North Carolina Department of Health and Human Services

Pat McCrory
Governor

Aldona Z. Wos, M.D.
Ambassador (Ret.)
Secretary DHHS

April 30, 2013

The Honorable Louis Pate, Co-Chair
Appropriations on Health
and Human Services
Room 406, Legislative Office Building
Raleigh, NC 27603

The Honorable Ralph Hise, Co-Chair
Appropriations on Health
and Human Services
Room 1026, Legislative Building
Raleigh, NC 27601-2808

Dear Senators Pate and Hise:

Pursuant to General Statute 143B-150.20 the Department of Health and Human Services, Division of Social Services submits this report of the activities of the Child Fatality Review Team. The report outlines the activities of the past fiscal year, and it identifies several areas in which improvement can be made.

We appreciate the opportunity to share this report with you and look forward to responding to any questions you may have. If you have questions about the report, please contact Jack Rogers, Deputy Director of the Division of Social Services. He can be reached at (919) 733-3055 or via e-mail at Jack.Rogers@dhhs.nc.gov.

Sincerely,

Aldona Wos, M.D.
Secretary

AW:bs

cc: Susan Jacobs
Pam Kilpatrick
Patricia Porter
Sarah Riser
Kristi Huff
Brandon Greife
Sherry Bradsher
Jim Slate
Adam Sholar
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North Carolina Department of Health and Human Services

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April 30, 2013

The Honorable Justin Burr, Co-Chair
Legislative Oversight Committee on Health and Human Services
Room 538, Legislative Office Building
Raleigh, NC 27603

The Honorable Nelson Dollar, Co-Chair
Legislative Oversight Committee on Health and Human Services
Room 307-B1, Legislative Office Building
Raleigh, NC 27603

The Honorable Louis Pate, Co-Chair
Legislative Oversight Committee on Health and Human Services
Room 406, Legislative Office Building
Raleigh, NC 27603

Dear Representatives Burr, Dollar and Senator Pate:

Pursuant to General Statute 143B-150.20 the Department of Health and Human Services, Division of Social Services submits this report of the activities of the Child Fatality Review Team. The report outlines the activities of the past fiscal year, and it identifies several areas in which improvement can be made.

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Secretary DHHS

April 30, 2013

Mark Trogdon, Director
Fiscal Research Division
Room 619, Legislative Office Building
Raleigh, NC 27603

Dear Mr. Trogdon:

Pursuant to General Statute 143B-150.20 the Department of Health and Human Services, Division of Social Services submits this report of the activities of the Child Fatality Review Team. The report outlines the activities of the past fiscal year, and it identifies several areas in which improvement can be made.

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Pat McCrory
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April 30, 2013

The Honorable Marilyn Avila, Co-Chair
Appropriations Subcommittee on Health
and Human Services
Room 2217, Legislative Building
Raleigh, NC 27601

The Honorable William Brisson, Co-Chair
Appropriations Subcommittee on Health
and Human Services
Room 405, Legislative Office Building
Raleigh, NC 27603

The Honorable Mark Hollo, Co-Chair
Appropriations Subcommittee on Health
and Human Services
Room 639, Legislative Office Building
Raleigh, NC 27603

Dear Representatives Avila, Brisson and Hollo:

Pursuant to General Statute 143B-150.20 the Department of Health and Human Services, Division of Social Services submits this report of the activities of the Child Fatality Review Team. The report outlines the activities of the past fiscal year, and it identifies several areas in which improvement can be made.

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North Carolina State Child Fatality Review Report

SFY 2011-12

G.S. 143B-150.20

North Carolina Department of Health and Human Services

Division of Social Services

2012

State Child Fatality Review Report for SFY 11-12
Executive Summary

The State Child Fatality Review Team was established in the Department of Health and Human Services, Division of Social Services (the Division), pursuant to N.C.G.S. §143B-150.20 in 1997. The Division is responsible for convening a State Child Fatality Review Team consisting of community representatives 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." 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 intensive and typically requires two full days to complete. The process includes not only interviews with selected individuals who have knowledge of the child and his/her family, but also a comprehensive 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 examines activities of the local department of social services as well as the role and involvement of the broader community in protecting children. At the conclusion of each review, the State Child Fatality Review Team issues a formal report that includes findings and recommendations. The written report is available to the public upon request. The CCPT is expected to review the recommendations and develop strategies to address pertinent issues within local control. Following the release of each report, Division of Social Services staff present the recommendations with statewide impact to the State Child Fatality Prevention Team. This step helps identify the most appropriate state-level entity to accept responsibility for each state-level recommendation.

During State Fiscal Year 2011-12, a total of 141 deaths were reported to the Division of Social Services. Of those reports, the Division identified 21 that met the criteria for an Intensive State Child Fatality Review. Division staff requested information from departments of social services or the Office of the Chief Medical Examiner regarding seven other fatality reports 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 2011-12, 35 final fatality review reports were issued following completion of the reviews. Another 11 cases have been reviewed and the Division expects these reports will be released in SFY 2012-2013. In addition, 6 fatality reports are finalized but at the time this report was prepared have not yet been

released due to criminal investigations or prosecutions at the request of District Attorneys.

In the reports released during SFY 2011-12, the Review Teams identified the following eight major themes. Many of the recommendations overlap multiple themes.

1. Interagency Communication and Collaboration

Informed decisions require appropriate and timely information. Almost one third of the reports released identified inadequate communication and collaboration among community partners. Review Teams described several instances in which the information a facility or agency possessed was not considered important enough to share, but proved critical to other agencies working with the family in hindsight.. Facilitated discussions during Community Child Protections Team meetings regarding the importance of communication and collaboration will foster a better understanding of roles and needs of community partners.

The Review Teams recommended a number of actions at the local level, including:

- inviting additional partners to join Community Child Protection Teams,
- expanding use of memoranda of understanding and protocols, and
- coordinating activities between Child and Family Team Meetings and Permanency Planning Action Team meetings.

2. Community Support Services

Review Teams examined the role of community-based agencies, such as the Care Coordination for Children that provides early intervention services and recommended greater referrals to and provision of these voluntary services. In some instances, although the services were available, referrals were not made promptly. These delays combined with inadequate referral information resulted in a less than optimal level of services and support than might have been provided if providers had accurate, complete information that conveyed the urgency of the family's situation.

In a number of the reviews, it was found that services were adequate to meet the family's needs, but that parents and caregivers did not follow providers; advice and recommendations.

3. Reporting of Child Abuse and Neglect

Like previous years, 2011-2012 reports again noted failure to report suspected abuse and neglect in accordance with the mandatory reporting law, GS §7B-301 as a contributory problem. Reviews revealed that professionals constituted the most common source that failed to report potential child maltreatment. In most of the recommendations, the local Community Child Protection Team will be coordinating efforts to target professional groups for education campaigns on recognizing and reporting child abuse and neglect. These types of education activities help to ensure

that information is reported to the departments of social services if there a suspicion of child maltreatment.

4. Community Education on Keeping Children Safe

In more than one-third of the reviews, Teams recommended that agencies facilitate opportunities for community education on a wide range of topics, such as safe sleeping, Periods of Purple Crying, SIDS, Shaken Baby Syndrome, smoking and fire prevention, and selecting quality child care.

The Teams in these reviews presented creative ideas for disseminating information, including using lobby televisions, medical providers, and community agencies that interact with at-risk populations, but may not normally address child maltreatment issues.

5. Substance Abuse

Departments of Social Services recognize that substance abuse of legal and illegal drugs constitute an ongoing problem. Unauthorized use of prescription drugs continues to increase. Teams found that medical providers inconsistently use the Controlled Substance Reporting Inventory. This inconsistency involves both entering information into the system and checking it before writing drug prescriptions. Regular use of the NC Controlled Substances Reporting System has the potential not only to decrease the number of prescriptions written, but also to provide early identification of persons at risk of addiction.

Review Teams are increasingly focusing on evidence-based practices. One review addressed behavioral health and substance abuse treatment practices and recommended collaboration with the Local Management Entity to hold providers accountable for outcomes for services that are not evidence-based. Several reviews identified difficulty in securing information on parental substance abuse. Federal law restricts the information that can be shared without a special hearing or a release of information. The Teams proposed additional training on and review of these legal procedures to facilitate the flow of information.

6. The Child Welfare System and Law Enforcement

Law enforcement is a critical partner in responding to child maltreatment and child fatalities. Information is critical in any response. Teams identified that sometimes departments of social services and law enforcement agencies did not always exchange relevant information. In other cases, when these agencies did share information, they did not take action on it. Local conversations through the Community Child Protection Teams, which include members of both departments of social services and law enforcement agencies, are intended to highlight each agency's policies and procedures regarding what type of information can be shared, as well as how, and when.

Two reviews identified the need for training for law enforcement on child death scene investigations. The Office of the Chief Medical Examiner provides this training at a number of different levels, but smaller law enforcement agencies may not have had the capacity to access it. The Teams recommended bringing the training to the county to make it readily available to all law enforcement personnel.

Teams also determined that lack of access to national criminal databases undermines the safety of children. Although federal legislation has been passed to provide this access to departments of social services, the logistics for the access have been delayed. Although local law enforcement agencies can use these databases, they cannot provide information to the departments of social services except in criminal investigation cases. Alternative searches for local departments of social services involve time-consuming and costly jurisdiction-by-jurisdiction requests, which may not yield the needed information.

7. Change and Accountability

As the Division of Social Services has moved toward accountability in the reviews, the local Teams are increasingly holding community agencies accountable for changing ineffective practices and implementing the recommendations. In one example, one team suggested that the local law enforcement agencies participate in the child death scene investigation training. In two other reviews, Teams advised that the local departments of social services report on their progress on implementing recommendations to the Community Child Protection Team. Other recommendations focused on refining internal processes and developing a quality assurance system.

In one review, the Team recommended higher levels of accountability for community service providers. The local Community Child Protection Team is working with the Local Management Entity to hold behavioral health and substance abuse providers accountable for the outcomes on the services they offer. The community wants to invest in quality evidence-based practices that studies have shown are effective.

8. Child Welfare Policy and Best Practice Issues

In over half of the reviews, the Review Teams identified issues with the intervention of the department of social services. The major areas involved the lack of a thorough assessment, supervisory oversight, staff turn over, and access to records.

Child protective services (CPS) assessments include securing and reviewing information to ascertain the level of maltreatment and the risk to the child's safety. At times, the volume of information is great, while at other times it is difficult to locate relevant data. The process requires collecting information from specific sources, including children, parents, and collateral contacts. In addition, CPS workers must research background information. Review Teams examined CPS practices, such as the

frequency of contacts with the family by the social worker and the documentation of activities.

Teams listed supervisory oversight as a critical factor in the reviews. The supervisor can provide reliable guidance based on knowledge and experience to ensure a consistent quality of assessments from social worker to social worker. New tools for social workers which reinforce critical thinking skills and additional training opportunities are critical to bolstering the effectiveness of supervision in case management.

In one review, the department of social services had more than a 37% annual staff turnover rate. High levels of turnover challenge agencies, which must then meet demands for mandatory services with fewer, more experienced social workers. This problem reinforces the need for supervisors to provide support and direction to assure CPS workers conduct thorough assessments and offer quality services.

Current Initiatives

The Division of Social Services has implemented a wide range of activities, such as Multiple Response System, NC FAST case management system, and Reaching for Excellence and Accountability in Practice (REAP) in North Carolina's child welfare system. These types of innovative initiatives will positively impact some of the overarching themes identified in the individual reviews.

The Division continues to work with a group of county department of social services supervisors and the University of North Carolina to look at supervision in North Carolina. This group is reviewing models for supervision, including the wide variety of expectations of supervisors and how to help supervisors best meet them.

The Department of Health and Human Services is currently developing an automated statewide case management system called NC FAST, to facilitate information sharing between county departments of social services. NC FAST will provide more accurate and timely information to social workers in the field and give supervisors new tools for tracking cases and activities.

The Division continues to implement the Reaching for Excellence and Accountability in Practice (REAP) project. The goal of this initiative involves developing a continuous quality improvement model for the child welfare system to use data to identify issues and most effectively target the Division's resources toward resolving those issues. REAP will develop accountability in the child welfare system by analyzing outcomes and developing strategies to improve them.

As the REAP model evolves, the way that the Division provides technical assistance to county departments of social services will also evolve. The Division is developing a Technical Assistance Gateway in which technical assistance to counties can be tracked. This allows Division staff to analyze common trends from specific requests for technical assistance. In addition, the Division will be able to provide technical assistance from the best content experts available and assess the outcome of the technical assistance provided. This assessment is critical to assure that effective change occurs.

Drawing on advice from community professionals participating in the fatality reviews, the Division is redesigning the fatality review process as a continuous quality improvement model. The Teams spend considerable time developing findings and recommendations to improve North Carolina's child welfare system. A continuous quality improvement model will offer greater accountability for action to implement recommendations.

CONCLUSION

The backlog of reviews has decreased in the past year from 64 cases awaiting a review to 21 cases awaiting review at the time that this report was prepared. Thirty five reports were released this past state fiscal year, compared with 24 for SFY 10-11. A variety of innovations in the Child Fatality Review process, and in the larger Child Welfare Program operations, are expected to improve outcomes for children and families. An increase focus on accountability for actions on the recommendations will be stressed in the future. Additionally, collaboration with community and statewide partnerships will assist in addressing the issues identified.