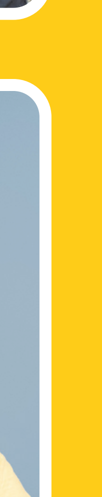
NORTH CAROLINA

Child Fatality Task Force

Annual Report | May 2026 | Raleigh, NC



Our **Children**
Our **Future**
Our **Responsibility**

May 2026

Dear Governor Stein, Distinguished Members of the North Carolina General Assembly, and Secretary Sangvai,

We are pleased to submit to you the 2026 North Carolina Child Fatality Task Force Annual Report containing recommendations to prevent child deaths and support child safety and well-being. The report also includes information on Task Force work, the functioning of the broader statewide Child Fatality Prevention System, and data on child deaths.

This year marks 35 years since the North Carolina Child Fatality Task Force was created by state statute in 1991. Since then, state leaders have been very responsive and many of the recommendations made by the Task Force have led to changed laws and state funding for strategies that protect our most vulnerable North Carolina citizens – our children. In fact, our historical tracker of advancements is nearly two dozen pages long. Since 2023, however, progress on Task Force recommendations has slowed.

In three years since 2023, we can estimate that North Carolina lost well over 4,000 children ages zero to 17. We know that so many of these deaths are preventable. Examples include an estimated 370 infants dying by unsafe sleep circumstances, 300 children killed by firearms and another 300 children killed in motor vehicle accidents. In the meantime, our youth are experiencing serious mental health challenges, many of which are prompted or exacerbated by the harmful impacts of nicotine vaping, widely available intoxicating cannabis products, and addictive social media algorithms – none of which are being adequately regulated to protect children. We can see great progress on all these issues and more by implementing the actions recommended in this report.

After the Child Fatality Task Force completed its most recent cycle of meetings, we received 2024 child death data from the North Carolina Department of Health and Human Services, and we have included the 2024 data in this report. We were thrilled to learn that North Carolina's 2024 infant mortality rate reached an all-time low for our state. However, our rate is still higher than the national rate and our disparity ratios remain virtually unchanged, with Black infants dying at rates almost three times higher than white infants. Meanwhile, 2024 rates of deaths for children aged one to 17 are essentially unchanged. We celebrate the decrease in infant mortality rates while acknowledging there is still much work to be done.

We are proud of our focus on data and evidence to inform our work, which you will see in this report for each of our recommendations. Many of this year's recommendations are being repeated because they did not advance in prior years and the evidence continues to show that these are important strategies to save children's lives and support their well-being.

For 35 years, the Child Fatality Task Force has been delivering on our statutory mandate to study data and report to state leaders on actions they can take to prevent future deaths and promote child well-being. We never forget that every child death results in unimaginable heartbreak for a family, a community, and is a loss to our state as children ARE our future. At every Task Force meeting, we take a moment of silence to honor those children who have died since our last meeting before we begin the very serious work of determining how to prevent future deaths. We owe it to North Carolina's children, their families, and the future of our state to do everything we can to give children the best chance for a healthy childhood and a chance to celebrate their 18th birthday.

Thank you for taking into consideration the recommendations of the North Carolina Child Fatality Task Force.

Jill Cox	*Karen McLeod*	*Kella Hatcher*
CO-CHAIR	CO-CHAIR	EXECUTIVE DIRECTOR

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Executive Summary & Introduction

The last annual report for the Child Fatality Task Force was submitted in February of 2025, and since then Task Force members, leaders, staff, and experts who serve on committees or present to the Task Force have contributed immeasurable time, effort, and knowledge to the mission of preventing child deaths and promoting child well-being. This report shows the broad range of topics covered, the depth of expertise and data that is tapped for this work, and the way the Task Force uses evidence to guide its recommendations.

In addition to studying data, evidence, and developing recommendations, the Task Force also shares its work broadly and is proud to be a source of information for others who work on issues surrounding child well-being. New laws that became effective in July of 2025 began an exciting new era in child fatality prevention, and this annual report explains the progress being made by many to implement changes to the statewide Child Fatality Prevention System that are intended to save lives and better protect our children.

For the sake of brevity, this year's report does not address prior Task Force accomplishments as it has in years past. A historical list of accomplishments can be found here on the Task Force website and a shorter overview of accomplishments is available here on the website.

The latest child death data for 2024 from the North Carolina State Center for Health Statistics was not available in time for the Task Force to study the 2024 data set. However, that data is now available and a summary report of the data as well as highlighted trends from the data are included in this annual report. 2024 data points are also noted throughout the report. The most noteworthy trend change seen in the 2024 data is a decrease in the infant mortality rate, which represents a historical low for our state. However, the overall 2024 death rate for children ages 1 to 17 remained virtually unchanged compared to 2023.

Task Force Meetings that Led to the 2026 Action Agenda

<table>
<tr><td>Meetings took place between 9/4/25 and 2/25/26</td><td rowspan="5">The Task Force approved 10 recommendations for inclusion on its 2026 Action Agenda aimed at changing laws and prioritizing state funding to prevent child deaths, prevent child abuse and neglect, and promote child well-being.

The Task Force also included 4 administrative (non-legislative) efforts on its 2026 Action Agenda that involve further study on issues of interest to the Task Force.</td></tr>
<tr><td>9 meetings of the subcommittees: 3 meetings each of the Perinatal Health Committee, the Unintentional Death Prevention Committee, and the Intentional Death Prevention Committee</td></tr>
<tr><td>3 meetings of the full Task Force</td></tr>
<tr><td>Presentations by 44 experts and leaders</td></tr>
<tr><td>Approximately 40 topics addressed</td></tr>
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The Child Fatality Task Force is making recommendations for 2026 that call for these actions to prevent child death and promote child well-being

(Specific recommendations along with more detailed explanations are detailed later in this report)

State laws to address the following:

- Age restrictions, packaging requirements, and retail licensure requirements to protect children from **harmful intoxicating hemp/cannabis products:** After federal laws changed to legalize hemp there was a surge in the manufacture and sale of intoxicating cannabis products. NC retailers, especially vape shops, sell these products in various forms like candy, baked goods, snack foods, beverages, and vape pens and

they often have packaging that appeals to children or mimics popular snacks. There is no minimum age for the purchase of these products in North Carolina and no safety regulations are in place for packaging. Following this surge in the availability of these products, there has been a dramatic increase in emergency department visits in NC related to THC ingestion by children and youth. Children and youth can suffer severe immediate or long-term harm from intoxicating cannabis.

- Raising the age for sale of tobacco products to 21 to align with federal law and require licensing of tobacco product retailers to protect children from **harmful impacts of tobacco/nicotine/vaping:** Nicotine products, especially vapes, are commonly used by many high school and even middle school youth. Nicotine can disrupt brain development for youth and is highly addictive; vapes can also contain harmful chemicals that can cause serious health problems. NC is one of only six states that does not align with the federal minimum age of 21 for purchasing tobacco products, and one of only eight states that does not require tobacco retailers to obtain a license or permit. Without licensing, enforcement of any age requirement is challenging since there's no way to know who these retailers are. The licensing of tobacco retailers had been identified as an evidence-based measure to reduce tobacco sales to youth.
- Closing a **gap in NC's child access prevention law** to prevent firearm deaths and injuries to children: Firearm injuries are a leading cause of death among NC children and youth. North Carolina's law addressing safe storage of firearms to protect minors applies only to a gun owner or one who possesses a gun who *'resides in the same premises as a minor.'* The recommended change from the Task Force would no longer limit application of the law to those who reside with a minor. A person who owns or possesses a gun who does not reside in the same premises as a minor may nevertheless be in situations where, for example, a child or teen is visiting their home or riding in their car, and if their gun is not safely stored, the risks of what can happen when a child or teen accesses that gun are no different than they are for someone who resides with a child.
- Protecting children from harmful, **addictive social media algorithms b**y restricting data collection from minors: Many medical organizations have formally raised concerns about the role social media is playing in the worsening status of youth mental health. A 2023 study showed that teens spend an average of 4.8 hours a day on social media. Kids who spend more than three hours a day on social media face double the risk of poor mental health. Kids with high or increasingly addictive use patterns with social media and mobile phones have a two to three times greater risk of suicidal behaviors and ideation. The Task Force is endorsing a policy approach that restricts a company's use of a minor's data, thereby making social media less targeted, a measure intended to make it less addictive and less likely to show the minor harmful content.
- **Strengthening the child passenger safety law** to address best practices to prevent motor vehicle deaths and injuries to children: Motor vehicle injuries are a leading cause of death among children. North Carolina's child passenger safety law differs from the best practice recommendations of the American Academy of Pediatrics and the National Highway Traffic Safety Administration. In consultation with experts, the Child Fatality Task Force identified three areas of North Carolina's child passenger safety law that could be strengthened to better address best practice recommendations for safety to save children's lives.

State funding for the following:

- $250K in annual funding for a **statewide initiative to prevent infant deaths in unsafe sleep environments**: Each year an average of 123 infants in North Carolina lose their lives in unsafe sleep environments. This is a leading cause of infant death in North Carolina and is largely preventable. Prevention requires a multifaceted approach with a broad reach to connect not only with parents and caregivers, but with those who can educate them and reinforce consistent, accurate messaging about safe sleep repeatedly. Current funding of only $97,000 has not been sufficient for a robust statewide initiative. More than 120,000 babies are born each year in North Carolina and sustained, adequate funding of $250K annually is essential for an effective statewide initiative to ensure that these babies are not lost to unsafe sleep.
- Funding to **increase the number of school nurses, social workers, counselors and psychologists** toward meeting recommended ratios to effectively support youth mental and physical health: Suicide is among the leading causes of death for youth ages 10 to 17. School nurses, social workers, counselors, and psychologists play a critical role in identifying a child who is struggling or at risk, whether the struggle is with mental health issues, suicide ideation, bullying, food or housing insecurity, abuse or neglect, or even

at risk of harming others. These professionals are in the best position to directly address a child's needs or connect a child and their family to mental health and/or community resources to address individual or family needs. Yet North Carolina remains far below nationally recommended ratios for these professionals. The poor status of youth mental health and poor ratios for these school professionals led to an assigned grade of "F" in mental health and "F" in school health on the 2025 North Carolina Child Health Report Card, a joint project of the NC Institute of Medicine and NC Child.

- $2.26 million in annual funding for a **statewide firearm safe storage initiative** that distributes gun locks and educates gun owners about the importance storing guns safely: In the five year-period from 2020 through 2024, over 525 North Carolina children ages 17 and younger died from firearm injuries. Each year in North Carolina, there are around five times as many emergency department visits for firearm injuries as there are deaths of children from firearms. Evidence is clear that safe storage of firearms saves lives, yet many guns are not stored safely. In fact, about 30% of North Carolina high school and middle school students report that it would take them less than an hour to get and be ready to fire a loaded gun without a parent or other adult's permission. The NC S.A.F.E. (Secure All Firearms Effectively) statewide initiative to educate about the importance of safe storage has been operating through temporary funds since May of 2023. Evaluations of the initiative show that it's working; the need for education is ongoing and sustained funding is needed for this initiative to continue.
- Expanded **investments in the early child care system** to support child well-being and prevent child abuse and neglect: Ensuring that families have access to affordable, quality early care is a recognized strategy in preventing child abuse, neglect, and even death, and supports overall child well-being. But in North Carolina, too many parents and caregivers lack access to affordable, quality child care. Meanwhile, the child care business model is in crisis and cannot be sustained without significant state investments. From January through October of 2025, 280 licensed child care providers closed. Child care subsidies help eligible families afford child care, but only a fraction of eligible North Carolina families receive child care subsidies because there is not enough subsidy funding to meet the need and because North Carolina's subsidy reimbursement rates for child care providers do not cover their costs, exacerbating the challenges that providers face.
- $905K in annual funding for a statewide program to ensure **quality improvement initiatives in hospitals** to improve maternal and infant health outcomes: An important prevention strategy identified long ago by the Child Fatality Task Force was to support state funding for the work of the Perinatal Quality Collaborative of North Carolina (PQCNC). Perinatal Quality Collaboratives consist of networks of teams who work in hospitals to employ best practices to improve outcomes in maternal and infant health. PQCNC had been operating since 2009 until it lost funding in October of 2025. Operating in 40 to 60 NC hospitals in any given year, not only has PQCNC been able to improve maternal and infant health and save lives, but many of its initiatives have also resulted in significant cost savings. Without funding to support its work, North Carolina would be the only state in the nation without a Perinatal Quality Collaborative. *[Note: after this recommendation was made but prior to the publication of this report, it was learned that funds are now available for PQCNC via NCDHHS; the program is nevertheless highlighted here to explain its importance.]*

Administrative (non-legislative) efforts are also on the 2026 Action Agenda for further study of the following topics:

- Maternity care deserts and strategies to improve maternal and infant care with continued study of licensure for certified professional midwives, expanded use of doulas, further workforce expansion and support, and the impact of funding shifts and changes on this population.
- Information on Paid Family and Medical Leave Insurance including the employer and business perspective.
- The impact of AI (Artificial Intelligence) chatbots and companions on youth, including the study of design features.
- The Graduated Driver License (GDL) and the science behind the GDL.

NC CHILD FATALITY TASK FORCE
Mandate and Study Process

Task Force Background and Purpose

The North Carolina Child Fatality Task Force (CFTF or 'Task Force') derives its authority from Article 14 of the North Carolina Juvenile Code. The Task Force is one of four components of the broader statewide Child Fatality Prevention System created in 1991, which has an overarching purpose of preventing child deaths and child maltreatment. This system also has multidisciplinary teams across the state that review individual cases of child deaths to better understand these deaths and identify and address gaps or deficiencies in systems that can prevent child deaths and maltreatment. The Task Force is focused on data and policy and does not conduct individual case reviews. An overview of the Child Fatality Prevention System is included later in this report.

The Task Force studies and reports on child death data and learns about prevention strategies. It hears presentations from a variety of experts and leaders about data as well as evidence-driven prevention strategies and receives information from teams who review child deaths. In recent meetings, the Task Force also heard from individuals about their personal experiences related to certain topics of study, like a 19-year-old who shared her experiences as a young teen becoming addicted to nicotine vapes and intoxicating cannabis; a nurse who lost an infant nephew due to unsafe sleep practices; and a police chief who is too familiar with children being killed or injured by guns that are not safely stored.

The Task Force is required to submit an annual report to the governor, the General Assembly, and multiple state leaders addressing its activities, the functioning of the Child Fatality Prevention System, and recommendations to address changes in law, policy, rules or the implementation of evidence-driven prevention strategies that the Task Force has determined will promote the safety and well-being of children.

Task Force recommendations and efforts have helped to advance many laws and initiatives to protect children since its 1991 creation. An updated list of Task Force accomplishments through the years is available on the Child Fatality Task Force website.

Task Force Study Process, Issues of Focus, and Expert Presenters

Three committees, sometimes called 'subcommittees,' focus on specific areas of study to inform the work of the Task Force. These committees hear presentations, engage in discussion, and prepare recommendations for consideration by the full Task Force. Recommendations only become final once approved by the Task Force.

Committee participants include Task Force members who are each assigned to one of the three committees, as well as volunteers with subject matter expertise in the committee's area of focus. Committee meetings for the 2025-26 cycle of meetings were virtual, and meetings of the full Task Force were in-person but with a virtual participation option for members unable to attend in person. Membership rosters of each committee for 2025-26 are included at the end of this report.

The **Intentional Death Prevention Committee** studies homicide, suicide, and child abuse and neglect.

The **Perinatal Health Committee** studies issues surrounding infant mortality by addressing healthy pregnancies, birth outcomes, and infants.

The **Unintentional Death Prevention Committee** studies accidental injury and death – such as those related to motor vehicle accidents, fire, poisoning, drowning, firearms, and more.

The Task Force and its committees meet between legislative sessions to determine an 'Action Agenda' of recommendations for the coming year and refers to this set of meetings as a 'study cycle.' During its most recent study cycle from September 4, 2025, to February 25, 2026, the Task Force had 12 meetings, including nine committee meetings (three for each committee) and three meetings of the full Task Force.

Over the course of these 12 meetings, the Task Force addressed approximately 40 topics. More than 44 experts and leaders made presentations in meetings of the Task Force and its committees to educate about topics relevant to Task Force work. Agendas, minutes, and presentations for all Task Force meetings and committee meetings can be found on the Task Force website, hosted by the North Carolina General Assembly: https://sites.ncleg.gov/nccftf/.

Topics Addressed in Meetings During the Study Cycle that Took Place from September 2025 Through February 2026

General Topics

- Updates from the 2025 legislative session
- Impacts of child fatality prevention system legislation on the CFTF
- Approval of new CFTF policies and procedures per new CFTF statutes
- What's at stake with 2025 recommendations that did not advance
- State and federal funding and policy impacts: updates from NCDHHS

Reports on functioning of the newly restructured Child Fatality Prevention System

- Reports from the director of the new State Office of Child Fatality Prevention System on State Office implementation of new statutes
- Report from the NC Chief Medical Examiner on the role of the Office of the Chief Medical Examiner in the Child Fatality Prevention System
- Reports on the implementation of a new statute governing reviews of child maltreatment deaths
- Report on the implementation of new requirements for Citizen Review Panels

Preventing infant deaths and promoting healthy birth outcomes

- Licensure of Certified Professional Midwives, including hearing perspectives on this topic from five medical organizations
- Maternity care deserts
- Maternal Care Desert Workforce Solutions Action Team
- Use of doulas via the value-based option in a health plan
- Federal HR1 (House Reconciliation Bill) anticipated impacts on infant and maternity care in hospitals
- Infant deaths related to unsafe sleep and funding status of prevention efforts
- Perspective on unsafe sleep from a nurse who lost an infant relative due to unsafe sleep
- NC Birth Defects Monitoring Program and birth defects data
- Perinatal Quality Collaborative of NC and its funding status

Suicide prevention, youth mental health, juvenile justice, and data surrounding intentional deaths

- The role of school nurses, social workers, counselors & psychologists in supporting student mental and physical health, and ratios of these professionals in North Carolina
- Impacts and policy efforts related to addictive social media algorithms that harm youth
- Understanding AI chatbots and companions and how they impact youth; policies addressing AI chatbots and companions
- Juvenile Justice update from the Department of Public Safety
- Data update on intentional deaths and injuries among children and youth

Supporting child and family well-being while preventing infant and child deaths and child maltreatment

- North Carolina's child care crisis including the work of the NC Task Force on Child Care and Early Education and perspective from Western North Carolina
- Update on efforts to seek partnerships to assist information gathering for Paid Family and Medical Leave Insurance 2025 administrative item

Preventing firearm deaths and injuries

- Data update on firearm deaths and injuries among children and youth
- Updates on the NC S.A.F.E. statewide firearm safe storage initiative
- Perspective from a police chief on firearm safe storage
- North Carolina's firearm child access prevention law and its limits to those who 'reside with a minor'

Harmful substances

- Updates on efforts to raise the age of tobacco product sales to 21 and requiring licensing for tobacco product retailers
- Perspective on vaping from a School Resource Officer
- Updates on efforts to prevent child and youth access to intoxicating cannabis products
- Perspective from a neuropsychologist on the impact of nicotine and cannabis on the adolescent brain
- Perspective from a teen on the addictive and harmful nature of nicotine and THC vaping, and easy access to these products
- Data update on fentanyl poisoning among children and youth; prevention strategies
- Prevention strategies for youth substance use and highlights of prevention implementation in North Carolina

Motor vehicle safety & other unintentional deaths

- Data update on unintentional deaths and injuries among children and youth
- Teen driving and the Graduated Driver License Program: the science and recent legislative activities
- Child passenger safety laws and best practices, including updates on legislation
- Pedestrians, bicycles, and micromobility devices

NOTE about 2024 child death data: The Task Force typically examines in its meetings the most recent child death and infant mortality data released by the NC State Center for Health Statistics within the NC Department of Health and Human Services. For the meetings that took place in the recent study cycle that ended on February 25, 2026, the most recent data (from 2024) was in most cases not yet available for examination by the Task Force. However, 2024 data is now available and has been included in this report.

Experts and leaders presenting in Task Force and committee meetings during this study cycle represented state and local agencies and academic institutions as well as state and community programs with a range of expertise:

- Director, **NC State Office of Child Fatality Prevention**, NCDHHS Division of Public Health
- Deputy Secretary for **Juvenile Justice and Delinquency Prevention, NC Department of Public Safety**
- President & CEO, **Communities in Schools**
- Chief Medical Examiner, Chief Toxicologist & Forensic Laboratory Director, and Epidemiologist – all from **Office of the Chief Medical Examiner**, NCDHHS Division of Public Health
- Chief of Police, **Albemarle Police Department**, Albemarle, NC
- Deputy Secretary for External Affairs, **NC Department of Health and Human Services**
- Executive Director, Assistant Director, and Research Associate—all from **UNC Collaborative for Maternal and Infant Health, UNC School of Medicine**

- Substance Use Prevention Director, **Poe Center for Health Education**
- President & CEO, **Benchmarks NC**
- Clinical Practice Consultant, Maternal Child Health, NC Health Plan, **UnitedHealthcare Community & State**
- Section Chief, **NC Healthy Schools, NC Department of Public Instruction**
- Associate Professor of Media and Information, **Michigan State University**
- Program Coordinator, **Western North Carolina Early Childhood Coalition**
- Branch Head, **Birth Defects Monitoring Program, State Center for Health Statistics**, NC Division of Public Health
- Director, **Jordan Institute for Families at UNC School of Social Work**
- Clinical Neuropsychologist, **Jacksonville Police Department**
- Child Care Business Liaison & staff to the **NC Task Force on Child Care and Early Education, North Carolina Department of Commerce**
- Epidemiologist and Unit Manager and Injury Epidemiologist, both from **Injury Epidemiology, Surveillance and Informatics Unit (ESI)**, NC Division of Public Health
- President, **NC Pediatric Society**
- Section Chief for Safety, **NCDHHS Division of Social Services, Child Welfare**
- Senior Research Scientist and Research Associate, both from **UNC Highway Safety Research Center**
- **NC State Health Director and Co-Chair of NC Advisory Council on Cannabis**, NCDHHS
- Vice President, Policy, **NC Healthcare Association**
- Executive Director, **Governor's Highway Safety Program**
- Campaign Director, **NC Tobacco 21 Coalition, NC Public Health Association**
- Section Chief, **Women, Infant, and Community Wellness Section, Title V MCH Director**, NCDHHS Division of Public Health
- Representative, **NC College of Emergency Physicians**
- School Resource Officer, **Alamance County Sheriff's Office**
- Mayor Pro Tem, **City of Albemarle** & President, **NC League of Municipalities**
- Branch Head, **Maternal Health Branch**, Women, Infant, and Community Wellness Section, NCDHHS Division of Public Health
- President, **NC Association of Certified Professional Midwives**
- President, **NC Association of Certified Nurse Midwives**
- Representative, **NC Obstetrical and Gynecological Society**
- Child Abuse & Juvenile Court Resource Prosecutor, **NC Conference of District Attorneys**
- Policy Director, **Young People's Alliance**
- Director, **Chatham County Department of Social Services**
- Director, **Perinatal Quality Collaborative of North Carolina (PQCNC)**, Professor of Pediatrics, **UNC School of Medicine**
- Executive Director, **NC Child Fatality Task Force**

Widespread Sharing of Task Force Work

Widespread sharing about Task Force work leads to increased awareness about causes and trends in child deaths and strategies to prevent child deaths, which helps to advance the Task Force goal to prevent child deaths and support child well-being.

Data and evidence studied by the Task Force are contained in presentations made by subject matter experts during meetings of the Task Force and its committees. Meetings are open to the public and presentations are posted on the Task Force website. Data shared in Task Force meetings and reports is regularly referenced by individuals and organizations external to the Task Force whose work relates to child well-being.

Task Force data and recommendations are also frequently reported by news organizations who attend Task Force meetings and/or follow Task Force work. The Task Force sometimes issues press releases, as it did in 2025 to announce submission of its annual report and to highlight recently released child death data. Following the release of the 2025 CFTF Annual Report and through the end of the CFTF 2025-26 study cycle in February of 2026, Task Force staff identified around 50 media news reports that were focused on Task Force work, noted Task Force work, or reported CFTF data as part of a story.

The work of the Task Force, its recommendations, and the supporting data that led to the recommendations are also shared widely by the Task Force Executive Director and other Task Force leaders through various communication channels throughout the year. These leaders participate in a broad range of state-level committees, advisory groups, conferences, and initiatives where they have formal and informal opportunities to educate about Task Force data and recommendations.

The "New" North Carolina Child Fatality Prevention System

On July 1, 2025, North Carolina began an exciting new era of child fatality prevention to strengthen our state's ability to prevent child deaths and promote child well-being!

An original statutory duty of the Task Force involved developing the statewide multidisciplinary child death review system, yet evaluating or considering changes to that system was not undertaken by the Task Force (or others) for decades. Beginning around 2017, the Child Fatality Task Force started to look at how the statewide Child Fatality Prevention System was functioning since its creation in 1991, with the goal of understanding what was working well, what challenges were being experienced, and whether changes were needed to improve outcomes in child health and safety.

Using feedback from professionals from across the state who work in the system, many of whom came together at a statewide Child Fatality Prevention System Summit in 2018, as well as a variety of stakeholders and experts, the Task Force developed recommendations to strengthen the system.

Recommendations to strengthen the system first appeared on the Task Force's annual agenda in 2019, and legislation that addressed the recommendations passed in 2023.[1] Provisions in the legislation that created a new State Office of Child Fatality Prevention went into effect in October of 2023; most other provisions of the legislation did not become effective until July 1, 2025, and other parts became effective January 1, 2026.[2] An explanation of the recommendations and the reasons for them can be found in Child Fatality Task Force Annual Reports each year from 2019 through 2023, all of which are available on the CFTF website. A shorter version of the explanation is available in this 2023 fact sheet addressing the recommendations.

The newly structured Child Fatality Prevention System has four components including: child death review teams in all 100 counties (called 'Local Teams'); a State Office of Child Fatality Prevention ('State Office') located in the North Carolina Department of Health and Human Services Division of Public Health that supports and trains Local Teams and manages and reports data surrounding child death reviews; Medical Examiner Child Fatality Staff in the Office of the Chief Medical Examiner; and the Child Fatality Task Force.

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.

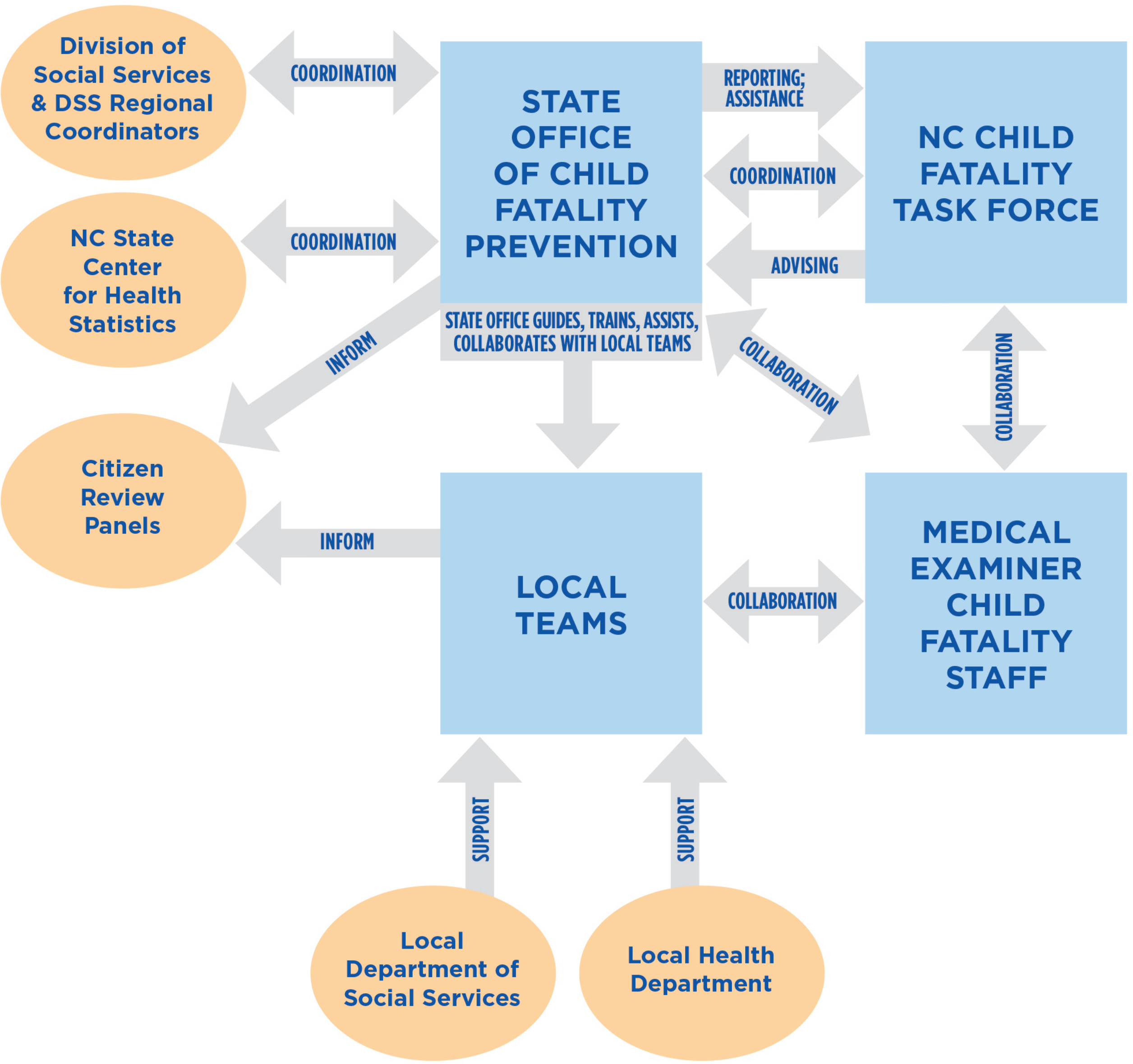
At its first meeting in 2025, the Task Force reviewed the new structure of the Child Fatality Prevention System as well as the flow of information within that system. A narrative overview of the system is available here on the CFTF website. The following graphics that illustrate the system were shared with the Task Force, along with a more detailed version of the graphics that is also available on the CFTF website.

[1] Section 9H.15. of Session Law 2023-134. [Section 3.6 of Session Law 2024-1 made a technical correction to address an error in SL 2023-134 related to the effective dates for certain provisions.]

[2] Section 2B.2 of Session Law 2024-57 provided for a six-month extension on all effective dates and timelines related to the implementation of the 2023 legislative changes to the system.

Structure of the North Carolina Child Fatality Prevention System

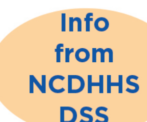
Statutory provisions for the NC Child Fatality Prevention System are in G.S. 7B-1400 through 7B-1414; also G.S. 143B-150.25 through 143B-150.27 (State Office). Citizen Review Panels are per G.S. 108A-15.20



The blue rectangles 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.

Flow of Information in the NC Child Fatality Prevention System

START



Info from NCDHHS DSS

Vital Records Data from SCHS

State Office of Child Fatality Prevention
Collects info; sends info packet to Local Teams; inputs info into NFRCRS

NFR-CRS Data System
(as of 1/1/26)

Local Team
Receives info from State Office; gathers local info; inputs review info into NFR-CRS; reports are submitted to local leaders and State Office

NFR-CRS Data System
(as of 1/1/26)

OCME
Inputs info into NFR-CRS; sends ME reports to State Office

Public Reports
in certain cases related to maltreatment

State Office of Child Fatality Prevention
Analyzes info received; provides reports to Task Force and others

Citizen Review Panel
may get info from State Office or Local Team

Local Leaders Receive Reports
Board of County Commissioners; Local Board of Health; Local Social Services Board

Child Fatality Task Force
Receives info from State Office which informs 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	Ovals	Ovals	Circles
CFP System Component (all receive and report information)	Information receiver	Information provider	National Fatality Review Case Reporting System

This 2026 Child Fatality Task Force Annual Report is the first one pursuant to new statutes that became effective in July of 2025. Under the new laws, the Task Force itself is not undergoing major changes, but does have some new duties and reporting responsibilities, most of which will be addressed for the first time in this report:

- The CFTF is to **receive and consider reports from State Office of Child Fatality Prevention** related to whole system functioning and other matters; this is addressed below in this report.
- The CFTF is to **report on the functioning of the statewide Child Fatality Prevention System** as a whole; this is addressed below in this report.
- The CFTF is to **study aggregate information from Local Teams** that review child deaths. This change will be made possible through the use of a new data system by Local Teams that will enable the collection, analysis, and reporting of aggregate information. However, use of the data system, which is now required by statute, began January 1, 2026, and there is not yet enough information gathered for the CFTF to study aggregate information from Local Teams, so this year's report cannot address this.
- The CFTF is to **advise the State Office of Child Fatality Prevention** on the operation of an effective statewide CFP system. The CFTF has not yet *formally advised* the State Office, as the CFTF is gathering new information from the newly created State Office. However, the CFTF Executive Director has been involved in some aspects of DHHS efforts to implement the 2023 legislation that created the State Office and restructured the Child Fatality Prevention System, and has been coordinating with the Director of the new State Office.
- **The CFTF is to submit its annual report to additional state leaders.** Besides reporting to the General Assembly and the governor as it has always done, the CFTF is to submit its report to these additional state leaders, all of whom will receive this year's report:
    - Secretary, North Carolina Department of Health and Human Services
    - Chairs, House Appropriations Committee on Health and Human Services
    - Chairs, Senate Appropriations Committee on Health and Human Services
    - Chairs, Joint Legislative Oversight Committee on Health and Human Services
    - Chairs, Joint Legislative Oversight Committee on Justice and Public Safety
    - Chairs, Joint Legislative Education Oversight Committee

Report on the Functioning of the North Carolina Child Fatality Prevention System

During its 2025-26 study cycle, the Child Fatality Task Force and its Intentional Death Prevention Committee heard six presentations related to the functioning of the statewide Child Fatality Prevention System and implementation of the 2023 legislation that changed the system. This included the following:

- A presentation to the Child Fatality Task Force by its Executive Director, Kella Hatcher, on the impacts of child fatality prevention system legislation on the CFTF and new CFTF duties.
- Two presentations to the Child Fatality Task Force from the Director of the new State Office of Child Fatality Prevention, Kerry Young, to report on the work of that office and the implementation of new laws related to the Child Fatality Prevention System. Presentations were in September of 2025 and February of 2026.
- A presentation to the Child Fatality Task Force in February of 2026 by Dr. Michelle Aurelius, Chief Medical Examiner, on the role of her office in child fatality prevention work.
- Presentations in January of 2026 to the Intentional Death Prevention Committee, whose work includes the prevention of abuse and neglect, by
    - Kerry Young, Director of the State Office of Child Fatality Prevention, on the State Office's role and progress implementing new requirements for the review of child deaths where there was or may have been abuse or neglect or where the child or family was involved with Child Protective Services; and
    - Kathy Stone of the NCDHHS Division of Social Services on the role of the Division related to the reviews of child deaths where there was involvement from Child Protective Services. Ms. Stone also presented on the implementation of new laws requiring Citizen Review Panels.

After passage of the legislation to strengthen the Child Fatality Prevention System in 2023, the NC Department of Health and Human Services (NCDHHS) was tasked with implementing changes required by the new legislation and created a work group to address the changes.

One aspect of the 2023 legislation was the creation of a new State Office of Child Fatality Prevention (State Office), located in the Division of Public Health, which was required to be sufficiently staffed to be operational and to support Local Teams by July 1, 2025. This was also the effective date for Local Teams that review child deaths to transition to a modified structure, with revised requirements for conducting reviews, and the date by which the Department was required to ensure that any contractual agreements and interagency data sharing agreements necessary for participation in a new data system (explained below) would be executed. January 1, 2026 is the date by which Local Teams were to have begun using the new data system, after receiving training and guidance provided by the State Office.

Status of the State Office of Child Fatality Prevention and implementation of legislative changes to the Child Fatality Prevention System

The new State Office has multiple powers and duties according to statute. Duties that might be characterized as 'core' functions relate to: support and coordination of the statewide system; providing training, guidance, resources, and technical assistance for Local Teams that review child deaths; implementing and managing a centralized data and information system; and working with the medical examiner, the State Center for Health Statistics, the NCDHHS Division of Social Services, and others to carry out system requirements.

Other powers and duties of the State Office relate to: educating leaders and the public about the system and about prevention strategies; collaboration with others to facilitate prevention initiatives; evaluating the ability of the system to achieve intended outcomes; research and collaborative efforts to better understand causes of death and prevention strategies; and seeking and administering grant and other non-state funding to support the work of the system. The State Office Director reported that because it is new and is not yet fully staffed, it has prioritized the other more pressing core duties and has not yet addressed these duties.

Staffing the State Office

The legislation that created the State Office and appropriated funds to do so went into effect on October 3, 2023. Legislation required the NC Department of Health and Human Services to ensure that the State Office was sufficiently staffed and prepared to carry out its powers and duties by July 1, 2025.[3] When fully staffed, the State Office is to have six full-time positions, and as of the time of the writing of this report, the office has three of these positions in place:

- The Director of the State Office began her role in December of 2024
- A Database Manager began her role in April of 2025
- An Epidemiologist began his role in January of 2026

Three additional positions that are expected to be hired include a Child Maltreatment Program Coordinator, a Local Team Program Coordinator, and an Administrative Specialist.

The Director of the State Office reported to the Task Force that delays in hiring have related to factors such as: waiting for Human Resources to move a position through their system beginning with position posting through authorization to extend an offer; a hiring freeze for all vacant positions due to the lack of a state budget; and the complications of transferring a position from one DHHS division to another.

Support for Local Teams and use of the NFR-CRS data system

Prior to the July 1, 2025 statutory deadline for having an operational State Office and the effective date for transitions by Local Teams, NCDHHS and the new State Office Director worked to communicate with Local Teams about the changes that were coming and advise them on preparations that they should make. State Office staff conducted training for Local Teams on the various new requirements in the legislation.

NCDHHS and State Office staff also worked to get all the agreements in place that were necessary for using a new data system, the National Fatality Review Case Reporting System (NFR-CRS), and prior to using the NFR-CRS in January of 2026, State Office staff offered both in-person and virtual trainings for Local Teams to learn how to use the system. Local Teams began using the NFR-CRS January 1, 2026, and the State Office Database Manager and Epidemiologist have a role in supporting that work. North Carolina is the last state in the nation to use this system, which was created for the purpose of collecting and analyzing information that is learned from child death reviews. Once the system has enough data for meaningful analysis, reports containing aggregate information will be provided to the Child Fatality Task Force and others to help inform prevention initiatives and policy changes.

[3] See footnotes #1 and 2.

Implementation of new requirements for reviews of child maltreatment deaths or deaths with CPS involvement

One of the changes for Local Teams resulting from the legislation involves new requirements for conducting child death reviews where child abuse or neglect was or may have been involved, or where the child or family was known to Child Protective Services. A new statute that governs these cases, G.S. 7B-1407.5, sets out special requirements for Local Teams in conducting these reviews, as well as special responsibilities of the State Office related to these reviews.

The Intentional Death Prevention Committee heard reports in its January 2026 meeting related to the implementation of these requirements. Reports were from the State Office Director and from NCDHHS Division of Social Services (DSS). Highlights from the reports include the following:

- These reviews under G.S. 7B-1407.5 are being called “escalated reviews.”
- The State Office and the Division of Social Services have worked out a system to identify cases that will be reviewed under the requirements of this statute.
- The State Office has created a manual providing guidance for local teams on these cases; this manual will continue to be revised and improved as needed.
- DSS Regional Child Welfare Consultants will attend these reviews to provide expertise on child welfare policy.
- Training for review of these cases has been offered to Local Teams and recorded for later viewing.
- The State Office plans to offer technical assistance to Local Teams in these cases per statutory requirements, however technical assistance will be limited until the Child Maltreatment Coordinator position in the State Office is filled, as this position will focus on these cases.
- The State Office has worked on the process and procedures for creation and release of reports in these cases.
- The State Office is working on a process to follow up on the implementation status of recommendations made in these cases and help facilitate the advancement of these recommendations.
- DSS conducts its own internal reviews when they learn that a child who is or was recently in the child welfare system has died. These reviews, called a Child Welfare Practice Review, are separate from Local Team reviews; they occur very soon after the death and are intended to identify safety and practice issues that may need to be addressed. The State Office and DSS are working to determine how information from DSS internal fatality reviews can appropriately inform Local Team reviews, and how information from escalated reviews can be shared with Citizen Review Panels.

Report on the work of child fatality staff in the Office of the Chief Medical Examiner

The Medical Examiner (ME) system has jurisdiction over the investigation of certain types of deaths, primarily sudden, unexpected, suspicious, and violent deaths. In 2024, 593 child deaths were under ME jurisdiction (this is roughly 40% of North Carolina child deaths in 2024). The goal of the Child Fatality Staff in the Office of the Chief Medical Examiner (OCME), as described by the North Carolina Chief Medical Examiner, is to ensure that the youngest patients have a voice in death prevention. Some highlights of their efforts since the 2023 child fatality prevention legislation passed include the following:

- Accelerated the review process on child fatality cases.
- Improved the quality of child fatality data through training and timely review of ME reports in child fatality cases to provide feedback to local MEs to ensure that they are gathering the necessary information regarding circumstances surrounding the case which aids in understanding the death and tracking relevant data.

- Expanded training not only for MEs in the field but also law enforcement related to child death scene investigation to ensure the quality of these investigations – they provided formal training of 63 MEs in child death investigation and educated over 200 law enforcement personnel on child death investigation.
- Improved efficiency with a new information technology system to track data from ME reports.
- Implemented new workflow to provide the State Office of Child Fatality Prevention quarterly child fatality reports and to respond to queries.
- Processed cases to collect specific data points and elements for input in the NFR-CRS data system.
- A new data dashboard is being created related to infants and unsafe sleep environments.
- Periodic reports on child deaths will also be available on the OCME website.

Extending Our Thanks!

Many thanks to Task Force Members, contributing experts, and community volunteers who devoted their time and expertise to Task Force work during the past year. Their efforts and commitment to protecting the children of North Carolina are reflected in the 2026 Action Agenda and this report on their work.

NORTH CAROLINA CHILD FATALITY TASK FORCE
2026 Action Agenda

Legislative "support" items receive the highest level of support from the CFTF.

Legislative "endorse" items are led by others and endorsed by the CFTF.

"Administrative" items are currently non-legislative items sought to be further studied by the Task Force and/or advanced by the CFTF through collaborative, non-legislative efforts.

Note: Many of the 2026 agenda items, as well as parts of the explanations of these items, are being repeated from prior years because they have not yet advanced and the Task Force continues to view them as important strategies to prevent child death and promote child well-being. These recommendations are noted with an asterisk (*); in some cases the wording of a legislative recommendation or administrative item has been slightly modified but the general intent from prior years' recommendations remains the same.

Recommendations to prevent harm from tobacco, nicotine, and intoxicating cannabis products

***RECOMMENDATION: Taking into account recent federal law changes to the definition of hemp effective November 12, 2026, and uncertainty around these laws and their impacts, the CFTF supports legislation and/or other measures to ensure the protection of children from harmful intoxicating hemp/cannabis products to accomplish the following:**

- **prevent the sale or distribution of such products to those under 21;**
- **require the packaging of such products to contain appropriate warnings, be child-resistant and to prohibit packaging that is attractive to children and youth;**
- **require permitting for retailers who sell such products; and**
- **prohibit those under 21 from entering vape shops.**

The CFTF began to learn about the issue of intoxicating cannabis and its impact on kids in the fall of 2024 and included its first recommendation on the topic on its 2025 Action Agenda. Since then, we have seen more scientific studies about harms to children, proposed state legislation, new federal laws, a new state advisory council on cannabis, and media outlets putting a spotlight on this topic and the broader issues surrounding cannabis access and regulation. The CFTF returned to examine this issue in the fall of 2025, having heard information that served to confirm the need to continue to push for state action to protect children from the harmful impacts of intoxicating cannabis.

2018 and 2025 changes in the law related to hemp and intoxicating cannabis

In 2018, the federal Farm Bill legalized hemp production and CBD that comes from hemp, and the definition of hemp in the bill resulted in a surge in the manufacture and sale of intoxicating cannabis/hemp products construed to be legal under the new laws.[4] North Carolina laws related to the legality of hemp were revised to align with federal law and permanently exclude hemp from the State Controlled Substances Act.[5] These intoxicating products are being sold by various types of NC retailers, especially vape shops, in a variety of forms like candy, snack foods, beverages, and vape pens.

Many intoxicating cannabis edibles have packaging that appeals to children or mimics other popular snacks. Unlike some other states, **there is no minimum age for the purchase of intoxicating cannabis products in North Carolina and no safety regulations are in place for packaging, presenting dangers to children and youth of all ages.**

Cannabidiol (CBD) and tetrahydrocannabinol (THC) are both naturally occurring compounds called cannabinoids found in cannabis plants. The 2018 Farm Bill legalized CBD that comes from hemp, defined by the Farm Bill as cannabis containing less than 0.3% delta-9 THC by weight. This threshold has a different impact when applied to a hemp plant compared to hemp-derived products. Also, the bill did not address the legal status of other forms of THC besides delta-9. Semi-synthetic THC forms, like delta-8, delta-10, and many others have become widely available.

Products being manufactured and sold that claim they are legal under the 2018 Farm Bill may contain high levels of intoxicating THC. An example from the Cannabis Regulators Association: "A 50-gram chocolate bar at 0.3% THC would have around 150 mg of THC (30 times the standard 5 mg THC dose established by the National Institute on Drug Abuse)."[6] National data shows that cannabis-related incidents reported to poison control centers increased from about 930 cases in 2009 to more than 22,000 in 2024, and there are cases in which children need intensive care treatment.[7]

The NC Child Fatality Task Force heard from a Special Agent of the North Carolina Alcohol Law Enforcement Division (ALE) of the Department of Public Safety about what ALE sees related to intoxicating cannabis products and what's happening in vape shops. ALE is the agency charged with enforcing compliance with state laws related to alcohol and tobacco sales (as well as other laws). The lack of permitting or licensing in NC for retailers like vape shops that routinely sell tobacco and cannabis products combined with the lack of regulations around the cannabis products means that ALE doesn't know who all these retailers are and ALE has limited authority – they can only enforce existing state laws.

ALE responds to reports that involve things like illegal activity at a vape shop or a youth becoming ill from a product sold in a vape shop. The ALE Special Agent explained to the Task Force that when ALE's response includes testing cannabis products, the contents of the products can vary widely and usually exceed the legal delta-9 THC limit, with some products containing levels up to 30 times the legal threshold. ALE raids on vape shops have often resulted in seizures of illegal products and felony charges for illegal activities.[8]

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[4] Information on the 2018 federal Farm Bill and the resulting surge in the manufacture and sale of intoxicating cannabis:

- Harlow AF, Leventhal AM, Barrington-Trimis JL. Closing the Loophole on Hemp-Derived Cannabis Products: A Public Health Priority. JAMA. 2022 Nov 22;328(20):2007-2008. doi: 10.1001/jama.2022.20620. PMID: 36331491; PMCID: PMC10406389.
- National Academies of Sciences, Engineering, and Medicine. 2024. Cannabis Policy Impacts Public Health and Health Equity. Washington, DC: The National Academies Press. https://doi.org/10.17226/27766.
- Blog on the website for the Association of State and Territorial Health Officials, "Hemp's Hazy Legal Status Challenges Public Health Efforts," by Christina W. Severin, BSN, JD.
- CANNRA Urges Federal Action to Address Hemp-Derived Cannabinoid Product Regulation, Cannabis Regulators Association, 2023: https://www.cann-ra.org/news-events/sx2s63c2fudq9n0zmk4ekviku9747f.

[5] See North Carolina Session Law 2022-32. (Session Law 2018-113 is also relevant in terms of definitions related to hemp and THC.)

[6] *CANNRA Urges Federal Action to Address Hemp-Derived Cannabinoid Product Regulation*, Cannabis Regulators Association: https://www.cann-ra.org/news-events/sx2s63c2fudq9n0zmk4ekviku9747f.

[7] Danielle Ivory, Julie Tatte and Megan Twohey. "Cannabis Poisonings Are Rising, Mostly Among Kids." *New York Times website*, August 10, 2025. Poison control data from America's Poison Centers.

[8] Information on ALE activities with vape shops sourced from a presentation by an ALE officer to the Child Fatality Task Force on December 10, 2024.

A new federal law passed in November of 2025 that goes into effect in November of 2026 makes many of these products illegal by changing the definition of hemp again; the change is intended to prevent the unregulated sale of intoxicating hemp products that began occurring after the 2018 Farm Bill changed the definition of hemp.[9] However, there is a great deal of uncertainty surrounding implementation and enforcement of the federal law. A Library of Congress publication analyzing this change in federal law specifically discusses this uncertainty, and other articles have done so as well.[10] In the meantime, North Carolina children and youth are still at risk and may continue to be even after federal laws are in place, unless there is state action to protect them.

Recent efforts in North Carolina

In June of 2025, Governor Josh Stein created the North Carolina Advisory Council on Cannabis. This council has been studying multiple issues surrounding cannabis, including regulation, public health, public safety, and more, with one of its primary goals focused on protecting youth. Final recommendations from the council are expected in December of 2026.

Meanwhile, the 2025 legislative session in North Carolina saw several bills introduced that addressed the regulation of intoxicating cannabis.[11] The bills had different but overlapping approaches to the issue, and none of them became law.

Harmful impacts of intoxicating cannabis on children and youth

Since 2018 and following this surge in the availability of intoxicating cannabis, the rate of emergency department visits in North Carolina for cannabis consumption among children and youth ages 17 and under increased more than 470 percent; among children aged 10 to 14, the rate increased nearly 800 percent.[12] Young children and youth can have severe reactions to ingesting cannabis including breathing problems,[13] and youth who use intoxicating cannabis can experience multiple negative impacts such as: problems with memory, learning, school and social life; impaired driving; potential for addiction; and increased risk of mental health issues including depression, anxiety, psychosis, schizophrenia, and suicidal behaviors.[14]

In December of 2025, the CFTF heard from a neuropsychologist about the negative impacts of nicotine and THC on the developing brains of adolescents, and how the brain plasticity of youth makes them more susceptible to long-term changes in brain function compared to adults. The CFTF also heard from a 19-year-old woman about her experience becoming addicted to these types of cannabis products as a younger teen and how easy it was for her to get these products at vape shops.

These harms are the reason the Child Fatality Task Force continues to recommend state action addressing intoxicating cannabis to protect children and youth.

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[9] "Change to Federal Definition of Hemp and Implications for Federal Enforcement." *Congress.gov*, Library of Congress, 23 March 2026, https://www.congress.gov/crs-product/IN12620.

[10] Ibid. See also, e.g., blog post from the UNC School of Government, December 17, 2025: https://www.sog.unc.edu/about/news/faculty-member-phil-dixon-discusses-how-federal-restrictions-thc-will-impact-growing-hemp-economy.

[11] See: HB 680, HB 607, HB 507, HB 328, SB 265, SB 483.

[12] Source: NC DETECT ED Visits, Cannabis Consumption Definition, pulled 3/2026; analysis by the Injury and Violence Prevention Branch, NC Division of Public Health, NC Department of Health and Human Services.

[13] *Cannabis and Poisoning* page on the website for the U.S. Centers for Disease Control and Prevention: https://www.cdc.gov/cannabis/health-effects/poisoning.html.

[14] *Cannabis Risk Factors* page on the website for the U.S. Centers for Disease Control and Prevention: https://www.cdc.gov/cannabis/risk-factors/index.html; *Cannabis and Teens* page on the website for the U.S. Centers for Disease Control and Prevention: https://www.cdc.gov/cannabis/health-effects/cannabis-and-teens.html#cdc_risk_factors_who-negative-effects-of-teen-cannabis-use. See also: Hinckley J, Mikulich-Gilbertson S, He J … Cannabis Use Is Associated With Depression Severity and Suicidality in the National Comorbidity Survey–Adolescent Supplement JAACAP Open, 2023; 1, 24-35, https://www.jaacapopen.org/article/S2949-7329(23)00003-0/fulltext.

*RECOMMENDATION: Endorse legislation to raise the legal age for sale of tobacco products in NC from 18 to 21 to align with federal law; legislation to include licensing of tobacco product retailers and appropriate enforcement measures.

A 2024 national survey showed that tobacco/nicotine use among youth is declining, but nicotine vapes and other products like nicotine pouches are commonly used by many high school and even middle school youth. The most recently available data from the 2023 North Carolina Youth Risk Behavior Survey showed that 37% of North Carolina high school students say they have used a vape product, one in three 12th graders reported current use of vape products, and one in ten middle schoolers reported current use of vapes.

North Carolina is one of only six states that does not align with the federal minimum age of 21 for purchasing tobacco products, and one of only eight states that does not require tobacco retailers to obtain a license or permit. Without licensing, enforcement of any age requirement is challenging since there's no way to know who these retailers are. A U.S. Surgeon General, the National Academy of Medicine, and the CDC have identified the licensing of tobacco retailers as an evidence-based measure to reduce tobacco sales to youth.[15]

Harms from Vaping

Nicotine can disrupt brain development for youth, potentially causing problems with attention, impulse control, mood and reward sensitivity.[16] E-cigarettes (used for vaping) can contain high doses of nicotine available in flavors attractive to youth. Nicotine is highly addictive and tobacco product use in any form, including e-cigarettes, is unsafe for youth.[17] Besides nicotine, the aerosol (not a vapor) may contain volatile organic compounds, ultrafine particles, heavy metals, cancer-causing chemicals, and flavoring that may be linked to lung disease.[18]

Nicotine is also toxic to developing fetuses and impairs fetal brain and lung development; tobacco use during pregnancy is associated with leading causes of infant death.[19] Maternal use of electronic products, even without co-use of cigarettes or other combustible tobacco products, is associated with a more than 12% increase in preterm birth and more than 10% increase in low birth weight,[20] both of which are leading causes of infant death.

Many if not most youth and parents do not know about the health risks associated with vape products and don't understand that the aerosol contains harmful substances or that vaping can lead to death. In 2024, the Task Force heard a heartbreaking story from a mom about her teenage stepson's death, and how his pulmonologist attributed it to vaping.

Vape products are attractive to youth and problematic for schools

Besides having flavors attractive to youth, some vape products are made to look like toys and now some have a gaming component that can exacerbate the addictive aspects of these products. A gamified product may, for example, encourage users to take more puffs to earn points.

[15] NC Tobacco and Prevention Control Branch, Division of Public Health, NC Department of Health and Human Services.
[16] Presentation to the CFTF on December 9, 2025 by Dr. Tobi Gilbert, Psy.D., ASPBB-APIT, NERPSC, HSP, Clinical Neuropsychologist, Jacksonville Police Department.
[17] U.S. Centers for Disease Control and Prevention.
[18] NC Tobacco and Prevention Control Branch, Division of Public Health, NC Department of Health and Human Services.
[19] University of North Carolina Collaborative for Maternal and Infant Health.
[20] Regan AK. Adverse Birth Outcomes Associated With Prepregnancy and Prenatal Electronic Cigarette Use. Obstet Gynecol 2021; 00:1–10, https://pubmed.ncbi.nlm.nih.gov/34259468/.

Vaping devices that are tiny and may resemble a flash drive or a pen deliver a high dose of nicotine and are used by teens for discreet vaping anywhere, including in school. In a North Carolina school study conducted in collaboration with the CDC which included a survey of school staff, most school staff identified e-cigarette use among students as: problematic (88%); harmful (95%); contributory to learning disruptions (84%), and a high priority issue for school administration (90%).

Easy access to vape products and challenges with enforcement

Part of the reason vaping is so pervasive among youth is that it's easy for them to buy vape products. Youth are getting them from a variety of retail locations like gas stations, grocery stores, or vape shops. Studies have shown youth are regularly not carded by retailers who sell these products. For example, in 2023, the NCDHHS Division of Mental Health, Developmental Disabilities and Substance Use Services and the North Carolina Alcohol Law Enforcement Division (ALE) conducted a statewide Vape Shop Pilot compliance check with 16- and 17-year-old buyers of electronic vape products with 400 vape shops statewide, and the violation rate for selling to those underage was 37%.

Having a minimum age at 18 instead of 21 for sale of tobacco products not only results in more 18-year-olds vaping, it also means younger teens have easier access to vape products through older friends. Without licensing of tobacco retailers, getting retailers to adhere to any age requirement is more challenging. The North Carolina Alcohol Law Enforcement Division (ALE) of the Department of Public Safety is the agency responsible for enforcing state laws related to tobacco. With licensing, ALE would have a record of who all the retailers are and would have authority to conduct inspections.

North Carolina is at risk of losing millions of federal dollars for prevention, treatment, and recovery services block grant funding if it does not effectively prevent underage sales of tobacco products to young people due to potential penalties under the Federal Synar Law for Retail Violation Rates (for selling to underage customers) that exceed a threshold of 20%, which was far exceeded by the results in the 2023 North Carolina pilot study referenced above.[21]

The Child Fatality Task Force has identified the vaping epidemic among youth to be a serious concern for years, and these policy changes are critical to address this epidemic that poses a serious threat to the health of our children.

Recommendations to promote healthy birth outcomes, prevent deaths of infants and young children, and promote infant and child well-being

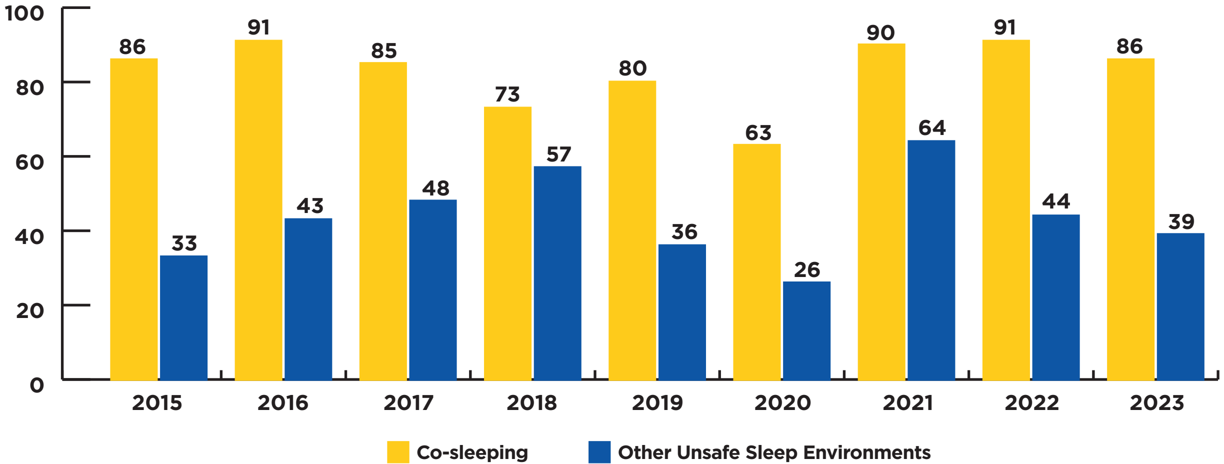
*RECOMMENDATION: Support recurring funding of $250K for the infant safe sleep program to prevent sleep-related infant deaths.

Unsafe sleep is a leading cause of infant death in North Carolina and these deaths are largely preventable.

In North Carolina, an infant dies every three days in an unsafe sleep environment, and Black infants are twice as likely as white infants to die in unsafe sleep environments. More than 120,000 babies are born each year in North Carolina and sustained, adequate funding is essential for an effective statewide initiative to ensure that these babies are not lost to unsafe sleep.

[21] NC Tobacco and Prevention Control Branch, Division of Public Health, NC Department of Health and Human Services.

In the nine years from 2015 through 2023: 1,135 North Carolina infants died in unsafe sleep environments.[22]



Guidelines from the American Academy of Pediatrics to create a safe sleep environment and reduce risk of infant death have evolved during the past decade, with the most recent updates made in 2022. Studies show that unsafe sleep practices are common and that parents and caregivers are not always receiving correct advice or education, even from health and child care providers. In fact, **one study found that nearly half of caregivers did not receive correct advice *from health care providers.*[23]**

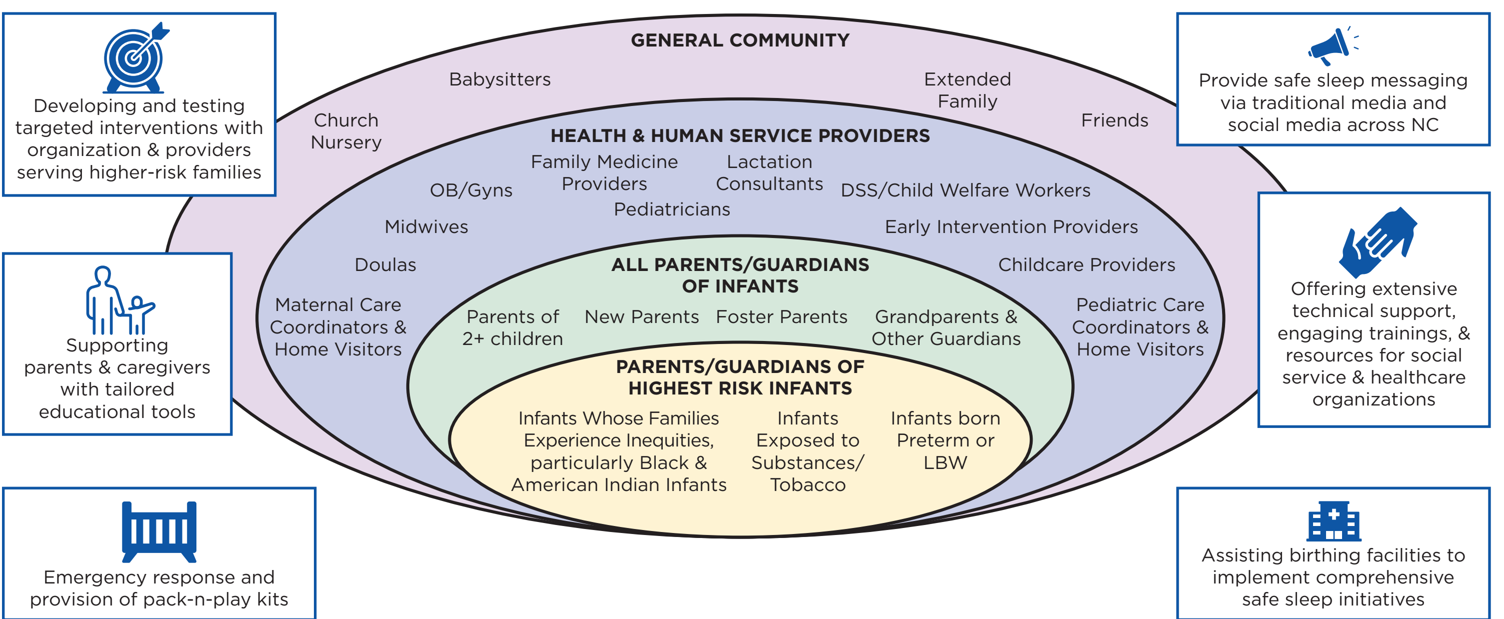
Examples of an unsafe sleep environment include sleeping on a soft surface (e.g., couch, adult mattress); sleeping with toys, blankets, pillows or crib bumpers; sleeping on the stomach or on an inclined surface; or sharing a sleep space with another individual, sometimes called 'bed sharing' or 'co-sleeping.' Co-sleeping is unsafe, and the risks significantly increase for some infants such as those born too soon, too small, or who are in households where tobacco or other substances are used.[24]

Prevention requires a multifaceted approach with a broad reach to connect not only with parents and caregivers, but with health care providers and others who educate them and reinforce consistent, accurate messaging about safe sleep repeatedly, rather than just one time at hospital discharge after birth.

[22] Death Data Source: Medical Examiner Information System, 2015-2023. The data presented reflect finalized infant fatality cases within the Medical Examiner (ME) system's jurisdiction in which the certifying pathologist identified the infant's sleep environment, sleep position, or both as contributing risk factors to the death.

[23] Colson ER, Geller NL, Heeren T, et al. Factors Associated With Choice of Infant Sleep Position. Pediatrics. 2017;140(3):e20170596.

[24] See: Rachel Y. Moon, Rebecca F. Carlin, Ivan Hand, THE TASK FORCE ON SUDDEN INFANT DEATH SYNDROME AND THE COMMITTEE ON FETUS AND NEWBORN; Sleep-Related Infant Deaths: Updated 2022 Recommendations for Reducing Infant Deaths in the Sleep Environment. Pediatrics July 2022; 150 (1): e2022057990. 10.1542/peds.2022-057990



Evidence shows that this type of multi-level approach to prevention is essential and effective. For example, Sacramento County California's Safe Babies Initiative reduced their sleep-related infant death rate by 54% and their Black/white disparities rate by 66% over 5 years.[25]

Teams that review child deaths in North Carolina repeatedly identify the need to expand statewide efforts with safe sleep education to prevent these deaths. State funding to prevent these deaths has never been more important because the federal office dedicated to this work was shut down on April 1, 2025.[26] Current funding for statewide prevention efforts of only $97,000 is via the MCH Block Grant, and this funding is insufficient for an effective initiative in a state with over 120,000 babies born each year.

RECOMMENDATION: Support reinstatement of annual funding of $905,000 for the Perinatal Quality Collaborative of North Carolina.

Note: *after the CFTF made this recommendation for PQCNC funding and released its 2026 Action Agenda, it was learned that funding for PQCNC from NCDHHS via Medicaid would enable PQCNC to resume its work. This recommendation and its explanation are still included in this report to highlight the importance of this program.*

An important strategy to prevent infant mortality and improve birth outcomes identified by the Perinatal Health Committee beginning around 2011 was to support state funding for the work of the Perinatal Quality Collaborative of North Carolina (PQCNC). Perinatal Quality Collaboratives consist of networks of teams who work in hospitals to employ best practices to improve outcomes in maternal and infant health.

PQCNC had been operating since 2009 until it lost state funding in October of 2025. Operating in 40 to 60 NC hospitals in any given year, not only has PQCNC been able to improve maternal and infant health and save lives, but many of its initiatives have also resulted in significant cost savings. This program estimates that their initiatives have resulted in cost avoidance of $98 million, and a return on investment of 925%.

[25] First 5 Sacramento Reduction of African American Perinatal & Infant Deaths, Final Evaluation Report, July 1, 2015-June 30, 2018.
[26] See this May 6,, 2025 article from the American Academy of Pediatrics, and this article from WFMY News2 in Greensboro related to impacts in North Carolina.

Examples of PQCNC initiatives include reducing different types of infections, reducing the primary C-section delivery rate, promoting exclusive human milk feeding in newborn nurseries and NICUs, lessening opioid use disorder impact, improved management of newborn hypoglycemia and maternal pre-eclampsia, etc. Examples of specific initiatives of PQCNC along with their impact and estimated cost savings were shared with the CFTF as follows:[27]

Clinical Impact and Annual Savings

- Reducing CLABSI (74% reduction) ($4M over 4 years)
- Reducing Elective Early Deliveries (34% reduction) ($11M over 5 years)
- Reducing the Primary CS Rate (14% reduction) ($13M over 7 years)
- Comprehensively Lessening Opioid Use Disorder Impact for Moms and Babies (Screening from 1% to 75%, SW Referrals 50 to 98%, Referrals for positive screens 28 to 53%, 20% reduction in ALOS…9 days… for infants in NICUs due to Eat/Sleep/Console statewide) ($4.5M over 3 years but…$32.4M projected in state)
- Reducing Antibiotic USE in NBN and NICUs (47% reduction in antibiotic exposure in NBN, 14% reduction in antibiotic use in the NICUs)
- OB Hemorrhage Care (75% increase in hemorrhage carts in L&Ds, 50% increase in measuring blood loss via QBL)
- Sepsis in Obstetrics (Sepsis screening tool adoption 25 to 83%, monitoring antibiotics within 1 hour 0 to 69%)
- Care of the Late Preterm Infant (Readmits 6% to 3%, appointments within 48 hours 67 to 87%, breastfeeding at DC 48 to 60%) ($1.1M over 2 years)
- Cardiac Care in Obstetrics (Screening tool adopted 0 to 70%). On average maternal and newborn projects annually effect care of 65,000 mothers and infants.

PQCNC

PQCNC has been the only statewide organization in North Carolina working at the hospital and clinic level to execute perinatal quality improvement initiatives. Investments in Perinatal Quality Collaboratives are among the current policy priorities of the March of Dimes, which are aimed at improving maternal and infant health. Without funding to support its work, North Carolina would be the only state in the nation without a Perinatal Quality Collaborative.

*RECOMMENDATION: Support growth and expansion of investments in the early child care system, including increases for child care subsidies.

Ensuring that families have access to affordable, quality early care is a recognized strategy in preventing child abuse, neglect, and even death, and supports overall child well-being. But in North Carolina, too many parents and caregivers lack access to affordable, quality child care. Meanwhile, the child care business model is in crisis and cannot be sustained without significant state investments combined with other creative solutions.

Access to affordable child care promotes child well-being and can prevent child abuse and neglect

A growing body of evidence shows that increased access to economic and concrete supports for families can prevent child abuse and neglect, and access to affordable, quality child care is one type of support that can make a difference.[28] Experts have said, "Even modest improvements in families' economic well-being, whether it be through economic and concrete supports or reductions in out-of-pocket expenses, have been shown to decrease rates of child maltreatment . . ."[29]

[27] This information is from a slide shared by the Director of PQCNC, Dr. Martin McCaffrey, at the CFTF meeting on February 25, 2026.
[28] *Evidence to Impact: State Policy Options to Increase Access to Economic & Concrete supports as a Child Welfare Prevention Strategy.* June 2023. American Public Human Services Association & Chapin Hall at the University of Chicago.
[29] Henry T. Puls, Paul J. Chung, Clare Anderson; Universal Child Care as a Policy to Prevent Child Maltreatment. Pediatrics August 2022; 150 (2): e2022056660. 10.1542/peds.2022-056660.

A publication from the U.S. Centers for Disease Control (CDC), Child Abuse and Neglect Prevention Resource for Action: A Compilation of the Best Available Evidence, sets out five prevention strategies for child maltreatment that are based on research.[30] Two of these strategies include providing quality care and education early in life; and strengthening economic support to families, including subsidized child care. The CDC says, “Better quality child care increases the likelihood that children will experience safe, stable, nurturing relationships and environments and decreases the risk of maltreatment-related fatalities.” The CDC publication also says:

> *“Access to affordable child care also reduces parental stress, and having access to high-quality child care is associated with fewer symptoms of maternal depression. Both parental stress and maternal depression are risk factors for child abuse and neglect. Moreover, children who live with unrelated adults are nearly 50 times more likely to die of inflicted injuries than children who live with both biological parents, thereby highlighting the importance of quality child care, as mothers would not have to leave the child alone with other (unrelated) adults in the home.”*

Other CDC publications related to preventing Adverse Childhood Experiences and Intimate Partner Violence also discuss the importance of access to high-quality child care.[31]

Experts in North Carolina echo the importance of child care as a prevention strategy. The North Carolina Perinatal Health Strategic Plan, the North Carolina Institute for Medicine’s 2015 Task Force for Essentials for Childhood and its 2025 update publication all highlight access to affordable, quality child care as being important to support infant and child well-being and prevent child maltreatment.[32] The North Carolina State Child Fatality Prevention Team that reviewed child maltreatment deaths also raised access to child care as an area of concern. The North Carolina Positive Childhood Alliance, which is the state chapter of Prevent Child Abuse America, also counts access to quality, affordable child care and early education among their key primary prevention strategies.

Quality early care positively impacts the brain development of young children, setting them up for better outcomes later in life. Eighty-five percent of the physical brain develops by the age of three, and children’s early experiences build their brain architecture for life. This is one reason why investments in early care and learning have been shown to have a high rate of economic return resulting from a combination of factors such as the impact of higher achievements with school and career, reduced costs in health and criminal justice expenditures, and increased opportunity for workforce participation and economic security. Studies have shown that the earlier the investments in children, the higher the rate of economic return given the increased productivity and reduced social spending.[33]

The child care crisis in North Carolina and economic impacts

The CFTF first made a recommendation for child care funding in 2024, and since then the child care crisis has worsened. COVID federal stabilization grants were helping to keep many centers open, but that funding ended in January of 2025. From January through October of 2025, 280 licensed child care providers closed in North Carolina.[34] Hurricane Helene that struck in September of 2024 exacerbated the crisis in Western North Carolina.

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[30] Fortson, B. L., Klevens, J., Merrick, M. T., Gilbert, L. K., & Alexander, S. P. (2016). *Child Abuse and Neglect Prevention Resource for Action: A Compilation of the Best Available Evidence.* Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/pdf/CAN-Prevention-Resource_508.pdf.

[31] Adverse Childhood Experiences Prevention Resources for Action: A Compilation of the Best Available Evidence, https://www.cdc.gov/violenceprevention/pdf/ACEs-Prevention-Resource_508.pdf, and Intimate Partner Violence Prevention Resources for Action: A Compilation of the Best Available Evidence, https://www.cdc.gov/violenceprevention/pdf/IPV-Prevention-Resource_508.pdf.

[32] North Carolina Perinatal Health Strategic Plan, https://wicws.dph.ncdhhs.gov/phsp/phsp.htm, and NCIOM 2015 Task Force on Essentials for Childhood, https://nciom.org/wp-content/uploads/2017/07/Essentials4Childhood_report_FINAL.pdf; North Carolina Institute of Medicine. Building Resilience and Promoting Well-Being: An Updated Action Plan for North Carolina’s Children and Families. Chapel Hill, NC: North Carolina Institute of Medicine; 2025, https://nciom.org/wp-content/uploads/2025/05/E4C-Report-Final.pdf.

[33] Sourced from presentation to the Task Force by the Director of the Division of Child Development and Early Education, NC DHHS; see research by Nobel Laureate economist James Heckman: https://heckmanequation.org/resource/13-roi-toolbox/.

[34] North Carolina Task Force on Child Care & Early Education, 2025 Year-End Report, December 2025.

The crisis is fueled by multiple, interconnected issues: child care teachers can't afford to stay in the profession due to low wages and lack of benefits; parents struggle to find and pay for quality care due to lack of spaces and the high costs of care; child care programs struggle to stay open because what they take in does not cover their costs and they struggle to find and keep teachers; and employers are losing workers who can't access affordable child care.

In November of 2025, the CFTF Intentional Death Prevention Committee learned about the work of the NC Task Force on Child Care & Early Education, established by Governor Josh Stein in March of 2025 to identify opportunities to improve access to affordable, high-quality child care and early education in North Carolina.[35] The committee also heard about the report Empowering Work: How Increasing Employment Among Parents of Young Children Can Grow North Carolina's Economy, a joint project by the NC Department of Commerce and NC Child.

Some findings from the 2024 *Empowering Work* report include the following:

- One in five North Carolina employers attribute hiring challenges to lack of access to child care.
- 100,000 fewer working-age parents with young children participated in North Carolina's labor force in 2023 than in 2019.
- An estimated 14,498 – 31,067 working-age North Carolinians with young children could have potentially returned to the workforce in 2023; these new 2023 labor market entrants would have created an additional $5.7 – $13.3 billion in annual economic output for North Carolina.
- From 2000 to 2023, the price of child care in the U.S. rose 123%, outpacing overall inflation of 77%.
- The average annual cost of center-based care in North Carolina for one infant is nearly $13,000 and a toddler's care is $11,500 annually.
- North Carolina's licensed, high-quality child care professionals could only serve 66% of children with all parents in the labor force.

Many state leaders, experts, and advocates have been discussing strategies to address the child care crisis, and there seems to be broad recognition that multiple strategies are needed to make significant progress. The NC Task Force on Child Care & Early Education has developed six recommendations to address the child care crisis, the first of which is to set a statewide child care subsidy reimbursement rate floor.[36] This recommendation requires state funding and overlaps with the recommendation being made by the CFTF to support growth and expansion of investments in the early child care system, including increases for child care subsidies. The *Empowering Work* report also highlights how public investments to enhance the child care subsidy program, starting with creating a statewide floor for subsidy reimbursements, would help address the crisis.

[35] The ID Committee heard updates from Samantha Cole, the Department of Commerce Child Care Business Liaison & staff to the NC Task Force on Child Care & Early Education.

[36] North Carolina Task Force on Child Care & Early Education, 2025 Year-End Report, December 2025.

Child care subsidies help eligible families afford child care, but only a fraction of eligible North Carolina families are actually getting child care subsidies.[37] There is not enough subsidy funding to meet the need and North Carolina's subsidy reimbursement rates for child care providers do not cover their costs. Subsidy reimbursement rates are set by the NC General Assembly and on average, current subsidy reimbursement rates only cover about half of what it costs providers to deliver services, and rates are lower in rural counties.[38] Increasing subsidy reimbursement rates ensures that child care providers get a rate that is closer to covering the actual cost of care delivery, which helps providers keep teachers, keep their doors open, and serve more children who qualify for subsidies.[39]

While multiple strategies will need to be implemented to address the current child care crisis, significant progress cannot be made without increased state investments. The 2025 Year-End Report from the NC Task Force on Child Care and Early Education noted, "Panelists warned that without meaningful public investment in our state's child care and early education system, the state would likely see more closures of child care programs that are critical for our children, working parents, and our state's economy."

ADMINISTRATIVE EFFORT: Continue to study maternity care deserts and strategies to improve maternal and infant care with continued study of licensure for certified professional midwives, expanded use of doulas, workforce expansion and support, and the impact of funding shifts and changes on this population.

This administrative effort encompasses several issues the Perinatal Health Committee wants to study further to inform potential future recommendations to prevent infant deaths, improve birth outcomes and address the problem of maternity care deserts. For many years, North Carolina had an infant mortality rate that was among the highest dozen in the nation. Latest data from 2024 shows a significant decrease in our state's infant mortality rate, going from 6.9 per 1,000 live births in 2023 to 6.3 in 2024, which is a historic low for our state. This moves North Carolina from the 10th highest rate in 2023 to the 18th highest in 2024 when compared with other states.[40] However, the Black/white disparity in infant mortality remains virtually unchanged, with a ratio of 2.98 in 2024 compared with the 2023 ratio of 3.02. During the 5-year period 2020 to 2024, North Carolina's Black infants experienced death rates 2.74 times higher than white infants.[41]

21% of NC counties are maternity care deserts: they have no obstetric clinicians AND do not have a hospital or birth center offering obstetric care

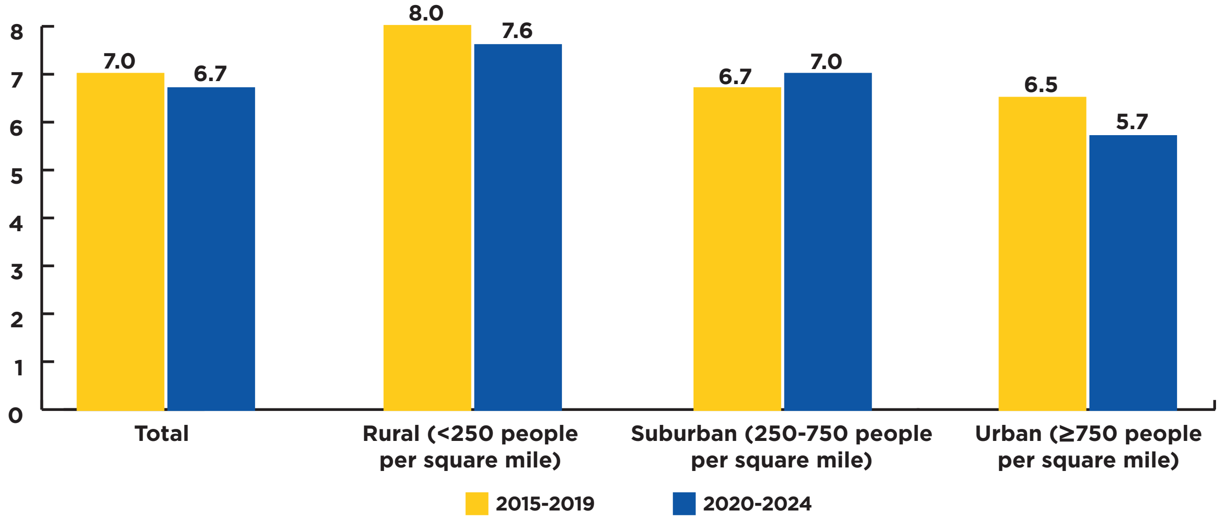
Quality care during pregnancy, delivery, and in the postpartum period is critical, yet for many the best care is not available or hard to access. According to the latest data from the March of Dimes, in North Carolina 21% of counties are defined as maternity care deserts, meaning they do not have a hospital or birth center offering obstetric care *and* they do not have an obstetric clinician, which is defined as an obstetrician, a family physician who provides obstetric care, a nurse midwife, or a certified midwife.[42] In rural areas in North Carolina, 60% of women do not have a birthing hospital within 30 minutes, and some women must travel an hour to reach the nearest birthing hospital.[43] "The farther a woman travels to receive

[37] Data source: Division of Child Development and Early Education, NC Department of Health and Human Services.
[38] 2025 Year-End Report. December 2025. North Carolina Task Force on Child Care & Early Education.
[39] "Empowering Work: How Increasing Employment Among Parents of Young Children Can Grow North Carolina's Economy." October 2024. NC Department of Commerce and NC Child.
[40] Data from the NCDHHS Division of Public Health - Title V Office, in conjunction with the State Center for Health Statistics, Division of Public Health.
[41] Ibid.
[42] J, Lucas, R, Stoneburner, A, Brigance, C, Hubbard, K, Jones, E, Mishkin, K. Where You Live Matters: Maternity Care Deserts and the Crisis of Access and Equity in North Carolina. March of Dimes. 2023. https://www.marchofdimes.org/peristats/reports/north-carolina/maternity-care-deserts.
[43] Ibid.

maternity care, the greater the risk of maternal morbidity and adverse infant outcomes, such as stillbirth and NICU admission."[44] The chart below illustrates rural differences in infant death rates.[45]

INFANT DEATH RATES ARE HIGHER IN RURAL AREAS OF NORTH CAROLINA

Infant Death Rates* by Urban/Rural Status (as defined by NC Rural Center), NC Residents 2015-2019 & 2020-2024



NC Rural Center Classifications: https://www.ncruralcenter.org/how-we-define-rural/

*Source: NCDHHS, Division of Public Health, Title V Office analysis of NC Resident Death Certificate Data * Deaths per 1,000 live births*

Certified Professional Midwives

For the past two years, the Perinatal Health Committee has been studying the topic of the potential for North Carolina to license Certified Professional Midwives (CPMs). This topic was of interest to the Task Force because of the shortage of maternity care providers in North Carolina and the need to examine ways to meet maternity care needs, especially in rural areas. A Certified Professional Midwife is "trained and credentialed to offer expert care, education, counseling and support to birthing people during the pregnancy, birth, and the postpartum periods. CPMs practice as autonomous health professionals working within a network of relationships with other care providers who can provide consultation and collaboration when needed."[46] All CPMs meet the standards for certification set by the North American Registry of Midwives. **CPMs are not licensed to practice in North Carolina, although in 37 other states CPMs have a path to licensure.**[47] Certified Nurse Midwives (CNMs) are different than CPMs and are already licensed to practice in North Carolina.

During its meetings in 2025, the Perinatal Health Committee heard perspectives on the licensing of CPMs from multiple organizations including: the NC Association of Certified Professional Midwives; the NC Association of Certified Nurse Midwives; the NC OB-GYN Society; the NC Pediatric Society; the NC College of Emergency Physicians; and the NC Academy of Family Physicians. Some organizations shared evidence and perspectives on how the licensing of CPMs will help address the maternity care desert problem and produce more positive birth outcomes; other organizations shared concerns about

[44] Ibid. See also: Lucas R, Thames T, Chestnut JF, DeMaria AL, Stoneburner A. Maternity Care Access and Infant Mortality. JAMA Netw Open. 2025 Nov 3;8(11):e2542831. doi: 10.1001/jamanetworkopen.2025.42831. PMID: 41217753; PMCID: PMC12606374.

[45] NCDHHS Division of Public Health, Title V Office analysis of NC Resident Death Certificate Data. Note that this data chart below was not available to or studied by the Task Force during its 2025-26 study cycle; it became available later when the 2024 child death data was finalized.

[46] According to the National Association of Certified Professional Midwives.

[47] "Who are CPMs?" National Association of Certified Professional Midwives. https://www.nacpm.org/whoarecpms?rq=path%20to%20licensure.

licensure. For its meetings in 2026, the committee will seek to hear from surrounding states about their experience with licensing and integrating CPMs and the outcomes they are seeing, and will also seek to learn more about the potential for better utilizing family practice physicians in maternity care.

Doula Services

Besides the need for quality clinical care, pregnant and postpartum mothers need to have care that ensures signs and symptoms of problems during pregnancy and the postpartum period, whether medical, psychological, or social, do not go unrecognized and unaddressed. They can also benefit from support and education that facilitates a more positive and safe experience with pregnancy, delivery, and the challenges of postpartum life. This is where a doula comes in.

Doulas are not clinicians who can replace maternity care providers, but doula services are increasingly recognized as an effective means of improving maternal and infant health outcomes and experiences (including in maternity care deserts) and improving disparity gaps. Various experts and entities are encouraging expanded use of doulas, in fact this is among the policy priorities identified by the March of Dimes and a goal in the North Carolina Perinatal Health Strategic Plan. In 2024 and 2025, the CFTF recommended Medicaid reimbursement of doula services; this recommendation was made prior to various federal and state changes (and uncertainties) impacting Medicaid funding in North Carolina that began to unfold in 2025.

During its recent meetings, the Perinatal Health Committee heard from United Healthcare about their experience with members using doula services via the value-added benefit in Medicaid, and they reported significantly better birth outcomes with their population served by doulas compared to their whole delivery population and the state population. For meetings in 2026, the committee plans to examine more information on the expectations and standards for education and training for doulas, and on the effective integration of doulas in health care systems.

Understanding the maternal desert landscape and new funding challenges for perinatal health

Also during recent meetings, the Perinatal Health Committee heard about the work of the Maternal Care Desert Workforce Solutions Action Team that is a collaborative effort between NCDHHS and the NC Institute of Medicine to bring experts together to identify possible solutions and recommendations related to maternal care deserts. They learned about themes the Action Team was exploring, and the committee looks forward to hearing final recommendations from the team in the future.

An important issue that impacts maternal and infant health is funding, and 2025 saw some dramatic changes in the funding landscape. The Perinatal Health Committee heard a presentation from the NC Healthcare Association about the hospital impacts of federal H.R. 1 and about hospitals' investments in perinatal health. Some of the key takeaways from that presentation include how hospitals are impacted by the reduction of the provider tax threshold and states' directed payment programs (among other impacts), and under H.R. 1, North Carolina hospitals will lose approximately $32 billion over the next 10 years and will have to make changes. Although Rural Health Transformation Program Funds are coming to the state, this funding will not come close to making up for the losses. Hospitals have invested in a variety of programs that support perinatal health, but the impacts of the lost funding to hospitals on those programs is unknown and there is a concern that changes will negatively impact perinatal programs. As the funding landscape in maternal and infant health continues to change, the Perinatal Health Committee will seek to understand the impact on the access to and quality of care for mothers and infants.

*ADMINISTRATIVE EFFORT: Continue to gather information on Paid Family and Medical Leave Insurance including the employer and business perspective.

Paid Family and Medical Leave Insurance (PFMLI) has been a topic of interest to the Task Force since 2017. Task Force work on PFMLI led to an independent study by Duke University on the costs and benefits of Paid Family Leave Insurance in North Carolina that was published in 2019; among its findings were that Paid Family Leave Insurance in North Carolina could save 26 infant lives per year.[48] In 2020, the Task Force recommended legislation to address Paid Family Leave Insurance. In 2021, the Perinatal Health Committee recommended repeating this recommendation, but the Task Force did not approve it as some members wanted more input from the business community. More recent involvement of the Task Force with PFMLI has included administrative efforts in 2024 and 2025 for further study of this topic, with a focus on learning more about the business impacts and employer perspective on PFMLI.

Paid Family and Medical Leave Insurance and Its Relevance to the Child Fatality Task Force

Most working people in the U.S. do not have paid family leave and access worsens for lower wage workers.[49] PFMLI is a specific type of paid family and medical leave that is publicly provided and operates statewide. PFMLI programs are operating or are soon to be implemented in 15 states, and Virginia was the most recent state to pass laws to implement a PFMLI program.[50] The structure of these programs can vary widely, with each state approaching this policy a bit differently.[51] PFMLI utilizes a state-managed fund which lets all workers earn a portion of their pay while they care for their own serious health condition, for a family member with a serious health condition, or for birth or adoption (and sometimes foster placement) of a child. This type of leave is different from sick leave which involves very short-term absences. In PFMLI programs, employees (and sometimes employers too) pay an insurance premium as a percent of income (e.g., .35%) into a fund from which they can draw for qualified leave purposes – e.g., an employee might pay $1.50 - $4.50 per week. Eligibility for benefits may include a certain number of minimum hours worked or minimum earnings in the past year. An employee eligible for PFMLI would receive a certain percentage of wages, typically with a weekly maximum cap.

Evidence on the benefits of Paid Family Leave and Paid Family and Medical Leave Insurance on the health and well-being of children and families is clear. Access to paid family leave supports overall child and family well-being, and can also prevent child maltreatment and even deaths. The Duke study noted above found 26 infant lives could be saved per year if North Carolina had Paid Family Leave Insurance, and a 2020 study of California's paid family leave insurance policy showed that its implementation was associated with a 12 percent reduction in post neonatal mortality.[52] Other studies have shown the preventive impacts of PFMLI on child maltreatment and/or infant mortality.[53]

[48] Gassman-Pines, A. & Ananat, E.O. (March 2019). *Paid Family Leave in North Carolina: An Analysis of Costs and Benefits*. Center for Child and Family Policy, Sanford School of Public Policy, Duke University. The study is posted on the CFTF website: https://webservices.ncleg.gov/ViewDocSiteFile/81983.

[49] See: Bureau of Labor Statistics data showing worker access to different types of paid leave: https://www.bls.gov/charts/employee-benefits/percent-access-paid-leave-by-wage.htm

[50] "Virginia Becomes First Southern State to Pass Paid Leave, Setting Example for a National Affordability Agenda." Website for A Better Balance. March 13, 2026. https://www.abetterbalance.org/virginia-becomes-first-southern-state-to-pass-paid-leave-setting-example-for-a-national-affordability-agenda/.

[51] For more information about the structure of PFMLI programs in other states, visit this page on the U.S. Department of Labor website: https://www.dol.gov/agencies/wb/paid-leave/State-Paid-Family-Medical-Leave-Laws. See also: website for A Better Balance, *Interactive Overview of Paid Family and Medical Leave Laws in the United States:* https://www.abetterbalance.org/family-leave-laws/.

[52] Montoya-Williams D, Passarella M, Lorch SA. The impact of paid family leave in the United States on birth outcomes and mortality in the first year of life. Health Serv Res. 2020; 55: 807–814. https://doi.org/10.1111/1475-6773.13288

[53] See, e.g., Tanis, Klein, Boyke (June 2024). State paid family leave policies and infant maltreatment, Child Abuse and Neglect, Volume 152 https://doi.org/10.1016/j.chiabu.2024.106758; Bullinger LR, Klika B, Feely M, Ford D, Merrick M, Raissian K, Rostad W, Schneider W. Paid Family Leave: An Upstream Intervention to Prevent Family Violence. J Fam Violence. 2023 Jan 17:1-11. doi: 10.1007/s10896-022-00486-3. Epub ahead of print. PMID: 36685754; PMCID: PMC9843119; Klevens J, Luo F, Xu L, Peterson C, Latzman NE. Paid family leave's effect on hospital admissions for pediatric abusive head trauma. Inj Prev. 2016 Dec;22(6):442-445. doi: 10.1136/injuryprev-2015-041702. Epub 2016 Feb 11. PMID: 26869666; PMCID: PMC4981551.

A variety of organizations have recognized these prevention impacts, for example:

- Access to paid leave is cited by the Centers for Disease Control and Prevention (CDC) as an economic support strategy that can prevent child maltreatment.[54]
- Promoting access to paid leave is among the goals identified in the North Carolina Perinatal Health Strategic Plan and among the priorities identified by the March of Dimes.[55]
- The American Academy of Pediatrics (AAP) published a policy statement citing the research on the positive effects of PFML on the physical and mental health of infants, children, and their families and said that Paid Family and Medical Leave was a "key component of improving the health of children and families and is critically needed in the U.S."[56]

With respect to employer impacts of PFMLI, studies show that Statewide PFLI programs are generally viewed by employers as having a positive effect or no noticeable effect on them. In fact, a 2023 review of the research on this topic stated that "research on US employers has shown no adverse impacts of state PFL policies on a range of employer outcomes."[57]

Addressing the 2024 and 2025 CFTF Administrative Items to gather more information, focusing on the employer perspective

There are no known studies or surveys to ascertain North Carolina employers' perspectives on the concept of Paid Family and Medical Leave Insurance in North Carolina. With no existing research to draw from, a project was undertaken in 2024 to address the Task Force administrative item that called for gathering feedback from the business community on PFMLI.[58] Given limited resources, the project was small in scope and its intent was to begin to understand the thoughts of the business community.[59]

Project leaders shared with the Perinatal Health Committee and the Task Force about their outreach to the business community and what they learned from a small number of participants. In general, participants they spoke with knew very little about PFMLI. When the concept of PFMLI was explained, participants could understand the benefits of PFMLI but some were concerned about implementation and wanted more specific information, especially from employers in other states about their experience implementing PFMLI. Among several take-aways was the need for a much larger and better resourced effort to get meaningful feedback from the business community and to educate the business community about PFMLI including what employers in states with PFMLI are experiencing, all of which would require the involvement of an organization who could undertake this work.

This led to the 2025 administrative item for "efforts to explore partnerships in our state to advance a conversation about Paid Family and Medical Leave Insurance and bring a report on developments back to the Task Force." Project leaders then worked to identify potential partners who were qualified and willing to assist with this project even though there was no funding available for the work.

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[54] Fortson, B. L., Klevens, J., Merrick, M. T., Gilbert, L. K., & Alexander, S. P. (2016). Child Abuse and Neglect Prevention Resource for Action: A Compilation of the Best Available Evidence. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/pdf/CAN-Prevention-Resource_508.pdf

[55] See the 2022-2026 NC Perinatal Health Strategic Plan, https://wicws.dph.ncdhhs.gov/phsp/inequities.htm; and the March of Dimes 2025-2026 Policy Priorities, https://www.marchofdimes.org/sites/default/files/2025-01/2025_2026_OGA_Policy_Priorities.pdf.

[56] Christiane E. L. Dammann, Kimberly Montez, Mala Mathur, Sherri L. Alderman, Maya Bunik, COUNCIL ON COMMUNITY PEDIATRICS, COUNCIL ON EARLY CHILDHOOD, SECTION ON BREASTFEEDING, SECTION ON NEONATAL PERINATAL MEDICINE; Paid Family and Medical Leave: Policy Statement. Pediatrics November 2024; 154 (5): e2024068958. 10.1542/peds.2024-068958.

[57] This Public Health Journal Article summarizes much of the research on PFMLI, and it summarizes findings from various studies related to employer impact: Ann Bartel, Maya Rossin-Slater, Christopher Ruhm, Meredith Slopen, Jane Waldfogel. 2023. The Impacts of Paid Family and Medical Leave on Worker Health, Family Well-Being, and Employer Outcomes. *Annual Review Public Health*. 44:429-443. https://doi.org/10.1146/annurev-publhealth-071521-025257.

[58] These efforts involved a collaboration by the Task Force Executive Director with individuals working with the NC Essentials for Childhood Project, which is managed by North Carolina Institute of Medicine in partnership with the NCDHHS Division of Public Health. Essentials for Childhood is a CDC-funded project aimed at preventing child abuse and neglect. Those assisting were Lisa Finaldi and Beth Messersmith, and their expertise and efforts made this work possible.

[59] The project involved outreach to about 35 individuals representing employer associations, chambers of commerce, and individual businesses, and nine of those 35 individuals elected to provide feedback.

In December of 2025, a partnership was identified: a graduate student consulting team at the Sanford School of Public Policy at Duke University, supervised by a Duke faculty member. Although a comprehensive project would involve gathering information from employers in other states and using that information to help educate North Carolina employers about PFMLI and make efforts to gather their feedback on it, the student group had only one semester to perform the project. As a result, the student project was limited to the first phase of information gathering from other states, with hopes to identify other partners to undertake the next phase of the project in the future.

The policy question provided to the Duke student team was as follows:

> *What economic and business impacts have been experienced in states who have implemented a Paid Family and Medical Leave Insurance Program (PFMLI), how have these impacts varied by business size and sector, and what impacts should North Carolina anticipate were it to enact and implement a PFMLI program? Are there policy features that have been shown to mitigate any potential harmful impacts?*

GOALS of the project included the following (abbreviated here):

- **Identify and briefly summarize any new research** on economic and business impacts and outcomes of PFMLI on employers in states that have implemented a PFMLI program, noting a state's size, geography, main sectors/industries, etc. as compared to North Carolina…
- **Prepare 3-4 case studies** of 3-4 states where a PFMLI program has been implemented and involve interviews with stakeholders representing business associations, businesses of varying sizes and industry sectors…
- **Based upon the case studies, provide an analysis of the most common economic/business impacts of PFMLI.**

A four-person graduate student team from Duke University began their work in January of 2026 and will complete their project in April of 2026. Results will be reported to the CFTF Executive Director when the project is completed, and will be shared with the Perinatal Health Committee when they meet again later in 2026. The CFTF has this PFMLI administrative item on its 2026 Action Agenda for further study as it continues efforts to gather more information, including the employer and business perspective.

Recommendations to prevent youth suicide, promote youth mental health, and prevent firearm deaths and injuries

*RECOMMENDATION: Support recurring funds to increase the numbers of school nurses, social workers, counselors and psychologists to support the physical and mental health of students and to move North Carolina toward achieving nationally recommended ratios for these professional positions in schools.

Supporting youth mental health and preventing youth suicide continue to be an important focus of the CFTF. The latest data from 2024 showed a decrease in youth suicide rates in North Carolina, yet in 2024, suicide was the leading cause of death among children ages 10 to 14, and the fourth leading cause of death among teens age 15 to 17.[60] In 2024, North Carolina lost 44 children age 10 to 17 to suicide. And each year, there are thousands of emergency department visits for self-injury among 10 to 17-year-olds.

The following data presented to the Intentional Death Prevention Committee of the Task Force provides insight into some of the circumstances surrounding youth suicides in North Carolina.

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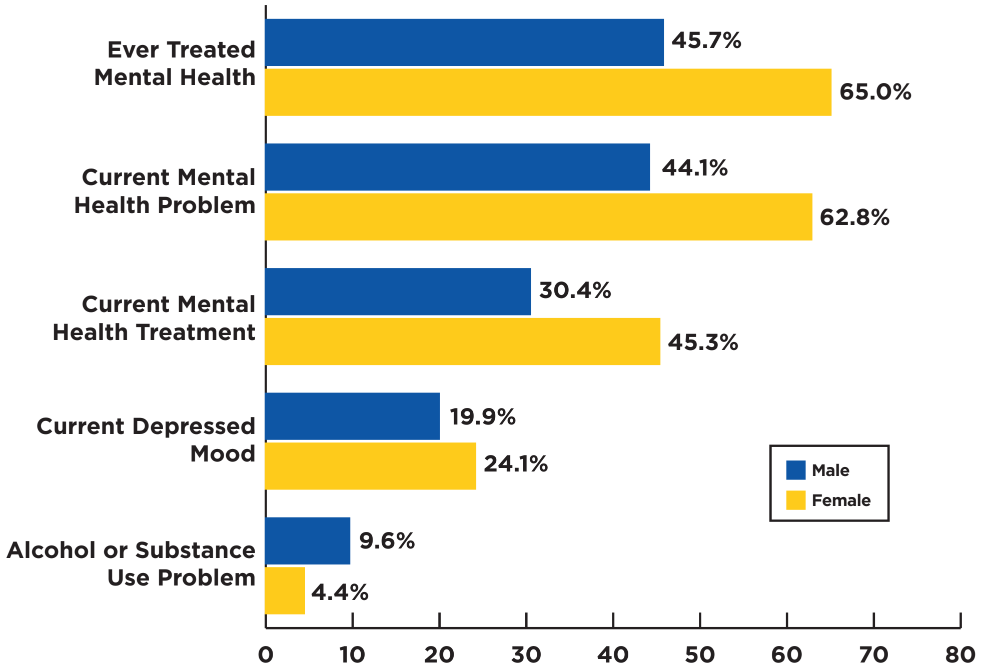
[60] Data from the NCDHHS Division of Public Health - Title V Office, in conjunction with the State Center for Health Statistics, Division of Public Health.

HALF OF CHILDREN WHO DIED BY SUICIDE HAD A CURRENT MENTAL HEALTH PROBLEM

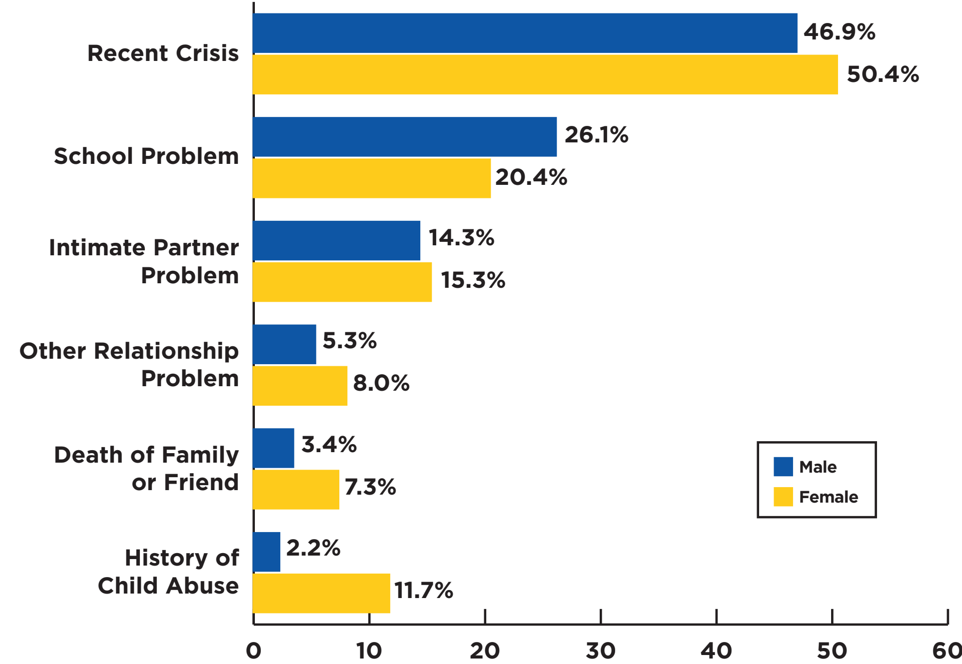
Females were more likely to experience a current or previous mental health problem or were currently undergoing treatment. Males were more likely to have an alcohol/substance use problem.



Circumstances known for 94.7% of males and 95.1% of females | Limited to NC Residents ages 10-17
Source: NC-VDRS (2014-2023) | NCDHHS Division of Public Health; Injury and Violence Prevention Branch; Epidemiology, Surveillance, and Informatics Unit

NEARLY HALF OF CHILDREN WHO DIED BY SUICIDE HAD EXPERIENCED A RECENT CRISIS

Females were more likely to experience recent crisis, a relationship problem, death of family/friend, or history of child abuse. Males were more likely to have a school-related problem.



Circumstances known for 94.7% of males and 95.1% of females | Limited to NC Residents ages 10-17
Source: NC-VDRS (2014-2023) | NCDHHS Division of Public Health; Injury and Violence Prevention Branch; Epidemiology, Surveillance, and Informatics Unit

These data illustrate how common it is for youth who die by suicide to have experienced mental health issues or crises of various types. Also, the latest Youth Risk Behavior Survey data from 2023 showed that among North Carolina high school students, 18% reported seriously considering suicide in the past 12 months and for gay, lesbian, or bisexual students it was 37%.[61] Thirty-nine percent of high school students reported feeling sad or hopeless and only 55% reported that they feel good about themselves.[62]

These mental health issues, crises, and various struggles that youth are dealing with aren't confined to home and family; they are with children when they come to school, a place where they are likely to spend more time than anywhere else other than home. A robust team of school nurses, social workers, counselors, and psychologists is critical to recognizing and supporting youth with these kinds of issues. Yet the latest data from the NC Department of Public Instruction shows NC continues to fall far short of having robust teams:[63]

SPECIALIZED INSTRUCTIONAL SUPPORT PERSONNEL RATIOS

School Counselors	2025	1:367	Recommended	1:250	68%
School Social Workers	2025	1:1,055	Recommended	1:250	24%
School Psychologists	2025	1:1,954	Recommended	1:500	26%
School Nurses	2025	1:876	Recommended	1 per school	51%

These professionals play an important role in many ways in supporting students' needs which include:

- Identifying a child who is struggling or at risk, whether the struggle is with emotional/mental health issues, dealing with a crisis, suicide ideation, bullying, food or housing insecurity, abuse or neglect, or even at risk of harming others.
- Connecting a child and their family to mental health and/or community resources to address individual or family needs.
- Developing and implementing school-wide programs and training that can support mental and physical health and improve the school environment.
- Providing individual and group counseling.
- Identifying and addressing health conditions or learning challenges and needs.

Other experts and organizations agree that having enough of these health support professionals in schools is an important aspect of supporting student mental health. For example, this was noted in the 2021 U.S. Surgeon General's Advisory on the Youth Mental Health Crisis and in the North Carolina 2023 School Behavioral Health Action Plan. It was also the focus of a September, 2023 article in the North Carolina Medical Journal titled, "Specialized Instructional Support Personnel (SISP): A Promising Solution for North Carolina's Youth Mental Health Crisis."[64]

This recommendation is also reinforced by research reported to the CFTF that teens want emotional support but would rather get in-person support from local professionals like school nurses or counselors compared to AI chatbots (see administrative item below addressing AI chatbots).

The poor status of youth mental health and poor ratios for these school professionals led to an assigned grade of "F" in mental health and "F" in school health on the 2025 North Carolina Child Health Report Card, a joint project of the NC Institute of Medicine and NC Child. It's clear that more of these professionals are essential to effectively support the needs of North Carolina students.

[61] 2023 NC High School Youth Risk Behavior Survey (YRBS), US Centers for Disease Control and Prevention.
[62] Ibid.
[63] Data provided by NC Healthy Schools of the NC Department of Public Instruction.
[64] Close J, Schmal S, Essick E, Scott DN, Shankar M. Specialized Instructional Support Personnel (SISP): A Promising Solution for North Carolina's Youth Mental Health Crisis. North Carolina Medical Journal. 2023;84(5). doi:10.18043/001c.87524

*RECOMMENDATION: Endorse legislation that addresses addictive algorithms in social media that harm children.

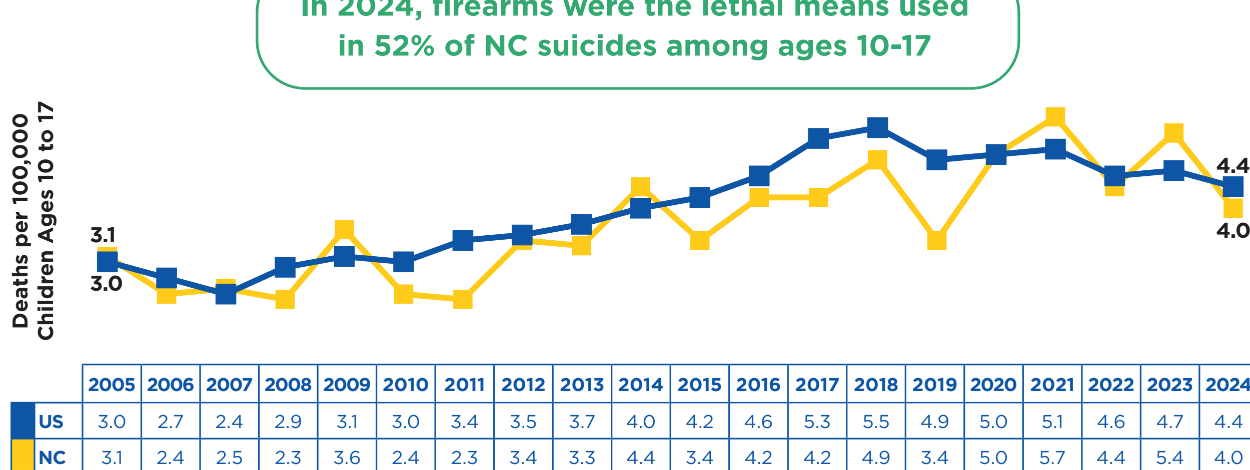
In 2025, the CFTF heard from a young adult about her experiences in early adolescence with social media, illustrating how because of algorithms, benign use of a social media platform can take the user to extreme and harmful content. She explained how she was looking at, but not clicking on swimsuit ads, whereupon the algorithm began showing her not only more swimsuit ads but also extreme fitness content, then diet content, then eating disorder content that would teach a teen how to have an eating disorder and hide it from parents. She said she didn't choose the content, but the algorithm kept feeding it to her. Because the platform was created by adults, as a young teen she assumed that adults wanted her to see this content and she began matching her behavior to this content. She worked with her therapist to report the ads that made her uncomfortable but nothing was done about it and she continued to see her feed filled with eating disorder content.

A 2023 Gallup study showed that teens spend an average of 4.8 hours a day on social media.[65] Yet frequent social media use may be associated with changes in the developing brain, and kids who spend more than three hours a day on social media face double the risk of poor mental health.[66] A 2025 study found that kids with high or increasingly addictive use patterns with social media and mobile phones had a two to three times greater risk of suicidal behaviors and ideation, and worse mental health.[67]

Youth suicide rates in North Carolina were lower in 2024 compared to 2023 or when they peaked in 2021, but looking at a 20-year period, youth suicide rates have been on the rise.[68]

AMONG CHILDREN AGES 10 TO 17, SUICIDE RATES HAVE INCREASED OVER THE LAST 20 YEARS IN BOTH THE US AND NC

Suicide Rates, Ages 10 to 17: US & NC 2005-2024*



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
US	3.0	2.7	2.4	2.9	3.1	3.0	3.4	3.5	3.7	4.0	4.2	4.6	5.3	5.5	4.9	5.0	5.1	4.6	4.7	4.4
NC	3.1	2.4	2.5	2.3	3.6	2.4	2.3	3.4	3.3	4.4	3.4	4.2	4.2	4.9	3.4	5.0	5.7	4.4	5.4	4.0

** Suicides include the following ICD mortality codes : X60-X84 (Intentional self-harm; Y87.0 (Sequelae of intentional self-harm), U03 (Suicide Terrorism) | Source: NC State Center for Health Statistics & CDC/National Center for Health Statistics*

[65] Gallup Familial and Adolescent Health Survey. 2023. https://news.gallup.com/poll/512576/teens-spend-average-hours-social-media-per-day.aspx.

[66] "Social Media and Youth Mental Health: The U.S. Surgeon General's Advisory." 2023. https://www.hhs.gov/surgeongeneral/reports-and-publications/youth-mental-health/social-media/index.html.

[67] Xiao Y, Meng Y, Brown TT, Keyes KM, Mann JJ. Addictive Screen Use Trajectories and Suicidal Behaviors, Suicidal Ideation, and Mental Health in US Youths. JAMA. 2025 Jul 15;334(3):219-228. doi: 10.1001/jama.2025.7829. PMID: 40531519; PMCID: PMC12177733.

[68] NCDHHS Division of Public Health, Title V Office analysis of NC Resident Death Certificate Data. Note that this data chart below was not available to or studied by the Task Force during its 2025-26 study cycle; it became available later when the 2024 child death data was finalized.

Concern about the role social media is playing in the worsening status of youth mental health has been widespread. Some examples of this concern include the following:

- In 2023, the **U.S. Surgeon General** issued an Advisory on Social Media and Youth Mental Health, and in 2024 the Surgeon General called for a warning label of social media platforms.
- In 2023, the **American Academy of Child & Adolescent Psychiatry** issued a Policy Statement on the Impact of Social Media on Youth Mental Health.
- In 2023, the **American Psychological Association** issued a Health Advisory on Social Media Use in Adolescence.
- The **American Academy of Pediatrics** has a "National Center of Excellence on Social Media and Youth Mental Health," which developed a policy addressing Digital Advertising to Children, and also publishes various blogs and resources for pediatricians related to this topic.
- In October of 2023, then **North Carolina Attorney General** Josh Stein joined 41 other attorneys general when it sued Meta, which owns social media platforms Instagram and Facebook, related to the harm their platforms cause to young people.

Already this year, some juries in the U.S. have found that technology companies have harmed young users, with harms related to social media platforms' addictive design features and dangerous content as well as insufficient safety protocols that allowed sexual predators to contact minors.[69]

The CFTF first made this recommendation for legislation to address harmful social media algorithms in 2024. Prior to that, the CFTF heard from a national expert on social media and adolescent mental health, Dr. Eva Telzer of the University of North Carolina.[70] Dr. Telzer explained that social media use by youth is not inherently beneficial or harmful; the impacts depend on many factors related to the individual using it (strengths and vulnerabilities, time online, how they use it) and the social media platform (content, algorithms, functions). Some adolescents can benefit from finding affinity/identity communities, immediate social support, increasing diversity of their peers, and online civic engagement. However, there are a number of negative impacts, many of which are complicated by the fact that the adolescent brain is still developing.

Among the research conveyed by Dr. Telzer to the Task Force was that nearly all adolescents report spending more time on social media than they intended, with one-quarter perceiving that they are "moderately" or "severely" addicted to social media. Half of adolescents report that being away from social media results in experiencing difficulties in engaging with daily life activities. Social media use can interfere with sleep, and poor sleep is linked to physical and mental health issues, risky behaviors, poor school performance, and altered brain development.

Representatives from the Young People's Alliance, an organization leading advocacy work on this topic, have explained to the CFTF how various policy strategies have been attempted by other states to address the problem, and in some cases strategies have been struck down by courts as unconstitutional. They believe their approach is the strongest and can avoid constitutional challenges, as it addresses addictive algorithms in social media by restricting a company's use of a minor's data, thereby making social media less targeted, a measure intended to make it less addictive and less likely to show the minor harmful content. This is the approach being endorsed by the Child Fatality Task Force.

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[69] See, e.g.: New Mexico Department of Justice Press Release on March 24, 2026; and Bobby Allyn, "Jury finds Meta and Google negligent in social media harms trial," NPR, March 25, 2026, https://www.npr.org/2026/03/25/nx-s1-5746125/meta-youtube-social-media-trial-verdict.

[70] Eva Telzer, PhD, is a Professor of Psychology and Neuroscience at UNC Chapel Hill. Dr. Telzer is an Associate Editor at *Child Development and Social Cognitive Affective Neuroscience*, and the co-director of the Winston National Center on Technology Use, Brain and Psychological Development.

ADMINISTRATIVE EFFORT: Continue to study the impact of AI (Artificial Intelligence) chatbots and companions on youth, including the study of design features.

In 2025, the CFTF began to learn about the impact of AI (Artificial Intelligence) chatbots and companions on youth, hearing from an academic expert at Michigan State University who studies this topic, Dr. Celeste Campos-Castillo, and from a policy expert from the Young People's Alliance, Ava Smithing.

Key takeaways from Dr. Campos Castillo's presentation include the following:

- Chatbots pose harm when users become overly reliant on them for emotional support.
- A majority of teens are using chatbots, but few use chatbots only for emotional support. Many use them for homework, and some may also then seek emotional support.
- Teens would prefer emotional support from local humans like school counselors or nurses instead of chatbots.
- To reduce harms to kids, we need to improve local resources for emotional support and regulate chatbot design.

Dr. Campos-Castillo explained that a chatbot mimics human conversation using AI. Chatbots that pose the most risk are the ones that don't give the user a list to choose from for questions, but allow the user to ask any question in a text box, and then the conversation looks like text messaging. Character-based chatbots are like text-based chatbots, but the chatbot has a personality that can be like a celebrity or a character custom built by the user, and this makes it seem more human – these are sometimes referred to as AI Companions. Both of these types of chatbots have been linked to suicide among teens and she shared examples of teens who have died.

Recently, the American Psychological Association, as part of its 2026 Trends Report, published an article "AI chatbots and digital companions are reshaping emotional connection." Two of the key points from the article, which highlights various studies related to the topic, are that research shows excessive use of these tools may worsen loneliness and erode social skills, and how experts and advocates are calling for guardrails and regulations to ensure user safety and well-being.

The CFTF heard from the Young People's Alliance about various federal and state policy approaches to address harms to youth from using AI chatbots and companions. When it meets again in the fall, the Intentional Death Prevention Committee will seek to continue to learn about this topic to inform future policy considerations.

*RECOMMENDATIONS on Firearm Safety:

- **Support recurring funding of $2.26 million for the NC S.A.F.E. Campaign that educates about firearm safe storage.**
- **Support legislation changing the current law addressing safe storage of firearms to protect minors to remove language from N.C.G.S. 14-315.1(a) that says "resides in the same premises as a minor."**

In the five year-period 2020 – 2024, over 525 North Carolina children ages 17 and younger died from firearm injuries.[71] Although firearm-related child death rates have declined since their peak in 2021, 2024 rates are still about two and a half times what they were in 2015.[72]

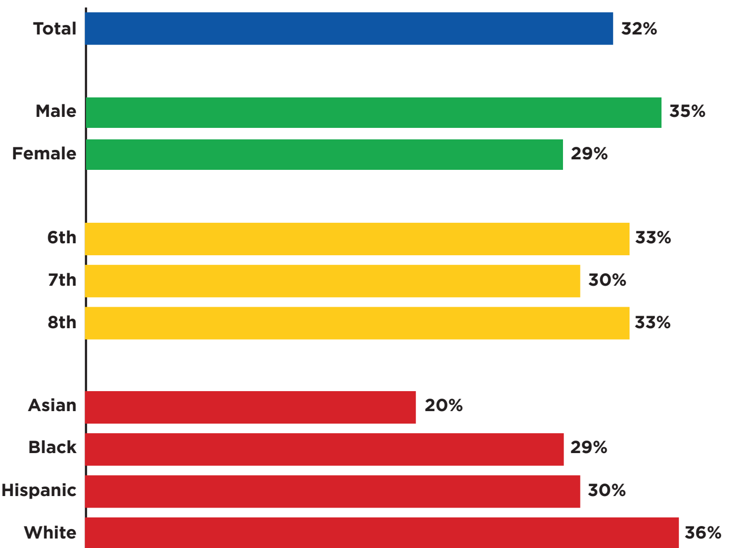
[71] Child Death Data Reports from the NC State Center for Health Statistics.
[72] Based on data from the NCDHHS Division of Public Health - Title V Office, in conjunction with the State Center for Health Statistics, NCDHHS Division of Public Health.

Evidence is clear that guns are often not stored safely and that reducing access to guns saves lives.

Studies have shown that most kids know where parents keep their guns, but parents often think they don't.[73] Also, most guns used in youth suicide and school shootings come from home. It's estimated that up to 32% of suicide and unintentional youth firearm deaths could be prevented through safe storage of firearms in homes with youths.[74]

A 2024 survey indicated that more than 40% of North Carolina adults have a firearm in or around their home; over two in five adults store their firearm loaded and nearly half of firearms that are stored loaded are also unlocked.[75] About 30% of North Carolina middle and high school students report that it would take them less than an hour to get and be ready to fire a loaded gun without a parent or other adult's permission.[76]

32% OF MIDDLE SCHOOL STUDENTS SAY THEY COULD BE READY TO FIRE A LOADED GUN IN LESS THAN AN HOUR WITHOUT A PARENT'S OR OTHER ADULT'S PERMISSION



**Gun could be theirs or someone else's and it could be located in their home or car or someone else's home or car*

^W > A (Based on t-test analysis, $p < 0.05$)

All Hispanic students are included in the Hispanic category. All other traces are non-Hispanic

This graph contains weighted results

Source: North Carolina Department of Public Instruction, Youth Risk Behavior Survey, 2023

When a firearm is not safely stored, there is also a risk of theft and that the stolen gun could be used in a crime or could be the cause of a child's injuries or death. North Carolina's Deputy Secretary for Juvenile Justice and Delinquency Prevention at the North Carolina Department of Public Safety, William Lassiter, has presented to the Unintentional Death Prevention Committee and explained how common it is for guns that are not safely stored to be stolen, especially from cars. He reported that from 2019 through 2024, 10,876 firearms were stolen from private citizens in North Carolina.

The NC S.A.F.E. Firearm Safe Storage Initiative is working, but needs funding to continue

The NC S.A.F.E. (Secure All Firearms Effectively) statewide initiative to encourage safe firearm storage practices has operated since May, 2023 through temporary funds but the need to educate gun owners is ongoing. In addition to broad outreach via its media campaign, NC S.A.F.E. has distributed over 150,000 gun locks; it has established many partnerships to share messaging and resources; and has programs for schools and health professionals. This initiative, which has roots in a Child Fatality Task Force recommendation, needs $2.26 million in recurring funds to continue. NC S.A.F.E. has been evaluated by RTI (Research Triangle International) and results show it's working! In fact, RTI recommended increased funding for NC S.A.F.E.

[73] Baxley F, Miller M. Parental Misperceptions About Children and Firearms. Arch Pediatr Adolesc Med. 2006;160(5):542–547. doi:10.1001/archpedi.160.5.542.

[74] Monuteaux MC, Azrael D, Miller M. Association of Increased Safe Household Firearm Storage with Firearm Suicide and Unintentional Death Among US Youths. JAMA Pediatr. 2019;173(7):657–662. doi:10.1001/jamapediatrics.2019.1078

[75] Information presented to the NC Child Fatality Task Force by the NCDHHS Division of Public Health, sourced from the 2024 North Carolina Behavior Risk Factor Surveillance System (BRFSS), Firearm Safety Module, https://schs.dph.ncdhhs.gov/data/brfss/2024/nc/all/topics.htm.

[76] According to the 2021 and 2023 North Carolina Youth Risk Behavior Surveys.

Findings shared with CFTF on RTI evaluation results of NC S.A.F.E.[77]

Evidence of Progress Across Outcomes

Findings are based on a two-wave survey conducted in 2025 among adult firearm owners in North Carolina, allowing comparison of outcomes over time and by campaign exposure.

There was increased awareness of safe firearm storage and NC S.A.F.E. messaging.

Over half (**58.8%**) of respondents recalled having seen at least one campaign advertisement in the past 3 months.

There was a meaningful shift in attitudes and beliefs about the risks of unsafe firearm storage.

Among campaign-exposed NC gun owners, average agreement with campaign-related safe storage beliefs reached **75%**.

There was movement toward safer firearm storage intentions.

From Wave 1 to Wave 2, there was a nearly **26-fold increase** in intent to secure firearms to prevent unintentional child injury among campaign-exposed respondents.

Strengthening North Carolina's law to protect children and youth

State laws that address access to guns by children and hold gun owners accountable for unsafe storage, often called "child access prevention laws," are proven to be an effective tool to prevent gun deaths and injuries to kids.[78] Such laws vary among states, and North Carolina enacted its child access prevention law in 1993 which has since remained unchanged. **North Carolina's current child access prevention law applies only to a gun owner or one who possesses a gun who *"resides in the same premises as a minor."* The recommended change from the Task Force is to remove this phrase about residing with a minor from the law** (see highlighted language below).

§ 14-315.1. Storage of firearms to protect minors.
(a) Any person who ~~resides in the same premises as a minor,~~ owns or possesses a firearm, and stores or leaves the firearm (i) in a condition that the firearm can be discharged and (ii) in a manner that the person knew or should have known that an unsupervised minor would be able to gain access to the firearm, is guilty of a Class 1 misdemeanor if a minor gains access to the firearm without the lawful permission of the minor's parents or a person having charge of the minor and the minor:
(1) Possesses it in violation of G.S. 14-269.2(b);
(2) Exhibits it in a public place in a careless, angry, or threatening manner;
(3) Causes personal injury or death with it not in self defense; or
(4) Uses it in the commission of a crime.
(b) Nothing in this section shall prohibit a person from carrying a firearm on his or her body, or placed in such close proximity that it can be used as easily and quickly as if carried on the body.
(c) This section shall not apply if the minor obtained the firearm as a result of an unlawful entry by any person.
(d) "Minor" as used in this section means a person under 18 years of age who is not emancipated.

A person who owns or possesses a gun who does not reside in the same premises as a minor may nevertheless be in situations where, for example, a child or teen (e.g., grandchild, nephew, neighbor, child they are babysitting) is visiting their home or riding in their car, and if their gun is not safely stored, the risks of what can happen when a child or teen accesses that gun are no different than they are for someone who resides with a child. Note that the law only applies under specific circumstances as stated in N.C.G.S. § 14-315.1 where the person knew or should have known that an unsupervised minor would be able to gain access to the firearm and under other specific circumstances detailed in the statute's language above.

[77] Information presented to the NC Child Fatality Task Force by the NC Department of Public Safety, Division of Juvenile Justice and Delinquency Prevention. Evaluation conducted by RTI (Research Triangle International). Evaluation showed a variety of positive results that show the campaign is working.

[78] Villarreal, S., Kim, R., Wagner, E. Somayaji, N., Davis, A., & Crifasi, C. K. (2024). Gun Violence in the United States 2022: Examining the Burden Among Children and Teens. Johns Hopkins Center for Gun Violence Solutions. Johns Hopkins Bloomberg School of Public Health. https://publichealth.jhu.edu/sites/default/files/2024-09/2022-cgvs-gun-violence-in-the-united-states.pdf.

At its meeting in February of 2026, the CFTF heard from the Chief of Police of Albemarle, who shared about his experiences dealing with tragedies that occur when firearms are not safely stored and a child dies, and how these tragedies extend far beyond a child's family to the whole community. He emphasized that these are preventable deaths and there is a need for a strong child access prevention law that is extended beyond those who reside with a child because the current law leaves too many children at risk.

Recommendations to prevent deaths and injuries from motor vehicle accidents

***RECOMMENDATION: Support legislation to strengthen NC's child passenger safety law to address best practices by making the following changes:**

1. **to address the importance of younger children riding in rear seat, require children under age 8 to be properly restrained in the rear seat of a vehicle when the vehicle has a passenger side front air bag and has an available rear seat;**
2. **to clarify the need for infants and toddlers to ride in rear-facing seats, modify law to say that a child must be properly secured in a weight and height-appropriate child passenger restraint system according to manufacturer instructions, including instructions for the use of rear-facing restraint systems for infants and toddlers;**
3. **to clarify safe transition from booster seat to adult seat belt, require a child to be properly secured in a weight-appropriate child passenger restraint system until the child is four feet 9 inches tall (57 inches) and the adult seat belt fits properly without a booster seat (law to describe proper fitting of seat belt).**

In 2024, 45 North Carolina children age 14 and younger died from motor vehicle accidents.[79] Proper use and placement of the right kind of child passenger safety seat (car seats and booster seats) to suit various stages of child growth and development can impact whether a child suffers injury or death in the event of a motor vehicle crash.

North Carolina's child passenger safety law (G.S. 20-137.1) differs from the best practice recommendations of the American Academy of Pediatrics and the National Highway Traffic Safety Administration. **Evidence shows that children are more likely to ride in the recommended type of child restraint when their state's law includes wording that follows best practice recommendations.**[80]

Many motor vehicle-related child deaths in North Carolina occur in circumstances where a child is completely unrestrained, but data also show deaths and injuries of young children who were restrained but riding in the front seat and of young children who were restrained only by a seat belt and not a child restraint system – neither of which reflects best practices for safety.[81]

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[79] 2024 Child Death Data Report from the NCDHHS Division of Public Health - Title V Office, in conjunction with the State Center for Health Statistics, Division of Public Health.

[80] Benedetti M, Klinich KD, Manary MA, Flannagan CA. Predictors of restraint use among child occupants. Traffic Inj Prev. 2017 Nov 17;18(8):866-869. doi: 10.1080/15389588.2017.1318209. Epub 2017 Apr 21. PMID: 28429962.

[81] Data presented to the Unintentional Death Prevention Committee of the Task Force by a representative from the NC Department of Transportation.

The Child Fatality Task Force, in consultation with child passenger safety experts, identified three areas of North Carolina's child passenger safety law that could be strengthened to better address best practice recommendations for safety that are based on research.

Task Force recommendations to strengthen the child passenger safety law were addressed in HB 368 in 2025 which passed the House unanimously; this bill was not taken up by the Senate in 2025 but remains eligible for consideration in 2026.

The "best practices" noted in the recommendations below are reflected in the American Academy of Pediatrics (AAP) Policy Statement from 2018.[82]

1. **Address the importance of younger children riding in the rear seat**
   Current law in North Carolina only requires that children under age 5 and less than 40 pounds ride in the back seat (in vehicles with a front passenger air bag and available rear seat).[83] Best practice is that children should ride in the back seat longer,[84] and nearby states such as Virginia, Tennessee, and South Carolina require riding in the rear seat (with some exceptions) for children under age 8. The Task Force is recommending that North Carolina's law require children under age 8 to be properly restrained in the rear seat of a vehicle when the vehicle has a passenger side front air bag and has an available rear seat.
2. **Clarify the need for infants and toddlers to ride in rear-facing seats**
   Best practice for infants and toddlers is that they ride in a rear-facing seat as long as possible according to the height and weight requirements for their car seat. North Carolina law does not explicitly address infants and toddlers riding in rear-facing seats but says that children must be "properly secured in a weight-appropriate child passenger restraint system."[85] The Task Force recommendation seeks to explicitly use wording about rear-facing seats by modifying North Carolina's law to say that a child must be properly secured in a weight- and height-appropriate child passenger restraint system according to manufacturer instructions, *including instructions for the use of rear-facing restraint systems for infants and toddlers*. The Task Force recommendation does not specify a certain age to be rear-facing because to do so could prompt a child to be moved prior to reaching the limits on a particular seat which is not best practice.
3. **For older kids, clarify safe transition from a booster seat to an adult seat belt**
   Seat belts are designed to fit adults. Booster seats position kids so that the seat belt fits properly – with a lap belt low on the hips and a shoulder belt across the collarbone. Best practice is for children to be in a booster seat until an adult seat belt fits properly without the booster seat. North Carolina law says: *"A child less than eight years of age and less than 80 pounds in weight shall be properly secured in a weight-appropriate child passenger restraint system."* The NORTH CAROLINA law does not address the transition from booster seat to adult seat belt according to proper fitting of the adult seat belt.

The Task Force is recommending a modification of North Carolina's law to require a child to be properly secured in a weight-appropriate child passenger restraint system until the child is four feet 9 inches tall (57 inches) and the adult seat belt fits properly without a booster seat, with the law to describe proper fitting of an adult seat belt as some other states (such as South Carolina) have done.[86] In developing a

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[82] Dennis R. Durbin, Benjamin D. Hoffman, COUNCIL ON INJURY, VIOLENCE, AND POISON PREVENTION, Phyllis F. Agran, Sarah A. Denny, Michael Hirsh, Brian Johnston, Lois K. Lee, Kathy Monroe, Judy Schaechter, Milton Tenenbein, Mark R. Zonfrillo, Kyran Quinlan; Child Passenger Safety. Pediatrics November 2018; 142 (5): e20182460. 10.1542/peds.2018-2460

[83] NC laws says: *"In vehicles equipped with an active passenger-side front air bag, if the vehicle has a rear seat, a child less than five years of age and less than 40 pounds in weight shall be properly secured in a rear seat, unless the child restraint system is designed for use with air bags."*

[84] While the best practice recommendations from the AAP in 2018 were to ride in the rear seat until age 13, experts consulted by the Task Force noted that more recent research is showing that the back seat may not be safer for older children given technology in newer cars, and the Unintentional Death Prevention Committee determined that under age 8, the same as surrounding states, was an appropriate recommendation.

[85] Since certain systems are designed for rear-facing use with size requirements, the NC law only implicitly requires rear-facing seats for infants and toddlers.

[86] S.C. Ann. Section 56-5-6410 (A)(4).

recommendation to address this transition, the Unintentional Death Prevention Committee considered information that technically, a child may have an adult belt fit them correctly well before they outgrow the maximum size requirements for a booster seat, so it did not recommend requiring a booster seat until the child "outgrows" the booster. The committee also learned from experts that referencing a child's height is more relevant than weight when it comes to proper fitting of an adult seat belt, and that 57 inches tall is an appropriate height to reference.

ADMINISTRATIVE EFFORTS: Educate about the Graduated Driver License (GDL), the importance of the science behind the GDL, and continue to get updates on the science surrounding the GDL to inform future work.

Looking at North Carolina data on child death rates and rates of emergency department visits due to motor vehicle accidents, the highest rates are among older teens.[87] Since 2022, rates of deaths from motor vehicle accidents significantly increased among teens ages 16 and 17.[88]

This is the age at which teens are learning to drive and becoming new, independent drivers. This is a vulnerable time for teens when it comes to driving, and the enactment of the Graduated Driver License (GDL) laws in 1997, which the CFTF helped to advance, proved to be very successful in bringing down crash rates with teens.

However, enacted and proposed state legislation in recent years has altered or sought to alter the GDL, and experts have explained how some changes weaken safety aspects of the GDL and put teen drivers and everyone on the road at greater risk of an accident.

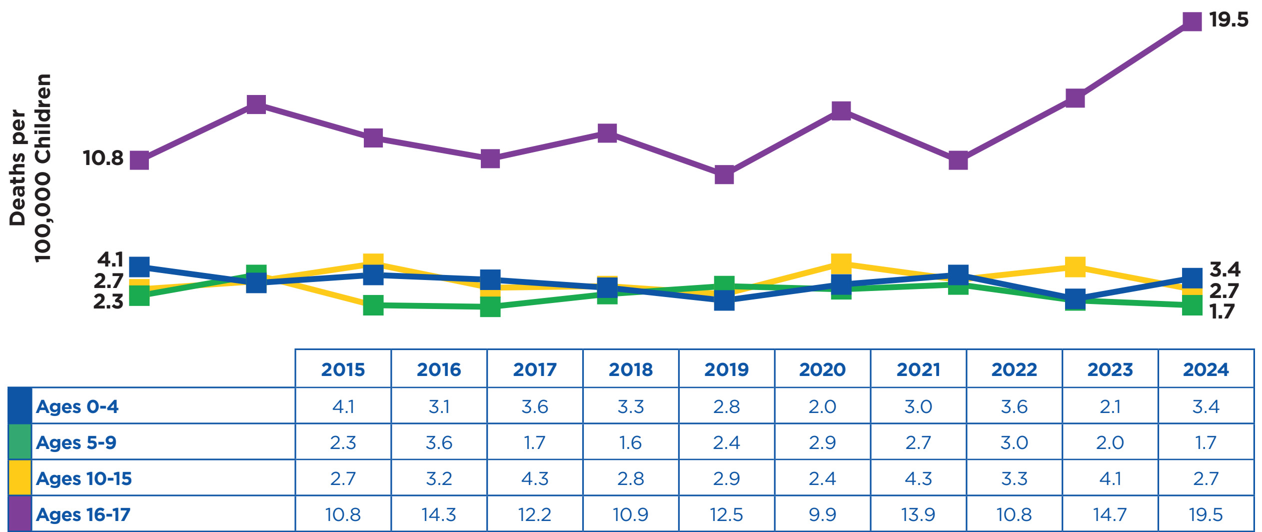
In 2025, the CFTF's Unintentional Death Prevention Committee heard presentations on the topic of teen driving and North Carolina's Graduated Driver License Program. The committee heard from Dr. Justin Owen, a scientist at the UNC Highway Research Center who specializes in teen driving, and Mark Ezzell, Executive Director of the Governor's Highway Safety Program.

[87] Presentation to the Unintentional Death Prevention Committee in October of 2025 of data sourced from: NC DETECT – ED Visits (2020-2024), NCDHHS Division of Public Health, Injury and Violence Prevention Branch, Epidemiology, Surveillance, and Informatics Unit.

[88] NCDHHS Division of Public Health, Title V Office analysis of NC Resident Death Certificate Data. Note that this data chart below was not available to or studied by the Task Force during its 2025-26 study cycle; it became available later when the 2024 child death data was finalized.

TEENAGERS OF DRIVING AGE (AGES 16-17) HAVE THE HIGHEST MVA MORTALITY RATES & THEIR RATES ROSE AGAIN IN 2024

Motor Vehicle Accident (MVA) Mortality Rates* by Age Group, Children Ages 0 to 17: NC, 2015-2024



	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Ages 0-4	4.1	3.1	3.6	3.3	2.8	2.0	3.0	3.6	2.1	3.4
Ages 5-9	2.3	3.6	1.7	1.6	2.4	2.9	2.7	3.0	2.0	1.7
Ages 10-15	2.7	3.2	4.3	2.8	2.9	2.4	4.3	3.3	4.1	2.7
Ages 16-17	10.8	14.3	12.2	10.9	12.5	9.9	13.9	10.8	14.7	19.5

** MVA deaths include the following ICD mortality codes: V02-V04,V09.0,V09.2,V12-V14,V19.0-V19.2,V19.4-V19.6, V20-V79,V80.3-V80.5,V81.0-V81.1,V82.0-V82.1,V83-V86,V87.0-V87.8,V88.0-V88.8, V89.0,V89.2 | Source: NCDHHS Division of Public Health, Title V Office analysis of NC Resident Death Certificate Data*

North Carolina's GDL and Recent Legislative Activities Surrounding the GDL

The Graduated Driver License (GDL) program was developed in North Carolina by experts at the UNC Highway Safety Research Center (HSRC) based on research, and North Carolina was the second state in the nation to pass a GDL law. North Carolina's current GDL law involves three levels of licensing, with a variety of requirements at each level. The following is an overview of requirements.[89]

- A Level 1 Limited Learner Permit allows driving only while accompanied by an experienced adult driver. After completing at least 9 months gaining experience, new drivers are then eligible for a Level 2 license. ***Note that the learning period had been 12 months since enactment of the GDL, until 2021 when the law changed it to six months and in 2023 the learning period was changed to nine months.***
- A Level 2 Limited Provisional License allows for mostly unsupervised driving, but adult accompaniment is still required when driving in certain conditions considered to be most dangerous—after 9 p.m., or with multiple young passengers. After 6 months at this level new drivers are eligible for a Level 3 license.
- A Level 3 Full Provisional License is almost like a regular driver license, with a few minor differences, that is issued to drivers under age 18.

In 2025, a proposed House Bill would have eliminated the learning period altogether, but it did not pass the House.[90] In committee hearings, legislators cited research from the UNC Highway Safety Research Center that gave rise to safety concerns about enacting such changes.

[89] See N.C.G.S. 20-11.

[90] H.B. 584.

Science Behind Teen Driving and the Graduated Driver License

Some of the facts about the science behind the GDL from the UNC Highway Safety Research Center include the following:[91]

- Teen driver fatal crashes in North Carolina have recently trended upward.
- Inexperience is the primary cause of teen driver crashes. An extensive period of learning allows teens to become familiar with a variety of driving situations, road types, as well as light and weather conditions in all seasons with an experienced driver supervising them.
- A full 12 months of a learning period for the GDL is considered the "gold standard" in safety. After the GDL was implemented in North Carolina, 16-year-old driver crashes in North Carolina declined by 38%; fatal/serious injury crashes declined by 46%. Research regarding six-month and three-month learning periods shows significantly less decreases in teen crashes as compared to the 12-month period.
- Requiring a set number of practice hours has not been shown to result in fewer crashes among new teen drivers, so required hours cannot replace a long learning period for ensuring safety.
- Parent approval of the GDL since it began has remained virtually unchanged over time, with 95% of parents approving the 12-month learner license period.
- Level 2 requirements that still require an adult supervising driver when there are multiple young passengers or at night is based on science showing these are particularly dangerous circumstances where it is safest to have an adult co-driver.

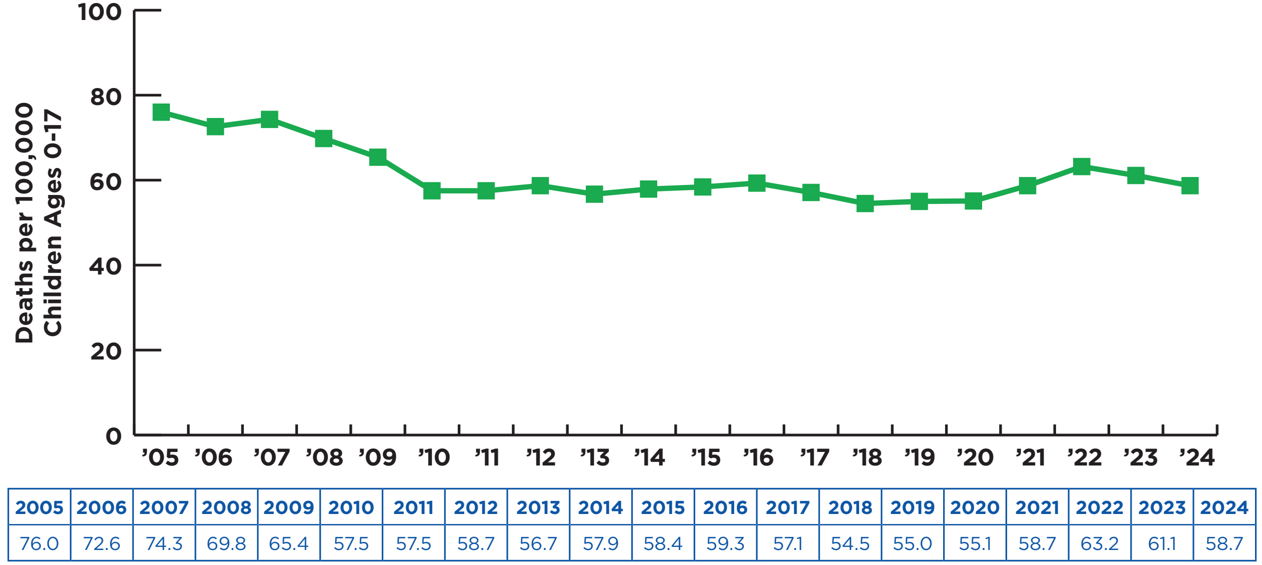
Many aren't aware that components of the GDL exist because science has proven they will make everyone on the roads, not just teen drivers, safer. That is why for this administrative effort, the CFTF is seeking to educate about the GDL and the science behind it. In addition, scientists are continuing to collect data and analyze the impacts of recent changes to the GDL, and the CFTF seeks to learn more when it meets again in 2026.

[91] Presentation by Dr. Justin Owen to the Unintentional Death Prevention Committee, November 7, 2025; and materials from the UNC Highway Safety Research Center: Information about the GDL in NC; 4 Quick Facts about Teen Driver Licensing and Safety in North Carolina.

2024 Child Death Data

Note: The child death data in this section is from the NCDHHS Division of Public Health; report and analysis produced by the Title V Office, in conjunction with the North Carolina State Center for Health Statistics, Division of Public Health. This data was not available in time for study by the Child Fatality Task Force during its 2025-26 study cycle which ended February 25, 2026, but will inform ongoing work of the Task Force.

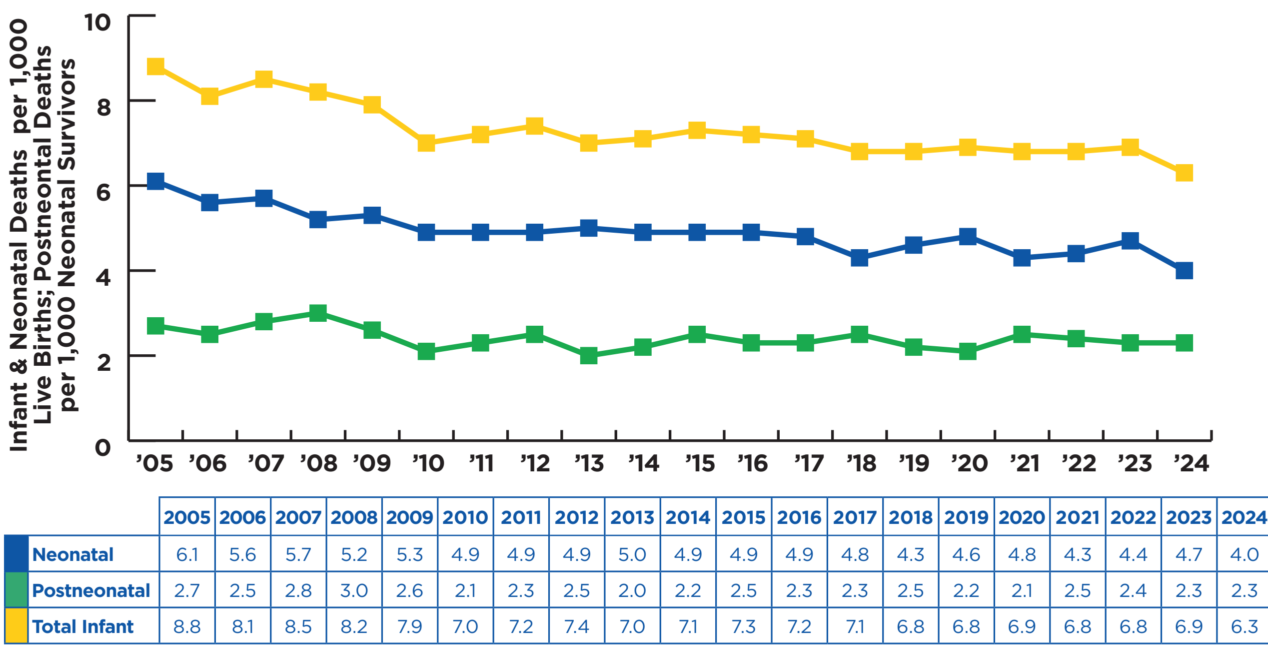
Figure 1. 2005-2024 Trends in North Carolina Resident Child Death Rates* Ages Birth Through 17 Years



2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
76.0	72.6	74.3	69.8	65.4	57.5	57.5	58.7	56.7	57.9	58.4	59.3	57.1	54.5	55.0	55.1	58.7	63.2	61.1	58.7

** Death rates are per 100,000 Resident population ages 0 to 17. Rates prior to 2024 have been recalculated using the latest available population data*

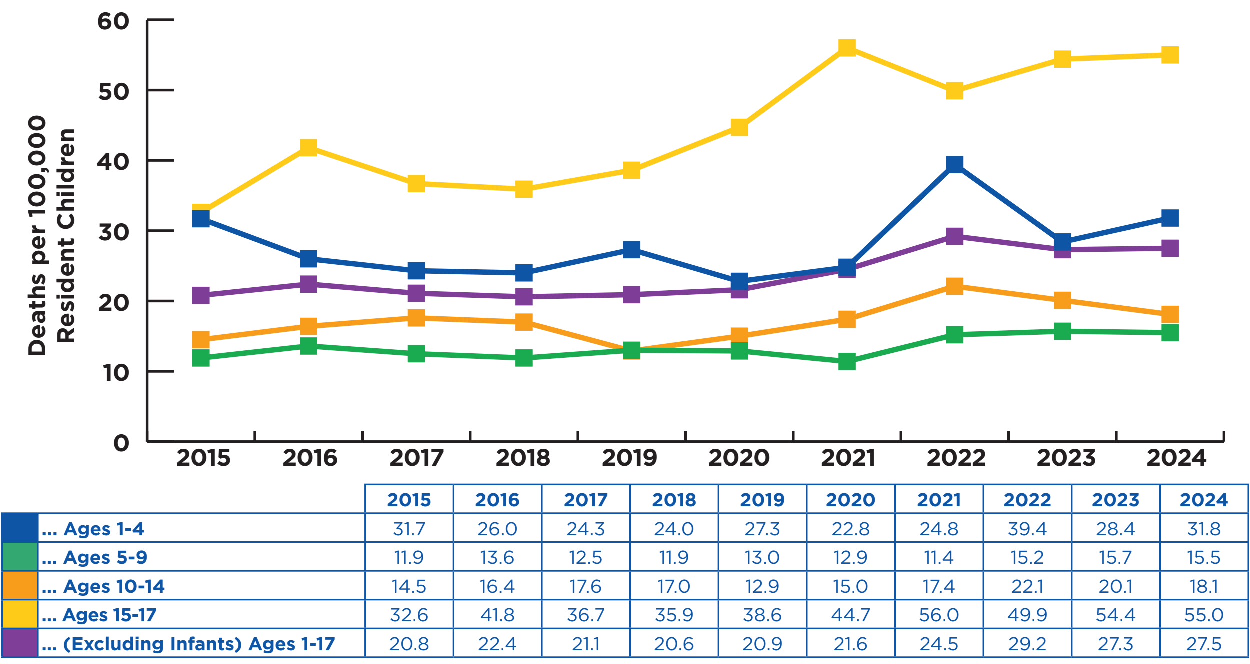
Figure 2. 2005-2024 Trends in North Carolina Resident Infant*, Neonatal† & Postneonatal^ Death Rates



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Neonatal	6.1	5.6	5.7	5.2	5.3	4.9	4.9	4.9	5.0	4.9	4.9	4.9	4.8	4.3	4.6	4.8	4.3	4.4	4.7	4.0
Postneonatal	2.7	2.5	2.8	3.0	2.6	2.1	2.3	2.5	2.0	2.2	2.5	2.3	2.3	2.5	2.2	2.1	2.5	2.4	2.3	2.3
Total Infant	8.8	8.1	8.5	8.2	7.9	7.0	7.2	7.4	7.0	7.1	7.3	7.2	7.1	6.8	6.8	6.9	6.8	6.8	6.9	6.3

** Infant deaths represent the death of a liveborn infant within the first year of life (less than 365 days). Rates are presented per 1,000 live births | † Neonatal deaths represent the death of a liveborn infant under 28 days of age. Rates are presented per 1,000 live births | ^ Postneonatal deaths represent the death of a liveborn infant age 28 days and over but less than one year of age. Rates are presented per 1,000 neonatal survivors (live births minus neonatal deaths).*

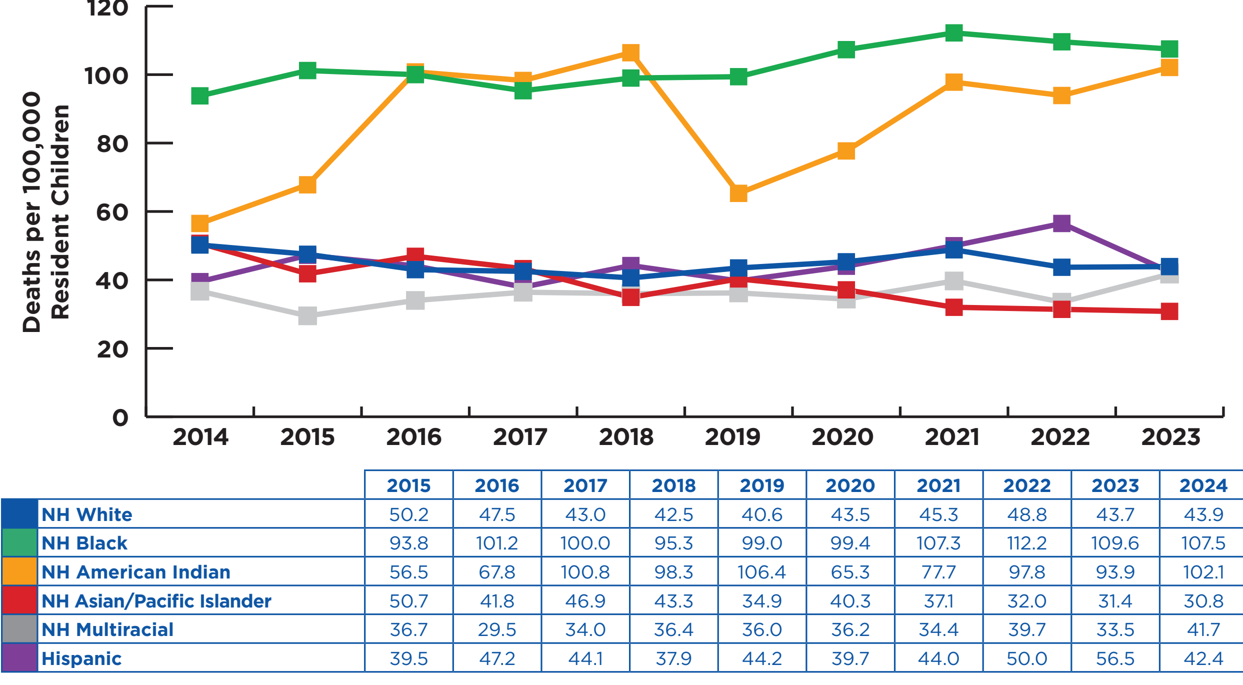
Figure 3. 2015-2024 Trends in North Carolina Resident Non-Infant Child Death Rates* by Age Group



	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
... Ages 1-4	31.7	26.0	24.3	24.0	27.3	22.8	24.8	39.4	28.4	31.8
... Ages 5-9	11.9	13.6	12.5	11.9	13.0	12.9	11.4	15.2	15.7	15.5
... Ages 10-14	14.5	16.4	17.6	17.0	12.9	15.0	17.4	22.1	20.1	18.1
... Ages 15-17	32.6	41.8	36.7	35.9	38.6	44.7	56.0	49.9	54.4	55.0
... (Excluding Infants) Ages 1-17	20.8	22.4	21.1	20.6	20.9	21.6	24.5	29.2	27.3	27.5

** Death rates are per 100,000 Resident population ages 1 to 17. Rates prior to 2024 have been recalculated using the latest available population data*

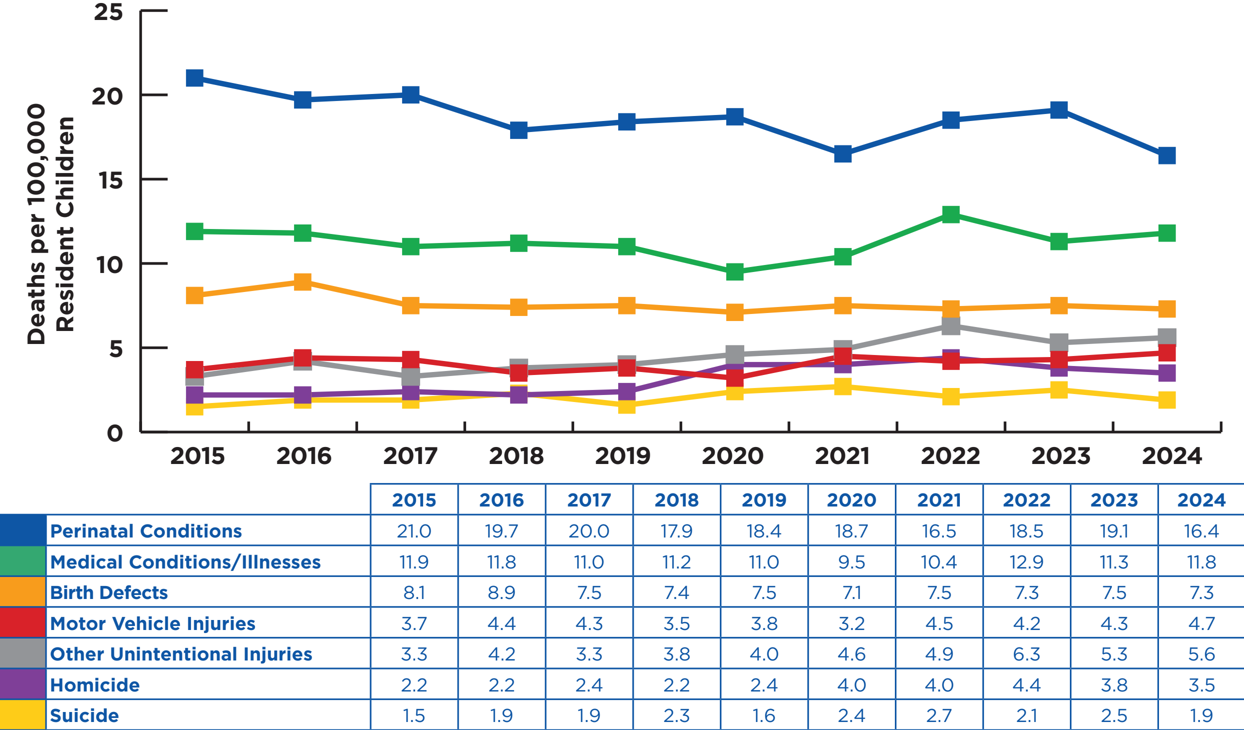
Figure 4. 2015-2024 Trends in North Carolina Resident Non-Infant Child Death Rates* by Age Group



	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
NH White	50.2	47.5	43.0	42.5	40.6	43.5	45.3	48.8	43.7	43.9
NH Black	93.8	101.2	100.0	95.3	99.0	99.4	107.3	112.2	109.6	107.5
NH American Indian	56.5	67.8	100.8	98.3	106.4	65.3	77.7	97.8	93.9	102.1
NH Asian/Pacific Islander	50.7	41.8	46.9	43.3	34.9	40.3	37.1	32.0	31.4	30.8
NH Multiracial	36.7	29.5	34.0	36.4	36.0	36.2	34.4	39.7	33.5	41.7
Hispanic	39.5	47.2	44.1	37.9	44.2	39.7	44.0	50.0	56.5	42.4

** Death rates are per 100,000 Resident population ages 0 to 17. Rates prior to 2024 have been recalculated using the latest available population data | Caution: Racial categories have changed from prior years and now reflect single race categories & multi-race. Comparisons with prior reports are not advised. | NH=Non-Hispanic*

Figure 5. 2015-2024 Trends in North Carolina Resident Child Death Rates1 for Selected Causes of Death, Ages Birth Through 17 Years



	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Perinatal Conditions	21.0	19.7	20.0	17.9	18.4	18.7	16.5	18.5	19.1	16.4
Medical Conditions/Illnesses	11.9	11.8	11.0	11.2	11.0	9.5	10.4	12.9	11.3	11.8
Birth Defects	8.1	8.9	7.5	7.4	7.5	7.1	7.5	7.3	7.5	7.3
Motor Vehicle Injuries	3.7	4.4	4.3	3.5	3.8	3.2	4.5	4.2	4.3	4.7
Other Unintentional Injuries	3.3	4.2	3.3	3.8	4.0	4.6	4.9	6.3	5.3	5.6
Homicide	2.2	2.2	2.4	2.2	2.4	4.0	4.0	4.4	3.8	3.5
Suicide	1.5	1.9	1.9	2.3	1.6	2.4	2.7	2.1	2.5	1.9

** Death rates are per 100,000 Resident population ages 0 to 17. Rates prior to 2024 have been recalculated using the latest available population data*

Table 1. 2024 NC Resident Child Deaths Ages 0-17 By Age Group & Cause of Death

CAUSE OF DEATH	TOTAL AGES 0-17		AGE GROUP (years)									
			Infants		1-4		5-9		10-14		15-17	
TOTAL DEATHS	1,386		770		158		100		120		238	
Cause of Death Category:	N	%	N	%	N	%	N	%	N	%	N	%
Perinatal Conditions	**387**	**27.9**	**386**	**99.7**	**1**	**0.3**	**0**	**0.0**	**0**	**0.0**	**0**	**0.0**
... Short Gestation/Low Birthweight	104		104		0		0		0		0	
... Maternal Complications	67		67		0		0		0		0	
... All Other Perinatal Conditions	216		215		1		0		0		0	
Medical Conditions	**278**	**20.1**	**71**	**25.5**	**54**	**19.4**	**46**	**16.5**	**59**	**21.2**	**48**	**17.3**
... Malignant Neoplasms (Cancer)	51		1		10		11		15		14	
... Heart Disease	35		10		4		4		9		8	
... Chronic Lower Respiratory Diseases	9		0		0		4		3		2	
... Septicemia	7		2		1		1		1		2	
... Pneumonia/Influenza	17		2		3		3		7		2	
... Coronavirus Disease (COVID-19)	3		0		2		0		0		1	
... All Other Medical Conditions	156		56		34		23		24		19	
Birth Defects	**172**	**12.4**	**133**	**77.3**	**13**	**7.6**	**13**	**7.6**	**9**	**5.2**	**4**	**2.3**
... Circulatory System	47		33		6		4		3		1	
... Nervous System	30		18		4		5		1		2	
... Respiratory System	7		7		0		0		0		0	
... All Other Birth Defects	88		75		3		4		5		1	
Motor Vehicle Injuries	**111**	**8.0**	**3**	**2.7**	**18**	**16.2**	**11**	**9.9**	**13**	**11.7**	**66**	**59.5**
Other Unintentional Injuries	**133**	**9.6**	**31**	**23.3**	**43**	**32.3**	**18**	**13.5**	**9**	**6.8**	**32**	**24.1**
...Suffocation/Choking/Strangulation	33		27		5		0		0		1	
...Drowning	31		1		15		6		2		7	
...Poisoning	32		1		6		2		4		19	
...Bicycle	0		0		0		0		0		0	
...Firearm	10		0		6		1		1		2	
...Smoke, Fire & Flames	7		1		3		3		0		0	
...All Other Accidental Injuries	20		1		8		6		2		3	
Homicide	**83**	**6.0**	**7**	**8.4**	**14**	**16.9**	**9**	**10.8**	**8**	**9.6**	**45**	**54.2**
... Involving Firearm	59		0		3		6		6		44	
... All Other Homicides	24		7		11		3		2		1	
Suicide	**44**	**3.2**	**0**	**0.0**	**0**	**0.0**	**0**	**0.0**	**18**	**40.9**	**26**	**59.1**
... by Firearm	23		0		0		0		9		14	
... by Hanging	**18**		**0**		**0**		**0**		**9**		**9**	
... by Poisoning	3		0		0		0		0		3	
... All Other Suicides	0		0		0		0		0		0	
Other Injuries Undetermined Manner	**13**	**0.9**	**3**	**23.1**	**2**	**15.4**	**0**	**0.0**	**1**	**7.7**	**7**	**53.8**
... Hanging/Strangulation/Suffocation	2		2		0		0		0		0	
... Poisoning	4		1		1		0		0		2	
... All Other Undetermined Injuries	7		0		1		0		1		5	
Pending/Unknown Causes	**142**	**10.2**	**123**	**86.6**	**10**	**7.0**	**2**	**1.4**	**2**	**1.4**	**5**	**3.5**
All Other Causes of Death	**23**	**1.7**	**13**	**56.5**	**3**	**13.0**	**1**	**4.3**	**1**	**4.3**	**5**	**21.7**

Note on Cause of Death Figures: Numbers in this report from the State Center for Health Statistics (SCHS) may differ slightly from numbers reported later by the Office of the Chief Medical Examiner (OCME). The SCHS bases its statistics on death certificate coding only and closes out annual data at a specific point in time. The OCME makes its determinations utilizing a variety of information sources when conducting its death reviews, does not close out their data, and some of its cases are still pending when SCHS closes their annual data files. Therefore, the cause and manner of death determined by the OCME may be modified based on OCME review after the time period during which the SCHS finalizes annual data files.

Table 2. Leading Causes of Child Death by Age Group, NC Residents 2024

** Note: These tables use National Center for Health Statistics standards for classifying cause of death and may differ from tabulations presented in Table 1.*

ALL AGES, 0-17			
Rank	Cause	#	%
1	Conditions originating in the perinatal period	387	27.9%
2	Congenital anomalies (birth defects)	172	12.4%
3	Unintentional Injuries not related to Motor Vehicles	133	9.6%
4	Motor vehicle injuries	111	8.0%
5	Homicide	83	6.0%
6	Cancer	51	3.7%
7	Suicide	44	3.2%
8	Diseases of the heart	35	2.5%
9	Pneumonia & influenza	17	1.2%
10	Chronic lower respiratory diseases	9	0.6%
All other causes (Residual)		344	24.8%
TOTAL DEATHS — ALL CAUSES		1,386	100.0%

AGES 1 TO 17			
Rank	Cause	#	%
1	Motor vehicle injuries	108	17.5%
2	Unintentional Injuries not related to Motor Vehicles	102	16.6%
3	Homicide	76	12.3%
4	Cancer	50	8.1%
5	Suicide	44	7.1%
6	Congenital anomalies (birth defects)	39	6.3%
7	Diseases of the heart	25	4.1%
8	Pneumonia & influenza	15	2.4%
9	Chronic lower respiratory diseases	9	1.5%
10	In-situ/benign neoplasms	5	0.8%
10	Septicemia	5	0.8%
All other causes (Residual)		138	22.4%
TOTAL DEATHS — ALL CAUSES		616	100.0%

INFANTS			
Rank	Cause	#	%
1	Congenital anomalies (birth defects)	133	17.3%
2	Short gestation - low birthweight	103	13.4%
3	Maternal complications of pregnancy	42	5.5%
4	Respiratory distress	38	4.9%
5	Unintentional Injuries not related to Motor Vehicles	31	4.0%
6	Bacterial sepsis	22	2.9%
7	Complications of placenta, cord, and membranes	20	2.6%
8	Intrauterine hypoxia and birth asphyxia	19	2.5%
9	Necrotizing enterocolitis	17	2.2%
10	Diseases of the circulatory system	13	1.7%
All other causes (Residual)		332	43.1%
TOTAL DEATHS — ALL CAUSES		770	100.0%

AGES 1 TO 4			
Rank	Cause	#	%
1	Unintentional Injuries not related to Motor Vehicles	43	27.2%
2	Motor vehicle injuries	18	11.4%
3	Homicide	14	8.9%
4	Congenital anomalies (birth defects)	13	8.2%
5	Cancer	10	6.3%
6	Diseases of the heart	4	2.5%
7	Pneumonia & influenza	3	1.9%
8	COVID-19	2	1.3%
9	Acute bronchitis & bronchiolitis	1	0.6%
9	Cerebrovascular disease	1	0.6%
9	Complications of medical and surgical care	1	0.6%
9	Conditions originating in the perinatal period	1	0.6%
9	Nutritional deficiencies	1	0.6%
9	Septicemia	1	0.6%
All other causes (Residual)		44	27.8%
TOTAL DEATHS — ALL CAUSES		158	100.0%

AGES 5 TO 9			
Rank	Cause	#	%
1	Unintentional Injuries not related to Motor Vehicles	18	18.0%
2	Congenital anomalies (birth defects)	13	13.0%
3	Cancer	11	11.0%
	Motor vehicle injuries	11	11.0%
5	Homicide	9	9.0%
6	Chronic lower respiratory diseases	4	4.0%
6	Diseases of the heart	4	4.0%
8	Pneumonia & influenza	3	3.0%
9	Cerebrovascular disease	2	2.0%
10	Anemias	1	1.0%
10	Aortic aneurism and dissection	1	1.0%
10	Chronic liver disease & cirrhosis	1	1.0%
10	Diseases of appendix	1	1.0%
10	In-situ/benign neoplasms	1	1.0%
10	Septicemia	1	1.0%
All other causes (Residual)		19	19.0%
TOTAL DEATHS — ALL CAUSES		100	100.0%

AGES 10 TO 14			
Rank	Cause	#	%
1	Suicide	18	15.0%
2	Cancer	15	12.5%
3	Motor vehicle injuries	13	10.8%
4	Congenital anomalies (birth defects)	9	7.5%
4	Diseases of the heart	9	7.5%
4	Unintentional Injuries not related to Motor Vehicles	9	7.5%
7	Homicide	8	6.7%
8	Pneumonia & influenza	7	5.8%
9	Chronic lower respiratory diseases	3	2.5%
10	Diabetes mellitus	2	1.7%
All other causes (Residual)		27	22.5%
TOTAL DEATHS — ALL CAUSES		120	100.0%

AGES 15 TO 17			
Rank	Cause	#	%
1	Motor vehicle injuries	66	27.7%
2	Homicide	45	18.9%
3	Unintentional Injuries not related to Motor Vehicles	32	13.4%
4	Suicide	26	10.9%
5	Cancer	14	5.9%
6	Diseases of the heart	8	3.4%
7	Congenital anomalies (birth defects)	4	1.7%
8	In-situ/benign neoplasms	3	1.3%
9	Chronic lower respiratory diseases	2	0.8%
9	Diabetes mellitus	2	0.8%
9	Pneumonia & influenza	2	0.8%
9	Septicemia	2	0.8%
All other causes (Residual)		32	13.4%
TOTAL DEATHS — ALL CAUSES		238	100.0%

Highlights of 2024

CHILD DEATH DATA FACTS AND TRENDS

In 2024, 1,386 North Carolina children ages zero to 17 died. The rate of child deaths overall in 2024 was 58.7 per 100,000 children age zero to 17. This represents a decrease from the 2023 rate of 61.1, however the rate is still higher than the historical low seen in 2018, which was 54.5.

Since the Child Fatality Task Force was initiated in 1991, child death rates among children ages 0 to 17 have decreased by 45%, from a rate of 107.6 deaths per 100,000 children in 1991 to a rate of 58.7 in 2024. While North Carolina experienced relatively steady declines in child mortality rates from 1991 through 2010, statewide child mortality rates have stagnated with no significant reductions since 2010.

56% WERE INFANTS

In 2024, 56% (770) of child deaths were of infants (babies under one year of age). The next largest age category for child deaths was for older teens, ages 15 to 17 (238 deaths).

27.5 MORTALITY RATE

While the infant death rate decreased to a historic low in 2024, the rate of deaths for North Carolina children ages one to 17 has not decreased. North Carolina's 2024 mortality rate of 27.5 among children ages one to 17 remains virtually unchanged from the rate two decades ago (26.8 in 2005). From 2008 through 2020, rates were lower and fluctuated, ranging from 20.6 to 23.9.

Infant Deaths

- **Historic low:** From 2023 – 2024, the statewide infant death rate decreased by 8.7%, moving from 6.9 per 1,000 live births in 2023 to 6.3 in 2024. Over the last 10 years, from 2015 to 2024, the state infant mortality rate declined 14 percent from a rate of 7.3 to 6.3 per 1,000 live births. The 2024 infant mortality rate represents a historic low in North Carolina.
- **National comparison:** Based on US infant mortality data, North Carolina had the 18th highest infant mortality rate in the U.S. in 2024 which represents an improvement from 2023 when the state had the 10th highest infant death rate in the country.
- **Race/ethnicity:** In 2024, the infant mortality rate for Hispanics decreased 27% compared to 2023. The Black/white disparity in infant mortality remains virtually unchanged with a ratio of 2.98 in 2024 compared with the 2023 ratio of 3.02. During the 5-year period 2020 to 2024, North Carolina's non-Hispanic (NH) Black infants experienced death rates 2.74 times higher than NH white infants.
- **Decline in neonatal deaths:** The decline in the overall infant mortality rate occurred only among neonatal deaths (deaths occurring within the first month of life). The neonatal mortality rate declined 15% from a rate of 4.7 in 2023 to 4.0 in 2024.
- **Leading causes of death:** For infants, birth defects were the leading cause, followed by prematurity/low birthweight and then maternal complications of pregnancy.
- **SUID deaths:** The number of deaths related to Sudden Unexplained Infant Death (SUIDs) cause categories increased in 2024, rising from 137 deaths attributed to SUIDs in 2023 to 156 SUIDs-related deaths in 2024. [The NC Office of the Chief Medical Examiner (OCME) conducts thorough reviews of Sudden and Unexpected Infant Death (SUID) cases; although OCME data is not yet available for 2024, OCME analysis reveals that a majority of SUID cases are associated with unsafe sleep environments.]
- **Rural rates are highest:** Infant mortality rates decreased in urban, suburban, and rural areas of North Carolina, however rural areas continue to have the highest rates.

Child Deaths

- **Rates unchanged but national ranking worsens:** Excluding infants, North Carolina's child death rate of children ages 1 to 17 remained virtually unchanged at a rate of 27.3 in 2023 and 27.5 in 2024. This puts North Carolina at the 12th highest mortality rate for 2024 for non-infant children in the U.S., as compared to other states. This represents a worse ranking compared to 2023 when the state had the 17th highest rate in the country.
- **Trends by age:** Examining changes in mortality rates by age group among children ages 1 to 17, there were no statistically significant changes among any age category in 2023 and 2024. However, teens ages 15 to 17 continue to have the highest mortality rates, which have increased significantly over the last decade.
- **Race and ethnicity:** Among children ages one to 17, Hispanic children were the only racial/ethnic group to experience statistically significant changes in child mortality from 2023 to 2024. The mortality rate for Hispanic children ages 1 to 17 declined 26%, with cancer (11 fewer deaths) and suicide (8 fewer deaths) experiencing the largest decreases. In 2024, NH Black children experienced the highest child mortality, with rates 2.45 times higher than NH white children (virtually unchanged from a ratio of 2.51 in 2023).
- **Rural rates highest:** Rural areas of North Carolina have higher rates of death for children ages 1 to 17 compared to urban or suburban areas.
- **Causes of death and trends:** Examining causes of death for 2024 among the 616 deaths to non-infant children ages 1 to 17 (see Table 2 above for additional details):
  - **Motor vehicle accidents (MVAs)** were the #1 leading cause of death among teens ages 15 to 17, who have recently experienced a significant increase in rates of MVA deaths. MVAs were the second leading cause of death for ages 1 to 4. MVA death rates among children age zero to 17 have increased 27% since 2015.
  - **Suicide** was the leading cause of death among children ages 10 to 14. Over two decades, youth suicide rates overall have trended upward, however youth suicide rates in 2024 represent the lowest rate recorded since 2019.
  - **Other accidental injuries (non MVA)** were the leading cause of death among children aged 1 to 4 and ages 5 to 9, with drowning as the most common non MVA accidental injury cause for both age groups. Other types of non MVA accidental injuries include deaths from poisoning, firearm, smoke/fire, and choking/suffocation. There were also three child deaths related to Hurricane Helene in 2024.
  - **Firearm deaths (homicide, suicide, or accidental deaths involving a firearm)** saw a significant increase during the past decade, peaking in 2021 with rates three times that of 2015 rates, and declining in 2024 with rates still high at 2.5 times that of 2015 rates. In 2024, firearms remained the most common lethal means used in child and youth homicides and suicides.
  - **Homicide** was the second leading cause of death for older teens age 15 to 17. Homicide rates among children ages zero to 17 rose during the past decade, peaking in 2022 at 4.4 deaths per 100,000 children and declining the past two years with rates in 2024 at 3.5.
  - **For medical conditions** that caused the deaths of children ages 1 to 17, cancer was the most common cause, followed by heart disease then pneumonia/influenza. The rates of deaths due to medical conditions/illnesses overall did not change significantly in 2024.

CHILD FATALITY TASK FORCE
Leadership & Contact Information

Biographies of the Task Force Leadership Team are available on the CFTF website.

Task Force Leadership

Executive Director

Kella W. Hatcher, JD
Email: kella.hatcher@dhhs.nc.gov

Co-Chairs

Karen McLeod, MSW
President/CEO, Benchmarks NC
Email: kmcleod@benchmarksnc.org

Jill Cox
President/CEO, Communities in Schools NC
Email: jcox@cisnc.org

Committee Leadership

The **Intentional Death Prevention Committee** focuses on preventing homicide, suicide, child abuse, and neglect.

Co-Chairs

- **Jennifer Kristiansen, MSW, LCSW**, Director of Social Services, Chatham County
- **Whitney Belich, JD**, Child Abuse Resource Prosecutor, NC Conference of District Attorneys

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The **Perinatal Health Committee** focuses on the reduction of infant mortality through strategies that support healthy pregnancies, birth outcomes, and infants.

Co-Chairs

- **Belinda Pettiford, MPH**, Section Chief for Women, Infant, and Community Wellness in the Division of Public Health, NC Department of Health and Human Services
- **Sarah Verbiest, MSW, MPH, DrPH**, Executive Director, Collaborative for Maternal and Infant Health in the UNC School of Medicine and Director, Jordan Institute for Families in the UNC School of Social Work

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The **Unintentional Death Prevention Committee** focuses on preventing unintentional child deaths, such as those due to motor vehicles, poisoning, drowning, firearms, and fire.

Co-Chairs

- **Martha Sue Hall, MS**, Mayor Pro Tempore, City of Albemarle; President, North Carolina League of Municipalities
- **Scott K. Proescholdbell, MPH**, Epidemiologist and Unit Manager, Injury Epidemiology, Surveillance and Informatics Unit, Division of Public Health, Injury and Violence Prevention Branch, NC Department of Health and Human Services

NC CHILD FATALITY TASK FORCE
Member Roster [92]

(As of the last meeting of the Task Force on 2/25/26)

GOVERNOR APPOINTEES (4)	MEMBER OR DESIGNEE
1. A director of a county department of social services, appointed by the Governor upon recommendation of the President of the North Carolina Association of County Directors of Social Services	**Jennifer Kristiansen** Director of Social Services Chatham County
2. A representative from a Sudden Infant Death Syndrome or safe infant sleep counseling and education program, appointed by the Governor upon recommendation of the Maternal and Child Health Section of the Department of Health and Human Services	**Dr. Sarah Verbiest** Executive Director UNC Collaborative for Maternal & Infant Health
3. A representative from NC Child, appointed by the Governor upon recommendation of the President of the organization	**Erica Palmer Smith** Executive Director NC Child
4. A director of a local department of health, appointed by the Governor upon the recommendation of the President of the North Carolina Association of Local Health Directors	**Wes Gray** Health Director Pitt County Health Department
HOUSE SPEAKER APPOINTEES (10)	
1. A representative from a private group, other than NC Child, that advocates for children, appointed by the Speaker of the House of Representatives upon recommendation of private child advocacy organizations	**Karen McLeod** President and CEO Benchmarks
2. A pediatrician, licensed to practice medicine in North Carolina, appointed by the Speaker of the House of Representatives upon recommendation of the NC Pediatric Society	**Dr. Martin McCaffrey** Pediatrician UNC
3. A representative from the North Carolina League of Municipalities, appointed by the Speaker of the House of Representatives upon recommendation of the League	**Martha Sue Hall** Albemarle City Council; President, NC League of Municipalities
4. One public member, appointed by the Speaker of the House of Representatives	**Katherine Pope**
5. One representative of the NC Domestic Violence Commission, appointed by the Speaker of the House of Representatives upon recommendation of the Director of the Commission	**TeAndra Miller** Managing Attorney & Project Director, DVSA Practice Group, Legal Aid of North Carolina
6. **Five members** of the House of Representatives, appointed by the Speaker of the House of Representatives.	**Rep. Grant Campbell** **Rep. Carla Cunningham** **Rep. Cody Huneycutt** **Rep. Donnie Loftis** **Rep. Donna White**

[92] According to law enacted in 2015, third-party recommendations for legislative appointments are discretionary, not binding, and legislative appointments on this chart where a third-party recommender is noted may or may not have been made according to a third-party recommendation.

SENATE APPOINTEES (10)	
1. A representative from the North Carolina Association of County Commissioners, appointed by the President Pro Tempore of the Senate upon recommendation of the Association	**Hope Haywood** County Commissioner, Randolph County
2. One public member, appointed by the President Pro Tempore of the Senate	**Jill Cox** President & CEO Communities in Schools NC
3. One representative of the NC Coalition Against Domestic Violence, appointed by the President Pro Tem of the Senate upon recommendation of the Executive Director of the Coalition	**Trishana Jones** Programs Director, NC Coalition Against Domestic Violence
4. A county or municipal law enforcement officer, appointed by the President Pro Tempore of the Senate upon recommendation of organizations that represent local law enforcement officers	**Sergeant Santana Menard** Investigator, Reidsville Police Department
5. A district attorney appointed by the President Pro Tempore of the Senate upon recommendation of the President of the North Carolina Conference of District Attorneys	**Ashlie Shanley** District Attorney Cabarrus County
6. **Five members** of the Senate, appointed by the President Pro Tempore of the Senate	**Sen. Gale Adcock** **Sen. Sydney Batch** **Sen. Jim Burgin** **Sen. Mark Hollo** **Sen. Dana Jones**
EX OFFICIO MEMBERS (12) (Members besides the Chief Medical Examiner may choose to designate a representative to serve)	
The Chief Medical Examiner	**Dr. Michelle Aurelius** Chief Medical Examiner
The Attorney General	**Sara Perdue** Outreach and Policy Advisor, AG Jeff Jackson, NC DOJ
The Director of the Division of Social Services, Department of Health and Human Services	**Lisa Cauley** Senior Director of Child, Family, & Adult Services, Division of Social Services, NCDHHS
The Director of the State Bureau of Investigation	**Karen Fairley** Exec. Director, NC Center for Safer Schools, SBI
The Director of the Division of Public Health, Department of Health and Human Services	**Dr. Kelly Kimple** Chief Medical Officer and Director, Division of Public Health, NCDHHS
The Chair of the Council for Women and Youth Involvement	**Charnessa Ridley** Director, Division for Women and Youth
The Superintendent of Public Instruction	**Susanne Schmal** School Health Partnerships and Policy Consultant, DPI
The Chairman of the State Board of Education	**Dr. Ellen Essick** Section Chief NC Healthy Schools, DPI
The Director of the Division of Child and Family Well-Being, Department of Health and Human Services	**Dr. Gerri Mattson** Senior Medical Director, Division of Child & Family Well-Being, NCDHHS
The Secretary of the Department of Health and Human Services	**Dr. Larry Greenblatt** State Health Director & Chief Medical Officer, NCDHHS
The Director of the Administrative Office of the Courts	**Lorrie L. Dollar** Administrator, Guardian Ad Litem Program
Director of the Division of Juvenile Justice, Department of Public Safety	**William Lassiter** Deputy Secretary for Juvenile Justice, DPS

NC CHILD FATALITY TASK FORCE
Committee Rosters

Perinatal Health Committee 2025-26

STATUTORY MEMBER OF THE CHILD FATALITY TASK FORCE	SEAT ON THE TASK FORCE HELD ACCORDING TO STATUTE (AND RELEVANT ROLE OR AREA OF EXPERTISE)
Dr. Sarah Verbiest [Committee Co-Chair]	Expert on Safe Infant Sleep/ Director for UNC Collaborative for Maternal & Infant Health; Director of Jordan Institute, UNC School of Social Work
Senator Gale Adcock	Member of NC Senate/Nurse Practitioner
Senator Jim Burgin	Member of NC Senate
Representative Grant Campbell	Member of NC House/Obstetrician
Representative Carla Cunningham	Member of NC House of Representatives/Nurse
Dr. Kelly Kimple	Director, NCDHHS Division of Public Health/Pediatrician
Dr. Martin McCaffrey	Pediatrician/Neonatologist, UNC
Karen McLeod	Private child advocate group/President & CEO, Benchmarks NC
Dr. Gerri Mattson	NCDHHS Division of Child & Family Well-Being/Early Intervention Medical Director, NC Infant Toddler Program, Early Intervention Part C/Pediatrician
Katherine Pope	Public Member/Nonprofit experience in child abuse and neglect prevention
Erica Palmer Smith	Executive Director, NC Child

VOLUNTEER MEMBER	ORGANIZATION AND/OR AREA OF EXPERTISE
Belinda Pettiford [Committee Co-Chair]	Section Chief for Women, Infant, and Community Wellness Section, NCDHHS Division of Public Health
Christina Peterson	Child & Family Health Manager, NC Partnership for Children
Iris Derrick	Eastern Regional Administrator, NC Guardian ad Litem
Dr. Hendree Jones	Senior Advisor, UNC Horizons/pregnancy and substance use specialist
Erica Little	Healthy Start Robeson County
Erin McClain	Assistant Director, UNC Collaborative for Maternal & Infant Health/expertise in infant safe sleep and perinatal tobacco use
Mark Ownbey	MIECHV Healthy Families America State Consultant (Home Visiting Programs), NCDHHS Division of Child & Family Well-Being
Pat Campbell	Director, Maternal and Infant Health Initiative, March of Dimes North Carolina
Chiara Phillips	Nutrition Services, NCDHHS Division of Child & Family Well-Being/breastfeeding expertise
Phil Redmond	Director of Child & Family Well-Being, The Duke Endowment
Melissa Godwin	Clinical Associate Professor, Behavioral Health Springboard, School of Social Work, UNC Chapel Hill; NC Pregnancy and Opioid Exposure Project
Tara Shuler	Maternal Health Branch Head, NCDHHS Division of Public Health/Doula
Dauline Singletary	Maternal and Child Health, Wake County Health Department
Dr. Velma Taormina	Women's Health Consultant, Division of Health Benefits, NCDHHS/OBGYN physician
Erin Crites	Albemarle Maternal Mental Health Coalition; The Villages of North Carolina, Founder; Postpartum Support International Area Coordinator
Danielle Little	MCH Consultant, Durham Children's Initiative

Intentional Death Prevention Committee 2025-26

STATUTORY MEMBER OF THE CHILD FATALITY TASK FORCE	SEAT ON THE TASK FORCE HELD ACCORDING TO STATUTE (AND RELEVANT ROLE OR AREA OF EXPERTISE)
Jennie Kristiansen [Committee Co-Chair]	Social Services Director/Director, Chatham County DSS
Dr. Michelle Aurelius	Chief Medical Examiner
Senator Sydney Batch	Member of NC Senate/expertise in child welfare & family law
Lisa Cauley	Director of NCDHHS Division of Social Services/Senior Director of Child, Family, & Adult Services, NCDHHS Division of Social Services
Jill Cox	Public Member/President & CEO, Communities in Schools NC
Lorrie L. Dollar	Administrative Office of the Courts/Administrator, NC Guardian ad Litem Program
Dr. Ellen Essick	Department of Public Instruction/Section Chief, NC Healthy Schools
Senator Dana Jones	Member of NC Senate
Trishana Jones	NC Coalition Against Domestic Violence/Programs Director, Coalition Against Domestic Violence
TeAndra Miller	NC Domestic Violence Commission/Managing Attorney & Project Director, DVSA Practice Group, Legal Aid of North Carolina (representing Domestic Violence Commission)
Charnessa Ridley	Council for Women & Youth/ Director, Division for Women & Youth
Ashlie Shanley	District Attorney/District Attorney, Cabarrus County/Local child death review team
Representative Donna White	Member of NC House of Representatives/Nurse

VOLUNTEER MEMBER	ORGANIZATION AND/OR AREA OF EXPERTISE
Whitney Belich [Committee Co-Chair]	Child Abuse Resource Prosecutor, NC Conference of District Attorneys
Dr. Molly Berkoff	Physician with Child Medical Evaluation Program; NC Pediatric Society's Committee on Child Abuse & Neglect/child abuse pediatrician/local child death review team
Jane Miller	Comprehensive Suicide Prevention Team, NCDHHS Division of Public Health
Dr. Cindy Brown	Clinical Director, Children's Advocacy Centers of NC/child abuse pediatrician, child trauma expertise
Dr. Nicole Lawrence	Duke Center for Child and Family Policy; former member of local CFPT
Dr. Natasha Scott	Executive Director of Student Services Cumberland County/school social work expertise/former member of local CFPT
Jennifer Corso	School Nurse Consultant, NCDHHS Division of Public Health
Sharon Hirsch	President & CEO, Prevent Child Abuse North Carolina
Kathy Stone	Section Chief for Safety, Child Welfare, NCDHHS Division of Social Services
Sharon Bell	Deputy Director, NCDHHS Division of Child and Family Well-Being/ youth mental health expertise

Unintentional Death Prevention Committee 2025-26

STATUTORY MEMBER OF THE CHILD FATALITY TASK FORCE	SEAT ON THE TASK FORCE HELD ACCORDING TO STATUTE (AND RELEVANT ROLE OR AREA OF EXPERTISE)
Martha Sue Hall [Committee Co-Chair]	NC League of Municipalities/Mayor Pro Tem, Albemarle City Council; President, NC League of Municipalities/expertise in NC court system
Sergeant Santana Menard	Law Enforcement Officer/Investigator, Reidsville Police Department
Karen Fairley	State Bureau of Investigation/Executive Director, NC Center for Safer Schools
Wes Gray	Local Health Director/Health Director, Pitt County
Dr. Larry Greenblatt	NCDHHS/State Health Director, NCDHHS/Internal Medicine Physician
Hope Haywood	County Commissioner/Commissioner, Randolph County
Senator Mark Hollo	Member of NC Senate
Representative Cody Huneycutt	Member of NC House
William Lassiter	NC Department of Public Safety/Deputy Secretary, Juvenile Justice
Representative Donnie Loftis	Member of NC House
Sara Perdue	NC Attorney General/Outreach and Policy Advisor NC Department of Justice
Susanne Schmal	Superintendent of Public Instruction/School Health Partnerships and Policy Consultant, Department of Public Instruction

VOLUNTEER MEMBER	ORGANIZATION AND/OR AREA OF EXPERTISE
Scott Proescholdbell [Committee Co-Chair]	Epidemiologist and Unit Manager, Injury Epidemiology, Surveillance and Informatics Unit (ESI), Injury & Violence Prevention, NCDHHS Division of Public Health
Allan Buchanan	Director, Safe Kids NC & Community Risk Reduction Programs, Office of State Fire Marshal/expertise in child injury prevention
Mark Ezzell	Executive Director, Governor's Highway Safety Program
Brittany McKinney	Staff Attorney, Guardian ad Litem State Office
Sergeant Christopher Knox	State Highway Patrol
Michelle McKinley	Director of Communications & Grant Administration, YMCA of the Triangle
Dr. Beth Moracco	Director, UNC Injury Prevention Research Center
Sally Herndon	Retired Branch Head of Tobacco Control & Prevention/Tobacco Prevention, NCDHHS Division of Public Health
Shawn Troy	Executive Committee for Highway Safety/DOT traffic safety engineer
Greg Edwards	EMS for Children Program Manager, Office of Emergency Medical Services of the NCDHHS Division of Health Service Regulation
Kristel Robison	UNC Highway Safety Research Center/teen driver and child passenger safety expertise
Sergeant Bill Tarplee	NC Wildlife Officer
Tracy Russ	Institute of Transportation Research, NC State University