


Rhode Island Department of Children, Youth and Families Department Operating Procedure			
	DOP Number: 100.0165	Effective Date: July 23, 1990	Page 1 of 10
	Version #: 4	Revised Date: August 23, 2016	Director:
Section: General Administration and Management		Title: Child Fatality and Near Fatality Response	
Legal Authority:			
<ul style="list-style-type: none"> • Child Abuse Prevention and Treatment Act (CAPTA), (P.L. 93-247) • CAPTA Reauthorization Act of 2010 (P.L. 111-320) • Rhode Island General Law §42-72 • Rhode Island General Law §42-72-8(c)(3) • Rhode Island General Law §40-11-3.1 			
Related DOPs:			
<ul style="list-style-type: none"> • Burial and Funeral Arrangement Procedure (in draft) • Critical Information Communications (in draft) 			
Related Forms:			

I. PURPOSE

The Department of Children, Youth and Families (Department) is responsible to investigate all child fatalities and near fatalities in the following situations:

- A child fatality in which child abuse or neglect is suspected to be a contributing factor regardless of whether the family is currently active or has ever received services from the Department;
- A child fatality or near fatality in which child abuse or neglect could be a contributing factor and the family is active or has been active with any division of the Department within the previous 12 months; or
- A child fatality or near fatality in which abuse or neglect is not suspected to be a contributing factor but the family is active or has been active with any division of the Department within the previous 12 months.

The Department is the primary agency contact with hospital/medical personnel, the office of the Medical Examiner, any law enforcement agencies involved including police departments and the Office of the Attorney General.

The Department's Critical Review Administrator (CRA) conducts a Critical Event review within 3 business days of the Department's receipt of notification of the fatality/near fatality for any cases involving a child fatality or near fatality as described above. The CRA identifies and invites participants for the review panel; completes and distributes a case timeline; and prepares a summary report of events and recommendations for the Department Director as well as follow up reports at designated intervals. Participants on the review panel include current and previously assigned staff with direct knowledge of the case as well as administrative representatives from across the Department who can provide input on policy, procedure, and practice and assist in assessing any systemic factors that may have contributed to the fatality/near fatality or for which improvement is recommended.

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The CRA provides a verbal report of the results and recommendations of the Critical Event review panel to the Department Director and Chief of Staff no later than the close of business on the same day as the review. When circumstances of the case warrant further investigation or review by community stakeholders the CRA recommends the matter be referred to the Citizens Review Panel for a Child Fatality/ Near Fatality Review and that the Office of the Child Advocate be notified.

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The CRA maintains a record of each fatality/near fatality review. At the end of each fiscal year a summary of the reviews conducted during that 12 month period is developed and provided to the Department Director for review and dissemination.

The Department's fatality/near fatality review process provides an opportunity for the Department to identify needed improvements to state statutes, Department regulations, operating procedures, practices and training. Uniform response to and review of child fatalities and near fatalities allows the Department to:

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

II. TERMS DEFINED

Fatality – The death of any child in which maltreatment is suspected to be a contributing factor regardless of whether the child is active with the Department at the time of death; the death of a child currently active or who was open to any division of the Department during the last 12 months regardless of manner or cause of death.

Near Fatality – An act that, as certified by a physician, places a child currently active or who was open to any division of the Department during the last 12 months in serious or critical condition, regardless of manner or cause of the injury.

Serious Physical Injury – An injury deemed so by the Department inclusive of abusive head trauma, skull fracture or multiple broken bones.

III. PROCEDURE

A. Notification

1. When the Department receives a report regarding a child fatality, near fatality or serious physical injury, notification must be made within the Department at the executive, administrative, and operational levels as well as to key stakeholders outside of the Department.
2. Child fatalities, near fatalities and serious physical injuries, as defined above that occur in cases active in any division of the Department, including guardianship and adoption subsidies, must be reported to the Child Protective Hotline by the assigned Department staff member as soon as he/she learns of the incident.
3. Within 1 hour of notice to the Department of the occurrence of a child fatality, near fatality, or serious physical injury, the Call Floor Supervisor notifies the CPS

administrator via a high priority e-mail and telephone contact containing the following information:

- Child and family name;
- Child's DOD;
- Caregiver's DOB;
- Child's place of residence and caregiver(s);
- The new allegation if applicable; include brief synopsis of events;
- Case status: currently active, previously active or not active;
- Child's legal status if any;
- Whereabouts, legal status and condition of any other children in the family as received in the report;
- Information about any other children in the placement setting if the fatality or near fatality occurred in a placement setting of any type; and
- The status of law enforcement notification and involvement.

4. Within 1 hour of notification to the Department of a child fatality, near fatality, or serious physical injury, the CPS administrator notifies the agency Director, Chief of Staff, and Critical Review Administrator via high priority e-mail containing all of the relevant information listed above.

- a. The Director notifies the Governor and the Office of the Child Advocate verbally and in writing within 48 hours of a confirmed fatality or near fatality of a child involved with the Department.
- b. The Department provides the Office of the Child Advocate with access to any written material about the case.
- c. The Chief of Staff notifies the Communications Officer of a child fatality or near fatality within the same business day. The Chief of Staff and Communications Officer develop a media strategy.
 - i. The Department makes public disclosure within 48 hours of a confirmed fatality or near fatality of any child with Department involvement within the last 12 months.
 - ii. Public disclosure is made upon determination that the child was the victim of child abuse or neglect, provided that disclosure of such information is in general terms and does not jeopardize a pending criminal investigation.
- d. The CRA notifies the Chief Legal Counsel within 1 hour of a fatality. In cases of a near fatality the CRA notifies the Chief Legal Counsel within 24 hours or the next business day. The Chief Legal Counsel notifies the Chief of the Family Court as appropriate if the family is court involved.
- e. The CRA notifies the Administrator of Licensing within 1 hour of a child fatality in a home or facility licensed by the Department. In cases of a near fatality the Licensing Administrator is notified in compliance with the Department's CPS procedures. The Licensing Administrator notifies assigned staff within that division as appropriate.
- f. The CRA notifies the appropriate regional/divisional administrator in FSU or Juvenile Correctional Services in cases where agency involvement predates the fatality or near fatality as follows:
 - i. Immediately or within 1 hour of the time the Department is informed of the fatality/near fatality if received during routine business hours.
 - ii. The following morning at or before the start of the work day if the Department is informed of the fatality/near fatality after hours on a week night.
 - iii. No later than 24 hours after the Department is informed of a fatality/near fatality if on a weekend or holiday.

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- g. The divisional administrator is responsible for notification to their assigned staff within these same parameters.
- 5. The Department Director or his or her designee discloses all investigative findings to the Office of the Child Advocate within 5 business days of the completed investigation when there is a substantiated finding of child abuse or neglect that resulted in a child fatality or near fatality.
 - a. The Department may disclose the same information to the Office of the Attorney General.
 - b. Information must be disclosed in accordance with RIGL 42-72-8(c)(3) and includes:
 - i. A summary of the report of abuse or neglect and a factual description of the contents of the report;
 - ii. The date of birth and gender of the child;
 - iii. The date that the child suffered the fatality or near fatality;
 - iv. The cause of the fatality or near fatality, if such information has been determined; and
 - v. Whether the Department or a court appointed special advocate had any contact with the child before the fatality or near fatality and if so:
 - The frequency of any contact or communication with the child or member of the child's family or household before the fatality or near fatality and the date on which the last contact or communication occurred before the fatality or near fatality;
 - Whether the Department made any referrals for child welfare services for the child or for a member of the child's family or household before or at the time of the fatality or near fatality;
 - Whether the Department took any other action concerning the welfare of the child before or at the time of the fatality or near fatality;
 - A summary of the status of the child's case at the time of the fatality or near fatality, including, whether the child's case was closed by the Department before the fatality or near fatality and if so, the reasons why the case was closed;
 - Whether the Department, in response to the fatality or near fatality:
 - Has provided or intends to provide an/or make a referral for child welfare service to the child or to a member of the child's family or household; and
 - Has taken or intends to take any other action concerning the welfare and safety of the child or any member of the child's family or household.

B. CPS Investigative Responsibility:

- 1. CPS proceeds with its investigation as per Department procedure. If the family is currently active with another division of the Department, CPS coordinates its activities with assigned staff from those divisions.
- 2. The CPI initiates contact with other assigned Departmental staff to share information regarding the reported fatality/near fatality, review the family's current or recent history with the Department, identification of potential safety concerns for any other children in the home or placement in which the child fatality or near fatality occurred, and potential or available relative/kinship resources.

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- a. Contact is initiated by the CPI prior to the start of the investigation when possible, exceptions being weekend, holidays and afterhours events.
 - b. Contact at the above stated times is initiated if information necessary to the investigation is not available.
3. The CPI assess 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 that may reside elsewhere, and develops safety plans accordingly. Safety plans are shared with other agency staff assigned to the case. Responsibility for changes in placement, medical clearances, legal consults and the writing and filing of petitions if necessary, is shared between CPS and other assigned divisions for those cases active at the time of the fatality or near fatality.
- a. The CPI is responsible to conduct interviews required for the investigation including those with family members, both immediate and extended.
 - b. The CPI is the primary agency contact with hospital/medical personnel, the office of the Medical Examiner, any law enforcement agencies involved including police departments and the Office of the Attorney General.
 - c. The CPI and supervisor participate in the Critical Event Review as scheduled.
 - d. The CPI updates the CRA as to the outcome of the Department's investigation, findings from the Medical Examiner's office, and the status of any law enforcement investigations/activity inclusive of local police and the Attorney General's office.
4. The divisional administrator assesses and arranges for the initial level of support needed by the assigned CPI staff, the unit and the division as appropriate. Supports may be accessed through the Department's Peer Support Team, the State of RI EAP, and the employee's medical benefits.
5. The divisional administrator arranges for coverage of tasks associated with other cases assigned to the CPI and CPI supervisor managing the child fatality or near fatality and monitors work on those cases as needed.

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C. Intake/FSU/JCS Responsibility:

1. Intake, FSU and/or JCS staff already assigned to and working with the family at the time of the child fatality or near fatality remain the primary agency staff assigned to the case.
- a. Once notified of the fatality or near fatality, Department staff assigned to the case do not enter any CANS or case information into RICHIST or alter the hard copy record in any way until completion of the Critical Event Review or as advised by the CRA.
 - b. Hard copy records are turned over to the CRA.
2. In recognition of the difficulty of experiencing a child fatality or near fatality, casework responsibility for other cases assigned to the worker/supervisor are distributed for coverage within the unit or region for up to 7 business days, if necessary.
- a. Line and supervisory staff assigned to the case in which the fatality or near fatality occurred use this time to address the needs of the involved family and to care for their own wellbeing.
 - b. Management staff in these divisions provide direct assistance and support to the assigned staff in addressing the needs of the involved

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family as well as assess the emotional wellbeing of the assigned staff, the involved unit and division as a whole and secure supports for them as necessary and appropriate.

3. The primary worker, in consultation with the CPI and in coordination with the investigation, assists with identifying and determining the appropriateness of family/kinship placements if needed. The primary worker is responsible to assess the wellbeing needs of any other children in the family and to secure services and supports to meet those needs.
 - a. The primary worker and supervisor are responsible to assess the needs of the parents and to secure services and supports to meet those needs inclusive but not limited to, emotional supports, grief counseling, and financial assistance for funeral and burial arrangements. (See Burial and Funeral Arrangement policy for details).
 - b. The divisional administrator, in conjunction with the CRA, assists with arrangements for funeral and burial services as needed.
 - c. If the child fatality or near fatality occurred in a foster home the primary service worker in conjunction with the Licensing worker (and provider agency if appropriate) assess the needs of the foster parents. The Licensing worker is responsible to assist the foster parents (see Licensing Activity section below).
 - d. The primary worker and supervisor do not enter any CANs or other information into the RICHIST or hard copy records once notified of the child fatality or near fatality and until such time as the Fatality/Near Fatality Review is conducted or as advised by the CRA.
 - e. The primary worker and supervisor provide the hard copy record and any un-entered notes, unfiled reports/evaluations or other materials pertinent the case to the CRA for use in the development of the case timeline necessary for the Child Fatality/Near Fatality review meeting. All hard copy records are provided to the CRA immediately after notification is received by the assigned staff of the fatality/near fatality.
 - f. The divisional administrator meets with their assigned staff to discuss the events and assess the level of support needed by them as well as by the unit and the division as a whole. Services can be accessed through the Peer Support Team, the State of RI EAP, or the employee's medical benefits.
 - g. The primary worker and assigned supervisor participate in the Critical Event review as scheduled.

D. Licensing Responsibility:

1. The Licensing division takes any necessary licensing action if the fatality or near fatality occurred in a foster home, congregate care facility or daycare facility licensed by the agency.
2. Once notified of the critical incident, Licensing staff assigned to the foster home or congregate care placement do not enter any CANs or case information into RICHIST or alter the hard copy licensing record in any way until completion of the Critical Event Review or as advised by the Critical Review Administrator.
 - a. The licensing worker and supervisor provide the hard copy record and any un-entered notes, unfiled reports/evaluations or other materials pertinent the case to the CRA for use in the development of the case timeline necessary for the Child Fatality/Near Fatality review meeting.
 - b. All hard copy records are provided to the CRA immediately after notification is received by the assigned staff of the fatality or near fatality.

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3. The licensing worker, in conjunction with the primary service worker and provider agency (if appropriate) is responsible to assess the needs of the foster parents. The licensing worker is responsible to communicate with the involved congregate care agency regarding the needs of their staff.
 - a. The licensing worker, in conjunction with their supervisor, administrator and any private provider agencies involved will work to secure services and supports to meet those needs.
 - b. The divisional administrator meet with their assigned staff to discuss the events and assess the level of support needed by them as well as by the unit and the division as a whole.
 - c. The divisional administrator makes arrangements for coverage tasks associated with any other cases assigned to the primary worker and supervisor for a period of up to 7 business days, if necessary.
 - d. The divisional administrator monitors work on those cases as needed.
 - e. The Licensing worker and supervisor participate in the Critical Event review as scheduled.

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E. Critical Review Administrator (CRA)

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1. The CRA schedules and conducts a Critical Event review for any case involving a child fatality or near fatality as described in this procedure.
2. The CRA identifies and invites participants for the review panel, completes and distributes a case timeline and prepares a summary report of events and recommendations for the Department Director as well as follow up reports at designated intervals.
 - a. Participants on the review panel include current and previously assigned staff with direct knowledge of the case as well as administrative representatives from across the Department who can provide input on policy, procedure, and practice and assist in assessing any systemic factors that may have contributed to the fatality or near fatality or for which improvement is recommended.
 - b. The Office of the Child Advocate is invited.

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3. The CRA schedules a Critical Event review of the case to be held within 3 business days of the Department's receipt of notification of the child fatality or near fatality. Participants include individuals within the agency who have working knowledge of the family and/or facility (if the incident took place in a foster home, congregate care setting or daycare licensed through the Department), and are currently assigned to the case or were assigned prior to closing if closing was within the last 12 months. This includes, but is not limited to:
 - the CPI and CPI Supervisor
 - the primary service worker
 - RITS social worker
 - the Licensing worker and Supervisor if the fatality or near fatality occurred in a licensed foster home or congregate care setting, and
 - Legal Counsel

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4. Administrative staff from all divisions are asked to participate in reviews on a rotating basis to provide input and feedback regarding implications for practice, training, policy, or systemic issues such as supervision, staffing, and access to resources.
5. In preparation for the review the CRA develops a case summary and timeline of the Department's involvement with the family.

- a. The CRA contacts the Records Center (for a closed case) or regional/division administrator (for an active case) to request the hard copy record and any ancillary reports, evaluations, treatment summaries, service plans or other documents related to the family.
- b. If the incident occurred in a foster home, congregate care placement or daycare licensed by the Department the CRA may request records from that division.
- c. Requested records are provided to the CRA the same day as requested.

6. The CRA's case summary and time line is prepared and shared with meeting attendees' one business day before the scheduled Critical Event review. The summary includes, but is not limited to, the following information:

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- Case name and RICHIST case number;
- Name, DOB and DOD (if applicable) of the involved child;
- Parents and other adults in the child's household/family;
- Siblings – maternal and paternal;
- Caregiver names and type of living arrangement, including licensure status if applicable, for the involved child and siblings;
- Summary of the current allegations including location where the critical event occurred;
- Investigative history – number, nature and outcome of any prior CPS contacts;
- Number and nature of any post-CPS or non-CPS openings to the Department including the current if applicable;
- Placement history for the involved child in question;
- Any known or identified medical, mental health, education or community/social challenges for the identified child;
- Identification of any other children in the placement if the child lived out of home;
- Any investigative history for the placement (if applicable);
- Legal status and permanency plan for the involved child and any siblings; and
- Any services in place to involved child, parents or caregivers at the time of the critical event.

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7. The Critical Event review focuses on:

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- Review of the known information related to the critical event including: actions or inactions on the part of the parents or caretakers that may have contributed to the fatality or near fatality; preliminary findings of the medical examiner and/or medical team; the scope and extent of law enforcement involvement if any; the scope and nature of any court involvement related to the fatality/near fatality; the scope and extent of media involvement, if any.
- A review of the family's current and prior involvement with DCYF including: the investigative history, reasons and duration for any prior openings; the reason for any current opening, the scope, nature, and appropriateness of any services in place for the parents, caregiver and involved child at the time of the fatality or near fatality; and any unfulfilled services needs and the barriers to obtaining these.
- Factors considered in decision making regarding legal action and placement of the involved child and any siblings.
- Risk and safety concerns and the family's protective capacities, and available natural supports.
- Actions taken or needed as to the placement the involved child was living in at the time of the fatality or near fatality.

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- Lessons learned from previous agency involvement with the family that could guide and assist in developing an effective safety plan for any other children in the family.
- Victim and family service needs at the time of the fatality or near fatality.
- The effects of secondary trauma to DCYF and provider staff involved and how to best meet those needs.
- Relevant practice, training, policy issues or systemic issues such as supervision, staffing or access to records that may be relevant.

8. The CRA provides a verbal report of the results and recommendations of the Critical Event review to the Director and Chief of Staff no later than the close of business on the same day as the review. When circumstances of the case warrant further investigation or review by community stakeholders the CRA recommends the matter be referred to the Office of the Child Advocate for further action.

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9. When circumstances raise concern about the actions or inactions of Department staff related to a child fatality or near fatality, the CRA recommends contact is made by the Department Director or designee with the State Division of Human Resources.

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10. The CRA contacts the involved regional/divisional administrators within 24 hours and after notification to the Director, of the findings of the review inclusive of any identified secondary trauma needs of staff.

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- Staff needs may extend beyond those of staff assigned to the present investigation and/or who had worked with the family at any point prior to the fatality/near fatality.
- Secondary trauma can be related to: the fatality/near fatality; media coverage of events; communication with medical personnel; political factors related to the event; and to communication – formal and informal within the Department.
- Supports for any/all sources of secondary trauma can include a referral to EAP, the Department's Peer Support team, a formal crisis debriefing, written communication from the Office of the Director or designee, supportive check ins from the individual/group's chain of command and other interventions.

11. The CRA collaborates with the Chief of Staff and the agency Communications Officer to ensure that any information or recommendations resulting from the Critical Event review are provided and available to inform the Department's media response/strategy as appropriate.

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12. The CRA completes summary reports related to each critical event review as follows:

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- A preliminary written report within 14 business days after the critical event review;
- An updated written report within 30 days; and
- A final report to include, to the extent possible any/all information from the Medical Examiner, within 60 days. This report is amended as needed when the official cause of death is received in fatality cases.

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13. The report addresses caregiver behavior that contributed to the child fatality or near fatality; Department efforts to ensure the safety of the child and other children in the household; practice, policy and training issues identified during the review, as well as systemic issues including supervision, staffing, access to records, and access to resources identified during the review.

14. All reports are provided to the Director and Chief of Staff for review and approval. Once approved the CRA provides copies to the involved CPS and regional/divisional administrators, the Chief Legal Counsel, the Licensing Administrator (if applicable) and the Department's Communications Officer. Provision to the Governor's office and the Office of the Child Advocate is made upon request by the Department Director or designee.
15. The CRA maintains a record of each fatality/near fatality review. At the end of each fiscal year a summary of the reviews conducted during that 12 month period is developed and provided to the Department Director for review and dissemination at his/her discretion.

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