State of Rhode Island and Providence Plantations

Senate Chamber

Dr. Trista Piccola
Director
Department of Children, Youth and Families
101 Friendship St.
Providence, RI 02903-3716

April 5, 2017

Dear Dr. Piccola:

Thank you for your attendance at the March 28, 2017 Senate Committees on Health and Human Services and Finance joint hearing to discuss the report of the Office of the Child Advocate's Fatality Review Panel, issued the week earlier. I believe everyone at the hearing was shaken by what we heard, and we share the responsibility to act with a sense of urgency. Of immediate importance are the current child safety issues identified, including the reported backlog of abuse/neglect reports pending investigation.

We cannot state clearly enough that we do not fault the staff at the department for the issues identified. As the Child Advocate testified, the front-line workers deserve our support, not our criticism. They have highly challenging and unpredictable jobs, made more difficult by having excessive caseloads and being under-resourced. We also understand that many of the issues identified represent problems that existed or were created prior to your recent arrival at the department. We welcome the strong child welfare experience that you will bring to improving our child protection policies and practice.

As we take steps to ensure that our children remain as our priority, we would like to hear your department's response to the recommendations contained in the report. We plan to hold a follow-up hearing to receive a detailed update from you on progress being made to address the deficiencies noted. To guide your responses to us, we have prepared this listing of questions that stem from the OCA Review Panel Report, as well as those asked by Senators at the hearing. We recognize that some of the issues identified demand immediate, or short-term responses, while others will require long-term progress. We also recognize the many changes have occurred within the department over the last year, and we hope that you can point to those child-safety initiatives that have been completed or are in-progress. Finally, we are aware that some of the recommendations will require the active involvement of the Governor's Children's Cabinet, and we welcome their participation in this discussion.

Below is an outline of the twenty-one recommendations in the report. For each, please indicate the department's response, the time frame needed for implementing the recommended change, and any statutory and fiscal barriers that will need to be overcome:

1. The Child Protective Services Unit (CPS) should shift from an incident-based system to a risk-based system. Realizing that implementing a change of this magnitude will take much research, planning, funding and most importantly time, the Child Fatality Review Panel would like the following changes to be implemented under the current system, effective immediately:
    a. Conduct a multi-state analysis and evaluate the systems/models utilized by other CPS Units in states that have comparable populations and have been deemed to be effective.
    b. Following the receipt of a call involving allegations of abuse or neglect of a child under the age of six (6), a Child Protective Investigator should be mandated to respond to the home and put eyes on the child, to assess potential risks and ensure the safety and well-being of the child.
    c. That the Department develop a policy, which outlines in great detail the way in which a call made to the Child Abuse and Neglect Hotline, should be recorded into RICHIST, DCYF's electronic database.
    d. Complete overhaul or repeal of DCYF Policy 500.0040, Information/Referral (I/R) Reports. A more strict procedure for the use of the category must be developed to prevent its misuse and overuse.
    e. That the Department develop a policy, which mirrors the former "Early Warning" process.
    f. The Department should improve the verification of reports indicating participation in medical and other services, which are self-reported by families or foster families.
    g. That the Department create an internal policy requiring the response of at least two (2) Child Protective Investigators to investigate any call reporting a child fatality.
    h. That DCYF, more specifically CPS, should not categorize a child fatality or near fatality be categorized as an "Information/Referral", especially when the family has had prior involvement with DCYF.
    i. Training of CPS and Intake staff to ensure quality of information recorded and reports distributed.
    j. Re-evaluate administrative staff operating the CPS Unit to ensure that they meet the educational and experience requirements and to ensure that the qualifications of their administrative staff adhere to Rhode Island general law, specifically, R.I.G.L. § 42-72-6, which requires that, "...all assistant directors, associate directors or executive directors shall have a master's degree in social work (M.S.W.) or in a closely related field."
2. Reinstitute the use of "Legal Supervision" by DCYF, outlined in R.I.G.L. § 40-11-12, that will place the family under the supervision of the Family Court and DCYF to ensure that the family complies with community-based services.
3. Following the expanded use of "Legal Supervision", if it is determined that Establishment of a Diversion Court through the Family Court, which will operate with the goal of overseeing cases under "Legal Supervision", to work with the family to prevent further involvement with DCYF and the potential removal of children from their home while ensuring that the community-based services provided to the family mitigate the risks involved with the case.
4. The Department to develop a robust array of community based services to meet the complex needs of the children and families they serve.

5. Coordination of medical records within the medical community to improve the exchange of medical information.
6. That the use of medical marijuana by a primary caretaker, regardless of its legality, be assessed by the Department as a risk factor, similar to alcohol and prescription medication when determining risk and need for a family.
7. That the Department strictly adhere to DCYF Policy 500.0125, to ensure the appropriate level of DCYF involvement upon the confirmation of drug use by a parent during their pregnancy.
8. That when the Department receives a call reporting drug use during pregnancy and is verified by one of the forms of evidence outlined above, this should prompt an immediate hospital alert.
9. 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.
10. Enhance the work of the Department of Health by dedicating resources for a new public education campaign to target the public, professionals who are in the child welfare system and foster parents regarding the dangers of co-sleeping. It is believed that to have an effective campaign that DCYF, local hospitals, DOH and the OCA, should be involved. Also, begin a pilot program in a high risk community to test any recommendations of the inter-agency collaboration.
11. Engage the Children's Cabinet to assist with the development and execution of a state-wide agenda to ensure safe sleeping practices, based upon the work of the agencies named in the previous recommendation.
12. That the Office of Vital Statistics reinstitute their previous MOU with the OCA, to provide the OCA with notice of every recorded child death from ages 0-21.
13. Ensure compliance with mandatory training requirements for all DCYF employees. In accordance with R.I.G.L. § 42-72-5 (10), which requires the employees of DCYF to complete a minimum of twenty (20) hours of training per year.
14. 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.
15. For the Department to strictly adhere to the statutory obligations delineated in R.I.G.L. § 42- 72-8, including but not limited to R.I.G.L. § 42-72-8 (c)(2) which states "The director shall make public disclosure of a confirmed fatality and near fatality of a child that is the subject of a DCYF case within 48 hours of confirmation, provided disclosure of such information is in general terms and does not jeopardize a pending criminal investigation."
16. That upon completion of a Critical Event Review by the Department, the OCA shall be provided with a copy of the final report generated by the Department.
17. Fill vacancies for front line workers, including social workers, intake and CPS to ensure that caseloads are compliant with national best practice and to ensure that there is appropriate staffing on for each shift, every day of the week.
18. That the OCA be provided with advance notice of any policy change to take place within the Department to have the opportunity to be a part of the revision process in collaboration with the Department, as well as other relevant entities.
19. That the Department, in collaboration with the OCA, evaluate the methods utilized in other states to determine best practices for tracking data on child fatalities and near fatalities.
20. That the timely implementation of each of these recommendations be overseen by the Senate Task Force for DCYF and the OCA.
21. That the OCA be provided with appropriate staff and resources to have the ability to effectively monitor the Department and provide a heightened level of oversight, which has become increasingly necessary to ensure the safety and well-being of children in state care.

In addition to responding to the above recommendations, please address the following specific concerns expressed by members of the Senate Committee on Health and Human Services and the Senate Committee on Finance at the hearing on the report:

1. **Chairman Miller**
    a. In your estimation, how many of the recommendations would be minimized or diminished based on reducing the caseload burden?
    b. The long-term improvement in caseload requires investment. How much of the current turnover might be minimized with improved procedures?
2. **Senator DiPalma**
    a. Hiring will take time due to the fact that eleven workers have double the caseload and three have triple—totaling seventeen additional staff people. Might some of the community providers that are interacting with families today on a whole variety of issues be able to assist with some of this to be able to bring some information back to the department?
    b. How else can we bridge this gap because the caseload isn't going away tomorrow?
    c. We need to have a disciplined repeated process followed by every caseworker. How might this address the problem here?
    d. Did the case workers involved in these six cases know there was another child in the household?
    e. With regards to supervision, there's supervision within DCYF of the caseworkers. Does DCYF meet the required 1:5 ratio?
    f. The cases would have eventually been looked at by a supervisor. Can you comment on the expected supervision and the quality assurance/quality control that should have been done with the caseworkers?
    g. With regards to the risk-based approach—and from a child advocate's perspective—have you looked at how predictive analytics might be able to help alleviate some of the challenges the department has?
3. **Senator Goldin**
    a. Regarding the large percentage of Information/Referral cases that were identified by the OCA as misclassified, has DCYF gone back and investigated them, even if the usual time period for investigation has passed?
    b. Is the person who was appointed as the acting supervisor of CPS still in that role?
4. **Chairman Conley**
    a. Chairman Conley cross-referenced the OCA report with "The Impact of Ethics to Reduce Out-of-Home Placements." If one compares the FY 2014 to FY 2015 and FY 2016 it shows is that the number of maltreatment reports stayed the same, but the number of investigations declined dramatically. There were 1200 fewer investigations conducted by CPS compared to FY 2014 even though there is a similar call volume based on their own data. How did this drop in investigations not trigger an inquiry?
5. **Senator Crowley**
    a. If a mother is getting assistance for prenatal care, someone must note that the mother is under the influence of some kind of drug, so why aren't we being more proactive than reactive following that pregnancy?
    b. Are you looking at resources for young mothers?
6. **Senator Satchell**

a. No procedures were being followed in blatant disregard for DCYF policy. In your opinion is that due to sheer negligence or was that done for self-preservation?

7. **Senator Felag**
   a. The recommendation that will have the greatest impact is the shift from an incident-based system to a risk-based system. Is this a training issue or an unwillingness to shift to a new type of model?
   b. Do we need to put more money into training?
8. **Senator Seveney**
   a. Who looks at the Information/Referrals, and what happens after they're initially established?
   b. Are the cases coded as Information/Referrals tracked in the computer so a caseworker is alerted if this the fifth Information/Referral in one family within a number of months?
9. **Senator Paolino**
   a. The computer system is very old. Are there any plans for new one? If so, what recommendations will potentially be improved by a new IT system?
10. **Senator Calkin**
   a. Moving to risk-based system seems to make a lot of sense. Are there any additional data elements that should be collected to move to a risk-based model?
   b. If we transition to a new system, is there a way to make sure that the information is presented in a way to the people taking the calls so that they can see the bigger picture?
   c. The Medical Examiner reported a death to DCYF. DCYF did not initiate an investigation and logged it as an Information/Referral. Is there any way that if the Medical Examiner is reporting to DCYF that DCYF is then required to submit some additional information back to the Medical Examiner? Is there any trigger that can happen in DCYF to force an investigation, just in case there are any other children living in that house?

Again, we would like to thank you for attending the Joint meeting of the Senate Committees and for reaching out to us to discuss the issues raised. We would appreciate an initial written response from you by April 14, giving your general preliminary response to the report and any specific actions taken to-date to address these concerns. We particularly look forward to hearing of your immediate plans to ensure the consistent, timely, and proper treatment of reports of abuse and neglect. A more thorough and complete response will be the topic of an upcoming hearing.

Together, we can and will do better for the sake of the children in Rhode Island.

Sincerely,

Joshua B. Miller
Chairman
Health and Human Services

William J. Conley Jr.
Chairman
Finance Committee

Gayle L. Goldin
Vice Chairman
Health and Human Services

Louis P. DiPalma
First Vice Chairman,
Finance Committee