Utah Child Fatality Review

Annual report 2020 data

- In 2020, there were 451 Utah residents aged 0-18 who died.
- 177 child deaths were reviewed by the Utah Child Fatality Review Committee (CFRC).
- Suicide was the leading cause of child injury death and accounted for more than 29.4% of the deaths reviewed by the Utah CFRC.
- In 2020, child firearm deaths were the highest ever recorded (dated back to 1999) and youth homicides were higher than they had been in 13 years.
- There were significantly higher rates of child injury deaths in Utah males, infants, and older teens.
- Rural populations and those who identify as American Indian/Alaska Native or Black/African Americans had significantly higher rates of child injury deaths in Utah.
- This report includes 5 priority recommendations and 66 injury-specific recommendations to help prevent future child deaths in Utah.

Utah Department of
Health & Human
Services

Utah Child Fatality Review Committee (CFRC)

The Utah CFRC brings together diverse agencies and organizations that serve Utah children and families. This multidisciplinary approach allows members to share available information from different sources to better understand how and why a child has died. It is this coordination that improves the process of thoroughly reviewing child deaths in Utah.

The Utah CFRC includes representatives from the following agencies:

- Administrative Office of Courts
- Division of Juvenile Justice Services
- Intermountian Healthcare
- Primary Children's Hospital
- Salt Lake County District Attorney's Office
- University of Utah
- Utah Attorney General's Office
  - Children's Justice Division
  - Children's Protective Division
- Utah Center for Reproductive Health
- Utah Department of Health and Human Services
  - Bureau of Emergency Medical Services
  - Division of Child and Family Services (DCFS)
  - Division of Juvenile Justice and Youth Services
  - Division of Mental Health
  - Emergency Medical Services for Children (EMSC) Program
  - Office of Service Review
  - Office of the Medical Examiner
  - Utah Office of Victims of Crime
  - Violence and Injury Prevention Program (VIPP)
- Valley Mental Health

Periodically, other individuals are invited to attend reviews if they have expertise or history related to a particular case. These individuals may include representatives from support services, law enforcement agencies, fire marshals, child care centers, and child advocacy centers. All information and data regarding each child's death is treated confidentially. Committee members and invited guests sign a confidentiality agreement that prohibits them from sharing case information outside the meeting. The review meetings are not open to the public.

Introduction

The death of a child is a tragedy for families and communities. In 2020, there were 451 Utah children 0-18 years of age who died. Of those deaths, 29.4% (n=139) were determined to be from injury. Injury deaths are mostly preventable, yet they continue to be the leading cause of death for children aged 1-18 in Utah[1].

The Utah Child Fatality Review Committee (CFRC) applies a public health approach to prevent child death by aggregating data from individual child deaths, describing trends and patterns of the deaths, and recommending and implementing prevention strategies.

Between 2020 and 2022, the Utah CFRC reviewed 177 child deaths that occurred during 2020. This report summarizes the data from these reviews and the prevention recommendations made by the Utah CFRC.

The review process and data overview

Manner of death

The Utah death certificate has 5 manners of death: natural, unintentional injury, suicide, homicide, and undetermined. The manner of death is a classification made by a doctor. Any death that is not clearly from a natural medical cause is sent to the Utah Department of Health and Human Services Office of the Medical Examiner (OME). Highly trained forensic pathologists and physicians at the OME determine the manner of death following a thorough review of the circumstances surrounding the death, autopsy results, and relevant medical records.

Figure 1: Number of child deaths aged 0-18 by manner, Utah, 2020

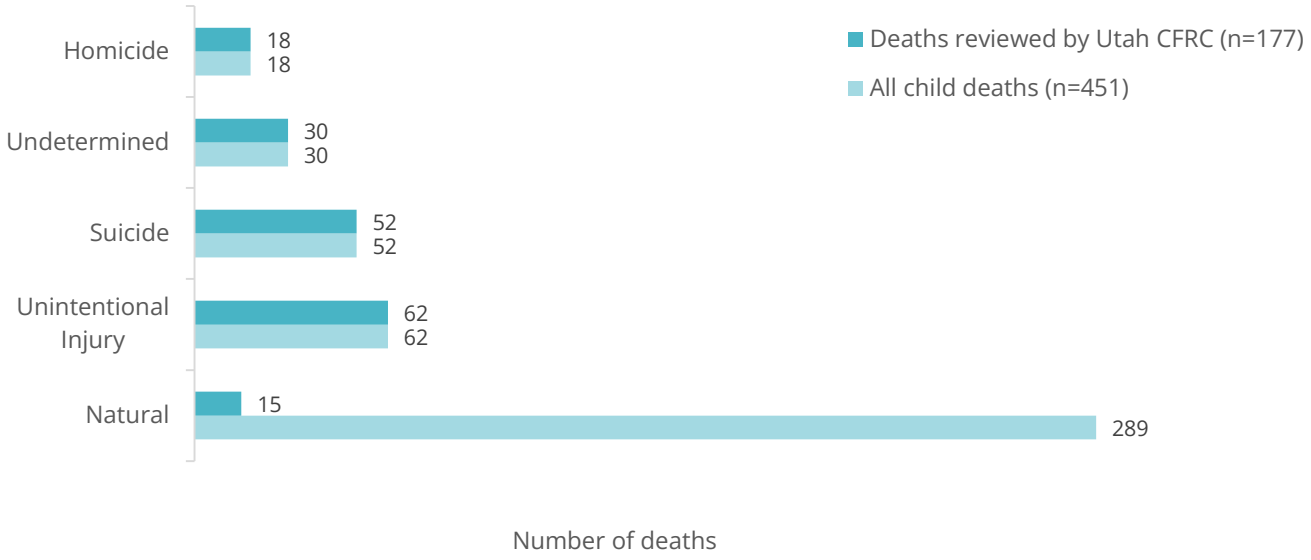


Figure 1 shows that the majority of the 451 Utah child aged 0-18 deaths in 2020 were determined to be natural, 64.1%, followed by unintentional injury, 13.7%, suicide, 11.5%, undetermined, 6.7%, and homicide 3.1%. The Utah Child Fatality Review Committee (Utah CFRC) reviewed 177 of the total child deaths that occurred during 2020. By contrast, the most frequent manners of death were unintentional injury 35.0%, suicide, 29.4%, undetermined 16.9%, homicide 10.2%, and natural 8.5%.

Every child death in Utah receives at least 1 review. Every natural death receives a basic death certificate review to confirm the cause and manner by a trained physician. Natural deaths involving birth defects are reviewed by the Utah Department of Health and Human Services Birth Defects Network and natural deaths involving premature births are reviewed by the Utah Department of Health and Human Services Perinatal Mortality Review Committee to inform prevention and mitigation efforts. All other injury (unintentional injury, suicide, and homicide) and undetermined deaths are then reviewed by the Utah CFRC along with a small number of natural deaths that may fall into the Sudden Unexpected Infant Death (SUID) and Sudden Death in the Young (SDY) Case Registry definition.

SUID/SDY and the advanced clinical review committee

The Utah Department of Health and Human Services takes part in the U. S. Centers for Disease Control and Prevention (CDC) SUID and SDY Case Registry. The registry has data on children who died suddenly and unexpectedly from states across the country. This information helps public health better understand the causes of these deaths and find ways to prevent them. After an initial review of cases that meet the SUID and SDY definition by the Utah Child Fatality Review Committee, the cases are sent to an advanced clinical review committee. This committee includes pediatric medical experts, neurologists,forensic pathologists, cardiologists, geneticists, and genetic counselors. The committee categorizes the cases and addresses any questions regarding the pathologies or genetic issues that have been identified

Cause of death

The cause of death is the specific injury or disease that resulted in the death such as drowning, poisoning, or motor vehicle crash. Table 1 displays the leading causes of death in 2020 among Utah children aged 0-18 and the percentage of the total 2020 child deaths they represent. The leading causes of death included perinatal conditions (24.6%, n=111), congenital malformations (17.1%, n=77), and unintentional injuries (14.4%, n=65)[1].

Table 1. Leading causes of death among children aged 0-18, Utah, 2020

	n	%
Certain conditions originating in the perinatal period	111	24.61
Congenital malformations, deformation, and chromosomal	77	17.07
Unintentional injuries	62	13.97
Intentional self-harm (suicide)	52	11.53
Malignant neoplasm (cancer)	21	4.66

Figure 2: Number of child injury deaths reviewed by the Utah CFRC by leading causes of death, Utah, 2020 (n=177)

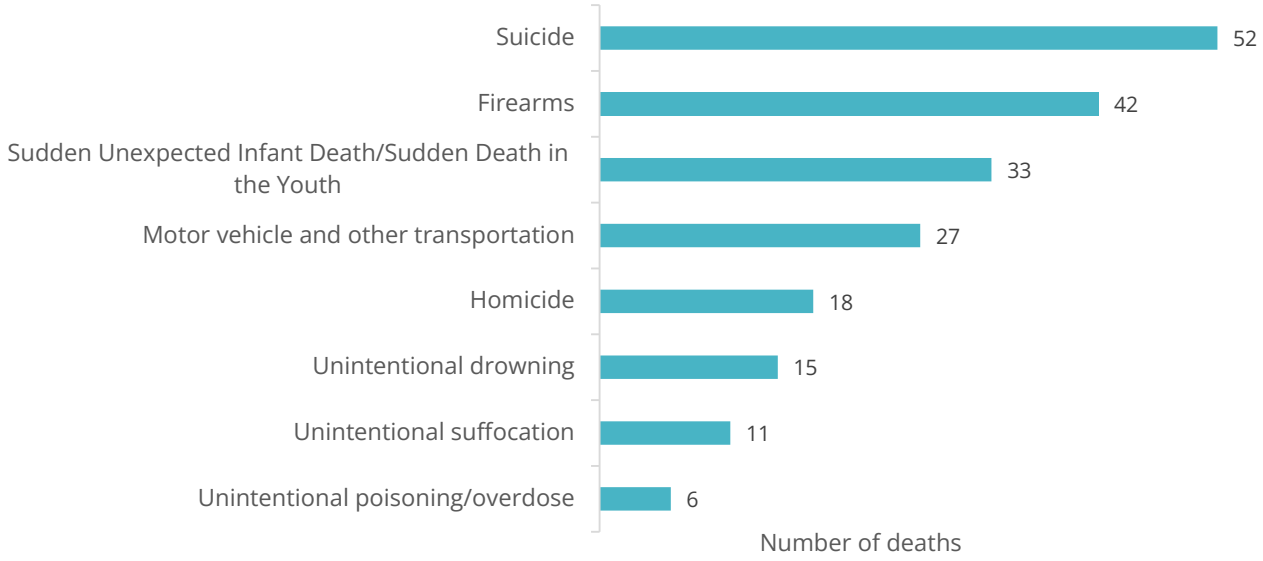


Figure 2 shows the leading causes of injury death in 2020 for Utah children that were reviewed by the Utah CFRC. Suicide and homicide are manners of death instead of causes, but are included in this list and in the following breakdowns of data because of their prominence and relevance to the recommendations included in this report. Suicide and homicide deaths are mostly caused by firearms, suffocation, and blunt force trauma. Because of overlaps in the manner and cause of death, some child deaths may fall into multiple categories. For example, firearm deaths include both suicide deaths and homicide deaths (59.5% and 40.5%).

Suicides (52) were the most frequently reviewed deaths by the Utah CFRC, followed by SUID/SDY (33) and motor vehicle and other transportation (27). Firearms were the most common method of suicide followed by suffocation (48.1% and 40.4%). Most of the SUID/SDY deaths were among infants who were found in an unsafe sleep environment (84.8%). This means the infant was found sleeping in something other than a crib or bassinet; sharing a bed with another person; sleeping on their stomach; or the sleep area had soft bedding, bumper pads, or other items in it. Transportation deaths consisted primarily of children who died as passengers in a motor vehicle or on a motorcycle (59.3% and 18.5%). Other leading causes of death include homicide (18), unintentional drowning (15), unintentional suffocation (11), and unintentional poisoning or overdose (6).

Understanding the trends: summary of 2011-2020 child injury report findings

Figure 3: Rates of the leading causes of injury death among children aged 0-18 by year, Utah, 2011-2020 (n=1,228)[1]

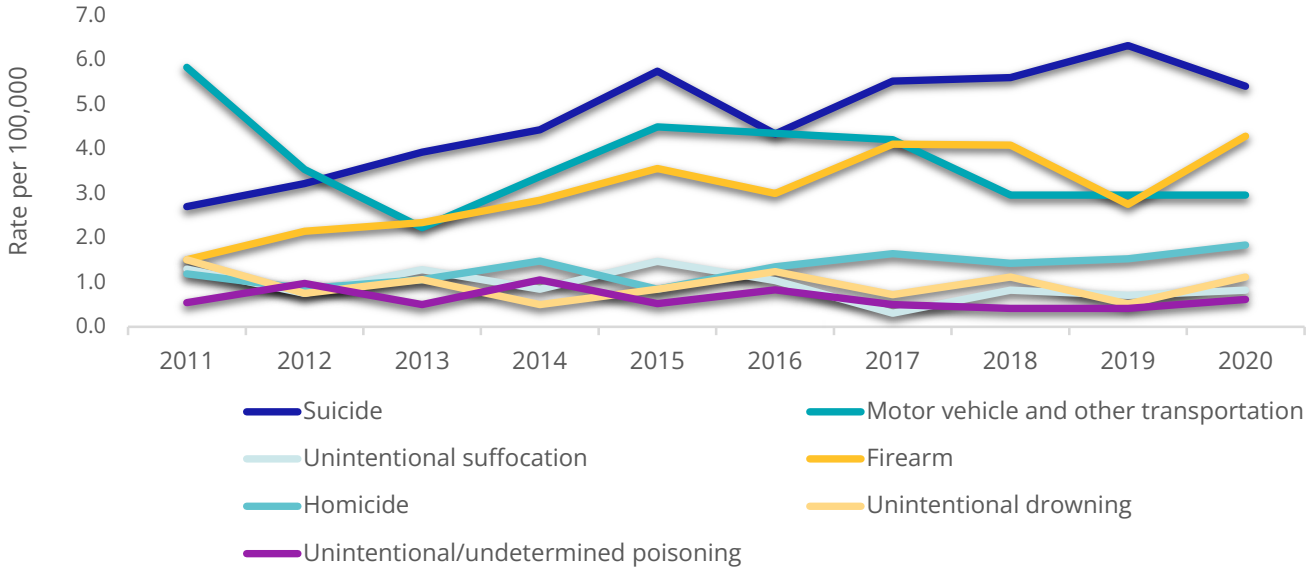


Figure 3 shows the rates of the leading causes of injury death among Utah children by year for the last 10 years. The figure includes trends in suicides and homicides even though they are manners of death, not causes of death. The rates of child injury deaths by cause remained stable from 2011 to 2020 (no significant change). However, the suicide rate more than doubled from 2011 to 2020 (2.70 to 5.41 per 100,000 population). The rates of unintentional death from motor vehicle and other transportation deaths, unintentional suffocation, unintentional drowning, and unintentional/undetermined poisoning) decreased significantly from 2011 to 2020 (10.27 to 6.64 per 100,000 population). The decrease in the unintentional injury death rate was driven by a significant reduction in the rates of motor vehicle and other transportation deaths (5.84 to 2.96 per 100,000 population)[1]. In 2020, the rate of child firearm deaths was the highest since 1999 (4.29 per 100,000 population). The rate of child homicide deaths was the highest since 2007 (1.84 per 100,000 population).

Disparities by age

Figure 4: Differences in the rate of injury death among children aged 0-18 by age group, Utah, 2011-2020 (n=1,282)

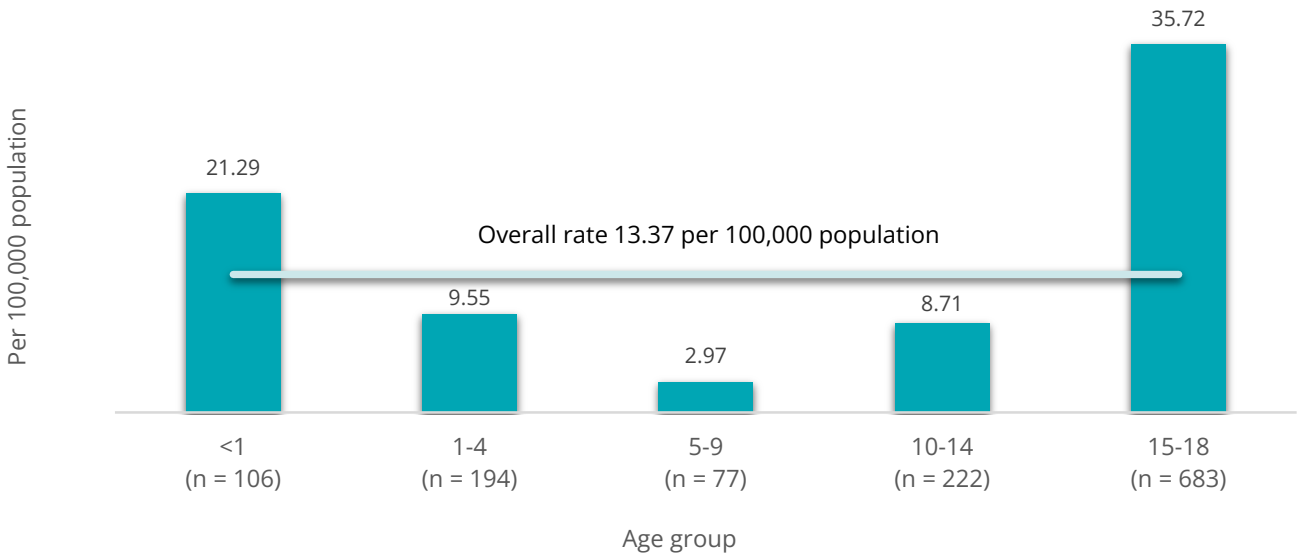


Figure 4 shows the rate of injury death by age group. Youth aged 15-18 had the highest rate of injury death followed by infants younger than 1. Both had significantly higher rates of injury death compared to the overall child injury death rate. Children aged 15-18 have statistically higher rates of suicide, firearm, motor vehicle and other transportation deaths than the overall child injury death rates for those causes of death (19.04 compared to 4.75, 12.24 compared to 3.08, 9.21 compared to 3.67 per 100,000 population). Infants have statistically higher rates of unintentional suffocation and homicide than the overall child injury death rates for unintentional suffocation and homicide (11.65 compared to 3.08 and 4.62 compared to 1.32 per 100,000 population)[1].

Disparities by sex

Figure 5: Differences in the rate of injury deaths among children aged 0-18 by sex, Utah, 2011-2020 (n=1,282)

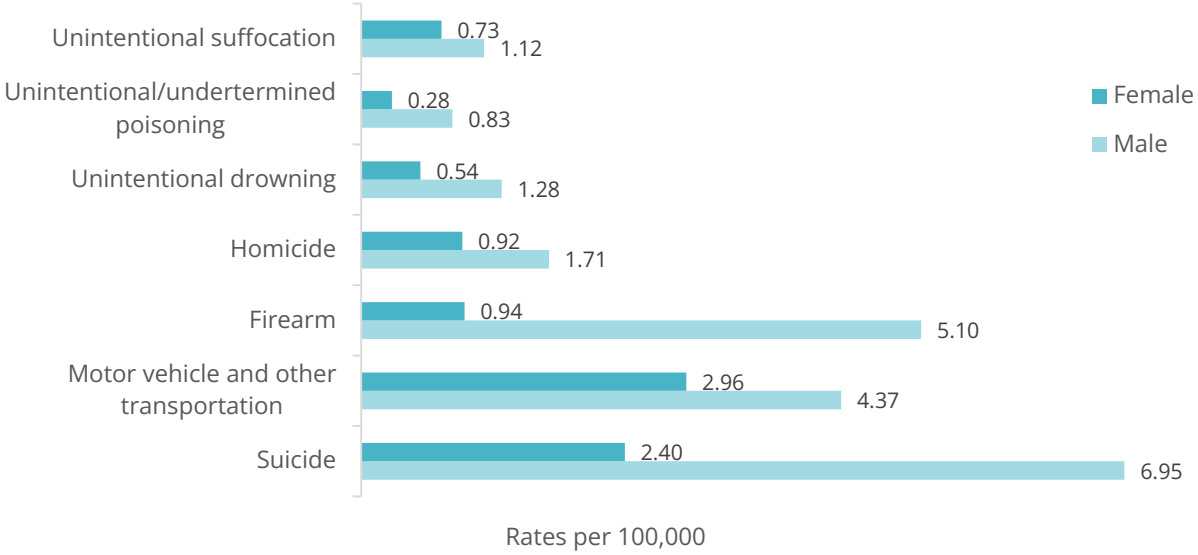


Figure 5 shows that males had significantly higher rates of injury death for all causes of death compared to females. Overall, males (0-18) were more than 5 times as likely to die from firearms as females (5.10 compared to 0.94 per 100,000 population). Males were more than 2 times as likely to die of suicide, unintentional drowning, and unintentional/undetermined poisoning as females (6.95 compared to 2.40, 1.28 compared to 0.54, and 0.83 compared to 0.28 per 100,000 population). Males were also significantly more likely than females to die from motor vehicle and other transportation, homicide, and unintentional suffocation (4.37 compared to 2.96, 1.71 compared to 0.92, and 1.12 compared to 0.73 per 100,000 population)[1].

Disparities by geography

Figure 6: Differences in the rate injury death among children aged 0-18 by urban and rural/frontier counties, Utah, 2011–2020 (n=1,282)

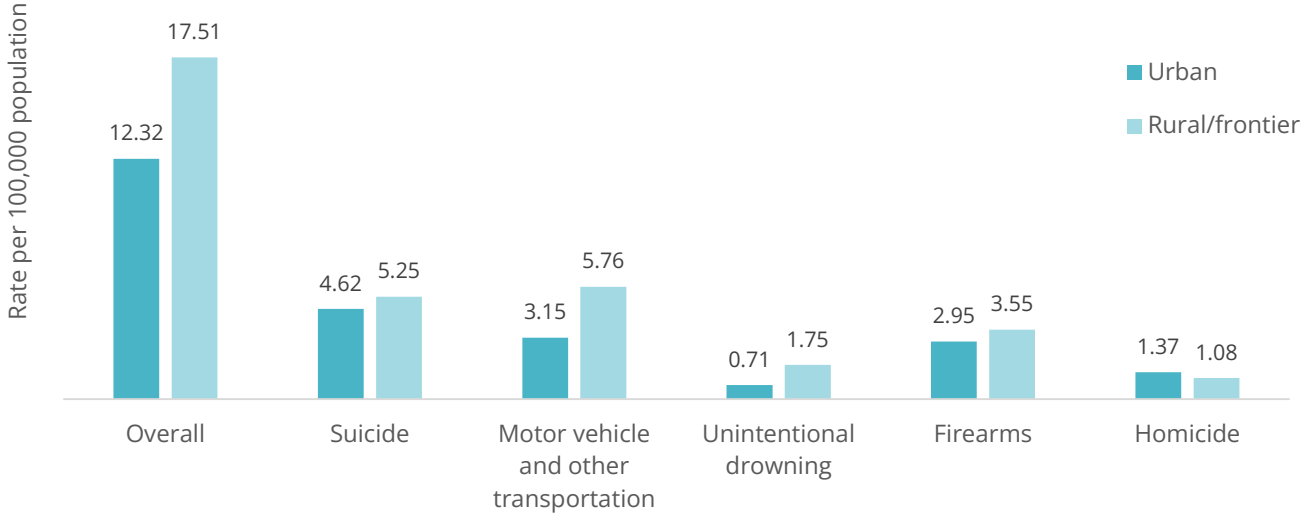
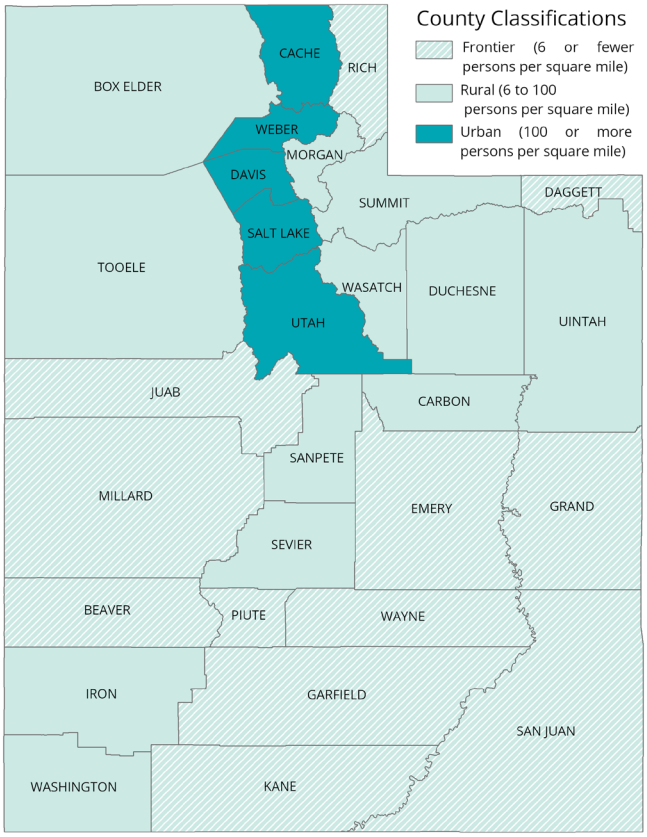


Figure 6 shows an overall significantly higher rate of child injury deaths in rural and frontier counties compared to urban counties (17.51compared to 12.32 per 100,000 population). Children living in rural and frontier counties were statistically more likely to die from suicide, motor vehicle and other transportation crashes, or firearms than children living in an urban county (5.25 compared to 4.62, 5.76 compared to 3.15, and 3.55 compared to 2.95 per 100,000 population). Children living in an urban county were statistically more likely to die by homicide than children living in rural and frontier counties (1.37 compared to 1.08 per 100,000 population).



Disparities by race/ethnicity

Figure 7: Rates of injury death among children aged 0-19 by race/ethnicity, Utah, 2011-2020 (*0-19, n=1,502)

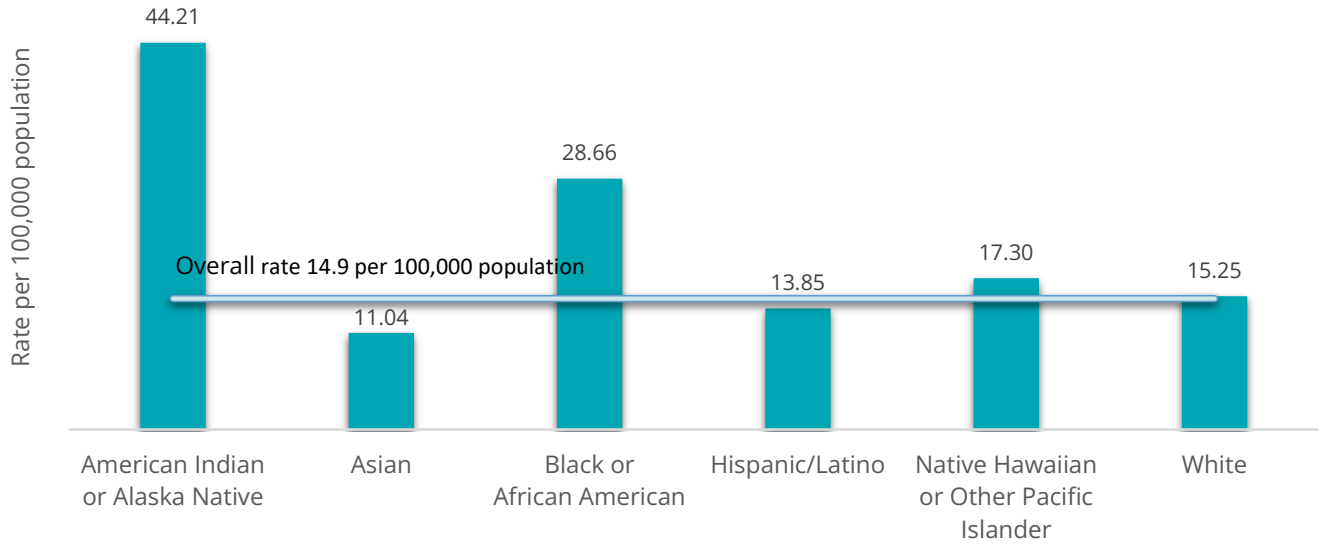


Figure 7 shows the overall differences in the rates of child injury death by race and ethnicity. American Indian or Alaska Native children had a nearly 3 times higher rate of injury deaths compared to white children (44.21 compared to 15.25 per 100,000 population). Black or African American children had a nearly 2 times higher rate of injury deaths compared to white children (28.66 compared to 15.25 per 100,000 population).

There were also significant differences in specific causes of child injury deaths by race/ethnicity. American Indian or Alaska Native children were about 3 times more likely to die by suicide or motor vehicle and other transportation crashes compared to white children (17.68 compared to 6.03 and 15.47 compared to 3.99 per 100,000 population). White children were nearly 2 times more likely to die by suicide as Hispanic/Latino children (6.03 compared to 3.19 per 100,000 population). However, Hispanic/Latino children were nearly 3 times more likely to die from homicide compared to white children (3.01 compared to 1.06 per 100,000 population)1.

*Note: The 0-19 age group was used for the data analysis in Figure 7 because race/ethnicity population data are only available in 5-year age groups (0-4, 5-9, 10-14, and 15-19).

Social disparities

It is known that health outcomes are impacted by inequities linked to economic, socio-cultural, racial/ethnic, and geographic disadvantages[6]. At the same time, it's challenging to measure those associations. In order to link health outcomes to health disparities, the Utah Department of Health and Human Services (DHHS) created the Health Improvement Index (HII)[2]. The HII measures health equity in communities and is a composite measure of social determinants of health that is analyzed at the community level, utilizing Utah's 99 Small Areas. It includes 9 indicators that describe important determinants of health such as demographics, socioeconomic deprivation, economic inequality, resource availability, and opportunity structure. The HII is grounded on methods used for the Area Deprivation Index[3]. The higher the value, the more disparities or inequities that area or community was found to have.

Figure 8: Rates of injury death among children aged 0-18 by Health Improvement Index, Utah, 2010-2020 (n=1,282)

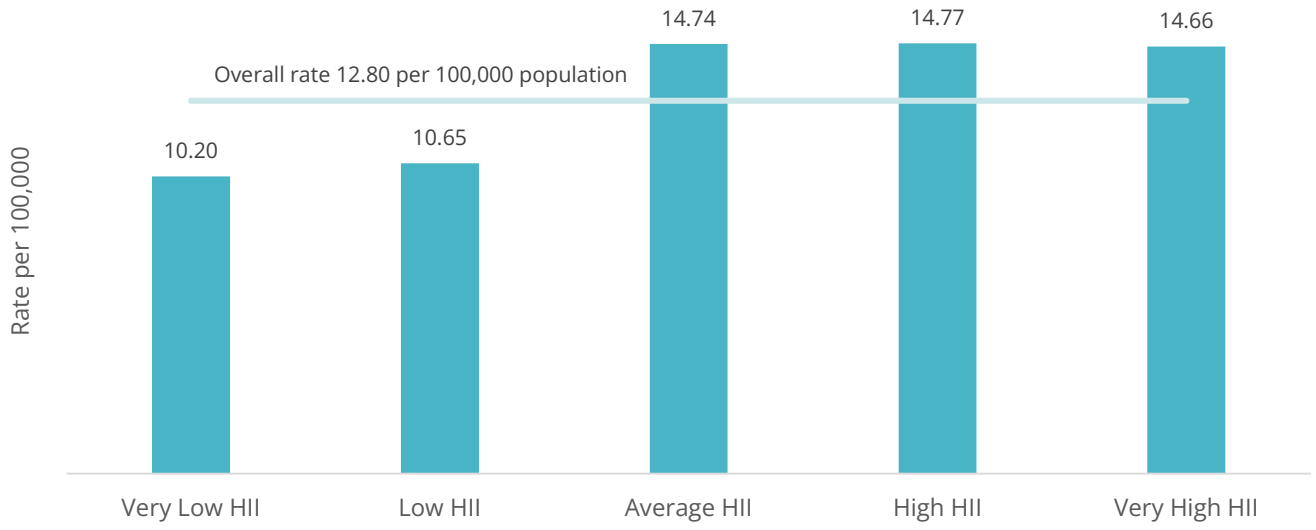


Figure 8 shows when child injury deaths were analyzed at the small area level by HII, children living in small areas identified as High HII, Average HII, and Very High HII (most deprived areas) were significantly more likely to die from an injury than children in the state as a whole (14.77, 14.74, and 14.66 compared to 12.80 per 100,000 population). High HII areas experienced significantly higher rates of child suicide deaths than the state as a whole (5.69 compared to 4.62 per 100,000 population). Very High HII areas experienced 2 times higher rates of homicide than the state as a whole (2.84 compared to 1.28 per 100,000 population)

We acknowledge that generations-long social, economic, and environmental inequities can result in adverse health outcomes. These inequities affect communities differently and have a greater influence on a person's health than either their individual choices or their ability to access healthcare[7]. Where families live, how much money or education they have, and how they are treated because of their racial or ethnic backgrounds can contribute to the rates of death seen across the state. Policies, practices, and organizational systems that reduce inequities can help improve opportunities for all Utahns.

Recommendations to prevent child deaths in Utah

Top 5 recommendations to prevent child injury deaths

A multi-sector team of prevention professionals and the Utah CFRC participants was assembled to review the aggregate 2020 data, trend data, and the full list of recommendations (found below). Using the expertise of the team and the combined data, the following priorities were identified.

 Data sharing and care coordination	Improve data sharing and care coordination between health systems, healthcare providers, mental health providers, schools, government services, and other states.
 Mental and behavioral health	Increase access and funding for mental health, behavioral health, and substance abuse services across Utah. Support broad adoption of evidence-based school programs to support social emotional learning and to engage parents in collaborative efforts in the home.
 Evidence-based evaluation tools	Implement validated, evidence-based tools such as Safe Environment for Eve Kids (SEEK) and Edinburgh Postnatal Depression Scale (EPDS) to support parents and parenting, strengthen families, and thereby promote children's health, development, and safety.
 Home visiting	Expand evidence-based home visitation programs.
 Firearms	Implement a validated screening tool to help therapists, counselors, and physicians know if a client or patient is at risk of suicide and has access to a lethal mean, such as a firearm.

What follows is a list of the recommendations made by the CFRC after the review of 177 child deaths from 2020-2022. These recommendations are grouped by the person or organization which is best suited to implement the recommendation and make an impact. The recommendations can help correct gaps and deficiencies in policies, education, and services that can lead to injury and death. Implementing these recommendations can help strengthen child welfare and safety across the state of Utah. Each recommendation includes a reference to one or more of the following areas of impact:

A. Suicide prevention
B. Motor vehicle and other transportation-related deaths prevention
C. Firearm death prevention
D. Homicide prevention
E. Sudden unexpected infant death (including unintentional suffocation/sudden death in the young) prevention
F. Unintentional drowning/poisoning prevention

General prevention recommendations

1. Increase access and funding for mental health, behavioral health, and substance abuse services across Utah (A, B, C, D, E, F).
   - Increase funding for every school to have social workers and counselors respond to trauma on-site at the school, help provide return-to-school education and resources to students following traumatic events, and implement Counseling on Access to Lethal Means (CALM).
   - Increase access to mental and behavioral telehealth services, especially in rural Utah.
   - Increase the diversity of the behavioral healthcare workforce.
   - Improve the integration of mental and behavioral health into primary care and emergency response.
   - Provide victims of trauma and sexual abuse and those who have lost a loved one to suicide with counseling and wrap-around services as needed.
   - Expand crisis resources and knowledge of those resources across the state.
   - Increase opportunities for individuals within the criminal justice system who have substance use disorders to get treatment instead of jail time.
   - Provide naloxone and support to individuals with substance abuse disorders when they leave prison.
   - Expand access to support groups for youth with substance use issues, gender identity concerns, or mental health struggles.
2. Expand evidence-based home visitation programs. These programs should be available to parents who have children with complex medical conditions, families experiencing homelessness, parents of multiples, and ideally, every first-time parent. (A, B, C, D, E, F).
3. Increase family friendly work policies and quality, affordable child care (A, B, C, D, E, F).
4. Increase broadband access across the state to support telehealth (A, C, D, E).
5. Implement a validated screening tool to help therapists, counselors, and physicians know if a client or patient is at risk of suicide and has access to a lethal means, such as a firearm (A, C, D).
6. Improve data sharing and care coordination between health systems, healthcare and mental health providers, schools, government services and other states (A, B, C, D, E, F).
   - Implement something similar to New Jersey's Handle with Care Program that allows law enforcement to share information with schools to get at-risk kids additional support when needed.
   - Improve coordination among community groups in postvention response. Postvention response refers to the actions taken by a community after a tragic event like a suicide, homicide, or other traumatic experiences.
7. Create education campaigns that promote safe, stable, nurturing relationships and environments for Utah children. (A, B, C, D, E, F).
   - Educate the public about suicide safe homes, including safe gun storage and proper medication storage and disposal.
   - Education the public about common suicide risk factors and how other factors in a person's life (like past abuse, sleep problems, or neurodevelopemtnal disorders and disabilities) can compound or increase the risk for suicide.
   - Provide effective safe sleep education to youth and caretakers which includes special emphasis on harm reduction if bed sharing is happening (no substance use, remove blankets and pillows, etc.).
   - Promote healthy social connections for youth, caregivers, and encourage help-seeking if needed.

- Continue to promote and educate about the correct and constant use of safety equipment (seat belts, care seats in cars and planes, helmets, fencing around pools, etc.).
- Educate everyone on how to correctly identify and report child maltreatment.
- Provide education on the important research around social-emotional learning in the home as well as the school setting.
- Education to caretakers of children on how to implement safe Internet practices in the home with a focus on preventing cyberbully, pornography, and visiting websites that promote suicide.
- Promote resources that can help prevent child injury deaths, like crisis nurseries, postpartum support, free car seat checks, free bicycle helmets, etc.
- Educate the public about the Good Samaritan law and how to help in a crisis.
- Continue education campaigns focused on young drivers and distracted driving.

8. Secure funding for more prevention and mitigation resources like Pack N plays, helmets, naloxone, gun locks, etc. (A, B, C, E, F).
9. Ensure equity by evaluating whether or not resources and education are available to all Utahns regardless of income, where they live, language, race/ethnicity, disability status, religion, or criminal history
    - Educate immigrant and refugee populations about 911and other community emergency services.
    - Provide outreach to gang members and the formerly incarcerated to ensure they are aware of available community supports.
    - Build trust between healthcare providers and polygamous communities.
    - Increase access to quality affordable attorneys for individuals with low-income.

Policymakers

10. Provide basic mental health coverage for all Utah youth (A, B, C, D, F).
11. Enact legislation that prohibits individuals charged with community service hours from working with vulnerable groups as part of their sentence (C, D).
12. Enact legislation to regulate the number of children with special healthcare needs who can be adopted by a single family (C, D).
13. Enact legislation that requires children to wear a bicycle helmet and provide funds to help families with low-incomes get helmets for their children. (B).
14. Secure funding to research firearm deaths and the impact of different policies on the prevention of these deaths (A, C, D).
15. Secure funding to increase staff capacity and improve data collection on child injury deaths (A, B, C, D, E, F).
    - Fund additional full-time OME death scene investigators to improve scene investigations.
    - Fund other support staff who can fill out the sudden unexpected infant death investigation (SUIDI) form in situations where police might be unwelcome.
    - Fund a full-time DHHS employee to abstract all Child Fatality Reporting System cases.
    - Fund OME employees and social workers who can do next-of-kin interviews to inform suicide and overdose prevention and to support expanded interviews for infant deaths.
    - Fund the purchase of death scene investigator doll reenactment supplies and train death scene investigators on how to properly use these.

Criminal justice professionals

16. Create a state rapid response team to assist law enforcement investigators in smaller departments with child fatalities, child near fatalities, or cases of suspected of child abuse (A, B, C, D, E, F).
17. Conduct psychological evaluations of parents during divorce proceedings (D, E, F).
18. Enforce seat belt laws (B).
19. Enforce all-terrain vehicle (ATV) laws (helmets, street use, etc.) (B).
20. Continue to limit high-speed chases that can lead to deadly crashes (B).
21. Improve data sharing of crash records between the DHHS and Utah Highway Patrol to help better understand the causes of motor vehicle crash deaths. (B).
22. Educate law enforcement officers about how and when to report to the Department of Health and Human Services Divisions of Child and Family Services (DCFS) (A, B, C, D, E, F).
23. Provide naloxone to law enforcement officers responding to drug concerns so it can be left with individuals and families (F).

Healthcare and crisis responders

24. Educate all providers who work with children on the signs of suspected abuse and how to report (C, D).
    - Providers should examine infants while they are undressed during well-child checks to look for signs of abuse.
25. Educate healthcare providers about the importance of a 2-week follow-up appointment with patients who are prescribed selective serotonin in reuptake inhibitors (SSRIs). This education should include information for parents on the dangers of and how to safely store lethal means like firearms and pills (A, C).
26. Educate healthcare providers and crisis responders on the importance of making sure youth patients and their parents or caregivers are sober before performing a crisis evaluation. (A, D).
27. Screen parents for mental health concerns and safe sleep environments in the home during well-child visits and provide parents with resources based upon the results of the screenings (A, C, D, E, F).
28. Have a dedicated space in every emergency department across the state for mental health crises, including having social workers available to assist patients and families and provide resources (A, C, D).
29. Implement policies and procedures in health clinics and physician offices to make sure patients with chronic health conditions receive mental health screenings at visits (A, C).
30. Provide professional development on suicide prevention for those who work with individuals on the autism spectrum (A, C).
31. Develop materials and education for healthcare providers on how to work with patients who indicate gender identity concerns or who need guidance on transition best practices (A, C).
32. Provide CPR training to parents of children with epilepsy or other high-risk health issues (E).
33. Educate patients who are prescribed controlled substances for pain on harm reduction strategies (fentanyl test strips, naloxone, etc.) (F).
34. Screen parents who have infants in a newborn intensive care unit (NICU) for situational stress and make sure their needs, like childcare, are being met (A, B, C, D, E, F).
35. Implement special support and care management for youth with high-risk conditions (for example, type 1 diabetes) and their caregivers (A, C, D, E).
36. Educate healthcare providers on the importance of following up with patients who need a rescue inhaler medication refill because of multiple acute asthma episodes (E).
37. Screen patients who are pregnant or who recently gave birth for domestic violence (A, C, D).

38. Continue well-child visits for all youth as they transition to adulthood and assess for mental health concerns during thee visits (American Academy of Pediatrics [AAP] recommendation) (A, C, D, F).
39. Require CALM (Counseling on Access to Lethal Means) training for all healthcare providers (A, C).
40. Consider the cumulative suicide risk of patients who may have multiple risk factors even when they may not score high on the PHQ-9 (Patient Health Questionnaire-9) (A, C).
41. Provide training to mental health providers on sexuality and gender issues, and when and how to refer children to appropriately trained providers (A, C).
42. Screen all patients hospitalized with a traumatic brain injury for suicide risk and make sure follow-up care plans are implemented for patients who are at an increased risk of suicide (A, C).

Public health, public safety, and human services professionals

43. Make sure wrap-around services are available and provided for those who report assault or abuse (A, C, D).
44. Provide naloxone to families being served by the DHHS Division of Child and Family Services (DCFS) when drug concerns may be present (F).
45. Caseworkers or counselors should be assigned to ensure children are in safe and health situations after a parent is incarcerated (A, B, C, D, E, F).
46. Make sure all families who adopt a child with special healthcare needs have appropriate support and guidance to prevent medical neglect (C, D).
47. Education the general public about the role of the DHHS Office of the Medical Examiner in death investigations (A, B, C, D, E, F).
48. Educate the public about how to support parents and, when necessary, how to report suspected child abuse to the DHHS DCFS. (B, C, F, E).
49. Provide training to DHHS DCFS staff and caseworkers on when to involve the police (C, D).
50. Provide education and resources to the public on how to be more inclusive and accepting of those with different sexual orientations and identities (A, C).
51. Promote safe pool guidelines and the lanyard program which recommends a designated pool supervisor be used at all times when children are swimming (F).
    - Work with pool cleaners and rental properties to provide safe pool education, especially in southern Utah where pools are more prevalent.
52. Include suicide prevention education during required hunter safety education courses (A, C).

Education professionals

53. Implement later school start times for secondary schools (A, C, D).
54. Implement comprehensive sex education programs in school, including discussions on consent, pornography, and healthy relationships (A, D, F).
55. Include discussions and education on healthy relationships in sex education courses (A, C, D).
56. Promote healthy environments in schools for students who are at an increased risk of suicide, including students who identify as LGBTQ+ and those who are diagnosed with ADHD, autism, or chronic conditions (A, C).
57. Provide suicide prevention education to elementary and secondary school counselors and educators (A,C).
58. Implement policies and procedures for parents to be notified of student disciplinary actions taken at school (A, C).
59. Provide education and outreach to parents after a suicide death in their student's school. Parents should be made aware of copycat suicides or suicide waves, how to find support for their child, and how to safely secure weapons and other lethal means (A, C).

60. Continue to educate school administrators and teachers on safe suicide prevention messaging best practices found in the After a Suicide: A Toolkit for Schools (C, D).
61. Provide evidence-based firearm education in schools (C, D).
62. Provide education and support to resident advisors in college dorms on how to recognizing and addressing suicide risk, mental health crises, and domestic/dating violence (A, C, D).
63. Implement evidence-based suicide prevention programs in schools (A, C).
65. Implement policies and required training to get children into services when they disclose suicidal thoughts or a history of abuse (A, C, D)

Clergy and faith leadership

66. Implement policies and required training to get children into services when they disclose suicidal thoughts or a history of abuse (A, C, D)

Media

67. Follow safe reporting best practices of all suicide deaths (A, C).

Conclusion

The purpose of the Utah Child Fatality Review Committee (CFRC) and this report is to prevent future child injuries and deaths. The data presented in this report helped inform the recommendations of the Utah CFRC. Policymakers and leaders of state, local, and community based organizations can help promote and implement the recommendations outlined in this report. While education is important, research shows that changes in policy and enforcement of laws are the most effective prevention strategies for many types of child deaths[5].

The recommendations outlined in this report do not necessarily reflect the official viewpoint of the Utah Department of Health and Human Services.

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A Special thank you to all the amazing professionals who participated in Utah's CFRC and the Action Committee. Your time, expertise, and effort are appreciated as we continue to work to make Utah a better and safer place for our children.

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Children are the world's most valuable resource and its best hope for the future.

- John F. Kennedy

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