Chris Jones, EXECUTIVE DIRECTOR

NORTH DAKOTA CHILD FATALITY REVIEW PANEL

DETAILED ANNUAL REPORT

2015 and 2016

May 2018

CHILDREN AND FAMILY SERVICES DIVISION
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BISMARCK, NORTH DAKOTA 58505-0250

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THE NORTH DAKOTA CHILD FATALITY REVIEW PANEL

History

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's charge is to "protect the health and welfare of children by identifying the cause of children's deaths, when possible; the identifying of those circumstances that contribute to children's deaths; and the recommending of changes in policy, practices, and law to prevent children's deaths."

Purpose

The North Dakota Child Fatality Review Panel reviews deaths of all children (under 18 years of age), which occur in the state. The Panel

- identifies the cause of children's deaths,
- identifies circumstances that contribute to children's deaths, and
- recommends changes in policy, practices, and law to prevent children's deaths.

Their careful review process results in a thorough description of the factors related to child deaths. The reviews make a difference. These collaborations, partnerships and activities are proof that communities are aware that knowledge of the facts about a child death is not sufficient to prevent future deaths. The knowledge must be put into action.
By sharing information and reviewing data, panel members review the circumstances surrounding the deaths and look for patterns or trends to identify possible prevention strategies.

A determination of the Panel's agreement with the manner of death indicated on the death certificate and the preventability of death is made by a consensus of the Panel members. A data form is maintained for each case reviewed by the Panel to document the findings and recommendations. This data form is used in compiling non-identifying, death related information that serves as the basis for this annual report. Meetings are closed to the public and all case discussions and documents, except for this annual report, are confidential by law (NDCC 50-25.1-04.5).

After an in-depth review, the NDCFRP 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.

This Child Fatality Review Annual Report was compiled in February 2018 and presents information from the in-depth reviews of child deaths that occurred in calendar years 2015-2016. This report is intended for the public audience.

Every child's death is a tragic loss for the family and community. Especially tragic is the child death that could have been prevented. Through careful review of child deaths, we are better prepared to prevent future deaths. The NDCFRP members acknowledge that the circumstances involved in most child deaths are too complex and multidimensional for responsibility to rest with a single individual or agency. The child death review process has raised the collective awareness of all participants and has led to a clearer understanding of agency responsibilities and possibilities for collaboration on all efforts addressing child health and safety. It is only through continued collaborative work that we can hope to protect the health and lives of our children.

Panel Membership

The NDCFRP is a multidisciplinary, multi-agency, appointed panel (NDCC 50-25.1-04.2). 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.

The Panel members agree that no single agency or group working alone can determine how and why a child has died. The shared commitment is to work together to improve agency and community responses to child deaths and to identify prevention initiatives.

Members of the State Child Protection Team serve as the core members of the Child Fatality Review Panel. The core members include: designee of the Department of Human Services who serves as the presiding officer; representative of each of the following: child placing agency, the North Dakota Department of Health, North Dakota Attorney General's Office, North Dakota Department of Public Instruction, North Dakota Department of Corrections, and the lay community. Other appointed members include: the State Forensic Medical Examiner, a North Dakota licensed peace officer, a mental health professional, a physician, a representative of North Dakota Injury Prevention, a representative of Emergency Medical Services, and consultants invited to assist in review of specific cases. During the years of 2015 and 2016, NDCFRP was unable to recruit representatives to fill each vacant role and these efforts continue.

Panel Members 2015 and 2016

Marlys Baker – CFRP Presiding Officer
Child Protection Services Administrator,
ND Department of Human Services

Tracy Miller – CFRP Administrator
Children and Family Services,
ND Department of Human Services

Dr. Terry Dwelle, State Health Officer
ND Department of Health

Dr. William Massello,
State Medical Examiner
ND Department of Health

Mandy Slag, Injury Prevention Director,
ND Department of Health

Bobbi Peltier, Health Specialist
Indian Health Services

Jonathan Byers,
Assistant Attorney General
ND Attorney General's Office

Kris Dirk, Children and Family Services,
ND Department of Human Services

Duane Stanley, Special Agent
ND Bureau of Criminal Investigation

Dr. Scott Stephens, Pediatrician
Sanford Health

Shelly Arnold - Emergency Medical
Services - Trauma Services,
Sanford Health

Dr. Mary Ann Sens, Forensic Pathologist
UND School of Medicine & Health Services

Steve Kukowski, Sheriff
Ward County

Carol Meidinger,
Citizen Member

CPT Lisa Bjergaard, Director
Division of Juvenile Justice

CPT Karen Eisenhardt, Educator
Citizen Member

North Dakota Child Fatality Review Panel (NDCFRP) Recommendations

Sudden Unexplained Infant Death (SUID)

1. Consistent and uniform statewide reporting of sudden unexpected infant deaths; utilizing the completion of a Sudden Unexplained Infant Death Investigation Reporting Form (SUIDIRF) with the family after the death of an infant. The SUIDIRF guides investigators and standardizes data collection to assist in determining accurate cause of death.
2. Complete and thorough death scene investigations that include doll re-enactment.
3. Continue to get safe sleep information and education into the hands of parents and caregivers.
4. Educate the public that antihistamines, like Benadryl, should only be used with children over the age of two or when prescribed by a licensed medical provider.

Motor Vehicle Crashes

5. Address the societal issues of seat belts, distracted driving and alcohol/drug usage of teens by continuing education and media campaigns.
6. Educate the public regarding the dangers of children riding on or operating recreational vehicles including snowmobiles, All Terrain Vehicles (ATVs), Utility Terrain Vehicles (UTVs), and dirt bikes.
7. As part of the investigation, obtain cell phone records of the child to see if the child was using the phone (i.e. talking or texting) while driving.
8. Continue to promote child safety seat inspection programs and free or low cost car seat distribution.
9. Educate the public to increase booster seat usage for children fewer than 4 feet 9 inches.
10. Strengthen drivers licensing law for minors with primary enforcement including mandatory seat belt use for all occupants, nighttime driving restrictions and limits on the number of children passengers.
11. All children involved in a motor or recreational vehicle fatality receive an autopsy.

Medical/Reporting

12. Continue to train and educate the medical field on timely notification to child protective services when a child presents with trauma and where child abuse or neglect may reasonably be suspected.
13. Hospitals continue to use peer review as a means to examine trauma processes and protocols in regards to child injuries and death.

Suicide

14. Continue suicide prevention strategies to educate school personnel, parents, friends, and family members of adolescents on the signs and symptoms of depression, the risk factors for suicide, and the factors that may protect teens from suicide.
15. Develop a statewide suicide investigation protocol with Suicide Prevention, State Medical Examiner, and Law Enforcement.
16. Increase frequency of mental health screenings, including those in schools, to identify students with problems that could be related to suicide, depression and impulsive or aggressive behaviors.

Other

17. Educate the public on preventing carbon monoxide exposure; specifically the health effects of carbon monoxide, how to recognize the effects, identifying the sources of carbon monoxide in the home and promoting the installation of carbon monoxide detectors in all residences.
18. Public awareness to recognize drowning risks with emphasis on constant supervision of young children near water, the use of life preservers, not swimming alone or without adult supervision and the presence of a CPR trained person.

Table 1. Child Deaths in North Dakota, Calendar Year (CY) 2015-2016

	2015	**2016**
Total Child Deaths	101	98
Status B: deaths due to natural causes or that are not unexpected (i.e., long term illness).	57	56
Status A: Deaths that are sudden, unexpected, or unexplained	44	42
Status A: The 'death-causing' event occurs outside of North Dakota	2	0
Status A: In-State Child Deaths (in-Depth Reviews)	**42**	**42**

CHILD FATALITY CASES THAT RECEIVED AN IN-DEPTH REVIEW

Annual reports of the North Dakota Child Fatality Review Panel (NDCFRP) are based on cases reviewed by the panel for deaths that occurred during a calendar year. In some cases, annual reports are delayed due to a pending criminal investigation regarding a death.

Table 2. Child Deaths by Status, CY 2015-2016

	2015	2016
Status A	44	42
Status B	57	56
Total	101	98

Case Status

Each death certificate received from the Department of Health is reviewed by a Child Fatality Review Panel (CFRP) subcommittee. Each death is identified as a Status A case or a Status B case (Table 2). Status A cases are all cases of children whose death is sudden, unexpected, and/or unexplained, including natural deaths. 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 that are due to other natural causes. Status B cases may only be presented for review by the NDCFRP in a brief, general format in order to give all panel members an opportunity to request that the case be changed from Status B to Status A.

Table 3. Status 'A' Child Deaths by In-State and Out-of-State, CY 2015-2016

	2015	2016
In-State	42	42
Out-of-State	2	0
Total	44	42

In-State and Out-of-State Child Deaths

When the 'death-causing' event/injury is identified as occurring outside of the state, the death is considered an out-of-state child death. All other child deaths with North Dakota death certificates are considered in-state child deaths and are reviewed by the CFRP.

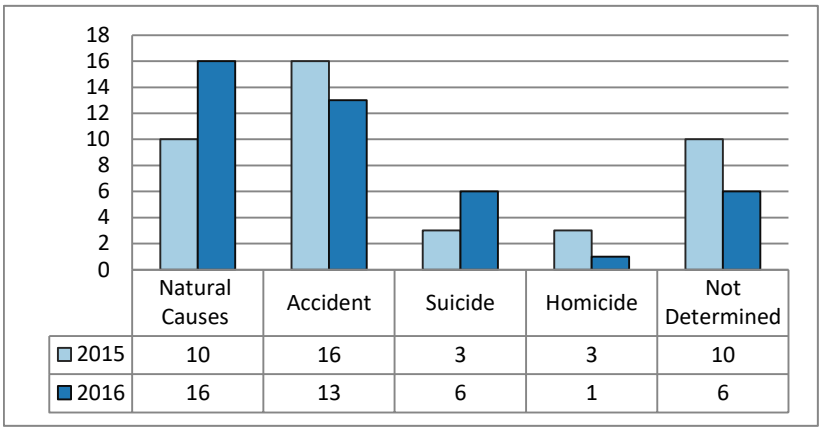
The NDCFRP conducts in-depth reviews of child deaths within the state that are sudden, unexpected, or unexplained. Compared to the 44 child deaths reviewed in 2014, the number of in-state sudden, unexpected, or unexplained deaths decreased by 4% in 2015 and 2016.

Manner of Death of Child in Cases that Received an In-Depth Review

North Dakota Death Certificates list the following five manners of death:

1. Natural,
2. Accident,
3. Suicide,
4. Homicide, or
5. Could Not Be Determined.

Figure 1. Number of Child Fatalities by Manner of Death, CY 2015-2016



The largest category for the manner of child death in 2015 was Accidents, which claimed the lives of 16 children (38%). This number decreased in 2016 to 13 children (31%) (Figure 1).

Unintentional injury deaths are commonly referred to as 'accidents' both by the general public and by manner of death as recorded on death certificates. The term accident implies that the death could not have been prevented. The NDCFRP prefers the term 'unintentional' because these deaths are predictable, understandable and preventable.

In 2016, deaths by natural causes (16, 38%) outnumbered child deaths from accidents (13, 31%). The percentage of accidental child deaths in 2016 (14.29%) was the lowest in ten years (Table 4).

Table 4. Manner of Death Accident CY 2007-2016

2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
19	13	20	18	14	18	13	14	16	13
46.34%	44.82%	46.51%	37.50%	28.00%	33.96%	34.21%	31.82%	23.81%	14.29%

There were no deaths reclassified by the Panel in 2015 and 2016.

The number of child deaths where the manner of death could not be determined had been steadily increasing and made up over a third of the cases reviewed in 2013 and 2014. However, as Table 5 shows, the counts and percentages of undetermined manner of death declined in 2015, making up (10, 23.8%) and 2016 (6, 14.29%) of the child deaths.

Table 5. Manner of Death Not Determined, CY 2007 – 2016

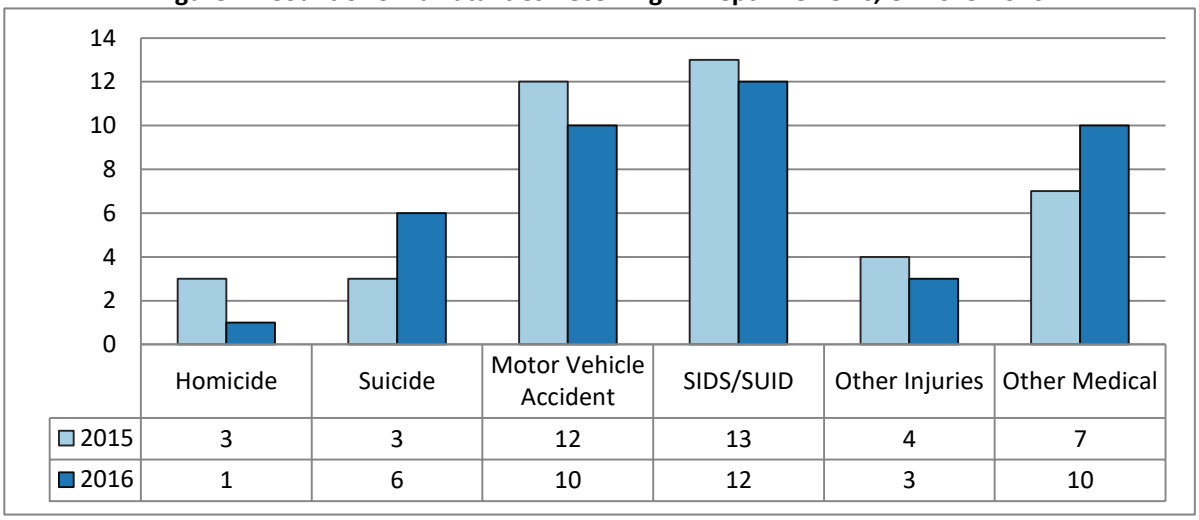
2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
3	6	7	4	9	11	13	15	10	6
7.30%	20.70%	15.60%	12.50%	17.00%	20.75%	34.21%	34.09%	23.81%	14.29%

Cause of Death in Cases that Received an In-Depth Review

In the years 2015 and 2016, the highest number of child fatalities with in-depth reviews had a cause of death of Sudden Infant Death Syndrome (SIDS) / Sudden Unexplained Infant Death (SUID) (29.7%) followed by motor vehicle accidents (26%)(Figure 2).

Unintentional child deaths accounted for (85.7%) of those reviewed (Figure 2).

Figure 2. Count of Child Fatalities Receiving In-Depth Reviews, CY 2015-2016



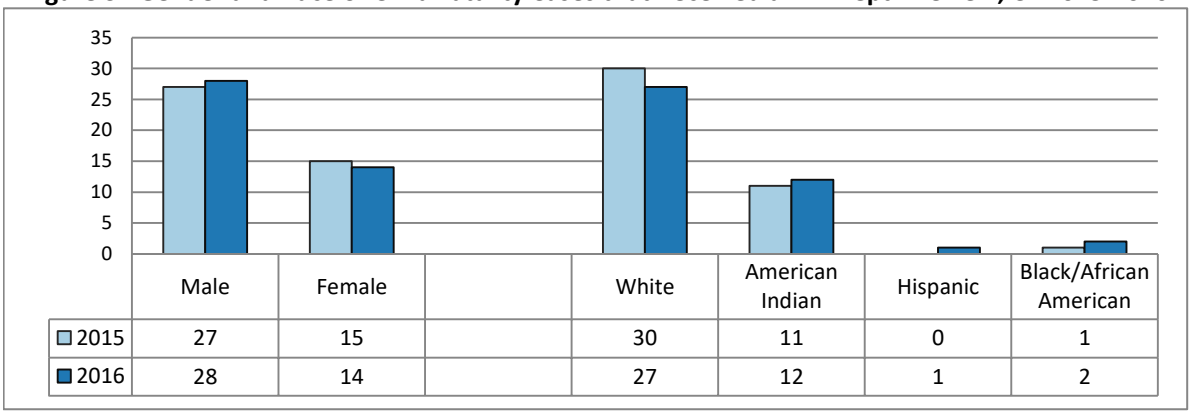
	Homicide	Suicide	Motor Vehicle Accident	SIDS/SUID	Other Injuries	Other Medical
2015	3	3	12	13	4	7
2016	1	6	10	12	3	10

Gender and Race of Child in Cases that Received an In-Depth Review

The child population in North Dakota is evenly matched with half male (51.3%) and half female (48.7%) (CDC[1]).

In 2015 and 2016, child fatalities among males (2015: 27, 64.3%; 2016: 28, 66.6%) were nearly double that of females (2015: 15, 35.7%; 2016: 14, 33.3%).

Figure 3. Gender and Race of Child Fatality Cases that Received an In-Depth Review, CY 2015-2016



	Male	Female		White	American Indian	Hispanic	Black/African American
2015	27	15		30	11	0	1
2016	28	14		27	12	1	2

In 2016, about one in 10 (9.68%) of children in North Dakota were American Indian (CDC[1]). In calendar years 2015 and 2016 about one in four child deaths reviewed were American Indian (Figure 3) which is an overrepresentation of this population.

[1] Vintage 2016 Bridged-Race Postcensal Population Estimates: pcen_v2016_y16
https://www.cdc.gov/nchs/nvss/bridged_race/data_documentation.htm#vintage2016

Age of Child in Cases that Received an In-Depth Review

The vast majority of child deaths occur with the very young, newborn to one year of age, (46.43%) and the older youth ages 15 to 18 years (19.05%) (Figure 4). Combined, the youngest and oldest children accounted for 55 of the 84 cases (65%) receiving in-depth reviews in 2015 and 2016.

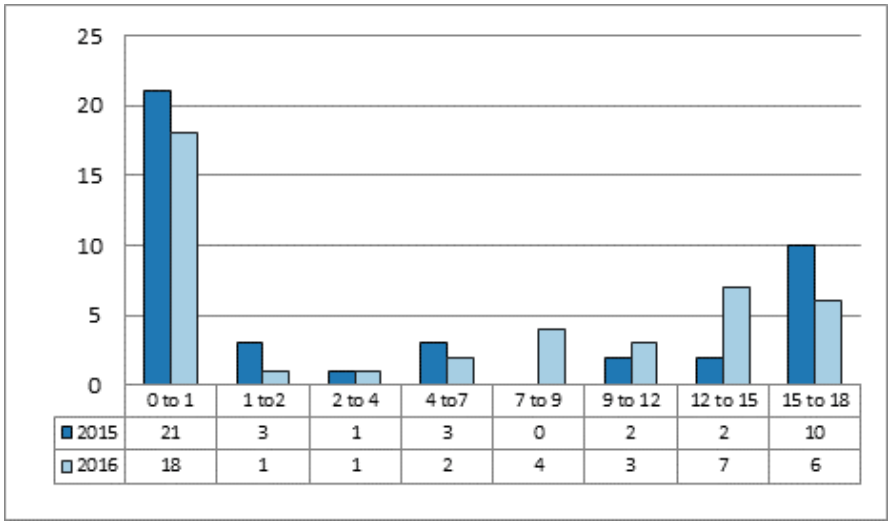
During 2015-2016, Sudden Unexplained Infant Death and Sudden Infant Death Syndrome were the leading causes of death in infants under one year of age.

In 2015, the leading cause of death for older youth ages 15 to 18 years was motor vehicle accidents (8, 80%). In five of these eight motor vehicle deaths, the youth was the operator of the vehicle.

In 2016, the leading cause of death for older youth ages 15 to 18 years was suicide (3, 50%).

Youth ages 12 to 15 years made up 17% of the cases that received in-depth reviews in 2016. The leading cause of death for this population in 2016 was suicide.

Figure 4. Count by Age in Child Fatality Cases that Received an In-Depth Review, CY 2015-2016



	0 to 1	1 to2	2 to 4	4 to7	7 to 9	9 to 12	12 to 15	15 to 18
2015	21	3	1	3	0	2	2	10
2016	18	1	1	2	4	3	7	6

CAUSES AND MANNERS OF CHILD FATALITY

VEHICULAR DEATHS

There were 22 vehicular child fatalities in 2015 and 2016; 12 in 2015 and 10 in 2016. Males represented 64% of the vehicular child fatalities (Table 6).

Youth ages 15 to 18 years continue to be the largest age group involved in vehicular fatalities (Table 6).

Table 9 shows the number and percent of vehicular child fatalities for the age group 15 to 18 years, by calendar year since 2007.

Table 6. Vehicular Child Fatalities by Gender, Age, and Race, CY 2015-2016

	2015	2016	Total
Males	8	6	14
Females	4	4	8
0 to 1	0	0	0
1 to2	2	0	2
2 to 4	0	1	1
4 to7	1	1	2
7 to 9	0	1	1
9 to 12	1	3	4
12 to 15	0	2	2
15 to 18	8	2	10
White	10	6	16
American Indian	2	3	5
Black/ African American	0	1	1
Total	12	10	22

Seat Belt Use / Safety Restraints

Of the 22 vehicular deaths, 12 (55%) involved children victims inside a moving vehicle.

Of the 12 deaths involving children inside a moving vehicle, only three (25%) were wearing a seat belt / safety restraint (Table 7).

Table 7. Seat Belt Use, CY 2015-2016

	2015	2016
Wearing seat belt	1	2
Not wearing seat belt	5	3
Seat belt use unknown	0	1
Seat belt not applicable	6	4
Total	12	10

'Seat belt not applicable' includes: recreational vehicles (i.e. snowmobiles, All Terrain Vehicles, dirt bikes), school bus passengers, farm equipment, pedestrians and bicycles. These account for 10 (45%) of the vehicular deaths in 2015-2016.

Table 9. Ages 15 to 18 Vehicular Child Fatalities for last 10 years

Calendar Year	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	10-yr Total
15 to 18	10	7	5	8	5	11	6	5	8	2	67
0-14	3	5	7	3	8	6	4	8	4	8	56

Victims outside of the moving vehicle (seat belt use not applicable) included:

- A 14-year-old riding a bicycle
- A 16-year-old operating a dirt bike
- A 10-year-old on a snowmobile
- A nine-year-old operating an ATV
- A 14-year-old pedestrian struck by a moving vehicle
- A five-year-old walking a bicycle struck by motor vehicle
- A 10-year-old operating a Utility Terrain Vehicle (UTV)
- A 5-year-old and two one-year-olds were struck by a vehicle operating in reverse

Position of Decedent in or out of the Vehicle

In ten of the 22 vehicular deaths, (45%) of youth were the operators of the vehicle (Table 8).

The average age of the driver was 14.7 years old.

Table 8. Position of Decedent, CY 2015-2016

	2015	2016
Driver	6	4
Passenger	3	4
Pedestrian/ Other	3	2
Total	12	10

Type of Vehicle

Of the 22 vehicular child fatalities in 2015 and 2016, 50% involved a motor vehicle. The most predominate type of motor vehicle involved was a car (18%). Trucks and SUVs each comprised 14% of the motor vehicle accidents (Table 10).

Recreational vehicles such as dirt bikes and ATVs were involved in 18% of motor vehicle fatalities.

Table 10. Vehicular Deaths by Type of Vehicle

	2015	2016
Motor Vehicle	7	4
Recreational Vehicle	2	2
Pedestrian	3	2
Bicycle	0	1
Airplane	0	1

SUDDEN INFANT DEATH SYNDROME (SIDS)
SUDDEN UNEXPLAINED INFANT DEATH (SUID)

According to the Centers of Disease Control and Prevention (CDC), in 2015, there were about 3,700 sudden unexpected infant deaths in the United States, of these 1,600 were due to SIDS, 1,200 deaths had an unknown cause and about 900 deaths were due to accidental suffocation and strangulation in bed.

According to the North Dakota Century Code 11-19.1-13, the term "sudden infant death syndrome" (SIDS) 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.

Per NDCC 11-19.1-13 Cause of death – Determination, a "sudden unexplained infant death" (SUID) is when all the above criteria for sudden infant death are not met or when a risk factor is identified or another cause cannot be ruled out.

A standardized reporting form, the Sudden Unexplained Infant Death Investigation Reporting Form (SUIDIRF), is to be completed as part of the death investigation. The SUIDIRF was developed by the US Center for Disease Control to aid in the determination of cause of death. For a medical examiner or coroner to determine the cause of the death, a thorough case investigation including an examination of the death scene, including a doll re-enactment, and a review of the infant's clinical history must be conducted. A complete autopsy needs to be performed, ideally using the information gathered from the scene investigation. Even when a thorough investigation is conducted, it may be difficult to separate SIDS from other types of sudden unexpected infant deaths (SUID), such as accidental suffocation.

Despite a major drop in SIDS since the Back to Sleep movement began in the early 1990's, declines in sudden unexpected infant death rates have slowed since 1998. SUID rates only decreased 7% from 1999 through 2015 as compared to 45% from 1990 through 1998. In recent years, sudden unexpected infant deaths are being classified less often as SIDS and more often as SUID or accidental suffocation as the result of an unsafe sleeping environment.

In 2015-2016, there were a total of 25 infant deaths identified as SIDS/SUID.

Nine infant deaths were identified as sudden infant death syndrome (SIDS).
Sixteen were identified as sudden unexplained infant death (SUID).

Males represented 72% of the sudden unexpected infant deaths. Of these 25 deaths, 52% were American Indian, 44% were White and 4% were Hispanic (Table 11). The number of child fatalities due to SIDS / SUID among American Indian children far overrepresented the total population.

Table 11. Child Fatalities Due to SIDS/SUID by Gender and Race, CY 2015-2016

	SIDS		SUID		
	2015	2016	2015	2016	Total
Males	1	4	7	6	18
Females	3	1	2	1	7
White	3	2	2	4	11
American Indian	1	2	7	3	13
Hispanic	0	1	0	0	1
Total	4	5	9	7	25

Over the five year period, 2012 to 2016, 58 child fatalities were due to SIDS / SUID. Each year, there are more SUID than SIDS deaths. Because the counts are small and because they fluctuate from year to year, a trend is not discernible (Table 12).

Table 12. Child Fatalities Due to SIDS/SUID, CY 2012 -2016

	2012	2013	2014	2015	2016	5-yr Total
SIDS	4	0	3	4	5	16
SUID	7	8	11	9	7	42

The age where the number of SIDS / SUID deaths peaked was three months (32%). Ages one to five months made up 84% of all the SIDS / SUID deaths (Figure 5).

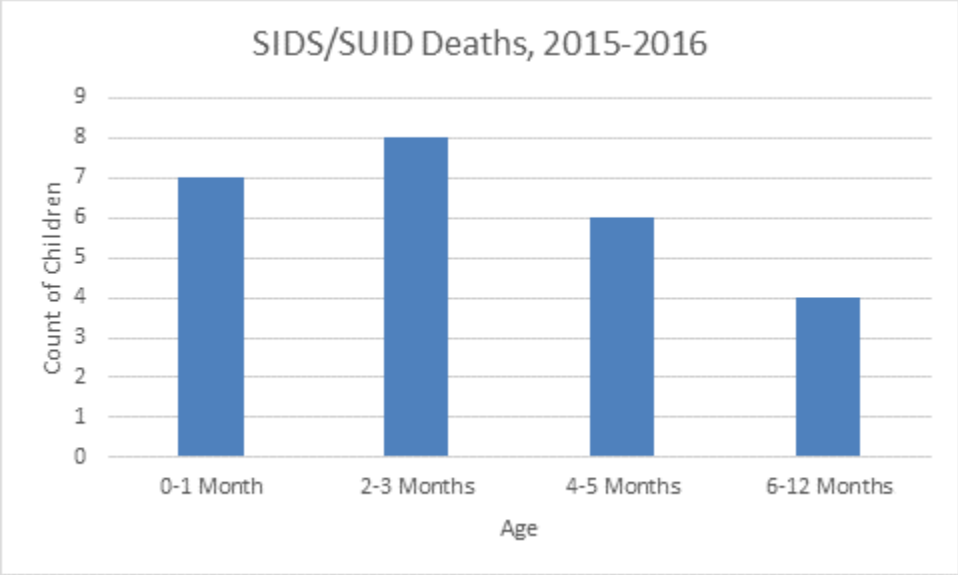


Figure 5. Total Child Fatalities from SIDS / SUID by Age, CY 2015-2016

The most common risk factor for SUID identified by the Panel was an unsafe sleep environment for the infant. An unsafe sleep environment may include one or more of the following whereby the infant was: placed to sleep on their stomach; co-sleeping with others; sleeping with multiple blankets and/or pillows.

Of the 16 Sudden Unexplained Infant Deaths reviewed in calendar year 2015 and 2016:

- 63% were prenatally exposed to a controlled substance
- 50% were sleeping with multiple blankets
- 44% were co-sleeping with an adult in a standard bed
- 38% were discovered on their stomach

OTHER INJURIES (Unintentional / Preventable)

Child fatalities in 2015 and 2016 reviewed by the NDCFRP with death due to other injuries were attributed to asphyxia (2), drowning (2), firearm, carbon monoxide poisoning and fire. Of the seven fatalities due to other injuries; the manner of death was recorded as accident and preventable in all seven cases.

The two unintentional asphyxia deaths were the result of unsafe sleeping environments.

OTHER CONDITIONS INCLUDING MEDICAL (Unintentional)

Of the 84 child fatality deaths reviewed in 2015 and 2016, about 20% (17) of the deaths were due to other conditions including medical reasons and of these:

- 65% were under age two
- 65% the manner of death was natural and determined to be unpreventable
- 35% preventability could not be determined

Of the child fatalities where the death was due to other conditions, including medical, 59% of the children were male, 53% were less than one year of age, and 76% were White (Table 13).

Table 13. Child Fatalities Due to Other Medical by Gender, Race, and Age, 2015-2016

	2015	2016
Males	5	5
Females	2	5
0 to 1	4	5
1 to2	1	1
2 to 4	1	0
4 to 7	0	1
7 to 9	0	3
9 to 12	1	0
12 to 15	0	0
15 to 18	0	0
White	7	6
American Indian	0	3
Black or African American	0	1
Total	7	10

Table 14. Child Fatalities Due to Injury/Medical by Year, CY 2007 - 2016

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Other Injury	6	3	7	8	5	6	6	7	4	3
Other /Medical	5	4	7	10	8	8	7	3	7	10

Homicides and Suicides

The number of child fatalities due to homicide for 2015-2016 was four.

As Table 15 shows, the number of male homicide victims for 2015-2016 (75%) triples that of females (25%). In addition, 67% of the suicide victims were male as compared to female (3, 33%).

Homicides were results of blunt force head injury (2), asphyxia (1), and firearms (1).

The number of child fatalities due to suicide for 2015-2016 was nine.

Of the nine suicides, four were by hanging, four were by firearm, and one by the child overdosing on prescription medication.

Table 15. Child Fatalities by Suicide and Homicide by Gender, Age, Race, CY 2015-2016

	Homicide		Suicide	
	2015	2016	2015	2016
Males	2	1	1	5
Females	1	0	2	1
0 to 1	3	0	0	0
1 to 2	0	0	0	0
2 to 4	0	0	0	0
4 to 7	0	0	0	0
7 to 9	0	0	0	0
9 to 12	0	1	0	0
12 to 15	0	0	2	4
15 to 18	0	0	1	2
White	1	1	2	5
Black or African American	1	0	0	0
American Indian	1	0	1	1
Total	3	1	3	6

The NDCFRP determined all but one of the homicide and suicide deaths were preventable on a systems level.

The number of suicides tripled from each of the years 2007 and 2008 to 2010 (Table 16). From 2010-2015, the number of suicides remained more than double that of 2007 and 2008. In 2015, the number of suicides decreased by half, marking the year as the lowest for child suicide since 2008 (Table 16).

The average age at which most of the suicides occurred was 13 years (44%).

Seventy-eight percent of the suicide victims were White.

Table 16. Child Fatalities by Homicide/Suicide, CY 2007-2016

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Suicide	3	3	4	9	7	6	6	6	3	6
Homicide	3	2	4	2	4	5	1	1	3	1

PREVENTABLE DEATHS

The Panel 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 could be made to prevent these deaths, for instance changes in policy, practice and law. The majority (81%) of child deaths reviewed by the Panel in 2015 and 2016 were preventable. The Panel concluded the preventability for the majority of sudden unexplained infant deaths to be undetermined (80%), but did identify multiple risk factors which can increase the risk for sudden infant death. About a third of the preventable deaths were motor vehicle related (32%). The second largest number of preventable child deaths was due to suicide.

Table 17. Panel Determination of Preventability and Intentionality, CY 2015-2016

			Preventable			Non-Preventable	Preventability Undetermined	Total
			Intentional	Unintentional	Intention Undetermined			
2015	Cause of Death	Homicide	2	1	0	0	0	3
		Suicide	2	0	0	1	0	3
		Motor Vehicular	0	12	0	0	0	12
		SIDS/SUID	0	0	0	1	12	13
		Other Medical	0	1	0	4	2	7
		Asphyxia	0	1	0	0	0	1
		Drowning	0	1	0	0	0	1
		Fire/Burns	0	1	0	0	0	1
		Firearms	0	0	0	0	0	0
		Poison/Overdose	0	1	0	0	0	1
2016	Cause of Death	Homicide	1	0	0	0	0	1
		Suicide	6	0	0	0	0	6
		Motor Vehicular	0	10	0	0	0	10
		SIDS/SUID	0	0	0	4	8	12
		Other Medical	0	0	0	6	4	10
		Asphyxia	0	1	0	0	0	1
		Drowning	0	1	0	0	0	1
		Fire/Burns	0	0	0	0	0	0
		Firearms	0	1	0	0	0	1
		Poison/Overdose	0	0	0	0	0	0

CHILD ABUSE AND NEGLECT DEATHS AND NEAR DEATHS

According to NDCC 50-25.1-04.5 and Section 106(b)(2)(B)(x) of the Federal Child Abuse Prevention and Treatment Act, the annual report involving child abuse and neglect deaths and near deaths must include the following in each case of a child fatality or near fatality:

- the cause of and circumstances regarding the fatality or near fatality
- 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 by and the actions of the State on behalf of the child that are pertinent to the child abuse or neglect that led to the fatality, in accordance with section NDCC 50-25.1-06, unless disclosure is otherwise prohibited by law

Deaths due to Child Abuse and Neglect

Note: The child abuse and neglect determination date defines the reporting calendar year for each of the following child abuse and neglect deaths and near deaths.

2015

A two-month-old female died of Positional Asphyxia during unsafe sleep, manner of death is Accident. There were no 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 infant's death. The reports were combined into one assessment. An assessment determination of "Services Required" was made for fatal neglect. In home case management, foster care case management, safety permanency funds, supervised visitation, parental capacity evaluations, mental health services, transportation assistance, parent aide services, parenting education, and domestic violence services were provided.

A two-month-old female died of Homicide due to Asphyxia by Strangulation. There were no previous reports of child abuse and neglect that pertained to the death. Three reports of child abuse and neglect were received as a result of the death. The reports were combined into one assessment. An assessment determination of "Services Required" was made for fatal neglect/physical neglect due to caregiver capacity concerns. No services were offered or provided.

A one-year-old male died of Global Anoxic Brain Injury due to immersion drowning in a bathtub; the manner of death is Accident. There was one previous report of child abuse and neglect that pertained to the neglect leading to the child's death. The assessment determination for this report was "No Services Required." One report of child abuse and neglect was received as a result of the death. An assessment determination of "Services Required" was made for fatal neglect. No services were provided.

A five-year-old female died of Anoxic Encephalopathy as a result of drowning; the manner of death is Accident. There were no previous reports of child abuse and neglect that pertained to the death. Three reports of child abuse and neglect were received as a result of the child's death. The reports were combined into one assessment. An assessment determination of "Services Required" was made for fatal neglect and physical neglect; inadequate supervision. No services were provided.

2016

A six-month-old male died of Homicide from complications of Blunt Force Craniocerebral Injury. There were no 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 injuries and subsequent death. The reports were combined into one assessment. An assessment determination of "Services Required" was made for fatal physical abuse, however, the subject of this assessment was unknown. No services were offered or provided.

A two-month-old male infant died of Homicide due to Blunt Force Head and Cervical Spine Trauma. There were no previous reports of child abuse and neglect that pertained to the death. A report of child abuse and neglect was received as a result of the child's death. An assessment determination of "Services Required" was made for fatal abuse. Foster care case management, in-home case management, supervised visitation and mental health services were provided.

A nine-year-old male died of Craniocerebral Trauma as a result of an all-terrain vehicle accident; the manner of death is Accident. There were no previous reports of child abuse and neglect that pertained to the death. A report of child abuse and neglect was received as a result of the child's death. An assessment determination of "Services Required" was made for fatal neglect. Foster care case management services were provided.

Near Deaths due to Child Abuse and Neglect

2015

A 10-month-old female presented at the hospital after being found unresponsive. Non-accidental head trauma was established. There was one previous report of child abuse and neglect that pertained to the near death; the case determination was "No Services Required." A report of child abuse and neglect was received regarding the child's near death. An assessment determination of this report was "Services Required" for physical abuse and medical neglect. Foster care case management, in-home case management, supervised visitation, intensive in-home therapy, infant development services, safety permanency funds and adoption services were provided.

A seven-month-old male presented to the hospital because he was losing weight and had regressed in developmental milestones. Nonaccidental head trauma was diagnosed. There were no previous reports of child abuse and neglect that pertained to the near death. A report of child abuse and neglect was received regarding the near death. An assessment determination of this report was "Services Required" for physical abuse by an unknown subject. Foster care case management, in-home case management, supervised visitation, kinship placement, developmental disabilities case management, and transportation assistance were provided.

A six-month-old male presented to the hospital with multisystem trauma, including a fractured skull and ribs. There was one previous report of child abuse and neglect that pertained to the near death. The assessment determination was "No Services Required." One report of child abuse and neglect was received as a result of the child's near death. An assessment determination of this report was "Services Required" for physical neglect; failure to protect and caregiver capacity concerns. Foster care case management, child care, safety permanency funds, family group decision making, supervised visitation, infant development services, developmental disabilities case management services, and in-home case management services were provided.

A newborn male was prenatally exposed to methamphetamine, opiates, and marijuana and the mother's active drug usage had a direct impact on the newborn. As a result, a report of child abuse and neglect was received. An assessment determination of this report was "Services Required" for physical neglect. The services provided were foster care case management, supervised visitation, developmental disabilities case management services, infant development, and substance abuse treatment services. There were three prior reports of child abuse or neglect that pertained to the near death. Three assessments were completed with two having a determination of "Services Required" for physical neglect. The services provided for these assessments were foster care case management, family team decision making, mental health services, child care, and supervised visitation.

A three-year-old male child was brought to the hospital after being kicked in the head by a horse causing significant facial trauma and a traumatic brain injury. There was one previous report of child abuse and neglect that pertained to the near death. An assessment was completed and had a determination of "No Services Required." One report of child abuse and neglect report was received as a result of the child's near death. An assessment determination of this report was "Services Required" for physical neglect; inadequate supervision. In-home case management services were provided.

2016

A five-month-old female was admitted to the hospital due to injuries consistent with Shaken Baby Syndrome and Failure to Thrive. As a result, two child abuse and neglect reports were received. Child protection services had previously received two reports of child abuse and neglect and all four reports were combined into one assessment. The assessment determination was "Services Required" for physical abuse and nutritional neglect. There were no previous reports of child abuse and neglect that pertained to the near death. The services provided were foster care case management, family team decision making, developmental disability case management services and adoption.

A two-year-old female was admitted to the hospital with nonaccidental head trauma. A review of her growth chart revealed the child had gained only a pound in the past year. Five reports of child abuse and neglect were received regarding the child's injuries and poor weight gain. The five reports were combined into one assessment. The assessment determination was "Services Required" for physical neglect; failure to protect and psychological maltreatment. There were no previous reports of child abuse and neglect that pertained to the child abuse and neglect that caused the near death. The services provided were foster care case management and infant development services.

A four-month-old female was admitted to the hospital due to a skull fracture, retinal hemorrhages and bleeding of the brain. There were no previous reports of child abuse and neglect that pertained to the near death. As a result of the infant's injuries, a child abuse and neglect report was received. An assessment determination of this report was "Services Required" for physical abuse by an unknown subject. The services provided were foster care case management, in-home case management, infant development, developmental disabilities case management, relative placement, supervised visitation and parenting education.

A two-year-old male was admitted to the hospital after being found unresponsive in a swimming pool. As a result, two reports of child abuse and neglect were received. The reports were combined into one assessment and the case determination was "Services Required" for physical neglect; inadequate supervision and failure to protect. There were no previous reports of child abuse and neglect that pertained to the child neglect that caused the near death. The services provided were in-home case management, mental health services, developmental disability case management, infant development, parenting education and relative placement.

LONG TERM TRENDS

Table 18. Child Deaths by Status, CY 2007-2016

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Status A Deaths[1]	45	36	52	53	56	55	40	46	44	42
Status B Deaths[2]	56	47	43	40	42	44	61	40	57	56
Total Child Deaths[3]	101	83	95	93	98	99	101	86	101	98
In-State Child Deaths[4]	**41**	**40**	**43**	**48**	**53**	**53**	**38**	**44**	**42**	**42**
Out-of-State Child Deaths[5]	13	9	9	5	3	2	2	2	2	0

[1]Status A cases consist of all cases of children whose death is sudden, unexpected, and/or unexplained.
[2]Status B cases are deaths that are not unexpected (i.e., long term illness) and/or deaths that are due to natural causes. (Review of death certificate only)
[3]From all causes.
[4]Child deaths with North Dakota death certificates that were reviewed in depth by the NDCFRP.
[5]The 'death-causing' event/injury is identified as occurring outside of North Dakota. They were not reviewed in depth by the NDCFRP.
SOURCE: Child Fatality Review Panel

Table 19. Changes in North Dakota Child Population and Child Deaths, CY 2012 to 2016

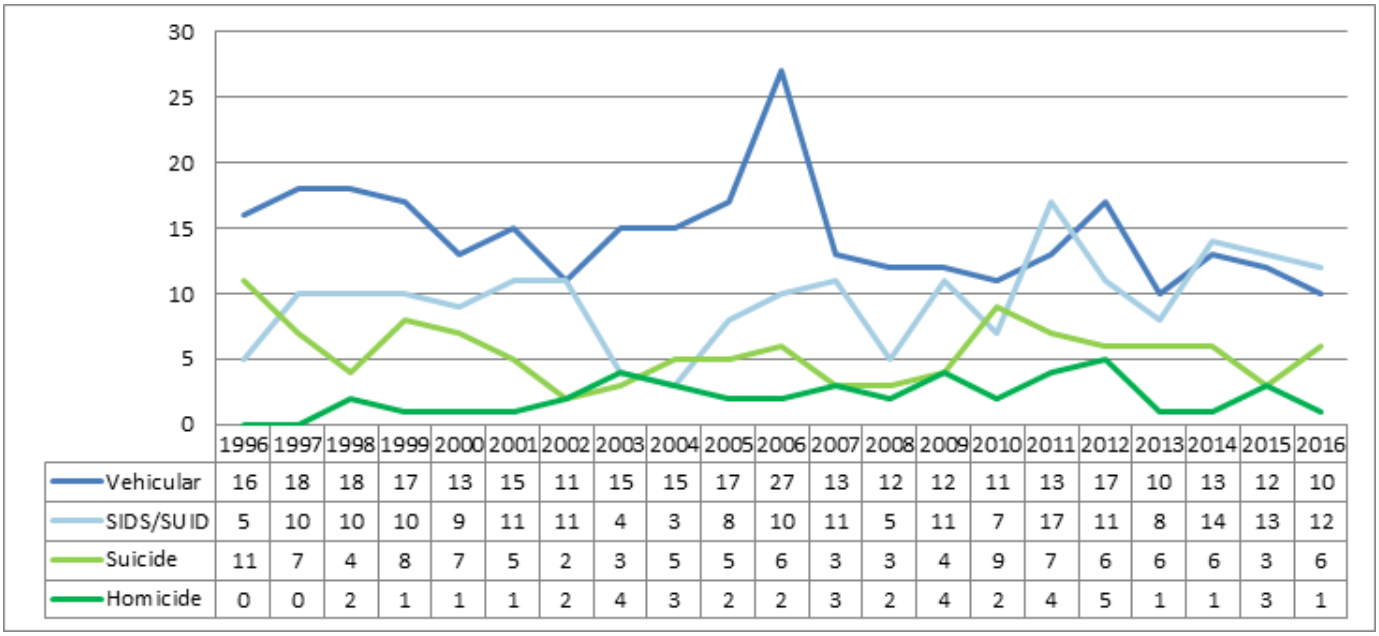
	Population Under age 18	Difference from Previous Year	% Difference of Child Population from Previous Year	Child Deaths	Difference in Child Deaths from Previous Year	% Difference of Child Deaths from Previous Year
2012	157,276	4,657	2.96%	99	1	1.01%
2013	163,429	6,153	3.76%	101	2	1.98%
2014	168,815	5,386	3.19%	86	-15	-17.44%
2015	174,411	5,596	3.21%	101	15	17.44%
2016	176,311	1,900	1.08%	98	-3	-2.97%

Source of Population Data: CDC[1]

In 2015, there was a 3.21% child population increase from 2014 and a 17.44% increase in child deaths. Therefore, North Dakota child fatalities increased at a higher percentage rate than the child population increased. As shown in Table 19, the year 2014 was an atypical year with 86 child fatalities; child deaths have consistently been about 100 a year, 2014 was the exception.

In 2016, there was a 1.08% child population increase from 2015, however, the number of child deaths decreased by 2.97%. Thus, while the child population grew, there was a reduction in child deaths.

Figure 6. Number of In-Depth Child Fatality Reviews by Selected Manner of Death, CY 1996-2016



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Vehicular	16	18	18	17	13	15	11	15	15	17	27	13	12	12	11	13	17	10	13	12	10
SIDS/SUID	5	10	10	10	9	11	11	4	3	8	10	11	5	11	7	17	11	8	14	13	12
Suicide	11	7	4	8	7	5	2	3	5	5	6	3	3	4	9	7	6	6	6	3	6
Homicide	0	0	2	1	1	1	2	4	3	2	2	3	2	4	2	4	5	1	1	3	1

The number of deaths attributed to vehicular, SIDS / SUID, suicide, and homicide are shown for the years 1996 to 2016 in Figure 6. The year 2006 saw a dramatic spike in vehicular child deaths (27). Motor vehicle fatalities contributed to the highest number of total child deaths receiving an in depth review a year from 1996 to 2010. In 2011 and since 2014, child fatalities due to SIDS / SUID have outnumbered those of motor vehicle fatalities.

CONTINUED EFFORTS

Many child deaths are preventable and every citizen can play a role in reducing child fatalities.

The majority (81%) of child deaths reviewed by the Panel in 2015 and 2016 were preventable. A vast majority of the preventable child deaths are motor vehicle related deaths. Currently, laws are in effect which restrict minors with driving permits and safety restraint use. Societal issues such as excessive speed, alcohol and drug involvement, and failure to use seat belts contributed to the vehicle related deaths in 2015 and 2016. Issues such as young drivers of recreational vehicles, adolescent seat belt use, and limits on child passengers are not addressed by current strategies. Effective social marketing and education focused on injury prevention and safety concepts may benefit parents and North Dakota adolescents. The number of teen suicide deaths in the state is concerning and each death highlights the need for continued education and prevention. Strategies for prevention include education for school personnel, parents, friends, and family members of teens on the signs and symptoms of depression, the risk factors for suicide, and the factors that may protect teens from suicide. This education must include information on how to access community mental health resources and what to do if someone is concerned about a youth.

The Panel, with interagency support, must continue to find a way to promote increased cooperation and access to records across all jurisdictions.

The Panel's ability to access relevant records for review remained a challenge in 2015-2016. In 6% of the cases in which the Panel requested information from the appropriate agencies, their requests went unheeded. Progress has been made within regards to this effort and continues with increased cooperation.

North Dakota law (NDCC 50-25.1-04.4) provides that, 'Upon the request of a coroner or the presiding officer of a NDCFRP, any hospital, physician, medical professional, medical facility, mental health professional, or mental health facility 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).

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 during the preceding six months and to identify trends or patterns in the deaths of minors'" (NDCC 50-25.1-04.3) 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.

The Panel continues to strive to ensure all child deaths receive a thorough and comprehensive investigation.

Even though there has been an observable increase in the quality of scene investigation in cases of infant death since the inception of the Panel, 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. 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. Information regarding the child and family history, abuse, violence, alcohol and drug use, mental health issues, domestic violence and other such issues are 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.

The Panel has also become concerned that child victims of vehicle fatalities are not always identified as a coroner case and as a result an autopsy is not performed. According to state law, any person who acquires first knowledge of the death of any minor, when the minor died suddenly when in apparent good health, shall immediately notify law enforcement and the office of coroner of the known facts concerning the time, place, manner, and circumstances of the death (NDCC 11-19.1-07). There were 12 vehicular deaths in 2015; four of them did not receive an autopsy. Of the 10 vehicular deaths in 2016, two did not receive an autopsy.

The Panel will continue to promote increased statewide quality of child death investigations and interagency communication.