Children's Committee Hearing 2.23.2017 Regarding Critical Incidents—

PRESENTED BY: THE OFFICE OF THE CHILD ADVOCATE

OCA Responds to Critical Incidents

Conn. Gen. Stat. 46a-13*l*. Child Advocate's duties.

- Evaluate the delivery of services to children by state agencies and those entities that provide services to children through funds provided by the state;
- Review periodically the procedures established by any state agency providing services to children, … with a review toward the rights of the children and recommend revisions to such procedures;
- Review complaints of persons concerning the actions of any state or municipal agency providing services to children… investigate those where the Child Advocate determines that a child or family may be in need of assistance or that a systemic issue in the state's provision of services to children is raised by the complaint;
- Pursuant to an investigation, provide assistance to a child or family who the Child Advocate determines is in need of such assistance;
- Recommend changes in state policies concerning children;
- Take all possible action including, but not limited to, conducting programs of public education, undertaking legislative advocacy and making proposals for systemic reform … to secure and ensure the legal, civil and special rights of children.

Child Fatality Review Panel

46a-13l*(b)* **There is established a child fatality review panel composed of thirteen permanent members as follows**: The Child Advocate, or a designee; the Commissioners of Children and Families, Public Health and Public Safety, or their designees; the Chief Medical Examiner, or a designee; the Chief State's Attorney, or a designee; a pediatrician, appointed by the Governor; a representative of law enforcement, appointed by the president pro tempore of the Senate; an attorney, appointed by the majority leader of the Senate; a social work professional, appointed by the minority leader of the Senate; a representative of a community service group appointed by the speaker of the House of Representatives; a psychologist, appointed by the majority leader of the House of Representatives; and an injury prevention representative, appointed by the minority leader of the House of Representatives. A majority of the panel may select not more than three additional temporary members with particular expertise or interest to serve on the panel. Such temporary members shall have the same duties and powers as the permanent members of the panel. The chairperson shall be elected from among the panel's permanent members. The panel shall, to the greatest extent possible, reflect the ethnic, cultural and geographic diversity of the state.

Child Fatality Review/OCA

Child death review in Connecticut

- CFRP *reviews overall cases.*
- OCA *investigates*. OCA can investigate *sua sponte* or can be *directed* by the CFRP to investigate.
- OCA consults with CFRP on investigations.

46a-13l:

(c) The panel shall review the circumstances of the **death of a child placed in out-of-home care or whose death was due to unexpected or unexplained causes** to facilitate development of prevention strategies to address identified trends and patterns of risk and to improve coordination of services for children and families in the state.

OCA Responsibilities: Child Death/Critical Incident Review

Conn. Gen. Stat. 46a-13*l(b)*

"Upon request of two-thirds of the members of the [CFRP] and within available appropriations, the Governor, The General Assembly or at the Child Advocate's discretion, the Child Advocate shall conduct an in-depth investigation and review and issue a report with recommendations on the death or critical incident of a child."

Recent Publications/Activities Child Death/Critical Incident Review.

1. Five Year Fatality Review, 2011-2015. (Report released by OCA 2016.)

2. Dylan C. (Report published by OCA 2016.) (Presentation to Children's Committee.)

2. Londyn Sack (Report published by OCA, in consultation with CFRP 2015.)

2. Sandy Hook (Report published 2014 by OCA and partners, in consultation with CFRP.)

3. East Haven: death of two children by homicide. (Report pending, consultation with CFRP.)

4. Zaniyah Calloway (directed by legislators) (Report published by OCA and CCADV, 2015.)

5. Death of children in day-care, recommendations regarding licensing framework (ongoing, consultation with CFRP and OEC).

6. Public Health Alert regarding Youth Suicide (Alert published by OCA/CFRP, 2015.)

7. Public Health Alert regarding Un-Safe Sleep Deaths (Alert published by OCA/CFRP, 2014.)

8. Deaths of Infants-Toddlers in Connecticut (Alert published by OCA, consultation with CFRP, 2014.) (presentation to Children's Committee.)

All reports are available on the OCA website.

Critical Injury Review Process- injuries suspicious for maltreatment.

OCA receives a copy of notification regarding any injury to a child, suspicious for maltreatment, that is called in to the DCF Careline and is coded by DCF as a "critical incident."

Per DCF Policy, the Department shall report and track critical incidents as a means of maintaining and improving quality of services.

The DCF Careline is responsible for notification of critical incidents to the Commissioner's Office, all appropriate Administrators, the Risk Management Unit, the Public Information Officer, the Agency Legal Director, the Licensing Program Supervisor, the Office of the Child Advocate and the Court Monitor.

Critical Injury Review

DCF notifications of critical incidents include:

- The death of a DCF minor client;
- A DCF minor client with a life-threatening condition;
- Broken bones in a child under 6 years of age, suspicious for maltreatment;
- Serious injury to a DCF minor client, including lacerations, bone fractures, substantial hematoma, burns, and injuries to internal organs whether self-inflicted or inflicted by someone else.

Critical Injuries in Connecticut: OCA Review

OCA is currently working on an investigation of critical injuries to children in the state of Connecticut.

OCA's Investigation of Critical Incidents

OCA's current investigation of critical incidents includes the children noted by this Committee's agenda:

1. Hailey E.

2. Matthew T., deceased.

OCA's investigation of recent critical incidents is *not* limited to these two children's cases.

The above-referenced cases are, however, under *active investigation* and OCA has not completed findings and recommendations at this time.

For purposes of this meeting, OCA is providing information that is publicly available through media reports, police warrants, and public statements from state and local agencies/providers.

OCA will provide *brief* additional information necessary to describe our activities as they relate to ongoing investigations.

OCA's Preliminary Review: Hailey

Public Information on this case is available through media reports, and law enforcement affidavits/warrants. Such information includes the following:

1. Child, age 2, was brought to the hospital by her mother in the early morning hours of February 4, 2017. Child presented with first and second degree burns over 11 percent of her body.

2. Explanations provided for the injuries, i.e. child causing accidental electrical fire, were not consistent with presentation of injuries, which appeared to be the result of scalding burns. Fire and police investigators questioned the validity of the parent's story.

3. Parent subsequently and allegedly provided alternative explanation that child and older brother (age 6) were being supervised by mother's boyfriend overnight while mother was working and that child was accidentally burned in the bathtub in the early morning hours.

OCA's Preliminary Review: Hailey

5. Parent allegedly told police that she lied because she knew that her **boyfriend was not allowed to be alone with her children because of a DCF case**.

6. Police obtained a copy of the recently executed "Department of Children and Families **Safety Plan**" which documented that "**due to unexplained injuries to [mother's] children and documented substance abuse by [mother's boyfriend] that he was not to have unsupervised contact with the children… This safety plan was signed by both [mother] and [boyfriend]**. (Warrant.)

7. Upon examination of the family's apartment, police documented "conditions of the apartment, specifically that there was an **extremely strong odor** of what was believed to be recently burnt marijuana."

8. Upon examination of the family's apartment, warrant indicates that electrical fire was staged.

OCA's Preliminary Review: Hailey

9. Police alleged that child's mother gave false statements to police, failed to comply with the DCF safety plan, and delayed in seeking medical attention for her young child. Parent was charged with False Report, False Statement, Injury or Risk of Injury to a Child, Cruelty to Persons.

10. **Additional information (OCA)—** child is two years old, with significant developmental delays and special health care needs due to **previous sustained trauma/physical abuse (another caregiver)**.

Recent reports included allegations of physical neglect as well.

OCA investigation—Hailey

OCA's investigation activities will/do include review of the following

1. Child/ren's history with DCF, **review of allegations of abuse/neglect**, how such issues were assessed and resolved.

2. Children's **developmental/educational/medical needs**, how such needs were affected, if at all, by abuse/neglect, how needs have been and are currently being met.

3. Efficacy of DCF risk and safety assessments and interventions, including **whether the safety agreement was effective** and reasonably designed to mitigate safety concerns and the risk of recurrent or future child maltreatment.

4. **Any other issues as they arise** through the fact-finding process.

OCA's Preliminary Review: Matthew T.

Public Information on this case is available through media reports, and publicly-disclosed law enforcement affidavits/warrant, statements from school organizations and the Department of Children and Families. Such information includes the following:

1. OCA, Police and the Department of Children and Families were contacted by the Office of the Chief Medical Examiner regarding the **death of a 17 year old boy, suspicious for maltreatment**.

2. The youth presented with several areas of **bruising to multiple parts of his body**, including his face, forearms and hands. The youth presented as "**severely malnourished and neglected.**" (Warrant.) Youth was approximately 5'-08" tall and weighed approximately 84 lbs. Normal approximate body weight for this child should be around 120 lbs. (Warrant.)

3. Youth is identified as Autistic and non-verbal. (Warrant.)

OCA's Review, Matthew T.

4. Youth's injuries included: numerous injuries in "Various stages of healing… injuries consisted of three broken ribs, a laceration to the head, several bruises and contusions on his upper body, a pattern type of injury to the upper back and bed sore type injuries to the left buttocks." Injuries "appeared to be the result of long term abuse and neglect." (Excerpt from Warrant.)

5. Mother allegedly stated that she kept all cabinets in the kitchen locked and screwed shut to prevent youth from over-eating or eating all of the food. (Warrant.)

6. Police warrant alleged that probable cause existed to charge mother with **Cruelty to Persons** due to depriving youth from accessing food, failing to address his injuries, failure to offer an explanation as to how youth sustained these injuries while under her direct care.

7. **Manner of death remains pending** with the Medical Examiner.

OCA's Preliminary Review: Matthew

8. **Youth had not been attending school**, and had not been seen at his school (a program for children with disabilities) in more than a year. Program reported his absence to DCF and the Hartford Public Schools.

9. DCF had prior and recent involvement with the family and publicly reported that the case was closed by the agency in January, 2017. DCF reported to the Hartford Courant that DCF had investigated "whether children in the family were **attending school, and that "[t]here were no indications of safety concerns involving Matthew or other children in the home until this week**." DCF reported to the Hartford Courant: "**the mother would not allow DCF staff access to the home and refused to engage in services or accept the attempts of the department to help the family**."

10. OCA provides the following information: The most recent DCF cases regarding the family involved allegations of physical neglect, educational neglect, and physical abuse (2014 to 2016). **The mother was placed on the state's Central Registry**. A neglect petition was filed in Juvenile Court in 2016. Matthew was not seen for several months prior to case closure.

OCA's Review: Matthew T.

10. Child's mother stated to police that is his primary caregiver, and "is the only person who cares for him," that he recently lost a lot of weight, that she "did not seek medical attention for her son." She allegedly stated that he began to get sick the previous weekend, presenting as "ill and vomiting," but she did not seek medical attention, instead monitoring him at home. (Warrant.)

OCA Ongoing Investigation: Matthew

1. Review of entire child welfare history, allegations, responses, efficacy of interventions.
   - Examination of whether risks and safety concerns in the family were adequately identified and whether interventions corresponded to such identified or identifiable risks and concerns.
   - Review of whether all steps were taken to address inability to see and evaluate the children prior to case closure.
   - Review of how Matthew's needs and vulnerabilities were assessed, given his status as a child with complex disabilities with limited communication.

2. Review of educational history for Matthew and his sister.
   - Examination of how attendance and any other concerns were identified, monitored, and/or reported to relevant state or local agencies.

3. Review of court records to examine how concerns about the family were documented and addressed.

4. Review of role of children's appointed lawyer.

5. Review of medical records to determine history of care, identification of any issues of concern, how such issues were addressed.

OCA's current investigation of critical/fatal injuries.

- OCA's investigations are pending as critical/fatal injuries are very recent.
- OCA can report to the committee regarding its findings as expeditiously as possible.
- OCA is currently investigating circumstances leading to the death or critical injuries of multiple other children, including several children who were under DCF supervision at the time of their injuries. OCA can provide a future update to the legislature regarding these activities, general findings and recommendations.

OCA's Recent Recommendations Regarding Child Welfare Interventions

- Heightened Case Review/Supervision for Infant-Toddler cases.
- Risk and Safety Assessments, evaluation and standards.
- Kinship Diversion/Family Arrangements, standards, additional evaluation.
- Reporting regarding maltreatment of infants and toddlers.

OCA Previous Recommendations

Heightened Case Review/Supervision for Infant-Toddler Cases

That specific protocols be developed as part of DCF's practice guide for young children that includes specific requirements for:

1. Heightened case supervision;
2. Frequent visitation between caseworker and child/family;
3. High Risk Infant Policy;
4. Expected documentation of case activities relevant to the safety and well-being of the child;
5. Development of a case supervision tool specific to the unique needs and risk status of infants and toddlers.

OCA Previous Recommendations: Safety Agreements--Standards

Amend Ch. 17a-101 to require that DCF create standards regarding the use of voluntary family safety agreements for children who are identified as victims of abuse/neglect or at elevated risk of abuse or neglect. Standards should address when the use of such agreements is appropriate based, in part, on the use of evidence-based risk and safety assessment tools. Standards shall also require that safety agreements document how safety concerns will be immediately addressed, what level of monitoring the DCF will provide to ensure implementation of the agreement, and what services will be put in place, and when, to ensure the safety of the child in the home. Standards shall ensure heightened requirements for safety agreements involving children under 36 months of age. Standards shall address how substitute caregivers will be assessed by DCF. DCF shall periodically audit the use of such agreements, and compile data regarding the efficacy of such agreements for promoting the safety, well-being and permanency for children.

OCA Previous Recommendations

Strengthen standards for utilization of DCF-facilitated family arrangements/kinship diversion agreements.

Amend Ch. 17a-114 to require written standards and evaluation protocols for the use of “family arrangements” facilitated by DCF, when such agreements are used for children who are deemed at moderate or high risk of child abuse or neglect as determined by DCF’s utilization of evidence-based risk and safety assessment tools, or who are substantiated victims of abuse or neglect.

See addendum to this presentation.

Rationale. See Annie E. Casey Foundation report, *The Kinship Diversion Debate: Policy and Practice Implications for Children, Families and Child Welfare Agencies (2013)*

"Without an intentional approach to diversion policies and practices and appropriate data to measure their impact, child welfare agencies cannot adequately determine whether they are meeting their fundamental goals of safety, permanence and well-being for many children who come to their attention."

OCA Previous Recommendations: Report re Risk and Safety Assessments

(Statute: NEW) Risk and Safety Assessment Practice. Reporting Requirement. The Department of Children and Families shall annually track and publicly report regarding the efficacy of its evidence-based risk and safety assessment practices with clear demonstration of the methodology for determining the reliability of its assessment practice, fidelity to evidence-based practice and tools, and the effectiveness of the assessment process for identifying children at risk of child abuse or neglect.

OCA Previous Recommendations: Report regarding safety of infants and toddlers.

Statute: (NEW) Specific to Infants and Toddlers

DCF shall report annually regarding 1) the number of accepted reports of abuse and neglect regarding children age birth to three, 2) the number of such cases that included previous DCF involvement within the previous twelve, twenty-four and thirty-six months, 3) the number of critical incidents as defined by agency policy in the previous twelve months that involved abuse or neglect of a child under thirty-six months of age, and the percentage of those children that had current or previous DCF involvement within the last 36 months or who were assigned to a Family Assessment Response, 4) information regarding any identified trends that DCF has identified with regard to risk and protective factors for children birth to three who have experienced critical injuries or incidents of abuse/neglect that DCF has classified as “critical.”

OCA Previous Recommendations. ACR/Quality Assurance Unit

DCF should assess the workload of the quality assurance unit and the efficacy and *reliability* of its current framework for evaluating the safety and well-being of children in care.

Over 14,000 ACRs in a given year. Approximately 50 staff in the ACR unit statewide. Current expectation is that each worker reviews the entire case record for the Period Under Review, facilitates a stakeholder meeting, and makes critical findings. DCF aggregates findings into reports regarding child well-being.

Determine whether ACR unit can assist with evaluating *efficacy* and *reliability* of risk/safety assessments.

OCA Recommendations Emanate from Findings Arising from Critical Case Reviews.

OCA regularly reviews critical incidents of children, where injuries are suspicious for abuse and neglect. These are the issues that emerge.

OCA's recommendations emanate from *serious concerns regarding the consistency and reliability of risk and safety assessments and the corresponding responses for children* who are substantiated victims of abuse/neglect or who are at elevated risk of abuse and neglect. OCA is concerned that guidelines corresponding to DCF's risk and safety assessments are not consistently followed.

OCA's concerns are heightened for children under the age of 3, and particularly children under the age of 12 months.

OCA supports a goal of maintaining children in their homes whenever possible and in their best interests, but this must be done in a way that does not compromise safety or well-being.

OCA Preliminary Concerns Arising from Critical Case Reviews

The shift away from utilizing foster care as a primary safety intervention (consistent with the national trend) *requires strong, reliable and effective practices with regard to risk assessment and safety planning.* Meaning, everything that happens from the time a call comes into the Careline until a plan is made to protect and support a child deemed to be at risk of ongoing abuse/neglect.

Cases cannot be closed without seeing children who are deemed at elevated risk of abuse or neglect. (East Haven case.) This must be an immediate change. See addendum.

High risk infants must be seen multiple times per week, and oversight must include announced *and unannounced* monitoring and visitation. OCA tool.

Special attention must be paid to cases that involve children with disabilities, who are uniquely vulnerable to abuse and neglect and may be less able to advocate for themselves or tell people what is happening to them.

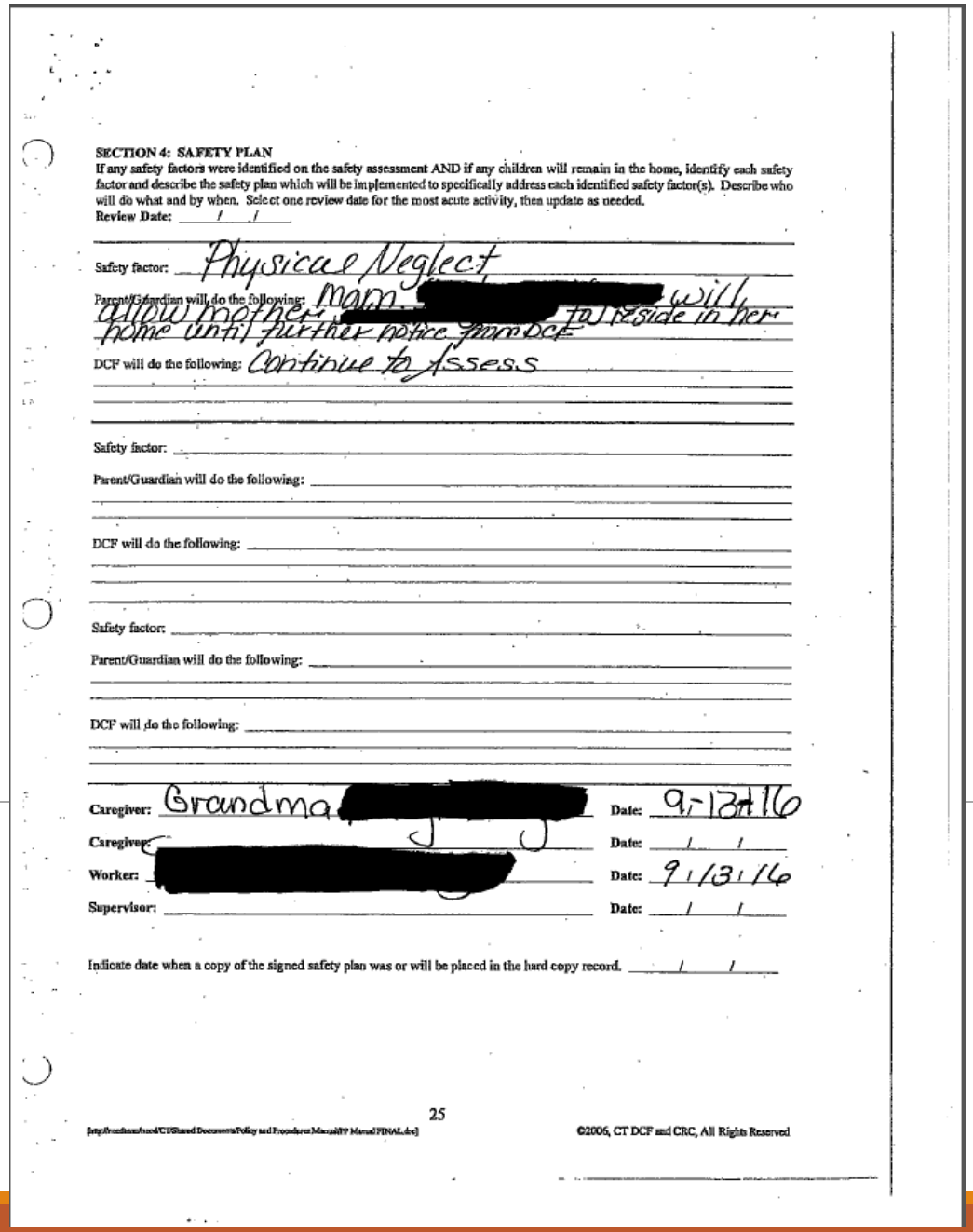
Example of issue with Risk/Safety Tools

How to respond to lack of cooperation from parent, lack of access to children.

Risk tool as utilized, may default to lower risk if the parent *does not cooperate*.

Safety tool indicates that failure to provide access to children is a documentable “safety *concern*.”

Safety Plan



SECTION 4: SAFETY PLAN

If any safety factors were identified on the safety assessment AND if any children will remain in the home, identify each safety factor and describe the safety plan which will be implemented to specifically address each identified safety factor(s). Describe who will do what and by when. Select one review date for the most acute activity, then update as needed.

Review Date: __/__/__

Safety factor: Physical Neglect

Parent/Guardian will do the following: Mom [redacted] will allow mother to reside in her home until further notice from DCF

DCF will do the following: Continue to Assess

Safety factor: _____

Parent/Guardian will do the following: _____

DCF will do the following: _____

Safety factor: _____

Parent/Guardian will do the following: _____

DCF will do the following: _____

Caregiver: Grandma [redacted] **Date:** 9-13-16

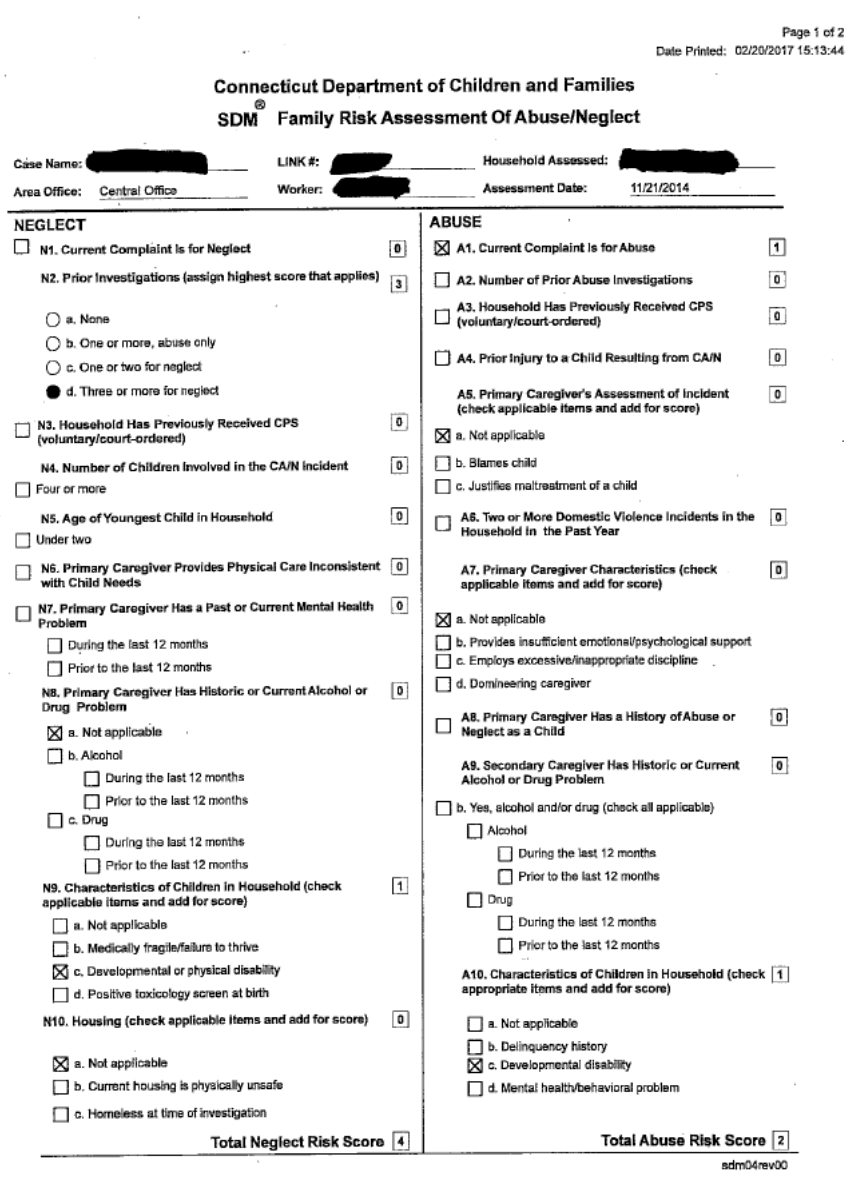
Caregiver: _____ **Date:** __/__/__

Worker: [redacted] **Date:** 9/13/16

Supervisor: _____ **Date:** __/__/__

Indicate date when a copy of the signed safety plan was or will be placed in the hard copy record. __/__/__

SDM Risk Assessment Protocol



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Connecticut Department of Children and Families

SDM® Family Risk Assessment Of Abuse/Neglect

Case Name: [redacted] LINK #: [redacted] Household Assessed: [redacted]

Area Office: Central Office Worker: [redacted] Assessment Date: 11/21/2014

NEGLECT

- ☐ N1. Current Complaint is for Neglect — 0
- N2. Prior Investigations (assign highest score that applies) — 3
  - ○ a. None
  - ○ b. One or more, abuse only
  - ○ c. One or two for neglect
  - ● d. Three or more for neglect
- ☐ N3. Household Has Previously Received CPS (voluntary/court-ordered) — 0
- N4. Number of Children Involved in the CA/N Incident — 0
  - ☐ Four or more
- N5. Age of Youngest Child in Household — 0
  - ☐ Under two
- ☐ N6. Primary Caregiver Provides Physical Care Inconsistent with Child Needs — 0
- ☐ N7. Primary Caregiver Has a Past or Current Mental Health Problem — 0
  - ☐ During the last 12 months
  - ☐ Prior to the last 12 months
- N8. Primary Caregiver Has Historic or Current Alcohol or Drug Problem — 0
  - ☒ a. Not applicable
  - ☐ b. Alcohol
    - ☐ During the last 12 months
    - ☐ Prior to the last 12 months
  - ☐ c. Drug
    - ☐ During the last 12 months
    - ☐ Prior to the last 12 months
- N9. Characteristics of Children in Household (check applicable items and add for score) — 1
  - ☐ a. Not applicable
  - ☐ b. Medically fragile/failure to thrive
  - ☒ c. Developmental or physical disability
  - ☐ d. Positive toxicology screen at birth
- N10. Housing (check applicable items and add for score) — 0
  - ☒ a. Not applicable
  - ☐ b. Current housing is physically unsafe
  - ☐ c. Homeless at time of investigation

Total Neglect Risk Score 4

ABUSE

- ☒ A1. Current Complaint is for Abuse — 1
- ☐ A2. Number of Prior Abuse Investigations — 0
- ☐ A3. Household Has Previously Received CPS (voluntary/court-ordered) — 0
- ☐ A4. Prior Injury to a Child Resulting from CA/N — 0
- A5. Primary Caregiver's Assessment of Incident (check applicable items and add for score) — 0
  - ☒ a. Not applicable
  - ☐ b. Blames child
  - ☐ c. Justifies maltreatment of a child
- ☐ A6. Two or More Domestic Violence Incidents in the Household in the Past Year — 0
- A7. Primary Caregiver Characteristics (check applicable items and add for score) — 0
  - ☒ a. Not applicable
  - ☐ b. Provides insufficient emotional/psychological support
  - ☐ c. Employs excessive/inappropriate discipline
  - ☐ d. Domineering caregiver
- ☐ A8. Primary Caregiver Has a History of Abuse or Neglect as a Child — 0
- A9. Secondary Caregiver Has Historic or Current Alcohol or Drug Problem — 0
  - ☐ b. Yes, alcohol and/or drug (check all applicable)
    - ☐ Alcohol
      - ☐ During the last 12 months
      - ☐ Prior to the last 12 months
    - ☐ Drug
      - ☐ During the last 12 months
      - ☐ Prior to the last 12 months
- A10. Characteristics of Children in Household (check appropriate items and add for score) — 1
  - ☐ a. Not applicable
  - ☐ b. Delinquency history
  - ☒ c. Developmental disability
  - ☐ d. Mental health/behavioral problem

Total Abuse Risk Score 2

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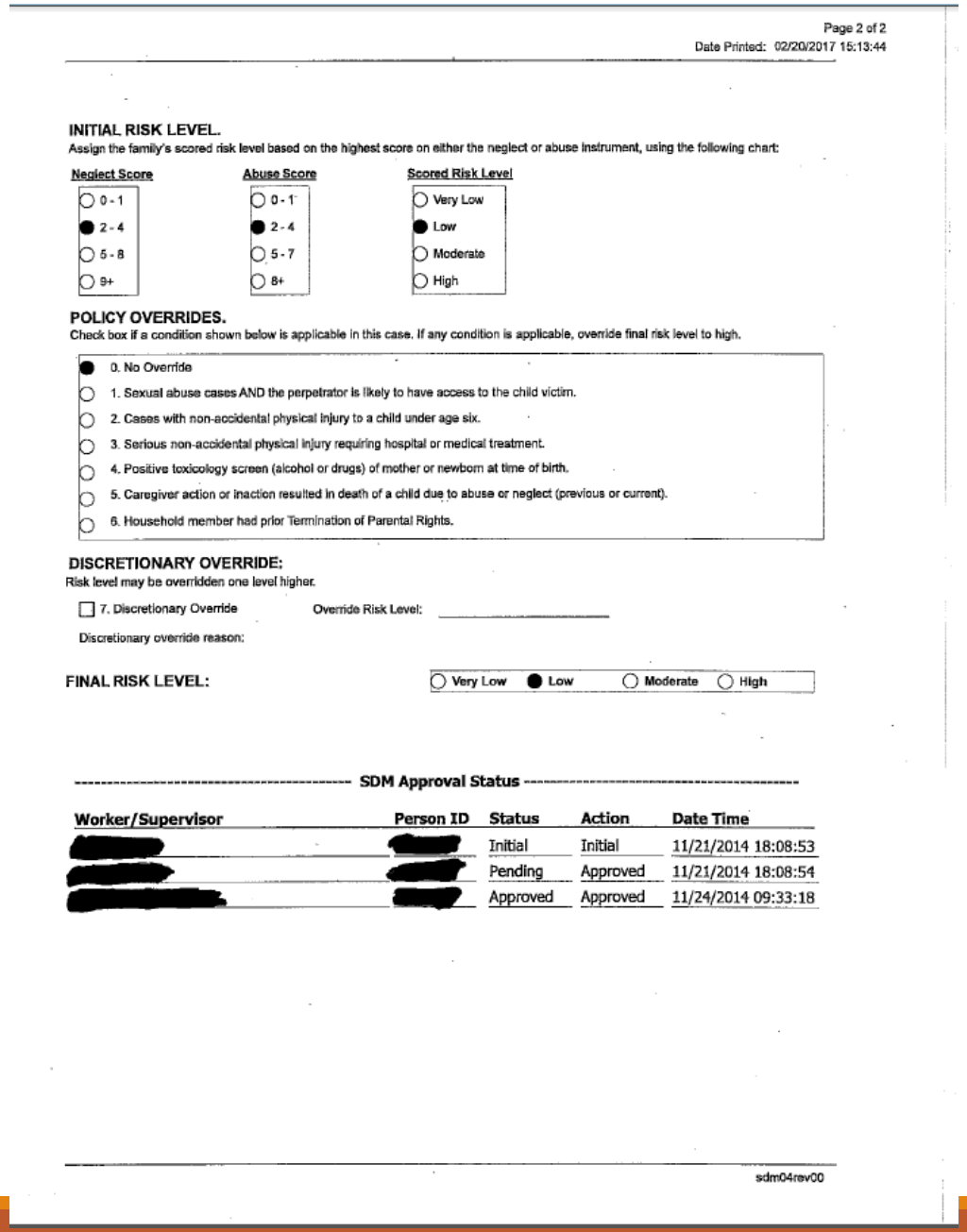
SDM Risk Assessment Protocol (continued)



INITIAL RISK LEVEL.
Assign the family's scored risk level based on the highest score on either the neglect or abuse instrument, using the following chart:

Neglect Score	Abuse Score	Scored Risk Level
○ 0 - 1	○ 0 - 1	○ Very Low
● 2 - 4	● 2 - 4	● Low
○ 5 - 8	○ 5 - 7	○ Moderate
○ 9+	○ 8+	○ High

POLICY OVERRIDES.
Check box if a condition shown below is applicable in this case. If any condition is applicable, override final risk level to high.

- ● 0. No Override
- ○ 1. Sexual abuse cases AND the perpetrator is likely to have access to the child victim.
- ○ 2. Cases with non-accidental physical injury to a child under age six.
- ○ 3. Serious non-accidental physical injury requiring hospital or medical treatment.
- ○ 4. Positive toxicology screen (alcohol or drugs) of mother or newborn at time of birth.
- ○ 5. Caregiver action or inaction resulted in death of a child due to abuse or neglect (previous or current).
- ○ 6. Household member had prior Termination of Parental Rights.

DISCRETIONARY OVERRIDE:
Risk level may be overridden one level higher.

☐ 7. Discretionary Override Override Risk Level: _____

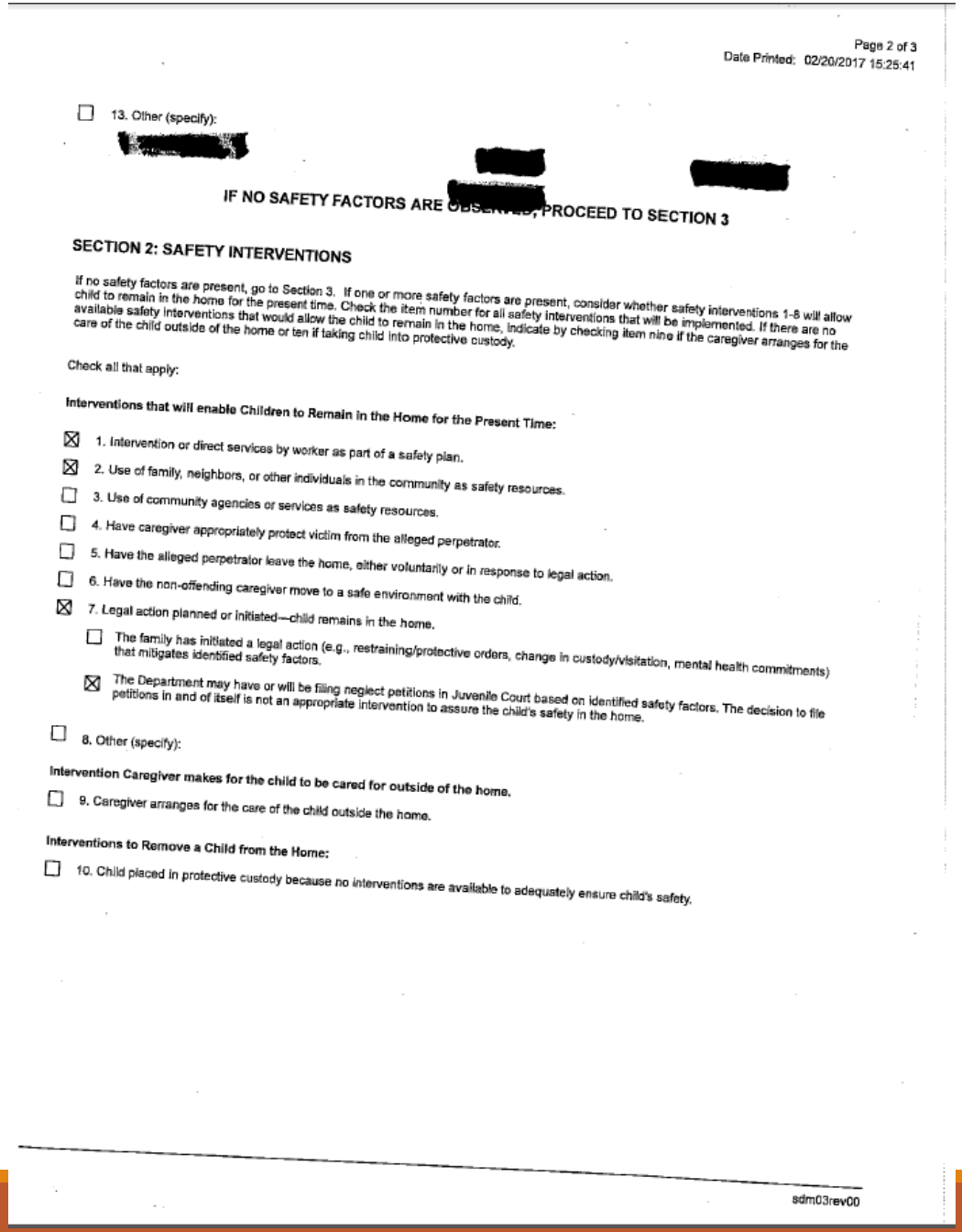
Discretionary override reason:

FINAL RISK LEVEL: ○ Very Low ● Low ○ Moderate ○ High

SDM Approval Status

Worker/Supervisor	Person ID	Status	Action	Date Time
[redacted]	[redacted]	Initial	Initial	11/21/2014 18:08:53
[redacted]	[redacted]	Pending	Approved	11/21/2014 18:08:54
[redacted]	[redacted]	Approved	Approved	11/24/2014 09:33:18

SDM Risk Assessment Protocol – Safety Interventions



☐ 13. Other (specify):

[redacted]

IF NO SAFETY FACTORS ARE [redacted], PROCEED TO SECTION 3

SECTION 2: SAFETY INTERVENTIONS

If no safety factors are present, go to Section 3. If one or more safety factors are present, consider whether safety interventions 1-8 will allow child to remain in the home for the present time. Check the item number for all safety interventions that will be implemented. If there are no available safety interventions that would allow the child to remain in the home, indicate by checking item nine if the caregiver arranges for the care of the child outside of the home or ten if taking child into protective custody.

Check all that apply:

Interventions that will enable Children to Remain in the Home for the Present Time:

☒ 1. Intervention or direct services by worker as part of a safety plan.

☒ 2. Use of family, neighbors, or other individuals in the community as safety resources.

☐ 3. Use of community agencies or services as safety resources.

☐ 4. Have caregiver appropriately protect victim from the alleged perpetrator.

☐ 5. Have the alleged perpetrator leave the home, either voluntarily or in response to legal action.

☐ 6. Have the non-offending caregiver move to a safe environment with the child.

☒ 7. Legal action planned or initiated—child remains in the home.

- ☐ The family has initiated a legal action (e.g., restraining/protective orders, change in custody/visitation, mental health commitments) that mitigates identified safety factors.
- ☒ The Department may have or will be filing neglect petitions in Juvenile Court based on identified safety factors. The decision to file petitions in and of itself is not an appropriate intervention to assure the child's safety in the home.

☐ 8. Other (specify):

Intervention Caregiver makes for the child to be cared for outside of the home.

☐ 9. Caregiver arranges for the care of the child outside the home.

Interventions to Remove a Child from the Home:

☐ 10. Child placed in protective custody because no interventions are available to adequately ensure child's safety.