Child Fatality Prevention Team
County Commissioners/Board of Health Annual Reports

MEMORANDUM

TO: Rutherford County Commissioners/Board of Health

FROM: Joanne Lopez, CFPT Chairperson
Rutherford County Child Fatality Prevention Team (CFPT)

SUBJECT: Local CFPT Annual Report

DATE: May 1, 2026

North Carolina Session Law (NCSL) 2023-134 enacted changes to strengthen the state's child fatality prevention system which included the establishment of a State Office of Child Fatality Prevention (CFP) State Office) within the Division of Public Health (DPH), Department of Health and Human Services (the Department), made changes to the Child Fatality Prevention System, and made it mandatory to report child fatalities into the National Fatality Review Case Reporting System (NFRCRS).

The NFR-CRS is a web-based system hosted by the National Center for Fatality Review and Prevention within the Center for National Prevention Initiatives of the Michigan Public Health Institute (MPHI) and is used by many states to provide child death review teams with a data system for capturing, analyzing, and reporting of information shared at a child death or serious injury review. MPHI has a Cooperative Agreement with the Maternal and Child Health Bureau, Health Resources and Services Administration, Us. S. Department of Health and Human Services, to manage the National Center for Fatality Review and Prevention.

Per NCSL 2023-134, Local Teams are defined as a multidisciplinary child death review team that is either a single or multicounty team responsible for performing any type of child fatality review pursuant to Article 14 of Chapter 7B of the General Statutes.

This program receives an Agreement Addendum which provides funding for the Local Team to conduct child fatality reviews pursuant to Article 14 of Chapter 7B of the General Statues as well as continue use of the NFR-CRS.

The Local Teams are expected to (1) conduct child fatality review pursuant to Article 14 of Chapter 7B of the General Statues; (2) identify gaps or deficiencies that may exist in order to improve the delivery of services to children and families; (3) make recommendations for changes and carry out changes that could prevent future child fatalities; and (4) educate their communities on how to prevent children dying in their counties.

The Rutherford County Local Team has identified the following recommendations for systemic improvements based on reviews during the 2025 calendar year:

- Identify deficiencies in the delivery of services to children and families by public agencies;
- Make and carry out recommendations for changes that will prevent future child deaths; and
- Promote understanding of the causes of child deaths.

Attached is the Rutherford County CFPT annual report for your review for the calendar year 2025. Please feel free to contact me at (828) 287-6100 if you have any questions.

Attachment

I. Introduction

In 1993, the North Carolina General Assembly established a network of local Child Fatality Prevention Teams (CFPT) across the state to confidentially review medical examiner reports, death certificates, and other records of deceased residents under age 18. Each local team consists of representative of public and nonpublic agencies in the community such as law enforcement, Guardian Ad Litem, and health departments, among others, that provide services to children and their families.

The purpose of this report is to give a summary of the causes of death, the number of cases reviewed, recommendations for prevention, if any, that have been made and to share local team activities and accomplishments.

II. Role of the Rutherford County Commissioners and Board of Health

- Receive annual reports which contain recommendations and advocate for system improvements and needed resources, if requested.
- Appoint members of the local team as identified by the membership.

III. Child Deaths by Cause, System Problem Identified, Recommendations for Prevention & Proposed Action

In 2025, the Rutherford County CFPT reviewed 6 child deaths and identified 2 system problems and recommendations for future prevention efforts.

Below are highlights:

Cause of Death	System Problem Identified	Recommendation	Proposed Action
Suffocation due to co-sleeping in adult bed.	Co-sleeping with adult in bed and possible strangulation.	Provide educational information to the community about the importance of following Safe Sleep guidelines	The Health Department will feature safe sleep educational information on social media and continue to provide safe sleep educational information through clinics. DSS will educate and provide safe sleep materials to clients at each interaction. Safe sleep educational materials will be distributed to medical providers in the community. The local hospital RRMC also provides on admission a brochure offered by Association of Women's Health, Obstetrics and Neonatal Nursing (AWHONN) and "Nothing but Baby" pamphlet at discharge, which highly discourages co-sleeping and promotes healthy safe sleeping education.

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Neonate with acute necrotizing chorioamnionitis and funisitis; probable trisomy 21 with transient abnormal myelopoiesis	Lack of prenatal Care Substance Abuse	Provide educational information to the community about the importance of prenatal care. Strengthen community education around substance use, particularly drug use during pregnancy.	The Health Department will feature on social media about the importance of prenatal care as well as continue to make referrals / appts to establish prenatal care appts with providers around community. Promote access to contraception and family planning services.

The Rutherford County Local Team has identified the following needed resources to address identified gaps and deficiencies in the existing system:

- Community Planning for Health Assessment: Frameworks and tools that emphasize community engagement to facilitate community change and improvement
- Targeted Resource Mapping Toolkit: Guidance and support for courts to better understand existing resources, identify service gaps, and build relationships with community providers.

IV. Rutherford County CFPT Activities and Accomplishments

- The Annual CFPT Activity Summary was completed and sent by the date requested.
- One team member partnered with the Rutherford County Cooperative Extension to offer a *Safe Sitter* training, which includes education on safe sleep practices as well as basic first aid.
- Individual reports were completed on child deaths reviewed by the team and were forwarded to the State Coordinator.

V. Conclusion

Thank you to the members of the Rutherford County Commissioners/Board of Health for the opportunity to share with you the successes and dedicated work of the local team as we continue to review child fatalities, make recommendations, and take action to prevent future child deaths.

Please contact the Health Director or Chairperson at Foothills Health District, respectively, if you have any questions about this report.

Health Director

Joanne Lopez

Chairperson

3/31/2026

Date

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