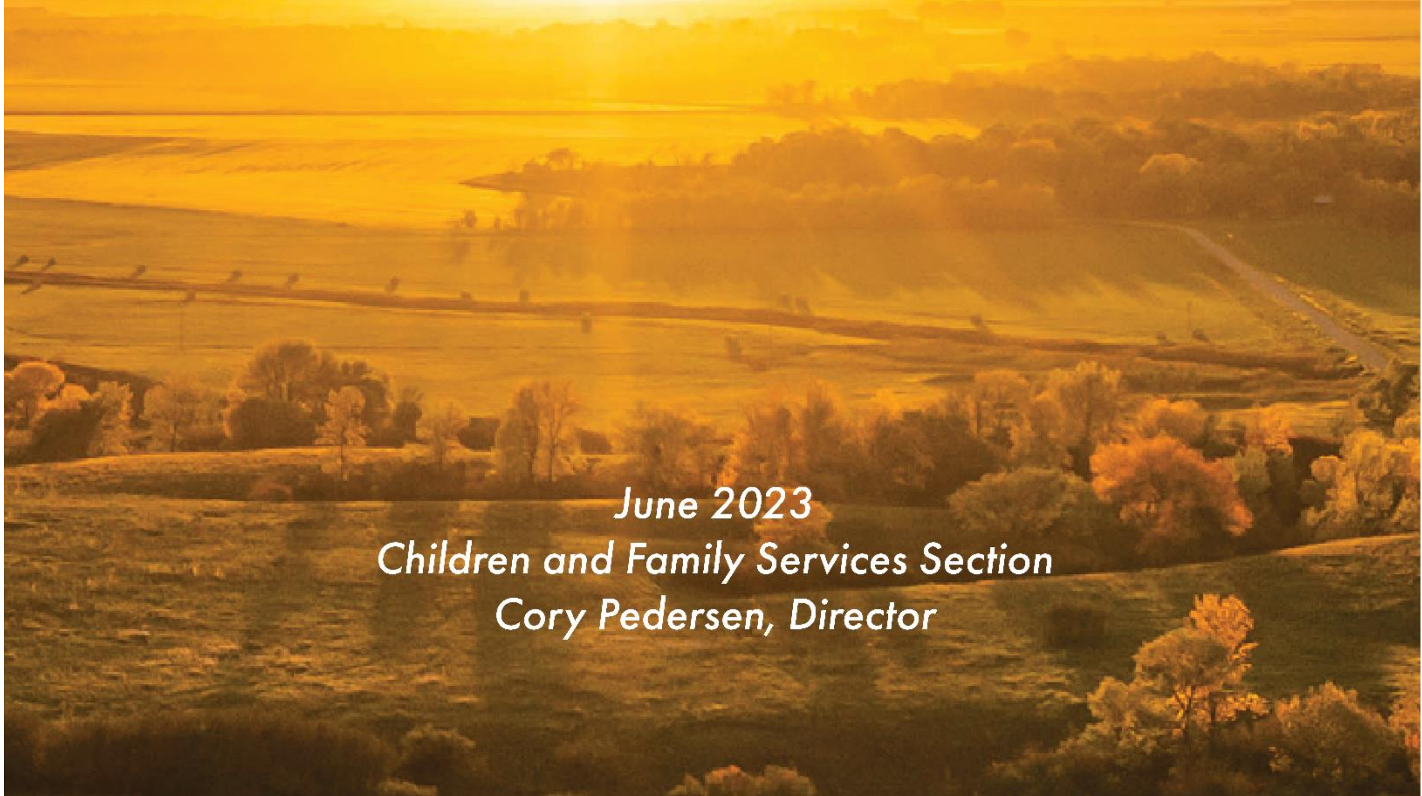
North Dakota Child Maltreatment Fatality Prevention Plan

FFY 2023



June 2023
Children and Family Services Section
Cory Pedersen, Director

North Dakota Statewide Plan to Prevent Child Maltreatment Fatalities:

Child Maltreatment Fatality Prevention Plan

An Executive Report by the Child Fatality Review Panel on Child Abuse and Neglect Fatalities

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TABLE OF CONTENTS

INTRODUCTION 1
NORTH DAKOTA CHILD FATALITY REVIEW PANEL (NDCFRP) 2
Purpose and Duties 2
Membership 2
NDCFRP Members 2022 3
CHILD MALTREATMENT FATALITY 4
Abused Child Defined 4
Neglected Child Defined 4
Contributing Factor of Maltreatment 5
Conditions of Neglect 6
CHILD MALTREATMENT PREVENTION 7
Adverse Childhood Experiences (ACEs) 7
Pair of ACEs Trees 11
PUBLIC HEALTH MODEL 12
Step One – Define and Monitor the Problem 13
Step Two – Identify Risk and Protective Factors 16
Step Three – Develop and Test Prevention Strategies 16
Step Four – Assure Widespread Adoption 16
PARTNER ACKNOWLDGEMENTS 15
DEMOGRAPHICS AND DATA 17
DATA SOURCES 17
Preventable Death Defined 18
Status A and Status B Death Reviews 18
Out of State Deaths 18
DATA CY 2008-2020 19
CONFIRMED FATAL MALTREATMENT 20
Manner of Death 21
Cause of Death 23
Death Classification of Sudden Unexpected Infant Death (SUID) 24
CHILD DEMOGRAPHICS 25
Age 25
Gender 26
Race 27
PERPETRATORS OF FATAL MALTREATMENT 28
CIRCUMSTANCES OF CONTRIBUTING MALTREATMENT 29

Manner and Cause of Death 30
CHILD DEMOGRAPHICS 31
Age 31
Gender 32
Race 32
GEOGRAPHY 33
PRIOR INVOLVEMENT WITH CHILD PROTECTION SERVICES 35
KEY FINDINGS AND PREVENTION STRATEGIES 35
Three Key Areas 36
UNSAFE INFANT SLEEP 37
Risk Factors of SUID 37
GOAL ONE 40
Objectives 40
Prevention Strategies 41
Monitoring Data Source 43
FIREARM HAZARD 60
Risk Factors of Suicide Related to Firearms 60
GOAL TWO 62
Objectives 62
Prevention Strategies 63
Monitoring Data Source 66
ABUSIVE HEAD TRAUMA 68
Risk Factors of Abusive Head Trauma 70
GOAL THREE 72
Objectives 72
Prevention Strategies 73
REFERENCES 78

LIST OF TABLES

1. Confirmed Fatal Abuse and Neglect, CY 2008-2020 20
2. Fatal Maltreatment Manner of Death, CY 2008-2020.... 22
3. Fatal Maltreatment Cause of Death, CY 2008-2020.... 23
4. Fatal Maltreatment by Child Age, CY 2008-2020.... 26
5. Fatal Maltreatment Involving Infants, CY 2008-2020 26
6. Fatal Maltreatment by Gender, CY 2008-2020 27
7. Fatal Maltreatment by Race, CY 2008-2020.... 28
8. Circumstances of Contributing Maltreatment Deaths, CY 2016-2020 29
9. Contributing Maltreatment Manner and Cause of Death, CY 2016-2020.... 30
10. Contributing Maltreatment Death by Child Age, CY 2016-2020 31
11. Contributing Maltreatment Death by Child Gender, CY 2016-2020 32
12. Contributing Maltreatment Death by Child Race, CY 2016-2020 33
13. Abusive Head Trauma by Age; Fatal Maltreatment, CY, 2008-2020, and Child Abuse and Neglect Near Death CY, 2016-2020.... 68
14. Abusive Head Trauma by Race; Fatal Maltreatment, CY 2008-2020, and Child Abuse and Neglect Near Death CY, 2016-2020.... 69
15. Abusive Head Trauma and Prior Sentinel Injuries / Child Protection Services Involvement, Fatal Maltreatment, CY 2008-2020, and Child Abuse and Neglect Near Death CY, 2016-2020.... 69

LIST OF FIGURES

1. Ten Year Firearm Deaths Per 10,000 Children Under 18 in Population, CY 2009-2019 34
2. Ten Year SIDS / Sudden Unexpected Infant Deaths Per 10,000 Children Under 18 in Population, CY 2009-2019.... 34

INTRODUCTION

Section 422(b)(19) of the Social Security Act (42 U.S.C. 622(b)(19)) provides that states document the steps taken to track and prevent child maltreatment deaths. This legislation requires states to develop and implement a coordinated comprehensive state plan to prevent child maltreatment fatalities that takes an early intervention approach. In North Dakota, many agencies from the public and private sector work together to prevent children's deaths and promote the safety and well-being for all the state's population. This child maltreatment fatality prevention plan creates a call to action for the state's health and human service departments, as well as other state and local organizations and communities. The plan details the goals with measurable objectives and strategies, along with agencies responsible to implement the strategies over the two-year timeline. Child deaths and near deaths resulting from child abuse and neglect are preventable and together, North Dakota can reduce the number of children dying.

NORTH DAKOTA CHILD FATALITY REVIEW PANEL

The North Dakota Child Fatality Review Panel (NDCFRP) was established by North Dakota Century Code (NDCC) Chapter 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."

The NDCFRP, as described in Section IV "Citizen Review Panel", serves as the state's Citizen Review Panel as allowed by CAPTA Section 106 (c). The North Dakota Child Fatality Review Panel reviews deaths of all children who receive a North Dakota death certificate, including but not limited to child deaths that occur as a result of child abuse or neglect. These retroactive records reviews also include reviews of child abuse and neglect near deaths. Both types of reviews take place at least every other month and include case level analysis of system functioning in the investigative, administrative, and judicial handling of child abuse and neglect cases.

The NDCFRP's careful review process results in a thorough description of the factors related to child deaths. A determination of the Panel's agreement with the manner of death indicated in the death certificate, the preventability of the death and circumstances of maltreatment contributing to the death is made by consensus of the Panel members.

CHILD FATALITY REVIEW PANEL MEMBERSHIP

The NDCFRP 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.
Each panel member is responsible for dissemination and implementation of NDCFRP recommendations for child fatality prevention with their respective community, agency, and professional counterparts.

North Dakota Child Fatality Review Panel Members 2022

Jenn Grabar – Child Fatality and Maltreatment Manager / CFRP Presiding Officer – DHHS Children and Family Services

Kelly Dillon – ND Attorney General's Office

Dr. Barrie Miller – State Forensic Medical Examiner

Dr. Mary Ann Sens – Department of Pathology – University of North Dakota

Lisa Bjergaard – Division of Juvenile Justice

Duane Stanley – Bureau of Criminal Investigation

Bobbi Peltier – Indian Health Services Injury Prevention

Karen Eisenhardt – Citizen Member

Dr. Melissa Seibel- Sanford Health Pediatrics

Dr. Jada Ingalls – Sanford Health Child Abuse Referral and

Evaluation Elizabeth Oestreich – Injury Prevention Program Director- DHHS

Dr. Rosalie Etherington – ND State Hospital Superintendent

Dr. Tracy Miller – Epidemiologist – DHHS

Todd Porter – Emergency Medical Services / State Legislator

CHILD MALTREATMENT FATALITY

North Dakota defines a child maltreatment fatality as death "caused by an injury resulting from abuse or neglect or where abuse or neglect is a contributing factor." In North Dakota, child abuse and neglect determinations are made thorough child protection services after a child protection assessment is conducted.

North Dakota Century Code 50-25.1-02(3) defines a physically abused child as an individual under the age of eighteen years who is suffering from mental injury, bodily injury, substantial bodily injury, or serious bodily injury caused from intentional force by a person responsible for the child's welfare.

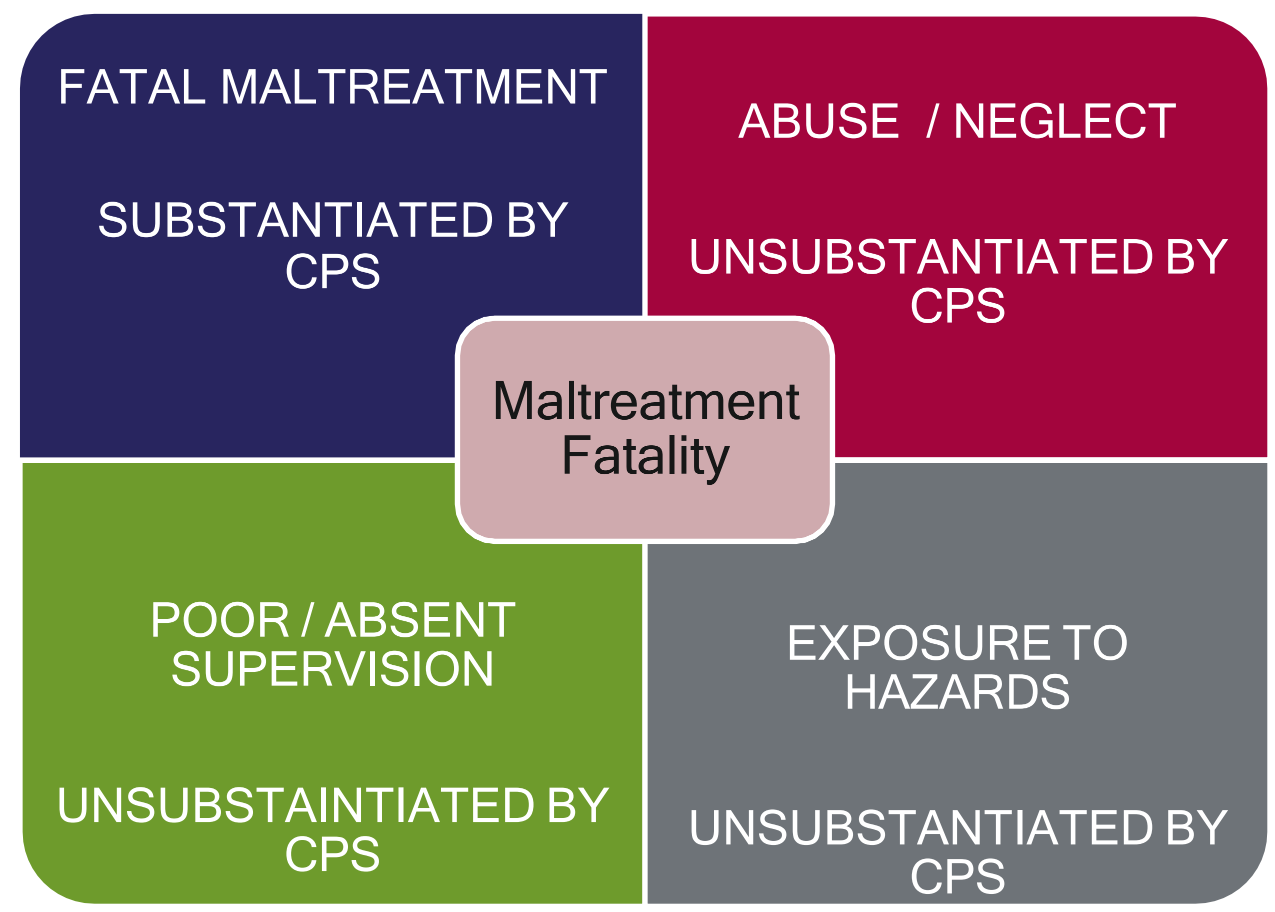
A neglected child is defined in North Dakota Century Code 50-25.1-02(19) as a child who due to the action or inaction of a person responsible for the child's welfare:

a. Is without proper care or control, subsistence, education as required by law, or other care or control necessary for the child's physical, mental, or emotional health, or morals, and is not due primarily to the lack of financial means of a person responsible for the child's welfare;
b. Has been placed for care or adoption in violation of the law;
c. Has been abandoned;
d. Is without proper care, control, or education as required by law, or other care and control necessary for the child's well-being because of the physical, mental, emotional, or other illness or disability of a person responsible for the child's welfare, and that such lack if care is not due to a willful act of commission or act of omission, and care is requested by a person responsible for the child's welfare;
e. Is in need of treatment and a person responsible for the child's welfare has refused to participate in treatment as ordered by the juvenile court;
f. Was subject to prenatal exposure to chronic or severe use of alcohol or any controlled substance in a manner not lawfully prescribed by a practitioner;
g. Is present in an environment subjecting the child to exposure of a controlled substance including any amount of marijuana, chemical substance, or drug paraphernalia;
h. Is a victim of human trafficking

North Dakota Century Code 50-25.1-02(1) defines a person responsible for a child's welfare as an individual who has responsibility for the care and supervision of a child AND who is the child's parent, an adult family member of the child, any member of the child's household, the child's guardian, or the child's foster parent; or an employee of, or any person providing care for the child in a child care setting.

A preponderance of evidence is needed in order to confirm abuse and neglect. A "preponderance of the evidence" is a standard of proof in which the facts alleged more likely than not occurred and is at times referred to as the 51% standard. This standard of proof is more stringent than reasonable doubt but less stringent than clear and convincing evidence.

The child maltreatment deaths reported in this document include not only those identified through child protection services as having a substantiated fatal maltreatment finding, which is those identified and reported to the National Child Abuse and Neglect Data System (NCANDS). In addition, this report includes those maltreatment deaths identified by the NDCFRP as preventable deaths in which child abuse, neglect; poor supervision and/or exposure to hazards contributed to the child's death. Therefore, a report of suspected child abuse and neglect and a subsequent assessment with a confirmed finding for abuse or neglect is not necessary for a child maltreatment fatality to have been identified by the NDCFRP. The graphic below illustrates what constitutes a maltreatment fatality as identified in this plan.



CONDITIONS OF NEGLECT

Conditions of neglect include the following:

- Failure to provide necessities
  - Nutrition
  - Shelter
  - Other
- Abandonment
- Failure to seek / follow treatment
- Psychological maltreatment
- Failure to provide adequate supervision
- Exposure to hazards
  - Hazards in the sleep environment
  - Fire hazard
  - Unsecured medication / toxic substance / controlled substance
  - Firearm hazard
  - Water hazard
  - Motor vehicle hazard
  - Prenatal substance exposure
  - Other hazards

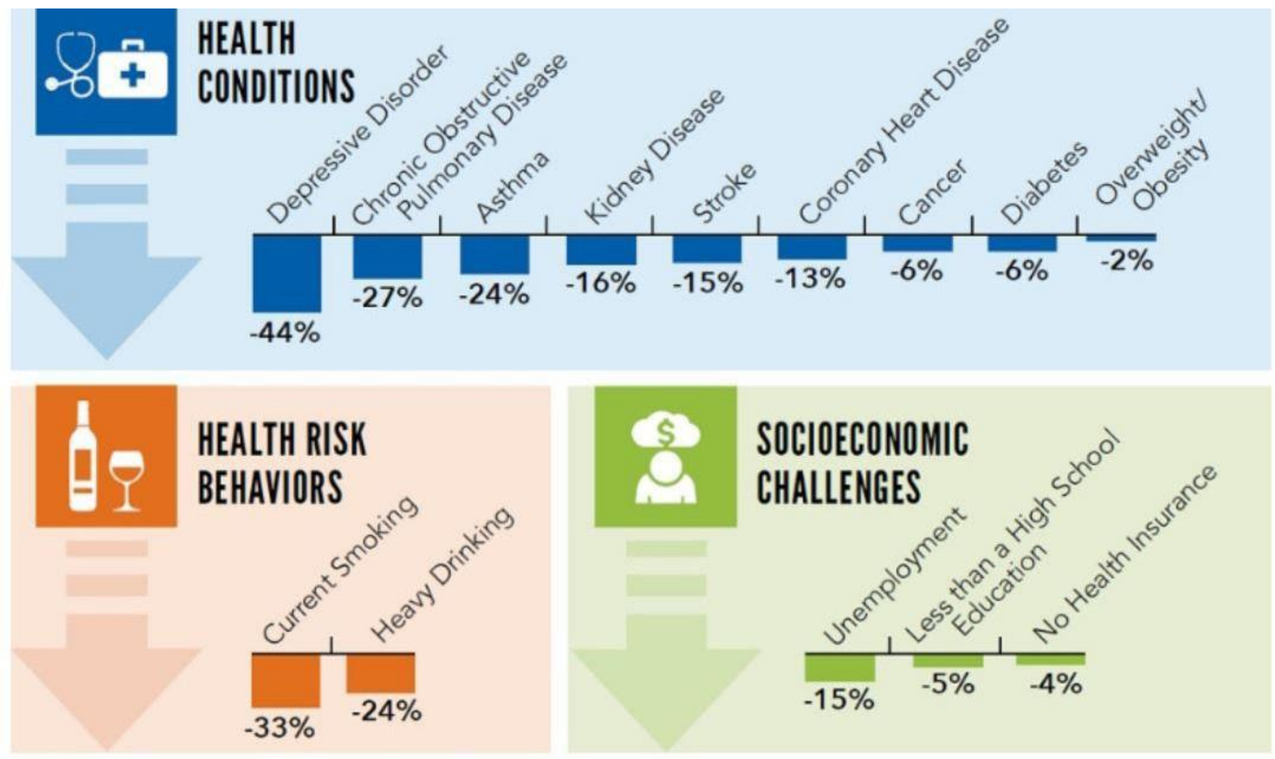
CHILD MALTREATMENT PREVENTION

Child maltreatment fatality prevention involves all systems (child welfare, law enforcement, public health, child care providers, educators, clinicians, courts, tribes) to work together to promote safe, stable, and nurturing environments and relationships for children and families. Victims of child abuse and neglect can experience short and long-term impacts as a result of the maltreatment; some injuries of maltreatment are not immediately apparent (Richmond-Crum M, 2013).

ADVERSE CHILDHOOD EXPERIENCES (ACES)

Physical abuse, sexual abuse, neglect, and psychological maltreatment are all forms of child trauma, adverse childhood experiences (ACEs), and experiencing maltreatment can result in toxic stress and excessive activation of the stress-response system, leading to wear and tear on the body and the brain. Experiencing toxic stress, especially during infancy and early childhood when the brain is developing, has been shown to negatively impact brain and cognitive development and may have lasting impacts on child development, academic achievement, and a child's social and emotional development (Prevention, 2021).

Additionally, research has shown that ACEs are directly linked to negative health and well-being outcomes such as depression, heart disease, diabetes, substance abuse and suicide. Preventing ACES could reduce a great number of health conditions. The chart below demonstrates the potential reduction of negative outcomes from preventing ACES:

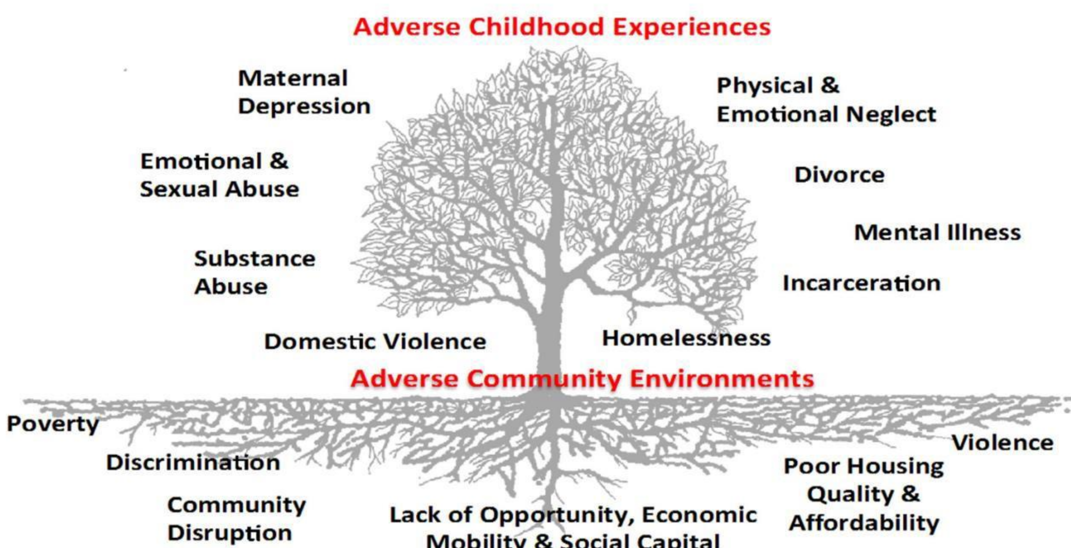


SOURCE: BRFSS 2015-2017, 25 states, CDC Vital Signs, November 2019

Child maltreatment is costly, the total lifetime economic burden associated with child abuse and neglect was about $592 billion in 2018; North Dakota's share was $1.8 million. In the immediate term, these costs come from child protection assessments into reports, from foster care placements and from medical and mental health treatment and services to meet the needs of the child victims. When considering the long-term, child abuse costs stack up resulting from special education, juvenile and adult crime, substance use, chronic health problems, and other costs across the life span (Centers for Disease Control and Prevention, 2022).

In order to address and prevent child maltreatment, we need to look through a wider lens, and move away from child maltreatment as a child and family problem, or a child welfare problem. In order to prevent child maltreatment, we need to broaden the scope to a societal lens. Utilizing a multi-level approach that necessitates primary, secondary, and tertiary prevention strategies with an aim of reducing maltreatment, addressing adverse childhood and community experiences and employs interventions to enhance parental mental health, protective factors, relationships, and caregiving experiences (Brenda Jones Harden, 2021).

The Pair of ACES tree created by the Center for Community Resilience illustrates the relationship between adverse childhood experiences and adverse community environments to assist in a greater understanding of how the systemic roots of adverse childhood community environments, conditions such as poverty, discrimination, poor housing, violence, community disruption and the lack of equal opportunities grow branches of adverse childhood experiences. The tree's soil is rich with adversity and the inequities of the tree's roots feed the adverse experiences of the tree's branches. The leaves are trauma rich and poor outcomes span across generations (George Washington University, Milken Institute School of Public Health , 2022).



Ellis, W., Dietz, W.H., Chen, K.D. (2022). Community Resilience: A Dynamic Model for Public Health 3.0. Journal of Public Health Management and Practice, (28)1, S18-S26. doi: 10.1097/PHH.0000000000001413

Pictured below, the Resilience tree illustrates the relationship between communities with access to equitable, trauma-informed systems and supports, and the positive health and social outcomes they produce for children and families (George Washington University, Milken Institute School of Public Health, 2022).

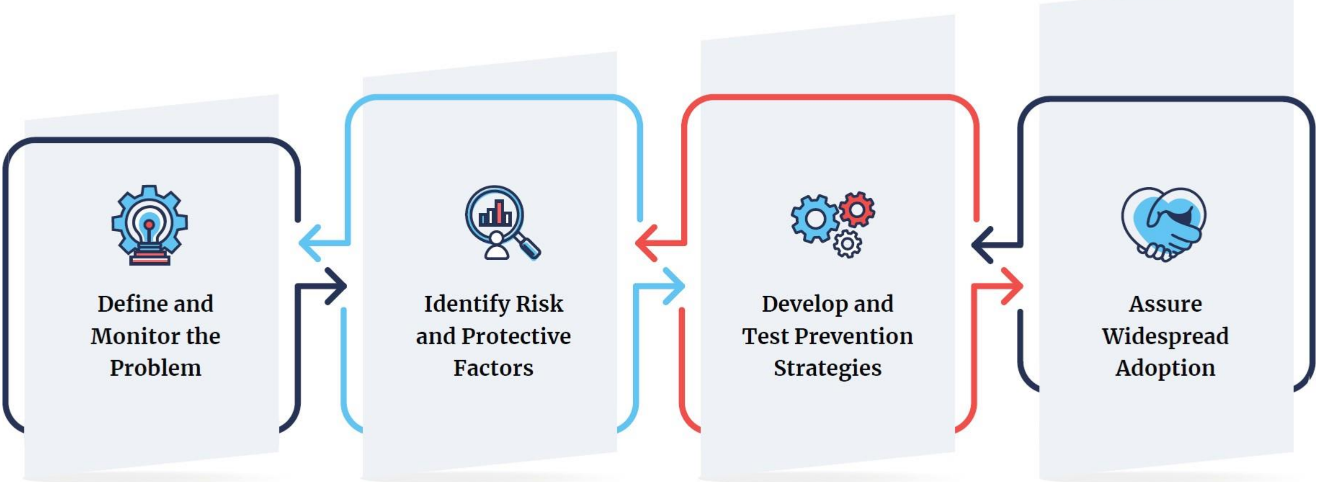
PUBLIC HEALTH MODEL

The NDCFRP utilizes the public health model to child maltreatment fatality prevention and relies on the knowledge and collaboration of each of its Panel members from a range of disciplines including child protection services, medical, emergency services, law enforcement, forensic pathology, epidemiology, courts, mental and behavioral health, education, juvenile justice, policy and law, public health, tribes and the lay community to define and develop prevention strategies with a focus on improving the health, safety and well-being of children and their caregivers across the state. Stakeholders and partners in prevention are consistent in their belief that child maltreatment is a public health matter and takes continuous collaboration from all systems, working together at the same time.

Through careful review of child deaths, Panel members identify patterns, trends, and prevention opportunities; the reviews make a difference. The Panel acknowledges that the circumstances involved in most child deaths are too complex and multidisciplinary for responsibility or prevention to rest with any single agency. It is only through knowledge and statewide community and professional collaboration efforts addressing the health, safety and protective factors of our children and families that we can hope to protect the health and safety of our children.

The public health approach is a systematic, scientific four-step process, with each step informing the next with an emphasis on multidisciplinary collaboration (National Center for Injury Prevention and Control, 2022).

The Four Step Public Health Model to Child Fatality Prevention



Step 1. Define and Monitor the Problem

In step one, the problem is identified through collecting child fatality case level data on the "who", "what", "when", "where" and "how". The NDCFRP gathers and reviews records and reports from a variety of sources including but not limited to death certificates, birth records, medical records, law enforcement reports, child protection services records, coroner and pathology reports, education records, mental and behavioral health, and juvenile justice records. NDCFRP access to these records is enabled by NDCC 50-25.1-04.4.

In 2019, statistical child maltreatment fatality data, specifically those with an identified substantiated fatal maltreatment finding from child protection services, from calendar years 2008-2018 was compiled and a power point presentation was developed highlighting the demographics, cause of death, identified risk and protective factors, and potential prevention recommendations and actions.

The goal of the power point presentation was to define and highlight the identified problem of child maltreatment fatalities for stakeholders, to gain their insight on risk and protective factors contributing to these children's deaths, to assess system challenges, to identify opportunities and determine action steps for child maltreatment fatality prevention to bring about a shared accountability for the health, safety, and well-being of North Dakota's children.

In 2020, the presentation was provided to various stakeholders across the state, through in person meetings and virtual webinars. Following each session, a survey was conducted with the participants to solicit feedback regarding their role in child abuse and neglect fatality prevention and to identify prevention action steps.

What can you do?

We must gather the knowledge, skills, and resources of all public and private agencies and communities; we each play a role, we need shared accountability and system wide collaboration to end child abuse and neglect deaths.

PARTNER ACKNOWLEDGEMENTS

The following stakeholders were represented, received the statistical power point defining the "who", "what", "where", "when" and "how" of child abuse and neglect fatalities in North Dakota, completed the participant survey and are acknowledged as partners in the strategic development of North Dakota's statewide plan to prevent child maltreatment fatalities:

City and County Law Enforcement
Parent Education Resource Centers
Public Housing
State's Attorney Offices
ND Attorney General's Office / US Attorney's Office
American Academy of Pediatrics ND Chapter
ND Department of Public Instruction
ND DHHS Behavioral Health Division
Domestic Violence Advocates and Shelter Staff
Community Action
Public Health
ND Medical Examiner's Office
Coroners
ND Hospital Association
Alliance for Children's Justice
Children's Advocacy Centers
Juvenile and District Court
Head Start
Human Service Zones (Child Welfare Supervisors and Field Staff)
Youthworks
Homeless Coordinator / Shelter
ND Home Visiting Coalition / Healthy Families
ACE Trainers
Mental Health Providers (including both the public and private sector)
ND Bar Association
Child Support
Foster Parents
Parents with Lived Experience
Maternal Child Health State Advisory Group
ND County / Human Service Zone Directors
ND Court Improvement Project
Family Voices
Child Care Aware
ND Injury Prevention Coalition
Bright and Early Program
Authentic Voices (Survivors of Child Maltreatment)

Step 2. Identify Risk and Protective Factors

In step two, the question "why" is asked to help better understand what factors put children at greater risk for maltreatment death and what factors protect children from fatal child abuse and neglect. The development of child fatality prevention strategies are then developed by decreasing the identified risk factors and increasing the factors that protect children from abuse and neglect.

- Risk Factor – Circumstance or characteristic that increases the likelihood of child maltreatment fatality.
- Protective Factor – Circumstance or characteristic that decreases the likelihood of a child maltreatment fatality.

Step 3. Develop and Test Prevention Strategies

In step three, prevention strategies are developed, tested, and evaluated to assess and determine if they are effective in reducing child fatality. High level NDCFRP recommendations for child maltreatment fatality prevention, specific to child abuse and neglect deaths, were provided to stakeholders and participants were surveyed to acquire feedback on their perceived effectiveness of the proposed recommendations. Furthermore, the survey asked participants to provide additional strategies for the prevention of child abuse and neglect fatalities, opportunities for agency collaborations and to identify community resources and agencies to assist in action steps for the statewide fatality prevention plan. The CFRP recommendations and the survey responses were compiled to form the strategies for this plan.

Step 4. Assure Widespread Adoption

In step four, the strategies shown to be effective in step three are broadened and expanded to a greater area. Additional training and technical assistance are provided to service providers to assure the prevention effort is being implemented as intended. The prevention strategies are monitored and evaluated for effectiveness by looping back to steps one and two in the process, by again examining the statistical data and risk / protective factors and asking:

Did the strategy do what it was intended to do?
Does this strategy reach the people who need it?

DEMOGRAPHICS & DATA

DATA SOURCES

The sources of information used to compile the following data is that from the National Child Abuse and Neglect Data System (NCANDS) and the North Dakota Child Fatality Review Panel (NDCFRP). The state child welfare data management system reports to NCANDS those children who have died from confirmed 'Fatal Abuse' or 'Fatal Neglect'. The individual who abused or neglected the child must be a 'person responsible for the child's welfare' as identified in statute. The state child welfare data management system does not include tribal child welfare data as each tribe maintains a separate database that does not share information with the state's child welfare data management system.

The NDCFRP receives all North Dakota issued death certificates of children (under age 18 years) and includes children in tribal and military jurisdictions. Each death certificate received from the Department of Health and Human Services Vital Records is reviewed and categorized as a Status A case or a Status B case.

Status A cases are all cases of children whose death is sudden, unexpected, and/or unexplained, including those deaths with a manner of 'Natural'. Additionally, all children with an open Child Protection Services assessment or prior involvement with child welfare, and those children in the custody of the Human Service Zone (formerly County Social Services) or the Division of Juvenile Services at the time of their death are also included as Status A.

Status A cases receive an in-depth, comprehensive review, identifying:

- The cause of child's death,
- The circumstances that contributed to the death (risk factors) including circumstances of maltreatment that contributed to the death,
- Preventability of the death; and
- Recommendations to changes in policy, practice, and law to prevent future child deaths.

A 'preventable death' is a death related to risk factors which could have reasonably been avoided.

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 do not receive an in-depth review by the Panel and are not included in this data.

OUT-OF-STATE 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 and are not reviewed by the NDCFRP. When the 'death causing' event/injury occurs in the state however the death certificate is issued out-of-state, the death is reviewed and categorized as a Status A case or Status B case. These children are identified by the Department of Health and Human Services Vital Records and the Panel members, including Child Protection Services and the Medical Examiner's office; the forensic pathologists completing the children's autopsies are Panel members and are in a position to identify those children who may not have come to the attention of Child Protection Services. This allows the Panel to track all ND child deaths.

Every child's death is a tragic loss for the family and community, especially tragic is the child death that could have been prevented.

DATA, CY 2008-2020

The child maltreatment fatality data used for the compilation of this prevention plan includes child deaths occurring in calendar years 2008-2020 and identified by the NDCFRP as preventable deaths with either:

- A confirmed fatal maltreatment determination; or
- An identified circumstance of maltreatment as a contributing factor of the child's death

The statistical details for each of the sub-categories have been separated to allow for a more thorough examination and understanding of the similarities and differences between those children identified by child protection services as having died by abuse and/or neglect and those children without child welfare involvement and/or a confirmed finding for abuse and/or neglect. The confirmed maltreatment statistics are taken from deaths occurring in calendar years 2008-2020, allowing a greater sample size of these death types. Whereas the maltreatment as contributing factor death statistics were taken from NDCFRP reviews of child deaths occurring in calendar years 2016-2020, noting 2016 is when ND began taking a closer look at preventable deaths with a contributing factor of maltreatment.

CONFIRMED FATAL MALTREATMENT

There were forty-six (46) children who died as a result of confirmed child abuse and/or neglect in the twelve-year time period (CY 2008-2020). Of particular note, there were no child maltreatment fatalities in 2016 and over half (54%) of the 46 identified maltreatment deaths occurred in the most recently reported three years, 2018-2020 (Table 1).

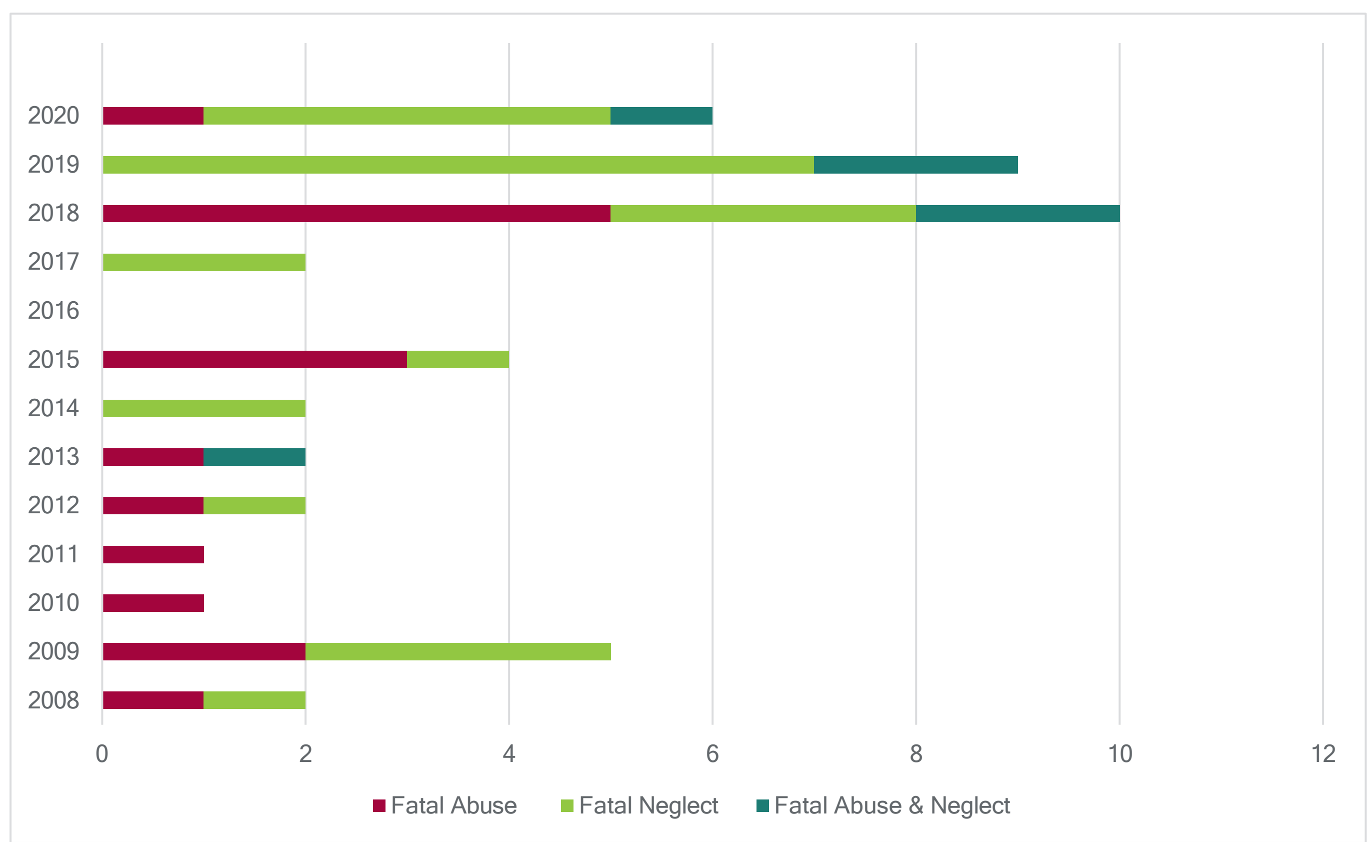


Table 1. Confirmed Fatal Abuse and Neglect, CY 2008-2020

FATAL MALTREATMENT: MANNER AND CAUSE OF DEATH

The manner and cause of death are two required death determinations documented on a death certificate. The manner of death refers to the classification of death based upon the circumstances surrounding the death.

There are five manner of death classifications defined by the National Association of Medical Examiners (National Association of Medical Examiners, 2002):

- Natural: "A death due solely or nearly totally to disease and/or the aging process"
- Accident: "An injury or poisoning causes death and there is little or no evidence that the injury or the poisoning occurred with intent to harm or cause death. In essence, the fatal outcome was unintentional."
- Suicide: "An injury or poisoning as a result of an intentional, self-inflicted act committed to do self-harm or cause the death of one's self"
- Homicide: "A volitional act committed by another person to cause fear, harm, or death. Intent to cause death is a common element but it is not required for classification as homicide. It is to be emphasized that the classification of Homicide for the purposes of death certification is a 'neutral' term and neither indicates nor implies criminal intent, which remains a determination within the province of legal processes."
- Undetermined: "Information pointing to one manner of death is no more compelling than one or more other compelling manners of death in thorough consideration of all available information"

"In general, when death involves a combination of natural processes and external factors such as injury or poisoning, preference is given to the non-natural manner of death."

The classified manner of death for the forty-six (46) identified child maltreatment fatalities in 2008-2020 was most often Homicide (48%) followed by Undetermined (32%) and Accident (20%) (Table 2).

Table 2. Fatal Maltreatment Manner of Death, CY 2008-2020

HOW ARE CHILDREN DYING?

The immediate or direct cause of death is defined as the actual disease, condition, abnormality, injury / poisoning, or complication that directly results in the death.

The leading cause of death for children with an identified fatal maltreatment is unsafe infant sleep (28%) followed by abusive head trauma (26%) and gunshot wounds (13%) (Table 3).

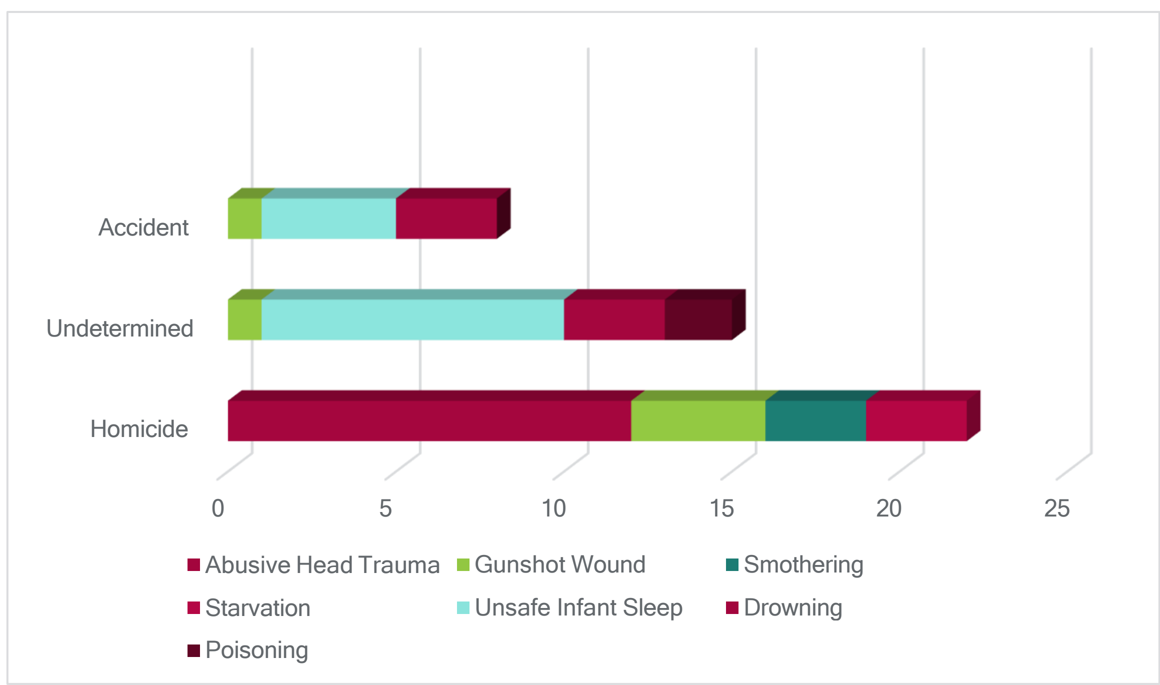


Table 3. Fatal Maltreatment Cause of Death, CY 2008-2020

The immediate cause of death for homicide (intentional acts) was most often abusive head trauma (54%), followed by gunshot wounds (18%), asphyxia / smothering (14%) and malnutrition / starvation (14%).

Although homicide was the most common manner of death in maltreatment death, the unintentional acts of infant sleep related deaths were the leading causes of classified accidental and undetermined confirmed maltreatment deaths.

Accidental suffocation / asphyxia related to unsafe sleep environments for infants was the leading cause of unintentional fatal maltreatment injury deaths for children (44%). Drowning, with a contributing factor of neglect, was the cause in 33% of the accidental deaths where neglect was confirmed.

The majority of the fatal maltreatment deaths with a classified manner of undetermined had a cause of death related to hazards present in the infant's sleep environment (60%).

DEATH CLASSIFICATION OF SUDDEN UNEXPECTED INFANT DEATH

In 2017 and 2019, a group of experts in their field, (which included Dr MaryAnn Sens, a forensic pathologist, and North Dakota Child Fatality Review Panel member) came together to find common ground for classifying sudden infant deaths. The group, the National Association of Medical Examiners (NAME) Panel on Sudden Unexpected Death in Pediatrics, made a recommendation that death certifiers discontinue the use of the term "sudden infant death syndrome" (SIDS) and use the term "unexplained sudden death" specifying whether intrinsic and extrinsic risk factors were identified as contributing factors to the death; the manner of death in these situations is then classified as 'Undetermined' (Goldstein, 2019).

The terminology used to classify infant deaths in the sleep environment has changed from 2008-2020. The term "sudden infant death syndrome" (SIDS) is no longer appearing on North Dakota death certificates. When the death scene investigation, medical records, and autopsy findings do not provide adequate details to determine the death was the result of the infant's sleep environment, North Dakota medical examiners are using the term "Sudden Unexpected or Unexplained Infant Death" (SUID) and then identifying if there were intrinsic and/or extrinsic factors that potentially contributed to the death (Carrie K. Shapiro-Mendoza, et al., 2021).

- Intrinsic Factors: Natural conditions or risk factors associated with abnormal physiology or anatomy that are concerning as contributors to death but are insufficient as a cause (for example: low birth weight, prematurity, small for gestational age, concurrent non-lethal illness, history of febrile seizures), or natural conditions of unknown significance (for example: cardiac channelopathy or seizure gene variants of unknown significance)."

- Extrinsic Factors: Conditions in the child's immediate environment that are a potential threat to life but cannot be deemed the cause of death with reasonable certainty (for example: side or prone sleep if unable to roll to supine, over-bundling without documented hyperthermia, objects in immediate sleep environment, sleep environment not specifically designed for infant sleep, soft or excessive bedding, and sleep surface sharing), injuries or toxicologic findings that are either non-lethal or of unknown lethality, or circumstances or findings otherwise concerning for unnatural death.

FATAL MALTREATMENT: CHILD DEMOGRAPHICS

CHILD AGE

According to the US Census (2020) 24% of the population in North Dakota is under the age of 18 years, with only 6.6% of these children under age 5 years. Between 2010-2021, there was a 21% increase in the population group ages 5 years to 19 years (United States Census Bureau, 2021).

However, infants, children under one year, accounted for 70% of all the child maltreatment fatalities and were the largest population of maltreatment victims for Homicide, Accident and Undetermined manners of death. Of note, 93% of the children with an Undetermined manner of death were under one year of age (Table 4).

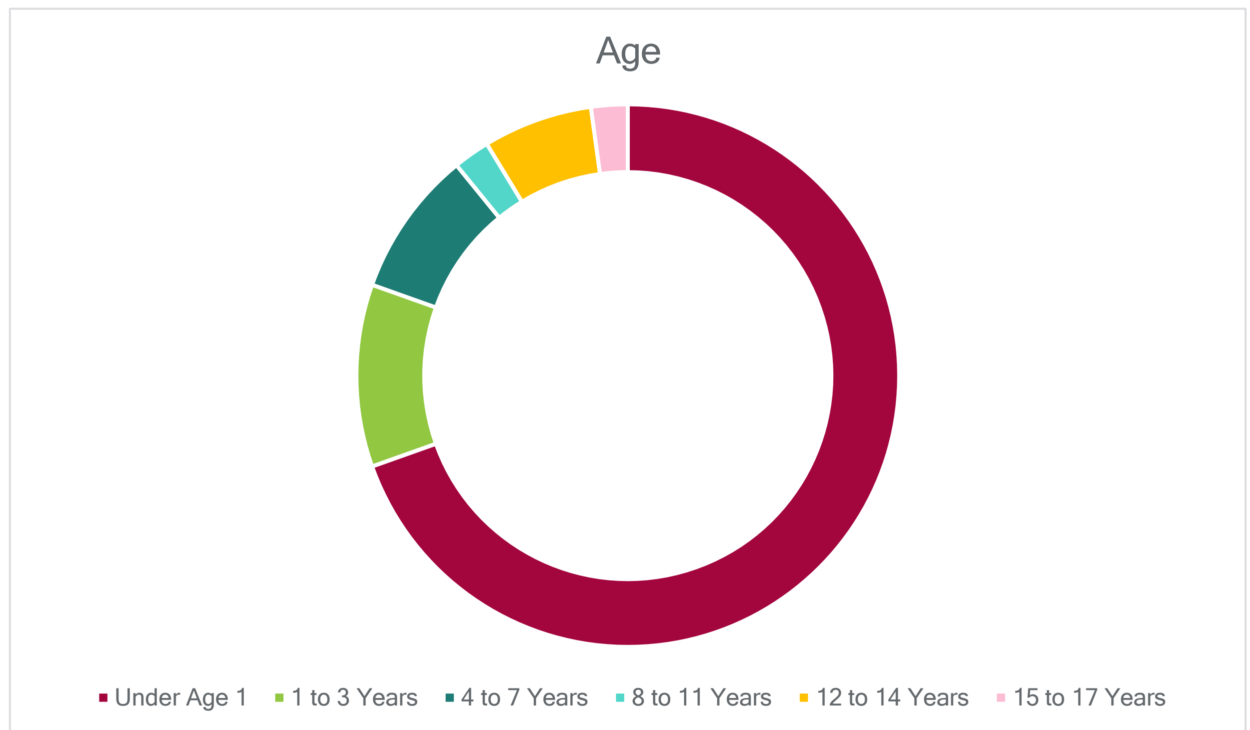


Table 4. Fatal Maltreatment by Child Age, CY 2008-2020

Young children are the most vulnerable for many reasons including their dependency, small size, and inability to defend themselves. Table 5 provides a closer look at the age of the infants that died from fatal maltreatment; over 50% of those infants were under four months of age.

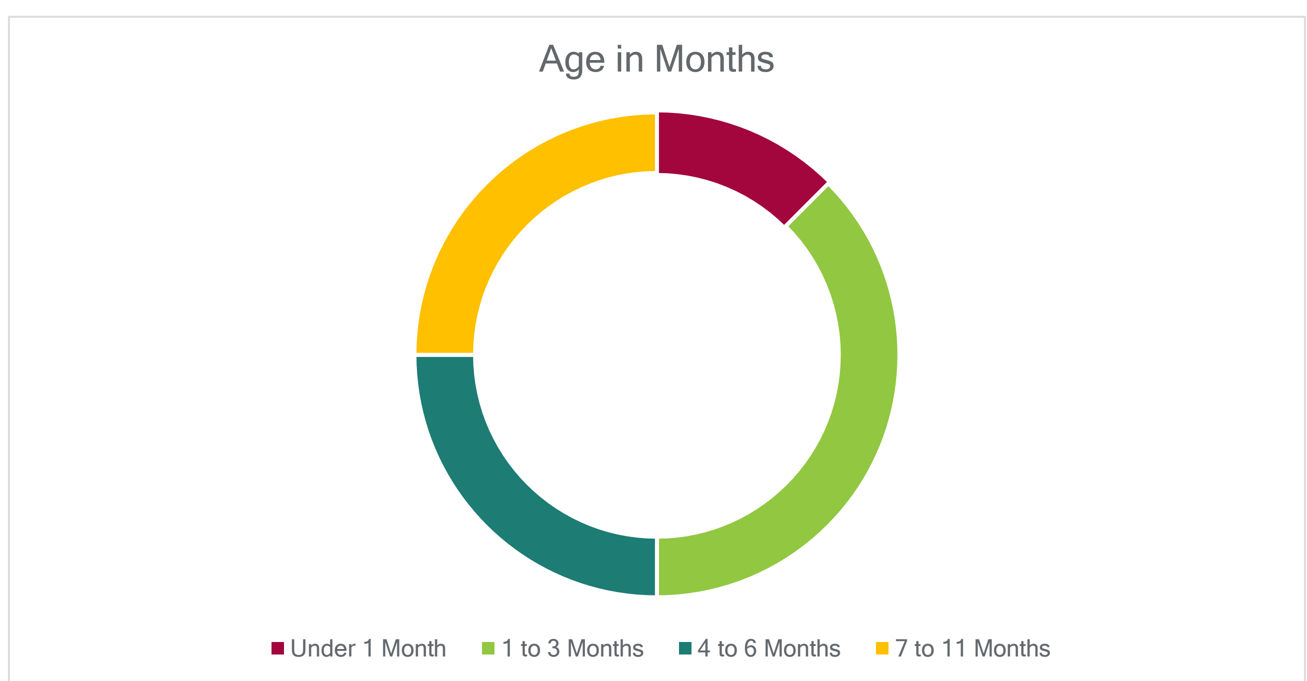


Table 5. Fatal Maltreatment Involving Infants, CY 2008-2020

CHILD GENDER

Male children are more likely to die from fatal maltreatment in North Dakota, 57% of the children that died from fatal child abuse and/or neglect were male (Table 6). According to the CDC, 48% of the population in North Dakota is female (Centers for Disease Control and Prevention, 2019).

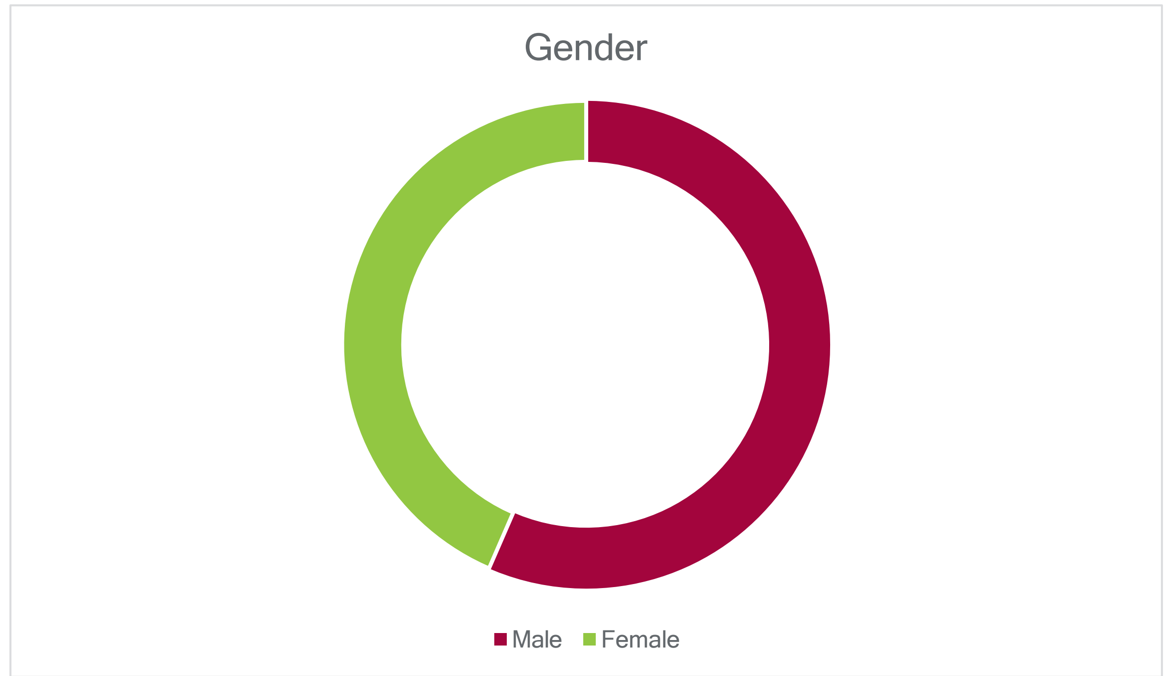


Table 6. Fatal Maltreatment by Gender, CY 2008-2020

CHILD RACE

According to the CDC, in 2016, about one in ten (9.68%) children in North Dakota were American Indian, however 28% of the child abuse and neglect fatalities were American Indian children, an over representation of this population (Table 7).

Additionally, 3.5% of the population in North Dakota is African American, however, 7% of the child maltreatment deaths were children with a race of African American (Centers for Disease Control and Prevention, 2019).

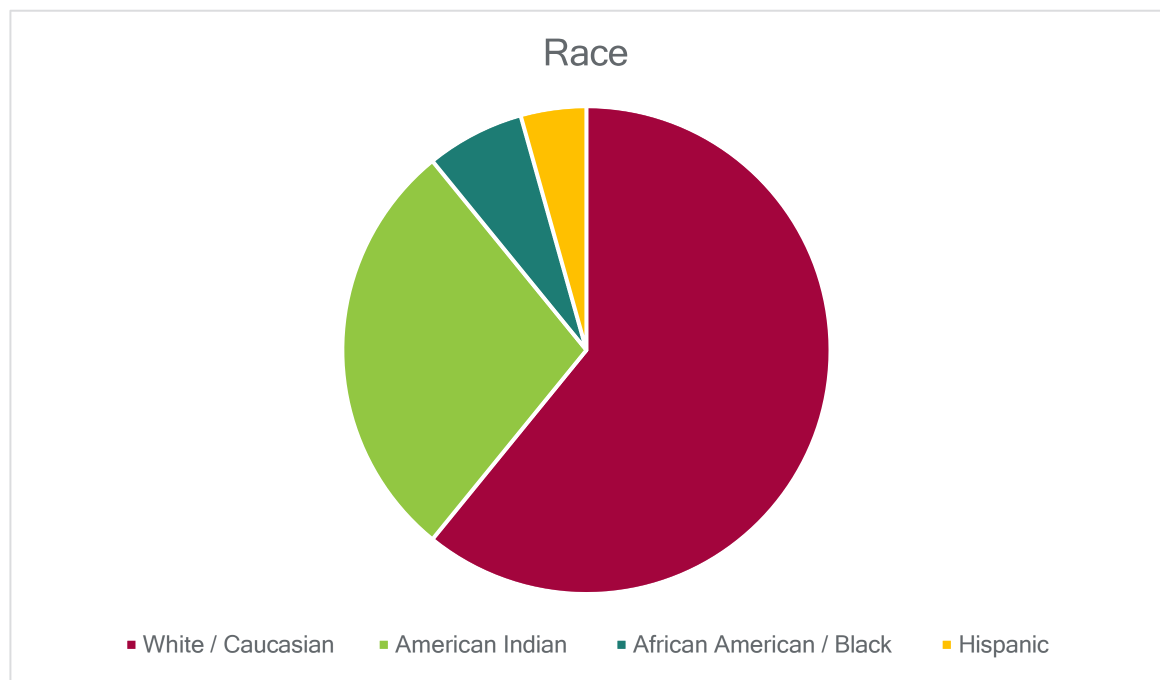
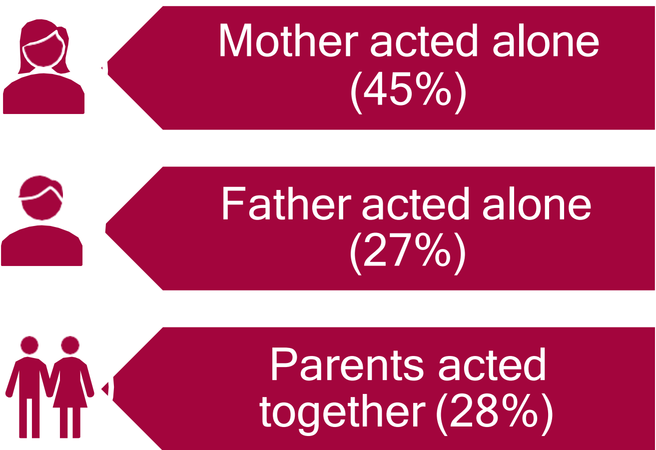


Table 7. Fatal Maltreatment by Race, CY 2008-2020

PERPETRATORS OF FATAL MALTREATMENT

In order for a determination of fatal child abuse and/or neglect by child protection services, the perpetrator, or individual that willfully or recklessly acts or fails to act, of fatal maltreatment must be a person responsible for the child's welfare. The parents of the child victims were the perpetrators in 83% of fatal maltreatment deaths. Most often the mother acted alone.



When the perpetrator was not a parent of the child (17%), the caregiver was most often a significant other of the parent (50%) or a child care provider (38%). When the caregiver was a significant other of the parent, they were most often male (75%). When the child care provider was the perpetrator of fatal maltreatment, the child care was unlicensed in every instance.

CIRCUMSTANCE OF CONTRIBUTING CHILD MALTREATMENT

There were 239 North Dakota child deaths that occurred in calendar years 2016-2020 that were categorized as Status A and received an in-depth review by the NDCFRP. Of these 108 deaths (45%) were identified as preventable deaths with a circumstance of contributing child abuse and/or neglect.

The NDCFRP had been using a state level Access database for the review of child deaths prior to 2020 when it adopted the utilization of the National Child Fatality Death Review Case Reporting System. Since 2019, there has been an increase in the identification of preventable deaths, exposure to hazards and the presence of a contributing maltreatment factors (Table 8). This increase is likely due in part to a greater understanding and recognition as a result of the new review tool and database (National Center for Fatality Review and Prevention, 2022).

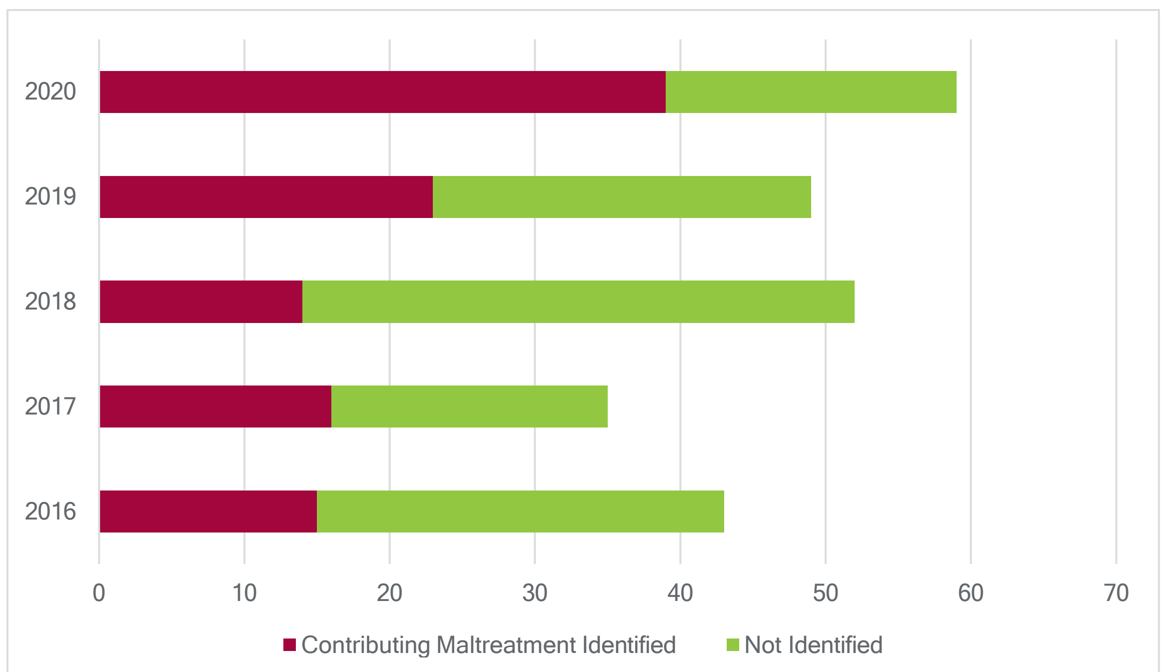


Table 8. Circumstance of Contributing Maltreatment Deaths, CY 2016-2020

CIRCUMSTANCE OF CONTRIBUTING MALTREATMENT: MANNER AND CAUSE OF DEATH

When preventable deaths in which child abuse, neglect, poor supervision and/or exposure to hazards contributed to the child's death, the circumstance most commonly identified by the NDCFRP was a hazard in the infant's sleep environment (42%), followed by firearm hazard (19%), motor vehicle hazards (19%), fire hazards (5%), water hazards / drowning (3%) and abusive head trauma (3%). Neglect, specifically, inadequate supervision, was noted in over 70% of the deaths identified with a contributing maltreatment factor and most commonly identified in accidental deaths of young drivers operating all-terrain vehicles and in suicide deaths of children with a mental health diagnosis. Table 9 provides a greater look at the cause and manner of death when a contributing factor of child maltreatment has been identified.

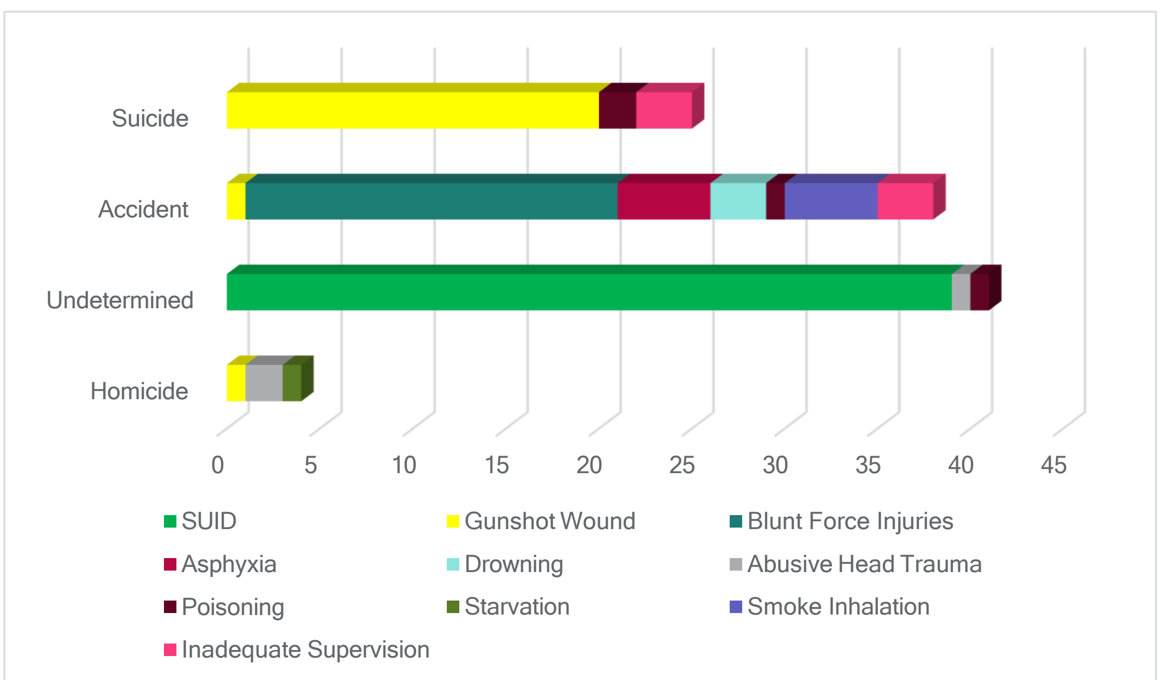


Table 9. Contributing Maltreatment Manner and Cause of Death, CY 2016-2020

Deaths involving hazards in the infant's sleep environment accounted for most of the deaths with a manner of 'undetermined' (93%); these deaths were classified as Sudden Unexpected Infant Death (SUID) with extrinsic and/or intrinsic factors, as well as additional deaths classified as 'accidental' with a cause of death of positional asphyxia.

CIRCUMSTANCE OF CONTRIBUTING CHILD MALTREATMENT: DEMOGRAPHICS

CHILD AGE

Infants, children under one year, were the most prevalent (46%) age group of child fatalities with an identified maltreatment factor (Table 10), consistent with data findings related to the most commonly identified maltreatment related cause and manner of death, unsafe infant sleep. When suicide was the manner of death and there was a contributing maltreatment factor, such as unsecured firearms, medications, and lack of supervision; the child's age was predominately 12-17 years old (28%). When the child's cause of death was blunt force injuries as a result of a motor-vehicle-collision, the operator of the vehicle was most often the child and the child's age most commonly was 9-12 years old. All but one of the five smoke inhalation deaths were in the age category of 4-7 years (80%).

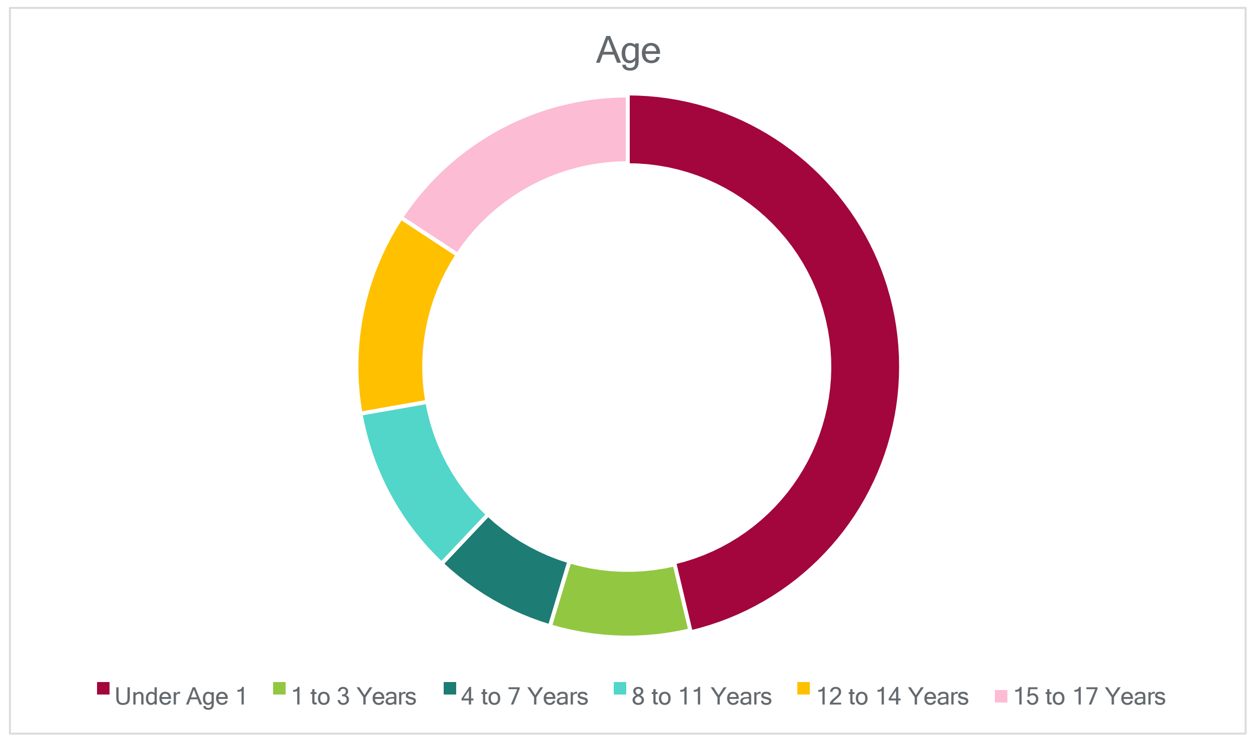


Table 10. Contributing Maltreatment Death by Child Age, CY 2016-2020

GENDER

Male children as compared to female children, were more often identified as having a circumstance of contributing maltreatment (66%) (Table 11). Males were more likely to die by unsafe infant sleep, motor vehicle collisions, drowning, and suicide.

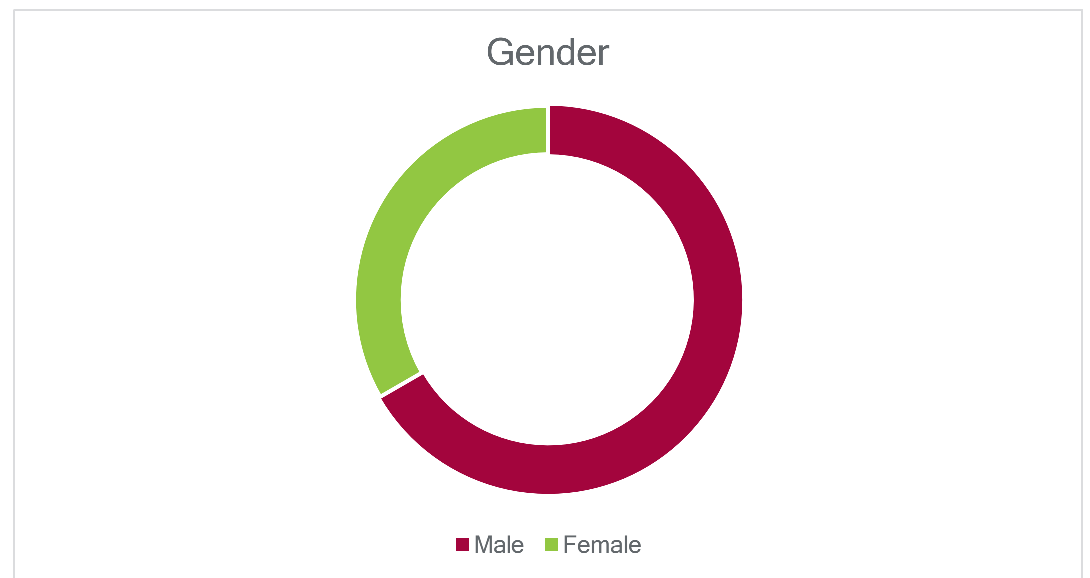


Table 11. Contributing Maltreatment Death by Child Gender, CY 2016-2020

RACE

The child demographics related to race did not vary from those children in which confirmed abuse and/or neglect caused the child's death as compared to those children where maltreatment contributed to the cause of the child's death. As shown in Table 12, Contributing Maltreatment Child Race, American Indian children accounted for 29% and African American children accounted for 6% of child deaths with an identified child maltreatment factor.

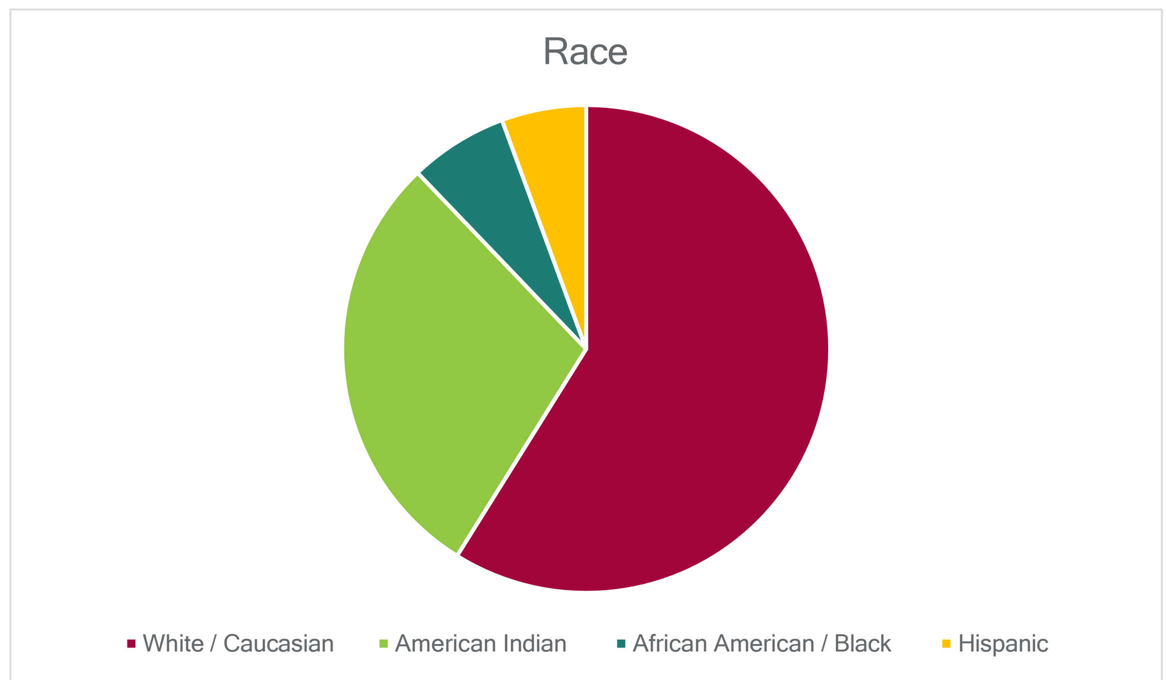


Table 12. Contributing Maltreatment Death by Child Race, CY 2016-2020

GEOGRAPHY

More child maltreatment deaths occur in the western part of the state (55%) as compared to the eastern side of the state (30%), even though, the largest populated county/city (Cass/Fargo) is situated on the eastern part of the state. Children residing in rural communities, accounted for 49% of state's child maltreatment deaths which was higher than in urban cities (36%) (Centers for Disease Control and Prevention, 2019). Children residing within the jurisdiction of the state's tribal lands, made up 15% of the identified child maltreatment deaths. Figures 1 and 2 provide a statewide look at the geography and rate of firearm and SUID deaths per 10,000 children under 18 in population.

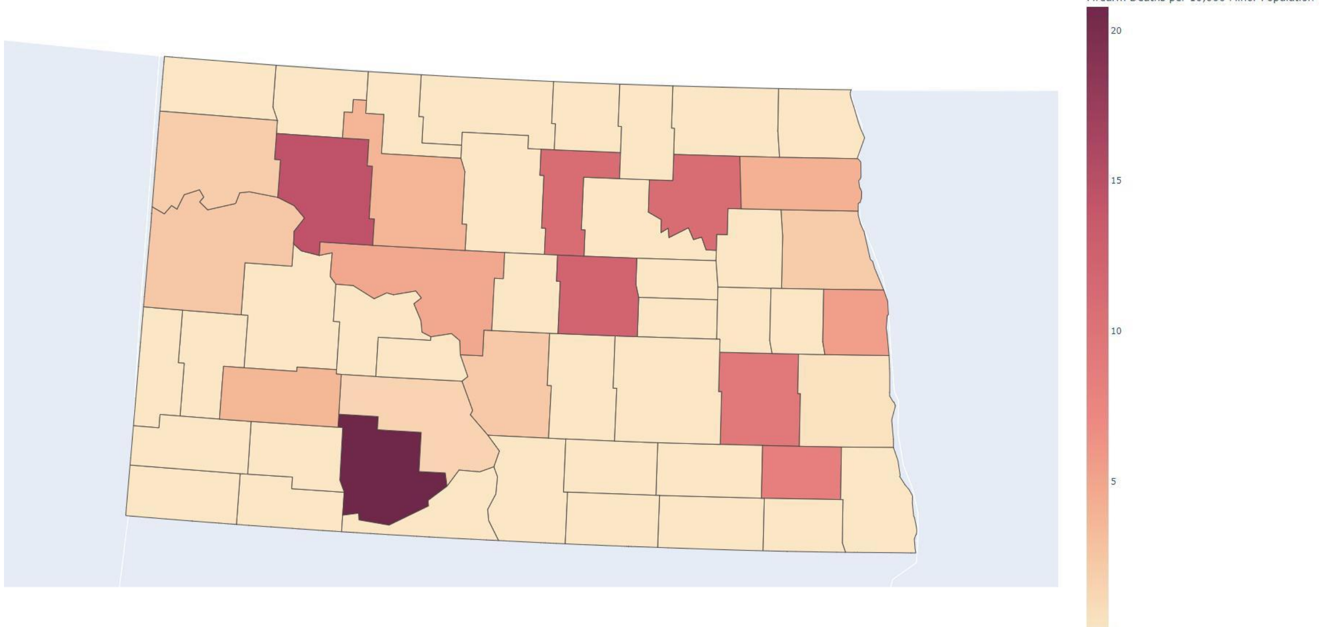


Figure 1. Ten Year Firearm Deaths Per 10,000 Children Under 18 in Population, CY 2009-2019

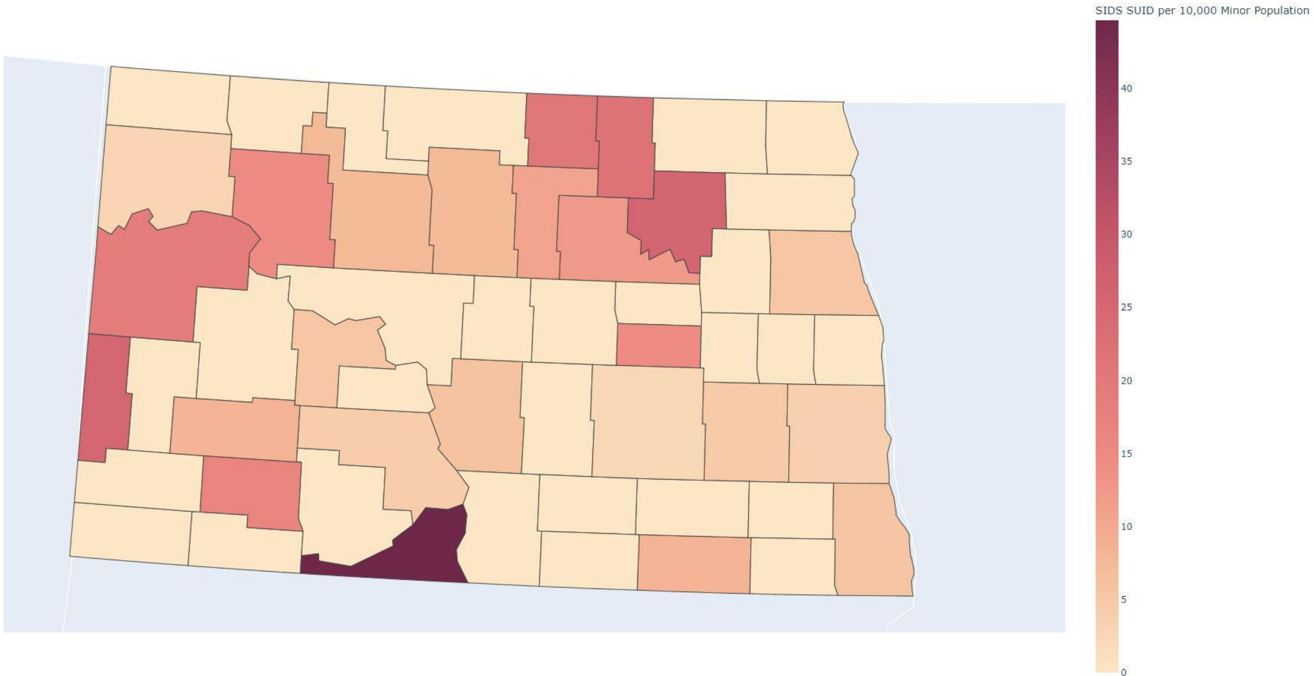


Figure 2. Ten Year SIDS / SUID Deaths Per 10,000 Children Under 18 in Population, CY 2009-2019

CHILD PROTECTION SERVICES HISTORY

The history of a report of suspected child abuse and neglect, regardless of the child protection services assessment finding, was the strongest identified predictor of a child's potential risk for abuse and/or neglect related death. There was a history of child protection involvement in 54% of the child maltreatment fatalities between 2008-2020. This was also an identified factor in 56% of the Status A child deaths with a contributing maltreatment factor, were children and/or caregivers known to the child protection services program.

When child protection services had previously completed an assessment, the suspected and/or determined maltreatment was most often related to neglect, specifically inadequate supervision, prenatal substance exposure, and domestic violence in the presence of the child.

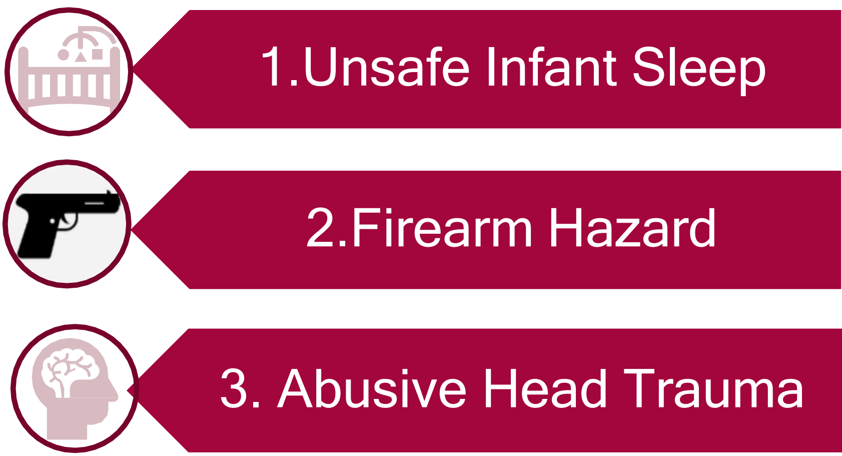
The manner and cause of death most identified when there was a history of child protection services involvement was unsafe infant sleep (25%), suicides with a firearm hazard (19%), motor-vehicle collisions in which the driver did not have a driver's license (14%) and fire hazards, lack of smoke alarms and fire extinguishers (6%).

KEY FINDINGS AND PREVENTION STRATEGIES

Step 1. Define and Monitor the Problem

Thorough examination of the child maltreatment death review data indicated the leading cause of death for children with an identified fatal maltreatment was unsafe infant sleep (28%) and this was also the leading cause of death for children where maltreatment was a contributing factor (42%). Hazards present in the infant's sleep environment was followed by deaths resulting from gunshot wounds, in which there was an unsecured firearm, these deaths accounted for 13% of fatal maltreatment deaths and 19% of contributing maltreatment deaths. Abusive head trauma was the third leading cause of maltreatment related fatalities (26% of fatal maltreatment deaths and 3% of contributing maltreatment deaths).

Prevention strategies focusing on these three key areas will likely result in the greatest reduction of fatal child maltreatment.



Step 2. Identify Risk and Protective Factors

What identified factors, circumstances or characteristics place children at greater risk or decrease the likelihood for death resulting from child maltreatment, specifically child death from unsafe infant sleep, gunshot wounds, abusive head trauma and neglectful environments?

Step 3. Develop and Test Prevention Strategies

1 Unsafe Infant Sleep

Unintentional suffocation is the leading cause of injury death among infants less than one-year-old in the US; 82% of these are attributed to accidental suffocation and strangulation in bed. Accidental suffocation or asphyxia in bed is an explained, sudden, and unexpected death in a sleep environment (bed, crib, couch, chair, etc.) in which the infant's nose and mouth are obstructed, or the neck or chest is compressed from soft or loose bedding, or an overlay or wedging caused the infant to asphyxiate. Most often, when an infant dies in their sleep environment, evidence of asphyxia is not present, and the infant's death is classified as undetermined with a cause of Sudden Unexpected Infant Death with intrinsic and/or extrinsic factors. The presence or absence of these factors provide keys to a better understanding of preventing infant death related to sleep environments (The Task Force on Sudden Infant Death Syndrome and the Committee on Fetus and Newborn, 2022).

In North Dakota, the top five risk factors for SUID identified by the Panel are very similar to those identified across the nation, they are: infant placed on an adult bed, bed or sleep surface sharing, otherwise known as co-sleeping with an infant, loose and soft bedding, such as blankets and pillows present in the infant's sleep environment, prenatally exposed to alcohol or substances in addition to smoke in the environment of the infant, and infant placed on their stomach or side for sleep.

RISK FACTORS OF SUDDEN UNEXPECTED INFANT DEATH

1. Birth weight of the infant; those born prematurely or at a low birth weight; infants under age four months were the most susceptible.
2. Respiratory colds which may contribute to breathing problems.
3. Sleeping on their stomach or side; babies who sleep on their stomach have longer periods of deep sleep, are less reactive to noise, experience less movement and experience sudden decreases in blood pressure and heart rate control.
4. Sharing a bed; sleeping on the same surface as another adult, child, or animal
5. Sleeping on a soft surface and/or loose bedding; soft / foam mattresses, comforters, blankets, pillows, and cushions can block an infant's airway.
6. Smoke exposure, both smoking by pregnant women and smoke in the infant's environment are risk factors for SUID. This risk increases when the infant shares a bed with an adult smoker, even if the adult does not smoke in the bed (National Center for Fatality Review and Prevention, 2022).

7. Swaddling / Overheating; infants that are swaddled may roll over and become trapped, blocking their airway and being too warm while sleeping also increases the risk of sudden unexpected infant death.
8. Bottle propping can lead to a steady flow of milk even after the baby has stopped sucking, resulting in aspiration and death.
9. Substance abuse by caregivers, the use of alcohol, marijuana, opioids, and other controlled substances during pregnancy increases an infant's vulnerability to sudden infant death. Additionally, when infants are environmentally exposed to controlled substances and/or their caregivers are under the influence of sedating substances they may be unable to recognize the dangers present in the infant's sleep environment or may lack the ability to respond to the infant.
10. Quality of supervision at the time of death, the safest place for a baby to sleep is on a separate sleep surface designed for infants close to the parent's bed. The risk of dying suddenly and unexpectedly is almost three times higher when the infant is not sleeping in the same room as the caregiver (Room Sharing vs Bed Sharing).
11. Family's ability to provide a safe sleep environment for the child. Safe infant sleep environments include cribs, bassinets, portable cribs or play yards that conforms to the safety standards of the Consumer Product Safety Commission (CPSC) and have been set up properly. The use of sitting devices such as car seats, bouncers, swings, and rockers are not safe for infant sleep and increase the risk of sudden infant death. When there is a lack of a safe sleep environment, an alternative device (box or basket) with a firm and flat surface can be used without pillows, blankets, or loose bedding. When families are transient, when an infant's sleeping environment changes often and/or when multiple families are sharing a residence, the risks factors for maltreatment fatalities related to unsafe infant sleep increase.

FIVE RISK FACTORS FOR MALTREATMENT FATALITIES RELATED TO UNSAFE INFANT SLEEP
1
INFANT PLACED ON A ADULT BED
2
BEDSHARING AND CO-SLEEPING
3
SOFT / LOOSE BEDDING (BLANKETS, PILLOWS, FOAM MATTRESS)
4
PRENATALLY EXPOSED TO ALCOHOL OR DRUGS
5
PLACED TO SLEEP ON STOMACH OR SIDE

GOAL 1

Decrease accidental asphyxia-related to hazards in the infant's sleep environment and SUID related to extrinsic factors of sleep environment hazards by 20% from 2020 to 2025

Objective 1:

Increase the percentage by 41.5% in 2020 to 50% in 2025 of American Indian women who responded 'always' to the following question:

- In the past 2 weeks, how often has your new baby slept alone in his or her own crib or bed?

Source: North Dakota PRAMS (North Dakota Department of Health and Human Services, 2023)

Objective 2:

Decrease the percentage of non-Caucasian women who reported their new baby has slept on an adult bed in the past two weeks from 48.5% of American Indian women in 2020 and 45.9% of women of 'Other' races to 60% for both population groups in 2025.

Source: North Dakota PRAMS (North Dakota Department of Health and Human Services, 2023)

Objective 3:

Increase the percentage of women of all races who reported a doctor, nurse, or other health care provider told them to place their baby to sleep in a crib, bassinet, or pack-n-play from 88.9% in 2020 to 95% in 2025.

Source: North Dakota PRAMS (North Dakota Department of Health and Human Services, 2023)

STRATEGIES

- Engage parents with lived experience, (those that have lost their child due to hazards in the sleep environment) and collaborate with the Department of Health and Human Services to create and disseminate public information educational materials, such as videos, social media posts and billboards that highlight the dangers of unsafe infant sleep to the public. Provide statewide data and real-life testimonials about the children that die in unsafe sleep environments and educates and encourages the public to follow the American Academy of Pediatrics recommendations for safe sleep environments which recommends that infants under one year be placed to sleep on their back in a safety approved crib, bassinet, or portable crib with a firm mattress and tight fitting sheet and that infants sleep on a surface that is separate from adults, other children, and animals and that it is free of objects such as blankets, pillows, and toys (The Task Force on Sudden Infant Death Syndrome and the Committee on Fetus and Newborn, 2022). The testimonials for this strategy must include at least one from the American Indian population and at least one father's voice; the key to effective engagement is lived experience (Casey Family Programs, 2023).

- Continued collaboration with medical professionals, public health providers, childcare providers, parenting education programs, child welfare, home visiting programs, midwives, behavioral health, substance use disorder providers and other entities to provide safe infant sleep information and tools for having authentic conversations about safe sleep practices with caregivers of infants. The information should include the dangers of bed, couch, and recliner sharing, particularly when the caregiver may be impacted by exhaustion or sedating substances. In addition, the dangers to infants prenatally or environmentally exposed to alcohol or controlled substances, particularly how it increases their vulnerability to sudden infant death, should also be included in the information.

- Public information on adequate supervision of infants during feeding, including the dangers of bottle propping and adequate supervision during sleep hours should be provided to address infant safe sleep. This includes having the infant in the same room but on a separate sleep surface, use of video monitors, importance of caregiver / infant interaction, and limits on infant's time spent alone in cribs is also important information for the public's awareness.

- Community wide promotion of referring eligible families for the distribution of safe sleep resources, such as "Cribs for Kids," including proper utilization education for caregivers by the distributers of safe sleep resources and the promotion of caregiver preparation ensuring infants have a portable crib when spending the night away from home (North Dakota Department of Health and Human Services Prevention and Healthy Living, 2022).

- Distribution of safe sleep resources and portable cribs by Cribs for Kids to shelters, hotels, and motels statewide (including tribal lands) at no cost.

- Encourage medical providers to inquire and discuss current infant sleep practices during a woman's post-partum medical visit and refer to Cribs for Kids when a portable crib is needed.

- Initial and ongoing training and education for child welfare professionals regarding their role in creating a culture of safe sleep for infants and tools and resources on how to effectively approach this topic with parents and caregivers, specifically when the infant may have increased vulnerability from prenatal substance exposure and/or environmental exposure to controlled substances (Michigan Health and Human Services, 2023).

- Expand home visiting services, such as Healthy Families and the Nurse-Family Partnership Program to tribal areas and those urban areas near tribal lands (North Dakota Department of Human Services, 2020).

- Promote statewide participation in the #ClearTheCrib Challenge utilizing social media to expand its popularity (National Institute of Child Health and Human Development, 2022).

- Promote that all advertising and public information images depict infants in safe environments without the presence of sleep related hazards.

- Universal toxicology testing for pregnant mothers and their baby at birth; when the test is positive for alcohol and/or drugs, prompt referral to substance use treatment services, child development services, home visiting as well as a mandated report of suspected child abuse and neglect.

- Public education on the dangers of infants sleeping in car seats outside of the vehicle and when not attached to the car seat base.

- Automatic referral to child development services for a developmental evaluation of any identified substance exposed newborn; evaluation / assessment is conducted in the infant's home environment with the infant's caregiver.

- Increase access to substance use disorder treatment services for pregnant and post-partum women; increase access to virtual and in-home substance use treatment services.

- Disseminate safe infant sleep education, tools, and safe sleep resources statewide to Parent Resource Centers, high schools with a child development / life sciences course, public health fairs, well-baby clinics, Indian Health Services, and WIC offices.

- Promote the statewide web-based continuing education course for nurses on reducing the risk of sleep related infant deaths.

- Continue to promote the statewide website for childcare providers regarding infant safe sleep practices and require safe sleep training for licensed childcare and foster care providers.

- Place floor and shelf talker infant safe sleep education information such as Always Alone on Back in Crib, Room Sharing = Safe / Bed Sharing = Unsafe, and #CleartheCrib in grocery stores across the state with specific attention to those stores that are on or near tribal lands and the state's largest city, Fargo (North Dakota Department of Health and Human Services Prevention and Healthy Living, 2022).

MONITORING DATA SOURCE

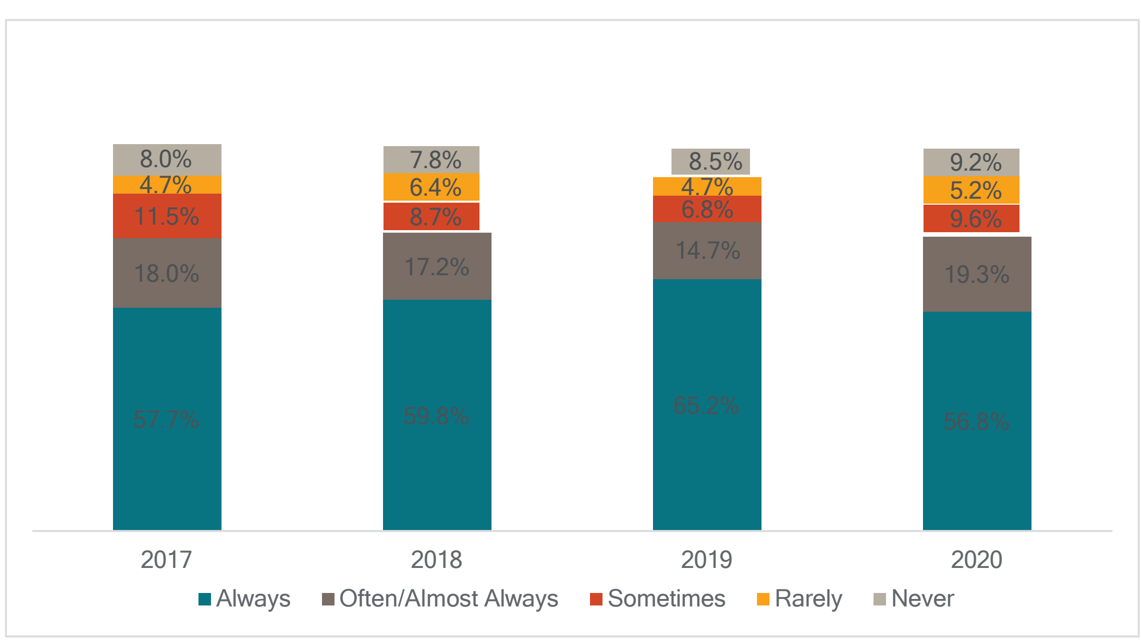
ND Pregnancy Risk Assessment Monitoring System (PRAMS) collects state-specific, population-based data on maternal attitudes and experiences before, during and shortly after pregnancy. This data can be used to identify groups of women and infants at high risk for health problems, monitor changes in health status, and measure progress towards the goals of improving the health of mothers and infants. North Dakota began to collect PRAMS data in 2017. The survey asks mothers the following questions about safe sleep practices:

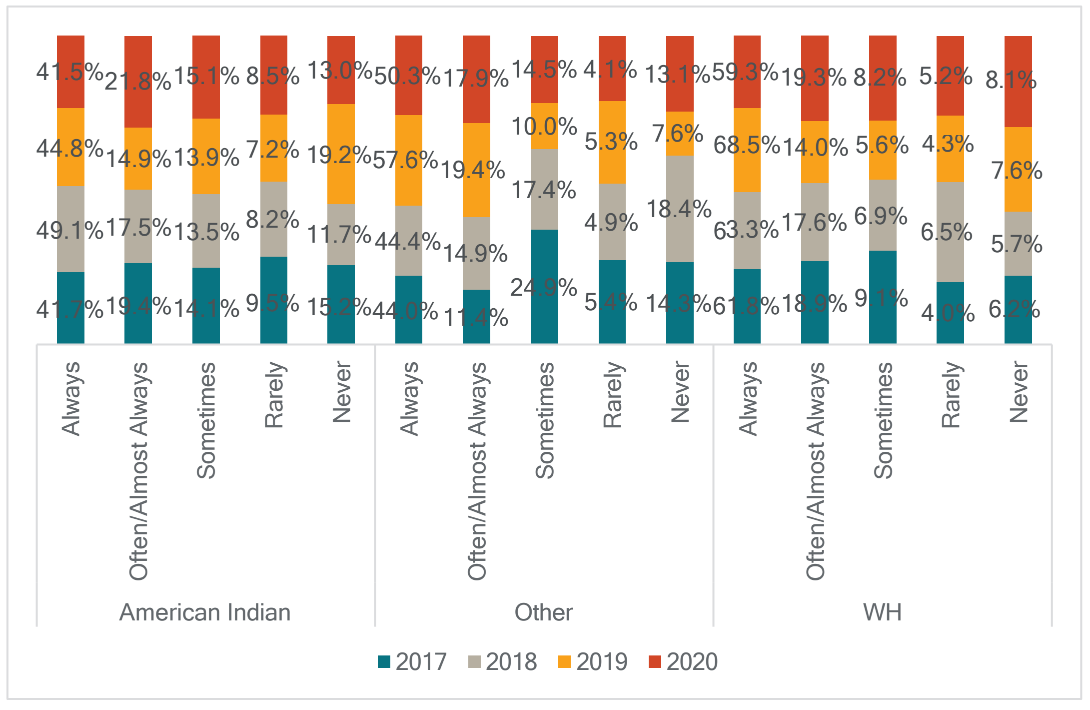
- *In the past 2 weeks, how often has your new baby slept alone in his or her own crib or bed?*
- *In which one position do you most often lay your baby down to sleep now?*
- *When your new baby sleeps alone, is his or her crib or bed in the same room where you sleep?*
- *Listed below are some more things about how babies sleep. How did your new baby usually sleep in the past 2 weeks? For each item, check No if your baby did not usually sleep like this or yes, if he or she did*
    - *On a couch, sofa, or armchair*
    - *In a crib, bassinet, or pack and play*
    - *On a twin or larger mattress or bed*
    - *With a blanket*
    - *With crib bumper pads (mesh or non-mesh)*
    - *In a sleeping sack or wearable blanket*
    - *In an infant car seat or swing*
    - *With toys, cushions, or pillows, including nursing pillows*

- *Did a doctor, nurse, or other health care worker tell you any of the following things? For each thing, check No if they did not tell you or yes if they did.*
    - *Place my baby on his or her back to sleep*
    - *Place my baby to sleep in a crib, bassinet, or pack and play*
    - *Place my baby's crib or bed in my room*
    - *What things should and should not go in bed with my baby*

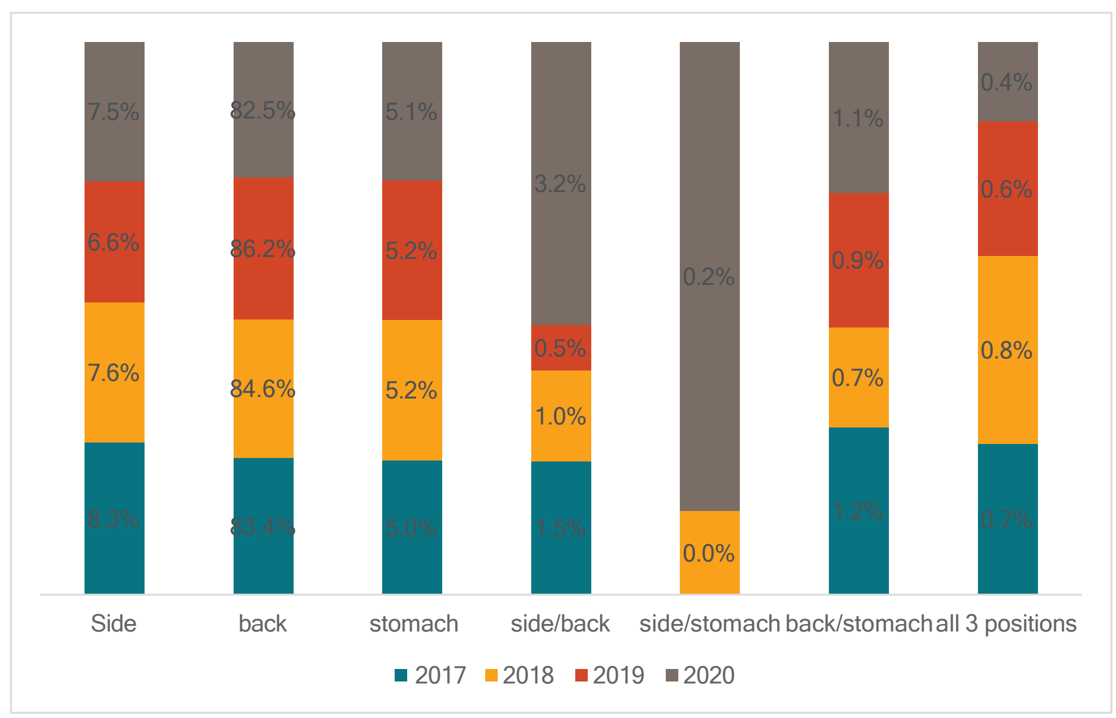
In general, the results of the survey indicated that there are differences in the responses by race of women. There were slight increasing and/or decreasing trends that were observed when comparing 2017-2019 and the 2020 pandemic start year. Detailed results for each question are presented below, questions that have been highlighted are those being monitored for this goal:

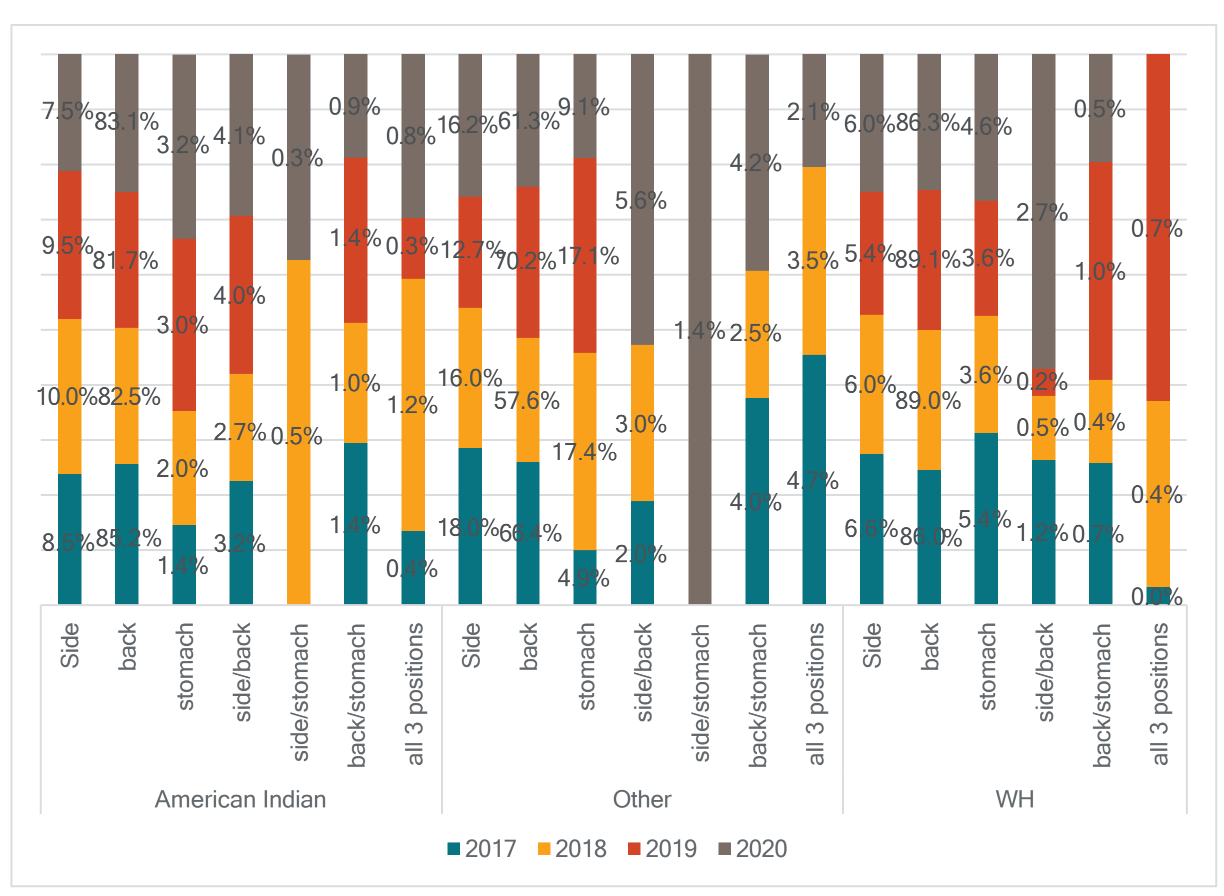
In the past 2 weeks, how often has your new baby slept alone in his or her own crib or bed?



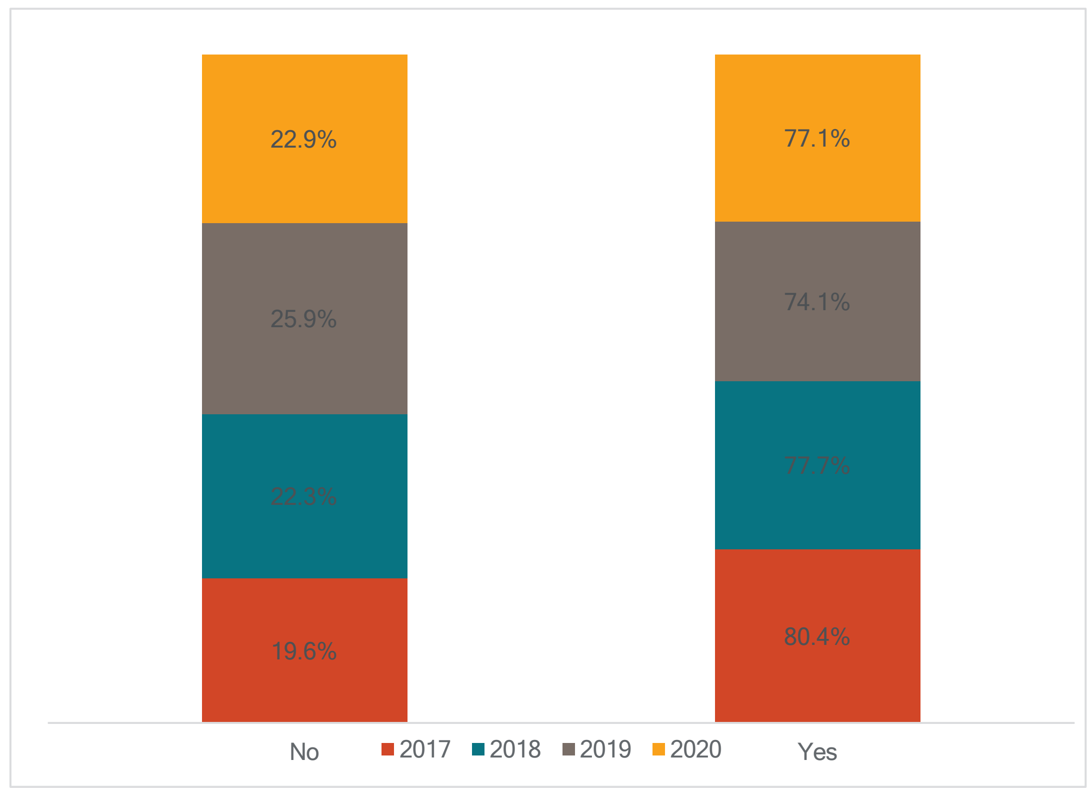


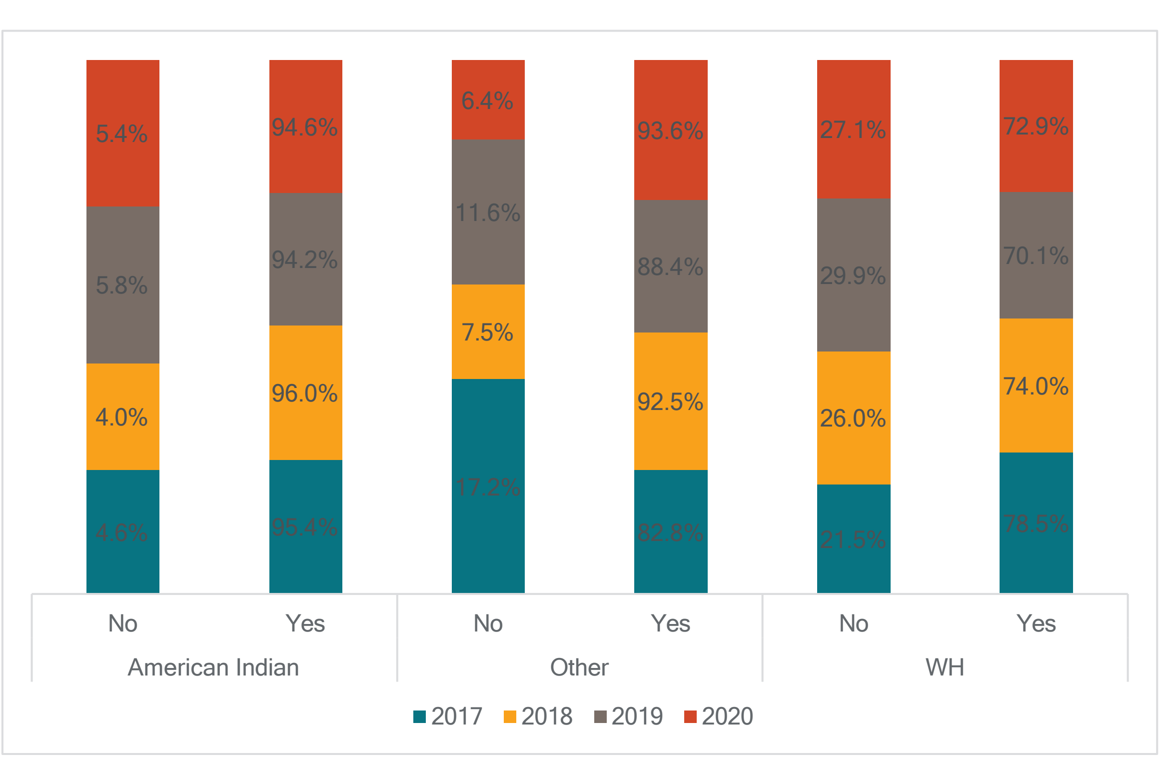
In which one position do you most often lay your baby down to sleep now?



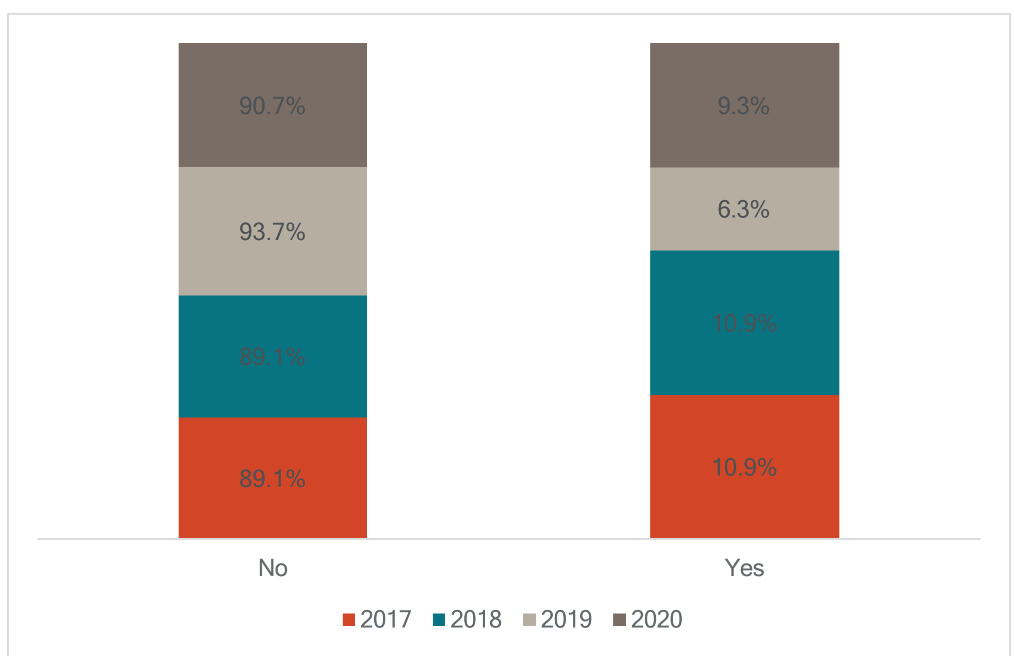


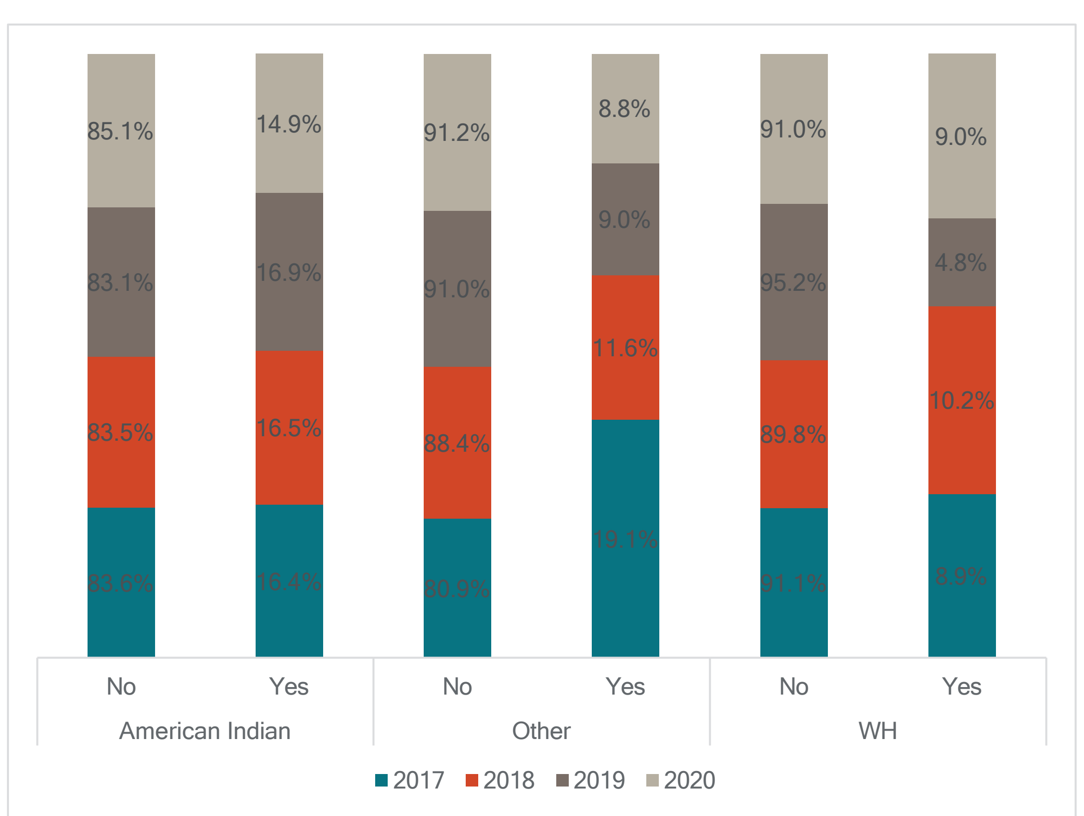
When your new baby sleeps alone, is his or her crib or bed in the same room where you sleep?



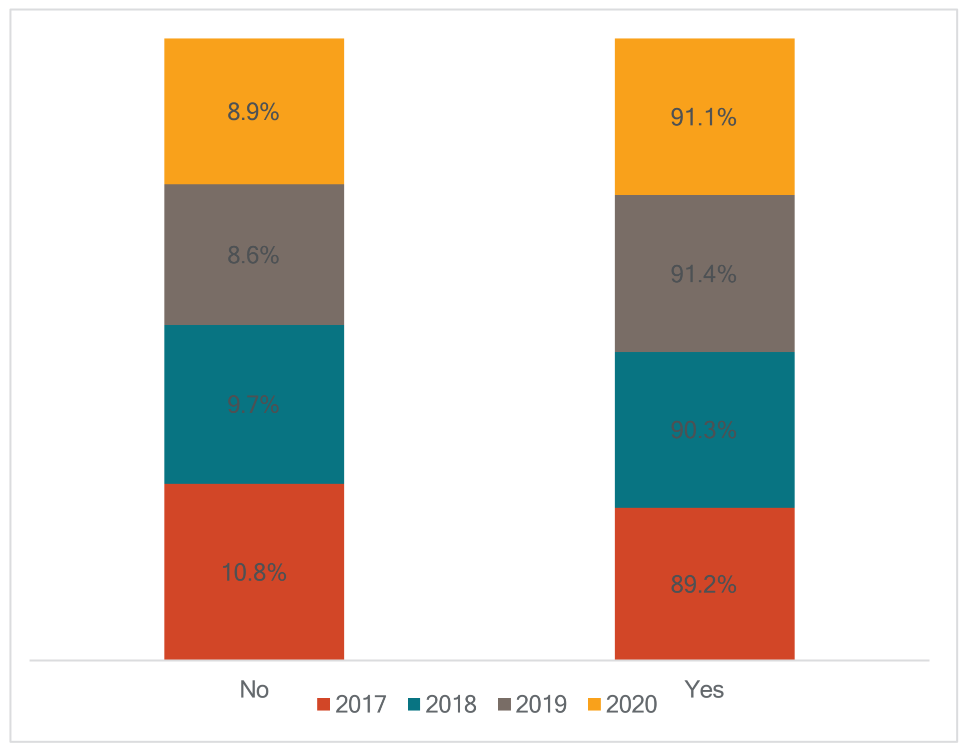


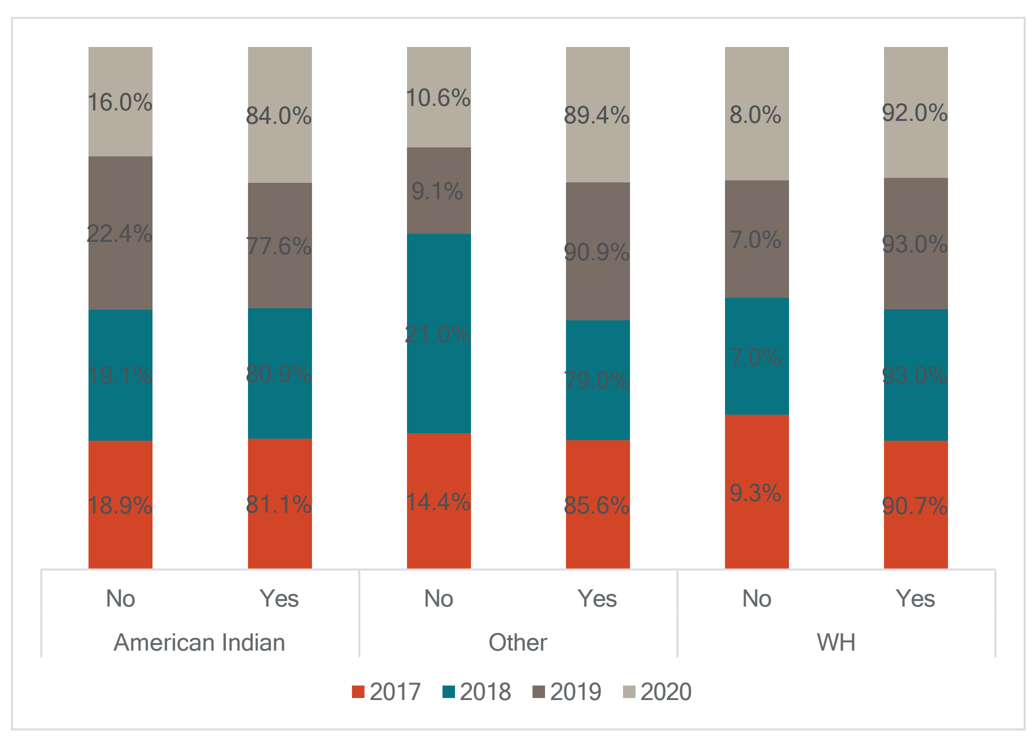
How did your new baby usually sleep in the past 2 weeks? On a couch, sofa, or armchair



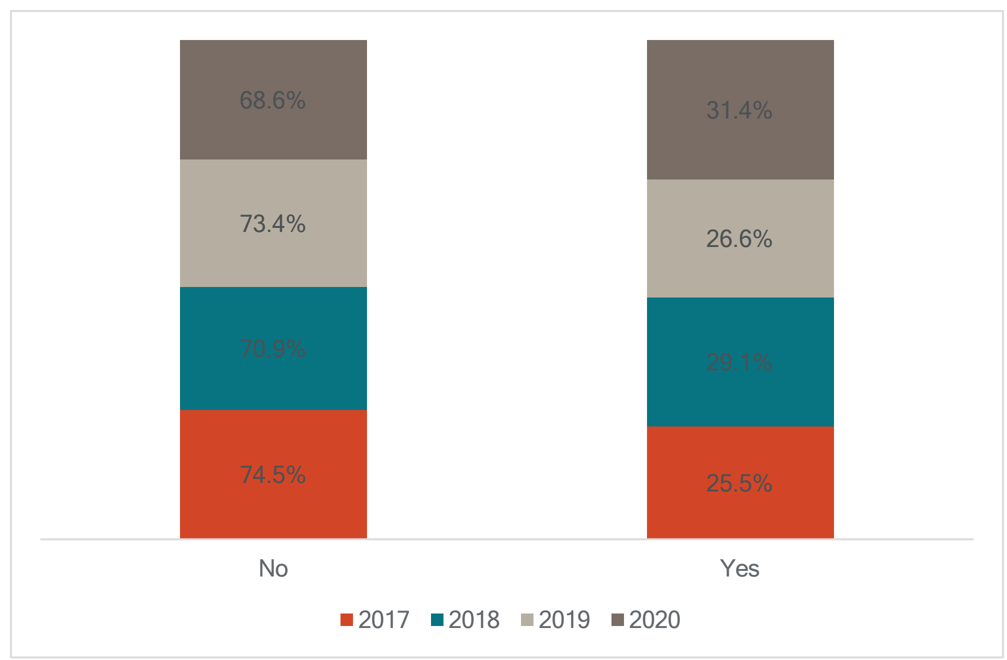


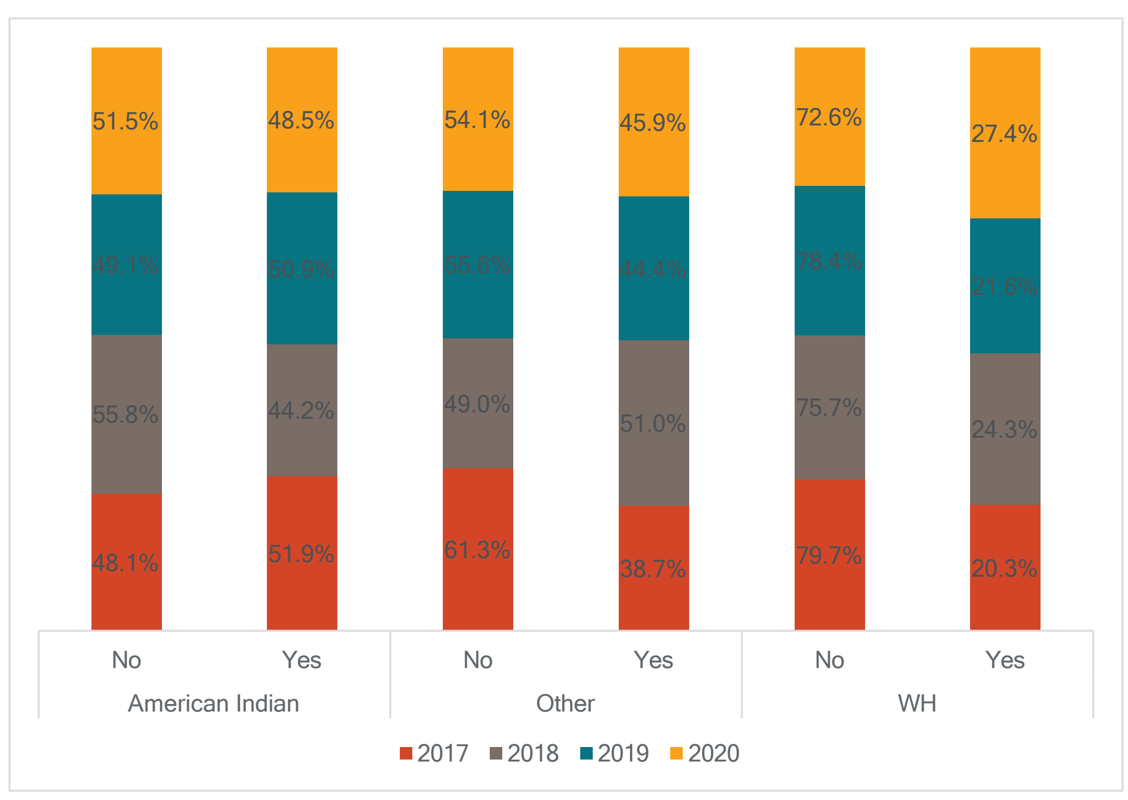
How did your new baby usually sleep in the past 2 weeks? In a crib, bassinet, or pack and play



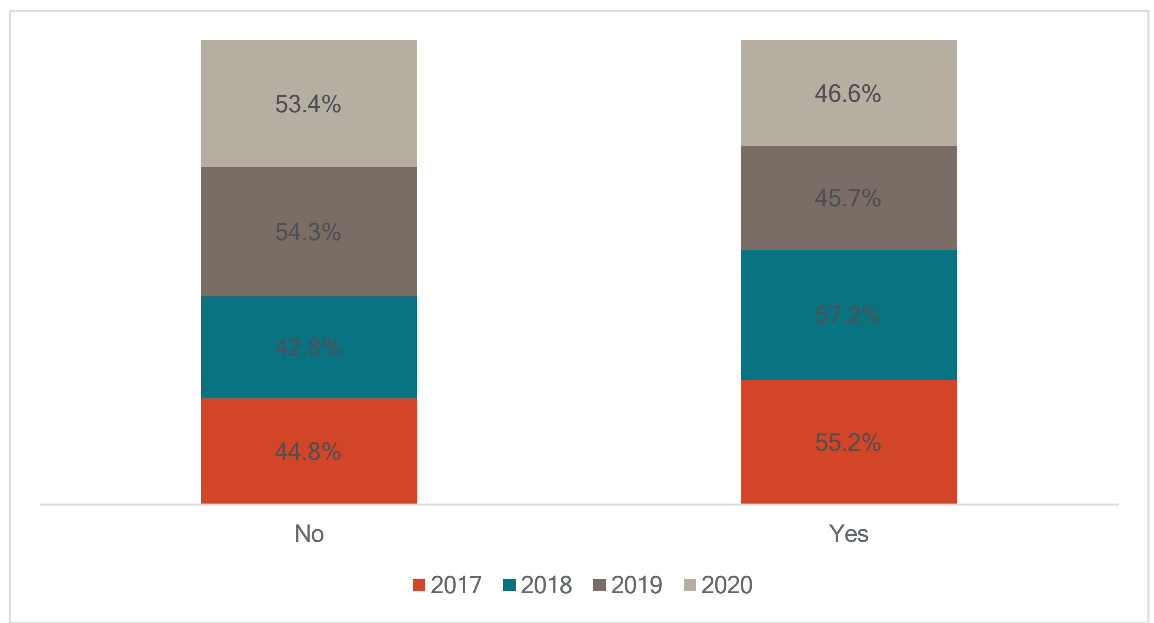


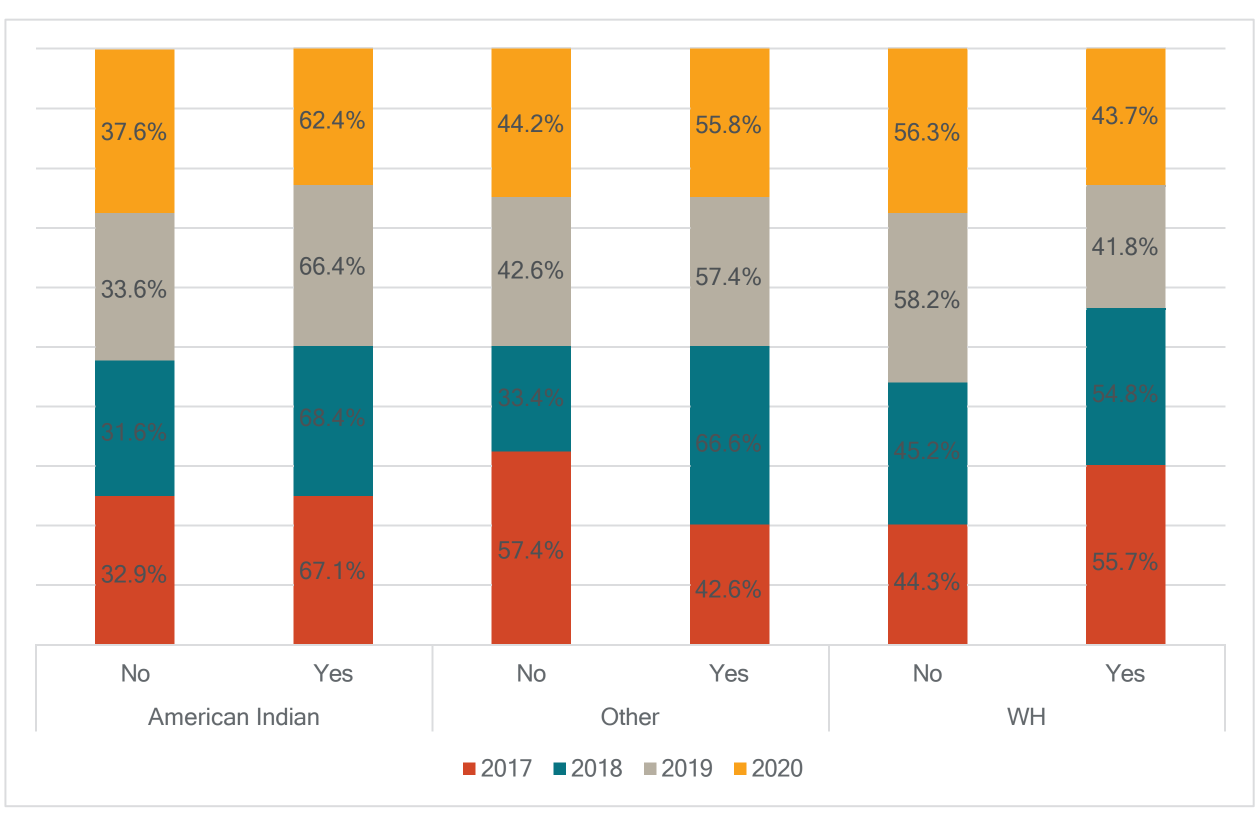
How did your new baby usually sleep in the past 2 weeks? On a twin or larger mattress or bed



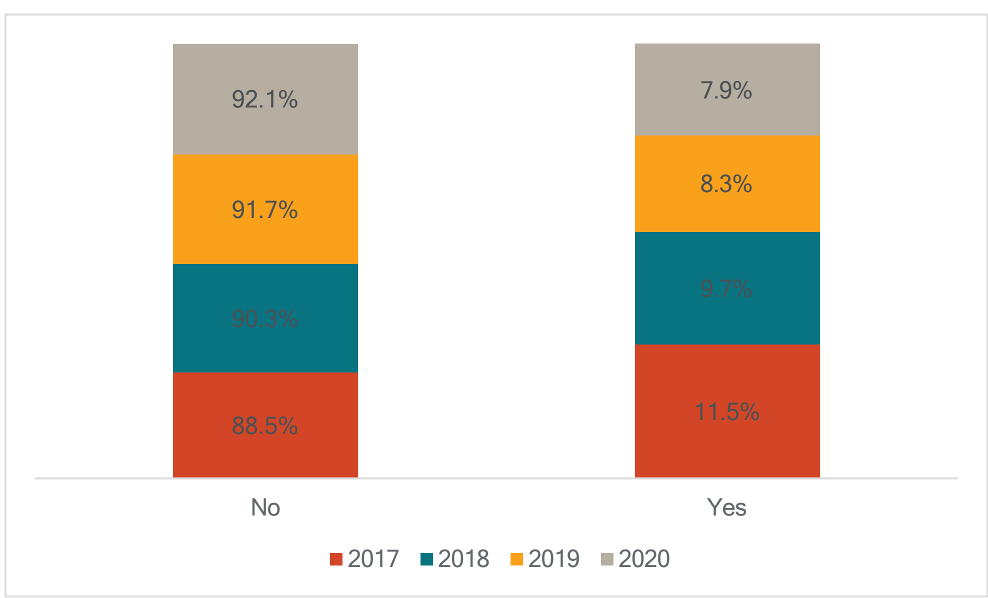


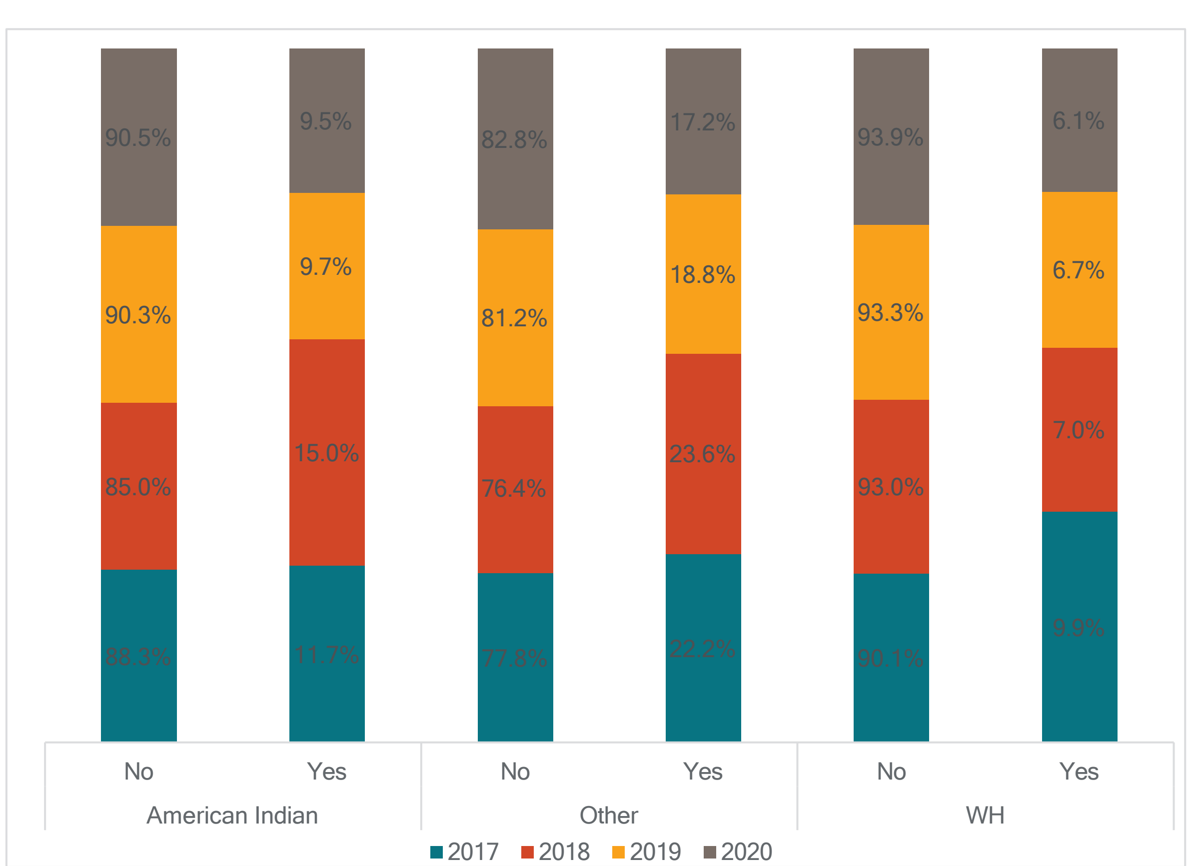
How did your new baby usually sleep in the past 2 weeks? With a blanket



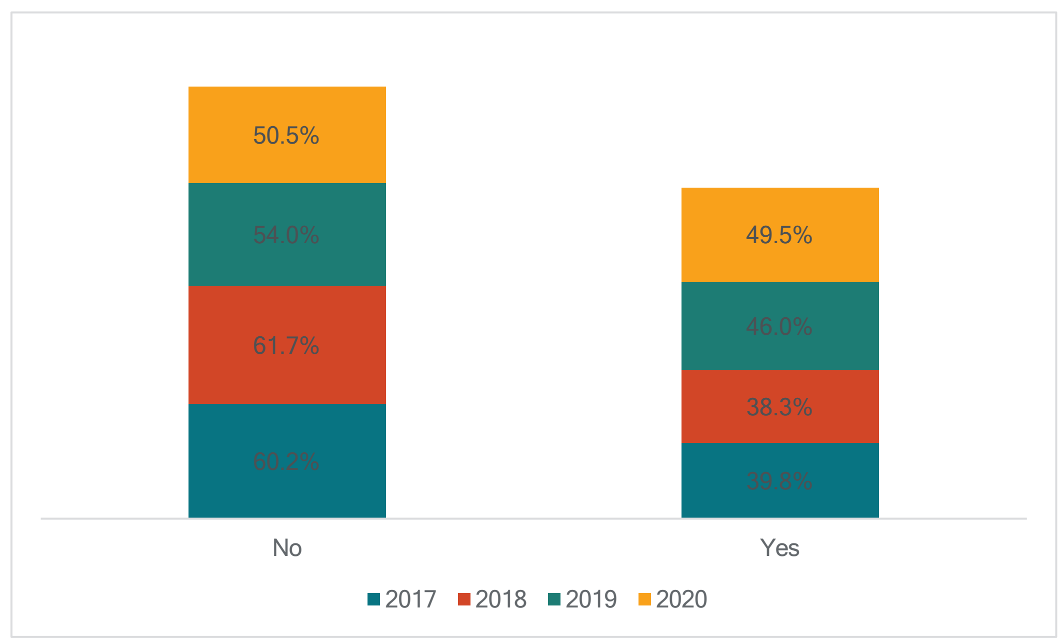


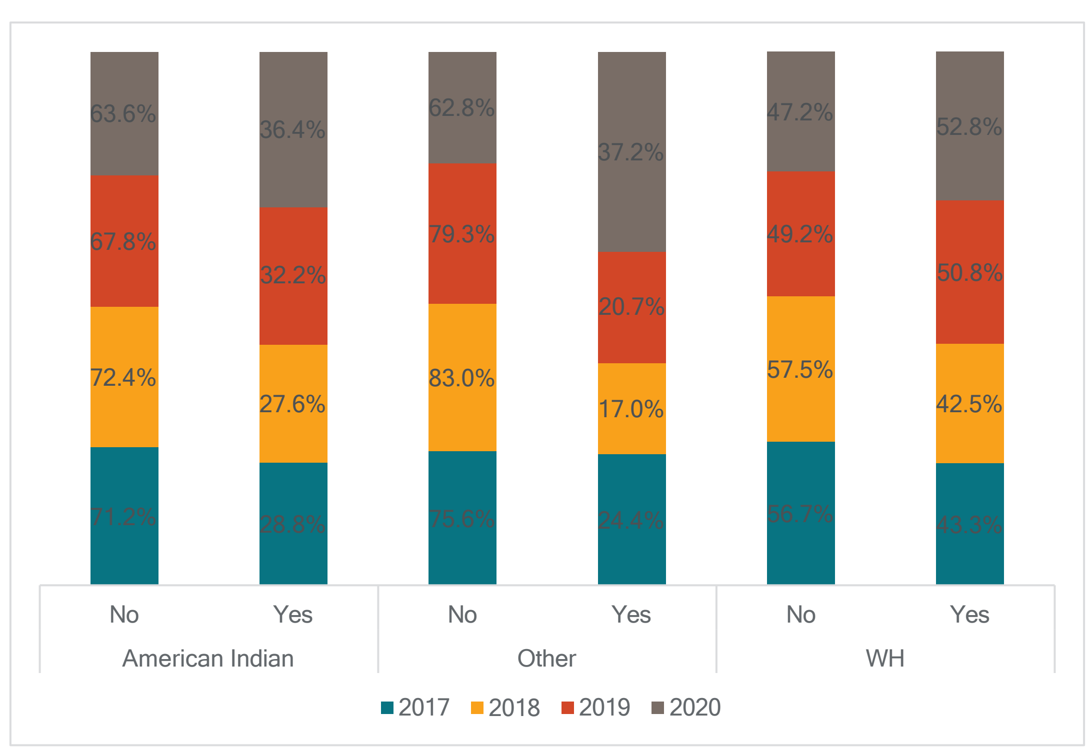
How did your new baby usually sleep in the past 2 weeks? With crib bumper pads (mesh or non-mesh)



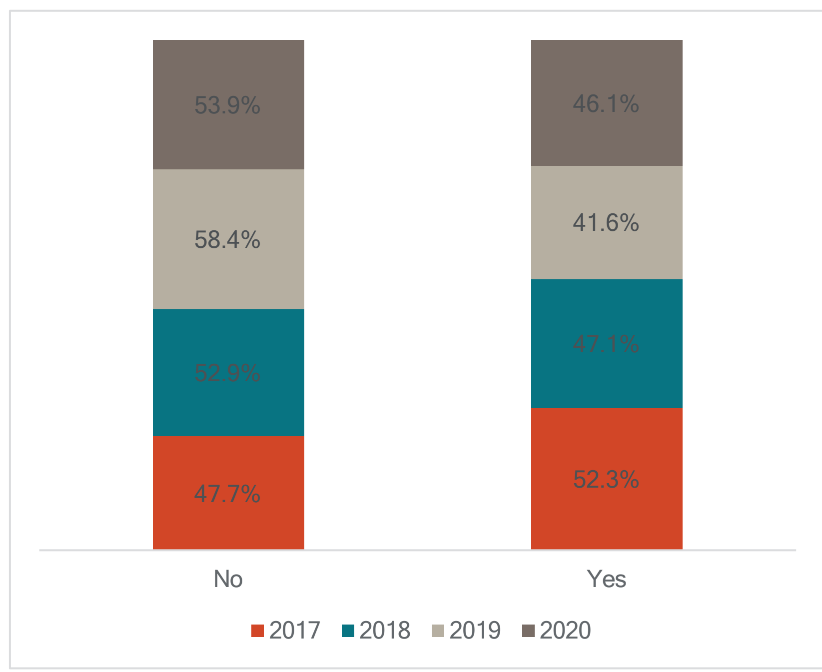


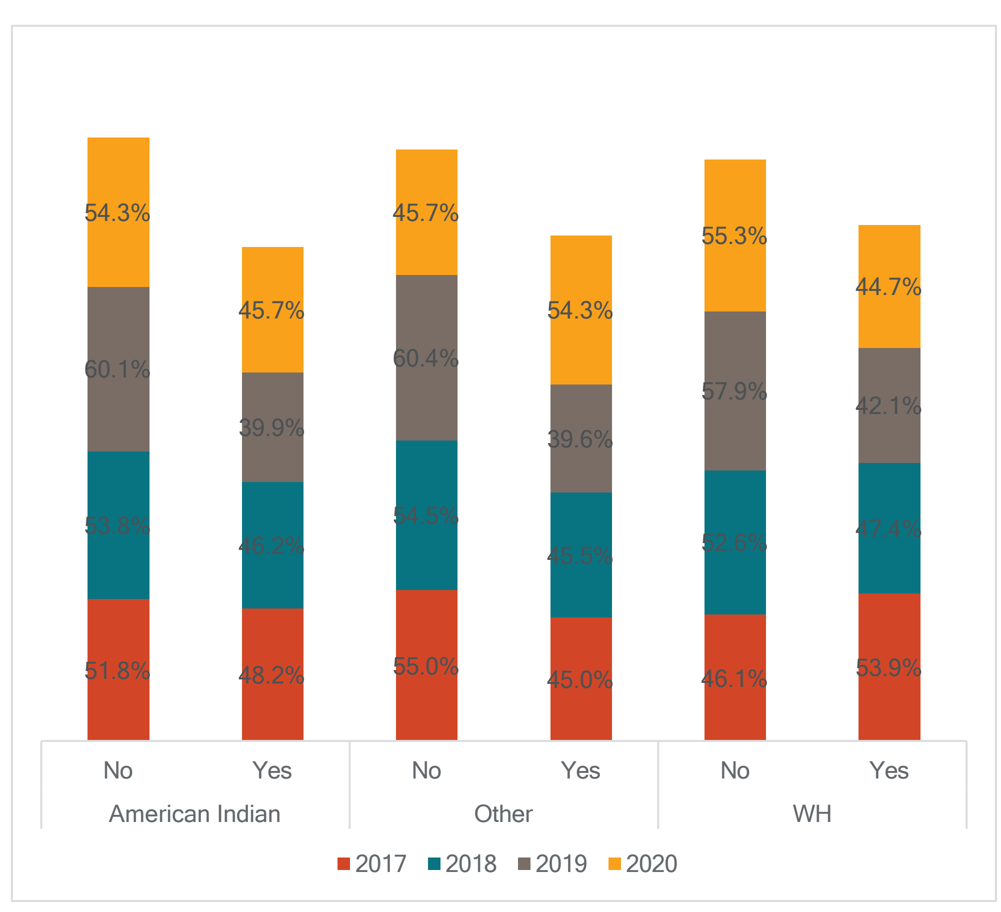
How did your new baby usually sleep in the past 2 weeks? In a sleeping sack or wearable blanket



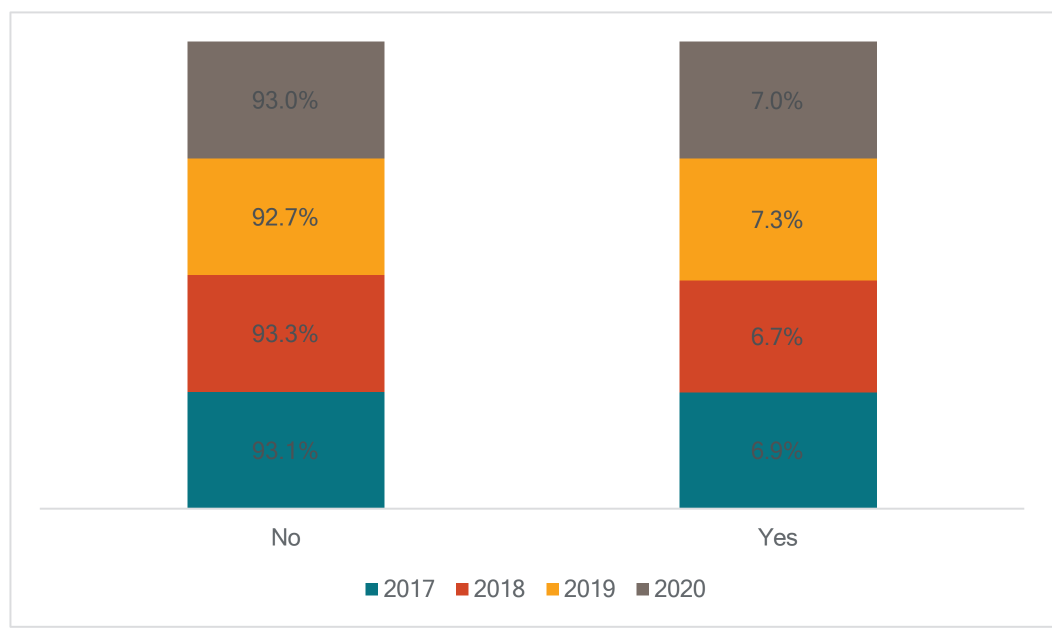


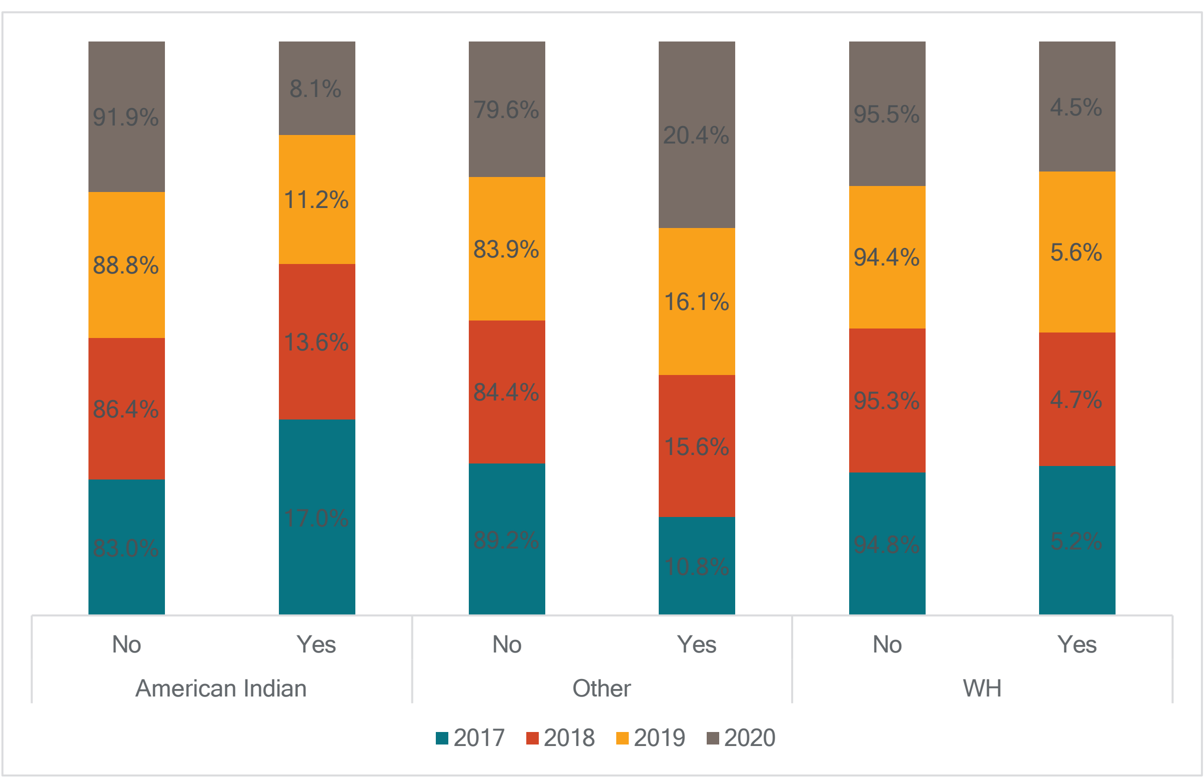
How did your new baby usually sleep in the past 2 weeks? In an infant car seat or swing



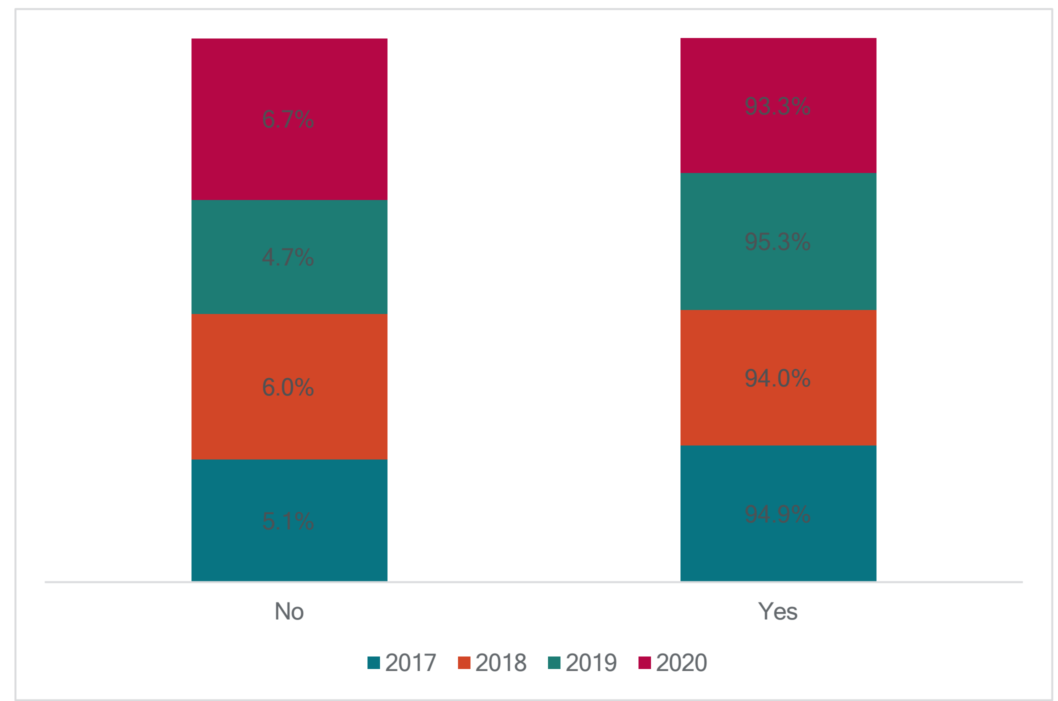


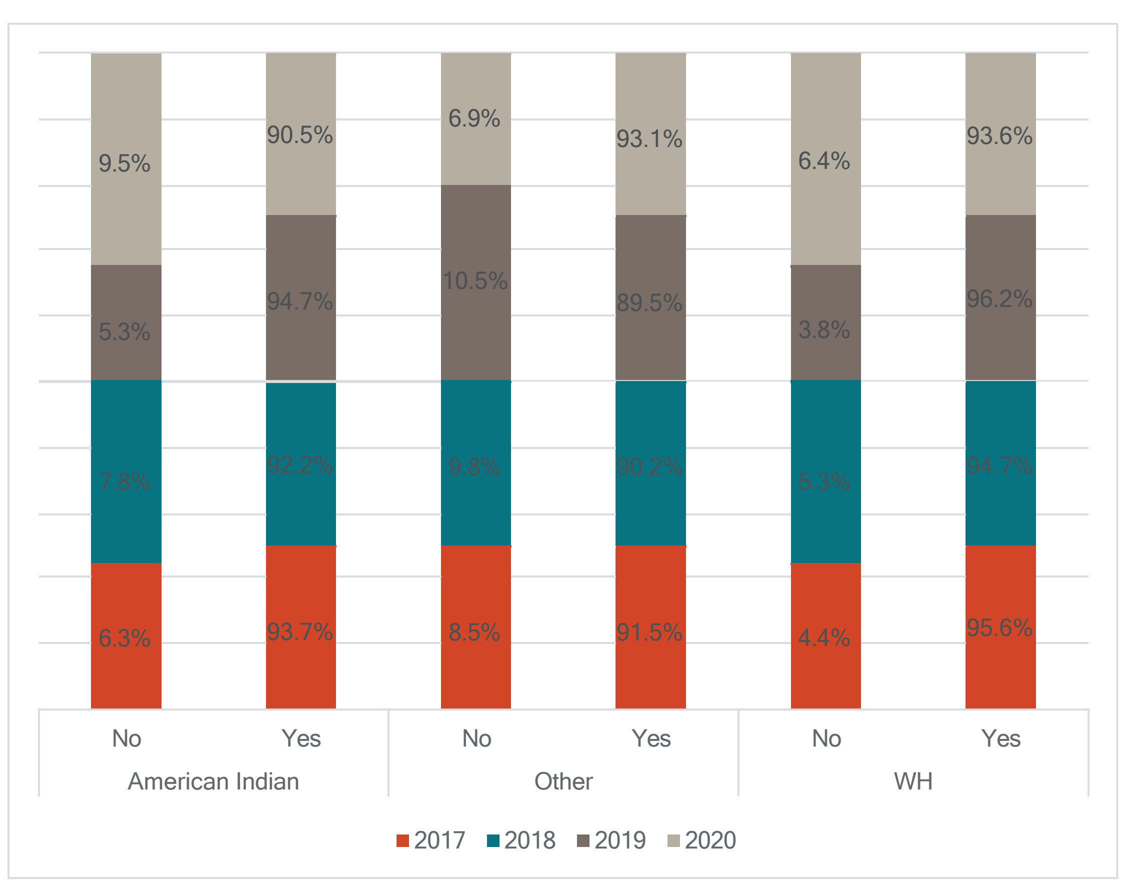
How did your new baby usually sleep in the past 2 weeks? With toys, cushions, or pillows, including nursing pillows





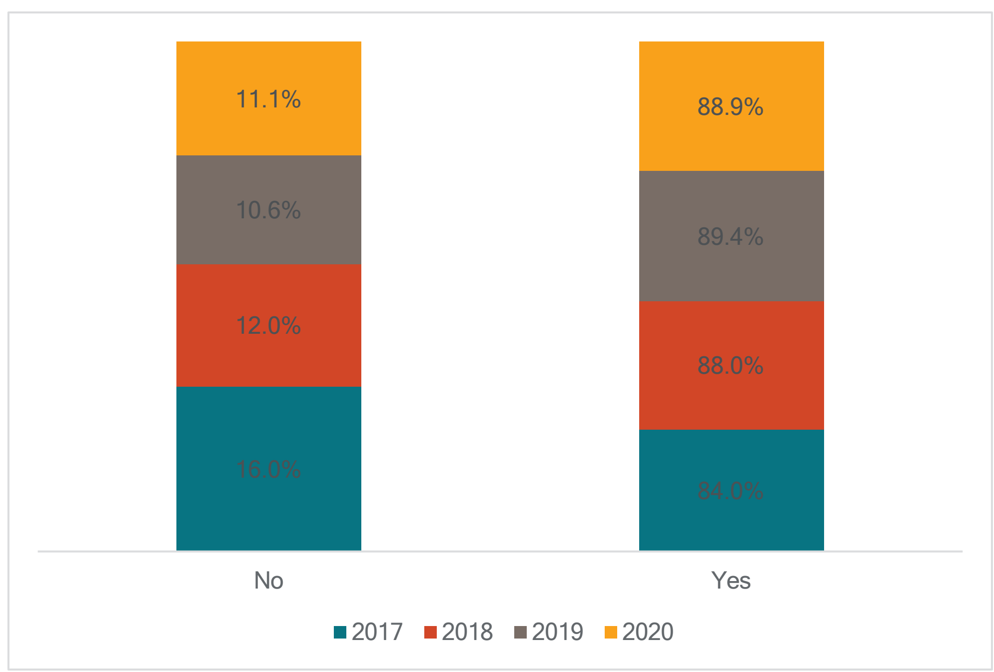
Did a doctor, nurse, or other health care worker tell you any of the following things? Place my baby on his or her back to sleep

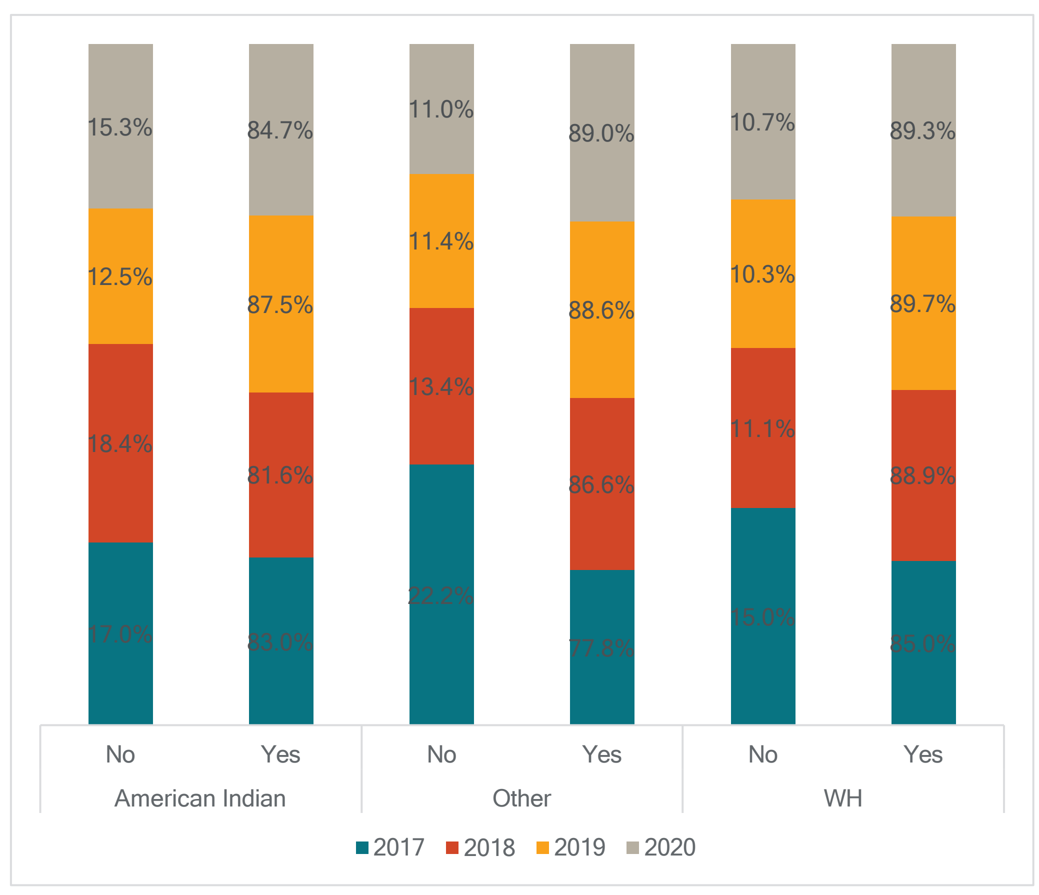




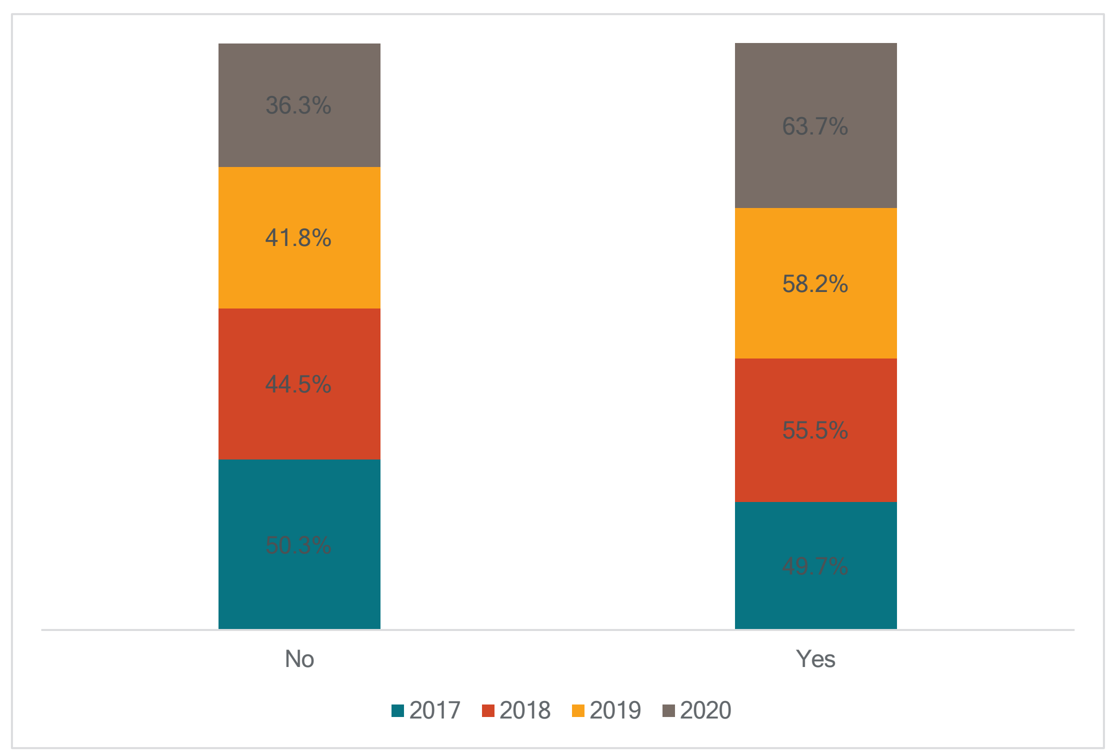
Did a doctor, nurse, or other health care worker tell you any of the following things?

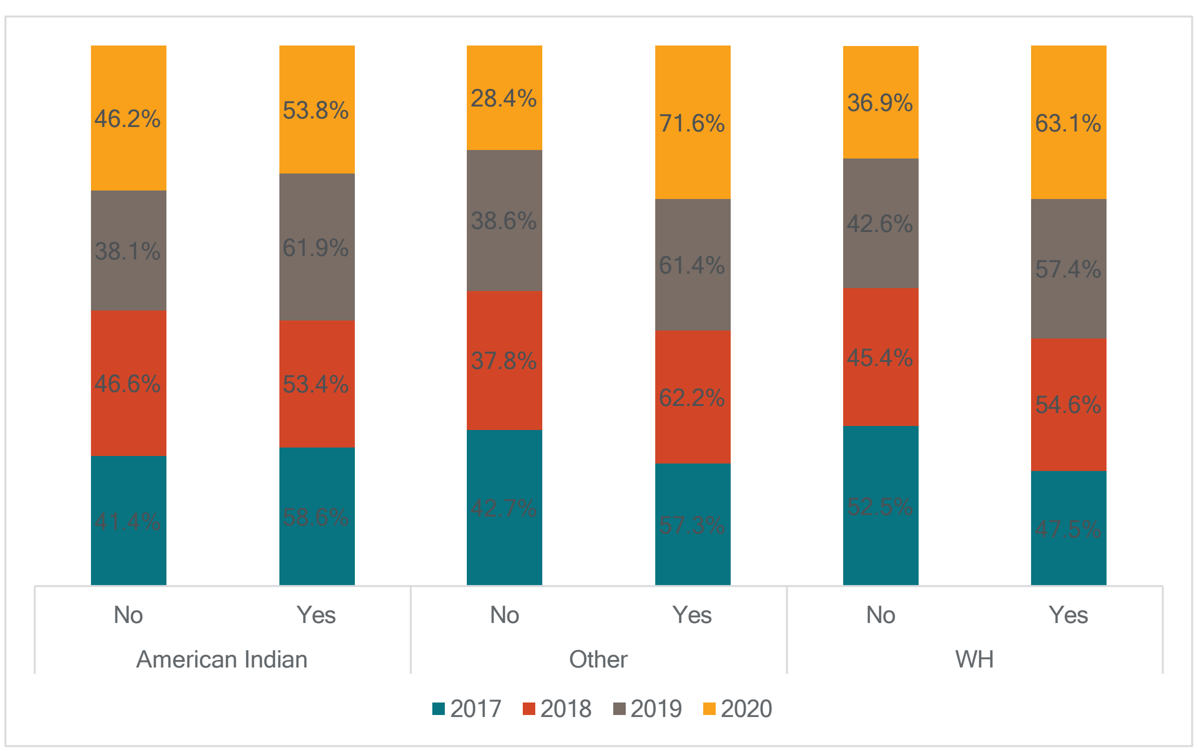
Place my baby to sleep in a crib, bassinet, or pack and play





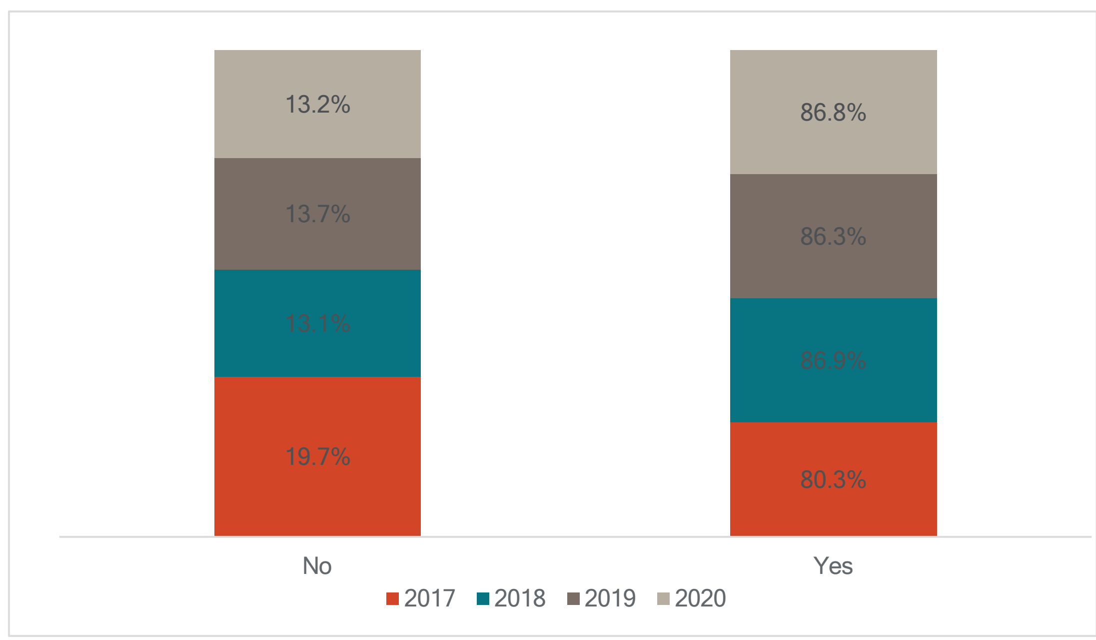
Did a doctor, nurse, or other health care worker tell you any of the following things? Place my baby's crib or bed in my room

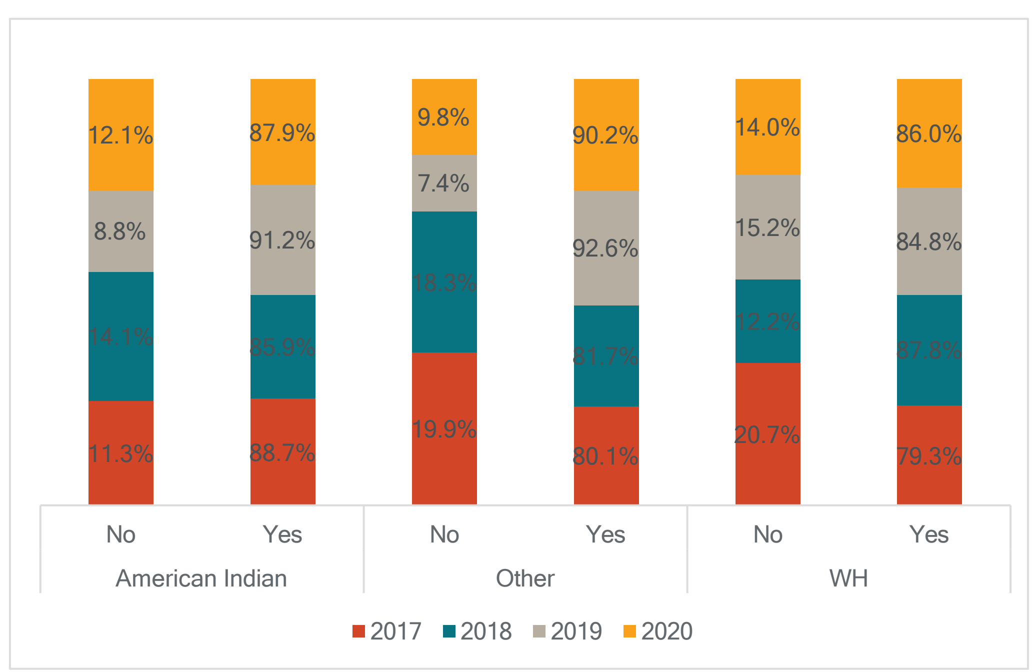




Did a doctor, nurse, or other health care worker tell you any of the following things?

What things should and should not go in bed with my baby





2 Firearm Hazard

Nationwide, children are three times more likely to die due to firearm-related homicide and four times more likely to die by suicide when there is a gun in the home. Firearms are now the leading cause of death for US children (Firearm-Related Injuries and Death in Children and Youth, 2022). In North Dakota, firearm related child deaths (homicides, accidents, and suicides) have continued to rise since 2016 (North Dakota Department of Health and Human Services, 2022). According to the RAND Corporation (Schell, 2020) 55.1% of adults in North Dakota have a gun in their home, nearly 31,000 new gun licenses were issued to North Dakotans in 2021.

Firearm related suicide deaths of children have **tripled** from 2016 to 2020. Suicide is preventable and one strategy is to safely store firearms so this lethal means is out of children's access. The safest home for children and teens is a home with no guns.

A review of the maltreatment fatalities with a contributing factor of firearm hazard indicated the firearms most often were stored unsecured in the family home, that is the gun was stored unlocked, or if the gun was under lock the child had the key or code to access the weapon. Most often the ammunition was stored with the firearm and over 60% of the time the gun was stored loaded and ready to fire. Alarmingly, 40% of the firearms were stored unlocked, loaded and in the bedroom belonging to the child.

Adverse childhood experiences (abuse and neglect, violence) increase the likelihood of trauma and place children at greater risk for suicide. Separation from loved ones due to death, divorce, incarceration, deployment, and foster care as well as the loss of stable housing all can raise the risk for youth suicide. Adolescents with a mental health diagnosis of depression and/or those that have expressed suicidal thoughts, feelings or behaviors are more likely to attempt suicide. Over 65% of the children identified with a maltreatment contributing factor of firearm hazards had a mental health diagnosis, a previous suicide attempt and/or had expressed thoughts, feelings, or behaviors of suicide.

RISK FACTORS OF SUICIDE RELATED TO FIREARMS

1. Unsecured / unlocked firearms; all guns in the home should be locked and unloaded with ammunition locked separately from the firearm. Children and teens should not be able to access any keys or combinations to gun safes or lock boxes.

2. Children playing with guns; children should not clean, handle and/or show another child firearms when not under the direction and supervision of an adult trained in safe gun practices (Schaechter, Judy; American Academy of Pediatrics, 2021).

3. Discrimination, hostility, and rejection can lead to an increase in suicidal thoughts and actions. Youth who identify as LGBTQIA2S+ are four times more likely to attempt suicide then their peers and this risk further increases when the youth experience negative family reactions to their sexual orientation or gender identity (The Trevor Project, 2021).

4. Suicide risk factors are present (American Academy of Pediatrics, 2023)
   - Previous suicide attempts
   - Expresses suicidal thoughts, feelings or behaviors
   - Expresses feelings of hopelessness or being a burden to others
   - Recent triggering event such as the loss of a relationship or job; academic challenges
   - Isolation
   - Violent, reckless or impulsive behavior
   - Marked changes in usual patterns of behavior
   - Use or increased use of alcohol or drugs
   - Mental health diagnosis (depression, anxiety, mood dysregulation, eating disorders)
   - Victim of maltreatment
   - Loss of someone close to them from suicide
   - Victim of bullying

5. Youth started taking prescribed medication for mental health within the past three months.

6. Caregiver and/or youth drug use and distribution

7. Alcohol use by youth and/or caregiver

8. Caregiver and/or youth gang affiliation and violence

9. Caregivers misinterpret suicidal ideation and threats as attention seeking behavior

10. Caregivers work full-time outside the family home

Decrease suicide child fatalities by firearm by 25% from 2020 to 2025.

Objective 1:

Decrease the percentage of middle and high school students who ever seriously thought about killing themselves from 25.9% (middle school) and 18.6% (high school) in 2021 to 18% (middle school) and 15% (high school) in 2025.
Source: North Dakota Youth Risk Behavior Survey (North Dakota Department of Public Instruction, 2021)

Objective 2:

Increase the percentage of middle and high school students who reported there is at least one teacher or other adult in their school that they can talk to if they have a problem by 54.8% (middle school) and 61.8% (high school) in 2021 to 70% in 2025.
Source: North Dakota Youth Risk Behavior Survey (North Dakota Department of Public Instruction, 2021)

Objective 3:

Distribute 3,000 gun-safety kits and trigger locks through *Project Child Safe*, with at least 2,000 being distributed to the western part of the state. (Project Child Safe; National Shooting Sports Foundation, 2023)

STRATEGIES

- Development of a statewide coalition for child firearm safety and a statewide approach to firearm safety education and awareness with an emphasis that gun safety and gun rights are not mutually exclusive.

- Public education and awareness campaign for all gun owners with an emphasis on suicide preventability through the utilization of safe gun storage (Everytown for Gun Safety Support, 2022):
  - Firearms are stored unloaded and locked in a cabinet, safe, gun vault or storage case
  - Bullets are locked in a place separate from the firearm
  - The keys or passcode are hidden or not accessible
  - Safely store firearms in vehicles
  - Keep guns out of the homes where children and teens reside, especially when suicide risk factors are present

- Promote and expand telehealth mental health services for youth

- Increase timely access to mental health services for youth in crisis, including improving access to mental health services in the school setting.

- Increase mental health and crisis response services, medical services, and resources and supports, specifically in rural communities and with the LGBTQIA2S+ population.

- Develop community safety supports for adolescent children who are experiencing suicidal thoughts and cannot be left unsupervised; these community safety supports should focus on building resiliency and focus on community involvement and betterment (National Conference on Child Abuse and Neglect, 2023-2024).

- All children ages 10 and over be screened for depression and suicide risks during annual well child checkups. DHHS Behavioral Health services partner with medical providers to provide mental health / suicide risk screenings with youth at the medical facilities where they are receiving an annual / sports physical. Provide support, resources and referrals to children and families identified as being at risk.

- Statewide distribution of free gun safety kits and trigger locks through Project ChildSafe

- Encourage pediatricians and medical providers across the state to universally inquire with youth and caregivers about the presence of guns and how they are stored in their home, (at the time of annual physicals and when a child is identified as having a mental health diagnosis), provide education about safe gun storage, and additionally provide or refer the family for a free gun safety kit and trigger lock (Committee on Injury, Violence, and Poison Prevention, 2009).

- When law enforcement identifies the presence of unsecured firearms in a home with children, they offer the family a free gun lock.

- Educators and child care providers educate young children about guns and what to do if they see a gun, including all Head Starts (National Conference on Child Abuse and Neglect, 2023-2024) (Project Child Safe; National Shooting Sports Foundation, 2023)

- Add two additional school districts to the Handle with Care program; engage tribal schools and tribal law enforcement to participate to mitigate negative effects experienced by children's exposure to trauma and connect children and families to mental health services (Prevent Child Abuse North Dakota , 2022).

- Statewide suicide prevention / intervention education and training such as Question Persuade Refer or #BeThe1To that includes all medical providers, including ancillary providers, public health, clinicians, child care providers, foster parents, child welfare, educators, and students, specifically starting in elementary school.

- Disseminate education to child welfare staff about firearm safety, access to lethal means, and how to normalize conversations about guns in the home and how they are stored. In addition to how to identify suicidal behavior, encourage a suicidal person to accept help and ensure a person has a support system in place.

- Create public education campaigns about youth suicide risk and protective factors, how to have a conversation about suicide and provide education about 988, the Suicide and Crisis Lifeline.

- Additional education and training for law enforcement on the requirements for a comprehensive child death investigation, including interview techniques, evidence gathering.

- Require all schools to adopt and implement comprehensive suicide prevention / intervention policies and procedures.

- Create feedback loops between the Behavioral Health Resource Coordinators in schools and the Department of Health and Human Services Behavioral Health Unit in which each school district provides an annual report detailing how the suicide prevention resources, specifying the curriculum used, and education provided by DHHS was utilized or shared within that school.

- Implement school-based suicide prevention with mandatory annual suicide risk assessments for all youth ages 9-17 years. If a youth is identified as being at risk, the student is then referred for services. (American Academy of Pediatrics, 2023)

- Suicide risk assessments be completed by professional at the school every time a youth is suspended from academics or athletic events or when a student requests to leave school and there is no apparent illness or other commitment.

- Raise awareness and access about the STOPit Solutions, which allows ND students to confidentially report tips on potential threats to child safety or violence directed at students and its role in suicide prevention.

- Educators implement alternative methods for responding to negative youth behaviors that do not result in removing positive social emotional connections from the youth such as extra-curricular activities as the removal of such activities in a child's life further results in negative outcomes.

- Parents and caregivers ask about guns and gun storage at the homes their children visit

- All youth handling a firearm participate in a Hunter Safety education certification course; ensuring gun safety is part of every conversation about hunting and firearms, in addition, caregivers are teaching children about proper safe gun handling and storage.

- Adopt Hunter Safety / Firearm Safety as an elective course for high school students.

- Increase community awareness through connections, visibility, and advocacy for the LGBTQIA2S+ community, such as Dakota Out Right

MONITORING DATA SOURCE

The Youth Risk Behavior Survey (YRBS) was developed in 1990 by the Centers for Disease Control and Prevention (CDC) to help inform our understanding of behaviors that contribute to the leading causes of death, disability, and social problems among students. YRBS data allows us to monitor trends in health behaviors, guide programmatic interventions, and informs school health policies and practices. North Dakota began participating in the YRBS survey in 1995. Students in grades, 7-8 & 9-12 are surveyed in the spring of the odd years. The survey is voluntary and completely anonymous. The data points selected from the survey are focused on three categories: injury to oneself and suicide, connections with people at school and mental health. Additionally, a data point in the school violence category regarding the percentage of students who carried a weapon on school property is being monitored as there has been a noticeable increase in this number in the western part of the state.

North Dakota 2021 High School YRBS Results:
All Grades: Behaviors that Result in Unintentional and Intentional Injuries

North Dakota 2021 Middle School YRBS Results:
All Grades: Behaviors that Result in Unintentional and Intentional Injuries

North Dakota 2021 High School (Grades 9-12) YRBS Results
(Including breakdowns by region and urban/rural)

Unintentional Injuries and Violence

Injury to Oneself & Suicide		Winkelman Consulting Results								
Question	CDC North Dakota Results	CREA Bismarck-Mandan-Minot Area	GNWEC Williston Area	NCEC Bottineau-Rugby Area	NESC Devils Lake Area	RESP Dickinson Area	RRVEC Grand Forks Area	SEEC Fargo-Jamestown Area	Urban Towns	Rural Towns
Percentage of students who seriously considered attempting suicide (ever during the 12 months before the survey) (NDHqn26, CDC QN26)	**18.6%**	21.4%	24.0%	17.8%	22.6%	19.0%	15.0%	17.4%	20.6%	18.5%
Percentage of students who made a plan about how they would attempt suicide (during the 12 months before the survey) (NDHqn27, CDC QN27)	**14.8%**	17.3%	21.4%	15.8%	18.8%	13.8%	11.0%	14.9%	17.2%	15.1%
Percentage of students who actually attempted suicide (one or more times during the 12 months before the survey) (NDHqn28, CDC QN28)	**6.1%**	8.9%	9.5%	8.4%	9.9%	8.2%	5.6%	5.9%	7.5%	7.9%

School Violence		Winkelman Consulting Results								
Question	CDC North Dakota Results	CREA Bismarck-Mandan-Minot Area	GNWEC Williston Area	NCEC Bottineau-Rugby Area	NESC Devils Lake Area	RESP Dickinson Area	RRVEC Grand Forks Area	SEEC Fargo-Jamestown Area	Urban Towns	Rural Towns
Percentage of students who carried a weapon on school property (such as a gun, knife, or club, on at least 1 day during the 30 days before the survey) (NDHqn16, CDC QN12)	**5.0%**	5.6%	7.9%	5.2%	6.3%	10.5%	3.7%	3.7%	4.4%	6.2%

Connections with People at School		Winkelman Consulting Results								
Question	CDC North Dakota Results	CREA Bismarck-Mandan-Minot Area	GNWEC Williston Area	NCEC Bottineau-Rugby Area	NESC Devils Lake Area	RESP Dickinson Area	RRVEC Grand Forks Area	SEEC Fargo-Jamestown Area	Urban Towns	Rural Towns
Percentage of students who participate in school activities one or more hours (such as sports, band, drama, or clubs, during an average week when they are in school) (NDHqn84, CDC QN116)	**66.7%**	69.0%	61.5%	76.5%	67.0%	72.9%	70.8%	72.5%	64.9%	74.3%
Percentage of students who reported there is at least one teacher or other adult in their school that they can talk to if they have a problem (NDHqn85, CDC QN117)	**61.8%**	61.5%	59.1%	66.1%	60.9%	60.5%	62.5%	66.8%	61.5%	64.3%

Mental & Physical Health Issues		Winkelman Consulting Results								
Question	CDC North Dakota Results	CREA Bismarck-Mandan-Minot Area	GNWEC Williston Area	NCEC Bottineau-Rugby Area	NESC Devils Lake Area	RESP Dickinson Area	RRVEC Grand Forks Area	SEEC Fargo-Jamestown Area	Urban Towns	Rural Towns
Percentage of students who felt sad or hopeless (almost every day for >=2 weeks in a row so that they stopped doing some usual activities, ever during the 12 months before the survey) (NDHqn25, CDC QN25)	**36.0%**	39.2%	45.7%	38.1%	41.1%	30.9%	30.6%	34.8%	39.7%	34.8%

North Dakota 2021 Middle School (Grades 7-8) Statewide YRBS Results

(Including breakdowns by region and urban/rural)

Unintentional Injuries and Violence

Injury to Oneself & Suicide		Winkelman Consulting Results								
Question	CDC North Dakota Results	CREA Bismarck-Mandan-Minot Area	GNWEC Williston Area	NCEC Bottineau-Rugby Area	NESC Devils Lake Area	RESP Dickinson Area	RRVEC Grand Forks Area	SEEC Fargo-Jamestown Area	Urban Towns	Rural Towns
Percentage of students who ever seriously thought about killing themselves (NDMqn15, CDC QN14)	**25.9%**	27.7%	29.1%	25.2%	29.5%	23.6%	26.5%	25.6%	25.8%	27.8%
Percentage of students who ever made a plan about how they would kill themselves (NDMqn16, CDC QN15)	**19.1%**	21.3%	23.6%	23.5%	24.4%	18.8%	20.1%	18.1%	19.4%	21.7%
Percentage of students ever who tried to kill themselves (NDMqn17, CDC QN16)	**9.3%**	10.5%	11.4%	10.3%	14.4%	9.7%	11.2%	8.2%	9.1%	10.9%

Social Capital (Connections with Others)

Connections with People at School		Winkelman Consulting Results								
Question	CDC North Dakota Results	CREA Bismarck-Mandan-Minot Area	GNWEC Williston Area	NCEC Bottineau-Rugby Area	NESC Devils Lake Area	RESP Dickinson Area	RRVEC Grand Forks Area	SEEC Fargo-Jamestown Area	Urban Towns	Rural Towns
Percentage of students who participate in school activities one or more hours (such as sports, band, drama, or clubs, during an average week when they are in school) (NDMqn49, CDC QN62)	**71.3%**	74.4%	75.1%	81.0%	73.0%	81.0%	75.7%	70.9%	68.4%	80.9%
Percentage of students who reported there is at least one teacher or other adult in their school that they can talk to if they have a problem (NDMqn50, CDC QN63)	**54.8%**	56.1%	51.7%	51.6%	55.6%	60.0%	57.7%	60.5%	56.9%	58.1%

Mental & Physical Health Issues		Winkelman Consulting Results								
Question	CDC North Dakota Results	CREA Bismarck-Mandan-Minot Area	GNWEC Williston Area	NCEC Bottineau-Rugby Area	NESC Devils Lake Area	RESP Dickinson Area	RRVEC Grand Forks Area	SEEC Fargo-Jamestown Area	Urban Towns	Rural Towns
Percentage of students who felt sad or hopeless (almost every day for >=2 weeks in a row so that they stopped doing some usual activities, ever during the 12 months before the survey) (NDMqn14, CDC QN50)	**35.1%**	38.4%	40.8%	31.9%	41.3%	39.4%	34.6%	32.5%	35.7%	36.3%

3 Abusive Head Trauma

Abusive head trauma (AHT), which includes shaken baby syndrome, is a preventable and severe form of physical child abuse that results in an injury to the brain of a child. Nearly all victims of AHT suffer serious, long-term health consequences, for example, vision problems, cognitive and developmental delays, physical disabilities, and hearing loss. At least one of every four babies who experience abusive head trauma will die as a result of the inflicted abuse (Parks SE, 2012). The CFRP also reviews cases of children who are near death as a result of maltreatment. Over 60% of children with confirmed abuse that were near death as a result of the maltreatment were the result of abusive head trauma / shaken baby. From 2008-2020 there were twelve children that died as a result of abusive head trauma and child protection services made a fatal maltreatment determination. In addition to these twelve children, from 2016-2020 there were sixteen children identified as being near death as a result of abusive head trauma that was inflicted by a person responsible for the child's welfare (Table 13). The data below provides a closer look at those children, the perpetrators and the circumstances involved. Over 60% of the children were under the age of 1 year, over 50% were under 6 months.

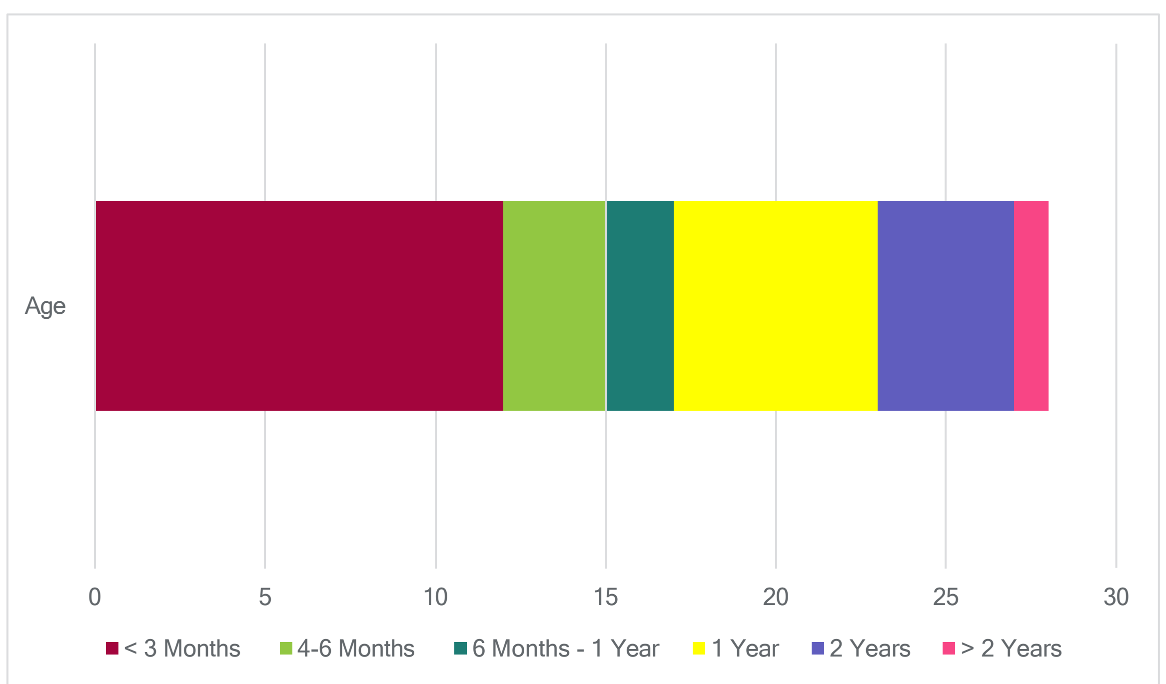


Table 13. Abusive Head Trauma by Age; Fatal Maltreatment, CY 2008-2020, and Child Abuse and Neglect Near Death, CY 2016-2020

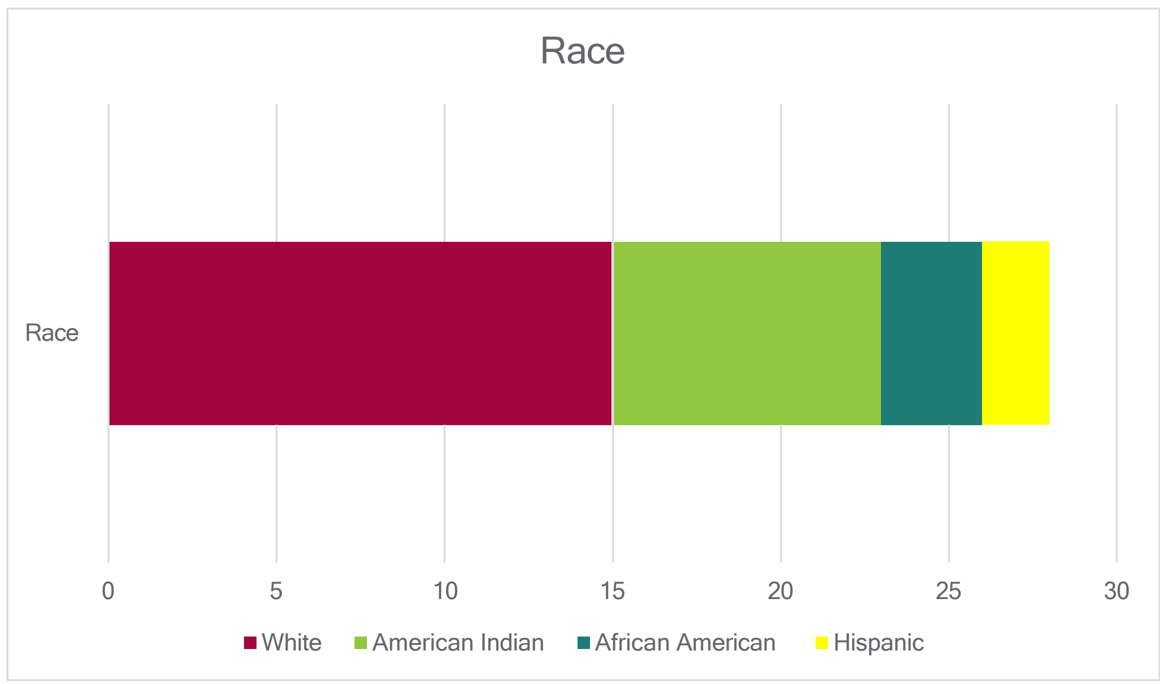


Table 14. Abusive Head Trauma by Race; Fatal Maltreatment, CY 2008-2020, and Child Abuse and Neglect Near Death, CY 2016-2020

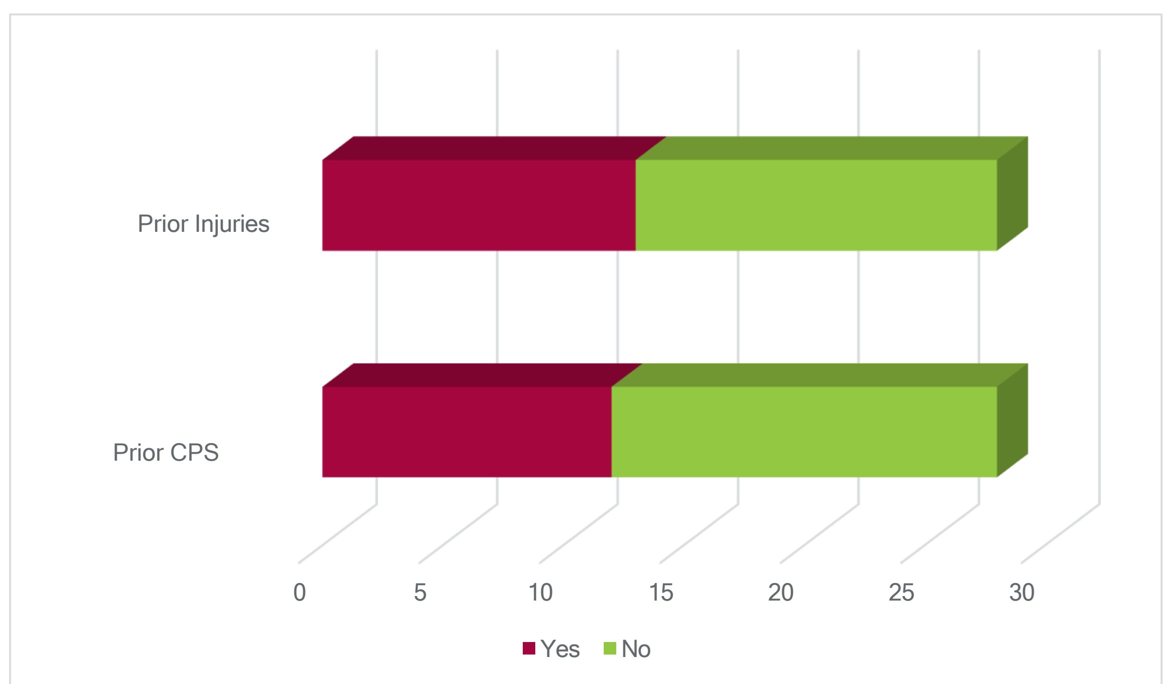


Table 15. Abusive Head Trauma and Prior Sentinel Injuries / Prior CPS Involvement; Fatal Maltreatment, CY 2008-2020, and Child Abuse and Neglect Near Death, CY 2016-2020

The child and family were often known to the child welfare system as there had been prior reports of suspected child abuse and neglect regarding the child as a victim and/or the caregiver had previously been identified as a subject of child maltreatment. When CPS had received prior reports, they were most often related to prenatal substance exposure, physical abuse, and domestic violence (Table 15). It is also noted that the age of the perpetrators of this maltreatment are most often young and unexperienced in the caregiving role; over 60% were under the age of 25 years.

The prevalence of prior injuries, including those that had and had not been treated by a medical provider was identified in 46% of the abusive head trauma maltreatments. According to American Academy of Pediatrics more than 27% of the children seen in the emergency department for abusive head trauma had been seen previously for an injury that was overlooked as an accidental injury (Narrang SK, 2020).

RISK FACTORS OF ABUSIVE HEAD TRAUMA

1. Crying inconsolable infants
2. Toilet training and diapering
3. Colic or fussy babies
4. Poor feeding
5. Substance exposed infants
6. Premature infants and those with special medical needs
7. Infants with GERD / vomiting / spitting up
8. Infants with previous sentinel injuries
9. Caregivers with a history of delinquency
10. Young / inexperienced caregivers
11. Caregivers with poor coping skills, those that become easily frustrated or agitated.
12. Caregivers that experience irritability, anger, and act recklessness
13. Caregivers that perceive infants as an interruption of their wants and needs (i.e., crying that disrupts a video game) or as a burden
14. Caregivers with a history of threats of violence against others
15. Caregivers with a history of hurting animals
16. Caregivers with a learning disability / borderline intellectual functioning
17. Caregivers with a mental health diagnosis that are not taking medication as prescribed.
18. Domestic violence occurring in the home; caregivers with a history of perpetrating violence; especially those with a previous incident with a weapon.
19. Parents with a recent loss (relationship, housing, job)
20. Lack of affordable child care resulting in parents leaving their children with people they do not know or with those that have a history of violent behavior.

21. Caregivers that were themselves victim of child maltreatment, multi-generational child abuse and neglect
22. Impulsive and aggressive caregivers; history of ADHD
23. Lack of a support system / lack of friends and family
24. Isolation
25. Rural community
26. Lack of food / cutting meals / food insecurity
27. Financial stress / receiving public assistance
28. Caregiver alcohol and drug use
29. According to the CDC, when protective factors for families and communities are strengthened, the risk for child abuse and neglect is reduced (CDC Violence Prevention, 2022)

INDIVIDUAL PROTECTIVE FACTORS

- *Caregivers who create safe, positive relationships with children*
- *Caregivers who practice nurturing parenting skills and provide emotional support*
- *Caregivers who can meet basic needs of food, shelter, education, and health services*
- *Caregivers who have a college degree or higher and have steady employment*

FAMILY PROTECTIVE FACTORS

- *Families with strong social support networks and stable, positive relationships with the people around them*
- *Families where caregivers are present and interested in the child*
- *Families where caregivers enforce household rules and engage in child monitoring*
- *Families with caring adults outside the family who can serve as role models or mentors*

COMMUNITY PROTECTIVE FACTORS

- *Communities with access to safe, stable housing*
- *Communities where families have access to high-quality preschool*
- *Communities where families have access to nurturing and safe childcare*
- *Communities where families have access to safe, engaging after school programs and activities*
- *Communities where families have access to medical care and mental health services*
- *Communities where families have access to economic and financial help*
- *Communities where adults have work opportunities with family-friendly policies*

Decrease fatal and near-death abusive head trauma by 50% from 2020 to 2025.

Objective 1:

Increase the distribution of Period of Purple crying materials to birthing hospitals by adding three additional hospital distributers, one must be in the north east part of the state.
Source: Prevent Child Abuse North Dakota (Prevent Child Abuse North Dakota, 2022)

Objective 2:

Increase the number of medical professionals completing the newly redesigned Mandated Reporter training by 20% from 2023 to 2025.
Source: ND Mandated Reporter Training Report (Prevent Child Abuse North Dakota, 2022)

Objective 3:

Add the Period of Purple Crying as a foster care and child care license requirement by 2025. (Prevent Child Abuse North Dakota, 2022)

STRATEGIES

- Increase access to affordable, quality child care and provide child care vouchers for families in substance abuse treatment services or those accessing domestic violence services. (National Conference on Child Abuse and Neglect, 2023-2024) (Anderson, 2022).
- Increase community awareness of the Baby Safe Haven program thorough public service announcements, social media ads and the hospital / clinic education network. Engage pharmacies, liquor establishments, domestic violence service providers, and casinos to also display public information materials about the Baby Safe Haven program (Federal Commission to Eliminate Child Abuse and Neglect Fatalities, 2018).
- Require the Period of Purple Crying training for all licensed child care and foster care providers.
- Convene a statewide multidisciplinary child abuse and neglect conference that brings together law enforcement, child protection services, children's advocacy centers, medical providers, prosecutors, judges, victim advocates, tribal partners, forensic pathologists, mental health providers, and prevention service providers across the state to improve systemic cross agency response to reports of suspected child abuse and neglect through relationship building and protocol development that highlights information exchange, role identification and responsibilities and the efficiency of resources (Herbert, 2019).
- Increase community awareness about the Period of Purple Crying, Never Shake a Baby and other abusive head trauma prevention through public service announcements, social media ads and the hospital / clinic education network (Centers for Disease Control and Prevention, 2020).
- Incorporate Yoga Calm curriculum at the Youth Correctional Center (Still Moving Yoga, 2020)
- All elementary schools and preschools participating in the Handle with Care program shall also institute the Yoga Calm curriculum.
- The Nurturing Parenting Program (North Dakota State University , 2023) shall institute Yoga Calm in the curriculum provided in the 16-week program that is designed to increase parenting skills and promote healthy family life. Yoga Calm shall be included in the Nurturing Parenting Program for both children and their caregivers.

- Develop and disseminate new educational materials (posters, brochures, videos, social media ads) about abusive head trauma prevention utilizing the CDC prevention recommendations (CDC, 2022):
    - Understand that infant crying is worse in the first few months of life, but it will get better as the child grows.
    - Try calming a crying baby by rocking gently, swaddling in a blanket, offering a pacifier, holding your baby against your bare skin, singing or talking softly, taking a walk with a stroller, or going for a drive in the car.
    - If the baby won't stop crying, check for signs of illness and call the doctor if you think the child is sick.
    - If you are getting upset, focus on calming yourself down. Put the baby in a safe place and walk away to calm down, checking on the baby every 5 to 10 minutes.
    - Call a friend, relative, neighbor, parent helpline, or your child's healthcare provider for support.
    - Never leave your baby alone with a person who is easily irritated, has a temper, or a history of violence. No matter who takes care of your baby make sure they know that it is okay to call you if they begin to become very frustrated.
    - When you begin to become very frustrated with a baby's crying, it is time to set the infant in a safe place and walk away.

- Engage the ND Youth Advisory Association to collaborate with DHHS and Prevent Child Abuse ND to develop and disseminate new educational materials about preventing abusive head trauma and Baby Safe Haven with a purposed population focus of teenagers and young parents under the age 25.

- Disseminate and display the newly developed abusive head trauma prevention materials at all Human Service Zones, Human Service Centers, birthing hospitals, and video game stores.

- Review current laws and policy regarding child protection services and timely medical evaluations reported to be present during a physical assault (i.e., domestic violence).

- Develop and disseminate a training discussing ACE's, trauma, and the Period of Purple Crying to be delivered to high school students completing a child development / life sciences education course.

- Add the ability for the state's tribal child welfare agencies to add subjects to the North Dakota Child Abuse Information Index when the tribe has confirmed the individual has perpetrated child abuse and/or neglect.

- Develop a parent support line, where parents can connect virtually with experts and other parents with lived experience on matters of child development, parenting, and support.

- Real time data sharing between child welfare, law enforcement, children's advocacy centers and the courts so that each system can access critical information about children and families they are working with in order to provide each system a comprehensive lens to assess and respond to circumstances of child safety and well-being. When a child / family is involved in one system, the other shall receive an alert of the open contact and action taken by each system to facilitate communication and partnership toward the goal of maintaining children safely in their homes (Federal Commission to Eliminate Child Abuse and Neglect Fatalities, 2018).

- Implement Support over Silence a bystander training program that prepares community members, hospital personnel, and other professionals to confidently defuse challenging moments between caregivers and their children in public. Engage faith-based groups, colleges, clinics, Parent Resource Centers, Prevent Child Abuse of ND, retail stores and restaurants as potential training participants (Weaver, 2022)

- Develop a state child fatality intake form that is to be completed by the child welfare agency / worker that first becomes aware of the child fatality and documents the name of the deceased child, surviving children in the home, caretakers and others involved, details the status of current and prior child welfare involvement, provides the known circumstances of the fatality, suspected cause of death, actions taken by child welfare in regards to the fatality, provides law enforcement death investigation contacts, lists pending criminal charge and lists other professionals working with the family. Add child protection policy to include the child fatality intake form and the process and procedures for completing the form and dispersing it to the Child Fatality Review Panel Presiding Officer.

- Increase access to parent-child interaction therapy by increasing providers statewide. (Pecora, 2017)

- Continued education and training to physicians on their ability under the state law to contact child protection services and receive information to assist them in determination of follow up treatment.

- Engage medical child abuse experts to compose an article for the Hospital Association Newsletter or present the topic of child abuse identification specific to TEN-4-FACESp Model (Pierce, 2022), timely notification to CPS and LE and access to the redesigned training at the American Academy of Pediatrics North Dakota Chapter.

- Consolidate nonprofit agencies providing IV-E prevention services with Prevent Child Abuse of North Dakota to create a consortium of child abuse and neglect prevention that would leverage resources and increase capacity towards primary, secondary, and tertiary prevention. Through this partnership and collaboration of resources the one organization would have greater success, by maximizing their efforts towards the common goal of statewide prevention of child maltreatment with a focus on building individual, family, and community protective factors and providing concrete supports, especially when there is a disparity to access of such services, programs and/or concrete needs. The one agency would streamline connections to concrete goods for families so that accessing help does not equate to an inability to provide or parent and so that asking and accessing help does not involve child welfare. In addition, this consolidated trusted organization would provide the state an alternative for addressing intakes of suspected child maltreatment that do not meet the definition of a report, specifically addressing reports of suspected child maltreatment that have been administratively assessed and involve suspected victims under the age of three, whereas these intakes would receive a response from the prevention partner and services and supports could be linked and provided to address the concerns presented to child protection services. (Illuminate Colorado, 2023)

- Modify and supplement the state's mandated reporter training to include a lesson that teaches the training users to check their biases, how to increase protective factors for children and families, links to community resources and supports and provides guidance to reporters on how to connect children and families to resources before a report of suspected child abuse and neglect becomes necessary. This lesson will focus on when to report and when to support and refer; the overall message for reporters is our common societal goal: to end child abuse and neglect and to accomplish the goal we all play a role in supporting parents, caregivers, and children by increasing protective factors and meeting concrete needs so that child maltreatment is prevented from ever occurring.

- Redesign the current interactive web-based mandated reporter training to include vignettes and videos specific to mandated reporter professional roles and includes education and training materials about the TEN-4-FACESp Model for identifying traumatic injuries in young children and the timely notification to child protection services / law enforcement when a child presents with trauma and where child abuse and neglect may be reasonably suspected. (Pierce, 2022)

- All child deaths receive a thorough, quality, and comprehensive investigation of the death scene and circumstances surrounding the child's death; that the state develops and implements a team of regional child death scene investigators for the specialization and standardization of child death investigations and that a standardized statewide protocol be developed for child death investigations, specifically those involving a child/adolescent suicide and firearm deaths. All infant and child death investigations include a videotaped re-enactment and completion of the SUIDIRF (Sudden Unexpected Infant Death Investigation Reporting Form) (Centers for Disease Control and Prevention, 2022).

- That all children who die suddenly and unexpectedly receive an autopsy. All documentation of the child's injuries as well as the scene re-enactment be shared with the forensic pathologist completing the autopsy. Universal alcohol and drug testing for every child fatality; that when children present to medical facilities with severe trauma, admission blood is universally taken for toxicological purposes. Toxicology testing for all caregivers that are suspected of being under the influence when a child dies while under their care and supervision. Mandatory cross reporting / notification of child deaths between medical (ER), law enforcement, coroners / Medical Examiners, and child protection services. (National Center for Fatality Review and Prevention, 2023) All child death investigations shall include a review of the child protection services history. (AAP Council on Injury, Violence, and Poison Prevention, 2022)

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