State CFPT Child Fatality Recommendations
Child Fatality Reviews with Dates of Death: 2020

Firearm Safety and Storage Education and Continued Awareness in Prevention of Firearm Related Deaths

A. Background

1. Over the years of 2019 to 2021, there have been a total of 239 firearm related child fatalities (55 in 2019, 100 in 2020, and 114 in 2021) in North Carolina. Consistent with prior years, the use of firearms continues to be a significant ongoing issue among child deaths. To address this continuing concern, prioritization of ongoing training and safety initiatives need to be of utmost focus for the safety of our youth.

B. Recommendations

1. The State Child Fatality Prevention Team supports ongoing statewide prioritization of firearm safe storage education and continued awareness as well as statewide focus on gun safety issues with the goal of preventing firearm deaths and injuries while continuing to strive to have timely data to inform, improve, and provide an educational foundation.

2. The State Child Fatality Prevention team recommends that the NC Child Fatality Task Force encourage continued statewide prioritized work on prevention of firearm related deaths due to gun violence through gun safety, education, and awareness as well as a focus on social drivers that relate to gun deaths.

Child Abuse and Neglect Reporting Education and Awareness

A. Background

1. With a collective priority to keep children safe, reviews completed by the State Child Fatality Prevention Team and DSS Intensive Reviews continues to show child abuse and neglect reporting challenges state-wide. Although the Child Fatality Task Force has addressed the topic of child abuse and neglect reporting, child fatality data demonstrates this continues to be an ongoing issue.

2. The CFPT staff designates subcategories to child homicides to assist in identifying clear trends among the ages/manners. Homicide by Parent or Caregiver is a subset of homicides defined as a death that is the direct result of the action(s) of the person(s) responsible for the child's well-being at the time of the death. This classification is assigned by the NC Child Fatality Prevention Team based on the injuries and circumstances of the death.

a. Over the years of 2019 to 2021, there have been a total of 64 child fatalities categorized as Homicide by Parent or Caregiver (19 in 2019, 27 in 2020, and 18 in 2021) in North Carolina.

B. Recommendations

1. The State Child Fatality Prevention Team recommends continued work within the NC Child Fatality Task Force Intentional Death Prevention Committee focused on education and awareness around child abuse and neglect reporting statewide emphasizing mandated reporting responsibilities and how to access resources about reporting.

Family Support

A. Background

1. Infant/child development, the importance of understanding the needs of youth, and the impacts of social determinants of health were at the forefront of many discussions among Local Child Fatality Prevention Teams. Through reviews of 2020 child fatalities, The State Child Fatality Prevention Team continues to identify needs for collaboration and support of programs providing support to assure expecting parents and their children are receiving appropriate services. This includes a family's health and well-being needs prenatally, and throughout infancy. 1,778 childcare programs are projected to close due to federal funding ending in NC in 2024, making it even harder for families to find safe, nurturing, childcare options.

B. Recommendation

1. Infant/child development, the importance of understanding the needs of youth, and the impacts of social determinants of health were at the forefront of many discussions among The State Child Fatality Prevention Team and Local Child Fatality Prevention Teams. Through reviews of 2020 child fatalities. The State Child Fatality Prevention Team continues to identify needs for collaboration and support of programs providing support to assure children and their families are receiving appropriate services, including a family's health and well-being needs prenatally, and throughout infancy.

Maternal Substance Use

A. The case reviews of the NC Child Fatality Review Team have clearly demonstrated over years the association of maternal substance use in the home with infant and young child fatalities. The national data on child fatalities demonstrates the same. In these cases, findings include toxic exposure of unsupervised infants and children to dangerous substances. Data in NC and nationally demonstrates that maternal substance use has increased dramatically over the past 10 years. The COVID era brought with it a rise in a higher potency synthetic opioid, Fentanyl. Fentanyl is responsible for the 81% rise of national perinatal overdose deaths from 2017 to 2020.[1] National mortality data (deaths/100,000) clearly demonstrates that presence of fentanyl in a home increases the risk of child exposure to this potentially lethal substance.[2] For adolescents aged 15 to 19

years, the mortality rate between 2018 and 2021 increased 289.8%, from 1.67 (95% CI, 1.49-1.84) to 6.51 (95% CI, 6.16-6.85) (P < .001 for trend); among children aged 0 to 4 years, it increased 590.0%, from 0.10 (95% CI, 0.06-0.15) to 0.69 (95% CI, 0.57-0.81) (P < .001 for trend). In 2021, fentanyl was responsible for the deaths of 40 infants and 93 children aged 1 to 4 years. [3]

1. The Division of Health Benefits (DHB) has funded a statewide quality improvement project, Comprehensively Lessening Opioid Use Disorder Impact on Moms and Babies (clOUDi) executed by the Perinatal Quality Collaborative of North Carolina. clOUDi has sought to improve outcomes for mothers and infants dealing with opioid use disorder. PQCNC data being tracked across 63 hospitals suggests that at least 1% of North Carolina births are complicated by opioid use disorder. At project start, only 7% of PQCNC participating hospitals conducted evidence based verbal screening for perinatal substance use. Over the course of this project, that rate has increased to 85% of PQCNC participating hospitals conducting evidence based verbal screening. This was a vital first step as not only did our screening rates increase, but so did subsequent referrals for a Plan of Safe Care and for treatment referral for all positive perinatal substance use screens. Initial rates of referral to treatment were 20% and have increased to 50% for pregnant patients with a positive substance use verbal screen. Plan of Safe Care referrals have increased from 40% to 80% of infants with a diagnosis of neonatal abstinence syndrome (NAS). These increases in screening, referral to treatment and offering of Plans of Safe Care are critical components in reducing the impact of maternal substance use on maternal and infant deaths.

2. A last element of the DHB funded PQCNC clOUDi initiative has been leading birthing facilities in the creation of distribution of naloxone to all patients being discharged after the delivery of an infant. Certainly, mothers with substance use disorder are at risk for needing naloxone, but children are at risk for toxic exposure and naloxone is the antidote. Additionally, there may be other family members using opioids, and there may be medicinal fentanyl in homes in the form of fentanyl patches. Naloxone distribution is an important strategy for treating opioid overdoses.

B. Recommendation

1. Continue to support evidence based, universal perinatal substance use screening. Consistent use of evidence-based screening tools to identify risk factors that affect maternal morbidity and mortality risks, like screening for perinatal substance use, decreases poor outcomes. At the system level there must be consistent and supportive mechanisms for health care provider teams to effectively implement screening. This requires organizational and payer commitment to recognize the time and competing screening requirements during perinatal care. Our NC Medicaid has addressed this through increased Medicaid reimbursement for conducting high risk prenatal screening, which includes both mental health and substance use screening tools. The state has increased reimbursement from only one screen now up to three screens to be conducted during a pregnancy.

2. Continue to deliver evidence-based trauma informed care. While pregnant individuals are perhaps at a point in their lives where they are most highly motivated to seek treatment to protect the health of their children and improve their own quality of life, they face numerous barriers.[2-4] Pregnant individuals are less likely to engage in prenatal care or treatment in environments where substance use during pregnancy is criminalized, largely out of fear of losing custody of their children, making such laws counterproductive to supporting maternal and child health. In seeking to create an environment in which patients are willing to disclose drug use, transparent conversations about the role of social services, maximizing the opportunity to keep a family intact and full disclosure and consent for drug testing needs to be a standard.

3. Continue to prioritize support of North Carolina Perinatal Substance Use Disorder programs and identify and support expansion in areas where needed. North Carolina is the home of nationally recognized outpatient and residential perinatal substance use treatment programs. Patients and care providers need increased capacity and access to such programs. Comprehensive, integrated care is the national standard model for treating perinatal substance use disorder as this model promotes non-fragmented access to perinatal care and concurrent substance use disorder treatment, pharmacological therapy, pediatric care, and case management with safeguards against discrimination. [4]

4. Improve access to Naloxone. The highest risk for perinatal opioid overdose spikes at 7-12 months postpartum. Increasing access of Naloxone not only in the communities most at risk for overdose, but also in the public. This is proven to decrease the stigma associated with substance use disorder as well as the stigma surrounding access to treatment. Reducing stigma will bring more of those impacted by opioid use disorder into treatment. Naloxone/Narcan saves lives.

5. Building strategies and systems that address child safety begins prenatally. Child fatalities related to unintentional overdose and/or poisoning are devastating to the families affected and to our communities at large. Building pathways for shared education, collaboration, and community created strategies to address this should be created and sustained. We need to make non-stigmatizing efforts to alert mothers to the risks posed to their children when opioids are in the home. A practical step would be considering that when a Plan of Safe Care is activated after the birth of a child at risk for NAS, the family receives a pack and play (safe sleep surface), naloxone nasal spray and a small lock box for illicit or licit drugs in the home.

Safe Sleep Initiatives

A. Background

1. Local Child Fatality Prevention Teams noted unsafe sleep system environments at the time of death as the number one issue identified among their reviews. Unsafe sleep environments for infants includes circumstances of co-sleeping, unsafe sleep locations

(such as couch, adult bed, and among adult pillows, etc.), and a crowded sleep space. There continues to be significant numbers of infant deaths in unsafe sleep environment across the state.

2. Consistent and targeted messaging is needed state-wide highlighting education for parents and caregivers of infants on awareness of safe sleep practices and risks of unsafe sleep environments, including co-sleeping. Education and evidence driven strategies need to begin prenatally and continue once the child is born with tailored messaging considering languages, cultures, and educational needs.

B. Recommendation

1. Local Child Fatality Prevention Teams recommend prioritized ongoing support and resources for a statewide campaign to promote and implement evidence-based strategies and consistent messaging prenatally and throughout the child's first year to reduce unsafe sleep environments at the time of death.

Identified Trend: Affordable and Accessible Childcare

A. Background

1. In instances where a full recommendation could not be identified, noting trends allows recognition of the issue and the ability to bring the topic to the CFTF without a full recommendation. Often caregivers are being used during nontraditional work times reflective of a parent working late shifts and are part of the parents' friend/family circle. In these cases, child decedents share common threads of inattentive caregivers.

B. Affordable and Accessible Childcare

1. The State Child Fatality Prevention Team identifies the need to study the accessibility of adequate childcare in emergency situations. Improving availability to quality childcare centers with staff trained in appropriate management of children's care, growth, and development with a focus on affordable cost and reasonable location is essential for improved safety of all children.

References – Maternal Substance Use

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2. Frazer Z, McConnell K, Jansson LM. Treatment for substance use disorders in pregnant women: motivators and barriers. Drug Alcohol Depen. 2019;205(107652).

3. Paris R, Herriott AL, Maru M, Hacking SE, Sommer AR. Secrecy versus disclosure: women with substance use disorders share experiences in help seeking during pregnancy. Matern Child Health J. 2020;24(11):1396-1403.

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