MAGGIE ANDERSON, INTERIM EXECUTIVE DIRECTOR

NORTH DAKOTA CHILD FATALITY REVIEW PANEL

DETAILED ANNUAL REPORT

2012, 2013, & 2014

February 2017

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

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

Report By:
Tracy Miller
Child and Family Services
tramiller@nd.gov
701-328-1725

Data Compiled by:
Jessica Van Neste
DHS Decision Support Services
jvanneste@nd.gov
701-328-8705

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

THE NORTH DAKOTA CHILD FATALITY REVIEW PANEL

This Child Fatality Review Annual Report was compiled in December 2016 and presents information from the in-depth reviews of child deaths that occurred in calendar years 2012-2014. This report is intended for the public audience.

Every child's death is a tragic loss for the family and community. Especially tragic is the child death that could have been prevented. Through careful review of child deaths, we are better prepared to prevent future deaths. The Child Fatality Review Panel members acknowledge that the circumstances involved in most child deaths are too complex and multidimensional for responsibility to rest with a single individual or agency. The child death review process has raised the collective awareness of all participants and has led to a clearer understanding of agency responsibilities and possibilities for collaboration on all efforts addressing child health and safety. It is only through continued collaborative work that we can hope to protect the health and lives of our children.

History

The North Dakota Child Fatality Review Panel (NDCFRP) was established by North Dakota Century Code (NDCC) 50-25.1 and began reviewing child deaths in 1996. The NDCFRP's charge is to "protect the health and welfare of children by identifying the cause of children's deaths, when possible; the identifying of those circumstances that contribute to children's deaths; and the recommending of changes in policy, practices, and law to prevent children's deaths."

Purpose

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

- identifies the cause of children's deaths,
- identifies circumstances that contribute to children's deaths, and
- recommends change in policy, practices, and law to prevent children's deaths.

Their careful review process results in a thorough description of the factors related to child deaths. The reviews make a difference. These collaborations, partnerships and activities are proof that communities are aware that knowledge of the facts about a child death is not sufficient to prevent future deaths. The knowledge must be put into action.
By sharing information and reviewing data, panel members review the circumstances surrounding the deaths and look for patterns or trends to identify possible prevention strategies.

A determination of the Panel's agreement with the manner of death indicated on the death certificate and the preventability of death is made by a consensus of the Panel members. A data form is maintained for each case reviewed by the Panel to document the findings and recommendations. This data form is used in compiling non-identifying, death related information that serves as the basis for this annual report. Meetings are closed to the public and all case discussions and documents, except for this annual report, are confidential by law (NDCC 50-25.1-04.5).

After an in-depth review, the Child Fatality Review Panel either agrees or disagrees with the manner of death indicated on each death certificate. When the Panel does not agree with the manner of death indicated on a death certificate, the Panel reclassifies the manner of death for its own purposes. It does not change the classification on the death certificate, but the Panel's decisions regarding manner of death serve as the basis of this report.

North Dakota Child Fatality Review Panel (NDCFRP) Recommendations

SIDS/SUID

1. Consistent and uniform statewide reporting of SIDS deaths; look to the possibility of others such as Public Health Nurses completing the SUIDI reporting form with the family after the death of an infant.
2. Complete and thorough death scene investigations that include doll re-enactment.
3. Statewide home visitation services offered to all families with infants.
4. Continue to get safe sleep information and education into the hands of parents and caregivers.

Motor Vehicle Crashes

5. Address the societal issues of seat belts, distracted driving and alcohol/drug usage of teens by continuing education and media campaigns.
6. Educate the public regarding the dangers of children riding on adult sized All-Terrain Vehicles (ATVs).
7. As part of the investigation, obtain cell phone records of the child to see if the child was using the phone (i.e. talking or texting) while driving.

Medical/Reporting

8. Continue to train and educate the medical field on timely notification to child protective services when a child presents with trauma and where child abuse or neglect may reasonably be suspected.
9. Hospitals continue to use peer review as a means to examine trauma processes and protocols in regards to child injuries and death.

Suicide

10. Continue suicide prevention strategies to educate school personnel, parents, friends, and family members of adolescents on the signs and symptoms of depression, the risk factors for suicide, and the factors that may protect teens from suicide.

Table 1. Child Deaths in North Dakota, CY 2012-2014

	2012	2013	2014
Total Child Deaths	99	101	86
Status B: deaths due to natural causes or that are not unexpected (i.e., long term illness).	44	61	40
Status A: Deaths that are sudden, unexpected, or unexplained	55	40	46
Status A: The 'death-causing' event occurs outside of North Dakota	2	2	2
Status A: In-State Child Deaths (in-Depth Reviews)	**53**	**38**	**44**

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 each of the following : child placing agency, the North Dakota Department of Health, North Dakota Attorney General's Office, North Dakota Department of Public Instruction, North Dakota Department of Corrections, and the lay community. Other appointed members include: the State Forensic Medical Examiner, a North Dakota licensed peace officer, a mental health professional, a physician, a representative of North Dakota Injury Prevention, Department of Health, a representative of Emergency Medical Services, Department of Health, and consultants invited to assist in review of specific cases.

Panel Members 2012, 2013 and 2014

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

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

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

Dr. William Massello, State Medical Examiner
ND Department of Health

Diana Read, Injury Prevention Director
ND Department of Health

JoAnne Hoesel, Director MHSAS
ND Department of Human Services

Jonathan Byers, Assistant Attorney General
ND Attorney General's Office

Mark Sayler/Duane Stanley, Special Agent
ND Bureau of Criminal Investigation

Dr. Arne Graff, Pediatrician
Sanford Health

Kathey Wilson/Bobbi Peltier, Health Specialist
Indian Health Services

Shelly Arnold - Emergency Medical Services
Trauma Services – MedCenter One

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

Steve Kukowski, Sheriff
Ward County

Carol Meidinger,
Citizen member

CPT Lisa Bjergaard, Director
Division of Juvenile Justice

CPT Karen Eisenhardt, Educator
Citizen member

CPT Carla Pine,
Citizen member

CPT Alison Dollar, Special Education Director
ND Department of Public Instruction

CHILD FATALITY CASES THAT RECEIVED AN IN-DEPTH REVIEW

Annual reports of the Child Fatality Review Panel (CFRP) are based on cases reviewed by the panel for deaths that occurred during a calendar year.

Case Status

Each death certificate received from the Department of Health is reviewed by a Child Fatality Review Panel (CFRP) subcommittee. Each death is identified as a Status A case or a Status B case (Table 2). 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 2. Child Deaths by Status, CY 2012-2014

	2012	2013	2014
Status A	55	40	46
Status B	44	61	40
Total	99	101	86

Status B cases are deaths that are not unexpected (i.e. long term illness) and/or deaths that are due to other natural causes. Status B cases may only be presented for review by the Child Fatality Review Panel in a brief, general format in order to give all panel members an opportunity to request that the case be changed from Status B to Status A.

In-State and Out-of-State Child Deaths

When the 'death-causing' event/injury is identified as occurring outside of the state, the death is considered an out-of-state child death. All other child deaths with North Dakota death certificates are considered in-state child deaths and are reviewed by the CFRP.

Table 3. Status 'A' Child Deaths by In- State and Out-of-State, CY 2012-2014

	2012	2013	2014
In-State	53	38	44
Out-of-State	2	2	2
Total	55	40	46

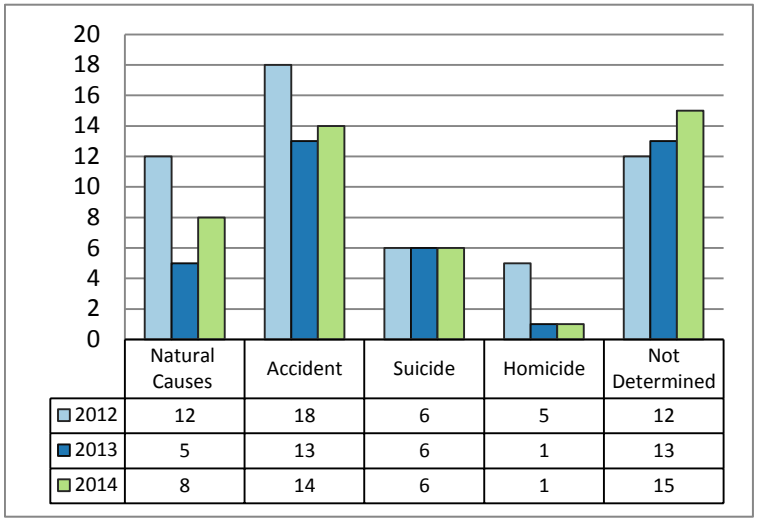
The Child Fatality Review Panel conducts in-depth reviews of child deaths within the state that are sudden, unexpected, or unexplained. Compared to the 50 child deaths reviewed in 2011, the number of in-state sudden, unexpected, or unexplained deaths increased in 2012 to 53 (6.0%) but decreased in 2013 and 2014 (by 24.0% and 12.0% respectively).

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.

Figure 1. Number of Child Fatalities by Manner of Death, CY 2012-2014



	Natural Causes	Accident	Suicide	Homicide	Not Determined
2012	12	18	6	5	12
2013	5	13	6	1	13
2014	8	14	6	1	15

The manner of child death with the highest count was Accidents. In the last ten years the highest number of accident deaths took place in 2006 at 33. The lowest was 13 in 2008 and 2013. The term accident implies that the death could not have been prevented. The NDCFRP prefers the term 'unintentional' because these deaths are predictable, understandable and preventable.

In 2012, the Panel reclassified 5 deaths: changing 1 from 'accident' to 'suicide'; 2 from 'natural' to 'not determined'; 1 from 'accident' to 'not determined'; and one from 'not determined' to 'homicide'.

In 2014, the Panel reclassified 4 deaths: changing 2 from 'natural' to 'not determined'; and 2 from 'accident' to 'not determined'.

There were no deaths reclassified by the Panel in 2013.

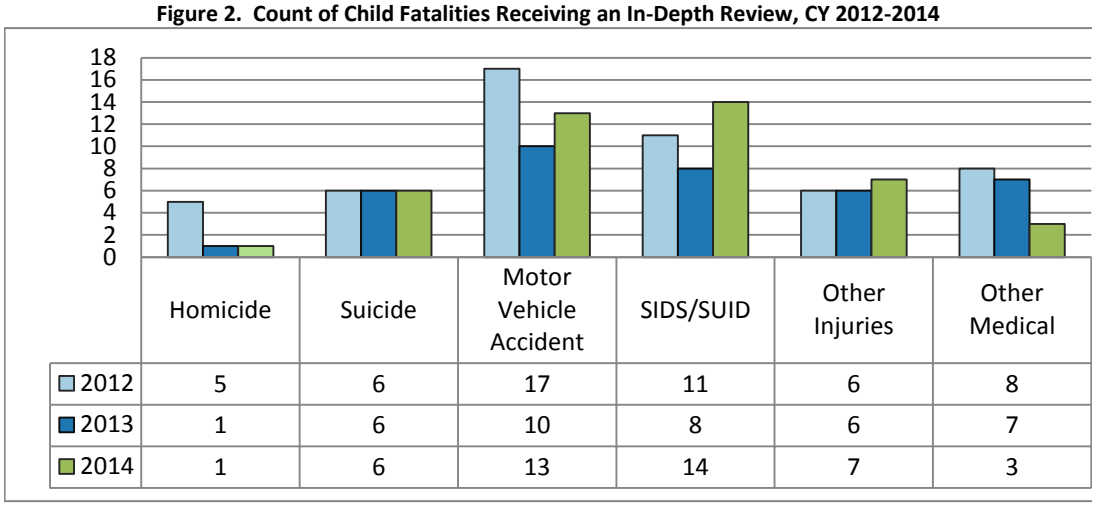
Deaths classified with the manner as 'not determined' have continued to increase. These deaths now represent roughly 1/3 of all reviewed cases.

Table 4. Manner of Death Not Determined by Year 2005 – 2014

2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
2	6	3	6	7	4	9	12	13	15
5.00%	10.00%	7.30%	20.70%	15.60%	12.50%	17.00%	22.64%	34.21%	34.09%

Cases that Received an In-Depth Review

Figure 2. Count of Child Fatalities Receiving an In-Depth Review, CY 2012-2014



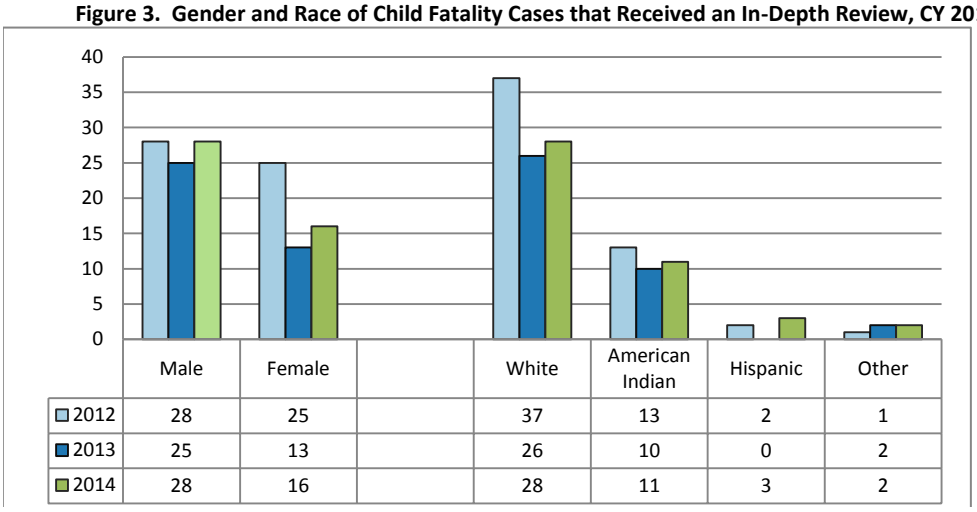
	Homicide	Suicide	Motor Vehicle Accident	SIDS/SUID	Other Injuries	Other Medical
2012	5	6	17	11	6	8
2013	1	6	10	8	6	7
2014	1	6	13	14	7	3

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

The child population in North Dakota is evenly matched with half male (51.3%) and half female (48.7%) (U.S. Census Bureau[1]). The number and percent of male (28, 52.8%) child fatalities reviews in 2012 was more than similar that of females (25, 47.2%). However, in 2013 and 2014 males (2013: 25, 65.7%; 2014: 28, 63.6%) were nearly double that of females (2013: 13, 34.2%; 2014: 16, 36.4%).

In 2014 about one in eleven (8.87%) of children in North Dakota were American Indian (U.S. Census Bureau[2]). In 2012-2014 about one in four child deaths reviewed were American Indian (Figure 3 and Table 6) which is an over- representation of this population.

Figure 3. Gender and Race of Child Fatality Cases that Received an In-Depth Review, CY 2012-2014



	Male	Female		White	American Indian	Hispanic	Other
2012	28	25		37	13	2	1
2013	25	13		26	10	0	2
2014	28	16		28	11	3	2

[1] Annual Estimates of the Civilian Population by Single Year of Age and Sex for the United States and States: April 1, 2010 to July 1, 2014; https://www.census.gov/popest/data/state/asrh/2014/SC-EST2014-AGESEX-CIV.html

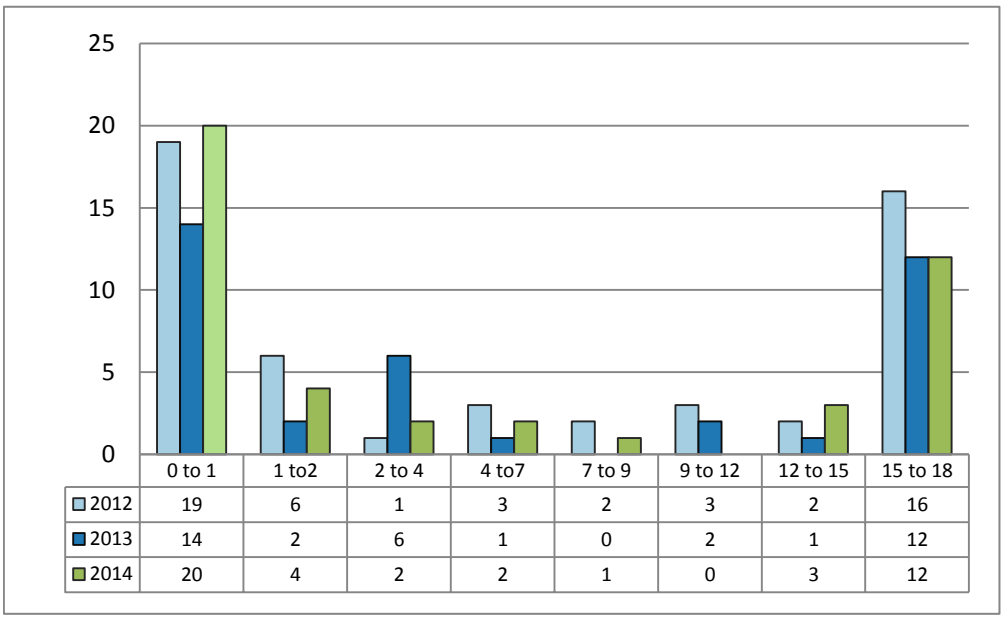
[2] Annual State Resident Population Estimates for 6 Race Groups (5 Race Alone Groups and Two or More Races) by Age, Sex, and Hispanic Origin: April 1, 2010 to July 1, 2014; https://www.census.gov/popest/data/state/asrh/2014/SC-EST2014-ALLDATA6.html

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

The vast majority of child deaths occur with the very young ages 0 to 1 (40.29%) and the older youth ages 15 to 18 (29.6%) (Figure 4). Combined, the youngest and oldest children accounted for 93 deaths of all child fatalities receiving in-depth reviews in 2012-2014.

During 2012-2014 sudden infant death syndrome (SIDS) was the leading cause of death in infants ages 0-1 and motor vehicle crashes was the leading cause of death for older youth ages 15 to 18.

Figure 4. Count by Age Group in Child Fatality Cases that Received an In-Depth Review, CY 2012-2014



	0 to 1	1 to2	2 to 4	4 to7	7 to 9	9 to 12	12 to 15	15 to 18
2012	19	6	1	3	2	3	2	16
2013	14	2	6	1	0	2	1	12
2014	20	4	2	2	1	0	3	12

CAUSES AND MANNERS OF CHILD FATALITY

VEHICULAR

There were 40 vehicular child fatalities in 2012-2014 (Table 5). Children ages 15 to 18 continue to be the largest age group involved in vehicular fatalities.

According to the data in Table 6, the use of seat belts by the decedent decreased from 2012 to 2014.

Table 5. Vehicular Child Fatalities by Gender, Age, and Race, CY 2012-2014

	2012	2013	2014	**Total**
Males	9	6	9	**16**
Females	8	4	4	**24**
0 to 1	0	0	0	**0**
1 to2	1	1	2	**4**
2 to 4	0	1	1	**2**
4 to7	1	0	2	**3**
7 to 9	2	0	1	**3**
9 to 12	2	2	0	**4**
12 to 15	0	0	2	**2**
15 to 18	11	6	5	**22**
White	14	8	8	**30**
American Indian	1	2	4	**7**
Hispanic	2	0	0	**2**
Other	0	0	1	**1**
Total	17	10	13	**40**

Seat Belt Use / Safety Restraints

Table 6. Seat Belt Use by the Decedent, CY 2012-2014

	2012	2013	2014
Wearing seat belt	6	1	1
Not wearing seat belt	6	4	7
Seat belt use unknown	2	2	1
Seat belt not applicable	3	3	4
Total	17	10	13

Position of Decedent in or out of the Vehicle

Table7. Position of Decedent, CY 2012 - 2014

	2012	2013	2014	3-yr Total
Driver	9	4	4	17
Passenger	4	3	5	12
Pedestrian/Other	4	3	4	11
Total	17	10	13	40

Type of Vehicle

During 2012-2014, cars (14) were the predominate type of vehicle involved in child deaths, followed by pickup trucks (5) (Table 8).

Table 8. Number of Vehicular Child Deaths by Type of Vehicle, CY 2012-2014

Car	Pickup	ATV	Bicycle	Van	Motorcycle	Snowmobile	Tractor
14	5	4	2	1	1	1	1

Table 9. Ages 15 to 18 Vehicular Child Fatalities by Year 2005-2014

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	10-yr Total
15 to 18	7	15	10	7	5	8	5	11	6	5	79
0-15	10	12	3	5	7	3	8	6	4	8	66
% 15 to 18 year olds	41%	56%	77%	58%	42%	73%	38%	65%	60%	38%	54%

SUDDEN INFANT DEATH SYNDROME (SIDS)
SUDDEN UNEXPLAINED INFANT DEATH (SUID)

According to the North Dakota Century Codes, the term "sudden infant death syndrome" (SIDS) 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. A "sudden unexplained infant death" (SUID) is when all the above criteria for sudden infant death applies but a risk factor is identified.

In 2012-2014 there were a total of 33 infant deaths identified as SIDS/SUID (Table 10.) Of these 33 deaths 39.4% were American Indian, 54.5% were White and 6% were Hispanic.

In 2012 there were 11 infant deaths 4 (SIDS) and 7 (SUID); in 2013 there were 8 infant deaths all determined as SUID; in 2014 there were 14 infant deaths 3 (SIDS) and 11 (SUID.)

Of the SUID deaths the most common risk factor identified by the Panel was an unsafe sleep environment for the infant. Unsafe sleep environment may include one or more of the following whereby the infant was: placed to sleep in an adult bed; placed to sleep on their stomach; co-sleeping with others; sleeping with multiple blankets and pillows.

Table 10. Child Fatalities Due to SIDS/SUID by Gender and Race, CY 2012-2014

	2012	2013	2014	Total
Males	5	6	9	20
Females	6	2	5	13
White	4	5	9	18
American Indian	7	3	3	13
Hispanic	0	0	2	2
Total	11	8	14	33

Over the 10 year period 2005 to 2014, 102 child fatalities were due to SIDS/SUID. Because the counts are small and because they fluctuate from year to year, a trend is not discernible (Table 11.)

Table 11. Child Fatalities Due to SIDS/SUID by Year 2005 -2014

2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	10-yr Total
6	8	9	2	7	8	17	11	8	14	102

OTHER INJURIES/OTHER CONDITIONS INCLUDING MEDICAL

Child fatalities in 2012, 2013, and 2014 reviewed by the NDCFRP with death due to other injuries were attributed to asphyxia, drowning, a fall, firearms, poison/overdose, and other injury. In these cases 73.7% of the children were male, 52.6% were less than 1 year of age and 21.1% were American Indian (Table 12.)

Of the child fatalities where the death was due to other conditions including medical 61.1% of the children were female, 61.1% were less than 1 year of age and 27.8% were American Indian (Table 13.)

Table 12. Child Fatalities Due to Other Injuries by Gender, Age, and Race, CY 2012-2014

	2012	2013	2014
Males	4	5	5
Females	2	1	2
0 to 1	4	2	4
1 to2	1	1	2
2 to 4	0	3	0
4 to 7	1	0	0
7 to 9	0	0	0
9 to 12	0	0	0
12 to 15	0	0	0
15 to 18	0	0	1
White	5	5	4
American Indian	1	1	2
Other	0	0	1
Total	6	6	7

Table 13. Child Fatalities Due to Other Conditions/Medical by Gender, Age, and Race, CY 2012-2014

	2012	2013	2014
Males	3	4	0
Females	5	3	3
0 to 1	5	4	2
1 to2	2	0	0
2 to 4	1	1	1
4 to 7	0	1	0
7 to 9	0	0	0
9 to 12	0	0	0
12 to 15	0	1	0
15 to 18	0	0	0
White	4	4	1
American Indian	3	1	1
Other	1	2	1
Total	8	7	3

Table 14. Child Fatalities Due to Other Injury and Other/Medical by Year 2005 - 2014

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Other Injury	5	9	6	3	7	8	5	6	6	7
Medical	3	6	5	4	7	10	8	8	7	3

Homicides and Suicides

The number of child fatalities due to homicide for 2012-2014 was 7.

Most notable (Table 15) is the number of homicide victims that were male (71.4%) compared to female (28.6%.)

Homicides were results of firearms (3), blunt head injury (2), battered child syndrome (1), and chronic starvation (1).

The number of child fatalities due to suicide for 2012-2014 was 18. Of the suicides, 11 were by hanging, 6 by firearm and 1 by the child stepping in front of a moving vehicle.

Table 15. Child Fatalities by Homicide and Suicide by Gender, Age and Race, CY 2012-2014

	Homicide			Suicide		
	2012	2013	2014	2012	2013	2014
Males	4	0	1	3	4	4
Females	1	1	0	3	2	2
0 to 1	0	0	0	0	0	0
1 to 2	2	0	0	0	0	0
2 to 4	0	1	0	0	0	0
4 to 7	1	0	0	0	0	0
7 to 9	0	0	0	0	0	0
9 to 12	1	0	0	0	0	0
12 to 15	1	0	1	1	0	0
15 to 18	0	0	0	5	6	6
White	5	0	1	5	4	5
Native American	0	1	0	1	2	1
Total	5	1	1	6	6	6

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

The number of suicides tripled from each of the years 2007 and 2008 to 2010 (Table 16). Although there were 2 fewer in 2011 than in 2010, the number of suicides remained more than double that of 2007 and 2008. With a slight decrease in 2012 the number of deaths to suicide remains consistent through 2014 at 6.

Table 16. Child Fatalities by Homicide and Suicide by Year 2005-2014

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Suicide	5	6	3	3	4	9	7	6	6	6
Homicide	2	2	3	2	4	2	4	5	1	1

PREVENTABLE DEATHS

The Panel uses the determination of preventability for the identification of systems issues. To the Panel the word preventability does not imply negligence. The Panel looks at what systemic changes can be made to prevent these deaths, for instance changes in policy, practice and law. The majority of preventable child deaths reviewed by the Panel in 2012-2014 occurred as a result of injuries. Almost half of all the preventable deaths were motor vehicle related (48%). Deaths due to SIDS continue to be the second largest number of child deaths. The Panel concluded the preventability for the majority of SIDS deaths to be undetermined, but did identify multiple risks factors which can increase the risk of SIDS. The third largest number of child deaths is due to suicide. The Panel agrees that all 18 of these suicide deaths were preventable at a systems level.

Table 17. Panel Determination of Preventability and Intentionality, CY 2012-2014

		Preventable			Non-Preventable	Preventability Undetermined	Total
		Intentional	Unintentional	Intention Undetermined			
2012	Homicide	5	0	0	0	0	5
	Suicide	6	0	0	0	0	6
	Motor Vehicular	0	16	0	0	1	17
	SIDS/SUID	0	1	0	4	7	12
	Other Medical	0	1	0	5	1	7
	Other Injury	0	0	0	0	0	0
	Asphyxia	0	1	0	0	2	3
	Drowning	0	0	0	0	0	0
	Fall	0	1	0	0	0	1
	Poison/Overdose	0	1	0	0	0	1
	Undetermined	0	0	0	0	1	1
2013	Homicide	1	0	0	0	0	1
	Suicide	6	0	0	0	0	6
	Motor Vehicular	0	10	0	0	0	10
	SIDS/SUID	0	2	0	1	5	8
	Other Medical	0	0	0	3	4	7
	Other Injury	0	2	0	0	1	3
	Asphyxia	0	0	0	0	0	0
	Drowning	0	0	0	0	1	1
	Fall	0	0	1	0	0	1
	Poison/Overdose	0	1	0	0	0	1
	Undetermined	0	0	0	0	0	0
2014	Homicide	1	0	0	0	0	1
	Suicide	6	0	0	0	0	6
	Motor Vehicular	0	12	0	1	0	13
	SIDS/SUID	0	0	0	2	12	14
	Other Medical	0	1	0	2	0	3
	Other Injury	0	0	0	0	0	0
	Asphyxia	0	1	0	0	3	4
	Drowning	0	1	2	0	0	3
	Fall	0	0	0	0	0	0
	Poison/Overdose	0	0	0	0	0	0
	Undetermined	0	0	0	0	0	0

Cause of Death

CHILD ABUSE AND NEGLECT DEATHS AND NEAR DEATHS

According to 50-25.1-04.5 the annual report involving child abuse and neglect deaths and near deaths must include the following: the cause of and circumstances regarding the death or near death; the age and gender of the child; information describing any previous child abuse and neglect reports or assessments that pertain to the child abuse or neglect that led to the death or near death; the result of any such assessments; and the services provided in accordance with section 50-25.1-06, unless disclosure is otherwise prohibited by law.

Deaths due to Child Abuse and Neglect

2012
A one year old male died from homicide due to Blunt Head Injury in Battered Child Syndrome. A report of child abuse and neglect was received as a result of the death. There were no previous reports of child abuse and neglect that pertained to the death. An assessment determination of "No Services Required" was made for fatal abuse. A determination of "Services Required" was made on an unknown subject for fatal abuse. Due to not having an identified subject of the services required finding, no services were offered or provided.

An eighteen month old male died from Hypoxic Encephalopathy, Child Abuse. The manner of death listed on the death certificate is Undetermined. However, the Child Fatality Panel disagreed with the manner listed and reclassified it as a Homicide. There were no previous reports of child abuse and neglect that pertained to the death. A report of child abuse and neglect was received as a result of the death. An assessment determination of "Services Required" was made for physical abuse resulting in death. A referral for services was offered and services were declined.

2013
A two year old female died of homicide due to Blunt Force Head Trauma, assault by another. Because this child lived on one of the state's Indian reservations, which maintains separate child welfare systems, the NDCFRP is unable to obtain any previous child abuse and neglect reports, assessments and if any services were provided.

2014
A 13 year old male died from homicide due to Chronic Starvation. A report of child abuse and neglect was received as a result of the death. There was a prior report of suspected child abuse and neglect on this child that pertained to the neglect that ultimately led to his death. An assessment determination of this prior report was "No Services Required" for neglect, inadequate healthcare. The assessment determination of the report received as a result of the death was "Services Required" for fatal abuse, educational neglect, medical neglect and neglect; condition of the home. Due to ongoing legal processes and incarceration services were not provided.

Near Deaths due to Child Abuse and Neglect

A 16 month old male presented at the hospital after being found minimally responsive, seizing with bruising on his face and body. As a result, a report of child abuse and neglect was received. An assessment determination of this report was "Services Required" for physical abuse. There were no previous reports of child abuse and neglect that pertained to the near death. The services of foster care case management, family team decision making and parent aide services were provided as a result of a prior CPS assessment that did not pertain to the near death. Due to the ongoing legal processes and incarceration services were not provided.

A newborn female infant tested positive for THC at birth. The newborn needed to be intubated and was placed in the NICU. As a result, a report of child abuse and neglect was received. An assessment determination of this report was "Services Required" for prenatal drug exposure. There were no previous reports of child abuse or neglect that pertained to the near death. The service of in-home case management was provided.

A five month old male presented at the hospital with a fractured skull and possible bleeding of the brain. As a result, a report of child abuse and neglect was received. An assessment determination of this report was "Services Required" for physical abuse. There were no previous reports of child abuse or neglect that pertained to the near death. Due to ongoing legal processes and incarceration services were not provided.

A twelve year old male was hospitalized due to uncontrolled diabetes. As a result, a report of child abuse and neglect was received. An assessment determination of this report was "Services Required" for medical neglect. The services provided were case management and counseling services for the child. There were nine prior reports of child abuse or neglect that pertained to the near death. Six assessments were completed with all six having a determination of "Services Required" for medical neglect. The services provided for these assessments were foster care case management services, relative placement, mental health services for the child, family counseling, parent aide services, Intensive in-home therapy and safety permanency funds.

A five month old female was found unresponsive and taken to a local hospital. The child was in cardiac arrest, had bruising to her body and face and signs of being sexually assaulted. As a result, a child abuse and neglect report was received. An assessment determination of this report was "Services Required" for physical abuse, sexual abuse, and psychological maltreatment on one of the subjects. Due to incarceration this subject was not provided services. There was one previous report of child abuse and neglect that pertained to the near death. This report together with the report of the near death was combined into a single assessment. The assessment determination of "Services Required" for psychological maltreatment and inadequate supervision was made on a second subject. The services provided were foster care case management, therapeutic care, medical care, and infant development.

An eleven month old female was admitted to the hospital after being found face down in the bathtub. As a result, a child abuse and neglect report was received. An assessment determination of this report was "Services Required" for neglect; inadequate supervision. There were no previous reports of child abuse and neglect that pertained to the near death. The services provided were In-home case management, family team decision making, parent aide services, early intervention services and safety permanency funds.

A two year old male was admitted to the hospital due to having seizures. The child was also noted to have multiple bruises and abrasions on the body. As a result, a report of child abuse and neglect was received. An assessment determination of this report was "Services Required" for physical abuse and physical neglect. There were two previous reports of child abuse and neglect that pertained to the abuse that caused the near death. The two reports were received together and combined into a single assessment in regards to the child having bruises on his head, face and body. An assessment determination of these two reports was "No Services Required" for physical abuse. The services provided were foster care case management, family team decision making and parent aide.

LONG TERM TRENDS

Table 18. Child Deaths by Status by Year 2005-2014

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Status A Deaths[1]	46	62	45	36	52	53	56	55	40	46
Status B Deaths[2]	48	50	56	47	43	40	42	44	61	40
Total Child Deaths[3]	94	112	101	83	95	93	98	99	101	86
In-State Child Deaths[4]	**40**	**59**	**41**	**40**	**43**	**48**	**53**	**53**	**38**	**44**
Out-of-State Child Deaths[5]	6	3	13	9	9	5	3	2	2	2

[1]Status A cases consist of all cases of children whose death is sudden, unexpected, and/or unexplained.
[2]Status B cases are deaths that are not unexpected (i.e., long term illness) and/or deaths that are due to natural causes. (Review of death certificate only)
[3]From all causes.
[4]Child deaths with North Dakota death certificates that were reviewed in depth by the NDCFRP.
[5]The 'death-causing' event/injury is identified as occurring outside of North Dakota. They were not reviewed in depth by the NDCFRP.
SOURCE: Child Fatality Review Panel

Table 19. Changes in North Dakota Child Population and Child Deaths by Year 2010 to 2014

	Population Under age 18	Difference From Previous Year	% Difference of Child Population From Previous year	Child Deaths	Difference in Child Deaths from Previous Year	% Difference of Child Deaths From Previous year
2010	150,182			93		
2011	152,444	2,262	1.48%	98	5	5.10%
2012	157,101	4,657	2.96%	99	1	1.01%
2013	163,467	6,366	3.89%	101	2	1.98%
2014	168,527	5,060	3.00%	86	-15	-17.44%

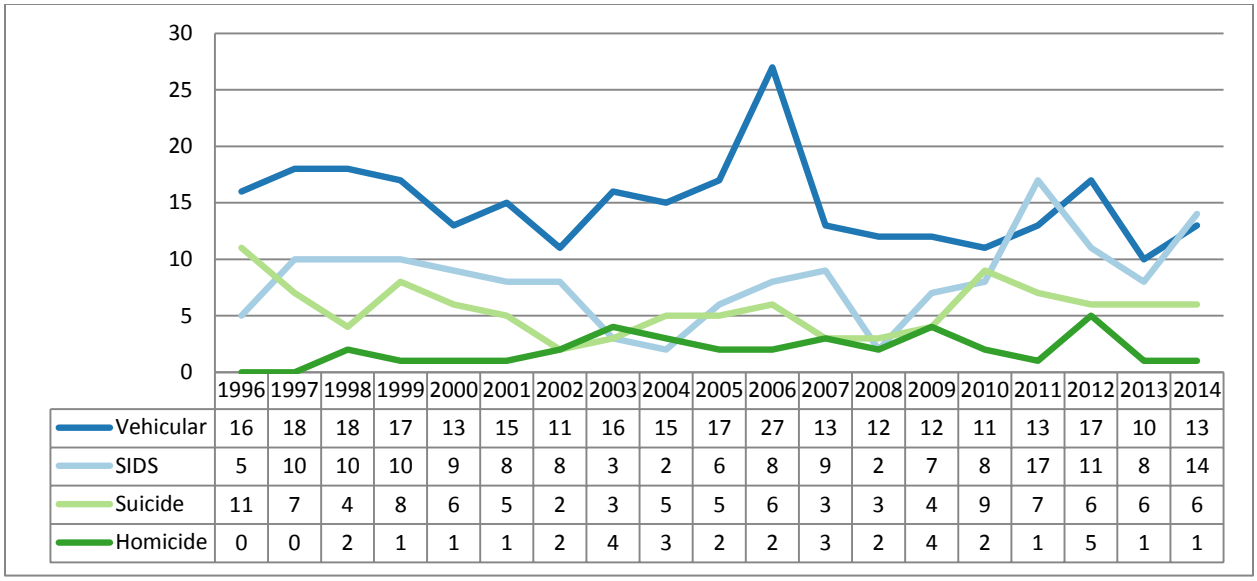
Source of Population Data: U.S. Census Bureau[1]

In 2012, there was a 2.96% child population increase from 2011, however only a 1.01% increase in child deaths. Therefore ND child fatalities increased at a lower percentage rate than the child population increased.

In 2013, there was a 3.89% child population increase from 2012, however only a 1.98/% increase in child deaths. Therefore ND child deaths increased at a lower percentage rate than the child population increased.

In 2014, the child population continued to grow at 3%, however the number of child deaths decreased from previous years by 17.44 %. Thus while the child population grew, there was a large reduction in child deaths.

Figure 5. Number of In-Depth Child Fatality Reviews by Selected Manner of Death for Years 1996-2014



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Vehicular	16	18	18	17	13	15	11	16	15	17	27	13	12	12	11	13	17	10	13
SIDS	5	10	10	10	9	8	8	3	2	6	8	9	2	7	8	17	11	8	14
Suicide	11	7	4	8	6	5	2	3	5	5	6	3	3	4	9	7	6	6	6
Homicide	0	0	2	1	1	1	2	4	3	2	2	3	2	4	2	1	5	1	1

The number of deaths attributed to vehicular, SIDS, suicide, and homicide are shown for the years 1996 to 2014 are shown in Figure 8. The year 2006 saw a dramatic spike in vehicular child deaths (27). Motor vehicle fatalities contributed to the highest number of total child deaths a year from 1996 to 2010. In 2011, child fatalities due to SIDS outnumbered those of motor vehicle fatalities.

CONTINUED EFFORTS

The Panel, with interagency support, must continue to find a way to promote increased cooperation and access to records across all jurisdictions.

The Panel's ability to access relevant records for review remained a challenge in 2012-2014. Following is the percentage of cases in which records requested by the Panel were not received: 19% in 2012, 7% in 2013 and 11% in 2014.

North Dakota law (NDCC 50-25.1-04.4) provides that, 'Upon the request of a coroner or the presiding officer of a CFRP, any hospital, physician, medical professional, medical facility, mental health professional, or mental health facility shall disclose all records of that entity with respect to any child who has or is eligible to receive a certificate of live birth and who has died'. This statute also states, 'All law enforcement officials, courts of competent jurisdiction, and appropriate state agencies shall cooperate in fulfillment of the purposes of this chapter' (NDCC 50-25.1-12).

Regardless of these mandates, information is too often not forthcoming in response to Panel requests. When this occurs, the Panel's statutory mandate to "review the deaths of all minors which occurred in the state during the preceding six months and to identify trends or patterns in the deaths of minors'"(NDCC 50-25.1-04.3) is hindered. The Panel has no investigatory authority of its own and is completely dependent on the work and cooperation of the agencies with this authority.

There are also other entities such as the Federal Bureau of Investigation, the Bureau of Indian Affairs, and tribal entities that are outside the jurisdiction of state statutes. These entities possess detailed and valuable information about a given child, whose records are not addressed in state law. If not provided by request, these records remain inaccessible to the Panel.

The Panel continues to strive to ensure all child deaths receive a thorough and comprehensive investigation.

Even though there has been an observable increase in the quality of scene investigation in cases of infant death since the inception of the Panel, the Panel continues to be concerned about the quality of all child death scene investigations. Many child death investigations do not include interviews with the parents and others who live in the home or who were present in the home at the time of the death.

The investigations of some child deaths continue to be minimal. Investigations do not always explore circumstances leading up to the death or are not comprehensive enough to uncover information vital to identifying the cause and manner of death or in identifying risk factors and formulating effective interventions. The thoroughness of child death investigations varies greatly. 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.