New Child Fatality Prevention System Frequently Asked Questions

FUNDING

1. **What is the new funding formula for the Agreement Addendum for child fatality?**

   Counties in the top quartile for Social Vulnerability (based on Centers for Disease Control and Prevention and Agency for Toxic Substances and Disease Registry Social Vulnerability Index) will receive $1,000 in base funding. Counties in all other SVI quartiles receive $400 in base funding. The remaining $134,000 will be allocated across the counties based on their proportion of statewide child deaths occurring in the previous 5-year period. This funding formula was developed collaboratively with the North Carolina Association of Local Health Directors. Funds are distributed via Agreement Addendum 701 to Local Health Departments.

2. **Can the funding be used for child fatality prevention activities instead of personnel to complete the report form?**

   The Agreement Addendum 701 provides funding for the Local Health Department to prepare and begin using the National Fatality Review-Case Reporting System (NFR-CRS). Funds were appropriated by the NC General Assembly to support implementation of the changes authorized by NCSL 2023-134 to restructure child death reviews by Local Teams and to offset the costs associated with Local Team participation in the NFR-CRS.

   Funding provided through Agreement Addendum 352 can continue to be used for programming, hiring of staff to support the CFPT (future Local Team), safety equipment/prevention efforts and/or child fatality trainings.

TEAM OPERATION

3. **Can we opt to have a single team that will be a combination of our County CFPT and CCPT?**
   As of January 1, 2025, all teams will operate as a single combined team. The new legislation combines the current CCPT and CFPT configuration as of January 2025, and these terms will no longer be used. The combined team will be referred to as the 'Local Team'. Your Board of County Commissioners can choose to remain a single county team (as opposed to a multi-county team).

4. **For multi-county team structure, how do counties choose who to partner with? Have you seen or do you anticipate that the multi-county team approach is a more systems driven process?**

Counties can choose to partner with one or more counties to form a multi-county team if approved by each county's Board of County Commissioners. The new legislation directs the Board of County Commissioners to consult with their Department of Public Health Director and Department of Social Services Director to get their input and recommendation to help the Board of County Commissioners make this decision. A multi-county approach may benefit counties with low number of child fatalities each year, minimal resources, or established heath districts. However, there are likely challenges (e.g., allocation of resources, membership, travel / meeting logistics) that would need to be addressed with a multi-county approach. Counties may decide in the future to combine into a multi-county team.

5. **Do the county commissioners need to make a formal vote for the single or multi-county team?**

   Each county's local board of county commissioners shall evaluate and determine whether the county will have its own Local Team or be part of a multicounty team. This determination, in consultation with the director of the local health department and the director of the local department of social services, may include a formal process for engagement and decision making, such as a vote. It is, ultimately, a local decision as to what is done to evaluate and come to a decision.

   If desired, a template for board action can be found on the CFPT resource page.

6. **Can the county teams still utilize a subcommittee?**

   The new child fatality legislation does not explicitly address the use of subcommittees. Historically, subcommittees were established to allow the larger CFPT to concentrate on fatalities with greater potential for prevention efforts. The new legislation narrows the categories for review but does require all fatalities within the listed categories of death to be entered into the NFR-CRS starting July 1, 2025. Although the legislation does not prohibit Local Teams from using subcommittees, the original purpose for subcommittees may no longer be applicable for use by Local Teams.

7. **What and how will training for these new changes be implemented prior to January 2025?**

   DHHS continues to establish and hire for the State Office of Child Fatality Prevention and will develop a timeline for specific training for the coming year. In addition, we are working on developing a Toolkit for Local Teams to serve as a comprehensive resource to guide Local Teams through the enhanced child fatality review process. The Toolkit will contain details about the overall process, how information will flow, and details about the roles and responsibilities of the Local Teams. The Toolkit will also contain resources (e.g., technical

assistance, subject matter experts) that are available to Local Teams to help them complete effective child fatality reviews. We will share more details about the Toolkit and available resources in the upcoming months.

Specific training on use of the National Fatality Review-Case Reporting system is anticipated in the new year.

In the meantime, Local Teams should consult the latest communication document from DHHS (link) with steps on the following:

- Determining if the Local Team will operate as a single county team or as a multi-county team
- Identify a Chair for the Local Team
- Confirm all required positions are filled
- Identify potential ad hoc members, see question/answer 24

8. **What is the estimated time frame for when the training to use the National Fatality Review - Case Reporting System? How much time will this training take? Who needs to take this training? Who is ultimately responsible for entering the data into this system?**

   The new legislation requires the entry of child fatality review data into the National Fatality Review – Case Reporting System starting in July 2025. Agreement Addendum 701 provides funding to offset the costs associated with Local Team participation in the National Fatality Review Case Reporting System, including supporting training on the use of the NFR-CRS. Appropriate data use agreements will have to be in place.

   We are still designing the reporting process, including what information will be entered into this system, training logistics, and who will enter the information. We anticipate the design will be completed by the end of this calendar year and will provide more details as they become available.

9. **How much time is anticipated from Local Team members to accommodate these new requirements (e.g., will this need to be a fulltime position)?**

   The legislation requires Local Teams to meet a minimum of two times a year. Additional meetings can be scheduled as frequently as necessary to fulfill requirements. The amount of time needed for Local Team members will be impacted by the number of child fatality reviews that are conducted and the complexity of the individual cases.

10. **How do we train the ad hoc members for serving on the team? It may be harder to get participation in this format. Is anyone else concerned about this?**

Ad hoc members will continue to sign the confidentiality form, as is the current practice for CFPTs. When inviting ad hoc members, we encourage the Local Team to communicate their purpose and the role these individuals will play in achieving the overarching goals of the review. We expect training materials and documentation to be available from the State Office after January 2025.

11. **I'm noticing that this document states the team should meet a minimum of twice each year; however, our AA says 4 meetings per year. Once this takes effect, will our AA be updated to reflect that change?**

    For fiscal year 2025 (July 1, 2024, to June 30, 2025), Local Teams will continue to operate under the DCFW Agreement Addendum 352, which has the 4-meeting minimum.

    Starting in Fiscal Year 26, a singular Agreement Addendum will include the necessary information and all funding (combined from AA 352 and AA 701.) Teams will then be required to meet a minimum 2 times a year.

12. **Will Local Teams be sent all child fatalities or only ones required in the legislation?**

    We are still in the process of setting up the new Office of Child Fatality Prevention, which includes hiring staff to fill the budgeted positions, developing standard operating procedures, and determining what information will be entered into the NFR-CRS/ sent to Local Teams. We anticipate the design will be completed by the end of this calendar year and will provide more details as they become available.

TEAM MEETINGS

13. **What should teams do with cases that are still open within Law Enforcement for investigation?**

    In order to avoid interference with an active law enforcement investigation or subsequent case with the District Attorney, Local Teams are advised to wait to conduct the child fatality review process until all open law enforcement and District Attorney cases are resolved. This approach also allows the Local Team to have a more complete picture of the facts associated with the child fatality to help inform its findings and recommendations.

14. **Can teams look up other children in the family (live children) for more current information?**

    Local Teams should consult their Department of Social Services Director or the State Division of Social Services Regional Support Team for guidance.

15. **Can Local Teams use AI in team meetings (e.g., to support note taking), or is this considered a breach of confidentiality?**

    Due to the sensitivity of the information being discussed during the child fatality review process, we would recommend refraining from using AI during team meetings. For a formal legal opinion, Local Teams can consult with the Legal departments within their county agencies.

16. **Does there have to be a quorum at Local Team meetings?**

    The legislation does not address the issue of quorums at Local Team meetings. Local Teams are encouraged to set their own expectations for meeting attendance. In developing these expectations, teams should consider the necessary composition for a productive review. The composition of the teams is intended to ensure there is appropriate representation from necessary and various perspectives to adequately review a child death and make informed recommendations for prevention.

17. **Are CFPT meetings required to be in-person starting in 2025?**

    This is not addressed by the legislation. Teams are encouraged to structure their meetings in a way that facilitates the highest quality reviews for their Local Team.

TEAM MEMBERSHIP

1. **Does the review coordinator role continue to support the Local Team?**

   Yes. It is not the intention of the legislation for the review coordinator position responsibilities to end; this role can continue to support the Team. Staff supporting the functioning of the team do not need to count towards a team's Ad Hoc members. A person functioning in the role of review coordinator, is a staff person supporting the team rather than an Ad Hoc member.

2. **Can the 5 "ad hoc" members be pre-selected/appointed and just kept on standby or even routinely invited OR should they be chosen at the time when the review will be taking place? *Example, CMARC nurse who has an abundance of information for the review does not fall in as a 'required member'**

   The appointment and structure of Ad Hoc members will be a local team decision. Local Teams should use their Ad Hoc members in a way that best supports the Local Team's review needs. The new State Office will be available to support local teams in developing a process and structure for appointing Ad Hoc members that best support high quality reviews.

3. **Can co-chair be an ad hoc member?**

   The legislation does not take a position on whether or not an ad hoc member can serve as a co-chair. Whether or not this is feasible, largely depends on how a local team decides to structure the use of the ad hoc members.

4. **With our current set-up, the health director designee holds the chair position. Would the health director/designee also be able to hold chair while also serving at that direct role?**

   Yes, the health director can be the chair if that is the desire of the Team. It is known that some counties may have informally given the chair role to a health department employee as a 'health director designee', however this is not in compliance with current or future legislation. As of now, there is no designee for the health director's role. An ad-hoc position can be used for a health department employee to serve in the chair role.

5. **Does our team need to elect a new Chair at our next meeting for the next calendar year and can the Chair still be a person from the community versus a LHD staff member?**

   The legislation does not create new standards for who can serve as chair.
   A new chair does not necessarily need to be elected as long as the current Chair is a member of the new consolidated team, they can continue to serve as chair.

6. **Does the HD/DSS Director or Health and Human Services Combined Director need to attend?**

   Either the DSS Director of Human Service Combined Director, whichever has authority over DSS practice needs to be a member of the local team. In addition, a member of the appropriate Director's staff should be appointed to the team as well.

7. **What do counties do for the position of member of the DSS board if they don't have a DSS board and instead have an advisory board or health and human services board?**

   A member should be appointed by the closest equivalent board with oversight responsibilities over local DSS practice.

OTHER

8. **How will the new Office of Child Fatality Prevention monitor Local Teams?**
   We are still in the process of setting up the new Office of Child Fatality Prevention, which includes hiring staff to fill the budgeted positions and developing standard operating procedures. Although the Office of Child Fatality Prevention's specific approach to monitor Local Teams has not been developed, it may be similar to how the Division of Child and Family Wellbeing currently conducts periodic monitoring visits with local child fatality

review teams and provides a completed form with feedback to the Chair to include in their county accreditation documentation.

9. **Do local CFPT need to have our 2023 Quarter 4 reviews completed before January 1, 2025, due to the consolidation?**

   While it would be ideal for local CFPTs to complete their 2023 Quarter 4 reviews before January 1, 2025, the current guidance mandates that a CFPT Confidential Report Form be submitted to the program coordinator within 45 days of the review date. This requirement will remain in effect until January 1, at which point the latest Quarter 4 review report forms should be submitted by February 14, 2025, which is 45 days after the end of Quarter 4.