

Idaho Child Mortality Review Team

Annual Report for Childhood Deaths 1997



Idaho Department of Health & Welfare

EXECUTIVE SUMMARY

This is the first report of the Idaho Child Mortality Review Team. It was a challenging year. One of the biggest challenges was determining which information is available and useful to the team in determining whether the death was preventable. The team relies on information already gathered by others (e.g. coroners, law enforcement, and medical personnel), and does not contact the family or friends of children who have died. A few of the biggest obstacles the team found in preparing this report were:

- Death investigators have varied levels of training, skills, and resources available to them, which results in a wide variety of quality of information they gather and report. Frequently, coroner reports were incomplete or not sent to us, for example.
- Records with information about events surrounding a child death were often unobtainable, either because they were not completed or not sent to us.

Summary of Findings and Recommendations

Forty-two (42) children died in motor vehicle accidents in Idaho in 1997.

We recommend:

- Increased emphasis in driver's education on how to avoid over-correction of turns and slides and the importance of consistent seatbelt use.
- Public education regarding the proper use of child safety restraints, including seatbelts, child safety seats, and booster seats.

We strongly urge the introduction of new legislation to:

- Prohibit passengers in pickup truck beds.
- Encourage the use of seatbelts and child safety seats, including making it a primary offense to not use seatbelts.

Twenty (20) children died of sudden infant death syndrome (SIDS) in Idaho in 1997.

We recommend:

- Public education campaigns to help decrease the incidence of SIDS, including:
 - Sleep positioning on the back, as promoted in the national "Back to Sleep" campaign.
 - Keeping the baby's head uncovered during sleep.
 - Avoiding exposure of babies to tobacco smoke both before and after birth.
 - Seeking regular prenatal care and pediatric care.
- Use of a standardized SIDS investigation protocol to promote further understanding of SIDS, including a thorough case investigation, autopsy, review of clinical history, and examination of the death scene when there is a presumptive diagnosis of SIDS.
- Public assistance in funding autopsies in children with a presumptive SIDS diagnosis.

Nineteen (19) children died due to firearms in Idaho in 1997; 14 of these were suicides.

We recommend public education regarding:

- Firearm safety, including safe storage.
- Recognition of depression and suicide warning signs in adolescents.
- Recognition of drug and alcohol use in children and adolescents and their caregivers.

Thirty-four (34) children died due to other non-natural causes in Idaho in 1997, including falling, being shaken by a caregiver, suffocation, fire, and drowning.

We recommend:

- Public education regarding:
 - Open water safety.
 - Avoiding shaking babies.
 - Use of personal flotation devices.
 - Use of smoke detectors, including regular battery changes.
 - Use of safety helmets when riding bicycles, motorcycles, all-terrain vehicles, and horses.
- Education of health care workers, child care providers, and educators regarding recognition of, and reporting of, suspected child abuse.
- Efforts to decrease the use of illegal drugs and alcohol by children and adolescents and their caregivers, and public education regarding recognition of such use in children and adolescents.
- Improved training in pediatric emergencies and equipment requirements for emergency medical services (EMS) providers.
- Consistent use of pediatric response protocols by EMS providers, which should be updated and reviewed regularly.

We strongly urge the introduction of new legislation to establish a state medical examiner system.

Other areas we support:

- Parent and provider education about immunizations in children and the diseases that they can prevent, and the current efforts to improve Idaho's immunization rate.
- Parent and provider education regarding the health and well-being of children, including oral rehydration during diarrheal illness and recognition of signs and symptoms of illnesses requiring medical care.
- Open communication between parents, educators, and children regarding sexual education. We recommend resources be made available to these groups to better help adolescents and children understand sexual health.
- Heightening awareness of available resources for pregnancy prevention, prenatal care, and sexual health counseling.

HISTORY

Concern for the welfare of children, particularly those who are abused or neglected, has been longstanding among public and private social service agencies, professionals, and the general public. In response to this concern, Los Angeles County, California started child mortality review in 1978. Their success in identifying preventable child deaths has led to many states instituting statewide child mortality review teams. The overall goals of the teams include focusing on creating effective multiagency case management and improving prevention and intervention programs to protect children from serious injuries and deaths.

In response to this same concern, then-Governor Philip E. Batt with Executive Order No. 98-10 (Appendix A) formed Idaho's Child Mortality Review Team on July 16, 1998. The team is appointed by the Director of the Department of Health and Welfare, and consists of a multidisciplinary, multi-agency board. Bureaus within the Division of Health and the Office of Highway Safety provide support to the team.

In the 22 years since Los Angeles County began the process, child mortality review teams have become a national standard in the effort to protect children. In April 1999, a survey conducted by Dr. Michael Durfee, founder of the Los Angeles County team, found that statewide child death review teams exist in 46 of the 50 states and the District of Columbia. Idaho is one of those 46 states.

Child Mortality Review Team

The Child Mortality Review Team in Idaho represents a combination of public, criminal justice, health, and social service organizations. Team members participate in the review and make decisions, through voting on the preventability of the death and identification of prevention activities and target audiences. The Director of the Department of Health and Welfare appointed the following members to the team:

Matthew Brown, MD, Pediatrician, Chair

Shirley Alexander, MSW, Child Protection Program Specialist, and
Children at Risk Task Force Member

D. Lee Binnion, MD, Emergency Physician

Robert Cihak, MD, Pathologist

Vicki DeGeus, Coroner, Canyon County

Eve Dickinson, Keeping Children Safe Panel Member, Community Representative

William Douglas, Prosecuting Attorney, Kootenai County

Christine Hahn, MD, State Epidemiologist

Julene Parsons, MD, Pediatrician

Tony Wallace, Sgt., Boise Police Department

Assistants to the Child Mortality Review Team

The Child Mortality Review Team has the support of many state agencies in their efforts to review child deaths. The assistants provide record review and clerical support. They do not have decision making or voting authority on the team. The Epidemiologist and Child Protection Program Specialist from the team meet with the screening group monthly. Following are the assistants to the team:

Dia Gainor, Chief, Bureau of Emergency Medical Services

Pam Marcum, Consultant, former Forensic Scientist, Idaho Department of Law Enforcement

Jo Ann Moore, Manager, Office of Highway Safety

Jane Smith, Chief, Bureau of Vital Records and Health Statistics

Jan Wick, Biostatistical Services Supervisor, Bureau of Vital Records and Health Statistics

Diane Prince, Administrative Assistant, Bureau of Clinical and Preventive Services

Members bring a wide variety of experience and perspectives on children's health, safety, and maltreatment issues. Because of the varied expertise the team possesses, the ability to identify prevention and intervention activities is greatly enhanced.

OBJECTIVES

The team has developed the following objectives to direct its work:

- Identify potentially preventable causes of death.
- Identify the risk factors leading to the death.
- Collect and organize the information into meaningful summaries of causes of child death in Idaho.
- Make specific and feasible recommendations to the Governor and chairs of the Senate and House Health and Welfare committees on ways in which child mortality can be reduced in Idaho.

“By removing known safety hazards, we are keeping children safe from preventable death and disability.”

Idaho Governor Dirk Kempthorne

METHODOLOGY

Deaths of Idaho resident children under 18 years of age during 1997 were reviewed. The Bureau of Vital Records and Health Statistics identified deaths of these children occurring in Idaho. An abstract of each death certificate was supplied to the screening group, which met monthly to preview the abstracts and identify potentially preventable deaths. The screening group selected the death for further review when it met one or more of the following criteria:

- Death was due to an external cause, or
- Death was unexplained, or
- Death was due to a cause with modifiable risk factors.

The death was then assessed to identify additional information necessary for a comprehensive review. Additional information was then requested from the appropriate agency. These sources of information could include:

- Autopsy reports.
- Coroner reports.
- Law enforcement reports.
- Medical records.
- EMS records.
- Child Protection records.

Recognizing that the records of child deaths and circumstances leading to the deaths are kept by multiple agencies, the team strives to make a coordinated effort to examine the events leading to death across systems and over time. The team does not have subpoena power and cannot always obtain confidential records.

After available records were collected, the assistants reviewed the information, and the cases were prepared for presentation before the Child Mortality Review Team (CMRT). Of 224 deaths in 1997, 138 were considered to warrant further review and were presented to the CMRT. The team, including the assistants, met quarterly. The chair presented available information/records on the child deaths, with additional input from the team members or assistants.

The preventability of each death was stratified by identifying risk factors that might have contributed to the death and placed into categories as outlined in the following table:

<u>Preventable:</u>	
Definitely	Definite actions could have been taken to prevent this death.
Probably	Certain actions may have decreased the likelihood of this death.
Probably Not	This was probably not preventable.
Not Preventable	No preventive measures found.
Unsure/unable to agree	

Only deaths that were judged to be definitely or probably preventable were considered “preventable” for the purposes of this document:

A child's death is considered to be preventable if an individual or the community could reasonably have done something to alter the conditions that led to the child's death, thereby preventing the child's death, or could reasonably do something now to reduce the likelihood of future deaths. Examples include, but are not limited to, implementing safety rules, laws, or policies; creating or improving barriers around dangerous areas; educating children or adults in the community; or improving access to health care.

Risk factors, prevention opportunities, and intervention activities were identified. A data collection form was completed on each case reviewed. If additional records were needed, or specific questions were raised that required more information, a case review was continued at the next meeting. If additional information was unobtainable, the case was considered incomplete, and a determination of preventability was not made. Of the 138 cases presented to the CMRT, 17 records were so incomplete that preventability could not be determined. For an additional 4 cases, agreement could not be reached as to preventability. Information from the data collection form was then entered into an Access 97 database, from which this report was produced.

OVERVIEW

The population of Idaho on July 1, 1997 was estimated at 1,208,865. Of the total, 350,371 were under the age of 18, including 180,111 males and 170,260 females.

The population of children under age 18 in Idaho was estimated to be 96.5% white, 0.6% black; 1.3% Asian or Pacific Islander, and 1.6% American Indian. Ten (10.1) percent of the children were of Hispanic ethnicity.

Among the population under 18 years of age, 224 died in Idaho in 1997. The age groups of the children who died are shown below.

	Age Group			
	<1	1-4	5-14	15-17
Number	91	28	62	43
Percent	40.6	12.5	27.7	19.2

The largest number of deaths occurred in the children less than one year of age; these were mainly natural deaths. The sex of children who died is shown below.

	Sex	
	Female	Male
Number	95	129
Percent	42.4	57.6

The race of children who died is shown below.

	Race			
	Asian/Pacific Islander	Black	Native American	White
Number	1	1	3	219
Percent	0.4	0.4	1.3	97.8

Twenty-seven of the children who died were Hispanic; 127 were Non-Hispanic.

The manner of death for record-keeping purposes is determined either by the coroner or physician signing the death certificate. The manner of death for all 224 resident children dying in Idaho in 1997 is shown below.

Manner of Death	Number	Percent
Natural	126	56.3
Accidental	76	33.9
Suicide	16	7.1
Homicide	6	2.7
<i>Total</i>	<i>224</i>	<i>100%</i>

Natural and accidental deaths are the most common manners of death for Idaho children.

AUTOPSIES

Autopsies can be an important aspect of many death investigations but are not mandated by Idaho state law. The table below shows the number and percent of autopsies performed, by cause of death.

Autopsies performed on children, by cause of death -- 1997

Cause	Percent autopsied	Number of autopsies per number of deaths
Natural—not SIDS	29.2	31/106
SIDS	90.0	18 / 20
Motor vehicle accidents	11.9	5 / 42
Fire or burns	77.8	7 / 9
Drowning or submersion	25.0	2 / 8
Firearms	10.5	2 / 19
Suffocation or strangulation	50.0	2 / 4
Shaken baby or other abuse	75.0	3 / 4
Trauma—other	0.0	0 / 10
ALL CAUSES	31.7	71 / 224

For many causes of death, autopsies were rarely performed, but for SIDS the rate was 90%. Autopsy results were not always available to the team, however, and when done, the level of detail present in the autopsy report was highly variable. For example, in some reports, results from blood alcohol and drug tests were missing.

NATURAL DEATHS

The rate of death in children due to natural causes is highest in the first year of life, and results generally from such causes as pregnancy complications, congenital anomalies, and sudden infant death syndrome (SIDS). Natural causes of death quickly become less common as children grow older. Of the 138 deaths reviewed by the team, 43 were identified as natural. Of these deaths, 11 were thought to be preventable. SIDS accounted for 8 of the preventable deaths (see next page). The other 3 preventable deaths are outlined below.

A 2-month old child died of pertussis, which may have been acquired from other young children in the child's environment.

A 5-year old child died of dehydration from severe dysentery.

A newborn died after being born at home to a teenage girl who hid her pregnancy from her parents.

Conclusions and recommendations

The team is concerned about incomplete immunization of children for preventable childhood diseases.

The team strongly encourages parent and provider education about vaccine-preventable diseases and immunizations available for children, and fully supports the current efforts to improve Idaho's immunization rate.

The team is concerned about insufficient parental education in the areas of health and well-being of their children.

The team strongly encourages parent education regarding the health and well-being of their children, including emphasis on oral hydration for diarrhea and recognition of signs and symptoms of serious illness that require medical care.

The team is concerned about the inadequacy of sex education efforts.

The team strongly encourages open communication among parents, educators, and children regarding sexual education.

The team recommends that resources be made available to these groups to help adolescents and children better understand sexual health.

The team recommends furthering access to available resources for prevention of pregnancy, crisis counseling for pregnant teenagers, improved access to prenatal care, and improved access to counseling about sexual health.

Sudden Infant Death Syndrome (SIDS)

SIDS is the leading cause of death in babies from 1 month up to 1 year of age. In 1997, 20 Idaho children had SIDS listed as the cause of death on their death certificate. In the United States, 2,991 infants died of SIDS in 1997.

SIDS is defined as the sudden death of an infant under one year of age which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene, and a review of the clinical history.

Most SIDS deaths occur when a baby is between 1 and 4 months of age. More boys than girls are victims, and deaths occur more frequently during the fall, winter and early spring months. The death is sudden and unpredictable; in most cases, the baby seems healthy prior to death. Death occurs quickly, usually during sleep time. In 15% of suspected SIDS cases, evidence for the cause of death can be found on autopsy, including previously unknown congenital anomalies, evidence of trauma, and infanticide.

In Idaho and the rest of the Northwest, SIDS rates have been historically higher than the national average, but rates in all areas have declined in recent years. Idaho's resident rate of SIDS in 1990 was 261.5 per 100,000 live births, compared to the national rate of 130.3. By 1997, rates had dropped to 107.9 and 77.1, respectively. Among whites, the Idaho rate in 1997 was 106.7, and the national rate was 64.0 per 100,000 live births. Some of the decrease in SIDS rates is thought to be due to the recognition that SIDS risk increases when infants are not placed on their back for sleep.

Although the cause of SIDS is unknown, SIDS is associated with many maternal, infant, and environmental risk factors. Some risk factors associated with SIDS that can be identified before or at birth include:

- Low birth weight.
- Symmetric intrauterine growth retardation.
- Multiple births per pregnancy (especially a lower weight twin).
- Short interpregnancy interval.
- Maternal opiate or cocaine use.
- Maternal smoking during pregnancy.
- Digital/palmar dermatoglyphic patterns (types of handprint).
- Dysmorphism or congenital anomalies.

Risk factors associated with SIDS that occur after birth include:

- Exposure to tobacco smoke.
- Sleeping on the stomach -- especially with a history of recent illness, when swaddled, on a soft natural-fiber mattress, or in a heated room.
- Lack of breast feeding.
- Overheating: warm bedroom temperature, heavily wrapped, and excess clothing.
- Co-sleeping with mothers who smoke.
- Co-sleeping on soft surfaces or with pillows.

Nationally, the most consistently reported and potentially modifiable risk factors are exposure to tobacco smoke before and after birth, stomach sleeping position, and lack of breast feeding. Of the 20 Idaho SIDS deaths reviewed for 1997, 8 were identified as having preventable risk factors present

that may have contributed to the death. In several cases, insufficient detail was available to make a determination of whether risk factors were present. The table below lists the preventable risk factors associated with the Idaho deaths.

Identified preventable risk factors associated with 8 Idaho SIDS deaths

Co-sleeping	2
Maternal smoking	4
Position other than back	3
Soft bedding	1
Infant overheated/overdressed	1

In addition, drug use by a parent was reported in 3 households where a SIDS death occurred.

In 1997, 18 of the 20 children with SIDS listed as the primary cause of death had an autopsy performed.

A 2-month old infant died of SIDS. The infant was found lying face down on soft bedding in a make-shift crib. The mother smoked. No evidence of trauma was found in this well-nourished, well-developed infant.

Conclusions and recommendations

The team is concerned about the incidence of preventable risk factors present in SIDS deaths.

We recommend public education campaigns to help decrease the incidence of SIDS, including:

- Proper positioning for sleep -- on baby's back, as promoted in the national "Back to Sleep" campaign.
- Keeping the baby's head uncovered during sleep.
- Avoiding exposure of babies to tobacco smoke before and after birth, targeting pregnant women.
- Seeking regular prenatal care and pediatric care.
- Educating doctors that parents and caregivers are more likely to place infants to sleep on their backs when advised to do so by their infants' doctors.

The team is concerned about Idaho's lack of uniform criteria and inconsistent data collection for the determination of SIDS as the cause of death.

We recommend:

- Use of a SIDS investigation protocol to promote further understanding of SIDS.
- A thorough case investigation, autopsy, review of clinical history and examination of the death scene for all children with a presumptive diagnosis of SIDS.
- Assistance in state funding of autopsies in children with a presumptive SIDS diagnosis.

We strongly support the introduction of new legislation to establish a statewide medical examiner system.

UNINTENTIONAL INJURY

Injuries play a greater role in mortality as children grow older. Of the 138 deaths reviewed by the team, injuries claimed the lives of 97 children; the majority (74) of the deaths were unintentional.

Classification of injuries into two categories, unintentional and intentional, allows emphasis to be placed on prevention activities. The phrase "unintentional injury" is used in this document interchangeably with "accident." Unintentional injuries are generally understandable, predictable, and most importantly, preventable.

The team felt that all 74 deaths were preventable. Unintentional injury deaths were due to the following causes:

Unintentional injury deaths by type (N=74)

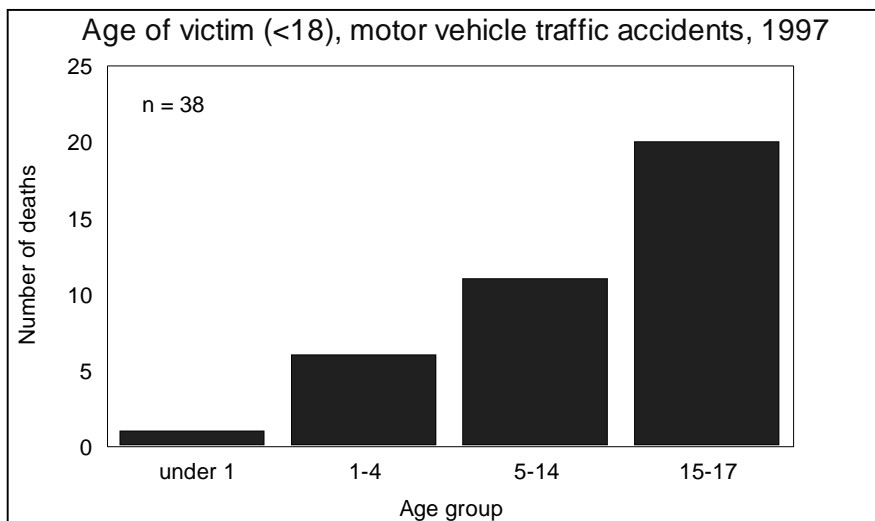
Cause of Death	Number	Percent of injury deaths (%)
Motor vehicle accidents		
Traffic	38	51.4
Non-traffic	4	5.4
Fire / Burn	9	12.2
Drowning / Submersion	8	10.8
Firearm	3	4.1
Suffocation / Strangulation	3	4.1
Other unintentional injuries	10	13.5

Motor Vehicle Fatalities

Deaths associated with motor vehicles account for the largest number of injury fatalities. In 1997, 38 children died in 32 separate motor vehicle traffic accidents, and 4 children died in motor vehicle accidents while not in traffic. Currently, some statutes are in place to protect children in motor vehicles (Appendix B).

Motor Vehicle Traffic Accidents

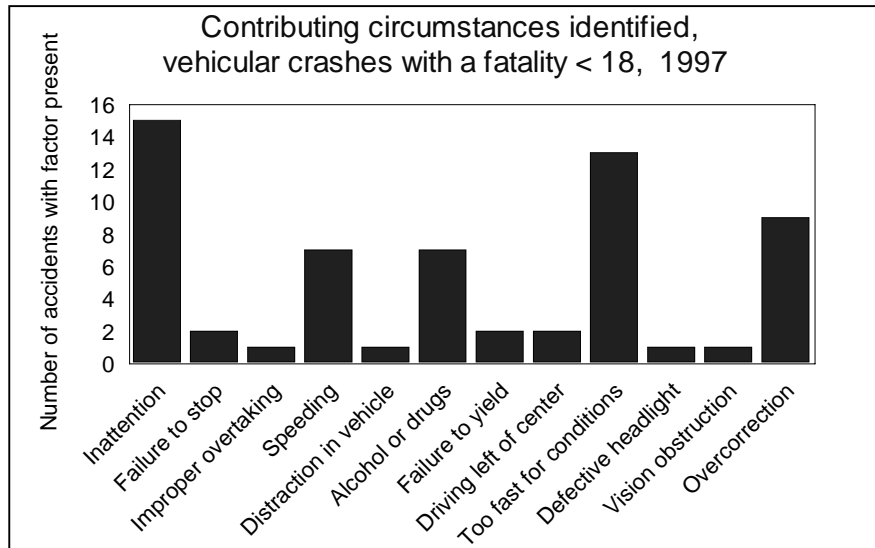
The incidence of motor vehicle traffic deaths increases with the age of the child. The 15–17 year old age group is known to be at high risk due to a lower skill level of driving, and increased risk-taking behavior, including lower seatbelt use rates. The ages of children dying in motor vehicle crashes is illustrated below.



Of the motor vehicle traffic fatalities, 14 were drivers, 18 were passengers inside or on a vehicle, 1 was riding in the bed of a pickup, and 5 were pedestrians.

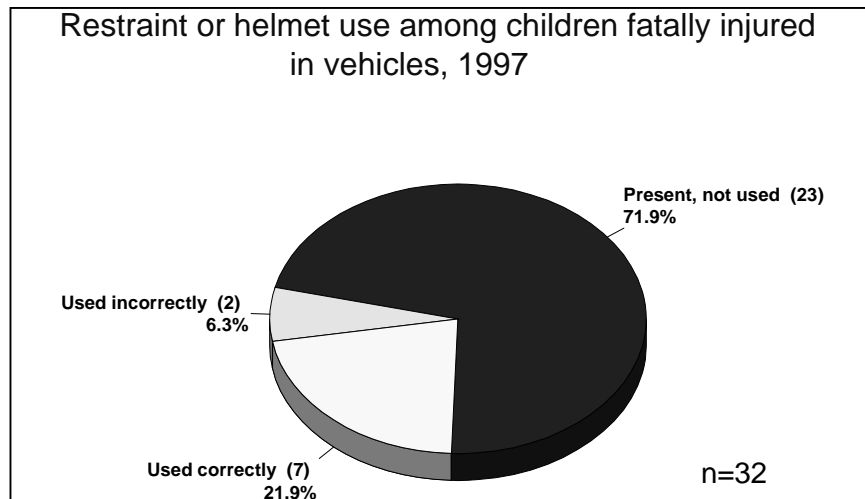
The risk of fatal crash involvement is particularly high for teenage drivers traveling, day or night, with 2 or more teenage passengers. Among these 32 crashes, 21 (66%) involved a teenage driver in the victim's vehicle (often the victim was the driver). There was at least one teenage passenger in the vehicle in 12 of the 21 (57%) crashes in which a teenager was driving. In contrast, the driver of the victim's vehicle was 20 years of age or older in only 11 crashes.

Law enforcement officers identify many factors at the scene that contribute to the cause of a motor vehicle crash, including driver errors, weather and road conditions, and mechanical failures. The contributing circumstances of the accident determined by law enforcement are shown in the next graph. Note that the investigating officer could indicate more than one contributing circumstance.



Drugs and alcohol are known to increase the incidence of motor vehicle crashes. Information on drug or alcohol use was not always available on the deaths reviewed. Although alcohol or drug use was suspected in several of the accidents reviewed, testing was not consistently done, and results were often not available to the team.

Of the 32 traffic fatalities that occurred while the child was in a vehicle, 1 occurred on a motorcycle; the others occurred in vehicles in which seat belts may have been protective. Of these children, the vast majority (77.9%) did not have properly used protective devices in place at the time of the fatal injury. In 23 deaths, restraints were present but not used; in 2 deaths, restraints were used incorrectly, as shown below.



A 16-year-old driver and a 17-year-old friend were driving on a rural road at 11:30 pm. The driver lost control while attempting to retrieve an object that had dropped onto the seat. The vehicle left the pavement and traveled in the borrow pit for a distance. The driver over-corrected and the victim was partially thrown from the vehicle as it rolled. The victim was not wearing a seatbelt.

Motor Vehicle Non-Traffic Accidents

Four children died in vehicle accidents while not in traffic, including:

- A 10-year old child, who was not wearing a helmet, lost control of an ATV and rolled down a hillside.
- A teenage spectator who was struck by a vehicle during an event at a fairgrounds.
- A teenager who was thrown from a dirt bike and died of head injury, despite wearing a helmet.
- A young child who was pinned by a gate in the back of a stationary pickup truck while playing in the vehicle.

Conclusions and recommendations

The team is concerned about the number of children killed in motor vehicle traffic crashes who are not properly restrained according to Idaho law.

We recommend public education regarding the proper use of safety restraints, including seatbelts, child safety seats, and booster seats.

We strongly urge the introduction of new legislation to:

- Ensure passengers may not legally ride in the beds of pickup trucks.
- Encourage the use of seatbelts, child safety seats, and booster seats, including creation of a law which makes it a primary offense to not use safety restraints for all ages.

The team is concerned about the number of child deaths in which over-correction was identified as a contributing circumstance.

We recommend that driver's education programs increase focus on avoiding over-correction of turns and slides, as this appears to be a major factor in fatal motor vehicle accidents in adolescents.

We strongly urge the introduction of new legislation to ensure graduated driver licensure.

The team is concerned about the role of alcohol and drugs in some of the motor vehicle fatalities.

We recommend public education regarding recognition of drug use in children and adolescents.

We recommend increased emphasis on educating adolescents and the caregivers of children on the dangers of drug or alcohol use before driving.

We recommend that alcohol and drug tests be performed on drivers involved in motor vehicle crashes with a child fatality, and results made part of the coroner's report.

Fire and Burns

Nine children lost their lives in 4 separate fires in 1997. One of the fires caused the death of 6 of these children. Smoke alarms were present in 3 of the 4 homes in which a child died; however, only one of these alarms was functioning properly.

The cause of the fire was determined in 2 cases. They were identified as:

- overloaded extension cord.
- cigarette left on or near sofa.

For the other two fires, the source was not clear, but in one, the fire appeared to start in the bed on which the victim was playing.

A school-aged child died in an upstairs bedroom from smoke inhalation due to a house fire. An overloaded light duty extension cord in the room sparked the fire that claimed the life of this young child. Smoke detectors were only located on the main floor of this home.

Conclusions and recommendations

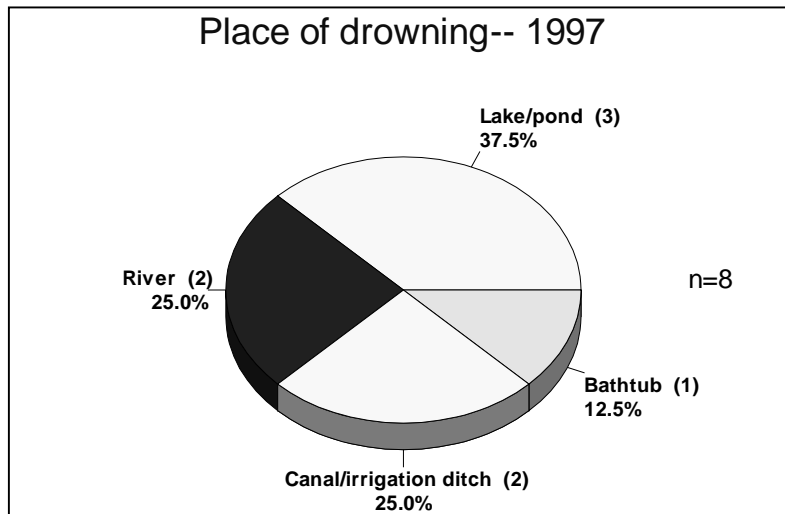
The team is concerned about the lack of functioning smoke detectors in the homes where the fires occurred.

We recommend:

- Public health efforts to promote local free smoke detector availability.
- Public education regarding the proper use of smoke detectors, including regular battery replacement.
- Placement of a working smoke detector on each level of every home.

Drowning and Submersion

In 1997, 8 children died by drowning or submersion. The deaths occurred in the following bodies of water:



At the time of the drowning, 2 of the children were swimming, 4 were playing in or near the water, 1 had wandered away from home, and 1 was bathing at home. The deaths were considered preventable due to the presence of the following factors:

Factors identified that may have contributed to drowning deaths

Factor	Number of drownings
Lack of supervision	3
Lack of flotation device	3
No barrier in place	1
Child unable to swim	1

A toddler died as a result of drowning. Only minutes before, the child was seen playing on the bank of a ditch in the family's backyard.

A teenager died while attempting to swim across a pond to reach his friends.

Conclusions and recommendations

The team is concerned about the lack of adult supervision of children when the potential for injury exists, especially near open bodies of water.

The team is concerned about the lack of use of flotation devices when children are in open bodies of water.

We recommend public education regarding open water safety and the proper use of personal flotation devices.

Firearms

Firearms are involved in about five percent of childhood and adolescent mortality. According to the document “Health and the American Child: A Focus on Mortality among Children”, published by the Public Health Policy Advisory Board in 1999, one out of every three deaths among adolescents involves a firearm.

In Idaho in 1997, there were 3 unintentional firearm deaths, all of which were thought to be preventable. Those 3 deaths are outlined below:

A toddler accidentally shot herself while left alone with a weapon inside a vehicle.

A teen accidentally shot himself while playing Russian roulette.

A child accidentally shot another school-aged child when they were playing with a loaded revolver they found in a relative’s home.

Conclusions and recommendations

The team is concerned about gun safety and storage.

We recommend increased public education regarding firearm safety, emphasizing safe storage of firearms.

Suffocation and Strangulation

In 1997, 3 children died as a result of suffocation or strangulation. Those deaths are outlined below:

A 10-month old child became entangled in crib blankets while sleeping.

A 3-week old infant was accidentally suffocated by its parent while they were sleeping in the same bed.

An 8-month old child with an underlying respiratory illness apparently compacted a blanket against own nose and mouth while sleeping.

Conclusions and recommendations

The team is concerned that caregivers are not always aware of how to provide a safe sleeping environment for children.

We recommend that infants be provided with an environment which protects them and leaves their nose and mouth free of blankets and other objects, as outlined by the Consumer Product Safety Commission:

- Place baby on his/her back on a firm tight-fitting mattress in a crib that meets current safety standards.
- Remove pillows, quilts, comforters, sheepskins, stuffed toys, and other soft products from the crib.
- Consider using a sleeper or other sleep clothing as an alternative to blankets, with no other covering.
- If using a blanket, put baby with feet at the foot of the crib. Tuck a thin blanket around the crib mattress, reaching only as far as the baby's chest.
- Make sure your baby's head remains uncovered during sleep.
- Do not place baby on a waterbed, sofa, soft mattress, pillow, or other soft surface to sleep.

Other Unintentional Injuries

There were 10 deaths that occurred from other unintentional injuries. The causes are outlined below:

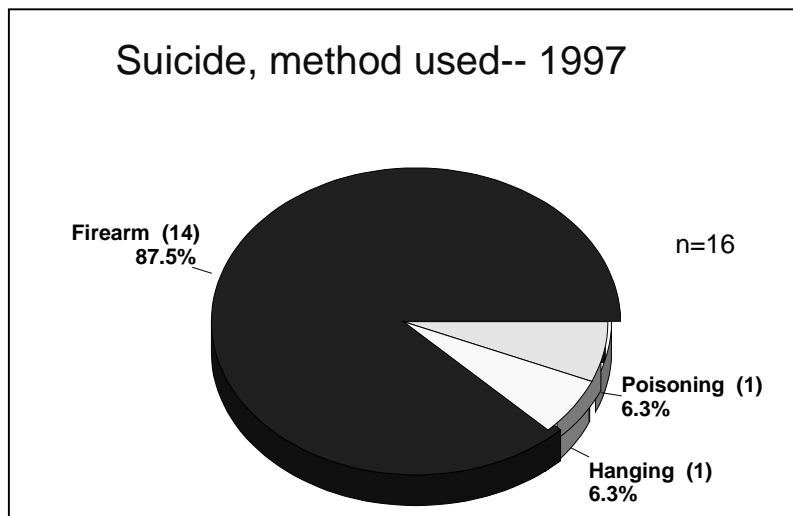
- An airplane crash.
- An insulin overdose.
- An accidental overdose while inhaling nitrous oxide gas recreationally.
- A fall down the stairs.
- Complications during a medical procedure.
- A fall from a tractor which overturned.
- An injury from a derrick pole.
- A fall from a boat.
- 2 falls from horses.

INTENTIONAL INJURIES

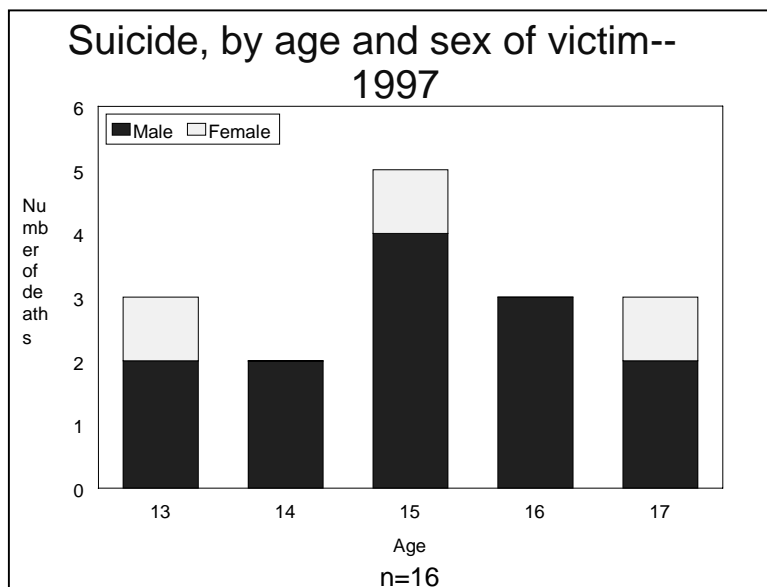
In 1997, 16 children committed suicide, and 6 were victims of homicide.

Suicide

Suicide among children is a national concern. In 1997, it was the third leading cause of death for the age group 15-19 in the U.S. Idaho's suicide rate is higher than the national average. In Idaho in 1997, it was the third leading cause of death for ages 10-14, and the second leading cause of death for ages 15-19. Firearms accounted for 14 (87%) of the suicide deaths. The remaining 2 suicides were completed by hanging and poisoning.



Suicide was more frequent among males; 13 of 16 suicide victims were male. Children committing suicide ranged from 13 to 17 years of age, as shown below:



In many of the cases, a recent stressful event had occurred, that seemed to have contributed to the adolescents' desire to end their life, including:

- a recent arrest for possession of drug paraphernalia.
- a fight at school.
- a fight with a girlfriend.
- a car accident while driving on a suspended license.

In several cases, friends reported that the victim had spoken about committing suicide, but in several other cases, family and friends were surprised by the suicide and said that no warning was given.

Three of the victims had alcohol detected in their bloodstream during autopsy.

A 14-year old teen fatally shot himself after experiencing difficulty with household and school rules.

Conclusions and recommendations

The team is concerned about the high number of suicides in children.

We recommend public education regarding recognition of depression and suicide warning signs in adolescents.

We recommend public education regarding recognition of alcohol and drug use in children and adolescents, including the risk of extreme behavior while under the influence of these substances.

We recommend strengthening education to decrease the use of illegal drugs or alcohol by children and adolescents.

Homicide

Homicide in children is often due to child abuse. Across the nation, 1,238 children died in 1997 of abuse or neglect; this incidence was 37% higher than it had been in 1985.

The deaths of 6 children in 1997 were classified as homicide. Of these:

- Three were due to shaken baby syndrome. The ages at death were 1 year, 2 years, and 6 years. The 6-year old had a delayed death after being shaken as an infant.
- One was due to blunt trauma to the head. The child was 1 year old.
- Two were due to firearms. The ages of the children at death were 14 and 16. Both teenagers were shot, in separate incidents, by another teenager playing with a firearm. Both deaths were determined to be accidental, but were investigated for reckless endangerment by the youths handling the weapons. These deaths were reported as homicide by the coroner since one person was involved in taking the life of another individual in each case.

Conclusions and recommendations

The team is concerned about the occurrence of shaken baby syndrome in Idaho in 1997.

We recommend continued public education regarding shaken baby syndrome.

The team is concerned about the lack of information on one of the homicides.

We recommend that each child death have a complete coroner's report, including the circumstances and probable cause of death, which is made available to the team for review.

USE OF A FIREARM IN INJURY DEATHS

This is cumulative data from both unintentional and intentional injury deaths by firearm

In 1997 there were a total of 19 firearm deaths, unintentional and intentional. Of the 19 deaths, the person handling the firearm at the time of the incident was:

- Victim 16
- Child family member 1
- Other child 1
- Unknown to team 1

The firearm involved in the incident was identified as:

- Handgun 6
- Rifle 4
- Shotgun 6
- Unknown to team 3

The use of the firearm at the time of the incident was:

- Intending to do harm (suicide) 14
- Two children or adolescents were playing with the firearm 3
- One adolescent was playing Russian roulette 1
- Unknown to team 1

For 13 deaths, no records indicated how the weapon was accessed by the child or adolescent. For the other 6 deaths, were able to identify the following:

- The gun was kept between the mattress and box springs when accessed by the adolescent.
- The gun was in a gun safe, but was unlocked by a teenage friend of the victim.
- The gun was kept in a gun safe (unclear if it was locked).
- The gun was apparently taken from a bedroom dresser drawer by the adolescent.
- The gun was inside the vehicle with the child.
- The gun was found under a coffee table by the child.

APPENDIX A

Executive Order

THE OFFICE OF THE GOVERNOR

EXECUTIVE DEPARTMENT
STATE OF IDAHO
BOISE
EXECUTIVE ORDER NO. 98-10
CHILD MORTALITY REVIEW TEAM

WHEREAS, the health and safety of Idaho children are of primary importance; and

WHEREAS, the child death rate in Idaho exceeds that of the nation; and

WHEREAS, some child deaths are due to preventable causes; and

WHEREAS, records of children's deaths and circumstances leading to their death are kept by multiple agencies but not coordinated, on-going effort is being made to evaluate these records; and

WHEREAS, expertise exists within the state to evaluate these records and identify circumstances leading to or contributing to the deaths of children; and

WHEREAS, the identification of risk producing circumstances and recommendations to remediate them may reduce child death rates;

NOW THEREFORE, I, PHILIP E. BATT, Governor of the State of Idaho, by virtue of the authority vested in me under the Constitution and laws of this state, do hereby establish the Child Mortality Review Team.

The duties of the Team shall include reviewing data on selected cases of child death and developing recommendations for systems improvement which lead to reduced mortality. The Director of the Department of Health and Welfare shall appoint the members of the Team. The Team shall establish the terms of appointment, chairmanship, and other operating guidelines in bylaws. Membership shall include:

- a pediatrician,
- an emergency medicine physician,
- a pathologist,
- a coroner,
- a prosecutor,
- a law enforcement representative,
- a Children at Risk Task Force member,
- the state epidemiologist, and
- a representative of the public.

An annual report with the Team's findings and recommendations shall be presented to the Governor and to the Chairs of the Senate and House Health and Welfare Teams.

This Executive Order shall cease to be effective four years after its entry into force.

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Idaho at Boise the Capitol, the 16th day of July, in the year of our Lord nineteen hundred ninety-eight, and of the Independence of the United States of America the two hundred twenty-third and of the Statehood of Idaho the one hundred ninth.

PHILIP E. BATT
GOVERNOR
PETE T. CENARRUSA

APPENDIX B

Idaho Statutes

**TITLE 49: MOTOR VEHICLES: CHAPTER 6: RULES OF THE ROAD:
PASSENGER SAFETY FOR CHILDREN.**

(1) No noncommercial motor vehicle operator shall transport a child who is under the age of four (4) years and weighs less than forty (40) pounds in a motor vehicle manufactured with seatbelts after January 1, 1966, unless the child is properly restrained in a car safety seat that meets the requirements of federal motor vehicle safety standard no. 213. The provisions of this section shall not apply:

(a) If all of the motor vehicle's seatbelts 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 seat and held by the attendant for the purpose of nursing the child or attending the child's other immediate physiological needs.

(2) The failure to use a child safety seat shall not be considered under any circumstances as evidence of contributory negligence, nor shall such failure be admissible as evidence in any civil action with regard to negligence.

**TITLE 49: MOTOR VEHICLES: CHAPTER 6: RULES OF THE ROAD
49-673. SAFETY RESTRAINT USE.**

(1) Except as provided in section 49-672, Idaho Code, and subsection

(b) of this section, each occupant of the front seat of a motor vehicle which has a gross vehicle weight of not more than eight thousand (8,000) pounds, and which was manufactured with safety belts in compliance with federal motor vehicle safety standard no. 208, shall have a safety belt properly fastened about his body at all times when the vehicle is in motion.

(2) The provisions of this section shall not apply to:

(a) An occupant of a motor vehicle who possesses a written statement from a licensed physician that he is unable for medical reasons to wear a safety belt;

(b) Occupants of motorcycles, implements of husbandry and emergency vehicles;

(c) Occupants of the front seat of a motor vehicle in which all safety belts are then properly in use by other occupants of that vehicle;

(d) Mail carriers.

(3) If a person is convicted of a violation of any traffic law, other than a violation of the provisions of sections 49-1229 or 49-1230, Idaho Code, relating to proof of liability insurance, it shall be an additional infraction for any person to violate the provisions of this section, for which a fine of five dollars (\$5.00) shall be imposed. A conviction under this section shall not result in violation point counts as prescribed in section 49-326, Idaho Code. In addition, a conviction under this section shall not be deemed to be a moving traffic violation for the purpose of establishing rates of motor vehicle insurance charged by a casualty insurer.

(4) The department shall initiate and conduct an educational program, to the extent sufficient private donations or federal funds for this specific purpose are available to the department, to encourage compliance with the provisions of this section and to publicize the effectiveness of use of safety belts and other restraint devices in reducing risk of harm to occupants of motor vehicles.

(5) The department shall evaluate the effectiveness of the provisions of this section and shall include a report of its findings in its annual evaluation report on the Idaho Highway Safety Plan which it submits to

National Highway Traffic Safety Administration and Federal Highway Administration pursuant to 23 U.S.C. 402.

(6) The failure to use a safety belt shall not be considered under any circumstances as evidence of contributory or comparative negligence, nor shall such failure be admissible as evidence in any civil action with regard to negligence.

