NORTH CAROLINA

Child Fatality Task Force

Annual Report to the Governor and General Assembly

FEBRUARY 2023
RALEIGH, NC

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

FEBRUARY 2023
The Honorable Roy Cooper, Governor, State of North Carolina
Distinguished Members of the North Carolina General Assembly

We are pleased to submit this year's annual report of the Child Fatality Task Force containing recommendations for laws and state funding for prevention strategies that will save children's lives.

This year's report shares disturbing data about a significant increase in firearm deaths and injuries to children and a crisis in youth mental health with increased rates of suicide and self-harm. Other troubling data shows an infant mortality rate that is not decreasing, and has kept North Carolina among the highest 15% of infant mortality rates in the nation.

The good news is that there are evidence-driven strategies to prevent so many child and infant deaths, and if the strategies recommended by the Task Force are prioritized in state policy, we can and will see many families and communities spared the unbearable heartbreak of losing a child.

Recommendations for changes in law and for state funding that are being made by the Task Force for 2023 address a range of issues, among them: gun deaths, youth suicide, the youth mental health crisis, infant deaths in unsafe sleep environments, preterm birth, strengthening the statewide child fatality prevention system, child abuse and neglect, motor vehicle deaths, harm caused by tobacco and nicotine use, and more. Sadly, many of the 2023 recommendations are being repeated from prior years because they have not yet fully advanced but have continued to be identified by the Task Force as being important policy strategies to prevent child deaths and promote child well-being.

Problems that threaten child health and safety can only be addressed once the problem is identified and efforts are undertaken to understand solutions that are likely to work. This is the work of the Task Force: to study and report on data surrounding child deaths to identify the problem, and to study the evidence surrounding potential prevention strategies to determine what solutions will work. A primary strength and value of Task Force work lies in its ability to study and widely educate about the data surrounding child deaths and about evidence-driven strategies to prevent them, which is explained more in this year's report.

Another strength of the Task Force is its unique composition of members and volunteers that include experts in child health and safety, state agency leaders, community leaders, and ten state legislators. When these individuals come together, they are not only able to develop well-informed policy recommendations to save children's lives, but they also encourage collaboration to help move prevention work forward that does not require new laws or state funding. This report provides a glimpse of such collaborative work.

Fortunately for North Carolina's children and their families, since the creation of the Task Force in 1991 North Carolina leaders have been responsive to so many Task Force recommendations, saving countless lives through enacting thoughtful policy. Our hope is that we will look back on 2023 as a banner year of progress in seeing North Carolina leaders prioritize children by enacting new laws and state funding that will save children's lives and promote child wellbeing.

Sincerely,

Karen McLeod
CO-CHAIR

Jill Cox
CO-CHAIR

Kella Hatcher
EXECUTIVE DIRECTOR

Table of Contents

Executive Summary

Task Force Meetings that Led to the 2023 Action Agenda

- Meetings took place **between 8/29/22 to 12/12/22**
- **8 committee meetings:** two committees had 3 meetings each; one committee had 2 meetings
- **3 meetings** of the full Task Force
- Presentations by experts and leaders from **25+ organizations**
- **30+ topics** addressed

The Task Force **approved 11 legislative recommendations** for inclusion on its 2023 Action Agenda aimed at changing laws and policies to prevent child deaths, prevent child abuse and neglect, and promote child well-being.

The Task Force **completed its work on 10 administrative efforts** from the 2022 Action Agenda involving further study of topics or advancement of prevention strategies through non-legislative efforts.

Highlights of 2021 Child Death Data Facts & Trends

- **The overall child death rate in NC for ages 0 – 17 of 59.1 per 100,000 resident children in 2021 was the highest rate seen since 2016.** Since 1991, there was a steady decline in the death rate until 2010, when rates began to level off and since then there have been only small fluctuations.
- **The infant mortality rate for 2021 remains virtually unchanged** with a rate of 6.8 per 1,000 live births in 2021 compared to 6.9 in 2020, and 6.8 in both 2018 and 2019. While the rate of 6.8 remains the lowest rate NC has recorded, this rate puts North Carolina among 15% of states with the highest infant mortality rates in the country.
- **The disparity ratio of deaths among non-Hispanic black infants compared to white infants decreased somewhat in 2021, however disparities persist** and black infants are still more than twice as likely to die than white infants.
- **Notable categories of death that showed increased rates include homicide, suicide, motor vehicle injuries, and other unintentional injuries unrelated to motor vehicles.**
- **The firearm death rates for children ages 0 - 17 increased dramatically in 2020 and in 2021.** North Carolina saw an increase of 120.8% in rates from 2019 through 2021, and an increase of 231.3% from 2012 through 2021. Firearms were the lethal means used in more than 70% of the 2021 suicides and homicides; especially among ages 15 – 17 (83%).
- **Homicide rates for the last 2 years have increased dramatically** compared to prior years. Nearly all homicides of children over the age of 4 have involved firearms (93%). Homicide rates are particularly high in the 15 – 17 year-old age group.
- **The 2021 suicide rate (among ages 10 to 17) represents the highest rate in two decades.** Youth suicide rates have been increasing over the past decade, and firearm-related suicides in particular have increased.
- **In 2021, 14 North Carolina children died of COVID-19.** Ten of these deaths were of teens ages 15 to 17.
- **There has been a significant increase in deaths for ages 15 - 17.** From 2020 to 2021, there was a 26% increase and from 2012 to 2021, there was a 47% increase. Much of this increase can be attributed to a significant increase in homicides for this age group, as well as an increase in suicides. In particular, firearm-related homicides and suicides have risen dramatically.

2023 Legislative Recommendations	Highlighted Data and Information Supporting Recommendations
Launch a statewide firearm safe storage education and awareness initiative	• Child deaths in NC due to firearm injury skyrocketed in 2020 and 2021; firearm injuries to children and youth offenses involving firearms also rose sharply. • From 2012 through 2021: over 600 North Carolina child firearm deaths. • Firearms are the lethal means used in the majority of youth suicides and homicides in North Carolina. • More than half of all gun owners store at least one gun unsafely and most guns used in youth suicide and school shootings come from home.
Recurring funds to increase numbers of school nurses, social workers, counselors and psychologists	• A 2021 student survey showed more than one in five (22%) of NC high school students had seriously considered attempting suicide and 43% of high school students said they felt sad or hopeless. • From 2020-2021, there was a 46% increase in self-inflicted injury emergency department visits among females ages 10 – 14. • Numbers of health support professionals are far below national recommendations, e.g., national recommendations are for one school social worker for every 250 students but in NC the ratio is 1: 1,025
Implement a statewide electronic school health data system	• Schools are required to provide certain health-related services and to keep records about those services. • There is no universal system of recordkeeping of health data for NC Schools; some schools still use hard copy records. • A statewide electronic system is needed to keep up with student needs and services as they move from school to school or district to district, facilitate recordkeeping needed for Medicaid billing, and protect confidentiality.
Strengthen and restructure the statewide Child Fatality Prevention System	• Restructuring the system is critical to optimize its strengths and address multiple system challenges to effectively prevent deaths and maltreatment. • NC needs to join 48 other states in using a national data system that will dramatically improve data collection, analysis, and reporting of information learned in child death reviews. • These recommendations are supported by NCDHHS and were adopted in a 2019 state child welfare reform plan submitted to the legislature.
Funding to expand efforts to prevent infant deaths related to unsafe sleep environments	• From 2016 – 2020, there were approximately 650 infant deaths in NC that were associated with unsafe sleep environments (621 deaths) or Sudden Infant Death Syndrome (28 deaths). • Unsafe sleep practices, such as co-sleeping, are common, and studies show that parents and caregivers frequently do not get correct advice from their families, peers, and health and childcare providers. • NC's current funding of $97K per year is insufficient to provide the level of education and outreach needed to educate parents and caregivers of over 120,000 newborns each year.
Medicaid funding to support maternal healthcare strategies known to produce better birth outcomes	• North Carolina's infant mortality rate is among the highest 15% in the nation. • The mortality rate of black infants is more than 2.5 times higher than that of white infants. • Group prenatal care and doula services are known to produce better birth outcomes and reduce disparities; funding is needed to expand use of these healthcare strategies. • For obstetrical care providers treating Medicaid patients, the reimbursement rate in NC pays only 59.4% of the Medicare rate; increasing this rate would attract more maternal care providers to take Medicaid patients, especially in rural areas where providers are lacking.
Strengthen NC's Infant Safe Surrender law	• The infant safe surrender law was originally advanced by the Task Force in 2001. • The Task Force, with input from juvenile law experts, identified 4 areas of the law that need to be strengthened 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.
Strengthen NC's child passenger safety law to address best practices for safety	• North Carolina's child passenger safety law differs from the best practice recommendations of the American Academy of Pediatrics. • Evidence shows children are more likely to ride in the recommended type of child restraint when their state's law includes wording that follows best practice recommendations. • The Task Force is recommending strengthening NC's child passenger safety law in 3 areas to better address best practices for safety.
Funding to enable comprehensive toxicology testing in child deaths	• Currently, the NC Medical Examiner does not have the necessary resources to conduct comprehensive toxicology screening in all child deaths under their jurisdiction. • NC does less toxicology testing on children with an established cause of death than any other state. • Without comprehensive toxicology testing on certain case types, there may be missed opportunities to determine contributing factors to a fatality.
Funding for programs to prevent harms to youth and infants caused by tobacco/nicotine use	• One in four North Carolina high school students uses e-cigarettes, which can contain high doses of nicotine. • Nicotine is highly addictive and can harm adolescent brain development. • Nicotine is toxic to developing fetuses and impairs fetal brain and lung development; tobacco use during pregnancy is associated with leading causes of infant death. • North Carolina's spending on tobacco use prevention drastically decreased since 2012/2013 and since then, use of e-cigarettes by youth has increased dramatically.
Require lifeguards at children's day camps that offer time in the water	• Currently there is no law or rule in North Carolina addressing water safety at all children's day camps that offer time in the water. • Evidence is clear that lifeguards provide an important layer of protection to prevent drowning.

NC Child Fatality Task Force Mandate and Study Process

Task Force Background and Purpose

The North Carolina Child Fatality Task Force (CFTF or "Task Force") derives its authority from Article 14 of the North Carolina Juvenile Code. The Task Force was created with the broader statewide Child Fatality Prevention System in 1991. The charge of the system is: to develop a communitywide approach to child abuse and neglect; to study and understand causes of childhood death; to identify gaps in service delivery in systems designed to prevent child abuse, neglect, and death; and to make and implement recommendations for laws, rules, and policies that will support the safe and healthy development of children and prevent future child abuse, neglect, and death. This system has local and state-level teams that review individual cases of child deaths. The Task Force is the "policy arm" of the system and does not conduct individual case reviews.

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

Task Force recommendations and efforts have helped to advanced many laws and initiatives since its 1991 creation. An updated 19-page list of legislative and other accomplishments by the Task Force is available on the Child Fatality Task Force website at https://webservices.ncleg.gov/ViewDocSiteFile/74396. Past annual reports of the Task Force have also included such a list.

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

Task Force work is accomplished through three committees who meet to hear presentations, engage in discussion, and prepare recommendations for consideration by the full Task Force. Committee participants include Task Force members as well as volunteers with subject matter expertise in the committee's area of focus.

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

The **Perinatal Health Committee** focuses on infant mortality through addressing healthy pregnancies, birth outcomes, and infants.

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

Committee recommendations only become Task Force recommendations once approved by the full Task Force. During its most recent study cycle, the Task Force had a total of eleven meetings, including eight committee meetings and three meetings of the full Task Force. Over the course of these 11 meetings, which took place August 29, 2022 to December 12, 2022, there were more than 50 presentations covering more than 30 topics.

Agendas, minutes, and presentations for all Task Force meetings and committee meetings can be found on the Task Force website which is hosted on the website for the NC General Assembly: https://sites.ncleg.gov/nccftf/.

Topics addressed in meetings

Broad topics:

- Legislative updates
- Recent data trends in child injury deaths
- New data from the 2021 Youth Risk Behavior Survey
- Recommendations from the State Child Fatality Prevention Team

Child fatality prevention system and toxicology testing

- Information from national experts on child fatality prevention systems

- Perspective and information from leaders of child fatality prevention systems in other states
- Perspective from local child death review team leaders on the work of local review teams, the child fatality prevention system, and CFTF efforts to strengthen the system
- CFTF efforts to strengthen the child fatality prevention system; how NC's system differs from other states
- Toxicology testing in child deaths and lack of resources for comprehensive testing

Perinatal health and infant mortality

- Infant safe sleep & data addressing infant deaths related to unsafe sleep
- Group prenatal care
- Doula services
- Review of obstetric provider bundled payments under NC Medicaid
- NC Perinatal Health Strategic Plan
- Update on NC's infant mortality reduction efforts
- Update on CFTF administrative recommendation addressing a breastfeeding hotline and NCDHHS plans to launch a statewide breastfeeding hotline

Firearm deaths and injuries to children

- Data update on firearm deaths and injuries to children
- Addressing firearm deaths and injuries via firearm safe storage; CFTF safe storage recommendation
- Data related to juvenile offenses involving firearms
- Information on efforts by the Department of Public Safety for a one-year media campaign addressing firearm safe storage

Youth suicide, youth mental health, and school support for students

- Data on ratios of school health support personnel (nurses, social workers, counselors, psychologists) to students in NC, and spending of temporary COVID funds on personnel
- Local perspective on the role of school health support professionals in addressing student mental health and the impact of adding temporary personnel
- Status of school health data and lack of a statewide electronic school health data system
- Data update on youth suicide and self-harm
- Update on progress made with CFTF administrative recommendation to create position of state coordinator for suicide prevention
- Child behavioral health priorities from the Division of Child and Family Wellbeing, NCDHHS
- Updates on implementation of the school mental health policy
- Highlights from Department of Public Instruction's report to the General Assembly on the status of school health support professionals

Child abuse and neglect

- Updates on progress made with CFTF administrative recommendation to strengthen child abuse and neglect reporting training for law enforcement officers and healthcare providers
- DSS intensive fatality reviews and Community Child Protection Teams
- Infant safe surrender law

Motor vehicle-related deaths and injuries to children

- Data update on motor vehicle deaths and injuries
- North Carolina child passenger safety laws in relation to recommended best practices
- Update on progress made with CFTF administrative recommendation to strengthen education of youth about the importance of rear seat restraints

Other topics related to unintentional deaths and injuries

- Data update on child poisonings
- Explanation of North Carolina's opioid settlement and what it means for communities
- Tobacco and nicotine use and harms; prevention funding
- Data update on child drowning deaths and injuries
- Lack of laws/regulation requiring lifeguards at day camps

NOTE about 2021 child death data: The Task Force typically examines in its meetings the most recent child death and infant mortality data released by the North Carolina State Center for Health Statistics. For the meetings that took place in the recent study cycle, the most recent data (from 2021) was not available for examination. However, the Task Force was, in many cases, able to look at provisional 2021 data to inform its work. The 2021 child death data report is now available and is included in this report.

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

- Cabarrus County Community Child Protection and Child Fatality Prevention Team (Chair)
- Chatham County Department of Social Services (Director)
- Collaborative for Maternal and Infant Health, University of North Carolina School of Medicine (Executive Director; Assistant Director)
- Colorado Child Fatality Prevention System (System Leader)
- Committee on Child Abuse and Neglect, NC Pediatric Society (physician/member)
- Division of Child and Family Wellbeing, NCDHHS (Child Behavioral Health Manager)
- Division of Juvenile Justice and Delinquency Prevention, Department of Public Safety (Deputy Secretary)
- Gaston County Community Child Protection Team (Chair)
- Governor's Highway Safety Program (Director)
- Healthy Schools & Specialized Instructional Support, NC Department of Public Instruction (Section Chief; Social Work Consultant)
- Infant and Community Wellness Section, NC Division of Public Health, NCDHHS (Section Chief; Perinatal Health Strategic Plan Coordinator; Maternal Health Branch Head)
- Injury & Violence Prevention Branch, NC Division of Public Health, NCDHHS (Epidemiologist)
- Iredell County Child Fatality Prevention Team (Chair)
- Jordan Institute for Families, University of North Carolina School of Social Work (Director)
- Michigan Child Death Review Program (Leader)
- National Center for Fatality Review and Prevention (Senior Project Coordinator)
- NC Association of County Commissioners (Director of Strategic Health & Opioid Initiatives)
- NC Child Fatality Prevention Team (Coordinator)
- NC Community Child Protection Team State Advisory Board (Co-Chair)
- NC Conference of District Attorneys (Child Abuse Resource Prosecutor)
- NC Department of Justice (Senior Policy Counsel)
- NC Department of Transportation (Traffic Safety Engineer)
- NC Medicaid, Division of Health Benefits, NCDHHS (Associate Medical Director; Associate Director, Strategy & Planning)
- Office of the Chief Medical Examiner, NC Division of Public Health, NCDHHS (Chief Medical Examiner; Deputy Chief Toxicologist)
- Safety and Prevention Services, NC Division of Social Services, NCDHHS (Section Chief)
- Student Services, Cumberland County Schools (Executive Director)
- University of North Carolina Injury Prevention Research Center (Director)

Ongoing Efforts, Progress on Administrative Items, and Special Events

Central to the statutory role of the Task Force is studying and reporting on data surrounding child deaths. The Task Force then uses that data as well as information learned from child death reviews and evidence about effective prevention strategies to formulate recommendations.

Formal Task Force reports are required to be submitted to the governor and the General Assembly annually, but Task Force work also informs many organizations and individuals across the state. Broad education and awareness about the data surrounding child deaths and strategies to prevent them has been an important aspect of Task Force work since its inception. Also important is the Task Force's unique structure that facilitates collaboration among state and community leaders to accomplish prevention work that does not require changed law or state funding, but instead requires the attention, expertise, and existing resources of certain organizations and individuals to come together to get something done.

Task Force data and recommendations are widely shared

Data and evidence studied by the Task Force is contained in presentations made by subject matter experts during meetings of the Task Force and its committees. Meetings are open to the public and presentations are posted on the Task Force website. Data shared in Task Force meetings is regularly used by individuals and organizations external to the Task Force whose work relates to child wellbeing, and is also frequently reported by news organizations who attend Task Force meetings.

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

The Task Force maintains a large (400+) email list that includes Task Force members as well as individuals interested in being updated on Task Force work. Email updates related to Task Force meetings, legislation addressing Task Force recommendations, and news and events related to Task Force work are sent to the email list throughout the year.

In 2022, Task Force data and recommendations were highlighted through various forms of media including multiple TV, radio, web, and print news stories; an article in the NC Medical Journal; blog posts; and a Task Force press release addressing its annual report and recent child death data.

Progress on Administrative Items

The Task Force Action Agenda often includes "administrative" items, which are not legislative recommendations but rather efforts to further study a topic or to make progress on prevention through collaborative efforts that do not require changed laws or state funding.

Several of the 2022 administrative items helped lead to important prevention work including the following:

- **Lead suicide prevention coordinator:** A multi-year administrative item on the Task Force agenda was to promote creation of a lead suicide prevention coordinator role for the state. The NC Suicide Action Plan, released in 2022, included this priority and the NC Department of Health and Human Services reported that they identified a funding source and were working to create and fill this role.
- **Strengthening child abuse and neglect reporting education for law enforcement and healthcare professionals:** A multi-year administrative item on the Task Force agenda has been to strengthen education and awareness surrounding child abuse and neglect reporting for law enforcement professionals, medical professionals, and

school professionals. As a result of the Task Force's request in 2021 to the NC Justice Academy's Joint In-Service Training Committee to consider strengthening CAN reporting training for law enforcement, the training committee determined there would be a four-hour juvenile block for law enforcement with at least two hours devoted to this topic. The Task Force heard reports in 2022 on the collaborative efforts to develop and implement this training for law enforcement. Development of the training was completed in 2022 and by December of 2022, the two hours of training, which focused on detecting possible abuse, reporting requirements, working with DSS, and speaking with children on the scene, was completed and delivery to all of NC's sworn law enforcement had begun. In addition, the Task Force heard reports in 2022 on efforts underway to develop and disseminate trainings tailored for medical professionals. The development of this training involves collaboration with members of the Pediatric Society's Committee on Child Abuse and Neglect, which includes medical experts in child abuse, the NC Division of Social Services, the Conference of District Attorneys, and Prevent Child Abuse NC.

- **Review of NC Medicaid's prenatal bundle rate:** The Task Force requested the Division of Health Benefits at NC Medicaid to review the prenatal bundle rate and its impact on group prenatal care. This review took place, and one of the results was the identification of current challenges that impact infant and maternal health and funding needs to address those challenges. Information about the review and the challenges was shared with the Task Force. The Task Force utilized that information in developing related recommendations.
- **Strengthening education around the importance of rear seat restraints:** One of the Task Force administrative items was to encourage efforts by the Governor's Highway Safety Program to strengthen education and awareness among youth about the importance of rear seat restraints. The Governor's Highway Safety Program reported to the Unintentional Death Prevention Committee of the Task Force in 2022 about their significant efforts in this area, including production of videos and a social media campaign, use of social media influencers, and a partnership with the NC High School Athletic Association.

Other 2022 administrative items involved further study that led to legislative recommendations being made on the 2023 Action Agenda, including recommendations addressing:

- Funding for more school nurses, social workers, counselors and psychologists
- Implementation of a statewide electronic school health data system
- Expanding access to group prenatal care, doulas, and maternity care generally via expanding Medicaid funding
- Strengthening laws addressing child passenger safety
- Requiring lifeguards at children's day camps offering time in the water

Collaboration on Special Events

Task Force work in 2022 also involved collaboration of Task Force leaders with other organizations on special events related to child safety and the Child Fatality Prevention System. This included:

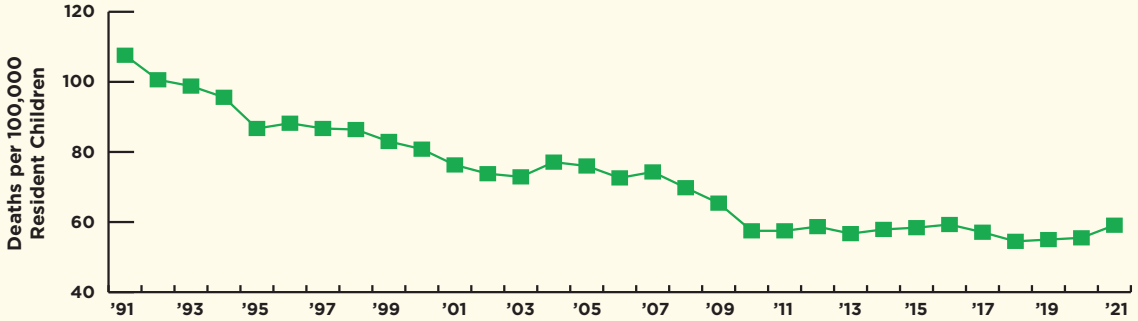
- Collaboration among individuals from several organizations with an interest in motor vehicle safety for a **celebration of the 25th anniversary of the Graduated Driver Licensing (GDL) System** and all the lives it has saved. The Task Force helped to advance this law in 1997, and North Carolina was the second state in the nation to pass such a law after the University of North Carolina Highway Safety Research Center developed the original GDL program based on scientific research. This collaboration involved an in-person celebratory event and various efforts to disseminate information to promote teen driving safety.
- Collaboration with the Jordan Institute for Families, UNC School of Social Work who hosted a **webinar for those involved in the statewide child fatality prevention system** to explain the importance of the statewide system, the roles and connections of individuals and teams within the system, and provide updates on efforts of the Child Fatality Task Force and others to strengthen the system and optimize the work of everyone involved.
- Collaboration with individuals who work in the child fatality prevention system to **plan an in-person child fatality prevention system summit in March of 2023.** The summit will be hosted by the Jordan Institute for Families, UNC School of Social Work, in partnership with the NC Department of Health and Human Services and will include professionals from across the state who work on child death review teams, the Task Force, and in various other roles that support the system.

EXTENDING OUR *Thanks!*

Many thanks to Task Force Members, contributing experts, and community volunteers who devoted their time and expertise to Task Force work in 2022. Their efforts and commitment to protecting the children of North Carolina are reflected in the 2023 Action Agenda.

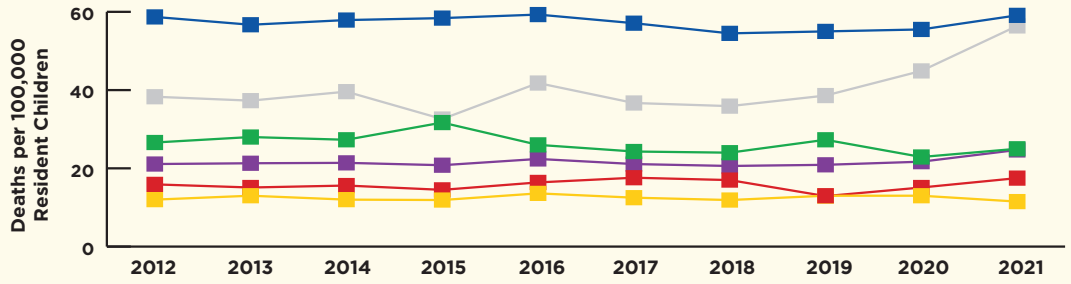
Produced by the NC Division of Public Health - Title V Office in conjunction with the State Center for Health Statistics

FIGURE 1. 1991-2021 TRENDS IN NORTH CAROLINA RESIDENT CHILD DEATH RATES AGES BIRTH THROUGH 17 YEARS



1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
107.6	100.6	98.8	95.6	86.7	88.2	86.7	86.4	83.0	80.8	76.3	73.8	72.9	77.1	76.0	72.6	74.3	69.8	65.4	57.5	57.5	58.7	56.7	57.9	58.4	59.3	57.1	54.5	55.0	55.5	59.1

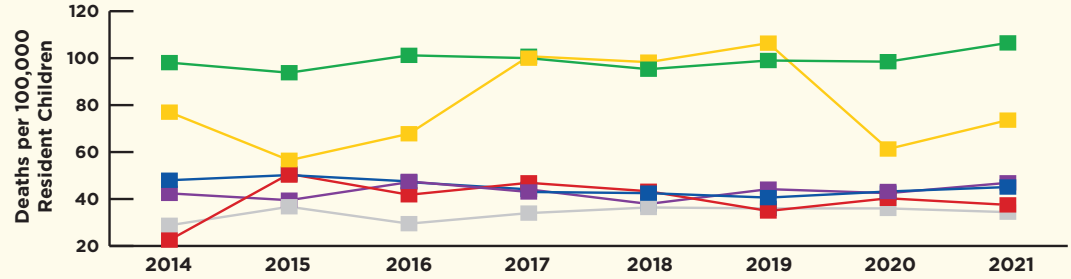
FIGURE 2. 2012-2021 TRENDS IN NORTH CAROLINA RESIDENT CHILD DEATH RATES† BY AGE GROUP



	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Total Ages 0-17	58.7	56.7	57.9	58.4	59.3	57.1	54.5	55.0	55.5	59.1
... Ages 1-4	26.6	28.0	27.3	31.7	26.0	24.3	24.0	27.3	22.9	25.0
... Ages 5-9	12.0	13.0	12.0	11.9	13.6	12.5	11.9	13.0	13.0	11.5
... Ages 10-14	15.9	15.1	15.6	14.5	16.4	17.6	17.0	12.9	15.1	17.5
... Ages 15-17	38.3	37.3	39.6	32.6	41.8	36.7	35.9	38.6	44.9	56.4
... (Exc. Infants) Ages 1-17	21.1	21.3	21.4	20.8	22.4	21.1	20.6	20.9	21.7	24.7

† Child death rates prior to 2021 have been recalculated using the latest available population data

FIGURE 3. 2014-2021 TRENDS IN NORTH CAROLINA RESIDENT CHILD DEATH RATES† BY RACE*/ETHNICITY, AGES BIRTH THROUGH 17 YEARS



	2014	2015	2016	2017	2018	2019	2020	2021
NH White	48.0	50.2	47.5	43.0	42.5	40.6	43.2	45.1
NH Black	98.1	93.8	101.2	100.0	95.3	99.0	98.5	106.5
NH American Indian	77.0	56.5	67.8	100.8	98.3	106.4	61.3	73.6
NH Asian/Pacific Islander	22.5	50.7	41.8	46.9	43.3	34.9	40.3	37.5
NH Multiracial	28.8	36.7	29.5	34.0	36.4	36.0	36.0	34.4
Hispanic	42.4	39.5	47.2	44.1	37.9	44.2	42.5	46.9

† Child death rates prior to 2021 have been recalculated using the latest available population data

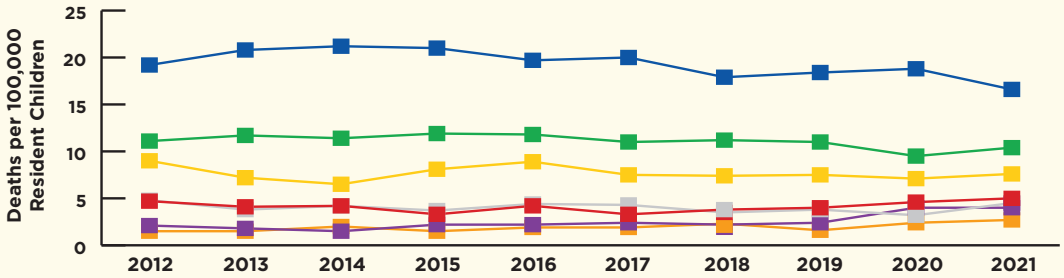
* Caution: Racial categories have changed from prior years and now reflect single race categories & multi-race. Comparisons with prior reports are not advised. • NH=Non-Hispanic

TABLE 1. 2020 NC RESIDENT CHILD DEATHS BY AGE GROUP & CAUSE OF DEATH

	TOTAL AGES 0-17		AGE GROUP (years)									
			Infants		1-4		5-9		10-14		15-17	
Cause of Death Category:	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Perinatal Conditions	**382**	**28.1**	**381**	**99.7**	**1**	**0.3**	**0**	**0.0**	**0**	**0.0**	**0**	**0.0**
... Short Gestation/Low Birthweight	107		106		1		0		0		0	
... Maternal Complications	78		78		0		0		0		0	
... All Other Perinatal Conditions	197		197		0		0		0		0	
Medical Conditions	**240**	**17.6**	**80**	**33.3**	**46**	**19.2**	**27**	**11.3**	**42**	**17.5**	**45**	**18.8**
... Malignant Neoplasms (Cancer)	42		1		12		7		15		7	
... Heart Disease	30		14		6		2		2		6	
... Chronic Lower Respiratory Diseases	7		1		2		1		1		2	
... Septicemia	3		0		0		2		0		1	
... Pneumonia/Influenza	8		3		3		0		1		1	
... Coronavirus Disease (COVID-19)	14		0		0		2		2		10	
... All Other Medical Conditions	136		61		23		13		21		18	
Birth Defects	**174**	**12.8**	**149**	**85.6**	**10**	**5.7**	**6**	**3.4**	**5**	**2.9**	**4**	**2.3**
... Circulatory System	46		35		5		2		3		1	
... Nervous System	23		20		0		2		1		0	
... Respiratory System	14		13		0		0		1		0	
... All Other Birth Defects	91		81		5		2		0		3	
Motor Vehicle Injuries	**104**	**7.6**	**4**	**3.8**	**14**	**13.5**	**16**	**15.4**	**27**	**26.0**	**43**	**41.3**
Other Unintentional Injuries	**114**	**8.4**	**38**	**33.3**	**24**	**21.1**	**14**	**12.3**	**11**	**9.6**	**27**	**23.7**
...Suffocation/Choking/Strangulation	36		32		1		0		0		3	
...Drowning	20		1		9		2		4		4	
...Poisoning	19		2		3		0		1		13	
...Bicycle	4		0		0		1		2		1	
...Firearm	11		0		4		2		1		4	
...Smoke, Fire & Flames	10		1		3		6		0		0	
...All Other Accidental Injuries	14		2		4		3		3		2	
Suicide	**62**	**4.6**	**0**	**0.0**	**0**	**0.0**	**0**	**0.0**	**20**	**32.3**	**42**	**67.7**
... by Firearm	36		0		0		0		9		27	
... by Hanging	21		0		0		0		11		10	
... by Poisoning	3		0		0		0		0		3	
... All Other Suicides	2		0		0		0		0		2	
Homicide	**93**	**6.8**	**4**	**4.3**	**14**	**15.1**	**7**	**7.5**	**10**	**10.8**	**58**	**62.4**
... Involving Firearm	73		0		3		4		10		56	
... All Other Homicides	20		4		11		3		0		2	
Other Injuries Undetermined Manner	**15**	**1.1**	**9**	**60.0**	**2**	**13.3**	**0**	**0.0**	**1**	**6.7**	**3**	**20.0**
... Hanging/Strangulation/Suffocation	7		7		0		0		0		0	
... Poisoning	3		0		2		0		0		1	
... All Other Undetermined Injuries	5		2		0		0		1		2	
All Other Causes of Death	**176**	**12.9**	**155**	**88.1**	**8**	**4.5**	**2**	**1.1**	**2**	**1.1**	**9**	**5.1**
TOTAL DEATHS	**1,360**	**100.0**	**820**		**119**		**72**		**118**		**231**	

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

FIGURE 4. 2012-2021 TRENDS IN NORTH CAROLINA RESIDENT CHILD DEATH RATES† FOR SELECTED CAUSES OF DEATH, AGES BIRTH THROUGH 17 YEARS



	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Perinatal Conditions	19.2	20.8	21.2	21.0	19.7	20.0	17.9	18.4	18.8	16.6
Medical Conditions/Illnesses	11.1	11.7	11.4	11.9	11.8	11.0	11.2	11.0	9.5	10.4
Birth Defects	9.0	7.2	6.5	8.1	8.9	7.5	7.4	7.5	7.1	7.6
Other Unintentional Injuries	4.7	4.1	4.2	3.3	4.2	3.3	3.8	4.0	4.6	5.0
Motor Vehicle Injuries	4.8	3.8	4.2	3.7	4.4	4.3	3.5	3.8	3.2	4.5
Homicide	2.1	1.8	1.5	2.2	2.2	2.4	2.2	2.4	4.0	4.0
Suicide	1.5	1.5	2.0	1.5	1.9	1.9	2.3	1.6	2.4	2.7

† Child death rates prior to 2021 have been recalculated using the latest available population data

*TABLE 2. LEADING CAUSES OF CHILD DEATH BY AGE GROUP, NC RESIDENTS 2021

ALL AGES, 0-17

Rank	Cause	Number	%
1	Conditions originating in the perinatal period	382	28.1%
2	Congenital anomalies (birth defects)	174	12.8%
3	Other Unintentional injuries	110	8.1%
4	Motor vehicle injuries	108	7.9%
5	Homicide	93	6.8%
6	Suicide	62	4.6%
7	Cancer	42	3.1%
8	Diseases of the heart	30	2.2%
9	COVID-19	14	1.0%
10	Pneumonia & influenza	8	0.6%
All other causes (Residual)		337	24.8%
Total Deaths — All Causes		1,360	100.0%

AGES 1 TO 17

Rank	Cause	Number	%
1	Motor vehicle injuries	104	19.3%
2	Homicide	89	16.5%
3	Other Unintentional injuries	72	13.3%
4	Suicide	62	11.5%
5	Cancer	41	7.6%
6	Congenital anomalies (birth defects)	25	4.6%
7	Diseases of the heart	16	3.0%
8	COVID-19	14	2.6%
9	Chronic lower respiratory diseases	6	1.1%
10	Pneumonia & influenza	5	0.9%
All other causes (Residual)		106	19.6%
TOTAL DEATHS — ALL CAUSES		540	100.0%

INFANTS

Rank	Cause	Number	%
1	Congenital anomalies (birth defects)	149	18.2%
2	Short gestation - low birthweight	105	12.8%
3	Maternal complications of pregnancy	41	5.0%
4	Other unintentional injuries	38	4.6%
5	Bacterial sepsis	25	3.0%
	Complications of placenta, cord, and membranes	25	3.0%
7	Respiratory distress	22	2.7%
8	Necrotizing enterocolitis	21	2.6%
9	Diseases of the circulatory system	19	2.3%
10	Intrauterine hypoxia and birth asphyxia	12	1.5%
All other causes (Residual)		363	44.3%
TOTAL DEATHS — ALL CAUSES		820	100.0%

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

AGES 1 TO 4			
Rank	Cause	Number	%
1	Other Unintentional injuries	24	20.2%
2	Homicide	14	11.8%
	Motor vehicle injuries	14	11.8%
4	Cancer	12	10.1%
5	Congenital anomalies (birth defects)	10	8.4%
6	Diseases of the heart	6	5.0%
7	Cerebrovascular disease	3	2.5%
	Pneumonia & influenza	3	2.5%
9	Chronic lower respiratory diseases	2	1.7%
10	Conditions originating in the perinatal period	1	0.8%
	Diseases of appendix	1	0.8%
	Nutritional deficiencies	1	0.8%
All other causes (Residual)		28	23.5%
TOTAL DEATHS — ALL CAUSES		119	100.0%

AGES 10 TO 14			
Rank	Cause	Number	%
1	Motor vehicle injuries	29	24.6%
2	Suicide	20	16.9%
3	Cancer	15	12.7%
4	Homicide	10	8.5%
5	Other Unintentional injuries	9	7.6%
6	Congenital anomalies (birth defects)	5	4.2%
7	COVID-19	2	1.7%
	Diseases of the heart	2	1.7%
9	Anemias	1	0.8%
	Chronic lower respiratory diseases	1	0.8%
	Diabetes mellitus	1	0.8%
	Pneumonia & influenza	1	0.8%
All other causes (Residual)		22	18.6%
TOTAL DEATHS — ALL CAUSES		118	100.0%

AGES 5 TO 9			
Rank	Cause	Number	%
1	Motor vehicle injuries	17	23.6%
2	Other Unintentional injuries	13	18.1%
3	Cancer	7	9.7%
	Homicide	7	9.7%
5	Congenital anomalies (birth defects)	6	8.3%
6	Anemias	2	2.8%
	COVID-19	2	2.8%
	Diseases of the heart	2	2.8%
	Septicemia	2	2.8%
10	Chronic lower respiratory diseases	1	1.4%
	Complications of medical and surgical care	1	1.4%
	Diseases of appendix	1	1.4%
	In-situ/benign neoplasms	1	1.4%
	Meningitis	1	1.4%
All other causes (Residual)		9	12.5%
TOTAL DEATHS — ALL CAUSES		72	100.0%

AGES 15 TO 17			
Rank	Cause	Number	%
1	Homicide	58	25.1%
2	Motor vehicle injuries	44	19.0%
3	Suicide	42	18.2%
4	Other Unintentional injuries	26	11.3%
5	COVID-19	10	4.3%
6	Cancer	7	3.0%
7	Diseases of the heart	6	2.6%
8	Congenital anomalies (birth defects)	4	1.7%
9	Chronic lower respiratory diseases	2	0.9%
10	Cerebrovascular disease	1	0.4%
	In-situ/benign neoplasms	1	0.4%
	Infections of kidney	1	0.4%
	Pneumonia & influenza	1	0.4%
	Septicemia	1	0.4%
All other causes (Residual)		27	11.7%
TOTAL DEATHS — ALL CAUSES		231	100.0%

2023 Child Fatality Task Force Action Agenda

Legislative Recommendations for 2023 **Legislative "support" items receive the highest level of support from the CFTF. Legislative "endorse" items are led by others and endorsed by the CFTF.**	**Recommendation addresses . . .**
*SUPPORT **legislation to launch and fund a new statewide firearm safety initiative,** as recommended by the 2017 Firearm Safety Stakeholder group, that is focused on education and awareness surrounding firearm safe storage and distribution of free gun locks with minimum two-year funding of $250,000.	**Prevention of youth suicides, accidental shootings, firearm assaults & homicides, school shootings, crimes involving guns**
*SUPPORT recurring **funds to increase numbers of school nurses, social workers, counselors and psychologists** to support the physical and mental health of students and to move North Carolina toward achieving nationally recommended ratios for these professional positions in schools; funding at least sufficient to sustain current positions whether sourced through temporary or permanent funding. SUPPORT **funding sufficient to sustain implementation and continued use of a statewide school health data system** beginning in 2024.	**Prevention of youth suicides; support for youth mental and physical health; strengthening of recognition and response to child abuse and neglect**
*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. • 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. • 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, Sudden Unexpected Infant Death (SUID), suicide, deaths not expected in next six months, additional infant deaths (review of other categories optional)] • 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. • 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. **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.	**Prevention of all types of child deaths for all ages. Changes are aimed at strengthening NC's ability to understand the circumstances surrounding child deaths to inform policy and system changes at the state and local levels to prevent future child deaths and promote child wellbeing.**

*SUPPORT recurring **funding totaling $250,000 per year to expand efforts to prevent infant deaths related to unsafe sleep environments.**	**Prevention of infant deaths related to unsafe sleep environments**
Support the funding request that has come from NC Medicaid/Division of Health Benefits, for the maternal morbidity and mortality funding bundle which includes **funding for an incentive for group (prenatal care) visits, funding for broad doula coverage, and funding to increase the maternity provider reimbursement for bundled payments.** (State share is approximately $9 million in recurring funds.)	**Prevention of infant deaths, especially those related to pre-term and low birthweight births**
*SUPPORT **legislation to strengthen the infant safe surrender law** to make it more likely the law will be used in circumstances for which it was intended – to protect a newborn infant at risk of abandonment or harm – by making legislative changes to accomplish the following: 1. remove "any adult" from those designated to accept a surrendered infant; 2. provide information to a surrendering parent; 3. strengthen protection of a surrendering parent's identity; 4. incorporate steps to help ensure the law is only applied when criteria are met.	**Prevention of newborn infant deaths or harm to newborns related to abuse or neglect**
SUPPORT **legislation to strengthen NC's child passenger safety law to address best practices** by making the following changes: 1. **To address importance of younger children riding in rear seat,** require children under age 8 to be properly restrained in the rear seat of a vehicle when the vehicle has a passenger side front air bag and has an available rear seat. 2. **To clarify the need for infants and toddlers to ride in rear-facing seats,** modify law to say that a child must be properly secured in a weight- and height-appropriate child passenger restraint system according to manufacturer instructions, including instructions for the use of rear-facing restraint systems for infants and toddlers. 3. **To clarify safe transition from booster seat to adult seat belt,** require a child to be properly secured in a weight-appropriate child passenger restraint system until the child is four feet nine inches tall (57 inches) and the adult seat belt fits properly without a booster seat (law to describe proper fitting of seat belt).	**Prevention of infant and child deaths and injuries related to motor vehicle crashes**
*SUPPORT an appropriation of $550,000 in nonrecurring funds and $110,000 in recurring **funds to enable the North Carolina Office of the Chief Medical Examiner to conduct comprehensive toxicology testing** in all Medical Examiner jurisdiction child deaths.	**Prevention of child deaths via more information about death circumstances to inform prevention strategies**
*ENDORSE an appropriation of $17 million in recurring **funds for programs to prevent tobacco/nicotine use** and encourage cessation by youth and to prevent harms to infants and children caused by tobacco/nicotine use.	**Prevention of poor birth outcomes including death; prevention of harm to youth**
ENDORSE **legislation requiring lifeguards at children's day camps** that offer time in the water.	**Prevention of fatal and nonfatal drownings at day camps**

* Indicates this item is the same or similar to an item appearing on the 2022 Action Agenda.

Explanation of 2023 Action Agenda[1]

Launch a Statewide Firearm Safe Storage Initiative

Recommendation: SUPPORT **legislation to launch and fund a new statewide firearm safety initiative,** as recommended by the 2017 Firearm Safety Stakeholder group, that is focused on education and awareness surrounding firearm safe storage and distribution of free gun locks with minimum two-year funding of $250,000.

Data on firearm deaths and injuries

Firearm deaths and injuries to children in North Carolina have been on the rise during the past decade and skyrocketed in 2020 and 2021. The facts are disturbing:[2]

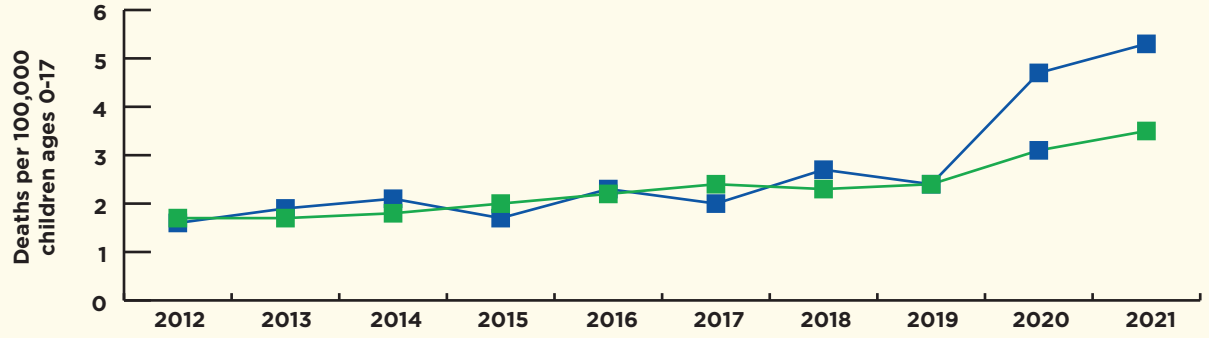
- In 2021, 121 North Carolina children ages 0 to 17 died of firearm injuries.
- From 2012 through 2021, over 600 North Carolina children ages 17 and younger died from firearm-related injuries, and each year there are five or six times as many firearm-related hospitalizations and emergency department visits as there are deaths.
- U.S. rates have also increased, similar to NC, with NC rates higher than US rates in both 2020 and 2021.
- NC saw an increase of 120.8% in rates from 2019 through 2021, and an increase of 231.3% from 2012 through 2021.
- Firearms were the lethal means used in more than 70% of the 2021 suicides and homicides; especially among youth ages 15 – 17 (83%).
- Child firearm injury hospitalizations increased by 120% from 2016-2020, and child emergency department visits for firearm injury increased by 68% from 2017-2021.

Safe firearm storage and child access

Guns are frequently not stored safely. A 2016 study found that more than half of all gun owners store at least one gun unsafely.[3] A 2021 survey indicated that more than 2/5 of North Carolina adults have a firearm in or around the home, and over half of firearms that are stored loaded are also unlocked.[4]

FIREARM-RELATED DEATH RATES HAVE INCREASED SUBSTANTIALLY IN NORTH CAROLINA IN THE LAST TWO YEARS

FIREARM-RELATED MORTALITY RATES, CHILDREN AGES 0 TO 17: NC & US, 2012-2021



	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
US	1.7	1.7	1.8	2.0	2.2	2.4	2.3	2.4	3.1	3.5
NC	1.6	1.9	2.1	1.7	2.3	2.0	2.7	2.4	4.7	5.3

* Firearm deaths include the following ICD mortality codes : W32-W34 (Unintentional), X72-X74 (Suicide), X93-X95 (Homicide), U014 (Terrorism), & Y22-Y24 (Undetermined Intent)

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

[1] Some recommendations are the same or similar to recommendations from prior years; explanations may be the same or similar to prior CFTF reports.
[2] Firearm-related death and injury data sourced from the Division of Public Health, NC Department of Health and Human Services.
[3] Crifasi CK, Doucette ML, McGinty EE, Webster DW, Barry CL. Storage Practices of US Gun Owners in 2016. Am J Public Health. 2018 Apr;108(4):532-537. doi: 10.2105/AJPH.2017.304262. Epub 2018 Feb 22. PMID: 29470124; PMCID: PMC5844398.
[4] Information presented to the NC Child Fatality Task Force by the NC Division of Public Health, sourced from the 2021 North Carolina Behavior Risk Factor Surveillance System, Firearm Safety Module: https://schs.dph.ncdhhs.gov/data/brfss/2021/nc/all/topics.htm#fr.

A 2021 survey showed **30% of North Carolina high school students** reporting that it would take them less than an hour to get and be ready **to fire a loaded gun without a parent or other adult's permission.**

Studies have shown that most kids know where parents keep their guns, but parents often think they don't.[5] A 2021 survey showed 30% of North Carolina high school students reporting that it would take them less than an hour to get and be ready to fire a loaded gun without a parent or other adult's permission; for white males, it was 40%.[6]

A significant surge in gun sales in recent years elevated the risks of more guns in homes that may not be safely stored, making them accessible to curious young children or youth who may be at risk of harming themselves or others.[7] A study published in 2022 found a significant increase from 2015 through 2021 in the number of children in the U.S. living in households with firearms, which is estimated to be approximately 4.6 million.[8]

Safe storage and youth suicide, school safety, youth crime

Task Force work on the issue of firearm safe storage began in 2017 with a recommendation from the State Child Fatality Prevention Team (State Team) that reviews child deaths. Each year since 2017 the State Team has continued to express concern about kids' access to guns, especially in the context of suicide, and asked the Task Force to focus on education and awareness around firearm safe storage.

Studies show that most guns used in youth suicide come from home.[9] Evidence on the increased risk of suicide when there is access to a firearm is well explained on the "Means Matter" website of the Harvard T.H. Chan School of Public Health. A person's decision to attempt suicide is often made quickly during a short-term crisis, and if that person has access to a firearm, their attempt is much more likely to be fatal than with other common methods of suicide. The fact that a suicide attempt is made does not mean that the person is likely to die from suicide: around 90% of those who attempt suicide and survive do not go on to die by suicide later.[10]

Studies have shown that guns used in school shootings typically come from home,[11] and school shooters are most often school age.[12] Safe storage is a school safety issue and preventing youth access to firearms can help prevent school shootings.

The increase in the number of guns being purchased has coincided with a significant increase in juvenile offenses in North Carolina involving a firearm. Data presented to the Task Force from the NC Department of Public Safety (DPS) showed increases for youth offenses such as robbery with a dangerous weapon, larceny of a firearm, possession of a handgun by minor, and breaking and entering a motor vehicle with a related firearm complaint.[13] DPS explained that many complaints have involved unsecured guns stolen from the front seat of a vehicle.

[5] Baxley F, Miller M. Parental Misperceptions About Children and Firearms. Arch Pediatr Adolesc Med. 2006;160(5):542–547. doi:10.1001/archpedi.160.5.542.
[6] Information presented to the NC Child Fatality Task Force by the NC Department of Public Instruction, sourced from the 2021 North Carolina *Youth Risk Behavior Survey*.
[7] Regarding the surge in gun sales, see, e.g., Ramos, E. and Murphy, J. (May 25, 2022.) "6 charts that show the rise of guns in the U.S. – and people dying from them." NBC News. www.nbcnews.com/data-graphics/6-charts-show-rise-guns-us-people-dying-rcna30537.
[8] Miller M, Azrael D. Firearm Storage in US Households With Children: Findings From the 2021 National Firearm Survey. JAMA Netw Open. 2022;5(2):e2148823. doi:10.1001/jamanetworkopen.2021.48823
[9] Grossman DC, Reay DT, Baker SA. Self-inflicted and Unintentional Firearm Injuries Among Children and Adolescents: The Source of the Firearm. Arch Pediatr Adolesc Med. 1999;153(8):875–878. doi:10.1001/archpedi.153.8.875
[10] The source for much of the evidence on this topic that has been provided in Task Force meetings and in this report comes from the "Means Matter" website of the Harvard T.H. Chan School of Public Health which summarizes studies related to means reduction as a suicide prevention strategy.
[11] See. e.g., U.S. Department of Homeland Security, United States Secret Service, National Threat Assessment Center, Protecting America's Schools: A U.S. Secret Service Analysis of Targeted School Violence, 2019. Hobbs, Tawnell D. (April 5, 2018). "Most Guns Used in School Shootings Come From Home." Wall Street Journal.
[12] Jillian Peterson and James Densley. (February 8, 2019.) "School Shooters Usually Show These Signs of Distress Long before They Open Fire, Our Database Shows." The Conversation https://bit.ly/2vBTA3J.
[13] According to data presented to the Child Fatality Task Force on October 31, 2022 by William Lassiter, Deputy Secretary for Juvenile Justice and Delinquency Prevention, NC Department of Public Safety, Division of Juvenile Justice and Delinquency Prevention.

The Task Force recommendation is for locally-tailored initiatives that focus on educating adult gun owners

Task Force efforts on this issue included study and input from a diverse group of stakeholders whose work in 2017 informed the CFTF recommendation for this initiative.[14] Central to the recommended initiative is a focus on giving communities tools and assistance to launch local initiatives.

The initiative being recommended by the Task Force utilizes but goes beyond and differs from a media campaign. A media campaign is important to jump-start safe storage awareness in North Carolina, and DPS reported to the Task Force that it is launching a statewide safe storage media campaign in 2023 that is funded through June 30, 2023. The CFTF initiative, however, would begin after that date and is focused on resources and dedicated state-level injury prevention staff that would build on this campaign and provide tools, outreach and technical assistance to help communities launch locally-tailored initiatives across the state. Initiatives would be built around community needs and resources and could range from one-time public events to group presentations to the formation of community gun safety teams and much more, involving trusted leaders and stakeholders from within the community.

The 2017 stakeholder group recommended a priority focus on educating adult gun owners. While educating youth about the dangers of carrying guns and having programs to prevent gun violence by youth are important, this was not the recommended primary focus from the stakeholder group. Educating youth about gun safety is not an area of focus for youth suicide prevention. Also, studies have shown that teaching young children gun safety does not reduce the likelihood that children will handle guns when they are unsupervised.[15]

Firearm deaths and injuries to children are preventable, and studies show that reducing access to firearms through safe storage practices saves lives. A study published in JAMA Pediatrics in 2019 estimated that up to 32% of youth firearm deaths by suicide and unintentional firearm injury could be prevented through safe storage of firearms in homes with youths.[16] This recommended initiative from the Task Force (repeated each year since 2018) has already seen strong bipartisan support in our state but has not yet become law.[17] Alarming increases in firearm deaths and injuries to kids combined with disturbing statistics that show the worsening mental health of youth illustrate the urgent and critical need to focus on this agreed upon strategy that will make a difference.

Increase the Numbers of School Nurses, Social Workers, Counselors, and Psychologists

Recommendation: SUPPORT recurring **funds to increase numbers of school nurses, social workers, counselors and psychologists** to support the physical and mental health of students and to move North Carolina toward achieving nationally recommended ratios for these professional positions in schools; funding at least sufficient to sustain current positions whether sourced through temporary or permanent funding.

Over the past decade in North Carolina, the youth suicide rate and measures of youth mental health have been worsening. In 2021, there were 62 youth suicides among youth ages 10 - 17 in North Carolina, and the 2021 suicide rate (among ages 10 to 17) represents the highest rates in two decades. Firearm-related suicides in particular have increased. Also in 2021, there were 783 hospitalizations and 3,362 ED visits for self-injury among youth ages 10 - 17.[18] A particularly alarming data point for 2021 was the increase in self-injury among female youth.

A 2021 student survey from the Centers for Disease Control and Prevention, the *Youth Risk Behavior Survey (YRBS)*, showed 22% of North Carolina high school students surveyed had seriously considered attempting suicide. For gay, lesbian, or bisexual students that number rose to 48%. The survey also showed 43% of high school students said they felt sad or hopeless; less than half reported feeling good about themselves; and 33% said they felt alone in their life.

[14] The work of the stakeholder group is explained in the CFTF 2018 Annual Report.

[15] See, e.g., Holly C., Porter S., Kamienski M., Lim A. School-Based and Community-Based Gun Safety Educational Strategies for Injury Prevention. Health Promotion Practice. May 2018. DOI: 10.1177/1524839918774571.

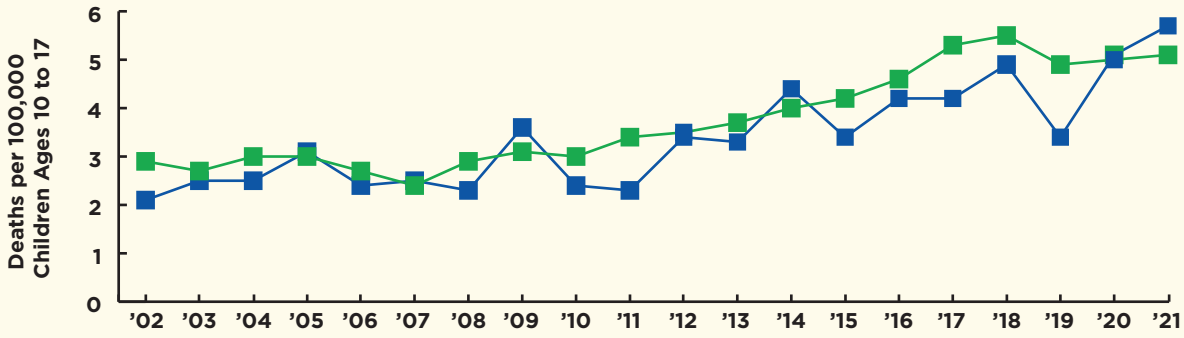
[16] Monuteaux MC, Azrael D, Miller M. Association of Increased Safe Household Firearm Storage With Firearm Suicide and Unintentional Death Among US Youths. JAMA Pediatr. 2019;173(7):657–662. doi:10.1001/jamapediatrics.2019.1078. See also Grossman DC, Mueller BA, Riedy C, et al. Gun Storage Practices and Risk of Youth Suicide and Unintentional Firearm Injuries. JAMA. 2005;293(6):707–714. doi:10.1001/jama.293.6.707

[17] In 2019, the Task Force firearm safety initiative was addressed in the Appropriations Act that never became law. In 2021, it was addressed in HB 427, which passed the NC House on a vote of 116 to 1 and was also included in the House version of the budget, but was not included in the final Appropriations Act of 2021 and was never taken up by the NC Senate.

[18] Data source for child deaths and injuries: Division of Public Health, NC Department of Health and Human Services.

AMONG CHILDREN AGES 10 TO 17, SUICIDE RATES INCREASED IN BOTH THE US AND NC OVER THE LAST TWO DECADES

SUICIDE RATES, AGES 10 TO 17: US & NC 2002-2021*



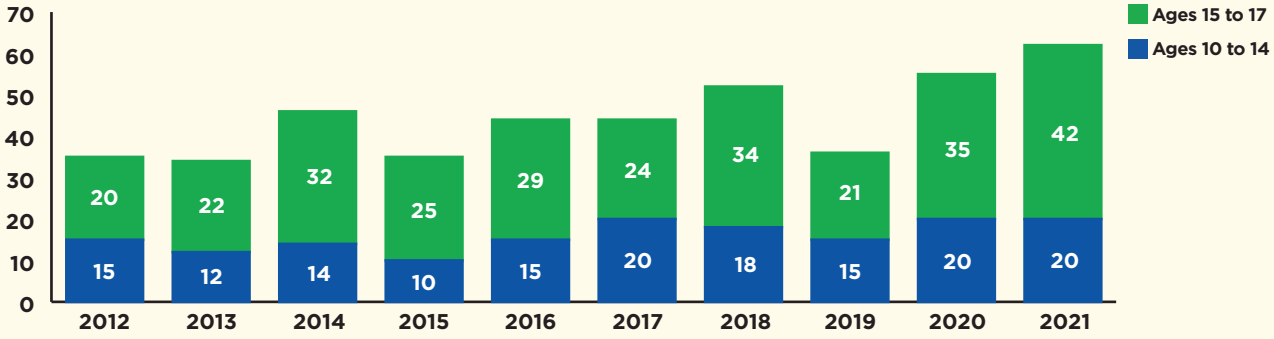
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
US	2.9	2.7	3.0	3.0	2.7	2.4	2.9	3.1	3.0	3.4	3.5	3.7	4.0	4.2	4.6	5.3	5.5	4.9	5.0	5.1
NC	2.1	2.5	2.5	3.1	2.4	2.5	2.3	3.6	2.4	2.3	3.4	3.3	4.4	3.4	4.2	4.2	4.9	3.4	5.1	5.7

* Suicides include the following ICD mortality codes : X60-X84 (Intentional self-harm; Y87.0 (Sequelae of intentional self-harm), U03 (Suicide Terrorism)

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

SUICIDES HAVE BEEN RISING AMONG NC CHILDREN AGES 10 TO 17 OVER THE LAST DECADE, WITH OLDER TEENS EXPERIENCING THE LARGEST INCREASE

NUMBER OF SUICIDES BY AGE GROUP: AGES 10 TO 17, NC 2012-2021

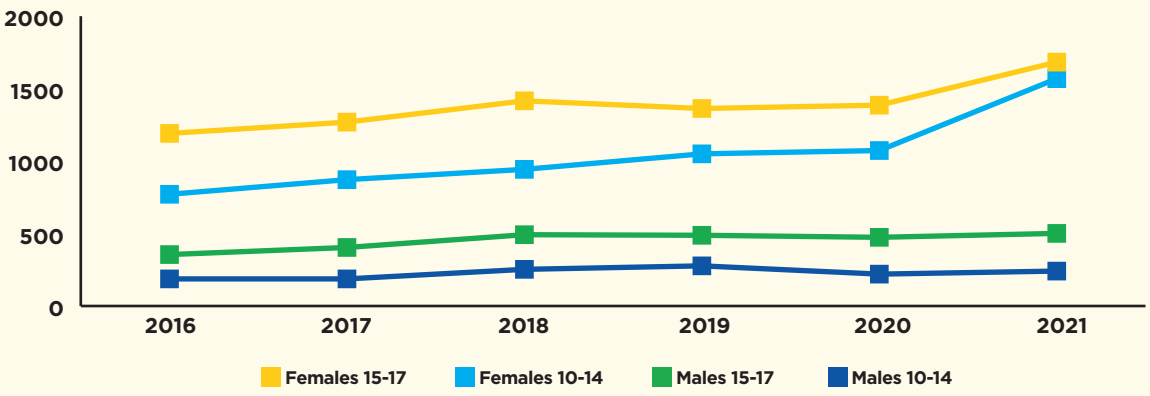


* Suicides include the following ICD mortality codes : X60-X84 (Intentional self-harm; Y87.0 (Sequelae of intentional self-harm), U03 (Suicide Terrorism)

Source: NC State Center for Health Statistics

THERE WAS A 46% INCREASE IN SELF-INFLICTED INJURY ED VISITS AMONG FEMALES AGES 10-14 FROM 2020-2021.

NORTH CAROLINA CHILD (AGES 10-17) SELF-HARM INJURY EMERGENCY DEPARTMENT VISITS BY SEX AND AGE GROUP, 2016-2021

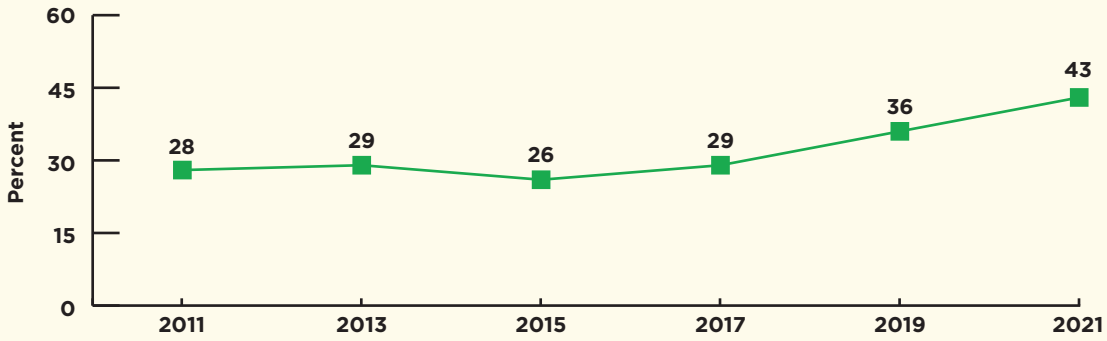


Note: limited to NC residents ages 10-17

Source: NC DETECT Emergency Department Visit Data, 2016-2021

The following data from the 2021 North Carolina *Youth Risk Behavior Survey* analyzed and presented by the NC Department of Public Instruction was among the YRBS results shared with the Task Force in December of 2022 (charts included here with permission):

PERCENTAGE OF HIGH SCHOOL STUDENTS WHO FELT SAD OR HOPELESS

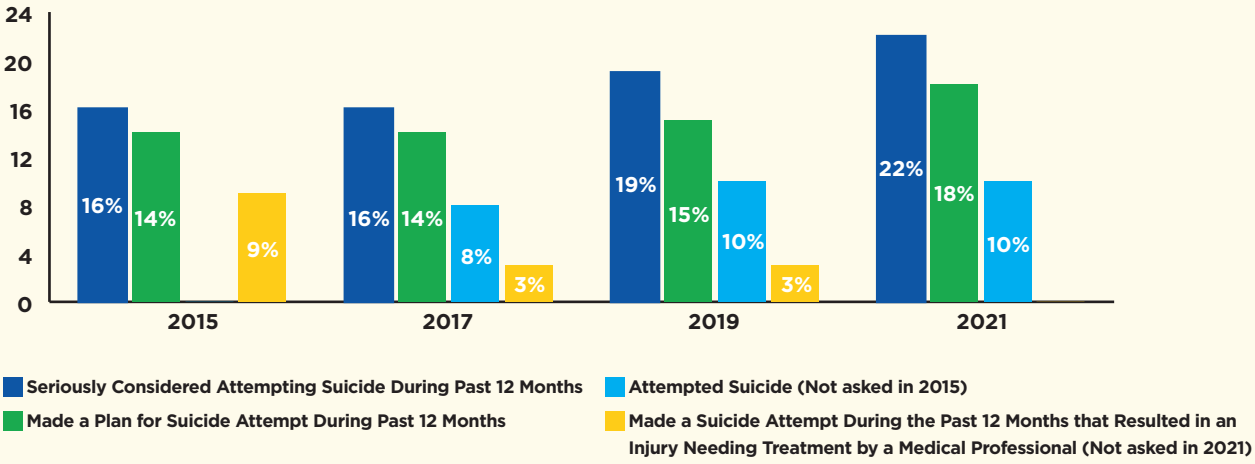


*Almost every day for >=2 weeks in a row so that they stopped doing some usual activities, ever during the 12 months before the survey

†Increased 2001-2021, no change 2001-2015, increased 2015-2021 [Based on linear and quadratic trend analyses using logistic regression models controlling for sex, race ethnicity, and grade ($p < 0.05$). Significant linear trends (if present) across all available years are described first followed by linear changes in each segment of significant quadratic trends (if present).]

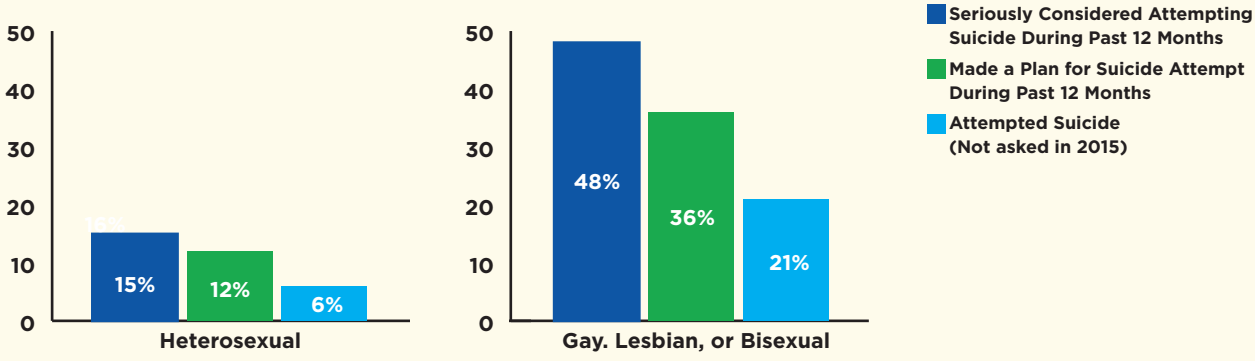
Source: North Carolina - YRBS, 2011-2021

SUICIDAL BEHAVIORS 2015-2021 NC HIGH SCHOOL STUDENTS



Source: NC High School Youth Risk Behavior Survey

SUICIDAL BEHAVIORS 2021 NC HIGH SCHOOL STUDENTS



Source: NC High School Youth Risk Behavior Survey

	Current Ratios in NC (These ratios include a modest number of temporary positions added from nonrecurring COVID funding)	Nationally Recommended Ratio
School Counselors	1:335	1:250
School Nurses	1:890 (48% of NC school nurses serve in more than one school)	1 per school
School Social Workers	1:1,025	1:250
School Psychologists	1:1,815	1:500

Data report by the NC Department of Public Instruction to the Task Force in September, 2022

National and state leaders have acknowledged there is a significant youth mental health crisis underway that requires urgent attention and resources.[19] In recent years, education leaders presenting to the Task Force have explained the critical role that school nurses, social workers, counselors and psychologists play in identifying and supporting students who are struggling or in crisis. Yet in North Carolina, the numbers of these professionals are far below nationally recommended ratios. For example, national recommendations are for one school social worker for every 250 students but in North Carolina, there is one for every 1,025 students.

Not only do these professionals connect with students one-on-one to build important relationships and provide counseling, they also connect students and their families to community resources to address or avert a crisis. These professionals are also the ones to implement programs in schools to support student mental health and prevent youth suicide. They also have an important role in recognizing and responding to suspected child abuse or neglect.

Federal COVID funds that came to North Carolina in recent years enabled a very modest, temporary increase in the numbers of these professionals with nonrecurring funding of approximately $40 million.[20] But when these funds are gone, the positions will also be gone, along with the investments of time and resources dedicated to hiring and training these professionals. The Task Force learned in its meetings about how the temporary nature of the positions made it harder to attract professionals to the positions and about the administrative challenges of adding temporary staff to permanent teams. The Task Force heard from one school system about these hiring challenges, how the additional temporary staff had a clear positive impact on their schools' ability to support students, families and other school staff, and about the importance of not losing these positions.[21]

While the temporary funding enabled schools to hire more of these professionals, even with these additions the numbers of these professionals in North Carolina are still far below nationally recommended ratios. The Task Force recommendation is for *recurring* state funding to increase these numbers to move toward nationally recommended ratios, and at the very least to have recurring funding that enables schools to turn the recently hired temporary positions into permanent positions.

[19] In December of 2021, the U.S. Surgeon General issued an Advisory on the Youth Mental Health Crisis. In October of 2021, there was a *Declaration of a National Emergency in Child and Adolescent Mental Health* from the American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry and the Children's Hospital Association.

[20] A presentation of information from the NC Department of Public Instruction to the Child Fatality Task Force on October 31, 2022, explained the approximately $40 million in temporary COVID funding used to hire these professionals and how schools had managed to spend this funding in spite of the challenges in hiring temporary positions.

[21] Natasha Scott, Ed.D., MSW, Executive Director for Student Services of Cumberland County Schools, explained to the Task Force on October 31, 2022 the challenges faced in hiring these temporary professionals, the positive impact the additional positions have had on their schools, and the anticipated negative consequences of losing these positions when the funding source is gone.

Implement A Statewide Electronic School Health Data System

Recommendation: SUPPORT **funding sufficient to sustain implementation and continued use of a statewide school health data system** beginning in 2024.

Schools are required to keep certain health-related information and to provide health-related services that impact educational access and success. About 25% of students live with a chronic health condition and many students have mental health needs – all of which may require school support. However, there is no universal system of recordkeeping of health data for North Carolina Schools. Current practices in NC schools for health record keeping is varied and there is no uniform/consistent means of keeping health records in schools or for connectivity among school record-keeping systems. In fact, many schools still use hard copy records.

In 2021 and 2022, the State Child Fatality Prevention Team, which reviews cases of child deaths, recommended to the Task Force supporting efforts to implement a statewide electronic school health data system.

Some of the benefits of having a statewide electronic school health record system used by all schools include the following:[22]

- Allows school health support professionals to keep up with student needs and services as they move from school to school or district to district to shorten the time for student support to be in place when a student moves.
- Facilitates school health support professionals to collaborate with one another within the school to ensure there is no fragmentation or duplication of services.
- Facilitates the kind of record keeping and information needed that is required for a school to bill for eligible Medicaid services; currently, few schools are billing for Medicaid services because of the complexity of collecting and reporting information.
- Helps ensure appropriate protection of confidential information by allowing restricted access to appropriate individuals and eliminating less secure methods of record keeping.

While potential funding has been identified to initially launch such a system, sustained funding is needed for ongoing implementation. Estimated costs for the system are from $1 million to $1.5 million per year.

Strengthen the Statewide Child Fatality Prevention System

Recommendation: 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.
- 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.
- **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)].
- **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.
- **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.**

[22] Information sourced from presentations by representatives from the NC Department of Public Instruction and the NC Division of Public Health to the Intentional Death Prevention Committee of the Task Force.

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.

This set of recommendations to strengthen the Child Fatality Prevention System (CFP System) is the result of Task Force work that began in 2018. The Task Force itself is part of this system, and has a responsibility to help ensure effective functioning of the system as a whole.[23]

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 in 2019. The NC Department of Health and Human Services undertook further study, planning, and stakeholder engagement related to implementing these recommendations, as the recommendations were aligned with DHHS priorities. Although the recommendations have been addressed in bills in 2019 and 2021, those bills did not become law and the recommendations cannot be implemented without legislation that would restructure and fund the system.[24]

Main groups who work within the current Child Fatality Prevention System:[25]

- **Two types of local child death review teams in all 100 counties:** Community Child Protection Teams (CCPTs) and Child Fatality Prevention Teams (CFPTs). CCPTs review certain deaths where there has been social services involvement with the family as well as some active DSS cases; CFPTs review all other deaths. In most counties, these teams are "blended" and meet together.
- **Two types of state-level child death review teams:** State Child Fatality Prevention Team (State CFPT), chaired by the Chief Medical Examiner, and the State Child Fatality Review Team (CFRT), led by NC DSS and composed of local team members. These state teams each review a subset of child deaths and in many cases, the same death (which may also have been reviewed by a local team).
- **Child Fatality Task Force:** studies child death data and prevention strategies and makes policy recommendations to the governor and General Assembly (does not review individual child deaths)

[Note: detailed diagrams illustrating the current structure of the CFP System and the flow of information within the system can be found in CFTF Annual Reports each year since 2018, all of which are available on the CFTF website; these reports also contain other information about these recommendations and Task Force work to strengthen the CFP System. A document distributed to the Task Force with charts that explain the system and the recommended changes is also available on the CFTF website.]

These recommendations are aimed at optimizing strengths of the current system while addressing or eliminating its challenges.

Strengths of the current system include:

- Multidisciplinary local **review teams covering all 100 NC counties;**
- a **state medical examiner system** with dedicated child fatality staff;
- a **Child Fatality Task Force** composed of experts in child health and safety, state agency leaders, and ten legislators with a history of success in advancing policy to save lives and prevent child maltreatment; and
- **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.

[23] The Child Fatality Prevention System is addressed in Article 14 of the NC Juvenile Code. Within Article 14, one of the articulated duties of the Task Force is to "develop a system for multidisciplinary reviews of child death . . ." (G.S. 7B-1403(2)).

[24] 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.

[25] Note: 1991 provisions addressing creation of the Child Fatality Task Force within Article 14 originally made the Task Force a temporary organization but the law changed by 1998 to remove sunset provisions to make the Task Force permanent. The State Child Fatality Review Team is not addressed in Article 14 but is addressed in G.S. 143B-150.20 and involves members of local review teams addressed in Article 14. Thus, all of these groups are involved in the same CFP System.

THE PREVENTION POTENTIAL IS HUGE when these community leaders come together on a local team to understand the circumstances surrounding a death and take steps to prevent it from happening again **AND...** local teams need state-level support to optimize their efforts.

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 death 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 areas of 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 compared to other states, and CCPTs can't effectively meet both state CCPT laws and federal CRP requirements.

Since 2018, efforts to strengthen the Child Fatality Prevention System have included input from many sources and the inclusion of various stakeholders and experts in these discussions has been continuous. During the two recent cycles of Task Force meetings, the Task Force and its committees heard from a number of individuals about their experiences working in a child death prevention system. Some individuals were leaders of systems in other states, some were leaders of local child death review teams (CCPTs and CFPTs) in North Carolina, and some were experts from the National Center for Fatality Review and Prevention (National Center).

Information shared by leaders from other states' child death review systems and the National Center highlighted some of the ways in which North

Carolina is different from other states and how some of those differences are strengths for North Carolina and others present challenges. These perspectives complemented other research that has been done into other states' systems since the Task Force began working on ways to strengthen the system. A particular point of discussion has been about use of the National Fatality Review Case Reporting System (used by 48 states but not NC) as an integral and valuable part of other states' prevention systems. Examples were shared about the depth of valuable information other states are able to collect and report as a result of using the national data system compared to the minimal information that North Carolina collects and reports related to child death reviews.

Leaders of local child death review teams in North Carolina talked about the importance of their teams' work in their communities, and shared examples of the ways in which their teams have been able to make their communities safer. They also provided their perspective on the challenges they face and how the changes being recommended by the Task Force would support and optimize their work. In particular, local leaders talked about the need for better data collection, analysis, and reporting of information learned in child death reviews and how they looked forward to one day being able to use the National Fatality Review Case Reporting System to track and report data. They also talked of the need to ensure that the work they were doing was seen and used at the state-level, and how they would benefit from increased state-level support.

Expand Initiatives to Prevent Infant Deaths Related to Unsafe Sleep Environments

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

The North Carolina Office of the Chief Medical Examiner reports that in the five-year period 2016 – 2020, there were about 650 infant deaths in North Carolina that were associated with unsafe sleep environments (621 deaths) or Sudden Infant Death Syndrome (28 deaths). In North Carolina, black infants are twice as likely as white infants to die in unsafe sleep environments.

Sleep-related deaths often involve bed sharing, also referred to as co-sleeping, the intentional or unintentional practice of an infant sharing a sleep space with another individual.[26] More than 60% of mothers report bed sharing with their baby.[27] The common practice of bed sharing is concerning because of the dangers associated with it, and the risks of bed sharing significantly increase for some infants such as those born too soon, too small, or who are in households where tobacco or other substances are used.[28]

In North Carolina, **over 100 babies die** in unsafe sleep environments each year.

[26] Office of the Chief Medical Examiner, Division of Public Health, North Carolina Department of Health and Human Services.
[27] Centers for Disease Control and Prevention, Vital Signs, Safe Sleep for Babies: www.cdc.gov/vitalsigns/safesleep/.
[28] See: Rachel Y. Moon, Rebecca F. Carlin, Ivan Hand, THE TASK FORCE ON SUDDEN INFANT DEATH SYNDROME AND THE COMMITTEE ON FETUS AND NEWBORN; Sleep-Related Infant Deaths: Updated 2022 Recommendations for Reducing Infant Deaths in the Sleep Environment. Pediatrics July 2022; 150 (1): e2022057990. 10.1542/peds.2022-057990

Guidelines from the American Academy of Pediatrics to create a safe sleep environment and reduce risk of infant death have evolved during the past decade, with the most recent updates made in 2022. Studies show that unsafe sleep practices are common and that parents and caregivers are not always receiving correct advice from their families, peers, and health and childcare providers. In fact, one study found that nearly half of caregivers did not receive correct advice on safe sleep practices from healthcare providers.[29] Outreach and education on safe sleep needs to reach healthcare providers and others who are in a position to educate parents and caregivers.

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

North Carolina's current spending of only $97,000 per year is insufficient to provide the level of education and outreach needed to get parents and caregivers of over 120,000 newborns each year to prevent these sleep-related deaths. The Task Force is recommending $153K in additional recurring funds to reach total spending of $250,000 ($2.10 / baby) to expand these prevention efforts.

Promote Maternal Healthcare Strategies Known to Produce Better Birth Outcomes

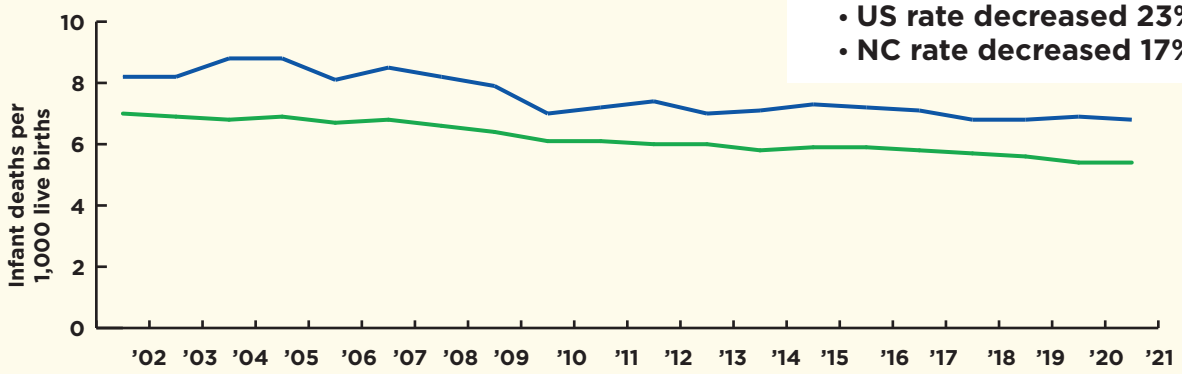
Recommendation: SUPPORT the funding request that has come from NC Medicaid, DHB, for the maternal morbidity and mortality funding bundle which includes **funding for an incentive for group (prenatal care) visits, funding for broad doula coverage, and funding to increase the maternity provider reimbursement for bundled payments.** (State share is approximately $9 million in recurring funds.)

North Carolina's infant mortality rate is among the highest 15% in the nation. Disparities have persisted with the mortality rate of black infants more than 2 times higher than that of white infants. This recommendation supports maternal healthcare strategies that are known to produce better birth outcomes to reduce infant mortality rates and health disparities.

NORTH CAROLINA INFANT MORTALITY RATES ARE CONSISTENTLY HIGHER THAN US RATES AND HAVE DECLINED AT A SLOWER PACE

INFANT DEATHS PER 1,000 LIVE BIRTHS: US & NC 2002-2021

2002-2021:
- **US rate decreased 23%**
- **NC rate decreased 17%**



	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
US	7.0	6.9	6.8	6.9	6.7	6.8	6.6	6.4	6.1	6.1	6	6	5.8	5.9	5.9	5.8	5.7	5.6	5.4	5.4
NC	8.2	8.2	8.8	8.8	8.1	8.5	8.2	7.9	7	7.2	7.4	7	7.1	7.3	7.2	7.1	6.8	6.8	6.9	6.8

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

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

Group Prenatal Care

Group prenatal care brings birthing people together for obstetrical visits, providing an opportunity for individuals to meet one-on-one with a healthcare provider and to participate in group education and facilitated group discussions on topics relevant to pregnancy and childbirth. There are various models for group care, and Centering Pregnancy is a model that started in 1993 and has been the most widely studied. A typical group care model assembles a group of about 8 – 10 birthing people (and their support partners) at the start of the second trimester. The group then meets every few weeks until the last month of pregnancy.

Preterm and low birthweight births are among the leading causes of infant deaths.[30] There are studies showing that group prenatal care lowers the risk of preterm birth and low birthweight births, and reduces/closes the racial disparity gap for preterm births.[31] There are also studies showing various other positive maternal and infant health outcomes associated with group prenatal care such as increased breastfeeding rates and better pregnancy spacing.

Although Medicaid reimburses providers for group prenatal care as part of traditional (or non-group) prenatal care, this type of care is more challenging and costly for providers, who would be more likely to offer group care with incentives to cover the additional challenges and cost.

Doulas

A doula is a trained non-clinical person who provides continuous physical, emotional, and informational support to a birthing person and their support person; a doula also provides support before, during and shortly after childbirth to help achieve the healthiest, most satisfying experience possible. Evidence has shown positive maternal and infant health outcomes from doula support during childbirth. A systematic review of data found that continuous labor support has "impressive benefits," especially when provided by a doula.[32] Among the benefits noted were an increased likelihood of a spontaneous vaginal birth and shorter labor, with a decreased likelihood of a cesarean birth, an instrumental vaginal birth, a low Apgar score for the infant and a negative birth experience.

North Carolina Medicaid does not currently reimburse doulas for their services, so most Medicaid beneficiaries will not use a doula unless and until doula services are covered.

Medicaid Provider Rates for Obstetrical Care

For providers of obstetrical care to Medicaid patients, the current reimbursement rate in North Carolina pays only 59.4% of the Medicare rate for bundled maternity care, putting NC's rate well below the national average.[33]

Having a bundled maternity care rate at 100% of the Medicare rate would not only compensate obstetrical providers fairly for maternal care, but would help attract more obstetrical providers to take Medicaid patients. More Medicaid providers are especially needed in rural areas of the state. In North Carolina, there are more than 20 counties with no maternal health professionals and 39 counties without a labor & delivery hospital.[34]

Funding Needs

A state appropriation of approximately $800,000 in nonrecurring funds over two years and $9 million in recurring funds (this is the state share of funds needed) would cover the costs for NC Medicaid to be able to provide an incentive for group (prenatal care) visits, funding for broad doula coverage, and funding to increase the maternity provider reimbursement for bundled payments. Of the $9 million in recurring funds, over 90% would be to raise the bundled payment rate; less than 6% would be for doula services and less than 4% would be incentives for group prenatal care. For the $800,000 in nonrecurring funds, 550,000 is for doula support funds for training, promotions, and doula engagement; $250,000 is for group prenatal care training, promotions, and site set-up.

[30] See 2021 child death data report at the beginning of this annual report.

[31] See, e.g., Crockett AH, Heberlein EC, Smith JC, Ozluk P, Covington-Kolb S, Willis C. Effects of a Multi-site Expansion of Group Prenatal Care on Birth Outcomes. Matern Child Health J. 2019 Oct;23(10):1424-1433. doi: 10.1007/s10995-019-02795-4. PMID: 31230168; Cunningham SD, Lewis JB, Shebl FM, Boyd LM, Robinson MA, Grilo SA, Lewis SM, Pruett AL, Ickovics JR. Group Prenatal Care Reduces Risk of Preterm Birth and Low Birth Weight: A Matched Cohort Study. J Womens Health (Larchmt). 2019 Jan;28(1):17-22. doi: 10.1089/jwh.2017.6817. Epub 2018 Sep 25. PMID: 30256700; Ickovics JR, Kershaw TS, Westdahl C, Magriples U, Massey Z, Reynolds H, Rising SS. Group prenatal care and perinatal outcomes: a randomized controlled trial. Obstet Gynecol. 2007 Aug;110(2 Pt 1):330-9. doi: 10.1097/01.AOG.0000275284.24298.23. Erratum in: Obstet Gynecol. 2007 Oct;110(4):937. PMID: 17666608; PMCID: PMC2276878; Picklesimer AH, Billings D, Hale N, Blackhurst D, Covington-Kolb S. The effect of CenteringPregnancy group prenatal care on preterm birth in a low-income population. Am J Obstet Gynecol. 2012 May;206(5):415.e1-7. doi: 10.1016/j.ajog.2012.01.040. PMID: 22542115.

[32] National Partnership for Women & Families. Continuous Support for Women During Childbirth: 2017 Cochrane Review Update Key Takeaways. J Perinat Educ. 2018 Oct;27(4):193-197. doi: 10.1891/1058-1243.27.4.193. PMID: 31073265; PMCID: PMC6491161.

[33] According to the Division of Health Benefits, NC Medicaid, as presented to the Child Fatality Task Force.

[34] Information presented to the Child Fatality Task Force by representatives of the NC Division of Public Health.

Strengthen the Infant Safe Surrender Law

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

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

In 2001 North Carolina passed HB 275 (S.L. 2001-291) known by many as the "Infant Safe Surrender" law. This law was recommended and advanced by the NC Child Fatality Task Force. These types of laws exist in every state (some are "safe haven" laws), and although they vary they are all designed to provide a safe alternative for a desperate parent of a newborn who may be tempted to engage in actions harmful to the infant. The 2001 Safe Surrender law altered some provisions in the NC Juvenile Code as well as some criminal law provisions to decriminalize abandonment of a newborn infant under certain circumstances and to modify some procedures involving abandoned newborns. In recent years the Child Fatality Task Force, with input from experts in juvenile law, examined the Safe Surrender law and developed these recommended changes to strengthen the law.[35]

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

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

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

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

These recommendations to strengthen the safe surrender law have been recommended by the CFTF before and were addressed in proposed legislation. Most recently, HB 473 was introduced in 2021 and received a favorable report in the Committee on Children, Families, and Aging, a favorable report from the Health and Rules Committees, and went on to pass the House unanimously. The bill was then sent to the Senate Rules Committee but did not receive a hearing.

[35] For more information on CFTF work on Infant Safe Surrender that led to these recommendations, see the 2018 CFTF Annual Report.

Strengthen North Carolina's Child Passenger Safety Laws to Address Best Practices for Safety

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

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

From 2017 through 2021 more than 400 children age 0 to 17 died in motor vehicle accidents in North Carolina and many more were severely injured. Proper use and placement of the right kind of child passenger safety seat (car seats and booster seats) to suit various stages of child growth and development can impact whether a child suffers injury or death in the event of a motor vehicle crash.

According to data presented to the Task Force by the NC Department of Transportation, many motor vehicle-related child deaths in NC occur in circumstances where a child is completely unrestrained. Data also shows deaths of young children who were riding in the front seat and of young children who were restrained only by a seat belt and not a child restraint system – neither of which reflects best practices for safety.[36]

North Carolina's child passenger safety law differs from the best practice recommendations of the American Academy of Pediatrics and the National Highway Traffic Safety Administration. Evidence shows that children are more likely to ride in the recommended type of child restraint when their state's law includes wording that follows best practice recommendations.[37]

The Child Fatality Task Force identified three areas of North Carolina's child passenger safety law that could be strengthened to better address best practice recommendations for safety that are based on research. The "best practices" noted below are reflected in the American Academy of Pediatrics (AAP) Policy Statement from 2018.[38]

In studying this topic, the Task Force received input from North Carolina experts in child passenger safety, including experts from the University of North Carolina Highway Safety Research Center and the Occupant Protection Task Force of the Governor's Highway Safety Program. These experts provided valuable data and perspective that went beyond the AAP guidelines to inform the development of these recommendations. In addition, research into other states' child passenger safety laws, especially in nearby states, helped to inform these recommendations.

[36] Data presented to the Unintentional Death Prevention Committee of the Task Force by a representative from the NC Department of Transportation.
[37] Benedetti, Klinich, Manary, Flannagan, Predictors of restraint use among child occupants, Traffic Injury Prevention, Volume 18, 2017, Issue 8, published June 23, 2017.
[38] Dennis R. Durbin, Benjamin D. Hoffman, COUNCIL ON INJURY, VIOLENCE, AND POISON PREVENTION, Phyllis F. Agran, Sarah A. Denny, Michael Hirsh, Brian Johnston, Lois K. Lee, Kathy Monroe, Judy Schaechter, Milton Tenenbein, Mark R. Zonfrillo, Kyran Quinlan; Child Passenger Safety. Pediatrics November 2018; 142 (5): e20182460. 10.1542/peds.2018-2460

Young children riding in rear seat instead of front seat

Current law in North Carolina only requires that children under age 5 and less than 40 pounds ride in the back seat: *"In vehicles 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."*[39] Best practice is that children should ride in the back seat until they are 13 years old, and nearby states such as Virginia, Tennessee, and South Carolina require riding in the rear seat (with some exceptions) for children under age 8. The Task Force is recommending that North Carolina's law require children under age 8 to be properly restrained in the rear seat of a vehicle when the vehicle has a passenger side front air bag and has an available rear seat.

Rear-facing seats for infants and toddlers

Best practice for infants and toddlers is that they ride in a rear-facing seat as long as possible according to the height and weight requirements for their car seat. North Carolina law does not explicitly address infants and toddlers riding in rear-facing seats. What NC law says is that children must be *"properly secured in a weight-appropriate child passenger restraint system."* Since certain systems are designed for rear-facing use with size requirements, the NC law only implicitly requires rear-facing seats for infants and toddlers.

According to the Governors Highway Safety Association, about half of states require children younger than two to be in a rear-facing seat.[40] The Task Force recommendation does not specify a certain age because to do so could prompt a child to be moved prior to reaching the limits on a particular seat which is not best practice.

The Task Force recommendation seeks to explicitly use wording about rear-facing seats by modifying North Carolina's law to say that a child must be properly secured in a weight and height-appropriate child passenger restraint system according to manufacturer instructions, including instructions for the use of rear-facing restraint systems for infants and toddlers.

Booster seats and restraints for older kids

Seat belts are designed to fit adults. Booster seats position kids so that the seat belt fits properly – with a lap belt low on the hips and a shoulder belt across the collarbone. Best practice is for children to be in a booster seat until an adult belt fits properly without the booster seat.

North Carolina law says: *"A child less than eight years of age and less than 80 pounds in weight shall be properly secured in a weight-appropriate child passenger restraint system."* It does not address the transition from booster seat to adult seat belt according to proper fitting of the adult seat belt.

Some states have laws that address transitioning from a booster seat to an adult seat belt; such laws may address age or size and may address outgrowing a seat according to the manufacturer's instructions. In developing a recommendation to address this transition, the Unintentional Death Prevention Committee considered information that technically, a child may have an adult belt fit them correctly well before they outgrow the maximum size requirements for the booster. The committee also learned from experts that referencing a child's height is more relevant than weight when it comes to proper fitting of an adult seat belt, and that 57 inches tall is an appropriate height to reference.

In some states, the law specifically articulates the proper fitting of an adult seat belt. For example, South Carolina's law is as follows:

A child at least eight years of age or at least fifty-seven inches tall may be restrained by an adult safety seat belt if the child can be secured properly by an adult safety seat belt. A child is properly secured by an adult safety seat belt if:

(a) the lap belt fits across the child's thighs and hips and not across the abdomen;

(b) the shoulder belt crosses the center of the child's chest and not the neck; and

(c) the child is able to sit with his back straight against the vehicle seat back cushion with his knees bent over the vehicle's seat edge without slouching.[41]

The Task Force is recommending a modification of North Carolina's law to require a child to be properly secured in a weight-appropriate child passenger restraint system until the child is four feet nine inches tall (57 inches) and the adult seat belt fits properly without a booster seat (with the law to describe proper fitting of an adult seat belt).

[39] NCG.S. 20-137.1.
[40] See: www.ghsa.org/state-laws/issues/Child%20Passenger%20Safety
[41] S.C. Ann. Section 56-5-6410 (A)(4).

Enable Comprehensive Toxicology Testing in Child Deaths

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

For the second year in a row, the State Child Fatality Prevention Team recommended to the Task Force efforts to enable the Medical Examiner (ME) to conduct comprehensive toxicology testing in all ME jurisdiction child deaths. (The following information was provided by the Office of the Chief Medical Examiner.)

Currently, the NC Office of the Chief Medical Examiner does not have the necessary resources to conduct comprehensive toxicology screening in all child deaths under their jurisdiction; only certain cases get comprehensive screening. In fact, our state does less toxicology testing on children with an established cause of death than any other state. Cases where comprehensive toxicology is not conducted are limited to the testing for alcohol, and other volatiles, and no screening for the presence of drugs or other foreign substances is conducted. Without comprehensive toxicology testing on certain case types, there may be missed opportunities to determine contributing factors to a fatality.

Expanding comprehensive toxicology testing to more case types for the pediatric population can identify information related to a death that could help to explain more about the circumstances that may be relevant to inform strategies for the prevention of deaths and injuries. For example, comprehensive testing would reveal whether there were drugs in the bloodstream of a young driver, a drowning victim, or an active shooter killed by law enforcement. (Funding needs are $550,000 in nonrecurring funds and $110,000 in recurring funds.)

Expand Programs to Prevent Harm to Infants and Youth Caused by Tobacco/Nicotine Use

Recommendation: ENDORSE an appropriation of $17 million in recurring **funds for programs to prevent tobacco/nicotine use** and encourage cessation by youth and to prevent harms to infants and children caused by tobacco/nicotine use.

A recent student survey showed that about one in four North Carolina high school students use e-cigarettes,[42] which can contain high doses of nicotine available in thousands of flavors attractive to youth. Nicotine is highly addictive and can harm adolescent brain development; tobacco product use in any form, including e-cigarettes, is unsafe for youth.[43]

[42] According to the 2021 Youth Risk Behavior Surveillance System survey from the U.S. Centers for Disease Control and Prevention, data presented to the Task Force by the NC Department of Public Instruction in December, 2022.
[43] U.S. Centers for Disease Control and Prevention.

Nicotine is also toxic to developing fetuses and impairs fetal brain and lung development; tobacco use during pregnancy is associated with leading causes of infant death.[44] Maternal use of electronic products, even without co-use of cigarettes or other combustible tobacco products, is associated with a more than 12% increase in preterm birth and more than 10% increase in low birth weight,[45] both of which are leading causes of infant death.

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

North Carolina's spending on tobacco use prevention has drastically decreased since 2012/2013, despite receiving an average of $149,825,874 per year since 2001 from the Tobacco Master Settlement Agreement. Since that time, use of e-cigarettes by youth has increased dramatically.

Require Lifeguards at Children's Day Camps Offering Time in the Water

Recommendation: ENDORSE **legislation requiring lifeguards at children's day camps** that offer time in the water.

From 2016 through 2020, there were more than 120 drowning deaths in North Carolina for children ages 0 to 17 and many more near-drownings requiring medical attention.[46] Drowning is one of the leading causes of unintentional injury death among children.

Currently there is no law or rule in North Carolina addressing water safety at all children's day camps that offer time in the water and there is no regulatory structure in North Carolina that addresses or has the authority to address water safety requirements at all day camps. Evidence is clear that lifeguards provide an important layer of protection to prevent drowning,[47] and when a children's day camp offers water activities, the presence of certified lifeguards would provide protection to help prevent drownings and near-drownings.

[44] University of North Carolina Collaborative for Maternal and Infant Health (which has provided presentations to the Task Force in recent years related to the impact of tobacco and nicotine use on fetal and infant health).
[45] Regan AK. Adverse Birth Outcomes Associated With Prepregnancy and Prenatal Electronic Cigarette Use. Obstet Gynecol 2021; 00:1–10.
[46] Data sourced from the Division of Public Health, Department of Health and Human Services.
[47] Information about the effectiveness of lifeguards as a drowning prevention strategy was shared with the Unintentional Death Prevention Committee of the Child Fatality Task Force by Stephen Marshall, PhD, Professor, Department of Epidemiology, UNC Gillings School of Global Public Health, and Director, UNC Injury Prevention Research Center.

Child Fatality Task Force Contact Information & Leadership Structure

Leadership

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Committee Leadership

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

Co-Chairs

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

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

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

Co-Chairs

Belinda Pettiford, MPH – Section Chief for Women, Infant, and Community Wellness in the NC Division of Public Health, Department of Health and Human Services

Sarah Verbiest, MSW, MPH, DrPH – Executive Director, Collaborative for Maternal and Infant Health in the UNC School of Medicine and Director, Jordan Institute for Families in the UNC School of Social Work

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

Co-Chairs

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

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

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Representative Steve Tyson
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Representative Diane Wheatley
NC House of Representatives

Representative Donna White
NC House of Representatives

* This list reflects membership as it was at the conclusion of the 2022-2023 study cycle.