Child Fatality and Near Fatality Response

Rhode Island Department of Children, Youth and Families
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The Department requires an immediate and thorough response to the fatality or near fatality, resulting from abuse or neglect, of a child who is under the care and supervision of the Department. The Director or designee will schedule an administrative meeting to gather all available information and review the incident.

When further investigation is necessary, a response team, which includes Department staff and community partners, is appointed to examine the circumstances surrounding the fatality or near fatality. This review enables the Department and the community to identify important issues related to child protection and take appropriate action to improve efforts to prevent child fatalities and near fatalities in the future. The Department is not alone in its responsibility to protect children; therefore, reviews and subsequent recommendations address issues of interagency collaboration, communication and decision-making. The Department may also review the fatality or near fatality, resulting from abuse or neglect, of a child who was previously under the care and supervision of the Department.

The Child Abuse Prevention and Treatment Act (CAPTA) requires the Department to disclose the findings or information about the case of child abuse or neglect that has resulted in a child fatality or near fatality. A near fatality, as defined under CAPTA, is an act that, as certified by a physician, places the child in serious or critical condition.

Support services for Departmental employees are coordinated through the Department's Critical Incident Stress Management Team, and the RI Employee Assistance Program is also available on a self-referral basis.

Related Procedure

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Procedure From Policy 100.0165: Child Fatality and Near Fatality Response

A. Immediate Departmental Response

1. In all fatalities and near fatalities resulting from abuse and/or neglect, involving children under the care and supervision of the Department, the Director or designee is notified immediately of the incident. The Child Protective Services (CPS) Assistant Director or designee makes the notification if the incident is reported to the Call Floor during standard working hours. The on-call CPS administrator makes the notification if the incident is reported during nights, holidays or weekends.
2. The Director or designee notifies the Child Advocate immediately upon receipt of the information of all fatalities and near fatalities of children under the care and supervision of the Department.
3. The Director or designee notifies the Deputy Director, administrative legal counsel, Regional Director or administrator of the respective division, and the Chief of Staff. The Regional Director or administrator notifies the worker, supervisor and unit administrator.
4. Worker, supervisor and administrator with case responsibility reviews the case record and prepares a chronology of Departmental involvement for the administrative review.
5. An administrative review is scheduled by the Director or designee and includes all administrative and direct care Department and community partner staff who have involvement with the family, the Chief of Staff and administrative legal counsel. If a foster family is involved, the licensing administrator also attends. The child's case record and legal case record is available for review at this meeting.
6. The purpose of this meeting is to review the incident and gather all available information.
7. The Deputy Director or designee coordinates the assignment of staff responsibilities relating to gathering additional information, interacting with other agencies and preparing a report and/or press statement.
8. If it is determined that a more in-depth review is required, a Child Fatality Response Team is convened.

B. Child Fatality Response Team

1. When the circumstances require further investigation, a response team, which includes Department staff and community partners, is convened and coordinated by the Deputy Director or designee.
2. The purpose of this review is to examine the circumstances surrounding the child fatality or near fatality and to evaluate the implications for future practice.
3. The team assesses the quality of services provided by the Department and community partners, evaluating compliance with applicable regulations and policies.
4. The review may require staff interviews for the purpose of obtaining first hand information of critical case events. Employees may have representation present during this process.
5. A coordinated and cooperative effort with other departments and agencies such as hospitals, Medical Examiner, Attorney General and police departments may be required. During the review, the Deputy Director or designee coordinates the assignment of staff responsibilities relating to gathering the necessary information and interacting with other agencies.
6. Agenda items include, but are not limited to:

a. ~~Current and past involvement with the Department, including CPS investigations~~

b. ~~Legal status, court orders~~
c. ~~Present living arrangement, other children in the placement, adult providers, other adults living in or who frequent the home or facility~~
d. ~~Medical and behavioral history~~
e. ~~Review of case record, assessment and service plan, case documentation, client contact~~
f. ~~Agency's effort for providing identified services~~
g. ~~Worker's caseload size, supervisory ratio~~
h. ~~Worker's training record~~
i. ~~Case records of other service providers involved with the family~~
j. ~~Applicable policies and procedures~~
k. ~~Drug/alcohol use by child, family members and caretakers~~
l. ~~Runaway attempts and documented efforts at locating child~~
m. ~~Strategies for assisting the remaining children, parent(s), foster family, relatives, significant others and staff~~
n. ~~Review of plans and needs, for remaining children in home or facility to ensure safety, permanency and well-being~~
o. ~~Licensing status of substitute care provider~~
p. ~~Police and coroner reports~~
q. ~~Development of an agency position and draft statement for the press~~

7. ~~A final report is submitted to the Director within 30 working days. The final report includes a summary of the findings and recommendations to improve any identified management and/or systems issues that were cited during the review process. In some situations, all the facts may not be available to the team within this timeframe. In these instances the Director may allow an extension until the necessary information is available. Weekly updates are provided to the Director in all cases.~~
8. ~~The Director conducts a follow-up review within 60 days of receiving the final report to ensure that the recommendations are addressed and/or implemented.~~
9. ~~Staff must assist and cooperate with the Child Advocate's Office concerning any review or investigation, including providing the Child Advocate's Office with all information known to the Department.~~

C. ~~Release of CPS information pursuant to the Child Abuse and Prevention Treatment Act (CAPTA).~~

1. ~~The Department discloses facts to the public about a child abuse or neglect case that results in a child's fatality or near fatality.~~
2. ~~The Department releases the following information to the public:~~
   a. ~~Cause of, and circumstances regarding, the fatality or near fatality.~~
   b. ~~Age and gender of the child.~~
   c. ~~Summary information describing any previous reports or child abuse or neglect investigations that are pertinent to the child abuse or neglect that led to the fatality or near fatality.~~
   d. ~~Whether an investigation has been initiated in the instant case.~~
   e. ~~Result of the completed investigation, or information about such a case, if there are no findings.~~
   f. ~~Services provided and actions of the Department, on behalf of the child, that are pertinent to the child abuse or neglect that led to the fatality or near fatality.~~
   g. ~~Dates and outcomes of child abuse or neglect investigations concerning the child.~~
3. ~~The Department may restrict the release of certain information:~~

a. ~~In order to ensure the safety and well-being of the child, parents and family, or~~

b. ~~When releasing the information would jeopardize a criminal investigation, or~~

c. When releasing the information would interfere with the protection of those who report child abuse or neglect, or

d. When releasing the information would harm the child or the child's family.

4. The Department responds to inquiries from the media regarding child fatalities and near fatalities, but does not initiate contacts with the media unless otherwise determined by the Director.
5. The Director determines on a case by case basis who will be the Department's spokesperson.
6. All information is distributed consistent with the Department's policies relating to confidentiality and public information and relations.

D. Staff Support

1. Each individual's response to stress is unique. In some instances the worker may not realize the extreme pressure that he/she is under. The Department recognizes that at times, crises occur overwhelming our ability to cope effectively. The Department understands these pressures and promotes a system to assist each staff member who has been affected by the child's death.
2. Support services for Departmental employees are coordinated through the Department's Critical Incident Stress Management (CISM) Team, which is available to provide peer support to colleagues during stressful events.
3. The CISM Team mission is to provide peer support to colleagues during these stressful events. Team members are nominated by peers and represent the Department's various divisions.
4. The RI Employee Assistance Program (RIEAP) is also available to assist employees on a self referral basis.