State of Kansas

State Child Death Review Board

Annual Report

2001 Data

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Attorney General

Office of the Attorney General
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Phill Kline

Attorney General

December 2003

Dear Friends:

The State Child Death Review Board was established by the Kansas legislature in 1992 with a desire to learn more about child mortality. When a child dies, everyone in a community is affected. That's why the state of Kansas has been fortunate to have a dedicated, all-volunteer board of professionals to review child fatalities. With the information collected annually by the board, we can learn more through studying trends in child deaths and use what we learn to formulate strategies to help reduce further child deaths from occurring.

This year's report comprehensively addresses data from the year 2001 and highlights many of the Board's findings for the eight-year period from 1994-2001. The board presents its recommendations and addresses many of the most important issues facing child health and safety.

By reviewing this year's report, I hope we can all learn more about ways to protect our state's most treasured asset, our children.

Sincerely,

Phill Kline
Kansas Attorney General

EXECUTIVE SUMMARY

The State Child Death Review Board (SCDRB) comprehensively reviewed 522 child deaths that occurred during calendar year 2001. The manner of death, as determined by the SCDRB, is placed in one of six main categories: natural, unintentional injury (UI), homicide, Sudden Infant Death Syndrome (SIDS), suicide, or undetermined.

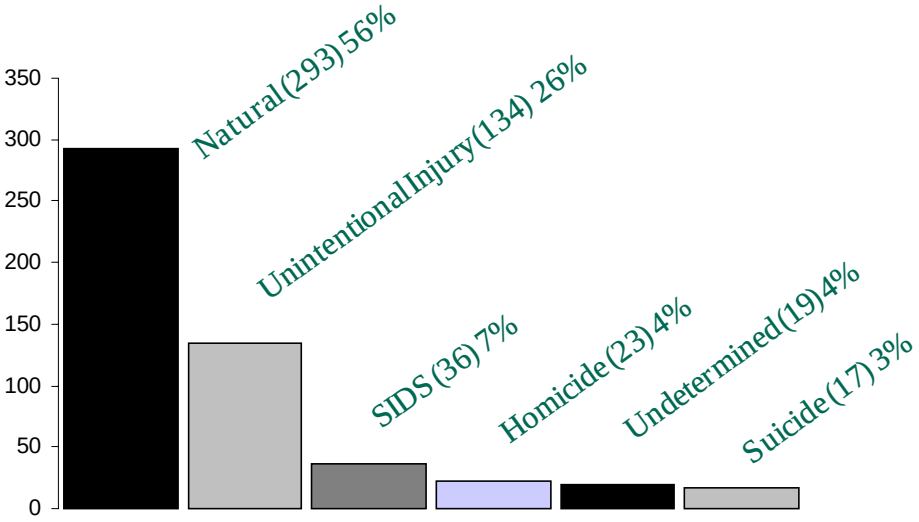
The SCDRB is a multi-disciplinary, multi-agency board that examines the circumstances surrounding the deaths of all Kansas children (birth through 17 years of age) and children who are not Kansas residents, but who die in the state. The goals of the SCDRB are to describe trends and patterns of child deaths in Kansas, develop prevention strategies, and improve sources of data and communication among agencies so that recommendations can be made.

Of the 522 deaths, natural and unintentional injury deaths continue to be the two largest categories of death of Kansas children. The largest group of children, 56 percent, died of natural causes, not including SIDS, in 2001.

The second largest manner of death, unintentional injuries, claimed the lives of approximately 26 percent of the children who died in 2001. Unintentional injuries are divided into two categories; vehicular and non-vehicular. The non-vehicular deaths consist of injury fatalities such as asphyxia (suffocation or drowning), fire/burn, firearm, chemical/drug, fall or blunt trauma, crush injuries, and deaths by electrocution.

SIDS claimed the lives of 36 infants in 2001, 23 children were victims of homicide, and 17 children committed suicide. Lastly, after a comprehensive review of all available records, the manner of death for 19 children could not be determined by the SCDRB.

Figure 1:
All Manners of Death in 2001.
N= 522



According to the United States Census Bureau as reported by the Kansas Department of Health and Environment/Center for Health and Environmental Statistics (KDHE/CHES), Kansas had 702,262 children under the age of 18 in 2001. Females accounted for 49 percent of the Kansas population, and males accounted for 51 percent. However, of the 522 child deaths reviewed by the SCDRB, 41 percent were female and 59 percent of the children were male.

EXECUTIVE SUMMARY

In 2001, whites composed approximately 88 percent of the Kansas population under the age of 18. Eight percent of the population consisted of blacks, and the remaining four percent were Asian/Pacific Islanders, American Indian/Alaskan Natives, and other races. The SCDRB's data from 2001 revealed that 81 percent of the children who died were white, 16 percent were black, two percent were Asian/Pacific Islander, and one percent were American Indian/Alaskan Native.

Any questions about this report, or about the work of the SCDRB should be directed to:

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www.ksag.org/contents/scdrb

The 522 deaths reviewed by the SCDRB in 2001 included 194 neonates (less than 29 days of age); 106 postneonatal infants (ranging from 30 days to one year old); 66 children from one to four years old; 29 children from five to nine years old; 45 children from 10 to 14 years old; and 82 adolescents from 15 to 17 years of age.

Since 1994, an important objective of the SCDRB has been to use the data collected on child deaths to educate the general public and professionals on risk factors and prevention issues for children. **The most critical lesson learned by the SCDRB's review of child fatalities is that hundreds of child deaths can be prevented with reasonable individual or community action.** The SCDRB has determined that 169 of the unintentional injury deaths, homicides, and suicides occurring in 2001 may have been prevented.

The SCDRB's public policy recommendations are highlighted on pages 1-3.

It is also important to mention how statistics are collected and used for purposes of the annual report. Because the SCDRB reviews deaths of not only Kansas children but also deaths of non-Kansas residents who die while in the state, its figures may, and probably will, vary slightly from those provided by KDHE or other governmental agencies. Also, after a thorough case review, the SCDRB may draw a conclusion about a cause and manner of death that differs from the conclusion drawn by a coroner or attending physician.

Additionally, over the past year the SCDRB has completed its transfer of data for the years 1994-2000 from an in-house database to an on-line database. The on-line database allows board members to directly enter case information, greatly reducing the possibility for error in data entry. Most of the data in this report was generated by the SCDRB's on-line host, Creative Sociomedics.

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Public Policy Recommendation #1

ENHANCE CHILD PASSENGER SAFETY LAWS AND REQUIREMENTS FOR DRIVER LICENSING

Every year, the SCDRB includes its recommendations for preventing child fatalities. In the past, these recommendations have addressed every manner of death. This year, the Board has chosen to address two topics: child passenger safety and child death investigations.

For a third year the Board has focused attention on motor vehicle crashes (MVCs), the leading cause of unintentional injury deaths for Kansas children.

During the period from 1994 to 2001, the leading cause of unintentional injury deaths was due to motor vehicle crashes. In 2001 76% percent of children killed in car crashes were either not using safety restraints or not using safety restraints properly at the time of the collision. An alarming 86.4 percent of teenagers ages 15 through 17 who died in motor vehicle crashes were not restrained. It is clear that the lives of many children can be saved by requiring that adults buckle them into seatbelts and/or properly installed safety seats.

Currently, Kansas law requires children younger than 14 years old to be properly restrained when riding in motor vehicles, regardless of where they are seated. Children under the age of four must ride in a child safety seat. A $20 fine is incurred by violators of this law. Additionally, front seat passengers are required to be properly restrained, regardless of age. A violation of this law results in a $10 fine. Consequences for non-compliance by caregivers of young children and of adolescents should be severe enough to change unsafe behaviors. The SCDRB recommends that the fines for non-compliance with child passenger safety laws be increased.

The number of youth killed in crashes while riding in the back seat is also significant: 29% of motor vehicle crash fatalities. The SCDRB recommends expanding primary enforcement of the child safety restraint law to require that youth younger than 18, seated anywhere in the vehicle, use age-appropriate safety restraint systems.

The SCDRB will continue to support efforts by the Kansas SafeKids Coalition to effect legislation that tightens gaps in current state law and provides increased protection for Kansas children. The SCDRB is particularly concerned about the current lack of safety protection for children older than age four. While children under four are required to be restrained in a child safety seat, children who are between the ages of four and eight or weigh less than 80 pounds are at risk because they are often graduated into adult seat belts too soon. Children in this age and size category should be placed in booster seats. Small children do not fit into adult seat belts, where they are put at great risk for injury and fatality in the event of a crash. Parents often don't realize they need to alter the type of safety restraints they use as children grow.

Public Policy Recommendation #1 Cont.

Public Policy and Safety Restraint Use

MYTH	Public education campaigns alone can do an adequate job of instructing the younger generation about seat belt safety.	FACT	Education alone does not convince most young people to buckle up. Seat belt use declines from age five to about 25. Young people, especially young men ages 16-25, do not always think about being injured or killed. Yet they are the nation's highest risk drivers, with more impaired driving, more speeding, and more crashes.
MYTH	Vehicular injuries and fatalities only affect the individuals involved—there is little impact on the State.	FACT	Everyone pays for traffic accidents, and the economic costs are substantial. In 2000, crashes cost Americans over $200 billion. Each fatality results in a lifetime economic cost to society of nearly $1 million. The average cost for each critically injured survivor exceeds $1 million.
MYTH	The State has more important things to do than devote attention and resources to increasing seat belt use.	FACT	Traffic crashes are a leading threat to public health. Increasing seat belt use is the single most effective and immediate way we can save lives and reduce injuries on Kansas roadways. Seat belt usage saves thousands of lives each year.

Finally, the SCDRB supports a graduated licensing system that would likely reduce the death rate from motor vehicle crashes for not only Kansas teenagers, but for all Kansans. According to the Insurance Institute for Highway Safety, a graduated licensing law (GDL) would allow the beginning stage of driving to start at age 16, require a minimum mandatory holding period of six months, and require certification of 30 to 50 hours of supervised driving. In the intermediate stage there should be restrictions on nighttime driving and transporting teenage passengers. Full unrestricted driving privileges should not occur before age 18.

Public Policy and GDL

MYTH	Improving driver education programs would solve the problem of young driver crashes. The licensing system doesn't need changing.	FACT	Although helpful in teaching beginners how to drive, there is no research evidence to suggest that driver education programs reduce crashes. A revised approach might be beneficial, but such a change could be very costly.
MYTH	GDL would punish everybody for the mistakes of some young drivers.	FACT	GDL is designed to support and protect new drivers, not punish them. It allows new drivers to demonstrate their competence and responsibility. Loosely restricted licensing systems put inexperienced, sometimes immature beginners into a complex and risky driving environment.
MYTH	GDL is just another attempt to protect people from themselves.	FACT	Young drivers often cause crashes in which both their passengers and occupants of other vehicles are hurt or killed. GDL is designed to protect everyone who uses the roadways, not just young drivers.

Public Policy Recommendations #2

COMPLETION OF THOROUGH INVESTIGATIONS OF CHILD DEATHS.

In order to classify a death properly, it is vital that all agencies cooperate and review all relevant information necessary to complete a proper death investigation. District Coroner and SCDRB member Dr. Erik Mitchell provides the following comments, "Thorough investigation of child deaths is a mandate of the State Child Death Review Board. Such an investigation should include more than the cause of death and manner of death. An understanding of the mechanisms of death is of critical importance if we are to develop strategies for the prevention of future deaths. For example, in a single car crash the investigation should include sufficient examination of the vehicle and environment to exclude or to describe mechanical and physical factors that caused or increased the probability of the crash.

Also, the examination should include investigation of potential medical factors- toxicology and previously undiagnosed physical infirmities or illnesses- that could play a role in causing the crash. While a single car crash looks deceptively simple on superficial examination, there can be factors that affect the crash, or the outcome of injuries, where only a detailed examination of the event and of the decedent will permit a complete understanding of how and why this death occurred.

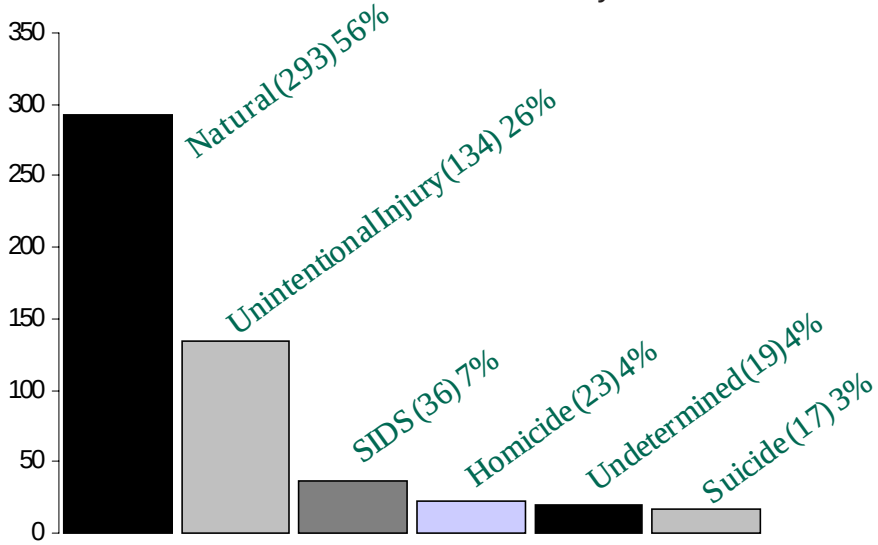
The State Child Death Review Board has long recognized the limitations of resources that inhibit the extent of death investigations. Consequently, in 2002, the SCDRB sought and obtained a change in statute. Counties can now obtain a refund of reasonable expenses of child autopsies from the District Coroner Fund in cases that fall under guidelines set by the SCDRB. In other words, if an autopsy is performed for a child where there is reason to believe that non-natural mechanisms are at play- accident, suicide, homicide- the County can request and receive reimbursement for reasonable autopsy costs from the District Coroner's Fund. It is hoped that the availability of funds will encourage the inclusion of autopsies in all potentially non-natural child deaths."

2001 Overview

The SCDRB comprehensively reviewed 522 child deaths that occurred during calendar year 2001. The manner of death, as determined by the SCDRB, is placed in one of six main categories: natural - excluding Sudden Infant Death Syndrome (SIDS); natural - SIDS; unintentional injury; homicide; suicide; or undetermined.

The chart below illustrates the number of deaths in each of the six manners of death reviewed by the SCDRB in 2001. The undetermined category is used when, after a thorough review of all available information, the manner of death cannot be conclusively determined.

Figure 1:
All Manners of Death in 2001.
N= 522



Natural and unintentional injury deaths continue to make up the two largest categories of death of Kansas children. The largest group of children, 56 percent, died of natural causes, not including SIDS.

The second largest manner of death, unintentional injuries, claimed the lives of 26 percent of the children who died in 2001. Unintentional injuries are divided into two categories - vehicular and non-vehicular. The non-vehicular deaths consist of injury fatalities such as asphyxia (suffocation or drowning), fire/burn, firearm, chemical/drug, fall or blunt trauma, crush injuries, and deaths by electrocution.

SIDS claimed the lives of 36 children in 2001, 23 children were victims of homicide, and 17 children committed suicide. Lastly, after a comprehensive review of all available records, the manner of death for 19 children could not be determined by the SCDRB.

2001 Overview

The following figures compare the demographics of deaths of Kansas children with the Kansas population who are less than 18 years of age. According to the United States Census Bureau as reported by KDHE, Kansas had 702,262 children under age 18. Females accounted for 48.6 percent of this population, and males accounted for 51.4 percent. However, of the 522 child deaths reviewed by SCDRB, 41.2 percent of the children were female, and 58.8 percent were male.

Figure 2:
Kansas Population by Sex. Ages Birth Through 17. Source: US Census Bureau, KDHE
N= 702,262

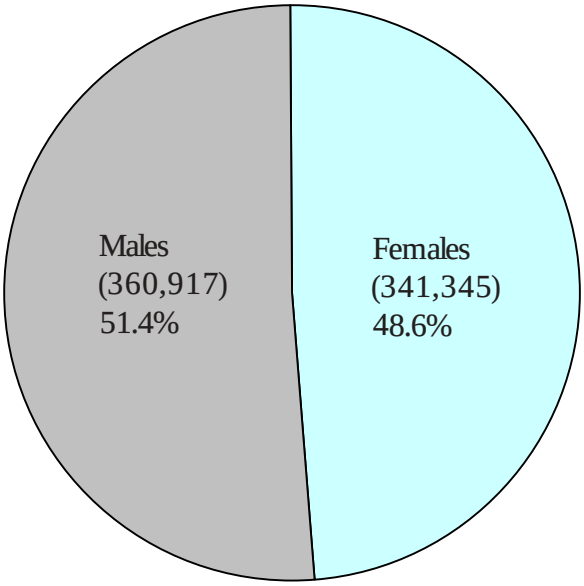
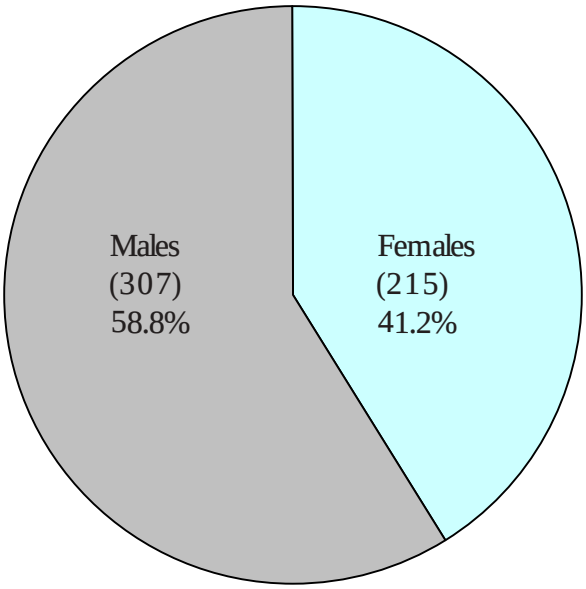


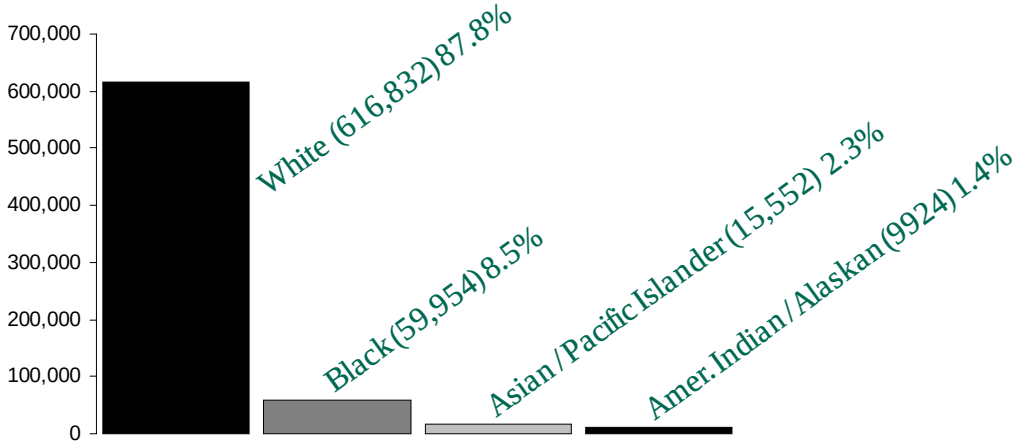
Figure 3:
Child Deaths in 2001 by Sex. Ages Birth Through 17.
N= 522



2001 Overview

In 2001, whites composed 87.8 percent of the Kansas population under the age of 18. 8.5 percent of the population consisted of blacks, and the remaining 3.7 percent were Asian/Pacific Islanders, American Indian/Alaskan Natives and other races.

Figure 4: Kansas Population by Race in 2001. Ages Birth Through 17. Source: US Census, KDHE.



The SCDRB's data from 2001 revealed that 81.6 percent of children who died were white, 16.3 percent were black, 1.7 percent were Asian/Pacific Islander, and .4 percent were American Indian/ Alaskan Native. Figure 6 illustrates child deaths by race and manner.

Figure 5: Child Deaths in 2001 by Race. Ages Birth Through 17. N= 522

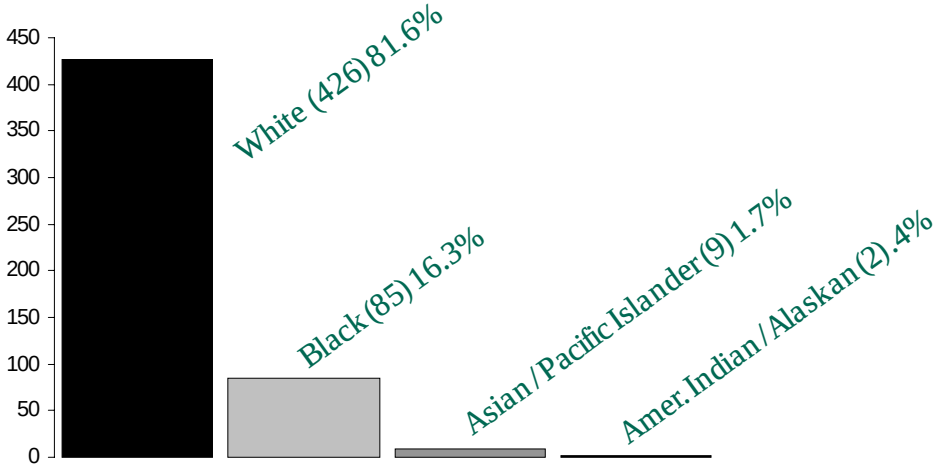


Figure 5: Child Deaths in 2001 by Race and Manner. Ages Birth Through 17. N= 522

	White	Black	American Indian/Alaskan Native	Asian/Pacific Islander	TOTAL
Natural, Non-SIDS	233	51	2	7	293
Unintentional Injury - Vehicular	77	7	0	0	84
Unintentional Injury – Non-vehicular	43	6	0	1	50
Natural-SIDS	30	6	0	0	36
Homicide	16	7	0	0	23
Suicide	17	0	0	0	17
Undetermined	10	8	0	1	19
TOTAL	426	85	2	9	522

2001 Overview

The figure below shows the 522 child deaths in 2001 by age group. Neonates (less than 29 days of age) accounted for 194 deaths. 106 postneonates (30 days up to one year old) died. The deaths reviewed also included 66 children from one to four years of age; 29 children between five and nine years old; 45 children between 10 and 14 years old; and 82 adolescents from 15 to 17 years of age.

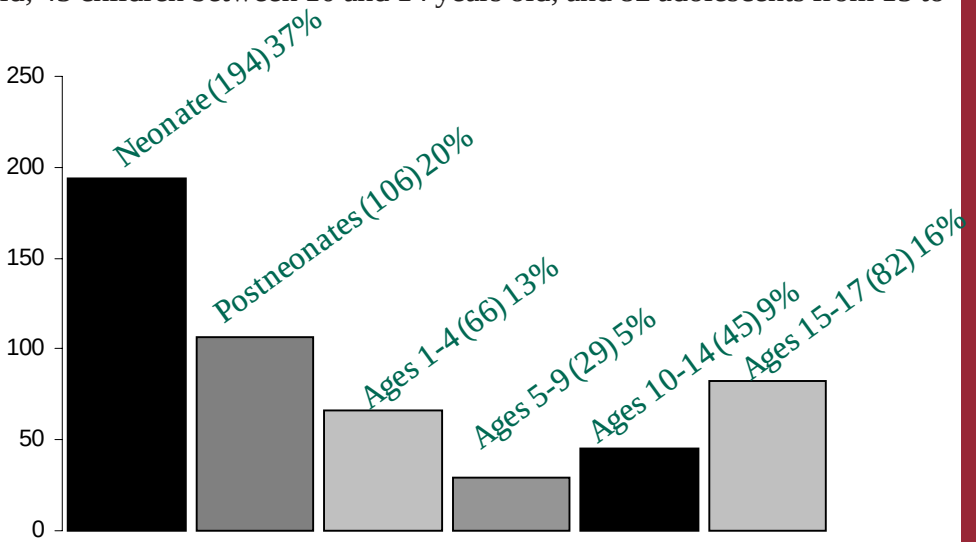


Figure 7: Child Deaths by Age Group in 2001. Ages Birth Through 17. N= 522

The SCDRB's priority is to use the data collected on child deaths to educate the general public as well as professionals on risk factors and prevention issues for children. The chart below compares the total number of deaths in selected categories with the number of those deaths than may have been prevented with reasonable individual or community action.

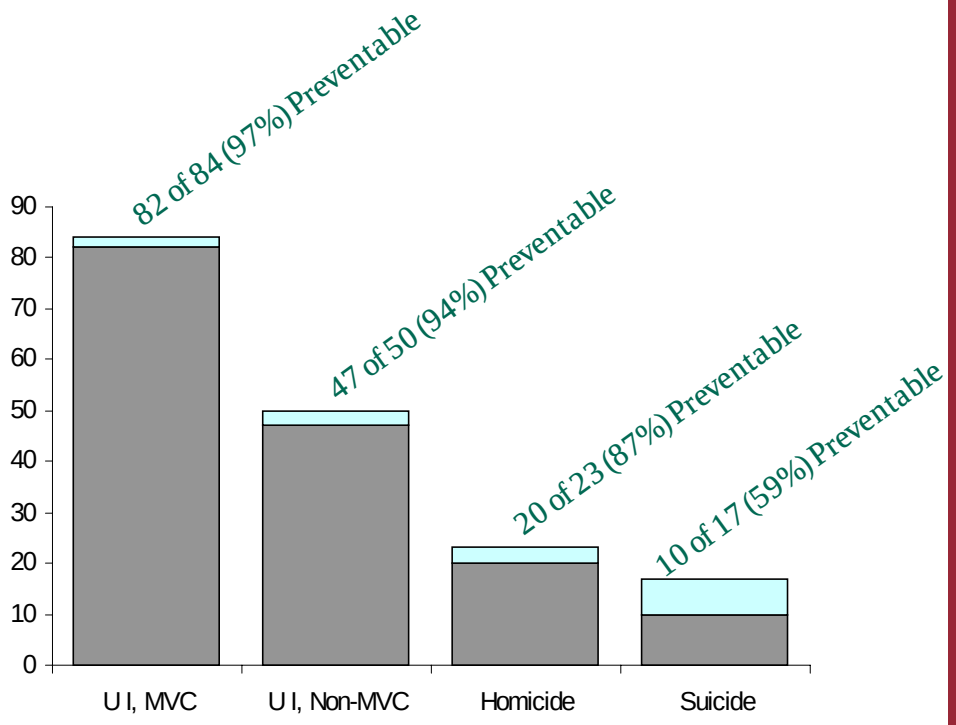
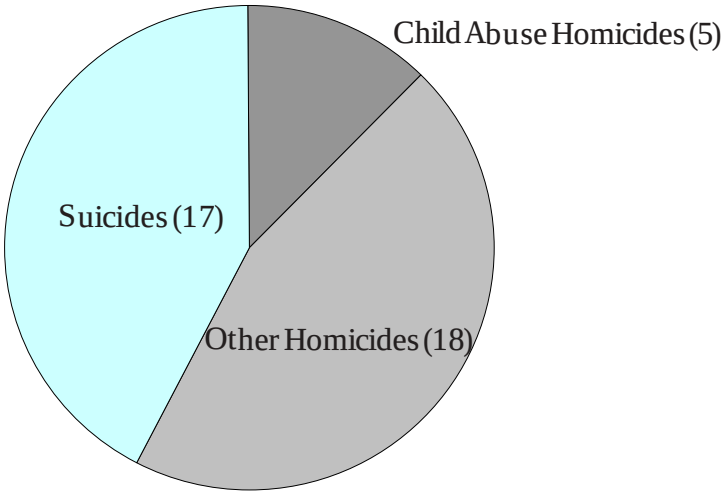


Figure 8: Preventable Child Deaths by Selected Manners in 2001 Compared with Total Deaths by Selected Manners. Ages Birth Through 17.

I. Violence Related Deaths

In 2001, 40 children were victims of violence-related deaths. A total of 23 children were victims of homicide. Five of these homicide deaths were the result of child abuse as identified by the SCDRB. Seventeen children committed suicide. Per 100,000 children, .71 were victims of child abuse homicide, 2.56 were victims of other types of homicide, and 2.42 were victims of suicide. Per 100,000 children, 5.70 were victims of all types of violence-related deaths.

Figure 9:
Violence-Related Death in 2001.
N= 40



Child abuse and neglect is a serious issue in Kansas. The following comments are from SCDRB member, Sarah Johnston, MD. "Several risk factors for child abuse and neglect have been identified. Maternal risk factors include young age, fewer than 12 years of education, late or no prenatal care, and being unmarried. Child risk factors include male gender and low birth weight. Household risk factors include prior substantiation of child abuse and neglect, substance abuse, low socioeconomic status, and presence in the household of an adult male not related to the child. The most effective methods for preventing child abuse involve programs which enhance parenting skills for at-risk parents. Examples of successful programs include home visits by nurses who provide coaching in parenting skills as well as quality pre-kindergarten programs which include parent training."

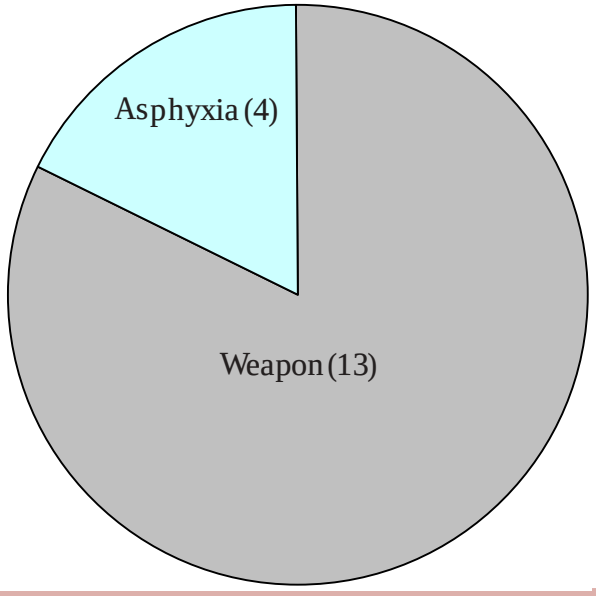
Firearms

MYTH	Young children aren't interested in playing with guns.	FACT	Children are naturally curious and may not know the difference between a toy gun and a real gun. Even young children are strong enough to pull a trigger.
MYTH	I don't have a firearm in my home, so I don't need to worry about my children accessing firearms.	FACT	Even if you don't own a gun, your neighbors may own a firearm for hunting, home security, sport shooting, or because he/she is a collector. Don't ever assume that a friend's home doesn't have a firearm in it. Many households with children have guns.
MYTH	"The gun just went off."	FACT	Guns don't just go off by themselves. Teach children that guns can be extremely dangerous but that something must happen in order for a gun to discharge. That is why they must never be played with. Guns are not toys.

A 15-year old female victim suffered from severe depression, attention deficit disorder and had suicidal tendencies. One of the child's parents was suffering from chemical dependency. The child was in therapy and had seen a psychiatrist earlier that week. When the child's father retuned home on the day of her death, he found the victim in the house with a self-inflicted gunshot wound to the head. She left a note next to where she died.

In 2001, the SCDRB reviewed 17 child suicide deaths. Fourteen males and three females took their lives. Four suicide deaths were due to asphyxia. Thirteen adolescents took their lives with firearms.

Figure 10:
Suicide Deaths by Method in 2001.
N= 17



A 15-year-old hung himself from a rafter in a spare room of his house while a friend who was staying the night went to sleep. Later in the evening, the victim's mother called up for the boys to turn down their stereo but only got a response from her son's friend. The friend and the mother eventually found the boy in a spare room. The victim had carved a short note into the ceiling's woodwork. Unfortunately, there was very little investigative work done on this case.

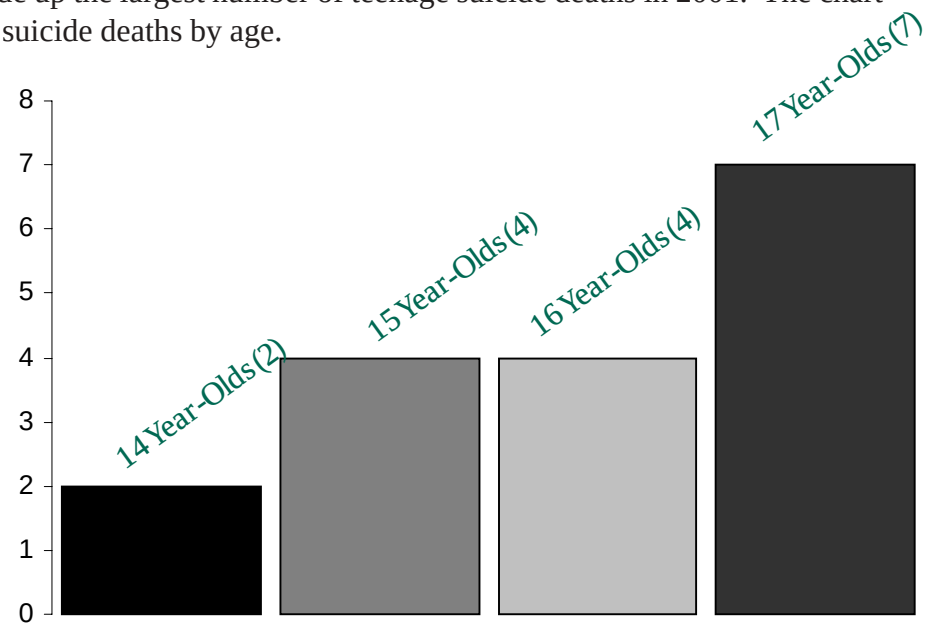
Suicidal behaviors are complex and usually the result of ongoing processes that involve multiple risk factors such as: mood disorders; drug and alcohol abuse; family discord; and lack of resources including access to services. The following suicide prevention points are from the United States Department of Health and Human Services Substance Abuse and Mental Health Services Administration.

- Promote awareness that suicide is a public health problem that is preventable.
- Improve access to and community linkages with mental health and substance abuse services.
- Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse, and suicide prevention services.

I. Violence Related Deaths

Seventeen year olds made up the largest number of teenage suicide deaths in 2001. The chart below illustrates the 17 suicide deaths by age.

Figure 11:
Suicide Deaths by Age in 2001.
N= 17



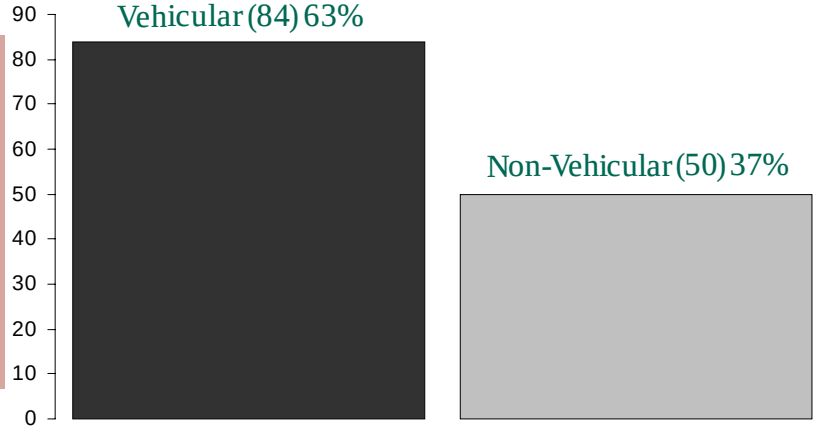
Suicide

MYTH	Talking about suicide may give kids the idea.	FACT	Actually, the opposite is true. Asking someone directly will often lower the anxiety level and act as a deterrent to suicidal behavior. Discussing suicide openly and honestly is one of the most helpful things you can do.
MYTH	Young people don't kill themselves.	FACT	Nationally suicide ranks as one of the top killers of young people between the ages of 15 and 24.
MYTH	Teens who talk about committing suicide rarely follow through.	FACT	Most of the teens who attempt or commit suicide give clues or warnings of their intentions. Do not ignore statements like "I can't see my way out," or "You'll be sorry when I'm dead." No matter how casually or jokingly said, these may really indicate suicidal feelings.
MYTH	The suicidal person wants to die and feels there is no turning back.	FACT	Suicidal people are usually ambivalent, wavering until the last moment between wanting to live and wanting to die. Most suicidal people do not want death. They want the pain to stop.
MYTH	Improvement following a suicidal crisis means the risk is over.	FACT	The greatest danger of suicide exists during the first three months following an attempt or deep depression. A "miraculous recovery" could be a significant danger signal. It may take months to feel consistently better and in control.

II. Unintentional Injuries

More children, ages one through 17, die from unintentional injuries than from all childhood diseases combined. Unintentional injuries are divided into two categories: vehicular and non-vehicular. Non-vehicular deaths include asphyxial (suffocation or drowning), fire/burn, chemical/drug, blunt trauma injuries (falls and crush injuries), sharp trauma, or deaths by electrocution.

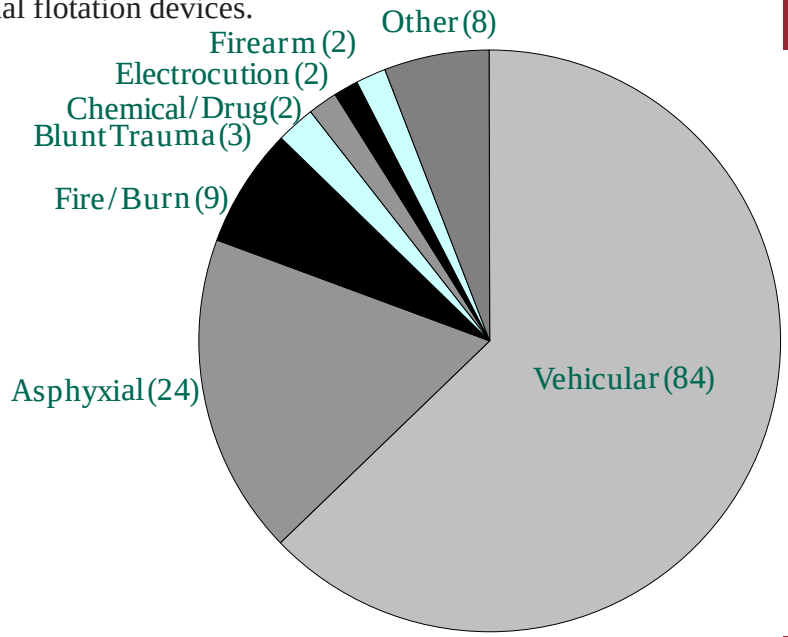
Figure 12:
Unintentional Injuries-Vehicular and Non-Vehicular in 2001.
N= 134



Unintentional injuries caused a total of 134 child deaths in 2001. 84 deaths were vehicular and 50 were non-vehicular. The breakdown of non-vehicular deaths was: 24 asphyxial deaths (12 drownings and 12 deaths due to suffocation/strangulation); 9 fire/burn deaths; 3 blunt trauma deaths; 2 chemical/drug deaths; 2 electrocution deaths; 2 firearm deaths; and 8 death from other circumstances.

Of the 134 unintentional injury deaths, 129 (96.2 percent) had at least one issue of preventability noted by the SCDRB. The prevention issues noted by the SCDRB in vehicular-related deaths were: non-use of safety restraints; excessive speed; alcohol/drug use while driving; inexperienced drivers; failure to obey traffic laws; and inattentive driving. Some of the prevention issues noted in the non-vehicular deaths were: inadequate supervision; absent or non-working smoke detectors; and non-use of personal flotation devices.

Figure 13:
Unintentional Injuries by Cause in 2001.
N= 134



II. Unintentional Injuries
A. Motor Vehicle Deaths

A 15-year-old girl was driving on a freshly graded country road with her two young sisters when their car began to fishtail and eventually flipped. As the car rolled, the victim and the sister riding in the front seat were ejected from the vehicle. Both died of head injuries; neither were wearing a seatbelt. The sister situated in the backseat was restrained and survived the crash.

Motor vehicle crashes continue to be the cause of the largest number of unintentional injury fatalities, claiming the lives of 84 children in 2001. Motor vehicle fatalities include drivers and passengers of motor vehicles, pedestrians who are struck by motor vehicles, bicyclists, and occupants of any other form of transportation. The chart below depicts the victim status, or position at the time of injury. Nineteen children were front-seat passengers in vehicles; twenty-four were rear-seat passengers; thirty-one adolescents were drivers of vehicles; four were pedestrians; one was a bicyclist (who was not wearing a helmet); and in five cases, it was impossible to determine where a child was located in the vehicle at the time of the accident or other circumstances were involved. In at least 18 motor vehicle crashes, alcohol was known to be involved.

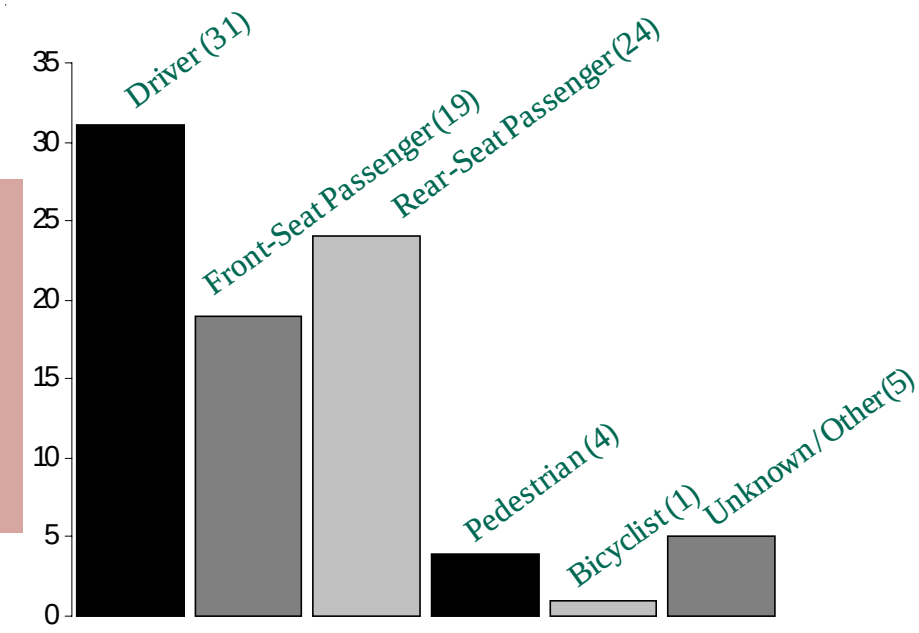


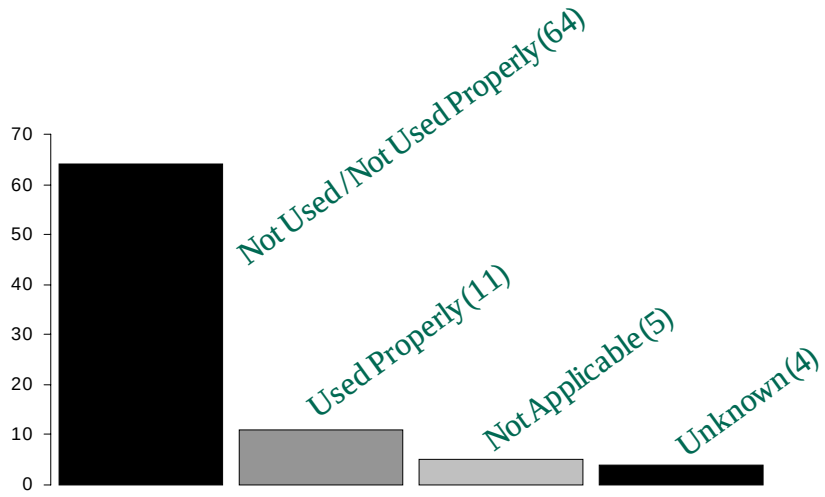
Figure 14:
Victim Status in Vehicular Unintentional Injuries in 2001.
N= 84

A 16-year-old girl was driving an ATV with a friend across a rural road late at night. The girl was under the influence of alcohol and was not wearing a helmet. According to the passenger, who survived, the ATV hit the embankment and overturned. The victim sustained massive head injuries and did not respond to resuscitation attempts by EMS.

II. Unintentional Injuries

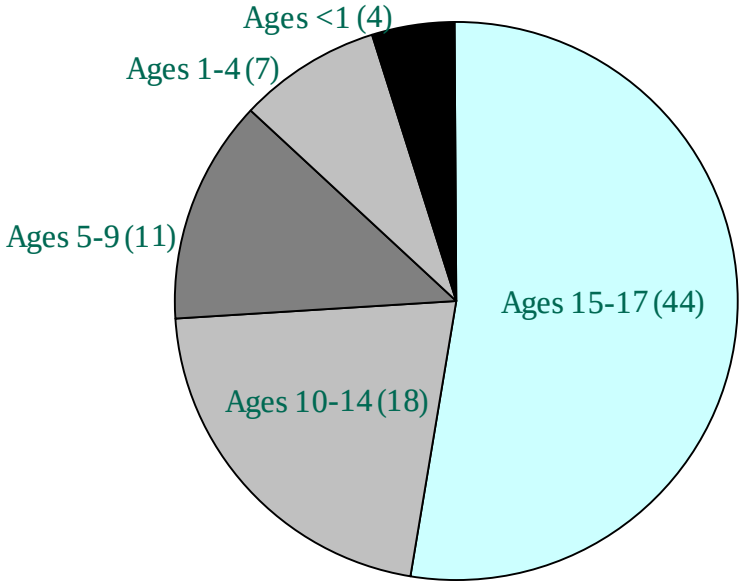
In a crash, a seat belt is the primary device that protects the occupants of a vehicle. In 2001, 64 children who were not wearing seat belts, not wearing seat belts properly, or not restrained in child safety seats were killed in vehicular crashes. Safety restraints were used properly in eleven cases; in five cases safety restraints were not applicable (deaths involving pedestrians or children riding bicycles); and in four cases safety restraint information was not known.

Figure 15:
Proper Safety Restraint Use in Vehicular Crashes.
N= 84



Because of inexperience, teens are often more likely to be involved in a crash than the rest of the driving population. The age group that had the highest number of vehicular deaths in 2001 was 15 through 17 year olds. The chart below illustrates the number of children who died in vehicular crashes by age group

Figure 16:
Vehicular Fatalities by Age Group in 2001.
N= 84



A 5-year-old boy was in a vehicle driven at a high rate of speed by an older friend. It was estimated that at the time of their accident, the car was traveling at more than twice the posted speed limit. The driver lost control of the car, it left the road and then struck a stop sign and a utility pole before coming to rest in a creek. The boy, who was not wearing a seatbelt, was killed when he was ejected from car and landed in the creek. The driver of the car was killed when his body was crushed between the passenger-side door frame of the vehicle and its collapsed roof.

Motor Vehicle Crashes

MYTH	I don't need a seat belt. The air bag will save me.	FACT	Air bags are designed to work with seat belts, not by themselves. An air bag, by itself, reduces the risk of dying by only 12 percent. A seat belt will reduce the risk by 45 to 60 percent. Seat belts help prevent air bag injuries by keeping occupants the proper distance away from deploying air bags.
MYTH	Child safety seats or seat belts aren't important on short, low-speed trips around town.	FACT	In a crash, a 10-pound child riding in a car traveling 30 mph is thrown forward at a force of 300 pounds. It's equivalent to dropping a child from a third story window. More than 80 percent of all crashes occur at speeds less than 40 mph. Three out of four crashes causing death occur within 25 miles of home.
MYTH	If I wear a seatbelt, I might be trapped in a burning or submerged car.	FACT	Less than one-half of one percent of all injury-producing collisions involve fire or submersion. Individuals are better off wearing safety belts at all times in a car. With safety belts, occupants are more likely to be unhurt, alert, and capable of escaping quickly.
MYTH	It's better to be thrown clear of the car.	FACT	Individuals are four times more likely to die if they are thrown from the vehicle during a crash. They are 14 times more likely to receive a spinal cord injury. Three quarters of people who are thrown from the car in crashes are killed.
MYTH	Seat belts are as likely to harm you as help you.	FACT	Wearing a seat belt reduces the chances of being killed or injured in a crash by 45 to 60 percent. Seat belts keep occupants from being thrown out of the car or from slamming into the window, dashboard, or other people.

Figure 17 depicts the time fatal vehicle crashes occurred in the 15-17 year-old age group from 1994 to 2001. Among 15 through 17 year-olds, there were noticeable increases in the number of crashes during the day commonly associated with traveling to and from school. In addition, there was an increase in fatal motor vehicle crashes between the hours of 9:00 p.m. and 3:00 a.m. This information reiterates the need for a graduated drivers license system, as adolescents traveling at night and/or with their peers are at a higher risk of being involved in a fatal car crash than young people traveling alone or with a responsible adult.

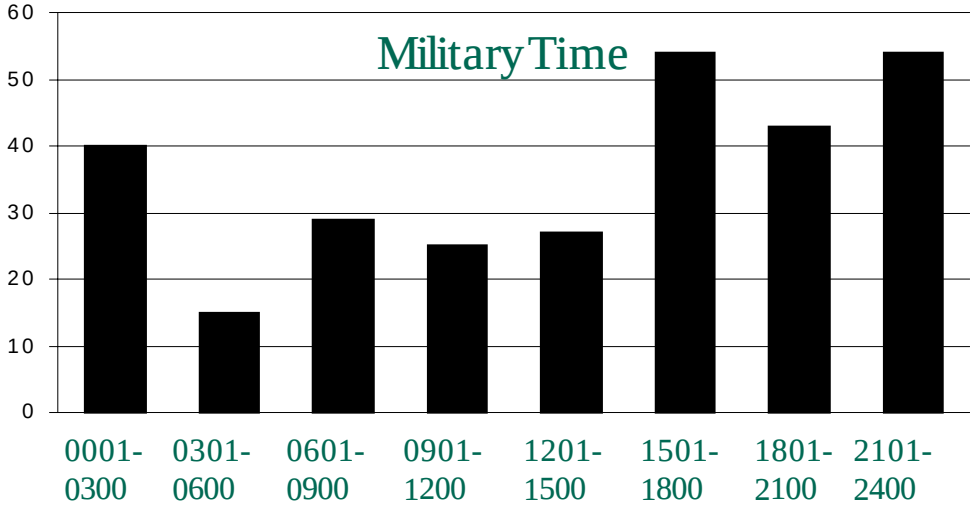


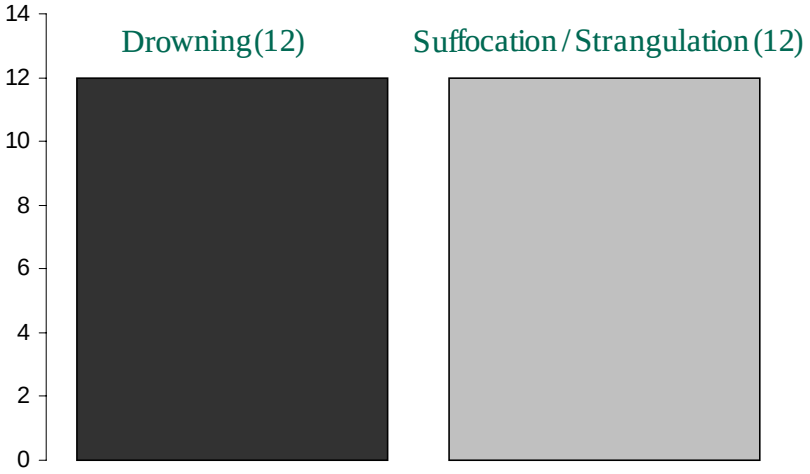
Figure 17: Motor Vehicle Crashes by Time of Crash and Age Group from 1994-2001. Ages 15 Through 17

II. Unintentional Injuries

B. Asphyxial Deaths

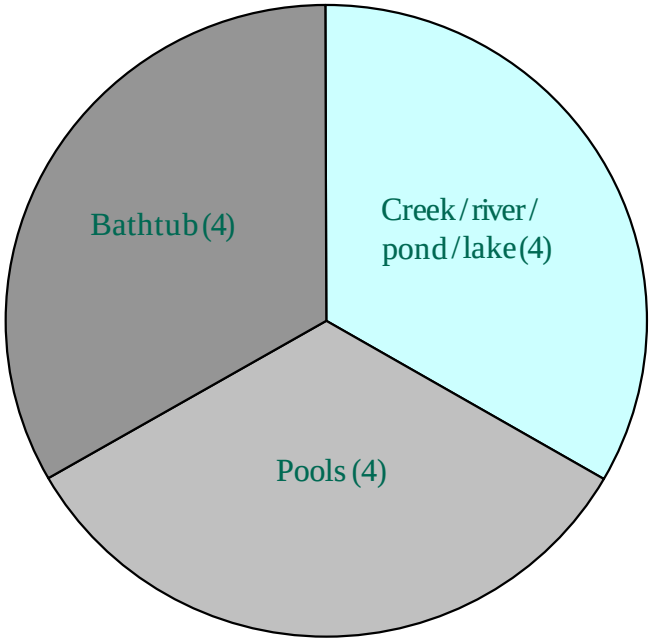
In 2001, 24 children lost their lives to unintentional asphyxial injuries. Unintentional drownings claimed the lives of 12 children. Unintentional suffocation or strangulation claimed the lives of 12 children. Many asphyxial deaths can be prevented with proper supervision.

Figure 18:
Unintentional Asphyxial Deaths in 2001.
N= 24



According to the National SAFE KIDS Coalition, "For every child who drowns, two children are hospitalized for near-drowning; for every hospital admission, approximately three children are treated in hospital emergency rooms." Of the 12 drowning fatalities reviewed by the SCDRB in 2001, four children drowned in creeks, rivers, ponds, or lakes; four children drowned in swimming pools; and four children drowned in bathtubs.

Figure 18:
Unintentional Drowning Deaths by Location in 2001.
N= 12



II. Unintentional Injuries

A mother left her 1-year-old and 3-year-old sons in a bathtub for a few minutes in order to get bottles and pajamas for the children. Upon her return, she found the older brother holding the younger child under water. The mother pulled the baby from the water, went across the street, and called 911. She attempted CPR prior to the ambulance's arrival but the child did not respond. There were reports that the older child had been rough at times with his younger brother.

Drowning

MYTH	I've taken life-saving and CPR, so I can rescue my child.	FACT	CPR and life-saving don't replace life vests and supervision. It only takes being under water for a few minutes to have brain damage, a cardiac arrest, or death.
MYTH	Drowning is noisy. I'll hear my child splashing and struggling in time to help.	FACT	Young children sometimes don't have the developmental ability to figure out what to do in water, such as right themselves or stand up, even in just a few inches of water. As a result, they can quietly "slip away."
MYTH	I don't live or vacation near water, so I don't have to worry.	FACT	Water hazards exist in and around every home. Toddlers have drowned in five-gallon buckets, rain-swollen trash cans, and toilet bowls. Keep young children out of the bathroom except when directly supervised, and don't leave buckets or barrels where they can accumulate water. Children can drown in just a few inches of water.
MYTH	Kids won't wear life vests.	FACT	They'll wear them if the expectation is consistent and clear. Make life vests part of all water activities. Most drownings happen during momentary lapses in supervision. A life vest is no substitute for supervision, but it can buy time.

A pregnant woman awoke in the middle of the night not feeling well. Reports indicate that the woman began soaking in the bathtub when she passed out. When she awoke she found that she had delivered her baby. She had a friend come over who cut the umbilical cord with a knife and then called 911. Responders arrived and found the infant submerged in the bathtub full of water. The baby was pronounced dead a short time later. An investigation revealed gas bubbles in the lungs indicating that the baby was breathing at one time. The manner of death was ruled a drowning.

A 1-year-old child was placed in a bathtub with her 3-year-old brother. Police suspect that the father left the area and subsequently fell asleep in another room. When the father returned to check on the children, he found that the 3-year-old had crawled out of the tub. The 1-year-old was found dead, face down between the bath seat and the wall of the tub. The father said he was mentally and physically tired, that he was depressed, and that he was on medication.

II. Unintentional Injuries

Many infant deaths due to suffocation are associated with unsafe sleeping arrangements. According to the American Academy of Pediatrics (AAP), "Bed sharing or cosleeping may be hazardous under certain conditions." An infant's inability to lift his or her head or remove him or herself from dangerous situations increases the chance of injury or death. In 2001, the SCDRB reviewed the deaths of 12 children who died from unintentional suffocation, strangulation, or choking. Prevention issues identified by the SCDRB included, proper supervision, appropriate sleeping arrangements, and proper bedding materials.

C. Fire/Burn Deaths

Nine children lost their lives due to fire/burn incidents in 2001. All nine deaths were identified as preventable by the SCDRB. Prevention issues for parents and caregivers are related to supervising small children, limiting access to lighters, matches or candles, properly maintaining a chimney or furnace, planning an escape route, and maintaining or installing working smoke detectors.

A 6-year old girl, her mother, and one of her brothers died in a mobile home fire when one of the children lit a chair on fire while playing with birthday candles and matches. The child who set the fire escaped the blaze.

A 7-year old child, his adult sister and his young nephew were killed in a house fire. Fire investigators surmise that one of the children took a burning candle from the kitchen and laid it on the couch, setting off a raging fire. The children fled to a bedroom and huddled in a closet where they died of burns and smoke inhalation. The adult sister also died in the blaze.

Fire

MYTH	The smoke from the fire isn't the real danger.	FACT	Smoke kills more people than do burns. In a matter of minutes fire robs the air of oxygen and fills it with carbon monoxide and other deadly gases.
MYTH	Smoke alarm batteries need to be changed but the actual smoke alarm will last a lifetime.	FACT	Like other electronic devices, smoke alarms won't last forever. Replace them every ten years. A properly functioning smoke alarm reduces the risk of dying in a fire by almost 50 percent, but nearly 1,200 children die each year in homes without working alarms. Keep smoke alarms connected and working. Replace low batteries immediately and all batteries annually. Hit the "test" button each month to check the alarm. A chirp signals a low battery on newer models.
MYTH	Portable heaters are a safe way to provide constant heat to a home.	FACT	Portable heaters are meant to provide extra heat for a short time, but not while sleeping. Keep portable heaters three feet away from bedding, furniture and other combustible materials. Never leave a heater unattended.

II. Unintentional Injuries
D. Other Unintentional Injuries

Seventeen children died of other unintentional injuries in 2001. These deaths are attributable to poisons/chemicals, falls, crush injuries or other blunt trauma, electrocution, weapons, or other causes.

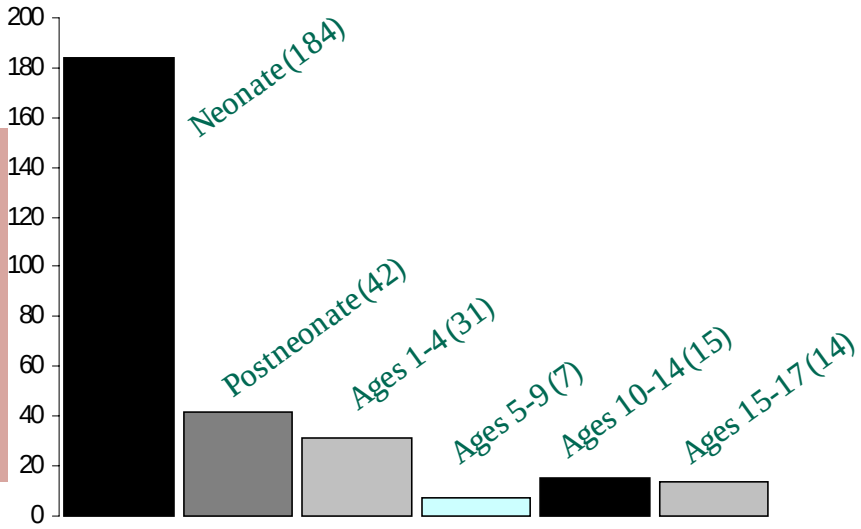
A 5-year old child was described by his parents as a night owl. On the night of the child's death, his parents put the child in his room at 10 p.m. and started a movie for him. In the early morning hours the child entered the parents room and spoke with the parents. The mother told the boy to go back to bed. When the mother got up two hours later to check on the boy, she could not find him. The father eventually found the child dead in a wooden toybox. Law enforcement officers surmise that the boy climbed into the box and accidentally closed the latch. The child suffocated in the box.

In 28 (56 percent) of the 50 non-vehicular unintentional injury deaths, lack of supervision was noted as a risk factor. While no one can watch their children every second of the day, the fact is that most preventable injuries happen while caregivers are called away or distracted, even for a moment. If a child is in a potentially dangerous area and you must leave, always take him or her with you. Pay special attention when doing something out of the normal routine. Childproofing is not enough. Always keep a close eye on children.

III. Natural Deaths

Natural deaths include causes related to prematurity, congenital anomalies, infections, and other diseases. Most child deaths are due to natural causes, and the majority of natural deaths occur in the first year of life. 56 percent, or 293 of the deaths reviewed for 2001, were attributed to natural causes. Neonates, children less than 29 days old, accounted for 184 (62.8 percent) of the natural deaths in 2001.

Figure 19:
Natural Deaths by Age Group in 2001.
N= 293



In 2001, 175 males and 118 females died of natural causes. The breakdown by cause of the 293 natural deaths in 2001 was as follows: 124 deaths due to prematurity; 66 deaths due to congenital malformations; 29 deaths due to infections; 21 deaths due to metabolic/genetic disorders; 19 deaths due to neoplasms (cancer); and 34 deaths due to other medical conditions.

Asthma deaths are a perennial concern. While asthma is a chronic disease, it is manageable and attacks are treatable. Caregivers and children with asthma need to be aware of asthma triggers and how to avoid them, take appropriate medication for asthma management, and know how to appropriately respond in the event of an asthma attack. Because many children are not at home for a significant number of hours each day, other adults such as school nurses, coaches, and child care providers must be familiar with a physician-prescribed asthma action plan. This can help prevent severe asthma attacks and increase recognition of medical emergencies.

In reviewing the natural deaths of children under one year of age, the information provided indicates that 40 mothers smoked tobacco products during their pregnancies; 40 mothers were non-compliant with their prenatal care; five mothers were known to use alcohol; and five used illicit drugs.

IV. Sudden Infant Death Syndrome

After more than 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 indicate that most SIDS deaths occur when infants are between one and four months of age. Fall, winter, and early spring tend to be the times when most SIDS deaths occur.

In 2001, the SCDRB reviewed 36 SIDS deaths. It is of critical importance to identify all possible risk factors in SIDS deaths. As stated in every previous SCDRB report, placing a healthy baby on his or her back to sleep lowers the incidence of SIDS. According to the information provided to the SCDRB on the 36 SIDS deaths in 2001, risk factors identified during the review revealed that 21 infants were known to have been sleeping on their stomachs or sides and 19 had a recent history of mild upper respiratory infection or other illness. In an overwhelming number of cases, risk factors could not be identified due to a lack of information which should have been provided from scene documentation and interviews.

Figure 20:
SIDS Deaths by Age in Months in 2001.
N= 36

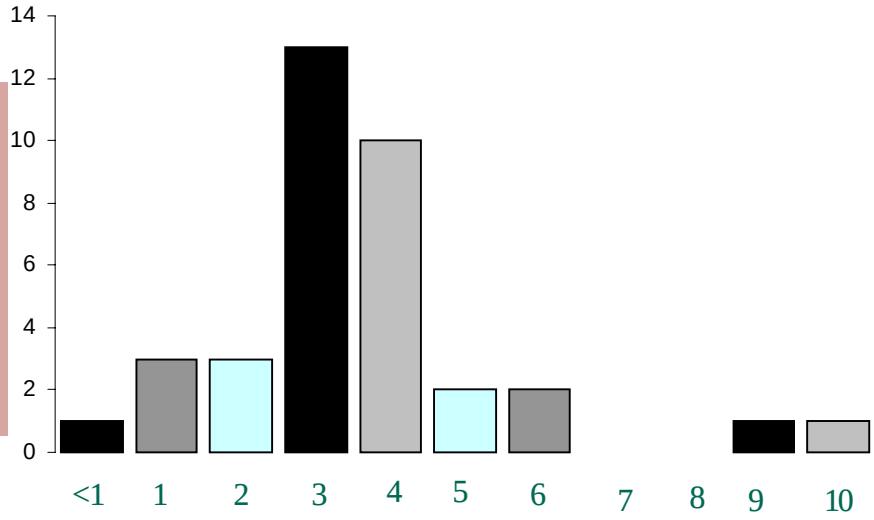
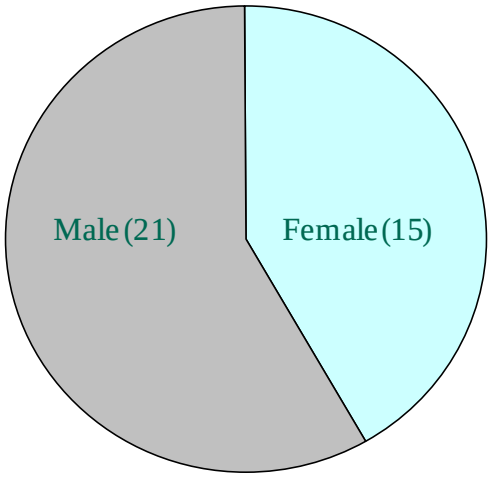


Figure 21:
SIDS Deaths by Sex in 2001.
N= 36



IV. Sudden Infant Death Syndrome

The single most significant factor in reducing the risk of SIDS is sleep position. Healthy infants should always be placed on their backs to sleep, never on their stomachs. In addition, infants should not be placed to sleep on soft bedding products, even if those products are marketed for use by infants. The Consumer Product Safety Commission (CPSC) indicates that some infants placed on fluffy, plush products such as sheepskins, quilts, comforters, and pillows have been found on their stomachs with their faces, noses, and mouths covered by the soft bedding.

According to the National Institute of Child Health and Human Development (NICHD), the Centers for Disease Control and Prevention (CDC), and the American Academy of Pediatrics, a number of factors seem to place a baby at higher risk of dying from SIDS. In addition to sleep position, these risk factors include: improper sleeping arrangements; mothers who smoke during pregnancy; babies who are exposed to second-hand smoke; late or no prenatal care; lack of breast feeding; young maternal age; and premature or low birth weight babies.

In addition, the NICHD warns parents that the incidence of SIDS increases during cold weather. The increase in SIDS during winter months may, in part, be attributed to babies being over-bundled and/or overheated. Parents and caregivers should keep the temperature in the baby's room so that it feels comfortable for an adult.

SIDS

MYTH	SIDS can occur at any age.	FACT	SIDS is the unexplained death of a baby under one year of age. Most SIDS deaths happen between one and four months of age. The number of babies dying of SIDS dramatically drops after six months of age.
MYTH	Babies can "catch" SIDS.	FACT	SIDS cannot be caught. It is not contagious and there are no symptoms before death.
MYTH	A SIDS death can be prevented.	FACT	Although there is no way to make sure a baby will not die of SIDS, the chance of a baby dying of SIDS can be greatly reduced by placing babies on their backs to sleep.
MYTH	Cribs cause "crib death" or SIDS.	FACT	Cribs do not cause SIDS.
MYTH	Babies who sleep on their backs can choke on spit-up or vomit.	FACT	Babies swallow or cough up fluid that enters their airway. Doctors have found no increase in choking or other problems in babies who sleep on their backs.

V. Undetermined Deaths

The "undetermined" category is used when the manner of death cannot be conclusively determined after a comprehensive review of all available information. In 2001, the SCDRB categorized 19 deaths to be of an undetermined manner. In order to classify a death properly, it is vital that all agencies cooperate and review all relevant information necessary to complete a proper death investigation.

A 17-year old boy was sitting on railroad tracks as a train quickly approached. As the train neared, it blew its horn and applied its brakes. The young man stood up, faced away from the train and began to walk. Unable to stop in time, the train struck the boy at 79 miles per hour, killing the boy instantly. It is unclear if the adolescent intended to commit suicide or if he simply could not get off the tracks for some reason.

A four-month old male with a history of health problems was found dead in his crib. During the autopsy, the child's brain was not examined. If examination of the central nervous system had been performed and been negative, this death might have been classified as SIDS or complications of prematurity. Additionally, scene investigators made no mention about the infant's sleeping position. Due to a lack of investigation and documentation as well as a lack of examination of the brain during the autopsy, this death was classified as undetermined.

The SCDRB strives to avoid categorizing 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 accurately determining the cause and manner of deaths.

Cumulative Data 1994-2001

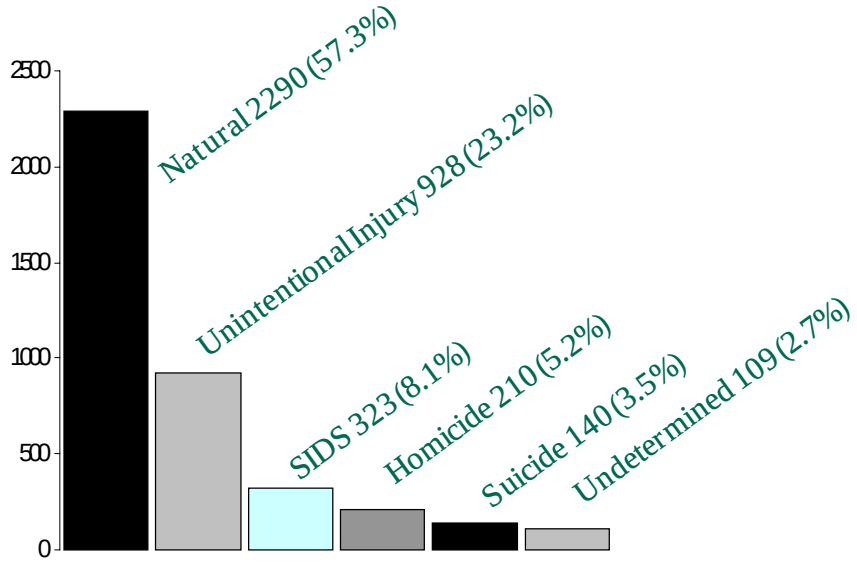
Figure 22:
Child Deaths by Manner and Year from 1994-2001.
Ages Birth Through 17.
N=4000

This section contains a study of calendar years 1994 through 2001. The number of children who died each year, by manner of death, are as follows:

	1994	1995	1996	1997	1998	1999	2000	2001	TOTAL
Natural	264	226	328	281	298	305	295	293	2290
Unintentional Injury	98	84	125	107	123	121	136	134	928
Natural-SIDS	49	44	35	46	32	40	41	36	323
Homicide	33	25	31	22	36	21	19	23	210
Suicide	15	12	16	21	26	16	17	17	140
Undetermined	5	13	20	17	11	11	13	19	109
TOTAL	464	404	555	494	526	514	521	522	4000

In total, 4000 child fatalities were reviewed by the SCDRB in this eight-year period. Natural causes claimed the lives of 2290 (57.3 percent) children. Unintentional injuries claimed the lives of 928 (23.2 percent) children; 323 deaths (8.1%) were due to SIDS; 210 (5.2 percent deaths were homicides; 140 (3.5 percent) deaths were suicides; and 109 (2.7 percent) deaths were classified as undetermined.

Figure 23:
Child Deaths by Manner and Year from 1994-2001.
Ages Birth Through 17.
N=4000



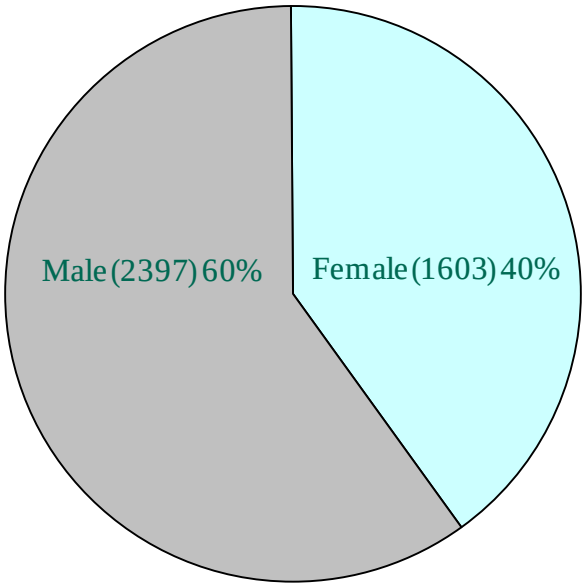
Cumulative Data 1994-2001

Figure 24: Child Deaths by Sex and Year from 1994-2001. Ages Birth Through 17. N=4000

During the period from 1994 through 2001, 2397 males and 1603 females younger than age 18 died.

	1994	1995	1996	1997	1998	1999	2000	2001	TOTAL
Males	274	246	334	304	315	314	303	307	2397
Females	190	158	221	190	211	200	218	215	1603
TOTAL	464	404	555	494	526	514	521	522	4000

Figure 25: Child Deaths by Sex from 1994-2001. Ages Birth Through 17. N=4000



The figure below illustrates child deaths by age group during the eight-year period. Children less than one year of age accounted for 55 percent of the deaths reviewed by the SCDRB. In the period from 1994 through 2001, 477 one to four year olds died, along with 261 five to nine year olds, 390 10 to 14 year olds, and 659 15 to 17 year olds.

Figure 26: Child Deaths by Age Group and Year from 1994-2001. Ages Birth Through 17. N=4000

	1994	1995	1996	1997	1998	1999	2000	2001	TOTAL
Neonate	153	136	205	178	181	202	187	194	1436
Postneonate	108	83	96	101	97	88	98	106	777
Ages 1-4	47	51	63	60	62	62	66	66	477
Ages 5-9	31	31	40	34	38	30	28	29	261
Ages 10-14	40	40	61	42	54	55	53	45	390
Ages 15-17	85	63	90	79	94	77	89	82	659
TOTAL	464	404	555	494	526	514	521	522	4000

During the eight-year period from 1994 through 2001, the SCDRB concluded that 1037 unintentional injuries and violence-related deaths may have been prevented.

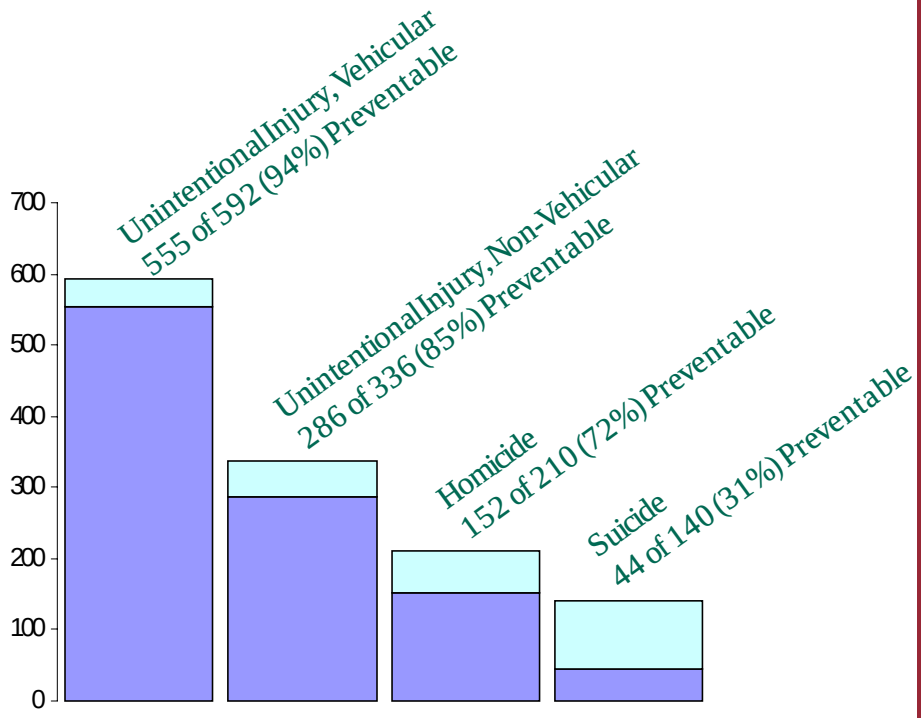


Figure 27: Preventable Child Deaths by Selected Manners from 1994-2001. Ages Birth Through 17. N= 1037

Figure 28 compares the number of motor vehicle injury deaths for the period 1994 to 2001 over every year of childhood and adolescence.

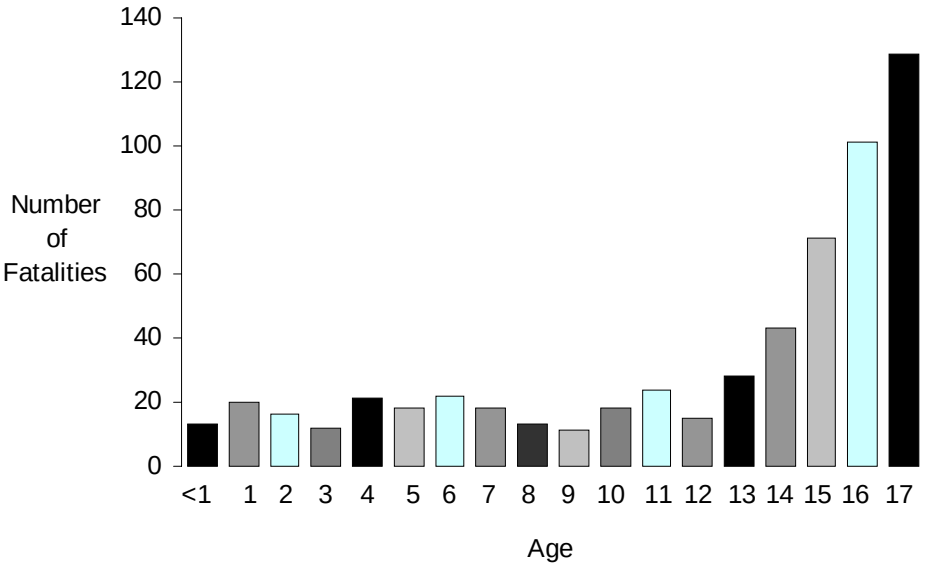


Figure 28: Motor Vehicle Crashes by Age from 1994 - 2001. Ages Birth Through 17. N= 1037

Appendices

Appendix A
Child Deaths by County of Residence

2001 Data
N = 522

County of Residence	County Population 17&under	Total	Natural	Un. Inj.	Un. Inj.MVC	SIDS	Suicide	Homicide	Undetermined
Allen	3,630	3	1	1	0	0	1	0	0
Anderson	2083	0	0	0	0	0	0	0	0
Atchison	4368	4	2	0	2	0	0	0	0
Barber	1230	3	0	1	1	0	1	0	0
Barton	7063	4	1	0	2	0	0	0	1
Bourbon	3812	0	0	0	0	0	0	0	0
Brown	2720	2	1	1	0	0	0	0	0
Butler	16,541	4	1	0	3	0	0	0	0
Chase	687	0	0	0	0	0	0	0	0
Chautauqua	976	0	0	0	0	0	0	0	0
Cherokee	5700	2	0	1	1	0	0	0	0
Cheyenne	715	3	0	0	3	0	0	0	0
Clark	607	1	0	0	1	0	0	0	0
Clay	2111	0	0	0	0	0	0	0	0
Cloud	2173	2	1	0	0	1	0	0	0
Coffey	2280	0	0	0	0	0	0	0	0
Comanche	448	0	0	0	0	0	0	0	0
Cowley	9107	11	8	2	0	1	0	0	0
Crawford	8664	4	3	0	1	0	0	0	0
Decatur	780	0	0	0	0	0	0	0	0
Dickinson	4754	1	1	0	0	0	0	0	0
Doniphan	2022	2	1	0	1	0	0	0	0
Douglas	20,438	12	10	0	1	1	0	0	0
Edwards	815	1	0	0	1	0	0	0	0
Elk	695	0	0	0	0	0	0	0	0
Ellis	5904	3	2	0	0	0	0	0	1
Ellsworth	1316	0	0	0	0	0	0	0	0
Finney	13,641	12	5	6	0	1	0	0	0
Ford	9917	12	6	0	1	4	0	1	0
Franklin	6745	6	4	1	1	0	0	0	0
Geary	8154	13	11	0	0	0	0	1	1
Gove	757	0	0	0	0	0	0	0	0
Graham	601	1	0	0	1	0	0	0	0
Grant	2480	0	0	0	0	0	0	0	0
Gray	1824	1	1	0	0	0	0	0	0
Greeley	418	0	0	0	0	0	0	0	0
Greenwood	1772	1	1	0	0	0	0	0	0
Hamilton	743	3	0	3	0	0	0	0	0
Harper	1543	1	0	1	0	0	0	0	0
Harvey	8370	1	0	0	1	0	0	0	0
Haskell	1369	3	2	0	1	0	0	0	0
Hodgeman	571	0	0	0	0	0	0	0	0
Jackson	3465	1	0	0	0	1	0	0	0
Jefferson	4870	5	1	0	4	0	0	0	0
Jewell	745	0	0	0	0	0	0	0	0
Johnson	123,073	67	45	3	8	5	2	1	3
Kearny	1514	0	0	0	0	0	0	0	0
Kingman	2272	0	0	0	0	0	0	0	0
Kiowa	718	1	1	0	0	0	0	0	0
Labette	5648	2	0	0	2	0	0	0	0
Lane	499	0	0	0	0	0	0	0	0
Leavenworth	18,173	12	9	0	0	1	1	0	1
Lincoln	794	0	0	0	0	0	0	0	0
Linn	2354	0	0	0	0	0	0	0	0

Appendix A
Child Deaths by County of Residence

2001 Data
N = 522

County of Residence	County Population 17&under	Total	Natural	Un. Inj.	Un. Inj MVC	SIDS	Suicide	Homicide	Undetermined
Logan	753	1	0	0	1	0	0	0	0
Lyon	9117	6	2	0	2	0	1	1	0
Marion	7264	0	0	0	0	0	0	0	0
Marshall	3182	1	0	0	0	0	1	0	0
McPherson	2551	5	1	1	1	1	1	0	0
Meade	1334	1	0	0	1	0	0	0	0
Miami	7755	6	1	1	4	0	0	0	0
Mitchell	1603	0	0	0	0	0	0	0	0
Montgomery	8762	10	5	2	1	1	0	0	1
Morris	1474	0	0	0	0	0	0	0	0
Morton	966	0	0	0	0	0	0	0	0
Nemaha	2921	0	0	0	0	0	0	0	0
Neosho	4179	2	0	0	2	0	0	0	0
Ness	735	0	0	0	0	0	0	0	0
Norton	1265	0	0	0	0	0	0	0	0
Osage	4362	2	0	0	1	1	0	0	0
Osborne	990	1	0	0	1	0	0	0	0
Ottawa	1538	0	0	0	0	0	0	0	0
Pawnee	1674	2	1	0	0	0	0	0	1
Phillips	1406	4	3	1	0	0	0	0	0
Pottawatomie	5255	3	0	0	3	0	0	0	0
Pratt	2210	2	1	0	0	0	1	0	0
Rawlins	650	0	0	0	0	0	0	0	0
Reno	15,349	16	7	3	5	0	0	1	0
Republic	1220	0	0	0	0	0	0	0	0
Rice	2527	1	0	0	1	0	0	0	0
Riley	11,669	9	4	1	1	1	0	0	2
Rooks	1315	0	0	0	0	0	0	0	0
Rush	760	0	0	0	0	0	0	0	0
Russell	1516	0	0	0	0	0	0	0	0
Saline	13,855	10	5	1	1	3	0	0	0
Scott	1317	0	0	0	0	0	0	0	0
Sedgwick	127,411	119	86	10	7	5	5	3	3
Seward	7181	6	5	0	0	0	0	1	0
Shawnee	42,696	41	16	4	6	4	2	6	3
Sheridan	683	0	0	0	0	0	0	0	0
Sherman	1578	2	0	2	0	0	0	0	0
Smith	910	0	0	0	0	0	0	0	0
Stafford	1195	1	1	0	0	0	0	0	0
Stanton	694	0	0	0	0	0	0	0	0
Stevens	1608	1	0	0	1	0	0	0	0
Sumner	7093	2	0	0	0	1	0	0	1
Thomas	2040	0	0	0	0	0	0	0	0
Trego	735	0	0	0	0	0	0	0	0
Wabaunsee	1723	1	1	0	0	0	0	0	0
Wallace	463	0	0	0	0	0	0	0	0
Washington	1430	2	0	0	1	1	0	0	0
Wichita	701	0	0	0	0	0	0	0	0
Wilson	2539	2	1	0	1	0	0	0	0
Woodson	779	1	0	0	1	0	0	0	0
Wyandotte	44,776	42	23	4	5	3	1	5	1
Out of State*	N/A	16	12	0	1	0	0	3	0
Grand Total	**702,262**	**522**	293	50	84	36	17	23	19

*Out of State is included for those children who were not Kansas residents, but who died in Kansas.
2001 county population data comes from KDHE/CHES. County of Residence data provided by database host, Creative Sociomedics.

Appendix B
Acknowledgments

The review of each child's death in Kansas could not be accomplished without the enormous commitment of many people across the state. The State Child Death Review Board (SCDRB) remains grateful for the significant contributions of county coroners, law enforcement agencies, the Department of Social and Rehabilitation Services (SRS), the Kansas Department of Health and Environment (KDHE), physicians, hospitals, child advocates, county and district attorneys, the Office of Kansas Attorney General Phill Kline, and all others who offer their assistance in supplying the information necessary for our review.

As a multi-disciplinary, multi-agency board we enjoy the support of those by whom we are employed, as they allow us the time necessary to fulfill our responsibilities as board members.

Each board member plays a vital role in the collection and review of sensitive data. The function the SCDRB performs is unique as it is not duplicated by any other agency in Kansas.

The SCDRB would like to acknowledge the significant contributions of former board member Julie Richey. Ms. Richey served faithfully on the SCDRB as the district attorney appointee of the Kansas County and District Attorneys Association. The SCDRB is grateful for her commitment of time, energy, and talent.

Finally, the SCDRB would like to recognize and express its gratitude to the agencies providing the grants that help us continue this important mission. This publication is funded by the Children's Justice Act Grant through Social and Rehabilitative Services. Additional funding for staff was provided by the Kansas Health Foundation, Wichita, Kansas. The Kansas Health Foundation is a philanthropic organization whose mission is to improve the health of all Kansans.

Appendix C
SCDRB Members

Attorney General appointee
Kevin Graham, J.D., Chairperson
Assistant Attorney General, Topeka

Director of Kansas Bureau of Investigation appointee
David Klamm
KBI Senior Special Agent, Wichita

Secretary of Social and Rehabilitation Services appointee
Paula Ellis, MSW
Department of Social and Rehabilitation Services, Topeka

Secretary of Health and Environment appointee
Lorne A. Phillips, Ph.D.
State Registrar, Topeka

Commissioner of Education appointee
Sarah Johnston, M.D.
USD 490 Board of Education, El Dorado
University of Kansas School of Medicine, Wichita

State Board of Healing Arts appointees
Erik K. Mitchell, M.D. (Coroner member)
District Coroner, Topeka

Jaime Oeberst, M.D. (Pathologist member)
Deputy Coroner, Wichita

Katherine J. Melhorn, M.D. (Pediatrician member)
University of Kansas School of Medicine, Wichita

Attorney General appointee to represent advocacy groups
Mary A. McDonald, J.D.
Wichita City Prosecutor's Office, Wichita

Kansas County and District Attorneys Association appointee
Keith Schroeder, J.D.
Reno County Attorney, Hutchinson

Staff		**General Counsel**
Eric Haar	Liz Rogers	Ralph Dezago
Executive Director	Research Specialist	Assistant Attorney General

Interns: Samantha Dravis, Andrew Gallimore, Danielle Small

Appendix D
Methodology

Each month, the KDHE Vital Statistics Office provides the SCDRB with a listing of children whose deaths have been reported in Kansas for the previous month. The SCDRB reviews the deaths of all children (birth through 17 years of age) who are residents of Kansas and die in Kansas, children who are residents of Kansas and die in another state, and nonresident children who die in Kansas. Attached to the listing is a death certificate for each child and a birth certificate, if available.

The SCDRB's executive director must receive a Coroner Report Form before a case can be opened for investigation. The death certificate and coroner's report contain the information necessary to begin a case review. To ensure that each child death in Kansas is being reviewed, these documents serve as a check and balance system.

Once a case is opened, the death and birth certificates, the coroner's report, and the report of death are assessed to identify additional information necessary for a comprehensive review. Any additional information that is needed is then requested from the appropriate agency. Additional information may consist of autopsy reports, law enforcement reports, medical records, SRS records, and records from the State Fire Marshal. In some cases, it is necessary to obtain mental health, school, and other protected records. All information obtained by the SCDRB is confidential.

After all records have been collected, cases are assigned to board members for initial review and assessment. Each member reviews his or her assigned cases and enters case information into an on-line database.

During the SCDRB's monthly meetings, members present their cases orally, and circumstances leading to the deaths are discussed. If additional records are needed, or specific questions are raised, a case may be continued to the next meeting. Otherwise, upon full agreement of the cause and manner of death, cases are closed. In some instances the SCDRB may determine that it is appropriate to refer a case back to the county or district attorney in the county where the death occurred with a recommendation that a follow-up investigation be done based on the SCDRB's findings.

Any questions about this report or about the work of the SCDRB should be directed to Eric Haar, Executive Director, at (785) 296-2215.

Appendix E
Goals and History

The SCDRB has developed the following three goals to direct its work:

1) To describe trends and patterns of child deaths (birth through 17 years of age) in Kansas and to identify risk factors in the population.
2) To improve sources of data and communication among agencies so that recommendations can be made regarding recording of the actual cause of death, investigation of suspicious deaths, and system responses to child deaths. This interagency communication should occur at the individual case level and at the local and state levels.
3) To develop prevention strategies including community education and mobilization; professional training; and needed changes in legislation, public policy, and/or agency practices.

The SCDRB was created by the 1992 Kansas Legislature and is administered by the Office of the Kansas Attorney General. SCDRB membership is appointed according to K.S.A. 22a-241 et. seq. Membership includes: one member each from the Office of the Attorney General, the Kansas Bureau of Investigation (KBI), the Department of Social and Rehabilitation Services (SRS), the Kansas Department of Health and Environment (KDHE), and the Department of Education; three members appointed by the Board of Healing Arts: a district coroner, a pathologist, and a pediatrician; one representative of a child advocacy group appointed by the Attorney General; and one county or district attorney appointed by the Kansas County and District Attorneys Association. No term limit is set on appointments. In 1994, the Legislature amended the statute to enable the SCDRB to appoint an executive director.

This multi-agency, multi-disciplinary volunteer board meets monthly, with no travel or expense reimbursement, to examine circumstances surrounding the deaths of Kansas children (birth through 17 years of age). Members bring a wide variety of experience and perspective on children's health, safety, and maltreatment issues. Because of this combination of expertise, the effectiveness of intervention and prevention is greatly increased.

With assistance from law enforcement agencies, county and district attorneys, SRS, physicians, coroners, and other medical professionals, the SCDRB is given the comprehensive information needed to thoroughly examine circumstances which lead to the deaths of children. By understanding how children are dying, the SCDRB is able to propose ways of reducing the number of preventable deaths.

When the SCDRB began its work, data was compiled on a fiscal year (July 1993 - June 1994) basis. In 1997 the SCDRB changed its review to a calendar year format, beginning with the 1995 study year, to bring its data into conformity with fatality review boards in other states so that future trends and patterns can be compared.

In 1999, the SCDRB added a research analyst to its staff. This position was funded through a grant from the Kansas Health Foundation. The research analyst compiled, analyzed, and reported the statistics accumulated from the work of the SCDRB. Although the funding period for this position elapsed in February, 2003, the KHF's generosity has allowed for a research and data specialist to join the SCDRB as a part-time, temporary staff member.

Appendix F
Resources

American Academy of Child and Adolescent Psychiatry
http://www.aacap.org/web/aacap

American Academy of Pediatrics (AAP)
http://www.aap.org

American Association of Suicidology
www.suicidology.org or call 1-202-237-2280

Centers for Disease Control and Prevention (CDC), National Center for Injury Prevention and Control (NCIPC)
www.cdc.gov/ncipc/ncipchm.htm

The Economic Impact of Motor Vehicle Crashes 2000, U.S. Department of Transportation.

Peter Hart Research Associates, "Americans' Attitudes on Children's Access to Guns: A National Poll for *Common Sense about Kids and Guns*," July 1999.

Fightcrime.org

Insurance Institute for Highway Safety, Highway Loss Data Institute. U.S. Licensing Systems for Young Drivers. 2001.

Kansas Center for Health and Environmental Statistics, Center for Health and Environmental Statistics
http://www.kdhe.state.ks.us/ches

Kansas SAFEKIDS Coalition
http://www.kdhe.state.ks.us/safekids

Kellermann AL, Rivara FP, Rushforth NB et al. Gun ownership as a risk factor for homicide in the home. *New England Journal of Medicine.* 1993;329:1084-1091.

Nathens AB, Jurkovich GJ, Cummings P, Rivara FP, and Maier RV. The Effect of Organized Systems of Trauma Care on Motor Vehicle Crash Mortality. JAMA. 2000;283:1990-1994.

National Highway Transportation Safety Administration (NHTSA)
http://www.nhtsa.dot.gov

National Institute of Child Health and Human Development (NICHD)
http://www.nih.gov

National Institute of Mental Health (NIMH)
www.nimh.nih.gov

National SAFEKIDS Campaign
http://www.safekids.org

Appendix F
Resources

National Suicide Prevention Strategy
www.sg.gov/library/calltoaction/strategymain.htm

NCHS National Vital Statistics System for numbers of deaths, U.S. Bureau of Census for population estimates. Statistics compiled using WISQARS™ produced by the Office of Statistics and Programming, NCIPC, CDC.

Substance Abuse and Mental Health Administration (SAMHSA)
www.samhsa.gov

U.S. Consumer Product Safety Commission (CPSC)
http://www.cpsc.gov/

United States Census Bureau
www.census.gov

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Kansas Child Death Review Board 2001 Data