

**Gaston County  
Community Child Protection Team (CCPT)  
Child Fatality Prevention Team (CFPT)**

**ANNUAL REPORT TO THE HEALTH & HUMAN SERVICES BOARD and  
BOARD OF COUNTY COMMISSIONERS  
Calendar Year 2021  
March 2022**

**Background**

North Carolina's Child Fatality Prevention System includes two statutorily mandated multi-disciplinary and multi-agency teams: Community Child Protection Team (CCPT) and Child Fatality Prevention Team (CFPT). Each team of community representatives meets regularly to promote a community-wide approach to the problem of child abuse and neglect. The teams work to study and understand causes of childhood deaths, identify gaps and deficiencies in the service delivery to children and families, and to make and implement recommendations for changes to help prevent future child deaths and support safe and healthy development of children.

The CCPT and CFPT were established by law (General Statute 7B-1406) in 1991 and 1995, respectively. The CCPT reviews selected active child protective services' cases and cases in which a child died as a result of suspected abuse or neglect. The CFPT reviews all deaths of Gaston County children not reviewed by CCPT. Through the review of all available records, the team identifies gaps in services and future prevention efforts.

**Team Composition**

The composition of the CCPT and CFPT is mandated by law and includes appointed members of various agencies and organizations and some at large members. For the most part, the membership requirements are the same for both teams. Required members:

- A. The county Department of Social Services' director and member of the director's staff;
- B. A local law enforcement officer;
- C. An attorney from the district attorney's office, appointed by the district attorney;
- D. The executive director of the local community action agency;
- E. The superintendent of each local school system or the superintendent's designee;
- F. A member of the county DSS Board, appointed by the chair;
- G. A local mental health professional;
- H. The local guardian ad litem coordinator, or the coordinator's designee;
- I. The director of the Health Department; and
- J. A local health care provider.

To meet the requirements of the CFPT, the following representatives also serve on the team:

- A. Emergency Management Services;
- B. A district court judge;
- C. The County Medical Examiner;
- D. A representative of a child care facility or Head Start; and
- E. A parent of a child who died prior to their eighteenth birthday.

The policies of both teams, as well as GS 7B-1407(d), give county commissioners the authority to appoint up to five additional members to represent various county agencies or the community at large. Currently, there are four such appointees on each team. A current membership list is attached to this report. Those appointed by the Board of County Commissioners are listed as "Additional County Agency or Community Member." The Board of Commissioners may appoint to any of these five slots at any time. There are no time limits on the terms of appointments.

### **Meeting Schedule**

The Gaston County CCPT meets the first Thursday of each month at 7:30 am, with the exception of July. Meetings in February, May, August, and November reviewed child fatalities in which maltreatment was suspected. The other seven meetings were dedicated to reviewing open child welfare cases.

The Gaston County CFPT meets quarterly, the first Thursday of the month at 8:30 am and reviews those deaths not suspected to have involved maltreatment.

### **Community Child Protection Team (CCPT)**

Duties and responsibilities of the Community Child Protection Team include reviewing active cases in which abuse, neglect, or dependency was suspected to identify any lack of resources, gaps, and/or deficiencies that affected the outcome; to advocate for system improvements and needed policy and legislative changes; to promote collaboration between agencies in the creation or improvement of resources for children; and to inform county commissioners about actions needed to prevent child abuse, neglect, or dependency. Active child welfare cases may also be brought for review at the specific request of a team member or the Department of Social Services. Conducting these reviews provided insight as to how our community can better families' needs through discussion with community professionals serving on the team. It also enhances the working relationship between the agencies represented on the team.

### **Child Fatality Prevention Team (CFPT)**

Child Fatality Prevention Team duties and responsibilities are similar to those of the CCPT. This team reviews all child deaths in Gaston County not reviewed by the CCPT, deaths not believed to be the result of maltreatment and not having child welfare involvement in the last year.

The CFPT reviews also focus on identifying gaps in the community's service delivery that can help prevent future child fatalities. Based on the team's findings, recommendations can be made for changes in laws, rules, and policies to support the safe and healthy development of children. Further, the team strives to strengthen multi-agency collaboration and communication. Parents of the children are never contacted, and the deaths are reviewed in closed session, with each team member held to strict confidentiality guidelines.

### **Open Case Reviews**

The CCPT reviewed six open child welfare cases in 2021, representing twenty-two children. Issues present in these cases included domestic violence, poverty, homelessness, sexual abuse, cultural competency barriers, and unmet needs related to child medical and mental health, transgendered youth, and permanent homes. Childhood trauma for the children, and often the parents, was present in every case reviewed.

Discussion includes identifying gaps or barriers in service delivery and ways community services can successfully address them. Barriers identified this year include the following:

- Reduced access to mental health and medical services during the pandemic,
- Reduced in-home services for children and parents during the pandemic,
- Lack of adoptive homes for older foster children and those with complex needs,
- Community and professional reluctance to report child maltreatment,
- Lack of awareness regarding infant safe sleep among the general public and many professionals who serve families.

At the end of each review, team members make recommendations, and often commit to assist the social work team with navigating the identified needs and barriers. This year, team members assisted with the following:

- Housing assistance through Continuum of Care and Habitat for Humanity
- Domestic violence services through Hope United
- Parenting class options
- Mental health assessment and treatment options
- Foster care placements
- LGBTQ+ advocacy
- Peer supports
- School supports for children (IEP and 504 plans)
- Trauma assessments

### **Subcommittees**

Two subcommittees – CPS Reporting and Infant Sleep Related Death - met throughout the year to address identified systems issues. Each subcommittee's membership represents a diverse group of leaders from multiple community agencies and members of the community at large. Each group has launched targeted public awareness campaigns that will continue in 2022. In addition, safe infant sleep education was provided to high-risk groups in the community, an effort that will continue through 2022.

In partnership with Cribs for Kids, a national organization, the teams have also launched an initiative focused on preparing first responders to assess and address unsafe infant sleep as well as a hospital certification program with CaroMont.

A third subcommittee – Cultural Awareness Training – met through mid-year and provided two cultural awareness trainings for community professionals from twelve different agencies with the goal of improving partnerships and service provision to our Spanish-speaking community members. The other two subcommittees very intentionally incorporate culturally competent strategies in their public awareness efforts.

### **Intensive Child Fatality Reviews**

Some child deaths in which child abuse or neglect is suspected and/or child welfare has relevant history with the family require a more intensive two-day review facilitated by the North Carolina Department of Health & Human Services. Seven such reviews were held in 2021.

A summary of the intensive review findings and recommendations as well as the CCPT's efforts to address each are below. State-level recommendations have been shared with our State partners who will respond in writing through their annual report. These recommendations are to be used as a guide to improve local systems of care and highlight areas in which services can be improved locally and statewide. 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.

#### **Safe Sleep** *(consistent theme in 4 of the 7 intensive reviews)*

- **Findings:**
  - Adult /infant bed-sharing continues to be common, despite placing infants at increased risk for death and extensive efforts to address safe sleep. North Carolina has sustained higher rates of unexpected infant death than the national average. Local communities must expand messaging to broader audiences, particularly grandparents, relatives, babysitters, and childcare providers.
  - Several hundred infants die each year in sitting devices such as car seats, bouncers, and swings.
  - In 2020, a statewide needs assessment found Gaston County had several indicators supporting the need for increased home visiting. Around this same time, DHHS temporarily discontinued maternal home visiting services due to staffing and funding.
- **Local Recommendations:**
  - CCPT and CFPT advocate for DHHS to re-initiate home visiting services.
    - **Progress:** Public Health is filling a position to provide home visiting services.
  - Continue strategies designed to reduce infant sleep-related deaths. Consider more attention-grabbing materials. Include other caretakers as a target audience. Include substance use as a target area in materials.
    - **Progress:** Public awareness campaign underway in partnership with the Communications Office.
  - Encourage prenatal care providers to have conversations about substance use and safe sleep practices with prospective parents early and often.
    - **Progress:** Met with CaroMont-affiliated prenatal care providers. Future meetings with additional providers pending.

#### **Child Abuse/ Neglect Reporting** *(consistent theme in 3 of the 7 reviews)*

- **Findings:**
  - Healthcare providers must understand they are legally mandated to promptly notify CPS of prenatal exposure to drugs at birth.
  - Several community members, including professionals, failed to report suspected maltreatment in multiple cases.
  - CPS must effectively engage those who report child abuse to gather all information.
- **Recommendations:**
  - Gaston DHHS and CCPT should continue and enhance the *Remove the Tape* campaign to encourage the public and professionals to report suspected child maltreatment.
    - **Progress:** Public awareness campaign underway in partnership with the Communications Office.
  - DHHS implement additional quality assurance to improve accuracy in CPS reporting.

- **Progress:** New process implemented to ensure all reports are properly documented.

### Interdisciplinary /Interagency Collaboration

#### ▪ **Medical Community**

##### ○ **Findings:**

- The steadily increasing prevalence of health conditions impacting youth and families highlights the need to improve collaboration between social workers and medical professionals.
- Child deaths referred to the Medical Examiner for autopsy should include accurate information to ensure forensic autopsies are conducted when needed.

##### ○ **Recommendations:**

- DHHS explore ways to develop an interdisciplinary team approach to CPS, with social workers and medical professionals working together.
  - **Progress:** Discussions beginning with medical professionals.
- Collaborate with the Office of the Chief Medical Examiner and the Mecklenburg County Medical Examiner to improve accuracy of autopsy screening decisions.
  - **Progress:** Local medical examiner's office implemented a process that includes calling DHHS to learn family history before referring deaths for autopsy.

#### ▪ **Improve Communication**

- **Finding:** Children who are born drug-exposed require a referral to the Care Management for At-Risk Children program. Inaccurate referral information results in missed opportunities for intervention with at-risk children.
- **Recommendation:** CCPT advocate for a coordinated network of health care providers, government agencies, service providers, and other systems of care to build partnerships that ensure resources to support maternal and infant health.
  - **Progress:** Public Health is assisting with exploration.

#### ▪ **Substance Abuse and Mental Health Treatment Providers**

- **Finding:** Parental substance use is one of the most significant risk factors in child maltreatment. Child welfare and substance use treatment providers must work more closely together and share information.
- **Recommendations:**
  - Develop a formal internal protocol requiring child welfare workers to contact all known mental health and substance use treatment providers during an assessment.
    - **Progress:** Protocol is in place. Barriers to receiving information are being addressed by child welfare leadership.
  - Develop a system that allows child welfare staff to liaison with a provider when assessing child safety.
    - **Progress:** Options being explored.
  - Coordinate cross-discipline trainings for social workers and mental health/substance use disorder treatment providers to enhance relationships and encourage sharing knowledge and expertise.
    - **Progress:** Discussing cross-training with substance use treatment providers.
  - CCPT lead an effort to adopt a collaborative interagency approach for improving collaboration between substance use treatment providers and child welfare.



- **Progress:** Exploring options, including leveraging partnership with the Substance Use Coalition.
- **Law Enforcement**
  - **Finding:** Law enforcement and child welfare engage in concurrent investigations and closely collaborate. The team has recognized opportunities to enhance these partnerships and improve communication between systems in Gaston County.
  - **Recommendations:**
    - Explore models for strategic interagency collaboration with a police-social work co-response model to streamline communication, improve emergency crisis response, and build stronger collaboration.
      - **Progress:** Model has been researched, developed, and presented to leadership for review.
    - Explore strategies for conducting multidisciplinary reviews of cases referred from community sources.
      - **Progress:** Team members have been encouraged to bring cases from their respective agencies for review. One such case has been reviewed thus far.

### Information Access

- **Findings:**
  - Child welfare encounters several barriers to gathering criminal histories and CPS records from other states.
  - Children living in poverty are more likely to encounter changes in residence and household composition. NC Vital Records access would be a valuable resource for maintaining accurate data.
- **Recommendations:**
  - Currently, Gaston County DHHS contracts with a third-party vendor to obtain nationwide criminal history information. Under the Adam Walsh Child Protection Act of 2006 and a NCDSS partnership with the SBI, child welfare can access nationwide criminal records. Gaston County DHHS should explore partnering with local law enforcement to utilize this resource.
    - **Progress:** Two local law enforcement agencies are exploring the required partnership that will allow DSS access to nationwide criminal records checks.
  - DHHS explore a partnership with the Gaston County Register of Deeds to allow local child welfare workers access until there is a fully implemented statewide child welfare case management system in place.
    - **Progress:** Exploration phase.
  - DHHS extend an invitation to the Children's Developmental Services Agency (CDSA) to boost a community-wide approach to child abuse and neglect.
    - **Progress:** CDSA is now an active member of both CCPT and CFPT.

### Access to Long-acting Contraception

- **Finding:** Access to contraceptive care is vital to reduce unintended pregnancy and improve outcomes. It is crucial for Gaston County to explore ways to expand access to sterilization.
- **Recommendation:** Study local access to sterilization and identify strategies for ensuring any individual who desires sterilization has access, including mobile, community-based services.
  - **Progress:** Public Health is exploring new / alternative strategies to increase access.

### **Data: 2021 Child Fatalities Reviewed**

The teams reviewed a total of thirty-seven deaths in 2021. Due to delays from the State office, the deaths reviewed in 2021 represent some children who died in 2020 and some of the children who died in 2021. The charts below reflect the age ranges, race, gender, and causes of death for the thirty-seven cases reviewed by the CCPT and CFPT.

<b>Age Range</b>	<b>Number of Deaths</b>
Under 1 year	25
1-3	4
4-6	1
7-10	2
11-13	4
14-17	1

<b>Race &amp; Gender</b>	<b>Number of Deaths</b>
White Male	11
White Female	7
Black Male	9
Black Female	7
Hispanic Female	1
Hispanic Male	2

<b>Race</b>	<b>Number of Deaths</b>
White	18
Black	16
Hispanic	3

<b>Gender</b>	<b>Number of Deaths</b>
Male	22
Female	15

<b>Cause of Death</b>	<b>Number of Deaths</b>
Perinatal Conditions	13
Illness	1
Infant Sleep-Related Death	8
Malignant Neoplasm (Cancer)	3
Unknown	1
Birth Defects	4
Leukemia	1
Homicide	2
Maternal prenatal substance use	1
Accident	3

### **Infant Sleep-Related Deaths**

Gaston County experienced an increase in infant sleep-related deaths. Eight such cases were reviewed in 2021; however, there were actually twelve such deaths in calendar year 2021. For reference, there were fourteen infant sleep related deaths in the prior two years combined. Please see relevant data below:

<b>2021: 12 Infant Sleep-Related Deaths</b>		
<b>Race</b>		
White	3	25%
Black	6	50%
Hispanic	3	25%
<b>Gender</b>		
Male	6	50%
Female	6	50%
<b>Mother's Age</b>		
19-24	5	42%
25-30	2	17%
31-35	3	25%
36-40	2	17%
<b>Infant's Age</b>		
< 1 month	3	25%
1-4 mos	7	58%
5-6 mos	2	17%
<b>Bed Sharing</b>		
Yes	7	58%
<i>With Parent(s)</i>		<i>6 of 7</i>
<i>With Sibling(s)</i>		<i>5 of 7</i>
<b>CPS History</b>		
Yes	8	67%
<b>Reported Maltreatment Type</b>		
Substance Use	5	42%
Supervision	5	42%
Physical Abuse	4	33%
DV	3	25%
Discipline	3	25%
Injurious Env.	3	25%
DEI	2	17%
Sex Abuse	2	17%
<i>% is of total, not only those w/ CPS hx</i>		
<b>Open CPS case at death</b>		
Yes	5	42%
<i>4 Gaston; 1 Meck (perm plan)</i>		

In response to the significant increase, the teams intensified efforts to address infant sleep-related deaths:

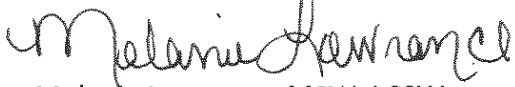
- Joined North Carolina's workgroup and are helping to revise policy and training for child welfare staff.
- Partnered with Cribs for Kids, a national organization striving to reduce infant deaths.
- Partnering with local first responders to provide infant safe sleep training and materials they will share with families.
- Met with CaroMont-affiliated prenatal care providers who committed to prioritizing safe infant sleep conversations with expectant parents.
- CaroMont is pursuing Cribs for Kids hospital certification, which will provide system-wide training and policy to encourage safe infant sleep practices.
- Enhanced data collection and analysis efforts to better identify higher risk groups and better target awareness efforts.
- Launched a public awareness campaign, specifically targeting higher risk groups.
- Met with local groups of parents and community members who represent higher risk groups.
- Ongoing partnership with Safe Sleep NC to enhance efforts at the local and state level.

Gaston County is fortunate to have these dedicated teams of professionals who are committed to strengthening our community's system of care for children and families. Collaboration among team members is high and represents their commitment to preventing child abuse and neglect.



The Gaston County CCPT and CFPT appreciate the efforts of the Health & Human Services' Board and Board of County Commissioners to provide programs and services to the families of Gaston County. Your support is vital. Needs experienced by our community's families cannot be addressed in isolation or solely by professional agencies and boards but must be embraced by the entire community.

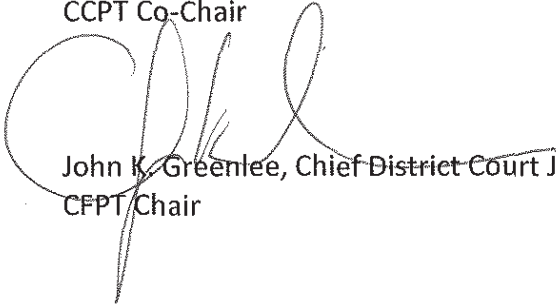
Respectfully Submitted,



Melanie Lowrance, MSW, LCSW  
Gaston County DHHS  
CCPT Co-Chair



Deborah Gullledge, JD  
Gaston County District Attorney's Office  
CCPT Co-Chair



John K. Greenlee, Chief District Court Judge  
CFPT Chair

## Gaston County Community Child Protection Team

Position	Name
Director, Social Services	Angela Karchmer
Social Services Employee / Co-Chair	Melanie Lowrance
Local Law Enforcement	Darrell Griffin
Attorney from DA's Office / Co-Chair	Deborah Gulledge
Exec. Director of Local Community Action Agency	Arin Farmer
School Superintendent or Designee	Christy Garcia
Local Mental Health Professional	Rebecca Jones
GAL Coordinator of Designee	Gerald Mack
Director, Public Health	Steve Eaton
Local Health Care Provider	Dr. Marty Baker
Additional County Agency or Community Member	Captain Billy Downey, GCPD
Additional County Agency or Community Member	Ronnie Bowers
Additional County Agency or Community Member	Dr. Gina Ramsey
Additional County Agency or Community Member	Andrew Schrag
Review Coordinator	Catherine Oglesby
Non-Voting	Joy Tilley
Non-Voting	Ann Stroupe
Non-Voting	Lynn Harmon
Non-Voting	Michelle Jenkins
Non-Voting	Carol McManus
Non-Voting	Heather Kauffman
Non-Voting	Brittain Kenney
Non-Voting	Chrys Kolodny
Non-Voting	Tereasa Osborne
Non-Voting	The Honorable John Greenlee
Non-Voting	Sgt. Adrienne Walker-Hall, Gastonia PD
Non-Voting	Jocelyn Williams

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Attorney from DA's Office	Debbie Gulledge
Exec. Director of Local Community Action Agency	Arin Farmer
School Superintendent of Designee	Christy Garcia
Social Services Board Member	Sandi Farnham
Local Mental Health Professional	Rebecca Jones
GAL Coordinator of Designee	Gerald Mack
Director, Public Health	Steve Eaton
Local Health Care Provider	Dr. Marty Baker
EMS or Firefighter	Jamie McConnell
District Court Judge / Chair	John Greenlee
County Medical Examiner	Carol Pinkard
Local Child Care Facility or Head Start Rep	Jean Nivens
Bereaved Parent	Dr. Ed Smith
Additional County Agency or Community Member	Captain Downey, GCPD
Additional County Agency or Community Member	Ronnie Bowers
Additional County Agency or Community Member	Dr. Gina Ramsey
Additional County Agency or Community Member	Darrell Griffin, GCSO
Review Coordinator	Catherine Oglesby
Non-Voting	Joy Tilley
Non-Voting	Ann Stroupe
Non-Voting	Chrys Kolodny
Non-Voting	Michelle Jenkins
Non-Voting	Tara Joyner
Non-Voting	Carol McManus
Non-Voting	Heather Kauffman
Non-Voting	Andrew Schrag
Non-Voting	Joseph Shepherd
Non-Voting	Brittain Kenney
Non-Voting	Tereasa Osborne
Non-Voting	Jocelyn Williams
Non-Voting	Ronnie Bowers