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South Carolina
CHILD FATALITIES

The Report of the Child Fatalities Oversight Committee

Joseph J. Casper, Co-Chairperson
Jules W. Riley, Jr., Co-Chairperson

Commissioned by:
SOUTH CAROLINA
DEPARTMENT OF
SOCIAL SERVICES

South Carolina Child Fatalities

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Child Fatalities Oversight Committee

February 10, 1988

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SOUTH CAROLINA CHILD FATALITIES OVERSIGHT COMMITTEE

Joseph J. Casper, Co-Chair
Federal Bureau of Investigations / Retired

Jules W. Riley, Co-Chair
Council on Child Abuse & Neglect

Frank Barron
South Carolina Coroner's Association

Marlene Bowling
South Carolina Department of Education

Judy Cullison
South Carolina Hospital Association

Anne Cushman
Joint Legislative Committee on Children

Barry G. Dowd
South Carolina Department of Social Services

Margaret Dreher
Human Resource Management

John D. "Jay" Elliott
South Carolina Bar Association

Honorable Parker Evatt
South Carolina House of Representatives

Joyce Franklin
South Carolina Department of Health & Environmental Control

Bob Haney
South Carolina Society for Hospital Social Work Directors

Jerome Hanley
South Carolina Department of Mental Health

Kay Kirkpatrick
South Carolina Society for Hospital Social Work Directors

Ann Kleckley
Richland County Guardian Ad Litem Project

George Markert
South Carolina Court Administration

Linda Marsh
State Law Enforcement Division

Lee Matthey
South Carolina Department of Parole & Community Corrections

Jesse A. McCall
13th Circuit Solicitors Office

M. Robert Newton
South Carolina Department of Mental Health

Mary Piepenbring
South Carolina Hospital Association

Shirley Fitz-Ritson
South Carolina Department of Social Services

Max Metcalf
Office of the Governor

Sara Shingler
South Carolina Child Protection Advisory Committee

Jarrell Smith
South Carolina Department of Youth Services

Barbara Whitaker
South Carolina Medical Association

DSS STAFF LIAISON

Pamela G. Bond
Child Protective and Preventive Services

David Harvin
Legal Services

Wilbert Lewis
Child Protective and Preventive Services

SOUTH CAROLINA CHILD FATALITIES OVERSIGHT COMMITTEE

SUB-COMMITTEE STRUCTURE

MEDICAL

S.C. Medical Association
S.C. Hospital Association
S.C. Society for Hospital Social Work Directors
S.C. Child Protection Advisory Committee

LAW ENFORCEMENT

S.C. Sheriff's Association
Coroner's Association
State Law Enforcement Division

PUBLIC AGENCY

Department of Social Services
Department of Mental Health
Department of Education
Department of Parole & Community Corrections

LEGAL AND LEGISLATIVE

Joint Legislative Committee on Children
S.C. Bar Association
S.C. Court Administration
Family Court
Solicitor's Association
Governor's Office

Introduction and Summary of Committee Activities

The South Carolina Child Fatalities Review Committee was formed in November of 1985 at the request of Commissioner James L. Solomon of the Department of Social Services in response to a dramatic increase in deaths related to abuse and neglect. This multidisciplinary committee, chaired by Joseph J. Casper, was comprised of leading representatives of the public and private sector whose organizations deal with the problem of child maltreatment. The committee examined each child fatality that had occurred from 1983 to 1985. Complete access to all records was given and personal testimony from professionals involved in these situations was taken. The findings of the Child Fatalities Review Committee identified the problems that had been noted in these cases and made specific recommendations to alleviate deficiencies. As a result of this report the South Carolina Child Fatalities Oversight Committee was formed in October of 1986 to facilitate implementation of these recommendations. Since that time Oversight Committee members and the agencies and organizations they represent have contributed both time and resources to accomplish these objectives. Committee members have contributed in excess of five thousand volunteer hours in various projects related to this effort. Virtually every major public and private agency dealing with abused children and their families has participated either directly or in a consultative role. The work of the Oversight Committee itself stands as a milestone in that it represents the first time that both public and private agencies have participated together at this level to work on mutual goals. It is hoped that the precedent

set by this effort will encourage further cooperative work focused on the interests of children. This opportunity to work together has also allowed a dialogue process to occur that has broadened the perspective of those involved and has resulted in a better mutual understanding of the larger problems facing the total child welfare system.

The Oversight Committee has achieved significant progress in areas of vital concern that will affect the long term ability of children's services to impact on the problems surrounding child abuse, neglect and child fatalities. Achievements reported by committee members include the full mobilization of local multidisciplinary case advisory teams in all forty six counties including a revised training and resource package; the development and implementation of an interagency training program on child abuse and neglect that is being provided to related agency personnel in the identification, reporting and management of these cases. Three statewide conferences have been held featuring nationally recognized figures in the field of child maltreatment. These conferences, and other relevant training provided over thirty thousand (30,000) contact hours of specific instruction in 1987. At least four statewide conferences are already planned for 1988. Through the efforts of the medical community standardized guidelines for the hospital management of child abuse situations have been formally adopted. Specific protocols for autopsies in cases of child abuse related fatalities have been identified and will be distributed to all of the states coroners. Model agreements for use between local hospitals and county DSS offices have been developed. Legislation has

been introduced that will increase reporting accountability by deleting the ability of professionals to delegate this responsibility. New interagency agreements to clarify and define roles and responsibilities of agencies and their personnel have been drafted. New public awareness material has been produced by both public and private sector organizations and is now being distributed throughout South Carolina. Public service announcements, also sponsored by both public and private agencies, have been aired statewide with material now being prepared for radio and television exposure in 1988. Policy and procedural manuals used by child protection staff have been revised to fully incorporate necessary modifications suggested by the Child Fatalities Review Committee. A resolution clarifying lines of authority within the Department of Social Services was adopted by their state board in November of 1987. As a result of a subsequent opinion from the Attorney General, the State Board of Social Services moved at its January meeting to hold the resolution in abeyance until March. During this period the DSS commissioner will be working with a representative group of county based chairpersons to achieve a consensus agreement on the respective roles and responsibilities for evaluation and discipline of county directors. A ten point process has been adopted to guide these efforts. The Child Fatalities Oversight Committee stands in support of this process to facilitate uniformity in compliance with departmental policy, procedures, regulations and the South Carolina Children's Code.

A major accomplishment establishes a standing Child Fatalities Review Committee that will begin their work in the first quarter of 1988. This will insure that abuse related death cases are fully reviewed following the litigation process to continually monitor the circumstances surrounding these situations and make recommendations to futher enhance our system's response. It should be noted that South Carolina is the first state to provide this comprehensive approach in cases of child abuse fatalities.

South Carolina's work, and the efforts of both the Child Fatalities Review Committee and the Child Fatalities Oversight Committee have been featured at national conferences sponsored by the National Committee for Prevention of Child Abuse in Chicago and the American Humane Association in Austin, Texas. This exposure has resulted in several other states requesting the South Carolina model to start their own effort to examine child fatalities.

The co-chairmen of the Child Fatalities Oversight Committee have met with several legislative committees to articulate concerns and request needed assistance. These include the House Ways and Means Committee, the Senate Judiciary Committee, the Joint Legislative Committee on Children, and the House Medical, Military, Public and Municipal Affairs Committee. A meeting with representatives from the Office of the Governor was also held in January of 1988.

Along with the efforts of the Child Fatalities Oversight Committee other independent, but closely related, achievements have occurred over the past year. The first is the expansion of the state's Guardian Ad Litem Program that provides independent representation for children in

cases coming before the Family Court. This program was endorsed by the Child Fatalities Review Committee in its original report. Through the efforts of dedicated staff and volunteers the program anticipates full implementation by the end of 1988. This accomplishment is seen as one of the most positive developments for children in recent years.

The other notable factor impacting on the plight of children is the expanding role of the Children's Trust Fund of South Carolina. Established in 1984 and funded through a check off on state income tax forms, Children's Trust Fund has invested over four hundred thousand ($400,000) dollars in local efforts throughout the state to encourage the development of innovative, private sector initiatives on behalf of South Carolina's children. Two of the major projects undertaken by members of the Oversight Committee were made possible through Children's Trust Fund grants. These include the training of local multidisciplinary teams by the South Carolina Child Protection Advisory Committee and the state conference on child abuse and neglect sponsored by the Council on Child Abuse and Neglect. The Children's Trust Fund has emerged as an invaluable resource to facilitate the development of programs for children.

These achievements notwithstanding there continue to be areas that will require diligent work and ongoing attention. South Carolina's child protective services program remains understaffed and underfunded which continues to result in caseloads that are far above the nationally recommended level and high rates of staff turnover annually. Unless these problems are addressed it is unrealistic to expect DSS staff to be able to provide maximum response in all

situations. Problems in service delivery are but the logical outcome of a chronically overburdened, underfunded, program. However, even with these shortages social services staff still require the availability of ongoing, high quality training, combined with structured, accessible supervision in order to maximize existing resources. Also, the problems inherent in a county administered social services delivery system will require ongoing organizational attention. The inconsistencies in practice and procedure previously identified among the forty six county offices can only be addressed through clearer lines of authority, accountability and administrative control.

Another long term need for South Carolina's child welfare system is more mutually supportive, coordinated efforts between the public and private sectors. This need is most vital in the area of child abuse prevention strategies as we move into the 1990's. Joint planning and program coordination to insure maximum use of resources while avoiding duplication of efforts must be continually pursued. Community based prevention initiatives need to be encouraged and supported. Mechanisms to enhance communication, cooperation and information sharing among the various professional disciplines involved with abusive and neglecting families must be encouraged.

Finally, continuing public awareness activities by both public and private organizations need to be expanded. The best weapon in the fight against child abuse and neglect is a fully informed public that stands united in the belief that maltreatment of children is no longer acceptable. Heightened public awareness also carries with it a

heightened element of professional responsibility. Persons making reports involving child abuse and neglect need to be informed when action is taken. The perception that no response is initiated leads to an inevitable loss of faith in the system. This loss of faith may result in valid reports not being made and children being left at risk. Agencies also should continually work to enhance their public image through proactive efforts that make our citizens aware of positive accomplishments, the ongoing needs of the organization and ways in which their community can be of assistance. Finally, we as citizens should not expect organizations alone to bring about the end of the problem of child abuse, neglect and fatalities. Efforts have to start with neighbors helping neighbors, communities working together on behalf of their children to provide a safe, nurturing environment to promote the health and well being of our state's future generations.

I. Reporting

The report of the original Child Fatalities Review Committee identified the need for greater awareness on the part of professionals as to their responsibilities to report suspected cases of child abuse and neglect. The following actions have been taken to address this need.

It was recommended that the language in section 20-7-150 (A) of the Child Protection Act be amended deleting the clause "or cause a report to be made" to eliminate a failure to report by delegation of responsibility. Draft legislation was presented by the Oversight Committee to the Joint Legislative Committee on Children for legislative action.

Members of the Oversight Committee appeared before the JLCC to endorse this legislation. The proposed bill was subsequently approved and passed out of this committee for consideration by the legislature. The legislation, H.2962 - S.685, was jointly introduced in the House of Representatives and the Senate under the authorship of Senators Smith, Hayes, and Moore, and Representatives Evatt, Beasley, and Hayes. The The Co-Chairman of the Oversight Committee appeared before the Senate Judiciary Committee in January of 1988 to again stress the need for passage of this bill. Final action is now anticipated prior to the end of the current legislative session.

Another area of concern focused on reporting by physicians, and their perceived reluctance to become involved in subsequent legal action. In response, the South Carolina Medical Association published an article in their Winter 1987 edition of the Physician Risk

Management Bulletin, entitled, "Reporting of Suspected Abuse or Neglect". The article outlined relevant sections of the Child Protection Act as they relate to physician reporting. This publication reached over 7,000 South Carolina physicians, hospitals, and other health providers. Also in this bulletin was an article entitled, "Testifying in Child Abuse Cases" that explained the procedure used by Family Courts allowing physicians to be on telephone standby for testimony rather than having to spend hours of waiting time prior to being called as a witness.

The South Carolina Medical Association and the Medical Association Auxiliary have also provided public service announcements featuring Emmanuel Lewis, star of the television series, "Webster". These announcements, entitled "No, Go, and Tell" have been distributed throughout the state and are directed towards children to enable them to self-report in cases of abuse.

The South Carolina Department of Social Services has now begun a comprehensive campaign to increase community awareness of indicators of abuse and neglect. Brochures have been developed and are being distributed throughout South Carolina. This campaign to raise the awareness of the general public has also been augmented by organizations in the private sector.

II. Procedures

In the review of child death cases undertaken by the Child Fatalities Review Committee it became apparent that the effective use of county Multidisciplinary Case Advisory Teams would greatly enhance not only case decision making, but also open much needed channels of communications. A review of the use and functioning of these teams was undertaken by the Department of Social Services to determine how many teams were operational statewide. The results of this survey indicated a wide range of team functioning in the counties. To address this problem an effort was initiated to develop clear guidelines as to the purpose, function, objectives, membership, access to records, team organization, operation, case selection and required forms. The resulting model was developed based on direct input from counties having functioning teams in place. Primary assistance was provided by representatives from teams in Kershaw, Marlboro, and Richland Counties. This effort was coordinated by the Child Protective and Preventive Services sub-committee of the Children and Family Services Advisory Committee to the South Carolina Department of Social Services. This sub-committee includes representatives from the South Carolina Child Protection Advisory Committee, the South Carolina Foster Care Review Board, the Council on Adoptable Children, the Council on Child Abuse and Neglect, the Department of Mental Health, the Department of Education and a Residential Care Facility. This re-designed model has now been distributed to each county through the Department of Social Services.

The second phase of this effort was to see that teams were established where no teams existed and to provide training on the new model to all counties. The revised model was presented to representatives of the local teams at the Spring conference of the South Carolina Child Protection Advisory Committee in April of 1987. This presentation was done by members of the Marlboro County Multidisciplinary Case Advisory Team. However, to assure that all counties had been provided training, the South Carolina Child Protection Advisory Committee applied for, and received a $15,000 grant from the Children's Trust Fund of South Carolina to accomplish this task. A nationally recognized trainer was identified and contracted to provide the training. Because of the grant from Children's Trust Fund, travel costs and expenses for participants were paid to encourage attendance. The resulting four days of training held in Columbia was attended by representatives from 42 of the state's 46 counties. A second training for those counties not represented is now being scheduled.

Another critical recommendation of the Child Fatalities Review Committee concerned the need for full implementation of the state's Volunteer Guardian Ad Litem Project in all counties. The volunteer Guardians in their capacity as an independent voice for children in court proceedings have proven to be invaluable. This program was operational in twenty four counties at the end of 1986. In 1987 an additional ten counties were added, bringing the current number of operational programs to 34. To date, over 700 volunteers have been trained as guardians-ad-litem with approximately 513 now actively

working on cases. It is anticipated that the additional eleven counties needing this program will be fully operational by the end of 1988. It should be noted that Richland County has its own guardian-ad-litem program with over 125 guardians working with approximately 380 individual cases.

Legislation is currently pending (H.2945 - S.654) that would ensure the long term existence of child guardians through statutory mandate. The Child Fatalities Oversight Committee stands in full support of this initiative.

A critical concern of the Child Fatalities Review Committee focused on the internal accountability mechanisms within the Department of Social Services. It was recommended that "a state DSS audit team should conduct an on-site, systematic, unannounced audit of each county's CPPS unit annually. When counties are found not to be in compliance with policy, there should be an established mechanism for handling these situations".

The Department of Social Services has now put in place a two tiered internal review process. Each county office is assigned a state level consultant from the Child Protective and Preventive Services Division who is responsible for conducting bi-monthly visits to each county's CPPS units to provide technical assistance and consultation in order to assure compliance with policy and procedure.
These examinations also include the review of randomly selected cases chosen by the consultant. County staff have no knowledge of which cases will be reviewed. Upon completion of these reviews, verbal feedback is given to the county which is followed in writing outlining

deficiencies. The county must then respond with a corrective action plan that is reviewed for compliance on the consultant's next visit.

The second level of county reviews are conducted annually and involve the examination of not only the CPPS unit, but also foster care, adoptive licensing, and economic services. To insure an objective review, the regular county consultants are not allowed to serve on the reviewing team. Teams consist of from two to six members depending on the size of the county office. These reviews again involve the random selection of cases. The records selected include both active and unfounded reports. Cases are also selected from the various typologies of maltreatment including physical abuse, sexual abuse, physical neglect, and emotional maltreatment. The written findings of these review teams are transmitted to the County Director as well as individual supervisors. A written corrective action plan is required from the county office with compliance being monitored by the State Department of Social Services. These ongoing reviews have now resulted in policy as well as personnel action being taken to correct deficiencies.

III. Practice

A critical recommendation in the area of practice proposed the joint training of a Department of Social Services caseworker and a law enforcement representative in each county to handle cases involving child fatalities. To this end the co-chairman of the South Carolina Child Fatalities Oversight Committee presented this proposal to the Executive Director of the South Carolina Criminal Justice Academy to determine the feasibility and costs for this project. This initiative resulted in a tentative agreement to move forward in planning with a projected cost of approximately $23,000 plus any curriculum development or speakers fees. On January 8, 1987 this information was transmitted to the Chief of the South Carolina Law Enforcement Division to inform him that a meeting had been held between representatives of the Criminal Justice Academy, the Department of Social Services, and the Fatalities Oversight Committee. In this correspondence it was stated that plans were "on go". On January 23, 1987 the State Commissioner of Social Services transmitted a letter to the State Law Enforcement Division stating his support for the project pending the location of the necessary funding.

On January 28, 1987 the co-chairmen of the Fatalities Oversight Committee met, along with Commissioner James L. Solomon, with the House Ways and Means Committee to discuss the needed funding to implement this project as well as others requiring new state dollars to meet essential needs for FY 1987-1988. Included in these needs were not only funds to implement recommendations of the Fatalities Committee, but also to upgrade county CPS staff, expand Medicaid coverage for

pregnant women and children, and to implement differential staffing patterns to help reduce caseload levels. All of these issues were directly related to the recommendations in the report of the Child Fatalities Review Committee (July 1986). Despite the critical need for these additional funds these requests were denied. When the unavailability of funds from the legislature was determined with the passage of the final state budget in June efforts to secure an alternate funding source were begun. It now appears that dollars to implement this program have been identified. The Department of Social Services has been notified by the Governor that they will receive funds under the Children's Justice Grant that can be used to move forward on this recommendation. The implementation of this program is vital to assure the elimination of overlap in investigations, timely and thorough evidence collection, avoidance of communication problems, delayed or inadequate investigations and proper protection of children at risk.

It was also recommended that DSS casework staff have clear guidelines for assessing risk to surviving children while investigations are being conducted. The past year has seen several specific programs presented on this topic. Assessment of risk was a featured workshop at the Resource '87 conference sponsored by the Department of Social Services in April that was attended by over 400 professionals including DSS staff, teachers, health care professionals, and law enforcement personnel. A second program entitled "Risk Management: Making the Tough Decisions" was presented at the Spring conference of the South Carolina Child Protection Advisory Committee

which was attended by over 200 professionals in the field of child welfare. A recent initiative by the Department of Social Services has, after review of several national models, identified a curriculum that provides specific guidelines that can be used by child protection staff to assess and monitor risk to children. This curriculum, delivered by ACTION for Child Protection, a national child welfare consulting firm, has now been piloted in two South Carolina counties. Initial reports indicate that this training package has received high evaluations by participating staff and provides the necessary information to more accurately assess the severity of family dynamics related to risk. Based on the results of this pilot project, this curriculum is being proposed for delivery to DSS staff statewide.

The South Carolina medical community has taken the following actions in the area of practice to address issues surrounding child maltreatment. These actions occurred through the collaborative efforts of the South Carolina Medical Association, the South Carolina Hospital Association, the South Carolina Hospital Social Workers Association, and the South Carolina Child Protection Advisory Committee. Based on the findings of a survey conducted by the Oversight Committees medical sub-committe, it was determined that uniform guidelines needed to be made available to hospitals throughout the state on how to deal with situations of suspected abuse and/or neglect. Based on these findings the sub-committee obtained the American Hospital Association's "Guidelines for the Management of Child Abuse and Neglect Cases". These guidelines were reviewed and formally adopted by the South Carolina Hospital Association. The Hospital Association Journal has

disseminated these guidelines for use in local hospitals across the state. In another medically related initiative, the South Carolina Medical Association has developed a videotape to provide instruction to physicians giving depositions in court proceedings.

A major recommendation directed to the Department of Social Services to impact the medical community has now been finalized. DSS has now contracted with Dr. Ron Porter of the Medical University to provide seminars throughout the state to local physicians. This contract was effective August 1, 1987. Dr. Porter will also provide consultation and technical assistance in individual cases. When indicated, he will also serve as a liaison between the medical community and DSS. S.C. DSS and Dr. Porter are now in the process of acquiring information regarding specific local educational/training needs on the medical aspects of abuse and neglect as they relate to health care providers, law enforcement personnel and DSS employees. Implementation of training will commence upon receipt and analysis of this data. The availability of this combination of training, consultation, and technical assistance puts in place a much needed bridge between the medical and social work communities.

IV. Staffing

A primary concern of the Child Fatalities Review Committee in the area of staffing stated that "funds must be provided to the Department of Social Services for hiring sufficient staff to provide for a caseload that is manageable". The critical need for additional casework positions in the area of children's services has been thoroughly documented. Reports attesting to the needs include:

"Omni Staffing Study" 1984

"The Governor's Coordinating Committee Report" 1984

"Child Protective Services Program Evaluation Report" prepared by the American Humane Association, June 1984

"Legislative Audit Council, Management and Performance Review of the South Carolina Department of Social Services", February 1985

"Report of the Child Fatalities Review Committee" 1986

In the face of this overwhelming body of material consistently identifying lack of adequate staff, and repeated requests from the Commissioner of the Department of Social Services, the state legislature has consistently denied funding to accomplish this recommendation. These denials come in spite of documented increases of over 100% in the incidence of child abuse, neglect and fatalities. The results of this inaction can be clearly seen in the area of casework practice. The existing staff mandated to respond to reports of child maltreatment are placed in a situation where caseloads are double, and in some cases triple, the nationally accepted level. These chronically overburdened staff are placed in a position where tney can only respond to the most critical situations in their caseload which

means that other less critical, but vital problems cannot be effectively addressed. This inevitably leads to frustration, burnout, and high turnover ratios among staff that now approach 50% per year in some counties. The new staff are then required to take over caseloads of high risk families with little or no advance knowledge of the individual cases or their existing level of risk. Under these obviously unworkable conditions the inability of staff to be fully effective and the inevitable situations of children "falling through the cracks" can only be seen as a logical outcome.

A second issue related to staffing recommended that the probationary period for all human services workers be extended from six months to one year to assure a competency level commensurate with job responsibility. This recommendation was explored with the states' Human Resource Management Division. Upon review, it was determined that under the current personnel system this could only be implemented to affect a single class of employee through legislation. It was felt however, that the intent of this recommendation could be addressed through existing mechanisms. Current policy allows a supervisor to extend the probationary period for up to ninety (90) days if an employee is not meeting required standards. This option is now included in the training program for supervisory staff to fully ensure their awareness of this option and the circumstances under which it should be employed.

V. Policy

The Child Fatalities Review Committee identified revisions required in Department of Social Services policy manual to address specific problematic areas. These included; (1) further specifications of what constituted high risk situations, (2) actions involving intercounty investigations, and (3) the need for prevention services. The DSS policy manual was under review during the fatalities study and since that time all recommended changes have been incorporated. A specific listing of high risk situations is now included, intercounty procedures are delineated and manual material for prevention services has been developed and approved.

The incorporation of preventive services into the Division of Children, Family and Adult Services is noted as a major step forward. Child Protective Services (CPS) has now been retitled Child Protective and Preventive Services (CPPS). The ability to influence events prior to a child being injured should save the needless suffering of many children. Full time staff have now been hired in State Office to develop this program. An independent advisory committee made up of professionals from across the state has been appointed and are meeting regularly to assist DSS in implementing specific programs. A Preventive Services Development Plan has been adopted and public awareness materials are now available.

A major task facing the Child Fatalities Oversight Committee was to establish a mechanism for review of child abuse related deaths in a timely, ongoing fashion. Before undertaking this effort, consideration was given to those factors that would serve as the underpinning for

this function. Those elements included:

1) The review committee must be multidisciplinary in nature.

2) The committee must represent the major disciplines and entities, both public and private, that deal with these problems.

3) The committee must be independent of organizational constraints to allow for an objective, open process.

4) Reports of the committee will be presented to a public body having authority to implement needed changes.

5) A mechanism must be in place to allow for feedback as to the status of these recommendations and the need for further action.

With these broad objectives in mind, the Oversight Committee began the development process. This has resulted in a plan that should meet the criteria outlined above.

With the final adjournment of the Oversight Committee in January of 1988, there will be established a permanent South Carolina Child Fatalities Review Committee. The purpose of this committee will be to review the deaths of children resulting from abuse and neglect perpetrated by parents, guardians, or other persons responsible for their welfare as defined in the Child Protection Act, section 20-7-490. Upon review, the committee shall prepare its findings with specific recommendations for actions within the child welfare system to alleviate any systems problems which may have prevented effective intervention or response. The Fatalities Review Committee shall consist of nine members. Those members shall include representatives from the following disciplines or organizations.

1) Medical Profession (Pathologist/Pediatrician)

2) Legal/Law Enforcement

3) Joint Legislative Committee on Children

4) South Carolina Department of Social Services

5) South Carolina Department of Health and Environmental Control

6) South Carolina Department of Mental Health

7) Coroner

8) A representative from private agencies working with child abuse and neglect.

9) A private citizen involved in South Carolina's child welfare system.

The multidisciplinary make up of this committee should ensure the comprehensive review required in these complex situations.

During the review process the committee can utilize other consultants on an "as needed" basis to provide specialized information. The Fatalities Review Committee shall be given full access to all records and information including DSS records, court reports, medical reports, autopsy records, and any other relevant material. The committee will also be given the opportunity to interview persons directly involved in these cases to assure full disclosure of information.

The committee will be housed in the Department of Social Services to expedite the acquisition of records. DSS will also provide secretarial and staff support for committee needs. A full time staff position in the DSS State Office has been approved to coordinate these efforts. The Fatalities Review Committee will be convened quarterly to review all cases completing the litigation process during that period. It is anticipated that the reports of this committee will be

transmitted to a number of bodies as there is no single committee that has authority to implement recommendations in both the public and private sectors. However, since the majority of human services are provided by state agencies the primary body to receive and act on these reports will be the State Health and Human Services Coordinating Council. Membership on this body includes:

- Commissioner, South Carolina Department of Youth Services
- Commissioner, South Carolina Department of Mental Health
- Commissioner, South Carolina Department of Health and Environmental Control
- Director, State Commission on Alcohol and Drug Abuse
- Director, Children's Foster Care Review Board
- Commissioner, South Carolina Vocational Rehabiliation Department
- Executive Director, State Health and Human Services Finance Commission
- Director, South Carolina Commission on Aging
- Commissioner, South Carolina Department of Mental Retardation
- Commissioner, South Carolina Department of Social Services
- Executive Director, South Carolina Employment Security Commission
- Director, South Carolina Department of Veterans Affairs
- Superintendent, Wil Lou Gray Opportunity School

Other state agencies to receive these reports will include the Office of the Governor, the State Attorney General and the Legislative Audit Council.

Organizations in the private sector receiving these reports will include, but not be limited to the South Carolina Medical Association,

the South Carolina Hospital Association, the South Carolina Bar Association, and the South Carolina Coroner's Association.

The report of the Child Fatalities Review Committee will transmit specific recommendations related to the involved agencies or organizations to the appropriate agency head. Members of the Fatalities Committee will follow the status of recommendations to assure that appropriate action is taken.

It should be noted that South Carolina is the only state in the country to put in place a comprehensive mechanism for accomodating required service delivery and policy modifications in child abuse related death cases.

VI. Training

During the child fatalities review process one of the most often expressed needs was in the area of professional training. Representatives from every discipline involved in the assessment and management of these cases identified the need for more specific, ongoing education in the area of child maltreatment. For this reason the Oversight Committee membership has attempted to put in place mechanisms to achieve this objective. To this end the following steps have been taken. In 1987 three statewide conferences were held that incorporated elements of the Fatalities Committee recommendations as part of the program.

1) "Resources '87" sponsored by the Child Protective and Preventive Services Division of the South Carolina Department of Social Services was held April 22 and 23 in Columbia. This conference was attended by over 450 child welfare professionals.

2) The Spring Conference of the South Carolina Child Protection Advisory Committee. Attended by over 200 professionals, sessions dealt with legal and medical issues as well as the use of multidisciplinary volunteers.

3) "Working Together in the Best Interest of Children" presented by the Council on Child Abuse and Neglect. Workshops were presented dealing with preventive and treatment issues related to child abuse and neglect. This conference was attended by over 600 professionals and volunteers.

These three conferences alone provided over 11,400 contact hours of specific training and included representatives from social work, law, medicine, education, law enforcement, counseling and guidance, mental health, nursing and administration. Plans are now underway to again provide these statewide events for 1988.

Other training initiatives implemented during 1987 include:

- The South Carolina Medical Association has contracted with pediatricians to provide training in the identification of child sexual abuse.
- Sessions on child abuse and neglect were presented at this year's conference for solicitors and other members of the Bar Association.
- DSS and the USC Department of Pediatrics are now providing consultation and training for physicians at the local level.
- The South Carolina Medical Association offered sessions with continuing medical education credits at their 1987 annual conference. The Medical Association has also contacted Pediatrics, OB-GYN, Emergency Room Medicine, and Family Practice Societies of the availibility of education programs.
- The South Carolina Department of Education is now actively presenting programs to children on what they can do for themselves when faced with an abusive situation.
- The Council on Child Abuse and Neglect continues to present its "How To Be Your Own Best Hero" program to fourth grade students. Focused on prevention of sexual abuse this curriculum has reached over 6,000 children.

- The South Carolina Coroner's Association is developing plans to establish educational requirements for coroners.
- The State Law Enforcement Division and the Department of Social Services continue to plan for joint training on child death investigations.
- Training in the area of risk assessment has been piloted in two counties by the Department of Social Services.
- As mentioned earlier in this report, training was provided to representatives of 42 of the 46 county multidisciplinary teams by the South Carolina Child Protection Advisory Committee.
- A state conference jointly sponsored by Forensic Mental Health Associates, the Council on Child Abuse and Neglect, and the University of South Carolina College of Social Work on the clinical assessment and treatment of child sexual abuse is now scheduled for April, 1988.

A major initiative completed by the Department of Social Services is the new Interagency Training Program on child abuse and neglect. The curriculum package has now been finalized and a "training of trainers" has been conducted. Representatives from 42 of the 46 county Health Departments of the Department of Health and Environmental Control (DHEC) participated in the 2 1/2 day course. These trainers are now conducting a training needs assessment of the remainder of DHEC staff. Additional persons to receive this training include health professionals, residential care workers, educators, law enforcement, day care and child development specialists as well as foster care, adoptive and economic services workers.

VII. Interagency Communication and Coordination

Problems of communication and coordination among the various child serving agencies and disciplines were cited as a pressing problem in the report of the Child Fatalities Review Committee. Steps have been taken in the past twelve months to enhance communication and define specific roles and responsibilities.

New interagency agreements involving the Department of Social Services, the Department of Health and Environmental Control, and the Department of Education have now been drafted and are pending approval upon final review.

Another critical component in the area of interagency coordination has been accomplished with the full establishment of county multidisciplinary case advisory teams. These teams are made up of representatives from local, public, and private agencies to facilitate decision making in specific cases. With teams now operating in all counties the coordination of services at the local level should see improvement. The availability of these teams in all counties stands as a major achievement.