2025 ANNUAL CRITICAL EVENT REVIEW

This document summarizes the key findings presented in the annual Critical Event Review Report for the year 2025.

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.
- 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 other severe situation as identified by the Department Director or designee.

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

Of the 9 critical events reviewed in 2025, the majority were near fatalities.

- **DCYF Involvement:** There were slightly more cases open to the Department at the time of the incident compared to the number that were not open.
- **Age Distribution:** Most critical events occurred among youth aged 14-21years.
- **Gender Distribution:** Most critical events in 2025 involved males.
- **Race Distribution:** Most critical events involved white youth.

Cited causes of fatalities and near fatalities* included:

- Physical abuse (negligence, assault)
- Fentanyl/Percocet overdose
- Overdose
- Suffocation/Co-sleep
- Community violence (gunshot)

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

FINDINGS AND RECOMMENDATIONS TO IMPROVE OUTCOMES

Critical Event Reviews are conducted by a multidisciplinary team of DCYF staff, law enforcement professionals, medical practitioners, DCYF providers and other state and community partners.

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 between Agencies, Systemic Issues, Needed Resources, Policy and Procedure Issues, and Needed Services.

Number of Recommendations by Category*

- Collaboration between agencies: 20
- Systemic issues: 0
- Needed resources: 2

- Policy and procedure issues: 18
- Training: 4

* Cases may have more than one recommendation per category.

Recommendations for Addressing Key Issues

- **Strengthen substance use services** by enhancing screening, expanding treatment options, improving discharge planning, increasing family involvement and strengthening collaboration among DCYF; Rhode Island Department of Behavioral Healthcare, Developmental Disabilities & Hospitals; hospitals; and treatment providers.
- **Improve interagency coordination and information sharing** among child welfare agencies, healthcare, DCYF's Office of Juvenile Probation, the Medical Examiner's office and neighboring states, particularly in response to fatalities, near fatalities and substance use-related incidents.
- **Enhance policies, procedures and staff training** through the development of clear protocols for custody decisions, dependency petitions, probation reviews, communication with providers, critical incident response and substance use referrals.
- **Expand prevention, education and public awareness efforts** by providing training on substance use, community violence, gang involvement, mandatory reporting and child safety to staff, hospitals, families and youth.
- **Increase service capacity and access to care** by expanding residential, outpatient and specialized treatment options, reducing waitlists and addressing barriers to ongoing treatment for youth with substance use and behavioral health needs.

Status of Recommendations

There were 44 recommendations in the 2025 Critical Event Review Report. Of those, 45.45% have been implemented, while 54.55% remain open or are ongoing.*

Recommendations were distributed across External Partners (10), DCYF's Division of Family Services/Critical Event Review Unit (15), Child Protective Services (12), DCYF's Division of Children's Behavioral Health (3), DCYF's Director's Office (4), DCYF's Office of Juvenile Probation (6), DCYF's Workforce Development (1), DCYF's Legal Department (1).

* Data is current as of June 3, 2026.

Sources: DCYF Critical Event Review Master Database, RICHIST, Critical Event Reviews.
Data is reported out on a calendar year. Due to RI DCYF small number policy, counts, percentages and rates based on fewer than 6 are suppressed.