Child Fatality Task Force

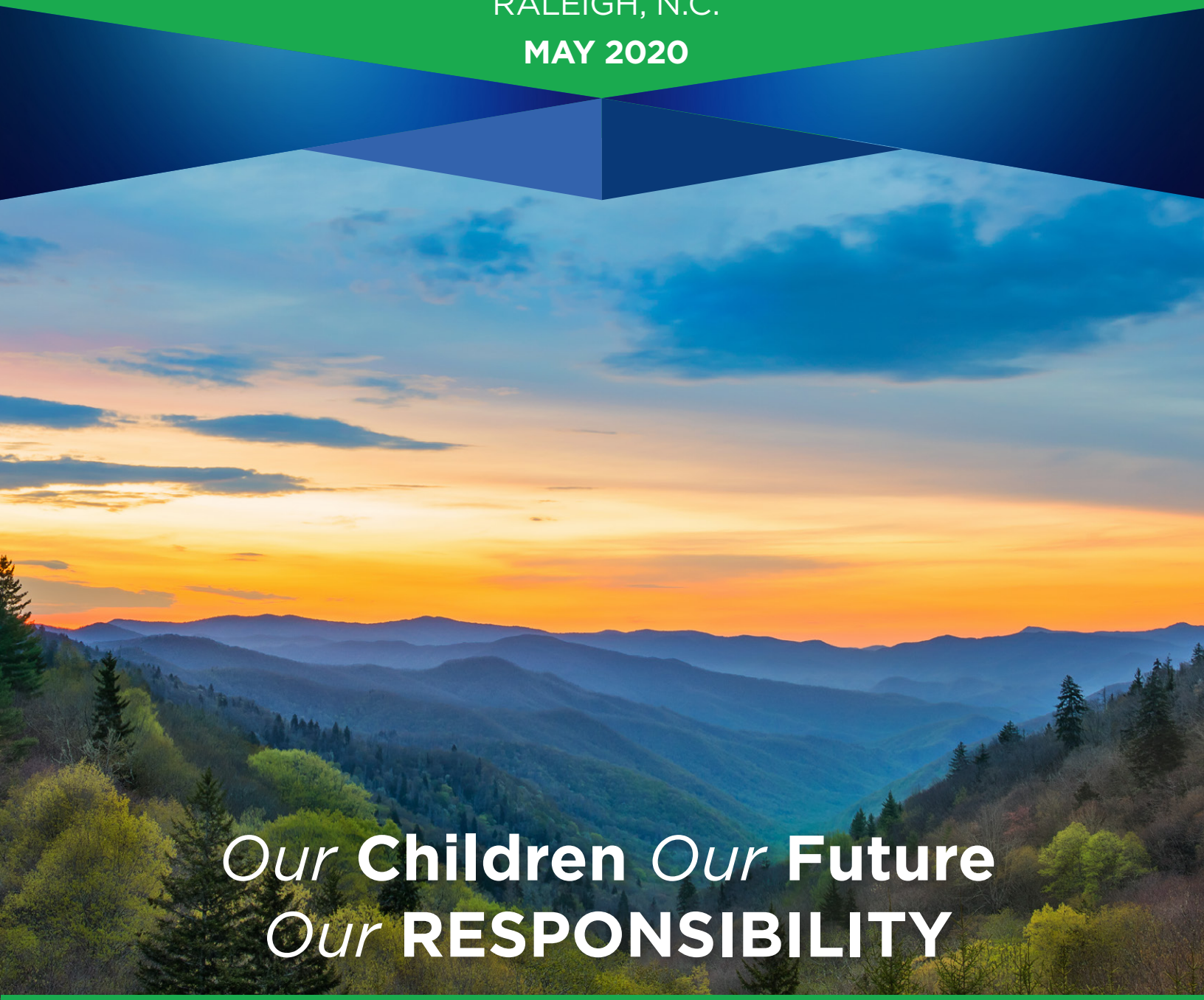
North Carolina Child Fatality Task Force

ANNUAL REPORT

to the Governor and General Assembly

RALEIGH, N.C.

MAY 2020



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

Our **RESPONSIBILITY**

MAY 2020

The Honorable Roy Cooper
Governor, State of North Carolina

Distinguished Members of the North Carolina General Assembly

We are pleased to submit this year's annual report with the good news that the child death rate in North Carolina reached a historic low. However, there is much work to be done as North Carolina's infant mortality rate (also at a historic low) remains among the highest in the nation, and we are seeing concerning upward trends in youth suicide and firearm-related deaths to children and youth. (You can find more data about child deaths in North Carolina on pages 9-12 and 73-80 of this report.) This report addresses progress on recommendations made by the North Carolina Child Fatality Task Force in 2019, presents new recommendations for 2020, and provides child death data and other information related to Task Force work.

The 2019-2020 time-period for the North Carolina Child Fatality Task Force was unique and especially challenging but in spite of these challenges, a great deal of progress was made in advancing Task Force policies and prevention work aimed at preventing child deaths and child maltreatment and promoting child well-being. As we write this letter, our state and our country are in the middle of the COVID-19 pandemic. The pandemic forced the Task Force to end its 2019-2020 study cycle without a final meeting and delayed submission of this annual report. The recent study cycle of the Task Force was also impacted by the unusually long duration of the 2019 legislative session which led to meeting cancellations. In addition, the unusual circumstance of not having a finalized Appropriations Act in 2019 (HB 966) meant that several of our recommendations addressed in this budget bill did not become law. (You can read more about the Task Force study process on pages 5-8 of this report.)

For the first time, this report contains some recommendations labeled "pending." The final meeting of the Task Force that had to be cancelled would have been devoted to considering a number of recommendations coming from Task Force committees. Because the Task Force did not have an opportunity to determine approval of some committee recommendations, these will be listed in this report as "pending" items that will be taken up when the Task Force reconvenes.

Several 2019 recommendations of the Task Force were taken up in the 2019 legislative session. Even in circumstances where legislation did not fully advance, the Task Force saw progress with widespread bipartisan support for legislation to strengthen the statewide Child Fatality Prevention System, to launch and fund a statewide firearm safe storage initiative, and to require suicide prevention training and a risk referral protocol in schools. Legislation that did fully advance addressed recommendations for funding to increase the number of school nurses and funding to

implement Raise the Age, both of which were causes being advanced by multiple organizations in addition to the Task Force. (You can read more about progress on NC Child Fatality Task Force 2019 Action Agenda recommendations on page 69-71 of this report.)

Many of the Task Force recommendations for 2020 and pending items from committees are carrying over from 2019 to continue advancing priorities not yet fully advanced but remaining critically important. These carry-over recommendations relate to strengthening the statewide Child Fatality Prevention System, youth suicide prevention, firearm safety, nicotine use prevention, infant safe sleep, and motor vehicle safety. One new set of recommendations for 2020 relates to workplace measures that prevent families from having to make dangerous choices between earning essential income and caring for themselves, their family, or protecting those who may be infected if they were to go to work sick or send their child to school or day care sick. The complete 2020 Action Agenda of Task Force recommendations can be found on pages 13-15, and the detailed explanation of information supporting action agenda items can be found on pages 16-54.

The set of recommendations (for both 2019 and 2020) to strengthen the statewide Child Fatality Prevention System has already seen a great deal of progress even though legislation addressing the recommendations has not become law. The North Carolina Department of Health and Human Services (DHHS) embraced these recommendations as being aligned with DHHS priorities and formed groups of leaders and stakeholders to plan for a future State Office of Child Fatality Prevention, the restructuring of child fatality review teams, and implementing a new system for managing case review information. (More information about strengthening the Child Fatality Prevention System can be found on pages 39-44.)

The Task Force has a nearly three-decade track record of advancing important public policy in North Carolina that saves kids' lives and supports their well-being, and these accomplishments are noted in 55-71 of pages in this report. Much of the credit for this success goes to the responsiveness of state leaders to Task Force recommendations. With hopes for continued responsiveness to the 2020 recommendations in this report, we remain optimistic about continuing to decrease North Carolina's child death rate and making strides to better support child well-being.

Karen McLeod
CHAIR

Kella Hatcher
EXECUTIVE DIRECTOR

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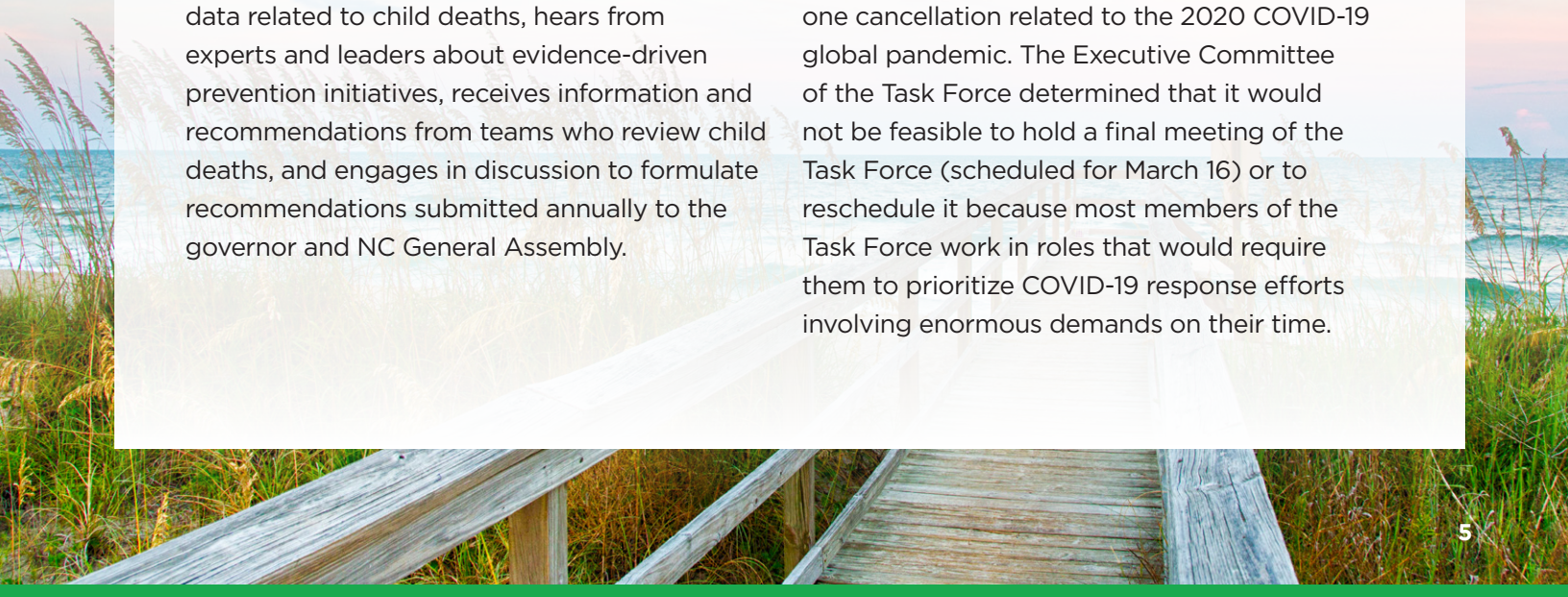
NC Child Fatality Task Force **Mandate, Study Process, and Ongoing Efforts**

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 part of the broader statewide Child Fatality Prevention System created in 1991. The charge of the system is: to develop a community-wide approach to child abuse and neglect; to study and understand causes of childhood death; to identify gaps in service delivery in systems designed to prevent child abuse, neglect, and death; and to make and implement recommendations for laws, rules, and policies that will support the safe and healthy development of children and prevent future child abuse, neglect, and death. This system has local and state-level teams that review individual cases of child deaths. The Task Force is the "policy arm" of the system and does not conduct individual case reviews.

The Task Force studies and reports on data related to child deaths, hears from experts and leaders about evidence-driven prevention initiatives, receives information and recommendations from teams who review child deaths, and engages in discussion to formulate recommendations submitted annually to the governor and NC General Assembly.

Sources of issues that come before the Task Force for consideration during a given meeting cycle include: those identified through an issue application process; identification of a concerning trend arising from data; reports or recommendations from the State Child Fatality Prevention Team; information from work groups studying issues of interest to the Task Force; relevant national or statewide initiatives; policy issues from the prior year not yet fully advanced; and other updates and education on issues relevant to Task Force work.

During its most recent study cycle, the Task Force had a total of nine meetings, including seven committee meetings and two full Task Force meetings where attendees heard more than 50 presentations. For this study cycle, four scheduled meetings had to be cancelled. Three cancellations related to the extended duration of the legislative long session and one cancellation related to the 2020 COVID-19 global pandemic. The Executive Committee of the Task Force determined that it would not be feasible to hold a final meeting of the Task Force (scheduled for March 16) or to reschedule it because most members of the Task Force work in roles that would require them to prioritize COVID-19 response efforts involving enormous demands on their time.

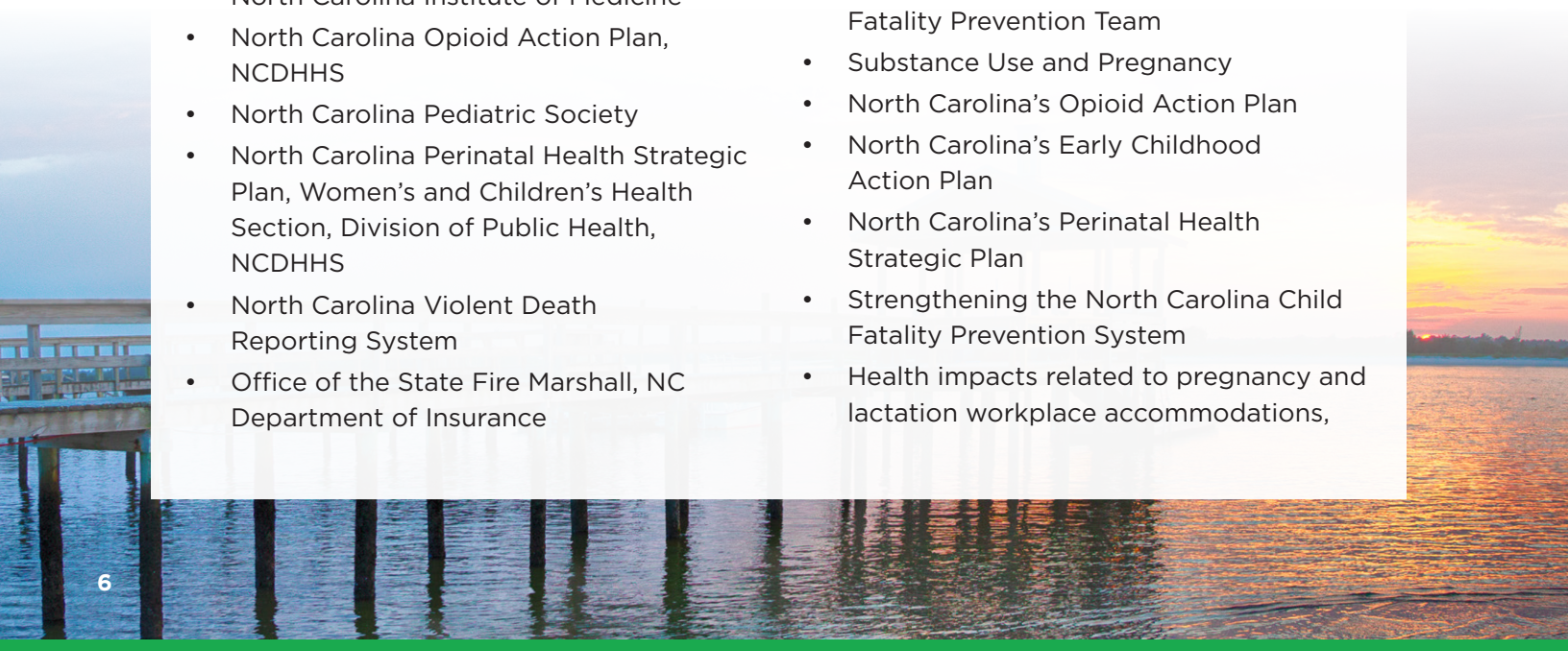


Experts and leaders presenting to the Task Force and its committees during the 2019-2020 study cycle represented state and local agencies and academic institutions, as well as state and community programs such as:

- Centering Healthcare Institute
- Children's Services Committee, NC Association of County Directors of Social Services
- Duke University Center for Child and Family Policy
- Essentials for Childhood, Division of Public Health, NCDHHS
- Forensic Tests for Alcohol Branch, Division of Public Health, NCDHHS
- Get Ready Guilford Initiative
- March of Dimes
- Moms Rising North Carolina
- National Center for Catastrophic Sport Injury Research; University of North Carolina Department of Exercise and Sport Science
- NC Child
- North Carolina Child Fatality Task Force
- Division of Motor Vehicles, NC Department of Transportation
- Division of Social Services, NCDHHS
- North Carolina Early Childhood Action Plan, NC DHHS
- Injury and Violence Prevention Branch, Division of Public Health, NCDHHS
- North Carolina Institute of Medicine
- North Carolina Opioid Action Plan, NCDHHS
- North Carolina Pediatric Society
- North Carolina Perinatal Health Strategic Plan, Women's and Children's Health Section, Division of Public Health, NCDHHS
- North Carolina Violent Death Reporting System
- Office of the State Fire Marshall, NC Department of Insurance
- Prevent Child Abuse North Carolina
- Safe Sleep NC, University of North Carolina Center for Maternal and Infant Health
- State Child Fatality Prevention Team, NC Office of the Chief Medical Examiner, NCDHHS
- Tobacco Prevention and Control Branch, Division of Public Health, NCDHHS
- UNC Horizons
- University of North Carolina School of Medicine, Department of Obstetrics and Gynecology
- University of North Carolina School of Social Work
- Women's and Children's Health Section, Division of Public Health, NCDHHS
- Women's Health Branch, Division of Public Health, NCDHHS

Presentation topics addressed at meetings of the Task Force and/or its three committees for the 2019-2020 study cycle included:

- 2018 North Carolina Child Death Data
- 2018 North Carolina Infant Mortality Data
- Recommendations from the State Child Fatality Prevention Team
- Substance Use and Pregnancy
- North Carolina's Opioid Action Plan
- North Carolina's Early Childhood Action Plan
- North Carolina's Perinatal Health Strategic Plan
- Strengthening the North Carolina Child Fatality Prevention System
- Health impacts related to pregnancy and lactation workplace accommodations,



kin care and safe days leave, and paid family leave
- Workplace accommodations for pregnancy and lactation
- Kin care and safe days leave
- Paid family leave insurance study by Duke University
- Infant safe sleep
- Get Ready Guilford Initiative
- Home visiting programs in North Carolina
- Child abuse and neglect reporting
- Firearm deaths and injuries data
- Suicide prevention: data update and carry over recommendations
- Pediatric perspective on paid leave
- Impact of paid leave in the context of child abuse and domestic violence
- Youth nicotine use prevention
- Catastrophic injuries and illnesses in North Carolina youth athletes
- Firearm safe storage: data update and carry over recommendation
- March of Dimes Preconception Health Campaign
- Recent grants received in North Carolina to benefit maternal and infant health
- Quitline NC and tobacco cessation
- Perinatal Systems of Care Task Force
- Centering Pregnancy
- North Carolina's Ignition Interlock Program
- Update on fireworks safety
- Data on motor vehicle-related deaths and injuries
- Forensic Tests for Alcohol funding
- Primary enforcement of rear seat restraints

Meeting agendas also included committee reports, legislative updates, and other business.

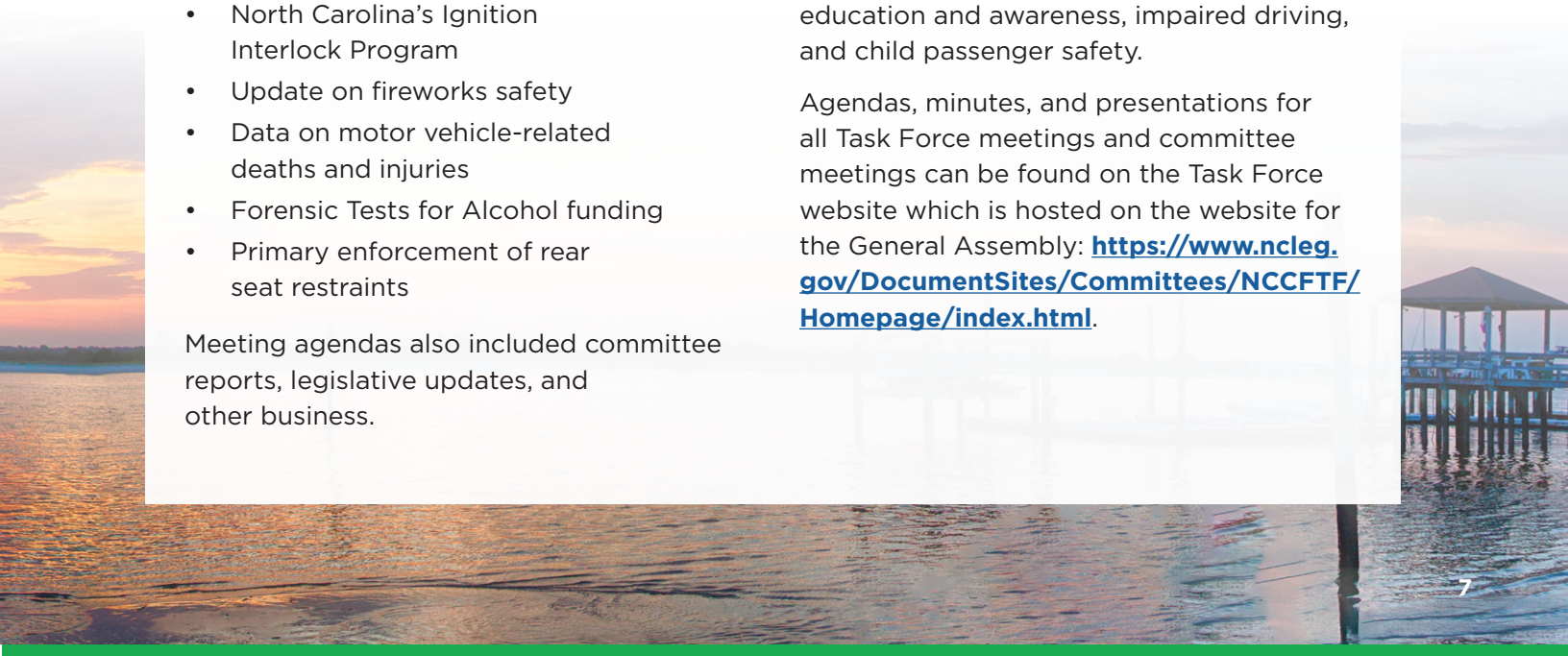
Task Force work is accomplished through three committees that prepare recommendations for consideration by the full Task Force. Committee participants include Task Force members, as well as volunteers with subject matter expertise in the committee's area of focus.

The **Intentional Death Prevention Committee** studies homicide, suicide, and child maltreatment. For this study cycle this committee focused on and developed recommendations and administrative items in two areas: suicide prevention and strengthening education and awareness around child abuse and neglect reporting.

The **Perinatal Health Committee** studies infant mortality and women's health. This committee's work and recommendations for the 2019-2020 study cycle address infant safe sleep, perinatal tobacco use, workplace measures to strengthen child and family well-being, and continuing a set of recommendations aimed at strengthening the statewide Child Fatality Prevention System.

The **Unintentional Death Prevention Committee** studies unintentional injury and death. For the 2019-2020 study cycle, this committee examined and developed (or repeated) recommendations and administrative items related to youth nicotine use prevention, firearm safe storage education and awareness, impaired driving, and child passenger safety.

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 General Assembly: **https://www.ncleg.gov/DocumentSites/Committees/NCCFTF/Homepage/index.html**.



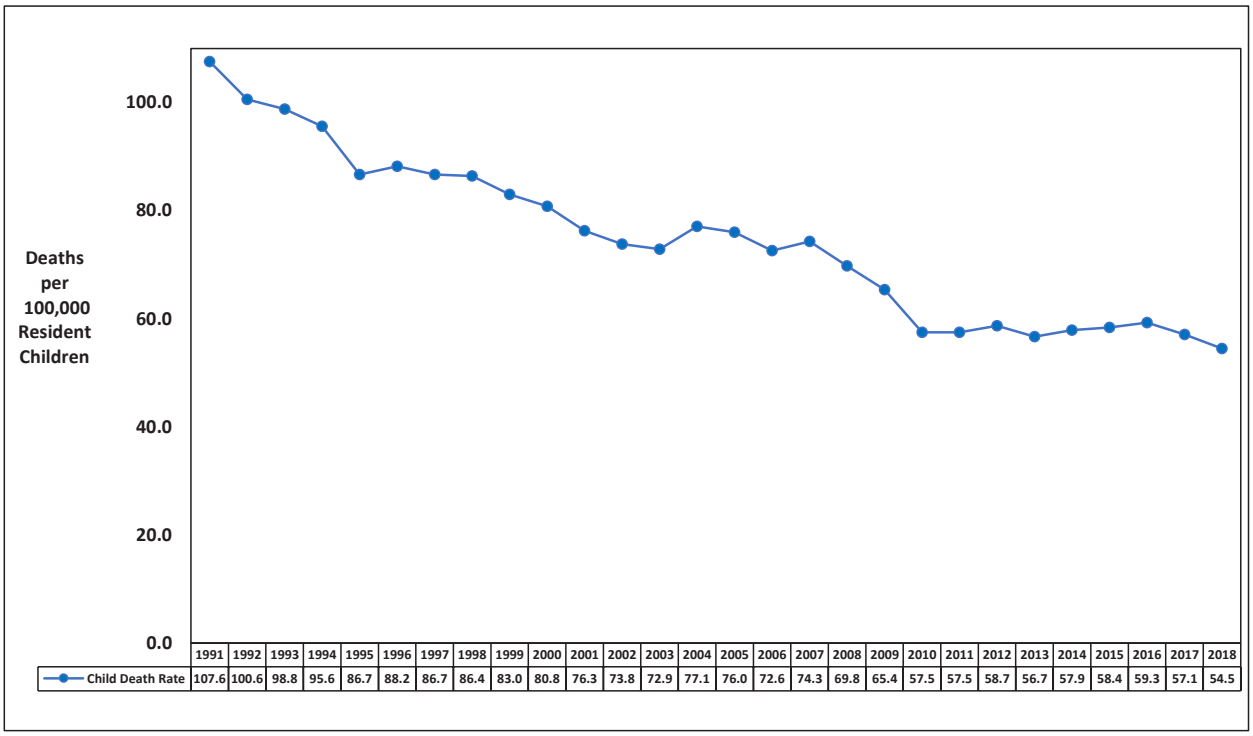
Explanations for each of the 2020 recommendations from the Task Force, including highlights of evidence to support the recommendations, can be found in this report.

Child Fatality Task Force priorities are set out in its yearly action agenda, and these priorities are shared not only in the annual report of the Task Force, but they are also shared widely through broad communications about Task Force work and through the involvement of the Task Force Executive Director and other members of the Executive Committee in various state-level committees and initiatives.

The Child Fatality Task Force Executive Committee thanks all Task Force Members, contributing experts, and community volunteers who devoted their time and expertise to Task Force work. Their efforts and commitment to protecting the children of North Carolina are reflected in the 2020 Action Agenda.

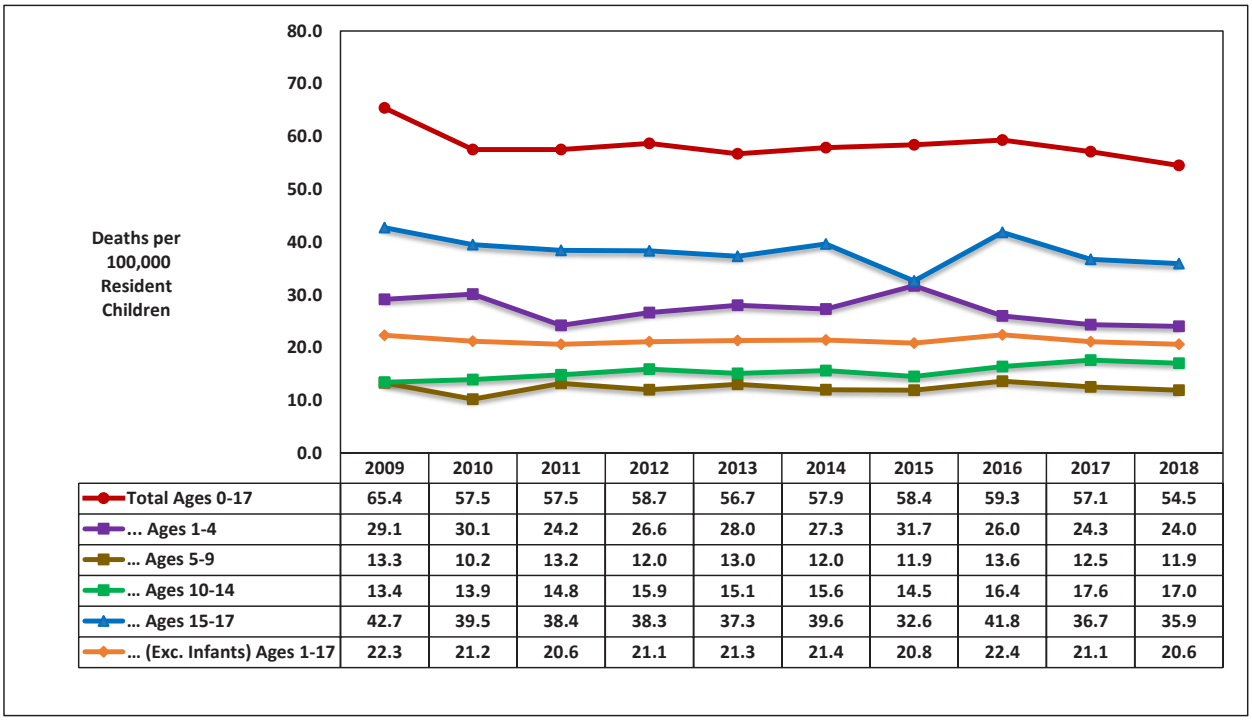
*The rate of child deaths in North Carolina **has decreased by 49%** since the 1991 creation of the Child Fatality Task Force and the broader Child Fatality Prevention System.*

1991-2018 TRENDS IN NORTH CAROLINA RESIDENT CHILD DEATH RATES† AGES BIRTH THROUGH 17 YEARS



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

2009-2018 TRENDS IN NORTH CAROLINA RESIDENT CHILD DEATH RATES† BY AGE GROUP



	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Total Ages 0-17	65.4	57.5	57.5	58.7	56.7	57.9	58.4	59.3	57.1	54.5
... Ages 1-4	29.1	30.1	24.2	26.6	28.0	27.3	31.7	26.0	24.3	24.0
... Ages 5-9	13.3	10.2	13.2	12.0	13.0	12.0	11.9	13.6	12.5	11.9
... Ages 10-14	13.4	13.9	14.8	15.9	15.1	15.6	14.5	16.4	17.6	17.0
... Ages 15-17	42.7	39.5	38.4	38.3	37.3	39.6	32.6	41.8	36.7	35.9
... (Exc. Infants) Ages 1-17	22.3	21.2	20.6	21.1	21.3	21.4	20.8	22.4	21.1	20.6

† Child death rates prior to 2018 have been recalculated using the latest available population data

Data reported on this page is produced by the NC Division of Public Health - Women's and Children's Health Section in conjunction with the State Center for Health Statistics

2018 NC RESIDENT CHILD DEATHS BY AGE GROUP & CAUSE OF DEATH

	TOTAL AGES 0-17		AGE GROUP (years)									
			Infants		1-4		5-9		10-14		15-17	
Cause of Death:	N	%	N	%	N	%	N	%	N	%	N	%
• Perinatal Conditions	411	32.7	408	93.9	2	0.5	1	0.2	0	0.0	0	0.0
• Medical Condtions	257	20.5	90	35.0	45	17.5	32	12.5	55	21.4	35	13.6
• Birth Defects	170	13.5	140	82.4	13	7.6	9	5.3	7	4.1	1	0.6
• Motor Vehicle Injuries	81	6.5	6	7.4	14	17.3	10	12.3	18	22.2	33	40.7
• Other Unintentional Injuries	86	6.9	22	25.6	27	31.4	17	19.8	6	7.0	14	16.3
– Suffocation/Choking/Strangulation	27	-	17	-	6	-	3	-	1	-	0	-
– Drowning	27	-	0	-	13	-	5	-	2	-	7	-
– Poisoning	4	-	1	-	1	-	0	-	0	-	2	-
– Bicycle	1	-	0	-	0	-	1	-	0	-	0	-
– Firearms	4	-	0	-	1	-	0	-	1	-	2	-
– Smoke, Fire & Flames	12	-	0	-	3	-	7	-	2	-	0	-
– All Other Accidental Injuries	11	-	4	-	3	-	1	-	0	-	3	-
• Suicide	52	4.1	0	0	0	0	0	0	18	34.6	34	65.4
– by Firearm	26	-	0	-	0	-	0	-	8	-	18	-
– by Hanging	21	-	0	-	0	-	0	-	9	-	12	-
– by Poisoning	2	-	0	-	0	-	0	-	1	-	1	-
– All Other Suicides	3	-	0	-	0	-	0	0	0	0	3	-
• Homicide	51	4.1	9	17.6	7	13.7	3	5.9	8	15.7	24	47.1
– Involving Firearm	32	-	1	-	1	-	2	-	5	-	23	-
– All Other Homicides	19	-	8	-	6	-	1	-	3	-	1	-
• All Other Causes of Death	147	11.7	131	89.1	10	6.8	3	2.0	1	.07	2	1.4
TOTAL DEATHS	1,255	100	806	64.2	118	9.4	75	6	113	9	143	11.4

† Child death rates prior to 2018 have been recalculated using the latest available population data

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 State Center for Health Statistics 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 its data, and some of its cases are still pending when the State Center for Health Statistics closes its annual data files. Therefore, the cause and manner determined by the OCME may be modified based on OCME review after the time period during which the SCHS finalizes annual data files.

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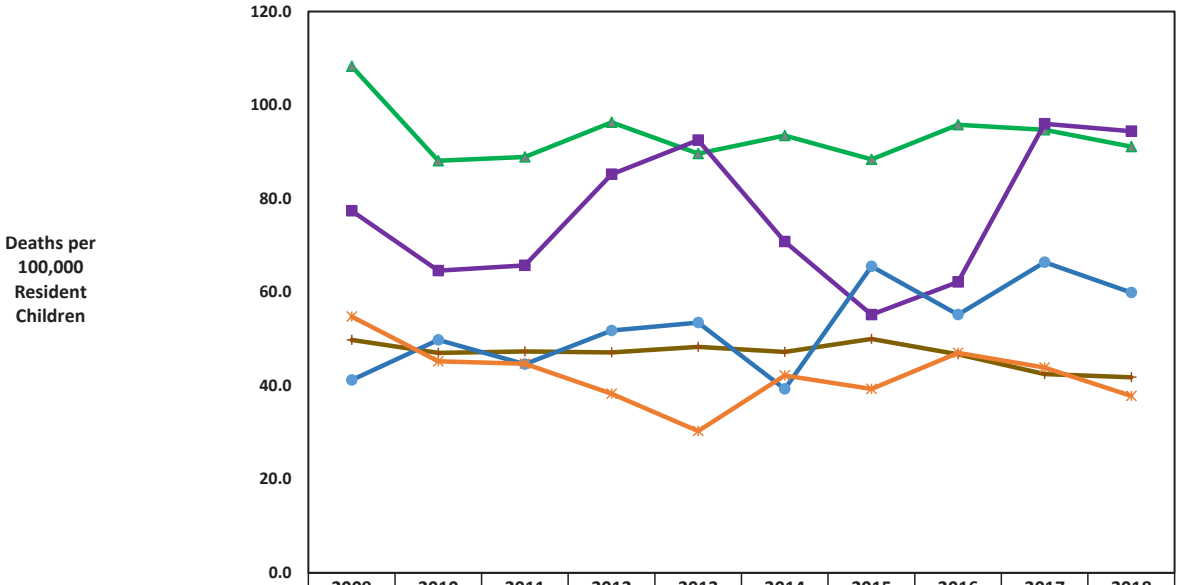
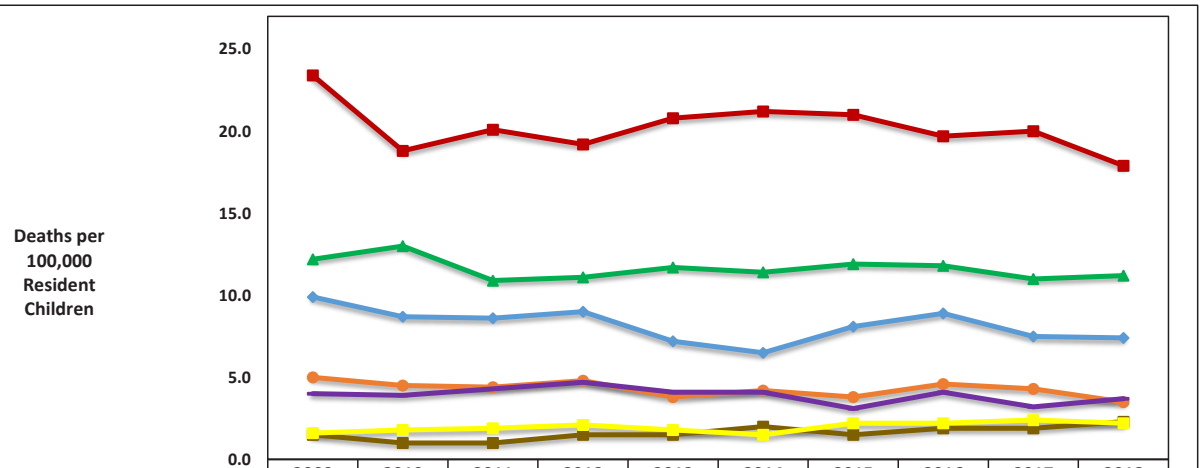
2009-2018 TRENDS IN NORTH CAROLINA RESIDENT CHILD DEATH RATES† BY RACE/ETHNICITY, AGES BIRTH THROUGH 17 YEARS



	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Non-Hispanic White	49.8	47.0	47.3	47.1	48.3	47.2	50.0	46.7	42.5	41.8
Non-Hispanic Black	108.3	88.1	88.9	96.3	89.6	93.5	88.4	95.8	94.7	91.1
Non-Hispanic American Indian	77.4	64.6	65.7	85.2	92.5	70.8	55.2	62.2	96.0	94.4
Non-Hispanic Other	41.2	49.8	44.6	51.8	53.5	39.3	65.5	55.2	66.4	59.9
Hispanic	54.8	45.2	44.7	38.3	30.3	42.2	39.3	47.0	43.9	37.8

2009-2018 TRENDS IN NORTH CAROLINA RESIDENT CHILD DEATH RATES† FOR SELECT CAUSES OF DEATH, AGES BIRTH THROUGH 17 YEARS



	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Perinatal Conditions	23.4	18.8	20.1	19.2	20.8	21.2	21.0	19.7	20.0	17.9
Birth Defects	9.9	8.7	8.6	9.0	7.2	6.5	8.1	8.9	7.5	7.4
Illnesses	12.2	13.0	10.9	11.1	11.7	11.4	11.9	11.8	11.0	11.2
Motor Vehicle Accidents	5.0	4.5	4.4	4.8	3.8	4.2	3.8	4.6	4.3	3.5
Other Accidents	4.0	3.9	4.3	4.7	4.1	4.1	3.1	4.1	3.2	3.7
Suicide	1.5	1.0	1.0	1.5	1.5	2.0	1.5	1.9	1.9	2.3
Homicide	1.6	1.8	1.9	2.1	1.8	1.5	2.2	2.2	2.4	2.2

† Child death rates prior to 2018 have been recalculated using the latest available population data

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LEADING CAUSES OF CHILD DEATH BY AGE GROUP, NC RESIDENTS 2017

ALL AGES, 0-17			
Rank	Cause	Number	%
1	Conditions originating in the perinatal period	411	32.7%
2	Congenital anomalies (birth defects)	170	13.5%
3	Other Unintentional injuries	86	6.9%
4	Motor vehicle injuries	81	6.5%
5	Suicide	52	4.1%
6	Homicide	51	4.1%
7	Cancer	47	3.7%
8	Diseases of the heart	29	2.3%
9	Pneumonia & influenza	21	1.7%
10	Cerebrovascular disease	10	0.8%
	Chronic lower respiratory diseases	10	0.8%
All other causes (Residual)		287	22.9%
TOTAL DEATHS — ALL CAUSES		1.255	100.0%

INFANTS			
Rank	Cause	Number	%
1	Congenital anomalies (birth defects)	140	17.4%
2	Short gestation - low birthweight	133	16.5%
3	Maternal complications of pregnancy	51	6.3%
4	Bacterial sepsis	27	3.3%
5	Complications of placenta, cord, and membranes	26	3.2%
6	Diseases of the circulatory system	22	2.7%
	Other Unintentional injuries	22	2.7%
	Respiratory distress	22	2.7%
9	Necrotizing enterocolitis	14	1.7%
10	Atelectasis	11	1.4%
All other causes (Residual)		338	41.9%
TOTAL DEATHS — ALL CAUSES		806	100.0%

AGES 1 TO 4			
Rank	Cause	Number	%
1	Other Unintentional injuries	27	22.9%
2	Motor vehicle injuries	14	11.9%
3	Congenital anomalies (birth defects)	13	11.0%
4	Diseases of the heart	9	7.6%
5	Cancer	7	5.9%
	Homicide	7	5.9%
7	Pneumonia & influenza	3	2.5%
8	Conditions originating in the perinatal period	2	1.7%
	Septicemia	2	1.7%
All other causes (Residual)		34	28.8%
TOTAL DEATHS — ALL CAUSES		118	100.0%

AGES 5 TO 9			
Rank	Cause	Number	%
1	Other Unintentional injuries	17	22.7%
2	Cancer	14	18.7%
3	Motor vehicle injuries	10	13.3%
4	Congenital anomalies (birth defects)	9	12.0%
5	Pneumonia & influenza	4	5.3%
6	Homicide	3	4.0%
7	Chronic lower respiratory diseases	2	2.7%
	In-situ/benign neoplasms	2	2.7%
	Septicemia	2	2.7%
All other causes (Residual)		12	16.0%
TOTAL DEATHS — ALL CAUSES		75	100.0%

AGES 10 TO 14			
Rank	Cause	Number	%
1	Motor vehicle injuries	18	15.9%
	Suicide	18	15.9%
3	Cancer	12	10.6%
4	Homicide	8	7.1%
5	Congenital anomalies (birth defects)	7	6.2%
6	Other Unintentional injuries	6	5.3%
7	Diseases of the heart	4	3.5%
	Pneumonia & influenza	4	3.5%
9	Cerebrovascular disease	3	2.7%
	Chronic lower respiratory diseases	3	2.7%
10	Pneumonia & influenza	2	1.7
All other causes (Residual)		30	26.5%
TOTAL DEATHS — ALL CAUSES		113	100.0%

AGES 15 TO 17			
Rank	Cause	Number	%
1	Suicide	34	23.8%
2	Motor vehicle injuries	33	23.1%
3	Homicide	24	16.8%
4	Cancer	14	9.8%
	Other Unintentional injuries	14	9.8%
6	Chronic lower respiratory diseases	2	1.4%
	Pneumonia & influenza	2	1.4%
All other causes (Residual)		20	14.0%
TOTAL DEATHS — ALL CAUSES		143	100.0%

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NC Child Fatality Task Force
2020 Action Agenda
With Pending Committee Recommendations

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 non-legislative items sought to be further examined by the CFTF.

(Note: Items with an asterisk (*) are those carrying over from the 2018 CFTF Action Agenda.)

Note: Items with an asterisk (*) are those carrying over from the 2019 CFTF Action Agenda. Items marked **"pending"** are those being recommended by Task Force committees but not yet approved by the full Task Force due to cancellation of the final meeting of the Task Force during the pandemic.

Recommendations and administrative efforts to prevent youth suicide and firearm-related deaths and injuries to children

***SUPPORT** legislation requiring suicide prevention training and a risk referral protocol in schools, with specific requirements related to frequency and duration of the training, who receives the training, and minimum criteria for training components.

[PENDING]: *Support state funding for a new statewide firearm safety initiative, as recommended by the 2017 Firearm Safety Stakeholder group, that is focused on education and awareness surrounding firearm safe storage and distribution of free gun locks; funding to go to DHHS to appropriately engage a third-party organization to implement the initiative. (Two-year funding estimate is for $155,700 — $86,500 for year one; $69,200 for year two.)

[PENDING]: *Administrative support to explore and pursue possibilities for funding for a three-year lead suicide prevention coordinator position in North Carolina that would coordinate cross-agency efforts to carry out implementation of the 2015 NC Suicide Prevention Strategic Plan and determine a sustainability plan for ongoing statewide coordination for implementation of the Strategic Plan.

Recommendations on workplace supports to strengthen child and family health, well-being, and economic stability

ENDORSE legislation that would guarantee all North Carolina workers the right to reasonable pregnancy and lactation accommodations in the workplace.

ENDORSE passage of a kin care and safe days bill that would guarantee all North

[1] **Important note:** Due to the 2020 COVID-19 pandemic, it was necessary to conclude the 2019-2020 study cycle of the Child Fatality Task Force without a final meeting of the full Task Force. The final meeting would have been devoted to considering several recommendations from Task Force committees that were being submitted to the full Task Force for their approval. These committee recommendations are therefore noted on this Action Agenda as "pending," as they have not received final approval from the full Child Fatality Task Force and will be considered when the Task Force reconvenes. **Pending items on this agenda that are legislative items are being repeated from one or more prior years, which means that the Task Force has approved these items in prior years even though it did not have the opportunity to approve them for 2020.**

[2] While this recommendation was not presented to the full Task Force for 2020, the Task Force did approve a related **resolution** urging the North Carolina Senate to take up and pass House Bill 434, which requires schools to adopt and implement a suicide risk referral protocol and mental health training program that includes suicide prevention; this bill passed the House on April, 25, 2019.

Carolina workers the right to use their sick days (whether paid or job-protected unpaid) to care for a sick loved one, seek preventative care, or deal with the physical, mental, or legal impacts of domestic violence, sexual assault, or stalking.

ENDORSE legislation addressing paid family leave insurance in North Carolina.

Recommendations to strengthen the statewide Child Fatality Prevention System to increase the system's ability to prevent child abuse, neglect, and death

***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 and with child fatality staff in the Office of the Chief Medical Examiner (OCME) remaining in OCME.

II. Implement a centralized electronic data and information system that includes North Carolina joining 45 other states to participate in the National Child Death Review Case Reporting System.

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.

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 (including intensive-type reviews of abuse or neglect-related deaths with state-level staff assistance), and giving teams the option to choose whether to be single or multi-county teams. DHHS should study and determine an effective framework for meeting the federal requirements for Citizen Review Panels and for reviewing active DSS cases without using all local review teams for these purposes.

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 the required report to be distributed to additional state leaders beyond the governor and General Assembly.

***SUPPORT** for maintaining current state funding for existing positions and operations that support Child Fatality Prevention System work and for additional recurring funding to support this work 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.

*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 child deaths, **support** funding to enable implementation of the evidence-informed practice of FIMR as a pilot.

Recommendation and administrative effort to prevent infant deaths

***SUPPORT** a state appropriation of $85,000 in additional funding to expand the Safe Sleep NC program that works to prevent sleep-related infant deaths.

[PENDING]: Administrative support for continuing to work on strengthening laws addressing infant safe surrender with the

intent to bring this item back for consideration prior to the 2021 legislative long session.

Recommendation and administrative efforts to prevent motor vehicle-related injuries and deaths to children

[PENDING]: *Support legislation that would require ignition interlocks for all DWI offenders.

[PENDING]: Administrative support to continue efforts to gather information on the potential for future legislation that allows for primary enforcement of all unrestrained back seat passengers with the intent to bring this item back for consideration by the Unintentional Death Prevention Committee prior to the 2021 legislative long session.

[PENDING]: Administrative support for a child passenger safety study by outside group to examine the status of North Carolina child passenger safety laws in comparison to recommendations from the American Academy of Pediatrics and the National Highway Safety Board. The study will be performed by experts including the University of North Carolina Highway Safety Research Center, the Governor's Highway Safety Program, the North Carolina Pediatric Society the Office of the Chief Medical Examiner, and the North Carolina Division of Public Health, bringing information learned back to the Task Force.

Recommendations to prevent harm to infants and youth caused by tobacco and nicotine use

[PENDING]: *Endorse additional Quitline NC funding of $3 million.

[PENDING]: *Endorse at least $7 million in funding for youth nicotine use prevention, including e-cigarettes.

Administrative efforts to strengthen child abuse and neglect reporting education and awareness

[PENDING]: Administrative support for the NCDHHS Division of Social Services in the development of more robust and user-friendly web pages dedicated to education and information on child abuse and neglect reporting, which includes information on prevention resources and services, what happens to the family and reporter once a report is made, and resources for learning more such as a link to video training. DSS should also ensure that NC Cares 360 includes information on CAN reporting, and web techniques should be used to make it more likely that relevant web searches will show DSS web pages focused on abuse and neglect reporting as a primary source of information in North Carolina.

[PENDING]: Administrative support for work being done by Prevent Child Abuse NC through its contract with the Division of Social Services to develop training and collateral materials addressing child abuse and neglect reporting to support broad education of professionals and the public.

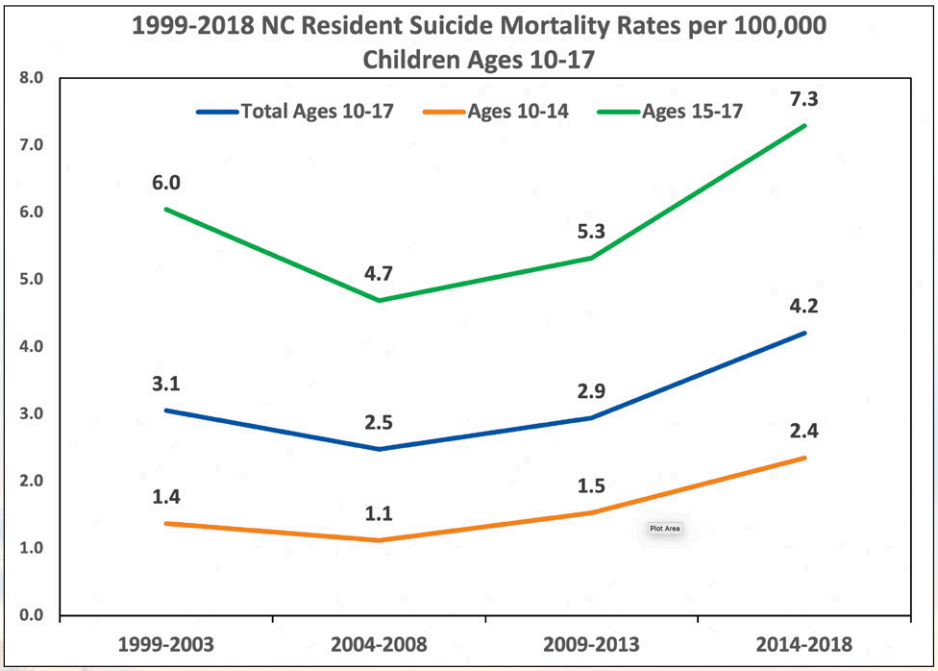
[PENDING]: Administrative support for contacting the Justice Academy about including training on child abuse and neglect reporting for training of law enforcement officers.

Explanation of
CFTF 2020 Action Agenda
With Pending Committee Recommendations[3]

Recommendations and administrative efforts to prevent youth suicide and firearm-related deaths and injuries to children

Youth suicide rates and firearm-related deaths to children are both on the rise in North Carolina. The most recently available rates for youth suicide in North Carolina are the highest seen by the Child Fatality Task Force. In North Carolina for 2018, there were 52 youth suicides and suicide was the leading cause of death for North Carolina youth ages 15 to 17 and the second leading cause of death for youth ages 10 to 14[4]. In North Carolina, firearms are the lethal means used in almost half of youth suicides and more than half of youth homicides.

In 2018, youth suicide rates and firearm-related death rates for children and youth were the highest seen by the Child Fatality Task Force. For 2018, suicide was the leading cause of death for NC youth ages 15 to 17 and the 2nd leading cause of death for youth ages 10 to 14.

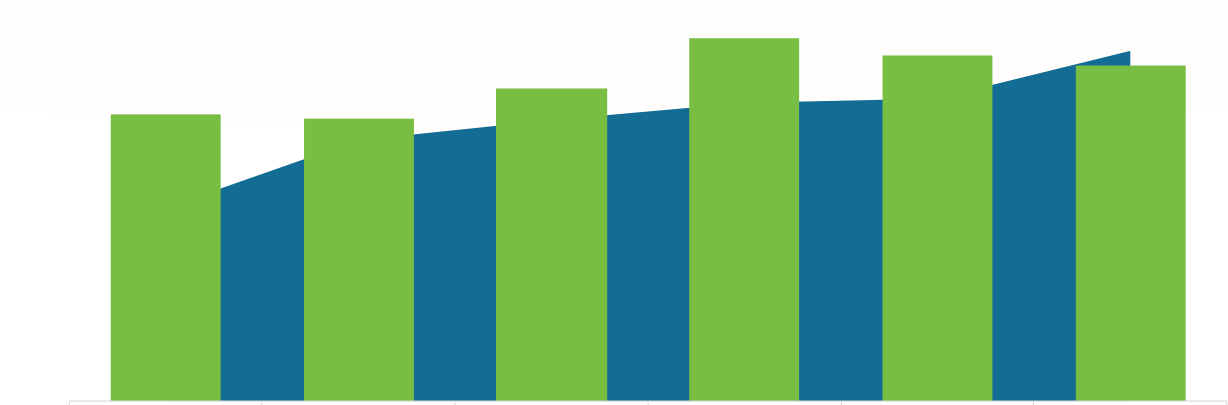


Source: North Carolina Death Certificate Datafiles, 1999-2018 analysis by NC DHHS Division of Public Health, Women's & Children's Health Section.

[3] **Important note:** Due to the 2020 COVID-19 pandemic, it was necessary to conclude the 2019-2020 study cycle of the Child Fatality Task Force without a final meeting of the full Task Force. The final meeting would have been devoted to considering several recommendations from Task Force committees that were being submitted to the full Task Force for their approval. These committee recommendations are therefore noted on this Action Agenda as "pending," as they have not received final approval from the full Child Fatality Task Force for 2020 and will be considered when the Task Force reconvenes. **Pending items on this agenda that are legislative items are being repeated from one or more prior years, which means that the Task Force has approved these items previously even though it did not have the opportunity to approve them for 2020.**

[4] Child Deaths in North Carolina, Annual Report for 2018, produced by the NC DHHS. Division of Public Health – Women's and Children's Health Section in conjunction with the State Center for Health Statistics.

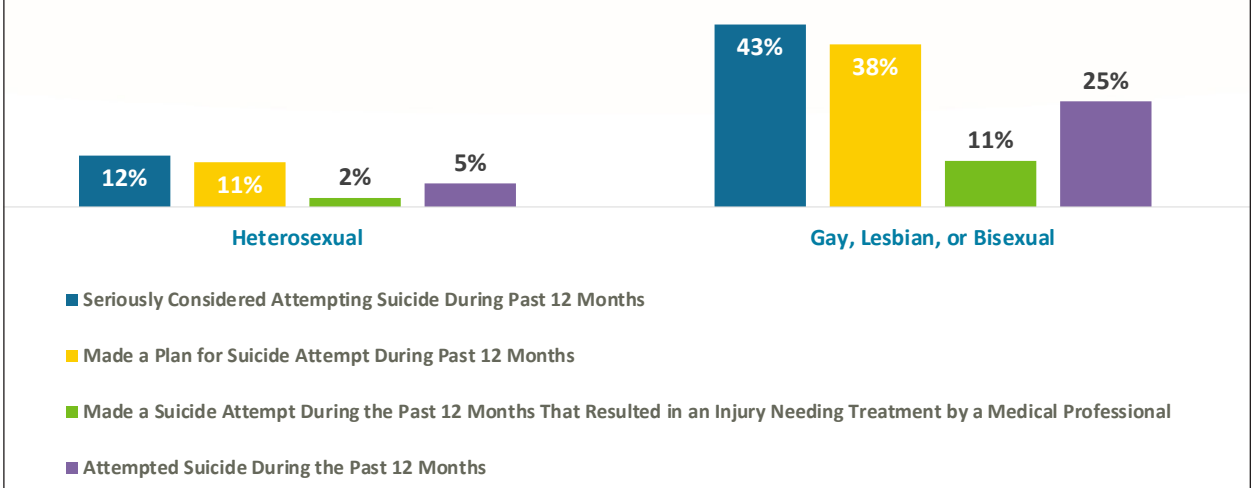
SERIOUSLY CONSIDERED SUICIDE
2007-2017 NC HIGH SCHOOL STUDENTS



	2007	2009	2011	2013	2015	2017
Black	8.9%	12.0%	12.9%	13.7%	13.9%	16.1%
White	13.2%	13.0%	14.4%	16.7%	15.9%	15.4%

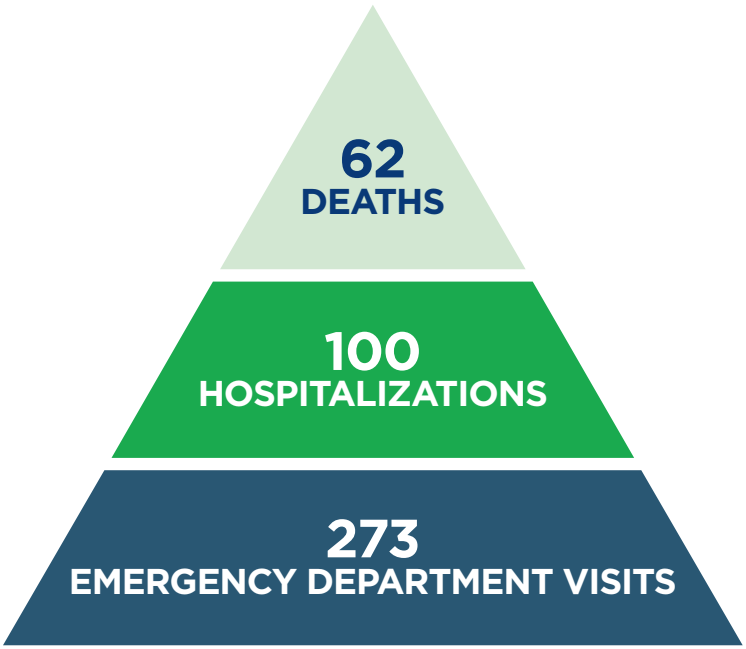
Black White

SUICIDAL BEHAVIORS
2017 NC HIGH SCHOOL STUDENTS



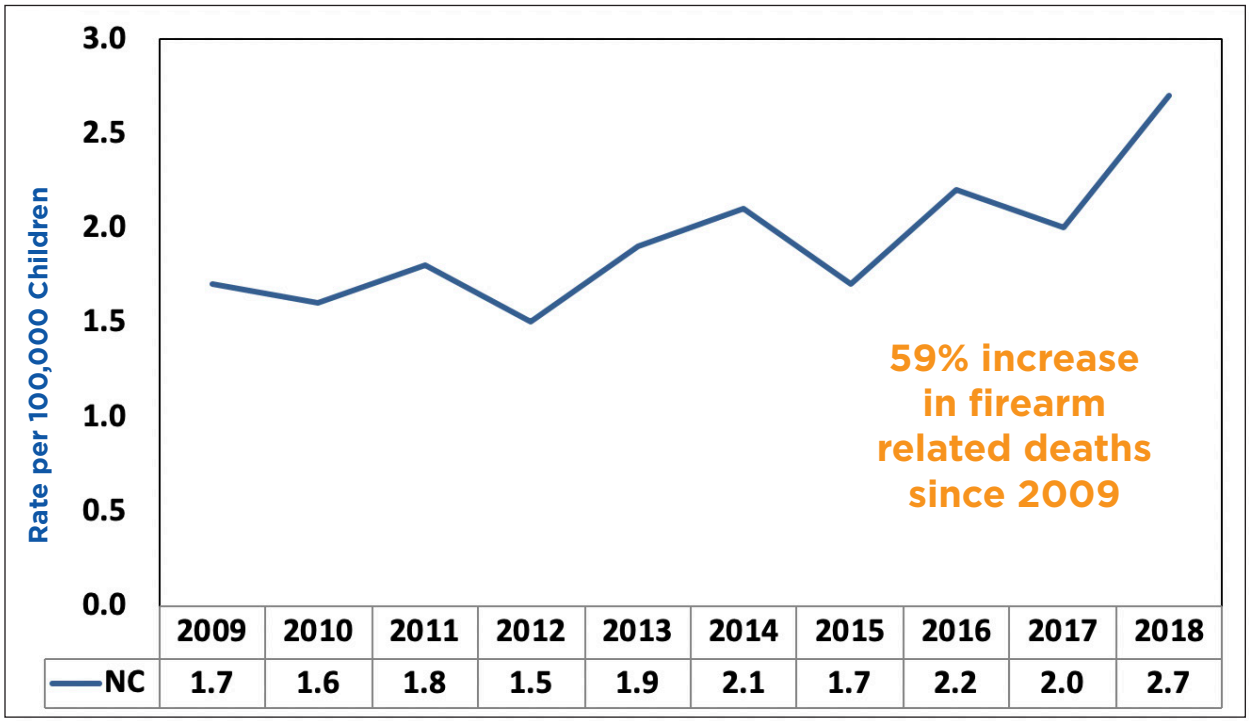
Source for charts: NC Heathy Schools based on data from the NC High School Youth Risk Behavior Survey

FIREARM-RELATED DEATHS AND INJURIES TO NC CHILDREN AGES 0 TO 17 IN 2018



Source: Death data from NC State Center for Health Statistics. For Hospitalizations, NC State Center for Health Statistics, Hospital Discharge Data, 2018; for Emergency Department Data, NC DETECT, ED Visit Data, 2018. Analyses by: Injury and Violence Prevention Branch (IVPB), Epidemiology, Surveillance and Informatics Unit, Division of Public Health. All data are subject to change.

NC RESIDENT FIREARM-RELATED MORTALITY RATES, CHILDREN AGES 0 TO 17: 2009-2018



	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
NC	1.7	1.6	1.8	1.5	1.9	2.1	1.7	2.2	2.0	2.7

Source: State Center for Health Statistics, Division of Public Health.

Between 2009 and 2018, there was a 59% increase in firearm-related deaths in North Carolina children age 0 to 17.[5] In the most recent 10-year period of 2009–2018, North Carolina lost more than 440 children and youth (age 17 and younger) to firearm-related injuries.[6] In the three-year period of 2016–2018, there were 275 firearm-related hospitalizations and 855 firearm-related emergency department visits for children and youth in North Carolina ages 0 to 17.[7]

In North Carolina, over 40% of residents own a firearm, yet only about half of North Carolina gun owners and less than half of gun-owning parents keep their gun secured — that is, the gun is stored in a gun cabinet or with a trigger or cable lock.[8] National data and studies tell us this: about one in three handguns is kept loaded and unlocked;[9] most kids know where parents keep their guns;[10] more than 75% of guns used in suicide attempts and unintentional injuries of kids were stored in the home of the victim, a relative, or a friend;[11] and guns used in American mass school shootings often come from home.[12]

The COVID-19 pandemic prompted a dramatic increase in people purchasing firearms and ammunition in the U.S. In a letter from the CFTF Executive Committee to CFTF

members and those who subscribe to CFTF email updates, the Executive Committee addressed some elevated risks for children resulting from the pandemic and referenced this surge in gun buying, saying it is fair to assume this recent surge means there are more guns in more homes that are not safely stored and are therefore accessible to curious young children or youth who may be at risk for suicide. Added to this risk is the fact that during stay-at-home orders or social distancing measures, these curious children or struggling youth spend much more time at home than usual, plus they and their families may be experiencing far greater stress than usual brought on by circumstances created by the pandemic.

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[5] Data source: North Carolina State Center for Health Statistics, NC Division of Public Health.

[6] Data source: North Carolina Office of the Chief Medical Examiner, NC Division of Public Health.

[7] Data source: Injury and Violence Prevention Branch, NC Division of Public Health.

[8] According to the 2011 North Carolina Behavioral Risk Factor Surveillance System, 41.6% of North Carolina residents own firearms (2011 was the last year this data was collected). Approximately half of North Carolina residents with a firearm reported that the firearm is unsecured (secured = gun cabinet, trigger or cable lock), and 62.5% of residents who are parents left their firearms unsecured.

[9] *Gun Violence: Facts and Statistics. Center for Injury Research and Prevention*, Children's Hospital of Philadelphia Research Institute. **https://injury.research.chop.edu/violence-prevention-initiative/types-violence-involving-youth/gun-violence/gun-violence-facts-and#.Xr_R5xNKiWg**.

[10] 73% of children under age 10 living in homes with guns reported knowing the location of their parents' firearms. 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.

[11] 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.

[12] Giffords Law Center to Prevent Gun Violence: "A report published by the US Secret Service and the Dept. of Education found that in 65% of school shootings covered by the study, the shooter used a gun obtained from his or her own home or from the home of a relative." Report: "The Final Report and Findings of the Safe School Initiative – Implications for the Prevention of School Attacks in the United States." (July 2004). In addition, A Wall Street Journal report in April of 2018 examining nearly three decades of American mass school shootings stated that the killers in these shootings mostly used guns owned by a family member; the report addressed the big role that a lack of gun safety at home has played in school shootings. [Hobbs, Tawnell D. (April 5, 2018). "Most Guns Used in School Shootings Come From Home," Wall Street Journal.]

For the past several years, the CFTF Action Agenda has featured several recommendations to address youth suicide and access to lethal means, all of which were developed through the study of data and input from experts and stakeholders.[13] Some of these recommendations have advanced such as funding for more school nurses who spend a third of their time addressing student mental health and funding that can expand use of the Program *Counseling on Access to Lethal Means*. Other recommendations are being repeated again on this 2020 Action Agenda because they have not yet been fully carried out, and the committees who studied these issues continue to believe these are important strategies that North Carolina should implement to prevent child deaths. The following recommendations are also relevant to discussions taking place in North Carolina and nationally regarding the broader topic of school safety and the importance of better addressing the mental health needs of children and teens and ways to prevent tragedy when students may be at risk of harming themselves or others.

1. SUPPORT legislation requiring suicide prevention training and a risk referral protocol in schools, with specific requirements related to frequency and duration of the training, who receives the training, and minimum criteria for training components.[14]

This recommendation for training and a risk referral protocol reflects one of the most promising prevention strategies identified through evaluation of the Garrett Lee Smith Youth Suicide Prevention Grants — to increase awareness of risks and seek help when identified.[15] Adults in the school setting may be the first to recognize an issue with a student, but they must be trained to recognize risks and know how and where to refer at-risk kids.

Currently, the existence, attributes, and implementation of suicide prevention programs, efforts, and protocols in North Carolina schools varies widely and is solely in the discretion of local districts and school administrators.

Subject matter experts who informed this recommendation emphasized that a required training should have certain minimum components in order to be effective.[16] They also emphasized that the training frequency mattered, because evaluations indicate that youth suicide prevention gatekeeper trainings are effective at reducing suicide rates, but the effectiveness may depend on the frequency of training.[17] This recommendation as originally presented was for the development and implementation of a two-hour online training tailored for school personnel that could be accessed at any time for free; the goal was to have an easy but effective option for meeting training requirements.

[13] Explanations of the previous work done on these issues, including input from experts and stakeholders, is available in the 2017 and 2018 CFTF Annual Reports, available on the CFTF website.

[14] While this recommendation was not presented to the full Task Force for 2020, the Task Force did approve a related **resolution** urging the North Carolina Senate to take up and pass House Bill 434, which requires schools to adopt and implement a suicide risk referral protocol and mental training program that includes suicide prevention; this bill passed the House on 4/25/2019. Also, this recommendation is carrying over from 2019.

[15] Evaluation by the Substance Abuse and Mental Health Services Administration (SAMHSA).

[16] These suggested minimum components were outlined in the 2017 CFTF Annual Report, when this recommendation first appeared on the CFTF Action Agenda, and included: rationale for training that conveys state and national data on suicide deaths and attempts, means, and populations with increased risk; myths and attitudes surrounding suicide; warning signs and symptoms for suicide; identification of students at risk and steps to take for referral; protective factors as prevention; and safe messaging.

[17] An evaluation was done on the effectiveness of youth suicide prevention "gatekeeper" trainings which are trainings for populations such as school personnel that teach recognition of risks and how to appropriately refer for help. Such trainings were found to result in significantly lower suicide rates during the year after the training in the county where the training was implemented as compared to counties that did not implement such a training; however, there was no evidence of an effect beyond one year after training implementation. Walrath, C., Garraza, L., Reid, H., Goldston, D., & McKeon, R. (2015). Impact of the Garrett Lee Smith Youth Suicide Prevention Program on Suicide Mortality. *Research and Practice, American Journal of Public Health,* Vol. 105, No. 5.

The majority of states now require suicide prevention training in schools, but North Carolina does not. According to the American Foundation for Suicide Prevention, 47 states now have laws addressing suicide prevention training for school personnel, but North Carolina is NOT one of them; of those states, 33 *require* training in suicide prevention; 14 states *encourage* training.[18]

The Child Fatality Task Force has had this recommendation on its agenda since 2017, and since then, six bills have been introduced that address this recommendation in some fashion, but none have become law. Out of those six bills, four passed the House and one was sent to a conference committee.[19]

2. [PENDING]: *Administrative support to explore and pursue possibilities for funding for a three-year lead suicide prevention coordinator position in North Carolina that would coordinate cross-agency efforts to carry out implementation of the 2015 NC Suicide Prevention Strategic Plan and determine a sustainability plan for ongoing statewide coordination for implementation of the Strategic Plan.

North Carolina has a statewide comprehensive suicide prevention plan created in 2015. This plan is the result of a collaborative 16-month process utilizing the input of approximately 180 diverse suicide prevention stakeholders. Unlike some other statewide prevention or action plans in North Carolina that rely on the collaborative efforts of many, the **2015 NC Suicide Prevention Plan**[20] does not have a designated leader to coordinate implementation of strategies contained in the plan.[21] With suicide rates increasing for all age groups, and especially with fears about the current pandemic's impact on mental health, leadership in suicide prevention is essential.

Currently, suicide prevention efforts in North Carolina are facilitated and managed by government agencies, nonprofits, and academic institutions. Experts informing this recommendation agreed that while a great deal of excellent work is taking place across the state, having one individual and/or organization serving in a lead role would:

- provide a single source of support and coordinate information sharing in order to guide efforts and ensure best practice;
- serve as a catalyst to turn ideas and plans into action;
- help ensure various aspects of the 2015 statewide suicide prevention plan are being carried out and reduce duplication;
- help ensure efficient use and sharing of limited resources.

Experts who informed this recommendation articulated goals for this position that include: coordination of current interventions and research related to suicide prevention; coordination of funding for suicide prevention efforts; coordination of consistent messaging; coordination of priority strategies; monitoring of outcomes; and consistency with training. They also highlighted the potential for this position to reside outside of a government agency.

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[18] American Foundation for Suicide Prevention. (Updated September 2019). *State Laws: Suicide Prevention in Schools (K-12)*. **https://afsp.org/wp-content/uploads/2019/10/AFSP-K-12-Schools-Issue-Brief-9-18-19.pdf**.

[19] 2017-18 Legislative Session: HB 894 passed the House, did not move out of Senate Rules Committee; HB 285 = SB 316 passed the House, did not move out of Senate Rules Committee. 2019 Legislative Session: HB 434 passed the House, did not move out of Senate Rules Committee; SB 601 did not move out of Senate Rules Committee; SB 476 passed the House, Senate failed to concur, Conference Committee appointed.

[20] The 2015 N.C. Suicide Prevention Plan is available at **https://www.injuryfreenc.ncdhhs.gov/preventionResources/docs/2015-NC-SuicidePreventionPlan-2015-0505-FINAL.pdf.**

[21] Examples of statewide plans with designated leaders include the Opioid Action Plan, the Early Childhood Action Plan, and the Perinatal Health Strategic Plan.

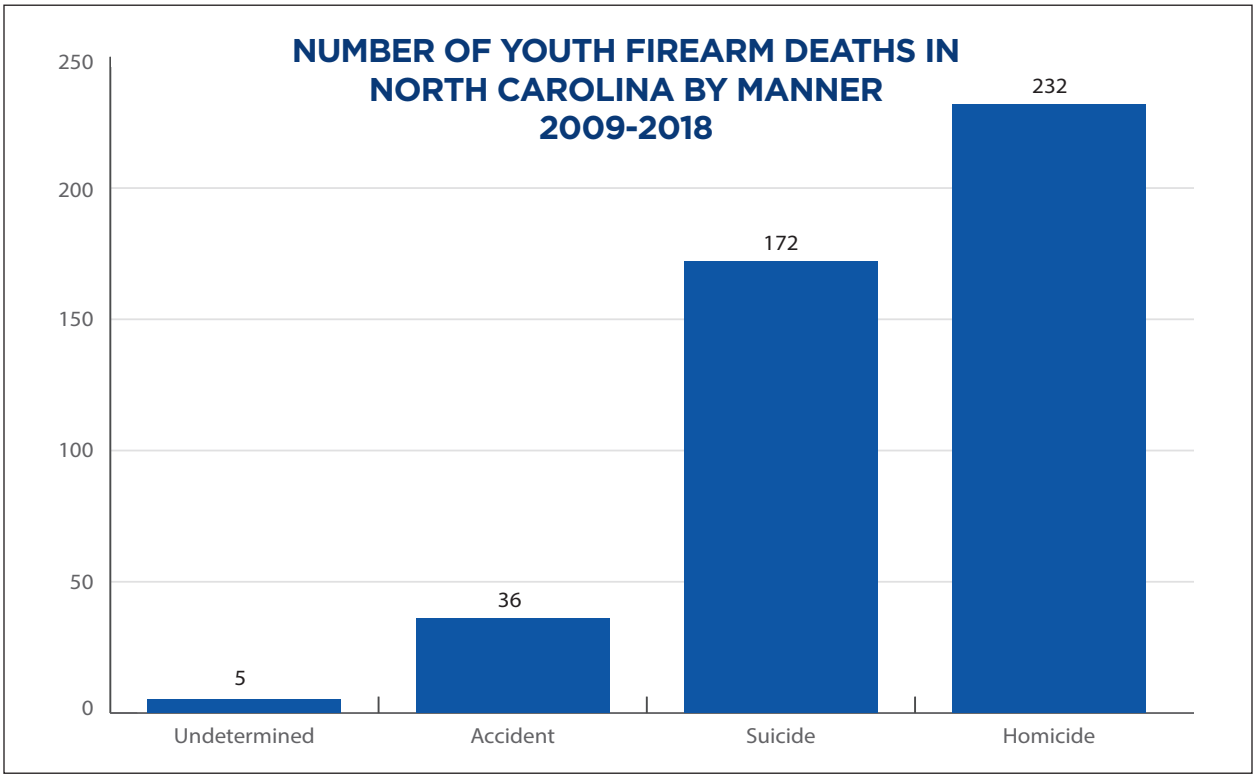
In North Carolina, over 40% of residents own a firearm, yet only about half of NC gun owners and less than half of gun-owning parents keep their gun secured.

National studies show that most kids know where parents keep their guns; that more than 75% of guns used in suicide attempts and unintentional injuries of kids were stored in the home of the victim, a relative, or a friend; and guns used in American mass school shootings often come from home.

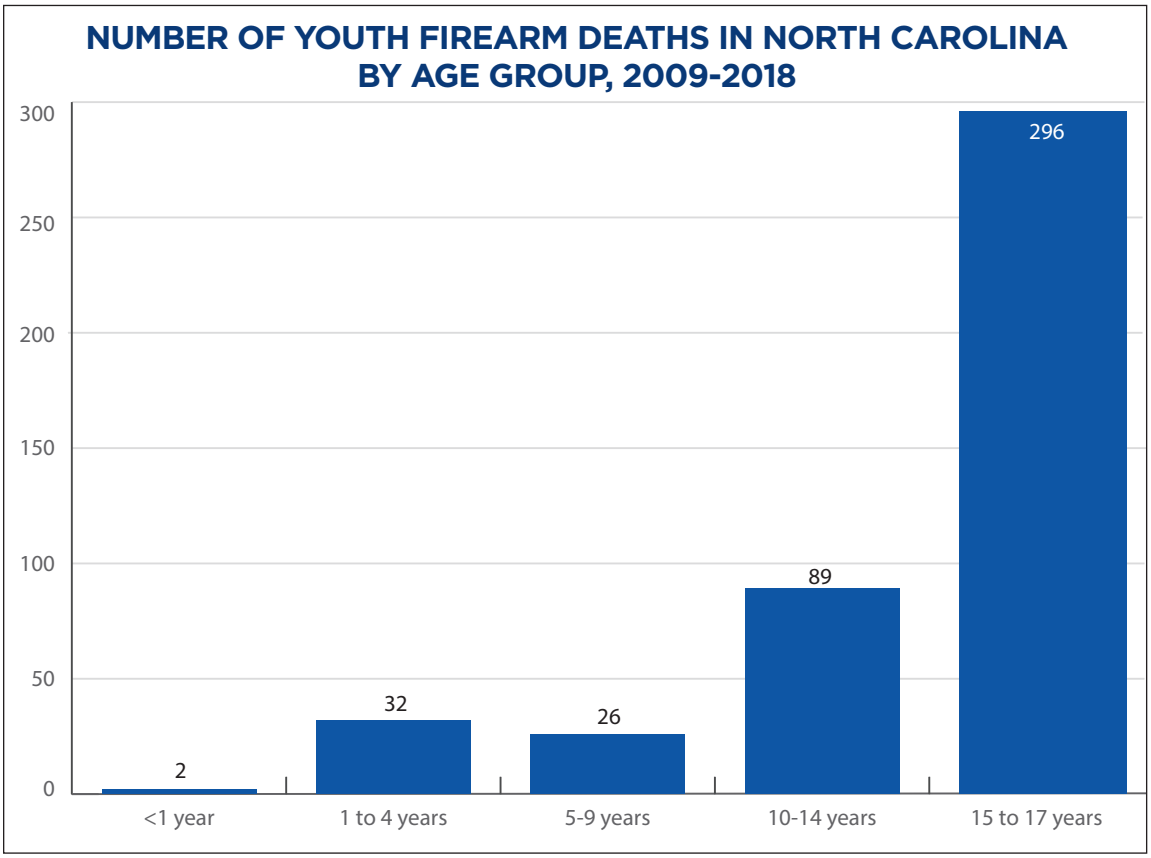
3. PENDING: *Support state funding for a new statewide firearm safety initiative, as recommended by the 2017 Firearm Safety Stakeholder group, that is focused on education and awareness surrounding firearm safe storage and distribution of free gun locks; and funding to go to DHHS to appropriately engage a third-party organization to implement the initiative.

(Two-year funding estimate was originally for $155,700— $86,500 for year one; $69,200 for year two.)

Concern about youth access to lethal means was brought to the attention of the CFTF by the State Child Fatality Prevention Team, chaired by the Chief Medical Examiner. This team reviews cases of child deaths and expressed specific concern about youth access to firearms in the context of youth suicide. They recommended formation of a firearm safety stakeholder group to examine firearm safety education and awareness, and the work of this diverse group of stakeholders in 2017 informed the CFTF recommendation for this firearm safety initiative.[22]



[22] For more information on the work of the stakeholder group, see the 2018 CFTF Annual Report located on the CFTF website.



Data source for these charts: Office of the Chief Medical Examiner, Division of Public Health.

Funding is needed for this firearm safety initiative to support two years of focused work by a qualified organization (and/or individuals) to launch a statewide initiative. Central to this initiative is the need to provide one-on-one outreach and technical assistance to help local communities launch their own firearm safety initiatives.

The 2017 stakeholder group that informed this recommendation learned about the effectiveness of various education and awareness prevention strategies and determined local community mobilization initiatives had the best chance of effectively educating people and getting them to engage in safe storage practices. The group also emphasized the need to provide firearm safety information, resources, and tools at the state level, but getting people to use those resources and tools is what will increase safety.

Proposed legislation in 2019 addressed this 2019 Task Force recommendation to launch and fund a firearm safety initiative. Originally introduced in March of 2019 as House Bill 508, the bill had bipartisan support. The text of this bill was then included in House Bill 966, the 2019 Appropriations Act, which never became law.

In the last decade (2009-2018) there has been a **59% increase in firearm-related deaths to North Carolina children under 18,** and during that time, North Carolina lost more than 440 children and youth under 18 to firearm-related injuries.

In August of 2019, North Carolina Governor Roy Cooper signed a gun safety Executive Directive containing a number of required actions aimed at promoting firearm safety and preventing firearm violence.[23] Among those actions, the directive required the NC DHHS to develop a public education campaign that educates about the importance of safe storage and also required DHHS to update recommendations in the state's Suicide Prevention Plan related to suicides caused by firearms.

This directive set in motion the development and compilation of firearm safety tools and resources by the Division of Public Health, using elements of the firearm safety stakeholder's recommendations to inform this work. A webpage on the Division of Public Health website now provides information on firearm safety.[24] However, without funding from the legislature for the type of initiative recommended by the Task Force, there are no resources for providing the kind of dedicated, one-on-one outreach and technical assistance that will be needed to get communities across the state launching local firearm safety initiatives.

Tools and information provided by the state are most likely to be used, and used effectively, if and when community leaders are contacted by a knowledgeable representative of this initiative who brings attention to these resources and offers individualized technical assistance to help launch a local initiative tailored to suit their community's needs. Having a dedicated and skilled person or persons who can do outreach and offer individualized technical assistance to communities to help them launch local initiatives is believed to be critical to the success of this initiative.

Recommendations on workplace supports to strengthen child and family health, well-being, and economic stability

North Carolina's infant mortality rate has improved but nevertheless remains among the worst dozen in the nation, and two-thirds of all child deaths in North Carolina are to infants under one year. Maternal and child health experts who have presented to the Child Fatality Task Force have emphasized that in order to see the infant mortality rate and the child death rate decline in North Carolina, strategies that focus on social determinants of health are critical, and a priority among these determinants is economic stability. Economic stability is impacted by employment, and an individual's well-being (and therefore a family's well-being) may also be impacted by workplace circumstances.

[23] The gun safety Executive Directive is located on the website for the North Carolina Governor: **https://files.nc.gov/governor/documents/files/2019_08_12_Executive_Directive_Improving_Firearm_Safety3_0.pdf.**

[24] This firearm safety website is located on the Division of Public Health website here: **https://injuryfreenc.ncdhhs.gov/safestorage/.**

Strategies focused on workplace supports for families are aligned with goals in the NC Perinatal Health Strategic Plan, the NC Early Childhood Action Plan, and recommendations from the NC Institute of Medicine's Task Force on Building a Perinatal System of Care.

Strategies that focus on workplace supports for families are aligned with goals in two statewide plans that address infant and child well-being, as well as recent recommendations made by a North Carolina Institute of Medicine (IOM) Task Force. Representatives of these two plans and the IOM have presented to the Child Fatality Task Force and/or the Perinatal Health Committee of the Child Fatality Task Force. A main goal of the **North Carolina Perinatal Health Strategic Plan**, which is designed to reduce infant mortality in North Carolina, is to address social and economic inequities. Within that goal is the strategy to "support working mothers and families" which includes the goal to "create and expand paid parental and sick leave policies" and "create and expand safe work place environments and accommodations for pregnant and breastfeeding women."[25] **The North Carolina Early Childhood Action Plan** also has multiple goals that center on improving families' economic stability in order to improve outcomes for young children in North Carolina. This plan specifically promotes "encouraging breastfeeding-friendly policies and services in local communities" and "promoting family-friendly work places, such as paid sick leave, paid parental leave and reliable work schedules."[26] In addition, recommendations from the **North Carolina Institute of Medicine's Task Force on Building a Perinatal System of Care** includes a recommendation that "North Carolina employers, including the state, should provide pregnancy accommodations such as paid family and medical leave, paid sick days, and pregnancy and breastfeeding accommodations."[27]

[25] The North Carolina Perinatal Health Strategic Plan is available on the NC Division of Public Health website here: **https://whb.ncpublichealth.com/phsp/**.

[26] North Carolina Early Childhood Action Plan, February 2019, see page 42: **https://files.nc.gov/ncdhhs/ECAP-Report-FINAL-WEB-f.pdf**.

[27] North Carolina Institute of Medicine. (April, 2020). *Healthy Moms, Healthy Babies: Building a Risk-Appropriate Perinatal System of Care for North Carolina.*, see page 47. Available at: **http://nciom.org/wp-content/uploads/2020/04/Perinatal-Report-FINAL.pdf**. (Recommendations from this IOM Task Force were presented to the Child Fatality Task Force Perinatal Health Committee prior to publication of the report.)

Employers, employees, and the overall economy are currently impacted by workers struggling to balance work and family.

- 65% of North Carolina children live in households where all available parents are currently working.[28]
- Two-thirds of mothers with children under age six are in the U.S. labor force, and three-quarters of mothers with children under 18 are in the labor force.[29]
- In North Carolina, about 44% of mothers are the sole or primary breadwinner for their families, earning at least half of their total household income, and an additional 21% of mothers are married mothers whose wages comprise at least 25% of total household earnings.[30]
- A North Carolina survey showed that 75% of mothers and 50% of fathers say they have passed up work opportunities, switched jobs, or quit to care for their children, and nearly 40% of parents say they've left a job because it lacked flexibility.[31]
- Workers are frequently caregivers to family besides their own children. More than 1 in 6 American workers assists with the care of an elderly or disabled family member, relative, or friend. [32]

Workplace policies that support the realities of balancing work and family help with labor force participation, productivity, morale, retention, and more. Many employers who have adopted family-friendly work policies and benefits have done so because they believe that such policies are good for their business.[33] A North Carolina survey of employers of all sizes showed that employers see family-friendly practices as an effective way to grow a more prosperous company.[34]

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[28] NC Council for Women and Youth Involvement and Institute for Women's Policy Research. (June, 2018). *Status of Women in NC: Employment and Earnings.* North Carolina Department of Administration. **https://ncadmin.nc.gov/advocacy/women/status-women-north-carolina**.

[29] U.S. Bureau of Labor Statistics. (April, 2020). *Employment Characteristics of Families Summary, 2019*. **https://www.bls.gov/news.release/famee.nr0.htm**.

[30] Glynn, S.J. Center for American Progress. (May 10, 2019). *Breadwinning Mothers Continue to Be the U.S. Norm.* **https://www.americanprogress.org/issues/women/reports/2019/05/10/469739/breadwinning-mothers-continue-u-s-norm/**.

[31] Family Forward NC, North Carolina Early Childhood Foundation. (2018). *North Carolina Employers Agree: Family-friendly practices are good for business.* **https://files.familyforwardnc.com/wp-content/uploads/2018/04/Family-Forward-Research-Report_Online_091218.pdf**.

[32] Family Caregiver Alliance. *Caregiver Statistics: Work and Caregiving*. **https://www.caregiver.org/caregiver-statistics-work-and-caregiving**.

[33] See Family Forward NC, North Carolina Early Childhood Foundation. (2018). *North Carolina Employers Agree: Family-friendly practices are good for business.* https://files.familyforwardnc.com/wp-content/uploads/2018/04/Family-Forward-Research-Report_Online_091218.pdf.

[34] Family Forward NC, North Carolina Early Childhood Foundation. (2018). North Carolina Employers Agree: *Family-friendly practices are good for business.* **https://files.familyforwardnc.com/wp-content/uploads/2018/04/Family-Forward-Research-Report_Online_091218.pdf**

"These recommendations address workplace issues that simultaneously impact a family's economic security and their health and well-being."

The following three recommendations address workplace issues that simultaneously impact a family's economic security and their health and well-being.

These recommendations are "endorse" items on the Child Fatality Task Force agenda which means that these recommendations are being advanced by other organizations and the Task Force is endorsing the advancement of these policies.[35]

1. ENDORSE legislation that would guarantee all North Carolina workers the right to reasonable pregnancy and lactation accommodations in the workplace.

Each year, about 1.6% of the North Carolina labor force gives birth.[36] Healthy birth outcomes depend on a healthy pregnancy, and the health benefits of breastfeeding to both mothers and infants are well documented. A woman's ability to care for her health during pregnancy and to succeed at breastfeeding can be impacted by the physical and logistical demands of her job and whether she receives reasonable accommodations from her employer to address these demands.

Jobs that may involve increased exposure to toxins, disease, or physical hazards pose some of the more obvious risks for pregnant women. In addition, physically demanding work may increase risk for pre-term birth.[37] In North Carolina, prematurity and low birth weight are leading causes of infant mortality, and another leading cause involves "maternal complications" which can relate to the mother's health.[38] Many women have jobs and/or uncomplicated pregnancies that require no workplace accommodations or only minor ones to stay healthy, but when accommodations are needed it's important that laws and policies facilitate, rather than impede, a woman's ability to get them. The American College of Obstetricians and Gynecologists issued an opinion highlighting the importance of pregnancy accommodations in the workplace for women who need them.[39]

Over one in five pregnant workers are employed in low-wage jobs, which are particularly likely to be physically demanding, and women of color are disproportionately represented in these low-wage jobs.[40] Some of the most common occupations for pregnant workers include: school teachers,

[35]The Task Force has not at this time studied or made recommendations regarding the composition or inclusion of specific provisions or language in potential laws addressing these recommendations.

[36] National Women's Law Center. (March, 2013). *Pregnant Workers Make Up a Small Share or the Workforce and Can Be Readily Accommodated: A State-By-State Analysis.* **https://www.nwlc.org/sites/default/files/pdfs/state_by_state_analysis.pdf**.

[37]See: van Beukering, M.D.M., van Melick, M.J.G.J., Mol, B.W. et al. Physically demanding work and preterm delivery: a systematic review and meta-analysis. Int Arch Occup Environ Health 87, 809–834 (2014). **https://doi.org/10.1007/s00420-013-0924-3**.

[38] Child Deaths in North Carolina, Annual Report for 2018, produced by the N.C. Division of Public Health – Women's and Children's Health Section in conjunction with the State Center for Health Statistics.

[39] American College of Obstetricians and Gynecologists. (April, 2018). *Employment Considerations During Pregnancy and the Postpartum Period*. Committee Opinion number 733.

[40] Harwood, M. & Heydemann, S. (August, 2019). *By the Numbers: Where Do Pregnant Women Work?* National Women's Law Center. **https://nwlc.org/wp-content/uploads/2019/08/Pregnant-Workers-by-the-Numbers-v3-1.pdf**.

nurses, cashiers, administrative assistants, health aids, customer service representatives, food servers, and retail sales.[41]

Examples of workplace adjustments that can promote a healthy pregnancy include:

- assistance with manual labor, such as help with heavy lifting;
- access to food and drink and permitting meals and beverages at work stations;
- more frequent and longer breaks;
- changes in a work station or seating equipment (e.g., for a position that typically involves standing, provide a stool);
- modified work assignments (with respect to schedule or physical demands).

Three months after giving birth, more than half of U.S. women who worked during pregnancy have returned to work,[42] and a study based on U.S. Census data estimated that nearly one in four women are back at work within two weeks of giving birth.[43] Experts recommend breastfeeding for one year with exclusive breastfeeding for at least six months following birth.[44] While over 80% of infants born in the U.S. start out breastfeeding, less than half are exclusively breastfed at three months and only one-third are breastfeeding at six months.[45] A worksite environment that impedes a woman's ability to express breast milk is one of the barriers women face in continuing to breastfeed for a year after giving birth.

At least half of all states have enacted laws to address accommodations for pregnancy because federal laws are seen as falling short of necessary protections

There are federal laws that address some workplace accommodations related to pregnancy, such as the Pregnancy Discrimination Act (PDA), Americans with Disabilities Act (ADA), and Affordable Care Act (ACA). However, there is no federal law guaranteeing comprehensive accommodations for pregnant and postpartum workers. While most employers honor requests for reasonable accommodations, one report estimated that 250,000 pregnant workers every year are denied requests for accommodations while more don't bother asking for fear of retaliation.[46] Federal laws as interpreted by the courts have been viewed as frequently falling short of providing necessary protections.[47] As a result, at least half of all states now have their own laws that provide

[41] Ibid.

[42] See Laughlin, L. United States Census Bureau. (October, 2011). *Maternity Leave and Employment Patterns of First-Time Mothers: 1961 – 2008, Household Economic Studies*. **https://www.census.gov/prod/2011pubs/p70-128.pdf**.

[43] In These Times. (August 18, 2015). T*he Real War on Families: Why the U.S. Needs Paid Leave Now*. **http://inthesetimes.com/article/18151/the-real-war-on-families**.

[44] Association of Maternal and Child Health Programs. (August, 2017). *Promoting Workplace Breastfeeding Accommodations: Regulations, Best Practices, and the Critical Role of Title V Programs*. **http://www.amchp.org/Policy-Advocacy/health-reform/resources/Documents/Kellogg_WorkplaceBreastfeedingAccommodations.pdf**.

[45] Centers for Disease Control and Prevention. (2018). *Breastfeeding Report Card, United States, 2018*. **https://www.cdc.gov/breastfeeding/data/reportcard.htm**

[46] National Partnership for Women & Families. (January, 2014). *Listening to Mothers: The Experiences of Expecting and New Mothers in the Workplace*, Childbirth Connection, National Partnership for Women & Families. **https://www.nationalpartnership.org/our-work/resources/economic-justice/pregnancy-discrimination/listening-to-mothers-experiences-of-expecting-and-new-mothers.pdf**.

[47] Under current law, the federal Pregnancy Discrimination Act (PDA) of 1978 mandates that pregnant workers be able to participate fully and equally in the workplace and prohibits discrimination based on pregnancy, childbirth, or related medical conditions. However, the report "Long Overdue" (referenced in the footnote below) states that many women who seek accommodations under doctor's orders and are refused by employers are unable to make valid claims under the PDA because of its limitations and the way it has been interpreted by courts. The federal Americans with Disabilities Act (ADA) requires employers to provide reasonable accommodations to workers with disabilities and although some pregnancy-related disabilities apply, pregnancy itself is not a disability, which leaves gaps in accommodations protections. The federal Affordable Care Act (ACA) amended Section 7 of the Fair Labor Standards Act to require employees to provide women with adequate break time to express breast milk for one year after child birth and for employers to provide a private, clean space to pump (other than a bathroom) as well as break times to do so; the break time requirement does not apply to employers with fewer than 50 employees if they can show an undue hardship.

protections and there have been recent bipartisan efforts to expand protections under federal law.[48]

In December 2018, Governor Roy Cooper issued Executive Order 82, which addresses protections afforded to pregnant state employees who work for any North Carolina department or agency for which the governor has oversight responsibility. Without a state law, however, only a very limited number of North Carolina workers are covered by these protections. In 2019, a bipartisan bill was introduced in North Carolina to address pregnancy accommodations, but this bill has not become law (the Child Fatality Task Force was not involved in the 2019 bill).[49]

Employer impact, economic issues, and bipartisan support

The percent of workers who need accommodations related to pregnancy and lactation is relatively small and most accommodations needed are minor. Each year 1.6% of the state's labor force gives birth and only a portion of these workers require more than minor accommodations — like more frequent bathroom breaks. Whether the accommodation relates to pregnancy or breastfeeding, the circumstances requiring accommodation are temporary.

Laws and/or resulting policies addressing accommodations can increase employee retention and morale which saves turnover costs. With 72% of mothers with children under age 18 in the work force and 62% of mothers with children under age 3 in the workforce,[50] having policies that support and help keep women in the workforce results in economic benefits overall, as well as individual benefits that are frequently critical for a household to maintain economic security. Employers have often supported pregnancy accommodation laws because they create a clear standard for accommodating pregnant workers, and the response from Chamber of Commerce organizations to such laws is typically supportive or neutral.[51] State-level pregnancy accommodation laws passed since 2013 have had bipartisan or unanimous support, and the pregnancy accommodations bill introduced in North Carolina in 2019 had bipartisan support as well.

2. ENDORSE passage of a kin care and safe days bill that would guarantee all North Carolina worker the right to use their sick days (whether paid or job-protected unpaid) to care for a sick loved one, seek preventative care, or deal with the physical, mental, or legal impacts of domestic violence, sexual assault, or stalking.

About three-quarters of workers have access to some type of paid sick leave, and others may have unpaid but job-protected sick leave,[52] but the form that sick leave takes varies considerably. This recommendation is for legislation that would give North Carolina workers the right to use existing sick leave (whether paid or job-protected unpaid) to care for a sick loved one, seek preventative care, or deal with the physical, mental, or legal impacts of domestic violence, sexual assault, or stalking; it does not address the

[48] See Bakst,D., Gedmark, E., Brafman, S. (May, 2019). *Long Overdue: It Is Time for the Federal Pregnant Workers Fairness Act*. A Better Balance, The Work and Family Legal Center. **https://www.abetterbalance.org/wp-content/uploads/2019/05/Long-Overdue.pdf**. Also see the federal Pregnant Workers Fairness Act, H.R. 2694: **https://www.congress.gov/bill/116th-congress/house-bill/2694**.

[49] North Carolina Senate Bill 558, introduced April 2, 2019.

[50] U.S. Bureau of Labor Statistics for 2019.

[51] See Bakst,D., Gedmark, E., Brafman, S. (May, 2019). *Long Overdue: It Is Time for the Federal Pregnant Workers Fairness Act*. A Better Balance, The Work and Family Legal Center. **https://www.abetterbalance.org/wp-content/uploads/2019/05/Long-Overdue.pdf**.

[52] 2019 National Compensation Survey, U.S. Bureau of Labor Statistics.

overall amount of sick leave provided by employers or whether that leave time is paid or unpaid. (Note that the next recommendation, #3 below, addresses paid leave in the context of a statewide Paid Family and Medical Leave Insurance program.)

Many workers are not only responsible for their own health, but they care for the health of other family members. Of course, parents are caring for children, but many workers are also providing care to other family members. Being healthy is not just about reacting to illness or injury, it's also about preventing illness or injury. Prevention could mean taking time to go to the doctor for wellness checks or vaccinations, but it may also mean taking the time to protect oneself and one's family from intimate partner violence or to deal with its impacts. The ability to take time off from work for preventive care, not just for illness, is especially important for pregnant women who need to have consistent prenatal visits.

Safe Days Leave

"Safe days leave" allows for leave time to be used for steps to prevent violence or deal with the impacts of intimate partner violence.

Unfortunately, intimate partner violence is common, and it has devastating impacts for children. More than one in three North Carolina women have experienced at least one type of intimate partner or sexual violence in their lifetime.[53] The Centers for Disease Control and Prevention reports that about one in four women and nearly one in 10 men have experienced contact sexual violence, physical violence, and/or stalking by an intimate partner during their lifetime and reported some form of intimate partner-related impact.[54]

Research suggests that nearly 30 million children in the U.S. will be exposed to some type of family violence before the age of 17, and there is a 30% to 60% overlap of child maltreatment and domestic violence.[55] Children's exposure to domestic violence can have immediate and long-term impacts, including social and emotional problems, cognitive and attitudinal problems, higher risk of delinquency and substance use, and other health impacts.[56] "Safe days leave" allows for leave time to be used for steps to prevent violence or deal with the impacts of intimate partner violence.

In October 2019, Governor Cooper signed an Executive Directive enabling eligible employees of departments and agencies that are under the governor's oversight to use their earned sick and vacation leave to address intimate partner violence, to seek counsel from an attorney or social services provider, participate in legal proceedings such as filing a restraining order, relocate to a safe location, or take other steps necessary to secure and restore their health and safety. Legislation is needed for safe days leave to be available beyond these state employees covered by the governor's Executive Directive.

Kin Care Leave & the Importance of Preventing the Spread of Contagious Disease

The pandemic of 2020 brought into focus

[53] Shaw, E. & Tesfaselassie, A. (2019). The Status of Women in North Carolina: Health & Wellness. Institute for Women's Policy Research, commissioned by the North Carolina Council for Women and Youth Involvement. North Carolina Department of Administration. **https://files.nc.gov/ncdoa/cfw/documents/R592_NC_Health_Report_Final.pdf**.

[54] Centers for Disease Control and Prevention. Violence Prevention, Fast Facts, Intimate Partner Violence. **https://www.cdc.gov/violenceprevention/intimatepartnerviolence/fastfact.html**.

[55] Child Welfare Information Gateway. U.S. Children's Bureau. (October, 2014). D*omestic Violence and the Child Welfare System* (citing Hamby, Finkelhor, Turner, & Ormrod, 2011; Taggart, 2011). **https://www.childwelfare.gov/pubPDFs/domestic-violence.pdf**.

[56] Child Welfare Information Gateway. U.S. Children's Bureau. (October, 2014). D*omestic Violence and the Child Welfare System* (citing Hamby, Finkelhor, Turner, & Ormrod, 2011; Taggart, 2011). **https://www.childwelfare.gov/pubPDFs/domestic-violence.pdf**.

the importance of people being able to stay home when they are sick, not only to get better but to prevent infecting others if they are contagious. Parents need to be able to use their sick leave to stay home with a sick child or to get children to wellness visits so that they aren't forced to choose between economic stability and the health of their loved ones or others that may be infected if they or their children go to work or school sick.

Besides caring for their own children, many workers are called upon to care for or help other family members. A study of unpaid caregiving in the U.S. showed that approximately 16% of adults provide some type of unpaid care to another adult, with 85% of these caregivers providing care for a relative, most often a parent or parent-in-law, and one in 10 providing care for a spouse.[57] This study also found that six in 10 unpaid caregivers reported being employed at some point in the past year while caregiving, with more than 50% of those caregivers working full time.[58]

The federal Family and Medical Leave Act provides certain employees with up to 12 weeks of unpaid, job-protected leave per year that can be used for certain reasons, including care of a family member who has a serious health condition.[59] With kin care leave of the type being discussed here, use of sick leave for caregiving can be different. For example, use of sick leave to care for a child would not be limited to a child with a serious health condition, but could be used to stay home with a child who has a temporary illness, such as a contagious illness like the flu. Kin care laws vary; a proposed kin care and safe days leave bill in North Carolina in 2019 limited this type of leave used to care for family members to five days.[60]

It should be noted that the Child Fatality Task Force did not take up the issue of

paid short-term sick leave, as this kin care recommendation addresses using both paid and unpaid sick leave for the purpose of caring for a family member. However, the Task Force did take up the issue of paid family leave insurance which relates to longer-term paid leave (see next recommendation). When it comes to using leave to prevent the spread of an infectious disease, both short-term leave (of the type addressed with this kin care leave recommendation) and longer-term leave (addressed in the recommendation below related to paid family leave insurance) are important. For example, short-term leave is typically needed to deal with most cases of the seasonal flu, but longer-term leave could be needed if there are complications from the flu that lead to a more serious illness, and the same would be true for COVID-19.

Data related to the flu provides relevant information on the importance of all family

[57] AARP Real Possibilities Public Policy Institute and the National Alliance for Caregiving. (June, 2015). Caregiving in the U.S. **https://www.aarp.org/content/dam/aarp/ppi/2015/caregiving-in-the-united-states-2015-report-revised.pdf**

[58] Ibid.

[59] See U.S. Department of Labor, Wage and Hour Division. Fact Sheet #28: *The Family and Medical Leave Act.* **https://www.dol.gov/sites/dolgov/files/WHD/legacy/files/whdfs28.pdf**.

[60] The proposed legislation in North Carolina in 2019 was House Bill 899, which had bipartisan sponsorship. Note: The Child Fatality Task Force was not involved in this specific 2019 bill.

members needing leave time for preventative care, including flu shots and staying home when sick. There have been studies examining the impact of leave time on the spread of influenza, although these types of studies typically look at *paid* leave. Studies indicate that children of parents with paid time off are 13% more likely to have well-child visits and flu vaccines, and parents without paid sick days are twice as likely to send a sick child to school or child care.[61] A lack of paid sick leave has been associated with a lower likelihood of workers getting flu vaccinations.[62] One study comparing flu rates in cities with and without mandatory paid leave showed an infection rate could be 40% lower in a city with paid leave.[63] Another study showed how providing paid sick leave could have saved employers between $0.63 billion and $1.88 billion in reduced absenteeism costs per year related to flu-like illness between 2007 to 2014.[64] In this way, there are both public health and economic benefits to ensuring paid leave to reduce the spread of disease.

3. Endorse legislation addressing paid family leave insurance in North Carolina.

The issue of paid family leave came to the Child Fatality Task Force through multiple channels. In 2016, the State Child Fatality Prevention Team, chaired by the Chief Medical Examiner, made a recommendation to the Child Fatality Task Force to support legislation that enables families to accumulate paid sick leave to care for children when they become sick, and paid family leave to use after the birth of a child. Then in 2017, the Child Fatality Task Force received a request to study the issue of paid family leave insurance programs as a strategy to address infant mortality and family well-being. In addition, the work of the Perinatal Health Committee of the Task Force is continuously informed by the statewide Perinatal Health Strategic Plan, which includes among its strategies creating and expanding paid parental leave.

The Task Force heard from experts about the impacts of paid family leave and about paid family leave insurance programs that are in effect in some other states. Realizing the complexities of a statewide paid family leave insurance program, the Task Force determined that an in-depth study of this issue would need to take place, but that such a study was beyond the scope of Task Force structure and capacity. A multi-sector group was formed for the purpose of outlining the various issues that such a study would need to address in order 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.[65] This study was published in March 2019 and was presented to the Task Force during its 2019-2020 study cycle; its findings are highlighted below.

Throughout the course of the Task Force's examination of paid leave, experts presenting to the Child Fatality Task Force emphasized that access to paid family leave is not simply an attractive benefit and that access to paid family leave can save lives while supporting a family's economic stability as well as their physical and emotional wellbeing.

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[61] Presentation by NC Pediatric Society to the Perinatal Health Committee of the NC Child Fatality Task Force, October 28, 2019.

[62] Zhai Y, Santibanez TA, Kahn KE, Black CL, de Perio MA. Paid sick leave benefits, influenza vaccination, and taking sick days due to influenza-like illness among U.S. workers. Vaccine. 2018;36(48):7316–7323. doi:10.1016/j.vaccine.2018.10.039.

[63] VOX CEPR Policy Portal. Pchler, S. & Ziebarth, N.R. (May 12, 2018). *The pros and cons of sick pay schemes: Contagious presenteeism and noncontagious absenteeism behavior*. **https://voxeu.org/article/pros-and-cons-sick-pay.**

[64] Asfaw, A., Rosa, R., & Pana-Cryan, R. (2017). Potential economic benefits of paid sick leave in reducing absenteeism related to the spread of influenza-like illness.Journal of occupational and environmental medicine,59(9), 822-829.

[65] 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. **https://duke.app.box.com/s/9wti16byhdyyz6k99ri2yib3ttlprgl8**. Note: The Task Force was not directly involved in the study itself.

What is Paid Family Leave Insurance?

Paid family leave insurance ("PFLI" and sometimes called paid family and medical leave insurance) is a specific type of paid family leave that is publicly provided and operates statewide. A PFLI program is funded through employees (and sometimes also employers) paying a small insurance premium into a fund from which they can draw for qualified leave purposes such as caring for a new child after birth or adoption or caring for oneself or a family member due to illness. PFLI programs have been adopted in eight states and the District of Columbia and many other states have studied and/or introduced legislation addressing paid family leave insurance.[66]

Current status and scope of family leave

The concept that paid family leave is essential and not merely an attractive benefit is illustrated by the fact that 41 other developed countries have paid family leave.[67] Findings from an international report showed that among 42 developed countries, the United States is the only one that does not have any paid family leave.[68] Among 36 of these 42 countries [36 are members of the Organisation for Economic Co-operation and Development (OECD) who did the report], on average mothers are entitled to just over 18 weeks of paid maternity leave around childbirth and almost all of these countries provide at least 14 weeks of paid maternity leave. In some countries maternity leave is much longer; in the U.K., for example, mothers get up to nine months of paid maternity leave. Many countries also offer parental and/or home care leave that is often supplementary to specific maternity and paternity leave and among the 36 OECD countries, the average entitlement available to mothers was at just under 36 weeks.[69]

The U.S. Family and Medical Leave Act provides eligible employees with up to 12 weeks of unpaid, job-protected leave per year that can be used for parental leave or care of oneself or a family member for a serious health condition.[70] However, the eligibility requirements for FMLA only cover about 60% of American workers,[71] and many eligible workers cannot afford to take leave under the FMLA because it is unpaid. Paid parental leave for federal employees was contained in the National Defense Authorization Act, approved in late 2019. While there has been proposed federal legislation for nationwide paid family leave, no proposals have become law.

"Data indicates that **only 19% of U.S. civilian workers have access to paid family leave** and among the lowest 25% of wage earners access to paid family leave is only 9% while it is 30% for the highest 25% of wage earners. A paid family leave insurance program makes all wage earners eligible for paid family leave, thereby addressing inequities in access to leave that perpetuate economic and health disparities."

[66] The states that have these programs (some are in place and some have not yet begun) include: Rhode Island, California, New Jersey, New York, Washington, Massachusetts, Connecticut, Oregon, and the District of Columbia. A chart outlining the basics of these programs can be found on the website for A Better Balance, the Work and Family Legal Center: **https://www.abetterbalance.org/resources/paid-family-leave-laws-chart/**.

[67] Organisation for Economic Co-operation and Development (OECD). (Updated August 2019). *Report on parental leave systems*. **http://www.oecd.org/els/soc/PF2_1_Parental_leave_systems.pdf**.

[68] Ibid.

[69] Ibid.

[70] See U.S. Department of Labor, Wage and Hour Division. *Fact Sheet #28: The Family and Medical Leave Act*. **https://www.dol.gov/sites/dolgov/files/WHD/legacy/files/whdfs28.pdf**.

[71] Kaiser Family Foundation. (January 28, 2020). *Paid Family and Sick Leave in the U.S.* **https://www.kff.org/womens-health-policy/fact-sheet/paid-family-leave-and-sick-days-in-the-u-s/**.

In 2019 Governor Cooper signed Executive Order 95, which provides paid parental leave to state employees under the governor's purview. Many other North Carolina state agencies, as well as the UNC Board of Governors and multiple local governments in North Carolina, have done the same.[72] Republican and Democratic governors in other states have issued similar orders.[73] In 2019, legislation was introduced that would create a PFLI program in North Carolina; however, this legislation did not become law.[74]

Some employers choose to provide paid family leave as a benefit for their employees. However, data indicates that only 19% of U.S. civilian workers have access to paid family leave, access to paid family leave is only 9% among the lowest 25% of wage earners, while it is 30% for the highest 25% of wage earners.[75] This means that a mother who is a low wage earner and least likely to be able to afford to take unpaid family leave is also much less likely than high wage earners to have access to paid family leave. A paid family leave insurance program makes all wage earners eligible for paid family leave, thereby addressing inequities in access to leave that perpetuate economic and health disparities.

Duke Study's Findings on the Costs and Benefits of Paid Family Leave Insurance in North Carolina[76]

The Duke University study on paid family leave insurance analyzed the existing research on paid family leave and existing policies on PFLI in the U.S. The study also modeled the costs, benefits, and feasibility of two sample policy proposals for instituting a PFLI program in North Carolina.

The key findings from the Duke University study include the following (excerpt from the report):

Paid family and medical leave
- **increases labor force participation and employee retention and**
- **improves the health of mothers and infants.**

Statewide PFLI programs are generally viewed by employers as having had a positive effect or no noticeable effect.

Potential cost savings from estimated impacts of PFLI on North Carolina families would well-beyond outweigh administrative costs to implement and run a PFLI program.

Two benefits of PFLI could have a particularly significant impact in North Carolina:
- **decreased infant mortality and**
- **decreased nursing home usage.**

Twenty-six infant lives in North Carolina would be saved per year, among other benefits, under the PFLI proposal that simulates a statewide 12-week paid leave model with 80 percent wage replacement [This would reduce the state's infant mortality rate.]

This study concludes that a paid family and medical leave insurance program for all North Carolina workers would have a positive impact for North Carolina workers and families.

[72] Presentation to the Child Fatality Task Force by MomsRising, February 2020.

[73] For example, Tennessee, Idaho, and Michigan.

[74] North Carolina House Bill 696, 2019 legislative session. The NC Child Fatality Task Force was not involved in this bill.

[75] U.S. Bureau of Labor Statistics, National Compensation Survey, March 2019.

[76] Excerpts from the Duke PFLI study are reprinted in this report with permission. 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. https://duke.app.box.com/s/9wti16byhdyyz6k99ri2yib3ttlprgl8.

In the two models simulated in the Duke study, funding for the program is from employees only, with no contribution to premiums by employers, and the reasons for taking leave include caring for one's own health, a new child, or family caregiving. The full study should be reviewed for details and what follows are some tables and highlights from the study.

The study is available on the website for Duke Center for Child and Family Policy here: **https://duke.app.box.com/s/9wti16byhdyyz6k99ri2yib3ttlprgl8.**

The study's analysis of two simulations found that:

- A PFLI program in North Carolina would cover more than 4.7 million North Carolina workers
- Estimates are that between 4.1 and 5.7 percent of North Carolina workers covered by PFLI would take advantage of PFLI for their own serious health conditions, bonding with a child, or family caregiving.
- Workers in North Carolina would receive average weekly individual benefits between $330 to $537 (the simulation presumes caps on benefits).
- Premiums paid by workers would be between $1.47 and $4.59 per week. (Both models presume employee contributions only with no employer contributions.)

Although not part of the simulation of two North Carolina proposals, the Duke study also discussed potential administrative costs of a PFLI program in North Carolina, as well as how other states have handled appeals and dispute resolution, penalties for noncompliance or fraud, claims processing and premium collection, fund management, coordination with other benefit programs, and the administrative bodies that operate PFLI programs in other states.

Simulation of two PFLI Proposals for North Carolina used in the study

	Proposal A	Proposal B
Maximum Duration of Leave	8 weeks	12 weeks
Amount of Benefit	55% of wages up to weekly max	80% of wages up to weekly max
Maximum Weekly Benefit	$486	$875
Wage Base for Premium	Up to $25,292	Up to $45,526
Waiting Period	One week	No waiting period
Eligibility	• Worked at least 80 hours in the last year • At least $1,560 total earnings in last year	• Worked at least 80 hours in the last year • At least $1,560 total earnings in last year

Estimated costs for two PFLI proposals in NC used in the study

	Proposal A		Proposal B	
	Model 1	Model 2	Model 1	Model 2
Employee premium as a % of earnings per year	0.35%	0.54%	0.58%	0.89%
Average weekly premium cost per worker	$1.47	$1.97	$3.52	$4.59

Estimated participation for two PFLI proposals in NC used in the study

	Proposal A		Proposal B	
	Model 1	Model 2	Model 1	Model 2
Covered employees per year	0.35%	0.54%	0.58%	0.89%
Number of covered employees taking PFLI leave per year	193,389	229,483	193,389	277,744
Average weekly PFLI benefits paid to employees taking PFLI leave	$335	$330	$537	$520
Total amount of PFLI benefits paid to all PFLI leave takers PY	$360m	$497m	$865m	$1,157m

Reducing Infant Mortality

Of special interest to the Child Fatality Task Force is the impact of PFLI on infant mortality. The Duke study on PFLI in North Carolina estimated that PFLI in North Carolina could save 26 infant lives per year. The report discussed research that a 10-week expansion in paid family leave leads to a 2.5% fall in infant mortality and that some reasons for this include the increase in parent's ability to access pre- and post-natal medical care, reduced stress due to decreased financial constraints, and improved infant health from increased breastfeeding. In addition, paid leave is estimated to reduce the number of infants born with low birth weight, which is a leading cause of infant mortality in North Carolina, and this may be attributable to increased access to time off prior to delivery.

The Science of Infant Development and the "Fourth Trimester"

Experts who presented to the Child Fatality Task Force emphasized the importance of the "fourth trimester." The fourth trimester is the time between birth and 12 weeks postpartum. Maternal and infant health experts have increasingly focused attention on this time period with the recognition that it is a very vulnerable time for new mothers, infants, and their families. Infants are adjusting to life outside the womb, mothers are adjusting to new parenthood, and there are significant biological, psychological, and social changes taking place.[77]

Newborns are incredibly helpless and dependent beings. Not only do they need the basics like diaper changes and good nutrition to thrive, but their relationship with their parents or caregivers is key to

> "A study by Duke University concluded that **a paid family and medical leave insurance program in North Carolina would save an estimated 26 infant lives in one year.**"

[77] Verbiest, S.B., Tully, K.P., Stuebe, A.M. University of North Carolina at Chapel Hill. (March 2017). Promoting Maternal and Infant Health in the 4th Trimester. Zero to Three Journal. **https://4thtrimester.web.unc.edu/files/2017/06/ZERO-TO-THREE-Journal.pdf.**

brain development.[78] The Harvard University Center on the Developing Child explains early development, noting that more than one million new neural connections are formed every second during the first few years of life and after that, connections are reduced through a pruning process to make brain circuits more efficient.[79] An important part of this brain development process is the "serve and return" relationship between children and their parents and other caregivers. This is when "young children naturally reach out for interaction through babbling, facial expressions, and gestures, and adults respond with the same kind of vocalizing and gesturing back," and without these types of responses or with inappropriate responses, the brain's architecture does not form as expected.[80]

Meanwhile, mothers during this fourth trimester are facing challenges such as: problems with maternal mood and emotional well-being (which when serious can also impact the well-being of the infant); challenges with infant care and feeding including establishment of breastfeeding; problems with sleep and fatigue; physical recovery from childbirth; and more.[81]

Navigating this fourth trimester is inevitably time consuming and challenging for all mothers of newborns as they address these challenges, bond with a new child, and establish new routines and ways of life. Yet, a study based on U.S. Census data estimated nearly 1 in 4 women are back at work within two weeks of giving birth.[82] The timing for a return to work after childbirth can inevitably be impacted by the realities of generating family income. At the same time, paid family leave is associated with higher childhood vaccination rates and reduced rates of some child health problems.[83] Paid time off from work for all or part of this fourth trimester prevents a mother from potentially having to choose between economic security for her family and the health and well-being of herself and her child.

Paid Leave and Preventing the Spread of Disease

As was noted above in recommendation #2 above, the pandemic of 2020 brought into focus the importance of people being able to stay home when they are sick, not only to get better faster but to prevent infecting others if they are contagious. People are more likely to go to work sick, send a child to school sick, or forego wellness visits and vaccinations if taking time off means sacrificing pay or risking job security. [See discussion above on pages 30 - 32 for data examples] The importance of paid family leave in preventing the spread of disease is illustrated by the swift action of federal and state governments in providing for paid leave in the context of the COVID-19 pandemic. The COVID-19 pandemic provides an example of how a disease can be mild or quickly turn serious and prolonged, requiring longer-term leave for hospitalization and recovery, not only for the sick person but also for a family member caring for the sick person.

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[78] The importance of newborn brain development and of the fourth trimester was emphasized in a presentation to the Child Fatality Task Force by Dr. Alison Steube, M.D., MSc, Professor, Maternal-Fetal Medicine and Interim Director of the Division of Maternal-Fetal Medicine, Co-Director of the University of North Carolina Center for Maternal and Infant Health.

[79] Center on the Developing Child. Harvard University. In Brief: The Science of Early Childhood Development **https://developingchild.harvard.edu/resources/inbrief-science-of-ecd/.**

[80] Ibid.

[81] Verbiest, S.B., Tully, K.P., Stuebe, A.M. University of North Carolina at Chapel Hill. (March 2017). Promoting Maternal and Infant Health in the 4th Trimester. Zero to Three Journal. **https://4thtrimester.web.unc.edu/files/2017/06/ZERO-TO-THREE-Journal.pdf**.

[82] In These Times. (August 18, 2015). The Real War on Families: Why the U.S. Needs Paid Leave Now. **http://inthesetimes.com/article/18151/the-real-war-on-families**.

[83] 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. **https://duke.app.box.com/s/9wti16byhdyyz6k99ri2yib3ttlprgl8**.

Paid Family Leave and Preventing Child Maltreatment

Policies that strengthen economic security for families and that improve caregivers' ability to meet children's needs can prevent adverse childhood experiences.[84] More specifically, a CDC report says research suggests

access to paid leave may be protective against depression, pediatric abusive head trauma, and intimate partner violence.[85]

California has had paid family leave insurance in place since 2004, longer than any other state. A 2015 study that examined associations between California's paid family leave policy and hospital admissions for pediatric abusive head trauma showed a significant decrease of abusive head trauma admissions for children under 2 years old in California as compared to seven other states with no paid family leave policies.[86] Of note in this same 2015 study is the finding that comparison states without paid family leave experienced increased rates of abusive head trauma during the years known as the great recession while California did not; this finding may have increased significance given the 2020 pandemic and the resulting economic fallout.

The Economics of Paid Family Leave

A survey of employers about their experience with a statewide PFLI program found that a majority reported PFL had either a positive effect or no noticeable effect on productivity (89%), profitability/performance (91%), and employee morale (99%).[87] Also, a majority of employers reported that PFL had minimal impact on their business operations.[88] A scientific opinion poll found a large majority of small business employers support a paid family and medical leave insurance program.[89]

PFLI has positive impacts when viewed from the broader lens of the overall health of the economy such as:

- **Increased labor force participation.** PFLI increases the labor force participation rate, especially by women.[90] This is important at a time when the number of workers with caregiving responsibilities (for children and other family members) is on the rise and the population of North Carolinians 65 years of age and over is growing, which adds to the need for caregivers and increases the number of people aging out of the workforce.[91]
- **Economic equity.** As was noted earlier, the lowest wage earners are also the least likely to have access to paid family leave. This lack of access puts low wage earners at a disadvantage and creates greater economic inequality, but PFLI provides access to all wage earners.
- **Reduced uptake of public assistance programs.** Not only would PFLI provide economic support for low wage earners, but the Duke PFLI study noted that PFLI reduces the use of public benefits like

[84] See National Center for Injury Prevention and Control, Division of Violence Prevention, Centers for Disease Control and Prevention (2019). *Preventing Adverse Childhood Experiences (ACEs): Leveraging the Best Available Evidence.* **https://www.cdc.gov/violenceprevention/pdf/preventingACES.pdf**.

[85] Ibid.

[86] Klevens, J., Luo, F., Xu, L., Peterson, C., & Latzman, N. E. (2016). Paid family leave's effect on hospital admissions for pediatric abusive head trauma. I*njury prevention : journal of the International Society for Child and Adolescent Injury Prevention*, 22(6), 442–445. **https://doi.org/10.1136/injuryprev-2015-041702**.

[87] Appelbaum, E. & Milkman, R. (2011). *Leaves That Pay: Employer and Worker Experiences with Paid Family Leave in California*. **https://www.cepr.net/documents/publications/paid-family-leave-1-2011.pdf**.

[88] Ibid.

[89] Small Business Majority (March 30, 2017). *Opinion Poll: Small Businesses Support Paid Family Leave Programs.* **https://smallbusinessmajority.org/our-research/workforce/small-businesses-support-paid-family-leave-programs**.

[90] 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. **https://duke.app.box.com/s/9wti16byhdyyz6k99ri2yib3ttlprgl8**.

[91] Ibid.

the Supplementary Nutrition Assistance Program and Temporary Assistance for Needy Families.[92]

- **Better health resulting in cost savings and stronger communities.** As noted earlier, there are verified health benefits of paid family leave for mothers and children. Healthier mothers and children mean fewer health care expenses which impacts costs for families, employers, and government programs that fund health care. Healthier mothers and children also result in more positive contributions to communities and economies.

Recommendations to strengthen the statewide Child Fatality Prevention System to increase the system's ability to prevent child abuse, neglect, and death

The North Carolina Child Fatality Prevention System (CFP System) is large and complex. It was created in 1991 by state statute and consists of local child fatality review teams in every county (Child Fatality Prevention Teams and Community Child Protection Teams, collectively called "Local Teams"); a state Child Fatality Prevention Team (State Team) led by the Chief Medical Examiner; and the Child Fatality Task Force (Task Force), a legislative study commission that makes policy recommendations and does not conduct child fatality reviews.[93] There is also a State Child Fatality Review Team that reviews certain child maltreatment-related fatalities and utilizes members from Local Teams, but it is addressed in a statute that is separate from the rest of the CFP System.[94]

These groups that are part of the CFP system are each multidisciplinary and cross-sector in terms of their membership. They are comprised of local and state government leaders, as well as experts in child health and safety. Participants in the CFP System work to study and understand causes of childhood deaths, advance a communitywide approach to the prevention of child fatalities and child maltreatment, and identify gaps in systems designed to prevent child maltreatment and death. A primary purpose of the CFP System is to make and implement recommendations for laws, rules, and policies that will support the safe and healthy development of children and prevent future child fatalities and maltreatment.

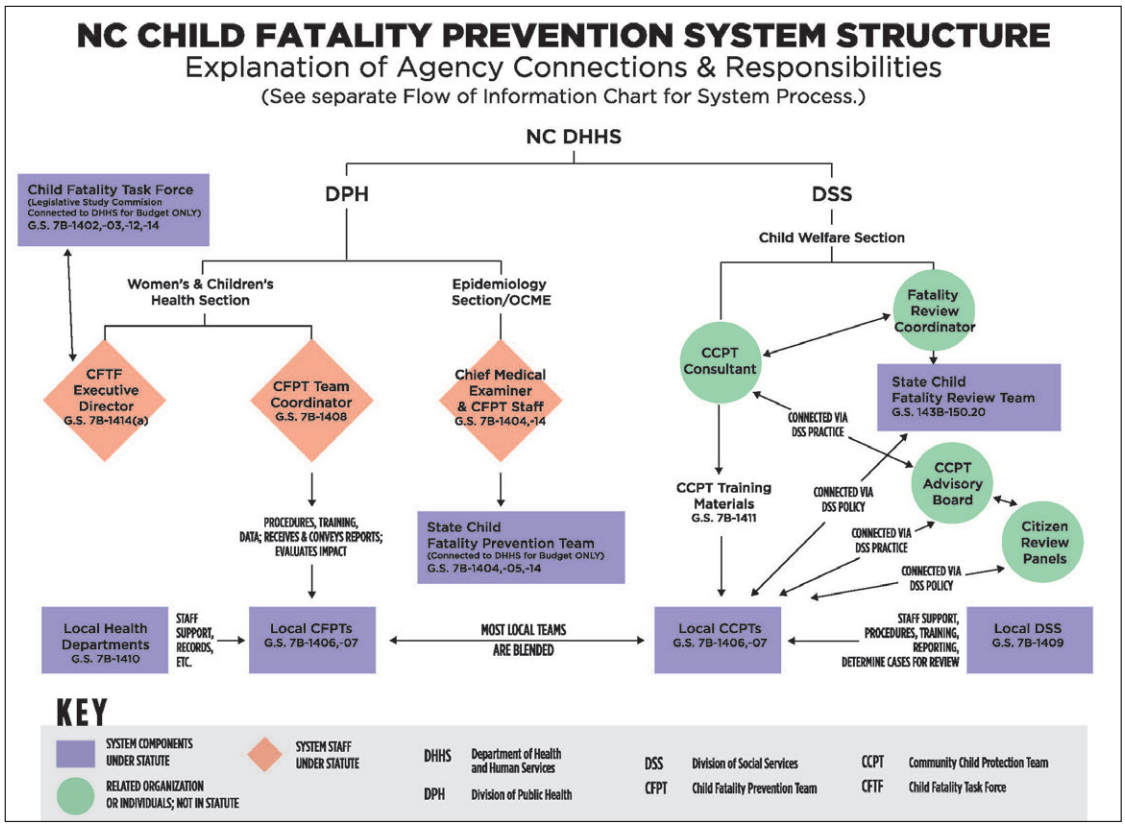
Recommendations stemming from state and local review teams and the Task Force are directed to various entities ranging from boards of county commissioners, local and state-level social services leaders, to the governor and the General Assembly. In addition, the CFP System is structured for certain information and recommendations to be passed among review teams and the Task Force.

[92] Ibid.

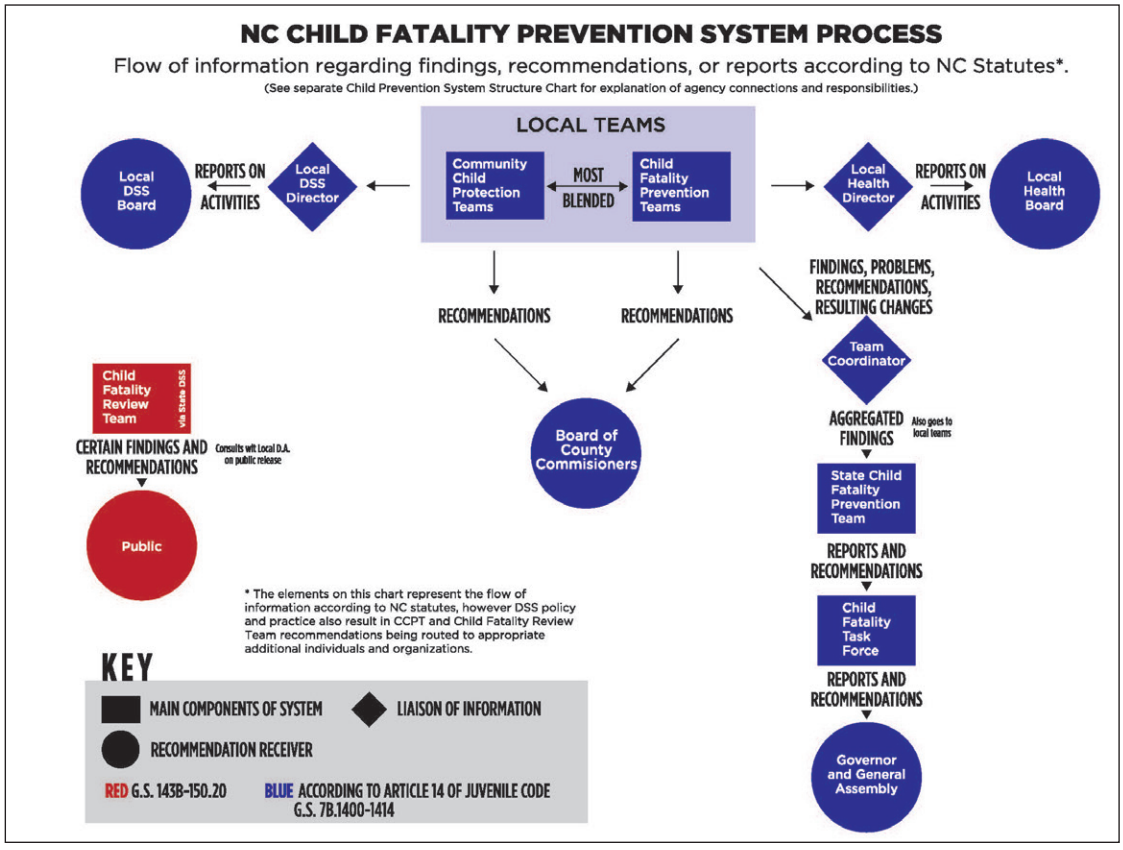
[93] N.C.G.S. 7B-1400 – 1414.

[94] N.C.G.S. 143B-150.20.

Graphic representation of how the Child Fatality Prevention System is currently structured:[95]



Here is a graphic illustration of the flow of information within the current CFP System according to statutes:



[95] Updated information: The CFTF Executive Director position is no longer located within the Division of Public Health as this graphic illustrates; this position is currently located in the Department of Health and Human Services, Office of the Secretary.

As these two graphics illustrate, the system has many people, parts, and information that are in some ways connected and in other ways disconnected. The fact that the system is complex and has disconnected components makes it challenging even for those working within the system to understand its many moving parts and to coordinate with other parts of the system.

Since 2018, the Child Fatality Task Force has been examining ways to strengthen the Child Fatality Prevention System and these efforts have included input from stakeholders across the state as well as national experts in child fatality review and prevention. (More detail about this work is available in the 2018 and 2019 CFTF Annual Reports.) For its 2019 Action Agenda, the Task Force included a set of recommendations aimed at strengthening the Child Fatality Prevention System, and although there were no new laws addressing these recommendations in 2019, these recommendations have partially advanced. These recommendations were addressed in the 2019 legislative session in House Bill 825, and the language from that bill was then included in the 2019 Appropriations Act, House Bill 966, which did not become law. The NC Department of Health and Human Services has already undertaken further study and planning related to these recommendations, as the recommendations are aligned with current DHHS priorities and the statewide Early Childhood Action Plan. These recommendations of the Task Force were also adopted in the Child Welfare Reform Plan Final Report from the Center for the Support of Families.[96] For the 2020 Action Agenda, the Child Fatality Task Force is now repeating those recommendations.

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.

Structural outcomes these changes seek to address:

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

[96] Center for the Support of Families (May 6, 2019). Child Welfare Reform Plan Final Report. State of North Carolina Office of State Budget and Management (OSBM) with Department of Health and Human Services (DHHS) **https://files.nc.gov/ncosbm/documents/files/ChildWelfareReform_FinalPlan.pdf**.

The following recommendations are intended as a starting point for system change as they take into account the necessity of continuing to involve CFP System stakeholders and state and national experts in making additional determinations regarding system structure and process that represent best practice but are also logical and feasible. These recommendations are aimed at strengthening the overall Child Fatality Prevention System with the ultimate goal of preventing future child abuse, neglect, and death. **The details with additional underlying explanations for these recommendations were addressed in the CFTF 2019 Annual Report, and what follows is a shorter summary addressing the recommendations**.

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 with the formation of a new cross-sector Fatality Review and Data Group and with child fatality staff in the Office of the chief Medical Examiner remaining in OCME.

The current system has no lead organizational unit or individual. Individuals who are in state-level roles supporting the current system work in separate "silos" within a structure that is not conducive to interaction or coordination with one another, even though some of their functions overlap. Having a centralized state-level staff connects the CFP System components, streamlining state-level support functions to enable increased efficiency and capacity while also promoting the standardization of tools and resources for all local review teams. A new cross-sector Fatality Review and Data Group would serve as a liaison of information among local teams, OCME, and the Task Force and could be structured to do occasional state-level reviews of cases, if needed. Child fatality staff with the OCME would remain in the OCME and continue to review all child fatality medical examiner cases.

II. Implement a centralized electronic data and information system that includes North Carolina joining 45 other states to participate in the National Child Death Review Case Reporting System.

Under the current system structure, there are gaps and complexities with information collection, analysis, sharing and reporting that need to be addressed. The use of one electronic national data system that is free and already used by 45 other states would modernize and standardize data collection. It would also promote gathering richer layers of data than what is currently collected by most types of review teams, which leads to a strengthened ability to inform prevention initiatives and policy change.

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.

North Carolina is the ninth most populated state and had 1,313 child deaths in 2017 and 1,255 child deaths in 2018 (ages 0 to 17). Reducing the number of deaths reviewed by teams to those categories most likely to yield identification of system problems and/or prevention opportunities allows for optimization of CFP efforts systemwide.

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 (including intensive-type reviews of abuse or neglect-related deaths with state-level staff assistance), and giving teams the option to choose whether to be single or multi-county teams. DHHS should study and determine an effective framework for meeting the federal requirements for Citizen Review Panels and for reviewing active DSS cases without using all local review teams for these purposes.**

The current North Carolina system has four different types of review teams — two at the local level and two at the state level — plus the NC Child Fatality Task Force, which does not conduct reviews but is the policy arm of the system. This structure results in duplication with different teams routinely reviewing the same case. This recommendation removes duplication of efforts, with the goal of getting all of the very best local and state-level information available for one case in front of a local team for one effective review. An important aspect of this recommendation is the need to structure team reviews so the procedures and required participants can be adjusted to most effectively address the type of death being reviewed, such as deaths related to abuse or neglect which can still receive an "intensive review" similar to the current reviews by the State Child Fatality Review Team.

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.**

The Child Fatality Task Force has for much of its 29-year existence found successful functioning by structuring its work through three committees: Perinatal Health, Unintentional Death Prevention, and Intentional Death Prevention. More formally defining these committees and requiring certain committee members ensures consistent expert and agency input and member attendance in committee meetings. With the above recommendations, components of the system would be more connected — so it would be appropriate and meaningful for this annual report to address not only the work of the CFTF but the work of the system as a whole and for the report to be submitted to additional state leaders.

Recommendation #2: Support for maintaining current state funding for existing positions and operations that support Child Fatality Prevention System work, and for additional recurring funding to support this work 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.

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 support funding to enable implementation of the evidence-informed practice of FIMR as a pilot.

Recommendation and administrative effort to prevent infant deaths

1. *Support a state appropriation of $85,000 in additional funding to expand the Safe Sleep NC program that works to prevent sleep-related infant deaths.

Sleep-related infant death remains a leading cause of infant mortality, both in North Carolina and nationally. According to the North Carolina Office of the Chief Medical Examiner, 131 infant deaths in 2017 in North Carolina were related to an unsafe sleep environment with an additional eight deaths certified as Sudden Infant Death Syndrome (SIDS).[97] In the five-year period between 2013 to 2017, 567 infant deaths in North Carolina were associated with unsafe sleep environments (for example, 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, sharing a sleep space with another individual).[98] This means approximately 13% of all infant deaths in North Carolina between 2013 and 2017 were associated with unsafe sleep environments.

Approximately 70% of those infant deaths from 2013 to 2017 that were associated with unsafe sleep environments were associated

The NC Office of the Chief Medical Examiner reports that from 2013 to 2017, **567 infant deaths were associated with unsafe sleep environments.** Approximately 70% of those infant deaths were associated with bed sharing, also referred to as co-sleeping.

[97] Office of the Chief Medical Examiner, Division of Public Health, North Carolina Department of Health and Human Services. Infant fatalities under the category of sleep-related infant death are categorized for their *potential* unsafe sleep environments. Most of these cases are assigned an undetermined manner of death—it cannot be known if the sleep space lead to their demise. Asphyxiation, as a result of the sleep space, may be a contributing factor among these cases, however, since this manner often leaves no traces, the distinction cannot be made. Therefore, information collected at the scene and with partners during the investigation process is imperative to understanding the circumstances around the fatality. Such is noted in the autopsy summary as reasoning behind the undetermined manner classification. By noting the *potential* relationship to the sleep environment, a more accurate account is made that the death could have been related to the sleep environment or a natural occurrence (such as SIDS) or some other cause of death but, due to circumstances of the case, such cannot be determined.

[98] Office of the Chief Medical Examiner, Division of Public Health, North Carolina Department of Health and Human Services.

with bed sharing, also referred to as co-sleeping, — the intentional or unintentional practice of an infant sharing a sleep space with another individual.[99] During the past 20 years, the number of parents reporting sharing a bed with their infants has grown from about 6% of parents in 1993[100] to 24% in 2015.[101] In North Carolina, almost half of new mothers surveyed shared that they practiced bed sharing with their infant.[102]

This common practice is concerning because of the awareness of the dangers associated with bed sharing, especially among higher risk infants, including those born too soon or too small or in households where tobacco and other substances are used. [103]

Research has found that parents need support navigating the challenges of nighttime parenting and that they would listen to health care providers if counseled about the dangers of the practice of bed sharing and given additional support in adhering to the safe infant sleep recommendations.[104] Additionally, a study found that nearly half of caregivers did not receive correct advice on safe sleep practices from health care providers.[105] Provider advice is an important, modifiable factor to improve safe sleep practice. Expanded efforts to reach population groups with multiple overlapping risks — such as smoking, soft bedding, and bed sharing— are needed.[106] North Carolina health care providers have asked for support engaging parents and caregivers in nuanced conversations about sleep and nighttime parenting to help reduce the risk of infant death.[107]

State funding for infant safe sleep programming to educate about the importance of safe sleep and prevent these types of deaths currently totals $45,000. Not only is this level of funding insufficient to address so many preventable infant deaths, but the source of this funding matters. This $45,000 in funding is currently designated in the state budget to come from the federal Maternal and Child Health Block Grant. When block grant funds are used for this type of purpose, as opposed to using general state funds for this purpose, whatever is designated in the block grant for this purpose is potentially being diverted away from other important maternal and child health initiatives.

Additional funding of $85,000 for the Safe Sleep NC campaign would support the development and dissemination of online training modules for key health care providers, including pediatric providers and home visitors, across the state. It would also allow increased dissemination of education and information for new parents and other caregivers, including social media and marketing efforts. With this additional funding, North Carolina would be spending approximately $1 for safe sleep outreach per each infant in our state.

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[99] Office of the Chief Medical Examiner, Division of Public Health, North Carolina Department of Health and Human Services.

[100] Colson ER, Willinger M, Rybin D, et al, 2013. Trends and Factors Associated With Infant Bed Sharing, 1993-2010. The National Infant Sleep Position Study. JAMA Pediatr. 167(11):1032–1037. doi:10.1001/jamapediatrics.2013.2560.

[101] MMWR Morb Mortal Wkly Rep. 2018 Jan 12; 67(1): 39–46. Published online 2018 Jan 12. doi: [10.15585/mmwr.mm6701e1] PMCID: PMC5769799 PMID: 29324729.

[102] North Carolina Pregnancy Risk Assessment Monitoring System Survey Results 2017, Sleep Position and Bed Sharing **https://schs.dph.ncdhhs.gov/data/prams/2017/SLEEPB.html**.

[103] American Academy of Pediatrics, 2016. SIDS and other sleep-related infant deaths: Updated 2016 recommendations for a safe infant sleeping environment, 138 (5) (2016), pp. 1-12, 10.1542/peds.2016-2938.

[104] Salm Ward and Balfour, 2016. Infant safe sleep interventions, 1990–2015: A review. Journal of Community Health, 41 (1) (2016), pp. 180-196, 10.1007/s10900-015-0060-y; Moon et al., 2016. Safe infant sleep interventions: What is the evidence for successful behavior change? Current Pediatric Reviews, 12 (1) (2016), pp. 67-75, 10.2174/5733963116615102611014 8.

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

[106] Hirai AH, Kortsmit K, Kaplan L, et al. Prevalence and Factors Associated With Safe Infant Sleep Practices. Pediatrics. 2019;144(5):e20191286.

[107] UNC Center for Maternal and Infant Health.

2. [PENDING]: Administrative support for continuing to work on strengthening laws addressing infant safe surrender with the intent to bring this item back for consideration prior to the 2021 legislative long session.

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. In recent years the Child Fatality Task Force, with input from experts in juvenile law, examined the Safe Surrender law and developed recommended changes to strengthen the law. These recommended changes were contained in the 2018 and 2019 Action Agendas for the Task Force, and although legislation was introduced in 2019 addressing these recommendations, this legislation did not advance.[108] The broad recommendations from 2018 and 2019 are as follows, and further explanation for each can be found in the 2019 CFTF annual report on pages 13–14.[109]

1. Remove "any adult" from those designated to accept a surrendered infant.
2. Provide information to a surrendering parent.
3. Strengthen protection of surrendering parent's identity.
4. Incorporate steps to help ensure law is only applied when criteria are met.

The Intentional Death Prevention Committee of the Task Force determined that while this issue remains important, the complexities of the legislation in the context of current changes in child welfare should be further examined, with the goal of bringing this item back for consideration prior to the 2021 long session.

Recommendation and administrative efforts to prevent motor vehicle-related injuries and deaths to children

The leading cause of injury-related death among children in North Carolina is motor vehicle crashes. Among childhood injuries in North Carolina in 2018, motor vehicle crashes were the third leading cause of hospitalizations and emergency department visits for those ages 0-17.[110] North Carolina ranks among the highest for all 50 states in terms of medical and work loss costs associated with motor vehicle crash deaths.[111] The areas of focus below address two primary risk factors for crash deaths identified by the CDC — not using seat belts and drunk driving.[112]

1. [PENDING]: **Support* legislation that would require ignition interlocks for all DWI offenders.

Alcohol is involved in approximately one-fourth of all fatal crashes in North Carolina. In 2017, 368 people were killed in alcohol-related crashes in North Carolina.[113]

On average, one alcohol-impaired-driving fatality occurs every 48 minutes in the United States.[114] Of traffic deaths among children ages 0 to 14 in 2017, 19% involved an alcohol-impaired driver, and in the majority of these deaths, the children were occupants of vehicles with drivers who were impaired.[115] About one-third of those arrested for impaired driving are repeat offenders.[116] One study showed that the average alcohol-impaired

[108] North Carolina House Bill 799 addressed these recommendations.

[109] The 2019 CFTF Annual Report is posted on the CFTF website.

[110] Injury and Violence Prevention Branch of the NC Division of Public Health.

[111] Centers for Disease Control and Prevention. *Motor Vehicle Crash Deaths: Costly but Preventable*. www.cdc.gov/motorvehiclesafety/statecosts/index.html.

[112] CDC Vital Signs (July, 2016). *Motor Vehicle Crash Deaths, How is the US Doing?* https://www.cdc.gov/vitalsigns/pdf/2016-07-vitalsigns.pdf.

[113] Injury and Violence Prevention Branch, NC Division of Public Health, data source: NC Department of Transportation.

[114] National Highway Transportation Safety Administration, based on 2017 data.

[115] National Highway Transportation Safety Administration.

[116] National Highway Traffic Safety Administration (February, 1995). Repeat DWI Offenders in the United States.

driver has driven under the influence of alcohol over 80 times before their first arrest.[117]

Alcohol ignition interlocks are breath test devices installed in a motor vehicle to prevent operation of the vehicle by a driver who has a blood alcohol concentration over a pre-set low limit. Current North Carolina law makes ignition interlocks mandatory if the person's blood alcohol level is greater than .15 or if the person is a second or subsequent offender (the requirement relates to restoration of a license or obtaining a limited driving privileges after a conviction for driving while impaired).[118]

The CDC recommends mandating ignition interlocks for all DWI offenders, including first-time offenders, as a highly effective strategy to prevent repeat DWI-related offenses.

At least 32 states now require ignition interlocks for all DWI offenders, but North Carolina is not one of them.

The CDC recommends ignition interlocks as highly effective strategy to prevent repeat driving while impaired (DWI) offenses while installed and recommends that interlocks be mandated for all DWI offenders, including first-time offenders. At least 32 states now require ignition interlocks for all offenders, but North Carolina is not one of them. The North Carolina Executive Committee for Highway Safety, chaired by the Secretary of Transportation, approved a resolution to support legislation in North Carolina that mandates ignition interlocks for all alcohol-impaired driving offenders.[119]

While installed, ignition interlocks reduce repeat offenses for driving while intoxicated by about 70%.[120] One study found that state laws that mandate ignition interlocks for all drunk driving offenders were associated with a 7% decrease in the number of alcohol-involved (BAC 0.08) fatal crashes, whereas laws that apply to only a subset of DWI offenders were associated with about a 2% reduction in alcohol-involved fatal crashes.[121]

With North Carolina's current ignition interlock program, as with programs in most states, costs associated with the devices themselves are borne by the offender. For offenders who cannot afford the fees associated with an interlock sanction, a growing number of states have developed special indigent offender funds to help offset the costs, with sources for those funds coming from fees imposed on all DWI offenders, fees added to license reinstatement, or a charge added by vendors to their paying customer's fees.[122] (Neither the Child Fatality Task Force nor the Unintentional Death Prevention Committee of the Task Force has made any specific recommendation related to addressing costs of interlock devices.)

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[117] National Highway Traffic Safety Administration (February, 1995). Repeat DWI Offenders in the United States.
[118] N.C.G.S. 20-17.8 and 20-179.3.
[119] This resolution is available on the NC DOT website: **https://connect.ncdot.gov/groups/echs/Documents/2019/Ignition%20Interlock%20Resolution.pdf**.
[120] Centers for Disease Control and Injury Prevention. Motor Vehicle Safety. *Increasing Alcohol Ignition Interlock Use.* **https://www.cdc.gov/motorvehiclesafety/impaired_driving/ignition_interlock_states.html**.
[121] McGinty et al, (April 1, 2017). Ignition Interlock Laws: Effects on Fatal Motor Vehicle Crashes, 1982 – 2013. *American Journal of Preventive Medicine*, Volume 52, Issue 4.
[122] U.S. Department of Transportation, National Highway Traffic Safety Administration (February, 2014). *Ignition Interlocks – What You Need To Know: A Toolkit for Policymakers, Highway Safety Professionals, and Advocates.* **https://www.nhtsa.gov/sites/nhtsa.dot.gov/files/documents/ignitioninterlocks_811883_0.pdf**. North Carolina has an indigency application that may be filled out to determine eligibility for waiving installation on additional vehicles, see **https://www.ncdot.gov/dmv/license-id/license-suspension/Pages/ignition-interlock-devices.aspx**

2. [PENDING]: *Administrative* support to continue efforts to gather information on the potential for future legislation that allows for primary enforcement of all unrestrained back seat passengers with the intent to bring this item back for consideration by the Unintentional Death Prevention Committee prior to the 2021 legislative long session. (This was a legislative support item in 2019.)

This item was a legislative support recommendation made by the Child Fatality Task Force from 2016–2019. While the Unintentional Death Prevention Committee of the Task Force considers this prevention strategy to still be important, the committee recommended for purposes of the 2020 CFTF Action Agenda for this item to be administrative with continued gathering of information on this issue with the intent to bring this item back for consideration by the Committee prior to the 2021 legislative long session. For that reason, general information on this topic is provided below while more detailed information related to the recommendation made in prior years can be found in the CFTF 2019 Annual Report.[123]

North Carolina law currently requires passengers in all positions of a vehicle to be restrained; however, failure to wear a seatbelt in the back seat by those 16 and up cannot be justification for a traffic stop, so it is a "secondary enforcement" (as opposed to primary enforcement) offense.[124] According to the National Highway Traffic Safety Administration (NHTSA), primary enforcement seat belt laws lead to higher usage rates, and seat belt use is the most effective way to prevent fatalities and injuries in the event of a motor vehicle crash. Data clearly illustrates the dangers of passengers being unrestrained in the back seat, not only causing injury to the person who is unrestrained but to other passengers as well. NHTSA has formally urged North Carolina to close this gap in its passenger safety law.[125] In addition, the North Carolina Executive Committee for Highway Safety, chaired by the NC Secretary of Transportation and comprised of leading highway safety experts and stakeholders, approved a resolution in 2018 in support of this recommendation.

3. [PENDING]: *Administrative* support for a child passenger safety study by outside group to examine the status of North Carolina child passenger safety laws in comparison to recommendations from the American Academy of Pediatrics and the National Highway Safety Board. The study will be performed by experts including the University of North Carolina Highway Safety Research Center, the Governor's Highway Safety Program, the North Carolina Pediatric Society the Office of the Chief Medical Examiner, and the North Carolina Division of Public Health, bringing information learned back to the Task Force.

A preliminary examination of best practice recommendations for child passenger safety laws indicates that there are some areas of North Carolina law that do not align with certain best practice recommendations. Further examination is needed to do a more thorough analysis of the difference between North Carolina law and best practice recommendations, the effectiveness of the best practice recommendations, and the possible impacts of changes in North Carolina laws.

[123] The CFTF 2019 Annual Report is available on the CFTF website.

[124] See N.C.G.S. 20-135.2A(d1) & (e); restraint of children under age 16 is according to G.S. 20-137.1.

[125] Occupant protection assessments for NC are conducted by the National Highway Traffic Safety Administration (NHTSA),and have resulted in the recommendation for primary enforcement of a mandatory seat belt law for all seating positions. In December, 2015, the National Transportation Safety Board sent a letter to former Governor McCrory urging enactment of legislation to accomplish this recommendation.

Recommendations to prevent harm to infants and youth caused by tobacco and nicotine use

1. PENDING: Endorse additional Quitline NC funding of $3 million.

Quitline NC provides free assistance to help people quit tobacco through an evidence-based telephone tobacco treatment program; an interactive web-based tobacco treatment program (which can be combined with telephone coaching or stand-alone) and texting; coaching calls with highly trained and skilled multilingual coaches; and starter kits of nicotine patches for Medicaid and Medicare recipients and eight weeks of combination therapy (patches plus gum/lozenges) for uninsured residents. Studies show that coaching, when combined with FDA-approved tobacco treatment medications, such as nicotine replacement therapy, triples a tobacco user's chances of quitting successfully over quitting without assistance.[126]

Tobacco use during pregnancy is directly associated with the top causes of infant mortality in North Carolina.

Helping people quit tobacco is important for the health of infants and youth. Tobacco use during pregnancy is directly associated with the top causes of infant mortality in North Carolina.[127] More than one in 12 babies in North Carolina are born to mothers who report smoking during pregnancy; in some counties, over 30% of babies are born to women who smoke.[128] Maternal smoking is also causally associated with ectopic pregnancy and orofacial clefts.[129] As more youth become addicted to nicotine through use of electronic cigarettes (see data in the next recommendation), the need to provide services to help them quit increases.

Not only is quitting important for health reasons, but it also has an economically positive impact. For every dollar spent in FY2011, QuitlineNC provided $2.55 return on investment; however, this was based on coaching services alone, without tobacco treatment medication.[130] This return on investment increases with adequate funds to treat all tobacco users with at least four coaching calls and 8-12 weeks of nicotine patches and gum. Providing NRT and QuitlineNC services increased the State Health Plan's (SHP) return on investment. For every dollar spent, SHP was provided $3.95 return on investment.

[126] Zbikowski SM, et.al. "North Carolina Tobacco Use Quitline Final Comprehensive Evaluation Reports." Free & Clear, Inc. & Alere Wellbeing Inc. 2006-2016; Fiore MC, Bailey WC, Cohen SJ, et. al. Treating Tobacco Use and Dependence: A Clinical Practice Guideline. US Department of Health and Human Services. Public Health Service, 2008.

[127] University of North Carolina Center for Maternal and Infant Health, You Quit Two Quit, 2018.

[128] North Carolina Selected Vital Statistics Vol. 1 2016, NC State Center for Health Statistics.

[129] U.S. Department of Health and Human Services. The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.

[130] Tobacco Prevention and Control Branch and Health and Wellness Trust Fund QuitlineNC Financial Reports. FY11.

2. PENDING: Endorse at least $7 million in funding for youth nicotine use prevention, including e-cigarettes.

Ninety percent of tobacco users start before the age of 18. Latest available data is that three in every 10 high school students and one of every 10 middle school students use some type of tobacco product.[131]

Between 2011 and 2017, current use of electronic cigarettes among North Carolina high school students jumped by 894%, from 1.7% to 16.9%. During the same time period, electronic cigarette use among middle school students increased 430%, from 1% to 5.3%.[132] E-cigarettes contain liquids with nicotine that can be bought in thousands of flavors. Nicotine is highly addictive and can harm adolescent brain development; tobacco product use in any form, including e-cigarettes, is unsafe for youth.[133] Devices such as the very popular JUUL e-cigarette, that looks like a flash drive and delivers a high dose of nicotine, have a sleek design attractive to teens who use them for discreet vaping anywhere, including in school.

The U.S. Surgeon General, working with the Centers for Disease Control and the Food and Drug Administration, issued an advisory on youth use of e-cigarettes on December 18, 2018. This advisory called e-cigarette use among youth an epidemic based on the 2018 National Youth Tobacco Survey showing that e-cigarette use among high school students increased from 11.7% in 2017 to 20.8% in 2018. Additionally,the 2018 Monitoring the Future national high school study release showed the spike in e-cigarette use among youth in 2018 is the largest increase in youth drug use in 43 years — since 1975.

In 2019, a new concern emerged when there was a national outbreak of e-cigarette or vaping product use-associated lung injury (referred to as EVALI). As of February 18, 2020, a total of 2,807 hospitalized EVALI cases or deaths were reported to the CDC. Among those hospitalized EVALI cases or deaths, 15% of the patients were under 18 years old.[134] The CDC determined that vitamin E acetate is strongly linked to the EVALI outbreak, and cases have been declining since September 2019.

The funding being recommended by the Task Force (which would be directed to DHHS, DPH Tobacco Prevention and Control Branch) would support educational programs across North Carolina to reach young people with effective tobacco use prevention messages and programs, leadership training for peer-led and adult-supported tobacco use prevention programs, as well as educational materials and evaluation of data. The North Carolina Institute of Medicine's Healthy North Carolina 2030 report has targets to reduce youth tobacco use in North Carolina by 2030 through CDC's levers for change.[135]

[131] NC Youth Tobacco Survey, 2015.

[132] N.C. Youth Tobacco Survey 2011-2017, N.C. Division of Public Health.

[133] U.S. Centers for Disease Control and Prevention.

[134] Centers for Disease Control and Prevention. Outbreak of Lung Injury Associated with the Use of E-Cigarette, or Vaping, Products. **https://www.cdc.gov/tobacco/basic_information/e-cigarettes/severe-lung-disease.html**.

[135] Healthy North Carolina 2030, North Carolina Institute of Medicine (February 18, 2020). See page 68. **http://nciom.org/healthy-north-carolina-2030-a-path-toward-health/**.

Administrative efforts to strengthen child abuse and neglect reporting education and awareness

In 2018 and in 2019, the State Child Fatality Prevention Team recommended that the Child Fatality Task Force examine the issue of Child Abuse and Neglect Reporting (CAN reporting). Experts presenting to the Task Force provided information on the law addressing CAN reporting, the current system of reporting, data on reports made, and the current situation related to CAN reporting education and awareness. The 2019 CFTF Action Agenda included an administrative item to gather additional information and further study this issue, and the Intentional Death Prevention revisited this topic during the 2019–2020 study cycle.

In North Carolina, the law in the Juvenile Code addressing CAN reporting states "any person or institution who has cause to suspect that any juvenile is abused, neglected, or dependent, as defined by G.S. 7B-101, or has died as the result of maltreatment, shall report the case of that juvenile to the director of the department of social services in the county where the juvenile resides or is found."[136] Therefore, all adults in North Carolina are mandatory reporters, which differs from some other states with laws that list only certain types of professionals as mandatory reporters.

[Note: the topic focused on here is the reporting law in the North Carolina Juvenile Code under G.S. 7B-301 and the related response system; however, there are other laws in North Carolina that require reports related to children to be made to different agencies, including a new law passed in 2019 that requires adults to report certain crimes against children to law enforcement (S.L. 2019-245).]

The system of reporting in North Carolina requires that CAN reports be made to the county department of social services (DSS). There is no means of making a report at the state level; there is no state level "hotline" for reporting. When they receive reports, counties use a structured intake process from the DHHS Division of Social Services as a tool to determine the appropriate response by DSS according to law and policy.

At the outset of examining the topic of CAN reporting during its recent study cycle, the Intentional Death Prevention Committee's work was framed by noting some especially relevant excerpts from the report of the 2016 National Commission to Eliminate Child Abuse and Neglect Fatalities.

[136] N.C.G.S. 7B-301. There is also a new law passed in 2019 that requires adults to report certain crimes against children to law enforcement (S.L. 2019-245).

From the Report of the 2016 National Commission to Eliminate Child Abuse & Neglect Fatalities:[137]

A prior report to CPS, regardless of its disposition, was the single strongest predictor of a child's potential risk for injury death (intentional or unintentional) before age 5.

2.5X Given the same risk factors, a child reported to CPS had about a two-and-a-half times greater risk of any injury death.

5.8X Children with a prior CPS report had an almost six (5.8 times greater risk of death from intentional injuries.

5X A child with a prior report of physical abuse had a risk of intentional injury death that was five times greater than a child reported for neglect.

▲ Children reported for neglect had a significantly higher risk of unintentional injury death.

3.5X Risk of sleep-related death was about three-and-a-half times greater when there had been a previous report of child abuse or neglect.[138]

*"The Commission's best estimate is that as many as **half of fatality victims' families have had prior CPS agency contact. In many cases, victims of fatal maltreatment are not known to CPS because of their very young age** (most frequently, under a few months of age) … Infants and young children often are not visible outside the home, as families with young children tend to be socially isolated."*

***"Nonetheless, review of most fatality cases reveals that the children and families were known to someone who was in a position to help.** Most often, this includes—at a minimum—medical personnel at the hospital where the mother gave birth. Other common touch points include interactions with other medical providers, domestic violence advocates, mental health and substance abuse treatment providers, and/or neighbors who noticed the parent was having a challenging time."* [139]

The Intentional Death Prevention Committee examined and discussed the challenges of the current system; what can be learned from other research, evaluations, and recommendations related to CAN reporting; and what can be learned from other states. They discussed potential actions to address CAN reporting challenges in North Carolina, considering such actions in the current context of what may be feasible now compared to what may be feasible in the future.

Challenges with the current Child Abuse and Neglect Reporting System discussed by the committee include the following:

There are 100 different county department of social services (DSS) numbers to call to report CAN in North Carollina instead of just one number.

[137] Commission to Eliminate Child Abuse and Neglect Fatalities, Final Report (2016). Within Our Reach: A National Strategy to Eliminate Child Abuse and Neglect Fatalities. https://www.acf.hhs.gov/cb/resource/cecanf-final-report

[138] Findings from a population-level study based on multiple sources of data from California on risk factors for fatal child maltreatment.

[139] Commission to Eliminate Child Abuse and Neglect Fatalities, Final Report (2016). *Within Our Reach: A National Strategy to Eliminate Child Abuse and Neglect Fatalities.* https://www.acf.hhs.gov/sites/default/files/cb/cecanf_final_report.pdf.

There are limitations with policies and resources. While the Division of Social Services has provided model policies for counties to respond to reports, there can be limitations to a county's ability to respond to reports and implement policies effectively. These limitations could result in a reporter's experience being difficult, frustrating, or delayed — all of which could discourage reporting or make reporting less likely. Examples of limitations include:

- Reporting by means other than phone is not optimized in some counties.
- Technology problems can arise with phone systems relied upon for receiving and routing calls appropriately.
- A system for receiving reports relies on well-trained staff to consistently handle intake of reports, so challenges with training or staff shortages can impact a county's ability to handle reports.
- A county's only option for a backup system when their reporting phone line cannot be used for any reason is the 911 emergency number.

There needs to be easy-to-find, comprehensive information – Information about CAN awareness and reporting via state-level North Carolina organizations needs to be strengthened to be easier to find, comprehensive, and user-friendly. Information about reporting too often lacks an emphasis on the fact that reporting may lead to a family getting needed help (the incorrect assumption is that the response is always punitive) and lacks an explanation about what happens after a report is made (to both the reporter and the family).

Professionals lack training – Many professionals who are most likely to encounter CAN situations lack training related to CAN recognizing and reporting (e.g., law enforcement and other first responders, school personnel, health care professionals, etc.).

There are challenges with the necessary and statutorily required exchange of information between DSS and law enforcement. This process is handled different ways in different counties with varying degrees of ease and efficiency.

State level responsibility is unclear – It is unclear where exactly state-level responsibility for ensuring strong education and awareness focused on CAN reporting in North Carolina resides.

Data collection challenges – Besides reports of child maltreatment made to DSS pursuant to the Juvenile Code, there are other types of agencies that may be involved in reports of child maltreatment, including local law enforcement agencies across the state (for reports that don't involve parents, guardians, custodians, or caretakers and also pursuant to a new 2019 law for reports about certain crimes committed against juveniles), and the DHHS Division of Child Development and Early Education (for reports in child care settings). Circumstances of the report determine which agencies investigate a report, and agencies are required to notify one another in certain circumstances. Because there is no single collection point for all reports involving child maltreatment, it is challenging to understand the scope of reports across DSS, law enforcement and DCDEE.

Screening inconsistency – While DSS provides to counties policies and screening tools for performing intake of reports, such policies and tools may be applied inconsistently not only among counties but also within a county. This particular challenge was emphasized in findings from a recent report on Child Protective Services Screening by the Program Evaluation Division of the North Carolina General Assembly, and this report made several recommendations to

address this problem.[140] Among other problems, screening inconsistency can discourage or frustrate professionals who are most likely to encounter CAN situations and the need to make a report.

The Intentional Death Prevention Committee considered and discussed a variety of actions to strengthen CAN reporting in North Carolina. An important feature of this discussion was the feasibility of potential actions. For example, developing and implementing a statewide hotline that would provide intake of all CAN reports would address certain challenges, but it would not be feasible at this time because intake would require electronic access to child welfare case information in all counties, and the technology does not currently exist to support this. Although technology that would enable electronic access to information was being developed through an NC FAST child welfare project, a 2019 law put this project on hold and called for a study, and it is unknown at this time when the state will have the electronic technology necessary for a hotline. [141]

A recurring theme in these committee discussions related to feasibility was that North Carolina's child welfare system is currently under a tremendous amount of strain and undergoing major changes. The 2017 "Rylan's Law" set into motion a number of systemic changes and many county departments of social services are simultaneously facing workforce challenges. Given these major challenges already taking place in child welfare, some potential actions for strengthening the CAN reporting system may not be feasible at this time or may not be actions that can or should be prioritized right now among the many actions taking place in the context of child welfare reform. As the committee determined actions to approve for 2020, the committee noted that while some potential actions may not be feasible at this time, it would be important for the committee to revisit this topic and potential actions in the future.

The Intentional Death Prevention Committee recommended the following administrative items for the 2020 Action Agenda aimed at addressing some of the challenges noted above to strengthen child abuse and neglect reporting. At the time of the writing of this report, some progress has already been made on all three of these administrative items, and progress details will be shared with the Intentional Death Prevention Committee when it reconvenes.

1. [PENDING]: *Administrative* support for the North Carolina Division of Social Services in the development of more robust and user-friendly web pages dedicated to education and information on child abuse and neglect reporting which includes information on prevention resources and services, what happens to the family and reporter once a report is made, and resources for learning more such as a link to video training. DSS should also ensure that NC Cares 360 includes information on CAN reporting, and web techniques should be used to make it more likely that relevant web searches will show NC DSS webpages focused on abuse and neglect reporting as a primary source of information in North Carolina.

2. [PENDING]: *Administrative* support for work being done by Prevent Child Abuse NC through its contract with NC Division of Social Services to develop training and collateral materials addressing child abuse and neglect reporting to support broad education of professionals and the public.

3. [PENDING]: Administrative support for contacting the Justice Academy about including training on child abuse and neglect reporting for training of law enforcement officers.

[140] Program Evaluation Division, North Carolina General Assembly (November 2019). Child Protective Services Intake Screening Lacks Consistency. Report No. 2019-10. **https://www.ncleg.gov/PED/Reports/documents/CPS/CPS_Report.pdf**.

[141] Session Law 2019-240 postponed deployment of the NC FAST child welfare data system.

Legislative
History and Accomplishments

Every year since its creation in 1991, the North Carolina Child Fatality Task Force has helped achieve legislative victories for children. The following list is organized by year and includes most — but not all — of the legislative accomplishments of the Child Fatality Task Force.

1991

North Carolina Child Fatality Task Force established. The Task Force, a diverse legislative study commission, was charged to study the incidence and causes of child death as well as to make recommendations for changes to legislation, rules, or policies that would promote the safety and well-being of children. The Task Force was also charged to develop a system for multi-disciplinary review of child deaths.

Community Child Protection Teams (CCPTs) established. CCPTs were established in each county by Executive Order. Each CCPT has the responsibility to review selected active Child Protection Services cases of the county Department of Social Services and review all cases in the county in which a child died as a result of suspected abuse and neglect. The purpose of these reviews is to identify gaps and deficiencies in the community child protection system and safeguard the surviving siblings.

North Carolina Child Fatality Review Team (State Team) established. The State Team, a multi-agency panel, was directed to review all cases of fatal child abuse, all deaths of children known to Child Protective Services before their deaths, and additional cases of child maltreatment. The purpose of the reviews is to discover the factors contributing to child fatalities in North Carolina. The State Team is required to report to the Task Force and to recommend legislation to prevent child deaths.

1992

North Carolina Child Fatality Task Force membership expanded to include members of the General Assembly. Two Senators and two members of the House of Representatives, as well as one local health director, were appointed.

North Carolina Child Fatality Task Force extended to 1995.

Additional funds appropriated for Child Protective Service Workers. The Task Force requested $5 million, with a plan to request a total of $30 million over several years. The bill also called for a study of the financing of CPS positions in county Departments of Social Services. The General Assembly appropriated $1 million

Pilot programs for Family Preservation Services funded. The General Assembly appropriated $410,000 for the Basic Social Services plan in three to five counties as pilots, and $50,000 to develop and implement model programs of locally based Family Preservation Services.

Study of Child Protective Services funded. The General Assembly appropriated $80,680 to conduct a study to determine a method that would ensure accountability by the county Child Protective Services programs, to ascertain the best management structure for

Child Protective Services, and to determine the need for stronger state supervision of county programs.

"Hot Lines" established. The General Assembly appropriated $62,000 to establish 24-hour Protective Services "hot lines" in each county.

Additional funds for the Child Medical Evaluation Program appropriated. The General Assembly appropriated $935,750 for the Child Medical Evaluation program, $180,000 of which was allocated for a backlog of claims for services and was non-recurring.

Protocols required. The legislation directed the DHHS Division of Social Services to ensure that community interdisciplinary teams develop protocols for use in child abuse and neglect reviews.

1993

Local Child Fatality Prevention Teams (CFPTs) established. Local CFPTs were directed to review all child deaths in each county unless the death was already under review by the local Community Child Protection Team (CCPT). Since each county now had two community-based teams, the local CFPT and CCPT were given the option of joining together or operating independently. The multi-agency membership for the local teams was established by state statute.

Child Fatality Task Force specifically charged to study the incidence and causes of child abuse and neglect.

Additional funds for Child Protective Services Workers appropriated. The General Assembly appropriated $2 million, but maximum caseload standards were not established by statute.

Committee established to develop a payment plan for the evaluation of maltreated children. The resulting committee recommended funding regional maltreatment resource centers.

NCGA Chapter 7A revised. Changes include creating the duty to report and investigate child dependency as well as child abuse and neglect; requiring county Department of Social Services directors, upon receiving a report about a child's death as a result of suspected child maltreatment, to ascertain immediately whether or not there are other children in the home; improving information sharing; and mandating child fatalities from alleged maltreatment be reported to the Division of Social Services Central Registry.

Driving While Impaired (DWI) law amended. The amended statute provides that the presence of a child under 16 years of age in a vehicle driven by a person convicted of a DWI violation shall be considered a grossly aggravating factor in sentencing.

Funding for student services personnel provided. The General Assembly appropriated $10 million for school counselors, to fulfill a provision of the Basic Education Plan.

Comprehensive health screening for kindergarten students mandated. This law requires each child to have a comprehensive health screening evaluation by the time he or she enters kindergarten.

1994

Six additional members of the General Assembly appointed to the Task Force. Three Senators and three members of the House of Representatives were appointed.

North Carolina Child Fatality Task Force extended to 1997.

Family Preservation Program expanded. The General Assembly appropriated $500,000 to expand this program.

Prosecutorial child protection law passed. This law provides for bail and pretrial release conditions determined by the judge in child abuse cases. It also provides for children to be made comfortable in courtrooms during child abuse cases.

Child passenger safety law strengthened. This law requires children under 12 to be safely restrained while riding in a car, whether they sit in the front or the back seat. Infants and toddlers under age four must be secured in child safety seats; older children must use seat belts.

The following laws were passed during the Special Session on Crime called by the governor in 1994:

The Task Force supported several components of the governor's crime package of legislation that applied to juveniles: **Family Resource Centers, Wilderness Camps, the Mentor Training Program for Coaches, and the Governor's One-On-One Program.**

The Task Force worked to amend a bill calling for a comprehensive study of the Division of Youth Services' Juvenile Justice System. The amendment provided for **diagnostic assessments of all youth in state training schools to determine that each youth has been properly placed.**

Community-Based Alternatives program funded. The General Assembly appropriated $5 million for programs that are intended to reduce the number of youths committed to training schools by rehabilitating these troubled youths in their communities.

The Task Force also worked to increase **the penalty for illegally selling guns to a minor from a misdemeanor to a felony.** This felony charge for a weapons violation enables law enforcement to aggressively prosecute those who illegally sell firearms to minors.

1995

Training for child sexual investigations initiated. The Task Force requested $125,000 for statewide, multidisciplinary training for child sexual abuse investigations. The training was funded for $38,336 recurring and $5,000 non-recurring funds through the State Bureau of Investigation.

Underage drinkers prohibited from driving. The Task Force endorsed legislation requiring "zero tolerance" for alcohol measured in the blood or breath of drivers 18–20 years old.

Smoke detectors required in all rental property. This law filled in a gap in North Carolina's smoke detector laws by requiring landlords to install operable smoke detectors for every dwelling.

Sale of fireworks to children prohibited. Before 1993, the sale of pyrotechnics was illegal in North Carolina. In 1993, the General Assembly allowed the sale of some pyrotechnics. The Task Force sought to repeal these changes to the pyrotechnics law in 1995. The General Assembly did not repeal the 1993 law, but a bill was passed that restricts the sale of those pyrotechnics to persons over the age of 16.

Adoption proceedings moved from Superior to District Court. The Task Force sponsored this legislation as a first step toward creating a comprehensive family court system in North Carolina.

1996

Child abduction law strengthened. This law applies the penalty for abducting a child from a parent, guardian, or school or abductions from any agency or institution lawfully entitled to the child's custody.

1997

Dependent juvenile definition changed. The old statute defined a juvenile as dependent if his or her parents were unable to provide care "due to physical or mental incapacity." This language did not make provision for other situations, such as one in which one or both parents are incarcerated. This law broadened the definition of dependent juvenile and enabled hundreds more children to receive help from the county Departments of Social Services.

Intensive Home Visiting partially funded. The Task Force had a standing goal of encouraging the state to appropriate $3.2 million for intensive home visiting programs shown to be effective in reducing the incidence of child abuse and neglect, unwanted pregnancy, and juvenile involvement with the courts. In 1997, the General Assembly appropriated $825,000 for home visiting, with an additional $200,000 in 1998.

Graduated Driver's License mandated. This measure gives new teenage drivers more experience — and a greater chance of survival — as the result of a three-step process for obtaining a driver license. This ensures beginning drivers get a full year of supervised practice driving with a parent. It also restricts night-time driving for new licensees during the first six months of unsupervised driving.

1998

Sunset of the Task Force lifted.

Court Improvement Project launched. To reduce the amount of time that children are in foster care, the Task Force supported legislation to change the process for handling abuse and neglect cases. As a result of this legislation, termination of parental rights may now be a motion in the cause, adjudication must take place within 60 days of the filing of the petition, the first hearing must be at 90 days, and the second hearing within six months.

Smoke detector penalty set. This law sets a $250 penalty for landlords who fail to install smoke detectors in rental units and a $100 penalty for tenants who destroy or disable smoke detectors after they have been installed.

1999-2000

Child passenger safety law strengthened. The passage of Senate Bill 1347 will save an estimated five lives and 45 serious injuries among child passengers aged 16 or younger each year. The new law imposes a two-point driver's license penalty on drivers who do not see that young passengers are in age-appropriate safety restraint. The enactment of this law closes one of the last remaining gaps in the state's motor vehicle passenger safety laws.

Juvenile procedures clarified. Passage of House Bill 1609 will help move children from abusive, dangerous environments toward safer, permanent homes. The old law required that parents be given separate notices of the possible termination of their parental rights, even if termination is clearly best for the child. This measure streamlines the legal process while preserving parents' rights to proper notification.

Guardianship strengthened. Sometimes called "soft adoption," guardianship is a good option for some children who need a safe, nurturing home. Passage of Senate Bill 1340 clarifies the rights and duties of a legal guardian and thereby creates a more stable home for children with court-appointed guardians.

2001

Infant Homicide Prevention Act passed. House Bill 275 created a safe haven for newborns who would otherwise be abandoned by their distraught mothers.

Child Bicycle Safety Act passed. House Bill 63 established that bicycle riders age 15 and younger must wear an approved helmet when riding on public roads and rights-of-way.

Child Fatality Task Force 10-Year Anniversary celebrated. In the 10 years of the Task Force's existence, the child death rate in North Carolina dropped approximately 20%. At 76.4 deaths per 100,000 children, North Carolina experienced the lowest child fatality rate it had ever recorded.

2002

"Kids First" license tags issued. The General Assembly and the Division of Motor Vehicles authorized and issued "Kids First" license tags with the proceeds going the North Carolina Children's Trust Fund.

Key programs continued. During a time of intensive budget cuts, the Intensive Home Visiting program, the Healthy Start Foundation, the folic acid campaign, and the birth defects monitoring program all received continued funding.

Graduated Driver Licensing system improved. A provision was added to the existing system which limits the number of passengers under age 21 that a novice driver may transport during the first six months of unsupervised driving (allowing only one young, non-family member).

2003

Safe Surrender supported. Task Force members lent their support to the Division of Public Health who was successfully awarded a grant from the Governor's Crime Commission for FY 2003-04 to increase public awareness of the Infant Homicide Prevention Act (aka NC Safe Surrender Law).

2004

NC Booster Seat Law (Senate Bill 1218) ratified. The law established that a child less than 8 years of age and less than 80 pounds in weight shall be properly secured in a weight-appropriate child passenger restraint system. In vehicles equipped with an active passenger-side front air bag, if the vehicle has a rear seat, a child less than 5 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. If no seating position equipped with a lap and shoulder belt to properly secure the weight-appropriate child passenger restraint system is available, a child less than 8 years of age and between 40 and 80 pounds may be restrained by a properly fitted lap belt only.

Endorsed. The Task Force endorsed strengthening penalties when methamphetamine is manufactured in a location that endangers children.

2005

All-Terrain Vehicle Safety Law (Senate Bill 189) ratified. The law established that a child less than 8 years of age is not allowed to operate an ATV. In addition the law creates restrictions based on age and machine size for children between the ages of 8 and 16. The law also requires adult supervision for children under 16, restricts passengers to those ATVs designed for more than one person, bans operation on public streets, roads and highways, and outlines equipment standards for sellers and buyers. In addition, safety training is now required for operators, as is the use of safety equipment.

2006

Unlawful Use of a Mobile Phone Law (Senate Bill 1289) ratified. The law established that children under the age of 18 cannot operate a motor vehicle while using a mobile phone or any technology associated with mobile phones. Exceptions were created for teens talking with their parents, spouses, or emergency personnel.

Rear Passenger Safety Law (Senate Bill 774) ratified. The law requires use of rear-seat safety belts by all passengers of non-commercial vehicles.

Strengthen Sex-Offender Registry Law (House Bill 1896) ratified. The law strengthened North Carolina's existing sex offender registry system by requiring additional standards for monitoring sex offenders, including extensive monitoring of the most predatory offenders upon their release from prison.

Funds to Prevent Child Maltreatment (Senate Bill 1249) appropriated. $90,000 in recurring funds was allocated to the NC Department of Health and Human Services for one position to staff the Child Maltreatment Leadership Team and carry forth recommendations of the North Carolina Institute of Medicine's Task Force on Child Abuse Prevention.

General Statute 7B-302 DSS Disclosure of Confidential Information (Senate Bill 1216) amended. The amendment clarified the ability of county Departments of Social Services to share confidential information with other professional entities. The amendment also put North Carolina in compliance with federal child welfare funding guidelines and allowed for continued federal support.

Funds to Prevent Preterm Births (Senate Bill 1741) appropriated. $150,000 in non-recurring funds was allocated to provide medications to low-income women at-risk of a second premature birth. The medication is proven to reduce recurring preterm births by 33%.

Funds to establish a Perinatal Health Network (Senate Bill 1253) appropriated. $75,000 in non-recurring funds was allocated for the creation of a professional perinatal health network. The network will bring together perinatal health leaders to plan strategically for the reduction of infant mortality and promotion of women's and infants' health in North Carolina.

Endorsed. The Task Force endorsed: 1) continuing the Medicaid Family Planning Waiver; 2) recurring funding of the North Carolina Folic Acid Campaign at $300,000; 3) recurring funding for the North Carolina Healthy Start Foundation for statewide infant mortality reduction initiatives and conversion of non-recurring funding to recurring funding status; 4) recurring funding for the North Carolina Birth Defects Monitoring Program at $325,000.

Administrative changes recommended. 1) support the DHHS Division of Public Health efforts to procure grant funds for youth suicide prevention; 2) form a CFTF subcommittee to work on gun safety, specifically pursuing a gun safety awareness campaign, creating talking points on gun safety, and seeking common ground to prevent injury and death to children and youth due to firearms.

2007

Child Passenger Safety Exemption (Senate Bill 23) ratified. Amended § 20-317.1. (Child restraint systems required), by removing exemption (b)ii "when the child's personal needs are being attended to" in order to qualify North Carolina for the continuation of $1 million in child passenger safety funding from the National Highway Traffic Safety Administration.

Funds to address infant deaths secured. Appropriations recommended by the Child Fatality Task Force were secured and included $97,000 in non-recurring funds to prevent preterm births by providing the medication known as 17-Progesterone to uninsured women and $150,000 in non-recurring funds for a statewide Safe Sleep awareness campaign.

Endorsed. The Task Force endorsed: 1) $200,000 in recurring funds were provided for the birth defects monitoring system; 2) $150,000 in non-recurring funds were provided for the North Carolina Healthy Start Foundation; 3) the Fire Safe Cigarette Act (House Bill 1785) passed and requires cigarette manufactures to produce and market only cigarettes that adhere to an established cigarette fire safety performance standard.

Legislative charge received. Senate Bill 812 directed the Child Fatality Task Force to study issues relating to requiring the installation and use of passenger safety restraint systems on school buses and report findings by May 2008.

2008

Amend Child Abuse (Senate Bill 1860) ratified. An act to increase the criminal penalty for misdemeanor child abuse and to amend the criminal offense of felony child abuse.

Hospital Report Child Injuries (House Bill 2338) ratified. An act to require hospitals and physicians to report serious, non-accidental trauma injuries in children to law enforcement officials.

Funds to prevent preterm births provided. $97,000 in non-recurring funds appropriated to continue efforts to provide minority and low-income women at-risk for delivering a premature infant with a preventative treatment to reduce the risk of a recurring preterm birth.

Funds to reduce infant deaths secured. $150,000 in non-recurring funds appropriated to continue funding for a statewide public awareness campaign to promote safe sleep and reduce infant deaths due to Sudden Infant Death Syndrome (SIDS) and unintentional suffocation/strangulation.

Child Passenger Safety Technician Liability (House Bill 2341) ratified. An act to limit liability for the acts of certified child passenger safety technicians and sponsoring organizations of child safety seat educational and checking programs when technicians and sponsoring organizations are acting in good faith and child safety seat inspections, installation, adjustment or education programs are provided without fee or charge.

Require Carbon Monoxide Detectors (Senate Bill 1924) ratified. An act to authorize the North Carolina Building Code Council to adopt provisions in the Building Code pertaining to the installation of carbon monoxide detectors in certain single-family or multifamily dwellings; to require the installation of operational carbon monoxide detectors in certain residential rental properties and to provide for mutual obligations between landlords and tenants regarding the installation and upkeep of carbon monoxide detectors.

Transporting Children in Open Bed of Vehicle (House Bill 2340) ratified. An act to increase the protection of children who ride in the back of pickup trucks or open beds of vehicles by raising the minimum age to 16 and removing the exemption that made allowances for small counties.

Change Format of Driver Licenses/Under 21 (House Bill 2487) ratified. An act to change the format of a driver license or special identification card being issued to a person less than 21 years of age from a horizontal format to a vertical format to make recognition of underage persons easier for clerks dealing in restricted age sales of products such as alcoholic beverages and tobacco products.

2009

Funding to prevent preterm births provided. $97,000 in non-recurring funds appropriated to continue efforts to provide minority and low-income women at-risk for delivering a premature infant with a preventative treatment to reduce the risk of a recurring preterm birth.

Funding to reduce infant deaths provided. $150,000 in non-recurring funds appropriated to continue funding for a statewide public awareness campaign to promote safe sleep and reduce infant deaths due to Sudden Infant Death Syndrome (SIDS) and unintentional suffocation/strangulation.

The Division of Medical Assistance directed to explore interconceptional care. This direction allows DMA to pursue a federal waiver or other mechanism to offer a basic

package of interconceptional care services to low-income women at high-risk for delivering prematurely.

Funding continued for Child Medical Evaluation System. This system provides diagnostic services to children suspected of being victims of child maltreatment.

Interagency agreements established to better protect children from violent sex offenders. The federal Adam Walsh Child Protection and Safety Act requires a more comprehensive, nationalized system for registration of sex offenders. To meet this goal, interagency collaboration has been established between the State Bureau of Investigation, the Sheriff's Association, the Division of Social Services and others.

An Act to Prohibit the Retail Sale and Distribution of Novelty Lighters (Senate Bill 652) ratified. This act to protect children by banning the sale of novelty lighters.

The Nicholas Adkins School Bus Safety Act (House Bill 440) ratified. This measure assures that pictures taken of drivers committing a stop arm violation are acceptable evidence for conviction and makes it a felony if a student is killed due
to an illegal pass of a stopped school bus.

Youth employment protections passed. Enhance Youth Employment Protection Act (H22) enhances reporting and surveillance requirements by the Department of Labor. Strengthen Child Labor Violation Penalties (H23) increases penalties to employers who violate child labor requirements.

2010

Funding to preserve infant mortality prevention infrastructure maintained. Due to on-going state budget constraints, the Task Force focused on maintaining a package of services that works together to help babies be born healthy and to make it to their first birthday. Elements of the package include the following: $350,000 for the NC Folic Acid/Preconception Health Campaign to decrease neural tube defects and improve birth outcomes; $325,000 for the Eastern Carolina University High-Risk Maternity Clinic to improve birth outcomes in Eastern North Carolina; $150,000 for Safe Sleep to avoid SIDS and other sleep-related deaths; $97,000 for 17-Progesterone distribution to help prevent pre-term births; $408,000 for the Healthy Start Foundation to improve maternal health prior to and during pregnancy.

Increase Driver's License Restoration Fee (S655) ratified. This act increases the fee that drivers who have their licenses suspended following conviction for impaired driving must pay to have their licenses later restored. All funds raised (an estimated $560,000 each year) will go to Forensics Tests for Alcohol to continue programs to deter, detect, and convict impaired drivers.

2011

Funding to preserve infant mortality prevention infrastructure maintained. Due to on-going state budget constraints, the CFTF focused on maintaining a package of services that works together to help babies be born healthy and to make it to their first birthday. Elements of the package include the following: $350,000 for the NC Preconception Health Campaign to decrease neural tube defects and improve birth outcomes; $150,000 for Safe Sleep to avoid SIDS and other sleep-related deaths; $47,000 for 17-Progesterone distribution to help prevent pre-term births. These items were funded nonrecurring out of the Maternal and Child Health Block Grant.

Fine for speeding in a school zone increased to $250 (S49) Speeding just an extra 10 mph in a school zone greatly increases the chance of death for a student hit by a car. The chance of pedestrian death increases nine-fold (from 5% to 45%) with an increase in speed from 20 mph

to 30 mph. This bill makes the fine for speeding in a school zone equal to that of speeding in a construction zone.

Sale of certain dangerous synthetic substances banned (S7) This act bans substances previously available legally — including a synthetic cannabinoid that produces a marijuana-like high and MDPV, a synthetic that produces a cocaine-like high and hallucinations. The ban went into effect June 1, 2011. Throughout the early implementation period, the CFTF has worked with law enforcement and others to monitor the effectiveness of the ban.

Penalty for driving impaired with a child in the car enhanced (S241). Motor vehicle crashes are the leading injury-related cause of death for children and impaired driving is a factor in 15% -20% of those deaths. National data show that most children who die in crashes where alcohol is involved are the passenger of the impaired driver. Additionally, impaired drivers are also less likely to buckle-up their children safely.

Concussion protocols established (The Gfeller-Waller Athletic Concussion Awareness Act -H792). This act requires that coaches, other school personnel, and parents of middle and high school athletes receive information about concussions and prohibits same-day return-to-play. Only once cleared for play by specified health providers may athletes later return to practice or play.

Changes to the graduated driver licenses system monitored. Since North Carolina adopted graduated driver licensing, crashes are down 38% for 16-year-olds and 20% for 17-year-olds, among the best results of any state. Time spent driving and gaining experience is critical for teens learning to drive more safely. Changes from Modify Graduated Licensing Requirements (S636) include requiring learning drivers keep a log of time and conditions driven. Additionally, a provisional license will be revoked if the licensee is charged with a variety of serious driving violations, such as excessive speeding. The Division of Motor Vehicles is charged with evaluating the effectiveness of the provisions.

Endorsed. The Perinatal Quality Collaborative of NC received $250,000 in funding (from the Maternal and Child Health Block Grant).

2012

Funding to preserve infant mortality prevention infrastructure partially maintained. Due to on-going state budget constraints, the CFTF focused on maintaining a package of services that works together to help babies be born healthy and to make it to their first birthday. Elements of the package include the following: $350,000 for the NC Preconception Health Campaign to decrease neural tube defects and improve birth outcomes; $375,000 to the East Carolina University High-Risk Maternity Clinic; and $47,000 for17-Progesterone distribution to help prevent pre-term births. These items were funded nonrecurring out of the Maternal and Child Health Block Grant. However, funding for Safe Sleep and the NC Healthy Start Foundation were eliminated.

Replacement of conventional smoke alarms with tamper-resistant lithium-battery alarms in rental units (S77). Over the past five years, 75 children and hundreds of adults have died due to fire. Fire and flame is the fourth leading cause of death of North Carolina children ages 5 to 9. Furthermore, national data reveal that two-thirds of fire deaths occur in homes without an operating smoke alarm, often because the battery has been removed or is not working. The new science of tamper-resistant lithium battery alarms can help solve this problem since alarms with these batteries work for ten years and the batteries cannot be removed for other uses. This measure requires landlords to phase-in tamper-resistant lithium battery units as conventional battery units are scheduled for replacement.

Funding to preserve evidence-based treatment programs for children maintained. Due to on-going state budget constraints, the CFTF focused on maintaining a package of services that works together to help screen and treat at-risk children: Funding was maintained at flat levels, often with federal funds, for the Child Medical Evaluation Program, Child Advocacy Centers, the Child Treatment Program, and suicide gatekeeper programs.

Endorsed. The Perinatal Quality Collaborative of NC received $250,000 in funding (from the Maternal and Child Health Block Grant). A bill (H176) passed addressing concerns on tracking of domestic violence cases to make more clear when "assault on a female" (or other crimes) occur between intimate partners or strangers. In addition to improving data and understanding of ways to address problems, this may help workers within the Division of Social Services have more complete information on when domestic violence is a factor in the home. Smoking cessation and prevention was funded at $2.7 million from the Social Services Block Grant.

2013

Revise Controlled Substance Reporting (S222). Poisoning is the fastest growing cause of teen death. The bill made changes to the Controlled Substance Reporting System (CSRS) to deter pill mills, to make it easier for doctors to check to see previous prescription-fill history to avoid duplicate prescriptions and to offer treatment as needed, to provide more timely data, and to allow data tracking relating to atypical prescribing or filling, as well as other provisions.

Require Pulse Oximetry Screening (S98). Pulse oximetry is a quick and inexpensive test that screens newborns for certain congenital heart disease. If the baby is sent home before this condition is detected, the baby may get very sick and need to be rushed to the hospital for emergency surgery. Pulse oximetry screening allows timely, non-emergency intervention that can save lives.

Health Curriculum/Preterm Birth (S132). Prematurity is one of the leading causes of infant deaths. This bill incorporates into the Healthy Behaviors Curriculum information about the preventable risks of preterm birth including induced abortion, smoking, alcohol consumption, the use of illicit drugs, and inadequate prenatal care.

Funding to preserve infant mortality prevention infrastructure partially maintained. Due to on-going state budget constraints, the CFTF focused on maintaining a package of services that work together to help babies be born healthy and to make it to their first birthdays. Elements of the package include the following: the NC Preconception Health Campaign to decrease neural tube defects and improve birth outcomes; East Carolina University High-Risk Maternity Clinic to treat high-risk pregnancies in the eastern part of the state;17-Progesterone distribution to help prevent pre-term births; NC Healthy Start Foundation to provide community-based organization with evidence-based strategies and communications to improve the health of women of reproductive age and their babies; the Perinatal Quality Collaborative to promote best practices with hospitals; the Safe Sleep Campaign to promote safe sleep including in hospitals; and You Quit Two Quit to provide training assistance to help medical practices implement evidence-based protocols to reduce smoking by pregnant women. ECU was funded recurring with state funds. Other funded items were funded nonrecurring out of the Maternal and Child Health Block Grant. However, no funding was provided for the Healthy Start Foundation or You Quit Two Quit tobacco cessation for women.

Funding for Child Treatment Program. The Child Treatment Program (CTP) is an evidence-based treatment for children who have experienced trauma. The CFTF supported funding of $2 million for an implementation platform to assure the treatment was used statewide with fidelity. Funding was included in the budget.

Funding for services to stabilize families and prevent children from being removed from their homes. Changes in federal funding resulted in loss of $12 million to the Division of Social Services for services to help keep children at-risk of abuse or neglect safe in their own homes. Funding of $4.8 million was provided.

Endorsed. Funding for Child Advocacy Centers and the Child Medical Evaluation Program; measures to make it easier for doctors to prescribe and third parties to use a medication (naloxone) to reverse drug overdoses (S20).

2014

Funding to preserve infant mortality prevention infrastructure partially maintained. The CFTF continued to focus on maintaining a package of services that work together to help babies be born healthy and to make it to their first birthdays. Elements of the package include the following: the NC Preconception Health Campaign to decrease neural tube defects and improve birth outcomes; East Carolina University High-Risk Maternity Clinic to treat high-risk pregnancies in the eastern part of the state;17-Progesterone distribution to help prevent pre-term births, NC Healthy Start Foundation to provide community-based organization with evidence-based strategies and communications to improve the health of women of reproductive age and their babies, the Perinatal Quality Collaborative to promote best practices with hospitals, the Safe Sleep Campaign to promote safe sleep including in hospitals, and You Quit Two Quit to provide training assistance to help medical practices implement evidence-based protocols to reduce smoking by pregnant women. ECU was funded recurring with state funds. Other funded items were funded nonrecurring out of the Maternal and Child Health Block Grant. However, no funding was provided for the Healthy Start Foundation or You Quit Two Quit tobacco cessation for women. A special budget provision allows programs that provide tobacco cessation services for pregnant women and new mothers to apply for a certain competitive grant process.

Funding for services to stabilize families and prevent children from being removed from their homes. Changes in federal funding resulted in a loss of $12 million to the Division of Social Services for services to help keep children at-risk of abuse or neglect safe in their own homes. Funding of at least $9 million was provided.

Coverage of lactation support through the Division of Medical Assistance: Given the strong cost savings and lifesaving benefits of breastfeeding, DMA was authorized to reimburse costs associated with lactation consultants. (Initially, legislation was sought, but it was later determined to be unnecessary.) This is estimated to save 14 to 18 infant lives per year.

Endorsed. Funding for Child Advocacy Centers and the Child Medical Evaluation Program; authorization of the NC Department of Environment and Natural Resources (now known as the NC Department of Environmental Quality) to participate in the Interstate Chemicals Clearinghouse for the purposes of access to key data necessary to enhance safety in use of toxic chemicals.

2015

A new law protecting children from nicotine poisoning: North Carolina became one of the first states to prohibit the sale of e-cigarette liquid containers without child-resistant packaging and without labeling those that contain nicotine. This protects small children who may access liquid nicotine (often sold in candy or fruit flavors) resulting in exposure that may cause injury or death. Calls to Carolinas Poison Centers related to liquid nicotine have risen dramatically in recent years, going from 8 calls in 2011 to 137 calls in 2014.

A new law protecting children from skin cancer: The "Jim Fulghum Teen Skin Cancer Prevention Act" prohibits tanning bed operators from allowing persons under age 18 to use their tanning equipment. With melanoma rates in North Carolina higher than the national average and studies showing the majority of melanoma cases in young adults are connected to indoor tanning bed use, the purpose of this measure is to reduce the incidence of skin cancer.

Measures to address prescription drug misuse and poisoning: Approximately one in five high school seniors in North Carolina reports having taken prescription drugs without a prescription. Medications are among the most common type of exposure prompting calls to Carolinas Poison Control Center regarding children and adolescents. The CFTF recommended funding for safe drug disposal (Operation Medicine Drop) to decrease access to drugs that can result in misuse or poisoning, and this item was funded as non-recurring. The CFTF endorsed the reinstatement of funding for Carolina's Poison Control Center, which was funded as recurring, and also endorsed measures to strengthen the Controlled Substances Reporting System, resulting in a number of improvements to the system.

Endorsed: Funding to preserve infant mortality prevention infrastructure: The CFTF focused on maintaining a package of services that works together to help babies be born healthy and make it to their first birthday, including funding for the following: East Carolina University High-Risk Maternity Clinic to treat high-risk pregnancies in the eastern part of the state; 17-Progesterone distribution to help prevent pre-term births; the Perinatal Quality Collaborative (PQCNC) to promote best practices with hospitals; the Safe Sleep Campaign to promote safe sleep; and the NC March of Dimes Preconception Health Campaign to decrease birth defects and improve birth outcomes. ECU and PQCNC were funded with state funds. Other items were funded out of the Maternal and Child Health Block Grant.

Endorsed: Funding to support accredited Child Advocacy Centers in North Carolina who provide services for abused children by bringing together local child protective services, law enforcement, prosecutors, and medical and mental health providers. The CACs were funded with nonrecurring state funding and maintained block grant funding.

2016

Funding for perinatal tobacco cessation and prevention: Tobacco use during pregnancy is directly associated with the top four causes of infant mortality in North Carolina. The goal of You Quit Two Quit Program, which received $250,000 in nonrecurring funds, is to ensure there is a comprehensive system in place for high quality screening and treatment for tobacco use in women, including pregnant and postpartum mothers.

Funding for safe drug disposal: Operation Medicine Drop, which received $120,000 in nonrecurring funds, is a nationally recognized North Carolina program that uses drug take-

back events and permanent medicine drop boxes to collect 15 to 20 million doses of unused medications each year. Safe disposal of medications is one tool to addresses a current epidemic of prescription drug misuse and drug overdose by reducing access to drugs, particularly by small children and teens who often obtain drugs from friends and family.

A new law prohibiting unlawful transfer of custody of a child: This legislation is aimed at preventing child maltreatment, including situations where a parent or guardian feels unable or unwilling to care for his or her child and locates a stranger, for example over the internet, who takes physical custody of the child. Such unlawful transfers can result in children ending up in abusive or neglectful homes or in human trafficking rings. [Session Law 2016-115]

Change in CSRS law to facilitate research and education: The Controlled Substances Reporting System (CSRS) is an important tool in North Carolina's battle to understand and react to the current opioid overdose epidemic. Prior to this technical change, the law required CSRS data purging at six years, preventing epidemiologists and researchers from doing effective longitudinal evaluation and analysis of the CSRS system and trends. This change to the law requires quarterly purging of data more than six years old, but instead of permanently discarding the data, it will now be maintained in a separate database so it can be used for statistical, research, or educational purposes.

Endorsed: Funding to support Children's Advocacy Centers in North Carolina. Children's Advocacy Centers provide services for abused children by bringing together local child protective services, law enforcement, prosecutors, and medical and mental health providers. The CAC model is an evidence-based national model with multiple proven benefits for children.

Monitored and maintained: Funds provided to the following perinatal health programs previously supported by the Child Fatality Task Force remained unchanged in the 2016 budget: Perinatal Quality Collaborative NC; East Carolina University High Risk Maternity Clinic; March of Dimes Preconception Health Campaign; 17-Progesterone; Safe Sleep Campaign.

2017

Recurring funding for perinatal tobacco cessation and prevention: Tobacco use during pregnancy is directly associated with the top four causes of infant mortality in North Carolina. The 2017 legislative budget contained $500,000 in recurring funds for both the You Quit Two Quit Program and Quitline NC, both of which can help prevent tobacco use during pregnancy.

Recurring funding to the Child Medical Evaluation Program: A Child Medical Evaluation (CME) is a specific evaluation performed by a qualified medical expert for neglect, physical abuse, or sexual abuse when it is suspected that a child is being abused or neglected by their parent. Evaluations are requested and findings are used by local departments of social services and medical professionals to determine a course of medical treatment for the child. An increase in recurring funds ($723,000 per year) was needed in order to bring the reimbursement rate for CMEs in North Carolina to the regional average rate of $575. Prior to this increase, CMEs in North Carolina had been reimbursed a flat fee payment of $250 for suspected sexual abuse and $150 for other types of suspected maltreatment, putting North Carolina at risk of losing these specialized professionals for this important work requiring extensive hours and a high degree of expertise.

CFTF was one of many seeking strengthened tools for combating the opioid epidemic: In 2017, a major piece of legislation called the "STOP Act" (Strengthen Opioid Misuse Prevention Act) containing numerous provisions addressing strategies for preventing opioid misuse passed the legislature unanimously (S.L. 2017-74). Many organizations and individuals were involved in advancing the STOP Act and although the CFTF was not primarily responsible, some of the STOP Act provisions aligned with 2017 CFTF Action Agenda recommendations: the STOP Act includes mandatory use of the Controlled Substances Reporting System by the medical profession (the Task Force recommended increased use of CSRS by medical professions); the STOP Act made a technical correction in the law to enable interstate data sharing for the Controlled Substances Reporting System (a recommendation by the CFTF); the STOP Act removed some barriers and provided funding for the Harm Reduction Coalition to continue their important work (the CFTF endorsed the efforts of the Harm Reduction Coalition to continue their work fighting the opioid epidemic).

Endorsed: Legislation authorizing civil penalties for passing a stopped school bus and the utilization of school bus cameras to facilitate automatic civil enforcement. [S.L. 2017-188]

Monitored and maintained: Funds provided to the following perinatal health programs previously supported by the Child Fatality Task Force remained unchanged in the 2017 budget: March of Dimes Preconception Health Campaign, 17-Progesterone, and the Safe Sleep Campaign. The CFTF had been monitoring implementation of the child welfare case management system as part of NC FAST and the 2017 legislative budget contained funding for this purpose.

Child Fatality Prevention System Summit held on April 9 and 10, 2018 in Raleigh. Although not a legislative event, this was a first-of-its-kind historic event during which Child Fatality Prevention System professionals from across the state came together to learn from state and national experts, share best practices and challenges, and take part in launching state and local initiatives focused on strengthening the CFP System and creating safer and healthier communities for North Carolina's children. The idea for the summit originated with the Executive Committee of the Task Force, who received support from the full Task Force for advancing plans for the Summit.

2018

Legislation passed to require a study of maternal and neonatal risk-appropriate care at health care facilities across North Carolina. This legislation requires 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. The study is to identify disparities, service gaps, and other issues, and to make recommendations to ensure quality care in risk-appropriate facilities. This study is aimed at ensuring newborns and their mothers can access timely, comprehensive medical services from a medical facility able to meet their specific medical needs. [Session Law 2018-93]

Legislation passed to add three conditions to the state's newborn screening program: Pompe (Glycogen Storage Disease Type II), MPS-I (Mucopolysaccharidosis Type I), and X-ALD (X-linked Adrenoleukodystrophy). Early detection of these conditions can lead to early treatments that can prevent or improve many of the effects of these conditions, including prevention of early death. This legislation was addressed in the 2018 budget bill, Session Law 2018-5. The March of Dimes was a significant partner in this work.

School safety grant funding that includes CALM (Counseling on Access to Lethal Means) among the programs for which grants may be used. As part of its work on suicide prevention and addressing access to lethal means, the 2018 CFTF Action Agenda included a recommendation to expand the use of the CALM program in North Carolina. This program is designed to train practitioners (medical, mental health) and others to implement strategies to help those who are deemed to be at risk for suicide by enlisting the help of their families and supportive others to reduce their loved ones' access to lethal means, particularly firearms. The 2018 budget bill, Session Law 2018-5, included $3 million of funds directed to the Department of Public Instruction to be used for nonrecurring school safety grants to community partners to provide training to help students develop healthy responses to trauma and stress. CALM was included among several trainings designated in the budget bill as being suitable for these grants.

Some funding to add school nurses: As part of its suicide prevention work, the CFTF had recommended $5 million in recurring funds to expand the state's School Nurse Funding Initiative to add 100 nurses in high-need schools in order to get closer to meeting nationally recommended ratios. The 2018 budget bill, Session Law 2018-15, included $10 million in nonrecurring grants for schools to add school mental health support personnel (defined as nurses, counselors, psychologists, and social workers). (The Program Evaluation Division of the General Assembly released a report in May 2017 stating it would cost between $45 and $75 million annually to meet national recommendations for the numbers of nurses in schools.)

Funding for a birth certificate initiative of the Perinatal Quality Collaborative of NC: The 2018 budget bill included funding to support a project of the Perinatal Quality Collaborative of NC intended to improve the accuracy of birth certificate data.

Endorsed: Some recurring funding for the Quitline and You Quit Two Quit perinatal tobacco cessation programs. The CFTF had endorsed the efforts of others to advance $3 million in additional funding for QuitlineNC, a statewide tobacco cessation program. The 2018 budget contained $250,000 in additional recurring funds for both QuitlineNC and the You Quit Two Quit Program (a perinatal tobacco cessation program supported on previous action agendas by the CFTF).

Endorsed: Some funding to support tobacco prevention for youth. The CFTF had endorsed the efforts of others to advance $7 million in state funding for youth tobacco prevention. The 2018 budget contained an additional $250,000 in nonrecurring funds for youth tobacco prevention programs.

2019

Note about unique 2019 legislative session: A highly unusual outcome of the 2019 legislative session was that the 2019 Appropriations Act, HB 966, never became law. This bill was ratified by the legislature, was vetoed by the governor, then the House voted to override the veto, but the Senate never voted on the veto override. Some of the 2019 recommendations of the Child Fatality Task Force were addressed in HB 966, but they did not fully advance, since HB 966 itself did not fully advance. Some other bills addressing appropriations referred to as "mini budget bills" did pass in 2019.

Partially Advanced: Firearm Safe Storage Initiative. Two 2019 bills addressed the 2019 Task Force's recommendation to launch and fund a firearm safety initiative. Originally introduced in 2019 as House Bill 508, the bill had bipartisan support. The text of this bill was then included in House Bill 966, the

2019 Appropriations Act, which was ratified but never became law. This initiative by DHHS was to educate the public about the importance of the safe storage of firearms, to facilitate the distribution of gun locks, and to provide outreach and technical assistance to help communities launch local safe storage initiatives. On August 12, 2019, Governor Cooper signed a gun safety Executive Directive, and this directive set in motion the development and compilation of firearm safety tools and resources by the Division of Public Health, using elements of the Child Fatality Task Force's firearm safety stakeholder recommendations to inform this work. A webpage on the Division of Public Health website now provides information on firearm safety.

Partially Advanced: Strengthening of the North Carolina Child Fatality Prevention System. Two 2019 bills addressed Task Force's recommendations to strengthen the statewide Child Fatality Prevention System. House Bill 825 addressed these recommendations, then the text of HB 825 was included in the 2019 Appropriations Act, HB 966, which was ratified but did not become law. The recommendations of the Task Force were adopted in the Child Welfare Reform Plan Final Report submitted by the Center for the Support of Families to the State of North Carolina Office of State Budget and Management and Department of Health and Human Services. The Department of Health and Human Services has already undertaken further study and planning related to these recommendations, as the recommendations are also aligned with current NC DHHS priorities and the statewide Early Childhood Action Plan.

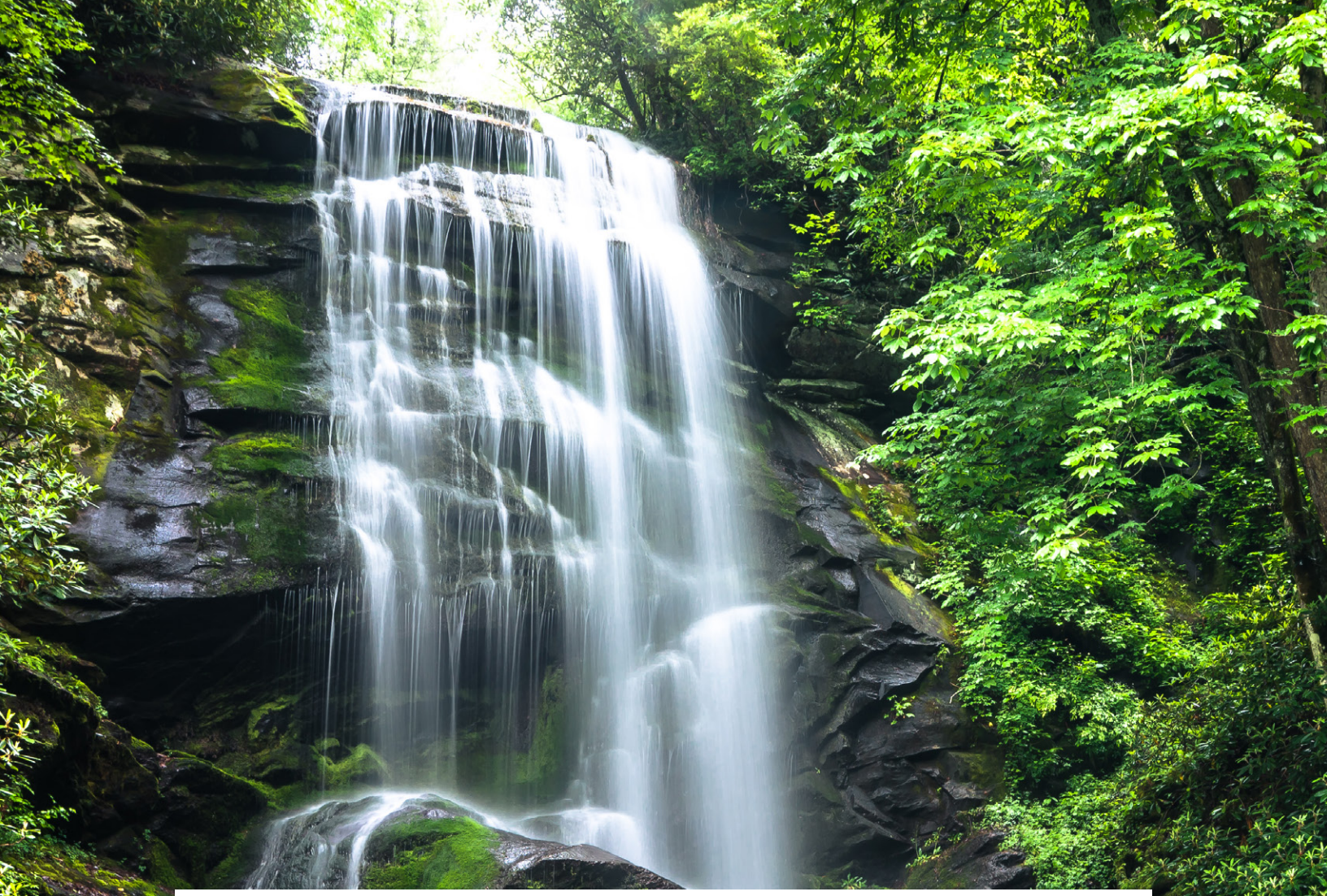
Funding for more school nurses. S.L. 2019-222 includes additional funding in the Department of Public Instruction's instructional support allotment to be used during the fiscal biennium 2019-2021 to improve student mental health by increasing the number of school mental health support personnel (school nurses, counselors, psychologists, and social workers) in each local school administrative unit. The Child Fatality Task Force was one of multiple organizations advancing a recommendation to fund more school nurses.

The CFTF was one of many seeking funding for Raise the Age implementation. In 2017, North Carolina became the last state in the nation to pass a law to raise the age of juvenile court jurisdiction so that 16- and 17-year-olds charged with most crimes and infractions will be dealt with in the Juvenile Court system rather than adult system. Funds were needed to implement "Raise the Age," which went into effect in December 2019, and in the 2019 legislative session, S.L. 2019-229 appropriated funds to add court personnel (clerks, judges, attorneys), additional staff and support for the Division of Juvenile Justice, juvenile court counselors, support for centers serving juveniles, and for other purposes. Many organizations worked to advance this funding.

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. (See further explanation above for this item in 2019.) 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. The report was also presented to the Perinatal Health Committee of the Child Fatality Task Force.

Paid Family Leave Insurance Study: In recent years the Child Fatality Task Force heard from experts about the impacts of paid family leave and paid family leave insurance programs in effect in some other states. Realizing the complexities of a statewide paid family leave insurance program, the Task Force determined in 2017 an in-depth study of this issue would need to take place, but that such a study was beyond the scope of Task Force structure and capacity. A multi-sector group was formed for the purpose of outlining the various issues such a study would need to address in order 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 was published by Duke University in March 2019 and was presented to the full Task Force and the Task Force Perinatal Health Committee during its 2019-2020 study cycle.



NC CFPT

NORTH CAROLINA
Child Fatality
Prevention Team

North Carolina Office of the Chief Medical Examiner

Michelle Aurelius, M.D.

Chief Medical Examiner and Chair, NC CFPT

NC Child Fatality Prevention Team Annual Summary
2018 Child Deaths in NC (ages 0-17 years)

Report prepared by:

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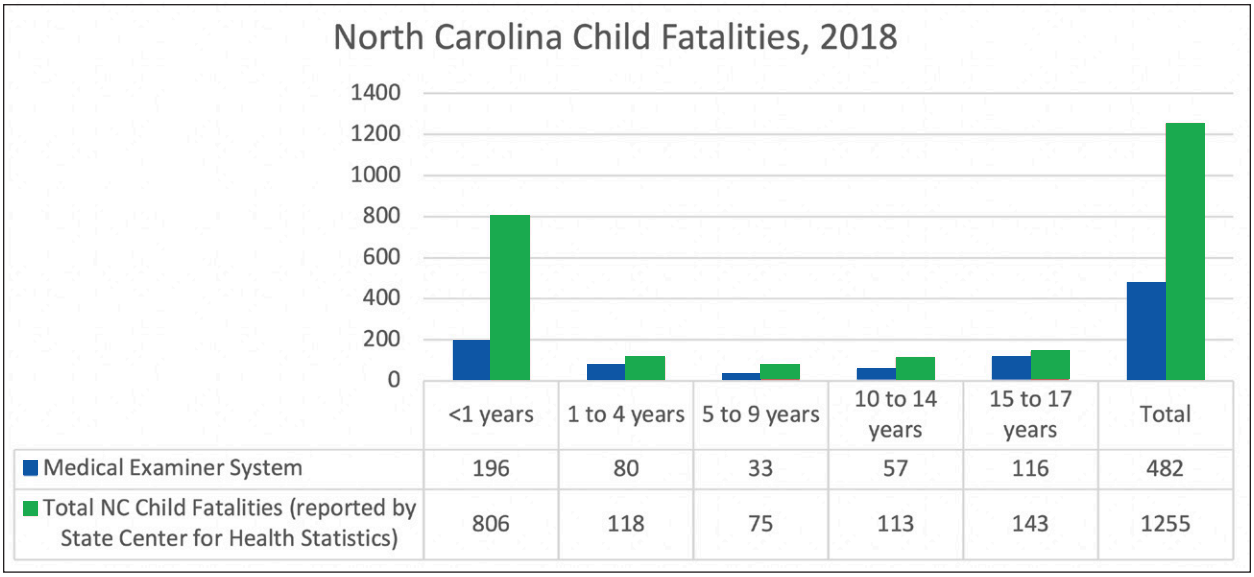
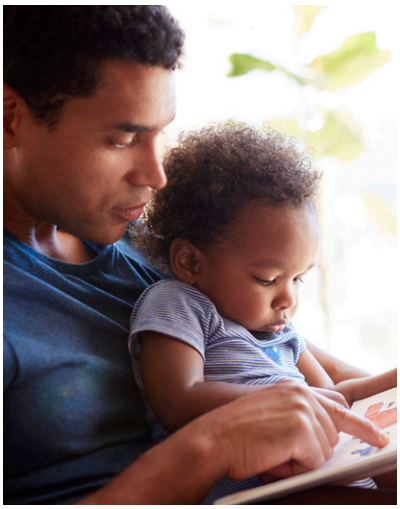
Report from North Carolina
Child Fatality Prevention Team

TOTAL NUMBER OF DEATHS 2018 // NC RESIDENTS UNDER THE AGE OF 18 YEARS

Throughout the 2018 calendar year, the State Center for Health Statistics (SCHS) reported **1,255** children died in North Carolina. Many of these deaths were expected and included children who died from a known natural disease or illness. The North Carolina Medical Examiner system investigated the cause and manner of death for **482** children. The cases investigated by the Medical Examiner system included a number of natural deaths, as well as accident, homicide, suicide, and deaths for which no cause and/or manner of death could be determined.



	<1 years	1 to 4 years	5 to 9 years	10 to 14 years	15 to 17 years	Total
Medical Examiner System	196	80	33	57	116	482
Total NC Child Fatalities (reported by State Center for Health Statistics)	806	118	75	113	143	1255



38% of all child deaths that occurred in North Carolina were reviewed by the CFPT staff at the Office of the Chief Medical Examiner. Represented below are child fatality reviews, excluding cases pending manner and means certification, which totals 477 children. Due to pending cases, numbers are subject to change.

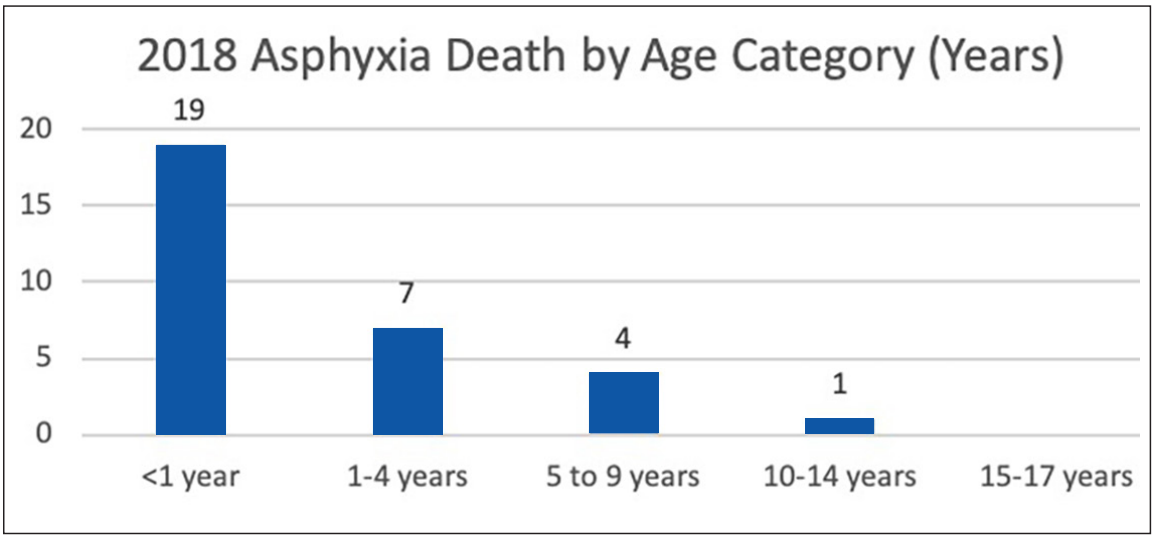
201 OCME CHILD FATALITIES BY MANNER AND MEANS		Number
ACCIDENT (170)	Animals	1
	Asphyxia	31
	Blunt	3
	Drowning	31
	Electrocution	1
	Exposure	1
	Fall	1
	Fire	13
	Gun	4
	Medical Treatment	1
	Machinery	1
	Motor Vehicle	76
	Toxin	6
HOMICIDE (52)	Asphyxia	5
	Blunt	10
	Gun	32
	Motor Vehicle	1
	Other	3
	Unknown	1
NATURAL (70)	Natural	67
	SIDS	3
SUICIDE (52)	Asphyxia	23
	Fall/Jump	1
	Fire	1
	Gun	25
	Motor Vehicle	1
	Toxin	1
UNDETERMINED (126)	Asphyxia	1
	Toxin	1
	Unknown	122
	Other	2
Fetal		7
	Pending	5

ACCIDENTS

Each year, accidental deaths comprise the largest number of non-natural deaths of children in North Carolina. In 2018, there were 170 deaths investigated by the NC Medical Examiner System certified as accident in manner. The CFPT utilizes multiple means based upon circumstances of these deaths.

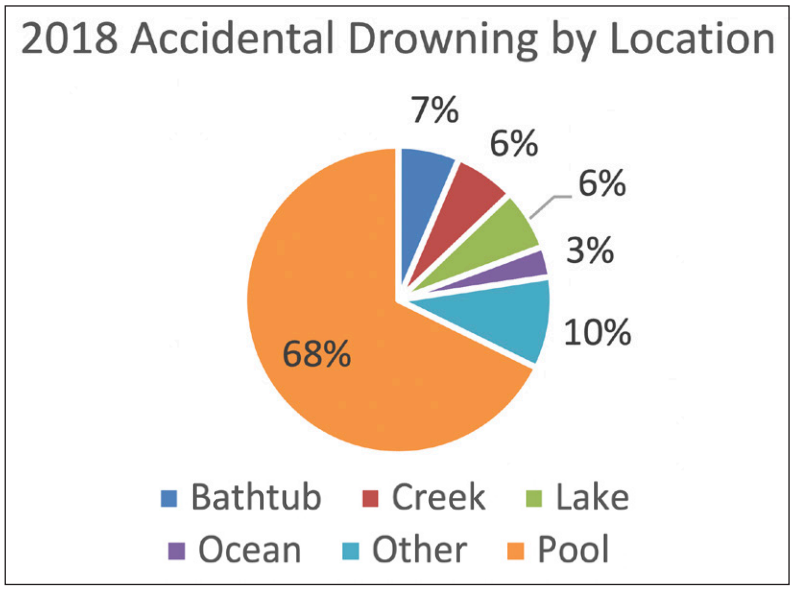
Asphyxia

Accidental asphyxiation caused the deaths of 31 children in 2018. Infants constituted the majority, 19, of deaths with 16 deaths due to accidental asphyxiation in a sleep environment — either during co-sleeping or by being placed in an unsafe sleep environment. Twelve accidental asphyxiation deaths of children between the ages of 1 and 14 years included seven deaths due to choking, three deaths were related to positional asphyxia, one death related to asphyxia due to a cord, and one death to smoke inhalation of a house fire.



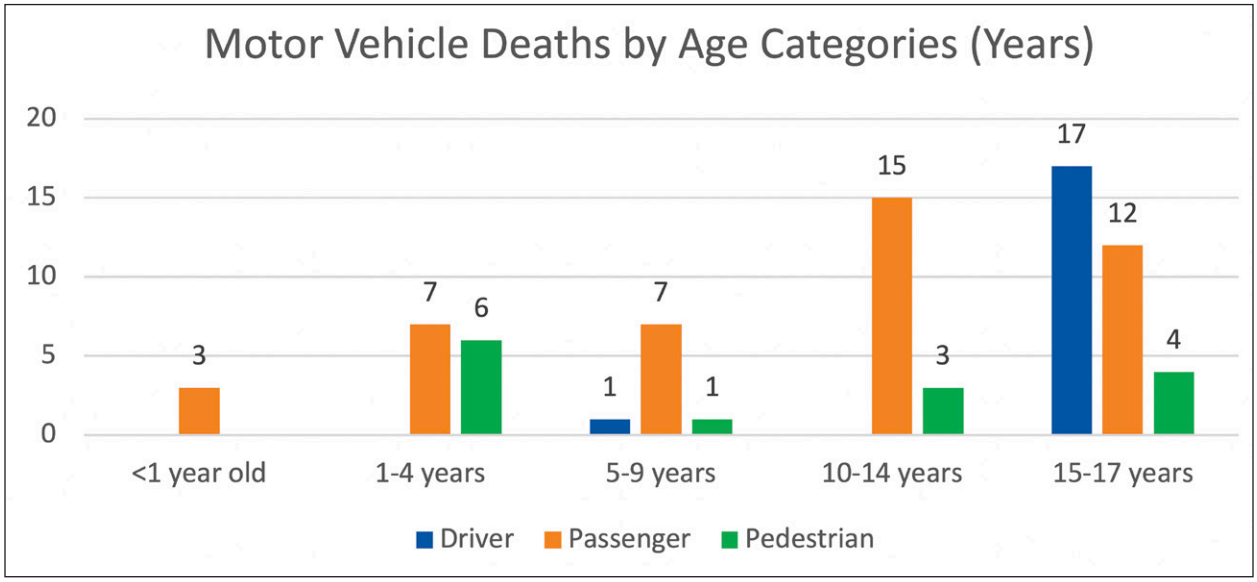
Drowning

Drowning resulted in the deaths of 31 children in 2018. Twenty-one drownings occurred in a pool, two drownings in a bathtub, two drownings in a creek, two drownings in a lake, one drowning in an ocean, and three drownings located in other locations identified as a waterpark structure, toilet, and flooded road. Of the drowning deaths, one child was under 1 year of age, 18 children were ages 1 to 4 years, five children were ages 5 to 9 years, and seven children were between 15 and 17 years old.



Vehicle-Related

In 2018, there were 76 vehicle related deaths. Majority of these deaths, 44, were passengers, while 18 deaths were of drivers, and 14 deaths were of children outside of a vehicles/pedestrian.



Other

Other deaths with an accidental manner included

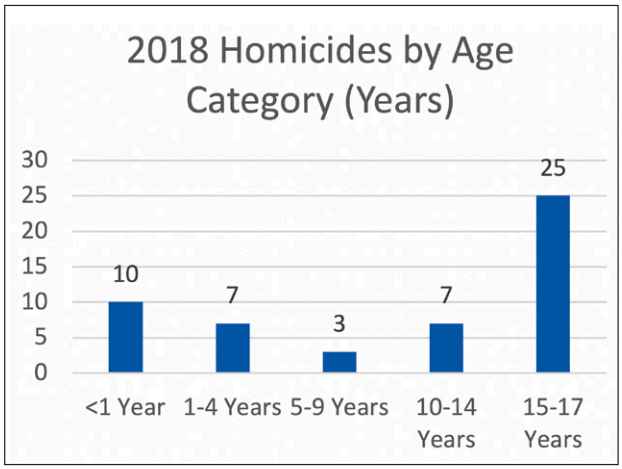
- 13 deaths from fire
- Six deaths from toxic substances (i.e. poisoning)
- Four firearm deaths
- Three blunt related trauma deaths
- One of each following means of death: animal, electrocution, exposure, fall/jump, medical, and machinery

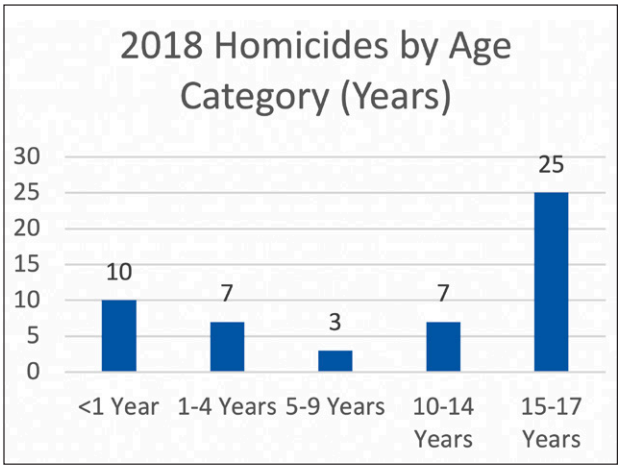
HOMICIDES

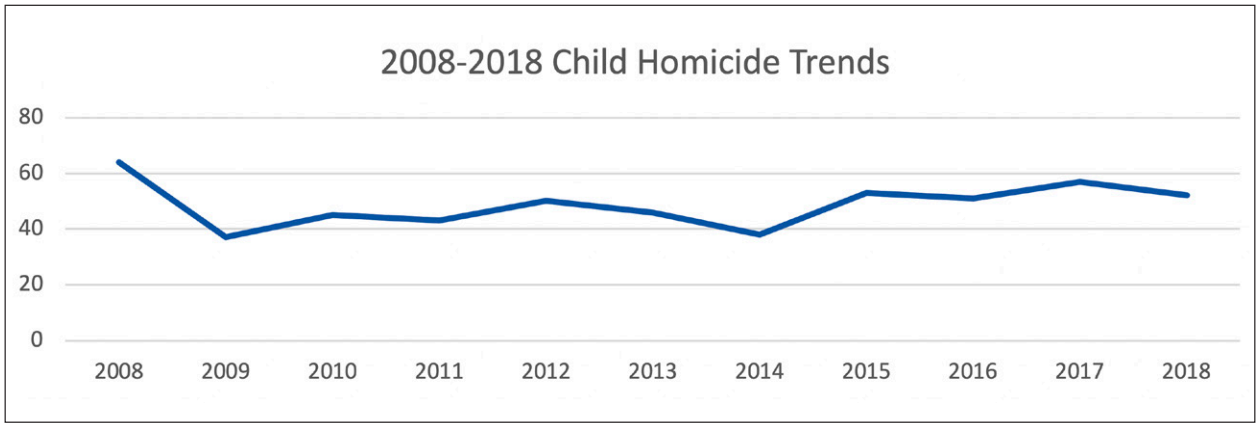
There were 52 children who died at the hands of another in 2018.

Infants, children under 1 year of age, accounted for 10 deaths. Children between the ages of 1 year and 17 years accounted for 17 total deaths.

Regarding means, asphyxia accounted for five deaths, blunt force trauma for 10 deaths, firearms for over half the total child homicides at 32 deaths, three deaths by other means, one death by motor vehicle and one unknown means.



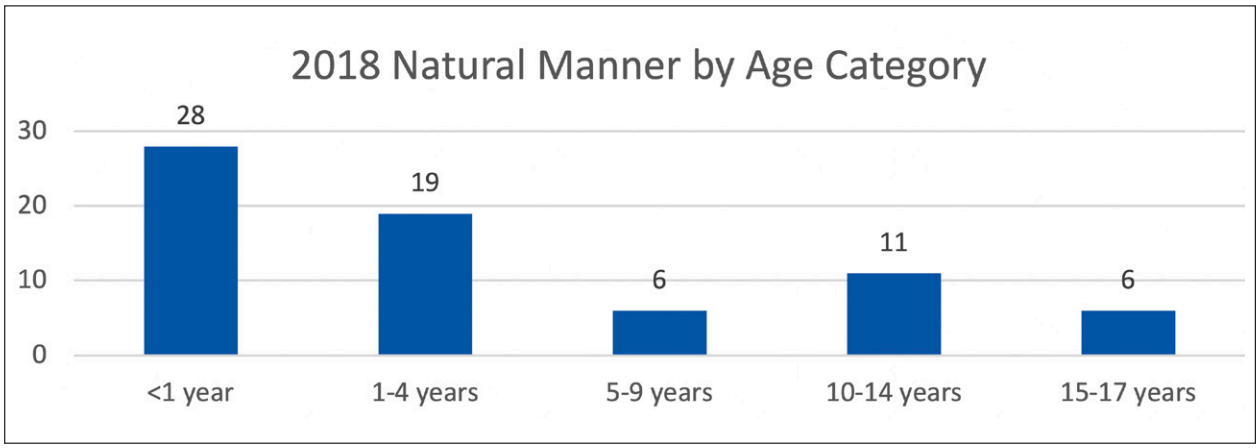


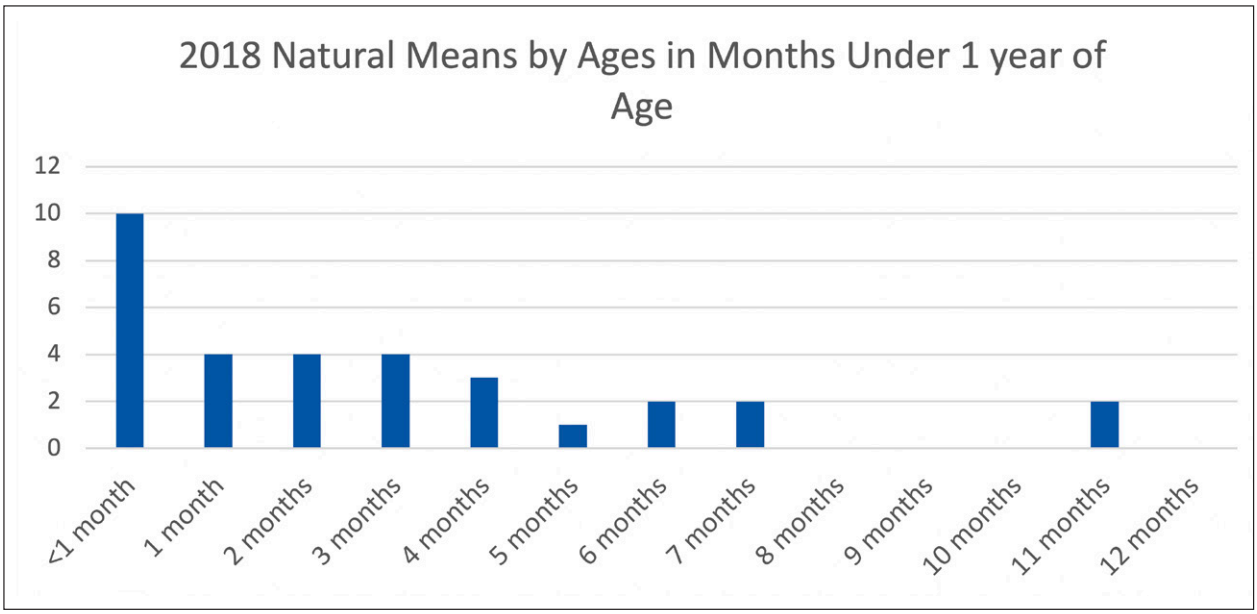


NATURAL

Seventy deaths were determined to be natural in manner. Of these, three deaths were given a classification of Sudden Infant Death Syndrome (SIDS), and 67 were other natural causes.

The top five means with a natural manner of death in 2018 were: complications of pneumonia, congenital heart defect, seizure, complications of prematurity, and underlying neurological disorder.



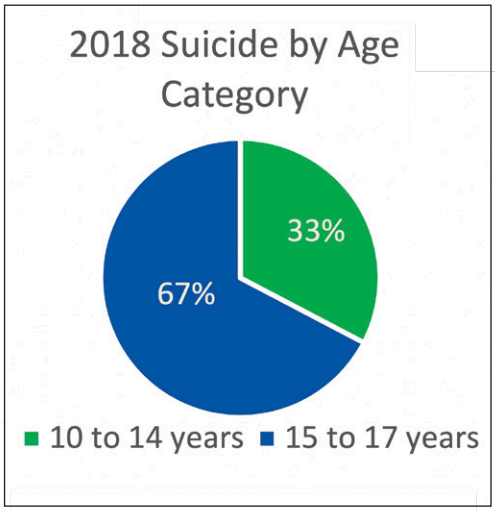


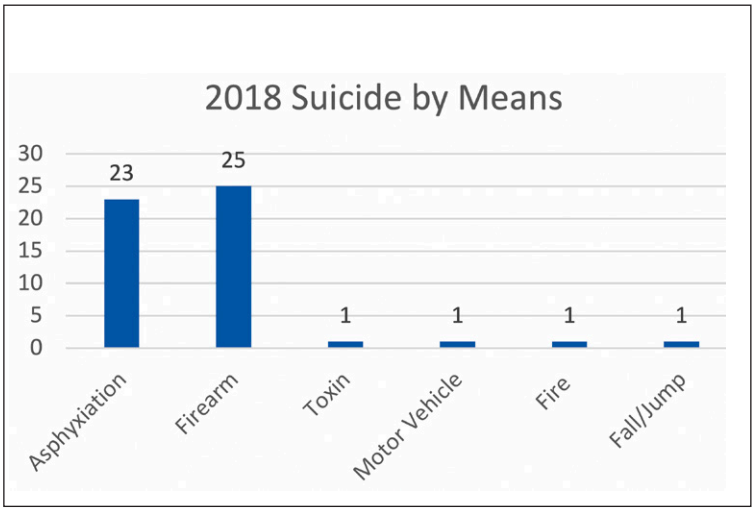
SUICIDE

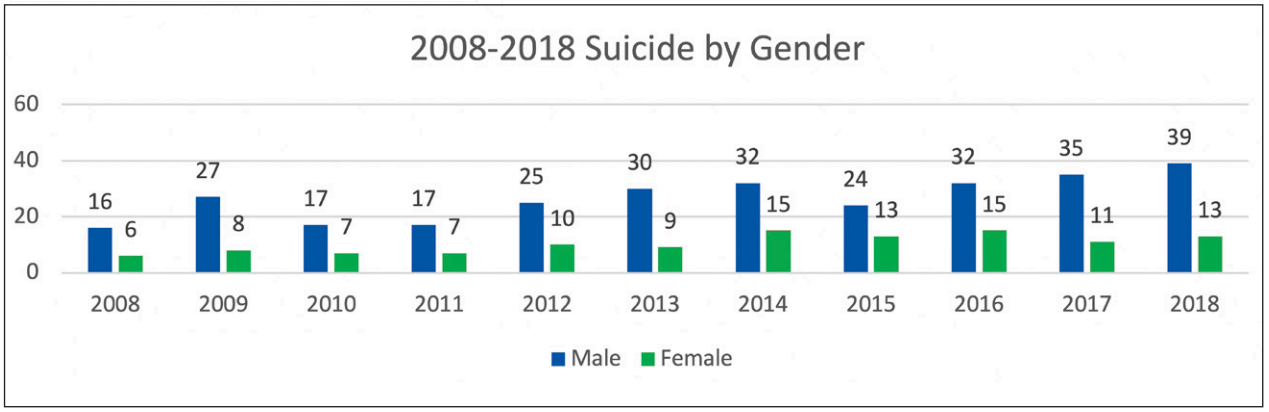
Suicide was the manner of death of 52 children in 2018. Most of the deaths with a suicide manner were of children between the ages of 15 to 17 years, accounting for 35 deaths (67%). Additionally, there were 17 deaths with a suicide manner of children between the ages of 10 to 14 years.

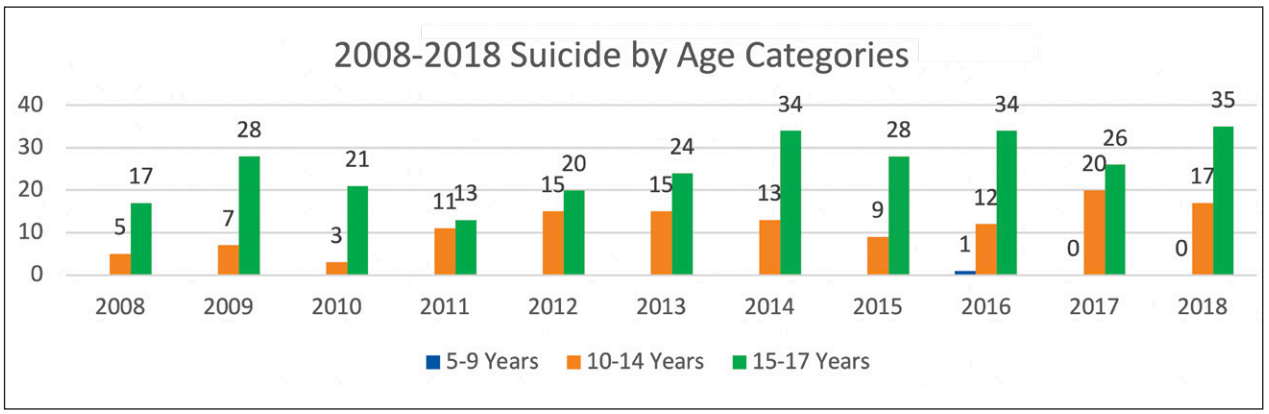
Males accounted for 39 deaths, females for 13 deaths.

The means of death in suicides included 23 deaths from an asphyxia event, 25 deaths from use of a firearm, one death from toxin, one death due to a motor vehicle crash, one death from a fire, and one death due to a fall/jump.







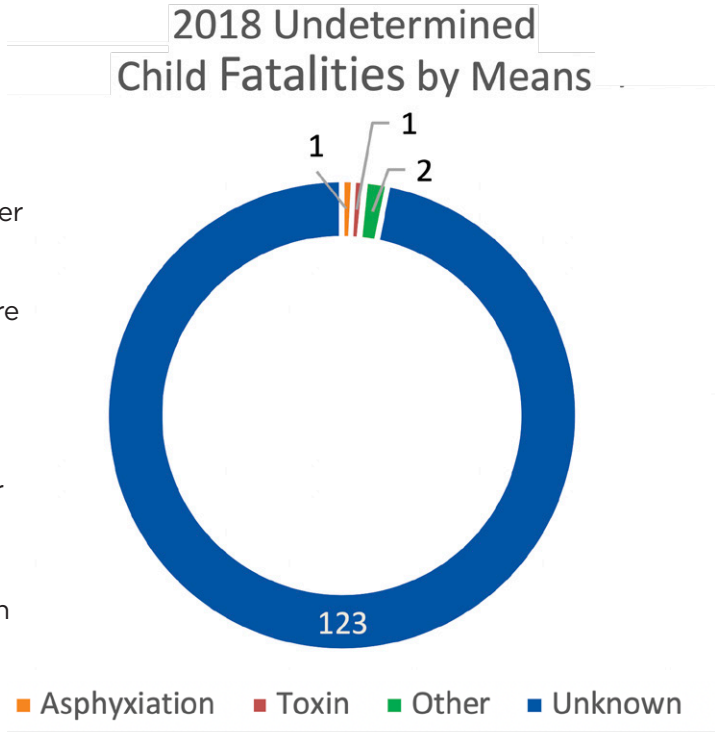


UNDETERMINED

There were 126 deaths that were certified as undetermined manner. Of those, 122 deaths were certified as unknown means, one death was certified as an asphyxiation, one death was related to toxin, and two deaths with other means of death.

Of the undetermined manner, 118 children were under 1 year of age, seven children were ages 1-4 years, and one child was age 15-17 years.

As is the case for most of the infants with an undetermined manner, when a known risky or potential unsafe sleeping situation is noted, the possibility of asphyxiation as a result of suffocation cannot be entirely excluded which leads to the certification of an unknown means of death.



State Child Fatality Prevention Team
2019 Recommendations

In the fall of 2019, the State Child Fatality Prevention Team presented the following recommendations to the NC Child Fatality Task Force:

Student School Support

- Continued efforts for nationally recommended staffing ratios for school mental health professionals.
- Evidence-based training for all school personnel: recognizing the risks of suicide; effective strategies for safety planning; reducing access to lethal means; promoting student resilience for all school personnel.
- Effective strategies for students in recognizing anxiety, depression and suicide risk in self, peers, others and ways to get help.

Infant Safe Sleep Practices

The NC Child Fatality Task Force Perinatal Health Committee should, once again, study expanding efforts of the UNC Center for Maternal and Infant Health Safe Sleep program to promote best practices for infant safe sleep across the state as well as endorse education and awareness of safe sleep practices and the risks of unsafe sleep environments, including accidental asphyxiation.

Child Abuse/Neglect Reporting

The NC Child Fatality Task Force Intentional Death Prevention Committee should focus on abuse and neglect reporting with respect to statewide strategies for education on awareness of the NC mandatory reporting law and the benefit and feasibility of establishing use of a 24/7 statewide 1-800 reporting hotline.

Child Fatality Task Force
Contact Information and Leadership Structure

LEADERSHIP

Executive Director

Kella W. Hatcher
Phone: 919-527-7541
Email: kella.hatcher@dhhs.nc.gov

Chair

Karen McLeod
President/CEO, Benchmarks NC
Phone: 919-828-1864
Email: kmcleod@benchmarksnc.org

COMMITTEES

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

Co-Chairs

Michelle Hughes, Executive Director, NC Child

Jennifer Kristiansen, Director of Social Services, Chatham County

The Perinatal Health Committee focuses on healthy pregnancies, birth outcomes, and infants with a focus on reducing infant mortality.

Co-Chairs

Belinda Pettiford, Branch Head, Women's Health Branch, NC Division of Public Health, NCDHHS

Dr. Sarah Verbiest, Executive Director, UNC-CH Center for Maternal and Infant Health; Director, Jordan Institute for Families

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

Co-Chairs

Alan Dellapenna, Branch Head, Injury and Violence Prevention Branch, NC Division of Public Health, NCDHHS

Martha Sue Hall, Mayor Pro Tempore, City of Albemarle

NC Child Fatality Task Force
Members*

Dr. Michelle Aurelius
NC Chief Medical Examiner

Cindy Bizzell
Administrator,
Guardian Ad Litem Program
Administrative Office of the Courts

Senator Jim Burgin
NC Senate

Brent Culbertson
Assistant Director
State Bureau of Investigation

Senator Don Davis
NC Senate

Arianna Del Palazzo
County Commissioner
Lee County

John Dickerson
Public Member

Dr. Ellen Essick
State Board of Education

Martha Sue Hall
Mayor Pro Tempore
Albemarle City Council

Eric Harbour
Child Mental Health Lead
NC DMH/DD/SAS

John P. Harris
Brevard Chief of Police

Dr. Lynn Harvey
NC Department of Public Instruction

Representative Craig Horn
NC House of Representatives

Michelle Hughes
Executive Director, NC Child

Representative Howard Hunter
NC House of Representatives

Representative Perrin Jones
NC House of Representatives

Senator Todd Johnson
NC Senate

Trishana Jones
Programs Director
NC Coalition Against
Domestic Violence

Dr. Kelly Kimple
Section Chief, Women's & Children's Health, Division of Public Health, NC DHHS

Sarah Kirkman
Conference of District Attorneys

Jennifer Kristiansen
Director of Social Services
Chatham County

Representative Donny Lambeth
NC House of Representatives

Dr. Martin McCaffrey
Perinatal Quality Collaborative of NC

Karen McLeod
CEO, Benchmarks

Senator Jim Perry
NC Senate

Katherine Pope
Public Member

Bruce Robistow
Health Director
Halifax County

Senator Vickie Sawyer
NC Senate

Bradford Sneeden
Legislative Counsel
NC Department of Justice

Pamela T. Thompson
Alamance-Burlington School Board

Dr. Betsey Tilson
State Health Director & Chief Medical Officer, NC DHHS

Dr. Sarah Verbiest
Executive Director,
UNC Center for Maternal and Infant Health; Director, Jordan Institute for Families

Representative Donna White
NC House of Representatives

Mary Williams-Stover
Director Council for Women & Youth Involvement

This list reflects membership as of February 2020 when the 2019-2020 study cycle ended