NORTH DAKOTA CHILD FATALITY REVIEW PANEL

DETAILED ANNUAL REPORT

2017, 2018 & 2019

June 2023

CHILDREN AND FAMILY SERVICES DIVISION
600 EAST BOULEVARD AVENUE, DEPARTMENT 325
BISMARCK, NORTH DAKOTA 58505-0250

To obtain additional copies, please phone (701) 328-3580.

Report By:
Jenn Grabar
Children and Family Services
jjgrabar@nd.gov
701-328-1863

Data Compiled by:
Jessica Van Neste
NDIT Data Analytics Team
jvanneste@nd.gov
701-328-8705

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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 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.

This Child Fatality Review Annual Report was compiled in June 2023 and presents information from the in-depth reviews of child deaths that occurred in calendar years 2017-2019. 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 Child Fatality Review Panel 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 Child Fatality Review Panel 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.

Child Fatality Review 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.

The members include a designee of the Department of Human Services from Child Protection 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. It is noted the Department of Health and Human Services were operating as separate divisions and merged into the Department of Health and Human Services in September 2022.

Panel Members 2017, 2018 and 2019

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

Tracy Miller – Prevention (2017, 2018)
Children and Family Services,
ND Department of Human Services

Jenn Grabar, CFRP Administrator
Child Protection Services
ND Department of Human Services

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, (2017, 2018)
Assistant Attorney General
ND Attorney General's Office

Paul Emerson, (2019)
ND Attorney General's Office

Duane Stanley, Special Agent
ND Bureau of Criminal Investigation

Dr. Melissa Seibel, Pediatrician
Sanford Health

Todd Porter, (2019)
Emergency Medical Services,
Metro Ambulance

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

Dr. Tracy Miller, (2019)
Epidemiologist
ND Department of Health

Carol Meidinger,
Citizen Member

Lisa Bjergaard, Director
Division of Juvenile Justice

Karen Eisenhardt, Educator
Citizen Member

Kris Dirk, Children and Family Services,
(2017)
ND Department of Human Services

North Dakota Child Fatality Review Panel (NDCFRP) Recommendations

Sudden Unexpected Infant Death (SUID)

1. Consistent and uniform statewide reporting of the sudden and unexpected death of infant; utilizing the completion of a SUIDI reporting form with the family / caregiver after the death of an infant.
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. The information should include the dangers of placing an infant on their stomach for sleep; the dangers of infants sleeping in car seats outside of the vehicle without the approved car seat base; the dangers of bed, couch and recliner sharing, particularly when the caregiver may be impacted by exhaustion or sedating substances as well as the dangers to infants prenatally or environmentally exposed to alcohol or controlled substances, particularly how it increases their vulnerability to sudden infant death.
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 that target not just new drivers but also those caregivers of new drivers that act as role models for appropriate driving behavior.
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, including the utilization of helmets and safety gear.
7. As part of the death 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. Educate the public about safety in and around vehicles with an emphasis on performing a walk-around the vehicle before placing it in reverse.
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 regard 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 children from suicide.
15. Develop a statewide suicide investigation protocol with Behavioral Health - 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.
17. Develop a statewide approach to firearm safety education and awareness that includes an examination of firearm safety messaging, addresses the barriers to easy access and develops public awareness for all gun owners with an emphasis on suicide preventability through utilization of proper gun storage.

Other

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, the presence of a CPR trained person and how to recognize and respond to a swimmer in trouble.
19. Abusive head trauma evidence-based prevention program, the Period of Purple Crying, to be provided to parents and caregivers of newborns through the birthing hospital, healthcare providers, home visitation programs, childcare providers, parenting resource centers, child welfare and private and public providers.
20. Educate the public regarding fire prevention including proper maintenance and regular testing of smoke alarms, possession of working fire extinguishers and training on how to properly use them; utilization of appropriate extension cords as directed; safe storage of smoking materials, lighters and matches in a location that children cannot access and teaching children never to play with these items. As well as community-wide education and promotion of fire escape plans to be created with all families / household occupants, and that the fire escape plan is regularly practiced and includes two ways of escape from every room in the home and education on what to do if a fire occurs in the home.

Table 1. Child Deaths in North Dakota, CY 2017-2019

	2017	2018	2019
Total Child Deaths	90	95	115
Status B: deaths due to natural causes or that are not unexpected (i.e., long term illness).	55	42	61
Status A: Deaths that are sudden, unexpected, or unexplained	35	53	54
Status A: The 'death-causing' event occurs outside of North Dakota	0	2	3
Status A: In-State Child Deaths (in-Depth Reviews)	**35**	**51**	**51**

CHILD FATALITY CASES THAT RECEIVED AN IN-DEPTH REVIEW

Annual reports of the Child Fatality Review Panel (CFRP) 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 or prosecution regarding a death.

Case Status

Each death certificate received from the Department of Health Vital Records 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).

Table 2. Child Deaths by Status, CY 2017-2019

	2017	2018	2019
Status A	35	53	54
Status B	55	42	61
Total	90	95	115

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 Child Fatality Review Panel 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.

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. When the 'death-causing' event/injury is identified as occurring in North Dakota, however the child was transferred out of state for treatment and died out of state, the death is then categorized as a Status A or Status B case.

Table 3. Status 'A' Child Deaths by In-State and Out-of-State, CY 2017-2019

	2017	2018	2019
In-State	35	51	51
Out-of-State	0	2	3
Total	35	53	54

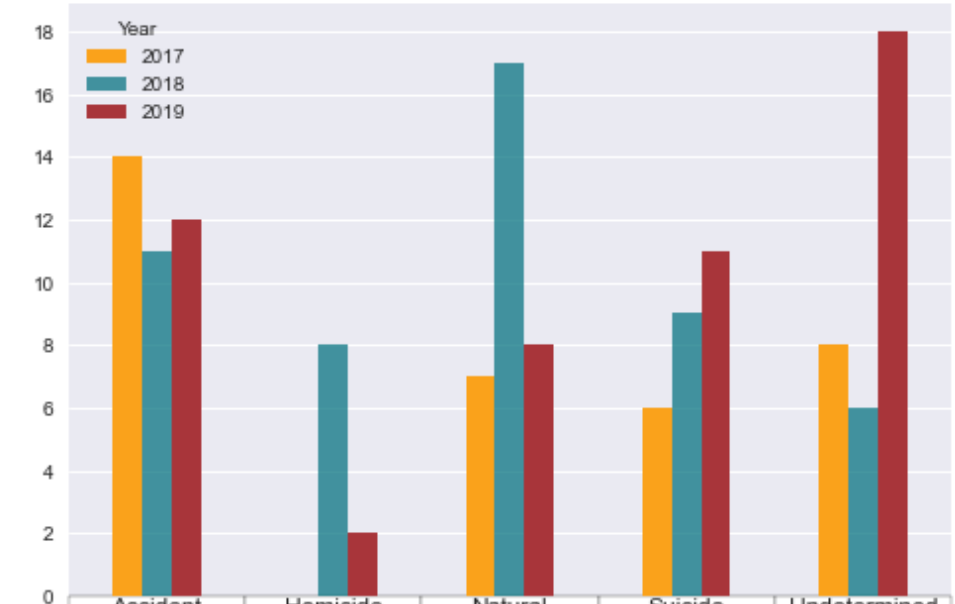
The Child Fatality Review Panel conducts in-depth reviews of Status A deaths, those that are sudden, unexpected, or unexplained. Compared to the 42 child deaths reviewed in 2015 and 2016, the number of in-state sudden, unexpected, or unexplained deaths decreased by 17% in 2017. However, child deaths reviewed increased by over 30% from 2017 to 2018 and 2019 (Table 3).

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. Undetermined.

Figure 1. Number of Child Fatalities by Manner of Death, CY 2017-2019



	Accident	Homicide	Natural	Suicide	Undetermined
2017	14	0	7	6	8
2018	11	8	14	9	9
2019	12	2	7	11	19

The largest category for the manner of child death in 2017 was Accidents, which claimed the lives of 14 children (40%). This number decreased in 2018 to 11 children (22%) and 12 children (24%) in 2019 (Table 4).

Table 4. Manner of Death Accident for Years 2010-2019

2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
18	14	18	13	14	16	13	14	11	12
37.50%	28.00%	33.96%	34.21	31.82	23.81	14.29	40.00%	21.57%	23.53%

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 2018, deaths by natural causes (14, 27%) outnumbered child deaths from accidents (11, 22%).

In 2019, deaths where the manner was 'undetermined' (19, 37%) made up a majority of the child deaths.

In 2017, the Panel reclassified 1 death from 'natural' to 'undetermined.'

In 2018, the Panel reclassified 7 deaths: changing 2 from 'undetermined' to 'homicide'; and 5 from 'natural' to 'undetermined'.

In 2019, the Panel reclassified 8 deaths: changing 7 from 'natural' to 'undetermined' and 1 from 'undetermined' to 'homicide'.

One 2019 death is not included in this report as it remains under investigation and the records have not yet been received by the Panel.

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. As Table 5 shows, the count and percentage of undetermined manner of death declined in 2015 (10, 23.81%) and 2016 (6, 14.29%). However, this increased in 2017 (8, 22.86%), decreased slightly in 2018 (9, 17.64%) and by 2019, deaths where the manner could not be determined made up over a third of the child deaths (19, 37.25%).

Table 5. Manner of Death Not Determined for Years 2010–2019

2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
4	9	11	13	15	10	6	8	9	19
12.50%	17.00%	20.75%	34.21%	34.09%	23.81%	14.29%	22.86%	17.64%	37.25%

The majority of child deaths with a classified manner of 'undetermined' were infants and the cause of death was related to hazards present in the infant's sleep environment.

In 2019, the National Association of Medical Examiners (NAME) Panel on Sudden Unexpected Death in Pediatrics[1], 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[2] and extrinsic[3] risk factors were identified as contributing factors to the death; the manner of death in these situations is then classified as 'Undetermined'.

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

[2] 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)."

[3] 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.

The increase in 'undetermined' deaths is due to the reclassification of infant deaths with a manner of death as 'natural' and cause of death as SIDS, but in which the Panel identified extrinsic factors, thus resulting in the reclassification to 'undetermined.' This is also reflected in Table 13.

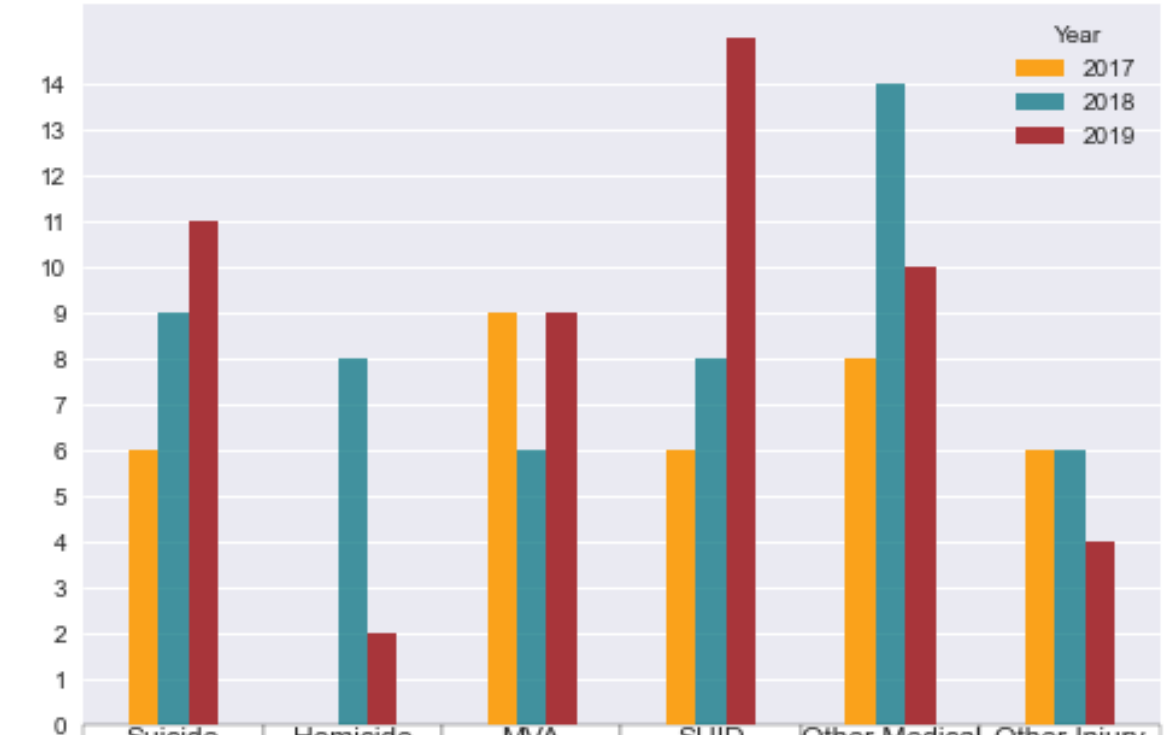
Cause of Death in Cases that Received an In-Depth Review

In 2017, the highest number of child fatalities with in-depth reviews had a cause of death of motor vehicle accident (25.7%), followed by deaths from other medical causes (22.8%).

In 2018, the largest percentage were child deaths by other medical causes (27.4%), followed by suicide (17.6%).

In 2019, the greatest number of child fatalities had a cause of death of Sudden Unexpected Infant Death (SUID) (29.4%), followed by suicide (21.5%) (Figure 2).

Figure 2. Count of Child Fatalities Receiving In-Depth Reviews, CY 2017-2019



	Suicide	Homicide	MVA	SUID	Other Medical	Other Injury
2017	6	0	9	6	8	6
2018	9	8	6	8	14	6
2019	11	2	9	15	10	4

Unintentional child deaths accounted for (73.7%) of those reviewed (Figure 2).

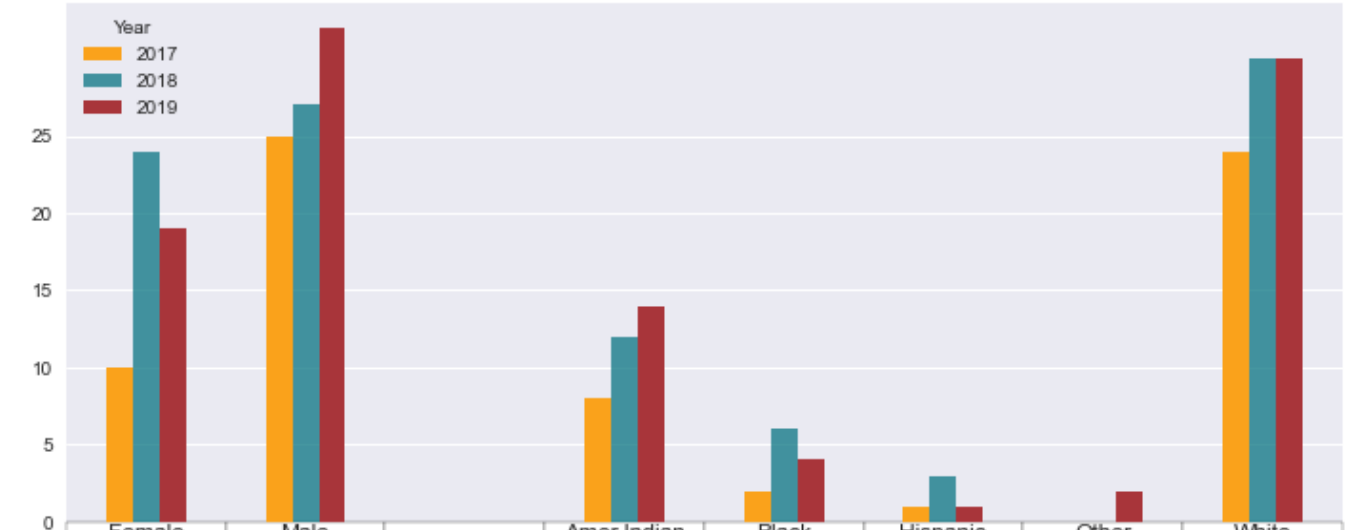
Gender and Race of Child in Cases that Received an In-Depth Review

The child population in North Dakota is evenly matched with half male (51.1%) and half female (48.9%) (CDC[4]).

In 2017, 2018 and 2019, there were more male child fatalities than female. In 2017, child fatalities among males (25, 71.4%) were almost triple that of females (10, 28.6%). In 2018, the gender of child fatalities was closer to that of the population (males: 27, 52.9%; females: 47.1%). In 2019, child fatalities among males (32, 62.7%) were almost double that of females (37.3%) (Figure 3).

In 2018 about one in ten (9.97%) of children in North Dakota were American Indian (CDC) In 2017-2019 about one in four child deaths reviewed were American Indian (Figure 3) which is an over-representation of this population.

Figure 3. Gender and Race of Child Fatality Cases that Received an In-Depth Review, CY 2017-2019



	Female	Male		Amer.Indian	Black	Hispanic	Other	White
2017	10	25		8	2	1	0	24
2018	24	27		12	6	3	0	30
2019	19	32		14	4	1	2	30

[4] Vintage 2018 Bridged-Race Postcensal Population Estimates: pcen_v2019_y18
https://www.cdc.gov/nchs/nvss/bridged_race/data_documentation.htm#vintage2018

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

The vast majority of child deaths occur with the very young, those under one year of age (43.8%) and the older youth, ages 16 to 18 years (17.5%) (Figure 4). Combined, the youngest and oldest children accounted for 84 of the 137 deaths (61.3%) in 2017-2019 receiving in-depth reviews.

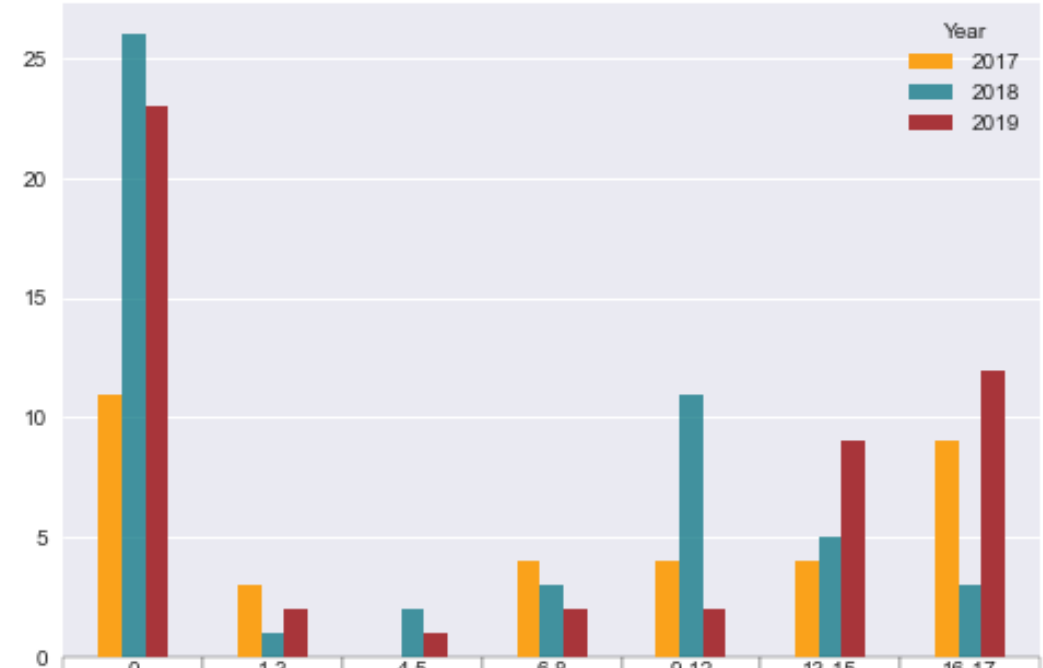
During 2017-2019 Sudden Unexplained Infant Death (SUID) was the leading cause of death in infants ages 0-1.

In 2017 and 2018, the leading cause of death for older youth ages 16 to 18 was suicide (5, 55.6%; 2, 66.7%).

In 2019, the leading causes of death for children ages 16-18 were suicide (5, 41.67%) and motor vehicle accidents (5, 41.67%). Of these 5 motor vehicle deaths, the youth was the driver in three.

Youth ages 9 to 15 years accounted for 25.5% of the 2017-2019 fatalities that received an in-depth review. The leading cause of death for this population was suicide (37.1%), followed by motor vehicle accidents. Of these 9 motor vehicle deaths, the youth was the driver in three.

Figure 4. Count by Age in Child Fatality Cases that Received an In-Depth Review, CY 2017-2019



	0	1-3	4-5	6-8	9-12	13-15	16-17
2017	11	3	0	4	4	4	9
2018	26	1	2	3	11	5	3
2019	23	2	1	2	2	9	12

CAUSES AND MANNERS OF CHILD FATALITY

VEHICULAR DEATHS

There were 24 vehicular child fatalities in 2017-2019: 9 in 2017 and 2019 and 6 in 2018. Males represented 70.8% of the vehicular child fatalities (Table 6).

Youth ages 13 to 18 continue to be the largest age group involved in vehicular fatalities (Table 6).

Table 8 shows the number and percent of vehicular child fatalities for the age group 15 to 18, by year since 2010.

Table 6. Vehicular Child Fatalities by Gender, Age, and Race, 2017-2019

	2017	2018	2019	Total
Female	1	3	3	7
Male	8	3	6	17
< 1 Year	0	1	0	1
1-3	2	0	1	3
4-5	0	0	0	1
6-8	2	0	1	3
9-12	1	2	0	3
13-15	2	1	3	6
16-17	2	1	4	7
Hispanic	0	1	0	1
American Indian	3	0	4	7
White	6	5	5	16
Total	9	6	9	24

Seat Belt Use / Safety Restraints

Of the 24 vehicular deaths, 16 (67%) involved child victims inside a moving vehicle. Of these 16 (69%) were wearing a seat belt / safety restraint (Table 7).

Table 7. Seat Belt Use, 2017-2019

	2017	2018	2019	3-Yr Total
Wearing seat belt	2	4	5	11
Not wearing seat belt	2	0	3	5
Seat belt not applicable	5	2	1	8
Total	9	6	9	24

'Seat belt use not applicable' includes recreational vehicles (i.e., snowmobiles, ATV's, dirt bikes), school bus passengers, farm equipment, motorcycles, watercraft (i.e., boats, jet-skis, inflatables), pedestrians and bicycles. These account for 10 (33%) of the vehicular deaths in 2017-2019 (Table 7).

Table 8. Ages 15 to 18 Vehicular Child Fatalities for last 10 years

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	10-yr Total
15 to 18	8	5	11	6	8	8	2	2	2	6	58
0-14	3	8	6	4	8	4	8	7	4	3	55

Position of Decedent In or Out of the Vehicle

In 8 of the 24 vehicular deaths (33%) youth were the operators of the vehicle (Table 9).

The average age of the driver was 15.38 years old.

Table 9. Position of Decedent, CY 2017-2019

	2017	2018	2019
Driver	3	0	5
Passenger	4	4	4
Pedestrian/ Other	2	2	0
Total	9	6	9

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

- A 11-year-old operating an All-Terrain Vehicle (ATV)
- A 3-year-old in a tractor
- A 15-year-old operating an All-Terrain Vehicle (ATV)
- A 14-year-old on a bicycle struck by a motor vehicle
- A 16-year-old in the cargo area of a motor vehicle
- A 10-year-old on a watercraft struck by another watercraft
- A 2-year-old pedestrian struck by a vehicle operating in reverse
- A 14-year-old operating a motorcycle

Type of Vehicle

Of the 24 vehicular child fatalities in 2017-2019, 71% involved a motor vehicle. The most predominate type of motor vehicle involved was a car (47%). SUVs comprised 29% of the motor vehicle accidents, followed by trucks (18%) (Table 10).

Recreational vehicles such as dirt bikes and All-Terrain vehicles (ATVs) were involved in 17% of vehicular fatalities.

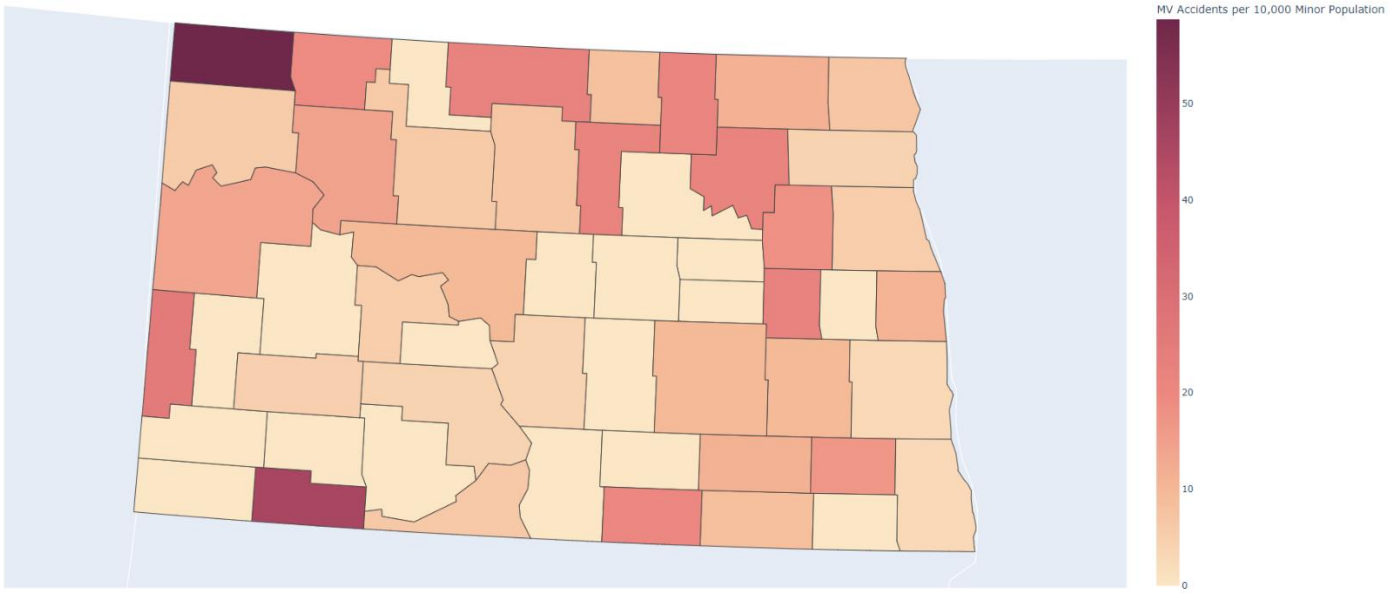
Table 10. Vehicular Deaths by Type of Vehicle

	2017	2018	2019
Motor Vehicle	4	5	8
Recreational Vehicle	2	1	1
Pedestrian	1	0	0
Bicycle	1	0	0
Tractor	1	0	0

Geography of Motor Vehicle Accident Fatalities

Figure 5 provides a state-wide look by county of the rate of child fatalities by motor vehicle accident per 10,000 children in population. This rate is highest on the western side of the state, particularly in Divide and Adams counties.

Figure 5. 10 Year Motor Vehicle Accident Rate Per 10,000 Children Under 18 in Population



Road Type

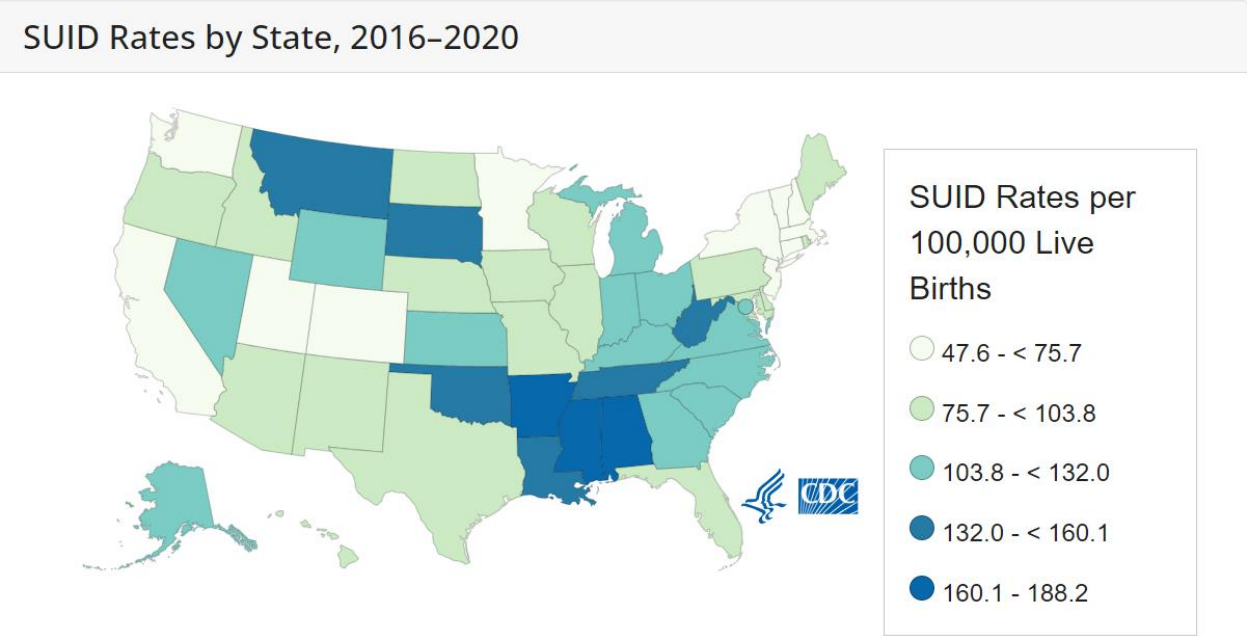
The most common road type surface for motor vehicle fatalities in 2017-2019 was rural county roads (9, 38%), followed by two-lane highways (6, 25%) and interstates (5, 21%) (Table 11).

Table 11. Vehicular Deaths by Type of Road

	2017	2018	2019
City Street	0	0	1
Farmyard	1	0	0
Interstate	1	3	1
Rural / County Road	5	1	3
Two-lane Highway	1	1	4
Other	1	1	0

SUDDEN UNEXPLAINED INFANT DEATH (SUID)

According to the Centers of Disease Control and Prevention (CDC[5]), each year there are about 3,400 sudden unexpected infant deaths in the United States, of these 2,500 had an unknown cause and about 900 deaths were due to accidental suffocation and strangulation in bed. SUID with extrinsic factors is the leading cause of preventable death among infants aged 1-12 months. The national SUID rate for 2017-2019 was 91.47, North Dakota's SUID rate is 93.9.



In 2017-2019 there were a total of 29 infant deaths identified as SUID.

There were 2 additional deaths from accidental suffocation as a result of hazards in the infant's sleep environment.

Males represented 62% of the SUID deaths. Of these 29 deaths, 52% were White, 38% were American Indian, and 10% were African American or Black. (Table 12). The number of child fatalities due to SUID among American Indian children far over represent the total population.

[5] *CDC/NCHS, National Vital Statistics System, Mortality Files. Rates calculated via CDC WONDER.*

Table 12. Child Fatalities due to SUID by Gender and Race

	SUID			
	2017	2018	2019	Total
Males	2	6	10	18
Females	4	2	5	11
White	4	6	5	15
American Indian	2	2	7	11
Black	0	0	3	3
Total	6	8	15	29

The number of infants dying suddenly and unexpectedly decreased in 2017 and 2018 as compared to previous years, however in 2019, the number of SUID nearly doubled. As Table 13 reflects, the term Sudden Infant Death Syndrome (SIDS) is no longer used to certify child deaths. Over the past 5-year period 2015 to 2019, 54 child fatalities were due to sudden unexpected infant death.

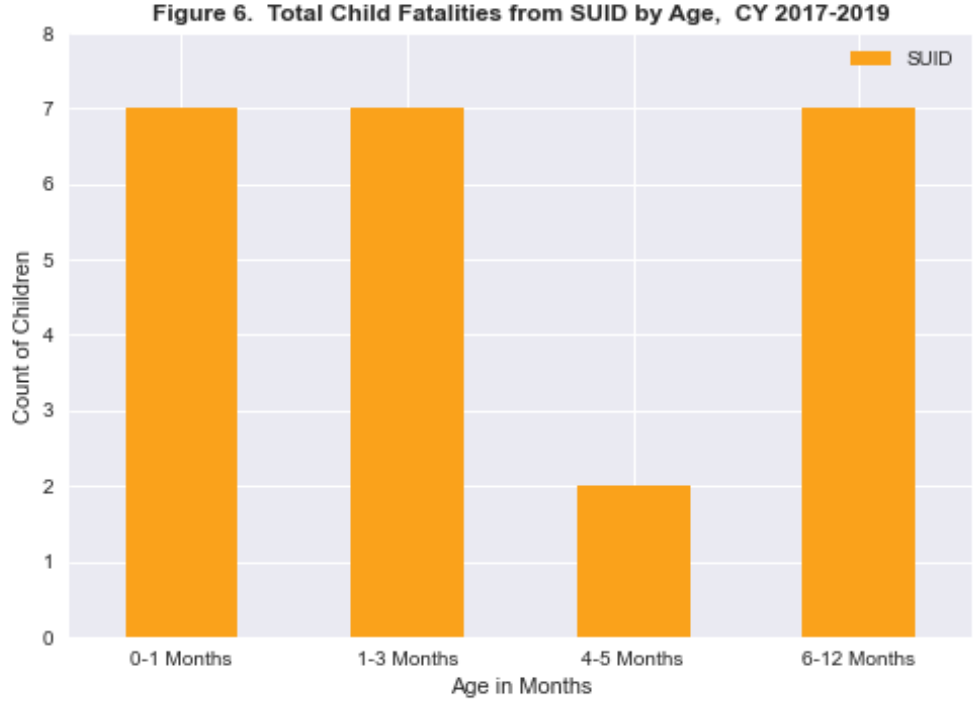
Table 13. Child Fatalities Due to SIDS/SUID by Year

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	10-yr Total
SIDS	5	9	4	0	3	4	5	0	0	0	30
SUID	2	9	7	8	11	9	7	6	8	15	82

Sudden Unexplained Infant Deaths amongst the youngest and most vulnerable, those three months and younger, accounted for 48% of the SUID deaths in 2017-2019 (Figure 6).

The average age for SUID was four months old.

Figure 6. Total Child Fatalities from SUID by Age, CY 2017-2019



The most common risk factor for Sudden Unexplained Infant Death 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 an adult bed, on their stomach or side; co-sleeping / sleep surface sharing with others; sleeping on a soft surface or with blankets and/or pillows. The most frequent infant sleep location identified in SUID in 2017-2019 was an adult bed (13, 45%), followed by a couch or recliner chair (6, 21%) (Table14).

Table 14. SUID Fatalities by Sleep Location by Year

	2017	2018	2019
Adult Bed	3	3	7
Bassinet	0	1	2
Box / Basket	0	0	1
Car / Infant Seat	0	0	1
Crib	0	0	1
Couch / Chair	2	2	2
Portable Crib	1	0	1
Unknown	0	2	0

SUID Risk Factors

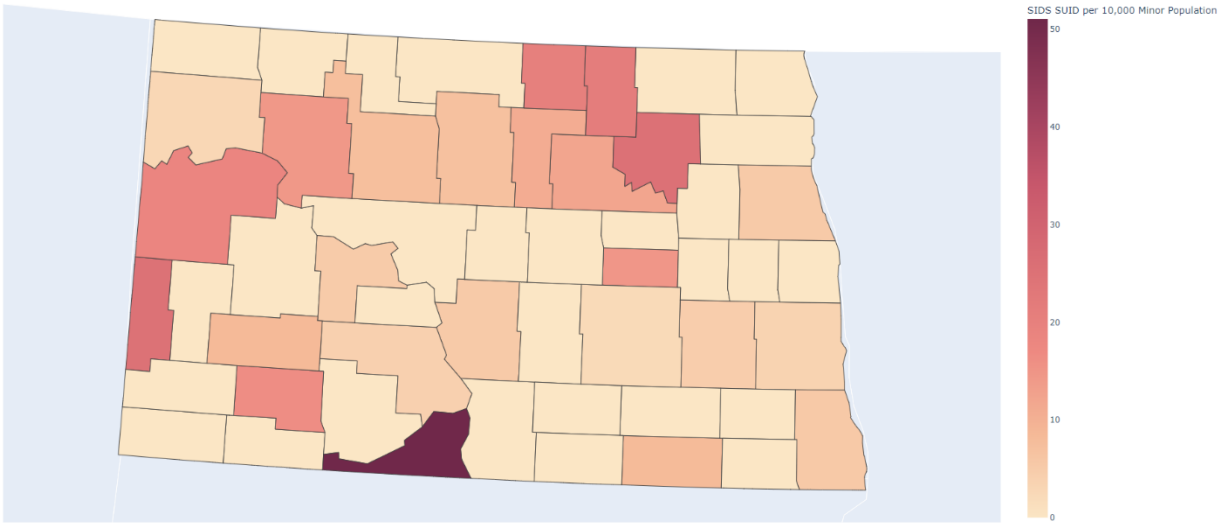
Of the 29 Sudden Unexplained Infant Deaths that occurred in 2017-2019, the following risk factors were most commonly identified:

- 93% were sleeping with blankets / pillows
- 48% were discovered on their stomach
- 45% were exposed to second-hand smoke
- 45% were co-sleeping / sleep surface sharing with an adult
- 38% were prenatally exposed to alcohol and/or controlled substances
- 24% were born premature

Geography of SUID Fatalities

Figure 7 provides a state-wide look by county of the rate of child fatalities by SIDS / SUID per 10,000 children in population. This rate is highest in Sioux, Golden Valley, and Ramsey counties; notably where tribal lands are located.

Figure 7. 10 Year SIDS/SUID Rate Per 10,000 Children Under 18 in Population



OTHER INJURIES (Unintentional / Preventable)

Child fatalities in 2017, 2018 and 2019 reviewed by the NDCFRP with death due to other injuries were attributed to drowning (38%), asphyxia (31%), fire (19%) and blunt force trauma (12%).

The most common location for drowning was the child's bathtub (67%). In each of these deaths the child was left unattended in the bath water for a short period of time. The second most common body of water for drownings to occur were culverts filled with water (33%).

Two of the asphyxia deaths were related to hazards in the infant's sleep environment resulting in the infant becoming wedged and suffocating.

When children died as a result of a house fire, there was not a working smoke alarm in the home.

Of the 16 fatalities due to other injuries; the manner of death was recorded as accident and preventable in 13 (81%) of the deaths, in addition the Panel noted child maltreatment was a contributing factor in all of these 13 deaths.

Table 15. Child Fatalities Due to Injury/Medical by Year, 2010 - 2019

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Other Injury	8	5	6	6	7	4	3	6	6	4
Other /Medical	10	8	8	7	3	7	10	8	14	10

OTHER CONDITIONS INCLUDING MEDICAL (Unintentional)

Of the 137 child deaths that occurred in 2017, 2018 and 2019 that received an in-depth review, 23% (32) were due to other conditions including medical reasons:

- 63% were under age 1 year
- 63% were natural and unpreventable
- 31% preventability could not be determined

Of the 32 child fatalities where the death was due to other conditions, including medical; 53% of the children were female; 66% were less than 3 years of age, 16% were 13-17 years old; 56% were White and 22% were American Indian (Table 16).

Table 16. Child Fatalities Due to Other Medical by Gender, Race and Age

	2017	2018	2019
Males	5	6	4
Females	3	8	6
< 1 Year	5	8	7
1 to 3	0	1	0
4 to 5	0	1	0
6 to 8	0	1	0
9 to 12	1	3	0
13 to 15	0	0	2
16 to 17	2	0	1
White	4	7	7
American Indian	2	3	2
Black / African American	1	3	0
Hispanic	1	1	0
Other	0	0	1
Total	8	14	10

HOMICIDES AND SUICIDES

Table 17. Child Fatalities by Suicide and Homicide by Gender, Age, Race 2017-2019

	Homicide			Suicide		
	2017	2018	2019	2017	2018	2019
Males	0	5	1	4	4	8
Females	0	3	1	2	5	3
< 1 Year	0	5	1	0	0	0
1 - 3	0	0	0	0	0	0
4 - 5	0	0	1	0	0	0
6 - 8	0	1	0	0	0	0
9 - 12	0	1	0	1	4	1
13 - 15	0	1	0	0	3	4
16 - 17	0	0	0	5	2	6
White	0	5	2	5	4	9
Hispanic	0	1	0	0	0	0
American Indian	0	1	0	1	4	1
Other	0	0	0	0	0	1
Black or African American	0	1	0	0	1	0
Total	0	8	2	6	9	11

The number of child fatalities due to Homicide for 2017-2019 was ten (7%); 80% of these occurred in 2018.

Homicides were the result of firearms (4), blunt force head trauma (3), asphyxia (1), starvation (1) and drowning (1).

The number of child fatalities due to suicide for 2017-2019 was 26 (19%).

Of the 26 suicides, 50% were by firearm, 42% were by hanging and 1 death was by the child overdosing on prescription medication, and another was the result of injuries from a fall from height. Of the suicides from firearm, the youth was male 85% of the time. Of the suicides by hanging, the youth was 65% female.

Of note, 62% (16) of the suicide victims were male compared to female (10, 38%) (Table 17).

The age at which most of the suicides occurred in 2017-2019 was 17 years old (56%).

The average age for youth suicide from 2017-2019 was 15 years old.

The NDCFRP determined all of the homicide and suicide deaths were preventable.

From 2015 to 2019, the number of suicides remained around 35 as compared to that from 2010-2014. In 2015, the number of suicides decreased by half, marking the year as the lowest for child suicide since 2008. In 2018, suicide deaths increased by 30% and again in 2019 by 18% (Table 18).

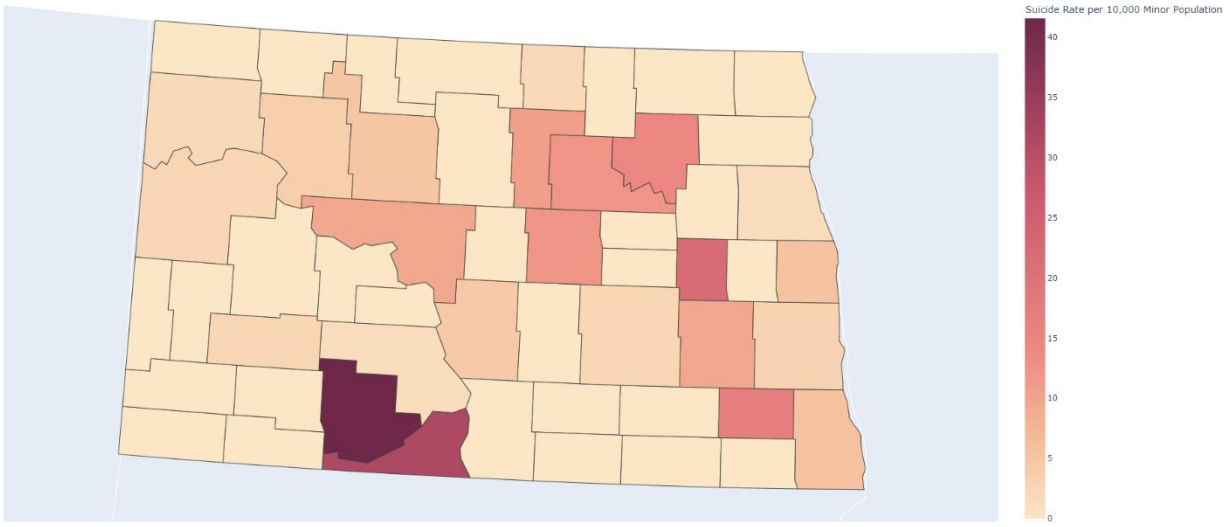
Table 18. Child Fatalities by Homicide/Suicide, 2010-2019

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Suicide	9	7	6	6	6	3	6	6	9	11
Homicide	2	4	5	1	1	3	6	0	8	2

Geography of Suicide Fatalities

The highest rate for suicides per 10,000 children in population were located in Grant and Sioux counties, followed by Griggs County (Figure 8).

Figure 8. 10 Year Suicide Rate Per 10,000 Children Under 18 in Population



Firearms

During 2017-2018, there were 17 child fatalities resulting from gunshot wounds, 13 were suicides (76%) and 4 were homicides (24%) (Table 19).

Table 19. Child Fatalities by Firearm and Manner of Death

	2017	2018	2019
Homicide	0	3	1
Suicide	4	3	6

The firearm used most often was a handgun (8, 47%) followed by a rifle (7, 41%) (Table20).

Table 20. Type of Firearm Used

	2017	2018	2019
Handgun	1	5	2
Rifle	2	0	5
Shotgun	1	1	0

When a child died as a result of gunshot wounds in 2017-2019, the manner in which the firearm was most often stored was unlocked and loaded (59%). In only one death was the firearm locked and unloaded (Table 21).

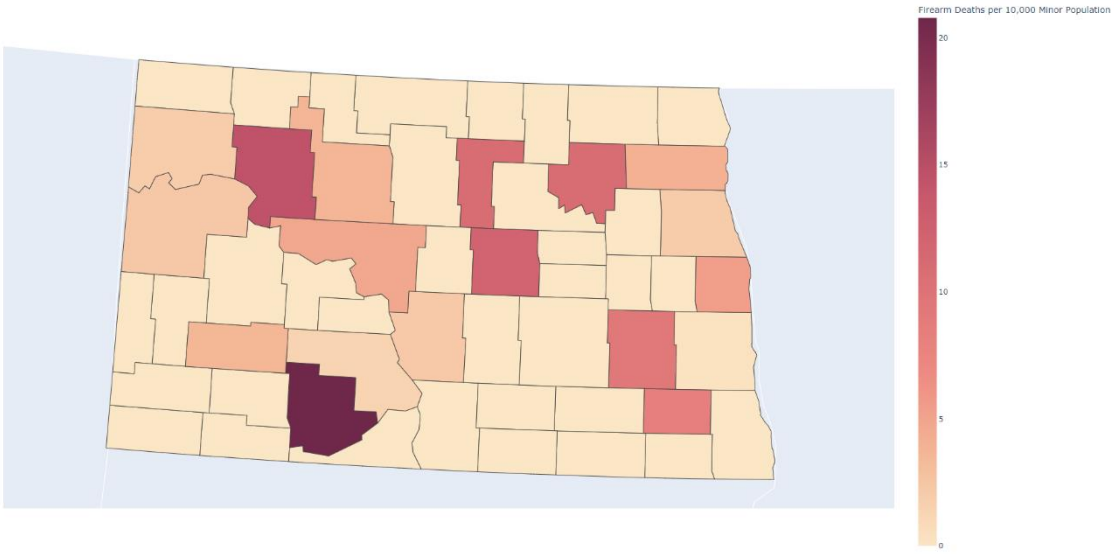
Table 21. Storage of Firearm Used

	2017	2018	2019
Locked / Loaded	1	1	0
Locked / Unloaded	1	0	0
Unlocked / Loaded	0	5	5
Unlocked / Unloaded	1	0	0
Unknown	1	0	2

Geography of Firearm Fatalities

The highest rate for child fatalities by firearm per 10,000 children in population was in Grant County followed by Mountrail County (Figure 9).

Figure 9. Ten Year Firearm Deaths Per 10,000 Children Under 18 in Population



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 can be made to prevent these deaths, for instance changes in policy, practice, and law. Preventable deaths accounted for 51% of the child deaths that occurred in 2017-2019 and were reviewed by the Panel. Sudden Unexpected Infant Death (SUID) Deaths was the second leading cause of preventable death (22%) reviewed by the Panel. Since these deaths are classified as 'undetermined', the Panel concluded the preventability for all the sudden unexplained infant deaths to be undetermined but did identify multiple extrinsic factors which can increase the risk. A third of the preventable deaths were motor vehicle related (33%). The largest number of preventable child deaths was due to suicide. The Panel agrees that all of these suicide deaths were preventable at a systems level (Table 22).

Table 22. Panel Determination of Preventability and Intentionality, 2017-2019

			Preventable		Non-Preventable	Preventability Undetermined	Total
			Intentional	Unintentional			
2017	Cause of Death	Homicide	0	0	0	0	0
		Suicide	6	0	0	0	6
		Motor Vehicular	0	9	0	0	9
		SUID	0	0	0	6	6
		Other Medical	0	1	6	1	8
		Asphyxia	0	1	0	0	1
		Drowning	0	0	1	0	1
		Fire / Burns	0	3	0	0	3
		Undetermined	0	0	0	1	1
2018	Cause of Death	Homicide	8	0	0	0	8
		Suicide	9	0	0	0	9
		Motor Vehicular	0	6	0	0	6
		SUID	0	0	0	8	8
		Other Medical	0	0	8	5	13
		Asphyxia	0	1	0	1	2
		Drowning	0	3	0	0	3
		Tornado	0	0	1	0	1
		Undetermined	0	0	0	0	1
2019	Cause of Death	Homicide	2	0	0	0	2
		Suicide	11	0	0	0	11
		Motor Vehicular	0	8	0	1	9
		SUID	0	0	0	15	15
		Other Medical	0	0	6	4	10
		Asphyxia	0	1	0	1	2
		Drowning	0	1	0	1	2
		Undetermined	0	0	0	0	0

CHILD ABUSE AND NEGLECT DEATHS AND NEAR DEATHS

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.

Deaths due to Child Abuse and Neglect

There was one child maltreatment fatality in 2017, 8 in 2018 and 9 in 2019.

2017

A female 36-week gestation neonate died following her birth. The death was classified as Undetermined; methamphetamine toxicity from prenatal substance exposure was noted. 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 death. The reports were combined into one assessment. An assessment determination of "Services Required" was made for fatal neglect due to prenatal substance exposure. In-home case management, substance use, mental health and transportation services were provided.

2018

A four-month-old male infant died of Homicide due to Starvation and Environmental Exposure. 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 death. An assessment determination of "Services Required" was made for fatal abuse. No services were offered or provided.

A male neonate died as the result of Drowning and the death was classified as Undetermined. 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 "Services Required" was made for fatal neglect. No services were offered or provided.

A five-month-old female died of Homicide due to Cranio-Cerebral and Cervical Trauma. 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 "Services Required" was made for fatal neglect. No services were offered or provided.

A ten-year-old male died of Homicide due to Gunshot Wounds. There were twelve 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 "Services Required" was made for fatal abuse. No services were offered or provided.

A fourteen-year-old male died of Homicide due to Gunshot Wounds. There were twelve 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 "Services Required" was made for fatal abuse. No services were offered or provided.

A six-year-old female died of Homicide due to a Gunshot Wound. There were twelve 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 "Services Required" was made for fatal abuse. No services were offered or provided.

A seven-month-old male's cause of death was Sudden Unexpected Infant Death in an Unsafe Sleep Environment, and the manner of death was Undetermined. 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 "Services Required" was made for fatal neglect. Foster care case management, parent aide, supervised visitation, mental health, parenting education, home visiting, financial, child care, vocational rehabilitation, and housing services were provided.

A five-month-old male died due to Blunt Head Injury and the manner of death was Undetermined. There were no previous reports of child abuse and neglect that pertained to the death. Four reports of child abuse and neglect were received as a result of the child's injury and death. An assessment determination of "Services Required" was made for fatal abuse. No services were offered or provided.

2019

A seven-year-old male died as a result of Blunt Force Injuries from a Motor Vehicle Accident. There were five previous reports of child abuse and neglect that pertained to the death. Four reports of child abuse and neglect were received as a result of the child's death. An assessment determination of "Services Required" was made for fatal neglect. No services were offered or provided.

A one-month-old male died of Homicide due to Smothering. There was one previous report 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 "Services Required" was made for fatal abuse. No services were offered or provided.

A one-month-old female's cause of death was Sudden Unexpected Infant Death with Co-Sleeping, and the manner of death was Undetermined. 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 "Services Required" was made for fatal neglect. No services were offered or provided.

A four-year-old female died from a Gunshot Wound and the manner of death was Undetermined. 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 "Services Required" was made for fatal neglect. In-home case management services were provided.

A one-month-old male's cause of death was Sudden Unexpected Infant Death with Co-Sleeping, and the manner of death was Undetermined. There were three 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 "Services Required" was made for fatal neglect. In-home case management services were provided.

An eight-month-old male's cause of death was Sudden Unexpected Infant Death, and the manner was classified as Natural. There were three previous reports of child abuse and neglect that pertained to the death. One report of child abuse and neglect were received as a result of the child's death. An assessment determination of "Services Required" was made for fatal neglect. In-home case management services were provided.

A two-year-old male died of Accident due to Drowning. There were no previous reports of child abuse and neglect that pertained to the death. One report of child abuse and neglect were received as a result of the child's death. An assessment determination of "Services Required" was made for fatal neglect. No services were offered or provided.

A three-month-old female died from Pneumonia with other contributing factors and the manner was classified as Undetermined. There was one previous report of child abuse and neglect that pertained to the death. Five reports of child abuse and neglect were received as a result of the child's death. An assessment determination of "Services Required" was made for fatal neglect. Foster care, supervised visitation, parent aide, mental health, parenting education, home visiting, child care and adoption services were provided.

A seven-month-old female's cause of death was Sudden Unexpected Infant Death, and the manner was classified as Undetermined. There were three previous reports of child abuse and neglect that pertained to the death. One report of child abuse and neglect were received as a result of the child's death. An assessment determination of "Services Required" was made for fatal neglect. In-home case management, parent aide, transportation, parent education, child development, mental health, anger management and substance use services were provided.

Near Deaths due to Child Abuse and Neglect

In 2017-2019 there were 16 children who were near death resulting from child abuse and neglect: 7 in 2017, 4 in 2018 and 5 children in 2019.

2017

A two-month-old female presented to the hospital with multisystem trauma, including a fractured skull and ribs, bleeding of the brain, and retinal hemorrhages. 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. In-home case management, Developmental Disabilities case management, infant development services, safety permanency funds, transportation assistance, mental health services, parenting education, and respite services were provided.

A five-month-old female presented to the hospital with a gunshot wound to her neck. 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 neglect. In-home case management, mental health services, infant development services, and firearm education services were provided.

A two-year-old male presented to the hospital with non-accidental head trauma, including bleeding of the brain. There were no previous reports of child abuse and neglect that pertained to the near death. Three reports of child abuse and neglect were received regarding the near death. An assessment determination of this report was "Services Required" for physical abuse. In-home case management services were offered. Child development services were provided.

An eleven-month-old female presented to the hospital after being found unresponsive. Multisystem trauma including non-accidental head trauma and retinal hemorrhages were established. There were no previous reports of child abuse and neglect that pertained to the near death. Three reports of child abuse and neglect were received regarding the near death. An assessment determination of this report was "Services Required" for physical abuse. Foster care and in home case management services, kinship placement, transportation assistance, supervised visitation, infant development services, and parenting education services were provided.

A one-month-old male presented to the hospital with seizures. A traumatic brain injury resulting from non-accidental head trauma and retinal hemorrhages were established. There were five 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. An assessment determination of this report was "Services Required" for physical abuse and medical neglect. Foster care case management, supervised visitation, transportation assistance, anger management, kinship placement, parenting education, substance use services, mental health services, and adoption services were provided.

A four-year-old male presented to the hospital with third degree burns to his head, face, torso, and extremities. There were five previous reports of child abuse and neglect that pertained to the near death. Seven reports child abuse and neglect were received regarding the near death. An assessment determination of this report was "Services Required" for physical neglect, inadequate supervision, and environmental neglect. In-home case management services, transportation assistance, substance use, and mental health services were provided.

A two-year-old male presented to the hospital with multisystem trauma including brain bleeds and several fractured thoracic vertebrae. There was one previous report of child abuse and neglect that pertained to the near death. There were four reports of child abuse and neglect received regarding the near death. An assessment determination of this report was "Services Required" for physical abuse and neglect, failure to protect. Foster care and in-home case management services, supervised visitation, child developmental disabilities services, respite services, parenting education, child care assistance, transportation assistance, parent coaching, mental health services, parent aide services, safety permanency funds and adoption services were provided.

2018

A four-month-old male was brought to the hospital as the infant was inconsolable. He was admitted with non-accidental head trauma. He had suffered a traumatic brain injury and retinal hemorrhages consistent with being shaken. 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. An assessment determination of these reports was "Services Required" for physical abuse by an unknown subject and neglect. In-home case management services, infant developmental disabilities services, parenting education, parent aide services and substance use, and mental health services were provided.

A two-month-old male went unresponsive and was brought to the hospital where he was admitted for non-accidental had trauma, bleeding of the brain and retinal hemorrhages. There were three previous reports of child abuse and neglect received that pertained to the near death. One 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 and neglect. The services provided included foster care case management, supervised visitation, parent aide services, infant developmental disabilities services, parenting education and mental health services.

A two-year-old male was admitted to the hospital with internal bleeding and injuries consistent with blunt force trauma. There were three previous reports of child abuse and neglect that pertained to the near death. Three reports of child abuse and neglect were received regarding the child's injuries and near death. An assessment determination of these reports was "Services Required" for physical abuse, medical neglect, and failure to protect. Services provided included foster care case management, in-home case management services, safety permanency funds, child developmental services, and mental health services.

A two-month-old male was admitted to the hospital with non-accidental head trauma, specifically bilateral skull fractures and bleeding of the brain. The infant also suffered cervical spine injuries and retinal hemorrhages consistent with being shaken. There was one previous report of child abuse and neglect that pertained to the near death. Four reports of child abuse and neglect were received regarding the infant's injuries and near death. An assessment determination of these reports was "Services Required" for physical abuse, medical neglect, and failure to protect. Services provided included foster care case management, infant development services, developmental disabilities services, mental health services, anger management, substance use services, transportation assistance, parent aide services, supervised visitation, safety permanency funds, and adoption services.

2019

A one-year-old male was admitted to the hospital with multi-system trauma including bruising, burns, lacerations, fractures, and internal bleeding. 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 child's injuries and near death. An assessment determination of these reports was "Services Required" for medical neglect and failure to protect. Services provided included foster care case management, child development services, developmental disabilities services, mental health services, housing assistance, substance use services, transportation assistance, kinship placement, supervised visitation, and safety permanency funds.

A five-year-old male was a passenger in a motor-vehicle-accident. First responders discovered the unresponsive child and began life saving measures. He was admitted to the hospital with bleeding of the brain and a collapsed lung. There were five previous reports of child abuse and neglect that pertained to the near death. Four reports of child abuse and neglect were received as a result of the child's injuries and near death. An assessment determination of "Services Required" was made for neglect, driving under the influence with minors in the vehicle. No services were offered or provided.

A three-month-old male was admitted to the hospital with multi-system trauma including chronic and acute bleeding of the brain and cervical neck injury and extensive retinal hemorrhaging consistent with being shaken. 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 as a result of the infants near death. An assessment determination of these reports was "Services Required" for physical abuse, medical neglect, and failure to protect. Services provided included foster care case management, infant development services, developmental disabilities services, mental health services, substance use services, transportation assistance, supervised visitation, safety permanency funds, and adoption services.

An eight-month-old male overdosed on heroin and fentanyl, Narcan was administered by first responders, and he was transported to the hospital. There were two previous reports of child abuse and neglect that pertained to the near death. Two reports of child abuse and neglect were received as a result of the infants near death. An assessment determination of these reports was "Services Required" for neglect, environmental exposure to controlled substance. Services provided included in home case management, kinship placement, infant development services, safety permanency funds and transportation assistance.

A seven-month-old male was resuscitated after drowning in a bathtub, he was admitted to the hospital and remained in a coma. There were no previous reports of child abuse and neglect that pertained to the near death. Three reports of child abuse and neglect were received as a result of the infants near death. An assessment determination of these reports was "Services Required" for neglect, inadequate supervision. No services were provided.

LONG TERM TRENDS

Table 23. Child Deaths by Status, CY 2010-2019

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Status A Deaths[1]	53	56	55	40	46	44	42	35	53	54
Status B Deaths[2]	40	42	44	61	40	57	56	55	42	61
Total Child Deaths[3]	93	98	99	101	86	101	98	90	95	115
In-State Child Deaths[4]	**48**	**53**	**53**	**38**	**44**	**42**	**42**	**35**	**51**	**51**
Out-of-State Child Deaths[5]	5	3	2	2	2	2	0	0	2	3

[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

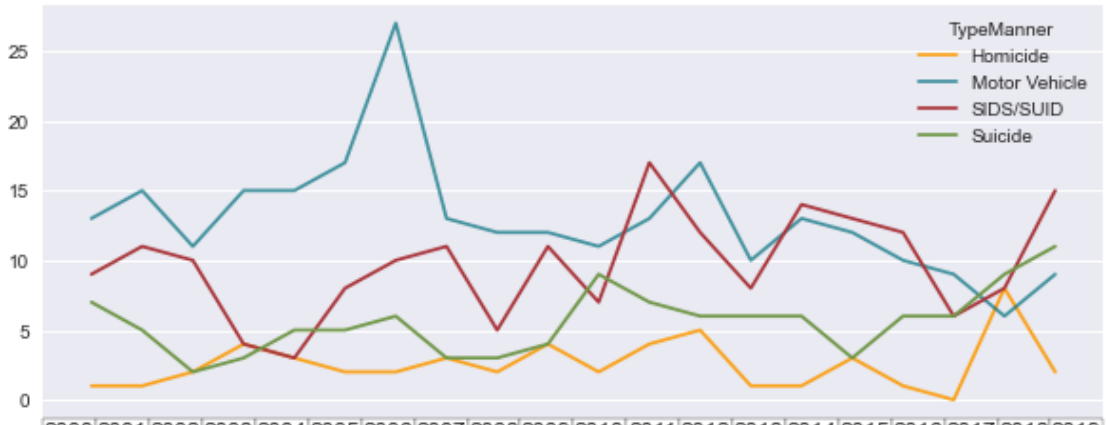
Table 24. Changes in North Dakota Child Population and Child Deaths by Year 2015 to 2019

	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
2015	168,815	5,386	3.19%	101	15	17.44%
2016	174,184	5,369	3.18%	98	-3	-2.97%
2017	175,390	1,206	0.69%	90	-8	-8.16%
2018	176,337	947	0.54%	95	5	5.56%
2019	178,055	1,900	0.97%	115	20	17.39%

Source of Population Data: CDC[1]

The child population in North Dakota has continued to grow each year. From 2015 to 2019, there was a 5% increase in the child population. From 2017 to 2018 there was a 5.56% increase in child deaths and the difference of child deaths between 2018 and 2019 increased by 17.39%. Therefore, ND child fatalities increased at a higher percentage rate than the child population increased (Table 24).

Figure 10. Number of In-Depth Child Fatality Reviews by Selected Manner of Death for Years 2000-2019



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Homicide	1	1	2	4	3	2	2	3	2	4	2	4	5	1	1	3	1	0	8	2
Motor Vehicle	13	15	11	15	15	17	27	13	12	12	11	13	17	10	13	12	10	9	6	9
SIDS/SUID	9	11	10	4	3	8	10	11	5	11	7	17	12	8	14	13	12	6	8	15
Suicide	7	5	2	3	5	5	6	3	3	4	9	7	6	6	6	3	6	6	9	11

The number of child fatalities attributed to vehicular, SIDS/SUID, suicide, and homicide are shown for the years 2000 to 2019 in Figure 9. The year 2006 saw a dramatic spike in vehicular child deaths (27). Motor vehicle fatalities contributed to the highest number of total child deaths a year from 2000 to 2013, with the exception of 2011. Child fatalities due to SIDS/SUID decreased by half in 2017 and have been increasing since. In 2016, deaths by suicide doubled and have been increasing (Figure 10).

CONTINUED EFFORTS

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

The majority of child deaths occurring in 2017-2019 reviewed by the Panel were preventable. In 2019, Sudden Unexplained Infant Death claimed the largest number of North Dakota children. While SUID preventability is considered undetermined, there are extrinsic factors, such as placing an infant on an adult bed, co-sleeping / sleep surface sharing, the use of blankets and pillows in the sleeping area, and placing an infant to sleep on their stomach, that increase the risk. As these risk factors are eliminated, the number of sudden unexpected infant deaths decline. Infant safe sleep education, resources, and tools in the hands of parents, childcare providers and family caregivers has the potential to impact the number of infant deaths in the state. A vast majority of the preventable child deaths are motor vehicle related deaths. Societal issues such as excessive speed, alcohol and drug involvement, distracted driving, and failure to use seat belts and safety restraints as intended contributed to the vehicle related deaths in 2017-2019. Issues such as young drivers operating recreational vehicles, adolescent drinking and driving and numerous child passengers were also noted. Effective social marketing and education focused on injury prevention, safety concepts and role modeling safe driving practices may positively benefit parents and North Dakota youth.

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 and resources for 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. 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 increasing number of fatalities by firearm and the manner in which the weapon was stored also highlights an opportunity for prevention regarding youth's access to lethal means when experiencing suicidal thoughts, feelings, or behaviors.

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 2017-2019. In 9% 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 CFRP, 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 across the state. Information regarding the child and family history, 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 become concerned that child victims of vehicle fatalities and infants dying suddenly or unexpectedly are not always identified as a coroner case and as a result an autopsy is not performed. In addition to children's deaths that were never reported to law enforcement for an investigation into how the child died.

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 six deaths in 2017-2019 that were classified as either 'accident' or 'undetermined' and did not receive an autopsy. A child death investigation did not occur in four of these deaths and law enforcement was never notified about the death of three of these children.

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