Child Fatality Task Force

Our Children, Our Future, Our RESPONSIBILITY

2019 Recommendations to Strengthen the Statewide Child Fatality Prevention System

Recommendation #1: Support legislation, agency action, and policy change to implement the following changes to the Child Fatality Prevention System (CFP System):

I. Implement centralized state-level staff with whole-system oversight in one location within the Department of Health and Human Services (DHHS) with the formation of a new cross-sector Fatality Review and Data Group.

DHHS, in consultation with those knowledgeable about North Carolina's Child Fatality Prevention System as well as national experts in fatality review and prevention, should determine the most appropriate placement and staffing configuration for this "central office," taking into consideration that most child fatalities relate to issues addressed within the Division of Public Health (DPH). The Fatality Review and Data (FRD) Group, convened by the central office, should act as a liaison with the Child Fatality Task Force (CFTF) for information coming from local fatality review teams and the Office of the Chief Medical Examiner (OCME), with the Chief ME and OCME child fatality staff having a role with this FRD Group. Child fatality staff in the OCME should remain in the OCME and continue to review all child fatalities that come through the medical examiner system. The CFTF should continue to function separately and independently and not as part of DHHS, however staff support functions for the CFTF would be included in the central office and the CFTF report would address whole-system functioning.

II. Implement a centralized electronic data and information system that includes North Carolina joining 46 other states to participate in the National Child Death Review Case Reporting System.

Central office staff should manage the system and DHHS, in consultation with CFP system stakeholders as well as data and legal experts, should develop and implement appropriate procedures and policies for participation in the national system as well as procedures and policies for appropriate information sharing and protection as it relates to information used by or generated from child fatality reviews. Central office staff should work with NC DSS related to defining, identifying, counting and reporting child maltreatment deaths to align with federal requirements.

III. Reduce the volume of team reviews by changing the types of deaths required to be reviewed by fatality review teams to be according to certain categories most likely to yield prevention opportunities.

Teams should be required to review the following types of deaths: undetermined causes; unintentional injury; violence; motor vehicle

Structural outcomes addressed by these changes

- Eliminates the "silos" within which the current system functions.
- Implements centralized oversight.
- Streamlines state-level support functions of CFP System & adds capacity to elevate the effectiveness of all system components.
- Eliminates the redundancy/duplication of team reviews but keeps critical functions & diverse contributions of expertise.
- Ensures that review teams have the training and resources they need to conduct effective reviews and make effective recommendations.
- Maximizes the usefulness of data/information learned from reviews by expanding, improving, and standardizing data capture, analysis, and reporting.
- Ensures that relevant & appropriate information & recommendations from team reviews reaches local leaders, state agency leaders, and the CFTF in a timely fashion.
- Ensures that CFTF's ability to study data, evaluate evidence, and advance policies continues.

incidents; child abuse or neglect/child protective services involvement; sudden unexpected infant death; suicide; and deaths not expected in the next 6 months. Teams could choose to review other types of deaths as well. In addition, DHHS, in consultation with child fatality review and prevention experts as well as perinatal health experts, should determine: 1) any additional special criteria that should be used for determining which types and/or percentages of infant deaths (which account for two-thirds of all child deaths) should be reviewed by teams in order to optimize the identification of prevention opportunities; and 2) area(s) of North Carolina in which a specialized Fetal and Infant Mortality Review (FIMR) program should be launched and integrated with the larger CFP System to inform state-level action related to the prevention of infant deaths (dependent on available funding).

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

Intensive-type reviews for fatalities related to suspected abuse or neglect or families involved with DSS should still take place with coordination and technical onsite assistance from state-level staff. DHHS, in consultation with child welfare and child fatality experts, should determine appropriate policies, procedures, and required participants for these types of intensive reviews, whether there should be distinct and special procedures or required participants for certain other types of deaths reviewed, and whether and under what circumstances the Fatality Review and Data Group (referenced above in I) should have the ability to do occasional state-level team reviews with the involvement of the OCME. The Chief Medical Examiner and OCME child fatality staff would no longer be leading routine State CFPT reviews but they would continue to perform all other current functions related to child fatalities that enter the ME system, they could contribute information to local team reviews, they would perform case analysis and reporting that they contribute to the new Fatality Review and Data group and to the larger system, and they would work closely with the CFP central office. Citizen Review Panels should no longer be combined via policy with all local Community Child Protection Teams, and active DSS cases (not involving a fatality) should not be required by statute to be reviewed by local teams who review fatalities.

V. Formalize the three committees of the Child Fatality Task Force (CFTF) with certain required committee members and expand the required CFTF report to address the whole CFP system with required report to be distributed to additional state leaders beyond the Governor and General Assembly.

Outcomes we want to achieve FOR KIDS

- Ensure that the prevention of child fatalities and maltreatment is approached as a community-wide and state-wide responsibility.
- Identify and address system problems or gaps in order to prevent future fatalities & maltreatment.
- Accurately collect and analyze child death data for the purpose of better understanding the apparent and contributing causes of child death and opportunities to prevent future deaths.
- Identify effective strategies for the prevention of child fatalities and maltreatment.
- Implement effective local and state-level strategies (in the form of programs or changes in law or policy) for the prevention of child fatalities and maltreatment.
- Leverage the collaboration and expertise of multidisciplinary teams to draw on public and private resources at the state and local level to accomplish all of the above outcomes in order to prevent future child abuse, neglect, and death.

Formalize the existence, functioning, and membership of the three committees of the CFTF with CFTF Executive Committee determination for how CFTF members will be assigned to specific committees, whether there should be additional members, and other policies that impact the effective functioning of committees. With connections between the CFTF and fatality reviews being strengthened in this restructuring, the annual report the CFTF currently submits to the Governor and General Assembly should be expanded to address the whole CFP system, as the CFTF serves in an advisory role to the CFP Central Office to help ensure whole-system effectiveness. The CFTF report should be submitted to additional state leaders such as certain legislative committees and agency leaders whose work impacts child health and safety.

Recommendation #2: Maintain current state funding for existing positions and operations that support Child Fatality Prevention System work, and pursuant to DHHS determinations to be made related to the most appropriate placement and staffing configuration for this central office as well as funding needs of local health departments to support CFP system work, appropriate additional recurring funding to support this work. (Funding estimate is for $550K.)

Recommendation #3: Pursuant to DHHS determinations to be made related to launching a Fetal and Infant Mortality Review Program to inform state-level action related to the prevention of infant deaths (see III above), support funding to enable implementation of the evidence-informed practice of FIMR as a pilot. (Funding estimate is for $300K.)

Note: Additional explanation and background related to these recommendations will be set out in the 2019 CFTF Annual Report, to be released at the beginning of the 2019 legislative session. A fact sheet on the recommendations will also be available in early 2019.