2024 ANNUAL CRITICAL EVENT REVIEW

This document summarizes the key findings presented in the annual Critical Event Review Report for the year 2024.

What is a Critical Event Review?

A **Critical Event Review (CER)** is the process in which the Department of Children, Youth & Families conducts a detailed case analysis following a child fatality, near fatality or other serious or critical condition.

CERs provide an opportunity for the Department to conduct a detailed case analysis following a child fatality, near fatality or other serious situation that warrants a review, in accordance with state law RIGL§ 42-73-2.3. The case analysis process enables the Department to determine whether the incident reflects a more significant systemic issue the Department must address.

CERs are convened in the following situations:

- A child fatality in which child abuse or neglect is suspected to be a contributing factor regardless of whether the family is currently active ("open") to the Department or has ever received services from the Department.
- A child fatality or near fatality in which child abuse or neglect could be a contributing factor and the family is active or has been active with any division of the Department within the previous 12 months or
- A child fatality or near fatality in which abuse or neglect is not suspected to be a contributing factor, but the family is active or has been active with any division of the Department within the previous 12 months.
- Any severe other situation as identified by the Department Director or designee. (None of the 2024 critical events fell in this category.)

Definitions

"**Fatality**" means the death of any child in which maltreatment is confirmed to be a contributing factor.

"**Near Fatality**" means a child in serious or critical condition as certified by a physician due to abuse, neglect, self-harm or other unnatural causes. The child being placed in

serious or critical condition must be classified by the treating and/or consulting physician and reflected in the medical chart. The treating physician's determination that the child is in serious or critical condition is accepted without further assessment by the Department.

"**Serious or Critical Condition**" means the patient's vital signs are unstable and not within normal limits. The patient is acutely ill, and/or unconscious, and/or has respiratory or cardiovascular instability, and/or has a neurological status change, requiring medical intervention because of abuse or neglect.

Overview of Critical Events

29 critical events occurred in 2024; at the time of the report, 28 had been reviewed. Of the 29, 14 were fatalities and 15 were near fatalities.

- **DCYF Involvement:** 11 cases were open to the Department at the time of the incident, while 17 were not open at the time of the report.

Trends and Demographics

- **Age Distribution:** Most fatalities and near fatalities occurred among youth aged 0-13 years (19 incidents in 2024).
- **Gender Distribution:** 19 of the 29 critical events in 2024 involved males, compared to 14 of 24 critical events in 2023.
- **Race Distribution:** 18 of the 29 critical events involved white youth, compared to 14 of 24 in 2023.

Causes of Critical Events

Of the 28 cases reviewed at the time of this report, 11 children were open to the Department.

Physical abuse was the most frequently cited cause of critical events in 2024, cited in 8 out of 28 reviewed critical events. Additionally,

- 7 of 28 reviewed critical events were due to co-sleeping
- 6 of 28 reviewed critical events were due to drug misuse/exposure;
- 11 of 28 were due to either accidents or community violence;

Cited Causes* in Fatalities & Near Fatalities Included:

- Physical Abuse (Excessive/Inappropriate Discipline, Gunshot-Murder)
- Co-Sleeping (Suffocation, including Sleep Rollover)

- Drug Exposure and Drug Misuse
- Accidents (Drowning, Motor Vehicle, Falls from Heights)
- Community Violence (Gunshot, Stabbing)
- Underlying Medical Conditions
- Suicide

* In descending order; multiple factors involved in some critical events.

Investigation Outcomes and Perpetrators

- **Investigation Outcomes:** At the time this report was published, 13 of 28 reviewed critical events (46%) were "Indicated," meaning child abuse or neglect was investigated and found to be a contributing factor.
- **Perpetrator Relationship:** Family members (Biological Parent or Stepparent) had direct involvement as perpetrators in 15 of the 28 reviewed critical events.

Findings and Type of Recommendations to Improve Outcomes

Critical Event Reviews are conducted by a multidiscipline team from DCYF, law enforcement, medical practitioners and other departments heads.

Each CER includes an examination of the applicable statutes, regulations, Department operating procedures, practices, training and use of ancillary systems. A uniform response to critical events allows the Department to:

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

This review process results in findings and recommendations to consider for future activities that could improve outcomes. They fall into four categories: Collaboration, Systemic Issues, Needed Resources, Policy and Procedures and Needed Services.

- **2024 Recommendations by Category***
    - Collaboration Between Agencies: 30 cases
    - Systemic Issues: 23 cases
    - Needed Resources: 23 cases
    - Policy and Procedure Issues: 18 cases
    - Needed Services: 17 cases

- **Key Systemic Issues Contributing to Fatalities and Near Fatalities**
    - Lack of Awareness Regarding Co-Sleeping Risks
    - Housing Instability
    - Gang Violence
    - Substance Misuse

* Cases may have more than one recommendation per category.

Status of Recommendations*

There were 101 recommendations in the 2024 Critical Event Review Report. Of those, 64.35% have been implemented, while 35.64% remained open at the time of the report.

- **Distribution by Department:** Recommendations were distributed across various departments, including External Partners (8), Division of Family Services (2), Child Protective Services (17), Children's Behavioral Health (9), Director's Office (5), Juvenile Probation (2), Workforce Development (5), Management Information Systems (1).

* Data is current as of time of report, April 14, 2025.

Data Source: DCYF Critical Event Review Master Database; RICHIST, Critical Event Reviews.
Data is reported out on a calendar year.