The North Carolina Child Fatality Task Force: Advancing Public Policy to Save Children's Lives Since 1991

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Since 1991, the North Carolina Child Fatality Task Force has been a unique forum for advancing policy to save children's lives. A continued focus by the Task Force on data, evidence, and finding common ground remains important as we face current challenges of high infant mortality rates, suicide rates, and gun deaths.

Introduction

The North Carolina Child Fatality Task Force (the Task Force) was originally created to last just two years, from 1991 to 1993 [1]. Its work was extended for five more years, and during those seven years the Task Force played an important role in advancing public policy in child health and well-being in North Carolina [2, 3]. By 1998, the Task Force was established by state statute as a permanent component of a statewide child fatality prevention system (CFP system) [4].

The purpose of the CFP system, which also includes county- and state-level child death review teams, is to better understand the causes of child deaths and to identify system deficiencies in order to make and implement recommendations for preventing future child deaths and maltreatment[a] [5]. The Task Force is the policy arm of the CFP system and does not review individual cases of child deaths. Rather, the Task Force studies data surrounding child deaths as well as strategies for preventing child deaths and maltreatment. It is required to annually report child death data and make recommendations for changes in law or policy that promote child safety and well-being to the governor and General Assembly [6, 7]. The Task Force is comprised of 36 members, including state agency leaders, community leaders, experts in child health and safety, and 10 state legislators [8].

During its more than 30-year history, Task Force recommendations and efforts have led to numerous laws in North Carolina related to child health and safety, many of which are well-woven into our daily lives [3]. Examples include laws requiring smoke and carbon monoxide detectors, various child passenger safety laws, bike helmets for children, school bus and school zone laws, and the graduated driver license system for teens (North Carolina was the second state in the nation to adopt such a program, which was developed at the University of North Carolina). The Task Force also has played an important role in strengthening laws and systems related to addressing child abuse and neglect, and in advancing recommendations to prioritize funding for programs that address infant mortality prevention.

More recently, some examples of Task Force work that helped change public policy include laws and funding to prevent opioid-related deaths, a new law to require suicide prevention training for school personnel and a risk-referral protocol in schools, a law to expand newborn screening, and a law requiring a study of maternal and neonatal risk-appropriate care in hospitals. Some other recommendations made by the Task Force in the past few years that have not yet become law but have seen strong bipartisan support include a firearm safe storage initiative, strengthening the statewide CFP system, and strengthening the infant safe surrender law.[b] These are only a few of many health and safety policy advancements worked on by the Task Force through the years [3].

Since the 1991 creation of the Task Force and the broader

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[a] In addition to the Task Force, the larger statewide CFP system also has two types of local child death review teams in each county that review child deaths and some active child protective service cases, plus a state Child Fatality Prevention Team that is required to review child deaths related to abuse or neglect. (See Article 14 of the NC Juvenile Code.) There is also a separate but related state Child Fatality Review Team that uses some members of local teams to conduct in-depth reviews of deaths where the child or family was involved in child protectives services in the 12 months preceding the fatality (see N.C.G.S. 143B-150.20).

[b] A recommendation to launch and fund a statewide firearm safe storage awareness initiative was addressed in HB 427 in 2021, which passed the House on a vote of 116 to 1 and was included in the House version of the 2021 Appropriations Act but not the final Appropriations Act; this recommendation was also addressed in 2019 in HB 508, which was then included in the Appropriations Act of 2019, which never became law. A recommendation to strengthen the state's infant safe surrender law was addressed twice in legislation, most recently in HB 473, which passed the House unanimously in 2021 but did not receive a hearing in the Senate. A set of recommendations to strengthen the statewide child fatality prevention system was addressed in 2019 in HB 825 and in the 2019 Appropriations Act, which did not become law; in 2021 this set of recommendations was addressed in SB 703, which did not receive a hearing.

CFP system, the rates of child death in North Carolina have been cut almost in half; however, there is a great deal of work that remains [9]. During the past decade, the child death rate in North Carolina has not decreased significantly, and not as much as the US rate (Figure 1).[c] North Carolina's infant mortality rate in 2020 (the most recent finalized data) ranked among the eight highest in the nation. With infant deaths making up two-thirds of all child deaths in our state, the infant mortality rate is driving overall rates [9].

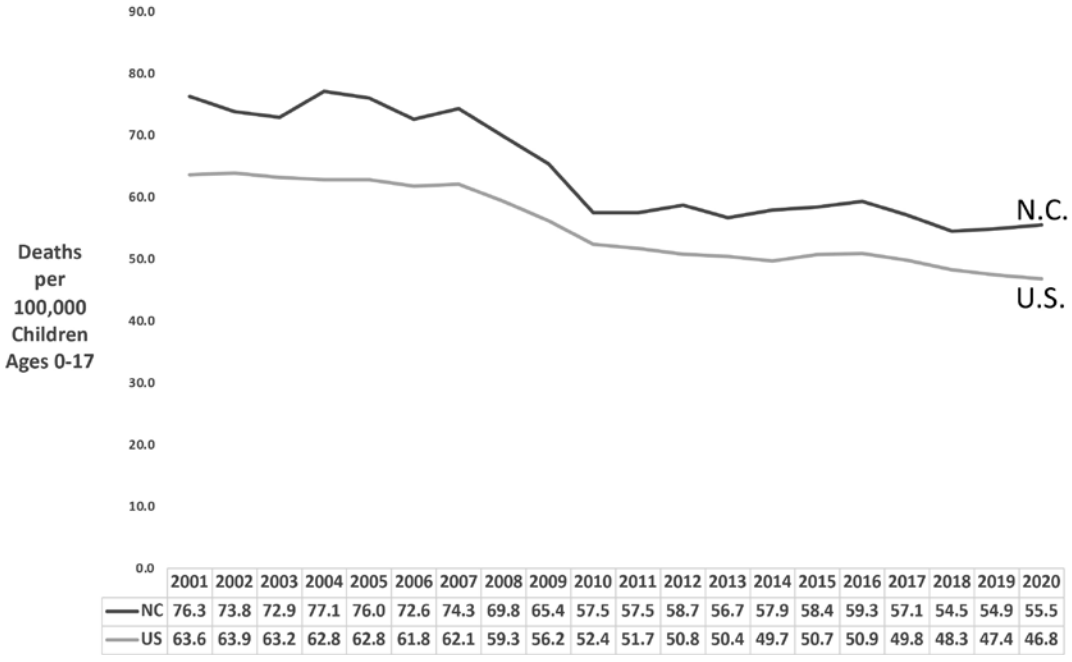
Recently, North Carolina has seen rising youth suicide rates (Figure 2); homicide rates; and related to those, a dramatic rise in firearm-related deaths (Figure 3) as firearms were the lethal means used in most homicides and suicides in 2020 [9, 10].[d] These concerning increases have coincided with a surge in gun purchases in the United States and a nationally recognized crisis in youth mental health [11–13].

Prevention Strategies

It is daunting to tackle problems like these, but there is so much that we can and must do! Many deaths are preventable through very tangible, concrete strategies that have recently been the subject of Task Force recommendations. For example, many infant deaths are preventable through prioritizing (which often means adequately funding and resourcing) prevention initiatives, such as those to prevent tobacco and nicotine use during pregnancy (associated with leading causes of infant death) or initiatives focused on the importance of infant safe sleep practices (in a typical year more than 100 infant deaths in North Carolina are associated with unsafe sleep environments) [3].

We also know that many firearm-related deaths are preventable through practicing safe firearm storage, so it is important to implement initiatives focused on safe storage [14]. When it comes to addressing youth mental health and suicide prevention, we know that school nurses, social workers, psychologists, and counselors each play a critical role.[e] Part of prevention means prioritizing policies and funding to close a significant gap between the numbers of those professionals currently in our North Carolina schools and the nationally recommended numbers, which are far higher.[f] Both the Task Force and the US Surgeon General's 2021 Advisory, "Protecting Youth Mental Health," have made

FIGURE 1.
Child Death Rates: United States and North Carolina, 2001–2020



	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
NC	76.3	73.8	72.9	77.1	76.0	72.6	74.3	69.8	65.4	57.5	57.5	58.7	56.7	57.9	58.4	59.3	57.1	54.5	54.9	55.5
US	63.6	63.9	63.2	62.8	62.8	61.8	62.1	59.3	56.2	52.4	51.7	50.8	50.4	49.7	50.7	50.9	49.8	48.3	47.4	46.8

Source. North Carolina Department of Health and Human Services, Division of Public Health, Title V Office.

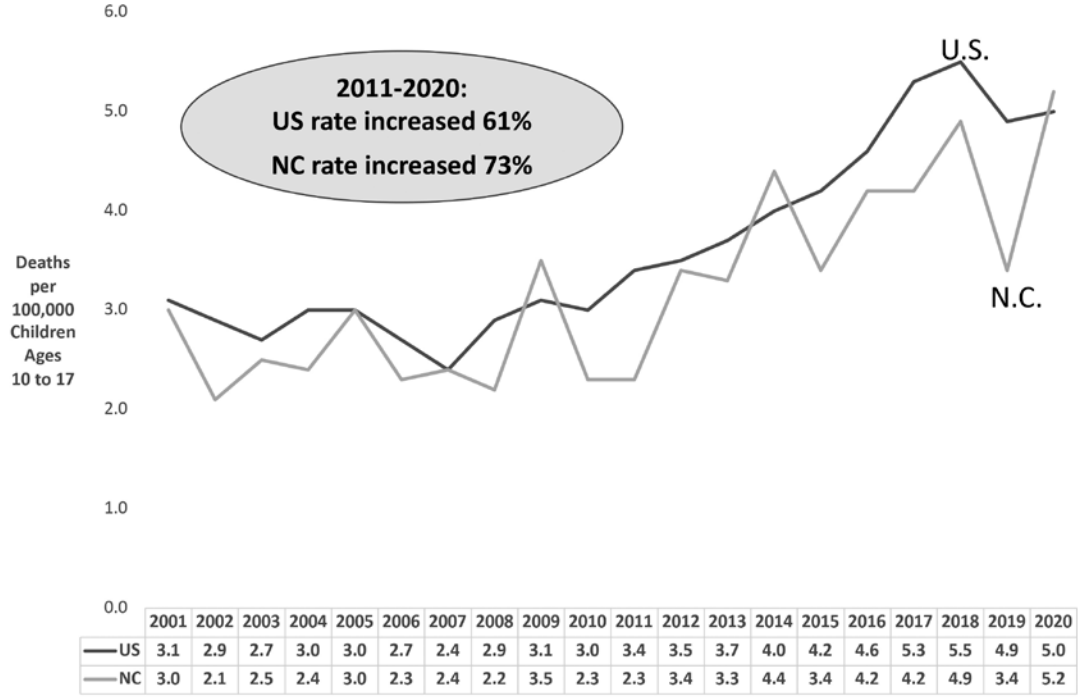
[c] The reduction in the child death rate in North Carolina from 2011 to 2020 was -3.5%, whereas the US reduction during that time period was -9.5%.

[d] In 2011, the rate of youth suicides in North Carolina was 2.3 per 100,000 children aged 10–17 and for 2020 that rate was 5.2. In 2011, the rate of homicides in North Carolina was 1.9 per 100,000 children aged 0–17 and in 2020 that rate was 4.0. In 2011, the rate of firearm-related deaths in North Carolina was 1.8 per 100,000 children aged 0–17 and in 2020 that rate was 4.7. In 2020, firearms were the lethal means used in 55% of youth suicides and 73% of child and youth homicides.

[e] To illustrate the involvement of these professionals in supporting student mental health and suicide prevention, the School Health Unit of the NC Division of Public Health reported that for the 2017–2018 school year, North Carolina school nurses reported over 2000 counseling sessions related to suicide ideation, over 5400 sessions related to depression, and over 13,000 sessions related to other mental health issues.

[f] Ratios for school health support personnel in North Carolina from data presented to the NC Child Fatality Task Force on February 7, 2022, by NC Dept. of Public Instruction: School counselor current ratio is 1:335 while recommended ratio is 1:250; school nurse current ratio is 1:890 while recommended ratio is 1 per school and in North Carolina 48% of school nurses serve in more than one school; school social worker current ratio is 1:1,025 while recommended ratio is 1:250; school psychologist current ratio is 1:1,815 while recommended ratio is 1:500.

FIGURE 2.
Suicide Rates, Ages 10 to 17: North Carolina and United States, 2001–2020



	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
US	3.1	2.9	2.7	3.0	3.0	2.7	2.4	2.9	3.1	3.0	3.4	3.5	3.7	4.0	4.2	4.6	5.3	5.5	4.9	5.0
NC	3.0	2.1	2.5	2.4	3.0	2.3	2.4	2.2	3.5	2.3	2.3	3.4	3.3	4.4	3.4	4.2	4.2	4.9	3.4	5.2

Source. North Carolina Department of Health and Human Services, Division of Public Health, Title V Office.

recommendations related to firearm safe storage and to expanding the numbers of these school professionals [3, 12].

Then there is a category of prevention strategies that are not so concrete, as they seek to address social factors that are complex but critically important to moving the needle on child deaths and infant mortality. Experts presenting to the Task Force have emphasized that factors contributing to leading causes of death often relate to social determinants of health, structural inequities, and adverse childhood experiences—all of which can be interrelated.

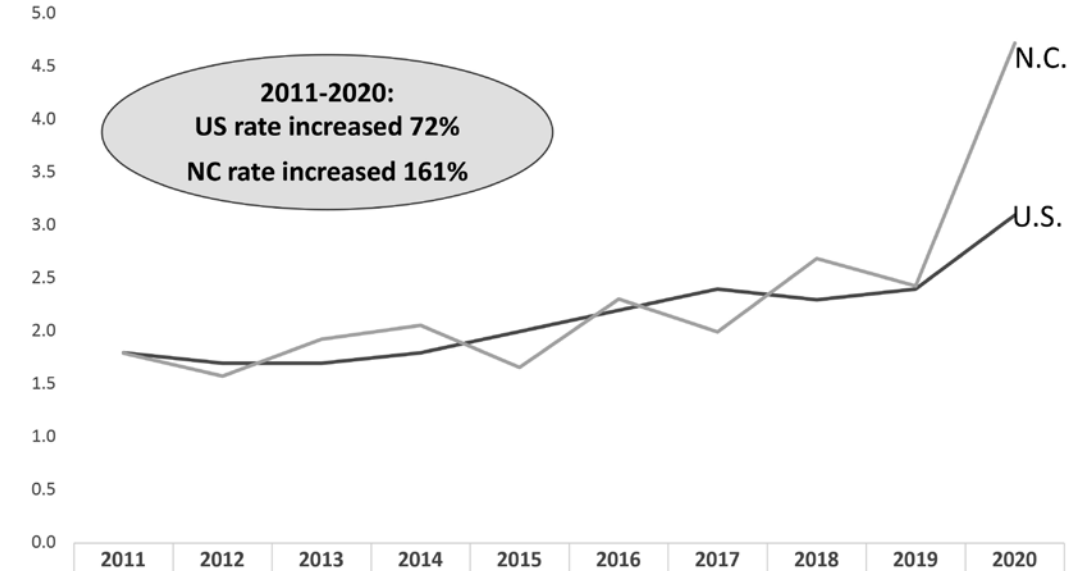
Addressing Social Determinants of Health, Inequity, and Adverse Experiences

As discussed in Task Force reports, social factors such as economic stability, access to quality health care and child care, safe housing, transportation, and the ability to take sufficient leave from work for illness or following child birth can impact health and well-being, while exposure to violence, racism, or any type of discrimination are examples of adverse experiences that can result in lasting negative physical and mental impacts [15, 16]. In fact, the Task Force has seen maps of North Carolina showing geographic patterns in social determinants of health and how areas of the state with higher infant mortality rates tend to be areas with more challenges related to social determinants of health [10]. Many of these types of social factors and adverse experiences may also impact one's risk of suicide or of being the victim or perpetrator of violence [17, 18].

An important part of this policy work—especially related to social factors—is using data to connect the dots on how certain factors can impact risk of death or adverse health outcomes, and allowing for education and conversation about that data. The composition and structure of the Task Force is well suited to this, providing a unique forum where experts in child health and safety (who can speak to data and evidence), state legislators (who have the power to create or change laws and systems), and state and community agency leaders (who are often implementing changes to laws and systems), come together to learn about data and evidence, ask questions of experts, and engage in discussion. Much of the success of the Task Force is no doubt attributable to this uniquely structured forum that lends itself to better understanding of issues, leading to more informed policy recommendations.

One example of Task Force work that focused on social factors—and where "connecting the dots" was important—was the Task Force's recommendation on paid family leave insurance in 2020. Some Task Force members were initially skeptical about the relevance of this topic to the goal of preventing child deaths. Task Force efforts to learn more led to an in-depth, outside study of the issue performed by Duke University [20]. Results of the study reported to the Task Force showed various benefits that paid family leave insurance in North Carolina would have for families and employers, including saving an estimated 26 infant lives per year [19]. While a statewide paid family leave insurance pro-

FIGURE 3.
Firearm-related Mortality Rates,* Children Ages 0 to 17: North Carolina and United States, 2011–2020



	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
US	1.8	1.7	1.7	1.8	2.0	2.2	2.4	2.3	2.4	3.1
NC	1.8	1.6	1.9	2.1	1.7	2.3	2.0	2.7	2.4	4.7

Source. North Carolina Department of Health and Human Services, Division of Public Health, Title V Office.
*Firearm deaths included the following ICD mortality codes: Unintentional W32-W34; Suicide X72-X74, Homicide X93-X95, U014, Undetermined Y22-Y24

gram has not (yet) become a reality in North Carolina (bills have been introduced but have not advanced), more North Carolina leaders now have information about how paid time off to care for a newborn would literally save babies' lives.

Another lever for improving social factors through better information lies within the CFP system's local child death review teams that exist in every county in North Carolina, and their potential to be significant engines of local prevention and change. These teams are made up of community leaders from a variety of sectors that have a role in child well-being, including public health, social services, schools, courts, mental health, law enforcement, and more [20]. A team's review of individual deaths has the potential to identify social factors that could have contributed to a death, providing opportunities for those leaders to pool their collective resources or make recommendations to county commissioners to address a need in their community. For example, a team might identify and work to implement solutions to barriers in their community for accessing prenatal health care, mental health services, or help for domestic violence, and their work could be useful in informing state policy. The important role of these teams is why the Task Force has been working to optimize their reviews, their recommendations, their collection and reporting of data, and their ability to inform local- and state-level prevention work and policy change.

Engaging Stakeholders on Common Ground

An important area of policy work generally, and one of the keys to Task Force success, is in stakeholder engagement and the ability to bring people from different perspectives together to find common ground.

The Task Force's recommendation for legislation to launch and fund a statewide firearm safe storage initiative was informed by the work of a diverse group of experts and stakeholders, including advocates from both sides of the gun issue, who came together to identify ways to move forward to improve safe storage practices in our state. This Task Force recommendation has twice resulted in proposed legislation, most recently in a bill that passed the House one vote shy of unanimously in 2021 and funding for a safe storage awareness campaign and for gun locks was in the 2022–2023 budget of Governor Roy Cooper [21]. While we have not yet seen new laws or state funding to support a firearm safe storage initiative, the fact that this recommendation received significant support demonstrates that consensus on an issue involving guns is possible and we may see progress on this in the future.

A second example of the importance of stakeholder engagement is the extensive work done by the Task Force related to strengthening the statewide child fatality prevention system. This began with a statewide child fatality prevention summit in 2018 that included leaders from child death review teams across the state, national experts in child health and safety, and other state leaders who came together to share information about best practices and challenges in their work. More than 200 individuals convened to learn from one another and from experts, and to help identify improvements to the system [22]. Building on work that

began at this summit, the Task Force developed a set of recommendations to strengthen the system that were adopted in an outside evaluator's child welfare reform plan presented to the legislature in 2019 [23]. Work to strengthen the system also has included significant engagement with leaders in the North Carolina Department of Health and Human Services (NCDHHS), who supported the Task Force recommendations and collaborated with the North Carolina Institute of Medicine on additional stakeholder engagement to gather feedback on how NCDHHS would implement them. The Task Force recommendations were twice addressed in legislation that, despite meeting no opposition, has not become law, and the topic of ensuring a strong child fatality prevention system remains an issue of focus for the Task Force [3].

The path to advancing public policy to save children's lives has many challenges, twists, and turns, and not every recommendation gets over the finish line. The North Carolina Child Fatality Task Force continues to leverage its unique structure and membership—as well as the passion and dedication of those involved in its work—to advance policies that save children's lives and improve child well-being. NCMJ

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