NORTH Dakota | Health & Human Services
Be Legendary.

August 2023-August 2025

Annual Report

North Dakota
Child Fatality Review Panel

With respect and deepest sympathy, this annual report of the ND Child Fatality Review Panel is dedicated to the memory of those children represented within this report; they are not only tragic losses for the family but also for our community.

ND Child Fatality Review Panel

The North Dakota Child Fatality Review Panel (NDCFRP) was established by **North Dakota Century Code (NDCC) 50-25.1** and began reviewing child deaths in 1996. The NDCFRP also serves as the state's Citizen Review Panel as allowed by the Child Abuse Prevention and Treatment Act (CAPTA) Section 106(c).

The NDCFRP reviews deaths of all children (under 18 years of age), which occur in the state or whose death causing event occurred in the state. Our mission is to identify the causes of children's deaths, the circumstances that contribute to children's deaths, and to make recommendations for changes in policy, practices, and law to prevent deaths of children. The CFRP is instrumental in determining circumstances of preventable deaths and contributing factors of abuse and neglect of children, improving investigations of child deaths and highlighting needed system changes.

A determination of the CFRP's agreement with the manner and cause of death indicated on the death certificate and the preventability of death is made by a consensus of the Panel members. Meetings are closed to the public and all case discussions and documents, except for the data of the annual report, are confidential. (**NDCC 50-25.1-04.5**).

Acknowledgements

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Executive Summary

Child Fatality Reviews 2023-2025

This report includes data from reviews conducted by the North Dakota Child Fatality Review Panel (CFRP) between August 2023 and August 2025 on deaths of children aged 17 years and younger that occurred in the years 2022, 2023 and 2024. The report also comprises the review of all child abuse and neglect deaths that occurred in the years 2022, 2023 and 2024 and child abuse and neglect near deaths that occurred in the years 2022 and 2023.

Each death certificate received from the ND Department of Health and Human Services Vital Records is reviewed by the Child Fatality Review Panel and identified as a 'Status A' case or 'Status B' case.

Status A are all cases of children whose death is sudden, unexpected, and/or unexplained, including natural deaths. Additionally, all children with an open Child Protection Services assessment or prior involvement with child welfare, and those children in the custody of the Human Service Zone (formerly County Social Services) or the Division of Juvenile Services at the time of their death are also included as Status A. Status A cases receive an in-depth, comprehensive review and are included in the analysis of this report.

Status B cases are deaths that are not unexpected (i.e. long-term illness) and/or deaths due to other natural causes. Status B cases may only receive a brief review to give Panel members the opportunity to request the case be changed from **Status B to Status A**.

When the death causing event/injury occurs outside of the state, the death is considered an out-of-state child death and does not receive an in-depth review. When the event/injury occurs in North Dakota, and the child is transferred out of state for treatment and died out of state, the death is then categorized as **Status A or Status B**.

Child Fatalities Reviewed | 2022-2024

- Between **August 2023 – August 2025**
- **89** deaths were reviewed

2022 Child Deaths Ages 0-17 years | 80

- **35** received an in-depth review
- **1** death remained open at the time of this report
- **38** were 'Status B'
- **6** children's death causing events took place out of state
- **97%** of all eligible deaths were included in this report

2023 Child Deaths Ages 0-17 years | 102

- **48** received an in-depth review
- **11** deaths remain open at the time of this report
- **40** were 'Status B'
- **13** children's death causing events took place out of state
- **80%** of all eligible deaths were included in this report

2024 Child Deaths Ages 0-17 years | 94

- **6** received an in-depth review
- **46** remain open for review
- **40** were 'Status B'
- **7** children's death causing events took place out of state
- **12%** of eligible deaths were included in this report

Case information reported in the remaining executive summary provides limited 2024 data, and substantial data highlighting trends for 2022-2023 cases reviewed.

The death reviews are retroactive and occur following any criminal investigation, prosecution and judicial handling. Comprehensive death reviews are limited to those records obtained. After an in-depth review, the CFRP either agrees or disagrees with the manner of death indicated on each death certificate. When the Panel does not agree, the Panel reclassifies the manner of death for its own purposes. It does not change the classification on the death certificate, but the Panel's decisions regarding manner of death serve as the basis of this report.

Leading Manner of Child Death | 2022 to 2024

Accidents

Homicide

Natural

Suicide

Undetermined

As seen above, **Accidents** were the most common manner of death among the cases reviewed, at approximately **30%**. **Suicides, Undetermined and Natural** deaths followed each at approximately **20%** of cases**. Homicides** were the least common manner of death reviewed at **10%** of the fatalities.

Five child fatalities that occurred in **2022** were reclassified from Natural to Undetermined

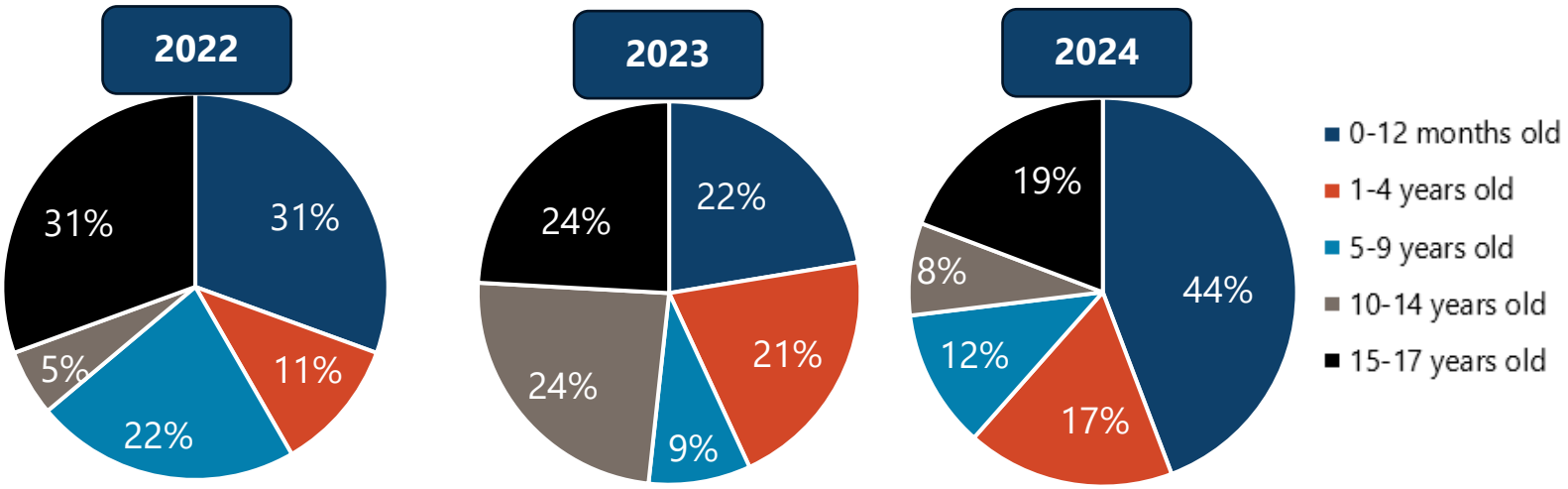
One child fatality that occurred in **2023** was reclassified from Undetermined to Homicide

Six child fatalities that occurred in **2023** were reclassified from Natural to Undetermined.

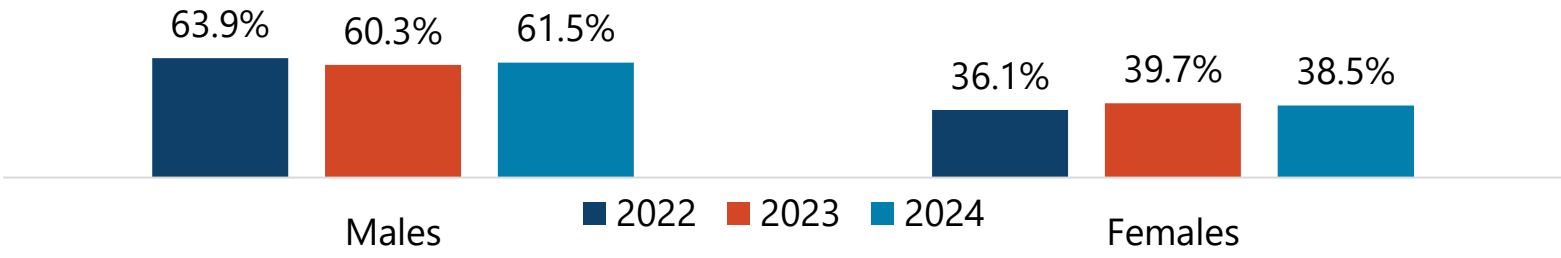
Intentional deaths, those by Suicide and Homicide surpassed Accidental deaths in **2023**

Status A Child Deaths 2022-2024

Age



Sex



Race

22.3 per 100,000 children were **White**

75.8 per 100,000 children were **Black**

79.1 per 100,000 children were **American Indian**

24.4 per 100,000 children were **Hispanic**

28.1 per 100,000 children were **Asian**

Status A and B Infant Deaths, 2022-2023

Status A & B infant deaths occurred 1.4 times more often among male children compared to female children. The Status A & B infant deaths occur at a rate of **238.8/100,000** among the American Indian population which is more than **3.25 times higher** than the White population.

Sex

Males

Females

Race

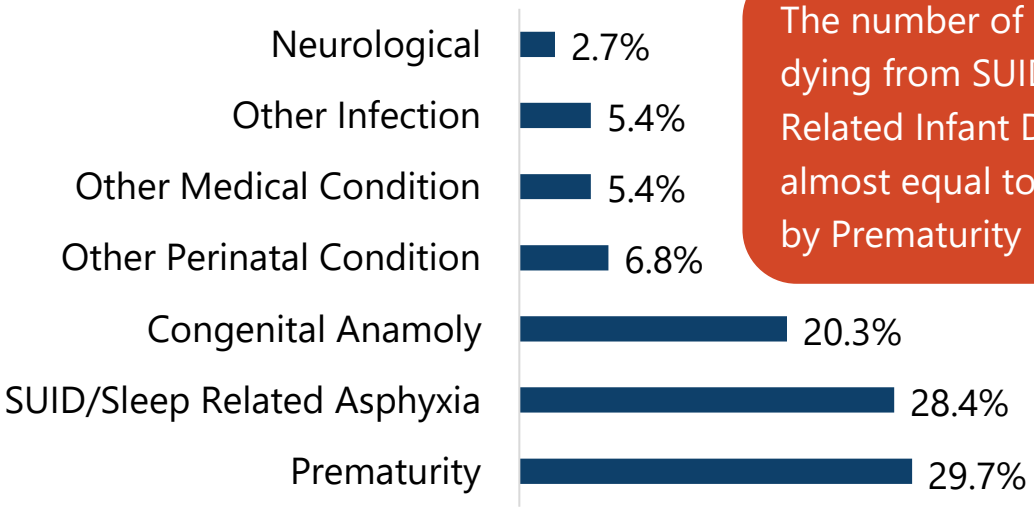
238.8 per 100,000 infants were **Black**

212.2 per 100,000 infants were **American Indian**

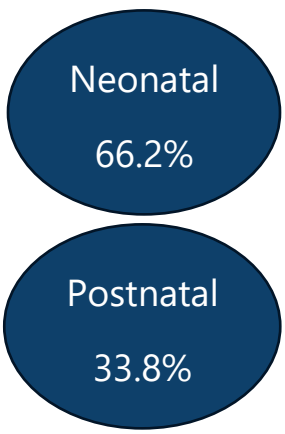
72.9 per 100,000 infants were **White**

30.8 per 100,000 infants were **Hispanic**

Cause of Death

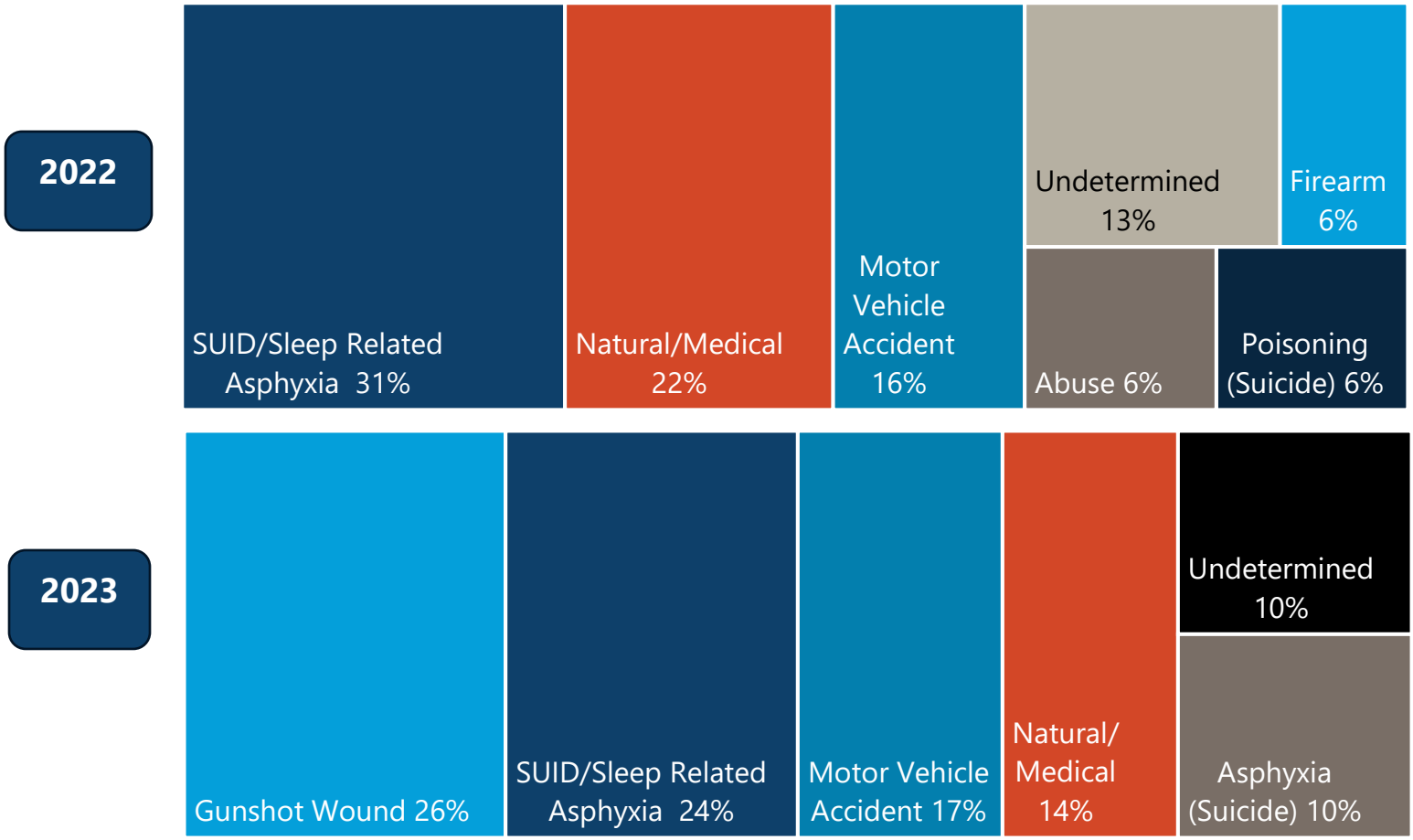


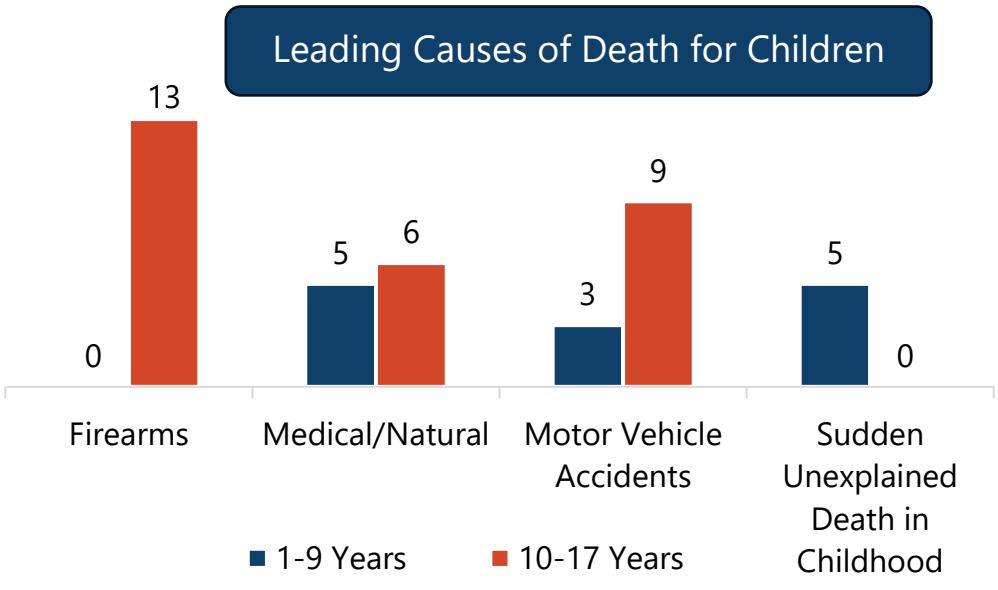
The number of babies dying from SUID/ Sleep Related Infant Death is almost equal to those dying by Prematurity



[1] Neonatal deaths are those that occur before the 28th day of life; post neonatal deaths are those that occur between 28 days and 364 days of life.

2022-2023 | Leading Cause of Death for Children of All Ages (0-17 Years)





Those with a cause of death of Sudden Unexplained Death in Childhood were all age 1 year and died suddenly and unexpectedly in their sleep

The children that died of Medical causes were most often related to complex medical needs, asthma and diabetes.

Introduction

Case Identification

The Child Fatality Review Panel receives all North Dakota issued death certificates of children (under the age of 18 years), this includes children in tribal and military jurisdictions. Each death certificate received from the Department of Health and Human Services Vital Records is reviewed and categorized as a Status A case or a Status B case. Deaths that are Status A receive a comprehensive in-depth review.

Records are abstracted from:

- **Death Certificates** – obtained from the North Dakota Division of Vital Records.
- **Medical Forensic Examiner Reports** –obtained from the State Forensic Examiner and the University of North Dakota Forensic Pathology Department
- **County Coroner Reports** – obtained from 53 county coroners.
- **Law Enforcement Reports** – obtained from more than 100 local and tribal law enforcement agencies across the state and the North Dakota Highway Patrol.
- **Child Protection Services –** obtained from 19 Human Service Zones.

North Dakota statute (NDCC 50-25.1-04.4) provides that, 'Upon the request of a coroner or the presiding officer of a CFRP, any hospital, physician, medical professional, medical facility, mental health professional, mental health facility, school counselor, or division of juvenile services employee shall disclose all records of that entity with respect to any child who has or is eligible to receive a certificate of live birth and who has died'. This statute also states, 'All law enforcement officials, courts of competent jurisdiction, and appropriate state agencies shall cooperate in fulfillment of the purposes of this chapter' **(NDCC 50-25.1-12)**.

The CFRP abstracts records regarding the circumstances of the child's death from a variety of sources (i.e. medical, coroner, forensic pathology, law enforcement, child protection services, mental health, school, court, driving records, etc.).

Regardless of these mandates, information is too often not forthcoming in response to Panel requests. When this occurs, the Panel's statutory mandate to review the deaths of all minors which occurred in the state in a timely manner is hindered. The Panel has no investigatory authority of its own and is completely dependent on the work and cooperation of the agencies with this authority. There are also other entities such as the Federal Bureau of Investigation, the Bureau of Indian Affairs, and tribal entities that are outside the jurisdiction of state statutes. These entities possess detailed and valuable information about a given child, whose records are not addressed in state law. If not provided by request, these records remain inaccessible to the Panel.

CFRP Process for Fatality Reviews

The Panel began utilizing the National Fatality Review-Case Reporting System (NFR-CRS), a web-based standardized case reporting system for reviewing deaths occurring since 2020. The NFR-CFR is a national platform for child death review teams to capture data elements using a standard report and accompanying data dictionary.

1. Share, clarify and question case information to better understand all the circumstances leading to and involved with the child's death incident.
2. Discuss the investigation to determine if all pertinent questions about the death's circumstances were answered.
3. Discuss the delivery of services prior, at the time of the child's death and in response to the death.
4. Identify protective and risk factors involved in a child's death. Identifying protective and risk factors are essential to formulating recommendations that could reduce risk factors for other children, subsequently preventing future deaths.
5. Recommend System Improvements. Identify gaps in policy, practice and law. Each Panel member serves as a liaison to their professional counterparts, provides definitions of their profession's terminology, and interprets the procedures and policies for their agency.
6. Identify and take action to implement prevention recommendations.

There are no fiscal appropriations to the CFRP. The Panel members act as catalysts for change by sharing recommendations with key partners and agencies that carry recommendations into actions.

Manner and Cause of Death

A certificate of death contains two death determinations, manner and cause.

Manner of death refers to the circumstances surrounding how a death occurred. There are five manners of death defined by the National Association of Medical Examiners (NAME).

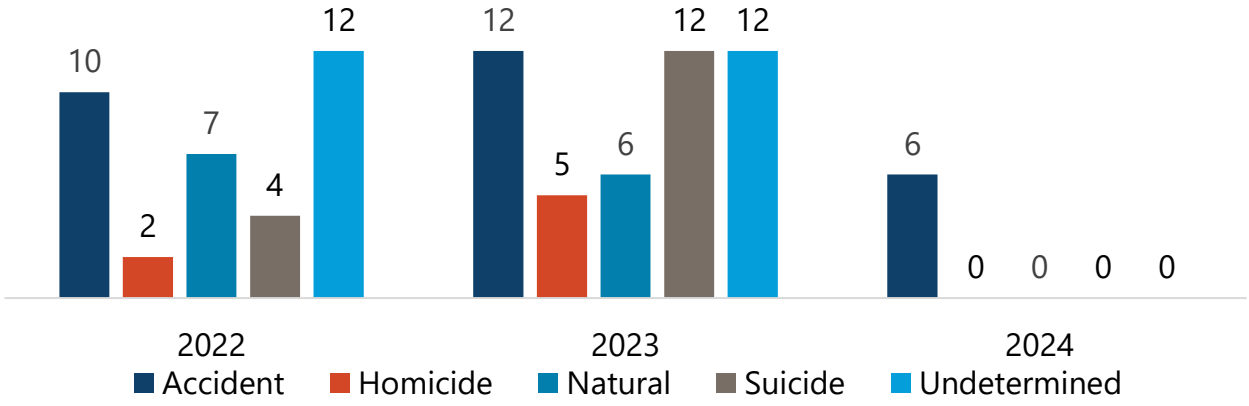
- **Natural** — A death due solely or nearly totally to disease and/or the aging process.
- **Accident** — An injury or poisoning causes death and there is little or no evidence that the injury or the poisoning occurred with intent to harm or cause death. In essence, the fatal outcome was unintentional.
- **Suicide** — An injury or poisoning as a result of an intentional, self-inflicted act committed to do self-harm or cause the death of oneself.
- **Homicide** — A volitional act committed by another person to cause fear, harm, or death. Intent to cause death is a common element but it is not required for classification as homicide. It is to be emphasized that the classification of Homicide for the purposes of death certification is a 'neutral' term and neither indicates nor implies criminal intent, which remains a determination within the province of legal processes.
- **Undetermined** — Information pointing to one manner of death is no more compelling than one or more other compelling manners of death in thorough consideration of all available information.

Cause of death refers to the actual disease, injury or condition directly resulting in the death.

North Dakota Century Code 11-19.1-13. Cause of death - Determination. The cause of death, the manner of death, and the mode in which the death occurred must be incorporated in the death certificate filed with the registrar of vital statistics of this state. The term "unexplained sudden death in infant or child with or without intrinsic or extrinsic factors, or both" may be entered on the death certificate as the principal cause of death only if the child is under the age of one year and the death remains unexplained after a case investigation that includes a complete autopsy of the infant at the state's expense, examination of the death scene, and a review of the clinical history of the infant.

Manner of Death of those Reviewed

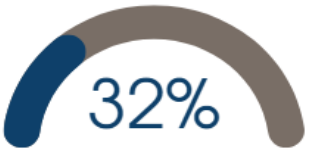
After an in-depth review, the Child Fatality Review Panel either agrees or disagrees with the manner of death indicated on each death certificate. When the Panel does not agree with the manner of death indicated on a death certificate, the Panel reclassifies the manner of death for its own purposes. It does not change the classification on the death certificate, but the Panel's decisions regarding manner of death serve as the basis of this report.



In 2022 **Undetermined** and **Accidents** were the largest categories of deaths reviewed.

In 2023, **Suicides** and **Undetermined** deaths were each a quarter of the deaths reviewed.

Accidents were the most reviewed manner of death Between:
August 2023 -August 2025



73% of Undetermined deaths were among infants under the age of **1 year old**

Of the natural deaths reviewed the causes of death included: asthma, cardiac, diabetes, infection and neurological/seizures

Intentional child deaths comprised **26%** of deaths reviewed

The **majority** of child deaths with a classified manner of death of Undetermined were infants and the cause of death was **Sudden Unexplained Infant Death (SUID)** with Intrinsic and/or Extrinsic factors.

Intrinsic Factors: Natural conditions or risk factors associated with abnormal physiology or anatomy that are concerning as contributors to death but are insufficient as a cause (for example: low birth weight, prematurity, small for gestational age, concurrent non-lethal illness, history of febrile seizures), or natural conditions of unknown significance (for example: cardiac channelopathy or seizure gene variants of unknown significance).

Extrinsic Factors: Conditions in the child's immediate environment that are a potential threat to life but cannot be deemed the cause of death with reasonable certainty (for example: side or prone sleep if unable to roll to supine, over-bundling without documented hyperthermia, objects in immediate sleep environment, sleep environment not specifically designed for infant sleep, soft or excessive bedding, and sleep surface sharing), injuries or toxicologic findings that are either non-lethal or of unknown lethality, or circumstances or findings otherwise concerning for unnatural death. [2]

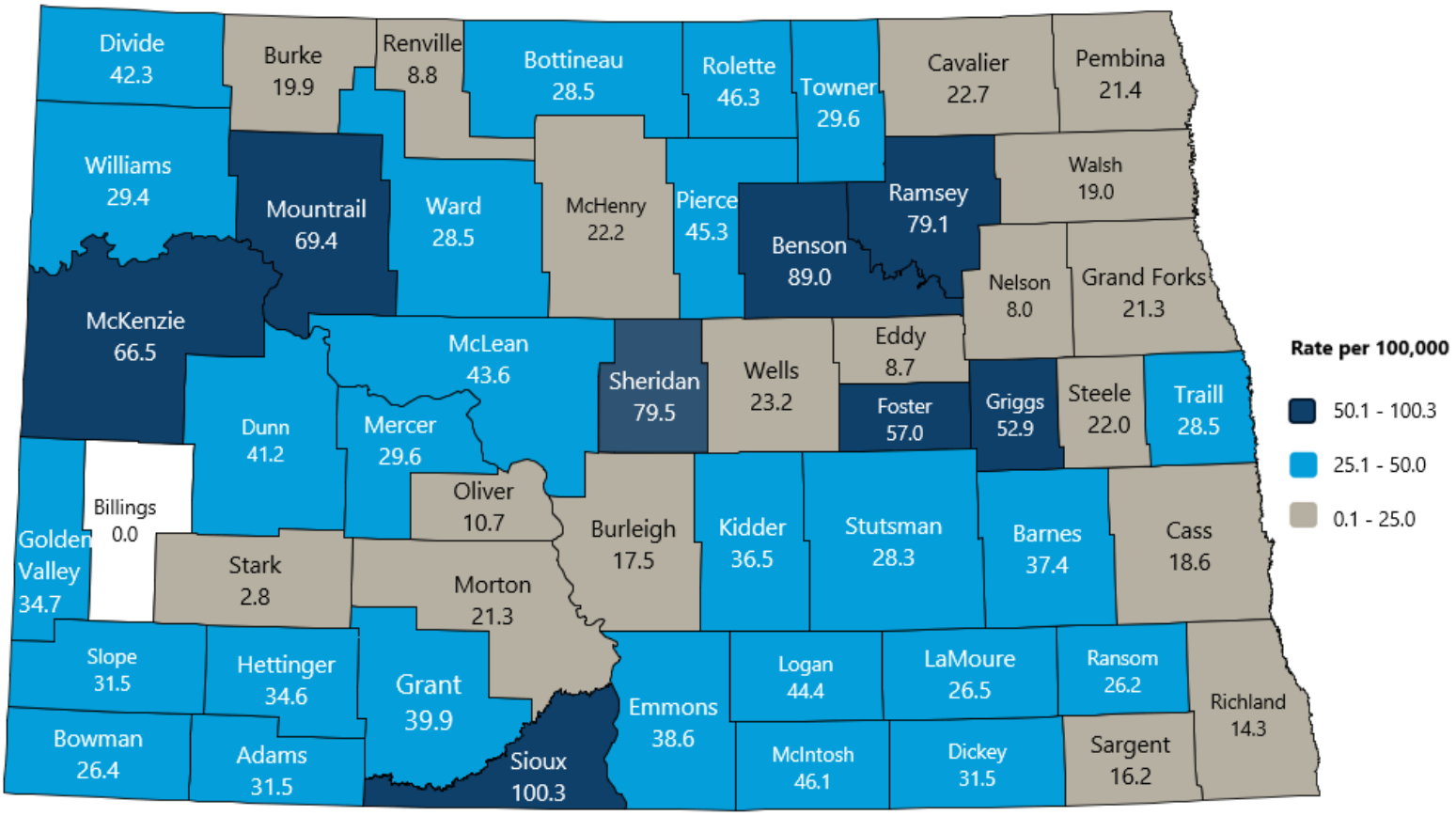
Notably, in **2019**, the National Association of Medical Examiners made a recommendation that death certifiers discontinue the use of the term "sudden infant death syndrome" (SIDS) and use the term **"unexplained sudden death"** specifying whether intrinsic and extrinsic factors were identified as contributing factors of the death; the manner of these situations is then classified as undetermined, resulting in an increase of this manner of death.

[2] National Association of Medical Examiners. (2022) A Guide for Manner of Death Classification. More on Manner of death.

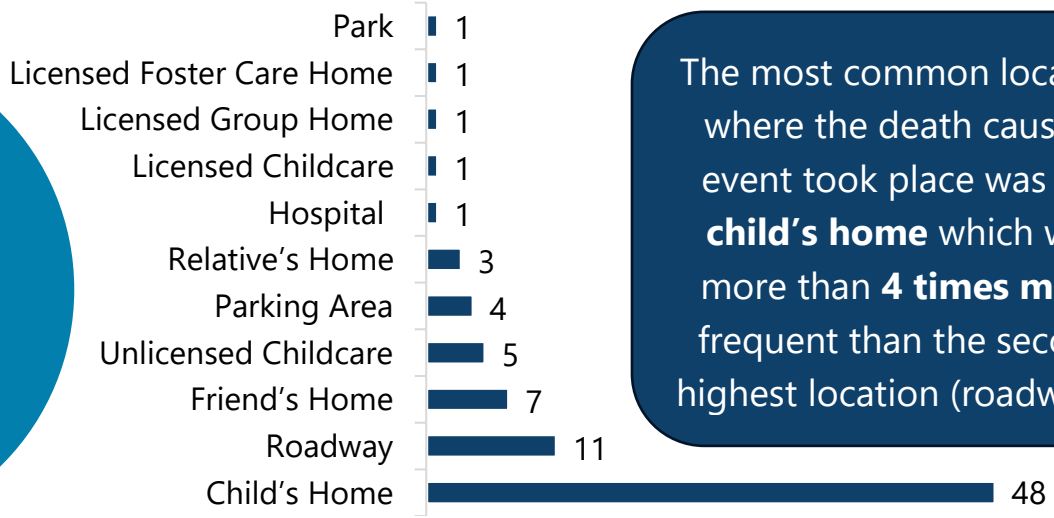
Section I: Overall Location of Child Fatality Trends 2022-2023

WHERE ARE CHILDREN DYING?

Heat Map 2003-2023



Location of death causing injury is not always the same as the death location or residential county



The most common location where the death causing event took place was the **child's home** which was more than **4 times more** frequent than the second highest location (roadways).

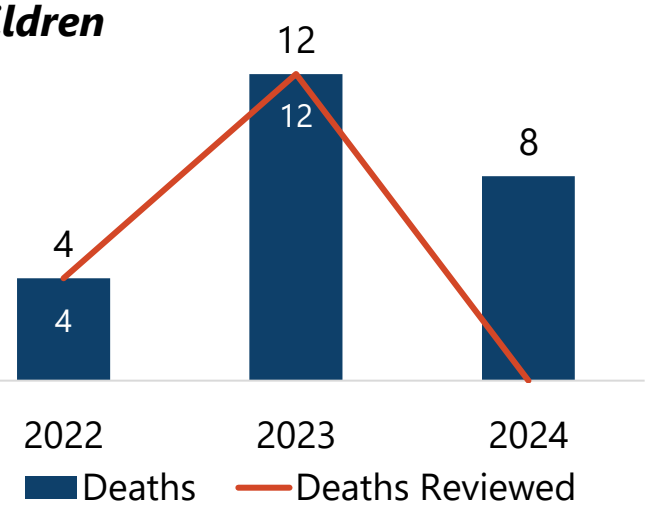
Section II: Suicide, ND 2022-2023

Basic Characteristics of Suicides of Children

Sex

Male

Female



There were **16** suicide fatalities among children from **2022-2023**, reviewed by the CFRP and included in this annual report.

Race

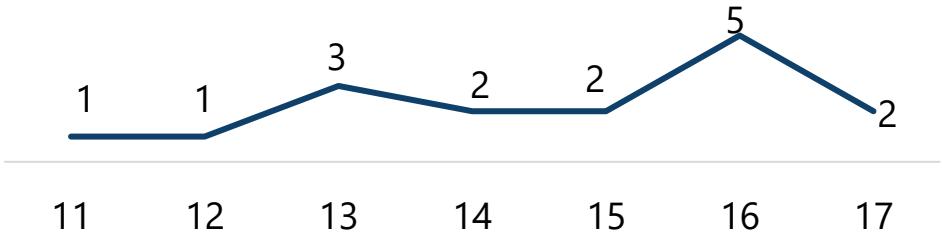
4.8 per 100,000 children were **White**

8.5 per 100,000 children were **American Indian**

21.1 per 100,000 children were **Asian**

In 2023, the ND suicide rate was more than **2.5 times** the US suicide rate among children **(6.4 vs 2.2 per 100,000)**

Age

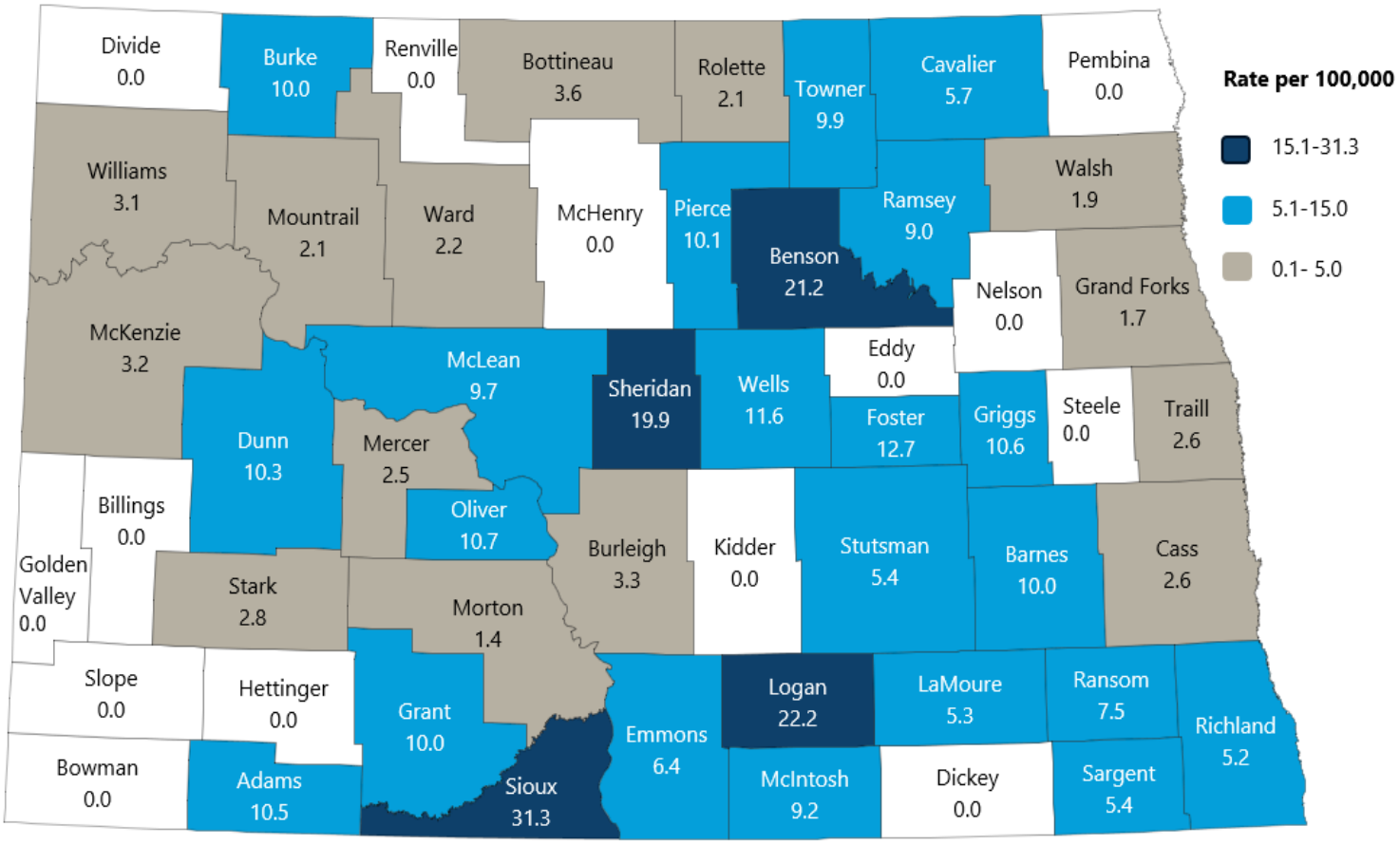


Suicides occurred **3 times** more often among Male children compared to Female children. The rate of Suicide among Asian children is **21.1/100,000** which is more than **4 times higher** than the White population.

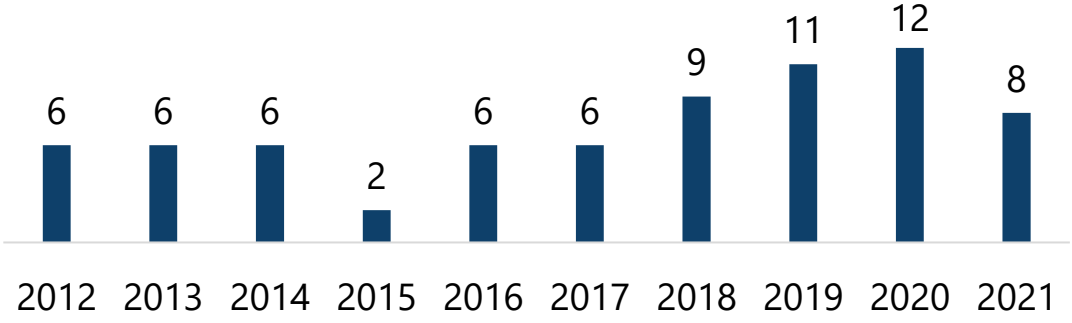
86.7% of Suicides occurred in the **child's home**

Location of Incident

Suicides by County 2003-2023

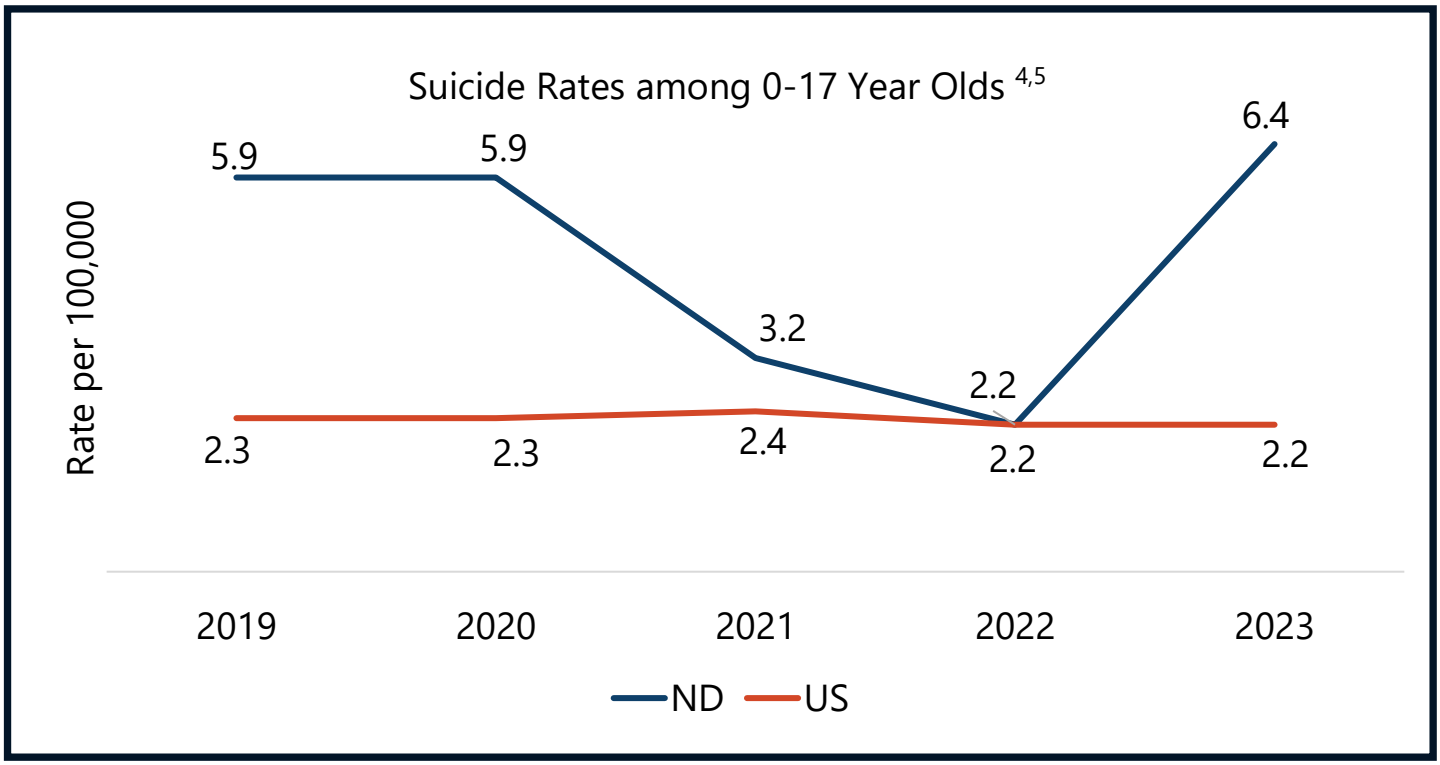


Historical Suicide Fatalities



As seen in the map above, the rates of Suicide among children per County range from **0/100,000** to **31.3/100,000** (Sioux County).

In the US in **2022**, Suicide was the **second leading cause** of death among **10–14-year-olds** and the **third leading cause** of death among **15–17-year-olds**. [3]



North Dakota, 2022

- Suicide was the **leading** cause of death among **10–14-year-olds.**
- Suicide was the **second leading** cause of death among **15–17-year-olds**

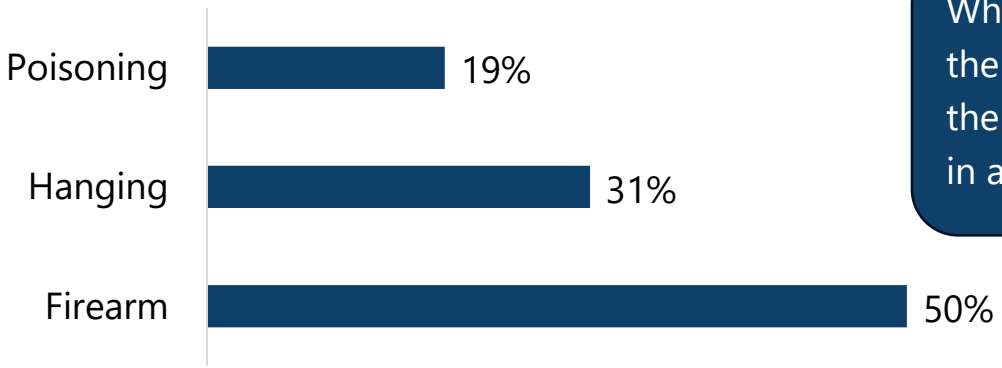
North Dakota, 2023

- Suicide was the **leading** cause of death among **10–14-year-olds**
- Suicide was the **leading** cause of death among **15–17-year-olds**

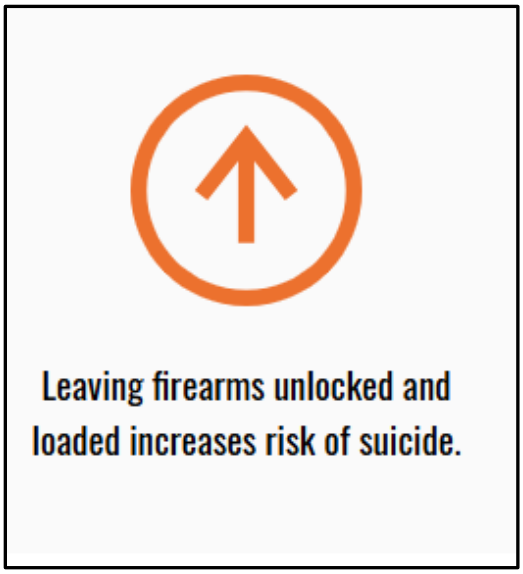
[3] Suicide - National Institute of Mental Health (NIMH)
[4] North Dakot Violent Death Reporting System
[5] CDC Wonder Data

Suicide Method

Suicide Method in Child Fatalities



When a firearm had been used, the weapon was accessible to the youth and had been stored in an unlocked location



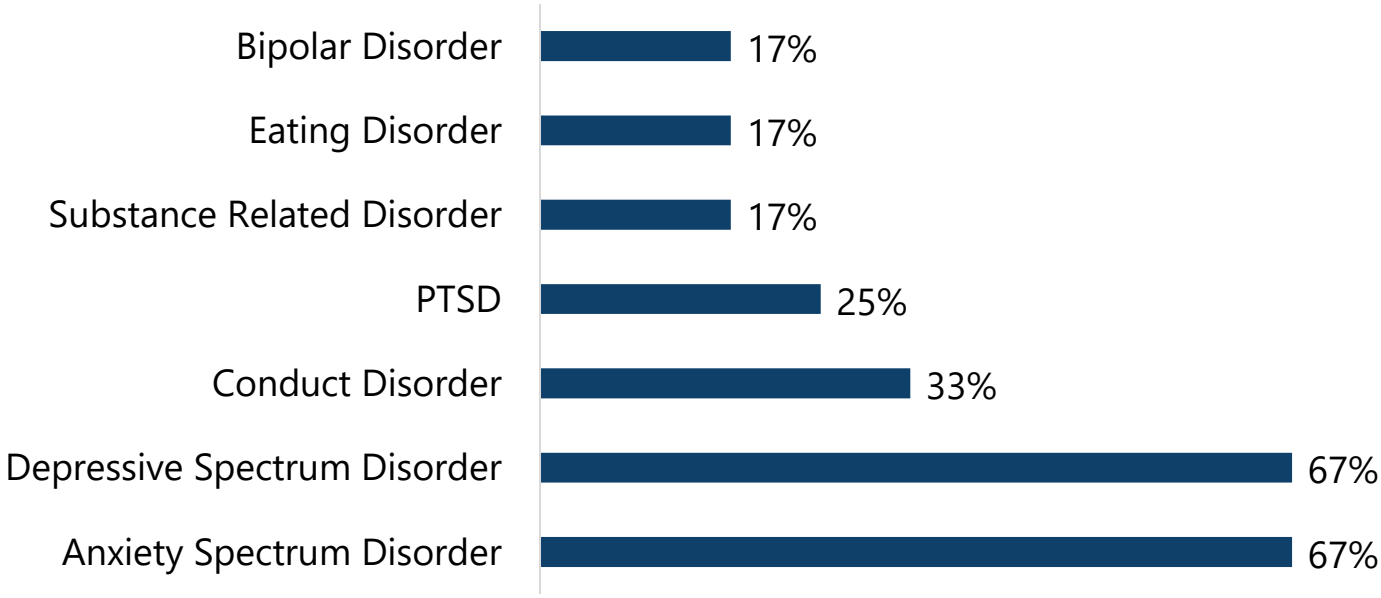
Handguns were the most common firearm used, and were **six times** more common than shotguns or rifles

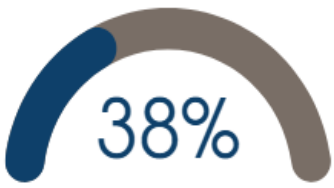
Over the Counter medications were the most common substance in intentional poisonings, with **Diphenhydramine** as the most common substance

There were **no illicit substances** reported as the cause of intentional poisoning

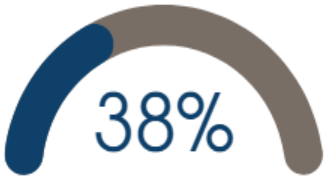
Behavioral Health History

Three fourths of the suicides reviewed had a documented mental health diagnosis. The most identified was Depression and Anxiety (67%). A third of the youth had been diagnosed with ADHD and medicated with Ritalin in elementary school.





of youth were the recipient of mental health services at their time of death



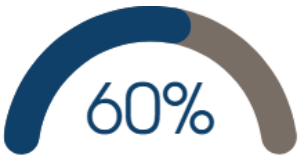
of youth had been seen by a health care provider less than 30 days before their death.

of youth had visited an Emergency Room related to suicidal thoughts and/or behaviors in the 12 months prior to their death.

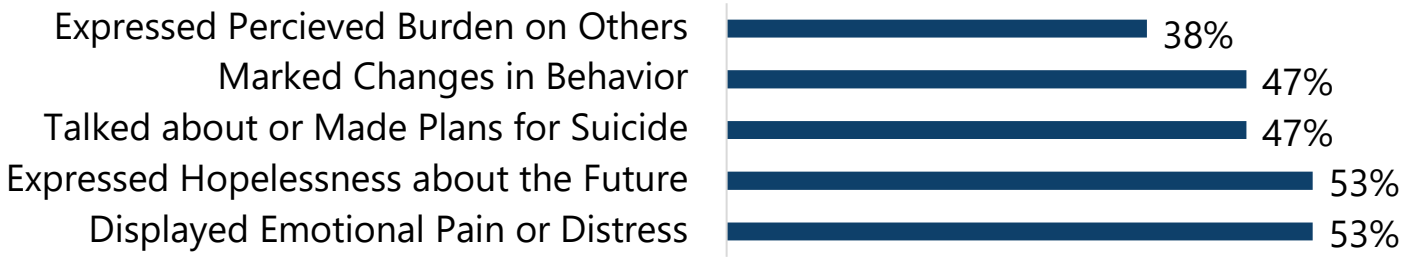
Suicidality History

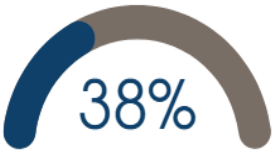
of the youth **experienced a known crisis** within 30 days of their death (Breakup with a significant other, argument with parent, school suspension, criminal involvement, bullying, gender dysphoria, recent or impending move).

81% of youth had exhibited warning signs of suicidal behavior within 30 days of their death



of youth had **reported Suicidal behavior**, actions that indicate a future intention to die by suicide or preparing for one's own death and/or previous suicide attempts.

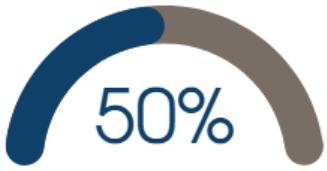




of youth had a documented **previous suicide attempt**

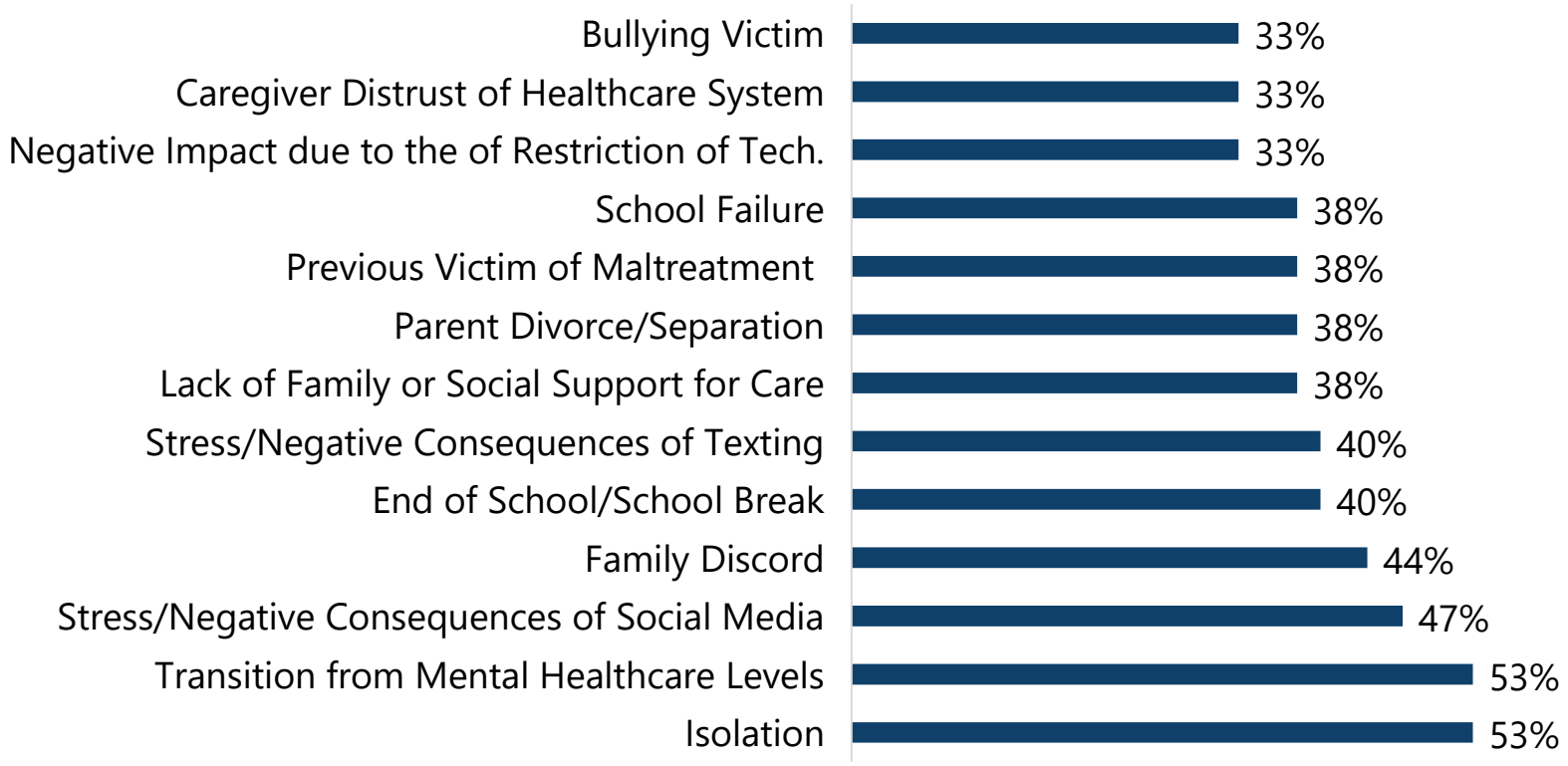
of the youth **left a suicide note behind**

Life Stressors



of the children that died by suicide in **2022-2023** had a history of involvement with **child protection services**.

Children can be impacted by factors of their environment; the following Life Stressors were those most often identified by the CFRP as being present in youth suicides occurring in **2022-2023**:

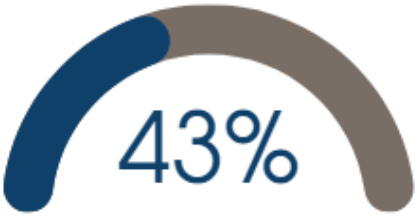


Investigating Child Suicide

North Dakota Century Code 11-19.1-07 provides that deaths of minors that die suddenly and when in good apparent health, law enforcement shall investigate the death, and the coroner shall inform the state forensic examiner of each said death and an autopsy performed. Of the sixteen suicides that occurred in 2022-2023, **a death scene investigation and autopsy was completed 69% of the time**; five children did not receive an autopsy.

Toxicology

of the cases had reported toxicology results



At least one substance present

Positive for Alcohol

The CFRP notes children who died by suicide were more likely to have a positive toxicological test for the presence of a substance. At least one substance was present in **43%** of suicides. Alcohol was present in **21%** of suicides. Highlighting the connection of suicide prevention and behavioral health services.

Recommendations for Suicides

Recommendation 1

Increase statewide suicide prevention strategies to educate school personnel, parents, caregivers, friends, and family members of children about the signs and symptoms of depression, the risk factors for suicide, and the factors that may protect children from suicide.

- **Increase education and training on evidence-based suicide prevention for law enforcement responding to youth delinquency.**
- **Increase gatekeeper training for professionals working with youth, specifically child welfare agencies, to help to identify children who may be at risk of suicide and how to respond effectively.**

Visit: Behavioral Health and Education | Health and Human Services North Dakota

Recommendation 2

Increase suicide prevention training for medical providers completing sports physicals and well child checks with closer examination into marked changes and responses provided by youth on the PHQ-4, asking follow-up questions and critical follow up and referrals. Include a suicide screen such as the Columbia Suicide Severity Rating Scale (C-SSRS) screening tool.

Recommendation 3

Increase awareness and access for parents/caregivers for resources, guides/checklists on how to talk with children about how they are feeling, suicide and safety and what to do and where to go when their children need support.

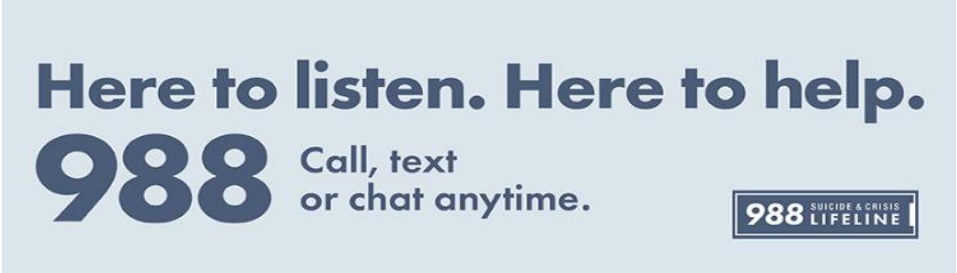
- **Include education and tips about passcodes to cellular phones and electronic devices and the importance of sharing passcodes with parent(s) or one trusted adult**
- **Include education and tips on how to support their child after a loss (i.e. breakup) or traumatic events**
- **Develop a statewide mental health directory to help identify mental health programs and services**
- **Provide access to mental health navigators to assist parents/caregivers in identifying resources and facilitate the connection for service delivery**

- **Partner Parents Lead with the ND Homeschool Association to provide resources, conversation guides and education to support the behavioral health of children that are homeschooled.**

Recommendation 4

Increase statewide awareness and promotion of the suicide and crisis lifeline, 988, call, text or chat for crisis intervention and suicide prevention.

- **Display information about 988 in all schools, sport centers, and medical offices that serve children, including ancillary providers**
- **Increase awareness about 988 amongst the Asian population**



Recommendation 5

Increase access to suicide prevention education and training statewide that includes all medical providers, including ancillary providers, child welfare, educators (including those home school educators), coaches, and students, specifically starting in elementary school as waiting until high school or even middle school is too late.

- **Statutorily mandate all public schools have a suicide prevention policy.**
- **Social emotional learning curriculums in all elementary and middle schools to increase resiliency, self-esteem and help seeking behaviors**
- **Access to mentoring (one trusted adult) and licensed therapists in all public schools at all education levels**
- **Mandate sexual extortion education for all middle and high school students**
- **Require schools to connect and follow up with all youth that have dropped out of school within 30 days to provide mentoring/case management to re-engage students and provide needed support and referrals.**
- **Alternative methods for responding to negative youth behaviors that do not result in removing positive social emotional connections**

Recommendation 6

Improve emergency department and in-patient hospital discharge practices following a suicide attempt or suicidal ideation crisis to include discharge plans with access to crisis services and follow-up case management for youth at high risk for suicide.

Recommendation 7

Decrease stigma for seeking mental health services or accessing help for a suicidal child by normalizing and increasing mental health seeking behaviors and educating the public that accessing help for suicidal ideation does not always lead to in-patient hospitalizations.

Recommendation 8

ND THRIVES
Rural & Tribal Youth Suicide Prevention

Increase access to remote mental health services (telehealth therapy/psychiatry/addiction support appointments, virtual support groups, peer support) to better serve those in rural communities.

- **Increased awareness and statewide access to 24/7 mobile crisis units for children experiencing suicidal/self-harm thoughts or behaviors.**

Visit: Lethal Means Safety in North Dakota | Health and Human Services North Dakota

ND HOPES

Recommendation 9

Increase schools participating in the Check & Connect, an evidence-based intervention that pairs students with a mentor who can provide support, help solve problems, build skills and enhance competence.

Recommendation 10

Reduce access to lethal means by children who are at acute risk of suicide (safe storage of medications, firearms, ammunition, and household products).

- **Education for all gun owners with an emphasis on suicide preventability through the utilization of safe gun storage, whereas firearms are always stored unloaded and locked with the ammunition stored and locked in a separate location and the keys or passcode are hidden and not accessible to children, and addresses the need for supervision, education and that caregivers are ensuring gun safety is part of every conversation about hunting and firearms, in addition, caregivers are teaching children about proper safe gun handling and storage.**
- **Address access to lethal means during safety planning for those youth in acute mental health crisis**
- **Provide access to medication lock boxes, trigger locks, gun safes and Naloxone, especially licensed facilities and homes.**
- **Increase public information about the process for reporting stolen firearms.**

CALM
COUNSELING ON ACCESS TO LETHAL MEANS

Recommendation 11

All children that die by suicide receive a comprehensive death investigation that includes an investigation of the scene, an autopsy and toxicological testing.

- **Increase use of the Suicide Critical Risk Assessment Profile (SCRAP) form by coroners/death investigators to enhance available information that will better inform future recommendations.**
- **Expand access of the SCRAP to law enforcement death investigators.**
- **Increase SCRAP education and training for death investigators that includes a process for sharing the SCRAP with the forensic pathologist completing the autopsy.**

Recommendation 12

Handle With Care

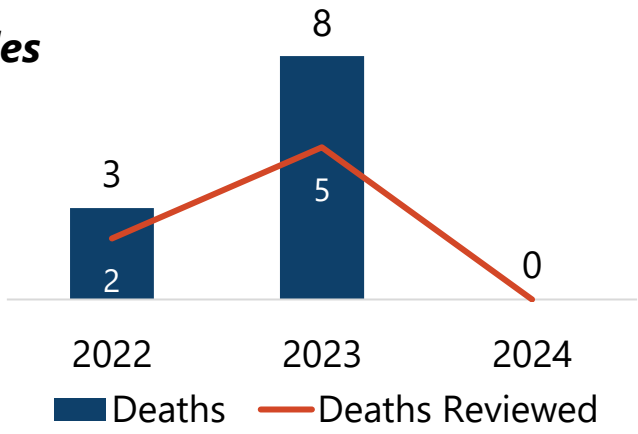
- **Increase the number of schools / law enforcement agencies participating in Handle With Care, allowing police to notify schools when they encounter a child at a traumatic scene so that school staff and mental health providers can wrap support for the student.**

Families Flourish ND

Section III: Homicide, ND 2022-2023

Basic Characteristics of Child Homicides

Sex



Race

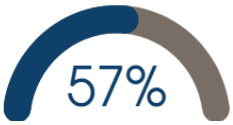
1.9 per 100,000 children were **White**

14.2 per 100,000 children were **Black**

Age

0-12 Months

5-9 Years

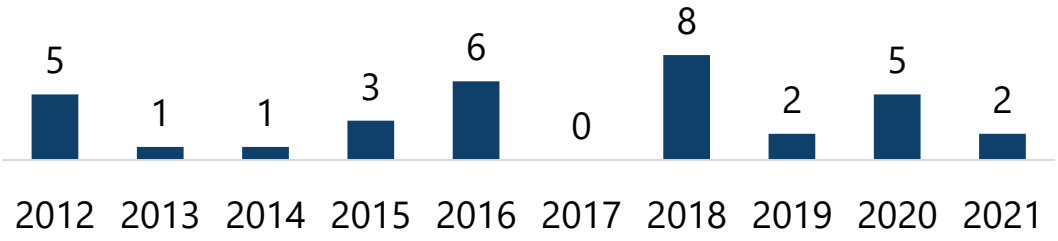


15-17 Years

Homicides occurred two times more often among Male children compared to Female children, and most homicides occurred amongst 15–17-year-olds. The largest percentage occurred among the White population, but the rate of Homicides among the Black population is **14.2/100,000** which is more than **7 times higher** than the White population.

As seen in the graph below, Homicides among children vary by year, with the highest number occurring in 2018.

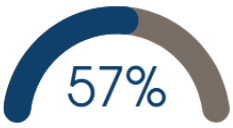
Historical Homicide Fatalities



Homicide Quick Facts

There were **11** children that died by Homicide in 2022-2023; **7** of these deaths had been reviewed by the Panel by the publishment of this annual report.

Firearms



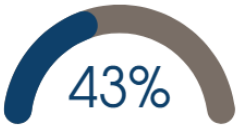
Of youth homicides from 2022-2023 were caused by Gunshot Wound

Firearms are the most frequent weapon reported

Of youth homicides from 2023 were committed with a firearm that had been stolen

Handguns are the most frequent firearm reported

Child Abuse



Of youth homicides from 2022-2023 were due to child physical abuse

Types of Abuse:

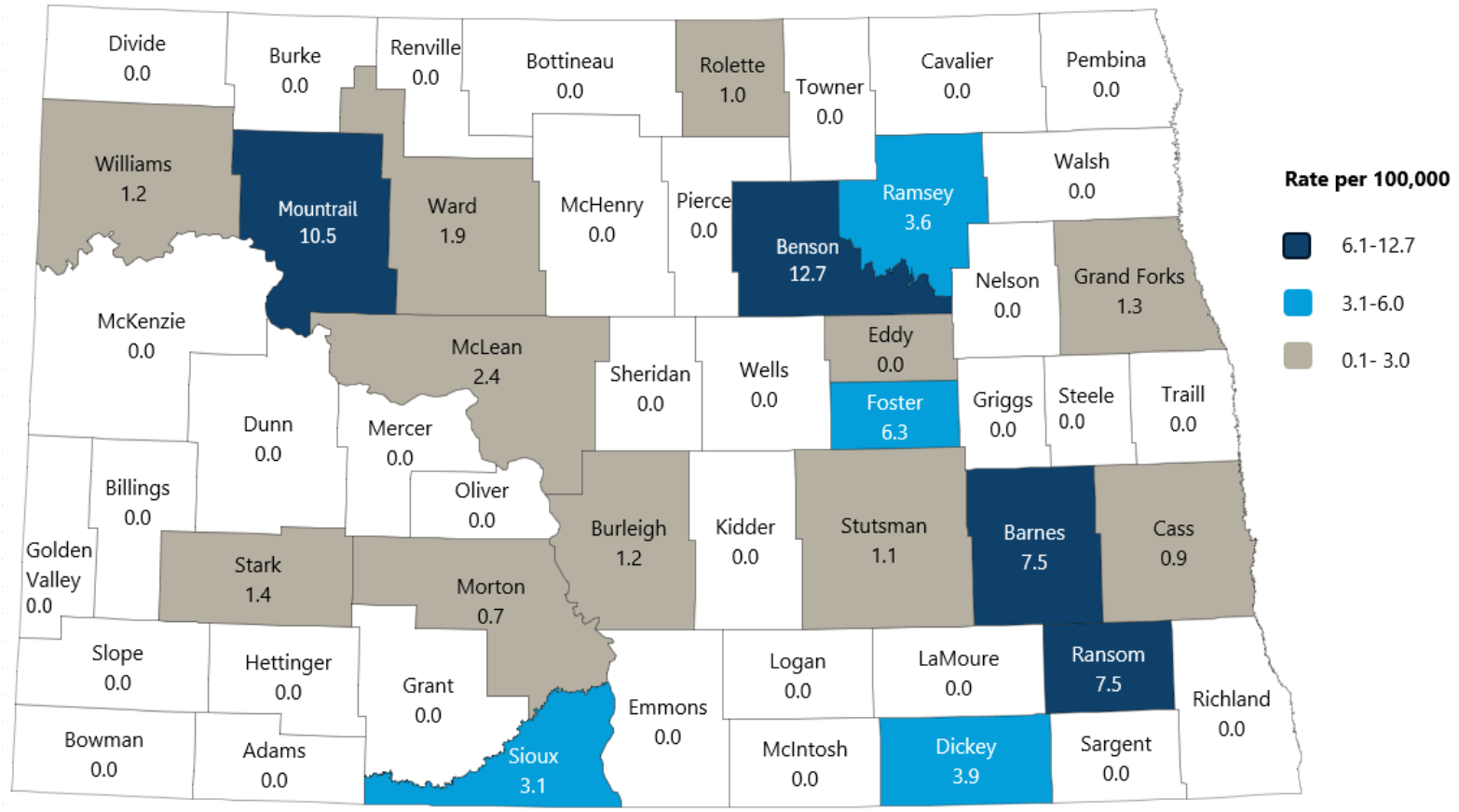
- Abusive Head Trauma
- Chronic Battered Child Syndrome
- Beating/Kicking
- Scalding or Burning
- Smothering

Events triggering child abuse:

- Crying
- Toilet Training
- Disobedience
- Feeding Problems

Location of Homicide Causing Incident

Homicides Heat Map 2003-2023



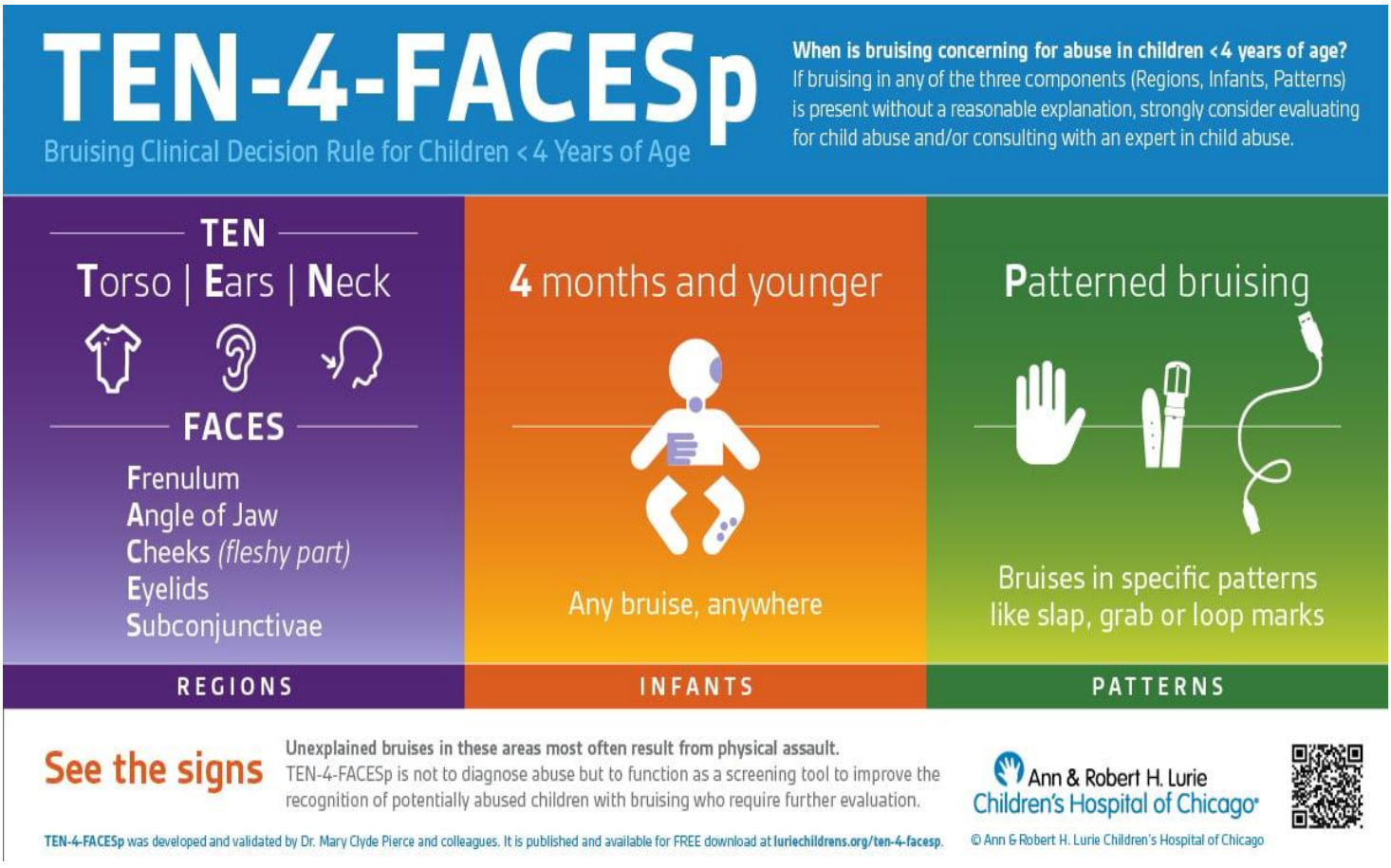
As seen in the map above, the rates of Homicide by county of death causing event ranges from **0/100,000** to **12.7/100,000 (Benson County)**. These numbers are based on the location of the death causing event, not on the county of residence of the child.

Location of Fatality 2022-2023

Recommendation 1

Provide medical professionals additional training opportunities about how to recognize child abuse and neglect, the process for protective custody (i.e. medical hold) and timely notification to child protection services when a child presents with trauma and where child abuse and neglect may be reasonably suspected.

- **Increase the number of medical professionals completing the DHHS web-based Mandated Reporter Training.**
- **Increase awareness by mandated reporters of child abuse and neglect, especially medical professionals of TEN-4-FACESp to help identify children under the age of four at risk of physical abuse.**



Recommendation 2

Increase public education about how to report suspected child abuse and neglect and how to access help for children and families to meet concrete needs and support for caregivers.

- **Increase promotion of the statewide phone number for reporting suspected child abuse and neglect (i.e. media campaign)**
- **Statewide community-based violence awareness for prevention and intervention (i.e. Green Dot)**
- **Increase statewide sexual abuse prevention training opportunities for the general community, with an emphasis on western ND**

Mandated Reporters
INTERACTIVE TRAINING

CHILD ABUSE AND NEGLECT REPORTING LINE 1-833-958-3500

Recommendation 3

Develop a follow-up/reconnect service for high schools to ensure adequate follow up with all youth that have dropped out of school within 30 days to provide mentoring/case management, to re-engage students, and provide needed support and referrals

Recommendation 4

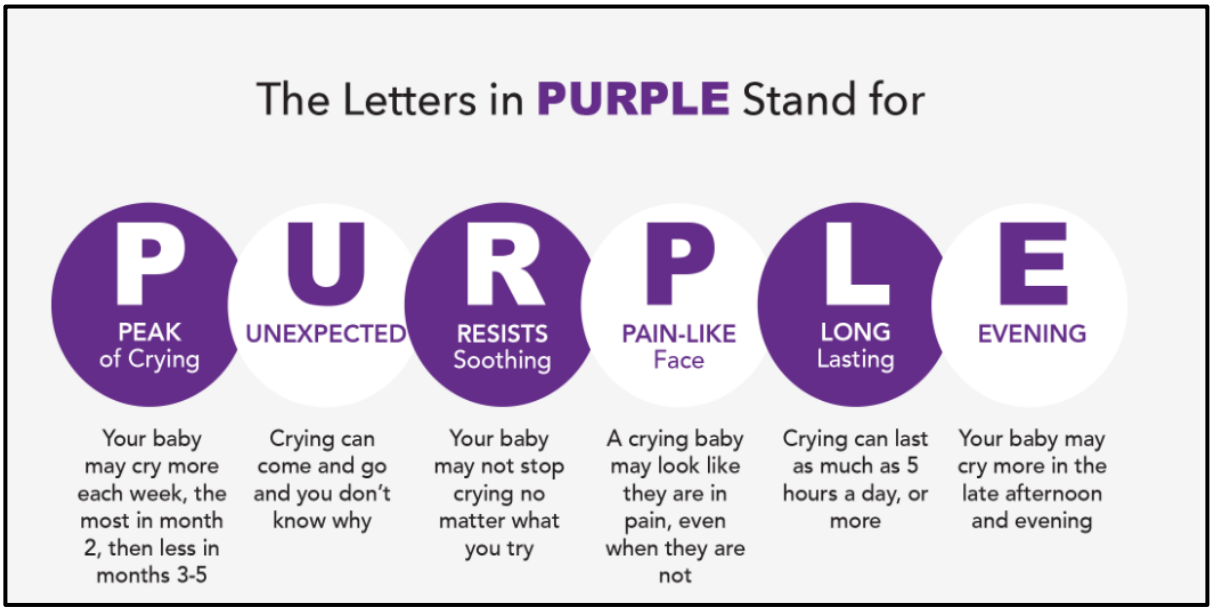
Increase statewide community awareness of the Baby Safe Haven program and the approved locations for releasing an unharmed infant.

Increase the number of those completing the DHHS Baby Safe Haven web-based training.

NORTH DAKOTA
Baby Safe Haven

Visit: Home | ND Baby Safe Haven Training | https;//babysafehaven.pcand.org

Recommendation 5



The abusive head trauma evidence-based prevention program, the Period of Purple Crying, shall be provided to all parents and caregivers of newborns through the birthing hospital, healthcare providers, home visitation programs, parenting resource centers, child welfare and private and public providers, with an emphasis on the inclusion of fathers.

- **Require the Period of Purple Crying for all licensed childcare and foster care providers.**
- **Increase statewide promotion of Never Shake a Baby**

Recommendation 6

Urban communities ensure the provision of events and activities (i.e. sporting/recreation) that provide youth free opportunities for healthy, structured activities while building connections and enhancing social emotional wellbeing. These activities must be provided during late-night hours (after 10pm) in order to be effective at reducing delinquency.

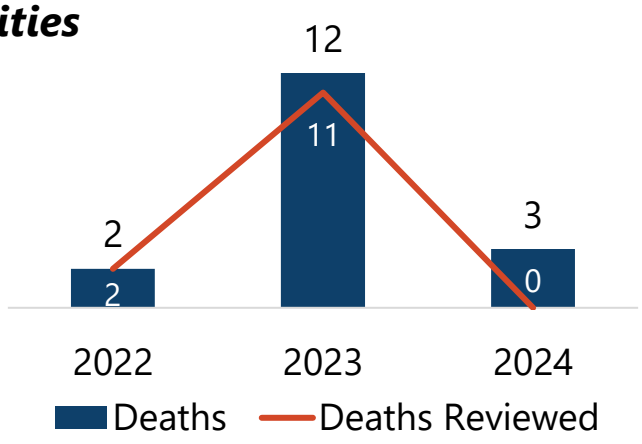
Recommendation 7

Statewide firearm theft prevention campaign providing gunowners with tips and education about securing their weapon to prevent theft and provide directions on what to do when a firearm has been stolen.

- **Increase promotion of 9pm Routine (i.e. Lock it or Lose It), a nightly reminder to lock vehicle doors and remove valuables so that firearms are not stolen.**
- **Develop and include tips, resources and education for parents/caregivers about how to communicate with their child on the topic of firearm safety and what to do when they witness unsafe storage or utilization of a firearm.**
- **Increase statewide promotion of anonymous tip lines for youth to report concerning behaviors (i.e., playing with guns, gang, drug activity)**
- **Community anonymous text lines to report suspicious activity; display public awareness for the tip lines in apartments by mailboxes.**

Section VIII: Firearm Deaths

Basic Characteristics of Firearm Fatalities



Sex

Male

Female

Race

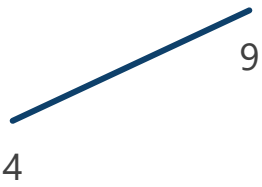
28.4 per 100,000 children were **Black**

7.4 per 100,000 children were **White**

8.5 per 100,000 children were **American Indian**

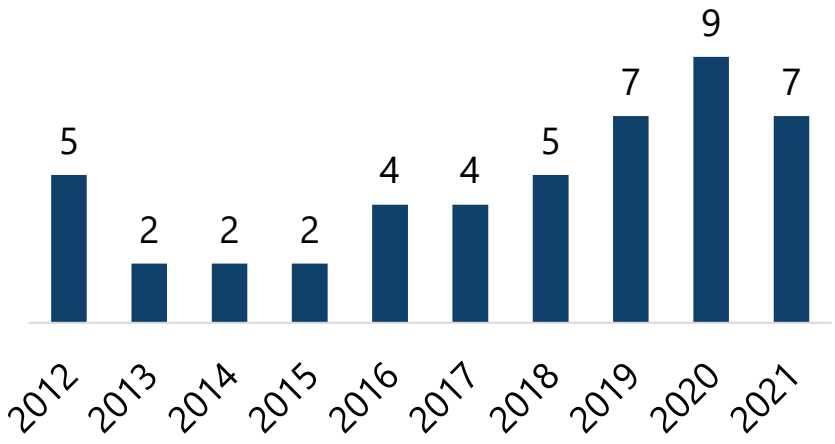
Black children were more than **3.5 times more likely** to be involved in a firearm fatality than White children.

Age



10-14 Years 15-17 Years

Historical Firearm Fatalities



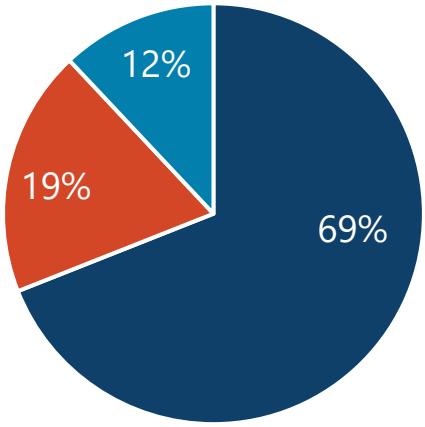
Firearm Fatality Circumstances

In 2022 the ND child fatality by firearm rate was more than 2 times the US rate (3.5 vs. 1.7 per 100,000)

Most common firearm type:

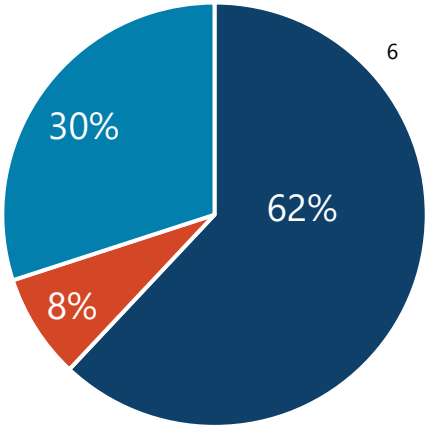
1. **Handgun**
2. Rifle
3. Shotgun

2020-2021



Suicide
Accident
Homicide

2022-2023



[6]

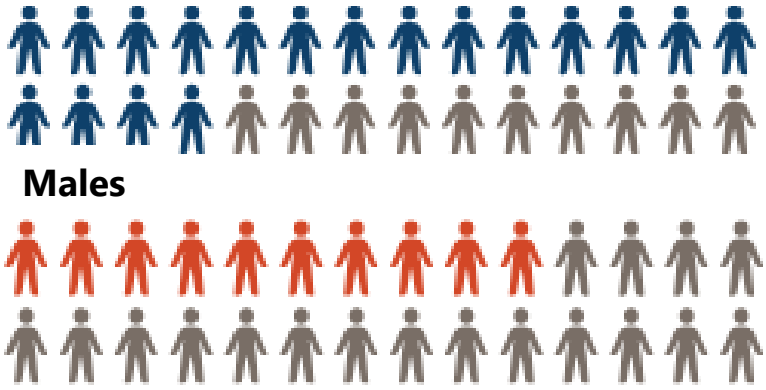
Of these firearm fatalities, only **31%** of the events had a firearm that was locked and unloaded following lethal means safety measures. A **caregiver** was the most frequently reported firearm owner at **38%** followed by **stranger** and **acquaintance**.

[6] Annual Gun Violence Data Report 2022

Section IV: Accident

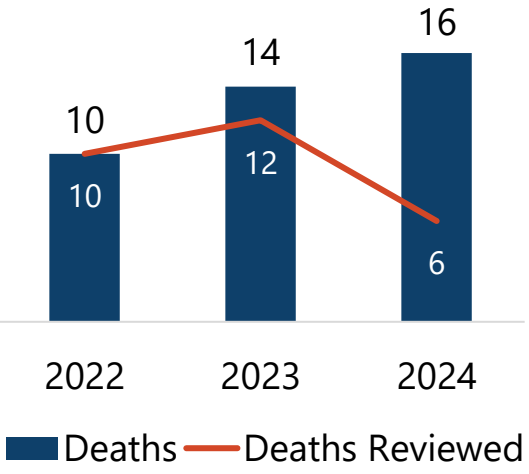
Basic Characteristics of Accidents

Sex



Males

Females



There were **28** Accident fatalities among children from **2022-2024,** that were reviewed by the CFRP and included in this annual report.

Race

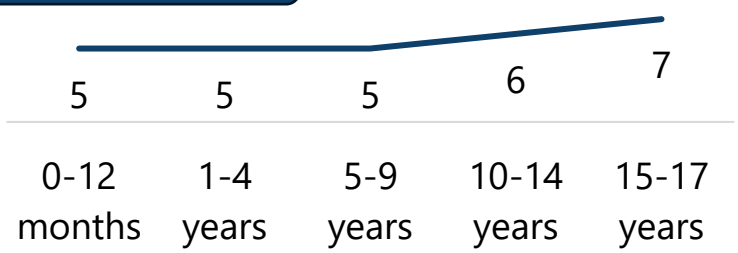
5.0 per 100,000 children were **White**

18.9 per 100,000 children were **Black**

5.6 per 100,000 children were **American Indian**

4.9 per 100,000 children were **Hispanic**

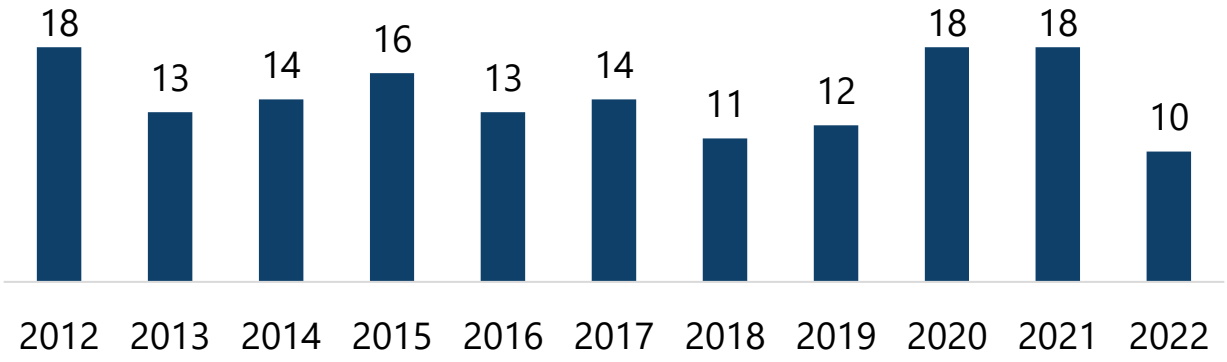
Age



Between 2022-2024, Accidents occurred most often among children aged 15-17 with the rate of Accidents highest (18.9 per 100,000) occurring among the Black population. Accidents occurred approximately 2 times more often among Male children.

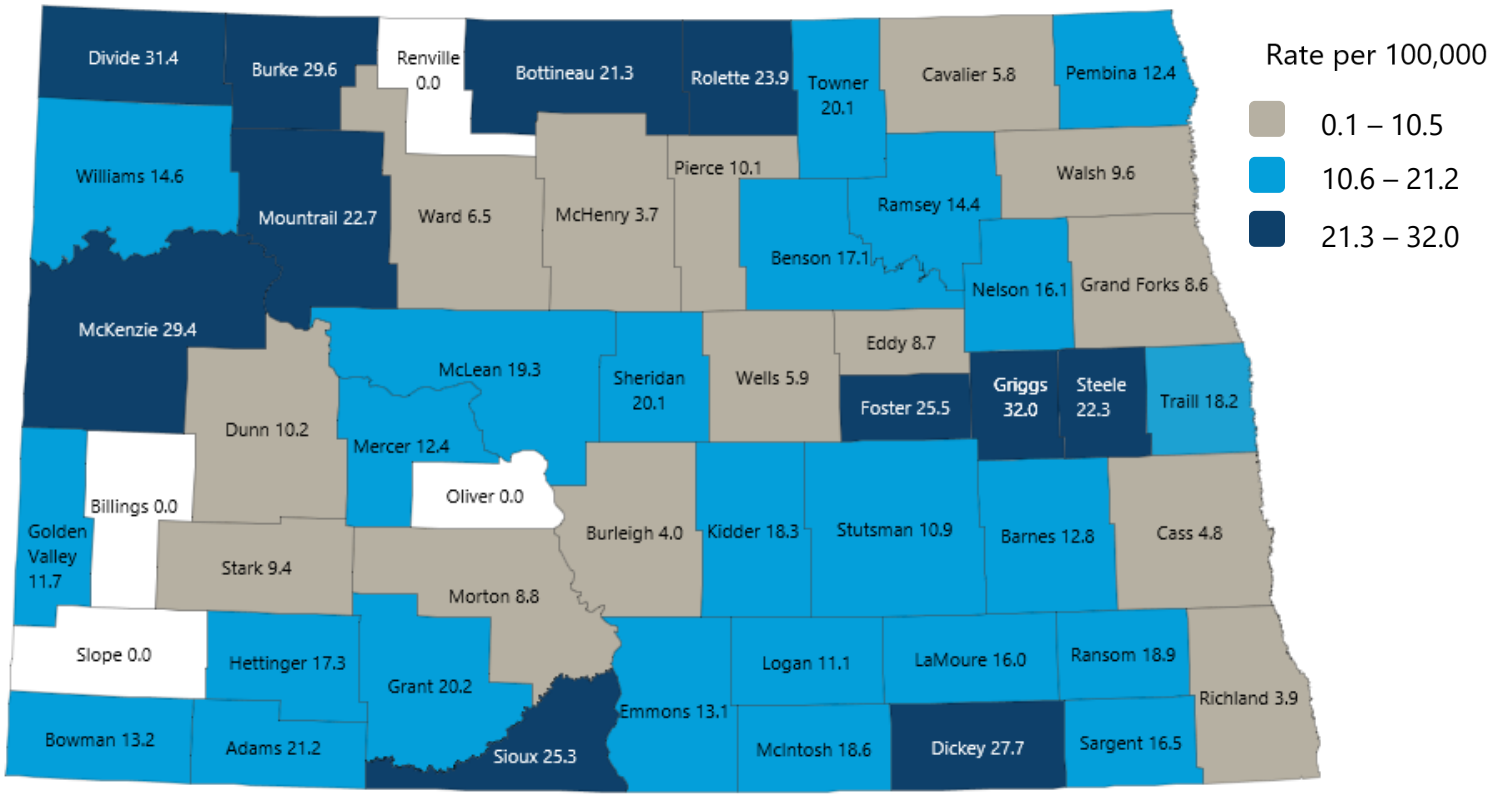
Historical Accident Fatalities

As seen in the graph below, years with the highest number of accidents were 2012, 2020 & 2021.

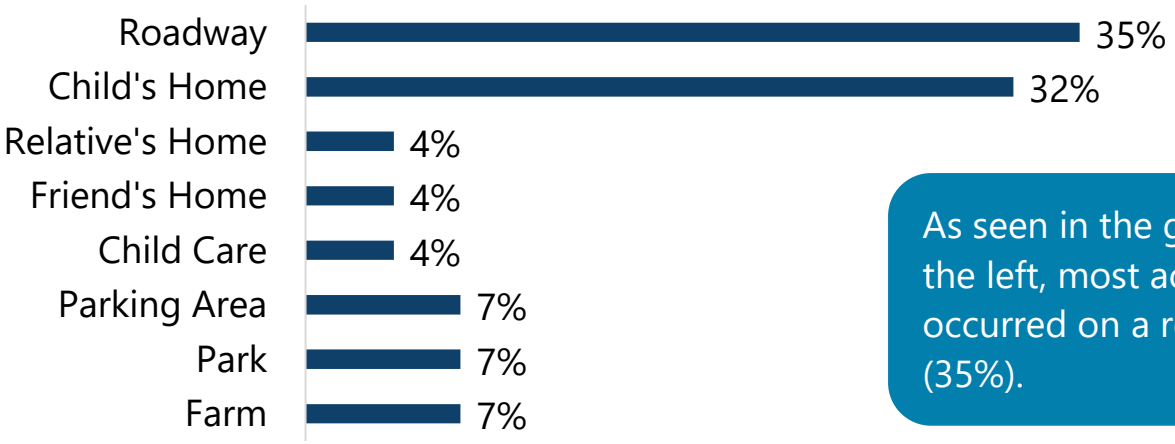


Accident Heat Map (2004-2024)

As seen in the map below, the rates of Accident fatality by county ranges from **0/100,000** to **32.0/100,000 (Griggs County)**. These numbers are based on the location of the Accident, not on the county of residence of the child or the location of death .



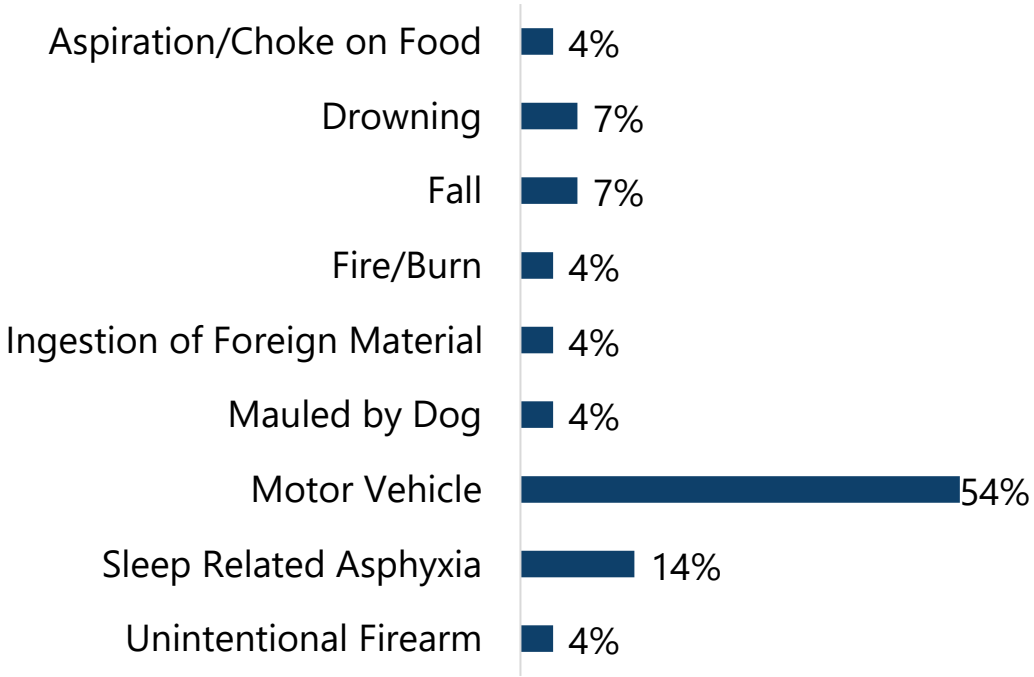
Location of Accident



As seen in the graph to the left, most accidents occurred on a roadway (35%).

Accident Fatality Causes

As seen in the graph to the right, most of the child deaths classified as Accident were caused by **motor vehicle accidents (54%)**, followed by **sleep related asphyxia (14%)**



Motor Vehicle Fatalities (2022-2024)

There were **15** motor vehicle fatalities reviewed by the CFRP and included in this annual report.

5 took place in 2022

100% included in this report

8 took place in 2023

88% included in this report

8 took place in 2024

38% included in this report

Sex

Males

Females

Race

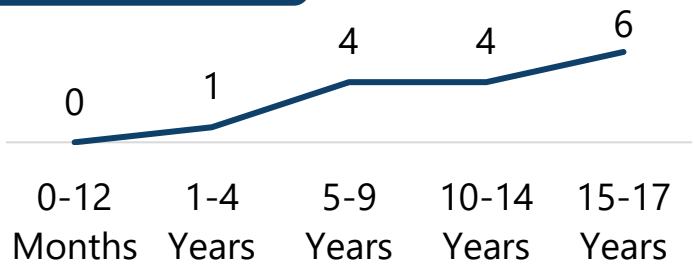
3.2 per 100,000 children were **White**

2.8 per 100,000 children were **American Indian**

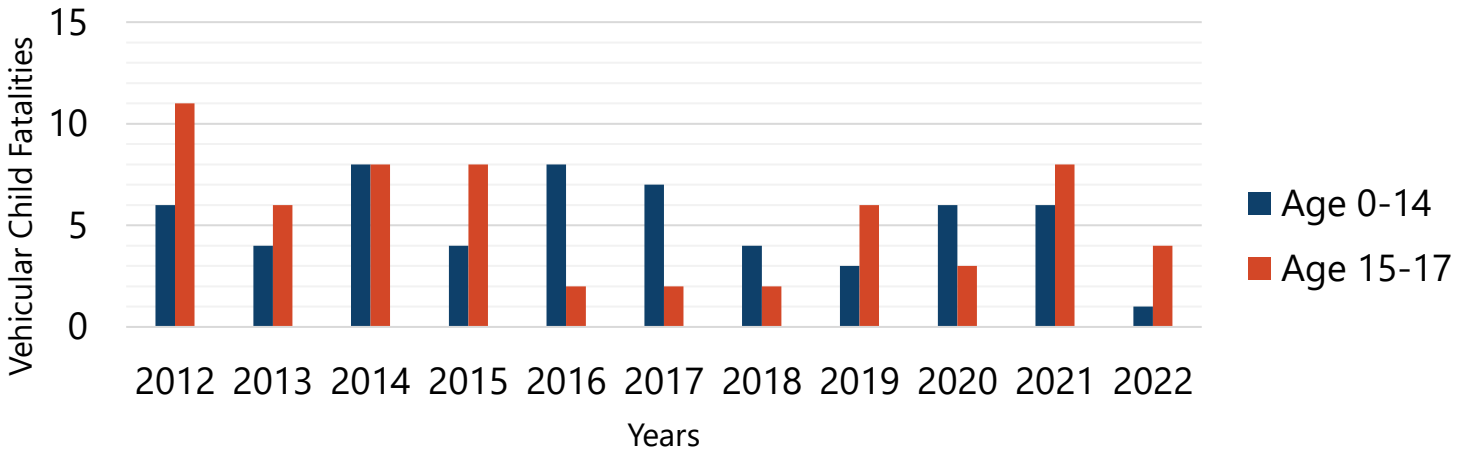
2.4 per 100,000 children were **Hispanic**

Between 2022-2024, most motor vehicle accidents occurred among Male (60%), children who were White (87%) between the age of 15-17 years (40%).

Age

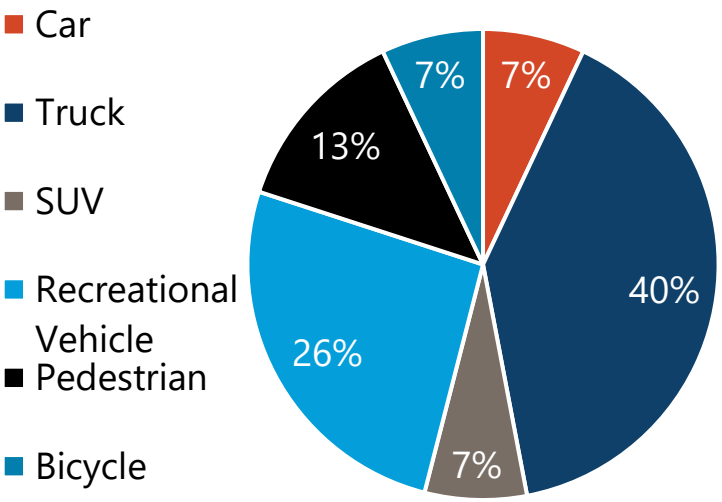


Historical Vehicular Child Fatalities



As seen in the graph above, between 2012-2024 children aged 0-14 made up more than half of the vehicular fatalities.

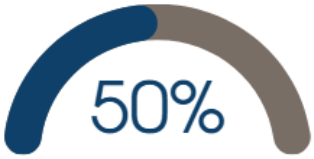
Type of Vehicle



The most common type of vehicle involved was a truck

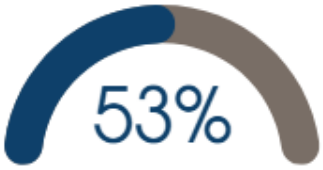
Seat Belt/Safety Restraint

Involved **motorized recreational vehicles** without seat belts



Involved the child being an **unrestrained front seat passenger** of a **truck**

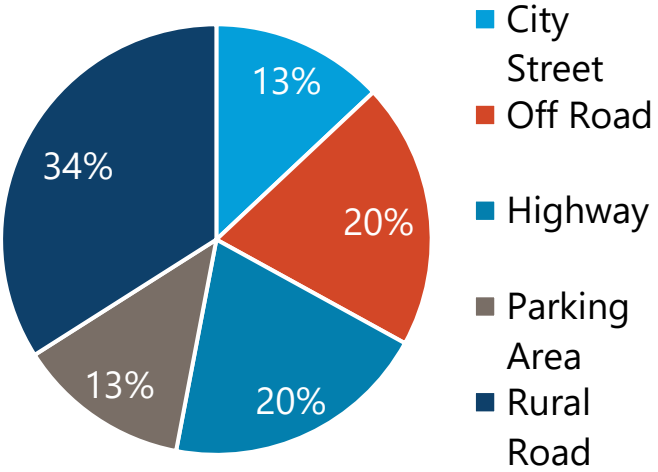
Of children were wearing a **seatbelt**



Involved **children inside a moving vehicle equipped with seatbelts**

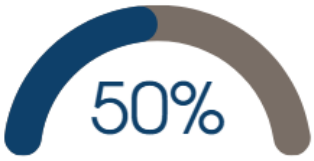
Involved **were infants or toddlers requiring a safety restraint**

Road Type



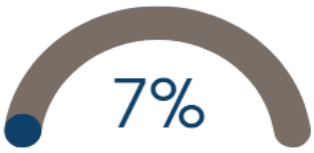
Motor vehicle fatalities occurred most often on rural roads where factors such as gravel, speed, and railroad crossings were factors.

Circumstances of Motor Vehicle Accident

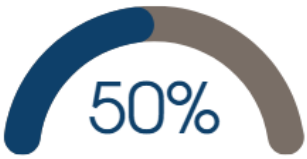


Of children were not the driver of the motor vehicle, the driver was **another youth**

Of children were **pedestrians** who were struck by a motor vehicle

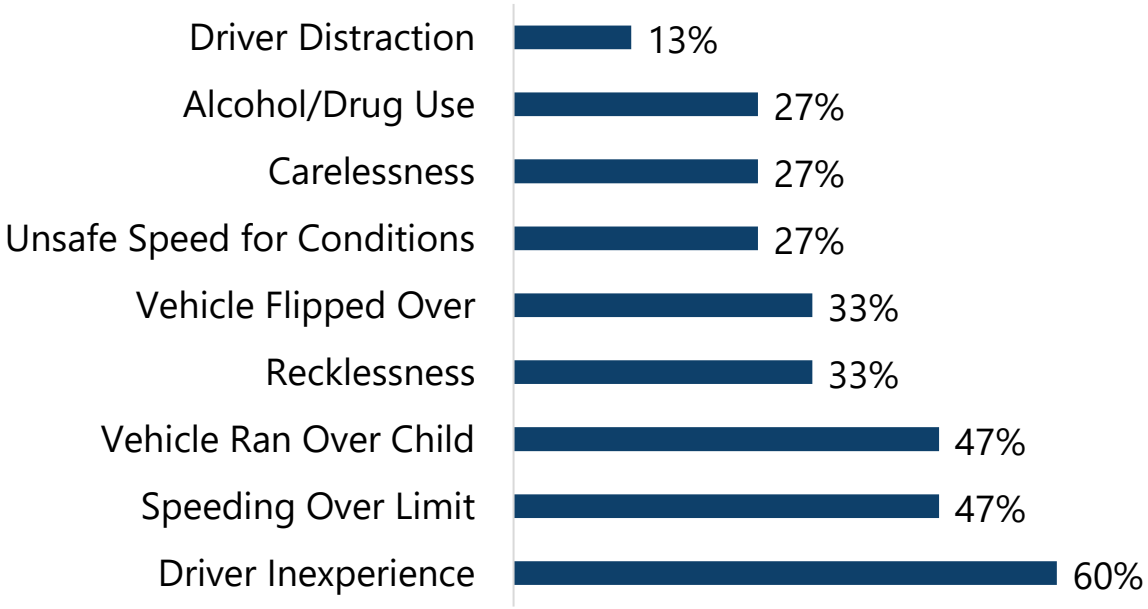


Of children were riding a **bike** when hit by a moving vehicle



Involved the youth as the **driver** and the person responsible for the accident

Contributing Factors



As seen in the graphs to the left and above, 60% of motor vehicle accidents involved an inexperienced driver. Most of the accidents occurred in a truck and on a rural road.

Recommendations for Accident Fatalities

Motor Vehicle Fatality Recommendations

Recommendation 1

Increased education and enforcement of the Primary Seat Belt law, *especially in rural areas*.

Recommendation 2

Address the societal issues of seat belts, distracted driving, and alcohol/drug usage of teens by continuing education and media campaigns that target not just new drivers but also those caregivers of new drivers that act as role models for appropriate driving behavior.

Recommendation 3

Increase resources and tools for parents and grandparents to engage youth in conversations about driving while under the influence, distracted driving and what to do when they are in a vehicle and the driver is under the influence.

Recommendation 4

Increase young driver education and promotion of safe driving practices including the dangers of activities that take attention away from drivers, such as operating a cell phone, texting, eating, turning the radio, or talking with passenger and the dangers of alcohol and drug usage by those operating a motor vehicle, with specific attention to community-wide education about never drinking and driving and never driving while impaired by other drugs or substances; specifically increase the number of schools participating in *Impact Teen Drivers*.

Visit: ImpactTeenDrivers.org/NorthDakota

Recommendation 5

ALIVE AT 25 DEFENSIVE DRIVING COURSE

Statewide promotion and increased access to *Alive at 25*, a defensive driving course targeted at drivers under the age of 25. *Specifically increase access to young drivers in western ND.*

Visit: Alive at 25 - ND Safety Council

NDSC
NORTH DAKOTA SAFETY COUNCIL
A private non-profit.

Recommendation 6

Increased young drivers' education about the dangers of railroad crossings and never try to outrun a train.

Recommendation 7

Increased young drivers' education about the risks of gravel roads, and speed limits of gravel roads.

Recommendation 8

Utilize / increase sobriety checkpoints on tribal lands.

Recommendation 9

Continue to promote child safety seat inspection programs and free or low-cost car seat distribution. Increase frequency and access of these programs in areas on and near tribal lands.

Visit: North Dakota Car Seat Distribution Locations | Health and Human Services North Dakota

Recommendation 10

Educate the public about safety in and around vehicles with an emphasis on performing a walk-around the vehicle before placing it in reverse.

Recommendation 11

Increase public education about the dangers of children riding on or operating recreational vehicles including snowmobiles, All-Terrain Vehicles (ATVs), Utility Terrain Vehicles (UTVs), and dirt bikes. Safety messaging includes direct supervision at all times and riders always wear appropriate safety gear including a helmet, long sleeves, pants, gloves, and belt and utilizing a seat belt.

Recommendation 12

Promotion and enforcement of the state law which requires youth ages 12-16 years complete the state *OHV Safety Course* before operating an ATV on public land and riding an ATV that is safe for the child's age, ride only on designated areas and at safe speeds and *no child under the age of 12 years operate an ATV/OHV*.

Register for OHV Safety Courses

Visit: OHV Safety | ND Parks and Recreation - Business and Grants

Recommendation 13

Public education for ATV/UTV owners about the importance of powering off the off-highway vehicle when not in use so that it cannot be engaged by a child.

Recommendation 14

NDSU NORTH DAKOTA STATE UNIVERSITY

Visit: Youth Farm Safety | NDSU Agriculture

Children should not operate large farm equipment without a driver's license and/or training from the *NDSU Farm Safety Camp*.

Recommendation 15

Motor vehicle related fatality investigators should obtain cellular phone records to determine if the driver was utilizing the device while operating the vehicle, as well as toxicological testing of all drivers.

Recommendation 16

Create safe environments for children to ride their bikes in areas where there are many children and few recreational opportunities so that parking lots do not become playgrounds.

Recommendation 17

Increase public education and awareness (English, Spanish and pictures only) that parking lots are not playgrounds for children, especially when there is large machinery operating in the area.

Recommendation 18

Engage the refugee resettlement office on the matter of safe environments for child play.

Recommendation 19

Increase youth utilization of appropriate protective equipment while engaging in sports with jumps (e.g., wearing a helmet while skateboarding, biking or snowboarding).

Recommendation 20

Increase access (subsidies or giveaway) for youth bicycle helmets, specifically in Cass, McKenzie, and Williams counties.

Drowning Fatality Recommendations

Recommendation 1

Infants and young children must be supervised (eyes on) at all times when they are near water and within an arm's reach. Prepare all bathing materials prior to placing the child in the water. If you have to leave the bathroom do not leave without first removing the infant from the water. Safe bathing education is needed for parents of young children in the form of social media advertisements and the health information education network at local public health agencies.

Recommendation 2

Increased education for caregivers and youth about never swimming alone and choosing safe places to swim.

Recommendation 3

Increase access to quality life jackets for youth and education to parents about selecting a proper fitting life jacket based upon the child's weight that fits snug against the body and will not come off in the water.

Save Lives In Your Community

Life Jacket Loaner Stations

Visit: https://ndpa.org/lifejacketloanerstations/

Fire Fatality Recommendations

Recommendation 1

Provide public education about lithium-ion battery safety and fire prevention. *Charge into Fire Safety; Lithium- Ion Batteries in Your Home.* Buy products that meet safety standards. Charge devices safely, always use the cords that came with the product to charge. Charge on a hard surface, never a bed. Don't overcharge, unplug the device when it has reached a full charge. Never throw lithium-ion batteries in the garbage because they could start a fire.

Charge into Fire Safety: 3 Steps

Buy only listed products. When buying a product that uses a lithium-ion battery look for a safety certification mark such as UL, ETL, or CSA. This means it meets important safety standards.

Charge devices safely. Always use the cords that came with the product to charge. Follow the instructions from the manufacturer. Buy new chargers from the manufacturer or one that the manufacturer has approved. Charge your device on a hard surface. Don't overcharge your device. Unplug it or remove the battery when it's fully charged.

Recycle batteries responsibly. Don't throw lithium-ion batteries in the trash or regular recycling bins because they could start a fire. Recycle your device or battery at a safe battery recycling location. Visit call2recycle.org to find a recycling spot near you.

Recommendation 2

Increase smoke alarm and carbon monoxide alarm give-away programs that serve low-income families.

TAKE CHARGE OF BATTERY SAFETY

Recommendation 3

Keep smoking materials (lighters, matches, burners) locked away from children and teach children (especially preschoolers) to stay away the items, the dangers of fires and what to do if there is a fire.

Recommendation 4

Fire safety prevention for preschool aged children (Head Start, Preschool, Child Care) that includes practicing fire escapes and two ways of exit.

Recommendation 1

Increase public education on age-appropriate foods and sizes for safe ingestion, specifically providing an image depicting the actual size of a toddler's windpipe and foods to avoid (i.e. popcorn, whole grapes, chunks of cheese, hot dogs) and the importance of supervising mealtimes for infants and young children.

NDSU | EXTENSION

Choking Prevention Tips

- For infants to age 1, cut up foods into small pieces no larger than ¼-inch. Toddlers generally can eat foods cut in ½-inch pieces or slightly larger.
- Watch infants and young children when they are eating. Eating while walking, running or laughing may lead to a choking incident.
- Parental supervision during mealtime is essential. Remind children to chew food thoroughly, take small bites and eat slowly. Siblings should not be put in charge of feedings.
- Keep dangerous toys, foods and household items out of children's reach.
- Learn how to provide emergency first aid for choking infants and children. The American Heart Association and American Red Cross provide courses on basic life support and CPR.

Recommendation 2

Display warning labels on popcorn sold at athletic, community and school events that states consumption not for children under age four.

Recommendation 3

Increase access to CPR and Heimlich Maneuver education and training for parents of young children.

Recommendation 4

Provide education to parents and caregivers of young children, including licensed childcare and foster care providers about the dangers of ingesting Kinetic Sand. Provide direct supervision of young children when they are playing with Kinetic Sand. Educate children and ensure they understand they should not eat Kinetic Sand. Keep Kinetic Sand stored out of reach of children when not in use.

Other Accident Fatality Recommendations

Recommendation 1

School and community safety education provided to preschool and elementary age children should include information about stray animal safety. This education is especially important in areas where there is a higher population of stray and vicious dogs.

Recommendation 2

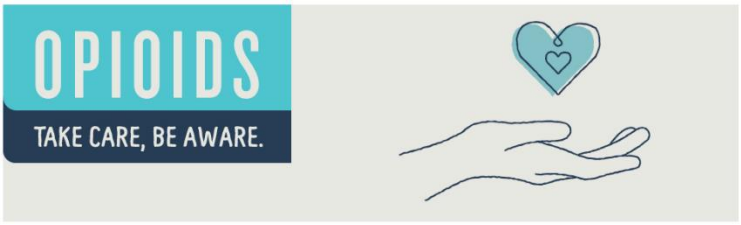
Increase stray dog control and the frequency of mobile neutering clinics on tribal lands.

Recommendation 3

Strengthen public awareness of the Good Samaritan Law and where to access Naloxone and Fentanyl testing strips.

To request free Narcan (naloxone) kits, please click the button below or call a behavioral health team member at 701-328-8920.

Request Narcan (naloxone)



Recommendation 4

Increase community education on the proper storage and disposal of medications, the importance of keeping medicine, drugs and paraphernalia, chemicals, cleaning products and batteries locked and out of young children's reach.

Recommendation 5

Increase public education about how and when to contact Poison Control.

Poison Help Number
1-800-222-1222

Recommendation 6

Pilot a medication lock bag program in Fargo. Engage and train public health agencies and pediatricians in medication and controlled substance safety counseling and provide medication lock bags for distribution to caregivers of children during routine healthcare visits.

Recommendation 7

Landlords of properties that are three stories or more with windows less than three feet from the ground shall install window guards to prevent falls.

Recommendation 8

Public education for parents and caregivers of children about fall prevention must include images that depict windows closed, windows with guards and that children should not play near open windows or patio doors.

Recommendation 9

Increase the number of clinicians performing firearm safety screening to caregivers of children for the presence of a firearm in the home or vehicle, educating them about proper storage and firearm safety and providing access to gun locks/safes for clinician distribution to families.

Recommendation 10

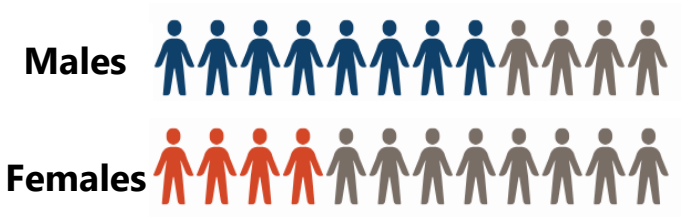
Statewide firearm theft prevention campaign providing gunowners with tips and education about securing their weapon to prevent theft and provide directions on what to do when a firearm has been stolen.

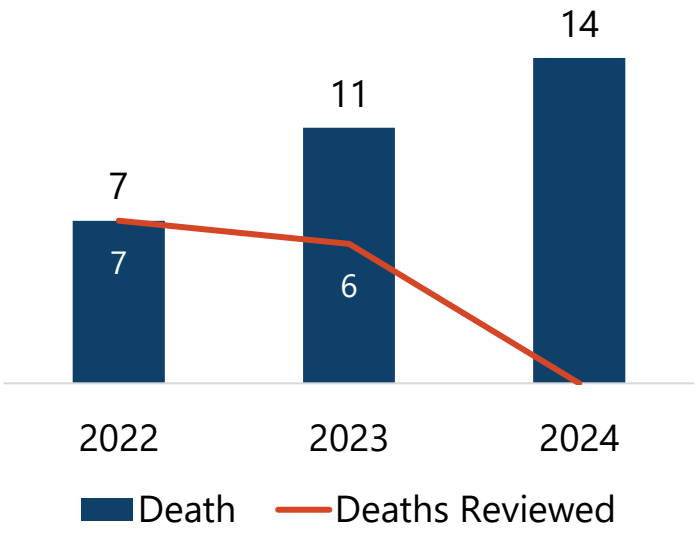
Section V: Natural

Basic Characteristics of Natural Fatalities

The CFRP reviewed **13** fatalities among children from 2022-2023 where the manner of death was Natural

Sex





Race

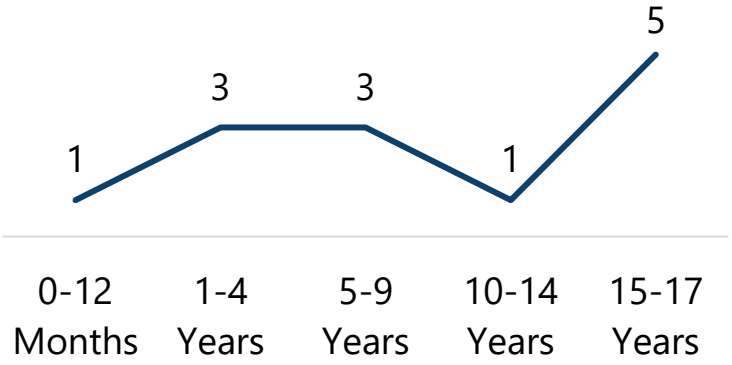
7.1 per 100,000 children were **White**

3.7 per 100,000 children were **Hispanic**

12.7 per 100,000 children were **American Indian**

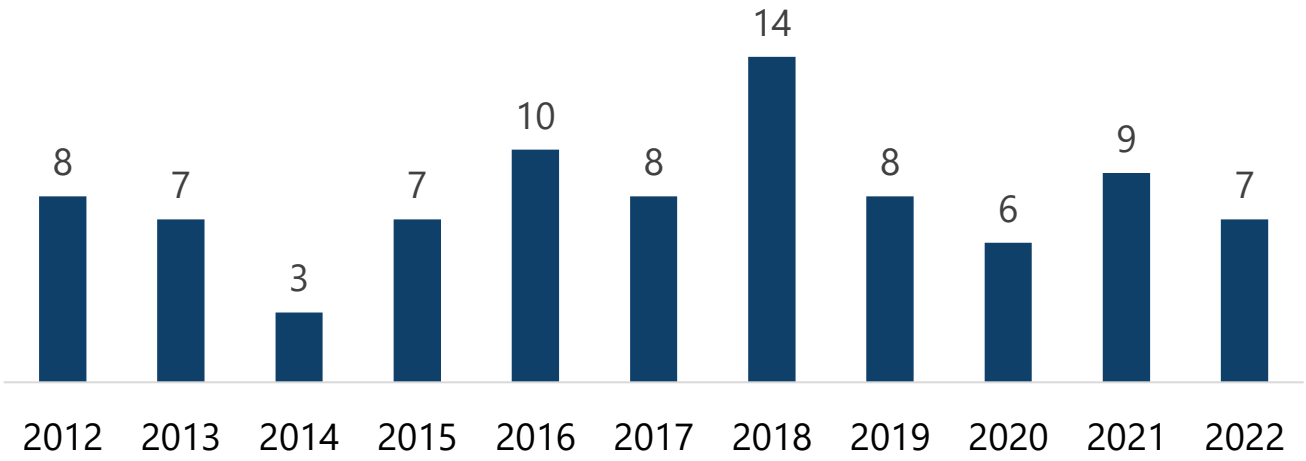
Between 2022 and 2023, Males made up more than half (66%) of the Natural fatalities. The rate of Natural deaths was highest among American Indians (12.7 per 100,000).

Age



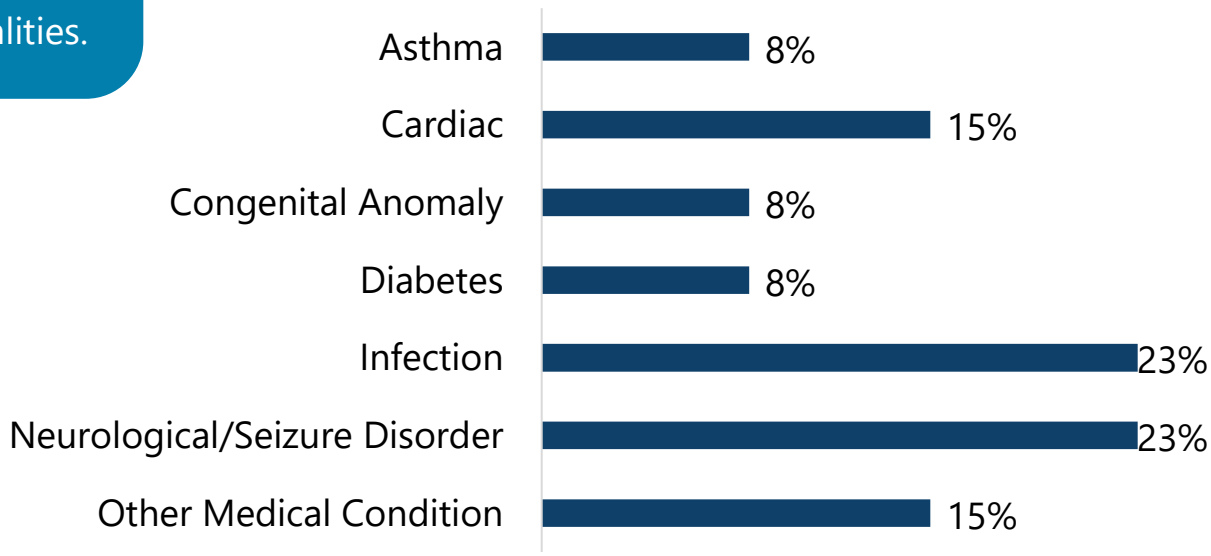
Natural deaths comprised approximately **15%** of the child death reviews. Years with the highest number of natural deaths were 2016 and 2018

Historical Fatalities



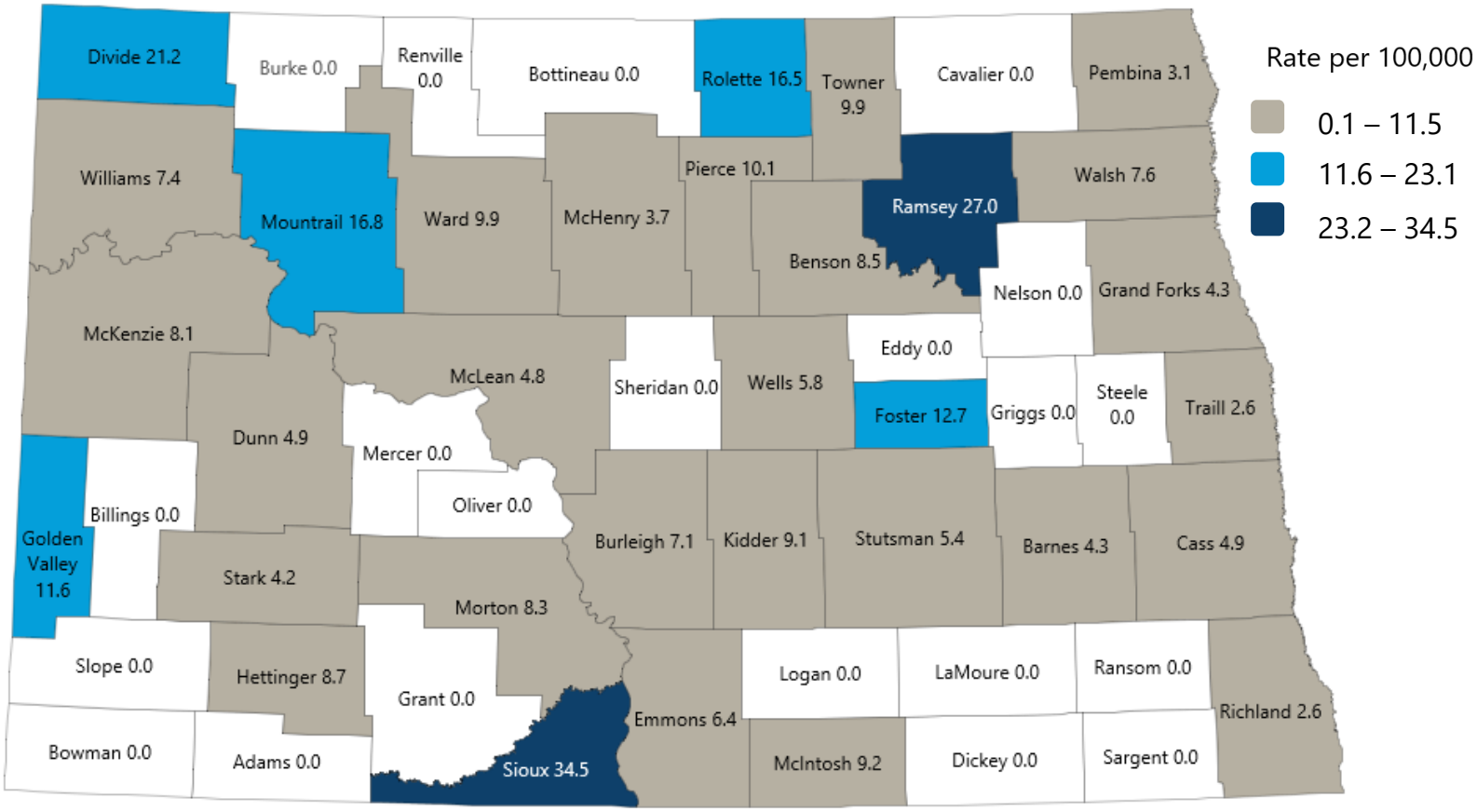
As seen in the graphs to the right, Infection and Neurological/Seizure Disorder made up most of the Natural fatalities.

Causes of Natural Fatality



Location of Incident by County

Natural Fatality Heat Map (2003 – 2023)



As seen in the map above, the rates of Natural death of children per county range from **0/100,000** to **34.5/100,000 (Sioux County)**. These numbers are based on the location of the fatality, not on the county of residence of the child.

Recommendations for Natural Fatalities

Recommendation 1

1-800-545-8256 Home Health Hotline

Statewide access to home health nursing services for all families with a child under the age of one year, all children with insulin dependent diabetes and all children with asthma so that these identified vulnerable populations receive access to timely health assessment, treatment, referrals, and services, especially those in rural and tribal communities.

Recommendation 2

Provide parents, caregivers and elementary educators with information about diabetes warning signs and symptoms in children. Ensure this information is also provided in Spanish.

Recommendation 3

Public health agencies and pediatricians increase education for parents of toddlers about febrile seizures, what to do when your child has a fever, and the importance of close supervision of children with a fever especially during the night hours.

NORTH DAKOTA
FULL-SERVICE COMMUNITY SCHOOLS CONSORTIUM

HOW TO DO IT

Schools interested in learning more about Check & Connect, including the program's history, national outcomes, and funding opportunities, are encouraged to visit checkandconnect.umn.edu. To bring Check & Connect to your school, please reach out to Anne Williamson directly:

Anne Williamson, Community Coordinator
Central Regional Education Association
Anne.Williamson@k12.nd.us, 701-340-5026

Recommendation 4

All children with a new asthma diagnosis develop an asthma action plan with their medical provider that includes parent/caregiver education that asthma is a serious medical condition that could be fatal and must be monitored and routinely assessed.

Recommendation 5

Home health nursing be offered families to assess and educate for environmental triggers and review asthma action plans, medications and supplies following (within 60 days) of a child's hospitalization for asthma exacerbation.

Recommendation 6

Increase education for parents that children of all ages should receive an annual well child physical examination from a medical provider and provide a directory of where to access a well child check at reduced or free cost for families new to the area and those without medical insurance.

Recommendation 7

Statewide access to residential substance abuse treatment services for pregnant women and mothers with children.

Recommendation 8

Increase access and awareness of free prenatal care, specifically targeting those pregnant women that are homeless and/or abusing controlled substances.

Services Available to You

For a list of prenatal, pregnancy, postpartum, and parenting services, resources and contact information, visit life.nd.gov.

24 Hour Support

Dial 2-1-1 or 701-235-SEEK (7335) if you are wondering about local community resources (food, housing and shelter, utility assistance, transportation, etc.) or if you would like listening and support.

988 Suicide and Crisis

If you are experiencing a suicidal, substance use, and/or mental health crisis - or any other kind of emotional distress - or know someone that is, call or text 988 anytime, day or night. Or chat at 988lifeline.org/chat.

Recommendation 9

All newborns prenatally exposed to controlled substances are monitored for no less than 48 hours prior to hospital discharge.

Recommendation 10

Increase communitywide education on the signs, symptoms and seriousness of eating disorders, how to talk to youth about eating disorders and where to access services and support.

PARENTS LEAD.ORG

Visit: https://www.parentslead.org/

Section VI: Undetermined

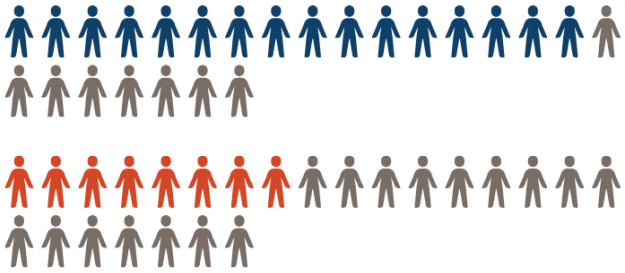
Basic Characteristics of Undetermined Fatalities

There were **24** undetermined fatalities among children from 2022-2023, that were reviewed by the CFRP and included in this annual report.

Sex

Male

Female



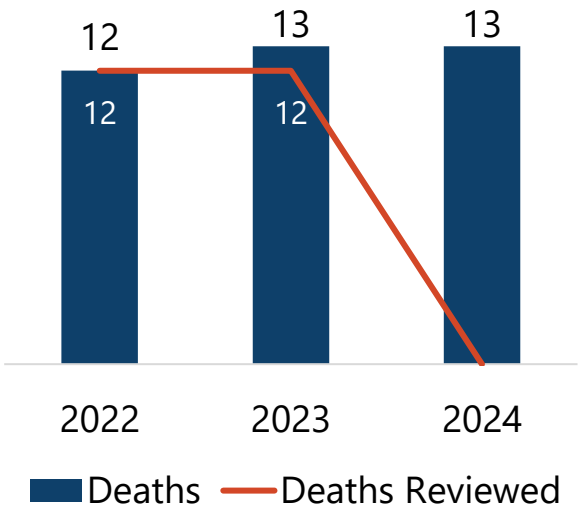
Race

5.2 per 100,000 children were **White**

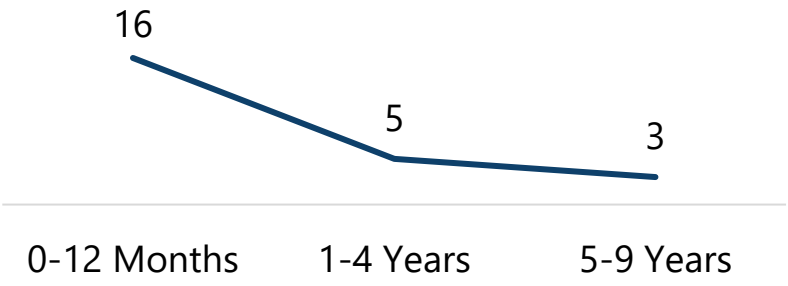
14.2 per 100,000 children were **Black**

21.1 per 100,000 children were **American Indian**

11.0 per 100,000 children were **Hispanic**



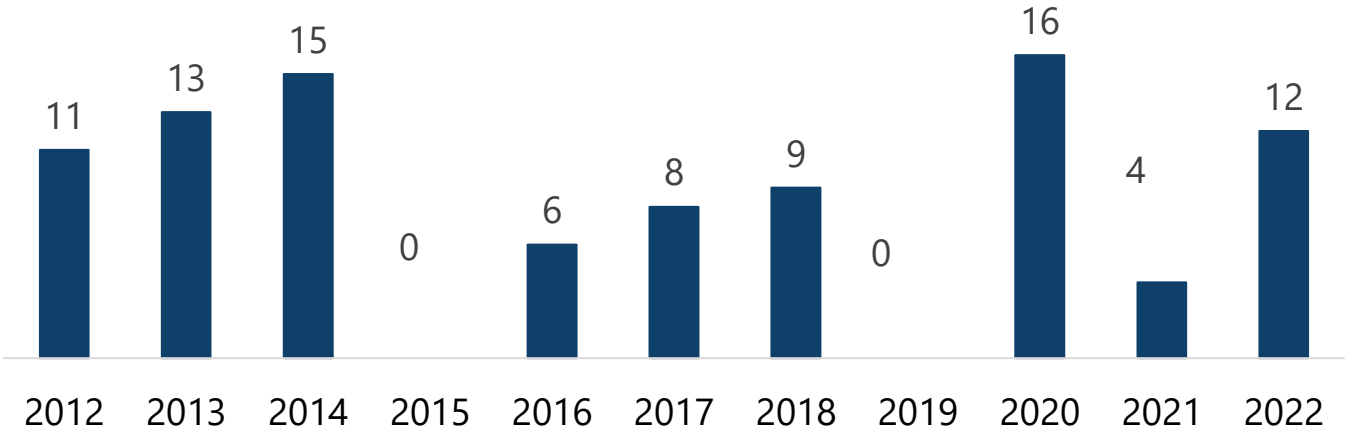
Age

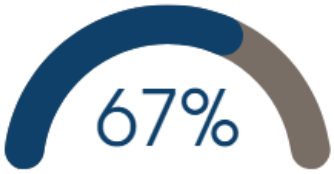


The rate of Undetermined fatalities among American Indian children is **21.1/100,000** which is **4 times higher** than the White population.

Undetermined deaths comprised approximately **20%** of the child death reviews between 2022-2023. Years with the highest number of Undetermined deaths were 2014 and 2020

Historical Undetermined Fatalities





Of the Undetermined deaths were **infants** with a cause of death of Sudden Unexplained Infant Death with Intrinsic and/or Extrinsic Factors identified

Were **age 1 year** when they died suddenly and unexpectedly in their **sleep** (Cause: Sudden Unexplained Death in Childhood)

Recommendations for Undetermined Fatalities

Recommendation 1

1-800-545-8256 Home Health Hotline

Increase access to home health care services for medically complex children in the northwestern part of the state.

Recommendation 2

Hospitals continue to use peer reviews as a means to examine trauma processes and protocols in regard to child injuries and death.

Recommendation 3

Mandatory cross reporting/notification of child deaths between medical (ER), law enforcement, coroners/Medical Examiners, and child protection services. All child death investigations shall include a review of the child protection services history.

Recommendation 4

Provide training for child welfare on the topic of medically complex children that includes a process for consultation with a child maltreatment specialist to perform medical record reviews and chart extractions and family centered engagement meetings to develop plans for managing the child's cares and services.

Recommendation 5

Provide education and training to coroners about their mandate and the process for reporting suspected child abuse and neglect. Increase the number of coroners completing the DHHS web-based training for reporting suspected child abuse and neglect.

Recommendation 6

Increase fatal injury prevention by providing parents and caregivers of infants and toddlers resources, checklists and guidelines about keeping toddlers safe at home. This information should include never allowing toddlers in the kitchen or bathroom without an adult present, utilization of safety gates, ensuring infants and toddlers don't have access to suffocation hazards (i.e. cords, plastic bags, balloons, marbles, Legos) and adequate supervision at all times.

Visit: A_Parents_Guide_to_Home_Safety.pdf

Recommendation 7

Increase statewide promotion and access to immunizations and well child clinics.

Recommendation 8

Complete and thorough death scene investigations that include a death scene investigation, scene photographs, collection of evidence, a recorded doll re-enactment with those providing care (placing, last known alive, and finding), a photograph of every layer of the sleep environment, individual and witness interviews, completion of a Sudden Unexpected Infant Death Investigation Reporting Form (SUIDIRF) / or Suicide Critical Risk Assessment Profile (SCRAP) and a review of the medical and Child Protection Services history.

Section VII: Sleep-Related Infant Deaths

Sleep-Related Infant Death is defined as the sudden, unexpected death of an infant that occurs during an observed or unobserved sleep period, or in a sleep environment.

The National Association of Medical Examiners made a recommendation in 2019 that death certifiers discontinue the use of the term "Sudden Infant Death Syndrome" (SIDS) and use the term "unexplained sudden death" specifying whether intrinsic and extrinsic factors were identified as contributing factors of the death; the manner of these situations is then classified as Undetermined.

Per the recommendations of the National Association of Medical Examiners, the term **Sudden Infant Death Syndrome (SIDS)** is no longer used to certify child deaths in North Dakota. In 2022 there was a statutory change removing the terminology of Sudden Infant Death Syndrome as a cause of death and replacing it with **Unexplained Sudden Death in Infant or Child with or without Intrinsic or Extrinsic factors, or both**.

Intrinsic Factors are defined as those natural conditions or risk factors associated with abnormal physiology or anatomy that are concerning as contributors to death but are insufficient as a cause (for example, low birth weight, prematurity, small for gestational size, concurrent non-lethal illness, history of febrile seizures). These can also include natural conditions of unknown significance (for example, cardiac or neurological).

Extrinsic Factors are conditions in the child's immediate environment that are a potential threat to life but cannot be deemed the cause of death with reasonable certainty (for example, side or prone sleep, over-bundling, objects in the sleep environment, sleep environment not specifically designed for infant sleep, soft or excessive bedding, and sleep surface sharing), injuries or toxicological findings, or circumstances or findings otherwise concerning for unnatural death.

Accidental strangulation or suffocation in bed is defined as an explained sudden and unexpected infant death in a sleep environment (bed, crib, couch, chair, etc.) in which the infant's nose and mouth are obstructed, or the neck or chest is compressed from soft or loose bedding, an overlay, or wedging causing asphyxia.

Wedging or entrapment is a form of suffocation or mechanical asphyxia in which the nose and mouth or thorax are compressed or obstructed because of the infant being trapped or confined between objects, preventing respiration. The most common wedging scenario is when an infant becomes stuck between a mattress and a wall or bedframe in an adult bed.

American Academy of Pediatrics (AAP) Sleep-Related Infant Death: Updated 2022 Recommendations for Reducing Infant Deaht in the Sleep Environment

A= Always **Alone** for sleep	**B=** Place babies on their **Back**	**C= Clear Crib**	**D= Drug free home**
Room share, don't bed share. Place your baby's crib in your room close to your bed.	Place babies on their back for every sleep. Babies that sleep on their backs are less likely to die suddenly and unexpectedly than babies placed on their side or stomach. Baby's will not choke when they are on their back.	Keep soft objects and loose bedding out of the sleep environment. Blankets and pillows increase the risks for sleep related suffocation.	Don't smoke, vape or use drugs around your baby.
Never sleep with your baby. Avoid falling asleep with your baby in bed, couch or recliner. The risk of sleep related infant death is up to 67 times higher when infants sleep with someone on a couch or soft armchair or cushion.	Use a firm, flat sleep surface that is intended for infant sleep. Any surface that inclines more than 10 degrees is not safe for babies to sleep in (swing, car seat, nursing pillow).		If you have been drinking alcohol, used marijuana, or have taken medications or illicit drugs -The risk for sleep related infant death is more than **10 times higher.**
The risk of sleep related infant death while bedsharing with an infant under four months of age is 10 times higher.			

Visit: Sleep-Related Infant Deaths: Updated 2022 Recommendations for Reducing Infant Deaths in the Sleep Environment

Basic Characteristics of Sleep Related Infant Death

There were **20** infant fatalities identified as Sleep Related Infant Deaths and included in this annual report: 8 SUID (Undetermined) and 2 Asphyxia (Accident) per year (2022 & 2023). Nationally, **3,500** infants die of SUID each year, about 3 babies every day.

Sex

Male

Female

There have been **51 Sleep-Related Infant Deaths in the past 5 years.**

Race

3.7 per 100,000 children were **White**

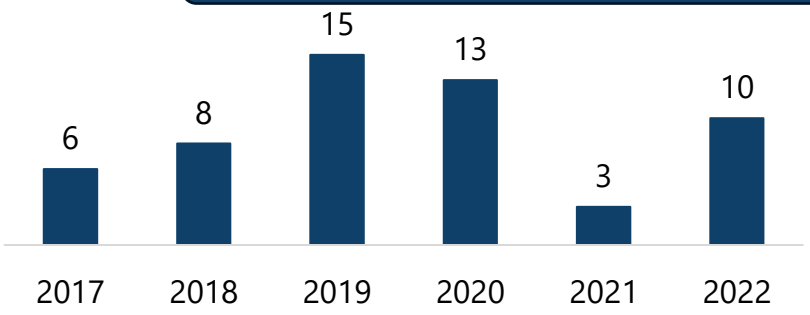
16.9 per 100,000 children were **American Indian**

28.4 per 100,000 children were **Black**

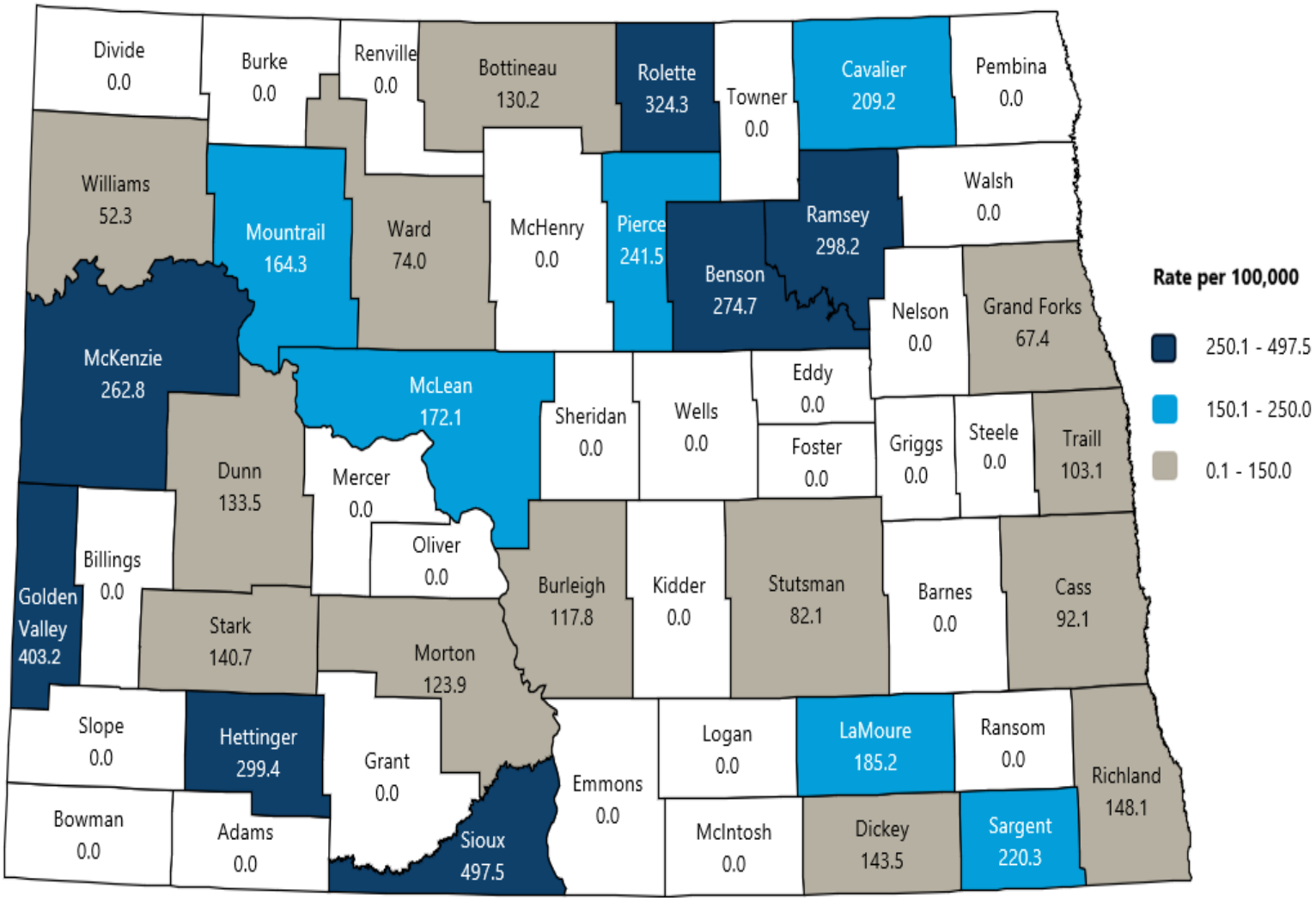
7.3 per 100,000 children were **Hispanic**

Age

Historical Sleep Related Fatalities

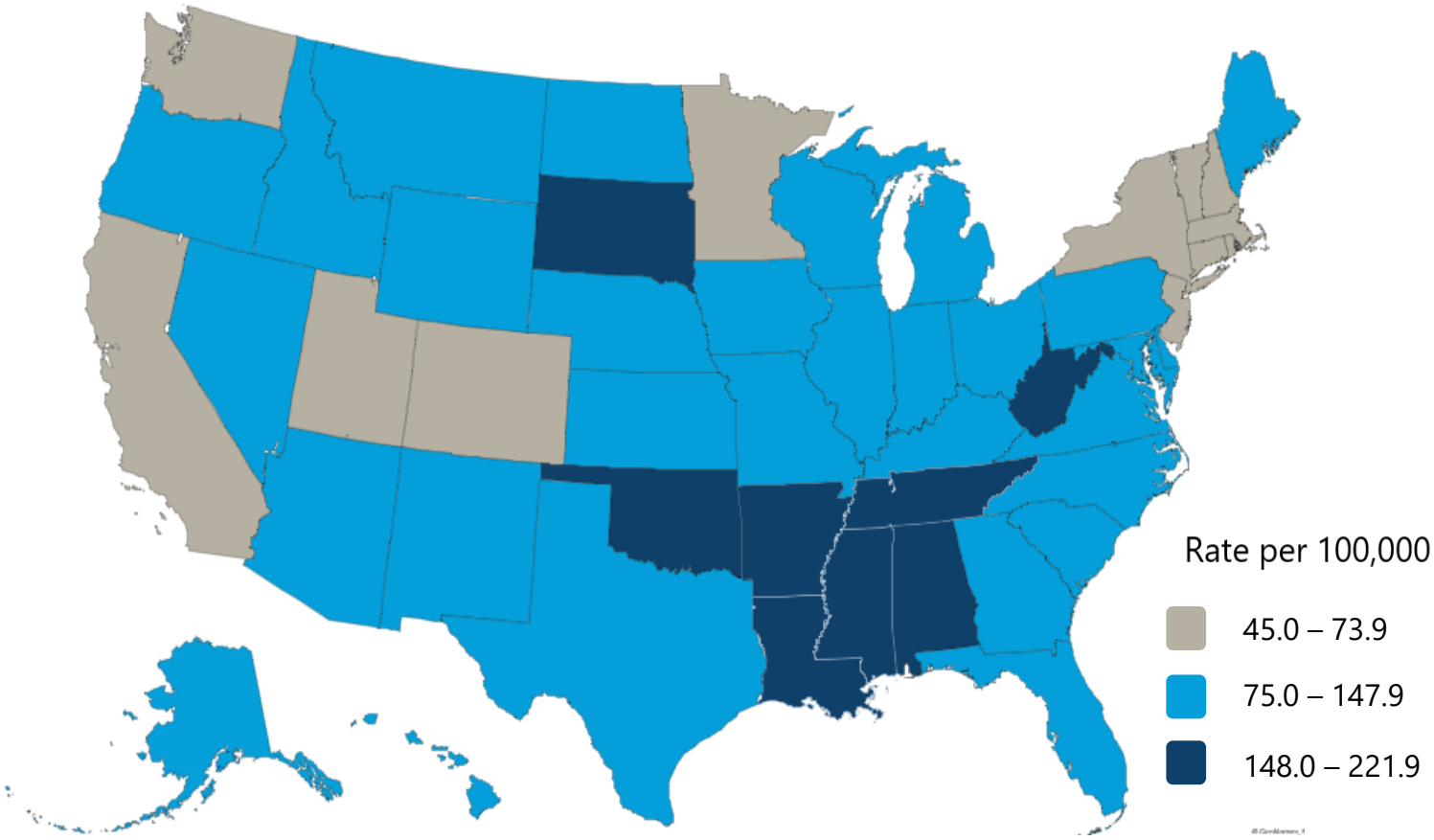


SUID Heat Map (2014-2024)



As seen in the map above, the rates of Sleep Related Infant Death by county range from **0/100,000** to **497.5.4/100,000 (Sioux County)**. These numbers are based on the location of the death causing event, not on the county of death or residence of the infant.

US SUID Heat Map (2018-2022)



As seen in the map [a] above, the rates of Sudden Unexplained Infant Death (SUID) per state. **North Dakota's SUID rate was 86.6/100,000** while the **national average rate was 94.8/100,000.**

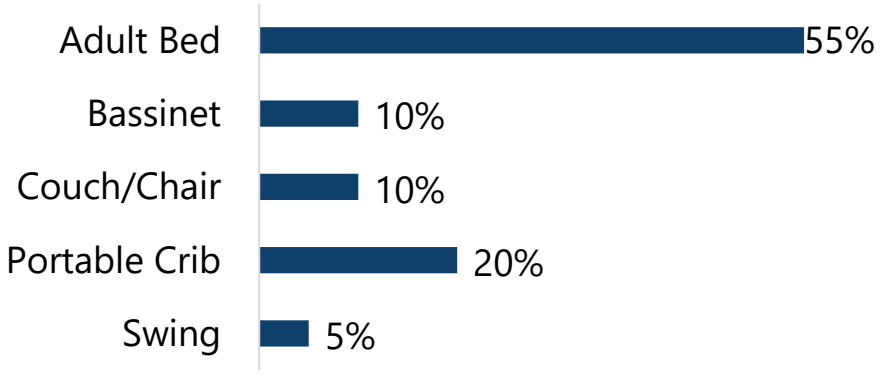
[a]CDC/NCHS, National Vital Statistics System, Mortality Files. Rates calculated via CDC Wonder.

Location of Sleep Related Infant Death

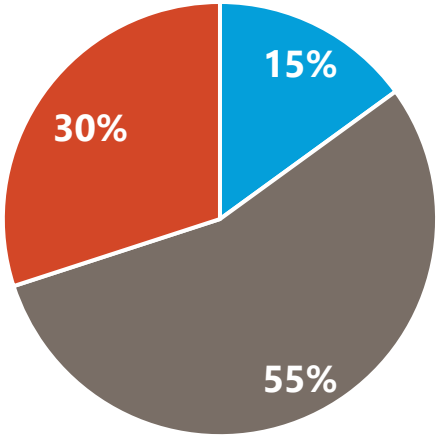
As seen in the graph to the left, most Sleep Related Infant Deaths occurred in the infant's home.

Sleep Location

As seen in the graph to the right, most Sleep Related Infant Deaths occurred in an adult bed. **50%** of Sleep Related Infant Deaths **shared a sleep surface.**



Sleep Position



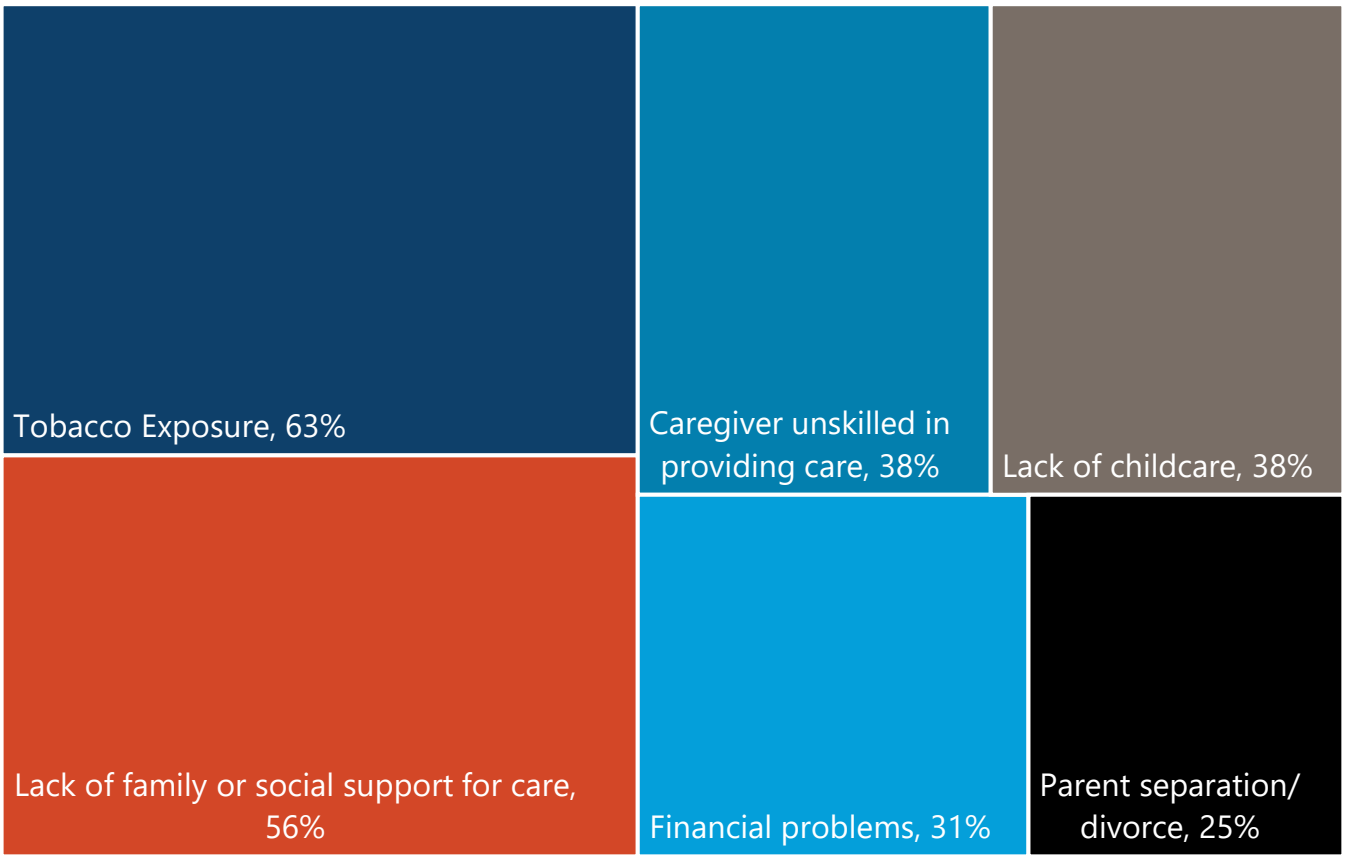
- In Caregivers' Arms
- Placed on Back
- Placed on Side or Stomach

40% of infants were swaddled

These graphs demonstrate that none of these infants were placed Alone, on their Backs in a Clear Crib. Of these infants, 40% were swaddled.

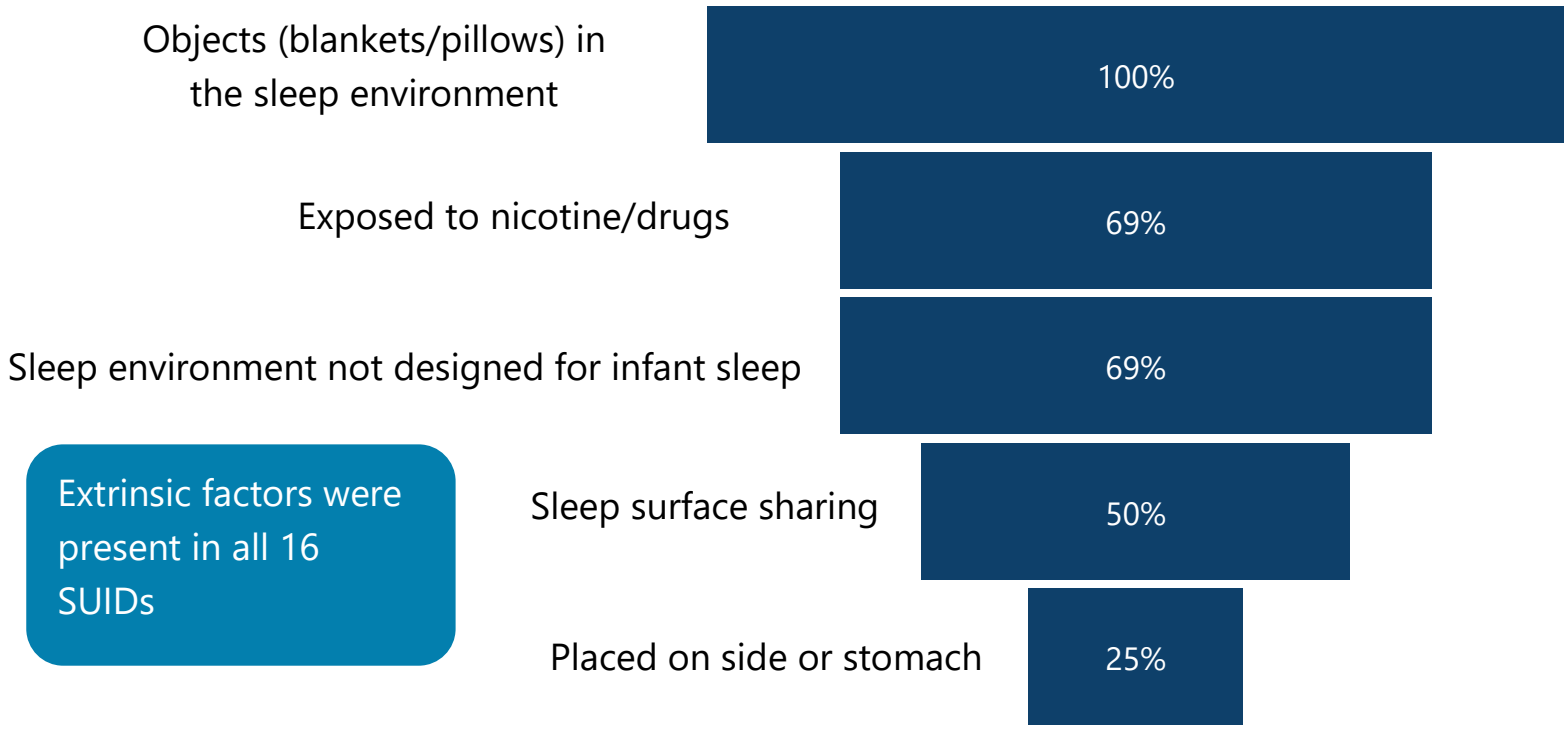
Life Stressors

The CFRP identified that **tobacco exposure (63%) followed by lack of family/social support for care (56%)** was the most common **life stressor** in sleep related infant deaths.



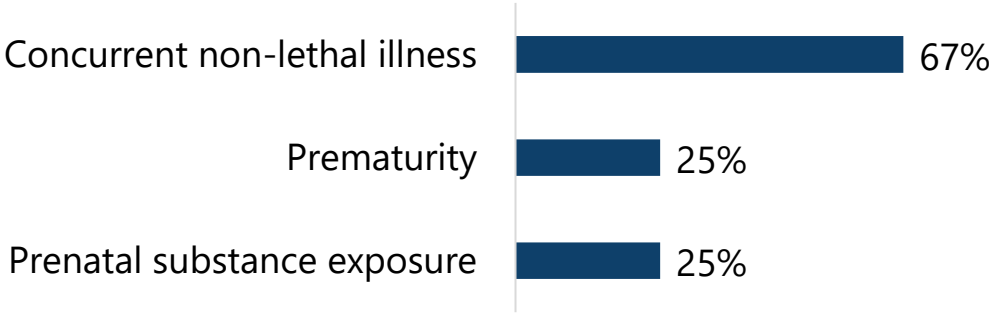
35% of Sleep Related Infant Deaths had **no access** to a **safe sleep environment**.

Extrinsic Factors: SUID



Extrinsic factors were present in all 16 SUIDs

Intrinsic Factors: SUID



Intrinsic factors were present in 75% of Sudden Unexplained Infant Deaths

When a **concurrent illness / virus** was identified it was:

- **75% Enterovirus /Rhinovirus**
- **40% Coronavirus (COVID-19)**

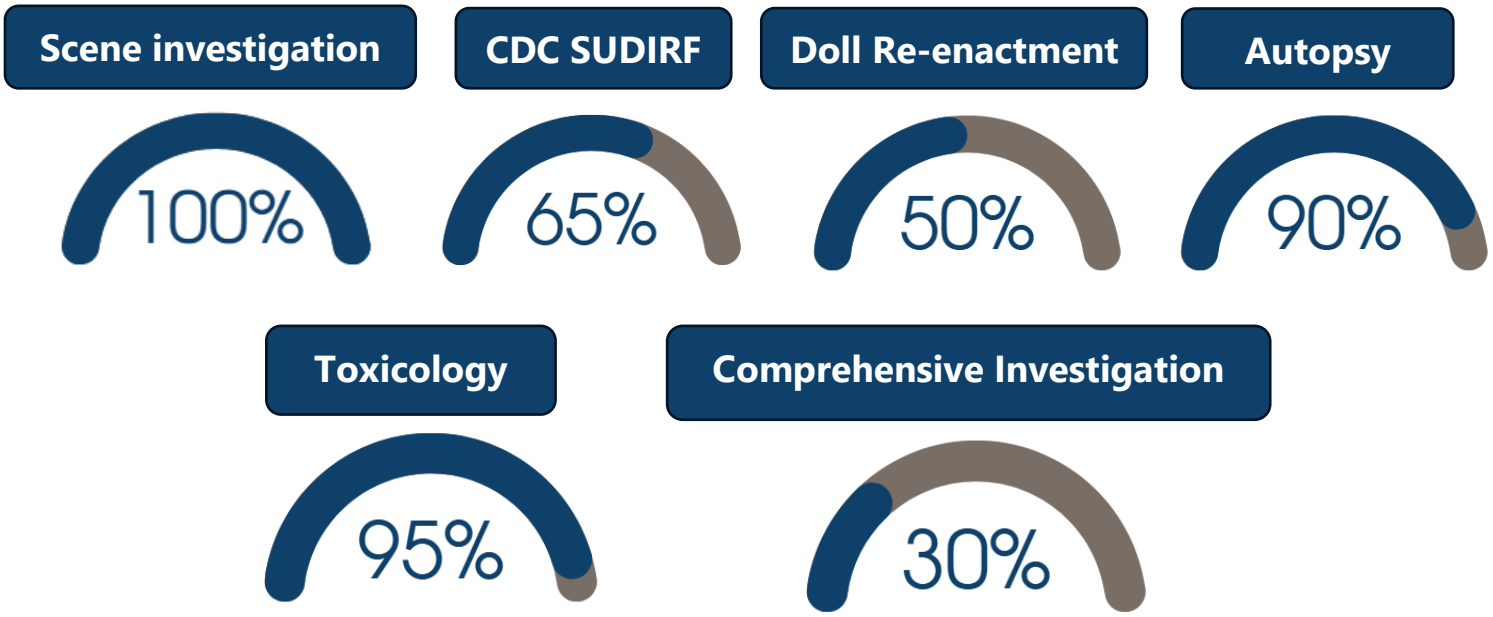
Many of these infants were **ill with cold symptoms** (congestion, running nose, cough) resulting in some parents making **modification to their sleep environment** (placing infants on their side, at an include, propping them on pillows and bringing them into bed to soothe and provide care).

Infant Death Investigations

A comprehensive death investigation is crucial to accurately determine cause and manner of sudden unexplained infant deaths. These investigations should include an examination of the death scene, ideally with doll re-enactment, documentation of the circumstances of the death with the use of the CDC Sudden Infant Death Investigation Reporting Form (SUIDIRF), a review of the infant's medical history, radiographic examination, and a complete autopsy with lab testing including histology, neuropathology, toxicology, and microbiologic studies. [7]

Death Scene Investigation

Death scene investigations are critical to understanding the environmental factors that may have contributed to the infant's death. Of the 20 Sleep-Related Infant deaths in 2022-2023, 30% received a comprehensive investigation.



[7] *Forensic Sci Med Pathology. Author manuscript; available in PMC 2021 March 01. Protocols, practices, and needs for investigating sudden unexpected infant deaths. Cottengim, Parks, Rhoda, Andrew, Nolte, Fudenberg, Sens, Brustrom, Payn, Shapiro-Mendoza*

Recommendations for Sleep Related Infant Death

Recommendation 1

Statewide infant safe sleep campaign promoting and educating parents, caregivers, grandparents, childcare providers, adolescents and young adults about the American Academy of Pediatrics recommendations for reducing infant deaths in the sleep environment.

American Academy of Pediatrics

Visit the AAP for guidelines regarding safe infant sleep : Sudden Unexpected Infant Death (SUID) Prevention Program

Recommendation 2

All infants, those under 12 months of age, are to be placed to sleep on their back in a clear safety-approved crib on a firm, flat mattress (no incline) with no items (i.e. blankets, pillows, stuffed animals) except for a pacifier.

Recommendation 3

Infants under six months should be placed to sleep in the same room as the parent's room, close to the parent's bed, but on a separate sleep surface designed for infants.

Recommendation 4

Avoid bundling, swaddling, overheating and head coverings in infants.

Recommendation 5

NDQuits

Avoid exposing infants to smoke, nicotine, vape, and controlled substances.

Recommendation 6

Promptly remove sleeping infants from swings, car seats not attached to a base and infant seats to prevent sleep related asphyxia.

Firm, Flat, and Level: Learn about safe sleep surfaces and other features of a safe sleep environment for baby.

Recommendation 7

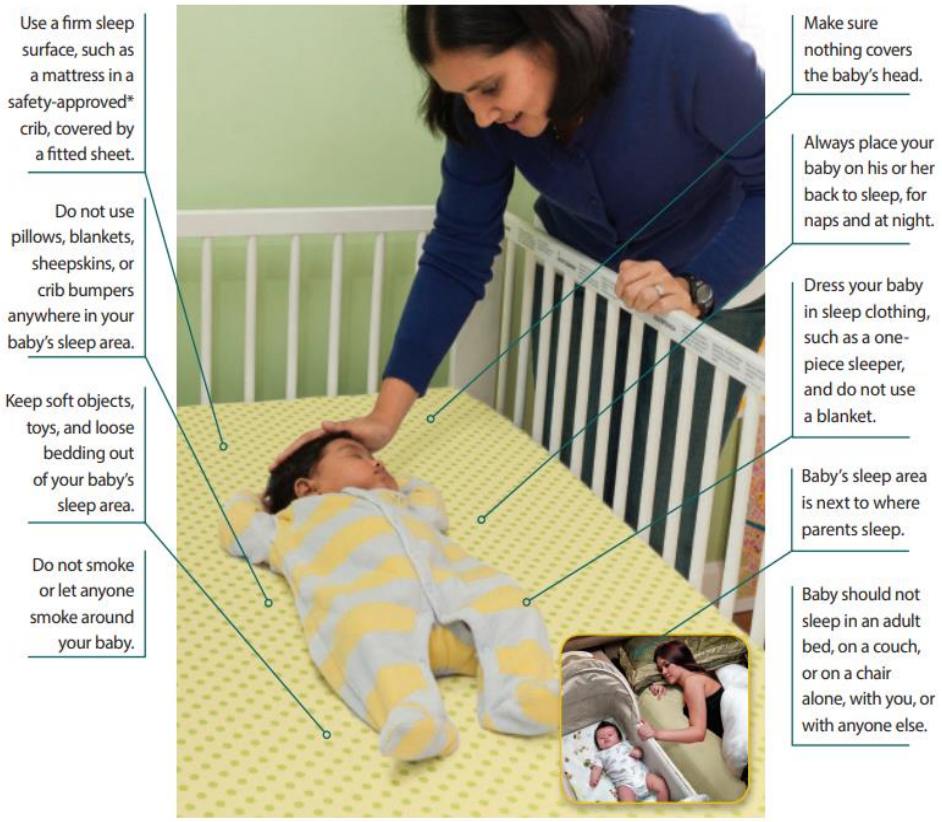
Never sleep with an infant, if a baby is brought to the bed to feed or comfort, ensure to place them on a separate sleep surface before laying down to go to sleep. If there is a possibility of falling asleep, set an alarm to go off in ten minutes.

Recommendation 8

Safe sleep education should include information about the utilization of video/audio monitors to supervise infant sleep and include guidance on limits for an infant's time spent

Recommendation 9

Educate grandparents and caregivers on the dangers of placing a sleeping infant on a bed with pillows and blankets acting as a barrier to prevent rolling as it increases the risks for sleep related asphyxia.



*For more information on crib safety guidelines, contact the Consumer Product Safety Commission at 1-800-638-2772 or http://www.cpsc.gov.

Recommendation 10

Sleep related infant death prevention needs to include information about the dangers of swaddling infants after they have shown signs of attempting to roll over, which is not a determined set age but rather based on developmental abilities.

Recommendation 11

Increase the number of high schools providing child development/parenting education courses that contain specific instruction about sleep related infant death, SUID, and infant safe sleep.

Recommendation 12

Increase education about the dangers of bottle propping and the importance of holding infants during feedings. Direct this education to young parents and as part of child development and parenting high school education curriculum.

Recommendation 13

Utilize public service advertisements, social media and a data dashboard to expand community knowledge and awareness of sleep related infant death, safe sleep practices and where to access safe sleep resources.

Recommendation 14

Utilize digital storytelling to allow parents to share their experience regarding the loss of their infant who died when there were hazards present in the sleep environment. These personal stories are powerful fatality prevention as individuals often judge the frequency of occurrence on their ease of recalling an event and perception of risk is the driver of changing a behavior.

Recommendation 15

Increase the number of Cribs for Kids distribution sites in areas with higher rates of American Indian and Black children. Additionally, provide an alternative option for bedside sleeper distribution for this specific population.

Recommendation 16

Increase the referrals by birthing hospitals and child welfare to Cribs for Kids for the distribution of safe sleep resources and education about proper utilization.

Recommendation 17

Training and education for child welfare professionals regarding safe sleep for infants and sleep related infant death with a focus on effectively engaging with parents and caregivers about these topics, specifically when the infant may have increased vulnerability from prenatal substance exposure and/or environmental exposure to controlled substances, performing safe sleep assessments, and where and how to refer to families to access safe sleep resources.

Recommendation 18

When a safe sleep surface is not available, a temporary crib can be created with a bare dresser drawer that has been removed or a bare flat basket. There should be no blankets, cushions or pillows present in the drawer/basket. Move baby to a CSPC-approved sleep surface as soon as one is available.

Recommendation 19

Increase sleep related infant death prevention education and resources for parents accessing medication assisted therapy and/or substance use treatment services with an emphasis on the dangers to infants prenatally or environmentally exposed to alcohol or controlled substances, particularly how it increases their vulnerability to sudden infant death and the additional risk of caregiver exhaustion or use of sedating substances.

Recommendation 20

Policy recommendations requiring DHHS licensed childcare and foster care providers follow the AAP recommendations for reducing infant deaths in the sleep environment which includes never placing an infant to sleep with a blanket or pillow.

Section IX: Death Investigations for Overall Child Fatalities

Even though there has been an observable increase in the quality of death investigations for child fatalities as compared to five years ago. The Panel continues to be concerned about the quality of all child death scene investigations. Many child death investigations do not include interviews with the parents and others who live in the home or who were present in the home at the time of the death. The investigations of some child deaths continue to be minimal, without a death scene investigation, autopsy or toxicological testing. Investigations do not always explore circumstances leading up to the death or are not comprehensive enough to uncover information vital to identifying the cause and manner of death or in identifying risk factors and formulating effective interventions. The thoroughness of child death investigations varies greatly statewide. There is a vast variance in education, training and experience for the state's coroners and there are no statutory requirements for education training or experience of the state's coroners. Information gathering regarding the child and family history, child development, supervision, alcohol and drug use, mental health, domestic violence, and consumer product safety are all vital to understanding the circumstances surrounding the deaths of children and for planning to prevent future deaths, yet this is the very information that is often not gathered or not recorded in an investigation.

Recommendation 1

All children that die suddenly and unexpectedly receive a complete autopsy with toxicological testing.

Recommendation 2

Admission hospital blood be kept for toxicological purposes.

Recommendation 3

Support the ND Coroners Association and web based portal for training and information dissemination. Expand opportunities for child death investigation training for law enforcement and coroners.

NORTH DAKOTA CORONER TRAINING PORTAL

Recommendation 4

Enhanced capacity for comprehensive infant death investigation and prosecution of child neglect.

Recommendation 5

Add a forensic social worker to each of the state's forensic pathology offices completing autopsies to enhance postmortem and bereavement support for families as well as assist forensic pathologists in gathering and providing pertinent information.

Section X: Preventable Deaths

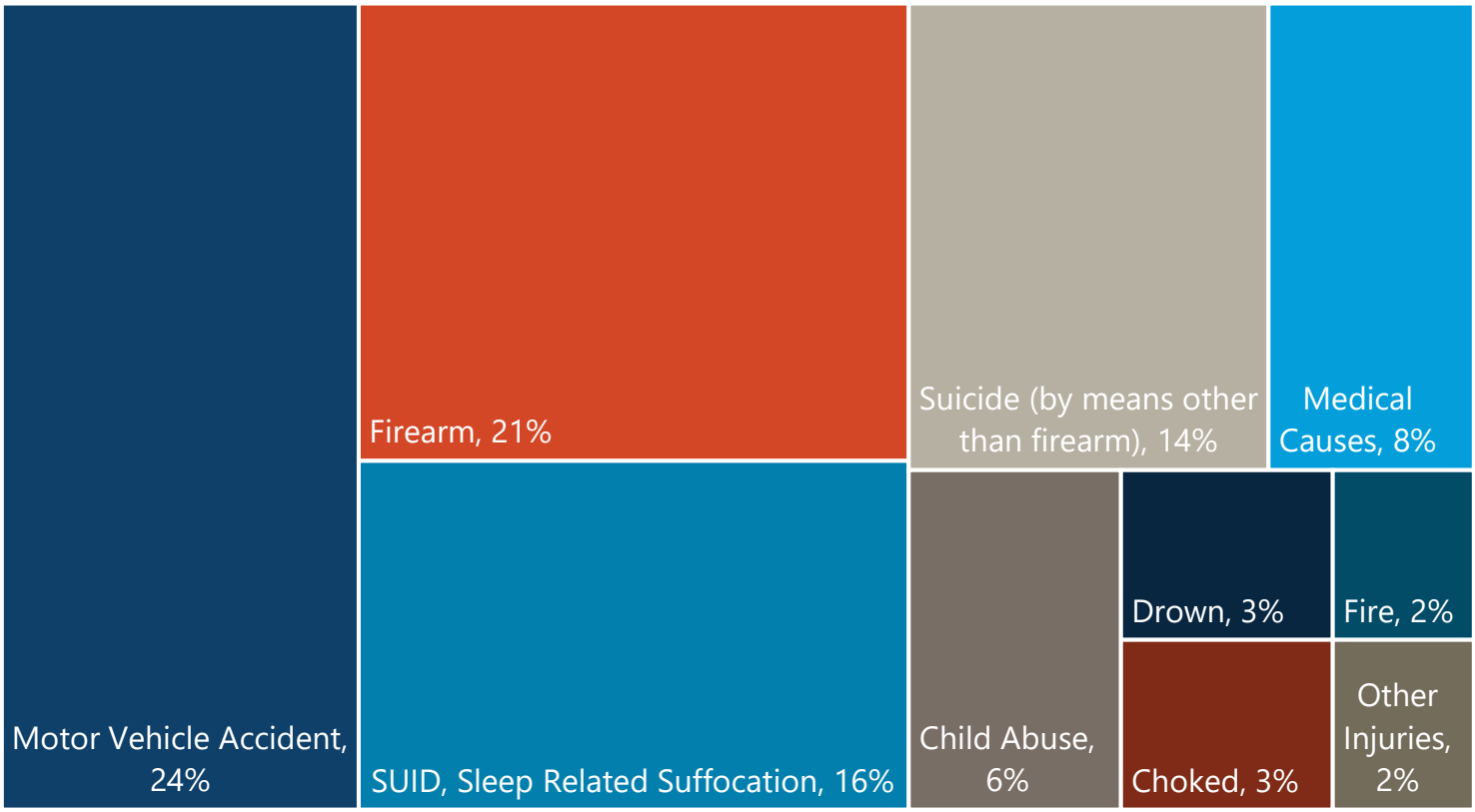
The CFRP uses the determination of **preventability** for the identification of systems issues. To the Panel, the word preventability does not imply negligence. The Panel looks at what systemic changes can be made to prevent children from dying, for instance changes in policy, practice, and law.

The panel determined that **72%** of fatalities reviewed were preventable.

Preventability was undetermined in **23%** of deaths reviewed. **5%** of fatalities reviewed were determined to be unpreventable.

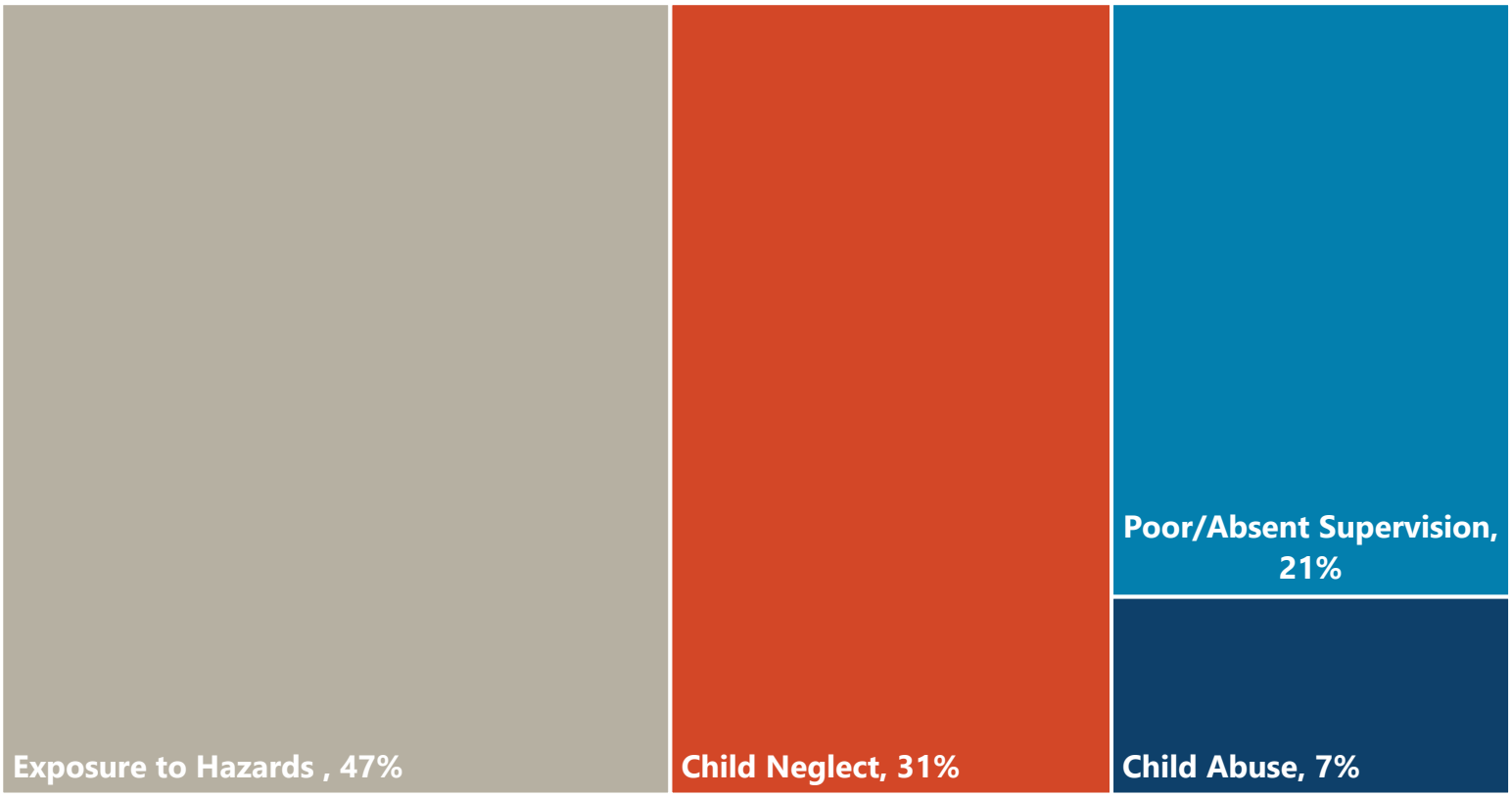
Sudden Unexpected Infant Death (SUID) was the leading cause of death for infants in 2022 and 2023 and accounted for 18% of deaths reviewed by the Panel between 2023- July 2025 Since these deaths are classified as 'undetermined', the Panel often concluded the preventability for these sudden unexplained infant deaths to be undetermined but did identify extrinsic factors which can increase the risk for sleep related suffocation and SUID.

Leading Cause of Preventable Deaths Reviewed



Contributing Factors

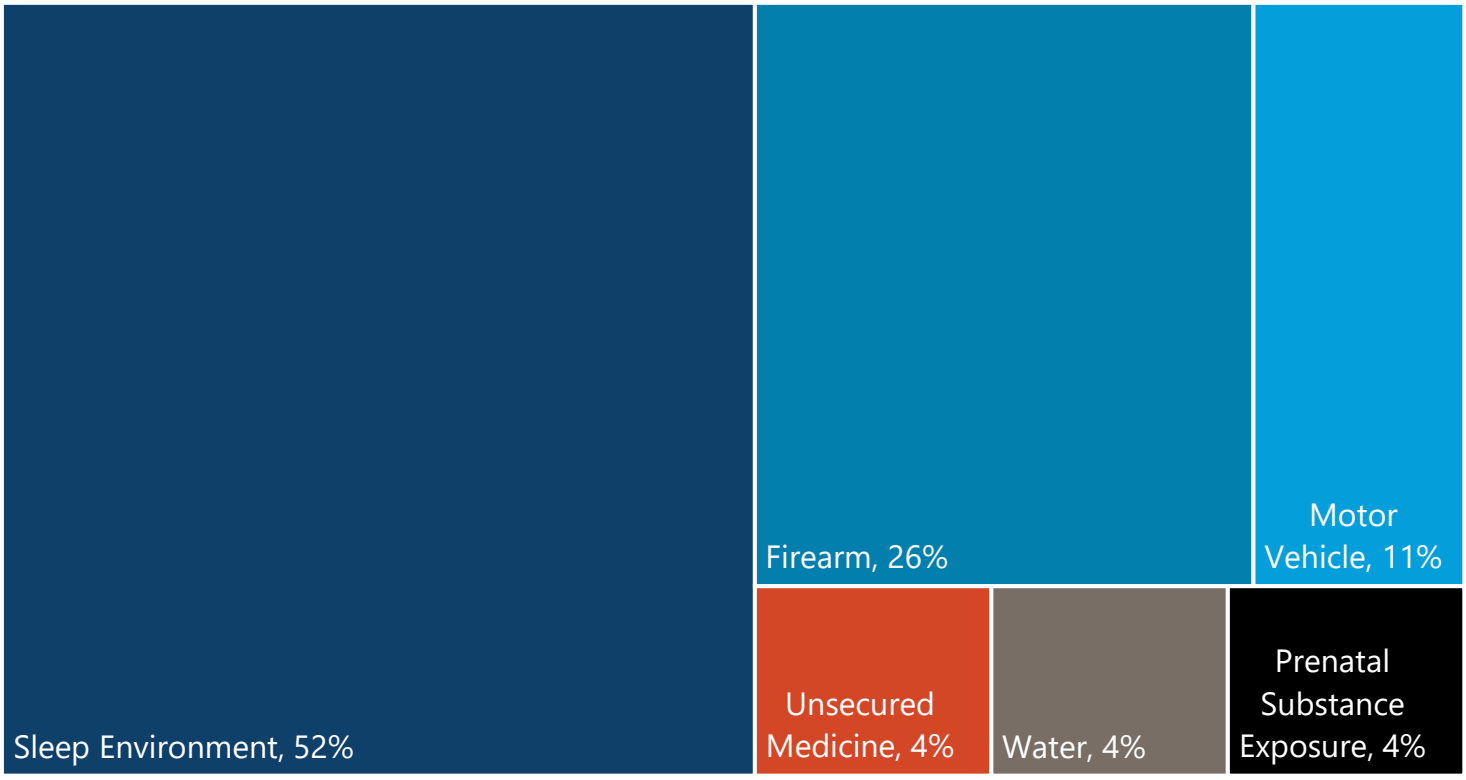
The CFRP identified contributing factors of child abuse, child neglect, poor/absent supervision or exposure to hazards in **66%** of the child fatalities reviewed. The most commonly identified contributing factor was Exposure to a Hazard (47%).



Exposure to Hazards

The CFRP identifies seven types of hazards (Fire, Firearm, Motor Vehicle, Prenatal Substance Exposure, Sleep Environment, Unsecured Medication / Poison, and Water.

The most commonly identified Hazard was a Sleep Environment Hazard (52%), followed by a Firearm Hazard (26%)

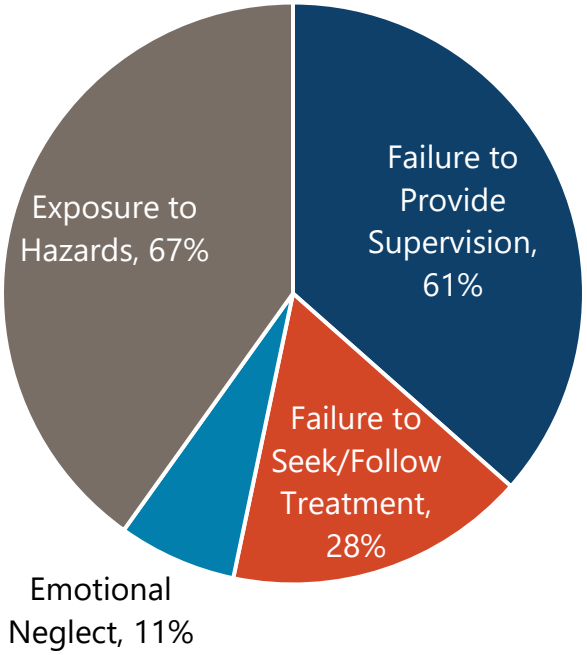


Child Neglect

The Panel identified contributing factors of Child Neglect in **31%** of deaths reviewed.

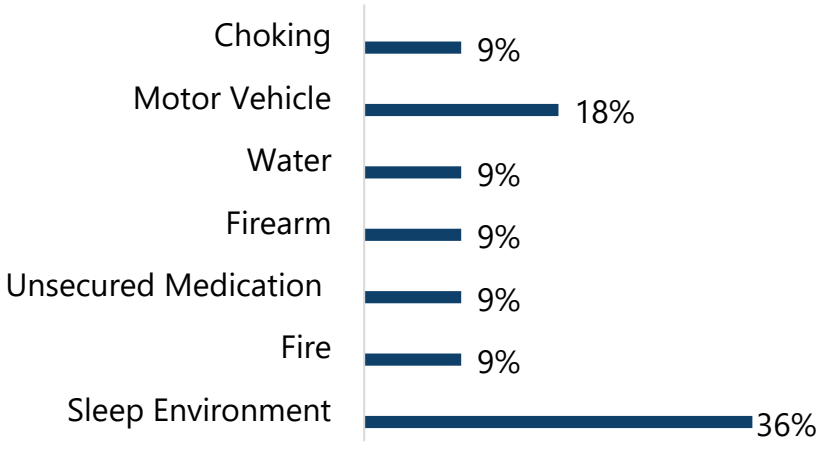
The Panel determines four types of child neglect; failure to provide supervision, failure to seek / follow treatment, emotional, and exposure to hazards. The most commonly identified type of neglect in child fatalities reviewed by the Panel was Exposure to Hazards (67%), followed by Inadequate Supervision (61%)

Child Neglect Types



When child neglect; exposure to a hazard was identified, it most often was a hazard present in the sleep environment (36%)

Child Neglect- Exposure to Hazards



Section XI: Deaths from Child Abuse and Neglect & Near Deaths from Child Maltreatment

Child Abuse and Neglect Fatalities

There were **7** child abuse and neglect fatalities among children from 2022-2024, that were reviewed by the CFRP and included in this annual report.

Sex

Male

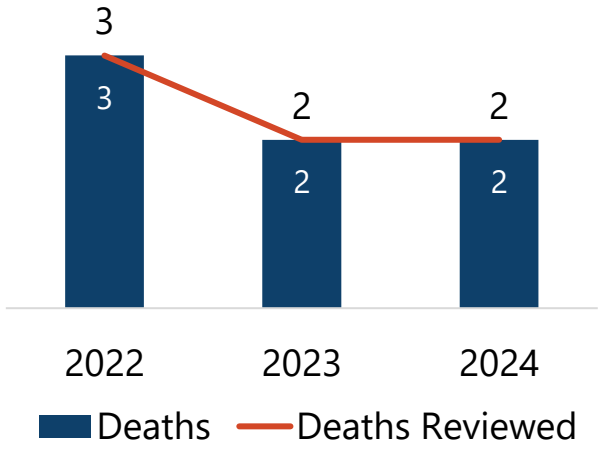
Female

Race

11.8 per 100,000 children were **American Indian**

4.1 per 100,000 children were **White**

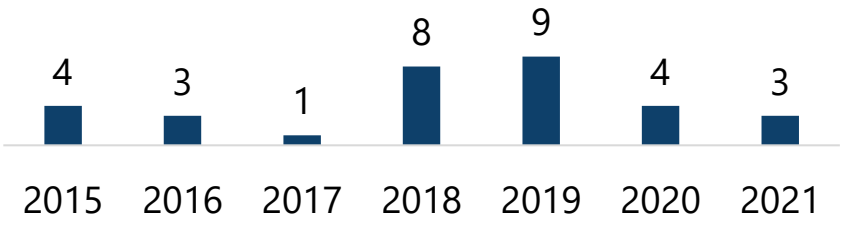
28.9 per 100,000 children were **Black**



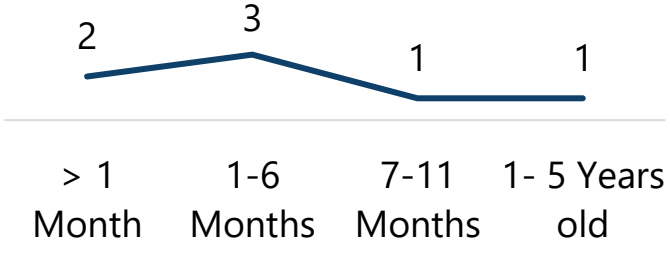
The rate of child maltreatment fatalities among Black children is **28.9/100,000** which is 7 times higher than the White population.

A **preponderance of evidence** is needed to confirm abuse and neglect. A "preponderance of the evidence" is a **standard of proof** in which the facts alleged more likely than not occurred and is at times referred to as the **51% standard**. This standard of proof is more stringent than reasonable doubt but less stringent than clear and convincing evidence.

Historical Maltreatment Fatalities



Age



North Dakota defines a **child maltreatment** fatality as death "caused by an injury resulting from abuse or neglect or where abuse or neglect is a contributing factor." In North Dakota, child abuse and neglect determinations are made by DHHS upon the completion of a child protection assessment, which are conducted by the 19 Human Service Zones.

2022

A five-year-old male died of Homicide; the cause of his death 'Battered Child Syndrome." There was one previous report of child abuse and neglect that pertained to the death. Five reports of suspected child abuse and neglect were received because of the child's death. An assessment determination of "Confirmed" was made for fatal abuse and neglect with impending danger. Foster care case management, safety planning, parenting education and adoption services were provided.

A female neonate died while same sleep surface sharing with an adult and other children on an adult bed with pillows and blankets. The cause of death was SUID with intrinsic and extrinsic factors identified and manner of death was Undetermined. There were three prior reports of suspected child abuse and neglect that pertained to the death. One report of suspected child abuse and neglect was received as a result of the baby's death. An assessment determination of "Confirmed" was made for fatal neglect with impending danger. Foster care management, safety planning, parenting education, parent aide services, transportation, supervised visitation and behavioral health services were provided.

A prenatally substance exposed, and premature three-month old male died while same sleep surface sharing with an impaired adult on an adult bed with pillows and blankets. The cause of death was SUID with intrinsic and extrinsic factors identified and manner of death was Undetermined. There was one prior report of child abuse and neglect that pertained to the death. One report of child abuse and neglect was received because of the baby's death. An assessment determination of "Confirmed" was made for fatal neglect. Impending danger was not identified as there were no other children under the care of the person responsible. No services were provided.

2023

A five-month-old male died from Complications of Head and Neck Trauma, and the

manner of death was classified as Homicide. There were no reports previously received of suspected child abuse and neglect that pertained to the death. One report of child abuse and neglect was received because of the infant's non-accidental injuries and subsequent death. An assessment determination of "Confirmed" was made for fatal abuse. Impending danger was not identified; the perpetrator was incarcerated. No services were provided.

A one-month-old female died while sleeping on a couch with an adult and several pillows and blankets. The cause of death was SUID with extrinsic factors identified and the manner of death was Undetermined. There were five previous reports of child abuse and neglect that pertained to the death. One report of child abuse and neglect was received as a result of the baby's death. An assessment determination of "Confirmed" was made for fatal neglect with impending danger. In home case management, foster care case management, supervised visitation, relative care, safety planning, parenting education and parent aide services were provided.

2024

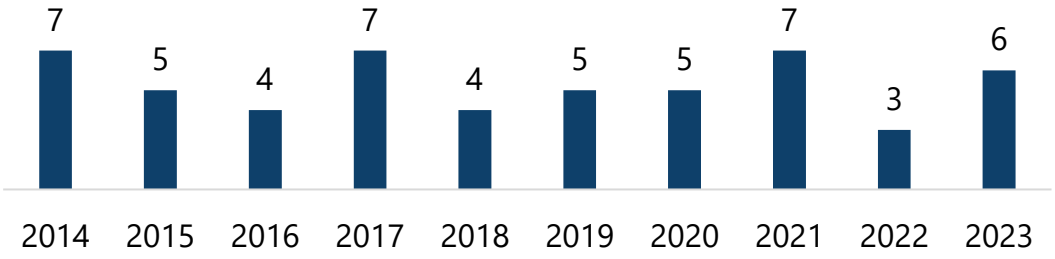
A three-month-old male died of Asphyxia resulting from a plastic bag being placed over his head. The manner of death was Undetermined. There were two previous reports of child abuse and neglect that pertained to the death. Two reports of child abuse and neglect were received as a result of the child's death. An assessment determination of "Confirmed" was made for fatal neglect. In-home case management, foster care, and parent aide services were provided. Impending danger was not identified as there were no other children under the care of the person responsible. No services were provided

A seven-month-old female died after being left alone in a bathtub. The cause of death was Drowning, and the manner was Accident. There were no previous reports of child abuse and neglect that pertained to the death. One report of child abuse and neglect was received as a result of the child's death. An assessment determination of "Confirmed" was made for fatal neglect. In-home case management, foster care, and parent aide services were provided. Impending danger was not identified, and no services were provided.

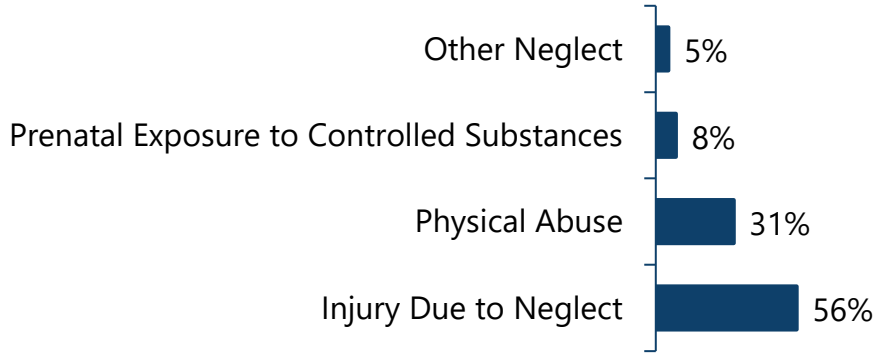
Child Abuse and Neglect Near Death

Child abuse and neglect near death means an act that, as certified by a physician, places a child in serious or critical condition. (**NDCC 50-25.1-02(19)**). A determination of confirmed maltreatment by ND DHHS Child Protection Services and a near death certification was made for three (3) children in 2022. There were six (6) children with a near death resulting from child abuse and neglect determination in 2023.

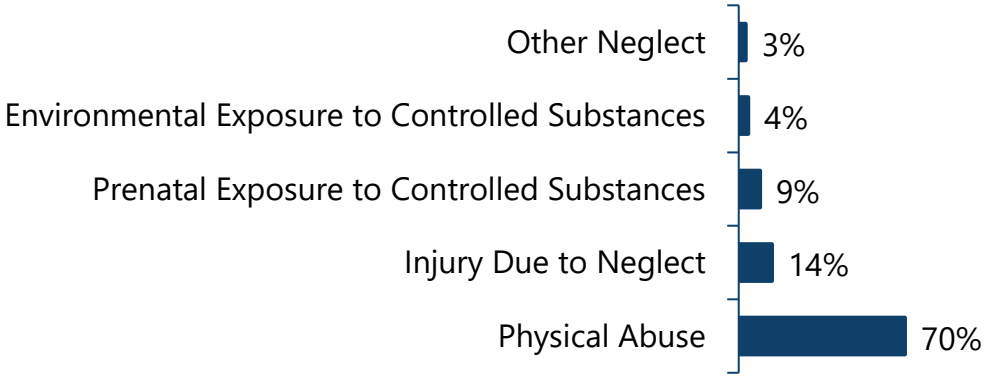
Historical Child Maltreatment Near Death



Types of Maltreatment for Child Abuse and Neglect



Types of Maltreatment for Near Death



Each **tribe in ND maintains** their own separate **child welfare data** management system. The **state and tribe** child welfare data systems **do not share data for reporting**. The child maltreatment death and near death counts in this section are **excusive** to those determinations of the state for children in **state jurisdiction** and do not include those children on tribal lands.

According to **50-25.1-04.5** the annual report involving child abuse and neglect deaths and near deaths must include the following: the cause of and circumstances regarding the death or near death; the age and gender of the child; information describing any previous child abuse and neglect reports or assessments that pertain to the child abuse or neglect that led to the death or near death; the result of any such assessments; and the services provided in accordance with section **50-25.1-06**, unless disclosure is otherwise prohibited by law.

2022

A one-month-old male was transported to the hospital after going unresponsive; there was extensive bruising to his body and imaging revealed multiple rib fractures, subdural hemorrhages, and fractures of both femurs. There was one previous report of child abuse and neglect that pertained to the near death. Three reports of child abuse and neglect were received regarding the near death. These reports were combined into one child protection assessment, which had an assessment determination of "Confirmed" for physical abuse. Foster care and in-home case management services, supervised visitation, transportation, and infant development services were provided.

A female newborn was in respiratory distress following birth and toxicological testing of the neonate and mother indicated methamphetamine exposure. The newborn was treated for significant drug withdrawal and Neonatal Abstinence Syndrome. There was one previous report of child abuse and neglect that pertained to the near death. Two reports of child abuse and neglect were received regarding the near death. These reports were combined into one child protection assessment, which had an assessment determination of "Confirmed" for prenatal exposure to a controlled substance. In-home case management services, parent aid services, infant development services, Developmental Disabilities case management, and drug testing services were provided.

A female newborn was in critical condition following birth and toxicological testing indicated prenatal exposure to methamphetamine, heroin, fentanyl, benzodiazepines, and opiates. The neonate was diagnosed with Neonatal Abstinence Syndrome. There was one previous report of child abuse and neglect that pertained to the near death. Three reports of child abuse and neglect were received regarding the near death. These reports were combined into one child protection assessment, which had an assessment determination of "Confirmed" for prenatal exposure to a controlled substance. Foster

care case management, infant development services, Developmental Disability case management, relative search and adoption services were provided.

2023

A two-year-old female was transported to the hospital following an overdose of fentanyl in her home. The child was provided multiple doses of Naloxone. There were six previous reports of child abuse and neglect that pertained to the near death. Two reports of child abuse and neglect were received regarding the near death. These reports were combined into one child protection assessment, which had an assessment determination of "Confirmed" for neglect: environmental exposure to controlled substances (fentanyl) and environmental neglect (exposure to drug paraphernalia). Foster care case management, supervised visitation, parent aid services, transportation, developmental evaluations and safety permanency funds were provided.

A two-year-old female was transported to the hospital following an overdose of fentanyl in her home. The child was provided multiple doses of Naloxone and was hospitalized for pneumonia. There were nine previous reports of child abuse and neglect that pertained to the near death. Two reports of child abuse and neglect were received regarding the near death. These reports were combined into one child protection assessment, which had an assessment determination of "Confirmed" for neglect: environmental exposure to controlled substances (fentanyl) and failure to protect. Foster care case management, supervised visitation, transportation services, drug testing, developmental evaluations and adoption services were provided.

A one-month-old female presented to the hospital with seizures. Imaging revealed multisystem trauma, including numerous acute and chronic brain bleeds, numerous retinal hemorrhages and fractures of both tibias and femurs. There were no previous reports of child abuse and neglect that pertained to the near death. Four reports of child abuse and neglect were received regarding the near death. These reports were combined into one child protection assessment, which had an assessment determination of "Confirmed" for physical abuse. Foster care case management services, infant development services, Developmental Disabilities case management, relative search, and parenting education services were provided.

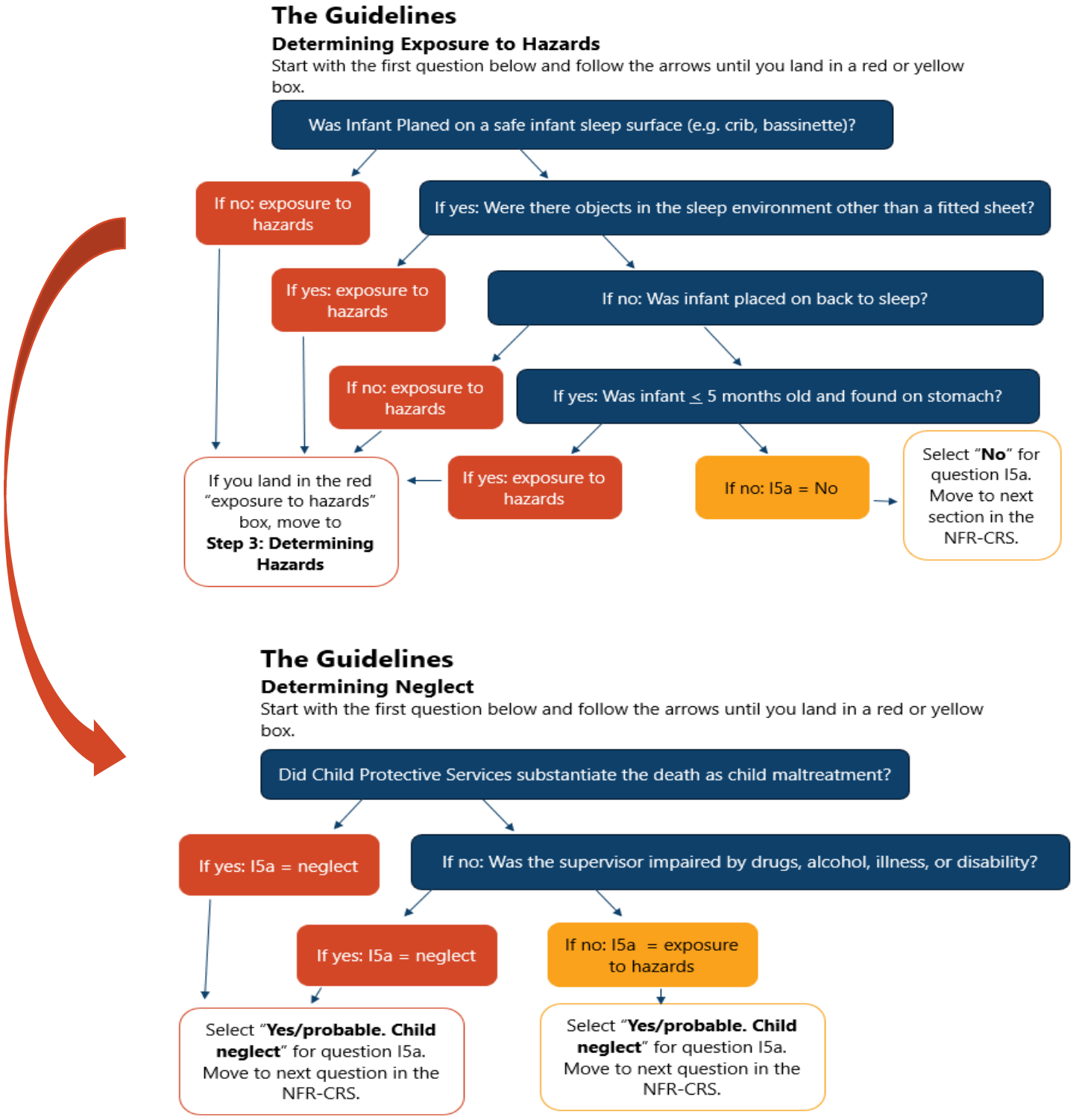
A female newborn was in severe respiratory distress following birth and toxicological testing of the neonate and mother indicated methamphetamine and marijuana exposure. There were three previous reports of child abuse and neglect that pertained

to the near death. Two reports of child abuse and neglect were received regarding the near death. These reports were combined into one child protection assessment, which had an assessment determination of “Confirmed” for neglect: prenatal exposure to a controlled substance and abandonment. Foster care case management, transportation, relative search, infant development services, Developmental Disabilities case management services, and adoption services were provided.

A two-year-old female presented to the hospital with multisystem trauma, including extensive bruising in the TEN-4-FACESp distribution, lacerated liver, new and old fractures of radius and ulna, and additional trauma of the throat and neck. There were no previous reports of child abuse and neglect that pertained to the near death. Four reports of child abuse and neglect were received regarding the near death. These reports were combined into one child protection assessment, which had an assessment determination of “Confirmed” for physical abuse and neglect, failure to protect. Foster care case management, Developmental Disabilities case management services, relative search and adoption services were provided.

A three-month-old male went unresponsive at home and was transported to the hospital following resuscitation. Imaging revealed bilateral subdural hematomas, bilateral retinal hemorrhages, a femur fracture, bilateral tibia fractures and multiple healing rib fractures. There were no previous reports of child abuse and neglect that pertained to the near death. Two reports of child abuse and neglect were received regarding the near death. These reports were combined into one child protection assessment, which had an assessment determination of “Confirmed” for physical abuse. Foster care case management, infant development services, Developmental Disability case management, transportation, supervised visitation and parent aide services were provided.

Appendix A: Contributing Factor Guidelines



CHILD SUPERVISION AGE MATRIX

Sponsors and parents are responsible for the welfare and safety of children in the military community. Each child is unique. Personality, environment, developmental progress and maturity level are factors used to determine when children are ready to accomplish activities with little or no supervision. ***Sponsors and parents are responsible for making this decision.*** The following are minimum community standards. These guidelines apply to all Military, DOD and Invited Contractors personnel living on or off post.

Age of Child	Required Supervision	Left Alone in Quarters	Left Alone Overnight	Play Outside Unattended	Left in Car Unattended	Child Sit Siblings	Child Sit Others
Newborn -5 years old	Requires close supervision at all times.	**NO**	**NO**	**NO**	**NO**	**NO**	**NO**
6-7 years old	Direct Supervision Required	**NO**	**NO**	**YES** With immediate access (visual sight and hearing distance) to adult supervision. Children six years old may not walk alone to and from school or school bus stop. Children seven years old are exempt from "outside unattended" rule when walking to and from school or school bus stop. They may not walk alone & must be accompanied by a buddy or sibling so the child is not alone.	**NO**	**NO**	**NO**
8-9 years old	Direct Supervision Required	**NO**	**NO**	**YES** With ready access to an adult who is in the immediate area in case of an emergency and the Sponsor and/or parent knowing the location and activity of the child. May walk unaccompanied to and from school or school bus stop with a buddy. Parents need to buddy partner or use siblings so child is not alone.	**NO**	**NO**	**NO**
10-11 years old	Indirect Supervision Required This is a transitional time and children are accepting more responsibility; however they continue to require indirect supervision. Sponsor should know child's location and activities. Emergency contact available.	**YES** Ten year olds for up to 1 hour. Eleven year olds up to 3 hours (occasionally, not on a daily basis). Must have access to indirect supervision (neighbor, checking with Sponsor by phone).*	**NO**	**YES** With ready access to adult supervision. Sponsor checks on the child or has the child check in with sponsor, parent or caregiver hourly. Ready access can be accomplished with cell phone. Must be 30 minutes or less to respond to the child in crisis.	**YES** Not more than ten minutes and the keys MUST be removed and parking brake applied.	**YES** Eleven year olds may sit siblings 6 years and older for up to 1 hour. Ten year olds may not sit siblings.	**NO**
12-13 years old	Indirect Supervision required Children are approaching the adolescent years when there is need for increased responsibility. The amount of responsibility should be carefully evaluated	**YES** For up to six hours with ready access to adult supervision and intermittent contact with a supervisor. *	**NO**	**YES** With access to adult supervision. Sponsor checks on the child or has the child check in person or by phone every 2 hours. Parent must know child's location and activity and respond to the child within 1 hour.	**YES**	**YES** Up to 6 hours during daylight hours	**YES** Limit up to 6 hours. Not overnight. Babysitter Course Required.
14-16 years old	Children continue to need to know how to access Sponsor and guidance for emergency situations. Sponsors are responsible for their children and their actions.	**YES** No longer than 9 hours with ready access to adult supervision.	**NO**	**YES** With access to adult supervision by phone or a designated caregiver within 2 hours. Contact must be made every 3 hours.	**YES**	**YES**	**YES** May sit up to 9 hours, not overnight. Babysitter Course Required.
17-18 years old	Sponsors are responsible for their children and their actions as long as Family Member status is maintained.	**YES** No more than two consecutive overnight periods with access to adult supervision.	**YES** Indirect Supervision	**YES** Time is left up to the Sponsor's discretion.	**YES**	**YES**	**YES** Babysitter course required.

American Red Cross Babysitter's Training Course: POC 738-3670 and/or CYS Services Babysitter Training: POC 736-8122 is required to care for any minor child sitting children other than immediate Family members. Home Alone Self Care: POC 736-8122. **To report violations of this policy that may constitute child neglect, please call the US Army Military Police 724-3004 or Abuse Hotline 737-4101.**

*Unless there is a pattern of behavioral misconduct indicating otherwise.

Updated October 1, 2013

Appendix B: Child Welfare Definitions

North Dakota Century Code 50-25.1-02(1) defines **a person responsible for a child's welfare** as an individual who has responsibility for the care and supervision of a child AND who is the child's parent, an adult family member of the child, any member of the child's household, the child's guardian, or the child's foster parent; or an employee of, or any person providing care for the child in a child care setting.

North Dakota Century Code 50-25.1-02(2) defines an **abused child** as an individual under the age of eighteen years who is suffering from abuse as defined in section 14-09-22 caused by a person responsible for the child's welfare.

North Dakota Century Code 50-25.1-02(2) defines an **abused child** as an individual under the age of eighteen years who is suffering from abuse as defined in section 14-09-22 caused by a person responsible for the child's welfare.
A **neglected child** is defined in North Dakota Century Code 50-25.1-02(20) as a child who due to the action or inaction of a person responsible for the child's welfare:

a. Is without proper care or control, subsistence, education as required by law, or other care or control necessary for the child's physical, mental, or emotional health, or morals, and is not due primarily to the lack of financial means of a person responsible for the child's welfare;
b. Has been placed for care or adoption in violation of the law;
c. Has been abandoned;
d. Is without proper care, control, or education as required by law, or other care and control necessary for the child's well-being because of the physical, mental, emotional, or other illness or disability of a person responsible for the child's welfare, and that such lack if care is not due to a willful act of commission or act of omission, and care is requested by a person responsible for the child's welfare;
e. Is in need of treatment and a person responsible for the child's welfare has refused to participate in treatment as ordered by the juvenile court;
f. Was subject to prenatal exposure to chronic or severe use of alcohol or any controlled substance in a manner not lawfully prescribed by a practitioner;
g. Is present in an environment subjecting the child to exposure of a controlled substance including any amount of marijuana, chemical substance, or drug paraphernalia;
h. Is a victim of human trafficking

Appendix C: Population Rate Counts

	Population Counts used in Rates	Source
Infants Rates		
Infant rates per 100,000 by race were used in this report.	Population data for ND residents aged 5 years and younger by race was used to calculate these rates.	American Community Census Data
Children Rates		
Children rates per 100,000 by race were used in this report.	Population data for ND residents aged 17 years and younger by race was used to calculate rates.	American Community Census Data
County Rates		
County rates were used for each manner of death to make heat maps.	Population data for ND residents 17 years and younger were used for each county to make heat maps.	North Dakota Kids Count Data

State of North Dakota • Kelly Armstrong Governor
Department of Health and Human Services • Pat Traynor
Children and Family Services •

North Dakota Child Fatality Review Panel

2025 Annual Report