Child Fatality Task Force Recommendations to Strengthen the Statewide Child Fatality Prevention System

Since 1991, the NC Child Fatality Prevention System has been advancing policy changes and implementing health and safety initiatives across the state to save countless children's lives and support their wellbeing. It's time to streamline, modernize, and restructure the system to make it more efficient and effective at doing the very difficult work of understanding child deaths and maltreatment to prevent future deaths and support child wellbeing.

Strengths of the current system

- Multidisciplinary local **review teams covering all 100 NC counties**
- Community leaders on local teams willing and able to **collaborate and implement prevention initiatives** in their county despite having extremely limited resources and support for their work
- Having a **state medical examiner system** with dedicated child fatality staff
- Having a **Child Fatality Task Force** composed of experts in child health and safety, state agency leaders, and 10 legislators with a history of success in advancing policy to save lives and prevent child maltreatment

Challenges of the current system (these are also areas where NC differs from many states)

- **Complexity:** NC may have the most complex system in the U.S. with over 200 review teams and several types of local and state-level groups
- **Duplication of efforts:** One case may be reviewed by 3 different teams.
- **No modern, coordinated data system for all reviews:** NC does not use the National Fatality Review Case Reporting System as 48 other states do to enable tracking, analyzing, and reporting of information learned from team reviews; NC does not track or report on most information learned in team reviews.
- **Weak connections between local teams and state:** information and recommendations from local reviews may not reach appropriate state-level organizations and leaders to inform policy or provide the stimulus for system change and prevention strategies.
- **Under-resourced and decentralized state-level support for local teams:** state-level support staff for the system work in different offices throughout DHHS and there is no lead office to coordinate the work of the whole system or ensure accountability; local teams need more state-level support to optimize reviews, develop and implement recommendations.
- **Volume can compromise quality:** Requiring a team review of all child deaths in the state (1200+ per year) without providing sufficient resources can dilute resources needed for quality reviews of cases most in need of review.
- **NC has designated 100 CCPTs to also serve as federally required Citizen Review Panels** (CRPs) required to evaluate state and local child protective services agencies. This is a highly unusual structure for CRPs, and CCPTs can't effectively meet both state CCPT laws and federal CRP requirements.

Main components of current Child Fatality Prevention (CFP) System

Two types of local child death review teams in all 100 counties: Community Child Protection Teams (CCPTs) and Child Fatality Prevention Teams (CFPTs)

Two types of state-level child death review teams: State Child Fatality Prevention Team (State CFPT) and State Child Fatality Review Team (CFRT)

Child Fatality Task Force: studies child death data and prevention strategies and makes policy recommendations to governor and General Assembly (does not review individual child deaths)

Child Fatality Task Force

Our Children, Our Future, Our RESPONSIBILITY

Over for recommendations

Child Fatality Task Force Recommendations

[The CFTF is considering these recommendations at their December 12th meeting for inclusion on the 2023 Action Agenda]

SUPPORT legislation, agency action, and policy change to strengthen the statewide Child Fatality Prevention System through these changes:

Implement centralized state-level staff with whole-system support in one location in DHHS (however OCME child fatality staff remains in OCME); form new Fatality Review and Data Group to be information liaison.

Instead of having limited state-level support roles located in various places in DHHS, there would be a state office with a team of individuals to provide more support for local teams and to coordinate the CFP system, including data collection & reporting.

Implement a centralized electronic data and information system that includes **North Carolina participating in the National Fatality Review Case Reporting System** used by 48 other states.

The new data system will easily allow for information learned from reviews to be collected, analyzed, and reported at the local and state level. A much greater depth of information based on national best practice for child death reviews will be collected to help identify trends and concerns in order to drive prevention actions and policy.

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

Fewer required reviews would allow for limited resources to be devoted to high quality reviews of cases most in need of team reviews; one of the goals is to strengthen reviews of infant deaths which make up 2/3 of all child deaths.

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

Eliminates duplication of reviews and recognizes the strength of local reviews. Different procedures and participants for different types of deaths reviewed can optimize effectiveness, and state-level CFP staff can provide technical assistance for certain types of reviews or in certain situations – e.g., can continue to assist with intensive-type reviews currently done by the Child Fatality Review Team.

Formalize (in statute) the 3 CFTF committees with certain required members and expand CFTF reports to address whole CFP System and to be distributed to additional state leaders.

Updated provisions addressing the Child Fatality Task Force would formalize the long-functioning and effective three-committee system of the Task Force. Reporting on the whole CFP system would be possible through system restructuring.

Funding: maintain current CFP funding and appropriate additional funds pursuant to DHHS determinations related to (the needs of) state office, local teams, and Fetal and Infant Mortality Review pilot.

Funding is needed to support the creation of a fully staffed state office of child fatality prevention, to better support local teams who currently receive little to no state funding, and to launch one or more Fetal and Infant Mortality Review Pilots (a specialized type of infant death review used in most other states but not in NC).

Support for and collaboration in developing these recommendations

These recommendations were developed through **engagement of stakeholders statewide and consultation with state and national experts**. The recommendations were adopted in the Child Welfare Reform Plan Final Report from the Center for the Support of Families which was submitted to the NC legislature. The recommendations were addressed in **HB 825 in 2019** which was then included in the 2019 Appropriations Act which was the year the Appropriations Act did not become law. The recommendations were addressed in **SB 703 in 2021** which did not receive a hearing (though CFTF leaders never heard of any opposition).

The **NC Department of Health and Human Services** undertook further study, planning, and stakeholder engagement related to advancing these recommendations, as the recommendations are aligned with DHHS priorities. However, recommendations cannot be implemented without legislation.