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May 13, 2003

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

SUBJECT: State Child Fatality Review Report: SFY 01-02

The Division of Social Services is pleased to provide you with the attached State Child Fatality Review Report: SFY 01-02. 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 January 2003 for SFY 01-02.

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 01-02. 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 01-02. 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 of local communities that have resulted from recommendations from State Child Fatality Review Teams.

If you have any questions or suggestions, please feel free to contact Kevin Kelley, Team Leader for the Licensing and Policy Team, at (919) 733-7831.

Sincerely,

JoAnn Lamm, Program Administrator
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Attachments

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CS-11-03

State Child Fatality Review Report

SFY 01-02

G.S. 143B-150.20

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

January 2003

Report to the General Assembly
From the State Fatality Review Team

Table of Contents

Executive Summary

I. History

II. Review Process

III. Facts regarding State Child Fatality Review Process

IV. Lessons Learned

- A. *Assessments in Children's Services Cases*
- B. *Response to Child Fatalities*
- C. *CPS Reporting and Intake Process*
- D. *Information Sharing/Confidentiality*
- E. *Collaboration between DSS and DMH/DD/SAS*
- F. *Public Education Regarding Safety For Children*

V. Conclusions

VI. Appendices

State Child Fatality Review Report

SFY 01-02
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 the 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 01-02, 31 final fatality review reports were issued following completion of the reviews. During the year, the Division of Social Services identified 27 child fatalities that met the criteria for a State Child Fatality Review Team review out of 137 deaths reported. Out of the 27 deaths, neglect was suspected to have contributed to the fatality in 20 cases and abuse was suspected in 7.

Throughout the reviews conducted during the year, review teams identified six major themes most often. First, the review teams identified the need for DSS agencies to improve their assessments in CPS cases, particularly around issues of current safety, risk of future harm, and broad-based family assessments. Second, many of the fatality reviews identified the need for a consistent protocol for response to fatalities among all of the community agencies involved in investigating deaths and death scenes. The third major theme involved the need for continued efforts to educate and encourage the public and community professionals to report suspected child abuse and neglect to the county departments of social services. In conjunction with the need for more consistent reporting, the review teams identified the need for improvements in the CPS intake process and in recognizing when information on open cases constitutes a new report. The fourth major theme identified was better information sharing among community agencies, across North Carolina county lines, and among states. Related to the issues of sharing information is the need for clarification of confidentiality laws and policies. Better collaboration between departments of social services and mental health agencies constituted the fifth major theme. Finally, increased public education around safety issues was identified as the sixth major theme. Additional themes and issues were identified and will be listed in Appendix A to this report. Appendix B lists accomplishments by local communities as a result of recommendations from reviews.

State Child Fatality Review Team
Annual Report

Pursuant to G.S. 143B-150.20, the following is State Child Fatality Review Team annual report to the N.C. General Assembly for SFY 01-02. This report includes a summary of findings and recommendations of child fatality reviews conducted by the State Child Fatality Review Teams during SFY 01-02. 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.

I. History

In 1997, the General Assembly enacted G.S. 143B-150.20 and established 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 information available to the public through 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 ownership by the local communities with Review Team recommendations and commitment to implementation of the resulting action plans. The State Child Fatality Reviewers have implemented six-month follow-up contacts with the local Community Child Protection Teams (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.

II. 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 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.
5. Division staff on the team begins 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.

III. 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. During SFY 01-02, 31 final fatality review reports were issued following completion of reviews. One review involved the deaths of three children. Two other reviews involved 2 siblings each who had died.

The State Division of Social Services identified 27 child fatalities (out of 137 deaths reported) in 15 counties that met the criteria for a State Child Fatality Review Team review during SFY 01-02. Four of those 27 child fatalities involved 2 sets of two siblings each. 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 27 child deaths, neglect was suspected in 20 cases and abuse was suspected in 7 cases

IV. Lessons Learned

The State Child Fatality Review Teams often identify similar issues in the cases that they review. At other times, there may be a major issue identified that had not been noted previously but that has statewide impact. Other findings are more case specific or community specific.

The six most commonly identified major findings and lessons learned from the 31 child fatality reviews completed during SFY 01-02 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. Achievements at the state level related to these findings are noted where relevant. Appendix A reflects recommendations that were identified less often or that were more case-specific but that were still important recommendations that should be considered statewide. Appendix B reflects achievements at the local levels that have resulted from recommendations from State Child Fatality Reviews.

A. *Assessments in Children's Services Cases*

In almost half of the reviews conducted during SFY 01-02, the review teams noted that assessments of current safety, future risk, and broader family assessments were not adequately done for children and families involved in children's services cases. In some cases, current safety and immediate situational factors were the focus, but not future risk.

Broad-based family assessments were not consistently done to identify underlying behaviors in the family that might contribute to future risk. Well-being issues were not always included in assessments. More extensive use of collateral contacts, including collaboration with other agencies involved with the family, were needed in order to ensure more adequate and thorough assessments of risk and safety. In one case, the review team noted that the assessment of risk and safety did not focus on all children in the family. Assessments of risk did not always include a history of all family members and did not always take into account the developmental level of family members with mental health or developmental disabilities.

When assessments were done appropriately, the case decisions and case plans were not always based on the risk assessments that had been done. In some cases, the inadequate assessment of future risk led to premature case closure.

Recommendations from the fatality review teams frequently called for a revision to state policy regarding assessments of current safety, future risk and broader family

assessments in CPS investigations, CPS in-home services and placement cases. These recommendations echoed similar recommendations from reviews conducted in previous years. Since 1994, the Division of Social Services has provided in policy and administrative rule a risk assessment process and tool to be used following a CPS substantiation and in child placement cases. Effective April 1, 2002, the Division adopted new policy and structured assessment tools. Accompanying changes have been made in Administrative Rule.

A new Safety Assessment guides the social worker in the assessment of the current safety of the child, the development of a written Safety Response when indicated, and identification of Safety Resources to assist in enforcing the Safety Response. A new Risk Assessment guides the social worker in the assessment of future risk to the child and is much more thorough and quantifiable than the previous risk assessment tool. A new structured Family Strengths and Needs Assessment guides the social worker in a broad-based family assessment of the family's strengths and needs that identifies well-being issues for the whole family.

These three assessment tools are completed during all CPS investigations and prior to a case decision. The information from these three assessments is used in conjunction with a structured Decision-Making Tool to make the decision whether or not to substantiate the case based on the severity and frequency of maltreatment, the assessment of current safety and risk of future harm, and whether the child is need of protection.

A structured Risk Re-Assessment tool and a Family Reunification Assessment tool were also implemented effective April 1, 2002. Policy and Administrative Rule dictate specific times for the completion of the Risk Re-Assessment while the case is open for services as a result of a CPS substantiation and when the child remains in the home. This assessment guides the social worker in determining the progress the family is making toward achieving the goals and objectives of their case plan. This assessment also helps determine when the appropriate time is for case closure. The Family Reunification Assessment is completed at designated times when a child is in foster care and helps guide the social worker in determining the progress of the family and in decision making around family reunification.

All of these tools are research based nationally, and together, they are a comprehensive set of tools to assist social workers in more consistent and thorough assessments. These tools are designed to drive the case planning process with families and to assist in decision making throughout the family's involvement with children's services.

B. *Response to Child Fatalities*

The next most frequently identified issue noted by the child fatality review teams was the need for a consistent protocol for a coordinated response to fatalities by agencies and individuals charged with investigating a death or death scene. In several cases, the review teams noted that there was a lack of clarity around the roles and responsibilities of all the different agencies involved in investigating child deaths. Jurisdictional issues with law enforcement agencies complicated investigations in some cases.

Law enforcement, DSS, pathologists, medical examiners, EMS, and hospital emergency room staff all have different, but critical, roles and responsibilities in responding to child deaths. Fatality reviews revealed that there is a serious need for better coordination among all of these responders and increased exchange of information among them. Improved coordination and exchange of information would lead to more accurate decisions regarding autopsy results, determinations of cause of death, criminal charges, and findings from CPS investigations on surviving children.

Fatality review teams frequently found that there were not consistent community protocols for responding to child deaths. In some cases, the actual death scenes were not secured immediately, and therefore potentially valuable evidence was compromised. Recommendations included the need for all unattended child deaths to be considered suspicious until otherwise proven. Law enforcement should be dispatched immediately at the same time that EMS is dispatched to the scene of an unattended child death and the scene should be secured immediately to preserve evidence. Another recommendation was that the medical examiner should always attend the death scene with law enforcement in order to collaborate together regarding the observations of the scene.

A coordinated protocol for responding to child fatalities should also include comprehensive investigations from all responsible parties and full exploration of information by each party. The review teams recommended that local law enforcement should consider contacting the SBI for assistance with child fatality investigations when additional expertise is needed.

In some of the cases reviewed, the empathy for the family clouded the decisions by the professionals responding to the fatality and affected the depth of investigations. In some cases, this empathy resulted in the failure to recognize the need for an autopsy or for a criminal investigation at all. Review teams recommended that crisis debriefing for all first responders to assist in dealing with the trauma of their jobs in child deaths should be included in a consistent protocol.

In addition to the recommendation for a consistent protocol for responding to child deaths, the review teams recommended that ongoing and coordinated training for all responsible parties is needed. This coordinated training should include clarification of the roles and responsibilities of each discipline, as well as training on the protocol.

The Office of the Chief Medical Examiner for North Carolina has on staff a Child Death Scene Investigator/Trainer who has developed a draft protocol for a multidisciplinary, coordinated response to child fatalities. The draft is currently under review and, once finalized, will be made available to local communities as a model. This Investigator/Trainer has also developed curricula for multidisciplinary training in responding to child deaths that is available both live and on-line. A number of local communities have already taken advantage of the training available.

C. *CPS Reporting and Intake Process*

All citizens are responsible for reporting child abuse. North Carolina G.S. 7B-301 states:

> Any person or institution who has cause to suspect that any juvenile is abused, neglected, or dependent, … or has died as a result of maltreatment, shall report the case of that juvenile to the director of the department of social services in the county where the juvenile resides or is found.

The State Child Fatality Review Teams often found that reports of suspected abuse or neglect were not made to the local DSS with tragic consequences. Recommendations from the fatality review teams included the need for more training in the local communities about the requirements for reporting suspected child abuse and neglect, as well as increased public awareness campaigns on how to report such suspicions. Mental health agencies, domestic violence shelters, all hospital and emergency room staff, pediatricians, and law enforcement agencies need to be particularly targeted for training on recognizing signs of abuse and neglect and on the requirement for reporting suspicions to DSS. One recommendation was that there should be statewide training on the aspects of reporting child abuse and neglect for professionals outside of the DSS system and for DSS staff in other program areas, such as income maintenance staff. Another recommendation from this same review team was that the Department of Health and Human Services should require all state and local agencies under the auspices of the Department incorporate in their orientation and staff training programs the aspects of reporting.

Additional clarification is needed with all first responders to child fatalities (EMS, local law enforcement, hospital emergency room staff, medical examiners) about the need to make a report to DSS when a child dies and there are surviving children in the home.

It should be noted that Children's Services Program Management Standards issued by the Division of Social Services requires that all county Departments of Social Services provide regular community awareness and public education programs on recognizing and reporting abuse, neglect, and dependency. In one county that experienced a child fatality review this year, the local CCPT/CFPT held a training conference for pediatric service providers. The content of this training included the responsibility of reporting all suspected abuse and neglect cases. Another county reported that they had coordinated through their local Child Advocacy Center to provide training for local law enforcement, which included identifying abuse and neglect along with the requirements for reporting suspicions to DSS. Training had also been provided to local hospital staff. Although all of the counties provide regular ongoing community awareness and public education programs, these efforts continue to be needed.

In addition to local efforts, Prevent Child Abuse North Carolina has long played a vital role in raising public awareness statewide about recognizing abuse and neglect and how to report suspicions to the local DSS. This organization has thirty (30) affiliates statewide and has the goal of identifying a member or an affiliate in each community in the state. Through their Helpline (1-800-CHILDREN), they provide information and guidance to citizens on how to report suspected abuse or neglect to DSS. They also provide a Prevention Resource Center that has public education and awareness material and training curricula that is available to local CCPT's and CFPT's. Their web site is also easily accessible at www.preventchildabusenc.org*. The organization is in the process of providing training across the state for local community educators, after-school personnel, and child care employees and anticipates around 1,000 individuals being trained. This training is designed for the trainees to have the capacity to return to their local communities to train others in the community on recognizing abuse and neglect and how to report.*

In addition to finding that suspicions of abuse or neglect were not always reported to DSS by the community, the review teams identified related issues that involved the DSS intake process. There were several instances where someone from the community believed that they were making a CPS report to DSS in active cases where the social worker involved with the case did not recognize it as a new report but rather as additional information. Usually, these circumstances involved cases where there had already been a substantiation for abuse or neglect, and the case was assigned to an ongoing worker for CPS in-home services or where the child was in foster care. Recommendations from the review teams included the need for focused training for all children's services social workers in all program areas on how to recognize when information being provided constitutes a new CPS report. Also, children's services supervisors in all program areas need to continually evaluate with their staff whether new information should be taken as a new report for investigation.

Persons making a CPS report to DSS are often emotional when reporting the information that they have. Information is best received and analyzed by the intake worker if the information is as factual as possible. One recommendation was that intake workers need to look for ways to assist callers in giving specific, factual information and in defining clearly what they mean. Clear and complete information from the reporter must be documented on the intake form including all allegations of abuse and neglect that need to be addressed by the investigative worker.

The Division of Social Services issued revised standards in December 2001 to clarify requirements for DSS staff in recognizing when information received on open cases constitutes a new CPS report that requires an investigation. These revised standards were designed to assure that all DSS agencies have clear information and consistent practice so that all maltreatment instances are addressed in all new and open cases. These revised standards are now incorporated into the Division's mandated training curricula provided to DSS social workers.

The Division of Social Services is in the process of developing structured intake tools that will help county DSS intake staff to make consistent and appropriate CPS intake decisions. These tools guide the intake worker to ask reporters clarifying questions through a structured format. The intake tools will also serve to assure that potential substance abuse and domestic violence issues are consistently assessed in conjunction with the CPS issues. Once implemented statewide, the structured intake tools will assist agencies in validating their CPS screening decision.

D. *Information Sharing/Confidentiality*

As in previous years, the State Child Fatality Review Teams identified a critical need for more information to be shared 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. The perception among some agencies about confidentiality has complicated the appropriate sharing of information with other agencies. In addition, information sharing across county lines and from one state to another has special challenges for county DSS agencies in their efforts to protect children and adequately serve families.

In several of the child fatalities reviewed, the review teams found that human services agencies involved with the same families experienced difficulty in accessing and sharing information with one another, which affected each agency's ability to intervene with the families appropriately. Integrated case management was often affected by concerns about confidentiality. There was resulting lack of coordination regarding decision-making or case planning with the families by the involved agencies. Although there were multidisciplinary teams established in some of the cases, not all agencies involved fully participated.

Frequently, there was a lack of clear understanding between agencies regarding their individual roles, agency guidelines, degree of expected involvement, and language. At times, information was eventually shared across agencies involved with the families but not in a timely manner. Confidentiality issues were not clearly understood by some professionals and may be complicated further with the implementation of HIPPA.

Recommendations from the review teams included the need for community agencies involved with serving children and families to clarify their individual roles with one another and to define for each other the constraints that their agency guidelines and mandates place on them. There is a need to avoid the use of discipline-related jargon and to determine common language so that each agency understands what is meant when dealing with one another. Once these recommendations are implemented at the local level, efforts should be made to establish specific protocols among community agencies to facilitate the timely exchange of information about children and families that they are commonly serving. All agencies should be made aware of the requirements of G.S. 7B-302(e) that allows for access to information and records by the DSS director in cases open for child protective services. Confidentiality rules should be clarified and a plan developed to facilitate DSS getting relevant information in such cases. There should be careful examination of confidentiality by agencies as to what information is and is not confidential when working with other agencies in serving the same families.

Additional recommendations addressed the need for more multi-disciplinary teams in serving families and children. These teams are critical in assessing with families their needs, in developing coordinated service plans with those families, and in case decision-making.

The Division's fatality workgroup has begun evaluation of various laws related to confidentiality. This evaluation thus far indicates that the laws related to confidentiality are much less restrictive in most areas than is commonly perceived by many agencies. Federal laws, particularly related to substance abuse and HIPPA, are more restrictive and continue to pose a barrier in some cases.

There are a number of initiatives underway that promote the use of multidisciplinary teams for serving families and children. Mental Health's System of Care calls for the use of such teams that include the family and all agencies serving that family coming together to identify the needs and to establish coordinated plans for intervention and service delivery. Community collaboratives also bring various agencies together to increase communication, coordinate resources and plan for local community efforts in the System of Care.

Similarly, the Family to Family initiative sponsored by the Annie E. Casey Foundation in five DSS agencies in the state promotes cross-agency collaboration and the use of Family Team Decision-Making. These teams are designed to bring the family together with their own support resources along with community resources in making placement decisions and in ensuring a network of support for children at risk of entering foster care.

The Division of Social Services is piloting the Multiple Response System (MRS) in ten counties across the state. In one component of this MRS pilot, agencies are using Child and Family Teams in CPS in-home services cases. Like the Family Team Decision-Making meetings in Family to Family, these Child and Family Teams bring the family together with their natural supports and community resources for planning and decision-making. Plans are to obtain legislative support for taking MRS statewide in the near future. If that is successful, Child and Family Teams will become practice statewide and should promote better information sharing and collaboration across agencies in serving children and families.

General Statues require that all 100 North Carolina counties have a Community Child Protection Team (CCPT). Part of the responsibility of the CCPT is to provide an avenue to staff open CPS cases. Since the membership of the CCPT is multidisciplinary, more opportunities should be made in using the CCPT to staff particularly complicated cases that involve multiple agencies. This team staffing would promote better sharing of information among the involved agencies and better coordination of planning.

In addition to the need for sharing information across multiple agencies, the review teams identified the need for better sharing of information across county lines within North Carolina. Because children's services in North Carolina is county administered/state supervised, county lines sometimes are a barrier in serving families who move from one county to another or who have different members of the family living in different counties. Crucial information is not always readily available from one county to another, resulting in incomplete assessments of risk and safety. Case planning with families is interrupted when information is not shared timely from one county to another or when there is not a coordinated, collaborative effort between counties. When families move from one county to another when the case is open for CPS or other critical services, the transfer of services is often hampered. There were also instances identified when a family that had a CPS case open in one county moved to another county that was never notified of the family's presence.

Review teams made recommendations for a statewide protocol for timely sharing of information and case transfers across counties when families moved across county lines. The recommendations called for standardized time frames and consistent formats for thorough case summaries. In addition, there was a call for a protocol for consistent response to referrals of services to families when different members of the family live in different counties.

The Division of Social Services has identified a workgroup of state and county DSS staff to develop statewide policy that will address cross-county issues in child protective services, ongoing CPS in-home services, and child placement services. It is anticipated that comprehensive policy clarification will be in place in 2003.

The exchange of information from state to state was another area identified by the review teams as a barrier to protecting children and serving families. Currently, there is not a national database on child abuse and neglect that would identify children and families who have been involved with child protective services. Even when North Carolina DSS agencies have been able to determine that another state has been involved with a child and family in another state, they have been unable to obtain full access on a timely basis to the information from the other state. The lack of timely and complete information often hampers a thorough and accurate assessment of the safety and risk to children.

Review teams recommended that North Carolina advocate with the United States Department of Health and Human Services, Administration for Children and Families (ACF), to provide protocol to all states around interstate sharing of information in child protective services cases.

The Division of Social Services has raised this issue with the ACF regional consultant for North Carolina. In addition, the Division will be contacting national associations for assistance in advocating with ACF on this issue.

E. *Collaboration between DSS and DMH/DD/SAS*

In many of the fatalities reviewed, the review teams identified the need for better collaboration between DSS and DMH/DD/SAS agencies at the local level. In a number of the reviews, there were concerns about how the new Mental Health State Plan would impact the availability for services to children and parents that are involved with child protective services across the state. Particularly, rural areas currently experience poor access to mental health services for DSS clients. Also, the oversight of contracted providers needs to be carefully monitored as it relates to ensuring the safety of children, appropriate placements through Mental Health or Developmental Disabilities, and ongoing services. When families move from one area of the state to another, there should be a mechanism in place to ensure that Mental Health services are provided and coordinated in the county of residence regardless of where the services originated. Although procedures exist for facilitating a memorandum of understanding regarding transfer of responsibility for care coordination and services delivery, protocols should be reviewed to assure effective continuity of care. These protocols are particularly needed in cases that also have involvement with DSS

Better communication and collaboration between local DSS and Mental Health agencies was indicated in several cases where the DSS had made a referral to Mental Health and the family did not follow through for needed evaluations or services. Review teams identified that more training is necessary for DSS social workers and supervisors about mental health issues and how to access services.

When both agencies are involved with a family, the review teams found that better coordination was often needed in identifying a lead case manager. DSS and Mental Health in several of the communities need to better educate their staffs about the processes of each agency. The assessments of risk for children and families frequently differ between DSS and Mental Health, particularly when there is substance abuse by parents or developmental disabilities at issue. Cross training of DSS and DMH/DD/SAS staff in risk assessment is needed.

If fully functional in all communities, the System of Care that is now incorporated in the Mental Health State Plan should enhance the collaboration between DSS and DMH/DD/SAS.

F. *Public Education Regarding Safety For Children*

Repeatedly in the child fatality reviews this year, the teams identified issues of safety for children that need further attention in community awareness and public education. Among these safety issues, safe sleeping for infants was identified several times by review teams. Public awareness and education campaigns need to address the fact that parents place infants at high risk when the parents sleep in the same bed with their children while under the influence of any drug, including alcohol and marijuana. Multiple family members sleeping in the same bed with infants also place the infants at high risk.

Other safety issues identified as needing public education included road safety on rural roads, and supervision of children around water. One child died as a result of being left alone in a car. Although there are no current state laws prohibiting this, there needs to be community awareness and public education that children under the age of twelve should not be left alone in a car. Another case highlighted the need for more education to parents and the public about the health dangers with exposing infants and children to cigarette smoke.

One child died as a result of a house fire. The review team noted that more public education is needed regarding the potential hazards of space heaters, the importance of functional smoke alarms, and existing fire laws.

In at least two of the fatalities reviewed, the need for community awareness and public education about safety issues included the need to target the Hispanic community. Materials and campaigns are needed that are sensitive to cultural issues and that are available in Spanish.

Many of the counties that experienced fatality reviews that identified these safety issues have already developed local community awareness and public education campaigns. As mentioned previously, Prevent Child Abuse NC has long been a significant vehicle for statewide public awareness campaigns. They have recently focused on specific issues similar to the ones listed above. The organization is currently working with UNC Chapel Hill around shaken baby research with the goal of eventually developing a pilot project.

The State Child Fatality Prevention Team has formed a Safety Committee to develop a plan to address public education and community awareness campaigns around safety issues identified in fatality reviews. There are a number of existing organizations involved in such campaigns for various issues. The goal of the Safety Committee is to bring together those organizations already involved in education and awareness campaigns around child safety to determine if some of the issues identified in fatality reviews can be incorporated or added to the existing efforts of those organizations. For example, the "Back to Sleep" campaign has been extremely successful. If the other identified safe sleeping issues could be incorporated into that effort, it is felt that there would be significant additional benefits.

V. Conclusion

The contributions of informed state and community professionals that served on the State Child Fatality Review Teams during SFY 01-02 have made this report possible. These individuals devoted countless hours during the reviews, frequently volunteering their time without compensation. The review team members intensively reviewed the circumstances of each child's death and confirmed that protecting children is a shared community responsibility.

The findings and recommendations of these multidisciplinary teams have statewide implications. It is recommended that state agencies and all local communities in North Carolina use this report to examine the issues relevant to the protection of children and the prevention systems in place in order to make any improvements 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.

Appendix A

Appendix A reflects additional recommendations that were either identified less frequently than those in the body of the report or that were case specific. These are important recommendations that can be implemented statewide.

Criminal Background Checks

- DSS should have the same access to the statewide criminal information system that is available to the Guardian Ad Litem Program.
- The Division of Social Services should discuss with state law enforcement officials the possibility of establishing a process or a protocol that would allow county DSS agencies to obtain national criminal information on family members in children's services cases.
- The local CCPT should encourage the District Attorney's Office to ensure that the District Attorney secure complete criminal history profiles before court hearings.

The role of Attorneys Representing the DSS

- A discussion between State Child Welfare Attorneys and the DSS Attorneys would provide guidance in specifying both Social Work Supervisory and Attorney roles and responsibilities.
- It is the role of the supervisor and worker to make the case decision regarding the need for removal of children from the home. DSS workers should present the case for all children in a home to be removed with an attorney when discussing a petition for one child.
- The role of the attorneys for DSS should be to provide consultation on the merits of the case. When there is insufficient legal merit to file a petition, the attorney should provide direction to the supervisor about what is needed to have sufficient legal grounds to petition.

Issues for Judges, Attorneys, and Law Enforcement

- The county Departments of Social Services should coordinate training with local law enforcement, attorneys and judges, along with The Institute of Government and the Family Court Improvement Project. This training should address issues of abuse and neglect, particularly related to assessing future risk to children.
- Judges need to closely examine the facts presented before them as it relates to the safety and future risk of children.
- The court should seek home studies on any parent before custody is given to the parent to ensure the safety and wellbeing of the child in question. A complete assessment is essential before entering judgement regarding placement/custody of a child.
- In one case, the initial petition for custody was for neglect and dependency. When in court the parties stipulated to dependency with no hearing on the merits of the case for neglect. DSS should discuss the implications for this practice for permanency planning.
- Judges should take into consideration the affect of custody switches between parents on children.
- All judges should receive substantial training in child maltreatment. This training should be mandatory for all judges as a part of the initial training new judges receive.
- The county Department of Social Services should partner with local law enforcement to provide training around the aspects of abuse and neglect. Regional State Highway Patrol officers should be invited to participate.

- Local law enforcement agencies and county Departments of Social Services are encouraged to initiate training workshops together regarding North Carolina General Statute 7B-500. This training should enable law enforcement and DSS to develop a unified county protocol on law enforcement taking a child into temporary custody when there is imminent risk to a child at the time of a response by law enforcement to a report of abuse, neglect or dependency and when the local Department of Social Services is not immediately present.

Resistant Families in Child Protective Services

- The North Carolina Division of Social Services should review the utilization of safety plans as related to the legal authority to enforce them and provide guidance for county DSS agencies when the plan is not followed. Safety plans should be specific and monitored for compliance. When violation of the safety plan increases risk to the children, supervisors and workers should consult with attorneys regarding petitioning for custody.
- When an alternative living arrangement is necessary because inappropriate behavior has not changed and safety issues remain if the child were to return to the parent, the agency should not close the case until that alternative living arrangement is legally secure. The local DSS should petition the court for substantiated child protective services cases and request a court ordered placement when safety issues warrant an alternative living arrangement.
- When agencies make a referral for a family, they should follow up with the service provider to see if the family made an appointment or kept an appointment that was made when a child's wellbeing is at stake. The agency should be clear about what the response will be when an agreed upon plan of action is not carried out by the family.
- DSS supervisors should monitor work in any case on a weekly basis and assure the family being worked with carries out case plans. The local DSS management should set an expectation that a weekly case staffing will occur between workers and their supervisors.
- Children cannot be protected when legal barriers prevent service providers from gaining immediate access to children. Statutes must allow for immediate and objective access to children in an appropriate environment for assessment. It is imperative for children's safety to distinguish a person's property, which might be protected by constitutional right, from the lives of children who may need protection within the legal system. It should be remembered when considering laws pertaining to protection of children, that parental rights can be in conflict with children's safety.
- The Division of Social Services should provide guidance to agencies in the form of specific policy, protocols and training for social workers when encountering resistant families, as this resistance in and of itself greatly elevates the risk to children.

Medical Examiner Issues

- North Carolina needs a Medical Examiner system that disseminates, distributes and applies the science and other information that exits in the central State Medical Examiner's office through every community and county requiring that information.
- There should be clarification regarding the difference between the role of a coroner and a medical examiner.
- The pathologist always should clearly specify the cause of death or that it cannot be determined in the final autopsy report.

Paternity Issues

- Aggressive efforts to identify paternity should occur for all cases involved with DSS. Child Protective Services and Child Support should establish a protocol for determining paternity. This is important for child support, social security, and future planning for the children.
- In all cases, DSS should attempt to identify the father's whereabouts, as well as clarify what his potential role is in the life of his children.

Substance Abuse Issues

- When making assessments, it is recommended that Mental Health collect other collateral information, look at using actuarial assessments for substance abuse, and scrutinize assessments. Being careful of recommendation content sent to other human service agencies by Mental Health agencies will increase the accuracy and validity of the assessment that will assist other human service agencies involved in serving the family.
- More training regarding working with families who have substance abuse issues should be provided for DSS agency employees who provide services. This training should include information about how to intervene with those families.
- The Division of Social Services should explore the development of a standardized procedure, which includes a standardized list of collaterals for substance abuse, domestic violence and sexual abuse that should always be contacted when investigating issues relating to the aforementioned.

Prosecution issues

- Law enforcement and the District Attorney should investigate and consider prosecution of all indecent liberties and statutory rape cases that are reported.
- In several of the fatalities review, the review teams recommended that additional consideration be given by local law enforcement and district attorneys to file charges in the deaths of children.

Parenting Education

- There should be more information on parenting available for father figures.
- Resources should be developed in order to provide families with long term mentoring in parenting.
- There should be greater consistency of outreach to parents who give birth, regardless of whether the parent is in the hospital when the Health Department is making rounds. This outreach to parents who have given birth is especially needed for those parents who did not have pre-natal care.
- The North Carolina Department of Health and Human Services should partner with the Governor's Office of Latino affairs to provide statewide cultural diversity training for all agencies. The Team also requests that NCDHHS make available correct bilingual forms and information around the aspects of parenting. Further, the team requests that the North Carolina General Assembly provide financial resources for these agencies to provide this service as a part of child abuse prevention services meeting federal requirements.
- The local CCPT/CFPT should have a discussion addressing having available a Community Resource Packet and a Welcome Baby Club. The local DSS should implement from that discussion a checklist of information that can be given to families addressing parenting, safety and supervision.

Prevention and Day Care Services

- The General Assembly of North Carolina should allocate adequate funding to the Division of Social Services and County Departments of Social Services for child abuse prevention services.
- The local Community Child Protection Team should explore ways to develop therapeutic preschools and placement possibilities for severely disturbed pre-school children. Smart Start funding and collaborative effort can be explored to serve this population.
- The Baby Love Program, the Woman, Infant and Child Program, and the Maternal Child Case Coordination Program are available to families, but some families are dropped from the programs because of non-participation. These programs are a benefit to any new parents, especially because they talk about appropriate sleeping arrangements for the baby and SIDS, but preliminary reports state that these programs are unfortunately perceived to be for the poor, low-income, and uneducated, which makes them unattractive to anyone to seek the service. The North Carolina Department of Health and Human Services should partner with all counties to re-launch a statewide awareness campaign on the benefits of these programs to all new expecting parents.
- The local CCPT should remind agencies about the prevention aspect of day care provision.

School Issues

- Public schools should be more proactive when it comes to attendance. In addition to attendance being important for school achievement, it is also an indicator relating to the child's health and wellbeing. The local CCPT's should hold discussions with their school systems regarding more aggressive enforcement of existing policies including any legal recourse and to better educate the community about the truancy hotline and school options for ensuring school attendance.
- The State Child Fatality Task Force should look at the correlation of home schooling and protection issues for children.
- While County School Systems are careful about documenting incidents in children's records, some incidents are not recorded. The Department of Public Instruction should explore providing guidance to County School Systems on documenting a critical incident that has occurred with a child that attends one of their schools. This can allow the county school to follow the well being of the child throughout the remainder of the child's primary education. This is important because, while the incident may not affect the child right away, it can affect the child in years to come. If there is no documentation that the incident occurred, no one can help the child, unless the child verbalizes that he/she is suffering from the incident that occurred some time ago.

DSS Supervisory Oversight

- DSS should utilize after-hours workers to monitor supervision of families. DSS management should remind workers and supervisors of the importance of utilizing after hour's workers.
- The local CCPT's should become more of an active resource for the interagency staffing of particularly problematic cases involved with the County Department of Social Services.
- The local CCPT's should review regularly children's cases that are in the custody of the County Department of Social Services as a result of adjudication of delinquency or undisciplined behavior.

- Supervisors of DSS blended teams should ensure that all cases are staffed a minimum of once a month. DSS supervision should include continually evaluating whether new information should be taken as a new report for investigation. DSS should review its agency's mission, goals and the role of supervisors in meeting these goals.
- The local DSS should ensure that a multi-level ongoing accountability and quality improvement plan is in place to assure that CPS protocols are carried out.
- DSS supervisors should look at the quality of collateral contacts to ensure that they get the best information possible in order to ensure the protection of children.
- DSS should adhere to the state standard requiring a case decision within 30 days or provide documentation as to why the decision cannot be made within that time frame. DSS supervisors should ensure compliance with the policy.
- Team meetings should occur anytime that several agencies are involved in the same family. When DSS is involved they should initiate meetings with various agency personnel and establish roles and responsibilities for all the workers involved with the family. This community team should see that the intervention is tailored to the client to include cultural issues. DSS supervisors should ensure team meetings are scheduled as appropriate. Supervisors should consider attending team meetings with inexperienced workers.

Medical Issues

- All group homes should adhere to Mental Health Licensure rules set forth by the Division of Facility Services. Drug administration errors and significant adverse reactions should be reported immediately to a physician or pharmacist. An entry of the medication administered and the drug reaction should be properly recorded in the drug record.
- The Division of Social Services should review and revise the current health component form DSS#5125 to allow space for extensive medical history.
- The county DSS should establish a policy to forward any medical information of the child that was received while the child was in custody to the parent upon return of child to parent.
- The local CCPT should advocate to prescribing physicians, service provider agencies, and medical case management teams in the community about the importance of following medical protocol in conducting medical assessments, including a review of all medications and diagnoses of a patient and the possible side effects on a scheduled basis.
- A letter reporting the concerns found relating to the physician's mental health practice prior to one fatality should be sent to the N. C. Medical Board. The Division of Social Services should initiate discussions with the Society about following up on this matter.
- The Department of Medical Assistance should review eligibility criteria of programs for medically fragile children to consider the needs of the child and the family regardless of birth order.
- All health workers should be educated about how to identify the risk factors and the importance of a complete medical history in the identification of risk during prenatal care. Health Departments and community health clinics should ensure that prenatal care includes information to be obtained and given regarding health risks to unborn children, particularly when health issues and substance abuse may significantly affect birth outcomes.

Use of Collateral Contacts

- Close attention should be paid to determining who might be able to provide objective information in which to verify parental reports.
- The county DSS should increase their usage of collateral contacts in order to conduct a complete CPS investigation.
- Where there are substance abuse allegations, family members are often in denial and the use of collaterals should go beyond the minimal requirements and outside the family to thoroughly assess risk to children.

Domestic Violence Issues

- The local CCPT should advocate with the local Administration of Courts to explore having domestic violence staff available at the magistrate's office at all times to ensure victims are provided with information and support initially through the process.

Crisis Debriefing

- Crisis debriefing to first responders should continue to be offered.
- A protocol should be established for first responders to offer information regarding services for survivors of catastrophic events.
- It is recognized that family members suffer from grief when there has been a child fatality. The county DSS should assist with arranging grief and family counseling for all appropriate family members following a fatality.

Undocumented Children

- The North Carolina General Assembly, Department of Health and Human Services, and the regional office of the United States Department of Immigration and Naturalization Services should provide clear guidance on how to provide services to undocumented children.

Appendix B

Appendix B reflects some of the achievements reported by local communities that resulted from recommendations from State Child Fatality Reviews.

- Cumberland County's CCPT applied for a grant to initiate a parenting program within the community specifically geared to fathers, with the goal of having fathers function as mentors to other fathers and to participate directly in the training. Also, Cumberland County's Partnership for Children (Smart Start) has successfully provided for speech and developmental screenings of 3,400 children this year. They have provided subsidized day care for 4,700 children. These increase efforts are the result of findings and recommendations from fatality reviews related to assisting single parents with safe, quality day care as better choices for their children.

  According to City and County law enforcement representatives, there has been an increase in consultation with trained juvenile officers in Cumberland County when there is a child fatality in order to determine better whether abuse or neglect may have contributed to the death.

  Through the Families Helping Families initiative of DSS and the System of Care initiative of child mental health, there is an increased emphasis on collapsing meetings together and consolidating mandates from different agencies to avoid attendance at multiple meetings. When possible, these efforts are coordinated with the school meetings that may be occurring. School personnel are invited to other meetings as appropriate.

  The Cumberland County Health Department coordinated a Press Conference this year with participation from the chair of the CCPT/CFPT on the "Back to Sleep" campaign.

- The Forsyth County CCPT partnered with the "Que Pasa" newspaper to begin publishing state, county and city laws in Spanish, along with services and programs offered in the community. This project was so successful that a local Spanish speaking radio station has partnered with a police officer and others from the CCPT to answer similar questions for the station's listeners.

- In Cleveland County, the result of a fatality review there has meant increased community awareness of the issues, related risk factors, and potential consequences when adolescents are involved sexually with older adults. Various agencies are working together to develop protocols and procedures to deal with these cases in an effort to prevent future tragedies.

- In Guilford County, the CCPT chair and a DSS representative met with the Chief District Court Judge to discuss the role of the CCPT and some of the court-related issues that the CCPT has identified through their involvement in fatality reviews. There is a plan to have a follow-up meeting with all of the judges in the district. Guilford County DSS is one of the 10 counties piloting the Multiple Response System (MRS). The agency firmly believes that this pilot and ultimately the full implementation of MRS will contribute to better child protective services for families and to safer outcomes for children. MRS has been recommended by numerous fatality review teams over the past couple of years.

- A task force in Scotland County has been identified to develop and implement protocols and training for agencies to work more collaboratively together in protecting children.

- Onslow County has developed policy and protocol related to closing cases for CPS Case Planning and Case Management only when children are not only in a safe home, but when there is legal security for them in that home. Their policy and protocol have become a model for other counties when allowing parents to place their children voluntarily with a family member or kinship arrangement without DSS assuming custody.

- The Buncombe County CCPT noted that Critical Stress Debriefings are available to professionals responsible for handling child death scene investigations. The team plans to invite a member of the Critical Incident Stress Debriefing team to attend one of their meetings for the purpose of raising awareness of this resource and increasing the use of the resource.

- The Mecklenburg County Community Child Fatality Prevention and Protection Team members held an all-day retreat focusing on the findings and recommendations from fatality reviews in their county. The group identified specific action plans for each of the issues identified from these reviews.

- The Wayne County DSS has recently served all families on the waiting list of child daycare services. Requests for daycare are now being processed immediately. There are daycare centers in Wayne County, which provide care during non-traditional hours, and this information is shared with parents. When parents apply for daycare services at the DSS, they are given information regarding choosing appropriate caregivers for their children. Wayne County First Steps also assists in this area by providing information to new parents at the hospital.

  Wayne County First Steps has recently formed a subcommittee to address child abuse and neglect issues, and the chairperson of this committee has been appointed to serve on the CCPT. This will allow Wayne County First Steps to be involved in addressing needs in the county such as parenting education for extended family members. Wayne County First Steps and pediatricians at the local hospital are also providing information about SIDS to parents.

  Employees in Wayne County agencies have been made aware of resources in the county providing grief counseling and available support groups.

  The Wayne County CCPT has approached Goldsboro Pediatrics regarding the possibility of its associates being certified as Medical Examiners and responding in the event of a death of a child. The group is willing to do this and they are in the process of adopting a written protocol.