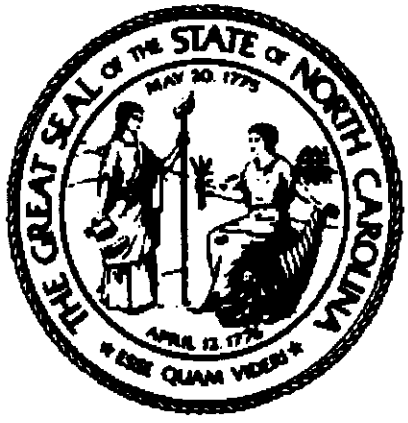
North Carolina
State Child Fatality Review Report
SFY 10-11
G.S. 143B-150.20



North Carolina Department of Health and Human Services
Division of Social Services
Child Welfare Services Section

2011

Report to the General Assembly
From the State Fatality Review Team

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State Child Fatality Review Report for SFY 10-11
Executive Summary

The Department of Health and Human Services, Division of Social Services, pursuant to N.C.G.S. 143B-150-20, is charged with the responsibility of convening 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 twelve 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 to 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." For each child fatality review, a State Child Fatality Review Team is convened. By statute, each Team must include representatives from the Division of Social Services and the local Department of Social Services, a representative from the local Community Child Protection Team (CCPT), a representative from the local Child Fatality Prevention Team (CFPT), a representative from local law enforcement, a medical professional and a prevention specialist.

The fatality review is an intensive one that typically spans two full days. The process includes interviews with selected individuals who have knowledge of the child and his/her family and a review of case records from the local departments of social services along with records from community agencies and service providers that had contact with the child and his/her family. The review focuses attention not just on activities of the local department of social services, but on the role and involvement of the broader community in protecting children. At the conclusion of each review, a formal report is issued which includes findings and recommendations from the State Child Fatality Review Team. The report may be presented in a public meeting of the Community Child Protection Team, and the written report is available to the public upon request. The Community Child Protection Team is expected to review the recommendations and develop strategies to address pertinent issues within local control. Following the issuance of each report, staff from the Division of Social Services presents 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 State Fiscal Year 2010-11, a total of 120 deaths were reported to the Division of Social Services. Of those reports, the Division of Social Services identified 16 that met the criteria for an Intensive State Child Fatality Review and will be scheduled for an intensive review. Information was requested from departments of social services or the Office of the Chief Medical Examiner regarding 21 other reports that were received to determine if they meet the criteria to conduct an intensive review.

Reviews and final reports are not necessarily completed during the state fiscal year in which the fatality occurs. During SFY 2010-11, 24 final fatality review reports were issued following completion of the reviews. Fifteen reports are in various pre-release stages of review. In addition, 6 fatality reports are finalized but have not yet been released due to criminal investigations or prosecutions. At the end of SFY 2010-11, there were a total of 64 fatalities that were awaiting reviews.

In the reports released during SFY 2010-11, the review teams identified eight major themes, and recommendations are included in the full report below.

A. Interagency Collaboration

Communication among providers to address the needs of children and families was found to be challenging in several cases. One highlighted example was the relationship between county departments of social services and child placing agencies and facilities in which the county departments are charged with investigating allegations of child abuse and neglect. County departments of social services receive and investigate reports of maltreatment, and make recommendations for ameliorating those conditions that led to the maltreatment. However, it is beyond their scope to ensure action is taken on the recommendations by the agency or facility. Gaps were also identified in the inspection of facilities, which evaluate sleeping quarters, but not the facilities where the children are in day treatment, school, and other activities during the daytime hours.

A second challenging area was coordination of services through participation by community providers in child and family team meetings, a cornerstone of the North Carolina child welfare system. They are designed to bring all persons and agencies involved with a family together for planning. Active participation results in a free flow of information between providers and families to assure coordinated, applicable services. The challenge is assuring the team meetings occur with all essential professionals involved.

B. Medical Professionals and Facilities

The child fatality review teams identified several areas in which changes in procedures could improve outcomes for children. These include consistent instruction to new parents regarding safe sleeping; screening to identify possible domestic violence victims; thorough documentation of non-accidental injuries to children; collaboration on treatment between emergency department physicians and the patient's primary care physician; access and review of medical history prior to treatment; and, reconciling findings from the Office of Chief Medical Examiner when the cause of death seems to contradict the law enforcement investigative findings.

C. Community Education on Reporting Child Abuse and Neglect

Teams identified the need to increase community awareness of when and where to report suspected child abuse and neglect. In too many instances, professionals and persons in the community were aware of risks to children and did not report it. Instead, they came forward after a catastrophe. Reports contained recommendations from the Teams to address this need.

D. Community Education Regarding Child Safety

Additional community education efforts were recommended in regard to the safety risks for children. Several areas needing such efforts include safe sleeping and co-sleeping practices, securing residential pools, child safety around water, and safe bathing practices.

E. Training for Community Professionals

Several reports included recommendations to develop a dialog among community professionals to cultivate a deeper understanding of the needs and situations facing children and families involved with their services or systems. Among professionals, there was an observed insufficiency of awareness and recognition of specific issues such as the effects of trauma on children, mental health needs, domestic violence, substance abuse, clear documentation of non-accidental trauma, and the misuse of prescription drugs.

F. Lack of Appropriate Community Resources and Services

Although concerns regarding children and their families were assessed and needs were identified, the adequacy of services to address those needs was a theme that appeared frequently. Challenges included the availability, capacity, and access to local domestic violence programs, and other mental health services, along with communication among providers, and the absence of insurance when seeking treatment services.

G. Responses to Substance Abuse

Substance abuse was often identified as a major factor during the reviews. Concerns included: early identification and reporting of children who are at risk due to substance abusing parents; continuity of care for substance abusers between in-patient and out-patient follow up services; and, the maintenance and use of the NC Controlled Substance Reporting System.

H. Child Welfare Policy and Best Practice Issues

Review teams identified the need for improved adherence to best practice and fidelity to policy developed by the North Carolina Division of Social Services in child protective services cases. Recommendations from reports discussed supervision and training to strengthen the performance of departments of social services to consistently meet their statutory obligations in child protection.

Current Initiatives

The North Carolina Division of Social Services is currently pursuing several innovations and initiatives that will impact some of the overarching themes identified in the individual reviews. These include improvements to the process of collaboration between the state Division of Social Services and the individual local county departments of social services as they work to implement child welfare policies consistently across North Carolina. The Division of Social Services continues to explore and encourage expanded use of technology and data to inform practice and ensure improved communication, especially in training and technical assistance. These initiatives and other recommendations are expanded upon in the full report below.

State Child Fatality Review Team
SFY 2010-2011 Annual Report

Pursuant to G.S. 143B-150.20, the following is the State Child Fatality Review Team annual report to the N.C. General Assembly for SFY 2010-11. This report includes a summary of findings and recommendations from the child fatality reviews conducted by the State Child Fatality Review Teams during SFY 2010-11. These teams conduct multidisciplinary reviews when there is suspicion that parental neglect or abuse contributed to a child's death and the local departments of social services Children's Services Program was involved with the child or family at any time during the twelve months prior to the child's death.

I. History

In 1997, the General Assembly enacted G.S. 143B-150.20 which established the State Child Fatality Review Team to conduct in-depth reviews of any child fatalities that occurred in families involved with local Departments of Social Services Child Protective Services in the 12 months preceding the fatality. The purpose of the Reviews was not to investigate the fatality, but draw from the community's collective experiences to identify new or improved ways to enhance the community's response to child safety and well being.

The collaborative, multi-disciplinary approach to these reviews ensures a broad perspective in exploring opportunities to improve services and provide community education. The entire community must be involved in the efforts to prevent future child deaths.

Local participation in the deliberations of State Child Fatality Review Teams assures community ownership of the recommendations along with a commitment to act on those recommendations. The Division of Social Services will review progress towards addressing the recommendations and offer technical assistance when needed.

I. Review Process

The review process is a multi step process involving many individuals and groups.

A. 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).

B. Within 5 days of receiving information regarding a child death, county departments of social services must report to the Division of Social Services information that they possess regarding the child fatality.

C. The Division of Social Services reviews the report and any other relevant information to determine whether the fatality report meets the criteria to convene a State Child Fatality Review Team for an intensive review.

D. One of the Division of Social Services' Child Fatality Reviewers meets with the local Community Child Protection Team to outline the review process, assist in the selection of the Team, and discuss the logistics for obtaining all necessary records for the review.

E. A State Fatality Review Team is convened. The Team must include representatives from the Division of Social Services and the local Department of Social Services, a representative from the local Community Child Protection Team, a representative from the local Child Fatality Prevention Team, a representative from local law enforcement, a medical professional and a prevention specialist.

F. The Intensive Child Fatality Review includes reviews of case records from the county Department of Social Services along with those from other agencies that provided services to the child and family. As part of the Review, the Team will interview selected individuals who were involved with providing services, or who are able to provide information helpful in developing recommendations. The review process focuses attention on the role and involvement of the whole community in protecting children.

G. The Team develops findings and recommendations for system improvement and the Division of Social Services' Child Fatality Reviewer drafts the initial report.

H. A written report is finalized by the team and becomes available to the general public upon request.

I. The Team may present the final report in a public meeting of the Community Child Protection Team to develop a plan to implement recommendations for system improvement within the local community.

J. Division of Social Services staff present recommendations that have statewide impact to the State Child Fatality Prevention Team to identify the most appropriate state level entity to follow up on each recommendation.

K. Recommendations designated for addressing at the local level are reviewed by the Child Welfare Services Section Management Team for opportunities to provide technical assistance to local departments of social services toward improving service delivery to children and families.

II. Facts Regarding State Child Fatality Review Process

There are two primary requirements that must be met in order for a report of a child death to meet the criteria for an intensive child fatality review. These are:

1) the child and/or family must have been involved with a local Department of Social Services Child Protective Services in the 12 months preceding the fatality; and,

2) a determination by the Division of Social Services that there is a suspicion that parental or caretaker abuse or neglect was a contributing factor in the fatality.

During SFY 10-11, the Division of Social Services received 120 reports from local county departments of social services with information on child fatalities. After reviewing the information provided, along with other pertinent information, 16 child fatality reports met the criteria for an intensive State Child Fatality Review. The Fatality Reviewers are awaiting additional information such as autopsies and investigative reports regarding 21 reports to determine if a review will be conducted. This extends the time for making decisions on some reports since availability of this information is dependent upon the complexity of the circumstances surrounding the fatality.

Of the 16 reports that met the criteria for an intensive review and were accepted in SFY 2010-11:

- 2 instances in which co-sleeping is suspected;
- 2 cases in which abuse was suspected, both resulting in criminal charges;
- 1 case was suspected to involve Sudden Infant Death Syndrome (SIDS);
- 1 homicide, resulting in criminal charges;
- 1 from accidental strangulation;
- 6 cases in which children drowned, 1 resulting in criminal proceedings;
- 3 cases in which the cause of death was unknown/undetermined.

There are some situations in which criminal charges are filed at a later time as law enforcement agencies continue their investigations into the fatalities.

Finalizing a fatality report involves negotiations between members of the state team and legal staff to assure the reports meet the requirements established by General Statute. Before the final release of a report, the local District Attorney must be consulted according to General Statute 7B-2902 (d). Although the results of the Review cannot be used in any civil or criminal litigation, if the District Attorney believes that information contained in the report may compromise the criminal prosecution or jeopardize the defendant's ability to have a fair trial, he or she will request that the report not be released until conclusion of the criminal proceedings. Due to the length of time involved with prosecuting charged individuals, a substantial period of time may pass before a report can be released. There are currently 6 final reports from completed reviews that are being held at the request of district attorneys due to criminal proceedings.

The Division of Social Services has two Child Fatality Reviewers that schedule entrance conferences, facilitate the child fatality reviews, and construct the final reports. The Reviewers, along with other Division of Social Services staff, provide consultation and technical assistance to counties when necessary to act on recommendations generated during the Review process. During SFY 2010-11, both Child Fatality Reviewer positions were filled and progress was made toward decreasing the backlog of final reports needing release and reviews needing to be conducted. Twenty four final reports were released during SFY 2010-11 regarding fatality reviews that were reported to the Division of Social Services in previous fiscal years, a three fold increase over the number released in SFY 2009-10. There were 64 reviews scheduled or waiting to be scheduled at the end of the fiscal year

Over the years, a concern has arisen about keeping reviews and subsequent reports current and relevant. There is a benefit in allowing some time to elapse in order for the community to recover from the initial collective trauma that the fatality of a child can produce so members of the team can be reflective rather than reactive during their deliberations. However, because the highly stressful Child Fatality Reviewer positions have historically "turned over" about every two years, this cycle, with its attendant difficulties with recruitment and need for introductory training has contributed to an extension of the time between the date of the fatality and the date of the release of the report. When a Reviewer position becomes vacant, it not only impacts the number of reviews that can be conducted, but adversely impacts the timing in reviews that were already completed, but the reports have not yet been finalized and released. A new Reviewer who is filling a position that has been vacant must dedicate a larger investment of time in order to preserve the continuity and integrity of the interrupted process and to assure the concerns of the team who did the review are adequately addressed. The greater the delay, the greater chance there is that the relevancy of the findings and recommendations could be compromised.

Progress has been made in addressing the backlog since both of the Child Fatality Reviewer positions have been filled, but an unfortunate collateral result of choosing to focus on the backlog has been an increase in the time before a current reported child fatality can be scheduled for an intensive review.

Delays have also been caused and extended within the past year because the State Child Fatality Reviewers and the Teams have encountered increasing difficulty in securing records from all sources. Medical records are sometimes difficult to secure due the Health Insurance Portability and Accountability Act (HIPAA) and education records are protected by the Individuals with Disabilities Education Act (IDEA). Substance abuse records are difficult to secure due to confidentiality afforded by federal rules and regulations. Law enforcement findings cannot be secured due to their objections that it could jeopardize criminal proceedings. Teams have at times proceeded with a review, using available records, but concluded that there was additional information that would have added context, insight, and additional facts to their deliberations. The state review team has not sought court relief to secure the release of such records that are already permitted to be released for these reviews under state statutes. However, in the face of increasing resistance to releasing required and crucial records, court action is being seriously considered in order to achieve and preserve the integrity of the child fatality reviews to keep them timely and relevant after the death of a child.

This past year has seen a tragic series of high profile child fatalities in North Carolina. The relationship between the reviews and criminal prosecutions has become preeminent. The General Statutes are clear that the child fatality reviews are intended to seek ways to improve the child protection system in communities and the state. The reviews are not intended to indict or find fault, nor can the information from the review be used in any civil or criminal proceeding. When system deficiencies are identified, the team also develops remedial recommendations that are intended to be addressed by local community child protection teams to improve services and decrease the risk of another

fatality from that cause. The findings and recommendations by the Team cannot be used in any civil or criminal proceedings. Despite this, it has been common for law enforcement agencies and district attorneys to request that a review be delayed and/or decline to provide information for or participate in the reviews until the criminal investigations or proceedings are completed. This can sometimes take years. The Division of Social Services is examining current approaches and procedures to better ensure timely reviews that result in actionable recommendations for the system without jeopardizing criminal proceedings.

III. Fatality Reviews and Major Themes for SFY 10-11

As reports are finalized and released, common themes and issues emerge that have statewide implications. This report examines those emerging themes and issues to identify possible actions to better align services in the state with a goal of improved outcomes or achievements for children and families. Some findings in individual reports do not lend themselves to these broader applications since they are very case or community specific.

Each final report from a Child Fatality Review makes it clear that it cannot be known, what, if any, impact the recommendations could have had on the reviewed case if they had been in place at the time of the fatality. The objective is, instead, to identify any and all opportunities to improve the child welfare system for protection of children and services to families in the future.

Of the 24 reports on 26 children that were released during the year, the causes of death were identified as:

- 6 from physical abuse
- 3 from neglect, 1 resulting was a sibling pair
- 4 from drowning
- 2 from a co-sleeping situation with accidental overlay or suffocation
- 3 homicide deaths
- 4 ruled as SIDS
- 2 suicide
- 2 siblings died in a residential fire

The eight major themes identified in the child fatality reports released during SFY 10-11 are summarized below. By identifying these themes and specific issues and recommendations, the expectation is that the Division of Social Services, the local departments of social services, and other state and county agencies will look for opportunities to make systemic improvements focused on the safety of children.

A. Interagency Collaboration

The old adage that "everybody needs to be reading from the same page" applies when there are multiple entities working with children or a family. Interagency collaboration is essential to keep the family from becoming confused and to hold them accountable for the safety and well-being of their children. There are two areas identified in this theme.

In the first area, county departments of social services are charged with the responsibility for assessing allegations of abuse and neglect in residential child placing facilities, but their authority only extends to assessing allegations and making recommendations to the agency or facility. Unlike those assessments involving families, the departments have no oversight in the implementation of the recommendations. This is the domain of the Division of Health Service Regulation. Child placing agencies and facilities develop their policies and procedures in accordance with the requirements enforced by those regulatory agencies. Several Teams recommended closer coordination between the departments of social services, child placing agencies and facilities, and other regulatory agencies to ensure that any recommendations developed as the result of an assessment into allegations of abuse or neglect in a residential child placing facility are incorporated in the policies and procedures of the agencies and facilities.

It was discovered in one review that the Division of Health Service Regulation is responsible for monitoring residential child placing facilities for compliance with building safety codes and regulations. However that Division's monitoring authority relates only to children's sleeping quarters. There is no identified policy to monitor the building safety codes and regulations within other areas of the facilities in day treatment, educational, and recreational areas where children spend much of their waking hours to assure they do not pose a threat to the overall safety of children. The Team recommended that the oversight of facilities extend beyond just sleeping quarters to safety and security plans in all areas to which children have access.

The second area concerned interagency collaboration in individual case planning and management. The use of child and family teams as part of the collaborative, pro-active development of case plans is a cornerstone of policy and best practice for child welfare services in the Division of Social Services and local departments of social services.

Active participation in these child and family team meetings by representatives from local agencies and community professionals who are involved with families receiving child protective services is critical. All involved agencies and professionals need to be engaged with the family as their case plan is developed in order to ensure that services to families are appropriate and necessary. This venue permits communication to flow continuously between agencies, professionals, and the family, and to ensure that all team members have a common understanding of the goals and requirements on the case plan. Several Teams indicated that a lack of participation in child and family team meetings, or the failure to hold the meetings, was a significant impediment to the free flow and full disclosure of critical case information. Discussions about strategies to encourage greater participation continue at the local level.

B. Medical Professionals and Facilities

As with all professionals who have a relationship with a family, medical professionals have a crucial role in abusive and neglectful situations. The local departments of social services depend heavily upon the opinions of medical staff in regards to direction for child welfare

services. County departments of social services rely on the information from medical professionals when making case decisions regarding allegations of child abuse and neglect, and as part of safety and case planning for children. Effective utilization and management of patient records is necessary for all medical facilities and providers to ensure that consistent documentation accurately details a patient's medical history and documents any concerns that could provide indicators of risk and safety concerns for children and families.

Some of the issues that are being addressed at the local level which may have some ramifications on a broader level include:

1. Medical professionals in emergency departments need to ask questions to probe for the presence of domestic violence if suspected;
2. Oversight of discharge instructions regarding safe sleeping for infants is needed, so that language is very clear. For instance, be sure it states "crib" or "bassinet" rather than "position the baby in the bed" which could lead parents to believe any bed is acceptable.
3. In one case, hospital staff suspected possible non-accidental trauma in reference to an injury seen on a child in the Emergency Department, but that suspicion was not documented.
4. In one instance, a Team was concerned that the findings of the law enforcement investigation and the findings of the Office of the Chief Medical Examiner upon autopsy of the child did not align. The cause of death was determined by the Medical Examiner to be "SIDS/natural" but the findings of the law enforcement investigation related to the positioning of the child did not support that determination.
5. Some cases revealed that medical providers did not thoroughly evaluate a patient's past medical history and did not consult with past or current providers when treating or seeing a patient;
6. Primary care physicians or pediatricians were not being notified that a patient was seen in the emergency department;
7. A child's medical chart concerning the assessment and plan of care was incomplete;
8. Emergency departments need to require physicians to seek medical history when child abuse or neglect is suspected.

C. Community Education on Reporting Child Abuse and Neglect

The absence of information reported about suspected child abuse or neglect was a predominant issue identified in reports released in SFY 2010-11. Persons failing to report suspicions included doctors, hospitals, law enforcement, family, community professionals and service providers, and the general public.

North Carolina General Statute §7B-301 states "Any person or institution who has cause to suspect that any juvenile is abused, neglected, or dependent, as defined by G.S. §7B-101, or has died as the 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." Lack of adherence to this existing law continues to plague the child protection system.

One recommendation involved the local department of social services providing instruction regarding the child protective services intake process for law enforcement to take the mystery out of the process and create awareness of the information needed.

The respective teams recommended community education projects to insure that the community, especially professionals, were aware of the reporting laws. Most recommended that the local Community Child Protection Team coordinate the efforts. Several Teams also identified the efforts of Prevent Child Abuse, North Carolina in this area as a potential source of expanded community education.

D. Community Education Regarding Child Safety

Co-sleeping infants and adults has been an issue in previous years and appeared in two cases this year. There is a wide range of opinions among professionals and communities regarding co-sleeping. Regardless of the variety of beliefs, it is clear in reports that use of drugs, legal and illegal, by the parent or caretaker substantially increases the risk of accidental rollovers when co-sleeping. It was recommended that information be made available on co-sleeping, and that a plan for distributing this information to mothers and fathers be implemented under the leadership of the Community Child Protection Teams. Because drugs played such a prominent role, it is recommended that community education emphasize information that use of drugs, legal and illegal, can substantially increase the risk of accidental rollovers when co-sleeping.

A need was identified for education of the public around safe practices for the bathing of infants and young children. It was noted that the bath water was too hot and not checked by the child's caretaker before submerging the child into the water. It was also noted that children are being left unsupervised with other small children or completely alone when given a bath.

There were several recommendations regarding education about pool safety combined with recommendation for ordinances to make residential pools more secure. It was determined that above ground residential swimming pools are not included in local safety regulations and requirements aimed at preventing a child's unauthorized access to a residential swimming pool. Teams recommended that residential swimming pools be secured and proposed an annual event to publically promote pool safety. It was also recommended that local ordinances need to require barriers around pools, including above ground pools, to restrict unauthorized access to them, as well as providing guidelines on the distance of the pool entrance from the home. The installation of audible alarms would assure a rapid response if there is unauthorized access.

The Community Child Protection Teams most often decided to spearhead these community education efforts as a project, especially among community professionals.

Since the composition of each Community Child Protection Team includes many of these community professionals, or persons having regular contact with them, it is an appropriate starting point for communities to take on the task of assuring community members recognize child safety issues and are of one accord.

E. Training for Community Professionals

There were a substantial number of recommendations focused on the need for increasing education opportunities for community professional development on a variety of topics. These included:

1. Equipping foster parents to recognize and respond to the increased potential for child depression, especially during permanency decisions for children;
2. Offering training for social workers at various stages of their employment regarding domestic violence, the impact of substance abuse on families, safe sleeping practices and co-sleeping, how to assess risk and safety at all stages of child protection services, the medical aspects of child maltreatment, safe bathing practices, as well as training social workers to educate community members and professionals regarding the duty to report suspected child abuse, neglect or dependency;
3. Better education for families from mental health agencies on accessing care, recognizing mental health needs, and coping strategies.
4. Training for community professionals about serious injuries to children 5 years of age and under, and when to suspect non-accidental trauma.

Foster and adoptive parents are a beacon of hope for many children who are placed in the department of social services' custody. All children who come into the custody and placement authority of the county agency must be placed in a state licensed foster home, an appropriate licensed facility, or other placement specifically approved by the court. Foster parents need agency support. Ongoing training for foster and adoptive parents is necessary for them to understand the vital role they play in the lives of children. This includes education about how the decision they make regarding permanence through adoption can impact that child's life. When a foster family expresses ambivalence about permanence for the child in their home, this can lead to depression that can be life threatening for the child.

Community professionals' ability to recognize, understand, and appropriately respond to domestic violence is vital to ensuring children and adult victims are safe. Knowing when to intercede and how to safely navigate through the complexity of the family dynamics is a challenge for many professionals. Training for community professionals was identified as a significant need. Cross agency training would most benefit children and families.

In addition to domestic violence, instruction on mental health issues and understanding injuries to young children were also cited as needs. The development of a consensus among community professionals in identifying and treating these conditions will lead to greater recognition and better coordination of services for children and families.

F. Lack of Appropriate Community Resources and Services

During the reviews, Teams identified a lack of community resources in several areas that make it very difficult to link families to necessary services in their immediate area.

Although services for victims of domestic violence and their children can be found across the state, the adequacy of those services was a concern. There is an identified need to assist professionals in understanding and screening for domestic violence. This area has been adversely impacted by a lack of awareness of the problem in their community. Increased community education by the domestic violence programs could address this concern.

Additional concerns related to domestic violence include availability of and barriers to accessing shelter services by adult victims and their children. Some programs have waiting lists for entering the shelters. Some adult victims have experienced a barrier to accessing the shelter services due to the policies around housing male children of certain ages with their parent, typically their mother. A view towards developing alternate services or actions in these situations was encouraged.

Mental health services are lacking in certain parts of the state and are fragmented in others. Some counties found they have no reliable resources for outpatient mental health counseling and social workers and families must look for services in other counties, adding transportation as another barrier. Inpatient services for teens, especially special populations such as pregnant teens who have been approved for level IV residential psychiatric facilities, are not available at all despite mental health qualifying and authorizing the child for those services. Recommendations included a further examination of need and availability of services approved for children and families and the distribution of the resources to meet them.

In one case, it was found that there were sufficient service resources, but the process for transferring patients from one provider to another hindered the timing of services for the child. In another instance, there was a significant lapse in time before a substance abusing mother could receive recommended after care services upon release from an inpatient facility. In a third, a lack of communication between a psychiatrist and a therapist led to difficulties in assuring adequate treatment for the patient. In another instance, a parent was court ordered to receive treatment and the providers were not aware of this involvement, which could have opened additional treatment options. It was recommended that the Local Management Entity review the processes for ensuring the timely transmission of information between providers to ensure a continuity of care for their patients.

Insurance coverage remains a concern identified in Intensive Child fatality reviews. Indigent clients without Medicaid or insurance coverage face significant barriers to receiving any services from providers. It was found that families cannot afford private medical insurance but cannot access Medicaid because their income exceeds income eligibility requirements. Even when private insurance is secured, private companies place

significant restrictions on treatment, especially mental health treatment. Families were observed to be reluctant to call their regularly used private providers, or in urgent situations use urgent care centers or local emergency departments due to failure to pay previous bills or fear that they will not be seen without health coverage. By the time treatment is sought, the conditions have worsened and the response may need to be more intensive. This issue rose to prominence in one review, but discussions regarding the means needed to access services was a reoccurring theme, especially for parents with mental health and/or substance abuse issues.

G. Responses to Substance Abuse

Professional awareness of the correlation between suspected substance abuse by a parent or caregiver and the potential for child abuse or neglect was identified as a concern for Teams, especially the need to report these suspicions. In their deliberations they identified a need to increase the effective recognizing and reporting of substance abuse when others, especially children, are placed at risk. These community conversations could be facilitated by the local Community Child Protection Teams since many of these professionals are already involved with the Protection Teams. It was also recommended that Community Child Protection Teams look toward educating the general public about recognizing and responding to substance abuse, especially prescription drugs, which could result in early recognition of problems. Of special concern is ensuring parents are aware of these issues to increase their ability to not choose substance abusers as child care providers. Substance abuse treatment should involve a continuity of care beginning with admission to inpatient care and continuing care in the community following discharge. During one review, information from the community referral source that was not provided to the treatment center could have been useful in better supporting a mother. This information could have impacted the extent to which the mother received services while in treatment to address the cycle of domestic violence, as well as supporting the mother upon her return to the community, with activities such as verification of the mother's compliance with her discharge plan upon her release, and comprehensive services to prevent relapse. One team also noted that there is a lack of inpatient substance abuse treatment facilities in western North Carolina as well as a lack of qualified outpatient substance abuse providers.

In one review, there were substantial deliberations on the use of the North Carolina Controlled Substances Reporting System (CSRS) as a tool to prevent prescription drug abuse. Questions were raised as to whether physicians were entering information into the System, and whether it was being checked before writing prescriptions for certain drugs. Because of what appeared to be the lack of use of the System, prescription drug abusers were able to slip through the cracks by visiting hospital emergency rooms in other counties, and engaging in doctor hopping behavior. Effective use and management of the CSRS could significantly reduce the success of drug seeking behaviors that can place children at risk. There was also a concerning incident where a pharmacist returned a prescription back to the person trying to fill it, even after the pharmacist verified that the prescription had in fact been altered. The pharmacist called the doctor to verify the amount but failed to note the forgery in the System or contact the local law enforcement agency to respond. It was recommended that there be increased education about

appropriate use of the CSRS by medical and pharmaceutical providers, and that a protocol be developed for dealing with forged prescriptions. The statute allows for access to the System for medical personnel and law enforcement, but does not provide access by departments of social services when child protective services are involved. It was recommended by one Team that access would have facilitated the identification of the prescription substance abuse sooner than they were able through other means.

H. Child Welfare Policy and Best Practice Issues

Inconsistent compliance with established policy and best practice within county departments of social services was a finding in many of the State Child fatality reviews across North Carolina during SFY 2010-11. Some of the reasons for this inconsistent compliance included inexperienced staff, inappropriate use of structured decision making tools, lack of follow up to ensure services were appropriately meeting the needs for families, failure to ascertain resources available to aid in making an accurate and thorough case decision, caseloads that exceeded state standards, staff turnover, and miscommunication between counties. This resulted in increased safety risk to children and their families. Adherence by staff to policy and best practice was more the issue than was the content of the policy provided. Developing and maintaining the processes and procedures to ensure compliance was a challenge identified in many of the reviews. Workloads at the time of the fatality were an issue. Staffing patterns and social worker experience was an issue. Policy provides a framework, but experience provides the basis for implementing best child welfare practice and assuring adherence to policy in child welfare. Adequate performance of the activities prescribed in policy involves timing and skill. Specifically, the identified issues or needs included:

1. Appropriate application of community resources and fully engaging community professionals in service plans and planning;
2. Conducting child and family team meetings for case planning and uncovering family resources;
3. Maintaining sufficient contact with children, their families, and community professionals to accurately assess the child's level of risk;
4. Timely transfer of information from after hours staff to day shift staff, which has been found to be critical to prevent delays in follow up with the child and family;
5. Case documentation was not thorough and complete;
6. Allegations received initially or throughout the case were not thoroughly addressed or assessed in regards to child safety and wellbeing;
7. Filing a petition to bring a case to court should be considered when risk to a child was determined to be high;
8. Supervisor consultations with social workers need to be consistent, and documented in the case record;
9. Requesting records from and consulting with other counties that had involvement with families is critical. A statewide case management system such as NCFAST was cited as a resource that could alleviate many inter-country issues.
10. Appropriate use and interpretation of standardized assessment tools provided by the Division of Social Services to guide service planning to reduce risk to children;
11. Conducting and documenting assessments on kinship care resources for children and follow up to assure compliance with expectations;

12. Reviewing all available child welfare history.

The development of internal procedures within departments of social services regarding new reports on open cases to assure all allegations are assessed was an issue identified in reviews. In some counties, there was an assumption that any additional allegations or new information could be handled by the assigned social worker. However, it was the conclusion of Teams that bringing in another social worker to assess a situation where there were additional allegations could result in improved services to assure the safety and well being of the child.

Establishing protocols for ensuring that policy and best practices are consistently adhered to is a daunting challenge, especially in larger counties. Using "checklists" to record that activities are completed runs the risk of putting process over the quality of the activities. It is a challenge to find the proper balance to maintain focus on child protection and the well-being of the families that are caring for them while maintaining thorough and adequate documentation for the case.

Child Welfare Supervisors in departments of social services are the key professionals in establishing and maintaining the balance between overseeing compliance with the process and guiding the quality of the services. The application of each department's resources is guided at the supervisor level. Supervisors are the role models for social workers and are typically responsible for training new social workers and evaluating performance. Providing guidance and direction to assist supervisors in coaching social workers through setting priorities, using tools correctly and maintaining quality contacts with families and professionals was considered a critical factor in effective child protective services interventions. Additional time and resources need to be designated to supporting supervisors' professional development at the local and state level in order to move each supervisor's practice towards more effective leadership and increased accountability. It was also recommended that new supervisors have mentors so they can have opportunities to observe the modeling of strong supervision. This would serve as a guide for them as they develop as supervisors of child welfare social workers.

Teams recommended that training for child welfare social workers needs to be timely and ongoing. Teams recognize that trainings for staff were not always readily available depending on their location, job duties, and prerequisites. A recommendation was to provide more core trainings using webinars, virtual classrooms, and online trainings. Active supervisory support and consultation, including awareness of the content during training, should be a critical part of social worker training.

There were 5 reviews that included issues related to cases that involved more than one county. Recommendations related to these issues included:

1. Timely sharing of information;
2. Increasing the use of cross county staffing of cases when families move between counties;
3. Local departments of social services need to openly share all available information with other counties;
4. Face to face meetings to transfer cases from one jurisdiction (county) to another.

In North Carolina, the child welfare system is a "state supervised county administered." County departments of social services are responsible for developing protocols for practice in accordance with policies and guidance provided by the state Division of Social Services. State policies outline best practice in managing cases in which there are multiple counties involved. However, policy cannot be designed to give guidance that covers each of the complex human situations found when providing services to families, and each of North Carolina's 100 counties has some latitude in designing protocols that meet the policy requirements. Therefore, recommendations from the Teams on multiple county cases focus on specific areas in which communication between counties must be improved. The absence of a statewide case management system creates a substantial barrier to rapid and consistent cross county collaboration on child welfare interventions.

V. Current Initiatives

The issue of community education regarding the child abuse reporting law has also appeared in reports from previous years. Although efforts to address this area through contracts with Prevent Child Abuse, North Carolina to conduct public awareness campaigns have been helpful, the issue persists. New efforts are being discussed for future contracting to look at new alternatives to our traditional approaches. Teams called for efforts toward greater penetration into medical, education, law enforcement, and other professional communities who often are the persons with front line contact with children and their families. Enlisting the assistance of professional organizations in these fields to collaborate in educating their constituencies would increase awareness of their statutory requirements to report suspected child abuse, neglect or dependency. Other efforts include closer support and technical assistance to community child protection teams to mount community campaigns, with the goal of improving recognition and means of responding to suspected child abuse and neglect.

Within this past fiscal year, the Division of Social Services started a process of having Children's Program Representatives follow up on the recommendations of the Child Fatality Review Teams with the associated county departments of social services. This is a new endeavor that is in the process of being fully implemented, the results of which will be included in next year's report.

A major overarching theme identified from a review of the reports is the importance of the consistent provision of an appropriate type and level of services to children and families by local county departments of social services. The North Carolina child welfare policies have been developed and implemented by the Division of Social Services based on evidence based practices and are designed to clarify parameters outlined in state and federal statutes and rules so that counties have guidelines for the provision of services to children and families. Teams found inconsistencies in how the policies are implemented at the county level. With 100 counties in the state implementing policy requirements in the state supervised/county administered system, there is a wide range of interpretations on how the policy should look like in practice. Without sufficient guidance along with training and technical assistance toward implementing policy best practices, inconsistency in service provision and intervention practices across the state becomes a

problem. Recognizing this, there are several initiatives in which the Division of Social Services is currently engaged that should have a substantial impact toward improving consistency in implementing, and sustaining, best practices statewide.

The Division of Social Services is working with local departments of social services and other stakeholders to develop an improved means of providing training and technical assistance to local departments of social services. The REAP Project (Reaching for Excellence and Accountability in Practice) for Child Welfare in North Carolina was begun 2 years ago with a technical assistance grant from the Atlantic Coast Child Welfare Implementation Center, a national resource center.

The mission of this initiative is for *"The North Carolina Division of Social Services and County Departments of Social Services, in collaboration with our community partners, will share accountability for reaching core achievements for children, youth and families. We will adopt a quality-improvement approach to child welfare that is data-driven, results-oriented, and tailored to the specific strengths and needs of each community. This approach encompasses the use of best practices, technical assistance, and training to continuously improve outcomes for children, youth, and families in our state."*

The REAP Project has 3 elements: the development of a technical assistance model that is proactive and responsive, a system for counties to create a child welfare self assessment which includes community participation, and setting benchmarks for achievements in the North Carolina child welfare system. Objectives of the REAP project include directing and managing the application of resources to address needs in the child welfare system by fostering and implementing evidence based practice focused on producing successful outcomes for children and families.

The intent of the REAP Project to realign when, how, and where state training and technical assistance resources are applied. County departments of social services are expected to engage community partners in examining their community's achievements in child welfare and identify means by which the community's resources can be applied to enhance the achievements that are prioritized for attention. Transparency in ongoing community conversations is expected, and the Division of Social Services will provide training and technical assistance to the county when they identify further needs as they develop and work their achievement plan.

The Division of Social Services is exploring means to expand training opportunities to more locales. Some training, due to the volume of material and length of time required, are not conducive to shifting locales. However, many of the other training opportunities offered by the Division of Social Services and contract staff could be provided at a variety of sites or through a variety of venues such as on line or by webinar. In addition, the Division of Social Services is developing a means to maintain contact with supervisors and program managers through regional meetings using a hybrid of on site and webinar to insure access by all supervisors, even if they are unable to travel. The objective is to initiate and maintain an ongoing conversation between staff in various

counties regarding policies, procedures, and achievement of goals and benchmarks in child welfare practice.

The Division of Social Services has partnered with a Supervisors' Advisory Group that is tasked with the responsibility for developing ways to enhance supervision in child welfare in the state. To date, a best practice site has been created with tools for supervisors to use in the supervision of social workers. In addition, a survey of supervision needs was completed with the assistance of the University of North Carolina at Chapel Hill to examine what supervision needs are from the supervisors' and social workers' perspectives. The Group is beginning work on the next stage of developing plans for the implementation of the recommended practices.

Development of a statewide, computer based, case management system, such as NC FAST, has been anticipated for many years as a solution for many findings in fatality reviews. Such a system is seen as a vehicle that will facilitate the rapid exchange of accurate and complete information in situations in which families engage in "county hopping" to avoid child protective services. Many of the fatality reports released involved more than one county. In the absence of a statewide case management system, the management of data and information in counties continues to range from hand written to self designed data bases making tracking families across county lines cumbersome, labor intensive, and inconsistent, which has been observed to contribute to increased risk for children.

VI. Conclusion

There is a three fold increase in the number of final reports released this state fiscal year compared to last year. The Division of Social Services is continuing the effort to make deeper inroads into the backlog of intensive reviews that need to be completed. This year's increase in report releases is a step in that direction. Further efforts planned include an evaluation of the protocol to determine if there are other enhancements made to improve team performance.

There are recurring issues that continue to appear in these year end child fatality reports. These include such issues as reporting by persons who have knowledge of children at risk and compliance with rules and guidelines. Further efforts need to be made to explore the reasons for these recurring issues at a statewide level. The Division of Social Services began follow up on review recommendations late in the fiscal year to determine whether some action has been taken on the recommendations and if done, were they successful. The Division of Social Services expects to identify opportunities to assist counties implement recommendations where no action as occurred. If counties successfully implemented recommendations, the efforts will be evaluated to determine if they can be replicated to counties that are struggling.

The Department of Health and Humans Services with the DHHS Excels effort defines and brings increased focus to what is expected in the provision of services. The Division of Social Services moves this effort one step further through the REAP (Reaching for

Excellence and Accountability in Practice) project for child welfare with the effort to take new approaches in providing training and technical assistance to county staffs to improve outcomes for children and families. As the various facets of this project are implemented, this first of its kind project in the country will focus on bringing best practice models demonstrated in other jurisdictions to local staffs. The application of training and technical assistance will be results focused and evaluated for effectiveness.

To address the efficient and effective use of staff, the use of technology is critical. To bring content experts to the places they are needed most effectively means expanded use of technology. This report over the last couple of years has had findings regarding the need for a state wide case management system to move information and quickly identify at risk children and families when they cross county lines. NCFAST is still in development and to address this urgent need, temporary solutions are being sought to address this ongoing critical need that could clearly help identify and protect children.

The needs are many and the resources are slim. New approaches focused on successful outcomes for children and families are being pursued. The effective and efficient use of resources is needed to meet this challenge to improve our child welfare system.