State of Rhode Island
Office of the Child Advocate

Report of the

MULTI-DISCIPLINARY TEAM

A REVIEW OF THREE CASES THAT INVOLVED INFANT DEATHS

MARCH, 2016

Contents

Multi-Disciplinary Team

Regina M. Costa, Esq. Regina was appointed as Child Advocate by Governor Lincoln D. Chafee. Ms. Costa was confirmed by the Senate on March 31, 2011, for a five-year term. She graduated from Rhode Island College with a Masters in Social Work in 1994, and from New England School of Law with her Juris Doctor in 1992. She was admitted to the Rhode Island Bar in 1992 and the U.S. District Court in 1993. Ms. Costa also has a Masters in Counseling and a Bachelor of Arts degree in Elementary Education. Prior to being appointed as the Child Advocate, she joined the State of Rhode Island in 1984, as an employee of the Department of Children, Youth and Families. During her tenure with the Department of Children, Youth and Families, she served in positions such as Social Caseworker, Social Service Analyst, Senior Legal Counsel, Probation and Parole Counselor II, Senior Probation and Parole Counselor, and Probation and Parole Supervisor. Ms. Costa is an adjunct faculty member at Salve Regina University.

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

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

Catherine Cool Rumsey Catherine is a former Rhode Island State Senator and former Co-Chair of the Senate Taskforce on the Department of Children Youth and Families and the Family Care Networks. Ms. Cool Rumsey currently works for Berean Group International, a consulting company specializing in informational technology services. She earned a B.S. in Sociology from Nazareth College of Rochester, NY and an M.S. in Quality Management from Anna Maria College in Massachusetts. She is also a former licensed foster parent.

Ken Fandetti Ken earned his BA in Sociology from Providence College and a Master of Science in Social Services from the Boston University School of Social Work. Throughout his career, Ken served in a variety of public social service roles bringing a wealth of knowledge and experience to the team. Some of his past roles include Social Caseworker for the Rhode Island Department of Children, Youth and Families; Family Court Liaison Worker for Child Welfare Services; Residential Services Coordinator Department of Corrections Juvenile Division; Assistant to the Director Department of Corrections; Superintendent Rhode Island Training School for Youth; Assistant Director of the Division of Direct Service of the DCYF; Project Director to establish the Rhode Island Child Abuse and Neglect Tracking System (CANTS); Assistant Director of the Child Protective Services Division at the DCYF; the Executive Director of the Rhode Island DCYF and the Acting Director of the Rhode Island DCYF.

Additionally, Ken served as an Ad Hoc Committee Member reporting on abusive treatment of children at the Rhode Island Children's Center, Rhode Island's State Liaison Officer to the National Center on Child Abuse and Neglect (NCCAN) and was the founding member of the New England Association of Child Welfare Commissioners and Directors. Ken has since become a certified sea kayak instructor for both the

American Canoe Association and the British Canoe Union.

Jim Queenan, Esq. Jim received his undergraduate degree from the University of Rhode Island in 1974. From 1975-1978, Jim worked as a community organizer at Project Hope in Central Falls, Rhode Island. Subsequent to Jim's time with this organization, he worked as a Social Case Worker for the Rhode Island Department of Children, Youth and Families. Jim earned his Juris Doctorate from Suffolk Law School in 1982. That same year, Jim initiated his career at the Rhode Island Public Defender's Office. In 1985, he became the Chief of the Parental Rights Unit at the Public Defender's Office. Jim has experience in managing the Superior Court trial calendar and significant experience in the Rhode Island Family Court. Jim retired from the Public Defender's Office on June 26, 2015.

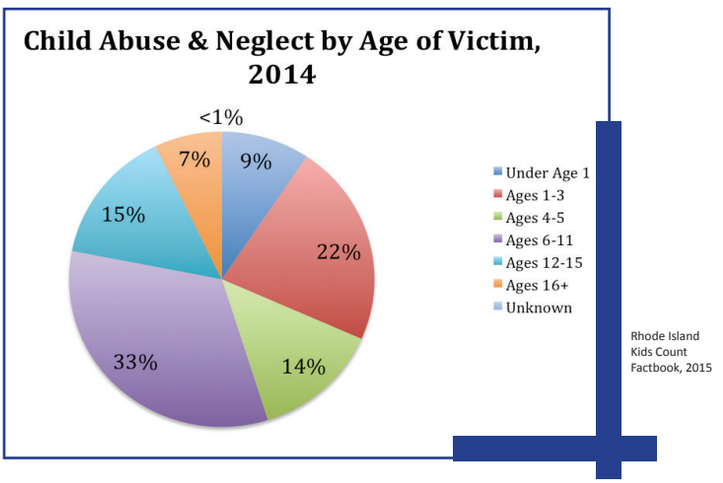
Bethany Macktaz, Esq. Bethany earned her B.A. from the University of Connecticut and her Juris Doctorate from Suffolk Law School. Bethany commenced her legal career as a clerk for the Supreme Court of Rhode Island from 1994-1995. Subsequent to working for the Supreme Court, Bethany worked for the Rhode Island Attorney General's Office from 1996-2011. Throughout her career as a prosecutor, Bethany worked on the Grand Jury Unit from 1997-1998; on the Narcotics and Organized Crime Unit from 1998-2003; as the Unit Chief for the District Court Unit from 2003-2005; the Unit Chief for the Narcotics and Organized Crime Unit from 2005-2008; and as the Assistant Attorney General for the Criminal Division from 2008-2011. Since, 2011, Bethany has worked as a sole practitioner, specializing in family law, criminal law and personal injury.

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

Introduction

The death of a child is a significant event in a state and a community. There is need for particular attention when the death occurs while a child is under the care and protection of a state's child welfare agency. Nationally, children under the age of six are more likely to experience abuse or neglect when compared to older children. In 2015, there were more than 3,300 reports of child maltreatment that involved children under the age of six in Rhode Island. There were more than 3,200 completed investigations by the Department of Children, Youth and Families. Of these 3,200 investigations, more than 1,300 (40%) were indicated cases of child abuse or neglect with 1,450 individual victims of maltreatment.[1] The standard used for indicating a case in Rhode Island is "a preponderance of the evidence."[2]

"Nationally, and in Rhode Island, young children are the most vulnerable to maltreatment. In 2013, more than 27% of maltreatment victims in the United States were under the age of three and more than 19% were aged three to five years old."[3] Children who die from abuse and neglect are overwhelmingly young; approximately one-half are less than one-year-old and 75% are under the age of three.[4]



In 2015, there were six children whose deaths came to the attention of the OCA. Five of the children were in the care of the Department of Children Youth and Families (DCYF or the Department) at the time of their death.[5] The OCA also became aware of an additional fatality of an infant not in the care of the Department. While the death of even one child deserves our attention, the death of multiple children warrants a closer look. To that end, the Office of the Child Advocate, pursuant to Rhode Island General Laws (RIGL) § 42-73-1, et. seq., convened a Multi-Disciplinary Team (Team) for the purpose of reviewing protocols and policies that may have been relevant to the deaths of the children under the care of the Department. Subsequent to an overview of the cases and the ability of the Team to thoroughly review multiple cases in a timely manner, a decision was made to focus this review on three recent infant deaths. Thousands of pages of documents were reviewed and this report contains findings and recommendations related to policy and procedure that can improve safety for all children, particularly those under the age of six in the care of the Department. The decision to focus this review on only three fatalities was not a decision that was taken lightly and is not a reflection of value or importance. The Team strongly recommends a thorough review of the other fatalities by the newly appointed Child Advocate, particularly to examine systems and practices related to congregate care, permanency, and reunification.

In 2015, there were five children who were under the care of DCYF at the time of their death

16 year old medically fragile youth

11 year old youth who had reunified with birth family

3 Infants

Of the three cases reviewed, two of the children were six months old, and one was seven months old. Two were active with DCYF and placed in relative foster care, while the third child did not have any prior DCYF

1 Rhode Island Kids Count, *Young Children in the Child Welfare System Issue Brief*, Dec. 2015
2 "Preponderance of evidence" is a standard often used in civil cases. It means that the evidence is of great weight or more convincing than the evidence which is offered in opposition to it. Blacks Law Dictionary
3 Rhode Island Kids Count, *Young Children in the Child Welfare System Issue Brief*, Dec. 2015
4 Commission to Eliminate Child Abuse and Neglect Fatalities, *Within Our Reach: A national strategy to eliminate child abuse and neglect fatalities*, Mar 2016
5 One of these deaths were reported directly to the OCA by the DCYF, the remaining deaths were obtained through review of calls to the hotline. It is unknown if this number constitutes the full number of fatalities at the Department

involvement (with the exception of both parents having been active with DCYF as minors). As a result of this review, it is evident that a coordinated and multi-system effort that addresses the impact of adverse childhood experiences is crucial. Experiences such as abuse, neglect, domestic violence, parental mental health and substance abuse should be addressed.

The intent of the review was to gain a better understanding of how and why these children died and identify any warning signs or preventive measures that could have been put in place. **This was not intended to be forensic investigation.** During the period of this review, none of the autopsy reports were complete or available. Based upon preliminary assessments "no foul play" has been determined. However, as the report was in its final stages of completion, the autopsy report for one of the infants under review was received by the OCA. The report in this instance reflected asphyxia as the cause of death due to "unsafe sleeping environment and prone position." Although one family has been indicated for child neglect by DCYF in the death of the infant, the Team was not made aware of any criminal charges pending in any of these cases. With the information the team had available, no blame can be placed on any individual or organization for the tragic deaths of these infants, nor can we rule it out. However, the Team could look at opportunities for improvements in our system to strengthen our interventions with the goal of preventing future tragedies.

We acknowledge the hard work of DCYF and many others who advocate on behalf of this most vulnerable population. The Rhode Island Family Court, the Court Appointed Special Advocates (CASA), Guardians *ad litem* (GAL), other public and private attorneys, and other service providers who deliver seasoned input and expertise in the planning for each of these children. In some instances, services are provided for a family, twenty-four hours a day, seven days a week.

This report is dedicated to the children of Rhode Island. In submitting this report, our intent is to identify opportunities for system improvements so children are protected, families are supported, the workforce is adequately resourced, and the community is engaged to come together to improve the well-being of our state's vulnerable infants and young children.

The Team's Objectives

- Recommendations for improving service delivery to children under the care of the Department of Children, Youth, and Families
- Identification of significant risk factors and trends in infant deaths
- Identification of specific barriers and systems issues involved in the deaths of infants
- Improving communication between private, local and state agencies to enhance the coordination of efforts and the sharing of information
- Increasing access to real-time information about children and families to ensure the protection of children

Children are the world's most valuable resource and its best hope for the future.

- John F. Kennedy`

Review Process

The Office of the Child Advocate (OCA) utilizes various methods of reviewing the fatality or near fatality of a child or children under the care of the Department of Children, Youth and Families. For instance, the death of a medically fragile child with no evidence that the death is related to abuse or neglect may result in an internal inquiry by OCA staff with a recommendation that no further review is required. In addition, over the years the Department of Children, Youth and Families would convene a review of child fatalities or near fatalities, that included staff and community providers and they would invite the Office of the Child Advocate. DCYF may also complete an internal review of a child fatality in which a report would be generated and the results shared with the OCA. If the Child Advocate was not satisfied with any of these outcomes or simply believed it to be appropriate to review the death of a child, the Office could exercise its own power and review the deaths or near fatalities involving DCYF children.

In 2015, there were five child fatalities at the Department: two were older youth and three were infants. The OCA also became aware of an additional fatality of an infant not in the care of DCYF. This additional infant death was included in this review due to the circumstances of the death. Though the parents of this child had been open to the Department as minors, the infant child had no involvement with DCYF. Given the number of deaths that became known to the OCA in a short period of time, the OCA determined that a review was warranted and a Multi-Disciplinary Team was formed. The Team members were selected for their expertise in their various fields, such as social work, prosecution, defense work, pediatric medicine, familiarity with family court, and legislation. The Team wants to be clear that its review was absent autopsy reports and final determination of the cause of death by the medical examiners office in two of the three cases reviewed. The timeliness of autopsy reports is also addressed later in the report. There were no preconceived ideas with respect to the work of the team, other than reading through the information provided to the group and offering suggestions and recommendations based on that information.

This review **was not** intended to be a forensic investigation into the deaths of these infants. The purpose was to review the practices of DCYF and other agencies with a goal of recommending improvements in the system that may help to prevent similar deaths in the future. An ancillary objective was to improve upon this review process in the future.

The Team members met over a period of six weeks for a minimum of two hours each week. They spent a significant amount of additional time in between meetings reviewing thousands of documents, including DCYF records, both current and in some instances, multi-generational family history. The review included records of child protective services investigations, social caseworker records, relative foster home licensing applications and data from the Department's reports. In addition, the review included but was not limited to, pediatric records, police reports, criminal records, records from services providers, to name a few additional resources. The OCA did not subpoena any documents or witnesses for purpose of this review, but at the request of the team members, representatives from the Department appeared to provide clarification in the areas of child protective services and licensing.

While there were clear parameters with respect to time from the start of this review, the members of the Multi-Disciplinary Team were cognizant of the time constraints and have expressed a willingness to reconvene as needed under the newly appointed Child Advocate. The staff in the Office of the Child Advocate would like to thank the members of this Team for sharing their expertise, passion and commitment to children. The team believes that if the actions

recommended are taken, they will improve outcomes for children and families. The work of this Office could not have been completed without the time the team members invested in healthy debate and discussions that took place, as well as their willingness to share their expertise to further the best interest of children.

We thank each of the team members for their service.

The Cases Reviewed

Three cases were reviewed by the Multi-Disciplinary Team in the six weeks between February and March 2016. All three cases involved infants who died in the preceding five months at the age of six or seven months. Two of the infants were involved with the Department in an out-of-home placement at the time of their deaths. The third infant was not previously involved with the Department, but both parents had extensive histories of DCYF involvement has minors. The death of the infant resulted in both parents being indicated for neglect. The Team chose to include this third case as it could provide additional insight into the medical community's role in alerting DCYF of potential risks to infants.

These three cases included three mothers, all in their mid-twenties; a total of seven children; and six fathers. Several of the fathers had been "reg flagged" in DCYF's system due to prior Terminations of Parental Rights or indicated cases of abuse. Many of the fathers' backgrounds also included substance use and criminal activity, including some violent crime and domestic violence.

All three families had a familial history with DCYF as children. Both cases that were previously open to the Department had numerous Child Protective Services (CPS) reports from multiple credible reporters during the time that the family was open to DCYF. Concerns regarding substance abuse and housing issues were present in all three cases. In two cases, there were multiple risk factors including substance abuse, mental health challenges, domestic violence, and criminal histories.

Two deceased infants were living in unlicensed, relative/kinship foster care at the time of their death. Two siblings of the deceased infants remain in unlicensed kinship foster homes. One has been unlicensed for over a year. There are questions and concerns regarding the family's ability to remediate disqualifying information.

Safe sleep concerns were present in all three cases, including concerns regarding the kinship foster families' ability to provide a safe sleep environment. Infant immunization compliance and receiving pediatric care was an issue in all three cases. Two of the cases received numerous contacts to the CPS hotline from credible reporters including medical providers, law enforcement and community service providers expressing concerns about the safety of the children in these families. Most of these reports were either downgraded to "information/referral" calls or unfounded because the parent agreed to voluntary services. There were numerous referrals to voluntary services, despite repeated contacts with CPS for the same child/family. There was little to no evidence that families were followed up with to determine compliance with services necessary to keep children safe.

Two of the cases have preliminary findings of unsafe compromised sleep conditions. These incidents appear to be tragic accidents that could likely have been avoided. The third child was taken to the emergency room after several days of cold-like symptoms. The child later went into respiratory arrest. An autopsy is not yet complete and the cause of death is unknown at this time.

FINDINGS

Timely Receipt of Relevant Information

Completion of a comprehensive fatality review for a child under the care and protection of the state requires notification of the death and an expeditious exchange of information from various sources. The Office of the Child Advocate is an independent and autonomous state agency responsible for protecting the legal rights and interests of children in state care.

Rhode Island General Law § 42-73-9 affords the Office of the Child Advocate certain rights, powers and access, including "…the right to inspect, copy and/or subpoena records held by the clerk of the family court, law enforcement, agencies, and institutions, public or private, and other agencies, or persons with whom a particular child has been either voluntarily or otherwise placed for care, or has received treatment within or without the state." RIGL § 42-73-9 also provides the OCA with the power to take "…whatever steps are appropriate to see that the persons are made aware of the services of the Child Advocate's Office, its purpose, and how it can be contacted." Additionally, RIGL § 42-73-7 specifies that the Office of The Child Advocate will "review periodically the procedures established by the department of children, youth, and families to carry out the provisions of chapter 72… with a view toward the rights of the children and to investigate in accordance with the established rules and regulations adopted by the child advocate, the circumstances relating to the death of any child who has received services from the department of children, youth, and families."

In an effort to provide a comprehensive and multi-disciplinary review of available records on the three cases identified, the Office of the Child Advocate requested all available records from the following state agencies, city departments and private organizations:

- Rhode Island Department of Children, Youth and Families
- Rhode Island Office of the Attorney General
- Rhode Island Medical Examiner's Office
- Warwick Police Department
- Central Falls Police Department
- Pawtucket Police Department
- Providence Police Department
- Hasbro Children's Hospital
- Private Physicians Offices
- Private non-profit human service organizations

Although extensive information was gathered for review, the Office of the Child Advocate experienced numerous challenges in obtaining the information from several of the above sources. There are gaps in understanding and compliance with the statutory provisions of the OCA which requires expeditious receipt of ALL information when exercising its legal right and obligation to review the fatalities of any child who has current or past involvement with DCYF. Release of information should occur regardless of whether or not the death is determined the result of maltreatment. The scope of the OCA's review is more expansive than a review of the cause of death. The OCA's purview includes review for the purpose of identifying trends, gaps in service and lessons to be learned that will enhance the safety of all children in the state's care.

RI DCYF Prior to convening the Multidisciplinary Fatality Review, the DCYF had provided information to the OCA on one out the of five child fatalities that occurred while under the care of the Department. The OCA did not receive direct notification from DCYF regarding the other four fatalities. During the process, the OCA requested extensive information from the DCYF regarding the cases under review. The OCA provided notice to the DCYF and despite the statute that allows for inspection, the OCA needed to make multiple attempts to gain access to DCYF records and arrange for the appearance of Department staff at a meeting before the review team. Computer records and documents for review were obtained from DCYF through the OCA's network access.

Rhode Island Office of the Attorney General The Office of the Attorney General indicated they required a subpoena to release records to the OCA.

Rhode Island Medical Examiner The autopsy report of one infant under review was received just prior to completion of the review.

Private Pediatricians and Private Non-Profit Human Service Organizations Information was provided to the OCA as requested.

City Police Departments The majority of police departments released the information immediately upon request.

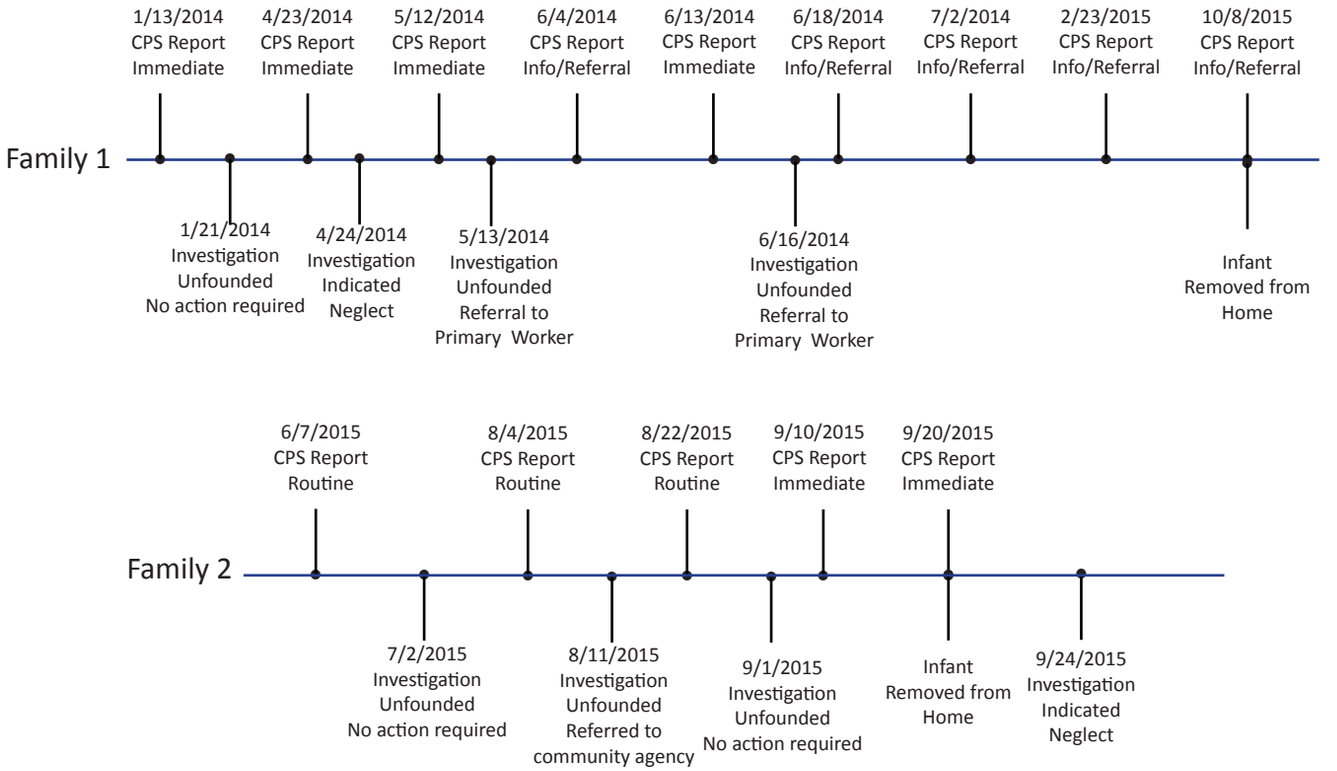
Information Verification

A call to the Child Protective Services (CPS) Hotline, regardless of the disposition is the best predictor of a subsequent child abuse and neglect fatality.[7] Accountability is a critical component of success. The DCYF must work together along with a range of providers to collaborate, as well as to hold each other accountable. Numerous complaints were received by the DCYF hotline regarding these children. It was troubling to the Multi-Disciplinary Team that each incident appeared to have been investigated independently of prior complaints or investigations.

There was concern about potential risk posed by the accumulation of reports by multiple, reliable and independent reporters. In at least one incident the complaint was closed rapidly, because it was received close in time to another investigation. This secondary investigation was closed with the same recommendation for referral to the Family Care Community Partnership (FCCP), however, no actual confirmation of the family's participation was noted.

CPS Involvement[8]

For the two cases with prior DCYF involvement



Other concerns about the well-being of the children in these families were noted in family case notes and are not included in these timelines.

It is unclear if the decision making process is structured and consistent, therefore, we are not able to determine whether the decision making practice on the cases under review is or is not in compliance

7 Commission to Eliminate Child Abuse and Neglect Fatalities, *Within Our Reach: A national strategy to eliminate child abuse and neglect fatalities*, Mar 2016
8 RI DCYF Rhode Island Children's Information System (RICHIST)

with DCYF policy and procedure. However, the Team asserts that repeated screening out of individual accounts of abuse and neglect without careful assessment of these reports in the context of prior concerns and expectations leave an at-risk population more vulnerable. This is a particular concern if the family has not complied with prior recommendations or interventions made by CPS staff in prior investigations, and compliance is not verified. If allegations from prior complaints were unfounded, it appeared as though any subsequent complaint was treated as if it was the first. While there is general recognition that the State of Rhode Island has utilized an incident based CPS system for decades, there needs to be an ability to easily and effectively look at historical information and patterns of complaints when making investigative determinations. There needs to be particular care and scrutiny in instances where multiple complaints are similar in nature and involve behaviors we know to place infants at risk of harm. Complaints involving concerns such as domestic violence, parental substance abuse and mental health, particularly when they involve infants, should require a response.

Failure to verify information, particularly related to the medical and home care the infants were receiving was another concern. The two infants active with DCYF were placed in relative foster care. Both before and after the placement of these two children, self-reports of medical care were received. In some instances, these self-reports were inconsistent with the medical records. For instance, missed appointments were reported as kept and immunizations were reported to be up to date when they were not.

Of particular significance in one foster home, a nurse from an early intervention program reported to the Department, that she observed the foster mother to have an eye that was severely bruised and swollen. The nurse expressed concern that it may have been the result of domestic violence. The Department screened out this complaint by determining that they had seen the foster mother the day before the alleged injury occurred and there was no injury to her eye. In a subsequent conversation with the foster mother, she reported that she had an ulcer in her eye. Again there was no comprehensive assessment or verification of this information.

In this same home, the infant was living without a crib for two months, despite conflicting reports by the foster mother regarding whether or not she had a crib. Additionally, it was reported to the social worker on one occasion that she did not have formula and diapers for the infant. While any one of these incidents in isolation may not rise to the level of risk of harm, as an unlicensed relative foster placement, collectively these issues raise concerns. In an unlicensed foster home situation, there should be intense engagement by the Department until the licensing process is completed. Subsequent to the emergency placement with a relative, strict time frames for licensing must be implemented, with no child remaining in a home where a license is pending beyond six months.

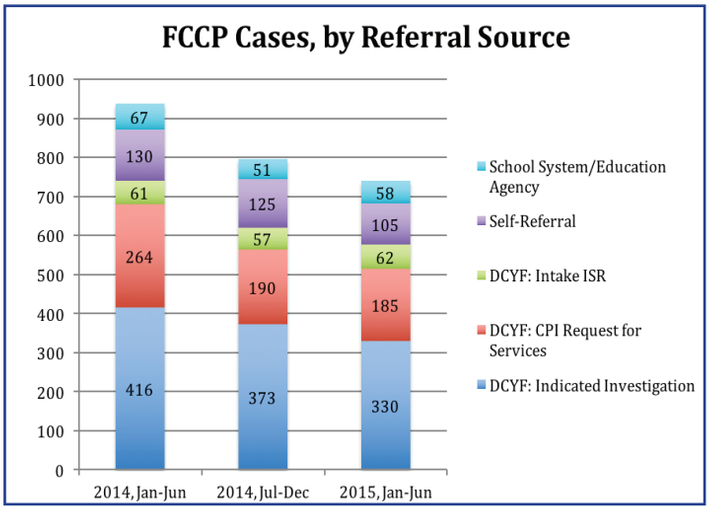
The Family Care Community Partnerships (FCCPs) are diversion / prevention programs available to DCYF. The Department's website identifies the FCCPs as a way to work together to strengthen families. They were

FCCP Cases Closed, By Reason[9`]	2014, Jul-Dec	2014, Jan-Jun	2015, Jan-Jun
Team agrees wrap goal have been met	318	275	217
Unable to contact family	74	61	79
Team agrees wrap goals were not met	57	59	57
Triaged and referred out	22	42	43
Family declined services	78	56	36
Other	68	33	57
Primary child opened to DCYF & remained in home	28	24	26
Primary child opened to DCYF & removed from home	24	16	8
Family moved out of area	29	21	22
Transfer primary child to another FCCP	19	18	10

9 RI Family Care Community Partnerships Semi-Annual Report, July 2015

developed to provide prevention services to families with the recognition that every family struggles from time to time. Families that receive services from the FCCPs do not have an open case with DCYF. The FCCPs utilize a nationally recognized practice model "Wraparound" to successfully bring a family to its fullest potential. The FCCP's were utilized as voluntary services for two of the cases we reviewed. Given that the FCCPs' are a voluntary prevention service option to the Department, it does not appear that there are consistent, case specific mechanisms for reporting non-compliance back to the Department. If a family is referred and non-compliant, they would simply be closed. There were elevated concerns when the referral linked back to an indicated or substantiated case of abuse or neglect , particularly when the case involved an infant.

Independent verification of information by CPS allows reporters to maintain anonymity. Maintaining the anonymity of reporters who make calls to the CPS hotline encourages calls and protects the safety and well-being of children. The response the reporter receives on the hotline is an essential component that encourages future communications. In one of the cases reviewed, it appears that the mother changed pediatricians in part because she blamed the pediatrician for the removal of her older child. Discussion occurred with respect to the potential deterrent this may have on mandated reporters. Again, if looking at this situation in isolation, one could miss the larger implications. Namely, as a result of that call, the pediatrician involved lost the ability to follow up with a high-risk family and vulnerable children. This issue can be easily transferred in other settings as well, such as school settings, and within provider organizations. Protecting reporters and having access to actual information verifying concerns will assist CPS in making sure that they receive all reports of abuse and neglect.

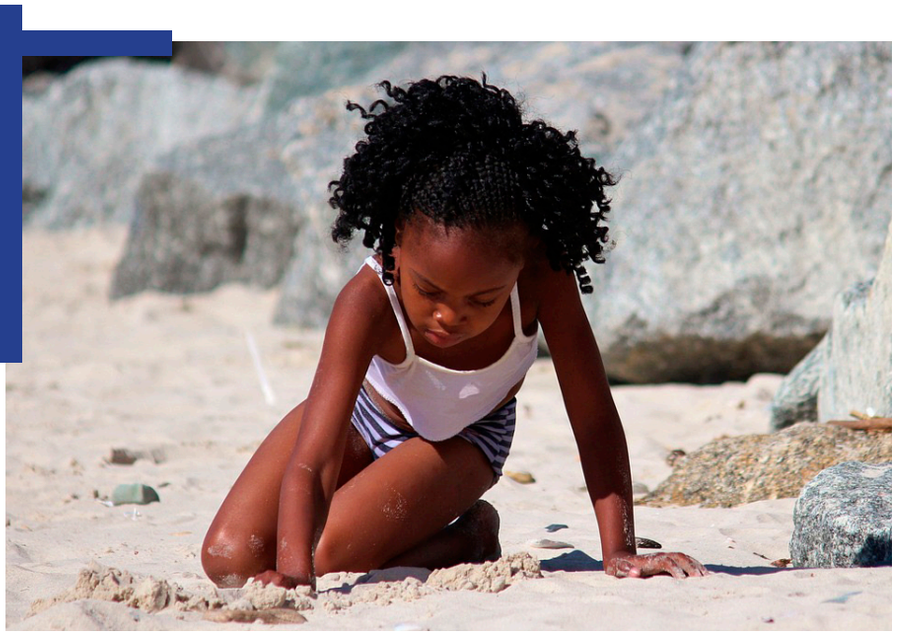


9 RI Family Care Community Partnerships Semi-Annual Report, July 2015

Interagency Accountability

There is no clear communication and information sharing process between the DCYF and the OCA with respect to reporting of known child fatalities or near fatalities for children under the care of the Department. While past protocol included a phone call with follow-up documentation in all child deaths and near fatalities by the DCYF to the OCA, actual personal notice to the Child Advocate occurred in only one instance in 2015. The remaining fatalities involving a child in the care of DCYF were found by the OCA in a review of daily reports to the CPS hotline. There appears to be difference of opinion between the two agencies with regards to the circumstances under which a death or near fatality should be reported to the Office of the Child Advocate. It is a question of whether all fatalities and near fatalities should be reported or only those that are the result of maltreatment.

As DCYF provides public reporting on the deaths of children in care pursuant to the Federal CAPTA (Child Abuse and Neglect Treatment Act), it seems that there is no accurate reporting mechanism for identifying the deaths of all children who were involved in care at DCYF unless the death was related to maltreatment. While there is an established protocol for the sharing of information between the DCYF and the OCA during a child fatality review, it should be revisited and updated.



Risk Assessment

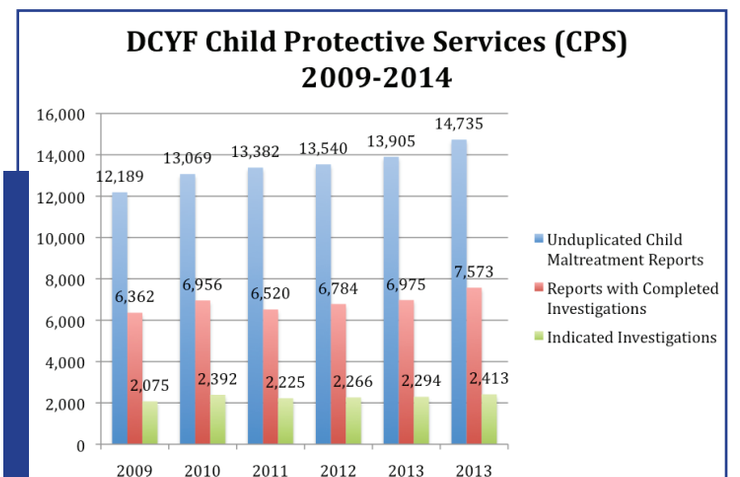
DCYF needs a comprehensive and meaningful risk and safety assessment process. In 2012, Siegel proposed an analogy of "rolling icebergs" as a way to understand how families come to the attention of child welfare agencies.[10] In this analogy, a child maltreatment report represents one point where the iceberg surfaces, indicating a problem with family functioning. Subsequent reports on families over time tend to vary in type and nature. This incident based reporting fails to capture a broader picture of concern when multiple isolated reports accumulate around the functionality of a single family. This apparent disconnect between incident based reporting and subsequent safety assessments were challenges grappled with throughout the review of these cases.

Identifying strategies to make it easier for DCYF investigators, licensing workers and caseworkers to get a comprehensive assessment of risk and safety issues in a family was identified as an area in need of further review. In one case there was inconsistent information regarding a family member being flagged as a perpetrator of abuse. In two of the cases the Multi-Disciplinary Child Fatality Team needed to read through numerous reports, progress notes, court reports, medical and police reports to get a comprehensive assessment of the family risks and protective factors. We recommend that DCYF fully implement and integrate appropriate screening and assessments into all aspects of case decision making and data collecting.

Additionally, DCYF's information technology system should be updated to improve DCYF staff's ability to uphold their mandate. Consistent with the Commission to Eliminate Child Abuse and Neglect, we also recommend evidenced-based screening tools for Adverse Childhood Experiences (ACES's) and parental risks. A more family centered approach of risk assessment is necessary at various points in time in the child welfare service continuum, beginning with child protective services, and incorporating assessment of foster placements, as well.

In January of 2015, a report released by a Senate Task Force reviewing DCYF and the family care networks[11] also addressed the issue of assessments at the Department. The information presented to the Senate suggested that the needs of children under the care of DCYF were not assessed soon enough. The Child and Adolescent Needs and Strengths (CANS) Assessment was designed to be administered to all children removed from their home, but at the time of the hearings, just one in four children were receiving the assessment. The time frame for assessment also extended out forty-five days. The Task Force made a recommendation that "DCYF should fully implement and integrate appropriate assessments into all aspects of case decision making and data collecting." It is our understanding that the percentage of children receiving a CANS assessment has improved.

The Department would benefit from a plan that allows for ongoing comprehensive assessment of needs throughout the child's involvement. Although the CANS is an important assessment tool, it is not the only assessment tool needed to assess risk, safety, trauma, and service needs for all populations served by DCYF. This is particularly true when looking at the needs of infants and young children placed in relative and non-relative foster care.



RI DCYF Rhode Island Children's Information System (RICHIST), Mar 2016

10 Siegel, G.L. and Loman, L.A. (2006). Extended Follow-up Study of Minnesota's Family Assessment Response. St. Louis: Institute of Applied Research

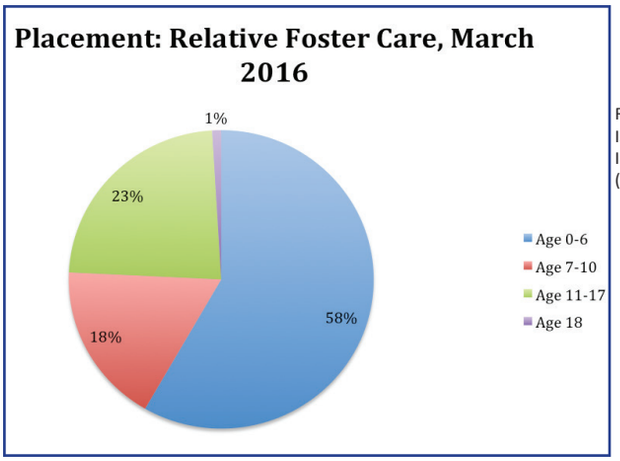
11 *The Senate Taskforce on the Department of Children Youth and Families and the Family Care Networks*, Report Issued Jan 2015

Although we are not aware of all the changes currently underway at the DCYF, we are encouraged to hear that the Department is considering options to address some, if not all of the concerns regarding ongoing assessment of the safety needs of children in the child welfare system. We hope the anticipated structured decision making assessment system will address the concerns expressed here. A good assessment process is necessary for comprehensive change impacting all aspects of the child welfare system. While not an issue taken up in great detail during this review, there is recognition that assessment will be of little value if it is not supported by the necessary preventive or other services that families will require to be successful. We also understand that the Department has embarked upon a procurement process seeking a comprehensive array of services that will improve long -term outcomes for children and families. This is also encouraging.

Foster Care

Kinship and relative caregivers are a vital resource to the child welfare system. Placing children with grandparents, aunts, uncles and other relatives or close family friends is recognized as the preferred resource for children. It maintains a child's connections and reduces the likelihood that a child will experience multiple placements.

Nationally, approximately 25% of all children placed outside the home are placed with a relative.[12] In 2014 in the United States, 48% of all children removed from their home were under the age of six and 17% of those were children under the age of one. Young children are more likely to be removed from their homes than older children.



RI DCYF Rhode Island Children's Information System (RICHIST), Mar 2016

In 2015 in Rhode Island, 99% of all children under the age of six who were placed out of their homes were living in foster or pre-adoptive homes. More than 60% of the children placed in foster care in the state of Rhode Island are in kinship foster homes, the remaining 40% are in placements with non-kin.[13] From 2010 to 2015, 42% of children under the age of five were placed with relatives upon entering DCYF care; an additional 14% were subsequently placed with relatives.[14] The Federal Fostering Connections to Success and Increasing Adoptions Act promotes kinship care and requires states to notify relatives when children enter care. Rhode Island's commitment to placing children with family is generally recognized as a strength of our child welfare system. Rhode Island provides temporary foster care board and permanency guardianship assistance to relatives who care for children through DCYF.

DCYF is in the midst of significant reforms aimed at improving services to and outcomes for children and families through data driven decision-making and innovation, streamlining and improving day-to-day agency efficiency, and implementing stronger financial controls. (State of Rhode Island, Solicitation Information, March 15, 2016) DCYF has a much higher percentage of youth in group settings than most states - almost twice the national average (AECF Kids Count data 2012). DCYF is implementing various strategies to reduce the over reliance on congregate care. DCYF has recently completed an assessment of their current capacity of foster families. With the support from Annie E. Casey, the DCYF is providing trainings to community foster care agencies on methods to increase and enhance foster care recruitment strategies. The need for both relative and non-relative foster families has never been greater.

Children who are removed from their parents for abuse and neglect must be placed in a safe and stable environment. **As the DCYF moves to shift placements from congregate care to lesser restrictive care, such as relative and non-relative foster care, there must be heightened attention to the recruitment, assessment, training, licensing, and oversight Appropriate service provision must be made to ensure the safety and well-being of Rhode Island's children. Child safety is paramount.** It must be the lens used in all cases while promoting well-being and moving toward permanency. Additionally, the needs of children entering care are different for the population of children 0-5 than they are for 13 and above. Careful attention to these distinct population needs must be taken when shifting our focus from congregate care to family-based care. DCYF must have a strong foster care licensing, training and support foundation within the state agency to increase

12 US Department of Health & Human Services, Administration for Children and Families, AFCARS Report #22
13 RI Kids Cout, *Young Children in the Child Welfare System*, Dec 2015
14 RI Kids Count, Mar 2016

capacity in this area given that there are already infants and young children remaining in unlicensed homes now. Currently, according to their monthly report for February 2016, the Department has approximately 200 Licensed Relative Foster Homes and another 323 Relative Foster Homes that are pending licensing. There are more than one hundred relative foster homes caring for children that remain unlicensed for more than six months.

In the United States, thousands of children are hurt and some die each year at the hands of those who were supposed to protect them. These children die from abuse and neglect, including starvation, inadequate medical care, and unsafe and co-sleeping.[15] As advocates for children, we must make sure to expand the screening process of caregivers who present with elevated risk factors or multiple disqualifiers. Much like the reasons for removal, risk factors may include multi-generational child welfare history, domestic violence, substance abuse and mental health issues.

Requirements necessary to become a foster parent include criteria such as a minimum age of twenty-one years of age or older, physically and psychologically able to care for a child, be finger-printed and able to pass a criminal investigation check and clearance through DCYF, have economic means sufficient to care for your family without reliance on the foster board payment and the home must pass a fire inspection. For a family applying to be foster parents for non-relative children, the process must be completed before they are able to take in a child. The process for vetting these non-relative homes can be six months or longer.

The process for foster home licensing requires completion of an application, a thirteen-week foster parent training, compliance with all the component parts, such as finger-printing, medical clearances and DCYF clearances. In addition, a comprehensive twenty-hour home study must be completed. All must be done and approved before a family is ready to take placement of a child.

Relatives being utilized as an emergency home tend to take placement of a child immediately and prior to the licensing requirements being completed. Some initial clearances are completed and there is a significantly shortened version of the training process for relative caretakers. Even in situations where the foster parents are non-compliant with services, there appears to be little or no practical consequence. The data for turnaround in the licensing process should be collected and tied to a measure of performance for the DCYF. There should be criteria to meet requirements within mandatory time frames. The licensing process should require more intense supervision, including more frequent visits during the period the home remains unlicensed. The rationale for differing processes for kinship and non-kin foster placements should be explored further, particularly around the training components.

Child safety is paramount.

During this review, it was observed that emergency relative or kinship placements may receive approval for the placement of a child with them despite disqualifying information. Some disqualifying information includes a criminal conviction or charge pending disposition, DCYF involvement that is deemed detrimental to the care of children, or a household member poses an immediate safety risk to the child in care.[16] The Department can provide administrative overrides in a situation where disqualifiers exist. Reviewing the administrative override and diligent search processes should also be undertaken.

The relative foster care placements utilized in the cases under review remained unlicensed through the deaths of the infants. In some instances, the relative foster family placements of the siblings remain unlicensed. Outstanding licensing issues in the cases under review included prior DCYF involvement, a caretaker with an elevated risk factor as a perpetrator of abuse and neglect in multiple families, relative caretakers with criminal charges and fire inspections

15 Commission to Eliminate Child Abuse and Neglect Fatalities, *Within Our Reach: A national strategy to eliminate child abuse and neglect fatalities, Mar 2016*
16 State of RI, Department of Children Youth and Families, Foster Care and Adoption Regulations for Licensure, October 8, 2013

that remained unresolved. In one instance the licensing issues remained unresolved for more than a year without a comprehensive home study, while at the same time DCYF was reporting to the court that the family was an adoption resource for the child. This issue raised concerns regarding the likely lack of knowledge by the Family Court that a home remains unlicensed when they are approving placements for children.

Further concerns noted in these relative homes were inappropriate sleeping arrangements. In one instance, the foster parent reported having resolved the issue about obtaining a crib for the infant on at least two occasions, when in fact it took two months to actually obtain the crib. Housing concerns, particularly around safety and cleanliness, were raised in several of these relative homes. In one instance the foster family moved on several occasions over a fifteen-month period, resulting in the need to start the licensing process over each time. Missed medical appointments, inability to maintain a stock of diapers and formula for the infant, missed appointments with service providers and a report to the hotline by one service providers regarding an injury to a foster mother's eye went uninvestigated. In addition, a young relative caretaker with multiple children under the age of six, including two infants under the age of seven months old were all concerns raised with regards to these placements. In one instance, the court appointed Guardian ad litem (GAL) expressed safety concerns in a family court proceeding regarding two separate relative placements where siblings resided. The Court ordered the social caseworker to investigate the concerns of the GAL.

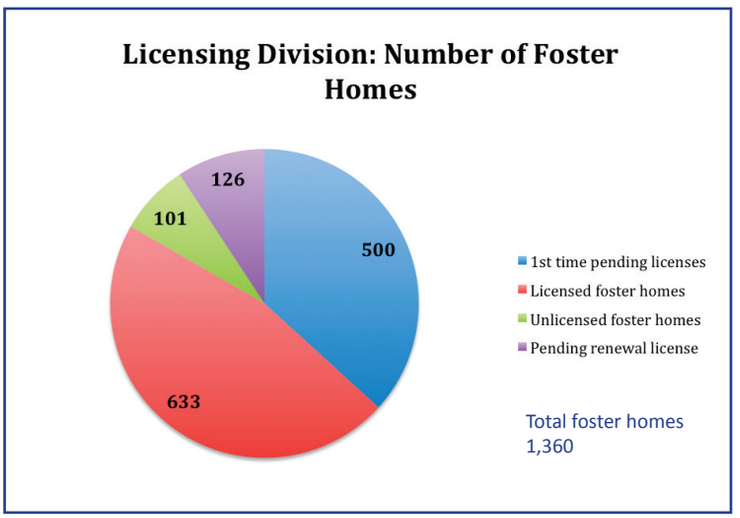
It was agreed throughout this review process relatives should be the first placement option considered when a child is placed out of the home. However, due to the scarcity of non-relative foster homes through DCYF, the agency must be vigilant in maintaining the best interest of children when considering relative foster placements.

Currently there are more than one hundred relative foster homes caring for children that remain unlicensed for more than six months

When there are multi-generational records replete with histories of abuse and neglect by the relative caretakers, as well as some with criminal histories, maintaining these placements for more than an emergency basis raises the question, "At what point do we eliminate family members as a placement resource?" As a state we must be cognizant of the divergent needs of all DCYF children; while being particularly sensitive to at-risk populations, such as those under the age of six.

The Multi-Disciplinary Team concurs with the recommendations in the report of The Anne E. Casey Foundation Assessment of the DCYF System (May 2014) and the Senate Task Force on The Department of Children, Youth and Families and the Family Care Networks (January 2015). The Team agrees that DCYF must enhance its non-relative foster family recruitment, development, support and capacity, while contemporaneously developing a stronger kinship family finding and support component. Similarly, this Team recommends that DCYF Licensing review its procedures as well as address any staffing challenges that interfere with a comprehensive and time-efficient licensing process.

As DCYF moves to decrease its reliance on congregate care placements for children, a robust foster care system will be required. The need could not be more urgent for development of a marketing strategy that appeals to the citizens of Rhode Island to open their homes and give a child a family. Sustained recruitment efforts are needed within minority groups and faith-based communities, as well as, in specialized areas, such as individuals able to care for medically fragile children. In addition, as the Department depends more and more on relative and fictive kin placements,



RI DCYF Fact Sheet, Children Served Month Ending 2/29/2016, Mar 1 2016

an updated policy is recommended regarding the licensing process to ensure the safety of children as a priority when reviewing disqualifying information. The emergency placement of a child with a relative must require more intensive oversight until the licensing process is completed. Established time frames and benchmarks for completing the licensing process is recommended.

Caseload Concerns

During the period that the cases under review were open, the DCYF staff had responsibility of more cases and children than national best practice standards recommend. A vacancy rate in excess of 25% undermines the ability of staff to undertake investigations and case management activities, prohibiting meaningful efforts to engage with a family to help them succeed. No child welfare system can function well under these conditions. DCYF needs to be fully funded to meet national caseload standards.

Heavy caseloads and workloads have repeatedly been cited as a reason for worker turnover in child welfare agencies. Caseload and workload management are often key ingredients in a state's comprehensive strategy to improve outcomes for children. The benefits of a reasonable caseload and manageable workload include retaining staff and reducing turnover while delivering quality services, engaging families and building relationships and positive outcomes for children and families.

The Annie E. Casey Foundation recommends no more than twelve to fifteen cases per social caseworker, with each intact family counting as a case and each child in foster care counting as a case. Additionally, they recommend the assignment of no more than eight to ten cases per month to a child protective investigator and no more than five social workers assigned to supervisors in child welfare.[18]

In January of 2015, after hearing testimony over a five month period in its recommendations, the RI Senate Task Force addressed the issue of DCYF staffing. The committee recognized that, "when DCYF caseloads are too high, more children are removed from their families, since workers have too little time to assess whether or not a child is safe at home." At the time of the Senate Committee hearings, DCYF was reporting a vacancy rate for social workers near 25%. The Casey Foundation recommends carrying a vacancy rate of no more than 15%. The Senate Committee found that DCYF caseloads should target a national best practice standard of fourteen cases per worker. The recommendation of the Senate Committee was that "DCYF should develop a continuous pipeline of recruitment and training of staff to address the high turnover of social workers, case managers and supervisors, to ensure that caseloads remain at reasonable levels."

However, despite national best practice standards and the recommendations of the Senate Committee, there has been no significant increase in the case carrying staff at the Department in at least the past two years. Caseloads in some instances remain in the twenties with the number of children being supervised into the thirties. Without significant changes in caseload levels at DCYF, it is challenging to anticipate good outcomes for children and families.

Service/Caseload Type	**Annie E. Casey Foundation, Child Welfare Strategy Group**
Child Protective Services (CPS) Caseloads/Investigation	No more than 8-10 cases per month; per 1 CPS Investigator
CPS - Ongoing Cases	Investigations to be completed within policy guidelines (DCYF Policy states within 10 days)
Social Caseworkers	12-15 cases, count each intact family as a case and each child in foster care as a case
Supervision	1 supervisor per 5 social case worker or child protective services worker

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

Caseload Statistics - Children Served Month ending 02/29/2016[19]

Children in on-going services: Intake, Monitoring, Family Services Unit	
Total Workers	139
Number of cases*	3,589
Avg. number of cases per worker*	26

*Duplicated number - some cases may be involved in more than one unit

The Department also needs skilled frontline caseworkers.[20] The Department needs pre-service and ongoing training that addresses staff members' varied levels of experience and work assignments. Rhode Island General Law § 42-72-5 (10) requires the Department to establish a minimum mandatory level of twenty hours of training per year and provide ongoing staff development for all staff. In addition, it requires that subsequent to 1991 all social workers hired within the Department will have a minimum of a bachelor's degree in social work or a closely related field, and must be appointed from a valid civil service list. The Casey Foundation recommends that child welfare agencies establish "just in time" hiring practices that streamline hiring and ensure staff are in the pipeline for projected vacancies. Preparing for vacancies will increase morale and provide conducive work environments reducing turnover and the vacancy rate.

Secondary trauma became a concern of the Team during the review of these cases for various reasons. The workers were managing high caseloads while attending to the deaths of these children. During this review it was learned that the Department has recently implemented the Child Welfare Training Toolkit to address secondary trauma in its workforce and the Resource Parent Curriculum for families caring for children who have been exposed to trauma. We applaud these efforts as a very positive step in addressing the needs of the workforce. However, in the cases reviewed there was no evidence of providing immediate support or assistance to the staff who were working directly with these families. Effective elimination of secondary trauma should be explored with the understanding that a resilient child protective and social work staff is linked to the promotion of self-care and effective professional and social supports.[21] The Team is empathic to the many stressors that the DCYF line staff faces on a daily basis, often with relatively few resources at their disposal. It was clear they manage many tasks in a given day, each with its own level of intensity. They attend RI Family Court proceedings, attend multiple planning meetings, interface with medical professionals, educators, attorneys, various service providers, and most importantly, children and families. They are responsible for a minimum number of face-to-face contacts with their clients, particularly the children, and the completion of service planning and documentation. They have many responsibilities and are under resourced. The Team hopes to highlight these challenges as a way to inform policy makers of priority areas for our state. Our hope is to better meet the needs of abused and neglected children and their families.

Furthermore, the Department's plan to hire social case workers remains unclear. Hiring and appropriate levels of training are intrinsically linked to improved outcomes for children and families in DCYF care.

Limited staffing impacts the ability to maintain even the minimum standards for face to face visits on a monthly basis. Social workers in each of the four regions and the case monitoring unit are able to have face to face contacts with their children approximately 67% of the time.[22] This impacts not only the intensity of service to children, but the quality of the service. Similarly, under the prolonged conditions that have existed in this state over the last two years, with a significant vacancy rate and turnover in staff, the likelihood of burnout, compassionate fatigue and secondary trauma in the workforce is increased.

19 RI DCYF Fact Sheet, Children Served Month Ending 02/29/2016, Mar 1, 2016
20 The Annie E. Casey Foundation, *10 Practices: A child welfare leader's desk guide to building a high performing agency*, Tracey Fields, 2015
21 CWS360, *Secondary Trauma and the Child Welfare Workforce*, Spring 2012

Children with no face-to-face contact documented for Month of February 2016[22]

	Case Monitoring	Region 1	Region 2	Region 3	Region 4	Total
# children w/no face-to-face	67	126	228	148	409	978
Total number in care	121	748	528	511	1,184	3,092
No face to face by age, 0-3	12	29	47	40	109	237
No face to face by age, 4-6	24	19	18	15	44	120

22 RI DCYF Rhode Island Children's Information System (RICHIST), Mar 2016

Medical Care for Foster Children

A majority of foster children enter foster care with at least one chronic or acute condition that needs medical treatment, yet national estimates suggest that nearly one third of foster children had unknown health needs that remained unmet while they were in foster care. Similarly, the transient nature of families where children are at high-risk make continuity of care by a pediatrician challenging. Often these children are more vulnerable as a result of parental substance abuse, mental health or family violence. Infants and children in the child welfare system require a more consistent transfer of information between medical providers. The Federal Fostering Connections Act requires the formation of a state plan for the coordination of health care needs for children in foster care.

Passage of the Fostering Connections to Success and Increasing Adoptions Act represented a landmark achievement in addressing the health care access needs of children within the foster care system. Nationally, more than 650,000 children enter foster care each year, most have experienced some form of abuse and neglect. Typically they enter foster care with a high prevalence of undiagnosed or under-treated chronic medical problems. Between 35% and 60% of children entering foster care have at least one chronic or acute physical health condition that needs treatment.[23] Despite the overwhelming evidence of need, studies consistently demonstrate that many health care needs for children in the foster care system go unmet. Research that suggests children are not receiving timely medical services has come from a range of studies. Estimates suggest that as many as one third of the children in foster care had health needs that remained unattended to while in out-of-home care.

In the infant cases under review there was inconsistent information self-reported with respect to the medical care they were receiving during the time they remained with their biological parents, as well as, upon entering foster care. The increased level of vulnerability that children in high-risk homes experience is significant. Parental concerns, such as, substance abuse, mental health and domestic violence can increase the level of risk for these infants. Invariably concerns regarding the medical care of a child can put the pediatrician at odds with a biological or foster family. At times reports by the pediatrician to child protective services can result in an increased level of vulnerability, as the parent may not return to the doctor, leaving no one to follow up with the infant. The reality of this scenario was demonstrated in part by the decision of a parent in one of the cases under review. She assigned blame for the placement of her child by DCYF on her pediatrician. As a result, she changed pediatricians, potentially depriving the next pediatrician of the benefits associated with the child patient's history.

This above scenario raised significant concern for the medical needs of children involved in the child welfare system. The irony of this is that children in our nation's foster care system account for 25-41% of expenditures within the Medicaid Program, and approximately 90% of these costs are attributed to 10% of the children. Therefore, a small number of children are receiving intensive, expensive services because system has neglected them until their needs become catastrophic.[23] The medical needs of foster children often remain unaddressed due to a lack of information and care coordination. Currently, there are no medical doctors on staff at DCYF other than by contract at the RI Training School.

In Rhode Island there are health care services available to children in foster care that are often underutilized. All children in foster care are covered by Rite Care. Hasbro Children's Hospital offers specialty care for children in foster care who may have been abused or neglected. The Physical Abuse, Neglect and Diagnostic Assessment (PANDA) Clinic provides a child-friendly environment to complete medical evaluations of allegations of abuse and neglect. The Child Protection Unit at Hasbro offers an additional resource and child friendly place where specially trained pediatricians can provide detailed and comprehensive evaluations of children who may be the victims of maltreatment and sexual abuse. Yet despite these resources to foster

23 The FosteringConnections.org Project, *Summary Brief, Perspectives on Fostering Connections: A series of white papers on the Fostering Connections to Success and Increasing Adoption Act of 2008, Feb 2013*

children, pediatricians still face the challenges that many others do across the country. They continue to encounter obstacles in obtaining the child's medical history, as well as, barriers to sharing and accessing health information.[24]

The number of complaints made to the Department and particularly to the hotline from physicians and other medical professional were of particular concern. The Physician's Report of Examination (PRE) was repeatedly discussed as to its limited ability to capture chronic neglect. One significant concern expressed about chronic neglect was that often there is little physical evidence or injury. In these instances a PRE may be completed with regards to the child, but without evidence of injury or any additional historical information, the physician has limited ability to authorize a hold on the child. In some instances the PRE without authorizing a hold may be interpreted to mean that there is little or no grounds for intervention by the Department. This was a troubling assumption and one the Team believed warranted review of the statutory provisions of the Physician's Report of Examination (PRE) under Rhode Island General Laws § 40-11-4, § 40-11-5 and § 40-11-6.

Section 205 of the Fostering Connections Act requires states to develop and coordinate a collaborative plan between the state Medicaid and child welfare agencies, in consultation with pediatricians and other experts in the area of health care, a plan for the ongoing coordination of medical services for any child in a foster care placement. The plan must be a coordinated strategy that responds to the health care needs of children in foster care, including mental health and dental needs.

The plan should include the following components:

- A schedule of initial and follow-up health screenings that meet reasonable standards of medical practice
- How health needs identified through screenings will be monitored and treated
- How medical information for children in care will be updated and appropriately shared, which may include the development and implementation of an electronic health record
- Steps to insure the continuity of health care services, which may include the establishment of a medical home for every child in care
- The oversight of prescription medications
- How the state actively consults with and involves physicians or other appropriate medical or nonmedical professionals in assessing the health and well-being of children in foster care and in determining appropriate medical treatment for the children
- Steps to ensure that the components of any transition plan for children aging out of foster care includes information about the options for health insurance; information about a health care power of attorney, health care proxy, or other similar document recognized under state law; and provide the power for a child to execute such an agreement upon exiting care (per PL 111-148)
- Steps to monitor and treat emotional trauma associated with a child's maltreatment and removal, in addition to other health needs identified through screenings (per PL 112-34)
- Protocols for the appropriate use and monitoring of psychotropic medications (per PL 112-34)

24 RI Kids Count, *Young Children in the Child Welfare System Issue Brief*, Dec 2015

A medical home is not a place, but a knowledgeable, compassionate health care provider and care team chosen by a patient and their family to take care of the child/youth's health needs. The Pediatric Practice Enhancement Project (PPEP) is a medical home model initiated in RI in 2003. The initiative is an effort of the RI Department of Health, Office of Special Needs in collaboration with Rhode Island Medicaid, the RI Chapter of the American Academy of Pediatrics and Family Voices. This initiative provides supports to improve the coordinated care of children and youth with special health care needs. This medical home model includes two key components; a Family/Peer Specialist and a data component.

The medical home model should be adopted for all children in foster care. This model would address the lack of historical data to pediatricians as family's transition from one to another. The creation of an electronic record would also allow families to move from one physician to another without losing the historical knowledge necessary for a physician to make good assessments of risk to a child.

In the alternative, it is imperative for children to be seen by a pediatrician within twenty four hours of their entry into foster placement. A detailed follow-up visit should occur within thirty days. It would be good practice to have social workers participate in the thirty day follow up examination in order to provide information with regards to any trauma the child may have suffered. In addition, in the absence of the medical home model for children in foster care, a medical passport should be maintained in order for information to travel from one place to another.

Safe sleeping and co-sleeping was an additional challenge encountered in the review of these infant fatalities. The Center for Disease Control and Prevention (CDC) reported that in 2014 there were 38.7 infant deaths per 100,000 live births attributed to Sudden Infant Death Syndrome (SIDS) and in RI there were 10,000 live births in 2014, suggesting an average number of just under 4 infant deaths in RI. This review involved the death of three infants, two of which could be attributed to unsafe sleeping situations. Sudden Unexplained Infant Death (SUID) is a category that is inclusive of SIDS, Accidental Suffocation and Strangulation in Bed, and Unknown Causes. Clearly, more education is necessary regarding safe sleeping for infants, particularly infants in the care of DCYF. Updating our foster care regulations to better address safe sleeping would also be recommended.

Safe sleeping was a significant concern in the cases reviewed.

Office of the Child Advocate

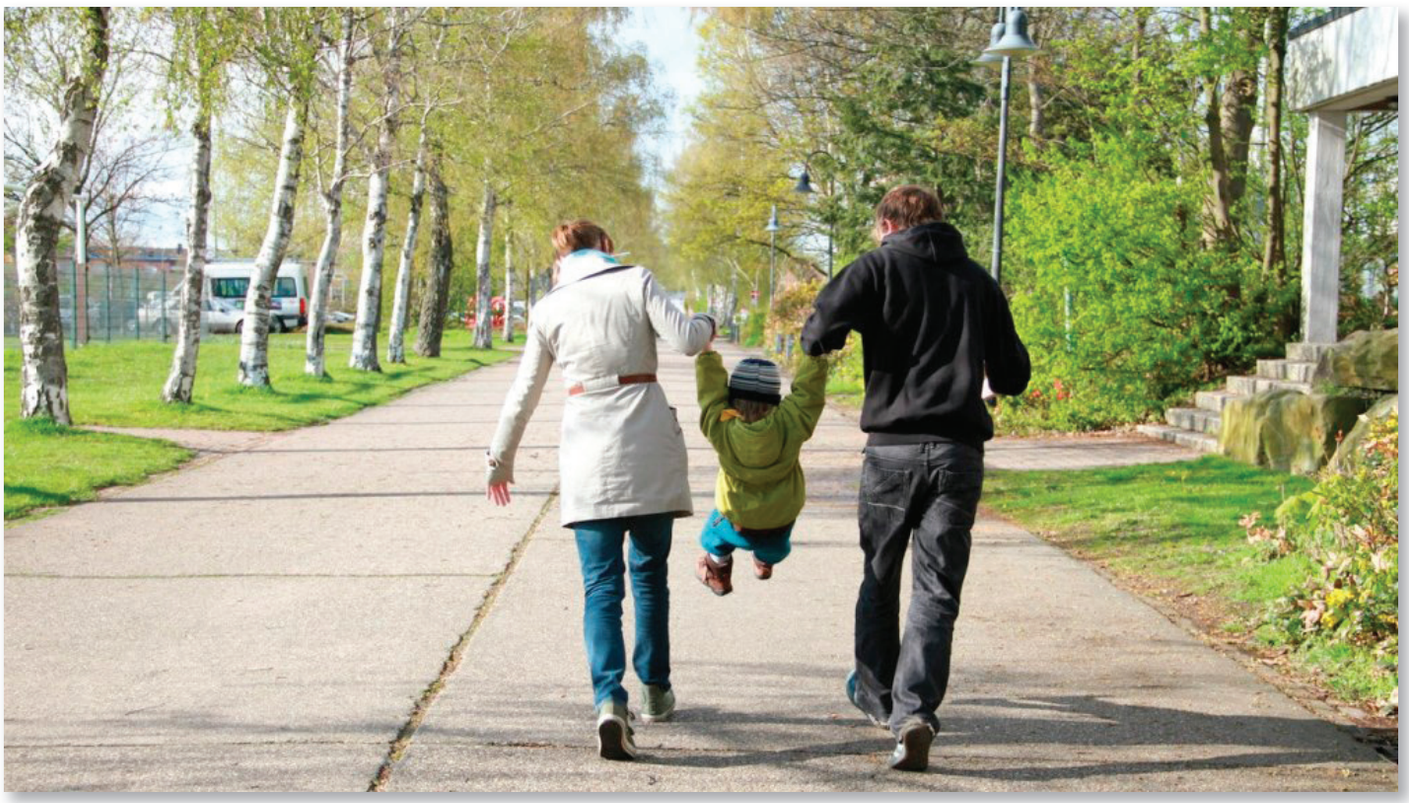
The Office of the Child Advocate is an independent agency created by statute to protect the legal, civil and special rights of all children and youth in the protective care, custody or treatment of the Department of Children, Youth and Families. The primary purpose of the OCA is to monitor DCYF and its operations and to ensure that collateral agency concerns such as the budget and personnel issues do not negatively affect the vulnerable children who are victims of abuse and neglect. As a result, a natural, but healthy tension exists between the OCA and DCYF. However, it is imperative to maintain good communication between the two agencies, particularly at times of significant change, as has been the situation for many years.

In 2012, the Department ushered in a Network System of Care headed by two Lead Agencies, Child & Family Services of Newport and Family Services. The State and these two agencies engaged in a private – public partnership that changed the service delivery system in the State for several years. Recently, the Department has incrementally resumed responsibility for the delivery of service in these services in the state, with network contracts scheduled to terminate effective March 31, 2016. At that time, DCYF will resume responsibility for all aspects of service delivery for children under its care.

Sweeping changes in the service delivery system in addition to substantial reductions in the Department's budget in a short period of time has not been without growing pains. Ensuring a strong OCA is critical to a successful system of care. In completing its work, the Team recommends that the OCA implement a Child Fatality Panel, with responsibility for the regular review of the death of children under the care of DCYF. The Panel would be ongoing and review all cases. The Panel would maintain data from the reviews and report out annually on the fatalities and near fatalities that occur at the Department regardless of the cause of death. The Team recognizes that in order to accomplish that the OCA requires regular notice of all fatalities and near fatalities at the Department. Explicit and express notice requirements by the Department and / or the Department of Health is required to keep an accurate record. As broad changes occur at DCYF, input from the OCA should be sought. Regular updates about policy and practice changes occurring at the Department should be shared with the Child Advocate. While tension between the agencies may be a natural consequence of the relationship, collaboration between the two will yield better results for children and families. Information sharing should be open and transparent and the goal to achieve what is in the best interest of children.

The OCA has no written protocols for investigating, reporting and data collection of fatalities and near fatalities. Establishing such protocols for the review of fatalities and near fatalities will ensure fidelity and transparency.

Recommendations



Recommendations

1. Update the statutory provisions that provide specificity and clarity regarding the exchange of information between state agencies to assist in expediting the process of reviewing fatalities involving children currently or previously involved with DCYF. Require the release of demographic information on all child fatalities and near fatalities in the State of Rhode Island to the OCA for the purpose of data collection and annual reporting.

2. As autopsy reports can take months or years to complete, alternatives should be considered as outcomes may have an impact on the state's ability to address the safety of children, particularly those who may remain in the homes of caretakers following the death of a child. The RI Medical Examiners Office should complete autopsy reports in child fatalities within six months or consider alternative external contracts to do so. Pediatric Pathologists may be one particular source available, in order to complete them in a timelier manner.

3. DCYF should provide immediate notice with a subsequent written report of all fatalities and near fatalities to the OCA within forty-eight hours, to include demographic information identifying the circumstances of the fatality or near fatality known to the Department regardless of whether or not the death is initially deemed to be the result of child abuse and neglect. DCYF should allow staff from the OCA prompt access to DCYF records.

4. The OCA and The Office of the Attorney General develop a protocol regarding release of information requests by the OCA.

5. The OCA will continue to send notification of statutory authority to local police departments of RIGL § 42-73-9 with future requests for information.

6. The state organizations charged with children's health, safety and well-being prepare a comprehensive child fatality prevention plan.

7. The OCA is aware that the DCYF is currently updating its policy on Fatalities and Near Fatalities, the policy should include the reporting of ALL child fatalities and near fatalities at DCYF, not just situations where the cause of death is linked to maltreatment. The agencies should collaborate to clearly define what constitutes a near fatality.

8. While DCYF should continue to have primary responsibility for reporting all child fatalities and near fatalities to the OCA, alternative options for notice of child fatalities to the OCA should be explored, such as notice from vital statistics at the RI Department of Health.

9. DCYF should provide any written reports of a Child Fatality Response Team to the OCA.

10. The OCA should establish written protocols for the investigating, reporting and data collection of fatalities and near fatalities. The OCA should develop a panel that consistently reviews the death of children involved with DCYF with the resources to staff the process. A report should be completed annually.

11. The DCYF should improve the verification of reports of medical and other services self-reported by families or foster families before closing a CPS investigation or approving relative or other foster care licenses.

12. Review of the statutory provisions of the Physician's Report of Examination (PRE) under Rhode Island General Laws § 40-11-4, § 40-11-5 and § 40-11-6, particularly to addressing concerns regarding chronic neglect.

13. DCYF to adopt and integrate a comprehensive set of evidenced-based investigation and risk assessment tools that address the needs of children and families at every level of their involvement. Particular attention to determining the best tools and process for children under age six with multiple reports to the DCYF. Explore investigation and assessment tools that utilize Structured Decision Making and screening tools for Adverse Childhood Experiences (ACES).

14. DCYF to develop a robust array of community based services to meet the complex needs of the children and families they serve. A focus on the needs of infants and young children with parental substance abuse, mental health, domestic violence, and other risk factors is recommended.

15. Review of DCYF licensing procedures to

address any staffing challenges that interfere with a comprehensive and efficient licensing process. Staffing should include a member dedicated to the coordination and oversight of kinship care.

16. Identify and act on a marketing strategy for recruitment and maintenance of foster families. The current differences in foster parent training requirements and criteria for licensing between relative and non-relative foster families should be reviewed to ensure all children in care remain safe and have their needs met.

17. Intense oversight of unlicensed foster placements requiring regular visitation to the home until license is obtained. DCYF should include time frames for completing foster home licensing process as a Performance Measure. Ensure all relative and non-relative caretakers have knowledge of safe sleeping and are equipped with safe bedding immediately upon placement. Address safe sleeping in foster care regulations.

18. Address DCYF caseload concerns and bring caseload bearing staff into compliance with national standards. Provide DCYF staff the twenty hours of annual training as required by statute. Ensure secondary trauma is addressed in the child welfare workforce and provide post trauma and grief services for the parents and foster families after the death of a child.

19. The DCYF and Department of Health develop a coordinated strategy to identify and respond to the health care needs of children in foster care, including the efficient transfer of records between health care providers.

20. Review of OCA functions, staffing and structure should occur to ensure that the office is able to effectively meet its mandate including but not limited to the ability to identify, track, monitor, report and make recommendations related to child fatalities and near fatalities.

"Every child abuse and neglect fatality represents an immeasurable loss to the family and to the community... We mourn the death of each child, but I want to learn from those deaths. I think we have an obligation to learn from those deaths."

Judge John Special, Commissioner of the Texas Department of Family and Protective Services

Our hearts go out to all families who have suffered the loss of a child.

Respectfully Submitted,

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Public Document 2016-001