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

Raleigh, North Carolina
May 2014
Distinguished Members of the General Assembly

The future prosperity of North Carolina depends on the health and well-being of our next generation. Promoting strong policies to improve health, reduce death and decrease abuse and other injuries is central to positive child development. The NC Child Fatality Task Force is a legislative study commission charged with examining trends in child deaths and recommending changes in law and policy to promote well-being and prevent future deaths. The Task Force serves as the policy arm of our state’s Child Fatality Prevention System, which also includes the State Child Fatality Prevention Team, and local Community Child Protection Teams and Child Fatality Prevention Teams. More than 11,000 additional children are alive today – many of them now adults – thanks to the lower child fatality rate. This reduction is a testament to the work of CFTF members and participants, policy-makers, and front-line workers putting these policies into practice on daily basis.

Since the Martin Administration, the NC Child Fatality Task Force has enjoyed the support of both the Governor and the General Assembly. Recommendations submitted each year to prevent child deaths have been given serious consideration, and often have been adopted. The positive response to these recommendations has played a critical role in reducing North Carolina’s child death rate by 45 percent since the inception of the Task Force. The 2012 child death rate was less than 59 deaths per 100,000 children under age 18.

Continued improvement will require that we maximize the return of every public dollar spent on children. That is why the CFTF recommends that the State conduct an ROI analysis of children’s program through the Results First model. In addition to this cross-cutting recommendation, we also have recommendations relating to helping babies be born healthier and reaching their first birthdays, strengthening adoption services, and assuring that the progress NC has made in taking back opioids and other medications is not stymied by lack of funding for safe disposal.

The recommendations reflect the time and input of diverse experts. However, it is the support of the Governor and General Assembly that transforms these recommendations into state policies to that can save lives.

Our children, Our future, OUR responsibility…

Karen McLeod, Co-Chair  Peter Morris, Co-Chair  Elizabeth Hudgins, Executive Director
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The NC Child Fatality Task Force Study Process

The three committees of the North Carolina Child Fatality Task Force used 2011 and 2012 child fatality data, trend data and other professional expertise to study the causes of child deaths and to prepare recommendations for Task Force consideration for the 2013 and 2014 Legislative Agendas. A separate work group examined the issue of return on investment in child portfolios.

• The Intentional Death Prevention Committee, which studies violent deaths such as homicide and suicide, put forth a recommendation relating to disrupted adoptions. It also seeks to preserve funding at 2012 levels for certain services for children who have been abused or neglected, Child Advocacy Centers and the Child Medical Evaluation Program.

• The Perinatal Health Committee, which studies infant mortality and women’s health, put forth the recommendation for one-time funding to expand a permanent facility (Horizons) to provide medical and wrap-around services to pregnant and recently delivered women and their children affected by substance abuse disorders, coverage of lactation services through Medicaid which is predicted to both save lives and state dollars even in the short-run, and funding to preserve a bundle of key infant mortality prevention programs that addresses preconception, pregnancy, clinical needs, and first year of life.

• The Unintentional Death Committee, which studies public health unintentional injury and death, put forth a variety of recommendations including assuring continued progress on efforts to “take-back” opioids and other medications through events and permanent drop boxes by providing funds for safe disposal, banning minors from using commercial tanning beds, and funding to monitor and track poisonings across the state.

The members of the NC Child Fatality Task Force thank all its committee members for their hard work, expertise, and commitment to protecting children. Their effort is reflected in the action agenda, which was adopted on April 7, 2014.
2012 CHILD DEATHS IN NORTH CAROLINA

Trend in Rate of Child Deaths 1991-2012* 
Ages Birth through 17 Years

<table>
<thead>
<tr>
<th>Cause of Death</th>
<th>Average Annual Number 2008-2012</th>
<th>Number in 2011</th>
<th>Number in 2012</th>
<th>Percent Change 2011-2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth defects</td>
<td>211</td>
<td>197</td>
<td>206</td>
<td>4.6%</td>
</tr>
<tr>
<td>Other birth-related conditions</td>
<td>477</td>
<td>458</td>
<td>437</td>
<td>-4.6%</td>
</tr>
<tr>
<td>Sudden infant death syndrome</td>
<td>73</td>
<td>50</td>
<td>28</td>
<td>-44.0%</td>
</tr>
<tr>
<td>Illnesses</td>
<td>275</td>
<td>248</td>
<td>254</td>
<td>2.4%</td>
</tr>
<tr>
<td>Unintentional injuries</td>
<td>213</td>
<td>202</td>
<td>216</td>
<td>6.9%</td>
</tr>
<tr>
<td>Motor vehicle injuries</td>
<td>109</td>
<td>98</td>
<td>108</td>
<td>10.2%</td>
</tr>
<tr>
<td>Bicycle injuries</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>**</td>
</tr>
<tr>
<td>Injuries caused by fire</td>
<td>9</td>
<td>7</td>
<td>8</td>
<td>**</td>
</tr>
<tr>
<td>Drowning</td>
<td>29</td>
<td>20</td>
<td>29</td>
<td>45.0%</td>
</tr>
<tr>
<td>Falls</td>
<td>3</td>
<td>1</td>
<td>6</td>
<td>**</td>
</tr>
<tr>
<td>Poisoning</td>
<td>14</td>
<td>16</td>
<td>13</td>
<td>-18.8%</td>
</tr>
<tr>
<td>Other unintentional injuries</td>
<td>47</td>
<td>58</td>
<td>50</td>
<td>-13.8%</td>
</tr>
<tr>
<td>Homicide</td>
<td>45</td>
<td>43</td>
<td>47</td>
<td>9.3%</td>
</tr>
<tr>
<td>Suicide</td>
<td>28</td>
<td>23</td>
<td>35</td>
<td>52.2%</td>
</tr>
<tr>
<td>All other</td>
<td>83</td>
<td>91</td>
<td>116</td>
<td>27.5%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>1,405</td>
<td>1,312</td>
<td>1,339</td>
<td>2.1%</td>
</tr>
</tbody>
</table>

Child Deaths by Age

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Average 2008-2012</th>
<th>Number in 2011</th>
<th>Number in 2012</th>
<th>Percent Change 2011-2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant</td>
<td>935</td>
<td>866</td>
<td>883</td>
<td>2.0%</td>
</tr>
<tr>
<td>1-4</td>
<td>140</td>
<td>122</td>
<td>132</td>
<td>8.2%</td>
</tr>
<tr>
<td>5-9</td>
<td>80</td>
<td>84</td>
<td>77</td>
<td>-8.3%</td>
</tr>
<tr>
<td>10-14</td>
<td>92</td>
<td>95</td>
<td>103</td>
<td>8.4%</td>
</tr>
<tr>
<td>15-17</td>
<td>157</td>
<td>145</td>
<td>144</td>
<td>-0.7%</td>
</tr>
</tbody>
</table>

Data reflect state residents.


* Child death rates for 1990-1999 are not the same as published in some previous reports due to revised population estimates.

** Percent change is not calculated because the numbers are too small, and are subject to random variation over time.

***Population estimates are derived from the Vintage 2012 bridged-race postcensal population estimates files.

Produced by the NC Division of Public Health Women and Children’s Health Section in conjunction with State Center for Health Statistics
Legislative – Recommend/Support

1. Recommend General Assembly and Governor include in the budget bill a statement of interest in conducting an analysis of return on investment through Results First with cooperation of the Executive and Legislative branches

2. Support one time funding of $1 million to UNC-Chapel Hill for capital funds to secure an expanded and permanent site for operations of the Horizons program to provide medical and wrap-around services to pregnant and recently delivered women affected by substance use disorders.

3. Request study of best ways to promote adoption/discourage disruption for recommendations for 2015 legislative session by Omnibus Foster Care and Dependency Committee.

4. $120,000 recurring to the State Bureau of Investigation for Safe Drug Disposal

5. Provide legislative permission for DMA to cover medical lactation services, with the provision that coverage of these services would be projected to be cost saving to the Medicaid budget (moved from “endorse” in 2013)

6. Ban minors from using commercial/regulated tanning beds (moved from “endorse” in 2013)

7. Provide at least $12 million in state dollars to DSS to partially replace lost federal funds to stabilize families and prevent children being removed from their homes (carry over; funded at $4.8 M in FY13)

8. Restore of $575,000 for funding for the Carolinas Poison Center (carry-over)

9. Fund $75,000 to Injury and Violence Prevention in the Division of Public Health to enhance public health capacity on prescription drug misuse (carry over)

10. Continue to fund key perinatal health promotion efforts
   a. 17-Progesterone ($52,000)
   b. East Carolina University High Risk Maternity Clinic ($375,000)
   c. March of Dimes Preconception Health Campaign ($425,000)
   d. NC Healthy Start Foundation ($175,000)
   e. Perinatal Quality Collaborative of North Carolina (PQCNC) ($350,000)
   f. Safe Sleep Campaign ($202,000)
   g. You Quit Two Quit ($200,000) (partially funded in 2014)

11. Funding of $50,000 non-recurring to the Perinatal Quality Collaborative to implement the data and quality initiative pieces relating to pulse oximetry screening (related to 2013 recommendation)

Legislative - Endorse

12. Legislation to require drivers of scooters to wear reflective clothing

13. Legislation to pilot the use of speed cameras in school zones (Phoebe’s Law) (carry over)

14. Legislation to reduce childhood exposure to toxins (NC Toxic Free Kids Act) (carry over)

15. Funding of $625,000 for Child Advocacy Centers (child focused place where child protective services investigators, medical experts, law enforcement and others can come together to respond appropriately to alleged child abuse and neglect) (carry over)

16. Continued funding for the Child Medical Evaluation Program which helps assure appropriate medical evaluations when children are allegedly abused or neglected

17. Restore $17.3 million from the Master Settlement Agreement to tobacco cessation and prevention (carry over)

Bold indicates a substantially new item for 2014
Administrative Recommendations and Issue Monitoring

Administrative
1. Support efforts by Horizons to administer methadone treatment/obtain OTP license
2. Promote voluntary breastfeeding friendly efforts by workplaces (carry over)
3. Write letters of support for grants as needed for Centering Pregnancy (carry over)
4. Efforts of Prevent Child Abuse NC to work with the Medical Board to strongly encourage medical professionals to receive training to recognize and report child abuse and neglect. The Child Fatality Task Force recommends that the word “all” be deleted from the final draft. (The original request was to encourage training for “all” medical professionals.) (carry over)
5. Promote permanent lock boxes for collection of unneeded prescription medications (carry over)
6. Promote awareness of dangers of misuse of controlled substances, perhaps in conjunction with education on around other substances, such as alcohol (carry over)

Track and Monitor
7. Federal legislation relating to foreign and other adoptions
8. CSRS implementation (based on item supported in 2013)
9. Implementation of Child Treatment Program (based on item supported in 2013)
10. Children’s Trust Fund use and funding level (carry over)
11. Legislation pertaining to home births (carry over)
12. Developments relating to Centering Pregnancy (carry over)
13. Licensure for International Board Certified Lactation Consultants (carry over)
14. Second-hand smoke laws (carry over)
15. Helmet laws (carry over)
Legislative History and Accomplishments
Legislative History and Accomplishments

Every year since its creation in 1991, the North Carolina Child Fatality Task Force has helped achieve legislative victories for children. The following list is organized by year and includes most—but not all—of the legislative accomplishments of the Child Fatality Task Force. These sustained and strategic efforts have helped result in more than 10,000 child deaths being averted since the inception of the CFTF.

1991

**North Carolina Child Fatality Task Force established.** The Task Force, a diverse legislative study commission, was charged to study the incidence and causes of child death as well as to make recommendations for changes to legislation, rules, or policies that would promote the safety and well-being of children. The Task Force was also charged to develop a system for multi-disciplinary review of child deaths.

**Community Child Protection Teams (CCPTs) established.** CCPTs were established in each county by Executive Order. Each CCPT has the responsibility to review selected active Child Protection Services cases of the county Department of Social Services and review all cases in the county in which a child died as a result of suspected abuse and neglect. The purpose of these reviews is to identify gaps and deficiencies in the community child protection system and safeguard the surviving siblings.

**North Carolina Child Fatality Review Team (State Team) established.** The State Team, a multi-agency panel, was directed to review all cases of fatal child abuse, all deaths of children known to Child Protective Services before their deaths, and additional cases of child maltreatment. The purpose of the reviews is to discover the factors contributing to child fatalities in North Carolina. The State Team is required to report to the Task Force and to recommend legislation to prevent child deaths.

1992

**North Carolina Child Fatality Task Force membership expanded to include members of the General Assembly.** Two Senators and two members of the House of Representatives, as well as one local health director, were appointed.

**North Carolina Child Fatality Task Force extended to 1995.**

**Additional funds appropriated for Child Protective Service Workers.** The Task Force requested $5 million, with a plan to request a total of $30 million over several years. The bill also called for a study of the financing of CPS positions in county Departments of Social Services. The General Assembly appropriated $1 million
Pilot programs for Family Preservation Services funded. The General Assembly appropriated $410,000 for the Basic Social Services plan in three to five counties as pilots, and $50,000 to develop and implement model programs of locally-based Family Preservation Services.

Study of Child Protective Services funded. The General Assembly appropriated $80,680 to conduct a study to determine a method that would ensure accountability by the county Child Protective Services programs, to ascertain the best management structure for Child Protective Services, and to determine the need for stronger state supervision of county programs.

“Hot Lines” established. The General Assembly appropriated $62,000 to establish 24-hour Protective Services “hot lines” in each county.

Additional funds for the Child Medical Evaluation Program appropriated. The General Assembly appropriated $935,750 for the Child Medical Evaluation program, $180,000 of which was allocated for a backlog of claims for services and was non-recurring.

Protocols required. The legislation directed the State Division of Social Services to ensure that community interdisciplinary teams develop protocols for use in child abuse and neglect reviews.

1993

Local Child Fatality Prevention Teams (CFPTs) established. Local CFPTs were directed to review all child deaths in each county unless the death was already under review by the local Community Child Protection Team (CCPT). Since each county now had two community-based teams, the local CFPT and CCPT were given the option of joining together or operating independently. The multi-agency membership for the local teams was established by state statute.

Child Fatality Task Force specifically charged to study the incidence and causes of child abuse and neglect.

Additional funds for Child Protective Services Workers appropriated. The General Assembly appropriated $2 million, but maximum caseload standards were not established by statute.

Committee established to develop a payment plan for the evaluation of maltreated children. The resulting committee recommended funding regional maltreatment resource centers.

NCGA Chapter 7A revised. Changes include creating the duty to report and investigate child dependency as well as child abuse and neglect; requiring county Department of Social Services directors, upon receiving a report about a child’s death as a result of suspected child maltreatment, to ascertain immediately whether or not there are other children in the home; improving information sharing; and mandating that child fatalities from alleged maltreatment be reported to the State Division of Social Services Central Registry.

Driving While Impaired (DWI) law amended. The amended statute provides that the presence of a child under 16 years of age in a vehicle driven by a person convicted of a DWI violation shall be considered a grossly aggravating factor in sentencing.
Funding for student services personnel provided. The General Assembly appropriated $10 million for school counselors, to fulfill a provision of the Basic Education Plan.

Comprehensive health screening for kindergarten students mandated. This law requires each child to have a comprehensive health screening evaluation by the time he or she enters kindergarten.

1994

Six additional members of the General Assembly appointed to the Task Force. Three Senators and three members of the House of Representatives were appointed.


Family Preservation Program expanded. The General Assembly appropriated $500,000 to expand this program.

Prosecutorial child protection law passed. This law provides for bail and pretrial release conditions determined by the judge in child abuse cases. It also provides for children to be made comfortable in courtrooms during child abuse cases.

Child passenger safety law strengthened. This law requires children under 12 to be safely restrained while riding in a car, whether they sit in the front or the back seat. Infants and toddlers under age four must be secured in child safety seats; older children must use seat belts.

The following laws were passed during the Special Session on Crime called by the Governor in 1994:

The Task Force supported several components of the Governor’s crime package of legislation that applied to juveniles: Family Resource Centers, Wilderness Camps, the Mentor Training Program for Coaches, and the Governor’s One-On-One Program.

The Task Force worked to amend a bill calling for a comprehensive study of the Division of Youth Services’ Juvenile Justice System. The amendment provided for diagnostic assessments of all youth in state training schools to determine that each youth has been properly placed.

Community-Based Alternatives program funded. The General Assembly appropriated $5 million for programs that are intended to reduce the number of youths committed to training schools by rehabilitating these troubled youths in their communities.

The Task Force also worked to increase the penalty for illegally selling guns to a minor from a misdemeanor to a felony. This felony charge for a weapons violation enables law enforcement to aggressively prosecute those who illegally sell firearms to minors.
1995

Training for child sexual investigations initiated. The Task Force requested $125,000 for statewide, multidisciplinary training for child sexual abuse investigations. The training was funded for $38,336 recurring and $5,000 non-recurring funds through the State Bureau of Investigation.

Underage drinkers prohibited from driving. The Task Force endorsed legislation requiring “zero tolerance” for alcohol measured in the blood or breath of drivers 18 to 20 years old.

Smoke detectors required in all rental property. This law filled in a gap in North Carolina’s smoke detector laws by requiring landlords to install operable smoke detectors for every dwelling.

Sale of fireworks to children prohibited. Before 1993, the sale of pyrotechnics was illegal in North Carolina. In 1993, the General Assembly allowed the sale of some pyrotechnics. The Task Force sought to repeal these changes to the pyrotechnics law in 1995. The General Assembly did not repeal the 1993 law, but a bill was passed that restricts the sale of those pyrotechnics to persons over the age of 16.

Adoption proceedings moved from Superior to District Court. The Task Force sponsored this legislation as a first step toward creating a comprehensive family court system in North Carolina.

1996

Child abduction law strengthened. This law applies the penalty for abducting a child from a parent, guardian, or school or abductions from any agency or institution lawfully entitled to the child’s custody.

1997

Dependent juvenile definition changed. The old statute defined a juvenile as dependent if his or her parents were unable to provide care “due to physical or mental incapacity.” This language did not make provision for other situations, such as one in which one or both parents are incarcerated. This law broadened the definition of dependent juvenile and enabled hundreds more children to receive help from the Department of Social Services.

Intensive Home Visiting partially funded. The Task Force had a standing goal of encouraging the state to appropriate $3.2 million for intensive home visiting programs that have been shown to be effective in reducing the incidence of child abuse and neglect, unwanted pregnancy, and juvenile involvement with the courts. In 1997, the General Assembly appropriated $825,000 for home visiting, with an additional $200,000 in 1998.

Graduated Drivers License mandated. This measure gives new teenage drivers more experience – and a greater chance of survival – as the result of a three-step process for obtaining a driver license. This ensures that beginning drivers get a full year of supervised practice driving with a
parent. It also restricts night-time driving for new licensees during the first six months of unsupervised driving.

1998

Sunset of the Task Force lifted.

Court Improvement Project launched. To reduce the amount of time that children are in foster care, the Task Force supported legislation to change the process for handling abuse and neglect cases. As a result of this legislation, termination of parental rights may now be a motion in the cause, adjudication must take place within 60 days of the filing of the petition, the first hearing must be at 90 days, and the second hearing within six months.

Smoke detector penalty set. This law sets a $250 penalty for landlords who fail to install smoke detectors in rental units and a $100 penalty for tenants who destroy or disable smoke detectors after they have been installed.

1999-2000

Child passenger safety law strengthened. The passage of Senate Bill 1347 will save an estimated five lives and 45 serious injuries among child passengers aged 16 or younger each year. The new law imposes a two-point driver’s license penalty on drivers who do not see that young passengers are in age-appropriate safety restraint. The enactment of this law closes one of the last remaining gaps in the state’s motor vehicle passenger safety laws.

Juvenile procedures clarified. Passage of House Bill 1609 will help move children from abusive, dangerous environments toward safer, permanent homes. The old law required that parents be given separate notices of the possible termination of their parental rights, even if termination is clearly best for the child. This measure streamlines the legal process while preserving parents’ rights to proper notification.

Guardianship strengthened. Sometimes called “soft adoption,” guardianship is a good option for some children who need a safe, nurturing home. Passage of Senate Bill 1340 clarifies the rights and duties of a legal guardian and thereby creates a more stable home for children with court-appointed guardians.

2001

Infant Homicide Prevention Act passed. House Bill 275 created a safe haven for newborns who would otherwise be abandoned by their distraught mothers.

Child Bicycle Safety Act passed. House Bill 63 established that bicycle riders age 15 and younger must wear an approved helmet when riding on public roads and rights-of-way.
**Child Fatality Task Force 10-Year Anniversary celebrated.** In the ten years of the Task Force’s existence, the child death rate in North Carolina dropped approximately 20 percent. At 76.4 deaths per 100,000 children, North Carolina experienced the lowest child fatality rate it had ever recorded.

**2002**

*“Kids First” license tags issued.* The General Assembly and the Division of Motor Vehicles authorized and issued “Kids First license tags with the proceeds going the North Carolina Children’s Trust Fund.

**Key programs continued.** During a time of intensive budget cuts, the Intensive Home Visiting program, the Healthy Start Foundation, the folic acid campaign, and the birth defects monitoring program all received continued funding. **Graduated Driver Licensing system improved.** A provision was added to the existing system which limits the number of passengers under age 21 that a novice driver may transport during the first six months of unsupervised driving (allowing only one young, non-family member).

**2003**

**Safe Surrender supported.** Task Force members lent their support to the Division of Public Health who was successfully awarded a grant from the Governor’s Crime Commission for FY ’03-’04 to increase public awareness of the Infant Homicide Prevention Act (aka NC Safe Surrender Law).

**2004**

**NC Booster Seat Law (Senate Bill 1218) ratified.** The law established that a child less than eight years of age and less than 80 pounds in weight shall be properly secured in a weight-appropriate child passenger restraint system. In vehicles equipped with an active passenger-side front air bag, if the vehicle has a rear seat, a child less than five years of age and less than 40 pounds in weight shall be properly secured in a rear seat, unless the child restraint system is designed for use with air bags. If no seating position equipped with a lap and shoulder belt to properly secure the weight-appropriate child passenger restraint system is available, a child less than eight years of age and between 40 and 80 pounds may be restrained by a properly fitted lap belt only.

**Endorsed.** The Task Force endorsed: Strengthening penalties when methamphetamine is manufactured in a location that endangers children.
2005

**All-Terrain Vehicle Safety Law (Senate Bill 189) ratified.** The law established that a child less than eight years of age is not allowed to operate an ATV. In addition the law creates restrictions based on age and machine size for children between the ages of eight and 16. The law also requires adult supervision for children under 16, restricts passengers to those ATVs designed for more than one person, bans operation on public streets, roads and highways, and outlines equipment standards for sellers and buyers. In addition, safety training is now required for operators as is the use of safety equipment.

2006

**Unlawful Use of a Mobile Phone Law (Senate Bill 1289) ratified.** The law established that children under the age of 18 cannot operate a motor vehicle while using a mobile phone or any technology associated with mobile phones. Exceptions were created for teens talking with their parents, spouses or emergency personnel.

**Rear Passenger Safety Law (Senate Bill 774) ratified.** The law requires use of rear-seat safety belts by all passengers of non-commercial vehicles.

**Strengthen Sex-Offender Registry Law (House Bill 1896) ratified.** The law strengthened North Carolina’s existing sex offender registry system by requiring additional standards for monitoring sex offenders, including extensive monitoring of the most predatory offenders upon their release from prison.

**Funds to Prevent Child Maltreatment (Senate Bill 1249) appropriated.** $90,000 in recurring funds was allocated to the Department of Health and Human Services for one position to staff the Child Maltreatment Leadership Team and carry forth recommendations of the North Carolina Institute of Medicine’s Task Force on Child Abuse Prevention.

**General Statute 7B-302 DSS Disclosure of Confidential Information (Senate Bill 1216) amended.** The amendment clarified the ability of county Departments of Social Services to share confidential information with other professional entities. The amendment also put North Carolina in compliance with federal child welfare funding guidelines and allowed for continued federal support.

**Funds to Prevent Preterm Births (Senate Bill 1741) appropriated.** $150,000 in non-recurring funds was allocated to provide medications to low-income women at-risk of a second premature birth. The medication is proven to reduce recurring preterm births by 33 percent.

**Funds to establish a Perinatal Health Network (Senate Bill 1253) appropriated.** $75,000 in non-recurring funds was allocated for the creation of a professional perinatal health network. The network will bring together perinatal health leaders to plan strategically for the reduction of infant mortality and promotion of women’s and infants’ health in North Carolina.
Endorsed. The Task Force endorsed: 1) continuing the Medicaid Family Planning Waiver; 2) recurring funding of the North Carolina Folic Acid Campaign at $300,000; 3) recurring funding for the North Carolina Healthy Start Foundation for statewide infant mortality reduction initiatives and conversion of non-recurring funding to recurring funding status; 4) recurring funding for the North Carolina Birth Defects Monitoring Program at $325,000.

Administrative changes recommended. 1) support the North Carolina Division of Public Health efforts to procure grant funds for youth suicide prevention; 2) form a CFTF subcommittee to work on gun safety, specifically pursuing a gun safety awareness campaign, creating talking points on gun safety, and seeking common ground to prevent injury and death to children and youth due to firearms.

2007

Child Passenger Safety Exemption (Senate Bill 23) ratified. Amended § 20-317.1. (Child restraint systems required), by removing exemption (b)ii “when the child’s personal needs are being attended to” in order to qualify North Carolina for the continuation of $1 million in child passenger safety funding from the National Highway Traffic Safety Administration.

Funds to address infant deaths secured. Appropriations recommended by the Child Fatality Task Force were secured, and included: $97,000 in non-recurring funds to prevent preterm births by providing the medication known as 17-Progesterone to uninsured women, and $150,000 in nonrecurring funds for a statewide Safe Sleep awareness campaign.

Endorsed. The Task Force endorsed: 1) $200,000 in recurring funds were provided for the birth defects monitoring system; 2) $150,000 in non-recurring funds were provided for the North Carolina Healthy Start Foundation; 3) the Fire Safe Cigarette Act (House Bill 1785) passed and requires cigarette manufactures to produce and market only cigarettes that adhere to an established cigarette fire safety performance standard.

Legislative charge received. Senate Bill 812 directed the Child Fatality Task Force to study issues relating to requiring the installation and use of passenger safety restraint systems on school buses and report findings by May 2008.

2008

Amend Child Abuse (Senate Bill 1860) ratified. An act to increase the criminal penalty for misdemeanor child abuse and to amend the criminal offense of felony child abuse.

Hospital Report Child Injuries (House Bill 2338) ratified. An act to require hospitals and physicians to report serious, non-accidental trauma injuries in children to law enforcement officials.

Funds to prevent preterm births provided. $97,000 in non-recurring funds appropriated to continue efforts to provide minority and low-income women at-risk for delivering a premature infant with a preventative treatment to reduce the risk of a recurring preterm birth.
Funds to reduce infant deaths secured. $150,000 in non-recurring funds appropriated to continue funding for a statewide public awareness campaign to promote safe sleep and reduce infant deaths due to Sudden Infant Death Syndrome (SIDS) and unintentional suffocation/strangulation.

Child Passenger Safety Technician Liability (House Bill 2341) ratified. An act to limit liability for the acts of certified child passenger safety technicians and sponsoring organizations of child safety seat educational and checking programs when technicians and sponsoring organizations are acting in good faith and child safety seat inspections, installation, adjustment or education programs are provided without fee or charge.

Require Carbon Monoxide Detectors (Senate Bill 1924) ratified. An act to authorize the North Carolina Building Code Council to adopt provisions in the Building Code pertaining to the installation of carbon monoxide detectors in certain single-family or multifamily dwellings; to require the installation of operational carbon monoxide detectors in certain residential rental properties and to provide for mutual obligations between landlords and tenants regarding the installation and upkeep of carbon monoxide detectors.

Transporting Children in Open Bed of Vehicle (House Bill 2340) ratified. An act to increase the protection of children who ride in the back of pickup trucks or open beds of vehicles by raising the minimum age to 16 and removing the exemption that made allowances for small counties.

Change Format of Driver Licenses/Under 21 (House Bill 2487) ratified. An act to change the format of a driver license or special identification card being issued to a person less than twenty-one years of age from a horizontal format to a vertical format to make recognition of underage persons easier for clerks dealing in restricted age sales of products such as alcoholic beverages and tobacco products.

2009

Funding to prevent preterm births provided. $97,000 in non-recurring funds appropriated to continue efforts to provide minority and low-income women at-risk for delivering a premature infant with a preventative treatment to reduce the risk of a recurring preterm birth.

Funding to reduce infant deaths provided. $150,000 in non-recurring funds appropriated to continue funding for a statewide public awareness campaign to promote safe sleep and reduce infant deaths due to Sudden Infant Death Syndrome (SIDS) and unintentional suffocation/strangulation.

The Division of Medical Assistance directed to explore interconceptional care. This direction allows DMA to pursue a federal waiver or other mechanism to offer a basic package of interconceptional care services to low-income women at high-risk for delivering prematurely.

Funding continued for Child Medical Evaluation System. This system provides diagnostic services to children suspected of being victims of child maltreatment.
Interagency agreements established to better protect children from violent sex offenders. The federal Adam Walsh Child Protection and Safety Act requires a more comprehensive, nationalized system for registration of sex offenders. To meet this goal, interagency collaboration has been established between the State Bureau of Investigation, the Sheriff’s Association, the Division of Social Services (DSS) and others.

An Act to Prohibit the Retail Sale and Distribution of Novelty Lighters (Senate Bill 652) ratified. This act to protect children by banning the sale of novelty lighters.

The Nicholas Adkins School Bus Safety Act (House Bill 440) ratified. This measure assures that pictures taken of drivers committing a stop arm violation are acceptable evidence for conviction and makes it a felony if a student is killed due to an illegal pass of a stopped school bus.

Youth employment protections passed. Enhance Youth Employment Protection Act (H22) enhances reporting and surveillance requirements by the Department of Labor. Strengthen Child Labor Violation Penalties (H23) increases penalties to employers who violate child labor requirements.

2010

Funding to preserve infant mortality prevention infrastructure maintained. Due to on-going state budget constraints, the Task Force focused on maintaining a package of services that works together to help babies be born healthy and to make it to their first birthday. Elements of the package include the following: $350,000 for the NC Folic Acid/Preconception Health Campaign to decrease neural tube defects and improve birth outcomes; $325,000 for the Eastern Carolina University High-Risk Maternity Clinic to improve birth outcomes in Eastern North Carolina; $150,000 for Safe Sleep to avoid SIDS and other sleep-related deaths; $97,000 for 17-Progesterone distribution to help prevent pre-term births; $408,000 for the Healthy Start Foundation to improve maternal health prior to and during pregnancy.

Increase Drivers License Restoration Fee (S655) ratified. This act increases the fee that drivers who have their licenses suspended following conviction for impaired driving must pay to have their licenses later restored. All funds raised (an estimated $560,000 each year) will go to Forensics Tests for Alcohol to continue programs to deter, detect and convict impaired drivers.

2011

Funding to preserve infant mortality prevention infrastructure maintained. Due to on-going state budget constraints, the CFTF focused on maintaining a package of services that works together to help babies be born healthy and to make it to their first birthday. Elements of the package include the following: $350,000 for the NC Preconception Health Campaign to decrease neural tube defects and improve birth outcomes; $150,000 for Safe Sleep to avoid SIDS and other sleep-related deaths; $47,000 for 17-Progesterone distribution to help prevent pre-term births. These items were funded nonrecurring out of the Maternal and Child Health Block Grant.
Fine for speeding in a school zone increased to $250 (S49) Speeding just an extra 10 mph in a school zone greatly increases the chance of death for a student hit by a car. The chance of pedestrian death increases 9-fold (from 5% to 45%) with an increase in speed from 20 mph to 30 mph. This bill makes the fine for speeding in a school zone equal to that of speeding in a construction zone.

Sale of certain dangerous synthetic substances banned (S7) This act bans substances previously available legally including a synthetic cannabinoid that produces a marijuana-like high and MDPV, a synthetic that produces a cocaine-like high and hallucinations. The ban went into effect June 1, 2011. Throughout the early implementation period, the CFTF has worked with law enforcement and others to monitor the effectiveness of the ban.

Penalty for driving impaired with a child in the car enhanced (S241). Motor vehicle crashes are the leading injury-related cause of death for children and impaired driving is a factor in 15%-20% of those deaths. National data show that most children who die in crashes where alcohol is involved are the passenger of the impaired driver. Additionally, impaired drivers are also less likely to buckle-up their children safely.

Concussion protocols established (The Gfeller-Waller Athletic Concussion Awareness Act -H792). This act requires that coaches, other school personnel and parents of middle and high school athletes receive information about concussions and prohibits same-day return-to-play. Only once cleared for play by specified health providers may athletes later return to practice or play.

Changes to the graduated driver licenses system monitored. Since North Carolina adopted graduated driver licensing, crashes are down 38% for 16-year-olds and 20% for 17-year-olds, among the best results of any state. Time spent driving and gaining experience is critical for teens learning to drive more safely. Changes from Modify Graduated Licensing Requirements (S636) include requiring that learning drivers keep a log of time and conditions driven. Additionally, a provisional license will be revoked if the licensee is charged with a variety of serious driving violations, such as excessive speeding. The Division of Motor Vehicles is charged with evaluating the effectiveness of the provisions.

Endorsed. The Perinatal Quality Collaborative of NC received $250,000 in funding (from the Maternal and Child Health Block Grant).

2012

Funding to preserve infant mortality prevention infrastructure partially maintained. Due to on-going state budget constraints, the CFTF focused on maintaining a package of services that works together to help babies be born healthy and to make it to their first birthday. Elements of the package include the following: $350,000 for the NC Preconception Health Campaign to decrease neural tube defects and improve birth outcomes; $375,000 to the East Carolina University High-Risk Maternity Clinic and $47,000 for 17-Progesterone distribution to help prevent pre-term births. These items were funded nonrecurring out of the Maternal and Child Health Block Grant. However, funding for Safe Sleep and the NC Healthy Start Foundation were eliminated.
Replacement of conventional smoke alarms with tamper-resistant lithium-battery alarms in rental units (S77). Over the past five years, 75 children and hundreds of adults have died due to fire. Fire and flame is the fourth leading cause of death of North Carolina children ages five to nine. Furthermore, national data reveal that two-thirds of fire deaths occur in homes without an operating smoke alarm, often because the battery has been removed or is not working. The new science of tamper-resistant lithium battery alarms can help solve this problem since alarms with these batteries work for ten years and the batteries cannot be removed for other uses. This measure requires landlords to phase-in tamper-resistant lithium battery units as conventional battery units are scheduled for replacement.

Funding to preserve evidence based treatment programs for children maintained. Due to on-going state budget constraints, the CFTF focused on maintaining a package of services that works together to help screen and treat at-risk children: Funding was maintained at flat levels, often with federal funds, for the Child Medical Evaluation Program, Child Advocacy Centers, the Child Treatment Program and suicide gatekeeper programs.

Endorsed. The Perinatal Quality Collaborative of NC received $250,000 in funding (from the Maternal and Child Health Block Grant). A bill (H176) passed addressing concerns on tracking of domestic violence cases to make more clear when “assault on a female” (or other crimes) occur between intimate partners or strangers. In addition to improving data and understanding of ways to address problems, this may help workers within the Division of Social Services have more complete information on when domestic violence is a factor in the home.

2013

Revise Controlled Substance Reporting (S222). Poisoning is the fastest growing cause of teen death. The bill made changes to the Controlled Substance Reporting System (CSRS) to deter pill mills, to make it easier for doctors to check to see previous prescription-fill history to avoid duplicate prescriptions and to offer treatment as needed, to provide more timely data, and to allow data tracking relating to atypical prescribing or filling, as well as other provisions.

Require Pulse Oximetry Screening (S98). Pulse oximetry is a quick and inexpensive test that screens newborns for certain congenital heart disease. If the baby is sent home before this condition is detected, the baby may get very sick and need to be rushed to the hospital for emergency surgery. Pulse oximetry screening allows timely, non-emergency intervention than can save lives.

Health Curriculum/Preterm Birth (S132). Prematurity is one of the leading causes of infant deaths. This bill incorporates into the Healthy Behaviors Curriculum information about the preventable risks of preterm birth including induced abortion, smoking, alcohol consumption, the use of illicit drugs and inadequate prenatal care.
Funding to preserve infant mortality prevention infrastructure partially maintained. Due to on-going state budget constraints, the CFTF focused on maintaining a package of services that work together to help babies be born healthy and to make it to their first birthdays. Elements of the package include the following: the NC Preconception Health Campaign to decrease neural tube defects and improve birth outcomes; East Carolina University High-Risk Maternity Clinic to treat high-risk pregnancies in the eastern part of the state;17-Progesterone distribution to help prevent pre-term births, NC Healthy Start Foundation to provide community-based organization with evidence-based strategies and communications to improve the health of women of reproductive age and their babies, the Perinatal Quality Collaborative to promote best practices with hospitals, the Safe Sleep Campaign to promote safe sleep including in hospitals, and You Quit Two Quit to provide training assistance to help medical practices implement evidence-based protocols to reduce smoking by pregnant women. ECU was funded recurring with state funds. Other funded items were funded nonrecurring out of the Maternal and Child Health Block Grant. However, no funding was provided for the Healthy Start Foundation or You Quit Two Quit tobacco cessation for women.

Funding for Child Treatment Program. The Child Treatment Program (CTP) is an evidence-based treatment for children who have experienced trauma. The CFTF supported funding of $2 million for an implementation platform to assure the treatment was used statewide with fidelity. Funding was included in the budget.

Funding for services to stabilize families and prevent children from being removed for their homes. Changes in federal funding resulted in loss of $12 million to the Division of Social Services for services to help keep children at-risk of abuse or neglect safe in their own homes. Funding of $4.8 million was provided.

Endorsed. Funding for Child Advocacy Centers and the Child Medical Evaluation Program; measures to make it easier for doctors to prescribe and third parties to use a medication (naloxone) to reverse drug overdoses ($20).
ROI Analysis for Children’s Programs/

Results First

Assuring current dollars are invested strategically is an important step towards optimizing child outcomes, reducing child injury and death in the long run and averting unnecessary costs: Research repeatedly demonstrates that the same risk factors that are linked to family violence are also linked to self-violence (such as suicide) and community violence. By the same token, the same resiliency factors that improve family functioning also reduce violence.1 Additionally, repeated negative experiences and abuse of children are associated with worse health outcomes in adulthood, such as smoking, depression, obesity and unintended pregnancies.2 These conditions when experienced by women of childbearing age are often linked to less healthy pregnancies and birth outcomes, including low birth-weight and prematurity.3 Additionally, some programs designed to improve family function and reduce violence, also prevent injuries.4

Current funds for children should be invested in a fiscally responsible way: Since there has not been a statewide assessment of the current investment mix, NC may spend funds in ways that do not maximize outcomes. Investments could be counterproductive, duplicative, inequitable or insufficient. Only by reviewing our investment mix and the evidence base will we be able to make these determinations to assure that the mix of funding is designed to optimize outcomes in a fiscally responsible manner. Dollars should not only be invested in best practice, but given limited resources, it is critical that the best practices complement one another to best move NC forward.

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1 For general resiliency factors, please see Search Institute: http://www.search-institute.org/; For a synthesis of experimentally evaluated programs, including how programs can have positive impacts across different domains please see Child Trends: http://www.childtrends.org/what-works/links-syntheses/

For protective factors at individual, relationship and community level, please see the Children’s Bureau Promoting Protective Factors for In-Risk Families and Youth: http://www.dsonline.com/acf/PF_Research_Brief.pdf


For building resiliency to mitigate family and youth violence, please see Bud Lavery presentation to IDPC: http://www.ncleg.net/DocumentSites/Committees/NCCFTF/Intentional%20Death%20Prevention%202011-2012/Evidence-Based%20Youth%20Violence%20Prevention%20Programs%20Lavery%2011-14-11.pdf


3 Please see, for example, Centers for Disease Control and Prevention (CDC), Agency for Toxic Substances and Disease Registry (ATSDR), Recommendations to improve preconception health and health care—United States: A report of the CDC/ATSDR Preconception Care Work Group and the Select Panel on Preconception Care. Atlanta: CDC; 2006. 23 p. [MMWR Recomm Rep. 2006;55[RR-06]]. Available from: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5506a1.htm

Many states are turning to a “return on investment” (ROI) model to focus investments to maximize long-term gain: Facing mounting budget pressures from an ever increasing demand for prison beds, Washington State sought ways use cost-benefit analysis to inform investment decisions, reduce crime, and reduce prison costs. The Washington State Institute for Public Policy (WSIPP) was created. It uses state-specific cost-benefit analysis to assess the likely pay-off from various investments. Their findings consistently show that carefully targeting investment in children and families produces savings both to the society and to government. Recommended investments include prevention (such as nurse home visiting) and treatment (such as Multi-Systemic Therapy). This basic model is being replicated in 14 other states through a project called Results First. (The other states are Connecticut, Florida, Idaho, Illinois, Iowa, Kansas, Massachusetts, Mississippi, New Mexico, New York, Oregon, Rhode Island, Texas, and Vermont. Additionally 3 counties in California are participating.)

The NC Legislature and Executive should explore participating in the Results First model as a way to maximum our return on investment for expenditures relating to children’s programs: Suggested activities include the following:

- Focus on public investments in children and families
- Bring in Results First,
- Hear from other states who have been involved with Results First, including at least one county-administered state and at least one state with substantial rural populations
- Consider long term staffing and institutional support needs, such as an entity which is non-partisan, has research and training experience, and has ability to work collaboratively across state agencies and branches of government
- Determine technological capacity and need
- Explore appropriate mechanisms to establish and maintain a continuum of services that provides best practice interventions, to assure best practice services across the continuum of needs even when there is no evidence-based practice (EBP), to support adequate infrastructure for implementation with fidelity of sanctioned programs, to promote equities in outcomes, and to coordinate sanctioned approaches across divisions and agencies (including reimbursement rates).
- Determine the maximum mix of resources. Services need to be provided across the continuum of need; when multiple best practices exist, the State or localities may want to focus resources on support of one EBP or best practice rather than spreading resources thinly across a range of similar programs that address the same need for the same age group. Equity issues should also be considered. Existing infrastructure should be maximized.
- Consider key funding sources to include in analysis (state/federal/local/private, etc.)
- Define sufficient evidence threshold for initial considerations
- Determine how the process would work in a county-administered state
- Include key stakeholders throughout the process

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5 WSIPP mainpage: [http://www.wsipp.wa.gov/](http://www.wsipp.wa.gov/)
6 WSIPP Mental Health analysis: [http://www.wsipp.wa.gov/BenefitCost?topicId=5](http://www.wsipp.wa.gov/BenefitCost?topicId=5)

As a short-term strategy, NC could develop a report looking at the practice landscape within our current mix of investments. This strategy would allow us to determine

- Operational definitions for “evidence-based,” “best practice,” “publicly funded,” “children’s programs,” and other key terms
- The EBP and other best practice in which NC invests across the continuum of need, care and age
- If those EBP and best practice are predicted to be among the more cost efficient strategies
- If NC is spending funds on disproven or ineffective programs which should be redirected to other children’s programs using best practice
- The strength of the infrastructure support to maintain program fidelity
- If the state is fully utilizing existing infrastructure for EBP and other best practice
- If there are gaps in the continuum or equity of care
- The coordination and collaboration of investment in EBP and best practice across agencies (ability to support array of programs with fidelity; ability of systems – including reimbursement structures – to reinforce rather than undercut EBP, etc.)

Key stakeholders should be involved throughout the process: In addition to policy-makers, key stakeholders include the Arc of NC, Benchmarks, business and philanthropic leaders, the Child Treatment Program, Community Care of NC, March of Dimes, MST Services, NC Child, the NC Department of Health and Human Services (including the Divisions of Child Development and Early Education, Medical Assistance, Mental Health/Developmental Disabilities/Substance Abuse Services, Public Health, and Social Services), the NC Department of Public Instruction, the NC Department of Public Safety (including Adult Corrections and Juvenile Justice), the NC Early Childhood Foundation, NC Institute of Medicine, NC Office of the Courts, NC Partnership for Children, Pregnancy Medical Homes, Prevent Child Abuse NC, Race to the Top, and local representatives of health departments, law enforcement, K-12 education, and social services.

Other Factors for Consideration

Prevention saves money, but sometimes in a different year or line-item. For example, evidence-based home visiting programs that provide key supports to a pregnant woman and follow-up with the newborn and family have many demonstrated benefits, including reduced crime and need for special education services. The funding for such programs generally comes through the Department of Health and Human Services whereas reduced need for special education would likely be a savings for the Department of Public Instruction and less crime would be a savings for the Department of Public Safety.

Our current investment in children represents a complex mix of state, local, federal and private dollars: One example would be services to adopted children and their families. Services to abused and neglected children prior to termination of parental rights are funded by a mix of local and federal dollars. Post-adoption supports to families are paid with federal dollars. Mental and physical health services for adopted children are generally paid with Medicaid, a mix of state and federal funding. Local Divisions of Social Services may use local dollars and/or secure private grants to provide enhanced services, such as the Success Coach model in Catawba County. Non-profits, such as the Children’s Home Society, may supplement public funding they receive with privately raised dollars to provide more needed services to families. Medical providers, such as the Center for Child and Family Health, may use private funding to assure evidence-based treatment with fidelity when Medicaid and private insurance reimbursements are insufficient to cover the cost of the evidence-based intervention. Defining what funds constitute “investment in children and families” will be an important consideration.
Evidence-based programs (EBP) implemented with fidelity are the gold standard: Some programs incorporated rigorous evaluation, including control groups, into early program design and can show with a high degree of reliability that they produce the desired results when implemented with fidelity. Since only programs implemented with fidelity produce these results, it is also important to analyze the adequacy of resources assuring the ability of the program and the community to support the EBP model. WSIPP ranks study quality into 5 levels to account for such differences.\(^8\)

Best-practice, evidence-informed strategies may be necessary to assure a continuum of services to address a continuum of needs and ages when there is not EBP: For example, trauma-focused cognitive behavioral therapy is an evidence-based treatment for children who have experienced trauma. However, it only works for children who have memory of the traumatic event. Other strategies must be used with very young children and infants. While there is no “evidence based practice” there are therapies that are considered best practice (and yet others that are considered harmful).

Every public dollar invested in children’s programs in NC should meet best practice standards to assure the best results for children and families in the most cost-efficient way possible across the continuum of need, care, and age: NC currently supports a variety of programs to reduce childhood death and injury and improve long-term outcomes. Investment in the early years and in prevention efforts are often seen as providing the “most bang for the buck.” Careful evaluation can provide important answers about whether or not NC is getting the maximum return from the investment by assuring use of best practice programs and concentrating investment in an array of effective programs that maximize returns across the continuum of need, care and age in a way that promotes equity.

Many thanks to the work group who worked on this recommendation: Dr. Max Crowley, Michelle Hughes, Dr. Joel Rosch, Rob Thompson and Sarah Vidrine.

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\(^8\) WSIPP Cost-Benefit Technical Manual, see pages 16 and 17 for 5 categories
Child Fatality Task Force
Contact Information and Structure

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Committees

The Intentional Death Prevention Committee focuses on preventing violent child deaths, such as those due to homicide, child maltreatment and suicide.

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

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

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

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

Co-Chairs
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Councilmember Martha Sue Hall, City of Albemarle
NC Child Fatality Task Force Members –April 2014

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Senator Austin Allran
NC Senate

Senator Chad Barefoot
NC Senate

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