Child Fatality Task Force
Meeting Minutes

Type of Meeting: Intentional Death Prevention Committee	**Date: November 14, 2022**	
Facilitators: Whitney Belich and Jennie Kristiansen, Committee Co-Chairs	**Time called to order:** Approximately 1:00 pm	**Location:** Virtual via WebEx Webinar Platform
The slides presented in this meeting were combined into one deck titled "Combined slides ID meeting 11-14-22" which can be found on the CFTF website here: https://webservices.ncleg.gov/ViewDocSiteFile/72424.		
Committee Members in Attendance: Anne Geissinger, Whitney Belich, Billy Lassiter, Danielle Carman, Catherine Joyner, Lisa Cauley, Dr. Dana Hagele, Lorrie Dollar, Dr. Ellen Essick, Jenifer Simone, Jennie Kristiansen, Jill Cox, Kerry Young, Sarah Kirkman, Christy Malott, Melea Rose-Waters, Dr. Molly Berkoff, Murphy Jones, Dr. Natasha Scott, Dr. Nicole Lawrence, Rachel Zarcone, Trishana Jones, Emi Wyble, Sarah Owens Weeks (left early) **Committee Members Absent:** Rep. Donna White, Rep. Kristin Baker, Brett Loftis, Sen. Don Davis, Glorina Stallworth, Michelle Zechmann		
Jennie Kristiansen welcomed everyone. Self-introductions of committee members were made.		
Approval of minutes from previous meeting dated October 17, 2022		
The minutes were sent out and posted in advance of the meeting. Jill Cox made a motion to approve the minutes, Dr. Ellen Essick seconded the motion. The motion was approved with no opposing votes or abstentions voiced.		
A moment of silence was taken to honor those children who have died since the committee last met		
Jennie Kristiansen provided an overview of the day's agenda.		
Topic #1: Overview of the NC Child Fatality Prevention System and CFTF recommendations to strengthen it		
Topic presenter: Kella Hatcher, JD, CFTF Executive Director		
Online presentation: Slides # 3 – 20 of combined slide deck.		
Scope of presentation: Kella Hatcher explained that these recommendations have come through the Perinatal Health Committee, but the CFTF Executive Committee wanted to ensure that each of the committees were familiar with this body of work. She shared background information on Task Force efforts to strengthen the Child Fatality Prevention (CFP) System that have been underway since 2018. She explained the main components of the CFP System, how it is structured, and the process of information that makes its way through the system. She explained how the Task Force efforts to strengthen the system have progressed and the various stakeholders, experts, and organizations who have been involved. She shared some of the challenges and strengths of NC's CFP System and the composition of local review teams. Kella Hatcher shared common themes that have been repeated from stakeholders regarding the changes that are needed to strengthen the system, and she explained the set of recommendations the Task Force developed and recommended in prior years to strengthen the CFP System. She shared an example of what could be done with data if NC joined the National Fatality Review Case Reporting System.		
Main topics covered during questions or discussion related to presentation: (While there was no discussion immediately following this presentation, the following discussion on this topic took place after the presentation on topic #2). There was discussion about how federal laws will have to be taken into consideration in any CFP		

System restructuring. There was also discussion about how the current CFP system has a disconnect between what happens in CCPTs/Intensive Reviews and Task Force work, and DSS was invited to present on this topic in order to create more of a connection.

Kella Hatcher invited committee members who have served on a local review team to comment on any aspects of the Child Fatality Prevention System Strengthening work.

Christy Malott who chairs Durham's CCPT/CFPT said that it's encouraging to see the efforts to improve the system and that the problem areas have been accurately identified. She said that review work is challenging and stressful for busy people who have to review one case after another then go back to their jobs. She said support at the state level is so important, and team members have to feel like this work is worth their time and that recommendations are going somewhere given the heartbreak they experience in doing the reviews. Teams want to know that someone at the state level is hearing them and can help them implement some recommendations. Their team identified unsafe sleep as a significant issue, and due to Christy's work on this ID committee she thought to contact Kella Hatcher who put her in touch with Safe Sleep NC, who helped and put her in touch with another local team doing work in this area. This led to some specific recommendations and a specific subcommittee to work on this issue.

Dr. Natasha Scott, who has also served on a local team, commented that like Christy, she feels review team work is heartbreaking and challenging for teams. She went on to give an example of an issue their team identified that needed to be addressed, and how addressing that issue made a difference. Jennie Kristiansen said her experience chairing a local team has been similar to what Christy and Natasha said. Their county is much smaller, which makes it hard to see trends, so having a better tool for seeing what's happening across the state will be a big benefit.

Whitney Belich commented on the importance of being able to identify trends through better data collection to be able to react appropriately. Kathy Stone commented on how their improved tracking system for intensive reviews can help with trends. Kella Hatcher commented that the deaths being reviewed as an intensive review are a very small subcategory of all deaths; they are only those deaths that have touched the CPS system within 12 months prior to death.

Actions taken: None, for information only.

Topic #2: Overview of DSS Intensive Reviews (State Child Fatality Review Team), Community Child Protection Teams, and data related to child maltreatment deaths

Topic presenter: Kathy Stone, Section Chief for Safety and Prevention Services, Division of Social Services, Child Welfare, NC DHHS

Online presentation: Slides #21 – 37 of combined slide deck.

Scope of presentation: Kathy Stone first commented on the fact that they are working on a better tracking system for recommendations made from Intensive Reviews. She explained what Community Child Protection Teams are and that they also serve as Citizen Review Panels. She explained State Child Fatality Review Team work (Intensive Reviews). Kathy Stone shared data on the number of notifications of fatalities they get and the proportion of those that are screened in for an intensive review (about 50%), and data showing the trend for screened-in reports in recent years. She showed a map of the number of fatalities screened in for an intensive review by county, and a graph of data showing the age groups for screened-in reviews with ages 0 to 3 being by far the most common age group. A graph was shown related to the race of a child whose case received an intensive review, showing that a disproportionate number of cases were Black children. A graph was shown with data on the sex of the child receiving an intensive review, with more male children reviewed. A chart was shared to illustrate the manner of death from the OCME for cases receiving an intensive review, and the largest

category was undetermined – many of which relate to unsafe sleep. Another chart was shared showing causes of death in reviewed cases (data on cause following the review), with the largest category being related to unsafe sleep. Kathy Stone shared a graph showing contributing factors identified in reviews, such as a substance affected infant, mother who was drug positive at birth, household member with mental health condition, or history of domestic violence in household. Next, she shared common systems issues that are identified through intensive reviews:

- (Problems with) reporting of maltreatment – (others knew there was or may be an issue but did not report)
- Incidents of substance affected infants and co-sleeping, there is a need for community shared understanding and messaging on the risk of death
- Providers should address the impact of substance use and mental health on parenting
- Mental health and substance use practitioners and Child Welfare should work in partnership to ensure child safety
- Untreated trauma impacts parenting
- (Challenges with) availability of Child Welfare Workforce/Staffing
- Identification of Sentinel Injuries—(need to disseminate better information on this so that such injuries can be recognized as potential abuse)

Kathy Stone then shared information on prevention initiatives that have related to issues identified by Intensive Reviews.

Main topics covered during questions or discussion related to presentation: none on this presentation.

Actions taken: None, information only.

Topic #3: Further discussion of carry-over and State Team recommendation on comprehensive toxicology testing in Medical Examiner child deaths

Topic presenters: Dr. Michelle Aurelius, Chief Medical Examiner, NC Division of Public Health; **Dr. Sandra Bishop-Freeman,** Chief Toxicologist, Office of the Chief Medical Examiner, NC Division of Public Health

Online presentation: Slide # 38 – 46 of combined slide deck.

Scope of presentation: Whitney Belich explained this carry-over topic and the 2022 recommendation which was: *SUPPORT an appropriation of $550,000 in nonrecurring funds and $110,000 in recurring funds to enable the OCME to conduct comprehensive toxicology testing in all Medical Examiner jurisdiction child deaths.* She explained how today's presentation is intended to help us better understand what is gained from comprehensive toxicology testing (the OCME currently does not have the resources to do comprehensive testing in all child deaths). Dr. Aurelius shared information on the extent of toxicology testing done in NC on child deaths compared to other states who do expanded testing; NC is the only state she is aware of that does such limited testing. She then talked about why expanded toxicology testing is important and provided some examples. Understanding the toxicology contributes to understanding the death for prevention purposes. Dr. Sandra Bishop-Freeman then shared more case examples where additional toxicology testing would make a difference. Dr. Aurelius emphasized how more information means more power for prevention, but also, parents of these children need more information to get answers about their child's death.

Main topics covered during questions or discussion related to presentation: Whitney Belich said that the committee can now discuss whether they would like to advance this recommendation. Kerry Young said that during the last meeting there was a question about how this type of testing relates to the national data system being recommended (as part of CFP system strengthening); she looked into this and there are three different sections in the national data system that relate to toxicology issues. Without this toxicology information, those data fields in the national system would be left blank. Whitney Belich commented on how this expanded toxicology dovetails with the goal in CFP system strengthening of having more information. Kerry Young

commented that in her experience with child death review team work, it's common for teams to not have enough information, and yet in this instance the information could be available if testing was done and could be very helpful. There was also a question about whether this testing could be done in a timely way if resources were available, and Dr. Aurelius said yes.
Actions taken: Whitney Belich made a motion to repeat this 2022 recommendation (in italics above), Danielle Carman seconded the motion. Jennie Kristiansen commented that increased information about suicides in particular would be helpful. A vote was taken with results in favor of the motion, with no opposing votes or abstentions voiced.
Announcements: Kella Hatcher said that this is the last meeting of this committee until next fall; the remaining ID committee recommendations will go to the full CFTF at their December meeting when the 2023 Action Agenda of recommendations will be finalized. Whitney Belich said that with respect to the child abuse and neglect reporting training for law enforcement that this committee has worked on, those training materials have been completed, and she talked about the training. They have done their first delivery of the training to the instructors which went very well; this will be part of a mandatory in-service training for all law enforcement. She thanked DSS and this committee for their work on this.
Adjourned at 2:47.