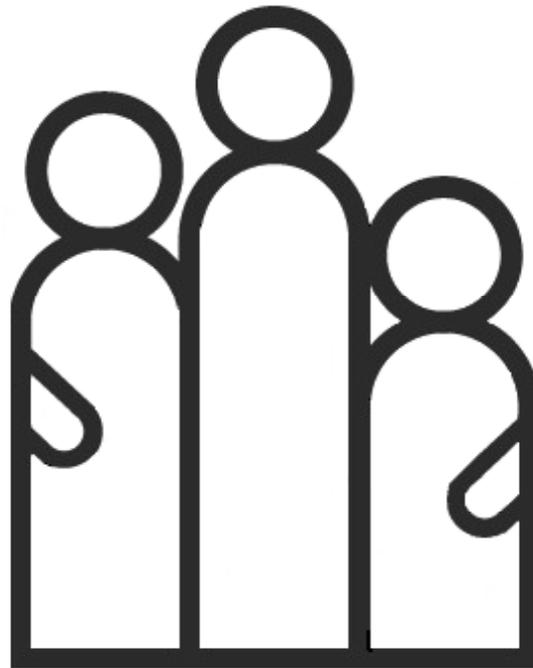


# North Dakota Child Fatality Review Panel

**2003 Annual Report**



**North Dakota Department of Human Services  
Carol K. Olson, Executive Director**

**Children and Family Services  
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# 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 and/or practice
- 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 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** – support services for surviving family members

# Panel Members

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
- Physician
- 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
- North Dakota Injury Prevention – Department of Health
- EMS for Children – Department of Health
- North Dakota States Attorney's Association
- 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 children are dying. The shared commitment is to work together to improve agency and community responses to child deaths and to identify prevention initiatives.

# Panel Members – 2003

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

Sandy Anseth  
Maternal & Child Health – ND Health Dept

Leann Bertsch  
Burleigh County Assistant State's Attorney

Karen Eisenhardt, Educator  
State Child Protection Team – lay member

Warren Emmer, Parole & Probation  
ND Department of Corrections

Dr. George Mizell  
State Forensic Examiner

Shelly Arnold  
ESMC, ND Health Dept

Carla Pine  
Burleigh County Social Services

Steve Kukowski  
Minot Police Department

Marlys Baker – CFRP Administrator  
Child Protection Services – DHS

Jonathan Byers  
Assistant ND Attorney General

Carol Meidinger  
Injury Prevention Program – ND Health Dept

Dr. Gordon Leingang  
Emergency Trauma, St. Alexius Health Services

Jerry Theisen  
Bureau of Criminal Investigation

Dr. Terry Dwelle – State Health Officer  
ND Health Department

Marilyn Brucker  
ND Department of Public Instruction

Dr. Ron H. Miller  
MeritCare Children's Hospital

Tom Dahl  
ND Bureau of Criminal Investigation

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# Introduction

The North Dakota Child Fatality Review Panel was established by North Dakota Century Code 50-25.1 and began reviewing child deaths in 1996.

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. For example, when nearly half of the deaths from unintentional injuries (11 of 21) occur among children ages 12 to 17 and almost as many (10 of the 21) are determined to be caused by the reckless conduct of the deceased child, we learn that strategies for more effective social marketing of safety concepts and injury prevention are needed in order to reach teens. Laws are in effect which mandate graduated driver's licensing, and safety restraints. Education such as "Click It or Ticket" has been provided, but may not be effective in convincing teens. Societal issues such as underage alcohol usage, driving while intoxicated, underage and inexperienced drivers, unsafe use of recreational vehicles, excessive speed, and failure to use safety equipment (seat belts, helmet, etc.) contributed to 13 of the 16 vehicle related deaths in 2003. The Panel presents all of these issues to the public for attention.

## **Child Homicides**

Since 1996, when Child Fatality Review Panel data began to be recorded, there have never been more than two child homicides in any year - until 2003. (1996=0, 1997 = 0, 1998 = 2, 1999 = 1, 2000 = 1, 2001= 1, 2002 = 2, 2003 = 4). Of the eleven child homicide deaths since 1996, six were due to firearms; two were due to blunt force injuries, two children died as the result of Shaken Baby Syndrome, and one by suffocation. Although the number of North Dakota children who die as the result of homicide may not seem large and the number of these deaths does not yet appear to be a developing trend, nonetheless, the Panel finds this increase disturbing.

## **Challenges to Effective Child Fatality Reviews**

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.
- ◆ Inter-county and interstate communications regarding child death.

## **Introduction (Continued)**

**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 quality since the inception of the Panel, too many scene investigations remain below a satisfactory standard. With encouragement and support from the forensic examiner's office, the use of the Sudden Unexpected Infant Death Investigation Report Form, developed by the Centers for Disease Control, has increased. The completion of this tool, however, remains inconsistent. Sections of the form are often left blank, or someone who was not actually at the scene of the death completes the form. 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. Some death scenes are not investigated because the child is transported to a hospital, where the actual death occurs, so the home is not considered the scene of a death, even though the death-causing event begins in the home. Information in this report that is presented as "unknown" is often the result of information not gathered during an investigation.

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 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.

### **Access to records**

North Dakota law 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"(NDCC 50-25.1-04.4). 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, such as school records, and records of substance abuse treatment professionals.

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 government 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 has been increasingly concerning that federal records remain inaccessible.

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

# **Calendar Year 2003**

## **Overview**

# Overview

## General Procedure

The North Dakota Department of Health provides vital statistic records for each child who has died in North Dakota. 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 prepared for review by the Administrator of the Child Fatality Review Panel or Panel member assigned to the case by the presiding officer. The Child Fatality Review Panel is scheduled to meet on a regular basis, at which time the compiled information is presented to panel members at the meeting for discussion, recommendations, and determination of preventability of death. 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.

## 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 due to natural causes and/or deaths that are not unexpected (i.e. long term illness). 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.

	2003
Status A Deaths	43
Status B Deaths	64
Total Child Deaths	107

## In-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.

	2003
In-State Deaths	38
Out-of-State Deaths	5
Total Child Deaths	43

# Overview

Each Status A death is thoroughly reviewed by the Child Fatality Review Panel and classified by manner of death, type of fatal injury/event, and preventability of the death.

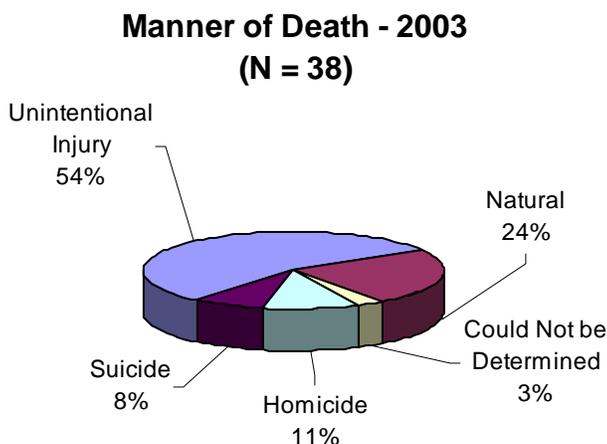
## Manner of Death

Death Certificates list one of the following five manners of death: Natural, Accident, Suicide, Homicide, or “Could Not Be Determined”. After careful review of each case, the Child Fatality Review Panel either agrees or disagrees with the manner of death listed on the 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 death for its own purposes. It is the Panel’s classification that serves as the basis of this report. The Panel reclassified three deaths in 2003. One death was reclassified from “undetermined” to “natural”. The second death was reclassified from “pending investigation” to “homicide”. The third death was reclassified from “accident” to “homicide”.

The largest category of death was unintentional injury, which claimed the lives of 21 children in 2003.

**Unintentional Injury Deaths are commonly referred to as accidents, both by the general public and by manner of death as recorded on birth 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.**

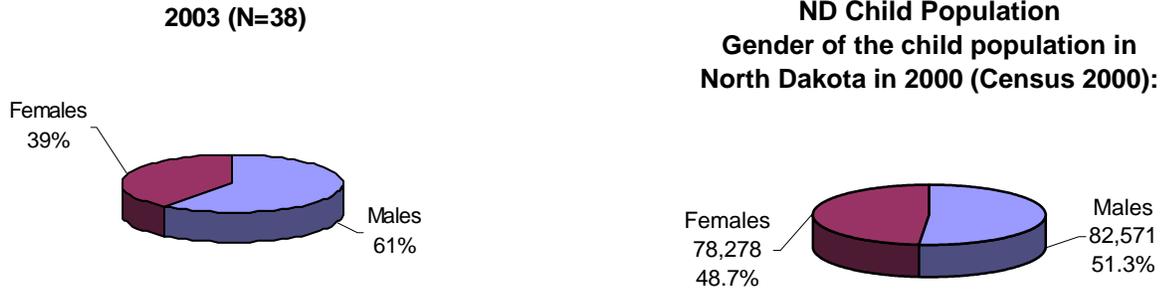
The second largest category of death was natural, which claimed the lives of nine children in 2003. The category suicide consisted of three child deaths in 2003. Four deaths were classified as homicides in 2003. The “Could Not Be Determined” category (one death in 2003) includes deaths in which the manner 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.



# Overview

## Demographics

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



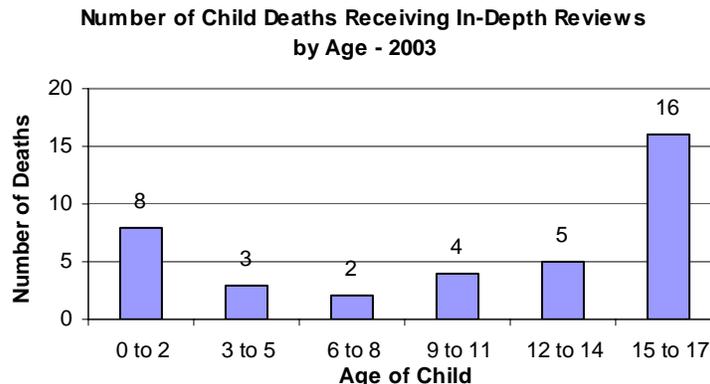
According to the North Dakota Data Center, North Dakota’s child population is nearly equally male and female (51.3% male; 48.7% female). However, 23 of the 38 (60.5%) children that died in North Dakota during 2003 were male.

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



According to the North Dakota Data Center, North Dakota’s child population is 87.5% Caucasian, and 8.0% Native American. However, 13 of the 38 (34%) children that died in North Dakota during 2003 were Native American.

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



# **Calendar Year 2003**

## **I. Unintentional Injury Deaths**

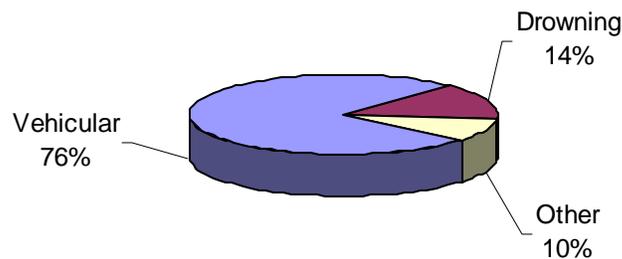
# Unintentional Injury Deaths

## Type of Fatal Injury/Event

There were 38 in-state child fatalities reviewed in 2003, 21 (55.2%) were 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 16 (76.1%) of the 21 unintentional injury child deaths during 2003.** Each of the type of fatal injury/event categories for unintentional injury is examined further in this section.

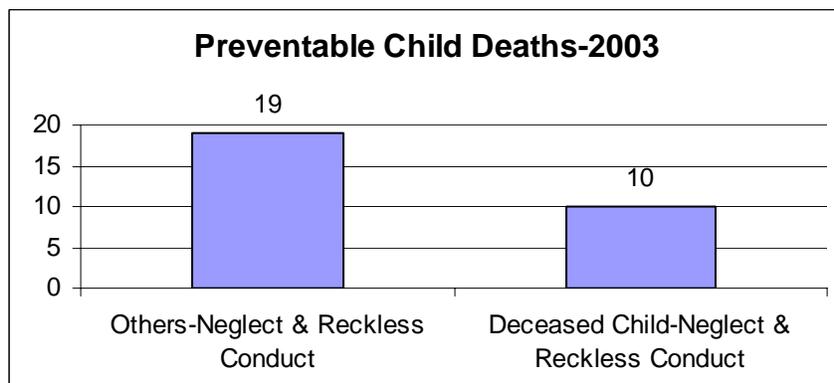
## Unintentional Injury Deaths - 2003

### Type of Fatal Injury/Event (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 2003, all 21 were categorized as preventable. The two main reasons for preventable child deaths were: 1) Neglect & Reckless Conduct of Others (19 of the 21 deaths) and 2) Neglect & Reckless Conduct of the Deceased Child (10 of the 21 deaths).**



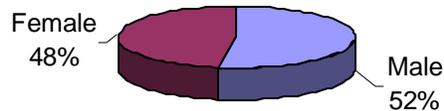
**Unintentional Injury Deaths are commonly referred to as accidents, both by the general public and by manner of death as recorded on death certificates. However, the term accident implies that the fatal injury/event could not have been prevented. Therefore, the Child Fatality Review Panel prefers the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

# Unintentional Injury Deaths

## Demographics

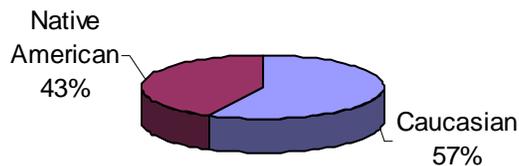
Of the 21 unintentional injury deaths in 2003, ten (45.5%) were female children compared to 11 (54.5%) male children.

**Gender - 2003 (N=21)**



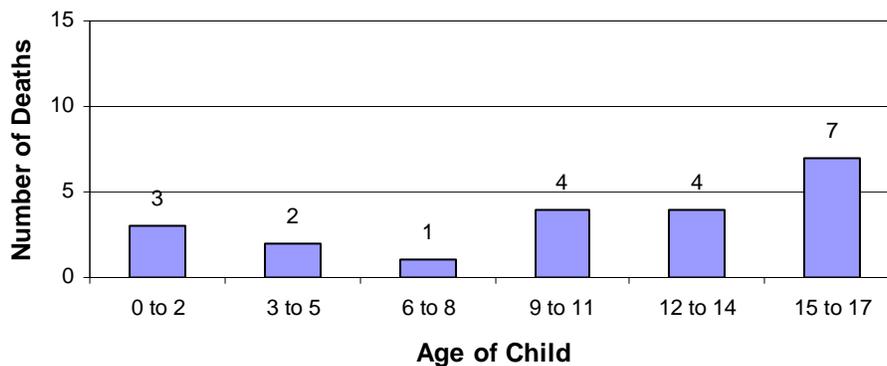
In 2003, 13 (59.1%) of the children who died because of unintentional injuries were Caucasian, and nine (40.9%) were Native American.

**Race - 2003 (N=21)**



The ages of the children involved in unintentional injury deaths are reported in the chart below.

**Number of Unintentional Injury Deaths  
by Age - 2003**



# Unintentional Injury Deaths

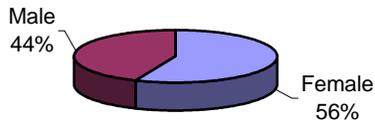
## Vehicular

In 2003, 16 children died in vehicle related deaths. (This includes one death where the cause of the death is asphyxia, which occurred on an all terrain vehicle). The Child Fatality Review Panel classified all of these deaths preventable.

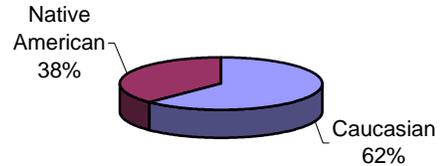
**In 2003, nine (56%) of the children who died were females compared to seven (44%) males.**

**In 2003, 10 (62%) of the children who died were Caucasian, and six (38%) were Native Americans.**

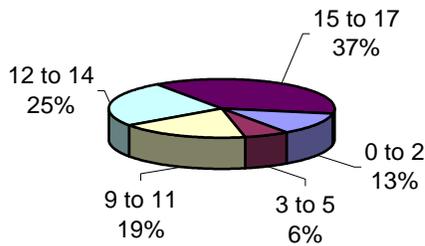
**Gender - 2003 (N=16)**



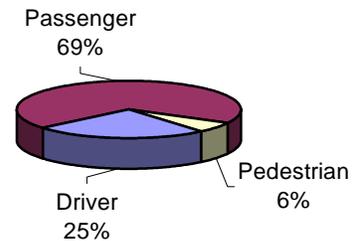
**Race - 2003 (N=16)**



**Age - 2003 (N=16)**

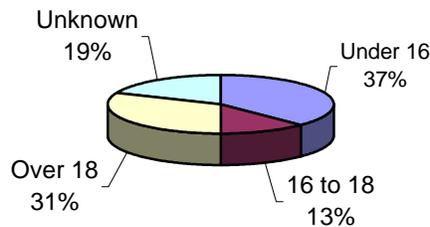


**Position of Decedent - 2003 (N=16)**



\*No children between Age 6 to nine died in 2003

**Age of Person Driving the Deceased Child's Vehicle - 2003 (N=16)**

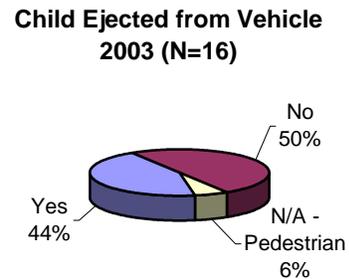


# Unintentional Injury Deaths

## Vehicular (Cont.)

### Safety Restraints Used/ Ejection from a vehicle

The use of safety restraints did not apply to five child deaths (3 took place on all terrain vehicles, one on a snowmobile, and one child was a pedestrian). Of the remaining 11 deaths, the use of safety restraints is unknown in two of the deaths. In the nine remaining cases where use of a vehicle restraint applies, none of the children who died were restrained. Five children were ejected from the vehicle.



Of the vehicular deaths in 2003, fifteen involved single vehicles and one involved multiple vehicles. In addition, of the child vehicular deaths in 2003, nine involved excessive speed and/or recklessness: the deceased child was the driver in four of these deaths and a passenger in six of the deaths.

### Contributing factors

Excessive speed or recklessness was a factor in nine deaths. Driver intoxication was a contributing factor in three deaths, while underage drinking was found in four deaths. Other contributing factors include: driver inexperience (3), under age operation of an all terrain vehicle (2); under age/unlicensed driver (1); weather conditions (1); improper turning (1); driver distraction (1)

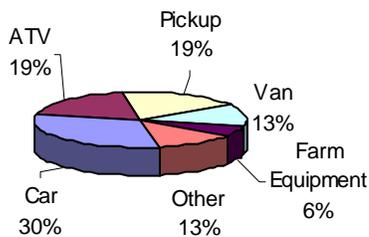
### Helmet Use

The use of helmets did not apply in 12 cases. In the four deaths where the use of protective headgear applied, two were wearing helmets, one was not wearing a helmet, and helmet use is unknown in one case.

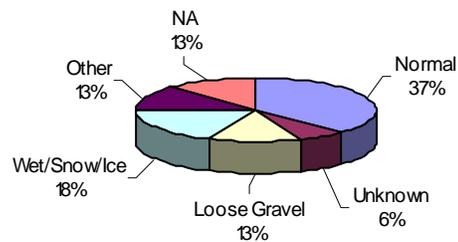
### Road Conditions

The road conditions were normal in six deaths. There were holes or bumps on the driving surface in two deaths. There was loose gravel in two deaths. Other conditions were wet (1), snow (1), and ice (1). One death occurred in a driveway and one in a yard. Conditions were unknown in one death.

**Type of Vehicle (N=16)**



**Road Conditions (N=16)**



## **PREVENTING VEHICLE CRASH DEATHS**

Many complex and varied factors surround children whose deaths result from motor vehicles. Viewed individually, these child deaths are commonly perceived as terrible tragedies, devastating for the family of a child who has died and for the community where the family lives. However, when these deaths are viewed broadly, and as a group, common themes in these heartrending situations are identified and strategies can be developed for the prevention of future tragedies.

Vehicles present hazards to children of any age. For young children (3 children under age five died in 2003), danger lies in having access to vehicles without supervision. They may put the vehicle in motion, often with tragic results. Danger for these little ones also lies in not using child restraints that are properly installed and correctly used, placing them at risk to be ejected in a crash.

Latency age children (3 children ages 9-11 died in 2003) face jeopardy when they or their caregivers overestimate their maturity and allow them to access, or even to drive, vehicles before they have reached the legal age to obtain a license or permit to drive.

Teens (10 children 12 – 17 died in 2003) face peril when confidence and bravado overcome judgment and maturity. When inexperience is combined with excessive speed, under age alcohol use, and varying weather or road conditions, the results are too often disastrous.

Children of any age are placed in harm's way when laws and/or manufacturer's instructions for operation of motorized recreational vehicles are ignored or when children are unsupervised.

While the factors in these deaths may vary considerably, the solutions for preventing many vehicle related deaths lie, not only with laws such as graduated drivers licensing, but also with educated and with vigilant adults.

Parents are primary in the prevention of vehicle related child deaths. Parental assessment of a teenager's maturity before providing a teen with a vehicle or granting permission to drive can have a powerful effect on issues such as driving during late-night hours, driving with passengers, and driving over unfamiliar roads and road surfaces. Parental insistence on wearing safety restraints combined with parentally imposed penalties for non-compliance can also be effective. Organizations such as Kids In Cars and the National Children's Center for Rural and Agricultural Health and Safety offer practical guidance for parents to become educated and motivated to take an active role in keeping children safe in and around vehicles.

## **Unintentional Injury Deaths**

### **Drowning**

There were three unintentional injury deaths from drowning in 2003. One was a two-year-old child, left unattended in a running vehicle that plunged into 25 feet of water. One was a 5 year old who drowned while kayaking with an adult. One was a 9 year old who drowned in a motel swimming pool. The Panel determined all three of these drowning deaths to be preventable.

### **Firearm**

**There were no firearm unintentional injury child deaths in 2003.**

### **Poisoning/Overdose**

**There were no unintentional poisoning/overdose injury child deaths in 2003.**

### **Asphyxia**

**In 2003, one child (white, male, age nine) died due to asphyxia related to being crushed by a garage door while driving an all terrain vehicle (this death was included in the vehicle related deaths).**

### **Fall Injury**

**No children died from unintentional fall injury deaths in 2003.**

### **Fire**

**No children died from unintentional fire injury deaths in 2003.**

### **Electrocution**

**No children died from unintentional electrocution injury deaths in 2003.**

### **Other Injuries**

**There were two child deaths from other injuries in 2003. A 16-year-old Native American Female died from environmental cold exposure and a six-year-old white male died after a gate fell on him.**

# **Calendar Year 2003**

## **II. Natural Deaths**

## Natural Deaths

### Type of Fatal Injury/Event

**The manner of death was classified as natural for nine (23.7%) of the 38 child deaths in 2003.**

### SIDS

Two children died from SIDS (Sudden Infant Death Syndrome) during 2003. A 1 month old died at home. A two-month-old white female died in childcare. Neither of these children was sleeping in a crib designed for safe infant sleep.

### Other Natural Deaths

During calendar year 2003, seven deaths did not fall into one of the 13 types of fatal injury/event data categories. The following conditions led to these seven child deaths.

- Acute peritonitis (14 yr old) An autopsy was performed.
- Pulmonary atelectosis (2 month old) An autopsy was performed.
- Acute renal failure. Shock. Pneumonia. No autopsy was performed. (This case may have been best classified as a category "B" case. Death occurred in a hospital. The attending physician described this as an "expected death". Child had pre-existing medical conditions.) (15 year old)
- Cardiac arrest. Reactive airways disease. Obstructive apnea. Anuric acute renal failure. Metabolic acidosis. Obesity. (4 year old) An autopsy was performed.
- Acute intracerebral hemorrhage; Primitive Neuroectodermal Tumor (PNET) of right cerebral hemisphere. (2 year old) An autopsy was performed.
- Brain herniation syndrome. No autopsy was performed. (The County Coroner documented, an "autopsy would not be revealing".) (17 year old)
- Cardiac Arrhythmia Myocarditis (17 year old) An autopsy was performed.

**Calendar Year 2003**

**III. Suicide Deaths**

## **Suicide Deaths**

### **Suicide Deaths**

There were three suicide deaths in children during calendar year 2003. The Child Fatality Review Panel classified all three deaths as preventable. Two were 15-year-old males; one was a 16-year-old male. Two deaths resulted from hanging. One death resulted from firearms.

**Calendar Year 2003**

**IV. Homicide Deaths**

## **Homicide Deaths**

### **Homicide Deaths**

In 2003, there were four homicide deaths. An 8-year-old white male; a 17-year-old white male; a 16-year-old white female; and a 17 year old Native American male.

In two of the homicide deaths, the Panel disagreed with the manner of death as stated on the death certificate and reclassified one death from “accident” to homicide and one death from “pending investigation” to homicide. Three of the homicides involved firearms. One involved a blunt force injury to the head. None of the homicide deaths involved child abuse by the child’s caregiver. All of the homicide deaths were determined to be preventable.

**Calendar Year 2003**

**V. Manner Could Not be  
Determined Deaths**

## **Manner Could Not be Determined Deaths**

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

There was one death in 2003 in which the manner of death could not be determined. A three-day-old infant was found unresponsive while sleeping on an adult mattress with two adults. Although there were numerous risk factors present for SIDS (Sudden Infant Death Syndrome), the possibility of suffocation could not be ruled out, even after an autopsy was performed.

