EMBARGOED until 12 noon on November 1, 2019

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Child Fatality Task Force Examines Child Death Data with Historic Low Rate*

RALEIGH. On Monday, November 4th the North Carolina Child Fatality Task Force (Task Force) will examine newly released child death data for 2018 showing a total rate that is a historic low for the state. The overall child death rate in 2018 was 54.5 per 100,000 NC resident children ages 0 to 17, which represents a 4.6% decrease from 2017 and a 49% decrease since creation of the Task Force and the larger Child Fatality Prevention System in 1991.**

"While we celebrate the lowest rate we've seen, we know it will take sustained efforts to ensure that this trend line continues to decrease," said Karen McLeod, Chair of the Task Force. "We are also keenly aware that most deaths are preventable, and whether we are advancing a change in traffic laws, funding for programs to reach new moms, or a health equity initiative, we know prevention happens through a variety of strategies."

All age groups saw declines in the child death rate between 2017 and 2018 and all but one group, age ten to 14, saw a decreased rate over the course of the last decade. An almost 27% increase in the death rate for ten to 14-year-olds over the past decade appears to be attributable to the rise in rates for suicide, homicide, and illness.

While rates for most leading causes of death have generally declined in the past decade, the youth suicide rate has increased and the 2018 rate is the highest the Task Force has seen. Similarly, looking at deaths related to firearms (which includes suicide, homicide, and accidental), the 2018 rate is the highest seen in the past decade. These two increases overlap since almost half of youth suicides are firearm-related.

Recently, the Task Force has emphasized the prevention of youth suicide and firearm-related deaths with a range of recommendations, some of which have succeeded while others remain stalled. For example, legislation requiring suicide prevention training in schools has been addressed in several bills which have not become law. A 2019 bill that would mandate and fund a statewide firearm safe storage initiative is included in the stalled state budget bill, and such an initiative was also addressed in a recent Executive Directive from Governor Cooper. State leaders have successfully advanced funding for more school professionals who can address student mental health, as well as funding for school safety grants including training that addresses youth access to lethal means.

A historic low in the state's death rate of infants, who make up two-thirds of all child deaths (64% in 2018), has helped to decrease the overall child death rate.*** However disparities persist, and although the 2018 African American infant mortality rate was its lowest ever, the rate is more than twice that of white infants. Recent Task Force recommendations to address infant mortality include an initiative to ensure that high-risk moms and babies have access to the medical care they need, support for programs that prevent tobacco use during pregnancy, promotion of safe infant sleep, and the addition of conditions to the state's newborn screening panel.

Motor vehicle injuries remain the leading cause of unintentional deaths. Between 2017 and 2018, motor vehicle death rates showed the largest decline among all leading causes of death (an 18.6% decrease) and the same was true for the past decade with a 30% decrease. The Task Force has continued to recommend improvements to laws that address two primary risk factors for crash deaths: not using seat belts and impaired driving.

A set of 2019 Task Force recommendations aimed at strengthening the statewide Child Fatality Prevention System represents a broad initiative by the Task Force to address all types of deaths within all age groups. These recommendations were addressed in House Bill 825 which was included in the stalled state budget bill. "Strengthening the Child Fatality Prevention System that involves multidisciplinary fatality review teams across the state would absolutely improve our ability to identify system issues and implement local and state-level strategies that can prevent future deaths," said Kella Hatcher, Executive Director of the Task Force.

*__Understanding these data:__ Data is from the North Carolina State Center for Health Statistics. For detailed information regarding child deaths, including trend and county information, please visit: https://schs.dph.ncdhhs.gov/data/vital/cd/2018/. Note that numbers in the report from the State Center for Health Statistics (SCHS) may differ slightly from numbers reported by the Office of the Chief Medical Examiner (OCME). The SCHS bases its statistics on death certificate coding only and must close out annual data at a specific point in time. The OCME makes its determinations utilizing a variety of information sources when conducting its death investigations and reviews, does not close out its data by a set date, and some of its cases are still pending when the State Center for Health Statistics closes their annual data files. Therefore, the cause and manner of death determined by the OCME may be finalized or modified based on OCME review after the time period during which the SCHS finalizes annual data files.

__About the Child Fatality Task Force and the NC Child Fatality Prevention System__
The Task Force is a legislative study commission with a 28-year history of making recommendations to the Governor and General Assembly on changes in law and policy to reduce child death, prevent abuse and neglect, and support the safety and well-being of children. Task Force recommendations are based on data, research, and evidence-driven practice conveyed by experts and reflect hundreds of hours of volunteer input. Task Force meetings are open to the public. The Task Force is part of the state's Child Fatality Prevention System which also includes state and local teams composed of multidisciplinary groups who review individual cases of child deaths to identify and address what is causing child deaths and how to prevent future deaths. For more information on the Child Fatality Task force, visit: https://www.ncleg.gov/DocumentSites/Committees/NCCFTF/Homepage/index.html.

***__Infant mortality and perinatal health information:__ State Center for Health Statistics 2018 infant mortality data is available at: https://schs.dph.ncdhhs.gov/data/vital/ims/2018/. The Task Force Perinatal Health Committee receives regular updates on the progress and implementation of the North Carolina Perinatal Health Strategic Plan, and many of the committee's recommendations address strategies in this plan.