IDAHO

Child Fatality Review Report

2019

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IDAHO CHILD FATALITY REVIEW

The Idaho Child Fatality Review (CFR) 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 to identify what information and education may improve the health and safety of Idaho's children.

Idaho's Child Fatality Review (CFR) process is in response to the longstanding public concern for the welfare of children. 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 Child Fatality Review (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 2019 reviews:

Kourtni Ball, Program Coordinator, St. Luke's Children's Injury Prevention
Tahna Barton, Court Appointed Special Advocates (CASA), CFR Team Chair
Amy Barton, MD, St. Luke's Medical Center, CARES
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
Cristi Litzsinger, RDN, LD, Idaho Department of Health and Welfare, Clinical and Preventive Services
Alana Minton, JD, Lead Deputy Attorney General, Criminal Division
Dotti Owens, Ada County Coroner
Kara Stevens, Idaho Department of Health and Welfare, Clinical and Preventive Services
Eric Studebaker, Ph.D., Director of Student Engagement & Safety Coordination, Idaho State Department of Education
Garth Warren, MD, Ada County Coroner, Forensic Pathologist
Michelle Weir, Idaho Department of Health and Welfare, Child and Family Services
Christine Hahn, MD*, Idaho State Epidemiologist, Medical Director, Idaho Department of Health and Welfare *(subcommittee member)*
Gayla Smutny, PhD*, Principal Research Analyst, Bureau of Vital Records and Health Statistics, Idaho Department of Health and Welfare *(analytical and reporting support)*

**Non-voting members*

ACKNOWLEDGEMENTS

Idaho Department of Health and Welfare (IDHW) serves as the fiscal agent, and provides staff support to the Child Fatality Review (CFR) Team utilizing federal Children's Justice Act funding. The CFR Team relies on the support of many state and local 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 Child Fatality Review 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 *(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 Child Fatality Review 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 2019 were reviewed. Deaths occurring out of state were not reviewed since pertinent records are not available for the team's use.

The designated Child Fatality Review (CFR) research analyst within the department's Bureau of Vital Records and Health Statistics identified the deaths using the Vital Records system and retrieved death certificates. Deaths were selected for further review when meeting 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

All deaths caused by unintentional injury (accident), suicide, unexplained infant death, and assault (homicide) were reviewed. In addition to detailed reviews of deaths by external causes, a subcommittee made up of members of the Child Fatality Review (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 evaluation, the subcommittee identified cases for further review when questions were raised about information listed on the birth and/or death certificate and/or if a direct link to an existing medical condition was not apparent to identify preventable risk factors and opportunities for system improvement.

Information necessary for a comprehensive review was then requested by the CFR research analyst from the appropriate agencies. The information may have included:

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

typically highly cooperative and responsive to information requests. Agreements are now in place with several Idaho hospitals to provide medical records to the team, while adhering to specific practices to safeguard patient privacy in compliance with the Health Insurance Portability and Accountability Act (HIPAA). However, in the absence of subpoena power or statutory authority, the team continues to face barriers due to the inability to obtain certain records. The challenges include: 1) incomplete or missing records such as coroner reports or law enforcement incident reports (not available, redacted, or refused based on privacy concerns); and 2) missing academic and behavioral records from schools, due to confidentiality requirements of the Family Educational Rights and Privacy Act (FERPA).

Information gathered from various sources and team conclusions were entered into the National Child Death Review Case Reporting System by the Child Fatality Review (CFR) analyst. A data use agreement between the Michigan Public Health Institute and the IDHW 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 sometimes carefully guarded as sensitive and confidential information. Idaho's Child Fatality Review (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 Child Fatality Review (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

This report presents the findings and recommendations of the Idaho Child Fatality Review (CFR) Team. Of 187 child deaths occurring in Idaho in 2019, 85 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.

2019 Deaths to Children (Birth to Age 18) Occurring in Idaho

	Total	Reviewed by CFR Team
Perinatal Conditions	44	13
Congenital Malformations	18	1
Unintentional Injuries (Accidents)	37	37
Suicide	14	14
Unexplained Infant Death*	10	10
Assault (Homicide)	4	4
Malignancies	14	0
Flu/Pneumonia	4	0
COVID-19	0	0
Non-ranking/All Other Causes**	42	6
	187	**85**

**Includes Sudden Unexplained Infant Death (SUID) as well as "ill-defined" undetermined causes of infant death.*
***Includes "natural" manner deaths. e.g., heart and pulmonary disease, cerebral palsy, and medical diseases or infections not included in above categories.*

The CFR Team met five times between January 2021 and January 2022 to conduct 2019 case reviews. The team's typical annual review schedule was disrupted by the COVID-19 pandemic, with meetings postponed during a roughly two-month period (September 16 – November 22, 2021) when the statewide crisis of care standards were in place. When the team did meet, risk factors, systems issues, missing information, 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.

The team reviewed 85 deaths to children under the age of 18 which occurred in Idaho during calendar year 2019. 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.

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 2019, there were eight SUID cases occurring in Idaho. Additionally, the team reviewed two ill-defined infant deaths and five infant deaths caused by accidents in the sleeping environment.

Unsafe sleep environment (e.g., on adult sized mattresses, thick bedding, "sleep nests" such as doc-a-tots or snuggle me organics, couches, car seats), co-sleeping, smoking and/or vaping in pregnancy and/or in the home, lack of vaccinations, lack of breastfeeding, and improper swaddling were common risk factors in these infant deaths. Many of the SUID deaths occurred in families with a history of Child Protection Services (CPS) referrals and/or when parents themselves had suffered adverse childhood experiences (ACEs), (a negative or traumatic event that occurs before a person reaches 18 years of age – i.e. neglect, abuse, experiencing or witnessing violence in the home) (https://www.cdc.gov/violenceprevention/aces/index.html).

Continued promotion of American Academy of Pediatrics (AAP) safe sleep guidelines, scheduled immunizations, and breastfeeding are recommended to prevent SUID deaths. Additional investments in family support services such as home visiting programs (with awareness of intergenerational maltreatment patterns), mental health resources, and parent and childcare education may also support at risk families and prevent infant deaths.

Motor Vehicle Accidents

In 2019, 19 children died in motor vehicle accidents in Idaho. Sixteen fatalities were traffic accidents and three fatalities occurred in non-roadway, non-traffic circumstances. Most of the victims were passengers, with the majority being driven by adults. Eleven females and eight males died. Inattentive or distracted driving, driving alcohol or drug impaired, excessive speed, and lack of safety restraint use were key factors contributing to these deaths. Driver error was found to be a factor in all the traffic accidents involving a teen driver.

As was also the case in 2017 and 2018, the team noted a high percentage of 2019 motor vehicle fatalities occurred on Idaho's rural roads. Exploring engineering solutions to improve the safety of rural roads along with ongoing public reminders of safe driving practices and expanded access to driver's training are recommended actions for preventing motor vehicle fatalities. Additionally, lack of proper safety restraint usage (seat belt or safety seat) and inattentive driving continue to be major modifiable risk factors.

Drowning

There were seven drowning deaths in 2019. Five of the drowning deaths were to children under the age of 10. Toddler and preschool children drowned in wide variety of circumstances, including in bathtubs, irrigation ponds, and rivers.

Inadequate supervision was a risk factor in most of the drowning accidents. Parents and/or other caregivers should practice “touch supervision” whenever children are in water (that is, be in the water with the child or be within an arm’s length of the child), learn Cardiopulmonary resuscitation (CPR), and ensure children wear Coast Guard Approved life jackets when they are near bodies of water even if there are no plans to swim.

Suicides

The team reviewed 14 youth suicides occurring in Idaho in 2019. An equal number of males and females died by suicide and eight who died were 15 years of age or younger. Seven suicides were completed via hanging, six via gunshot, and one via overdose. As in past years, prior suicidal ideation, relationship turmoil, ease of access to lethal means including guns and ligatures and ligature points, and depression continued to be commonly observed precursors.

The department’s Suicide Prevention Program (SPP) 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, efforts to increase awareness of the highly lethal nature of hanging, and expanded access to mental health treatment along with an anti-stigma campaign designed to normalize the use of mental health services.

Homicides/Assaults

In 2019 the team reviewed four assault-related child deaths. Causes included firearm shootings, suffocation, and poisoning/drug exposure and two of the victims were under the age of one year.

Family history with Child Protection Services (CPS), family history of substance abuse, and access to firearms were among the risk factors noted. The number of deaths involving family instability suggests a need for greater access to services that support families. 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 13 perinatal condition deaths.

Nearly all perinatal condition deaths were related to low birth weight and/or prematurity. Maternal obesity, previous poor pregnancy outcomes, child protection or trauma histories, and tobacco use in pregnancy 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. 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.

Other natural manner deaths

Non-ranking deaths include natural manner deaths that are not categorized elsewhere. In 2019 the team reviewed seven deaths due to varied causes or related to underlying medical conditions. Causes included appendicitis, sleep apnea, and other viral and bacterial infections.

Lack of safe childcare and parental or caregiver child protection histories emerged as a risk-factors in these deaths.

RECOMMENDATIONS FOR PREVENTING AND RESPONDING TO CHILD DEATHS

- **Address the dangers posed by rural roads**

  The CFR Team continues to observe child fatalities occur on rural roads at high rates. The team recommends engineering changes to make rural road safer as well as educational efforts to increase awareness of the dangers posed by rural roads.

- **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 in-patient and out-patient 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.

- **Follow infant safe sleep practices**

  Unsafe sleep environments are closely associated with sudden unexplained infant death and infant fatalities that occur in a sleep environment. Parents and caretakers should be educated on safe sleep environments and practices including that the Alone, on my Back, in a Crib (ABCs) is the safest sleeping practice for infants under one year of age, that infants should *not* be allowed to sleep in car seats other than during active transportation, and that infants should *not* be swaddled once any signs of trying to rollover are noticed.

- **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 for help with substance abuse or mental health concerns.

- **Recognize the warning signs of suicide**

  Widespread familiarity with the warning signs of suicide and knowledge of the resources available to help youth in a crisis can aid in suicide prevention and assist youth and families navigating mental health emergencies. deaths.

- **Recognize the frontline position primary care physicians (PCPs) play in the current adolescent mental health crisis**

  Acknowledging the need for PCPs to spend increased time with adolescents and responding with appropriate reimbursement and providing mental health treatment and training and educational opportunities for PCPs. (https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf)

- **Offer CPR Courses and First Aid Training in More Languages**

  Providing non-English speaking residents of Idaho with CPR and first aid training in their native language may facilitate decisive action in emergencies thus preventing child deaths.

- **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 Code § 16-1605*) and report concerns to the Idaho Department of Health and Welfare (IDHW).

- **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. Parents should keep children in rear-facing car seats and positions until the children have reached the highest weight or height limit of the car seats.

- **Follow safe gun handling practices**

  Gun owners can make their homes and communities safer by storing guns securely - locked, unloaded, and separate from ammunition. Securing firearms protects children by preventing unintentional shootings and gun suicides.

- **Conduct toxicology testing more frequently**

  Widespread and uniform toxicology testing could provide vital information for understanding whether substances caused, contributed to, or were not related to child deaths. The CRF Team recommends toxicology tests be performed on children who die as well as on caretakers and others involved when a child dies (e.g., all drivers involved in traffic fatalities; supervisors involved in drowning deaths).

- **Provide service referrals to families and communities touched by a child fatality**

  Connecting families and communities with referrals for assistance such as bereavement counseling, economic support, funeral arrangements, legal services, and mental health services should be a priority for the professionals responding to child deaths. Ensuring the siblings of children who die receive support, both in the immediate aftermath of the tragic loss and in the longer term, should be a principal concern.

- **Notify CPS when other children are in the home**

  It is essential the IDHW be notified of a child death when other children are in the home to enable caseworkers to take steps to ensure the safety and support of all involved household members.

RECENT ACTIONS AND COLLABORATIVE EFFORTS

Advancing Child Health and Safety in Idaho. While the COVID-19 pandemic continued to pose challenges to some efforts to prevent child fatalities in Idaho, American Rescue Plan (ARP) funds facilitated other prevention initiatives. The following actions and collaborative efforts detailed below demonstrate the ongoing commitment to stem child fatalities in the state.

Safe Sleep Message Campaign. For October 2021's Safe Sleep Awareness Month, the Maternal and Child Health (MCH) program ran their Safe Sleep social media campaign which included an animated 30-second Public Service Announcement (PSA), with the messaging "*Alone. Back. Crib. Every Nap. Every Night,*" in English and Spanish. Paid social media ads on Facebook, YouTube, and paid search ads/results on Google were also part of these efforts. The 2021 campaign outperformed last year's campaign, receiving 5,388 clicks versus 3,392 clicks in 2020. (https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=3648&dbid=0&repo=PUBLIC-DOCUMENTS&searchid=dfa1e9f4-85af-424d-9d10-ee64003e1347).

Additional Safe Sleep Initiatives. In 2021, the Maternal and Child Health (MCH) program maintained ongoing collaboration with the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program by supplying the program with cribs. Due to the continuation of the pandemic, in-person outreach methods were limited. The MCH Program was able to secure a sole source authorization and purchase order with Cribs for Kids, allowing the program to purchase more cribs and other safe sleep products, than in previous years. The increase in allowable funds that can be spent on cribs is a step forward in better meeting the need for safe sleep environments for babies throughout the state.

Home Visiting Programs Receive American Rescue Plan Funds. In 2021, all seven Idaho public health districts received American Rescue Plan (ARP) funds to enhance and support evidence-based home visiting programs. Districts provided either the Parents as Teachers model, Nurse-Family Partnership model, or both, and one district continued an Infant and Early Childhood Mental Health home visiting program. Research demonstrates evidence-based home visiting programs prevent child abuse and neglect, encourage positive parenting practices, promote child development, improve the health of families and their children, and improve families' economic self-sufficiency. ARP funds were provided to help programs hire and train new and existing home visitors and provide emergency supplies such as diapers, formula, and food to families.

Home Visiting Programs Prepare for Expansion. In 2021, based on the results of the 2020 Community Needs Assessment, all seven public health districts were able to utilize federal dollars to expand into new counties. The needs assessment determined that 27 out of the state's 44 counties had high concentrations of risks factors such as intimate partner violence, crime, vaccination exemptions, and adverse perinatal outcomes. Because those counties were able to receive federal funding, the districts served more families in need.

Idaho Suicide Prevention Program (SPP) Efforts. The SPP sponsors youth-focused programming through subgrants to the State Board of Education (SBE) which partners with Idaho Lives Project (ILP) to implement prevention, intervention, and postvention to schools across the state. The partnership provided direct support, gatekeeper and peer-led trainings, suicide ideation screening and evidence-informed prevention resources to schools and community organizations.

The ILP provided approximately 45 Suicide Prevention Fundamentals Instruction (SPFI)™ trainings to over 1,300 K-12 school staff. Each year ILP provides youth suicide prevention program grants to schools. During the 2021/2022 school year, ILP trained approximately 157 adults and 729 students from middle, junior, and senior high schools in Sources of Strength. In addition, ILP provided Sources of Strength Booster or Reboot trainings to approximately 175 adults and 964 students whose schools had previously implemented the program. Approximately 72 staff from 30 elementary schools received a two-day Sources of Strength training so the program could be implemented in roughly 194 classrooms among 3rd through 6th graders.

The SPP also added English and Spanish radio spots to their "Rock Your Role" communications campaign. The campaign's media mix of radio, television, and social media helped to broaden the reach of suicide prevention messages to vulnerable Idahoans, including youth residing in rural regions.

Implementation of the AWARE Project. The purpose of the Idaho AWARE Project is to build or expand the capacity of State Educational Agencies, in partnership with the State Mental Health authority (SMHA) and three local education agencies (LEAs) to: 1) increase awareness of mental health issues among school-aged youth; 2) provide training for school personnel and other adults who interact with school-aged youth to detect and respond to mental health issues, and; 3) connect school-aged youth, who may have behavioral health issues, and their families

to needed services. The grant project period is 9/30/2020-9/29/2025. Participating LEAs are the Kimberly, Glenns Ferry, and Marsing School Districts.

Forthcoming Launch of 988, the New Suicide and Crisis Lifeline. The Substance Abuse and Mental Health Services Administration (SAMHSA) has partnered with the Federal Communications Agency (FCC) to implement a new three-digit dialing code (9-8-8) to strengthen and expand the National Suicide Prevention Lifeline. Beginning in July 2022, individuals experiencing a behavioral health crisis or suicidal ideations will be able to call or text 9-8-8 from any U.S. location and reach a trained responder for immediate support and connections to appropriate care. 988 crisis workers will be available 24/7 every day of the year and the service will be free to those who call or text, similar to 911.

The Division of Behavioral Health (DBH) is leading efforts to prepare for the nationwide launch of 988. DBH is working with Idaho stakeholders, including the Idaho Crisis and Suicide Hotline, in preparation for the 988 launch.

The Department of Health and Welfare's SPP supported Idaho Crisis and Suicide Hotline's transition to the new number by substantially increasing the annual subgrant award, allocated from state General Fund and federal sources. This additional funding supports staffing, training, and infrastructure upgrades required to manage the anticipated higher call volume.

Department of Education Participation in CFR Team. In 2021 a representative from the Department of Education became a member of the CFR team, adding the valuable perspective of a professional educator to case review meetings and advancing the team's ongoing efforts to obtain, within the confidentiality dictates of the Family Education Rights and Privacy Act (FERPA), school-related information illuminating the circumstances surrounding child deaths (e.g., bullying data; whether the school the child attended had a suicide prevention program).

POPULATION AND YOUTH DEMOGRAPHICS

The total population of Idaho in 2019 was estimated at 1,826,913. Of that number, 451,043 (about 25%) were children under the age of 18. Hispanics represented just under 19% of the state's child population.

Population	Number	Percent
Idaho total	1,826,913	100%
Age 0-17	**451,043**	**24.5%**
Residents, age 0-17 by sex		
Males	230,889	51.2%
Females	220,154	48.8%
Residents aged 0-17 by race		
White	420,698	93.3%
Black	8,835	2.0%
American Indian or Alaska Native	12,004	2.7%
Asian/Hawaiian/Pacific Islander	9,507	2.1%
*Residents aged 0-17 by ethnicity**		
Hispanic	84,548	18.7%
Non-Hispanic	366,495	81.3%

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

Source: U.S. Census Bureau

OVERVIEW: IDAHO MORTALITY DATA, THREE-YEAR AGGREGATE (2017-2019)

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

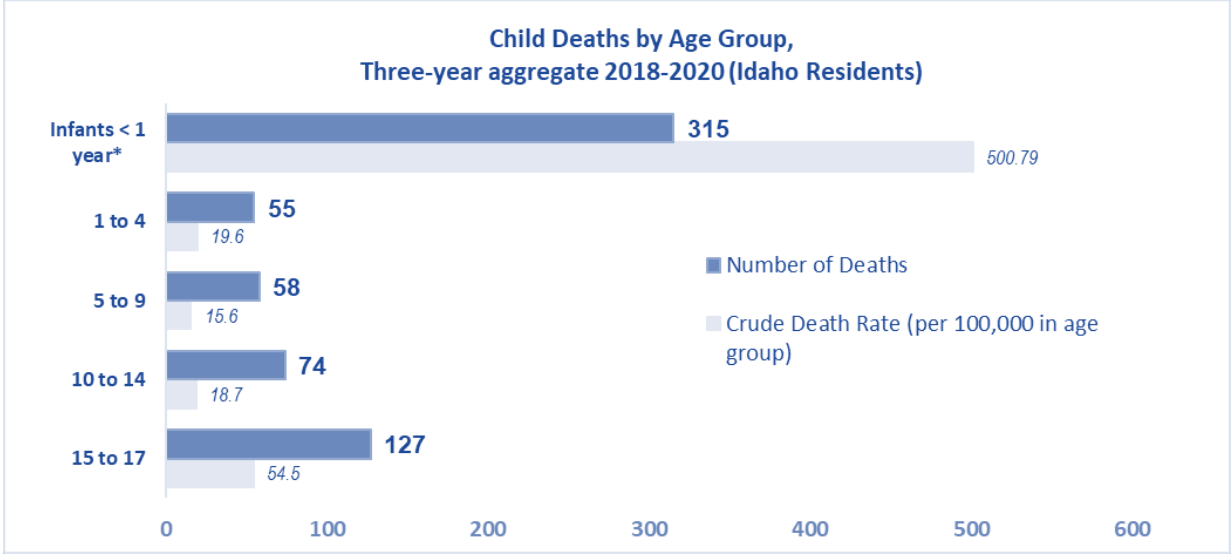
The number and cause of death to Idaho children varied by age group. There was a total of 629 deaths to infants and children (under age 18) between 2018 and 2020. Infants (under 1 year of age) have a much higher death rate than older children, comprising 50% of these deaths (315). Common causes of infant deaths were birth defects and conditions originating in the perinatal period such as short gestation/low birth weight, SUID, and maternal conditions. 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, 2018-2020

Rank	***Infants (under 1 year of age)***
1	Congenital malformations/chromosomal abnormalities (birth defects)
2	Short gestation/low birth weight
3	Sudden unexpected infant death
4	Maternal complications of pregnancy
5	Complications of placenta, cord, membranes
6	Accidents
7	Neonatal hemorrhage
8	Diseases of the circulatory system
9	***Tie:*** Bacterial sepsis of newborn, *and* Necrotizing enterocolitis of newborn

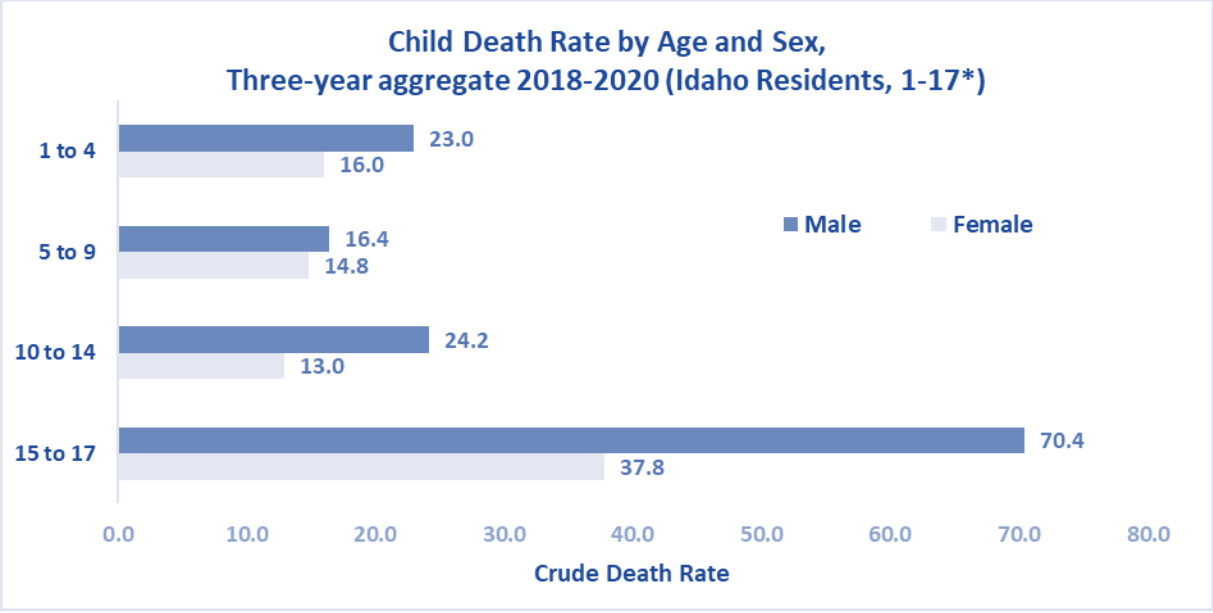
Rank	***Children (Age 1-17 years)***
1	Accidents
2	Intentional Self-Harm (Suicide)
3	Malignant Neoplasms
4	Diseases of Heart
5	Congenital Malformations (birth defects)
6	Assault (Homicide)

Mirroring patterns for the U.S. as a whole, the three-year aggregate death rate for Idaho infants (under 1 year of age) was substantially higher than for all other age groups between 2018 and 2020. Older teenagers (15 to 17 years of age) in Idaho also died at a higher rate than those in younger age groups (1 to 14 years of age) between 2018 and 2020.



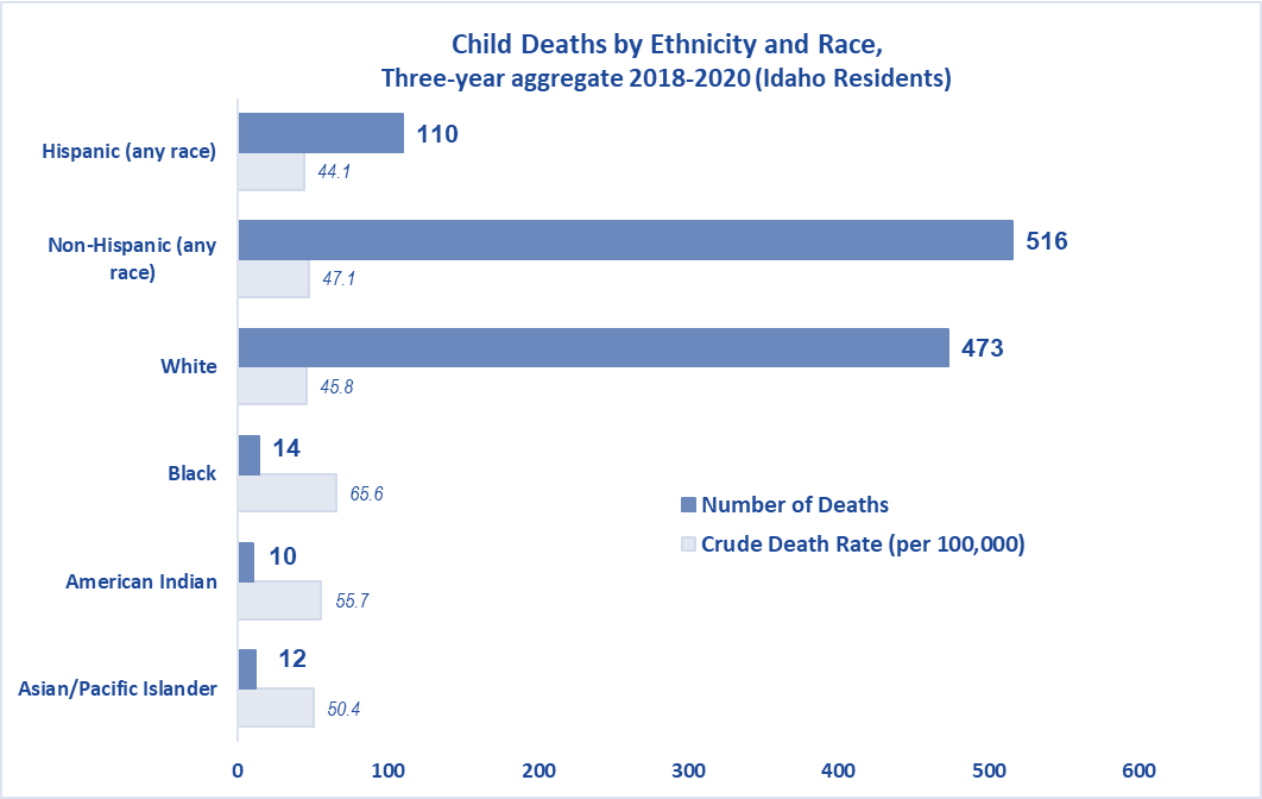
* Rate for infants under the age of 1 year is based on 100,000 live births

The overall crude death rate for male children (53.5 per 100,000) was substantially higher than for female children (39.6 per 100,000) between 2018 and 2020. Male children dying at higher rates than female children were particularly evident in the 15–17-year-old and 10–14-year-old age groups, with male children dying at nearly twice the rate of female children in these age groups.



*Infants < 1 year were purposely excluded from this figure given their much higher crude death rates. Between 2018-2020 male infants died at a rate of 512.4 compared to a rate of 455.1 for female infants (rates based on 100,000 live births).

Children of Hispanic origin had a death rate slightly lower than non-Hispanic children between 2018 and 2020. While the rate for Blacks, American Indians, and Asian/Pacific Islanders are higher than for Whites, the small numbers of recorded deaths (ranging from 10 to 14 over three years) makes it difficult to draw firm conclusions regarding the impact of race on child death in Idaho.



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).

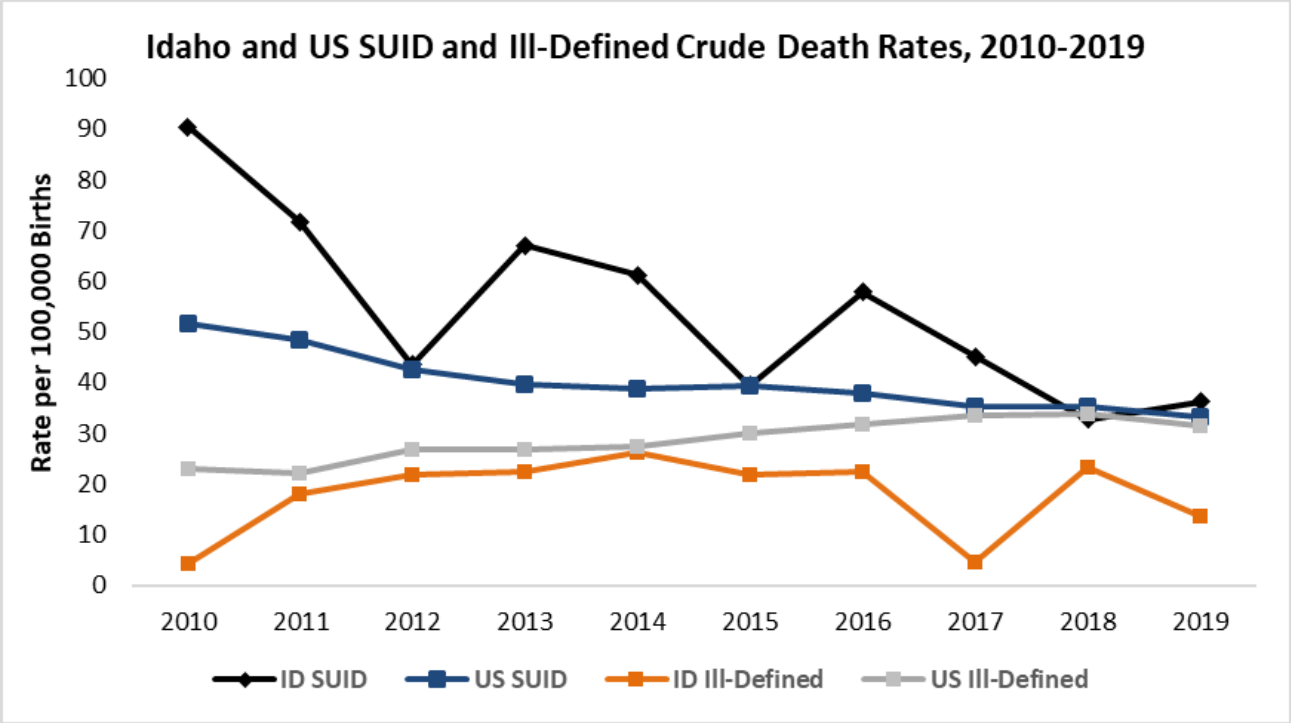
Infant deaths not meeting the CDC's definition of "SUID" (see above) may be reported as "other ill-defined and unknown causes of mortality." Historically, the SUID death rate has been higher for Idaho than for the U.S. overall while the rate of ill-defined infant deaths has been lower. The total combined number of Idaho SUID and ill-defined infant deaths remained comparatively low between 2017 and 2019 as compared to earlier in the decade. **The CFR Team continues to emphasize thorough investigation techniques and consistent coding to ensure infant deaths are correctly categorized as SUID.**

Idaho and U.S. Resident SUID Deaths (< age 1 year)
and Rates per 100,000 Births, 2010-2019

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Total Number Idaho Resident SUID deaths	**21**	**16**	**10**	**15**	**14**	**9**	**13**	**10**	**7**	**8**
Idaho Resident SUID death rate	90.5	71.7	43.6	67.1	61.2	39.4	57.9	45.1	32.7	36.3
U.S. Resident SUID death rate	51.6	48.3	42.5	39.7	38.7	39.4	38.0	35.4	35.2	33.3

Idaho and U.S. Resident Ill-Defined Infant Deaths (< age 1 year) and Rates per 100,000 Births, 2010-2019

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Total Number Idaho Resident Ill-defined infant deaths	**1**	**4**	**5**	**5**	**6**	**5**	**5**	**1**	**5**	**3**
Idaho Resident Ill-defined death rate	4.3	17.9	21.8	22.4	26.2	21.9	22.3	4.5	23.4	13.6
U.S. Resident Ill-defined* death rate	23.0	22.1	26.9	26.8	27.4	30.1	31.7	33.4	33.8	31.4



*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 and Infant Sleep Accidents

In 2019, the CFR Team reviewed eight deaths that occurred in Idaho 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. Because of their common circumstances, the CFR reviewed SUID cases along with two additional infant deaths classified as "undetermined" cause (for a total of ten Idaho resident SUID/undetermined infant deaths) *and* five infant sleep accidents.

According to the 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 2019, most Idaho SUID infant deaths followed this age-related pattern, with five SUID deaths to infants between 2 and 4 months of age and one SUID death each to infants in the following age groups: 1 month old; 5 to 6 months old; and 7 or months old. In 2019, Idaho SUID deaths occurred more frequently in the meteorological seasons (three-month groupings based on the annual temperature cycle and the calendar – e.g., winter includes December, January, and February) of spring and summer with 3 deaths each in those seasons and one death each in fall and winter.

In 2019, seven of the SUID deaths were to non-Hispanic White infants while one death was to an Asian/Pacific Islander infant. Deaths were split evenly by gender with four deaths occurring to males and four to females.

Systems Issues

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, including parent/caregiver toxicology. Indeed, the CFR Team has frequently noted the omission of parent/caregiver toxicology while simultaneously recognizing its importance in understanding the circumstances surrounding child deaths.

Infant Death Investigations / Accurate Cause of Death Coding

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. While in the recent past the CFR Team noted a marked improvement in the following of CDC and state guidelines related to investigating and

coding unexplained infant deaths, in 2019 the team suspected the majority of SUID cases were incorrectly coded as SUID and/or not thoroughly investigated (e.g., no autopsy conducted and/or CDC's Sudden Unexplained Infant Death Investigation Reporting Form (SUIDIRF) not completed as part of the death investigation).

Death Certificate Completion (Addressing Discrepancies and Adding Key Information)

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. When SUID is the stated cause of death, manner of death should be certified as "could not be determined". However, in three of the eight 2019 cases where SUID was the stated cause of death, manner of death was incorrectly certified as "natural" or "accident".

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.

Parent and Caretaker Education and Support Services

The CFR Team noted opportunities for expanding access to post-birth education and support services for parents in hospitals and clinics as well as providing education to daycare providers and individuals who babysit infants. Promoting knowledge of safe-sleep environment, feeding, hygiene, and infant CPR and may help prevent additional infant deaths.

Common Factors and Associations (All Infant Sleep-Related Deaths)

Unsafe sleep environment was noted in eight of the fifteen 2019 infant sleep-related deaths (SUID deaths, deaths of undetermined cause, and accidental deaths that occurred in a sleep environment). Examples of improper sleep environment included adult sized mattresses, couches, car seats, infant swings, and bouncer chairs. Unsafe surfaces for infants include soft mattresses, thick bedding, and pillows, "sleep nests" such as doc-a-tots and snuggle me organics, or surfaces cluttered with toys and other objects. Co-sleeping with an adult was observed in seven of the sleep-related deaths. As in past years, 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.

As in past year, the CFR Team found the many 2019 infant sleep deaths occurred in families with a history of CPS referrals as well as an unstable, hazardous, or unsanitary home environments. “Unstable” home environments include those without a consistent adult caretaker or with a parent with mental health and/or substance abuse issues. 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.
In 2019 the CFR Team also observed instances where housing instability and/or a lack of resources appeared to play a substantial role in thwarting the creation of safe sleep environment for infants. For example, young parents living with their infants in a single room of a home belonging to their parent(s), situations where infant care was coordinated among family members to facilitate night shift work, and infant care being provided through ad-hoc, low-cost arrangements to allow parents to work.

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 and may be underreported. The CFR Team also observed that a substantial of the children who died in 2019 were congested in the days leading up to their deaths. Improper infant swaddling, lack of breastfeeding, and infants not being current on scheduled immunizations were also risk factors the team commonly observed. As in past years, nearly every infant sleep-related case 2019 involved a combination of risk factors such as unsafe sleep environment and/or co-sleeping, housing instability and/or hazardous home environment, improper swaddling, and tobacco smoke exposure.

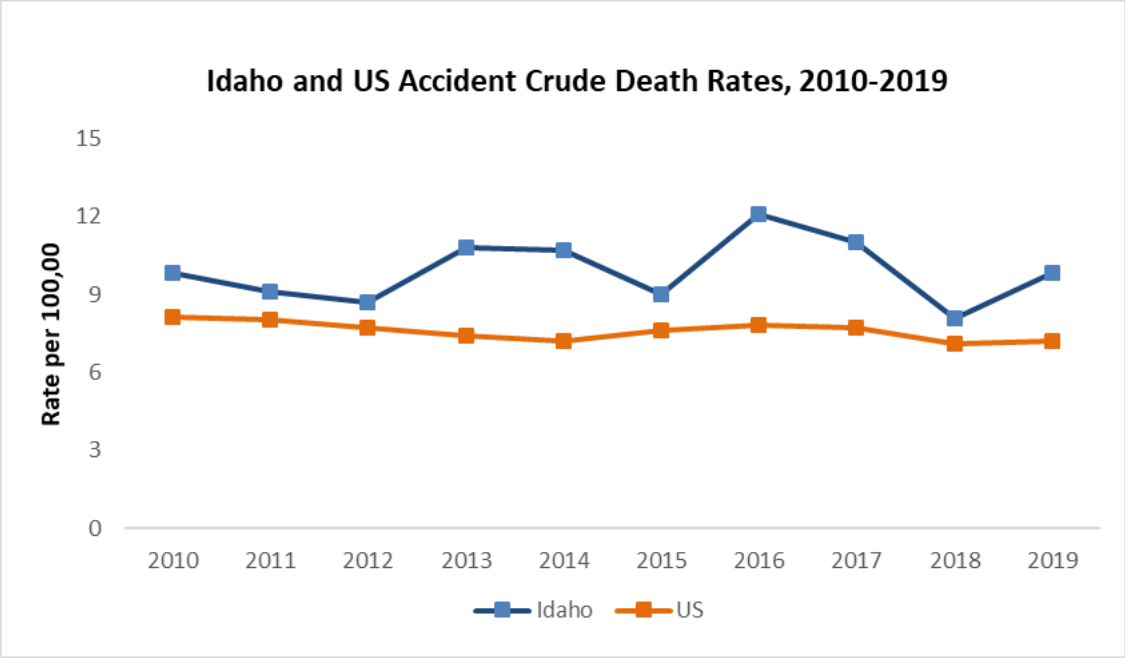
[1] Many unexplained infant deaths in Idaho appeared to be thoroughly investigated and included scene re-enactments, autopsies and/or review of medical history. However, as seen in past years, there were several instances in which “cause” and “manner” were coded inconsistently on death certificates. 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.

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 2019 rate of accident deaths in Idaho ticked up slightly from 2018 and continued the decade long pattern of exceeding the overall U.S. rate.

Idaho and U.S. Resident Accident Deaths (Age <18)
and Rates Per 100,000, 2010-2019

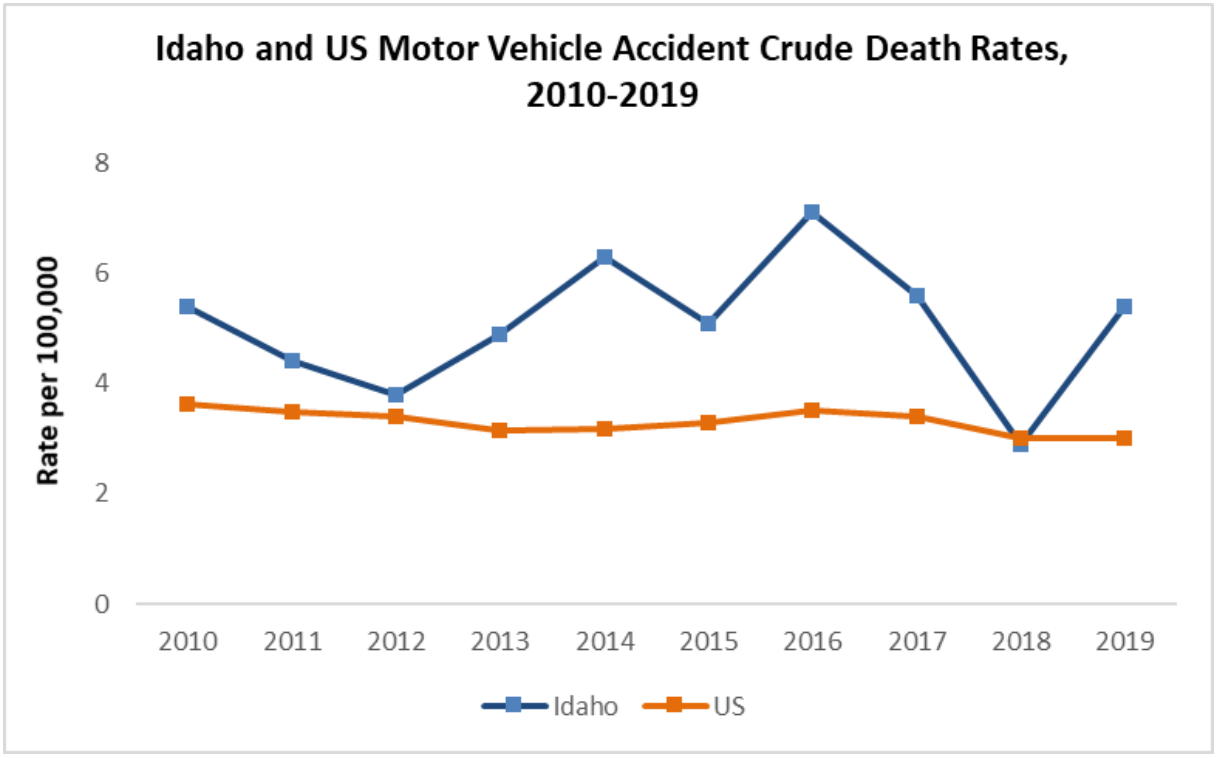
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Total number Idaho Resident accident deaths	**42**	**39**	**37**	**46**	**46**	**39**	**53**	**49**	**36**	**44**
Idaho Resident accident death rate	9.8	9.1	8.7	10.8	10.7	9.0	12.1	11.0	8.1	9.8
U.S. Resident accident death rate	8.1	8.0	7.7	7.4	7.2	7.6	7.8	7.7	7.1	7.2



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

Idaho and U.S. Motor Vehicle Accident Resident Deaths (Age <18) and Rates per 100,0000, 2010-2019

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Total number Idaho Resident accident deaths	**23**	**19**	**16**	**21**	**27**	**22**	**31**	**25**	**13**	**24**
Idaho Resident accident death rate	5.4	4.4	3.8	4.9	6.3	5.1	7.1	5.6	2.9	5.4
U.S. Resident accident death rate	3.6	3.5	3.4	3.2	3.2	3.3	3.5	3.4	3.0	3.0



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

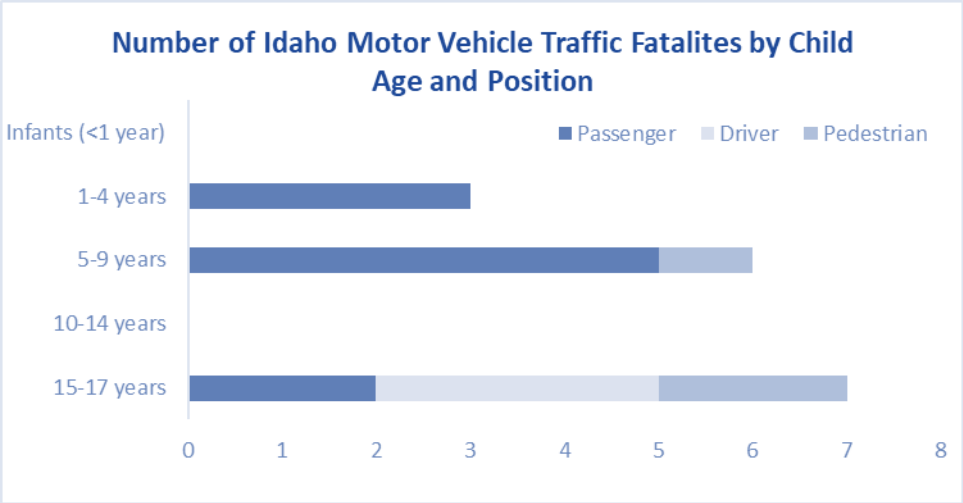
Rates based on 20 or fewer deaths may be unstable. Use with caution.

Idaho CFR Team Findings: Accidents

In 2019, 37 accidental deaths to children occurred in Idaho. Motor vehicle accidents (19) were the top cause of accidental deaths followed by drowning deaths (7) and fires (3). Five accidental infant deaths occurring in the sleeping environment are discussed in this report's section on SUID.

MOTOR VEHICLE ACCIDENTS

The CFR Team reviewed the 19 motor vehicle deaths that occurred in Idaho in 2019. Sixteen fatalities occurred in traffic accidents and three occurred in situations *not* involving traffic/roadways. One of the 16 traffic-related fatalities, one accident involved multiple deaths and as such the team reviewed 14 separate traffic accidents. There were ten female and six male fatalities, respectively. Two of the older (15-17 years) males who died in traffic/roadway accidents were pedestrians riding scooters.



Rural Roads

Seven motor vehicle accidents that involved traffic/roadways occurred on a rural road. Idaho's overall 2019 five-year motor vehicle fatality rate was 1.35 (per million vehicle miles traveled) but the five-year fatality rate on rural roads (1.80) was more than double the urban road rate (0.71) (Idaho Transportation Department, 2021). The CFR Team recommends relatively simple engineering changes, "such as rumble strips, median barriers, pavement markings, better lighting, and wider shoulders" (Pew Charitable Trust, 2021) could make rural roads safer as well as greater awareness of, and education about, the dangers of rural roads.

Teen Drivers

In 2019, five traffic accidents involved teen drivers. Driver error (e.g., reckless driving or distracted driving) was a factor in each of the crashes involving a teen driver. Other risk factors for accidents with teen drivers included alcohol or drug impairment, speeding, and 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. In 2019, seven fatalities occurred in summer, another seven happened in fall, and there was one fatality each in spring and winter.

Seat Belt and Safety Restraint Usage

As has been the case in previous years, improper safety restraint (i.e., seat belt or safety seat) was found to be a key preventable risk factor in motor vehicle fatalities. In five of the 16 traffic fatalities reviewed a seat belt was not worn and in four cases an age-appropriate child safety seat was not properly used.

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. In 2019, inattention or distracted driving were cited as contributing circumstances nine times, while driving alcohol or drug-impaired was cited in four instances, and failure to signal was cited in 3 times.

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. On an encouraging note, in six cases, toxicology was conducted on children who died and in four cases toxicology was conducted on the drivers with child passengers who died. Further, in another six cases toxicology was conducted on drivers of other involved vehicles. However, information regarding toxicology was missing in some instances and in other cases 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. Resource constraints may also play a role in incomplete

reports and/or failure to update reports. The CFR Team also suspected that in some cases, toxicology was not conducted because of a desire to avoid adding more distress to those involved in an already traumatic situation. Because complete and consistent toxicology testing (to include testing for prescription medications) of all drivers would help to better address the factors involved in motor vehicle crashes, the CFR Team recommends it become standard procedure to conduct toxicology testing on all drivers involved in fatal accidents. Further, the CRF Team believe toxicology testing of other vehicle occupants could in some cases provide a richer understanding of circumstances playing a role in motor vehicle accidents and recommends wider toxicology testing, particularly of teen passengers being driven by a peer.

Non-Traffic Fatalities

In 2019, there were 3 *non-roadway* accident fatalities. Risk factors were improper use of off-road vehicles, including underage and inexperienced drivers using off road vehicles without supervision.

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. 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. Further, Idaho Transportation Department (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). In these courses, law enforcement officers present traffic safety strategies for young drivers which emphasize responsible choices and decision-making while driving or riding as a passenger.

See Appendix for Additional Recommended Actions

DROWNING

Nationwide, drowning is the single-leading cause of death among children aged one through 4 years of age, and a top cause of death among teens (https://www.aap.org/en/news-room/campaigns-and-toolkits/drowning-prevention/). Children can slip into the water quickly and quietly. Drowning is silent and can happen much quicker than most people realize. In Idaho, drowning deaths are consistently the second highest cause of unintentional deaths, behind motor vehicle accidents. The team reviewed seven drowning deaths that occurred in Idaho in 2019. Two of the drownings occurred in Idaho rivers. Toddler or preschool aged children drowned in a wide variety of circumstances underscoring the dangers inherent in unsupervised children near water, including swimming pools, bathtubs, and water related to irrigation systems, including canals. Three deaths were of children under the age of five, two between the ages of five and nine and two between the ages of ten to seventeen.

Systems Issues

In four of the seven 2019 drowning fatalities, CPS was not notified of a child fatality when other children resided in the home. Additionally, in one drowning case, the CFR Team believed the child fatality should have resulted in a prosecution.

Common Factors and Associations

Negligence and inadequate supervision were factors in the majority of 2019 drowning accidents. In two cases adult supervision was lacking, not just for a few moments but for an extended time. In three cases, the CFR Team noted CPR was delayed. Unfamiliar surroundings may have also played a role in three of the drowning deaths.

Recommended Actions for Preventing Drowning Deaths

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).

See Appendix for Additional Recommended Actions

ADDITIONAL ACCIDENTAL DEATHS

Fires

Three child deaths were caused by two separate fires in 2019 with two children dying in the same fire. Common risks factors in the two fires were a family CPS history and smoke detectors missing altogether or devoid of batteries.

Systems Issues

Although all the children who died in fires in 2019 were known to CPS, none of the deaths were reported to CPS. The team also noted parent/caregiver toxicology was either not conducted or not reported. A positive element noted by the CFR Team in one of the cases was an immediate action to ensure a surviving family member was provided with trauma services.

The CFR Team noted sleeping in a room with a closed door may help prevent fire-related fatalities by slowing the spread of smoke, heat, and fire. The Team also recommends all families have a fire safety plan that is routinely practiced so children know what to do in case of a fire. This might involve drawing a floor plan of the home, marking two ways out of each room, including windows and doors. Lastly, the Team suggests homes be equipped with residential fire sprinklers and self-escape ladders.

ADDITIONAL CAUSES OF ACCIDENTAL DEATHS IN 2019

Other causes of 2019 accidental fatalities included an accidental overdose, an explosion, and a choking death. The CFR Team believed the faster first aid action and knowledge of the Heimlich maneuver might have averted the choking death and recommended that first aid/CPR courses be provided in a variety of languages. Additionally, the team urges those providing services to immigrants to Idaho to consider the timing of lifesaving education/training to avoid a “firehouse” effect where key information may not be maximally absorbed because it is presented with a great deal of other information.

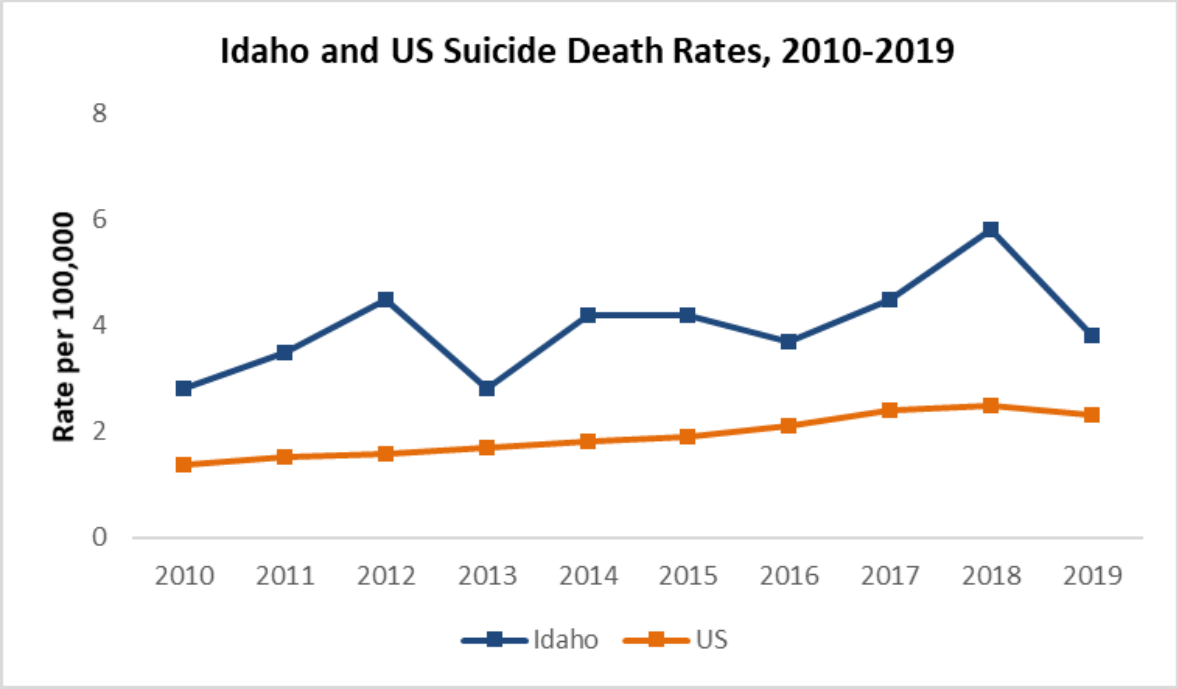
See Appendix for Recommended Actions

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 substantially higher than the overall U.S. rate and ranks in the top 10 among states. Although in 2019, the rate of youth suicide decreased as compared 2018, this decline did not persist into 2020 and 2021.

Idaho and U.S. Resident Suicide Deaths (Age <18)
and Rates per 100,000, 2010-2019

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Total Number Idaho Resident suicides	**12**	**15**	**19**	**12**	**18**	**18**	**16**	**20**	**26**	**17**
Idaho Resident suicide death rate	2.8	3.5	4.5	2.8	4.2	4.2	3.7	4.5	5.8	3.8
U.S. Resident suicide death rate	1.4	1.5	1.6	1.7	1.8	1.9	2.1	2.4	2.5	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: Suicides

The CFR Team reviewed 14 suicides occurring in Idaho in 2019. In a departure from previous years when the majority of those who died were male, in 2019 half of the suicide deaths were to females and half were to males. In 2019, under half (43%) those who died by suicide were 16-17 years of age and there were three suicides among children thirteen years of age or younger.

In 2019, very young females (13 years of age or less) died of suicide more freqently than males of the same age but slightly older males (14-15 years of age) died of suicide more frequently than female counterparts.

2019 Suicide Sex by Age Group Comparison

Age Group	Female	Male
13 or less years	43% (3)	0% (0)
14 - 15 years	14% (1)	57% (4)
16 - 17 years	43% (3)	43% (3)
Total	100% (7)	100% (7)

Twelve of the children who died by suicide in 2019 were White and Non-Hispanic. One Hispanic child and one Asian child comprised the remaining two cases.

In 2019, hanging was the mechanism of injury in half of cases and firearms were used in the majority of the remaining cases. There was minimal gender variation in injury mechanism in 2019.

Number of Suicides in Idaho by Mechanism and Gender, 2019

	Injury Mechanism Used		
Gender	**Hanging/asphyxiation**	**Firearm**	**Overdose**
Male	4	3	0
Female	3	3	1

2019 suicide deaths were more prevalent in the warmer seasons of spring (5) and summer (4) and less common in the winter (3) fall months (2). Six of the 14 completed suicides occurred in the school transiton months of May, August, and September with one completed suicide highly related to a school year transition. Because the beginning or ending of academic years can be

parituclarly stressful for young people, the CFR Team continues to monitor school transitions as a potential suicide risk factor.

Systems Issues

As with other causes of death in 2019, the CFR Team noted failures to report suicide deaths to CPS. In situations where the child who completed suicide had spent time in in-patient care, the Team noted that in-patient care discharge was inadequate, and that private insurance may not have sufficiently covered in-patient care forcing premature release from care. Additionally, in several instances the Team was unable to verify if a child who completed suicide was receiving mental health services at the time of their completed suicide or at any previous point.

The Team also recognized that primary care physicians (PCPs) are frequently not allowed adequate time to connect with their patients and delve into mental health issues and suicide risk factors that may be impacting children. Further, PCPs may require educational and training opportunities related to treating mental health issues to foster enhanced care.

Additionally, there were instances in which full autopsies and more comprehensive death investigations, including toxicology, could have resulted in better understanding of the circumstances leading to completed suicide deaths, particularly when medical and/or mental health issues or substance use/abuse may have been present and impacting the child.

Common Factors and Associations

In 2019, over half of those who died by suicide were experiencing romantic/sexual relationship conflicts. The majority also had suicidal ideations and almost half had a documented history of depression. The team noted a wide range of triggering events including social isolation, sexual assault allegations, past incidents of self-harm, suicide attempt histories, and past involvement with CPS. The team found evidence of one possible “cluster” in which two of those who completed suicide were close in age, lived in the same area, and one child was clearly aware of the other’s completed suicide. 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.

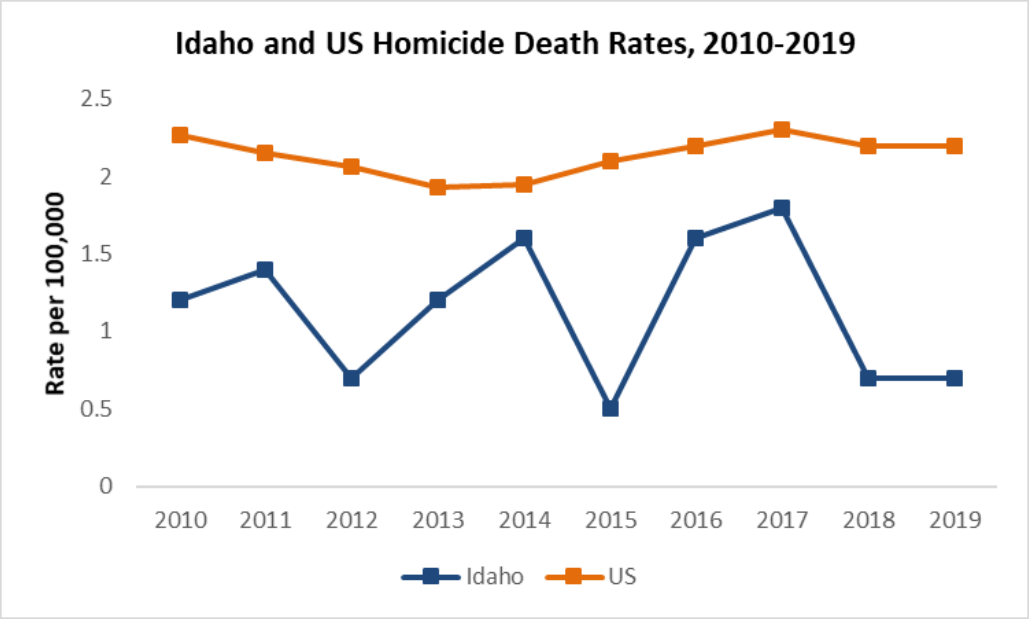
See Appendix for Recommended Actions

HOMICIDES (Assault)

There were three fatal assaults to Idaho resident children in 2019. While the rate of homicide in Idaho has historically been lower than the national rate, the size of the gap varies widely by year.

Idaho and U.S. Resident Homicide (Assault) Deaths (Age <18) and Rates per 100,000, 2010-2019

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Total Number Idaho Resident homicides	**5**	**6**	**3**	**5**	**7**	**2**	**7**	**8**	**3**	**3**
Idaho Resident homicide death rate	1.2	1.4	0.7	1.2	1.6	0.5	1.6	1.8	0.7	0.7
U.S. Resident homicide death rate	2.3	2.2	2.1	1.9	2.0	2.1	2.2	2.3	2.2	2.2



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 4 assault deaths which occurred in Idaho in 2019 – one homicide, one assault, and two instances where "intent" could not be determined. Causes of the 2019 assaults included firearm shootings, suffocation, and poisoning/drug exposure. Two of victims were infants under one year of age. Two of the children who died were female and two were male and three were non-Hispanic Whites while the other was a Native American.

Common Factors and Associations

Family CPS history and drug use were observed as common risk factors in Idaho's 2019 homicide and assault deaths.

As seen in other causes of child endangerment, violence may be rooted in a pattern of intergenerational maltreatment. The CFR Team has observed over the years that many of these violent episodes occur in families with a history of CPS involvement, some dating back to the parents' own childhood years. Proven, effective prevention strategies are those focused on building safe, supportive, and nurturing families and home environments.

Interagency cooperation can help ensure families receive the support they need and prevent future tragedies. Enhanced communication between law enforcement and CPS, particularly with regards to minors who may still reside in homes where violent episodes have occurred, could protect children and aid families in volatile situations.

See Appendix for Recommended Actions

PREVENTABLE NATURAL DEATHS

In addition to detailed reviews of deaths by external causes, a CFR subcommittee screened death records certified with a manner of "natural." Causes of natural manner deaths include perinatal conditions, congenital malformations, malignancies, viral infections, cerebrovascular conditions, 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 in an effort to identify preventable risk factors and opportunities for system improvement.

The subcommittee selected 20 natural manner deaths for a complete CFR Team review of additional information from death certificates, birth certificates, coroner/autopsy reports, medical records, and/or law enforcement reports (when applicable). The natural manner cases selected for additional review included: 13 perinatal conditions; and 7 non-ranking/all other cause cases, including one congenital malformation.

Perinatal Condition Deaths

The majority of perinatal condition deaths involved low birth weight and/or extreme prematurity. Maternal obesity, less resilient male babies, and previous poor pregnancy outcomes were commonly noted in the perinatal condition deaths. Maternal and paternal CPS history and/or an alcohol or drug use history were also observed. As in previous years, the CFR team found lack of prenatal care and maternal tobacco use during pregnancy were also factors in perinatal conditions deaths.

Other, Non-Ranking Deaths

Non-ranking deaths include natural manner deaths that are not categorized elsewhere. The deaths the team reviewed were due to varied causes with some cases involving underlying medical conditions. Causes included sleep apnea, adenovirus infection, acute appendicitis, and other viral and bacterial infections. Although risk factors associated with "other/non-ranking" varied widely, lack of safe childcare was observed in two of the six deaths that were reviewed. Maternal, paternal, and caregiver CPS history was also identified as a common risk factor in these deaths.

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 one death in 2019 might have been related to an infant from a family who refused medical care based on religious beliefs. Because this death was investigated thoroughly by both the county coroner and law enforcement, the CFR Team found evidence suggesting this death might have been prevented with timely medical treatment, and/or proper prenatal care for the mother.

Systems Issues

As with other cause of death, the CFR Team noted toxicology results were missing in several of the perinatal and other/non-ranking cause deaths making it difficult to ascertain what role alcohol or drugs may have played in these deaths. Other systems issues identified by the CFR team included a lack of safe, affordable childcare, and issues related to death investigations which included lack of communication between agencies, and failure to notify CPS of a child death when other children were in the house.

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Executive Department
State of Idaho

State Capitol
Boise

EXECUTIVE DEPARTMENT
STATE OF IDAHO
BOISE

EXECUTIVE ORDER No. 2022-01

GOVERNOR'S TASK FORCE ON CHILDREN AT RISK

WHEREAS, Idaho's children are her most valuable resource; and

WHEREAS, it is the responsibility of all Idahoans to provide a community system of support and protection for these children; and

WHEREAS, the protection of children from abuse and neglect is in the best interest of all Idahoans;

NOW, THEREFORE, I, Brad Little, Governor of the State of Idaho, by authority vested in me by the Constitution and laws of the State of Idaho, do hereby order the continuance of the Governor's Task Force on Children at Risk.

The Task Force is responsible for developing, establishing, and operating programs designed to improve:

a. *The assessment and investigation of suspected child abuse and neglect cases, including cases of suspected child sexual abuse and exploitation, in a manner that limits additional trauma to the child and the child's family;*

a. *The assessment and investigation of cases of suspected child abuse-related fatalities and suspected child neglect-related fatalities;*

b. *The investigation and prosecution of cases of child abuse and neglect, including child sexual abuse and exploitation; and*

c. *The assessment and investigation of cases involving children with disabilities or serious health-related problems who are suspected victims of child abuse or neglect.*

The Task Force shall continue to support a statewide child fatality review team to allow comprehensive and multidisciplinary review of deaths of children younger than 18 years old to identify what information and education may improve the health and safety of Idaho's children.

The Task Force shall be composed of eighteen (18) members appointed by the Governor. The Task Force may request the Governor to provide additional members if it is determined that certain interests are not adequately represented. The membership shall include, but will not be limited to, the following with consideration of geographical representation:

- *A member of the law enforcement community;*
- *A criminal court judge;*
- *A civil court judge;*
- *A prosecuting attorney;*

- *A criminal defense attorney;*
- *An attorney for children;*
- *A Court Appointed Special Advocate (CASA) representative;*
- *A health professional;*
- *A mental health professional;*
- *A member of a child protective service agency;*
- *An individual experienced in working with children with disabilities;*
- *An adult who is a former victim of child abuse or neglect;*
- *A member of the Administrative Office of the Courts;*
- *An individual experienced in working with homeless children/youth (as defined in section 725 of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a));*
- *An individual experienced in working with victims of abuse;*
- *A person who is a parent and/or a representative of a parent group;*
- *An education representative; and*
- *A juvenile justice representative.*

The members of the Task Force shall serve at the pleasure of the Governor for a four-year term. Members of the Task Force shall elect their chair from among their members.

The Task Force shall submit a written report by June 1 of each year to document its efforts.

The Department of Health and Welfare shall be the lead agency, providing support for the Task Force, and shall monitor contracts for staff to carry out the activities directed by the Task Force as funding is available.

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Idaho on this 13th day of January in the year of our Lord two thousand and twenty-two.

BRAD LITTLE
GOVERNOR

LAWERENCE DENNEY
SECRETARY OF STATE

Appendix

In the following tables prevention recommendations are grouped by target audience to facilitate expedient review of key recommendations by profession or role. The CFR Team encourages all readers to review the general recommendations as well as other recommendations that may touch on professional crossover areas.

Recommended Actions for Understanding and Preventing SUID

Table 1: General SUID Prevention Recommendations
Follow American Academy of Pediatrics (AAP) Safe Sleep Guidelines (https://www.healthychildren.org/English/ages-stages/baby/sleep/Pages/A-Parents-Guide-to-Safe-Sleep.aspx**).**
Immunize Infants in Accordance with AAP and CDC Recommendations (http://pediatrics.aappublications.org/content/138/5/e20162938).
Encourage Breastfeeding (https://www.aappublications.org/news/2017/10/30/BreastfeedingSIDS103017).
Increase Understanding of Intergenerational Maltreatment (IGM) / Continue to Invest in Parent and Childcare Education 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.

Table 2: Recommendations for Coroners and Law Enforcement on SUID Prevention
Perform Toxicology Tests on Parents/Caretakers 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 and sleep accident cases.
Use CDC's SUID Investigation Form Consistently Consistent usage of the CDC's SUID Investigation Reporting Form (www.cdc.gov/sids/SUIDRF.htm), or local equivalent, is recommended to properly guide
Work with Partner Agencies to Investigate Family Health and Safety Concerns Law enforcement agencies and coroners are encouraged to work cooperatively and share information with partner agencies (CPS, etc.) to investigate health and safety concerns within families.
Ensure SUID is Actual Cause of Death Before attributing a death to SUID, explore if unsafe sleep conditions were involved in the case.

Coroner Training Recommendations
To better understanding the circumstances involved in SUID, the CFR Team identified opportunities for continued coroner training on the following topics: guidelines for coding and detailing findings on death certificates[1]; SUID Investigation; and Inter-agency collaboration.
Law Enforcement Training Recommendations
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.com).

Table 3: Recommendations for Public Health Agencies on SUID Prevention
Continue Public Education Campaigns 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.
Educate Childcare Providers The CFR Team found educational opportunities related to safe sleep environment and infant CPR. Along with recommending training on these topics as part of care facility guidelines, training in these key areas could also be included as part of licensing requirements.
Expand Home Visiting Programs 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.
Utilize Case Workers to Provide Education During Home Visits Case workers play a key role in educating parents and childcare 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.
Ensure Health Educators Have Key Knowledge 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/)
Connect Families in Need with Items that Facilitate Safe Sleep Depending on the local area, "cribettes" (pack and plays) and other safe sleep items may be available to families in need. The IDHW's 2-1-1 Idaho Careline can be utilized to connect those in need to local resources.

Table 4: Recommendations for Health Care Professionals on SUID Prevention
Educate Parents Provide education to parents/caregivers at every medical appointment during the first year of life on safe sleep and sleep position, including: ○ Asking about infant's sleep environment ○ Discussing alternative sleep environments when crib is not available ○ Counseling on the dangers of co-sleeping ○ Providing advice on safe swaddling of infants to include ages/developmental milestones ○ Discussing safe tummy-time. Include tummy time is during direct supervision of infant. ○ Advising on the dangers of using bobby pillows, car seats, and swings for sleep.
Provide Home Visit Referrals 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).
Reassure Parents About Immunizations The CDC stresses that timely vaccinations are essential in providing immunity to life-threatening diseases. 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).

Table 5: Recommendations for Parents and Child Care Providers on SUID Prevention
Take Advantage of Childcare Courses and Home Visiting Services Many hospitals and community education centers offer parenting and childcare 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.
Follow Safe Sleep Guidelines Parents and care providers should be familiar with AAP safe sleep recommendations and follow them closely (https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/safe-sleep/Pages/Safe-Sleep-Recommendations.aspx). Parents and care providers should also be familiar the "ABCs of Safe Sleep. Baby should always sleep Alone. Baby should always sleep on their Back. Baby should always sleep in a Crib. (https://healthandwelfare.idaho.gov/health-wellness/healthy-infants-children/safe-sleep).
Immunize to Reduce Risk AAP research confirms that staying current with immunizations significantly reduces the risk of infant death. Routine childhood vaccines are available at no cost or reduced cost if financial barriers are a consideration. For information on where to obtain vaccines in Idaho see: (https://healthandwelfare.idaho.gov/services-programs/children-families/child-and-adolescent-immunization).
Breastfeed Infants 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.
Avoid Smoking or Vaping Idaho's Project Filter offers the "Quit Now" program to support cessation efforts: http://projectfilter.org.
Call 9-1-1 /Avoid Self-Transport

Recommended Actions for Understanding Unintentional Accidents

Table 6: Recommendations for Public Transportation Agencies to Prevent Motor Vehicle Fatalities
Explore Engineering Changes to Enhance the Safety of Rural Roads The CFR Team recommends engineering changes to rural roads, "such as rumble strips, median barriers, pavement markings, better lighting, and wider shoulders" to rural roads be explored. https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2021/08/17/deadly-crashes-on-rural-roads-prompt-new-safety-efforts
Continue Messaging / Explore Expanded Public Education Ongoing messaging on proper seat belt/safety restraint use, bicycling safety, and warnings against impaired, distracted, and aggressive driving may help prevent additional traffic fatalities. Increase public education on pedestrian safety education including the use of crosswalks, wearing reflective gear/light colors, and limiting distractions such as the use of cellphones/music while running or walking in busy areas. Opportunities may also exist for additional public education related to safety seat installation checkpoints and pedestrian safety.

Table 7: Recommendations for Law Enforcement to Prevent Motor Vehicle Fatalities
Continue Strict Enforcement of Drug and Alcohol Impairment Laws 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.
Provide More Details in Crash Reports 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 contributing causes. Providing detailed information serves to better identify various causes of accidents and may lead to improved driver education and preventive efforts.
Promote Compliance with Vehicle Safety Restraint Laws 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.

Table 8: Recommendations for Parents and Teen Drivers to Prevent Motor Vehicle Fatalities
Recognize Distinct Challenges Presented by Idaho's Rural Roads Idaho's rural road fatality rate is more than double the urban road fatality rate. The CFR Team recommends teen drivers gain experience driving on rural roads prior to obtaining a license.
Use Safety Restraints Properly 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. 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.(https://www.stlukesonline.org/health-services/health-information/health-topics/car-seat-safety). 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. IDHW's 2-1-1 Idaho Careline can be used to connect families in need of car seats and/or booster seats to resources in their local community.
Instill Safe Driving Habits *Recognize the Risk Posed by Using Electronic Devices* 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 (https://www.nhtsa.gov/risky-driving/distracted-driving). *Stop Aggressive 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. Shift Idaho offers tips for recognizing and reacting to aggressive drivers at: (https://shift-idaho.org/aggressive-driving/) *Avoid Multiple Passengers* Teen drivers are 2.5 times more likely to engage in risky behaviors when driving with one teenage peer and 3 times more likely to do so when driving with multiple passengers. The National Highway Transportation Safety Board (NTHSB) recommends parents enforce Idaho's graduated licensing law related to multiple passengers as well as set their own rules and consequences for their teens driving with multiple passengers. (https://www.nhtsa.gov/road-safety/teen-driving) *Use Teen-Parent Driving Contract to Set Driving Expectations* Establish a written teenager-parent contract that places expectations on the teen driver such as wearing a seat belt, obeying curfew, never driving while impaired by alcohol or other drugs.

Table 9: Recommendations for Preventing Pedestrian and Rider Fatalities
Ensure Children are Adequately Supervised Adults and caregivers should closely supervise children when walking, biking, skating, or riding scooters near roadways, driveways, and parking lots. During nighttime 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.
Drive With Extra Caution Near Child-Centered Areas 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.
Use Helmets to Protect Against Head Injuries 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. IDHW's 2-1-1 Idaho Careline can be used to connect those in need of a helmet to resources in their local community.

Recommended Actions to Prevent Drowning

Table 10: Recommendations for Public Health Agencies to Prevent Drowning Deaths
Continue Public Education Campaigns The CFR Team recommends 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.
Add Signage Near Natural Swimming Areas Adding signage near entry points of frequented river, creek, and lake swimming areas with warnings of the risks of swimming in natural waterways is a step the CFR Team endorses for preventing future accidental drowning deaths.
Warn of Swimming Dangers The CFR Team also recommends general warnings of the unpredictable nature of rivers, lakes and reservoirs be directed to teens and pre-teens of all swimming ability levels, as well as parents of young children.
Improve Access to Swimming Lessons Because formal swimming lessons can prevent drowning, the CFR Team encourages public health agencies to explore strategies for improving access to swimming lessons.

Table 11: Recommendations for Parents and Caregivers to Prevent Drowning Deaths
Use Life Jackets Anytime children are near bodies of water, even if there is no plan to get into the water, Coast Guard Approved life jackets should always be worn. Swimming lessons are the first step towards drowning prevention for children and parents. However, they do not take the place of life jackets.
Provide swimming lessons / Know CPR To prevent drowning injuries, the CDC advises everyone (children and parents) to know the basics of swimming (floating, moving through the water) and CPR.
Employ Touch Supervision Any Time a Child is in the Water Touch supervision is critical anytime children are in water. This means whoever is watching children while they are in the water, should either be in the water with them or an arm's length away. The person watching the children, also called the water watcher, should put down their phones, avoid all other activities, supervise even if there are lifeguards, and switch off with other adults for a break.
Add Child Safety Gates and Barriers to Open Water and Pools 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.
Know the Drowning Hazards Around Your Environment Parents and caregivers should know what drowning hazards (canals, rivers, swimming pools, irrigation ponds, ornamental ponds) are around the areas where they live as well as the places they visit. Parents/caregivers should also ensure children in their care know how to be safe around water both in and around their own homes and in the places they visit.

Table 12: Recommendations for Coroners and Law Enforcement to Prevent Drowning Deaths
Perform Full and Uniform Toxicology Tests Alcohol impairment is a well-known risk factor in drowning deaths and both illicit drugs and prescribed medication may also play a role in drowning deaths (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6474464/). As such, the CFR Team recommends widespread use of toxicology testing of the child decedent and of the caregiver(s)/supervisor(s) involved in drowning deaths.

Recommended Actions to Prevent Suicide

Table 13: Suicide Prevention Recommendations for Everyone

Know the Warning Signs

IDHW's Office of Suicide Prevention encourages *everyone* to be familiar with the warning signs for suicide which are nearly always present:

- 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

(http://healthandwelfare.idaho.gov/Families/SuicidePrevention/tabid/486/Default.aspx).

Take Action in Crisis Situations

If a person threatens suicide or has a weapon, **call 911** immediately.

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.

Obtain Training

QPR (Question, Persuade, and Refer) Gatekeeper Training for Suicide Prevention saves lives by providing practical, proven suicide prevention training to 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 instructors in person or online. Customizable trainings for practitioners are also offered (https://qprinstitute.com/).

Restrict Access to Lethal Means

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. 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 and as such not having the means at hand to complete the attempt may save lives.

Recognize the Power of Key Protective Factors

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. Proactively fostering these protective factors should be a priority for everyone who works with teens and tweens.

Table 14: Recommendations for Educators for Preventing Suicide
Utilize Resources Offered by the Idaho Lives Project Educators 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.
Encourage Communication and Connections 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 and counselors may serve as valued role models who young people may approach for emotional support and advice.

Table 15: Recommendations for Health Care Professionals for Preventing Suicide
Conduct Mental Health Screening / Collaborate with Behavioral Health Providers 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 Youth Empowerment Services (YES) system of care uses screening tools to help identify youth who have unmet mental health needs. Healthcare professionals can screen youth for mental health concerns by using a variety of mental health screeners (https://yes.idaho.gov/youth-empowerment-services/getting-started/community-members/healthcare-professionals/). The Suicide Prevention Resource Center (www.sprc.org/settings/primary-care/toolkit?sid=508) also offers resources for medical practices and professionals.
Follow Best Practices in Creating Care Transition Plans Health care providers are encouraged to follow best practices in care transitions when youth in suicidal crisis move from inpatient to outpatient care. Best practices include involving family and other natural support's in the patients care, inpatient and outpatient providers working collaboratively to detail the responsibilities of each organization, ensuring systems are in place for tracking the timeliness of outpatient services after inpatient discharge, and jointly developing a safety plan https://www.sprc.org/resources-programs/best-practices-care-transitions-individuals-suicide-risk-inpatient-care.
Conduct Prescription Drug Follow-ups In some cases, the CRF Team reviewed it was evident a child had been prescribed medications for mental health and/or other conditions, but it was unclear if the child was taking the medication(s) as prescribed. Well-documented follow-up regarding adherence to prescribed medication could aid in understanding the circumstances surrounding completed suicides.
Refer to the YES Program (https://youthempowermentservices.idaho.gov/) The Youth Empowerment Services (YES) Program is a system of care for youth in Idaho under 18 who may benefit from mental health support. Health care provides are urged to refer families who may not be able to afford mental health care to the YES program.
Afford Primary Care Providers Increased Time with Adolescent Patients and Mental Health Treatment Training and Educational Opportunities

Recognize the frontlines position primary care physicians (PCPs) are playing in the current adolescent mental health crisis (https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf), acknowledging the need for PCPs to spend increased time with adolescents and responding with appropriate reimbursement and providing mental health treatment and training and educational opportunities for PCPs.

Table 16: Recommendations for Public Health Agencies for Preventing Suicide
Increase Public Education Aimed at Parents Public Health Agencies are encouraged to increase parental awareness of suicide risk and protective factors as well make parents aware of information about youth mental health (https://www.nami.org/Your-Journey/Teens-Young-Adults).
Increase Gun Safety Education Nationally, firearm ownership and access have been correlated with higher rates of youth suicide. A 2020 report by the RAND Corporation ranks Idaho as fourth in average household firearm ownership rates nationwide (at 60%), behind only Montana, Wyoming, and Alaska (https://www.rand.org/pubs/tools/TL354.html) 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. *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.
Promote Greater Access to Mental Health Treatment in Rural Areas 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.

Table 17: Recommendations for Parents for Preventing Suicide
Collaborate with Health Care Workers and Educators In addition to being familiar with the warning signs of suicide risk, parents should readily consult health care providers and/or educators when concerns arise about their child's mental health.
Remove or Properly Store Lethal Items 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.
Promote Connection 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.

Limit Screen Time / Monitor Internet Use

American Academy of Child and Adolescent Psychiatry (https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Children-And-Watching-TV-054.aspx) 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 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).

Table 18: Recommendations for Coroner and Law Enforcement for Preventing Suicide
Investigate Cooperatively Coroners and law enforcement agencies should work cooperatively during suicide investigations to ensure conclusions are based on all available information. A Suicide Death Investigation Form developed by the Colorado Department of Public Health and designed to be used a multiple stages of the death investigation process may serve as a useful resource (https://cdphe.colorado.gov/suicide-prevention/suicide-investigation-form).
Provide Referrals for Family Members 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 Idaho Lives Project (www.idaholives.org).
Coroners: Conduct Toxicology 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 contributing circumstances should be included on the death certificate. Consistent access to this information may lead to better understanding of precursors and contributing factors of suicide.
Law Enforcement: Search Social Media Accounts and Devices Suicide 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.

Law Enforcement Training Recommendations
Law enforcement officers are encouraged to enroll in QPR (Question, Persuade, and Refer) Gatekeeper Training for Suicide Prevention (https://qprinstitute.com/professional-training) 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.
High quality law enforcement reports of suicide deaths facilitate detailed case reviews and assist in the development of targeted prevention strategies. Resources that may assist law enforcement include: the Suicide Prevention Resource Center (Law Enforcement section) (https://www.sprc.org/settings/law-enforcement) and PoliceOne Academy courses (https://www.policeoneacademy.com/law-enforcement-training/).

Recommended Actions for Preventing Assault/Homicide Deaths

Table 18: **Recommended Actions for Preventing Assault/Homicide Deaths**
Child Welfare Information Gateway provides examples of community-based primary prevention programs which may serve as a model for state and local organizations (https://www.childwelfare.gov/topics/preventing/).
The CDC also recommends that youth violence prevention strategies focus on interventions at all social ecological levels (the individual, relational, community, and societal levels) https://www.cdc.gov/violenceprevention/youthviolence/prevention.html.
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. *Prevent Child Abuse America* offers educational materials targeted at parents and professionals (https://preventchildabuse.org/).