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Kansas Attorney General
Stephen N. Six

Kansas Child Death Review Board

2007 Annual Report
(2005 Data)

WWW.KSAG.ORG

Attorney General Stephen N. Six

October 2007

Dear Friends:

There are few things more tragic than the death of a child. It affects families, as well as communities. To learn more about these tragedies and to try to prevent them, the Kansas Legislature established the Child Death Review Board in 1992.

The state of Kansas is fortunate to have a dedicated, volunteer board of professionals that reviews child fatalities and identifies risk factors and trends. Through additional research and information collected annually by the board, Kansas can develop strategies to help reduce instances of child death.

This year's report comprehensively evaluates the data collected during 2005 and highlights the board's findings for the twelve year period the board has been functioning. This report presents the board's recommendations and recognizes the most important issues and risks facing our children's health and safety.

Through the board's work, I believe we can learn more about protecting our children and reducing the dangers they face.

Sincerely,

Stephen N. Six
Kansas Attorney General

Board 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
SRS Assistant Director of Child Welfare, Topeka

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

Commissioner of Education appointee
Sarah Johnston, M.D.
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)
Department of Pediatrics
University of Kansas School of Medicine, Wichita

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

Kansas County and District Attorneys Association appointee
Kim Parker, J.D.
Sedgwick County District Attorney's Office, Wichita

Staff
Angela Nordhus
Executive Director

Staff
Mary Kennedy
Research Assistant

General Counsel
Rebecca Rand, JD
Assistant Attorney General

Acknowledgments

The review of each child death in Kansas could not be accomplished without the invaluable commitment of many people across the State. The Kansas State Child Death Review Board (SCDRB) remains grateful for the significant contributions of the Office of Attorney General, 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, 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 our employers who allow us the time necessary to fulfill our responsibilities as board members.

Finally, the SCDRB would like to recognize and express its gratitude to the Department of Social and Rehabilitative Services for providing us with the Children's Justice Act Grant, which funds the board, as well as the publication of this report.

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I. Executive Summary

The State Child Death Review Board (SCDRB) was created in 1992 as a multi-disciplinary agency panel to review child deaths in Kansas. The SCDRB has the statutory obligation to review the death of every child that is a Kansas resident or dies in the State of Kansas. This review process is not duplicated by any other state entity.

The Board has reviewed 5,983 child deaths since their inception, and categorizes the deaths into six categories: Natural-Except Sudden Infant Death Syndrome (SIDS); Unintentional Injury; Natural-SIDS; Homicide; Suicide; and Undetermined. As in the past, Natural death is the largest category, with children under one-year-of-age making up the majority of those deaths. The enclosed report contains data from calendar year 2005.

Kansas lost 499 children in 2005, a slight increase from previous years. As expected, 2005 trends are consistent with previous year data, particularly in relation to the Unintentional Injury - Motor Vehicle Crash (MVC) category. Cumulative data collected from 1994 to current year, show a uniform pattern of risk factors and trends, specifically with regard to inexperience/inattentive teen drivers. The most represented age group in MVC deaths was 15-17 year-olds. As in every year since the inception of the SCDRB, the majority of children dying in motor vehicle accidents were not properly restrained or using appropriate safety restraints.

In 2005, there were 18 Undetermined deaths. Often the Undetermined classification is the result of a lack of thorough, comprehensive investigations and/or autopsies, leaving the Board with inadequate information upon which to make a determination of cause or manner of death. This highlights the Board's recommendation for all entities involved in child deaths to perform thorough and complete death investigations.

In the policy recommendations this year, the Board is again focusing on MVC related incidents. These fatalities have some of the most easily implemented prevention policies. The Board strongly encourages the members of the State Legislature to consider the safety of their young constituents and implement a graduated driver's license law, in addition to placing restrictions on unattended children in vehicles and ATV use.

II. 2005 Overview

Kansas' 2005 population estimate is 2,688,418 with 28% of the population being under the age of 18.[5] In 2005, Kansas experienced a loss of 499 children, which breaks down to ***1.4 Kansas children losing their life daily***.

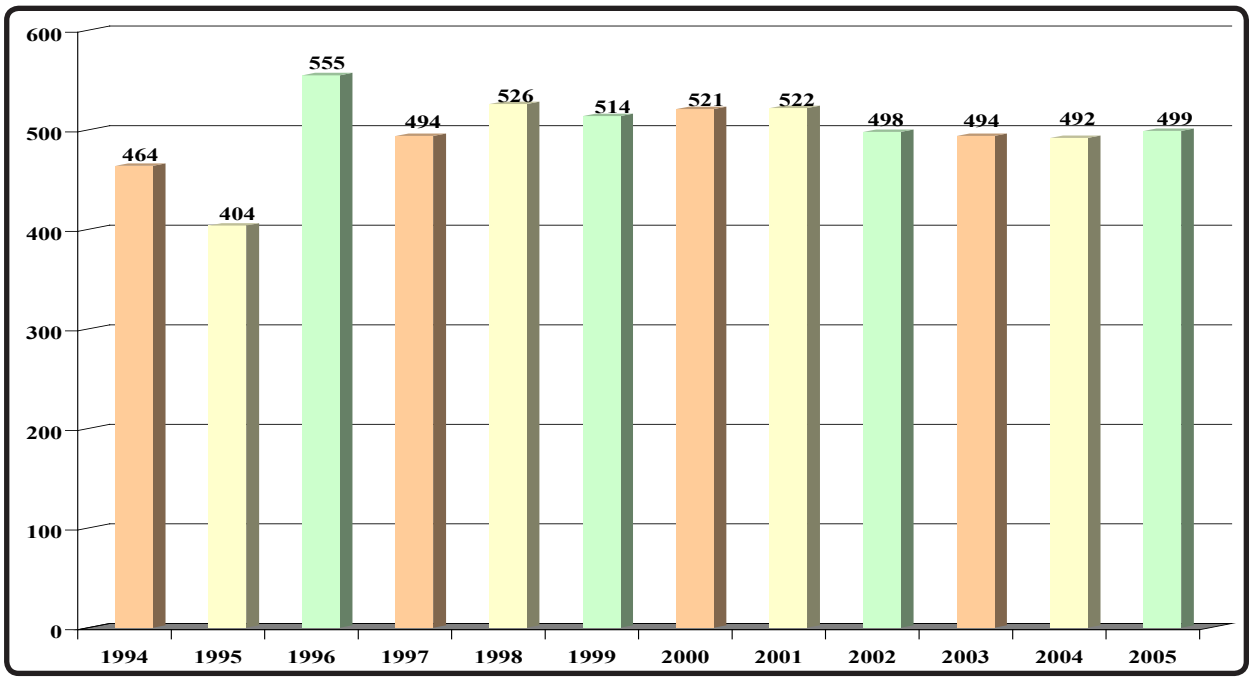
Every child death is classified in one of the six categories listed below. The most prevalent category for child death is Natural Deaths, followed by the second largest category, Unintentional Injury. Despite the SCDRB receiving improved and more complete information, associated prevention policies and strategies have not been adequately implemented to create a significant drop in the number of yearly fatalities. Unlike Natural and SIDS deaths, which generally rely on medical advances more than policy change for prevention, Unintentional Injury deaths have some easily identifiable and simple prevention points. These will be addressed in the Board's recommendations at the end of the report.

The Board classifies the manner of death into 6 categories:

- **Natural-Except Sudden Infant Death Syndrome (SIDS) -** death brought about by natural causes such as disease, congenital conditions and prematurity.
- **Unintentional Injury** - death caused by incidents such as motor vehicle crashes, drowning, or fire, which were not intentionally caused.
- **Natural-SIDS** - children who die prior to age one, and display no discoverable cause of death. Kansas statute requires that an investigation and an autopsy be performed before this classification can be applied.
- **Undetermined** - cases in which the manner of death could not be positively identified from the evidence collected.
- **Homicide** – death due to the intentional or unintentional injury or criminally negligent killing of another human being; including Child Abuse Homicide and Gang-Related Homicide.
- **Suicide –** death due to the intentional taking of one's own life.

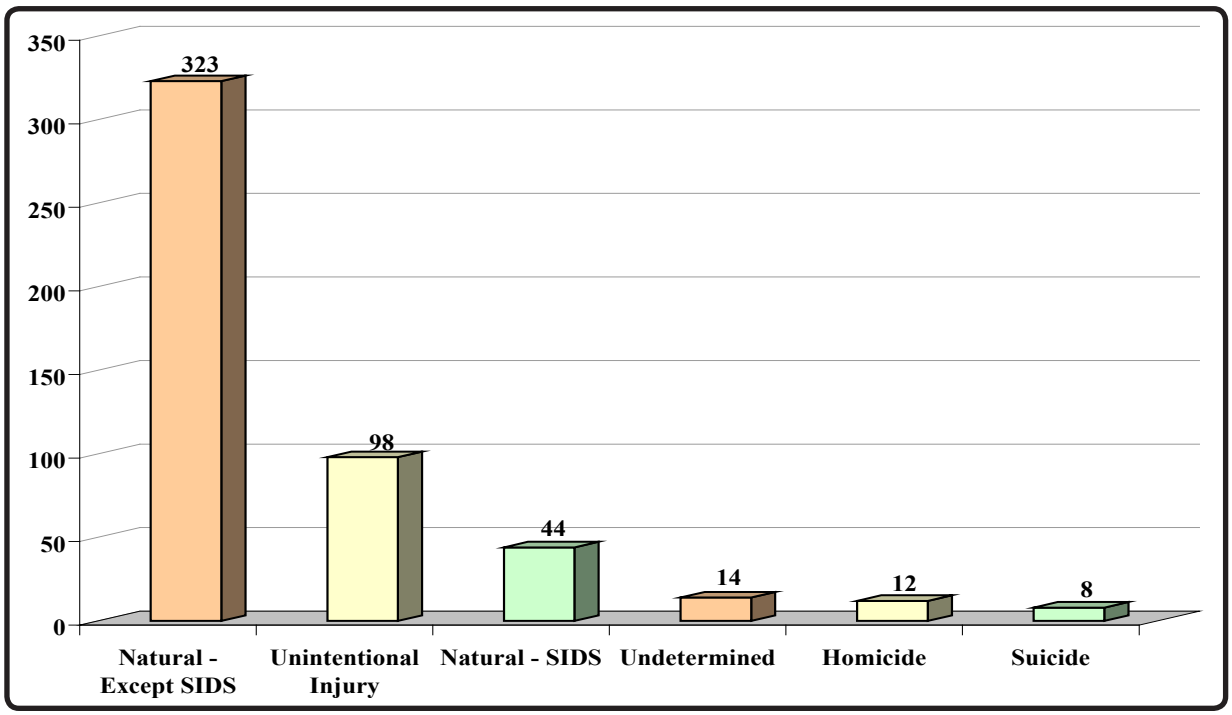
The following graphs compare 2005 with the total number of deaths, 1994 through 2005.

Total Deaths in Kansas, 1994 to 2005, N = 5,983



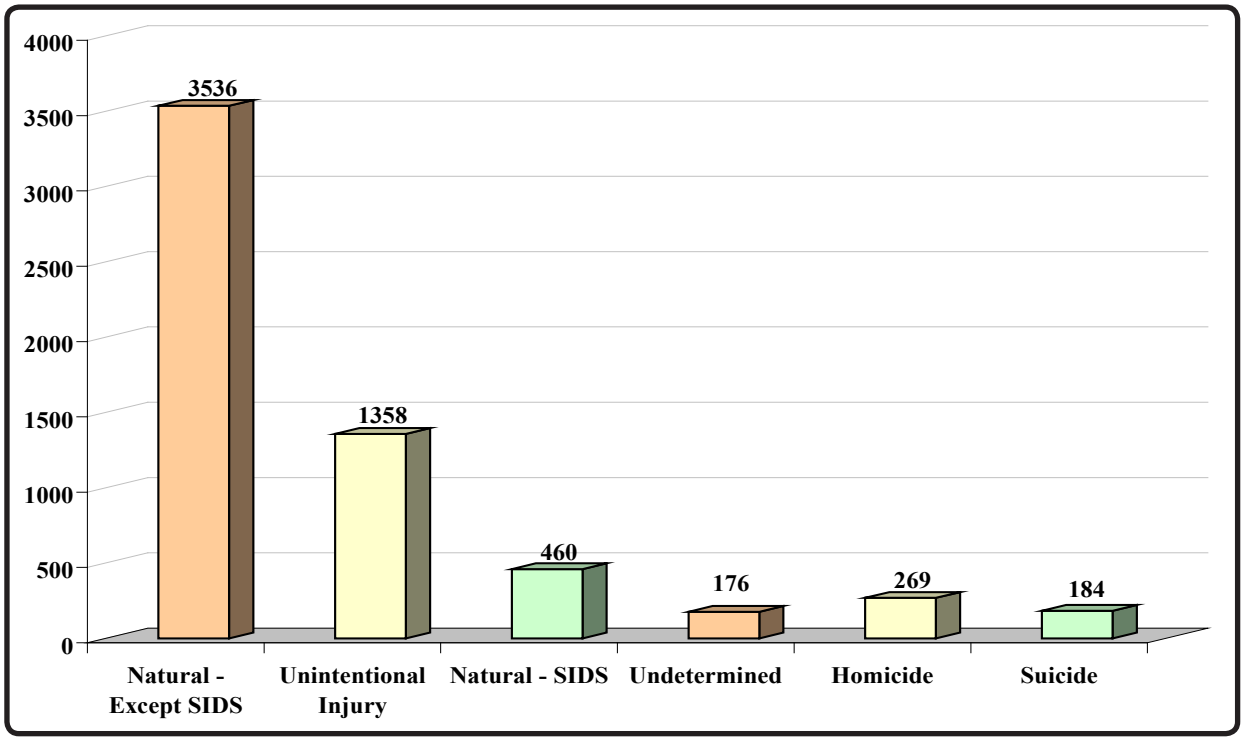
II. 2005 Overview

Analysis by Manner of Death in 2005, N = 499



The manner of death has remained consistent since the Board began reviewing cases. The majority of child deaths fall into the Natural category. There was, however, a decrease in both the number of Homicide and Suicide cases in 2005.

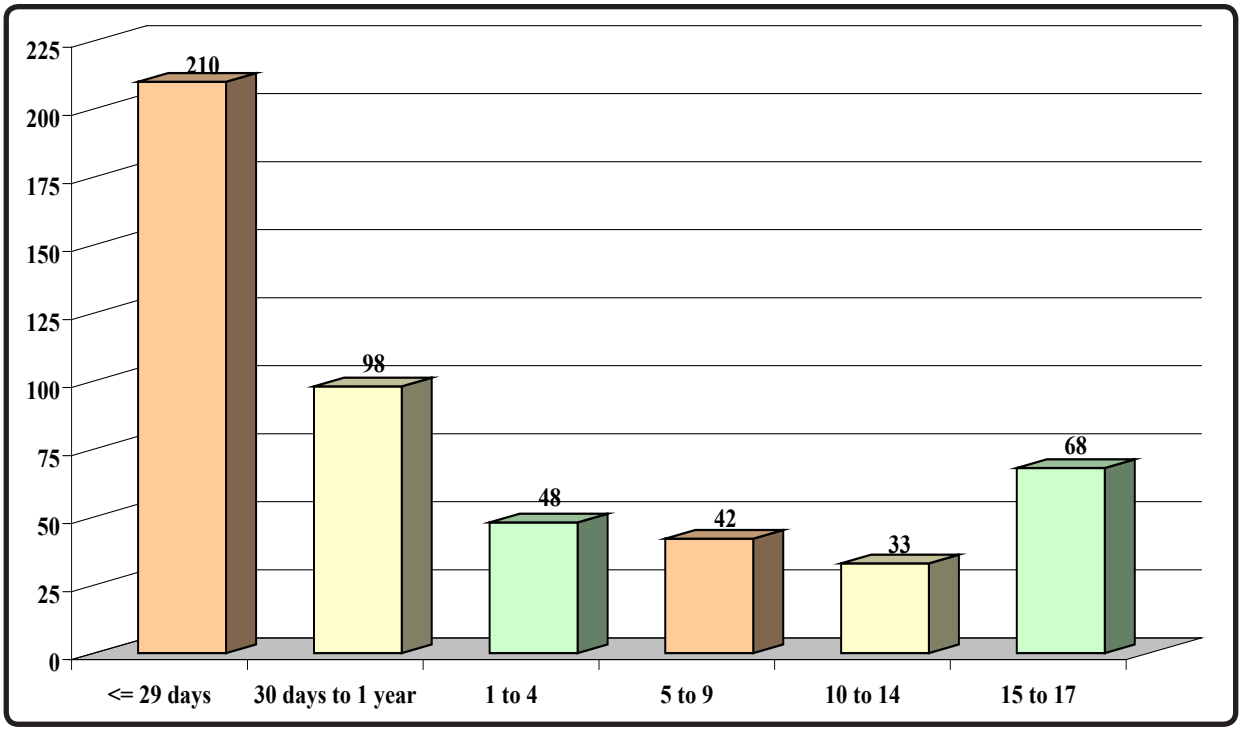
Analysis by Manner of Death, 1994 to 2005, N = 5,983



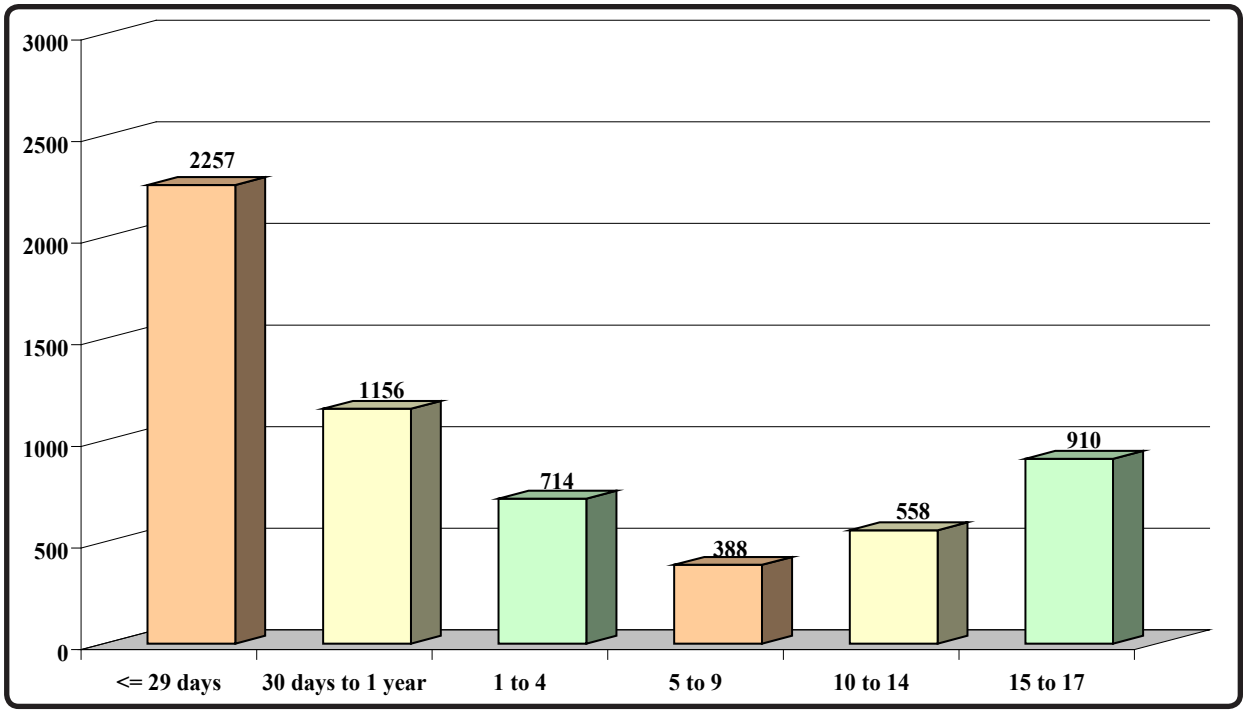
II. 2005 Overview

Again, the pattern of the total deaths by age in 2005 follows the same general distribution of the cumulative data.

Analysis by Age in 2005, N = 499



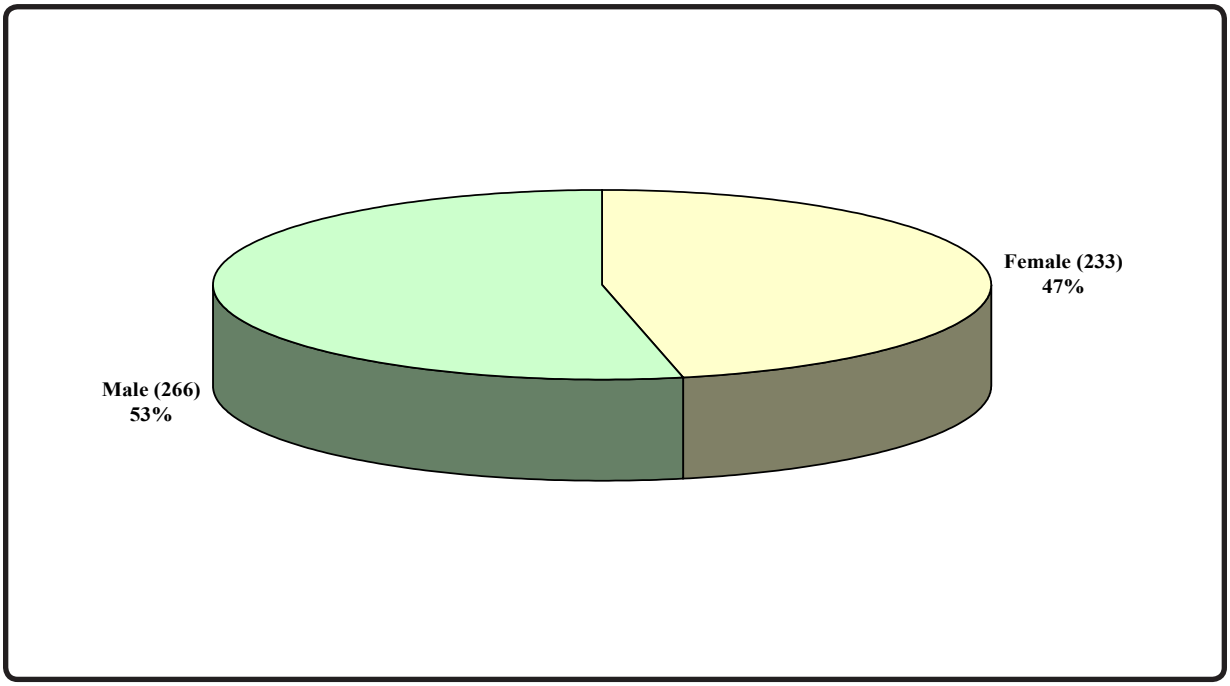
Analysis by Age, 1994 to 2005, N = 5,983



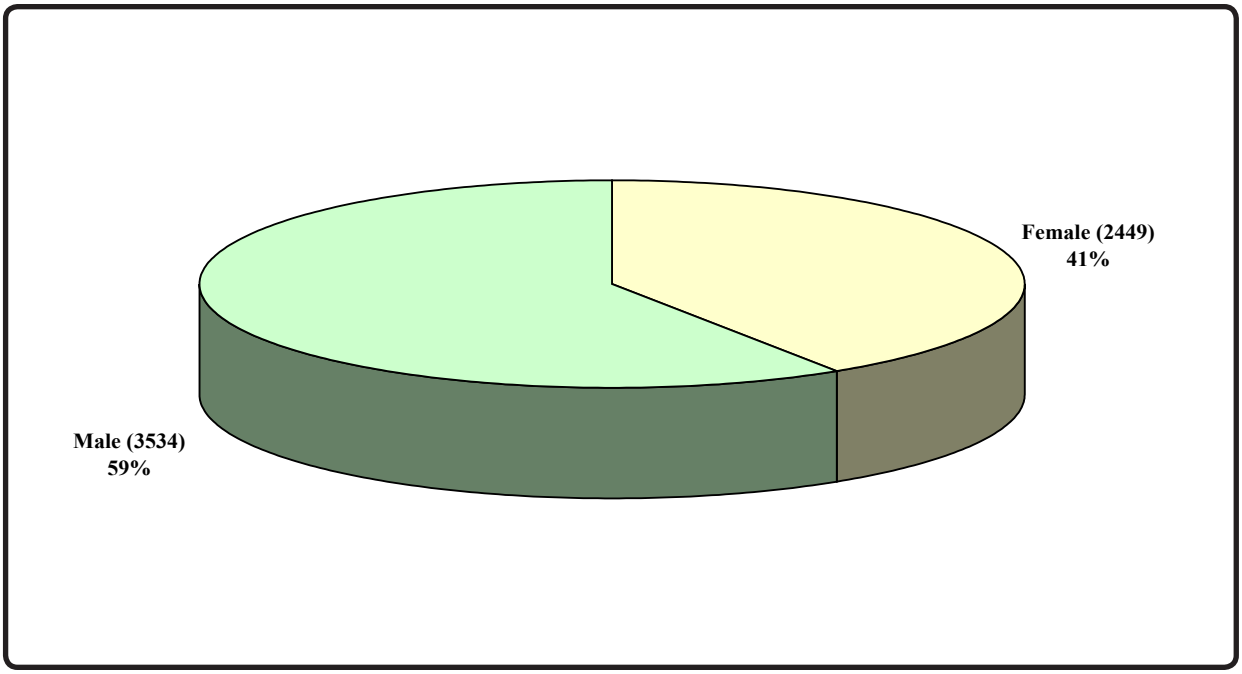
II. 2005 Overview

According to the U.S. Census Bureau, there are approximately 1% more females living in Kansas than males. However, 2005 followed the tradition of males dominating the representation in the total number of deaths.

Analysis by Gender in 2005, N = 499



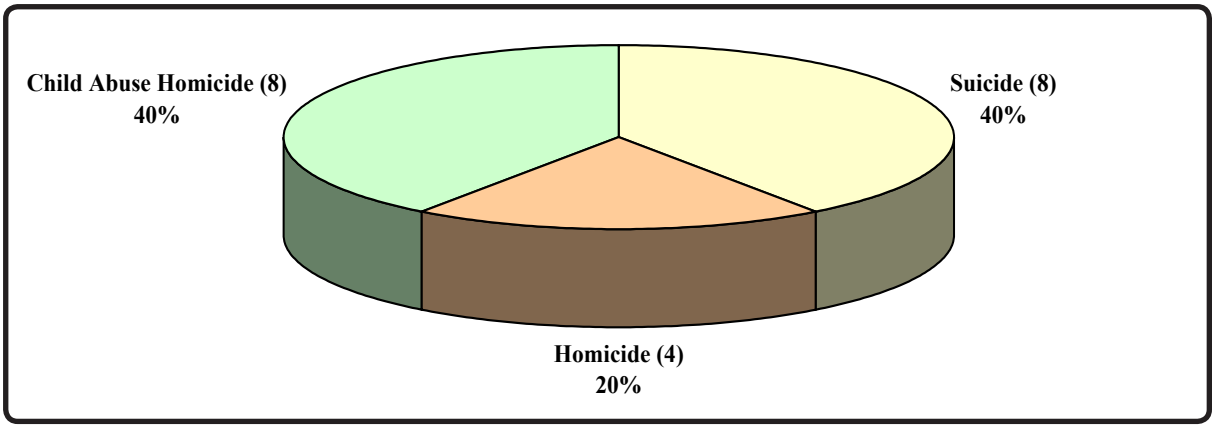
Analysis by Gender, 1994 to 2005, N = 5,983



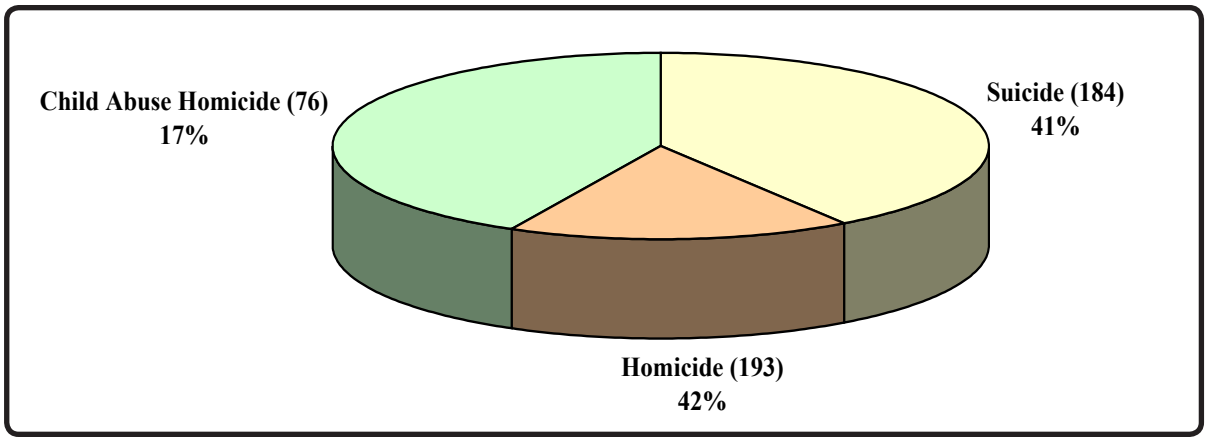
A. Violence-Related Deaths

Violence-related deaths include Homicide, Child Abuse Homicide, Gang-Related Homicide, and Suicide. Kansas experienced 20 Violence-Related Deaths in 2005. Although they represent a small number of the total deaths, they are the most alarming, and usually contain elements of preventability. As the graphs indicate, there was a slight increase in child-abuse homicides and a drop in suicides.

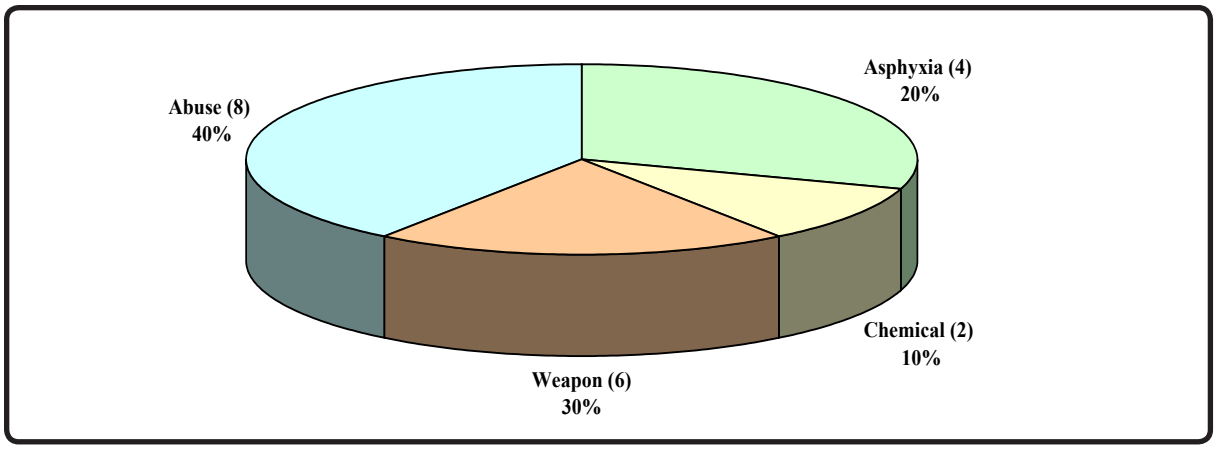
Violence-Related Deaths by Type in 2005, N = 20



Total Violence-Related Deaths by Type, 1994 to 2005, N = 453



Violence-Related Deaths by Method in 2005, N = 20

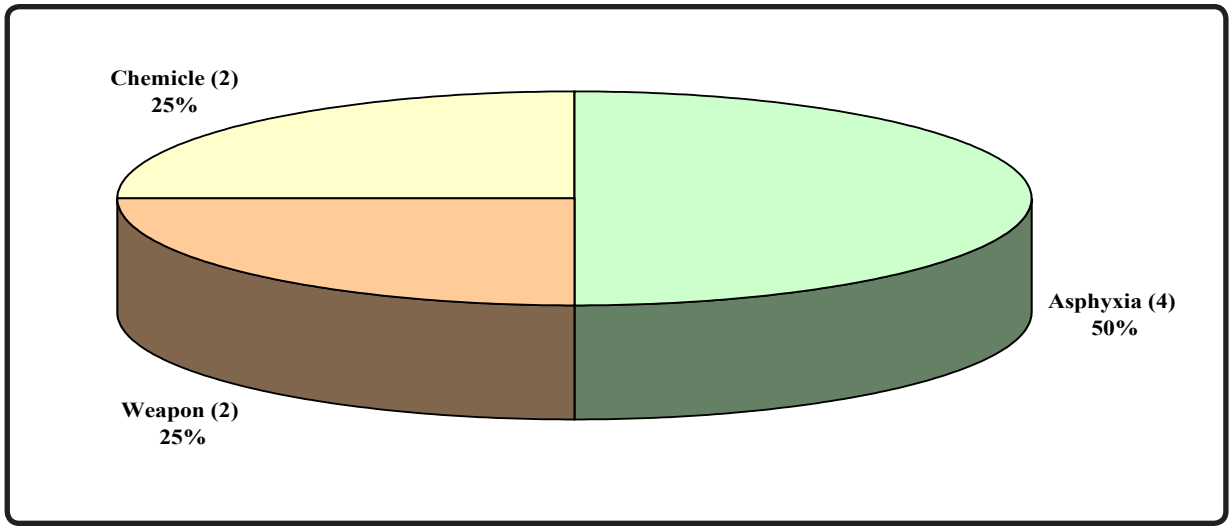


1. Suicide

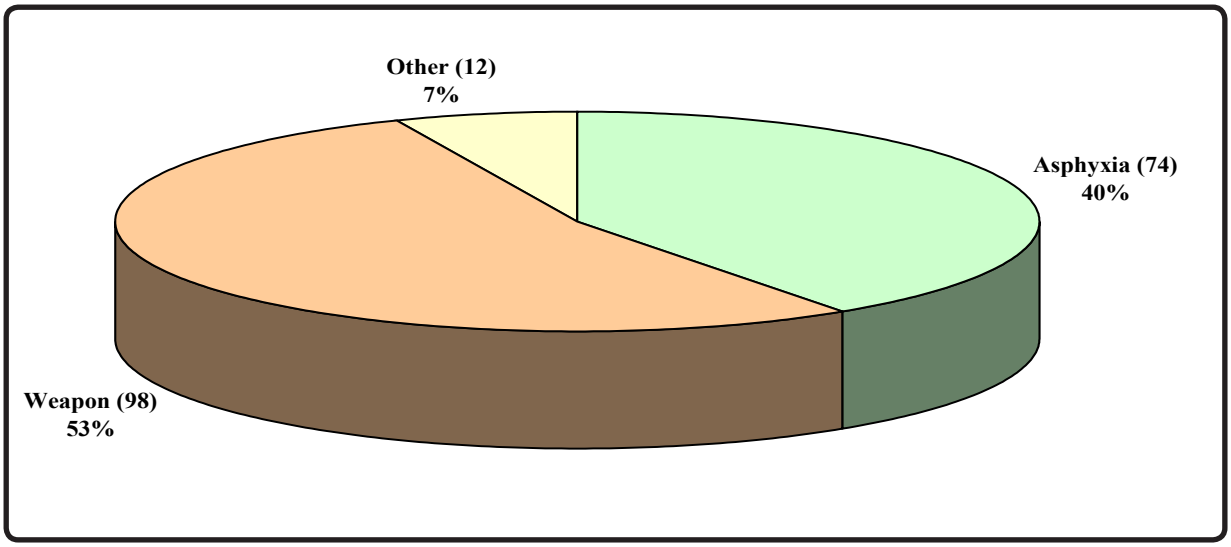
Nationally, suicide is the third leading cause of death for individuals ages 15 through 24.[1] In Kansas suicide routinely takes the lives of 10 to 25 children per year. In 2005, however, the suicide rate slightly decreased showing a total of 8 suicide cases.

Suicide is a sensitive issue that is devastating and confusing to the family and community. Although some suicide deaths are unpredictable, the Board often finds evidence that the child revealed suicidal ideation by subtle but detectable means. While it can be a painful process, thorough investigations of suicides are necessary to develop as much information as possible in hopes of developing effective prevention strategies. Often the Board reviews suicide deaths and discovers the family has not been thoroughly interviewed, or autopsies have not been performed in a manner which would provide a complete evaluation of the youth's situation and health at the time of death. The desire of families and communities to put such tragedies behind them is understandable. Unfortunately, improper investigation and autopsy exams can hinder efforts to prevent further deaths of Kansas children.

Suicide Deaths by Method in 2005, N = 8



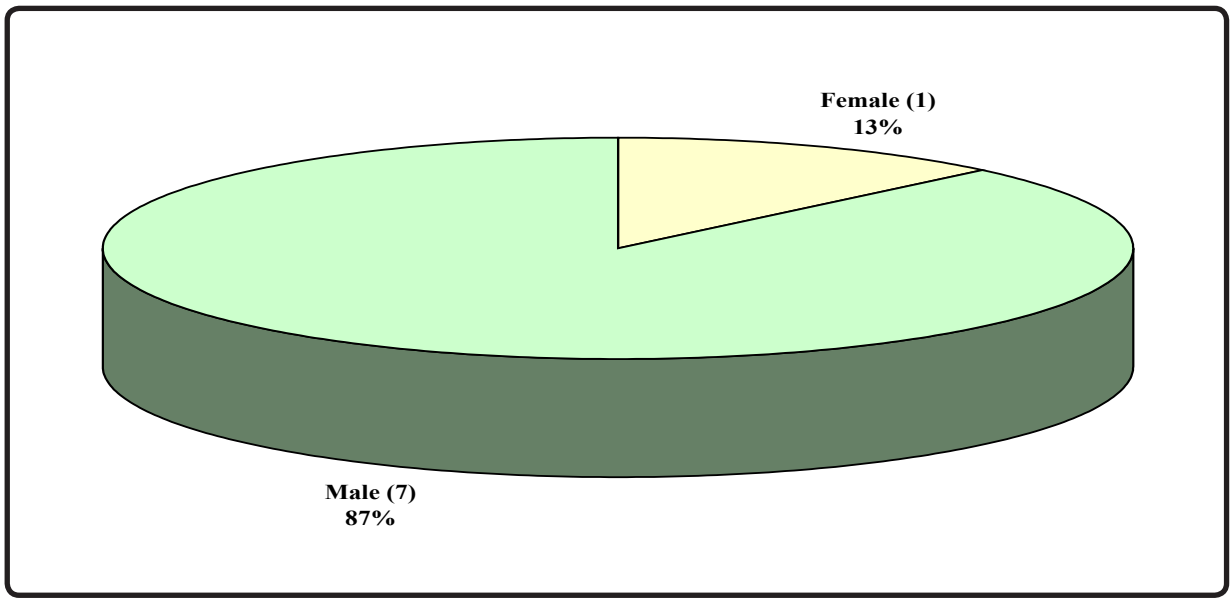
Total Suicide Deaths by Method, 1994 to 2005, N = 184



1. Suicide

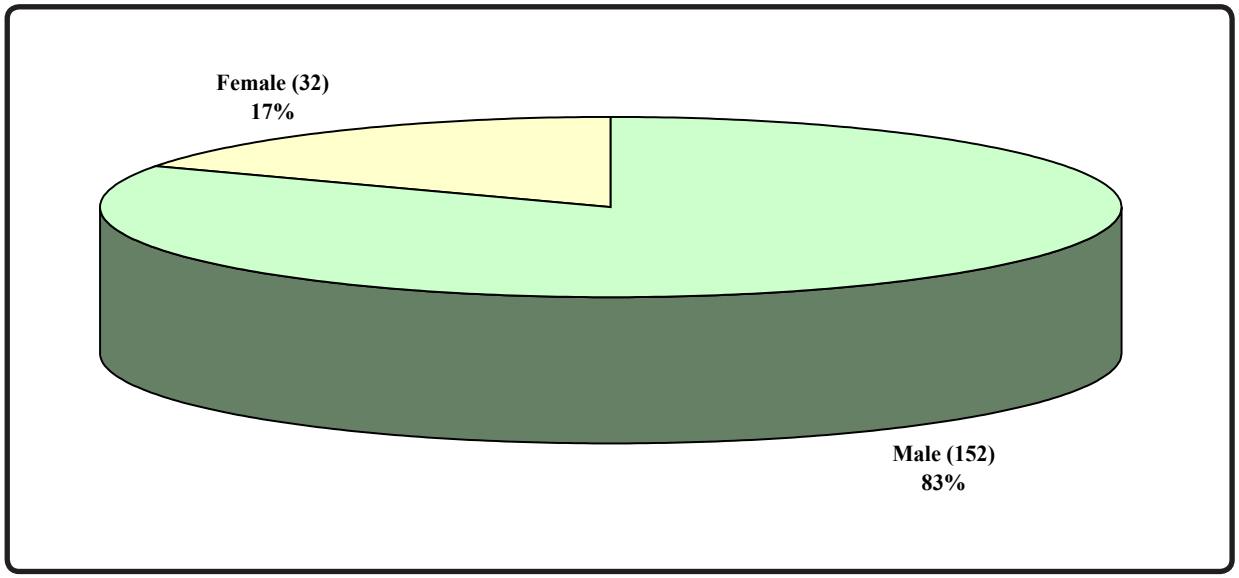
Kansas has begun to follow National suicide trends and is seeing an increase in asphyxial deaths rather than deaths by a weapon. Typically the Board sees 15 to 17-year-old males committing the majority of suicide deaths. 2005 continued this trend. Males were represented in 99% of the total 8 suicide cases, and 7 of the 8 fell into the 15 to 17-year-old age group.

Suicide Deaths by Gender in 2005, N = 8



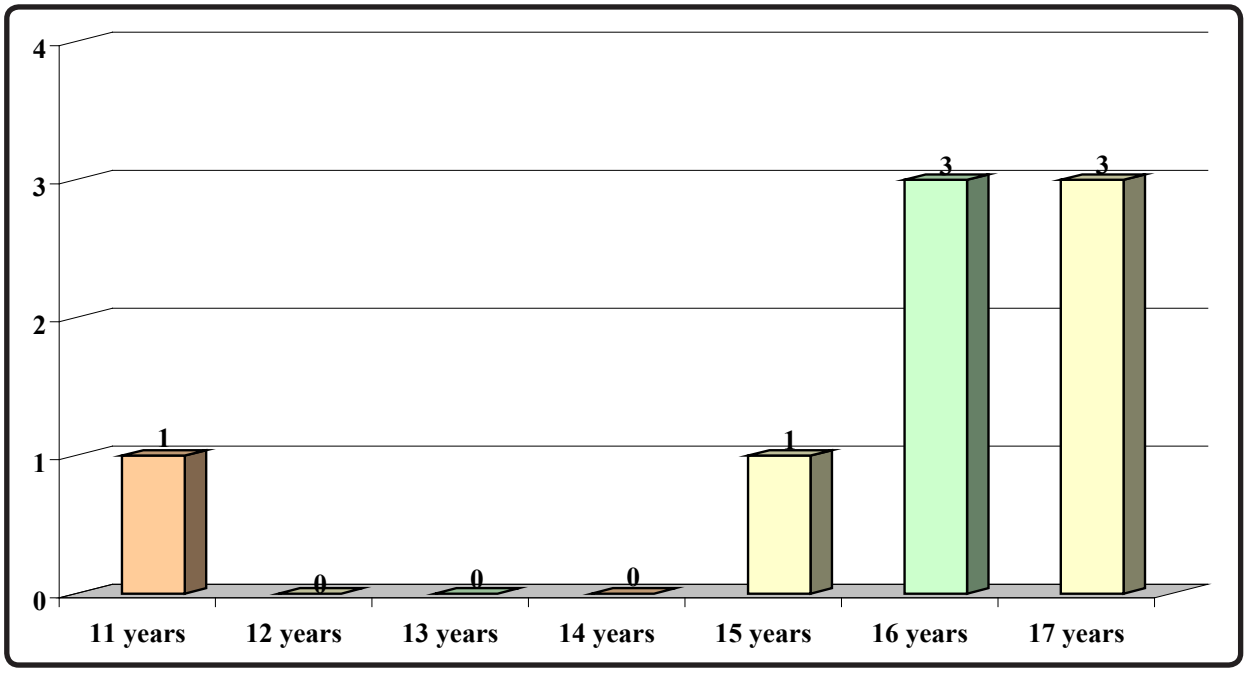
A 17-year-old male began to fail in school. He told several friends he was thinking about running away or killing himself. Prevention efforts were not addressed. The teenager was found with a self-inflicted gunshot wound to the head.

Total Suicide Deaths by Gender, 1994 to 2005, N = 184



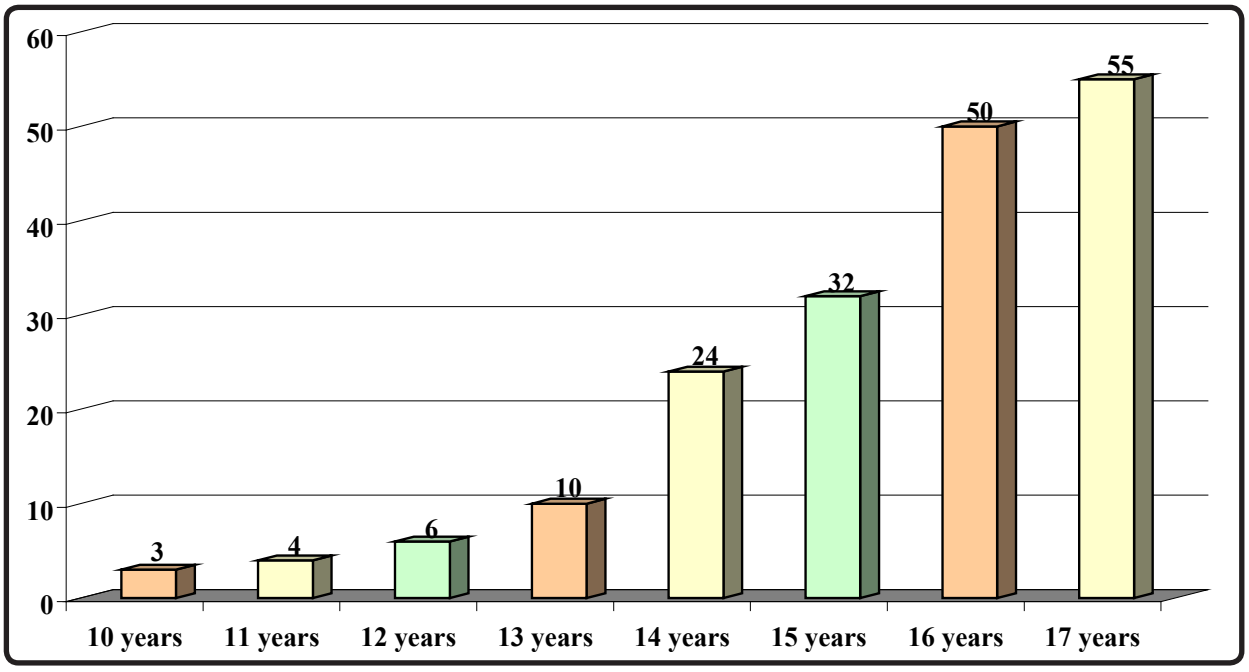
1. Suicide

Suicide Deaths by Age in 2005, N = 8



Discontented over recent changes in his life, an 11-year-old boy hanged himself. At the time of his suicide, he was taking medicine for ADHD, which has been suspected of increasing depression in youths.

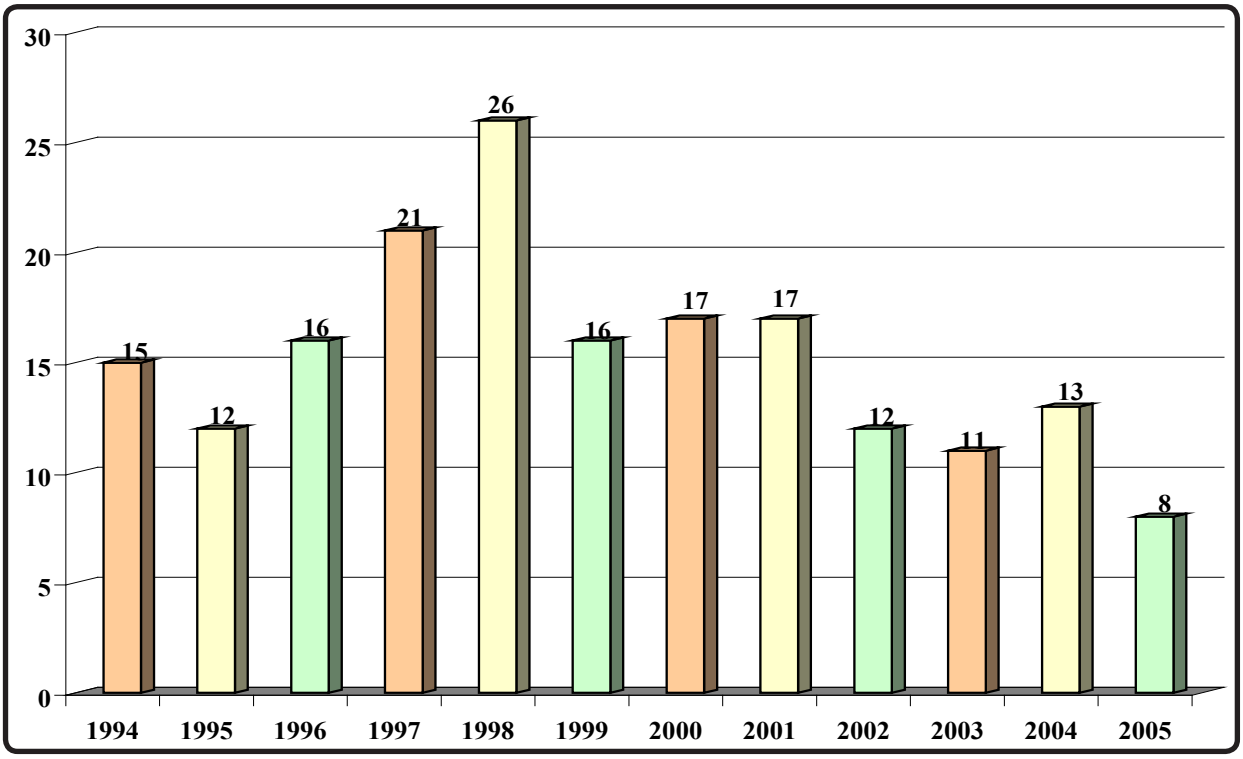
Total Suicide Deaths by Age, 1994 to 2005, N = 184



1. Suicide

In 2005, there were 8 suicides, which is a significant drop in the number of cases from the typical figure of 12-17 per year.

Total Suicide Deaths by Year, 1994 to 2005, N = 184



PREVENTION POINTS

- **Early Diagnosis and Treatment of Mental Conditions** - Early involvement of mental health professionals, may prevent suicide attempts.
- **Observation of Behaviors** – Watch for changes in one's psychological state (increase in rage, anxiety, depression, or hopelessness); withdrawal; acting recklessly; or engaging in substance abuse.
- **Evaluation of Suicidal Thinking** - Do not ignore statements about suicide, even if they seem casual or joking. The months following a suicide attempt or severe depression can be a time of increased risk, no matter how well the child seems to be doing. This is a critical time for family interaction.
- **Limit Access to Lethal Agents** - Easily obtained or improperly secured firearms or medications are often used in suicides. The harder it is for a child to put their hands on these items, the more likely they are to rethink their intentions allowing time for someone to intervene.
- **Talk About the Issue** - Bringing up suicide does not "give kids the idea", but rather gives them the opportunity to discuss their thoughts and concerns. This communication can act as a significant deterrent.

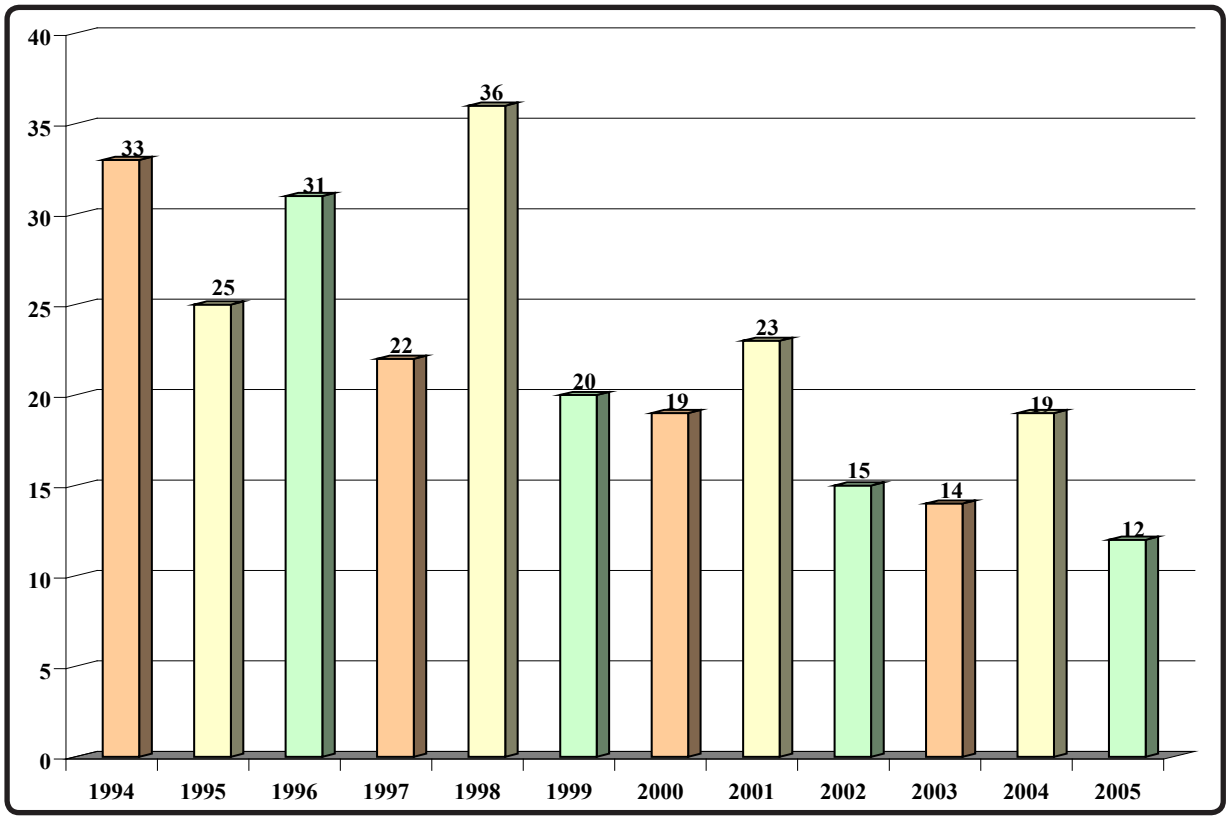
2. Homicide

Homicide is defined as the death of one person resulting from the intentional or unintentional actions of another person. In 2005, the Board reviewed 12 homicides, which included Child-Abuse Homicide and Gang-Related Homicide. All 12 homicides were considered preventable.

The biological father of a 5-month-old was convicted of first degree murder for causing the abusive death of his daughter. Intervention from prior concerns of abuse may have prevented this tragedy.

The Board defines Child-Abuse Homicide as children killed as the result of abuse from caretakers (inflicting injury with malicious intent, usually as a form of discipline or punishment) or neglect (failing to provide shelter, safety, supervision, and nutritional needs). Board member Dr. Sarah Johnston identifies several child abuse risk factors and prevention points: "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 early childhood programs which include parent training."

Total Homicide Deaths by Year, 1994 to 2005, N = 269

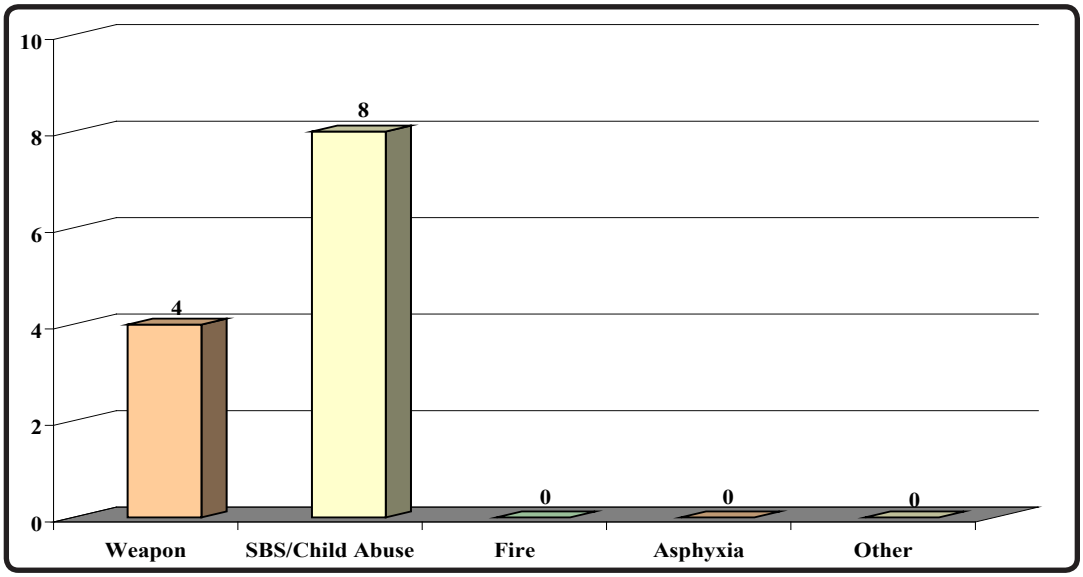


2. Homicide

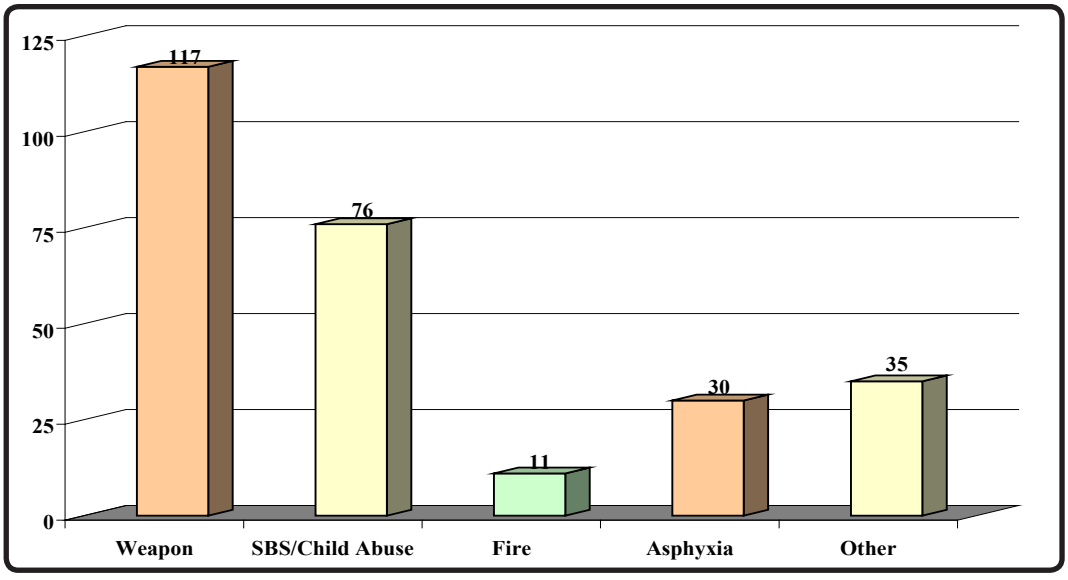
A frustrated parent caused the death of their infant by shaking the baby when it would not stop crying.

Of the 12 homicides in 2005, 8 of them were Child-Abuse Homicides. Of those 8 deaths, 3 were the result of Shaken Baby Syndrome (SBS). SBS takes place when an infant or toddler is severely or violently shaken resulting in serious injury and/or death. Infants have relatively weak neck muscles and do not yet have full support for their heavy heads. When they are shaken, their fragile brains move back and forth within their skulls. Often the blood vessels cannot tolerate the impact of the extensive shaking. The vessels break, causing internal bleeding. It can also cause serious injuries such as blindness or eye damage, delay in normal development, seizures, damage to the spinal cord (paralysis), brain damage or death. It is important to note that it is common for children that have been shaken to have no external evidence of trauma.

Homicide Deaths by Method in 2005, N = 12



33% of the total 2005 homicides involved weapons, all of which were firearms. Other methods of homicide that have been documented since 1994 include blunt trauma injuries, asphyxia, and fire.

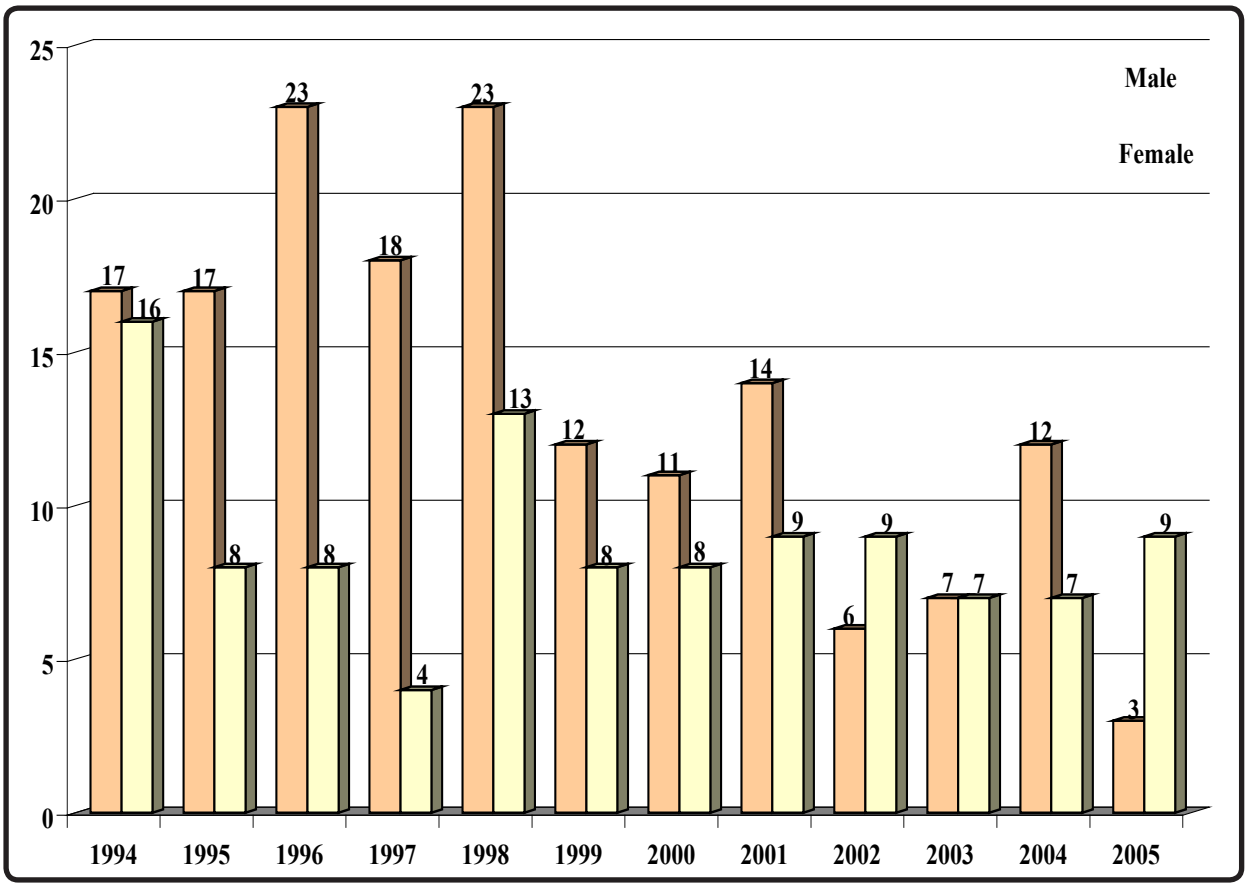


Total Homicide Deaths by Method, 1994 to 2005, N = 269

2. Homicide

On average, males have made up the majority of homicide deaths. However, in 2005 female deaths exceeded male deaths.

Homicide Deaths by Gender, 1994 to 2005, N = 269



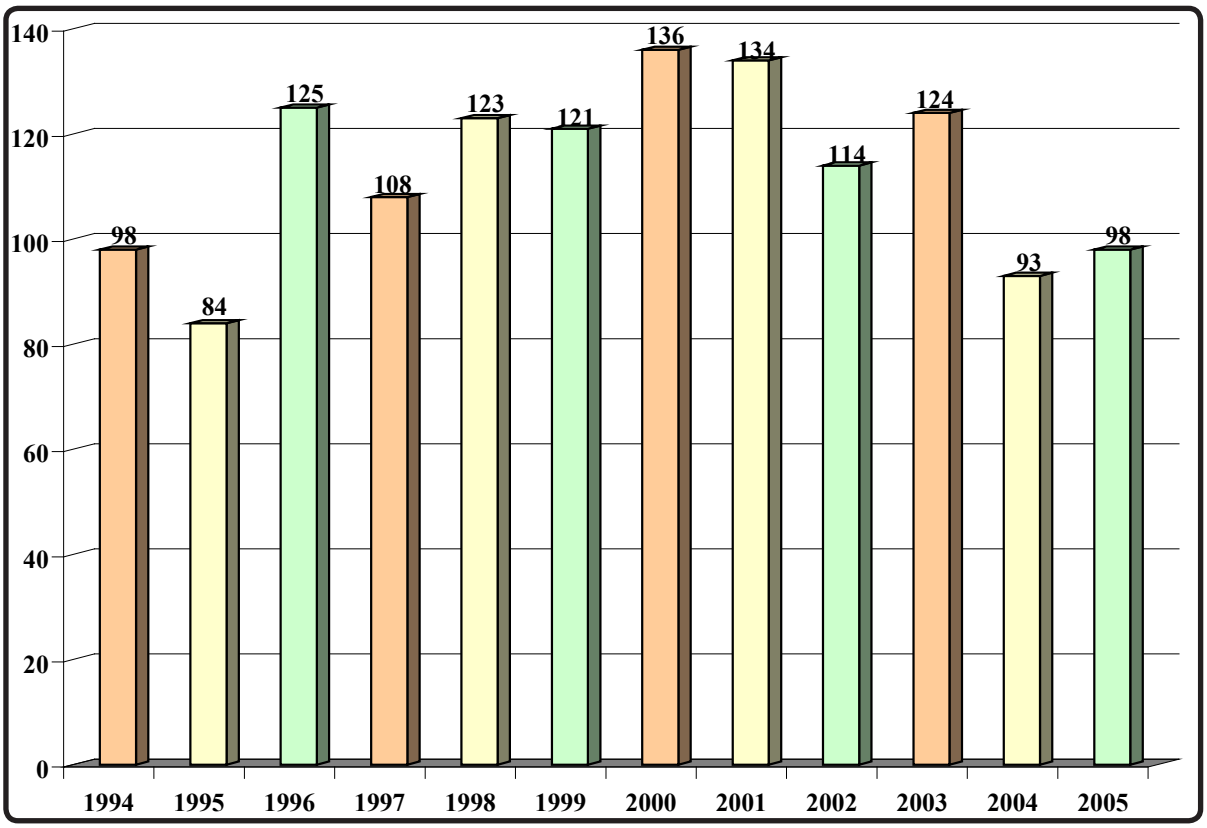
PREVENTION POINTS

- **Family Violence -** Most homicides occur between family members, friends, and neighbors. Many of the incidents the Board encounters are not cold, calculated acts. More often, they are emotionally driven acts that could be avoided if restraint of uncontrolled emotions was exercised.
- **Take Extra Care with Young Children -** Young children are often the victims of child abuse homicide. Frustrated caregivers, often without any parental training, combine unrealistic expectations for children's behavior with a lack of appreciation for their vulnerability. Abusive head trauma is an example of how an impact or violently shaking a baby can cause serious or fatal trauma to the child's brain. Caregivers should be mindful of a child's capabilities and susceptibility.

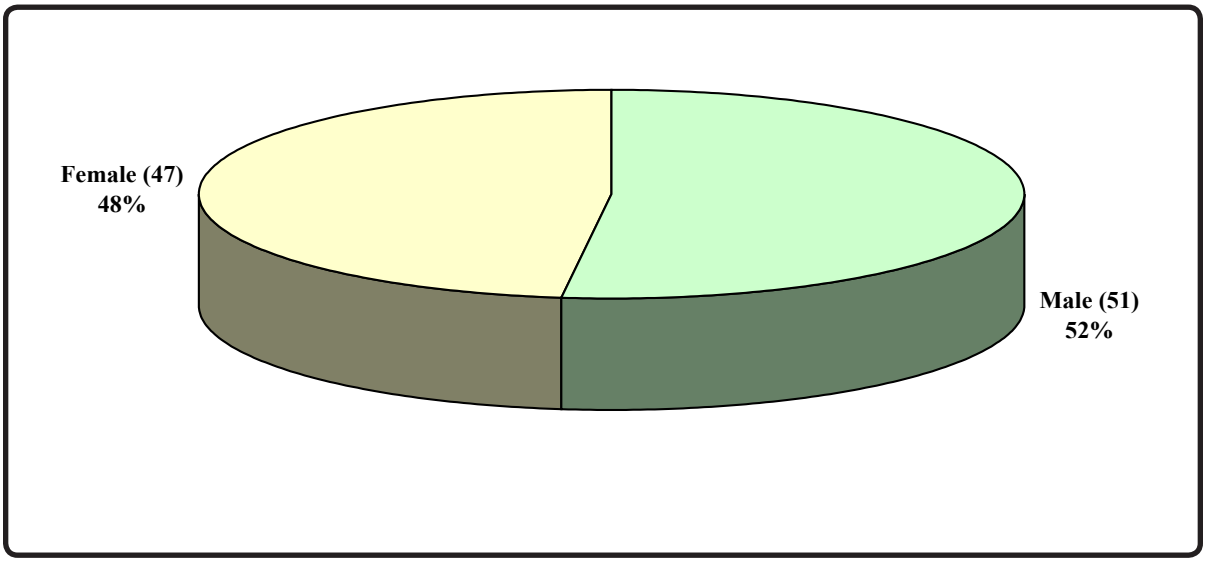
B. Unintentional Injury

Unintentional Injury deaths are consistently the second largest category of death and are often the most preventable. Corresponding with national trends, motor vehicle crashes (MVC) continue to make up a significant number of unintentional injury deaths in Kansas, with 15 to17-year-olds maintaining the tradition of being the most represented age group.

Total Unintentional Deaths, 1994 to 2005, N = 1,358

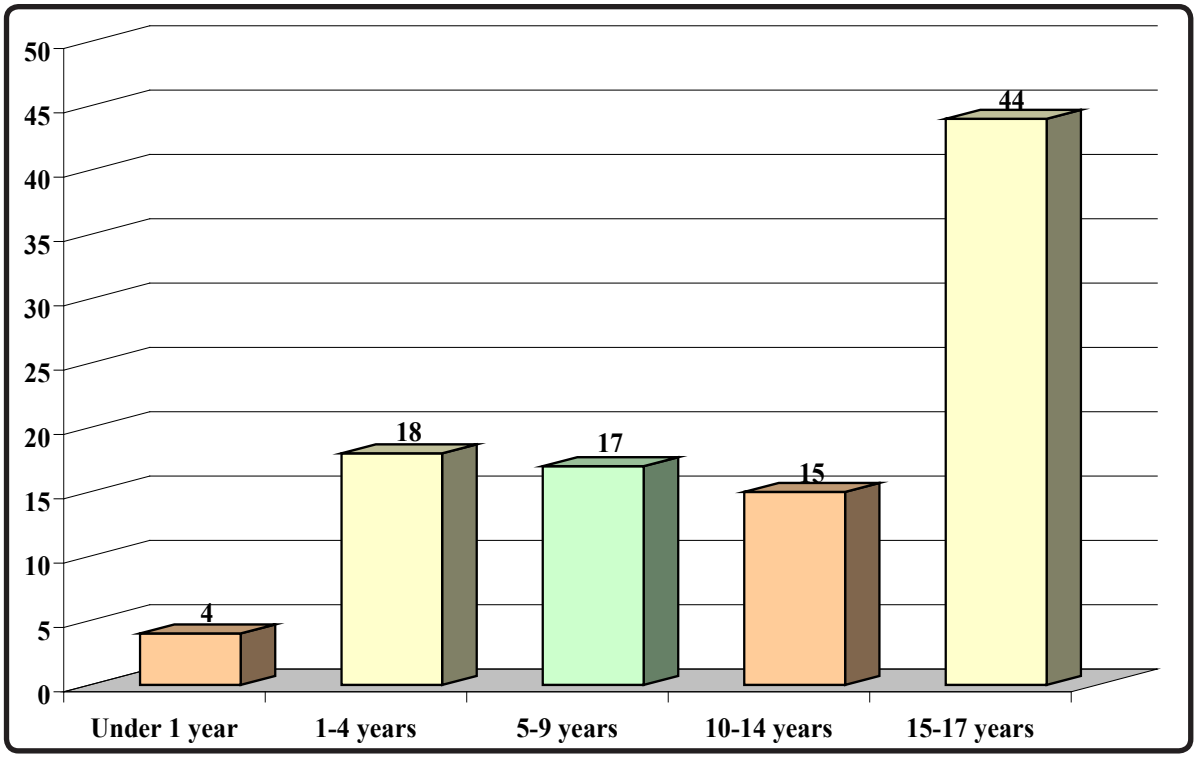


Unintentional Deaths by Gender in 2005, N = 98

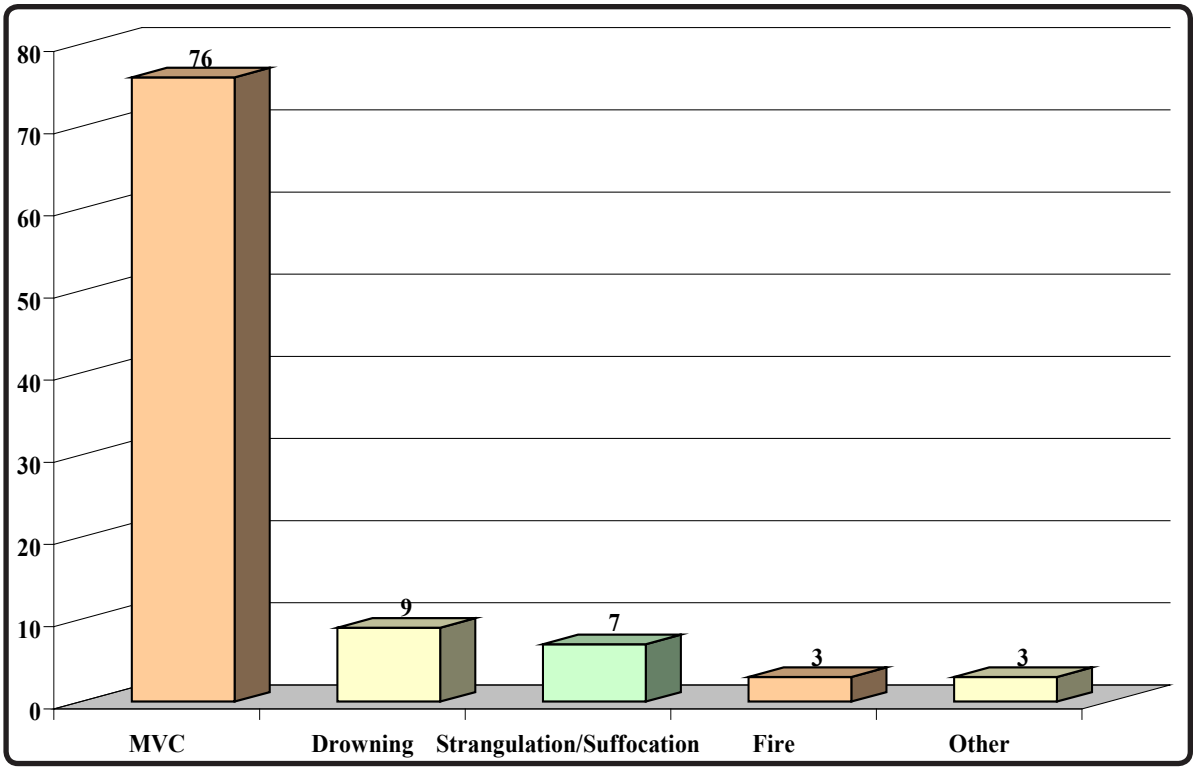


B. Unintentional Injury

Unintentional Deaths by Age in 2005, N = 98



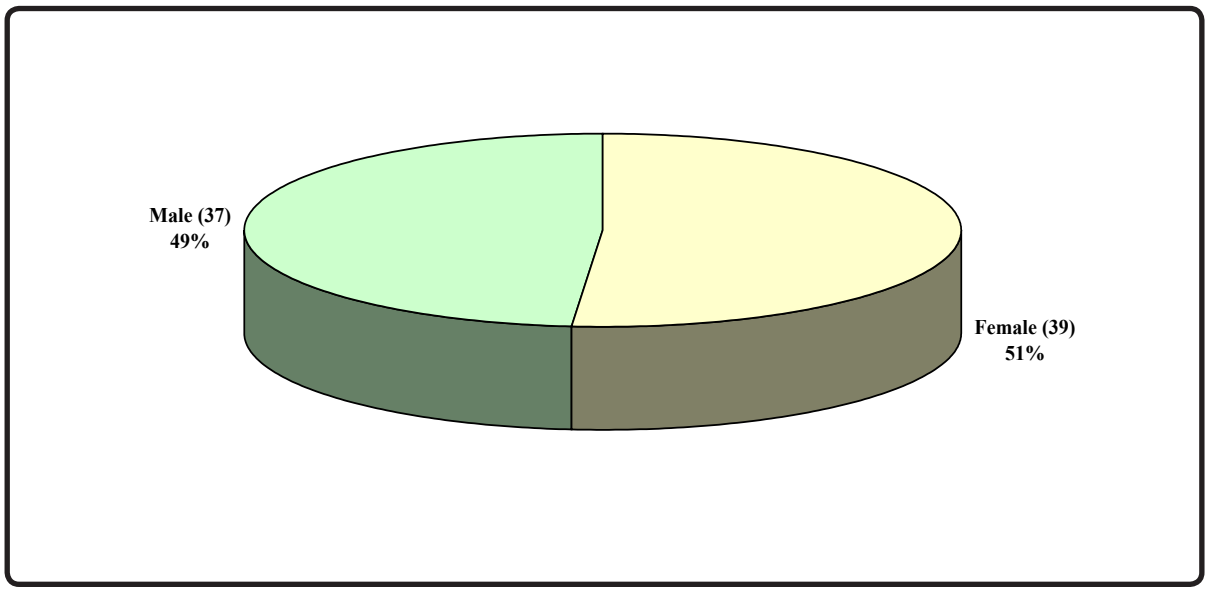
Unintentional Deaths by Cause in 2005, N = 98



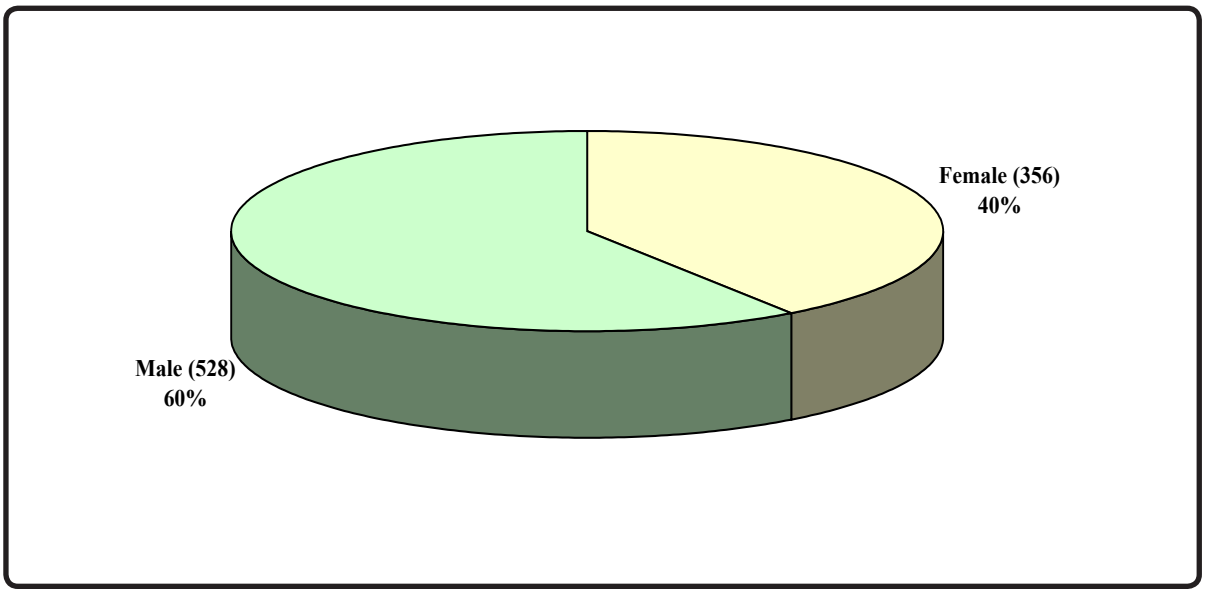
1. Motor Vehicle

According to the National Highway Traffic Safety Administration, MVC's are the leading cause of death for 15 to 20-year-olds.[2] Nationwide in 2005, 7,460 drivers in this age group were involved in a fatality crash and 3,467 were killed with another 281,000 injured.[2] Kansas lost 76 children in 2005 to MVC's. Females were the majority of those lost, with most of the deaths falling in the 15 to 17-year-old age group. The Board would like to note that almost all of the motor vehicle deaths involved risk factors which were preventable. For example, 59% of the MVC's involved a driver or passenger who was improperly restrained or was not restrained at all.

MVC Deaths by Gender in 2005, N = 76



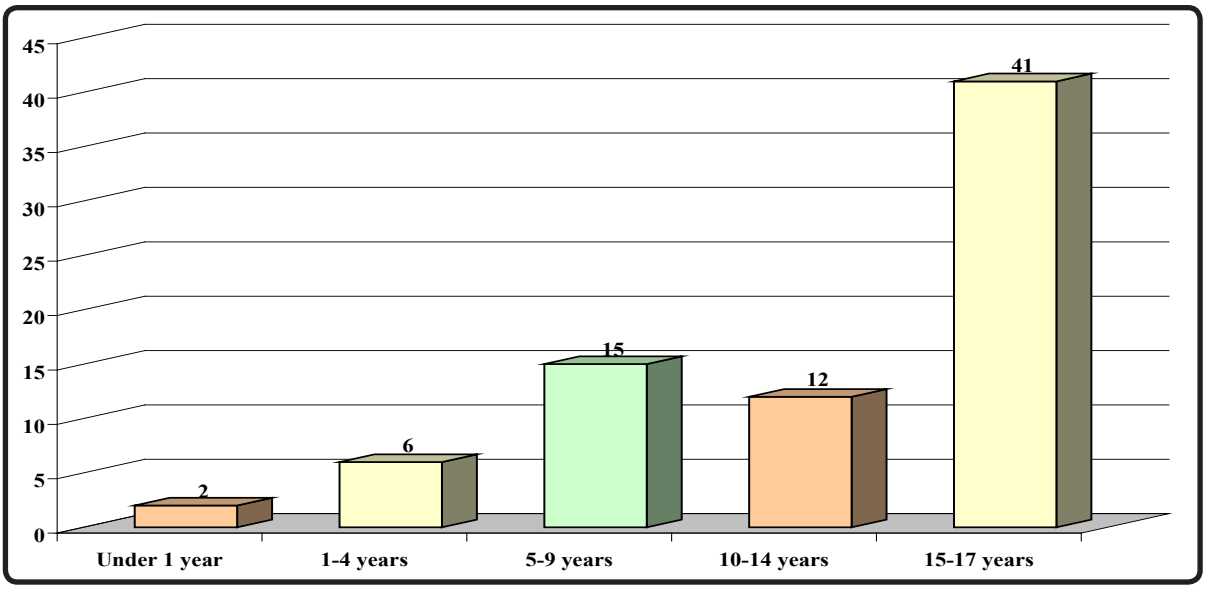
Total MVC Deaths by Gender, 1994 to 2005, N= 884



1. Motor Vehicle

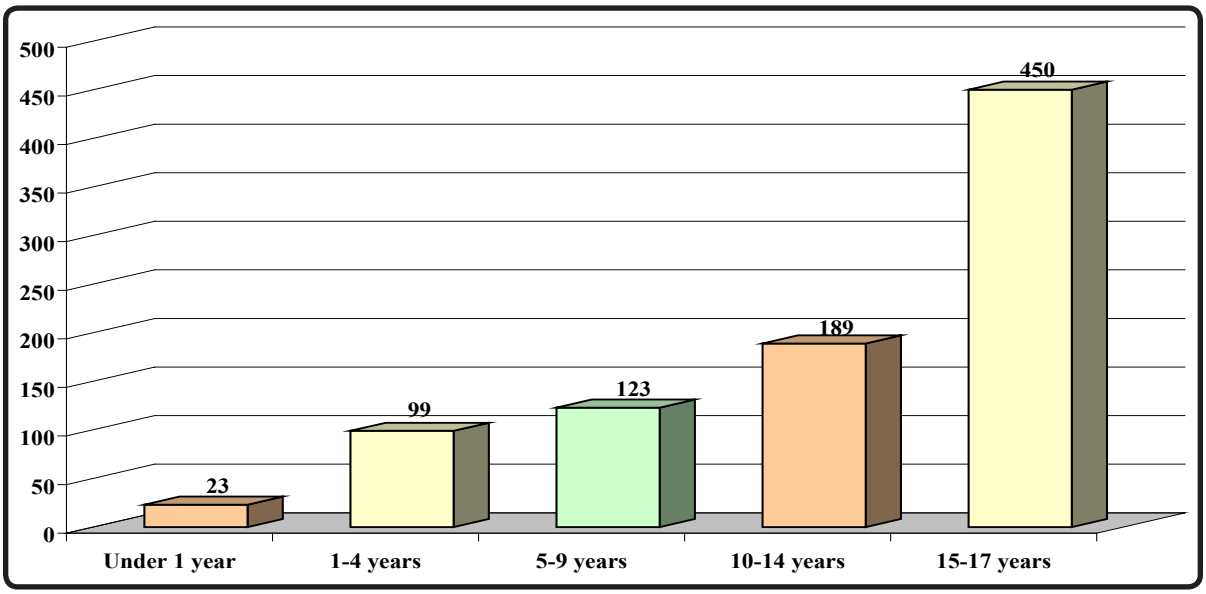
Young teenagers who are often the driver or a passenger riding with other teen drivers account for the greatest number of motor vehicle crash deaths. Currently, Kansas children may receive a learner's permit and begin driving at age 14. The SCDRB supports a graduated driver licensing system, which would prohibit driving until age 16, and would put specific restrictions on the driver for the next two years. The following graphs emphasize the data leading to the recommendation for implementation of a stronger graduated driver licensing program.

MVC Deaths by Age in 2005, N = 76



An unlicensed teen driver carrying two unrestrained teen passengers lost control of her vehicle when driving too fast on a gravel road. Two of the three died.

Total MVC Deaths by Age, 1994 to 2005, N = 884



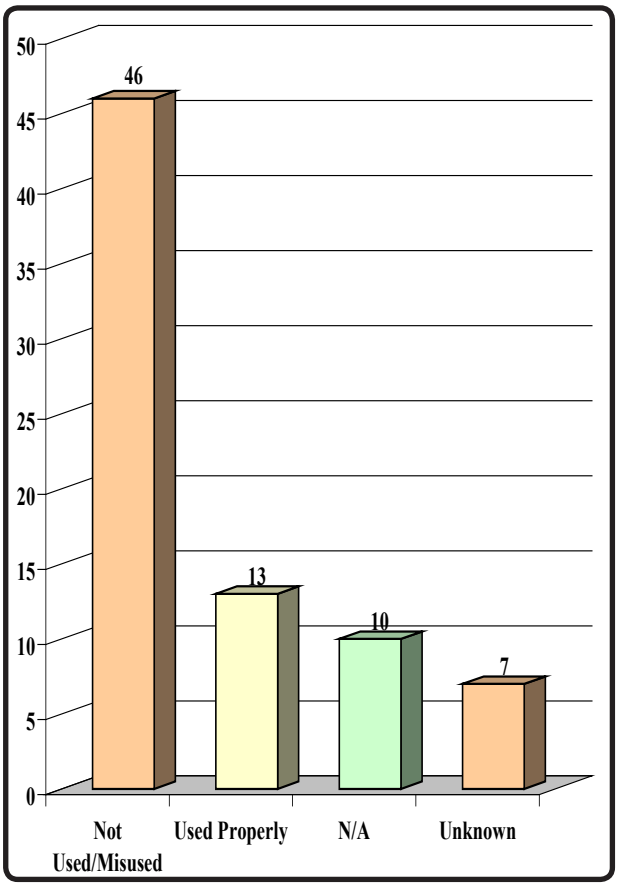
1. Motor Vehicle

In the majority of the MVC cases reviewed "unrestrained and ejected", "inattentive driving", or "excessive speed" are included in the descriptive report. These risk factors could be drastically reduced with the implementation of a graduated driver's license law. The Board details an effective and feasible graduated driver's license law at the end of this report in their Public Policy Recommendations.

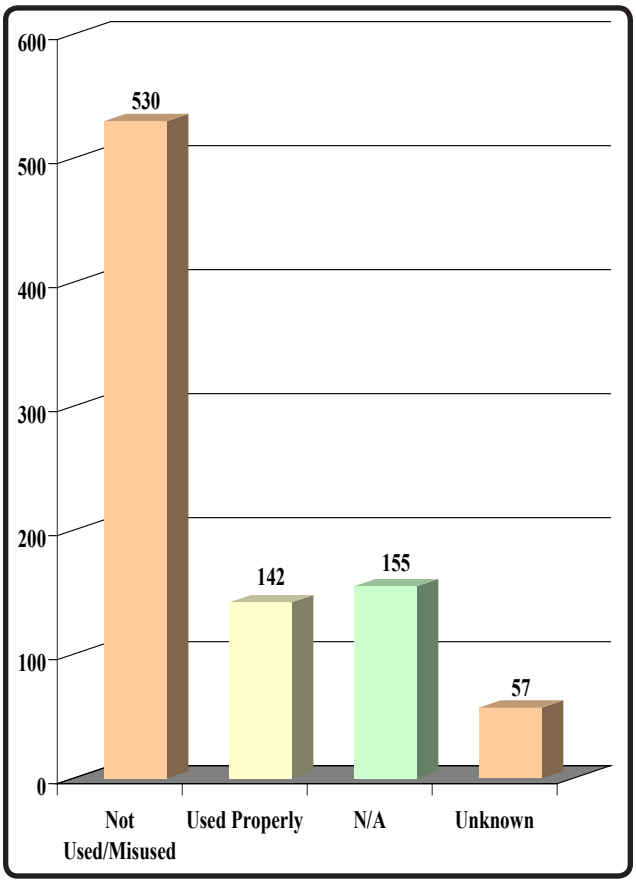
Despite the proven benefit of seatbelt use in preventing deaths, the percentage of Kansans who are unrestrained in fatal crashes remains high. The majority of children not using any form of restraint are ages 15-17. In 2005, 24 children in this age group were not using a restraint at the time of the crash. In the 10-14 year age group, 10 children were unrestrained or restrained improperly, and in the 9-&-under age group, 12 were not restrained or were restrained improperly. This illustrates the need for Kansas to enact a standard seatbelt law for all passengers, in addition to more stringent enforcement and judicial adherence to the law.

An adult driver lost control of the vehicle and rolled. Both the driver and front-seat passenger were restrained and received no injuries. The unrestrained backseat passenger lost her life.

MVC Deaths by Restraint Use in 2005, N = 76



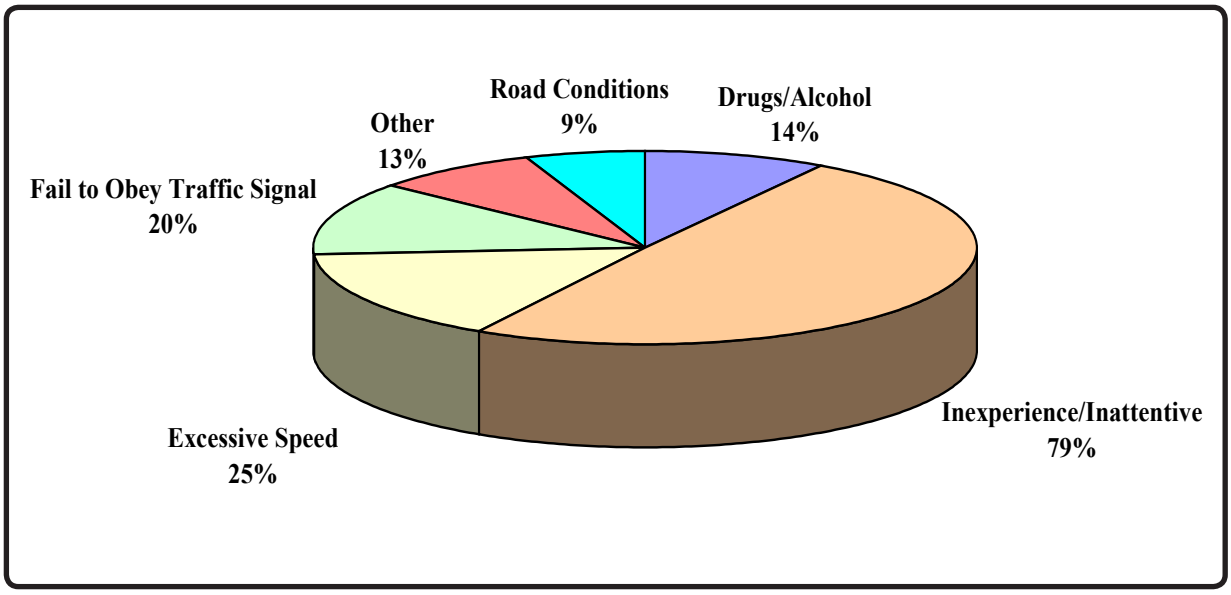
Total MVC Deaths by Restraint Use, 1994 to 2005, N = 884



1. Motor Vehicle

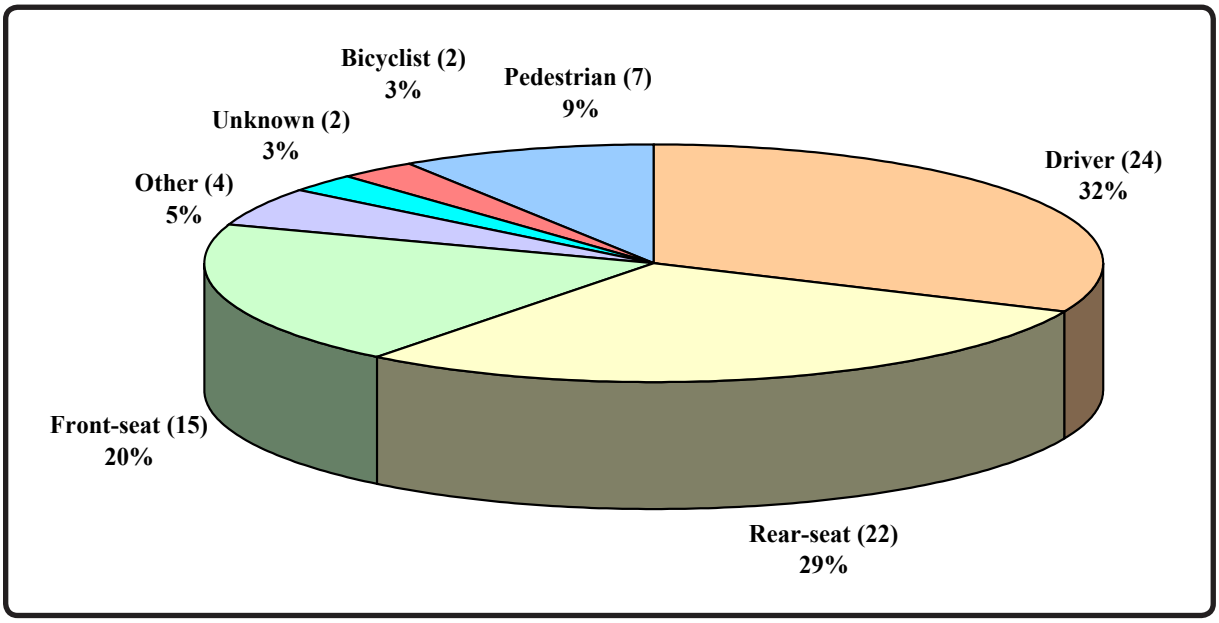
In addition to the lack of safety restraints, many MVC cases involve other, and often multiple, preventable factors; the most prevalent of which is inattentive or inexperienced driving and driving between the hours of 3:00 p.m. and Midnight.

MVC Deaths by Contributing Factor in 2005, N = 76



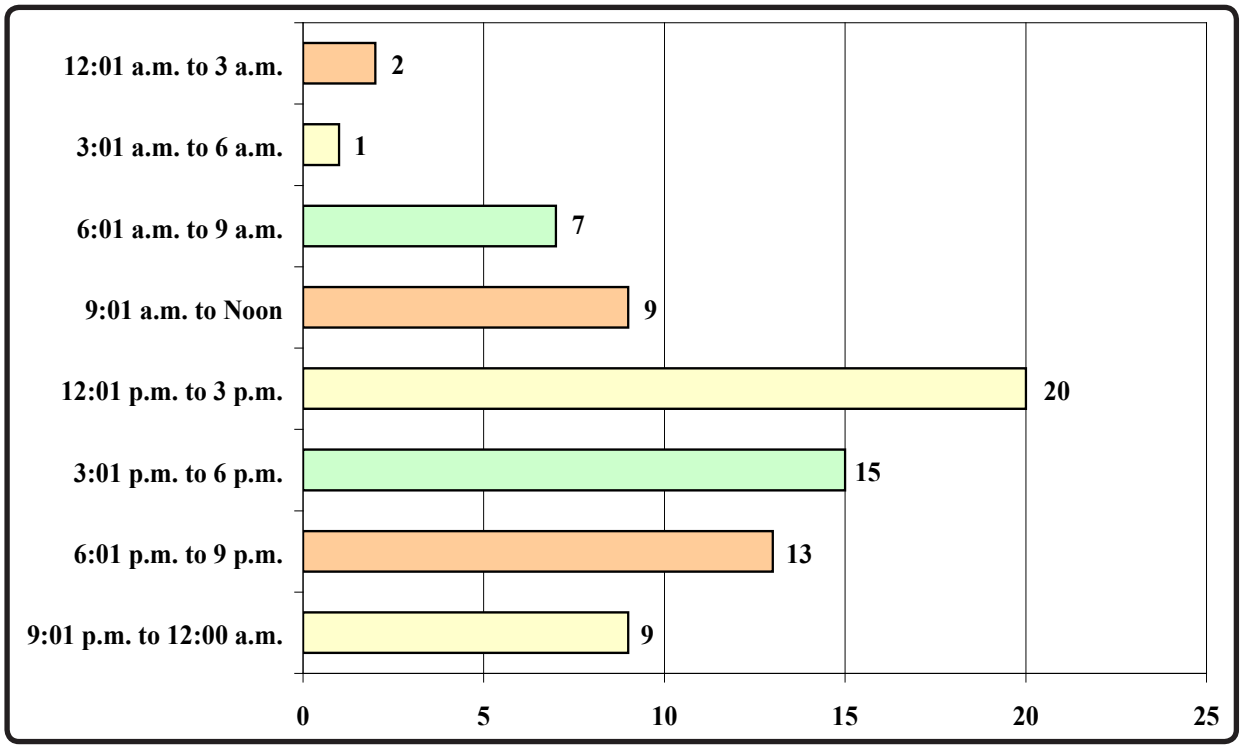
A 5-year-old died and 3 other children, all under the age of 15, were injured when a driver reached for the cell phone and struck another vehicle head-on.

MVC Deaths by Seating Position in 2005, N = 76

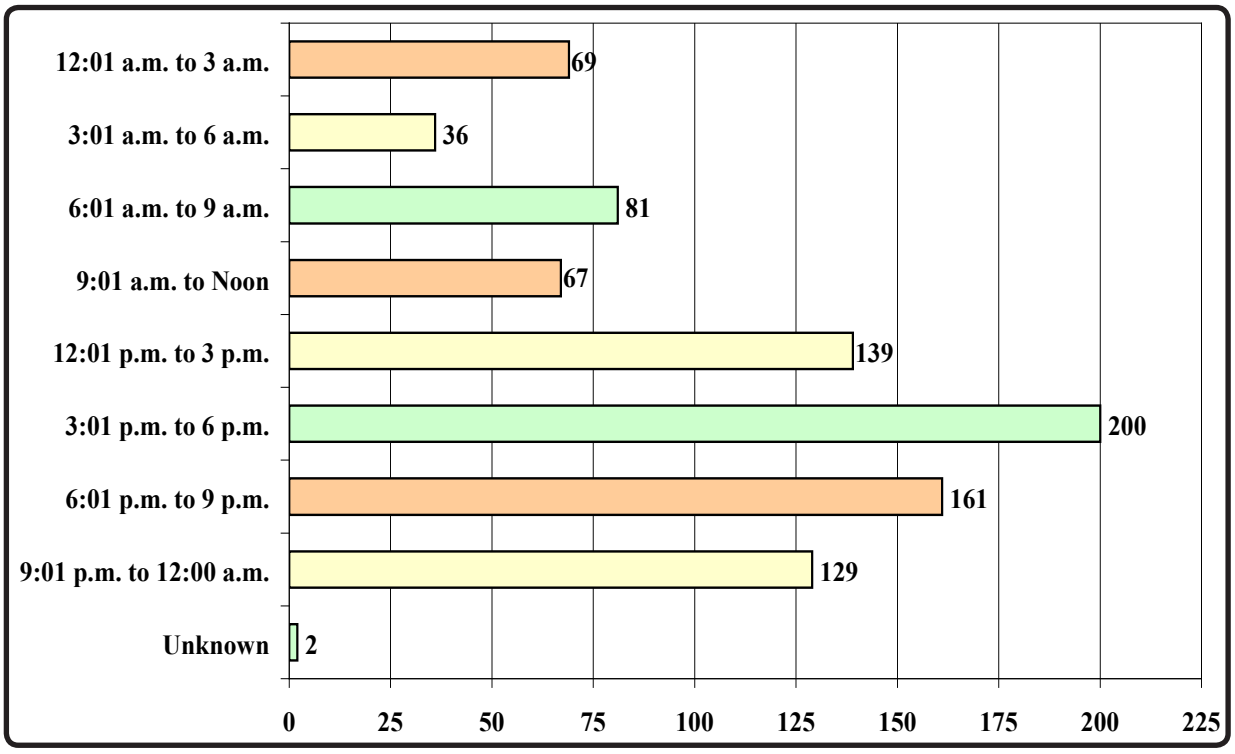


1. Motor Vehicle

MVC Deaths by Time of Crash 2005, N = 76



Total MVC Deaths by Time of Crash, 1994 to 2005, N = 884

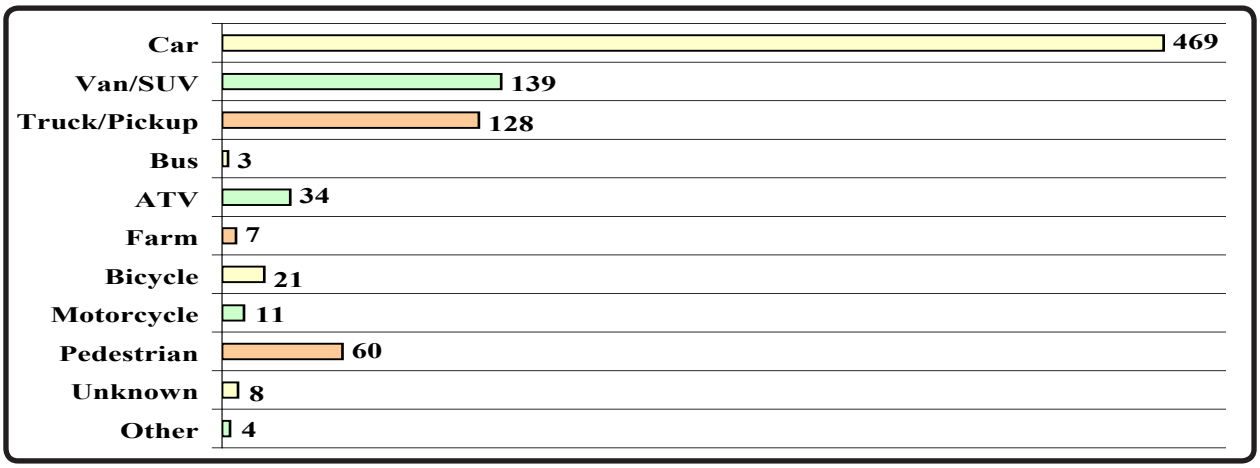


1. Motor Vehicle

Each year, in the United States, more than 100 children ages 16-and-under are killed and approximately 45,000 are injured on All-Terrain Vehicles (ATVs). Young riders often lack the size and strength to safely control an ATV. Other riders travel on roadways which are not designed for ATV travel and drive at speeds that are unsafe. In 2005, Kansas encountered 6 ATV-related fatalities. The Board makes suggestions to Kansas law regarding the use of ATV's at the end of this report.

Two teenagers riding an ATV were traveling on a gravel road going approximately 65 mph. One of them lost their life when the driver lost control and hit a tree. In a separate incident, a helmeted 8-year-old died when he crashed his ATV and it rolled over him.

Total MVC Deaths by Vehicle Type, 1994 to 2005, N = 884



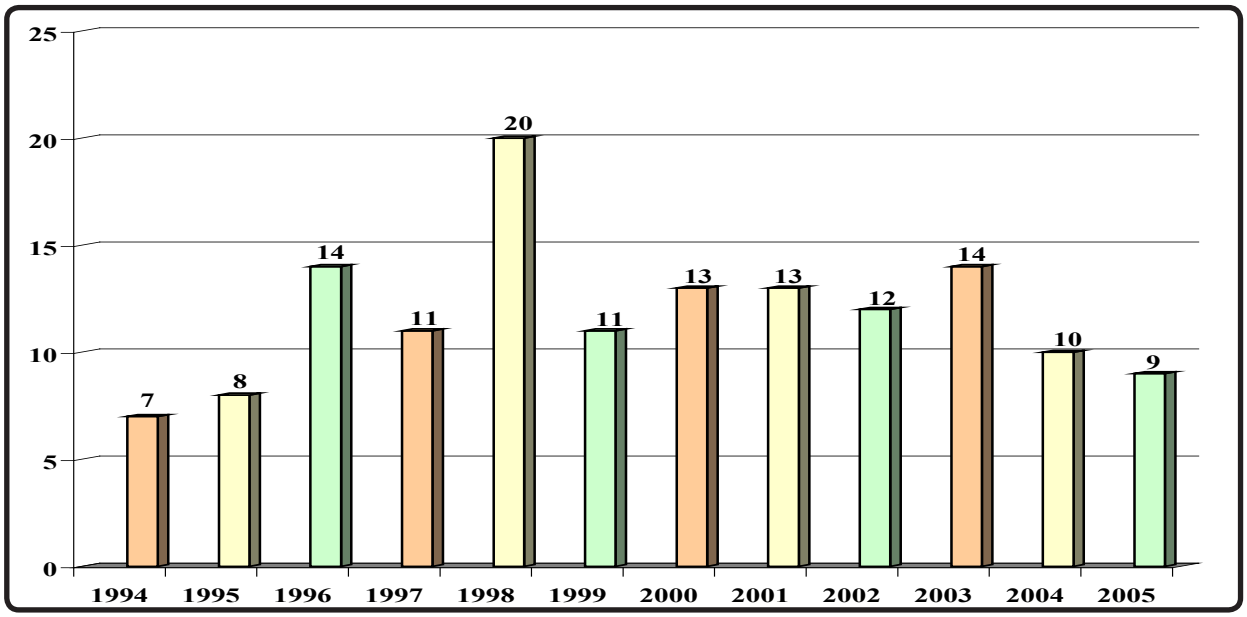
PREVENTION POINTS

- **Use of Proper Safety Restraints -** Wear seatbelts. Seatbelts and appropriate child safety restraints consistently prevent serious injury and death. The importance of parental seatbelt use as an example is invaluable. According to the National Highway Traffic Safety Administration, parents who buckle up are more likely to use safety restraints for their children than those who do not.[4] Children under 4-years-of-age should be placed in child safety firmly secured in the backseat. Children between the ages of 4 and 8 should be in belt-positioning booster seats.
- **Attentive Driving -** Avoid distractions such as cell phones and other electronic devices. Novice drivers should have limits placed on the number of passengers, a known risk factor.
- **Avoiding Alcohol or Drug Use -** It is never safe to drive after drinking alcohol or using narcotics or other mood-altering drugs. Avoid riding with anyone who is suspected of being under the influence of drugs and/or alcohol.
- **Driving Experience -** Driving is not a quickly learned skill and requires focus and good judgment. Young drivers should be accompanied by an experienced adult and avoid complex driving situations until more practiced. The graduated driver's license system recommended by the Board does not confer full driving privileges until age 18, and after significant, supervised driving time.
- **ATV Usage -** No child under age 12 should be permitted to operate an ATV of any size. All riders should wear a helmet and travel in permitted areas at safe speeds.

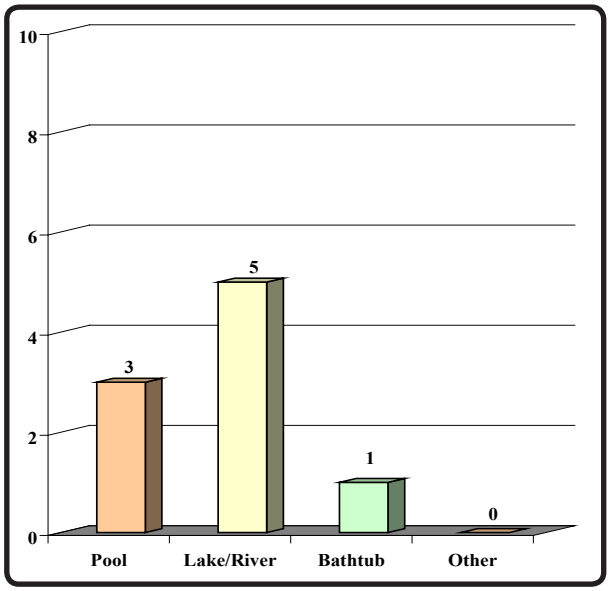
2. Drowning

In Kansas drowning was the 2nd leading cause of death in the Unintentional Injury category; however, many parents do not consider drowning a major hazard. Safe Kids USA reports that "drowning can happen in as little as one inch of water and is usually quick and silent. A child will lose consciousness within two minutes after submersion, with irreversible brain damage occurring within four to six minutes." Kansas lost 9 children to drowning in the year 2005. In 51% of the cases, the children had been left alone or were unsupervised when they drowned.

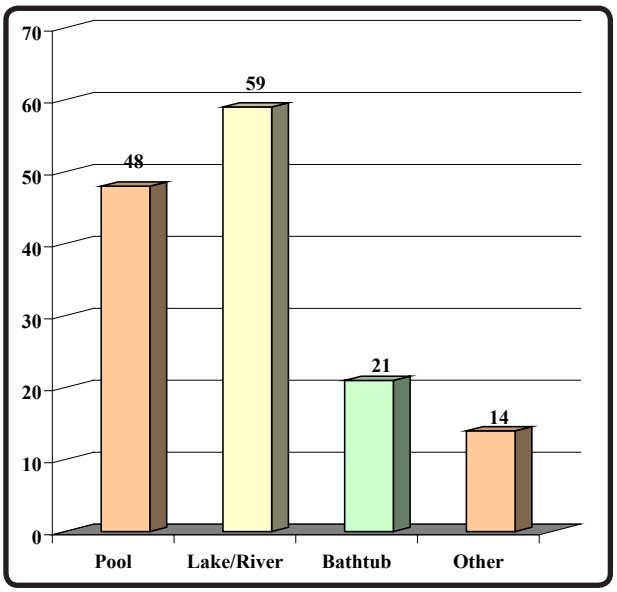
Total Drowning Deaths, 1994 to 2005, N = 142



Drowning Deaths by Location in 2005, N = 9

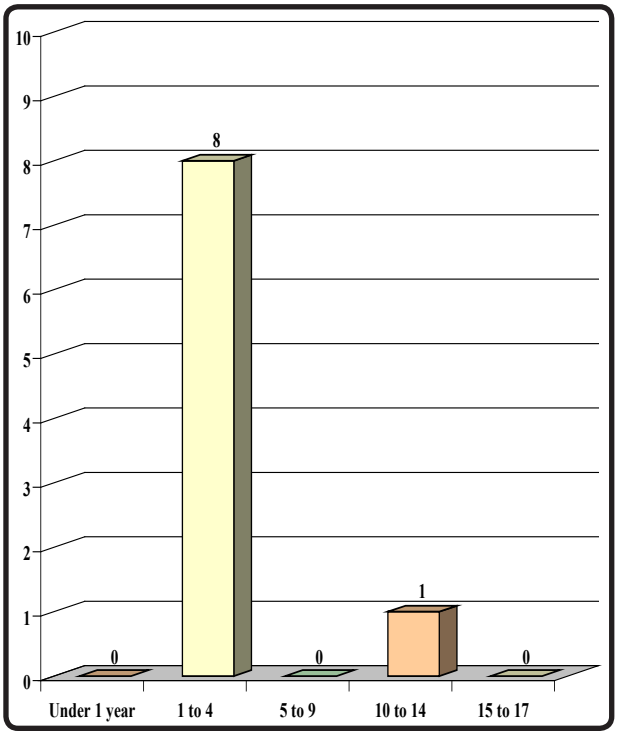


Total Drowning Deaths by Location, 1994 to 2005, N = 142

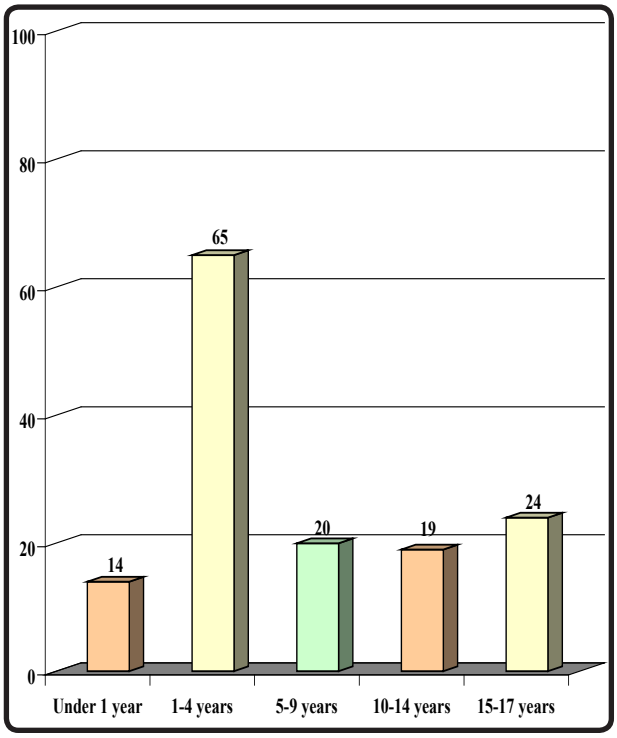


2. Drowning

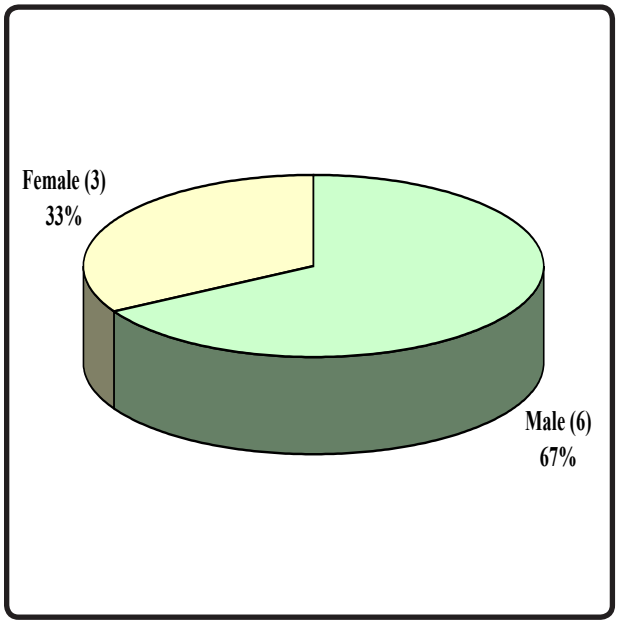
Drowning Deaths by Age in 2005, N = 9



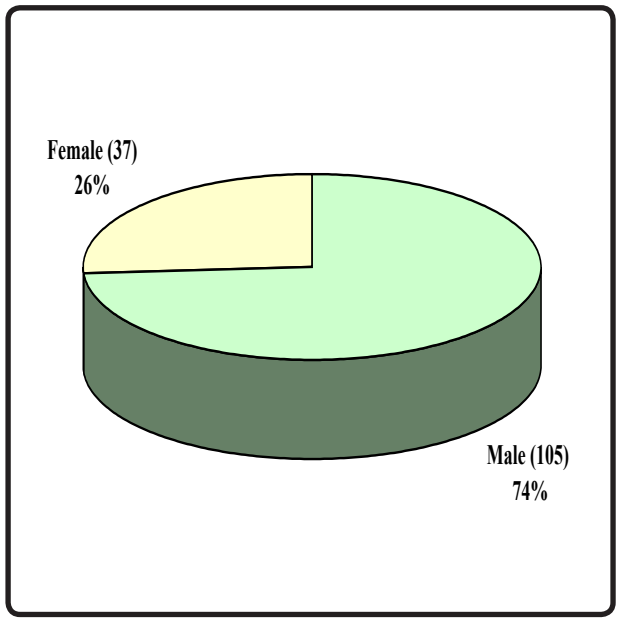
Total Drowning Deaths by Age, 1994 to 2005, N = 142



Drowning Deaths by Gender in 2005, N = 9



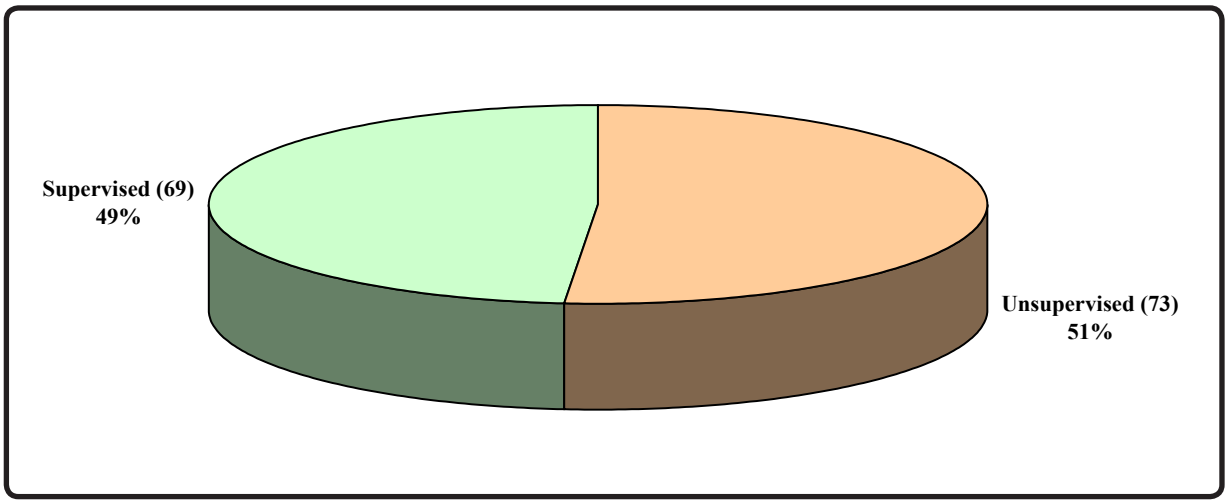
Total Drowning Deaths by Gender, 1994 to 2005, N = 142



2. Drowning

In all of the 2005 drowning deaths, lack of supervision was noted as a contributing factor. Caregivers must be diligent in supervising children around water, and should not rely solely on marketed products to keep their child safe.

Total Drowning Deaths by Supervision, 1994 to 2005, N =142



A 2-year-old child was left unattended in a bathtub and turned the water faucet on. A short time later, he was found unresponsive. CPR attempts were unsuccessful; the child died of drowning.

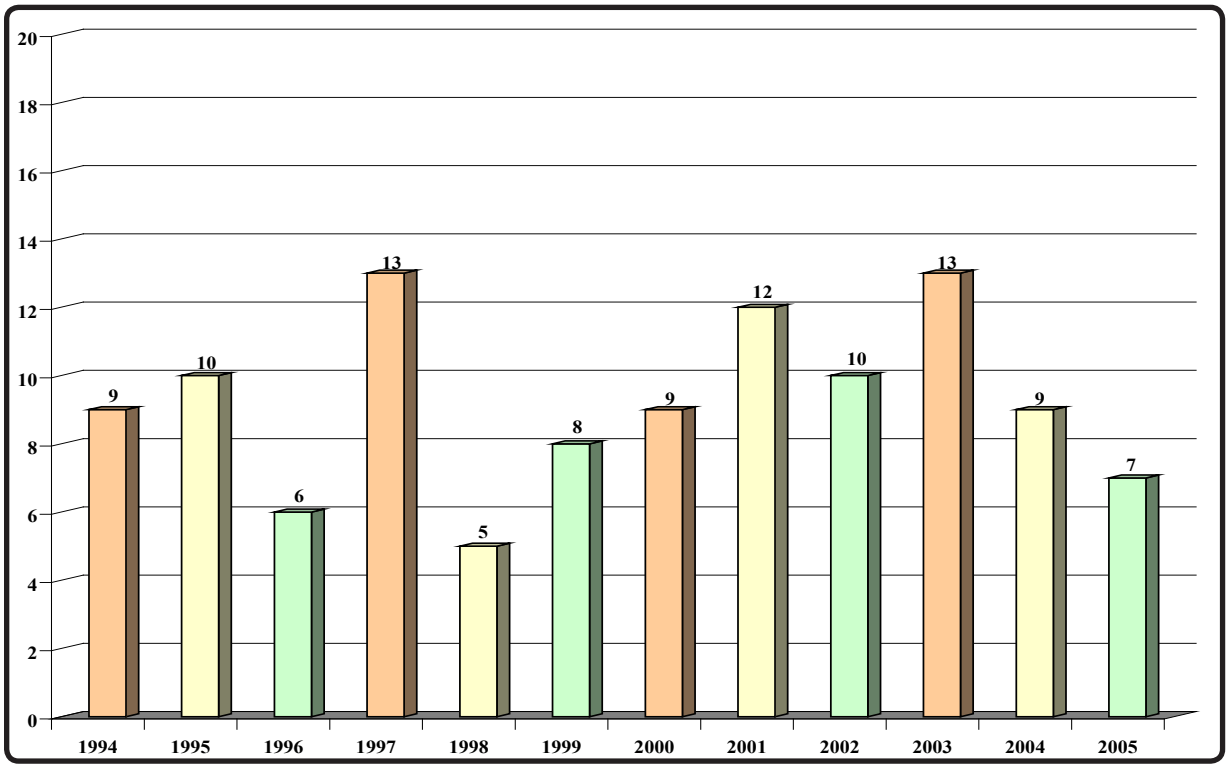
PREVENTION POINTS

- **Proper Supervision -** There should always be an adult, who is capable of responding to an emergency, observing children around water. The adult should be actively watching and avoid distractions. Assigning swimming "buddies" is a good idea, especially if there are many swimmers. Supervision also applies to bathtubs, where children are often left alone for short periods of time.
- **Pool/Environment Safety -** Pools should have safety equipment available and be inaccessible to small children. Five foot fencing with safety latched gates completely encircling a pool or hot tub is recommended. Specifically related to bathtubs, seats designed to hold a baby's head above water are no substitution for adult supervision. Also, there are cases where small children fall into buckets, toilets, washing machines or other such water holding basins and drown. Caregivers must be vigilant about less obvious dangers.
- **Use of Safety Equipment** - Children should always wear Personal Flotation Devices (PFDs) when participating in water activities that are Coast Guard Approved and are suited for the proper weight of the child. "Water wings" and other inflatable items are not adequate substitutes.
- **Water Safety Education -** Children should have swimming lessons and water safety education. The American Academy of Pediatrics recommends waiting until 4-years-of-age to begin lessons. While this is vital, swimming ability alone does not relieve the need for adult supervision or PFDs.

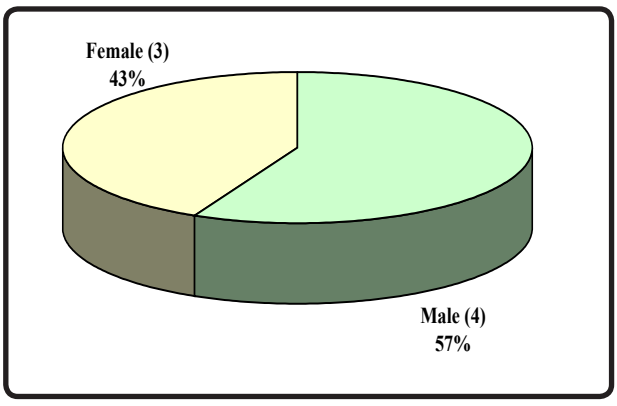
3. Suffocation/Strangulation

Unintentional Suffocation/Strangulation deaths most often affect very young children who have not yet developed the strength or motor skills to remove themselves from dangerous situations. Reviews from Kansas and across the Nation show that there are several common practices that increase the risk for asphyxial death. These include: sleeping somewhere other than a crib; being placed on the abdomen to sleep; sleeping in a cluttered area; being placed on a soft surface such as a pillow or quilt; and co-sleeping with parents or siblings. There are, however, instances where a child becomes entrapped and suffocates. Since 1994, Kansas has had 111 child deaths due to suffocation or strangulation, 7 of which occurred in 2005. Most of the deceased were of the male gender.

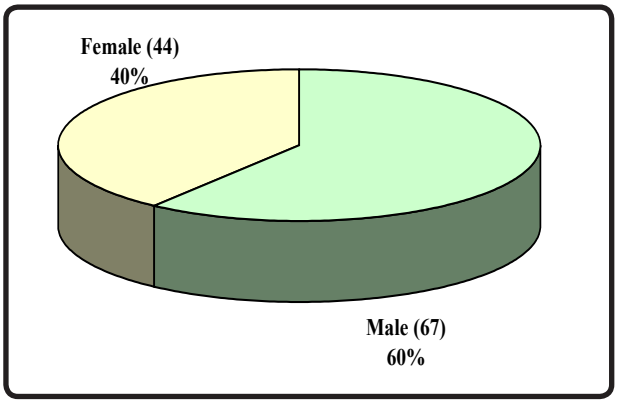
Total Suffocation/Strangulation Deaths, 1994 to 2005, N = 111



Suffocation/Strangulation Deaths by Gender in 2005, N = 7



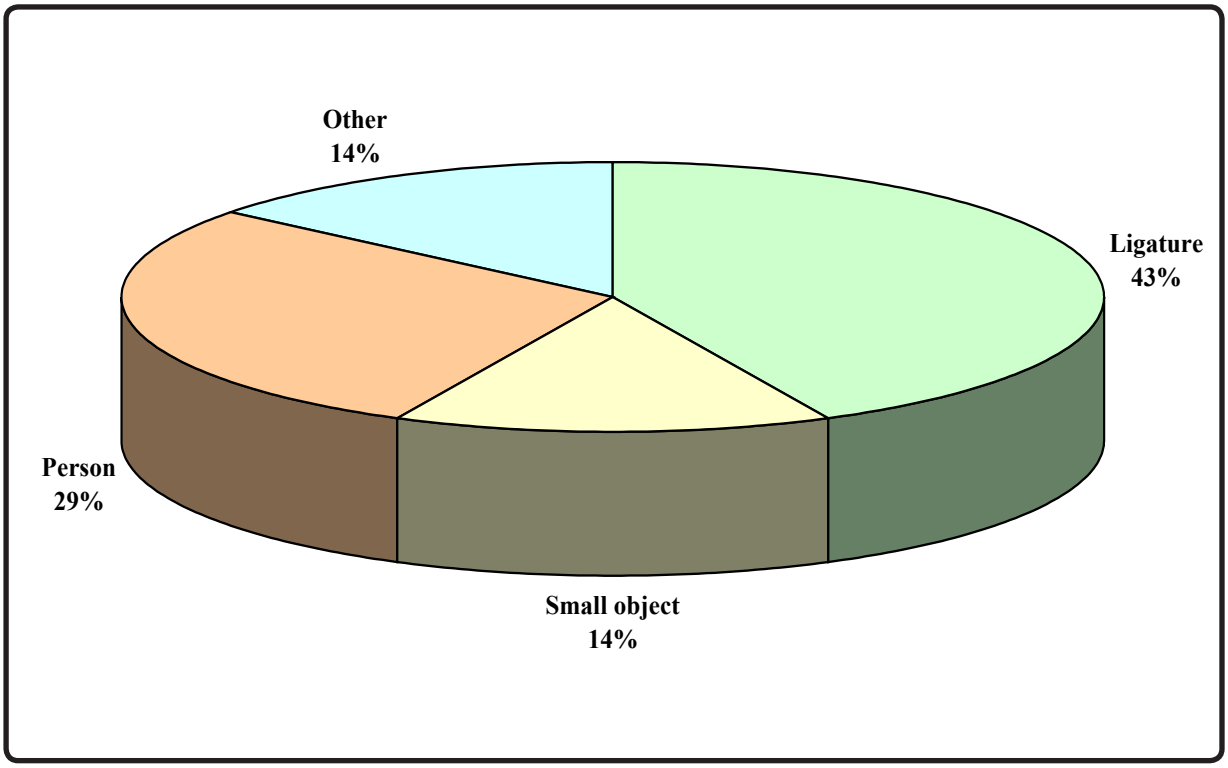
Total Suffocation/Strangulation Deaths by Gender, 1994 to 2005, N = 111



3. Suffocation/Strangulation

One of the most common and concerning causes of suffocation/strangulation is improper sleeping arrangements for infants. The Board reviews multiple cases each year in which a parent places an infant to sleep in soft bedding or on soft pillows, only to find the infant face down in the bedding and not breathing. In 2005, 29% of the suffocation/strangulation was attributed to improper sleeping arrangements.

Suffocation/Strangulation Deaths by Cause in 2005, N = 7



A young mother who had been drinking woke to find her infant between her and the back of the couch. The infant was not breathing and was pronounced dead.

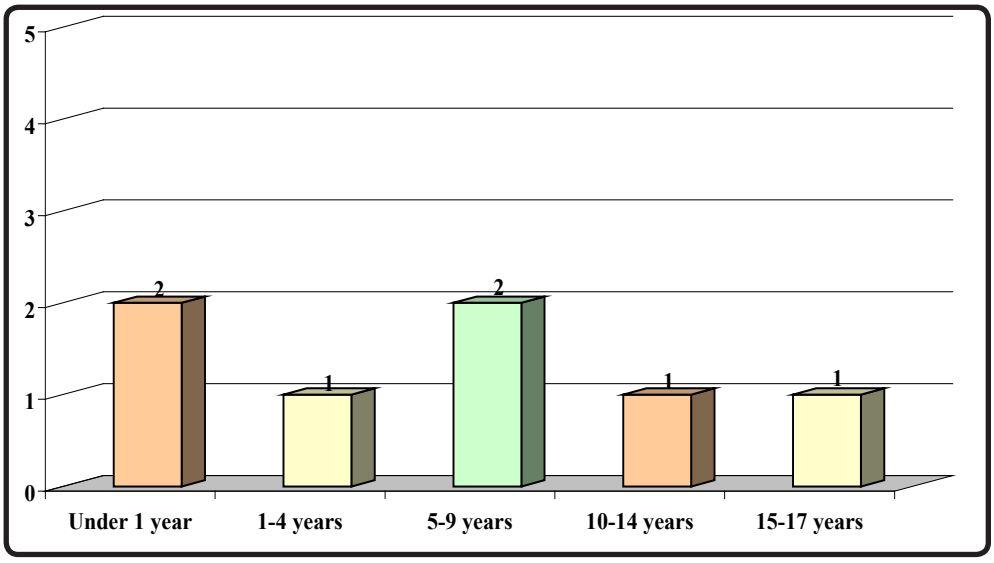
The majority of suffocation/strangulation deaths are caused by improper sleeping arrangements and exhibit a common characteristic in the injury category, lack of supervision. Most of the 2005 suffocation/strangulation deaths were preventable had infants been placed in proper sleeping areas with proper supervision.

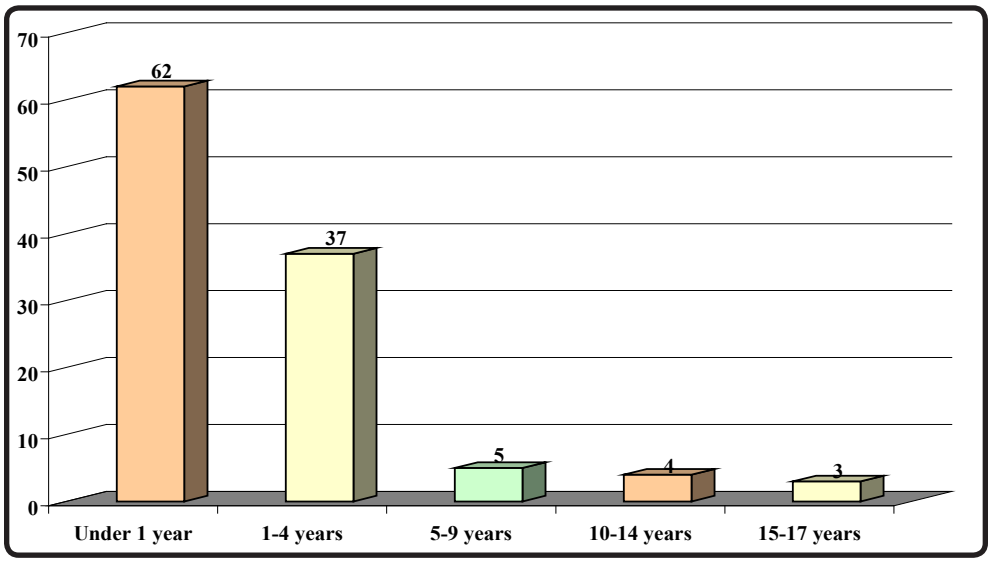
An unsupervised 14-month-old sleeping in a car seat was found strangled in the straps of the car seat.

Infants should never be placed on surfaces which could cause an obstructed airway.

3. Suffocation/Strangulation

Suffocation/ Strangulation Deaths by Age in 2005, N = 7





Total Suffocation/ Strangulation Deaths by Age, 1994 to 2005, N = 111

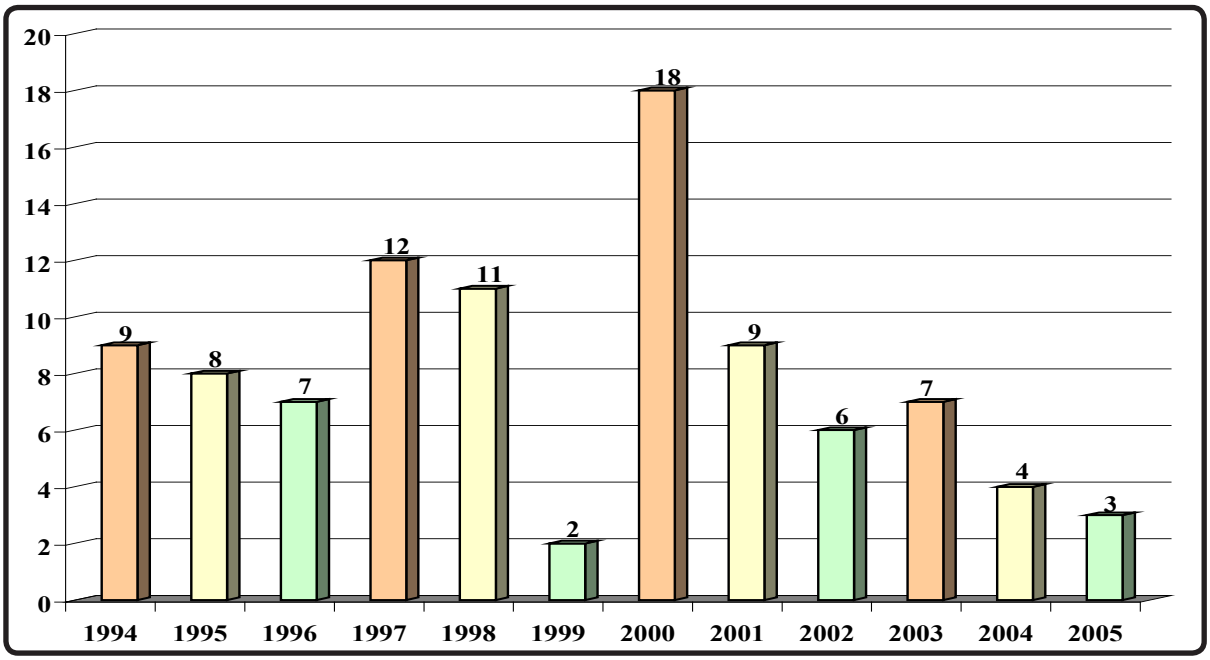
PREVENTION POINTS

- **Proper Supervision -** Young children should be watched attentively. Leaving them alone for extended periods of time, even 10 to 15 minutes, allows opportunities for accidents. Child-specific training in CPR and other emergency responses can help prevent death.
- **Safe Environments -** Be vigilant about potential dangers to children. Consideration must be given to their size, curiosity, and motor ability. Many things that are not threats to adults (e.g. chests or coolers with latches, hanging cords, and plastic bags) can be deadly to small children.
- **Infant Sleeping Arrangements -** The safest sleeping arrangement for an infant is in an approved crib, on his or her back. Babies should not sleep in adult beds and should not be placed in bed with parents or siblings. The crib mattress should be firm and fitted so the child cannot be trapped between the mattress and side of the crib. Soft items such as blankets, pillows, and stuffed animals provide opportunities for asphyxia and should not be in the crib.

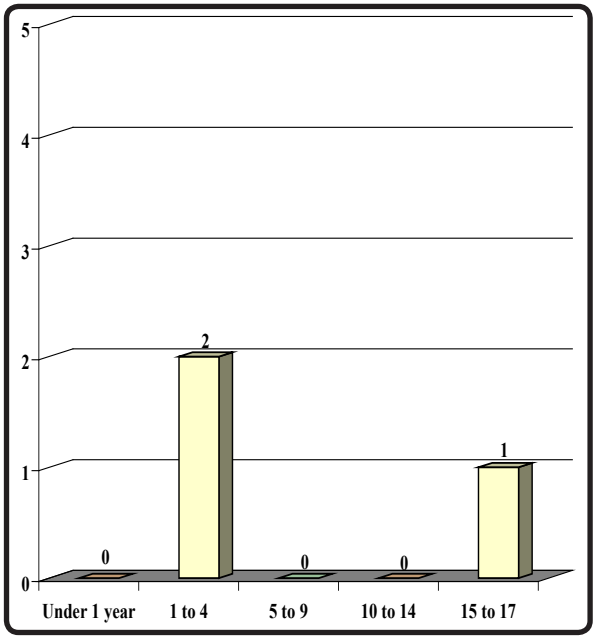
4. Fire

Deaths from fires and burns are the fifth most common cause of unintentional injury deaths in the United States (CDC 2005) and the third leading cause of fatal home injury. According to the National Fire Protection Association, in 2005 there were 1,602,000 reported fires in the United States, resulting in 3,675 deaths. 3 of the 3,675 deaths were Kansas children under the age of 18.[6] Since 1994, Kansas has lost 96 children to fires.

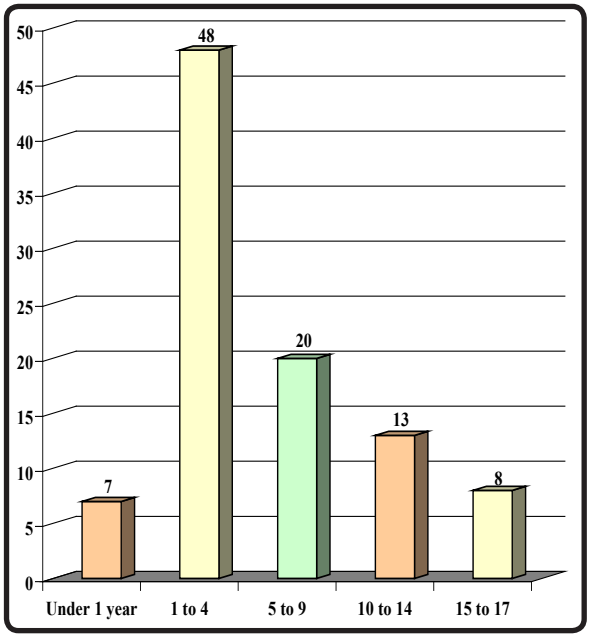
Total Fire Deaths, 1994 to 2005, N= 96



Fire Deaths by Age in 2005, N = 3



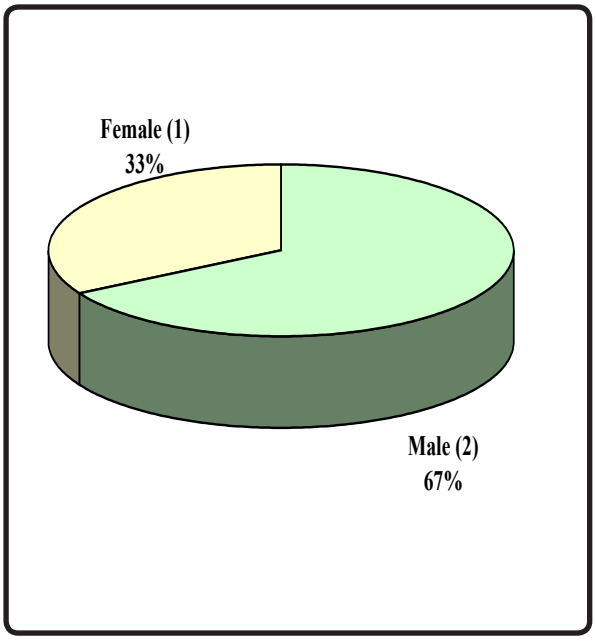
Fire Deaths by Age, 1994 to 2005, N = 96



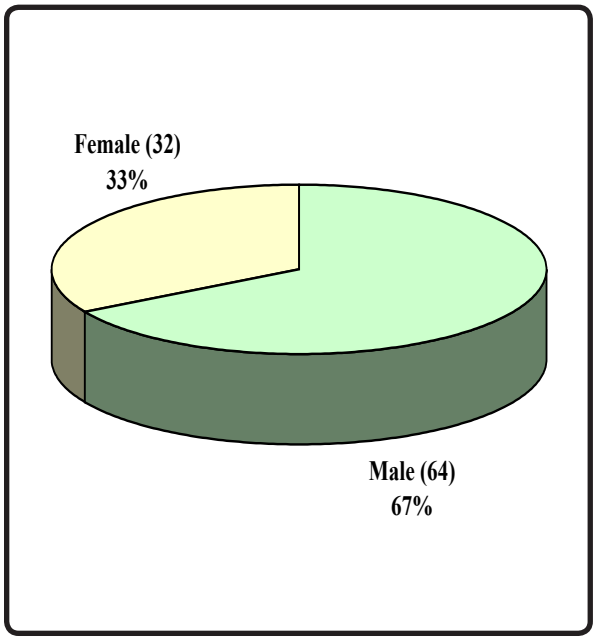
4. Fire

The 3 fire deaths in 2005 were a little out of character for what Kansas typically experiences in that none of the fires were set by children. One of the fire deaths was caused by an inattentive adult who was cooking, one was a propane tank explosion, and one was an accidental fire due to gasoline being stored in the home. The 3 deaths were the result of 3 separate fires. 2 of the children were male, and 1 was female. In all of the cases it was unknown if the detectors were functioning. All of the fires exhibited preventable risk factors.

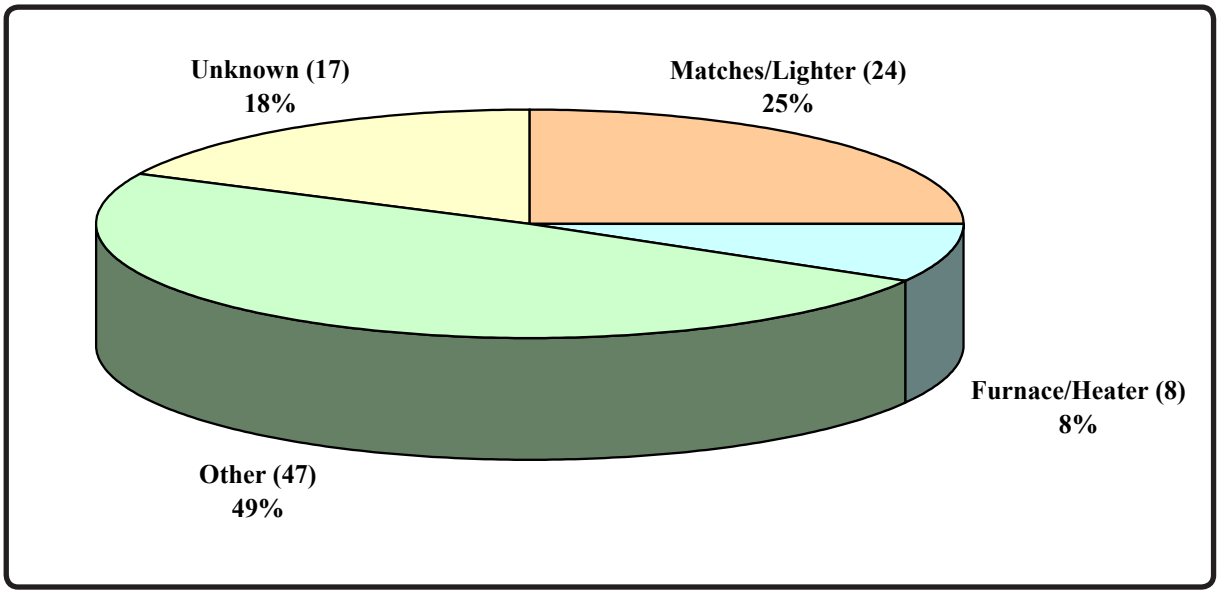
Fire Deaths by Gender in 2005, N = 3



Total Fire Deaths by Gender, 1994 to 2005, N = 96



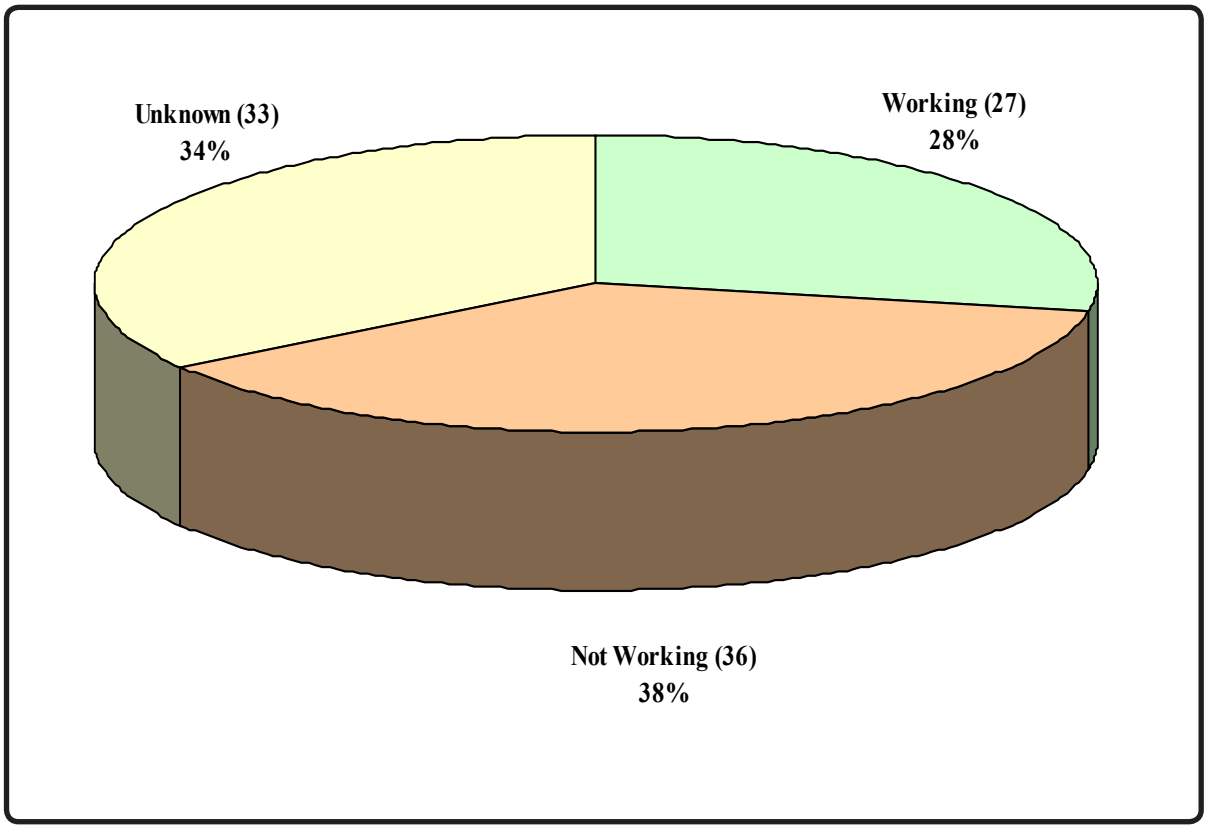
Total Fire Deaths by Ignition Source, 1994 to 2005, N= 96



4. Fire

Despite the fact that the 3 fire deaths in 2005 were not the result of a child, parents should continue to be watchful of children and educate them on the dangers of fire. Close supervision of children, safe storage of matches and lighters, and working smoke detectors in the home are critical.

Total Fire Deaths by Smoke Detector, 1994 to 2005, N= 96



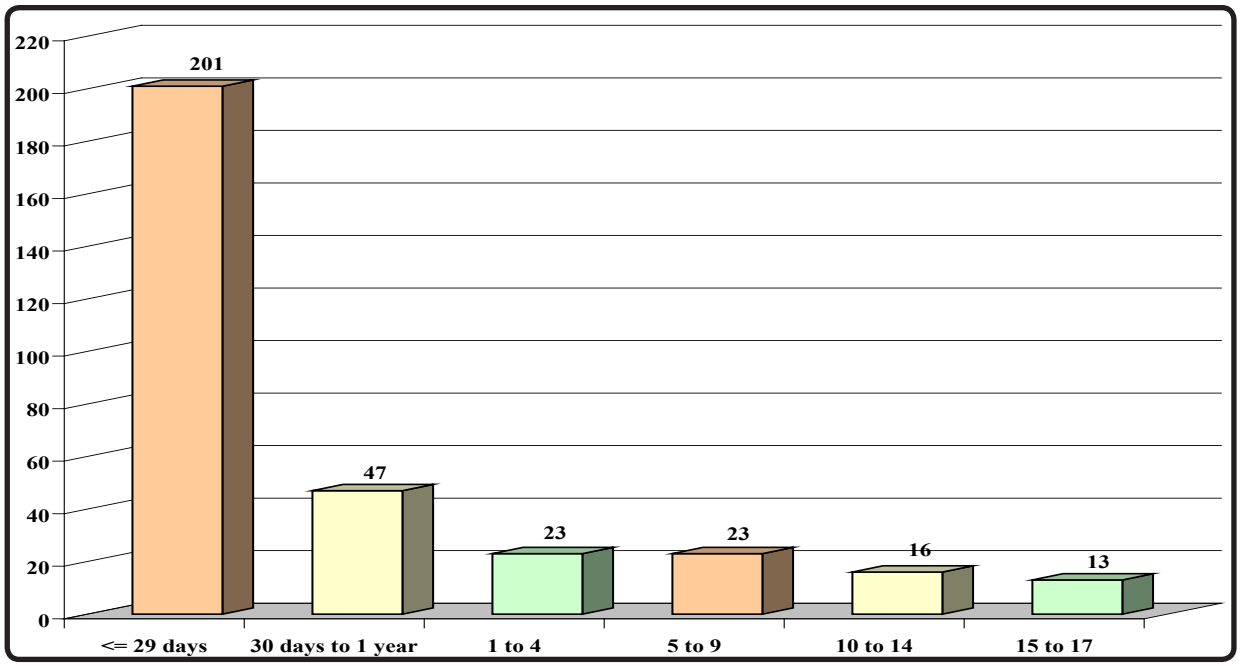
PREVENTION POINTS

- **Proper Supervision -** Young children must be watched closely. Leaving them unsupervised, especially if there are objects like candles or matches within their reach, could result in a serious injury or death.
- **Prevent Access to Fire-starting Material -** Matches, lighters, candles, etc. should be kept away from children. ***Do not assume a young child cannot operate a lighter or match***.
- **Working Smoke Detectors -** Smoke detectors should be placed in several locations throughout the house, and tested once a month to ensure they are working.
- **Emergency Fire Plan -** Everyone in the house, including the children, should know all exits from the house in case of a fire. Designate a central meeting location outside of the home and practice fire drills.

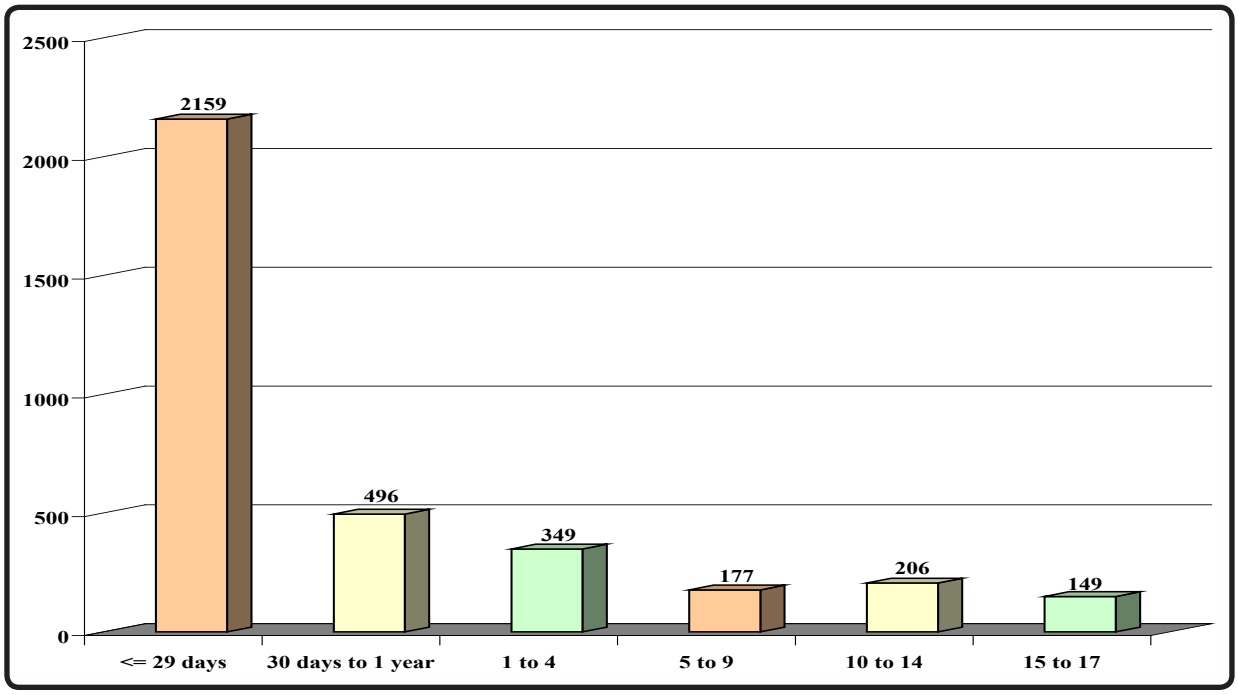
C. Natural Deaths-Except SIDS

Kansas continued its trend in 2005 with Natural Deaths making up the majority of all child deaths; 65% of the total 499 cases. Unlike other categories, prevention efforts are harder to define in natural deaths. These deaths are most prevalent in the first 29 days of life, correlating with prematurity and congenital disorders found during the neonatal period.

Natural Deaths-Except SIDS by Age in 2005, N= 323

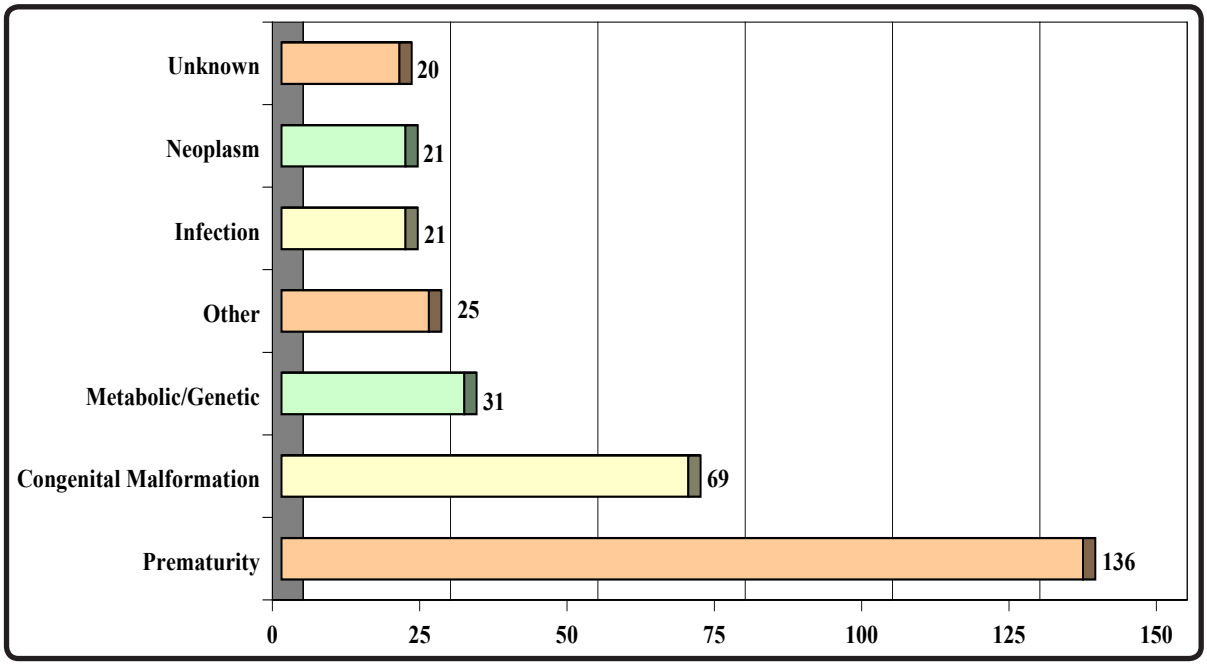


Total Natural Deaths-Except SIDS by Age, 1994 to 2005, N= 3,511



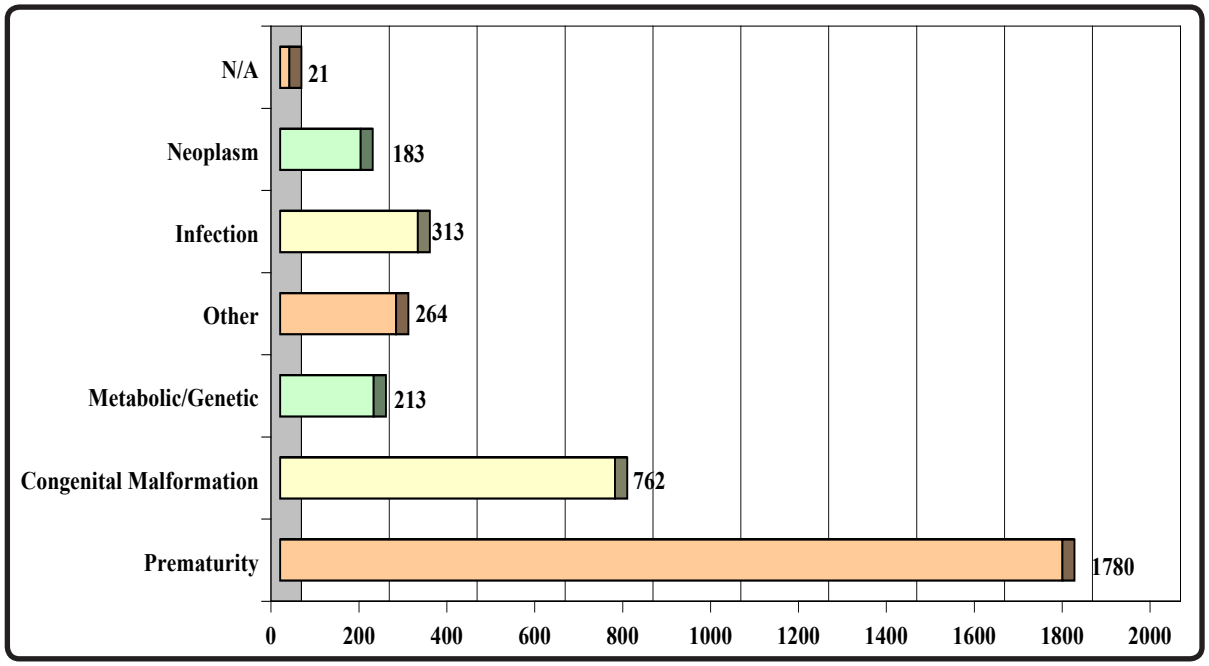
C. Natural Deaths-Except SIDS

Natural Deaths-Except SIDS by Cause in 2005, N= 323



The mother's medical condition can play a role in the child's demise, as was seen in 12 of the 31 metabolic/genetic cases in 2005. 20 cases indicated the mother's medical condition was unknown; thus, a determination as a contributing factor could not be established.

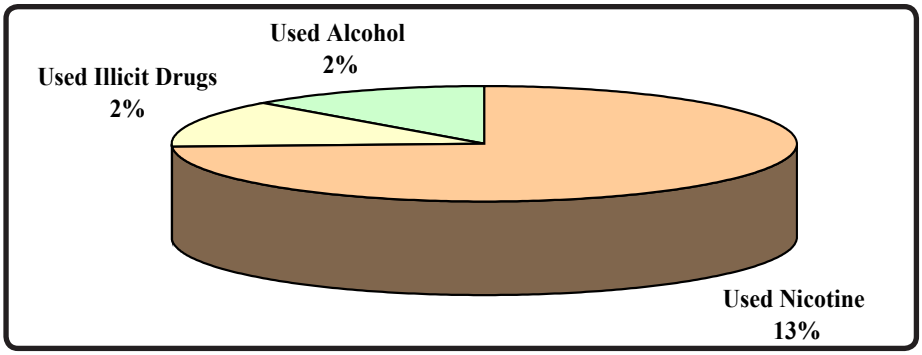
Total Natural Deaths-Except SIDS by Cause, 1994 to 2005, N= 3,511



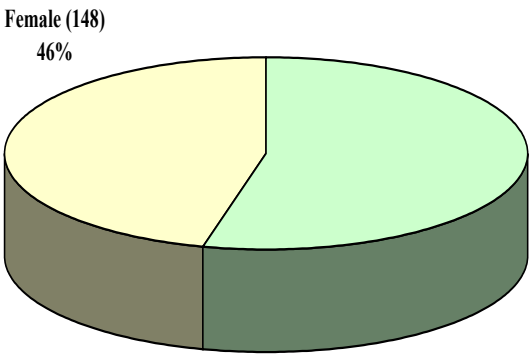
C. Natural Deaths-Except SIDS

While the degree to which prematurity can be prevented is unknown, there are risk factors for prematurity and poor health that can be addressed. The graph below indicates cases in which mothers used alcohol, illicit drugs, or cigarettes during their pregnancy. In 58% of the cases, it was unknown if the mother used nicotine, drugs, or alcohol due to the lack of documentation or testing.

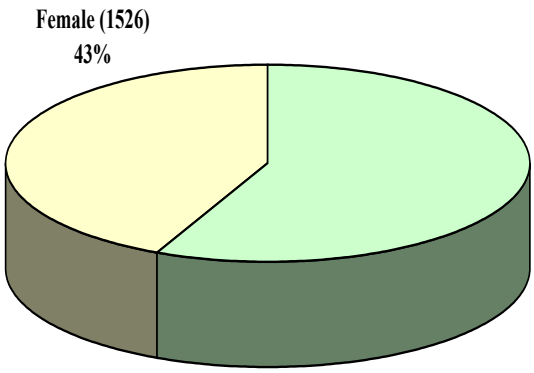
Natural Deaths-Except SIDS by Risk Factor in 2005, N = 323



Natural Deaths-Except SIDS by Gender in 2005, N = 323



Total Natural Deaths-Except SIDS by Gender, 1994 to 2005, N= 3,511



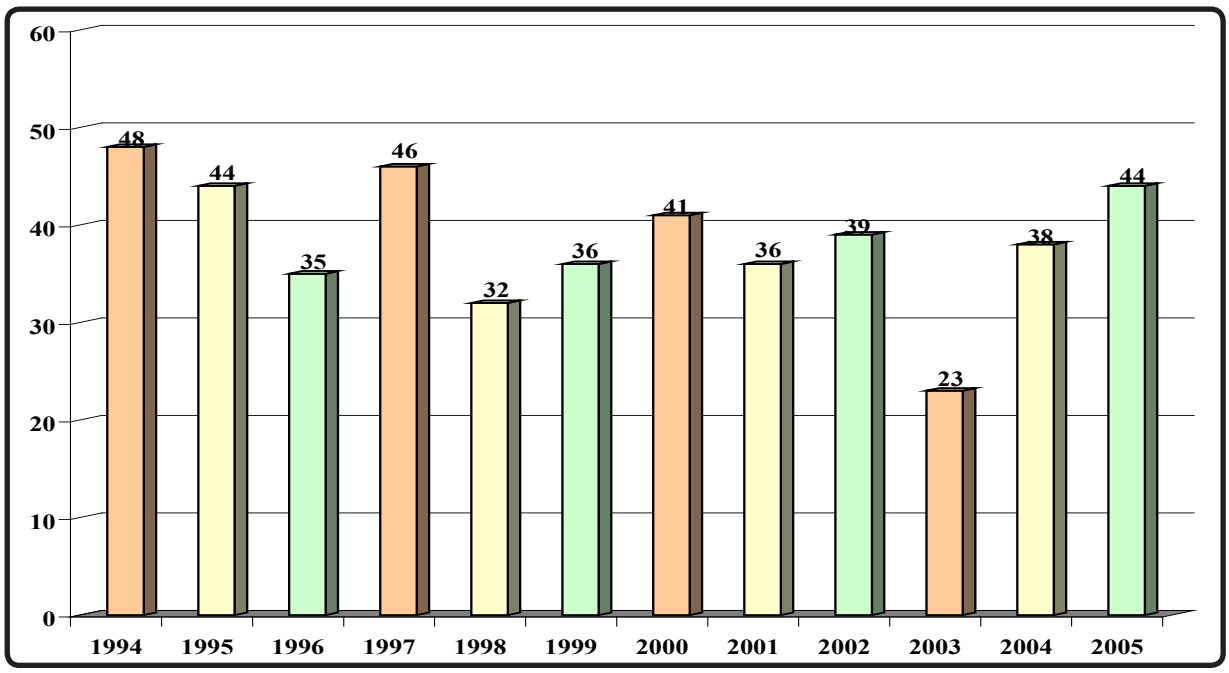
PREVENTION POINTS

- **Prenatal Care** - Medical care during a pregnancy is invaluable. Risk factors and problems addressed early can be avoided or treated to minimize poor outcomes. Proper nutrition and rest is vital to a pregnancy. Iron and folic acid supplements, along with other physician prescribed regiments can help ensure a healthy pregnancy and newborn.
- **Avoid Drugs, Alcohol, and Nicotine** - The use of illicit substances, alcohol, and nicotine should be avoided while pregnant. These elements all have the ability to cause serious health issues and even death for newborns and infants.

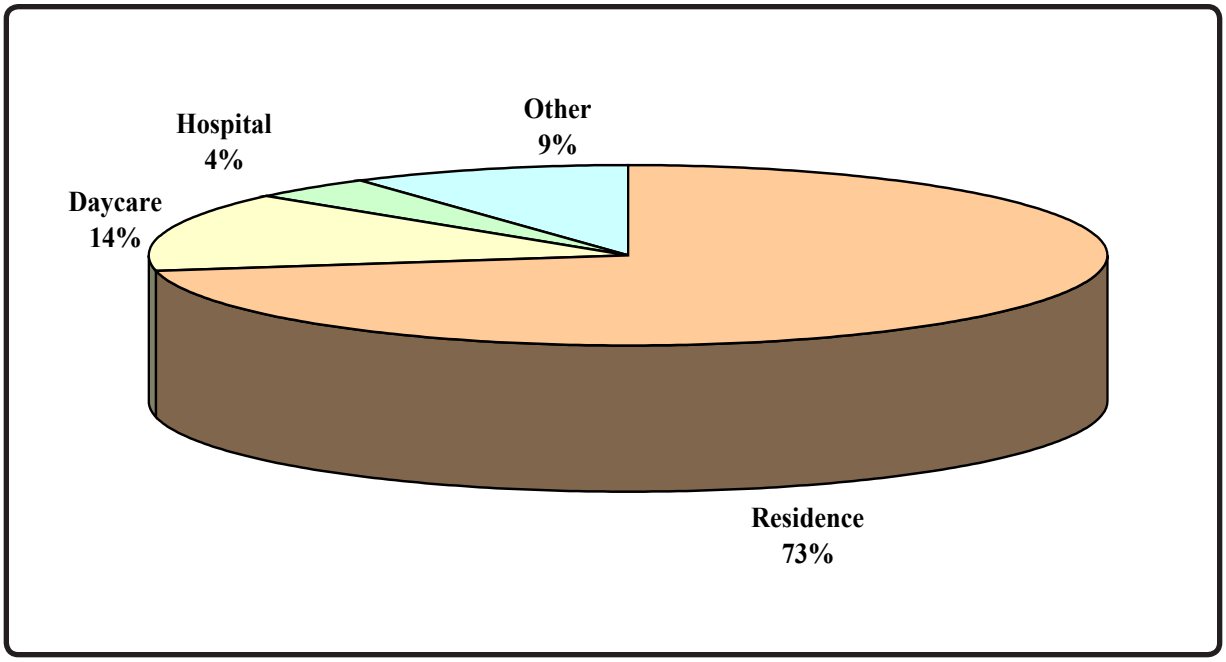
D. Natural Deaths - SIDS

Sudden Infant Death Syndrome (SIDS) is a very narrow classification of death specifically addressing infants who die unexpectedly in unwitnessed situations. Kansas coroners can only rule SIDS as the cause of death if the child is under 1-year-of-age, and an investigation and autopsy have revealed no known cause of death. Since the cause of SIDS is unknown, by definition these deaths would not be preventable. However, risk factors are known and are being mentioned in the data collection.

Total Natural Deaths-SIDS, 1994 to 2005, N = 462



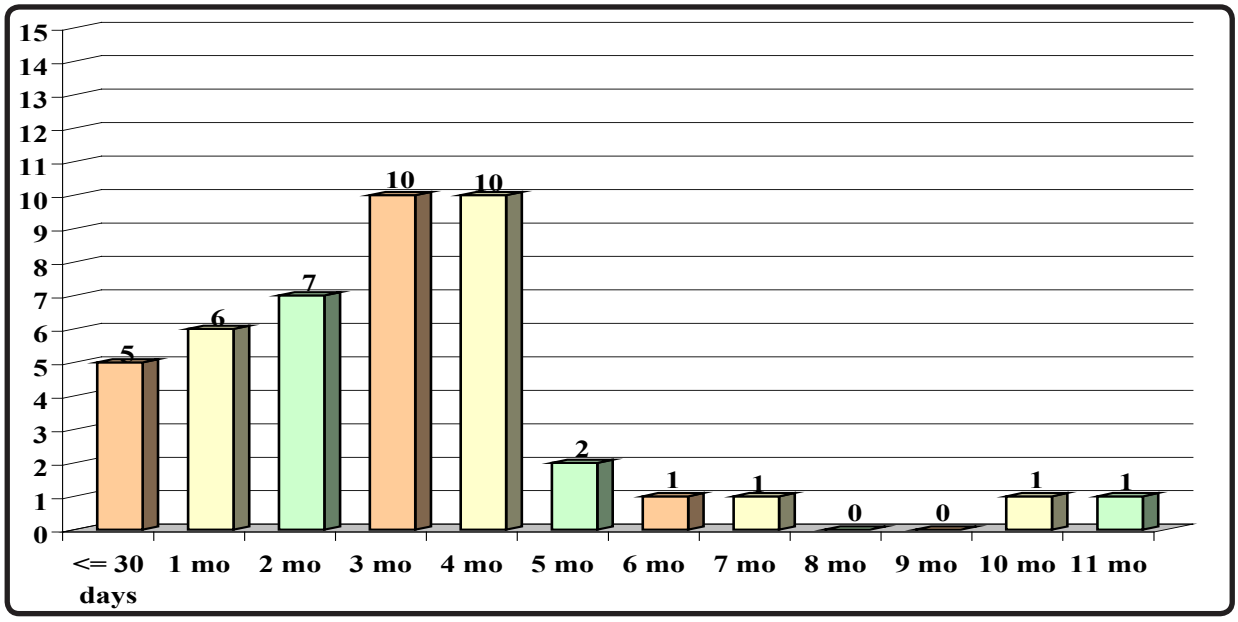
Total Natural Deaths-SIDS by Location, 1994 to 2005, N = 462



D. Natural Deaths - SIDS

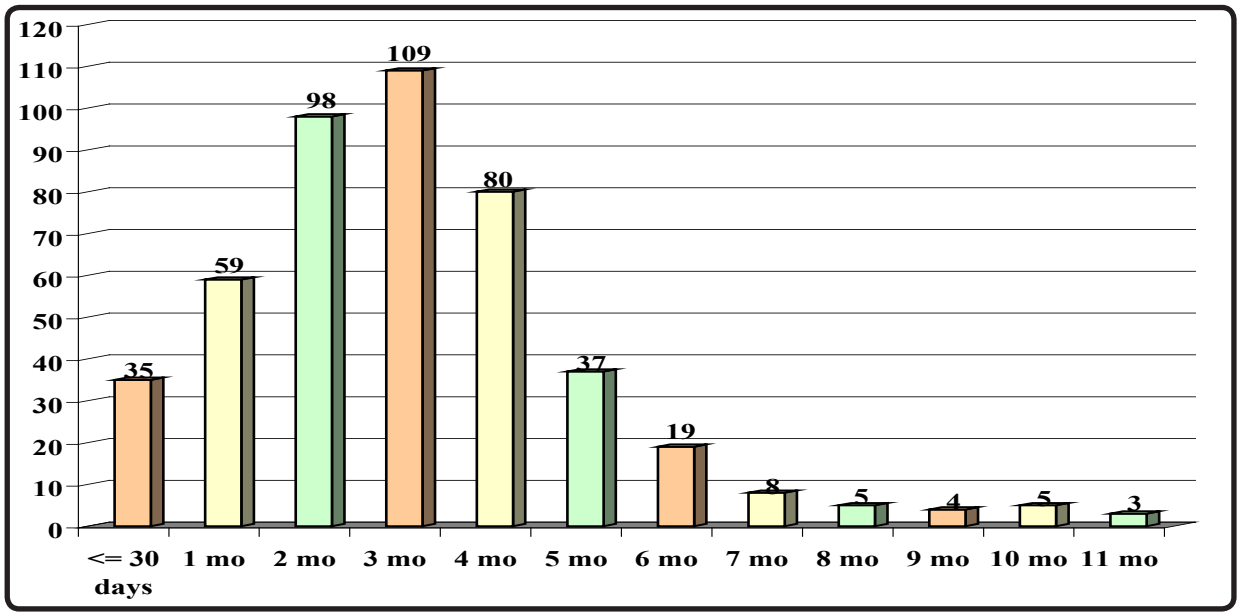
Although SIDS can occur when babies sleep on their backs, the American Academy of Pediatrics notes that the likelihood of SIDS is five times greater for children who are placed on their stomachs to sleep. High temperatures (overheating, over bundling), improper sleeping environment (co-sleeping, excess bedding and pillows, stuffed animals, etc.), and secondhand smoke can also increase the risk of SIDS. Other risk factors include low birth weight, prematurity, maternal smoking during pregnancy, multiple births (twins, etc.), young maternal age, and births less than 18-months apart.

Natural Deaths - SIDS by Age in Months in 2005, N= 44



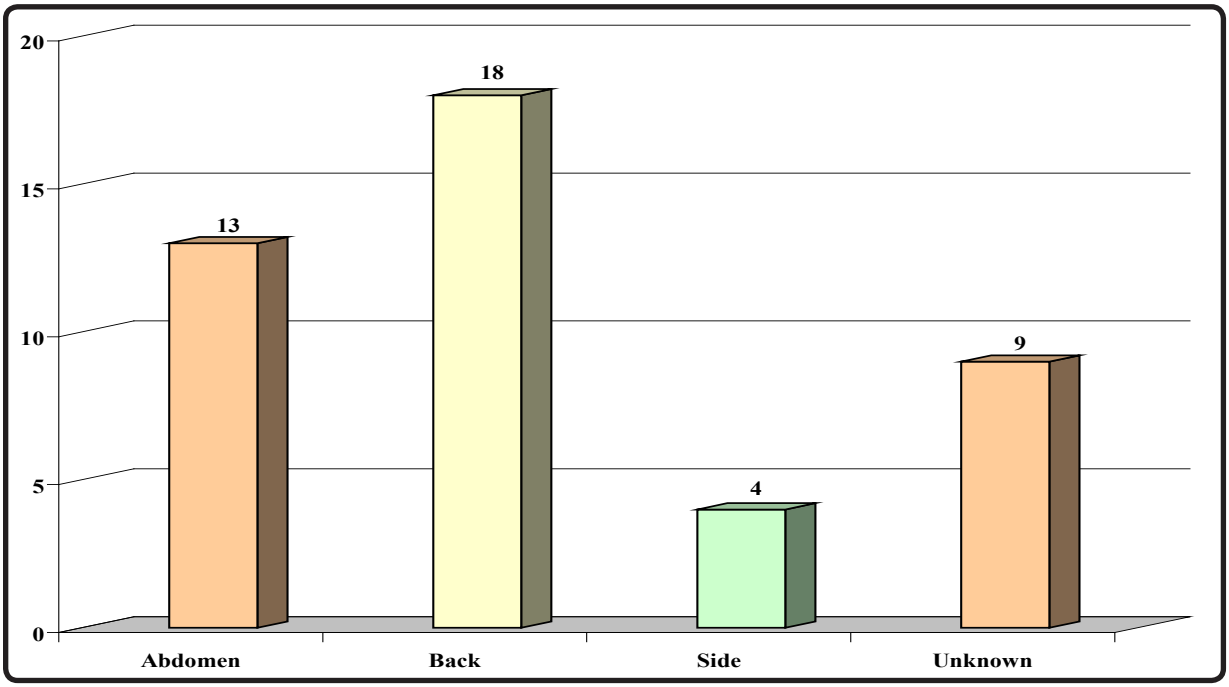
The majority (93%) of the 44 SIDS deaths in 2005, occurred in the first six months of life, which is consistent with national findings.

Total Natural Deaths - SIDS by Age in Months, 1994 to 2005, N = 462



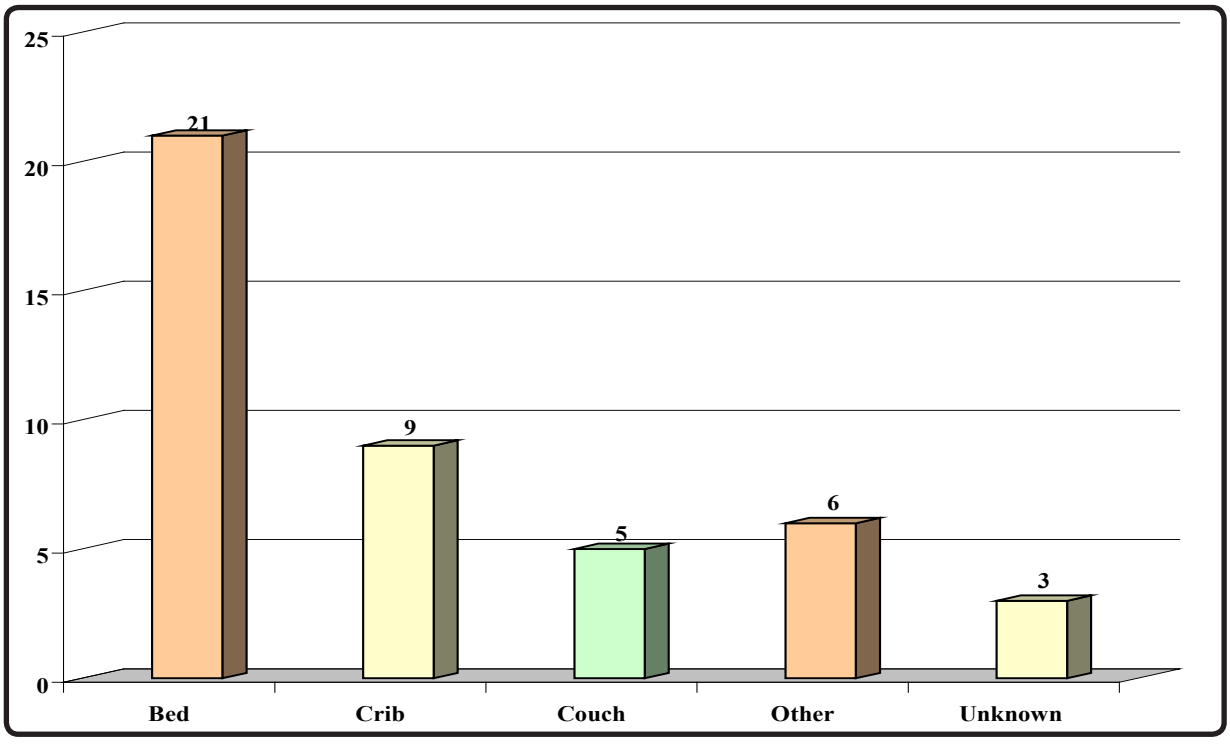
D. Natural Deaths - SIDS

Natural Deaths-SIDS by Baby's Position in 2005, N= 44



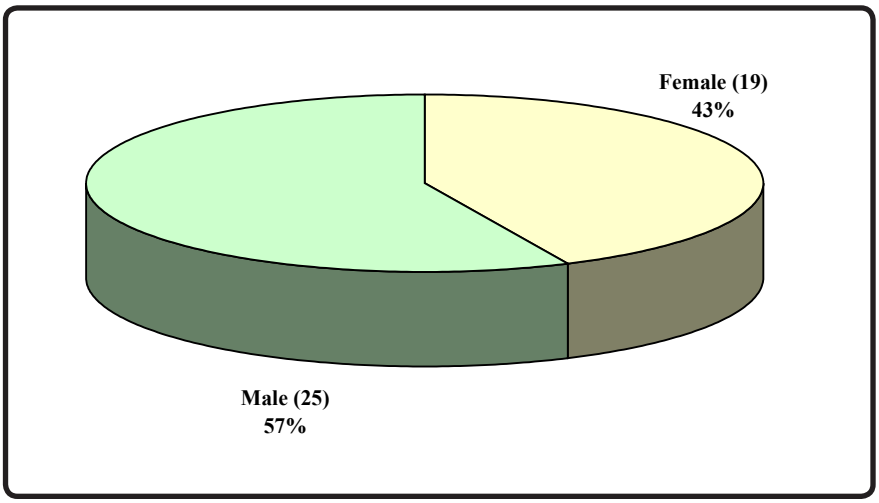
Placing babies to sleep on their back in approved cribs with a firm mattress reduces both the risk of SIDS and unintentional suffocation.

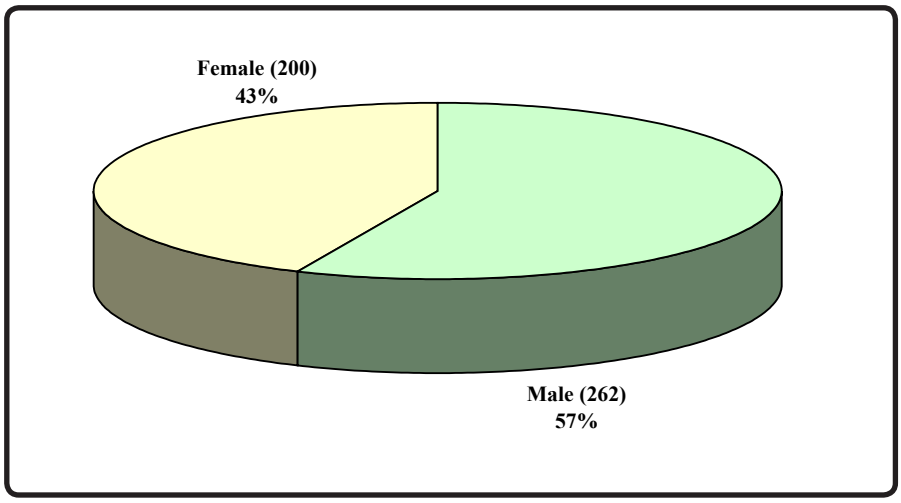
Natural Deaths-SIDS by Sleeping Place in 2005, N= 44



D. Natural Deaths - SIDS

Natural Deaths-SIDS by Gender in 2005, N = 44





Total Natural Deaths-SIDS by Gender, 1994 to 2005, N = 462

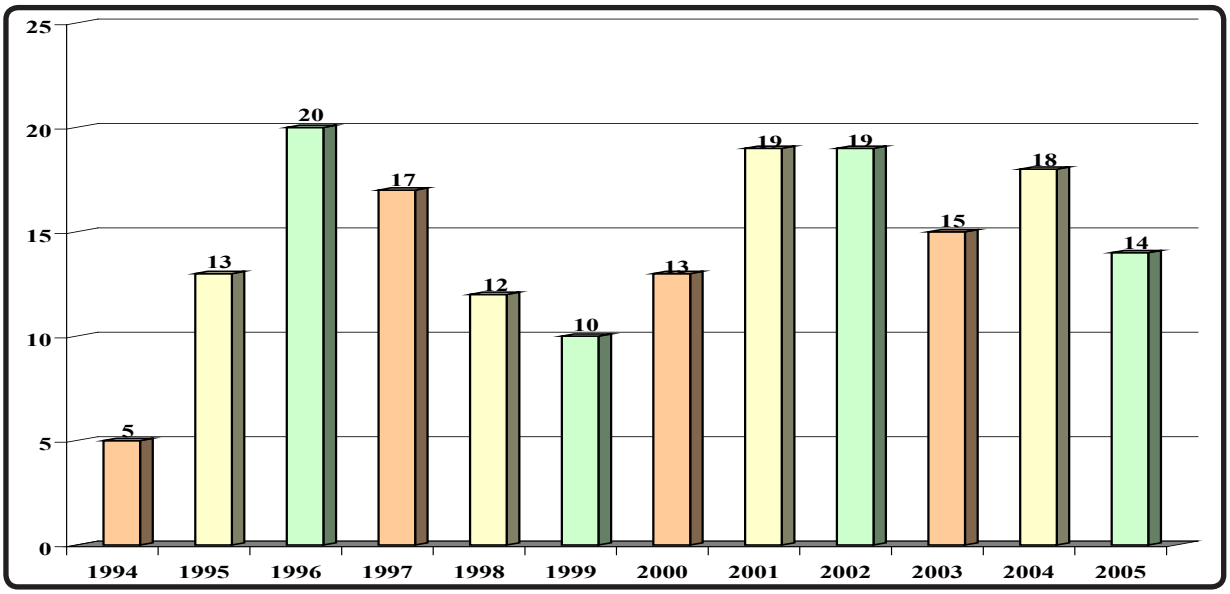
PREVENTION POINTS

- Infants should be placed to sleep in a supine position (on the back). Side sleeping is not as safe as supine sleeping, and is not advised.
- A firm sleep surface should be used. Soft materials such as pillows, quilts, comforters, or sheepskins should not be placed with the infant.
- Use sleep clothing, such as sleep sacks designed to keep the infant warm instead of bedding, which could overheat the infant or cover the baby's head. Avoid overheating the infant's room.
- Smoking during pregnancy is a major risk factor and should be avoided.
- A separate, but proximate sleeping environment is recommended. Bed sharing with adults or other siblings should be avoided.
- Pacifier use during sleep reduces the risk of SIDS, but should not be forced upon an infant or reinserted once the infant falls asleep.
- Devices promoted at reducing SIDS have not been proven to reduce the incidence of SIDS. Obtain an evaluation/recommendation from a medical professional before use of such products.

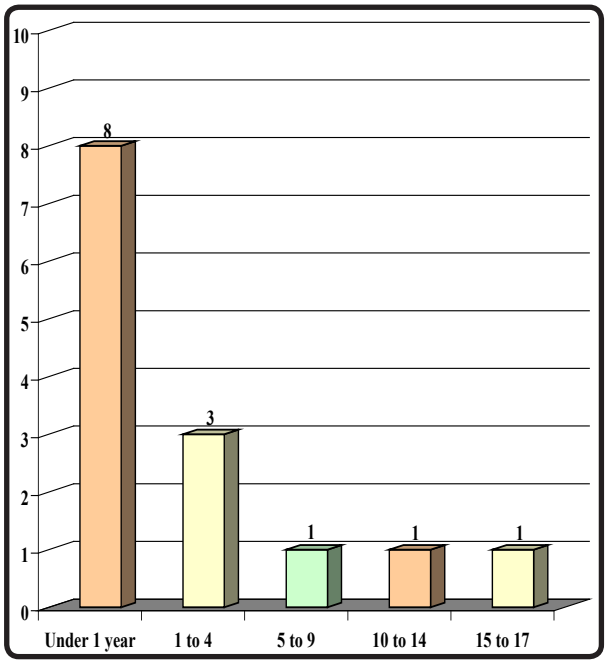
E. Undetermined

Periodically, the Board encounters cases where an investigation was conducted, but questions remain as to what could have contributed to the child's death. Contributing factors could include: the mother taking medication while breast feeding, a child not being properly supervised, illicit drugs in the environment, or concerns about social history. When there are multiple circumstances that could have contributed to the child's death and no identifiable cause is established, the Board may classify the death as Undetermined. The Board has reviewed 175 Undetermined deaths since 1994.

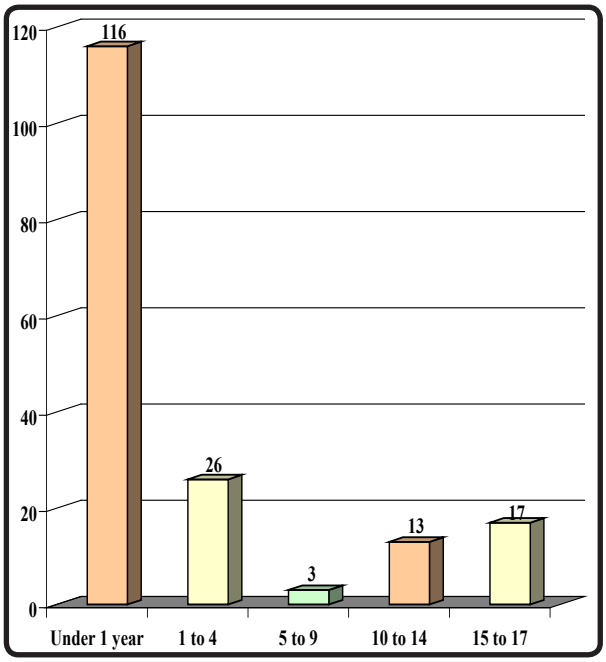
Total Undetermined Deaths, 1994 to 2005, N= 175



Undetermined Deaths by Age in 2005, N = 14



Total Undetermined Deaths by Age, 1994 to 2005, N = 175

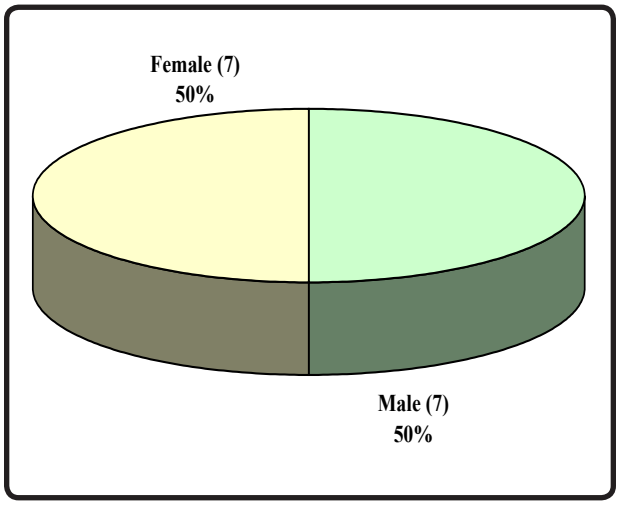


E. Undetermined

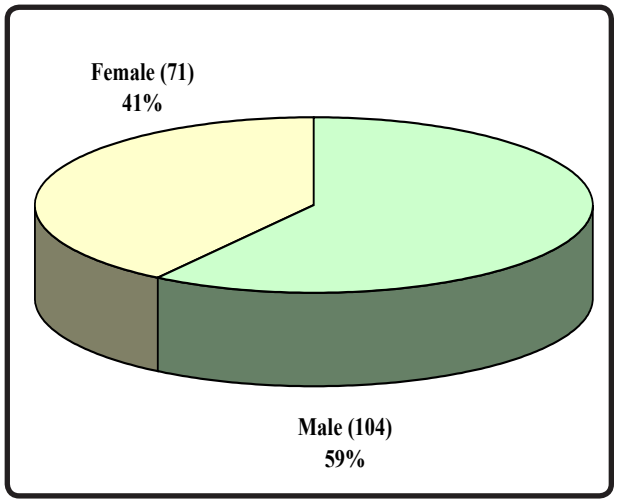
There were 14 Undetermined deaths in 2005, which cover a broad spectrum of investigative thoroughness. In some cases, although every effort was made to determine why a death occurred, there was no way to ascertain a cause of death. Other cases revealed incomplete investigations or law enforcement agencies not being informed of the death. In some instances, autopsies were not performed or were incomplete, or toxicology reports on the victim were not requested. This issue is important enough that the SCDRB has once again included in its public policy recommendations a call for thorough investigations.

A premature infant who had been doing fine at home was found cold and blue. Law enforcement responded, but did not conduct a complete scene investigation. An autopsy was performed after the child was embalmed. Complete x-rays, toxicology, and other pertinent information was not obtained making it virtually impossible to determine the cause of death.

Undetermined Deaths by Gender in 2005, N = 14



Total Undetermined Deaths by Gender, 1994 to 2005, N = 175



An infant was found unresponsive in the same bed with the mother and father. It could not be determined if the death was caused by positional asphyxia, as a thorough and proper investigation was not done.

PREVENTION POINTS

- **Thorough Investigations -** All non-natural child deaths should be exhaustively investigated. The circumstances and family situation should not affect the detail of the inquiry. Hospitals should have protocols in place to ensure law enforcement is notified when a child dies from other than expected natural causes.
- **Complete Autopsies -** Combined with excellent law enforcement investigations, complete autopsies often provide a better understanding of child deaths. However, there are situations in which an autopsy should have been performed and was not, or the autopsy did not include all aspects of a standard forensic investigation such as full-body x-rays, cultures, and metabolic/toxicologic studies. Coroners must be mindful of their statutory duties and should be aware of the reimbursement program through the Kansas Department of Health & Environment. Visit the SCDRB's website at http://www.ksag.org/content/page/id/49.

IV. Public Policy Recommendations

The Child Death Review Board has chosen to provide policy recommendations in areas that could significantly affect child deaths in Kansas. The information gathered and analyzed by the Board provides compelling support for the recommendations made below.

INSTITUTE GRADUATED DRIVERS LICENSE LAW

The State Child Death Review Board firmly agrees with published data that a graduated licensing system will reduce the number of motor vehicle crash (MVC) injuries and fatalities and should be instituted in Kansas.

MVC incidents take the lives of many Kansas children every year. Kansas has lost a total of 884 children under the age of 17 from 1994 through 2005. Almost all of the motor vehicle deaths involved risk factors such as inexperience or inattentive driving, lack of safety restraints, and/or excessive speed. The majority of cases reviewed involve passengers being ejected from the vehicle and inexperienced drivers. Above all, motor vehicle deaths are consistently shown to be preventable. A significant portion of MVC preventability comes with the proper use of safety restraints and suitable driving skills, which can be achieved through a graduated licensing system. According to a study from the Johns Hopkins Bloomberg School of Public Health's Center for Injury Research and Policy and the Johns Hopkins School of Medicine[3], a graduated licensing system on average reduces 20% of the fatal crashes involving teen drivers. Graduated licensing laws allow adolescents to become more proficient and experienced in their driving before having full driving privileges. A U.S. Department of Transportation report lists 38 states that have instituted a graduated licensing system. Kansas is not among them.[4] An effective graduated licensing system would encompass the following:

To receive a *Level One Limited Learner Permit* an applicant must be at least 15 years of age, have completed an approved driver education course, and successfully pass a written exam and vision test.

Provisions/Restrictions for *Level One Limited Learner Permit* holders:

- All occupants must be properly restrained.
- Only driver and supervising driver allowed in front seat.
- Driving hours are restricted from 5 am to 9 pm with supervising driver for first 6 months.
- The driver may not operate wireless devices while driving.

To receive a *Level Two Limited Provisional License* an applicant must be at least 16 years of age, have had a Level One permit for 12 months, and have had no moving violations, seat belt infractions, improper wireless use infractions, or Minor In Possession (MIP) violations within the preceding 6 months.

Provisions/Restrictions for *Level Two Limited Provisional License* holders:

- All occupants must be properly restrained.
- Supervising driver must be seated beside driver.
- The driver may not operate any wireless devices while driving.
- Driver may drive without supervision between 5 am and 9 pm, and anytime when driving directly to or from work.
- When driving without a supervisor, there can be no more than 1 passenger under 21-years-of-age unless they are members of the immediate family.
- No other passengers under 21-years-of-age are allowed when driving without a supervisor if a family member under 21-years-of-age is a passenger.

To be issued a *Level Three Full Provisional License* an applicant must have had a *Level Two Limited Learner License* for at least 6 months with no convictions of moving violations, seat belt infractions, improper wireless use, or MIP violations within the preceding 6 months.

Provisions/Restrictions for *Level Three Full Provisional License* holders:

- All occupants must be properly restrained.

IV. Public Policy Recommendations

ENHANCE ATV USAGE LAWS

ATV use in Kansas has increased, and with it, the ATV fatality rate. Since 1994, Kansas has lost 34 children in ATV-related crashes. Speed, inexperience, size, and lack of strength to safely control an ATV are major risk factors. In 2005, two separate ATV-related incidents involved a Kansas youth who died when the ATV they were navigating rolled over, pinning them between the ATV and the ground. In another 2005, incident a Kansas teen was riding an ATV driven by another teen who was traveling at approximately 65 mph. The driver lost control and struck a tree, killing the passenger and injuring himself.

Each year, in the United States, more than 100 children ages 17-and-under are killed and approximately 45,000 are injured on ATVs, which can reach speeds of 75 mph. Nationwide, children under the age of 16 account for 1/3 of both deaths and accidents.[2] Compared to a bicycle crash, an ATV crash is six times as likely to send a child to the hospital, and 12 times as likely to kill a child. In addition, a child under age 16 riding an ATV is four times as likely to be seriously injured as a rider over age 16.

To prevent such incidents, the Board makes the following recommendations:

- No child under the age of 12 be permitted to operate an ATV of any size.
- All riders are required to wear a helmet.
- ATV use on highways, byways, city and county roadways, or right-of-ways be prohibited; except for stipulations as stated in K.S.A. 8-15, 100 (b).
- Passengers may not be carried except for agricultural purposes and except for ATVs designed to carry more than one person.
- All ATVs shall be registered and titled.

ENACT LAWS PROHIBITING CHILDREN LEFT UNATTENDED IN VEHICLES

The Board firmly holds the position that there is no substitute for supervision, especially when it involves children and vehicles. On a yearly basis, the Board finds itself reviewing cases of children who were left unattended in a vehicle, which resulted in their untimely death. Most often the deaths take place within minutes of the child being left alone, and usually occur from one of following:

- Hypothermia
- Hyperthermia
- Strangulation from a car seatbelt
- Strangulation from an automatic power window
- A motor vehicle crash from the child putting the vehicle in gear

Another significant risk to the child's health and safety when left unattended in a vehicle is a car-jacking or theft. Unlocked and running vehicles are at a high risk of being stolen for joy rides or for use in the commission of a crime. If a child is in the vehicle when the thief takes control, the outcome could be tragic. Unattended children could also become locked in the trunk compartment and suffocate, while a frantic parent searches the surrounding area for the missing child.

It is the Board's belief that the Legislature should enact a law that encompasses the following:

- No child under the age of 5 may be left in a motor vehicle unless they are accompanied by another person 13-years-of-age or older.
- No child under the age of 5 shall be left unsupervised or unattended in a vehicle for more than 5 minutes, unless the vehicle is being loaded or unloaded.
- A fine of $25 should be imposed for the first conviction, and subsequent convictions that occur within three years of the first violation should result in a minimum fine of $250, not to exceed $500.

IV. Public Policy Recommendations

CONTINUE RIGOROUS ENFORCEMENT OF SAFETY RESTRAINT LAWS

Between 1994 and 2005, 884 Kansas children under the age of 18 died in motor vehicle crashes. That is more than one death a week. In 530 of the incidents, seatbelts were not used by the children that died.

The Board would like to see law enforcement officials and the judicial system be more diligent and consistent in their enforcement of the current seatbelt law.

FARM-RELATED ISSUES

Kansas has a rich farming history, and Kansas farmers are dependent on their farm help, which are often young teens. The Board recognizes this invaluable relationship while also recognizing the dangers related to farming. It is with this understanding that the Board proposes changes to Kansas law, which will reduce the number of farm-related child fatalities.

To obtain a Farm Permit for driving purposes in Kansas an applicant must be a least 14-years-of-age, have formal government issued proof that the person either lives on or works for a farm, have a signed affidavit by either a parent or guardian stating that the applicant has completed at least 50 hours of adult supervised driving with at least 10 of those hours being at night, and have passed a written and vision test. When driving using a Farm Permit a person is restricted to driving to or from, or in connection with, any farm-related work and may not transport non-sibling minor passengers. Unfortunately, the Board has reviewed several cases since its inception that indicate the Farm Permit requirements were not complied with and that risk factor contributed to a fatality.

The Board would like to see the following changes made to the Kansas Farm Permit law:

- All drivers are required to pass a formal driver's education course.
- In lieu of the signed affidavit of employment, a farm permit holder is required to provide a government issued 1099 or W2 form.
- Driving to and from school be prohibited.
- Strict adherence to and enforcement of Kansas law by law enforcement officials.

Another concern the Board has in relation to farm-related work is young children working around farm equipment. Every year the Board reviews cases that involve youths who are killed while working on the farm. The majority of these cases could be prevented if the following regulations were in place:

- No child under the age of 10 is allowed to ride as a passenger or helper on farm equipment.
- No child under the age of 14 is allowed to operate or assist in operation including starting, stopping, adjusting, feeding, or any other activity involving physical contact associated with farm equipment.
- No child under the age of 16 is allowed to operate farm equipment over 20 PTO horsepower, or connect/disconnect an implement or any of its parts to or from such equipment.
- No child under the age of 16 is allowed to handle or apply, including cleaning, decontaminating, disposing of, or recycling agricultural chemicals or empty containers classified under the Federal Insecticide, Fungicide, and Rodenticide Act (7 U.S.C. 135 et seq.).
- No child under the age of 16 is allowed to transport, transfer, or apply anhydrous ammonia.
- No child under the age of 16 is allowed to work inside a fruit, forage, or grain storage bin designed to retain an oxygen deficient or toxic atmosphere.

IV. Public Policy Recommendations

COMPREHENSIVE AND THOROUGH INVESTIGATION OF CHILD DEATHS

According to Dr. Erik Mitchell, District Coroner and Board member, "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 for 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 unnatural 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 unnatural child deaths."

The State Child Death Review Board would be incapable of performing its function without the dedicated efforts of law enforcement officers and county and district coroners. While the investigation of child deaths is a difficult task, only thorough examinations of these incidents allow the Board to gather accurate information. Without that foundation, the Board cannot make recommendations for ways to prevent the deaths of Kansas children.

SCDRB SERVES AS A CITIZEN REVIEW PANEL

The Kansas Child Death Review Board also serves in the capacity as one of three Citizen Review Panels in the State. Each state is required by the Federal Child Abuse Prevention and Treatment Act (CAPTA) to establish citizen review panels in order to receive federal funding for child abuse prevention services.
The purpose of the citizen review panels is to determine whether state and local agencies are effectively discharging their child protection responsibilities.

Citizen review panels are required by CAPTA to do the following:

- Measure agency performance by determining whether the state agency complies with the state CAPTA plan, including the state's assurances of compliance with federal requirements contained in the plan.
- Determine the extent of the agencies' coordination with the Title IV-E foster care and adoption systems and the review process for child fatalities and near fatalities.
- Prepare and make available to the public an annual report summarizing the panel's activities.
- Review policies and procedures of state and local agencies to evaluate the extent to which the agencies are effectively discharging their child protection responsibilities.
- Provide for public outreach and comments in order to assess the impact of current policies, procedures, and practices upon children and families in the community.
- Provide recommendations to the State and public on improving the child protective services system at the state and local levels.

V. Appendix

METHODOLOGY

Kansas Child Death Review Board 2005 Data

The SCDRB meets monthly to examine the circumstances surrounding the deaths of all Kansas children aged birth through 17 years, as well as children who are not residents but die in the state. Typically the SCDRB is alerted of a death when they receive birth/death certificates from the Kansas Department of Health and Environment (KDHE) Vital Statistics Department. On a monthly basis, KDHE provides the SCDRB with a listing of children whose deaths have been reported for the previous month. The Vital Statistics Department also has a close working relationship with other state vital statistics departments and receives death certificates from those departments when a Kansas child passes away in another state.

When a death certificate is received, the SCDRB staff creates a file. Death and birth certificates, as well as the coroner information, are used to identify additional information necessary for a comprehensive review. Before a case can be reviewed, all coroner information, e.g. coroner report form, autopsy report, and the report of death, must be in the file. In addition, all pertinent records which could provide a complete picture of the circumstances that led to the child's demise must accompany the file. Such records may include: medical reports, law enforcement reports, scene photographs, social history notes, SRS records, obituaries, etc. 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 a secured web-based database. The on-line database provides a relatively easy way to maintain information. However, transfers of information between outdated software to the new system in 2000 have created the possibility for slight number adjustments when reviewing data from past years.

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. This would include recommendations for follow-up investigation.

Any questions about this report or about the work of the SCDRB should be directed to Angela Nordhus, Executive Director, at (785) 296-7970 or by e-mail at angela.nordhus@ksag.org.

V. Appendix

GOALS & 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. As a result 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, KDHE, 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 in to conformity with fatality review boards in other states, so that future trends and patterns can be compared.

V. Appendix

Child Deaths By County of Residence in 2005

County	Total Population	Total Deaths	Natural - Exccept Sids	Unintentional Injury - MVA	Unintentional Injury	Natural - SIDS	Undeter-mined	Homicide	Suicide
Allen	14,385	1	0	0	0	1	0	0	0
Anderson	8,110	2	0	2	0	0	0	0	0
Atchison	16,774	1	0	0	0	0	1	0	0
Barber	5,307	1	0	0	1	0	0	0	0
Barton	28,205	4	2	2	0	0	0	0	0
Bourbon	15,379	4	4	0	0	0	0	0	0
Brown	10,724	2	0	2	0	0	0	0	0
Butler	59,482	3	2	0	0	0	0	0	1
Chase	3,030	0	0	0	0	0	0	0	0
Chautauqua	4,359	0	0	0	0	0	0	0	0
Cherokee	22,605	2	1	0	0	0	0	1	0
Cheyenne	3,165	0	0	0	0	0	0	0	0
Clark	2,390	0	0	0	0	0	0	0	0
Clay	8,822	0	0	0	0	0	0	0	0
Cloud	10,268	0	0	0	0	0	0	0	0
Coffey	8,865	0	0	0	0	0	0	0	0
Comanche	1,967	0	0	0	0	0	0	0	0
Cowley	36,291	2	0	1	0	0	1	0	0
Crawford	38,242	5	1	3	0	0	1	0	0
Decatur	3,472	1	0	0	1	0	0	0	0
Dickinson	19,344	1	0	0	1	0	0	0	0
Doniphan	8,249	1	0	0	0	0	1	0	0
Douglas	99,962	9	5	0	2	1	0	1	0
Edwards	3,449	0	0	0	0	0	0	0	0
Elk	3,261	1	0	0	0	0	0	1	0
Ellis	27,507	4	3	1	0	0	0	0	0
Ellsworth	6,525	0	0	0	0	0	0	0	0
Finney	40,523	13	1	8	0	3	0	0	1
Ford	32,458	5	2	1	1	0	0	1	0
Franklin	24,784	3	2	1	0	0	0	0	0
Geary	27,947	6	3	0	0	1	1	0	1
Gove	3,068	0	0	0	0	0	0	0	0
Graham	2,946	0	0	0	0	0	0	0	0
Grant	7,909	3	0	3	0	0	0	0	0
Gray	5,904	1	0	1	0	0	0	0	0
Greeley	1,534	2	0	0	1	1	0	0	0
Greenwood	7,673	2	0	2	0	0	0	0	0
Hamilton	2,670	1	1	0	0	0	0	0	0
Harper	6,536	4	0	3	0	0	0	0	1
Harvey	32,869	4	4	0	0	0	0	0	0
Haskell	4,307	0	0	0	0	0	0	0	0
Hodgeman	2,085	0	0	0	0	0	0	0	0
Jackson	12,657	3	3	0	0	0	0	0	0
Jefferson	18,426	0	0	0	0	0	0	0	0
Jewell	3,791	0	0	0	0	0	0	0	0
Johnson	451,086	41	33	3	0	5	0	0	0

V. Appendix

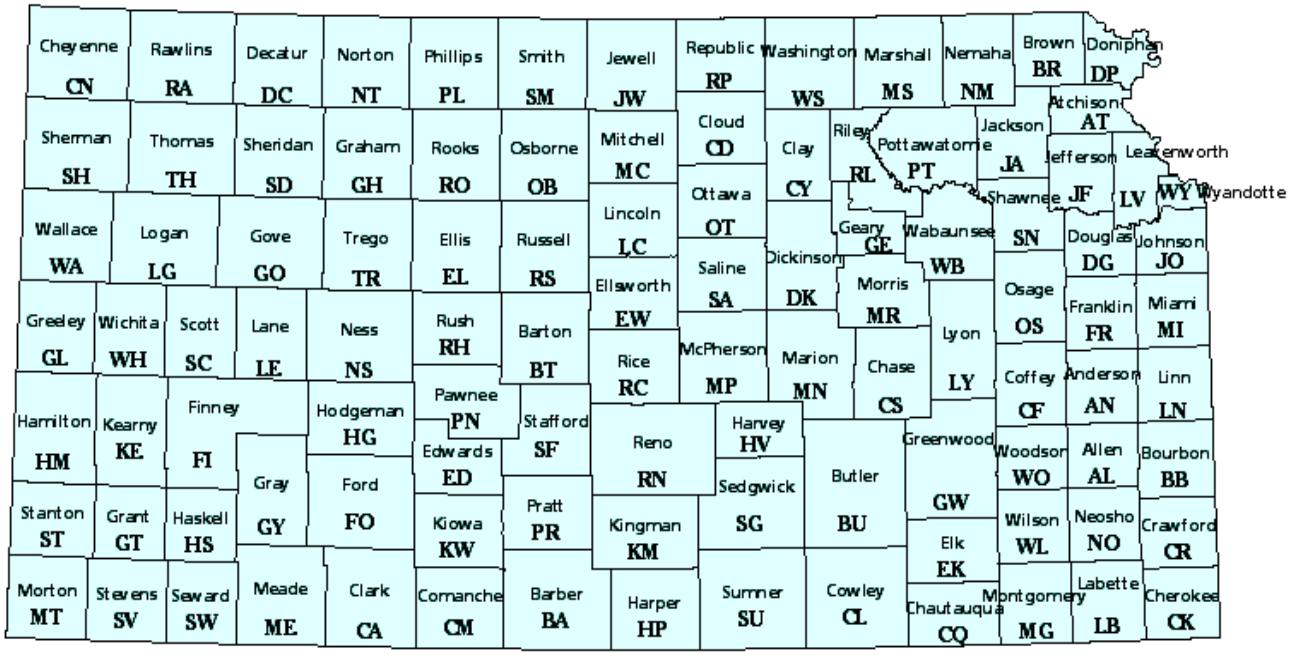
Child Deaths by County of Residence in 2005, Continued

County	Total Population	Total Deaths	Natural - Except Sids	Unintentional Injury - MVA	Unintentional Injury	Natural - SIDS	Undeter-mined	Homicide	Suicide
Kearny	4,531	1	0	1	0	0	0	0	0
Kingman	8,673	0	0	0	0	0	0	0	0
Kiowa	3,278	1	0	1	0	0	0	0	0
Labette	22,835	4	2	0	1	1	0	0	0
Lane	2,155	0	0	0	0	0	0	0	0
Leavenworth	68,691	5	1	2	2	0	0	0	0
Lincoln	3,578	1	0	0	0	1	0	0	0
Linn	9,570	0	0	0	0	0	0	0	0
Logan	3,046	0	0	0	0	0	0	0	0
Lyon	35,935	2	1	0	0	0	0	1	0
Marion	29,554	0	0	0	0	0	0	0	0
Marshall	13,361	0	0	0	0	0	0	0	0
McPherson	10,965	0	0	0	0	0	0	0	0
Meade	4,631	0	0	0	0	0	0	0	0
Miami	28,351	4	1	3	0	0	0	0	0
Mitchell	6,932	0	0	0	0	0	0	0	0
Montgomery	36,252	5	2	1	0	2	0	0	0
Morris	6,104	0	0	0	0	0	0	0	0
Morton	3,496	2	0	2	0	0	0	0	0
Nemaha	10,717	3	1	1	0	1	0	0	0
Neosho	16,997	1	1	0	0	0	0	0	0
Ness	3,454	0	0	0	0	0	0	0	0
Norton	5,953	1	0	1	0	0	0	0	0
Osage	16,712	0	0	0	0	0	0	0	0
Osborne	4,452	0	0	0	0	0	0	0	0
Ottawa	6,163	0	0	0	0	0	0	0	0
Pawnee	7,233	0	0	0	0	0	0	0	0
Phillips	6,001	2	1	0	0	0	1	0	0
Pottawatomie	18,209	1	0	1	0	0	0	0	0
Pratt	9,647	2	1	0	0	0	0	1	0
Rawlins	2,966	0	0	0	0	0	0	0	0
Reno	64,790	3	2	0	0	0	0	1	0
Republic	5,835	0	0	0	0	0	0	0	0
Rice	10,761	0	0	0	0	0	0	0	0
Riley	62,843	3	3	0	0	0	0	0	0
Rooks	5,685	0	0	0	0	0	0	0	0
Rush	3,551	1	0	1	0	0	0	0	0
Russell	7,370	0	0	0	0	0	0	0	0
Saline	53,597	6	6	0	0	0	0	0	0
Scott	5,120	1	1	0	0	0	0	0	0
Sedgwick	452,869	134	99	12	3	16	1	0	3
Seward	22,510	5	4	0	1	0	0	0	0
Shawnee	169,871	42	33	1	1	5	2	0	0
Sheridan	2,813	0	0	0	0	0	0	0	0
Sherman	6,760	1	1	0	0	0	0	0	0

V. Appendix

Child Deaths by County of Residence in 2005, Continued

County	Total Population	Total Deaths	Natural - Except Sids	Unintentional Injury - MVA	Unintentional Injury	Natural - SIDS	Undeter-mined	Homicide	Suicide
Sheridan	2,813	0	0	0	0	0	0	0	0
Sherman	6,760	1	1	0	0	0	0	0	0
Smith	4,536	0	0	0	0	0	0	0	0
Stafford	4,789	1	1	0	0	0	0	0	0
Stanton	2,406	0	0	0	0	0	0	0	0
Stevens	5,463	0	0	0	0	0	0	0	0
Sumner	25,946	2	1	0	0	0	0	0	1
Thomas	8,180	0	0	0	0	0	0	0	0
Trego	3,319	0	0	0	0	0	0	0	0
Wabaunsee	6,885	2	0	2	0	0	0	0	0
Wallace	1,749	0	0	0	0	0	0	0	0
Washington	6,483	1	1	0	0	0	0	0	0
Wichita	2,531	0	0	0	0	0	0	0	0
Wilson	10,332	1	1	0	0	0	0	0	0
Woodson	3,788	1	1	0	0	0	0	0	0
Wyandotte	157,882	45	34	2	1	4	3	1	0
Out of State		*83*	*57*	*12*	*6*	*2*	*2*	*4*	*0*
Total	***2,688,418***	***499***	***323***	***76***	***22***	***44***	***14***	***12***	***8***



V. Appendix

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