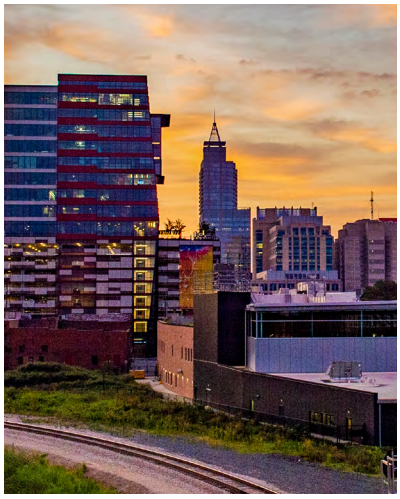
NORTH CAROLINA | MAY 2022 ▪ RALEIGH, NC

Child Fatality Task Force

Annual Report to the Governor and General Assembly






Our **Children** *Our* **Future** *Our* **RESPONSIBILITY**

MAY 2022

The Honorable Roy Cooper, Governor, State of North Carolina
Distinguished Members of the North Carolina General Assembly

Child Fatality Task Force

This year's submission of the annual report of the Child Fatality Task Force comes to you with optimism and hope in knowing that the evidence-driven recommendations being made by the Task Force for 2022, if they advance, really can save children's lives. There is also a sense of sadness in the realization that North Carolina has missed opportunities to prevent child deaths in our state as many of these recommendations are being repeated from prior years because they did not fully advance.

North Carolina lost 1,279 children in 2020, which is the latest year that finalized data is available. While this number represents a death rate that is about half of what it was in 1991 when the Task Force was first created, the rate has not changed significantly during the past decade. Yet many of the deaths occurring today are preventable through the kinds of targeted policy changes and funding priorities that have been advanced by the Task Force and saved countless lives throughout the past three decades.

Strategies recommended by the Task Force in this report are quite feasible, not only with respect to the ease with which they could be implemented but also the minimal cost in doing so when compared to the benefits of lives saved, traumas averted, and costs avoided. For example:

- **More than 100 infant deaths each year in North Carolina are associated with unsafe sleep environments or Sudden Infant Death Syndrome**, yet North Carolina spends only $45,000 per year on programs to prevent these deaths and the Task Force is recommending total spending of $250,000 per year, which amounts to about $2.10 per North Carolina baby.
- **North Carolina lost 525 children ages 17 and younger to firearm injuries in the ten-year period from 2011 to 2020 including 105 children in 2020 alone when firearm death rates skyrocketed along with sales of firearms.** There are about five times as many firearm-related hospitalizations and emergency visits as there are firearm deaths of children in a typical year. The Task Force recommendation to launch and fund a statewide firearm safe storage education and awareness initiative that would help communities across the state launch local initiatives to prevent many of these deaths and injuries would cost a minimum of $155,000 in nonrecurring funds for a two-year initiative.
- **Local child death review teams in every county in North Carolina are required by law to collectively review all child deaths (over 1000 per year)** to identify and address local and state-level system deficiencies to prevent future deaths and child maltreatment, yet there is no centralized state-level coordination, support, or data collection and reporting for these teams to optimize their efforts based on national best practice. The Task Force recommendation to have centralized coordination and support for these teams, to restructure reviews to reduce duplication of efforts, and to join 47 other states in using a free national data system that would significantly elevate our state's ability to understand and react to these child deaths comes at a cost of about $550,000 per year.

As you will see in this report, **suicide rates for youth have been rising during the past decade and alarms are sounding on the youth mental health crisis underway in our state and nation.** Multiple national organizations have echoed the types of strategies focused on by the Task Force that emphasize the important role that schools play in addressing this crisis and the urgent need to dedicate resources and funding to connect kids to mental health supports in the context of schools and elsewhere.

Our hope for 2022 is that North Carolina leaders will lift up and implement these Task Force recommendations to save children's lives and prevent the family and community trauma surrounding each child's death – a trauma experienced 1,279 times over in 2020 alone. Advancement of these Task Force recommendations would demonstrate that children are indeed a priority in North Carolina and deserving of all the protection and support state leaders can deliver as our state navigates challenges in year three of a global pandemic.

Sincerely,

Karen McLeod
CHAIR

Kella Hatcher
EXECUTIVE DIRECTOR

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Executive Summary

Task Force Meetings that Led to the 2022 Action Agenda

Meetings took place **between 9/20/21 & 2/7/22**

9 committee meetings: 3 committees had 3 meetings each

3 meetings of the full Task Force

Presentations by experts and leaders from **35+ organizations**

27 topics addressed

The Task Force **approved 9 legislative recommendations** and **10 administrative efforts** for inclusion on its 2022 Action Agenda aimed at changing laws and policies to prevent child deaths, prevent child abuse and neglect, and promote child well-being.

Highlights of 2020 Child Death Data Facts & Trends

- 1,279 North Carolina children died in 2020.
- The child death rate and the infant mortality rate for 2020 increased slightly compared to 2019.
- The infant mortality rate in NC is the 8th highest among states in the U.S.
- Infant deaths accounted for 63% of all child deaths.
- Disparities persist with the infant mortality rate; the rate for black infants is 2.5+ times that of white infants.
- Leading causes of infant death continue to be prematurity/low birthweight, birth defects, and maternal complications.
- Rates for suicides, homicides, and firearm deaths all increased in 2020; firearms were the lethal means used in most suicides and homicides.
- 74 children died in motor vehicle crashes in 2020; the 2020 rate for MV deaths was the lowest of a decade.
- Areas of the state with the highest child death rates and infant mortality rates are also areas with the highest social determinant risk factors such as poverty, unemployment, etc.

2022 Legislative Recommendations (abbreviated)	Highlighted Data and Information Supporting Recommendations	
Launch and fund a statewide firearm safe storage awareness initiative [$155K minimum for two-year initiative]	• The firearm death rate doubled between 2019 & 2020; by far the highest rate this decade. • 105 children died from firearms in 2020 and hundreds more were injured by guns. • Firearms were used in 55% of youth suicides and 73% of homicides in 2020. • More than half of gun owners store at least one gun unsafely. • Studies show that safe storage saves lives.	**HB 427 is Pending**
Timely and appropriate funding to address the significant youth mental health crisis	• The suicide rate for 2020 is the highest of a decade with 56 youth suicides in 2020. • Almost 550 hospitalizations and 2700+ emergency visits by youth for self-inflicted injury in 2020 alone. • National leaders have declared a youth mental health emergency in urgent need of resources. • School supports for mental health are critical & currently insufficient to meet expanding needs.	
Strengthen and restructure the statewide Child Fatality Prevention System [funding per DHHS determinations]	• Restructuring the system is critical to optimize its strengths and address multiple challenges. • NC needs to join 47 other states in using a national data system that will dramatically improve data collection, analysis, and reporting to inform prevention/policy initiatives. • These recommendations are supported by NCDHHS and were adopted in a 2019 state child welfare reform plan submitted to the legislature.	**SB 703 is Pending**
Funding to enable comprehensive toxicology testing in all Medical Examiner jurisdiction child deaths [$550K one-time & $110K/year]	• Resources are lacking to conduct comprehensive toxicology testing in all child deaths under Medical Examiner jurisdiction. • Comprehensive toxicology testing can identify information about the circumstances of a death that may be relevant to inform prevention strategies and have value to various stakeholders.	
Funding to expand efforts to prevent infant deaths related to unsafe sleep environments [$250K/year]	• From 2015 – 2019, there were 664 infant deaths in North Carolina that were associated with unsafe sleep environments (621 deaths) or Sudden Infant Death Syndrome (43 deaths). • Current spending of $45,000/year is insufficient to implement effective strategies to reach parents and caregivers of over 120,000 newborns born each year to prevent these deaths.	
Strengthen the infant safe surrender law	This law, created in 2001, needs to be strengthened in 4 areas to make it more likely the law will be used in circumstances for which it was intended to protect a newborn infant at risk of abandonment or harm.	**HB 473 is Pending**
Require ignition interlocks for all alcohol impaired DWI offenders, including first-time offenders	• Of 18,000+ children involved in 11,000 alcohol-related crashes from 2011 to 2020 in NC, 123 were killed and 344 had serious injuries. • Ignition interlocks reduce repeat offenses for driving while intoxicated by about 70%. • The CDC recommends requiring interlocks for all DWI offenders and most states do, but NC only requires them for a subset of offenders.	
Eliminate law prohibiting the use of state transportation funding for independent pedestrian and bicycle infrastructure projects	• From 2010 – 2019, almost 150 child pedestrian deaths occurred in North Carolina. • Studies show that pedestrian and bicycle infrastructure projects prevent deaths and injuries. • A law passed in 2013 has created a barrier to completing pedestrian and bicycle infrastructure projects intended to create safer conditions, especially in smaller, more rural communities.	
Increase funding for programs to prevent harm to youth and infants caused by tobacco and nicotine use [$17 million/year]	• One in five high school students uses e-cigarettes, which can contain high doses of nicotine. • Nicotine is highly addictive and can harm adolescent brain development and is also toxic to developing fetuses. • The dramatic increase in e-cigarette use during the past decade has corresponded with a dramatic decrease in North Carolina's sustained spending on tobacco use prevention programs.	

Administrative Efforts: In addition to the nine legislative recommendations above, the Task Force has ten administrative efforts on its 2022 Action Agenda through which it seeks to further examine or advance an issue through non-legislative efforts. These efforts address the following issues: suicide prevention and youth mental health; infant mortality and infant well-being; motor vehicle-related deaths and injuries; child abuse and neglect reporting; water safety.

NC Child Fatality Task Force Mandate, Study Process, and Ongoing Efforts

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 part of the broader statewide Child Fatality Prevention System created in 1991. The charge of the system is: to develop a communitywide approach to child abuse and neglect; to study and understand causes of childhood death; to identify gaps in service delivery in systems designed to prevent child abuse, neglect, and death; and to make and implement recommendations for laws, rules, and policies that will support the safe and healthy development of children and prevent future child abuse, neglect, and death. This system has local and state-level teams that review individual cases of child deaths. The Task Force is the "policy arm" of the system and does not conduct individual case reviews.

The Task Force studies and reports on data related to child deaths, hears from experts and leaders about evidence-driven prevention initiatives, receives information and recommendations from teams who review child deaths, and engages in discussion to formulate recommendations submitted annually to the Governor and NC General Assembly. These recommendations are aimed at the prevention of child death and maltreatment and at supporting the safety and well-being of children.

During its most recent study cycle, the Task Force had a total of twelve meetings, including nine committee meetings and three full Task Force meetings where attendees heard about 60 presentations. For this study cycle, which began on September 20, 2021 and ended on February 7, 2022, all meetings were held virtually due to the COVID-19 pandemic.

Task Force work is accomplished through three committees that prepare recommendations for consideration by the full Task Force. Committee participants include Task Force members as well as volunteers with subject matter expertise in the committee's area of focus. Committee recommendations only become Task Force recommendations once approved by the full Task Force.

The **Intentional Death Prevention Committee** studies homicide, suicide, and child maltreatment. For this study cycle this committee focused on the following areas: suicide prevention, student mental health, strengthening education and awareness around child abuse and neglect reporting, strengthening North Carolina's infant safe surrender law, the possibility of a statewide school health data system, and expanding toxicology testing on child deaths within the Medical Examiner's jurisdiction.

The **Perinatal Health Committee** focuses on infant mortality through addressing healthy pregnancies, birth outcomes, and infants. This committee's focus for the 2021-2022 study cycle included the following topics: infant deaths associated with unsafe sleep environments, continued efforts to strengthen the statewide Child Fatality Prevention System, a proposal for a statewide breastfeeding hotline, a proposal for provider incentives for group prenatal care, implementation of a new law expanding Medicaid for 12 months postpartum, and implementation of a new law allowing increased access to contraceptives and other medications via pharmacists.

The **Unintentional Death Prevention Committee** studies unintentional injury and death. For the 2021-2022 study cycle, this committee examined the following topics: firearm deaths and injuries to children and firearm safe storage education and awareness, ignition interlocks to prevent impaired driving, child passenger safety, strengthening use of rear seat restraints, tobacco and nicotine use impact and prevention, a proposal to require lifeguards at day camps, and a proposal to eliminate a law prohibiting the use of state transportation funding related to independent pedestrian and bicycle infrastructure projects.

Agendas, minutes, and presentations for all Task Force meetings and committee meetings can be found on the Task Force website which is hosted on the website for the NC General Assembly: www.ncleg.gov/DocumentSites/Committees/NCCFTF/Homepage/index.html.

Topic areas addressed during the 2021-2022 study cycle of the Child Fatality Task Force

Broad topic areas

- Update on data and information related to children and COVID-19 from the State Health Director
- Data on trends for injuries and deaths to children during the pandemic
- Legislative updates related to Child Fatality Task Force recommendations
- 2020 child death and infant mortality data from the State Center for Health Statistics
- Recommendations and data from the State Child Fatality Prevention Team

Topics related to child fatality review, the statewide Child Fatality Prevention System, and child maltreatment prevention

- North Carolina's statewide Child Fatality Prevention System and areas of the system in need of improvement or restructuring
- The role of local child death review teams in the statewide Child Fatality Prevention System
- Child death review and case data reporting from the National Center for Fatality Review and Prevention
- Toxicology testing in Medical Examiner jurisdiction child deaths
- Strengthening child abuse and neglect reporting education and awareness for law enforcement, school personnel, and healthcare providers

Topics focused specifically on infants

- Infant deaths related to unsafe sleep
- Strengthening North Carolina's infant safe surrender law
- Breastfeeding impact and a proposal for a breastfeeding hotline
- Impact of group prenatal care and a proposal for provider incentives for group prenatal care
- Implementation of a new law authorizing pharmacists to dispense, deliver and administer certain contraceptives and other medication
- Implementation of a new law extending Medicaid to 12 months postpartum

Topics focused on youth suicide prevention, the youth mental health crisis, and youth access to firearms

- Youth suicide data and prevention
- Youth mental health crisis and the role of school health support personnel
- Firearm deaths and injuries to children; firearm safe storage
- The potential for a statewide school health data system

Topics focused on motor vehicle-related deaths and injuries to children

- Ignition interlocks to prevent alcohol-impaired crashes
- Pedestrian and bicycle safety and related infrastructure funding
- Data and impact related to use of rear seat restraints in motor vehicles
- Driver education, teen drivers, and the science behind the Graduated Driver License Program
- Child passenger safety laws

Other topics related to unintentional deaths and child well-being

- Tobacco and nicotine use and its impact on youth and infants; funding for tobacco prevention
- Child drowning data, lifeguards as a drowning prevention strategy, and the status of current laws and regulations related to day camps and water safety

Experts and leaders presenting or serving as panelists in Task Force and committee meetings during the 2021-2022 study cycle represented state and local agencies and academic institutions, as well as state, national, and community programs with a range of expertise including:

- Bike Walk NC (Executive Director)
- Carolina Swims Foundation (Founder)
- Centering Healthcare Institute
- Chatham County Community Child Protection Team (Chair)
- Chatham County Department of Social Services (Director)
- Community Child Protection Team State Advisory Board (Chair)
- Division of Child Development and Early Education (Assistant Attorney General, NC Dept. of Justice)
- Driver Education Program, NC Department of Public Instruction
- Family law attorney specializing in child welfare
- Food Protection & Facilities, NC Division of Public Health (Branch Head)
- Forsyth County Community Child Protection Team (Chair)
- Halifax County Child Fatality Prevention Team (Chair) and County Health Department (Director)
- Injury and Violence Prevention Branch, NC Division of Public Health (Branch Head; Injury Epidemiologist)
- Jordan Institute for Families, University of North Carolina School of Social work (Director)
- National Center for Fatality Review and Prevention (Director)
- NC American Academy of Pediatrics State Chapter for Breastfeeding (Co-Coordinator and pediatrician)
- NC Association of Pharmacists (Executive Director)
- NC Department of Health and Human Services (State Health Director/Chief Medical Officer)
- NC Healthy Schools & Specialized Instructional Support, NC Department of Public Instruction (Section Chief)
- NC Medicaid Division of Health Benefits (Chief Medical Officer)
- North Carolina Medical Board (Chief Medical Officer)
- Office of the Chief Medical Examiner, Division of Public Health (Chief Medical Examiner; Chief Toxicologist)
- Safety and Prevention Services, Child Welfare, NC Division of Social Services (Section Chief)
- State Child Fatality Prevention Team
- State School Health Nurse Program, NC Division of Public Health
- Strategy and Planning, NC Division of Health Benefits (Associate Director)
- Tennessee Deputy Commissioner for Population Health
- Tobacco Prevention and Control Branch, NC Division of Public Health
- Traffic Safety Unit, NC Department of Transportation
- University of North Carolina Collaborative for Maternal & Infant Health (Executive Director; Assistant Director)
- University of North Carolina Gillings School of Global Public Health
- University of North Carolina Highway Safety Research Center
- University of North Carolina Injury Prevention Research Center
- Wake County Human Services (Child Welfare Director)
- Women's and Children's Health Section, NC Division of Public Health (MCH Epidemiologist)
- Women's Health Branch, NC Division of Public Health (Branch Head)

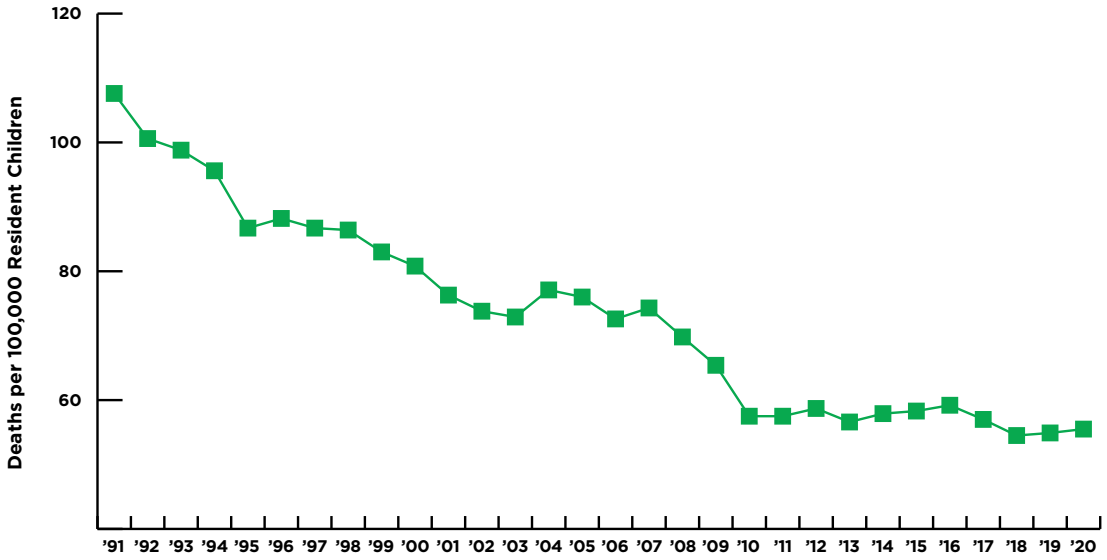
The rate of child deaths in North Carolina ***has decreased by 48%*** *since the 1991 creation of the Child Fatality Task Force & the broader Child Fatality Prevention System.*

Child Fatality Task Force recommendations are set out in the Task Force's yearly "Action Agenda," and these recommendations are shared not only in the annual report of the Task Force, but they are also shared widely through broad communications about Task Force work and through the involvement of the Task Force Executive Director and other members of Task Force leadership in various state-level committees and initiatives.

Explanations for each of the 2022 legislative recommendations and administrative efforts from the Task Force, including highlights of evidence to support the recommendations, can be found in this report on pages 16-45.

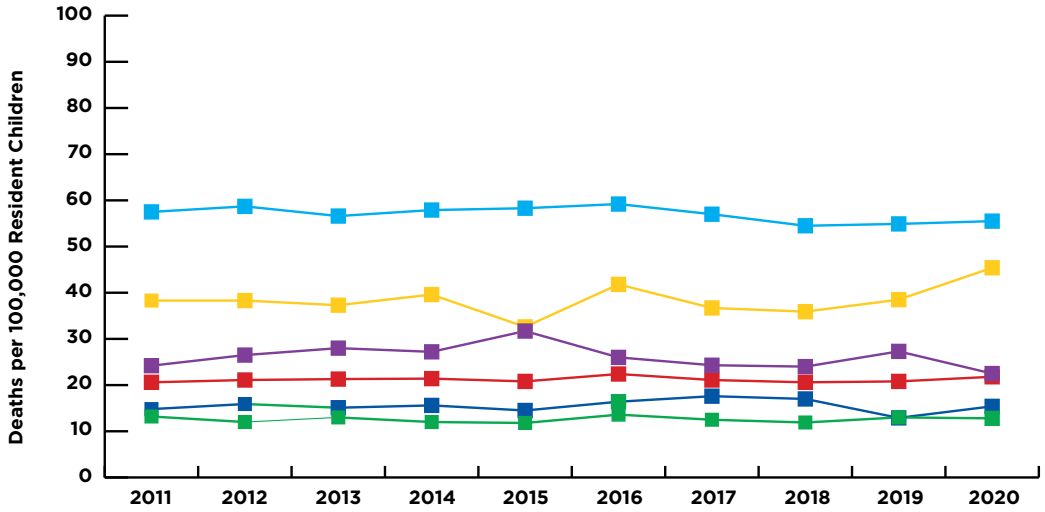
The Child Fatality Task Force Executive Committee thanks all Task Force Members, contributing experts, and community volunteers who devoted their time and expertise to Task Force work. Their efforts and commitment to protecting the children of North Carolina are reflected in the 2022 Action Agenda.

Figure 1. 1991-2020 Trends in North Carolina Resident Child Death Rates Ages Birth Through 17 Years



1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
107.6	100.6	98.8	95.6	86.7	88.2	86.7	86.4	83.0	80.8	76.3	73.8	72.9	77.1	76.0	72.6	74.3	69.8	65.4	57.5	57.5	58.7	56.6	57.9	58.3	59.2	57.0	54.5	54.9	55.5

Figure 2. 2011-2020 Trends in North Carolina Resident Child Death Rates† by Age Group



	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
TOTAL Ages 0-17	57.5	58.7	56.6	57.9	58.3	59.2	57.0	54.5	54.9	55.5
Ages 1-4	24.2	26.5	28.0	27.2	31.7	26.0	24.3	24.0	27.3	22.5
Ages 5-9	13.2	12.0	13.0	12.0	11.8	13.6	12.5	11.9	13.0	12.8
Ages 10-14	14.8	15.9	15.1	15.6	14.5	16.4	17.6	17.0	12.9	15.4
Ages 15-17	38.3	38.3	37.3	39.6	32.6	41.8	36.7	35.9	38.5	45.4
(Excl, Infants) Ages 1-17	20.6	21.1	21.3	21.4	20.8	22.4	21.1	20.6	20.8	21.8

† Child death rates prior to 2020 have been recalculated using the latest available population data

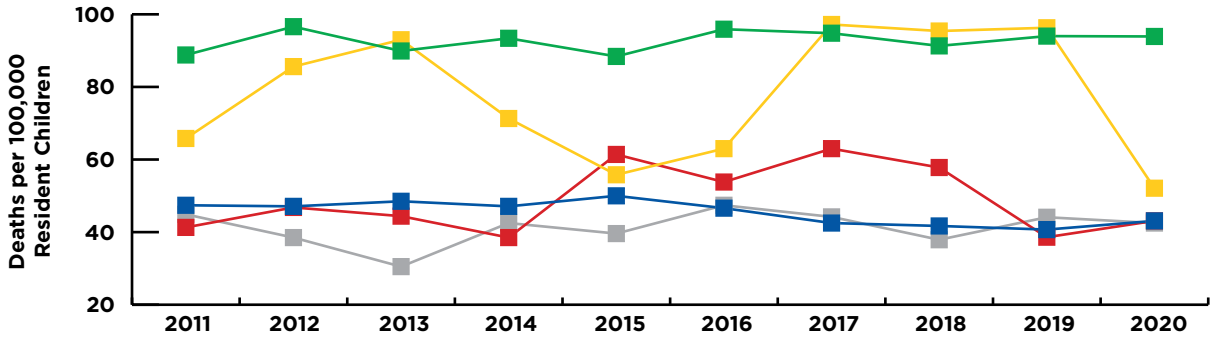
*Produced by the N.C. Division of Public Health - Women's and Children's Health Section in conjunction with the State Center for Health Statistics

Table 1. 2020 NC Resident Child Deaths By Age Group & Cause of Death

	TOTAL AGES 0-17		AGE GROUP (years)									
			Infants		1-4		5-9		10-14		15-17	
Cause of Death Category:	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Perinatal Conditions	**433**	**33.9**	**430**	**99.3**	**2**	**0.5**	**1**	**0.2**	**0**	**0.0**	**0**	**0.0**
... Short Gestation/Low Birthweight	153		152		1		0		0		0	
... Maternal Complications	85		85		0		0		0		0	
... All Other Perinatal Conditions	195		193		1		1		0		0	
Medical Conditions	**220**	**17.2**	**79**	**35.9**	**32**	**14.5**	**35**	**15.9**	**47**	**21.4**	**27**	**12.3**
... Malignant Neoplasms (Cancer)	47		4		8		11		16		8	
... Heart Disease	22		12		2		2		4		2	
... Chronic Lower Respiratory Diseases	8		1		0		1		6		0	
... Septicemia	8		6		1		0		0		1	
... Pneumonia/Influenza	13		6		4		1		0		2	
... All Other Medical Conditions	122		50		17		20		21		14	
Birth Defects	**164**	**12.8**	**146**	**89.0**	**8**	**4.9**	**4**	**2.4**	**3**	**1.8**	**3**	**1.8**
... Circulatory System	50		43		3		1		3		0	
... Nervous System	23		16		5		0		0		2	
... Respiratory System	24		24		0		0		0		0	
... All Other Birth Defects	67		63		0		3		0		1	
Motor Vehicle Injuries	**74**	**5.8**	**1**	**1.4**	**11**	**14.9**	**18**	**24.3**	**9**	**12.2**	**35**	**47.3**
Other Unintentional Injuries	**107**	**8.4**	**32**	**29.9**	**32**	**29.9**	**15**	**14.0**	**8**	**7.5**	**20**	**18.7**
...Suffocation/Choking/Strangulation	38		29		5		2		0		2	
...Drowning	21		0		14		3		1		3	
...Poisoning	17		0		3		2		2		10	
...Bicycle	3		0		0		0		2		1	
...Firearm	9		0		3		4		1		1	
...Smoke, Fire & Flames	6		0		1		3		1		1	
...All Other Accidental Injuries	13		3		6		1		1		2	
Suicide	**56**	**4.4**	**0**	**0.0**	**0**	**0.0**	**1**	**1.8**	**20**	**35.7**	**35**	**62.5**
... by Firearm	31		0		0		0		12		19	
... by Hanging	21		0		0		1		7		13	
... by Poisoning	3		0		0		0		1		2	
... All Other Suicides	1		0		0		0		0		1	
Homicide	**92**	**7.2**	**13**	**14.1**	**16**	**17.4**	**2**	**2.2**	**11**	**12.0**	**50**	**54.3**
... Involving Firearm	67		1		5		2		11		48	
... All Other Homicides	25		12		11		0		0		2	
Other Injuries Undetermined Manner	**9**	**0.7**	**2**	**22.2**	**1**	**11.1**	**1**	**11.1**	**3**	**33.3**	**2**	**22.2**
... Hanging/Strangulation/Suffocation	3		2		0		0		1		0	
... Poisoning	1		0		0		0		0		1	
... All Other Undetermined Injuries	5		0		1		1		2		1	
All Other Causes of Death	**124**	**9.7**	**100**	**80.6**	**8**	**6.5**	**4**	**3.2**	**2**	**1.6**	**10**	**8.1**
TOTAL DEATHS	**1,279**	**100.0**	**803**		**110**		**81**		**103**		**182**	

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 the State Center for Health Statistics 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.

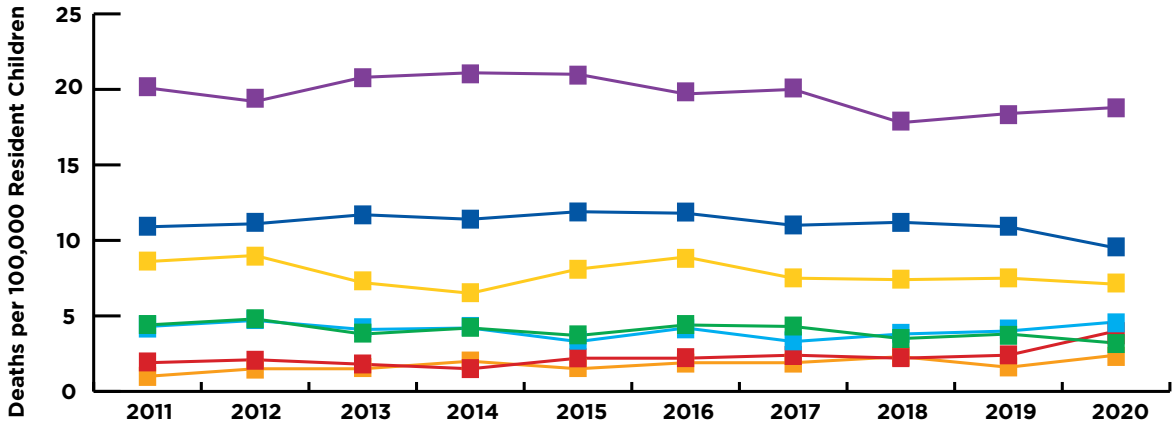
Figure 3. 2011-2020 Trends in North Carolina Resident Child Death Rates† by Race/Ethnicity, Ages Birth Through 17 Years



	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Non-Hispanic White	47.4	47.1	48.5	47.1	50.0	46.6	42.5	41.7	40.7	43.1
Non-Hispanic Black	88.8	96.6	89.9	93.4	88.4	95.9	94.8	91.3	94.0	93.9
Non-Hispanic American Indian	65.8	85.6	93.0	71.3	55.8	63.0	97.2	95.4	96.3	52.1
Non-Hispanic Other	41.3	46.8	44.4	38.5	61.4	53.8	63.0	57.8	38.6	43.1
Hispanic	44.9	38.5	30.5	42.5	39.6	47.4	44.2	37.9	44.1	42.5

† Child death rates prior to 2020 have been recalculated using the latest available population data

Figure 4. 2011-2020 Trends in North Carolina Resident Child Death Rates† for Selected Causes of Death, Ages Birth Through 17 Years



	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Birth Defects	8.6	9.0	7.2	6.5	8.1	8.9	7.5	7.4	7.5	7.1
Perinatal Conditions	20.1	19.2	20.8	21.1	21.0	19.7	20.0	17.8	18.4	18.8
Illnesses	10.9	11.1	11.7	11.4	11.9	11.8	11.0	11.2	10.9	9.5
Motor Vehicle Accidents	4.4	4.8	3.8	4.2	3.7	4.4	4.3	3.5	3.8	3.2
Other Unintentional Injuries	4.3	4.7	4.1	4.2	3.3	4.2	3.3	3.8	4.0	4.6
Homicide	1.9	2.1	1.8	1.5	2.2	2.2	2.4	2.2	2.4	4.0
Suicide	1.0	1.5	1.5	2.0	1.5	1.9	1.9	2.3	1.6	2.4

† Child death rates prior to 2020 have been recalculated using the latest available population data

Table 2. Leading Causes of Child Death by Age Group, NC Residents 2020

ALL AGES, 0-17			
Rank	Cause	Number	%
1	Conditions originating in the perinatal period	433	33.9%
2	Congenital anomalies (birth defects)	164	12.8%
3	Other Unintentional injuries	104	8.1%
4	Homicide	92	7.2%
5	Motor vehicle injuries	77	6.0%
6	Suicide	56	4.4%
7	Cancer	47	3.7%
8	Diseases of the heart	22	1.7%
9	Pneumonia & influenza	13	1.0%
10	Cerebrovascular disease	11	0.9%
All other causes (Residual)		260	20.3%
Total Deaths — All Causes		1,279	100.0%

AGES 1 TO 17			
Rank	Cause	Number	%
1	Homicide	79	16.6%
2	Motor vehicle injuries	76	16.0%
3	Other Unintentional injuries	72	15.1%
4	Suicide	56	11.8%
5	Cancer	43	9.0%
6	Congenital anomalies (birth defects)	18	3.8%
7	Diseases of the heart	10	2.1%
8	Cerebrovascular disease	9	1.9%
9	Chronic lower respiratory diseases	7	1.5%
9	Pneumonia & influenza	7	1.5%
All other causes (Residual)		99	20.8%
TOTAL DEATHS — ALL CAUSES		476	100.0%

INFANTS			
Rank	Cause	Number	%
1	Short gestation - low birthweight	150	18.7%
2	Congenital anomalies (birth defects)	146	18.2%
3	Maternal complications of pregnancy	45	5.6%
4	Complications of placenta, cord, and membranes	32	4.0%
5	Other unintentional injuries	32	4.0%
6	Bacterial sepsis	21	2.6%
	Respiratory distress	19	2.4%
	Diseases of the circulatory system	16	2.0%
9	Necrotizing enterocolitis	16	2.0%
10	Neonatal hemorrhage	15	1.9%
All other causes (Residual)		311	38.7%
TOTAL DEATHS — ALL CAUSES		803	100.0%

AGES 1 TO 4			
Rank	Cause	Number	%
1	Other Unintentional injuries	32	29.1%
2	Homicide	16	14.5%
3	Motor vehicle injuries	11	10.0%
4	Cancer	8	7.3%
4	Congenital anomalies (birth defects)	8	7.3%
6	Cerebrovascular disease	4	3.6%
6	Pneumonia & influenza	4	3.6%
8	In-situ/benign neoplasms	3	2.7%
9	Conditions originating in the perinatal period	2	1.8%
	Diseases of the heart	2	1.8%
All other causes (Residual)		20	18.2%
TOTAL DEATHS — ALL CAUSES		110	100.0%

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

Table 2. Leading Causes of Child Death by Age Group, NC Residents 2020

AGES 5 TO 9			
Rank	Cause	Number	%
1	Motor vehicle injuries	18	22.2%
2	Other Unintentional injuries	15	18.5%
3	Cancer	11	13.6%
4	Congenital anomalies (birth defects)	4	4.9%
5	Complications of medical and surgical care	2	2.5%
	Diseases of the heart	2	2.5%
	Homicide	2	2.5%
	In-situ/benign neoplasms	2	2.5%
9	Anemias	1	1.2%
9	Cerebrovascular disease	1	1.2%
9	Chronic lower respiratory diseases	1	1.2%
9	Conditions originating in the perinatal period	1	1.2%
9	Diseases of appendix	1	1.2%
9	Pneumonia & influenza	1	1.2%
9	Suicide	1	1.2%
All other causes (Residual)		18	22.2%
TOTAL DEATHS — ALL CAUSES		81	100.0%

AGES 10 TO 14			
Rank	Cause	Number	%
1	Suicide	20	19.4%
2	Cancer	16	15.5%
3	Homicide	11	10.7%
	Motor vehicle injuries	11	10.7%
5	Chronic lower respiratory diseases	6	5.8%
	Other Unintentional injuries	6	5.8%
7	Cerebrovascular disease	4	3.9%
	Diseases of the heart	4	3.9%
9	Congenital anomalies (birth defects)	3	2.9%
10	Diabetes mellitus	2	1.9%
All other causes (Residual)		20	19.4%
TOTAL DEATHS — ALL CAUSES		103	100.0%

AGES 15 TO 17			
Rank	Cause	Number	%
1	Homicide	50	27.5%
2	Motor vehicle injuries	36	19.8%
3	Suicide	35	19.2%
4	Other Unintentional injuries	19	10.4%
5	Cancer	8	4.4%
6	Congenital anomalies (birth defects)	3	1.6%
7	Diseases of the heart	2	1.1%
	Nutritional deficiencies	2	1.1%
	Pneumonia & influenza	2	1.1%
10	Anemias	1	0.5%
	Diabetes mellitus	1	0.5%
	Pneumonitis due to solids & liquids	1	0.5%
	Pregnancy, childbirth, and puerperium	1	0.5%
	Septicemia	1	0.5%
All other causes (Residual)		20	11.0%
TOTAL DEATHS — ALL CAUSES		182	100.0%

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

NC Child Fatality Task Force 2022 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 action items sought to be further examined or advanced by the CFTF.

Note: Items that are being repeated from prior years or are similar to an item from prior years are indicated with an asterisk (*). Each item below is explained later in this report.

Legislative recommendations and administrative efforts to prevent youth suicide and firearm-related deaths and injuries to children

Legislative recommendations:

***SUPPORT legislation to launch and fund a new statewide firearm safety initiative, as recommended by the 2017 Firearm Safety Stakeholder group, that is focused on education and awareness surrounding firearm safe storage and distribution of free gun locks with minimum two-year funding of $155,700.**

The Child Fatality Task Force recognizes the significant crisis that North Carolina faces in child behavioral health and the importance of SUPPORTING timely and appropriate funding to address this crisis.

Administrative efforts:

- Gather additional information on privacy and confidentiality of a potential statewide school health data system and further evaluation of funding needs related to implementation and recurring costs of the system, providing this information to the Intentional Death Prevention Committee prior to the 2023 legislative session.
- *Follow implementation of the study required in the 2021 Appropriations Act that the State Board of Education study and report on various policies, practices, and standards related to the professions of school nurses, social workers, counselors, and psychologists in public schools and to make recommendations on reducing and eliminating barriers of entry into these professions and improving the number and quality of these school health support personnel; the Intentional Death Prevention Committee to examine information from this study in its ongoing efforts to address the increased mental health needs of students and to support the increased funding to address staffing issues.
- *Follow implementation of provisions in the NC Board of Education School Mental Health Policy that relate to strengthened school/community connections to address student mental health; information on implementation to be studied by the Intentional Death Prevention Committee prior to the 2023 legislative session.
- Explore and pursue possibilities for funding of a three-year lead suicide prevention coordinator position in North Carolina that would coordinate cross-agency efforts to carry out implementation of the 2015 NC Suicide Prevention Strategic Plan and determine a sustainability plan for ongoing statewide coordination for implementation of the Strategic Plan.

Legislative recommendations to strengthen the statewide Child Fatality Prevention System to increase the system's ability to prevent infant deaths, child deaths, and child abuse and neglect

***SUPPORT legislation, agency action, and policy change to implement the following changes to the Child Fatality Prevention System (CFP System):**

I. **Implement centralized state-level staff with whole-system support in one location; Office of the Chief Medical Examiner (OCME) child fatality staff remains in OCME; form new Fatality Review and Data Group to be information liaison.**

II. **Implement a centralized electronic data and information system that includes North Carolina participating in the National Child Death Review Case Reporting System used by 47 other states.**

III. **Reduce the volume of team reviews by changing the types of deaths required to be reviewed by fatality review teams to be according to certain categories most likely to yield prevention opportunities [undetermined, unintentional injury, violence, motor vehicle, child abuse or neglect/Child Protective Services (CPS) involvement, Sudden Unexpected Infant Death (SUID), suicide, deaths not expected in next six months, additional infant deaths].**

IV. **Reduce the number and types of teams performing fatality reviews by combining the functions of the four current types of teams into one with different procedures and required participants for different types of reviews and giving teams the option to choose whether to be single- or multi-county teams. DHHS should study and determine an effective framework for meeting federal requirements for Citizen Review Panels and for reviewing active DSS cases.**

V. **Formalize the 3 CFTF Committees with certain required members; expand CFTF reports to address whole CFP System and to be distributed to additional state leaders.**

Funding: maintain current child fatality prevention funding and appropriate additional funds pursuant to DHHS determinations related to state office, local teams, and Fetal and Infant Mortality Review pilot.

SUPPORT an appropriation of $550,000 in nonrecurring funds and $110,000 in recurring funds to enable the OCME to conduct comprehensive toxicology testing in all Medical Examiner jurisdiction child deaths.

Legislative recommendations and administrative efforts focused on the prevention of infant deaths

[Other recommendations on this agenda addressing the prevention of infant deaths include recommendations to strengthen the Child Fatality Prevention System, recommendations to prevent motor vehicle-related deaths, funding for the prevention of tobacco and nicotine use, and strengthening education around child abuse and neglect reporting.]

Legislative recommendations:

***SUPPORT recurring funding totaling $250,000 per year to expand efforts to prevent infant deaths related to unsafe sleep environments.**

***SUPPORT legislation to strengthen the infant safe surrender law to make it more likely the law will be used in circumstances for which it was intended to protect a newborn infant at risk of abandonment or harm by making legislative changes to accomplish the following:**

1) **remove "any adult" from those designated to accept a surrendered infant;**
2) **provide information to a surrendering parent;**
3) **strengthen protection of a surrendering parent's identity;**
4) **incorporate steps to help ensure the law is only applied when criteria are met.**

Administrative efforts:

- Gather more information from relevant experts and stakeholders related to the potential for a statewide breastfeeding hotline and bring information back to the committee prior to the 2023 legislative session.
- Request the Division of Health Benefits, NC Medicaid to review the current prenatal bundle rate and its impact on group prenatal care.



Legislative recommendations and administrative efforts to prevent motor vehicle-related injuries and deaths to children

Legislative recommendations:

***ENDORSE legislation to require ignition interlocks for all alcohol impaired DWI offenders, including first-time offenders.**

ENDORSE legislation that eliminates the 2013 law prohibiting the use of state transportation funding related to independent pedestrian and bicycle infrastructure projects.

Administrative efforts:

- *Efforts to increase the use of rear seat restraints among youth including: Child Fatality Task Force to write a letter to the Driver Education Advisory Committee to request that the driver education curriculum include robust education around the importance of using rear seat restraints; efforts by the Governor's Highway Safety Program to strengthen public education and awareness about the importance of rear seat restraints; efforts by the Unintentional Death Prevention Committee to continue to gather and consider information on the topic of rear seat restraints.
- *Continued study of current NC child passenger safety laws and for the Unintentional Death Prevention Committee to revisit the potential need for changes in NC child passenger safety laws after the American Academy of Pediatrics releases revisions to child passenger safety guidelines.

Legislative recommendation to prevent harm to youth and infants caused by tobacco and nicotine use

***ENDORSE an appropriation of $17 million in recurring funds for programs to prevent tobacco use and cessation by youth and to prevent harms to infants and children caused by tobacco use (including the prevention of infant deaths that have causes associated with tobacco use during pregnancy).**

Administrative efforts to strengthen education and awareness around child abuse and neglect reporting

*Administrative support to continue to strengthen education and awareness surrounding child abuse and neglect reporting for law enforcement professionals, medical professionals, and school professionals, such efforts to include adding Child Abuse and Neglect reporting training to already mandated training for all three professions and for trainings to include trauma-informed response and prevention.

Administrative efforts to further study a proposal related to water safety

Administrative support for further study by the UNC Injury Prevention Research Center to quantify the potential impact of legislation requiring lifeguards at day camps that offer time in the water (as it relates to impact on preventing child drownings and near-drownings) to bring information back to the Unintentional Death Prevention Committee; Child Fatality Task Force to acknowledge the public health efficacy of utilizing lifeguards as a strategy to prevent child drownings in settings where children are in or around water, including day camp settings.

Legislative recommendations and administrative efforts to prevent youth suicide and firearm-related deaths and injuries to children

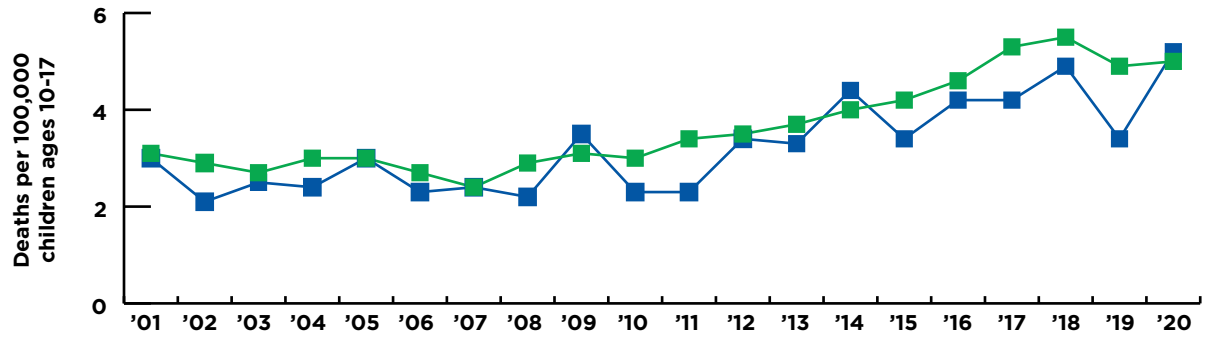
Data presented to the Child Fatality Task Force and its committees in meetings during the 2021-22 study cycle as well as in recent years have illustrated how much North Carolina youth are struggling with mental health issues. Over the past decade, the youth suicide rate and measures of youth mental health well-being have been worsening. Meanwhile, the rate of firearm deaths and injuries to children in North Carolina has also been on the rise with a dramatic increase seen in 2020.

Trends for firearms deaths and suicides are related because firearms are the lethal means used in about half of youth suicides in North Carolina. These trends in North Carolina were concerning prior to the COVID-19 pandemic, and the pandemic has exacerbated circumstances resulting in data that was even worse in 2020.

The latest available finalized data showed the following for **North Carolina kids in 2020**:[1]

- Suicide was the leading cause of death for youth ages 10 to 14.
- Suicide was the third leading cause of death for teens ages 15 to 17, and homicide was the leading cause of death for this age group with firearms being the lethal means used in 96% of those homicides.
- There were 56 youth suicides in North Carolina with firearms being the lethal means used in 31 of those deaths.
- There were almost 550 hospitalizations and over 2700 emergency department visits for self-inflicted injury among youth ages 10 to 17.
- The 2020 rate of firearm deaths to children was more than 2.5 times higher than it was a decade earlier in 2011, for a total of 105 deaths.

Suicide Rates, Ages 10 to 17: NC 2001-2020

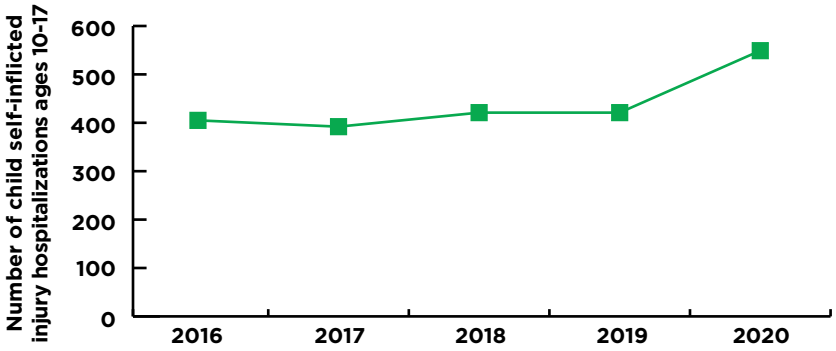


	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
US	3.1	2.9	2.7	3.0	3.0	2.7	2.4	2.9	3.1	3.0	3.4	3.5	3.7	4.0	4.2	4.6	5.3	5.5	4.9	5.0
NC	3.0	2.1	2.5	2.4	3.0	2.3	2.4	2.2	3.5	2.3	2.3	3.4	3.3	4.4	3.4	4.2	4.2	4.9	3.4	5.2

Source: NC State Center for Health Statistics & National Center for Health Statistics

[1] Death data source: Annual Child Death Data report based on 2020 death certificate data, contained at the beginning of this 2022 CFTF Annual Report and also available on the website for the State Center for Health Statistics: https://schs.dph.ncdhhs.gov/data/vital/cd/2020/FINAL-2020-ChildDeath-Main-Report.pdf. Hospitalization data source: hospital discharge data from the NC State Center for Health Statistics. Emergency Department data source: NC DETECT. Hospitalization and emergency department data analysis provided by the Injury and Violence Prevention Branch, NC Division of Public Health.

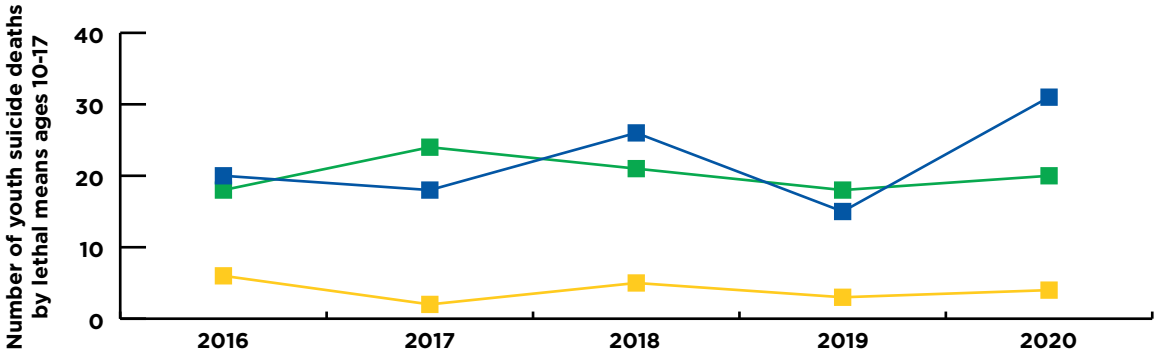
Number of Child Self-Inflicted Injury Hospitalizations, Ages 10 to 17: NC 2016-2020



	2016	2017	2018	2019	2020
NC	405	392	421	421	549

Source: NC State Center for Health Statistics, Hospital Discharge Data, 2016-2020

Number of Youth Suicide Deaths by Lethal Means, Ages 10-17: NC 2016-2020



	2016	2017	2018	2019	2020
Firearm	20	18	26	15	31
Suffocation	18	24	21	18	20
Other*	6	2	5	3	4

*Other category includes falls, fires/burns, drownings, as well as drug and non-drug poisonings • Data counts limited to North Carolina residents • Source: NC State Center for Health Statistics, Vital Statistics Death Certificate Data (2016-2020) • Analysis by: NC Division of Public Health, Injury and Violence Prevention Branch, Epidemiology, Surveillance & Informatics Unit

The concerning status of youth mental health is not unique to North Carolina. Two recent national calls to action on youth mental health make it clear that this is a national crisis. In December of 2021, the U.S. Surgeon General issued an Advisory on the Youth Mental Health Crisis. In October of 2021, there was a *Declaration of a National Emergency in Child and Adolescent Mental Health* from the American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry and the Children's Hospital Association. Both documents sought to raise attention about the crisis, called for an urgent response to the crisis, and provided recommendations to address it. Areas of focus by the Child Fatality Task Force in recent years and on the 2022 Action Agenda that are aimed at addressing youth suicide and mental health (detailed below) are aligned with many of the recommendations made in these national calls to action.

Legislative recommendation: SUPPORT legislation to launch and fund a new statewide firearm safety initiative, as recommended by the 2017 Firearm Safety Stakeholder group, that is focused on education and awareness surrounding firearm safe storage and distribution of free gun locks with minimum two-year funding of $155,700.

Firearm-related deaths and injuries to children in North Carolina have been on the increase and skyrocketed in 2020 (finalized data for 2021 is not yet available). Most firearm-related deaths to children in North Carolina are homicides and suicides, with a much smaller proportion accidental.

From 2011 to 2020 (ten years), there were over 525 child deaths due to firearm-related injuries to North Carolina children ages 17 and younger. In 2020 alone there were 105 firearm-related deaths, almost 200 firearm-related hospitalizations, and over 435 firearm-related emergency department visits for North Carolina children.

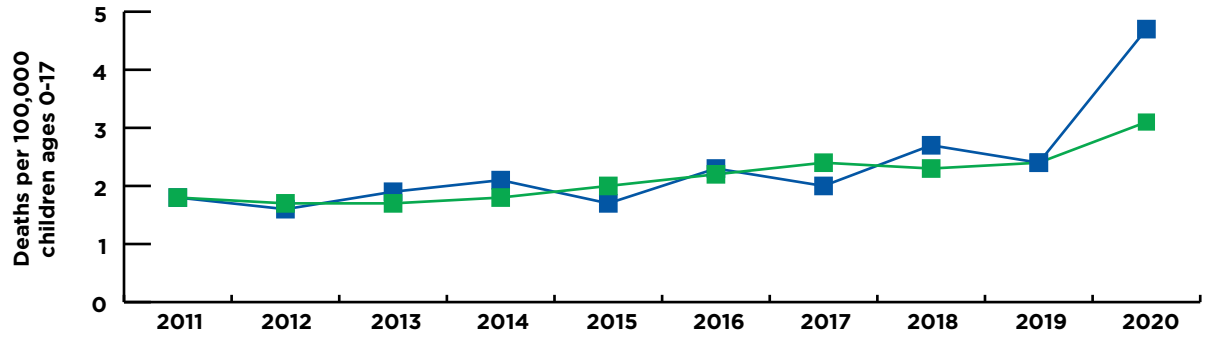
In 2020, homicide was the leading cause of death for teens ages 15 to 17 and third leading cause of death for ages 10 to 14 with firearms being the lethal means used in 57 out of 59 (97%) of homicides among 10 to 17 year-olds. As noted earlier, firearms are the lethal means used in about half of youth suicides and in 2020, firearms were used in 31 out of 56 youth suicides.

A disturbing reality for NC children:

- ***525 firearm deaths** from 2011-2020*
- ***105 firearm deaths in 2020 alone** (including 31 suicides)*
- ***Nearly 200 firearm hospitalizations** in 2020*
- ***Over 435 firearm emergency department visits** in 2020*

A disturbing reality in North Carolina is that each year hundreds of children are injured or killed by firearms, and all of these deaths and injuries are preventable. While no single isolated strategy will prevent all of these deaths and injuries, the safe storage of firearms has been proven to be a critical strategy to prevent gun deaths.

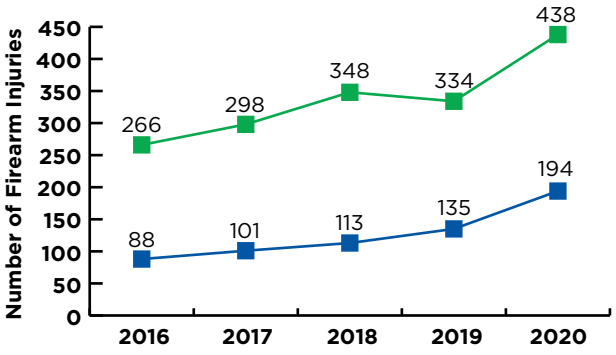
Firearm-related Mortality Rates, Children Ages 0 to 17: NC & US, 2011-2020



	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
US	1.8	1.7	1.7	1.8	2.0	2.2	2.4	2.3	2.4	3.1
NC	1.8	1.6	1.9	2.1	1.7	2.3	2.0	2.7	2.4	4.7

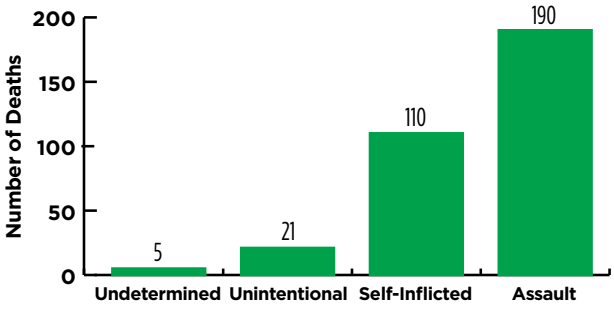
Source: NC State Center for Health Statistics & National Center for Health Statistics

Firearm-Related Emergency Department (ED) Visits and Hospitalizations Among Children (0-17) in NC*



*Limited to NC Residents • Source: NC State Center for Health Statistics, Hospital Discharge Data, 2016-2020 • NC DETECT ED Visit Data, 2016-2020

Number of Child Firearm Deaths by Intent, Ages 0-17, From 2016-2020



*Limited to NC Residents • Source: NC State Center for Health Statistics, Vital Statistics Death Certificate Data (2016-2020) • Analysis by: NCDHHS, Division of Public Health, Injury and Violence Prevention Branch, Epidemiology, Surveillance & Informatics Unit

More than half of gun owners *do not store guns safely, and guns used in youth suicides and in mass school shootings usually come from home.*

Data show guns are frequently not stored safely and that kids know where to find them. A 2016 study by Johns Hopkins researchers found that 54% of gun owners reported not storing all of their guns safely; safe storage was defined as stored in a locked gun safe, cabinet, or case, locked into a gun rack, or stored with a trigger lock or other lock.[2] Results from a 2015 national survey found that among gun-owning households with children, approximately two in ten gun owners store at least one gun in the least safe manner – loaded and unlocked; and only three in ten store guns in the safest manner – unloaded and locked.[3] National studies show that most kids know where parents keep their guns,[4] more than 75% of guns used in suicide attempts and unintentional injuries of kids were stored in the home of the victim, a relative, or a friend,[5] and guns used in American mass school shootings often come from home.[6]

Evidence is clear that reducing access to guns saves lives. A study published in JAMA Pediatrics in 2019 estimated that up to 32% of youth firearm deaths could be prevented through safe storage of firearms in homes with youths.[7] Presentations to the Task Force over the years have provided strong evidence that preventing access to a gun prevents suicides. Many suicide attempts are hastily decided upon and involve little or no planning, and 90% of those who attempt suicide and survive do not go on to die by suicide later. About 85% of attempts with a firearm are fatal compared to much lower lethality rates of many of the most widely used suicide attempt methods. Simply having a firearm in the home is a known risk factor for suicide. Evidence on this topic is well summarized on the "Means Matter" website of the Harvard T.H. Chan School of Public Health.[8] The importance of preventing access to firearms by children and youth as a suicide prevention strategy is also highlighted in the Surgeon General's Advisory on Youth Mental Health that was noted

[2] Crifasi CK, Doucette ML, McGinty EE, Webster DW, Barry CL. Storage Practices of US Gun Owners in 2016. Am J Public Health. 2018 Apr;108(4):532-537. doi: 10.2105/AJPH.2017.304262. Epub 2018 Feb 22. PMID: 29470124; PMCID: PMC5844398. • [3] Azrael D, Cohen J, Salhi C, Miller M. Firearm Storage in Gun-Owning Households with Children: Results of a 2015 National Survey. J Urban Health. 2018 Jun;95(3):295-304. doi: 10.1007/s11524-018-0261-7. PMID: 29748766; PMCID: PMC5993703. • [4] 73% of children under age 10 living in homes with guns reported knowing the location of their parents' firearms. 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. • [5] Grossman DC, Reay DT, Baker SA. Self-inflicted and Unintentional Firearm Injuries Among Children and Adolescents: The Source of the Firearm. Arch Pediatr Adolesc Med. 1999;153(8):875–878. doi:10.1001/archpedi.153.8.875. • [6] Giffords Law Center to Prevent Gun Violence: "A report published by the US Secret Service and the Dept. of Education found that in 65% of school shootings covered by the study, the shooter used a gun obtained from his or her own home or from the home of a relative." Report: "The Final Report and Findings of the Safe School Initiative – Implications for the Prevention of School Attacks in the United States." (July 2004). In addition, A Wall Street Journal report in April of 2018 examining nearly three decades of American mass school shootings stated that the killers in these shootings mostly used guns owned by a family member; the report addressed the big role that a lack of gun safety at home has played in school shootings. [Hobbs, Tawnell D. (April 5, 2018). "Most Guns Used in School Shootings Come From Home," Wall Street Journal.] • [7] 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 • [8] The source for much of the evidence on this topic that has been provided in Task Force meetings and in this report comes from the "Means Matter" website of the Harvard T.H. Chan School of Public Health which summarizes studies related to means reduction as a suicide prevention strategy.

earlier in this report. This Advisory not only identifies this strategy as one to be implemented by individuals but also notes that governments should collaborate with the private sector and local communities to promote safe storage.

The Task Force looked at data showing that firearm sales in the U.S. increased dramatically during the pandemic. This surge in gun purchases has logically resulted in more guns accessible to curious young children or youth at risk of hurting themselves or others.

Origin and focus of the Task Force recommendation for a statewide firearm safety initiative

An area of consensus within the Task Force related to preventing firearm-related deaths and injuries to children has long been focused on the importance of firearm safe storage. The current recommendation for a statewide firearm safe storage education and awareness initiative has been repeated by the Task Force each year since 2018.

*The **recent dramatic rise in gun purchases in the U.S.** has logically resulted in more guns accessible to curious young children or youth at risk of hurting themselves or others, elevating the importance and urgency of focusing on firearm safe storage to save children's lives.*

This recommendation grew from an initial recommendation of the State Child Fatality Prevention Team that reviews child deaths and expressed concerns about youth access to firearms in the context of suicide. This led to study and input from a diverse group of stakeholders whose work in 2017 informed the CFTF recommendation for this initiative. (For more information on the work of the stakeholder group, see the CFTF 2018 Annual Report, beginning on page 26.) This group of stakeholders had input and representation from the following organizations and areas of expertise:

- City Police Chief
- Department of Public Instruction
- Durham Gun Safety Team
- Hunter educator
- Injury & Violence Prevention Branch, NC Division of Public Health
- Juvenile Justice Health Services
- National Rifle Association
- NC Child Fatality Prevention Team
- NC Child Fatality Task Force
- NC Coalition Against Domestic Violence
- NC Department of Justice
- NC Wildlife Officer
- North Carolinians Against Gun Violence
- Pediatrician with expertise in child safety
- Safe Kids NC
- UNC Injury Prevention Research Center

In reviewing evidence about initiatives most likely to be effective, the stakeholder group determined that local community mobilization initiatives have the best chance of effectively educating people and getting them to engage in safe storage practices. The majority of funding for this initiative is intended to go toward providing state-level outreach and technical assistance to help local communities across the state launch local safe storage initiatives tailored to work for their particular community.

Legislation to accomplish the Task Force recommendation to launch and fund a statewide firearm safe storage initiative has been introduced in two legislative sessions and received strong bipartisan support, but has so far not become law. The firearm safety initiative was included in the 2019 Appropriations Act which never became law.[9] In 2021, the initiative was addressed in HB 427, which passed the House on a vote of 116 to 1 and was also included in the House version of the budget, but was not included in the final budget – the Appropriations Act of 2021. The Task Force has continued to recognize the importance of safe

[9] The 2019 Appropriations Act was passed by the General Assembly and vetoed by the governor.

storage as a prevention strategy and is repeating the recommendation for a statewide firearm safe storage education and awareness initiative for 2022.

Legislative recommendation: The Child Fatality Task Force recognizes the significant crisis that North Carolina faces in child behavioral health and the importance of SUPPORTING timely and appropriate funding to address this crisis.

Related Administrative Effort: Follow implementation of the study required in the 2021 Appropriations Act that the State Board of Education study and report on various policies, practices, and standards related to the professions of school nurses, social workers, counselors, and psychologists in public schools and to make recommendations on reducing and eliminating barriers of entry into these professions and improving the number and quality of these school health support personnel; the Intentional Death Prevention Committee to examine information from this study in its ongoing efforts to address the increased mental health needs of students and to support the increased funding to address staffing issues.

This legislative recommendation by the Task Force acknowledges the significant youth mental health crisis taking place in North Carolina as well as the need to help address the crisis through timely and appropriate state funding. The related administrative effort resulted from Task Force recognition that while the numbers of school nurses, social workers, counselors and psychologists in North Carolina fall far short of meeting nationally recommended ratios, funding for these positions is not the only challenge faced with efforts to improve the ratios. While increased funding is one strategy to improve ratios that has been recommended by the Task Force, it's also important to understand other challenges related to attracting and retaining these professionals and how these challenges may impact strategies related to funding.

In recent years and including during 2021-22 meetings, the Task Force has focused attention and recommendations on strategies to address youth mental health that are implemented in the context of schools. These recommendations have included:

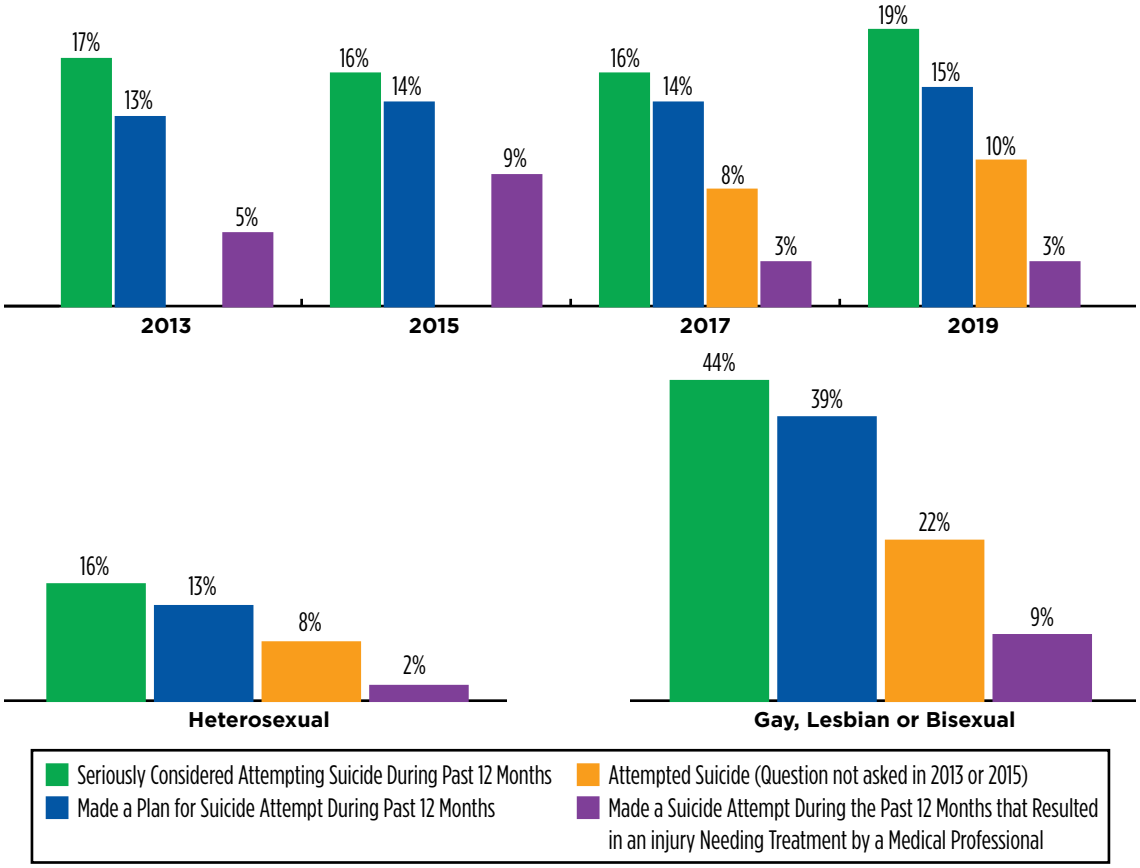
- Passing a law to require suicide prevention training for school personnel and a risk referral protocol in schools (accomplished in 2020 via S.L. 2020-7)
- Expanding training to reduce access to lethal means (appropriations for school safety grants in recent years have designated the program Counseling on Access to Lethal Means as an appropriate use of grant funds)
- Recurring funding to increase the number of school nurses, social workers, counselors and psychologists to move toward meeting nationally recommended ratios (while there has been some funding for this purpose, much of it has been temporary and the numbers of these professionals continue to fall far short of nationally recommended ratios)

The U.S. Surgeon General's Advisory on the Youth Mental Health Crisis and the *Declaration of a National Emergency in Child and Adolescent Mental Health* that were both noted earlier in this report confirm the importance of these types of strategies.

The hours that kids spend at school are likely the most hours spent in any single place outside of their own home. Schools and school personnel are significantly impacted by the youth mental health crisis, while schools provide an opportunity for students to access mental health services or to be referred for services when other means of accessing services may be challenging or impossible for families. Data and graphics below that have been shared with the Task Force further illustrate the mental health crisis that schools were faced with prior to the pandemic which has been exacerbated by the pandemic.

Presentations made to the Task Force by education experts have explained how school health support personnel, which include school nurses, social workers, counselors and psychologists, are uniquely qualified and positioned to identify and address the mental health needs of students. These are also the professionals who are most likely to be involved in the recognition and reporting of child abuse or neglect which is another area of Task Force focus. Experts presenting to the Task Force have emphasized how these four types of professionals act as a team, and the importance of having the strength of a team of all four types staffed sufficiently to meet the needs of every school. The current reality, however, is that there aren't nearly enough of these professionals in North Carolina Schools.

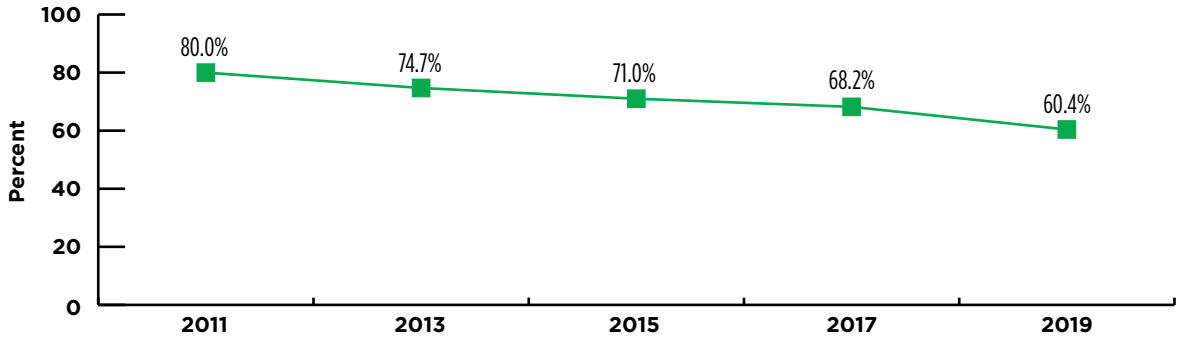
Suicidal Behaviors 2019 NC High School Students



Source: NC High School Youth Risk Behavior Survey

Suicidal Behaviors for NC High School Students pre-pandemic: ***almost 1 in 5 high school students seriously considered suicide.*** *In NC in 2020, suicide was the leading cause of death for 10 to 14 year-olds.*

Percentage of High School Students Who Strongly Agree or Agree That They Feel Good About Themselves*



*Decreased 2007-2019, increased 2007-2011, decreased 2011-2019 [Based on linear and quadratic trend analyses using logistic regression models controlling for sex, race/ethnicity, and grade ($p < 0.05$). Significant linear trends (if present) across all available years are described first followed by linear changes in each segment of significant quadratic trends (if present).] This graph contains weighted results.

Ratios for School Health Support Personnel in North Carolina (data presented to the CFTF on February 7, 2022 by the NC Department of Public Instruction)			
	Ratio Before (in 2020)	Ratio Now (impacted by temporary federal funding)	Nationally Recommended Ratio
School Counselors	1:353	1:335	1:250
School Nurses	1:1,007	1:890 (48% of NC school nurses serve in more than one school)	1 per school
School Social Workers	1:1,289	1:1,025	1:250
School Psychologists	1:1,798	1:1,815	1:500

In 2020 and 2021, some federal funding related to pandemic relief was directed toward increasing the numbers of these professionals in NC schools, however this funding is temporary. Education experts speaking to the Task Force have explained some of the challenges with temporary funding including the fact that it is more difficult to attract a person to a temporary position than a permanent one and the fact that once the funding is gone, the position is lost along with the ability to build a sustainable and experienced team of school health support personnel. The above table provides ratios presented to the Task Force for school support professionals prior to federal funding and currently with the expectation that ratios are likely to return to the "before" numbers once the temporary federal funding is gone.

Task Force discussions leading up to this recommendation for "timely and appropriate funding" acknowledged the breadth of the crisis and the need for some flexibility to respond to evolving circumstances and developing information so that determinations related to funding to address this crisis are informed by the latest available information.

Other Administrative Efforts to Address Youth Mental Health and Suicide Prevention

Administrative Effort: Gather additional information on privacy and confidentiality of a potential statewide school health data system and further evaluation of funding needs related to implementation and recurring costs of the system, providing this information to the Intentional Death Prevention Committee prior to the 2023 legislative session.

A recommendation from the State Child Fatality Prevention Team to the Task Force in 2021 was for the Task Force to recommend state funding to implement a statewide school health data system. The Intentional Death Prevention Committee of

the Task Force heard presentations explaining that current practices in NC schools for health record keeping is varied and there is currently no uniform/consistent means of keeping health records in schools or for connectivity among school record-keeping systems; many schools still use hard copy records. Some school systems can afford an effective electronic record system but many cannot, creating equity issues.

Those familiar with school health records explained to the committee that a statewide electronic school health record system used by all schools would:

- Allow school health support professionals to keep up with student needs and services as they move from school to school or district to district
- Facilitate school health support professionals to collaborate with one another within the school
- Facilitate the kind of record keeping and information needed that is required for a school to bill for eligible Medicaid services
- Help ensure appropriate protection of confidential information
- Cost approximately $1,104,000 per year

The Intentional Death Prevention Committee determined that it would like to learn more about the potential for the statewide school data system and will be examining additional information on this topic during the 2022-23 study cycle of the Task Force. In particular, the committee seeks to better understand privacy and confidentiality issues as well as funding related to a potential statewide system.

Administrative Effort: Follow implementation of provisions in the NC Board of Education School Mental Health Policy that relate to strengthened school/community connections to address student mental health; information on implementation to be studied by the Intentional Death Prevention Committee prior to the 2023 legislative session.

The Intentional Death Prevention Committee discussed the importance of optimizing schools' ability to connect with existing mental health resources in communities. Although in-school support professionals are essential, strong community resources including school-community partnerships are necessary to be able to effectively address the mental health needs of students. In the fall of 2020, the North Carolina Board of Education adopted a new School Mental Health Policy that contains provisions related to strengthened school/community connections to address student mental health including:

- Public School Units (PSUs) shall offer to enter into Memorandums of Understanding with the LME/MCOs and/or local mental health and substance use providers;
- inclusion in PSU mental health plans of strategies to improve access to community-based services; and
- efforts by PSUs to engage relevant stakeholders to support coordinated mental and social-emotional health and substance use supports and services for students.

The Intentional Death Prevention Committee recognized that these provisions in the new School Mental Health Policy demonstrate excellent steps toward strengthening school/community connections for addressing student mental health and the committee is interested in learning about implementation of these policies. The Department of Public Instruction (DPI) has been collecting information from schools on implementation of the new School Mental Health Policy and the Intentional Death Prevention Committee looks forward to hearing a report from DPI when the committee reconvenes.

Administrative Effort: Explore and pursue possibilities for funding of a three-year lead suicide prevention coordinator position in North Carolina that would coordinate cross-agency efforts to carry out implementation of the 2015 NC Suicide Prevention Strategic Plan and determine a sustainability plan for ongoing statewide coordination for implementation of the Strategic Plan.

North Carolina has a statewide comprehensive suicide prevention plan created in 2015 that is the result of a collaborative 16-month process utilizing the input of approximately 180 diverse suicide prevention stakeholders. In addition, the NC Department of Health and Human Services is currently in the process of finalizing a statewide Suicide Prevention Action Plan aimed at prioritizing

a smaller set of prevention strategies to be implemented within a three-year period. Unlike some other statewide prevention or action plans in North Carolina that rely on the collaborative efforts of many, these plans do not have a designated leader to coordinate implementation of prevention strategies.[10] With suicide rates increasing for all age groups, and especially with fears about the current pandemic's impact on mental health, leadership in suicide prevention is essential.

Currently, suicide prevention efforts in North Carolina are facilitated and managed by government agencies, nonprofits, and academic institutions. State prevention plans necessarily involve bringing many experts and leaders together to accomplish prevention goals, which requires coordination and leadership.

Experts who informed this recommendation articulated benefits and goals for this position that include: information sharing to guide efforts to ensure best practice; reducing duplication of prevention efforts and ensuring efficient use and sharing of limited resources; coordination of current interventions and research related to suicide prevention; coordination of funding for suicide prevention efforts; coordination of consistent messaging; coordination of priority strategies; monitoring of outcomes; and consistency with training.

This administrative effort by the Task Force is being repeated from prior years, and there has been progress with this effort. The NC Department of Health and Human Services has been convening meetings of a cross-divisional suicide prevention work group. This group has been working toward ensuring the necessary elements of a statewide infrastructure for suicide prevention and assisting with development of a statewide Suicide Prevention Action Plan. This DHHS work group and the draft Action Plan have identified the need for a lead suicide prevention coordinator role and efforts are currently underway at DHHS to identify potential resources to support this role.

Legislative recommendations to strengthen the statewide Child Fatality Prevention System to increase the system's ability to prevent infant deaths, child deaths, and child abuse and neglect

This set of recommendations to strengthen the Child Fatality Prevention System is the result of Task Force work that began in 2018 and these recommendations have been on the Task Force Action Agenda each year since 2019. The Task Force itself is part of this system, and has a responsibility to help ensure effective functioning of the system as a whole. Additional information about the system and the work leading to recommendations can be found in CFTF Annual reports each year since 2018.

System background: The North Carolina Child Fatality Prevention System (CFP System) is large and complex. It was created in 1991 by state statute and consists of local child fatality review teams in every county (Child Fatality Prevention Teams and Community Child Protection Teams, collectively called "Local Teams"); a state Child Fatality Prevention Team (State Team) led by the Chief Medical Examiner; and the Child Fatality Task Force (Task Force), a legislative study commission that makes policy recommendations and does not conduct child fatality reviews.[11] There is also a State Child Fatality Review Team that reviews certain child maltreatment-related fatalities and utilizes members from Local Teams, but it is addressed in a statute that is separate from the rest of the CFP System.[12] Although not part of the system described here, it should be noted that there is a separate internal review that is conducted by the NC Division of Social Services within seven days of the fatality of a child where DSS had any open in-home or permanency planning case.

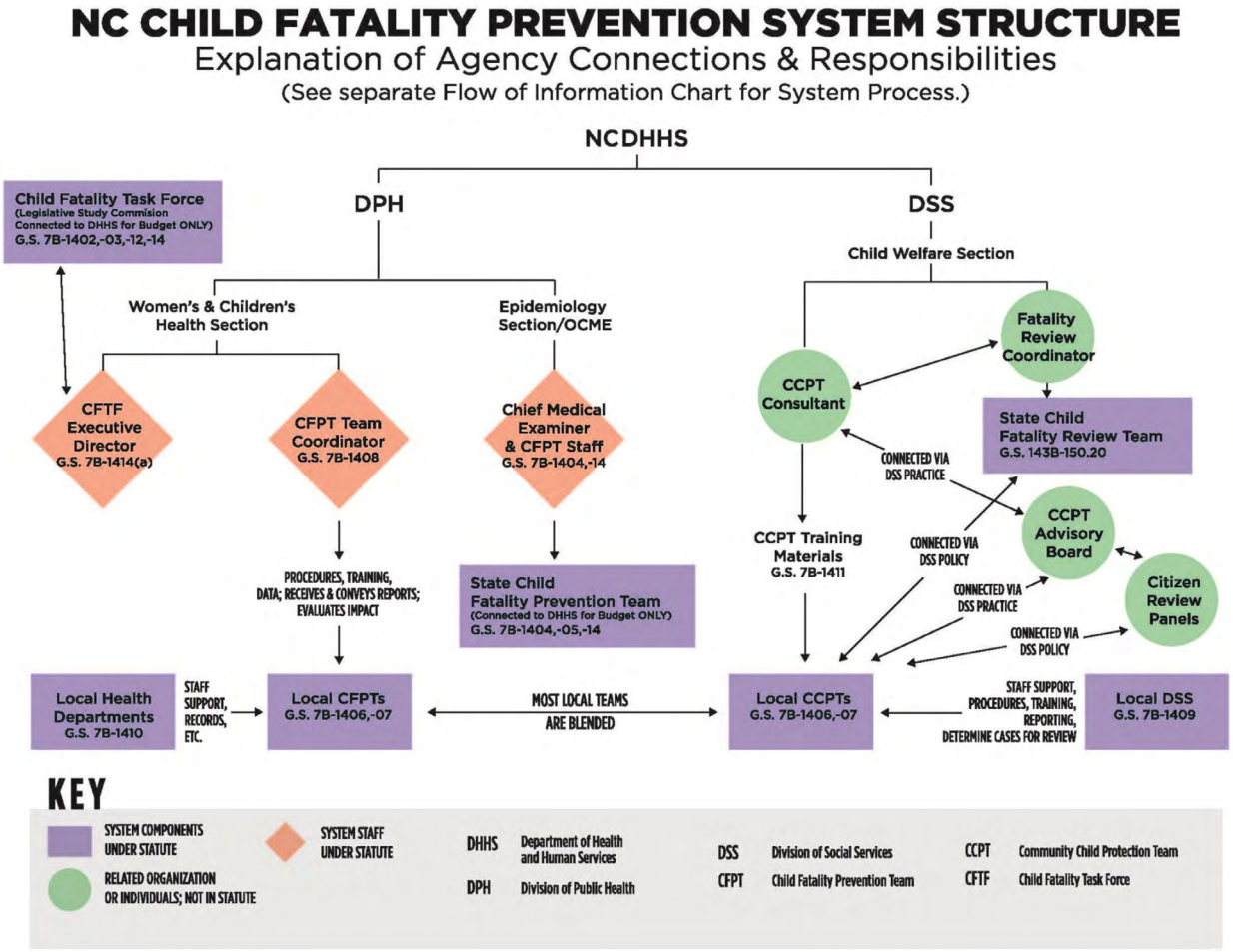
These groups that are part of the CFP system are each multidisciplinary and cross-sector in terms of their membership. They are comprised of local and state government leaders, as well as experts in child health and safety. Participants in the CFP

[10] Examples of statewide plans that have had designated leaders include the Opioid Action Plan, the Early Childhood Action Plan, and the Perinatal Health Strategic Plan. • [11] N.C.G.S. 7B-1400 – 1414. • [12] N.C.G.S. 143B-150.20.

System work to study and understand causes of childhood deaths, advance a community wide approach to the prevention of child fatalities and child maltreatment, and identify gaps in systems designed to prevent child maltreatment and death. A primary purpose of the CFP System is to make and implement recommendations for laws, rules, and policies that will support the safe and healthy development of children and prevent future child fatalities and maltreatment. Recommendations stemming from state and local review teams and the Task Force are directed to various entities ranging from boards of county commissioners, local and state-level social services leaders, to the governor and the General Assembly.

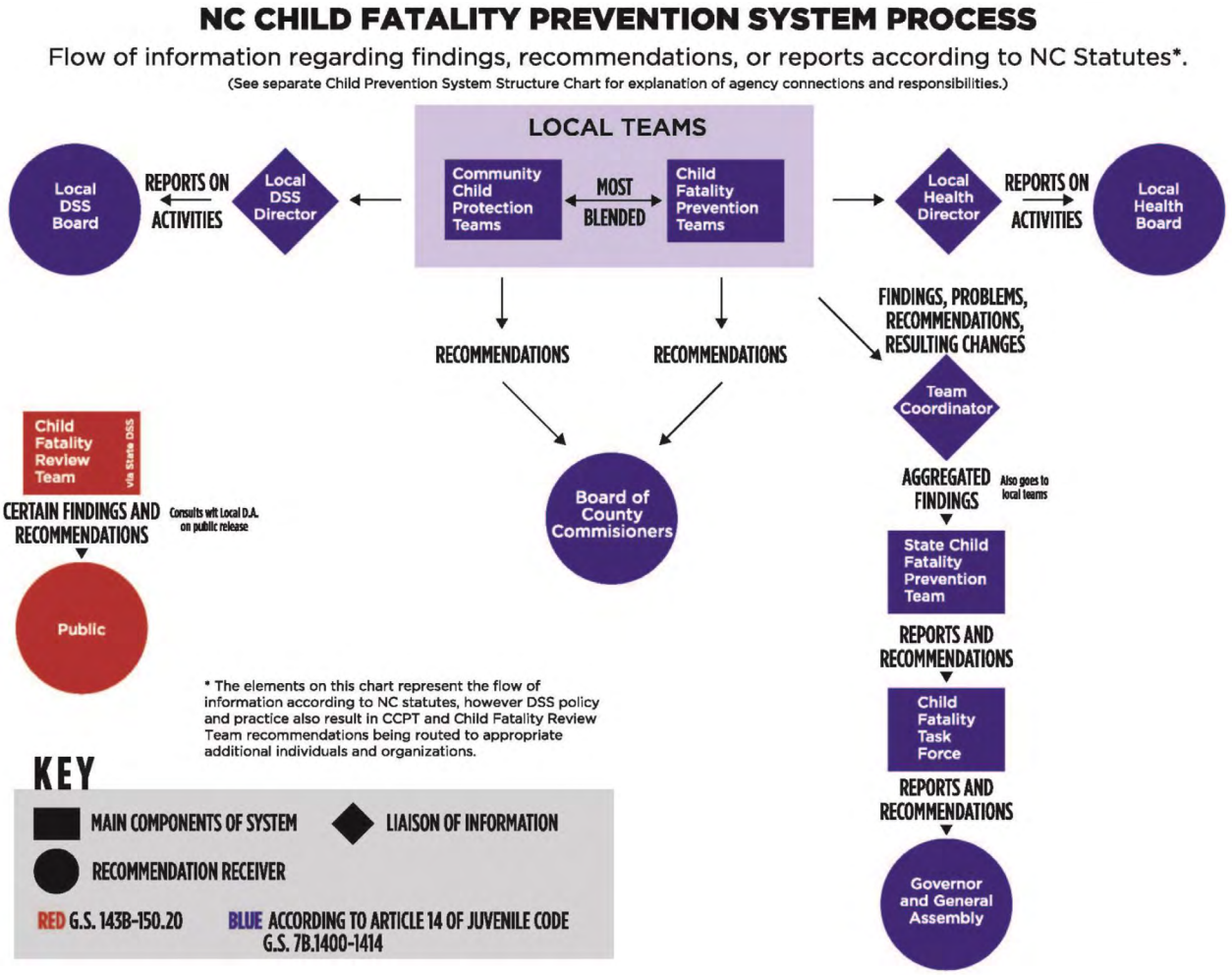
The current system structure (see below) has four types of child fatality review teams and some of these teams review the same cases. State-level support for teams is located in different areas of the NC Department of Health and Human Services. There is no coordination by a single entity or individual, yet some of the work among teams overlaps. All 100 local Community Child Protection Teams have been designated to fulfill federal requirements for Citizen Review Panels in addition to state requirements, however federal law only requires 3 such panels.

Here is a graphic representation of how the Child Fatality Prevention System is currently structured: [13]



[13] Updated information: The CFTF Executive Director position is no longer located within the Division of Public Health as this graphic illustrates; this position is currently located in the Department of Health and Human Services, Office of the Secretary.

Here is a graphic illustration of the flow of information within the current CFP System according to statutes:



The current system process for the flow of information (see above) stemming from reviews varies for each type of review team. Both local teams make recommendations to County Commissioners. Some aggregate information from local CFPTs makes its way to the State CFPT, who makes recommendations to the Task Force, who then makes recommendations to the governor and General Assembly. However, the system is not structured to connect the local CCPTs or the State Child Fatality Review Team with the Task Force or with other State entities. **None of the teams utilize the National Fatality Review Case Reporting System that is being used in 47 other states** to easily track information learned from reviews and generate reports to inform local and state-level prevention work; this national data system collects much richer layers of data than what is currently collected to enable us to better understand child deaths and trends. **Bottom line: information about system problems may not reach the appropriate leaders who can implement change.**

Task Force efforts to strengthen the Child Fatality Prevention System have included input from stakeholders across the state as well as national experts in child fatality review and prevention. This included a statewide Child Fatality Prevention System Summit in the spring of 2018 that brought together over 200 system participants, state and national experts and leaders to learn about best practice and address challenges and strengths of the system. (More detail about this work is available in the 2018 and 2019 CFTF Annual Reports.)

In the fall of 2019 and continuing throughout 2020, the **NC Department of Health and Human Services (DHHS) undertook further study and planning related to advancing these Task Force recommendations**, as the recommendations

North Carolina should use an electronic national data system to collect information learned from child death reviews that is free and already used by 47 other states. *Use of the system would modernize and standardize data collection and reviews based on national best practice and promote gathering much richer layers of data than what is currently collected, resulting in more effective reviews, the ability to easily generate local and state-level reports, and the ability to identify trends and concerns to inform prevention initiatives and policy change.*

were aligned with DHHS priorities and the statewide Early Childhood Action Plan, and were also adopted in the 2019 Child Welfare Reform Plan Final Report from the Center for the Support of Families which was submitted to the General Assembly in 2019.[14] This work by DHHS, presented to the Task Force in 2020 and 2021, included formation of a DHHS work group to discuss goals and structure of a new state office of child fatality prevention, interviews with other states related to their fatality review systems and Citizen Review Panels, and consultation with national experts. DHHS also partnered with the North Carolina Institute of Medicine to convene stakeholders from across the state whose local or state-level work overlaps with the Child Fatality Prevention System to get their input on various aspects of restructuring implementation.

In 2021, the Task Force heard a **presentation from the Director of the National Center for Fatality Review and Prevention** who shared about the important role of child fatality review and explained the National Fatality Review Case Reporting System. This system was established in 2005 and is a free, web-based data system available for use by all child death review and fetal mortality review teams across the country. The system is used in 47 states but is NOT being used in North Carolina. The Director of the National Center shared with the Task Force examples of the in-depth data that is reported through the system via 2600 variables (with multiple skip patterns) and the type of information collected on a particular cause of death. She also showed how the system can produce local and state-level data reports with aggregate information that can be used to better understand trends or circumstances surrounding deaths to inform policy to prevent future child deaths and maltreatment. (Use of this national data system by North Carolina child death review teams is included in the Task Force set of recommendations explained below.)

Also in 2021, the Task Force heard a **panel discussion from leaders of local child death review teams** who shared about the positive impacts in their communities from their teams' work along with the challenges they face. Panelists gave examples of multiple prevention initiatives in their communities that grew from the work of local teams and the value gained from collaboration among community leaders on these teams. These leaders also expressed frustration and a feeling of missed opportunity stemming from the statewide system's failure to collect more case-level data that can be aggregated and used locally and at the state level to inform policy and initiatives – data that would be collected if NC participated in the National Fatality Review Case Reporting System. Panelists talked about the inevitable high turnover that local teams experience and the need for a state child fatality prevention office to implement more frequent and robust training of team members, to provide more state-level support to create tools based on national best practice, and the importance of having an entity track and follow up on the implementation of recommendations – needs which are all addressed in Task Force recommendations below to strengthen the statewide system.

The following set of recommendations to strengthen the statewide Child Fatality Prevention System, with the exception of the recommendation addressing toxicology in medical examiner child deaths, has been repeated on the Task Force Action Agenda since 2019. These recommendations have been addressed in legislation twice, but both times the legislation did not fully advance. The recommendations were addressed in the 2019 legislative session in House Bill 825, and the language from that bill was then included in the 2019 Appropriations Act, House

[14] Center for the Support of Families (May 6, 2019). Child Welfare Reform Plan Final Report. State of North Carolina Office of State Budget and Management (OSBM) with Department of Health and Human Services (DHHS) https://files.nc.gov/ncosbm/documents/files/ChildWelfareReform_FinalPlan.pdf.

Bill 966, which did not become law.[15] In 2021, the recommendations were addressed in Senate Bill 703, but the bill did not receive a hearing.

The recommendations below are aimed at strengthening the overall Child Fatality Prevention System with the ultimate goal of preventing child deaths and maltreatment and supporting child safety and wellbeing.

Legislative Recommendation: SUPPORT legislation, agency action, and policy change to implement the following changes to the Child Fatality Prevention System (CFP System):

I. Implement centralized state-level staff with whole-system support in one location; Office of the Chief Medical Examiner (OCME) child fatality staff remains in OCME; form new Fatality Review and Data Group to be information liaison.

The current system has no lead organizational unit or individual. Individuals who are in state-level roles supporting the current system work in separate "silos" within a structure that is not conducive to interaction or coordination with one another, even though some of their functions overlap. Having a centralized state-level staff connects the CFP System components, streamlining state-level support functions to enable increased efficiency and capacity to provide technical assistance to local teams while also promoting the standardization of tools and resources that are based on best practices for all local review teams. A cross-sector Fatality Review and Data Group would serve as a liaison of information among local teams, OCME, and the Task Force. The current structure is not optimal for moving information and recommendations from local teams to the state level, or for tracking the implementation of recommendations made, both of which are meant to be addressed via this new state office structure.

II. Implement a centralized electronic data and information system that includes North Carolina participating in the National Child Death Review Case Reporting System used by 47 other states.

Under the current system structure, there are gaps and complexities with information collection, analysis, sharing and reporting that need to be addressed. Through this web-based national data system, local and state users can enter case data, findings, and recommendations. They can access and download their data, perform data analysis, and develop their own reports. The use of one electronic national data system that is free and already used by 47 other states would modernize and standardize data collection based on national best practice concerning relevant information needed for effective child death reviews. Use of the national system would promote gathering much richer layers of data than what is currently collected by most types of review teams, resulting in more effective reviews based on best practice and a strengthened ability to inform prevention initiatives and policy change. Use of the system would make it easy to generate local and state-level reports of aggregated and disaggregated data that can identify emerging trends and concerns at the state or local level. Successful and effective use of the national data system depends on sufficient state-level support that would come from staff in the newly created State Office of Child Fatality Prevention in the form of training, technical support, and data quality efforts.

III. Reduce the volume of team reviews by changing the types of deaths required to be reviewed by fatality review teams to be according to certain categories most likely to yield prevention opportunities [undetermined, unintentional injury, violence, motor vehicle, child abuse or neglect/Child Protective Services (CPS) involvement, Sudden Unexpected Infant Death (SUID), suicide, deaths not expected in next six months, additional infant deaths].

North Carolina is the ninth most populated state and had 1,279 child deaths in 2020 (ages 0 to 17). Reducing the number of deaths required to be reviewed by teams to those categories most likely to yield identification of system problems and/or prevention opportunities (while allowing for optional review of additional deaths) allows for optimization of CFP efforts systemwide. In particular, a goal is that in reducing the volume of reviews, the reviews of infant deaths, which make up two-thirds of all child deaths, can be strengthened. Recommendations are to require team reviews of the following categories of deaths: undetermined, unintentional injury, violence, motor vehicle, child abuse or neglect/CPS involvement, sudden

[15] In 2019, the Appropriations Act was passed by the legislature and vetoed by the governor.

unexpected infant deaths (SUIDs), suicide, deaths not expected in next six months, and additional infant deaths (criteria to be determined by DHHS).

IV. Reduce the number and types of teams performing fatality reviews by combining the functions of the four current types of teams into one with different procedures and required participants for different types of reviews and giving teams the option to choose whether to be single- or multi-county teams. DHHS should study and determine an effective framework for meeting federal requirements for Citizen Review Panels and for reviewing active DSS cases.

The current system structure results in duplication of efforts among the four types of teams, with different teams routinely reviewing the same case. This recommendation removes duplication of efforts, with the goal of getting all of the very best local and state-level information available for one case in front of a local team for one effective review. An important aspect of this recommendation is the need to structure team reviews so that the procedures, required participants, and degree of state-level technical assistance can be adjusted to most effectively address the type of death being reviewed, such as deaths related to abuse or neglect which can still receive an "intensive review" similar to the current reviews by the State Child Fatality Review Team.

Federal law requires states to have a minimum of three Citizen Review Panels (CRPs) and by DSS policy (not by statute), all 100 county Community Child Protection Teams (CCPTs, which are one type of child fatality review team) in North Carolina have been designated as CRPs. Although there is some overlap, CRPs have different required members and functions as compared to current local fatality review teams. Most states have fewer than 5 CRPs and frequently the number is 3. For CRPs and fatality review teams to function most effectively and adhere to their individual purposes and requirements, it is not optimal for CRPs to be combined with fatality review teams in all counties, so the Task Force is recommending that DHHS determine a new CRP structure.

V. Formalize the 3 CFTF Committees with certain required members; expand CFTF reports to address whole CFP System and to be distributed to additional state leaders.

The Child Fatality Task Force has for much of its 30-year existence found successful functioning by structuring its work through three committees: Perinatal Health, Unintentional Death Prevention, and Intentional Death Prevention. More formally defining these committees ensures consistent expert and agency input in committee meetings. The CFTF is currently required to submit an annual report to the governor and General Assembly addressing its own functions and responsibilities. Other groups within the system are not currently required to submit an annual report. Under the above recommendations, components of the system would be more connected so it would be appropriate and meaningful for this annual report to address not only the work of the CFTF but the work of the system as a whole, and for the report to be submitted to additional state leaders.

Funding: maintain current child fatality prevention funding and appropriate additional funds pursuant to DHHS determinations related to state office, local teams, and Fetal and Infant Mortality Review pilot.

The new system structure being recommended by the Child Fatality Task Force is intended to be coordinated through a newly created state office of child fatality prevention that combines state-support functions of the system in one office and supports the new structure. This new state office would have certain positions and areas of work that do not currently exist within the system and would therefore require some funding. Local teams are comprised of community leaders whose collaborative efforts have the potential to launch powerful prevention initiatives, however their ability to be engines of positive change in their communities depends on resources for implementation. The amount of funding for these purposes in SB 703, the 2021 bill addressing these Task Force recommendations, is $389,998 recurring for year one and $551,861 recurring for year two.

Under the current system in North Carolina, infant deaths are reviewed by state and local teams. Fetal and Infant Mortality Review (FIMR) programs utilize a more specialized model of fatality review and although more than half of states have FIMR programs, North Carolina does not currently have FIMR as part of its CFP system. FIMR utilizes different procedures and participants that require a great deal more staff support with specialized expertise, and therefore more resources, than what is required for typical child death reviews. Implementation of FIMR in some communities in North Carolina would be valuable to inform both local and state-level actions for prevention.

New Model Strengthens Team Reviews, Data, State-level Support, Reporting

Local Review Teams

Counties choose to be single or multi-county teams

One team for all types of reviews, but different procedures, required participants, and degree of state-level assistance for different types of reviews (e.g. abuse/neglect or infants).

Review info goes into **national data system**

Makes **local reports** (e.g. to County Commissioners) which also go to **State CFP Office**

State Office of Child Fatality Prevention
Whole system coordination

Support for local teams:
tools, resources, procedures, training, technical assistance

Centralized Information System
including use of national data system at local and state level

Prevention work:
follow up on team recommendations; implement prevention initiatives

State Office Staff report on whole system functioning

Aggregate information & recs from local teams is reported

NC Child Fatality Task Force

Studies data from local teams & other sources

Makes policy recommendations & reports on whole CFP system to General Assembly, Governor, other state leaders

CAN deaths: 7-Day Internal Reviews by State DSS

Citizen Review Panels: Evaluate CPS functioning

Structural outcomes these changes seek to address:

- Eliminate the "silos" within which current system functions.
- Implement centralized coordination/oversight.
- Streamline state-level support functions of CFP System & add capacity to elevate the effectiveness of all system components.
- Eliminate the redundancy/duplication of team reviews but keep critical functions & diverse contributions of expertise.
- Ensure that review teams have the training and resources they need to conduct effective reviews and make effective recommendations.
- Maximize the usefulness of data/information learned from reviews by expanding, improving, and standardizing data capture, analysis, and reporting.
- Ensure that relevant & appropriate information & recommendations from team reviews reaches local leaders, state agency leaders, and the CFTF in a timely fashion.
- Ensure that CFTF's ability to study data, evaluate evidence, and advance policies continues.

Outcomes we want to achieve FOR KIDS:

- Ensure that the prevention of child fatalities and maltreatment is approached as a community-wide and state-wide responsibility.
- Identify and address system problems or gaps in order to prevent future fatalities & maltreatment.
- Accurately collect and analyze child death data for the purpose of better understanding the apparent and contributing causes of child death and opportunities to prevent future deaths.
- Identify effective strategies for the prevention of child fatalities and maltreatment.
- Implement effective local and state-level strategies (in the form of programs or changes in law or policy) for the prevention of child fatalities and maltreatment.
- Leverage the collaboration and expertise of multidisciplinary teams to draw on public and private resources at the state and local level to accomplish all of the above outcomes in order to prevent future child abuse, neglect, and death.



Legislative Recommendation: SUPPORT an appropriation of $550,000 in nonrecurring funds and $110,000 in recurring funds to enable the Office of the Chief Medical Examiner to conduct comprehensive toxicology testing in all Medical Examiner jurisdiction child deaths.

One of the recommendations made to the Child Fatality Task Force by the State Child Fatality Prevention Team for this study cycle was for resources to conduct comprehensive toxicology testing in all Medical Examiner (ME) jurisdiction child deaths. Presentations on this topic to the Task Force were provided by the Chief Medical Examiner and the Chief Toxicologist from the Office of the Chief Medical Examiner in the NC Division of Public Health.

Currently, infant fatalities with appropriate samples receive comprehensive toxicology screening and confirmation that includes both licit and illicit substances. However, the toxicology screen for cases of children older than 1 year of age do not automatically receive a full toxicology screening; toxicology scope of analysis depends on the apparent manner/means of death and the case scenario. Cases where comprehensive toxicology is not conducted are limited to the testing for alcohol, and other volatiles, and no screening for the presence of drugs or other foreign substances is conducted.

Current toxicology screening practices by the ME are directly related to available resources to perform toxicology screening, and sufficient resources are not currently available to perform comprehensive toxicology testing in all child deaths. The current caseload at the NC OCME Toxicology Lab per analyst is very high compared to other government supported forensic toxicology laboratories in other states. The high case load per analyst and limited funding available for advanced equipment for testing has prevented the NC OCME from expanding the testing scope of analysis for child death cases where manner/means is apparent. The costs of this expanded testing include costs for personnel (2 positions), standards and reagents, basic lab equipment, sample preparation equipment, and analytical instrumentation.

Expanded toxicology testing would include an initial screening for about 100 commonly encountered drugs, prescription and illicit, and would enable the confirmation of the presence and quantity of the drug. In addition, advanced screening techniques would be conducted that allows for the detection of up to ~400 drug and foreign substance compounds.

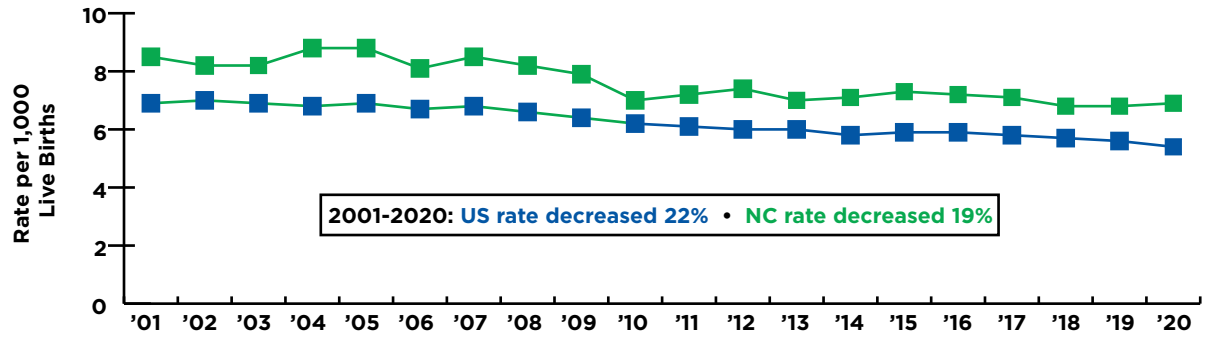
Without comprehensive toxicology testing on all child deaths, there is a missed opportunity to determine contributing factors to a fatality. In addition, when a toxicology test is limited to volatiles and the report is negative, there is the potential for a misunderstanding that no substances were present even though no testing was performed for substances other than volatiles. A comprehensive and complete toxicology report has value to a variety of stakeholders including families, public safety officials, legal representatives, insurers, etc., beyond the certifying toxicologist and pathologist.

Comprehensive toxicology testing can identify information related to a child's death that helps to explain more about the circumstances of the death. Such information, especially when utilized in the context of the Child Fatality Prevention System, may be relevant to inform strategies for the prevention of deaths and injuries.

Legislative recommendations and administrative efforts focused on the prevention of infant deaths

Two-thirds of all child deaths in North Carolina are of infants less than one year of age. **In 2020, 803 infants died before their first birthday.** North Carolina's infant mortality rates have remained higher than the U.S. rate and compared to other states the NC rate is among the highest 15% in the nation. Disparities have persisted with the mortality rate of black infants more than 2.5 times higher than the rate of white infants.

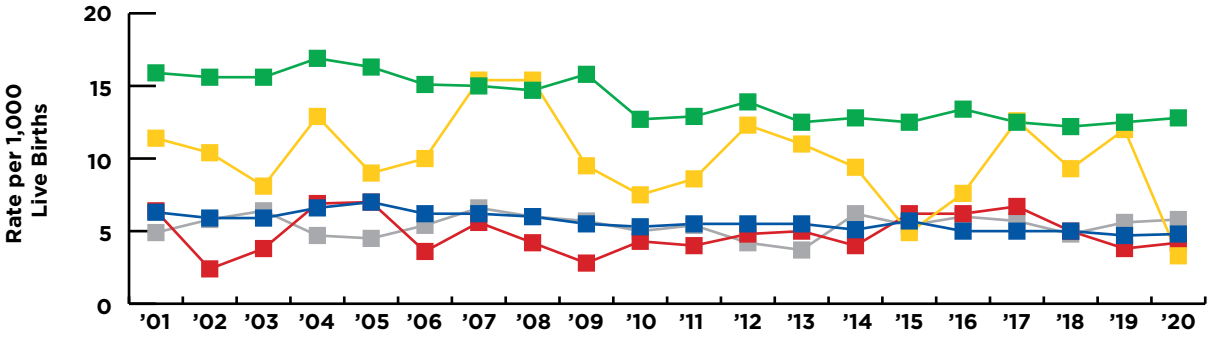
Infant Death Rates: 2001-2020, US & NC



	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
US	6.9	7	6.9	6.8	6.9	6.7	6.8	6.6	6.4	6.2	6.1	6	6	5.8	5.9	5.9	5.8	5.7	5.6	5.4
NC	8.5	8.2	8.2	8.8	8.8	8.1	8.5	8.2	7.9	7	7.2	7.4	7	7.1	7.3	7.2	7.1	6.8	6.8	6.9

Source: NC State Center for Health Statistics & National Center for Health Statistics

Infant Death Rates by Race/Ethnicity: NC 2011-2020



	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Non-Hispanic White	6.3	5.9	5.9	6.6	7	6.2	6.2	6	5.5	5.3	5.5	5.5	5.5	5.1	5.7	5	5	5	4.7	4.8
Non-Hispanic Black	15.9	15.6	15.6	16.9	16.3	15.1	15	14.7	15.8	12.7	12.9	13.9	12.5	12.8	12.5	13.4	12.5	12.2	12.5	12.8
Non-Hispanic American Indian	11.4	10.4	8.1	12.9	9	10	15.4	15.4	9.5	7.5	8.6	12.3	11	9.4	4.9	7.6	12.6	9.3	12	3.3
Non-Hispanic Other	6.4	2.4	3.8	6.9	7	3.6	5.6	4.2	2.8	4.3	4	4.8	5	4	6.2	6.2	6.7	5	3.8	4.2
Hispanic	4.9	5.8	6.4	4.7	4.5	5.4	6.6	6	5.7	5	5.4	4.2	3.7	6.2	5.4	6	5.7	4.8	5.6	5.8

Infant mortality rates are impacted by social determinants of health

Leading causes of infant death include prematurity/low birthweight, birth defects, maternal complications of pregnancy, and other perinatal complications. Experts presenting to the Task Force in recent years have emphasized that factors contributing to these leading causes and other causes of infant death are complex, and many relate to social determinants of health. Social factors such as access to quality healthcare, safe housing, nutrition, transportation, and the ability to take leave from work when ill or caring for a newborn are important. At the same time, exposure to violence, racism, and other adverse experiences are known to have a lasting negative physical and mental impact. These types of social factors may impact the well-being of a pregnant woman, her birth outcomes, her mental and physical health after giving birth, and the health and well-being of her infant. Experts presenting to the Task Force have shown how addressing these social factors will result in fewer infant deaths and decreased health disparities.

Data maps presented to the Task Force in December of 2021 show the correlation between areas with higher infant mortality rates in North Carolina and areas with more challenges related to social determinants of health, such as areas with high poverty and unemployment or lower education and health insurance coverage.[16]

In recent years the Task Force has recommended a variety of strategies focused on the prevention of infant deaths. Strategies in the past several years have included tobacco cessation and prevention, Medicaid coverage of lactation services, expanding the newborn screening panel of tests, requiring study of risk-appropriate maternal and neonatal care in hospitals, pregnancy and lactation accommodations in the workplace, paid family leave insurance, kin care and safe days leave, promoting safe infant sleep, strengthening the state's infant safe surrender law, and strengthening the state's Child Fatality Prevention System. Some of these strategies have advanced while others have not, and four of these strategies are areas of focus again in 2022.

As explained below, deaths associated with unsafe sleep circumstances comprise a large category of infant deaths, and the first recommendation below is to expand efforts to prevent these deaths. The second recommendation below addresses improvements to the state's infant safe surrender law that the Task Force has been working on for years. The two administrative efforts below address areas of work that the Task Force will continue to examine related to a breastfeeding hotline and provider incentives for group prenatal care. These administrative efforts could lead to legislative recommendations by the Task Force in the future.

Other items on the Task Force 2022 Action Agenda that would prevent infant deaths but are addressed in other sections of this report include:

- recommendations to strengthen the Child Fatality Prevention System,
- recommendations to prevent motor vehicle-related deaths,
- funding for the prevention of tobacco and nicotine use,
- strengthening education around child abuse and neglect reporting.

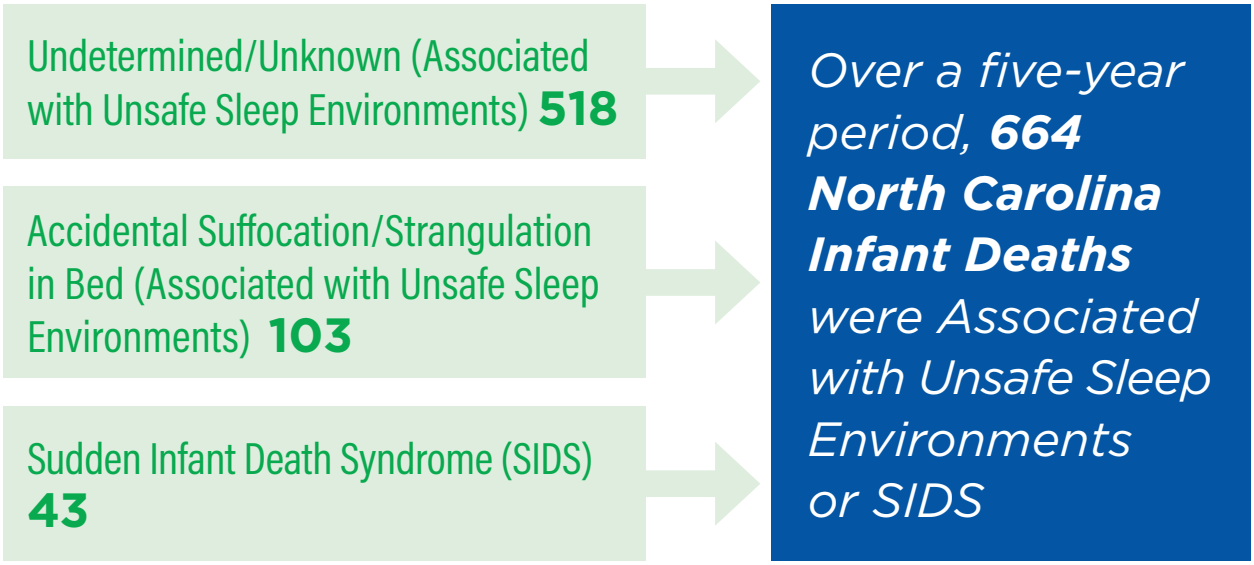
Legislative Recommendation: SUPPORT recurring funding totaling $250,000 per year to expand efforts to prevent infant deaths related to unsafe sleep environments.

In the five-year period between 2015 to 2019, 664 infant deaths in North Carolina were associated with unsafe sleep environments (for example, an infant found with his or her face covered by a blanket, found sleeping on a couch with the infant's face to the back of the couch or between cushions, or sharing a sleep space with another individual) or Sudden Infant Death Syndrome (SIDS).[17] In North Carolina, largely due to structural inequities, black infants are twice as likely to die of unsafe sleep-related causes as white infants.[18]

Almost all of these deaths are preventable. With North Carolina having over 100 babies each year dying in their sleep, expanded efforts to prevent sleep-related infant deaths could spare many families

[16] These maps are included in the presentation posted on the Task Force website titled "INFANT_CHILD_DEATHS_CY2020_FINAL_04DEC2021" • [17] Office of the Chief Medical Examiner, Division of Public Health, North Carolina Department of Health and Human Services. • [18] Office of the Chief Medical Examiner, NC Division of Public Health.

Infant Deaths Associated with Unsafe Sleep Environments or SIDS, NC 2015-2019



Source: Office of the Chief Medical Examiner-Division of Public Health North Carolina Department of Health and Human Services

from this devastating loss and significantly decrease infant mortality rates and disparities in our state.

These deaths often involve bed sharing, also referred to as co-sleeping, the intentional or unintentional practice of an infant sharing a sleep space with another individual.[19] The CDC reports that more than 60% of mothers report bed sharing with their baby.[20] In North Carolina, about half of new mothers surveyed indicated that their infant does not always sleep alone in their own crib or bed.[21] The common practice of bed sharing is concerning because of the dangers associated with it, especially among higher risk infants including those born too soon, too small, or in households where tobacco and other substances are used.[22]

Research has found that parents need support navigating the challenges of nighttime parenting, and that they would listen to healthcare providers if counseled about the dangers of the practice of bed sharing and given additional support in adhering to safe infant sleep recommendations.[23] Further, a study found that nearly half of caregivers did not receive correct advice on safe sleep practices from healthcare providers.[24] Provider advice is an important, modifiable factor to improve safe sleep practice. Expanded efforts to reach population groups with multiple overlapping risks, such as smoking, soft bedding, and bed sharing, are needed.[25] North Carolina healthcare providers have asked for support engaging parents and caregivers in nuanced conversations about sleep and nighttime parenting to help reduce the risk of infant death.[26]

This recommendation by the Task Force to expand funding to prevent sleep-related infant deaths has been driven by data and recommendations from state and local child death review teams. These teams review infant deaths and have frequently identified the need for more safe sleep education and repeatedly recommended expanded outreach and funding for this purpose.

State funding in North Carolina for infant safe sleep programming to educate about the importance of safe sleep and prevent these types of deaths currently totals $45,000, designated in the state budget to come from the federal Maternal and Child Health Block Grant. This level of funding is insufficient to address so many preventable infant deaths. The Task Force has

[19] Office of the Chief Medical Examiner, Division of Public Health, North Carolina Department of Health and Human Services. • [20] Centers for Disease Control and Prevention, Vital Signs, Safe Sleep for Babies: www.cdc.gov/vitalsigns/safesleep/. • [21] North Carolina Pregnancy Risk Assessment Monitoring System Survey Results 2019, Sleep Position and Bed Sharing; Question: "In the past two weeks how often has your baby slept alone in his or her own crib or bed?" • [22] American Academy of Pediatrics, 2016. SIDS and other sleep-related infant deaths: Updated 2016 recommendations for a safe infant sleeping environment, 138 (5) (2016), pp. 1-12, 10.1542/peds.2016-2938. • [23] Salm Ward and Balfour, 2016. Infant safe sleep interventions, 1990–2015: A review. Journal of Community Health, 41 (1) (2016), pp. 180-196, 10.1007/s10900-015-0060-y; Moon et al., 2016. Safe infant sleep interventions: What is the evidence for successful behavior change? Current Pediatric Reviews, 12 (1) (2016), pp. 67-75, 10.2174/5733 96311666151026110148. • [24] Colson ER, Geller NL, Heeren T, et al. Factors Associated With Choice of Infant Sleep Position. Pediatrics. 2017;140(3):e20170596. • [25] Hirai AH, Kortsmit K, Kaplan L, et al. Prevalence and Factors Associated With Safe Infant Sleep Practices. Pediatrics. 2019;144(5):e20191286. • [26] UNC Center for Maternal and Infant Health.

recommended increased funding for safe sleep for several years and although a bill was introduced in 2021 (SB 537) that would have provided additional funding, no additional funds were present in the 2021 Appropriations Act.

Multipronged efforts to educate about safe sleep have been shown to be effective. For example, after the inception of a Safe Sleep Baby education campaign in Sacramento, California that was aimed at reducing disparities of African American infant deaths, the rate of African American infant sleep-related deaths dropped 54% and there was a 62% decrease in disparity.[27]

Additional funding of $205,000 for a total of $250,000 for the Safe Sleep NC campaign would support the following:

- Development and dissemination of training modules and resources for health care providers across the state
- Increased dissemination of education and information for new parents and other caregivers, including social media and marketing efforts
- Outreach and training for those involved with home visiting, early intervention, and other relevant areas
- Implementation of a comprehensive hospital initiative
- Coordination of county-level collaborative campaigns
- Monitoring relevant state-level data
- Tracking and evaluating program efforts

With this additional funding, North Carolina would be spending approximately $2.10 for safe sleep outreach for each infant in our state.

Legislative Recommendation: SUPPORT legislation to strengthen the infant safe surrender law to make it more likely the law will be used in circumstances for which it was intended to protect a newborn infant at risk of abandonment or harm by making legislative changes to accomplish the following:

1) remove "any adult" from those designated to accept a surrendered infant;
2) provide information to a surrendering parent;
3) strengthen protection of a surrendering parent's identity;
4) incorporate steps to help ensure the law is only applied when criteria are met.

In 2001 North Carolina passed HB 275 (S.L. 2001-291) known by many as the "Infant Safe Surrender" law. This law was recommended and advanced by the NC Child Fatality Task Force. Such laws exist in every state, often called "safe haven" laws, and although they vary they are all designed to provide a safe alternative for a desperate parent of a newborn who may be tempted to engage in actions harmful to the infant. The 2001 Safe Surrender law altered some provisions in the NC Juvenile Code as well as some criminal law provisions to decriminalize abandonment of a newborn infant under certain circumstances and to modify some procedures involving abandoned newborns. In recent years the Child Fatality Task Force, with input from experts in juvenile law, examined the Safe Surrender law and developed these recommended changes to strengthen the law.[28] This set of recommendations has been included on the Task Force Action Agenda each year since 2018 and additional information about these recommendations can be found in other CFTF Annual Reports since 2018.

These recommendations to strengthen the safe surrender law have been addressed in proposed legislation during two legislative sessions, and one bill passed the House unanimously. Most recently, HB 473 and SB 535 were introduced in the 2021 session. These bills were nearly identical, and HB 473 received a favorable report in the

[27] First 5 Sacramento, Reduction of African American Perinatal & Infant Deaths, Final Evaluation Report, July 1, 2015 – June 30, 2018, available at: https://first5sacramento.saccounty.gov/Results/Documents/3-yr_RAACD_EvalReport.PDF • [28] For more information on CFTF work on Infant Safe Surrender that led to these recommendations, see the 2018 CFTF Annual Report.

Committee on Children, Families, and Aging, a favorable report from the Health and Rules Committees, and went on to pass the House unanimously. The bill was then sent to the Senate Rules Committee but did not receive a hearing.

The first recommended change is to remove "any adult" from those designated to accept a surrendered infant. Currently, the law requires four categories of professionals to accept a safely surrendered infant and says also that "any adult" "may" accept a safely surrendered infant. There are several reasons why the recommendation was made to change this aspect of the law: "any adult" cannot be trained about the requirements of the law nor can "any adult" be expected to provide accurate information about the law to a surrendering parent; there are concerns about human trafficking and unlawful custody transfer when "any adult" may claim an infant was surrendered to him or her pursuant to the law; this kind of "any adult" category is not typical in other states.

The second change involves providing information to a surrendering parent. Currently, no information about safe surrender is required to be provided to a parent who surrenders an infant in North Carolina. If and when information may be provided, there is no means for ensuring accuracy, consistency, or quality of that information. When possible, surrendering parents should be given accurate information regarding consequences, rights, and options related to safe surrender.

The third change involves strengthening protection of a surrendering parent's identity. Even though a surrendering parent in North Carolina does not have to give his or her identity at the moment of surrender, current NC law requires the Division of Social Services (DSS) to treat the case the same as any other abuse, neglect, or dependency case once they receive custody – this includes making immediate diligent efforts to identify and locate the surrendering parent for participation in all juvenile proceedings regarding the infant. Protections of a surrendering parent's identity are a critical aspect of safe surrender/safe haven laws in general, as a parent who believes that his or her identity has protections related to safe surrender may be more likely to use the law in circumstances for which it was intended — to protect a newborn infant at risk of abandonment or harm. Many other states have stronger protections for the identity of a surrendering parent compared to North Carolina.

The last change would incorporate steps to help ensure the law is only applied when criteria are met. More effort should be taken to ensure safe surrender protections are only available when criteria set out in the law are met because the law provides protections for a surrendering parent with respect to immunity and identity.

Administrative efforts focused on the prevention of infant deaths

Administrative Effort: gather more information from relevant experts and stakeholders related to the potential for a statewide breastfeeding hotline and bring information back to the committee prior to the 2023 legislative session.

In 2021 the CFTF received an issue application requesting the Task Force recommend recurring state funding for a statewide 24-hour breastfeeding hotline, estimated to cost $250,000 per year. The Perinatal Health Committee heard presentations explaining the basis for the hotline. Evidence was presented on the many maternal and infant health benefits to breastfeeding, the gap in NC between optimal goals for breastfeeding and actual rates and duration of breastfeeding, and the need for easier access to lactation consulting to address the gap. The proposal was for this hotline to be modeled after such hotlines in other states and information was shared on how the hotline has worked in Tennessee and on the outcomes from use of the hotline. The Perinatal Health Committee determined that it would like to learn more about the potential for a statewide breastfeeding hotline and will be examining additional information on this topic during the 2022-23 study cycle of the Task Force.

Administrative Effort: request the Division of Health Benefits, NC Medicaid to review the current prenatal bundle rate and its impact on group prenatal care.

In 2021 the Task Force received an issue application requesting the Task Force to recommend provider incentives for group prenatal care. Information was provided to the Perinatal Health Committee on how group prenatal care works, specifically the Centering

Pregnancy Program. Evidence was provided on the positive impacts Centering Pregnancy has seen in decreasing preterm births, low birth weight births, NICU admissions, cesarean deliveries, and on increasing breastfeeding and smoking cessation. Such outcomes include a 33 to 47% reduction in risk of preterm births compared to those receiving only individualized care. Information was provided on how over a dozen other states are using enhanced payment models for group prenatal care either as part of their Medicaid program or have one or more MCO's offering the benefit.

The Chief Medical Officer for NC Medicaid explained to the Perinatal Health committee about the current bundled packages payment model and how incentive payments work for maternal care. She also explained how group visits are supported under bundled payment methodology, how incentive payments to PHPs are permitted but must be budgeted, and also explained how the type of change being requested would likely require going through a policy change process and additional (currently unbudgeted) funds.

The committee determined that the best next step was to request the Division of Health Benefits at NC Medicaid to review the current prenatal bundle rate and its impact on group prenatal care. The committee will be following up on this work when it reconvenes for the 2022-23 study cycle of the Task Force.

Legislative recommendations and administrative efforts to prevent motor vehicle-related injuries and deaths to children

The trend for motor vehicle-related deaths to children has been on the decline in recent years, however motor vehicle-related injuries are still the leading cause of unintentional injury death among children in North Carolina. In 2020, deaths resulting from motor vehicle injuries were fifth among all causes of death for children ages 0 to 17 and second among all causes for children ages 1 to 17.[29] North Carolina lost 74 children to motor vehicle crashes in 2020.

Legislative Recommendation: ENDORSE legislation to require ignition interlocks for all alcohol impaired DWI offenders, including first-time offenders.

Alcohol-impaired crash fatalities account for about a third of all crash fatalities. Data presented to the Task Force by the NC Dept. of Transportation showed that between 2011 and 2020 there were about 18,000 kids involved in 11,000 crashes in NC where one of the drivers was suspected of using alcohol *and a child 17 or younger was present*. Of those 18,000+ kids: 123 were killed, 344 had serious injuries, with 5,600 more having some type of injury that was not classified as serious. Among those 18,000 kids: 7,244 were children in the vehicle of the alcohol driver; 10,882 were children in the other vehicle; and 1,086 were children who were the alcohol driver.

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- **123** were killed
- **344** had serious injuries
- **5,600** had some type of injury that was not classified as serious
- **7,244** were in the vehicle of the alcohol driver
- **10,882** were children in the other vehicle
- **1,086** were children who were the alcohol driver

[29] See Child Deaths in North Carolina Annual Report for 2020 at this beginning of this CFTF Annual Report.

Alcohol ignition interlocks are breath test devices installed in a motor vehicle to prevent operation of the vehicle by a driver who has a blood alcohol concentration over a pre-set low limit. Current North Carolina law makes ignition interlocks mandatory if the person's blood alcohol level is greater than .15 or if the person is a second or subsequent offender (the requirement relates to restoration of a license or obtaining limited driving privileges after a conviction for driving while impaired).[30]

The CDC recommends ignition interlocks as a highly effective strategy to prevent repeat driving while impaired (DWI) offenses while installed and recommends that interlocks be mandated for *all DWI offenders, including first-time offenders*. More than 30 states now require ignition interlocks for all offenders, but North Carolina is not one of them. The North Carolina Executive Committee for Highway Safety, chaired by the Secretary of Transportation, approved a resolution in 2019 to support legislation in North Carolina to mandate ignition interlocks for all alcohol-impaired driving offenders.[31]

One study showed that the average alcohol-impaired driver has driven under the influence of alcohol over 80 times before their first arrest.[32] While installed, ignition interlocks reduce repeat offenses for driving while intoxicated by about 70%.[33]

This recommendation to require ignition interlocks for all DWI offenders has been made by the Task Force each year since 2017. In 2021, a bill addressing a broad scope of issues related to ignition interlocks became law (S.L. 2021-182) and although this law did not expand the use of ignition interlocks to all DWI offenders as recommended by the CFTF, the law requires studying the issue of expanded use. (The bill changes several other aspects of laws addressing use of ignition interlocks related to alcohol impaired driving offenses – these changes are unrelated to CFTF work.)

*The CDC recommends **mandating ignition interlocks for all DWI offenders**, including first-time offenders, as a highly effective strategy to prevent repeat DWI-related offenses. While installed, ignition interlocks **reduce repeat offenses** for driving while intoxicated **by about 70%**.*

Mandating interlocks for all offenders, **including first-time offenders**, will have the greatest impact. **The number of impaired** (BAC ≥ 0.08%) **drivers in fatal crashes falls.**

3% when states require interlocks for repeat offenders only

8% when states require interlocks for repeat offenders and first offenders with high BACs

16% when states require interlocks for all DUI offenders, including first offenders

[30] N.C.G.S. 20-17.8 and 20-179.3. • [31] This resolution is available on the NC DOT website: https://connect.ncdot.gov/groups/echs/Documents/2019/Ignition%20Interlock%20Resolution.pdf. • [32] National Highway Traffic Safety Administration (February, 1995). Repeat DWI Offenders in the United States. • [33] Centers for Disease Control and Injury Prevention. Motor Vehicle Safety. Increasing Alcohol Ignition Interlock Use. www.cdc.gov/motorvehiclesafety/impaired_driving/ignition_interlock_states.html.

Legislative Recommendation: ENDORSE legislation that eliminates the 2013 law prohibiting the use of state transportation funding related to independent pedestrian and bicycle infrastructure projects.

In 2021, the Task Force received an issue application requesting the Task Force to endorse efforts to eliminate a 2013 law that prohibited the use of state transportation funding related to independent pedestrian and bicycle infrastructure projects. Experts from the University of North Carolina Highway Safety Research Center and Injury Prevention Research Center presented information on this topic.

Between 2010 and 2019, almost 150 child pedestrian deaths occurred in North Carolina.[34] Children are more likely to suffer severe or fatal injury than adult pedestrians when involved in a pedestrian-vehicle crash, and children also have a higher likelihood of enduring a traumatic brain injury.[35] Data show inequities in pedestrian deaths as Black/African American children make up 23% of NC's youth population and yet represent 37% of all child pedestrian fatalities while American Indian children make up 1% of NC's youth population but represent 2% of all child pedestrian fatalities in the state.[36]

Sidewalks, raised crossings, and lights at a crosswalk are examples of the types of pedestrian and bicycle infrastructure projects that can prevent deaths and injuries. Installing sidewalks can result in reductions in fatal and serious injuries of up to 60%.[37] Studies have shown that installing raised pedestrian crossings can result in a 32% crash reduction.[38] Raised bicycle crossings can result in a 51% crash reduction and installing separated bike lanes results in a 45% crash reduction.[39] Moreover, installing rapid flashing lights (called "rapid flashing beacons" or RRFBs) at a crosswalk can result in a 47% crash reduction.[40]

Walking and biking are known to be healthy travel modes for children.[41] Replacing some car trips with walking and biking can decrease air pollution and can have numerous associated health benefits for children and families, including decreased emergency room visits and hospitalizations for respiratory problems and less frequent school absenteeism.[42]

The Safe Routes to School program, which provided funding to improve the built environment by constructing sidewalks, bicycle lanes, and safe crossings near schools between 2005-2009, was shown to reduce the fatality risk of school-age children by 20% compared to adults 30-64 nationally.[43] In New York City, comparing areas (i.e., census tracts) with completed Safe Routes to School (SRTS) improvements (e.g., new traffic and pedestrian signals, adding timed crossings that allow pedestrians to cross before cars, high visibility crosswalks) to non-SRTS areas, there was a 44% overall pedestrian injury risk reduction during school travel times; and comparing areas with completed SRTS interventions to areas with incomplete SRTS interventions, there was an overall injury risk reduction of 32%.[44]

In 2013, the NC General Assembly passed the Strategic Transportation Investments Law and

[34] Cdc.gov. (2022). WISQARS (Web-based Injury Statistics Query and Reporting System)| National Center for Injury Prevention and Control |CDC. [online] Available at: https://wisqars.cdc.gov/cgi-bin/broker.exe. • [35] Harmon, K. J., et al., (2020). Selected characteristics and injury patterns by age group among pedestrians treated in North Carolina emergency departments. *Traffic Injury Prevention, 21*(S1), S157-S161. https://doi.org/10.1080/15389588.2020.1829912; Taylor, C. A., et al., (2017). Traumatic brain injury–related emergency department visits, hospitalizations, and deaths — United States, 2007 and 2013. MMWR. *Surveillance Summaries, 66*(9), 1-16. https://doi.org/10.15585/mmwr.ss6609a1. • [36] National Highway Traffic Safety Administration. (2019). 2018 Count of state child pedestrian fatalities. Retrieved from Fatality Analysis Reporting System (FARS): 2004-2018 Final File and 2018 Annual Report File (ARF); United States Census Bureau. (n.d.). [TableID: S0901] [Table]. Retrieved from https://data.census.gov/cedsci/table?q=north%20carolina%20children&g=0400000US37&hidePreview=-false&tid=ACSST5Y2018.S0901&t=Children&vintage=2018&layer=VT_2018_040_00_PP_D1&cid=S0901_C01_001E • [37] Alluri, P. M. et al. (2017). *Statewide analysis of bicycle crashes.* Florida Department of Transportation. • [38] Zegeer, C., et al. (2017). D*evelopment of crash modification factors for uncontrolled pedestrian crossing treatments.* NCHRP Report 841: Transportation Research Board, Washington, DC. • [39] Schepers, J. P., et al., (2011). Road factors and bicycle–motor vehicle crashes at unsignalized priority intersections. *Accident Analysis and Prevention, 43*(3), 853-861. https://doi.org/10.1016/j.aap.2010.11.005 • [40] Zegeer, C., et al. (2017). • [41] Lubans, D. R., et al., (2011). The relationship between active travel to school and health-related fitness in children and adolescents: A systematic review. *The International Journal of Behavioral Nutrition and Physical Activity, 8* (1), 5-5. https://doi.org/10.1186/1479-5868-8-5 • [42] Wendel-Vos, G. C. W., et al., (2008). Environmental attributes related to walking and bicycling at the individual and contextual level. *Journal of Epidemiology and Community Health (1979), 62*(8), 689-694. https://doi.org/10.1136/jech.2007.062869; Gilliland, F. D., et al., (2001). The effects of ambient air pollution on school absenteeism due to respiratory illnesses. Epidemiology (Cambridge, Mass.), 12(1), 43-54. https://doi.org/10.1097/00001648-200101000-00009; ; Hrubá, F., et al., (2001). Childhood respiratory symptoms, hospital admissions, and long-term exposure to airborne particulate matter. *Journal of Exposure Analysis and Environmental Epidemiology, 11* (1), 33-40. https://doi.org/10.1038/sj.jea.7500141; Park, J., et al., (2002). Impacts of poverty on quality of life in families of children with disabilities. Exceptional Children, 68(2), 151-170. https://doi.org/10.1177/001440290206800201; Gauderman, et al. (2007). Effect of exposure to traffic on lung development from 10 to 18 years of age: A cohort study. *The Lancet (British Edition), 369* (9561), 571-577. https://doi.org/10.1016/S0140-6736(07)60037-3. • [43] DiMaggio, C., et al., (2016). National safe routes to school program and risk of school-age pedestrian and bicyclist injury. *Annals of Epidemiology, 26* (6), 412-417. https://doi.org/10.1016/j.annepidem.2016.04.002. • [44] DiMaggio, C., et al., (2014). Timing and effect of a safe routes to school program on child pedestrian injury risk during school travel hours: Bayesian changepoint and difference-in-differences analysis. *Injury Epidemiology, 1* (1), 1-8. https://doi.org/10.1186/s40621-014-0017-0.



within it the Transportation Investment Strategy Formula prohibited Department of Transportation funding to be used for independent (meaning not combined with road or transit improvements) pedestrian and bicycle infrastructure projects.[45] Since this law passed, stakeholders working in road safety coalitions and in agencies across the state have frequently cited this change in the law as a barrier to completing pedestrian and bicycle infrastructure projects intended to created safer conditions and there have been advocacy efforts to change the law.[46]

According to the UNC Highway Safety Research Center (HSRC), North Carolina is unique in prohibiting local communities from using state transportation funding to match federal funding for pedestrian and bicycle infrastructure projects. HSRC provided an example to the Task Force that if a community wants to add a sidewalk or fill a sidewalk gap without expanding a roadway, the community may be able to obtain federal funding for a portion of the project but is expected to come up with matching funds as well. However, the matching amount may be impossible for the community to raise on its own, and this is especially true of small, rural communities. In other states, the community may be able to seek state transportation funding to help provide this match but because of the 2013 law, communities in North Carolina cannot.

Ending this prohibition would not guarantee the availability of state funding for these projects, but it would give local communities the chance to request and compete for state funding to install stand-alone bike and pedestrian safety projects.

Administrative efforts to prevent motor vehicle-related deaths and injuries to children:

Administrative Effort: efforts to increase the use of rear seat restraints among youth including: Child Fatality Task Force to write a letter to the Driver Education Advisory Committee to request that the driver education curriculum include robust education around the importance of using rear seat restraints; efforts by the Governor's Highway Safety Program to strengthen public education and awareness about the importance of rear seat restraints; efforts by the Unintentional Death Prevention Committee to continue to gather and consider information on the topic of rear seat restraints.

Task Force discussions around the topic of back seat seatbelts (rear seat restraints) began several years ago in the context of looking at North Carolina's seat belt laws related to rear seats.

North Carolina law currently requires passengers in all positions of a vehicle to be restrained; however, failure to wear a seatbelt in the back seat by those 16 and up cannot be justification for a traffic stop, so it is a "secondary enforcement" (as opposed to primary enforcement) offense.[47] According to the National Highway Traffic Safety Administration (NHTSA), primary enforcement seat belt laws lead to higher usage rates, and seat belt use is the most effective way to prevent fatalities and injuries in the event of a motor vehicle crash. Data clearly illustrates the dangers of passengers being unrestrained in the back seat, not only causing injury to the person who is unrestrained but to other passengers as well as unrestrained rear seat passengers may become a projectile in a crash. NHTSA has formally urged North Carolina to close this gap in its passenger safety law.[48] [More data and information on this topic is contained in the 2019 CFTF Annual Report.]

[45] *"The Department shall not provide financial support for independent bicycle and pedestrian improvement projects, except for federal funds administered by the Department for that purpose. This sub-subdivision shall not apply to funds allocated to a municipality pursuant to G.S. 136-41.1 that are committed by the municipality as matching funds for federal funds administered by the Department and used for bicycle and pedestrian improvement projects. This limitation shall not apply to funds authorized for projects in the State Transportation Improvement Program that are scheduled for construction as of October 1, 2013, in State fiscal year 2012-2013, 2013-2014, or 2014-2015."*[S.L. 2013-183] • [46] For example, in 2019, BikeWalk NC submitted a letter signed by 700 members of the public in addition to 11 Metropolitan and Rural Planning Organizations to Governor Cooper and members of the General Assembly requesting that they end the prohibition of state funding on active transportation infrastructure. • [47] See N.C.G.S. 20-135.2A(d1) & (e); restraint of children under age 16 is according to G.S. 20-137.1. • [48] Occupant protection assessments for NC are conducted by the National Highway Traffic Safety Administration (NHTSA), and have resulted in the recommendation for primary enforcement of a mandatory seat belt law for all seating positions. In December, 2015, the National Transportation Safety Board sent a letter to former Governor McCrory urging enactment of legislation to accomplish this recommendation.

A legislative recommendation made by the Child Fatality Task Force from 2016–2019 was to change North Carolina's law to require primary enforcement of rear seat restraints, however efforts to advance this legislation did not succeed. For the 2020 and 2021 CFTF Action Agenda, the Task Force instead worked on this topic through administrative efforts, continuing to gather information and consider the issue. During the 2021-22 study cycle, the Unintentional Death Prevention Committee heard additional data on this topic from the UNC Highway Safety Research Center, as well as a presentation related to driver education. The committee ultimately determined to focus efforts for 2022 on strengthening and expanding education related to the importance of rear seat restraints, as is set out in the administrative language above. During the 2022-23 study cycle, the committee will consider whether and how to continue to address this issue going forward.

Administrative Effort: continued study of current NC child passenger safety laws and for the Unintentional Death Prevention Committee to revisit the potential need for changes in NC child passenger safety laws after the American Academy of Pediatrics releases revisions to child passenger safety guidelines.

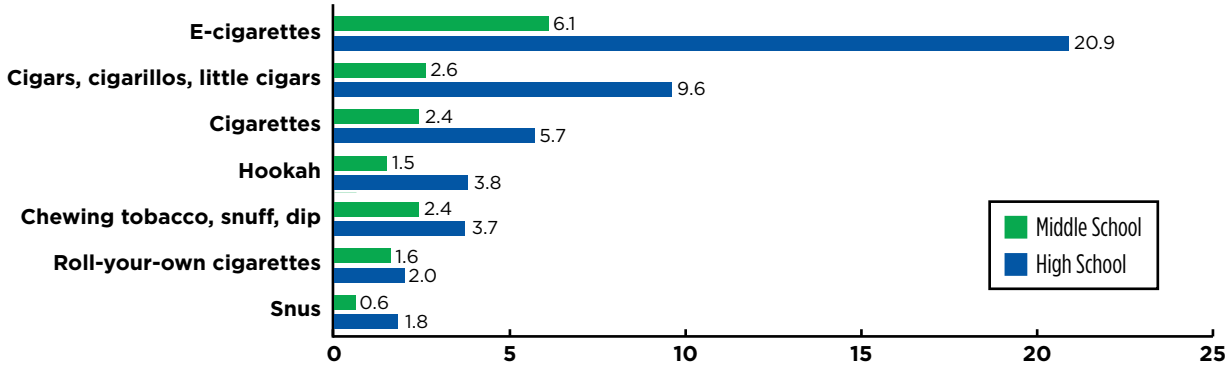
The CFTF 2020 Action Agenda contained an administrative item for a child passenger safety study by an outside group to examine the status of North Carolina's child passenger safety laws in comparison to recommendations from the American Academy of Pediatrics (AAP) and the National Highway Safety Board. NC Child presented information from a preliminary study on this topic to the Unintentional Death Prevention Committee, and North Carolina's Occupant Protection Task Force discussed the issue and shared additional data and analysis with the committee about current child passenger safety laws and potential changes to laws. Although the AAP was expected to release revised recommendations on child passenger safety in 2021, the AAP revision has been delayed and the Unintentional Death Prevention Committee decided to revisit this topic after those revised recommendations are released.

Legislative recommendation to prevent harm to youth and infants caused by tobacco and nicotine use

ENDORSE an appropriation of $17 million in recurring funds for programs to prevent tobacco use and cessation by youth and to prevent harms to infants and children caused by tobacco use (including the prevention of infant deaths that have causes associated with tobacco use during pregnancy).

Ninety percent of tobacco users start before the age of 18. From 2011 to 2017, use of electronic cigarettes among North Carolina high school students jumped by 894%, from 1.7% to 16.9%. During the same time period, electronic cigarette use among middle school students increased 430%, from 1% to 5.3%.[49] From 2017 to 2019, e-cigarette use among high school students increased an additional 24%.[50]

E-cigarettes #1 Product Used by youth (Past 30 Day Tobacco Product Use)



Source: 2019 North Carolina Youth Tobacco Survey Results

[49] N.C. Youth Tobacco Survey 2011-2017, N.C. Division of Public Health. • [50] N.C. Youth Tobacco Survey 2019.

The latest available data (from 2019) showed that one in five high school students were using e-cigarettes, which can contain high doses of nicotine coming in thousands of flavors attractive to youth. Nicotine is highly addictive and can harm adolescent brain development; tobacco product use in any form, including e-cigarettes, is unsafe for youth.[51]

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.[52] 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,[53] both of which are leading causes of infant death.

E-cigarettes can contain high doses of nicotine which is highly addictive. *Nicotine can harm adolescent brain development and is toxic to a developing fetus. Tobacco and nicotine use are associated with leading causes of infant death.*

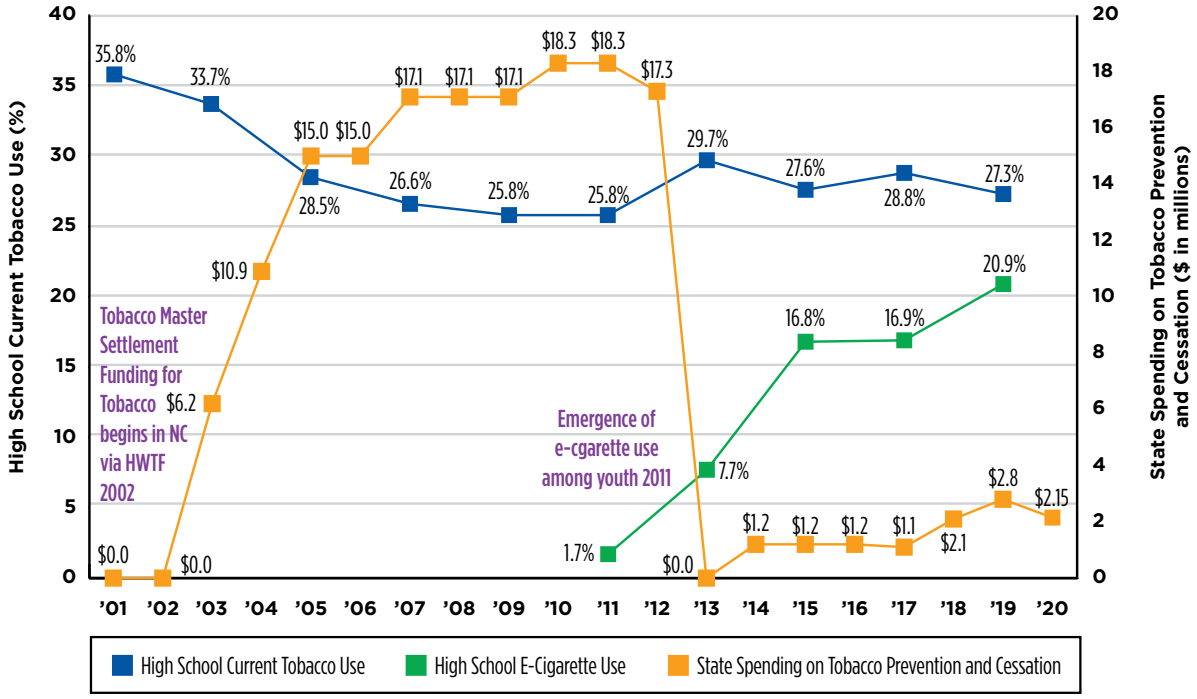
Devices such as the very popular JUUL e-cigarette, that look like a flash drive and deliver a high dose of nicotine, have a sleek design attractive to teens who use them for discreet vaping anywhere, including in school. Vaping during school is pervasive. In a North Carolina school study conducted in 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%).

In 2019 the NC Attorney General sued e-cigarette maker JUUL Labs for designing, marketing, and selling its e-cigarettes to attract young people and for misrepresenting the potency and danger of nicotine in its products. In 2021, the Attorney General reached an agreement with JUUL Labs that required JUUL to pay the state $40 million over six years and make changes to the way it conducts business. North Carolina's 2021 Appropriations Act included a portion of funds from the recent settlement with Juul to go to the NC Division of Public Health for tobacco and nicotine dependence prevention and cessation activities targeted at youth and young adults. This funding was for $13 million nonrecurring in year one and $8 million nonrecurring in year two, with $2 million directed to reimburse litigations costs incurred by the Attorney General in Juul litigation.

Experts presenting to the Task Force have emphasized the need for recurring, sustained funding that is targeted to prevention efforts in order to combat the harms caused by tobacco and nicotine use, and showed data illustrating how prevention spending cuts have corresponded with increased use. North Carolina's spending on tobacco use prevention has drastically decreased since 2012/2013, despite receiving an average of $149,825,874 per year since 2001 from the Tobacco Master Settlement Agreement. Since that time, use of e-cigarettes by youth has increased dramatically, as is illustrated in the following graphic.

[51] U.S. Centers for Disease Control and Prevention. • [52] University of North Carolina Center for Maternal and Infant Health (which has provided presentations to the Task Force in recent years related to the impact of tobacco and nicotine use on fetal and infant health) • [53] Regan AK. Adverse Birth Outcomes Associated With Prepregnancy and Prenatal Electronic Cigarette Use. Obstet Gynecol 2021; 00:1–10.

High School Tobacco Use and State Spending on Tobacco Use Prevention and Cessation in North Carolina, 2001-2020



Since 2001, North Carolina has received an average of $149,825,874 per year from the Tobacco Master Settlement Agreement.

In 2021, North Carolina received $167 million from the Tobacco Master Settlement Agreement.

Administrative efforts to strengthen education and awareness around child abuse and neglect reporting

Administrative support to continue to strengthen education and awareness surrounding child abuse and neglect reporting for law enforcement professionals, medical professionals, and school professionals, such efforts to include adding child abuse and neglect reporting training to already mandated training for all three professions and for trainings to include trauma-informed response and prevention.

North Carolina law requires that "any person or institution who has cause to suspect that any juvenile is abused, neglected, or dependent, as defined by G.S. 7B-101, or has died as the result of maltreatment, shall report the case of that juvenile to the director of the department of social services in the county where the juvenile resides or is found." The State Child Fatality Prevention Team that reviews child deaths has reported continued challenges with child abuse and neglect (CAN) not being reported and has repeatedly identified and recommended to the Task Force the need to focus on strengthening education and awareness around child abuse and neglect reporting.

Since 2019, CAN reporting has been an issue of focus for the Intentional Death Prevention Committee who has looked at: the laws and systems surrounding reporting in NC; data on CAN reports; NC challenges with reporting; research on CAN reporting and what could be learned from other states; and potential actions to address CAN reporting. The committee identified the need to strengthen education not only for the public but also for persons in professions most likely to encounter circumstances raising suspicions of abuse or neglect, such as law enforcement personnel, healthcare professionals, and school personnel who are among the top types of professionals who make CAN reports.

Progress has been made and efforts are ongoing to strengthen training around child abuse and neglect recognition and reporting

In 2020, the Task Force had an administrative item on its Action Agenda to strengthen CAN reporting education and awareness and that year progress was made by the NC Division

of Social Services (DSS) and Prevent Child Abuse North Carolina in strengthening web information on CAN reporting and on strengthening education for the public and professionals on CAN reporting through creation of new resources and improvements to existing resources. (More information about this work can be found in the 2021 CFTF Annual Report.) The 2021 Action Agenda included administrative support for continued efforts to strengthen education and awareness surrounding child abuse and neglect reporting, including strengthening ongoing training for law enforcement and training that is tailored for healthcare providers.

In 2021, a presentation was made to the NC Justice Academy's Joint In-Service Training Committee about Task Force efforts to strengthen CAN reporting training for law enforcement, asking that the committee consider adding this topic to in-service training for law enforcement as a means of broadening training efforts to reach more patrol officers and deputies to give them the knowledge and tools they need to recognize and respond to suspected abuse or neglect. The result of this presentation was that the Joint In-Service Training Committee determined it would include this topic in its 2023 training curriculum; there would be a 4-hour juvenile block of training with at least two hours devoted to this topic. The NC Division of Social Services committed to using existing resources to collaborate with other relevant experts on the development of this training.

With respect to healthcare, other organizations besides the Task Force have simultaneously looked at the need to strengthen CAN reporting training for healthcare providers including the NC Pediatric Society's Committee on Child Abuse and Neglect and the NC Medical Board. During the most recent study cycle, the Intentional Death Prevention Committee heard a presentation from the Chief Medical Officer for the NC Medical Board, who spoke about the Medical Board's interest in this issue, plans for education that were currently underway, as well as plans for continued efforts to educate healthcare providers about child abuse and neglect recognition and reporting.

For this 2022 Action Agenda, the Intentional Death Prevention Committee is continuing its efforts to strengthen CAN reporting education for professionals in law enforcement, healthcare, and schools. The Task Force is continuing to facilitate ongoing conversations among organizations related to their joint interests and efforts around this topic.

Administrative efforts to further study a proposal related to water safety

Administrative support for further study by the UNC Injury Prevention Research Center to quantify the potential impact of legislation requiring lifeguards at day camps that offer time in the water (as it relates to impact on preventing child drownings and near-drownings) to bring information back to the Unintentional Death Prevention Committee; Child Fatality Task Force to acknowledge the public health efficacy of utilizing lifeguards as a strategy to prevent child drownings in settings where children are in or around water, including day camp settings.

In 2021 the Task Force received an issue application requesting the Task Force to endorse legislation requiring lifeguards at children's day camps that offer time in the water. The Unintentional Death Prevention Committee looked at overall data related to child drownings and near drownings. The committee also heard about evidence and stakeholder support related to the important layer of drowning protection provided by lifeguards in general, and how some states have laws or administrative rules requiring lifeguards in camp settings. Representatives from the NC Division of Public Health (DPH) and the NC Division of Child Development and Early Education (DCDEE) spoke to the committee about relevant laws and regulatory structures related to this topic; current laws and structures do not address water safety at all children's day camps.

The committee determined that it would like more information as it considers this proposal for legislation, and in particular, information about the potential impact of the proposed legislation as it relates to drowning prevention. The UNC Injury Prevention Research Center (IPRC) volunteered to gather additional information for the committee to consider during the 2022-23 study cycle of the Task Force. Meanwhile, the Task Force has acknowledged the public health efficacy of utilizing lifeguards as a strategy to prevent child drownings in settings where children are in or around water, including day camp settings.

Legislative History & Accomplishments

Every year since its creation in 1991, the North Carolina Child Fatality Task Force has helped achieve legislative victories for children. The following list is organized by year and includes most — but not all — of the legislative accomplishments and some other accomplishments of the Child Fatality Task Force. "Endorsement" typically signifies that the Task Force endorsed the efforts of others to advance the legislation.

1991

North Carolina Child Fatality Task Force established. The Task Force, a diverse legislative study commission, was charged to study the incidence and causes of child death as well as to make recommendations for changes to legislation, rules, or policies that would promote the safety and well-being of children. The Task Force was also charged to develop a system for multi-disciplinary review of child deaths.

Community Child Protection Teams (CCPTs) established. CCPTs were established in each county by Executive Order. Each CCPT has the responsibility to review selected active Child Protection Services cases of the county Department of Social Services and review all cases in the county in which a child died as a result of suspected abuse and neglect. The purpose of these reviews is to identify gaps and deficiencies in the community child protection system and safeguard the surviving siblings.

North Carolina Child Fatality Review Team (State Team) established. The State Team, a multi-agency panel, was directed to review all cases of fatal child abuse, all deaths of children known to Child Protective Services before their deaths, and additional cases of child maltreatment. The purpose of the reviews is to discover the factors contributing to child fatalities in North Carolina. The State Team is required to report to the Task Force and to recommend legislation to prevent child deaths.

1992

North Carolina Child Fatality Task Force membership expanded to include members of the General Assembly. Two Senators and two members of the House of Representatives, as well as one local health director, were appointed.

North Carolina Child Fatality Task Force extended to 1995.

Additional funds appropriated for Child Protective Service Workers. The Task Force requested $5 million, with a plan to request a total of $30 million over several years. The bill also called for a study of the financing of CPS positions in county Departments of Social Services. The General Assembly appropriated $1 million

Pilot programs for Family Preservation Services funded. The General Assembly appropriated $410,000 for the Basic Social Services plan in three to five counties as pilots, and $50,000 to develop and implement model programs of locally based Family Preservation Services.

Study of Child Protective Services funded. The General Assembly appropriated $80,680 to conduct a study to determine a method that would ensure accountability by the county Child Protective Services programs, to ascertain the best management structure for Child Protective Services, and to determine the need for stronger state supervision of county programs.

"Hot Lines" established. The General Assembly appropriated $62,000 to establish 24-hour Protective Services "hot lines" in each county.

Additional funds for the Child Medical Evaluation Program appropriated. The General Assembly appropriated $935,750 for the Child Medical Evaluation program, $180,000 of which was allocated for a backlog of claims for services and was non-recurring.

Protocols required. The legislation directed the DHHS Division of Social Services to ensure that community interdisciplinary teams develop protocols for use in child abuse and neglect reviews.

1993

Local Child Fatality Prevention Teams (CFPTs) established. Local CFPTs were directed to review all child deaths in each county unless the death was already under review by the local Community Child Protection Team (CCPT). Since each county now had two community-based teams, the local CFPT and CCPT were given the option of joining together or operating independently. The multi-agency membership for the local teams was established by state statute.

Child Fatality Task Force specifically charged to study the incidence and causes of child abuse and neglect.

Additional funds for Child Protective Services Workers appropriated. The General Assembly appropriated $2 million, but maximum caseload standards were not established by statute.

Committee established to develop a payment plan for the evaluation of maltreated children. The resulting committee recommended funding regional maltreatment resource centers.

NCGA Chapter 7A revised. Changes include creating the duty to report and investigate child dependency as well as child abuse and neglect; requiring county Department of Social Services directors, upon receiving a report about a child's death as a result of suspected child maltreatment, to ascertain immediately whether or not there are other children in the home; improving information sharing; and mandating child fatalities from alleged maltreatment be reported to the Division of Social Services Central Registry.



Driving While Impaired (DWI) law amended. The amended statute provides that the presence of a child under 16 years of age in a vehicle driven by a person convicted of a DWI violation shall be considered a grossly aggravating factor in sentencing.

Funding for student services personnel provided. The General Assembly appropriated $10 million for school counselors, to fulfill a provision of the Basic Education Plan.

Comprehensive health screening for kindergarten students mandated. This law requires each child to have a comprehensive health screening evaluation by the time he or she enters kindergarten.

1994

Six additional members of the General Assembly appointed to the Task Force. Three Senators and three members of the House of Representatives were appointed.

North Carolina Child Fatality Task Force extended to 1997.

Family Preservation Program expanded. The General Assembly appropriated $500,000 to expand this program.

Prosecutorial child protection law passed. This law provides for bail and pretrial release conditions determined by the judge in child abuse cases. It also provides for children to be made comfortable in courtrooms during child abuse cases.

Child passenger safety law strengthened. This law requires children under 12 to be safely restrained while riding in a car, whether they sit in the front or the back seat. Infants and toddlers under age four must be secured in child safety seats; older children must use seat belts.

The following laws were passed during the Special Session on Crime called by the governor in 1994:

The Task Force supported several components of the governor's crime package of legislation that applied to juveniles: **Family Resource Centers, Wilderness Camps, the Mentor Training Program for Coaches, and the Governor's One-On-One Program.**

The Task Force worked to amend a bill calling for a comprehensive study of the Division of Youth Services' Juvenile Justice System. The amendment provided for **diagnostic assessments of all youth in state training schools** to determine that each youth has been properly placed.

Community-Based Alternatives program funded. The General Assembly appropriated $5 million for programs that are intended to reduce the number of youths committed to training schools by rehabilitating these troubled youths in their communities.

The Task Force also worked to increase **the penalty for illegally selling guns to a minor from a misdemeanor to a felony**. This felony charge for a weapons violation enables law enforcement to aggressively prosecute those who illegally sell firearms to minors.

1995

Training for child sexual investigations initiated. The Task Force requested $125,000 for statewide, multidisciplinary training for child sexual abuse investigations. The training was funded for $38,336 recurring and $5,000 non-recurring funds through the State Bureau of Investigation.

Underage drinkers prohibited from driving. The Task Force endorsed legislation requiring "zero tolerance" for alcohol measured in the blood or breath of drivers 18–20 years old.

Smoke detectors required in all rental property. This law filled in a gap in North Carolina's smoke detector laws by requiring landlords to install operable smoke detectors for every dwelling.

Sale of fireworks to children prohibited. Before 1993, the sale of pyrotechnics was illegal in North Carolina. In 1993, the General Assembly allowed the sale of some pyrotechnics. The Task Force sought to repeal these changes to the pyrotechnics law in 1995. The General Assembly did not repeal the 1993 law, but a bill was passed that restricts the sale of those pyrotechnics to individuals over the age of 16.

Adoption proceedings moved from Superior to District Court. The Task Force sponsored this legislation as a first step toward creating a comprehensive family court system in North Carolina.

1996

Child abduction law strengthened. This law applies the penalty for abducting a child from a parent, guardian, or school or abductions from any agency or institution lawfully entitled to the child's custody.

1997

Dependent juvenile definition changed. The old statute defined a juvenile as dependent if his or her parents were unable to provide care "due to physical or mental incapacity." This language did not make provision for other situations, such as one in which one or both parents are incarcerated. This law broadened the definition of dependent juvenile and enabled hundreds more children to receive help from the county Departments of Social Services.

Intensive Home Visiting partially funded. The Task Force had a standing goal of encouraging the state to appropriate $3.2 million for intensive home visiting programs shown to be effective in reducing the incidence of child abuse and neglect, unwanted pregnancy, and juvenile involvement with the courts. In 1997, the General Assembly appropriated $825,000 for home visiting, with an additional $200,000 in 1998.

Graduated Driver's License mandated. This measure gives new teenage drivers more experience — and a greater chance of survival — as the result of a three-step process for obtaining a driver license. This ensures beginning drivers get a full year of supervised practice driving with a parent. It also restricts night-time driving for new licensees during the first six months of unsupervised driving.

1998

Sunset of the Task Force lifted.

Court Improvement Project launched. To reduce the amount of time that children are in foster care, the Task Force supported legislation to change the process for handling abuse and neglect cases. As a result of this legislation, termination of parental rights may now be a motion in the cause, adjudication must take place within 60 days of the filing of the petition, the first hearing must be at 90 days, and the second hearing within six months.

Smoke detector penalty set. This law sets a $250 penalty for landlords who fail to install smoke detectors in rental units and a $100 penalty for tenants who destroy or disable smoke detectors after they have been installed.

1999-2000

Child passenger safety law strengthened. The passage of Senate Bill 1347 will save an estimated five lives and 45 serious injuries among child passengers aged 16 or younger each year. The new law imposes a two-point driver's license penalty on drivers who do not see that young passengers are in age-appropriate safety restraint. The enactment of this law closes one of the last remaining gaps in the state's motor vehicle passenger safety laws.

Juvenile procedures clarified. Passage of House Bill 1609 will help move children from abusive, dangerous environments toward safer, permanent homes. The old law required that parents be given separate notices of the possible termination of their parental rights, even if termination is clearly best for the child. This measure streamlines the legal process while preserving parents' rights to proper notification.

Guardianship strengthened. Sometimes called "soft adoption," guardianship is a good option for some children who need a safe, nurturing home. Passage of Senate Bill 1340 clarifies the rights and duties of a legal guardian and thereby creates a more stable home for children with court-appointed guardians.

2001

Infant Homicide Prevention Act passed. House Bill 275 created a safe haven for newborns who would otherwise be abandoned by their distraught mothers.

Child Bicycle Safety Act passed. House Bill 63 established that bicycle riders age 15 and younger must wear an approved helmet when riding on public roads and rights-of-way.

Child Fatality Task Force 10-Year Anniversary celebrated. In the 10 years of the Task Force's existence, the child death rate in North Carolina dropped approximately 20%. At 76.4 deaths per 100,000 children, North Carolina experienced the lowest child fatality rate it had ever recorded.

2002

"Kids First" license tags issued. The General Assembly and the Division of Motor Vehicles authorized and issued "Kids First" license tags with the proceeds going the North Carolina Children's Trust Fund.

Key programs continued. During a time of intensive budget cuts, the Intensive Home Visiting program, the Healthy Start Foundation, the folic acid campaign, and the birth defects monitoring program all received continued funding.

Graduated Driver Licensing system improved. A provision was added to the existing system which limits the number of passengers under age 21 that a novice driver may transport during the first six months of unsupervised driving (allowing only one young, non-family member).

2003

Safe Surrender supported. Task Force members lent their support to the Division of Public Health who was successfully awarded a grant from the Governor's Crime Commission for FY 2003 - 2004 to increase public awareness of the Infant Homicide Prevention Act (aka NC Safe Surrender Law).

2004

NC Booster Seat Law (Senate Bill 1218) ratified. The law established that a child less than 8 years of age and less than 80 pounds in weight shall be properly secured in a weight-appropriate child passenger restraint system. In vehicles equipped with an active passenger-side front air bag, if the vehicle has a rear seat, a child less than 5 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. If no seating position equipped with a lap and shoulder belt to properly secure the weight-appropriate child passenger restraint system is available, a child less than 8 years of age and between 40 and 80 pounds may be restrained by a properly fitted lap belt only.

[ENDORSEMENT] The Task Force endorsed strengthening penalties when methamphetamine is manufactured in a location that endangers children.

2005

All-Terrain Vehicle Safety Law (Senate Bill 189) ratified. The law established that a child less than 8 years of age is not allowed to operate an ATV. In addition the law creates restrictions based on age and machine size for children between the ages of 8 and 16. The law also requires adult supervision for children under 16, restricts passengers to those ATVs designed for more than one person, bans operation on public streets, roads and highways, and outlines equipment standards for sellers and buyers. In addition, safety training is now required for operators, as is the use of safety equipment.

2006

Unlawful Use of a Mobile Phone Law (Senate Bill 1289) ratified. The law established that children under the age of 18 cannot operate a motor vehicle while using a mobile phone or any technology associated with mobile phones. Exceptions were created for teens talking with their parents, spouses, or emergency personnel.

Rear Passenger Safety Law (Senate Bill 774) ratified. The law requires use of rear-seat safety belts by all passengers of non-commercial vehicles.

Strengthen Sex-Offender Registry Law (House Bill 1896) ratified. The law strengthened North Carolina's existing sex offender registry system by requiring additional standards for monitoring sex offenders, including extensive monitoring of the most predatory offenders upon their release from prison.

Funds to Prevent Child Maltreatment (Senate Bill 1249) appropriated. $90,000 in recurring funds was allocated to the NC Department of Health and Human Services for one position to staff the Child Maltreatment Leadership Team and carry forth recommendations of the North Carolina Institute of Medicine's Task Force on Child Abuse Prevention.

General Statute 7B-302 DSS Disclosure of Confidential Information (Senate Bill 1216) amended. The amendment clarified the ability of county Departments of Social Services to share confidential information with other professional entities. The amendment also put North Carolina in compliance with federal child welfare funding guidelines and allowed for continued federal support.

Funds to Prevent Preterm Births (Senate Bill 1741) appropriated. $150,000 in non-recurring funds was allocated to provide medications to low-income women at-risk of a second premature birth. The medication is proven to reduce recurring preterm births by 33%.

Funds to establish a Perinatal Health Network (Senate Bill 1253) appropriated. $75,000 in non-recurring funds was allocated for the creation of a professional perinatal health network. The network will bring together perinatal health leaders to plan strategically for the reduction of infant mortality and promotion of women's and infants' health in North Carolina.

[ENDORSEMENT] The Task Force endorsed: 1) continuing the Medicaid Family Planning Waiver; 2) recurring funding of the North Carolina Folic Acid Campaign at $300,000; 3) recurring funding for the North Carolina Healthy Start Foundation for statewide infant mortality reduction initiatives and conversion of non-recurring funding to recurring funding status; 4) recurring funding for the North Carolina Birth Defects Monitoring Program at $325,000.

Administrative changes recommended. 1) support the DHHS Division of Public Health efforts to procure grant funds for youth suicide prevention; 2) form a CFTF subcommittee to work on gun safety, specifically pursuing a gun safety awareness campaign, creating talking points on gun safety, and seeking common ground to prevent injury and death to children and youth due to firearms.

2007

Child Passenger Safety Exemption (Senate Bill 23) ratified. Amended § 20-317.1. (Child restraint systems required), by removing exemption (b)ii "when the child's personal needs are being attended to" in order to qualify North Carolina for the continuation of $1 million in child passenger safety funding from the National Highway Traffic Safety Administration.

Funds to address infant deaths secured. Appropriations recommended by the Child Fatality Task Force were secured and included $97,000 in non-recurring funds to prevent preterm births by providing the medication known as 17-Progesterone to uninsured women and $150,000 in non-recurring funds for a statewide Safe Sleep awareness campaign.

[ENDORSEMENT] The Task Force endorsed: 1) $200,000 in recurring funds were provided for the birth defects monitoring system; 2) $150,000 in non-recurring funds were provided for the North Carolina Healthy Start Foundation; 3) the Fire Safe Cigarette Act (House Bill 1785) passed and requires cigarette manufacturers to produce and market only cigarettes that adhere to an established cigarette fire safety performance standard.

Legislative charge received. Senate Bill 812 directed the Child Fatality Task Force to study issues relating to requiring the installation and use of passenger safety restraint systems on school buses and report findings by May 2008.

2008

Amend Child Abuse (Senate Bill 1860) ratified. An act to increase the criminal penalty for misdemeanor child abuse and to amend the criminal offense of felony child abuse.

Hospital Report Child Injuries (House Bill 2338) ratified. An act to require hospitals and physicians to report serious, non-accidental trauma injuries in children to law enforcement officials.

Funds to prevent preterm births provided. $97,000 in non-recurring funds appropriated to continue efforts to provide minority and low-income women at-risk for delivering a premature infant with a preventative treatment to reduce the risk of a recurring preterm birth.

Funds to reduce infant deaths secured. $150,000 in non-recurring funds appropriated to continue funding for a statewide public awareness campaign to promote safe sleep and reduce infant deaths due to Sudden Infant Death Syndrome (SIDS) and unintentional suffocation/ strangulation.

Child Passenger Safety Technician Liability (House Bill 2341) ratified. An act to limit liability for the acts of certified child passenger safety technicians and sponsoring organizations of child safety seat educational and checking programs when technicians and sponsoring organizations are acting in good faith and child safety seat inspections, installation, adjustment or education programs are provided without fee or charge.

Require Carbon Monoxide Detectors (Senate Bill 1924) ratified. An act to authorize the North Carolina Building Code Council to adopt provisions in the Building Code pertaining to the installation of carbon monoxide detectors in certain single-family or multifamily dwellings; to require the installation of operational carbon monoxide detectors in certain residential rental properties and to provide for mutual obligations between landlords and tenants regarding the installation and upkeep of carbon monoxide detectors.

Transporting Children in Open Bed of Vehicle (House Bill 2340) ratified. An act to increase the protection of children who ride in the back of pickup trucks or open beds of vehicles by raising the minimum age to 16 and removing the exemption that made allowances for small counties.

Change Format of Driver Licenses/Under 21 (House Bill 2487) ratified. An act to change the format of a driver license or special identification card being issued to a person less than 21 years of age from a horizontal format to a vertical format to make recognition of underage individuals easier for clerks dealing in restricted age sales of products such as alcoholic beverages and tobacco products.

2009

Funding to prevent preterm births provided. $97,000 in non-recurring funds appropriated to continue efforts to provide minority and low-income women at-risk for delivering a premature infant with a preventative treatment to reduce the risk of a recurring preterm birth.

Funding to reduce infant deaths provided. $150,000 in non-recurring funds appropriated to continue funding for a statewide public awareness campaign to promote safe sleep and reduce infant deaths due to Sudden Infant Death Syndrome (SIDS) and unintentional suffocation/ strangulation.

The Division of Medical Assistance directed to explore interconceptional care. This direction allows DMA to pursue a federal waiver or other mechanism to offer a basic package of interconceptional care services to low-income women at high-risk for delivering prematurely.

Funding continued for Child Medical Evaluation System. This system provides diagnostic services to children suspected of being victims of child maltreatment.

Interagency agreements established to better protect children from violent sex offenders. The federal Adam Walsh Child Protection and Safety Act requires a more comprehensive, nationalized system for registration of sex offenders. To meet this goal, interagency collaboration has been established between the State Bureau of Investigation, the Sheriff's Association, the Division of Social Services and others.

An Act to Prohibit the Retail Sale and Distribution of Novelty Lighters (Senate Bill 652) ratified. This act to protect children by banning the sale of novelty lighters.

The Nicholas Adkins School Bus Safety Act (House Bill 440) ratified. This measure assures that pictures taken of drivers committing a stop arm violation are acceptable evidence for conviction and makes it a felony if a student is killed due to an illegal pass of a stopped school bus.

Youth employment protections passed. Enhance Youth Employment Protection Act (H22) enhances reporting and surveillance requirements by the Department of Labor. Strengthen Child Labor Violation Penalties (H23) increases penalties to employers who violate child labor requirements.

2010

Funding to preserve infant mortality prevention infrastructure maintained. Due to on-going state budget constraints, the Task Force focused on maintaining a package of services that works together to help babies be born healthy and to make it to their first birthday. Elements of the package include the following: $350,000 for the NC Folic Acid/Preconception Health Campaign to decrease neural tube defects and improve birth outcomes; $325,000 for the Eastern Carolina University High-Risk Maternity Clinic to improve birth outcomes in Eastern North Carolina; $150,000 for Safe Sleep to avoid SIDS and other sleep-related deaths; $97,000 for 17-Progesterone distribution to help prevent pre-term births; $408,000 for the Healthy Start Foundation to improve maternal health prior to and during pregnancy.

Increase Driver's License Restoration Fee (S655) ratified. This act increases the fee that drivers who have their licenses suspended following conviction for impaired driving must pay to have their licenses later restored. All funds raised (an estimated $560,000 each year) will go to Forensics Tests for Alcohol to continue programs to deter, detect, and convict impaired drivers.

2011

Funding to preserve infant mortality prevention infrastructure maintained. Due to on-going state budget constraints, the CFTF focused on maintaining a package of services that works together to help babies be born healthy and to make it to their first birthday. Elements of the package include the following: $350,000 for the NC Preconception Health Campaign to decrease neural tube defects and improve birth outcomes; $150,000 for Safe Sleep to avoid SIDS and other sleep-related deaths; $47,000 for 17-Progesterone distribution to help prevent pre-term births. These items were funded nonrecurring out of the Maternal and Child Health Block Grant.

Fine for speeding in a school zone increased to $250 (S49). Speeding just an extra 10 mph in a school zone greatly increases the chance of death for a student hit by a car. The chance of pedestrian death increases nine-fold (from 5% to 45%) with an increase in speed from 20 mph to 30 mph. This bill makes the fine for speeding in a school zone equal to that of speeding in a construction zone.

Sale of certain dangerous synthetic substances banned (S7). This act bans substances previously available legally — including a synthetic cannabinoid that produces a marijuana-like high and MDPV, a synthetic that produces a cocaine-like high and hallucinations. The ban went into effect June 1, 2011. Throughout the early implementation period, the CFTF has worked with law enforcement and others to monitor the effectiveness of the ban.

Penalty for driving impaired with a child in the car enhanced (S241). Motor vehicle crashes are the leading injury-related cause of death for children and impaired driving is a factor in 15% -20% of those deaths. National data show that most children who die in crashes where alcohol is involved are the passenger of the impaired driver. Additionally, impaired drivers are also less likely to buckle-up their children safely.

Concussion protocols established (The Gfeller-Waller Athletic Concussion Awareness Act – H792). This act requires that coaches, other school personnel, and parents of middle and high school athletes receive information about concussions and prohibits same-day return-to-play. Only once cleared for play by specified health providers may athletes later return to practice or play.

Changes to the graduated driver licenses system monitored. Since North Carolina adopted graduated driver licensing, crashes are down 38% for 16-year-olds and 20% for 17-year-olds, among the best results of any state. Time spent driving and gaining experience is critical for teens learning to drive more safely. Changes from Modify Graduated Licensing Requirements (S636) include requiring learning drivers keep a log of time and conditions driven. Additionally, a provisional license will be revoked if the licensee is charged with a variety of serious driving violations, such as excessive speeding. The Division of Motor Vehicles is charged with evaluating the effectiveness of the provisions.

[ENDORSEMENT] The Perinatal Quality Collaborative of NC received $250,000 in funding (from the Maternal and Child Health Block Grant).

2012

Funding to preserve infant mortality prevention infrastructure partially maintained. Due to on-going state budget constraints, the CFTF focused on maintaining a package of services that works together to help babies be born healthy and to make it to their first birthday. Elements of the package include the following: $350,000 for the NC Preconception Health Campaign to decrease neural tube defects and improve birth outcomes; $375,000 to the East Carolina University High-Risk Maternity Clinic; and $47,000 for17-Progesterone

distribution to help prevent pre-term births. These items were funded nonrecurring out of the Maternal and Child Health Block Grant. However, funding for Safe Sleep and the NC Healthy Start Foundation were eliminated.

Replacement of conventional smoke alarms with tamper-resistant lithium-battery alarms in rental units (S77). Over the past five years, 75 children and hundreds of adults have died due to fire. Fire and flame are the fourth leading cause of death of North Carolina children ages 5 to 9. Furthermore, national data reveal that two-thirds of fire deaths occur in homes without an operating smoke alarm, often because the battery has been removed or is not working. The new science of tamper-resistant lithium battery alarms can help solve this problem since alarms with these batteries work for 10 years and the batteries cannot be removed for other uses. This measure requires landlords to phase-in tamper-resistant lithium battery units as conventional battery units are scheduled for replacement.

Funding to preserve evidence-based treatment programs for children maintained. Due to on-going state budget constraints, the CFTF focused on maintaining a package of services that works together to help screen and treat at-risk children: Funding was maintained at flat levels, often with federal funds, for the Child Medical Evaluation Program, Child Advocacy Centers, the Child Treatment Program, and suicide gatekeeper programs.

[ENDORSEMENT] The Perinatal Quality Collaborative of NC received $250,000 in funding (from the Maternal and Child Health Block Grant). A bill (H176) passed addressing concerns on tracking of domestic violence cases to make more clear when "assault on a female" (or other crimes) occur between intimate partners or strangers. In addition to improving data and understanding of ways to address problems, this may help workers within the Division of Social Services have more complete information on when domestic violence is a factor in the home. Smoking cessation and prevention was funded at $2.7 million from the Social Services Block Grant.

2013

Revise Controlled Substance Reporting (S222). Poisoning is the fastest growing cause of teen death. The bill made changes to the Controlled Substance Reporting System (CSRS) to deter pill mills, to make it easier for doctors to check to see previous prescription-fill history to avoid duplicate prescriptions and to offer treatment as needed, to provide more timely data, and to allow data tracking relating to atypical prescribing or filling, as well as other provisions.

Require Pulse Oximetry Screening (S98). Pulse oximetry is a quick and inexpensive test that screens newborns for certain congenital heart disease. If the baby is sent home before this condition is detected, the baby may get very sick and need to be rushed to the hospital for emergency surgery. Pulse oximetry screening allows timely, non-emergency intervention that can save lives.

Health Curriculum/Preterm Birth (S132). Prematurity is one of the leading causes of infant deaths. This bill incorporates into the Healthy Behaviors Curriculum information about the preventable risks of preterm birth including induced abortion, smoking, alcohol consumption, the use of illicit drugs, and inadequate prenatal care.

Funding to preserve infant mortality prevention infrastructure partially maintained. Due to on-going state budget constraints, the CFTF focused on maintaining a package of services that work together to help babies be born healthy and to make it to their first birthdays. Elements of the package include the following: the NC Preconception Health Campaign to decrease neural tube defects and improve birth outcomes; East Carolina University High-Risk Maternity Clinic to treat high-risk pregnancies in the eastern part of the state;17-Progesterone distribution to help prevent pre-term births; NC Healthy Start Foundation to provide community-based organization with evidence-based strategies and communications to improve the health of women of reproductive age and their babies; the Perinatal Quality Collaborative to promote best practices with hospitals; the Safe Sleep Campaign to promote safe sleep including in hospitals; and You Quit Two Quit to provide training assistance to help medical practices implement evidence-based protocols to reduce smoking by pregnant women. ECU was funded recurring with state funds. Other funded items were funded nonrecurring out of the Maternal and Child Health Block Grant. However, no funding was provided for the Healthy Start Foundation or You Quit Two Quit tobacco cessation for women.

Funding for Child Treatment Program. The Child Treatment Program (CTP) is an evidence-based treatment for children who have experienced trauma. The CFTF supported funding of $2 million for an implementation platform to assure the treatment was used statewide with fidelity. Funding was included in the budget.

Funding for services to stabilize families and prevent children from being removed from their homes. Changes in federal funding resulted in loss of $12 million to the Division of Social Services for services to help keep children at-risk of abuse or neglect safe in their own homes. Funding of $4.8 million was provided.

[ENDORSEMENT] Funding for Child Advocacy Centers and the Child Medical Evaluation Program; measures to make it easier for doctors to prescribe and third parties to use a medication (naloxone) to reverse drug overdoses (S20).

2014

Funding to preserve infant mortality prevention infrastructure partially maintained. The CFTF continued to focus on maintaining a package of services that work together to help babies be born healthy and to make it to their first birthdays. Elements of the package include the following: the NC Preconception Health Campaign to decrease neural tube defects and improve birth outcomes; East Carolina University High-Risk Maternity Clinic to treat high-risk pregnancies in the eastern part of the state;17-Progesterone distribution to help prevent pre-term births,

NC Healthy Start Foundation to provide community-based organization with evidence-based strategies and communications to improve the health of women of reproductive age and their babies, the Perinatal Quality Collaborative to promote best practices with hospitals, the Safe Sleep Campaign to promote safe sleep including in hospitals, and You Quit Two Quit to provide training assistance to help medical practices implement evidence-based protocols to reduce smoking by pregnant women. ECU was funded recurring with state funds. Other funded items were funded nonrecurring out of the Maternal and Child Health Block Grant. However, no funding was provided for the Healthy Start Foundation or You Quit Two Quit tobacco cessation for women. A special budget provision allows programs that provide tobacco cessation services for pregnant women and new mothers to apply for a certain competitive grant process.

Funding for services to stabilize families and prevent children from being removed from their homes. Changes in federal funding resulted in a loss of $12 million to the Division of Social Services for services to help keep children at-risk of abuse or neglect safe in their own homes. Funding of at least $9 million was provided.

Coverage of lactation support through the Division of Medical Assistance: Given the strong cost savings and lifesaving benefits of breastfeeding, DMA was authorized to reimburse costs associated with lactation consultants. (Initially, legislation was sought, but it was later determined to be unnecessary.) This is estimated to save 14 to 18 infant lives per year.

[ENDORSEMENT] Funding for Child Advocacy Centers and the Child Medical Evaluation Program; authorization of the NC Department of Environment and Natural Resources (now known as the NC Department of Environmental Quality) to participate in the Interstate Chemicals Clearinghouse for the purposes of access to key data necessary to enhance safety in use of toxic chemicals.

2015

A new law protecting children from nicotine poisoning: North Carolina became one of the first states to prohibit the sale of e-cigarette liquid containers without child-resistant packaging and without labeling those that contain nicotine. This protects small children who may access liquid nicotine (often sold in candy or fruit flavors) resulting in exposure that may cause injury or death. Calls to Carolinas Poison Centers related to liquid nicotine have risen dramatically in recent years, going from eight calls in 2011 to 137 calls in 2014.

A new law protecting children from skin cancer: The "Jim Fulghum Teen Skin Cancer Prevention Act" prohibits tanning bed operators from allowing individuals under age 18 to use their tanning equipment. With melanoma rates in North Carolina higher than the national average and studies showing the majority of melanoma cases in young adults are connected to indoor tanning bed use, the purpose of this measure is to reduce the incidence of skin cancer.

Measures to address prescription drug misuse and poisoning: Approximately one in five high school seniors in North Carolina reports having taken prescription drugs without a prescription. Medications are among the most common type of exposure prompting calls to Carolinas Poison Control Center regarding children and adolescents. The CFTF recommended funding for safe drug disposal (Operation Medicine Drop) to decrease access to drugs that can result in misuse or poisoning, and this item was funded as non-recurring. The CFTF endorsed the reinstatement of funding for Carolina's Poison Control Center, which was funded as recurring, and also endorsed measures to strengthen the Controlled Substances Reporting System, resulting in a number of improvements to the system.

[ENDORSEMENT] Funding to preserve infant mortality prevention infrastructure: The CFTF focused on maintaining a package of services that works together to help babies be born healthy and make it to their first birthday, including funding for the following: East Carolina University High-Risk Maternity Clinic to treat high-risk pregnancies in the eastern part of the state; 17-Progesterone distribution to help prevent pre-term births; the Perinatal Quality Collaborative (PQCNC) to promote best practices with hospitals; the Safe Sleep Campaign to promote safe sleep; and the NC March of Dimes Preconception Health Campaign to decrease birth defects and improve birth outcomes. ECU and PQCNC were funded with state funds. Other items were funded out of the Maternal and Child Health Block Grant.

[ENDORSEMENT] Funding to support accredited Child Advocacy Centers in North Carolina who provide services for abused children by bringing together local child protective services, law enforcement, prosecutors, and medical and mental health providers. The CACs were funded with nonrecurring state funding and maintained block grant funding.

2016

Funding for perinatal tobacco cessation and prevention: Tobacco use during pregnancy is directly associated with the top four causes of infant mortality in North Carolina. The goal of You Quit Two Quit Program, which received $250,000 in nonrecurring funds, is to ensure there is a comprehensive system in place for high quality screening and treatment for tobacco use in women, including pregnant and postpartum mothers.

Funding for safe drug disposal: Operation Medicine Drop, which received $120,000 in nonrecurring funds, is a nationally recognized North Carolina program that uses drug take-back events and permanent medicine drop boxes to collect 15 to 20 million doses of unused medications each year. Safe disposal of medications is one tool to addresses a current epidemic of prescription drug misuse and drug overdose by reducing access to drugs, particularly by small children and teens who often obtain drugs from friends and family.

A new law prohibiting unlawful transfer of custody of a child: This legislation is aimed at preventing child maltreatment, including situations where a parent or guardian feels unable or unwilling to care for his or her child and locates a stranger, for example over the internet, who takes physical custody of the child. Such unlawful transfers can result in children ending up in abusive or neglectful homes or in human trafficking rings. [Session Law 2016-115]

Change in CSRS law to facilitate research and education: The Controlled Substances Reporting System (CSRS) is an important tool in North Carolina's battle to understand and react to the current opioid overdose epidemic. Prior to this technical change, the law required CSRS data purging at six years, preventing epidemiologists and researchers from doing effective longitudinal evaluation and analysis of the CSRS system and trends. This change to the law requires quarterly purging of data more than six years old, but instead of permanently discarding the data, it will now be maintained in a separate database so it can be used for statistical, research, or educational purposes.

[ENDORSEMENT] Funding to support Children's Advocacy Centers in North Carolina. Children's Advocacy Centers provide services for abused children by bringing together local child protective services, law enforcement, prosecutors, and medical and mental health providers. The CAC model is an evidence-based national model with multiple proven benefits for children.

Monitored and maintained: Funds provided to the following perinatal health programs previously supported by the Child Fatality Task Force remained unchanged in the 2016 budget: Perinatal Quality Collaborative NC; East Carolina University High Risk Maternity Clinic; March of Dimes Preconception Health Campaign; 17-Progesterone; Safe Sleep Campaign.

2017

Recurring funding for perinatal tobacco cessation and prevention: Tobacco use during pregnancy is directly associated with the top four causes of infant mortality in North Carolina. The 2017 legislative budget contained $500,000 in recurring funds for both the You Quit Two Quit Program and Quitline NC, both of which can help prevent tobacco use during pregnancy.

Recurring funding to the Child Medical Evaluation Program: A Child Medical Evaluation (CME) is a specific evaluation performed by a qualified medical expert for neglect, physical abuse, or sexual abuse when it is suspected that a child is being abused or neglected by their parent. Evaluations are requested and findings are used by local departments of social services and medical professionals to determine a course of medical treatment for the child. An increase in recurring funds ($723,000 per year) was needed in order to bring the reimbursement rate for CMEs in North Carolina to the regional average rate of $575. Prior to this increase, CMEs in North Carolina had been reimbursed a flat fee payment of $250 for suspected sexual abuse and $150 for other types of suspected maltreatment, putting North Carolina at risk of losing these specialized professionals for this important work requiring extensive hours and a high degree of expertise.

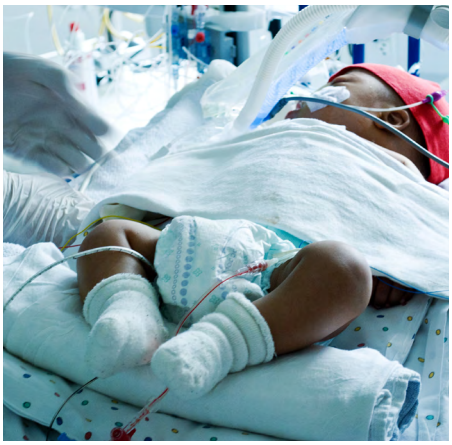
CFTF was one of many seeking strengthened tools for combating the opioid epidemic: In 2017, a major piece of legislation called the "STOP Act" (Strengthen Opioid Misuse Prevention Act) containing numerous provisions addressing strategies for preventing opioid misuse passed the legislature unanimously (S.L. 2017-74). Many organizations and individuals were involved in advancing the STOP Act and although the CFTF was not primarily responsible, some of the STOP Act provisions aligned with 2017 CFTF Action Agenda recommendations: the STOP Act includes mandatory use of the Controlled Substances Reporting System by the medical profession (the Task Force recommended increased use of CSRS by medical professions); the STOP Act made a technical correction in the law to enable interstate data sharing for the Controlled Substances Reporting System (a recommendation by the CFTF); the STOP Act removed some barriers and provided funding for the Harm Reduction Coalition to continue its important work (the CFTF endorsed the efforts of the Harm Reduction Coalition to continue its work fighting the opioid epidemic).

[ENDORSEMENT] Legislation authorizing civil penalties for passing a stopped school bus and the utilization of school bus cameras to facilitate automatic civil enforcement. [S.L. 2017-188]

Monitored and maintained: Funds provided to the following perinatal health programs previously supported by the Child Fatality Task Force remained unchanged in the 2017 budget: March of Dimes Preconception Health Campaign, 17-Progesterone, and the Safe Sleep Campaign. The CFTF had been monitoring implementation of the child welfare case management system as part of NC FAST and the 2017 legislative budget contained funding for this purpose.

2018

Child Fatality Prevention System Summit held on April 9 and 10, 2018 in Raleigh. Although not a legislative event, this was a first-of-its-kind historic event during which Child Fatality Prevention System professionals from across the state came together to learn from state and national experts, share best practices and challenges, and take part in launching state and local initiatives focused on strengthening the CFP System and creating safer and healthier communities for North Carolina's children. The idea for the summit originated with the Executive Committee of the Task Force, which received support from the full Task Force for advancing plans for the Summit.



Legislation passed to require a study of maternal and neonatal risk-appropriate care at health care facilities across North Carolina. This legislation requires NCDHHS to study the current status of North Carolina delivering hospitals related to capabilities for handling various complexity levels of care for mothers and newborns. The study is to identify disparities, service gaps, and other issues, and to make recommendations to ensure quality care in risk-appropriate facilities. This study is aimed at ensuring newborns and their mothers can access timely, comprehensive medical services from a medical facility able to meet their specific medical needs. [Session Law 2018-93]

Legislation passed to add three conditions to the state's newborn screening program: Pompe (Glycogen Storage Disease Type II), MPS-I (Mucopolysaccharidosis Type I), and X-ALD (X-linked Adrenoleukodystrophy). Early detection of these conditions can lead to early treatments that can prevent or improve many of the effects of these conditions, including prevention of early death. This legislation was addressed in the 2018 budget bill, Session Law 2018-5. The March of Dimes was a significant partner in this work.

School safety grant funding that includes CALM (Counseling on Access to Lethal Means) among the programs for which grants may be used. As part of its work on suicide prevention and addressing access to lethal means, the 2018 CFTF Action Agenda included a recommendation to expand the use of the CALM program in North Carolina. This program is designed to train practitioners (medical, mental health) and others to implement strategies to help those who are deemed at risk for suicide by enlisting the help of their families and supportive others to reduce their loved ones' access to lethal means, particularly firearms. The 2018 budget bill, Session Law 2018-5, included $3 million of funds directed to the Department of Public Instruction to be used for nonrecurring school safety grants to community partners to provide training to help students develop healthy responses to trauma and stress. CALM was included among several trainings designated in the budget bill as being suitable for these grants.

Some funding to add school nurses: As part of its suicide prevention work, the CFTF had recommended $5 million in recurring funds to expand the state's School Nurse Funding Initiative to add 100 nurses in high-need schools in order to get closer to meeting nationally recommended ratios. The 2018 budget bill, Session Law 2018-15, included $10 million in nonrecurring grants for schools to add school mental health support personnel (defined as nurses, counselors, psychologists, and social workers). (The Program Evaluation Division of the General Assembly released a report in May 2017 stating it would cost $45 to $75 million annually to meet national recommendations for the numbers of nurses in schools.)

Funding for a birth certificate initiative of the Perinatal Quality Collaborative of NC: The 2018 budget bill included funding to support a project of the Perinatal Quality Collaborative of NC intended to improve the accuracy of birth certificate data.

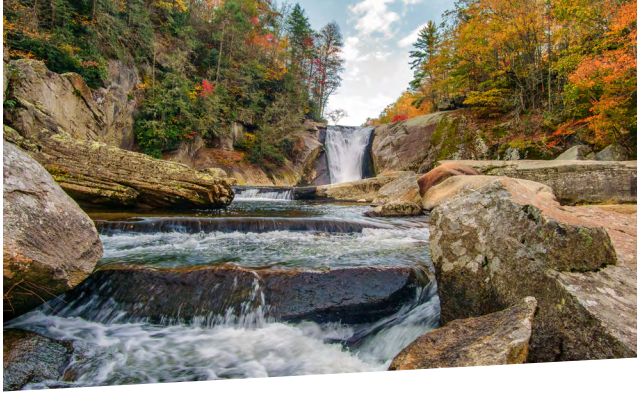
[ENDORSEMENT] Some recurring funding for the Quitline and You Quit Two Quit perinatal tobacco cessation programs. The CFTF had endorsed the efforts of others to advance $3 million in additional funding for QuitlineNC, a statewide tobacco cessation program. The 2018 budget contained $250,000 in additional recurring funds for both QuitlineNC and the You Quit Two Quit Program (a perinatal tobacco cessation program supported on previous action agendas by the CFTF).

[ENDORSEMENT] Some funding to support tobacco prevention for youth. The CFTF had endorsed the efforts of others to advance $7 million in state funding for youth tobacco prevention. The 2018 budget contained an additional $250,000 in nonrecurring funds for youth tobacco prevention programs.

2019

Note about unique 2019 legislative session: A highly unusual outcome of the 2019 legislative session was that the 2019 Appropriations Act, HB 966, never became law. This bill was ratified by the legislature, was vetoed by the governor, then the House voted to override the veto, but the Senate never voted on the veto override. Some





of the 2019 recommendations of the Child Fatality Task Force were addressed in HB 966, but they did not fully advance, since HB 966 itself did not fully advance. Some other bills addressing appropriations referred to as "mini budget bills" did pass in 2019.

Partially Advanced: Firearm Safe Storage Initiative. Two 2019 bills addressed the 2019 Task Force's recommendation to launch and fund a firearm safety initiative. Originally introduced in 2019 as House Bill 508, the bill had bipartisan support. The text of this bill was then included in House Bill 966, the 2019 Appropriations Act, which was ratified but never became law. This initiative by DHHS was to educate the public about the importance of the safe storage of firearms, to facilitate the distribution of gun locks, and to provide outreach and technical assistance to help communities launch local safe storage initiatives. On August 12, 2019, Governor Cooper signed a gun safety Executive Directive, and this directive set in motion the development and compilation of firearm safety tools and resources by the Division of Public Health, using elements of the Child Fatality Task Force's firearm safety stakeholder recommendations to inform this work. A webpage on the Division of Public Health website now provides information on firearm safety.

Partially Advanced: Strengthening of the North Carolina Child Fatality Prevention System. Two 2019 bills addressed Task Force's recommendations to strengthen the statewide Child Fatality Prevention System. House Bill 825 addressed these recommendations, then the text of HB 825 was included in the 2019 Appropriations Act, HB 966, which was ratified but did not become law. The recommendations of the Task Force were adopted in the Child Welfare Reform Plan Final Report submitted by the Center for the Support of Families to the State of North Carolina Office of State Budget and Management and Department of Health and Human Services. The Department of Health and Human Services undertook further study and planning related to these recommendations, as the recommendations were also aligned with NCDHHS priorities and the statewide Early Childhood Action Plan and were also adopted in the 2019 Child Welfare Reform Plan Final Report from the Center for the Support of Families.

Funding for more school nurses. S.L. 2019-222 included additional funding in the Department of Public Instruction's instructional support allotment to be used during the fiscal biennium 2019-2021 to improve student mental health by increasing the number of school mental health support personnel (school nurses, counselors, psychologists, and social workers) in each local school administrative unit. The Child Fatality Task Force was one of multiple organizations advancing a recommendation to fund more school nurses.

The CFTF was one of many seeking funding for Raise the Age implementation. In 2017, North Carolina became the last state in the nation to pass a law to raise the age of juvenile court jurisdiction so that 16- and 17-year-olds charged with most crimes and infractions would be dealt with in the Juvenile Court system rather than adult system. Funds were needed to implement "Raise the Age," which went into effect in December 2019, and in the 2019 legislative session, S.L. 2019-229 appropriated funds to add court personnel (clerks, judges, attorneys), additional staff and support for the Division of Juvenile Justice, juvenile court counselors, support for centers serving juveniles, and for other purposes. Many organizations worked to advance this funding.

Full Circle: Reports from outside groups that undertook studies originating from Child Fatality Task Force work

Perinatal Study Report: In 2019 the CFTF advanced legislation to require NCDHHS to study the current status of North Carolina delivering hospitals related to capabilities for handling various complexity levels of care for mothers and newborns. (See further explanation above for this item in 2019.) As a result of this legislation, a Perinatal Systems of Care Task Force was convened by the North Carolina Institute of Medicine, and a report with recommendations from this group was presented to the Joint Legislative Oversight Committee on Health and Human Services in March 2020. The report was also presented to the Perinatal Health Committee of the Child Fatality Task Force.

Paid Family Leave Insurance Study: In recent years the Child Fatality Task Force heard from experts about the impacts of paid family leave and paid family leave insurance programs in effect in some other states. Realizing the complexities of a statewide paid family leave insurance program, the Task Force determined in 2017 an in-depth study of this issue would need to take place, but that such a study was beyond the scope of Task Force structure and capacity. A multi-sector group was formed for the purpose of outlining the various issues such a study would need to address in order to inform North Carolina leaders about this issue. Using the outline created by this group as a framework, faculty at

the Duke University Center for Child and Family Policy elected to perform a pro bono study analyzing the costs and benefits of a potential paid family leave insurance program in North Carolina. This study was published by Duke University in March 2019 and was presented to the full Task Force and the Task Force Perinatal Health Committee during its 2019-2020 study cycle.

2020

Note about unique 2020 legislative session: The 2020 legislative session was like no other, as it took place in the first year of the COVID-19 global pandemic. Among the many unique features of this session: the legislature was reacting to revenue forecasts in May of 2020 estimating a $4.2 billion cumulative reduction to FY2019-21 budgeted revenues and that budgeted revenues would be insufficient by nearly $600 million to support the FY 2019-21 enacted appropriations; the legislature had to address the appropriation of COVID-19 relief funding that had come from the federal government with specific parameters; instead of a comprehensive budget bill being introduced as is typical, a series of budget bills was introduced; far fewer bills (on any topic) were filed than would typically be filed in a short session as the overwhelming focus of the session was on issues directly related to the COVID-19 pandemic.

New law requiring suicide prevention training for school personnel and a risk referral protocol in schools. For several years, the CFTF recommended required suicide prevention training for school personnel and a risk referral protocol in schools. In 2020, a bill passed that addressed this recommendation as part of a larger student mental health bill that requires a school-based mental health plan and mental health training on a number of topics beyond suicide prevention. [S.L. 2020-7] [Many stakeholders were involved in this bill and the Task Force was focused only on the suicide prevention aspects of the bill.]

Continued work to plan for a restructured and strengthened North Carolina Child Fatality Prevention System. In 2020, the Department of Health and Human Services continued its study and planning related to Task Force recommendations to strengthen the statewide Child Fatality Prevention System, collaborating with various subject matter experts including some members of the Task Force Executive Committee. This work included formation of a DHHS work group to discuss goals and structure of a new state office of child fatality prevention, interviews with other states related to their fatality review systems and Citizen Review Panels, and consultation with national and state experts. DHHS also partnered with the North Carolina Institute of Medicine to convene stakeholders from across the state whose local or state-level work overlaps with the Child Fatality Prevention System to get their input on various aspects of restructuring implementation.

Improved education and awareness surrounding child abuse and neglect reporting. The 2020 CFTF Action Agenda included administrative items focused on improving education and awareness surrounding child abuse and neglect reporting. The North Carolina Division of Social Services (DSS) and Prevent Child Abuse North Carolina (PCANC) have made progress related to these administrative items. For example, DSS greatly improved the quality and quantity of the content as well as the web navigation and searchability related to the topic of child abuse and neglect reporting on the NC DSS and DHHS website, NC Care 360 now includes information on CAN reporting, and NCDHHS has a webpage with various hotlines that now includes the county contact list to call to report CAN. PCANC is updating and strengthening its free online CAN reporting training now also available Spanish, and they are employing numerous online resources and social media tools to disseminate information about CAN reporting. PCANC also created flyers targeting educators and essential workers to help educate these individuals on how they play a role during pandemic-related shutdowns of recognizing and reporting suspicions of abuse and neglect.

2021

Partially Advanced: Legislation to strengthen infant safe surrender laws. Two bills, nearly identical, were introduced that addressed CFTF recommendations to strengthen infant safe surrenders laws, HB 473 and SB 535. HB 473 received a favorable report in the House Committee on Children, Families, and Aging, as well as the Health Committee and Rules Committee before going on to pass the House unanimously. It was then sent to the Senate Rules Committee where, like SB 535, it never received a hearing.

Partially Advanced: Legislation to launch and fund a firearm safe storage education and awareness initiative. HB 427 addressed CFTF recommendations to launch and fund a firearm safe storage initiative. This bill had broad bipartisan support; it received a favorable report from the House Judiciary 2 and Rules Committees before going on to pass the House on a vote of 116 to 1. It was then sent to the Senate Rules Committee and never received a hearing. The bill was then included in the House version of the 2021 Appropriations Act, however it was not included in the final version of that Act.

Partially Advanced: Legislation to strengthen the statewide Child Fatality Prevention System. SB 703 addressed a set of recommendations made by the Task Force to strengthen and restructure the statewide Child Fatality Prevention System and provided funding for that purpose. This bill was sent to the Senate Rules Committee and has not received a hearing.

Partially Advanced: Additional funding to expand prevention efforts for sleep-related infant deaths. SB 537 provided additional funding to DHHS to expand the infant safe sleep program, however this bill did not receive a hearing from the Senate Appropriations Committee and was not addressed in the 2021 Appropriations Act.

Partially Advanced: Funding for more school nurses, social workers, psychologists, and counselors. The Task Force recommendation for 2021 was for recurring funding to increase the numbers of these school professionals to move toward meeting nationally recommended ratios. The 2021 Appropriations Act included funds for an additional 115 school psychologists, but no additional recurring funding to increase the number of other types of school support professionals was included. The 2021 COVID-19 Response and Relief Act, which appropriated federal funds, included funding to be used for contracted services for school nurses, counselors, social workers, and psychologists to provide additional physical and mental health support services for students in response to COVID-19, however this funding was time-limited and not recurring. [Various organizations besides CFTF advocated for increased funding for these school professionals in 2021.]

[ENDORSEMENT] Funding for Tobacco and Nicotine Use Prevention: The 2021 Appropriations Act provided funds from the NC Attorney General's settlement with e-cigarette maker Juul Labs to go to DPH for tobacco and nicotine dependence prevention and cessation activities targeted at youth and young adults – $13 million nonrecurring year 1; $8 million nonrecurring year 2; $2 million of which was to go to reimburse litigations costs incurred by the AG in Juul litigation. The CFTF had endorsed the efforts of others in advancing this legislation.

Partially Advanced: Ignition Interlocks. The 2021 CFTF Action Agenda included a recommendation to require ignition interlocks for all DWI offenders instead of a subset of offenders as required in current law. In 2021, S.L. 2021-182 was enacted and while this bill does not expand the use of ignition interlocks to all DWI offenders as recommended by the CFTF, the law requires studying the issue of expanded use. [The law changes several aspects of NC laws addressing use of ignition interlocks related to alcohol impaired driving offenses; the CFTF was not involved in these changes.]

Progress to improve education and awareness surrounding child abuse and neglect reporting. The 2021 Action Agenda included continued administrative efforts to strengthen education and awareness surrounding child abuse and neglect (CAN) reporting, including strengthening ongoing training for law enforcement and training that is tailored for healthcare providers. In 2021, efforts by the Task Force through the NC Justice Academy's Joint In-Service Training Committee to strengthen CAN reporting training for law enforcement resulted in the Committee determining there would be a 4-hour juvenile block of training in 2023 with at least two hours devoted to this topic. The goal is to reach more patrol officers and deputies to give them the knowledge and tools they need to recognize and respond to suspected abuse or neglect, and the NC Division of Social Services has committed to using existing resources to collaborate with other relevant experts on the development of this training.

Report from North Carolina State Child Fatality Prevention Team

The North Carolina Child Fatality Prevention Team (known as the "State Team") is composed of nine ex officio and two appointed members, with the North Carolina Chief Medical Examiner serving as chair of the State Team and child fatality prevention staff from that office who support the work of the team. This is a multidisciplinary team with members representing agencies including legal, social services, law enforcement, medical and mental health, education, and EMS. The State Team reviews deaths of children under the age of 18 years that are investigated by the North Carolina Medical Examiner System with fatalities attributed to child abuse and neglect as well as other deaths when the decedent was previously reported as abused or neglected.

The Child Fatality Prevention staff reviews all child fatalities in North Carolina that are investigated by the statewide Medical Examiner system. This includes approximately 500 child deaths per year. Deaths investigated by medical examiners include apparent accidents, homicides, suicides, violent deaths, deaths occurring under suspicious circumstances, and sudden and unexpected deaths of children in apparent good health. Child fatality reviews provide a detailed analysis of factors that may have contributed to a child's death. The information gained from these reviews is used by the State Team for the purpose of making recommendations to the NC Child Fatality Task Force to support the creation of, or change in, laws, rules or policies in an effort to promote the safety and well-being of children in North Carolina.

Activities of the State Team with CFPT staff include the following:

- Monthly State Team meetings to review and discuss child fatality cases
- Review of local team recommendations
- Development of policy recommendations to submit to the NC Child Fatality Task Force
- Presentation of policy recommendations to the NC Child Fatality Task Force
- Refinement of process and timelines for recommendation development and submission
- Regular review and updating of the law enforcement investigation check list in an effort to collect the most detailed and pertinent information for each child death
- Maintaining a State Team Manual
- Maintaining a website to provide access and information to the community
- Providing specialized training in death scene reconstruction
- Providing data to prevention partners, the media, and researchers
- Providing state-wide child death investigation trainings
- Creating reports and presentations for a variety of relevant agencies and organizations focused on child well-being
- Creating new and strengthening existing relationships with child fatality prevention partners

State Team Recommendations submitted to the Child Fatality Task Force in 2021

1. Firearm Safety Education and Awareness in Prevention of Firearm Related Deaths

This recommendation for firearm safety and awareness had two components:

- Support for ongoing statewide prioritization of firearm safe storage education and awareness as well as statewide focus on gun safety issues with the goal of preventing firearm deaths and injuries while continuing to strive to have timely data to inform, improve, and provide an educational foundation.
- Continued statewide prioritized work on prevention of firearm related deaths due to gun violence through gun safety, education, and awareness as well as a focus on social drivers that relate to gun deaths.

2. **Full Toxicology for All Medical Examiner Jurisdiction Child Fatalities**

   Recommendation of funding for equipment, resources, and staff (estimated year one costs of $550,000 and recurring expenses at $110,000/year) to supplement the current resources at the State Lab of Public Health to complete full toxicology screenings for all child fatalities within the Medical Examiner System, with appropriate samples, in order to highlight supplemental issues and inform prevention initiatives.

3. **Community Based Programs Supporting Families' Health and Well-being**

   The State CFPT seeks to highlight the important work and acknowledge the ongoing need of programs and efforts within DHHS whose purpose is to provide health and well-being support to families through addressing the impacts of social determinants of health. Examples of programs with this identified purpose include but is not limited to NC Psychiatry Access Line (NC PAL), North Carolina Telehealth Partnership for Child and Adolescent Psychiatry Access (NCTP-CAPA), Making Access to Treatment, Evaluation, Resources and Screenings (NC MATTERS), and Healthy Opportunities.

4. **Abuse and Neglect Reporting Education and Awareness**

   - Recommend continued work within the NC Child Fatality Task Force Intentional Death Prevention Committee focused on education and awareness around child abuse and neglect reporting statewide emphasizing mandated reporting responsibilities and how to access resources about reporting.
   - The State CFPT supports the efforts occurring at DSS and recommends prioritizing recurring funding and resources towards strengthening NC Child Protective Services intake and initial assessment system to enhance reporting of child abuse and neglect.

5. **Education Around Suicide Awareness and Prevention**

   The State CFPT supports the efforts occurring at DSS and recommends prioritizing recurring funding and resources towards strengthening NC Child Protective Services intake and initial assessment system to enhance reporting of child abuse and neglect.

6. **State-wide School Support**

   - The State Child Fatality Prevention Team supports the efforts occurring at DPI to implement a cohesive statewide school data system to include medical history of students to best support student engagement and success.
   - The NC CFPT recommends recurring funding to increase specialized instructional support personnel (school nurses, school counselors, school social workers, school psychologists) to meet national recommended ratios.

7. **Safe Sleep Initiatives**

   - The State Child Fatality Prevention Team supports continued work within the NC Child Fatality Task Force Perinatal Death Prevention Committee focused around expanding outreach and funding for the UNC Center for Maternal and Infant Health Safe Sleep program in effort to promote evidence-based practices for infant safe sleep state-wide.
   - The State Child Fatality Prevention team recommends prioritized support and resources for a statewide campaign to promote and implement evidence-based strategies and consistent messaging prenatally and throughout the child's first year to reduce unsafe sleep environments at the time of death.

Data Availability

Reports and information of child fatality reviews are collected from public and confidential sources. The information collected by the CFPT can only be released in aggregate form. At the time of publication of this report, some 2020 cases remain in a pending status. Detailed reports of child fatality data can be found at www.ocme.dhhs.nc.gov. Additional reports and data may be available on request by calling (919) 743-9058.

Child Fatality Task Force Contact Information & Leadership Structure

Leadership

Executive Director

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Chair

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President/CEO, Benchmarks NC
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Committees

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

Co-Chairs

Jennifer Kristiansen, MSW – Director of Social Services, Chatham County

Whitney Belich, JD – Child Abuse Resource Prosecutor, NC Conference of District Attorneys

The **Perinatal Health Committee** focuses on the reduction of infant mortality with emphasis on perinatal conditions, birth defects, and SIDS.

Co-Chairs

Belinda Pettiford, MPH – Branch Head, Women's Health Branch, Women's and Children's Health Section, Division of Public Health, Department of Health and Human Services

Dr. 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

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

Co-Chairs

Alan Dellapenna, RS, MPH – Recently retired from role as Branch Head, Injury and Violence Prevention Branch, Chronic Disease and Injury Section, Division of Public Health, NC Department of Health and Human Services

Martha Sue Hall, MS – Mayor Pro Tempore, City of Albemarle

NC Child Fatality Task Force Members*

Dr. Michelle Aurelius
Chief Medical Examiner,
NC Division of Public Health

Representative Kristin Baker
NC House of Representatives

Senator Jim Burgin
NC Senate

Lisa Cauley
Senior Director of Child, Family, & Adult Services, Division of Social Services, NCDHHS

Danielle Carman
Executive Director, Council for Women & Youth Involvement

Jill Cox
President & CEO,
Communities in Schools NC

Brent Culbertson
Assistant Director,
State Bureau of Investigation

Senator Don Davis
NC Senate

Dr. Ellen Essick
Section Chief, NC Healthy Schools, NC Department of Public Instruction

Karen Fairley
Executive Director,
NC Center for Safer Schools

Martha Sue Hall
Mayor Pro Tempore,
Albemarle City Council

John P. Harris
Brevard Chief of Police

Michelle Hughes
Executive Director, NC Child

Representative Howard Hunter
NC House of Representatives

Trishana Jones
Programs Director, NC Coalition Against Domestic Violence

Senator Todd Johnson
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Arianna Lavallee
County Commissioner,
Lee County

Dr. Martin McCaffrey
Perinatal Quality Collaborative of NC

Karen McLeod
CEO, Benchmarks

Senator Jim Perry
NC Senate

Katherine Pope
Public Member

Renee Rader
Assistant Director for Policy & Programs, Division of Mental Health, Developmental Disabilities and Substance Abuse Services, NCDHHS

Bruce Robistow
Health Director, Halifax County

Senator Vickie Sawyer
NC Senate

Bradford Sneeden
Legislative Counsel,
NC Department of Justice

Dr. Betsey Tilson
State Health Director & Chief Medical Officer, NCDHHS

Representative Steve Tyson
NC House

Dr. Sarah Verbiest
Executive Director, UNC Center for Maternal and Infant Health
Director, Jordan Institute for Families

Representative Donna White
NC House of Representatives

* This list reflects membership as it was at the conclusion of the 2021-2022 study cycle. Members who departed prior to the end of the study cycle were ***Pamela Thompson*** and ***Kristin Jerger***.