolation (e.g., powerlessness, anxiety, desperation, etc.) leads to concerns for child safety related to providing basic parenting. Caregivers are often in some way incapacitated or unmotivated to perform necessary basic care tasks. The differences between friendly visiting and basic parenting assistance are that (1) the topic is always about essential parenting knowledge and skills and (2) the safety plan participant provides in-the-moment coaching to assure children's basic needs (e.g., feeding, essential hygiene, supervision, basic developmental needs, etc.) are met. As a secondary benefit, caregivers may build knowledge and skills, but this is not the focus of intervention. Basic Parenting Assistance can apply to children with special needs (e.g., infant, disabled child).

Safety Action: Supervision and Monitoring as Social Connection

Supervision and monitoring occur through conversations occurring during routine Safety Action visits (along with information from other sources). Within these routine in-home contacts the social conversations can also provide a social connection for the caregiver. The point here is to promote achievement of objectives of different safety categories and safety actions when the opportunity is available. See Supervision and Monitoring.

Safety Action: Social Networking

Social networking, as a Safety Action, refers to organizing, creating, and developing a social network for the caregiver. The term "network" is used liberally since it could include one or several people. It could include people the caregiver is acquainted with such as friends, neighbors, or family members. The network could include new people that the Safety Action provider introduces into the caregiver's life. The idea is the use of various forms of social contact formal and informal; contact with individuals and groups; and the use of contact that is focused and purposeful with the intention of reducing caregiver isolation, which would then directly and immediately have an impact on child safety.

Safety Action: Basic Home Management

This Safety Action provides support and assistance to caregivers who are unable to perform basic life skill functioning, which places the child's safety in question. Examples may include situations where the caregivers' functioning affects their ability to maintain a livable home or

where caregivers are unable to access necessary life services (e.g., medical care), which when left unattended, results in caregivers not being available to provide for the care of the children. The provision of Basic Home Management services is not appropriate for developing sustained long-term home management and life skills functioning where the primary purpose is to bring about change rather than control for the safety of the child. The actions provided must have an immediate effect on controlling the threats that affect safety.

Safety Management Category: Resource Support

Resource support refers to the safety category that is directed at a shortage of family resources and resource utilization, the absence of which directly threatens child safety.

Safety Actions:

Activities and actions that constitute resource support used to manage threats to child safety or are related to supporting continuing safety management include things such as:

- Resource acquisition related specifically to a lack of something that affects child safety;
- Transportation services particularly about an issue associated with a safety threat;
- Employment assistance as assistance aimed at increasing resources related to child safety issues;
- Housing assistance (including replacing a home that is directly associated with Impending Danger);
- General health care;
- Food and clothing; and
- Home Furnishings.

Safety Management Category: Separation

Separation is a safety category concerned with threats related to stress, caregiver reactions, child-care responsibility, and caregiver-child access. Separation provides respite for both caregivers and children. The separation action creates alternatives to family routine, scheduling, demand, and daily pressure. Additionally, separation can include a *supervision and monitoring* function concerning the climate of the home and what is happening. Separation refers to taking any member or members of the family out of the home for a period of time. Separation is viewed as a temporary action, which can occur frequently during a week or for short periods of time. Separation may involve any period of time from one hour to a weekend to several days in a row. Separation may involve professional and non-professional options. Separation may involve anything from babysitting to the temporary out-of-home placement of a child or combinations.

Safety Actions:

Safety actions that fit this safety category include:

- The planned absence of caregivers from the home;
- Respite care;
- Daycare that occurs periodically or daily for short periods or all day long;
- After school care;
- Planned activities for the children that take them out of the home for designated periods; and
- Child placement: short-term; weekends; several days; few weeks.

Chapter 15. Impending Danger Safety Plans

The Impending Danger Safety Plan is a written arrangement between caregivers and DCYF that establishes the management of Impending Dangers. The Impending Danger Safety Plan is not a temporary plan; a Impending Danger Safety Plan must be implemented, active, and remain in place as long as Impending Danger exists and Caregiver Protective Capacities are insufficient to ensure a child is protected. Impending Danger Safety Plans will likely remain in place for months and will co-exist with the ongoing Services Plan.

Documenting the Impending Danger Safety Plan

The Safety Plan is documented promptly after meeting with caregivers to confirm and explain the Safety Plan. The Safety Plan must be documented in the Safety Plan windows in Ritchest. The Safety Plan must be distributed to all key participants of the Safety Plan.

Safety Action

The Investigator identifies each expected Safety Action (e.g., behavior management). See Safety Management and Safety Actions)

Frequency

The Investigator identifies how often the Safety Action will occur (i.e., daily or weekly).

Duration

The Investigator identifies when the Safety Action will begin and the date that it will be reviewed. The Safety Action remains in place until Impending Danger no longer exists or until, through a review, the Safety Plan is revised.

Impending Danger Safety Plan Participant

The Investigator identifies the name of each person participating in the Impending Danger Safety Plan; these people are referred to as safety plan participants. These are the non-professionals (such as family members) and professionals (such as a visiting nurse) who provides the Safety Actions that manages the Impending Danger.

Communication Plan

The Investigator identifies how communication is accomplished, how participants can contact the Investigator, and discusses with participants the expectations concerning communication.

Capacity to Protect

The Investigator verifies the suitability and commitment of the Impending Danger Safety Plan participants to ensure that the Safety Plan is sufficient.

Oversight

The Investigator plans and documents how the Impending Danger Safety Plan will be managed.

Supervisor Approval

A Supervisor must approve the Impending Danger Safety Plan, indicated by his/her signature. Approval is a statement that the Supervisor believes the Safety Plan is the least intrusive, sufficient means for managing Impending Danger.

Impending Danger Safety Plan Criteria

The Impending Danger Safety Plan is valid only if it meets the criteria listed below. If, upon review, a plan does not meet these criteria, it should not be considered adequate to control Impending Danger Threats until the criteria are met.

- The single purpose of the Impending Danger Safety Plan is to control or manage Impending Danger. If any other purpose is included, it may not be a Safety Plan.
- The Impending Danger Safety Plan must have an immediate effect. The Impending Danger Safety Plan is created because the Investigator has identified Impending Danger. The definition for Impending Danger is that it is imminent; it is going to happen without intervention. Therefore, the Impending Danger Safety Plan must be established and implemented at the point the Impending Danger is identified, and be effective in managing Impending Danger the day it is implemented.
- People involved in the Impending Danger Safety Plan must be immediately accessible and available in accordance with the provisions of the Plan. Available means the provider has sufficient time and capacity to implement the Impending Danger Safety Plan. Accessible means the provider will be in place, readily responsive, and close enough to the family to meet the demands of the Impending Danger Safety Plan.
- Actions and services contained within the Impending Danger Safety Plan are designated specifically for the purpose of controlling or managing Impending Danger. Safety Actions must have an immediate effect. A Safety Action must fully achieve its purpose each time it is delivered. For instance, a visiting nurse ensures that a child's diabetes prescriptions are being ordered, or an aunt calls daily to ascertain that a mom is awake and functioning sufficiently to care for the children when they arrive home.

The Investigator's Responsibility for the Impending Danger Safety Plan

Once Impending Danger has been identified the Investigator is responsible to ensure that Impending Danger is managed. Caregivers cannot be expected to be responsible to ensure protection. It is unreasonable to judge that a child is not safe in his/her home, and then set up expectations for caregivers to provide protection. Therefore, the Investigator must be certain that the Impending Danger Safety Plans that he/she creates do not require caregivers to be responsible for specific behavior associated with keeping a child safe. Safety Plans that expect caregivers to quit drinking, to not hit their child, or to not leave their child unsupervised are dangerous, and a direct contradiction to the judgment that the child is not safe. To create such plans is dangerous, irresponsible practice.

An Example of an In-Home Impending Danger Safety Plan

The Sherman family Safety Plan is presented in a style that may not be identical to the format used in once the plan is implemented in Ritchest; it does, however, include the necessary information.

> *This is a domestic violence case that included harsh physical handling of the children by the father. Raphael is the father; Beatrice is the mother; Tanya is the 9-year-old daughter; and Lynnea is the 7-year-old daughter. Raphael's intimidation of and violence toward Beatrice, Lynnea, and specifically Tanya is a threat to child safety. This is compounded by his belief that anything he does is okay. He shows no remorse for his behavior. He is unmotivated to consider his parenting style, or how he needs to control it. Additionally, both girls are fearful of Raphael and, because of his behavior and their fragility and vulnerability (especially Lynnea), they are unable to seek protection on their own. Beatrice is unable to protect the girls. Some form of violence or aggression is reported to occur 2 – 3 times a month, and involves pushing or slapping Beatrice, handling the girls roughly; throwing, pushing, or shoving the girls. Verbal abuse, humiliation, and intimidation occur daily. There are no particular signs to predict when or how this will occur; it is relatively spontaneous and prompted by incidental things. Raphael's roughness with the girls is not associated with discipline.*

The Impending Danger Safety Plan Determination indicates that an In-Home Impending Danger Safety Plan can be implemented.

Safety Category: Behavior Management

Safety Action Description:	In-home supervision and observation of family interaction and functioning provided three times a week – 2 hours each visit in the home.
Frequency:	Twice weekly; at least one visit to occur on weekends
Start Date :	3/10
End Date:	4/10 - This service is to continue for 30 days, whereupon it will be evaluated.
Safety Participant/Role:	John Turner – Home Based Services. John Turner will be in the home a minimum of 3 times per week. He will monitor the father's impulsive behavior and support the mother's involvement. This will also limit the effects of the parents' inconsistent care of the girls and the detrimental expectations of Raphael. John will also be available on call 24 hours per day on an as-needed basis.
Contact Information:	Home Based Services is located at 1423 Oak Street. Turner's cell phone number is 301 3271.
Capacity to Protect Description:	John Turner has been confirmed as available, accessible, and suitable, and fully understands his role and responsibilities. He has been fully informed of the specific tasks and time frames.
Agency Oversight of Safety Plan:	Weekly contact with all providers. Weekly contact with Beatrice to determine general compliance with the Safety Plan and to determine potential or actual violence or aggression toward her or the girls. Bi-weekly contact with Raphael to evaluate his compliance with the Safety Plan, his attitude about participation and activity in the Plan, and his expectations for continuing DCYF intervention.

Safety Category: Separation

Safety Action Description:	Day care to provide separation of the girls from Raphael as the sole caregiver. This service is to continue for 30 days whereupon it will be evaluated.
Frequency:	Five times a week – 3 hours each day – following school.
Start Date :	3/10
End Date:	4/10 This service is to continue for 30 days whereupon it will be evaluated.
Safety Plan Participant/Role:	North Side Day Care will provide child care each day following school from 3 – 5 pm. This will relieve Raphael of child care responsibilities and separate the girls from Raphael during Beatrice's work day. Additionally, staff at North Side will monitor the girls' general care, emotional state, and, in particular, Tanya's provocative behavior.
Contact Information:	North Side is a licensed day care center located at 327 North Side Avenue. Phone: 771-4819
Capacity to Protect Description:	Mrs. Fields, the Director, is aware of the issues affecting the girls, and the role the center is being asked to fulfill.
Agency Oversight of Safety Plan:	Weekly contact with all providers. Weekly contact with Beatrice to determine general compliance with the Safety Plan and to determine potential or actual violence or aggression toward her or the girls. Bi-weekly contact with Raphael to evaluate his compliance with the Safety Plan, his attitude about participation and activity in the plan, his expectations for continuing DCYF intervention.

Safety Category: Behavior Management

Safety Action Description:	Observation and evaluation of the children's sense of security, satisfaction with the home life, and general emotional state. Janet will be specific with the children about home activity, family interaction, and in particular the girls' perception of their father. Identification of any aggressiveness or verbal attacks the girls may report.
Frequency:	Weekly
Start Date :	3/10
End Date:	4/10 - This service is to continue for 30 days whereupon it will be evaluated.
Safety Plan Participant/Role:	Janet Freeman, Washington Elementary counselor, will meet with each child weekly for a few minutes.
Contact Information:	Washington Elementary is located at 414 Coal Street. Janet's phone number is 312-9001.
Capacity to Protect Description:	Janet is supportive and in agreement with the In-Home Safety Plan and her role in it.
Agency Oversight of Safety Plan:	Weekly contact with all providers. Weekly contact with Beatrice to determine general compliance with the Safety Plan, and to determine potential or actual violence or aggression toward her or the girls. Bi-weekly contact with Raphael to evaluate his compliance with the Safety Plan, his attitude about participation and activity in the plan, his expectations for continuing DCYF intervention.

This Impending Danger Safety Plan manages the threats by:

- monitoring and addressing the stress that stimulates Raphael's aggressiveness.

- supporting Beatrice to assume primary care giving responsibilities, with no present expectations for Raphael.
- establishing a continuing outside presence that overtly gives support to Beatrice and respects Raphael, but clarifies that aggression is to be avoided.
- ensuring routine and constant contact with family members throughout the week and upon weekends.
- separating the girls from Raphael in a strategic manner, concerned with (1) his need not to provide caregiving, and (2) minimizing the girls' behavior that provokes Raphael.
- allowing Raphael to go about his business with minimal home/care giving expectations, while providing necessary support and resources to Beatrice to ensure that she can meet the primary caregiving roles and responsibilities.

Caretaker Acknowledgment and Agreement

It is crucial that caregivers participate in the formation of the Impending Danger Safety Plan. Caregivers should be fully aware of the details of the plan, the schedules, the providers and their roles. Respect, cooperation, and commitment to allow the Impending Danger Safety Plan to be implemented without disruption or interference are essential aspects of Safety Planning.

Chapter 15. Case Transfer

Case Transfer is an essential part of effective, systematic intervention. It should be seamless in terms of time and case movement. The Case Transfer Staffing should occur as soon as possible but no later than five business days from the establishment of the Impending Danger Safety Plan by the Investigator.

Case Transfer Staffing

The Case Transfer Staffing is a required meeting to ensure an effective hand-off of a case from the FFA component of SAFE to FSU Services. The staffing involves a face-to-face interaction between the Investigator, the FSU Caseworker and Supervisors for those workers. The staffing, no matter how limited, provides the opportunity for the Investigator to provide clarification to FSU Caseworker questions; provides additional information beyond what has been documented in the FFA and Impending Danger SPD; offers the Investigator's opinions and interpretations of the case; and discusses, in detail, the rationale for decisions and specifics about the Impending Danger Safety Plan.

It is best when the FSU Caseworker and the Investigator participate in the Case Transfer Staffing, accompanied by their respective Supervisors. The Case Transfer Staffing encourages a more formal, official deliberation, and contributes to the seamless transition of the family from FFA to the Ongoing FFA.

Purpose of the Case Transfer Staffing

The primary purpose of the consultation between the Investigator and the FSU Caseworker is to ensure that there is adequate attention to child safety at the initiation of the Ongoing FFA process and to prepare the FSU Caseworker to initiate the Ongoing FFA.

Objectives for the Case Transfer Staffing

- Ensure understanding of the justification for the Impending Danger Safety Determination.
- Discuss and/or clarify how negative conditions described in FFA documentation meet the Danger Threshold Criteria.
- Verify that documentation clearly supports Impending Danger.
- Reconcile discrepancies in information.
- Reconcile questions related to the sufficiency of Impending Danger Safety Plans.
- Seek guidance regarding how best to approach the Ongoing FFA with caregivers.

The Case Transfer Staffing convenes primarily to prepare the FSU Caseworker for meeting the family for the first time, and initiating the ONGOING FFA. Therefore, it is the responsibility of the FSU Caseworker to facilitate the Case Transfer Staffing.

The FSU Caseworker convenes the Case Transfer Staffing to consult with the Investigator within five days of the Case Transfer. The Case Transfer Staffing is a formal meeting that should be conducted in a "business-like" manner. The Case Transfer Staffing should be conducted using an agenda that is based on what needs to be accomplished to achieve the objectives for the meeting. It is the responsibility of the FSU Caseworker and Supervisor to come to the Case Transfer Staffing prepared to discuss specific questions or issues that need to be clarified prior to contact with caregivers. The Investigator and his/her Supervisor come to the Case Transfer Staffing prepared to provide information regarding case documentation and FFA decision making.

The Case Transfer Staffing is not merely an open discussion or general summary of the case. The business that occurs during the Case Transfer Staffing is focused on what must be known by the FSU Caseworker in order to effectively begin the ONGOING FFA Introduction stage.

Case Transfer Staffing Agenda

An agenda of the Case Transfer Staffing is based on the following issues:

- Identify specific information gaps that might exist in the FFA;
- Seek out further meaning and interpretation regarding information from the Investigator;
- Clarify and consider justification for FFA decisions (as indicated);
- Ensure that identified Impending Danger is clearly reflected in FFA documentation;
- Probe to understand all the details about the rationale and construction of the Safety Plan (as indicated);
- Discuss and clarify the status of Caregiver Protective Capacities and general family strengths;
- Discuss the Investigator's perspective regarding discrepancies in information between the FFA-documented functioning information and a caregiver's responses on the clinical measures;
- Consider the status of caregiver involvement with DCYF;
- Anticipate how caregivers will respond to and participate in the ONGOING FFA process;
- Ask the Investigator about his/her perception regarding caregivers' motivational readiness to change;
- Review the child's, or children's, needs, including summary of physical, behavioral, emotional, and educational information as available;
- Discuss and seek Investigator's opinion about "how best" to proceed to complete the ONGOING FFA process;

- Review existing court orders, upcoming court obligations, and timeframes for the completion of court reports (as necessary); and

- Review visitation schedules and logistics.

Safety Plan Management Responsibility

At the time of the Case Transfer, the Investigator maintains responsibility for Safety Management until the FSU Caseworker is informed and able to assume responsibility. If the Safety Plan fails during Case Transfer, the FFA Supervisor and FSU Supervisor should consult to determine who is best suited to adjust the Safety Plan - the Investigator or FSU Caseworker.

Case Transfer Responsibility and Time Line

Responsibility	**Time Requirement**
The FFA Supervisor must notify the FSU Supervisor of a Case Transfer request	Within 24 hours of the completion of the FFA
The FSU Supervisor must identify the FSU Caseworker that will receive the case assignment	Upon receipt of the request for Case Transfer and within 24 hours
The FSU Caseworker must schedule the Case Transfer Staffing	Within 5 business days following establishment of the Safety Plan by the Investigator
The Investigator and Supervisor attend the Case Transfer Staffing	Within 5 business days following establishment of the Safety Plan by the Investigator

Information/Referral (I/R) Reports

Rhode Island Department of Children, Youth and Families

Policy: 500.0040

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

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

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

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

Related Procedure...

Information/Referral (I/R) Reports

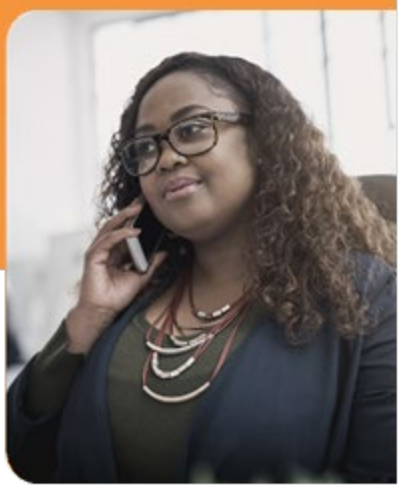
Related Policy...

Criteria for a Child Protective Services Investigation

EVIDENT CHANGE
Inform Systems. Transform Lives.

SDM® HOTLINE SCREENING & RESPONSE PRIORITY ASSESSMENT

Policy & Procedures Manual



Rhode Island Department of Children, Youth and Families

August 2023

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CONTENTS

GENERAL DEFINITIONS

ALLEGED PERPETRATOR

A person alleged to have caused or knowingly allowed the maltreatment of a child. This could include caretakers and substitute care providers as defined in this section.

CARETAKER

An adult, parent, or guardian in the household who provides care and supervision for the child. This could also include:

- Parents, adults fulfilling the parental role, guardians, children, and others related by ancestry, adoption, or marriage; or as defined by any person in one of the preceding categories.
- An out-of-home placement caretaker directly supervised by the Rhode Island Department of Children, Youth and Families (DCYF) or other agency, including in a foster family home, group home, or other childcare institution or facility.

HOUSEHOLD

A household includes all persons who have significant in-home contact with the child, including those who have a familial or intimate relationship with any person in the home. This may include those who do not live in the home but are in an intimate relationship with a parent in the household, or relatives with authority in parenting and childcare decisions as allowed by the legal parent.

Which household is assessed? When a child's parents do not live together, the child may be a member of two households. *Always* assess the household of the parent alleged to be the perpetrator. This may be the child's primary residence or the household of a non-custodial parent.

The following apply conditionally.

- If the alleged perpetrator is a person responsible for the child's welfare (e.g., foster parent, employee of a public or private residential home or facility, or staff person providing out-of-home care including daycare), also assess the custodial parent *if there is an allegation of failure to protect*.
- If the alleged perpetrator is a non-custodial parent, also assess the custodial parent *if there is an allegation of failure to protect*.
- If a child is being removed from a custodial parent, also assess any non-custodial parent identified if that parent will receive child welfare services.

SDM® HOTLINE SCREENING AND RESPONSE PRIORITY ASSESSMENT

Rhode Island Department of Children, Youth and Families

r: 06/23

Family name: _____

Worker name: _____ **Date:** _____

Report #: _____ **County:** _____

SECTION 1. PRELIMINARY SCREENING

AUTOMATIC SCREEN OUT

- ☐ All victims are age 18 years or older and not in state custody (instruct reporter to contact law enforcement)
- ☐ Alleged child abuse/neglect incident referred to another state
- ☐ Alleged perpetrator does not meet relationship requirements under statute (instruct reporter to contact law enforcement)

NON-INVESTIGATORY RESPONSE BY THE AGENCY MAY BE REQUIRED, BUT NO FURTHER USE OF SDM® TOOL IS REQUIRED

- ☐ Service request/courtesy interview for another jurisdiction
- ☐ Well-child check for another jurisdiction
- ☐ Resource referral
- ☐ Safe Haven for Infants Act

If any item in Section 1 is selected, the tool is complete, and no further screening is required.

SECTION 2. MALTREATMENT TYPE

SUSPICIOUS CHILD DEATH (AUTOMATIC PRIORITY 1 RESPONSE)

☐ Suspicious death of a child due to abuse or neglect

SEXUAL ABUSE OF A CHILD BY AN EMPLOYEE OR VOLUNTEER OF A SCHOOL SYSTEM (AUTOMATIC PRIORITY 3 RESPONSE)

☐ Sexual abuse of a child by an employee or volunteer of a school system

PHYSICAL ABUSE

☐ Inflicted physical injury
☐ Suspicious physical injury
☐ Physically excessive/inappropriate discipline
☐ Injury/harm caused by giving the child toxic chemicals, alcohol, or drugs
☐ Substance-exposed newborn
☐ Medical maltreatment (previously known as Munchausen syndrome by proxy/factitious disorder)
☐ Risk of physical abuse

SEXUAL ABUSE

☐ Alleged perpetrator engages in a sexual act or sexual contact with child
☐ Sexual exploitation/trafficking of a child
☐ Child exposed to sexually explicit conduct/material
☐ Physical indicators consistent with sexual abuse
☐ Concerns about sexual contact and/or force or coercion of a child by another child
☐ Risk of sexual abuse/duty to warn

NEGLECT

☐ Abandonment
☐ Lack of supervision
☐ Reckless behavior involving child
☐ Educational neglect

☐ Failure to meet basic needs

- ☐ Inadequate/hazardous shelter
- ☐ Inadequate clothing/hygiene
- ☐ Inadequate food/nutrition

☐ Medical neglect (includes neglect of dental, vision, and/or mental health care)

☐ No medical explanation for failure to thrive

☐ Caretaker does not protect child against abuse/neglect

EMOTIONAL ABUSE

☐ Alleged perpetrator's behaviors have led or are likely to lead to emotional harm of the child. (For domestic violence, select "Exposure to domestic violence.")

☐ Exposure to domestic violence

If any maltreatment types were selected, please indicate whether the allegations occurred:

○ Only in a foster home

○ Only in a kinship home

○ Only in a facility, residential setting, treatment facility, daycare, etc.

○ Only in a hospital setting

○ N/A—none of these apply

SECTION 3. INITIAL SCREENING DECISION

○ **No maltreatment type is selected.** Consider if further action is needed after overrides.

○ **Maltreatment type is selected.** One or more maltreatment types in Section 2 are selected, requiring an investigative response.

SECTION 4. OVERRIDES

○ **No criteria are selected, but report will be opened as an investigation.**

Select all that apply.

- ☐ Response required by court order
- ☐ Other (specify): _____

○ **One or more criteria are selected, but report does not require investigatory response based on one or more of the following.** No further Structured Decision Making® (SDM) assessments required.

Select all that apply.

☐ Insufficient information to locate child/family

☐ Duplicate report

☐ Another agency has jurisdiction and accepts responsibility

☐ Historical information only

Supervisory approval: _____ **Date:**_____

SECTION 5. FINAL SCREENING DECISION

○ **Report requires investigatory response.** One or more items were selected in Section 2, or there was an override to open an investigation. If allegations are in an out-of-home setting, refer to DCYF policy regarding notification of additional DCYF regulatory bodies.

○ **No maltreatment types in Section 2 are selected, OR an override to screen out was applied.** Consider if further action is needed. No further SDM assessments required.

GIVEN THE INFORMATION IN THE REFERRAL, IS FURTHER ACTION NEEDED (UNRELATED TO THE SCREENING DECISION)?

○ **Yes, an additional response is required.**

☐ Support and Response Unit (SRU)—refer to DCYF policy regarding eligibility criteria

☐ Protective service alert

☐ In-state or hospital alert

☐ Office of the Child Advocate

☐ Licensing supervisor/licensing worker

☐ Superintendent/deputy superintendent

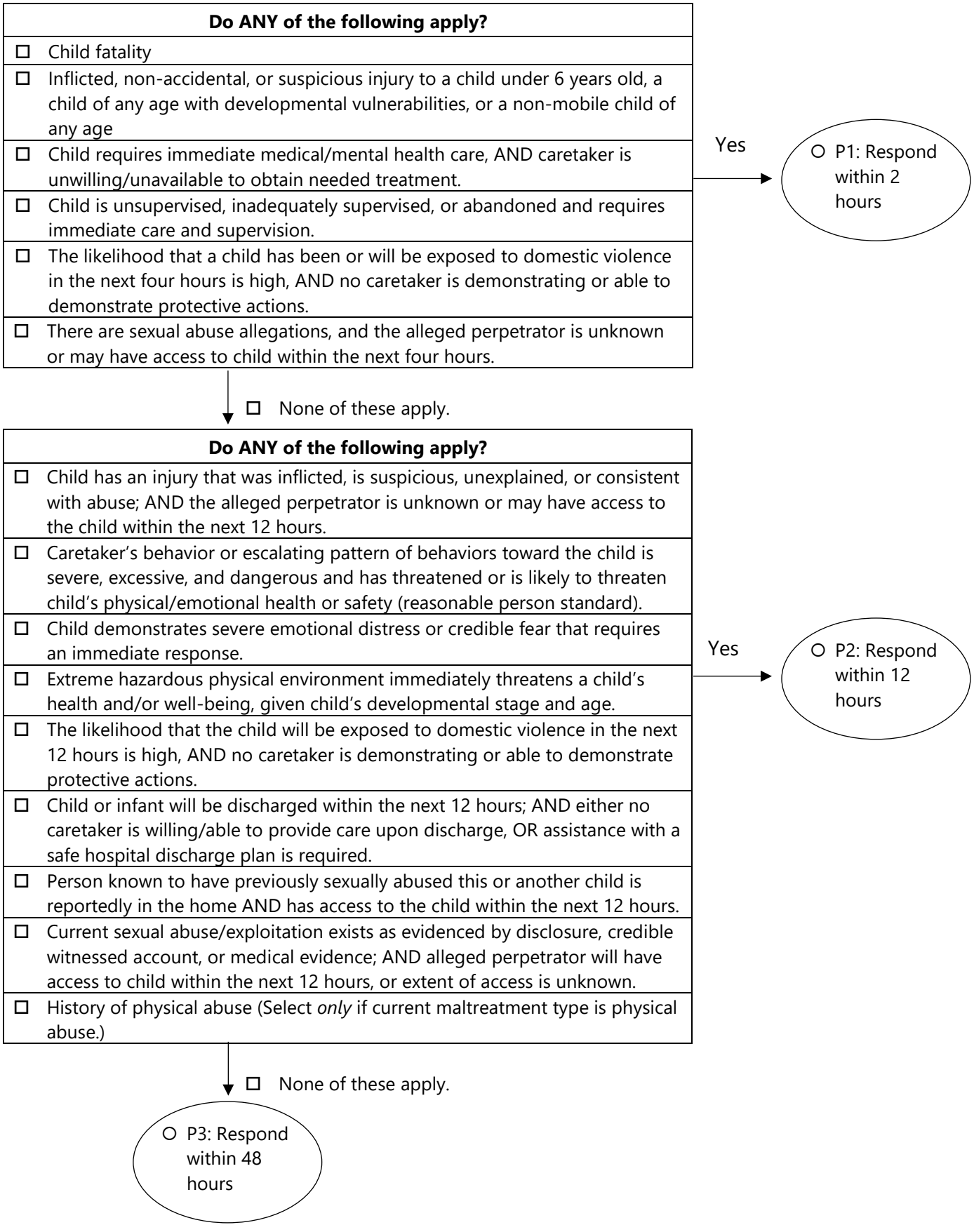
☐ Law enforcement

☐ Other: _____

○ **No additional response is required by DCYF.**

Supervisory approval: _____ **Date:**_____

SECTION 6. INITIAL RESPONSE PRIORITY



SECTION 7. OVERRIDES

POLICY OVERRIDE

Increase to Priority 1 whenever:

- ☐ Law enforcement requests an immediate response
- ☐ Forensic considerations would be compromised by a slower response
- ☐ There is reason to believe the family may flee

Decrease to Priority 2 (from Priority 1) or Priority 3 (from Priority 2) whenever:

- ☐ Child safety requires a strategically slower response
- ☐ The child is in an alternative safe environment
- ☐ The alleged incident occurred more than six months ago, AND no maltreatment is alleged to have occurred in the intervening period

DISCRETIONARY OVERRIDE

- ○ Increase priority of response level
- ○ Decrease priority of response level by one (requires supervisory approval)

Reason: _____

Supervisory approval: _____ **Date:** _____

SECTION 8. FINAL RESPONSE PRIORITY

○ Priority 1 (within 2 hours) ○ Priority 2 (within 12 hours) ○ Priority 3 (within 48 hours)

Call floor supervisor approval: _____ **Date:** _____

Call floor administrator approval: _____ **Date:** _____

Child protective services assistant director approval:_____ **Date:** _____

SDM® HOTLINE SCREENING AND RESPONSE PRIORITY ASSESSMENT DEFINITIONS

Rhode Island Department of Children, Youth and Families

SECTION 1. PRELIMINARY SCREENING

AUTOMATIC SCREEN OUT

All victims are age 18 years or older and not in state custody (instruct reporter to contact law enforcement)

If the victims are adults, the allegations should be forwarded to law enforcement.

Alleged child abuse/neglect incident referred to another state

DCYF does not have jurisdiction to accept the hotline report based on where the incident occurred and/or where the child resides. Forward the report to the appropriate jurisdiction.

A report should be referred to another state in the following situations.

- The alleged child abuse/neglect incident occurred outside of Rhode Island, AND the child does not reside in Rhode Island.
- The alleged child abuse/neglect incident occurred in Rhode Island; but the child does not reside in Rhode Island, AND there is no emergency situation as defined by law.

Do not select this item if the State of Rhode Island has a protective hold on any child victim. In the event of a protective hold, DCYF has jurisdiction to accept the hotline report, regardless of where the alleged abuse/neglect incident took place OR where the child resides.

Alleged perpetrator does not meet relationship requirements under statute (instruct reporter to contact law enforcement)

The alleged perpetrator is not a caretaker or a substitute caretaker as defined by Rhode Island statute.

NON-INVESTIGATORY RESPONSE BY THE AGENCY MAY BE REQUIRED, BUT NO FURTHER USE OF SDM® TOOL IS REQUIRED

Service request/courtesy interview for another jurisdiction

A caller from another jurisdiction requests a courtesy home assessment or interview of a family. Instruct the caller to fax/email the request on agency letterhead.

Well-child check for another jurisdiction

Response to confirm the condition and safety of a child or youth at the request of other DCYF divisions, other state child welfare authorities, or the court.

Resource referral

A request for services or resources provided by external agencies in a situation where child abuse or neglect is not a concern.

Safe Haven for Infants Act

A parent has voluntarily relinquished an infant in accordance with the Rhode Island Safe Haven for Infants Act. See Rhode Island General Law 23-13.1.

SECTION 2. MALTREATMENT TYPE

Maltreatment is an act of commission or omission by an alleged perpetrator in failing to provide adequate care for a child and attention to the child's needs. Consider age, developmental stage, and other child vulnerabilities when assessing reports for allegations of abuse or neglect.

SUSPICIOUS CHILD DEATH (AUTOMATIC PRIORITY 1 RESPONSE)

Suspicious death of a child due to abuse or neglect

Child death is unexplained, or concern exists that abuse or neglect by an alleged perpetrator contributed to or caused the child's death. Examples include but are not limited to the following.

- Suffocation of an infant in an unsafe sleeping arrangement
- Unsupervised child drowning in a bathtub, pool, or other body of water
- Child death due to head trauma or internal injuries that appear suspicious

SEXUAL ABUSE OF A CHILD BY AN EMPLOYEE OR VOLUNTEER OF A SCHOOL SYSTEM (AUTOMATIC PRIORITY 3 RESPONSE)

This item should only be selected if there are allegations or suspicions of sexual abuse of a child by an employee, agent, contractor, or volunteer of an educational program/school system as defined in Rhode Island General Law 40-11-2 and 40-11-3.3.

Do not select this item if:

- A child in a school abuses another child; instead, consider "Concerns about sexual contact and/or force or coercion of a child by another child."
- Allegations did not occur in a school or educational setting, and the alleged perpetrator is not employed by or a contractor or volunteer of a school system, e.g., allegations of sexual abuse by a coach in a community recreational sports league.

PHYSICAL ABUSE

Inflicted physical injury

Infliction of physical injury on a child by an alleged perpetrator. Include physical injuries to a child resulting from excessive disciplinary action or a domestic violence incident. Examples of injuries include but are not limited to the following.

- Cuts, bruises, welts
- Burns/scalding
- Human bites
- Bone fractures
- Sprains/dislocations
- Head injuries
- Internal injuries

Suspicious physical injury

Injury to a child for which the alleged perpetrator and/or the child can give no satisfactory explanation, and abuse is suspected. This includes but is not limited to the following situations.

- The alleged perpetrator or child provides details of the cause that are inconsistent with the injury.
- The injury appears suspicious, and the reporter has no information about the circumstances that caused this injury.
- The injury appears suspicious, and no caretaker can provide a reasonable explanation of how the injury occurred.

Physically excessive/inappropriate discipline

The alleged perpetrator's disciplinary action is in response to an action or inaction by the child, AND either the intensity of the alleged perpetrator's reaction or the discipline administered far exceeds the seriousness of the child's action/inaction based on the child's age or level of functioning. The alleged perpetrator's actions are intended to instill extreme fear, emotional distress, and intimidation rather than to educate. Examples of excessive and/or inappropriate discipline include but are not limited to the following.

- Causing any injury to the child requiring medical attention;
- Applying or threatening corporal punishment (corporal punishment is not to be used in foster homes);
- Giving punishment associated with food, naps, or toilet training;
- Pinching, shaking, or biting a child;
- Hitting a child with a hand or instrument causing cuts, bruises, welts, bone fractures, sprains, dislocations, head injuries, or internal injuries;
- Putting anything in a child's mouth;
- Humiliating, ridiculing, rejecting, or yelling at a child;
- Subjecting a child to harsh, abusive, or profane language;
- Placing a child in a locked or dark room, bathroom, or closet; and
- Requiring a child to remain silent or inactive for inappropriately long periods for the child's age.

Injury/harm caused by giving the child toxic chemicals, alcohol, or drugs

Substance given to the child caused or is likely to cause harm or illness. Examples include but are not limited to poison, gasoline, kerosene, bleach, cleaning agents, alcohol, illegal drugs, or an intentionally inappropriate dosage of medication.

Substance-exposed newborn

Substance-exposed newborn means a newborn who was exposed in utero to alcohol and/or a controlled substance (illicit or prescribed) that the birth mother ingested. This item should be considered if any of the following apply.

- A newborn has a positive toxicology screen for illegal or non-prescribed substances.
- Birth mother tests positive during the last trimester and/or at the time of birth for an illegal or non-prescribed substance regardless of whether the infant has tested positive.
- A newborn is treated for neonatal abstinence syndrome (NAS) as the result of maternal use of illegal, non-prescribed, or misuse of prescribed medication, or due to undetermined substance exposure; or a newborn has fetal alcohol spectrum disorder.
- Any case of a substance-exposed newborn with safety concerns.

Exclude reports that a pregnant woman is using drugs or alcohol (at any time during pregnancy) if there are no other children residing in the home, and consider the report's appropriateness for a hospital alert.

Medical maltreatment (previously known as Munchausen syndrome by proxy/factitious disorder)

Alleged perpetrator is causing injury to the child through unnecessary and harmful or potentially harmful medical care.

Risk of physical abuse

This describes circumstances in which the child has not yet experienced harm and there have been no clear-cut abusive actions, but it can reasonably be concluded that if the circumstances continue without change, significant harm will likely result in the near future due to the alleged perpetrator's pattern of abusive actions. Do not select this item if any item in the Physical Abuse category has been selected.

SEXUAL ABUSE

Alleged perpetrator engages in a sexual act or sexual contact with child

Determined by verbal/non-verbal disclosure, medical evidence, or credible witness account. Disclosure includes child's verbal statements or non-verbal expressions (e.g., drawing or pointing), whether spontaneous or in response to preliminary investigation, that indicate possible sexual abuse. Examples of a sexual act or sexual contact may include the following.

- Oral/genital contact between perpetrator and child.
- The penetration, however slight, of the anus or vulva by a hand, finger, penis, or any object with the intent to abuse, humiliate, harass, degrade, arouse, or gratify the sexual desire of any person.
- Alleged perpetrator touching the child's clothed or unclothed genitalia, anus, groin, breast, inner thigh, or buttocks (sexual areas) with a body part or any object with the intent to abuse, humiliate, harass, degrade, arouse, or gratify the sexual desire of any person.
- Alleged perpetrator touching a child with alleged perpetrator's sexual areas or having a child touch the alleged perpetrator's sexual areas with the intent to abuse, humiliate, harass, degrade, arouse, or gratify the sexual desire of any person.

Sexual exploitation/trafficking of a child

A caretaker or a known/unknown alleged perpetrator involves a child in obscene acts; engages the child in prostitution; or allows, permits, encourages, or engages in obscene or pornographic display, photographing, filming, or depicting a child as prohibited by law. A caretaker or a known/unknown alleged perpetrator makes sexual advances toward the child, including but not limited to asking the child to perform sexual acts or describing sexual activities.

If explicit photos are shared by a peer, not for profit and/or gratification, refer to law enforcement. Consider appropriateness of SRU referral for the alleged perpetrator.

Child exposed to sexually explicit conduct/material

Alleged perpetrator intentionally or recklessly exposes to a child, or allows a child to be exposed to, an actual or simulated sex act; sexual contact; bestiality; masturbation; lascivious exhibition of the genitals, anus, or pubic area; or other sexually explicit conduct (e.g., sexting).

Physical indicators consistent with sexual abuse

There is no disclosure, but a medical professional reports medical symptoms consistent with or suspicious for sexual abuse, e.g., pre-adolescent child has a sexually transmitted infection or symptoms of one; or genital or anal area is red, torn, or chafed.

Concerns about sexual contact and/or force or coercion of a child by another child

Allegations concerning sexual contact and/or coercion (as defined below) between children also must be referred to local law enforcement.

- *Sexual contact* means the intentional touching of the victim's or accused's intimate parts, clothed or unclothed, if that intentional touching can be reasonably construed as intended by the accused to be for the purpose of sexual arousal, gratification, or assault.
- *Force or coercion* means when the accused does **any** of the following.
  - » Uses or threatens to use a weapon or any article used or fashioned in a manner to lead the victim to reasonably believe it to be a weapon.
  - » Overcomes the victim by applying physical force or physical violence.
  - » Coerces the victim to submit by threatening to use force or violence on the victim, and the victim reasonably believes the accused can execute these threats.
  - » Coerces the victim to submit by threatening to, sometime in the future, murder, inflict serious bodily injury upon, or kidnap the victim or any other person; and the victim reasonably believes the accused can execute this threat.

Note: Also consider whether the facts indicate an additional allegation of a lack of supervision. Lack of supervision may be indicated if there is information that the alleged perpetrator is aware that children in the household engage in sexual behavior outside of normal exploration or in a way that involves coercion, violence, or exploitation AND that the alleged perpetrator does not intervene despite this knowledge.

Abusive Sexual Behavior Versus Age-Typical Sexual Behavior

The following tables provide examples of behaviors for different age groups. The first table indicates behaviors that are considered in young children: normal and common, less common but within normal boundaries, uncommon, and rarely normal. Behaviors that are uncommon or rarely normal should be considered suspicious. The second table summarizes normal sexual behaviors in older children, as well as sexual behaviors that indicate abuse. Behaviors listed as "abusive" in the second table should be considered suspicious.

EXAMPLES OF SEXUAL BEHAVIORS IN CHILDREN AGES 2–6			
NORMAL, COMMON BEHAVIORS	**LESS COMMON NORMAL BEHAVIORS**	**UNCOMMON BEHAVIORS IN NORMAL CHILDREN**	**RARELY NORMAL**
• Touching/ masturbating genitals in public/private • Viewing/touching peer's or new sibling's genitals • Showing genitals to peers • Standing/sitting too close • Trying to view peer/adult nudity • Sexual behaviors that are transient, few, and responsive to distraction	• Rubbing body against others • Trying to insert tongue in mouth while kissing • Touching peer's or adult's genitals • Crude mimicry of movements associated with sexual acts • Sexual behaviors that are occasionally, but persistently, disruptive to others • Sexual behaviors that are transient and moderately responsive to distraction	• Asking peer/adult to engage in specific sexual acts • Inserting objects into genitals • Explicit imitation of intercourse • Touching animal genitals • Sexual behaviors that are frequently disruptive to others • Sexual behaviors that are persistent and resistant to parental distraction	• Any sexual behaviors involving children who are four or more years apart • A variety of sexual behaviors displayed on a daily basis • Sexual behavior that results in emotional distress or physical pain • Sexual behaviors associated with other physically aggressive behaviors • Sexual behaviors that involve coercion • Sexual behaviors that are persistent; child becomes angry if distracted

Adapted from American Academy of Pediatrics. (2009). *Preventing sexual violence: An educational toolkit for health care professionals.*

EXAMPLES OF SEXUAL BEHAVIORS IN OLDER CHILDREN AND ADOLESCENTS	
SEXUAL BEHAVIORS	**ABUSIVE SEXUAL BEHAVIORS**
Age 7–10	
• Fondle and touch own genitals; masturbate • Become more secretive about self-touching • Interest in others' bodies becomes more about game-playing than exploratory curiosity (e.g., "I'll show you mine if you show me yours") • Boys may begin comparing size of penis • May develop extreme interest in sex, sex words, and dirty jokes • Begin to seek information or pictures that explain bodily functions • Touching may involve stroking or rubbing	• Sexual penetration • Genital kissing • Oral sex • Simulated intercourse • Behavior involves coercion, threats, secrecy, violence, aggression, or developmentally inappropriate acts
Age 11 and 12	
• Continuation of masturbation • Focus on establishing relationships with peers • Sexual behavior with peers (e.g., kissing and fondling) • Interest in others' bodies, which may take the form of looking at photos or other published material	• Sexual play with younger children • Any sexual activity between children of any age that involves coercion, bribery, aggression, secrecy, or a substantial peer or age difference
Age 13–17	
• Masturbation in private • Mutual kissing • Sexual arousal • Sexual attraction to others • Consensual sexual activity between peers • Sexual behavior that contributes to positive relationships • Sexual interaction through technology and social media	• Masturbation that causes physical harm or distress to self and others • Public masturbation • Unwanted kissing • Voyeurism, stalking, sadism (gaining sexual pleasure from others' suffering) • Non-consensual groping or touching of others' genitals • Coercive sexual intercourse/sexual assault • Coercive oral sex • Sexual behavior that isolates the young person who engages in it and is detrimental to their relationships with peers and family

Adapted from material presented in Araji, S. K. (2004). Preadolescents and adolescents: Evaluating normative and non-normative sexual behaviours and development. In O'Reilly, G, Marshall, W. L., Carr, A., & Beckett R. (Eds.), *The handbook of clinical intervention with young people who sexually abuse* (pp. 4–35). Brunner-Routledge.

Risk of sexual abuse/duty to warn

This refers to situations in which the child has not yet experienced harm and there may have been no clear-cut sexually abusive actions, but it can reasonably be concluded that the current circumstances represent a significant threat of sexual abuse in the near future. Do not select this item if any item in the

Sexual Abuse category has been selected. If the situation has already been addressed, consider if an allegation of lack of supervision is appropriate.

Examples of this type of situation may include but are not limited to the following.

- A person who previously sexually abused this or another child, including having prior or current child pornography charges, is a household member or has regained access to the child; AND the child begins to exhibit uncommon, rarely normal, or potentially abusive sexual behaviors. (Refer to the "Abusive Sexual Behavior Versus Age-Typical Sexual Behavior" tables.)
- There are indications that the child is being groomed. Grooming refers to a deliberate and escalating pattern of actions taken to lower a child's inhibitions in preparation for sexual abuse (e.g., treating the child as "more special" than other children, talking about age-inappropriate sexual topics, exposing the child to pornography, deliberate self-exposure).

NEGLECT

ABANDONMENT

Caretaker has deserted the child, and there are no known plans for return. An abandoned child's caretaker has made no effort to maintain a parental relationship, and reasonable efforts have been made by the reporting party or family to locate the caretaker.

LACK OF SUPERVISION

Alleged perpetrator is not meeting the child's need for supervision to the extent that the child has been harmed or threatened with harm. Consider the child's age/abilities, the child's emotional/developmental/behavioral status, and the length of time and time of day of the incident(s). Examples include but are not limited to the following.

- Alleged perpetrator made inadequate care arrangements for the child.
- Alleged perpetrator left child unsupervised with responsibilities beyond the child's capabilities AND/OR without a support system including phone numbers of caretakers, other family members, or neighbors; information about personal safety; and what to do in an emergency.
- Alleged perpetrator left a child with concerning behaviors (e.g., setting fires; aggressive, reactive behaviors) without supervision.
- Alleged perpetrator did not provide adequate supervision and the child (consider age and emotional/developmental/behavioral status, time of day, etc.) left the home and was harmed and/or could have been significantly harmed.
- Alleged perpetrator did not provide adequate supervision, and the child had access to dangerous objects that harmed or could have harmed the child (e.g., unsecured weapons, hazardous chemicals, drugs, and/or drug paraphernalia left within child's reach).
- Any child was left in a car seat or carrier for extended periods of time.

- Alleged perpetrator is unable to care for child due to substance use, mental illness, or developmental disability.
- Alleged perpetrator is unable to protect child in the home from a sibling with violent behavior.

RECKLESS BEHAVIOR INVOLVING CHILD

Alleged perpetrator displays reckless behavior toward the child or in immediate proximity to the child, including incidents of violence while the child is present. Consider a combination of child location, type of incident (e.g., pushing, throwing objects, use of a weapon), and child vulnerability. Examples include but are not limited to the following.

- Driving or operating a motorized vehicle or vessel (e.g., car or boat) under the influence of drugs or alcohol while the child is in the vehicle.
- Intoxicated/impaired alleged perpetrator bed-sharing with an infant (age 12 months or younger).
- Tying up a child: The alleged perpetrator has tied a child to furniture or other permanent fixture for a period of time, restricting the child from moving freely.
- Inappropriate confinement: In order to block or impede the child's ability to leave a space, the alleged perpetrator has confined the child in a bedroom, basement, or any other space for a period of time inappropriate for the child's age/vulnerability.

EDUCATIONAL NEGLECT

The caretaker of a school-age child (6 [as of September 1] to 18 years old) is failing to ensure that the child is provided with an education. Educational neglect exists only after remediation attempts have been made by school personnel—including attendance officers, court, and school social workers—and there is reason to believe that the caretaker is involved.

Examples include but are not limited to the following.

- A child age 6–18 is not enrolled in school AND is not registered and not participating in a homeschooling program approved by the local education agency.
- A child age 6–18 exceeds the permitted number of unexcused absences this academic year; and despite engagement efforts, the school reports that the caretaker cannot be contacted, has been uncooperative with school officials, or cannot provide an appropriate explanation for the child's absences. See local district policy regarding unexcused absences; contact the educational services coordinator for additional information.
- A child with an individualized education program, special educational needs, and/or medical or physical vulnerabilities exceeds the permitted number of approved absences this academic year; and despite engagement efforts, the school reports that the caretaker cannot be contacted, has been uncooperative with school officials, or cannot provide an appropriate explanation for the child's absences. See local district policy regarding unexcused absences; contact the educational services coordinator for additional information.

- A child's lack of attendance impacts educational achievement, and the caretaker refuses to allow the child to attend school or appears unable to support the child in attending school.

If the child is age 16–18, daily school attendance is not required if the youth is in a postsecondary program, has a superintendent-approved alternative learning program, or is being homeschooled.

Confirm enrollment/non-enrollment in school or homeschooling program, consecutive number of days the child has been absent, school's engagement or attempts to engage with caretaker, history of excessive school absences, the impact of absences on the child, and whether other maltreatment types are present, as well as the child's age and educational needs. Consider the following circumstances when deciding whether to select this item.

FAILURE TO MEET BASIC NEEDS

Inadequate/hazardous shelter

The child's living conditions are significantly unsanitary and/or contain hazards that have led or could lead to the child's injury or illness. Consider the child's age and emotional/developmental/behavioral status. This item should not be selected for a lack of housing in and of itself.

Examples include but are not limited to the following.

- Housing that is an acute fire hazard or has been condemned
- Unprotected exposed heaters
- Gas fumes
- Faulty electrical wiring
- No utilities (e.g., heat, water, electricity)
- Vermin, human, or animal excrement
- Illegal drug manufacturing in the home

Inadequate clothing/hygiene

Alleged perpetrator has failed to meet the child's basic needs for clothing and/or hygiene to the extent that the child's daily activities have been OR will be severely impacted without DCYF intervention (e.g., child experiences hypothermia or frostbite due to inadequate clothing). Consider the child's age and emotional/developmental/behavioral status.

Inadequate food/nutrition

Alleged perpetrator has not provided and/or does not provide sufficient food or hydration to meet the child's minimum nutritional requirements, AND the child experiences significant lack of food or unmitigated hunger due to lack of food. Exclude fasting for religious reasons.

MEDICAL NEGLECT (INCLUDES NEGLECT OF DENTAL, VISION, AND/OR MENTAL HEALTH CARE)

Alleged perpetrator unreasonably delays; refuses; or fails to seek, obtain, and/or maintain necessary medical, dental, vision, or mental health care when alleged perpetrator knows—or should reasonably be expected to know—that such actions may have an adverse impact on the child's health and welfare. Note: "Dental neglect" prevents child from eating AND/OR causes pain/infection, weight loss, or other serious symptoms.

NO MEDICAL EXPLANATION FOR FAILURE TO THRIVE

Child is diagnosed by or on behalf of a physician with non-organic failure to thrive or is showing signs thereof.

CARETAKER DOES NOT PROTECT CHILD AGAINST ABUSE/NEGLECT

The child is being or likely will be harmed by a person other than the caretaker, AND the caretaker is aware of this or should reasonably be expected to have this knowledge, AND there is no information or indication that the caretaker has acted to protect the child. Harm includes physical/sexual/emotional abuse or neglect. If the person causing harm is a caretaker in another household, screen in an additional report of child abuse or neglect on this caretaker.

EMOTIONAL ABUSE

ALLEGED PERPETRATOR'S BEHAVIORS HAVE LED OR ARE LIKELY TO LEAD TO EMOTIONAL HARM OF THE CHILD. (FOR DOMESTIC VIOLENCE, SELECT "EXPOSURE TO DOMESTIC VIOLENCE.")

Alleged perpetrator has a pattern of negative behavior; has repeated destructive interpersonal interactions; OR had a single, significant destructive interaction with the child that has or likely will have an impact on the child's emotional well-being. The child may exhibit harm through symptoms of depression, significant anxiety or withdrawal, self-destructive or outwardly aggressive behavior toward others, delayed development, or other behavior consistent with the child having suffered emotional harm. Examples include but are not limited to the following.

- **Rejecting:** Alleged perpetrator refuses to acknowledge the child's worth and the legitimacy of the child's needs. This may include singling one child out to criticize or punish, belittling a child, or shaming a child for expressing normal emotions such as affection or grief.

- **Withholding:** Alleged perpetrator limits affection or cognitive stimulation, fails to express care and love for the child, and/or uses affection as a reward.
- **Terrorizing:** Alleged perpetrator verbally assaults the child, creating a climate of fear and/or bullying and frightening the child so that the child believes the world is unpredictable and hostile. This may include threatening harm or actually harming self or a child's loved ones, including pets; intentionally placing the child in dangerous situations; or otherwise intentionally causing the child to experience extreme fear.
- **Ignoring:** Alleged perpetrator deprives child of essential stimulation and responses, negatively impacting emotional growth and intellectual development.
- **Isolating:** Alleged perpetrator limits interactions or cuts the child off from normal opportunities for social or cultural interaction, preventing the child from forming friendships and making the child feel alone in the world. This may include intentionally denying the child opportunities for interacting with peers or other adults.
- **Corrupting:** Alleged perpetrator "mis-socializing" the child, inciting the child to engage in destructive antisocial behavior that reinforces deviance and makes the child unfit for normal social experiences. Alleged perpetrator's actions encourage the child to develop self-destructive, antisocial, criminal, or deviant behaviors.
- **Exploiting:** Alleged perpetrator uses the child for their own gain, such as talking negatively about the other caretaker in an effort to sabotage the child's relationship with that caretaker.

EXPOSURE TO DOMESTIC VIOLENCE

Child is exposed to one or more incidents of domestic violence, as indicated by the child witnessing, hearing, or trying to intervene in the incident OR experiencing the buildup of tension or aftermath of the incident (e.g., observing victim's depression, bruises, or other injuries). Incidents of domestic violence include but are not limited to physical assault of one caretaker by another; sexual assault; verbal altercations that include coercion, intimidation, or threats; repeated or intentional manipulation or control of children through minimization, lies, or promises; isolation; and/or unreasonable control of the adult victim. If a child has been injured, also select "Inflicted physical injury" in the Physical Abuse category.

SECTION 3. INITIAL SCREENING DECISION

NO MALTREATMENT TYPE IS SELECTED.

Select this option if no criteria in Section 2 are selected, which means that the report does not meet statutory requirements for an in-person response. Consider if further action is needed after consideration of overrides.

MALTREATMENT TYPE IS SELECTED.

Select this option if any criteria in Suspicious Child Death, Physical Abuse, Sexual Abuse, Neglect, and/or Emotional Abuse are selected, which means that at least one reported allegation meets statutory requirements for an in-person response.

SECTION 4. OVERRIDES

Supervisory approval is required for all overrides.

NO CRITERIA ARE SELECTED, BUT REPORT WILL BE OPENED AS AN INVESTIGATION.

Select this decision if no criteria in Section A are marked, which means that the report does not meet statutory requirements for an investigation; however, an investigation will be opened in Rhode Island Children's Information System (RICHIST) for an in-person response due to circumstances such as a response required by court order or administrative directive.

ONE OR MORE CRITERIA ARE SELECTED, BUT REPORT DOES NOT REQUIRE INVESTIGATORY RESPONSE BASED ON ONE OR MORE OF THE FOLLOWING.

Insufficient information to locate child/family

The caller was unable to provide enough information about the child's identity and/or location to enable an investigation. Select only after following state protocol for attempting to determine identity/location from information provided by caller.

Duplicate report

Information received by DCYF is currently being investigated or has been investigated previously, and there is no new information.

Another agency has jurisdiction and accepts responsibility

State protocol determines that an agency such as law enforcement, another child protection agency that has jurisdiction, tribe, or court will be the investigating entity and accepts responsibility for this issue; AND a DCYF child welfare response is not required.

Historical information only

For this item to apply, ALL of the following must be true.

- Child is at least 13 years old; AND
- The alleged maltreatment occurred more than three years ago; AND
- There have been no reports of abuse or neglect since the alleged incident; AND
- The conditions that contributed to the alleged incident are no longer present; AND
- If the reported incident is sexual abuse, the alleged perpetrator must be either an unidentifiable non-household member or deceased.

SECTION 5. FINAL SCREENING DECISION

REPORT REQUIRES INVESTIGATORY RESPONSE

Select this item if any maltreatment type in Suspicious Child Death, Physical Abuse, Sexual Abuse, Neglect, Emotional Abuse, and/or Risk of Harm is selected; AND no override is applied to screen out. Also select when there is an override to screen in for investigation. If allegations are in an out-of-home setting, refer to DCYF policy regarding notification of additional DCYF regulatory bodies.

NO MALTREATMENT TYPES IN SECTION 2 ARE SELECTED, OR AN OVERRIDE TO SCREEN OUT WAS APPLIED.

Select if no maltreatment type criteria are selected in Section 2 AND no override is applied to screen in the report. Also select if an override is applied to screen out the report. Consider if further action is needed. No further SDM assessments are required.

GIVEN THE INFORMATION IN THE REFERRAL, IS FURTHER ACTION NEEDED (UNRELATED TO THE SCREENING DECISION)?

Yes, an additional response is required.

Support and Response Unit (SRU)—refer to DCYF policy regarding eligibility criteria

Refer to most recent DCYF policy regarding appropriateness of referral to SRU.

Protective service alert

Jurisdictions send out national alerts on missing children and/or families. This may mean a child protective services investigation is occurring in that jurisdiction and they are unable to locate the family. The hotline worker will document these alerts in RICHIST so they can be acted upon if the child/family comes to DCYF's attention.

In-state or hospital alert

Person with DCYF history known to pose a high risk of potential harm to a child, including pregnant women who test positive for illegal or non-prescribed substances during pregnancy.

Office of the Child Advocate

Refer to DCYF's most recent policy on reporting requirements.

Licensing supervisor/licensing worker

Refer to DCYF's most recent policy on reporting requirements.

Superintendent/deputy superintendent

Refer to DCYF's most recent policy on reporting requirements.

Law enforcement

Refer to DCYF's most recent policy on reporting requirements.

Other

No additional response is required by DCYF.

SECTION 6. RESPONSE PRIORITY

DO ANY OF THE FOLLOWING APPLY? *If so, a Priority 1 (P1) response is required. If not, continue to Priority 2 (P2) criteria.*

Child fatality

A child death has been reported, and there is another child in the home.

Inflicted, non-accidental, or suspicious injury to a child under 6 years old, a child of any age with developmental vulnerabilities, or a non-mobile child of any age.

A child under 6 years old—or a child of any age with the capability of a child younger than 6 years old due to developmental, physical, or emotional disability—has an injury that is more than superficial. The

reporter may not know how it was caused, AND the nature of the injury suggests that it is non-accidental. Include injuries that a medical professional describes as consistent with abuse.

Child requires immediate medical/mental health care, AND caretaker is unwilling/unavailable to obtain needed treatment.

Medical care is immediately necessary; and if it is not provided, the child's health and well-being will be seriously and possibly permanently affected. This includes necessary or in-progress treatment and/or evaluation of an injury, as well as treatment required for withdrawal symptoms in a newborn. It does not include a medical examination completed solely for forensic purposes. This does include situations in which injuries or illnesses pose a danger of death/near fatality, physical impairment, disfigurement, or disability. If a child required or currently requires medical treatment and the caretaker has sought/obtained needed treatment, do not select this criterion for a P1 response.

Examples include but are not limited to the following. Remember that this MUST also include the caretaker being unwilling or unable to keep the child safe.

- A child has symptoms associated with failure to thrive regardless of whether failure to thrive has been diagnosed; and either no medical attention is being provided currently, or the child's appearance and symptoms suggest medical attention should be given immediately.
- The caretaker is unwilling or refusing to obtain medical treatment; without such treatment, the child's condition may become life threatening or may result in permanent impairment.
- A child is experiencing extreme emotional/mental health concerns such as psychosis, self-harm, and threatening harm to others.
- A child has a serious illness or injury that has not been medically assessed, and the child's condition is worsening (e.g., prolonged vomiting or diarrhea, evidence of a worsening infection or chronic medical condition that affects child's breathing or ability to eat or drink).

Child is unsupervised, inadequately supervised, or abandoned AND requires immediate care and supervision.

Caretaker is either present and inadequately supervising the child or is not present and the child is currently unsupervised, AND the child requires immediate care and supervision. The likelihood of the child being physically injured or becoming ill is high if an immediate response does not occur. The child's age; emotional, physical, and developmental stage; weather; time of day; and immediate environment should all be considered when determining if a P1 response is required. Examples include but are not limited to the following.

- Child is currently alone (appropriate/inappropriate length of time varies with age and developmental stage).
- Child has been abandoned, and no caretaker is willing and able to provide care for a minimum of three days.

- Child was inadequately supervised and was injured, or the child avoided injury only due to intervention by a third party (e.g., alleged perpetrator was sleeping, and the child turned on the stove and burned their hand).
- Alleged perpetrator currently caring for the child is under the influence of drugs or alcohol OR is experiencing symptoms suggestive of suicidal, homicidal, or psychotic behavior or an intellectual impairment (e.g., caretaker is hearing commands to hurt the child or is incoherent/passed out with a child in their care); AND as a result, the alleged perpetrator is unable to adequately supervise the child.

The likelihood that a child has been or will be exposed to domestic violence in the next four hours is high, AND no caretaker is demonstrating or able to demonstrate protective actions.

A pattern of domestic violence behavior/incidents exists, and this creates a concern for the child's safety; AND no caretaker is demonstrating or able to demonstrate protective actions.

Examples include but are not limited to the following.

- Alleged perpetrator physically assaults the non-offending caretaker.
- Alleged perpetrator threatens to kidnap or refuses to return the children.
- Alleged perpetrator was involved in any incident that involved weapons, resulted in serious injury to any adult, or during which the child attempted to intervene in or was directly in the path of violence.

There are sexual abuse allegations, and the alleged perpetrator is unknown or may have access to child within the next four hours.

Allegations include current concerns of sexual abuse, and either the alleged perpetrator is unknown OR the alleged perpetrator may have access to the child within the next four hours.

DO ANY OF THE FOLLOWING APPLY? *If so, a P2 response is required. If not, recommended response is P3.*

Child has an injury that was inflicted, is suspicious, unexplained, or consistent with abuse; AND the alleged perpetrator is unknown or may have access to the child within the next 12 hours.

The child has an injury that is more than superficial. The reporter may not know how it was caused, AND the nature of the injury suggests it is non-accidental, AND the alleged perpetrator is unknown or may have access to the child within the next 12 hours. Include injuries that a medical professional describes as consistent with abuse.

Caretaker's behavior or escalating pattern of behaviors toward the child is severe, excessive, and dangerous and has threatened or is likely to threaten child's physical/emotional health or safety (reasonable person standard).

The caretaker acts in dangerous ways or has threatened to engage in brutal or dangerous acts toward the child, and these acts are likely to result in injuring the child. Consider the child's age, ability, and developmental stage. Examples of caretaker behaviors include but are not limited to the following.

- Hitting with closed fist
- Hitting the child's head, back, or abdomen with substantial force
- Choking, kicking, or hitting with belt buckle or other dangerous object
- Using restraints
- Poisoning
- Demonstrating behavior that could reasonably result in severe injury, such as the following.
  - » Dangling the child from heights
  - » Exposing the child to dangerous temperature extremes
  - » Throwing objects at the child that could cause severe injury
- Harming or threatening to harm self, others, or pets in the child's presence
- Using unusual forms of discipline that rely on humiliation, fear, and intimidation, such as forcing a 10-year-old to wear diapers
- Exhibiting extreme rejection of the child, such as not speaking to the child for extended periods, acting as if the child is not present for long periods, or misusing time-out techniques by using time limits far beyond what would be appropriate for the child's age/developmental stage
- Endangering the child's emotional health or safety through the caretaker's own actions, such as attempting or threatening suicide.

Child demonstrates severe emotional distress or credible fear that requires an immediate response.

Child is demonstrating severe emotional distress or disclosing credible fear of experiencing harm upon returning or remaining in the home. Examples of severe emotional distress include suicidal, homicidal, or self-harming behaviors. The fear is considered credible if the child can describe the incident in detail or is visibly distressed and/or if there is a history of abuse.

Extreme hazardous physical environment immediately threatens a child's health and/or well-being, given child's developmental stage and age.

The child's physical living conditions are hazardous and immediately threatening, based on the child's age and developmental stage. Examples include but are not limited to the following.

- Gas leaking from stove or heating unit

- Lack of water or utilities (e.g., heat, plumbing, electricity), and no alternative or safe provisions have been made
- Open/broken/missing windows
- Exposed electrical wires
- Excessive garbage or rotted or spoiled food that threatens the child's health
- Child has suffered serious illness or significant injury due to living conditions, and these conditions still exist (e.g., lead poisoning, rat bites).
- Evidence of human or animal waste throughout living quarters
- Illegal drug production in the home

The likelihood that the child will be exposed to domestic violence in the next 12 hours is high, AND no caretaker is demonstrating or able to demonstrate protective actions.

A pattern of domestic violence behavior/incidents exists, and this creates a concern for the child's safety, AND no caretaker is demonstrating or able to demonstrate protective actions. Examples include but are not limited to the following.

- Alleged perpetrator physically assaults the non-offending caretaker.
- Alleged perpetrator threatens to kidnap or refuses to return the children
- Alleged perpetrator was involved in an incident that involved weapons, resulted in serious injury to any adult, or during which the child attempted to intervene in or was directly in the path of violence.

Note: If a caretaker is demonstrating protective actions (e.g., leaving household with child, offending caretaker was arrested, and non-offending caretaker sought additional legal action), do not select this criterion for a P2 response.

Child or infant will be discharged within the next 12 hours; AND either no caretaker is willing/able to provide care upon discharge, OR assistance with a safe hospital discharge plan is required.

A child or infant is hospitalized and will be discharged within 12 hours; AND the sole caretaker/both caretakers appear unwilling or unable to provide for the child upon discharge, OR assistance with a safe hospital discharge plan is required. Examples include but are not limited to the following.

- The caretaker has not participated in discharge planning or has refused to comply with discharge plans to ensure the child's needs will be met.
- The caretaker has refused to accept child or infant upon discharge from the hospital.
- The caretaker has been unwilling or unable to participate in the child's medical care during hospitalization despite attempts made by medical staff.

Person known to have previously sexually abused this or another child is reportedly in the home AND has access to the child within the next 12 hours.

Although there are no indications that the child has experienced harm, a person who has been investigated and convicted of sexually abusing a child resides in the home AND has access to the child.

Current sexual abuse/exploitation exists as evidenced by disclosure, credible witnessed account, or medical evidence; AND alleged perpetrator will have access to child within the next 12 hours, or extent of access is unknown.

Disclosure may be verbal or nonverbal. Medical evidence includes medical findings related to sexual abuse and suspicious findings such as sexually transmitted diseases in young children.

History of physical abuse (Select *only* if current maltreatment type is physical abuse.)

There is credible information that the household has experienced one or more prior investigations related to physical abuse. Select *only* if at least one of the following applies.

- Allegations of physical abuse have been previously indicated in RICHIST.

OR

- Other credible information exists that indicates past physical abuse. This may include a reporter (e.g., law enforcement, medical professional, behavioral health professional, child protection investigator) stating they have observed past physical abuse. It may also include the child disclosing past physical abuse.

IF NO CRITERIA APPLY FOR A P1 OR P2 RESPONSE, A P3 RESPONSE IS RECOMMENDED.

SECTION 7. OVERRIDES

Supervisory approval is required for all overrides.

POLICY

Increase to Priority 1 whenever:

Law enforcement requests an immediate response

A law enforcement officer is requesting an immediate child protective services response.

Forensic considerations would be compromised by a slower response

Physical evidence necessary for the investigation will be compromised if the investigation does not begin immediately, OR there is reason to believe statements will be altered if interviews do not begin immediately.

There is reason to believe the family may flee

The family has stated an intent to flee or is acting in ways that suggest an intent to flee, OR there is a history of the family fleeing to avoid investigation.

Decrease to Priority 2 (from Priority 1) or Priority 3 (from Priority 2) whenever:

Child safety requires a strategically slower response

The child's current location is such that initiating contact may create a threat to the child's safety, OR the value of coordinating a multi-agency response outweighs the need for immediate response.

The child is in an alternative safe environment

The child is no longer in the same place or no longer with the caretaker who is the alleged perpetrator, and the child is not expected to return within the next 12 hours (for a decrease from Priority 1 to Priority 2) or within the next 48 hours (for a decrease from Priority 2 to Priority 3).

The alleged incident occurred more than six months ago, AND no maltreatment is alleged to have occurred in the intervening period

The incident being reported occurred at least six months prior to the report being made, AND no other maltreatment is alleged to have occurred in the intervening period.

SDM® HOTLINE SCREENING AND RESPONSE PRIORITY ASSESSMENT
POLICY AND PROCEDURES

Rhode Island Department of Children, Youth and Families

WHICH CASES

The SDM hotline screening and response priority assessment is completed for all reports of concerns for child abuse and/or neglect.

WHO

The hotline worker completes the assessment, and the supervisor reviews and approves it.

WHEN

The assessment is completed upon receipt of information that constitutes a report. This generally occurs while the hotline worker is talking with the reporter making a report. Occasionally, the hotline worker may need to gather additional information as part of the screening process. For these reports, the assessment is completed as soon as all necessary information is gathered, by end of shift.

DECISION

The assessment informs the decision of whether to accept a report for investigation and sets a response priority for reports screened in for investigation.

APPROPRIATE COMPLETION

SECTION 1. PRELIMINARY SCREENING

Complete this section based on information provided by the reporter. If any items in this section are selected, the report does not meet the criteria for an investigation. A non-investigatory response by the agency may be identified.

SECTION 2. MALTREATMENT TYPE

Proceed with the review of screening criteria and select all applicable maltreatment types, using the definitions to ensure that the reported information meets criteria. If no maltreatment types are identified, the worker should select the first item in Section 3: "Screen out: No maltreatment type is selected."

SECTION 3. INITIAL SCREENING DECISION

Complete this section based on whether items were selected in maltreatment types. Select the first item in this section if no maltreatment types were selected. If any maltreatment types were selected, select the second item in this section.

SECTION 4. OVERRIDES

Consider whether any overrides apply that would change the initial screening decision. Also select the reason for the override.

SECTION 5. FINAL SCREENING DECISION

Complete this section based on the initial screening decision and consideration of any overrides. After the final screening decision has been selected, consider if further actions need to be taken.

SECTION 6. RESPONSE PRIORITY

Within each set of criteria, begin at the first question or set of questions and determine whether "Yes" or "No" is appropriate, using the definitions. To determine whether "Yes" or "No" is the most appropriate response for each question, ask questions of the reporter until the response becomes clear. Consider each response priority criterion until a response priority (Priority 1, Priority 2, or Priority 3) is reached.