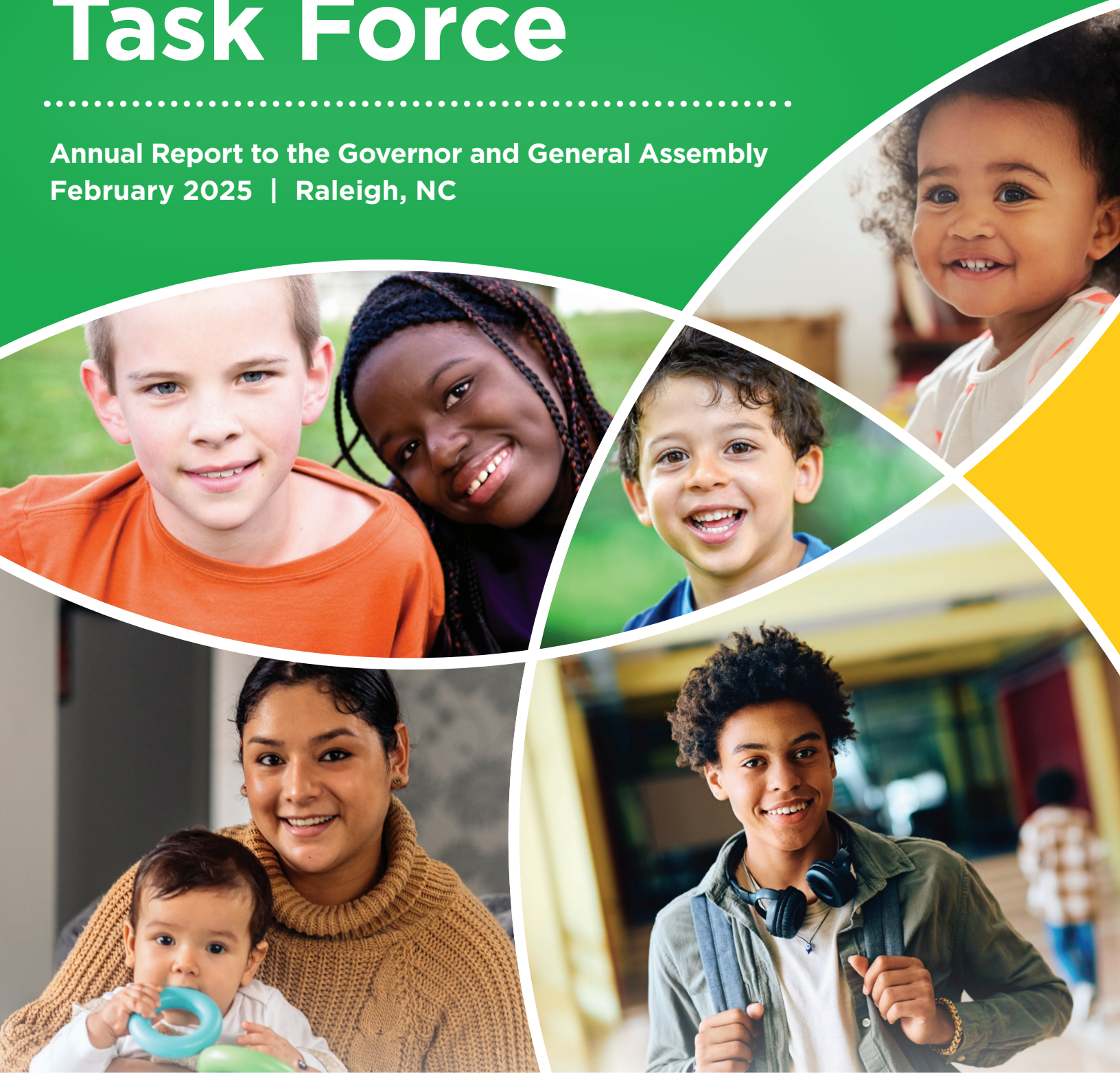
NORTH CAROLINA

Child Fatality Task Force

Annual Report to the Governor and General Assembly
February 2025 | Raleigh, NC



Our **Children** *Our* **Future** *Our* **Responsibility**

FEBRUARY 2025

The Honorable Josh Stein, 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 North Carolina Child Fatality Task Force. The children of North Carolina are precious, and our state's future depends on their well-being! We take very seriously our responsibility to protect children through the work of our Task Force to better understand child deaths and to develop thoughtful, evidence-driven policy recommendations to prevent child deaths and support child well-being.

This year's report contains recommendations for changes in law and state funding that address a range of issues that threaten child health and safety including:

- The easy access that many children and youth have to firearms, which contributes to alarming rates of firearm deaths and injuries among kids
- A child care system in crisis and in need of state support to ensure that children can access quality care without threatening their families' economic security
- High infant mortality rates and disparity ratios that could be improved through expanding doula support during pregnancy, childbirth, and postpartum
- The easy access that youth have to vape products and intoxicating cannabis products and the shortcomings in North Carolina's laws to protect youth from harm related to these products
- The need to prioritize robust statewide efforts to educate parents and caregivers about unsafe sleep practices that lead to more than 100 infant deaths in our state each year
- Numbers of school nurses, social workers, counselors and psychologists that fall far short of what's needed to effectively support youth mental and physical health including the prevention of youth suicide
- The addictive algorithms of social media that contribute to our youth mental health crisis
- Child passenger safety laws that are outdated and do not support best practices in child safety

Since 1991, the Child Fatality Task Force has been shining a light on the causes of child deaths and the changes that need to be made to our laws and systems to protect children. Over more than three decades, the Task Force has seen a great deal of progress when state leaders respond to Task Force recommendations by passing laws and appropriating funds to make North Carolina a better place for our children. The last long session, 2023, was an especially good year for seeing Task Force recommendations advance. We hope that for this 2025 long session, we will continue to see great progress with changes in laws and funding to protect North Carolina's children and our state's future.

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 2025 Action Agenda

The Task Force approved 11 legislative recommendations for inclusion on its 2025 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 also included 3 administrative (non-legislative) efforts on its 2025 Action Agenda that involve further study and collaboration on issues of interest to the Task Force.

KEY STATS
Meetings took place between 8/22/24 and 12/10/24
8 committee meetings
3 meetings of the full Task Force
Presentations and panel participation by 35+ experts and leaders
More than 25 topics addressed

Highlights of 2023 Child Death Data Facts & Trends

In 2023, 1,436 North Carolina children ages 17 or younger died. The rate of child deaths overall in 2023 was 61.5 per 100,000 NC children ages 0 to 17, which is a slight decrease from the 2022 rate of 63.3, and the second highest rate recorded since 2009.

The 2023 infant mortality rate remained largely unchanged. At 6.9 deaths per 1,000 births, this rate has fluctuated only slightly in recent years and remained stagnant with no significant changes since 2010. Prematurity/low birthweight and birth defects were the leading causes of infant death in North Carolina in 2023, which was typical in other years as well. Infant deaths (under age 1) accounted for 58% of all child deaths in 2023.

Racial/ethnic disparities in death rates persist. From 2014 to 2023, Non-Hispanic Black & American Indian children consistently had higher mortality rates compared to other racial/ethnic groups. In 2023, disparity ratios worsened for infants, with Black infants dying at rates three times higher than white infants.

Comparing North Carolina to other states: In 2023, North Carolina had the 10th highest infant mortality rate among states (in 2022 North Carolina had the 11th highest rate), and for deaths of children ages 1 to 17, North Carolina had the 17th highest rate (in 2022 North Carolina had the 12th highest rate).

Looking at death rates for age groups beyond infants for 2023: rates for children ages 1 to 4 decreased after reaching an unusually high rate in 2022, while death rates for older teens ages 15 to 17 went back up after seeing a bit of a decrease between 2021 and 2022. Over the last decade from 2014 to 2023, children aged 15 to 17 experienced the largest statistically significant increase in mortality (+38%), moving from a rate of 39.6 per 100,000 children ages 15 to 17 to a rate of 54.6. Rates for age groups 5 to 9 and 10 to 14 did not change significantly in 2023 compared to 2022, however rates in these age groups also increased between 2014 and 2023.

In 2023, among non-infant children in the broad age group 1 to 17, injuries were the leading cause of death, accounting for 55% of deaths among this age group. The top four leading causes of death in this age group were motor vehicle-related injuries (16.3%), unintentional injuries *unrelated* to motor vehicle accidents (16.1%), homicides (12.8%), and suicides (9.7%). Closely behind were cancer (9.5%), then birth defects (6.4%), and diseases of the heart (2.6%).

Looking at more narrow age groups, for 5- to 9-year-olds and 10- to 14-year-olds the leading cause of death in 2023 was cancer, followed by motor vehicle injuries, then unintentional injuries unrelated to motor vehicles. For the 10- to 14-year-olds, the fourth and fifth leading causes were homicide and suicide. For older teens ages 15 to 17, motor vehicle injuries were the leading cause of death, closely followed by homicide and suicide. For small children ages 1 to 4, unintentional injuries unrelated to motor vehicles accounted for 27% of deaths while birth defects accounted for 9% and homicide and motor vehicle injuries each accounted for 8.6% of deaths.

The youth suicide rate has increased over the past 20 years in both the US and North Carolina. The rate in 2023 was 5.4 deaths per 100,000 NC children ages 10 to 17, whereas the rate in 2004 was 2.5. Older teens ages 15 to 17 comprised about three-fourths of suicide deaths. **Firearms were the most common among lethal means for youth suicide in 2023, used in 44% of youth suicides in 2023.**

The homicide rate for NC children has remained high but was slightly lower in 2023 compared to the prior 3 years. Over the last decade, homicide rates have increased. Older teens ages 15 to 17 consistently account for the largest proportion of homicide deaths, comprising 53% of all child homicides in 2023. **The large increase in child homicide rates over the last decade is associated with a substantial increase in firearm-related homicides** (+200%), which rose from a rate of 0.9 in 2014 to a rate of 2.7 in 2023. Seventy-two percent of all child homicides in 2023 involved firearms. Among teens ages 15 to 17, 94% of homicides were firearm related.

Rates of accidental poisoning remained high in 2023 and the increase in accidental poisonings has contributed to the increase in unintentional injury rates overall. In 2014 there were 6 child deaths related to unintentional poisoning and in 2023 there were 31 deaths. Among the 2023 accidental poisoning deaths, 61% involved teens ages 15 to 17. Most (87%) noted fentanyl in the literal cause(s) of death (either alone or in combination with other drugs).

In 2023, the rate of child deaths from medical conditions or illnesses returned to typical rates after seeing an increase in 2022. In 2023, these deaths accounted for 18.5% of all child deaths. One recent change is that in 2022, Covid-19 was recorded as the underlying cause of death for 17 children ages 1 to 17 in contrast to **2023, when there were 3 deaths from Covid-19**.

2025 Legislative Recommendations

2025 LEGISLATIVE RECOMMENDATIONS (ABBREVIATED)	HIGHLIGHTED DATA & INFORMATION SUPPORTING RECOMMENDATIONS
Raise the legal age for sale of tobacco products in NC from 18 to 21 to align with federal law and require licensing of tobacco product retailers	• More than one in five North Carolina high school students vape and for 12th graders it's one in three; one in 10 middle schoolers are vaping. • Nicotine is highly addictive, and the harmful impacts of nicotine products and vaping can be significant for youth and can include death. • North Carolina is one of only seven states that do not align with the federal minimum age of 21 for sales of tobacco products, and one of nine states that do not require tobacco retailers to obtain a license or permit. • Licensing of tobacco retailers is an evidence-based measure to reduce tobacco sales to youth that has been supported by the CDC and the U.S. Surgeon General.
Support legislation to prevent child and youth access to intoxicating cannabis	• After federal laws changed to legalize hemp there was a surge in the manufacture and sale of intoxicating cannabis products. • NC retailers, especially vape shops, sell these products in various forms like candy, baked goods, snack foods, beverages, and vape pens and they often have packaging that appeals to children or mimics popular snacks. • There is no minimum age for the purchase of these products in North Carolina and no safety regulations are in place for packaging. • Since 2019, and following this surge in the availability of intoxicating cannabis, the rate of emergency department visits in North Carolina for ingestion of intoxicating cannabis among children and youth ages 17 and under increased more than 600 percent; among older teens, the rate increased more than 1000 percent.
Expansion of funding for the early child care system, including subsidies	• The child care industry is in crisis: teachers can't afford to stay in the profession; parents struggle to find and pay for quality care; child care programs struggle to stay open; and employers are losing workers. • Ensuring access to affordable, quality child care is a recognized strategy to support child well-being, including the prevention of child maltreatment and death. • Child care subsidies help families afford child care, but only about 15% of eligible North Carolina families get child care subsidies.
Recurring funding for more school nurses, social workers, counselors & psychologists	• 18% of North Carolina high school students have seriously considered suicide while 39% report feeling sad or hopeless. • These school professionals play a critical role in supporting student mental health through identification of needs, counseling, and making connections to needed services. • Numbers of these professionals in NC are far below national recommendations, e.g., NC needs almost four times the number of school social workers it now has to meet those recommendations.
Legislation to address addictive algorithms in social media	• One-quarter of adolescents perceive that they are "moderately" or "severely" addicted to social media and teens spend an average of 3.5 hours a day on social media. • Frequent social media use may be associated with changes in the developing brain; youth who spend more than three hours a day on social media face double the risk of poor mental health. • Many experts and national organizations are expressing concern and issuing advisories about the impact of social media on youth mental health.

Recurring funding for the NC S.A.F.E. firearm safe storage education and awareness campaign **Legislation to strengthen the law addressing safe storage of firearms to protect minors**	• Rates of firearm deaths and injuries to children and youth increased significantly in recent years; firearms are the lethal means used in most youth suicides and homicides in North Carolina. • From 2019 to 2023, nearly 500 North Carolina children ages 17 years and younger died from firearm injuries, which is double the number of firearm deaths from the prior five-year period. • 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; 30 percent of middle and high school students say they could get and be ready to fire a loaded gun in an hour without an adult's permission. • NC's current child access prevention law applies only to a gun owner or one possessing a gun who "resides in the same premises as a minor," whereas the recommended change from the Task Force would no longer limit application of the law to those who *reside with* a minor.
Funding to support the prevention of infant deaths due to unsafe sleep	• Each year more than 100 infants in North Carolina lose their lives in unsafe sleep environments, and unsafe sleep is a leading cause of infant death in North Carolina. • State and local teams that review child deaths repeatedly identify the need to prioritize statewide efforts to educate parents, caregivers, health care providers, and others to prevent these deaths. • Over 120,000 babies are born each year in North Carolina and sustained funding for prevention is essential to ensure that these babies are not lost to unsafe sleep.
Funding to enable Medicaid reimbursement of doula services	• North Carolina's infant mortality rate is the 10th highest among states. • Disparities persist. For example, the mortality rate of Black infants is 3 times the rate of white infants. • Doula services are known to produce better birth outcomes and reduce disparities, and Medicaid funding is needed to expand the use of doulas.
Legislation addressing Fetal & Infant Mortality Reviews (FIMRs)	• Fetal & Infant Mortality Reviews seek to improve systems that can prevent future fetal and infant deaths and reduce disparities. • There are approximately 146 FIMR programs in the U.S. but only one in NC, whose ability to do effective reviews is limited without FIMR legislation in NC. • FIMR legislation recommended by the Task Force would enable and support the information access and protection for FIMR teams needed for them to perform effective reviews and encourage the establishment of more FIMRs in NC.
Legislation to strengthen child passenger safety laws	• Motor vehicle injuries are a leading cause of death among children. • 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 a crash. • North Carolina's child passenger safety laws differ from the best practice recommendations of the American Academy of Pediatrics, and 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 to save young children's lives.
2024 ADMINISTRATIVE EFFORTS ON 3 TOPICS FOR FURTHER STUDY AND COLLABORATION (NON-LEGISLATIVE)	• Licensing of Certified Professional Midwives • Paid Family and Medical Leave Insurance • The prevention of fentanyl-related child deaths

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 is connected to the broader statewide Child Fatality Prevention System created in 1991, which has an overarching purpose of preventing child deaths and child maltreatment. This system also has multidisciplinary teams across the state that review individual cases of child deaths in an effort to better understand these deaths and identify and address gaps or deficiencies in systems that can prevent child deaths and maltreatment. The Task Force is focused on data and policy and does not conduct individual case reviews.

The Task Force studies and reports on child death data and learns about prevention strategies. It hears presentations from a variety of experts and leaders about data as well as evidence-driven prevention strategies and receives information from teams who review child deaths. In 2024, the Task Force also heard from individuals about their personal experiences related to certain topics of study, like a mom who lost her stepson to vaping, and the owner of a child care center who opened centers after her own personal struggles accessing child care but is now challenged to keep her doors open.

The Task Force is required to submit an annual report to the governor and General Assembly containing recommendations to address changes in law, policy, or rules that the Task Force has determined will promote the safety and well-being of children.

Task Force recommendations and efforts have helped to advance many laws and initiatives since its 1991 creation. An updated list of legislative and other accomplishments by the Task Force through the years is available on the Child Fatality Task Force website. Information on recent accomplishments and initiatives since 2020 is also included below in this report.

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 who are each assigned to one of the three committees, as well as volunteers with subject matter expertise in the committee's area of focus. Committee meetings are typically virtual, and the meetings of the full Task Force are typically in-person but with a virtual participation option for members unable to attend in person.

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

The **Perinatal Health Committee** studies issues surrounding infant mortality by 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, firearms, and more.

Committee recommendations only become Task Force recommendations once approved by the full Task Force. The Task Force and its committees meet between legislative sessions to determine an "Action Agenda" of recommendations for the coming year and refers to this set of meetings as a "study cycle." In a year leading up to a long session, like 2024, the Task Force is challenged to fit a study cycle into a short period of time from the end of one session to the beginning of the next. Nevertheless, during its most recent study cycle from August 22, 2024, to December 10, 2024, the Task Force had 11 meetings, including eight committee meetings and three meetings of the full Task Force.

Over the course of these 11 meetings, the Task Force addressed more than 25 topics. More than 35 experts and leaders made presentations or served as panelists in meetings of the Task Force and its committees to educate about topics relevant to Task Force work. 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 during the study cycle that took place from August through December of 2024

General Topics

- Updates from the 2024 legislative session
- 2022 child death data highlights and trends
- Recommendations from the State Child Fatality Prevention Team
- Data from the 2023 Youth Risk Behavior Survey

Preventing infant deaths and promoting healthy birth outcomes

- Expanding Medicaid coverage of doulas
- Fetal and Infant Mortality Reviews
- Licensure of Certified Professional Midwives
- Infant deaths related to unsafe sleep and related prevention efforts, including prevention efforts in Western North Carolina following Hurricane Helene
- Data and prevention efforts surrounding congenital syphilis
- Data and prevention efforts surrounding maternal mental health and substance use

Suicide prevention and supporting youth mental health

- Information surrounding school nurses, social workers, counselors & psychologists, including the role of these professionals in disaster relief following Hurricane Helene
- Impacts and policy efforts related to youth's use of social media
- Updates on school mental health plans

Preventing firearm deaths and injuries

- Data on firearm deaths of children and youth
- Updates on the NC S.A.F.E. statewide firearm safe storage initiative
- North Carolina's firearm child access prevention law

Preventing child abuse and neglect and supporting child and family well-being

- North Carolina's child care crisis and how access to child care prevents child deaths and maltreatment
- Paid Family and Medical Leave Insurance & information gathered about business perspectives

Homicide and Violence Prevention

- Data surrounding child homicides in North Carolina
- Child homicides in the context of child welfare in North Carolina
- Recognized violence prevention strategies

Harmful substances

- Fentanyl poisoning among children and youth; prevention strategies
- Vaping among youth; age restrictions and enforcement
- Child and youth access to intoxicating cannabis products and associated health and safety risks
- Perspective from Alcohol Law Enforcement related to youth vaping and access to intoxicating cannabis products

Motor vehicle safety

- Data on motor vehicle deaths and injuries to children and youth
- Child passenger safety laws and best practices

NOTE about 2023 child death data:

The Task Force typically examines in its meetings the most recent child death and infant mortality data released by the NC State Center for Health Statistics. For the meetings that took place in the recent study cycle that ended on December 10, 2024, the most recent data (from 2023) was not yet available for examination. However, that data is now available and has been 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 and community programs with a range of expertise:

- Professor of **Pediatrics, UNC School of Medicine** & Medical Director, **Child Medical Evaluation Program**
- Director of Prevention, **NC Coalition Against Domestic Violence**
- Child Abuse and Juvenile Court Resource Prosecutor, **NC Conference of District Attorneys**
- Perinatal Epidemiologist, **Title V Office, Division of Public Health**, NC Department of Health and Human Services (NCDHHS)
- Coordinator for **Safe Kids NC Coalition of Western North Carolina**
- Lead Nurse, **Durham Public Schools**

- Section Chief, **Women, Infant, and Community Wellness Section, Division of Public Health**, NCDHHS
- Director, **Chatham County Department of Social Services**
- Director, **Division of Child Development and Early Education**, NCDHHS
- Owner & Operator, **Little Believers Academy Child Care Centers**
- Section Chief, **NC Healthy Schools & Specialized Instructional Support, Academic Standards, NC Department of Public Instruction**
- Epidemiologist, **Office of the Chief Medical Examiner**, Division of Public Health, NCDHHS
- Volunteer with the **NC Alliance for Health**
- Deputy Secretary for Juvenile Justice and Delinquency Prevention, **Division of Juvenile Justice and Delinquency Prevention**, NC Department of Public Safety
- Assistant Director, **UNC Collaborative for Maternal & Infant Health**
- Substance Use Epidemiologist, **Injury and Violence Prevention Branch, Division of Public Health**, NCDHHS
- Owner, **Birth Sisters Doula Services**
- Director of the **Jordan Institute for Families, UNC School of Social Work & Executive Director, UNC Collaborative for Maternal and Infant Health**
- Epidemiologist and Unit Manager, Injury Epidemiology, **Surveillance and Informatics Unit (ESI), Injury and Violence Prevention Branch, Division of Public Health**, NCDHHS
- Special Agent in Charge, **Alcohol Law Enforcement Division, North Carolina Department of Public Safety**
- Medical Director, **HIV/STI & Director, Field Services Unit, Division of Public Health**, NCDHHS
- Executive Director, **NC Harm Reduction Coalition**
- Section Chief for **Safety, Child Welfare, Division of Social Services**, NCDHHS
- Director of Strategic Health and Opioid Initiatives, **NC Association of County Commissioners**
- Executive Director and Co-Founder, **Young People's Alliance**
- Branch Head, **Maternal Health Branch, Women, Infant, and Community Wellness Section, Division of Public Health**, NCDHHS
- President of the North Carolina Chapter of the **Association of Certified Professional Midwives**
- Social/Clinical Researcher, **Office of the Chief Medical Examiner**, Division of Public Health, NCDHHS
- Research Instructor, **UNC Department of Psychiatry** and Program Director, **NC-PAL and NC MATTERS**
- **Albemarle Maternal Mental Health Coalition**, The Villages of North Carolina, Founder, **Postpartum Support International** Area Coordinator
- Clinical Associate Professor, **Behavioral Health Springboard, School of Social Work**, University of North Carolina at Chapel Hill, **NC Pregnancy and Opioid Exposure Project**
- Community Health Educator, **Guilford County Health Department** & Coordinator of **Guilford County FIMR team**
- State Traffic Safety Engineer, **Traffic Safety Unit, NC Department of Transportation** Division of Mobility and Safety
- Youth Engagement Coordinator, **Tobacco Prevention and Control Branch, Division of Public Health**, NCDHHS
- NC State Opioid Treatment Authority (SOTA) Coordinator, **Addictions and Management Operations Section, Division of Mental Health, Developmental Disabilities and Substance Use Services**, NCDHHS

Task Force data and recommendations are widely shared, creating more awareness about safety issues and more prevention opportunities

Widespread sharing about Task Force work leads to increased awareness about causes and trends in child deaths and strategies to prevent child deaths, which helps to advance the Task Force goal to prevent child deaths and support child well-being.

Data and evidence studied by the Task Force are 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 and reports is regularly referenced by individuals and organizations external to the Task Force whose work relates to child well-being.

Task Force data and recommendations are also frequently reported by news organizations who attend Task Force meetings and/or follow Task Force work. The Task Force sometimes issues press releases, as it did in 2024 to announce submission of its annual report and to highlight recently released child death data. In 2024, there were dozens of media stories that were either focused on Task Force work or noted Task Force work as part of a story.

The work of the Task Force, its recommendations, and the supporting data that led to the recommendations are 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.

Changes Coming to Child Fatality Task Force Process & Reporting

As explained in this report on page 14-15, in 2023 the General Assembly passed legislation that addressed Task Force recommendations to strengthen the statewide Child Fatality Prevention System.[1] This legislation will, once it becomes effective, formalize some of the current functioning of the Task Force with respect to its committee structure, leadership, policies and procedures, and in these respects will not significantly change Task Force functioning.

However, the legislation puts new requirements on the Task Force related to studying data, such as aggregate data that will be collected from local child death review teams, and requires the Task Force to report on the functioning of the whole Child Fatality Prevention System (not just the Task Force) based on information received from a new State Office of Child Fatality Prevention (State Office). It also requires Task Force reports to be submitted to additional state leaders.

The timeline for the legislative changes was modified in 2024 legislation. While parts of the legislation were set to go into effect January 1, 2025, and other parts July 1, 2025, Session Law 2024-57 provides for a six-month extension on all effective dates and timelines related to the implementation of the 2023 legislative changes to the child fatality prevention system. Among the impacts of these modifications are that the State Office of Child Fatality Prevention is required to be operational by July 1, 2025 (instead of January 1, 2025) to serve local child death review teams that will at that time have a modified structure with different requirements, and local review teams will begin utilizing a new data system for reporting information learned from reviews by January 1, 2026 (instead of July 1, 2025). Modifications to Task Force requirements will be effective July 1, 2025.[2]

Extending Our Thanks!

MANY THANKS TO TASK FORCE MEMBERS, CONTRIBUTING EXPERTS, AND COMMUNITY VOLUNTEERS WHO DEVOTED THEIR TIME AND EXPERTISE TO TASK FORCE WORK DURING THE PAST YEAR. THEIR EFFORTS AND COMMITMENT TO PROTECTING THE CHILDREN OF NORTH CAROLINA ARE REFLECTED IN THE 2025 ACTION AGENDA AND THE RECENT ACCOMPLISHMENTS CONTAINED IN THIS REPORT.

[1] Section 9H.15 of Session Law 2023-134.

[2] Technical error in effective dates: Section 9H.15 of the 2023 Appropriations Act, which enacted changes to the Child Fatality Prevention System, incorporated the language of HB 862 from the 2023 legislative session but incorrectly stated timelines from HB 862 for effective dates of certain provisions. Section 9H.15.(i) of the Appropriations Act left out language from line 18 of page 16 of HB 862v2 that makes January 1, 2025, the effective date for a large part of the bill, instead making those provisions effective when the Appropriations Act becomes law which was October 3rd, 2023. This error was corrected in a technical corrections bill, Session Law 2024-1. Session Law 2024-57 then extended all effective dates and timelines by 6 months.

RECENT CHILD FATALITY TASK FORCE
Accomplishments, Progress & Initiatives (2020 to 2024)

As noted earlier, the Task Force has seen a great deal of success since its 1991 creation in advancing policies that save children's lives and support their well-being, and the list of accomplishments since then can be found here. What follows are highlights of progress made in various areas of Task Force work since 2020, both legislative and non-legislative. More detail on these areas of work can be found in CFTF Annual Reports from these prior years.

From 2020 to 2024, Task Force work was impacted by some unusual circumstances, the most extraordinary of which was the COVID-19 pandemic. In 2020, the Task Force, like most organizations, had to significantly alter its work and lower expectations for advancing legislative recommendations because the General Assembly's work was understandably focused on pandemic issues. In 2024, several Task Force recommendations included state funding, but the General Assembly did not pass a comprehensive budget bill in 2024 as it typically does, instead passing a "mini" budget bill that addressed only limited items. Despite these challenges, a big-picture overview of Task Force work since 2020 shows a great deal of progress.

New Laws and Funding 2020 - 2024

New law requiring suicide prevention training for school personnel and a risk referral protocol in schools. With youth suicide rates on the rise, the CFTF recommended required suicide prevention training for school personnel and a risk referral protocol in schools. In 2020, a bill passed that addressed this recommendation as part of a larger student mental health bill that requires a school-based mental health plan and mental health training on topics beyond suicide prevention. (The Task Force was only involved in the suicide prevention aspect of this mental health bill.)

Firearm Safe Storage Initiative: Firearm injury is a leading cause of death for North Carolina children and youth, with death and injury rates doubling in recent years. A law to require a statewide firearm safety initiative that was recommended by the Task Force passed in 2023 but did not include funding. Progress on firearm safety was nevertheless made when the Department of Public Safety (DPS) identified temporary funding to implement a safe storage media campaign, "NC S.A.F.E.," which was informed by CFTF work and launched in the spring of 2023. This work has continued with temporary funding, and for 2025 the Task Force is recommending recurring state funding to sustain these efforts being led by DPS.

New laws and funding to strengthen the statewide Child Fatality Prevention System: A multi-year effort by the Task Force to strengthen the Child Fatality Prevention System was addressed through legislation that became law via the 2023 Appropriations Act. The goal of the Task Force was to streamline, modernize, and restructure the system to make it more efficient and effective at doing the very difficult work of understanding child deaths and maltreatment to prevent future deaths and support child well-being. Among many important and significant changes being made, use of a new data system and support from a new State Office of Child Fatality Prevention will enable information being learned

from local child fatality reviews across the state to inform the work of the Task Force. Most changes to the system that are required by the legislation will begin July 1, 2025 (see page 13 explaining the applicable law and timeline). For more information on changes resulting from the legislation, see page 8 of the 2024 CFTF Annual Report. For more information on the reasons behind the recommended changes, see pages 22-25 of the 2023 CFTF Annual Report.

New laws to strengthen infant safe surrender: Infant safe surrender or safe haven laws exist in every state and are 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. In 2001 North Carolina passed S.L. 2001-291 known by many as the "Infant Safe Surrender" law. This law was originally recommended and advanced by the NC Child Fatality Task Force. The Child Fatality Task Force, with input from experts in juvenile law, re-examined the Safe Surrender law and developed recommended changes to strengthen the law to make it more likely the law would be used in circumstances as intended to protect a newborn from harm. These recommendations were addressed in legislation that became law in 2023.

Funding for more school nurses, social workers, counselors and psychologists: With increases in youth suicides and a crisis in youth mental health, an important area of prevention identified and recommended by the CFTF and others has been to increase the number of school nurses, social workers, counselors, and psychologists to work toward meeting nationally recommended ratios because NC currently falls far short of meeting national recommendations. The 2021 Appropriations Act included funds for an additional 115 school psychologists. The 2021 COVID-19 Response and Relief Act, which appropriated federal funds, included funding to be used for contracted services for school nurses, counselors, social workers, and psychologists to provide additional physical and mental health support services for students in response to COVID-19, however this funding was time-limited and not recurring. The 2023 Appropriation Act included nonrecurring funding for about 120 more of these positions. For 2025, the CFTF is again recommending recurring state funding to increase the numbers of these positions because North Carolina continues to fall far short of meeting recommended ratios.

Funding to prevent sleep-related infant deaths: North Carolina loses more than 100 infants each year who die in unsafe sleep environments and the CFTF has recommended increased funding for initiatives to prevent these deaths. The 2023 Appropriations Act included $250K in additional nonrecurring funding for this purpose, and for 2025 the Task Force is recommending that this funding be recurring to protect the 120,000 infants born in North Carolina each year.

Funds to enable comprehensive toxicology testing: The 2023 Appropriations Act addressed a recommendation of the Task Force for state funds to enable comprehensive toxicology testing in all medical examiner jurisdiction child deaths. Without this funding, the North Carolina Office of the Chief Medical Examiner lacked the resources to do comprehensive toxicology testing on certain types of cases, which could result in missed opportunities to determine contributing factors to a fatality.

Medicaid funding for group prenatal care incentives and to increase maternity provider reimbursement rates: North Carolina's infant mortality rate has remained stubbornly high and disparities have persisted. The CFTF and others identified incentivizing group prenatal care and increasing the Medicaid reimbursement rate for maternity care providers (to attract and retain providers) as important strategies in preventing infant deaths and decreasing disparities, and recommended Medicaid funding to support these strategies. This funding was included in legislation that became law in 2023.

Funding for programs to prevent harms from tobacco and nicotine use: Vaping among youth and young adults is common, and can have harmful effects to the developing adolescent brain and developing fetuses. The Task Force has repeatedly endorsed the efforts of others seeking recurring funds to prevent harm to youth and infants caused by tobacco and nicotine use. The 2021 and 2023 Appropriations Acts included nonrecurring funds for this purpose, although the amount was less than what was sought.

Temporary funding for the child care crisis: For both 2024 and 2025, the Task Force has recommended state funding to address the child care crisis. (Many organizations have been advocating for child care funding.) In what was called a "mini" budget bill in 2024, there was temporary funding for child care center grants, intended to help child care centers who were soon losing their federal funding. Reports were that this amount fell short of what was needed for the first half of the fiscal year to help child care centers keep their doors open.

Events and Initiatives (Non-Legislative Efforts) 2020 - 2024

Statewide Child Fatality Prevention System Summit: In March of 2023, a full-day child fatality prevention system summit was held at the Friday Center in Chapel Hill, hosted by UNC's Jordan Institute for Families in partnership with the NC Department of Health and Human Services. The summit's planning committee was led by the Executive Director of the Child Fatality Task Force and the Director of the Jordan Institute, and the committee included a variety of individuals with significant roles in the Child Fatality Prevention System. The summit brought together professionals from across the state who work in the CFP system to learn from experts, including four national experts, and one another about ways to optimize their work to prevent child deaths and strategies to take care of themselves. There were about 235 participants, with almost 70% participating in-person and the rest participating in morning plenary sessions virtually. Participant evaluations of the summit were overwhelmingly positive.

Strengthening child abuse and neglect reporting education: A multi-year administrative item on the Task Force agenda was to strengthen education and awareness surrounding child abuse and neglect (CAN) recognition and reporting not only for the public, but also for law enforcement professionals, medical professionals, and school professionals. A great deal of progress was made in this area through collaborative efforts that were initiated by the Task Force:

- **Strengthening existing resources:** In 2020, the NCDHHS Division of Social Services (DSS) improved the quality and quantity of the web content on this topic as well as the web navigation and searchability related to the topic of child abuse and neglect reporting on the DSS and NCDHHS website. Also, the NCDHHS tool NC Care 360 added information on CAN reporting. Prevent Child Abuse North Carolina (PCANC, now called the Positive Childhood Alliance) updated and strengthened their free online CAN reporting training and made it available in Spanish, and employed numerous online resources and social media tools to disseminate information about CAN reporting, including special efforts made during the pandemic.
- **Training for law enforcement:** In 2021, the Task Force made a request to the NC Justice Academy's Joint In-Service Training Committee to consider strengthening CAN reporting training for law enforcement, and the training committee determined there would be a four-hour juvenile block for law enforcement with at least two hours devoted to this topic. Development of the training was completed in late 2022 after which delivery of the training to all of NC's sworn law enforcement officers began.
- **Training for health care professionals:** Beginning in 2022 and through 2023, collaborative efforts were made to develop training specifically for health care professionals. Those involved in development included: members of the NC Pediatric Society's Committee on Child Abuse and Neglect which includes medical experts in child abuse; experts in child protective services from the NCDHHS Division of Social Services; the Child Abuse Resource Prosecutor with the NC Conference of District Attorneys; the CEO of Prevent Child Abuse NC; and the Child Fatality Task Force Executive Director. Through efforts of the NC Pediatric Society and others, the training began to be delivered to health care professionals in 2024.

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. This recommendation succeeded when the North Carolina Department of Health and Human Services in collaboration with the UNC Suicide Prevention Institute hired a state suicide prevention coordinator in 2023 who works jointly between the two organizations to help coordinate a broad range of suicide prevention work.

Efforts to implement 2023 legislation to strengthen the Child Fatality Prevention System: Following passage of the legislation addressing Task Force recommendations to strengthen the Child Fatality Prevention System, the NC Department of Health and Human Services has undertaken efforts to implement this legislation. The Task Force, through its Executive Director, has been involved in these implementation efforts which continue in 2025.

Strengthening education around the importance of rear seat restraints: One of the Task Force administrative items in 2022 was to encourage efforts by the Governor's Highway Safety Program to strengthen education and awareness among youth about the importance of buckling up in the back seat. The Governor's Highway Safety Program engaged in 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.

NC Medical Journal Article on CFTF: An article on the work of the Child Fatality Task Force was published in the NC Medical Journal in 2022. "The North Carolina Child Fatality Task Force: Advancing Public Policy to Save Children's Lives Since 1991," by Kella Hatcher, Executive Director of the Task Force, appeared in the September issue of the Medical Journal which was focused on improving life expectancy in North Carolina.

Celebrating the 25th anniversary of the Graduated Driver Licensing (GDL) System: In 2022, individuals from several organizations with an interest in motor vehicle safety and teen driving, including the Task Force executive director, came together to organize a celebration of the GDL 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.

Webinars: In 2023 and 2024, the Task Force hosted **webinars open to the public to share the most recent child death and infant mortality data**. These webinars featured a public health epidemiologist sharing highlights of leading causes of death, demographics, and trends so that anyone interested, not just the Task Force, could learn more about child deaths in our state. Many who attended the webinars work in fields where this data is relevant to their work. In 2022, the Task Force Executive Director and Chair collaborated 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.

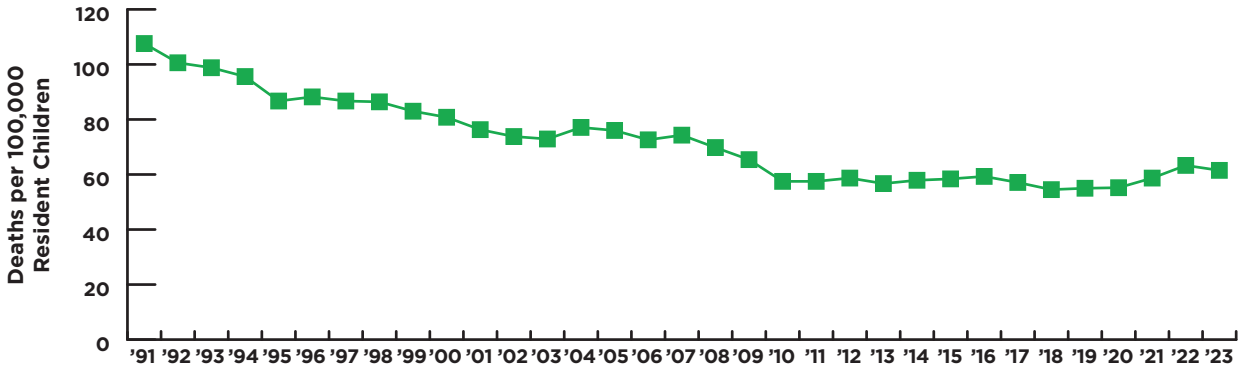
Full Circle: Reports from outside groups that undertook studies originating from Child Fatality Task Force work

- **Perinatal Study Report:** In 2019 the CFTF advanced legislation to require NC DHHS to study the current status of North Carolina delivering hospitals related to capabilities for handling various complexity levels of care for mothers and newborns. As a result of this legislation, a Perinatal Systems of Care Task Force was convened by the North Carolina Institute of Medicine, and a report with recommendations from this group was presented to the Joint Legislative Oversight Committee on Health and Human Services in March 2020.
- **Paid Family Leave Insurance Study:** The Child Fatality Task Force heard from experts about the impacts of paid family leave and paid family leave insurance programs on preventing child maltreatment and supporting child well-being and sought to learn more. A multi-sector group was formed for the purpose of outlining the various issues that a study of paid family leave insurance would need to address to inform North Carolina leaders about this issue. Using the outline created by this group as a framework, faculty at the Duke University Center for Child and Family Policy elected to perform a pro bono study analyzing the costs and benefits of a potential paid family leave insurance program in North Carolina. This study, "Paid Family Leave in North Carolina: an Analysis of Costs and Benefits," was published by Duke University in March 2019 and was presented to the full Task Force in 2020.

2023 Child Death Data

This report was produced by the NCDHHS Division of Public Health - Title V Office
in conjunction with the State Center for Health Statistics.

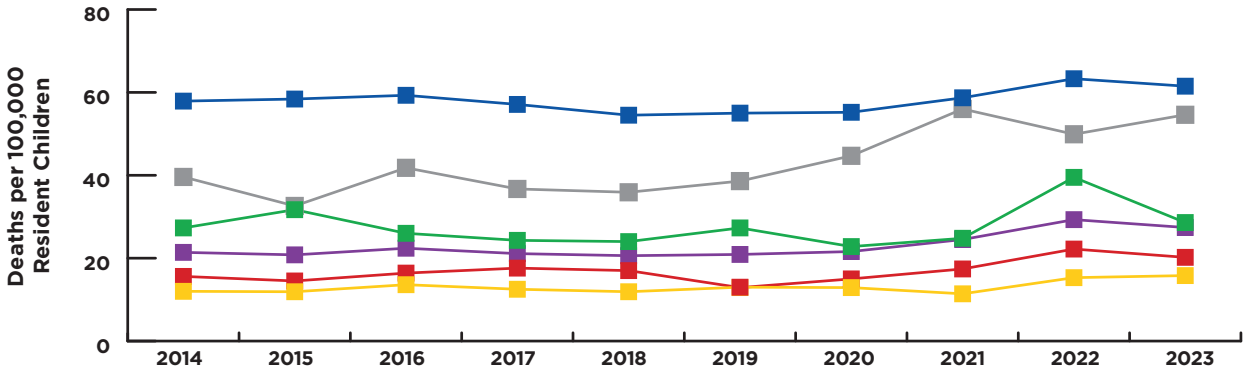
Figure 1. 1991-2023 Trends in North Carolina Resident Child Death Rates Ages Birth Through 17 Years



1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
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

2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
69.8	65.4	57.5	57.5	58.7	56.7	57.9	58.4	59.3	57.1	54.5	55.0	55.2	58.7	63.3	61.5

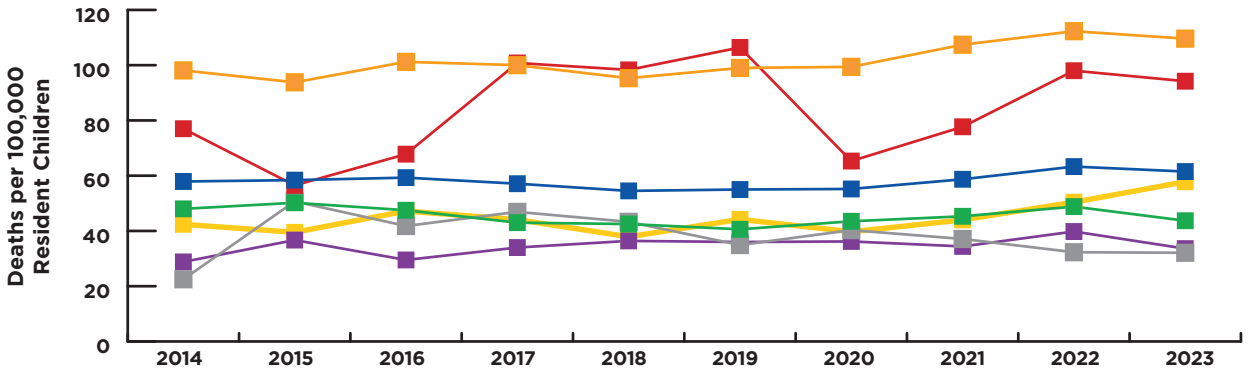
Figure 2. 2014-2023 Trends in North Carolina Resident Child Death Rates† by Age Group



	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Total Ages 0-17	57.9	58.4	59.3	57.1	54.5	55.0	55.2	58.7	63.3	61.5
... Ages 1-4	27.3	31.7	26.0	24.3	24.0	27.3	22.8	24.8	39.5	28.6
... Ages 5-9	12.0	11.9	13.6	12.5	11.9	13.0	12.9	11.4	15.3	15.8
... Ages 10-14	15.6	14.5	16.4	17.6	17.0	12.9	15.0	17.4	22.2	20.2
... Ages 15-17	39.6	32.6	41.8	36.7	35.9	38.6	44.7	56.0	49.9	54.6
... (Excluding Infants) Ages 1-17	21.4	20.8	22.4	21.1	20.6	20.9	21.6	24.5	29.3	27.4

† Child death rates prior to 2023 have been recalculated using the latest available population data

Figure 3. 2014-2023 Trends in North Carolina Resident Child Death Rates† by Race*/Ethnicity, Ages Birth Through 17 Years

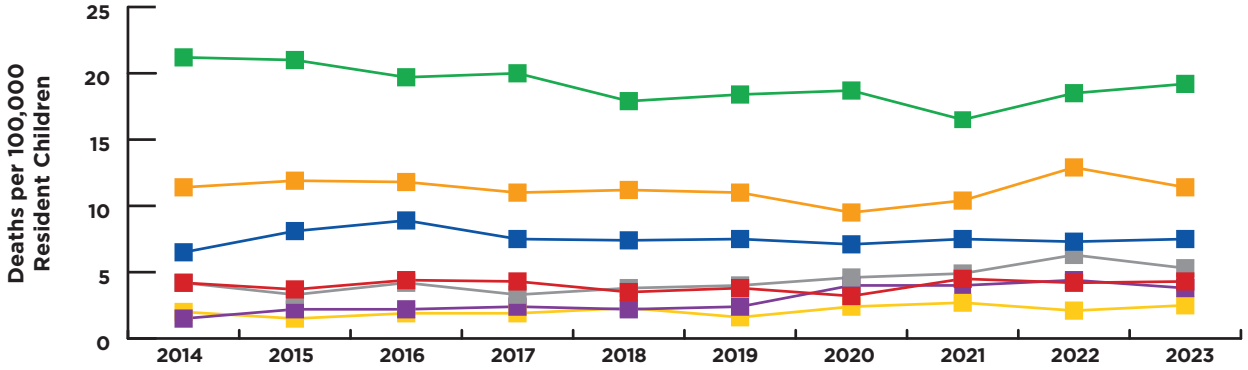


	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Total	57.9	58.4	59.3	57.1	54.5	55	55.2	58.7	63.3	61.5
NH White	48	50.2	47.5	43	42.5	40.6	43.5	45.3	48.8	43.7
NH Black	98.1	93.8	101.2	100	95.3	99	99.4	107.4	112.3	109.6
NH American Indian	77	56.5	67.8	100.8	98.3	106.4	65.3	77.7	98	94.2
NH Asian/Pacific Islander	22.5	50.7	41.8	46.9	43.3	34.9	40.3	37.1	32.3	32.1
NH Multiracial	28.8	36.7	29.5	34	36.4	36	36.2	34.4	39.8	33.6
Hispanic	42.4	39.5	47.2	44.1	37.9	44.2	39.7	44	50.4	57.8

* 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

Figure 4. 2014-2023 Trends in North Carolina Resident Child Death Rates† for Selected Causes of Death, Ages Birth Through 17 Years



	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Birth Defects	6.5	8.1	8.9	7.5	7.4	7.5	7.1	7.5	7.3	7.5
Perinatal Conditions	21.2	21	19.7	20	17.9	18.4	18.7	16.5	18.5	19.2
Medical Conditions/Illnesses	11.4	11.9	11.8	11	11.2	11	9.5	10.4	12.9	11.4
Motor Vehicle Injuries	4.2	3.7	4.4	4.3	3.5	3.8	3.2	4.5	4.2	4.3
Other Unintentional Injuries	4.2	3.3	4.2	3.3	3.8	4	4.6	4.9	6.3	5.3
Homicide	1.5	2.2	2.2	2.4	2.2	2.4	4	4	4.4	3.8
Suicide	2	1.5	1.9	1.9	2.3	1.6	2.4	2.7	2.1	2.5

Table 1. 2023 NC Resident Child Deaths By Age Group & Cause of Death

CAUSE OF DEATH	TOTAL AGES 0-17		AGE GROUP (years)									
			Infants		1-4		5-9		10-14		15-17	
TOTAL DEATHS	**1,436**	**100.0**	**828**		**139**		**101**		**134**		**234**	
Cause of Death Category:	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Perinatal Conditions	**448**	**31.2**	**444**	**99.1**	**3**	**0.7**	**0**	**0.0**	**1**	**0.2**	**0**	**0.0**
... Short Gestation/Low Birthweight	143		143		0		0		0		0	
... Maternal Complications	83		83		0		0		0		0	
... All Other Perinatal Conditions	222		218		3		0		1		0	
Medical Conditions	**266**	**18.5**	**71**	**26.7**	**51**	**19.2**	**53**	**19.9**	**53**	**19.9**	**38**	**14.3**
... Malignant Neoplasms (Cancer)	59		1		8		16		21		13	
... Heart Disease	26		10		5		5		2		4	
... Chronic Lower Respiratory Diseases	5		0		3		1		1		0	
... Septicemia	13		6		2		3		2		0	
... Pneumonia/Influenza	13		5		3		2		3		0	
... Coronavirus Disease (COVID-19)	3		1		1		0		0		1	
... All Other Medical Conditions	147		48		29		26		24		20	
Birth Defects	**176**	**12.3**	**137**	**77.8**	**12**	**6.8**	**10**	**5.7**	**11**	**6.3**	**6**	**3.4**
... Circulatory System	36		27		2		1		3		3	
... Nervous System	31		18		6		3		4		0	
... Respiratory System	10		10		0		0		0		0	
... All Other Birth Defects	99		82		4		6		4		3	
Motor Vehicle Injuries	**101**	**7.0**	**2**	**2.0**	**11**	**10.9**	**13**	**12.9**	**21**	**20.8**	**54**	**53.5**
Other Unintentional Injuries	**124**	**8.6**	**26**	**21.0**	**37**	**29.8**	**12**	**9.7**	**16**	**12.9**	**33**	**26.6**
...Suffocation/Choking/Strangulation	28		20		6		1		1		0	
...Drowning	31		2		14		6		6		3	
...Poisoning	31		3		6		1		2		19	
...Bicycle	0		0		0		0		0		0	
...Firearm	9		0		3		1		1		4	
...Smoke, Fire & Flames	13		0		6		2		3		2	
...All Other Accidental Injuries	12		1		2		1		3		5	
Homicide	**89**	**6.2**	**11**	**12.4**	**11**	**12.4**	**5**	**5.6**	**15**	**16.9**	**47**	**52.8**
... Involving Firearm	64		2		1		2		15		44	
... All Other Homicides	25		9		10		3		0		3	
Suicide	**59**	**4.1**	**0**	**0.0**	**0**	**0.0**	**0**	**0.0**	**14**	**23.7**	**45**	**76.3**
... by Firearm	26		0		0		0		5		21	
... by Hanging	**22**		**0**		**0**		**0**		**8**		**14**	
... by Poisoning	7		0		0		0		1		6	
... All Other Suicides	4		0		0		0		0		4	
Other Injuries Undetermined Manner	**23**	**1.6**	**16**	**69.6**	**3**	**13.0**	**3**	**13.0**	**0**	**0.0**	**1**	**4.3**
... Hanging/Strangulation/Suffocation	12		12		0		0		0		0	
... Poisoning	6		3		2		1		0		0	
... All Other Undetermined Injuries	5		1		1		2		0		1	
Pending/Unknown Causes	**121**	**8.4**	**108**	**89.3**	**8**	**6.6**	**2**	**1.7**	**0**	**0.0**	**3**	**2.5**
All Other Causes of Death	**29**	**2.0**	**13**	**44.8**	**3**	**10.3**	**3**	**10.3**	**3**	**10.3**	**7**	**24.1**

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 SCHS 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.

Table 2. Leading Causes of Child Death by Age Group, NC Residents 2023

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

ALL AGES, 0-17			
Rank	**Cause**	**#**	**%**
1	Conditions originating in the perinatal period	448	31.2%
2	Congenital anomalies (birth defects)	176	12.3%
3	Other Unintentional injuries	124	8.6%
4	Motor vehicle injuries	101	7.0%
5	Homicide	89	6.2%
6	Cancer	59	4.1%
6	Suicide	59	4.1%
8	Diseases of the heart	26	1.8%
9	Pneumonia & influenza	13	0.9%
9	Septicemia	13	0.9%
All other causes (Residual)		328	22.8%
TOTAL DEATHS — ALL CAUSES		1,436	100.0%

AGES 1 TO 17			
Rank	**Cause**	**#**	**%**
1	Motor vehicle injuries	99	16.3%
2	Other Unintentional injuries	98	16.1%
3	Homicide	78	12.8%
4	Suicide	59	9.7%
5	Cancer	58	9.5%
6	Congenital anomalies (birth defects)	39	6.4%
7	Diseases of the heart	16	2.6%
8	Pneumonia & influenza	8	1.3%
9	Septicemia	7	1.2%
10	Cerebrovascular disease	6	1.0%
All other causes (Residual)		140	23%
TOTAL DEATHS — ALL CAUSES		608	100.0%

INFANTS			
Rank	**Cause**	**#**	**%**
1	Short gestation - low birthweight	138	16.7%
2	Congenital anomalies (birth defects)	137	16.5%
3	Maternal complications of pregnancy	51	6.2%
4	Respiratory distress	41	5.0%
5	Bacterial sepsis	26	3.1%
5	Other unintentional injuries	26	3.1%
7	Complications of placenta, cord, and membranes	20	2.4%
8	Atelectasis	14	1.7%
9	Neonatal hemorrhage	13	1.6%
10	SIDS	12	1.4%
All other causes (Residual)		350	42.3%
TOTAL DEATHS — ALL CAUSES		828	100.0%

AGES 1 TO 4			
Rank	**Cause**	**#**	**%**
1	Other Unintentional injuries	37	26.6%
2	Congenital anomalies (birth defects)	12	8.6%
3	Homicide	11	7.9%
3	Motor vehicle injuries	11	7.9%
5	Cancer	8	5.8%
6	Diseases of the heart	5	3.6%
7	Acute bronchitis & bronchiolitis	3	2.2%
8	Chronic lower respiratory diseases	3	2.2%
8	Conditions originating in the perinatal period	3	2.2%
8	Pneumonia & influenza	3	2.2%
All other causes (Residual)		43	30.9%
TOTAL DEATHS — ALL CAUSES		139	100.0%

AGES 5 TO 9			
Rank	**Cause**	**#**	**%**
1	Cancer	16	15.8%
2	Motor vehicle injuries	13	12.9%
3	Other Unintentional injuries	12	11.9%
4	Congenital anomalies (birth defects)	10	9.9%
5	Diseases of the heart	5	5.0%
5	Homicide	5	5.0%
7	Septicemia	3	3.0%
8	Meningitis	2	2.0%
8	Pneumonia & influenza	2	2.0%
10	Anemias	1	1.0%
10	Cerebrovascular disease	1	1.0%
10	Chronic lower respiratory diseases	1	1.0%
10	Complications of medical and surgical care	1	1.0%
10	Nutritional deficiencies	1	1.0%
All other causes (Residual)		28	27.7%
TOTAL DEATHS — ALL CAUSES		101	100.0%

AGES 10 TO 14			
Rank	**Cause**	**#**	**%**
1	Cancer	21	15.7%
1	Motor vehicle injuries	21	15.7%
3	Other Unintentional injuries	16	11.9%
4	Homicide	15	11.2%
5	Suicide	14	10.4%
6	Congenital anomalies (birth defects)	11	8.2%
7	Pneumonia & influenza	3	2.2%
8	Cerebrovascular disease	2	1.5%
8	Diseases of the heart	2	1.5%
8	Septicemia	2	1.5%
All other causes (Residual)		27	20.1%
TOTAL DEATHS — ALL CAUSES		134	100.0%

AGES 15 TO 17			
Rank	**Cause**	**#**	**%**
1	Motor vehicle injuries	54	23.1%
2	Homicide	47	20.1%
3	Suicide	45	19.2%
4	Other Unintentional injuries	33	14.1%
5	Cancer	13	5.6%
6	Congenital anomalies (birth defects)	6	2.6%
7	Diseases of the heart	4	1.7%
8	Cerebrovascular disease	2	0.9%
8	Pregnancy, childbirth, and puerperium	2	0.9%
10	COVID-19	1	0.4%
10	Diabetes mellitus	1	0.4%
All other causes (Residual)		26	11.1%
TOTAL DEATHS — ALL CAUSES		234	100.0%

NORTH CAROLINA CHILD FATALITY TASK FORCE
2025 Action Agenda

[An explanation of each agenda item is included later in this report]

Legislative "support" items receive the highest level of support from the CFTF.

Legislative "endorse" items are led by others and endorsed by the CFTF.

"Administrative" items are currently non-legislative items sought to be further studied by the Task Force and/or advanced by the CFTF through collaborative, non-legislative efforts.

Legislative Recommendations

Recommendations to prevent harm from tobacco, nicotine, and intoxicating cannabis products

Endorse legislation to **raise the legal age for sale of tobacco products in NC from 18 to 21 to align with federal law; legislation to include licensing of tobacco product retailers** and appropriate enforcement measures.

Support legislation to **prevent child and youth access to intoxicating cannabis** by: prohibiting the sale or distribution of intoxicating cannabis or hemp products to those under 21; implementing regulations for the packaging of such products to require appropriate warnings, child-resistant packaging, and to prohibit packaging that is attractive to children and youth; requiring permitting for retailers who sell intoxicating cannabis or hemp products; and prohibiting those under 21 from entering vape shops.

Recommendations to promote healthy birth outcomes, prevent deaths of infants and young children, and promote infant and child well-being

Support recurring funding to enable **Medicaid reimbursement of doula services** throughout pregnancy and the postpartum period and to provide support services and technical assistance for the doula population.

Support **Fetal and Infant Mortality Review (FIMR) legislation** to include the following components: providing for the authority to implement a FIMR program and to access necessary medical records; to provide for immunity (protections) for reviewers and review materials; and for FIMRs to include best practices of family interviews and community action teams.

Support the extension of additional **funding to prevent sleep-related infant deaths** by continuing the $250K appropriated for fiscal years 23-24 and 24-25 for this purpose to be appropriated in 2025 as recurring.

Support growth and **expansion of investments in the early child care system**, including increases for child care subsidies.

Recommendations to prevent youth suicide, promote youth mental health, and prevent firearm deaths and injuries

Support **recurring funds to increase the 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.

Endorse **legislation that addresses addictive algorithms in social media that harm children**.

Support **recurring funding of $2.16 million for the NC S.A.F.E. Campaign** that educates about firearm safe storage.

Support legislation **changing the current law addressing safe storage of firearms to protect minors** to remove language from N.C.G.S. 14-315.1(a) that says "resides in the same premises as a minor."

Recommendation to prevent deaths and injuries from motor vehicle accidents

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

1) to address the importance of younger children riding in rear seat, require children under age eight 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 9 inches tall (57 inches) and the adult seat belt fits properly without a booster seat (law to describe proper fitting of seat belt).

Administrative Efforts

Administrative efforts to encourage collaboration and outreach to educate youth, parents, and caregivers about the dangers of fentanyl and counterfeit drugs, the importance of safe storage; and to increase access to and availability of Naloxone in schools, households, and youth-serving organizations.

Administrative efforts to assist legislative members of the Child Fatality Task Force Perinatal Health Committee in convening stakeholders around the issue of certified professional midwives.

Administrative efforts to explore partnerships in our state to advance a conversation about Paid Family and Medical Leave Insurance and bring a report on developments back to the Task Force.

EXPLANATION OF 2025 Child Fatality Task Force Action Agenda

Legislative Recommendations

Note: Several of the 2025 legislative recommendations below (as well as parts of the explanations of these recommendations), are being repeated from prior years because they have not yet advanced and the Task Force continues to view them as important strategies to prevent child death and promote child well-being. These recommendations are noted with an asterisk (*).

Recommendations to prevent harm from tobacco, nicotine, and intoxicating cannabis products

RECOMMENDATION: Endorse legislation to **raise the legal age for sale of tobacco products in NC from 18 to 21 to align with federal law; legislation to include licensing of tobacco product retailers** and appropriate enforcement measures.

In 2019, Congress increased the federal minimum legal sales age of all tobacco products, including e-cigarettes, from 18 to 21. North Carolina is one of only seven states that has not increased their minimum age to 21 to match federal law, and is one of only nine states that do not require tobacco retailers to obtain a license or permit. Meanwhile, "vaping" is pervasive among North Carolina youth and dangerous to their health.

Youth Vaping According to the 2023 NC Youth Risk Behavior Survey

- **37% of NC high school kids say they have used a VAPE product;** among 12th graders, it's more than 50%
- More than **one in five** NC high school kids report current use of VAPE products; for 12th graders it's one in three
- One in ten NC **middle schoolers** report current use of VAPE products

Harms from Vaping

E-cigarettes (used for vaping) 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.[3] Besides nicotine, the aerosol (not a vapor) may contain volatile organic compounds, ultrafine particles, heavy metals, cancer-causing chemicals, and flavoring that may be linked to lung disease.[4]

[3] U.S. Centers for Disease Control and Prevention.
[4] NC Tobacco and Prevention Control Branch, Division of Public Health, NC Department of Health and Human Services.

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.[5] 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,[6] both of which are leading causes of infant death.

Many if not most youth and parents do not know about the health risks associated with vape products and don't understand that the aerosol contains harmful substances or that vaping can lead to death. In 2024, the Task Force heard a heartbreaking story from a mom about her teenage stepson's death, and how his pulmonologist attributed it to vaping.

Vape products are attractive to youth and problematic for schools

Besides having flavors attractive to youth, some vape products are made to look like toys and now some have a gaming component that can exacerbate the addictive aspects of these products. A gamified product may, for example, encourage users to take more puffs to earn points.

Vaping devices that are tiny and may resemble a flash drive or a pen deliver a high dose of nicotine and 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%).

Easy access to vape products and challenges with enforcement

North Carolina is one of only seven states that has not increased its minimum age to 21 to match federal law, and is one of only nine states that do not require tobacco retailers to obtain a license or permit. Meanwhile, studies show that minors have easy access to vape products and are frequently not carded by retailers.

Part of the reason vaping is so pervasive among youth is that it's easy for them to buy vape products. Youth are getting them from a variety of retail locations like gas stations, grocery stores, or vape shops. Studies have shown youth are regularly not carded by retailers who sell these products. For example, in 2023, the NCDHHS Division of Mental Health, Developmental Disabilities and Substance Use Services and the North Carolina Alcohol Law Enforcement Division (ALE) conducted a statewide Vape Shop Pilot compliance check with 16- and 17-year-old buyers of electronic vape products with 400 vape shops statewide, and the violation rate for selling to those underage was 37%. Youth entering vape shops will not only encounter nicotine products but also many products containing intoxicating cannabis, for which North Carolina has no minimum age to purchase. The issue of youth accessing intoxicating cannabis is also of serious concern to the Task Force, and is addressed in a separate Task Force recommendation (see page 28 of this report).

Having a minimum age at 18 instead of 21 for sale of tobacco products not only results in more 18 year-olds vaping, it also means younger teens have easier access to vape products through older friends. Without licensing of tobacco retailers, getting retailers to adhere to any age requirement is more challenging. The North Carolina Alcohol Law Enforcement Division (ALE) of the Department of Public Safety is the agency responsible for enforcing state laws related to tobacco. Without licensing there's no way for ALE to know who all these retailers are, and they lack the authority to conduct inspections. The U.S. Surgeon General, the National Academy of Medicine, and the CDC have identified

[5] 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).
[6] Regan AK. Adverse Birth Outcomes Associated With Prepregnancy and Prenatal Electronic Cigarette Use. Obstet Gynecol 2021; 00:1–10, https://pubmed.ncbi.nlm.nih.gov/34259468/.

the licensing of tobacco retailers as an evidence-based measure to reduce tobacco sales to youth.[7] Aside from preventing youth from vaping, these policies to raise the age and require licensing could also improve merchant education efforts, protect law-abiding retailers by holding non-compliant retailers accountable, and reduce confusion among retailers and consumers by having one legal sales age for state and federal law.

North Carolina is also at risk of losing millions of federal dollars for prevention, treatment, and recovery services block grant funding if it does not effectively prevent underage sales of tobacco products to young people due to potential penalties under the Federal Synar Law for Retail Violation Rates (for selling to underage customers) that exceed a threshold of 20%, which was far exceeded by the results in the 2023 North Carolina pilot study referenced above.[8]

The Child Fatality Task Force has identified the vaping epidemic among youth to be a serious concern for years, having previously recommended sustained funding for prevention efforts. This year, however, the Task Force has recognized there is also a critical need for policy changes to address this epidemic that poses a serious threat to the health of our children.

RECOMMENDATION: Support legislation to prevent child and youth access to intoxicating cannabis by: prohibiting the sale or distribution of intoxicating cannabis or hemp products to those under 21; implementing regulations for the packaging of such products to require appropriate warnings, child-resistant packaging, and to prohibit packaging that is attractive to children and youth; requiring permitting for retailers who sell intoxicating cannabis or hemp products; and prohibiting those under 21 from entering vape shops.

In 2018, the federal Farm Bill legalized hemp production and CBD that comes from hemp, and the wording of the bill, including the definition of hemp, resulted in a surge in the manufacture and sale of intoxicating cannabis products.[9] North Carolina laws related to the legality of hemp were revised to align with federal law and permanently exclude hemp from the State Controlled Substances Act.[10] These intoxicating products are being sold by various types of NC retailers, especially vape shops, in a variety of forms like candy, baked goods, snack foods, beverages, and vape pens.

Many intoxicating cannabis edibles have packaging that appeals to children or mimics other popular snacks. Unlike some other states, **there is no minimum age for the purchase of intoxicating cannabis products in North Carolina and no safety regulations are in place for packaging, presenting dangers to children and youth of all ages.**

Since 2019 and following this surge in the availability of intoxicating cannabis, the rate of emergency department visits in North Carolina for intoxicating cannabis ingestion among children and youth ages 17 and under increased more than 600 percent; among older teens, the rate increased more than 1000 percent. Young children and youth can have severe reactions to ingesting cannabis,[11] and youth who

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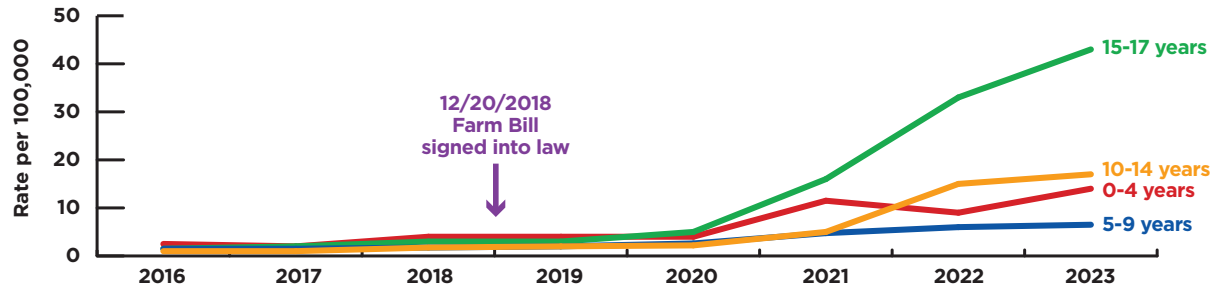
[7] NC Tobacco and Prevention Control Branch, Division of Public Health, NC Department of Health and Human Services.
[8] Ibid.
[9] Information on the 2018 federal Farm Bill and the resulting surge in the manufacture and sale of intoxicating cannabis:
- Harlow AF, Leventhal AM, Barrington-Trimis JL. Closing the Loophole on Hemp-Derived Cannabis Products: A Public Health Priority. JAMA. 2022 Nov 22;328(20):2007-2008. doi: 10.1001/jama.2022.20620. PMID: 36331491; PMCID: PMC10406389.
- National Academies of Sciences, Engineering, and Medicine. 2024. Cannabis Policy Impacts Public Health and Health Equity. Washington, DC: The National Academies Press. https://doi.org/10.17226/27766.
- Blog on the website for the Association of State and Territorial Health Officials, "Hemp's Hazy Legal Status Challenges Public Health Efforts," by Christina W. Severin, BSN, JD.
- CANNRA Urges Federal Action to Address Hemp-Derived Cannabinoid Product Regulation, Cannabis Regulators Association, 2023: https://www.cann-ra.org/news-events/sx2s63c2fudq9n0zmk4ekviku9747f.

[10] See North Carolina Session Law 2022-32. (Session Law 2018-113 is also relevant in terms of definitions related to hemp and THC.)
[11] *Cannabis and Poisoning* page on the website for the U.S. Centers for Disease Control and Prevention: https://www.cdc.gov/cannabis/health-effects/poisoning.html.

use intoxicating cannabis can experience multiple negative impacts such as: problems with memory, learning, school and social life; impaired driving; potential for addiction; and increased risk of mental health issues including depression, anxiety, psychosis, schizophrenia, and suicidal behaviors.[12]

Emergency Department Visit Rates in North Carolina for THC Ingestion for Children & Youth Ages 0-17



Data source: NC DETECT, 2016-2023 ED Visits; THC Ingestion Case Definition, pulled 11/2024, Division of Public Health, NCDHHS

Cannabidiol (CBD) and tetrahydrocannabinol (THC) are both naturally occurring compounds called cannabinoids found in cannabis plants. The 2018 Farm Bill legalized CBD that comes from hemp, defined by the Farm Bill as cannabis containing less than 0.3% delta-9 THC by weight. This threshold has a different impact when applied to a hemp plant compared to hemp-derived products. Also, the bill did not address the legal status of other forms of THC besides delta-9. Semi-synthetic THC forms, like delta-8, delta-10, and many others, have become widely available.

Products being manufactured and sold that claim they are legal under the 2018 Farm Bill may contain high levels of intoxicating THC. An example from the Cannabis Regulators Association: *"A 50-gram chocolate bar at 0.3% THC would have around 150 mg of THC (30 times the standard 5 mg THC dose established by the National Institute on Drug Abuse)."* [13]

The NC Child Fatality Task Force heard from a Special Agent of the North Carolina Alcohol Law Enforcement Division (ALE) of the Department of Public Safety about what ALE sees related to intoxicating cannabis products and what's happening in vape shops. ALE is the agency charged with enforcing compliance with state laws related to alcohol and tobacco sales (as well as other laws). The lack of permitting or licensing in NC for retailers like vape shops that routinely sell tobacco and cannabis products combined with the lack of regulations around the cannabis products means that ALE doesn't know who all these retailers are and ALE has limited authority – they can only enforce existing state laws.

ALE responds to reports that involve things like illegal activity at a vape shop or a youth becoming ill from a product sold in a vape shop. The ALE Special Agent explained to the Task Force that when ALE's response includes testing cannabis products, the contents of the products can vary widely and usually exceed the legal delta-9 THC limit, with some products containing levels up to 30 times the legal threshold. ALE raids on vape shops have often resulted in seizures of illegal products and felony charges for illegal activities.[14]

[12] *Cannabis Risk Factors* page on the website for the U.S. Centers for Disease Control and Prevention: https://www.cdc.gov/cannabis/risk-factors/index.html; *Cannabis and Teens* page on the website for the U.S. Centers for Disease Control and Prevention: https://www.cdc.gov/cannabis/health-effects/cannabis-and-teens.html#cdc_risk_factors_who-negative-effects-of-teen-cannabis-use.

[13] *CANNRA Urges Federal Action to Address Hemp-Derived Cannabinoid Product Regulation*, Cannabis Regulators Association: https://www.cann-ra.org/news-events/sx2s63c2fudq9n0zmk4ekviku9747f.

[14] Information on ALE activities with vape shops sourced from a presentation by an ALE officer to the Child Fatality Task Force on December 10, 2024.

Recommendations to promote healthy birth outcomes, prevent deaths of infants and young children, and promote infant and child well-being

RECOMMENDATION: Support recurring funding to enable Medicaid reimbursement of doula services throughout pregnancy and the postpartum period and to provide support services and technical assistance for the doula population*

Latest available data puts North Carolina's infant mortality rate at the 10th highest in the U.S.; NC rates have been stagnant since 2010.[15]

Disparities persist, and in 2023 in North Carolina, Black infants died at rates three times higher than white infants.[16]

Doulas are commonly defined as nonclinical, trained professionals who can provide emotional, physical, and informational support during pregnancy, delivery, and after childbirth. Doula services are increasingly recognized as an effective way to improve maternal and infant health, enhance birth outcomes and the perinatal experience, and close disparity gaps.[17]

Experts and professional organizations are encouraging increased access to doulas:

- The federal government has supported efforts to expand the doula workforce and encourage coverage of doula services in several health programs.[18]
- Medicaid and private insurance coverage for doula care services is a March of Dimes policy priority.[19]
- Expanding doula services and the doula workforce are part of the North Carolina Perinatal Health Strategic Plan.
- The number of states that are either actively reimbursing for doula services via Medicaid or are taking steps to do so has increased rapidly; in 2022 there were 21 states and in 2024 there were 43 states.[20]

Doula services have been shown to improve maternal and infant health outcomes and close disparity gaps.

Expanding the use of doulas in North Carolina can help lower North Carolina's high infant mortality rates and address racial disparities.

[15] NC State Center for Health Statistics, NCDHHS Division of Public Health and National Center for Health Statistics, based on 2023 data.
[16] NCDHHS Division of Public Health, Title V Office analysis of 2023 NC Resident Death Certificate & Live Birth Certificate Data.
[17] See, e.g., Knocke K, Chappel A, Sugar S, De Lew N, Sommers BD. Doula Care and Maternal Health: An Evidence Review. (Issue Brief No. HP-2022-24). Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. December 2022; Sobczak A, Taylor L, Solomon S, Ho J, Kemper S, Phillips B, Jacobson K, Castellano C, Ring A, Castellano B, Jacobs RJ. The Effect of Doulas on Maternal and Birth Outcomes: A Scoping Review. Cureus. 2023 May 24;15(5):e39451. doi: 10.7759/cureus.39451. PMID: 37378162; PMCID: PMC10292163.
[18] Knocke K, Chappel A, Sugar S, De Lew N, Sommers BD. Doula Care and Maternal Health: An Evidence Review. (Issue Brief No. HP-2022-24). Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. December 2022.
[19] See: https://www.marchofdimes.org/sites/default/files/2025-01/2025_2026_OGA_Policy_Priorities.pdf.
[20] *State Momentum on Medicaid Doula Coverage, Rate Increases,* Georgetown University McCourt School of Public Policy, Center for Children and Families, https://ccf.georgetown.edu/2024/04/11/state-momentum-on-medicaid-doula-coverage-rate-increases/.

Significant efforts have been made to study doulas and engage doula stakeholders in North Carolina. In 2023, the North Carolina Department of Health and Human Services published a report that provided data on doulas in North Carolina and a report on a doula summit held in 2022.[21] In 2024, a Doula Action Team was formed to recommend best practices and effective strategies. Through these efforts, a great deal has been learned from North Carolina experts and stakeholders as well as those in other states that can be utilized to effectively implement doula services within North Carolina's Medicaid system.

NC Medicaid does not currently reimburse for doula services, however some prepaid health plans as part of Medicaid managed care have added doula services as part of their value-added services. Funding estimates for this recommendation include $1 million recurring to implement Medicaid coverage of doula services and $550,000 recurring for training, promotion, and doula engagement.

RECOMMENDATION: Support Fetal and Infant Mortality Review (FIMR) legislation to include the following components: providing for the authority to implement a FIMR program and to access necessary medical records; to provide for immunity (protections) for reviewers and review materials; and for FIMRs to include best practices of family interviews and community action teams.*

A Fetal and Infant Mortality Review (FIMR) is a specific type of multidisciplinary team study of fetal and infant deaths designed to better understand why a baby died with the goal of preventing future deaths and eliminating disparities.

Fetal and Infant Mortality Reviews began in the late 1980's, and there are approximately 146 FIMR programs across 25 states. FIMR teams develop recommendations for prevention and implement local efforts to improve systems of care, services, and resources. North Carolina currently has only one FIMR program which is in Guilford County and ideally there would be more. Without FIMR legislation, the Guilford team faces challenges in effectively carrying out its work. FIMR legislation is needed to remove barriers that would prevent communities from starting and effectively operating a FIMR team.

There are existing laws in North Carolina that enable and support other types of child death review teams and a maternal mortality review team in NC,[22] but there are no such laws for FIMRs. These laws not only address the purpose and operation of teams but also provide for access to and protection of information that is essential for conducting effective reviews. A FIMR has similarities to the local, multidisciplinary child death reviews (CDRs) currently performed in every county in North Carolina, but FIMRs have significant variations that utilize different resources and policies that enable expanded opportunities to identify and address prevention strategies.

FIMR involves a team review of confidential, de-identified cases of fetal and infant deaths. FIMR teams develop recommendations and implement local efforts to improve systems of care, services, and resources. For these reviews, significant work is undertaken prior to the review that involves examination and abstraction of records as well as an interview with the family of the child who died (whenever possible and with the family's consent) to create a case summary that is presented to the review team. FIMR work requires staff with appropriate training and expertise who do data abstraction, family interviews, and prepare case summaries to present to the review team. Staff also work with the review team to generate recommendations and reports, and with a community action group to facilitate implementation of actions in response to recommendations. The scope of work required for this role is labor-intensive and typically involves staff who are dedicated to a FIMR team's work.

Because of the resources needed for FIMR work, there is not an expectation to have FIMRs in every county the way CDRs cover every county across North Carolina. However, a FIMR team anywhere in North Carolina can help inform prevention work at the State level, and ideally the number of FIMR teams

[21] Doulas in North Carolina: A Landscape Analysis and Summit Report, from the NC Department of Health and Human Services Division of Public Health; Women, Infant, and Community Wellness Section. https://wicws.dph.ncdhhs.gov/docs/WICWS-DoulaReport.pdf

[22] See Article 14 of the NC Juvenile Code and N.C.G.S. § 130A-33.60.

in our state would grow. Communities who have the resources to start and maintain a FIMR program, as Guilford has done, would benefit greatly from having legislation that enables, protects, and clarifies their functioning. This type of legislation would make it more likely that a community would consider establishing a FIMR because it would make it easier for them to operate and remove some of the barriers that may keep them from establishing a FIMR.

Why is FIMR legislation needed?

ACCESS TO INFORMATION: An important part of FIMR work is gathering and examining records and information related to the death of the infant or fetus. Statutes establishing child death review teams in North Carolina have provisions specifying that these teams are permitted access to many types of records for purposes of their review.[23] Statutes establishing the North Carolina Maternal Mortality Review Committee (MMRC) also have provisions addressing access to information.[24] It can be very challenging for FIMR staff to access records without a statute specifying that access is permitted for FIMR purposes; the Guilford FIMR team has limited access to some records and that is only through legal agreements that took more than a year to put in place.

PROTECTION OF INFORMATION: It is also important that information accessed, used, and generated by FIMR reviews be utilized only for FIMR purposes and protected for any uses beyond those purposes. Statutes establishing CDRs and the MMRC have provisions that speak to protecting such information, including provisions that make meetings and information not subject to open meeting or public records laws, not subject to discovery or introduction into evidence in any proceedings, and team members may not testify about meetings or information shared in meetings.[25]

FAMILY INTERVIEW: A critical component of the FIMR process is a confidential interview with the family who lost the infant or fetus, which is done by trained FIMR staff who are preparing a de-identified case summary for team review. Statutes establishing CDRs in North Carolina specifically prohibit contacting or interviewing the family, and a FIMR statute would ideally speak to the family interview as a permissible part of the process. The National Center for Fatality Review and Prevention explains the importance of the family interview as part of the FIMR process on their website as follows:

> *"Interviews provide a narrative and key details that are unavailable elsewhere, including the context of the pregnancy and the baby's life. The FIMR Interview provides insight into the social determinants of health that may have impacted the parent's and/or infant's health. Differences in health are striking in communities with unstable housing, poverty, unsafe neighborhoods, or substandard education. Parents' stories can also shed light on experiences of racial or other types of discrimination in accessing and receiving quality medical care."*

FIMR is widely used across the US as a tool to help prevent infant and fetal deaths and address disparities. Legislation that supports and encourages FIMRs in North Carolina can help our state make use of this tool at a time when it has never been more important to optimize strategies to lower North Carolina's high infant mortality rates and address racial disparities.

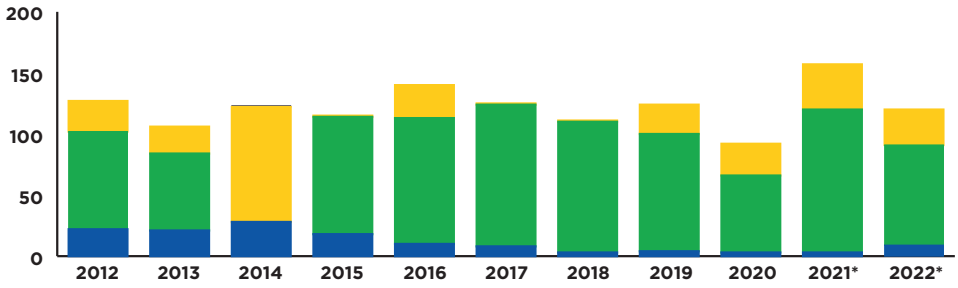
[23] See N.C.G.S. § 7B-1413(a).
[24] See N.C.G.S. § 130A-33.60(d).
[25] See N.C.G.S. § 7B-1413(b), (c) (d); N.C.G.S. § 130A-33.60(e), (f), (g), (i).

RECOMMENDATION: Support the extension of additional funding to prevent sleep-related infant deaths by continuing the $250K appropriated for fiscal years 23-24 and 24-25 for this purpose to be appropriated in 2025 as recurring.*

Each year in North Carolina, more than 100 infants die in unsafe sleep environments. Examples of an unsafe sleep environment include an infant found with his or her face covered by a blanket, found sleeping on a couch with the infant's face to the back of the couch or between cushions, or sharing a sleep space with another individual. In North Carolina, Black infants are twice as likely as white infants to die in unsafe sleep environments.

Unsafe sleep is a leading cause of infant death in North Carolina and these deaths are largely preventable. More than 120,000 babies are born each year in North Carolina and sustained funding is essential for an effective statewide initiative to ensure that these babies are not lost to unsafe sleep.

SUID Sleep-Related Infant Deaths, NC 2012-2022



Between 2012 and 2022 in North Carolina, there were over 1,200 infant deaths related to unsafe sleep.

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021*	2022*
SIDS (NOT associated with unsafe sleep)	22	21	28	18	10	8	3	4	3	3	9
Undetermined/Unknown (associated with unsafe sleep)	0	63	94	96	103	116	107	96	63	117	82
Accidental Strangulation or Suffocation in Bed (due to unsafe sleep)	5	22	1	1	27	1	1	24	26	37	29

*Cases are still pending, numbers could change. Data sources: NC State Center for Health Statistics and Office of the Chief Medical Examiner, Division of Public Health, NCDHHS

Sleep-related infant deaths often involve bed sharing, the intentional or unintentional practice of an infant sharing a sleep space with another individual. In a North Carolina survey, close to half of mothers reported bed sharing with their baby.[26] 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.[27]

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 child care providers. In fact, **one study found that nearly half of caregivers did not receive correct advice on safe sleep practices from health care providers**.[28] Outreach and education on safe sleep needs to reach health care providers and others who educate parents and caregivers.

[26] Pregnancy Risk Assessment Monitoring System, 2020 results for North Carolina survey. The 2020 NC PRAMS survey showed 45% of moms report bed sharing at least sometimes. 2020 is the most recent year that this data is available. https://schs.dph.ncdhhs.gov/data/prams/2020/SLEEPB.html

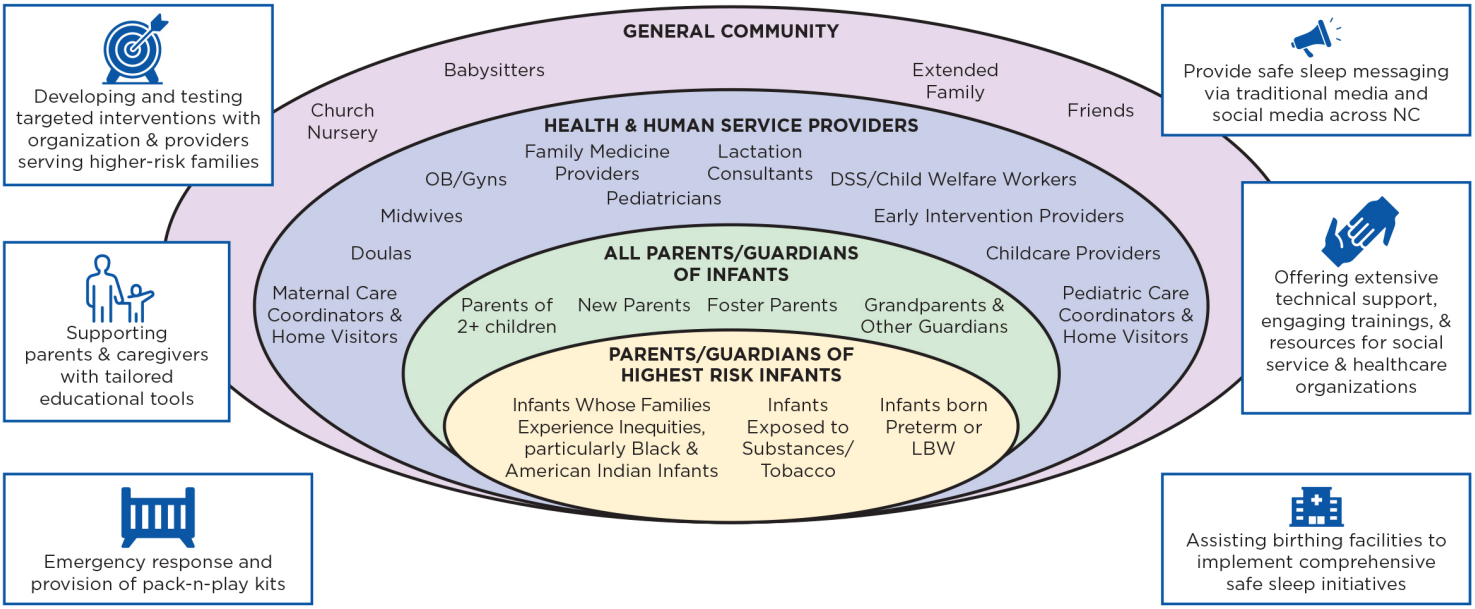
[27] See: Rachel Y. Moon, Rebecca F. Carlin, Ivan Hand, THE TASK FORCE ON SUDDEN INFANT DEATH SYNDROME AND THE COMMITTEE ON FETUS AND NEWBORN; Sleep-Related Infant Deaths: Updated 2022 Recommendations for Reducing Infant Deaths in the Sleep Environment. Pediatrics July 2022; 150 (1): e2022057990. 10.1542/peds.2022-057990

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

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 repeatedly identify the need for strengthened safe sleep education and expanded outreach and funding for this purpose.

In 2023, a *nonrecurring* appropriation of $250K was added to the $97K of block grant funding for efforts to prevent infant deaths due to unsafe sleep in North Carolina, but funding ends in June of 2025. This funding temporarily enabled a meaningful expansion of efforts targeting multiple levels of prevention and included emergency response in Western NC related to Hurricane Helene. Making this funding recurring would enable a robust and sustained statewide initiative to prevent infant deaths due to unsafe sleep.

Evidence-based efforts to prevent infant deaths due to unsafe sleep require sustained funding



Evidence shows that this type of multi-level approach to prevention is essential and effective.[29] For example, Sacramento County California's Safe Babies Initiative reduced their sleep-related infant death rate by 54% and their Black/white disparities rate by 66% over 5 years.[30]

RECOMMENDATION: Support growth and expansion of investments in the early child care system, including increases for child care subsidies.*

Evidence is clear that access to quality child care can save lives and prevent child maltreatment.

The Child Fatality Task Force is asking state leaders to expand child care funding because access to affordable child care can save lives and prevent maltreatment. A CDC publication, *Child Abuse and Neglect Prevention Resource for Action: A Compilation of the Best Available Evidence*, sets out five prevention strategies for child maltreatment.[31] Two out of five of these strategies include providing quality care and education early in life; and strengthening economic support to families, including subsidized child care. The CDC says, "Better quality child care increases the likelihood that children will experience safe, stable, nurturing relationships and environments and decreases the risk of maltreatment-related fatalities." Other

[29] This graphic was shared with the Task Force by an expert on infant safe sleep from the UNC Collaborative for Maternal and Infant Health, explaining the variety of strategies that need to be used to provide a comprehensive prevention approach.

[30] First 5 Sacramento Reduction of African American Perinatal & Infant Deaths, Final Evaluation Report, July 1, 2015-June 30, 2018. Microsoft Word - Final Evaluation Report_181128.docx.

[31] Fortson, B. L., Klevens, J., Merrick, M. T., Gilbert, L. K., & Alexander, S. P. (2016). Child Abuse and Neglect Prevention Resource for Action: A Compilation of the Best Available Evidence. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/pdf/CAN-Prevention-Resource_508.pdf.

CDC publications related to preventing Adverse Childhood Experiences and Intimate Partner Violence also discuss the importance of access to high-quality child care.[32]

Experts in North Carolina echo the importance of child care as a prevention strategy. The North Carolina Perinatal Health Strategic Plan and the North Carolina Institute for Medicine Task Force on Essentials for Childhood highlighted access to affordable, quality child care as being important to support infant and child well-being and prevent child maltreatment.[33] The North Carolina State Child Fatality Prevention Team that reviews child maltreatment deaths also raised access to child care as an area of concern.

Ensuring that families have access to affordable, quality early care is a recognized strategy in preventing child abuse, neglect, and even death. North Carolina's child care system is in crisis and needs state investments to protect children.

Quality early care positively impacts the brain development of young children, setting them up for better outcomes later in life. Eighty-five percent of the physical brain develops by the age of three, and children's early experiences build their brain architecture for life. This is one reason why investments in early care and learning have been shown to have a high rate of economic return resulting from a combination of factors such as the impact of higher achievements with school and career, reduced costs in health and criminal justice expenditures, and increased opportunity for workforce participation and economic security. Studies have shown that the earlier the investments in children, the higher the rate of economic return given the increased productivity and reduced social spending.[34]

The child care crisis hurts individuals, employers, and the economy

North Carolina has a child care crisis and the child care business model cannot sustain itself without significant state investments. Between January and August of 2024, 191 child care programs closed in North Carolina.[35] Teachers can't afford to stay in the profession; parents struggle to find and pay for quality care; child care programs struggle to stay open; and employers are losing workers. Child care subsidies help eligible families afford child care, but only about 15% of eligible North Carolina families are actually getting child care subsidies[36] because there is not enough subsidy funding to meet the need.

Some of the underlying facts that help explain the child care crisis are as follows:[37]

- Most NC children ages 0 to 5 live in households where all parents work.
- The average annual cost of infant care in North Carolina is $9,480, which is $790 per month and more than in-state tuition at a 4-year NC public college. Child care for two children – an infant and a 4-year-old – costs $17,593 annually. Infant care for one child would take up 17.8% of a median family's income in North Carolina.
- Child care teachers earn so little (averaging $14 per hour) that many can't meet basic needs and lack health insurance, so they take other jobs where they can earn more and get insurance, leaving a shortage of teachers.
- The State's child care subsidy rate pays only half of what child care actually costs to deliver, yet parents can't afford to pay what it costs for teachers to make a living wage.

[32] Adverse Childhood Experiences Prevention Resources for Action: A Compilation of the Best Available Evidence, https://www.cdc.gov/violenceprevention/pdf/ACEs-Prevention-Resource_508.pdf, and Intimate Partner Violence Prevention Resources for Action: A Compilation of the Best Available Evidence, https://www.cdc.gov/violenceprevention/pdf/IPV-Prevention-Resource_508.pdf.

[33] North Carolina Perinatal Health Strategic Plan, https://wicws.dph.ncdhhs.gov/phsp/phsp.htm, and NCIOM Task Force on Essentials for Childhood, https://nciom.org/wp-content/uploads/2017/07/Essentials4Childhood_report_FINAL.pdf

[34] Sourced from presentation to the Task Force; see research by Nobel Laureate economist James Heckman: https://heckmanequation.org/the-heckman-equation/

[35] See NCDHHS Press Release on "Take Care" documentary: https://www.ncdhhs.gov/news/press-releases/2024/11/14/new-documentary-shows-north-carolinas-child-care-crisis-close-state-and-community-leaders-attend.

[36] Data source: Division of Child Development and Early Education, NC Department of Health and Human Services.

[37] Ibid.

The last point above, that the state's child care subsidy rate pays only half of what child care actually costs to deliver, is one of the reasons the current system model is not sustainable. Currently in North Carolina, the state pays different rates depending on the county, the age of the child, the setting (center or home-based) and star rating of the program – this results in *3,000 different reimbursement rates*. The way rates are currently determined does not take into account a number of relevant factors, resulting in reimbursement rates that don't begin to cover costs.

The Task Force heard from the Director of the NCDHHS Division of Child Development and Early Education about their partnership with the American Institutes for Research to develop an updated subsidy reimbursement model that reflects the cost of providing quality child care services and sustaining child care businesses – which necessarily requires more funding. Her presentation emphasized how "switching to a new rate based on cost will keep teachers and providers in the field and help ensure that parents of young children can find quality affordable child care to work, advance their careers and contribute to the state's economy."

The child care crisis is also a problem for employees, employers, and the economy when too many North Carolinians are unable to fully participate in the workforce or advance their careers due to child care challenges. This comes at a time when North Carolina has 55 available workers for every 100 jobs.[38]

Availability of quality early care is a major factor in attracting and retaining businesses to bring jobs to our state. A North Carolina Chamber Foundation Child Care Survey showed that of parents with children five and under:

- 26% said they left the workforce because they couldn't find affordable child care;
- 60% missed work due to child care challenges;
- 37% refused a job opportunity, promotion, or job change because it would increase child care expenses; and
- 32% did not pursue job training or continuing education because of a lack of affordable child care.[39]

Many in North Carolina are working on innovative strategies to address this crisis related to workforce issues, a better business model, and a different means of determining subsidy rates for reimbursements. Increased funding, as recommended by the Task Force, is a critical component of addressing this crisis, and access to affordable, quality child care has significant health and safety implications for North Carolina's children.

[38] Data shared with Task Force from labor statistic according to the U.S. Chamber of Commerce: https://www.uschamber.com/workforce/understanding-north-carolinas-labor-market.

[39] Data shared with Task Force from NC Chamber Foundation Child Care Survey Findings: https://ncchamber.com/2023/05/10/nc-chamber-foundation-child-care-survey-findings-summary/.

Recommendations to prevent youth suicide, promote youth mental health, and prevent firearm deaths and injuries

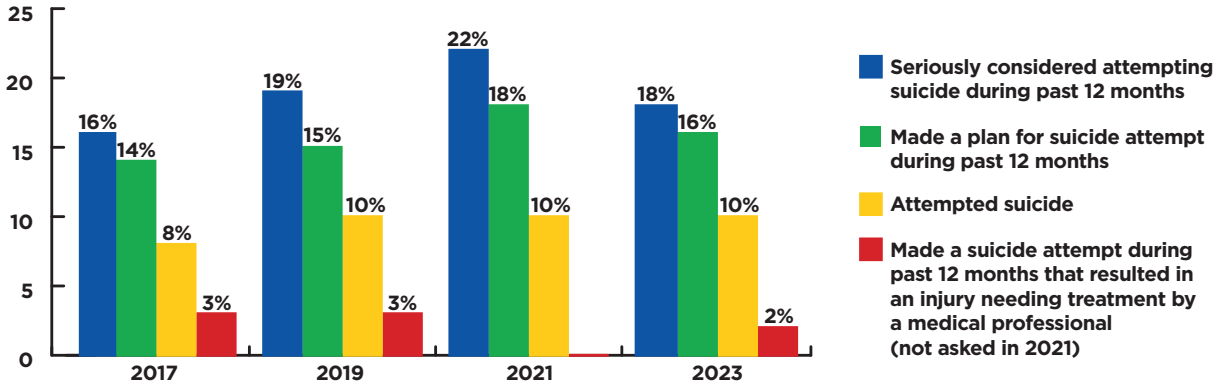
RECOMMENDATION: Support recurring funds to increase the numbers of school nurses, social workers, counselors and psychologists to support the physical and mental health of students and to move North Carolina toward achieving nationally recommended ratios for these professional positions in schools.*

Youth mental health and youth suicide remain a serious concern for the Child Fatality Task Force. The latest data show some mental health trends among youth improving since 2020 – 2021, but the data is still alarming.

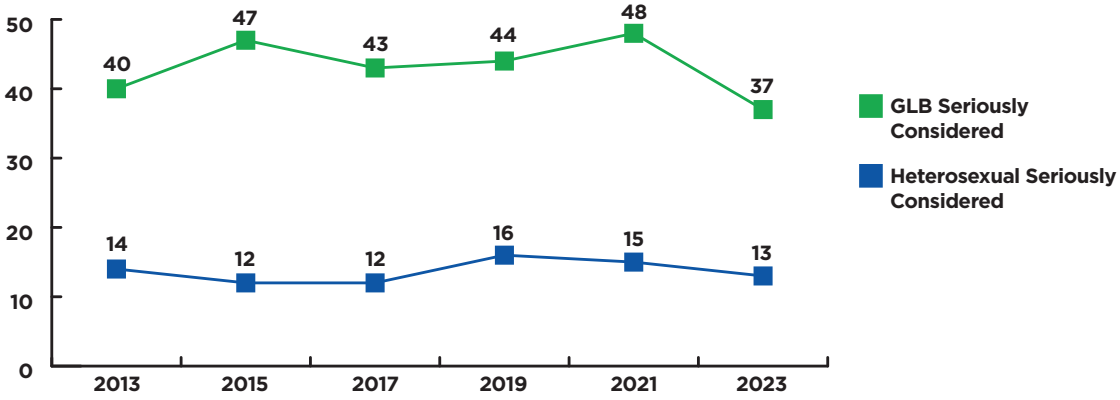
In 2023, 59 North Carolina youth ages 10 to 17 died by suicide, and over the past 20 years, the youth suicide rate has been increasing.[40] While the suicide rate for North Carolina youth in 2022 and 2023 was lower than a peak rate in 2021, rates still reflect an overall upward trend during the past 20 years. In 2023 in North Carolina, there were over 4,200 emergency department visits for self-harm for youth ages 10 to 17.[41]

The latest Youth Risk Behavior Survey data shows that among North Carolina high school students, 18% report seriously considering suicide in the past 12 months and for gay, lesbian, or bisexual students it was 37%.[42] Thirty-nine percent of high school students report feeling sad or hopeless and only 55% report that they feel good about themselves.[43]

Suicidal Behaviors, 2017-2023 NC High School Students



Percentage of NC High School Students Who Seriously Considered Suicide in the Past 12 Months, Heterosexual vs Gay, Lesbian, or Bisexual Students, 2013-2023



[40] Data source: NC State Center for Health Statistics, NCDHHS Division of Public Health.
[41] NC DETECT Emergency Department Visit Data. Analysis by the DPH Injury Epidemiology, Surveillance, and Informatics Unit, NCDHHS Division of Public Health.
[42] 2023 NC High School Youth Risk Behavior Survey (YRBS), US Centers for Disease Control and Prevention.
[43] Ibid.

The Child Fatality Task Force has looked at ways to better support youth mental health and has repeatedly determined that having a robust team of health support professionals in schools – school nurses, social workers, counselors, and psychologists – is foundational and critical. Yet the latest data presented to the Task Force by the NC Department of Public Instruction showed NC falling far short of having robust teams:[44]

	RATIOS IN NC	NATIONALLY RECOMMENDED RATIO
School Social Workers	1:969	1:250
School Psychologists	1:1,855	1:500
School Counselors	1:346	1:250
School Nurses	1:809	1 per school

These professionals play an important role in many ways in supporting students' needs which include:

- Identifying a child who is struggling or at risk, whether the struggle is with emotional/mental health issues, suicide ideation, bullying, food or housing insecurity, abuse or neglect, or even at risk of harming others.
- Connecting a child and their family to mental health and/or community resources to address individual or family needs.
- Developing and implementing school-wide programs and training that can support mental and physical health and improve the school environment.
- Providing individual and group counseling.
- Identifying and addressing health conditions or learning challenges and needs.

The North Carolina Child Health Report Card from the *NC Institute of Medicine* and *NC Child* tracks key indicators of child health and well-being and assigns a grade to various categories of well-being. **The 2023 Child Health Report Card (which is the most recent) gave North Carolina a grade of "F" in mental health and an "F" in school health**, with the school health grade related to the poor ratios of students to school health professionals, which have changed very little since then.

There is widespread recognition that having sufficient teams of these professionals in schools is an important strategy to address the youth mental health crisis.

Other experts and organizations agree that having enough of these health support professionals in schools is an important aspect of supporting student mental health. For example, this was noted in the 2021 U.S. Surgeon General's Advisory on the Youth Mental Health Crisis and in the North Carolina 2023 School Behavioral Health Action Plan. It was also the focus of a September, 2023 article in the North Carolina Medical Journal titled, "Specialized Instructional Support Personnel (SISP): A Promising Solution for North Carolina's Youth Mental Health Crisis."[45]

In addition to the impacts these professionals can have on student well-being, these professionals also alleviate strain on teachers and school administrators, who inevitably must put aside the focus of their work to deal with students' mental and physical health issues when there is no school health professional available to do so. They can also alleviate strain on the health care system through early identification of issues and connection to resources before an issue becomes more serious or reaches a crisis point, resulting in emergency room visits or psychiatric hospitalizations.[46]

[44] Data presented to the Task Force on November 13, 2024, by NC Healthy Schools of the NC Department of Public Instruction.
[45] Close J, Schmal S, Essick E, Scott DN, Shankar M. Specialized Instructional Support Personnel (SISP): A Promising Solution for North Carolina's Youth Mental Health Crisis. North Carolina Medical Journal. 2023;84(5). doi:10.18043/001c.87524
[46] Ibid.

Recurring, not temporary, funding for these positions is essential. Not only is temporary funding short-term, but education leaders have explained to the Task Force that it is hard to attract and retain professionals for temporary work and significant administrative time is spent navigating the process of onboarding temporary professionals into a permanent workforce.

RECOMMENDATION: Endorse legislation that addresses addictive algorithms in social media that harm children.*

There is growing concern about the role social media is playing in the worsening status of youth mental health. Some examples of this concern and related responses include the following:

- In 2023, the **U.S. Surgeon General** issued an Advisory on Social Media and Youth Mental Health, and in 2024 the Surgeon General called for a warning label of social media platforms.
- In 2023, the **American Academy of Child & Adolescent Psychiatry** issued a Policy Statement on the Impact of Social Media on Youth Mental Health.
- In 2023, the **American Psychological Association** issued a Health Advisory on Social Media Use in Adolescence.
- The **American Academy of Pediatrics** has a "National Center of Excellence on Social Media and Youth Mental Health," which developed a policy addressing Digital Advertising to Children, and also publishes various blogs and resources for pediatricians related to this topic.
- The **US Congress** has held hearings and introduced legislation on the topic, but such bills have not so far become law.
- In October of 2023, then **North Carolina Attorney General** Josh Stein joined 41 other attorneys general in suing Meta, which owns social media platforms Instagram and Facebook, related to the harm their platforms cause to youth.

The Child Fatality Task Force heard from a national expert on social media and adolescent mental health, Dr. Eva Telzer of UNC,[47] who presented to both the Intentional Death Prevention Committee and to the full Task Force on current research.

Experts agree that more research is needed to fully understand the impact of social media on youth. Current research indicates that social media use by youth is not inherently beneficial or harmful; the impacts depend on many factors related to the individual using it (strengths and vulnerabilities, time online, how they use it) and the social media platform (content, algorithms, functions). Some adolescents can benefit from finding affinity/identity communities, immediate social support, increasing diversity of their peers, and online civic engagement. However, there are a number of negative impacts, many of which are complicated by the fact that the adolescent brain is still developing.

The research conveyed by Dr. Telzer to the Task Force shows that:

- 78% of 13- to 17-year-olds report checking their devices hourly and 46% check almost constantly (compared to 24% in 2018).
- Nearly all adolescents report spending more time on social media than they intended, with one-quarter perceiving that they are "moderately" or "severely" addicted to social media.
- Half of adolescents report that being away from social media results in experiencing difficulties in engaging with daily life activities.
- Social media use can interfere with sleep, and poor sleep is linked to physical and mental health issues, risky behaviors, poor school performance, and altered brain development.

[47] Eva Telzer, PhD, is a Professor of Psychology and Neuroscience at UNC Chapel Hill. Dr. Telzer is an Associate Editor at *Child Development* and *Social Cognitive Affective Neuroscience*, and the co-director of the Winston National Center on Technology Use, Brain and Psychological Development.

The US Surgeon General's Advisory said that *"Children and adolescents on social media are commonly exposed to extreme, inappropriate, and harmful content, and those who spend more than 3 hours a day on social media face double the risk of poor mental health including experiencing symptoms of depression and anxiety."* The Advisory further noted that teens spend an average of 3.5 hours a day on social media. Related to impact on the developing brain, the Advisory says that *"Frequent social media use may be associated with distinct changes in the developing brain in the amygdala (important for emotional learning and behavior) and the prefrontal cortex (important for impulse control, emotional regulation, and moderating social behavior), and could increase sensitivity to social rewards and punishments."*

Those examining the issue have identified potential strategies to address the problem, some involving technology companies, some involving youth and their parents, and some involving policymakers. The focus of the Task Force is on making policy recommendations, and in 2023 the Task Force sought to understand the policy work that had begun to take place in North Carolina related to this issue.

Teens spend an average of 3.5 hours a day on social media; kids who spend more than 3 hours a day on social media face double the risk of poor mental health including experiencing symptoms of depression and anxiety.

Related legislation introduced in North Carolina in 2023 addressed data privacy for algorithms.[48] Although the bill did not become law, it had broad bipartisan support. Sam Hiner, a student at UNC Chapel Hill and Executive Director of the Young People's Alliance, who supported this legislation, spoke to the Task Force about the ways in which social media was harming his generation – he shared examples related to eating disorders (fueled by harmful content shown to users), loneliness (fueled by spending time online instead of having real world experiences), and political extremism.

Mr. Hiner explained the efforts of the Young People's Alliance to address this issue through policy by protecting the data privacy of minors to address the addictive algorithms in social media. One of the ways that social media can become "addictive" is through algorithms that use a user's data collected by the platform to target content that keeps them online. The concept is that legislation that restricts a company's use of a minor's data will make social media less targeted, which will make it less addictive and less likely to have harmful content. The Task Force recommendation endorses this type of policy effort.[49]

In 2024, Mr. Hiner updated a Task Force committee on national policy efforts related to social media in the form of the Kids Online Safety Act, which had broad bipartisan support but did not become law. He also confirmed that his organization was again advocating for state legislation like what was introduced in 2023, and the Task Force approved a recommendation to endorse these efforts again for 2025.

[48] HB 644, titled: "An Act to combat social media addiction by requiring that social media platforms respect the privacy of North Carolina users' data and not use a North Carolina minor's data for advertising or algorithmic recommendations and to make willful violations of data user privacy an unfair practice under G.S. 75-1.1."

[49] A Task Force "endorsement" of the efforts of others indicates support for such efforts generally, but the Task Force does not lead such efforts or specify details of legislation resulting from those efforts.

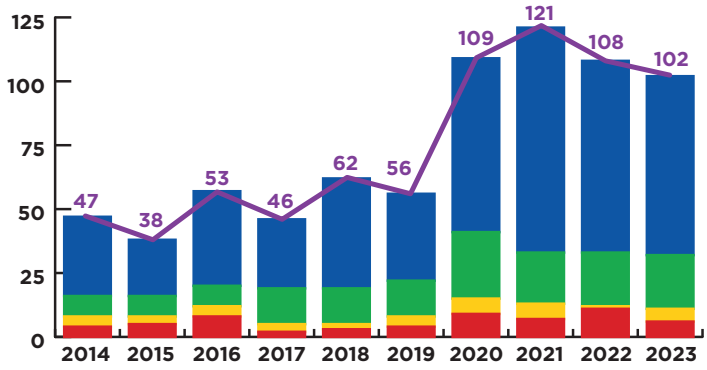
RECOMMENDATION: Firearm Safety Recommendations:*

- **Support recurring funding of $2.16 million for the NC S.A.F.E. Campaign that educates about firearm safe storage.**
- **Support legislation changing the current law addressing safe storage of firearms to protect minors to remove language from N.C.G.S. 14-315.1(a) that says "resides in the same premises as a minor."**

For 2025, the Task Force is continuing its longtime efforts to prevent children from being killed or injured by firearms. Firearm death rates reached horrific heights in recent years. Every firearm death or injury to a child or teen is preventable, and an important prevention strategy is the safe storage of firearms.

Firearm deaths to NC children have more than doubled since 2014[50]

Child deaths due to firearms by age group, NC residents 2014-2023



In JUST FIVE YEARS between 2019 and 2023, nearly 500 North Carolina children ages 17 years and younger died from firearm injuries, which is double the number of firearm deaths from the prior five-year period.

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Ages 0-4	31	22	37	27	43	34	68	88	75	70
Ages 5-9	8	8	8	14	14	14	26	20	21	21
Ages 10-14	4	3	4	3	2	4	6	6	1	5
Ages 15-17	4	5	4	2	3	4	9	7	11	6
Total Deaths	47	38	53	46	62	56	109	121	108	102

Evidence is clear that guns are often not stored safely and that reducing access to guns saves lives. 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.[51] A study in JAMA Pediatrics estimated that up to 32% of suicide and unintentional youth firearm deaths could be prevented through safe storage of firearms in homes with youths.[52]

Firearm safe storage is not just about protecting young children from accidents, it's also about preventing firearm suicides and homicides among teens. Most guns used in youth suicide and school shootings come from home.[53] Firearms are the leading cause of injury death for North Carolina children and youth, surpassing even motor vehicle deaths. In 2023 among older teens ages 15 to 17, firearms were the lethal means used in almost 95% of homicides and almost 50% of suicides.

[50] This includes homicides, suicides, unintentional, and undetermined firearm deaths. Source: NC State Center for Health Statistics & CDC/National Center for Health Statistics.

[51] Information presented to the NC Child Fatality Task Force by the NCDHHS 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.

[52] 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

[53] **Source on youth suicides:** 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; **source on school shootings:** 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.*

Part of the problem is the easy access that so many children and youth have to guns. Studies have shown that most children know where parents keep their guns, but parents often think they don't.[54] About 30% of North Carolina middle and high school students report 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.[55]

Sustained funding is needed for statewide firearm safety initiative

Getting gun owners to store their guns safely requires educating them about the importance of safe storage, the consequences of not practicing safe storage, and making sure they understand how to practice safe storage. That is why Task Force recommendations dating back to 2018 have included a statewide initiative to educate gun owners about safe storage. Legislation requiring a statewide firearm safe storage initiative became law in 2023, but there was no funding for this initiative. Progress was nevertheless made through efforts undertaken by the Department of Public Safety (DPS) which was able to get temporary funding for a safe storage media campaign.

The NC S.A.F.E. (Secure All Firearms Effectively) statewide initiative led by DPS is operating through temporary funds but the need to educate gun owners is ongoing. This initiative, which was informed by work of the Child Fatality Task Force, involves multiple media strategies to encourage firearm safe storage, toolkits and flyers for various community-level prevention efforts, and the purchase and distribution of gun locks and gun safes. Media formats include radio, DMV screens, billboards, gas station pumps, bus wraps, etc., and public service announcements. Digital ad channels have included Facebook, Instagram, YouTube, Nextdoor, Google Search, connected TV, and more. Over 50,000 gun locks and hundreds of gun vaults have been distributed since 2023. The next phase of this initiative adds a focus on securing firearms in vehicles, suicide prevention, and a broad school-focused initiative which is already underway. **Funding needed to sustain the NC S.A.F.E. initiative is $2.16 million recurring.**

Strengthen the child access prevention law to protect children and youth

State laws that address access to guns by children and hold gun owners accountable for unsafe storage, often called "child access prevention laws," are proven to be an effective tool to prevent gun deaths and injuries to children and youth.[56] Such laws vary among states, and North Carolina enacted its child access prevention law in 1993 which has since remained unchanged. Among states, NC has the 12th highest rate of gun deaths for children and youth ages 1-19.[57] **North Carolina's current child access prevention law applies only to a gun owner or one who possesses a gun who *"resides in the same premises as a minor."* The recommended change from the Task Force is to remove this phrase about residing with a minor from the law** (see highlighted language below).

> **§ 14-315.1. Storage of firearms to protect minors.**
>
> *(a) Any person who ~~resides in the same premises as a minor,~~ owns or possesses a firearm, and stores or leaves the firearm (i) in a condition that the firearm can be discharged and (ii) in a manner that the person knew or should have known that an unsupervised minor would be able to gain access to the firearm, is guilty of a Class 1 misdemeanor if a minor gains access to the firearm without the lawful permission of the minor's parents or a person having charge of the minor and the minor:*
>
> *(1) Possesses it in violation of G.S. 14-269.2(b);*
>
> *(2) Exhibits it in a public place in a careless, angry, or threatening manner;*

[54] 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.
[55] Source: 2021 (for high school age) and 2023 (for middle school age) NC Youth Risk Behavior Surveys.
[56] Villarreal, S., Kim, R., Wagner, E., Somayaji, N., Davis, A., & Crifasi, C. K. (2024). Gun Violence in the United States 2022: Examining the Burden Among Children and Teens. Johns Hopkins Center for Gun Violence Solutions. Johns Hopkins Bloomberg School of Public Health. https://publichealth.jhu.edu/sites/default/files/2024-09/2022-cgvs-gun-violence-in-the-united-states.pdf
[57] Ibid.

(3) Causes personal injury or death with it not in self defense; or

(4) Uses it in the commission of a crime.

(b) Nothing in this section shall prohibit a person from carrying a firearm on his or her body, or placed in such close proximity that it can be used as easily and quickly as if carried on the body.

(c) This section shall not apply if the minor obtained the firearm as a result of an unlawful entry by any person.

(d) "Minor" as used in this section means a person under 18 years of age who is not emancipated.

A person who owns or possesses a gun who does not reside in the same premises as a minor may nevertheless be in situations where, for example, a child or teen (e.g., grandchild, nephew, student, or neighbor) is visiting their home or riding in their car, and if their gun is not safely stored, the risks of what can happen when a child or teen accesses that gun are no different than they are for someone who resides with a child. Note that the law only applies under specific circumstances as stated in N.C.G.S. § 14-315.1 (above) where the person knew or should have known that an unsupervised minor would be able to gain access to the firearm and under other specific circumstances. When considering this recommendation, the Task Force heard from a police chief about the challenges faced by law enforcement with current wording of the law, and how removing the phrase "resides in the same premises as a minor" would clarify and strengthen the law.

Recommendation to prevent deaths and injuries from motor vehicle accidents

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

1) **to address the 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 9 inches tall (57 inches) and the adult seat belt fits properly without a booster seat (law to describe proper fitting of seat belt).**

Each year from 2021 - 2023, North Carolina lost around 100 children ages 0 to 17 to motor vehicle accidents 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.

North Carolina's child passenger safety laws (G.S. 20-137.1) differ 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.**[58]

[58] Benedetti M, Klinich KD, Manary MA, Flannagan CA. Predictors of restraint use among child occupants. Traffic Inj Prev. 2017 Nov 17;18(8):866-869. doi: 10.1080/15389588.2017.1318209. Epub 2017 Apr 21. PMID: 28429962.

Many motor vehicle-related child deaths in NC occur in circumstances where a child is completely unrestrained, but data also show deaths and injuries of young children who were restrained but 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.[59]

North Carolina's Child Passenger Safety law is outdated and does not reflect best practices articulated by the American Academy of Pediatrics and the National Highway Traffic Safety Administration.

The Child Fatality Task Force, in consultation with child passenger safety experts, 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.[60]

1. Address the importance of younger children riding in the rear 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 with a front passenger air bag and available rear seat).[61] Best practice is that children should ride in the back seat longer,[62] 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.**

2. Clarify the need for infants and toddlers to ride in rear-facing seats

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 but says that children must be "properly secured in a weight-appropriate child passenger restraint system."[63] **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*.**

The Task Force recommendation does not specify a certain age to be rear-facing 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.

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[59] Data presented to the Unintentional Death Prevention Committee of the Task Force by a representative from the NC Department of Transportation.

[60] 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

[61] NC laws says: *"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."*

[62] While the best practice recommendations from the AAP in 2018 were to ride in the rear seat until age 13, experts consulted by the Task Force noted that more recent research is showing that the back seat may not be safer for older children given technology in newer cars, and the Unintentional Death Prevention Committee determined that under age 8, the same as surrounding states, was an appropriate recommendation.

[63] 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.

3. For older children, clarify safe transition from a booster seat to an adult seat belt

Seat belts are designed to fit adults. Booster seats position children 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 seat 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."* The NC law does not address the transition from booster seat to adult seat belt according to proper fitting of the adult seat belt.

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 9 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 as some other states (such as South Carolina) have done.[64] In developing a recommendation to address this transition, the Unintentional Death Prevention Committee considered information from experts that technically, a child may have an adult belt fit them correctly well before they outgrow the maximum size requirements for a booster seat, so it did not recommend requiring a booster seat until the child "outgrows" 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.

Administrative Efforts

Task Force "administrative efforts" that appear on its action agenda are non-legislative and indicate the Task Force's intention to gather more information on a topic and/or encourage collaboration to make progress with prevention strategies through non-legislative efforts. For 2025, the Task Force has three administrative efforts on their agenda, and for two of the administrative efforts below, on fentanyl and paid family and medical leave insurance, there is also an explanation of work done on these topics in response to administrative efforts on the 2024 Action Agenda.

RECOMMENDATION: Administrative efforts to encourage collaboration and outreach to educate youth, parents, and caregivers about the dangers of fentanyl and counterfeit drugs, the importance of safe storage; and to increase access to and availability of Naloxone in schools, households, and youth-serving organizations.

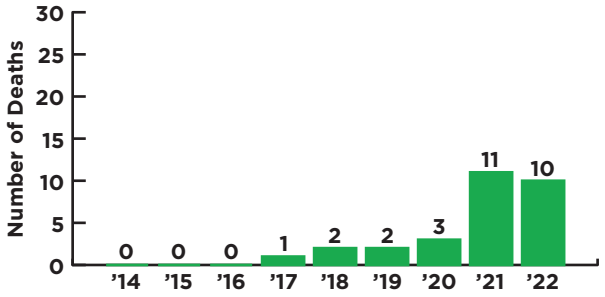
Rates of child deaths in North Carolina from poisoning have increased in recent years, and data show that this increase is related to fentanyl poisonings. Fentanyl is a synthetic opioid that is up to 50 times stronger than heroin and 100 times stronger than morphine; there is pharmaceutical fentanyl and there is also illegally made fentanyl.[65]

In 2023 and early 2024, the Task Force and its Unintentional Death Prevention Committee heard presentations on this topic from North Carolina's Chief Medical Examiner and from the Chief Toxicologist in the Office of the Chief Medical Examiner (OCME). Data from the OCME show upward trends in fentanyl deaths among NC children and youth ages 17 and under that began around 2017 and 2018 and sharply increased for 2020, 2021, and 2022 (2022 is the most recent data available). Increases in deaths were in the 0 to 4 age group and especially in the 13 to 17 age group (mostly 16- and 17-year-olds).

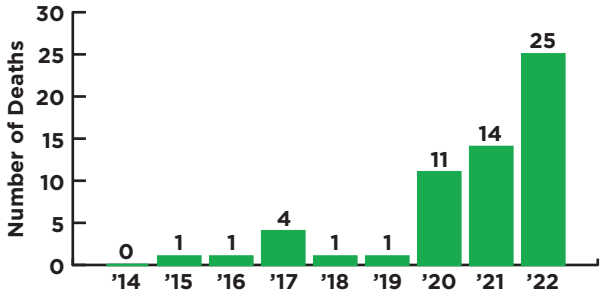
[64] S.C. Ann. Section 56-5-6410 (A)(4).

[65] "Fentanyl Facts" web page on the website for the Centers for Disease Control and Prevention: https://www.cdc.gov/stop-overdose/caring/fentanyl-facts.html?CDC_AAref_Val=https://www.cdc.gov/stopoverdose/fentanyl/index.html

NC OCME Pediatric Fentanyl Deaths (0-4 years of age)



NC OCME Pediatric Fentanyl Deaths (13-17 years of age)



For its 2024 Action Agenda, the Task Force included "administrative efforts to seek further collaboration and information gathering on issues surrounding fentanyl-related deaths to children and adolescents to bring information back to the Unintentional Death Prevention Committee."

Later in 2024 and following up on that administrative item, the Unintentional Death Prevention Committee examined more information on the topic and learned about evidence-driven prevention strategies from a three-person panel of experts.

National Data

Understanding national data was helpful to put state data in perspective. Highlights of additional (national) data on fentanyl deaths include the following:

- **National Data from a JAMA Pediatric Study on Trends in Pediatric Fentanyl Deaths** from 1999-2021 showed that in 1999, about 5% of 175 pediatric (ages 0 to 19) deaths from opioids were from fentanyl; by 2021, 94% of 1657 pediatric deaths from opioids were from fentanyl. This same study also showed that from 1999-2021, almost 90% of pediatric fentanyl deaths were among teens ages 15 to 19 while 6.6% were among children aged 0 to 4 years.[66]
- **A CDC Study of Overdose Deaths Among Youth ages 10 to 19** from July 2019 to December 2021 resulted in five main findings:[67]
    - Deaths increased substantially since the end of 2019
    - A majority of deaths involved illicit fentanyl
    - Nearly one quarter of deaths included evidence of counterfeit pills
    - Two thirds of decedents had a potential bystander present, although most provided no overdose response
    - Approximately 41% of decedents had a history of mental health conditions or treatment

[66] Gaither JR. National Trends in Pediatric Deaths From Fentanyl, 1999-2021. JAMA Pediatr. 2023;177(7):733–735. doi:10.1001/jamapediatrics.2023.0793

[67] Tanz LJ, Dinwiddie AT, Mattson CL, O'Donnell J, Davis NL. Drug Overdose Deaths Among Persons Aged 10–19 Years — United States, July 2019–December 2021. MMWR Morb Mortal Wkly Rep 2022;71:1576–1582. DOI: http://dx.doi.org/10.15585/mmwr.mm7150a2

- **Data from the National Center for Fatality Review and Prevention on Opioid Deaths** of Children ages 1 to 17 (all intents) from 2018 – 2022 based on 985 deaths reviewed by child fatality review teams provided insight into things like demographics, opioid type, manner of death, and also child history data such as: 49% of decedents had a history of child maltreatment as a victim; 33% had a prior disability or chronic illness; among 10 to 17 year olds, 91% had a history of substance use and 59% had received prior mental health services.[68]

Recognized Prevention Strategies

From research and conversations with experts, including those who were part of the panel discussion referenced above, several recognized prevention strategies were emphasized:[69]

- Harm reduction strategies
    - Expanded use of fentanyl test strips
    - Expanded access to naloxone; ensure naloxone is present in at-risk homes
- Treatment for parental and adolescent substance use (and mental health)
- Increased education about the dangers of fentanyl (and substance use education)
- Safe storage and disposal
- Upstream efforts:
    - Promoting protective factors and efforts focused on resilience and connectedness of adolescents
    - Programs and strategies that identify youth who are struggling to get them help
    - Prevent and address trauma
    - Address social drivers; support children and families

Taking all of this additional data and information into consideration, the Unintentional Death Prevention Committee determined that administrative efforts on this topic should be continued, this time to "encourage collaboration and outreach to educate youth, parents, and caregivers about the dangers of fentanyl and counterfeit drugs, the importance of safe storage; and to increase access to and availability of Naloxone in schools, households, and youth-serving organizations."

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[68] Data Source: National Center for Fatality Review and Prevention's Quick Look: Opioid-Related Deaths in Children Ages 1-17 based on data from the National Fatality Review Case Reporting System that collects data from child fatality review teams from across the country; data based on 985 deaths from opioid ingestion that were reviewed by fatality review teams. https://ncfrp.org/center-resources/quick-looks/opioid-related-deaths-in-children-ages-1-to-17/ Notes: NC data not included in this system as it will begin participating in January, 2026; each state has different criteria for a child death that receives a team review.

[69] **Panelists: Pamela Morrison**, LPA, LCAS, CCS, NC State Opioid Treatment Authority (SOTA) Coordinator, Division of Mental Health, Developmental Disabilities and Substance Use Services, Addictions and Management Operations Section, NCDHHS; **Elyse Powell**, PhD, Executive Director, NC Harm Reduction Coalition (and former State Opioid Coordinator, NCDHHS); **Nidhi Sachdeva**, MPH, Director of Strategic Health and Opioid Initiatives, NC Association of County Commissioners. **Research sources:** 1) Gaither JR. **National Trends in Pediatric Deaths From Fentanyl, 1999-2021. JAMA Pediatr.** 2023;177(7):733–735. doi:10.1001/jamapediatrics.2023.0793 Jama; 2) Julie R. Gaither, Sarah McCollum, Kirsten Bechtel, John M. Leventhal, Sasha Mintz; The **Circumstances Surrounding Fatal Pediatric Opioid Poisonings, 2004–2020**. Pediatrics November 2024; 154 (Supplement 3): e2024067043N. 10.1542/peds.2024-067043N; 3) **CDC page on Preventing Opioid Overdose**: https://www.cdc.gov/overdose-prevention/prevention/index.html; 4) Substance Abuse and Mental Health Services Administration. **SAMHSA Overdose Prevention and Response Toolkit**. Publication No. PEP23-03-00-001. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2023; 5) Tanz LJ, Dinwiddie AT, Mattson CL, O'Donnell J, Davis NL. Drug **Overdose Deaths Among Persons Aged 10–19 Years — United States, July 2019–December 2021**. MMWR Morb Mortal Wkly Rep 2022;71:1576–1582. DOI: http://dx.doi.org/10.15585/mmwr.mm7150a2; 6) **North Carolina Opioid and Substance Use Action Plan**: https://www.ncdhhs.gov/about/department-initiatives/overdose-epidemic/north-carolinas-opioid-and-substance-use-action-plan

RECOMMENDATION: Administrative efforts to assist legislative members of the Child Fatality Task Force Perinatal Health Committee in convening stakeholders around the issue of certified professional midwives.

In 2024, the Task Force received an issue application from the NC Chapter of the Association of Certified Professional Midwives (NC ACPM) asking the Task Force to endorse legislation to license and integrate Certified Professional Midwives (CPMs) into the perinatal healthcare system. (The Task Force has an issue application process that is sometimes used to identify evidence-driven prevention strategies that it may want to study.)

This topic was of interest to the Task Force because of the shortage of maternity care providers in North Carolina and the need to examine ways to meet maternity care needs. In North Carolina, 21% of counties are maternity care deserts and 17% of counties have low or moderate access; 13.4% of women have no birthing hospital within 30 minutes.[70] Access to maternity care is an important strategy in preventing adverse birth outcomes including death, and the North Carolina Perinatal Health Strategic Plan includes a recommendation for licensure of Certified Professional Midwives.[71]

A Certified Professional Midwife is "trained and credentialed to offer expert care, education, counseling and support to birthing people during the pregnancy, birth, and the postpartum periods. CPMs practice as autonomous health professionals working within a network of relationships with other care providers who can provide consultation and collaboration when needed."[72]

All CPMs meet the standards for certification set by the North American Registry of Midwives. CPMs are not licensed to practice in North Carolina, although they are licensed to practice in 38 other states.[73] Certified Nurse Midwives (CNMs) are different than CPMs and are already licensed to practice in North Carolina.

Highlights of information presented to the Perinatal Health Committee by the NC ACPM included the following:

- Midwifery care is associated with positive outcomes including reduced preterm and low birth weight births and reduced neonatal deaths; the 2018 Midwifery Integration Scoring System showed that the best outcomes for mothers and babies occur in states where all types of midwives are regulated and integrated into the health care system.[74]
- Integrating midwifery care into health care systems can help address disparities and inequalities in maternal health.
- Licensing CPMs creates a mechanism for regulatory frameworks and provider accountability, including continuing education, clinical practice guidelines, protocols for emergency situations, and informed consent disclosures.
- Licensing CPMs provides the opportunity to establish collaborative relationships with medical care providers and integrate into the health care system, improving safety for CPMs and the families they serve.
- Licensing CPMs increases North Carolina's capacity to grow and diversify the midwifery workforce, increasing access to high quality, culturally competent midwifery care; CPMs can be part of the perinatal workforce, helping to address a lack of providers, especially in rural and underserved areas.

[70] March of Dimes report, "Where you Live Matters: Maternity Care Access in North Carolina": https://www.marchofdimes.org/peristats/reports/north-carolina/maternity-care-deserts

[71] See goal 3.3 of the NC Perinatal Health Strategic Plan: https://wicws.dph.ncdhhs.gov/phsp/docs/PerinatalHealthStrategicPlan-9-15-22_WEB.pdf

[72] According to the National Association of Certified Professional Midwives.

[73] National Association of Certified Professional Midwives, Legal Recognition of CPMs: https://www.nacpm.org/legal-recognition-of-cpms-1.

[74] Vedam S, Stoll K, MacDorman M, Declercq E, Cramer R, Cheyney M, Fisher T, Butt E, Yang YT, Powell Kennedy H. Mapping integration of midwives across the United States: Impact on access, equity, and outcomes. PLoS One. 2018 Feb 21;13(2):e0192523. doi: 10.1371/journal.pone.0192523. PMID: 29466389; PMCID: PMC5821332.

After hearing a presentation from the NC ACPM, the Perinatal Health Committee of the Task Force discussed the importance of considering the licensing of CPMs as a potential strategy to address the maternity care crisis in North Carolina, but decided that it would be necessary to learn more from other stakeholders before making any determinations.

A subsequent effort to gather more information from stakeholders helped to inform the topic, including discussions about how the demand for midwifery care and the preference for home birth has increased. Stakeholders said that without choices, some mothers are opting for unassisted births and some are being assisted by those calling themselves midwives who are not certified – both of which present safety concerns. Some stakeholders in the medical community, however, expressed that they were not prepared to support this issue without time to learn more, but did not put forward specific objections. Legislative members of the Perinatal Health Committee expressed an interest in convening stakeholders on this topic, which is what led to this administrative item.

RECOMMENDATION: Administrative efforts to explore partnerships in our state to advance a conversation about Paid Family and Medical Leave Insurance and bring a report on developments back to the Task Force.

The Child Fatality Task Force began studying the topic of Paid Family and Medical Leave Insurance in 2017. This work led to an independent study by Duke University on the costs and benefits of Paid Family Leave Insurance in North Carolina that was published in 2019; among its finding were that Paid Family Leave Insurance in North Carolina could save 26 infant lives per year.[75] In 2020, the Task Force recommended legislation to address Paid Family Leave Insurance. In 2021, the Perinatal Health Committee recommended repeating this recommendation, but the Task Force did not approve it as some members wanted more input from the business community. Although bills to implement Paid Family Leave Insurance in North Carolina have been introduced over the years, none have advanced.

With growing recognition of access to paid leave as an important strategy to prevent child deaths and maltreatment, the Task Force revisited the topic of Paid Family Leave Insurance during its 2023/2024 study cycle. Study of this topic resulted in the following 2024 Action Agenda item: "Administrative efforts to gather information to bring back to the CFTF on paid family leave insurance (PFLI) including information on the impact of PFLI on businesses and employer feedback on PFLI."

During 2024, efforts were made pursuant to this administrative item to gather updated information surrounding PFMLI as well as information and feedback from the business community on the concept of Paid Family and Medical Leave Insurance (PFMLI).

Paid Family and Medical Leave Insurance and Its Relevance to the Child Fatality Task Force

Most working people in the U.S. do not have paid family leave and access worsens for lower wage workers.[76] PFMLI is a specific type of paid family and medical leave that is publicly provided and operates statewide. PFMLI has been implemented in 13 states. It utilizes a state-managed fund which lets all workers earn a portion of their pay while they care for their own serious health condition, for a family member with a serious health condition, or for birth or adoption (and sometimes foster placement) of a child. This type of leave is different from sick leave which involves very short-term absences.

[75] Gassman-Pines, A. & Ananat, E.O. (March 2019). *Paid Family Leave in North Carolina: An Analysis of Costs and Benefits*. Center for Child and Family Policy, Sanford School of Public Policy, Duke University. The study is posted on the CFTF website: https://webservices.ncleg.gov/ViewDocSiteFile/81983.

[76] See: Bureau of Labor Statistics data showing worker access to different types of paid leave: https://www.bls.gov/charts/employee-benefits/percent-access-paid-leave-by-wage.htm

The structure of PFMLI varies by state. Some aspects of programs and their variations include the following:[77]

- The way it is funded varies and involves contributions by an employee, an employer, or a mix of the two of a small amount as a percent of income (e.g., 0.35%) from each paycheck to an insurance fund from which an employee can draw for qualified leave purposes – e.g., an employee might pay $1.50 - $4.50 per week.
- Eligibility for benefits may include a certain number of minimum hours worked or minimum earnings in the past year.
- Level of wage replacement varies; an employee eligible for PFMLI would receive a certain percentage of wages (with a weekly maximum cap).
- Coverage for one's own health ranges from 12 to 52 weeks depending on the state; coverage for family leave varies by state from 8 to 12 weeks.
- Administration of programs varies; examples include temporary disability insurance programs, department of labor/employment, department of employment and economic development, etc.
- Some states provide grants to employers to help cover leave-related costs, such as hiring a temporary employee, as well as technical assistance.

Evidence on the benefits of Paid Family Leave and Paid Family and Medical Leave Insurance on the health and well-being of children and families is clear. Not only does access to paid family leave support overall well-being, but it can also prevent child maltreatment and prevent child and infant deaths. Besides the Duke study noted above that found 26 infant lives could be saved per year if North Carolina had Paid Family Leave Insurance, a 2020 study of California's paid family leave insurance policy showed that its implementation was associated with a 12 percent reduction in post neonatal mortality.[78] Other studies, including newer ones from 2023 and 2024, have shown the preventive impacts of PFMLI on child maltreatment and/or infant mortality.[79]

A variety of organizations have recognized these prevention impacts, for example:

- Access to paid leave is cited by the Centers for Disease Control and Prevention (CDC) as an economic support strategy that can prevent child maltreatment.[80]
- Promoting access to paid leave is among the goals identified in the North Carolina Perinatal Health Strategic Plan and among the priorities identified by the March of Dimes.[81]
- In October of 2024, the American Academy of Pediatrics (AAP) published a policy statement citing the research on the positive effects of PFML on the physical and mental health of infants, children, and their families and said that Paid Family and Medical Leave was a "key component of improving the health of children and families and is critically needed in the U.S."[82]

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[77] For more information about the structure of PFMLI programs in other states, visit this page on the U.S. Department of Labor website: https://www.dol.gov/agencies/wb/paid-leave/State-Paid-Family-Medical-Leave-Laws

[78] Montoya-Williams D, Passarella M, Lorch SA. The impact of paid family leave in the United States on birth outcomes and mortality in the first year of life. Health Serv Res. 2020; 55: 807–814. https://doi.org/10.1111/1475-6773.13288

[79] See, e.g., Tanis, Klein, Boyke (June 2024). State paid family leave policies and infant maltreatment, Child Abuse and Neglect, Volume 152 https://doi.org/10.1016/j.chiabu.2024.106758; Bullinger LR, Klika B, Feely M, Ford D, Merrick M, Raissian K, Rostad W, Schneider W. Paid Family Leave: An Upstream Intervention to Prevent Family Violence. J Fam Violence. 2023 Jan 17:1-11. doi: 10.1007/s10896-022-00486-3. Epub ahead of print. PMID: 36685754; PMCID: PMC9843119; Klevens J, Luo F, Xu L, Peterson C, Latzman NE. Paid family leave's effect on hospital admissions for pediatric abusive head trauma. Inj Prev. 2016 Dec;22(6):442-445. doi: 10.1136/injuryprev-2015-041702. Epub 2016 Feb 11. PMID: 26869666; PMCID: PMC4981551.

[80] Fortson, B. L., Klevens, J., Merrick, M. T., Gilbert, L. K., & Alexander, S. P. (2016). Child Abuse and Neglect Prevention Resource for Action: A Compilation of the Best Available Evidence. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/pdf/CAN-Prevention-Resource_508.pdf

[81] See the 2022-2026 NC Perinatal Health Strategic Plan, https://wicws.dph.ncdhhs.gov/phsp/inequities.htm; and the March of Dimes 2025-2026 Policy Priorities, https://www.marchofdimes.org/sites/default/files/2025-01/2025_2026_OGA_Policy_Priorities.pdf.

[82] Christiane E. L. Dammann, Kimberly Montez, Mala Mathur, Sherri L. Alderman, Maya Bunik, COUNCIL ON COMMUNITY PEDIATRICS, COUNCIL ON EARLY CHILDHOOD, SECTION ON BREASTFEEDING, SECTION ON NEONATAL PERINATAL MEDICINE; Paid Family and Medical Leave: Policy Statement. Pediatrics November 2024; 154 (5): e2024068958. 10.1542/peds.2024-068958.

With respect to employer impacts of PFMLI, studies show that Statewide PFLI programs are generally viewed by employers as having a positive effect or no noticeable effect on them. In fact, a 2023 review of the research on this topic stated that "research on US employers has shown no adverse impacts of state PFL policies on a range of employer outcomes."[83]

Addressing the 2024 Administrative Item: Efforts to gather perspective from the North Carolina business community on the concept of PFMLI

There are no known studies or surveys to ascertain North Carolina employers' perspectives on the concept of Paid Family and Medical Leave *Insurance* in North Carolina. There was, however, a poll that asked North Carolina small business owners about a national paid family and medical leave program. Among the **findings of this 2024 scientific opinion poll of NC small business owners** (116 respondents to survey) conducted for Small Business Majority and the National Partnership for Women & Families by Lake Research Partners were:

- 82% of North Carolina small business owners support the creation of a national paid family and medical leave program that would guarantee employees wage replacement for up to 12 weeks, funded by 0.5% employer and employee contributions each.
- When asked to choose between two approaches, small business owners were more than twice as likely to support a universal paid family and medical leave program (67%) than a voluntary insurance program that businesses could choose to buy into (31%).

With no existing research to draw from, a project was undertaken to address the Task Force administrative item that called for gathering feedback from the business community on PFMLI.[84] Given limited resources, the project was small in scope and its intent was to begin to understand the thoughts of the business community. The project involved outreach to about 35 individuals representing employer associations, chambers of commerce, and individual businesses, and nine of those 35 individuals elected to provide feedback.

Project leaders shared with the Perinatal Health Committee and the Task Force about this outreach and what they learned from a small number of participants. This provided a glimpse into how much participants knew about PFMLI, which was very little, and how participants reacted to the concept. In general, participants could understand the benefits of PFMLI but were concerned about implementation and wanted more specific information. Among several take-aways was the need for a much larger and better resourced effort to get meaningful feedback from the business community and to educate the business community about PFMLI, both of which would require the involvement of an organization well-positioned for this work.

Based on this information, the Perinatal Health Committee arrived at this administrative item for "efforts to explore partnerships in our state to advance a conversation about Paid Family and Medical Leave Insurance and bring a report on developments back to the Task Force."

[83] This Public Health Journal Article summarizes much of the research on PFMLI, and it summarizes findings from various studies related to employer impact: "The Impacts of Paid Family and Medical Leave on Worker Health, Family Well-Being, and Employer Outcomes" https://www.annualreviews.org/content/journals/10.1146/annurev-publhealth-071521-025257

[84] These efforts involved a collaboration by the Task Force Executive Director with individuals working with the NC Essentials for Childhood Project, which is managed by North Carolina Institute of Medicine in partnership with the NCDHHS Division of Public Health. Essentials for Childhood is a CDC-funded project aimed at preventing child abuse and neglect. Those assisting were Lisa Finaldi and Beth Messersmith, and their expertise and efforts made this work possible.

CHILD FATALITY TASK FORCE
Leadership and Contact Information

Task Force Leadership

Executive Director

Kella W. Hatcher, JD
Email: kella.hatcher@dhhs.nc.gov

Co-Chairs

Karen McLeod, MSW
President/CEO, Benchmarks NC
Email: kmcleod@benchmarksnc.org

Jill Cox
President/CEO, Communities in Schools NC
Email: jcox@cisnc.org

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

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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 Division of Public Health, NC 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

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

Co-Chairs

- **Martha Sue Hall, MS**, Mayor Pro Tempore, City of Albemarle; First Vice President, North Carolina League of Municipalities
- **Scott K. Proescholdbell, MPH**, Epidemiologist and Unit Manager, Injury Epidemiology, Surveillance and Informatics Unit, Division of Public Health, Injury and Violence Prevention Branch, NC Department of Health and Human Services

NC CHILD FATALITY TASK FORCE
Member Roster[85]

(As of the last meeting of the Task Force on 12/10/24)

GOVERNOR APPOINTEES (4)	MEMBER OR DESIGNEE	APPOINTMENT EXPIRATION
1. A director of a county department of social services, appointed by the Governor upon recommendation of the President of the North Carolina Association of County Directors of Social Services	**Jennifer Kristiansen** Director of Social Services Chatham County	1-31-26
2. A representative from a Sudden Infant Death Syndrome or safe infant sleep counseling and education program, appointed by the Governor upon recommendation of the Maternal and Child Health Section of the Department of Health and Human Services	**Dr. Sarah Verbiest** Executive Director UNC Collaborative for Maternal & Infant Health	1-31-25
3. A representative from NC Child, appointed by the Governor upon recommendation of the President of the organization	**Tiffany Gladney** Policy Director NC Child	1-31-25
4. A director of a local department of health, appointed by the Governor upon the recommendation of the President of the North Carolina Association of Local Health Directors	**Wes Gray** Health Director Pitt County Health Department	1-31-25
HOUSE SPEAKER APPOINTEES (10)		
1. A representative from a private group, other than NC Child, that advocates for children, appointed by the Speaker of the House of Representatives upon recommendation of private child advocacy organizations	**Karen McLeod** President and CEO Benchmarks	1-31-26
2. A pediatrician, licensed to practice medicine in North Carolina, appointed by the Speaker of the House of Representatives upon recommendation of the NC Pediatric Society	**Dr. Martin McCaffrey** Pediatrician UNC	1-31-26
3. A representative from the North Carolina League of Municipalities, appointed by the Speaker of the House of Representatives upon recommendation of the League	**Martha Sue Hall** Mayor Pro Tem, City of Albemarle; First VP, NC League of Municipalities	1-31-26
4. One public member, appointed by the Speaker of the House of Representatives	**Katherine Pope**	1-31-26
5. One representative of the NC Domestic Violence Commission, appointed by the Speaker of the House of Representatives upon recommendation of the Director of the Commission	**TeAndra Miller** Managing Attorney & Project Director, DVSA Practice Group, Legal Aid of North Carolina	1-31-26
6-10. **Five members** of the House of Representatives, appointed by the Speaker of the House of Representatives.	**Dr. Kristin Baker** **Carla Cunningham** **Donnie Loftis** **Diane Wheatley** **Donna White**	1-31-26 (all)

[85] According to law enacted in 2015, third-party recommendations for legislative appointments are discretionary, not binding, and legislative appointments on this chart where a third-party recommender is noted may or may not have been made according to a third-party recommendation.

SENATE APPOINTEES (10)		
1. A representative from the North Carolina Association of County Commissioners, appointed by the President Pro Tempore of the Senate upon recommendation of the Association	**Hope Haywood** County Commissioner, Randolph County	1-31-25
2. One public member, appointed by the President Pro Tempore of the Senate	**Jill Cox** President & CEO Communities in Schools NC	1-31-25
3. One representative of the NC Coalition Against Domestic Violence, appointed by the President Pro Tempore of the Senate upon recommendation of the Executive Director of the Coalition	**Trishana Jones** Programs Director NC Coalition Against Domestic Violence	1-31-25
4. A county or municipal law enforcement officer, appointed by the President Pro Tempore of the Senate upon recommendation of organizations that represent local law enforcement officers	**VACANT**	
5. A district attorney appointed by the President Pro Tempore of the Senate upon recommendation of the President of the North Carolina Conference of District Attorneys	**Sarah Kirkman** District Attorney Judicial District 22A	1-31-25
6-10. Five members of the Senate, appointed by the President Pro Tempore of the Senate	**Jim Burgin** **Todd Johnson** **Vickie Sawyer** **Sydney Batch** **Gale Adcock**	1-31-25 (all)
EX OFFICIO MEMBERS		
The Chief Medical Examiner	**Dr. Michelle Aurelius** Chief Medical Examiner	ongoing
The Attorney General	**Laura Brewer** Deputy Chief of Staff, AG Josh Stein, NC DOJ	ongoing
The Director of the Division of Social Services of the Department of Health and Human Services	**Lisa Cauley** Senior Director of Child, Family, & Adult Services, Division of Social Services, NCDHHS	ongoing
The Director of the State Bureau of Investigation	**Kevin Tabron** Asst. Director, SBI	ongoing
The Director of the Maternal and Child Health Section of the Department of Health and Human Services	**Dr. Kelly Kimple** Senior Medical Director for Health Promotion, NC Title V Director, NC Division of Public Health	ongoing
The Director of Council for Women and Youth Involvement	**Danielle Carman** Executive Director, CWYI	ongoing
The Superintendent of Public Instruction	**Karen Fairley** Executive Director NC Center for Safer Schools	ongoing
The Chairman of the State Board of Education	**Dr. Ellen Essick** Section Chief NC Healthy Schools, DPI	ongoing

The Director of the Division of Child and Family Well-Being of the Department of Health and Human Services	**Dr. Gerri Mattson** Senior Medical Director Division of Child & Family Well-Being	ongoing
The Secretary of the Department of Health and Human Services	**Dr. Betsey Tilson** State Health Director	ongoing
The Director of the Administrative Office of the Courts	**Lorrie L. Dollar** Administrator Guardian Ad Litem Program	ongoing
Director of the Juvenile Justice Section, Division of Adult Correction and Juvenile Justice, Department of Public Safety	**William Lassiter** Deputy Secretary for Juvenile Justice, DPS	ongoing