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

Our **RESPONSIBLITY**

Annual Report of the North Carolina Child Fatality Task Force to the Governor and General Assembly

Raleigh, North Carolina
January 2017

January, 2017

The Honorable Roy Cooper
Governor, State of North Carolina

Distinguished Members of the North Carolina General Assembly

At the end of 2016, past and present members and friends of the Child Fatality Task Force gathered to celebrate twenty-five years of advancing public policy to save children's lives in North Carolina. Work of the Task Force has contributed to a 46% reduction in the state's child death rate since creation of the Task Force and the larger Child Fatality Prevention System in 1991. The dedication and wisdom of those who started the Task Force is reflected in the efforts of the many hard-working experts and officials who served on the 2016 Task Force and contributed to the recommendations presented in this report.

The Task Force provides a unique forum that brings together agency officials, lawmakers, experts in child health and safety, and community volunteers to perform the important work of understanding what causes child fatalities and determining what we can do to prevent them. These recommendations are the product of thirteen meetings and more than fifty presentations by experts; they grew from thoughtful discussion, keen analysis, and contributions from many diverse perspectives to determine areas of focus for action in 2017.

This report includes recommendations addressing a wide range of issues including suicide prevention, motor vehicle safety, infant mortality, firearm safety, child maltreatment, the opioid epidemic, and more. Our 2017 agenda is admittedly bold, but we believe that North Carolina's children deserve nothing less.

The responsiveness of law makers and state leaders to Task Force recommendations throughout these past twenty-five years has been a critical element of Task Force success. Now, the health and safety of our state's children depends on all of us to work together to put these 2017 recommendations into action. Together, we can continue to save lives and build a better North Carolina future.

Kella Hatcher	Karen McLeod	Buck Wilson
Executive Director	Co-Chair	Co-Chair

Table of Contents

NC Child Fatality Task Force
Study Process

The Child Fatality Task Force taps a broad range of expertise and resources to formulate its recommendations. Three committees meet to study data, hear from experts, and prepare recommendations for consideration by the full Task Force.

During its most recent study cycle, the Task Force had a total of thirteen meetings, including nine committee meetings and four full Task Force meetings where attendees heard more than fifty presentations. Experts and leaders presenting to the Task Force and its committees represented state and local agencies, academic institutions, as well as state and community programs such as:

- State Center for Health Statistics, NC DHHS
- Office of the Chief Medical Examiner, NC DHHS
- Injury and Violence Prevention Branch of the Division of Public Health, NC DHHS
- Women's Health Branch of the Division of Public Health, NC DHHS
- Drug Control Unit, Division of Mental Health, Developmental Disabilities, Substance Abuse Services, NC DHHS
- Office of the State Fire Marshal, NC Department of Insurance
- School Health Unit, Children & Youth Branch of the Division of Public Health, NC DHHS
- The State Child Fatality Prevention Team
- Governor's Highway Safety Program
- NC Department of Public Instruction
- State Bureau of Investigation
- University of North Carolina Center for Maternal & Infant Health
- University of North Carolina School of Medicine
- State Laboratory of Public Health, NC DHHS
- National Fire Protection Association
- Tobacco Prevention and Control Branch, Division of Public Health, NC DHHS
- Juvenile Justice Health Services
- Child Medical Evaluation Program
- NC Child
- Cansler Collaborative Resources
- Safe Kids NC
- NC Healthy Start Foundation
- NC Harm Reduction Coalition
- University of North Carolina Highway Safety Research Center
- Wake County Public School System
- Community Care of North Carolina
- March of Dimes, NC Chapter

The study process is also informed by state and local Child Fatality Prevention Teams, who, along with the Task Force, are part of North Carolina's Child Fatality Prevention System. A report from the State Team is included here. The annual study cycle of the Task Force is fueled by more than 1000 hours of volunteer time, a testament to the dedication and expertise of professionals across the state who prioritize the health and well-being of North Carolina's children.

The **Intentional Death Prevention Committee** studies homicide, suicide, and child maltreatment. Due to a 2014 spike in the youth suicide rate in North Carolina, for the second year in a row this committee put special focus on the issue of youth suicide. A core group of agency representatives was formed for the purpose of determining priority youth suicide recommendations to bring back to the committee, and the multiple youth suicide recommendations presented in this report grew from the work of this core group, several members of which had expertise in youth suicide prevention. These recommendations include mandatory suicide prevention training and protocols in schools, increasing the number of school nurses in high need communities, creating and funding a state level coordinator position for school social workers, and having a three-year lead suicide prevention position to accelerate and coordinate implementation of the 2015 North Carolina Suicide Prevention Plan.

Another 2017 legislative recommendation from the Intentional Death Prevention Committee addresses strengthening efforts to identify and treat children who are suspected of being abused and neglected through increased funding for the Child Medical Evaluation Program. Non-legislative "administrative" items coming from the Intentional Death Prevention Committee address issues such as infant safe surrender, a study to examine paid family leave insurance programs, and the integration of mental health services in primary pediatric care. The committee also plans to monitor several issues, including programs and mobile applications related to youth suicide prevention, and the long-awaited creation and implementation of a child welfare case management system.

The **Perinatal Health Committee** studies infant mortality and women's health. This committee recommends continued state funding for the You Quit Two Quit Program that addresses perinatal tobacco cessation as a strategy to reduce infant mortality and promote healthy birth outcomes. The committee also recommends increased funding for the Infant Safe Sleep program which will help prevent sleep-related infant deaths. The committee recommends funding support to expand use of a free mobile application and texting service called Text4baby that supports pregnant and new mothers to achieve healthy birth outcomes and to care for new babies. Responding to federal recommendations, the committee also put forth a recommendation to add and fund three conditions to the state's newborn screening panel.

Recognizing the importance of breastfeeding to infant health, continued administrative efforts will be made to work on implementation of Medicaid coverage of medical lactation services. The committee also decided to send a letter to the federal government expressing concerns about the health impacts of electronic nicotine delivery systems (ENDS). The Committee will monitor previous funding commitments made by the General Assembly for the March of Dimes Preconception Health Campaign, the East Carolina University High Risk Maternity Clinic, and for 17-Progesterone, all of which address infant mortality and preconception health. It will also monitor Medicaid reform and any legislation pertaining to substance-exposed newborns. Reflecting priorities included in the state's Perinatal Health Strategic Plan, the committee will also monitor the work of parties currently engaged in addressing concerns with providing Long Acting Reversible Contraceptives in the immediate postpartum period while in the hospital.

The **Unintentional Death Prevention Committee** studies unintentional injury and death. This committee submitted several recommendations aimed at addressing the state's opioid epidemic including: continued funding for safe drug disposal; increased used of the Controlled Substances Reporting System by medical professionals; and an endorsement of efforts by the Harm Reduction Coalition who seeks support to continue their work fighting the opioid epidemic.

The issue of firearm safety and access to lethal means was brought to the attention of the Task Force by the State Child Fatality Prevention Team. Study of this issue resulted in the Task Force determining to partner with Safe Kids NC to form a firearm safety stakeholder group, and to recommend funding to

support the work of this group for a safe storage awareness campaign as well as free or discounted gun locks or lock boxes.

Motor vehicle safety was addressed by the committee through its recommendation to make rear seat restraints a "primary" traffic offense for all in order to increase use of seat belts in the back seat. The committee also endorsed evidence-based legislation aimed at strengthening impaired driving laws with particular emphasis on mandating ignition interlocks for all DWI offenders, a strategy recommended by the CDC as being highly effective in preventing repeat DWI offenses. Another endorsement by the committee included evidence-based legislation addressing school bus safety, including legislation addressing the use of school bus cameras.

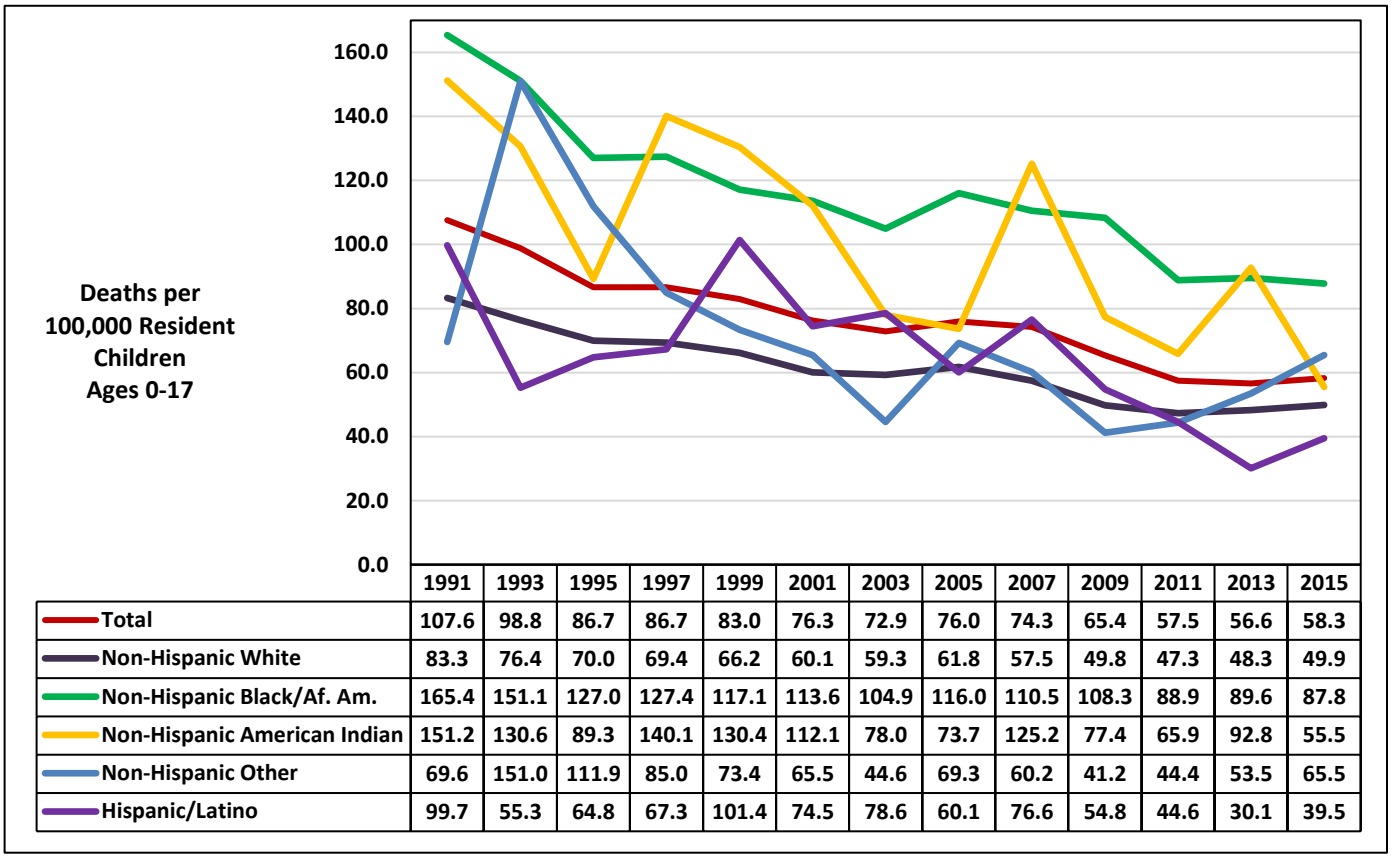
With respect to non-legislative items, the committee plans to add Task Force support to a petition to the Board of Agriculture asking for a rule to exclude toxic flame retardants from bedding in North Carolina. Reacting to Task Force history of addressing fireworks safety and legislation proposed in 2015 to revise NC pyrotechnics laws, the Task Force is joining the North Carolina Fireworks Safety Coalition and will also monitor any changes to NC pyrotechnics laws. The committee has other track and monitor items which are follow-up items from previous CFTF agendas.

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 2017 Action Agenda.

The rate of child deaths in North Carolina has decreased by 46% since creation of the Child Fatality Task Force in 1991

CHILD DEATHS IN NORTH CAROLINA: ANNUAL REPORT[1]

1991-2015 Trends in North Carolina Resident Child Death Rates* by Race/Ethnicity, Ages Birth Through 17 Years



	1991	1993	1995	1997	1999	2001	2003	2005	2007	2009	2011	2013	2015
Total	107.6	98.8	86.7	86.7	83.0	76.3	72.9	76.0	74.3	65.4	57.5	56.6	58.3
Non-Hispanic White	83.3	76.4	70.0	69.4	66.2	60.1	59.3	61.8	57.5	49.8	47.3	48.3	49.9
Non-Hispanic Black/Af. Am.	165.4	151.1	127.0	127.4	117.1	113.6	104.9	116.0	110.5	108.3	88.9	89.6	87.8
Non-Hispanic American Indian	151.2	130.6	89.3	140.1	130.4	112.1	78.0	73.7	125.2	77.4	65.9	92.8	55.5
Non-Hispanic Other	69.6	151.0	111.9	85.0	73.4	65.5	44.6	69.3	60.2	41.2	44.4	53.5	65.5
Hispanic/Latino	99.7	55.3	64.8	67.3	101.4	74.5	78.6	60.1	76.6	54.8	44.6	30.1	39.5

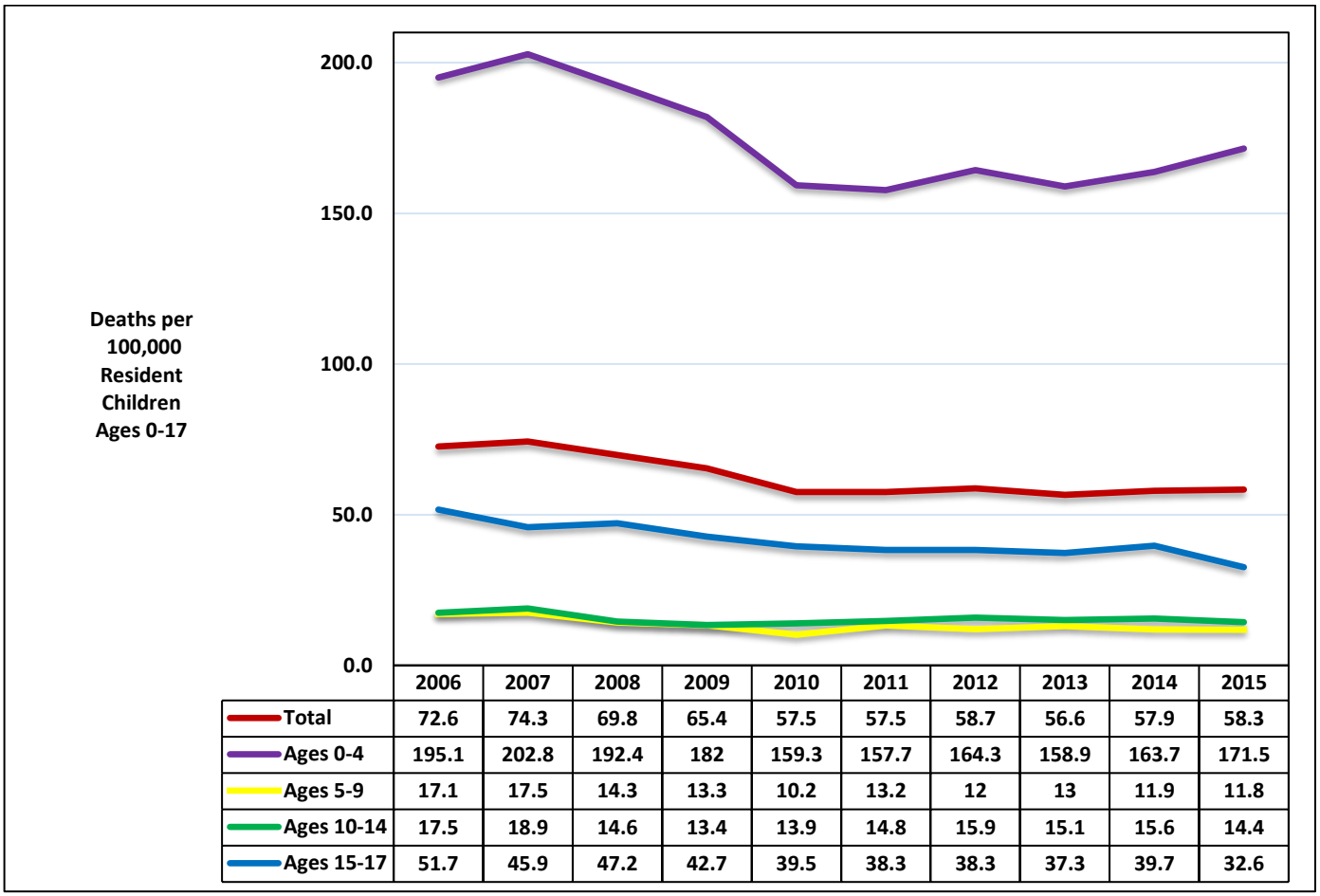
** Child death rates prior to 2015 have been recalculated using the latest available population data.*

[1] This Annual Child Death Data Report is produced by the N.C. Division of Public Health – Women's and Children's Section in conjunction with the State Center for Health Statistics.

2015 NC Resident Child Deaths By Age Group & Cause of Death						
Cause of Death	**Age Groups**					**TOTAL**
	Infants	**1-4**	**5-9**	**10-14**	**15-17**	
TOTAL DEATHS	**884**	**153**	**76**	**94**	**128**	**1,335**
…Percent of Total	**66.2%**	**11.5%**	**5.7%**	**7.0%**	**9.6%**	
Perinatal Conditions	479	1	1	0	0	**481**
Illnesses	91	61	42	48	30	**272**
Birth Defects	147	20	5	9	4	**185**
Unintentional Injuries	**25**	**42**	**22**	**21**	**53**	**163**
...Motor Vehicle Injuries	6	18	14	12	33	83
...Suffocation/Choking/Strangulation	16	3	2	1	0	22
...Drowning	0	13	2	0	4	19
...Poisoning	2	3	0	2	6	13
...Bicycle	0	1	1	3	2	7
...All Other Unintentional Injuries	1	4	3	3	8	19
Homicide	11	18	4	4	14	**51**
...Involving Firearm	0	4	3	2	11	20
...All Other Homicides	11	14	1	2	3	31
Suicide	0	0	0	10	25	**35**
...by Firearm	0	0	0	5	10	15
...by Hanging	0	0	0	4	11	15
...by Poisoning	0	0	0	1	2	3
...All Other Suicides	0	0	0	0	2	2
All Other Causes of Death	131	11	2	2	2	**148**

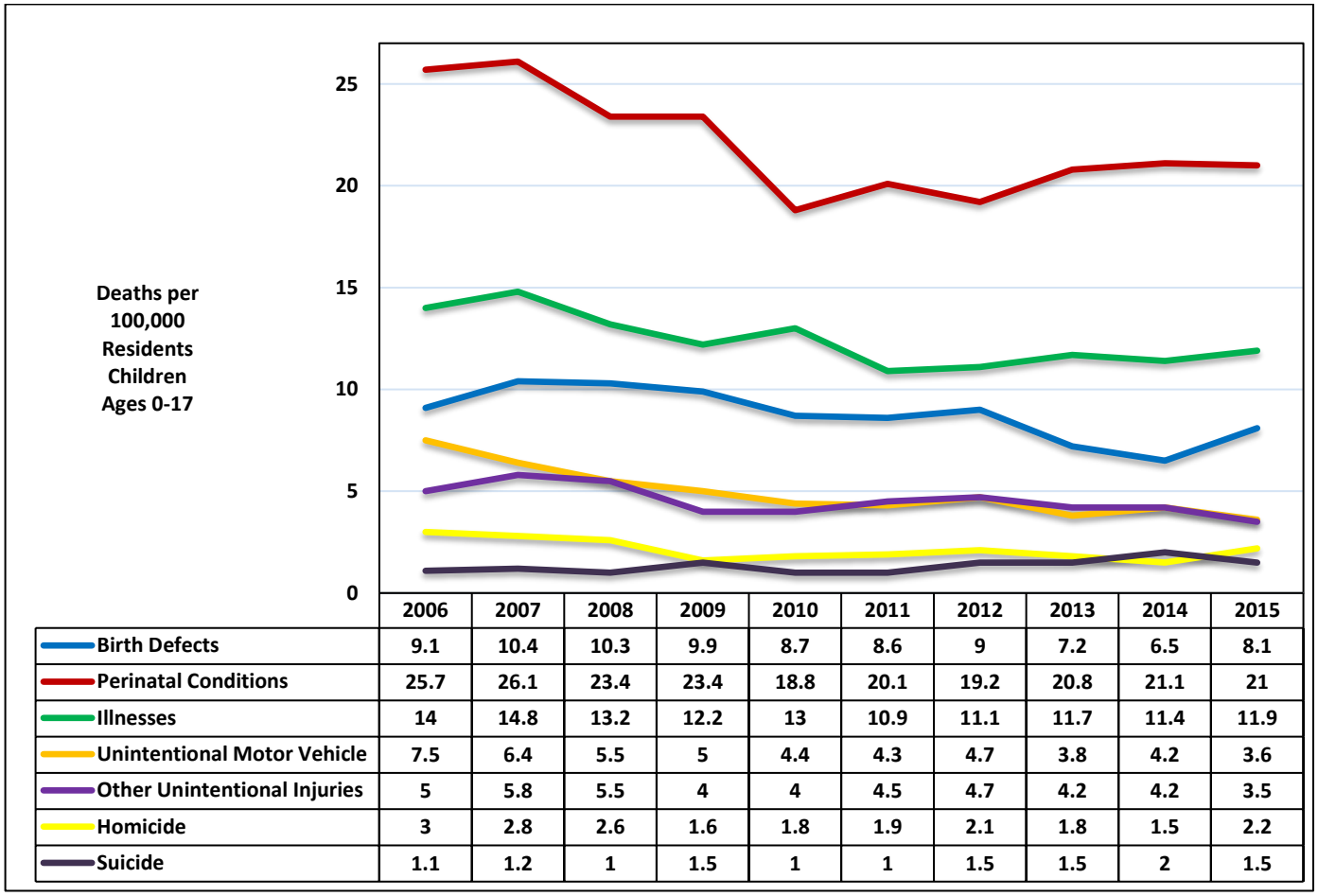
Note on Cause of Death Figures: Numbers in this report from the State Center for Health Statistics (SCHS) may differ slightly from numbers reported later by the Office of the Chief Medical Examiner (OCME). The SCHS bases its statistics on death certificate coding only, and closes out annual data at a specific point in time. The OCME makes its determinations utilizing a variety of information sources when conducting its death reviews, does not close out their data, and some of its cases are still pending when the SCHS closes their annual data files. Therefore, the cause and manner of death determined by the OCME may be modified based on OCME review after the time period during which the SCHS finalizes annual data files.

2006-2015 Trends in North Carolina Resident Child Death Rates by Age Group, Ages Birth Through 17 Years



	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Total	72.6	74.3	69.8	65.4	57.5	57.5	58.7	56.6	57.9	58.3
Ages 0-4	195.1	202.8	192.4	182	159.3	157.7	164.3	158.9	163.7	171.5
Ages 5-9	17.1	17.5	14.3	13.3	10.2	13.2	12	13	11.9	11.8
Ages 10-14	17.5	18.9	14.6	13.4	13.9	14.8	15.9	15.1	15.6	14.4
Ages 15-17	51.7	45.9	47.2	42.7	39.5	38.3	38.3	37.3	39.7	32.6

2006-2015 Trends in North Carolina Resident Child Death Rates for Selected Cause of Death, Ages Birth Through 17 Years



	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Birth Defects	9.1	10.4	10.3	9.9	8.7	8.6	9	7.2	6.5	8.1
Perinatal Conditions	25.7	26.1	23.4	23.4	18.8	20.1	19.2	20.8	21.1	21
Illnesses	14	14.8	13.2	12.2	13	10.9	11.1	11.7	11.4	11.9
Unintentional Motor Vehicle	7.5	6.4	5.5	5	4.4	4.3	4.7	3.8	4.2	3.6
Other Unintentional Injuries	5	5.8	5.5	4	4	4.5	4.7	4.2	4.2	3.5
Homicide	3	2.8	2.6	1.6	1.8	1.9	2.1	1.8	1.5	2.2
Suicide	1.1	1.2	1	1.5	1	1	1.5	1.5	2	1.5

NC Child Fatality Task Force

2017

Action Agenda

2017 CFTF Legislative Agenda

Explanations of each legislative "support" or "endorse" item below can be found on pages13 through 27.

Legislative-Support

- Support $150,000 in funding for Infant Safe Sleep Program.
- Support $150,000 in funding to expand use of free Text4baby texting service and mobile application to promote healthy pregnancies, birth outcomes, and infants.
- Support adding to NC newborn screening panel tests for detection of Pompe Disease, MPS1, and XALD, all of which are now on the federal *Recommended Uniform Screening Panel*; raise newborn screening fee to cover recurring costs of adding three tests to State Lab (additional $10 estimated); appropriate nonrecurring funds for initial expenses to State Lab of adding three tests ($1 million to $1.5 million estimated).
- Support $250,000 in continued funding for the You Quit Two Quit Perinatal Tobacco Cessation and Prevention Program.*
- Support a study bill to assess the timely and equitable access to high quality risk-appropriate maternal and neonatal care; study to result in actionable recommendations.
- Support legislation allowing for primary enforcement of unrestrained back seat passengers, and increase fine for unrestrained back seat passengers from $10 to $25 (carry over).
- Support a one-time appropriation of $50,000 to fund a firearm safety education and awareness campaign and to fund a program for distribution of free or discounted gun locks and lock boxes; both of which would be the product of the firearm safety work group to be convened in 2017 by the North Carolina Child Fatality Task Force and Safe Kids North Carolina. (This support item is related to the administrative item below that addresses the convening of a firearm safety work group.)**
- Support safe drug disposal with a minimum of $120,000 in continued funding to the State Bureau of Investigation for Operation Medicine Drop.*
- Support a technical correction to laws addressing the Controlled Substances Reporting System by enabling DHHS to engage the most appropriate service to enable interstate data sharing.*
- Support increased use of the Controlled Substances Reporting System by the medical profession.*

** Indicates item is part of CFTF Harmful Substances Initiative*

*** Indicates item is part of the Intentional Death Prevention Committee's ongoing strategy to address youth suicide prevention*

- Support increasing the state appropriation to the Child Medical Evaluation Program by $725,000 in recurring funds in order to bring the reimbursement rate for evaluations in NC to the national average rate.

- Support legislation to require that all personnel in NC schools, including public charter schools, who have direct interaction with students receive annual mandatory training related to identifying and referring students who may be at risk of suicide, and that schools have in place a process for implementation of training, a protocol for risk referrals, and that the protocol is proactively communicated to students and families.**

- Support an increase in funding to the School Nurse Funding Initiative by 2.5 million recurring to add 50 school nurses in high-need communities to move toward meeting nationally recommended ratios; legislation allocating this funding to address a process for examining outcomes from adding more school nurses and the identification of relevant outcome measures.**

- Support an appropriation of $100,000 in recurring funds for a full-time School Social Worker Consultant to be housed in DPI Student Support Services in order to provide coordination, training, support, and data collection for school social workers in North Carolina.**

- Support designation and appropriation for a three-year lead suicide prevention position in NC 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. Funding to go to DHHS to contract with appropriate non-agency organization to serve as backbone organization for this role; appropriation needed would be $125,000 per year for 3 years. (This support recommendation has a related administrative recommendation.)**

Legislative – Endorse

- Endorse evidence-based legislation that would strengthen impaired driving laws, including legislation requiring ignition interlocks for all DWI offenders.*

- Endorse evidence-based school bus safety legislation, including legislation addressing the use of school bus cameras.

- Endorse efforts of the NC Harm Reduction Coalition to fight the opioid overdose epidemic: $120,000 in funding for the cost of overdose reversal kits; $50,000 for a position within HRC to support overdose work; and legislation that allows for community groups to distribute overdose reversal kits.*

- Endorse efforts of others to increase funding for child care subsidies.

** Indicates item is part of CFTF Harmful Substances Initiative*

*** Indicates item is part of the Intentional Death Prevention Committee's ongoing strategy to address youth suicide prevention*

Administrative & Issue Monitoring

Administrative

Administrative items are those which do not require legislation but that the Child Fatality Task Force seeks to advance.

- Send letter of concern to FDA or Surgeon General addressing impact of Electronic Nicotine Delivery Systems on children and youth, addressing latest research on use of ENDS by youth, and advocating that federal rules ban flavored liquid and the marketing of ENDS products that target youth.*

- Administratively support the NC Child Fatality Task Force and Safe Kids NC to convene a group of firearm safety stakeholders to examine and make recommendations related to firearm safety, reporting back to the CFTF Unintentional Death Prevention Committee by November, 2017. (Group's work to include components specified by the Intentional Death Prevention Committee, explained on page 18.)**

- Administratively support the convening of a work group to study best practices for training on access to lethal means and specifically CALM (Counseling on Access to Lethal Means) in order to propose implementation plan for training to Unintentional Death Prevention Committee by November, 2017.**

- Administratively add CFTF support to a petition to the Board of Agriculture asking for a rule to exclude toxic flame retardants from bedding in North Carolina.*

- Administratively support the Child Fatality Task Force becoming a member of the North Carolina Fireworks Safety Coalition.

- Promote continued expansion of permanent medicine drop boxes, and support efforts to address drug disposal challenges (carry over).*

- If a lead suicide prevention position is funded (as recommended in the support item above), the CFTF ID committee will work with the Division of DHHS who is tasked with the RFP for this role to determine the specifications of the RFP to effectively carry out the recommendations of the ID committee (this item is connected to the legislative support item explained on page 26 & 27).**

- Administratively support CFTF formation of a work group to focus on an awareness campaign for Infant Safe Surrender; group to determine messaging, strategy, costs, and other factors for an effective campaign.

- Administratively support CFTF formation of a work group of child welfare attorneys, experts, and advocates to analyze and make recommendations regarding the issue of parental anonymity within Infant Safe Surrender laws.

** Indicates item is part of CFTF Harmful Substances Initiative*

*** Indicates item is part of the Intentional Death Prevention Committee's ongoing strategy to address youth suicide prevention*

- Administratively support creation of an advisory committee of diverse stakeholders convened by NC Child and the Child Fatality Task Force to identify (and determine funding sources for if needed) a qualified organization to conduct a study that determines: how paid family medical leave insurance programs are being implemented in others states; what research exists regarding the outcomes of these programs; whether and how such programs could be implemented in North Carolina. Advisory committee to provide input related to scope of study, sources of information, deliverables, and timeline. Advisory committee to report back to the Intentional Death Prevention Committee by October, 2017 on the status of its work or to present any completed report that is the result of a study initiated by the group.

- Administratively support efforts of DHHS and Community Care NC to move toward integration of mental health services in primary pediatric care (carry over).**

Issue Monitoring

The Child Fatality Task Force monitors certain issues of concern or interest that are not currently ripe for policy intervention or Task Force involvement but may require action at a later time.

- Implementation of Medicaid coverage of lactation services (carry over).
- "Baby Bundle" funding items that carry over from 2015/16: MOD, $350K in Block Grant; 17P, $52K in Block Grant; ECU high risk clinic in 2015 budget for $375K recurring.
- Work with parties currently engaged in addressing concerns with providing Long Acting Reversible Contraceptives immediately postpartum in the hospital (carry over).
- Medicaid Reform (carry over).
- Legislation pertaining to substance-exposed newborns (carry over)
- Legislation impacting pyrotechnics (carry over)
- Driver Education Program (carry over)
- Funding for tobacco cessation and prevention (carry over)*
- Legislation impacting impaired driving (carry over)*
- Track and monitor current NC programs addressing access to lethal means, including CALM, ASK, and other programmatic and educational efforts on safe firearm storage.**
- Track and monitor current mobile applications used in NC to address some aspect(s) of suicide prevention, including Spk Up, Text4Teens, and MyStrength.**
- Track and monitor efforts to expand and implement Youth Mental Health First Aid in NC (carry over).**
- Track and monitor creation and implementation of child welfare case management system as part of NC FAST (carry over).

** Indicates item is part of CFTF Harmful Substances Initiative*

*** Indicates item is part of the Intentional Death Prevention Committee's ongoing strategy to address youth suicide prevention*

Explanation of CFTF 2017 Legislative Action Agenda Items

The following explanations are intended to provide brief summaries of each legislative item, and some have accompanying administrative items. Additional information is available through the Task Force.

A. Recommendations to support healthy birth outcomes and reduce infant mortality

1. Support $150,000 in funding for Infant Safe Sleep Program to prevent sleep-related infant deaths.

- Safe sleep practices reduce the risk of Sudden Infant Death Syndrome (SIDS) and can prevent accidental strangulation or suffocation during sleep.
- In late 2016, the American Academy of Pediatrics (AAP) updated their recommendations on safe infant sleep. Federal agencies such as the National Institutes of Health, the Centers for Disease Control and Prevention, and the Maternal and Child Health Bureau have urged educating anyone who cares for infants younger than one year of age on the updated recommendations regarding safe infant sleep.
- The latest AAP recommendations have 19 overall guidelines for reducing the risk of SIDS and other sleep-related causes of infant death, with nine of those recommendations relating directly to the infant's sleep environment.
- In North Carolina, state support for infant safe sleep initiatives decreased in recent years, and more funding is needed for initiatives to promote, train, and educate about safe sleep practices. (Current state support is $45,000.)

2. Support $150,000 in funding to expand the use of free Text4baby texting service and mobile application to promote healthy pregnancies, birth outcomes, and infants.

- Text4baby is a national, free texting service available in English and Spanish that provides regular outgoing messages to expectant and new mothers tailored to a woman's due date or her baby's age. Information about the service can be found online at: https://www.text4baby.org/.
- Message content addresses a broad range of health and safety information such as prenatal care, signs of preterm labor, safe sleep, immunization, nutrition, family violence, physical activity, mental health, substance abuse, developmental milestones and many other issues. The Text4baby application provides medical appointment reminders, identifies subjects to discuss with the doctor, allows women to create interactive weekly to-do lists, and has links to health hotlines, videos and community resources.
- Dozens of federal agencies, national, state, and local organizations provided input into the content development of the messages which are ultimately reviewed by experts from a range of key agencies and organizations.
- Outcome data for Text4baby is routinely collected and analyzed, demonstrating that the service reaches participants early in their pregnancy, those living in high poverty areas and those from low-income households. Data also demonstrates evidence of increased knowledge and behavior change by participants as well as improvements with access to health services. (For specific

outcome information and statistics, see the fact sheet on Text4Baby Impact: https://partners.text4baby.org/templates/beez_20/images/HMHB/final%20impact%20factsheet.pdf.)

- Use of this texting service in North Carolina is lower than neighboring states of SC, VA, TN and of LA, MS, AL. This funding would support efforts to significantly increase the number of North Carolina women enrolled in and benefiting from Text4baby.

3. Support adding to the North Carolina newborn screening panel tests for detection of Pompe Disease, MPS1, and XALD, all of which are now on the federal *Recommended Uniform Screening Panel*; raise newborn screening fee to cover recurring costs of adding three tests to State Lab (additional $10 estimated); appropriate nonrecurring funds for initial expenses to State Lab of adding three tests ($1 million to $1.5 million estimated).

- The U.S. Department of Health and Human Services has an Advisory Committee on Heritable Disorders in Newborns and Children who determines the Recommended Uniform Screening Panel (RUSP) for newborns. When considering adding a condition to the panel, the committee examines the degree of certainty that screening would lead to a significant benefit as well as the degree of feasibility for states to add the condition.
- The federal RUSP is a recommendation to states and not a mandate. In North Carolina, legislation sets the fees for newborn screening; legislation would be required to add and fund new tests for the panel.
- Between March of 2015 and June of 2016, three additional conditions were added to the federal RUSP: 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.
- Initial start-up costs to the State Lab for adding these three tests are estimated to be between $1 million and $1.5 million dollars, and recurring costs for adding these three tests are estimated to be covered by raising the newborn screening fee by $10.00; however, further analysis is required in order to confirm or revise estimated costs. North Carolina's current newborn screening fee of $44.00 is a lower fee than many nearby states (fees in GA, VA, TN, SC, AL range from $50 to $150).

4. Support $250,000 in continued funding for the You Quit Two Quit Perinatal Tobacco Cessation and Prevention Program.

- Tobacco use during pregnancy is directly associated with the top 4 causes of infant mortality in NC, and is the single greatest modifiable risk factor that can reduce prematurity and infant death.[2]
- One in ten babies in NC are born to women reporting tobacco use during pregnancy; in some counties over 30% of babies are born to women who smoked.[3]
- The goal of You Quit Two Quit (YQ2Q) is to ensure that there is a comprehensive system in place for high quality screening and treatment for tobacco use in women, including pregnant and postpartum mothers. This funding will build on the current investment in personnel to support the delivery of evidence-based care to improve tobacco use rates among women of reproductive age.

[2] University of North Carolina Center for Maternal and Infant Health.

[3] Data source: State Center for Health Statistics, based on 2014 birth certificate data.

- Reviews of clinical outcomes of women who quit smoking during pregnancy demonstrate a 20% reduction in the number of low birth weight babies, an average increase in birth weight of 28 grams, and a 17% decrease in preterm births. For every $1 invested in tobacco cessation for pregnant women, there is a savings of at least $3 in immediate healthcare costs. [4]
- This item is part of the CFTF Harmful Substances Initiative.

5. Support a study bill to assess the timely and equitable access to high quality risk-appropriate maternal and neonatal care; study to result in actionable recommendations.

- Medically complex pregnant mothers and newborns should be cared for in a medical facility that can meet their medical needs. Studies have demonstrated that timely access to risk appropriate neonatal and obstetric care can reduce perinatal mortality and maternal mortality.
- The "levels of care" approach offers uniform criteria designating the capability of healthcare facilities to provide four levels of complexity of care to pregnant women and newborns.
- Healthcare facilities across North Carolina have varied capabilities for meeting different levels of complexity. A study is needed to determine: which facilities in North Carolina are available and prepared to manage different complexity levels of care; how current systems of referral and/or transport to different facilities based on patient risk are being managed; disparities in access to care; identification of service gaps; and other issues that impact the ability to most appropriately match patient need with provider skill. This information should provide a foundation for actionable steps in North Carolina to best ensure that pregnant mothers and newborns are cared for in a facility that can meet their clinical needs.
- This study would address several goals identified in the North Carolina Perinatal Health Strategic Plan.
- The designation of levels of care is endorsed by the American College of Obstetricians and Gynecologists, the Society for Maternal-Fetal Medicine, the American Academy of Pediatrics, and a number of other national medical organizations.

B. Recommendations to prevent motor vehicle-related injuries and deaths to children

Background information: The leading cause of injury-related death among children in North Carolina is motor vehicle crashes. Among childhood injuries in NC, motor vehicle crashes are the fourth leading cause of hospitalizations and the sixth overall cause of emergency department visits.[5] North Carolina ranks among the highest for all 50 states in terms of medical and work loss costs associated with motor vehicle crash deaths.[6] Recommendations below address two primary risk factors for crash deaths identified by the CDC: not using seat belts and drunk driving.[7]

1. Support legislation allowing for primary enforcement of unrestrained back seat passengers, and increase fine for unrestrained back seat passengers from $10 to $25 (carry over).

[4] Information source: UNC Center for Maternal and Infant Health, citing Lumley 2000, Goldenberg 2000 (regarding birth weights and preterm births) and Ruger 2008 (regarding cost savings).
[5] Based on data from 2011 – 2014 reported by the Injury and Violence Prevention Branch of the NC Division of Public Health in the *North Carolina Childhood Injury Report: 2011- 2014*.
[6] Motor Vehicle Crash Deaths: Costly but Preventable: www.cdc.gov/motorvehiclesafety/statecosts/index.html.
[7] CDC Vital Signs, Motor Vehicle Crash Deaths, July 2016: https://www.cdc.gov/vitalsigns/pdf/2016-07-vitalsigns.pdf.

- Currently, NC law 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 not a "primary enforcement" offense.[8] The fine for adults being unrestrained in the back seat is currently $10, while it is $25.50 for the front seat.
- In NC, motor vehicle crashes are the leading cause of death for teens ages 15 to 17.[9] Children ages 15 to 18 are significantly more affected by motor vehicle injuries in deaths, hospitalizations, and emergency department visits than other age groups 18 and under.[10] From 2009 to 2013, an average of 52% of teen motor vehicle fatalities in the U.S. were to kids not buckled up.[11]
- 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. In North Carolina, a greater percentage of fatal and serious injuries occur to unrestrained rear seat occupants than to unrestrained front seat occupants.[12]
- The odds of driver death in the presence of unrestrained rear seat occupants are much higher than when rear seat occupants are restrained;[13] an unrestrained rear seat passenger can be a source of injury to a front seat passenger in the event of a crash.
- Having rear seat primary enforcement and a minimum of a $25 fine for being unrestrained in the rear seat are two of the occupant protection criteria set by the National Highway Traffic Safety Administration (NHTSA), who requires North Carolina to meet 3 of 6 criteria for federal funding titled "Section 405b." Failure to meet these criteria makes it more difficult for NC to be eligible for $1.5 million in federal Section 405b funding, a portion of which is used to purchase child safety seats for low income families.

2. Endorse evidence-based legislation that would strengthen impaired driving laws, including legislation requiring ignition interlocks for all DWI offenders.

- According to the Centers for Disease Control and Prevention (CDC): 28 people in the United States die each day in an alcohol-related vehicle crash; of traffic deaths among children ages 0 to 14 in 2014, 19% involved an alcohol-impaired driver; of child passengers age 14 and younger who died in alcohol-impaired driving crashes in 2014, over half were riding in the vehicle with the alcohol-impaired driver.
- Alcohol is involved in approximately one-third of all fatal crashes in North Carolina. In 2014 in NC, 378 people were killed in crashes involving a drunk driver.[14]
- 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.

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

[9] Injury and Violence Prevention Branch, NC Division of Public Health.

[10] Based on data from 2011 – 2014 reported by the Injury and Violence Prevention Branch of the NC Division of Public Health in the *North Carolina Childhood Injury Report: 2011- 2014*.

[11] NC Governor's Highway Safety Program.

[12] NC Governor's Highway Safety Program, data source: North Carolina 2014 Traffic Crash Facts, NC Division of Motor Vehicles.

[13] D. Bose, et al., Accident Analysis & Prevention, Vol. 53, April 2013.

[14] Injury and Violence Prevention Branch, NC Division of Public Health.

- About one-third of those arrested for impaired driving are repeat offenders.[15] The CDC recommends ignition interlocks as a highly effective strategy to prevent repeat DWI offenses while installed, and recommends that interlocks be mandated for all DWI offenders, including first-time offenders. Current North Carolina law makes ignition interlocks mandatory only if the person's blood alcohol level is greater than .15 or if the person is a second or subsequent offender. About half of all states now require ignition interlocks for all offenders, but North Carolina is not one of them.
- This item is part of the CFTF Harmful Substances Initiative.

3. Endorse evidence-based school bus safety legislation, including legislation addressing the use of school bus cameras.

- The Child Fatality Task Force has a history of supporting legislation and/or funding to address school bus safety, including expansion of stop-arm cameras on school buses.
- Stop arm cameras can provide video evidence of a vehicle passing a stopped school bus that can be used to identify and prosecute offenders who illegally pass a stopped school bus. Currently, about 12% of school buses in North Carolina have stop arm cameras.
- Illegally passing a stopped school bus is a frequent occurrence, but identifying and prosecuting offenders can be challenging.
- On a single day in 2016, North Carolina school bus drivers reported over 3000 vehicles passed their buses illegally, while the bus was stopped to load or unload children.[16]

C. Recommendation and administrative actions to prevent firearm-related deaths and injuries to children

Background: For North Carolina children ages 0 to 17 during the five-year period between 2010 and 2014, there were 279 firearm-related hospitalizations, 777 firearm-related emergency department visits, and 210 firearm-related deaths. Of those firearm-related deaths, 15% were to children age 9 and under; 35% were to children age 14 and under.[17] During the five-year period between 2010 and 2014, firearms (of all types) were the lethal means used in almost 45% of suicides and over 50% of homicides to children ages 0 to 17.[18]

For the 2011 North Carolina Behavioral Risk Factor Surveillance System, approximately half of North Carolina residents with a firearm reported that the firearm is unsecured (secured = gun cabinet, trigger or cable lock). (2011 was the last year this data was collected.) Nationally, approximately one in three handguns is kept loaded and unlocked and most children know where guns are kept by their parents; more than 75 percent of guns used by youth in suicide attempts were kept in the home of the victim, a relative, or a friend.[19]

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[15] *Repeat DWI Offenders in the United States*, National Highway Traffic Safety Administration, 1995.
[16] Transportation Services, North Carolina Department of Public Instruction.
[17] Death data according to the Office of the Chief Medical Examiner, NC Department of Health and Human Services; other data according to NC Violent Death Reporting System, NC Department of Health and Human Services.
[18] Office of the Chief Medical Examiner, NC Department of Health and Human Services.
[19] *Gun Violence: Facts and Statistics*, from the Center for Injury Research and Prevention, Children's Hospital of Philadelphia Research Institute.

In 2016, the North Carolina Child Fatality Prevention Team recommended to the Child Fatality Task Force taking action to address child access to lethal means with specific recommendations to support implementation of the CALM (Counseling on Access to Lethal Means) Program and to establish a stakeholder group to address an access to means awareness and safe storage campaign.

1. **Support a one-time appropriation of $50,000 to fund a firearm safety education and awareness campaign and to fund a program for distribution of free or discounted gun locks and lock boxes; both of which would be the product of the firearm safety work group to be convened in 2017 by the North Carolina Child Fatality Task Force and Safe Kids North Carolina.**

   This legislative recommendation is related to the following two administrative (non-legislative) recommendations:

2. ***Administratively support* the NC Child Fatality Task Force and Safe Kids NC to convene a group of firearm safety stakeholders to examine and make recommendations related to firearm safety, reporting back to the CFTF Unintentional Death Prevention Committee by November, 2017. Group's work to include the following components specified by the Intentional Death Prevention Committee:**
   - Identification and engagement of stakeholders
   - Examination of firearm safety messaging, materials, and training currently in use in NC and nationally
   - Development of a statewide approach to firearm safety education and awareness
   - Examination and potential implementation/expansion of programs to distribute gun locks or lock boxes
   - Identification of effective local firearm safety groups or coalitions whose structure and efforts could serve as a model for duplication in other local communities
   - Recommendations as to whether/how NC could have an ongoing stakeholder group charged with addressing firearm safety to reduce firearm-related child deaths in NC
   - Recommendations as to associated funding that would be needed to sustain efforts

3. ***Administratively support* the convening of a work group to study best practices for training on access to lethal means and specifically CALM (Counseling on Access to Lethal Means) in order to propose implementation plan for training to Unintentional Death Prevention Committee by November, 2017.**

All of the above firearm safety recommendations are also part of the Child Fatality Task Force's ongoing efforts to prevent youth suicide.

D. Recommendations to address the opioid epidemic and prescription drug abuse

Background: Safe disposal of drugs, the Controlled Substances Reporting System, and efforts to expand the use of the overdose reversal drug naloxone are important tools in North Carolina's battle to address the current opioid overdose epidemic and prescription drug abuse. Prescription opioid overdoses claimed the lives of more than 740 North Carolinians in 2015, and there has been more than a 350% increase in overdose deaths in North Carolina since 1999, with most of those deaths due to prescription

medications.[20] This epidemic is taking a tremendous toll on the health and safety of children who suffer the unintended consequences of drug impairment or overdose by adults in their lives, and on teens who abuse drugs themselves. Small children are at risk of poisoning when prescription drugs are accessible, and teens often obtain drugs from friends and family.

1. Support increased use of the Controlled Substances Reporting System by the medical profession.

- The CSRS requires pharmacists to record the dispensing of controlled substances, and allows health care providers to see a patient's other prescriptions to avoid over-prescribing addictive medications.
- In North Carolina, current law requires prescribers to *register* to use the CSRS within 30 days after obtaining an initial or renewal license to prescribe a controlled substance, but *does not mandate* prescribers to use it. (This registration requirement, however, does not become effective until all CSRS system improvements required by 2016 legislation have been completed.) Estimates are that over 50% of those who prescribe controlled substances in North Carolina are currently registered to use the CSRS.
- Some states mandate use of their prescription drug monitoring system, and such laws are more acceptable to prescribers when carefully drawn to address special circumstances that call for exceptions, such treatment for cancer pain or palliative care.
- This item is part of the CFTF Harmful Substances Initiative.

2. Support a technical correction to laws addressing the Controlled Substances Reporting System by enabling DHHS to engage the most appropriate service to enable interstate data sharing.

- Prescription Drug Monitoring systems are most effective when there is interstate data sharing so that prescribers can see if patients are crossing state lines to have prescriptions filled.
- Language present in 2015 legislation regarding the interstate data sharing system to be engaged conflicts with language in 2016 legislation regarding security requirements for the system, resulting in challenges to move forward with interstate data sharing.[21]
- This item is part of the CFTF Harmful Substances Initiative.

3. Support safe drug disposal with a minimum of $120,000 in continued funding to the State Bureau of Investigation for Operation Medicine Drop.

- Operation Medicine Drop is a nationally recognized NC program that uses drug take-back events and permanent medicine drop boxes to collect 15 to 20 million doses of unused medications each year.

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[20] Injury and Violence Prevention Branch, NC Division of Public Health. Note that deaths involving illicitly manufactured fentanyl are included in the number of deaths categorized as being due to "prescription opioids" because there is not a separate coding category to capture this distinction. They are coded under Other Synthetic Narcotics (T40.4), historically all likely prescribed.

[21] According to the Drug Control Unit of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, NC Department of Health and Human Services.

- Medications collected fall into the same waste classification as pesticides, considered hazardous if not properly destroyed, and drugs not properly disposed may end up being misused or discarded in a manner that is not environmentally sound.
- Costs associated with safe disposal of medicine include the expense of EPA-approved incineration, secure transportation, law enforcement staffing, and permanent drop boxes.
- This item is part of the CFTF Harmful Substances Initiative.

4. Endorse efforts of the NC Harm Reduction Coalition to fight the opioid overdose epidemic: $120,000 in funding for the cost of overdose reversal kits; $50,000 for a position within HRC to support overdose work; and legislation that allows for community groups to distribute overdose reversal kits.

- The NC Harm Reduction Coalition (HRC) has played a critical role in North Carolina's efforts to address the opioid overdose epidemic, and the Child Fatality Task Force has previously supported HRC initiatives to expand access to the overdose reversal drug Naloxone.
- Since the HRC's Overdose Prevention Project became operational in 2013, they have dispensed over 38,000 free overdose rescue kits and as of the end of 2016 received 5,390 confirmed reports of successful administration of the overdose reversal drug naloxone by lay individuals. The HRC is seeking legislation and funding to be able to continue their work fighting the opioid epidemic.
- This item is part of the CFTF Harmful Substances Initiative.

E. Recommendations to promote quality caregiving for children and the identification and prevention of child maltreatment

Background: One of the purposes of the Child Fatality Prevention System is to prevent future child abuse and neglect,[22] and when children are suspected of being abused or neglected it is critical that maltreatment be identified and addressed. The Task Force is charged with making recommendations to promote the safety and well-being of children,[23] and quality child care is an essential aspect of child safety and well-being.

1. Support increasing the state appropriation to the Child Medical Evaluation Program by $725,000 in recurring funds in order to bring the reimbursement rate for evaluations in NC to the national average rate.

- A Child Medical Evaluation (CME) is a specific evaluation performed by a qualified medical expert (MD, NP, PA) 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 for case decisions. Additionally, CMEs are used by medical professionals to determine a course of medical treatment for the child, and by DSS to assist with understanding needs for family services and child placement.
- In addition to performing a medical evaluation of a child, CMEs involve extensive reviewing of past medical records, interviewing of parents and others, and providing information to investigators.

[22] See N.C.G.S. 7B-1400.
[23] See N.C.G.S. 7B-1412.

CMEs often include talking with court officials in preparation of a case and may sometimes include going to court one or more times and/or conferencing with subspecialty providers.

- Currently, CMEs in North Carolina are reimbursed a flat fee payment of $250 for suspected sexual abuse and $150 for other types of suspected maltreatment. The national average reimbursement payment for a CME in states with similar structures is $575.
- North Carolina is fortunate to have a number of professionals qualified to perform CMEs, but risks losing professionals who are unable to perform this service due to the current reimbursement rate, the number of hours needed to dedicate to the service as well as the degree of specialty required.

2. Endorse efforts of others to increase funding for child care subsidies.

- Child care subsidies provide financial support to defray all or a portion of the cost of child care for qualifying families. Approximately 60% of mothers in North Carolina work. A single parent earning $15 an hour would spend 31% of her income on child care based on the average county market rate of $820 per month. The waiting list for child care subsidies in North Carolina in the summer of 2016 was over 24,000.[24]
- In 2016, the North Carolina Child Fatality Prevention Team recommended to the Child Fatality Task Force supporting a recommendation by the North Carolina Institute of Medicine's Task Force on Essentials for Childhood to increase funding for child care subsidies.
- The North Carolina Task Force on Essentials for Childhood was tasked with studying and developing a strategic plan to reduce child maltreatment and secure family well-being in North Carolina. This group's 2015 report highlighted the importance of high quality early child care, with specific recommendations to increase funding for child care subsidies.[25]

F. Recommendations to prevent youth suicide and promote child well-being

Background: Suicide has always been a study subject for the Intentional Death Prevention Committee (ID Committee) of the Child Fatality Task Force. After seeing a spike in the youth suicide rate in 2014, the ID Committee focused extra attention on youth suicide, hearing from experts regarding data, risk factors, intervention strategies, and other issues impacting youth suicide.

Data points related to youth suicide in North Carolina

Youth suicide deaths (rates) per 100,000 North Carolina resident children age 17 and under:[26]

2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
1.1	1.2	1.0	1.5	1.0	1.0	1.5	1.5	2.0	1.5

[24] Source for data: information presented to CFTF by Child Care Services Association of North Carolina.

[25] Task Force on Essentials for Childhood: Safe, Stable, and Nurturing Relationships and Environments to Prevent Child Maltreatment (2015), available at: http://www.nciom.org/publications/?nciom-task-force-on-essentials-for-childhood-safe-stable-and-nurturing-relationships-and-environments-to-prevent-child-maltreatment. See Chapter 6 and recommendation 6.1 related to child care.

[26] Data source: State Center for Health Statistics, NC Department of Health and Human Services.

- The two most common means of youth suicide death are hanging and firearm, each of which have accounted for approximately 45% of youth suicide deaths in NC during the past ten years, with other means such as poisoning being far less common.[27]
- More females than males attempt suicide, while more males than females die by suicide.[28]
- Nationally, suicide is the second leading cause of death among persons aged 15 to 24 years.[29]

Some of the risk factors for suicidal behavior explained by experts who presented to the Child Fatality Task Force were:

- History of depression, anxiety, or other mental illness
- Alcohol or drug abuse
- Family history of suicide or violence
- Interpersonal conflicts or losses
- Legal or disciplinary events
- Minority sexual orientation
- Trauma or abuse
- Access to lethal means
- Isolation/lack of healthy social connections
- Recent crisis or hospitalization

In 2015, North Carolina produced the NC Suicide Prevention Plan, the work product of a diverse group of more than 180 stakeholders that contains broad goals with related specific objectives for different types of stakeholders to achieve these goals. This plan aligns closely with the 2012 National Strategy for Suicide Prevention.

In 2016, the Child Fatality Task Force Intentional Death Prevention committee convened a core group of state agency representatives ("core group") to prioritize and initiate a plan for implementation of 3 to 5 strategies from the 2015 NC Suicide Prevention Plan to address youth suicide. The core group was composed of representatives from the following organizations:

- Injury and Violence Prevention Branch of the Division of Public Health
- Department of Public Instruction
- Division of Adult Corrections and Juvenile Justice of the NC Department of Public Safety
- Children & Youth Branch of the Division of Public Health
- Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
- NC Center for Safer Schools
- Wake County Public School System
- NC Child
- North Carolina Child Fatality Task Force.

Several of the individuals in the core group had specific expertise in youth suicide prevention. This group reported back to the Intentional Death Prevention Committee with its recommendations and supporting information, which formed the basis of the following suicide prevention recommendations approved by

[27] Office of the Chief Medical Examiner, NC Department of Health and Human Services.
[28] Injury and Violence Prevention Branch, NC Division of Public Health.
[29] CDC Fact Sheet "Understanding Suicide," 2015.

the full Child Fatality Task Force. These recommendations align with numerous goals and specific objectives identified in the 2015 NC Suicide Prevention Plan.

The core group presented the context for their work as common agreement among group members on the following:

- Death by suicide is preventable.
- Suicide is complicated.
- There is usually a combination of risk factors, no one precipitating event.
- Some population groups are at higher risk than others.
- Protective factors can balance risks.
- Intervention and supports are effective.
- There is no one prevention or intervention strategy

What follows are 4 legislative recommendations for youth suicide prevention with one related administrative recommendation. Other items on the 2017 CFTF Action Agenda, including items above pertaining to firearm safety and certain items in the "track and monitor" portion of the agenda, are also related to youth suicide prevention.

1. **Support legislation to require that all personnel in NC schools, including public charter schools, who have direct interaction with students receive annual mandatory training related to identifying and referring students who may be at risk of suicide, and that schools have in place a process for implementation of training, a protocol for risk referrals, and that the protocol is proactively communicated to students and families.**

- 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.
- This recommendation addresses the need to increase awareness of suicide risks among school personnel and to have a protocol for responding to risks.

The core group further defined the components of this recommendation as follows:

a. Training

- **DPI online training can satisfy requirement**: A two-hour evidence-informed online training module already being created by the Department of Public Instruction (DPI) in consultation with the Department of Health and Human Services (DHHS) and accessible through an existing DPI online framework would serve as a mechanism for meeting training requirements for personnel.
- **Training requirement can be met other ways:** Local school districts and charter schools would also have the option to comply with this training requirement by utilizing other training resources, but training must include certain major components, the details of which would be conveyed to local school districts and charter schools by DPI.

  Components of training should include:
  - 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.

b. Protocol

- **A model policy can be used to satisfy requirement**: Model suicide prevention policies and resources created by DPI in consultation with DHHS would be available for local school districts and charter schools to use in formulating their process for implementation of training and protocol for risk referrals.
- **Individual polices can also be used:** Local school districts and charter schools would not be required to utilize this model policy/protocol, but any other protocol developed must include certain major components, the details of which would be conveyed to local school districts and charter schools by DPI.

  Components of protocol should include:
  - A plan for accomplishing mandatory suicide prevention training for school personnel.
  - A plan to ensure more specialized training is received by student support personnel including administrators, school nurses, counselors, social workers, and psychologists.
  - Safety plan for the school in the event child is identified as being at risk and in the event of a suicide death or suicide attempt by a student.
  - Designation of a school Suicide Prevention Responder.
  - Safety plan for child in the event a child is identified as being at risk of suicide.
  - Communication with parents in the event an at-risk student is identified.
  - Safe transfer of at-risk child to parent/guardian.
  - Creation of a Student Help Plan.
  - Care plan for peers and staff impacted by suicide or suicide attempt by a student.
  - Plan for immediate assistance - 911 or IVC (involuntary commitment) when needed.
  - Plan for postvention and re-entry into the classroom the same day or next day for student.

c. Annual report of compliance: Local school districts and charter schools would be required to report annually to DPI their compliance with these mandatory training and protocol requirements. This can be accomplished through DPI adding one or more questions to the Healthy Active Children report and/or to other annual reports collected by DPI.

d. All school levels should be included in this requirement, elementary through high school.

e. Personnel defined: All personnel who have direct interaction with students includes but is not limited to the following: teachers, counselors, social workers, psychologists, administration, administrative assistants, School Resource Officers, teacher assistants, bus drivers, cafeteria workers, janitorial staff, media coordinators, coaches.

f. Timeline: This requirement should be in place by January 2018.

2. Support an increase in funding to the School Nurse Funding Initiative by $2.5 million recurring to add 50 school nurses in high-need communities to move toward meeting nationally recommended ratios; legislation allocating this funding to address a process for examining outcomes from adding more school nurses and the identification of relevant outcome measures.

- Currently, the nationally recommended ratio of school nurses per students is 1: 750. The North Carolina ratio (2015-16) is 1:1086. That ratio is approximately 592 nurses (FTEs) short of meeting the recommendation. Currently, 46 out of 115 school districts in the state meet the recommended ratio. A school nurse serves between 2 and 6 schools and may only be in a school for one-half day each week.[30]
- School nurses fill an important role in suicide prevention efforts in schools, while simultaneously addressing overall health and wellness of students, and the complex needs of medically fragile students. A national study concluded that school nurses spend 32% of their time providing mental health services to students.[31] School nurses may also screen for abuse or neglect.
- Most school nurses may be seen without an appointment (unlike many other non-teacher staff in schools) and there is generally no stigma associated with visiting a school nurse.
- The 2015-16 NC School Heath Services Survey revealed the following information regarding school nurse involvement with mental health and suicide counseling of students during that one-year period:[32]

	Elementary School	Middle School	High School
Known Suicide Attempts	32	186	451
Counseling by SN Related to Depression	636	1,806	2,694
Counseling by SN Related to Other Mental Health Issues	2,952	3138	4,556
Counseling by SN Related to Suicide Ideation	198	637	657

[30] Data source for these statistics: School Health Unit, NC Division of Public Health.

[31] Foster, S., Rollefson, M., Doksum, T., Noonan, D., Robinson, G., & Teich, J. (2005). *School Mental Health Services in the United States, 2002–2003*. DHHS Pub. No. (SMA) 05-4068. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health.

[32] Data source: School Health Unit, NC Division of Public Health.

How expanding the School Nurse Funding Initiative adds nurses to high-need communities:

The School Nurse Funding Initiative (SNFI) requires that funds be spent only on school nurses and where SNFI nurses are assigned, local school districts are not permitted to eliminate other school nurse positions (no supplanting). SNFI position allotments are determined through an allocation formula consisting of the following criteria:

School nurse to student ratio

Economic status of community

- Percent of students eligible for free/reduced meals
- "Low wealth" counties eligible for education supplement

Health needs of children

- Infant mortality rate
- Substantiated child abuse and neglect rate
- Mortality rates ages 1 – 19
- Percent of students with chronic illness
- Percent of county population that is racial minority

Academic need

- Student drop-out rate
- Percent of schools meeting academic growth targets

This formula should achieve assignment of additional nurse positions to areas where there is the greatest need. Increasing the number of school nurses in communities with the greatest need is a strategy to positively impact overall health and wellness of North Carolina children and their families, and may be viewed as a strategy to help meet Healthy 2020 goals.

3. Support an appropriation of $100,000 in recurring funds for a full-time School Social Worker Consultant to be housed in the Department of Public Instruction Student Support Services in order to provide coordination, training, support, and data collection for school social workers in North Carolina.

- Currently, there is no state level position at the Department of Public Instruction (or elsewhere) devoted to school social workers in North Carolina. There is, however, a state level position for school nurses, psychologists, and counselors.
- Without a state level position, the ability to coordinate training and resources, provide collaborative opportunities, technical support, or collect data related to efforts and outcomes of school social workers is limited or lacking.
- School social workers play a critical role in addressing many barriers children face in getting to school and achieving academic success, and they have an important role in suicide prevention. A School Social Worker Consultant at DPI would have a central role in the coordination of a mandatory suicide prevention training and protocol requirement in schools if enacted by the legislature (see first suicide prevention recommendation above).

4. **Support designation and appropriation for a three-year lead suicide prevention 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. Funding to go to DHHS to contract with appropriate non-agency organization to serve as backbone organization for this role; appropriation needed would be $125,000 per year for 3 years.**

Suicide prevention efforts in NC are facilitated and managed by government agencies, nonprofits, and academic institutions. 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 that various aspects of the plan are being carried out and reduce duplication;
- help ensure efficient use and sharing of limited resources.

The core group further defined the components of this recommendation as follows:

- Goals for this position 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.
- The lead individual/organization should be a non-agency designee.
- The position should be funded for three years with the expectation that work during those three years will include the determination of a sustainability plan for ongoing statewide coordination, including funding sources for ongoing statewide coordination.
- The lead individual should have specific expertise in suicide prevention.
- The lead individual should be affiliated with an organization able to provide project management and administrative support for carrying out the duties of the position.
- The lead individual should be an M.D. or PhD in order to have the scientific background to ensure that efforts in the state are driven by evidence-informed scientific research and who can translate research into effective practical application in North Carolina.

This legislative support recommendation has a related administrative (non-legislative) recommendation that takes into account the core group's recommended components (above) for this position:

If a lead suicide prevention position is funded, the CFTF Intentional Death Prevention Committee will work with the Division of DHHS who is tasked with the RFP for this role to determine the specifications of the RFP to effectively carry out the recommendations of the Intentional Death Prevention Committee.

Child Fatality Task Force
Harmful Substances Initiative

Harmful substances in the form of drugs, alcohol, tobacco, and other toxins have a **significant negative impact** on the health and well-being of North Carolina's children. In fact, numerous causes of death studied by the NC Child Fatality Task Force have a connection to harmful substances. Meanwhile, there are multiple physical, mental, and social problems that contribute to and/or result from substance use and misuse which are often **interconnected.** The CFTF Harmful Substances Initiative is meant to bring attention to this significant negative impact and to the interconnection of multiple problems to illustrate the need for **multiple policy solutions** to improve children's well-being and save lives.

This Harmful Substances Initiative was introduced in 2016, and the Child Fatality Task Force 2016 Annual Report further explains the negative impact and interconnected problems giving rise to this initiative.

Categories of negative impact include the following:

Child Welfare	Poisonings	Accidents	Infant Health	Youth Substance Use
Factor in child maltreatment and removal from home	Young children and teens accessing substances causing unintentional overdose or illness	Root or contributing cause of MV accidents and other unintentional injuries	Factor in low birthweight, prematurity, stillbirth, miscarriage, illness, developmental problems, SIDS	Accidents, suicide, violent crime, multiple impacts on mental and physical health

The need to approach issues surrounding substance misuse as a public health problem is critical. As experts and society have come to understand the disease of addiction and approach it as a public health issue requiring prevention and treatment similar to other diseases, effective solutions are within reach.

The Child Fatality Task Force has recommended and will continue to recommend multiple types of policy solutions to address harmful substances such as:

- **Preventing access** (e.g., Controlled Substances Reporting System, drug take-back and safe disposal, child-resistant packaging, etc.)
- **Prevention education** (e.g., support for programs and policies that educate individuals and professionals)
- **Intervention and treatment** (e.g., support for evidence-based intervention and treatment programs)
- **Poison First Aid** (e.g., overdose reversal drug naloxone; poison control centers)
- **Integrated systems** (collaboration and alignment among mental health, courts & law enforcement, public health, social services, community programs, academic institutions)

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. These sustained and strategic efforts have helped result in more than 15,000 child deaths being averted since creation of the CFTF.

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 State 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 that child fatalities from alleged maltreatment be reported to the State 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 to 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 Department 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 that have been 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 that 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 ten years of the Task Force's existence, the child death rate in North Carolina dropped approximately 20 percent. 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 '03-'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 eight 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 five years of age and less than 40 pounds in weight shall be properly secured in a rear seat, unless the child restraint system is designed for use with air bags. 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 eight 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 eight 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 eight 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 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 percent.

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 North Carolina 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 nonrecurring 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 twenty-one 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 (DSS) 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 9-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 that 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 five to nine. 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 than 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 for 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 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 DENR 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 that are higher than the national average and studies showing that 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 1 in 5 high school seniors in NC 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 to 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 4 causes of infant mortality in NC. The goal of You Quit Two Quit Program, which received $250,000 in nonrecurring funds, is to ensure that 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 NC 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 NC's battle to understand and react to the current opioid overdose epidemic. Prior to this technical change, the law required CSRS data purging at 6 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 6 years old, but instead of permanently discarding the data, it will now be maintained in a separate database so that 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.

Report from North Carolina Child Fatality Prevention Team

The North Carolina Child Fatality Prevention Team (known as the "State Team") is composed of nine ex officio and two appointed members, with the North Carolina Chief Medical Examiner serving as chair of the State Team and child fatality prevention staff from that office who support the work of the team.[33] This is a multidisciplinary team with members representing agencies including legal, social services, law enforcement, medical and mental health, education, and the public. The State Team reviews deaths attributed to child abuse and neglect as well as other means of deaths of children under the age of 18 years that are investigated by the North Carolina Medical Examiner System. The Child Fatality Prevention staff reviews all child fatalities in North Carolina that are investigated by the statewide Medical Examiner system. This includes approximately 500 child deaths per year.

Deaths investigated by medical examiners include apparent accidents, homicides, suicides, violent deaths, deaths occurring under suspicious circumstances, and sudden and unexpected deaths of children in apparent good health. Child fatality reviews provide a detailed analysis of factors that may have contributed to a child's death. The information gained from these reviews is used by the State Team for the purpose of making recommendations to the NC Child Fatality Task Force to support the creation of, or change in, laws, rules or policies in an effort to promote the safety and well-being of children in North Carolina.

Activities of the State Team with CFPT staff include the following:

- Periodic State Team meetings to review and discuss child fatality cases
- Review of local team recommendations
- Development of policy recommendations to submit to the NC Child Fatality Task Force
- Presentation of policy recommendations to the NC Child Fatality Task Force
- Refinement of process and timelines for recommendation development and submission
- Regular review and updating of the law enforcement investigation check list in an effort to collect the most detailed and pertinent information for each child death
- Maintaining a State Team Manual
- Maintaining a website to provide access and information to the community
- Providing specialized training in death scene reconstruction
- Providing data to prevention partners, the media, and researchers
- Providing state-wide child death investigation trainings
- Creating reports and presentations for a variety of relevant agencies and organizations focused on child well-being

[33] The State Team is part of the North Carolina Child Fatality Prevention System addressed in Article 14 of the North Carolina Juvenile Code, N.C.G.S. 7B-1400 through 1414.

- Creating new and strengthening existing relationships with child fatality prevention partners

2016 State Team Recommendations

In the fall of 2016, the State Team presented recommendations to the Child Fatality Task Force addressing the following policy matters:

1. **Implementation of a statewide suicide prevention access to means awareness plan at a population level to reduce access to means of suicide in order to decrease child deaths.** This recommendation had two components: a) implement a consistent evidence informed statewide provider education on Counseling on Access to Lethal Means (CALM), and b) establish a stakeholder group to implement a consistent education on safe storage of firearms campaign.

2. **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.**

3. **Support recommendations from the North Carolina Institute of Medicine's Task Force on Essentials for Childhood related to increasing and improving child care subsidies.** [The work of the Task Force on Essentials focuses on strategies to prevent child maltreatment, and this strategy related to child care subsidies is found in recommendation 6.1 of their 2015 report.]

DATA EXPLANATION AND AVAILABILITY

Reports and information for child fatality reviews are collected from public and confidential sources. The information collected by the CFPT can only be released in aggregate form.

At the time of publication of this report, some 2015 cases are pending which prevents the release of a full report from the State Team on 2015 child death data.

Detailed reports of child fatality data can be found at www.ocme.dhhs.nc.gov. Additional reports and data may be available by request by calling (919)743-9000.

Child Fatality Task Force
Contact Information and Leadership Structure

Leadership

Executive Director

Kella W. Hatcher
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Co-Chairs

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Buck Wilson, Public Health Director, Cumberland County
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Committees

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

Co-Chairs
Dr. Elaine Cabinum-Foeller, ECU TEDI BEAR Children's Advocacy Center at Brody School of Medicine
Michelle Hughes, Executive Director, NC Child

The **Perinatal Health Committee** focuses on the reduction of infant mortality with emphasis on perinatal conditions, birth defects, and SIDS.

Co-Chairs
Belinda Pettiford, Branch Head, Women's Health Branch, NC Division of Public Health
Dr. Sarah Verbiest, UNC-CH Center for Maternal and Infant Health

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
Councilmember Martha Sue Hall, City of Albemarle

NC Child Fatality Task Force Members

William Adkins, II
Public Member

Representative Marilyn Avila
NC House of Representatives

Senator Chad Barefoot
NC Senate

Senator Stan Bingham
NC Senate

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

Jimmy (Tony) Braswell
Chair, Johnston County Board of Commissioners
NC Assoc. of County Commissioners

Dr. Elaine Cabinum-Foeller
NC Pediatric Society

Brent Culbertson
Assistant Director
State Bureau of Investigation

Senator Don Davis
NC Senate

Dr. Ellen Essick
State Board of Education

Donna Fayko
DSS Director, Rowan County

Martha Sue Hall
Albemarle city Council
NC League of Municipalities

Senator Kathy Harrington
NC Senate

John P. Harris
Brevard Chief of Police

Representative Craig Horn
NC House of Representatives

Michelle Hughes
Executive Director, NC Child

Kevin Kelley
Section Chief, Child Welfare Services
Division of Social Services, NC DHHS

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

Sarah Kirkman
Conference of District Attorneys

Senator Joyce Krawiec
NC Senate

Representative Donny Lambeth
NC House of Representatives

Dana Mangum
Executive Director
NC Coalition Against Domestic Violence

Dr. Ben Matthews
Deputy Chief Financial Officer for Operations
NC Department of Public Instruction

Dr. Martin McCaffrey
Perinatal Quality Collaborative of NC
Public Member

Karen McLeod
CEO, Benchmarks
Child Advocate

Representative Gregory Murphy
NC House of Representatives

Dr. Deborah Radisch
NC Chief Medical Examiner

Representative Robert Reives, II
NC House of Representatives

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NC Division of Mental Health/Developmental Disabilities/Substance Abuse Services

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Gale Wilkins
Director
Council for Women & Youth Involvement

Dr. Randall Williams
Deputy Secretary Health Services
NC DHHS

Buck Wilson
Health Director, Cumberland County
NC Assn of Local Health Departments

***This list reflects membership as of December 2016**