CHILD FATALITY, PREVENTION, AND REVIEW TEAM POLICY, PROTOCOL, AND GUIDANCE

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Community Child Protection Team

Definition
COMMUNITY CHILD PROTECTION TEAM **CHANGE # 01-2007 JANUARY 2007** **PURPOSE AND AUTHORITY** The North Carolina Division of Social Services (hereafter, the Division) is committed to the purpose of involving communities in protecting children. Individual communities have an opportunity to assure the protection of children in the community. Communities will make this determination based on North Carolina's child protection laws, community values, expectations, resources, etc. Child protection interest in communities will acknowledge a parent's rights to safely rear children as the parent chooses, will consider a wide range of parenting practices, and will allow children to be protected within their cultural and ethical beliefs. The Division recognizes child protection as a community responsibility. The Community Child Protection Team is one formal process that is used to ensure child protection while also providing social support. Community Child Protection Teams (hereafter, CCPT) were established as one means for the state and local communities to form a partnership to strengthen child protection. CCPT were established in response to Executive Order 142 in May 1991. The duties and responsibilities of the CCPT are contained in 10A NCAC 70A .0201. The original purpose and composition of the team was further formalized and expanded by N.C.G.S. §7B-1406 (formerly N.C.G.S. §7A 143576.1), effective July 1, 1993. The Federal Child Abuse Prevention and Treatment Act (CAPTA) was reauthorized and amended by the "The CAPTA Amendment of 1996" (Public Law 104-235) on October 3, 1996. Section 106 (formerly 107) of CAPTA's Title I was amended to direct the focus of the State grant program to one of support and improvement of State child protective services (hereafter, CPS) systems. One of those requirements established by CAPTA was the establishment of Citizen Review Panels. The purpose of these panels is to provide new opportunities for citizens to play an integral role in ensuring that states are meeting their goals of protecting children from abuse and neglect. In 1997, North Carolina designated the CCPT as its Citizen Review Panel. In North Carolina, each CCPT reviews active child welfare cases, fatalities, and other cases brought to the team for review. The purpose of the case reviews is to identify systemic deficiencies in child welfare services or resources. Once identified, teams develop strategies to address the gaps in the child welfare system within the county and report to the state areas of concern that warrant action by the state. Teams promote child well-being through collaboration. CCPT also promote child well-being through public awareness. In order for North Carolina to be in full compliance with the conditions of CAPTA, CCPT are required to: • examine the policies and procedures of state and local agencies • review specific cases where appropriate CCPT may review other criteria that it considers important to ensure the protection of children, including the extent to which state CPS is coordinated with the Title IV-E foster care and adoption program.

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NATURE AND PURPOSE OF THE COMMUNITY CHILD PROTECTION TEAM **(N.C.G.S. § 7B-1406)** The CCPT is an interdisciplinary group of community representatives who meet regularly to promote a community-wide approach to the problem of child abuse and neglect. The CCPT is not a Department of Social Services (DSS) team. The CCPT may not encompass a geographic nor governmental area larger than one county. The CCPT shall consist of representatives of public and nonpublic agencies in the community that provide services to children and their families and other individuals who represent the diversity of the community. Membership is mandated by law and includes: • The **county director of social services** and a member of the director's staff; • A **local law enforcement officer**, appointed by the board of county commissioners; • An attorney from the district attorney's office, appointed by the district attorney; • The executive director of a local community action agency, as defined by the Division of Economic Opportunity, Department Health and Human Services, or the executive director's designee; • The superintendent of each local school administrative unit located in the county, or the superintendent's designee; • A member of the county board of social services, appointed by • the chair of that board; • A local mental health professional, appointed by the director of the area authority established under N.C.G.S. §122-C; • The local **guardian ad litem coordinator**, or the coordinator's designee; • The director of the department of public health; and • A local health care provider, appointed by the local board of public health. The board of county commissioners may appoint a maximum of five additional members to represent various county agencies or the community at large to serve on any local team.	

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Team members appointed by the board of county commissioners should represent the diversity of the community. This is an opportunity for teams to involve all aspects of the community that impact children or have the potential to impact children. CCPT members may appoint an advisory committee to augment the team process. This committee may be composed of individuals that represent county entities that have child well-being as a focus but are not included in the mandated composition of the CCPT. The advisory committee may serve at the pleasure of the CCPT in whatever capacity the CCPT deems necessary. It is important that all members of the CCPT feel a part of the team, as the team pursues its purpose of protecting children. **When a mandated team member is by law a member of the CCPT in more than one county, that member is encouraged to select a designee who resides in the county where the team is located. This action will insure that local CCPT members have a vested interest in advancing child protection based on the needs of children and families in their county.** The original appointing authority shall fill vacancies within the CCPT. A list of each county's CCPT members shall be forwarded to the Division in January of each year. The list should include the mailing address, telephone number, and agency or group affiliation of each member. **STANDARD OPERATING PROCEDURES** The chairperson shall assure that each team develops standard operating procedures that include: • meeting logistics (i.e., frequency, times, locations, etc.) • membership composition • substitution of agency representatives; • terms of office for chairpersons • management of habitual absentees • procedure for informing members of cases to be reviewed • responsibility for record keeping and what will be included in CCPT records • plan for recruiting new members • method of reviewing and commenting on child welfare laws, policy and practice • plan for including consumers in the CCPT process	

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• confidentiality policy • plan for identifying training needs and informing the Division of those training needs • management of public awareness campaigns that support child wellbeing • how CCPT manages team conflicts **DUTIES AND RESPONSIBILITIES** **DUTIES AND RESPONSIBILITIES OF THE CHAIR** **(N.C.G.S. § 7B-1407(g)) A.** Each local team shall elect a member to serve as chairperson at the Team's pleasure. The chairperson shall schedule meetings, including time and place, and shall prepare an agenda. The chairperson should be an individual who is a proven leader and is willing to dedicate ample time and energy towards team maintenance. The chairperson shall participate in training developed by the Division of Social Services. Training opportunities for CCPT may be accessed through the NCDHHS CCPT website, https://www.ncdhhs.gov/divisions/social-services/child-welfare-services/community-child-protection-teams at the following link: https://youtu.be/Zo57WZYICeE Such training shall address the role and function of the child protection team, confidentiality requirements, an overview of CPS law and policy, and team record keeping. The Division shall be notified when a new chairperson is elected. **DUTIES OF THE COUNTY DIRECTOR OF SOCIAL SERVICES** **(N.C.G.S. §7B-1409)** The CCPT is a community team. **The team is not a DSS team.** The Division will channel CCPT business and information through the CCPT Chairperson and the county DSS Director as a means of continuity. To	

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augment the CCPT process the county DSS Director with the CCPT Chairperson shall perform the following duties: • Assure the development of a CCPT handbook to include the composition of membership, frequency of meetings, confidentiality policies, training of members. Additional areas which may be addressed in the operating procedures include, but are not limited to: terms of membership, absenteeism, substitution of agency representatives, expectations for decision-making and recommendations, procedures for follow-up, identification of a media spokesperson, reports to the board of county commissioners and duties and responsibilities of members, and procedures for bringing non-DSS cases for review. **The team may also establish parameters for responding to community requests that expand the team role.** The director shall ensure that all procedures are updated by the team as needed, reflecting changes in policy and law. • Assure that the Team defines the categories of cases that are subject to its review • Determine and initiate cases for review • Bring for review **any** case requested by a Team member • Provide staff support for these reviews • Maintain records, including minutes of all official meetings, lists of participants for each meeting of the Team, and signed confidentiality statements required under N.C.G.S. §7B-1413, in compliance with applicable rules and law • Report quarterly to the county board of social services, or as required by the board, on the activities of the Team **RESPONSIBILITY FOR TRAINING OF TEAM MEMBERS (N.C.G.S. §7B-1411)** The Division is required by statute to develop and make available on an ongoing basis a CCPT operational handbook outlining confidentiality requirements, overview of child protective services law and policy, and team record keeping. Teams are encouraged to integrate training into the structure of the team meetings on an ongoing basis. Such training may be offered by the county DSS staff or supervisors, the Children's Programs Representatives from the Division of Social Services, child welfare attorneys, other staff from the Family Support and Child Welfare Section, experts from the community and the Division's CCPT Coordinator. Cooperative training, sponsored by teams from other nearby counties as well as from the team's own team members, is also encouraged.	

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FREQUENCY OF MEETINGS (N.C.G.S. § 7B-1407(g)) CCPT meetings shall be scheduled with sufficient frequency to review defined cases but must meet at least quarterly. In deciding the frequency of team meetings, it is important to note that meeting frequency impacts on team effectiveness and participation. Additional meetings may be scheduled in order to review child fatalities in a timely manner. **DUTIES AND RESPONSIBILITIES OF THE CCPT (N.C.G.S. §7B-1406)** Review active cases in which abuse, neglect, or dependency is found and that are: • Selected from categories defined by the team • Brought for review at the specific request of a team member • Brought for review at the initiative of the director of the department of social services Federal and State laws require that a citizen review panel be in place to review certain cases receiving child welfare services. In North Carolina CCPT has been designated as the Citizen Review Panel**,** required by the Child Abuse Prevention and Treatment Act. This review panel shall include consumers of child welfare services. An example of a child welfare consumer may be a family member that has experienced the child welfare process through case management services, foster care services, adoption services, etc. Families that will benefit the CCPT process are families who can add an objective element to discussions around gaps in services and resources; developing strategies to address deficiencies, etc. A main focus for Citizen Review Panels is evaluating how child welfare policy established on a federal or state level impacts families and children on a local level. The purpose of reviews shall be to: • Identify whether gaps and deficiencies exist within the community child protection system which have impact on the incidence of abuse, neglect, or dependency or on the child fatality • Increase public awareness about conditions that impact on child protection within the community • Advocate for system changes by promoting collaboration between agencies in the creation or improvement of resources for children as a result of their review of selected cases • To use the CCPT as a means to assist the county director in the protection of children living in the family being reviewed and to inform the county commissioners about actions needed to prevent or ameliorate child abuse, neglect, or dependency. **SELECTION OF CASES FOR REVIEW**	

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Categories of cases reviewed by the team are to be based on local need, but may include one or more of the following groups of children noted in the literature to be at higher risk of subsequent injury or death as a result of child abuse, neglect, or dependency: • Substantiated cases of abuse, including sexual abuse (when considering substantiated cases that warrant a CCPT review, it is recommended that the cases reflect family issues that indicate a gap in services or a need for team collaboration) • Reports of neglect of a child, especially when made by a medical provider (specifically reports of maltreatment involving dehydration, bruises, broken bones, positive tests for controlled substances, etc.) • Cases in which the department has "Substantiated" or found the family to be "In Need of Services" two reports within a specific period, regardless of the type of report or referral source • Families that have been reported several times over a short span of time and the reports were screened out **or** other cases at the request of a team member, including children receiving any child welfare services, cases known to team members where there are indications that child has been affected by a deficiency in a community system or resource • Child fatalities **REVIEW OF CHILD FATALITIES** Each CCPT shall review fatalities which are suspected to have resulted from child abuse, neglect or dependency; **and** the county DSS has had contact through its child welfare programs with the child or family within the 12 months preceding the child's death. For more detailed information on the Child Fatality Review process please refer to the NC Child Welfare manual. **REPORT TO THE BOARD OF COUNTY COMMISSIONERS** N.C.G.S. §7B-1406, requires that the team submit an annual report to the board of county commissioners which contains recommendations, if any, and advocate for system improvements and needed resources when gaps and deficiencies exist. In January of each year a copy of the report to the Board of County commissioners will be sent to the Division along with the CCPT End of Year Report (https://www.ncdhhs.gov/divisions/social-services/program-statistics-and-reviews). **MULTIPLE RESPONSE SYSTEM (MRS)**	

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The Multiple Response System is a reform of the entire continuum of child welfare in North Carolina, from intake through placement services. MRS is based upon the application of family-centered principles of partnership through seven strategies. For a thorough explanation of each of the seven strategies please refer to Appendix 6, Best Practice Guidance for Social Worker Well-Being, in the NC Child Welfare manual. In keeping with CCPT responsibilities, the CCPT has a key role in assuring the success of MRS by: • Assessing the county for resources and services needed by families to provide adequate care for children • Developing strategies to address gaps in services and resources • Educating the county about MRS **ADVOCACY** Some advocacy strategies adopted by teams and recommended for consideration are: • Involvement of the media in educating the community about gaps in community services • Utilization of resources available through member agencies to create services in response to identified gaps • Sharing of information about under-utilized resources in the community which help to address service gaps • Directing concerns to the board of county commissioners about trends in abuse or neglect that suggest a need for increased or changed services in the community, and advocate for necessary resources to facilitate change. **ACCESS TO RECORDS (N.C.G.S. §7B-1413)** • Meetings of the CCPT are not subject to the provisions of the Open Meetings Law (N.C.G.S. §143-318.10). However, local teams may hold periodic public meetings to discuss in a general manner, not revealing confidential information, about children and families, the findings of their reviews and their recommendations for preventive actions. Minutes of all public meetings, excluding those of executive sessions, shall be kept in compliance with Article 33C of Chapter 143 of North Carolina General Statutes. These minutes shall be permanent public records and shall be maintained according to the standard administrative record retention schedule.	

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• Information regarding individual clients shall be discussed in executive session. If any minutes are generated in the executive session, they shall be sealed from public inspection. • Local teams shall have access to all medical records, hospital records, and records maintained by this State, any county, or any local agency as necessary to carry out the purposes of the law, including police investigations data, medical examiner investigative data, health records, mental health **records, and social services records.** The team may not, as part of the reviews authorize by law, contact, question, or interview the child, the parent of the child, or any other family member of the child whose record is being reviewed. Cases receiving child protective services at the time of review shall document the CCPT review as well as CCPT recommendations. Additional documentation shall be at the discretion of the director of the county DSS. • The county director shall maintain lists of participants for each team meeting and confidentiality statements signed by team members and invited participants. Such records shall be maintained by the standard administrative record retention schedule. **CONFIDENTIALITY (N.C.G.S. §108A-80; N.C.G.S. §7B-1413)** • This statute states that unless specifically excepted, "it shall be unlawful for any person to obtain, disclose or use, or to authorize, permit, or acquiesce in the use of any list of names or other information concerning persons applying for or receiving public assistance or social services that may be directly or indirectly derived from the records, files or communications of the Department or the county boards of social services, or county departments of social services or acquired in the course of performing official duties except for the purposes directly connected with the administration of the programs of public assistance and social services in accordance with federal law, rules and regulations, and the rules of the Social Services Commission or the Department." • Additionally, case records of juveniles under protective custody of DSS or under placement of the court are protected as confidential under N.C.G.S. §7B-2901. Breach of confidentiality is a misdemeanor offense. • Confidential information and records acquired or created by the CCPT in the exercise of its duties are not subject to discovery or introduction into evidence in any proceedings and may only be disclosed as necessary to carry out the purposes of the team. (N.C.G.S. §7B-1413(c))	

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• No member of the CCPT, nor any person attending a meeting of the team, may testify in any proceeding about what transpired at the meeting, about information presented at the meeting, or about opinions formed by the person as a result of the meetings. This does not prohibit a person from testifying in a civil or criminal action about matters within that person's independent knowledge. • The county director is authorized to share with the community child team any information available to him or her that is needed by the team members in the execution of their duties. In reviewing non-fatality cases CCPT shall have access to all medical records, hospital records, and records maintained by this State, any county, or any local agency as necessary to carry out the purposes of CCPT, including police investigation data, medical examiner investigative data, health records, mental health and social services records. • The federal Family Educational Rights and Privacy Act (FERPA), which is commonly known as the "Buckley Bill", limits with certain exceptions, the disclosure of information contained in public school records. One such exception pertinent to the purposes of a CCPT in reviewing non-fatality cases is when the health and safety of the student is in question. Thus, a public school whose student is the subject of an active protective service case may respond to an inquiry from the CCPT. • Information from alcohol and drug treatment programs is protected by federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2. The individual receiving these alcohol or drug treatment services must give written consent on the federal Consent for the Release of Confidential Information form. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. To obtain information from alcohol and substance abuse records without written consent from the patient CCPT must obtain a court order after a special hearing. • Each team member and invited participant shall sign a statement indicating their understanding of and adherence to confidentiality requirements including possible civil and criminal consequences of any breach of confidentiality. Rules regarding confidentiality shall apply to any personal files that are created or maintained by any team member or invited participant. A sample Confidentiality Agreement is provided at the end of this section.	

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• **Team members are permitted to share with their respective agencies, on a need-to-know basis, information acquired at a CCPT meeting regarding a current client or referred case.** • **Members of the team who have access to client information and fail to comply with the rules of confidentiality shall be denied access to confidential information and are subject to dismissal from the team.** • **Any invited participant who is given access to client information during the team review and fails to comply with the rules of confidentiality shall be denied participation in further team reviews.** • **The county director shall not share any information that discloses the identity of individuals who have reported suspected abuse, neglect, or dependency to the county DSS.** • **Minutes of the general session shall not contain case specific information**. **LIABILITY OF TEAM MEMBERS** Team members have no responsibility for case decisions or service provision, as their role is advisory. Therefore, it is the opinion of the Attorney General that they as individuals, or as a group, would not have liability in a child protective services case. **CHILD FATALITY PREVENTION TEAMS (N.C.G.S. §7B-1406)** • Each CCPT **may** review the records of **all** additional child fatalities and report findings in connection with these reviews to the Team Coordinator of the North Carolina Child Fatality Prevention Team (hereafter, CFPT) at the Department of Environment, Health, and Natural Resources. **Any CCPT that determines that it will not review additional child fatalities shall notify the CFPT Coordinator.** In this case, a separate CFPT shall be established in that county to conduct these reviews. It was the responsibility of the statewide Child Fatality Team Coordinator to develop a plan to establish Child Fatality Review Teams in each county by July 1, 1995. • According to N.C.G.S. §1407 a CCPT that chooses to review the records of additional (non-CPS) child fatalities shall include the following five additional members: • An emergency medical services provider or firefighter, appointed by the board of county commissioners • A district court judge, appointed by the chief district court judge in that district • A county medical examiner, appointed by the Chief Medical Examiner	

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• A representative of a local child care facility or Head Start Program, appointed by the director of the county DSS
• A parent of a child who died before reaching the child's eighteenth birthday, to be appointed by the board of county commissioners.
The Team Coordinator of the CFPT shall serve as an **ex officio** member of each local team that reviews the records of additional child fatalities.
 	
• Reports by the Child Fatality Prevention Team
N.C.G.S. §7B-1406 requires that reports regarding fatalities which are submitted to the Team Coordinator of the North Carolina CFPT shall contain:
 	
  • A listing of the system problems identified through the review process, and recommendations for preventative actions
  • Any changes that resulted from the recommendations made by the local team
  • Information about each death reviewed
  • Any additional information requested by the Team Coordinator.
Role of the Director of the Local Department of Health (N.C.G.S. §7B- 1410)
 	
When the CCPT reviews additional (non-CPS) child deaths, the Director of the local department of health shall assume responsibility for the following tasks:
 	
• Distribute copies of the CFPT handbook developed by the Team Coordinator under N.C.G.S. §7B-1408 to the administrators of all agencies represented on the local team and to all members of the team
• Maintain records, including minutes of all official meetings, lists of participants for each meeting of the local team, and signed confidentiality statements required under N.C.G.S. §7B-1413, in compliance with applicable rule and law
• Provide staff support for non-CPS reviews of child deaths
• Report quarterly to the local board of health, or as required by the board, on the activities of the local team.
CONCLUSION	

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The CCPT is in a unique position to encourage wide community involvement in the prevention of abuse and neglect and in the protection of children at risk. Local teams have an opportunity to identify and respond to gaps in the prevention / protection service network, maximizing the use of limited resources through creative approaches to local issues.	

7-Day Review of Foster Care/In-Home Services Child Fatalities

Definition
7 DAY REVIEW OF FOSTER CARE/IN-HOME SERVICES CHILD FATALITIES **Purpose** The North Carolina Division of Social Services' On-Site Review Team will review all child fatalities of children who are either in the custody of a County Department of Social Services or children who are part of an active In-Home Services cases at the time of the fatality. This review will be conducted using the current On-Site Review Instrument (OSRI) as provided by the Administration for Children and Families/Children's Bureau. The review of a fatality pursuant to this policy is not to investigate cause or death of a child, but to review the county's adherence to policy and expected practice. The information garnered from the review should be used by the county DSS to enhance the provision of child welfare services and to inform the State Child Fatality Review Team's determination if there is a need for an intensive review.

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Reporting of Child Fatalities of Children in Foster Care and In-Home Services Cases The county child welfare agency must, within 1 business-day of learning of the fatality, report all fatalities of children who are part of active In-Home Services or Foster Care cases to the Division of Social Services upon learning of the child's death. a) The county child welfare agency shall report the fatality within one business day of learning of the fatality by contacting their assigned Children's Program Representative (CPR) by phone. i) In After Hours – county child welfare agency must contact their Child Program Representative at the start of the next business day. b) The CPR must immediately notify the CPR Team Supervisor of the reported fatality. c) If the CPR is not available, the county department of social services staff person shall notify the CPR Team Supervisor.	

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d) The CPR Team Supervisor will immediately ensure that the following individuals are notified of the child's death by calling a meeting with the individuals or making individual calls: (1) OSRI Team Supervisor (2) Deputy Division Director for Child Welfare Services (3) Division Director for Social Services (4) Assistant Secretary for Human Services (a) The Assistant Secretary shall brief the Deputy Secretary for Human Services and the Secretary. e) The county child welfare agency shall complete the State Child Fatality Intake Form and submit the form to the State Child Fatality Review Team. i) The State Child Fatality Review Team supervisor will provide a copy of the State Child Fatality Intake Form to the CPR assigned to the county and the CPR Team Supervisor. **III. The Case Review** **Scheduling the 7-day review** Upon notification of the fatality of a child in the custody of the county department of social services or a member of an In-Home Services Case the OSRI Team Supervisor will: a) Assign an OSRI Team member to the 7-Day Fatality Review. b) The assigned OSRI Team Member will: i) Submit a scheduling letter to the Director of Social Services (1) The scheduling letter shall detail: (a) the name of deceased child, (b) the case name (c) The case number, (d) the date the review will begin.	

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ii) The review start date shall be within 7 business days from the date of the fatality. iii) The review end date shall be determined by the OSRI Team member. The length of time the case has been opened and complexity of the case will be mitigating factors. **IV. The Review** The process of this 7-day review is designed to have minimal impact on county operations. The county child welfare agency shall: 1. Identify a private space with a telephone for the reviewer. 2. Provide the complete family case record upon arrival of the OSRI Consultant. 3. Have all caseworkers and supervisors who have been assigned to this case or worked on the case available to answer questions regarding adherence to policy, practice, and documentation standards. a. It is preferable that the staff members be available for in person meetings. b. If the staff members are not available in person, the county must provide a list of telephone numbers where staff member may be reached. c. If the staff members are no longer employed by the county then the county has no duty to locate them. The OSRI Consultant shall: 1. Complete the review of the case file using the ACF/CB On-site Review Instrument (OSRI). 2. Interview or ask clarifying questions regarding the record to staff members who have been assigned to this case. 3. Complete the review using the on-line OSRI tool, using the ACF/CB Online Monitoring System (OMS). 4. Once this process is complete, the OSRI tool will be marked as “Complete” and is considered finished with no more editing.	

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5. At the end of the on-site review provide a copy of the OSRI report to the county Director of Social Services or designee. 6. Within 3 business days of the end of the on-site review convene a DSS staffing of the case to: i. Review the OSRI findings. ii. Determine if a corrective action plan will be required of the county department of social services b. The membership of this committee shall, at a minimum include: i. The OSRI Consultant completing the review ii. The assigned CPR iii. The Child Fatality Supervisor iv. The Child CPR Supervisor c. The CPR Supervisor shall provide the committee recommendations (from section IV of this policy) for corrective actions to the NC DSS Deputy Division Director for Child Welfare Services. **V. The Report** 1. NCDSS will complete and provide the OSRI to the county social services Director or designee immediately at the end of the on-site review 2. This report shall be considered confidential child welfare case information. 3. Copies of the report must be forwarded to the State Fatality Review Supervisor and the Deputy Director of Child Welfare Services. 4. The Child Fatality Supervisor shall use this information, in conjunction with other information collected to determine if an Intensive Fatality Review is required.	

7-Day Review of Foster Care/In-Home Services Child Fatalities

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VI. Findings 1. The NC DSS Deputy Division Director for Child Welfare Services shall draft a letter to the county director of social services including: a. The dates of the review. b. The reason for the review c. Any corrective actions required, including a specific timeline for the county's response d. Any changes to the program development plan, including a specific timeline for the county's response 2. Copies of the letter shall be submitted to: Assistant Secretary for Human Services Director of Division of Social Services State Child Fatality Review Team Supervisor County DSS Governing Body Chair	

State Child Fatality Review Protocol

Definition
STATE CHILD FATALITY REVIEW PROTOCOL In the Spring of 1991, three initiatives by the State established a statewide child fatality review system. These initiatives were the result of the growing awareness that child deaths in the State were both under-recognized and under-reported. These initiatives were: (1) the request by the N.C. Legislature, the Department of Human Resources and several other private agencies that the American Bar Association's Center on Children and the Law assist the state in establishing a statewide child fatality review committee, (2) the publication of The North Carolina Child Advocacy Institute's "Deaths from Child Abuse and Neglect in North Carolina: Closing the Loopholes", and (3) Governor James G. Martin's issuance of Executive Order Number 142: Child Protective Services. Governor Martin's Executive Order 142 directed the Division of Social Services (hereafter, the Division) to strengthen its supervision of county-administered child protective services programs. It called for Division review of child fatalities resulting from abuse and neglect and quarterly reports to the public on these deaths. The North Carolina General Assembly also responded to the growing concern over child deaths. It funded two consultant positions in the Division dedicated to reviewing child deaths when Child Protective Services (hereafter, CPS) has had prior contact with the child's family. In 1997, the North Carolina General Assembly passed legislation that established a State Child Fatality Review Team. N.C.G.S. §143B-150.20 states that this team is to: "conduct in-depth reviews of any child fatalities which have occurred involving children and families involved with local departments of social services child protective services in the 12 months preceding the fatality. Steps in this in-depth review shall include interviews with any individuals determined to have pertinent information as well as examination of any written materials containing pertinent information." The statute continues: "The purpose of these reviews shall be 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. The Division of Social Services shall make public the findings and recommendations developed for each fatality reviewed relating to improving coordination between local and State entities." Furthermore: "The State Child Fatality Review Team shall include representatives of the local Departments of Social Services and the Division of Social Services, a member of the local Community Child Protection Team, a member of the Local Child Fatality Prevention Team, a representative from local law enforcement, a prevention specialist, and a medical professional." On July 4, 2003 this statute was amended to include provisions for accessing

State Child Fatality Review Protocol

Definition
information while completing a State Child Fatality Review. This amendment provided the State Child Fatality Review Team the right to request a court order compelling disclosure when difficulties obtaining information are encountered. A Child Fatality Review Team is convened by the Division to conduct a fatality review whenever there is a suspicion abuse or neglect has contributed to a child's death and a county Department of Social Services (hereafter, DSS) has had contact through its child welfare programs with the child or family within the 12 months preceding the child's death. The purpose of the review is to enable the Division, the county DSS, state and local agencies, and the local community to identify important issues related to child protection and to take appropriate action to improve our collective efforts to prevent child fatalities. The review process is a collaborative, multi-disciplinary effort that involves representatives of the Review Team as outlined in statute. The Review Team issues a formal, public report designed to stimulate system improvements. Whenever a person is criminally charged in the fatality, the report is reviewed by the local District Attorney to ensure that its content does not interfere with any criminal investigation or prosecution. It is important to recognize that a child fatality review report is intended to provide information that can be put to constructive use in preventing future fatalities. These reports are made public with the expectation that community agencies, groups, and individuals can take positive action in the wake of tragic circumstances. It is not the purpose of these reports to determine whether a person, group, or agency could have prevented a fatality. It is also important to recognize that while the DSS in each county is charged with conducting CPS assessments of reports of suspected child abuse and neglect, the DSS is not alone in its responsibility to protect children or in prevention efforts. Each DSS relies on the broader community to provide information and to conduct related CPS assessments and examinations that help DSS and the court system to make important decisions concerning the safety of children. Consequently, the review process places particular emphasis on issues of interagency collaboration, communication and decision-making.

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REPORTS OF CHILD FATALITIES TO THE DIVISION AND DECISION TO CONDUCT A REVIEW According to N.C.G.S. §7B-301, "any person or institution who has cause to suspect that a juvenile … has died as a result of maltreatment shall report the case … to the director of the department of social services in the county where the juvenile resides or is found." In turn, N.C.G.S. §7B-311, requires that directors of county DSS report to the Department of Health and Human Services, Division of Social Services, all child fatalities that are a result of alleged maltreatment. This report is made using the State Child Fatality Intake Form	

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(Attachment A) which should be completed by the county DSS. This report is used to determine whether the circumstances in the death meet the criteria for a Child Fatality Review. The report shall be made to the Division within 5 business days of the agency's knowledge of a fatality suspected to be as a result of maltreatment. The report shall be made in writing **by fax** to: North Carolina Health and Human Services Child Welfare Section Fatality Review Team 820 S. Boylan Ave, McBride Building 2410 Mail Service Center Raleigh, NC 27699-2410 919 527 7240 Office 984 285-7103 Fax Division staff may directly contact the medical, law enforcement, or human service professionals for additional information. The final decision to conduct the review will be made by the Division with input from the county DSS and other appropriate professionals. The decision to conduct a fatality review will be communicated to the county DSS after the Division obtains all pertinent information needed to make the final decision. The assigned Children's Program Representative (hereafter, CPR) will be contacted at the time that decision is made to conduct a review. At the time the decision for a review is communicated to the county DSS, the Child Fatality Reviewer will ask the county DSS contact person to identify the Community Child Protection Team (hereafter, CCPT) chairperson. The Child Fatality Reviewer will then contact the chairperson of the CCPT to request a meeting of the CCPT for the purpose of presenting information about the fatality review process. If the CCPT does not have a regular meeting scheduled within 30 days of this contact, the CCPT will be asked to convene a special meeting within 30 days for the Child Fatality Reviewer to make this presentation. Every effort should be made to ensure full participation of the membership of the CCPT for this meeting. For more detailed information on the CCPT process please refer to the NC Child Welfare manual. **III. PREPARING FOR THE REVIEW**	

State Child Fatality Review Protocol

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A. Presentation The document, "Dimensions of an Intensive State Child Fatality Review" (Attachment B) provides an outline of the steps to be completed during the course of the fatality review. This is a general guideline and will be used flexibly as each fatality situation is unique. The Division's Child Fatality Reviewer will meet with the membership of the local CCPT to explain the fact that a review must be conducted, the purpose of the review, the composition of the review team mandated by law. During this presentation, the Child Fatality Reviewer will note the legal mandates of the CCPT in conducting the State Child Fatality Review process, along with the similarities and differences with the legal mandates for the State Child Fatality Review Team. **B. Selecting State Child Fatality Review Team Members** The following guidelines shall be used in selecting Review Team Members: 1. A local law enforcement representative who, if possible, has not had direct contact with the case in question to be selected by the county CCPT 2. A medical professional who, if possible, has not had direct contact with the case in question and who should have particular expertise in the area of child abuse and neglect 3. A prevention specialist from an agency that provides prevention services to families and children who, if possible, has not had direct contact with the case in question who has knowledge of child abuse and neglect issues 4. A member of the local CCPT to be selected by the county CCPT (this person should have knowledge of children's services issues and DSS procedures)	

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5. A member of the local Child Fatality Prevention Team (CFPT) to be selected by the county CFPT (this person should have knowledge of children's services issues and DSS procedures) 6. A member of the local DSS staff who, if possible, has not had direct contact with the case in question to be selected by the county DSS The county DSS or the local CCPT representative will be responsible for the collection and dissemination of team membership names, addresses, phone numbers, email addresses, and fax numbers. **C. The DSS Case Record** 1. The county DSS must send a copy of the DSS case record to: The North Carolina Division of Social Services Child Welfare Services Section Local Support Operations Team 820 S. Boylan Ave. Raleigh, NC, 27699-2439 A copy of all case documents will be made and provided to State Child Fatality Review Team members within adequate time for members to read and review prior to the on-site review. 2. The DSS case record should contain all child welfare information concerning the family or child, as well as Medicaid, Work First and Food Stamps eligibility and receipt. For example, if the child was in foster care, the agency will need to send a copy of the child's record along with any record of CPS provided to the child and family, as well as the foster parent record. If the county DSS has made a CPS report to another county DSS involved in the case, the information received from the other county DSS should also be	

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sent. Any CPS reports that were not accepted for CPS assessment should also be included, if available from the county DSS. **D. Other Agency Case Records** In order to fully carryout the purpose of the review as specified in N.C.G.S. §143B-150.20(b), it will be necessary to request written material from other agencies that have had direct contact with the case. This legislation provides the authority to obtain these records per paragraph (d). The State Child Fatality Review Team members will discuss which records are needed and will decide together who will take responsibility for obtaining the written materials from these agencies. Individual team members may decide to take on this responsibility based on their professional connections for obtaining the records and for making copies for dissemination to the team. The Division's Child Fatality Reviewer will assist in the event that there are problems obtaining any of the needed information as well as with copying and dissemination if needed. The distribution of agency records must be completed with sufficient time to allow for members to read and review the materials prior to the on-site review meeting. **E. Logistics** 1. The Child Fatality Reviewer and the designated State Child Fatality Review Team members will discuss the proposed length of time the review will require and determine a mutually convenient time to hold the review. Review Team Members will be informed that they must commit to participate for the number of days scheduled for the review. If an appointed person cannot make such a commitment, another person will be identified who can make this commitment. 2. The review can be held at the county DSS or at another location identified by the State Child Fatality Review Team members or the chairperson of the CCPT. In either case, the room chosen should be able to accommodate up to ten people. It will be helpful if a telephone with speakerphone capability can be located in the room. In the event that this is not possible, the host agency will be asked to identify a telephone nearby with this capability.	

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3. The Division's Fatality Reviewer must be notified in the event that the State Child Fatality Review Team's composition changes. No one may participate as a review team member without the prior knowledge and consent of the Division's Fatality Reviewer. 4. After receipt of the case records, each team member will provide to the Division's Child Fatality Reviewer a list of persons he / she wishes the team to interview. The Division's Child Fatality Reviewer will then forward this information to the county DSS contact person so that interviews can be scheduled. In every case, the DSS social workers for the child and family and their supervisors will be interviewed by the team. Generally, it is helpful to schedule interviews approximately one hour apart. However, the prospective interviewees should be informed that these time frames may have to change depending on circumstances. The State Child Fatality Review Team may designate someone other than the DSS contact person to arrange the interviews. 5. As the county DSS contact person (or any other person designated to arrange the interviews) talks with prospective interviewees, it is important that the Division's Fatality Reviewer is informed of any problems in interview scheduling. For example, if a physician says that he / she will not be available for the interview or if someone from another agency states that he / she does not believe they are required to be present for the interview, the Division's Child Fatality Reviewer should be informed immediately. In many cases, clarification of the purpose and role of the State Child Fatality Review Team and its authority to examine records and interview individuals will be enough to allay any concerns the individuals may have. The Division's Child Fatality Reviewer must be informed early so that such clarification can take place prior to the review. 6. The Division's Child Fatality Reviewer will send the State Child Fatality Review members a copy of the "Dimensions of an Intensive Fatality Review." This document outlines information regarding what the county	

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DSS, local Review Team members, and the Division's Child Fatality Reviewer are expected to do as a part of the review process. **IV. CONDUCTING THE ON-SITE REVIEW** **A. Entrance Conference** These activities may be completed at a meeting prior to the actual on-site review meeting: 1. Content - The entrance conference is designed to acquaint participants with the purpose and focus of child fatality reviews and to answer any questions about the review process. Information will be provided regarding the fatality review process and time frames for completion of the review and report. 2. Participants - Entrance conferences are open meetings. Consequently, attendance by media representatives and/or other interested community persons is permitted. Child Fatality Reviews are community focused. As a result, any agency and its staff that had contact with the child or family may attend. Persons named as interviewees may also attend the entrance conference, if they wish. **B. Interviewing Process** Face-to-face and telephone interviews with persons significant to the case are a major part of the Child Fatality Review. These interviews provide social workers, supervisors, and community agency staff with the opportunity to elaborate on their written documentation. Written documentation can address the essentials of the work with the family, but face-to-face interviews can detail the scope of the work. Interviews are conducted in a sensitive manner while also ensuring that relevant information is obtained. Generally, only those persons who have provided a service to the child or family while the family was known to DSS will be interviewed. There will be times, however, that private individuals may wish to approach the State Child Fatality Review	

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Team with information he / she believes may be important. At the time of the review, case discussions may produce the names of other persons the State Child Fatality Review Team members want to interview. The CPR assigned to the DSS may be interviewed as well. **C. Team Discussion of Preliminary Findings** After the fact-finding portion of the review, the State Child Fatality Review Team members will meet to discuss preliminary findings. Generally, this meeting will last from one-and-a-half to two hours. A draft of the report will be reviewed at this time. This will provide stakeholders an opportunity to seek specific clarification on the findings and recommendations **D. Exit Conference** This conference will occur after the Division has finalized the report. Like the Entrance Conference, the Exit Conference is an open forum. It is designed to acquaint the agencies involved in the fatality review with the final report of the State Child Fatality Review. It is a time for clarification and answers to questions that may have arisen regarding the review process. Consequently, media representatives or other interested persons may attend. **V. THE CHILD FATALITY REVIEW REPORT** **A. Process** 1. Content Each State Child Fatality Review will culminate in the issuance of a "State Child Fatality Review: Findings and Recommendations draft report" (Attachment C) that, upon demand, can be released to the public once finalized. This report will address issues relating to agency collaboration, communication and decision-making. The report will also address specific issues within agencies that the review team identifies as having direct bearing on the prevention of child fatalities. The report will contain recommendations for agencies when there are	

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issues directly related to the prevention of future child fatalities. The report will also contain recommendations for coordination between state and local entities that might have avoided the threat of injury or fatality and will identify appropriate remedies. It is strongly recommended that the report outline initial plans for action that can be initiated by the local community and its agencies. The Division's review will include guidance from legal counsel to ensure that the report does not disclose case specific information required to remain confidential or otherwise violate the law. Release of Information in the State Child Fatality Review Report The following categories of case specific information can be included in the final report: a. the name, gender, date of birth and date of death of the deceased child b. the fact that an investigation was conducted by the county DSS c. the fact that the State Child Fatality Review Team conducted a review d. the result of that review to the extent that it does **not** disclose any case specific information 2. Review Draft of the Report After receipt of the initial draft report State Child Fatality Review Team members will participate in a conference call to provide feedback to the Division Child Fatality Reviewer. This conference call will be scheduled prior to the close of the review. The State Child Fatality Review Team members may choose to have a face-to-face meeting, rather than a conference call. The State Child Fatality Review Team members will need to agree on the content of the report. Any concerns that the State Child Fatality Review Team members have will be addressed before the draft report becomes final. 3. Review by Local District Attorney Whenever anyone has been criminally charged in a child fatality, the Child Fatality Reviewer will send a copy of the draft report to the local District Attorney for review. The purpose of such a review is to ensure that the report	

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does not compromise any criminal investigation, prosecution or interfere with a defendant's right to a fair trial. **B. Issuance of the Final Report** 1. The Division's Child Fatality Reviewer will receive Division Management's feedback and incorporate any recommended changes. 2. The Division's Child Fatality Reviewer will send the report to the local District Attorney for approval. If the District Attorney recommends changes to the draft report in accordance with N.C.G.S. §7B-2902(d), the Division Child Fatality Reviewer will make those changes, and communicate the changes, if any, to all State Child Fatality Review Team members. 3. After the report has been finalized, copies will be sent to the State Child Fatality Review Team members and the directors of all agencies named in the report prior to releasing the report to any outside individuals/agencies. 4. After the report has been finalized by the Division and sent to the directors of all agencies named in the report, copies will be mailed to the following persons: • Chairperson of the local Community Child Protection Team • Chairperson of the local Child Fatality Prevention Team • Chairperson of the local Social Services Board • The Director of the Division of Social Services • The Deputy Director of the Division of Social Services • The Program Administrator for the Family Support and Child Welfare Services Section • Counsel for the Division of Social Services • All Family Support and Child Welfare Team Leaders • The assigned Children's Program Representative • The Director of Prevent Child Abuse North Carolina • The Chief Medical Examiner • The Medical Director of the State Fatality Prevention Team	

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• All members of the State Child Fatality Prevention Team 5. Dissemination of the State Child Fatality Review Report seldom takes place via a press conference. However, there are some cases in which the Division and county DSS determine that it is in the community's best interest to release the report in this manner. This decision is made on a case by case basis. **VI. PRESENTATION AND COMMUNITY RESPONSE TO THE STATE CHILD FATALITY REPORT** **A. Local CCPT** Following the on-site review, the State Child Fatality Review Team members will present the findings and recommendations to members of the local CCPT and agencies identified in the report. The purpose of this presentation is to clarify any issues contained in the report. The State Child Fatality Review Team will designate one of its members to make this presentation formally. However, it is strongly recommended that all members of the State Child Fatality Review Team be present for this presentation. **B. Follow Up** At approximately six months following the issuance of the State Child Fatality Review Report, a letter will be sent from the Division to the Chair of the local CCPT asking for feedback on specific actions the local community has taken in the aftermath of the fatality review. The response should include feedback from the community on the report's potential benefit to the community in helping to prevent future fatalities. This feedback will help the Division compile information on steps communities have taken to prevent future fatalities. This information will be used to develop the annual report to the General Assembly and will be disseminated to all local CCPT and to any state-level agencies that may need to address policy or practice issues. **Attachment A : State Child Fatality Intake Form** **Attachment B: Dimensions of an Intensive Fatality Review** **Attachment C: Review Findings and Recommendations**	

ATTACHMENT A:

STATE CHILD FATALITY INTAKE FORM

Fax Completed Forms to Local Support Operations
(919) 733-3823 fax

Date Prepared: _____ Prepared By: _____

County: _____ Assigned County CPR: _____

CPS Contact Person: _____ Director/Program Mgr.:_____

Telephone: _____ E-Mail Address: _____

Name of Deceased Child(ren):_____

*Race_____**Ethnicity_____ Gender_____ Date of Birth_____ Date of Death_____

Surviving Children in the Home:

Name	Date of Birth	*Race	**Ethnicity	Gender

Parent / Caretaker:

Name	Address	Age	*Race	**Ethnicity	Gender

Other Adults Involved:

Name	Address	Age	*Race	**Ethnicity	Gender

Status of Family's Case at Time of Child(ren)'s Death:

- ☐ Open CPS Assessment(s)
- ☐ Open CPS In-Home Services
- ☐ Closed CPS Case(s)
- ☐ DSS Custody
- ☐ Prior Screened Out Report(s)
- ☐ No Prior CPS History
- ☐ Family Preservation Services
- ☐ Other (Specify: _____)

*Race: American Indian or Alaskan Native=AI or AN; Asian=A, Black or African American=B; Native Hawaiian or Other Pacific Islander=PI; White=W

**Ethnicity: Hispanic or Latino=H; Not Hispanic or Latino =NH

ATTACHMENT A: STATE CHILD FATALITY INTAKE FORM

Prior Child Welfare Services (including screened out reports and all report dates and results):

_____

Known Circumstances of the Fatality (including a brief description of the circumstances surrounding this fatality including any physical injuries):

_____

_____

_____

_____

Suspected Cause of Death_____

Autopsy Conducted: ☐ Yes ☐ No

Autopsy Results_____

Actions Taken by DSS in Regard to the Fatality and Future Actions Anticipated:

_____

_____

_____

List Other Professionals Involved with Fatality:

Name Agency Telephone

_____

_____

_____

List Anyone (other than above) Who Expressed Concern About Fatality:

_____

_____

Pending Criminal Charges: _____

ATTACHMENT B:

DIMENSIONS OF AN INTENSIVE FATALITY REVIEW

I. In addition to DSS, determine which agencies' records need to be requested.

   A. Those agencies having significant knowledge of child, family and the situation leading up to the fatality and the assessment of fatality.

   B. Ensuring the nine life domains have been addressed (safe place to live, family, social life / supports, educational life, physical health, emotional and psychological health, legal issues, safety and crisis issues, and cultural / ethnic issues).

II. Determine those who will be interviewed.

   A. Those individuals having significant knowledge of child, family and the situation leading up to fatality and the investigation of fatality.

   B. Any DSS worker involved with the case and their supervisor, any law enforcement officer and their supervisor, and any other agencies' staff involved with the child and family.

   C. Offer up to 10 minutes for any additional persons who wish to be heard but the team has not requested to interview. A maximum agreed upon allotted amount of time should be set before informing interested parties about review. If the time allotted is not sufficient, information can be submitted in written form to an identified person within a specified time frame. Telephone conference calls can be utilized as well.

   D. No interviewees may remain with the State Child Fatality Team before the interview.

III. Inform all those involved with the process, whether directly or indirectly, about the process (how, why, and what).

   A. Identify those not scheduled to interview who wish to have input into the review fact finding and schedule time for them to speak.

   B. This may be accomplished through an Entrance Conference format.

IV. Put together a time frame of events, persons involved, and pertinent information.

V. Overlay the nine life domains.

VI. Note issues and questions as the time line is done and life domains are overlaid.

VII. Conduct Interviews which cover the following:

   A. Length of involvement with the child, family and/or situation.

   B. Identify services offered, including the assessment and plan for the child and/or family.

C. Identify any barriers to services or meeting plan goals.

D. Clarification of issues raised by time line and life domains.

VIII. Formulate findings of fact and recommendations.

IX. Develop a plan of action and plan for follow-up

X. Decide how to inform persons and agencies involved of initial findings and obtain their feedback on recommendations before writing the final report. This may be accomplished through an Exit Conference format.

XI. If there are criminal charges pending, the report must be reviewed by the District Attorney prior to being publicly released.

XII. Send a preliminary copy of the final, written report to any agency named in the report.

XIII. Present the final, written report that includes findings, recommendations, and plan to the CCPT and interested public.

XIV. The full CCPT will be offered the opportunity to file a written response to the Division regarding the Team's report. This response will be attached to the fatality review report and will be provided to anyone requesting a copy of the report.

XV. Specific feedback regarding the actions taken by the local community will be requested from the CCPT approximately six months after the review took place.

ATTACHMENT C:

STATE CHILD FATALITY REVIEW FINDINGS AND RECOMMENDATIONS COUNTY

, [DATE]

Prepared By:

_____, Division of Social Services

State Child Fatality Review Findings and Recommendations

_____, County

___ Date

A State Child Fatality Review Team comprised of _____ County Community Child Protection / Child Fatality Prevention Team members and Division staff me on _____to review the death of _____. Since this family had been involved with the _____County Department of Social Services within the twelve months preceding the death, an in-depth review was required pursuant to N.C.G.S. §143B-150.20. According to paragraph (b) of the statute, "The purpose of these reviews shall be to implement a team approach to identify 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."

Toward this end, a State Child Fatality Review Team consisting of representatives as required by state law was convened on . Team members, their agency titles and roles were as follows:

ATTACHMENT C: STATE CHILD FATALITY REVIEW FINDINGS AND RECOMMENDATIONS

Name	Agency Title	Role on Team

The Team reviewed pertinent records including police investigative data, medical examiner, and social service records. The Team also interviewed relevant personnel who provided professional, insightful information. The timeline was completed and the nine life domains (safe place to live, family, emotional / psychological, vocational / educational, physical health, legal, safety and crisis, social supports, and cultural / ethnic) were discussed. A summary of the report findings will be given to the full Community Child Protection Team and the Community Child Fatality Prevention Team in the near future.

Was born on and died on , at the age of . According to the North Carolina Medical Examiner's report, the cause of death was . The manner of death was . No criminal charges have been filed in this matter. Accordingly, the amount of information that may be released is limited.

Findings and Recommendations

During the Team's review of the circumstances surrounding death, several facts, themes and conclusions emerged.

Findings:

-

Recommendations:

-

While the Review Team developed its recommendations to better protect children in the future, it cannot be known what impact, if any, these recommendations could have had on the reviewed case if they had been in place at the time of the fatality.

In conclusion, the Community Child Protection / Child Fatality Prevention Team would like to thank the agencies that provided information and personnel to conduct this review. It is our hope that changes in policies and practice resulting from this report will improve future service provision.