

Annual Report of the **North Carolina
Child Fatality Task Force** to the
Governor and General Assembly

RALEIGH, NC // MAY 2018

Child Fatality Task Force



Our Children Our Future
Our RESPONSIBILITY

MAY, 2018

The Honorable Roy Cooper
Governor, State of North Carolina

Distinguished Members of the North Carolina General Assembly

Child Fatality Task Force



We are pleased to submit to you this annual report of the North Carolina Child Fatality Task Force. Since 1991, the Task Force has been part of a broader Child Fatality Prevention System that has contributed to a 45% decrease in child deaths in North Carolina. The recommendations included in this report are part of a long legacy of Task Force efforts to advance public policy to protect the safety and well-being of our youngest North Carolinians.

The Task Force provides a unique forum that brings together agency officials, lawmakers, experts in child health and safety, and community volunteers to perform the important work of understanding what causes child fatalities and determining what we can do to prevent them. The recommendations in this year's report are the product of twelve meetings where more than fifty presentations by experts took place, along with robust discussion and thoughtful analysis of issues from diverse perspectives.

This report includes recommendations addressing a wide range of issues including suicide prevention, firearm safety, infant mortality, motor vehicle safety, safe drug disposal, and more. Many of this year's recommendations, specifically those that fall in the category of suicide prevention and firearm safety, are relevant to discussions taking place in North Carolina and nationally regarding school safety and the need to better address the mental health needs of children and teens and ways we can prevent tragedy when students may be at risk of harming themselves or others.

This year the Task Force led a new initiative in planning a statewide Child Fatality Prevention System Summit. This Summit was a launching point for efforts to strengthen the entire statewide system that involves local and state child death reviews, the study of child death data, and resulting efforts to identify system problems and engage in actions to prevent future deaths and child maltreatment. The Summit was held in April of 2018, and this report explains what led to the Summit as well as efforts launched at the Summit to strengthen the statewide system.

The success of the Task Force in advancing public policy for over a quarter of a century is due in large part to the responsiveness of law makers and state leaders to Task Force recommendations. Thankfully, the bright futures of many children's lives have been saved because so many leaders do indeed agree on the importance of prioritizing child health and safety. We look forward to working with North Carolina leaders to put these 2018 recommendations into action for a better North Carolina future.

Kella Hatcher
EXECUTIVE DIRECTOR

Karen McLeod
CHAIR

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NC Child Fatality Task Force

Study Process

The Child Fatality Task Force (CFTF or “Task Force”) taps a broad range of expertise and resources to formulate its recommendations. Three committees meet to study data, hear from experts, and prepare recommendations for consideration by the full Task Force.

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 more than fifty presentations. Experts and leaders presenting to the Task Force and its committees represented state and local agencies, academic institutions, as well as state and community programs such as:

- Center for Maternal & Infant Health, UNC-Chapel Hill
- Child Welfare Services Section, NC Division of Social Services, NCDHHS
- Chronic Disease and Injury Section, NC Division of Public Health, NCDHHS
- Department of Obstetrics & Gynecology, UNC School of Medicine
- Duke University School of Medicine
- Governor’s Highway Safety Program, NC Department of Transportation
- Horizons Program, UNC-Chapel Hill
- Injury and Violence Prevention Branch, NC Division of Public Health, NCDHHS
- Institute for Transportation Research and Education, NC State University
- Jordan Institute for Families, UNC-Chapel Hill
- March of Dimes, NC Chapter
- Moms Rising
- National Center for Catastrophic Sport Injury Research
- National Fire Protection Association
- NC Breastfeeding Coalition
- NC Child
- NC FAST, NCDHHS
- New Hanover County Department of Social Services
- North Carolina Institute of Medicine
- Office of State Fire Marshall, NC Department of Insurance
- Office of the Chief Medical Examiner, NCDHHS
- Perinatal Quality Collaborative of NC
- SAS Institute
- State Bureau of Investigation
- State Center for Health Statistics, NCDHHS
- State Health Director, NCDHHS
- State Laboratory of Public Health, NCDHHS
- The State Child Fatality Prevention Team
- Tobacco Prevention and Control Branch, NC Division of Public Health, NCDHHS
- Women’s Health Branch, NC Division of Public Health, NCDHHS

The study process is also informed by state and local Child Fatality Prevention Teams, who, along with the Task Force, are part of North Carolina's Child Fatality Prevention System. Reports from state and local Child Fatality Prevention Teams are included here. The annual study cycle of the Task Force is fueled by more than 1000 hours of volunteer time, a testament to the dedication and expertise of professionals across the state who prioritize the health and well-being of North Carolina's children.

The **Intentional Death Prevention Committee** studies homicide, suicide, and child maltreatment. For the third year in a row this committee made the issue of youth suicide a priority, and four of its recommendations from the 2017 Action Agenda are being repeated. These recommendations stemmed from the work of a core group of agency representatives and suicide prevention experts who were convened by the Task Force in 2016 to determine youth suicide priorities from the statewide 2015 Suicide Prevention Plan. Recommendations include mandatory suicide prevention training and protocols in schools, increasing the number of school nurses in high need communities, creating and funding a state level coordinator position for school social workers, and having a three-year lead suicide prevention position to accelerate and coordinate implementation of the 2015 North Carolina Suicide Prevention Plan.

Another 2018 legislative recommendation from the Intentional Death Prevention Committee addresses strengthening North Carolina's Infant Safe Surrender law, which was originally advanced by the Task Force in 2001. This recommendation stemmed from a work group of child welfare attorneys who were convened by the CFTF and who studied safe surrender laws in other states to identify opportunities for strengthening North Carolina's safe surrender law. The Intentional Death Prevention Committee also recommended continued administrative support for an Infant Safe Surrender Education and Awareness work group which began its work in 2017.

Administrative efforts by this committee in 2017 also included working with NC Child to convene an advisory committee of diverse stakeholders who developed parameters and objectives for a qualified organization to conduct a study on paid family leave insurance programs. The need for such a study stemmed from a recommendation to the Task Force from the State Child Fatality Prevention Team who, along with other experts presenting to the Task Force, identified paid family leave as a strategy to decrease infant mortality rates and prevent child maltreatment. This study is now being managed by NC Child.

The **Perinatal Health Committee** studies infant mortality and women's health. Responding to federal recommendations, the committee repeated a 2017 recommendation to add (and fund) three conditions to the state's newborn screening panel. The committee also continued to support the need for a study to assess the timely and equitable access to high quality risk-appropriate maternal and neonatal care in North Carolina, repeating a 2017 recommendation for legislation requiring such a study by NCDHHS. Funding recommendations included endorsing additional funding for the "Quitline" with the goal of helping prevent perinatal tobacco use and supporting funding for the Perinatal Quality Collaborative of NC for continuation of a birth certificate project.

Recognizing the importance of breastfeeding to infant health, administrative efforts will be made to support continued work by others on insurance coverage for lactation services. Administrative support was also approved by this committee for the work of the North Carolina Breastfeeding Coalition, MomsRising, NC Child, and the Carolina Global Breastfeeding Institute in their efforts to examine ways in which pregnancy and lactation accommodations in the workplace can decrease infant mortality, increase child health and well-being, and address racial and socioeconomic health disparities; and also to research policies in place in other states that address these types of workplace accommodations.

The **Unintentional Death Prevention Committee** studies unintentional injury and death. The issue of firearm safety and access to lethal means was brought to the attention of the Task Force in 2016 by the State Child Fatality Prevention Team. Study of this issue resulted in the Task Force determining to partner with Safe Kids NC to convene a firearm safety stakeholder group, whose recommendation to support state funding for a new statewide firearm safety initiative was approved by the full Task Force. Also approved was a recommendation for state funding to support expansion of the program CALM, which stands for Counseling on Access to Lethal Means.

Motor vehicle safety was addressed by the committee through its repeat recommendation to make rear seat restraints a “primary” traffic offense for all in order to increase use of seat belts in the back seat and prevent deaths and injuries. The committee also recommends legislation that would strengthen impaired driving laws by requiring ignition interlocks for all DWI offenders, a strategy recommended by the CDC as being highly effective in preventing repeat DWI offenses.

The rate of child deaths in North Carolina has decreased by 45% since the 1991 creation of the Child Fatality Task Force & the broader Child Fatality Prevention System

Other recommendations from this committee include: legislation requiring county or municipal recreational sports programs to provide concussion awareness information and a concussion response protocol similar to schools; a recommendation to fund North Carolina's successful safe drug disposal program, Operation Medicine Drop; and to endorse \$7 million in state funding for youth tobacco prevention.

With respect to non-legislative items, the committee recommended administrative support for the work being done in North Carolina by the National Center for Sport Injury Research and the UNC Injury Prevention Research Center related to improving the reporting, prevention,

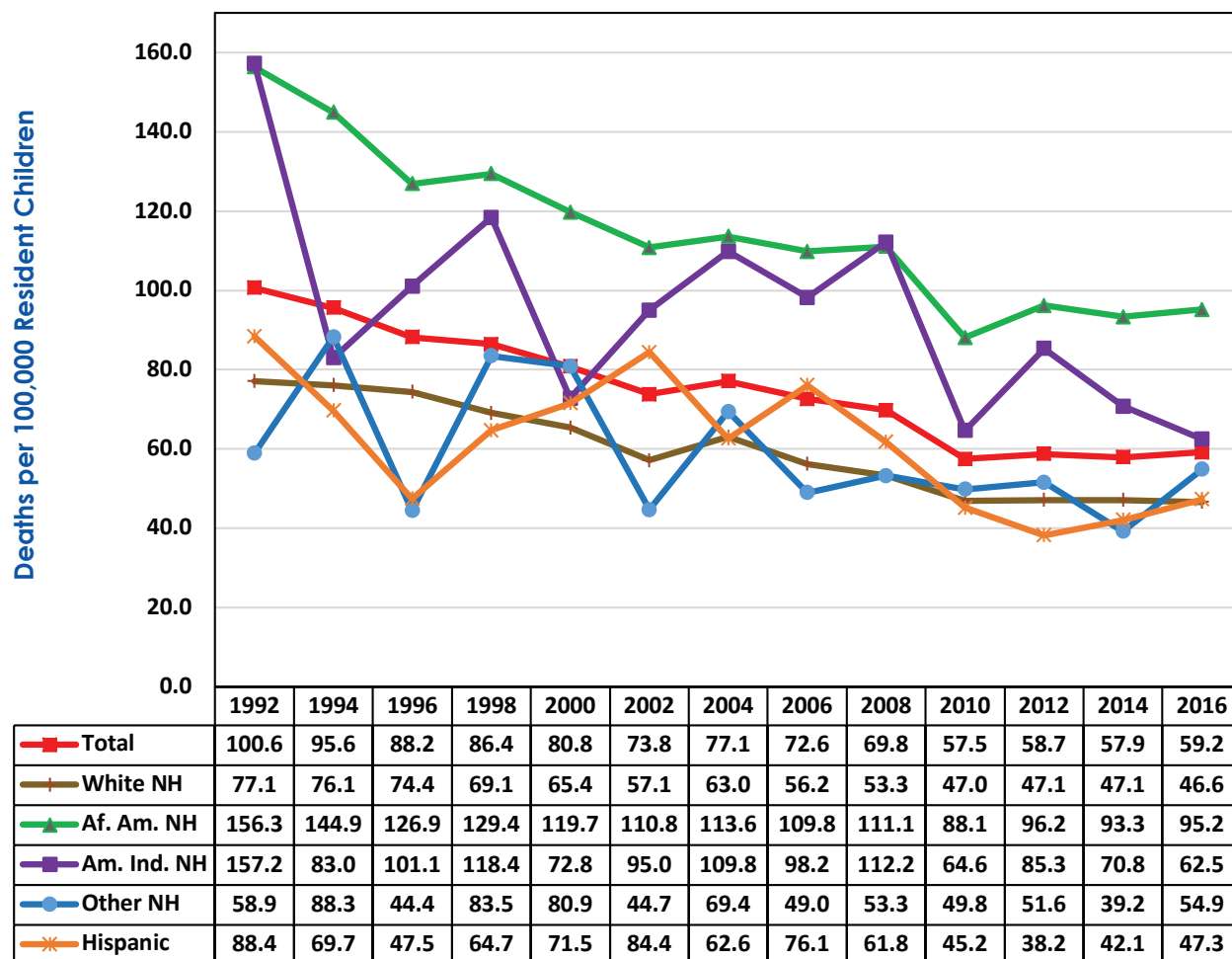
and mitigation of sport-related catastrophic injuries and illnesses to children and youth.

A **Child Fatality Prevention System Summit** was held on April 9th and 10th, 2018 in Raleigh. 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 Child Fatality Prevention 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, who received support from the full Task Force for advancing plans for the Summit. More information about the Summit is presented in this report.

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 2018 Action Agenda.

Child Deaths in North Carolina: Annual Report ¹

1992-2016 Trends in North Carolina Resident Child Death Rates*
by Race/Ethnicity, Ages Birth Through 17 Years



* Child death rates prior to 2016 have been recalculated using the latest available population data.

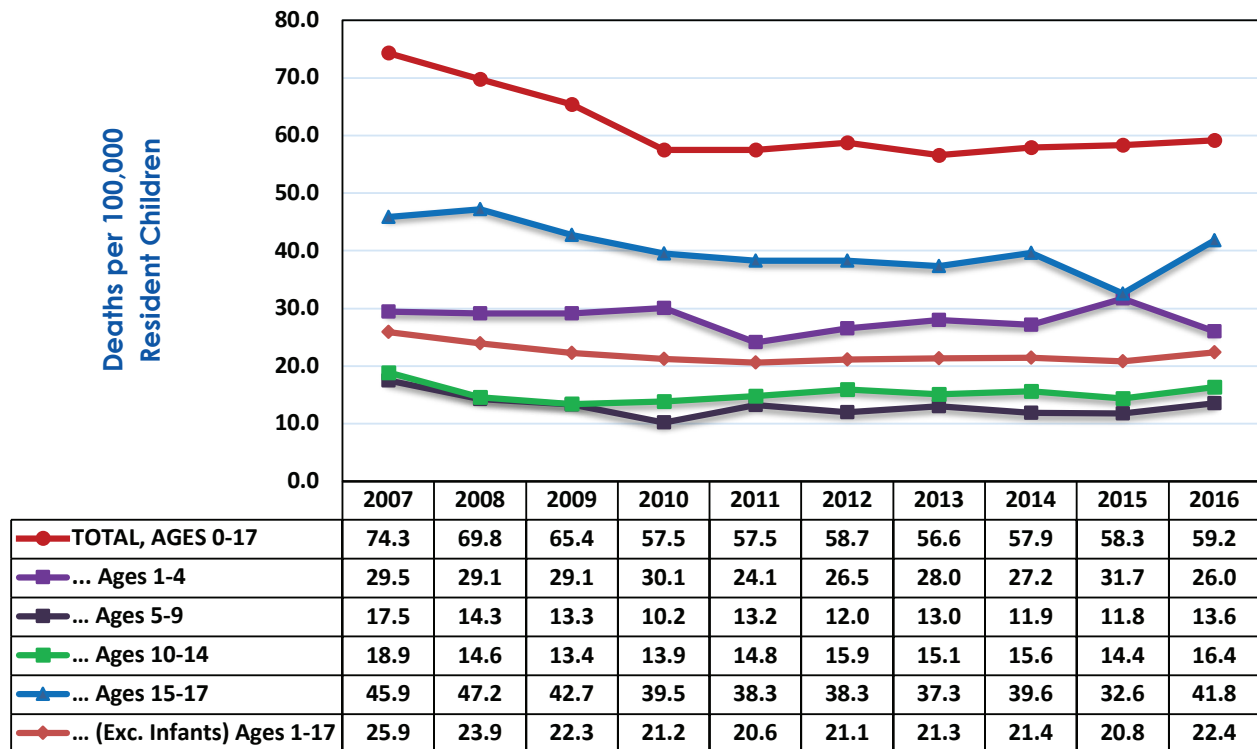
¹ This Annual Child Death Data Report is produced by the NC Division of Public Health – Women's and Children's Section in conjunction with the State Center for Health Statistics.

2016 NC Resident Child Deaths by Age Group & Cause of Death

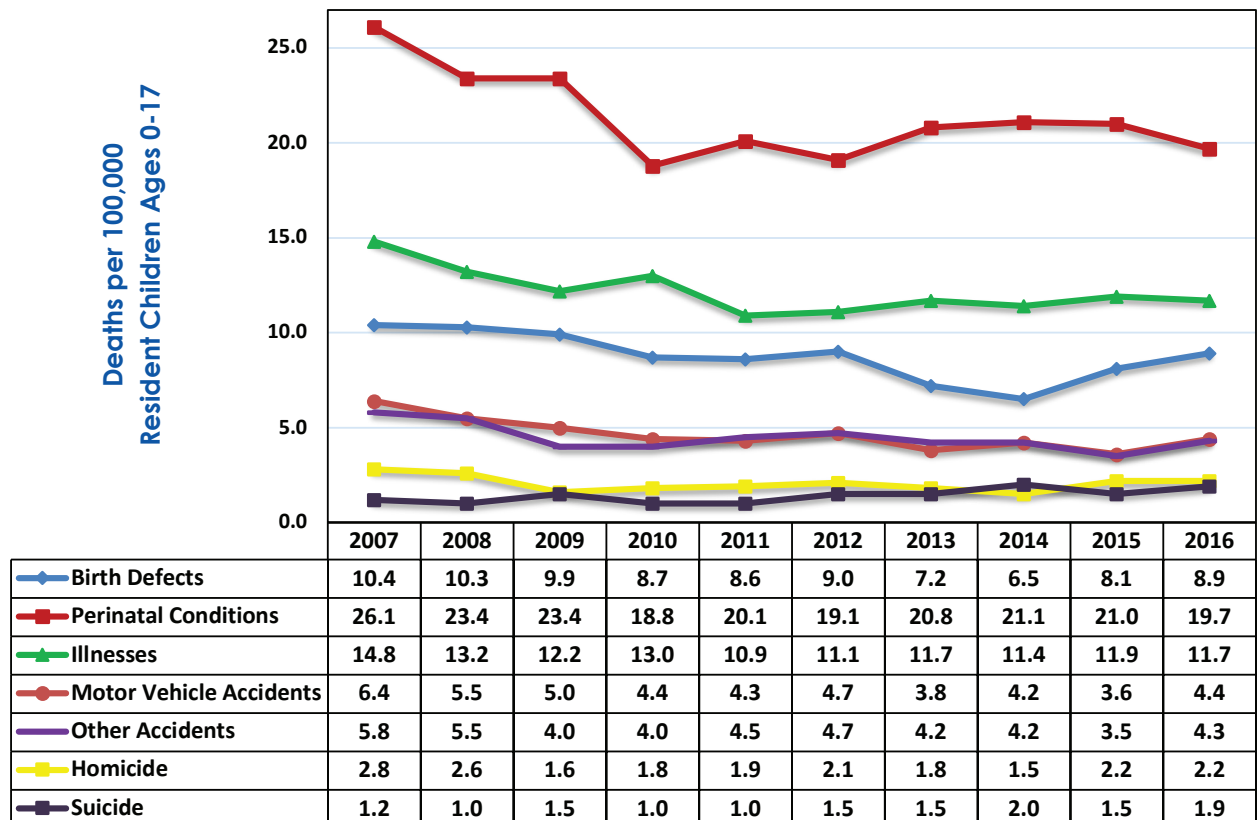
2016 NC Resident Child Deaths By Age Group & Cause of Death												
	TOTAL, AGES 0-17		AGE GROUP (years)									
			Infants		1-4		5-9		10-14		15-17	
	N	%	N	%	N	%	N	%	N	%	N	%
TOTAL DEATHS	1,360	100.0	873	64.2	126	9.3	87	6.4	107	7.9	167	12.3
CAUSE OF DEATH:	N	%	N	%	N	%	N	%	N	%	N	%
Perinatal Conditions	452	33.2	450	51.5	2	1.6	0	0.0	0	0.0	0	0.0
Illnesses	270	19.9	92	10.5	51	40.5	38	43.7	41	38.3	48	28.7
Birth Defects	204	15.0	166	19.0	17	13.5	10	11.5	9	8.4	2	1.2
Motor Vehicle Injuries	102	7.5	2	0.2	17	13.5	23	26.4	19	17.8	41	24.6
Other Unintentional Injuries	99	7.3	34	3.9	22	17.5	5	5.7	16	15.0	22	13.2
...Suffocation/Choking/Strangulati	33		28		1		1		1		2	
...Drowning	25		1		11		3		5		5	
...Poisoning	9		1		2		0		1		5	
...Bicycle	4		0		0		0		3		1	
...All Other Accidental Injuries	28		4		8		1		6		9	
Homicide	51	3.8	8	0.9	11	8.7	7	8.0	4	3.7	21	12.6
...Involving Firearm	29		0		3		4		2		20	
...All Other Homicides	22		8		8		3		2		1	
Suicide	44	3.2	0	0.0	0	0.0	0	0.0	15	14.0	29	17.4
...by Firearm	20		0		0		0		5		15	
...by Hanging	18		0		0		0		9		9	
...by Poisoning	1		0		0		0		0		1	
...All Other Suicides	5		0		0		0		1		4	
All Other Causes of Death	138	10.1	121	13.9	6	4.8	4	4.6	3	2.8	4	2.4

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.

**2007-2016 Trends in North Carolina Resident Child Death Rates
by Age Group, Ages Birth Through 17 Years**



**2007-2016 Trends in North Carolina Resident Child Death Rates
for Selected Cause of Death, Ages Birth Through 17 Years**



Leading Causes of Child Death by Age Group, NC Residents 2016

All Ages, 0-17			
Rank	Cause	Number	%
1	Conditions originating in the perinatal period	452	33.2%
2	Congenital anomalies (birth defects)	204	15.0%
3	Motor vehicle injuries	105	7.7%
4	Other Unintentional injuries	94	6.9%
5	Homicide	51	3.8%
6	Cancer	44	3.2%
	Suicide	44	3.2%
8	Diseases of the heart	28	2.1%
9	Septicemia	10	0.7%
10	Cerebrovascular disease	9	0.7%
	In-situ/benign neoplasms	9	0.7%
	Pneumonia & influenza	9	0.7%
All other causes (Residual)		301	22.1%
Total Deaths --- All Causes		1,360	100.0%

Ages 1 to 17			
Rank	Cause	Number	%
1	Motor vehicle injuries	103	21.1%
2	Other Unintentional injuries	61	12.5%
3	Suicide	44	9.0%
4	Cancer	43	8.8%
	Homicide	43	8.8%
6	Congenital anomalies (birth defects)	38	7.8%
7	Diseases of the heart	18	3.7%
8	Septicemia	9	1.8%
9	In-situ/benign neoplasms	7	1.4%
10	Pneumonia & influenza	6	1.2%
All other causes (Residual)		115	23.6%
Total Deaths --- All Causes		487	100.0%

Infants			
Rank	Cause	Number	%
1	Short gestation - low birthweight	176	20.2%
2	Congenital anomalies (birth defects)	166	19.0%
3	Maternal complications of pregnancy	47	5.4%
4	Other unintentional injuries	33	3.8%
5	Respiratory distress	29	3.3%
6	Bacterial sepsis	28	3.2%
7	Complications of placenta, cord, and membranes	21	2.4%
8	Atelectasis	19	2.2%
9	Diseases of the circulatory system	17	1.9%
10	SIDS	13	1.5%
All other causes (Residual)		324	37.1%
Total Deaths --- All Causes		873	100.0%

Ages 1 to 4			
Rank	Cause	Number	%
1	Other Unintentional injuries	21	16.7%
2	Congenital anomalies (birth defects)	17	13.5%
	Motor vehicle injuries	17	13.5%
4	Cancer	12	9.5%
5	Homicide	11	8.7%
6	Diseases of the heart	6	4.8%
7	Pneumonia & influenza	4	3.2%
	Septicemia	4	3.2%
9	Conditions originating in the perinatal period	2	1.6%
	In-situ/benign neoplasms	2	1.6%
	Meningitis	2	1.6%
	Nephritis, nephrotic syndrome, & nephrosis	2	1.6%
All other causes (Residual)		26	20.6%
Total Deaths --- All Causes		126	100.0%

Leading Causes of Child Death by Age Group, NC Residents 2016 (continued)

Ages 5 to 9			
Rank	Cause	Number	%
1	Motor vehicle injuries	23	26.4%
2	Cancer	10	11.5%
	Congenital anomalies (birth defects)	10	11.5%
4	Homicide	7	8.0%
5	Diseases of the heart	6	6.9%
6	Other Unintentional injuries	5	5.7%
7	Septicemia	2	2.3%
8	Anemias	1	1.1%
	Chronic lower respiratory diseases	1	1.1%
	Complications of medical and surgical care	1	1.1%
	In-situ/benign neoplasms	1	1.1%
	Nephritis, nephrotic syndrome, & nephrosis	1	1.1%
	All other causes (Residual)	19	21.8%
Total Deaths --- All Causes		87	100.0%

Ages 10 to 14			
Rank	Cause	Number	%
1	Motor vehicle injuries	21	19.6%
2	Suicide	15	14.0%
3	Other Unintentional injuries	14	13.1%
4	Cancer	9	8.4%
	Congenital anomalies (birth defects)	9	8.4%
6	Cerebrovascular disease	4	3.7%
	Homicide	4	3.7%
8	Chronic lower respiratory diseases	2	1.9%
	In-situ/benign neoplasms	2	1.9%
	Pneumonia & influenza	2	1.9%
	All other causes (Residual)	25	23.4%
Total Deaths --- All Causes		107	100.0%

Ages 15 to 17			
Rank	Cause	Number	%
1	Motor vehicle injuries	42	25.1%
2	Suicide	29	17.4%
3	Homicide	21	12.6%
	Other Unintentional injuries	21	12.6%
5	Cancer	12	7.2%
6	Diseases of the heart	6	3.6%
7	Anemias	2	1.2%
	Congenital anomalies (birth defects)	2	1.2%
	Diabetes mellitus	2	1.2%
	In-situ/benign neoplasms	2	1.2%
	Septicemia	2	1.2%
	All other causes (Residual)	26	15.6%
Total Deaths --- All Causes		167	100.0%

Trends in NC Child Death Rates* by Cause and Age

The chart below illustrates trends seen when comparing two five-year time periods, 2007 to 2011 and 2012 to 2016 as a means to identify certain trends for ages and causes.

- One type of illness death, septicemia, has seen a 39% decrease for all ages between those time periods.
- For motor vehicle injury deaths and other types of unintentional injury deaths for older teenagers, age 15 to 17, there has been a 32% decrease in the rate between those two five-year periods.
- Death rates due to unintentional poisoning for all ages decreased by 34% between those time periods.
- There was a 32% increase in the rate of homicides to infants between the two five-year time periods.
- There was a 48% increase in the rate of suicides for all ages between the two five-year time periods.

Cause of Death	Age Group	2007-2011 Rate*	2012-2016 Rate*	Percent Difference
Septicemia	All Ages	0.59	0.36	-39.52
Unintentional Motor Vehicle Injuries	Ages 15-17	15.56	10.57	-32.08
Other Unintentional Injuries	Ages 15-17	6.21	4.25	-31.63
Unintentional Poisoning	All Ages	0.64	0.42	-34.11
Other Unintentional Injuries	Ages 1-4	0.84	1.15	37.30
Homicide	Infants	5.43	7.17	32.09
Suicide	All Ages	1.14	1.70	48.64

*The rates are per 100,000 child residents

2018 CFTF Action Agenda

Explanations of each legislative “support” or “endorse” item below can be found on pages 14 through 29.

- **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 non-legislative items sought to be advanced or further examined by the CFTF.
- **“Track and Monitor”** items are those not currently ripe for policy intervention or CFTF involvement but which may require action at a later time.

Legislative Support & Endorse

Recommendations to support healthy birth outcomes, reduce infant mortality, and promote the well-being of infants

- **Newborn screening: Support** adding to the North Carolina newborn screening panel tests for detection of Pompe Disease, MPS1, and XALD, all of which are now on the federal Recommended Uniform Screening Panel, with accompanying state funds and increase of the state’s newborn screening fee to support start-up lab expenses and recurring costs of testing. [This recommendation was addressed in legislation introduced in 2017 (SB 190 = HB 270) that may be considered in 2018.]
- **Risk-appropriate maternal/neonatal care: Support** a study bill for NCDHHS to assess the timely and equitable access to high quality risk-appropriate maternal and neonatal care; study to result in actionable recommendations. [This recommendation was addressed in legislation introduced in 2017, which passed the House and is eligible for consideration in 2018 (HB 741 = SB 311).]
- **Infant Safe Surrender: Support** legislative changes to strengthen North Carolina’s 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.
- **Birth certificate project: Support** for funding of \$100,000 nonrecurring for Perinatal Quality Collaborative of NC’s birth certificate project.

Recommendation to address the opioid epidemic and drug misuse

- **Safe drug disposal: Support** safe drug disposal with a minimum of \$163,200 in funding to the State Bureau of Investigation for Operation Medicine Drop.*

Recommendations to prevent motor vehicle-related injuries and deaths to children

- **Rear seat restraints:** **Support** legislation allowing for primary enforcement of unrestrained back seat passengers, and increase fine for unrestrained back seat passengers from \$10 to \$25. [This recommendation was addressed in legislation introduced in 2017, HB 672 which may be considered in 2018.]
- **Ignition interlocks:** **Support** legislation that would require ignition interlocks for all DWI offenders.*

Recommendations to prevent youth suicide and/or firearm-related deaths and injuries to children

- **Required suicide prevention training and protocol in schools:** **Support** legislation to require that all personnel in NC schools, including public charter schools, who have direct interaction with students receive annual mandatory training related to identifying and referring students who may be at risk of suicide, and that schools have in place a process for implementation of training, a protocol for risk referrals, and that the protocol is proactively communicated to students and families. [Legislation introduced in 2017, HB 285 and HB 894, addressed this recommendation and both bills passed the House but not the Senate and are eligible for consideration in 2018.]
- **Increase number of school nurses:** **Support** an increase in funding to the School Nurse Funding Initiative by (at least) \$5 million recurring to add 100 school nurses in high-need communities to move toward meeting nationally recommended ratios.
- **School Social Worker Consultant:** **Endorse** an appropriation of \$100,000 in recurring funds for a full-time School Social Worker Consultant to be housed in the Department of Public Instruction Student Support Services in order to provide coordination, training, support, and data collection for school social workers in North Carolina.
- **Lead Suicide Prevention Coordinator:** **Support** designation and appropriation for a three-year lead suicide prevention 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. Funding to go to NCDHHS to contract with appropriate non-agency organization to serve as backbone organization for this role; appropriation needed would be \$125,000 per year for 3 years.
- **Firearm Safety Initiative:** **Support** state funding for 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; funding to go to NCDHHS to appropriately engage a third-party organization to implement the initiative. (Two-year funding estimate is for \$155,700: \$86,500 for year one; \$69,200 for year two.) The recommendations for components of this initiative include: state-level development of a firearm safety website; state-level development of a firearm safety toolkit; state-coordinated outreach for distribution of toolkits to local communities; and the formation of an ongoing Firearm Safety Stakeholder Group with diverse representation.
- **CALM expansion:** **Support** state funding to expand the CALM ("Counseling on Access to Lethal Means") Program in NC. Funding to go to NCDHHS to implement expansion through appropriate engagement with third parties. (Estimated funding for expansion is \$29,600.)

Recommendation to address sports injury prevention

Concussion awareness and protocol: **Support** legislation requiring county or municipal recreational sports programs to take precautions to ensure the safety and well-being of participants and to provide concussion awareness information and a concussion response protocol that is consistent with those required in schools.

Recommendations to prevent harm to children caused by tobacco use

- **Endorse** additional Quitline funding of \$3 million.*
- **Endorse** \$7 million in state funding for youth tobacco prevention.*

Administrative Issues

- **Administrative** support for the April 2018 Child Fatality Prevention System Summit, with Child Fatality Prevention System Work Groups formed at the Summit reporting back to the CTFP in the fall of 2018.
- Continued **administrative** support for Infant Safe Surrender Education and Awareness work group.
- **Administrative** support for the work being done in North Carolina by the National Center for Sport Injury Research and the UNC Injury Prevention Research Center related to improving the reporting, prevention, and mitigation of sport-related catastrophic injuries and illnesses to children and youth.
- **Administrative** support for continued work by others on insurance coverage for lactation services.
- **Administrative** support for the work of the North Carolina Breastfeeding Coalition, MomsRising, NC Child, and the Carolina Global Breastfeeding Institute in their efforts to: examine ways in which pregnancy and lactation accommodations in the workplace can decrease infant mortality, increase child health and well-being, and address racial and socioeconomic health disparities; and research policies in place in other states that address these types of workplace accommodations.

Track & Monitor

- **Monitor** legislation addressing fireworks.
- **Monitor** legislation addressing toxins.*

* Indicates item is part of the CTFP Harmful Substances Initiative

Explanation of CTF 2018 Legislative Action Agenda Items

The following explanations are intended to provide brief summaries of each legislative item. Additional information is available through the Task Force.

A. Recommendations to support healthy birth outcomes, reduce infant mortality, and promote the well-being of infants

Support adding to the North Carolina newborn screening panel tests for detection of Pompe Disease, MPS1, and XALD, all of which are now on the federal Recommended Uniform Screening Panel, with accompanying state funds and increase of the state's newborn screening fee to support start-up lab expenses and recurring costs of testing.

- The US Department of Health and Human Services has an Advisory Committee on Heritable Disorders in Newborns and Children who determines the Recommended Uniform Screening Panel (RUSP) for newborns. When considering adding a condition to the panel, the committee examines the degree of certainty that screening would lead to a significant benefit as well as the degree of feasibility for states to add the condition.
- Between March of 2015 and June of 2016, three additional conditions were added to the federal RUSP: 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.
- The federal RUSP is a recommendation to states and not a mandate. In North Carolina, legislation sets the fees for newborn screening; legislation would be required to add and fund new tests for the screening panel.
- Funding to enable the addition of these tests involves laboratory start-up costs that are nonrecurring, plus recurring costs for ongoing testing. In January of 2018, staff from the State Lab presented estimated costs for adding these conditions that included laboratory start-up costs of \$2.5 million, and recurring costs of \$2 million. Additional analysis is required in order to confirm or revise estimated costs, and to determine what portion of estimated costs can be covered by raising the state's newborn screening fee. North Carolina's current newborn screening fee of \$44.00 is a lower fee than many nearby states (fees in GA, VA, TN, SC, AL range from \$50 to \$150).
- This recommendation was addressed in legislation introduced in 2017 (SB 190 = HB 270), and may be considered in 2018.

Support a study bill to assess the timely and equitable access to high quality risk-appropriate maternal and neonatal care; study to result in actionable recommendations.

- Medically complex pregnant mothers and newborns should be cared for in a medical facility that can meet their medical needs. Studies have demonstrated that timely access to risk-appropriate neonatal and obstetric care can reduce perinatal mortality and maternal mortality.
- The "levels of care" approach offers uniform criteria designating the capability of healthcare facilities to provide four levels of complexity of care to pregnant women and newborns.

- Healthcare facilities across North Carolina have varied capabilities for meeting different levels of complexity. A study is needed to determine: which facilities in North Carolina are available and prepared to manage different complexity levels of care; how current systems of referral and/or transport to different facilities based on patient risk are being managed; disparities in access to care; identification of service gaps; and other issues that impact the ability to most appropriately match patient need with provider skill. This information should provide a foundation for actionable steps in North Carolina to best ensure that pregnant mothers and newborns are cared for in a facility that can meet their clinical needs.
- This study would address several goals identified in the [North Carolina Perinatal Health Strategic Plan](#).
- The designation of levels of care is endorsed by the American College of Obstetricians and Gynecologists, the Society for Maternal-Fetal Medicine, the American Academy of Pediatrics, and a number of other national medical organizations.
- This recommendation was addressed in legislation introduced in 2017, which passed the House and is eligible for consideration in 2018 (HB 741 = SB 311).

Support legislative changes to strengthen North Carolina's 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.

Background: 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 quite a bit 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 2015 and 2016, the CTF heard concerns about a lack of public awareness of the law in North Carolina, as well as potentially problematic aspects of law related to parental anonymity. The CTF collected some preliminary information on the issues and then approved administrative items for its 2017 Action Agenda to form two work groups to examine these issues further – one group to focus on education and awareness and one to focus on potentially problematic aspects of the law.

Both groups were convened in 2017, however the work of the education and awareness group was put on hold pending results of the group examining the law. The group examining the law, the "attorney group," was made up of attorneys who specialize in the Juvenile Code/child welfare law from various perspectives (GAL, parent, DSS) and a child advocate. The group examined other states' laws related to safe surrender, with a special focus on the issue of anonymity for a surrendering parent. Examination of the law and its application revealed potential opportunities for strengthening North Carolina's law in various areas, leading to the following recommendations now being made by the CTF:

1. 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.

2. Provide information to a surrendering parent

Currently, no information about safe surrender is required to be provided to a parent who surrenders an infant in NC. 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. Especially since many surrenders are occurring in hospitals after delivery, ensuring that a surrendering parent has good information and resources may yield a different choice by the parent that is ultimately better for both parent and child. This can be accomplished by adding a provision to the law that when possible, a surrendering parent be given information regarding safe surrender requirements, consequences, seeking reunification, voluntarily relinquishment of parental rights, a form to collect medical history information, and available services for help with relevant contact information. To ensure consistency and accuracy, the law can also require that NCDHHS develop written material that addresses the above information to be used across the state by those eligible to accept a surrendered infant (information can be easily downloaded from the web and local contact information can be filled in).

3. Strengthen protection of 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. Areas of the NC law where statutory changes could be considered to accomplish strengthening these protections (without changing a non-surrendering parent's rights) include: confidentiality provisions addressing information shared about identity; modification of the immediate response by DSS in safe surrender cases; modification of juvenile court process related to the surrendering parent.

4. Incorporate steps to help ensure 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. The types of statutory changes that could be considered to accomplish this include: adding a definition of “safely surrendered infant” and “surrendering parent” for

clarification; requiring that the infant be reasonably believed to be under seven days old and without signs of abuse or neglect at the time of surrender; requiring that DSS ascertain from a health care provider that the surrendered infant is, to a reasonable medical certainty, under seven days old and without signs of abuse or neglect; adding a provision that emphasizes that safe surrender law provisions are only applicable when criteria are met.

Support for funding of \$100,000 nonrecurring for Perinatal Quality Collaborative of NC's birth certificate project.

- Birth certificate data is used in multiple ways such as: evaluation of prenatal care; addressing congenital anomalies; monitoring risk factors causing poor pregnancy outcomes; health research and epidemiology; identification of important health issues and target problem areas; planning and evaluating new types of health services; making funding decisions and prioritizing the allocation of resources.
- Birth certificate data is recorded electronically, and there are 58 fields to populate with multiple sub-fields. Data is often collected by registrars with no clinical training. Accurate and thorough collection of data is challenging.
- The Perinatal Quality Collaborative of North Carolina has been working to improve the quality of birth certificate data and funding will enable continuation and expansion of their work in this area. This work will include multiple components, and those requiring funds include: development of data systems to support execution of the initiative and development of an electronic birth certificate dashboard for hospitals; a state meeting of key pilot stakeholders and registrars; regional training meetings; and PQCNC personnel to facilitate a pilot project.

B. Recommendations to prevent motor vehicle-related injuries and deaths to children

Background information: The leading cause of injury-related death among children in North Carolina is motor vehicle crashes. Among childhood injuries in NC, motor vehicle crashes are the fourth leading cause of hospitalizations and the sixth overall cause of emergency department visits.² North Carolina ranks among the highest for all 50 states in terms of medical and work loss costs associated with motor vehicle crash deaths.³ Recommendations below address two primary risk factors for crash deaths identified by the CDC: not using seat belts and drunk driving.⁴

Support legislation allowing for primary enforcement of unrestrained back seat passengers, and increase fine for unrestrained back seat passengers from \$10 to \$25.

- Currently, NC law 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 not a "primary enforcement" offense.⁵ The fine for adults being unrestrained in the back seat is currently \$10, while it is \$25.50 for the front seat.
- In NC, motor vehicle crashes are the leading cause of death for teens ages 15 to 17.⁶ Children ages 15 to 18 are significantly more affected by motor vehicle injuries in deaths, hospitalizations, and emergency department visits than other age groups 18 and under.⁷

²Based on data from 2011-2014 reported by the Injury and Violence Prevention Branch of the NC Division of Public Health in the *North Carolina Childhood Injury Report: 2011-2014*.

³Motor Vehicle Crash Deaths: Costly but Preventable: www.cdc.gov/motorvehiclesafety/statecosts/index.html.

⁴CDC Vital Signs, Motor Vehicle Crash Deaths, July 2016: <https://www.cdc.gov/vitalsigns/pdf/2016-07-vitalsigns.pdf>.

⁵See N.C.G.S. 20-135.2A(d1) & (e); restraint of children under age 16 is according to G.S. 20-137.1.

⁶Injury and Violence Prevention Branch, NC Division of Public Health.

⁷Based on data from 2011 – 2014 reported by the Injury and Violence Prevention Branch of the NC Division of Public Health in the *North Carolina Childhood Injury Report: 2011- 2014*.

From 2009 to 2013, an average of 52% of teen motor vehicle fatalities in the US were to kids not buckled up.⁸

- 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. In North Carolina, a greater percentage of fatal and serious injuries occur to unrestrained rear seat occupants than to unrestrained front seat occupants.⁹
- The odds of driver death in the presence of unrestrained rear seat occupants are much higher than when rear seat occupants are restrained;¹⁰ an unrestrained rear seat passenger can be a source of injury to a front seat passenger in the event of a crash.
- NC ranked 4th among all 50 states in terms of medical and work loss costs associated with motor vehicle crash deaths.¹¹ The 2012-2014 average annual comprehensive crash cost in NC was over 23 billion dollars.¹²
- Enacting primary enforcement of rear seat restraints is expected to result in reduced motor vehicle fatalities in North Carolina that could yield economic savings estimated at nearly \$100 million annually.¹³
- Having rear seat primary enforcement and a minimum of a \$25 fine for being unrestrained in the rear seat are two of the occupant protection criteria set by the National Highway Traffic Safety Administration (NHTSA), who requires North Carolina to meet 3 of 6 criteria for federal funding titled "Section 405b." Failure to meet these criteria makes it more difficult for NC to be eligible for \$1.5 million in federal Section 405b funding, a portion of which is used to purchase child safety seats for low income families.
- This recommendation was addressed in legislation introduced in 2017, HB 672, which did not progress in 2017 but may be considered in 2018.
- In 2018, the NC Executive Committee for Highway Safety, chaired by the NC Secretary of Transportation and comprised of leading highway safety experts and stakeholders, approved a resolution in support of this recommendation.

Support legislation that would require ignition interlocks for all DWI offenders.

- 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.
- About one-third of those arrested for impaired driving are repeat offenders.¹⁴ The CDC recommends ignition interlocks as a highly effective strategy to prevent repeat DWI offenses while installed and recommends that interlocks be mandated for all DWI offenders, including first-time offenders. Current North Carolina law makes ignition interlocks mandatory only if the person's blood alcohol level is greater than .15 or if the person is a second or subsequent offender.
- About half of all states now require ignition interlocks for all offenders, but North Carolina is not one of them.

⁸ NC Governor's Highway Safety Program.

⁹ NC Governor's Highway Safety Program, data source: North Carolina 2014 Traffic Crash Facts, NC Division of Motor Vehicles.

¹⁰ D. Bose, et al., *Accident Analysis & Prevention*, Vol. 53, April 2013.

¹¹ Motor Vehicle Crash Deaths: Costly But Preventable: www.cdc.gov/motorvehiclesafety/statecosts/index.html.

¹² NCDOT – North Carolina 2014 Traffic Crash Facts – Comprehensive Crash Cost is all crashes in North Carolina.

¹³ Findley, D., and Nye, T. "Estimating the Effect of Standard Enforcement of Rear Seat Belt Law for Rear Seat Fatality Prevention in North Carolina." Institute for Transportation Research and Education. North Carolina State University. February 1, 2017. Analysis based on NC Dept. of Transportation crash cost data.

¹⁴ *Repeat DWI Offenders in the United States*, National Highway Traffic Safety Administration, 1995.

- Each day, 29 people in the United States die in an alcohol-related vehicle crash. Of traffic deaths among children ages 0 to 14 in 2016, 17% involved an alcohol-impaired driver; of child passengers age 14 and younger who died in alcohol-impaired driving crashes in 2016, over half were riding in the vehicle with the alcohol-impaired driver.¹⁵
- Alcohol is involved in approximately one-third of all fatal crashes in North Carolina. In 2016 in NC, 392 people were killed in crashes involving a drunk driver.¹⁶
- The average alcohol-impaired driver has driven under the influence of alcohol over 80 times before their first arrest.¹⁷
- This item is part of the CFTF Harmful Substances Initiative.

C. Recommendations to prevent youth suicide and/or firearm-related deaths and injuries to children

Between 2016 and 2017, the CFTF convened three separate work groups with overlapping topics – one to address suicide prevention, one to address firearm safety, and one to address expansion of a specific program on access to lethal means. The overlap among these groups included data relevant to topics being addressed by all groups and the fact that all groups had a relationship to concerns and/or recommendations regarding access to lethal means and suicide raised by the State Child Fatality Prevention Team. Recommendations from these work groups were ultimately adopted by the full CFTF. All of these recommendations address strategies to prevent tragedy when kids may be at risk of harming themselves or others and are being presented collectively in this subsection.

Before explaining each work group and the resulting recommendations, it is important to understand the underlying relevant data, which played a significant role in driving these Task Force recommendations.

Suicide Data

- Nationally and in North Carolina, suicide is the second leading cause of death for youth between the ages of 10 and 17.¹⁸
- There were over 300 suicide deaths to North Carolina youth age 17 and younger during the ten-year time-period between 2006 and 2015.¹⁹
- For the 2015 NC Youth Risk Behavior survey, 9.3% of NC high school students surveyed reported attempting suicide, which is almost double the rates reported in 2011 and 2013.²⁰
- In 2016 (just one year), there were 2,135 emergency department visits and 772 hospitalizations for self-inflicted injuries among youth ages 10 to 17 in North Carolina (note that not all self-inflicted injuries are considered suicide attempts).²¹

¹⁵ National Highway Transportation Safety Administration.

¹⁶ Injury and Violence Prevention Branch, NC Division of Public Health, data source: NC Department of Transportation.

¹⁷ National Department of Transportation, Repeat DWI Offenders in the United States, Feb. 1995.

¹⁸ NC data - NCDHHS State Center for Health Statistics, based on 2015 NC Death Certificate data. US data - Centers for Disease Control and Prevention, National Center for Health Statistics, based on 2015 Underlying Cause of Death from CDC WONDER Online Database.

¹⁹ State Center for Health Statistics, NC Department of Health and Human Services.

²⁰ 2015 Youth Risk Behavior Survey, North Carolina High School Survey: <http://www.nchealthyschools.org/docs/data/yrbs/2015/statewide/highschool/trend.pdf>.

²¹ The percentage of these self-inflicted injuries where there was an intent to die cannot be determined from the hospital and emergency department data. Data source: NC State Center for Health Statistics, Vital Statistics-Hospitalizations; NC DETECT. Analysis by Injury Epidemiology and Surveillance Unit, NC Division of Public Health.

Firearm-Related Data

- In the seven-year period between 2010 and 2016, there were nearly 300 firearm-related deaths to North Carolina children and youth age 17 and under.²²
- In 2016 alone there were 35 firearm-related hospitalizations and 82 firearm-related ED visits among children ages 0 to 14, and 53 firearm-related hospitalizations and 175 firearm-related ED visits among youth ages 15 to 17 (totaling 88 hospitalizations and 257 ED visits).²³
- Approximately 40% of North Carolina residents own firearms, and approximately half of North Carolina residents with a firearm reported that the firearm is unsecured; 62.5% of residents who are parents left their firearms unsecured. (Secured = gun cabinet, trigger or cable lock.)²⁴
- During the five-year period between 2010 and 2014, firearms (of all types) were the lethal means used in almost 45% of suicides and over 50% of homicides to children and youth in NC ages 0 to 17.²⁵
- 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.²⁶

Suicide Prevention Core Group and resulting recommendations

In 2015, North Carolina produced the [NC Suicide Prevention Plan](#), the work product of a diverse group of more than 180 stakeholders. In 2016, the Child Fatality Task Force (CFTF) Intentional Death Prevention Committee (ID Committee) convened a core group of state agency representatives ("Core Group") to prioritize and initiate a plan for implementation of strategies from the 2015 NC Suicide Prevention Plan to address youth suicide. Several of the individuals in the Core Group had specific expertise in youth suicide prevention. This Core Group's work formed the basis of four primary suicide prevention recommendations approved by the full Child Fatality Task Force for inclusion on the 2017 CFTF Action Agenda. Three of these recommendations were funding recommendations which were not addressed in the 2017 legislative budget, and one was a policy recommendation which was addressed in legislation that passed the House in 2017 and is still eligible for consideration in the 2018 legislative session. In 2018, the Task Force approved these same four recommendations, with some adjustments, for the 2018 CFTF Action Agenda.

Support legislation to require that all personnel in NC schools, including public charter schools, who have direct interaction with students receive annual mandatory training related to identifying and referring students who may be at risk of suicide, and that schools have in place a process for implementation of training, a protocol for risk referrals, and that the protocol is proactively communicated to students and families.

- This recommendation reflects one of the most promising prevention strategies identified through the Substance Abuse and Mental Health Services Administration (SAMHSA) evaluation of the Garrett Lee Smith Youth Suicide Prevention Grants which was to increase awareness of risks and to seek help when identified.

²² Data from Office of the Chief Medical Examiner and NCDHHS State Center for Health Statistics.

²³ Data according to NC Violent Death Reporting System. Note that differences with these numbers compared to other publications could depend on the date of data collection (data files are always being updated and adjusted) and whether the data reflects NC residents or events occurring in NC; this statistic is for NC residents.

²⁴ 2011 North Carolina Behavioral Risk Factor Surveillance System (2011 was the last year this data was collected).

²⁵ Office of the Chief Medical Examiner, NC Department of Health and Human Services.

²⁶ Hobbs, Tawnell D. (April 5, 2018). "Most Guns Used in School Shootings Come From Home," *Wall Street Journal*.

*Suicide is the **2nd leading cause of death** for youth ages 10-17 nationally and in North Carolina. **

In North Carolina:

- over 340 suicide deaths among 17 and younger in 2006-2016 **
- 9.3% of high school students surveyed reported attempting suicide, which is almost double the rates reported in 2011 and 2013 ***

* NC State Center for Health Statistics (SCHS), Vital Statistics-Deaths, 2006-2016; CDC WISQARS, 2015. Analysis by Injury Epidemiology and Surveillance Unit ** 2015 NC Youth Risk Behavior Survey

- Besides family and friends, adults in the school setting may be in the best position to recognize kids at risk, but they need to be trained to recognize those risks and they need to know how and where to refer at-risk kids.
- Currently, the existence, attributes, and implementation of suicide prevention programs, efforts, and protocols in North Carolina schools varies widely, and is solely in the discretion of local districts and school administrators.
- Many states have already passed some type of legislation mandating suicide prevention training in schools, including neighboring states such as South Carolina, Georgia, and Tennessee.
- The 2017 Annual Report of the CTF set out the Core Group's specific recommendations for components of this required training, most of which were reflected in legislation proposed in 2017, HB 285 and HB 894. Both of these bills passed the House in 2017 but not the Senate, and are now eligible for consideration in 2018.

Support an increase in funding to the School Nurse Funding Initiative by \$5 million recurring to add 100 school nurses in high-need communities to move toward meeting nationally recommended ratios

- Currently, the nationally recommended ratio of school nurses per students is 1: 750. The North Carolina ratio (2016-17) is 1:1073. That ratio is approximately 573 nurses (FTEs) short of meeting the recommendation. A school nurse serves between 2 and 6 schools and may only be in a school for one-half day each week.²⁷
- School nurses fill an important role in suicide prevention efforts in schools, while simultaneously addressing overall health and wellness of students, and the complex needs of medically fragile students. School nurses are trained that suicide assessment is among their highest priority roles and responsibilities among many.
- A national study concluded that school nurses spend 32% of their time providing mental health services to students.²⁸ School nurses may also screen for abuse or neglect.

²⁷ Data source for these statistics: School Health Unit, NC Division of Public Health.

²⁸ Foster, S., Rollefson, M., Doksum, T., Noonan, D., Robinson, G., & Teich, J. (2005). *School Mental Health Services in the United States, 2002–2003*. NCDHHS Pub. No. (SMA) 05-4068. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health.

- Most school nurses may be seen without an appointment (unlike many other non-teacher staff in schools) and there is generally no stigma associated with visiting a school nurse.
- The 2016-17 NC School Health Services Survey revealed the following information regarding school nurse involvement with mental health and suicide counseling of students during that one-year period: ²⁹

	Elementary School	Middle School	High School
Known Suicide Attempts	76	235	545
Counseling sessions by SN Related to Depression	637	1,495	2,095
Counseling sessions by SN Related to Other Mental Health Issues	2,793	3,155	4,432
Counseling sessions by SN Related to Suicide Ideation	251	679	615

How expanding the School Nurse Funding Initiative adds nurses to high-need communities:

The School Nurse Funding Initiative (SNFI) requires that funds be spent only on school nurses and where SNFI nurses are assigned, local school districts are not permitted to eliminate other school nurse positions (no supplanting). SNFI position allotments are determined through an allocation formula consisting of the following criteria:

1) School nurse to student ratio

2) Economic status of community

- Percent of students eligible for free/reduced meals
- “Low wealth” counties eligible for education supplement

3) Health needs of children

- Infant mortality rate
- Substantiated child abuse and neglect rate
- Mortality rates ages 1-19
- Percent of students with chronic illness
- Percent of county population that is racial minority

4) Academic need

- Student drop-out rate
- Percent of schools meeting academic growth targets

This formula should achieve assignment of additional nurse positions to areas where there is the greatest need. Increasing the number of school nurses in communities with the greatest need is a strategy to positively impact overall health and wellness of North Carolina children and their families, and may be viewed as a strategy to help meet Healthy 2020 goals.

Endorse an appropriation of \$100,000 in recurring funds for a full-time School Social Worker Consultant to be housed in the Department of Public Instruction Student Support Services in order to provide coordination, training, support, and data collection for school social workers in North Carolina.

- Currently, there is no state-level position at the Department of Public Instruction (or elsewhere) devoted to school social workers in North Carolina. There is, however, a state level position for school nurses, psychologists, and counselors.
- Without a state-level position, the ability to coordinate training and resources, provide collaborative opportunities, technical support, or collect data related to efforts and outcomes of school social workers is limited or lacking.
- School social workers play a critical role in addressing many barriers children face in getting to school and achieving academic success, and they have an important role in suicide prevention and addressing mental health needs of students. A School Social Worker Consultant at DPI would have a central role in the coordination of a mandatory suicide prevention training and protocol requirement in schools if enacted by the legislature (see first suicide prevention recommendation above).

Support designation and appropriation for a three-year lead suicide prevention 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. Funding to go to NCDHHS to contract with appropriate non-agency organization to serve as backbone organization for this role; appropriation needed would be \$125,000 per year for 3 years.

Suicide prevention efforts in NC are facilitated and managed by government agencies, nonprofits, and academic institutions. Having one individual and/or organization serving in a lead role would:

- provide a single source of support and coordinate information sharing in order to guide efforts and ensure best practice;
- serve as a catalyst to turn ideas and plans into action;
- help ensure that various aspects of the plan are being carried out and reduce duplication;
- help ensure efficient use and sharing of limited resources.

The 2016 suicide prevention Core Group further defined the components of this recommendation as follows:

- Goals for this position include: 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.
- The lead individual/organization should be a non-agency designee.
- The position should be funded for three years with the expectation that work during those three years will include the determination of a sustainability plan for ongoing statewide coordination, including funding sources for ongoing statewide coordination.
- The lead individual should have specific expertise in suicide prevention.

- The lead individual should be affiliated with an organization able to provide project management and administrative support for carrying out the duties of the position.
- The lead individual should be an M.D. or PhD in order to have the scientific background to ensure that efforts in the state are driven by evidence-informed scientific research and who can translate research into effective practical application in North Carolina.

Firearm Safety Stakeholder Group and Resulting Recommendations

In 2017 at the recommendation of the State Child Fatality Prevention Team (chaired by the Chief Medical Examiner), who expressed concern about youth access to firearms and recommended the formation of a firearm safety group, the CFTF joined with Safe Kids NC to convene a “Firearm Safety Stakeholder Group” (FSSG) to examine development of a statewide approach to firearm safety education and awareness. The purpose of the FSSG set out by the CFTF was as follows:

- Examination of firearm safety messaging, materials, and training currently in use in NC and nationally
- Development of a statewide approach to firearm safety education and awareness
- Examination and potential implementation/expansion of programs to distribute gun locks or lock boxes
- Identification of effective local firearm safety groups or coalitions whose structure and efforts could serve as a model for duplication in other local communities
- Recommendations as to whether/how NC could have an ongoing stakeholder group charged with addressing firearm safety to reduce firearm-related child deaths in NC
- Recommendations as to associated funding that would be needed to sustain efforts

FSSG conveners and educators performed research and provided the structure, tools, and information needed to facilitate FSSG meetings. Firearm Safety Stakeholder Group members, educators, and conveners represented diverse organizations & areas of expertise including:

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

The FSSG reviewed firearm-related data, existing state and national firearm safety education/awareness campaigns and available evaluations of their effectiveness, and best practices for communications campaigns. Group members recognized early on the challenges of effectively reaching various audiences with limited resources. While many strategies could be employed, not all could be undertaken immediately or simultaneously. With that in mind, the FSSG developed priority strategies for initial statewide efforts, with the hope that ongoing efforts beyond an initial phase could include additional strategies.

It was determined that the initial priority focus for the audience should be on all gun owners, and the initial target behavior should be use of a gun lock. The primary target strategies should include: creating and distributing a community mobilization toolkit for local community groups that encompasses multiple prevention strategies; acquisition and distribution of free or discounted gun locks; and incorporation of information related to current NC laws on safe storage into prevention strategies.

As a result of this group's specific recommendations as well as an examination of firearm-related data (see page 20), the Task Force approved a recommendation for its 2018 Action Agenda addressing a new statewide firearm safety initiative, as explained below. A full report from the FSSG is available on the Child Fatality Task Force website: <https://www.ncleg.net/DocumentSites/Committees/NCCFTF/Presentations/2017-2018/Firearm%20Safety%20Stakeholder%20Group%20Report%2017-18.pdf>.

*Approximately 40% of NC residents own firearms; **about half of NC residents with a firearm reported that the firearm is unsecured**; 62.5% of residents who are parents left their firearms unsecured.*

(NOTE: secured = gun cabinet, trigger or cable lock)

2011 North Carolina Behavioral Risk Factor Surveillance System

Legislative support to 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; funding to go to NCDHHS to appropriately engage a third-party organization to implement the initiative. (Two-year funding estimate is for \$155,700: \$86,500 for year one; \$69,200 for year two.)

Reasons explaining the need for the initiative are explained above [on pages 20 (data) and 24-25]. The components of this initiative, set out by the FSSG, include the following:

a. State-level development of a website

A website should be developed (or likely dedicated pages on an existing agency or academic site) where NC citizens and communities can go for information about firearm safety and protecting children and youth from firearm-related deaths and injuries. This website should include, at a minimum:

- Messaging about the importance of safe storage
- Data on firearm-related deaths and injuries to children and youth
- Facts and data related to safe storage of firearms
- A toolkit (see below) for communities to use for firearm safety education and awareness at the local level
- Contact information for obtaining a free or discounted gun lock or lock box
- Information on NC's safe storage laws
- Links to various resources related to firearm safety such as those addressing domestic violence, hunter education, and suicide prevention

b. State-level development of a firearm safety toolkit that would include, at a minimum:

- Data related to firearm deaths and injuries to children as well as safe storage of firearms providing context as to WHY this toolkit should be used in communities
- Video PSA that can be distributed for use on social media and beyond
- A flyer and a poster that can be downloaded, printed, and posted with suggested venues for posting
- Contact information for obtaining free or discounted gun locks (if no existing local program for obtaining)
- Suggested structure, content, participants, and media outreach for holding a local gun safety education/awareness event
- List of the types of stakeholders for communities to involve in firearm safety initiatives
- Contact information to connect with experts who may be able to visit communities to make educational presentations
- Contact information to connect with experts who can offer advice on getting an ongoing firearm safety stakeholder group started in their community

c. State-coordinated outreach for distribution of toolkits to local communities

d. The formation of an ongoing Firearm Safety Stakeholder Group with diverse representation

e. State funding for the purchase and distribution of gun locks and to support implementation of the above recommendations

CALM Work Group and Resulting Recommendations

In 2017 at the recommendation of the State Child Fatality Prevention Team chaired by the Chief Medical Examiner, out of concern about youth access to firearms as well as other lethal means, the CFTF formed a work group to examine and make recommendations related to the expansion of the CALM Program in NC – CALM stands for “Counseling on Access to Lethal Means.” CALM work group members had suicide prevention expertise and knowledge of means reduction suicide prevention strategies and the CALM Program.

*Nationally, more than
**75% of guns used by youth
in suicide attempts** were
kept in the home of the
victim, a relative or a friend.*

As a result of this CALM work group's report, the CFTF approved including on its 2018 Action Agenda a recommendation for state funding to expand the CALM Program in NC. The CALM Work Group's report is available on the CFTF website: <https://www.ncleg.net/DocumentSites/Committees/NCCFTF/Presentations/2017-2018/CFTF%20CALM%20work%20group%20report%2011-7-17.pdf>.

Legislative support for funding to expand the CALM (“Counseling on Access to Lethal Means”) Program in NC. Funding to go to NCDHHS to implement expansion through appropriate engagement with third parties. (Estimated funding for expansion is \$29,600.)

- Counseling on Access to Lethal Means is a training designed to train practitioners (medical, mental health) and others to implement strategies to help those who are deemed to be 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 CALM Program and many of its components were developed by individuals from Dartmouth’s Injury Prevention Center and the Harvard School of Public Health.
- Evaluations of the CALM Program have demonstrated CALM to be effective.³⁰
- In-person CALM training in North Carolina has mostly taken place in the Western part of the state, as the only two known CALM trainers in NC are located in Boone; there is also a free online version of CALM that is available. Increasing the number of North Carolinians who access the online CALM Program is valuable; however the CALM work group believes in-person trainings are likely to be more effective – among other reasons, live trainings involve interactive work that includes role playing scenarios which strengthen the ability of trainees to apply their knowledge.³¹
- Having only two CALM trainers in the state dramatically limits the reach of this program, so expansion must include train the trainer events. The CALM group recommended expanding the reach of CALM by providing a training format that includes a two-day train the trainer workshop within which a CALM training is also offered to gatekeepers and clinicians.

D. Recommendation to address the opioid epidemic and prescription drug abuse

Background: An average of 5 people a day die from drug overdose in North Carolina. The number of medication and drug-related deaths has increased 440% from 363 deaths in 1999 to 1,965 deaths in 2016. These deaths are mostly driven by opiates and specifically prescription opioids.³² This epidemic is taking a tremendous toll on the health and safety of children who suffer the unintended consequences of drug impairment or overdose by adults in their lives, and on teens who abuse drugs themselves. Small children are at risk of poisoning when prescription drugs are accessible, and teens often obtain drugs from friends and family. In recent years, the North Carolina Child Fatality Task Force has successfully advanced various policy and funding initiatives aimed at addressing this epidemic, and this year the Task Force is focused on obtaining funding for safe drug disposal.

³⁰ Evaluations of the CALM Program have revealed post-training increases in the perception that lethal means restriction approaches are effective (Johnson, Frank, Ciocca, & Barber, 2011; Rosen, Michael, Jameson, in preparation) and a higher likelihood of implementing CALM principles after a 6-month post-training follow-up (Johnson, Frank, Ciocca, & Barber, 2011). A 2017 study concluded that in training mental health professionals, CALM increased knowledge, comfort, confidence and likelihood of discussions related to client access to lethal means, and also increased the number of clients with whom providers spoke to about access to lethal means. [Sale, E., Hendricks, V.W., Miller, C., Perkins, S., McCudden, S. (April 2018), *Community Mental Health Journal*, Volume 54, Issue 3.]

³¹ Past research indicates that interactive demonstrations and role plays are judged to be more effective in the acquisition of procedural skills necessary to deliver evidence-based psychosocial interventions. However, CALM group members are not aware of evaluations comparing the effectiveness of the online training to the in-person training for CALM specifically.

³² Data from NC State Center for Health Statistics, analysis by Injury and Violence Prevention Branch, NC Division of Public Health.

Support safe drug disposal with a minimum of \$163,200 in funding to the State Bureau of Investigation for Operation Medicine Drop.

- Operation Medicine Drop (OMD) is a nationally recognized NC program that uses drug take-back events and permanent medicine drop boxes to collect unused medications each year. In 2017, this program collected over 28 million doses of pills and the amount collected each year has been steadily increasing.
- Only law enforcement can legally receive a controlled substance from an individual. OMD works through the collaborative efforts of Safe Kids NC, local law enforcement agencies, and the State Bureau of Investigation.
- Medications collected fall into a waste classification that is considered hazardous if not properly destroyed, and drugs not properly disposed in a special EPA-approved incinerator may end up being misused or discarded in a manner that is not environmentally sound.
- Costs associated with safe disposal of medicine include the expense of EPA-approved incineration, secure transportation, law enforcement staffing, and permanent drop boxes.
- This item is part of the CTF Harmful Substances Initiative.

E. Recommendation to address sports injury prevention

Support legislation requiring county or municipal recreational sports programs to take precautions to ensure the safety and well-being of participants and to provide concussion awareness information and a concussion response protocol that is consistent with those required in schools.

- The number of sport-related concussions among youth 18 and under in the US is estimated to be between 1.1 million and 1.9 million.³³
- North Carolina has one of the most comprehensive laws in the US addressing sports safety in public high schools. Known as the Gfeller-Waller Law, it addresses concussion safety protocols to protect students in the event of a concussion.
- Many youth of all ages participate in county and municipal recreational sports programs, and there are no current laws addressing sports safety in these programs.
- If county and municipal recreational sports programs provided concussion awareness information and had a concussion response protocol that is consistent with those required in schools it would help protect many more children from getting a concussion or from worsening injury after a concussion.

F. Recommendations to prevent harm to children caused by tobacco use

Endorse additional QuitlineNC funding of \$3 million.

- Tobacco use during pregnancy is directly associated with the top four causes of infant mortality in North Carolina. About 10% of babies in North Carolina are born to women reporting tobacco use during pregnancy; in some counties over 30% of babies are born to women who smoked.
- QuitlineNC provides free assistance to help people quit tobacco through: an evidence-based telephone tobacco treatment program; an interactive web-based tobacco treatment program and texting (which can be combined with telephone coaching or stand-alone); coaching calls with highly trained and skilled multilingual coaches; and starter kits of nicotine patches for Medicaid and Medicare recipients and uninsured residents.

³³ See Kelley, M.E., Urban, J.E., Miller, L.E., Jones, D.A., Espeland, M.A., Davenport, E.M., Whitlow, C.T., Maldjian, J.A., Stitzel, J.D. (June 2017). Head Impact Exposure in Youth Football: Comparing Age- and Weight-based Levels of Play. *Journal of Neurotrauma*, Vol. 34, No. 11.

- Studies show that coaching, when combined with FDA-approved tobacco treatment medications, such as nicotine replacement therapy, triples a tobacco user's chances of quitting successfully over quitting without assistance.³⁴
- For every dollar spent in FY2011, QuitlineNC provided \$2.55 return on investment; however this was based on coaching services alone, without tobacco treatment medication.³⁵ This return on investment increases with adequate funds to treat all tobacco users with at least four coaching calls and 8-12 weeks of nicotine patches and gum.
- Providing NRT and QuitlineNC services increased the State Health Plan's (SHP) return on investment. For every dollar spent, SHP was provided \$3.95 return on investment.

Endorse \$7 million in state funding for youth tobacco prevention

- 90% of tobacco users start before the age of 18. Latest available data is that 3 in every ten high school students and one of every ten middle school students use some type of tobacco product.³⁶
- E-cigarettes contain liquids with nicotine that can be bought in thousands of flavors.
- Nicotine is highly addictive and can harm adolescent brain development; tobacco product use in any form, including e-cigarettes, is unsafe for youth.³⁷
- Between 2011 and 2015 current use of electronic cigarettes among NC high school students jumped by 888%, from 1.7% to 16.8%. During the same time period, electronic cigarette use among middle school students increased 599%, from 1% to 6.99%.³⁸
- Devices such as the very popular JUUL e-cigarette, that looks like a flash drive and delivers a high dose of nicotine, have a sleek design attractive to teens who use them for discreet vaping anywhere, including in school.
- This funding (directed to NCDHHS, DPH Tobacco Prevention and Control Branch) will support educational programs across NC to reach young people with effective tobacco use prevention messages and programs, leadership training for peer-led and adult-supported tobacco use prevention programs, as well as educational materials and evaluation of data.

³⁴ Zbikowski SM, et.al. "North Carolina Tobacco Use Quitline Final Comprehensive Evaluation Reports." Free & Clear, Inc. & Alere Wellbeing Inc. 2006-2016; Fiore MC, Bailey WC, Cohen SJ, et al. Treating Tobacco Use and Dependence: A Clinical Practice Guideline. US Department of Health and Human Services. Public Health Service, 2008.

³⁵ Tobacco Prevention and Control Branch and Health and Wellness Trust Fund QuitlineNC Financial Reports. FY11.

³⁶ NC Youth Tobacco Survey, 2015.

³⁷ US Centers for Disease Control and Prevention.

³⁸ NC Youth Tobacco Survey 2011-2015, NC Division of Public Health.

Child Fatality Prevention System Summit

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. Participants in the 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.

*In April of 2018, more than 200 professionals from across the state gathered in Raleigh with the **ultimate goal of strengthening the North Carolina Child Fatality Prevention System** to prevent child deaths and child 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. In addition, the CFP System is structured for certain information and recommendations to be passed among review teams and the Task Force. In 2016, the Executive Committee of the Child Fatality Task Force began discussing the role of the Task Force in helping to ensure that the CFP System as a whole was functioning as effectively as possible, 25 years after its inception. They determined that a first step toward addressing statewide system effectiveness was to bring together participants in the CFP System from across the state for an event focused on CFP System effectiveness and collaboration among CFP System professionals.

Without people or funding designated for the purpose of such an event, the Executive Committee nevertheless advanced planning for a statewide event through the convening of a planning team composed of CFP System leaders and other contributors, led by the Executive Director of the Task Force. The Child Fatality Task Force formalized its support and approval of the event by voting to support the April 2018 “Child Fatality Prevention System Summit,” with work groups formed at the Summit reporting back to the Task Force in the fall of 2018.

Through the collaborative efforts of several public and private organizations who provided funding, resources, and people power, the planning of this event took place over the course of 15 months. Planning included an electronic survey of all CFP System participants to determine the format for the event and topics to cover that would best address the needs and interests of those in the system along with the goals of strengthening system effectiveness. With funding to support registration for a limited number of participants, invited participants included: all chairs of Local Teams plus a designee from each team, all members of state-level groups affiliated with the CFP System including the Task Force, State Child Fatality Prevention Team, Community Child

Protection State Advisory Board, and State Child Fatality Review Team, plus all state-level staff and other various professionals associated with this work.

The North Carolina Child Fatality Prevention System Summit was held on April 9th and 10th, 2018 in Raleigh and drew over 200 professionals from across the state. Participants had the opportunity 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, with the ultimate goal of strengthening the CFP System to prevent child deaths and child maltreatment.

The Summit had plenary and breakout sessions with over 40 speakers and panelists featuring leaders such as the Secretary of the NC Department of Health and Human Services Dr. Mandy Cohen, Attorney General Josh Stein, NC House Representative Craig Horn, State Health Director Dr. Elizabeth Tilson, and Chief Medical Examiner Dr. Deborah Radisch. Numerous experts in child health and safety presented on topics ranging from suicide prevention, firearm safety, teen driving, and infant mortality to adverse childhood experiences, social determinants of health, the opioid epidemic, conducting effective fatality reviews, and much more.

Also speaking and participating in Summit sessions were national experts Abby Collier, Director of the National Center for Fatality Review and Prevention, Susanna Joy, also from the National Center, and Teri Covington, Director of Within Our Reach, the organization charged with implementing recommendations from the national Commission to Eliminate Child Abuse and Neglect Fatalities. Summit attendees participated in the launching of work groups focused on different aspects of the CFP System, and also had the opportunity to begin developing strategic action plans for strengthening their group's work within the CFP System.

Evaluations by participants after the Summit had an overwhelmingly positive response, with 97% of survey respondents rating their Summit experience as being positive (73% rated "excellent" and 24% rated "good"), and 96% of survey respondents saying it would be valuable to have a Summit like this in the future. When asked about whether the Summit was effective in achieving its goals, the responses were overwhelmingly positive that the Summit was successful at:

- Opening lines of communication and building connections
- Increasing understanding of individual and group roles within the system
- Increasing knowledge and providing tools and resources to help CFP professionals facilitate effective reviews and recommendations
- Identifying and sharing best practices, challenges, and needs among individuals and groups
- Increasing the effectiveness of local teams to implement prevention strategies and changes in their own communities to prevent future child deaths and maltreatment
- Increasing responsiveness from state and community leaders in utilizing what is learned from child death reviews to implement changes in systems, policies, and laws to prevent child deaths and maltreatment

The Summit was made possible through the collaborative contributions of many individuals and organizations offering their time, talent, and resources; the following organizations were represented in this effort:

- Child Welfare Services, NC Division of Social Services, NCDHHS
- Children & Youth Branch, NC Division of Public Health, NCDHHS
- Court Improvement Program, NC Judicial Branch
- Essentials for Childhood
- Guardian Ad Litem Program, NC Judicial Branch
- Local Teams via Team Coordinator, NC Division of Public Health, NCDHHS
- NC Child Fatality Task Force
- NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, NCDHHS
- NC League of Municipalities
- Office of the Chief Medical Examiner, NC Division of Public Health, NCDHHS
- Prevent Child Abuse NC
- State Child Fatality Prevention Team
- The Duke Endowment
- Winer Family Foundation
- Women's and Children's Health Section, NC Division of Public Health, NCDHHS

Child Fatality Task Force Harmful Substances Initiative

Harmful substances in the form of drugs, alcohol, tobacco, and other toxins have a **significant negative impact** on the health and well-being of North Carolina's children. In fact, numerous causes of death studied by the NC Child Fatality Task Force have a connection to harmful substances. Meanwhile, there are multiple physical, mental, and social problems that contribute to and/or result from substance use and misuse which are often **interconnected**. The CFTF Harmful Substances Initiative is meant to bring attention to this significant negative impact and to the interconnection of multiple problems to illustrate the need for **multiple policy solutions** to improve children's well-being and save lives.

This Harmful Substances Initiative was introduced in 2016, and the Child Fatality Task Force 2016 Annual Report further explains the negative impact and interconnected problems giving rise to this initiative.

Categories of negative impact include the following:

Child Welfare Factor in child maltreatment and removal from home	Poisonings Young children and teens accessing substances causing unintentional overdose or illness	Accidents Root or contributing cause of MV accidents and other unintentional injuries	Infant Health Factor in low birthweight, prematurity, stillbirth, miscarriage, illness, developmental problems, SIDS	Youth Substance Use Accidents, suicide, violent crime, multiple impacts on mental and physical health
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The need to approach issues surrounding substance misuse as a public health problem is critical. As experts and society have come to understand the disease of addiction and approach it as a public health issue requiring prevention and treatment similar to other diseases, effective solutions are within reach.

The Child Fatality Task Force has recommended in years past and will continue to recommend multiple types of policy solutions to address harmful substances such as:

- **Preventing access** (e.g., strengthening the Controlled Substances Reporting System, drug take-back and safe disposal, child-resistant packaging, etc.)
- **Prevention education** (e.g., support for programs and policies that educate individuals and professionals)
- **Intervention and treatment** (e.g., support for evidence-based interventions and treatment programs)
- **Poison First Aid** (e.g., overdose reversal drug naloxone; poison control centers)
- **Integrated systems** (collaboration and alignment among mental health, courts & law enforcement, public health, social services, community programs, academic institutions)

Legislative History and 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 of the Child Fatality Task Force. These sustained and strategic efforts have helped result in more than 15,000 child deaths being averted since creation of the CTF.

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 State 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 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 to 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 persons 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 Department 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 that have been 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 that 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 ten years of the Task Force's existence, the child death rate in North Carolina dropped approximately 20 percent. 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 '03-'04 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 eight 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 five years of age and less than 40 pounds in weight shall be properly secured in a rear seat, unless the child restraint system is designed for use with air bags. 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 eight years of age and between 40 and 80 pounds may be restrained by a properly fitted lap belt only.

Endorsed. 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 eight 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 eight 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 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 percent.

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.

Endorsed. 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 North Carolina Division of Public Health efforts to procure grant funds for youth suicide prevention; 2) form a CTFE 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.

Endorsed. 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 manufactures 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 twenty-one years of age from a horizontal format to a vertical format to make recognition of underage persons 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 (DSS) 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 (\$655) 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 CTF 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 (\$49). 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 9-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 (\$7). 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 CTF 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 (\$241). 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 (\$636) include requiring that 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.

Endorsed. 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 for 17-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 (\$77). Over the past five years, 75 children and hundreds of adults have died due to fire. Fire and flame is the fourth leading cause of death of North Carolina children ages five to nine. 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 ten 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.

Endorsed. 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 than 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 CTF 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 CTF 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.

Endorsed. 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 (\$20).

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 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.

Endorsed. Funding for Child Advocacy Centers and the Child Medical Evaluation Program; authorization of DENR 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 8 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 persons under age 18 to use their tanning equipment. With melanoma rates in North Carolina that are higher than the national average and studies showing that 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 1 in 5 high school seniors in NC 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.

Endorsed. 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 to 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.

Endorsed. 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 4 causes of infant mortality in NC. The goal of You Quit Two Quit Program, which received \$250,000 in nonrecurring funds, is to ensure that 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 NC 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 address 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 NC's battle to understand and react to the current opioid overdose epidemic. Prior to this technical change, the law required CSRS data purging at 6 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 6 years old, but instead of permanently discarding the data, it will now be maintained in a separate database so that it can be used for statistical, research, or educational purposes.

Endorsed. 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 4 causes of infant mortality in NC. 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 are also used by 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 NC to the regional average rate of \$575. Prior to this increase, CMEs in NC 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 profession); 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

their important work (the CFTF endorsed the efforts of the Harm Reduction Coalition to continue their work fighting the opioid epidemic).

Endorsed. 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; 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.

Child Fatality Prevention System Summit held on April 9th and 10th, 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 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, who received support from the full Task Force for advancing plans for the Summit.

Report from **North Carolina** **Child Fatality Prevention Team**

North Carolina Office of the Chief Medical Examiner

Deborah L. Radisch, MD, MPH

Chief Medical Examiner and Chair, NC CFPT

NC Child Fatality Prevention Team **Executive Summary of 2016 Child Deaths in NC**

A summary of child deaths investigated by
the NC Medical Examiner System and
reviewed by the NC Child Fatality Prevention Team

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North Carolina Child Fatality Prevention Team

The statutory function of the North Carolina Child Fatality Prevention Team (CFPT) is to “review current deaths of children when those deaths are attributed to child abuse or neglect or when the decedent was reported as an abused or neglected juvenile pursuant to G.S. 7B-301 at any time before death.” In practice, the CFPT reviews all deaths of children under the age of 18 years that are investigated by the North Carolina Medical Examiner System. Deaths investigated by medical examiners include apparent accidents, homicides, suicides, deaths occurring under suspicious circumstances, unattended deaths, and sudden and unexpected deaths of people in apparent good health. The CFPT reviews provide a detailed analysis of factors that may have contributed to a child's death. The information gained from these reviews is compiled and analyzed with 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 Child Fatality Prevention Team

The CFPT keeps the interest and safety of NC children in mind by:

- Regularly reviewing and updating the law enforcement investigation check list in an effort to collect the most detailed and pertinent information for each death
- Creating a form to mainstream the State Team's review process
- Updating the State Team Manual
- Developing a website to provide access and information to community members
- Providing specialized training in death scene reconstruction

The CFPT continues to:

- Provide data to prevention partners, the media, and researchers
- Provide state-wide child death investigation trainings
- Create reports and presentations for a variety of relevant agencies and organizations focused on child well-being
- Develop new and strengthen existing relationships with child fatality prevention partners

Data Availability

Reports and information are collected from public and confidential sources. The information collected by the CFPT can only be released in aggregate form. Detailed reports of child fatality data can be found at www.ocme.dhhs.nc.gov. Additional reports and data may be available by request. For further information, or to make a data request, please contact:

Kerry Robbins, MS

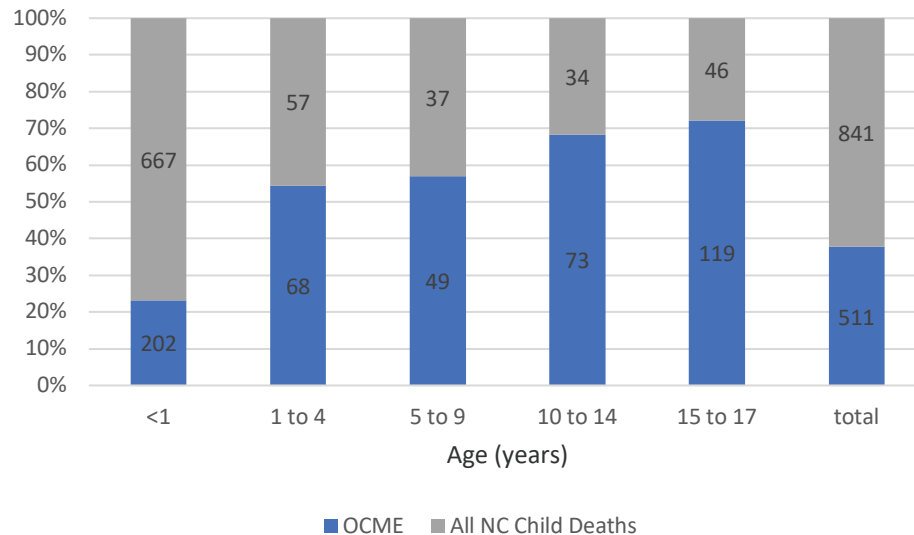
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Total Number of Deaths 2016

North Carolina Residents under the Age of 18 Years

The State Center for Health Statistics (SCHS) reported that in 2016, **1,360** children died in North Carolina. Many of these deaths were expected and included children who died from a known natural disease or illness. The Office of the Chief Medical Examiner investigated the cause and manner of death for **511** of the child fatalities. The cases investigated by the Medical Examiner System included a number of natural deaths, as well as accidental deaths, homicides, suicides, and deaths for which no cause and/or manner of death could be determined.



The CFPT reviews only child fatalities that are investigated by the OCME. With a total of 511 deaths investigated by the Medical Examiner System and 841 child deaths of all North Carolina child deaths, approximately 38% of all child deaths that occurred in North Carolina were reviewed by the CFPT. These deaths are categorized as follows:

Homicides

There were 52 children who died at the hands of another in 2016. The CFPT separates homicides into 2 categories; homicides that occur at the hands of a parent or caregiver and homicides that do not.

Homicide by Parent or Caregiver

Homicide by Parent or Caretaker deaths accounted for 27 of the 52 total child homicides in 2016. Infants accounted for 7 deaths, and toddlers, ages 1-4 years, accounted for 12 deaths. There were 8 deaths between the ages of 5-17 years: ages 5-9 accounted for 5 deaths, ages 10-14 for 2, and 15-17 for 1 deaths. Blunt force trauma caused 16 deaths, guns 4, asphyxia and sharp each 2 deaths, unknown 2, and other 1 (metabolic derangement).

Other Homicides

Other homicides, in which the parent or caregiver was not a suspect or perpetrator, comprised 25 of the 52 total 2016 child homicides. Teenagers between the ages of 15 and 17 years accounted for 19 of the homicides. This age group included 18 gun related deaths and 1 blunt trauma death. Among ages 0-14 years, 5 deaths were firearm-related, and 1 was caused by sharp trauma.

Of all the homicides, Black non-Hispanic children comprised the majority of homicides, 31 deaths; 18 deaths were White non-Hispanic children, 1 was White Hispanic, 1 was unspecified Hispanic, and 1 unspecified non-Hispanic race.

Suicides

Suicide was the manner of death of 47 children in 2016. Most children that committed suicide were between the ages of 15 and 17 years, accounting for 28 deaths (60%). There were 18 children between the ages of 10 and 14 years and 1 between the ages of 5 and 9 years. Males accounted for 32 deaths, females for 15 deaths. The means of death in suicides included asphyxia due to hanging in 22 of the deaths, use of a firearm in 20 of the deaths, 2 due to motor vehicle crashes, 2 due to fall/jump, and 1 from toxic substance.

Accidents

Each year, accidental deaths comprise the largest number of non-natural deaths of children in North Carolina. In 2016, there were 204 deaths investigated by the NC Medical Examiner System certified as manner "accident." The CFPT utilizes multiple categories to better analyze the circumstances of these deaths.

Vehicle-related

In 2016, there were 115 deaths involving vehicles. In a majority of these deaths, 59, were passengers, while 27 of these deaths were drivers, and 29 were outside of vehicles or in other-vehicle related crashes, or pedestrians.

In addition to motor vehicles, other vehicles involved in collisions included: 1 go-kart, 1 off-road motorcycle, 1 jet ski, 1 moped, 2 dirt bikes, 3 ATVs.

Nine of the 59 passenger deaths were being driven by drivers under the influence of drugs or alcohol.

Of the 27 drivers, 12 children were 17-years-old, 8 were 16-years-old, and 7 were 15 years or younger.

Of all the children involved in vehicle-related accidents, thirty-four children were either not wearing seat belts or were not properly restrained. For drivers specifically, 11 were wearing seat restraints.

Additional vehicle-related injuries included 1 train incident, 5 bicycles, 3 children who ran into the road, 2 who were in their yard or driveway at the time of collision, 2 unspecified, 1 in which no-one was operating the vehicle, 1 crushed while working on car maintenance, and 14 pedestrians on foot. Those involved in additional vehicle-related accidents included a total of 29 children: 2 children under 1 year of age, 5 children ages 1-4 years, 6 children ages 5-9 years, 7 children ages 10-14, and 9 children ages 15-17 years.

Asphyxia

Accidental asphyxiation caused the deaths of 33 children in 2016. Infants constituted the majority, 29, of deaths due to accidental asphyxiation in a sleep environment, either during co-sleeping or by being placed in an unsafe sleep environment (i.e., loose bedding, stuffed animals). Two other infant deaths, one due to being sat on by an older sibling and another for oxygen exclusion due to kerosene heating source. Two accidental asphyxia deaths of children between the ages of 1 year and 15 years included deaths from choking due to a food bolus and complications of an unsafe sleep environment.

Fire/Burns/Carbon Monoxide

Four fires resulted in 4 child fatalities from thermal burns and/or carbon monoxide inhalation toxicity. All fatal fires were residential.

Drowning

Drowning resulted in the deaths of 28 children in 2016. Four drowning deaths occurred in each a lake, pond, and tub (12); 2 occurred in an ocean, and 1 each in a creek, quarry, and river (3). Eleven deaths occurred in a pool location. Deaths were evenly split, 14 each, occurring while the child was alone or unsupervised; versus being engaged in a water activity with others.

Toxins

There were 7 deaths from toxic substances (i.e. poisoning). Five of these children were 15-17 years old, 1 13-year-old, and 1 4-year-old. Three overdosed on illicit drugs, 2 from prescription drugs not prescribed to them, and 1 from a prescription prescribed to the decedent. One other child died from carbon monoxide exposure on the back of a boat.

Firearms

There were 2 firearm injury deaths that were determined to be accidental in manner. In one, a 16-year-old was showing a gun to a friend when it discharged, killing that teenager, and in the other, the child found a parent's gun and it discharged, killing the 3-year-old child.

Other

Other deaths with an accidental manner, totaling 15 deaths, included 3 animal-related, 3 exposure, 4 fall/jump, 2 electrocution, and 1 each for falling object, medical treatment, and environmental.

Natural

Eighty-seven deaths were determined to be natural in manner. Of these, 11 were SIDS cases and 76 were other natural causes. The top 5 causes of death with a natural manner in 2016 were: SIDS, pneumonia, seizure, complications of a disease, and cardiac arrhythmia.

Sudden Infant Death Syndrome

There were 11 infants who died from Sudden Infant Death Syndrome (SIDS) in 2016. The majority of infants, 8, were white, 2 black, and 1 unknown. Four deaths occurred in cribs, followed by two alone in adult beds, and one infant in each of the following: Pack-N-Play, car seat, bassinet, infant swing, baby tent. Three infants were placed to sleep on their backs, four on their fronts, and 4 in unspecified positions.

Undetermined

There were 121 deaths that were certified as undetermined manner. Of those, 117 stated undetermined means, 2 were related to toxins, 1 to blunt trauma, and another to a firearm.

Of the undetermined means, 111 children, 95%, were under 1 year of age, 4 children were ages 1-4 years, 1 child age 10-14 years, and 1 child age 15-17 years.

As is the case for most of the 111 infants, children under one year of age, when a known risky or unsafe sleeping situation is noted, the possibility of asphyxiation as a result of suffocation cannot be entirely excluded which leads to the certification of an unknown means of death.

2017 State Team Recommendations

In the fall of 2017, the State Team submitted recommendations to the Child Fatality Task Force Executive Committee addressing the following policy matters:

1. **Increase in funding and expansion of state capacity to include a new Regional Autopsy Center.** This recommendation supports the recommended best practice in North Carolina that all medicolegal autopsies be performed by a board certified forensic pathologist, requiring at least one additional state-funded and state-supported autopsy facility and associated staff.
2. **Support and endorse efforts involving education surrounding infant safe sleep.**
3. **Endorse the CALM workgroup's recommendation in promoting safety planning and counseling on access to lethal means as well as other work taking place that is focused on firearm safety education and awareness.** These recommendations recognize the persistent trends overtime of firearms as the lethal means used in youth suicide deaths.

Report from Local Child Fatality Prevention Teams

Local Child Fatality Prevention Teams (CFPTs) are one of two types of Local Teams in North Carolina who review the deaths of children under age 18 who were born alive and were residents of North Carolina at the time death occurred. The purpose of the reviews is to identify system problems, make recommendations for prevention of future fatalities, act on those recommendations whenever possible. The majority of CFPT recommendations are focused on local issues. Recommendations and findings from local team reviews are shared with the CFPT Team Coordinator (housed in NC Division of Public Health) via quarterly reports. Recommendations are also reported to local county commissioners and boards of health as required by NC state statute and the CFPT Agreement Addenda with local health departments. Aggregate data is then provided to the State Child Fatality Prevention Team.

North Carolina's 100 counties have one or more Local Teams who review the county's child fatalities. According to Article 14 of the North Carolina Juvenile Code, Community Child Protection Teams (CCPTs) review all cases in which a child died because of suspected or confirmed abuse or neglect AND a report of abuse or neglect was made to DSS within the previous 12 months OR the child or child's family was a recipient of child protective services within the previous 12 months. All "additional" child fatality cases are reviewed either by the CCPT or, if the CCPT does not review "additional" child fatality cases, a CFPT reviews them. Most teams are blended CFPT and CCPT, collectively referred to as "Local Teams."

Local Teams are composed of appointed members representing agencies such as the health department, department of social services, police department, district attorney's office, guardian ad litem program, school system, medical examiner's office, fire department, and other child advocacy organizations as well as at-large members.

Each quarter, local CFPTs are provided data on the number of child deaths for each county which include the child's name, date of birth, date and cause of death, among other information. This data is provided through North Carolina's State Center for Health Statistics and the Office of the Chief Medical Examiner.

On-Going Initiatives and Programs

The Children and Youth Branch of the Division of Public Health has sponsored several webinars for CFPT members and updated report forms to provide the most up-to-date information and best practices to local teams on child safety and child fatality prevention:

1. The CFPT Confidential Report Form was revised for 2018. A live webinar was presented to local CFPT members as well as an archived training about the use and storage of the new refillable report form.
2. An online training needs assessment/survey was used to identify the top training needs for the local CFPTs.
3. Two webinars were presented to local team members on youth suicide prevention and the impact of prescription drugs on children.

Local CFPT Action

Many local CFPTs collaborate with other community groups to educate their communities on a variety of topics including overdose prevention, child safety and safe sleep. Below are highlights of team activities:

- Buncombe County CFPT: the team documented key demographics, cause of death, and risk factors for all reviewed 2016 child fatalities in their new internal (Buncombe County HHS) child fatality tracking system that enables them to run reports on aggregate child fatality data. The team plans to review the data annually to talk about trends to help inform their priorities, as well as to share with the community at large.
- Harnett County CFPT: The team worked to educate the community on various child health and safety issues. This past year they utilized print media through the local newspaper and they used social media as well. Several posts were featured each month on various child health/safety issues to increase awareness (e.g. poison prevention, school bus safety, National Teen Drive Safety Week, Child Passenger Safety Week, sleep related infant deaths). The team participated in promoting education on gun safety during National ASK Day. The team also provided free gunlocks for families in partnership with law enforcement and Partnership for Children.
- Martin County CFPT: The team partnered with the Safe Kids Riverbend Coalition to host a “hot car” display at a local community event. A portable thermometer was used to show the effects of increased heat even on an 89-degree overcast day. The inside temperature of the car reached 138 degrees. The team promoted Operation Medicine Drop events sponsored by the Martin County Sheriff's Office and bike safety activities coordinated by the Martin County Schools and the Williamston Fire/Rescue/EMS.
- New Hanover County CFPT: The team attended two webinars addressing – Successful Collaborative Research for Suicide Prevention and SIDS & Safe Sleep. The team purchased, distributed, and educated local families on the use of Pack N Plays.

Thank you to all the local child fatality prevention teams (CFPT) for your hard work, dedication and long-term commitment to North Carolina's children.

CHILD FATALITY TASK FORCE

Contact Information and Leadership Structure

LEADERSHIP

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Chair

Karen McLeod, 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

Michelle Hughes, Executive Director, NC Child

Jennifer Kristiansen, Director of Social Services, Chatham County

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

Co-Chairs

Belinda Pettiford, Branch Head, Women's Health Branch, NC Division of Public Health

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

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, Branch Head, Injury and Violence Prevention Branch, NC Division of Public Health

Martha Sue Hall, Mayor Pro Tempore, City of Albemarle

NC Child Fatality Task Force Members*

Senator Chad Barefoot

NC Senate

Stan Bingham

Public Member

Cindy Bizzell

Administrator, Guardian Ad Litem Program, Administrative Office of the Courts

Brent Culbertson

Assistant Director, State Bureau of Investigation

Senator Don Davis

NC Senate

Senator Cathy Dunn

NC Senate

Dr. Ellen Essick

NC Healthy Schools, NC Department of Public Instruction

Martha Sue Hall

Mayor Pro Tempore, Albemarle City Council

Senator Kathy Harrington

NC Senate

John P. Harris

Brevard Chief of Police

Representative Craig Horn

NC House of Representatives

Michelle Hughes

Executive Director, NC Child

Steve Jarvis

County Commissioner, Davidson County

Dr. Kelly Kimple

Section Chief, Women's & Children's Health, NC Division of Public Health

Sarah Kirkman

Conference of District Attorneys

Senator Joyce Krawiec

NC Senate

Jennifer Kristiansen

Director of Social Services, Chatham County

Representative Donny Lambeth

NC House of Representatives

Dana Mangum

Executive Director, NC Coalition Against Domestic Violence

Dr. Ben Matthews

Chief School Operations Officer, NC Department of Public Instruction

Dr. Martin McCaffrey

Perinatal Quality Collaborative of NC

Karen McLeod

CEO, Benchmarks

Representative Gregory Murphy

NC House of Representatives

Katherine Pope

Public Member

Dr. Deborah Radisch

NC Chief Medical Examiner

Representative Robert Reives, II

NC House of Representatives

Susan E. Robinson

Prevention and Early Intervention, NC DMH/DD/SAS

Stacie Saunders

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Legislative Counsel, NC Department of Justice

Pamela T. Thompson

Alamance-Burlington School Board, NC Domestic Violence Commission

Dr. Betsey Tilson

State Health Director & Chief Medical Officer, NCDHHS

Dr. Sarah Verbiest

Executive Director, UNC Center for Maternal and Infant Health; Director, Jordan Institute for Families

Representative Donna White

NC House of Representatives

Mary Williams-Stover

Director, Council for Women & Youth Involvement

*This list reflects membership as of March 2018

