

South Carolina Department of Social Services
Response to the Citizen Review Panels 2007 Annual Report
November 25, 2008

The South Carolina Department of Social Services (SCDSS) received the 2007 Annual Report of the Citizen Review Panels (CRP) on June 2, 2008. As required by CAPTA and in keeping with our working relationship, we provide the following response to the concerns identified and recommendations for improvement made by the South Carolina Citizen Review Panels. We are pleased to acknowledge that this response is made possible through the coordinated effort within the agency and with the agency's external partners who have responsibility for the areas impacted by recommendations made in the Annual Report. Input was provided from the State Law Enforcement Department, Child Fatalities Department (SLED), the Department of Health and Environmental Control, Division of Injury Prevention (DHEC), the SC Hospital Association (SCHA), the Department of Alcohol and Other Drug Abuse Services (DAODAS), and the Children's Law Center (CLC). In addition to these partner agencies, members of the Citizen Review Panels also participated in discussions which led to the following responses. We believe that this coordinated approach to the recommendations of the Panels has led to a more comprehensive response.

The Citizen Review Panels provide a unique opportunity for citizen input into South Carolina's child welfare system. Citizen participation leads to a better understanding of this complex system and of its strengths and areas needing improvement. The SC Department of Social Services welcomes input from the Citizen Review Panels and is pleased to work with the citizens of South Carolina in our joint effort to improve assessment and service delivery to children identified as abused or neglected. We look forward to continuing this partnership in the coming year.

Response to Overall 2007 Annual Report Narrative Content:

Within the body of the annual report, the Citizen Review Panels (CRP) comment on DSS' use of Child Abuse Prevention and Treatment Act (CAPTA) funds. CAPTA is the only discretionary and flexible funding to which Child Protective Services has access. It cannot be matched and is a relatively small amount of money so we are creative in using it and maximize all other funding sources that can be matched before using CAPTA. CAPTA is used in limited creative ways to improve the system by supporting innovative activities, intake and investigations, as well as for the prevention activities. We will use the monthly administrative meetings to follow up on your request for more information about CAPTA and how SCDSS uses those funds and will include fiscal management staff in those discussions. In addition to CAPTA, we have requested that the Data Report Manager meet with us to discuss how to craft a data report that will track the appointment of guardians ad litem for children to follow up on a concern noted in the 2006 Annual Report.

In addition, the 2007 Report mentions in the section on *Accountability* and the section headed *DSS Response to CRP Annual Report* that there was a time when DSS did not provide a written response to the Panels' report. We respectfully disagree with this information and will discuss this further at the Administrative Meeting to ensure that we fully understand these comments. From the DSS historical perspective, DSS received the first written report from the Panels for activities accomplished during SFY 02-03 and responded to this report. Subsequently, written Annual Reports were received for Calendar Years 2004, 2005, 2006, and 2007. DSS has provided a written response to all these reports. Copies of the agency's responses for FY 02-03, Calendar Years 2004, 2005, and 2006 are included with this response (See Attachment 1).

DSS RESPONSE TO THE CRP 2007 ANNUAL REPORT

Recommendation #1:

Create a uniform local child death review process with dedicated permanent funding and a mechanism for systematic input to the State database.

Response to Recommendation #1:

The Department continues to support your recommendation regarding local child death review (CDR) teams. This section will discuss the status of local teams and of efforts to institute a uniform review protocol in all forty-six counties. Although the subject of much discussion between the State Child Fatality Advisory Committee and local teams when the local teams were first established, South Carolina currently lacks a mechanism for systematic input to the State Child Fatality Advisory Committee data base and has little dedicated permanent funding. No legislation passed in the 2008 legislative session supporting this initiative.

Legislation mandating a local child death review process has been introduced at least twice in the past ten years through the State Child Fatality Advisory Committee (SCFAC), of which SCDSS is a member. This legislation did not pass in the SC General Assembly. While DSS, like the CRP, would like to see local review teams in place in every county operating with a consistent protocol and data reporting capability, DSS is not in a position to fund or initiate funding requests to support such a structure. DSS would support renewal of legislative proposals from the State Child Fatality Advisory Committee that had minimal fiscal impact.

In an effort to seek alternatives, DSS has initiated discussions with CRP, State Law Enforcement Department (SLED), Department of Health and Environmental Control (DHEC), SC Department of Alcohol and Other Drug Abuse (DAODAS), SC Hospital Association (SCHA), and Children's Law Center (CLC) to explore the barriers and opportunities and to develop a plan to maximize the state's resources in this area. This work group asked what the state can do to bring attention to this important work. One suggestion is to request that the State Child Fatality Advisory Committee add a section to their Annual Report that describes the actions and outcomes of the work of existing local child death review teams. This would give credit to what is being done at the local level to investigate and prevent child deaths.

In order to support local child fatality review teams, DSS plans to continue to use CAPTA funds for a staff position at DHEC to work with counties who have local child death review teams or want to develop such a team. This person also works with the State Child Fatality Advisory Committee. Under the scope of work in the contract with DHEC, the Child Death Review coordinator provides technical assistance to the existing local child death review teams and works to organize additional teams to support local child death review, in addition to other duties such as producing the annual report of the state team and analyzing trend data using Department of Health and Environmental Control's extensive data resources for unexpected and unexplained deaths and severe injuries. This staff person is also very active in the Southeastern Coalition on Child Death Review, an organization of southeastern states' child death review coordinators. South Carolina was a founding state in this organization and has hosted the annual conference several times. The Southeastern Coalition is also associated with the National Center on Child Death Review. The National Center on Child Death Review (NCCDR) has issued a uniform process and South Carolina uses this operating protocol to provide a consistent and uniform procedure for local child death review. A copy of the child death review process is available at the National Center's website at <http://www.childdeathreview.org/>.

The Child Death Review coordinator reports that currently there are local child death review teams in 11 of the 46 South Carolina counties. There are 10 Children's Health and Safety Councils and one child death review team associated with the Safe Kids county organization. Local child death reviews take place in Richland, Charleston, Greenville, Greenwood, Dillon, Horry, Lancaster, Kershaw, Marion, York, and Hampton counties. DHEC provides to each county with a local team and who want to start a local team, the NCCDR protocol for the composition, structure, and operating procedures for child death review.

The Coordinator met with DSS and the CRP at the administrative meeting to discuss the organization of the local teams and the barriers as well as strengths that she has identified. The Coordinator shared that the local review teams keep records of the individual review and the outcome but do not have a systematic and consistent method to report this information to the State Child Fatality Advisory Committee. DSS, DHEC, SLED, and CRP agreed to continue to explore how this sharing of information could best occur.

Through her work with the National Center on Child Death Review, the Coordinator has found that the National Center has recognized that lack of funding is a concern across the country and is working with other states around creative and alternative methods to support child death review. This effort will be beneficial to SC as we work on the same issues.

As further support of the local child death review in SC, the Children's Law Center in their role as staff to the Children's Justice Act Task Force developed a protocol in 2007 to guide the interaction between the members of the death investigation team and to define roles and responsibilities. As envisioned in this protocol, the child death investigation team is headed by the coroner and this team would use the SLED protocol in their investigation of the death. The two protocols are complementary to each other. The operating protocol includes the responsibilities for the coroner, law enforcement, medical emergency staff, hospital and others who might be part of an investigative team. This effort has met with limited success so far in pulling together the various players but it continues to be on the agenda for the Children's Justice Act Task Force. DSS, SLED, attorneys, judges, mental health, and other professionals participate on the Task Force and the CJA Task Force will continue to encourage the adoption of this protocol. The Children's Law Center provides training for coroners and law enforcement and has included the child death investigation protocol as part of this training. Copies of both protocols are attached for your information (see Attachment 2 and 3).

Through the brainstorming of the work group about how best to address this issue, we identified several challenges. This is not a complete list but represents our initial comments.

- A lack of funds for training for law enforcement and coroners
- The need for accurate and consistent data collection to capture trends from which to develop corrective action and preventive efforts
- Concern that legislation might create an unfunded mandate
- Part-time, unpaid coroners in many counties with few resources

The work group has concluded that training would bring about the most immediate results while we work on the long range goals of state-wide consistency of investigations through implementation of a protocol. The Children's Law Center has agreed to develop a training plan to include but not limited to: death scene investigation, medical aspects of severe child abuse and neglect – signs and indicators, data collection, and team building for death investigation. In order to maximize the potential for attendance and effectiveness, the training will be provided regionally to minimize travel for participants. In keeping with the effort to determine how we can do this within our existing means, we have identified several nationally-recognized professionals in SC who have expressed their willingness to provide components of the training for coroners, law enforcement, CPS workers, and others who would be involved in a child death investigation and subsequent death review.

In preparation for the training, the Child Death Review Coordinator has agreed to map existing child death and near death data by county, type of death, and any causal factors available. This mapping process will help to identify specific geographical areas where there are more child deaths. This will help us to focus on the areas with the greatest need for immediate training. As we agreed, this will be an ongoing discussion at the monthly CRP-DSS administrative meetings.

The 2007 Report asked whether DSS saw the coroners as to blame for the lack of legislation. The following is an excerpt from the agency's Response to the 2006 Report: *"The support of the county coroner is essential to the success of the fatality review process. The coroner is perhaps the most important gatekeeper to identifying deaths for review, providing autopsy information and coordinating investigative findings. If a coroner refuses to participate, creation of an active, effective team is difficult to impossible. If a coroner believes in fatality review, the team has the potential to become a national model."*

Rather than assigning blame to coroners, the DSS 2006 Response described the role the coroner plays in the fatality review process in order to emphasize their importance. The 2007 CRP Report stated that a survey conducted by CRP in 2003 found that the coroners who responded were in favor of a process. The DSS Response to the 2006 Report informed the CRP that SLED has provided coroners with a protocol, but the decision to use the process is at the sole discretion of the individual coroner. In our discussions, SLED reported that the basic components of a death review as outlined in the SLED protocol are generally present in the county coroners' reports. SLED reported that through additional efforts to provide training and a clear rationale for the benefit of using a consistent protocol, most are using the protocol's format.

Recommendation #2:

Standardize CDR and institute uniform documentation that specifically considers every possible role of substance abuse: by the victim, perpetrator, or caretaker; as a cause or contributing factor; in the present or past.

Response to Recommendation #2:

As noted above, SLED has developed and disseminated a protocol for the investigation of child deaths to all coroners in the state. All issues that impact on the child's death are explored as part of the process, to include but not limited to, the use/abuse of illegal and legal substances. These issues will be addressed through the efforts described in Recommendation #1.

Recommendation #3:

Make the preparation of mandated reporters the responsibility of their respective professions.

Response to Recommendation #3:

As stated in the Response to the 2006 Report, DSS believes that implementation of this recommendation is outside the scope of what the Department can accomplish because of the array of authorities responsible for licensing, training and certification of these entities and individuals. However, as this recommendation is pursued by other entities, DSS will speak in support of the concept and will work collaboratively with the responsible authorities as they design their programs.

The Department will continue to focus its efforts on the areas within our control. We are mandated by federal and state law to provide training to mandated reporters. We embrace this responsibility because well-trained mandated reporters are such a vital element of the child protection system. DSS remains committed to assure high quality content in the training we offer and sponsor, and assure widespread availability of training and information. The Children's Law Center (CLC) was involved in the discussions of the recommendation and supports its implementation in ways other than through the DSS contract for training, such as through the Children's Justice Act Task Force. Because of its diverse and multi-disciplinary membership, the CJA Task Force can be instrumental in reaching other mandated reporters as well as putting forward legislative recommendations to the General Assembly.

Through the DSS training contract for state FY 07-08, the CLC increased the number of mandated reporter training sessions and provided 89 sessions that included 3,979 mandated reporters. Nearly 1,000 more persons than in FY06-07 were provided with practical information to help them meet their mandate to report suspected child abuse and neglect. This is a substantial increase in the training effort to equip professionals who are mandated to report and we expect this effort will continue to grow. A detailed chart listing the specific training and the professions involved was submitted in the state's Annual Progress and Service Plan. Tracking of professions who participate helps us to target underserved groups of mandated reporters.

The CLC has continued the effort to reach mandated reporters who are not commonly touched by routine methods through the distribution of information packets and brochures developed specifically for film processors and computer technicians who are mandated reporters by state statute.

In an effort to reach students in professional programs where the graduates will become mandated reporters, the CLC provided special sessions to students in the College of Nursing and the College of Social Work at USC. In addition, a CLC staff attorney teaches a course at the USC School of Law around family court and child abuse issues as part of the state's ongoing efforts to ensure that attorneys who may work with abuse and neglect in family court cases or serve as guardians ad litem have received training to prepare them.

CLC engaged professionals in the community in an innovative manner in order to increase the state's capacity to train reporters. This effort included the provision of four half-day regional sessions for "training of trainers" of selected professionals who are expected to conduct training for community groups.

While we agree that training is not the only issue to be addressed in the state's efforts to improve mandatory reporting, it is an essential step toward ensuring that persons required to report have an understanding of what to report, how to report, and what they can expect from the system.

Recommendation #4:

Expedite publication of Children's Services Policy & Procedure Manuals on the Internet, adding the CRP Annual Reports and DSS Responses. (If the Manual or CRP Reports are on the site already, the recommendation becomes that they be promoted to greater accessibility.)

Response:

DSS has made enormous strides in improving its website. Some of the work was reported in last year's Response. The Panels have been given updates on this process over the past six months as improvements were made incrementally. Access to the prototype website was provided to the Panels so that you could visit the site and provide feedback to DSS. We were pleased to get positive comments from those who did visit the prototype.

During the past six months, an intranet has been released for agency employees and contains the information necessary for staff, to include but not limited to, the Human Services Policy and Procedures Manual. Our focus was to ensure that staff had access to policy manuals first. This has been accomplished and the webmaster is in the process of publishing the manuals on the internet for public access. This should be accomplished by the time this response is provided to the CRP or shortly thereafter. We will provide an update at the monthly administrative meeting. We will continue to request feedback from the Panels to update and enhance the website.

A unique link to the Citizen Review Panels' website has been added to the DSS website under the Community Advisory Groups section. Through our discussions, we have agreed that the CRP Reports and the Agency Responses will be posted at the CRP website with this noted at the DSS website. This information has been added to the DSS website.

Although not a separate recommendation this year, the enhancements to the automated system, Child and Adult Protective Services System (CAPSS), continue to be of interest to the Panels as noted in the Report narrative so we provide the following update. The CAPSS Project Manager met with a group which included the interim chairperson of the Midlands CRP and discussed the current efforts to complete enhancements to the system. CAPSS development and modifications continue in order to effect compliance with federal requirements. Temporary grant staffs (composed primarily of retired or former child welfare program staff) have been hired to assist with programming and report designs. DSS will receive additional consultation with the National Resource Center for Information Technology to assist CAPSS staff in data development and mapping. DSS has spent the last year working on a conversion of CAPSS to a new technology platform because the Microsoft Company has discontinued support of the old Visual Basic 6 Technology which served as the platform for the original CAPSS. The agency rolled out a new, enhanced version of CAPSS the first week in August 2008. This new version is known as "CAPSS-II", due to the fact that it will be using a new version of the Microsoft Visual Basic Language called "Dot.Net". This is the latest, fully supported language platform from Microsoft. This new version of CAPSS utilizes many of the

same screens that the users currently are familiar with, but also has a number of new features which are helpful to the user. Some of these new features are:

- The ability to have up to 6 screens active at the same time,
- A new tree view which will remember references that are used, allows the user to easily re-open screens that have been previously used without having to search for them. These will be saved even if the system is shut down and restarted.
- All grids used in the system are sortable on any column by simply clicking on the column heading you wish to sort on.
- An all-new menu system is available for use as a short-cut to desired screens.
- Online help is built into the system that can be open at the same time as user screens.
- Screens are re-sizeable, including the data and forms contained on each screen.
- Enhanced error messages are included, with all detected errors noted by an error symbol beside the erroneous fields, if an attempt is made to commit a screen with errors.
- The dictation section of the application has been extensively redone, with greatly increased usability.
- The reports section has also been extensively redone, with greatly increased usability (including multiple reports open at the same time).

To insure that all affected workers have been trained on use of the new system, the agency provided training on the new system during June and July 2008. Training was offered on a regional basis to minimize the amount of travel for individual workers. We will also provide follow-up training on the agency training scheduling system (DART), for supplemental training after the primary training is provided.

Once all workers were trained on this new technology platform and the release was installed and functional, the CAPSS-II development process was resumed. We are planning for another dozen or so major releases of new CAPSS functionality before the project concludes (currently scheduled for September 2010.) These releases include the assessment and service planning components as discussed with the Panels.

The Advance Planning Document (APD) is the detailed guiding document for all CAPSS revisions and provides specifics for the system and timelines for completion. As this is a very large document, we will discuss this document further at a monthly administrative meeting in order to answer any other questions that may come up about the system. The CAPSS Project Manager plans to meet with the Midlands Panel to give all members an update on CAPSS and the DSS Legal Case Management System to be developed for the DSS county attorneys.

Recommendation #5:

Notify hospitals of 2003 CAPTA Amendment requiring referral of infants born affected by maternal substance abuse to DSS for safe care planning.

Response:

In a letter jointly signed by DSS State Director Kathleen Hayes and SC Hospital Association President J. Thornton Kirby, we have requested that hospitals send to us a copy of their policy and procedures relating to the handling of substance exposed infants. A copy of the letter was provided to the Panel chairs at an administrative meeting earlier this year and is attached for information in the appendix of the Response (See Attachment 4).

As of October 17, 2008, we have received policy and procedures from 15 hospitals out of 48 medical facilities statewide that reported OB utilization and births during 2006. Out of the 48 facilities, 29 are licensed by DHEC as perinatal centers. Thirty-four percent of the 29 perinatal facilities have responded. A second request for information is being sent by the SC Hospital Association (SCHA) in follow up to the original request and we expect to get policies and procedures from most of the hospitals.

At this point in time, we have documentation that 31% of hospitals in South Carolina have in place policies and procedures to guide the reporting of suspected child abuse or neglect and specific procedures for reporting infants born affected by substances. It is our belief that virtually all hospitals do in fact have such procedures and we will continue to work with the SCHA to secure copies of policy and procedures from all hospital facilities and/or assist other facilities to develop such procedures. How well they are implemented and/or the need for additional training will be the basis for additional discussion once we determine their existence. It is clear from the cooperation of the SCHA that they are also committed to ensuring that member hospitals have policies and procedures in place to address the needs of substance affected newborns and will work with DSS to this end.

Recommendation #6:

Assure that the Panels complete projects begun in 2004 and 2005, and report the original findings, so as to keep faith with the subjects of the research and the Panels who were encouraged to undertake the work, as well as to produce baseline data for the agency.

Recommendation #7:

Re-administer or support the Panel's efforts to re-administer the questionnaires used in those projects and analyze the resulting data to obtain an objective assessment of the effects of the changes in the agency since the baselines were established.

Response to Recommendations #6 & #7:

As Recommendations #6 and #7 relate to the support of the Panels, we are responding to them together. We reiterate the statements of State Director Kathleen Hayes and Dr. Johnny Jones, Director of the Center for Child and Family Studies, who support the work of the Panels and intend to provide the facilitation and technical support necessary to accomplish the Panels' work. On October 21, 2008, we had the opportunity to meet for a Retreat of the CRP and DSS. The discussions and strategic planning further emphasize and validate the intentions of all to work together in the coming year.

Further, we all agree to use the monthly meetings to ensure that problems and barriers are discussed immediately and solved whenever they arise.

We are excited about continuing the projects and surveys already started by the Panels and believe that the information that can be gained from these projects will be beneficial to the Department and the child welfare system as a whole.

Recommendation #8:

Continuously measure and monitor morale and publish the results regularly throughout the agency.

Response to Recommendation #8:

As discussed at the Annual Retreat for the CRP and DSS in October 2008, the agency has released a monthly employee newsletter by e-mail that includes special reports of activities of county and state offices or individual projects of interest to employees. This is an effort to encourage all staff and raise morale by ensuring that information is shared on a regular basis. Members of the CRP are being added to the distribution list so that you will have this valuable information as well.

In addition to the newsletter, State Director Kathleen Hayes provides regular updates by e-mail and video posted to the intranet about current affairs which includes the budget situation or special recognition of projects or individuals. Dr. Hayes frequently recognizes the efforts of staff for notable activities and is committed to ensuring that critical information is shared with staff. Local DSS offices are pursuing positive media coverage of special events, to include but not limited to, those involving foster parents or foster children, youth in independent living programs, and DSS staff participating in community actions of merit. All these combine to reinforce that DSS staff have value and worth in the eyes of the agency and in the community.

Your recommendation that we publish findings about morale has been shared with the publishers of the newsletter so that they can include this information in the newsletter. We hope that another survey of staff morale might be one of the initiatives pursued by the Panels over the next year and that it will show an improvement agency-wide.

Closing:

We at the Department of Social Services appreciate all the work done by members of the Citizen Review Panels to study the child welfare system in South Carolina. We value the Panels' ideas and recommendations. We believe that significant improvements in our working relationship have occurred over the past few years and we value that relationship. We believe that together we can accomplish great things in the coming year as we work together to improve the child welfare system of South Carolina.