During the calendar year 2007, the Buncombe County Child Protection/Fatality Team, consisting of 21 representatives from 17 child community service systems, met on a monthly basis with an intent to enhance child protection in Buncombe County through collaboration and advocacy. Recognizing the importance of public participation and community engagement, the Team fosters a multi-disciplinary approach to problem solving. The structure of the meetings was designed to provide for a review of all child fatalities in the County for the previous year as well as a review of several current cases with CPS involvement at the Department of Social Services in an effort to identify any deficiencies in available resources or gaps in service that need to be addressed with strategic planning to ameliorate the conditions that compromise safety and well being for children.

Functioning as two distinct teams, the combined mission has been to:
- Identify deficiencies in the delivery of services to children and families
- Make and carry out recommendations for changes that will prevent future child abuse and neglect fatalities
- Advocate for community resources that impact on the community’s ability to protect children

This report gives a summary of the data, including number of cases reviewed, discussions of defined issues that were brought to attention, and recommendations that were made on a local and state level. Various relevant community activities in which the Team participated throughout the year are described as well.

**CHILD FATALITY STATISTICAL INFORMATION:**

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Others</td>
<td>2</td>
</tr>
<tr>
<td>Vehicular Accident</td>
<td>4</td>
</tr>
<tr>
<td>Homicide</td>
<td>1</td>
</tr>
<tr>
<td>Self Intentional Harm</td>
<td>1</td>
</tr>
<tr>
<td>SIDS</td>
<td>2</td>
</tr>
<tr>
<td>Cerebral Palsy</td>
<td>2</td>
</tr>
<tr>
<td>Fall</td>
<td>1</td>
</tr>
<tr>
<td>Birth defects</td>
<td>4</td>
</tr>
<tr>
<td>Overlaying</td>
<td>1</td>
</tr>
<tr>
<td>Shaken Baby</td>
<td>1</td>
</tr>
<tr>
<td>Viral Infection</td>
<td>1</td>
</tr>
<tr>
<td>Pre-maturity/perinatal</td>
<td>10</td>
</tr>
<tr>
<td>DSS Cases</td>
<td>6</td>
</tr>
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</table>
Quarterly, child fatalities were reviewed by the local Child Protection Team. During such reviews, discussions were held regarding any factors that might have contributed to the fatality and circumstances that might have impacted the inability to insure child safety and well being. The intent of the reviews was to be solution focused and the resulting recommendations encompassed any defined issues or conditions not currently being addressed, as well as deficiencies or inconsistencies in existing services. In 2007, after reviewing these fatalities, the CCPT identified several system problems or issues to be addressed. Recommendations based on these identified issues or problems were made at the community and state level.

On alternate months, cases were selected for review on the basis of current DSS involvement. Again, the panel approached the case discussions with a multi-disciplinary approach, collaborating to transform broad goals of child safety into specific directives that could be implemented to support the families and children in crisis. In each case, CCPT formulated a response aimed at suggestions for short term intervention strategies as well as solutions that would require systemic change. Some of the recommended solutions are now in place. Summaries of problems and possible solutions explored from both child fatality reviews and CPS case reviews are as follows:

Problem: No report made to DSS or mental health re: child's first incident of suicidal threat by Fire Dept. personnel.
Solution: Provide training to fire depts. and EMS personnel regarding the protocol of reporting child abuse/neglect. Team will get more information on the type of training that are already in place and would work from there.

Problem: Parents/care providers should be alerted to know when children are prone to committing suicide.
Solution: Teen screening that can be done by medical health providers which would assess teenagers/children’s behavioral patterns and will therefore be able to get early intervention. This is a plan for team’s future campaign.

Problem: Families are not well informed on the effects of letting babies sleep on the bed with parents or grown ups.
Solution: Educate community on what factors to look that would make it unsafe for parents to sleep with babies.

Problem: Families who cannot afford to buy cribs
Solution: Team would look into a program which can provide cribs for low income families

Problem: Lack of community awareness on teen driving safety
Solution: Team driving safety campaign and distribution of materials to parents and teen drivers to promote safe teen driving
Problem: Delayed adjudication prevented permanent plan being established for child within mandated timeframes
Solution: Advocate for ongoing communication with family court judges in order to problem solve barriers

Problem: Unavailability of mental health services for families with mental health issues that impair parenting ability. Also, lack of mental health resources for children with special needs.
Solution: Continued advocacy for appropriate and accessible mental health treatment

Problem: Lack of foster parents for children with special needs in DSS custody.
Solution: Recruit foster parents that have the ability and promote skills needed to parent this group of special needs children.

TEAM ACTIVITIES AND ACCOMPLISHMENTS:
1. Brochure produced to promote safe teen driving in collaboration with Safe Kids. Brochure dispensed in local high schools to parents of incoming Freshmen. Currently in discussion with NCDMV to distribute brochures to parents of children seeking their Learner’s Permit.
2. Recommendation from the committee to state representatives regarding Child Passenger Safety and law that permits removing child from restraint “when child’s personal needs are being attended to. The issue for car seat safety was amended successfully at the state level.
3. Collaboration with NC Prevent Child Abuse in Blue Bows campaign
4. Shaken Baby Campaign, in collaboration with Mission Hospital and DSS for training and distribution of the Period of Purple Crying video.
5. Sex Abuse Education for panel and community by Goeff Sidoli at Family Innovations.
6. Kids in Cars brochures distributed at NC Mountain Fair in an ongoing effort to educate about the danger of children being left unattended in cars.
7. The Team submitted an Annual Report to the Division of Social Services, reviewing activities of the team, sharing data with the state, and made recommendations regarding effective solutions on a local and state level for issues that impact child safety.

TEAM GOALS FOR 2008:
1. Participation in North Carolina’s Regional Community Child Protection Team, sharing goals with 11 urban counties, addressing regional concerns through collaborative efforts to improved service delivery to families and children across the State.
2. Members of the Team will serve as citizen reviewers in collaboration with DSS for ongoing Child and Family Service Reviews in an effort to examine social work practice, evaluate adherence to policy guidelines and procedures, and document that the agency is effectively discharging child protection responsibilities.
3. Continuation of public outreach and education regarding critical issues, such as internet safety for minors.
4. Continuation of case review process to identify needs in the child protection system and delineating recommendations which form basis for system change.

Respectfully submitted,

Cathie Beatty, MSW
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2007 Co- Chair
Buncombe County Child Protection/Fatality Review Team