

NORTH CAROLINA

Child Fatality Task Force

Annual Report to the Governor and General Assembly

April 2024 | Raleigh, NC







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

APRIL 2024
The Honorable Roy Cooper, Governor, State of North Carolina
Distinguished Members of the North Carolina General Assembly

We are pleased to submit this year's annual report of the Child Fatality Task Force, which comes with good news of progress made on several Child Fatality Task Force priorities. It also presents data and recommendations showing that there is much work to be done to prevent child deaths and protect the well-being of North Carolina's children.

In 2023, several long-time recommendations of the Task Force were addressed in legislation that became law, including: changes in laws and new funding to strengthen the statewide child fatality prevention system; changes to strengthen infant safe surrender laws; a new law to launch a statewide firearm safe storage education and awareness initiative; and new funding to prevent sleep-related infant deaths. The Task Force also saw success in 2023 on more recent recommendations for Medicaid funding to promote healthy birth outcomes and for funding to enable comprehensive toxicology testing for child deaths. There was also partial progress with funding for more school nurses, social workers, counselors and psychologists and to prevent harm from tobacco and nicotine use.

Unfortunately, the latest finalized child death data from 2022 shows an increase in the rate of child deaths overall as well as a stagnant infant mortality rate. 2022 data show persistent disparities with Black infants dying at rates more than 2.5 times the rate of white infants. In 2022, the youth suicide rate decreased, however there were increased rates of homicide with continued high rates of firearm-related deaths overall. There were also increased rates of deaths from various unintentional injuries and from medical conditions and illnesses.

Task Force legislative recommendations for 2024 encompass strategies to prevent youth suicide and support youth mental health, to prevent deaths and injuries from firearms, to ensure healthy birth outcomes and infancy, and to prevent child abuse and neglect. This year's Action Agenda also includes administrative (non-legislative) items signifying the Task Force's intention to further study certain topics including: paid family leave insurance; fentanyl-related deaths to children and adolescents; and the rise in congenital syphilis.

It's very disturbing to see child death rates in North Carolina rise for the second year in a row and to see that our State's infant mortality rate is among the highest in the nation. The fact that so many of these deaths are preventable means that we can and must persevere to prioritize changes in laws and funding that will save kids' lives.

North Carolina leaders have demonstrated many times since the creation of the Task Force in 1991, and especially most recently in 2023, a willingness to be responsive to Task Force recommendations aimed at preventing child deaths and promoting child well-being. We hope to see this kind of responsiveness continue as we work together to make North Carolina a safer and healthier place for our infants, children, and teens.

Sincerely,

Karen McLeod
CO-CHAIR

Jill Cox
CO-CHAIR

Kella Hatcher
EXECUTIVE DIRECTOR

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Executive Summary

Task Force Meetings that Led to the 2024 Action Agenda

The Task Force **approved 8 legislative recommendations** for inclusion on its 2024 Action Agenda aimed at changing laws and policies to prevent child deaths, prevent child abuse and neglect, and promote child well-being.

The Task Force also **included 3 administrative (non-legislative) efforts** on its 2024 Action Agenda that involve further study and collaboration on issues of interest to the Task Force.

KEY STATS
Meetings took place between **9/21/23 and 2/29/24**
9 committee meetings
3 meetings of the full Task Force
Presentations by experts and leaders from **30 organizations**
25+ topics addressed

2024 Legislative Recommendations

2024 LEGISLATIVE RECOMMENDATIONS	HIGHLIGHTED DATA & INFORMATION SUPPORTING RECOMMENDATIONS
Recurring funding for more school nurses, social workers, counselors & psychologists	• One in 5 NC high school students has seriously considered suicide and 1 in 10 has made a suicide attempt; 43 percent say they feel sad or hopeless. • These school professionals play a critical role in supporting student mental health through identification of needs, counseling, and making connections to needed services. • Numbers of these professionals in NC are far below national recommendations, e.g., NC needs 4 times the number of school social workers it has now to meet those recommendations.
Legislation to address addictive algorithms in social media	• One-quarter of adolescents perceive that they are “moderately” or “severely” addicted to social media. • Frequent social media use may be associated with changes in the developing brain; kids who spend more than 3 hours a day on social media face double the risk of poor mental health. • Many experts and national organizations are expressing concern and issuing advisories about the impact of social media on youth mental health.
Recurring funding for the NC S.A.F.E. firearm safe storage education and awareness campaign **Legislation to strengthen the law addressing safe storage of firearms to protect minors**	• Rates of firearm deaths and injuries to kids increased significantly in recent years; firearms are the lethal means used in the majority of youth suicides and homicides in North Carolina. • From 2013 to 2022 there have been more than 680 firearm-related deaths among NC kids ages 0 to 17. • More than half of all gun owners store at least one gun unsafely and most guns used in youth suicide and school shootings come from home. • NC’s current child access prevention law applies only to a gun owner or one possessing a gun who “resides in the same premises as a minor,” whereas the recommended change from the Task Force would no longer limit application of the law to those who reside with a minor.
Recurring funding for the NC Office of Violence Prevention	• Preventing violence, including firearm violence, involves a public health approach that leverages collaboration among a variety of state and local organizations and experts. • The new NC Office of Violence Prevention is positioned to be a conveyor, connector, and collaborator in violence prevention efforts across North Carolina. • This office was created by Executive Order and is at risk of being discontinued if not sustained as a permanent organization.
Funding to enable Medicaid reimbursement of doula services	• North Carolina’s infant mortality rate is the tenth highest among states in the nation (according to latest data in 2021). • Disparities persist. For example, the mortality rate of Black infants is more than 2.5 times the rate of white infants. • Doula services are known to produce better birth outcomes and reduce disparities and Medicaid funding is needed to expand use of doulas.

Legislation addressing Fetal & Infant Mortality Reviews (FIMRs)	• Fetal & Infant Mortality Reviews seek to improve systems that can prevent future fetal and infant deaths and reduce disparities. • There are approximately 146 FIMR programs in the U.S. but only one in NC, whose ability to do effective reviews is limited without FIMR legislation in NC. • FIMR legislation recommended by the Task Force would enable and support information access and protection for FIMR teams that is needed to perform effective reviews and encourage the establishment of more FIMRs in NC.
Expansion of funding for early child care system, including subsidies	• The child care industry is in crisis and is at risk of falling into a deeper crisis when federal funding used to sustain it ends in June of 2024. • Ensuring access to affordable, quality child care is a recognized strategy to support overall child and family well-being, including the prevention of child maltreatment. • Quality early care positively impacts the brain development of young children; investments in early care and learning have a high rate of economic return.
2024 ADMINISTRATIVE EFFORTS ON 3 TOPICS FOR FURTHER STUDY AND COLLABORATION (NON-LEGISLATIVE)	• Congenital syphilis • Paid family leave insurance • Fentanyl-related child deaths

New Laws and/or Funding Resulting from the 2023 Legislative Session that Addressed Nine Task Force Recommendations:

- Law to launch a statewide firearm safe storage education and awareness initiative
- Laws and funding to strengthen the statewide Child Fatality Prevention System
- Laws to strengthen infant safe surrender
- Funds to prevent sleep-related infant deaths
- Funds to enable comprehensive toxicology testing in medical examiner jurisdiction child deaths
- Some funding for more school nurses, social workers, counselors and psychologists
- Medicaid funding for group prenatal care incentives
- Medicaid funding to increase maternity care provider reimbursement rates
- Funding for programs to prevent harms from tobacco and nicotine use

Highlights of 2022 Child Death Data Facts & Trends

In 2022, 1,474 North Carolina children ages 17 or younger died. The rate of child deaths overall in 2022 was 64.2 per 100,000 NC children ages 0 to 17, which is an 8% increase over the 2021 rate of 59.6, and the highest rate recorded since 2009.

The 2022 infant mortality rate remained unchanged from the 2021 rate. At 6.8 deaths per 1,000 births, this rate has been stagnant in recent years and has kept North Carolina among the 10 highest infant mortality rates among states (although final infant mortality rates for 2022 by state have not been released yet). Prematurity/ low birthweight and birth defects were the leading causes of infant death in North Carolina in 2022, which was typical in other years as well.

Racial/ethnic disparities in death rates persist. From 2014 to 2022, Non-Hispanic Black & American Indian children consistently had higher mortality rates compared to other racial/ethnic groups. In 2022, nearly four in 10 child deaths were among Black children. Black infants die at rates more than two times higher than white infants.

Looking at mortality rates for age groups from 2021 to 2022, rates increased among children ages 1 to 4, ages 5 to 9, and ages 10 to 14 and decreased for ages 15 to 17. The largest increase occurred among younger children ages 1 to 4 who experienced a 59% increase in mortality rates from 2021 to 2022 and a 43% increase since 2013. Although rates for teens ages 15 to 17 decreased from 2021 to 2022, death rates have increased among this age group since 2013.

In 2022, among non-infant children ages 1 to 17, injuries were the leading cause of death, accounting for 52% of deaths among this age group. The top four leading causes of death in this age group were unintentional injuries unrelated to motor vehicle accidents, motor vehicle-related injuries, homicides, and suicides.

The youth suicide rate decreased in 2022, however, youth suicide rates have increased generally over the past 20 years in both the US and North Carolina. The rate in 2022 was 4.5 deaths per 100,000 NC children ages 10 to 17, whereas the rate in 2021 was 5.8 and the rate in 2020 was 5.1. Older teens ages 15 to 17 comprise about two-thirds of suicide deaths. **Firearms were the lethal means used in 54% of youth suicides in 2022.**

The homicide rate for NC children has continued to increase. Over the last decade, homicide rates have increased in both North Carolina and the US. However, while North Carolina rates typically mirrored national figures, in both 2020 and 2021 North Carolina rates were higher than US rates; US rates for 2022 are not yet available for comparison. North Carolina's homicide rate of 4.4 in 2022 was higher than the 2021 rate of 4.1 and more than double the rate in 2013 (1.8). Older teens ages 15 to 17 consistently account for the largest proportion of homicide deaths, comprising 57% of all child homicides in 2022. **72% of all child homicides involved firearms.** Among teens ages 15 to 17, 95% of homicides were firearm-related.

Rates of **accidental poisonings** increased again in 2022. Among 2022 poisoning deaths, two-thirds (67%) involved adolescents ages 15 to 17. Nearly all (94%) noted fentanyl in the literal cause(s) of death (either alone or in combination with other drugs).

Drowning deaths have increased slightly, moving from a rate of 0.9 in 2021 to a rate of 1.3 in 2022 (44% increase). The age group with the most drowning deaths is 1- to 4-year-olds.

In 2022, the rate of child deaths from medical conditions or illnesses increased, accounting for one in five child deaths. From 2013 to 2021, this rate has fluctuated with a low of 9.6 per 100,000 North Carolina children in 2020 and a high of 11.9 in 2015. But in 2022, the rate was 13.1. Medical conditions with increased rates for 2022 included malignant neoplasms (cancer), septicemia, cerebrovascular diseases, pneumonia/influenza, and other respiratory diseases. Additionally, in 2022, **Covid-19 was recorded as the underlying cause of death for 16 children** ages 1 to 17, making it the 8th leading cause of death among non-infant children. For comparison, in 2020, there was 1 Covid-19 related child death recorded and in 2021 there were 14 deaths with a primary cause of death related to Covid.

NC Child Fatality Task Force Mandate and Study Process

Task Force Background and Purpose

The North Carolina Child Fatality Task Force (CFTF or "Task Force") derives its authority from Article 14 of the North Carolina Juvenile Code. The Task Force is connected to the broader statewide Child Fatality Prevention System created in 1991. This system also has multidisciplinary teams across the state that review individual cases of child deaths in an effort to better understand these deaths and identify and address gaps or deficiencies in systems that can prevent child deaths and maltreatment. The Task Force is focused on data and policy and does not conduct individual case reviews.

The Task Force studies and reports on data related to child deaths, hears from experts and agency leaders about evidence-driven prevention strategies and prevention programs, receives information and recommendations from teams who review child deaths, and engages in discussion to formulate recommendations submitted annually to the governor and North Carolina General Assembly. These recommendations are aimed at the prevention of child death and maltreatment and at supporting the safety and well-being of children.

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

Task Force Study Process, Issues of Focus, and Expert Presenters

Task Force work is accomplished through three committees who meet to hear presentations, engage in discussion, and prepare recommendations for consideration by the full Task Force. Committee participants include Task Force members as well as volunteers with subject matter expertise in the committee's area of focus.

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

The **Perinatal Health Committee** studies issues surrounding infant mortality by addressing healthy pregnancies, birth outcomes, and infants.

The **Unintentional Death Prevention Committee** studies accidental injury and death – such as those related to motor vehicle accidents, fire, poisoning, drowning, firearms, and more.

Committee recommendations only become Task Force recommendations once approved by the full Task Force. During its most recent study cycle, the Task Force had a total of 12 meetings, including nine committee meetings and three meetings of the full Task Force. Over the course of these 12 meetings, which took place from September 21, 2023 to February 29, 2024, the Task Force addressed more than 25 topics. Representatives from about 30 organizations covering a range of expertise presented or served as a panelist in meetings of the full Task Force and/or one of its committees.

Agendas, minutes, and presentations for all Task Force meetings and committee meetings can be found on the Task Force website which is hosted on the website for the NC General Assembly: https://sites.ncleg.gov/nccftf/

Topics addressed in meetings during the 2023/24 study cycle

General Topics

- Updates from 2023 legislative session
- Child death data trends
- Equitable access to health care and health outcomes
- Recommendations from State Child Fatality Prevention Team

Preventing infant deaths and promoting healthy birth outcomes

- Expanding Medicaid coverage of doulas
- Fetal and Infant Mortality Reviews
- Congenital Syphilis
- Implementation of law allowing contraceptive access via pharmacists

Suicide prevention and supporting youth mental health

- Update on school supports for mental health
- Access to mental health services for youth in the community
- Data on youth suicide and self-harm
- The impact of social media on youth mental health
- Legislative efforts addressing addictive social media algorithms
- Department of Justice lawsuit against Meta
- Spending plans for recently appropriated behavioral health funds

Preventing firearm deaths and injuries

- Firearm safe storage
- NC Office of Violence Prevention
- Data on firearm deaths and injuries to youth
- NC S.A.F.E. media campaign on safe firearm storage
- NC child access prevention law

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

- Paid Family Leave Insurance
- Child care crisis and funding
- Updates on child abuse and neglect recognizing and reporting training for health care providers

Harmful substances

- Child deaths related to fentanyl poisoning
- Tobacco/nicotine use among youth

Motor vehicle safety

- Child passenger safety laws
- Legislative changes impacting teen drivers

NOTE about 2022 child death data: The Task Force typically examines in its meetings the most recent child death and infant mortality data released by the North Carolina State Center for Health Statistics. For the meetings that took place in the recent study cycle, the most recent data (from 2022) was not yet available for examination. The 2022 child death data report is now available and is included in this report. More details about child death and infant mortality data can be found on the website for the State Center for Health Statistics:

- 2022 child death data
- 2022 infant mortality data

Experts and leaders presenting or serving as panelists in Task Force and committee meetings during this study cycle represented state and local agencies and academic institutions as well as state, national, and community programs with a range of expertise:

- Benchmarks, NC (President & CEO)
- Chatham County Department of Social Services (Director)
- Child Advocacy Centers of NC (Director of Clinical Services)
- City of Brevard Police Department (Police Chief)
- Department of Psychology and Neuroscience & Developmental Social Neuroscience Lab, UNC Chapel Hill (Faculty & Lab Director)
- Division of Child Development and Early Education, NC Department of Health & Human Services (Director)
- Division of Juvenile Justice, NC Department of Public Safety (Deputy Secretary & Dir. of Analysis)
- Field Services Unit, NCDHHS Division of Public Health (Medical Director)
- Guilford County Health Department & FIMR Program (FIMR Coordinator)
- Healthy Schools and Specialized Instructional Support Office of Academic Standards, NC Department of Public Instruction (Section Chief)
- Injury & Violence Prevention Branch, NCDHHS Division of Public Health (Epidemiologist)
- Injury Prevention Research Center, UNC Chapel Hill (Director)
- Kate B. Reynolds Charitable Trust (President)
- Maternal Health Branch, NCDHHS Division of Public Health (Branch Head)
- MomsRising Together & Moms Rising Education Fund (Senior Campaign Director)
- National Center for Fatality Review and Prevention (FIMR Director)
- NC Conference of District Attorneys (Child Abuse Resource Prosecutor)
- NC Department of Justice, Attorney General (Deputy Chief of Staff)
- NCDHHS Division of Child and Family Well Being (Child Behavioral Health Manager)
- NC Medicaid, NCDHHS Division of Health Benefits (Director of Pharmacy and Ancillary Services)

- NC Office of Violence Prevention, NC Department of Public Safety (Executive Director)
- Office of the Chief Medical Examiner, NCDHHS Division of Public Health (Chief Toxicologist and Chief Medical Examiner)
- State Child Fatality Prevention Team (Coordinator)
- Student Engagement and Support Services, Orange County Schools (Director)
- Tobacco Control Branch, NCDHHS Division of Public Health (Director of Policy & Programs)
- UNC Eshelman School of Pharmacy (faculty)
- Women, Infant, and Community Wellness Section, NCDHHS Division of Public Health (Section Chief)
- Young People's Alliance (Executive Director)

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

Data and evidence studied by the Task Force is contained in presentations made by subject matter experts during meetings of the Task Force and its committees. Meetings are open to the public and presentations are posted on the Task Force website. Data shared in Task Force meetings is regularly used by individuals and organizations external to the Task Force whose work relates to child well-being. Task Force data and recommendations are also frequently reported by news organizations who attend Task Force meetings and/or follow Task Force work.

The work of the Task Force, its recommendations, and the supporting data that led to the recommendations is also shared widely by the Task Force Executive Director and other Task Force leaders through various communication channels throughout the year. These leaders participate in a broad range of state-level committees, advisory groups, and initiatives where they have formal and informal opportunities to educate about Task Force data and recommendations.

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

Changes Coming to Child Fatality Task Force Process & Reporting

As explained in this report on page 8, in 2023 the General Assembly passed legislation that addressed Task Force recommendations to strengthen the statewide Child Fatality Prevention System. This legislation formalizes some of the current functioning of the Task Force with respect to its committee structure, leadership, policies and procedures, and in these respects does not significantly change Task Force functioning. However, the legislation puts new requirements on the Task Force related to studying data, such as aggregate data collected from local child death review teams, and requires the Task Force to report on the functioning of the whole Child Fatality Prevention System (not just the Task Force) based on information received from a new State Office of Child Fatality Prevention (State Office). Task Force work related to these new requirements will take place after a State Office is operational and aggregate data is being collected from local teams, which will not happen until 2025.[1]

EXTENDING OUR THANKS!

Many thanks to Task Force Members, contributing experts, and community volunteers who devoted their time and expertise to Task Force work during the past year. Their efforts and commitment to protecting the children of North Carolina are reflected in the 2024 Action Agenda and the 2023 Accomplishments contained in this report.

[1] TECHNICAL ERROR IN EFFECTIVE DATES: Section 9H.15 of the 2023 Appropriations Act, which enacted changes to the Child Fatality Prevention System, incorporates the language of HB 862 but incorrectly stated timelines from HB 862 for effective dates of certain provisions. Section 9H.15.(i) of the Appropriations Act left out language from line 18 of page 16 of HB 862v2 that makes January 1, 2025, the effective date for a large part of the bill, instead making those provisions effective when the Appropriations Act becomes law which was October 3rd, 2023. This error created contradictions in the laws making implementation on this timeline impossible. As of the writing of this report, a technical correction in legislation is being sought to resolve this error to make the effective dates those set out in HB 862, and the NC General Statutes Commission has voted to recommend to the General Assembly that this correction be made.

2023 Child Fatality Task Force Accomplishments and Initiatives

In 2023, significant progress was made in advancing Task Force recommendations and initiatives to save children's lives and support their well-being. What follows is an explanation of progress made in various areas of Task Force work.

New law to launch a statewide firearm safe storage education and awareness initiative: Child deaths related to firearms increased dramatically in 2020 and 2021. Firearm injuries became a leading cause of death for children and THE leading cause of injury death, surpassing deaths from motor vehicle crash injuries. Legislation to launch a statewide firearm safe storage awareness initiative to educate the public about the safe storage of firearms became law after several years of seeing only partial progress on this CFTF recommendation. While requirements for the initiative largely reflect the CFTF recommendations, there was no funding included for the initiative which had been part of the CFTF recommendation. **Additional progress on firearm safety was made** when the Department of Public Safety identified one year of funding to implement a safe storage media campaign, "NC S.A.F.E.," which was informed by CFTF work surrounding firearm safety and launched in the spring of 2023.[2]

New laws and funding to strengthen the statewide Child Fatality Prevention System: Beginning in 2018, there was significant study and stakeholder engagement to assess ways to improve the statewide child fatality prevention system which resulted in a set of CFTF recommendations in 2019. These recommendations became law in 2023, as a bill addressing these recommendations, HB 862, was included in the final 2023 Appropriations Act, S.L. 2023-134. Most of the changes to the system that will take place will not occur until 2025. **The legislation addresses CFTF recommendations to strengthen the current system in these primary ways:**

- It restructures components of the system to reduce the number and types of teams performing fatality reviews to eliminate duplication of reviews and ensure quality reviews at the local level.

THE TASK FORCE SAW GREAT PROGRESS IN 2023 with advancing laws, funding, and initiatives to save kids' lives.

- It dramatically improves the collection, analysis, and reporting of information learned from team reviews of child deaths by joining 48 other states who have used a free national data system specifically created to support child death review teams in collecting and reporting information (the National Fatality Review Case Reporting System).
- It brings together state-level staff to work in a State Office of Child Fatality Prevention to coordinate whole system efforts and provide increased guidance, technical assistance, and data support to ensure effective local team reviews and ensure that their recommendations reach leaders who can react to prevent future deaths.
- It provides funding to support the work of the new State Office as well as some funding to be distributed to local review teams.
- It reduces the volume of required team reviews to ensure that limited system resources are devoted to doing quality reviews of certain categories of deaths most in need of a review.
- It ensures that federally required Citizen Review Panels (CRP) are structured in a way that will meet the intended purpose of panels to examine policies, procedures, and practices of state and local child protection agencies and evaluate agencies' effectiveness in discharging child protection responsibilities.

[2] Note on legislation addressing firearm safety initiative: Companion bills HB 72 and SB 67 addressed this Task Force recommendation in 2023; language from these bills was added to another bill, SB 41, which became law as SL 2023-8 after a veto override (Governor Cooper vetoed the bill due to its inclusion of other provisions addressing gun laws, including a repeal of the pistol purchase permit requirement). The only provisions in SL 2023-8 that relate to CFTF recommendations are those addressing the firearm safe storage initiative.

- It formalizes the long-standing committee structure of the Child Fatality Task Force and expands the content and recipients for Task Force annual reports.

New laws to strengthen infant safe surrender: The CFTF's long-time recommendations to strengthen infant safe surrender laws to make it more likely the laws would be used to prevent harm and deaths to newborns became law in 2023. The CFTF's recommendations, addressed in the new laws, sought to: strengthen protections of the surrendering parent's identity because a parent who believes that their identity has protections is more likely to use the law; provide information to a surrendering parent regarding consequences, rights, and options related to safe surrender (previously, no information was required to be provided to the surrendering parent); remove the option to surrender an infant to "any adult" as this option in the current law raised concerns about human trafficking and unlawful custody transfer; and incorporate provisions to ensure that protections offered by the law are only applied when safe surrender criteria are met.[3]

New funding to prevent sleep-related infant deaths: NC loses over 100 infants each year who die in unsafe sleep environments. The CFTF recommended additional funding for programs to prevent these deaths with a goal for total funding of $250K recurring annually. Legislation that included $250K in additional nonrecurring funding for this purpose became law.

Funds to enable comprehensive toxicology testing in all medical examiner jurisdiction child deaths: The CFTF heard from the North Carolina Office of the Chief Medical Examiner that due to lack of resources, North Carolina does less toxicology testing on children with an established cause of death than any other state and that without comprehensive toxicology testing on certain case types, there may be missed opportunities to determine contributing factors to a fatality. The CFTF recommended funding for this purpose, which was included in the final 2023 Appropriations Act.

Some recurring funding for more school nurses, social workers, counselors and psychologists: With increases in youth suicides and a crisis in youth mental health, an important area of prevention identified by the CFTF and others has been the role of schools. The CFTF recommended recurring funding for more school nurses, social workers, counselors, and psychologists to work toward meeting nationally recommended ratios because NC currently falls far short of meeting national recommendations. The final 2023 Appropriation Act included nonrecurring funding for about 120 more of these positions (a small fraction of what is needed to approach national recommendations, and nonrecurring funding is insufficient). Other organizations besides the CFTF were also advocating for funding for more of these professionals.

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

Funding for programs to prevent harms from tobacco and nicotine use: Student surveys show that about one in four North Carolina high school students uses e-cigarettes, which can contain high doses of nicotine, which is highly addictive and can harm adolescent brain development. Nicotine is also toxic to developing fetuses and impairs fetal brain and lung development; tobacco use during pregnancy is associated with leading causes of infant death. The Task Force endorsed the efforts of others seeking $17 million in recurring funding to prevent harm to youth and infants caused by tobacco and nicotine use. The final 2023 Appropriations Act included $11.25 million in nonrecurring funds for years one and two, most of which is to be used to fund evidence-based electronic cigarette and nicotine dependence prevention and cessation activities targeting students in grades 4 through 12.

[3] Note about safe surrender legislation: One of two bills originally addressing safe surrender in 2023, SB 20, saw a legislative journey resulting in a Proposed Conference Committee Substitute (PCCS) that was a different bill; all but 10 pages of the 46-page PCCS were devoted to topics unrelated to infant safe surrender and after passing each chamber on a divided vote, the bill was vetoed by Governor Cooper due to provisions changing abortion laws. The veto was overridden, and SB 20 became law as SL 2023-14. The CFTF has not studied or made any recommendations related to abortion.

Statewide Child Fatality Prevention System Summit: On March 30th, 2023, a full-day child fatality prevention system summit was held at the Friday Center in Chapel Hill, hosted by UNC's Jordan Institute for Families in partnership with the NC Department of Health and Human Services. The summit's planning committee was led by the Director of the Jordan Institute and the Executive Director of the Child Fatality Task Force, and the committee included a variety of individuals with significant roles in the Child Fatality Prevention System. The summit brought together professionals from across the state who work in the CFP system to learn from experts, including four national experts, and one another about ways to optimize their work to prevent child deaths and strategies to take care of themselves. There were about 235 participants, with almost 70% of them participating in-person and the rest participating in morning plenary sessions virtually. Participant evaluations of the summit were overwhelmingly positive.

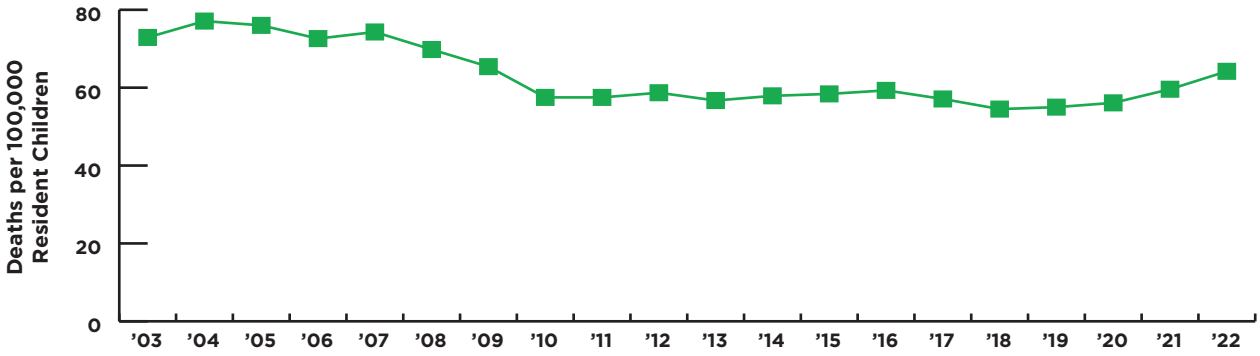
Success with lead suicide prevention coordinator: A multi-year administrative item on the Task Force agenda was to promote creation of a lead suicide prevention coordinator role for the state. This recommendation succeeded when the North Carolina Department of Health and Human Services in collaboration with the UNC Suicide Prevention Institute hired a state suicide prevention coordinator in 2023 who works jointly between the two organizations to help coordinate a broad range of suicide prevention work.

Progress strengthening child abuse and neglect reporting education for health care professionals: A multi-year administrative item on the Task Force agenda was to strengthen education and awareness surrounding child abuse and neglect recognizing and reporting for health care professionals (among other professionals). Efforts continued in 2023 to develop this training, which involved collaboration with: members of the NC Pediatric Society's Committee on Child Abuse and Neglect that includes medical experts in child abuse; experts in child protective services from the NCDHHS Division of Social Services; the Child Abuse Resource Prosecutor with the NC Conference of District Attorneys; the CEO of Prevent Child Abuse NC; and the Child Fatality Task Force Executive Director. The training has begun to be delivered to health care professionals this year through efforts of the NC Pediatric Society and others.

2022 Child Death Data Report

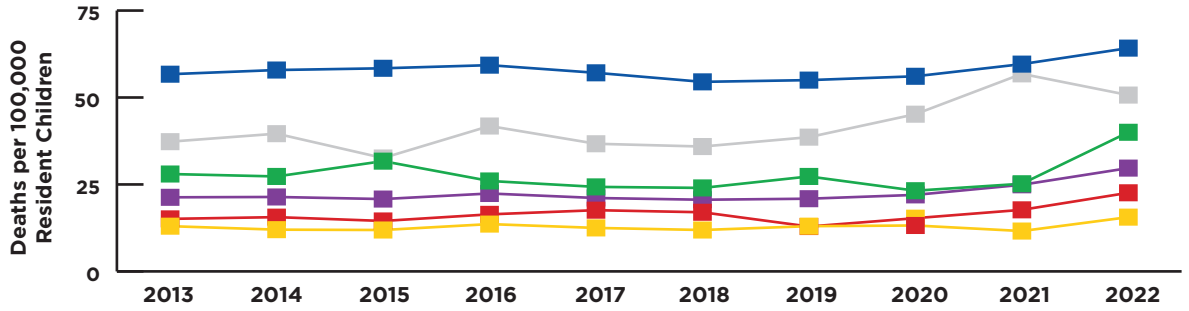
This report was produced by the NCDHHS Division of Public Health - Title V Office
in conjunction with the State Center for Health Statistics

Figure 1. 2003-2022 Trends in North Carolina Resident Child Death Rates Ages Birth Through 17 Years



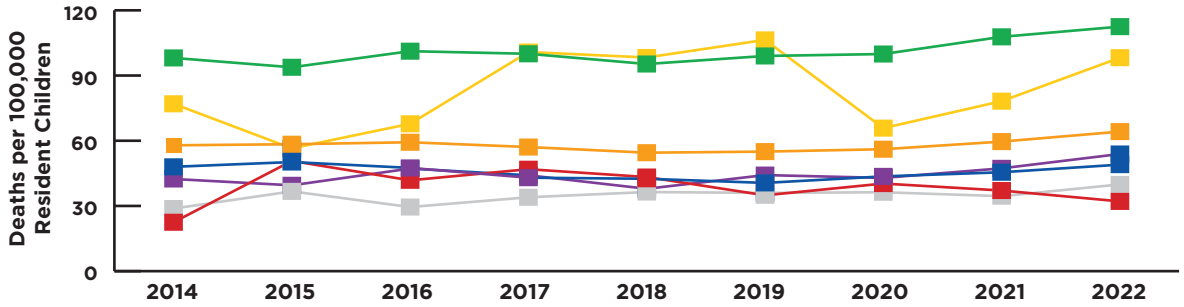
2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
72.9	77.1	76.0	72.6	74.3	69.8	65.4	57.5	57.5	58.7	56.7	57.9	58.4	59.3	57.1	54.5	55.0	56.1	59.6	64.2

Figure 2. 2013-2022 Trends in North Carolina Resident Child Death Rates† by Age Group



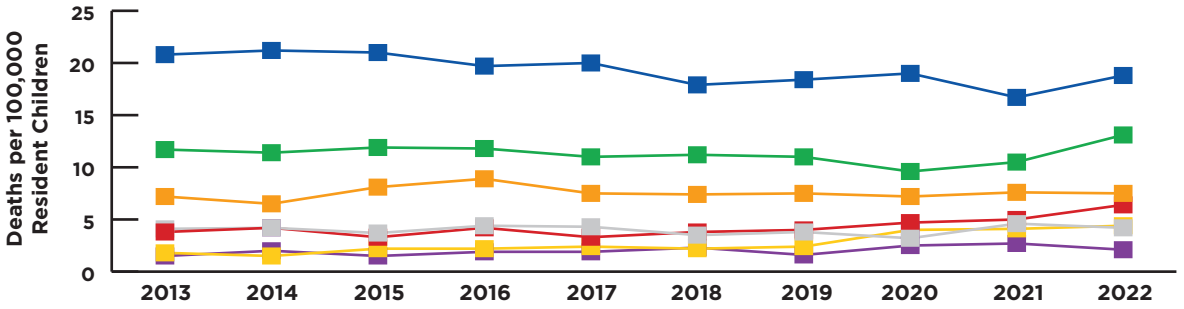
	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Total Ages 0-17	56.7	57.9	58.4	59.3	57.1	54.5	55.0	56.1	59.6	64.2
... Ages 1-4	28.0	27.3	31.7	26.0	24.3	24.0	27.3	23.2	25.2	40.0
... Ages 5-9	13.0	12.0	11.9	13.6	12.5	11.9	13.0	13.2	11.6	15.6
... Ages 10-14	15.1	15.6	14.5	16.4	17.6	17.0	12.9	15.3	17.7	22.6
... Ages 15-17	37.3	39.6	32.6	41.8	36.7	35.9	38.6	45.2	56.8	50.7
... (Exc. Infants) Ages 1-17	21.3	21.4	20.8	22.4	21.1	20.6	20.9	22.0	24.9	29.7

Figure 3. 2014-2022 Trends in North Carolina Resident Child Death Rates† by Race*/Ethnicity, Ages Birth Through 17 Years



	2014	2015	2016	2017	2018	2019	2020	2021	2022
Total	57.9	58.4	59.3	57.1	54.5	55.0	56.1	59.6	64.2
NH White	48.0	50.2	47.5	43.0	42.5	40.6	43.6	45.5	49.0
NH Black	98.1	93.8	101.2	100.0	95.3	99.0	99.9	107.8	112.5
NH American Indian	77.0	56.5	67.8	100.8	98.3	106.4	65.8	78.2	98.2
NH Asian/Pacific Islander	22.5	50.7	41.8	46.9	43.3	34.9	40.3	37.1	32.1
NH Multiracial	28.8	36.7	29.5	34.0	36.4	36.0	36.3	34.5	39.9
Hispanic	42.4	39.5	47.2	44.1	37.9	44.2	42.9	47.3	53.9

Figure 4. 2013-2022 Trends in North Carolina Resident Child Death Rates† for Selected Causes of Death, Ages Birth Through 17 Years



	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Birth Defects	7.2	6.5	8.1	8.9	7.5	7.4	7.5	7.2	7.6	7.5
Perinatal Conditions	20.8	21.2	21.0	19.7	20.0	17.9	18.4	19.0	16.7	18.8
Medical Conditions/ Illnesses	11.7	11.4	11.9	11.8	11.0	11.2	11.0	9.6	10.5	13.1
Motor Vehicle Injuries	3.8	4.2	3.7	4.4	4.3	3.5	3.8	3.2	4.6	4.2
Other Unintentional Injuries	4.1	4.2	3.3	4.2	3.3	3.8	4.0	4.7	5.0	6.4
Homicide	1.8	1.5	2.2	2.2	2.4	2.2	2.4	4.0	4.1	4.4
Suicide	1.5	2.0	1.5	1.9	1.9	2.3	1.6	2.5	2.7	2.1

† Child death rates prior to 2022 have been recalculated using the latest available population data

* Caution: Racial categories have changed from prior years and now reflect single race categories & multi-race. Comparisons with prior reports are not advised. | NH=Non-Hispanic

Table 1. 2020 NC Resident Child Deaths By Age Group & Cause of Death

	TOTAL AGES 0-17		AGE GROUP (years)									
			Infants		1-4		5-9		10-14		15-17	
Cause of Death Category:	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Perinatal Conditions	**432**	**29.3**	**427**	**98.8**	**4**	**0.9**	**0**	**0.0**	**1**	**0.2**	**0**	**0.0**
... Short Gestation/Low Birthweight	136		135		1		0		0		0	
... Maternal Complications	89		88		1		0		0		0	
... All Other Perinatal Conditions	207		204		2		0		1		0	
Medical Conditions	**301**	**20.4**	**72**	**23.9**	**69**	**22.9**	**57**	**18.9**	**63**	**20.9**	**40**	**13.3**
... Malignant Neoplasms (Cancer)	48		2		12		16		11		7	
... Heart Disease	28		10		2		4		7		5	
... Chronic Lower Respiratory Diseases	8		1		0		2		3		2	
... Septicemia	14		3		4		6		1		0	
... Pneumonia/Influenza	14		5		6		1		2		0	
... Coronavirus Disease (COVID-19)	17		1		4		2		7		3	
... All Other Medical Conditions	172		50		41		26		32		23	
Birth Defects	**171**	**11.6**	**134**	**78.4**	**17**	**9.9**	**4**	**2.3**	**12**	**7.0**	**4**	**2.3**
... Circulatory System	53		38		9		2		4		0	
... Nervous System	22		12		2		0		5		3	
... Respiratory System	4		4		0		0		0		0	
... All Other Birth Defects	92		80		6		2		3		1	
Motor Vehicle Injuries	**97**	**6.6**	**4**	**4.1**	**18**	**18.6**	**19**	**19.6**	**20**	**20.6**	**36**	**37.1**
Other Unintentional Injuries	**147**	**10.0**	**36**	**24.5**	**44**	**29.9**	**12**	**8.2**	**19**	**12.9**	**36**	**24.5**
...Suffocation/Choking/Strangulation	42		31		7		1		3		0	
...Drowning	29		0		14		4		8		3	
...Poisoning	33		1		7		0		3		22	
...Bicycle	1		0		0		0		0		1	
...Firearm	9		0		5		0		2		2	
...Smoke, Fire & Flames	6		1		2		3		0		0	
...All Other Accidental Injuries	27		3		9		4		3		8	
Suicide	**48**	**3.3**	**0**	**0.0**	**0**	**0.0**	**0**	**0.0**	**17**	**35.4**	**31**	**64.6**
... by Firearm	26		0		0		0		8		18	
... by Hanging	16		0		0		0		9		7	
... by Poisoning	4		0		0		0		0		4	
... All Other Suicides	2		0		0		0		0		2	
Homicide	**102**	**6.9**	**15**	**14.7**	**15**	**14.7**	**2**	**2.0**	**12**	**11.8**	**58**	**56.9**
... Involving Firearm	73		2		4		1		11		55	
... All Other Homicides	29		13		11		1		1		3	
Other Injuries Undetermined Manner	**24**	**1.6**	**15**	**62.5**	**6**	**25.0**	**1**	**4.2**	**2**	**8.3**	**0**	**0.0**
... Hanging/Strangulation/Suffocation	14		12		2		0		0		0	
... Poisoning	5		2		2		1		0		0	
... All Other Undetermined Injuries	5		1		2		0		2		0	
All Other Causes of Death	**152**	**10.3**	**125**	**82.2**	**17**	**11.2**	**2**	**1.3**	**3**	**2.0**	**5**	**3.3**
TOTAL DEATHS	**1,474**	**100.0**	**828**		**190**		**97**		**149**		**210**	

† Child death rates prior to 2022 have been recalculated using the latest available population data

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

Table 2. Leading Causes of Child Death by Age Group, NC Residents 2022

ALL AGES, 0-17			
Rank	**Cause**	**#**	**%**
1	Conditions originating in the perinatal period	432	29.3%
2	Congenital anomalies (birth defects)	171	11.6%
3	Other Unintentional injuries	146	9.9%
4	Homicide	102	6.9%
5	Motor vehicle injuries	98	6.6%
6	Cancer	48	3.3%
6	Suicide	48	3.3%
8	Diseases of the heart	28	1.9%
9	Cerebrovascular disease	20	1.4%
10	COVID-19	17	1.2%
All other causes (Residual)		364	24.7%
TOTAL DEATHS — ALL CAUSES		1,474	100.0%

AGES 1 TO 17			
Rank	**Cause**	**Number**	**%**
1	Other Unintentional injuries	110	17.0%
2	Motor vehicle injuries	94	14.6%
3	Homicide	87	13.5%
4	Suicide	48	7.4%
5	Cancer	46	7.1%
6	Congenital anomalies (birth defects)	37	5.7%
7	Diseases of the heart	18	2.8%
8	COVID-19	16	2.5%
9	Cerebrovascular disease	14	2.2%
10	Septicemia	11	1.7%
All other causes (Residual)		165	25.5%
TOTAL DEATHS — ALL CAUSES		646	100.0%

INFANTS			
Rank	**Cause**	**#**	**%**
1	Congenital anomalies (birth defects)	134	16.2%
2	Short gestation - low birthweight	128	15.5%
3	Maternal complications of pregnancy	42	5.1%
4	Other unintentional injuries	36	4.3%
4	Bacterial sepsis	34	4.1%
6	Complications of placenta, cord, and membranes	26	3.1%
7	Respiratory distress	21	2.5%
8	Diseases of the circulatory system	17	2.1%
9	Intrauterine hypoxia and birth asphyxia	17	2.1%
10	Necrotizing enterocolitis	17	2.1%
All other causes (Residual)		356	43.0%
TOTAL DEATHS — ALL CAUSES		828	100.0%

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

AGES 1 TO 4			
Rank	**Cause**	**#**	**%**
1	Other Unintentional injuries	44	23.2%
2	Motor vehicle injuries	18	9.5%
3	Congenital anomalies (birth defects)	17	8.9%
4	Homicide	15	7.9%
5	Cancer	12	6.3%
6	Cerebrovascular disease	7	3.7%
7	Pneumonia & influenza	6	3.2%
8	COVID-19	4	2.1%
8	Conditions originating in the perinatal period	4	2.1%
8	Septicemia	4	2.1%
All other causes (Residual)		59	31.1%
TOTAL DEATHS — ALL CAUSES		190	100.0%

AGES 5 TO 9			
Rank	**Cause**	**#**	**%**
1	Motor vehicle injuries	19	19.6%
2	Cancer	16	16.5%
3	Other Unintentional injuries	12	12.4%
4	Septicemia	6	6.2%
5	Congenital anomalies (birth defects)	4	4.1%
5	Diseases of the heart	4	4.1%
7	COVID-19	2	2.1%
7	Cerebrovascular disease	2	2.1%
7	Chronic lower respiratory diseases	2	2.1%
7	Homicide	2	2.1%
7	Nephritis, nephrotic syndrome, & nephrosis	2	2.1%
All other causes (Residual)		26	26.8%
TOTAL DEATHS — ALL CAUSES		97	100.0%

AGES 10 TO 14			
Rank	**Cause**	**#**	**%**
1	Motor vehicle injuries	20	13.4%
2	Other Unintentional injuries	19	12.8%
3	Suicide	17	11.4%
4	Congenital anomalies (birth defects)	12	8.1%
4	Homicide	12	8.1%
6	Cancer	11	7.4%
7	COVID-19	7	4.7%
7	Diseases of the heart	7	4.7%
9	Cerebrovascular disease	4	2.7%
10	Chronic lower respiratory diseases	3	2.0%
All other causes (Residual)		37	24.8%
TOTAL DEATHS — ALL CAUSES		149	100.0%

AGES 15 TO 17			
Rank	**Cause**	**#**	**%**
1	Homicide	58	27.6%
2	Motor vehicle injuries	37	17.6%
3	Other Unintentional injuries	35	16.7%
4	Suicide	31	14.8%
5	Cancer	7	3.3%
6	Diseases of the heart	5	2.4%
7	Congenital anomalies (birth defects)	4	1.9%
8	COVID-19	3	1.4%
9	Chronic lower respiratory diseases	2	1.0%
9	Legal intervention	2	1.0%
All other causes (Residual)		26	12.4%
TOTAL DEATHS — ALL CAUSES		210	100.0%

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

North Carolina Child Fatality Task Force 2024 Action Agenda

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

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

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

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

Legislative recommendations to prevent youth suicide, to support youth mental health and well-being, and to prevent firearm-related deaths and injuries and other forms of violence

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

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

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

Support **recurring funding for the NC Office of Violence Prevention**.

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

Legislative recommendations and administrative efforts focused on the prevention of infant deaths and improved birth outcomes

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

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

Administrative efforts to collaborate on the topic of congenital syphilis: to get data broken down by race, ethnicity and gender; for prevention efforts and education to be culturally sensitive and appropriate; to have health care systems in place for routine order sets and education; to have active community education on the topic; and to better understand where mothers are getting their information to enable improved education efforts.

Legislative recommendation and administrative efforts to prevent child abuse and neglect, prevent infant and child deaths, and promote child and family well-being

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

Administrative efforts to **gather information to bring back to the CFTF on paid family leave insurance** (PFLI) including information on the impact of PFLI on businesses and employer feedback on PFLI.

Administrative efforts to prevent fentanyl-related deaths of children and adolescents.

Administrative efforts to seek **further collaboration and information gathering on issues surrounding fentanyl-related deaths to children and adolescents**, and to bring information back to the Unintentional Death Prevention Committee.

Items of Interest to Monitor

The Task Force is not pursuing action on these items for 2024 but is interested in monitoring these items to potentially bring back for consideration before the 2025 long session.

- Monitor information surrounding **tobacco and nicotine** use among youth and the harmful impacts of tobacco and nicotine to youth and infants
- Monitor information surrounding the potential to **strengthen child passenger safety laws**
- Monitor information on the **impacts of 2023 changes to the graduated driver license laws, and 2023 changes to funding for driver education**, including socioeconomic considerations and impacts
- **Monitor the use of incoming funding to address the youth mental health crisis**, including any gaps, needs, or successes that appear in the use of that funding

Explanation of 2024 Child Fatality Task Force Action Agenda

Legislative recommendations to prevent youth suicide, to support youth mental health and well-being, and to prevent firearm-related deaths and injuries and other forms of violence

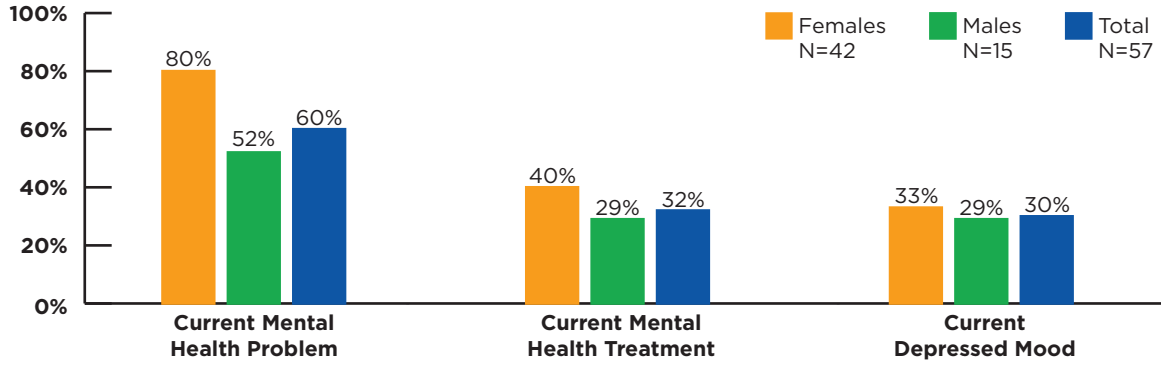
Support **recurring funds to increase the numbers of school nurses, social workers, counselors and psychologists** to support the physical and mental health of students and to move North Carolina toward achieving nationally recommended ratios for these professional positions in schools.

The youth mental health crisis continues to be a major area of focus for the Task Force, and data illustrates why:

- One in 5 North Carolina high school students has seriously considered suicide and 1 in 10 has made a suicide attempt.[4]
- In 2022, 48 North Carolina youth ages 10 to 17 died by suicide.[5] While the youth suicide rate decreased in 2022 compared to 2021, youth suicide rates have increased generally over the past 20 years in both the US and North Carolina.
- Older teens, ages 15 to 17, comprise about two-thirds of suicide deaths.[6]
- Firearms were the lethal means used in 54% of youth suicides in 2022.[7]
- In 2022 in North Carolina, there were 3,367 child (age 10-17) emergency department visits for self-harm.[8]

For the past several years and including 2023, the Task Force looked at ways to better support youth mental health and has repeatedly determined that having a robust team of health support professionals in schools – school nurses, social workers, counselors, and psychologists – is foundational and critical. Yet North Carolina's ratios of these professionals to number of students continues to fall far short of meeting national recommendations. The latest data presented to the Task Force by the NC Department of Public Instruction showed the following:[9]

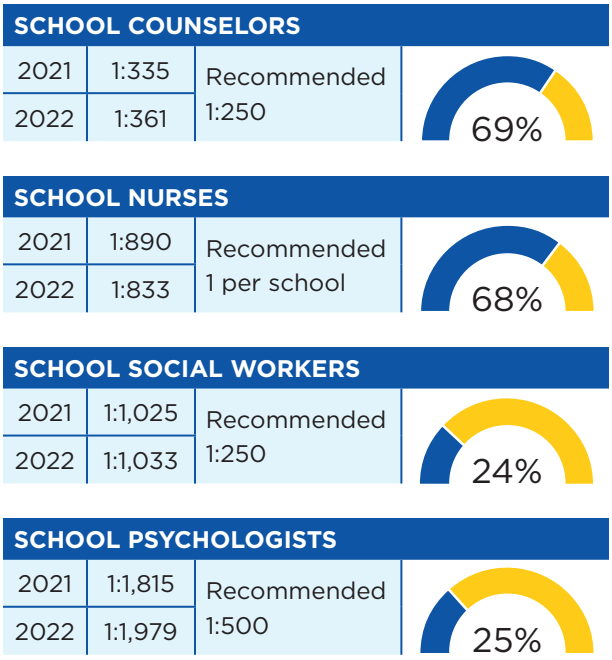
Figure 5. Mental Health (MH) circumstances of NC Child (Ages 10-17) Suicide Deaths, 2021



Note: Limited to NC residents ages 0-17 with reported circumstance information (males 97.7%; females 83.3%; overall 93.4%) | Source: NC VDRS, 2021; Analysis by the DPH Injury Epidemiology, Surveillance, and Informatics Unit

[4] 2021 NC High School Youth Risk Behavior Survey, US Centers for Disease Control and Prevention.
[5] See 2022 Child Death Data Report at the beginning of this Annual Report.
[6] Id.
[7] Id.
[8] NC DETECT Emergency Department Visit Data, 2016-2022. Analysis by the DPH Injury Epidemiology, Surveillance, and Informatics Unit. Information presented to Intentional Death Prevention Committee of the Task Force October, 2023.
[9] Table presented to the Task Force on December 13, 2023, by NC Healthy Schools of the NC Department of Public Instruction.

Figure 6. Specialized Instructional Support Ratios



While there was funding in the 2023 Appropriations Act for 120 more of these professionals, the funding was temporary. Not only is the fix short-term, but education leaders have explained to the Task Force that it is harder to attract and retain professionals for temporary work and significant administrative time is spent navigating the process of onboarding temporary professionals into a permanent workforce. Even if the 120 additional positions were permanent, 120 is not nearly enough to get North Carolina close to nationally recommended ratios.

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

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

Every two years, the *NC Institute of Medicine* and *NC Child* release a Child Health Report Card, tracking key indicators of child health and well-being, and assigning a grade to various categories of well-being. The 2023 Child Health Report Card focused on youth mental health, and gave North Carolina a grade of "F" in mental health and an "F" in school health, with the school health grade related to the poor ratios of students to school health professionals explained above.

Other experts and organizations agree that having enough of these health support professionals in schools is an important aspect of supporting student mental health. For example, this was noted in the 2021 U.S. Surgeon General's Advisory on the Youth Mental Health Crisis and in the North Carolina 2023 School Behavioral Health Action Plan. It was also the focus of a September, 2023 article in the North Carolina Medical Journal titled, "Specialized Instructional Support Personnel (SISP): A Promising Solution for North Carolina's Youth Mental Health Crisis."[10] This NC Medical Journal article explained the role and importance of the professionals and said that "there is a growing body of evidence that [these professionals] are a cost-effective way to improve both health-related and educational outcomes at the individual and population level," and went on to explain the evidence.

In addition to the impacts these professionals can have on student well-being, these professionals also alleviate strain on teachers and school administrators, who inevitably must put aside the focus of their work to deal with students' mental and physical health issues when there is no school health professional available to do so. They can also alleviate strain on the health care system through early identification of issues and connection to resources before an issue becomes more serious or reaches a crisis point, resulting in emergency room visits or psychiatric hospitalizations.[11]

[10] Close J, Schmal S, Essick E, Scott DN, Shankar M. Specialized Instructional Support Personnel (SISP): A Promising Solution for North Carolina's Youth Mental Health Crisis. North Carolina Medical Journal. 2023;84(5). doi:10.18043/001c.87524

[11] Id.

The Task Force focus on the youth mental health crisis also has involved learning more about mental health workforce challenges (both with school professionals and in the community), as well as various difficulties with access to mental health care in the community. Having enough school support professionals depends not only on funding but also on having a strong pipeline of these professionals to draw from, as well as a compensation structure that can attract and retain talent. And these professionals' ability to connect a student or family to services in the community depends on having available and accessible services that can actually serve their needs. While the Task Force did not develop recommendations related to these workforce topics for 2024, its Intentional Death Prevention Committee is continuing to learn more in these areas to better understand the ways policy can impact these challenges. This committee is also planning to learn how significant behavioral health funding included in the 2023 Appropriations Act will be utilized to make progress in addressing the youth mental health crisis in North Carolina.

Workforce challenges aside, recurring funding to significantly increase the numbers of school nurses, social workers, counselors and psychologists remains a critical component of supporting student mental health.

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

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

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

In 2023, the Child Fatality Task Force heard from a national expert on social media and adolescent mental health, Dr. Eva Telzer of UNC,[12] who presented to both the Intentional Death Prevention Committee and to the full Task Force on current research.

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

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

- 78% of 13- to 17-year-olds report checking their devices hourly and 46% check almost constantly (compared to 24% in 2018).
- Nearly all adolescents report spending more time on social media than they intended, with one-quarter perceiving that they are "moderately" or "severely" addicted to social media.

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

- Half of adolescents report that being away from social media results in experiencing difficulties in engaging with daily life activities.
- Social media use can interfere with sleep, and poor sleep is linked to physical and mental health issues, risky behaviors, poor school performance, and altered brain development.

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

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

There was legislation introduced in North Carolina in 2023 related to this topic that addressed data privacy for algorithms.[13] Although the bill did not become law, it had broad bipartisan support. Sam Hiner, a student at UNC Chapel Hill and Executive Director of the Young People's Alliance who supported this legislation, spoke to the Task Force about the ways in which social media was harming his generation – he shared examples related to eating disorders (fueled by harmful content shown to users), loneliness (fueled by spending time online instead of having real world experiences), and political extremism.

Mr. Hiner explained the efforts that his organization was making to address this issue through policy with an approach of having data privacy requirements for minors to address the addictive algorithms in social media, and why this approach is being pursued. One of the ways that social media can become "addictive" is through algorithms that use a user's data collected by the platform to target content shown to this user that keeps them online. The concept is that legislation that restricts a company's use of a minor's data will make social media less targeted, which will make it less addictive and less likely to have harmful content. The Task Force recommendation endorses this type of policy effort.[14]

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

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

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

The Task Force has for years been sounding the alarm on the rising rates of firearm deaths and injuries to North Carolina kids, which reached horrific heights in 2020, 2021, and 2022.

A prevention strategy long recommended by the Task Force that focuses on education and awareness around the importance of firearm safe storage saw a great deal of progress in 2023. Legislation requiring a statewide firearm safe storage initiative that was recommended by the Task Force became law, however there was no funding for this initiative. Progress was nevertheless made through efforts undertaken by the Department of Public Safety (DPS) which was able to get one year of funding for a safe storage media campaign.

That media campaign, "NC S.A.F.E." (Secure All Firearms Effectively), was informed by the work of the Task Force and launched in the spring of 2023. Although federal funding was secured for an additional year of the campaign, there is currently no source of recurring funds to keep this effort going. Meanwhile, efforts to get North Carolina gun owners to store guns safely have never been more important and the need for those efforts is going to continue long after temporary funds run out.

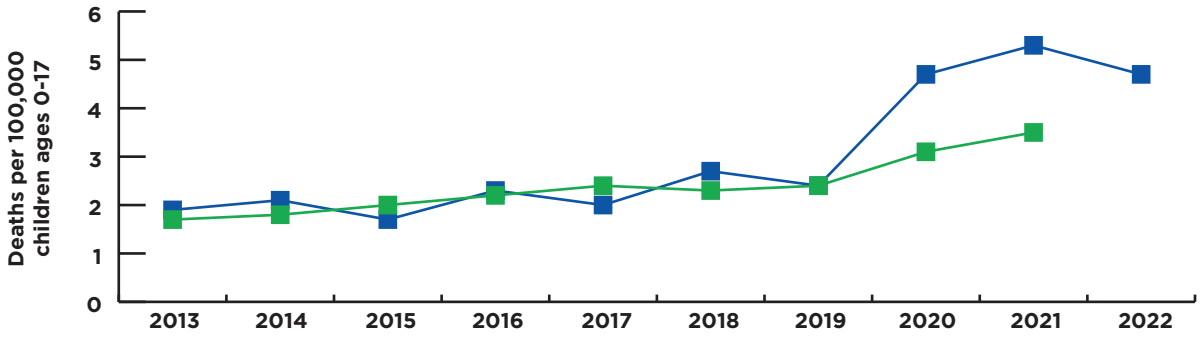
HOW SAFE STORAGE PREVENTS FIREARM DEATHS AND INJURIES

Prior Task Force reports have addressed the ways in which safe storage prevents firearm deaths and injuries, and the data supporting this prevention strategy, shared in Task Force meetings, bears repeating here:

Guns frequently are not stored safely. A 2016 study found that more than half of all gun owners store at least one gun unsafely.[15] A 2021 survey indicated that more than 2/5 of North Carolina adults have a firearm in or around the home, and over half of firearms that are stored loaded are also unlocked.[16]

Studies have shown that most kids know where parents keep their guns, but parents often think they don't.[17] A 2021 survey showed 30% of North Carolina high school students reporting that it would take them less than an hour to get and be ready to fire a loaded gun without a parent or other adult's permission; for white males, it was 40%.[18]

Figure 7. Firearm-related Mortality Rates*, Children Ages 0 to 17: NC & US, 2013-2022



	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
US	1.7	1.8	2	2.2	2.4	2.3	2.4	3.1	3.5	**
NC	1.9	2.1	1.7	2.3	2	2.7	2.4	4.7	5.3	4.7

*Firearm deaths include the following ICD mortality codes : W32-W34 (Unintentional), X72-X74 (Suicide), X93-X95 (Homicide), U014 (Terrorism), & Y22-Y24 (Undetermined Intent)
** US data are not yet available for 2022.
Source: NC State Center for Health Statistics & National Center for Health Statistics

[15] Crifasi CK, Doucette ML, McGinty EE, Webster DW, Barry CL. Storage Practices of US Gun Owners in 2016. Am J Public Health. 2018 Apr;108(4):532-537. doi: 10.2105/AJPH.2017.304262. Epub 2018 Feb 22. PMID: 29470124; PMCID: PMC5844398.
[16] Information presented to the NC Child Fatality Task Force by the NC Division of Public Health, sourced from the 2021 North Carolina Behavior Risk Factor Surveillance System, Firearm Safety Module: https://schs.dph.ncdhhs.gov/data/brfss/2021/nc/all/topics.htm#fr.
[17] Baxley F, Miller M. Parental Misperceptions About Children and Firearms. Arch Pediatr Adolesc Med. 2006;160(5):542–547. doi:10.1001/archpedi.160.5.542.
[18] Information presented to the NC Child Fatality Task Force by the NC Department of Public Instruction, sourced from the 2021 North Carolina Youth Risk Behavior Survey.

A significant surge in gun sales in recent years elevated the risks of more guns in homes that may not be safely stored, making them accessible to curious young children or youth who may be at risk of harming themselves or others.[19] The increase in the number of guns being purchased has coincided with a significant increase in juvenile offenses in North Carolina involving a firearm, and offenses frequently involve guns accessed from vehicles.[20]

Studies show that most guns used in youth suicide come from home.[21] Evidence of the increased risk of suicide when there is access to a firearm is well documented.[22] Firearms are the lethal means used in most youth suicides in North Carolina.

Studies have shown that guns used in school shootings typically come from home,[23] and school shooters are most often school-age.[24] Safe storage is a school safety issue and preventing youth access to firearms can help prevent school shootings.

Firearm deaths and injuries to children are preventable, and studies show that reducing access to firearms through safe storage practices saves lives. A study published in JAMA Pediatrics in 2019 estimated that up to 32% of youth firearm deaths by suicide and unintentional firearm injury could be prevented through safe storage of firearms in homes with youths.[25]

The NC S.A.F.E. campaign involves multiple media strategies to encourage firearm safe storage, and it also has toolkits and flyers for various community-level efforts as recommended by the Task Force. With the NC S.A.F.E campaign underway, information was presented to the Task Force on the progress of this campaign, plans for expanding efforts in the future, and funding estimates to make future work possible. In addition to the media campaign, funds have been and will continue to be used to purchase and distribute gun locks and gun safes, and future plans also include using funds to help support local initiatives.

FUNDING

DPS Juvenile Justice and Delinquency Prevention
NC DEPARTMENT OF PUBLIC SAFETY

- **Spent $1,764,534.70 in FY23**
  - $1.66 from carry forward from Governor's Office and $100,000 in JJDP funds
  - Goal – bare bones educational statewide campaign, distribution of safe storage tools
- **Received $2,499,953.56 in SCIP funding (beginning Oct 2023 for FY24)**
  - Contract and materials $1,799,903.56 plus $700,050 evaluation of campaign
  - Goal – an educational statewide campaign, distribution of safe storage tools, and an evaluation of the campaign
- **Seeking recurring funding beginning FY25: $2,159,884.27**
  - $1,799,903.56 plus 20% expansion
  - Goal – an educational statewide campaign, distribution of safe storage tools, enhanced strategy

[19] Regarding the surge in gun sales, see, e.g., Ramos, E. and Murphy, J. (May 25, 2022.) "6 charts that show the rise of guns in the U.S. – and people dying from them." *NBC News*. www.nbcnews.com/data-graphics/6-charts-show-rise-guns-us-people-dying-rcna30537. A study published in 2022 found a significant increase from 2015 through 2021 in the number of children in the U.S. living in households with firearms, which is estimated to be approximately 4.6 million: Miller M, Azrael D. Firearm Storage in US Households With Children: Findings From the 2021 National Firearm Survey. JAMA Netw Open. 2022;5(2):e2148823. doi:10.1001/jamanetworkopen.2021.48823

[20] According to data presented to the Task Force by the Division of Juvenile Justice, NC Department of Public Safety.

[21] Grossman DC, Reay DT, Baker SA. Self-inflicted and Unintentional Firearm Injuries Among Children and Adolescents: The Source of the Firearm. *Arch Pediatr Adolesc* Med. 1999;153(8):875–878. doi:10.1001/archpedi.153.8.875

[22] The source for much of the evidence on this topic that has been provided in Task Force meetings comes from the "Means Matter" website of the Harvard T.H. Chan School of Public Health which summarizes studies related to means reduction as a suicide prevention strategy.

[23] See. e.g., U.S. Department of Homeland Security, United States Secret Service, National Threat Assessment Center, Protecting America's Schools: A U.S. Secret Service Analysis of Targeted School Violence, 2019. Hobbs, Tawnell D. (April 5, 2018). "Most Guns Used in School Shootings Come From Home." *Wall Street Journal*.

[24] Jillian Peterson and James Densley. (February 8, 2019.) "School Shooters Usually Show These Signs of Distress Long before They Open Fire, Our Database Shows." *The Conversation* https://bit.ly/2vBTA3J.

[25] Monuteaux MC, Azrael D, Miller M. Association of Increased Safe Household Firearm Storage With Firearm Suicide and Unintentional Death Among US Youths. JAMA Pediatr. 2019;173(7):657–662. doi:10.1001/jamapediatrics.2019.1078. See also Grossman DC, Mueller BA, Riedy C, et al. Gun Storage Practices and Risk of Youth Suicide and Unintentional Firearm Injuries. JAMA. 2005;293(6):707–714. doi:10.1001/jama.293.6.707

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

For 2024, the Task Force took its efforts surrounding safe storage as a prevention strategy a step beyond education and awareness and made a recommendation to strengthen North Carolina's child access prevention law.

State laws that address access to guns by children and hold gun owners accountable for unsafe storage, often called "child access prevention laws," are known to be an effective tool to prevent gun deaths and injuries to kids.[26] Such laws vary among states, and North Carolina enacted its child access prevention law in 1993 which has since remained unchanged.

The current North Carolina child access prevention law applies only to a gun owner or one who possesses a gun who "resides in the same premises as a minor." The recommended change from the Task Force would no longer limit application of the law to those who reside with a minor. The full text of the law and the recommended change to remove one phrase from the law, highlighted below, are as follows:

§ 14-315.1. Storage of firearms to protect minors.

(a) Any person who ~~resides in the same premises as a minor,~~ owns or possesses a firearm, and stores or leaves the firearm (i) in a condition that the firearm can be discharged and (ii) in a manner that the person knew or should have known that an unsupervised minor would be able to gain access to the firearm, is guilty of a Class 1 misdemeanor if a minor gains access to the firearm without the lawful permission of the minor's parents or a person having charge of the minor and the minor:

(1) Possesses it in violation of G.S. 14-269.2(b);

(2) Exhibits it in a public place in a careless, angry, or threatening manner;

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

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

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

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

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

Task Force members discussed the need for this law to apply more broadly to protect kids and how the need for responsible gun ownership (and possession) is not limited to those who reside with children. Those with a gun who do not "reside in the same premises as a minor" may nevertheless be in situations where, for example, a child or teen is visiting their home or riding in their car and if their gun is not safely stored, the risks of what can happen when a child or teen accesses that gun are no different than they are for someone who resides with a child.

[26] See, e.g., Azad HA, Monuteaux MC, Rees CA, Siegel M, Mannix R, Lee LK, Sheehan KM, Fleegler EW. Child Access Prevention Firearm Laws and Firearm Fatalities Among Children Aged 0 to 14 Years, 1991-2016. JAMA Pediatr. 2020 May 1;174(5):463-469. doi: 10.1001/jamapediatrics.2019.6227. PMID: 32119063; PMCID: PMC7052788.



Support **recurring funding for the NC Office of Violence Prevention**

In the context of addressing firearm deaths and injuries, the Unintentional Death Prevention Committee of the Task Force held a panel discussion of experts in the field of violence prevention and the prevention of firearm deaths and injuries. These experts discussed the fact that there has recently been great momentum in North Carolina around this topic, and emphasized the importance of sustaining these efforts and ensuring coordination and collaboration among the variety of professionals and organizations involved in this lifesaving work.

This discussion formed the basis for the Task Force learning about, and then recommending ongoing support for, the newly created NC Office of Violence Prevention (OVP).

OVP is established within the Department of Public Safety and works in partnership with the NC Department of Health and Human Services to ensure a whole of government and public health approach to reducing violence. The mission of OVP is to "serve as North Carolina's central hub for coordinating and supporting evidence-based public health strategies that enhance public safety, prevent violence, and foster community healing."

The Executive Director of OVP explained to the Task Force OVP's work as a conveyor, connector, and collaborator by:

- Facilitating information sharing across state and local violence prevention partners and public health programs designed to prevent violence
- Conducting public awareness campaigns related to violence prevention
- Working with universities and research entities to share and promote best practices and evidence-based interventions
- Identifying and applying for federal and philanthropic funds to expand programs and resources
- Providing training, technical assistance, and executive advising to city and county leaders, community violence interruption programs, law enforcement, health and community groups

This office was created in March of 2023 by Governor Cooper through Executive Order 279, which remains in effect until March 31, 2025, unless rescinded or superseded by another applicable Executive Order. Recurring funding for this office, as recommended by the Task Force, would sustain and support the critical work of this office.

At the time the Task Force approved this recommendation, no details related to funding needs or estimates for sustaining or expanding the work of OVP were provided, but the need for action in order to make OVP permanent was conveyed to the Task Force.

Legislative recommendations and administrative efforts focused on the prevention of infant deaths and improved birth outcomes

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

North Carolina's infant mortality rate has been stagnant in recent years and has kept North Carolina's among the 10 highest infant mortality rates among states (although final infant mortality rates for 2022 by state have not been released yet). Prematurity/low birthweight and birth defects continue to be the leading causes of infant deaths. Racial/ethnic disparities in infant mortality rates have stubbornly persisted, with Black infants dying at rates more than two times the rate of white infants.

Doulas are commonly defined as nonclinical trained professionals who can provide emotional, physical, and informational support during pregnancy, delivery, and after childbirth. Doula services are increasingly recognized as an effective means of improving maternal and infant health outcomes and experiences, and improving disparity gaps.[27] Various experts and entities are encouraging expanded use of doulas, for example:

- The federal government is supporting efforts to expand the doula workforce and encourage coverage of doula services in a number of health programs.[28]
- A current policy priority of the March of Dimes is for Medicaid and private insurance coverage for doula care services.[29]
- Efforts around doula services and expanding the doula workforce are part of the North Carolina Perinatal Health Strategic Plan.
- At least 11 states are reimbursing for doula services in their Medicaid plans, with several others in the planning stages.

NC Medicaid does not currently reimburse for doula services, however some prepaid health plans as part of Medicaid managed care added doula services as part of their value-added services.

For 2023, the Task Force had a similar recommendation to support funding to enable Medicaid reimbursement of doula services, however there was no such funding appropriated in 2023. In meetings leading up to this 2024 recommendation of the Task Force for doula funding, presenters conveyed information about events and stakeholder work done in North Carolina to further explore topics surrounding doulas, including the potential for Medicaid coverage of doula services and integrating doulas into the health care system. These efforts have served to further inform the type of policy, practice, and systems that would best support Medicaid reimbursement for doula services. The North Carolina Institute of Medicine, in collaboration with DHHS, has established a Doula Action Team to focus on credentialing, scope and length of services from preconception and postpartum, reimbursement, and ways to support doulas with Medicaid reimbursement and other efforts. The Action Team will convene from April – August 2024.

At the time the Task Force approved this recommendation to support funding to enable Medicaid reimbursement of doula services, no updated figures or estimates for these costs were provided. However, the Task Force considered estimates from 2023 which included $1.5 million recurring to implement Medicaid coverage of doula services and $550,000 nonrecurring for training, promotions, and doula engagement.

[27] See, e.g., Knocke K, Chappel A, Sugar S, De Lew N, Sommers BD. Doula Care and Maternal Health: An Evidence Review. (Issue Brief No. HP-2022-24). Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. December 2022; Sobczak A, Taylor L, Solomon S, Ho J, Kemper S, Phillips B, Jacobson K, Castellano C, Ring A, Castellano B, Jacobs RJ. The Effect of Doulas on Maternal and Birth Outcomes: A Scoping Review. Cureus. 2023 May 24;15(5):e39451. doi: 10.7759/cureus.39451. PMID: 37378162; PMCID: PMC10292163.

[28] Knocke K, Chappel A, Sugar S, De Lew N, Sommers BD. Doula Care and Maternal Health: An Evidence Review. (Issue Brief No. HP-2022-24). Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. December 2022.

[29] See: www.marchofdimes.org/sites/default/files/2022-11/2023-24%20Policy%20Priorities.pdf.

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

A Fetal and Infant Mortality Review (FIMR) is a special type of multidisciplinary team review of fetal and infant deaths. It has similarities (and can be considered complementary) to the local, multidisciplinary child death reviews (CDRs) that are currently performed in every county in North Carolina, but FIMRs have significant variations that require different resources and policies.

Fetal and Infant Mortality Reviews began in the late 1980's, and now there are approximately 146 FIMR programs in 25 states,[30] with just one current FIMR program in North Carolina that began only recently in Guilford County.

In developing this FIMR recommendation, the Task Force and its Perinatal Health Committee heard from a representative of Guilford County's FIMR program, and its Perinatal Health Committee also heard from a FIMR expert from the National Center for Fatality Review and Prevention (NCFRP). The NCFRP has extensive information, tools, and resources related to FIMR to support FIMR teams across the US. They also provide technical assistance to local FIMR teams, and Guilford's team has benefited from their assistance and resources.

Through efforts of their local health department, Guilford County started its FIMR program as part of a multi-pronged effort in that county, "Every Baby Guilford," to address infant mortality rates that were among the highest in the state, and to address their especially high racial disparities as the infant mortality rate for Black infants is about three times higher than the rate for white infants. They are finding their FIMR work to be a valuable part of their local strategy to prevent infant deaths and address disparity gaps.

FIMR involves a team review of confidential, de-identified cases of fetal and infant deaths to understand how and why the death occurred in order to prevent future deaths. FIMR teams develop recommendations and implement local efforts to improve systems of care, services, and resources.

For these reviews, significant work is undertaken prior to the review that involves examination and abstraction of records as well as an interview with the family of the child who died (whenever possible) to create a case summary that is presented to the review team. Some differences between FIMRs and NC's current local CDRs include the following:

- CDRs in NC do not involve a family interview and in fact, contact with or interviews of the family are prohibited by statute; whereas in FIMR, the interview is an important aspect of the process.
- Ideally, review coordinators of local CDRs in NC gather information in advance of a review, but CDRs may not involve the same type of in-depth record abstraction and case summary preparation as is required in a FIMR.
- In a CDR process, the team is not examining de-identified information that is brought to them in the form of a case summary for review as is done with FIMR; rather, team members are bringing information they may have about a child (that is not de-identified) to inform the review.
- FIMRs often have a two-tiered model that includes the review team as well as a separate community action group who takes the recommendations made by the review team to implement prevention strategies in their community.

FIMR work requires staff with appropriate training and expertise who do data abstraction, family interviews, and prepare case summaries to present to the review team. Staff also work with the review team to generate recommendations and reports, and with the community action group to facilitate implementation of actions in response to recommendations. The scope of work required for this role is labor-intensive and typically involves staff who are dedicated to a FIMR team's work.

Because of the resources needed for FIMR work, there is currently not an expectation to have FIMRs in every county the way CDRs cover every

[30] Per information presented to the Perinatal Health Committee of the Task Force by a representative of the National Center for Fatality Review and Prevention on October 13, 2023.

county across North Carolina. However, a FIMR team anywhere in North Carolina can help inform prevention work at the State level, and ideally the number of FIMR teams in our state would grow. Communities who have the resources to start and maintain a FIMR program, as Guilford has done, would benefit greatly from having legislation that enables, protects, and clarifies their functioning. This type of legislation would make it more likely that a community would consider establishing a FIMR because it would make it easier for them to operate and remove some of the barriers that may keep them from establishing a FIMR team.

WHY IS FIMR LEGISLATION NEEDED?

Access to information: An important part of FIMR work is gathering and examining records and information related to the death of the infant or fetus. Statutes establishing child death review teams in North Carolina have provisions specifying that these teams are permitted access to many types of records for purposes of their review.[31] Statutes establishing the North Carolina Maternal Mortality Review Committee (MMRC) also have provisions addressing access to information.[32] The federal Health Insurance Portability and Accountability Act (HIPAA) has strong privacy protections for an individual's health information that prevent covered entities from disclosing information. However, there are exceptions in the federal law, and one that relates to the use of such information for research or public health surveillance is an exception that has been applied to FIMR work. But it can be very challenging for FIMR staff to access such records without a statute specifying that access is permitted for FIMR purposes. For example, Guilford's FIMR team has only limited access to some medical records after having reached a formal agreement with one health care entity, and this agreement took 14 months to be worked out among attorneys.

Protection of information: It is also important that information accessed, used, and generated by FIMR reviews be utilized only for FIMR purposes and protected for any uses beyond those purposes. Statutes establishing CDRs and the MMRC have provisions that speak to protecting such information, including provisions that make meetings and information not subject to open meeting or public records laws, not subject to discovery or introduction into evidence in any proceedings, and team members may not testify about meetings or information shared in meetings.[33]

Family interview: A critical component of the FIMR process is a confidential interview with the family who lost the infant or fetus, which is done by FIMR staff who are preparing a case summary for team review. As noted before, statutes establishing CDRs in North Carolina specifically prohibit contacting or interviewing the family, and a FIMR statute would ideally speak to the family interview as a permissible part of the process, but the decision of whether to *participate* in a confidential interview is still up to the family. The National Center for Fatality Review and Prevention explains the importance of the family interview as part of the FIMR process on their website as follows:

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

Legislation passed in 2023 in North Carolina enables and requires future use by CDR teams of the National Fatality Review Case Reporting System (NFR-CRS), a data system that has been used by 48 other states to help teams track, analyze, and report information learned from reviews of child deaths.[34] There is also a FIMR NFR-CRS that is designed specifically for FIMR reviews, and FIMR teams could choose to utilize this system.

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

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

Administrative efforts to collaborate on the topic of congenital syphilis: to get data broken down by race, ethnicity and gender; for prevention efforts and education to be culturally sensitive and appropriate; to have health care systems in place for routine order sets and education; to have active community education on the topic; and to better understand where mothers are getting their information to enable improved education efforts.

Congenital syphilis (CS) is a disease that occurs when a mother with syphilis passes it to her baby during pregnancy. Cases of congenital syphilis have increased significantly in the US and in NC in recent years.

The following chart illustrates that from 2012 through 2023, there was a 72-fold increase in congenital syphilis infections. In 2023, preliminary data showed nine congenital syphilis-related stillbirths and neonatal deaths in North Carolina.

Not only can congenital syphilis result in infant death or stillbirth, but it can cause miscarriage, prematurity, and low birth weight. Infants who are born with CS and survive can have major health impacts like deformed bones, severe anemia, enlarged liver and spleen, brain and nerve problems like blindness or deafness, or meningitis.[36]

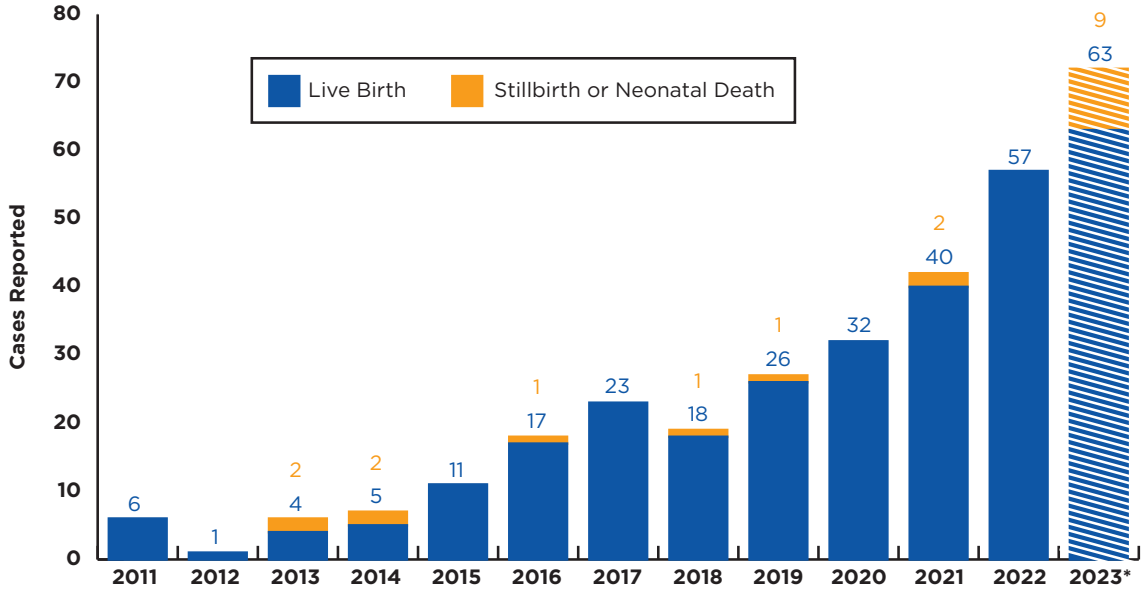
Congenital syphilis is preventable. With early screening for syphilis and treatment with specific antibiotics before or during pregnancy, syphilis can be cured and CS can be prevented. With early screening and treatment of CS in pregnancy or infancy, negative health impacts can be prevented or lessened.

Experts presenting to the Task Force explained how prevention work involves stepping up education and awareness about syphilis and CS, getting providers to screen for syphilis and CS during pregnancy, and ensuring that those diagnosed get prompt treatment.

The North Carolina Department of Health and Human Services has undertaken various prevention efforts, described in a February, 2024 press release on the topic and to the Task Force and its Perinatal Health Committee.

The Perinatal Health Committee of the Task Force, which developed this agenda item for administrative efforts around CS, recognized that prevention work is already taking place in North Carolina, and did not identify potential policy actions related to this topic at this time. However, this administrative agenda item shows the Task Force's intention to continue to get updates on data and prevention work, and to encourage continued collaboration in various areas of prevention.

Figure 8. Congenital Syphilis Infections in North Carolina, 2011-2023 (Preliminary)[35]



[34] Section 9H.15.(f) of Session Law 2023-134, § 7B-1413.5.
[35] Data source: NC EDSS HIV/STD Syphilis Line List and Congenital Syphilis Reports 02/09/2024, NC DHHS (chart with data presented to the Child Fatality Task Force February 29, 2024).
[36] CDC fact sheet on Congenital Syphilis: www.cdc.gov/std/syphilis/stdfact-congenital-syphilis.htm.

Legislative recommendation and administrative efforts to prevent child abuse and neglect, prevent infant and child deaths, and promote child and family well-being

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

Many organizations, experts, and advocates in North Carolina have been alerting state leaders to the current child care crisis and the looming "child care cliff" when a wave of federal funding that came to North Carolina via the American Rescue Plan Act, which has been used to stabilize child care, comes to an end in June of 2024.

Why is the North Carolina Child Fatality Task Force interested in child care? Because whether a family can access affordable, quality child care can have consequences for infant and child brain development, overall child and family well-being, as well as the possibility of a child experiencing abuse, neglect, or even death.

The US Centers for Disease Control & Prevention (CDC) has a publication, Child Abuse and Neglect Prevention Resource for Action: A Compilation of the Best Available Evidence, which sets out five prevention strategies for child maltreatment.[37] Two out of five of these strategies are:

- provide quality care and education early in life, and
- strengthen economic support to families, including subsidized child care.

This CDC publication summarizes evidence supporting these strategies for preventing child maltreatment. Although the extensive evidence cannot be detailed in this Task Force report, the evidence generally relates to: reduced parental stress and maternal depression; more parent engagement in education; increased parent connections and community supports for the family; and increased social skill and cognitive development in children. The publication states that, "Better quality child care increases the likelihood that children will experience safe, stable, nurturing relationships and environments and decreases the risk of maltreatment-related fatalities." Other CDC publications related to preventing Adverse Childhood Experiences and Intimate Partner Violence also discuss the importance of support for access to high-quality child care.[38]

The North Carolina Perinatal Health Strategic Plan and the North Carolina Institute for Medicine Task Force on Essentials for Childhood also highlighted access to affordable, quality child care as being important to support infant and child well-being and prevent child maltreatment.[39]

The North Carolina State Child Fatality Prevention Team, which reviews child deaths related to child maltreatment, included in its report to the Task Force in 2023 an "Identified Trend: Affordable and Accessible Child Care." This team noted that, "Often caregivers are being used during nontraditional work times reflective of a parent working late shifts and are part of the parents' friend/family circle. In these cases, child decedents share common threads of inattentive caregivers."

ENSURING THAT FAMILIES HAVE ACCESS TO AFFORDABLE, QUALITY EARLY CARE is a recognized strategy in preventing child abuse, neglect, and even death.

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

[38] Adverse Childhood Experiences Prevention Resources for Action: A Compilation of the Best Available Evidence, and Intimate Partner Violence Prevention Resources for Action: A Compilation of the Best Available Evidence.

[39] North Carolina Perinatal Health Strategic Plan and NCIOM Task Force on Essentials for Childhood.

Related to this perspective from NC's State Child Fatality Prevention Team, the CDC publication on child abuse and neglect prevention referenced above said that, "Children who live with unrelated adults are nearly 50 times more likely to die of inflicted injuries than children who live with both biological parents, thereby highlighting the importance of quality child care, as mothers would not have to leave the child alone with other (unrelated) adults in the home."

In meetings of the Child Fatality Task Force and its Intentional Death Prevention Committee, participants heard from a leading expert in child care and early learning. Ariel Ford, Director of the State's Division of Child Development and Early Education, described the current child care crisis and its impact, and shared much of the information presented below. She explained how **State investments in early child care are essential as the child care business model cannot sustain itself and is at great risk without significant support**. The following graphic was shared to illustrate the challenge.

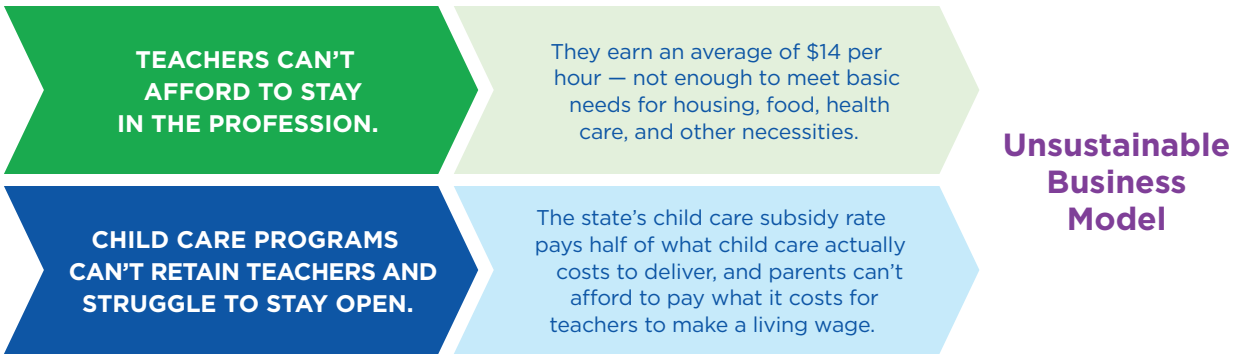
Some of the underlying facts that help explain the child care crisis are as follows:

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

The child care crisis is also an economic problem when too many North Carolinians are unable to fully participate in the workforce or advance their careers due to child care challenges. This comes at a time when North Carolina has 55 available workers for every 100 jobs.[40] Availability of quality early care is a major factor in attracting and retaining businesses to bring jobs to our state. A North Carolina Chamber Foundation Child Care Survey showed that of parents with children five and under:

- 26% said they left the workforce because they couldn't find affordable child care;
- 37% refused a job opportunity, promotion, or job change because it would increase child care expenses; and
- 32% did not pursue job training or continuing education because of a lack of affordable child care.[41]

Figure 9. Early Childhood Care and Education in Crisis



[40] Data shared with Task Force from labor statistic according to the U.S. Chamber of Commerce: www.uschamber.com/workforce/understanding-north-carolinas-labor-market,
[41] Data shared with Task Force from NC Chamber Foundation Child Care Survey Findings: https://ncchamber.com/2023/05/10/nc-chamber-foundation-child-care-survey-findings-summary/.

Quality early care positively impacts the brain development of young children, setting them up for better outcomes later in life. Eighty-five percent of the physical brain develops by the age of three, and children's early experiences build their brain architecture for life. This is one reason why investments in early care and learning have a high rate of economic return. Studies have shown that the earlier the investments in children, the higher the rate of economic return given the increased productivity and reduced social spending.[42]

Child care subsidies use state and federal funds to help families afford child care by sharing the cost of care with eligible families, with most parents paying a fee that depends on the size of their family and their income. Families can choose a child care provider so long as that provider participates in the Subsidized Child Care Program. However, less than a fifth of NC families who are eligible for child care subsidies are actually getting child care subsidies, as there is not enough subsidy funding to meet the need.

Many in North Carolina are working on innovative strategies to address child care workforce issues and a better business model as a means of addressing current challenges, as increased funding alone will not resolve the crisis. However, increased funding, as recommended by the Task Force, is a critical component of addressing this crisis, and access to affordable, quality child care has significant health and safety implications for North Carolina's children.

Administrative efforts to **gather information to bring back to the CFTF on paid family leave insurance** (PFLI) including information on the impact of PFLI on businesses and employer feedback on PFLI.

Worker access to paid family leave is repeatedly cited by experts to be an important strategy to improve child and family well-being, including preventing infant deaths and child maltreatment. An approach that is increasingly used by a number of states to enable broad access to paid leave is through a statewide *paid family leave insurance program* (also referred to as paid family and medical leave).

Paid family leave insurance (PFLI) is a specific type of paid family leave that is publicly provided and operates statewide. In PFLI programs, which are now in 13 states, employees (and in some states employers also) pay a small insurance premium as a percent of income (e.g., 0.35%) into a fund from which they can draw for qualified leave purposes such as caring for a new child or caring for oneself or a family member due to illness. For example, an employee might pay $1.50 - $4.50 per week. To be eligible, an employee may have to have worked a certain number of minimum hours or have certain minimum earnings in the past year. An employee eligible for PFLI would typically receive a certain percentage of their wages with a weekly maximum cap.

The topic of Paid Family Leave Insurance received a great deal of focus from the Task Force from 2017 through 2020. Task Force efforts to better understand PFLI led to a study by Duke University on the costs and benefits of PFLI in North Carolina, which was published in 2019 and presented to the Task Force.[43] The Task Force ultimately made a recommendation in 2020 for legislation to address Paid Family Leave Insurance. While legislation implementing a paid family leave insurance program has been proposed in North Carolina, it has not become law. In 2021, the Task Force considered making the same recommendation, but some Task Force members cited a need for more information from the business community, and the recommendation was not repeated.

Meanwhile, evidence about the positive impacts of paid family leave on child and family well-being has continued to grow, and more states and communities have adopted paid family leave policies and laws. Also, in 2023 the NC General Assembly recognized the importance of paid leave when it enacted legislation granting state employees eight weeks of paid parental leave and appropriated recurring funds to the Department of Public Instruction for this purpose.[44]

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

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

[44] Part V of S.L. 2023-14.




The Task Force and its Perinatal Health Committee heard updates on this topic during its most recent study cycle. Through this 2024 Task Force administrative agenda item, the Task Force is indicating its intention to study this topic further, including gathering information on the impact of PFLI on businesses and employer feedback on the concept of PFLI.

The positive impact of paid family leave on child health and well-being is widely recognized. Consider that 186 other countries provide some type of paid leave for new mothers (average length is 29 weeks), 174 countries offer paid leave for a personal health problem, and 109 countries have parental leave for fathers also; the U.S. is one of only six countries with no national paid leave.[45]

The evidence of this positive impact and the need for such leave is too extensive to detail in this report, but the following illustrative facts, some of which were presented to the Perinatal Health Committee of the Task Force by an expert on PFLI, include the following:[46]

- While the U.S. Family and Medical Leave Act (FMLA) provides eligible employees with up to 12 weeks of **unpaid**, job-protected leave per year,[47] the eligibility requirements for FMLA only cover about 60% of American workers,[48] and many eligible workers cannot afford to take leave under the FMLA because it is unpaid.
- In NC only about 22% of employees have access to paid leave; less than 40% have access to paid medical leave through temporary disability; and the remaining 50% rely on unpaid leave, often without job protection.[49]
- Nearly 1 in 4 women in the U.S. are back at work within two weeks of giving birth.[50]
- The 2019 Duke University study on the costs and benefits of PFLI in NC found that **PFLI in NC would: improve the health of mothers and infants which includes saving 26 infant lives in North Carolina each year & reducing low birthweight births**; increase labor participation and employee retention; reduce the need for nursing home care; and it would reduce the number of individuals needing public assistance.
- A 2020 study of California's paid family leave insurance policy showed that its implementation was associated with a 12 percent reduction in post neonatal mortality.[51] Another study that also found

[45] Article in the New York Times by Claire Cain Miller, *The World 'Has Found a Way to Do This': The U.S. Lags on Paid Leave*, Updated June 22, 2023, citing data from the World Policy Analysis Center at the University of California, Los Angeles. www.nytimes.com/2021/10/25/upshot/paid-leave-democrats.html.
[46] Tina Sherman, Senior Campaign Director, MomsRising Together & MomsRising Education Fund presented to the Perinatal Health Committee of the Task Force.
[47] See U.S. Department of Labor, Wage and Hour Division. *Fact Sheet #28: The Family and Medical Leave Act*. www.dol.gov/sites/dolgov/files/WHD/legacy/files/whdfs28.pdf.
[48] Kaiser Family Foundation. (January 28, 2020). *Paid Family and Sick Leave in the U.S.* www.kff.org/womens-health-policy/fact-sheet/paid-family-leave-and-sick-days-in-the-u-s/.
[49] According to a presentation to the Perinatal Health Committee of the Task Force by a representative from MomsRising, November 2023.
[50] In These Times. (August 18, 2015). *The Real War on Families: Why the U.S. Needs Paid Leave Now.* http://inthesetimes.com/article/18151/the-real-war-on-families.
[51] Montoya-Williams D, Passarella M, Lorch SA. The impact of paid family leave in the United States on birth outcomes and mortality in the first year of life. Health Serv Res. 2020; 55: 807–814. https://doi.org/10.1111/1475-6773.13288

decreases in infant and child mortality from paid leave found that unpaid leave, or paid leave without job protection, has no effect on infant or child mortality.[52]

- Access to paid leave is cited by the CDC as an economic support strategy that can prevent child maltreatment.[53] This maltreatment prevention strategy was also highlighted at a 2023 statewide summit in North Carolina, "Economic Supports: A Path to Reduce Childhood Adversity," convened by the North Carolina Institute of Medicine's Essentials for Childhood project.
- Promoting access to paid leave is among the goals identified in the North Carolina Perinatal Health Strategic Plan and among the priorities identified by the March of Dimes.[54]

Even though some workers can get paid family leave through employer benefits, such benefits are less likely to be available to the lowest wage workers, who are the ones who need it most. For example, six percent of private industry workers in the U.S. with an average wage in the lowest 10 percent had access to paid family leave, compared with 43 percent of workers with an average wage in the highest 10 percent.[55] Meanwhile, larger employers may be more likely to afford to offer paid family leave benefits than smaller employers. PFLI is said to "level the playing field" so that all workers have access to paid family leave and all employers can offer it.

The evidence on positive impacts of PFLI on health and well-being is clear. While evidence indicates that Statewide PFLI programs are generally viewed by employers as having had a positive effect or no noticeable effect on them,[56] what is less clear is the perspective of North Carolina employers on this issue. This Task Force administrative effort seeks to gather more information on employer impact and feedback from North Carolina employers to further understand their perspective in order to inform any future policy efforts related to the potential for PFLI in North Carolina.

Administrative efforts to prevent fentanyl-related deaths of children and adolescents.

Administrative efforts to seek **further collaboration and information gathering on issues surrounding fentanyl-related deaths to children and adolescents** to bring information back to the Unintentional Death Prevention Committee.

Rates of child deaths in North Carolina from poisoning have increased in recent years, and data show that this increase is related to fentanyl poisonings. Fentanyl is a synthetic opioid that is up to 50 times stronger than heroin and 100 times stronger than morphine; there is pharmaceutical fentanyl and there is also illegally made fentanyl.[57]

While the opioid epidemic has been going on for many years, opioid poisonings causing deaths among children were uncommon in North Carolina until recently, when illicit fentanyl became more prevalent and created increased risks as exposure to very small amounts of fentanyl can be fatal.

[52] As presented to the Task Force Perinatal Health Committee by MomsRising, based on the following article: Burtle A, Bezruchka S. Population Health and Paid Parental Leave: What the United States Can Learn from Two Decades of Research. Healthcare (Basel). 2016 Jun 1;4(2):30. doi: 10.3390/healthcare4020030. PMID: 27417618; PMCID: PMC4934583.

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

[54] See the NC Perinatal Health Strategic Plan and the March of Dimes 2023-24 Policy Priorities.

[55] U.S. Bureau of Labor Statistics "A look at paid family leave by wage category in 2021," published in January, 2022: www.bls.gov/opub/ted/2022/a-look-at-paid-family-leave-by-wage-category-in-2021.htm.

[56] See Paid Family Leave in North Carolina: An Analysis of Costs and Benefits. Center for Child and Family Policy, Sanford School of Public Policy, Duke University, 2019.

[57] "Fentanyl Facts" web page on the website for the Centers for Disease Control and Prevention: www.cdc.gov/stopoverdose/fentanyl/index.html#:~:text=Fentanyl%20is%20a%20synthetic%20opioid,nonfatal%20overdoses%20in%20the%20U.S.

The Task Force and its Unintentional Death Prevention Committee heard presentations on this topic from North Carolina's Chief Medical Examiner and from the Chief Toxicologist in the Office of the Chief Medical Examiner.

During the period of 2014-2022, pediatric fentanyl deaths in North Carolina were among two distinct age groups: infants and toddlers (age 0 to 4) and teens (age 13 to 17), with no fentanyl deaths among 5 to 12-year-olds. The graphs below with data from the NC Office of the Chief Medical Examiner show the significant increase in these deaths starting in 2020/2021.

Among the teen population, the exposure to fentanyl is typically in the context of recreational drug use – in some cases teens know they are taking fentanyl and in other cases they don't know the drug they are taking has fentanyl in it. Among infants and toddlers, examples of exposure could include a child who ingests a prescription or illicit pill or liquid that was within reach, or a child who handles or ingests drug trash or paraphernalia with fentanyl residue.

The topic of pediatric fentanyl poisoning deaths is new to the Task Force, and while the Task Force is beginning to learn about the data, it has not yet studied effective prevention strategies. This administrative item to collaborate and gather information on this topic is about learning more from a variety of experts and information sources to inform future Task Force discussions on the issue.

Figure 9. NC OCME Pediatric Fentanyl Deaths (0-4 years of age)

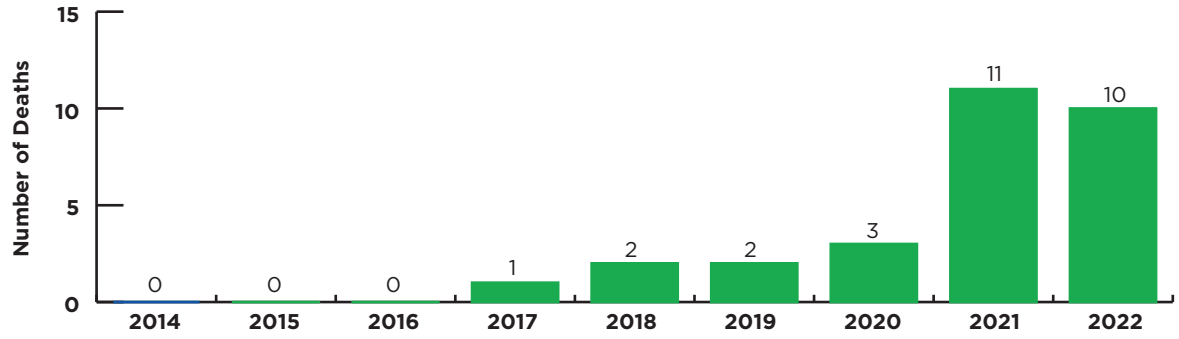
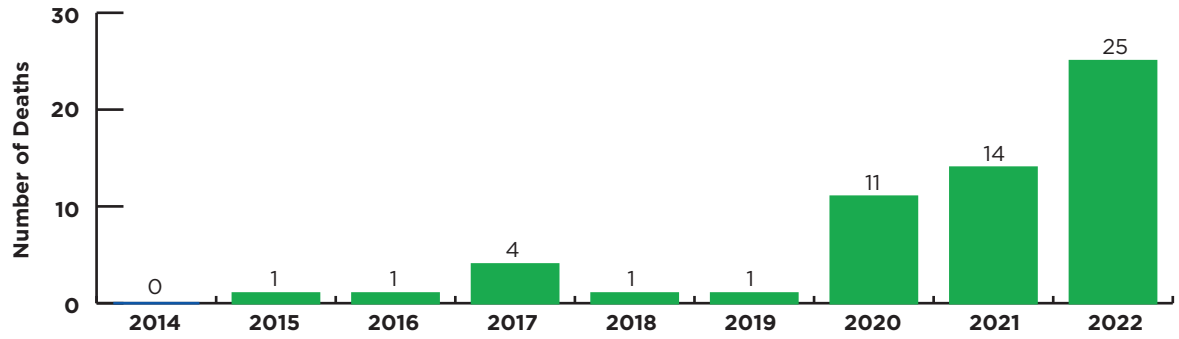


Figure 10. NC OCME Pediatric Fentanyl Deaths (13-17 years of age)



Child Fatality Task Force Leadership and Contact Information

Task Force Leadership

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

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

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

Committee Leadership

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

Co-Chairs: **Jennifer Kristiansen, MSW, LCSW,** Director of Social Services, Chatham County

Whitney Belich, JD, Child Abuse Resource Prosecutor, NC Conference of District Attorneys

The **Perinatal Health Committee** focuses on the reduction of infant mortality through strategies that support healthy pregnancies, birth outcomes, and infants.

Co-Chairs: **Belinda Pettiford, MPH,** Section Chief for Women, Infant, and Community Wellness in the Division of Public Health, NC Department of Health and Human Services

Sarah Verbiest, MSW, MPH, DrPH, Executive Director, Collaborative for Maternal and Infant Health in the UNC School of Medicine and Director, Jordan Institute for Families in the UNC School of Social Work

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

Co-Chairs: **Martha Sue Hall, MS,** Mayor Pro Tempore, City of Albemarle

Alan Dellapenna, RS, MPH, Retired from position as Branch Head, Injury and Violence Prevention Branch, Chronic Disease and Injury Section, Division of Public Health, NC Department of Health and Human Services (Alan was Co-Chair of this committee during the 2023-24 meeting cycle, departing the role on February 29th, 2024)

Scott K. Proescholdbell, MPH, (elected to begin serving as Co-Chair of this committee on February 29th, 2024) Epidemiologist and Unit Manager, Injury Epidemiology, Surveillance and Informatics Unit, Division of Public Health, Injury and Violence Prevention Branch, NC Department of Health and Human Services

NC Child Fatality Task Force Member Roster [58]

(As of the last meeting of the Task Force on 2/29/24)

Governor Appointees (4)

1. **A director of a county department of social services, appointed by the Governor upon recommendation of the President of the North Carolina Association of County Directors of Social Services**
   Jennifer Kristiansen, Director of Social Services, Chatham County | APPOINTMENT EXPIRATION: 1-31-26

2. **A representative from a Sudden Infant Death Syndrome or safe infant sleep counseling and education program, appointed by the Governor upon recommendation of the Maternal and Child Health Section of the Department of Health and Human Services**
   Dr. Sarah Verbiest, Executive Director, UNC Collaborative for Maternal & Infant Health | APPOINTMENT EXPIRATION: 1-31-25

3. **A representative from NC Child, appointed by the Governor upon recommendation of the President of the organization**
   Tiffany Gladney, Policy Director, NC Child | APPOINTMENT EXPIRATION: 1-31-25

4. **A director of a local department of health, appointed by the Governor upon the recommendation of the President of the North Carolina Association of Local Health Directors**
   Wes Gray, Health Director, Pitt County Health Department | APPOINTMENT EXPIRATION: 1-31-25

House Speaker Appointees (10)

1. **A representative from a private group, other than NC Child, that advocates for children, appointed by the Speaker of the House of Representatives upon recommendation of private child advocacy organizations**
   Karen McLeod, President and CEO, Benchmarks | APPOINTMENT EXPIRATION: 1-31-26

2. **A pediatrician, licensed to practice medicine in North Carolina, appointed by the Speaker of the House of Representatives upon recommendation of the NC Pediatric Society**
   Dr. Martin McCaffrey, Pediatrician, UNC | APPOINTMENT EXPIRATION: 1-31-26

3. **A representative from the North Carolina League of Municipalities, appointed by the Speaker of the House of Representatives upon recommendation of the League**
   Martha Sue Hall, Albemarle City Council; Board of Directors NC League of Municipalities | APPOINTMENT EXPIRATION: 1-31-26

4. **One public member, appointed by the Speaker of the House of Representatives**
   Katherine Pope | APPOINTMENT EXPIRATION: 1-31-26

5. **One representative of the NC Domestic Violence Commission, appointed by the Speaker of the House of Representatives upon recommendation of the Director of the Commission**
   Sarah Owens Weeks, Criminal Justice Faculty, Western Piedmont Community College | APPOINTMENT EXPIRATION: 1-31-26

6. **Five members of the House of Representatives, appointed by the Speaker of the House of Representatives.**
   Dr. Kristin Baker, Carla Cunningham, Donnie Loftis, Diane Wheatley, Donna White | APPOINTMENT EXPIRATION: 1-31-26 (all)

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

Senate Appointees (10)

1. **A representative from the North Carolina Association of County Commissioners, appointed by the President Pro Tempore of the Senate upon recommendation of the Association**
   Hope Haywood, County Commissioner, Randolph County | APPOINTMENT EXPIRATION: 1-31-25
2. **One public member, appointed by the President Pro Tempore of the Senate**
   Jill Cox, President & CEO, Communities in Schools NC | APPOINTMENT EXPIRATION: 1-31-25
3. **One representative of the NC Coalition Against Domestic Violence, appointed by the President Pro Tem of the Senate upon recommendation of the Executive Director of the Coalition**
   Trishana Jones, Programs Director, NC Coalition Against Domestic Violence | APPOINTMENT EXPIRATION: 1-31-25
4. **A county or municipal law enforcement officer, appointed by the President Pro Tempore of the Senate upon recommendation of organizations that represent local law enforcement officers**
   Thomas Jordan, Chief of Police, Brevard, NC | APPOINTMENT EXPIRATION: 1-31-25
5. **A district attorney appointed by the President Pro Tempore of the Senate upon recommendation of the President of the North Carolina Conference of District Attorneys**
   Sarah Kirkman, District Attorney, Judicial District 22A | APPOINTMENT EXPIRATION: 1-31-25
6. **Five members of the Senate, appointed by the President Pro Tempore of the SenateJim Burgin**
   Todd Johnson, Jim Perry, Vickie Sawyer, [Vacant] | APPOINTMENT EXPIRATION: 1-31-25 (all)

Ex Officio Members | APPOINTMENT EXPIRATION: ongoing

Ex Officio members may designate representatives to serve for them; members below with a * are designated representatives

The Chief Medical Examiner – Dr. Michelle Aurelius, Chief Medical Examiner

The Attorney General – Laura Brewer,* Deputy Chief of Staff, AG Josh Stein, NC DOJ

The Director of the Division of Social Services of the Department of Health and Human Services – Lisa Cauley, Senior Director of Child, Family, & Adult Services, Division of Social Services, NCDHHS

The Director of the State Bureau of Investigation – Kevin Tabron,* Asst. Director, SBI

The Director of the Maternal and Child Health Section of the Department of Health and Human Services – Dr. Kelly Kimple, Senior Medical Director for Health Promotion, NC Title V Director, NC Division of Public Health

The Director of Council for Women and Youth Involvement – Danielle Carman, Executive Director, CWYI

The Superintendent of Public Instruction – Karen Fairley,* Executive Director, NC Center for Safer Schools

The Chairman of the State Board of Education – Dr. Ellen Essick,* Section Chief, NC Healthy Schools, NCDPI

The Director of the Division of Child and Family Well-Being of the Department of Health and Human Services – Yvonne Copeland, Division Director, Child & Family Well-Being

The Secretary of the Department of Health and Human Services – Dr. Betsey Tilson,* State Health Director

The Director of the Administrative Office of the Courts – Lorrie L. Dollar,* Administrator, Guardian Ad Litem Program

Director of the Juvenile Justice Section, Division of Adult Correction and Juvenile Justice, Department of Public Safety – William Lassiter, Deputy Secretary for Juvenile Justice, DPS