Four Types of Child Death Review Teams Under Current North Carolina Statutes*

This chart highlights some aspects of review teams; statutory requirements are in Article 14 of the N.C. Juvenile Code (G.S. §7B-1400 – 1414) and G.S. §143B-150.20

	Local Community Child Protection Teams (CCPT) [Also designated as **Citizen Review Panels**, see note below**]	**Local Child Fatality Prevention Team (CFPT)**	**State Child Fatality Prevention Team** (State CFPT or "State Team")	**State Child Fatality Review Team** (State CFRT or "DSS Intensive Review")
DHHS Division and/or local agency providing support	NC Division of Social Services; local social services agency	NC Division of Family and Child Well Being; local health department	NC Division of Public Health	NC Division of Social Services
Local or State	Local – in every county (many meet with the local CFPT)	Local – in every county (many meet with the local CCPT)	State – chaired by Chief Medical Examiner	State administered, but uses local CFPT & CCPT members
Types of cases reviewed; description	Reviews selected active CPS cases and all fatalities with suspected or confirmed child abuse/neglect AND CPS involvement or a DSS report in last 12 months. Teams identify and respond to gaps and deficiencies in public systems.	Reviews all additional types of deaths when CCPT determines it will not. Teams identify and respond to gaps and deficiencies in public systems. CFPTs have several additional required members that CCPTs don't have.	Reviews deaths of children attributed to abuse/neglect or reported as abused or neglected. In practice, team also reviews some other fatalities that are investigated by the statewide Medical Examiner system. Gets some aggregate information from local CFPTs.	Reviews fatality cases with DSS involvement in the last 12 months. Conducts longer more in-depth reviews of abuse/neglect fatalities than CCPT or State Team. Recommendations are focused on improving coordination between local and state entities.
Where reports are directed	Makes recommendations to Board of County Commissioners; reports on activities to local social services board; answers annual survey done by CCPT State Advisory Board related to Citizen Review Panels (see note below).	Makes recommendations to Board of County Commissioners; reports on activities to the local board of health; reports findings to the state-level Team Coordinator; aggregate reports go to State Child Fatality Prevention Team via Team Coordinator.	Provides reports and makes recommendations to Child Fatality Task Force.	After consultation with D.A. produces report available to public.

*Chart updated 2/9/2022.

****CITIZEN REVIEW PANELS**: All 100 CCPTs have been designated via DSS policy (not by statute) to serve as federally required Citizen Review Panels (CRPs). Federal law requires a minimum of three Citizen Review Panels but due to this designation North Carolina has 100 CRPs. The general purpose of CRPs under federal law is to examine policies, procedures, and practices of state and local child protection agencies and, where appropriate, specific cases (including fatalities) to evaluate effectiveness and adherence to law and policies in order to ensure protection of children. A CCPT State Advisory Board works with N.C. State University to conduct an annual survey of local CCPTs used to produce a report with recommendations to the NC Division of Social Services. The NC Division of Social Services prepares a written response to this report, and both the report and response (related to federal reporting requirements for Citizen Review Panels) are included in the state's Annual Progress and Services Report to U.S. DHHS, Administration for Children and Families.

Comparison of Current Child Fatality Prevention System with Recommended Strengthened System

	Current CFP System	Recommended Strengthened System
STATE-LEVEL SUPPORT AND LEADERSHIP FOR CFP SYSTEM	• State-level support is located in different areas of DHHS with separate roles and limited connections with one another • There is no one office or individual in charge of coordinating support for the CFP System statewide	• State-level support would be located in one state office within DHHS to streamline and optimize efforts (but OCME staff would stay at OCME) • The state office would have a team to support the work of local teams and coordinate the CFP system, including data collection & reporting
DATA AND INFORMATION	• Each of four teams has different ways of handling data and information • There is no formal data/information system that connects system components or easily allows for data aggregation, disaggregation, analysis, and production of meaningful reports • The depth of review information collected is much less than would be collected through a national data system used by 48 states	• All teams will use the National Fatality Review Case Reporting System used by 48 other states. • The new data system will easily allow for data aggregation, disaggregation, analysis, and production of meaningful reports at the local and state level. • A greater depth of information will be collected to help identify trends and concerns in order to drive prevention actions and policy
NUMBERS AND TYPES OF DEATHS REVIEWED	Team reviews are required for all child deaths [There are over 1200 deaths per year in NC]	• Team reviews would be required for at least nine categories of deaths where a review is most likely to yield prevention opportunities • Fewer reviews would allow for limited resources to be devoted to quality reviews of cases most in need of reviews and would strengthen reviews of infant deaths which make up 2/3 of all child deaths
NUMBERS AND TYPES OF TEAMS PERFORMING REVIEWS	• 4 types of teams perform child death reviews: 2 state teams, 2 local teams (in all counties) • 3 types of teams may review the same death • 1 type of state team utilizes members of local teams to perform its team reviews, with technical assistance from state-level staff	• Functions of four teams would be consolidated into one local team – counties could choose to have one team in their county or join others to have a multi-county team • All relevant local and state-level information is examined in one local review as most relevant information is at the local level. • There may be different procedures and different participants for different types of death reviewed in order to optimize effectiveness • State-level CFP staff can provide technical assistance for certain types of reviews or in certain situations – e.g., can continue to assist with intensive-type reviews currently done by CFRT
CITIZEN REVIEW PANELS	All 100 local Community Child Protection Teams have been designated via policy as federally required Citizen Review Panels	A more effective way to meet federal requirements for Citizen Review Panels will be developed and implemented (Federal law requires 3 panels) to carry out the intended purpose of evaluating the effectiveness of local and state child protective services agencies.
WHERE INFORMATION IS REPORTED	• Each of 4 teams has different requirements and practices with respect to reporting on activities, findings, and/or recommendations coming from team reviews • There are gaps and challenges with information learned from team reviews reaching relevant and appropriate leaders and organizations who can implement system or policy change or prevention initiatives • There is no mechanism or requirement for a report that addresses the functioning of the child fatality prevention system as a whole	• Combining 4 teams into one and having a state office with an integrated information system will ensure that relevant and appropriate information reaches appropriate local and state audiences • The Task Force report will be expanded to address whole-system functioning • The Task Force report will be required to be distributed to more than the Governor and General Assembly to include other state leaders
CHILD FATALITY TASK FORCE	Statutory provisions addressing the Child Fatality Task Force were put in place to address what was originally meant to be a temporary organization but is now 31 years old	Updated provisions addressing the Child Fatality Task Force would formalize the long-functioning three-committee system of the Task Force and clarify other aspects of Task Force functioning

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