Overview of North Carolina's Child Fatality Prevention System

North Carolina's Child Fatality Prevention System (CFP System) was originally established in 1991 by state law. Legislation that passed in 2023 restructured the system and provided additional funding, although most changes required by the 2023 legislation did not go into effect until July 1, 2025.

Statutes that govern the system are contained in Article 14 of the North Carolina Juvenile Code (N.C.G.S. 7B-1400 through 7B-1414), as well as N.C.G.S. 143B-150.25, 143B-150.26, and 143B-150.27.

The purpose of the system includes studying data surrounding child deaths, utilizing multidisciplinary teams to review child deaths to better understand them, identifying system problems and evidence-driven prevention strategies, and making and implementing recommendations to prevent child deaths, prevent child maltreatment, and support child well-being. Recommendations may involve state or local action including system changes, changes in law or policy, or the implementation of various types of prevention initiatives.

Since its creation in 1991, this system has facilitated the implementation of local and state prevention initiatives, improved systems serving children, and has advanced changes to state law and funding that have saved children's lives and supported their well-being.

The Child Fatality Prevention System has four primary components:

1. **Local Teams** are multidisciplinary child death review teams in all 100 counties that are required to review child deaths that fall under nine categories of death and may review deaths beyond those categories. The nine categories include: undetermined, unintentional injury, violence, motor vehicle, maltreatment or child protective services involvement, sudden unexpected infant death, suicide, deaths not expected in the next six months, and additional infant deaths according to certain criteria established by the State Office. Child maltreatment deaths and deaths where there have been child protective services involvement with the family receive "escalated" reviews by Local Teams with special assistance & information from the State Office of Child Fatality Prevention (State Office) as well as state & local social services agencies.

   Teams track information learned in reviews through a data system that allows for local and state-level analysis to better understand child deaths. Teams share recommendations and reports containing aggregate information with local leaders and the State Office, and they implement prevention initiatives in their communities. In addition to receiving support from the State Office, teams also receive support and record-keeping assistance from local health departments and social services agencies. Local Teams have been in existence since 1991, with the structure and responsibilities of Local Teams changing since then.

2. The **State Office of Child Fatality Prevention (State Office)**, located in the NC Division of Public Health, coordinates and supports the statewide Child Fatality Prevention System. Staff in this office provide training, guidance, and technical assistance to Local Teams including extra assistance with cases involving child maltreatment. They also manage, analyze, and report aggregate information learned from Local Team reviews and other data sources. They report a variety of information, including aggregate findings and recommendations of Local Teams, to the Child Fatality Task Force, and they engage in various other efforts related to child fatality prevention. The State Office was created by 2023 legislation.

3. The **North Carolina Child Fatality Task Force (Task Force)** is a legislative study commission that has 36 members that include state agency leaders, ten state legislators, community leaders, and experts in child health & safety. An Executive Director for the Task Force is located in the NC Department of Health and Human Services. The Task Force studies data surrounding child deaths and strategies related to preventing child deaths and maltreatment and does not review individual deaths.

   The Task Force receives reports from the State Office of Child Fatality Prevention containing aggregate information from Local Team reviews and on other matters related to child deaths, and it advises the State Office on the operation of an effective statewide child fatality prevention system. The Task Force submits reports to state legislators, the governor, and other state leaders that address child death data, the functioning of the child fatality prevention system, as well as policy and other recommendations to prevent child deaths and support child well-being. The Task Force was created by state statute in 1991. Its accomplishments through the years are summarized here.

4. **Medical Examiner Child Fatality Staff** work in the Office of the North Carolina Chief Medical Examiner and investigate child deaths under medical examiner jurisdiction. They coordinate with the rest of the child fatality prevention system, contribute medical examiner reports to inform child death reviews, and they train law enforcement on child death investigations.

Reviews that are related to, but not part of, the Child Fatality Prevention System

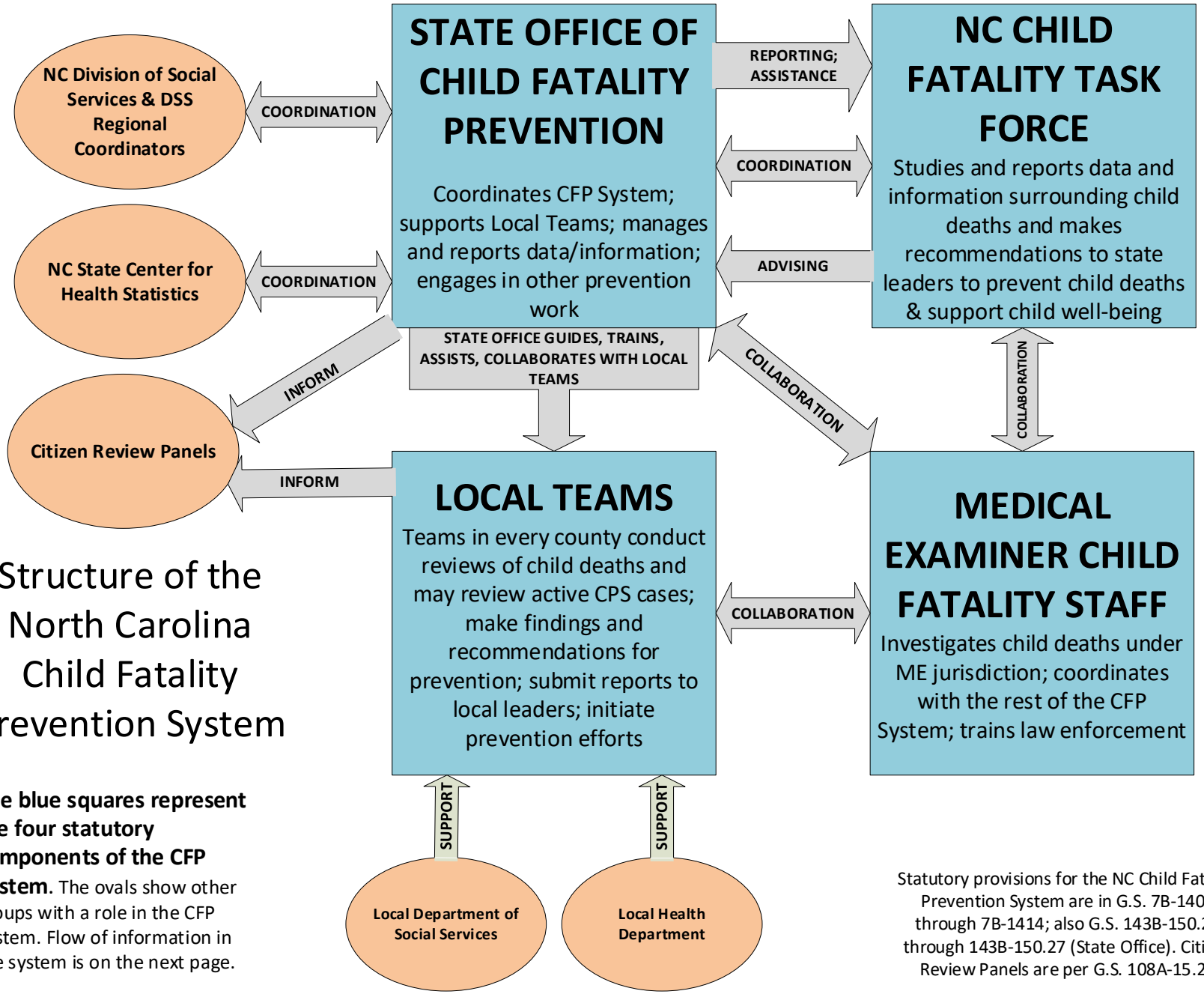
Laws addressing reviews by Local Teams of child maltreatment deaths or deaths of children with child protective services involvement include provisions that reference a connection with "internal fatality reviews conducted by the NC Division of Social Services" and "Citizen Review Panels."

Internal reviews of a child's death by NC DSS take place when a child fatality occurs during an open child welfare case. These internal reviews, called **Child Fatality Practice Reviews,** take place very soon after a child's death with a purpose of assessing compliance with North Carolina policy, statute and rules and to identify any practice issues or trends occurring in the local child welfare agency that need to be addressed in order to ensure safety of children in that county. A summary of findings and

recommendations from the Child Fatality Practice Review is shared with the State Office of Child Fatality Prevention and the local child welfare agency. The report is used as a component of the Local Team review of the maltreatment fatality along with information from other community stakeholders to inform recommendations for service provision and system change.

Citizen Review Panels (CRPs) are required by federal law and per 2023 legislation, CRPs are also required by state law. Federal law requires states to have at least 3 CRPs. The purpose of a CRP is to evaluate the extent to which the State is fulfilling its child protection responsibilities in accordance with the Child Abuse Prevention and Treatment Act State Plan by examining policies, procedures, and practices of state and local child protection agencies and, when appropriate, reviewing specific cases, which can include child fatalities. NC's law says that a CRP choosing to examine child fatalities may utilize information about reviews of child fatalities that take place as part of the Child Fatality Prevention System and may obtain aggregate information about child death reviews or information about individual case reviews, as requested by the panel from the State Office or Local Teams.

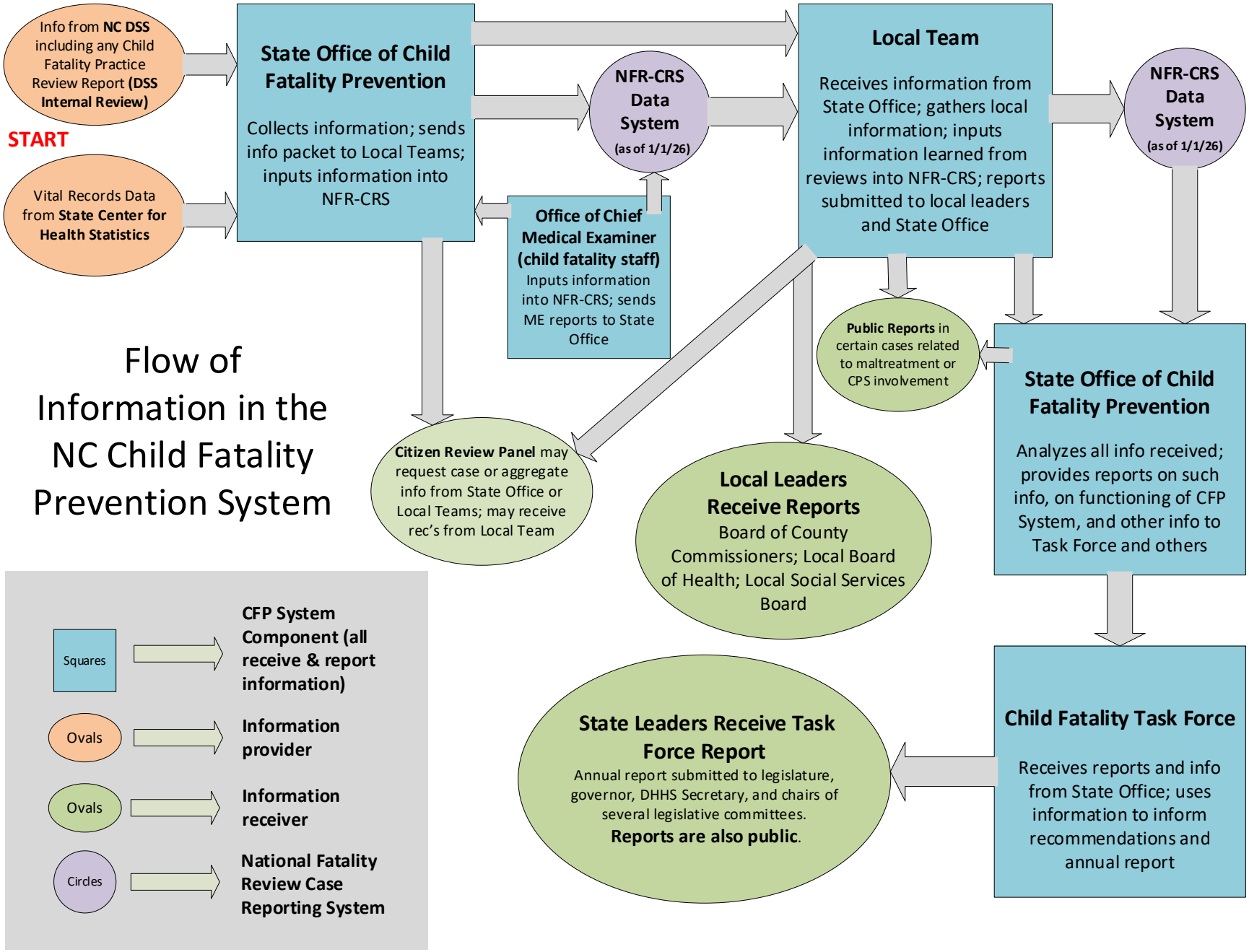
The following pages contain graphic illustrations of the structure of the Child Fatality Prevention System (first graphic) as well as the flow of information within the system (second graphic).



Structure of the North Carolina Child Fatality Prevention System

The blue squares represent the four statutory components of the CFP System. The ovals show other groups with a role in the CFP System. Flow of information in the system is on the next page.

Statutory provisions for the NC Child Fatality Prevention System are in G.S. 7B-1400 through 7B-1414; also G.S. 143B-150.25 through 143B-150.27 (State Office). Citizen Review Panels are per G.S. 108A-15.20


Info from **NC DSS** including any Child Fatality Practice Review Report **(DSS Internal Review)**
START
Vital Records Data from **State Center for Health Statistics**
State Office of Child Fatality Prevention
Collects information; sends info packet to Local Teams; inputs information into NFR-CRS
NFR-CRS Data System (as of 1/1/26)
Office of Chief Medical Examiner (child fatality staff)
Inputs information into NFR-CRS; sends ME reports to State Office
Local Team
Receives information from State Office; gathers local information; inputs information learned from reviews into NFR-CRS; reports submitted to local leaders and State Office
NFR-CRS Data System (as of 1/1/26)
Flow of Information in the NC Child Fatality Prevention System
Public Reports in certain cases related to maltreatment or CPS involvement
State Office of Child Fatality Prevention
Analyzes all info received; provides reports on such info, on functioning of CFP System, and other info to Task Force and others
Citizen Review Panel may request case or aggregate info from State Office or Local Teams; may receive rec's from Local Team
Local Leaders Receive Reports
Board of County Commissioners; Local Board of Health; Local Social Services Board
Child Fatality Task Force
Receives reports and info from State Office; uses information to inform recommendations and annual report
State Leaders Receive Task Force Report
Annual report submitted to legislature, governor, DHHS Secretary, and chairs of several legislative committees.
Reports are also public.
Squares
CFP System Component (all receive & report information)
Ovals
Information provider
Ovals
Information receiver
Circles
National Fatality Review Case Reporting System