RHODE ISLAND CHILD DEATH REPORT

For the Two-Year Period 1998 and 1999

Prepared by

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Rhode Island KIDS COUNT**

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MISSION

The Rhode Island Child Death and Injury Review Team is a multi-agency, multidisciplinary group of professionals who conduct systematic reviews of childhood deaths in Rhode Island. The team also reviews critical incidents leading to severe injury in children. The data are examined to identify risk factors, trends, and preventable child fatalities, with the ultimate goal of preventing child deaths and improving the lives of Rhode Island's children.

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EXECUTIVE SUMMARY

In October 1998, the Rhode Island Child Death and Injury Review Team was created by the Rhode Island Department of Children, Youth and Families. The team is a multidisciplinary group convened to examine child fatalities in Rhode Island. The team reviews all childhood deaths, birth through 18 years of age. A comprehensive data collection system has been created for the collection of data, for the identification of trends, and for the identification of preventable childhood deaths in Rhode Island.

This report is based on an examination of records of all child fatalities that occurred in Rhode Island between January 1, 1998 and December 31, 1999, a total of 350 child deaths. The Rhode Island Child Death and Injury Review Team follows standard protocols in reviewing death certificates and other records, as appropriate. The age, gender, and race/ethnicity of the children are examined, as is the manner of death, as determined by the Medical Examiner. All deaths of individuals up to 18 years of age in the State of Rhode Island are reported to the Rhode Island Medical Examiner's Office (Rhode Island General Law 23-4-7 [2e]). Thus, data were collected from one central source, allowing for review of all childhood deaths occurring during the two-year period covered in this report.

The mission of the Rhode Island Child Death and Injury Review Team includes preventing child fatalities and injuries. The team assesses the circumstances surrounding each child's death and makes a determination of whether or not the death was preventable. In addition, for each manner of death, more in-depth analysis considers the causality and/or circumstances of death and other characteristics of victims or responsible parties. Particular causes of death are singled out for more thorough consideration. Recommendations for prevention are included in the final section of this report.

Key Facts About Child Death in Rhode Island, 1998 and 1999

- There were 171 child deaths recorded in Rhode Island in 1998 and 179 in 1999. Of these 350 children, 174 (49.7%) were less than one month old at the time of death. Of these newborns, 168 lived less than one day.
- There were substantially more deaths involving males than females. Male children accounted for 62% of the deaths of children over one month of age.
- Minority children are at greater risk of childhood fatalities than their Caucasian counterparts. While minority children account for 27.3% of all children in Rhode Island, they account for 36.6% of all child deaths. African-American children have the highest fatality rates of any group.

Data on child deaths are examined to identify risk factors, trends, and preventable child fatalities, with the ultimate goal of preventing child deaths and improving the lives of Rhode Island's children.

- In children greater than one month of age, accidents account for more than one-fourth of child deaths, and homicides account for over 8% of child deaths. Accidents, homicides, and suicides combined account for more deaths of children 10 years and older than do natural causes.

- 75 (21.4%) of the 350 child fatalities within this two-year period could have been prevented. Of 154 children over one month of age, 46.8% (72) of Rhode Island's child fatalities in 1998 and 1999 were possibly preventable. The greatest number of preventable deaths occurred in the adolescent age group.

- Alcohol and/or drug use were known to have contributed to 29.3% (22 of 75 cases, including neonates) of the *preventable* childhood deaths that occurred in Rhode Island in 1998 and 1999. In 16 other cases, drugs and alcohol might have contributed to the death of a child.

- Of the 43 children who died of birth defects and genetic diseases, 17 children died of heart disease, 16 from malignancies, and 10 from infections.

- In 7 of 8 cases of Sudden Infant Death Syndrome (SIDS), the infants were found on their stomachs, face down. Sleeping prone (on the stomach) is known to increase an infant's risk of dying from SIDS.

- 26 children died in motor vehicle related incidents. Drugs and/or alcohol were known to be involved in 8 of the 22 roadway accidents killing children. Speeding was implicated in 14 and reckless driving in 13 of the roadway accidents. In cases in which the gender of the drivers involved in these motor vehicle related fatalities was known, 85% were male.

- 14 children drowned. All of the children who drowned and who were under age 12 were inappropriately supervised during the incident that caused their death. Only 4 of the 14 children were known to be competent swimmers. The others had never received swimming lessons.

- Fifteen young people under 19 years of age were victims of homicides. The perpetrators were all at least 2 years older than their victims. The average age difference between victims and alleged offenders was 18 years. All of the identified suspects were acquainted with or related to their victims. In six of the cases the alleged perpetrator was a family member. The mean age of the homicide victims was 10 years. The median age was 12.

- Child abuse or neglect was identified as a cause of death in 21 of the 350 child fatalities.

National Context

Child fatality review teams are recent outgrowths of efforts made by hospitals, medical examiners, police departments, social workers, lawyers, and child advocacy groups to better provide for the well-being of America's children. Fatality review was introduced in California in 1978, and over the past 20 years has become widespread in the United States. Review teams assess the circumstances leading to instances of child fatality and make recommendations for community action and policy reform based on their findings.

The goals of this systematic case review are:

- To provide a greater understanding of child safety hazards.
- To advance child abuse prevention.
- To foster improvements in the child welfare system.
- To educate the public about causes of child deaths in Rhode Island.
- To encourage better communication and coordination among community agencies.
- To inform public policy through data-driven recommendations for legislation and government action.
- To prevent future child deaths.

The federal government encourages the formation of review teams through the Child Abuse and Prevention Treatment Act (CAPTA) which mandates that states conduct child death reviews to receive certain federal funds. The Children's Justice Act (CJA) has financially supported the Rhode Island Child Death and Injury Review Team over the past two years.

RHODE ISLAND CHILD DEATH AND INJURY REVIEW TEAM MEMBERS

Elizabeth Laposata, MD	Chief Medical Examiner, State of Rhode Island; Co-Director, Rhode Island Child Death and Injury Review Team
Carole Jenny, MD, MBA	Professor of Pediatrics, Brown Medical School; Director, Child Protection Program, Hasbro Children's Hospital; Co-Director, Rhode Island Child Death and Injury Review Team
Kevin Aucoin, JD	Chief Legal Counsel, Rhode Island Department of Children, Youth and Families Office of Legal Counsel
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Angela Bucci, JD	Chief Legal Counsel, Family Court of Rhode Island
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Jane Ferguson, LICSW	Social Worker, Child Protection Program, Hasbro Children's Hospital
Lt. Emil R. Fioravanti	Director, Bureau of Criminal Identification, Providence Police Department
Special Agent Paul Graf	U.S. Naval Criminal Investigative Service, Cold Case Homicide Squad
Veronika Kot, JD	Policy Analyst, Rhode Island KIDS COUNT
Lt. William Labossiere	Director, Criminal Identification Division, Rhode Island State Police
Edward O'Donnell	Chief Investigator, Rhode Island Department of Children, Youth and Families
Sharon O'Keefe, JD	Assistant Child Advocate, State of Rhode Island
Linda Snelling, MD	Assistant Professor of Pediatrics, Brown University School of Medicine; Chief of Pediatric Critical Care, Hasbro Children's Hospital
Cindy Soccio, JD	Chief of the Juvenile Unit, Rhode Island Office of the Attorney General
James W. Thorp, MD	Clinical Professor of Pediatrics, Brown University School of Medicine; Chief of Neonatology, Brockton Hospital, Brockton, Massachusetts

DEMOGRAPHIC CHARACTERISTICS OF CHILD FATALITIES

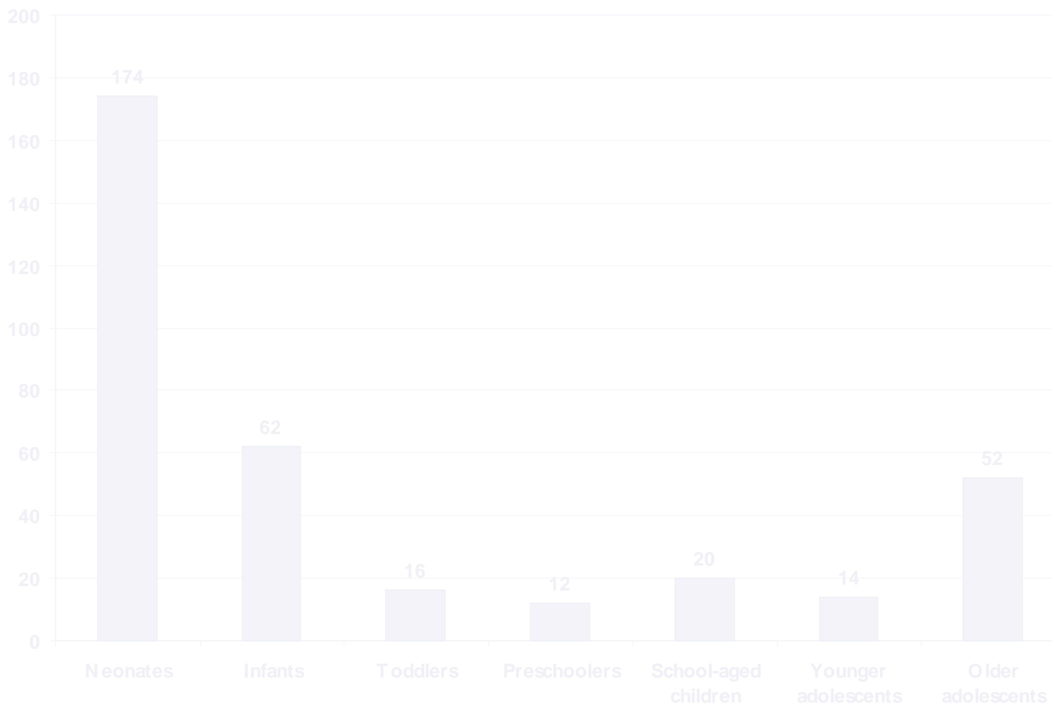
There were 350 child fatalities in Rhode Island in 1998 and 1999. Of these deaths, 171 were recorded in 1998 and 179 in 1999.

Children were divided into the following age groups for analysis:

Neonates	Less than one month of age
Infants	One month to 0.99 years of age
Toddlers	One to 2.99 years of age
Preschoolers	Three to 5.99 years of age
School-aged children	Six to 9.99 years of age
Young adolescents	Ten to 13.99 years of age
Older adolescents	Fourteen to 18.99 years of age

In many analyses, neonatal deaths (less than one month of age) are excluded. Neonatal deaths are due to miscarriages, stillbirths, non-survivable genetic conditions, severe prematurity, and complicated deliveries. Fetal deaths reported to the Medical Examiner are included in neonatal deaths.

NUMBER OF CHILD FATALITIES BY AGE GROUP RHODE ISLAND, 1998 AND 1999



There were 350 child fatalities in 1998 and 1999. Almost half (174) were less than one month old at the time of death; of these, 168 lived less than one day.

NUMBER OF CHILD FATALITIES BY GENDER RHODE ISLAND, 1998 AND 1999

There were substantially more deaths involving males (203 cases) than females (133 cases). There were 14 cases where the gender was unknown because the gender was not specified for some fetuses.

When excluding the neonates, this discrepancy persists; male children account for 62% of the deaths of children older than one month.

NUMBER OF CHILD FATALITIES BY RACE/ETHNICITY RHODE ISLAND, 1998 AND 1999

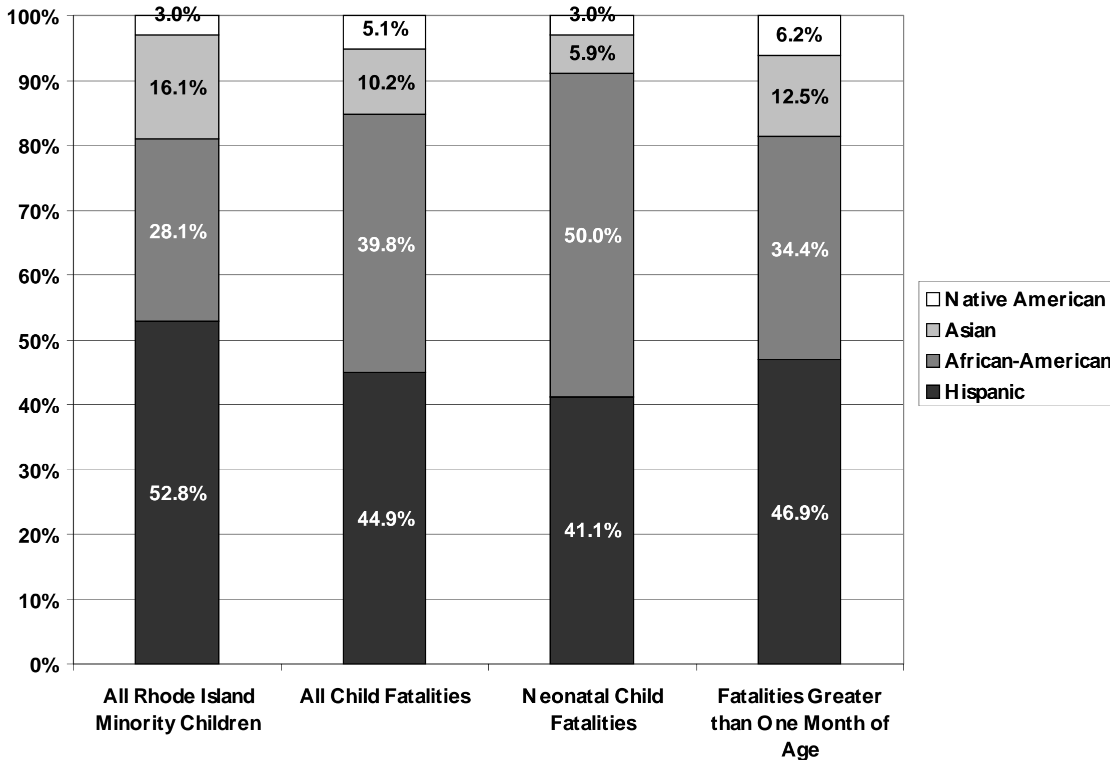
Ethnicity	Number of Child Deaths	Percentage of Child Deaths
Caucasian	180	63.4%
Hispanic	44	15.5%
African-American	39	13.7%
Asian	10	3.5%
Other	6	2.1%
Native American	5	1.8%
Total	**284**	**100.0%**

Note: Percentage of child deaths does not include fetal deaths in which race/ethnicity was unknown.

Of the children who died in 1998 and 1999, 63.4% were Caucasian, 15.5% were Hispanic, 13.7% were African-American, 3.5% were Asian, and 1.8% were Native Americans.

While 27.3% of Rhode Island's children are from a minority racial or ethnic group, 36.6% of child fatalities were among minority children.

PROPORTION OF CHILD FATALITIES AMONG MINORITY RACIAL/ETHNIC GROUPS, RHODE ISLAND, 1998 AND 1999



African-American children accounted for a disproportionate share of child deaths in all age groups. While African-American children constitute 28.1% of minority children, they account for 39.8% of minority child fatalities. Neonatal child fatalities were especially high among African-American children.

Native American children also had disproportionately high rates of mortality, accounting for 6.2% of fatalities of minority children over one month of age while constituting only 3% of minority children in Rhode Island.

MANNER OF CHILD FATALITIES

The Chief Medical Examiner of the State of Rhode Island determines the manner of all child fatalities in Rhode Island. Manners of death are categorized as natural causes, accidents, homicides, suicides, and undetermined.

MANNER OF ALL CHILD DEATHS
RHODE ISLAND, 1998 AND 1999

Manner	Number	Percent
Natural causes	279	79.7%
Accidents	46	13.2%
Homicides	15	4.3%
Suicides	4	1.1%
Undetermined	6	1.7%
Total	**350**	**100.0%**

MANNER OF ALL CHILD DEATHS, EXCLUDING NEONATES
RHODE ISLAND, 1998 AND 1999

Manner	Number	Percent
Natural causes	106	60.2%
Accidents	45	25.6%
Homicides	15	8.5%
Suicides	4	2.3%
Undetermined	6	3.4%
Total	**176**	**100.0%**

The majority of child fatalities are from natural causes. When neonates are excluded, accidents account for one-quarter of child deaths and homicides account for 8.5% of child deaths.

MANNER OF DEATH BY AGE GROUP
RHODE ISLAND, 1998 AND 1999

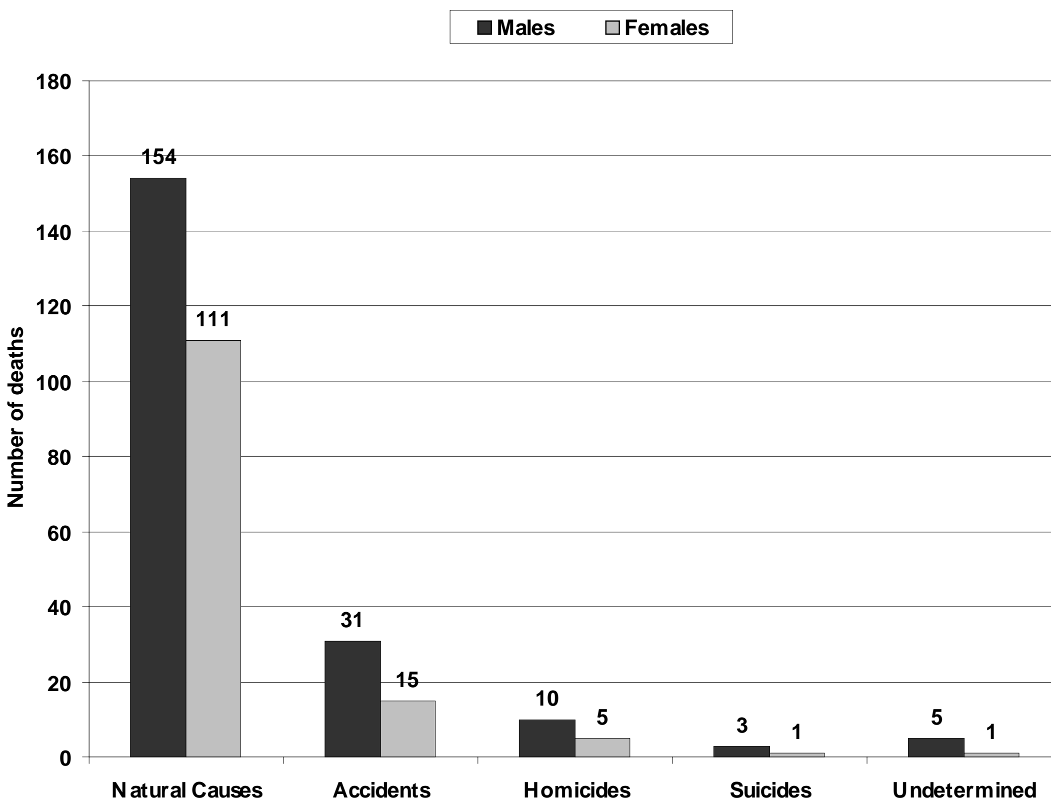
Age Group	Natural Causes	Accidents	Homicides	Suicides
Neonates	173	1	0	0
Infants	55	3	2	0
Toddlers	14	2	0	0
Preschoolers	8	2	2	0
School-aged	12	5	3	0
Young adolescents	3	9	1	0
Older adolescents	14	24	7	4
Total	**279**	**46**	**15**	**4**

Note: Excludes the 6 cases with manner of death undetermined.

Younger children are more likely than older children to die from natural causes.

Accidents, homicides, and suicides combined account for 68.2% of deaths of children 10 years and older, while natural causes account for only 25.8% of deaths in this age group.

MANNER OF DEATH BY SEX OF CHILD
RHODE ISLAND, 1998 AND 1999



When comparing manner of death of male children to manner of death of female children, males account for more deaths in every category.

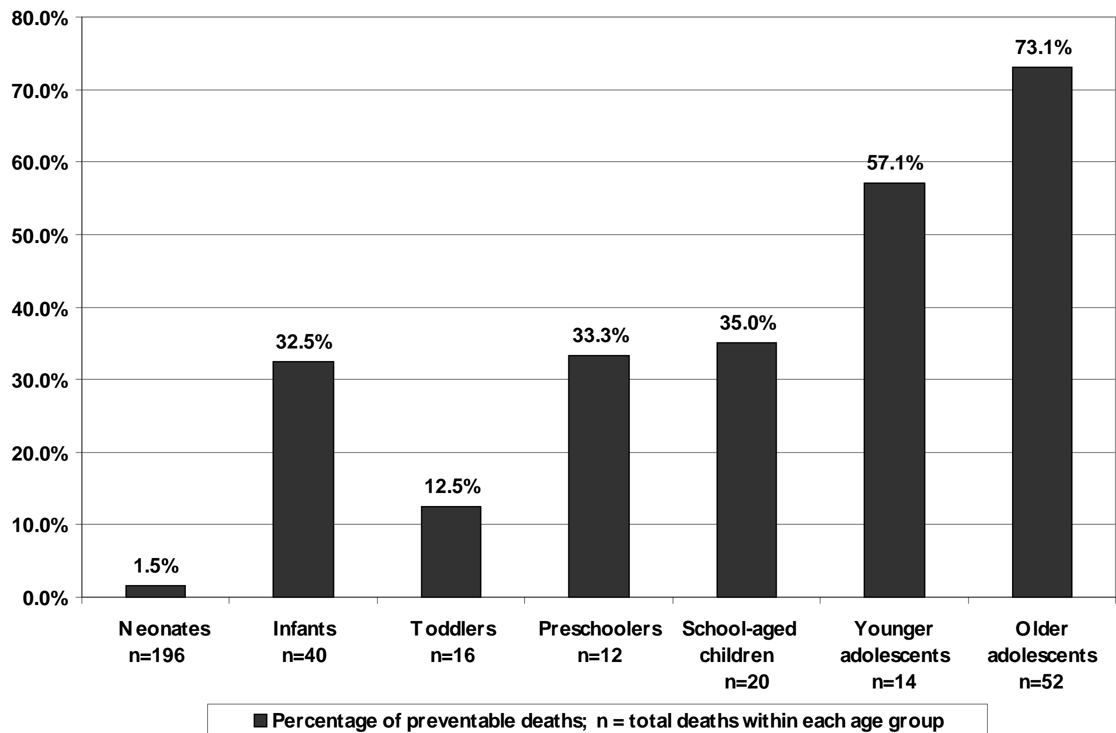
PREVENTABLE DEATHS

The Child Death and Injury Review Team made an assessment of preventability while reviewing each child death. Seventy-five (21.4%) of the 350 child fatalities within this two-year period were determined to be preventable.

The following definition was used for each case reviewed:

A child's death is considered to be preventable if reasonable precautions, supervision or actions by the community or by an individual could have changed the circumstances that led to the death. The designation of preventable does not imply that the death was caused by child abuse or neglect, or could absolutely have been prevented, but that reasonable intervention(s) might have prevented the death. *Reasonable* is defined by taking into consideration the circumstances and resources available.

PERCENTAGE OF ALL DEATHS THAT ARE PREVENTABLE DEATHS BY AGE GROUP, RHODE ISLAND, 1998 AND 1999



- 72 (46.8%) of the 154 Rhode Island child fatalities over one month of age in 1998 and 1999 were preventable.

- The greatest number of preventable deaths occurred in the adolescent age group. Three-quarters (73.1%) of the deaths of older adolescents were preventable.

- Alcohol and/or drug use were known to have contributed to 29.3% (22 of 75 cases, including neonates) of the preventable childhood deaths that occurred in Rhode Island in 1998 and 1999. In 16 other cases, drugs and alcohol may have contributed, but could not be confirmed with the data available at this time. This is a conservative estimate, because data on drug or alcohol use was not available in many of the deaths.

- Most preventable deaths were categorized as accidents and homicides, although 10 were categorized as natural causes. Of these 10, two preventable deaths reflected lack of timely seeking of medical care for obviously ill children. Seven were associated with infants who died of sudden infant death syndrome while lying on their stomachs, face down. One was a newborn who is known to have died because of complications due to the mother's drug use.

NATURAL CAUSES

There were 279 child deaths due to natural causes in 1998 and 1999. Of these, 172 deaths were related to perinatal conditions. Of the perinatal deaths, 116 deaths were due to premature birth (less than 35 weeks gestation) and 35 were due to death *in utero*.

Of the 17 deaths caused by heart disease, 13 deaths were due to congenital heart disease and 4 deaths were due to acquired heart disease.

Three of the 10 deaths from infectious diseases were caused by meningococcal meningitis or sepsis. Five deaths occurred in severely handicapped children who had sustained brain damage from infections that occurred months to years before they died.

NATURAL CAUSES OF CHILD DEATHS RHODE ISLAND, 1998 AND 1999

Cause of Death	Number of Cases
Perinatal deaths (see specific causes below)	172
Genetic diseases	22
Congenital anomalies	21
Heart disease	17
Malignant diseases	16
Infectious diseases	10
Sudden infant death syndrome	8
Seizure disorder	3
Metabolic disease (diabetes mellitus)	1
Immunologic disease	1
Gastrointestinal disease	1
Asthma	1
Other unknown natural causes	6
Total	**279**

SPECIFIC CAUSES OF PERINATAL DEATHS RHODE ISLAND, 1998 AND 1999

Cause of Death	Number of Cases
Prematurity	116
Complications of delivery	6
Intrauterine fetal demise	35
Died at delivery, mechanism unknown	15
Total	**172**

SUDDEN INFANT DEATH SYNDROME AND OTHER UNEXPECTED INFANT DEATHS

Sudden Infant Death Syndrome (SIDS) is defined as the sudden death of an infant under one year of age, which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene, and review of the clinical history (National Institute of Child Health and Human Development, 1991).

Ten cases were investigated as possible SIDS deaths during this two-year period. Eight were actually identified as SIDS. SIDS was ruled out in one case where death was determined to be due to accidental suffocation caused by overlying. In this case, a caretaker was sleeping with the child and was found on top of the child. The manner of death in another case of unexpected infant death was ruled undetermined.

In 7 of the 8 SIDS cases, the infants were found on their stomachs, face down. Sleeping prone (on the stomach) is known to increase an infant's risk of dying from SIDS. The position of one infant could not be determined by review of the records.

In the 14 motor vehicle events where the victim was the occupant of a car or sport-utility vehicle, the victim was the driver in 6 deaths, the front seat passenger in 4 deaths, and the rear seat passenger in 4 deaths.

Only 3 of the 14 children who died inside vehicles were appropriately restrained by a seat belt.

The bicyclist and the motorcyclist who were killed were not wearing helmets.

Drugs and/or alcohol were shown to be involved in the incident in 8 of the 22 roadway accidents. Speeding was implicated in 14 and reckless driving in 13 of the roadway accidents. In 7 events, neither speeding nor reckless driving were implicated.

MOTOR VEHICLE RELATED FATALITIES

Motorized vehicles were involved in 26 child fatalities during this two-year period. Eighteen of these deaths occurred in 1998 and eight in 1999. Twenty-two deaths involved cars, trucks or sport-utility vehicles, three involved trains, and one involved a motorcycle. No infants or toddlers died in motor vehicle related accidents.

MOTOR VEHICLE EVENTS LEADING TO CHILD FATALITIES RHODE ISLAND, 1998 and 1999

Event	Number of deaths
Victim was occupant of car or sport-utility vehicle	14
Victim hit by car/truck (6 pedestrians, 1 bicyclist)	7
Victim hit by train	3
Victim fell off trunk of moving car	1
Victim was driver of motorcycle	1
Total	**26**

AGE OF DRIVERS IN ROADWAY TRAFFIC DEATHS IN CHILDREN, RHODE ISLAND, 1998 AND 1999

	1998	1999
Number of deaths	18	8
Mean age of drivers involved	23.8 years	35.2 years
Age range of drivers involved	15-57 years	16-40 years
Median age of drivers involved	17 years	39 years

In cases in which the gender of the drivers involved in these motor vehicle related fatalities was known, 85% were male.

Rhode Island passed a graduated driving age law that took effect at the beginning of 1999 which sets differential licensing requirements based on age. In 1999, fewer people under nineteen years of age were killed in traffic accidents, and the age of drivers in those accidents was substantially older. With small numbers, it cannot be determined if this is causally related to the change in the law. Continued monitoring of trends in roadway deaths will be necessary to determine if the law is effectively decreasing child fatalities.

DROWNINGS

Fourteen Rhode Island children lost their lives to drowning during the two-year period reviewed in this report.

BODIES OF WATER IN WHICH FATAL DROWNINGS OCCURRED RHODE ISLAND, 1998 AND 1999

Location	Number of Fatalities
Ocean	3
Swimming pool	3
Reservoir	3
Pond	2
Bathtub	2
Lake	1
Total	**14**

Out of the 14 children who drowned, only 4 children were known to be competent swimmers. The others had never received swimming lessons.

All 6 of the children under age 12 who drowned were inappropriately supervised during the incident that caused their death.

The 3 private swimming pools where fatalities occurred did not meet building codes, and did not have safety amenities such as locked fences. Building codes for pool safety are different in each town.

Four fatalities may have been related to increased rainfall causing turbulence in reservoirs and waterways.

Twelve people have been charged or convicted in 10 of the deaths.

One person who is suspected of killing three children died shortly after the crime. Two deaths remain unsolved.

In the 13 cases that have been charged or solved, the perpetrators were all at least 2 years older and as much as 47 years older than their victims. The average age difference between victims and alleged offenders was 18 years.

All of the identified suspects were acquainted with or related to their victims. In 6 of the cases the alleged perpetrator was a family member.

HOMICIDES

Violence is becoming an all too familiar problem for our nation's youth, and unfortunately Rhode Island's children are not exempt from this phenomenon. There were 15 child deaths classified as homicides during the two-year period.

CAUSE OF DEATH IN HOMICIDES WITH AGE OF VICTIM RHODE ISLAND, 1998 AND 1999

Age of Victim	Cause of Death
6 weeks	Blunt force trauma
6 months	Starvation, malnutrition
2 years	Blunt force trauma
2 years	Blunt force trauma
6 years	Blunt force trauma (Hit and run vehicle)
6 years	Gun shot wound
9 years	Gun shot wound
12 years	Gun shot wound
17 years	Multiple stab wounds
17 years	Gun shot wound
18 years	Gun shot wound
18 years	Gun shot wound
18 years	Gun shot wound
18 years	Gun shot wound
18 years	Gun shot wound

SUICIDES

Four Rhode Island children committed suicide during the 1998 and 1999 time period. Of these children, one victim was 16, two were 17, and one was 18 years old. Two of the fatalities were caused by self-inflicted gun shot wounds, one victim was found suspended by the neck, and one stepped in front of a moving train.

There were two additional cases involving hanging, and two other cases involving drug overdoses. The Medical Examiner's office has classified the manner of death as undetermined in these cases.

CHILD MALTREATMENT

Child abuse or neglect was identified by the Child Death and Injury Review Team in 21 of the 350 cases of child deaths. The definition of neglect used for purposes of this report is broad and child-centered, i.e., does not consider the intention of the adult (see Appendix for definition). Using a different definition and different process, the Department of Children, Youth and Families classified six child deaths as resulting from child abuse or neglect during the same time period.

CHILD DEATH CASES INVOLVING POTENTIALLY PREVENTABLE DEATH BY MANNER OF DEATH, RHODE ISLAND, 1998 AND 1999

Type of Abuse or Neglect	Manner of Death	Number of Cases
Physical abuse	Homicide	3
Neglect	Homicide	1
Neglect	Accident	13
Neglect	Natural causes	4
Total		**21**

The largest number of deaths was classified as accidental by the Medical Examiner. However, in most cases the event would have been averted by reasonable supervision of the child.

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The 4 cases classified as natural causes involved the failure of caretakers to seek timely medical care for seriously ill children.

UNDETERMINED DEATHS

In undetermined deaths, the Medical Examiner's Office was unable to determine a manner of death, even after a thorough investigation. For example, in some drug ingestion deaths, it is unknown if the deceased actually meant to commit suicide, or whether the overdose was an accident. Six child deaths were ruled undetermined during the 1998 and 1999 time period.

RECOMMENDATIONS

The opinions expressed in the recommendations section of this report are those of the Rhode Island Child Death and Injury Review Team and do not necessarily reflect the opinion of the Office of the Medical Examiner, the Rhode Island Department of Health, or the Rhode Island Department of Children, Youth and Families.

To prevent child fatalities, the Rhode Island Child Death and Injury Review Team offers the following recommendations:

To prevent child fatalities related to medical conditions or prematurity:

- Facilitate enrollment into RIte Care for those children who are eligible.
- Continue to provide accessible prenatal care to all pregnant women.

To reduce preventable risk factors related to Sudden Infant Death Syndrome (SIDS):

- Continue to improve awareness of the "Back to Sleep" campaign in Rhode Island.
- Review with parents the potential danger of overlying deaths when infants sleep in adult beds.
- Educate parents on the dangers of having pillows, stuffed animals, or other soft objects and materials in infant cribs.
- Review the potential dangers for infants who sleep with caretakers who are impaired due to drug or alcohol consumption.
- Continue support groups and services for parents who have lost infants to SIDS.

To prevent child fatalities related to motor vehicle accidents:

- Continue to improve efforts to educate youth and parents regarding appropriate and consistent use of car seats and seat belts.
- Support programs that provide information on motor vehicle safety.
- Continue to analyze the impact of Rhode Island's graduated licensing law.
- Emphasize driver education and safety, particularly to young male drivers.

To prevent child fatalities related to drownings:

- Building codes for pool installations should be uniform throughout the entire state and should be rigorously enforced.
- Emphasize to the community the importance of never leaving children unsupervised for any length of time around water.
- Educate community on the dangers of swimming alone, at any age, regardless of swimming abilities.
- Improve availability of swimming lessons to the children of Rhode Island.
- Inform the public on the dangers that high rainfall and inclement weather can pose to swimmers and boaters.

To prevent child fatalities due to suicides:

- Improve access to mental health care for children and teenagers.
- Educate parents and school personnel on the signs and symptoms of depression and potential for suicide.
- Provide counseling for siblings of children that have died.
- Organize and offer critical incident debriefing after suspected suicides occur.

To prevent child fatalities related to violence:

- Improve coordination among law enforcement, schools and mental health agencies to identify and provide services to high-risk children and teens.
- Provide crisis intervention and support groups for young people who witness violence against peers or family members.
- Continue promoting gun safety, including locked storage boxes, trigger locks, and gun safety education.
- Support legislation in the state of Rhode Island that would ensure safe storage of firearms.
- Improve communities' knowledge of the availability of firearms and the use of firearms by teenagers. Collect and regularly report data on crimes involving firearms in Rhode Island.

To prevent child fatalities related to child maltreatment:

- Increase community education on the signs and symptoms of child abuse and neglect.
- Educate all caretakers about the dangers of shaking an infant.
- Educate professionals about mandatory reporting of suspected child abuse and neglect.
- Educate physicians and other health care providers about the need to report medical neglect.
- Improve coordination of services for high-risk families among community agencies.

The Rhode Island Child Death and Injury Review Team recognizes that the death of a child leaves a grieving family to cope with a tragic loss. We hope that by working as a community to prevent future deaths of children, we can honor the memory of the precious lives that have been lost.

APPENDIX

DEFINITIONS OF CHILD NEGLECT

First Degree:

Overt, on-going acts of neglect; multiple episodes of failure to provide basic, age-appropriate needs such as shelter, food, sanitation, safety and supervision, medical care, and/or education.

Subclasses:

1. Resulting in documented physical or psychological injury.
2. Not resulting in documented physical or psychological injury.
3. Not resulting in documented physical or psychological injury, but concerning for future psychological effects that could result from acts of neglect.

Types:

1. Physical neglect

   Subtypes:

   i. Nutritional neglect
   ii. Clothing neglect (example, lack of shoes or winter coat)
   iii. Shelter neglect
   iv. Hygiene neglect

2. Emotional neglect
3. Medical neglect
4. Supervisional neglect
5. Educational neglect
6. Dental neglect
7. Exposure to a violent environment, including domestic violence
8. Other neglect

Second degree:

An isolated neglectful episode where a parent or caretaker demonstrates a single act of obviously neglectful behavior or poor judgment, where the child was harmed or was put at risk of harm.

Subclasses:

1. Resulting in documented physical or psychological injury.
2. Not resulting in documented physical or psychological injury
3. Not resulting in documented physical or psychological injury, but concerning for future psychological effects that could result from acts of neglect.

Types: 1. Physical neglect

Subtypes:

- i. Clothing neglect (example, lack of shoes or winter coat)
- ii. Shelter neglect

2. Medical neglect
3. Supervisional neglect
4. Dental neglect
5. Other neglect

Third degree:

A single act of neglectful behavior or multiple acts of neglectful behavior by a parent or caretaker where the child is harmed or put at risk of harm, and where the neglectful act(s) or poor judgment are the result of factors beyond the parent's or caretaker's control, such as mental illness (other than drug addiction or alcoholism), extreme poverty, mental retardation, or debilitating physical illness. Would not include cases where the parent or caretaker refuses help offered by agencies such as food stamps, public assistance, home visitors, or in-home services, assuming parent was mentally competent and knew that the services would have protected the child.

Subclasses:

1. Resulting in documented physical or psychological injury
2. Not resulting in documented physical or psychological injury
3. Not resulting in documented physical or psychological injury, but concerning for future psychological effects that could result from acts of neglect.

Types: 1. Physical neglect

Subtypes:

- i. Nutritional neglect
- ii. Clothing neglect (example, lack of shoes or winter coat)
- iii. Shelter neglect
- iv. Hygiene neglect

2. Emotional neglect
3. Medical neglect
4. Supervisional neglect
5. Educational neglect
6. Dental neglect
7. Exposure to a violent environment, including domestic violence
8. Other neglect

Definitions of types of neglect

1. Physical neglect:	Failure to provide basic physical needs, including food, clothing, shelter, and hygiene.
2. Emotional neglect:	Passive inattention to the child's emotional needs, including nurturing and attention to the emotional well-being of the child.
3. Medical neglect:	Failure to provide prescribed medical treatments for the child, including immunizations, medications, recommended surgery, or other medical interventions required in cases of serious disease or injury; or failure to provide mental health services such as psychotherapy and prescribed medications after a child is found to have a treatable mental illness.
4. Supervisional neglect:	Failure to provide adequate, age-appropriate safety and supervision, putting the child at risk for physical or mental harm.
5. Educational neglect:	Failure to comply with the state's requirement for school attendance; or lack of parental cooperation with special programs or interventions recommended by and provided by the child's school.
6. Dental neglect:	Failure to provide necessary dental care and dental hygiene for the child. Before dental neglect can be established, the availability of dental resources in the community and the availability of personal or public funds for dental care must be documented.
7. Exposure to a violent environment:	Knowingly exposing a child to violence puts that child at risk of physical and/or psychological harm. Allowing a child to witness avoidable violence, including domestic violence can be considered neglectful and inconsiderate of the child's basic needs for security and safety.
8. Other neglect:	Other forms of neglect not covered by above definitions.

This is a child-centered definition of neglect. The intentionality of the neglecting adult is not at issue. For example, a child dying of a bacterial infection because the parents held a religious belief that prohibited medical care would be classified as first or second degree medical neglect, based on the chronicity of the problem. A child who is extremely malnourished due to a parent's fixed belief system about nutrition and health would be an example of first degree neglect.