North Carolina Department of Health and Human Services
2001 Mail Service Center • Raleigh, North Carolina 27699-2001
Tel 919-733-4534 • Fax 919-715-4645

Beverly Eaves Perdue, Governor

Lanier M. Cansler, Secretary

October 29, 2009

The Honorable Beverly M. Earle, Chair
Appropriations Subcommittee on Health
and Human Services
North Carolina General Assembly
Room 634, Legislative Office Building
Raleigh, NC 27603

The Honorable Verla Insko, Chair
Appropriations Subcommittee on Health
and Human Services
North Carolina General Assembly
Room 307-B1, Legislative Office Building
Raleigh, NC 27603

The Honorable Bob England, M.D. Chair
Appropriations Subcommittee on Health
and Human Services
North Carolina General Assembly
Room 303, Legislative Office Building
Raleigh. NC 27603

Dear Representative Earle, England, and Insko:

In accord with the provisions of N.C. G. S. 143B-150.20 (h), the Division of Social Services has prepared a report for North Carolina's State Child Fatality Review process for State Fiscal Year 2008 – 2009. The report is enclosed for your review.

The Department of Health and Human Services (DHHS) is charged with the responsibility of convening a State Child Fatality Review Team. This team conducts in-depth reviews of child fatalities that occur when children and families are involved with child protective services within the past twelve months preceding the fatality. The purpose of these reviews is to implement a comprehensive approach to identifying factors which may have contributed to conditions leading to the fatality. The findings are then used to develop recommendations for improving coordination between local and State entities to prevent future tragedies.

Should you have any questions regarding the report, please contact Sherry Bradsher, Director, Division of Social Services, at 733-3055.

Sincerely,

Lanier M. Cansler

LMC:cd

cc: Melanie Bush, Allen Feezor, Dan Stewart, Maria Spaulding, Pam Kilpatrick, Legislative Library(1 hard copy), Lisa Holloway, Sharnese Ransome, Sherry Bradsher, Jim Slate

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Lanier M. Cansler, Secretary

October 29, 2009

The Honorable William R. Purcell, Co-Chair
Appropriations on Health and
Human Services
North Carolina General Assembly
Room 625, Legislative Office Building
Raleigh, NC 27603

The Honorable Doug Berger, Co-Chair
Appropriations on Health and
Human Services
North Carolina General Assembly
Room 526, Legislative Office Building
Raleigh, NC 27603

Dear Senator Purcell and Berger:

In accord with the provisions of N.C. G. S. 143B-150.20 (h), the Division of Social Services has prepared a report for North Carolina's State Child Fatality Review process for State Fiscal Year 2008 – 2009. The report is enclosed for your review.

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Beverly Eaves Perdue, Governor

Lanier M. Cansler, Secretary

October 29, 2009

Ms. Marilyn Chism, Director
Fiscal Research Division
Room 619, Legislative Office Building
Raleigh, NC 27601

Dear Ms. Chism:

In accord with the provisions of N.C. G. S. 143B-150.20 (h), the Division of Social Services has prepared a report for North Carolina's State Child Fatality Review process for State Fiscal Year 2008 – 2009. The report is enclosed for your review.

The Department of Health and Human Services (DHHS) is charged with the responsibility of convening a State Child Fatality Review Team. This team conducts in-depth reviews of child fatalities that occur when children and families are involved with child protective services within the past twelve months preceding the fatality. The purpose of these reviews is to implement a comprehensive approach to identifying factors which may have contributed to conditions leading to the fatality. The findings are then used to develop recommendations for improving coordination between local and State entities to prevent future tragedies.

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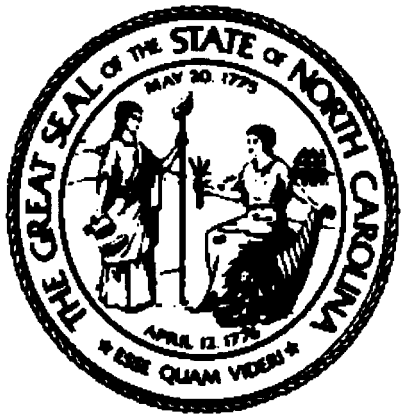
North Carolina
State Child Fatality Review Report
SFY 08-09
G.S. 143B-150.20



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

2009

Report to the General Assembly
From the State Fatality Review Team

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State Child Fatality Review Report for SFY 08-09
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." These reviews are also mandated by statute to include specific team membership that should consist of representatives from the Division of Social Services (the Division) and the local Department of Social Services (DSS), 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 usually spans two full days. The process consists of interviews with selected individuals who have knowledge of the child and his/her family and reviews of case records from the local DSS, other community agencies, and service providers that engaged 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 team presents these findings and recommendations in a public release meeting of the Community Child Protection Team. The written report is available to the public upon request. 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 the 2008-2009 fiscal year, there were 130 deaths reported to the Division of Social Services. Of the 130 deaths reported, the Division identified 22 child fatality reports that met the criteria for an intensive State Child Fatality Review. There were 16 reports awaiting additional information to determine if a review will be conducted.

Reviews and final reports are not necessarily completed during the state fiscal year (SFY) in which the fatality occurs. During SFY 08-09, thirteen (13) final fatality review reports were issued following completion of the reviews completed in previous years. In addition, there were 13 fatality reports not yet released due to pending criminal charges.

In the reports released during the year, the review teams identified five major themes.

First, the review teams identified the need for full compliance with child welfare policy prescribed by the state Division of Social Services in child protective services cases. This includes the activities of the counties in providing services to children and families within their counties and in cross county cases.

The second theme related to mental health treatment for children and families and the integration of child and family plans. There was also discussion regarding the availability of mental health services for families without Medicaid, insurance, or the ability to pay.

The third theme related to areas in which additional community education efforts were needed. There were several areas noted, including reporting child abuse or neglect, safe sleeping practices, the impact of domestic violence on children, and substance abuse during pregnancy.

The fourth theme involved law enforcement areas. This included the need for securing potential crime scenes and ensuring all information from investigations to be delivered to the medical examiner to assist in making an informed judgment on the cause of death.

The last theme included issues involving the medical community. There was the recommendation that medical examiners receive additional education and direction regarding the use of the SIDS diagnosis as the cause of death. A broader based issue involves education of doctors in the use of the controlled substances list when patients are prescribed often abused medications.

We hope that these findings are helpful in understanding some of the causes of child fatalities in hopes of preventing future fatalities.

State Child Fatality Review Team
SFY 2008-2009 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 08-09. This report includes a summary of findings and recommendations of child fatality reviews conducted by the State Child Fatality Review Teams during SFY 08-09. These teams conduct multidisciplinary reviews when there is suspicion that parental neglect or abuse contributed to a child's death and the local DSS 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 and established the State Child Fatality Review Team to conduct in-depth reviews of any child fatalities which have occurred in families involved with local Departments of Social Services Child Protective Services 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, allow these reviews to be learning opportunities for the entire community on how to improve our efforts to prevent future child deaths.

Feedback from those involved with State Child Fatality Review Teams indicates ownership of Review Team recommendations by the local communities along with a commitment to implementing action plans. Additional follow up regarding progress in these plans is conducted by Division staff.

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, the county DSS reports to the Division of Social Services information that they receive regarding any child fatalities.

C. The Division 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's 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 in obtaining all necessary records for the review.

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

F. The review includes interviews with selected individuals and reviews of case records of the county DSS and other agencies that provided services to the child and his/her family. The process focuses attention on the role and involvement of the broader community in protecting children.

G. The team writes a report that includes the findings of the review and recommendations for system improvement.

H. The team presents these findings and recommendations in a public meeting of the Community Child Protection Team. The written report is available to the general public upon request.

I. 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. Recommendations that have a more local, countywide impact are brought to the attention of the Division and are reviewed by the Child Welfare Services Section Management Team for any necessary action.

II. Facts Regarding State Child Fatality Review Process

There are two 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) it is determined by the Division that there is a suspicion that parental or caretaker abuse or neglect was a contributing factor in the fatality.

During SFY 08-09, the Division of Social Services received 130 reports from local county departments of social services with information on child fatalities. After reviewing the information provided along with other pertinent information, 22 child fatality cases met the criteria for an intensive State Child Fatality Review. Sixteen reports were awaiting additional information to determine if a review will be conducted. Of the 22 cases that met the criteria for an intensive review and were accepted in SFY 2008-09:

- neglect was suspected in 11 cases, 1 resulted in criminal charges
- abuse was suspected in 8 cases, of which 7 resulted in criminal charges
- 2 were suicides
- one was an illness.

It is important to note that law enforcement is involved in the investigative process, and criminal charges may still occur in the future pending the results of their investigations.

Finalizing a fatality report involves negotiations between members of the state team, legal staff and the district attorney to clarify the issues and recommendations. Whenever anyone has been criminally charged in a child fatality, the draft report must be reviewed by the local District Attorney to ensure that it does not compromise any criminal investigation and prosecution, or interfere with a defendant's right to a fair trial. If the District Attorney feels that information contained in the report may compromise the criminal proceeding, they will request that the report not be issued or released until completion of the criminal proceedings. Due to the length of time involved with prosecuting charged individuals, there may be a substantial period of time before a report can be released. There are currently 12 reports being withheld at the request of the district attorney where criminal charges are pending.

Reviews conducted and reports issued during the year include fatalities that were reported to the Division in previous fiscal years. The Division released 13 reports in SY 2008-09, all from reports received in previous years. Some of the cases identified for review in the current fiscal year will be reviewed in the next fiscal year. There were 36 reviews scheduled or waiting to be scheduled at the end of the fiscal year.

The Division has two Child Fatality Reviewers that schedule entrance conferences, facilitate the intensive child fatality reviews, and construct the final reports. The Reviewers along with other Division staff provide consultation and technical assistance to counties when necessary to implement plans generated by the Review process.

III. Fatality Reviews & Major Themes for SFY 08-09

The various State Child Fatality Review Teams often identify similar issues in the reviews. Some findings are more case specific or community specific.

Of the 13 reports on 14 children that were released during the year, the causes of death were identified as:

- 6 were undetermined
- 2 from SIDS
- 2 from illness
- 2 from smoke inhalation
- 1 from drowning
- 1 from blunt force trauma

The 5 major themes identified in the child fatality reports released during SFY 08-09 are summarized below. By identifying these themes and specific issues and recommendations, we expect the Division, local Departments of Social Services, and other state and county agencies to look for opportunities to make systemic improvements focused on the safety of children.

A. Inconsistent Compliance with Policy and Best Practice Issues

Inconsistent compliance with policy and best practice was a significant finding in many of the State Child Fatality Reviews across North Carolina during SFY 08-09. Some of the reasons attributed to this inconsistent compliance included inexperienced staff, caseloads that exceeded state standards, and staff turnover. This resulted in the frequency of contacts with children and families commiserate with the children's safety risk. The lack of comprehensive assessment of risk and needs was a missed opportunity to assure that all child safety and well being needs were addressed.

Adherence to policy and best practice was a challenge identified with many of the local departments of social services. Staffing patterns and social worker experience was an issue. Policy provides a framework, but experience provides the basis for implementing best practice and assuring thoroughness in child welfare. Performing the activities prescribed in policy involves timing and skill. The social worker's role as assessor and case manager to assist parents and families to meet the needs of children was a focus in a number of reviews. Specifically, these issues included:

1. Appropriate application of community resources and fully engaging community professionals, in service plans;
2. Inadequate coordination of the services to the family;
3. Conducting child and family team meetings for case planning and uncovering family resources;
4. Identifying the need for safety equipment such as smoke detectors;
5. Maintaining sufficient contact with children, their families, and community professionals based on the identified risk level; and,
6. Appropriate use and interpretation of assessment tools provided by the Division to guide service planning to ameliorate risk to children was noted.

Training was suggested as a means of resolving some of these issues, along with the development of NC Fast, a state wide case management system that is being developed. This was especially relevant in reviews that involved families that moved across county lines. The delays in locating families and transmitting information to the county where a family is located would be mitigated with this statewide case management and information system.

Earlier court intervention was cited in several cases as an issue that needed to be addressed. It was the belief of several review teams that there were delays in asking for court oversight when families were not compliant with case plans that would ameliorate the conditions resulting in the risk to children. This is also one of those areas that experience and recognizing when the local department has made reasonable efforts to engage the family in addressing risk is critical.

Internal protocols in departments of social services were also an issue addressed in reviews. This centered on the departments' need to have a protocol in place on handling information that is received on cases already known to the department. Rather than screening information to determine if the additional information meets the criteria for a new protective services report, information was routed to the assigned social worker without a clear plan for addressing the new concerns. This was an area to which the local departments were very attentive and moved to resolve.

B. Mental Health Services for Families

Within the reports released in SY 2008-09, there were 3 issues that arose in regard to mental health services:

1. Family mental Health plans;
2. Availability of parenting program; and,
3. Means of securing treatment;

The first recommendation identified was the need for an integrated family mental health plan when several family members were receiving services simultaneously. The coordination of the services to fully meet the recovery plans for all family members was critical. The coordination of planning would enable all the family members to progress towards a mutual family goal, avoiding potentially conflicting goals.

The second recommendation focused on assuring that services were available to assist parents in parenting. Referrals for services were not being made and arranged to parents since providers were focused on children as patients rather than the family. Parents needed to learn new skill sets to adequately provide for their children, but those services were not available.

The third recommendation was to find alternative funding for parents who did not have coverage to pay for their services. This was identified by local teams as a barrier to parents receiving the services they needed.

C. Community Education Needs

There were a substantial number of recommendations focused on the need for more community education regarding a variety of topics.

There were two recommendations for community education found in a majority of the released reports:

1. The child abuse reporting law for professionals and the community at large; and,
2. Safe sleeping practices.

G.S. 7B-301 requires that "Any person or institution who has cause to believe that any child is abused, neglected, or dependent... or who has died as the result of maltreatment shall report the case of that juvenile to the director of the county department of social services in the county where the juvenile resides or is found." In seven of the thirteen reports the failure to report suspicions by professionals and family members was determined by the team to be an issue in the review. The respective teams recommended community education projects to insure that the community, especially professionals, were aware of the reporting laws.

In eight of the thirteen reports co-sleeping of infants and adults was an issue. The practice of infants and young children sleeping with adults was a focus for these teams. There are a wide range of opinions regarding co-sleeping. The teams recommended that

information be made available on co-sleeping, and that a plan for distributing this information to target audiences be implemented locally and at a broader level. There were three reviews that narrowed the focus of education to publicizing the risks of co-sleeping and drug use, including alcohol. Being under the influence of drugs, legal and illegal, and co-sleeping was believed to substantially increase the risk to young children and infants.

There were four additional areas identified by teams as areas where community education was needed:

1. The dangers of drug use during pregnancy;
2. Bilingual information on fire safety
3. Safely securing pools; and,
4. The dangers to children in domestic violence situations.

It was determined that drug use, both legal and illegal, creates a substantially greater risk of problems for newborns. In one case, legal and illegal drug use was suspected as a contributing factor in a fatal birth defect. The Team discussed a renewed effort at community education.

Following a fire fatal to two children, the Team recognized that there was no bilingual information available on fire safety and fire prevention. The team found information available in English, but not in Spanish.

Securing swimming pools to prevent unsupervised access by children was an issue to a Team. The concern was focused on easy set up pools that are not secured by fencing or other access restrictions.

The impact of domestic violence and substance abuse on children was a concern for another Team. These areas were identified as a critical need when the team found that the domestic violence combined with substance abuse was known, but not reported because potential reporters were concerned about interfering in the family. This specific issue was also addressed with the education on the child abuse and neglect reporting law.

Law Enforcement

The recommendations in this theme focus on

1. Securing crime scenes;
2. Making all information available to the medical examiners; and,
3. Holding parents accountable for prenatal substance abuse.

There were three instances in which there were concerns by teams regarding securing potential crime scenes. It was believed by the teams that potential evidence which could have assisted in a clear identification of the cause of death was lost due to not securing an area. In one instance, EMS did not notify law enforcement regarding a fatality resulting in a significant delay in acquiring information. Recommendations involved increased attention to where a child's death happens as a possible crime scene.

There was an issue raised regarding proper routing of all investigative information from law enforcement to the medical examiner to assist in making determinations in the cause of death. Having the background and contextual information regarding a child's death was believed to be valuable. The identification of undetermined causes or SIDS in so many cases was a cause for concern.

There was a recommendation to create a law that allows for prosecution of mothers who give birth to babies who test positive for illegal or prescription drugs when there is a history of any drug abuse by the mother. The Team was concerned that the mother's drug use was well known, but there were no deterrents to her use.

Medical Community

There were three general areas in this theme:

1. Physician education on controlled substances;
2. Prompt application of medical resources for treatment; and,
3. Issues related to medical examiners.

There were 2 areas of concern regarding substance abuse and the medical community. There was a recommendation that the NC Medical Board should evaluate their standard of care coordination in regard to patients with drug seeking behavior and adopt rules requiring all practitioners prescribing controlled substances to access the Controlled Substance Reporting Database prior to writing a prescription for a controlled substance. The purpose is to avoid over prescribing or duplication of drugs. The second recommendation is that the NC Medical Board should provide education to physicians and pharmacists regarding North Carolina General Statutes, Chapter 90, Article 5E, titled "North Carolina Controlled Substances Reporting System Act", which states that "any concerns regarding any unusual patterns of medication prescription should be reported to the Attorney General's Office."

There was an issue raised related to the arrangement of services for high risk infants leaving the hospital. It was recommended that services be promptly set in place when high risk children were released from hospitals with parent education on care.

There were several recommendations regarding information being provided to the medical examiner to more adequately determine a cause of death. The critically needed information identified for medical examiners was regarding law enforcement investigations. This information it was believed could provide the context in which the medical examiner could seek to determine the cause of death. Associated with this recommendation was one in which medical examiners would receive additional education on the use of SIDS as the cause of death.

It was also recommended that medical examiners be oriented to view the autopsy as a means of reconciling sometimes contradictory information surrounding the child's death. In situations where there is contradictory information surrounding the context of the child's death, the medical examiner needs to be able to resolve those contradictions.

It was recommended that a broader toxicity screen be used to determine if there are other drugs in an infant that could potentially explain the death. There was concern expressed

that with the prevalence of drugs and drug use by parents and caretakers, this is an area that needs additional attention.

V. Conclusion

The contributions of informed state and community professionals that served on the State Child Fatality Review Teams during SFY 08-09 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.

It should also be noted that these teams, made up of a variety of persons in the communities, were honest and transparent in their deliberations and shared areas in which they need improvement. This further demonstrates their commitment to learning lessons for the community for the sake of children and their families.

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.