

**Agenda Item Number:**

**ORANGE COUNTY BOARD OF HEALTH  
AGENDA ITEM SUMMARY**

**Meeting Date:** May 27, 2015

**Agenda Item Subject:** Child Fatality Prevention Team/Community Child  
Protection Team Annual Report

**Attachment(s):** 2014 Child Fatality Prevention/Community Child Protection Team  
Annual Report

**Staff or Board Member Reporting:**

**Purpose:**  Action  
 Information only  
 Information with possible action

---

**Summary Information:** The report is a review of CFPT/CCPT in Orange County North Carolina. Included is a description of membership, duties, procedures and activities.

Per the Board of Health's Policies and Procedures, and North Carolina State Law, the report should be reviewed by the Board of Health and forwarded to the Board of County Commissioners for information.

**Recommended Action:**  Approve  
 Approve & forward to Board of Commissioners for action  
 Approve & forward to \_\_\_\_\_  
 Accept as information  
 Revise & schedule for future action  
 Other (detail): Review & forward to the Board of  
Commissioners for their information

# **Orange County Child Fatality Prevention Team/Community Child Protection Team 2010 Annual Report**

## **I. Introduction:**

The 1991 General Statute 7-B-Article 14 of the North Carolina Juvenile Code established a Community Child Protection Team (CCPT) in every county in North Carolina. In 1993 the legislature added Child Fatality Prevention Teams (CFPT) in every county. The charge of these two teams is to reduce preventable deaths in our state. Since the mandates and purposes of these teams are so similar, the Orange County's CFPT and CCPT have functioned as one interagency review team since 1998.

The general statutes require that CFPT/CCPT membership include the Department of Social Services (DSS) Director, DSS Staff, \*DSS Board, the Health Department Director, Law Enforcement, Superintendent of each School System, Mental Health, Guardian ad Litem Program, Health Care Providers, Emergency Medical Services, Medical Examiner's Office, Parent of a deceased child, \*District Attorney's Office, Day Care/Head Start, \*Community Action organization, \*District Court Judge, and up to five at-large community members (\* no current representation on CFPT/CCPT).

The general statute grants the CFPT/CCPT access to all medical, hospital, mental health, social service, and law enforcement records as well as records maintained by any state, county or local agency as necessary to carry out its duties. The local health director assures that the local CFPT completes mandated services while the local social services director assures that the local CCPT mandates are met. The CFPT/CCPT operates under strict confidentiality requirements; therefore, meetings are not subject to the Open Meetings Law. Both teams are required by statute to submit reports annually to the State of North Carolina, the local Boards of Health/Department of Social Services, and the local County Commissioners.

In 2014, the Orange County CFPT/CCPT functioned as a cohesive group of professionals with good attendance and participation. The Orange County CFPT/CCPT is comprised of excellent collegial professionals and community volunteers in keeping with the requirements of the governing statute.

Our local CFPT/CCPT received \$749 for FY 2014-1015 from the NC General Assembly. These funds were used to provide training for human service workers in the county on preventing Fetal Alcohol Syndrome.

## **II. Child Fatality Prevention Team**

### **A. Purpose:**

The CFPT meets at least quarterly to review deaths of children 0 through 17 years of age that occurred in the same quarter of the previous year for the following purposes:

1. To identify child death patterns,
2. To identify system problems or gaps in services to children and families, and
3. To make and carry out recommendations for change that will prevent future child deaths.

B. Activities—the CFPT met five times and reviewed a total of 16 fatalities in 2014:

1. Findings included:

- 2 infant deaths were due to complications related to extreme immaturity.
- 2 infants died within one day of birth due to physical disorders
- 3 infants died within 3 months of birth due to unspecified causes
- 1 child under 5 years of age died of complications of acute or chronic illness
- 4 youth under 18 years of age died of complications of acute or chronic illnesses.
- 2 youth under 18 years of age died due to motor vehicle accidents
- 1 youth under 18 years of age died due to intentional self-harm
- 1 child under 2 years of age died from an accident at home.

2. Potential System Problems identified:

- Infants being placed in unsafe sleeping positions or arrangements
- Unsafe use of infant sling carrier
- Alcohol use in pregnancy
- Home not adequately child-proofed for safety

### **III. Community Child Protection Team**

A. Purpose:

The CCPT reviews selected cases in which children are being currently served by child protective services and to review all cases in the county in which a child died as a result of suspected abuse or neglect to identify gaps in services in the community child protection system.

1. To ensure that families have resources available to them to enhance their ability to provide safe environments for their children,
  2. To inform the community regarding child protection issues that impact the ability of families to protect their children,
  3. To facilitate collaboration of team and community resources in order to protect vulnerable children, and
  4. To make recommendations for legislative changes.
3. Activities: The CCPT reviewed the cases of 10 families with 19 children who were actively involved with Child Protective Services (CPS). The team assisted in identifying resources for children. Recommendations were made regarding follow up.

1. Findings included:

- a. Substance abuse was an issue for 7 families.
  - a. One child was born positive for cocaine and marijuana
  - b. Mental health was an issue for 3 families.
  - c. Sexual abuse occurred in one family.
  - d. Domestic violence was present in four families.
  - e. DSS had legal custody of the children in 6 of the cases at the time of the review.

2. Potential system problems identified:

- a. Barriers to accessing supportive comprehensive mental health services.
- b. Challenges in maintaining substance abusers in treatment.
- c. Limited resources for the abusers in domestic violence cases.

**IV. Recommendations by CFPT/CCPT:**

1. Families need awareness of unsafe sleep environments for infants – reinforce dangers of co-sleeping.
2. Families need awareness of safety concerns with using an infant sling for carrying babies less than 3 months of age.
3. Need for greater access to parenting education.
4. Human service providers working with young women should stress dangers of alcohol use in pregnancy.

**V. Actions and Accomplishments of the Orange County CFPT/CCPT:**

- A. Met 5 times in 2014 to review child fatality and child protection cases. Thoughtful discussion with identification of system problems and subsequent recommendations occurred.
- B. Collaborated with Early Head Start to provide training for human service workers in the community. The training was presented by Amy Hendricks, Project Director for the NC Fetal Alcohol Prevention Program. Thirty-eight human service workers including nurse practitioners, nurses and social workers attended.
- C. Reported fatality associated with infant equipment to the Consumer Product Safety Commission.
- D. Provided a clearinghouse through e-mail for member agencies to share information on community events, pertinent news articles and data, and training opportunities on child health, safety, and protection issues.