

North Dakota Child Fatality Review

2006 Annual Report

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The North Dakota Child Fatality Review Panel (NDCFRP) fulfilled the duties mandated by the North Dakota Century Code during 2006. 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 Child Fatality Review Panel met quarterly through 2006.

Table 1. North Dakota Child Fatality Review Panel Number of Reviews

Calendar Year 2006	
Total Child Deaths (From all causes)	112
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)	50
Status A Deaths Status A cases consist of all cases of children whose death is sudden, unexpected, and/or unexplained.	62
Out-of-State Child Deaths The “death-causing” event/injury is identified as occurring outside of North Dakota. (Not reviewed in depth by the NDCFRP.)	3
In-State Child Deaths All other child deaths with North Dakota death certificates. (Reviewed in depth by the NDCFRP.)	59

Child Fatality Review Panel (2006).

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, 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 do not change classifications on death certificates. The Panel’s classifications serve as the basis of this report. The Panel reclassified one death in 2006 from “accident” to “not determined”, due to the lack of an autopsy.

2006 Trends

The Panel identified that Native American children are over represented in the Child Fatality numbers. According to North Dakota Kids Count, North Dakota’s child population is 86% Caucasian, and 9% Native American. However, 19 of the 59 (31.6%) deaths reviewed by the North Dakota CFRP during 2006 were Native American children.

Of the 59 deaths reviewed in-depth, 17 were ages 0-2 years (28.8%); 5 were ages 3-5 years (8.4%); 1 was age 6-8 years (1.7%); 3 were ages 9-11 years (5.1%); 8 were ages 12-14 (13.6%), and 25 were ages 15-17 (42.4%). These numbers indicate children at greatest risk of death are the very young and our teenagers.

Unintentional Injury Deaths

Unintentional injury is the largest category of child deaths for 2006. 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 terms unintentional injury as opposed to the term accident because the child deaths in this category are predictable, understandable, and preventable. In fact, the Child Fatality Review Panel classified all 32 unintentional injury deaths as preventable. The largest sub-category of unintentional injury death is vehicular, accounting for 27 of the 32 child deaths from all unintentional injuries in 2006. There were five deaths from other unintentional injuries; one death from firearm, one drowning death, one asphyxia death, and two deaths from inhalation of smoke.

Natural Deaths

The manner of death was classified as natural for thirteen (23.3%) of the 59 child deaths reviewed in 2006. All thirteen of the natural deaths received an autopsy. Eight babies died from SIDS (Sudden Infant Death Syndrome). Five natural deaths did not fall into one of the other identified types of fatal injury/event data categories. Of those five deaths, one death was determined by the Panel to have been preventable due to medical misadventures/foreseeable complications.

Suicide Deaths

There were six suicide deaths in children during 2006.

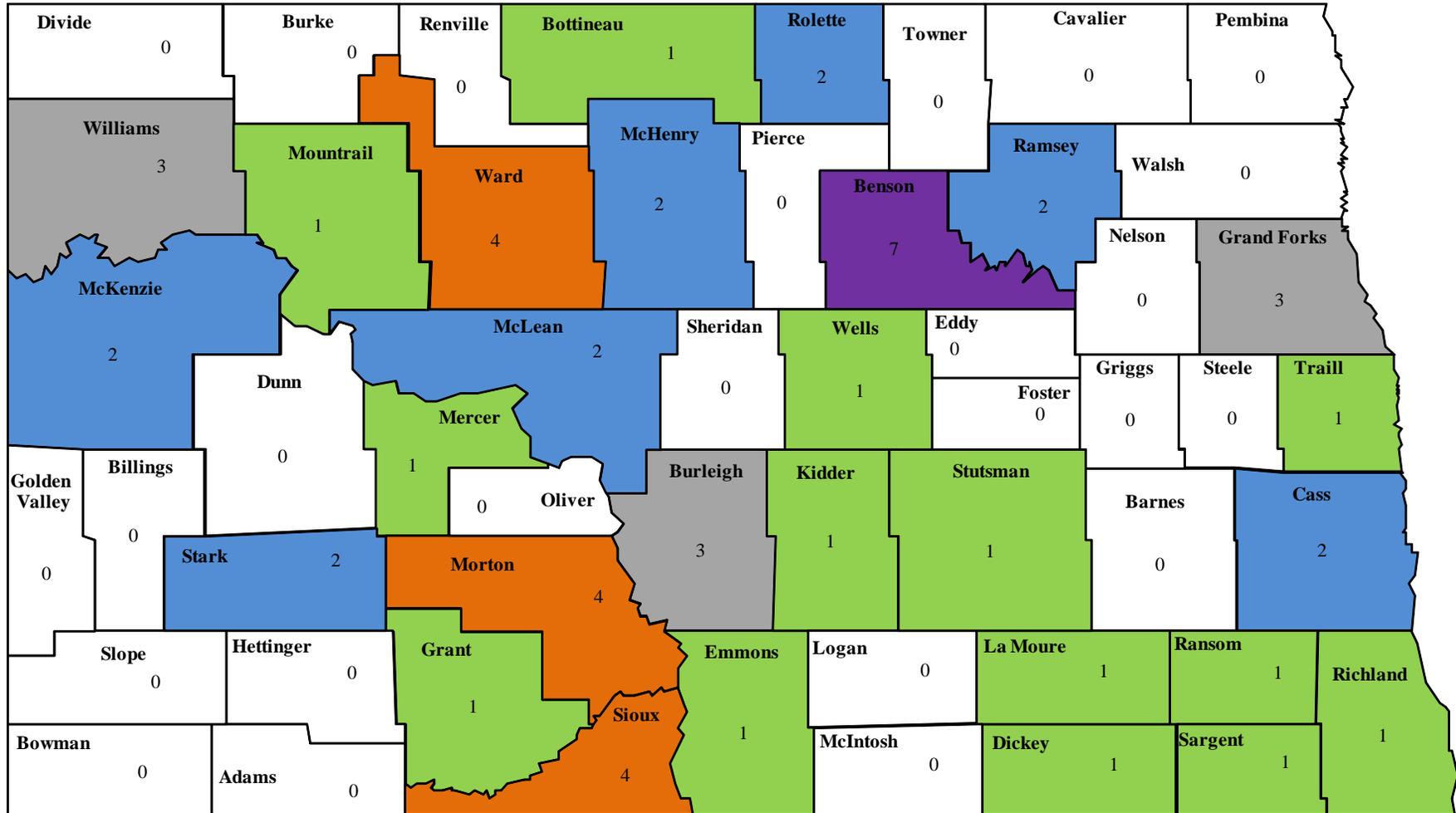
Homicide Deaths

In 2006, two children died as the result of homicide.

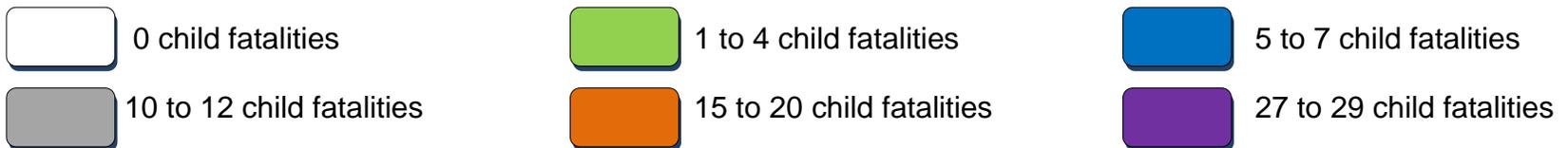
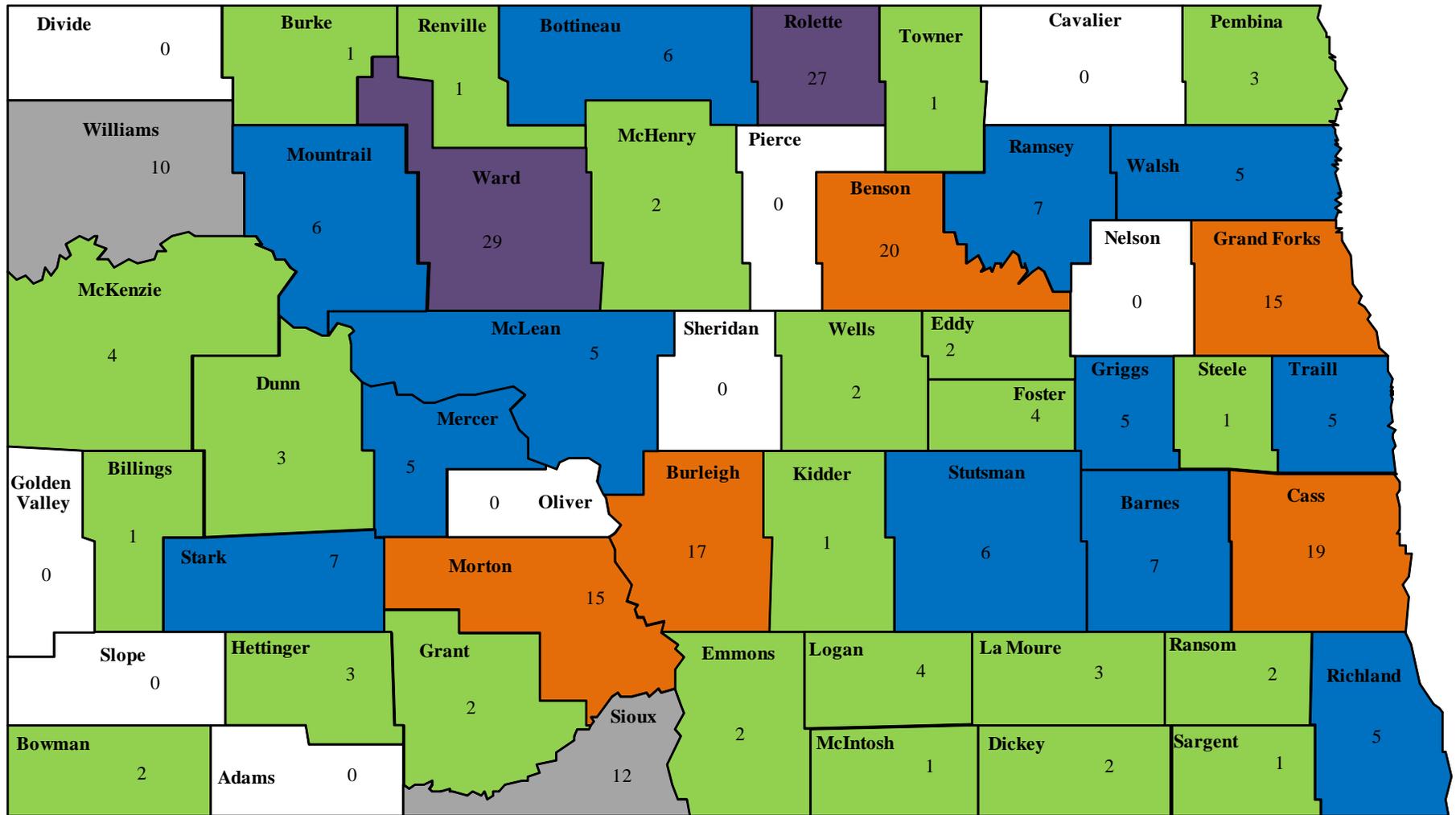
Deaths Where the Manner Could Not Be Determined

The Panel could not determine the manner of death for six deaths in 2006. In two cases, risk factors for SIDS could not be ruled out. One was reclassified from an accident to undeterminable because an autopsy had not been performed. One case involved cerebral edema with herniation and was not adequately investigated. Of the remaining two undeterminable deaths, one was a ligature hanging and one a gunshot wound.

Map 1. Child Fatalities That Received an in Depth Review by County of Residence, 2006 (N=56)



Map 2. Child Fatalities that Received an In Depth Review by County of Residence, 2000-2006 (N=281)



Challenges

Investigations of Children's Deaths

- Death scene investigations were identified as below satisfactory standard in four 2006 deaths.
 - Inadequate interviews of the parties involved.
 - No protocol for scene investigations on suicide deaths.
- 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.
- Autopsies were not completed on all minors involved in motor vehicle/ATV fatalities.

Access to Records

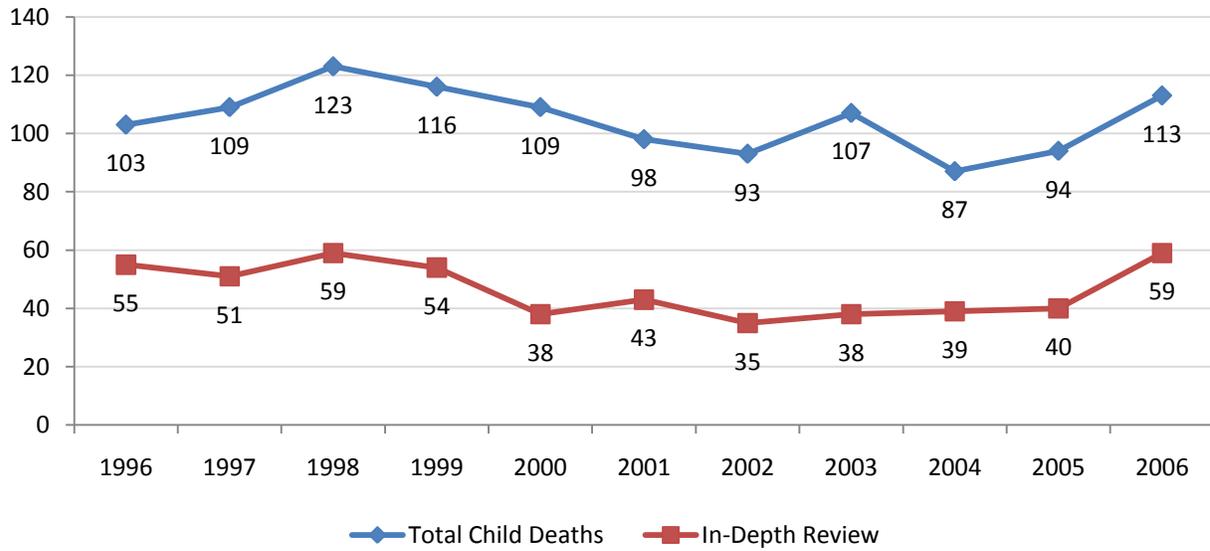
- North Dakota law (NDCC 50-25.1-04.4) provides that specific information be provided to the Panel upon request. This statute also mandates that law enforcement, courts, and agencies cooperate in fulfilling the purpose of the statute (NDCC 50-25.1-12).
 - Regardless of these mandates, information is 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 partner agencies.
- An additional barrier concerns entities outside the jurisdiction of state statutes. These entities 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.

Panel Recommendations

- The Panel recommends that blood alcohol testing be conducted in all traffic fatalities involving children.
- The Panel recommends that all children involved in a motor vehicle/ATV fatality receive an autopsy.
- 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

Figure 1. Total Child Deaths and Number of In-Depth Reviewed Annually



Child Fatality Review Panel (1996-2006).

Table 2. Child Deaths by Year

Year	Vehicular Deaths	SIDS Deaths	Suicide Deaths	Homicide Deaths
1996	16	5	11	0
1997	18	10	7	0
1998	18	10	4	2
1999	17	10	8	1
2000	13	9	6	1
2001	15	8	5	1
2002	11	8	2	2
2003	16	3	3	4
2004	15	2	5	3
2005	17	6	5	2
2006	27	8	6	2

Child Fatality Review Panel (1996-2006).

According to North Dakota Kids Count, the North Dakota child population in 2006 was 144,876. This is an increase of 4.98% above the child population in 2005 which was 137,998. The numbers related to child deaths in our state seem to reflect this population increase, showing corresponding increases in the total number of child deaths (93 child deaths in 2005 to 113 child deaths in 2006).

The number of vehicular deaths increased dramatically from 2005 to 2006. There were 17 vehicular deaths in 2005 and 27 in 2006 this is an increase of 59%. The average number of vehicular deaths keeps increasing year after year. In the last eleven years the vehicular deaths average 16.6 per year. Even though the numbers of vehicular deaths may not seem large when compared with deaths in more populated states, vehicular deaths have remained the primary cause of child fatalities North Dakota for the last ten years.

There is also concern about the numbers of Sudden Infant Death Syndrome (SIDS) deaths. SIDS deaths have averaged seven deaths per year over the past eleven years (8 in 2006). Numerous risk factors for SIDS are identified in too many of these cases. Research over this same period of time indicates a reduction in the identified risk factors is associated in a corresponding reduction in the number of SIDS deaths.

The Panel finds the number of youth succumbing to suicide very troubling. Child deaths from suicide have averaged five per year over the past eleven years (6 in 2006). Although research reports a reduction in North Dakota's suicide rate in the 10-24 year-old age group, this does not appear to be true for the 0-18 year-old population.

Although the number of North Dakota children who die as the result of homicide 2 in 2006, 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 any child homicide 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
- Inter-county 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 – 2006

Gladys Cairns – NDCFRP Presiding Officer

Administrator, Child Protection Services – DHS

Shelly Arnold - Emergency Medical Services

Trauma Services – MedCenter One

Marlys Baker – CFRP Administrator

Child Protection Services – DHS

Karin Bartoszuk

NDSU Extension Service

Jonathan Byers

Assistant ND Attorney General

Tom Dahl

ND Bureau of Criminal Investigation

Dr. Terry Dwelle – State Health Officer

ND Department of Health

Warren Emmer - Parole & Probation

ND Department of Corrections

Karen Eisenhardt - Educator

State Child Protection Team – lay member

Steve Kukowski

Minot Police Department

Dr. Gordon Leingang - Emergency Trauma

St. Alexius Medical Center

Carol Meidinger - Injury Prevention Program

ND Department of Health

Dr. Ron H. Miller

MeritCare Children's Hospital

Dr. George Mizell

State Forensic Examiner

Carla Pine

Burleigh County Social Services

Bob Rutten

Department of Public Instruction

Introduction

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.

Preventable Deaths

In determining the reasons for preventable deaths, the Panel is not seeking to place blame, but rather, pointing the way toward preventing future deaths. The majority of preventable child deaths reviewed by the Panel in 2006 occurred as a result of **unintentional injuries**. There were 32 unintentional deaths in 2006. The majority of these deaths (23) occurred among children ages 12 to 17. Three fourths of the unintentional injury deaths (24) are determined to be caused by reckless conduct of others. Most of the preventable deaths 27 of 32 (84%) 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. 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 (7), excessive speed (14), and failure to use seat belts (19) contributed to the vehicle related deaths in 2006. Issues such as driver distraction (2) and young drivers of ATVs (2) are not addressed by current strategies.

Sudden Infant Death Syndrome claimed the second largest number (8) of North Dakota children in 2006. While SIDS is still largely considered non-preventable, there are a number of risk factors present in all of these 2006 deaths, which if eliminated, have been shown to reduce the number of deaths from SIDS. Prevention information in the hands of parents, childcare providers and family caregivers has the potential to impact the number of SIDS deaths in our state.

The number of **teen suicide** deaths in our state continues to be disturbing with (6) deaths in 2006. 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. The Panel would like

to see the development of a standardized statewide protocol for scene investigations of suicide deaths.

Continuing Challenges for the Child Fatality Review Panel

Among the duties assigned to the North Dakota Child Fatality Review Panel by state law is 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
- Inter-county and interstate communications regarding child death.

The Panel identifies the following as ongoing challenges in accomplishing these 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 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 27 vehicular deaths in 2006, the coroner was not contacted in 2 of the deaths and 4 deaths where it was not identified if the coroner was contacted. Of these deaths an autopsy was not performed in 5 of the 6 deaths.

The Panel recommends that autopsies be performed for all child fatalities that are coroner's cases, including all child deaths resulting from motor vehicle crashes.

Access to records

The Panel's ability to access relevant records for review remained of concern in 2006.

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. If not provided by request, these records remain inaccessible to the Panel. These records frequently include school records, and records of substance abuse treatment professionals.

An additional barrier identified by the Panel concerns governmental entities that are outside the jurisdiction of state statutes. These governmental bodies 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 Law Enforcement, and tribal governmental agencies, such as tribal child welfare and tribal law enforcement. While many tribal governmental 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 twelve cases in 2006.

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

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. 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

Table 3. Child Deaths

2006	
Total Child Deaths	112
Status B Deaths	50
Status A Deaths	62

Child Fatality Review Panel (2006).

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. A status A case consists of 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. 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 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.

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. A status A case consists of all cases of children whose

In-State and Out-of-State Child Deaths

Table 4. “Status A” Child Deaths

2006 “Status A” Child Deaths	
Total Child Deaths	62
Out-of-State Child Deaths	3
In-State Child Deaths	59

Child Fatality Review Panel, 2006.

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.

Manner of Death

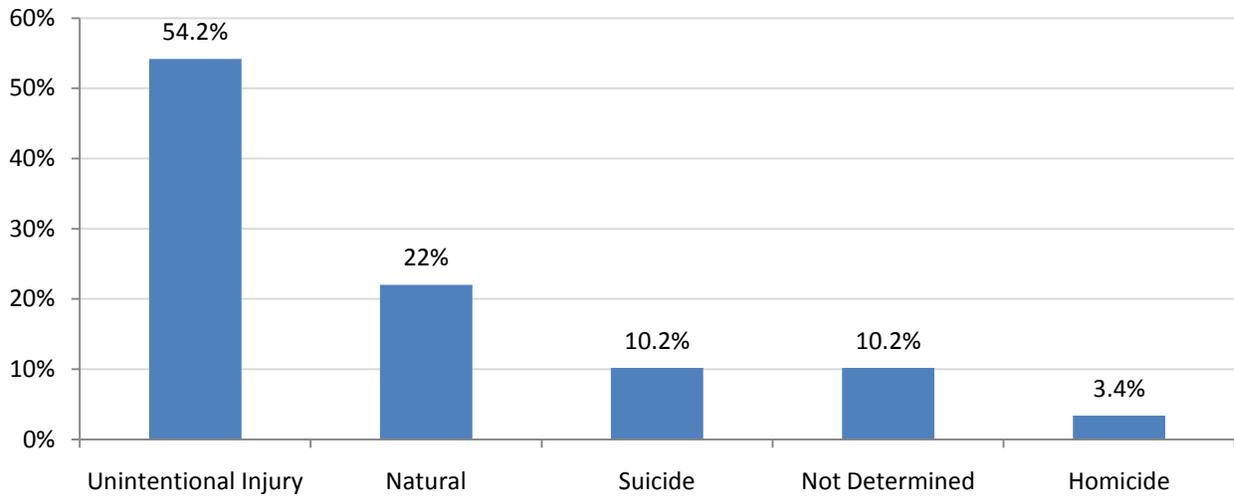
North Dakota Death Certificates list the following five manners of death: “Natural”, “Accident”, “Suicide”, “Homicide”, or “Could Not Be Determined”. After an in-depth review of each case, the Child Fatality Review Panel either agrees or disagrees with the manner of death indicated on each death certificate. 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 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 one death in 2006.

The largest category for the manner of death was unintentional injury, which claimed the lives of 32 children in 2006. 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.

The second largest category for the manner of death was “natural”, which claimed the lives of 13 children in 2006. The category “suicide” consisted of 6 child deaths in 2006. Two deaths were classified as “homicides” in 2006. There were 6 deaths in the “could not be determined” category. This category includes deaths in which the manner of death cannot be conclusively categorized by the Child Fatality Review Panel after an in-depth review of the case. See the respective manner of death sections of this report for more information on each category.

Figure 2. Manner of Death



Child Fatality Review Panel, 2006 (N=59).

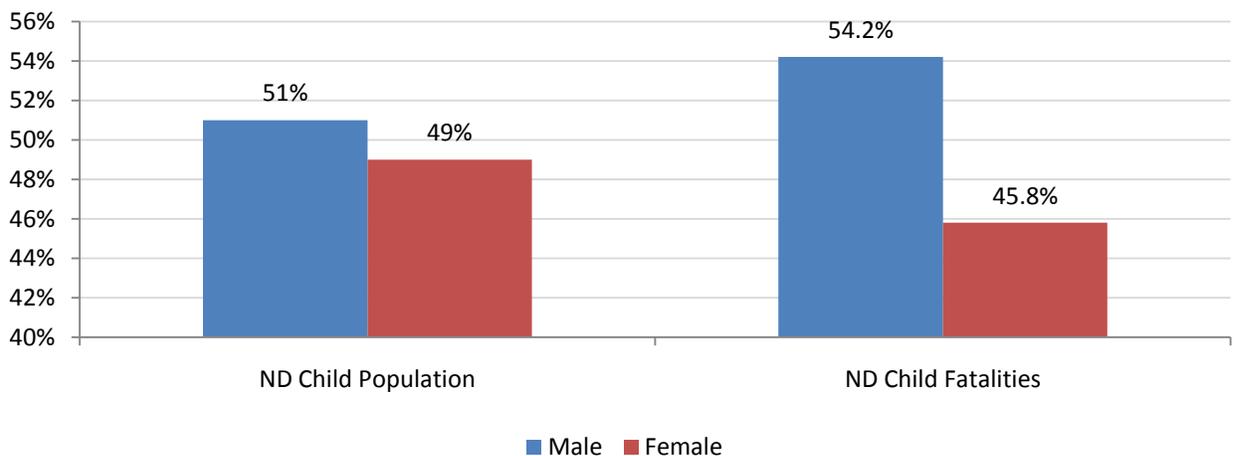
Data Overview

Each Status A death is thoroughly reviewed 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 59 deaths determined to be “Status A” deaths, which occurred in calendar year 2006, form the basis of this report.

Demographics

According to the North Dakota Data Center, North Dakota’s child population is nearly equally male and female (51% male; 49% female). In 2006, 32 of the 59 (54.2%) children that died in North Dakota were male and 27 of the 59 (45.8%) were female.

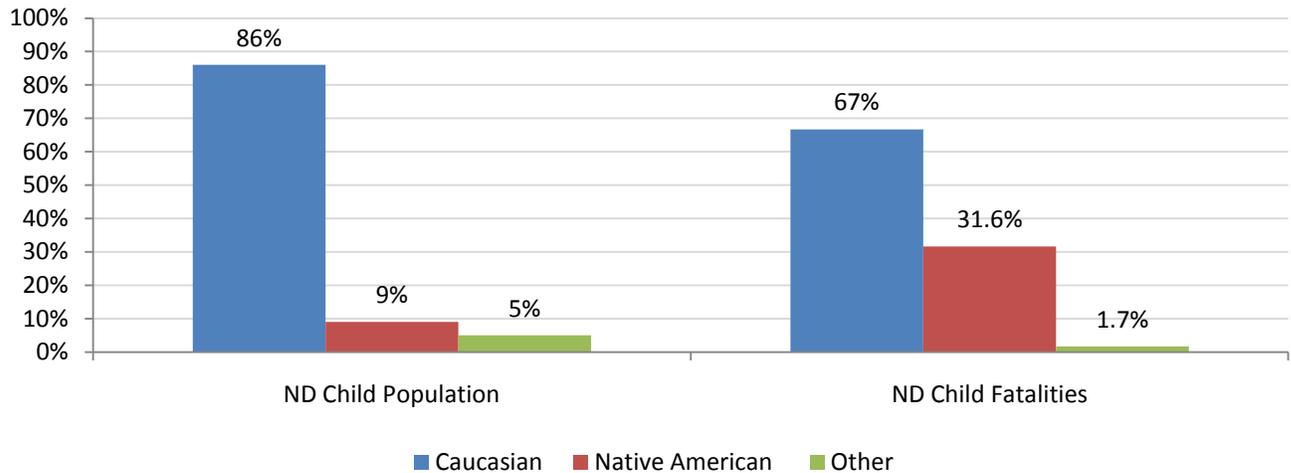
Figure 3. Gender of Children in North Dakota and in Fatality Cases that Received an In-depth Review



Child Fatality Review Panel, 2006 (N=59).

The Panel identified that Native American children are over represented in the Child Fatality numbers. According to North Dakota Kids Count, North Dakota’s child population is 86% Caucasian, and 9% Native American. However, 19 of the 59 (31.6%) deaths reviewed by the North Dakota CFRP during 2006 were Native American children, indicating an over-representation of Native American children.

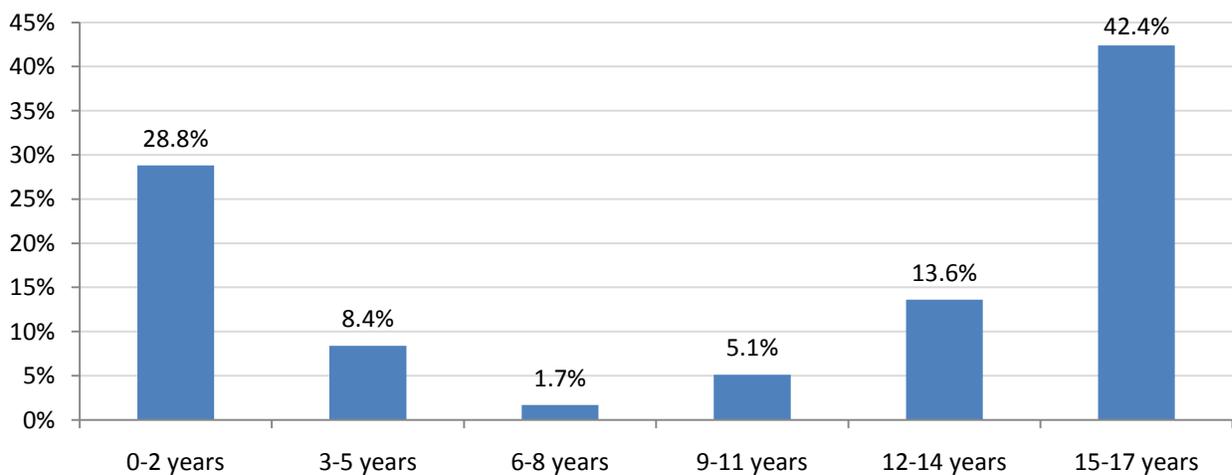
Figure 4. Race of Children in North Dakota and in Fatality Cases that Received an In-Depth Review



Child Fatality Review Panel, 2006 (N=59).

Of the 59 deaths reviewed in-depth, 17 were ages 0-2 years (28.8%); 5 were ages 3-5 years (8.4%); 1 was age 6-8 years (1.7%); 3 were ages 9-11 years (5.1%); 8 were ages 12-14 (13.6%), and 25 were ages 15-17 (42.4%). These numbers indicate children at greatest risk of death are the very young and our teenagers.

Figure 5. Age of Children in Fatality Cases that Received an In-depth Review



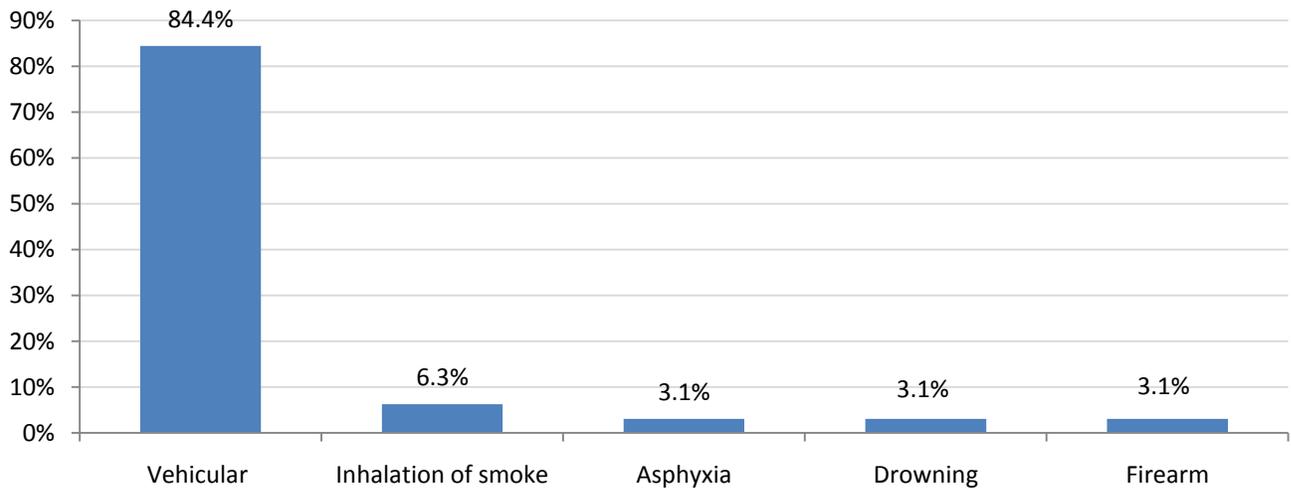
Child Fatality Review Panel, 2006 (N=59).

All Unintentional Injury Deaths

Type of Fatal Injury/Event

There were 59 child fatalities reviewed in-depth in 2006. There were 32 deaths (54.2%) 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 category of unintentional injury deaths is vehicular, which accounted for 27 of the 32 (84.4%) unintentional injury child deaths during 2006.** Each of the type of fatal injury/event categories for unintentional injury is examined further in this section.

Figure 6. Unintentional Injury Deaths



Child Fatality Review Panel, 2006 (N=32).

Preventability of Death

The Child Fatality Review Panel classifies each child's death as preventable or non-preventable. Of the 32 unintentional injury deaths in 2006, all 32 were categorized as preventable.

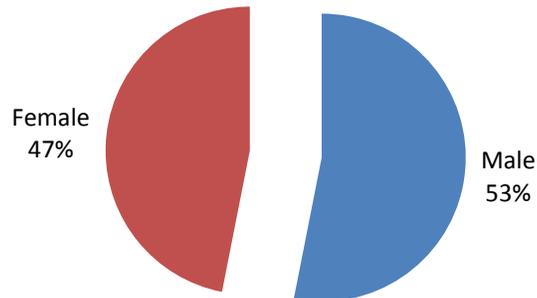
The two main reasons identified for preventable child deaths were: 1) Neglect & Reckless Conduct of Others (24 of the 32 deaths); and 2) Neglect & Reckless Conduct of the Deceased Child (26 of the 32 deaths).

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 injury" 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 32 unintentional injury deaths as preventable.

Demographics

Of the 32 unintentional injury deaths in 2006, 15 (46.9%) were female children compared to 17 (53.1%) male children.

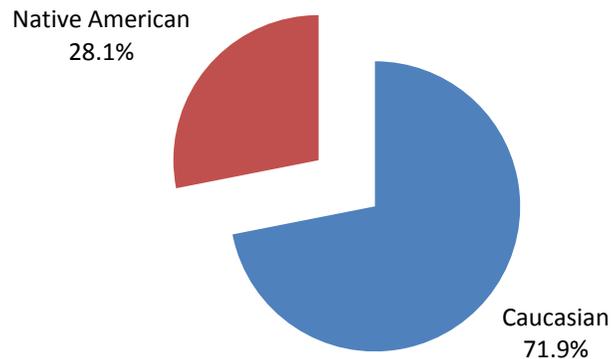
Figure 7. Unintentional Injury Deaths by Child Gender



Child Fatality Review Panel, 2006 (N=32).

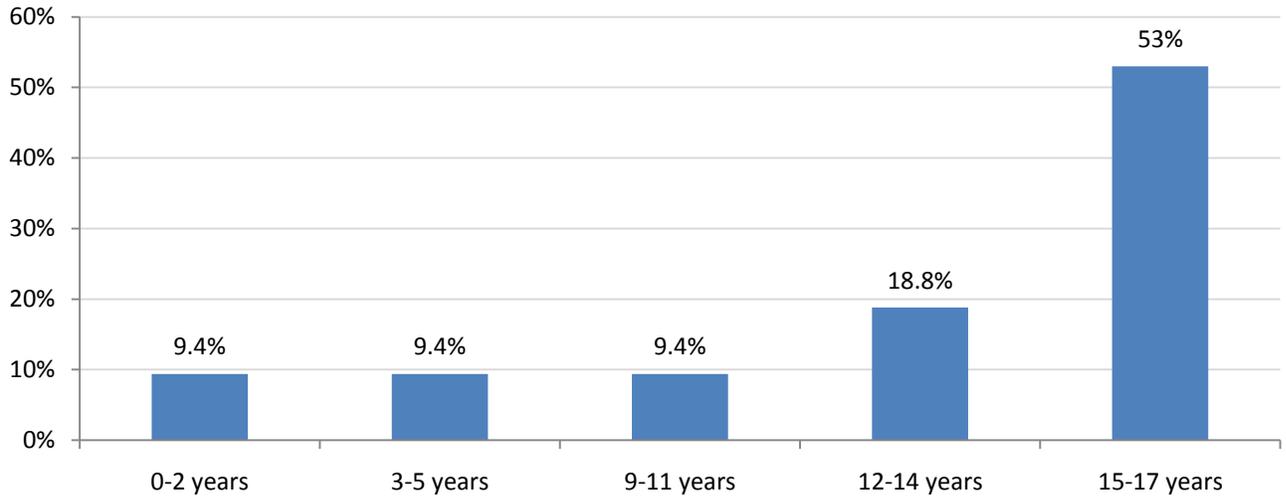
Of the 32 unintentional injury deaths in 2006, 23 (71.9%) of the children were Caucasian, and 9 (28.1%) were Native American.

Figure 8. Unintentional Injury Deaths by Child Race



Child Fatality Review Panel, 2006 (N=32).

Figure 9. Unintentional Injury Deaths by Child Age Range

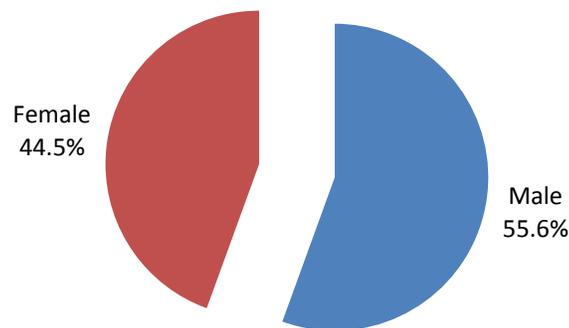


Child Fatality Review Panel, 2006 (N=32).

Vehicular Unintentional Injury Deaths

In 2006, 27 children died in vehicle related deaths. The Child Fatality Review Panel classified all of these deaths as preventable. In 2006, 12 (44.4%) of the children who died were females compared to 15 (55.6%) males.

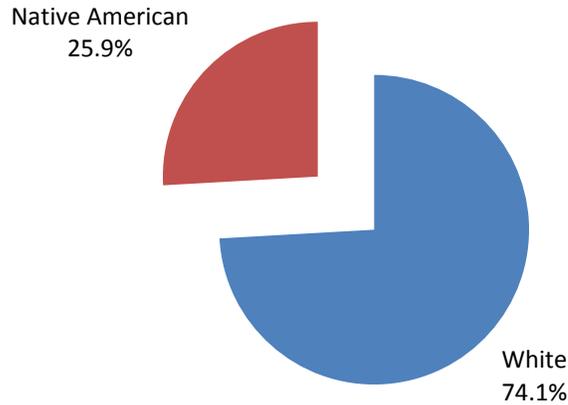
Figure 10. Vehicular Deaths by Child Gender



Child Fatality Review Panel, 2006 (N=27).

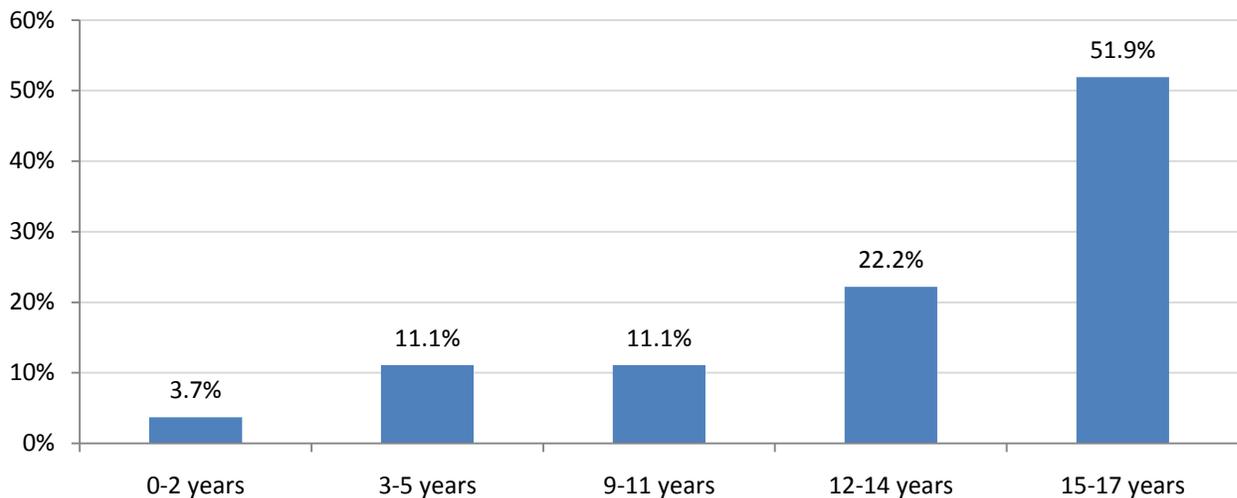
In 2006, 20 (74.1%) of the children who died were Caucasian and 7 (25.9%) were Native Americans.

Figure 11. Vehicular Deaths by Child Race



Child Fatality Review Panel, 2006 (N=27).

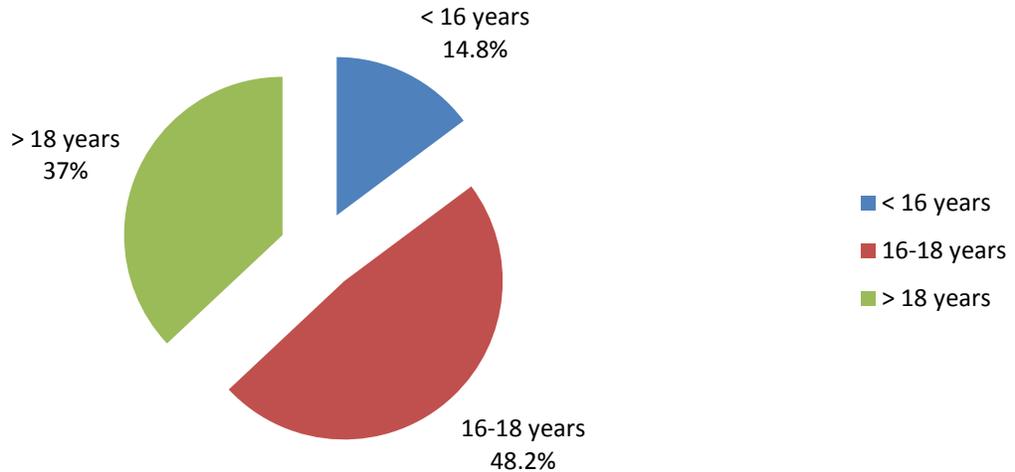
Figure 12. Vehicular Deaths by Child Age Range



Child Fatality Review Panel, 2006 (N=27).

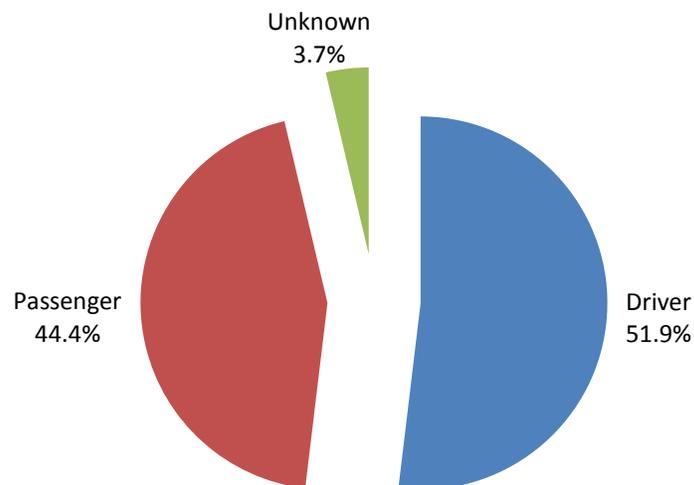
The deceased child was the driver in 14 of the vehicular deaths, a passenger in 12 and one where the position of the deceased child is unknown. Of the vehicular deaths in 2006, 21 involved single vehicles. Of those 21 deaths involving single vehicles, 15 were rollover crashes.

Figure 13. Age of Person Driving Deceased Child's Vehicle



Child Fatality Review Panel, 2006 (N=27).

Figure 14. Position of Deceased Child in Vehicle

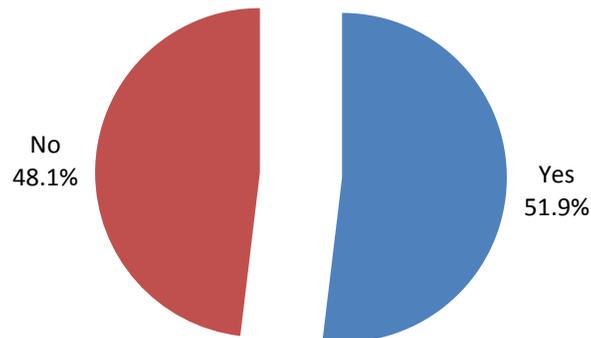


Child Fatality Review Panel, 2006 (N=27).

Safety restraints used/ Ejection from a vehicle

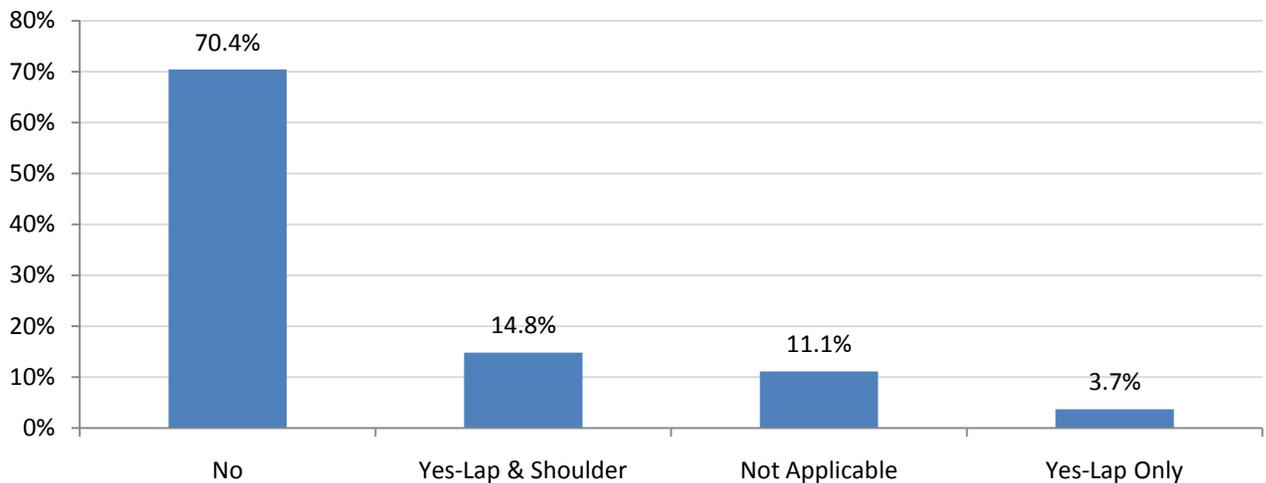
In the cases where use of a vehicle restraint applies, 19 of the children who died were not restrained. The use of safety restraints was not applicable in 3 child deaths as a safety restraint would not have been required in the situation (e.g. ATV riders). There were 14 children who were ejected from the vehicle. The element of ejection did not apply in 3 deaths. (Ejection does not apply to vehicles that are not enclosed e.g. bicycles, ATVs, etc.). The use of a helmet applied in 3 of the deaths; no helmet was worn in 1 of the 3 deaths.

Figure 15. Child Ejected from Vehicle



Child Fatality Review Panel, 2006 (N=27). Note: Ejection was not applicable in three deaths due to non-enclosed vehicles.

Figure 16. Safety Restraints Used



Child Fatality Review Panel, 2006 (N=27). Note: Three deaths (not applicable) occurred in vehicles in which a safety restraint would not have been required.

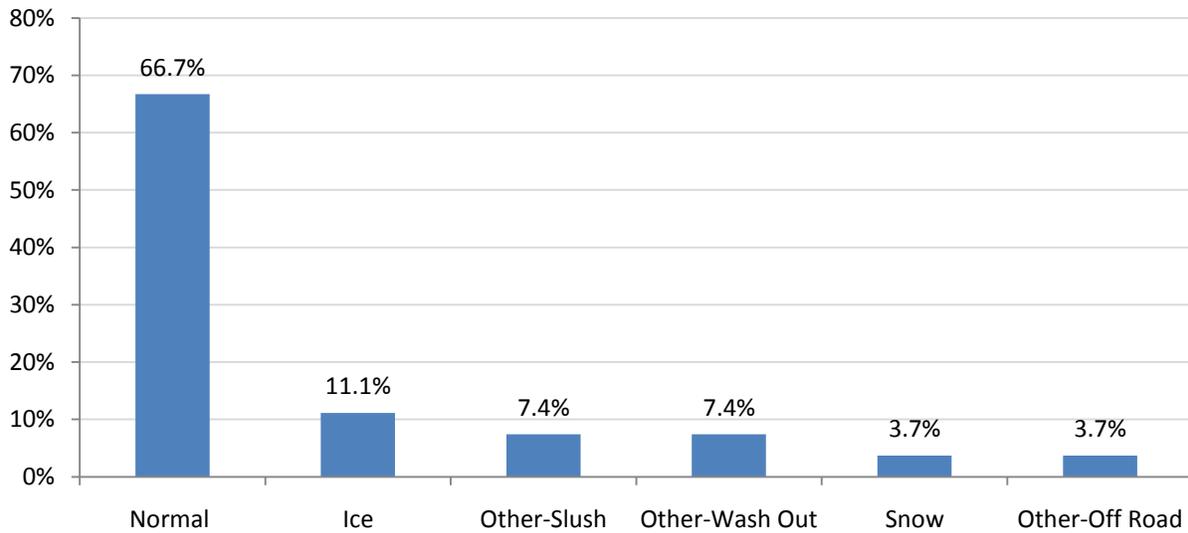
Contributing Factors

Excessive speed or recklessness was a factor in 14 deaths. Drug/Alcohol involvement was a contributing factor in 7 deaths. Other contributing factors include: driver distraction (2); road conditions (5); young ATV drivers (2); driver inexperience (3); unlicensed driver (4).

Road Conditions

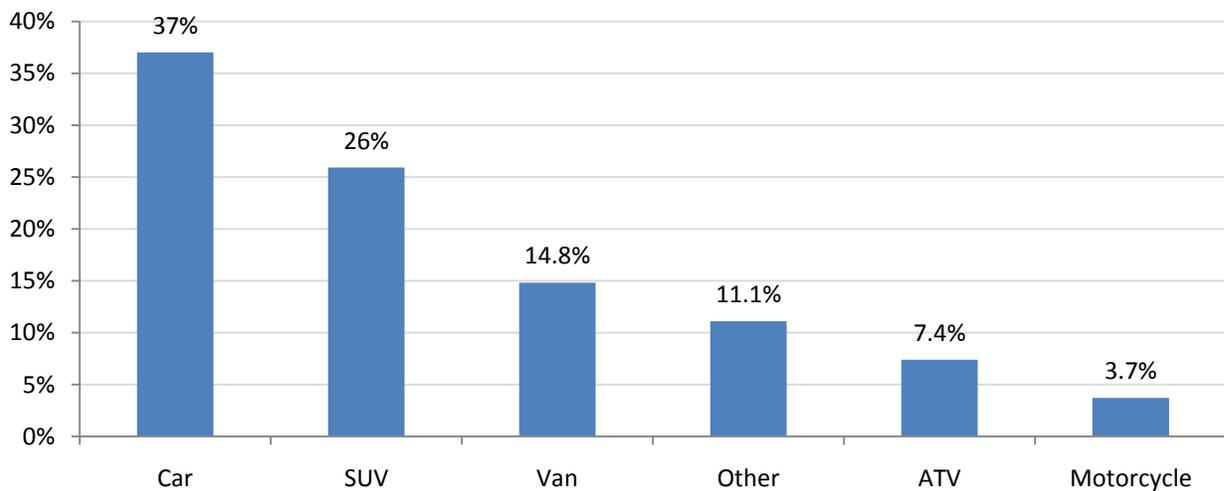
The road conditions were normal in 18 deaths. Other conditions were snow (1), and ice (3).

Figure 17. Road Conditions



Child Fatality Review Panel, 2006 (N=27).

Figure 18. Type of Vehicle



Child Fatality Review Panel, 2006 (N=27).

Other Unintentional Injury Deaths

Drowning

There was one unintentional injury death from drowning in 2006. A ten month old Native American female drowned when left unsupervised in a bathtub.

Firearm

There was one child death from an unintentional firearm injury in 2006. A seventeen year old Caucasian male died when he pulled the trigger, believing the firearm was not loaded.

Poisoning/Overdose

No children died from unintentional poisoning/overdose in 2006.

Asphyxia

There was one unintentional injury death from asphyxia in 2006. A seven month old Native American male died from positional asphyxia/neck compression when he rolled between the bed and wall and was suspended by an electrical cord.

Fall Injury

No children died from unintentional falls in 2006.

Fire

There were two unintentional fire related deaths in 2006. A three year old Native American female died from inhalation of smoke and soot during a house fire. A four year old Caucasian female died from carbon monoxide and thermal burns during a house fire.

Electrocution

No children died from unintentional electrocution in 2006.

Other Injuries

No children died with an injury categorized as "other injury" in 2006.

Natural Deaths Overview

Type of Fatal Injury/Event

The manner of death was classified as natural for thirteen (22%) of the 59 child deaths reviewed in 2006. **All thirteen of the natural deaths received an autopsy.** Eight babies died from SIDS (Sudden Infant Death Syndrome). Five natural deaths did not fall into one of the other identified types of fatal injury/event data categories. Of those five deaths, one of the deaths was determined by the Panel to have been preventable due to medical misadventures/forseeable complications.

SIDS

Eight babies died from SIDS (Sudden Infant Death Syndrome). There were four males and four females that died from SIDS. The race of the infants who died from SIDS was Caucasian (3) and Native American (5). Ages of the infants who died from SIDS were one month (2), two months (2), three months (2), four months (1), eleven months (1).

Of these eight infant deaths, two were placed to sleep in an infant crib. Three infants who died of SIDS were placed to sleep in unsafe infant sleep environments such as on adult beds (3); a playpen (1); a bassinette (1); a pack and play (1). In seven of the eight deaths, additional risk factors for SIDS were identified, including pillows and/or blankets present in the sleep environment (7), infants placed to sleep on their side (1) or stomach (3). Two of the infant sleep positions were unknown.

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 11-19.1-13. "Cause of death – Determination").

Other Natural Deaths

During calendar year 2006, five natural deaths did not fall into one of the other identified types of fatal injury/event data categories. The following conditions led to these child deaths:

- Septicemia: Fifteen year old white female.
- Adult Respiratory Distress Syndrome; Pneumonitis: Sixteen year old white female.
- Cerebral Edema – Cerebellum Tumor: Four year old white male.
- Cardiac Arrhythmia; Congenital Cardiac Anomalies: Seventeen year old white male.
- Cardiac Arrhythmia; Hypertrophic Cardimyopathy: Fourteen year old white male.

Suicide Deaths

Table 5. Child Deaths: Suicide

Year	Suicide Deaths
1996	11
1997	7
1998	4
1999	8
2000	6
2001	5
2002	2
2003	3
2004	5
2005	5
2006	6

There were six suicide deaths in children during calendar year 2006. The Child Fatality Review Panel classified all six deaths as preventable. Of the deaths by suicide, two involved firearms and three were due to ligature hanging. Four of the suicide deaths were male while two were female. There were four 17 year olds and two 16 year olds. Four of the deceased children were Caucasian and two were Native American. Two of the suicide deaths were drug or alcohol related.

Homicide Deaths

Table 6. Child Deaths: Homicide

Year	Homicide deaths
1996	0
1997	0
1998	2
1999	1
2000	1
2001	1
2002	2
2003	4
2004	3
2005	2
2006	2

In 2006, two children died as the result of homicide. These homicide deaths include a two year old Native American male and a four month old Caucasian female.

Of the two homicides, one resulted from blunt force injury to the head and one resulted from blunt force injury to the abdomen. The Panel identified that both homicides involved child abuse or neglect by the child's caregiver. The Panel determined these homicide deaths to have been preventable.

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

Deaths Where the Manner Could Not be Determined

The Panel could not determine the manner of death for six deaths in 2006.

- A sixteen year old white male died from a gunshot wound to the head.
- A fourteen year old white male's death was reclassified from an accident to undeterminable. No autopsy was performed.
- A six month old white female died from cerebral edema with herniation which was not adequately investigated.
- A seven year old black female died from a ligature hanging.
- There were two Sudden Unexpected Infant Deaths that were undeterminable. A four month old Native American female and an eleven month old Native American female.

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").