

**STATE CHILD FATALITY REVIEW  
FINDINGS AND RECOMMENDATIONS  
JOHNSTON AND WAKE COUNTIES  
June 2008**



**Prepared by:  
The Division of Social Services**

**State Child Fatality Review  
Findings and Recommendations  
Johnston and Wake Counties  
June 2008**

A State Child Fatality Review Team composed of Johnston and Wake County Community Child Protection/Child Fatality Prevention Team members and Division staff met on May 9, May 10 and May 25, 2006, to review the death of Sean Michael Paddock. Since this family had been involved with the Johnston and Wake County Departments of Social Services within the twelve months preceding Sean's death, an in-depth review was required pursuant to G.S. 143B-150.20. According to paragraph (b) of the statute, "The purpose of these reviews shall be to implement a team approach to identifying factors which may have contributed to conditions leading to the fatality and to develop recommendations for improving coordination between local and state entities which might have avoided the threat of injury or fatality and to identify appropriate remedies."

Toward this end, a State Child Fatality Review Team consisting of representatives as required by state law was convened. Team members, their agencies and roles were as follows:

| <b>Name</b>         | <b>Agency</b>                                 | <b>Role on Team</b>                          |
|---------------------|---|--|
| Dr. Peter Morris    | Wake County Human Services                    | Medical Professional – Wake County           |
| Kate Howard Franch  | SAFEchild                                     | Prevention Specialist – Wake County          |
| Linda Baker         | District Attorney's Office                    | Law Enforcement Representative – Wake County |
| Joan Dramis         | Wake County Human Services                    | Wake County CCPT Representative              |
| Addie Davenport     | Johnston County Schools                       | CFPT Representative – Johnston County        |
| Dr. Warren Ludwig   | Wake County Human Services                    | DSS Representative – Wake County             |
| Heather Skeens      | Division of Social Services                   | Division Representative                      |
| Denise Boyette      | Johnston County Department of Social Services | DSS Representative – Johnston County         |
| Gale Trevathan      | Division of Social Services                   | Children's Program Representative            |
| Rita Bland          | Division of Social Services                   | Division Representative                      |
| Deborah Moyer       | Johnston County Health Department             | CCPT Representative – Johnston County        |
| Dr. Marilyn Pearson | Johnston County Health Department             | Medical Professional – Johnston County       |

|                   |   |   |
|-------------------|---|---|
| Gaye Stryron      | Wake County Human Services                                      | DSS Representative – Wake County            |
| Sandy Cook        | Children’s Home Society   | CHS Representative                          |
| Naeime Livingston | Guardian ad Litem Program                                       | GAL Representative – Wake County            |
| Robert Tarpey     | Johnston County Department of Social Services                   | DSS Representative – Johnston County        |
| Jane Volland      | Guardian ad Litem Program – Administrative Office of the Courts | GAL State Representative                    |
| Selena Berrier    | North Carolina Child Fatality Task Force                        | Child Fatality Task Force Representative    |
| Tamika Williams   | Division of Social Services                                     | Adoptions Program Consultant Representative |
| Octavia Rainey    | Wake County Human Services Board                                | Wake County Board Representative            |

The Team reviewed pertinent records including police investigative data, medical examiner documentation, and social service records. The Team also interviewed relevant personnel who provided professional, insightful information. The timeline was completed and the nine life domains (safe place to live, family, emotional/psychological, vocational/educational, physical health, legal, safety/crisis, social supports, and cultural/ethnic) were discussed. A summary of the report findings will be given to the full Community Child Protection Team and the Community Child Fatality Prevention Team in the near future.

Sean was born on September 3, 2001, and died on February 26, 2006, at the age of four and a half years. According to the North Carolina Medical Examiner’s report, the cause of death was “asphyxiation.” The Summary and Interpretation section of this report states, “allegedly, the child had been getting up and walking about at night disturbing the family for a week prior to death. In order to resolve this problem the adoptive mother had taken to using a blanket tightly wrapped around the child as a binding. The number and tightness of the blankets was increased over several nights with the child being wrapped in three blankets on the third night to the point that it could not move.”

According to the Johnston County District Attorney’s Office, Lynn Marie Paddock was charged with felony murder and two counts of felony child abuse - serious injury.

### **Findings and Recommendations:**

During the Team's review of the circumstances surrounding Sean's death, several facts, themes and conclusions emerged.

#### **Findings #1:**

- **There is a variety of instructional material available on the internet that provides guidance on discipline techniques. Some of this material promotes physical and emotional abuse of children and is not supported by the North Carolina Division of Social Services, local Departments of Social Services or the Guardian ad Litem Program, or other child advocate and family agencies and programs.**
- **Part of the licensing requirements to become a foster/adoptive parent in North Carolina is participating in discussion about appropriate discipline techniques for foster care children. In addition, all foster/adoptive families must sign a Foster Parent Agreement promising to not utilize corporal punishment on child in foster care. Additionally, potential foster/adoptive parents must complete Model Approach to Partnerships in Parenting (MAPP) prior to being considered for licensure. The Paddocks completed MAPP and signed the Foster Parent Agreement.**
- **According to the North Carolina Medical Examiner's report, "allegedly, the child had been getting up and walking about at night disturbing the family for a week prior to death. In order to resolve this problem the adoptive mother had taken to using a blanket tightly wrapped around the child as a binding. The number and tightness of the blankets was increased over several nights with the child being wrapped in three blankets on the third night to the point that it could not move."**
- **Lynn Marie Paddock was charged with felony murder and two counts of felony child abuse – serious injury.**

#### **Recommendations #1:**

- **Local Departments of Social Services and all contracted private licensing agency should continue to encourage and enforce positive parenting techniques and discourage corporal punishment. There are a variety of agencies in North Carolina that have appropriate parenting material that can be utilized and referred to by local Departments of Social Services.**
- **When local Departments of Social Services are involved with families, a discussion of discipline techniques should be held to assess the appropriateness of the parenting styles to meet the child's individual needs. If concerns are present, appropriate parenting material, education or referrals should be provided to the parents.**

#### **Findings #2:**

- **This Child Protective Services (CPS) assessment involved two local Departments of Social Services. The fact that there were multiple social workers and agencies involved led to confusion and a delay in the completion of all paperwork required for a case decision on the CPS assessment.**
- **Johnston County Department of Social Services' written fatality summary indicates that there was a prior child protective services assessment intake that was accepted for a family assessment in Johnston County on the Paddock children while the Ford children were visiting with the Paddock family, a prospective adoptive family. The case regarding the Paddock children was found not in need of services by Johnston County.**
- **Wake County Department of Human Services' written fatality summary indicates that there was a prior child protective services assessment intake that was accepted for an investigative assessment in Wake County on the Ford Children while the Ford children were visiting with the Paddock family, a prospective adoptive family. The case regarding the Ford children was unsubstantiated in Wake County.**
- **The custodial county did not follow the Division of Social Services, Children's Service Manual, Conflict of Interest and Out of Home Placement Policy which provides guidance to the local Department of Social Services when more than one county may be involved in a child protective services assessment of a juvenile in the custody of the local Department of Social Services.**
- **The custodial county's child protective services involvement with Sean Paddock indicates that there were a number of issues and questions about the possible adoptive placement and therefore a meeting was called to discuss these issues. All parties concerned felt that Paddock family had several strengths to offer the children despite the licensing concerns that were addressed by the local departments of social services.**
- **The Guardian ad Litem (GAL) reported that the movement of the children in the Paddock home seemed to be restricted; this concern was shared with the local Department of Social Services and the licensed foster care placing agency. In the final court report, the GAL recommended that the adoption agency caseworker and the Wake County Human Services caseworker monitor placement of the child and his siblings with the prospective adoptive family.**
- **When there are reports of child abuse, neglect or dependency on a licensed foster home or prospective adoptive home, local Departments of Social Services must balance the allegations against the potential harm of moving the children out of the home, and when applicable, must have unambiguous cross-county and private agency communication protocols to ensure decisions are made based on complete information about the family.**

#### **Recommendations #2:**

- **When a child abuse, neglect or dependency allegation is received and accepted for an assessment on a potential adoptive placement, the local**

**Department of Social Services should consider whether to go forward with the adoptive placement. This decision should include not only whether the allegations are substantiated but also the specific information obtained during the assessment. The local Department of Social Services should convene a new adoption staffing to consider these issues.**

- When there is a child protective services assessment of a pre-adoptive home, an adoption petition should not be filed until all the documentation in the record clearly reflects that a case decision was made. Current laws and policy permit adoptions petitions being placed on hold when further assessments are needed to ensure that the finalization of the adoption is in the best interest of the child.**
- The North Carolina Division of Social Services and local Departments of Social Services should reinforce current policy to ensure that roles and definitions are clearly spelled out when the local departments of social services are utilizing state contracted private adoption agencies to assist with the completion of adoptions. When there are child protective services allegations/concerns involving children placed by these contracted private adoptive agencies, local Departments of Social Services and contracted private adoption agencies should work closely together to ensure that all relevant information is shared between the two parties and child safety issues are fully addressed. Strong collaboration between the two parties will ensure that all required contacts with the alleged victim child(ren) will be made by the appropriate social worker(s) that are in the best position to address all child safety issues. Documentation in the case record should clearly reflect this. The North Carolina Division of Social Services should reinforce current policy in this area.**
- The North Carolina Division of Social Services should explore the use of research-based tools in other states that assess adoptive placements for their appropriateness in meeting the needs of the child and evaluate if any such resource tools can or should be utilized in North Carolina.**
- The North Carolina Children Association of County Directors, Children Services Committee, in collaboration with the North Carolina Division of Social Services, should examine pre-adoptive assessments to strengthen these assessments and to make recommendations for revisions statewide. These assessments should specifically address a consideration of the number of children and their special needs.**
- The North Carolina Division of Social Services, in conjunction with NCFAST, should track the number of child protective service reports received and substantiated on adoptive placements to determine if pre-adoptive assessments are accurately assessing strengths and needs of the families.**
- The State Fatality Review Team recommends that the Guardian ad Litem program remain involved with children until the final decree of adoption is entered and that the General Assembly provide the necessary funding to support this.**

- **Local Departments of Social Services should monitor concerns that arise when one unit in Child Welfare conducts a child protective services assessment on a case being managed within another unit. Communication between the two units should be ongoing and systematic, and should include a formal meeting at the end of the child protective services assessment to review findings and implications. The unit completing the assessment should convene the meeting. If a private licensing contracted agency's foster/adoptive home is being utilized, the agency should be invited to participate in the meeting and assume responsibility for the written documentation of review findings and implications. The GAL, as an advocate for the child(ren), should participate in this meeting, and the GAL should be provided with a copy of the written documentation. The State Fatality Review Team supports the ongoing efforts of Wake County Human Services to implement these staffings.**
- **When local Departments of Social Services are working with a private foster/adoptive agency there should be ongoing communication, collaboration and documentation of strengths and needs in both the county's case file and the private agency's case file. This Fatality Review Team supports the efforts by Wake County Human Services to demonstrate best practice in this area.**
- **Wake County Human Services released a report to the media on July 7, 2006 indicating that the agency would increase county social workers' presence during an adoption process even when working with a private adoption agency and to strengthen the screening of adoptive parents. The State Fatality Review Team supports the continuation of these efforts by Wake County Human Services.**

**Findings #3:**

- **The North Carolina Division of Social Services has four statewide contracts with private adoption agencies to facilitate permanency for children available for adoption. These contracts provide guidelines for local Departments of Social Services to collaboratively identify prospective adoptive homes licensed through the private agencies and to place children in appropriate private adoption homes.**
- **The legal custodian county contracted with a private foster care placement agency.**
- **At the time of the fatality, the privately contracted agencies did not have access to any child protective service reports or case decisions unless notified by the local Department of Social Services.**

**Recommendations #3:**

- **There are basic services that are required of licensed foster homes for children in the foster care system. The contracted agency and the local Department of Social Services have an obligation to ensure that these services are offered and available to families when accepting children in foster care into their homes.**

- When issues are raised that do not reach the level of suspected child abuse, neglect or dependency in private licensed foster/adoptive homes, these concerns should be clearly and quickly expressed to the licensing agency. The licensing agency should provide the local Department of Social Services with written documentation that the issues were discussed and what, if any, recommendations or services were implemented to address the issues.
- When significant problems are identified with a foster home that do not rise to the level of child abuse or neglect, the decision of whether to move children out of the home is complicated by the fact that stability in placement is important to children's well being. Often, it will be in a child's best interests to bring the issues to the attention of the foster/adoptive home's licensing agency and to allow the child to remain in the home, so long as the child's safety and well-being is the primary concern. When this happens, systematic follow up should occur with the licensing agency to assure that issues are resolved.

**Findings #4:**

- Clear communication about families who are served by multiple counties is challenging.
- The Division of Social Services has three policies that are being brought into question here: Conflict of interest; Out of Home Placement; and Cross County Issues Policy. These policies can be perceived as inconsistent in guidance regarding conducting child protective service assessments when allegations and county of residence are in question.
- Despite some confusion regarding each county's role in the assessment process, Wake County Human Services and Johnston County Department of Social Services worked together with open communication and collaboration and agreed on the case decision as it related to their respective cases involving this family.
- Wake County Human Services released a report to the media on July 7, 2006, stating that the agency would establish ways to communicate better with social workers in other counties during abuse investigations.

**Recommendation #4:**

- The Division of Social Services has formed a county/state workgroup to address policy in the area of cross county issues. This workgroup is currently considering combining the three policies into one with the goal of offering the local departments of social services clearer guidance in this area. This State Fatality Review Team supports and encourages these efforts.
- The State Fatality Review Team supports the efforts of Wake County Human Services to increase communication between counties during a child protective services assessment.

**Findings #5:**

- According to the Department of Non-Public Instruction's web site, Lynn Paddock had a registered home school, Benjamin Street School.



- **The Department of Non-Public Instruction is unable to make site visits to monitor and support home schools' compliance with state policy due to limited funding and oversight resources.**
- **Home schooling may contribute to social isolation if children are not involved in outside activities and adoptive parents are not utilizing post adoptive services.**
- **The Division of Social Services began to gather statistics related to specific school situations in child protective services in May 2006.**

**Recommendations #5:**

- **The Department of Non-Public Instruction should conduct a study regarding a Needs Assessment and pursue funding to support increased monitoring and oversight to home schools.**
- **The State Fatality Review Team supports the continued efforts of the Division of Social Services in regard to the gathering of statistics related to specific school situations in child protective services.**
- **The State Fatality Review Team recommends that the Office of the Chief Medical Examiner begin to track school status at the time of death and make available this information on a yearly basis to the North Carolina Child Fatality Task Force and the state-level North Carolina Child Fatality Prevention Team.**

**Findings #6:**

- **Post-adoptive services are offered and available to all families that have adopted children; however, they are voluntary services.**
- **The Paddock family did not utilize voluntary post-adoptive services.**
- **Post-adoptive services are not fully funded to offer all the services that adoptive families might need.**

**Recommendations #6:**

- **The State of North Carolina should provide adequate resources to fund much needed post-adoptive services to families to maintain permanency for children.**
- **The Division of Social Services and local Departments of Social Services should continue to provide education to families regarding post-adoptive services and the importance of participating in services to continue to support and nurture the safety and well-being of family members.**

**Findings #7:**

- **Safety of children is an important guiding principle of the Division of Social Services and the local Departments of Social Services.**
- **In 2001, as a part of system reform in North Carolina, the Division of Social Services began piloting a Multiple Response System (MRS). All one hundred North Carolina counties will implement MRS in 2006. MRS includes seven strategies. One seven strategy involves a tailored response to conducting child protective services assessments. Social worker contact with families, to**

**include the frequency and nature of contact (e.g. announced or unannounced homes visits) are based on the level of risk, nature of concerns/allegations and the overall social work assessment.**

- **Policy does not preclude the local Departments of Social Services from making unannounced visits to homes or to speak with children first and separately if there is a concern for the child's safety.**

**Recommendation #7:**

- **If local Departments of Social Services have concerns about child safety based on the allegations in the child protective services report or during the provision of child welfare services then it is appropriate to speak with the child in seclusion and to make an unannounced home visit to ascertain the risk to the child.**

While the Review Team developed its recommendations to better protect children in the future, it cannot be known what impact, if any, these recommendations could have had on the reviewed case if they had been in place at the time of the fatality.

In conclusion, the Johnston and Wake Community Child Protection/Child Fatality Prevention Teams would like to thank the agencies that provided information and personnel to conduct this review. It is our hope that changes in policies and practice resulting from this report will improve future service provision.