Idaho Child Fatality Review

2021 Annual Report

Children at Risk Task Force

January 2024

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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 child deaths occurring in Idaho to children under age 18 in order 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 from 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 participated in 2021 reviews:

Tahna Barton, Court Appointed Special Advocates (CASA), CFR Team Chair
Jerrilea Archer, Ada County Sheriff's Office (retired)
Susan Bradford, MD, Pediatrician, Pediatric Residency of Idaho
Don Caagbay, Idaho Department of Health and Welfare, Behavioral Health
Curtis Carper, Law Enforcement, Nampa City Police
Justin Clemons, Fire Fighter/Paramedic, Pocatello Fire Department
Matthew Cox, MD, St. Luke's Medical Center, CARES
Hannah Crumrine, Suicide Prevention, Department of Education
Autum Ferris, Idaho Department of Health and Welfare, Division of Family and Community Services
Cristi Litzsinger, RDN, LD, Idaho Department of Health and Welfare, Clinical and Preventive Services
Alana Minton, JD, Lead Deputy Attorney General, Criminal Division
Teri Whilden, JD, Deputy Attorney General, Criminal Division
Garth Warren, MD, Ada County Coroner, Forensic Pathologist
Christina Di Loreto, MD, Ada County Coroner, Forensic Pathologist
Chiara Mancini, MD, Ada County Coroner, Forensic Pathologist
Lacey Williams, MPH, Program Coordinator, St. Luke's Children's Injury Prevention
Christine Hahn, MD*, Idaho State Epidemiologist, Medical Director, Idaho Department of Health and Welfare *(subcommittee member)*
Elsa Otander, MHS*, Principal Research Analyst, Division of Family and Community Services, 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 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:

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

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, 2022):*

1. Ensure the accurate identification and uniform reporting of the cause and manner of every child death.
2. Improve communication and linkages among local and state agencies to 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 barriers 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 in legislation, policy, and practices and expanded efforts in child health and safety to prevent child deaths.
9. Increase public awareness and advocacy for the issues affecting the health and safety of children.

In Idaho, the Child Fatality Review (CFR) 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 occurring in Idaho during calendar year 2021 were reviewed. Deaths occurring out-of-state were not reviewed because pertinent records are not available for the CFR Team's use.

The designated Child Fatality Review (CFR) research analyst in IDHW's Family and Community Services requested the data set for all deaths occurring in Idaho in 2021 to individuals under the age of 18 from Vital Statistics. The deaths were identified using the Vital Records system and the corresponding birth and death certificates were compiled and shared with the CFR research analyst. 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 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

The CFR Team met six times between April 2023 and January 2024 to conduct the 2021 case reviews. 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 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, if available.

Information gathered from various sources and CFR Team conclusions were entered into the National Child Death Review Case Reporting System by the CFR research 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

Although the CFR research analyst attempted to obtain all relevant records from the various agencies, the CFR 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 CFR Team continues to face barriers due to the inability to obtain certain records. These 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).

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).

In addition, data collection practices vary considerably from one local institution to the next. Each coroner, law enforcement, and hospital develop its own system for completing forms, records, and investigations. This includes who fills out the records, who reviews them, how the records are filed, and whether there is specific guidance for completion. Therefore, data sources vary widely and not all records and death information is available for each case that is reviewed.

EXECUTIVE SUMMARY

This report presents the 2021 review findings and recommendations of the Idaho Child Fatality Review (CFR) Team. Of 193 child deaths in Idaho in 2021, 106 were selected for detailed review by the CFR Team. Deaths that were *not* selected for full CFR Team review included most deaths due to perinatal conditions, congenital anomalies, malignancies, or other diagnosed medical conditions.

2021 Deaths to Children (Birth to Age 18) Occurring in Idaho

	Total	Reviewed by CFR Team
Perinatal Conditions	49	2
Congenital Malformations	22	2
Unintentional Injuries (Accidents)	52	52
Motor Vehicle Accidents	*24*	*24*
Sleep Accidents	*13*	*13*
Other Accidents	*15*	*15*
Suicides	25 [1]	24 [2]
Unexplained Infant Deaths	8	8
SUID	*2*	*2*
Ill-defined [3]	*6*	*6*
Assault (Homicide)	2	1 [4]
Malignancies	10	0
Influenza/Pneumonia	3	3
COVID-19	0	0
Non-ranking/All Other Causes	22	14
Cardiovascular/Pulmonary	*6*	*6*
Undetermined [5]	*3*	*3*
All other causes	*13*	*5*
Total	**193**	**106**

[1]Includes one death where manner was accident but was deemed suicide by CFR Team.

[2]One Suicide was not reviewed due to not receiving requested records.

[3]Includes one death, coded to ICD-10 code Y20.0, that was related to the sleep environment.

[4]One homicide case was pending in court proceedings, so the review was deferred.

[5]Undetermined causes of death to those 1-17 years of age.

The CFR Team met six times between April 2023 and January 2024 to conduct the 2021 case reviews. 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 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, if available.

The team reviewed 106 deaths to children under the age of 18 which occurred in Idaho during calendar year 2021. 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, not all records were available. Information gathered from various sources and CFR Team conclusions were entered into the National Child Death Review Case Reporting System by the CFR research analyst and summarized in this report.

SUMMARY OF FINDINGS

Sudden Unexplained Infant Death, Ill-defined Infant Deaths, and Sleep Accidents

(See page 22 for complete data analysis)

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 2021, there were two SUID cases in Idaho. Additionally, the CFR team reviewed six undetermined or ill-defined infant deaths and 13 infant deaths caused by accidents in the sleeping environment.

Co-sleeping, having a child protection history, prenatal and post birth caregiver drug use, prenatal exposure to smoking, NICU admission at birth, mother falling asleep while breastfeeding, unsafe sleep environments (e.g., on adult sized mattresses, thick bedding, "sleep nests" such soft baby loungers, couches, car seats), and caregiver alcohol use at time of incident 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).

Continued promotion of American Academy of Pediatrics (AAP) safe sleep guidelines, abstaining from prenatal drug use and exposure to smoking, and safe breastfeeding practices 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, substance abuse resources, and parent and childcare education may also support at risk families and prevent infant deaths.

Unintentional Injuries (Accidents)

(See page 29 for complete data analysis)

Motor Vehicle Accidents

In 2021, 24 children died in motor vehicle accidents in Idaho. Nineteen fatalities were traffic accidents and five fatalities occurred in non-roadway, non-traffic circumstances. Most of the victims were passengers, with the majority being driven by adults. Overall, 14 males and 10 females died. Four of the five non-traffic accident involved ATV or off-road vehicles. Inattentive or distracted driving, driving while 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 2018 and 2019, the team noted a high percentage of 2021 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.

Drownings

There were four drowning deaths in 2021. Three of the drowning deaths were children aged five and under. Two of the four children drowned in a swimming pool, while one drowned in a bathtub and one in an Idaho river.

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.

Other Accidents

There were three unintentional poisonings, two firearm related accidents, two avalanche deaths, and four miscellaneous accidents.

Suicides

(See page 39 for complete data analysis)

The team reviewed 24 of the 25 youth suicides in Idaho in 2021. Of the 24 reviewed suicide deaths, 15 were males and nine were females. Twelve suicides were completed via hanging, 11 by firearms, and one by self-poisoning. 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. All suicide deaths were determined to be preventable.

The IDHW'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 lethal means reduction 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 and Undetermined Cause

(See page 43 for complete data analysis)

In 2021 there were two deaths due to homicide. However, one of the cases was still open in court proceedings at the time of review, so the case was deferred. The CFR Team reviewed three undetermined cause deaths to children one year of age and older. Two of these deaths were under suspicious circumstances and though the manner was reported as undetermined, the team deemed these two deaths as preventable.

Family history with Child Protection Services (CPS), family history of substance abuse, and lack of adequate childcare were risk factors identified by the team. The number of deaths involving family instability suggests a need for greater access to services that support families, and greater follow through on complex CPS cases and home visitation screenings. Those who work with children should be familiar with the signs of abuse and readily report concerns. Interagency cooperation can help ensure families receive the support they need.

Natural Manner Deaths

(See page 45 for complete data analysis)

The CFR Team reviewed 19 natural manner deaths. The natural manner cases selected for additional review included: two perinatal conditions deaths, two congenital malformation deaths, three influenza and pneumonia deaths, six heart and pulmonary deaths and eight non-ranking/all other cause deaths. Of the 19 deaths, the team determined that 10 were preventable, 3 were not preventable, and the remaining four were deemed as unable to determine.

Religious Objections

Of the 106 cases reviewed by the team, there was evidence that at least two deaths in 2021 were likely related to families who refused medical care based on religious 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 due to religious objections.

RECOMMENDATIONS FOR PREVENTING AND RESPONDING TO CHILD DEATHS

- **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 observed.

- **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.

- **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.

- **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 mental health care may help prevent suicide and homicide deaths as well as accidental deaths resulting from inadequate child supervision.

- **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.

- **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, respond with appropriate reimbursement, and provide mental health treatment, 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).

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

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

- **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. Idaho code ID Code § 49-672 (2016) needs to be amended to improve child safety in motor vehicles. Current law requires children 6 years or younger to be properly secured in a child safety restraint with only "recommendations" for children older than seven to use a child restraint system. Exemplar booster seat laws from neighboring states require "Children over forty pounds or who have reached the upper weight limit for their forward-facing car seat must use a child seat with harness or a booster to 4'9" tall or age eight and the adult belt fits correctly." Amending ID Code § 49-672 to include similar enforced guidelines for children aged 7 is recommended. Further, current law allows for the following provisions we recognize as unsafe exceptions and is also recommended for amendment: (a) If all of the motor vehicle's seat belts are in use, but in such an event any unrestrained child to which this section applies shall be placed in the rear seat of the motor vehicle, if it is so equipped; or

(b) When the child is removed from the car safety restraint and held by the attendant for the purpose of nursing the child or attending the child's other immediate physiological needs.

- **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 CFR 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 prevent and reduce 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.

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.

988, the Suicide and Crisis Lifeline. The Substance Abuse and Mental Health Services Administration (SAMHSA) has partnered with the Federal Communications Commission (FCC) to implement a 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 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 2021 was estimated at 1,900,923. Children under the age of 18 represented 24.7% of the total population.

Population	Number	Percent
Idaho total	1,900,923	100%
Age 0-17	**469,026**	
Residents, age 0-17 by sex		
Males	240,429	51%
Females	228,597	49%
Residents aged 0-17 by race		
White	424,606	90.5%
Black	5,384	1.1%
American Indian or Alaska Native	10,182	2.2%
Asian/Hawaiian/Pacific Islander	7,841	1.7%
Multiple Race	21,013	4.5%
*Residents aged 0-17 by ethnicity**	**469,026**	
Hispanic	89,031	19.0%
Non-Hispanic	379,995	81.0%

Note: In 2021, the U.S. Census Bureau provided population estimates for the age group 0-19 at the county level by race and ethnicity and provided population estimates for the age group 0-17 at the county level, but not race or ethnicity. The estimates in this table for the age group 0-17 by county, race and ethnicity are based on the overall percentage of persons aged 0-19 years in each county who were aged 0-17, and these percentages were applied to persons aged 0-19 by county, race and ethnicity. Estimates are rounded to the nearest whole number. The sum of estimates by race and by ethnicity by county may not sum to the total due to rounding.

Source for total estimates of persons aged 0-17 by county: U.S. Census Bureau.
Source for estimates of persons aged 0-17 by race, ethnicity, and county: calculated by Idaho Bureau of Vital Records and Health Statistics.

*Race and ethnicity are reported separately by the Census. The sum of White alone, Black alone, American Indian and Alaskan Native alone, Asian and Pacific Islander alone, and Multiple Race equals the total for the age category. The sum of Hispanic and non-Hispanic equals the total for the age category.

OVERVIEW: IDAHO MORTALITY DATA, THREE-YEAR AGGREGATE (2019-2021)

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.

Leading Causes of Death

The number and cause of death to Idaho children varied by age group. There was a total of 649 deaths to infants and children (under age 18) between 2019 and 2021. Infants (under 1 year of age) have a much higher death rate than older children, totaling 50% (323) of these deaths. As shown in the table, common causes of infant deaths were birth defects and conditions originating in the perinatal period, 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.

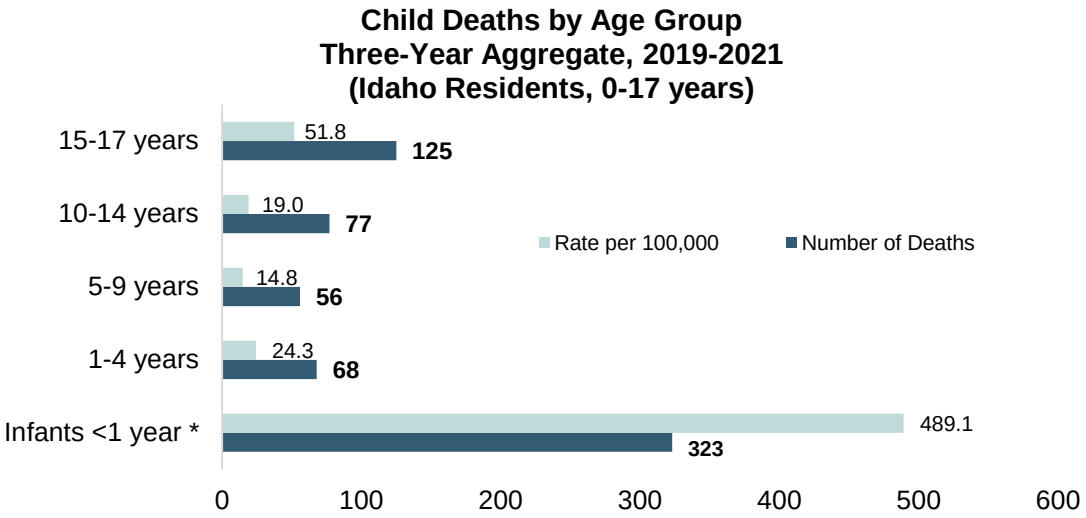
Leading Causes of Death to Idaho Child Residents
Three-Year Aggregate, 2019-2021

Rank	*Infants (under 1 year of age)*
1	Congenital malformations/chromosomal abnormalities (birth defects)
2	Short gestation/low birth weight
3	Accidents
4	Maternal complications of pregnancy
5	Sudden Infant Death Syndrome
6 (tie)	Complications of placenta, cord, and membranes Neonatal hemorrhage
8 (tie)	Respiratory distress of newborn Diseases of circulatory system
10	Assault (homicide)

Rank	*Children (Age 1-17 years)*
1	Accidents
2	Intentional self-harm (suicide)
3	Malignant neoplasms
4	Congenital malformations (birth defects)
5	Diseases of heart
6 (tie)	Assault (homicide) Influenza and pneumonia

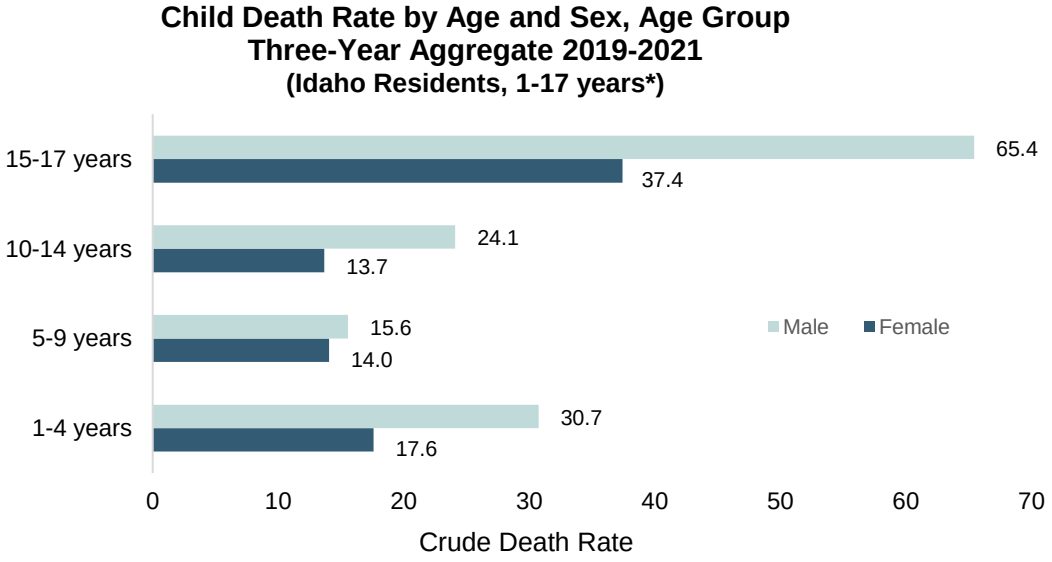
Demographics

As shown in the table, the three-year aggregate death rate for Idaho infants (under 1 year of age) was substantially higher than for all other age groups. 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). These findings mirror patterns for the U.S. as a whole.



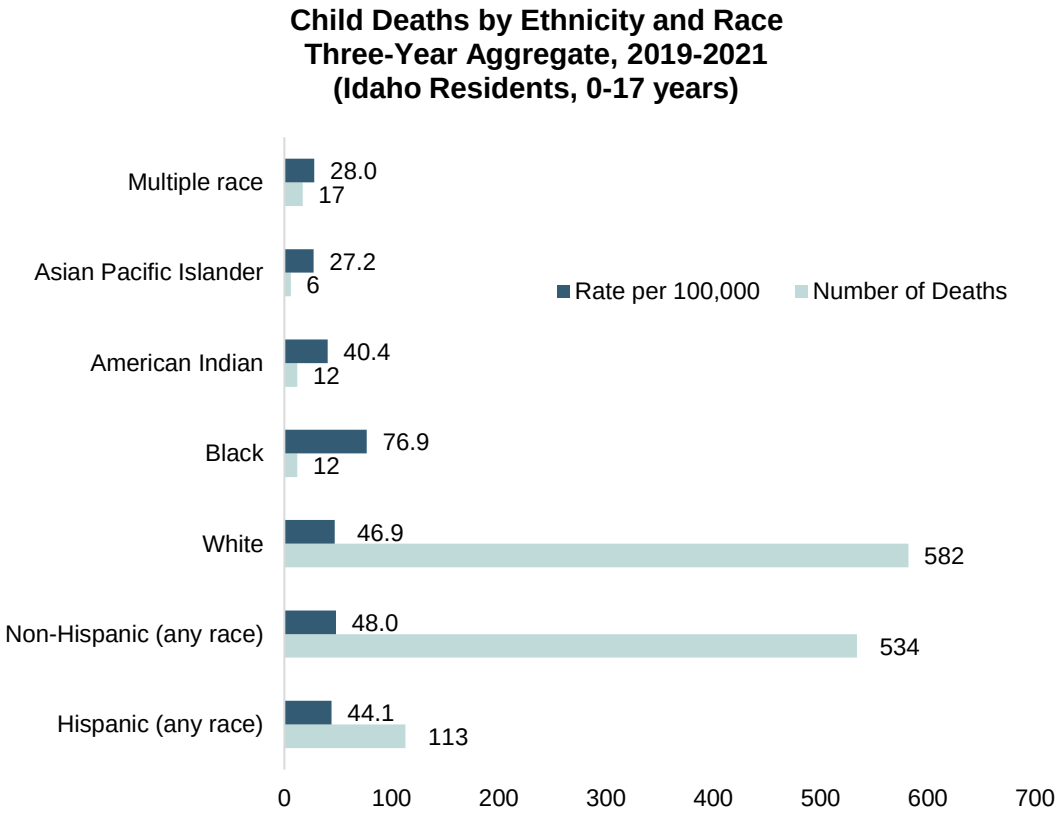
* Rate for infants under the age of 1 year is based on Idaho resident births.

The overall crude death rate for male children aged 1-17 years (30.7 per 100,000) was substantially higher than for female children aged 1-17 years (19.0 per 100,000). Male children dying at higher rates than female children were particularly evident in the 15–17-year-old, 10–14-year-old, and 1–4-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.

Children of Hispanic origin had a death rate slightly lower than non-Hispanic children. The death rate for Blacks was higher than for Whites, while American Indian, Asian Pacific Islander and those reporting multiple races were lower. However, the small numbers of recorded deaths (ranging from 6 to 17 over three years) makes it difficult to draw firm conclusions regarding the impact of race on child deaths 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, ILL-DEFINED INFANT DEATH, AND SLEEP ACCIDENTS

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.

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 2019 and 2021 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**.

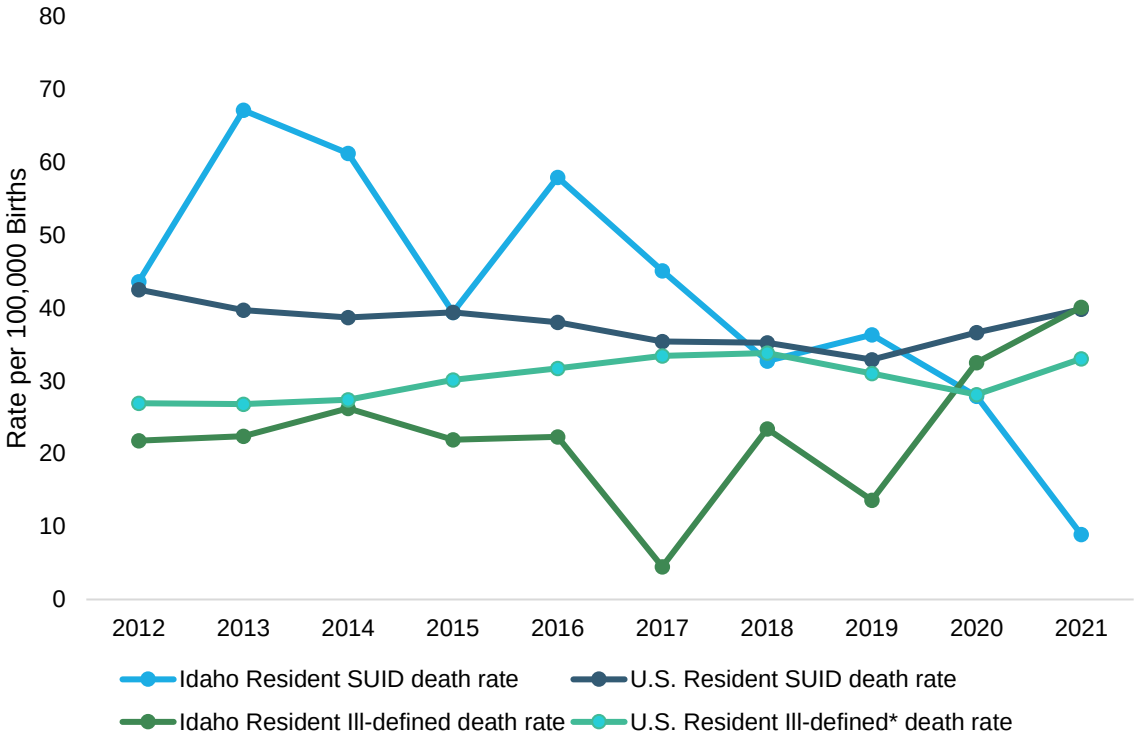
Idaho and U.S. Resident SUID Deaths (< age 1 year)
and Rates per 100,000 Births, 2012-2021

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Total Number Idaho Resident SUID deaths	**10**	**15**	**14**	**9**	**13**	**10**	**7**	**8**	**6**	**2**
Idaho Resident SUID death rate	43.6	67.1	61.2	39.4	57.9	45.1	32.7	36.3	27.9	8.9
U.S. Resident SUID death rate	42.5	39.7	38.7	39.4	38.0	35.4	35.2	32.9	36.6	39.8

Idaho and U.S. Resident Ill-Defined Infant Deaths (< age 1 year) and Rates per 100,000 Births, 2012-2021

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Total Number Idaho Resident Ill-defined infant deaths	**5**	**5**	**6**	**5**	**5**	**1**	**5**	**3**	**7**	**9**
Idaho Resident Ill-defined death rate	21.8	22.4	26.2	21.9	22.3	4.5	23.4	13.6	32.5	40.1
U.S. Resident Ill-defined* death rate	26.9	26.8	27.4	30.1	31.7	33.4	33.8	31.0	28.1	33.0

Idaho and U.S. SUID and Ill-Defined Crude Death Rates, 2012-2021



*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

SUID and Undetermined

The CFR Team reviewed two deaths with an immediate cause of "Sudden Unexplained Infant Death (SUID)," "Sudden Unexplained Death in Infancy," OR "Sudden Infant Death Syndrome (SIDS)." Deaths listed with any of these immediate causes are collectively referred to as "SUID" in this report. Because of their common circumstances, the CFR Team reviewed SUID cases along with six additional infant deaths classified as "undetermined" cause and/or manner (for a total of eight Idaho resident SUID and undetermined cause infant deaths).

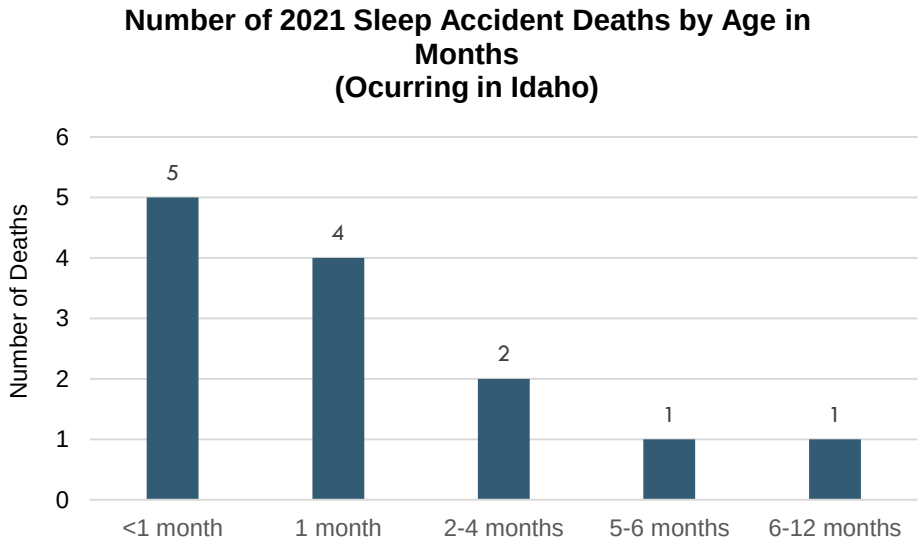
According to the American Academy of Pediatrics (AAP), most SUID events in the U.S. occur when a baby is between two and four months old, and during the winter months. In 2021, Idaho SUID and undetermined infant deaths followed this age-related pattern. The deaths occurred in the meteorological seasons (three-month groupings based on the annual temperature cycle and the calendar – e.g., winter includes December, January, and February) with four deaths in the fall, and one death in both winter and summer. The majority of SUID and undetermined deaths were to white non-Hispanic males (four deaths). The remaining two deaths were one Black male and one white non-Hispanic female. Of the eight SUID and undetermined cases, two had significant child protective histories, with one child being in state custody on an extended home visit when the injury occurred.

Preventability

Of the eight SUID and undetermined cause infant deaths, the team determined that four deaths could have been prevented, while three deaths were not preventable. There was one death where the team was unable to determine whether it was preventable.

Sleep Accidents

The CFR Team reviewed 13 infant deaths with a manner of "accident." In these cases, coroner and law enforcement investigations determined the deaths were linked to hazards in the sleep environment. Similar risk factors to those seen in SUID were observed in these cases. There were eight female and five male sleep accident deaths. Most sleep accident deaths in Idaho occurred to children less than two months old (with five deaths to those less than one-month old and four deaths to those one-month-old).



While no obvious relationship was observed between the rate of Idaho sleep accidents and seasonality, sleep accident deaths occurred most often in fall (five deaths) followed closely by summer (four deaths), while the remaining deaths occurred in winter (three deaths), and spring (one death).

Racial and ethnic disparities are best understood by examining data collected over several years (see “Child Deaths by Ethnicity and Race,” pg. 21). However, the team observed that the majority of infants (11 out of 13) who died of sleep accidents were White and Non-Hispanic. The team also observed that nearly half of the children who died from sleep accidents had a significant child protective history.

Preventability

The CFR Team determined that based on the information and records reviewed, all 13 sleep accident deaths could have been prevented had safe sleep practices been used.

Systems Issues

Resource Constraints

Coroner and law enforcement agencies face the 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 and use of doll reenactment during investigation. 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. The CFR Team had previously noted a marked improvement in the following of CDC and state guidelines related to investigating and coding unexplained infant deaths. In 2021 the trend continued, as the team felt the majority of SUID, sleep accident, and undetermined cause cases were correctly coded, with only a couple exclusions.

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". The two cases where SUID was the stated cause of death, manner of death was correctly certified as "undetermined". However, there were cases where Unexplained Infant Death or SUID was listed as the immediate cause of death, with secondary causes listed as suffocation or possible overlay and the manner was reported as accident. SUID and unexplained infant death should not be listed as the immediate cause of death in these circumstances as there were clear causes of death determined.

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.

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.

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 may help prevent additional infant deaths.

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

Co-sleeping was noted in 11 of the 21 deaths due to sleep-related deaths (SUID deaths, deaths of undetermined cause, hanging, strangulation, and suffocation of undetermined intent, and accidental deaths that occurred in a sleep environment). There were three deaths where the mother fell asleep breastfeeding the infant, and the infant was either smothered by the mother or suffocated due to an unsafe sleep environment. In addition, co-sleeping and unsafe sleep environments were a significant factor in these deaths, with 13 deaths citing unsafe or hazardous sleep environments. 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, blankets, and pillows, “sleep nests”, or surfaces cluttered with toys and other objects. 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 years, the CFR Team found that many infant sleep deaths occurred in families with a history of CPS referrals as well as 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 arm’s reach. In some cases, beds and cribs were cluttered with toys, clothing, or other household items to the point they were not usable for sleep. Such conditions may or may not meet the legal standard of child neglect, but documenting health and safety hazards may help identify families with a need

for additional support.

Prenatal smoking (as self-reported by mothers and recorded on birth certificates) and smoking or vaping in or around the home (mentioned in law enforcement reports) were frequently noted and may be underreported. The CFR Team also observed that a substantial number of the children who died were congested in the days leading up to their deaths. Improper infant swaddling, unsafe breastfeeding practices, and infants having had Neonatal Intensive Care Unit admissions were also risk factors the team commonly observed. As in past years, nearly every infant sleep-related death involved a combination of risk factors such as unsafe sleep environment and/or co-sleeping, parental drug and alcohol use (both prenatal and post birth by caregivers), having a child protection history and/or multigenerational child protective histories, hazardous home environment, and tobacco smoke exposure.

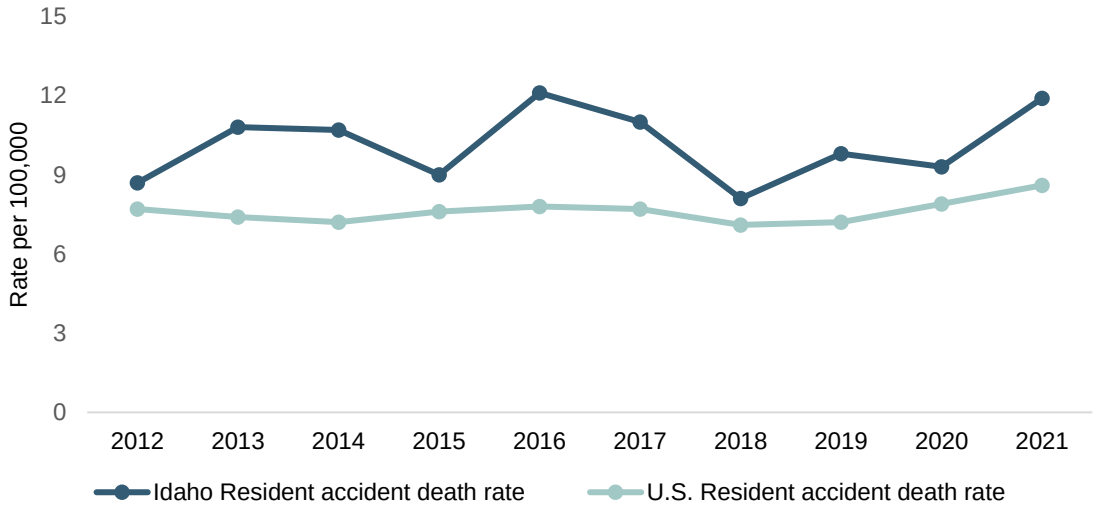
UNINTENTIONAL INJURIES

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 2021 rate of accident deaths to Idaho resident children (age <18 years) increased slightly from 2020 and continued the decade long pattern of exceeding the overall U.S. rate.

Idaho and U.S. Resident Accident Deaths (Age <18 years) and Rates Per 100,000, 2012-2021

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Total number Idaho Resident accident deaths	**37**	**46**	**46**	**39**	**53**	**49**	**36**	**44**	**42**	**56**
Idaho Resident accident death rate	8.7	10.8	10.7	9.0	12.1	11.0	8.1	9.8	9.3	11.9
U.S. Resident accident death rate	7.7	7.4	7.2	7.6	7.8	7.7	7.1	7.2	7.9	8.6

Idaho and U.S. Accident Crude Death Rates (Age <18 years), 2012-2021

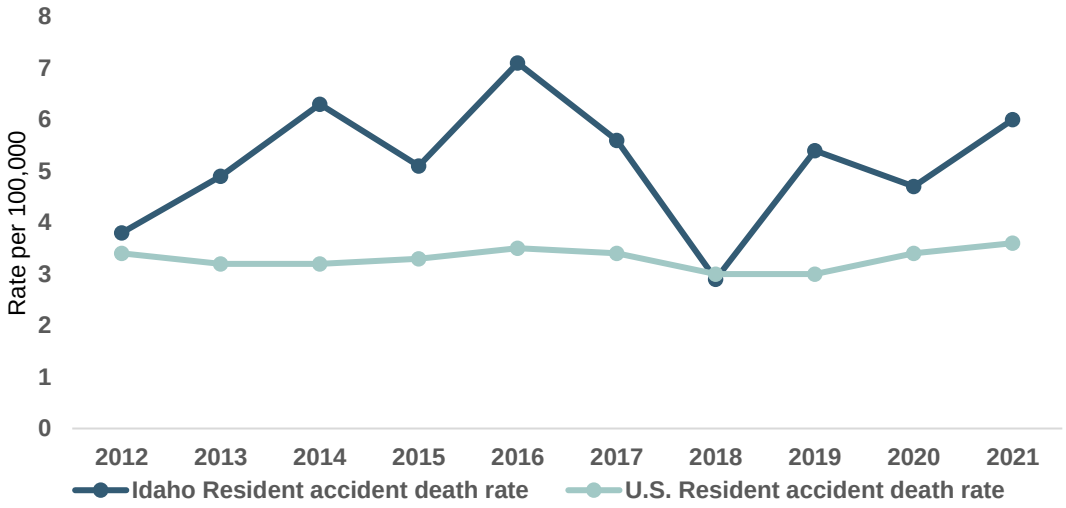


Source: *Bureau of Vital Records and Health Statistics, Idaho Department of Health and Welfare*

Idaho and U.S. Motor Vehicle Accident Resident Deaths (Age <18 years) and Rates per 100,0000, 2012-2021

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Total number Idaho Resident accident deaths	**16**	**21**	**27**	**22**	**31**	**25**	**13**	**24**	**21**	**28**
Idaho Resident accident death rate	3.8	4.9	6.3	5.1	7.1	5.6	2.9	5.4	4.7	6.0
U.S. Resident accident death rate	3.4	3.2	3.2	3.3	3.5	3.4	3.0	3.0	3.4	3.6

Idaho and U.S. Motor Vehicle Accident Crude Death Rates (Age <18 years), 2012-2021



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

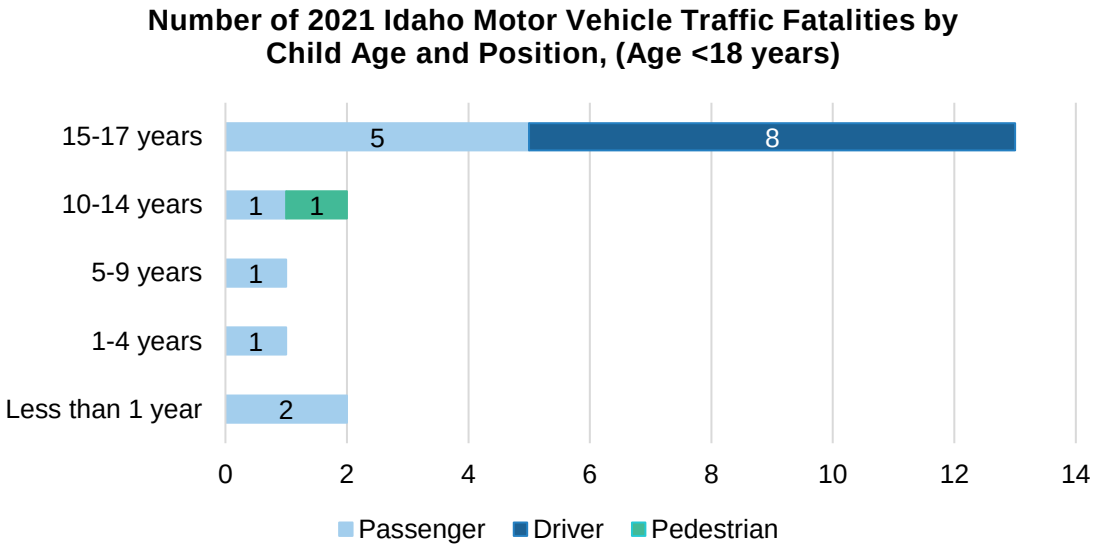
Rates based on 20 or fewer deaths may be unstable. Use with caution.

Idaho CFR Team Findings: Accidents

In 2021, there were 52 accidental deaths to children that occurred in Idaho. Motor vehicle accidents (24) were the leading cause of accidental deaths followed by drowning deaths (four), poisonings (three), firearm discharge and avalanche related deaths (two each), and four other individual causes of death. Thirteen accidental infant deaths occurring in the sleeping environment are discussed in this report's section on SUID and Sleep Accidents.

MOTOR VEHICLE ACCIDENTS

The CFR Team reviewed the 24 motor vehicle deaths. Nineteen fatalities occurred in traffic accidents and five occurred in situations *not* involving traffic/roadways. Of the 19 traffic-related fatalities, two accidents involved multiple deaths, so the team reviewed 17 separate traffic accidents. There were 10 male and nine female fatalities. Of the 19 traffic-related incidents, there was one male who was riding an electric scooter as a pedestrian when struck by a vehicle. Of the five non-traffic related deaths, there were four male and one female fatalities. Of the five non-traffic related deaths, four were ATV or off-road vehicle related.



Rural Roads

Four of the 19 (21%) motor vehicle accident-related deaths that involved traffic/roadways occurred on a rural road. Idaho's overall 2021 five-year motor vehicle fatality rate was 1.33 (per 100 million annual vehicle miles traveled), with 68 percent of the fatal motor vehicle crashes occurring on rural roadways (Idaho Transportation Department, 2022). 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) to make rural roads safer, as well as greater awareness of and education about the dangers of rural roads.

Teen Drivers

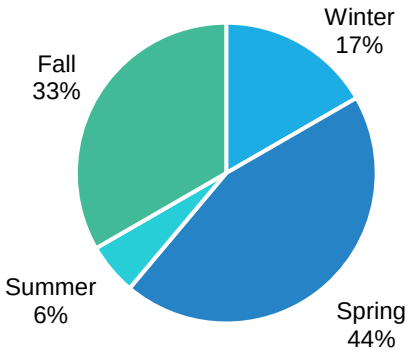
Nine traffic accidents involved teen drivers. Driver error (e.g., failure to yield, reckless driving or inattentive driving) was a factor in each of the crashes involving a teen driver. Other risk factors for accidents with teen drivers included alcohol or drug impairment, speeding, and lack of

seatbelt use. Youthful drivers, ages 15 to 19, continue to be over-involved in motor vehicle crashes. In 2021, youthful drivers were 2.4 times as likely as all other drivers to be involved in a fatal or injury crash (Idaho Transportation Department, 2022).

Time of day and Season of Accident

Along with considering the road and traffic conditions at the time of the accident, the CFR Team captured the time of day and the meteorological season of year when the accidents occurred. Four of the 19 accidents occurred between 12 and 6am. Additionally, most (eight) traffic related fatalities occurred in spring, while six happened in fall, three in winter, and one in summer.

Meterological Season of 2021 Idaho Child Traffic Related Deaths (Age <18 years)



Seat Belt and Safety Restraint Usage

Idaho Code § 49-673 mandates that seat belts are worn by all occupants whenever a vehicle is in motion, except under certain specific conditions. 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 seven of the 19 traffic-related fatalities reviewed, a seat belt was not worn and in two cases an age-appropriate child safety seat was not properly used. In one of those cases, the infant was removed from the car seat while driving.

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 Idaho Transportation Department (ITD) crash reports. Of the 19 deaths reviewed, both failure to

maintain lane and failure to yield were each cited as contributing circumstances five times, driving while alcohol or drug impaired was cited four times, failure to obey stop signs was cited three times, and driving at a speed too fast for conditions was cited twice. There were six other contributing circumstances cited singularly.

Non-Traffic Fatalities

There were five non-roadway accident fatalities. Risk factors were improper use of off-road vehicles, including underage and inexperienced drivers using off road vehicles without supervision, not wearing helmets, and inadequate supervision of young children.

Preventability

The CFR Team determined all 24 motor vehicle accidents were preventable.

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 eight cases, toxicology was conducted on children who died and in five cases toxicology was conducted on the drivers with child passengers who died. Further, in another five 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 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 that conducting toxicology testing on all drivers involved in fatal accidents become standard procedure. The CRF Team believes 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 another teen.

One significant system issue the team repeatedly observed was the lack of coroner records received by one singular county. Historically, this county has refused to send records despite

efforts made by the team. Without coroner reports from this county, the team felt there was significant information missing.

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 Idaho Department of Education. Courses are open to all Idaho residents (including non-students) between the ages of 14 ½ and 21. The Idaho Transportation Department (ITD) offers defensive driving courses at various locations for those aged 15 to 24 called *Alive at 25*. 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.

The team also recommends changing the seatbelt exemption law pertaining to lawfully removing infants from their safety seat while traveling. The team felt that one death could have been prevented had the child remained in their safety seat while traveling, therefore the team recommends the following: Idaho code § 49-672 (2016) needs to be amended to improve child safety in motor vehicles. Current law requires children 6 years or younger to be properly secured in a child safety restraint with only "recommendations" for children older than seven to use a child restraint system. Exemplar booster seat laws from neighbor states require "Children over forty pounds or who have reached the upper weight limit for their forward-facing car seat must use a child seat with harness or a booster to 4'9" tall or age eight and the adult belt fits correctly." Amending ID Code § 49-672 to include similar enforced guidelines for children aged 7 is recommended. Further, current law allows for the following provisions we recognize as unsafe exceptions and is also recommended for amendment: (a) If all of the motor vehicle's seat belts are in use, but in such an event any unrestrained child to which this section applies shall be placed in the rear seat of the motor vehicle, if it is so equipped; or (b) When the child is removed from the car safety restraint and held by the attendant for the purpose of nursing the child or attending the child's other immediate physiological needs.

See Appendix for Additional Recommended Actions

DROWNINGS

Nationwide, drowning is the single-leading cause of death among children one through 4 years of age, and a top cause of death among teens (AAP). 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 four drowning deaths. Two of the drownings occurred in swimming pools, one occurred in a bathtub, and one occurred in an Idaho river. Three deaths were to children aged five and younger and one death occurred to an individual between 15-17 years of age. The children who were aged five and under drowned in either a pool or bathtub. The one death that occurred in a river was to an individual who knew how to swim and was attempting to swim across a river without a personal flotation device (PFD).

Preventability

The CFR Team determined that all four of the drowning deaths could have been prevented if safe swim practices and water safety procedures had been followed.

Systems Issues

In two of the four drowning fatalities, CPS was not notified of a child fatality when other children resided in the home. As with other causes of child deaths, routinely performing toxicology testing of the decedent and/or caregiver would help to better understand the circumstances involved. Interagency cooperation (especially between CPS and law enforcement) may help identify unsafe home situations and prevent child deaths, as in two cases there were multiple CPS referrals. Another system issues the team observed was the lack of records received from one singular county.

Common Factors and Associations

Inadequate supervision, child's lack of ability to swim, and child's ability to gain access to swimming pools were prominent factors in the majority of 2021 drowning accidents. In three cases adult supervision was lacking, not just for a few moments, but for an extended time. Lack of availability of affordable housing, lack of availability of services for disabled children, and competency of caregiver were also risk factors.

Recommended Actions for Preventing Drowning Deaths

The main factors that affect drowning risk include lack of swimming ability, accessibility to swimming pools and unsafe sections of rivers, lack of close supervision while swimming, and

failure to wear life jackets. The team recommends increasing signage along riverways to avoid swimming and unsafe water activities, and continued education about securing access to pools.

See Appendix for Additional Recommended Actions

ADDITIONAL ACCIDENTAL DEATHS

Poisoning/Overdose

Three child deaths were caused by accidental poisonings, one by exposure to narcotics, and two due to other medicaments and biological substances. The CDC reports a steady increase in U.S. drug overdose deaths since 1999. Nationally, most of these deaths involve a prescription or illicit opioid. Recommended actions for reducing drug overdose include improved opioid prescribing practices (to reduce exposure and prevent abuse), promoting drug monitoring programs, and expanding access to substance abuse treatment. Medications should be stored out of reach of children and teens, especially those with a history of substance abuse and mental health concerns. The team also recommends increasing access to Narcan for both emergency medical personnel and community members.

Preventability

All three child deaths caused by accidental poisoning were deemed preventable by the CFR Team.

Handgun Discharge

There were two deaths due to accidental handgun discharge. One death was to a child under 3 years of age and one to a 15–17-year-old. To help prevent accidental firearm deaths, guns should be kept locked and not accessible to children and firearm safety courses are recommended. Improved coordination between agencies (notably, CPS and law enforcement) may help identify and address unsafe situations in homes, including access to guns and ammunition by children.

Preventability

The two deaths due to accidental handgun discharge were deemed preventable by the CFR Team.

Avalanche

There were two deaths where the children were victims of an avalanche. In this single avalanche, two children aged 15-17 years old were caught in the snow slide and were buried in snow. To prevent future avalanche related deaths, avalanche safety courses, wearing avalanche beacons, and increasing awareness of safe weather and snow patterns are recommended.

Preventability

The two deaths where children were victims of an avalanche were deemed preventable by the CFR Team. Practicing avalanche and snow safety precautions could have prevented the individuals from being in unsafe avalanche conditions.

All Other Causes

Other causes of accidental fatalities included a fall, anaphylaxis, and intrauterine pneumonia due to gross prenatal medical negligence. The CFR Team agreed that calling 911 immediately, and administering epinephrine immediately in one case, might have averted these deaths.

Preventability

The team determined that all other accidental cause deaths were preventable.

See Appendix for Recommended Actions

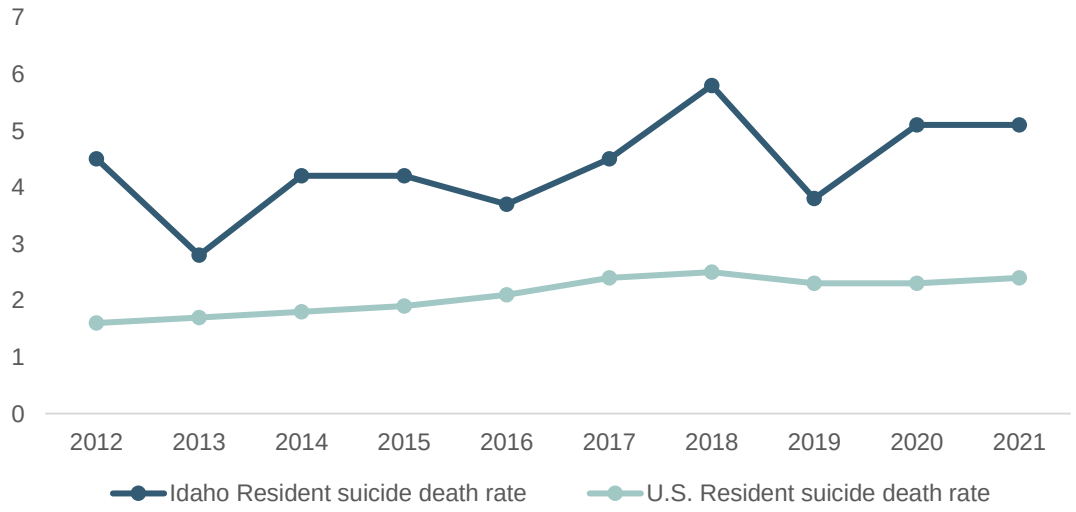
SUICIDES (INTENTIONAL SELF-HARM)

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. The rate of youth suicide remained the same from 2020 after increasing from 2019.

Idaho and U.S. Resident Suicide Deaths (Age <18 years) and Rates per 100,000, 2012-2021

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Total Number Idaho Resident suicides	**19**	**12**	**18**	**18**	**16**	**20**	**26**	**17**	**23**	**24**
Idaho Resident suicide death rate	4.5	2.8	4.2	4.2	3.7	4.5	5.8	3.8	5.1	5.1
U.S. Resident suicide death rate	1.6	1.7	1.8	1.9	2.1	2.4	2.5	2.3	2.3	2.4

Idaho and U.S. Suicide Death Rates (Age <18 years) , 2012-2021



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 was able to review records for 24 of the 25 suicides. The majority of those who died from suicide were male (15 deaths) verses female (9 deaths). There were 10 deaths by suicide to those 16-17 years of age, 10 deaths to those 14-15 years of age, and four deaths to those of 13 years of age or less.

As shown in the table, very young males (13 years of age or less) died of suicide more frequently than females of the same age. Slightly older males (14-15 years of age) died of suicide just as frequently as female counterparts, while males 16-17 years of age died more frequently than females of the same age group.

2021 Suicide Sex by Age Group Comparison

Age Group	Female	Male
13 or less years	11% (1)	20% (3)
14 - 15 years	56% (5)	33% (5)
16 - 17 years	33% (3)	47% (7)
Total	100% (9)	100% (15)

Of the children who died by suicide, 19 (79%) were White and Non-Hispanic and five (21%) were White and Hispanic.

Hanging was the mechanism of death in 12 (half) of cases while firearms were used in 11 cases. One additional death was caused by intentional self-poisoning. The team recognized that males were more likely than females to use firearms as the mechanism to die by suicide.

Number of Suicides in Idaho by Mechanism and Gender, 2021

	Mechanism Used		
Gender	**Hanging/asphyxiation**	**Firearm**	**Poisoning**
Male	5	10	0
Female	7	1	1

In contrast to previous years, 2021 suicide deaths were more prevalent in the cooler seasons of fall (12) and winter (7) and less common in the spring (2) and summer months (3). Six of the 24 suicides occurred in the school transition month of September with two suicides highly related to a school year transition. Because the beginning or end of academic years can be particularly

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

Preventability

The CFR team determined all 24 suicides were preventable. Recognizing the signs of depression and anxiety and accessing mental health care when needed are critical in preventing suicide deaths.

Systems Issues

As with other causes of death in 2021, the CFR Team noted failures to report suicide deaths to CPS. In situations where the child who died by 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. There were also instances where the waitlist for outpatient mental care, especially for those on Medicaid, were several months long, delaying access to mental health care. Additionally, in several instances the Team was unable to verify if a child who died by suicide was receiving mental health services at the time of their death or at any previous point.

There was one case where the manner of death was recorded as natural, not suicide. Based on the information on the death certificate and records gathered by the team, this death was clearly a suicide. Proper coding of suicide as manner on death certificates is an ongoing issue.

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 a 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

Twenty-five percent of those who died by suicide were experiencing romantic/sexual relationship conflicts. Over half had expressed suicidal ideation and had a documented history of depression. The team noted a wide range of triggering events including social isolation, family

dynamics, parent/child relational problems, recent disciplinary actions, electronics/phone removal as disciplinary consequence, past incidents of self-harm, parental drug use, suicide attempt histories, trouble in school, inappropriate access to firearms, and past involvement with CPS. 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*) and UNDETERMINED DEATHS

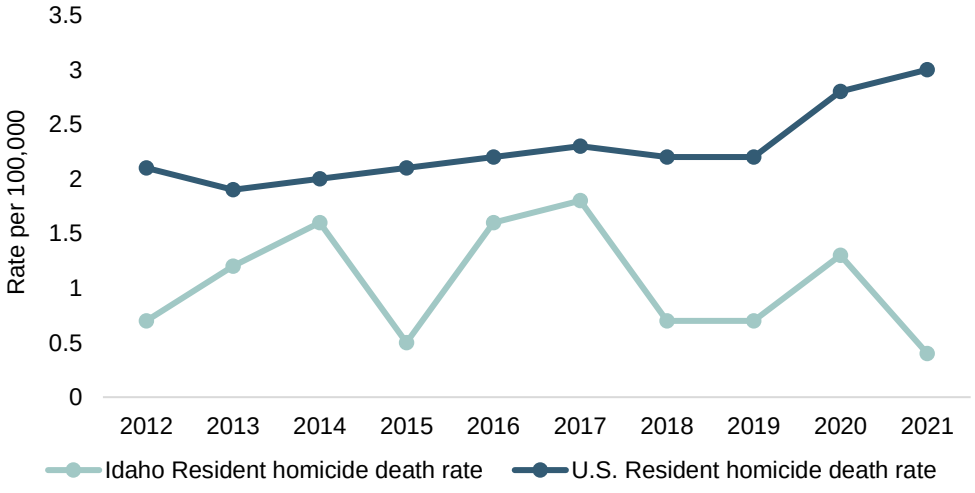
Homicides (Assault)

There were two fatal assaults to Idaho resident children. However, the team was only able to review one of the two deaths as one was still pending in court proceedings. While the rate of homicide in Idaho has historically been lower than the national rate, the size of the gap varies widely by year. The team determined that the one death due to homicide was preventable.

Idaho and U.S. Resident Homicide (Assault) Deaths (Age <18 years) and Rates per 100,000, 2012-2021

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Total Number Idaho Resident homicides	**3**	**5**	**7**	**2**	**7**	**8**	**3**	**3**	**6**	**3**
Idaho Resident homicide death rate	0.7	1.2	1.6	0.5	1.6	1.8	0.7	0.7	1.3	0.4
U.S. Resident homicide death rate	2.1	1.9	2.0	2.1	2.2	2.3	2.2	2.2	2.8	3.0

Idaho and U.S. Homicide Death Rates (Age < 18 years), 2012-2021



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.

Undetermined Deaths

There were three undetermined cause deaths that were reviewed by the team. Two of these deaths had similar circumstances to homicide (assault), however the manner of death could not be determined, and therefore all three cases are discussed in this section of the report. Two deaths were to children aged one year or younger, while the other death was to a child between 7-9 years of age. Two of the undetermined cases were deemed preventable by the CFR team. One of these cases had significant CPS involvement. However, there seemed to be a significant system issue with incomplete home visitation screenings, leaving the child in a vulnerable circumstance. Other risk factors identified for these cases included lack of quality supervision and appropriate childcare, parental/caregiver drug use, lack of regular well child visits with a primary care physician, and delay in seeking appropriate health care for illness and injuries.

Preventability

Based on the information and records reviewed, the CFR Team deemed two of the deaths coded to undetermined manner as preventable. The Team was unable to determine whether the remaining two deaths were preventable.

NATURAL CAUSES OF 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 19 natural manner deaths for a complete review by the CFR Team. The natural manner cases selected for additional review included: 2 perinatal conditions, 2 congenital malformation, 3 influenza and pneumonia deaths, 6 heart and pulmonary deaths and 8 non-ranking/all other cause cases.

Perinatal Condition Deaths

Maternal obesity, unknown pregnancy, and fetal intolerance of labor were noted in the two perinatal condition deaths. As in previous years, the CFR team found lack of prenatal care and maternal drug use during pregnancy were also factors in perinatal conditions deaths. The team determined that one perinatal death was preventable.

Heart/Pulmonary Deaths

Of the six heart and pulmonary related deaths, two deaths involved asthma, two involved cardiopulmonary compression, and the remaining two were unspecified heart issues. Common factors included secondary and contributing medical conditions, including viruses, and the decedent having complaints of chest pain but not seeking proper medical care. The CFR Team determined that three of the heart/pulmonary cause deaths were preventable while the Team was not able to determine the preventability of the other three 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 Hirschsprung's disease, epilepsy, respiratory syncytial virus (RSV) and other viral and bacterial infections. Although risk factors associated with "other/non-ranking" varied widely, the team observed that inadequate supervision of ill children, children with chronic health conditions or congenital anomalies, significant child protective

histories, and delayed medical care were all factors in these deaths. The CFR team determined that three of these deaths were preventable. There was one death where, after reviewing the records, the Team was unable to determine whether the death was preventable.

Refusal of Medical Care Because of Religious or Personal Beliefs

Since Idaho Vital Statistics does not compile the number of deaths for children who are not treated medically because of religious beliefs, it is difficult to estimate the actual number of preventable deaths to religious objectors. Of the 105 infant and child deaths reviewed, the CFR Team found evidence that two deaths were likely related to families who refused medical care based on religious beliefs. Because these deaths were investigated thoroughly by both the county coroner and law enforcement, the CFR Team found evidence suggesting both deaths might have been prevented with timely medical treatment.

Systems Issues

As with other causes of death, the CFR Team noted issues related to death investigations which included lack of communication between agencies, continuity of medical care, and failure to notify CPS of a child death when other children were in the house. The team found that CPS was not contacted regarding the death in seven of the 19 natural cause deaths.

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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 relevant 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 investigations.
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 developmental milestones ○ Discussing safe tummy-time. Include tummy time is during direct supervision of infant. ○ Advising on the dangers of using breastfeeding pillows, soft baby loungers, 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 Call 9-1-1 instead of self-transporting to seek medical care. Emergency Medical Services and Law Enforcement can provide more appropriate care in emergency situations.

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 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 Crisis and Suicide Hotline** accepts texts and phone calls **988**. 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 timely 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 Youth Suicide Prevention Program Educators are encouraged to access resources offered by the Idaho Youth Suicide Prevention Program. 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.
Encourage Communication and Connections School and community programs that 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 providers 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 by 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 the Idaho Youth Suicide Prevention Program
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 Police One 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 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/).