Strengthening the North Carolina Child Fatality Prevention System Stakeholder Workgroup

Meeting 1 – February 3, 2020
10:00 AM – 3:00 PM
630 Davis Drive
Morrisville, NC 27560

Attendance

Adam Zolotor, Alan Dellapenna, Belinda Pettiford, Brenda Edwards, Catherine Joyner, Cindy Bizzell, Debbie Jenkins, Debra Hawkins, Elaine Cabinum-Foeller, Emily Hooks, Eric Harbour, George Bryan, Gerri Mattson, Hattie Gawande, James Coleman, Jennie Kristiansen, Jenny Cooper, Joyce Hatem, Karen Wade, Kathleen Jones-Vessey, Kathy Hitchcock, Kella Hatcher, Kelly Kimple, Kerry Young, Melanie Meeks, Melea Rose-Water, Michelle Aurelius, Molly Berkoff, Paige Rosemond, Pam McCall, Phil Redmond, Sarah McCracken, Scott Proescholdbell, Selena McCarter, Teresa Strom, Terri Grant, Terri Reichert, Tom Vitaglione, Walker Wilson

Welcome & Strengthening the North Carolina Statewide Child Fatality Prevention System

Ms. Wade stated that bringing together this Stakeholder Workgroup to receive input on restructuring and strengthening the statewide child fatality prevention system is a priority for NCDHHS. The system is complex, and the expertise from this group will enable us to improve the system.

Dr. Zolotor shared an overview of the North Carolina Institute of Medicine. He explained that this stakeholder workgroup is part of the larger backbone organization that came out of the Task Force on Essentials for Childhood: Safe, Stable, and Nurturing Relationships and Environments to Prevent Child Maltreatment. He provided an overview of the workgroup and explained that materials would be posted on the Essentials for Childhood portion of the NCIOM website.

North Carolina Child Fatality Prevention System: Overview of the current structure and recommendations to strengthen the system

Ms. Hatcher provided an overview of the current structure and components of the North Carolina child fatality prevention system which consists of three main components – local teams (CCPTS and CFPTs), the State Child Fatality Prevention Team, and the NC Child Fatality Task Force. CCPTs and CFPTs differ in membership and support, but they operate at the local level, review individual cases, and report any recommendations annually to the Board of County Commissioners. CFPT reports are sent to the Team Coordinator and are then disseminated to the State Team and other local teams. CCPT reports are submitted to local DSS boards and their Board of County Commissioners report is submitted to NC DSS. The State Child Fatality Prevention Team is chaired by the Chief ME and reviews deaths of children attributed to abuse or neglect, reviews other types of child fatalities in NC that are investigated by the statewide Medical Examiner system, provides support to local teams, and makes recommendations and reports to the Task Force. The NC Child Fatality Task Force

analyzes and reports on incidences and causes of child deaths, develops a system for multidisciplinary review of child deaths, considers the report from the state team, and submits an annual report to the Governor and General Assembly with recommendations for changes to any law, rule, or policy that promotes the well-being and safety of children. There is a need for a more robust data system so that more of the task force's work can be more informed by analyzing trends from local teams. Ms. Hatcher shared that NC is one of only five states that do not participate in the National Child Death Review Case Reporting System. She explained that a centralized office in one location would allow streamlined state-level support for local teams, which will increase efficiency and allow for the connection of information among local teams. In addition, she reviewed recommendations from the North Carolina Child Fatality Task Force on strengthening the statewide child fatality prevention system, and discuss pending legislation dedicated to strengthening and restructuring the state-wide child fatality prevention system. The legislation establishes a state Office of Child Fatality Prevention within DHHS and directs DHHS, in consultation with individuals knowledgeable about child fatality review and prevention, to develop and submit a proposal that addresses five aspects of restructuring, and updates and clarifies statutes that address the task force.

Citizen Review Panels

Ms. Strom reviewed the CAPTA legislation that established citizen review panels in 1996 and shared that NC has the most citizen review panels in the country, and most states have less than ten. In 1997, NC determined that CCPTs met the federal requirements of citizen review panels. The CCPT advisory team collects data from CCPTs through an annual survey and develops a report for NC DSS. NC DSS then uses the feedback from that report to support the CAPTA CRP report. Mr. Bryan shared that CCPTs allow independence from DSS.

Local and State Team Panel

Ms. McCarter shared the perspective of intensive reviews which are required if CPS was involved in the last 12 months, if maltreatment was suspected, or a county requests an intensive review. Intensive review is guided by a statute that requires a multidisciplinary approach. The report that comes out of those intensive reviews contains findings and recommendations, as well as who is responsible for carrying those recommendations out. Ms. Rosemond shared the combined team (CCPT & CFPT) perspective. A strength of the Wake County combined team is the collaboration that occurs and the concrete recommendations and action steps for team members. They face several challenges, including maintaining motivation of volunteers participating in the process, the dominance of fatality reviews, and the struggle to fill the spot on the team of a parent of a child who has died. She echoed the need for improved access to data and more state contact, support, and technical assistance. Ms. Hatem explained the role of CFPTs, including the information that must be collected from various local agencies prior to meeting. The recommendations that have come out of the New Hanover CFPT are locally-focused and impactful. Dr. Cabinum-Foeller shared her experience on the Pitt County CFPT. The Pitt County CFPT also has difficulty getting a parent representative on the team but they also have good participation from a variety of local agencies.

She echoed the desire for more feedback from the state and the need to share ideas and information with teams across the state. Ms. Young addressed the state team's experience. The state team reviews around 500 child fatalities per year. The state team provides technical assistance to local teams, including regional trainings, and can also ask a local team for additional information on case reviews.

National Perspective: Information from other states' child death review systems

Ms. Gawande presented state child death review systems to serve as case studies. None of the states have local teams by county, and they offer either regional structures or are county-based with an opportunity for smaller, more rural counties to combine. Most states have statute prescribed membership requirements. Many states have state representation at every review; TN and TX will have state representation upon request. Although every state has a different way of case entry, all states struggled with data analysis when it is collected at the county level. Takeaways from these case studies include: there is a great need for state support when reviews are conducted at the local level; concentrating reviews at the local level enables the state to focus on prevention; and the national case reporting system is helpful to prevention work.

Group Discussions

Each table discussed the four different types of current teams and how their duties and roles can best be consolidated; anticipated challenges and barriers to consolidation; and issues and factors that need to be considered by NC counties as they decide to have a single or multi-county team.

Next Steps

The next meeting will be held on 2/25 from 10:00 AM – 3:00PM, and the following meeting will be held on 3/19 from 10:00 AM – 3:00PM.