North Carolina Department of Health and Human Services
Division of Social Services

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February 4, 2002

DEAR COUNTY DIRECTOR OF SOCIAL SERVICES AND CHAIR, COMMUNITY CHILD PROTECTION TEAM:

SUBJECT: State Child Fatality Review Report: SFY 00-01

The Division of Social Services is pleased to provide you with the attached State Child Fatality Review Report: SFY 00-01. The Division is required to make a formal report to the North Carolina General Assembly each year that summarizes the findings and recommendations of the child fatality reviews conducted by the State Child Fatality Review Teams. The purpose of the State Child Fatality Review Teams, as defined by G.S. 143B-150.20, is to "implement a team approach to identifying factors which may have contributed to conditions leading into the fatality and to develop recommendations for improving coordination between local and State entities which my have avoided the threat of injury or fatality and to identify appropriate remedies." The attached report was provided to the N.C. General Assembly in December 2001 for SFY 00-01.

The findings and recommendations of these multidisciplinary teams have statewide implications. We recommend that all local communities in North Carolina use this report to examine the issues relevant to their child protection and prevention system and to make any changes that are indicated. If the lessons learned as a result of a child's death can be applied in such a way as to prevent future fatalities, the state's protection of children will be significantly enhanced and the legislative intent will be met. To this end, we ask that you share a copy of this report with each of the members of your Community Child Protection Team (CCPT). We also recommend that the Team have a discussion regarding the findings and recommendations included in the report in order to determine if there are any lessons that have pertinent implications for your community.

We want to formally recognize the contributions of the state and local individuals that served on the State Child Fatality Review Teams during SFY 00-01. These individuals devoted countless hours during the reviews, frequently volunteering their time without compensation. It is through their contributions that the attached report is possible.

The attached report includes an Executive Summary, the full report that summarizes the review process and the major findings and recommendations from the reviews completed in SFY 00-01. Appendix A reflects recommendations that were more case-specific but that were still important recommendations that should be considered statewide. Appendix B outlines some of the achievements at both the State and local levels that have resulted from recommendations for State Child Fatality Review Teams.

If you have any questions or suggestions, please feel free to contact Sara Anderson Mims, Program Review Team Leader, at (919) 733-9461.

Sincerely,

Charles C. Harris, Chief
Children's Services Section

CCH/sam

CS-06-2002

Attachments

Cc: Pheon Beal, Director, Division of Social Services
Sherry Bradsher, Deputy Director, Division of Social Services
Paul Lesieur, Budget Officer, Division of Social Services
Children's Services Team Leaders
Children's Programs Representatives
John Butts, Chief Medical Examiner
Tom Bennett, Executive Director, State Child Fatality Task Force
Deborah Radish, State Child Fatality Prevention Team
Jennifer Tolle, Prevent Child Abuse North Carolina
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State Child Fatality Task Force Members
State Child Fatality Prevention Team Members
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State Child Fatality Review Report
SFY 00-01
Executive Summary

The Department of Health and Human Services, Division of Social Services, has the responsibility to convene a State Child Fatality Review Team to "conduct in-depth reviews of the child fatality which occurred involving children and families involved with local Departments of Social Services child protective services in the 12 months preceding the fatality." The purpose of these reviews is to "implement a team approach to identifying factors which may have contributed to conditions leading into the fatality and to develop recommendations for improving coordination between local and State entities which might have avoided the threat of injury or fatality and to identify appropriate remedies." These reviews are mandated by statue (G.S. 143B-150.20) with specified team membership that includes representatives from the Division of Social Services, the county DSS, representatives from the local Community Child Protection Team, the local Child Fatality Prevention Team, local law enforcement, a medical expert, and a prevention specialist.

The reviews consist of interviews with selected individuals and reviews of case records of the county DSS and other agencies that provided services to the child and family. The process focuses attention on the role and involvement of the broader community in protecting children. A formal report is issued at the conclusion of each review that includes the findings and recommendations from State Child Fatality Review Team. The team presents these findings and recommendations in a public meeting of the Community Child Protection Team. The written report is available to anyone who requests it. Following the issuance of each report, Division of Social Services staff present the recommendations that have statewide impact to the State Child Fatality Prevention Team in an effort to identify the most appropriate state level entity to follow up on each state level recommendation.

During SFY 00-01, nineteen reviews were completed and 27 final reports were issued. During the year, the Division of Social Services identified 28 child fatalities out of 137 deaths reported that met the criteria for a State Child Fatality Review Team review. Out of the 28 deaths, neglect was suspected to have contributed to the fatality in 21 cases and abuse was suspected in 6. In one case, both abuse and neglect were suspected to have contributed to the fatality.

Throughout the reviews conducted during the year, six major themes were consistently identified in the recommendations from the review teams. The need for additional community resources for parent education and support was identified, including the need for preventive services such as expanded in-home visiting programs. Most of the review teams noted the need for improved collaboration and information-sharing across community agencies that serve families and children, as well law enforcement agencies and the medical community. The Division's plans to pilot a multiple response approach to CPS investigative assessments was particularly noted as promising. Training needs were identified for several disciplines, including county DSS staff, law enforcement, Emergency Room and EMS staff. Cross training for community agencies was also identified. Continued efforts were recommended by the teams for public awareness of the reporting law for abuse and neglect. Recommendations included strengthening or adding to Child Protective Services policy, as well as better adherence to existing policies. Several of the recommendations addressed the need to improve recruitment and retention of qualified staff in county Departments of Social Services.

State Child Fatality Review Report

SFY 00-01

G.S. 143B-150.20

Children's Services Section
Division of Social Services
NC Department of Health and Human Services

December 2001

Pursuant to G.S. 143B-150.20, the following is the annual report to the N.C. General Assembly for SFY 00-01. This report includes a summary of findings and recommendations of child fatality reviews conducted by the State Child Fatality Review Teams during SFY 00-01. These teams conduct multidisciplinary reviews when there is suspicion that neglect or abuse caused a child's death and the county DSS children's services program was involved with the child or family any time in the previous year.

History

At the direction of the Governor, the Division convened a multidisciplinary team to review a series of fatalities that occurred in Rowan County and to make public the team's findings and recommendations. The focus became not just what the county Department of Social Services had or had not done, but what all community agencies could learn from the factors that contributed to the fatality.

This approach was much more helpful to the community and led to numerous changes in how Rowan DSS served abused and neglected children. Some of the changes included staffing the child abuse hotline around the clock (not just during business hours), recruiting medical and mental health professionals to help assess abused and neglected children, and intense training for social services staff. The deaths in Rowan County and subsequent reports lead to the enactment of legislation that changed the format of child fatality reviews conducted by the Division of Social Services. Additional the General Assembly establish the State Child Fatality Review Team to conduct in-depth reviews of any child fatalities which have occurred involving children and families involved with local departments of social services child protective in the 12 months preceding the fatality.

The collaborative, multi-disciplinary approach to these reviews, along with greater latitude in making more information public in the review reports, make these reviews learning tools for the entire community. These reviews can teach us how we can improve our efforts to prevent future child deaths.

Feedback from those involved with State Child Fatality Review Teams has been that there is increased ownership of the local communities with Review Team recommendations and increased commitment to implementation of the resulting action plans. The State Child Fatality Reviewers have implemented six-month follow-ups with the local CCPT's after a review is completed. These follow-up contacts with the CCPT's focus on the progress at the local level in implementing any systemic changes as a result of the recommendations from the Review Team.

Review Process

Currently, child fatality reviews are conducted as follows:

1. By State law, anyone who has cause to suspect that a child has died as the result of maltreatment must report the case to the director of the county Department of Social Services (DSS).
2. The DSS reports to the Department of Health and Human Services, Division of Social Services (the Division) information that they receive regarding any child who is suspected to have died as a result of maltreatment.
3. The Division determines whether the necessary criteria are met to invoke a review by a State Child Fatality Review Team based on information from the county DSS and any local law enforcement or health care professional who was involved in investigating the child's death or the death scene.
4. A State Fatality Review Team is convened, including representatives of the Division, the county DSS, representatives from the local Community Child Protection Team, the local Child Fatality Prevention Team, local law enforcement, a medical expert, and a prevention specialist.
5. Division staff on the team begin all reviews with an introduction about the review process to all participants.
6. The review consists of interviews with selected individuals and reviews of case records of the county DSS and other agencies that provided services to the child and family. The process focuses attention on the role and involvement of the broader community in protecting children.
7. The team writes a report that includes the findings of the review and recommendations for system improvement.
8. The team presents these findings and recommendations in a public meeting of the Community Child Protection Team. The written report is available to anyone who requests it.
9. As each State Child Fatality Review Report is completed and released, Division staff present recommendations that have statewide impact to the State Child Fatality Prevention Team in an effort to identify the most appropriate state level entity to follow up on each recommendation. For recommendations that need to be addressed by the Division, a work group established in the Children's Services Section examines the issues identified and presents the recommendations to the Children's Services Management Team for any necessary action.

Facts regarding State Child Fatality Review Process

The State Child Fatality Review process is an ongoing one, and there is overlap from one fiscal year to the next. Therefore, reviews conducted and reports issued include fatalities that were reported to the Division and decisions to conduct reviews from the previous fiscal year as well as those from the current fiscal year. Some of the cases identified for review in the current fiscal year will be reviewed in the next fiscal year. Nineteen reviews were completed and 27 final reports were issued during SFY 00-01. Teams completed twelve reviews and issued 24 reports for fatalities that had either been reported or identified for review in SFY 00-01. At the end of fiscal year 00-01, 7 intakes had not been decided, and 15 cases identified for review needed to be completed. Three reports were still being prepared for release. Five of the 7 intakes that had not been decided were subsequently determined to meet the criteria for review shortly after the end of SFY 00-01. These cases will be reviewed during SFY 01-02.

The State Division of Social Services identified 28 child fatalities (out of 137 deaths reported) in 18 counties that met the criteria for a State Child Fatality Review Team review during SFY 00-01. To meet the criteria for a State Child Fatality Review, there had to be a suspicion that abuse or neglect may have contributed to the fatality. In addition, the child or family must have been involved with a county Department of Social Services child protective services in the 12 months preceding the fatality. Of these 28 deaths, neglect was suspected in 21 cases and abuse was suspected in 6. In one case, both abuse and neglect were suspected.

Of the 28 intakes received during SFY 00-01 that met the criteria for an intensive review, 14 were cases that had been closed for Child Protective Services (CPS) and 5 were open for services to the family following a CPS substantiation. Five cases were open for CPS investigations, and 2 cases involved previous reports that had not been accepted for CPS investigations. Two of the fatalities involved children who were in the custody of DSS.

All major findings and lessons learned are summarized here so that the State Division of Social Services, county Departments of Social Services, and other state and county agencies can make systemic improvements focused on the safety of children. Appendix A reflects recommendations that were more case-specific but that were still important recommendations that should be considered statewide. Appendix B reflects achievements at both the State and local levels that have resulted from recommendations from State Child Fatality Reviews.

Recommendations

Community Resources for Parent Education and Family Support

The State Child Fatality Review Teams often identify a need for more community resources to provide education and support for parents and families. The following recommendations reflect those most frequently identified:

- Additional resources for voluntary services are needed statewide particularly for families who have had problems identified that do not rise to the level of neglect or abuse. These services should include parenting education and support, supportive services to families with children who have special needs, financial management, household management, etc. Currently, there are no available State funds for such additional resources. However, if funds become available, the teams highly recommend consideration for funding these resources.

- Support and education to parents (and grandparents) should include information about safe sleeping and bathing, as well as safety around water areas. Support and education should include exploration of differences within cultures regarding expectations of children. A comprehensive plan that includes cultural and family diversity for education regarding good parenting that can lead to the prevention of injuries and unintended child deaths should be developed. This plan should also include education to children about safety.

- Family support services need to be made available immediately following the death of any child. Communities need to evaluate existing resources and expand or enhance them if gaps are identified in collaboration with other family support and grief resources. These services need to be outreach oriented and available at times they are needed by families.

- Community agencies should develop a domestic violence protocol, which would include identification and a systematic approach to referrals and response to domestic violence.

- Intensive home visitation programs need to be expanded to include children other than non-medically fragile children and families who have had prior children.

- Mental Health assessments and services to children and families should be expanded to children and families served by the county DSS. Additionally, these services should be designed to assist with the outcomes of keeping children safe and providing them with permanence.

Interagency Collaboration and Information Sharing

Frequently the State Child Fatality Review Teams have discovered a critical need for more information to be shared and improved collaboration across agencies that are involved with children and families. Most of the reviews noted that one individual or agency had important information that another individual or agency needed, and that information was not shared. Additionally, interagency collaboration is key to serving families and protecting children.

The following recommendations summarize the issues most frequently identified regarding information sharing and collaboration:

- Communities need to develop protocols for interagency collaboration to share information regarding families "at risk" and for insuring that community resources are understood and utilized. Communities should develop information-sharing protocols to allow multiple agencies that provide services to children and families to access a common database. Through this information sharing process, high-risk children may be identified that need multi-agency team meetings on a monthly or quarterly basis. When such cases are identified and the children are in school, it is recommended that these meetings be coordinated at the school using the Student Services Team as a vehicle for accomplishing this when possible.

- Dual investigations involving collaboration and sharing of information between law enforcement and Departments of Social Services in child abuse cases would enhance the effectiveness and efficiency of child protection. The Division of Social Services should continue its efforts to implement the Multiple Response pilots. In the meantime, local law enforcement agencies and County Departments of Social Services should strengthen interagency protocols for responding to child abuse and neglect. Particular protocols should promote a collaborative effort to protect children in cases where domestic violence or substance abuse issues are involved.

- A community protocol for child deaths that are unattended by a physician is needed between local ER physicians, EMS, Medical Examiners, DSS and law enforcement. A community protocol is critical to ensuring that a multidisciplinary approach to a comprehensive forensic investigation occurs immediately upon notification of the death. It is recognized that local resources may be insufficient to support this service and that the State Bureau of Investigation may need to be invited to support local law enforcement in these cases.

- Better coordination is needed between county DSS and medical providers in sharing information about abuse and neglect

concerns so that more frequent monitoring and more active follow-up can be initiated. It is ideal that families "at risk" are scheduled to see the same provider in a medical practice and that aggressive outreach is provided.

- CPS investigators should have timely access to medical records upon request when conducting a CPS investigative assessment. Protocols are needed to ensure that health care providers are also provided with information from hospitals about common patients. Medical providers (pediatricians, family practice physicians, health departments, etc.) should routinely seek medical records for new patients who are two years of age and under that include prenatal information, hospital discharge summaries, and previous pediatric records.

- A mechanism is needed for the community to inform the county DSS of any pertinent changes with a family when these changes may fall short of a typical CPS report but may change the risk to the child substantially. It is also important that the county DSS has a mechanism in place by which they can systematically identify high-risk families, allowing for special attention to be given to any information that comes in on that family. This information could then be utilized in the protection of children, even if it does not rise to the level of accepting a complaint for investigation as abuse or neglect.

- Community Child Protection Teams should focus on full attendance at meetings to ensure interagency collaboration and the development of more resources. CCPT's should regularly review active CPS cases when there is an identified gap in services or lack of progress in the case. Expanded membership on CCPT's should include hospital personnel, local police departments, clergy, Smart Start, juvenile courts, domestic violence and EMS.

Training Needs

There were several recommendations from the State Child Fatality Review Teams regarding the need for enhanced training for county DSS staff and for other agencies' staff that would increase the knowledge and skills needed in the professional community to better protect children. Following are the recommendations most often mentioned:

- It is recommended that pre-service training for county DSS workers should include more training on the recognition of substance abuse and domestic violence as it relates to assessment and treatment planning. Interviewing skills to obtain information regarding substance abuse and domestic violence should follow this pre-service training.

- CPS intake and investigative assessment positions are critically important within Child Welfare. The mandated pre-service

training could be improved by requiring a person to demonstrate the competencies before they can be considered to have completed the training. This would help ensure new workers are prepared to handle the situations they are presented with while doing investigative assessments.

- Law enforcement, Emergency Room employees and EMS should be trained and have a protocol for identifying and reporting suspicions of abuse or neglect to DSS. DSS and law enforcement personnel should work together on training. Although there is some training in place currently, this is an area that needs additional emphasis.

- Community Child Protection Teams should ensure that cross training occurs with regard to various agency roles, mandates and responsibilities.

- Efforts should be made to prioritize training on domestic violence and substance abuse and it's connection to child welfare in county agencies.

CPS Best Practices

County Departments of Social Services are charged with investigating allegations of child abuse, neglect, and dependency and in providing child protective services and child placement services when required. Most of the recommendations made by the State Child Fatality Review Teams regarding Child Protective Services were that existing policies and standards should be followed more closely. Significant recommendations for new or enhanced policies or procedures in Child Protective Services are listed below:

- County DSS agencies should ensure that a comprehensive family history is included as a part of their CPS investigative assessments in order to identify patterns, areas of concern, and effective service needs.

- Whole family systems should be part of the investigative assessment in order to assess allegations within a larger context, as well as identifying additional issues that might lead to a substantiation of abuse or neglect. Currently, many agencies focus solely on the immediate family, rather than assessing extended family members and support systems.

- Standard practice for CPS investigative assessments should include obtaining complete criminal records, police reports, EMS service logs, DMV reports and calls for services on all relevant persons associated with household members.

- The Division of Social Services should continue its efforts to review the risk assessment tool to improve on identifying risk factors and

behavior, practical utilization of the tool, and effective training to ensure the tool is used appropriately. The risk assessment tool may not accurately reflect risk when workers do not use the risk assessment matrix with the checklist.

- County DSS should periodically reassess CPS investigative assessment protocols to insure the current and future health and safety of children under two years of age.

- When protection plans are indicated, at least one adult in addition to the parent or caretaker should agree to assist with ensuring compliance with the protection plan.

- Protocols should be developed and agreed upon both across the State and across the country for exchanging information in situations where families have moved. When information is requested from another agency or state, and a response is not received within a reasonable amount of time, the county DSS Director's assistance should be requested.

- A protocol is needed for dealing with domestic violence and substance abuse when it is a part of a report or a concern during the investigative assessment. This would facilitate appropriate referrals to services.

- County DSS should expand collateral contacts and broaden the information collected in collateral interviews in order to increase the information available to make a case decision.

- NC Children's Services Policy exists regarding when decision points are in a case and what should occur at those decision points that facilitates clarity in decision making. Therefore it is important that county DSS staff adhere to policy in order to protect and facilitate the safety, wellbeing and permanence of children.

- County DSS legal staff should only provide consultation around preparing a case for legal action and courts. Case decisions relating to safety and well being should be made my social work staff.

- When mental health and substance abuse issues are involved in a case, mental health and substance abuse professionals should be a part of staffings on a regular basis to assist CPS staff with safety assessments, wellbeing and permanency planning.

Staff Recruitment and Retention

Conducting CPS investigative assessments is the most stressful and unpredictable job in Child Welfare, and yet one of the most critical. County Departments of Social Services are experiencing considerable staff turnover statewide. Recruitment of adequate staff is one issue for county agencies, but retention of qualified, trained and experienced staff, particularly in CPS, is of critical importance. In several of the reviews, the State Child Fatality Review Teams made the following recommendations:

- The Division of Social Services or the North Carolina Association of County Directors of Social Services should consider contracting with a person or organization with expertise in social worker recruitment and retention. Such a contract should provide a vehicle to study the issues that lead to high turnover in CPS social workers and to the difficulty in attracting new recruits. The results from this study should include identification of factors that would contribute to successful recruitment and retention of qualified social workers and recommendations for implementation by both county Departments of Social Services and the Division.

- County DSS agencies should explore implementation of sign-on bonuses and retention bonuses as a way to recruit and maintain staff with the necessary knowledge and skills for multi-complex cases.

- Critical incidents, such as a child fatality, take a toll on the workers assigned to those cases. These incidents contribute to the stress that CPS social workers feel when working with difficult cases. County DSS agencies should discuss with their county's Employee Assistance Programs the possibilities of providing services to social workers when critical incidents arise.

- Tailoring CPS supervisory staffs' responsibilities to enable them to provide reflective and clinical supervision to line staff is important for accurate case decisions made upon a case.

Conclusions

These are the recommendations of informed State and community professionals who have intensively reviewed the circumstances of child deaths. On the whole, they confirm what child welfare professionals have increasingly realized—that protecting children is a community-wide responsibility. While law mandates DSS to intervene in circumstances of abuse and neglect, it must rely on other community agencies and individuals to help assess and help families at risk.

This information should help both State and local entities improve policies and practices to avert future child fatalities. Every community is encouraged to review the issues and recommendations summarized in this report for relevance in their own community and to take any indicated action.

Over the course of the next year, the Division will continue to look at how this information can be fully utilized to improve the safety of children in our state, including possible enhancements for policy and training provided by the Division. Our hope is that local community and county DSS agencies and other Departments and Divisions at the state level will engage in a dialogue with us about how we can best utilize this information in our collective efforts on the behalf of children and families.

Appendix A

Appendix A reflects recommendations that were case specific, but are important recommendations that can be implemented statewide.

- The use of photographs, drawings and measurements to schools, daycare facilities, and county Public Health agencies who are involved with children is significant in efforts to assist authorities in determining whether the injury resulted in abuse or not.
- Determinations of paternity should always be aggressively pursued for all cases involved with DSS.
- When reporting a non-caretaker to the District Attorney, DSS should consider obtaining feedback regarding the investigation in order to ensure a child is safe.
- Forensic interviewing often elicits information about neglect and abuse which can be helpful in assessing safety, wellbeing and permanence planning.
- Family Drug Courts to serve families with substance abuse issues whose children are in DSS legal custody is beneficial to children and their families.
- Substance abuse and drug dealing exist in a culture of secrecy. When DSS has substantiated a case, but cannot gain access to the child once the agency moves toward providing services, the agency should assess the family situation as high risk and consider petitioning for adjudication.
- When DSS is involved, the court should seek home studies on any parent before custody is given in order to ensure safety and wellbeing.
- In a fatality, the on scene law enforcement officer should always speak directly to the pathologist and attend the autopsy whenever possible.
- The ME system should systematically disseminate, distribute and apply the science and other information that exists in the central ME office.

Appendix B

Appendix B reflects achievements that resulted from recommendations from State Child Fatality Reviews.

- The Division of Public Health, Office of Chief Medical Examiner (OCME) is now collecting information on multiple deaths. The OCME is beginning to identify more specifically, neglect as a factor in child deaths. The OCME is encouraging local medical examiners to routinely notify County Department of Social Services of child deaths.

- The Children's Services Section of the Division of Social Services formed a Risk Assessment Committee to study the current process and tool used for assessing risk. From the results of the study, the committee will submit to the Children's Services Section an updated process for evaluating risk in the near future.

- A model for a Multiple response approach to CPS reports has been developed by the Division and will be implemented within the next several months.

- The Division has developed additional structure and guidance regarding critical CPS issues that will soon go out to counties DSS agencies.

- A re-bidding of contracts for Family Resource Centers will require coordination of services between county DSS agencies and the Family Resource Centers.

- A redesign of CPS Case Planning and Case Management services with accompanying changes in policy, service codes, and training is in process.

- The Division is currently holding a discussion regarding developing a strategy for improving supervisory oversight of CPS practice and for strengthening appropriate placement competence with county DSS staff.

- The Department of Health and Human Services is convening a task force to examine domestic violence and child maltreatment. Policies and procedures will be developed through the work of this task force.

- Plans are underway to implement a new CPS model in 10 counties with preference given to counties that have participated in TANF/CWS Collaborative, Multiple-response design, or CPS case planning / case management re-design in early 2002.

- Prevent Child Abuse of North Carolina reported that there is a new affiliate in Fayetteville located within the Child Advocacy Center.

- In Cumberland County, the Chamber of Commerce with the help of a private grant began a new project called the Neighborhood Guardian Program to prevent child abuse one community at a time. It will focus the attention of agencies that deal with child abuse in neighborhoods where child abuse is identified as a particular problem. The neighborhood guardian who lives in the neighborhood will be on the lookout for child abuse in the neighborhood and recommend to the agencies and the community what is needed to keep children safe.

- Onslow County developed a definition of both supervisors and attorney roles in case decision making, as well as outlining a protocol for looking at when to consider and file petitions.

- Onslow County has begun to work with the military to develop a process which ensures cases needing community staffing are either done in the military review committee or the Community Child Protection Team. Additionally, they have begun to work together on ways to utilize military resources for non-military families when services do not exist for those families in the community.

- Onslow County DSS developed a handbook relating to Kinship care as a resource for their agency.

- County agencies that have participated in reviews have learned more about their respective roles and responsibilities and are working at improving communication and collaboration.

- Mental Health QSAP positions through the Work First program are being utilized in several Children's Services programs in assessing substance abuse issues with families.

- Communities who have participated in reviews have been working on developing and strengthening protocols for investigation of child fatalities.

- Communities have been working on strengthening their knowledge of substance abuse and domestic violence as it relates to child safety. Mecklenburg and Cabarrus County have or are developing protocols for substance abuse. Mecklenburg County has developed one around domestic violence and employs a domestic violence expert to assist on cases. Mecklenburg County CCPT has set up committees to work on domestic violence and substance abuse issues as it relates to abuse and neglect issues within the community.

- Cabarrus County has added to their protocol for investigations involving children under the age of 2, the requirement to obtain medical records (including the hospital discharge summary at the time of birth) as a part of their assessment of risk to the child. The community CCPT applied for and received a CCPT grant to work on educating parents and grandparents about safe sleeping for infants. This grant targeted getting the information to persons who might not otherwise get the information. This was done by targeting public laundry facilities, fast food restaurants and local ministers and churches, and ensuring the materials are in both English and Spanish.

- The Cleveland County Department of Social Services developed a referral/reporting form that is used by all local agencies upon completion of call where children may potentially at risk.

- The Robeson County Department of Social Services held a series of retreats to implement a quality assurance process in their service delivery to families.