NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

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WRITTEN TESTIMONY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

North Carolina Department of Health and Human Services
Before the House Select Committee on Oversight and Reform

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Chair and Members of the Committee:

The death of any child is an unthinkable tragedy. The death of a child as the result of alleged abuse or neglect by a caregiver, like Dominique Moody's death, is even more difficult to comprehend.

Many of us who work in child welfare services for the North Carolina Department of Health and Human Services have been in this field for decades, and we can tell you that a child fatality never becomes normal. The death of one child is always too many, and we feel it deeply every time.

While the circumstance is tragic, we appreciate the opportunity to appear before you today to speak about NCDHHS' fatality review findings, deficiencies found in an analysis of more than 100 additional child welfare cases in Mecklenburg County, the components required by NCDHHS in Mecklenburg County's Corrective Action Plan, as well as future opportunities for reform. Our focus is to do everything possible to ensure a tragedy like this never happens again.

NCDHHS also understands that transparency is of critical importance in a situation like this one. At the same time, NCDHHS must follow all applicable confidentiality laws.

N.C. Gen. Stat. § 7B-302(a1) requires NCDHHS to maintain the strict confidentiality of all sensitive child welfare records and information. N.C. Gen. Stat. § 7B-2902 requires NCDHHS to consult with the relevant District Attorney before publicly releasing any findings or information about a child fatality. This required consultative process ensures that the public release of findings and information will not jeopardize the State's prosecution, or the defendant's right to a fair trial.

Together, these state statutes will necessarily limit, at least to some degree, the information that NCDHHS can release publicly or share in this open session. In particular, we will be unable to share any additional information about the Moody case that is not already included in the Corrective Action Plan letter we sent to the Mecklenburg County Department of Social Services (MCDSS) on May 20, 2026. Although we are not able to answer case-specific questions about

the Moody tragedy in open session, we welcome the opportunity to supply any necessary information or records about that case through a different channel, whether through a facilitated meeting at the Mecklenburg County DSS office or in a closed session pursuant to and as permitted by N.C. Gen Stat. § 7B-302(a3).

Dominique Moody Fatality Review

Any time a local county child welfare agency learns that a child has died, the agency must report the fatality to NCDHHS Division of Social Services (NCDHHS DSS). The agency determines whether the fatality meets criteria for a child welfare fatality review. Fatalities that meet criteria for review – including those where the child was previously known to the county child welfare agency – are reviewed by state staff to determine whether the county agency's practice or decision-making may have contributed to the outcome. Any identified practice concerns are brought to the attention of county leadership to be addressed, and state staff provide technical assistance and training as needed to support practice improvement. If the fatality review identifies violations of federal or state laws or regulations, NCDHHS may conduct an additional review of other child welfare cases in the same county to determine whether a more intensive response, like a Corrective Action Plan, is warranted.

NCDHHS was made aware of the death of Dominique Moody in Mecklenburg County on December 16, 2025, and began an extensive file review of the fatality. On January 16, 2026, state staff completed that review, which included a complete history of the family's involvement with Child Protective Services (CPS) in North Carolina.

The review of Dominique's case revealed serious concerns with MCDSS's child welfare practice, including numerous violations of state law, rule and policy.

For context, when a report of abuse or neglect is made to a county DSS, the county determines whether the information provided in the report meets the definition of abuse, neglect, or dependency (collectively referred to as maltreatment). Reports that do not meet the definition are "screened out" during CPS Intake, and do not move forward in the CPS process for further assessment. Reports that do meet the definition of maltreatment are "screened in" during CPS Intake, and the county child welfare agency must initiate a CPS Assessment to interview the child and assess where they live to determine safety and risk.

The following concerns related to the Dominique Moody fatality were included in the NCDHHS Corrective Action Letter issued to MCDSS on May 20, 2026.

Concerns related to CPS Intake (for screened-out reports):

- **Of the total number of screened out reports, 4 out of 5 reports met the definition of abuse and neglect for this family and were "screened out" with no further assessment of safety of the children.** During CPS Intake, county staff must determine whether information provided in a report meets the definition of abuse, neglect, or dependency ("screened in") or not ("screened out"). Reports that are "screened out" at CPS Intake do not move forward in the CPS process, meaning no further action is taken to assess safety of the children. NCDHHS found that information provided in four of the

five reports that MCDSS "screened out" did meet the definition of abuse and neglect, meaning they should have been "screened in" for a CPS Assessment.

Concerns related to CPS Assessment (for screened-in reports):

- **Contacts were not frequent enough to ensure safety.** North Carolina child welfare policy requires that the frequency of DSS's face-to-face contact with a victim child and their caretakers be based upon the risk to the child's safety. At a minimum, face to face contact with the victim child(ren) and parent(s)/caretaker(s) must occur twice a month and at least 7 calendar days apart, with additional contacts needed for high-risk situations. In this case, NCDHHS found that MCDSS did not make contact frequently enough to ensure safety.

- **Child Protective Services history was not reviewed, which would have shown a pattern of abuse and neglect.** Reviewing a child and family's CPS history is a critical part of the CPS process to ensure the social worker has a complete understanding of the full context surrounding a report of abuse or neglect, including if there has been similar information that has been reported previously.

- **Lack of thorough assessment of the child's medical, developmental, and physical environmental concerns.** These types of elements are vital to any child welfare assessment to ensure safety, and must be a prominent part of any case decision that is made to protect the child.

- **Collaterals significant to the case, to include medical personnel, were not contacted.** As part of a CPS Assessment, child protective services staff are required to engage with collaterals – persons who have significant knowledge of and contact with the family and child(ren) – so they are able to answer questions related to the caretaker's ability to provide a safe home for the children. Contact with relevant medical professionals is required in any case where a child's medical needs or history are relevant to ensuring their safety.

Concerns related to both CPS Intake and CPS Assessment:

- **Inaccurate case decisions were made that resulted in no services being provided to ensure safety of the children.** Both at Intake and during CPS Assessments, MCDSS staff's inability to accurately identify abuse and neglect, and to accurately assess risk and safety, led to "screened out," "unsubstantiated," and "services not recommended" case decisions. When a "screen out," "unsubstantiated," or "services not recommended" decision is made, then no child welfare services – such as Child Protective In-Home Services or Foster Care – are provided to mitigate safety concerns.

In short, MCDSS had multiple CPS reports that Dominique was being abused and neglected, and conducted CPS Assessments – yet failed to intervene. These failings amounted to clear violations of state law and policy.

Additional MCDSS Case Review

As a result of its findings in reviewing the Moody case, NCDHHS began a further file review across a large sample of MCDSS records to better understand whether the identified concerns existed more broadly. This review included 58 CPS Intake reports of abuse, neglect or dependency, and 64 CPS reports that were "screened in" at CPS Intake, as well as the CPS Assessments that resulted from those reports.

The review of the 58 CPS Intake reports revealed the following violations of law, rule or policy:

- In 52% of Intakes, intake workers did not ask sufficient questions to explore all alleged maltreatment. These intake questions are necessary to obtain critical information from the reporter that assists with discerning between abuse and neglect and determining appropriate response timeframes.

- Reporter notification letters were not sent within 5 days of the CPS intake in 37% of the intakes.

- In 36% of cases where reports contained allegations that may have met the criminal definition of child abuse, case files did not contain verbal and written notification to the District Attorney and law enforcement.

The review of the 64 CPS Assessment case records revealed the following violations of law, rule or policy:

- Safety assessments had safety plans that were adequate to ensure safety in only 43% of the cases.

- Face-to-face contacts with children occurred at the correct frequency at a rate of 48%; mothers at 52%; fathers at 34%; non-resident parents at 53%. This includes diligent efforts to locate children and parents.

- 45% of the cases did not document or show efforts to conduct separate, individual interviews with children regarding safety.

- 64% of cases contained supervisory oversight at a minimum of every other week; 58% of cases did not contain all required components of quality oversight.

While MCDSS did handle some cases appropriately, NCDHHS' review of the 122 MCDSS case records (CPS Intake and CPS Assessments) revealed broad, systemic failures, including a lack of appropriate safety planning, insufficient family contacts, and inadequate MCDSS supervisory oversight.

Requirement for Corrective Action in Mecklenburg County

As a result of the 122-record case review, NCDHHS sent a Corrective Action Letter to MCDSS and Mecklenburg County leadership on May 20, 2026, requiring that they develop a Corrective

Action Plan within 30 days to address these violations. The Corrective Action Plan must be approved by NCDHHS, and it must include, but is not limited to, the following:

- A plan for how the agency will ensure the current safety of children with an open child protective services case.
- Training for all staff, as well as demonstrated ability, to identify the safety risks to children when there are allegations of abuse and neglect.
- Ongoing coaching between supervisors and staff to ensure transfer from learning to skill development.
- Training for all staff with demonstrated ability to plan for the safety of children when direct safety threats are identified, to include following the Regional Abuse and Medical Specialists' guidance on applicable cases.
- Written protocols and processes to ensure accurate completion of and tracking for case initiations, ongoing contacts, and completion of all structured decision-making tools.
- Written protocols and processes to effectively utilize MCDSS' internal Quality Assurance Team to identify trends from file reviews and develop training to address deficits in policy, practice and knowledge.
- Leadership-developed strategies for providing ongoing and effective supervisory oversight for supervisors and social workers.
- Training for all supervisors and social workers in quality documentation and tracking to ensure that documentation is completed thoroughly and entered timely.
- Ensure staff participate in state trainings identified to address areas needing improvement.

NCDHHS DSS leadership met with the MCDSS Director and senior staff on May 19, 2026, as well as county leadership on May 20, 2026, to share the findings of the case sample and to communicate the requirement of a Corrective Action Plan.

NCDHHS will continue to work with MCDSS to provide state training, assist with policy interpretation, guide practice, and offer technical assistance support.

The Corrective Action Letter also notes that should the county fail to show progress in remedying the noted deficiencies within six months from the date of the Corrective Action Plan, NCDHHS will follow up with a letter to Mecklenburg County leadership pursuant to N.C. Gen. Stat. § 108A-74(a5). Additionally, failure to comply or further violations that impact the safety, permanence, and well-being of children may result in NCDHHS invoking provisions under N.C. Gen. Stat. § 108A-74(h), including divestiture of MCDSS's oversight and administration of child welfare services.

Key Changes to Improve Child Welfare in North Carolina

Laws contained in General Statutes Chapters 7B and 108A establish the relationship between NCDHHS and the state's 100 local departments of social services for the provision of programs of public assistance, including child welfare services. North Carolina has a state-supervised, county-administered social services system, meaning local county departments of social services have the authority and responsibility to administer child welfare services for their county.

NCDHHS is the supervising and oversight agency, with responsibilities that include but are not limited to: developing and conducting statewide training; providing technical assistance to improve county practice; developing tools to assist county staff in providing child welfare services; receiving and responding to constituent concerns; administering federal funding; licensing and regulation of foster care and private child welfare agencies; expanding access to evidence-based prevention services; providing regional support to county DSS Directors; implementing strategic initiatives such as PATH NC and the Children and Families Specialty Plan; issuing policy; and monitoring to ensure child welfare practice in compliance with federal and state laws, rules, and regulations.

NCDHHS works every day to create a North Carolina where children are protected and families are safe. We take seriously our responsibility to ensure the health and well-being of children and families, and our goal is for every child to grow up healthy in a safe, nurturing family and community.

We appreciate the North Carolina General Assembly's willingness to continue to work with NCDHHS to improve the child welfare system. There are changes we can make now that will have a long-term impact on the safety, protection, and well-being of children and families in our state.

- **State Oversight –** Legislation such as the Fostering Care Act has given additional authority to NCDHHS to intervene in specific case activities. This type of oversight is critical for the Department to fully meet our responsibilities as the child welfare supervisory agency. The NCDHHS Escalation Team proposed in House Bill 1144 – the Dominique Moody Safety Act – presents a similar opportunity, as that kind of team would give NCDHHS the ability to intervene sooner, with the goal of preventing fatalities.

- **System Modernization –** The General Assembly's continued funding to complete implementation of our new statewide child welfare information system, PATH NC, is essential. PATH NC addresses many of the concerns identified in NCDHHS' review of the Dominique Moody case, including by:

    - Providing staff with automatic access to a family's complete CPS history, no matter where they have lived in the state.
    - Guiding staff to better identify maltreatment and assess risk through newly redesigned structured decision-making tools built into the system.
    - Improving our ability at both the state and county level to monitor outcomes, identify concerns, and address problems before tragedies occur.

After PATH NC is fully integrated into county practice statewide, North Carolina will have the infrastructure in place to continue exploring other methods for modernizing the child welfare system, including tools like advanced analytics or predictive modeling that can help identify high risk situations, as well as better services and placements.

- **Supporting the Workforce –** Recruitment and retention of North Carolina's child welfare workforce are critical to improving outcomes. To attract the right workforce, all counties must offer sufficiently competitive salaries to attract trained, professional social workers capable of making life altering decisions. While funding of positions in a county-administered system is the responsibility of county governments, it bears emphasizing that counties will continue to struggle to attract and retain qualified staff due to insufficient funding and inconsistent salaries across county lines.

Additionally, NCDHHS appreciates the provision enacted in S.L. 2026-1 (HB696) to study state centralization of all social services, including child welfare services. The assessment of North Carolina's social services and child welfare system that was required under Rylan's Law (2017) led to significant transformation and change, including recent critical statewide initiatives such as implementation of the Regional Support Model, PATH NC, and the Children and Families Specialty Plan. Additional investigation of North Carolina's social services system through the lens of potential centralization is an important step toward continued system transformation.

The reality of North Carolina's county-administered system is that we have 100 separate child welfare agencies – overseen by 100 separate governance boards – each independently making decisions in an effort to prevent bad outcomes for children. NCDHHS continues to work within our authority toward more consistent, better quality child welfare practice statewide. But in a county-administered system, outcomes will always be influenced and impacted by the practice of the county where a family happens to live. The study required in S.L. 2026-1 will give us more insight into how to begin to address these challenges and improve outcomes for children statewide.

Conclusion

While there are systemic challenges within the North Carolina child welfare system that put children at greater risk for poor outcomes – including workforce shortages, lack of resources, and capacity issues – they cannot explain Dominique Moody's death. NCDHHS' review of her fatality case revealed continuous poor assessment and decision-making by MCDSS staff in the most basic areas of child welfare practice.

NCDHHS is requiring Mecklenburg County DSS to immediately address these concerns via a Corrective Action Plan, and NCDHHS will be closely monitoring their progress through weekly meetings and required monthly status reports from MCDSS.

At the same time, there are actions we can take now to strengthen our ability to protect children in North Carolina. We can increase state oversight through legislation like the Dominique Moody Safety Act (HB 1144). We can improve our ability to monitor and track child welfare practice – both at the state and county level – with full implementation of PATH NC. We can strengthen workforce recruitment and retention through more competitive and consistent salaries

statewide. And we can explore the opportunities of a centralized child welfare system in North Carolina.

Thank you to the General Assembly for your shared commitment to improving the health, safety, and well-being of the children and families we serve. We look forward to answering your questions.

Respectfully submitted,

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