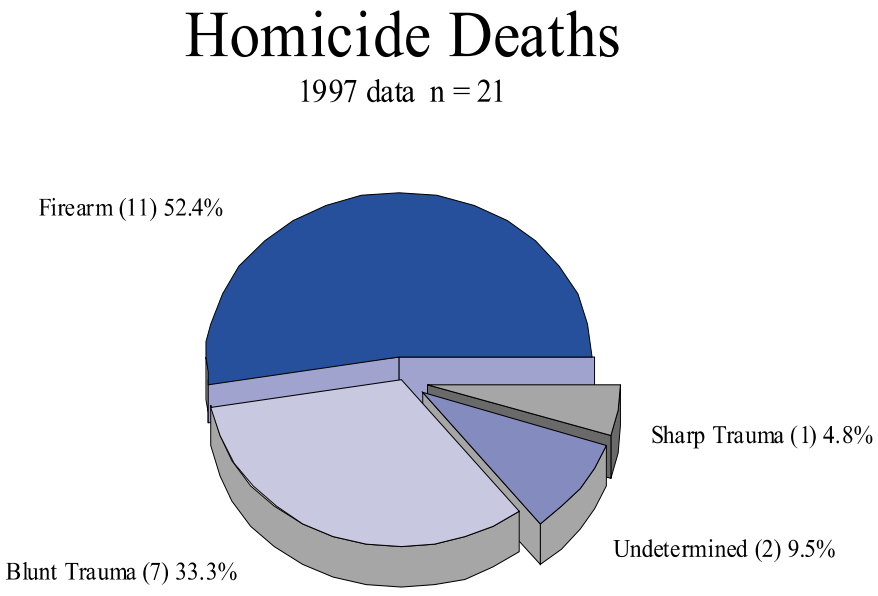
I. Homicide Deaths

In 1997, 21 children were victims of homicide. Eleven deaths were caused by firearms (one of which was gang-related), seven were by blunt trauma, one was caused by sharp trauma, and two were ruled undetermined. The seven blunt trauma deaths were caused by child abuse. In five of these cases, one perpetrator was found guilty of two counts of child abuse; one pled guilty to involuntary manslaughter; one pled guilty to reckless murder in the second degree; one father admitted to the abuse, but the homicide case is on appeal; and one suspected perpetrator committed suicide. In the remaining two child abuse homicides, a suspected perpetrator was identified, but charges were not filed, and one case has an unknown disposition.

One child abuse case originally was submitted to the Board as a natural death from cerebral palsy. In reviewing the case, however, the Board determined that the child suffered from shaken baby syndrome. Because the original injury which caused the cerebral palsy was from shaken baby syndrome, the child's death was reclassified as a homicide. The Board recommended that the case be returned to the county attorney's office for prosecution. Charges were filed against the suspect, however the case was eventually dismissed due to lack of evidence.

The homicide with an undetermined cause involved a 15 year-old female being found in a field. Because of the circumstances



of the girl's disappearance and information learned in the investigation, her death was ruled a homicide. The specific cause of death could not be determined, however, due to the decomposition of her body.

The Board is especially concerned about the deaths of seven Kansas children due to child abuse. Cases such as the one mentioned above involving shaken baby syndrome, and the following cases, reflect the harm being inflicted on Kansas children. A 17 month-old girl was killed by her father who was on drugs at the time he inflicted severe blunt trauma on her. A four year-old boy died from blunt trauma inflicted by his mother's boyfriend. A 23 month-old boy was abused by his stepmother who shoved him to the floor causing his death. A three year-old girl was killed by her mother's boyfriend. A 20 month-old boy died from blunt trauma, but a suspect was not identified. In the last case, a 14 month-old girl was killed by her mother's boyfriend because she wouldn't stop crying.

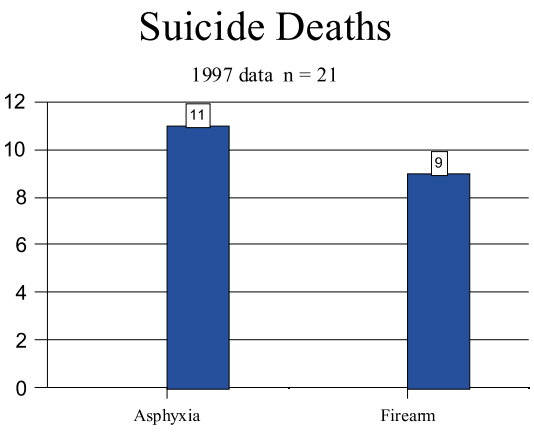
Clearly, for the victims of child homicide, the family was not a sanctuary, a haven, or a place of love and happiness. And for the many victims of child homicide whose deaths were the final episode of repeated abuse and neglect, the months, weeks, and days preceding the death must have been unimaginable.

Lack of parental intervention leads to child's death. The boyfriend of a mother with a four year-old son repeatedly abused the child, both physically and mentally, with the mother's knowledge. The man shoved the child's head into the wall in the corner of a room causing massive blunt trauma. A few days later the child died. Manner of death: homicide. This death was preventable.

II. Suicide Deaths

According to national statistics, the number of children who commit suicide has increased during the past 20 years, making suicide the third leading cause of death among adolescents across the nation.

In 1997, 21 suicide deaths were reported to the SCDRB. The breakdown by sex and race indicates that 17 white males, one black male, and three white females took their lives. In Kansas, 12 suicide deaths were due to asphyxia; 10 males and one female hung themselves, and one male died of carbon monoxide poisoning. Nine children took their lives using firearms (eight males and one female). According to the American Academy of Child & Adolescent Psychiatry (AAA), 60 percent of teen suicides involve the use of a firearm. The 1997 data indicates that all child suicides committed in Kansas were by youth between the ages of 10 and 17.



Information from investigations of the 1997 cases showed that two of the children had made prior attempts to commit suicide. Seven children had talked about taking their own lives before doing so, and another seven had received prior mental health intervention. In three of the suicides, the children gave no prior indications that they were considering suicide, and this information was not available in two cases. In the majority of suicides in Kansas, notes were written.

The Board stresses that thorough and comprehensive law enforcement investigations are necessary to establish that events leading to the deaths are consistent with suicide.

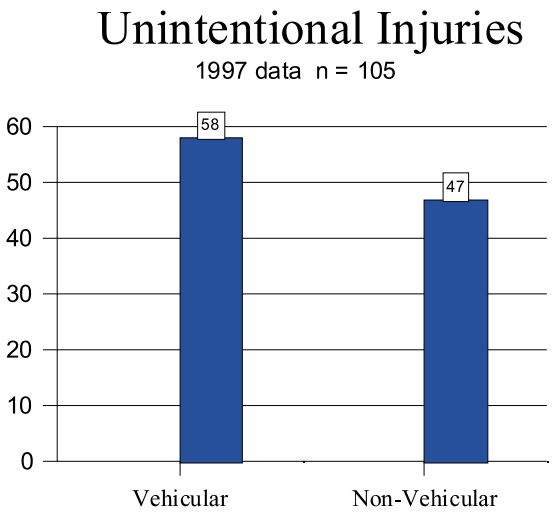
It is important to recognize that suicidal behavior should not be handled in isolation. Any threat of suicide should be taken seriously. Local crisis lines, hospitals, schools, and mental health clinics can provide assistance.

Children know where the guns are! A 16 year-old female wrote a suicide note after being grounded by her father for staying out all night. Later that evening, she was found by her father lying on the bed, unresponsive due to a self-inflicted gunshot wound from a revolver. When law enforcement officers questioned the father, he stated there were several guns in the house kept in a locked cabinet. However, the revolver was kept in the parents' bedroom underneath the bed with a box of shells next to it. The father did not believe his children knew where the gun was kept. Manner of death: suicide. This death was preventable.

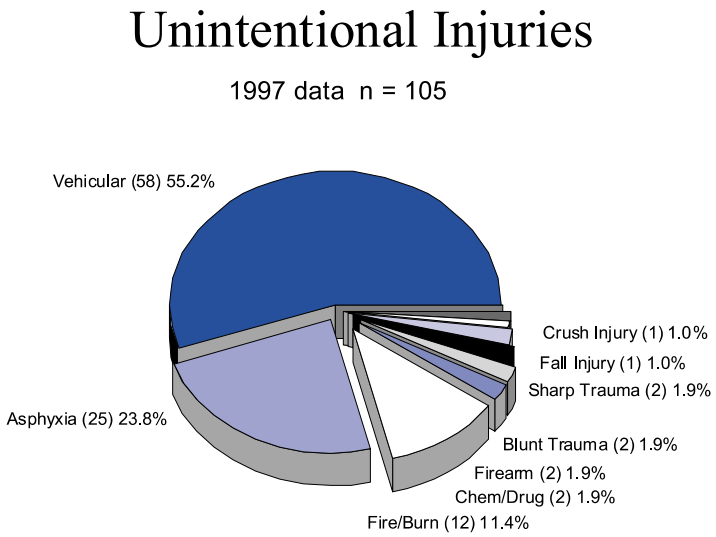
Keep guns locked up! A 16 year-old boy fought with a younger boy at school and lost. Extremely embarrassed and harassed by peers, the boy expressed humiliation and depression to a family member. However, it was assumed he would be able to handle the situation. After a phone call to the boy, his brother became concerned and went to check on him. The boy had been able to get a gun from home and was found with a self-inflicted gunshot wound. Manner of death: suicide. This death was preventable.

III. Unintentional Injuries

Unintentional injuries are divided into two sections - vehicular and non-vehicular. Non-vehicular deaths include asphyxia (suffocation or drowning), fire/burn, chemicals/drugs, fall or blunt trauma injuries, crush injuries, or deaths by electrocution.



Unintentional injuries resulted in a total of 105 children's deaths in 1997. Fifty-eight deaths were caused by vehicular accidents and 47 were non-vehicular deaths. The breakdown of non-vehicular deaths indicates there were 25 asphyxial deaths (12 drownings and 13 deaths due to suffocation); 12 fire/burn deaths; two chemicals/drugs deaths; two firearm deaths; two blunt trauma deaths: two sharp trauma deaths; one fatal fall injury; and one fatal crush injury.

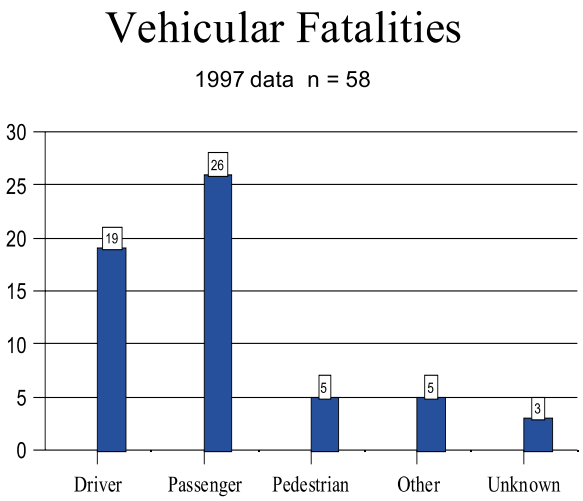


The Board continues to be concerned with the number of unintentional deaths. Many of these deaths could have been prevented with appropriate adult supervision and proper safety precautions.

Unintentional Injuries

A. Motor Vehicle Fatalities

Motor vehicle fatalities continue to be the cause of the largest number of unintentional injuries, claiming the lives of 58 children in Kansas in 1997. Nineteen deceased adolescents were drivers of the vehicles; 26 were passengers; five were pedestrians; in eight the information was not known. And finally, in four of the motor vehicle fatalities alcohol was known to be involved.



Parents must reinforce education in regard to their children being attentive and watching for traffic around them. Three deaths occurred when the child in each incident crossed a street and was hit by a vehicle. One case involved a 14 year-old who was skateboarding along the highway when he was struck by a vehicle.

Parents must be aware of where young children are playing and provide constant supervision. A two year-old child, unsupervised, was standing in front of a vehicle when the vehicle moved forward and struck her. In another case, a four year-old child on a bicycle rode behind a vehicle that was in the process of backing up, and was killed.

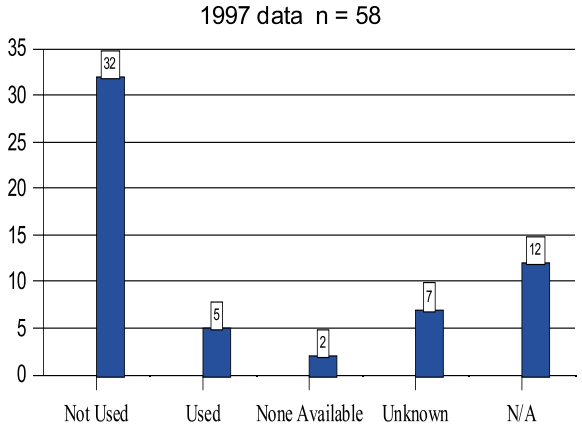
Parents must educate their children on the danger of motor vehicles. In the other vehicular fatalities in Kansas, four children lost their lives due to bicycle accidents involving motor vehicles. An example includes a 15 year-old who was riding his bike, turned in front of a vehicle and was killed.

There continues to be a large number of children who are killed in motor vehicle wrecks because they are not properly restrained according to Kansas law. The Child Passenger Safety Act, K.S.A. §8-1343, et.seq., requires children less than four years-old to be properly restrained in a child safety seat while in a moving vehicle. Passengers between the ages of four and 14 are required to be restrained regardless of where they are sitting in the vehicle; drivers and front-seat passengers are required to use safety restraints as well, regardless of age. In 31 of the motor vehicle fatalities, the children were not wearing safety restraints, causing them to be ejected from the vehicles.

Inattentive driving - No seatbelt. A 15 year-old was a passenger in a small pickup driven by a 16 year-old. Driving on a rural road, the 16 year-old ran a stop sign and struck a car. The 15 year-old passenger was ejected from the vehicle and pinned under the pickup which caught on fire. He died from multiple traumas. Neither the driver nor the passenger were wearing seatbelts. Manner of death: unintentional injury - vehicular. This death was preventable.

In a collision, seatbelts are the primary device that protects the occupants of a vehicle. In 1997, 32 Kansas children died in vehicle accidents because they were not wearing seatbelts. In five cases seatbelts were used; in two cases no seatbelts were in the vehicles; in seven cases it was unknown whether seatbelts were used; and in 12 cases seatbelts were not applicable (deaths involving pedestrians, or children riding bicycles).

Use of Safety Restraint



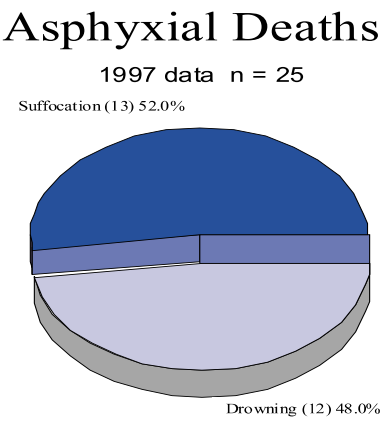
Careless driving - No seatbelt. A 17 year-old girl was driving alone on a rural road. She lost control of the car and ran off the road, up an embankment, through a fence, and into a field. The car rolled and she was ejected. There was no alcohol involved, but the girl's life probably would have been saved had she been wearing a seatbelt. Manner of death: unintentional injury - vehicular. This death was preventable.

Motor Vehicle accident - No seatbelt; alcohol. A 16 year-old was driving a vehicle with two passengers. The driver and his passengers were returning from a party when he lost control of the car. The car rolled three times, ejecting the driver and both passengers. None of the occupants were wearing seatbelts and alcohol was involved. Though the driver survived his injuries, his two passengers died. Manner of death: unintentional injury - vehicular. These deaths were preventable.

Unintentional Injuries

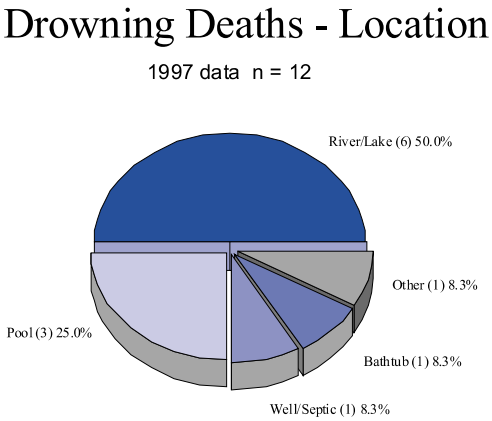
B. Asphyxial Deaths

In 1997, 25 children lost their lives to unintentional asphyxia. Accidental drownings claimed the lives of 12 children while suffocation or strangulation claimed 13.



According to the American Academy of Pediatric's policy statement on infant, child, and adolescent drownings, "for every child who drowns, four others are hospitalized for near-drowning, and as many as three suffer brain damage."

In six of the child death reports, drownings occurred in creeks, rivers, ponds, and lakes throughout Kansas. Three drowned in swimming pools; one drowned in a well; one in a bathtub; and one by other means. In the deaths mentioned above, there was a lack of both supervision and floatation devices. **The Board is concerned about the number of child drownings. Parents should be aware of the potential dangers that water holds for children, and should prohibit children from playing in and around water without proper supervision.**



No floatation device, unsupervised. Four children, ages eight to 11, were swimming in a river, unsupervised and without floatation devices. The 11 year-old was giving the eight year-old a piggyback ride in the river. The two went under and were caught in the undertow. The eight year-old drowned. Manner of death: unintentional injury - drowning. This death was preventable.

Improper sleeping arrangements contributed to the deaths of nine children in 1997. Infants placed in adult beds, waterbeds, or cribs that did not meet safety standards caused these fatal injuries.

Parents need to know that infants placed on adult beds can become wedged between the mattress and bed frame or wall, or between the bed and an adjacent piece of furniture. Even pillows left near sleeping infants can result in tragedy. Suffocation can also occur when infants sink into waterbed mattresses while sleeping on their stomachs. As stated by the U.S. Consumer Product Safety Commission, "the only safe place for infants less than two years-old is in a crib, whether putting them to sleep for the night or putting them down for a quick nap." For example, in 1997, two infants died after being improperly placed on adult beds, causing the babies to be smothered. Another child was found dead, wedged between a bed and a wall.

While a crib is generally a safe place for a baby to sleep, parents need to check baby beds to verify that they meet safety standards and place cribs in safe locations. Four infants suffocated after being placed in baby beds in 1997. One child died because a plastic diaper bag placed in the crib fell over the infant's face and suffocated him. Another infant died when she became entangled in the window blinds next to her bed. **These deaths would have been preventable if proper sleeping arrangements had been made.**

Unsafe sleeping arrangements - suffocation. A mother assumed her six month-old infant was asleep in his crib. Upon checking on him, she discovered the infant had slipped underneath a mattress that did not fit the baby bed properly. The infant was found hanging by the neck from the bed springs. Manner of death: unintentional injury - asphyxia. This death was preventable.

Unsafe sleeping arrangements - suffocation. A 10 week-old infant was placed in a swinging cradle with a pillow placed on the floor below the cradle. The sleeping infant tipped out of the cradle onto the pillow face down. Manner of death: unitentional injury - asphyxia. This death was preventable.

Unintentional Injuries

C. Fire/Burn Deaths

Twelve children lost their lives due to fire/burn incidents during 1997. Seven house fires claimed the lives of 10 children. Two of the seven homes did not have working smoke detectors; only one had a working detector; and in the remaining four this information was unknown. One child died in a camper trailer fire and one child died due to an explosion of a combustible liquid.

In three of the fires, small children were left unsupervised. In one case, a 10 month-old knocked over a lit candle, causing the bedroom to catch on fire. **It is extremely important for adults to closely supervise small children at all times around fires and candles, and to keep lighters and matches out of the sight and reach of young children. Education and information are the best tools that parents have to prevent children from experiencing burn injuries.**

In its 1998 session, the Kansas Legislature passed the Smoke Detectors Act, K.S.A. 31-160 through 31-164, which took effect in July 1998. This law requires at least one smoke detector to be used on each habitable story of both new and existing residential structures and requires that the person residing in the home ensure that the smoke detectors are maintained in working order. **In many cases, a working smoke detector can provide those extra seconds of warning that can mean the difference between life and death in a fire.**

Lighters should not be accessible to children! A mother was inside her home watching television while her five year-old was playing outside. The child had taken a lighter from the house and used it to set a can of gasoline on fire. The can exploded. The child suffered numerous burns and died. Manner of death: unintentional injury - fire. This death was preventable.

Small children should not be left alone! A three year-old was playing alone in the home while the mother went to a neighbor's house to use the phone. The mother mistakenly assumed she had turned the stove off before leaving. Something on the burners of the stove ignited, causing a fire which killed the child. Manner of death: unintentional injury - smoke inhalation. This death was preventable.

Unintentional Injuries
D. Firearm Deaths

Two deaths were caused by unintentional firearm usage in 1997. In both cases, the children involved were unsupervised. One incident involved a child who accidentally shot himself while playing with a gun in the presence of his younger brother. The other death occurred when a child moving a gun accidentally discharged it, killing another child.

Guns should be unloaded, locked, and out of reach of children. A mother asked her 17 and 13 year-old sons to remove an item from the family vehicle. The younger brother was moving a rifle from the back seat in order to get to the item needed by his mother when the rifle discharged killing his 17 year-old brother. Manner of death: unintentional injury - firearm. This death was preventable.

Unintentional Injuries
E. Other Unintentional Injuries

In 1997, eight children died due to other unintentional injuries: two were chemical and drug deaths; two were blunt trauma deaths; two were sharp trauma deaths; one death was the result of a fall; and one child died as a result of a crush injury. No deaths were reported due to electrocution during 1997.

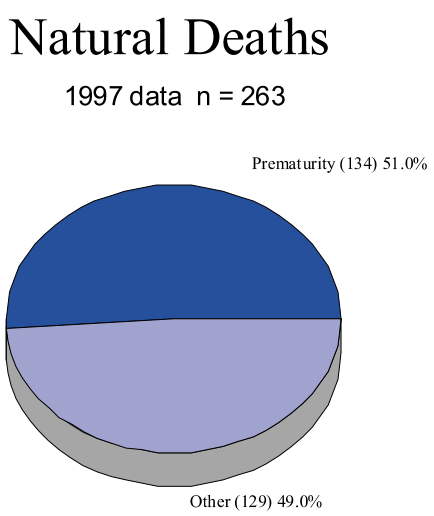
Examples include: a 10 year-old who was climbing on playground equipment in a public park when he fell 10 feet landing on the ground head first; and a three year-old who fell off the tractor he was riding on, and was crushed by its wheels. **Most of these incidents could have been prevented if appropriate safety precautions and adult supervision had been provided.**

Keep all chemicals out of reach of children! A one year-old was playing unsupervised in his father's workplace. The child ingested sulfuric acid from something that resembled a milk container. The child suffered massive internal burns and died. Manner of death: unintentional injury - chemical/drug. This death was preventable.

Lack of adult responsibility and supervision! Two boys, ages 10 and 11, were allowed to illegally operate jet skis. Due to lack of skill and knowledge, one child's jet ski violently hit the other jet ski, causing fatal trauma to one of the boys. Manner of death: unintentional injury - blunt trauma. This death was preventable.

IV. Natural Deaths

Fifty-one percent of the 1997 deaths were due to natural causes. Premature births contributed to 134 of the 263 natural deaths. The age breakdown for the 263 natural deaths is as follows: 160 neonates, defined as less than 29 days old; 34 infants, defined as children 30 days to 364 days old; and 69 children ages one through 17.



The breakdown by sex for natural deaths is 154 males and 109 females. In reviewing the deaths of children less than one year-old for 1997, the information provided indicates that 12 mothers used alcohol, 11 used drugs, and 38 smoked tobacco products during their pregnancies. Of the 194 infant and neonate deaths, only 91 mothers had adequate prenatal care. **While there is little that can be done to prevent natural deaths from occurring, the Board believes that one of the best precautions is for a pregnant woman to take care of her body; not only for her sake, but for the sake of her unborn child.**

For children who had no previous healthcare provided to them, because of lack of financial means the Board suggests that programs such as Healthwave (which also offers mental health assistance) would be beneficial. Healthwave is a program for children in families with limited incomes that provides insurance at little or no cost. It is important that all children be seen by a health care professional at least annually or when a child's illness requires professional intervention.

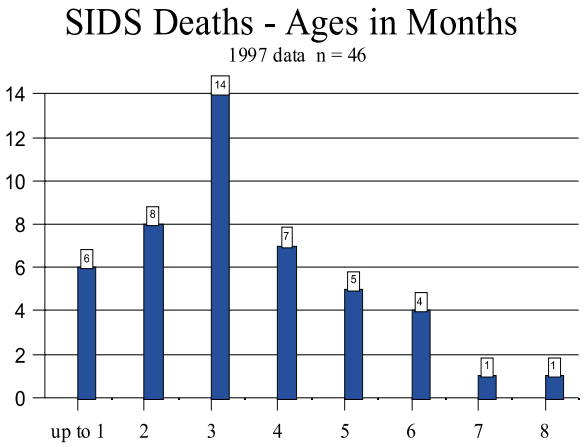
V. Sudden Infant Death Syndrome (SIDS)

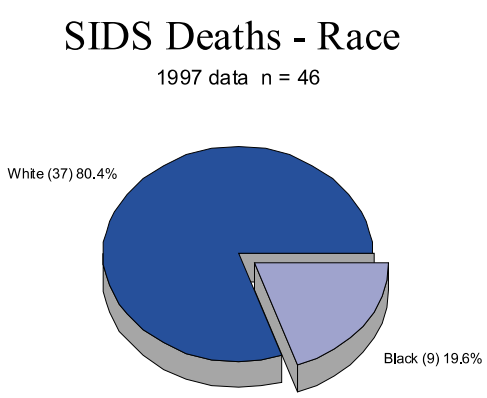
SIDS is defined as the sudden and unexplained death of an infant less than one year-old, which remains unexplained after a thorough case investigation, performance of a complete autopsy (including body x-rays, toxicology, and cultures), examination of the death scene, and a review of clinical history. With SIDS, a baby dies quickly, usually while sleeping.

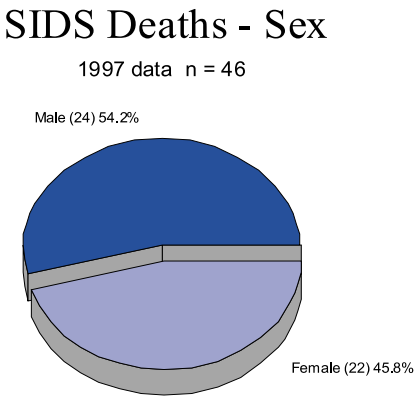
In an effort to create uniform criteria and consistent data collection for the determination of SIDS as the cause of death, the Kansas Attorney General, the KBI, and the SCDRB recommend that law enforcement agencies use the Sudden Unexplained Infant Death Investigation Report Form (SUIDIRF) when investigating the cause of death (Appendix E). This form was developed by the National Centers for Disease Control and Prevention in Atlanta, Georgia and the KBI approved it in 1997 for law enforcement use in Kansas.

After 30 years of research, scientists still have not found a specific cause for SIDS. Although there are factors that may reduce the risk of SIDS, there is no certain way to predict or prevent it. National statistics reflect that most SIDS deaths occur when the infants are between one and four months of age. Fall, winter, and early spring tend to be when most SIDS deaths occur and males are more likely to be victims of SIDS than females.

The Board found that 46 deaths were attributed to SIDS in 1997. The following charts demonstrate the number of SIDS deaths by age in months, race, and sex during 1997. Thirty-five of these deaths occurred between the first and fourth months of life. **Although there is no way to prevent SIDS deaths, it is important for caregivers to know that infants should be placed on their backs to sleep.**







VI. Undetermined Deaths

This category is used when the manner of death cannot be conclusively determined after a comprehensive review of all available information. In 1997, there were 16 deaths labeled undetermined by the Board. Five of these 16 cases remain undetermined despite adequate autopsies and investigations. Seven cases may have been excluded from this category if more information had been known.

Two of the undetermined deaths involved use of firearms. In both cases, having information such as mental health and school records may have been helpful in determining whether these deaths were self-inflicted or accidental. Unfortunately, despite the assurance of confidentiality and the ability of the Board to subpoena records, this type of information is not consistently provided to the Board.

In two of the 16 cases, no autopsies were conducted and a third had an incomplete autopsy. The three victims were infants in the age range for SIDS, but the Board had to declare their deaths undetermined due to a lack of information. If complete autopsies had been performed, information from them may have provided more insight into the causes and manners of the deaths. According to Kansas law, a complete autopsy is to be performed on every child less than one year of age. Certifying physicians and coroners must be aware of this requirement and must comply with it before the cause of death can be determined as Sudden Infant Death Syndrome.

Other cases labeled undetermined were due to a lack of adequate investigation by the appropriate authorities. One case was assumed initially to be a natural death, and when the autopsy failed to reveal any suspicious cause or manner of death no further detailed investigation was done. However, there were no natural findings significant enough to explain the death and there were other concerns about the child's history.

Another child was older than the average age for SIDS. When no anatomic cause of death was found during the autopsy, the county coroner declared the findings most consistent with SIDS, despite an inadequate scene investigation and incomplete autopsy. Recent information obtained about this case has led authorities to re-open the investigation as a suspected homicide.

The American Academy of Pediatrics, in a November 1999 policy statement from the committees on Child Abuse and Neglect and Community Health Services, stated that "Investigation of unexpected deaths requires the participation of numerous persons, including medical examiners, public health officials, physicians, and personnel from agencies involved with child welfare, education, social services, law enforcement, the judicial system, and mental health. Collaboration among agencies enhances the ability to determine accurately the cause and circumstances of death. Information about the death of one child may lead to preventive strategies to protect the life of another.

"An adequate death investigation includes a complete autopsy, investigation of the circumstances of death, review of the child's medical and family history, and review of information from relevant agencies and health care professionals. A complete autopsy consists of an external and internal examination of the body, removal and examination of the eyes, microscopic examination, and toxicological, microbiologic, and other appropriate studies including full-body x-rays. When possible, the autopsy should be performed by a forensic or other knowledgeable pathologist using standard infant and child death autopsy protocol.

"Investigation of the circumstances of death should include a scene investigation and interviews with caregivers and first responders by trained investigators who are sensitive to issues of family grief, yet who can objectively attain all necessary information. By current national standards, the diagnosis of SIDS cannot be made without a complete autopsy with appropriate ancillary studies, a review of clinical circumstances, and scene investigation.

"Interagency cooperation and review of all relevant records are necessary parts of a death investigation. Relevant records include, but are not limited to, all medical records from birth on, social services reports, including those from child protection services, emergency and paramedic records, child care and school records when applicable, and law enforcement reports."

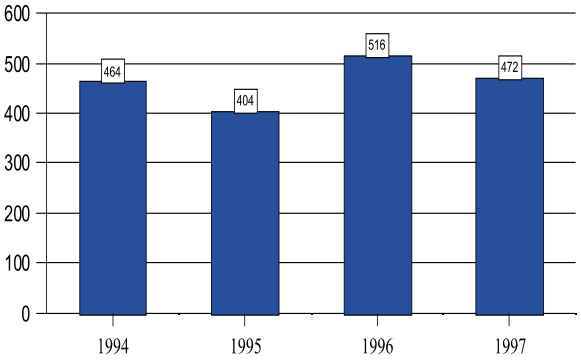
The Board's goal is to avoid identifying any child death as undetermined. Consistent, comprehensive law enforcement records, complete scene investigations, and autopsies (including cultures, total body x-rays, and toxicology), are absolutely critical in determining the cause of death.

Cumulative Data

This section contains a cumulative study of calendar years 1994, 1995, 1996, and 1997. The numbers of children who died each year are as follows:

Cumulative Number of Deaths

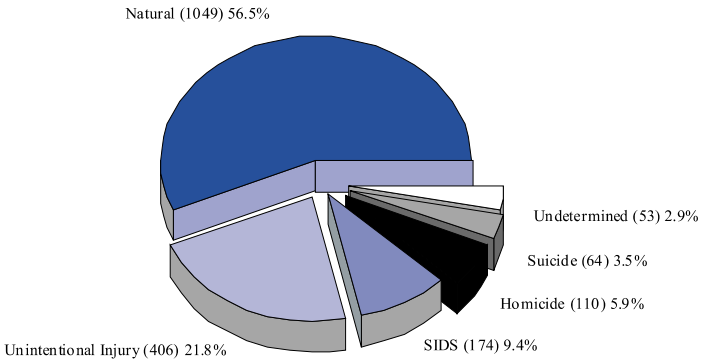
1994 - 1997 data n = 1856



In total, 1,856 Kansas children died during this four-year period; 729 were females and 1,127 were males. Natural causes claimed the lives of 1,049 children. Four hundred and six children died from unintentional injuries (255 vehicular deaths and 151 non-vehicular deaths); 174 died of SIDS; 110 were homicide deaths; 64 deaths were suicides, and 53 deaths were classified as undetermined.

Cumulative Manner of Death

1994 - 1997 data n = 1856



The following chart shows the breakdown of each manner of death per year. Natural deaths and unintentional injury deaths continue to be the largest categories of deaths in the state of Kansas.

Manner of Death (1,856 Deaths) Per Study Year

	1994	1995	1996	1997	TOTAL
Natural	264	226	296	263	1,049
Unintentional Injury	98	83	120	105	406
SIDS	50	43	35	46	174
Homicide	33	25	31	21	110
Suicide	15	12	16	21	64
Undetermined	4	15	18	16	53
Total	**464**	**404**	**516**	**472**	**1,856**