Child Deaths in Idaho

2017

A Report of Findings by the
Idaho Child Fatality Review Team
www.idcartf.org

Prepared March 2020

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IDAHO CHILD FATALITY REVIEW
2017

This report is a review of child deaths occurring in Idaho, summarizing the state's Child Fatality Review (CFR) process and findings. The Idaho Child Fatality Review Team was established in 2013 following an executive order from Gov. C.L. "Butch" Otter (No. 2012-03). The CFR Team is tasked with performing comprehensive and multidisciplinary reviews of deaths to Idaho children under age 18 in order to identify what information and education may improve the health and safety of Idaho's children.

Idaho's CFR process is in response to the longstanding public concern for the welfare of children, particularly those who are abused or neglected. Efforts to understand the factors that lead to a death may help prevent other injuries or deaths to children in the future. Following national guidelines and best practices, this is accomplished by a collaborative process that incorporates expertise and perspectives of multiple disciplines.

CHILD FATALITY REVIEW TEAM

The statewide CFR Team is established and supported by the Governor's Task Force on Children at Risk (CARTF). The following members were appointed and participated in 2017 reviews:

Tahna Barton, Court Appointed Special Advocates (CASA), CFR Team Chair
Jerrilea Archer, Ada County Sheriff's Office (retired),
Susan Bradford, MD, Pediatrician, Family Medicine Residency of Idaho
Josie Bryan, Program Coordinator, St. Luke's Children's Injury Prevention
Justin Clemons, Fire Fighter/Paramedic, Pocatello Fire Department
Matthew Cox, MD, St. Luke's Medical Center, CARES
Candace Falsetti, Idaho Department of Health and Welfare, Behavioral Health
Alana Minton, JD, Deputy Attorney General, Idaho Department of Health and Welfare,
Dotti Owens, Ada County Coroner
Kris Spain MS, RD, LD, Central District Health, Family and Clinic Services Division Administrator
Kara Stevens, Idaho Department of Health and Welfare, Clinical and Preventive Services
Garth Warren, MD, Ada County Coroner, Forensic Pathologist
Michelle Weir, Idaho Department of Health and Welfare, Child and Family Services
Teresa Abbott, MBA*, Principal Research Analyst, Bureau of Vital Records and Health Statistics, Idaho Department of Health and Welfare *(analytical and reporting support)*
Christine Hahn, MD*, Idaho State Epidemiologist, Medical Director, Idaho Department of Health and Welfare *(subcommittee member)*

**Non-voting members*

ACKNOWLEDGEMENTS

Idaho Department of Health and Welfare (IDHW) serves as the fiscal agent, and provides staff support to the CFR Team utilizing federal Children's Justice Act funding. The CFR Team relies on the support of many state agencies in their efforts to obtain records and review information.

These reviews are made possible because of the cooperation of numerous law enforcement agencies, coroner offices, and medical facilities throughout the state. In particular, the CFR Team would like to express its appreciation to following individuals for providing data support to the team:

Pam Harder, Research Analyst Supervisor, Bureau of Vital Records and Health Statistics, Idaho Department of Health and Welfare

Steve Rich, Principal Research Analyst, Idaho Transportation Department

THE OBJECTIVES OF CHILD FATALITY REVIEW

The National Center for Child Death Review provides resources and guidance to the Idaho CFR process. While multi-agency death review teams now exist in all 50 states and the District of Columbia, there are variations on how the process is implemented. However, all U.S. Child Death Review processes share the following key objectives *(National Center for Child Death Review, Program Manual for Child Death Review, 2005):*

1. Ensure the accurate identification and uniform, consistent reporting of the cause and manner of every child death.
2. Improve communication and linkages among local and state agencies and enhance coordination of efforts.
3. Improve agency responses in the investigation of child deaths.
4. Improve agency responses to protect siblings and other children in the homes of deceased children.
5. Improve delivery of services to children, families, providers and community members.
6. Identify specific barrier and system issues involved in the deaths of children.
7. Identify significant risk factors and trends in child deaths.
8. Identify and advocate for needed changes for policy and practices and expanded efforts in child health and safety to prevent child deaths.
9. Increase public awareness and advocacy for the issues that affect the health and safety of children.

The team's focus is to seek out common links or circumstances that may be addressed to avert future tragedies.

METHODOLOGY

Deaths of children under the age of 18 years which occurred in Idaho during calendar year 2017 were reviewed. Deaths occurring out of state were not reviewed since pertinent records are not available for the team's use.

The designated CFR research analyst within Idaho Department of Health and Welfare's Bureau of Vital Records and Health Statistics identified the deaths using the Vital Records system and retrieved death certificates. A subcommittee met separately from review team meetings to screen the list of deaths by cause and identify possibly preventable deaths for further review. The subcommittee selected a death for further review when it met one or more of the following criteria:

- Death was due to an external cause
- Death was unexplained
- Death was due to a cause with identified risk factors

The subcommittee next identified what additional information was necessary for a comprehensive review. The CFR research analyst then requested information from the appropriate agency. The information may include:

- Death certificates
- Birth certificates (full form)
- Autopsy reports
- Coroner reports
- Law enforcement reports
- Transportation Department crash and injury reports
- National Transportation Safety Board reports
- Medical records
- Emergency medical systems records
- Child protection records

Although the team attempted to obtain all relevant records from the various agencies, the team does not have subpoena power and could not always obtain confidential records. Agencies are cooperative and responsive to information requests, overall. Agreements are now in place with

some Idaho hospitals to provide medical records to the team, while adhering to specific practices to safeguard patient privacy in compliance with Health Insurance Portability and Accountability Act (HIPAA). However, in the absence of subpoena power or statutory authority, the team continued to face barriers due to the inability to obtain certain records.

The challenges include:

- Incomplete or missing records such as coroner reports or law enforcement incident reports (not available, redacted, or refused on the basis of privacy concerns)
- Missing academic and behavioral records from schools, due to cited restrictions under the Family Educational Rights and Privacy Act (FERPA)

Of 187 child deaths occurring in Idaho in 2017, 99 were selected for detailed review by the CFR Team. Deaths that were *not* selected for full CFR Team review included most deaths due to congenital anomalies, malignancies or other diagnosed medical conditions.

2017 Deaths to Children (Birth to Age 18) Occurring in Idaho

	Total	Screened by CFR Subcommittee	Reviewed by CFR Team
Perinatal Conditions	37	37	14
Congenital Malformations	33	33	0
Unintentional Injuries (Accidents)	47	47	47
Suicide	20	20	20
Unexplained Infant Death*	9	9	9
Assault (Homicide)	7	7	5**
Malignancies	6	6	0
Flu/Pneumonia	0	0	0
Non-ranking/All Other Causes	28	28	4***
	187	**187**	**99**

**Includes Sudden Unexplained Infant Death (SUID) as well as "ill-defined" undetermined causes of infant death*
***2 homicide cases were pending court proceedings, so reviews were deferred*
****2 injury deaths of undetermined manner were reviewed and summarized with homicides; 2 non-ranking cause deaths were reviewed with natural manner deaths.*

The CFR Team met five times between April 2019 and November 2019 to conduct case reviews. Risk factors, systems issues, and recommended actions were identified for each case and were summarized by cause of death. If the team determined that additional records were needed to complete a thorough review for a specific case, that review was revisited at a later meeting using newly obtained information.

Information gathered from various sources and team conclusions were entered into the National Child Death Review Case Reporting System by the CFR analyst. A data use agreement between the Michigan Public Health Institute and the Idaho Department of Health and Welfare establishes the terms and conditions for the collection, storage and use of data entered into the case reporting system. Summary statistics from the case reporting system are used throughout this report.

LIMITATIONS

Records relevant to the circumstances leading to deaths are retained by multiple agencies and are often carefully guarded as sensitive and confidential information. Idaho's CFR Team does not have subpoena power and consequently, some information required for a thorough review was not released.

The CFR Team is aware that for the purposes of seeking medical treatment, some deaths to Idaho residents occur out-of-state following an illness or injury that initiated within the state of Idaho. While the team makes every effort to consult with CFR coordinators and agencies in neighboring states to obtain complete information, it acknowledges the limitation of that approach in identifying all relevant cases and supporting information.

Calculation of rates is not appropriate with Idaho's CFR data because not all child deaths are reviewed. Instead of rates, CFR statistics have been reported as a proportion of the total reviews. Sample sizes are often small which result in unstable results. Please use caution in interpreting changes over time or comparing demographic subgroups.

DATA NOTES

In addition to data based on the child deaths reviewed by the CFR Team, this report includes Idaho and U.S. mortality data from the Vital Statistics System. Mortality data is presented as a way of understanding all child deaths to Idaho residents and their relationship to the subset of deaths selected for CFR Team review. Mortality data is based on all Idaho residents (regardless of where the incident occurred or where the child actually died) and CFR data is based on deaths occurring in Idaho. Mortality data may be based on aggregated years to provide larger population sizes, allowing for more stable analysis. Therefore, these data sources are not comparable.

Idaho Vital Statistics mortality trend data are from the Idaho death certificates and out-of-state death records for Idaho residents. Numbers of deaths by cause and rates are from the Bureau of Vital Records and Health Statistics, Idaho Department of Health and Welfare. National rates are from the National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention (CDC).

EXECUTIVE SUMMARY

The Idaho Child Fatality Review (CFR) Team presents its annual report on child deaths occurring in Idaho in 2017. The team was formed by the Governor's Task Force on Children at Risk (CARTF), under Executive Order 2012-03 to review deaths to children under the age of 18, using a comprehensive and multidisciplinary process. The team is tasked with identifying information and education that is needed to improve the health and safety of Idaho's children. Their goal is to identify common links or circumstances in these deaths that may be addressed to prevent similar tragedies in the future.

The team reviewed deaths to children under the age of 18 which occurred in Idaho during calendar year 2017. Deaths were identified, and manner and cause of death were categorized using the Vital Records system. The team utilized information already gathered by coroners, law enforcement, medical providers, and state government agencies in their reviews.

Although the team attempted to obtain all relevant records from the various agencies, it does not have subpoena power and could not always obtain confidential records. Challenges include incomplete, redacted or missing records, with some agencies citing privacy concerns. Schools cited Family Education Rights and Privacy Act (FERPA) restrictions in denying record requests.

SUMMARY OF FINDINGS

Sudden Unexplained Infant Death

Sudden Unexpected Infant Death (SUID) is the sudden death of an infant under one year of age, which remains unexplained after a comprehensive investigation. In 2017, there were 8 SUID cases occurring in Idaho. Additionally, the team reviewed 1 infant death of "undetermined" cause plus 4 infant deaths caused by accidents in the sleeping environment.

Unsafe sleep environment (e.g. on adult sized mattresses, thick bedding, couches, car seats), improper sleeping position (not on back), and/or co-sleeping were commonly seen risk factors in these infant deaths. Many of the SUID deaths occurred in families with a history of CPS referrals. Hazardous or extremely unsanitary home conditions were frequently noted. Continued promotion of American Academy of Pediatrics (AAP) safe sleep guidelines, scheduled immunizations, and breastfeeding is recommended. Additional investments in family support services such as home visiting programs (with awareness of intergenerational maltreatment patterns), mental health resources, and infant CPR training may support at risk families and prevent infant deaths.

Motor Vehicle Accidents

In 2017, 24 children died in motor vehicle accidents. Several of the victims were teenagers and most were male. Excess speed, impairment, failure to maintain lane and failure to stop/yield were top contributing causes. Driver error was found to be a factor in all the traffic accidents involving a teen driver.

The team noted that most of the 2017 motor vehicle accident fatalities occurred on Idaho's rural roads. Lack of proper safety restraint usage (seat belt or safety seat) continues to be a major modifiable risk factor. Ongoing public reminders of safe driving practices along with expanded access to driver's training are recommended actions for preventing motor vehicle fatalities.

Drowning

There were 11 drowning deaths in 2017. About half were toddlers or preschoolers who accidentally entered or slipped into the water. Drowning deaths to older children and teens typically occurred while swimming in a lake or pond.

Inadequate supervision was a risk factor in most drowning accidents. Parents should remain alert and nearby while children or teens are playing in or around the water. Public

education campaigns encouraging the use of U.S. Coast Guard approved personal floatation devices (PFDs) and safety barriers to prevent access to open water or pools may prevent drowning deaths. Children of all ages may benefit from swimming lessons and water safety courses.

Accidental Shootings/Firearms

One Idaho child died as the result of an accidental shooting in 2017. Unsecured gun storage and inadequate safety training were identified as common factors in firearm deaths.

Public health messaging should include reminders of responsible gun ownership and safe handling practices. Improved coordination between agencies (notably, CPS and law enforcement) may help identify unsafe situations in homes so they can be properly addressed.

Fire and Carbon Monoxide Inhalation

In 2017, 4 children died in a structure fire or from carbon monoxide poisoning. Risk factors included missing smoke or carbon monoxide detectors, and improper use or maintenance of heaters or other household appliances.

Smoke and carbon monoxide alarms should be installed in homes near sleeping areas. Batteries should be routinely checked and replaced. Families are encouraged to plan an escape route and have fire extinguishers accessible in the home. To prevent carbon monoxide poisoning, fireplaces and chimneys should be checked and cleaned at the start of each winter season. Cooking and heating appliances should be used as directed by manufacturers.

Overdose

There were 2 child deaths caused by accidental overdose of an illicit drug or prescribed medication. Nationally, drug overdose deaths have increased steadily since 1999 and most are related to opioid abuse.

Recommended actions for reducing overdose include improving prescribing practices, promoting drug monitoring programs, and expanding access to substance abuse treatment. Medications should be stored out of reach of children and teens. Unused medications should be disposed of in a safe location.

Suicides

The team reviewed Idaho's 20 youth suicides occurring in 2017. Those who died by suicide were predominantly male and ranged in age from 13 to 17, with most in their late teen years. Firearms were the most common method used, following by hanging. Access to a weapon, past suicidal ideation/attempts, and relationship turmoil were the most commonly observed precursors.

IDHW's Office of Suicide Prevention provides resources for recognizing the warning signs and supporting those at risk for suicide. They stress that warning signs are almost always present, and conditions are treatable. Proposed approaches to reducing suicide include gun safety education and expanded access to mental health treatment (particularly in rural communities). Families, educators and community organizations are encouraged to strengthen protective factors like strong social connections, conflict resolution skills, and cultural/religious beliefs which support self-preservation.

Homicides

The team reviewed 7 child deaths which were the result of homicide or suspected homicide. Causes included firearm shootings, blunt force head injury, and hyperthermia. The victims ranged from infants to teens. All of the intentionally inflicted deaths were at the hand of a parent or adult caretaker.

Substance abuse, mental health issues, criminal history and recent divorce were among the risk factors noted. Many of the violent incidents occurred in families with a history of CPS involvement and/or intergenerational maltreatment. The number of deaths involving a parent with reported mental health concerns suggests a need for greater access to mental health resources. Those who work with children should be familiar with the signs of abusive behavior and injuries and readily report concerns. Interagency cooperation can help ensure families receive the support they need.

Preventable Natural Manner Deaths

Perinatal conditions

As part of an effort to identify preventable risk factors in newborn infant deaths, the team reviewed 14 perinatal condition deaths.

Nearly all perinatal condition deaths were related to low birth weight and/or prematurity. Lack of prenatal care, maternal smoking, illicit drug use, and home births were repeatedly observed as modifiable risk factors. Women are encouraged to seek

prenatal care early in pregnancy to diagnose any health conditions and for support in modifying behaviors that could impact their own and their infant's health. Mothers who choose home birth, especially those with high risk pregnancies, should be aware of the benefits of delivering in a medical facility in case of birth complications. To help the team better understand the factors involved in perinatal condition deaths, physicians, midwives and other certifiers of state death records are requested to consistently provide details related to labor and delivery along with the mother's prenatal history.

Refusal of medical treatment due to religious or personal beliefs

The CFR Team found that 3 infant deaths in 2017 occurred in families that refused or delayed medical care/treatment because of religious or personal beliefs.

The team determined that these deaths might have been prevented with timely medical treatment, compliance with scheduled vaccinations and/or proper prenatal care for the mother.

Other natural manner deaths

Non-ranking deaths include natural manner deaths that are not categorized elsewhere. These deaths were due to varied causes or related to underlying medical conditions. Causes included septicemia, cerebral palsy, epilepsy, gastroenteritis and metabolic disorders.

None of the 2017 deaths were related to the influenza virus. However, proper hygiene and scheduled vaccinations (including an annual flu shot) can prevent the spread of infections and are especially important for medically vulnerable children.

Key Recommendations for Preventing Child Deaths in Idaho

- **Call 9-1-1 immediately at first sign of distress**

  In a medical emergency, seconds count and first responders are trained to save lives. When severe injury or illness occurs, react quickly. Call 9-1-1 first and avoid self-transporting children to hospital.

- **Expand access to mental health services**

  Some child deaths are linked to mental health concerns of the parent, caretaker, or the child. Improving access to high quality treatment and reducing social stigma of seeking care may help prevent suicide and homicide deaths as well as accidental deaths resulting from inadequate child supervision.

- **Invest in underserved populations in rural communities**

  Improve access to medical treatment facilities, EMS/first responder services and public health education in geographically isolated regions. Rural families may benefit from community-based primary prevention programs and services with targeted messaging on topics like parenting/infant care, suicide prevention, early childhood education, and safe driving habits.

- **Expand home visiting programs**

  Home visiting programs have proven successful at helping families create nurturing, healthy households. Programs like those offered through the Division of Public Health, local public health agencies, and non-profits offer referrals for resources like infant and childcare, home safety planning. nutritional support, CPR training, housing assistance, and referrals for help with substance abuse or mental health concerns.

- **Follow infant safe sleep practices**

  Unsafe sleep environment is closely associated with sudden unexplained infant death. Parents and caretakers should be made aware of and comply with AAP's safe sleep recommendations related to sleep surface (in infants' own cribs, uncluttered with toys or thick bedding) and sleeping position (on their backs).

- **Use seat belts or age-appropriate safety seats**

  Using lap and shoulder seat belts or properly installed infant safety seats or booster seats prevents severe injury and death in motor vehicle accidents.

- **Follow safe gun handling practices**

  Store ammunition and firearms separately, in a secure location. Keep weapons, keys and passcodes away from young children and those with a history of mental health concerns.

- **Store medications safely**

  Securely store medications and other toxic substances out of children's reach. Use child safe containers for prescription and OTC drugs. Safely dispose of unused prescription medications.

- **Improve prescribing practices**

  Health providers should follow CDC's recommendations for reducing abuse of opioids and other prescription medications.

- **Facilitate interagency cooperation**

  Law enforcement officers, medical providers, coroners, social workers and public health officials are encouraged to work together to support at-risk families as well as in investigating child welfare concerns. Those who work with children should be familiar with the state's mandatory reporting requirements (*Idaho Statute 16-1605*) and report concerns to Idaho Department of Health and Welfare.

RECENT ACTIONS AND COLLABORATIVE EFFORTS

Advancing Child Health and Safety in Idaho

- **Child Death Investigation Training.** In early 2019, CARTF funded Child Death Investigation training for all county coroners in Idaho, citing findings and recommendations from the CFR Team. Investigation tools including SUID dolls for re-enactments were provided to all participants.

- **Adverse Childhood Experience's (ACEs) Screening.** Adverse Childhood Experiences, also known as ACEs, are stressful or traumatic events that occur during childhood and have been linked with negative, long-term effects on health and well-being. IDHW's Maternal and Child Health (MCH) Program partnered with St. Luke's to offer a quality improvement project to Idaho primary care providers in support of ACE score screenings for parents of infants and young children. Resources are provided to parents as a prevention tool to break the cycle of intergenerational toxic stress and trauma and to build resiliency. In 2019, the ACEs and Resiliency Learning Collaborative had 45 providers at 20 sites in 12 cities participating across Idaho. In 2020, the goal is to increase perinatal provider enrollment.

- **Safe Sleep Initiatives.** Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program is partnering with the MCH Program to complete a statewide continuous quality improvement (CQI) project, aimed at improving safe sleep rates for infants enrolled in MIECHV-funded programs. The project will provide safe sleep education and training for home visitors throughout the state. The MCH Program also provides safe sleep resources for families, including swaddle sacks, sleep sacks, cribs, safe sleep pledges, and brochures. During 2020, MIECHV will track the percentage of infants under one year old enrolled in home visiting who always comply with safe sleep recommendations. Additionally, Idaho MIECHV will measure and track changes in family knowledge before and after safe sleep education.

- **Safe Sleep Message Campaign.** During Safe Sleep Awareness Month in 2019, the MCH Program ran a Safe Sleep social media campaign which included an animated 15 second PSA, with the messaging *"Alone. Back. Crib. Every Nap. Every Night"*. The Program also created an educational brochure and re-designed the IDHW website to

include information for parents, caregivers, childcare providers, and health care providers. In addition, the Program sponsored the *"**A**lone, **B**ack, **C**rib Guy"* walking tour to raise safe sleep awareness. Ada County Paramedics hosted the tour and provided swaddle sacks.

- **New Funding for Home Visiting Programs.** The Idaho State Legislature appropriated $1.6 million to support home visiting program expansion. The seven health districts expanded home visiting programs using the *Parents as Teachers* evidence-based program while one district launched an Infant and Early Childhood Mental Health home visiting program. Research demonstrates that evidence-based home visiting programs prevent child abuse and neglect, encourage positive parenting practices, promote child development and school readiness, improve the health of families and their children, and improve families' economic self-sufficiency. Home visiting is also a proven strategy for addressing ACEs and building resiliency within a family.

- **Maternal Mortality Review Committee.** In 2019, the Idaho legislature passed a bill to create a Maternal Mortality Review Committee (MMRC) in Idaho. The goals of the MMRC are to perform a multidisciplinary review of pregnancy-related and pregnancy associated deaths to identify trends and risk factors, provide recommendations to guide preventive measures and strategies, and disseminate the findings and recommendations to individuals and organizations. The goal of the MMRC is to learn from and prevent future maternal deaths. The first review will be held in March 2020 and an annual report will be provided to the legislature.

- **Idaho Suicide Prevention Program**. Reducing death by suicide of Idaho youth and young adults has continued to be a high priority for the IDHW Division of Public Health during 2019. IDHW provides funding and support to the State Board of Education through the Idaho Lives Project to implement prevention, intervention and postvention to schools across the state. Regional Coordinators work closely with individual schools to implement suicide safer school policies and practices. The Regional Coordinators currently support up to thirty schools to develop and implement a plan to conduct suicide prevention trainings.

POPULATION

The total population of Idaho in 2017 was estimated at 1,716,943. Of that number, 443,792 (about 26%) were children under the age of 18. Hispanics represented just over 18% of the state's child population.

Population	Number	Percent
Idaho total	1,716,943	100%
Age 0-17	**443,792**	**25.8%**
Residents, age 0-17 by sex		
Males	226,557	51.1%
Females	217,235	48.9%
Residents age 0-17 by race		
White	414,582	93.4%
Black	8,720	2.0%
American Indian or Alaska Native	11,520	2.6%
Asian/Hawaiian/Pacific Islander	8,970	2.0%
*Residents age 0-17 by ethnicity**		
Hispanic	81,429	18.3%
Non-Hispanic	362,363	81.7%

* Race and Hispanic origin are reported separately. Persons of Hispanic origin are included in approximate race totals.

Source: Census Bureau in collaboration with the National Center for Health Statistics.
Internet release date: June 27, 2018

OVERVIEW

Idaho Mortality Data, Three-Year Aggregate (2016-2018)

As a framework for understanding single year death reviews, Idaho mortality data analyzed over longer periods provide insight to the major causes of child death and may highlight vulnerable demographic groups.

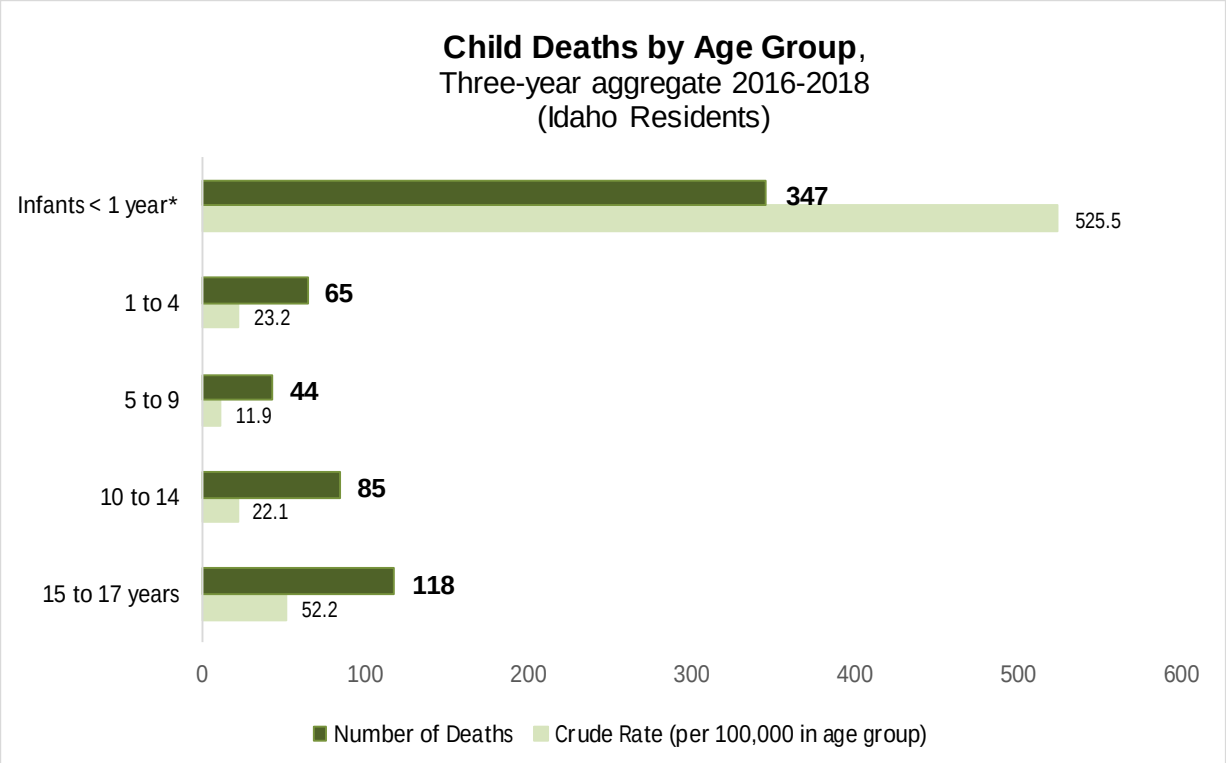
The number and cause of death to Idaho children varied by age group. There was a total of 659 deaths to infants and children (under age 18) between 2016 and 2018. Infants (under 1 year of age) have a much higher death rate than older children, comprising more than half of these deaths (347). Common causes of infant deaths were birth defects and conditions originating in

the perinatal period such as short gestation/low birth weight, maternal conditions, and complications during birth. Those in their late teen years (15 to 17) have a higher death rate than younger (non-infant) children. The leading cause of death to teens is unintentional injury (accidents) followed by suicide.

Leading Causes of Death to Idaho Child Residents, Three-year aggregate, 2016-2018

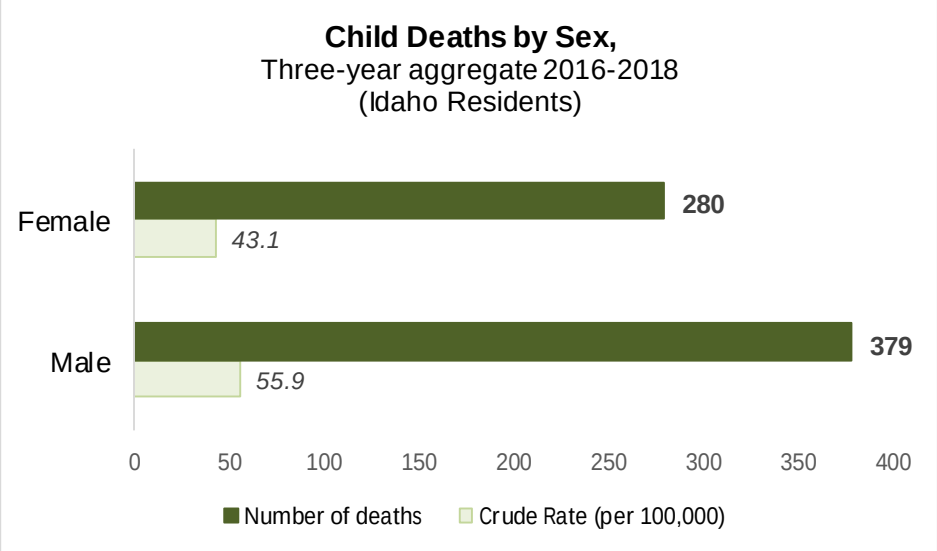
Rank	***Infants (under 1 year of age)***
1	Congenital malformations/chromosomal abnormalities (birth defects) (91)
2	Short gestation/low birth weight (34)
3	Maternal complications of pregnancy (31)
4	Sudden unexpected infant death (30)
5	Complications of placenta, cord, membranes (19)
6	Accidents (15)
7	Hydrops fetalis not due to hemolytic disease (9)
8	***Tie:*** Neonatal hemorrhage (7) *and*
	Respiratory distress (7)
9	***Tie:*** Diseases of the circulatory system (6)
10	Necrotizing enterocolitis of newborn (6)
	All other causes (92)

Rank	***Children (Age 1-17 years)***
1	Accidents (123)
2	Intentional Self-Harm (Suicide) (62)
3	Malignant Neoplasms (26)
4	Congenital Malformations (birth defects) (22)
5	Assault (Homicide) (14)
6	Diseases of Heart (13)
	All other causes (52)

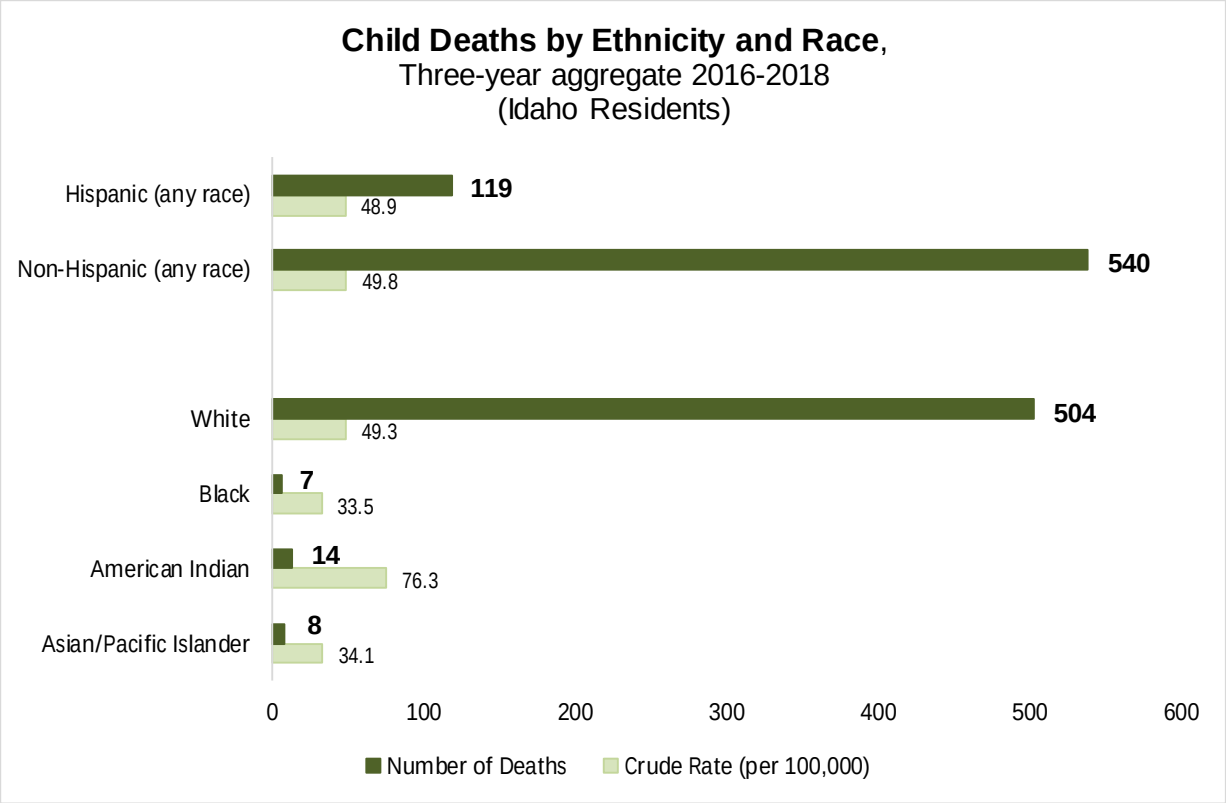


* Rate for infants under the age of 1 year is based on 100,000 live births

The death rate for male children (55.9 per 100,000) was significantly higher than for female children (43.1). While this was consistent across age groups, the difference was most pronounced among teens. Males aged 15 to 17 had a death rate nearly 3 times that of females in the same age group (a crude rate 75.3 for males compared with 28.0 for females).



Overall, children of Hispanic origin had a death rate comparable to that of non-Hispanics. While the rate for American Indians (76.3 deaths per 100,000) appears to be higher than for other races, the small number of recorded deaths (14 over three years) makes it difficult to draw firm conclusions. Although none of the differences between race categories are statistically significant, it suggests a topic for further study over a longer period.



Rates based on 20 or fewer deaths may be unstable. Use with caution.

Race and Hispanic origin are separate questions on death certificates. Hispanics are also included in race figures.

SUDDEN UNEXPLAINED INFANT DEATH

Sudden Unexpected Infant Death (SUID) is the sudden death of an infant under one year of age, which remains unexplained after a comprehensive investigation. Though a direct cause is not known, most of these deaths occur while the infant is in an unsafe sleeping environment (www.cdc.gov/sids/AboutSUIDandSIDS.htm).

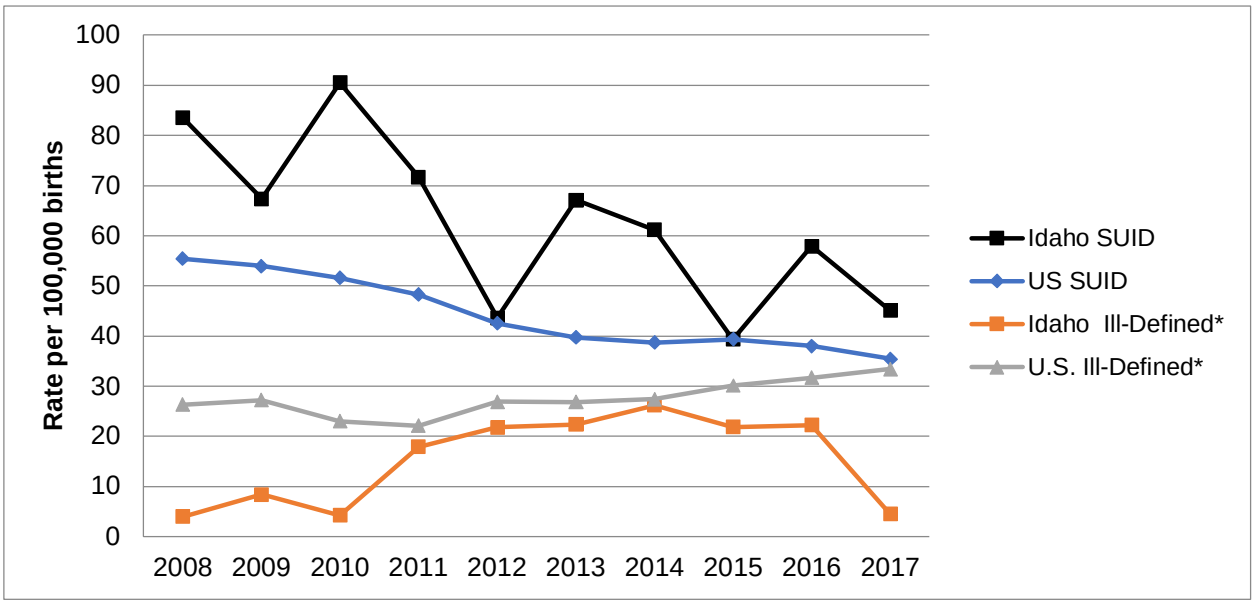
Infant deaths not meeting the CDC's definition of "SUID" (see above) may be reported as "other ill-defined and unknown causes of mortality." Historically, the SUID death rate has been higher for Idaho than for the U.S. overall while the rate of ill-defined infant deaths has been lower. The total combined number of Idaho SUID plus ill-defined infant deaths dropped to a decade low (11) in 2017. Although the single year change in the SUID rate is not statistically significant, the CFR Team expects ongoing improved practices throughout the state following recently updated coroner training which is focused on thorough investigation techniques and consistent coding.

Idaho and U.S. Resident SUID Deaths (< age 1 year)
and Rates per 100,000 Births, 2008-2017

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Total Number Idaho Resident SUID deaths	**21**	**16**	**21**	**16**	**10**	**15**	**14**	**9**	**13**	**10**
Idaho Resident SUID death rate	83.5	67.4	90.5	71.7	43.6	67.1	61.2	39.4	57.9	45.1
U.S. Resident SUID death rate	55.4	53.9	51.6	48.3	42.5	39.7	38.7	39.4	38.0	35.4

Idaho and U.S. Resident Ill-Defined Infant Deaths (< age 1 year)
and Rates per 100,000 Births, 2008-2017

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Total Number Idaho Resident Ill-defined infant deaths	**1**	**2**	**1**	**4**	**5**	**5**	**6**	**5**	**5**	**1**
Idaho Resident Ill-defined death rate	4.0	8.4	4.3	17.9	21.8	22.4	26.2	21.9	22.3	4.5
U.S. Resident Ill-defined* death rate	26.3	27.2	23.0	22.1	26.9	26.8	27.4	30.1	31.7	33.4



*All other ill-defined and unknown causes of mortality: ICD-10 codes: R96-R99.
SUID deaths are shown mutually exclusive in the tables and graph: ICD-10 code R95.

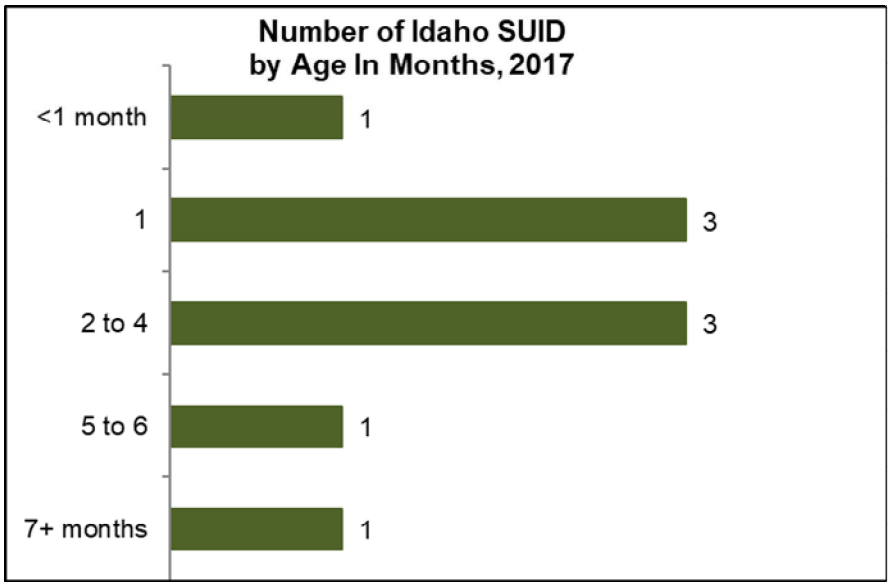
Source: *Bureau of Vital Records and Health Statistics, Idaho Department of Health and Welfare*

Rates based on 20 or fewer deaths may be unstable. Use with caution.

Idaho CFR Team Findings: Unexplained Infant Death

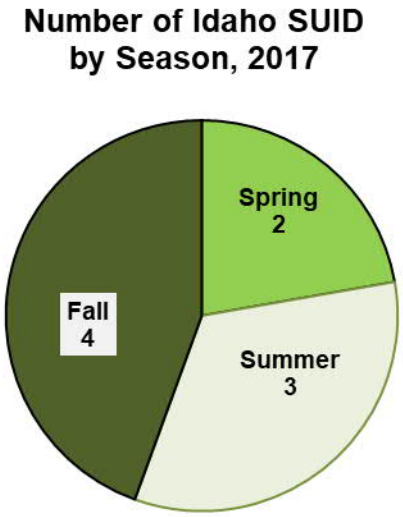
In 2017, there were 10 Idaho resident deaths with an immediate cause of "Sudden Unexplained Infant Death (SUID)," "Sudden Unexplained Death in Infancy," OR "Sudden Infant Death Syndrome (SIDS)." Deaths listed with any of these immediate causes are collectively referred to as "SUID" in this report. Of these, 8 of the SUID cases occurred in Idaho and were reviewed by the CFR Team. Because of their common circumstances, the CFR reviewed SUID cases along with 1 additional infant death classified as "undetermined" cause (for a total of 9 SUID/undetermined infant deaths).

According to the American Academy of Pediatrics (AAP), most SUID events in the U.S. occur when a baby is between two and four months old, and during the winter months. In 2017, most Idaho unexplained infant deaths occurred between 1 and 4 months of age.



[Based on 9 SUID/Undetermined cause cases]

While no obvious relationship was observed between the rate of Idaho SUID and seasonality, the 2017 deaths occurred most often in the fall and there were none in the winter months.



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[Based on 9 SUID/Undetermined cause cases]

Racial and ethnic disparities are best understood by examining data collected over several years (*see "Child Deaths by Ethnicity and Race," page 20*). Notably however, the team observed that 6 of the 9 infants who died of SUID in 2017 were of Hispanic origin. All of the infants' birth mothers were U.S. born (non-immigrants). No other racial or ethnic disparities were noted.

Systems Issues

Inadequate or Inconsistent Agency Cooperation

The team found multiple instances in which law enforcement and/or coroner agencies did not notify child protective services of an infant death, despite other children living in the home. There were also cases where information sharing and cooperation between agencies might have prompted legal or child protective service (CPS) intervention for family support and/or child protection measures.

Further, there were cases where police, coroners, and IDHW case workers separately investigated issues of concern, possibly duplicating efforts and/or missing relevant information. The team found opportunities for agencies to combine efforts in investigating infant deaths. This

extra step may be especially valuable in cases where the infant's medical and social history is limited.

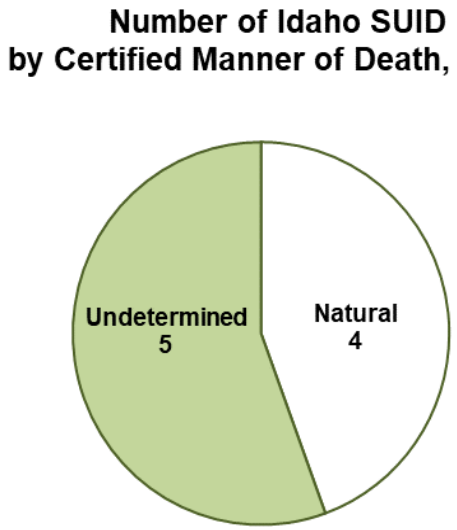
Infant Death Investigations

SUID is a diagnosis of exclusion to be made only if there is no other possible cause of death. A comprehensive investigation for unexplained infant deaths includes an autopsy, scene investigation, as well as social and health history. The CFR Team noted marked improvement in following CDC and state guidelines related to investigating and coding unexplained infant deaths. Updated statewide coroner trainings encourage the use of CDC's Sudden Unexplained Infant Death Investigation Reporting Form (SUIDIRF) and emphasize the importance of completing autopsies to rule out all possible causes of death. While most agencies apparently use such resources to guide and inform investigations, the CFR Team still found SUID cases that were not thoroughly investigated (e.g. no autopsy conducted, no doll reenactment, missing social history, no caretaker toxicology testing).

Death Certificate Completion

The IDHW Bureau of Vital Records and Health Statistics provides guidelines for completing and certifying death certificates. Both *cause* and *manner* of death are documented on the death certificate by a coroner or physician following established guidelines. According to the Idaho guidelines, cause of death is "a simple description of the sequence or process leading to death." Manner of death (natural, accident, suicide, homicide, or could not be determined) provides a broader classification for each death and should agree with the cause noted on the death certificate. In 4 of the 9 SUID cases, the manner of death was certified as "natural" which does not agree with the definition of "Sudden Unexplained Infant Death" as a cause.

There are also fields on the death certificate which allow for additional information such as "contributing circumstances" and "injury description." Including *all* potentially relevant information on these fields such as existing medical conditions, toxicology results, and sleep environment may lead to a better understanding and prevention of additional infant deaths.



[Based on 9 SUID/Undetermined cause cases]

Resource Constraints

Coroner and law enforcement agencies face challenges of a growing state population, resulting in higher caseloads. Additional resource allocation may be needed to support proper investigations and complete documentation.

Parent and Caretaker Education

The CFR Team noted opportunities for expanding access to parent and caretaker education in hospitals and clinics related to infant and child care. Promoting knowledge of safe-sleep environment, feeding, hygiene, and infant CPR and may help prevent additional infant deaths.

Common Factors and Associations

The CFR Team observed the following factors among the 2017 Idaho SUID and infant deaths of undetermined cause (ranked by frequency with number of instances in parenthesis):

1. Unsafe sleep environment/sleep surface (6)
    - Improper sleep surface/thick bedding (5)

   Intergenerational neglect/Parents' CPS history (6)
2. Co-sleeping-general (5)
    - With obese adult (3)

   CPS referrals related to infant (5)

Parent history of substance abuse (5)
Smoking, prenatal or in home (5)

3. Unsanitary/hazardous home conditions (4)
   Prematurity (4)
   Delayed 911 call (4)
4. Improper sleep position, not on back (3)
   Lack of adequate prenatal care (3)
5. Propped bottle while sleeping (2)
   Formula fed from birth/never breastfed (2)
   Mental health history of parent (2)
   Self-transport to ER (2)

[Based on 9 SUID/undetermined infant deaths]

Unsafe sleep environment and/or co-sleeping with adults was noted in the great majority of these unexplained infant deaths. Examples of improper sleep environment included adult sized mattresses, couches, and car seats. Car seats are to be used for safe transportation of infants and should not be used as an alternative to a crib or bassinet. Infants should sleep alone, on their backs on a firm, flat surface with no soft bedding. Unsafe surfaces for infants include those with soft mattresses, thick bedding and pillows, or cluttered with toys and other objects. Co-sleeping with an adult was separately observed in more than half of these incidents. The team also found instances in which the infant was sleeping with an adult who met the clinical definition of obesity (having a Body Mass Index of 30 or above). In national studies, parent obesity has been identified as a risk factor in co-sleeping infant deaths.

The CFR Team found that many of the SUID deaths occurred in families with a history of CPS referrals. This included cases in which the parents had reportedly experienced neglect or abuse during their own childhoods, resulting in a cycle of intergenerational maltreatment (IGM) or neglect. In such cases, unstable, hazardous or unsanitary home environments were frequently observed. "Unstable" home environments include those without a consistent adult caretaker or with a parent with a criminal history, mental health issues, and/or substance abuse. Examples of "hazardous/unsanitary homes" included those with floors or other surfaces strewn with uncontained food waste, soiled diapers, pet feces, cigarette butts, and/or illicit drugs and paraphernalia within harm's reach. In some cases, beds and cribs were cluttered with toys, clothing or other household items to the point that they were not usable for sleep. Such

conditions may or may not meet the legal standard of child neglect but documenting health and safety hazards may help identify families with a need for additional support.

Prenatal smoking (as self-reported by mothers and recorded on birth certificates) and smoking or vaping in or around the home (mentioned in law enforcement reports) were frequently noted in these SUID cases (5 of 9 deaths) and may be underreported. A similar number of cases involved a parent with a known history of substance abuse, although the parent's level of impairment at the time of the event was usually unknown. Nearly every case of SUID in 2017 involved a combination of risk factors such as unsafe sleep environment, tobacco smoke exposure, improper feeding (such as propping a bottle in bed or falling asleep with infant in bed following breastfeeding), and/or hazardous home environment.

Accidents in the Sleeping Environment

The CFR Team also reviewed 4 infant deaths with a manner of "accident." In these cases, coroner and law enforcement investigations determined that the deaths were linked to hazards in the sleep environment. Similar factors to those seen in SUID were observed in these cases--most notably, co-sleeping or other unsafe sleep environments, prenatal smoking, drug exposure, and unstable home environment.

Recommended Actions for Understanding and Preventing SUID

American Academy of Pediatrics (AAP) safe sleep guidelines for infants up to 1 year of age emphasize the importance of placing infants to sleep on their backs, in their own uncluttered crib or bassinet, routine immunization, and avoidance of tobacco smoke exposure (www.aappublications.org/news/2016/10/24/SIDS102416).

Infants should be immunized in accordance with AAP and Centers for Disease Control and Prevention recommendations. Recent evidence suggests that vaccinations may have a protective effect against SUID (http://pediatrics.aappublications.org/content/138/5/e20162938).

AAP research found that just two months of breastfeeding, even when combined with bottle feeding formula, provides the same benefit as exclusive breastfeeding. Babies receive immune benefits from breastfeeding which can reduce their risk of a viral infection. Other properties of breastmilk may also reduce risk of sudden infant death through their influence on brain development (www.aappublications.org/news/2017/10/30/BreastfeedingSIDS103017).

While research on the topic of intergenerational maltreatment (IGM) is limited and patterns are complex, some studies have found an association between a parent's experience of childhood maltreatment and the maltreatment experienced by his or her own children. The same studies emphasize that not *all* parents who experience childhood maltreatment will perpetrate child abuse or neglect (www.childwelfare.gov/pubs/issue-briefs/intergenerational/) and warn caseworkers not to generalize risk factors in predicting which parents will maltreat their children. Still, understanding the factors involved in IGM may help identify effective prevention strategies. The current body of research suggests that some significant factors might include the quality of parenting and attachment, substance use, intimate partner violence, trauma symptoms, and financial stressors. The presence of nurturing adult relationships and social support have been identified as protective factors in preventing child abuse and neglect. Along with staying abreast of new findings related to IGM, the CFR Team suggests continued investments in parent and childcare provider education programs which have helped reduce child maltreatment in the general population. Family support services such as home visiting programs and infant CPR training are also encouraged.

The CFR Team recommends blood alcohol and/or drug testing of parents or caretakers as a routine part of infant death investigations to better understand the role of alcohol or drug impairment in SUID cases.

Improved communication between agencies (CPS, law enforcement, healthcare providers and/or child care providers) and understanding of mandatory reporting requirements could prevent additional tragedies. Idaho Statute 16-1605 states:

> *"Any physician, resident on a hospital staff, intern, nurse, coroner, school teacher, day care personnel, social worker, or other person having reason to believe that a child under the age of eighteen (18) years has been abused, abandoned or neglected or who observes the child being subjected to conditions or circumstances which would reasonably result in abuse, abandonment or neglect shall report or cause to be reported within twenty-four (24) hours such conditions or circumstances to the proper law enforcement agency or the department."*

Health or safety concerns can be reported to law enforcement or to the Idaho Department of Health and Welfare by calling **2-1-1** so that issues can be properly investigated and potentially addressed.

The team has noted continued improvements in utilizing the Sudden Unexplained Infant Death Investigation Reporting Form (SUIDIRF) as part of thorough infant death investigations in Idaho. They urge investigators to use all available resources in ruling out other possible causes of death and identifying potential risk factors in infant deaths. The CDC makes a standard SUIDI reporting form available and some local agencies have developed their own simplified versions.

For Coroners

As a way of better understanding the circumstances involved in unexplained infant deaths, the CFR Team identified opportunities for continued coroner training on the following topics:

- Guidelines for coding and detailing findings on death certificates
- SUID Investigation (use of standardized forms like CDC's SUIDIRF, autopsies, doll re-enactments, toxicology, etc.)
- Inter-agency collaboration

Most unexplained infant deaths in Idaho appeared to be thoroughly investigated and included scene re-enactments, autopsies and/or review of medical history. However, as seen in past years, there were several instances in which "cause" and "manner" were coded inconsistently on death certificates. According to state and CDC guidelines, cause of death should only be coded as SUID when all external causes have been ruled out. Therefore, *all* unexplained infant deaths should be coded with a manner of "Could not be determined." Additionally, entering detailed information in all relevant fields on the death certificate (such as other significant conditions or injury descriptions) may help to identify SUID risk factors like co-sleeping, unsafe sleep surfaces, or specific medical conditions.

Investigative tools like CDC's SUIDIRF, full autopsies, toxicology testing and scene re-enactments can help understand the circumstances leading to death and help rule out other possible causes. The CFR Team recommends that these guidelines are continually reinforced in coroner training sessions. Consistent usage of the SUIDIRF (www.cdc.gov/sids/SUIDRF.htm), or local equivalent, is recommended to help guide investigations. Coroners are also encouraged to obtain medical and family history and conduct toxicology testing whenever possible.

Coroners should be familiar with Idaho's mandatory reporting laws (*Idaho Statute 16-1605*, *see page 29*) and are encouraged to work cooperatively with law enforcement partners and Idaho

Department of Health and Welfare (IDHW) to improve investigations and identify at-risk families. It is essential that IDHW be notified of a child death when other children are in the home so that caseworkers can take steps to ensure the safety and support of all involved household members.

For Public Health Agencies

IDHW Maternal and Child Health programs have successfully supported CFR Team recommendations for reducing the number infant death cases through interagency collaboration and by supporting training programs for parent and care providers. Public education campaigns should continue to emphasize safe sleep environment as well as the importance of prenatal visits, scheduled vaccinations, and calling 911 at the first sign of distress.

The CFR Team found opportunities for childcare provider education related to safe sleep environment and infant CPR. Along with recommending training on these topics as part of care facility guidelines, training on these topics could be included as part of licensing requirements.

Case workers play a key role in educating parents and child care providers. They are often in a unique position to identify and rectify unsafe sleep environments and other hazards during home visits. As part of demonstrating safe sleep practices, workers and other health educators should clarify that the protective factors of breastfeeding do not negate the high risk of co-sleeping and urge parents to avoid the risk of falling asleep during infant feedings.

Health educators should be cognizant of the association of certain factors in infant deaths (i.e. improper infant sleep environment, lack of timely immunizations, tobacco exposure, drug and alcohol impairment, mental health concerns, hazardous living spaces) as well as protective factors like social and emotional support, access to mental health treatment/therapy, and parenting education. They are encouraged to stay abreast of emerging research related to intergenerational patterns of child maltreatment and to be aware of the warning signs. (www.childwelfare.gov/pubs/issue-briefs/intergenerational/)

Home visiting programs support families as they build and maintain nurturing, healthy households. Expanded access and greater awareness of such programs via public health and non-profit agencies is recommended to prevent or correct unsafe situations for infants and young children.

Case workers should familiarize themselves with Idaho's mandatory reporting laws (*Idaho Statute 16-1605*, s*ee page 29)* and readily communicate with partner agencies when investigating health and safety concerns. Cooperative approaches with law enforcement and coroners may lead to improvements in supporting families and investigating concerns for child safety.

For Law Enforcement

Law enforcement officers should be familiar with the factors that are commonly associated with infant deaths (*see pages 26-27)* and use them to inform investigations. Trainings incorporating recent research findings and recommendations on infant death investigations are offered throughout Idaho by The Governor's Task Force on Children at Risk (www.idcartf.org), state coroner associations, and through Public Agency Training Council (www.patc.gov)

Consistent usage of the CDC's SUID Investigation Reporting Form (www.cdc.gov/sids/SUIDRF.htm), or local equivalent, is recommended to properly guide infant death investigations. Thorough investigations (including home environment, incident re-enactments, family medical history, caretaker toxicology, etc.) and consistent documentation helps to identify commonalities and risk factors which can prevent future deaths.

Law enforcement agencies are encouraged to work cooperatively and share information with partner agencies (i.e. coroners, CPS, etc.) to investigate health and safety concerns within families. Unsafe situations may be better substantiated and addressed through complete information and family history obtained from multiple sources. When resources are limited, smaller agencies are encouraged to seek support from other law enforcement agencies or coroner's offices which may provide additional expertise and resources to assist with these investigations.

Law enforcement officers should familiarize themselves with Idaho's mandatory reporting laws (*Idaho Statute 16-1605*, *page 29)* and readily communicate with partner agencies to investigate health and safety concerns involving children.

For Health Care Providers

Health care professionals play an important role in educating parents on the protective factors of prenatal care, breastfeeding, timely immunizations and safe sleep environment. As part of staying current on SUID research, they should be familiar with risk factors encountered during the prenatal through neonatal period (e.g. prematurity, tobacco/alcohol/drug exposure, family history of apnea, seizure disorders and other medical conditions).

Providers, including staff in newborn nurseries and NICU should endorse and model AAP risk-reduction recommendations, particularly related to safe sleep. Although currently concentrated in a few communities in Idaho, programs like *"Cribs 4 Kids"* and *"Sleep in Heavenly Peace"* donate safe cribs and beds to families via partner organizations. Expanding access to these or similar programs through partnerships with rural hospitals or remote public health clinics might help reach other families in need.

Potential topics for new parent education in hospitals may include proper swaddling techniques, infant CPR and breastfeeding support. The team urges support and referrals for home visiting programs and parent education for high-risk families (e.g. parents who have experienced abuse or neglect, or those with a history of mental illness or substance abuse). Home visiting programs are offered through local public health districts and other community agencies. In addition to providing information on prenatal health and newborn care, home visitors offer referrals for resources like nutritional support, housing and utility assistance, substance and mental health referrals, and home safety plans.

The CDC stresses that timely vaccinations are essential in providing immunity to life-threatening diseases. Idaho reportedly has eight of the top 10 counties in the U.S. with the highest exemption rates:
(https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1002578).
Parents may need reassurance from their medical providers of vaccine safety and the benefits of complying with the CDC's immunization schedule (www.cdc.gov/vaccines/schedules/parents-adults/resources-parents.html).

Providers should be familiar with Idaho's mandatory reporting laws (*Idaho Statute 16-1605, page 29*) Health or safety concerns can be reported to law enforcement or to the Idaho

Department of Health and Welfare by calling **2-1-1** so that they can be properly investigated and potentially addressed.

For Parents and Child Care Providers

Many hospitals and community education centers offer parenting and child care classes which include subjects like infant sleep safety, nutrition, first aid and CPR, along with tips for handling the physical and emotional demands of parenting.

Local public health districts and other community agencies provide home visiting services to eligible families. Home visitors provide information on prenatal health, newborn care and child development. They offer referrals for needed resources including nutritional support, housing and utility assistance, substance abuse and mental health referrals, and home safety plans. For information on eligibility, to seek family support, or report a safety concern, call the Idaho Department of Health and Welfare's Care Line: **2-1-1.**

Parents and care providers should be familiar with AAP safe sleep recommendations (www.healthychildren.org/English/ages-stages/baby/sleep/Pages/A-Parents-Guide-to-Safe-Sleep.aspx) and follow them closely. This link should be checked often for the latest updates and for recent product recalls related to infant and toddler safety.

Infants should be placed on their back to sleep until they are 1 year old. The safest place to sleep is in their own crib or bassinet, on a firm sleeping surface, free of toys, pillows, small objects and loose bedding. AAP recommends that the infant's sleep area be in the same room as the parents for at least 6 months (ideally for the first year) to make it easier to feed and comfort the baby. Parents should avoid alcohol and drug use while caring for an infant, as impairment can make it difficult to wake up and respond to an infant.

Couches, recliners, car seats, and infant swings are not intended for long periods of sleep and should be avoided for extended naps and night time sleep. A safer alternative when away from home is a portable crib such as a play-yard (e.g. "Pack 'n Play"). Consumers are warned not to rely solely on marketer's claims of product safety.

Mothers are strongly encouraged to breastfeed newborn infants to reduce SUID risk. Even those who choose to combine breastfeeding with formula for just the first few months of life are providing significant protective benefits (www.forbes.com/sites/tarahaelle/2017/10/31/any-breastfeeding-even-partial-cuts-sids-risk-in-half/#9d609df25191). Because of suffocation risk while co-sleeping, mothers should be sure to return the infant to his/her own crib or bassinet once feeding is complete.

Tobacco smoke exposure has been repeatedly shown to increase the risk of infant death. There is no safe level of smoking or vaping during pregnancy or around infants. Idaho's Project Filter offers the "Quit Now" program to support cessation efforts: http://projectfilter.org

Recent AAP research confirms that staying current with immunizations significantly reduces the risk of infant death. Those with a financial barrier can receive routine childhood vaccines at no cost or at a significantly reduced cost through their healthcare provider, local pharmacy, or their local public health district. For information on where to obtain vaccinations in Idaho see: https://healthandwelfare.idaho.gov/Health/IdahoImmunizationProgram/ChildandAdolescentImmunization/tabid/3768/Default.aspx).

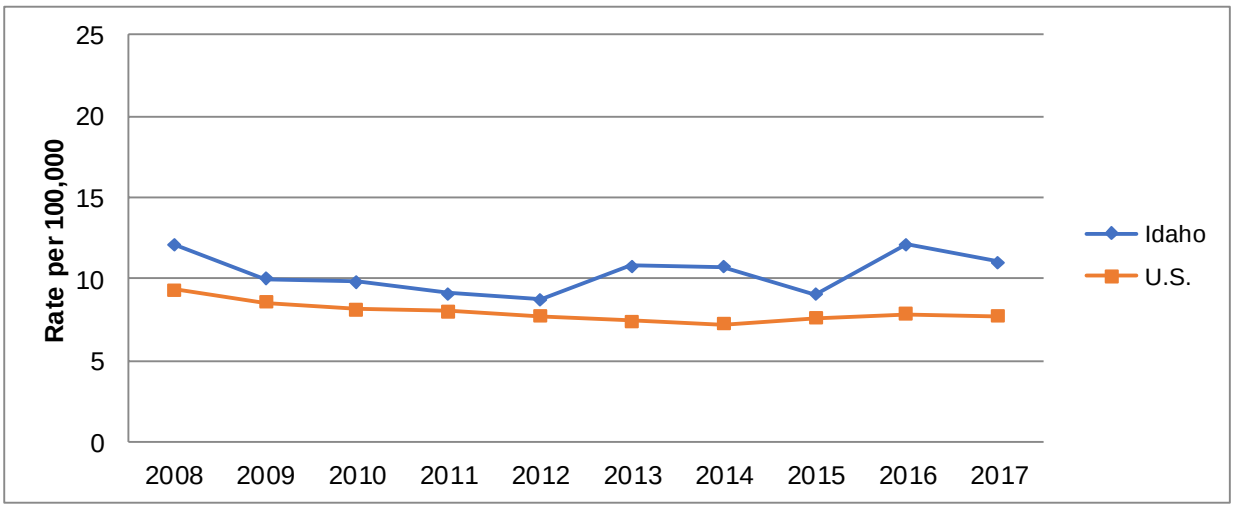
Parents and caretakers are reminded to **call 9-1-1** immediately when an infant or child appears to be in distress and to avoid transporting to medical facilities in personal vehicles. In these situations, every second is critical, and prompt medical assistance by professional first responders can save a life.

UNINTENTIONAL INJURIES

Unintentional injuries (accidents) are those that were not planned or that were accidentally inflicted by another person. Nationally, the leading causes of fatal accidents are motor vehicle collisions, drowning, fires, and poisoning. The 2017 rate of accident deaths in Idaho did not change significantly from the prior year but remained higher than the overall U.S. rate.

Idaho and U.S. Resident Accident Deaths (Age <18)
and Rates Per 100,000, 2008-2017

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Total number Idaho Resident accident deaths	**50**	**42**	**42**	**39**	**37**	**46**	**46**	**39**	**53**	**49**
Idaho Resident accident death rate	12.1	10.0	9.8	9.1	8.7	10.8	10.7	9.0	12.1	11.0
U.S. Resident accident death rate	9.4	8.6	8.1	8.0	7.7	7.4	7.2	7.6	7.8	7.7

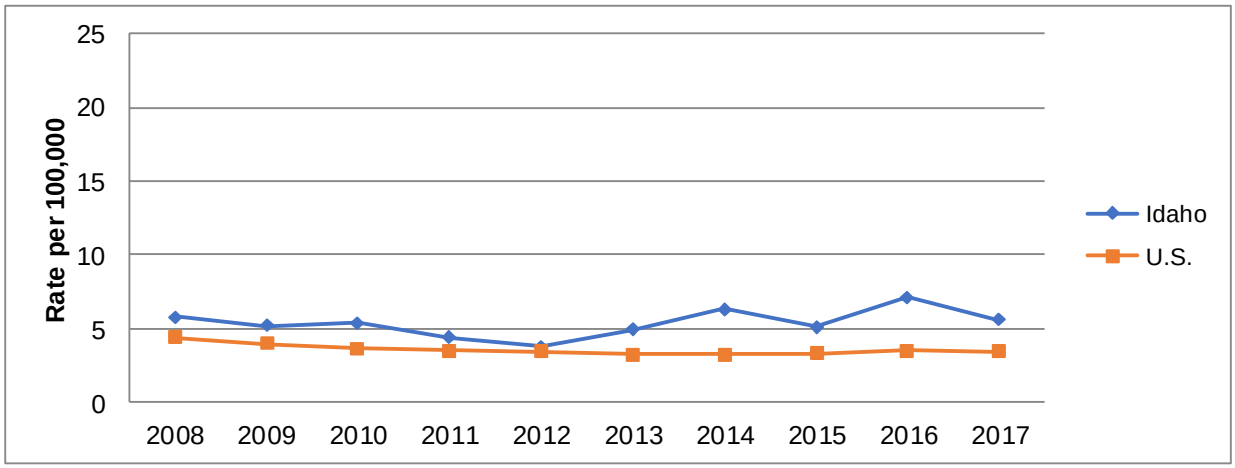


Source: *Bureau of Vital Records and Health Statistics, Idaho Department of Health and Welfare*

In 2017, Idaho's rate of child motor vehicle fatalities dropped slightly from the prior year and was not significantly higher than the overall U.S. rate.

Idaho and U.S. Motor Vehicle Accident Resident Deaths (Age <18) and Rates per 100,0000, 2008-2017

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Total number Idaho Resident accident deaths	**24**	**22**	**23**	**19**	**16**	**21**	**27**	**22**	**31**	**25**
Idaho Resident accident death rate	5.8	5.2	5.4	4.4	3.8	4.9	6.3	5.1	7.1	5.6
U.S. Resident accident death rate	4.4	4.0	3.6	3.5	3.4	3.2	3.2	3.3	3.5	3.4

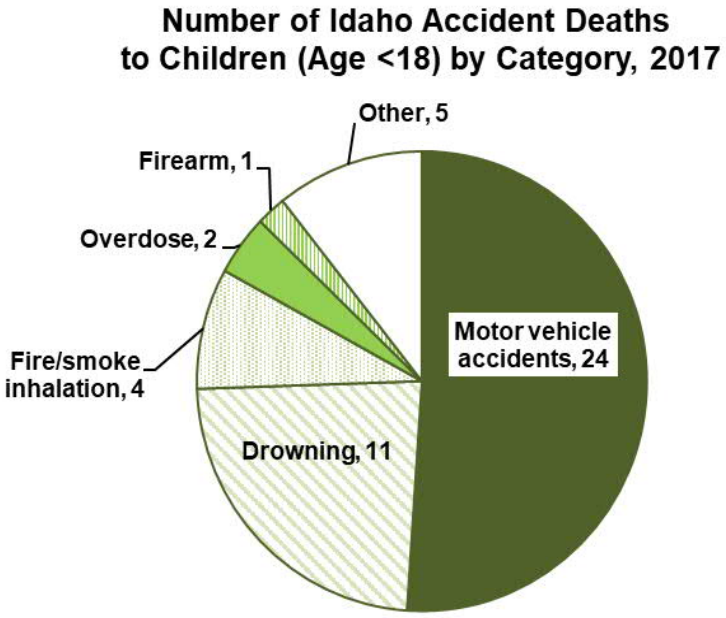


Source: *Bureau of Vital Records and Health Statistics, Idaho Department of Health and Welfare*

Rates based on 20 or fewer deaths may be unstable. Use with caution.

Idaho CFR Team Findings: Accidents

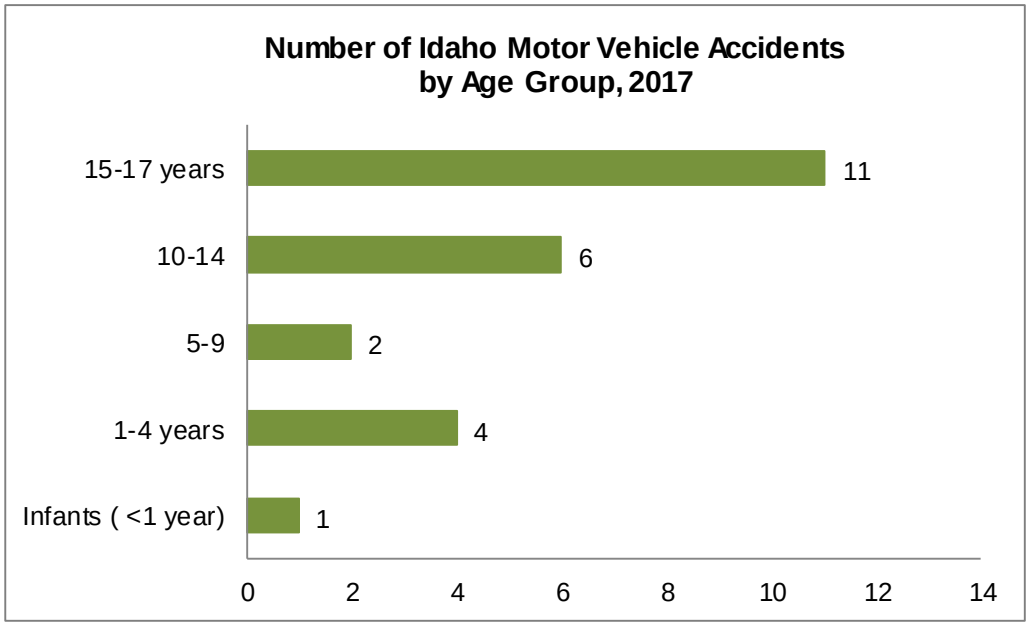
In 2017, there were 47 accident deaths to children occurring in Idaho. More than half of these deaths (24) were due to motor vehicle accidents. Drowning deaths accounted for 11 of these cases. Less commonly occurring types of accidents for the year were drug or medication overdoses (2) and firearm discharge (1). The category of "other" includes accidental asphyxiation and suffocation deaths to infants and children. Accidental infant deaths occurring in the sleeping environment are discussed in this report's section on sudden unexplained infant death (*see page 21*).

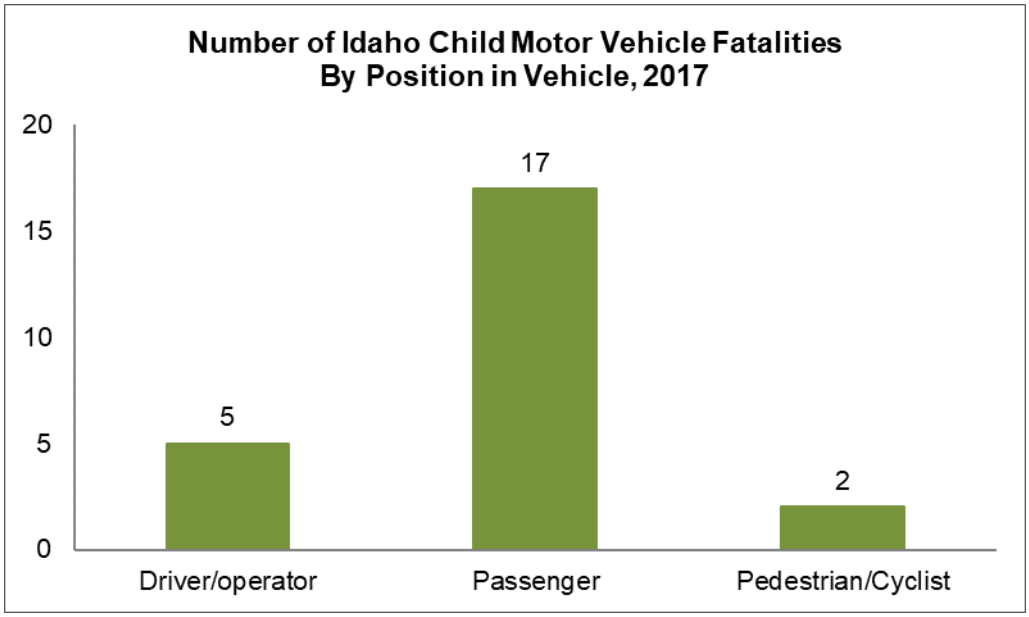


[Based on 47 accident deaths]

MOTOR VEHICLE ACCIDENTS

The CFR Team reviewed the 24 motor vehicle deaths that occurred in Idaho. A large number (11) of victims were in their mid to late teen years. In 2017, more of the victims were male (14) than female (10). The great majority (17) of the victims were passengers while 5 were drivers and 2 were pedestrians. There were no ethnic or racial disparities observed.





[Based on 24 motor vehicle or other transportation fatalities]

As 3 of these accidents resulted in multiple fatalities, there were a total of 20 separate motor vehicle accidents accounting for the 2017 child deaths. Additionally, 3 of the accidents occurred off-road or involved pedestrians. The following findings are based on the remaining 17 separate motor vehicle accidents which occurred on a road or in street traffic.

Vehicle Type

Passenger cars were the most common type of vehicle involved in these traffic fatalities followed by SUV/vans and pick-ups. In a departure from past years, there were no fatal accidents to children involving bicycles, motorcycles or ATVs in 2017.

Vehicle type of 2017 Idaho Accidents (child as occupant)

Car	Pick-up or truck	SUV or Van
9	2	6

*[Based on 17 motor vehicle traffic **accidents**]*

Teen Drivers

Almost one-third of the traffic accidents involved a teen driver (5 of 17). Driver error (failure to maintain lane, failure to yield, or distracted driving) was a factor in each of the crashes involving a teen driver. Some accidents involved multiple risk factors including alcohol or drug impairment, late night driving, teen passengers, graduated license violations, speeding, and/or lack of seatbelt use.

Season of Accident

Along with considering the road and traffic conditions at the time of the accident, the CFR Team captured the time of year that the accident occurred. The 2017 traffic accidents followed no distinct seasonal pattern.

Based on 17 motor vehicle traffic ***accidents****]*

Seat Belt and Safety Restraint Usage

Idaho Statute 49-673 mandates that seat belts are worn by all occupants whenever a vehicle is in motion, except under certain specific conditions. While Idaho law does not explicitly dictate children's position in a vehicle, the National Highway Traffic Safety Administration (NHTSA) states that the rear seat is the safest place for children of any age to ride. Idaho's Child Passenger Safety Law requires that all children six years of age or younger be properly restrained in an appropriate child safety restraint. Depending on the age and size of the infant or child, the appropriate restraint may be a rear facing car seat, forward facing car seat, or a belt positioning booster seat. Once a child reaches a height of 4 feet, 9 inches (typically between the ages of 8 and 12 years old), it is usually safe to begin using the vehicle's seat belt. (www.stlukesonline.org/health-services/health-information/health-topics/car-seat-safety)

When used properly, NHTSA estimates that seat belts (lap/shoulder belts) reduce the risk of fatal injury to front seat passenger car occupants by 45 percent. Further, the combination of an airbag plus a lap/shoulder belt reduces the risk of serious head injury among drivers by 85 percent.

Improper safety restraint (i.e. seat belt or safety seat) was found to be a key preventable risk factor in motor vehicle fatalities. In fact, of the 21 traffic fatalities reviewed, the team was able to confirm that just 5 of the victims were using a seat belt or an age-appropriate child safety seat.

One (1) child had been riding unrestrained in the cargo area of the vehicle. Notably, there were several instances where the vehicle occupants who were using a seat belt survived the crash while the unrestrained occupants in the same vehicle sustained fatal injuries. The team found definitive information showing that most of the children who died in motor vehicle crashes (12 of 21) were either *not* using an age appropriate safety restraint or the safety seat used was not installed properly. For 3 of the victims, safety restraint usage could not be conclusively determined, based upon information provided in law enforcement and Idaho Transportation Department (ITD) crash reports.

Seat belts not used	Child safety seats/booster seats not used *OR* improperly installed	Safety restraint usage not known
10	2	3

*[Based on 21 motor vehicle traffic **fatalities**]*

Contributing Circumstances

For each vehicle involved in a traffic collision, the investigating officer may indicate up to three circumstances that contributed to the resulting accident. These are summarized in ITD crash reports. The most commonly cited circumstances in the 2017 motor vehicle traffic accidents were excess speed, alcohol or drug impairment, failure to maintain lane, and failure to stop or yield.

Excess speed includes "too fast for conditions" and "exceeded posted speed"

*[Based on 17 motor vehicle traffic **accidents**]*

Systems Issues

The ITD crash report includes a field for toxicology results (blood alcohol content and drug test) of all drivers involved in the accident. However, there were a few instances where this information was missing and others that indicated that no toxicology was conducted. Resource issues and specific policies may prevent law enforcement agencies from conducting toxicology testing when intoxication is not obviously apparent or when intoxication from a single substance (e.g. alcohol) was already determined. Complete and consistent toxicology testing (to include testing for prescription medications) of drivers would help to better address the factors involved in motor vehicle crashes.

Inattention or distracted driving was selected as a contributing circumstance in 2 of the traffic accidents. However, the CFR Team observed that many of the contributing circumstances noted on ITD crash reports (e.g. failure to maintain lane, driving left of center, failure to

stop/yield) might also be related to distracted driving. Providing information on the cause of the accident and the source of driver distraction (as detailed in a narrative section of the ITD form) may help to better understand the magnitude of distracted driving as a cause of motor vehicle accidents. More thorough investigations into the sequence of events and the drivers' activities prior to these accidents will lead to better understanding of the causes and may ultimately help to prevent additional accidents.

Additional information pertaining to the role of electronic devices and other common types of distractions while driving would improve utility of the ITD reports. As noted in past years, the team felt that detailing the specific source of distraction on the crash report form (e.g. handheld phone, radio, pet, passengers, etc.) would help better identify the preventable factors, thus improving driver education and public messaging.

Common Factors and Associations

Along with the contributing circumstances obtained from ITD crash reports, the CFR Team separately captured common factors which may have played a role in these accidents. This additional step provides information that may enhance public education and safety messaging.

The team identified the following common factors in the fatal motor vehicle accidents (ranked by frequency with number of instances in parenthesis):

1. Rural road (13)
2. Inattentive driver (12)
3. No seat belt (10)
4. Excessive speed (7)
   Failure to obey signs/signals (7)
5. Drug or alcohol impaired driver (6)
6. Teen driver w/ graduated license violation (3)
7. Late night teen drivers (midnight to 6 a.m.) (2)
   No child safety seat used or improperly installed (2)
8. Cargo area riding (1)

*[Based on 21 motor vehicle traffic **fatalities**]*

More than half of the 2017 motor vehicle fatalities to children occurred on a rural road. Specifically, several were collisions at an intersection and involved an inattentive or distracted driver. Car collisions with large trucks or farming equipment were also observed. The fact that

many of the children were not using a proper safety restraint (either a seat belt or age appropriate safety seat) was noted as evidence that some of these deaths may have been prevented.

Most of the motor vehicle accidents were caused by driver error such as failing to obey a stop sign or driving too fast for conditions. Due to inexperience, teen drivers may be prone to errors which can cause serious accidents.

It was common to see an interplay of multiple risk factors present in the same accident. The combination of a speeding teen driver, with inattentive or impaired driving was often observed in the same accident.

Off-Road Vehicles

In 2017, there were 3 *non-traffic* accident fatalities which involved pedestrians, non-motorized vehicles (e.g. scooters, skateboards, etc.), and/or which occurred off-road. Common risk factors were night time riding, lack of safety gear/apparel (notably, riding without helmets and wearing dark clothing at night), improper vehicle backing, and inadequate supervision of young children.

Recommended Actions for Preventing Motor Vehicle Accident Deaths

The team recommends ongoing public reminders of safe driving practices as well as continued emphasis on driver's training for teens. The number of 2017 accidents occurring on rural roads at high speed highlights the need for special caution, even in areas with lighter traffic.

For Parents and Teen Drivers

Rural Driving

Despite lower traffic volume and usage, U.S. rural roads account for over half of the nation's vehicular deaths (www.ncsl.org/research/transportation/traffic-safety-on-rural-roads.aspx). Idaho's rural roadways present distinct safety hazards, particularly for less experienced teen drivers. National research indicates that rural crashes are commonly attributed to speeding, alcohol and/or lack of safety restraint usage. The same studies identified roadway environment, vehicle type, and travel distance to medical facilities after crashes as leading factors contributing to rural road fatalities. The CFR Team emphasizes that recommendations on safety restraints and safe driving habits are especially important when driving in rural areas. https://safety.fhwa.dot.gov/local_rural/training/fhwasa14082/

Safety Restraints

Improper safety restraint usage continues to be a common factor in motor vehicle fatalities. Many of the fatal injuries resulting from traffic accidents may have been less severe or prevented entirely with proper seat belt or child safety seat use.

Idaho's Child Passenger Safety Law requires that all children six years of age or younger be properly restrained in an appropriate child safety restraint. National Transportation Safety Board (NTSB) recommendations are stricter and are based on height and weight as well as age (booster seats until 4 feet 9 inches *OR* eight years old).

To ensure that the correct safety seat is used and installed correctly, ITD recommends routine inspection by a trained professional. Updated safety seat installation tips and check sites throughout Idaho may be found at: https://itd.idaho.gov/safety/?target=child-safety-seat and www.safekids.org/coalition.

Pickup Bed and Cargo Area Riding

Although not prohibited by Idaho law, children and teens should not ride in pickup beds or other vehicle cargo areas. Cargo areas are not intended for passenger use and therefore, do not meet occupant safety standards. Those who are injured when traveling in cargo areas of pickups are more likely to sustain severe injuries and have a greater likelihood of death than those riding in the cab. Studies have demonstrated those riding in cargo area are significantly more likely to be ejected from the vehicle (even during non-crash events like a sudden stop or

swerve) than those riding in seats designed for passengers (https://pediatrics.aappublications.org/content/106/4/857).

Safe Driving Habits

Parents should model good driving behavior by always wearing a seat belt, maintaining a safe speed, and avoid driving while distracted or under the influence of alcohol or drugs. Drivers should learn to recognize the signs of aggressive driving in themselves and others and respond in a calm, non-confrontational manner.

The National Highway Transportation Safety Administration (NHTSA) reports that electronic device usage while driving has been linked to an increase in distracted driving accidents. Teens were the largest age group reported as distracted at the time of fatal crashes (www.nhtsa.gov/risky-driving/distracted-driving).

According to Idaho Transportation Department (ITD), aggressive driving is a contributing factor in nearly half of all crashes in Idaho and teen drivers are more than 4 times as likely as adults to be involved. Driving behaviors like failure to obey traffic signs/signals, speeding, tailgating, unnecessary honking, passing on the shoulder, and weaving in traffic are all examples of aggressive driving. When confronted by an aggressive driver, it is important to stay calm and avoid engaging them with eye contact and gestures. Once they are in a safe place, drivers may report concerning incidents to law enforcement by calling 911 and providing details such as time, location, license plate number and descriptions of the vehicle and driver. ITD offers more tips how to recognize and react to aggressive drivers at: https://itd.idaho.gov/wp-content/uploads/2016/10/AggressiveCard_DRAFT_v2.pdf

Teen-parent contracts for driving guidelines and restrictions are a useful way to communicate expectations and remind new drivers to avoid risky behaviors. Whenever possible, teens should avoid driving late at night, especially with other young passengers in the car. In accordance with Idaho's zero tolerance laws (which make it illegal for those under age 21 to drive with any measurable amount of alcohol in their system), alcohol consumption should be strictly avoided prior to driving. Drivers should be aware that certain prescription drugs may cause impairment and seek doctor or pharmacist advice before operating vehicles while using medications.

Idaho public school districts offer driver training programs in cooperation with the Department of Education. Courses are open to all Idaho residents (including non-students) between the ages of 14 ½ and 21. Commercial driver training courses are also offered at locations throughout the state. ITD offers defensive driving courses at various locations for those aged 15 to 24 called *Alive at 25* (https://aliveat25.us/id/find-a-course). Law enforcement officers present traffic safety strategies for young drivers which emphasize responsible choices and decision-making while driving or riding as a passenger.

Pedestrian and Riding Safety

Adults and caregivers should closely supervise children when walking, biking, skating or riding scooters near roadways, driveways, and parking lots. During night time or early morning hours, walkers and riders should exercise extra caution and wear light colored clothing, reflectors and safety lights so that drivers are able to see them more easily. *Idaho Walk Smart,* by ITD and Idaho Highway Safety Coalition (https://apps.itd.idaho.gov/apps/ohs/docs/WalkSmart_digital.pdf) reminds parents of the vulnerability of children in navigating roadway and traffic environments.

Drivers should use caution when driving near schools and parks or other locations where children may be present. Before backing vehicles in driveways or parking lots, they should take extra precautions to make sure the area is clear. It is important to check the locations of nearby children and to avoid relying on mirrors (which have blind spots) for keeping track of their movements.

Safe Kids Worldwide reports that properly-fitted helmets while riding bikes, scooters, skates and skateboards, are the best way to prevent head injuries. Ensuring the correct fit can increase comfort and use. Saint Luke's Children's Injury Prevention program offers clinics on proper helmet with free bike and ski helmets for qualified families (stlukesonline.org/health-services/health-information/health-topics/helmet-safety).

For Public Transportation Agencies

Ongoing messaging on proper seat belt/safety restraint use, bicycling and warnings against impaired, distracted and aggressive driving may help prevent additional traffic fatalities. Opportunities may exist for additional public education related to safety seat installation checkpoints and pedestrian safety.

Updates to the ITD crash report forms to ensure that they completely capture relevant information pertaining to the cause of the accident may provide a better understanding of risk factors. Specifically, the team requests: 1) the addition of a field for the estimated speed of vehicles at the time of the crash and 2) the addition of specific phone/device usage fields (including whether the device was handheld or hands free/Bluetooth® enabled) as options for the "contributing circumstances" listed on the form.

For Law Enforcement

Officers play an important role in reminding drivers of safe habits related to safety restraints, rural driving, and avoiding aggressive and impaired driving.

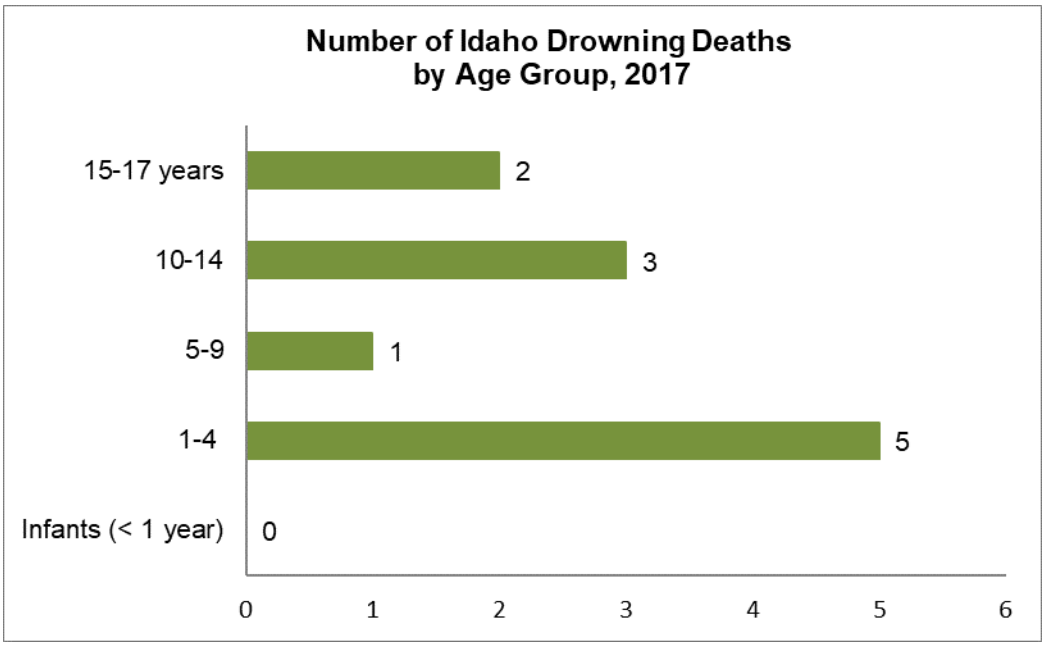
Continued strict enforcement of alcohol and drug impairment laws is vital. Ongoing public education on the consequences of impaired driving (including the dangers of prescription drug impairment) is recommended.

In completing narrative sections of ITD crash report forms, officers are encouraged to include details such as estimated vehicle speed, source of driver distraction (e.g. cell phones, passengers) and aggressive driving behaviors (e.g. speeding, unsafe passing, tailgating, emotional/angry drivers) as a contributing cause. Providing detailed information serves to better identify various causes of accidents and may lead to improved driver education and preventive efforts.

Law enforcement agencies should continue to promote compliance with vehicle safety restraint laws through existing driver's training programs like *Alive at 25*, school presentations, public education campaigns and strict enforcement of state laws.

DROWNING

The team reviewed the 11 drowning deaths that occurred in Idaho in 2017. Nearly half (5) of those who died were toddler or preschool aged children who entered or accidentally slipped into a pool or open water. Older children and teens were commonly swimming in a lake or pond with a group of peers prior to the incidents.



Number of drowning deaths by location

Body of water	#
Lake or pond	5
River or creek	3
Swimming pool	2
Canal	1

[Based on 11 drowning deaths]

Systems Issues

The team found a few examples in which law enforcement reports appeared to be incomplete or left them with unanswered questions. Specifically, there were cases with no information regarding safety barriers to open water/pools or the level of child supervision preceding the drowning accidents. As with other cause of child deaths, routinely performing toxicology testing of the decedent and/or caregiver would help to better understand the circumstances involved. Interagency cooperation (especially between CPS and law enforcement) may help identify unsafe home situations and prevent child deaths.

Common Factors and Associations

The CFR Team noted inadequate supervision as a factor in most of the drowning accidents. Children of all ages were often swimming or playing near water without wearing an approved personal floatation device (PDF). The incidents involving younger children often occurred on properties with no safety barriers to prevent access to swimming pools or open water. Most of the older children lacked swimming skills.

1. Lack of close supervision (9)
2. No life vest/PFD worn while swimming or playing near water (7)
3. No safety barrier to prevent entering water (5)
   No swimming skills (5)
   - Relocated/refugee family (1)

[Based on 11 drowning deaths]

Recommended Actions for Preventing Drowning Deaths

According to the CDC, drowning is the second leading cause of accidental death for children between the ages of 1 to 14 years. The main factors that affect drowning risk include lack of swimming ability, missing barriers to open water, lack of close supervision while swimming, and failure to wear life jackets.
(www.cdc.gov/HomeandRecreationalSafety/Water-Safety/waterinjuries-factsheet.html).

For Public Health Agencies

The team recommends that public education campaigns emphasize the importance of safety barriers or door alarms to prevent unsupervised access to open water and swimming pools. General reminders to closely supervise children and to use approved personal floatation devices while in or near the water may help prevent additional drowning injuries.

Warnings of the unpredictable nature of rivers, lakes and reservoirs should be directed to teens and pre-teens of all swimming ability levels, as well as parents of young children.

Over several years of reviews, the CFR Team observed multiple instances of drowning deaths to children from families that had recently resettled from other countries. Popular water sports played in Idaho's lakes and rivers present hazards which may not be familiar to those of different cultures or prior home environments. The Idaho Refugee Health Program has also previously identified a need for enhanced training on water safety. Agencies should ensure that water safety training (including access to swimming lessons, PFD usage, life saving techniques, and drowning prevention) is part of resettlement education.

For Parents and Child Care Providers

Children and teens of all ages should be closely supervised while playing in or near the water. To prevent drowning injuries, the CDC advises everyone to know the basics of swimming (floating, moving through the water) and cardiopulmonary resuscitation (CPR).

Parents should take steps to prevent young children from accessing or slipping into open water from yards, playgrounds, or walking paths. Property owners should install and carefully maintain four-sided fences (with self-closing and self-latching gates) or other barriers to prevent children from accessing open water or swimming pools. Fences should completely separate the house and play area from the pool. Pool toys and floats should be removed immediately after use so that children are not tempted to enter the pool area unsupervised.

Those supervising young children while swimming should remain alert and within arm's reach. As drowning happens quickly, parents and caretakers should avoid alcohol and drug use and distracting activities while children are playing in or near water. Research shows that

participation in swimming lessons reduces the risk of drowning for children aged 1 to 5 years. (www.cdc.gov/HomeandRecreationalSafety/Water-Safety).

U.S. Coast Guard approved personal floatation devices (PFDs) or life vests are strongly recommended for children of all ages in or near the water. Air-filled or foam toys, (e.g. "water wings", "noodles", or inner-tubes) are not life vests and are not designed to keep swimmers safe.

Even older children who demonstrate basic swimming skills should be supervised and should avoid swimming alone. Weather conditions should be closely monitored as they may result in abrupt changes to open water currents.

ACCIDENTAL SHOOTINGS (FIREARMS)

In 2017, 1 child died as the result of an accidental shooting. Unsecured gun storage and inadequate safety training have been identified as common factors in Idaho's firearm deaths.

The AAP publication *Pediatrics* reports that boys, teens, and ethnic minorities are disproportionately affected by firearm deaths. The shooting victim playing with a gun was the most common circumstance surrounding accidental firearm injuries *(*http://pediatrics.aappublications.org/content/early/2017/06/15/peds.2016-3486*).*

Public health messaging should include reminders of responsible gun ownership and safe handling practices (keeping guns out of reach of children, using gun locks and storing guns and ammunition in separate, secure locations). The ASK (Asking Saves Kids, www.askingsaveskids.org) campaign is a collaboration between the Brady Center to Prevent Gun Violence and the American Academy of Pediatrics which encourages parents to ask about unsecured guns in homes where their children play.

Project Child Safe (www.projectchildsafe.org) is a non-profit organization committed to promoting firearm safety. It offers additional resources such as educational materials, firearm safety tips, and free gun lock kits.

Improved coordination between agencies (notably, CPS and law enforcement) may help identify and address unsafe situations in homes, including access to guns and ammunition by children.

FIRE and CARBON MONOXIDE INHALATION

There were 4 child deaths resulting from a structure fire or carbon monoxide poisoning in 2017. Observed risk factors were missing or non-functioning smoke and carbon monoxide detectors in the home, improper use of heating appliances, and inadequate fireplace maintenance.

The National Safety Council (NSC) estimates that three-in-five fire deaths occur in homes without a working smoke alarm. They recommend installing smoke alarms on every level of the home. Alarms should be tested monthly and batteries should be changed annually. NSC offers other safety tips in the event of a house fire such as planning an escape route and teaching family members how to use fire extinguishers, which should be stored in accessible areas of the home (www.nsc.org/learn/safety-knowledge/Pages/safety-at-home-fires-burns.aspx).

As carbon monoxide (CO) is an odorless, colorless gas, it often goes undetected. It is produced by burning fuels including stoves, lanterns, grills, fireplaces, gas ranges, furnaces and engines. When CO builds up in enclosed spaces, even with ventilation, those who breathe it can be fatally poisoned.

CO poisoning is more likely to occur in winter months, when people use heating systems or leave cars idling in garages to warm-up. It is important to check and clean chimneys each season, and to ensure dampers are open before lighting. Heating appliances should be used only as directed by manufacturers. Gas cooking appliances should never be used for heating. Gas camp stoves can cause carbon monoxide to build up and should not be used indoors. Furnaces and water heaters should be regularly serviced by a qualified technician.

Carbon monoxide detectors should be installed near each sleeping area and replaced every five years. Batteries should be checked at least twice a year. As a way of remembering, NSC suggests checking CO detectors on the same schedule as smoke detector batteries or when setting clocks for the time change each fall and spring.

OVERDOSE

There were 2 child deaths caused by accidental overdose of an illicit drug or prescribed medication. The CDC reports a steady increase in U.S. drug overdose deaths since 1999. Nationally, most of these deaths involve a prescription or illicit opioid.

Recommended actions for reducing drug overdose include improved opioid prescribing practices (to reduce exposure and prevent abuse), promoting drug monitoring programs, and expanding access to substance abuse treatment.

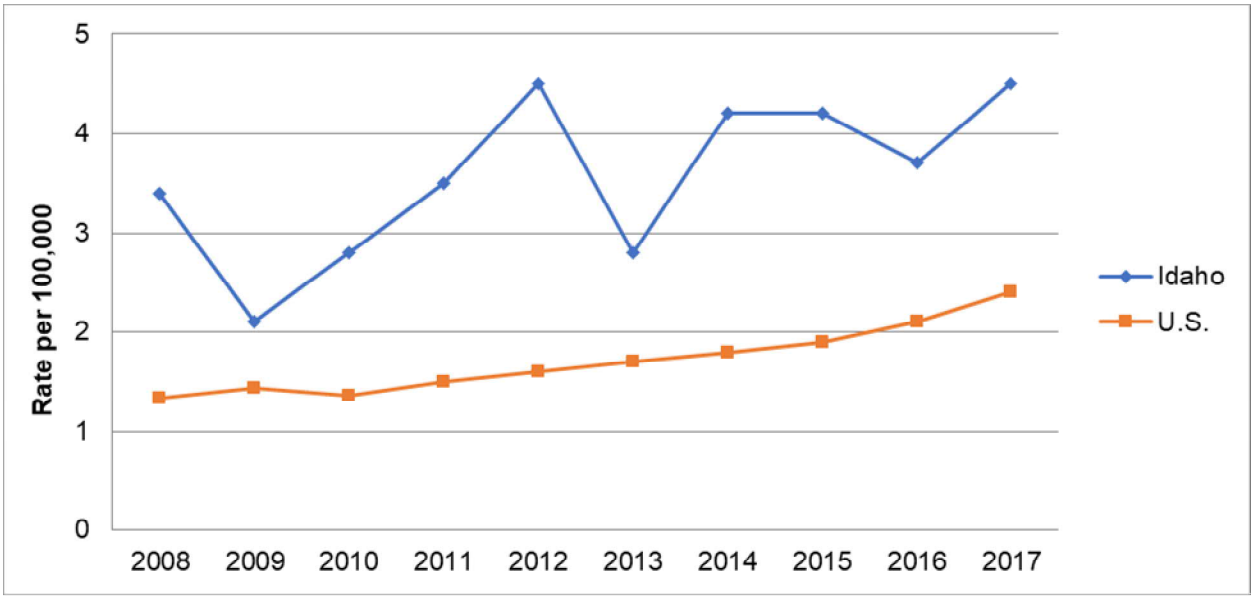
Medications should be stored out of reach of children and teens, especially those with a history of substance abuse and mental health concerns. Drug Free Idaho (www.drugfreeidaho.org/our-programs) offers information on youth programs and provides locations for safely disposing of unused and expired medications.

SUICIDES (Intentional Self Harm)

Suicide is the second highest cause of death to Idaho children (non-infants), after accidents. Idaho's rate of youth suicide is significantly higher than the overall U.S. rate and ranks in the top 10 among states. In 2017, the rate of youth suicide increased to its highest point within the past decade.

Idaho and U.S. Resident Suicide Deaths (Age <18) and Rates per 100,000, 2008-2017

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Total Number Idaho Resident suicides	**14**	**9**	**12**	**15**	**19**	**12**	**18**	**18**	**16**	**20**
Idaho Resident suicide death rate	3.4	2.1	2.8	3.5	4.5	2.8	4.2	4.2	3.7	4.5
U.S. Resident suicide death rate	1.3	1.4	1.4	1.5	1.6	1.7	1.8	1.9	2.1	2.4

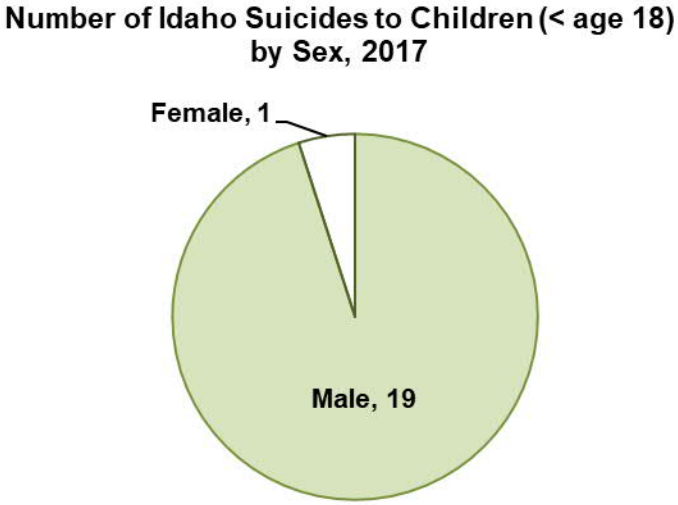


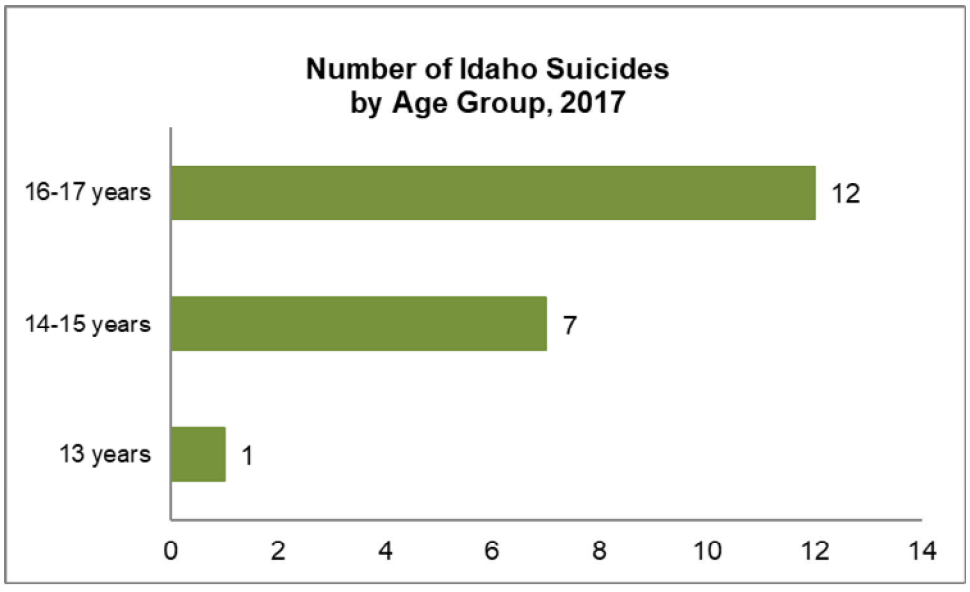
Source: *Bureau of Vital Records and Health Statistics, Idaho Department of Health and Welfare*
Rates based on 20 or fewer deaths may be unstable. Use with caution.

Idaho CFR Team Findings: Suicides

The CFR Team reviewed the 20 suicides occurring in Idaho. Those who died were predominantly male and in the teen years. Nearly all (18 of 20) were white and non-Hispanic.

The National Center for Child Death Review reports that U.S. adolescent males are four times more likely to complete suicides than females. However, females are twice as likely as males to attempt suicide.





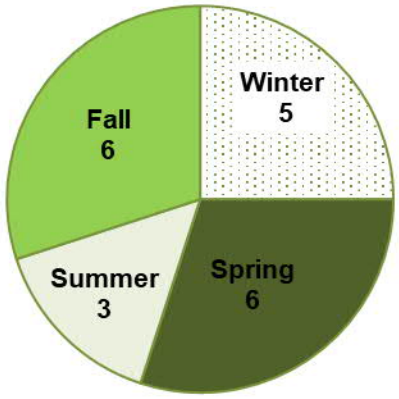
[Based on 20 suicide deaths]

Firearms were the most common mechanism of injury, followed by hanging. There did not appear to be a seasonable influence.

Number of Suicides in Idaho by Mechanism, 2017

Injury Mechanism Used	#
Firearm	13
Hanging/asphyxiation	7

Number of Idaho Suicides to Children (< age 18) by Season of Occurence, 2017



[Based on 20 suicide deaths]

Systems Issues

As noted in past years, CFR Team reviews were hampered by the absence of school records. Schools deny requests for academic and behavioral history, citing Family Education Rights and Privacy Act (FERPA) restrictions. The CFR Team has worked with the Department of Education to designate a representative for case reviews and provide aggregate data or other background information to improve the review process. An ongoing agreeable solution is still under discussion.

The team found other opportunities for improved interagency communication in preventing youth suicides and/or providing survivor support. There were a few examples of law enforcement contact with families where potential child endangerment was noted but not reported to CPS.

Additionally, there were instances in which coroners and law enforcement agencies did not complete separate investigations, which may result in an incomplete understanding of the circumstances leading to these deaths. The CFR Team had unanswered questions about the role of drugs and compliance with prescribed medications in some of the suicide deaths. Coroner and law enforcement investigations did not consistently cover home or school environment, medical and mental health history, or include toxicology testing of the deceased. Providing detailed information of the contributing circumstances on death certificates (e.g. diagnosed mental illness, substance abuse history, toxicology results) may improve suicide prevention efforts. The Idaho Board of Pharmacy was identified as a potential resource to the CFR Team for general education and to support coroner training on this topic.

Common Factors and Associations

Idaho's CFR Team found the following factors in reviewing the suicide deaths (ranked by frequency with number of instances in parenthesis):

1. Access to firearm (13)
2. Past suicidal ideation or attempt (11)
3. Interpersonal/romantic relationship turmoil (9)
4. Substance abuse (6)
    - Marijuana (3)
    - Opioid (1)
    - Methadone (1)
    - Alcohol (1)
5. History of depression or mental health concerns (5)
6. Recent school and/or criminal disciplinary event (4)
7. CPS History in family (3)
8. History of self-harm (2)
    - Social isolation (2)
    - Conflict with parents (2)
    - Foster care/adoption (2)
    - Possible cluster, subjects attended same school (2)
    - Achievement oriented/high performance standards (2)

[Based on 20 suicides]

Easy access to a lethal method (notably, firearms) was the most common factor identified in these suicides. Some incidents had an impulsive component involving an emotionally distraught

person who frantically accessed the weapon. These acts often followed a recent disciplinary event at home or school. Some of the events related to seemingly minor academic problems while others involved more serious allegations of criminal behavior or substance abuse.

The team noted a wide range of triggering events including romantic/sexual relationship conflicts, alleged bullying by peers, and family discord or turmoil (e.g. argument with parents, recent divorce/separation, a relative's illness or an unwanted move).

Many of those who died by suicide had threatened or engaged in self-harm in the past. Along with past ideation and attempts, examples included substance abuse and self-mutilation/cutting. The team found evidence of one possible "cluster" in which two of those who completed suicide were close in age and may have lived in the same area and attended the same school.

One-quarter of the suicide decedents had a documented history of mental illness (most often diagnosed depression). A similar number had a history of drug abuse or other criminal behavior. Several had a history of family instability (as indicated by CPS involvement, adoption or foster care, alleged physical or sexual abuse, parent incarceration, mental illness and/or other severe medical issue of a parent).

Although less common, the CFR Team observed over several review years that some teens who completed suicide tended toward high academic achievement and/or outstanding performance in extracurricular activities. As the risk factors for suicide are complex and varied, those who work with youth should be mindful that those most vulnerable do not strictly fit any specific profile.

Recommended Actions for Preventing Suicide Deaths

Suicide prevention research has found that 9-in-10 of those who die by suicide had a treatable mental health and/or substance abuse disorder. As the warning signs for suicide are almost always present and the conditions are treatable, these deaths are preventable.

According to IDHW's Office of Suicide Prevention, suicidal individuals typically give advance thought to the method and make a detailed plan for completing the act. However, most are highly ambivalent about death right up until the last moments. Further, method substitution rarely occurs. In teen suicides, there is sometimes an element of impulsivity related to a

triggering event. A triggering event (e.g. disciplinary action, relationship loss, or public embarrassment) may push an already suicidal person closer to an attempt. For these reasons, restricting access to lethal weapons and substances may disrupt the chain of events leading to an attempt and is a highly effective way to prevent suicides.

Nationally, firearm ownership and access have been correlated with higher rates of youth suicide. A 2015 survey by *Injury Prevention* ranks Idaho as third in gun ownership rates (at 57%), behind only Alaska and Arkansas and nearly double the national average. (http://injuryprevention.bmj.com/content/injuryprev/early/2015/06/09/injuryprev-2015-041586.full.pdf?keytype=ref&ijkey=doj6vx0laFZMsQ2). Gun safety education (including safe storage and removing gun access for at-risk individuals) is a proposed approach to reducing Idaho's high number of suicides.

The CFR Team found geographic and social isolation as a factor in some youth suicides. Health Resources and Services Administration (HRSA) reports that the prevalence of suicide is higher in rural areas. Rural community members face pronounced challenges related to mental healthcare access (compounded by stigma of seeking treatment due to lack of anonymity or other cultural barriers), substance abuse, firearm access, and limited opportunities for social engagement. However, characteristics found to act as protective factors may already exist such as community cohesiveness and a sense of family honor. Rural communities should leverage and strengthen these protective factors in suicide prevention programs.

Other key protective factors for suicide include strong social connections (to trusted adults, peers and community groups), access to effective clinical care, conflict resolution skills, and cultural or religious beliefs which support self-preservation.

Suicide Prevention Resource Center (SPRC) offers information on QPR (Question, Persuade, and Refer) Gatekeeper Training for Suicide Prevention. Gatekeepers can include anyone in a position to recognize and refer someone at risk of suicide (e.g., parents, friends, neighbors, teachers, coaches, caseworkers, police officers). The 1 to 2 hour course is offered by certified QPR gatekeepers instructors in person or online. Customizable trainings for practitioners are also offered (www.sprc.org/resources-programs/qpr-gatekeeper-training-suicide-prevention).

IDHW's Office of Suicide Prevention encourages everyone to be familiar with the warning signs of suicide and be prepared to seek help when they are seen: (http://healthandwelfare.idaho.gov/Families/SuicidePrevention/tabid/486/Default.aspx):

- Threatening, talking or writing about suicide
- Isolation or withdrawal (from family, friends, activities, etc.)
- Agitation, especially combined with sleeplessness
- Nightmares
- Previous suicide attempts or seeking methods
- Feeling depressed, hopeless, trapped
- Showing unexplained anger and aggression
- Changes in eating, sleeping, personal care or substance use
- Taking unnecessary risks/recklessness
- Loss of interest in favorite activities or hobbies
- Chronic headaches, stomach aches or fatigue
- Sudden, unexpected loss of freedom or fear of punishment or humiliation

The **Idaho Suicide Prevention Hotline** accepts texts and phone calls **at 1-208-398-HELP (4357)**. The hotline provides crisis intervention, emotional support, resource referrals, and follow-up. If a person threatens suicide or has a weapon, **call 911** immediately.

For Educators and Health Care Providers

Educators and providers are encouraged to access resources offered by the Idaho Lives Project (www.idaholives.org). Their goal is to create a network and culture of connectedness, resiliency and strength that will result in fewer students arriving at the point of feeling suicidal. They offer suicide prevention trainings for gatekeepers and students along with safe messaging guidelines for activities and events. Idaho Lives follows the "Sources of Strength," an evidence-based program which has been found to not only reduce suicide, but also decrease other risky behaviors.

Health care providers are encouraged to include mental health screening to identify those at risk and to establish treatment protocols or referrals to appropriate behavioral healthcare. The Suicide Prevention Resource Center (www.sprc.org/settings/primary-care/toolkit?sid=508)

and Health Resources and Services Administration (HRSA) (www.ruralhealthinfo.org/toolkits/suicide) offers resources for medical practices. Collaboration with behavioral health providers helps establish a climate of prevention and provides support in treating individuals requiring intervention.

School and community programs which encourage open communication and meaningful connections provide broader perspective to help young people navigate through academic pressures, relationship turmoil, family conflict, and other intense emotional experiences. Teachers, counselors and medical providers may serve as valued role models who young people may approach for emotional support and advice.

For Public Health Agencies

IDHW's Office of Suicide Prevention provides leadership, community outreach and resources as a part of a comprehensive approach to reducing Idaho's suicide rate. The CFR Team will continue to integrate their guidance when conducting case reviews and making recommendations.

Public education campaigns related to safe storage of lethal methods such as guns, ammunition, and drugs (prescription and OTC) can prevent tragedies in volatile situations. Families with a known risk for suicide should remove firearms and certain controlled medications from the home entirely.

The CFR Team continues to see a need for more mental health resources throughout Idaho. Access to treatment is particularly limited in rural areas, where research indicates the need may be more pronounced.

For Parents

Parents should familiarize themselves with warning signs of suicide risk *(see page 63)* and readily consult health care providers or educators when concerns arise. Experts point out that warning signs for suicide are almost always present in advance, and therefore these types of tragedies are preventable.

Those with a history of mental health concerns or suicidal ideation should not have access to a firearm in homes, vehicles, workshops or any other household areas. Guns and ammunition should be stored separately, secured with locks and kept out of the reach of children. Keys and

passcodes should be kept hidden. As with any other lethal method, prescription and over-the-counter medications should be secured and kept out of reach of children and teens.
A strong and positive connection to parents, family and/or school has been shown to provide immunity for teens when they are troubled. Today's teens face pressures of technology, school/work demands, and many have challenging family and peer dynamics. They often lack life experience, maturity and perspective to manage the effects of their stressors. Young people should be encouraged develop relationships with trusted adults whom they can approach for support when they (or their friends) are struggling.

Parents and others who interact closely with youth may benefit from QPR (Question, Persuade, and Refer) Gatekeeper Training for Suicide Prevention (www.sprc.org/resources-programs/qpr-gatekeeper-training-suicide-prevention).

American Academy of Child and Adolescent Psychiatry (aacap.org) reports that 90% of teens have used social media, with an average of 9 hours a day spent online (outside of schoolwork). While there are benefits of connecting with friends and exploring shared interests, potential risks of social media include exposure to harmful/explicit content, dangerous people, cyberbullying, and privacy concerns. Social media may also be the primary place where place young people express their feelings or share activities with peers. Parents are encouraged to communicate with their children to reach agreements for monitoring internet use and to limit screen time. AACAP offers more tips for developing safe and appropriate rules for social media use: https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Social-Media-and-Teens-100.aspx

For Coroners and Law Enforcement Agencies

Coroners and law enforcement agencies should work cooperatively in suicide investigations so that conclusions are based on all available information. The National Center for the Review and Prevention of Child Deaths offers guidelines, investigative protocols and other tools (https://www.ncfrp.org/tools_and_resources/).
Coroners should routinely include toxicology testing as a part of death investigations when suicide is a possible cause. All relevant detail regarding the role of substances or documented medical conditions as a contributing circumstance should be included on the death certificate.

Consistent access to this information may lead to better understanding of precursors and contributing factors of suicide.

Along with other frontline practitioners, law enforcement officers are encouraged to enroll in QPR (Question, Persuade, and Refer) Gatekeeper Training for Suicide Prevention (www.sprc.org/resources-programs/qpr-gatekeeper-training-suicide-prevention) to help learn to recognize the warning signs of crisis and know how to respond. Specialized modules are available for law enforcement, corrections officers, first responders, and others.

Investigations should include searches of personal social media accounts and devices of victims, friends and family members. Investigators should exhaust all available options for obtaining device passcodes and/or witness accounts of recent text exchanges or posts.

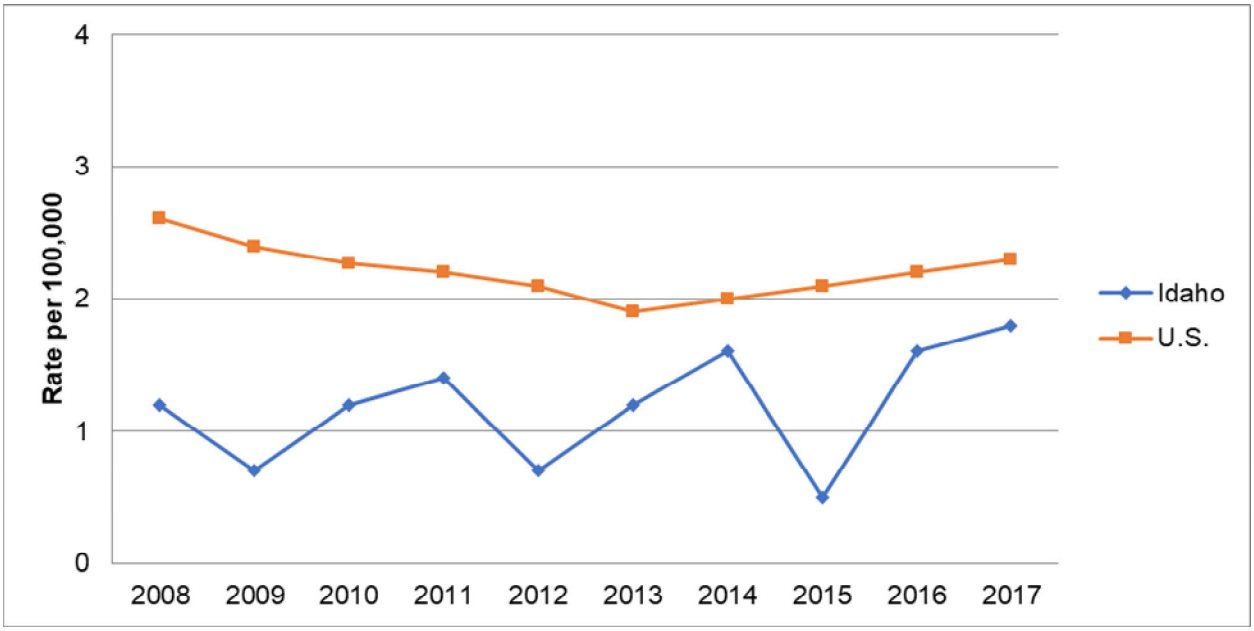
Officers and coroners are often the first point of contact for friends and family members following a tragic loss to suicide. Investigators may be in the best position to ensure that bereavement and counseling services are available for school personnel, peers, and loved ones. Resources and referrals are available through SPRC (www.sprc.org) and www.idaholives.org.

HOMICIDES (Assault)

There were 8 fatal assaults to Idaho resident children in 2017. The rate of homicide in Idaho has historically been lower than the national rate but in recent years, the gap has narrowed.

Idaho and U.S. Resident Homicide (Assault) Deaths (Age <18) and Rates per 100,000, 2007-2016

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Total Number Idaho Resident homicides	**5**	**3**	**5**	**6**	**3**	**5**	**7**	**2**	**7**	**8**
Idaho Resident homicide death rate	1.2	0.7	1.2	1.4	0.7	1.2	1.6	0.5	1.6	1.8
U.S. Resident homicide death rate	2.6	2.4	2.3	2.2	2.1	1.9	2.0	2.1	2.2	2.3



Source: *Bureau of Vital Records and Health Statistics, Idaho Department of Health and Welfare*
Rates based on 20 or fewer deaths may be unstable. Use with caution.

Idaho CFR Team Findings: Homicides (Assaults)

The team reviewed 7 assault deaths which occurred in Idaho in 2017. Since 2 of the homicide cases were pending criminal court proceedings, they were deferred for a later review leaving 5 cases for CFR Team review. Additionally, there were 2 child deaths investigated by authorities as possible homicide or child neglect cases, but which were eventually ruled as undetermined manner based on inconclusive findings. The team included these undetermined cause deaths for a total of 7 homicide or suspected homicide cases occurring in 2017.

Causes of the 2017 homicides included firearm shootings, blunt force head injuries and hyperthermia. The victims ranged in age from infants to teenagers. One (1) of the incidents was a suspected murder/suicide and resulted in multiple child deaths. All of the intentionally inflicted assaults were at the hand of a parent or adult caretaker.

Common Factors and Associations

Parents' substance abuse, mental health issues, criminal history, and recent divorce were observed as common risk factors in Idaho's child abuse and neglect deaths. Nationally, rates of abuse and neglect deaths are highest among infants and young children. https://www.acf.hhs.gov/media/press/2019/child-abuse-neglect-data-released

The CDC cites key risk factors for perpetration as lack of parenting skills, history of child abuse or neglect, social isolation, family dissolution and/or violence, as well as overall parent stress and mental health issues. Some studies note the presence of non-biologically related or transient caregivers (such as mother's male partner or other unfamiliar care provider) as risk factors for child abuse. (https://www.cdc.gov/violenceprevention/childabuseandneglect/riskprotectivefactors.html)

Recommended Actions for Preventing Homicide Deaths

As seen in other causes of child endangerment, assaults may be rooted in a pattern of intergenerational maltreatment. Many of these violent episodes occurred in families with a history of CPS involvement, some dating back to the parents' own childhood years. The number of homicide deaths which involved a parent with a history of mental health issues points to a need for greater access to quality mental health services.

Proven, effective prevention strategies are those focused on building safe, supportive and nurturing families and home environments. Child Welfare Information Gateway provides examples of community-based primary prevention programs which may serve as a model for other state and local organizations (www.childwelfare.gov/topics/preventing/)

Health care providers, law enforcement officers and others who work with children should be familiar with Idaho's mandatory reporting laws (*Idaho Statute 16-1605*, *page 29).* Professionals who work closely with children should seek training to identify signs of abusive behavior and injuries and should readily report concerns to the appropriate agencies. Interagency cooperation can help ensure families receive the support they need and prevent future tragedies. *Prevent Child Abuse America* offers educational materials targeted at parents and professionals (www.preventchildabuse.org).

To report suspected child abuse, neglect or abandonment in Idaho call the Careline at **2-1-1** or report to law enforcement by calling **9-1-1.**

PREVENTABLE NATURAL DEATHS

In addition to detailed reviews of deaths by external causes, a CFR subcommittee (made up of members of the CFR Team) screened death records certified with a manner of "natural." Causes of natural manner deaths include perinatal conditions, congenital malformations, malignancies, viral infections, cerebrovascular, and other non-ranking causes. As part of their review of preventable child deaths, the subcommittee identified cases for further review when questions were raised about the information listed on the death certificate and/or if a direct link to an existing medical condition was not apparent.

The subcommittee selected 16 of the natural manner deaths for a complete CFR Team review of additional information from death certificates, birth certificates, coroner/autopsy reports, and/or medical records. The natural manner cases selected for additional review fell into the following categories for 2017:

Perinatal Conditions	14
Non-ranking/All Other Causes	2
Total Reviews of Deaths of Natural Manner	***16***

Perinatal Condition Deaths and Home Births

As part of an effort to identify preventable risk factors and opportunities for system improvements, the subcommittee expanded their screening of Vital Statistics data for perinatal condition and congenital malformations deaths. While congenital malformation deaths were almost exclusively related to chromosomal abnormalities, most perinatal condition deaths involved low birth weight and/or extreme prematurity. The subcommittee referred 14 perinatal condition deaths (of 70 total deaths in this category) to the CFR Team for a detailed review to include available medical history and coroner reports.

Inadequate prenatal care by a licensed medical professional (whether late or non-existent) was commonly noted in the perinatal condition deaths. Smoking in pregnancy and illicit drug use was also observed. In a few cases, the mother had a prior history of poor pregnancy outcomes.

The team recommends that women visit a licensed health care provider when planning to become pregnant, or at latest, within the early weeks of pregnancy. A pre-pregnancy medical visit promotes a healthy pregnancy by ensuring that immunizations are up-to-date and that any existing health conditions are diagnosed and well controlled. High risk pregnancies can be identified and treated early on. In addition to screening for maternal and fetal health risks, providers can offer advice and referrals for nutritional support, tobacco or drug cessation and infant care. (www.womenshealth.gov/pregnancy/youre-pregnant-now-what/prenatal-care-and-tests)

Vital statistics death records indicated that 5 of the infants who died of perinatal condition were born at home or in a freestanding birth center. In nearly every case, the infant was transferred to a different medical facility for emergency care following birth. As home births (often delivered by an unlicensed midwife or family member) have specific known risk factors for perinatal condition deaths, the subcommittee referred these cases to the CFR Team for full review to include recent medical history of the mother and infant.

The team concluded that the deaths following home birth might have been prevented with proper prenatal care and/or if the infant had been born in a medical facility with access to specialized NICU care. Women are encouraged to seek prenatal care early in pregnancy to diagnose any health conditions and for advice and support in modifying behaviors that could impact their infant's and their own health. To support further research on this topic, physicians, midwives and other certifiers of death certificates are encouraged to consistently provide details related to labor and delivery along with the mother's prenatal history.

Idaho law requires midwives to be licensed under the Bureau of Occupational Licenses and includes minimum continuing education requirements. Additional research leading to recommendations for improved prenatal care, family and mid-wife education, and/or additional licensing requirements may help prevent maternal and infant deaths. As part of this effort, the CFR Team will work cooperatively with the recently formed Maternal Mortality Review Committee within IDHW.

Refusal of Medical Care Because of Religious or Personal Beliefs

Since Idaho Vital Statistics does not compile the number of deaths to children who are not treated medically because of religious beliefs, it is difficult to estimate the actual number of preventable deaths to religious objectors. In reviewing infant and child deaths of *all* causes, the

team found evidence that 3 deaths were to infants from families who refused medical care on the basis of religious beliefs. The team determined that these deaths might have been prevented with timely medical treatment, compliance with scheduled vaccinations and/or proper prenatal care for the mother.

Other Natural Manner Deaths

Non-ranking deaths include natural manner deaths that are not categorized elsewhere. These deaths were due to varied causes or related to underlying medical conditions. Causes included septicemia, cerebral palsy, epilepsy, gastroenteritis and metabolic disorders. None of the 2017 deaths were related to a positively identified influenza virus. However, proper hygiene and scheduled vaccinations (including an annual flu shot) can prevent the spread of infections and are especially important for medically vulnerable children.

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