Wake County Commissioners and Board of Health

I. Introduction

In 1993, the North Carolina General Assembly established a network of local Child Fatality Prevention Teams (CFPT's) across the state to confidentially review medical examiner reports, death certificates and other records of deceased residents under age 18. Each local team consists of representatives of public and nonpublic agencies in the community such as law enforcement, Guardian Ad Litem, health departments, among others, that provide services to children and their families.

The purpose of this report is to give a summary of the causes of death, the number of cases reviewed, recommendations for prevention, if any, that have been made and to share local team activities and accomplishments.

II. Role of the Wake County Commissioners and Board of Health

- Receive annual reports which contain recommendations and advocate for system improvements and needed resources, if requested.
- Appoint members of the local team as identified by the membership.

III. Child Deaths by Cause, System Problems Identified, Recommendations for Prevention & Proposed Action

In 2017, the Wake County CFPT reviewed 20 child deaths and identified 39 system problems and recommendations for future prevention efforts. Below are highlights:

Cause of Death	System Problem Identified	Recommendation	Proposed Action
Undetermined (co-sleeping)	Co-sleeping with parent	Increase awareness and capacity for safe sleep environment.	Dads to Dads community education program given educational material and information about Cribs for Kids Program. Team to arrange pediatric grand rounds on safe sleep environment for infants.
	Limited grief support resources for families who have lost a child.	Increase awareness of community grief resources.	Grief resources gathered by team members and shared with Wake Network of Care.
Homicide (strangulation by parent)	Lack of close follow up for parent after being prescribed anti-depressant medication.	Ask state to include reminders of Black Box warning of increased risk of suicide in the first month after starting an anti-depressant.	Recommendation given to state CFPT.
Homicide (blunt force trauma by parent)	Private school did not report suspected child maltreatment.	Increase knowledge and skills of private schools to recognize and report child maltreatment. Encourage all NC schools to have written policies for reporting suspected child maltreatment.	A workshop on recognizing and reporting child maltreatment was given to all staff at the affected school. A letter was sent to the national accrediting agency for the affected school encouraging mandatory adoption of policies to report suspected child maltreatment. The state CFPT was asked to pursue legislative options to require all schools operating in NC to have policies on reporting suspected child maltreatment.

Suicide	LE was not notified when child died in the hospital.	Internal review by hospital of case for quality improvement.	Review completed by team member.
	Excessive absences and family conflict were not reported to CPS.	Increase collaboration between school staff and CPS.	Trainings on CPS Reporting offered to school staff.
	Danger to a living sibling was revealed during CFPT review, and state law prohibits sharing of CFPT information.	State CFPT should explore legal exceptions to strict confidentiality of CFPT reviews when a living child is endangered.	Recommendation given to state CFPT.
	NC adolescents cannot consent to share their own medical and educational information.	State CFPT should explore changes to laws allowing adolescents to share their own information.	Recommendation given to state CFPT.
	CPS was not notified of this child's suicide.	All suicide child deaths should be reported to DSS.	Recommendation shared with team participating agencies.
Nonfatal CFPT: Meth lab exposure	CPS was involved with family but unaware of LE suspicion of meth lab operation in home.	Increase CPS staff recognition of meth lab signs. Increase LE awareness that child safety supersedes LE investigation if a home meth lab is suspected. CPS reporting is such cases is mandated by state law.	Training on meth lab recognition given to Wake County CPS staff. Recommendation shared with team participating agencies.
	Large quantities of Sudafed were purchased yet not recognized by pharmacy reporting.	Improve recognition of meth ingredient purchasing.	Incident reported to state pharmacy board.
Accident (drowning)	Lack of swimming skills. Lack of supervision.	Increase awareness of drowning prevention practices.	YMCA "Swim for Life" Free swim lesson information shared with team. Community partners WRAL, YMCA, City of Raleigh Aquatics, and SafeKids convened to share drowning prevention tools and messages. Drowning prevention messages shared through Wake County communications. Drowning Prevention pediatric grand rounds given. WCPSS representative to bring swim lesson information to preschools/ Kindergarten. Team chair contacted NC Child to increase media messaging state wide.
Homicide (blunt force trauma by caregiver)	Injuries suspicious for child maltreatment were not reported to CPS by daycare. Initial CPS investigation did not recognize signs of physical abuse.	Increase awareness of signs of child maltreatment among daycare providers. Improve assessment skills of CPS workers.	Letter sent to NC Child Care Licensing Agency with poster of Ten-4 bruising. Several CPS policy and practice changes made.
Accident (MVA)	Passenger was not in appropriate booster seat.	Increase awareness of resources to improve motor vehicle safety. Increase knowledge and skills of parents to install and use child vehicle restraints correctly.	Resources on Wake County car seat education events, low cost car seat purchase options, and state education materials (Buckle-Up North Carolina & NC Zero Organization) shared with team. Team disseminated Buckle Up NC information through Read to Feed. CFPT Chair met with NC Child regarding statewide media messaging on car seat safety. WCHS to assemble a workgroup to disseminate car seat specialist service to Wake Co. Community.

Undetermined (co-sleeping)	Community Care for Children (CC4C) form does not document presence of safe sleep environment for infants.	Recommend revision to state CC4C form. Improve internal WCHS care management documentation of infant sleep environment.	Recommendations given to state CFPT. Wake County CC4C and OB Case Management teams instructed to implement documentation of safe sleep location during home visits. Strengthen the Safe Sleep - Meeting between Wake Co and Rex to put into the community. Work on prior recommendations. NC Child Media Director meeting to work on several areas of actions. *Recommendation shared with state CFPT.
Suicide	Lack of parenting skills may have escalated the situation which led to the child's death. Lack of adequate mental health resource in the community. Lack of youth coping skills per when increased anxiety.	Increase access to parenting support. Increase MH supports for adolescents. Ask state to consider reducing high-stakes academic testing.	WCPSS and team given information on Family Services program, including in-home coaching resources. Encourage adequate funding of school psychologists, social workers, and community mental health supports. Support current curriculum which teaches 3rd, 4th, 5th grades coping skills and 7th, 9th, 12th grades suicide prevention. Recommendation shared with state CFPT.
Undetermined (co-sleeping)	Death scene reconstruction not completed.	Improve understanding of best practices in child death scene reconstruction among Wake County LE agencies, including ways to minimize trauma for affected families.	Training for team on Child Death Scene re-construction process to be scheduled.

IV. Wake County CFPT Activities and Accomplishments

Examples:

- The annual CFPT Activity Summary was completed and sent by the date requested.
- An in-service on pool safety was provided to local CFPT members.
- Individual reports were completed on child deaths reviewed by the team and were forwarded to the State Coordinator.

V. Conclusion

Thank you to the members of the Wake County Commissioners/Board of Health for the opportunity to share with you the successes and dedicated work of the local team as we continue to review child fatalities, make recommendations, and take actions to prevent future child deaths. Please feel free to contact the Health Director or Chairperson at 919-250-3762, respectively, should you have any questions about this report.

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Chairperson

October 5, 2018