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NORTH DAKOTA CHILD FATALITY REVIEW PANEL

ANNUAL REPORT

2007, 2008, 2009

July 2011

CHILDREN AND FAMILY SERVICES DIVISION
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THE NORTH DAKOTA CHILD FATALITY REVIEW PANEL

Child Deaths in North Dakota, CY 2007, 2008 and 2009

	2007	2008	2009
Total Child Deaths	101	83	95
Deaths that are not unexpected (i.e., long term illness) and/or deaths due to natural causes	56	47	43
Deaths that are sudden, unexpected, or unexplained	45	36	52
The 'death-causing' event occurs outside of North Dakota	4	7	9
In-State Child Deaths (in-Depth Reviews)	41	29	43

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 ... the identifying of 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."

The Panel presents all of these issues to the public for attention through this bulletin.

According to NDCC 50-25.1-04.3, 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.' More in-depth reviews are conducted on child deaths in the state that were sudden, unexpected, or unexplained. The Child Fatality Review Panel met quarterly in 2007, 2008, and 2009.

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.

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.

Duties

The following duties are assigned to the North Dakota Child Fatality Review Panel by state law (NDCC 50-25.1-04.3).

1. Interagency communication for the management of child death cases and for the management of future nonfatal cases.
2. Effective criminal, civil, and social intervention for families with fatalities.
3. Intervention and counseling of surviving and at-risk siblings, and offer the same.
4. Interagency use of cases to audit the total health and social service systems and to minimize misclassification of cause of death.
5. Evaluation of the impact of specific risk factors including substance abuse, domestic violence, and prior child abuse.
6. Interagency services to high-risk families.
7. Data collection for surveillance of deaths and the study of categories of causes of death.
8. The use of media to educate the public about child abuse prevention.
9. Intercounty and interstate communications regarding child death.
10. Use of local child protection team members as local child fatality review panelists.
11. Information that appraises a parent or guardian of the parent's or guardian's rights and the procedures taken after the death of a child.

Goals

Goals of the NDCFRP are to

- accurately identify and document the cause of death,
- collect uniform and accurate statistics,
- facilitate coordination among participating agencies,
- contribute to the improvement of criminal investigations and prosecution of child abuse homicides,
- recommend protocols for investigation of certain categories of child deaths,
- identify any changes needed in legislation, policy, practice, and/or training,
- use the media to educate the public about child fatality prevention,
- promote inter-county and interstate communications regarding child deaths,
- develop local child fatality review panels, and
- evaluate the impact of specific risk factors on child deaths including substance abuse and domestic violence

Strategies

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 – Establish uniform child death scene and death investigation protocols.
2. State Forensic Examiner/Coroners – Improve access to technical assistance, and thorough autopsies on all child deaths.
3. Public Health – Implement primary prevention programs focused on education and awareness campaigns such as 'Back to Sleep,' and 'Never Shake a Baby;' and safety programs for firearms, seat belts, child restraint, child abuse prevention; and fire and poison prevention.
4. Social and Mental Health Services – Provide supportive services for surviving family members and communities.

General Procedures

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. The Child Fatality Review Panel meets quarterly. The compiled case information is presented to Panel members for discussion. 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.

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.

Members of the State Child Protection Team serve as the core members of the Child Fatality Review Panel. The core members include:

- designee of the Department of Human Services who serves as the presiding officer,
- representative of 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, and
- representative of 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, Department of Health,
- a representative of Emergency Medical Services, Department of Health, and
- consultants invited to assist in review of specific cases.

Panel Members – 2007, 2008, 2009

Tara Muhlhauser - NDCFRP Presiding Officer (2007, 2008)
Children and Family Services, ND Department of Human Services

Marlys Baker – NDCFRP Presiding Officer (2009)
Child Protection Services, ND Department of Human Services

Tracy Miller – CFRP Administrator (2009)
Children and Family Services, ND Department of Human Services

Shelly Arnold - Emergency Medical Services (2007, 2008, 2009)
Trauma Services – MedCenter One

Lisa Bjergaard (2007, 2008, 2009)
Division of Juvenile Justice

Jonathan Byers (2007, 2008, 2009)
Assistant ND Attorney General

Tom Dahl (2007, 2008, 2009)
ND Bureau of Criminal Investigation

Dr. Terry Dwelle – State Health Officer (2007, 2008, 2009)
ND Department of Health

Karen Eisenhardt – Educator (2007, 2008, 2009)
State Child Protection Team – lay member

JoAnne Hoesel (2009)
ND Department of Human Services

Steve Kukowski (2007, 2008, 2009)
Minot Police Department

Dr. Gordon Leingang - Emergency Trauma (2007, 2008, 2009)
St. Alexius Medical Center

Dr. George Mizell, State Forensic Medical Examiner (2007)
ND Department of Health

Dr. William Massello, State Forensic Medical Examiner (2008, 2009)
ND Department of Health

Carol Meidinger - Injury Prevention Program (2007, 2008, 2009)
ND Department of Health

Dr. Ron H. Miller (2007, 2008, 2009)
MeritCare Children's Hospital

Carla Pine (2007, 2008, 2009)
State Child Protection Team, lay member

Diana Read, Injury Prevention (2007, 2008, 2009)
ND Department of Health

Bob Rutten (2007, 2008, 2009)
Department of Public Instruction

Dr. Mary Ann Sens, Department of Pathology (2007, 2008, 2009)
UND School of Medicine and Health Services

Jim Vukelic , State's Attorney (2008)
Grant County

CASES THAT RECEIVED AN IN-DEPTH REVIEW

Case Status

Each death certificate received from the Department of Health is reviewed by a Child Fatality Review Panel subcommittee; each death is identified as a Status A case or a Status B case (Table 1). 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 in this report.

Table 1. Child Deaths by Status, CY 2007, 2008, and 2009

	2007	2008	2009
Status A	45	36	52
Status B	56	47	43
Total	101	83	95

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 Child Fatality Review 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.

Table 2. Status 'A' Child Deaths by In- and Out-of-State, CY 2007, 2008, and 2009

	2007	2008	2009
In-State	41	29	43
Out-of-State	4	7	9
Total	45	36	52

The Child Fatality Review Panel conducts in-depth reviews of child deaths within the state that are sudden, unexpected, or unexplained. Compared to the 59 child deaths reviewed in 2006, the number of in-state sudden, unexpected, or unexplained deaths decreased to 41 (30.5%) in 2007, 29 (50.8%) in 2008, and 43 (27.1%) in 2009 (Table 2).

Caution

Throughout this report data show small numbers. Caution should be used when interpreting or representing the data. Small numbers that are standardized as percentages will be viewed as a table (small numbers) and a figure (%s). Considering both the number and percent will ensure a more accurate interpretation of the data.

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

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

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

In 2007, the Panel reclassified one death, changing it from 'accident' to 'could not be determined.' There had been no autopsy performed in that case. In 2008, three deaths were reclassified by the Panel: one from 'natural' to 'not determined;' one from 'accident' to 'not determined;' and one from 'accident' to 'homicide.' Autopsies had been performed in the first and third case. In 2009, the Panel reclassified a case from 'natural' to 'could not be determined.' The Panel did not believe that proper protocol had been followed.

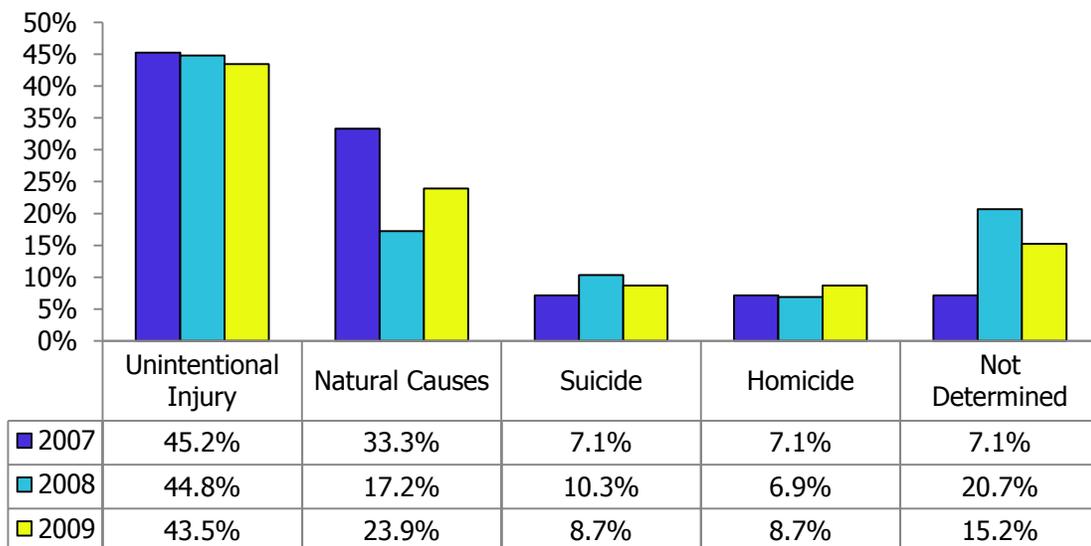


Figure 1. Percent of Child Fatalities by Manner of Death, CY 2007, 2008, and 2009

The largest category for the manner of death was 'unintentional injury,' which claimed the lives of 19 children in 2007, 13 in 2008, and 20 in 2009 (Figure 1

and Table 3). 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 child deaths in this category are predictable, understandable, and preventable.

'Natural' was the second largest category for the manner of death in 2007 and 2009, resulting in 14 and 11 child deaths, respectively (Figure 1 and Table 3). The number of child deaths where manner of death could not be determined increased each year, from three in 2007 to six in 2008 and seven in 2009.

Table 3. Number of Child Fatalities by Manner of Death in Child Fatality Cases that Received an In-Depth Review, CY 2007, 2008, and 2009

	2007	2008	2009
Unintentional Injury	19	13	20
Natural Causes	14	5	11
Suicide	3	3	4
Homicide	3	2	4
Not Determined	3	6	7
Total	41*	29	43*

* These columns will not add up to the totals because in 2007 one case was listed under both 'unintentional' and 'natural.' In 2009 two cases were listed as both 'homicide' and 'unintentional' and one case was listed both as 'not determined' and 'unintentional.'

Data Overview and Demographics

Each Status A death is reviewed thoroughly by the Child Fatality Review Panel. The Panel classifies each death by the manner of death, the type of fatal injury/event, and the preventability of the death. The Panel's review of the 41 child deaths in 2007, 29 in 2008, and 43 in 2009 determined to be 'Status A' deaths form the basis of this report.

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 (49.9%) and half female (50.1%) (U.S. Census Current Population Survey, Annual Social and Economic Supplement 2009). In 2007 and 2008, child deaths that received in-depth comprehensive reviews were closely representative of the population by gender (Figure 2 and Table 4). In 2009, the gap was wider with 24 males (55.8%) to 19 females (44.2%).

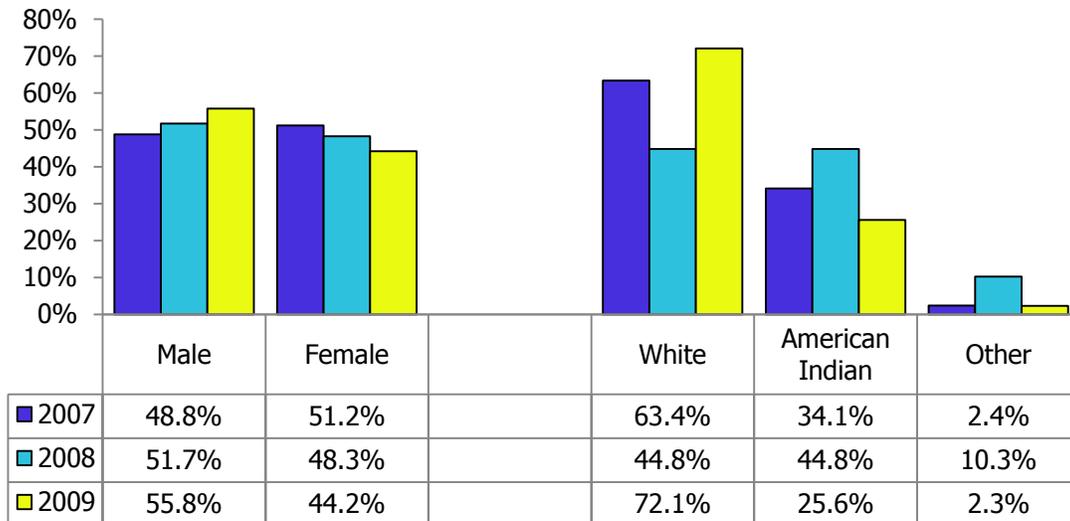


Figure 2. Gender and Race of Child Deaths in Child Fatality Cases that Received an In-Depth Review, CY 2007, 2008, and 2009

One in eight children in North Dakota are American Indian. They are over-represented in the child deaths in North Dakota. In 2007, about one in three (34.1%) child fatality deaths that received in-depth reviews were American Indian. In 2008 the ratio was slightly lower than one in two (44.8%). The ratio dropped to about one in four (25.6%) in 2009 (Figure 2 and Table 4). The actual number of American Indian child fatalities that were sudden, unexpected, or unexplained decreased each year from 14 in 2007 to 13 in 2008 and 11 in 2009 (Table 4).

Table 4. Number of Child Deaths by Gender and Race in Child Fatality Cases that Received an In-Depth Review, CY 2007, 2008, and 2009

	2007	2008	2009
Male	20	15	24
Female	21	14	19
White	26	13	31
American Indian	14	13	11
Other	1	3	1
Total	41	29	43

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

Even with the decline in percent and number of child deaths in the older youth from 2007 to 2009, the vast majority of child deaths occur with the very young ages (0 to 2) and the older youth (ages 15 to 17) (Figure 3 and Table 5).

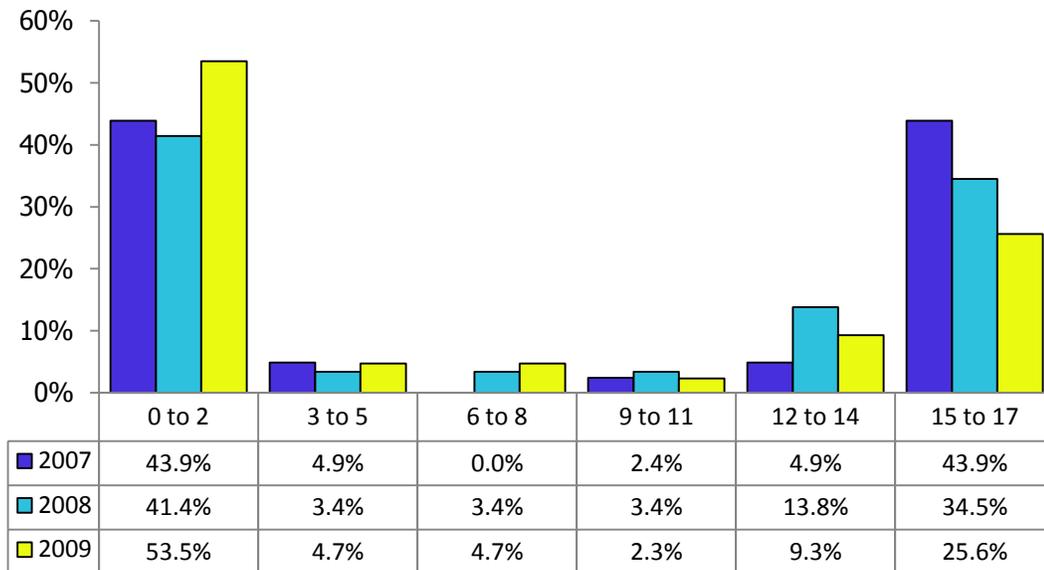


Figure 3. Percent of Child Deaths by Age in Child Fatality Cases that Received an In-Depth Review, CY 2007, 2008, and 2009

The percent of fatalities of children under age three that were reviewed by the Panel increased by about 10 percent from 2007 to 2009. The number increased from 18 in 2007 to 23 in 2009. On the other hand, the older youth decreased by over 18 percent from 2007 to 2009. The numbers declined from 18 in 2007 to 11 in 2009 (Figure 5 and Table 8).

Table 5. Number of Child Deaths by Age in Child Fatality Cases that Received an In-Depth Review, CY 2007, 2008, and 2009

	2007	2008	2009
0 to 2	18	12	23
3 to 5	2	1	2
6 to 8	0	1	2
9 to 11	1	1	1
12 to 14	2	4	4
15 to 17	18	10	11
Total	41	29	43

ALL CHILD UNINTENTIONAL INJURY DEATHS

Type of Fatal Injury/Event in Child Unintentional Injury Deaths

In 2007, the Panel found that 46.3% (19) deaths were unintentional. There was a decrease in 2008 to 44.8% (13) in deaths found to be unintentional. In 2009, the number of deaths found to be unintentional rose to 20 (46.5%) (Table 6). Figure 4 and Table 6 show the type of unintentional injury deaths. Vehicular deaths in 2007 accounted for 68.4% of unintentional injury deaths. In 2008, the percent rose to 92.3% and in 2009 the percent decreased to 60.0% (Figure 4).

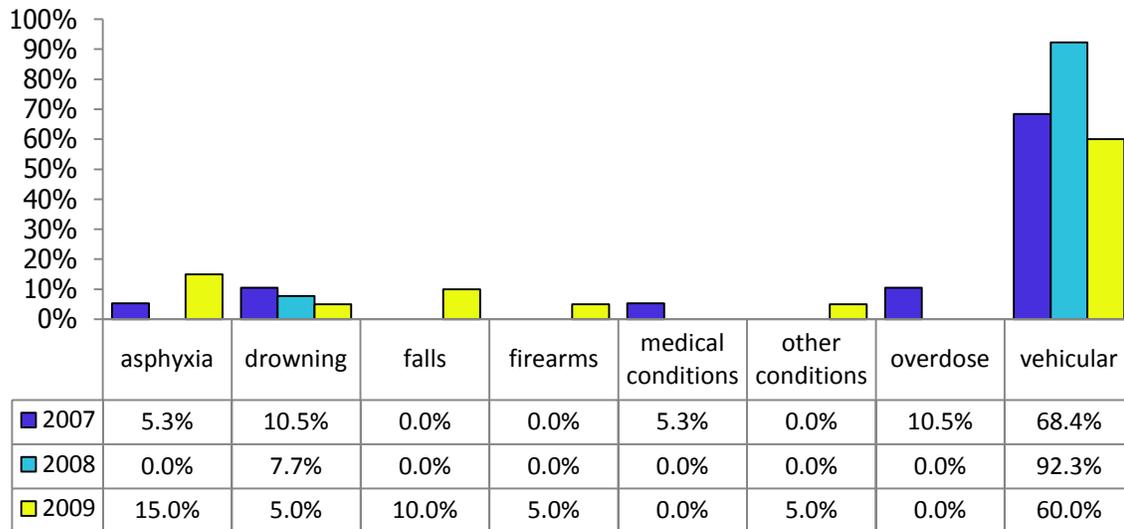


Figure 4. Percent of Child Unintentional Deaths by Type in Child Fatality Cases That Received an In-depth Review, CY 2007, 2008, and 2009

Table 6. Number of Child Unintentional Deaths by Type in Child Fatality Cases That Received an In-Depth Review, CY 2007, 2008, and 2009

	2007	2008	2009
Asphyxia	1		3
Drowning	2	1	1
Falls			2
Firearms			1
Medical Conditions	1		
Other Injuries			1
Overdose	2		
Vehicular	13	12	12
Total	19	13	20

Preventability of Child Unintentional Injury Deaths

The Child Fatality Review Panel classifies each child's death as preventable or non-preventable. In all three years the CFRP classified unintentional injury deaths as preventable. In 15 of 20 cases in 2007, 14 of 18 in 2008, and 11 of 13 in 2009, deaths were attributed to the neglect and reckless conduct of others. Neglect and reckless conduct by the deceased was observed in 8 of 20 cases in 2007, 11 of 18 in 2008, and 9 of 13 in 2009.

Gender and Race in Child Unintentional Injury Deaths

While 2008 and 2009 mirrored the distribution of child population in North Dakota by gender (49.9% male and 50.1% female), 2007 data show a wider gap between males (7) and females (12) (Figure 5 and Table 7).

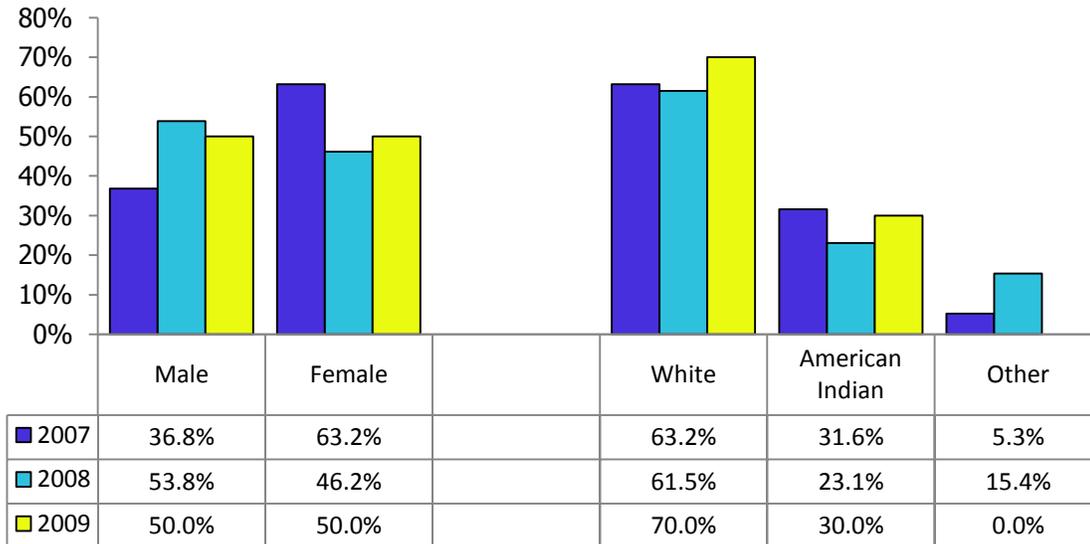


Figure 5. Percent of Child Unintentional Injury Deaths by Gender and Race in Child Fatality Cases That Received an In-Depth Review, CY 2007, 2008, and 2009

Child fatality from unintentional injuries by race varied somewhat in percent and number for the three years with a drop in percent and number from 2007 to 2008 followed by an increase in percent and number in 2009. American Indian deaths were well above the statewide percent of American Indian child population and therefore, continues to over represent that population.

Table 7. Number of Unintentional Injury Deaths by Gender and Race in Child Fatality Cases that Received an In-Depth Review, CY 2007, 2008, and 2009

	2007	2008	2009
Male	7	7	10
Female	12	6	10
White	12	8	14
American Indian	6	3	6
Other	1	2	
Total	19	13	20

Age in Child Unintentional Injury Deaths

In the years 2007-2008 the percent of unintentional injury deaths are heavily weighted in the upper age category. The 2009 percent for the 15 to 17 age category (30.0%) dropped to that similar to 2009 for the 0 to 2 years age category (30.0%) (Figure 6).

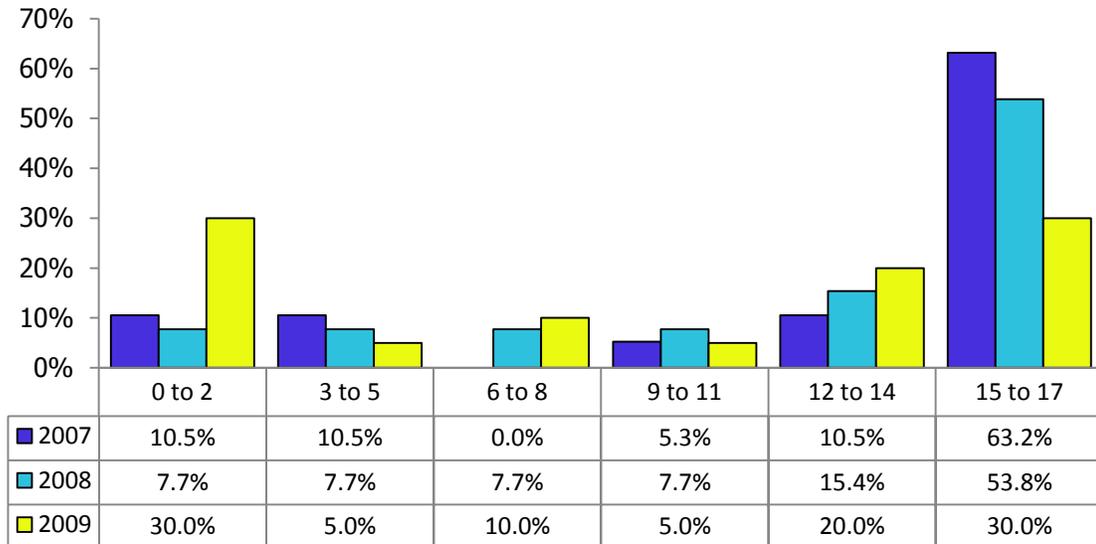


Figure 6. Percent of Unintentional Child Deaths by Age in Child Fatality Cases that Received an In-Depth Review, CY 2007, 2008, and 2009

The number of unintentional injury child deaths increased from 2007 to 2009 for those ages zero to two. The numbers decreased by half in the same time period for those ages 15 to 17 (Table 8).

Table 8. Number of Unintentional Child Deaths by Age in Child Fatality Cases that Received an In-Depth Review, CY 2007, 2008, and 2009

	2007	2008	2009
0 to 2	2	1	6
3 to 5	2	1	1
6 to 8		1	2
9 to 11	1	1	1
12 to 14	2	2	4
15 to 17	12	7	6
Total	19	13	20

ALL CHILD VEHICULAR DEATHS

Gender and Race in Child Vehicular Deaths

Children involved in vehicular deaths remained closely divided by gender for 2007 and 2008. In 2009, the ratio of female to male child vehicular unintentional vehicular deaths was about two to one (Figure 7 and Table 9).

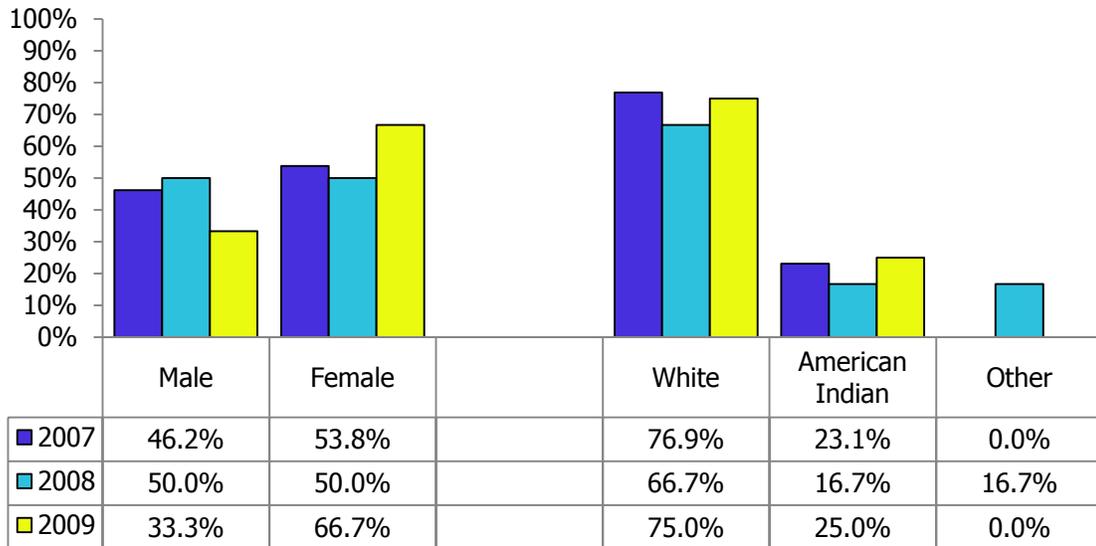


Figure 7. Percent of Vehicular Deaths by Gender and Race in Child Fatality Cases that Received an In-Depth Review, CY 2007, 2008, and 2009

In 2007 and 2009 the ratio of White to American Indian child vehicular deaths was 3 to 1. In 2008 the ratio was four White children to every American Indian child vehicular death (Table 9).

Table 9. Number of Vehicular Deaths by Gender and Race in Child Fatality Cases that Received an In-Depth Review, CY 2007, 2008, and 2009

	2007	2008	2009
Male	6	6	4
Female	7	6	8
White	10	8	9
American Indian	3	2	3
Other		2	
Total	13	12	12

Age in Child Vehicular Deaths

The age of children in vehicular deaths weighted heavily to the older youth age category, though the percent of deaths decreased each year from 2007 (76.9%) to 2009 (41.7%) (Figure 8). The number of child vehicular deaths declined from ten in 2007 to seven in 2008 to five in 2009 (Table 10).

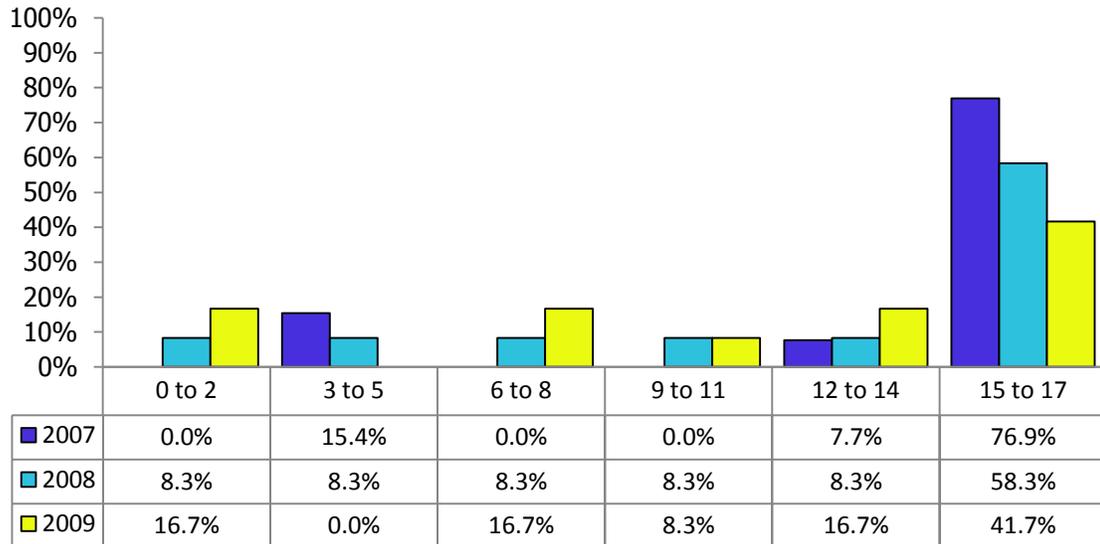


Figure 8. Percent of Vehicular Child Deaths by Age in Child Fatality Cases that Received an In-Depth Review, CY 2007, 2008, and 2009

Table 10. Number of Vehicular Child Deaths by Age in Child Fatality Cases that Received an In-Depth Review, CY 2007, 2008, and 2009

	2007	2008	2009
0 to 2		1	2
3 to 5	2	1	
6 to 8		1	2
9 to 11		1	1
12 to 14	1	1	2
15 to 17	10	7	5
Total	13	12	12

Age of Person Driving in Child Vehicular Deaths

The age of the persons driving vehicles in the event of a child death were primarily ages 18 and younger (76.9% in 2007; 75.0% in 2008, and 58.4% in 2009) (Figure 9). Drivers ages 16 and under numbered three in 2007, three in 2008, and two in 2009 (Table 11).

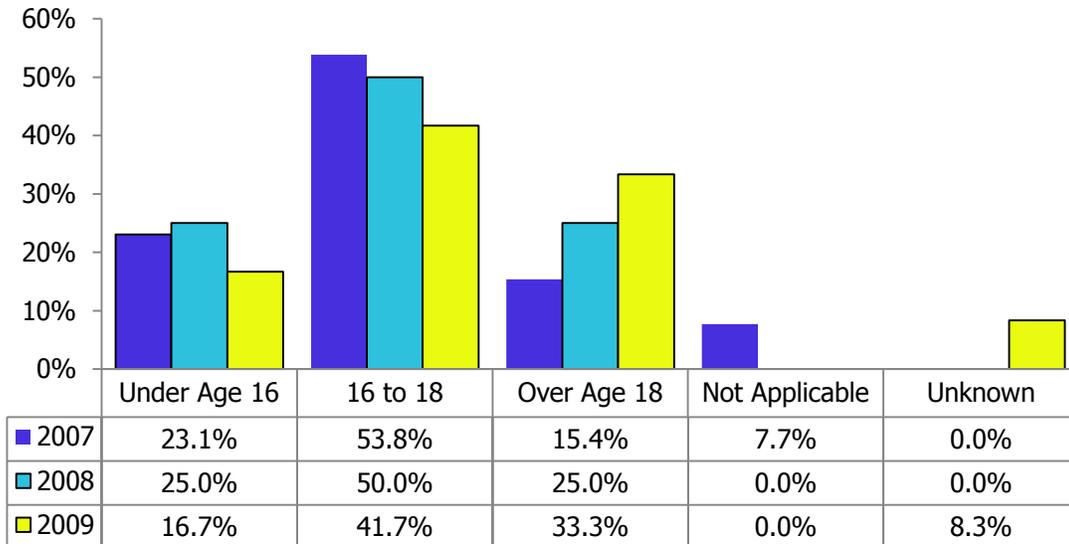


Figure 9. Percent of Vehicular Child Deaths by Age of Person Driving the Vehicle in Child Fatality Cases that Received an In-Depth Review, CY 2007, 2008, and 2009

Table 11. Number of Vehicular Child Deaths by Age of Person Driving the Vehicle in Child Fatality Cases that Received an In-Depth Review, CY 2007, 2008, and 2009

	2007	2008	2009
Under Age 16	3	3	2
16 to 18	7	6	5
Over Age 18	2	3	4
Not Applicable	1		
Unknown			1
Total	13	12	12

Position of Deceased Child in Vehicular Deaths

The deceased child in vehicular deaths was the driver in about half (50% in 2008) to under half of the cases (46.2% in 2007 and 41.7% in 2009) (Figure 10 and Table 12).

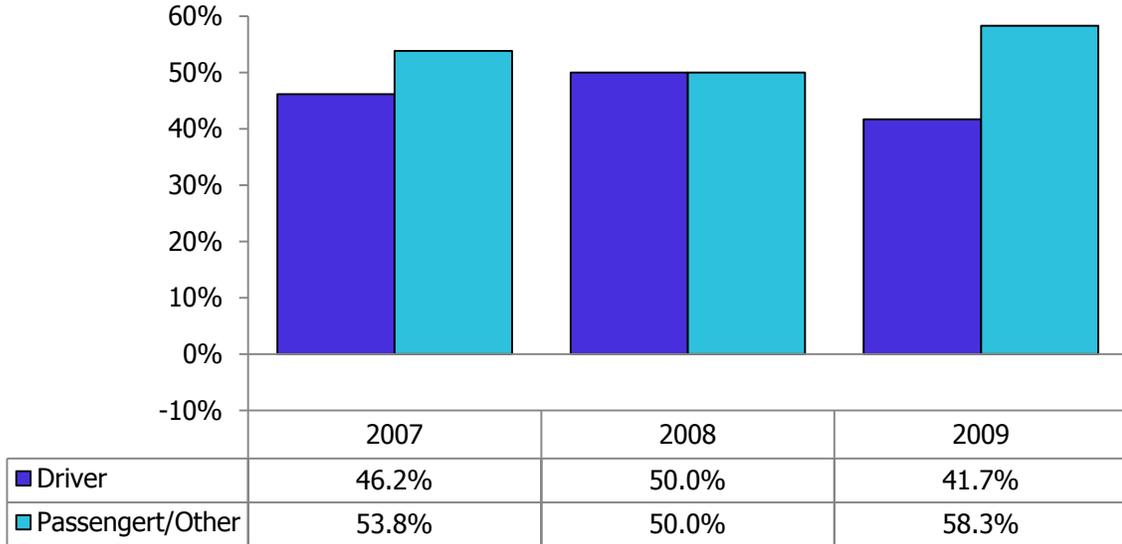


Figure 10. Percent of Deceased Child in Vehicular Child Deaths by Position in Vehicle, CY 2007, 2008, and 2009

Table 12. Number of Deceased Children in Vehicular Child Deaths by Position in Vehicle, CY 2007, 2008, 2009

	2007	2008	2009
Driver	6	6	5
Passenger/Other	7	6	7
Total	13	12	12

Safety Restraints Used in Child Vehicular Deaths

Restraint use varied in each year with no discernable pattern of use (Figure 11 and Table 13). The rates of child vehicular deaths for the number where safety restraints were not used fell from 53.3% (7) in 2007 to 41.7% (5) in 2008 and 33.3% (4) in 2009.

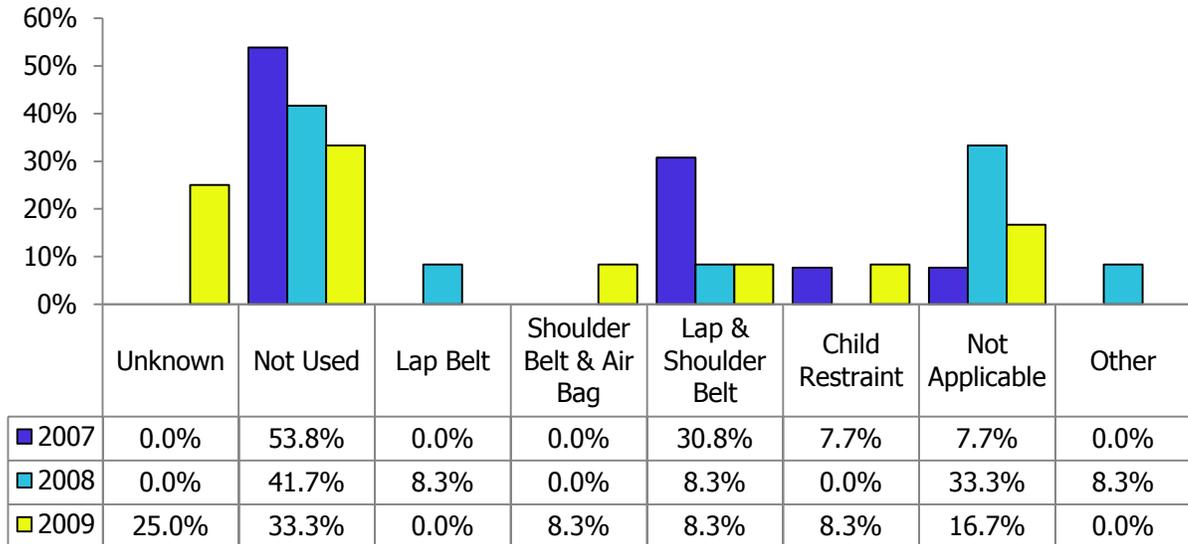


Figure 11. Percent of Vehicular Child Deaths by Using a Safety Restraint, CY 2007, 2008, and 2009

Table 13. Number of Vehicular Child Deaths by Using a Safety Restraint, CY 2007, 2008, and 2009

	2007	2008	2009
Unknown	0	0	3
Not Used	7	5	4
Lap Belt	0	1	0
Shoulder Belt & Air Bag	0	0	1
Lap & Shoulder Belt	4	1	1
Child Restraint	1	0	1
Not Applicable	1	4	2
Other		1	
Total	13	12	12

Child Vehicular Deaths In Which the Child was Ejected

Child vehicular deaths include deaths that involve ATVs and motorcycles. Therefore, ejection of the child was not applicable in all cases. The percent ejected of the remainder was 25% percent (3 of 12) each in 2007 and 2008 and over half (6 of 11) in 2009 (Table 14). The increase in the number of ejections from 2007 (3) and 2008 (3) to 2009 (6) may be interpreted as youth having less regard for using proper safety restraints.

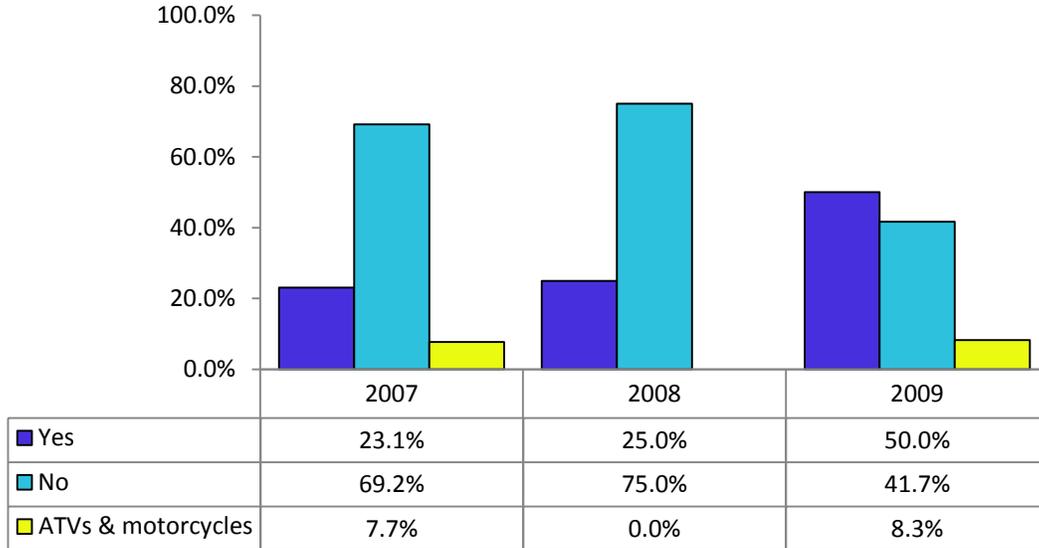


Figure 12. Percent of Vehicular Child Deaths and Ejection from Vehicle, CY 2006, 2007, 2008

Table 14. Number of Vehicular Child Deaths and Ejection from Vehicle, CY 2007, 2008, 2009

	2007	2008	2009
Yes	3	3	6
No	9	9	5
ATVs & motorcycles	1		1
Total	13	12	12

Road Conditions in Child Vehicular Deaths

For the most part, road conditions were normal for the child vehicular deaths (8, 61.5% in 2007; 10, 83.3% in 2008; and 9, 75.0% in 2009) (Figure 13 and Table 15). Other road conditions that may have contributed to car accidents varied by condition by year, with no discernable pattern.

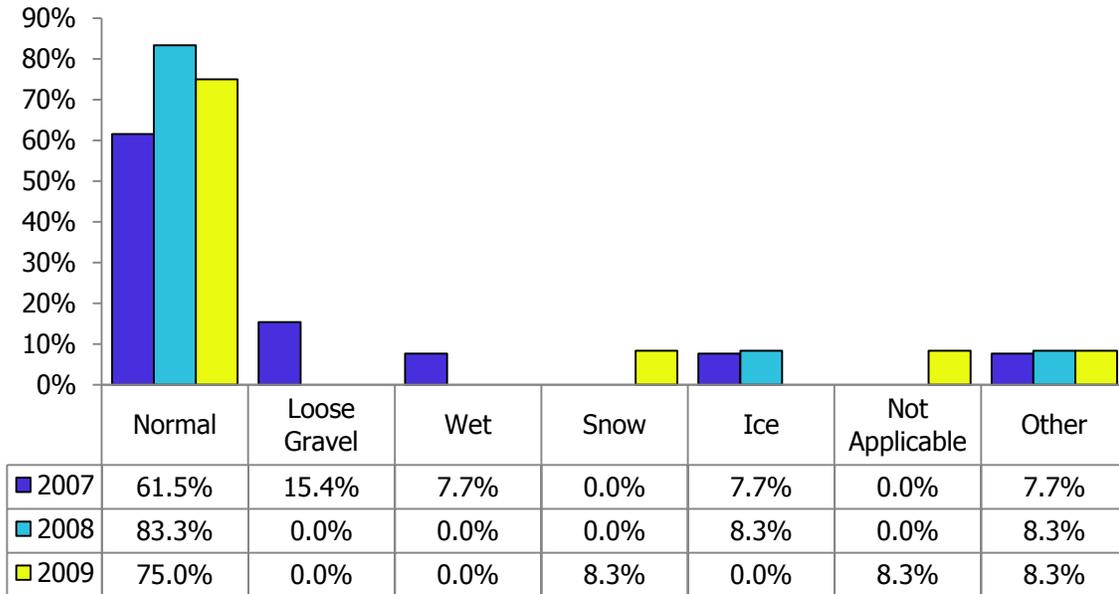


Figure 13. Percent of Vehicular Child Deaths by Road Conditions, CY 2007, 2008, and 2009

Table 15. Number of Vehicular Child Deaths by Road Conditions, CY 2007, 2008, and 2009

	2007	2008	2009
Normal	8	10	9
Loose Gravel	2	0	0
Wet	1	0	0
Snow	0	0	1
Ice	1	1	0
NA	0	0	1
Other	1	1	1
Total	13	12	12

Type of Vehicle Driven in Child Vehicular Deaths

The percent and number of type of vehicle varied across years leaving no discernable pattern (Figure 14 and Table 16). Even the percent and number of cars involved varied enough, though in 2007 and 2008 cars were involved in considerably more accidents than other types of vehicles. In 2009, cars matched vans in the number involved (three each year) (Table 16).

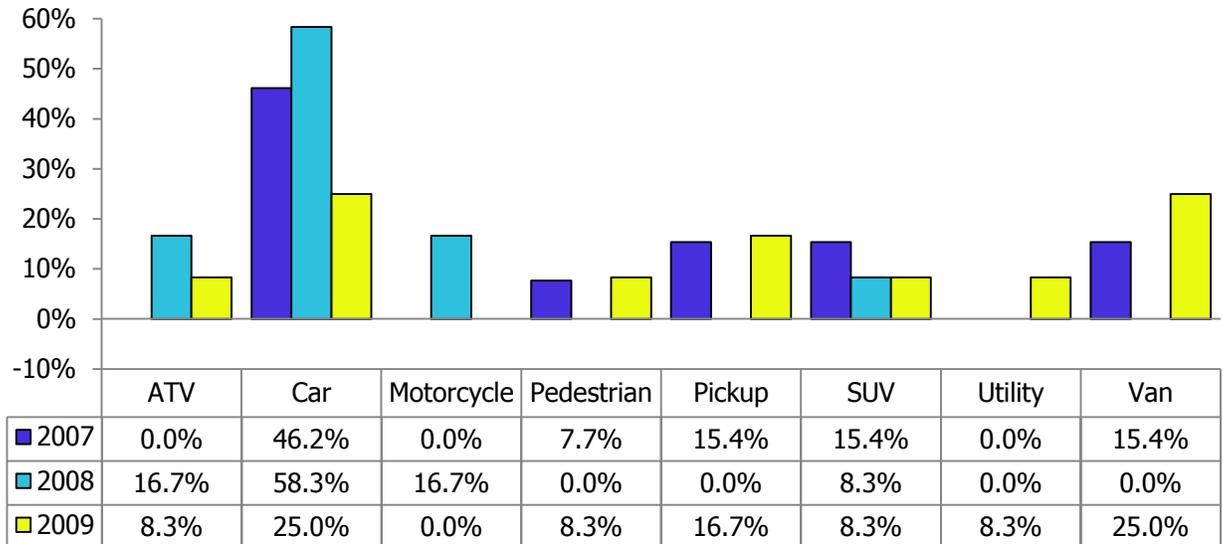


Figure 14. Percent of Vehicular Child Deaths by Type of Vehicle, CY 2007, 2008, and 2009

Table 16. Number of Vehicular Child Deaths by Type of Vehicle, CY 2007, 2008, and 2009

	2007	2008	2009
ATV	0	2	1
Car	6	7	3
Motorcycle	0	2	0
Pedestrian	1		1
Pickup	2	0	2
SUV	2	1	1
Utility			1
Van	2	0	3
Total	13	12	12

A SUMMARY OF CHILD DEATHS IN 2007, 2008, and 2009

In 2007, 43.9 percent of child fatality deaths that received in-depth reviews were under age three and 43.9 percent were between ages 15 and 17. In 2008, 41.4 percent were under age three and 34.5 percent were between ages 15 and 17. Again, in 2009 with 53.5 percent under age three and 25.6 percent between ages 15 and 17, the data demonstrate that children at greatest risk of death are the infants/toddlers and teenagers.

The gender of the children was fairly evenly divided during these three years. In 2007 there was one more male than female and in 2008 there was one more female than male. The gap was wider in 2009 with 24 males and 19 females. On average, the data reflect closely the gender distribution of individuals ages 0 to 17 in North Dakota's population.

Data show that American Indian children are over represented in the child fatality numbers. About 13 percent (one in eight) of North Dakota's child population is American Indian (U.S. Census Bureau Current Population Survey, Annual Social and Economic Supplement). However, of the child deaths reviewed by the Panel during 2007, 2008 and 2009, 34.1 percent (14) of 41 deaths, 44.8 percent (13) of 29 deaths, and 25.6 percent (11) of 43 deaths, respectively, were American Indian.

Unintentional Injury Deaths

Unintentional injury is the largest category of sudden, unexpected and unexplained child deaths for 2007 (19, 46.3%), 2008 (13, 44.8%), and 2009 (20, 46.5%). 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 injury as opposed to the term accident because the child deaths in this category are predictable, understandable, and preventable.

The largest sub-category of unintentional injury deaths is vehicular, accounting for 13 deaths from unintentional injuries in 2007, 12 in 2008, and 12 in 2009. Other unintentional injuries causing death in 2007 were drowning (2), overdose (2), and accidental hanging (1). In 2008, the one non-vehicular unintentional death was due to drowning. In 2009, the eight non-vehicular unintentional injury deaths were due to asphyxia (3), firearm (1), head trauma, (2) drowning (1), and starvation and dehydration (1).

Natural Deaths

During the years 2007, 2008, and 2009 there were 30 child deaths (26.5%) of the 113 reviewed, which the Child Fatality Review Panel classified as 'natural.' The Panel did not find that any of the natural deaths were preventable.

The manner of death was classified as 'natural' for 14 child deaths reviewed in 2007, 5 in 2008, and 11 in 2009. Autopsies were performed on all deaths attributed to natural causes. Natural deaths were generally not classified as accident or unintentional, though one natural child death in 2007 was classified as unintentional.

Eight (26.7%) of the thirty 'natural' child deaths occurred due to other 'natural' causes. The causes included: 1) Bronchopneumonia; 2) Hypoxic ischemic brain injury, airway obstruction, laryngomalacia; 3) Primary interstitial pneumonia; 4) Probable primary cardiac arrhythmia; 5) Seizure, hydrocephaly; 6) Small bowel infarction, torsion of intestines; 7) Streptococcal sepsis; and 8) Viral (coxsackie B), encephalomyocarditis. These 'natural' deaths occurred in six females and two males. Three children were over age one. The remainder were under age one. Two were American Indian and six were White.

SIDS

During the years 2007, 2008, and 2009, eighteen (60%) of the thirty 'natural' child deaths were attributed to SIDS. All infants were under the age of one. These included seven females and 11 males. Eight SIDS deaths were American Indian infants, one was another race, and nine were White.

All of the SIDS deaths were found by the Panel to have been non-preventable. All infants who died of SIDS received an autopsy, consistent with the legal criteria for listing SIDS as a cause of death on the death certificate (NDCC 11-19.1-1-13. "Cause of death – Determination").

The legal criteria for listing SIDS as a cause of death on the death certificate influenced the Panel's determination of the manner of death in these cases. The legal criteria for listing SIDS as a cause of death on the death certificate is stated in state law, "The term 'sudden infant death syndrome' may be entered on the death certificate as the principal cause of death only if the child is under the age of one year and the death remains unexplained after a case investigation that includes a complete autopsy of the infant at the state's expense, examination of the death scene, and a review of the clinical history of the infant" (NDCC 11-19.1-13 "Cause of Death – Determination").

Suicide Deaths

In the years 2007- 2009 there was a total of ten child suicide deaths. All were classified as preventable by the Child Fatality Review Panel. Eight male and two female deaths were the result of suicide. Eight were White and two were American Indian. Two suicide deaths were children ages 14, three were age 15, three were age 16 and two were age 17. Seven deaths were a result of hanging and three involved firearms.

Homicide Deaths

In the years 2007- 2009 there were nine child fatalities due to homicide. All were classified as preventable by the Child Fatality Review Panel. Five of the homicide victims were male and four were female. Four were White and five were American Indian. Six homicide victims were under age two and three were age 14 or older. One homicide involved a firearm, four were the result of a blunt head injury, two resulted from starvation and dehydration, and one from exposure (systemic hypothermia).

Deaths for Which the Manner Could Not Be Determined

The Child Fatality Review Panel ruled that the manner of death for 16 child fatalities during the years 2007- 2009 could not be determined. An autopsy was performed in each death. Seven of the deaths were attributed to sudden explained/unexpected infant death. In two cases there was evidence of craniocerebral trauma; in one case a gunshot wound to the head; in another case sepsis was involved; in another 'no anatomic cause of death;' and in four cases, simply 'undetermined.'

Eleven of the child fatalities where the manner could not be determined were females, five were male. Eleven were White, four were American Indian, and one was an 'other' race. These undetermined deaths occurred to some of the State's youngest and most vulnerable children. All but one (a three-year-old) were age two or younger. Eleven were three months old or younger.

LONG-TERM TRENDS

Table 17 shows death by status from 2003 through 2009. The average number of Status 'A' child deaths over the seven year period was 50. In 2007 and 2008, the number of Status 'A' child deaths declined to 45 and 36, respectively. The number rose to 52 in 2009.

Table 17. Child Deaths by Status, CY 2003-2009

	2003	2004	2005	2006	2007	2008	2009
Status A Deaths ¹	64	46	46	62	45	36	52
Status B Deaths ²	43	41	48	50	56	47	43
Total Child Deaths ³	107	87	94	112	101	83	95
In-State Child Deaths⁴	59	39	40	59	41	29	43
Out-of-State Child Deaths ⁵	5	7	6	3	4	7	9

¹Status A cases consist of all cases of children whose death is sudden, unexpected, and/or unexplained.

²Status 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)

³From all causes.

⁴**Child deaths with North Dakota death certificates that were reviewed in depth by the NDCFRP and are the subject of this report.**

⁵The '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

Figure 15 traces the number of total child deaths and the number of cases that received an in-depth review by the Panel from the years 1996 through 2009. Over the years child deaths requiring in-depth reviews have been between 35 and 54 percent of total child deaths. The average is about 43 percent. In 2007, 41 child deaths were reviewed. These accounted for 40.6 percent of all child deaths in 2007. In 2008, 29 child deaths were reviewed, accounting for 34.9 percent of all child deaths that year. In 2009, 43 child deaths were reviewed, accounting for 45.3 percent of all child deaths that year. The lowest number of child fatalities (83) since at least 1996 occurred in 2008.

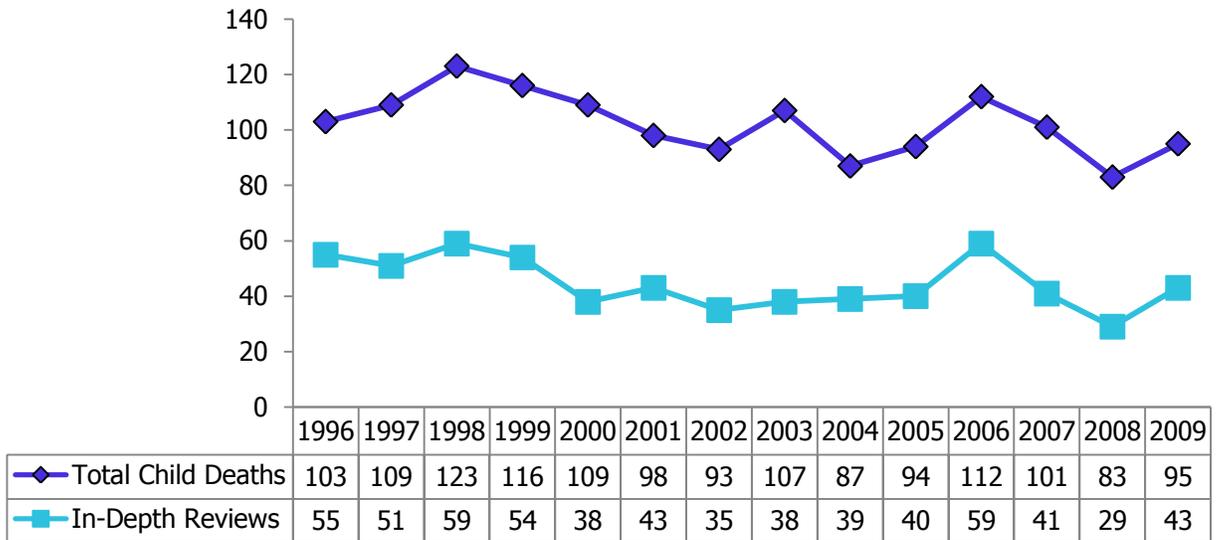


Figure 15. Number of Total Child Deaths and In-Depth Reviews, CY 1996-2009

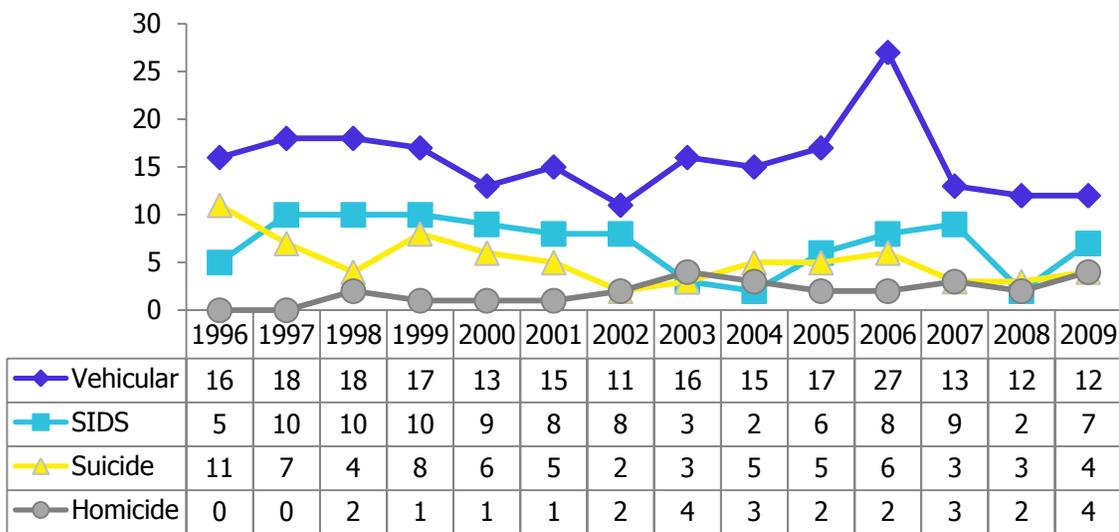


Figure 16. Child Deaths by Selected Type and Year, CY 1996-2009

Types of deaths are tracked by year. In Figure 16, the number of deaths attributed to vehicular, SIDS, suicide, and homicide are shown for the years 1996 to 2008. The year 2006 saw a dramatic spike in vehicular child deaths. Those deaths contributed to the highest number of total child deaths in any one year since 2000.

Vehicular child deaths have averaged about 16 per year since 1996, with a high of 27 in 2006 and low of 11 in 2002 (Figure 2). The number of vehicular deaths increased dramatically from 2005 to 2006. Compared to 2006 (27), vehicular child deaths decreased by over 50 percent in 2007 (13), 2008 (12), and 2009

(12). Vehicular deaths have remained the primary cause of child fatalities in North Dakota for at least the last twelve years.

Fatalities due to Sudden Infant Death Syndrome (SIDS) have averaged about seven per year since 1996, with highs of ten in the years 1997, 1998, and 1999 and lows of two in years 2004 and 2008 (Figure 2). SIDS cases numbered nine, two and seven in 2007, 2008, and 2009, respectively. Seven of the 18 SIDS cases in 2007, 2008, and 2009 were American Indian.

SIDS is the third leading cause of death in infants in the United States. The goal of the 2010 Healthy People Objective, established by the National Health Resources and Services Administration (HRSA), is that no more than 0.25 SIDS deaths occur per 1,000 live births. Numerous risk factors for SIDS continue to occur in too many of these cases, even though data show that SIDS has declined dramatically since 1995, following the 'Back to Sleep' campaign that began in 1994. In this campaign parents were advised to put their babies on their backs to sleep. Following this national campaign, the SIDS death rate for the United States declined 55.6 percent, from 0.9 SIDS deaths per 1,000 live births to 0.5 per 1,000 live births.

Child deaths due to suicide saw an all time high of 11 in 1996 (Figure 2). Discounting 1996 as an outlier, the yearly average of child deaths due to suicide is just under five (4.75). There were three suicide deaths in each of the years 2007 and 2008, and four child deaths due to suicide in 2009.

Homicide child deaths have averaged between one and two a year since 1996 with a high of four in 2003 and lows of zero in 1996 and 1997. Homicide deaths in 2007, 2008, and 2009 numbered three, two, and four, respectively.

According to U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, the North Dakota child population (ages zero through 18) in 2006 was 154,298. The changes in child population were minimal over the ensuing years (2007 was 153,602; 2008 was 153,378; and 2009 was 154,087). Changes in the number of child deaths in North Dakota by year does not appear to have any correlation to the changes in the State's child population.

Fourteen counties had ten or more sudden, unexpected, or unexplained child fatalities since 2000 (Table 18). Three counties had over 30, four had between 20 and 29, and seven had between 10 and 19. Seven counties (Adams, Golden Valley, Nelson, Oliver, Pierce, Sheridan, and Slope) did not have any in-state sudden, unexplained, or unexpected child fatalities since 2000. Fifteen counties did not have any sudden, unexpected, or unexplained child fatalities in the last three years (2007-2009).

Table 18. Child Fatalities that Received an In-Depth Review, by County of Residence, CY 2007, 2008, 2009, and 2000-2009

	2007	2008	2009	2000-2009		2007	2008	2009	2000-2009
Ward	1	1	6	37	Traill	0	0	0	5
Rolette	3	2	4	36	Logan	0	0	0	4
Burleigh	5	3	7	32	Dunn	1	0	0	4
Cass	3	4	3	29	Pembina	0	1	0	4
Benson	2	3	0	25	Dickey	0	1	0	3
Grand Forks	2	2	3	22	Emmons	0	1	0	3
Morton	3	2	0	20	Hettinger	0	0	0	3
Williams	2	0	5	17	Bowman	0	0	0	2
Sioux	1	1	2	16	Eddy	0	0	0	2
Stark	0	1	2	11	Grant	0	0	0	2
Stutsman	2	0	3	11	McHenry	0	0	0	2
Barnes	2	0	1	10	Ransom	0	0	0	2
McLean	2	1	2	10	Sargent	0	1	0	2
Ramsey	2	0	1	10	Steele	0	1	0	2
McKenzie	2	2	0	8	Wells	0	0	0	2
Mountrail	0	0	1	7	Billings	0	0	0	1
Bottineau	1	0	0	7	Burke	0	0	0	1
Walsh	0	2	0	7	Divide	1	0	0	1
Griggs	1	0	0	6	Kidder	0	0	0	1
Mercer	1	0	0	6	McIntosh	0	0	0	1
Richland	0	0	1	6	Renville	0	0	0	1
Foster	1	0	0	5	Towner	0	0	0	1
LaMoure	1	0	1	5	Out of State	2	0	1	
					TOTAL	41	29	43	392

PREVENTABLE DEATHS

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.

The Panel uses the determination of preventability for the purpose of systemic changes. To the Panel the word preventability does not imply negligence. The Panel looks at what can be done systemically to prevent these deaths, for instance changes in policy, practice and law. The majority of preventable child deaths reviewed by the Panel in 2007, 2008, and 2009 occurred as a result of injuries. There were 19, 13, and 20 unintentional deaths in 2007, 2008, and 2009, respectively. The majority of these deaths (33) occurred among children ages 12 to 17. About three-fourths of the unintentional injury deaths are

determined to be caused by reckless conduct of others. Most of the preventable deaths 37 of 52 (71%) are motor vehicle related deaths. Currently, laws are in effect which put restrictions on minors with a license and safety restraint use. Safety and seat belt campaigns have been provided. However, driver education courses offered in the public schools have decreased as schools struggle with resource concerns. Societal issues such as alcohol/drug involvement, excessive speed, and failure to use seat belts contributed to the vehicle related deaths in 2007, 2008, and 2009. Issues such as improper evasive action, and young drivers of ATVs, are not addressed by current strategies. Effective social marketing and education focused on safety concepts and injury prevention may benefit parents and teens.

In 2007, Sudden Infant Death Syndrome claimed the second largest number of North Dakota children. While SIDS is still largely considered non-preventable, there are a number of risk factors present in all the 2007, 2008, and 2009 SIDS deaths. As risk factors are eliminated, the number of SIDS deaths decline dramatically. Prevention information in the hands of parents, childcare providers and family caregivers has the potential to impact the number of SIDS deaths in the state.

The number of teen suicide deaths in the state continues to be concerning with 3, 3 and 4 deaths in 2007, 2008, and 2009, respectively. These suicides highlight the need for more accessible mental health care for adolescents. Strategies for prevention include education 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. Education needs to include information on how to access community mental health resources if someone is concerned about an adolescent. The Panel would like to see the development of a standardized statewide protocol for scene investigations of suicide deaths.

CONCLUSIONS

Continuing Challenges for the Child Fatality Review Panel

During the three year period 2007-2009, the Panel found that

- 17 cases involved unsafe sleeping environments
- In 3 cases a mandated reporter did not file a Child Protective Services report
- In 15 cases autopsies should have been done
- 4 cases involved non-licensed/approved child care
- 3 cases involved an unsupervised child with access to firearms
- In 3 cases toxicology testing should have been done

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

Investigations of Children’s Deaths

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, the Panel continues to be concerned about the quality of child death scene investigations. Many child death investigations do not include interviews with the parents and others who live in the home or who were present in the home at the time of the death.

The investigations of some child deaths continue to be minimal. Investigations do not always explore circumstances leading up to the death or are not comprehensive enough to uncover information vital to identifying the cause and manner of death or in identifying risk factors and formulating effective interventions. The thoroughness of child death investigations varies greatly. Information regarding the child and family history, abuse, violence, alcohol and drug use, mental health issues, domestic violence and other such issues are vital to understanding the circumstances surrounding the deaths of children and for planning to prevent future deaths, yet this is the very information that is often not gathered or not recorded in an investigation.

The Panel recommends that all child deaths receive a thorough comprehensive investigation.

The Panel has also become concerned that child victims of traffic fatalities too often are not identified as coroner cases and an autopsy is not performed. According to state law, any person who acquires the 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 13 vehicular deaths in 2007, the coroner was not contacted in 2 of the deaths and 2 deaths where it was not identified if the coroner was contacted. Of these deaths an autopsy was performed on two cases and is unknown for one case. Of the 12 vehicular child deaths in 2008, the coroner was not contacted in two of the deaths, and is unknown in one death. Autopsies were performed on five cases. In 2009, the coroner was contacted for each of the 12 vehicular child death cases. Autopsies were conducted on four cases.

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 all three years. In about a dozen cases in which the Panel requested information from the appropriate agencies, their requests went unheeded.

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 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. If not provided by request, these records remain inaccessible to the Panel.

An additional barrier identified by the Panel concerns governmental entities such as Federal Bureau of Investigation, the Bureau of Indian Affairs, and tribal entities that are outside the jurisdiction of state statutes. These governmental bodies are not required to share information with the Panel. It is a concern of the Panel that these records remain inaccessible. The lack of access to investigation records was identified as an obstacle to effective child fatality reviews in 2007, 2008, and 2009.

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

The Child Fatality Review Panel Recommends:

- that graduated drivers licensing be implemented;
- that all children involved in a motor vehicle/ATV fatality receive an autopsy;
- education on investigations involving firearms;
- alcohol testing in all fatalities;
- that blood alcohol testing be conducted in all traffic fatalities involving children;
- education on child abuse and neglect extend to WIC, child care and law enforcement;
- counseling for siblings of youth who commit suicide;
- education on knowing when to call emergency medical services (EMS);
- a suicide investigation protocol be developed along with gatekeeper training;
- trauma counseling for youth who survive an accident in which another is killed and for youth who witness such an accident;
- establishing standards for lifeguard to swimmer ratios and pool safety needs;
- a better team effort for the provision of services to families (a critical incident process is needed);
- physicians receive education about the importance of scene investigation information so they can adequately complete death scene forms;
- more education about the asphyxial game played by children for those who work with children;
- more grief counseling resources; and
- more education on risk factors for SIDS for parents, child care providers, small hospitals, and other entities. (NICU babies' parents should be given "safe sleep" information from the hospital.)