

North Dakota Child Fatality Review Panel

2004 Annual Report

**North Dakota Department of Human Services
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Table of Contents

Executive Summary	i-v
Purpose and Goals	1
Panel Membership.....	2
Panel Members 2004.....	3
Introduction	4-6
Calendar Year 2004	
Overview	8-10
General Procedure	8
Case status	8
In-State and Out of State Child Deaths.....	7
Manner of Death	9
Data Overview	10
Unintentional Deaths	11-16
Type of Fatal Injury/Event.....	12
Preventability of Death	12
Demographics	13
Vehicular Deaths	14-15
Drowning Deaths.....	16
Firearm Deaths.....	16
Poisoning/Overdose Deaths	16
Asphyxia Deaths	16
Fall Injury Deaths	16
Fire Deaths.....	16
Electrocution Deaths	16
Other Injury Deaths.....	16
Natural Deaths	17
Type of Fatal Injury/Event.....	18
SIDS Deaths.....	18
Other Natural Deaths	18
Suicide Deaths	20
Homicide Deaths	21
Deaths Where the Manner Could Not be Determined.....	22

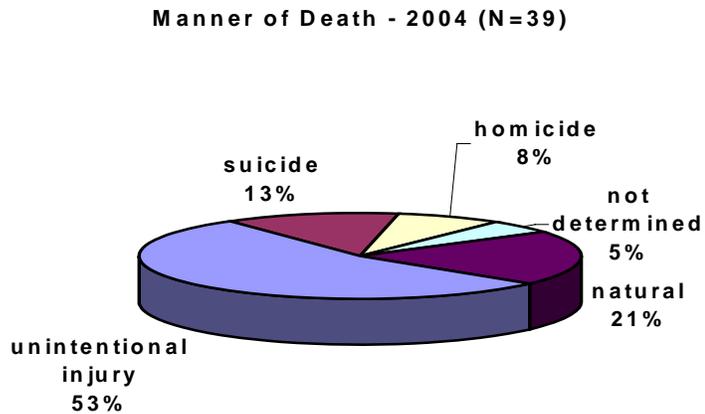
North Dakota Child Fatality Review Panel 2004 Executive Summary

The North Dakota Child Fatality Review Panel (NDCFRP) fulfilled the duties mandated by the North Dakota Century Code during 2004. By statute (50-25.1-01), the Panel is charged with responsibility for “the identifying of the cause of children's deaths, where 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”. Additionally, the Panel is to “meet at least semiannually 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. (NDCC50-25.1-04.3)”

The Panel met on a quarterly basis and completed the following number of reviews:

2004	
Total Child Deaths	87
Status B Deaths (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)	41
Status A Deaths (Status A cases consist of all cases of children whose death is sudden, unexpected, and/or unexplained. Reviewed in depth by the NDCFRP.)	46
Out-of-State Child Deaths (The “death-causing” event/injury is identified as occurring outside of North Dakota)	7
In-State Child Deaths (All other child deaths with North Dakota death certificates. Reviewed in depth.)	39

After an in-depth review of each case, the Child Fatality Review Panel either agrees or disagrees with the manner of death indicated on each death certificate. When the Panel, after an in depth review, does not agree with the manner of death indicated on each death certificate, the Panel reclassifies the manner of death for its own purposes. The Panel's classifications serve as the basis of this report. **The Panel reclassified two deaths in 2004.** One death was reclassified from “Undetermined” to “Homicide”. One death was reclassified from “Natural” to “Undetermined”. The Panel's classifications of the manner of death for 2004 is represented in the chart to the right:



2004 TRENDS

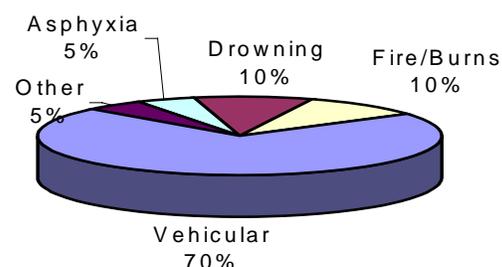
The Panel identified that Native American children are over represented in the numbers of child fatalities. According to North Dakota Kids Count for 2004, North Dakota's child population is 85% Caucasian, and 9.0% Native American. However, 13 of the 39 (33%) children that died in North Dakota during 2004 were Native American.

Of the 39 deaths reviewed in-depth, 30.8%(n=twelve) were ages 0-2 years; 20.5% (n=eight) were ages 12-14, and 35.9% (n=fourteen) were ages 15-17. These numbers indicate that the children most at risk of dying are the very young along with our teenagers.

Unintentional Injury Deaths

Unintentional injuries is the largest category of child deaths for 2004. Unintentional Injury Deaths are commonly referred to as accidents, both by the public and by the manner of death as recorded on death certificates. However, the term "accident" implies that the fatal injury/event could not have been prevented. Therefore, the Child Fatality Review Panel prefers the term Unintentional Injuries to replace the term accident because the child deaths in this category are predictable, understandable, and preventable. In fact, the Child Fatality Review Panel classified all 21 unintentional injury deaths as preventable.

**Unintentional Injury Deaths - 2004
(N=21)**



The largest sub-category of unintentional injury deaths is vehicular, accounting for 15 of the 21 child deaths from all unintentional injuries in 2004. The Child Fatality Review Panel classified all of these deaths as preventable. The deceased child was the driver in eight of the vehicular deaths and a passenger in six of the deaths. One child was a pedestrian. Of the vehicular deaths in 2004, 11 involved single vehicles and four involved multiple vehicles. Of the 11 deaths involving single vehicles, nine were rollover crashes. In the cases where use of a vehicle restraint applies, nine of the children who died were not restrained. The use of safety restraints was not applicable to one child death (A safety restraint would not have been required in the situation.). The use of safety restraints is unknown in two of the deaths. There were nine children who were ejected from the vehicle. Excessive speed or recklessness was a factor in six deaths. Driver intoxication was a contributing factor in two deaths, while underage drinking was found in one death. Other contributing factors include: driver inexperience (5); weather conditions (2); driver distraction (1); lack of sleep (1); improper overtaking (1); improper evasive action (1); driver with a suspended license (1); unlicensed driver (1); unknown licensing status of one driver. Societal issues such as underage alcohol usage (4 in 2004), inexperienced young drivers (5 in 2004), excessive speed (6 in 2004), and failure to use seat belts contributed to 13 of the 15 vehicle related deaths in 2004 (more than one factor can be identified in each case).

There were three deaths from other unintentional injuries in 2004. There were two unintentional injury deaths from drowning, one death from asphyxia, and two deaths from inhalation of smoke and soot in an apartment fire.

Natural Deaths

The manner of death was classified as natural for eight (22.5%) of the 39 child deaths in 2004. One of the deaths in this category was determined by the Panel to have been preventable if timely medical attention had been received for a treatable condition. Two babies died from

SIDS (Sudden Infant Death Syndrome). Six natural deaths did not fall into one of the other identified types of fatal injury/event data categories. All of these natural deaths received an autopsy.

Suicide Deaths

There were five suicide deaths in children during calendar year 2004.

Homicide Deaths

In 2004, three children died as the result of homicide.

Deaths Where the Manner Could Not Be Determined

The Panel could not determine the manner of death for two deaths in 2004. The Panel found one of these deaths to have been preventable. The Panel determined the preventability of one of these deaths to be undeterminable.

CHALLENGES:

Investigations of Children's Deaths

- Many scene investigations remain below a satisfactory standard.
 - 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.
- Investigations of traffic fatalities involving children often do not include alcohol testing of the child or of the vehicle's driver
 - Excluding this testing may mask the pervasiveness of alcohol related fatalities.

Interagency Communication

- Interdisciplinary failure to properly report child deaths promptly to appropriate authorities was identified in two deaths in 2004.
 - Failure to report these can result in evidence lost and families failing to receive needed services

Access to records

- North Dakota law (NDCC 50-25.1-04.4) provides that specific information be provided to the Panel upon request. This statute also mandates that law enforcement, courts, and agencies cooperate in fulfilling the purpose of the statute (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 (NDCC 50-25.1-04.3) to review the deaths of all minors is greatly 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.
- An additional barrier concerns entities outside the jurisdiction of state statutes are not compelled to share information with the Panel.
 - Federal agencies, such as the Federal Bureau of Investigation and the Bureau of Indian Affairs are not compelled to share information with the Panel.
 - Tribal governmental agencies, such as tribal child welfare and tribal law enforcement, are not compelled to share information with the Panel.
- The lack of access to investigation records was identified as an obstacle to effective child fatality reviews in six cases in 2004.

PANEL RECOMMENDATIONS

- The Panel recommends that blood alcohol testing be conducted in all traffic fatalities involving children.
- The Panel will continue to promote increased statewide quality of child death investigations and interagency communication.
- The Panel, with interagency support, must continue to promote increased cooperation among professional disciplines across all jurisdictions.

LONG TERM TRENDS

Child Deaths by Year:

Year	Total child deaths	Number reviewed in depth
1996	103	55
1997	109	51
1998	123	59
1999	116	54
2000	109	38
2001	98	43
2002	93	35
2003	107	38
2004	87	39

Vehicular Deaths by Year:

Year	Vehicular deaths
1996	16
1997	18
1998	18
1999	17
2000	13
2001	15
2002	11
2003	16
2004	15

SIDS Deaths by Year:

Year	SIDS Deaths
1996	5
1997	10
1998	10
1999	10
2000	9
2001	8
2002	8
2003	3
2004	2

Suicide Deaths by Year:

Year	Suicide Deaths
1996	11
1997	7
1998	4
1999	8
2000	6
2001	5
2002	2
2003	3
2004	5

Homicide Deaths by Year:

Year	Homicide deaths
1996	0
1997	0
1998	2
1999	1
2000	1
2001	1
2002	2
2003	4
2004	3

According to North Dakota Kids Count, the North Dakota child population continues to decline, from 157,703 in 1990 to 126,400 in 2003. The numbers related to child deaths in our state seem to reflect this population trend, showing corresponding decreases in the total number of child deaths as well as in the numbers of child deaths from SIDS and suicide. In addition to demographic decreases, there have also been campaigns, both locally and nationally aimed at decreasing the incidences of SIDS and occurrences of adolescent suicide. The NDCFRP is hopeful that the apparent decreases in these areas reflect effective prevention programming.

There are, however, two areas of concern. The numbers of vehicular crash deaths appear to be remaining steady, while child homicides appear to be increasing. Even though the numbers of crash deaths may not seem large when compared to more populated states, vehicular deaths remain the primary cause of child fatalities North Dakota.

Although the number of North Dakota children who die as the result of homicide may not seem large and an increase in the number of these deaths does not yet appear to be a trend, nonetheless, the Panel finds this increase in the number of child homicides disturbing.

Purpose and Goals

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

Purpose of the Child Fatality Review Panel

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

Goals of the Child Fatality Review Panel

- Accurate identification and documentation of the cause of death
- Collection of uniform and accurate statistics
- Coordination among participating agencies
- Improvement of criminal investigations and prosecution of child abuse homicides
- Protocols for investigation of certain categories of child deaths
- Identification of any changes needed in legislation, policy, practice, and/or training
- Use of media to educate the public about child fatality prevention
- Intercounty and interstate communications regarding child deaths
- Development of local child fatality review panels
- Evaluation of the impact of specific risk factors on child deaths including substance abuse and domestic violence

Strategies have been identified in North Dakota, and nationally, that will improve reporting of child deaths, death certification, and training for professionals responding to child fatalities. The following are areas of strategy development:

1. **Law Enforcement** – establishment of uniform child death scene and death investigation protocols
2. **State Forensic Examiner/Coroners** – improved access to, technical assistance, and thorough autopsies
3. **Public Health** – implementation of primary prevention programs focused on education and awareness campaigns such as “Back to Sleep”, “Never Shake a Baby”, safety programs for firearms, seat belts, child restraint, fire and poison prevention
4. **Social and Mental Health Services** – supportive services for surviving family members and communities

Panel Membership

(NDCC 50-25.1-04.2)

The Child Fatality Review Panel is a multidisciplinary, multi-agency, appointed panel. Each panel member serves as a liaison to their professional counterparts, provides definitions of their profession's terminology, interprets the procedures and policies for their agency and provides information from their records.

North Dakota State Child Protection Team (Core Membership)

- Designee of the Department of Human Services who serves as the presiding officer
- Representative of a child placing agency
- Representative of the North Dakota Department of Health
- Representative of the North Dakota Attorney General's office
- Representative of the North Dakota Department of Public Instruction
- Representative of the North Dakota Department of Corrections
- Representative of the lay community

Other Appointed Members

- State Forensic Examiner
- North Dakota Licensed Peace Officer
- Mental Health Professional
- A Physician
- North Dakota Injury Prevention – Department of Health
- Emergency Medical Services– Department of Health
- Consultants invited to assist in review of a specific case

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.

Panel Members – 2004

Gladys Cairns – CFRP Presiding Officer
Administrator, Child Protection Services – DHS

Shelly Arnold - DEMS
ND Department of Health

Steve Kukowski
Minot Police Department

Marlys Baker – CFRP Administrator
Child Protection Services – DHS

Dr. Gordon Leingang - Emergency Trauma
St. Alexius Medical Center

Jonathan Byers
Assistant ND Attorney General

Carol Meidinger - Injury Prevention Program
ND Department of Health

Tom Dahl
ND Bureau of Criminal Investigation

Dr. Ron H. Miller
MeritCare Children's Hospital

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

Dr. George Mizell
State Forensic Examiner

Warren Emmer - Parole & Probation
ND Department of Corrections

Carla Pine
Burleigh County Social Services

Karen Eisenhardt - Educator
State Child Protection Team – lay member

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History

The North Dakota Child Fatality Review Panel was established by North Dakota Century Code 50-25.1 and began reviewing child deaths in 1996. By law, the purpose of the NDCFRP is: "the identifying of the cause of children's deaths, 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." The Panel presents all of these issues to the public for attention.

Lessons Learned

The most important lesson learned from the Panel's reviews is that **many child deaths each year are preventable** and that every citizen can play a role in reducing child fatalities.

Preventability of death

In determining the reasons for preventable deaths, the Panel does not seek to place blame, but rather, to point the way toward preventing future deaths.

The majority of preventable child deaths reviewed by the Panel in 2004 occurred as a result of **unintentional injuries**. The majority of these deaths (14 of 21) occurred among children ages 12 to 17. Two thirds of the unintentional injury deaths (12 of the 21) are determined to be caused by reckless conduct of the deceased child. Most of these (15 of 21) are motor vehicle related deaths. As we study the circumstances of these tragedies, we learn that more effective social marketing and education focused on safety concepts and injury prevention are needed to reach parents and teens. Currently, laws are in effect which mandate graduated driver's licensing and safety restraint use. Driver education and safety campaigns have been provided. Societal issues such as underage alcohol usage (4 in 2004), inexperienced young drivers (5 in 2004), excessive speed (6 in 2004), and failure to use seat belts contributed to 13 of the 15 vehicle related deaths in 2004 (more than one factor can be identified in each case).

The tragedy of **teen suicide** is the second largest category of preventable death in our state. Of the 39 deaths reviewed by the Panel in 2004, five were the result of suicide. These suicides highlight the need for more accessible mental health care for adolescents, particularly in schools and on the state's Indian Reservations. Other strategies for prevention include education for 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 needs to include information on how to access community mental health resources if someone is concerned about an adolescent.

Continuing Challenges for the Child Fatality Review Panel

Among the duties assigned to the North Dakota Child Fatality Review Panel by state law are the promotion of:

- ◆ Interagency communication for the management of child death cases and for the management of future nonfatal cases;
- ◆ Effective criminal, civil, and social intervention for families with fatalities;
- ◆ Interagency use of cases to audit the total health and social service systems and to minimize misclassification of cause of death;
- ◆ Evaluation of the impact of specific risk factors including substance abuse, domestic violence, and prior child abuse; and
- ◆ Intercounty and interstate communications regarding child death.

The Panel identifies the following as ongoing challenges in accomplishing these assigned duties:

Investigations of Children's Deaths

The Panel continues to be concerned about the quality of child death scene investigations. Even though there has been some observable increase in the quality of scene investigation in cases of infant death since the inception of the Panel, too many scene investigations remain below a satisfactory standard. 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. **Information in this report that is presented as "unknown" is often the result of information not gathered during a death scene investigation.**

The death 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 investigations of traffic fatalities involving children often do not include alcohol testing of the child or of the vehicle's driver. Excluding this testing may mask the pervasiveness of alcohol related fatalities. The absence of alcohol testing was identified in three specific traffic fatalities involving children in 2004.

The Panel recommends that blood alcohol testing be conducted in all traffic fatalities involving children.

Interagency Communication

Interagency communication regarding child deaths needs to be improved, particularly requirements for reporting of child deaths across systems. Failure to report these deaths promptly to appropriate authorities can result in evidence lost and families failing to receive needed services. Interdisciplinary failure to properly report was identified in two deaths in 2004.

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

Access to records

The Panel's ability to access relevant records for review remained of concern in 2004.

North Dakota law (NDCC 50-25.1-04.4) provides that, "Upon the request of a coroner or the presiding officer of a child fatality review panel, 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 greatly 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 in possession of detailed and valuable information about a given child, whose records are not addressed in state law, and therefore remain inaccessible to the Panel. These include school records, and records of substance abuse treatment professionals.

An additional barrier identified by the Panel concerns entities that are outside the jurisdiction of state statutes are not compelled to share information with the Panel. This includes federal agencies, such as the Federal Bureau of Investigation and the Bureau of Indian Affairs, and tribal governmental agencies, such as tribal child welfare and tribal law enforcement. While most tribal government entities offer some support for the work of the Panel, it is a concern that federal records remain inaccessible. The lack of access to investigation records was identified as an obstacle to effective child fatality reviews in six cases in 2004.

The Panel, with interagency support, must continue to promote increased cooperation among professional disciplines across all jurisdictions.

Calendar Year 2004

Overview

Overview

General Procedure

The North Dakota Department of Health provides vital statistic records for each child who has died in North Dakota. North Dakota Century Code Health Statistics Act (NDCC 23-02.1) allows for the release of vital records information to the Child Fatality Review Panel (23-02.1-27 “Disclosure of records”).

The Child Fatality Review Panel presiding officer is allowed under NDCC 50-25.1-04.4 to request and receive records from any hospital, physician, medical professional, medical facility, mental health professional, mental health facility, law enforcement or social services. These entities are required to disclose all records requested by the Child Fatality Review Panel.

Case specific information is requested by the presiding officer and prepared for review by the Administrator of the Child Fatality Review Panel or a Panel member assigned to the case by the presiding officer. The Child Fatality Review Panel meets on a regular basis, at which time the compiled information is presented to Panel members for discussion. A determination of the Panel’s agreement as to the manner of death indicated on the death certificate and the preventability of death are determined by a consensus of the Panel members. A data form is maintained for each case reviewed to document panel 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)

Case Status

Each death certificate received from the Department of Health is reviewed by a Child Fatality Review Panel subcommittee that identifies each death as a Status A case or a Status B case. Status A cases consist of all cases of children whose death is sudden, unexpected, and/or unexplained. Status A cases receive an in-depth, comprehensive review and are included in the analysis in this report. Status B cases are deaths that are not unexpected (i.e. long term illness) and/or deaths that are due to natural causes. Status B cases are only presented for review by the Child Fatality Review Panel in a brief, general format in order to give all Child Fatality Review Panel members an opportunity to request that the case be changed from Status B to Status A. If no member requests a change in status, the death remains Status B and the data is not included in this report.

2004	
Total Child Deaths	87
Status B Deaths	41
Status A Deaths	46

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, even though a North Dakota death certificate is issued. All other child deaths with North Dakota death certificates are considered in-state child deaths. Both out-of-state child deaths and in-state child deaths are reviewed by the Child Fatality Review Panel, but only in-state child deaths are used for the analysis in this report.

2004 “Status A” Child Deaths	
Total Status A Child Deaths	46
Out-of-State Child Deaths	7
In-State Child Deaths	39

Overview (continued)

Manner of Death

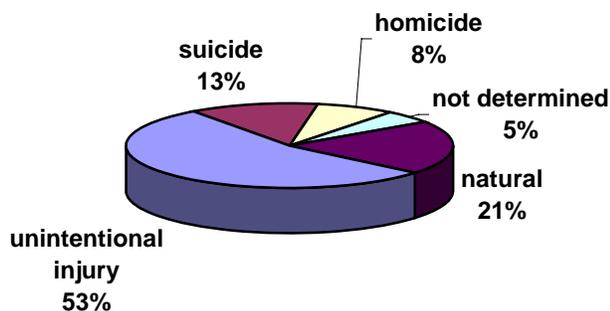
North Dakota death certificates list the following five manners of death as listed on the North Dakota Death Certificate: “Natural, Accident, Suicide, Homicide, or Could Not Be Determined”. After an in-depth review of each case, the Child Fatality Review Panel either agrees or disagrees with the manner of death indicated on each death certificate. If the Child Fatality Review Panel agrees, the manner of death listed on the death certificate is recorded as the Child Fatality Review Panel manner of death. However, if the Review Panel disagrees, the Panel reclassifies the manner of death for its own purposes. It is the Panel’s classifications that serve as the basis of this report.

The Panel reclassified two deaths in 2004. One death was reclassified from “Undetermined” to “Homicide”. One death was reclassified from “Natural” to “Undetermined”.

The largest category for the manner of death was unintentional injury, which claimed the lives of 21 children in 2004. **Unintentional Injury Deaths are commonly referred to as accidents, both by the general public and by manner of death as recorded on death certificates. However, the term “accident” implies that the fatal injury/event could not have been prevented. Therefore, the Child Fatality Review Panel prefers the term Unintentional Injuries to replace the term “accident” because the child deaths in this category are predictable, understandable, and preventable.**

The second largest category for the manner of death was “Natural”, which claimed the lives of eight children in 2004. The category “Suicide” consisted of five child deaths in 2004. Three deaths were classified as homicides in 2004. The “Could Not Be Determined” category (two deaths in 2004) includes deaths in which the manner of death cannot be conclusively categorized after an in-depth review of the case by the Child Fatality Review Panel. See the respective manner of death sections of this report for more information on each category.

Manner of Death - 2004 (N=39)



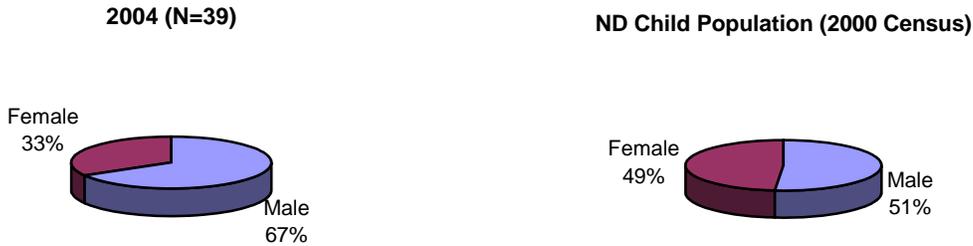
These categories will be explored further with additional data in pages 12-23 of this report.

Data Overview

Each Status A death is thoroughly reviewed by the Child Fatality Review Panel. The Panel then classifies each death by the manner of death, the type of fatal injury/event, and the preventability of the death. The Panel’s reviews of the 39 deaths determined to be “Status A” deaths, which occurred in calendar year 2004, form the basis of this report.

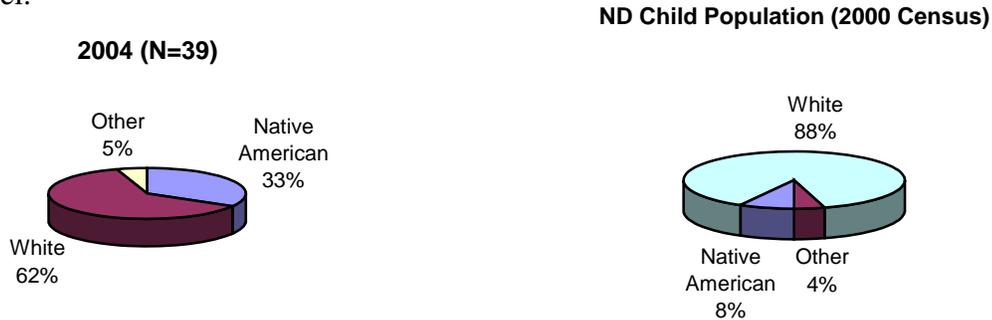
Demographics

Gender of the children who died in North Dakota and received an in-depth review by the Child Fatality Review Panel.



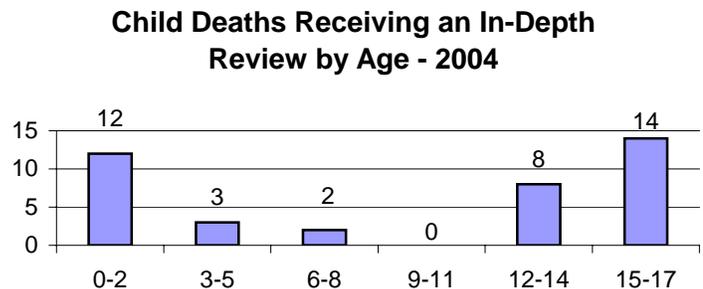
According to the North Dakota Data Center, North Dakota’s child population is nearly equally male and female (51.3% male; 48.7% female). However, 26 of the 39 (67%) children that died in North Dakota during 2004 were male.

Race of the children who died in North Dakota and received an in-depth review by the Child Fatality Review Panel.



According to North Dakota Kids Count for 2004, North Dakota’s child population is 85% Caucasian, and 9.0% Native American. However, 13 of the 39 (33%) children that died in North Dakota during 2004 were Native American, indicating an over-representation of Native American Children.

The age of the children who died in North Dakota and whose deaths received an in-depth review by the Child Fatality Review Panel is reported in the chart below.



Calendar Year 2004

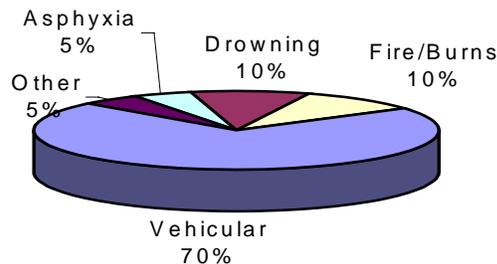
**Unintentional Injury
Deaths**

All Unintentional Injury Deaths

Type of Fatal Injury/Event

There were 39 in-state child fatalities reviewed in depth in 2004. There were twenty-one (53.8%) deaths categorized as unintentional injuries by the Child Fatality Review Panel. Each unintentional injury death was categorized by the type of fatal injury/event, as shown in the chart below. **By far the largest Unintentional Injury Death category is vehicular, which accounted for 15 (70%) of the 21 unintentional injury child deaths during 2004.** Each of the type of fatal injury/event categories for unintentional injury is examined further in this section.

**Unintentional Injury Deaths - 2004
(N = 21)**



Preventability of Death

The Child Fatality Review Panel classifies each child's death as preventable or non-preventable. **Of the 21 unintentional injury deaths in 2004, all 21 were categorized as preventable. The two main reasons identified for preventable child deaths were: 1) Neglect & Reckless Conduct of Others (15 of the 21 deaths) and 2) Neglect & Reckless Conduct of the Deceased Child (12 of the 21 deaths).**

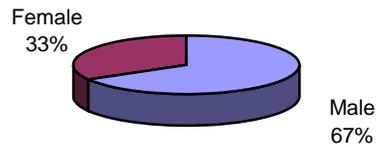
Unintentional Injury Deaths are commonly referred to as accidents, both by the public and by the manner of death as recorded on death certificates. However, the term "accident" implies that the fatal injury/event could not have been prevented. Therefore, the Child Fatality Review Panel prefers the term Unintentional Injuries to replace the term accident because the child deaths in this category are predictable, understandable, and preventable. In fact, the Child Fatality Review Panel classified all 21 unintentional injury deaths as preventable.

All Unintentional Injury Deaths

Demographics

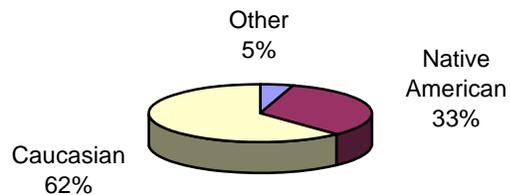
Of the 21 unintentional injury deaths in 2004, seven (33%) were female children compared to 14 (67%) male children.

Gender - 2004 (N=21)



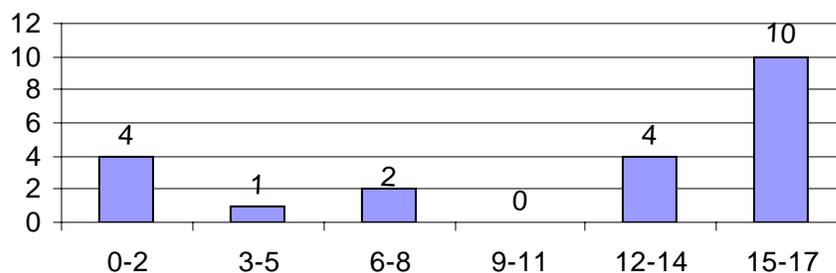
In 2004, 13 (62%) of the children who died because of unintentional injuries were Caucasian, and seven (33%) were Native American.

Race - 2004 (N=21)



The age of the children involved in unintentional injury deaths in 2004 is reported in the chart below.

Unintentional Injury Deaths by Age - 2004

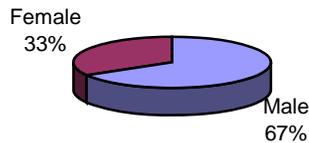


Vehicular Unintentional Injury Deaths

In 2004, 15 children died in vehicle related deaths. The Child Fatality Review Panel classified all of these deaths as preventable.

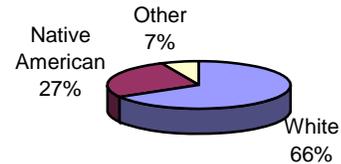
In 2004, five (33%) of the children who died were females compared to ten (67%) males.

Gender - 2004 (N=15)

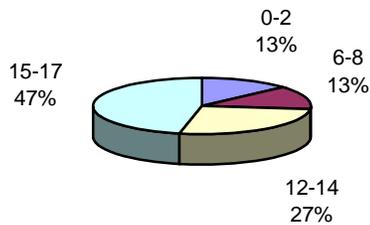


In 2004, 10 (66%) of the children who died were Caucasian, and four (27%) were Native Americans.

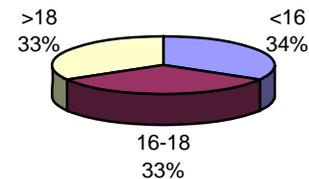
Race - 2004 (N=15)



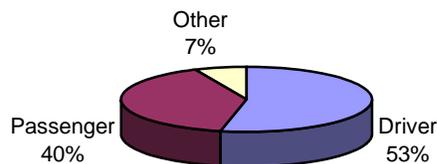
Age of Victim - 2004 (N=15)



Age of Person Driving the Deceased Child's Vehicle - 2004 (N=15)



Position of Decedent - 2004 (N=15)



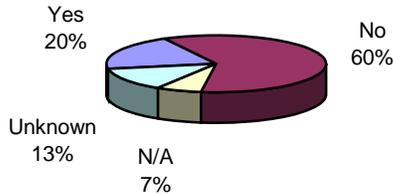
The deceased child was the driver in eight of the vehicular deaths and a passenger in six of the deaths. One child was a pedestrian. Of the vehicular deaths in 2004, 11 involved single vehicles and four involved multiple vehicles. Of the 11 deaths involving single vehicles, nine were rollover crashes.

Vehicular Unintentional Injury Deaths (continued)

Safety Restraints Used/ Ejection from a vehicle

In the cases where use of a vehicle restraint applies, nine of the children who died were not restrained. The use of safety restraints was not applicable to one child death (A safety restraint would not have been required in the situation.). The use of safety restraints is unknown in two of the deaths. There were nine children who were ejected from the vehicle.

Safety Restraints Used - 2004 (N=15)



Child Ejected From Vehicle - 2004 (N=15)



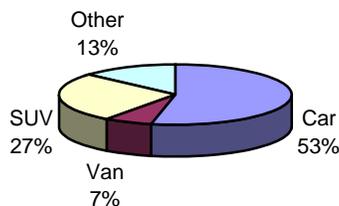
Contributing factors

Excessive speed or recklessness was a factor in six deaths. Driver intoxication was a contributing factor in two deaths, while underage drinking was found in one death. Other contributing factors include: driver inexperience (5); weather conditions (2); driver distraction (1); lack of sleep (1); improper overtaking (1); improper evasive action (1); driver with a suspended license (1); unlicensed driver (1); unknown licensing status of one driver.

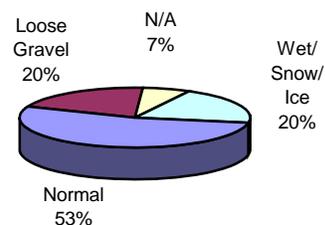
Road Conditions

The road conditions were normal in eight deaths. There was loose gravel in three deaths. Other conditions were wet (1), and ice (2). One death occurred in a parking lot.

Type of Vehicle - 2004 (N=15)



Road Conditions - 2004 (N=15)



Other Unintentional Injury Deaths

Drowning

There were two unintentional injury deaths from drowning in 2004. One was a seventeen year-old Native American female who drowned as the result of a seizure in the bathtub of her home. One was a 16 year-old male who attempted to go swimming while under the influence of inhaled chemicals.

Firearm

No children died from an unintentional firearm injury in 2004.

Poisoning/Overdose

No children died from unintentional poisoning/overdose in 2004.

Asphyxia

A one year-old child died of asphyxia after choking on popcorn.

Fall Injury

No children died from an unintentional fall in 2004.

Fire

Two Native American male siblings, ages two years and five years died from inhalation of smoke and soot when the apartment home they lived in caught fire.

Electrocution

No children died from unintentional electrocution in 2004.

Other Injuries

No children died from other injuries in 2004.

Calendar Year 2004

Natural Deaths

Natural Deaths Overview

Type of Fatal Injury/Event

The manner of death was classified as natural for eight (22.5%) of the 39 child deaths in 2004. One of the deaths in this category was determined by the Panel to have been preventable if timely medical attention had been received for a treatable condition. All the children in this category received an autopsy.

SIDS

Two babies died from SIDS (Sudden Infant Death Syndrome). A one month-old male and a five month-old male, both Caucasian, died in their own homes. There are circumstances present in both of these deaths that are recognized as risk factors for SIDS. Both deaths were found by the Panel to have been non-preventable. Both infants received an autopsy, consistent with the legal criteria for listing SIDS as a cause of death on the death certificate (NDCC 11-19.1-13.” Cause of death – Determination”)

Other Natural Deaths

During calendar year 2004, six natural deaths did not fall into one of the other identified types of fatal injury/event data categories. All of these natural deaths received an autopsy. The following conditions led to these seven child deaths:

- Acute intracerebral hemorrhage (bleeding within the brain) due to cerebral malformation (congenital abnormality of blood vessels) (4 year old)
- Cardiac arrhythmia (abnormal heart beat) due to myocarditis (inflammation of the heart) (17 year-old)
- Probable seizure, due to congenital central nervous system anomalies, due to in-utero cytomegalovirus infection (8 month-old)
- Acute bronchopneumonia (One year-old)
- Cardiopulmonary arrest due to complication of broncho pulmonary dysplasia (chronic lung disease) due to prematurity (One year-old)
- Congenital heart disease (Two month-old)

Calendar Year 2004

Suicide Deaths

Homicide Deaths

**Deaths Where the Manner
Could Not be Determined**

Suicide Deaths

Suicide Deaths

There were five suicide deaths in children during calendar year 2004. The Child Fatality Review Panel classified all five deaths as preventable. Of the deaths by suicide, two were 14 year-old males, one was a 16 year-old male, and one was a 17 year-old male. There was one suicide of a 14 year-old female. Of the suicide deaths, two were caused by hanging and three were caused by firearms. Two of the children who died from suicide were Native American and three were Caucasian.

The table below represents the number of child deaths by suicide by year for each year the Child Fatality Review Panel has been reviewing child deaths.

Year	Suicide Deaths
1996	11
1997	7
1998	4
1999	8
2000	6
2001	5
2002	2
2003	3

Homicide Deaths

Homicide Deaths

In 2004, three children died as the result of homicide. Homicide deaths include a 17 year-old male, a 7 year-old male and a 6 month-old male. Two of the homicides resulted from firearms and one from suffocation. The Panel identified that all three homicides involved child abuse or neglect by the child's caregiver. The Panel determined these three homicide deaths to have been preventable.

Since 1996, when Child Fatality Review Panel data began to be recorded, there had never been more than two child homicides in any year before 2003. In 2004, there are three child homicides. Although the number of North Dakota children who die as the result of homicide may not seem large and an increase in the number of these deaths does not yet appear to be a trend, nonetheless, the Panel finds this increase in the number of child homicides disturbing.

The table below represents the number of child deaths by homicide by year for each year the Child Fatality Review Panel has been reviewing child deaths.

Year	Homicide deaths
1996	0
1997	0
1998	2
1999	1
2000	1
2001	1
2002	2
2003	4

Deaths Where the Manner Could Not be Determined

The Panel could not determine the manner of death for two deaths in 2004. A fourteen year-old female died of a gunshot wound to the head. This death occurred on an Indian Reservation. Law enforcement investigation information was not provided to the Panel. The Panel found this death to have been preventable.

A three month-old male infant found unresponsive in his bed had a 19% level of carbon monoxide in his blood at the time of the autopsy. After investigation by law enforcement, it remains unknown as to how the baby was exposed to the carbon monoxide. The Panel determined the preventability of this death to be undeterminable.