DSS Directors

State Child Fatality Review Status Report

Debra McHenry
NC DHHS DSS

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June 2017 Point in Time Numbers

• In June 2018, an audit of the last 5 years identified 125 outstanding fatalities
• The backlog dates ranged from 2012 to 2017
• Counties had a range of 1 to 7 reviews needing completion
Where We Are Today

• 13 Backlog reviews to be completed by the end of June
• 2 that came of DA hold in the process of being scheduled
• 22 current year reviews are scheduled
• 24 are on DA hold
FY 2015 – 2017 Data

Unsafe sleep accounted 30% of our fatalities being reviewed

Homicide accounted for another 22%

Suicides were the next largest category with 18%

27% cases reviewed were open for assessment at the time of the death

41% were open for assessment or services at the time of death
Common Risk Factors

Unsafe Sleep

• Substance abuse: 10 of 15 deaths involved the infant tested positive at birth
• Mom had delayed or NO prenatal care
  • Substance abuse combined with mental illness

Homicide

• Substance abuse
• Substance abuse combined with mental illness
• Child had prior history of maltreatment
• Untreated mental health issues of caregivers
• Domestic violence in relationships
• Multiple CPS Reports