This Bill Analysis reflects the contents of the bill as it was presented in committee.

HOUSE BILL 862:
Strengthen Child Fatality Prevention System.

2023-2024 General Assembly

Committee:	House Health. If favorable, re-refer to Appropriations. If favorable, re-refer to Rules, Calendar, and Operations of the House	**Date:**	May 16, 2023
Introduced by:	Reps. K. Baker, White, Potts, Reeder	**Prepared by:**	Debbie Griffiths Staff Attorney
Analysis of:	First Edition		

OVERVIEW: House Bill 862 would do the following:

- ***Establish a State Office of Child Fatality Prevention (State Office) within the Department of Health and Human Services, Division of Public Health (DHHS-DPH), and appropriate funds for that purpose.***
- ***Restructure existing child death review teams.***
- ***Implement participation in the National Fatality Review Case Reporting System (NFR-CRS).***
- ***Clarify the functions of the North Carolina Child Fatality Review Task Force.***
- ***Establish North Carolina Citizen Review Panels as required by the federal Child Abuse Prevention and Treatment Act (CAPTA).***
- ***Make conforming and technical changes.***

CURRENT LAW: The current Child Fatality Prevention System is a statewide multidisciplinary, multiagency consisting of the North Carolina Child Fatality Prevention Team (the State Team) and Local Teams which include a Community Child Protection Team and, in some counties, a Child Fatality Protection Team.

Each county has a Community Child Protection Team which reviews (a) selected active cases where a child is being served by CPS and (b) cases where a child died as a result of suspected abuse or neglect where a report was made about the child or the child's family within the previous 12 months, or the child or the child's family received child protective services within the previous 12 months. The Community Child Protection Team may also review additional child fatalities which include any death not resulting from abuse or neglect and about which no report of abuse or neglect had been made within the previous 12 months. If the Community Child Protection Team chooses not to review additional child fatalities, A Child Fatality Prevention Team must be established in that county. Both teams must submit an annual report to the county commissioners with any recommendations and advocate for system improvement and needed resources to fill existing gaps. A report must be made the Team Coordinator regarding additional child fatalities including identification of system problems and recommendations for prevention as well as changes resulting from recommendations. The Team Coordinator reports information related to child fatalities to the State Team.

The State Team duties include review of child fatalities attributed to child abuse or neglect or when the decedent was reported as an abused or neglected juvenile at any point before their death, and reporting to

the Task Force recommendations for changes to rules, laws, and policies to promote the safety and well-being of children.

The North Carolina Child Fatality Task Force's (the Task Force) duties include undertaking a statistical study of incidences and causes of child deaths, developing a system for multi-disciplinary review of child deaths, and receiving and consideration of reports from the State Team.

BILL ANALYSIS:

PART I. ESTABLISHMENT OF STATE OFFICE OF CHILD FATALITY PREVENTION WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF PUBLIC HEALTH, AND APPROPRIATING FUNDS FOR THAT PURPOSE.

Part I would create a State Office to serve as the lead agency for child fatality prevention in the State, oversee the support for the statewide child fatality prevention system, maximize efficiency and effectiveness, and expand system capacity. The statewide child fatality prevention system would consist of Local Teams, the North Carolina Child Fatality Prevention Task Force, the State Office, and the medical examiner child fatality staff.

The powers and duties of the State Office would include:

- Coordination of the work of the statewide child fatality prevention system.
- Implementation and management of a centralized data and information system for gathering, analyzing, and reporting aggregate information from child death review teams.
- Creation and implementation of tools, guidelines, resources, and training, and providing technical support to local teams.
- Working with medical examiner child fatality staff and the North Carolina State Center for Health Statistics to provide local teams initial information about child deaths in their respective counties.
- Performance of research, consultation with stakeholders and experts, and collaboration with other organizations to understand the direct and contributing cause of child deaths and evidence driven strategies to prevent child deaths, abuse, and neglect.
- Education of State and local leaders, stakeholders, advocates, and the public about the child fatality prevention system and issues and prevention strategies addressed by the system.

For the 2023-2024 fiscal year, the recurring sum of $569,885 and the nonrecurring sum of $18,115 would be appropriated from the General Fund to the DHHS-DPH. For the 2024-2025 fiscal year, the recurring sum of $758,885 would be appropriated. The appropriation provisions would become effective July 1, 2023.

PART II. TRANSITION PLAN FOR SHIFTING STATE SUPPORT OF THE CHILD FATALITY PREVENTION SYSTEM TO THE STATE OFFICE, CREATING AND SUPPORTING A CENTRALIZED DATA AND REPORTING SYSTEM, AND RESTRUCTURING EXISTING CHILD DEATH REVIEW TEAMS.

Part II contains the transition plan to the State Office and would require DHHS to meet the following deadlines:

- **By July 1, 2024,** DHHS would be required to report to the Joint Legislative Oversight Committee on Health and Human Services, and the Fiscal Research Division, on the status of creating, implementing, and staffing the State Office, and would be required to provide support to the Local Teams.

- **By January 1, 2025,** DHHS would be required to have the State Office sufficiently staffed and prepared to carry out its required duties and have all necessary agreements executed for participation in the NFR-CRS.
- **By July 1, 2025,** DHHS, through the State Office, would be required to ensure all Local Teams have been provided training and guidelines regarding participation in NFR-CRS and Local Teams would be required to begin using that system.

PART III. MODIFICATIONS AND ADDITIONS TO CHILD FATALITY PREVENTION 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.

Part III amends Article 14 of Chapter 7B of the General Statutes, entitled North Carolina Child Fatality Prevention System, as follows:

- **The Child Fatality Prevention system** would be restructured. The current Community Child Protection Teams and Child Fatality Prevention Teams would be combined to form Local Teams. The system would also include the Task Force, the State Office, and the medical examiner child fatality staff.
- **The Task Force** would receive recommendations from three new committees-the perinatal committee, the unintentional death committee, and the intentional death committee. The recommendations would become effective upon majority vote of the Task Force. Additional duties would include use of evidence-driven strategies for preventing future child deaths, abuse, or neglect, and receipt and review of data, information, findings, and recommendations from the State Office. Annual reports 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 and several Joint Legislative Oversight Committees would be required.
- **Local Teams** would be single or multi-county, consist of multidisciplinary membership, review any child fatality in one of the following nine categories: (1) undetermined cause of death, (2) unintentional injury, (3) violence, (4) motor vehicle incidents, (5) deaths related to child maltreatment or where the child or the child's family was reported to CPS, (6) sudden unexpected infant death, (7) suicide, (8) deaths not expected in the next six months, and (9) infant deaths related to low birth weight, short gestation, perinatal complications, etc., and make findings regarding each death reviewed including challenges faced by the family, positive elements which may have promoted resiliency, recommendations, and initiatives to prevent future deaths, and whether the cause of death was related to child abuse or neglect. Review of child fatalities outside of the nine categories would be permissive. The Local Team would also review an active case or cases if requested by the director of the county department of social services.
- **Medical examiner child fatality staff** would be required to 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.
- Subject to all State and federal laws, the Local Teams, Task Force, and State Office would 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 purpose of Article 14. The child, parent of a

child, or any other family member of a child whose record is being reviewed could not be contacted. If the requested records are not received after 30 days from making the request, the requesting entity may file an application in district court seeking a court order compelling disclosure of the records.

- Local Teams, the State Office, and medical examiner child fatality staff would be required to use the NFR-CRS for collecting, analyzing, and reporting information learned through the child death reviews. The State Office would be required to provide policies, guidelines, and training to Local Teams. These provisions would become effective July 1, 2025.
- Except as otherwise provided, the provisions of Part III would become effective January 1, 2025.

PART IV. ESTABLISHMENT OF NORTH CAROLINA CITIZEN REVIEW PANELS.

Part IV would establish at least three citizen review panels as required by CAPTA to be operated and managed by a qualified organization independent from any State or county department of social services. Each panel would consist of volunteer members broadly representing the community including members with expertise in the prevention and treatment of child abuse and neglect and may include adult former victims of child abuse or neglect. The panels would evaluate the extent to which the State is meeting its responsibilities under its CAPTA State Plan, review policies, procedures, and practices of State and local child protection agencies, and may review any other criteria it determines important to the safety of children, including review of child fatalities and near fatalities, and the extent to which the State and local child protective services are coordinated with Title IV-E foster care and adoption assistance programs of the Social Security Act. The panels must include public outreach and comment to assess the impact of current procedures and practices on children and families. The panels would be required to prepare an annual report available to the State and public summarizing the panel's activities and recommendations for improvement of child protection at the State and local level. The Division of Social Services would be required to prepare a response to the review panels' report describing whether or how the recommendations will be incorporated to make measurable progress in improving State and local child protective services.

Part IV would become effective January 1, 2025.

EFFECTIVE DATE: Except as otherwise provided, the act would become effective when it becomes law.