2023-2024 General Assembly

HOUSE BILL 259:
2023 Appropriations Act, Sec. 9H.15(f)-(i): Modifications and Additions to Child Fatality System Statutes to Restructure Child Death Review Teams, Implement Participation in the National Fatality Review Case Reporting System, and Clarify the Functions of the North Carolina Child Fatality Task Force

Committee:		**Date:**	December 4, 2023
Introduced by:		**Prepared by:**	Debbie Griffiths
Analysis of:	Sec. 9H.15(f)-(i) of S.L. 2023-134		Staff Attorney

OVERVIEW: Section 9H.15(f)-(i) of S.L. 2023-134 amends Article 14, North Carolina Child Fatality Prevention System, of Chapter 7B of the General Statutes, by amending current statutes and creating new statutes pertaining to (i) the North Carolina Child Fatality Task Force; (ii) the responsibilities for the Local Team for each County or the Multicounty Local Team; (iii) the review of child maltreatment deaths; (iv) the review of infant deaths; (v) Team findings and reporting; (vi) the duties of the medical examiner child fatality staff; (vii) the duties of the director of the local department of health, director of county department of social services, or consolidated health and human services director; (viii) records access; (ix) participation in the National Fatality Review Case Reporting System; and (x) administration and funding.

The Child Fatality Prevention System is a statewide system that includes: Local Teams, the North Carolina Child Fatality Task Force (Task Force), the State Office, and the medical examiner child fatality staff. The following terms are defined as follows (G.S. 7B-1401):

- ***Local Team – A multidisciplinary child death review team that is either a single or multicounty team responsible for performing any type of review required by law (Article 14, Chapter 7B).***
- ***Medical Examiner child fatality staff – Staff within the Office of Chief Medical Examiner whose primary responsibilities involving reviewing, investigating, training, educating, or supporting death investigations of child fatalities falling under the medical examiner's jurisdiction.***
- ***National Fatality Review Case Reporting System (NFR-CRS) – The web-based system used by a majority of states to provide child death teams with a method of capturing, analyzing, and reporting a full set of information provided at the review.***
- ***State Office – The State Office of Child Fatality Prevention (as established in Section 9H.15(a) of S.L. 2023-134.)***

The North Carolina Child Fatality Task Force (G.S. 7B-1402.5) will receive recommendations from three new committees: a Perinatal Health Committee, an Unintentional Death Prevention Committee, and an Intentional Death Prevention Committee. The recommendations developed by the committees and submitted to the Task Force become effective upon majority vote of the Task Force. The Task

Force chair or cochairs will work with the Secretary of the Department of Health and Human Services to hire or designate staff to coordinate the work of the Task Force. Task Force duties (G.S. 7B-1403) are outlined below.

- ***Study the incidences and causes of child deaths in the State and evidence-driven strategies for prevention of future deaths, abuse, and neglect. The minimum study requirements include:***
    - ***Aggregate information from child death reviews complied by the State Office addressing data on child deaths, systemic problems, and Local Team recommendations for prevention or changes in law or policy.***
    - ***A data analysis of all child deaths by age, cause, race and ethnicity, socioeconomic status, and geographic distribution.***
    - ***Information from subject matter experts to aid in understanding the cause of child deaths, strategies to prevent child deaths, abuse, and neglect, or a combination of these.***
- ***Advise the State Office regarding an effective statewide system for multidisciplinary review of child deaths and implementation of evidence-driven strategies to prevent child deaths, abuse, and neglect.***
- ***Receive reports from the State Office addressing aggregate data, information, findings, and recommendations resulting from Local Team reviews of child deaths, the functioning of the statewide system, and any other information the Task Force deems relevant to carrying out its duties.***
- ***Recommend changes in law, policy, rules, or implementation of evidence-driven prevention strategies.***
- ***Any other study, evaluation, or determination the Task Force considers necessary to carry out its duties.***

Reports -The Task Force is required (G.S. 7B-1412) to report annually within the first week of the convening or reconvening of the General Assembly. The reports must be made to the General Assembly, the Governor, the Secretary of Health and Human Services, and the Chairs of the House and Senate Appropriations Committees on Health and Human Services, the Joint Legislative Oversight Committee on Health and Human Services, the Joint Legislative Oversight Committee on Justice and Public Safety, and the Joint Legislative Education Oversight Committee. At a minimum, the report must contain: a summary of the conclusions and recommendations for each of the Task Force's duties, a summary of activities and functioning of the Child Fatality Prevention System as a whole, and any other recommendations for changes to any law, rule, policy, or for the implementation of evidence-driven strategies that will promote the safety and well-being of children including specific legislative policies or proposals. The Task Force may seek assistance from the Fiscal Research Division of the General Assembly in the development of fiscal notes or other fiscal information to accompany the recommendations.

Administration – Current law (G.S. 7B-1414) is amended to require the Task Force to work with the Secretary of Health and Human Services to hire or designate staff consultants to assist the Task Force and its committees. The amendments also clarify travel and subsistence expense payment for Task Force members.

<u>Local Teams</u> (G.S. 7B-1406.5) – Each county's local board of commissioners must determine whether the county will have its own Local Team or participate in a multicounty Local Team. The board of commissioners will make the determination based on a consultation with the local health department

director, the local department of social services director or the consolidated human services director, and guidance created by the State Office. Local Teams must participate in periodic training provided by the State Office and must employ best practices in conducting child death reviews.

Local Team Mandatory and Permissive Review of Deaths - Each Local Team must conduct a mandatory review (G.S. 1406.5(c)) for all child deaths of resident children under age 18 in the county or counties comprising the Local Team that fall under the following categories: (i) undetermined cause of death, (ii) unintentional injury, (iii) violence, (iv) motor vehicle incidents, (v) deaths related to child maltreatment or where the child or the child's family was reported to child protective services, (vi) sudden unexpected infant death, (vii) suicide, (viii) deaths not expected in the next six months, and (ix) infant deaths related to low birth weight, short gestation, perinatal complications, etc (G.S. 7B-1407.6). A review of fatalities outside of the nine required categories is permitted. The Local Team would also review an active case or cases if requested by the director of the local department of social services. Under these circumstances, the Local Team is not required to make findings or create reports of such reviews but may develop recommendations.

Local Team Composition (G.S. 7B-1407) – Local Teams must consist of representatives of public and nonpublic agencies that provide services to children and their families and other individuals who represent the community. The required membership for the Local Team was increased from 10 to 15 members with the following representatives added: an emergency medical services provider or firefighter, a district court judge, a county medical examiner, a representative of a local childcare facility or Head Start program, and a parent of a child who died before reaching the child's eighteenth birthday. Previously, these five additional individuals were included under limited certain circumstances. The chair of the Local Team may appoint up to an additional five ad hoc members on a case-by-case basis if the chair believes the individual's area of expertise will aid in the evaluation of a specific case. An ad hoc member may be selected from outside of the area served by the Local Team and must sign the same confidentiality agreement as the permanent members.

Review of child maltreatment deaths and deaths of children known to child protective services (CPS) (G.S. 7B-1407.5) – The provisions of this law apply when, in addition to other requirements, the following criteria are met: the decedent was reported as being abused or neglected regardless of the final disposition of that report; there was a report of abuse or neglect involving the child's family within three years of the child's death regardless of the disposition; the decedent or the decedent's family was involved with CPS within three years of the child's death; available information indicates that possible abuse or neglect may be a direct or contributing cause of the child's death.

Under this new law, the State Office is required to perform the steps below for child death reviews when the criteria outlined above is met.

- ***Develop policies, procedures, and tools to address effective reviews of these types of deaths based on best practices and available resources.***
- ***Provide technical assistance to the Local Teams which may include assistance coordinating the review, gathering information, determining participants, following procedures, developing recommendations, and drafting reports.***
- ***Create a proper process that complies with federal and State laws for the creation and release of reports resulting from Local Teams' review of deaths under these categories. and addresses the following: findings and recommendations related to improving coordination between State and local entities regarding child deaths in these categories; disclosure of information in child fatality or near fatality cases (G.S. 7B-2902); and information the State is required to disclose under federal law.***

- ***Develop and implement a process to follow up with an agency on the implementation of recommendations. If feasible, the State Office should work with the agency to assist in implementation of the recommendations.***
- ***Work with the Division of Social Services, the Office of the Chief Medical Examiner, the State Center for Health Statistics, and other relevant experts and agencies in the development of a system for the State Office to identify these categories of child fatalities and a system for defining, identifying, and including the child fatality data North Carolina is required to report to the federal government.***
- ***Work with the Division of Social Services (DSS) to determine the manner in which information from internal fatality reviews by DSS can appropriately inform Local Team reviews of these cases.***
- ***Work with DSS to determine the manner in which information from a review of child maltreatment deaths and deaths of children know to CPS can be shared with citizen review panels (established under G.S. 108A-15.20).***

When reviewing child maltreatment deaths and deaths of children known to CPS, Local Teams have the following powers and duties regarding their review:

- ***Conduct reviews within the policies and procedures established by the State Office and seek technical assistance from the State Office when necessary.***
- ***When the Local Team determines it is necessary, the Team may conduct interviews of individuals who are determined to have pertinent information regarding the death under review and may examine pertinent written documentation. The Local Team may not contact or interview family members of the decedent or conduct an interview or take other action which would interfere with a law enforcement investigation or the duties of the district attorney.***
- ***Work with the State Office to produce a report appropriate for public release addressing the findings and recommendations within the limitations of State and federal law. Consultation with the district attorney must occur prior to the release of this report. The findings of this report are not admissible as evidence in any civil or administrative hearing against individuals or entities participating in a review required under these circumstances.***

Review of infant deaths (G.S. 7B-1407.6) – The State Office is required to consult with perinatal health experts and participants in reviews of infant deaths, to develop criteria Local Teams must use to identify a subset of additional infant deaths subject to review that fall outside of the nine categories for mandatory review of deaths (G.S. 7B-1406(c)) taking into account the leading causes of infant death such as short gestation, low birthweight, and perinatal complications. These criteria must be updated at least biannually.

Team Findings and Reporting (G.S. 7B-1407.10) - The Local Team must make findings addressing at least the following for each child death reviewed: significant challenges faced by the child or family, the systems with which they interacted, and the outcomes of those interactions; notable positive elements that may have promoted resiliency in the child or family, the systems with which they interacted and the outcome, recommendations and initiatives that could be implemented to prevent future deaths, and whether the cause or a contributing cause of death was related to child abuse or neglect. There are reporting requirements for required reviews, permissive reviews, and to the county commissioners:

- ***For each required review (G.S. 7B-1406(c)) information about the case, the circumstances surrounding the death, and the Local Team's finding must be entered into the National Fatality Review Case Reporting System (NFS-CRS) in accordance with required law (G.S. 7B-1413.5).***
- ***For each permissive review (G.S. 7B-1406.5(d)), the Local Team may enter case information into the (NFS-CRS).***
- ***Local Teams must submit an annual report to the board of county commissioners that includes recommendations, if any, for systemic improvements and resources needed to fill gaps or deficiencies. The report must be simultaneously provided to the State Office.***

Duties of the medical examiner child fatality staff (G.S. 7B-1407.15) - Medical examiner child fatality staff must work collaboratively with the State Office and Local Teams and provide Local Teams with access to completed reports for review, enter relevant information into NFR-CRS, respond to State Office or Task Force request for data, serve as subject matter experts, and offer training to law enforcement related to child death investigation.

Duties of the director of the local department of health; director of the county department of social services; or consolidated health and human services director for counties with consolidated human services (G.S. 7B-1410) – Current law is amended to add a duty for the director of the local department of health to serve alongside the Local Team as a liaison between the State Office and the Local Team. Additionally, the following duties for the local department of social services director as a member of the Local Team are added: serve along with the Local Team Chair as a liaison between the State Office and the Local Team; provide staff support for cases reviewed under the permissive review of active CPS cases (G.S. 7B-1405.5(e)) or review of child maltreatment deaths or deaths of children know to CPS (G.S. 7B-1407.5); report on Team activities quarterly to the county board of social services, or as required by the board; determine whether and when to request the Local Team, or citizen review panel, to review an active CPS case as required by law (G.S. 7B-1406.5(e) and G.S. 108A-15.20).

Participation in the National Fatality Review Case Reporting System (NFR-CRS) (G.S. 7B-1413.5) – A new law is created that requires Local Teams, the State Office, and medical examiner child fatality staff to utilize the NFR-CRS to collect, analyze, and report information on child death reviews. The State Office is required to provide coordination, training, management, and technical assistance to support the State's full and effective participation in NFR-CRS. The State Office is also required to provide policies, guidelines, and training for Local Teams for NFR-CRS use including the protection of information and authorized access.

Section 9H.15(i) of S.L. 2023-134 provides that participation in the NFR-CRS, as contained in G.S. 7B-1413.5, becomes effective July 1, 2025.

Access to records and Disclosure in child fatality or near fatality cases - Current law (G.S. 7B-1413) is amended to make conforming changes using the new process and terminology previously outlined above. With regard to record access, the law clarifies that subject to all State and federal laws, the Local Teams, Task Force, and State Office have access to all medical records, hospital records, and records maintained by the State, any county, or any local agency deemed necessary to carry out the law (Article 14, Chapter 7B). If requested information is not received within 30 days from making the request, the requesting entity may file an application in district court of the county where the review is taking place seeking a court order compelling disclosure of the records. The district court must schedule the matter for immediate hearing and appellate courts must give priority to appeal of those orders. Additionally, citizen review panels are given access to information obtained or created under these provisions when the information is relevant to the purposes of the citizen review panels.

***Disclosure in child fatality or near fatality cases** - Current law (G.S. 7B-2902) is amended to make conforming changes using the new process and terminology previously outlined above.*

***Effective Dates** - Except as otherwise provided, Section 9H.15 (f) and(g) summarized above became effective October 3, 2023.*

Section 9H.15(h) of S.L. 2023-134 repeals the following laws effective January 1, 2025: State Team creation, membership, duties (G.S. 7B-1404); State Team duties (G.S. 7B-1405), Community Child Protection Teams: Child Fatality Prevention Teams; creation and duties (G.S. 7B-1406), Child Fatality Prevention Team Coordinator; duties (G.S. 7B-1408), Community Child Protection Teams; duties of the director of the county department of social services (G.S. 7B-1409), Community Child Protection Teams; responsibility for training of team members (G.S. 7B-1411), State Child Fatality Review Team; establishment; purpose; powers; duties; report by Division of Social Services (G.S. 143B-150.20).