2017

AD ASTRA PER ASPERA

Kansas

State Child Death Review Board

KANSAS ATTORNEY GENERAL

Derek Schmidt

2017 Annual Report
(2015 Data)

www.ag.ks.gov

Kansas Attorney General Derek Schmidt

September 29, 2017

Dear Fellow Kansans:

For almost a quarter of a century, dedicated professionals serving on the State Child Death Review Board have worked diligently to review the causes of child death in our state. They toil to compile meaningful data and analysis that can be the basis for actions that will make our children safer. This year, as always, I am grateful for their service.

This report compiles and evaluates information collected from 2015, the most recent year for which data is available. It provides analysis, context and "prevention points" – recommendations for action that can help prevent similar deaths in the future. It also makes several public policy recommendations intended to reduce child mortality.

I hope this information will add to the many discussions about efforts in Kansas, both together and individually, to make Kansas a safer place for our children to grow up. As one of the great Kansans, Dwight David Eisenhower, said after the death of his young son, "There's no tragedy in life like the death of a child. Things never get back to the way they were."

Best wishes,

Derek

Derek Schmidt
Kansas Attorney General

Executive Summary

The State Child Death Review Board was created by statute in 1992. The Board is charged with reviewing all deaths of children ages birth through 17 years old who die within Kansas and Kansas residents in that age group who die outside the state. The Board works to identify patterns, trends and risk factors and to determine the circumstances surrounding child fatalities. The ultimate goal is to reduce the number of child fatalities in the state.

The Board is unique in its duties as it is the only entity in the State of Kansas that conducts a thorough review of each child death by analyzing medical records, law enforcement reports, social service histories, school records and other pertinent information including birth certificate, death certificate and autopsy results. The information collected is maintained confidentially and is used to review and analyze the circumstances of each child's death. This review allows the Board to assist other agencies in prioritizing education and prevention efforts. The Board members and staff collaborate with other agencies on child safety issues, testify on pertinent legislation, conduct trainings and serve on committees and task forces in an effort to support the work of protecting Kansas children.

Between July 1, 2016, and June 30, 2017, the Board:

- Held 13 board meetings
- Reviewed the deaths of 394 children
- Made twelve public policy recommendations
- Attended/participated in 82 public meetings/training seminars
- Submitted an annual report

Since 1994, the Board has reviewed 10,462 child deaths. In 2015, Kansas had 394 child fatalities. The manners of death are classified into one of the following six categories:

1. Natural-Except Sudden Infant Death Syndrome – death brought about by natural causes such as prematurity, congenital conditions, cancer and disease. Natural death remains the category with the most deaths: 238 in total. Of those causes, 40 percent were due to prematurity, 32 percent were due to congenital anomalies, and nearly 10 percent were due to cancer.

2. Natural-Sudden Infant Death Syndrome (SIDS) – children who die prior to age one, and display no discoverable cause of death. K.S.A 22a-242 requires an investigation and an autopsy be performed before this classification can be applied. There were 23 SIDS cases in 2015, all of which were classified as SIDS II, indicating the presence of one or more elements of unsafe sleep. A full description of SIDS categories is on page 10.

In addition, there were 4 Unclassified Sudden Infant Deaths (USID) for which manner of death was categorized as Undetermined. For further description of this category, see page 10.

3. Unintentional Injury – death caused by incidents such as motor vehicle crashes, drowning or fire, which were not the result of an intentional act. In 2015, there were 79 total unintentional injury deaths with the leading cause of death being motor vehicle crashes (MVC). Thirty-eight children died because of a MVC. Of all the age groups, the 15-17 year old group accounted for

the majority of the MVC deaths. Forty-four percent of the children in the 15-17 year old age group were not using a safety restraint at the time of the crash. That, coupled with inattentive driving, excessive speed and driver inexperience leaves this age group at the greatest risk of death or injury in MVCs.

The second most prevalent unintentional injury death was asphyxia. In 2015, 17 children died due to unintentional asphyxia, 15 of which were sleep related. All 15 sleep related asphyxia deaths included the presence of unsafe sleep factors.

4. Homicide – death due to an intentional act, unintentional act, or criminally negligent act leading to the death of another human being, including Child Abuse Homicide and Gang-Related Homicide. There were 21 child homicides in 2015, and of those, 14 were under the age of four. Fourteen of the 19 homicides were the result of child abuse. In 57 percent of all homicides, the event causing the death of the child took place at the residence of the child.

5. Suicide – death due to the intentional taking of one's own life. In 2015, there were 18 suicide deaths, six of which were age 14 or younger. The rate of suicides by Kansas youth continues to climb, despite a decline in the overall rate of child deaths. Of the 18 children who committed suicide, 56 percent had previously received or were receiving mental health services at the time of their death. In 22 percent of the suicides, the family felt the death was completely unexpected as the child did not have or display any history of mental illness, suicidal ideation, or other risk factors associated with suicide.

6. Undetermined – cases in which the manner of death could not be identified from the evidence collected. In 2015, 15 cases were classified as Undetermined and four of those were listed as Unclassified Sudden Infant Death (USID). Of the deaths listed as undetermined, 67 percent were children less than 1 year of age. Often the undetermined classification is assigned when there is a lack of thorough, comprehensive investigation and/or autopsy. In 2015, three of the 15 cases had an inadequate investigation and eight (53 percent) had an inadequate autopsy or an autopsy was not completed. In 60 percent of the cases, acts of omission or commission were felt to have probably either caused or contributed to the death. Many of those acts of omission/commission were related to child abuse, parental drug use, or negligence such as unsafe sleep and home conditions.

Contents

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 the Attorney General, county coroners, law enforcement agencies, the Department for Children and Families (DCF), 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 volunteer Board, we appreciate the support of our employers who allow us time to fulfill our responsibilities as Board members.

SCDRB Serves as a Citizen Review Panel

The Federal Child Abuse Prevention and Treatment Act (CAPTA) requires each state 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. The Kansas State Child Death Review Board serves in the capacity as one of the three Citizen Review Panels in the State. In addition to the SCDRB, the Kansas Intake to Petition Panel and Kansas Custody to Transition Panel serve as citizen review panels.

The citizen review panels, as a group, are required by CAPTA to accomplish 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 panels' 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.

Board Members

Attorney General appointee

Melissa G. Johnson, J.D., Chairperson
Assistant Attorney General, Topeka

Director of Kansas Bureau of Investigation appointee

Tony Weingartner, Assistant Director
Kansas Bureau of Investigation, Topeka

Secretary for Children and Families appointee

Susan Gile, Program Administrator
Department for Children and Families, Topeka

Secretary of Health and Environment appointee

Elizabeth W. Saadi, Ph.D.
Kansas Department of Health and Environment, Topeka

Commissioner of Education appointee

Andy Tompkins, Ed.D. (August 2015-March 2017)
Topeka

State Board of Healing Arts appointees

Erik Mitchell M.D. (Pathologist member)
Deputy Coroner, Kansas City

Charles Glenn M.D. (Coroner member,August 2015-August 2017)
District Coroner, Topeka

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.
McDonald Law LLC, Newton

Kansas County and District Attorneys Association appointee

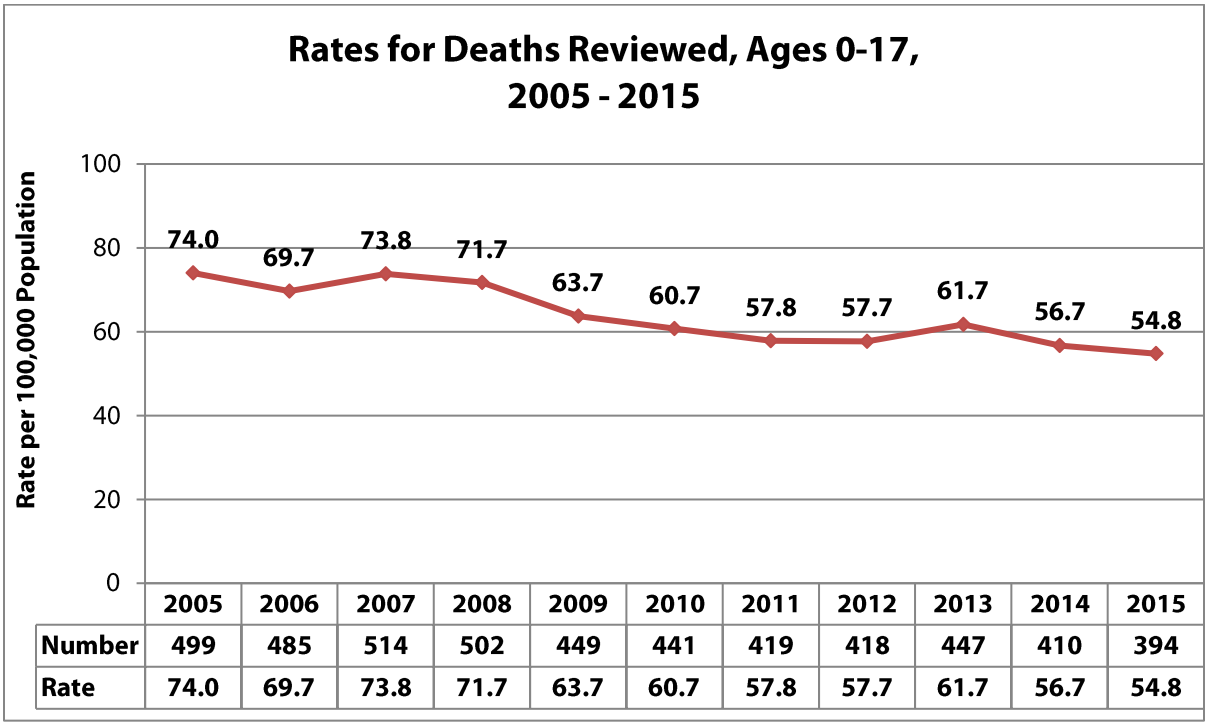
Kim Parker, J.D. (February 2007- November 2016)
Sedgwick County District Attorney's Office, Wichita

CJ Rieg, J.D. (November 2016-Current)
Douglas County District Attorney's Office, Lawrence

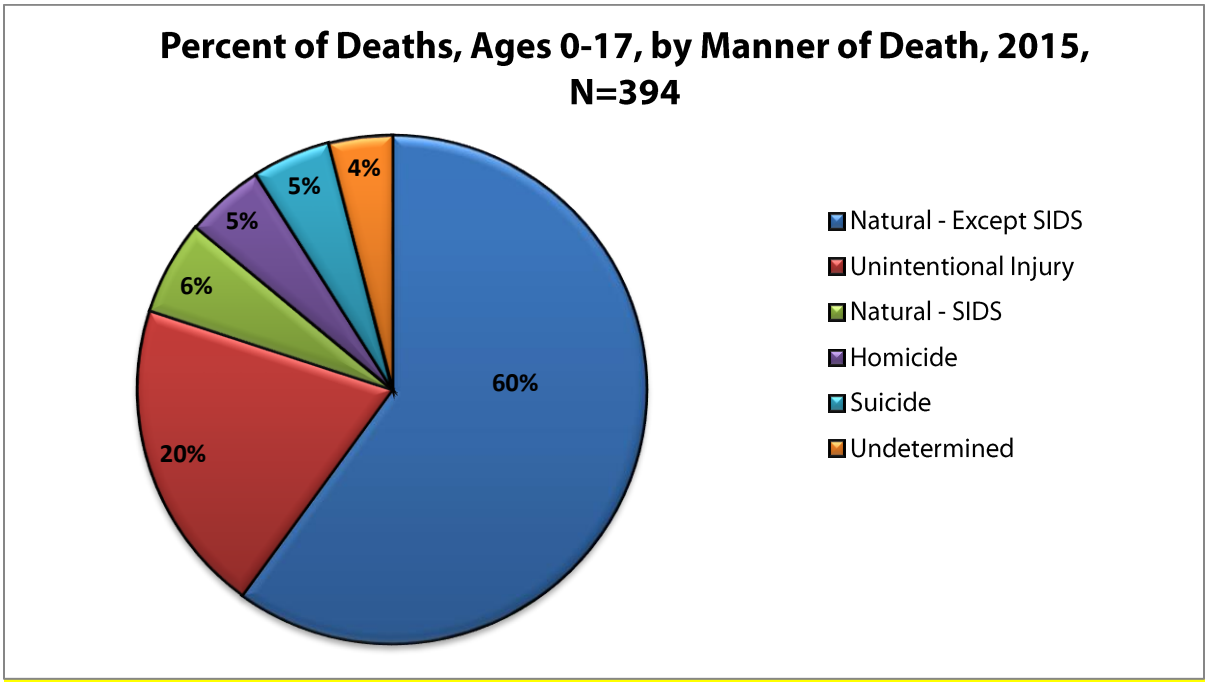
Staff	**Staff**	**General Counsel**
Executive Director	**Administrative Specialist**	**Assistant Attorney General**
Sara Hortenstine	Susan Croucher	Craig Paschang, J.D.

2015 Overview

The State Child Death Review Board reviewed the deaths of 394 children, aged 0-17, who died in Kansas, or were Kansas residents who died outside of the state during the year 2015. The death rate calculated per 100,000 Kansas children is decreasing and is the lowest since the Board began reviewing cases in 1994.



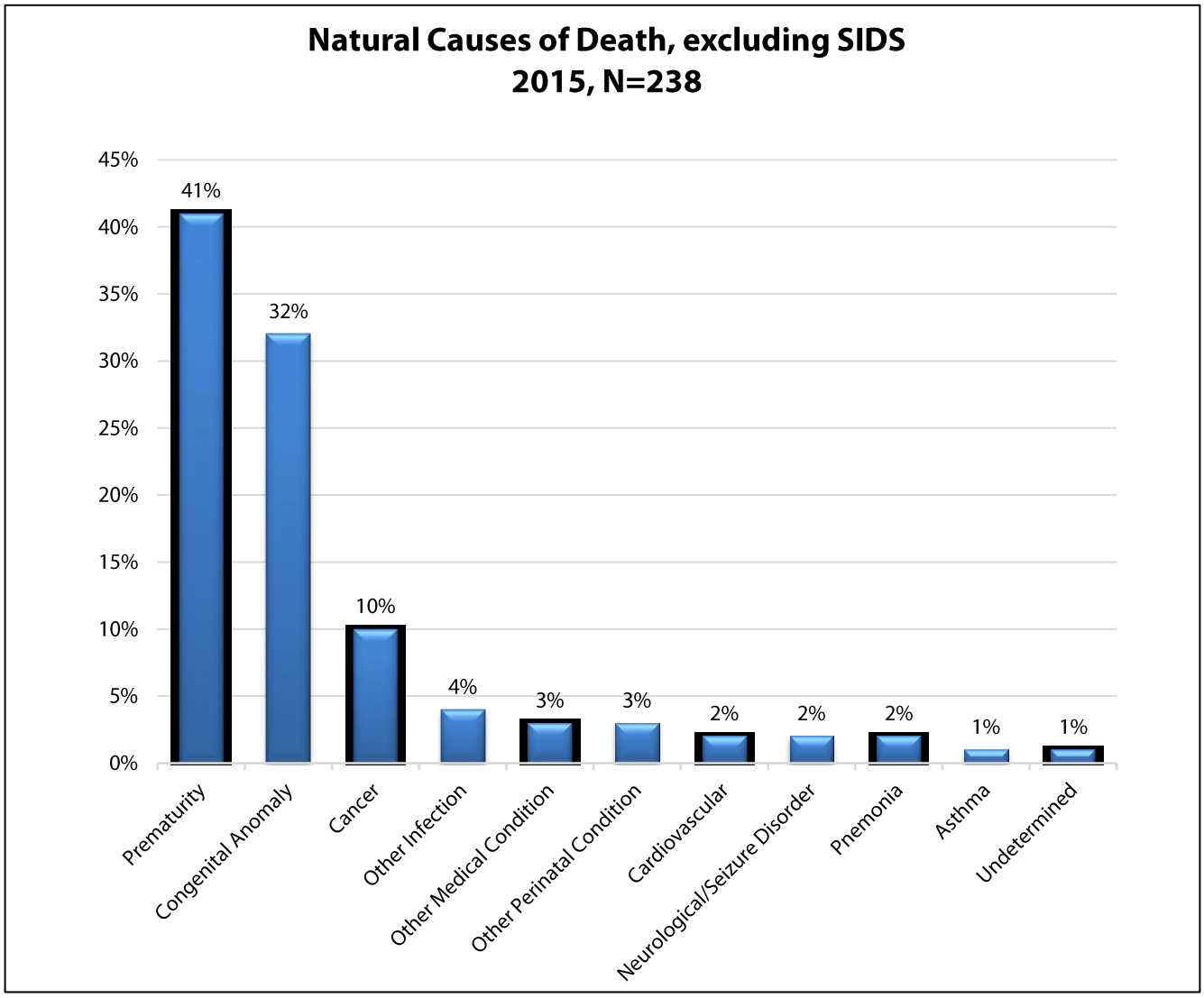
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Number	499	485	514	502	449	441	419	418	447	410	394
Rate	74.0	69.7	73.8	71.7	63.7	60.7	57.8	57.7	61.7	56.7	54.8

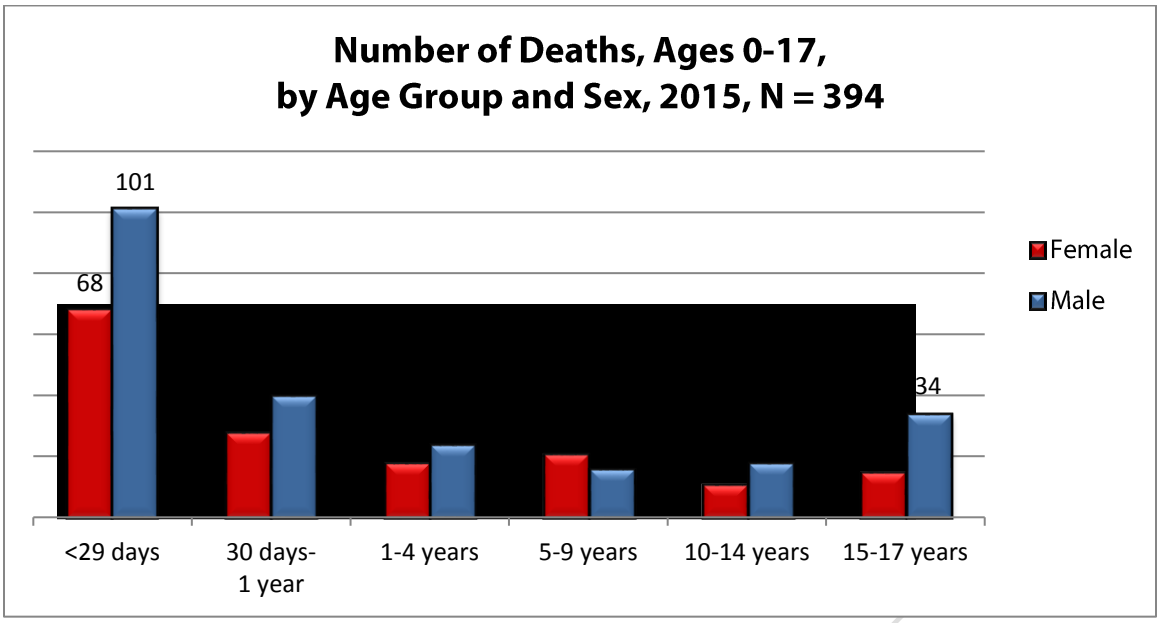


2015 Overview, continued

In 2015, the largest percentage of child deaths in Kansas were natural deaths and occurred in the youngest age groups, with 65 percent of children being less than 29 days of age, and 9 percent ages 30 days to one year. Males accounted for more deaths in most of the age groups and comprised 59 percent of all child deaths in 2015. Of the total deaths, 20 percent were due to unintentional injuries, 5 percent were due to homicide and 6 percent were due to Sudden Infant Death Syndrome (SIDS).

In 2015, death by natural manner, excluding SIDS, claimed the lives of 238 Kansas children. Prematurity and congenital anomalies combined accounted for 72 percent of the natural deaths excluding SIDS. Cancer claimed the lives of 23 children this year as the third leading natural cause of death, excluding SIDS.





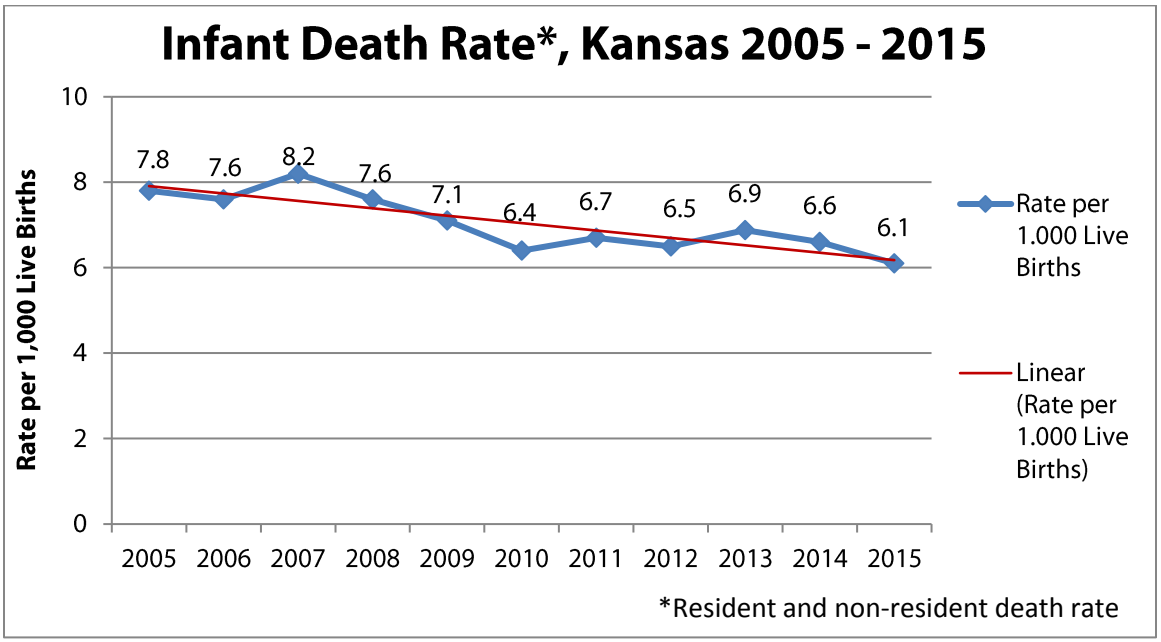
While the population of Kansas children is split almost equally between male and female, in 2015 the number of male children who died was 18 percent higher than the number of female deaths. Furthermore, males accounted for the highest number in all categories of death below, except for homicides.

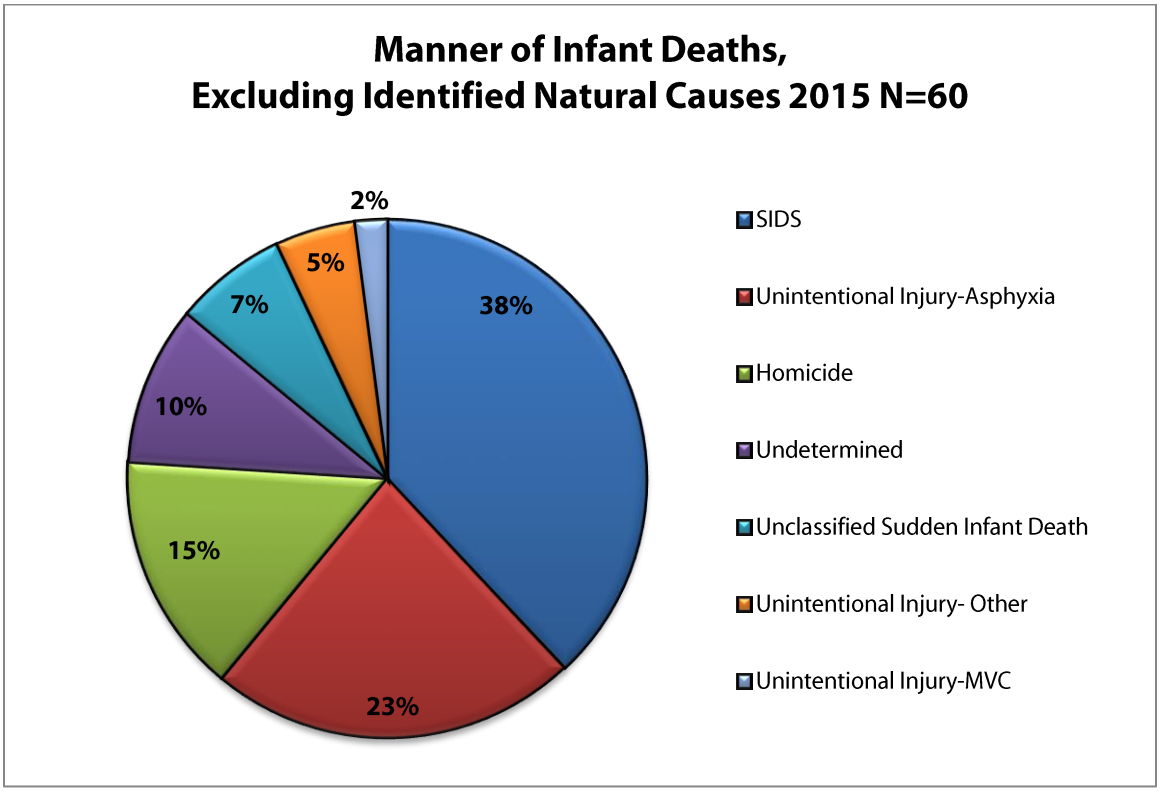
Manner Of Death	Number	Male	Female
Natural - except SIDS	238	130	108
Unintentional Injury - MVC	38	22	16
Unintentional Injury	41	35	6
Homicide	21	6	15
Natural - SIDS	23	16	7
Suicide	18	14	4
Undetermined	15	10	5
Total	394	233	161

Mortality Affecting Infants

(Age Less Than One Year)

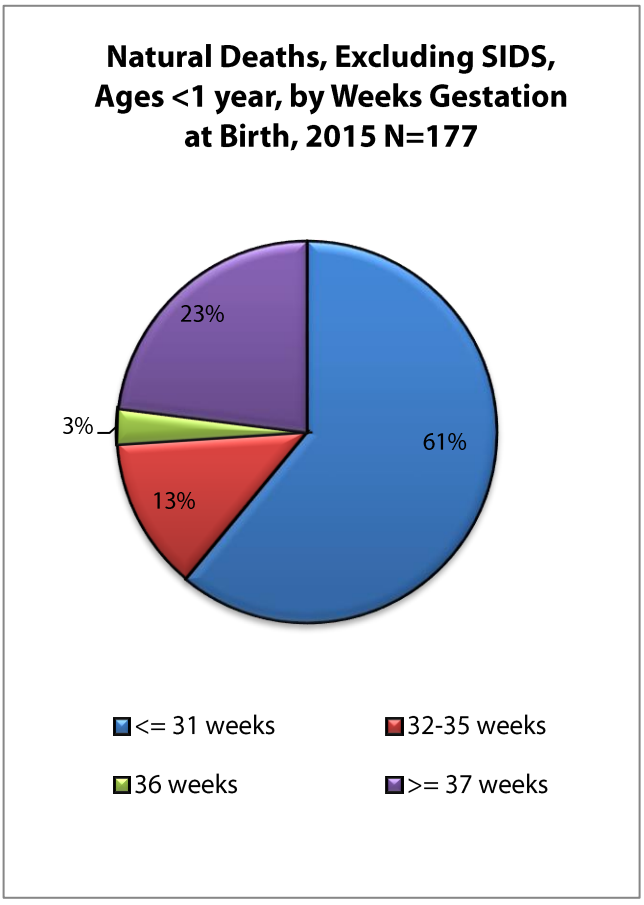
In Kansas, special emphasis has been placed on infant mortality (age less than one year) as an area in need of improvement. In 2015, the rate of infant deaths per 1,000 live births decreased to 6.1.*

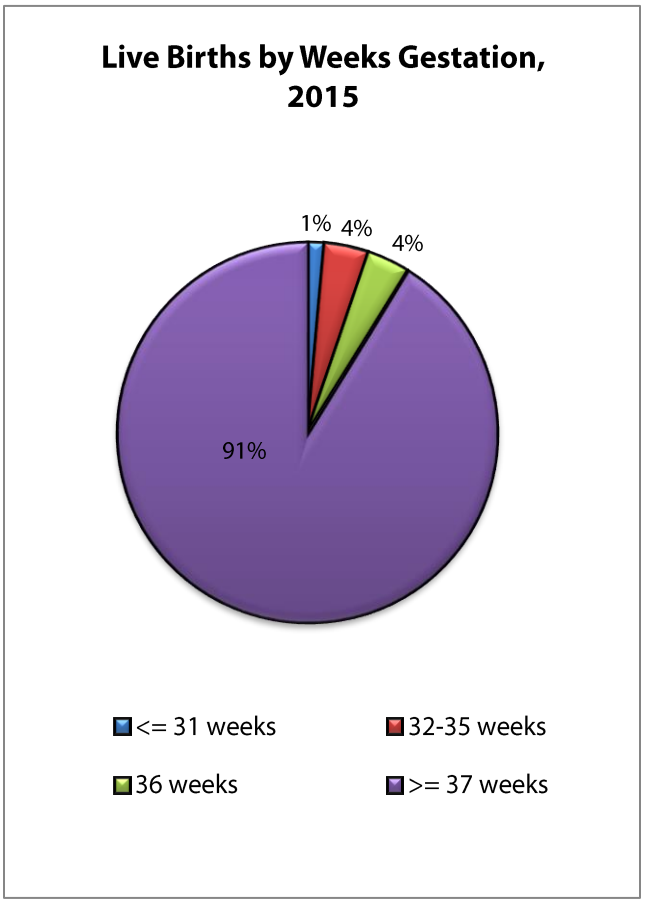




Of the 237 infant deaths in 2015, almost 25 percent (60) were due to reasons other than identified natural causes. Sudden Infant Death Syndrome accounted for 38 percent of those infant deaths while another 23 percent were due to Unintentional Injury by Asphyxia. Undetermined deaths accounted for 10 percent with an additional 7 percent listed as Unclassified Sudden Infant Death (description on page 10). The remaining non-natural infant deaths were due to Unintentional Injuries (Other), Homicide and Motor Vehicle Crashes (MVC).

It is important to note that SIDS is considered a natural manner of death when entered on a Kansas death certificate. The SCDRB classifies SIDS deaths separately due not only to the lack of a known cause, but also due to the unique and potentially preventable risk factors associated with those deaths.





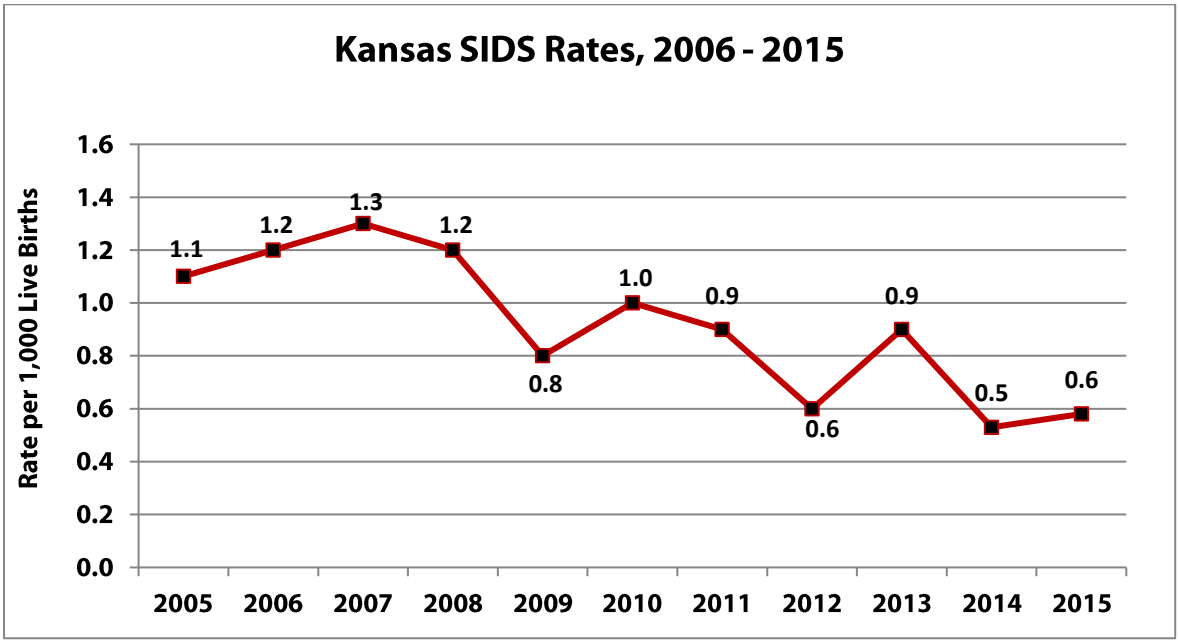
As shown above, 61 percent of the children who died from natural causes other than SIDS were born prior to 31 weeks gestation. Although the majority of infants are born at or after 37 weeks gestation, deaths are disproportionately associated with those born prior to 37 weeks gestation. In addition to being a direct cause of death, prematurity is an important risk factor for infant mortality from other causes.

PREVENTION POINTS

- **Prenatal Care** – Medical care during a pregnancy can identify risk factors and health problems, allowing for early treatment and minimizing poor outcomes. Proper nutrition is vital to a pregnancy. Iron and folic acid supplements, along with other physician prescribed regimens can help ensure a healthy pregnancy and newborn.
- **Avoid Drugs, Alcohol, and Nicotine** – The use of illicit substances, alcohol, and nicotine should be avoided during pregnancy. These elements are known to cause serious health problems and increase the risk for death in newborns and infants.
- **Diagnose and Manage Chronic Health Conditions** – Medical care for infants and children with chronic health conditions can optimize health. Having a medical home is essential for improving such conditions. The medical home is a care delivery model where patient treatment is coordinated through a primary care physician to ensure children receive necessary and consistent care when and where they need it, in a manner that is understood, and in which education and care for chronic conditions and illnesses can be monitored.

Sudden Infant Death Syndrome (SIDS)

SIDS is defined as the sudden unexpected death of an infant less than one year of age with onset of the fatal episode apparently occurring during sleep, which remains unexplained after a thorough investigation, including performance of a complete autopsy and review of the circumstances of death and clinical history. There were 23 SIDS deaths in Kansas in 2015. There were another 4 deaths, which were Unclassified Sudden Infant Deaths (USID), and were listed as an undetermined manner of death (see page 41). As shown in the chart below, the rate of SIDS in Kansas for 2015 has stayed relatively low.



While SIDS rates in Kansas have experienced a steady decline, the need to continue efforts to reduce these numbers remains.

Characteristics of the 23 SIDS Deaths, 2015

65% were co-sleeping with adults and/or other children
13% were sleeping on a couch
65% were sleeping in an adult bed
91% occurred at the decedent's residence
43% were not placed on their back to sleep (recommended position)
65% were not sleeping in a crib/bassinet, although there was one available in the home

The Board's concerns about unsafe sleep environments are affirmed in a safe-sleep study published in August 2014 in *Pediatrics*, the journal of the American Academy of Pediatrics. A cross-sectional examination of 8,207 sleep-related infant deaths extracted from the National Center for the Review and Prevention of Child Deaths Case Reporting System (NCRPCD) between 2004 and 2012, showed that 69 percent of the infants were bed-sharing (co-sleeping) at the time of their demise. It also noted that "older infants" (ages 4 months to 12 months) were more likely than younger infants to have objects in

their sleep area, such as pillows, blankets, bumper pads and stuffed animals, at the time of death." Causation and risk cannot be determined from these findings without a comparison group; however, it appears that co-sleeping continues to be a significant risk factor for SIDS. Data for this study was obtained from the NCRPCD Case Priority system, a database comprising reports of individual child deaths reviewed by state child death review teams. As of late 2013, 43 states were participating in the database.

By more clearly defining subsets of infant deaths that occur suddenly and unexpectedly, uniformity of diagnosis, accuracy of information, and accumulated data for research and assessment of recommendations are enhanced. The SCDRB has adopted the following sub-classifications for SIDS deaths:

Category IA: Classic features of SIDS present and completely documented

- Age more than 21 days and less than 9 months.
- Normal clinical history, growth and development.
- No similar deaths in the family, or in the custody of the same caregiver.
- Found in a safe sleeping environment with no evidence of accidental death.
- No evidence of unexplained trauma, abuse, neglect or unintentional injury.
- No evidence of substantial thymic stress effect.
- Negative results of toxicologic, microbiologic, radiologic, vitreous chemistry and metabolic screening studies.

Category IB: Classic features of SIDS present, but incompletely documented
Investigation of the various scenes where incidents leading to death might have occurred was not performed and/or one or more of the analyses listed above was not performed.

Category II: Infant deaths that meet Category I criteria, except for one or more of the following:

- Age range outside Category I.
- Similar deaths among family members or in the custody of the same caregiver.
- Neonatal or perinatal conditions that have resolved by the time of death.
- Mechanical asphyxia, or suffocation caused by overlay, cannot be ruled out with certainty.
- Presence of abnormal growth and development not thought to have contributed to the death.
- Marked inflammatory changes or abnormalities not sufficient to be unequivocal causes of death.

Unclassified Sudden Infant Death (USID):
Includes deaths that do not meet the criteria for Category I or II SIDS but for which alternative diagnoses of natural or unnatural conditions are equivocal, including cases for which autopsies were not performed. The Board most generally classifies these cases as Undetermined.

In 2015, the SCDRB determined the following number of child deaths due to SIDS and Unclassified Sudden Infant Death (USID):

Category	Total	Explanation
SIDS 1A	0	No children met the criteria for this category in 2015.
SIDS 1B	0	No children met the criteria for this category in 2015.
SIDS II	23	In all of these cases, an overlay or positional asphyxia could not be ruled out and each case had one or more elements that contributed to an unsafe sleep environment.
USID	4	All of the USID cases had an element of an unsafe sleep environment. Additionally, 50 percent of the cases had current or past DCF child protective services involvement. Two cases were classified as USID due to an incomplete autopsy. The Board stresses the importance of concise and thorough investigations by law enforcement and medical personnel, and properly conducted complete autopsies. Information on autopsy guidelines can be found at http://ag.ks.gov/docs/default-source/forms/autopsy-guidlines.pdf.

The SCDRB has significant concern about the number of SIDS deaths classified as Category II. Most Category II deaths are classified as such due to the inability to definitively eliminate overlay or positional asphyxia as a cause of death. These are babies sleeping with parents or siblings, placed to sleep on soft surfaces, or with pillows or excessive bedding in the sleep environment. Although these cases are suitable to classify as SIDS, the possibility exists that some of the deaths are due to overlay by a parent, or mechanical asphyxia from bedding or pillows. The large number of infants who sleep in less than ideal circumstances is a continued concern for the Board as some of these deaths may have been preventable had the child been in a safe sleeping environment.

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.
- Infants should always be placed on their backs to sleep during every sleep period, including naps. Sleep position should be consistent each time and at every location. When babies who usually sleep on their backs are placed to sleep on their stomachs, they are at a significantly increased risk of sudden death.
- 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 that 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 (co-sleeping) with adults or other siblings should be avoided.
- Many devices promoted to reduce SIDS have not been proven to reduce the incidence of SIDS. Obtain an evaluation/recommendation from a medical professional before use of such products.
- For more information on safe sleep, visit the SCDRB's website at http://ag.ks.gov/scdrb , the AAP at http://www.aap.org/, or Safe Kids Kansas at http://www.safekidskansas.org/.

Deaths in Non-Relative Childcare Homes and Centers

Since many infants and children spend a significant portion of their time in day care or other childcare environments, assuring safe sleeping arrangements and compliance with state safety regulations at every site is critical. Parents should talk about safe sleep practices with anyone who will be caring for their baby, including family, friends, babysitters and childcare providers.

Many SIDS deaths have been associated with the child being prone, especially when the baby is accustomed to sleeping on his or her back. Babysitters and family members who provide periodic care for babies may not be aware of the importance of supine sleeping and other safe sleeping arrangements. In licensed childcare settings, it is expected that safe sleep environments and sleep position recommendations be followed. For general information regarding the basis and purpose of childcare regulations, please visit http://www.kdheks.gov/bcclr/gen_info.html.

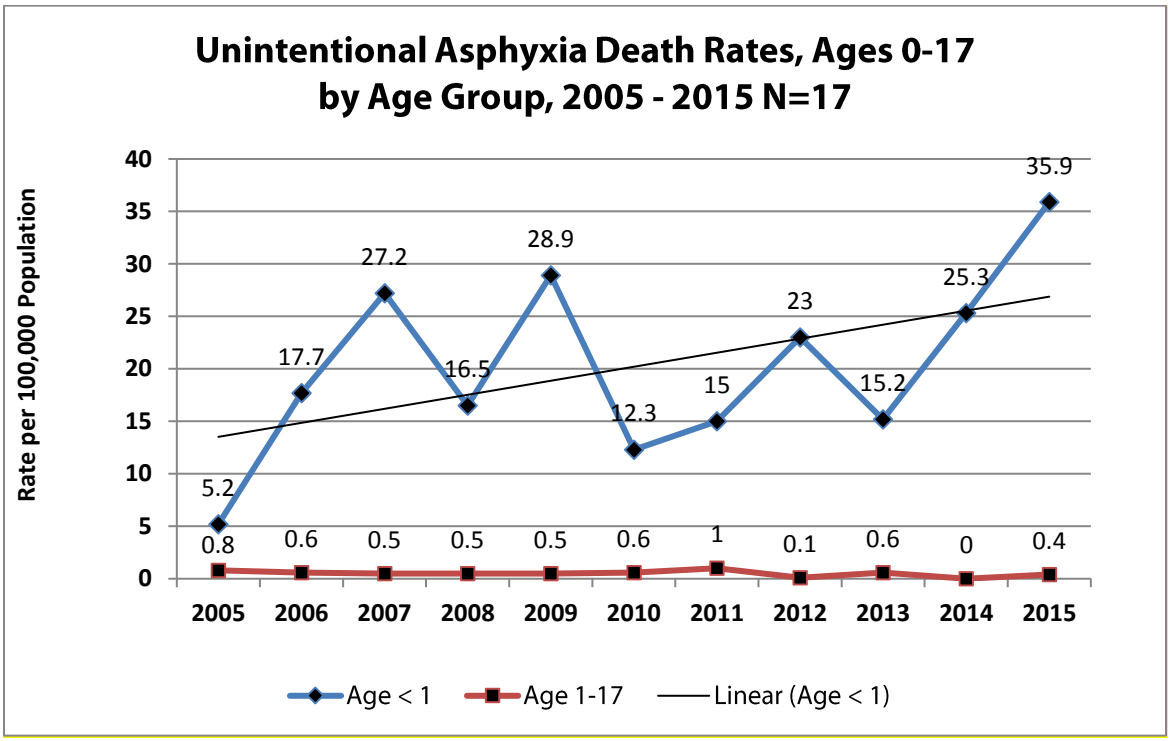
In the last six years (2010-2015), there have been 22 childcare deaths in Kansas with one of those occurring in 2015. Children under the age of one have accounted for 20 of these deaths. Of those 20 deaths, 19 were sleep-related and had unsafe sleep factors.

PREVENTION POINTS FOR PARENTS WHEN SELECTING CHILDCARE HOMES AND CENTERS

- Childcare homes and centers must be licensed by the Kansas Department of Health and Environment. Parents should ask to see the license or certificate – it documents the license type and maximum number of children that may be enrolled.
- The compliance history of a childcare facility in Kansas can be accessed by calling the Kansas Department of Health and Environment Child Care Licensing Program at 785-296-1270 or visiting https://kscapportalp.dcf.ks.gov/OIDS/ .
- Childcare providers should develop a safe sleep policy that is discussed with parents.
- Childcare providers and parents should communicate frequently to assure they understand safe sleep and that these practices are followed at home and in childcare. Safe sleep recommendations are listed with the SIDS prevention points on page 12.

Unintentional Asphyxia

Seventeen children died in 2015 due to unintentional asphyxia such as suffocation, strangulation, or choking. Of the 17 children who died due to unintentional asphyxia, 14 were under the age of one. As shown below, the rate of death by unintentional suffocation/strangulation deaths of children under one year of age has increased in the past two reporting years. Compared to a rate of 15.2 deaths per 100,000 population in 2013, in 2015 the rate increased to 35.9.



Unintentional asphyxia 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 there are several common practices that increase the risk for these deaths. These include sleeping somewhere other than a crib, sleeping in a cluttered area, being placed on a soft surface such as a pillow or quilt, and bed-sharing (co-sleeping) with parents or siblings. Of the 17 unintentional asphyxia deaths, 15 of the deaths were sleep-related and included one or more of the above factors as a cause of the suffocation/asphyxia.

Parents and caregivers should always remember the ABC's of safe sleep. Children should be placed **A**lone on their **B**acks in a **C**rib. While it may be tempting to bring a child to an adult bed, the safest place for them to sleep is in a crib that is clutter free.

Some cribs, bassinets and playpens have been recalled because of known or suspected risk of strangulation. Before caregivers purchase baby furniture, they should ensure no recalls have been issued. The U.S. Consumer Product Safety Commission (http://www.cpsc.gov/) is a resource for recall information.

Characteristics of the 17 Unintentional Asphyxia Deaths in 2015

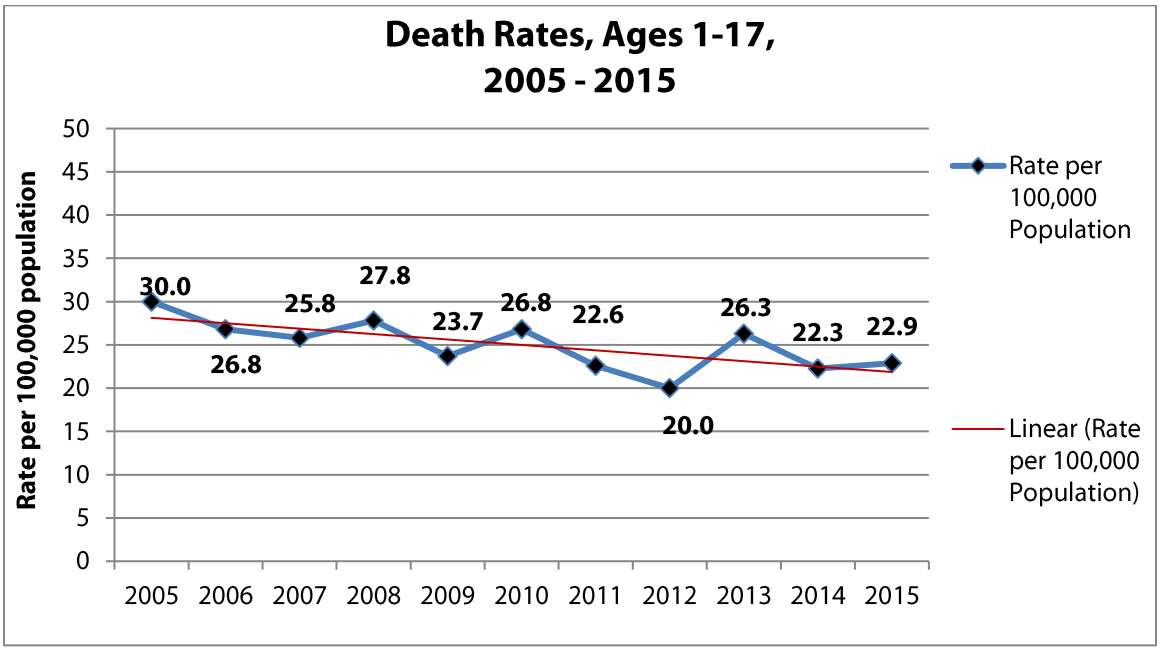
- 82% of the deaths occurred in children under the age of 1.
- 88% of the deaths occurred while both the child and caregiver were sleeping.
  - All had elements of unsafe sleep
  - 33% were in a crib, 33% on an adult bed, and 20% on a couch
    - Four of the children placed in a location other than a crib, had a crib available in the home.
  - 53% were co-sleeping
- Of the 2 deaths that were not sleeping related, 1 was due to accidental strangulation, and the other was due to choking on food.

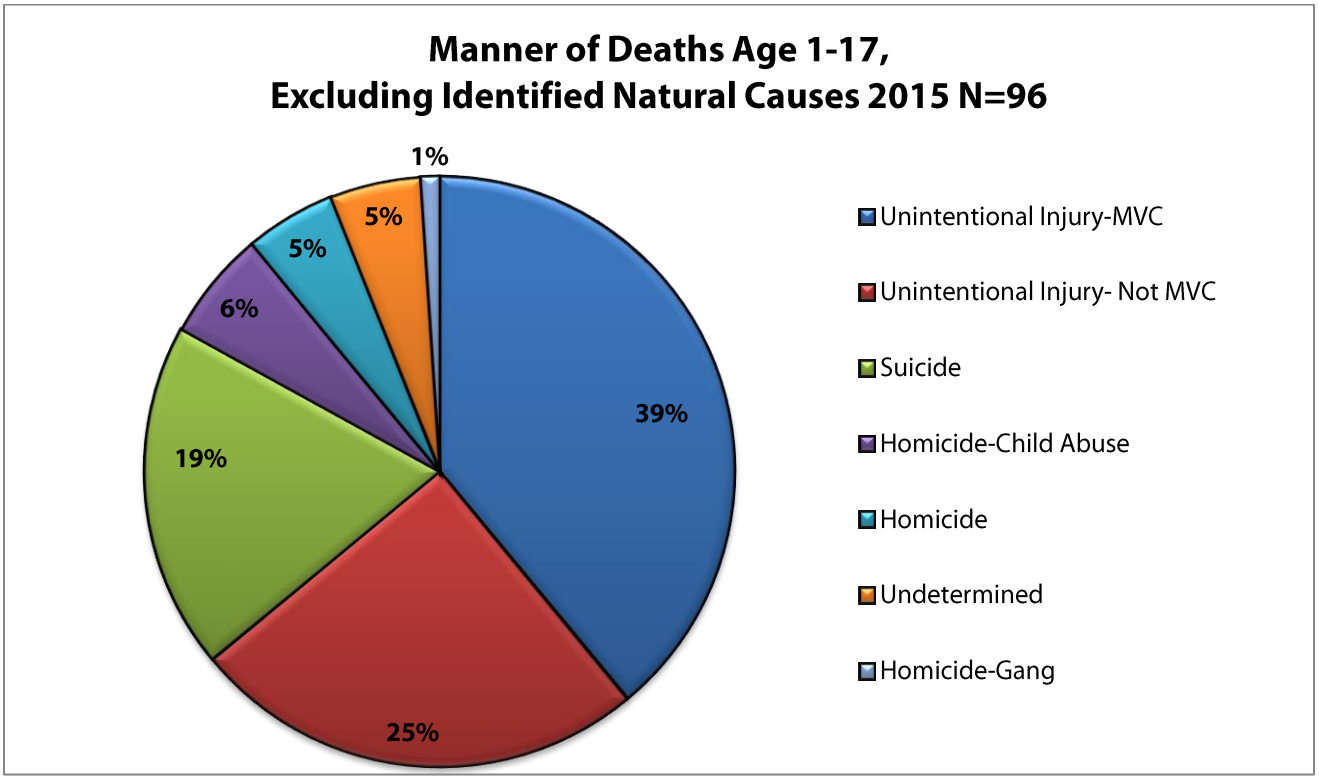
PREVENTION POINTS

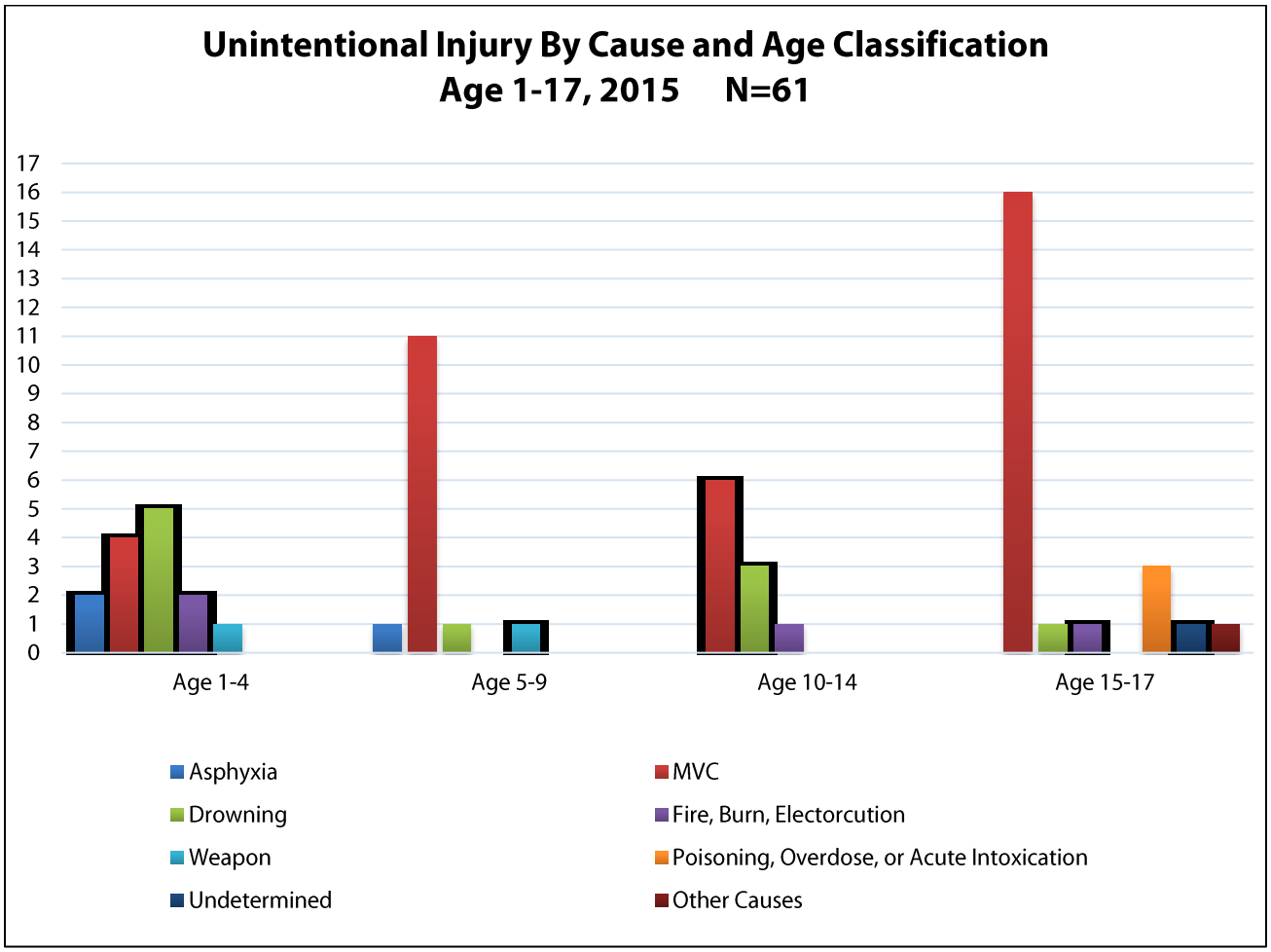
- **Proper Supervision** - Young children should be watched attentively. Leaving them alone for even a few minutes allows opportunities for unintentional injuries. Child-specific training in CPR and other emergency responses can help prevent death.
- **Safe Environments** - Be vigilant about potential dangers to children. Consideration must be given to their size, curiosity, and motor ability. Living, sleeping, and play areas should be routinely inspected for dangers which may not be threats to adults (e.g. chests/coolers, hanging cords, plastic bags), but can be deadly to children. Check play areas for hazards like protruding bolts that can catch clothing and strangle a child. Check playground equipment parts and hand rails for spaces that may be large enough to allow a child's body to slip through causing strangulation by trapping the head or neck.
- **Infant Sleeping Arrangements** - The safest sleeping arrangement for an infant is alone 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 fit tightly so the child cannot be trapped between the mattress and side of the crib. No other items, including blankets, bumper pads, pillows, stuffed animals, or infant supplies should be in the crib with the baby, as they create a risk for suffocation.

Mortality Affecting Children Ages 1-17

While infant mortality has declined, so has mortality for children ages 1-17. Overall, death rates for children ages 1-17 have declined since 2005. There were 156 deaths in this age group in 2015. The tables below indicate rates per 100,000 population for the past 11 years.







The chart above examines the breakdown of unintentional injuries by age classification, excluding infants. Motor vehicle crashes (MVC) remain the top cause for all age groups, except the 1-4 age group in which MVC deaths were exceeded by drowning deaths.

It should not go unnoticed that the second leading cause of unintentional injury death for teens aged 15-17 was the category of poisoning, overdose, or acute intoxication. A youth's environment can influence whether he or she will try drugs. Whether at home, school or in the community; caregivers, and school educators should address the dangers of drugs and alcohol and the risk of lethality from misuse or abuse.

OVERDOSE PREVENTION POINTS

Young people are at especially high risk of prescription drug abuse. These prevention steps may help prevent teens from using alcohol and abusing prescription medications.

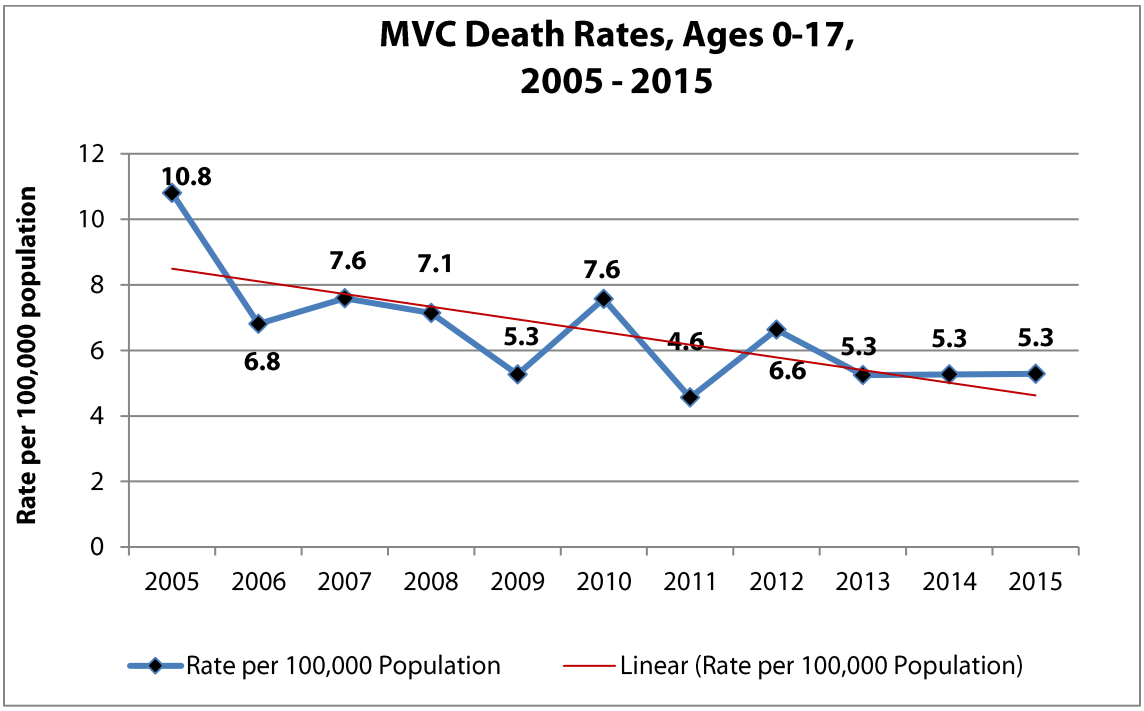
Discuss the dangers and rules of taking medications. Medications are prescribed by a physician for specific patients and specific purposes. The fact that they are prescribed does not make them safe for others. Children and teens should be instructed to never take medications that were not prescribed for them, never to share their medications with any other person, and to not combine medications without being instructed to by a pharmacist or physician.

- **Discuss the dangers of alcohol use.** Using alcohol with medications can increase the risk of accidental overdose.
- **Prescription drugs should not be accessible to children.** Quantities of medications should be tracked and all medications kept in a locked medicine cabinet.
- **The ability to order medications online is a risk factor for teens to access medications.** Some websites sell counterfeit and dangerous drugs that may not require a prescription. Internet use should be monitored and parents should assure teens are not accessing drugs through friends or outside sources.
- **Properly dispose of medications.** Unused or expired drugs should be discarded. Patient information guides with the medication may provide disposal instructions, or pharmacies can be contacted for advice on disposal.

Source: http://www.mayoclinic.org/diseases-conditions/prescription-drug-abuse/basics/prevention/con-20032471

Motor Vehicle Crash Deaths

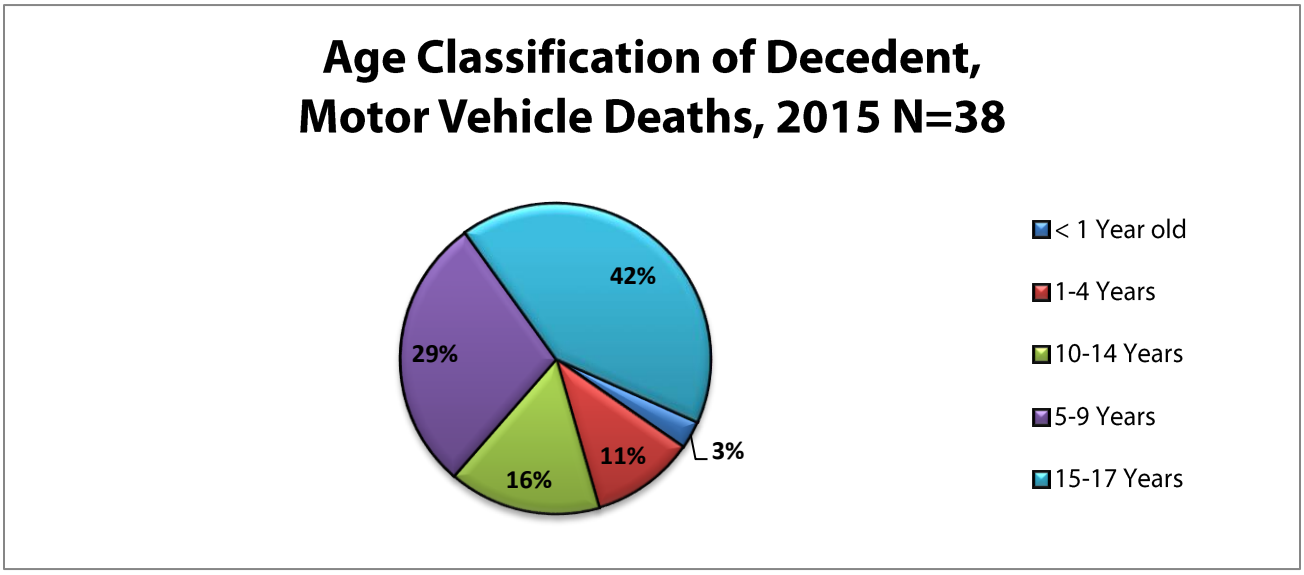
In 2015, 38 children died in Kansas because of a Motor Vehicle Crash (MVC). As shown in the charts below the death rate has shown a gradual overall decline.



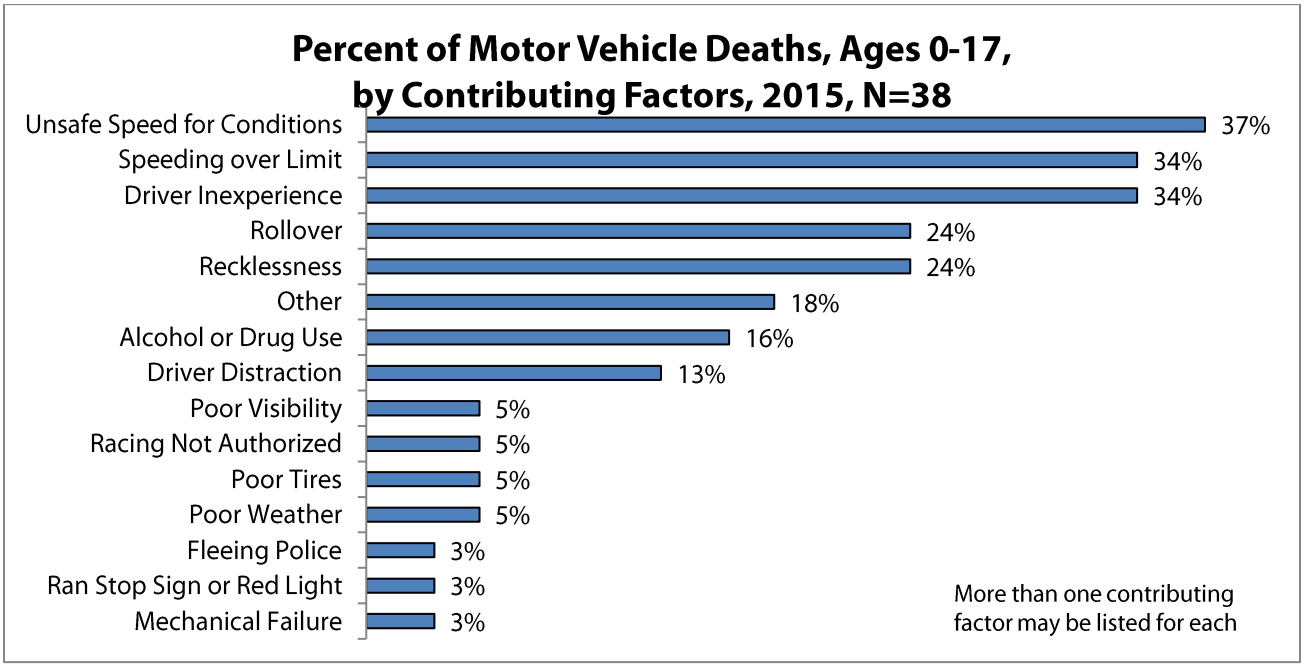
Motor Vehicle Death Rates per 100,000 Population, Ages 0-17, by Age Group, 2005-2015

	< 1 Year	Age 1-4	Age 5-9	Age 10-14	Age 15-17
2005	2.0	4.0	8.3	6.4	34.5
2006	3.0	2.6	2.1	7.3	18.9
2007	3.0	5.1	1.1	6.9	23.2
2008	0.0	5.6	2.1	6.9	21.2
2009	4.0	4.3	1.0	1.6	18.9
2010	0.0	6.1	5.9	3.0	22.5
2011	2.5	4.9	3.5	3.5	8.4
2012	2.5	4.3	3.9	6.5	16.1
2013	2.8	2.5	2.9	4.5	15.2
2014	5.0	2.5	3.9	4.0	13.5
2015	2.6	2.5	5.4	3.0	13.3
Average	2.5	4.0	3.6	4.9	18.7

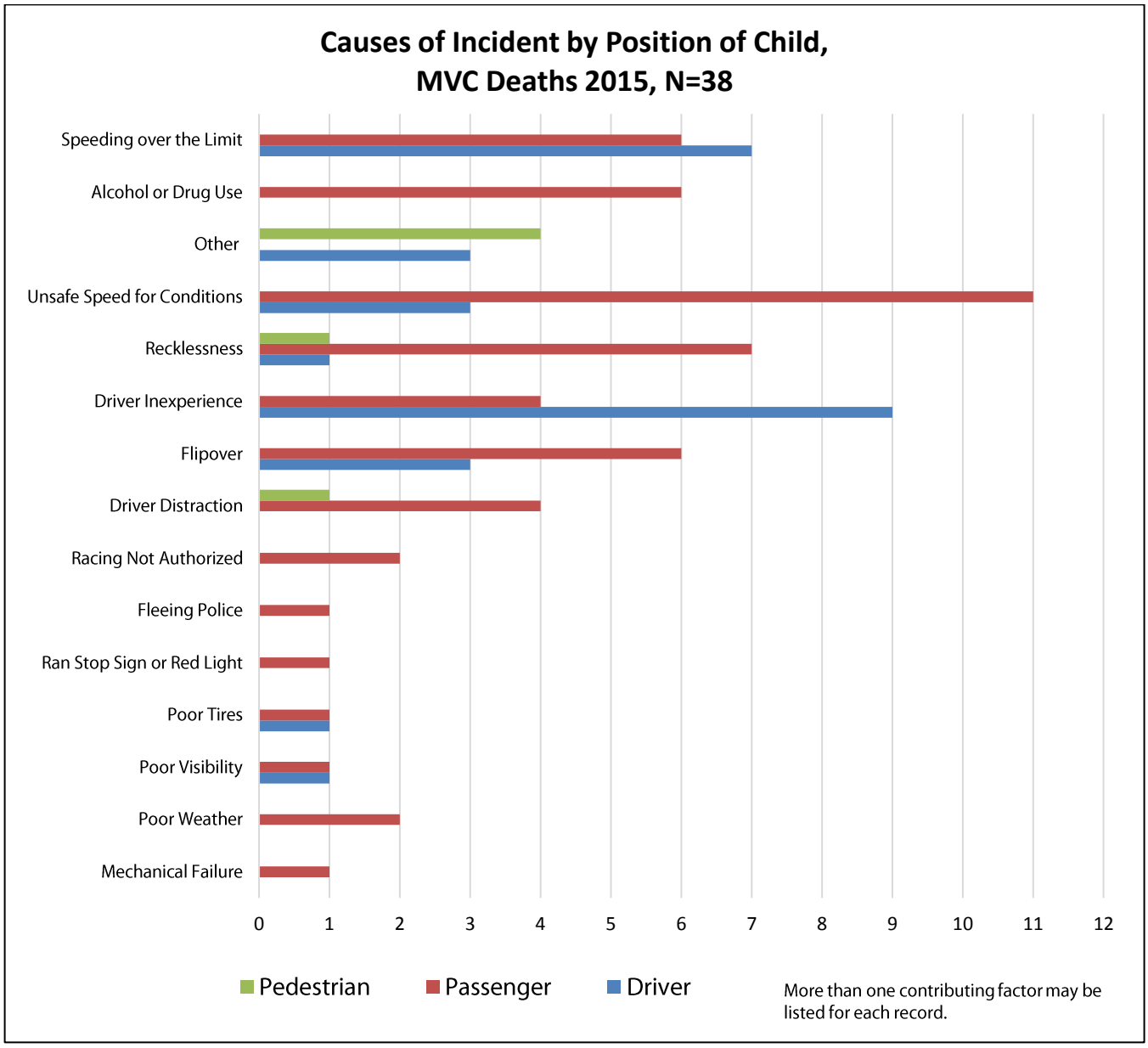
As noted in the graph on the preceding page and in the graph below, the likelihood of children dying due to motor vehicle crashes increases as the child becomes older. Teens aged 15-17 accounted for the highest percentage of MVC deaths with 42 percent of deaths occurring in that age group.



It is important to note that there are multiple factors that can lead to a MVC death. In 2015, speeding was a contributing cause in 71 percent of the cases. Driver inexperience accounted for 34 percent of the MVC deaths. Of note, while 16 percent of the MVC deaths had a contributing factor of alcohol or drug use, in each of those crashes, the decedent was the passenger in the vehicle, thus not "drinking and driving."



The following chart breaks down the causes of incident by position of decedent. In instances where the decedent was a driver, speed and driver inexperience played the largest roles in the crash. Of alarm, when decedents were passengers in vehicles, unsafe speed for conditions, recklessness, driver distraction, and alcohol or drug use were the main causes of the incidents.



Of the 38 Motor Vehicle Deaths in 2015, six decedents were pedestrians and 32 died while the child was either a driver or passenger of the vehicle. In 29 of those crashes, seatbelts were available for use; however, in only nine crashes were the decedents restrained correctly.

Of the 9 passengers who were in the front seat, 3 of the children were age 5-9 and were in a vehicle that had a backseat available. As indicated within the prevention points on page 23, children who are between the ages of 4 and 8 should be in belt-positioning booster seats in the back seat.

Safety Restraint Use by Decedent, 2015 N=32					
	Driver	**Passenger Front Seat**	**Passenger Back Seat**	**Passenger Other**	**Total**
Restrained	4	1	4	0	**9**
Restrained, Incorrectly	0	1	2	0	**3**
Unrestrained	4	5	7	1	**17**
Unknown if Restrained	2	1	0	0	**3**
Total	**10**	**8**	**13**	**1**	**32**

There were 5 child deaths resulting from All Terrain Vehicle (ATV) crashes in 2015. These were determined by the Board to be preventable deaths. The number of crashes and injuries while utilizing these vehicles continues to increase. ATV use is popular in both recreation and work. This type of vehicle size, maneuverability and durability makes it extremely handy and fun to ride. In Kansas, children ages 10 - 14 comprise the largest number of ATV child-related fatalities since the board began reviewing child deaths in 1994. In 2015, three children in this age group died in an ATV crash. Young riders lack the size and strength to safely control an ATV. Drivers of ATVs often use roadways that are not designed for ATV travel and often drive at unsafe speeds.

Characteristics of the 38 Motor Vehicle Crash Deaths, 2015

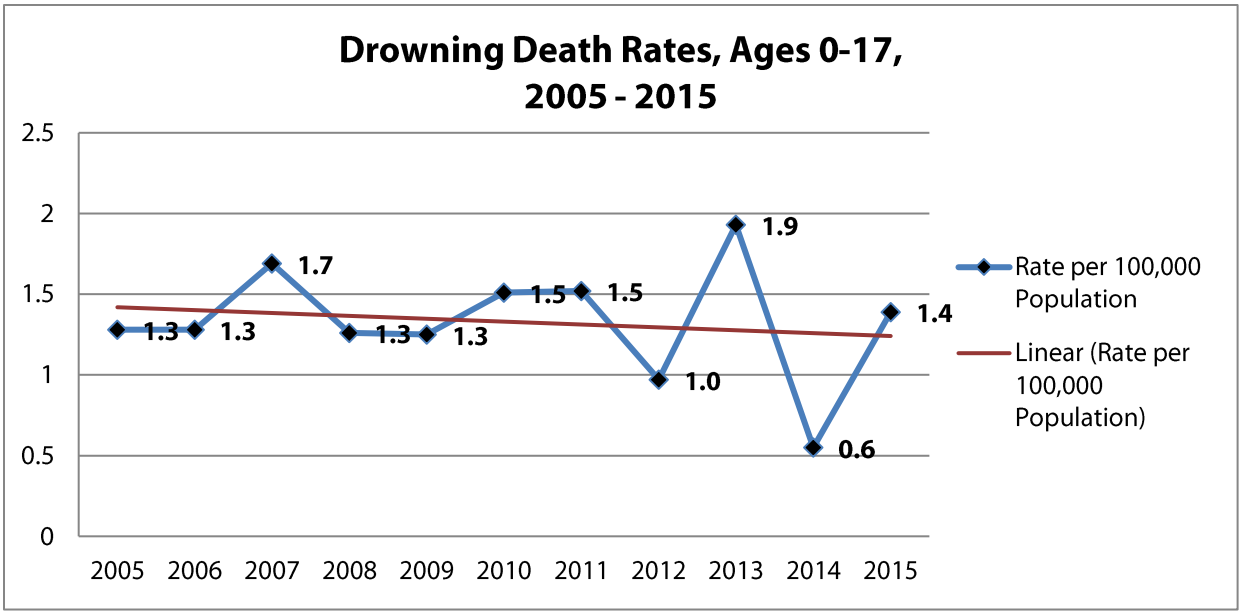
- Of the decedents, 22 were male and 16 were female.
- Only 10 of the decedents were driving a vehicle at the time of their demise.
  - Three of the 10 drivers were operating an ATV.
  - One of the drivers was in the 5-9 age group and should not have been permitted to drive.
  - Only 4 of the 10 drivers were properly restrained.
- Five children under the age of four died in motor vehicle crashes.
  - Two of these children were restrained correctly, one was a pedestrian, and the other two were either unrestrained or restrained incorrectly.
- Six children were pedestrians.
- Five children were either driving or a passenger in an ATV, at the time of the crash.

PREVENTION POINTS

- **Use of Proper Safety Restraints** - Wear seat belts. Seat belts and appropriate child safety restraints consistently prevent serious injury and death. According to the National Highway Traffic Safety Administration, parents who buckle up are more likely to use safety restraints for their children. Children under 4 years of age should be placed in a child safety seat firmly secured in the backseat. Children between the ages of 4 and 8 should be in belt-positioning booster seats in the back seat. Parental seatbelt use as an example to children and passengers is invaluable.
- **Attentive Driving** - Avoid distractions such as cell phones and other electronic devices. Novice drivers should have limits placed on the number of passengers and nighttime driving, both known risk factors. As of January 1, 2011, a person who is operating a motor vehicle is prohibited from using a wireless communication device to write, send, or read a written communication in Kansas.
- **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 or alcohol.
- **Driving Experience** - Driving is not a quickly learned skill and requires practice, focus and good judgment. Young drivers should be accompanied by an experienced adult and avoid complex driving situations. In January 2010, the revised graduated driver's license system was enacted and does not confer full driving privileges until age 17 and after significant supervised driving time.

Drowning

In 2015, 10 children died by drowning. Children are drawn to water. They like to splash and play in it, but this lure is deceptive and can lead to tragedy. Children can drown in a couple of minutes and in only a few inches of water. Between 2005 and 2015, the Board has reviewed 105 drowning cases. Since 2005, the 1 - 4 year age group, on average, has accounted for the highest rate of deaths compared to the other age groups. The tables below indicate rates per 100,000 population for the past 11 years.



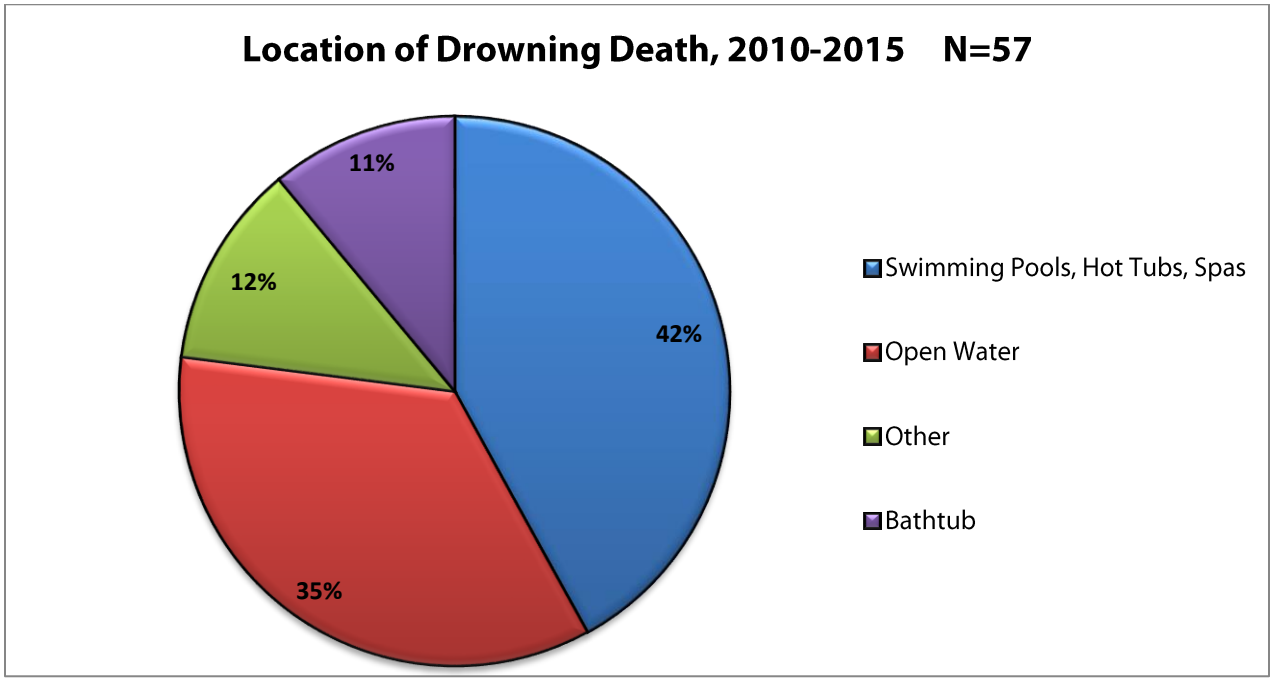
Drowning Death Rates per 100,000 population, Ages 0-17, by Age Group, 2005-2015

	< 1 Year	Age 1-4	Age 5-9	Age 10-14	Age 15-17
2005	0.0	5.4	0.0	0.5	0.0
2006	1.0	2.6	0.5	0.0	2.0
2007	2.0	3.2	0.5	1.6	0.8
2008	0.0	4.4	0.5	0.0	0.8
2009	0.0	3.1	0.5	1.1	0.9
2010	0.0	3.6	1.5	1.0	0.0
2011	0.1	0.4	0.6	0.1	0.3
2012	0.0	2.4	1.0	0.5	0.0
2013	0.0	3.1	0.5	2.5	4.2
2014	0.0	1.9	0.0	0.0	0.8
2015	0.0	3.2	0.5	1.5	0.8
Average	0.3	3.0	0.6	0.8	1.0

As shown in the chart below, swimming pools have been the primary location of child drownings within the last 5 years. Proper supervision and floatation devices for children of all ages are very important. Children not only are at risk during the summer when pools are mainly in use, but also

when they are not in use and still accessible. Four-sided fencing of swimming pools, including soft-sided pools on residential properties is an additional and necessary tool to prevent drownings.

Many of the same prevention points can be applied to the second most common locations for drownings over the last 6 years. Open water, which includes rivers, lakes, and ponds, are often very popular areas for Kansas children to visit. It is important to remember that despite the ability to swim, swimming in open water is more challenging than in a pool. Children and youth can tire quickly and if going under, the murky water and currents can make it difficult for even the best swimmer to be seen and rescued.



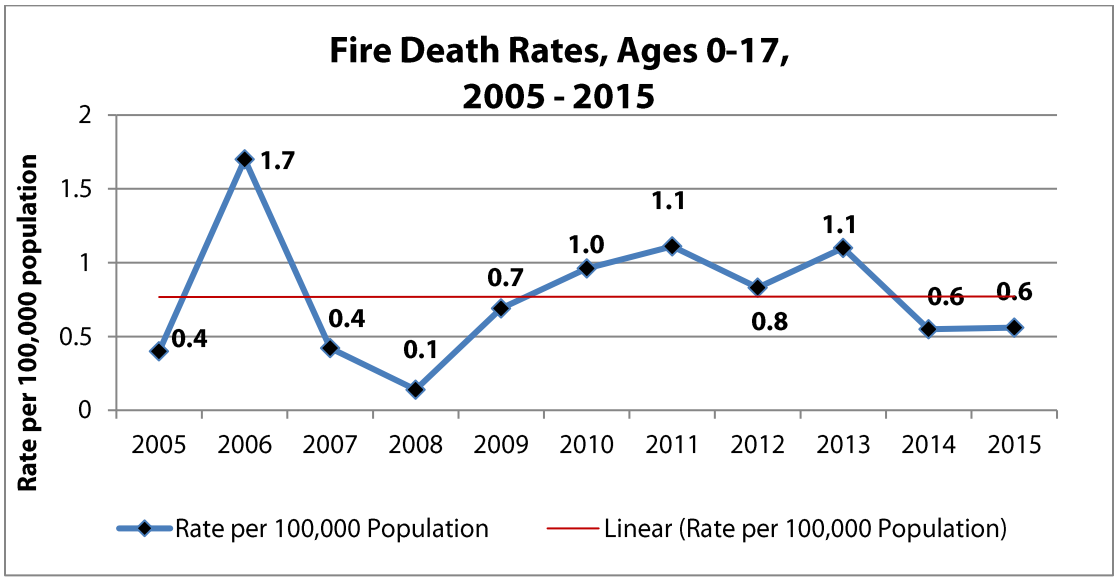
The use of personal floatation devices is essential for children of any age despite their ability to swim. Between the years of 2010 and 2015, 96 percent of the deaths occurred without the child using an approved floation device. Every minute counts in drowning situations. Proper supervision and appropriate personal floatation devices are key when children are near water.

PREVENTION POINTS

- **Proper Supervision** - An adult who is capable of responding to an emergency should always be supervising children around water. The adult should be actively watching and avoiding distractions. Assigning swimming "buddies" is a good idea, especially if there are many swimmers. Supervision also applies to bathtubs, where children should never be left alone even for short periods of time.
- **Pool/Environment Safety** - Most cities/counties have ordinances regarding fencing around pools. A five-foot fence with safety latched gates completely encircling a pool or hot tub is recommended. In bathtubs, seats designed to hold a baby's head above water are no substitution for adult supervision. Also, small children can drown after falling into buckets, toilets, washing machines or other such water holding basins. Caregivers must be vigilant about these less obvious dangers.
- **Use of Safety Equipment** - When participating in water activities, children should always wear Personal Flotation Devices (PFDs) that are Coast Guard approved and suited for the proper weight of the child. PFDs should be checked for broken zippers and buckles. "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 age 4 to begin lessons. While this is vital, swimming ability alone does not relieve the need for adult supervision or PFDs.
- **Water conditions**- Lakes, ponds and ditches often contain murky water and tangled branches or other items that pose a potential danger to swimmers. Research these areas and become familiar with possible dangers such as large rocks and underwater currents. Know water depth and underwater hazards before allowing children to jump into any body of water. It is also advised to check local weather conditions prior to swimming or boating as thunderstorms with lightning or strong winds could be fatal.

Fire

In 2015, four Kansas children died in fire-related incidents. Nationwide, fires and burns are a common cause of unintentional injuries and deaths. The tables below indicate rates per 100,000 population for the past 11 years in Kansas. Children 4 years and under are most at risk.



Fire Death Rates per 100,000 population, Ages 0-17, by Age Group, 2005-2015					
	< 1 Year	Ages 1-4	Ages 5-9	Ages 10-14	Ages 15-17
2005	0.0	1.3	0.0	0.0	0.8
2006	5.3	2.7	0.6	2.2	0.8
2007	0.0	0.7	1.0	0.0	0.0
2008	0.0	0.7	0.0	0.0	0.0
2009	0.0	2.0	1.0	0.0	0.0
2010	0.0	2.0	1.6	0.5	0.0
2011	2.5	1.2	1.5	0.5	0.8
2012	0.0	1.8	1.5	0.0	0.0
2013	0.0	3.7	0.5	0.5	0.0
2014	0.0	0.0	1.0	0.5	0.8
2015	0.0	1.3	0.0	0.5	0.8
Average	0.7	1.6	0.8	0.4	0.4

Parents and caregivers must be diligent about having functional smoke detectors in all appropriate locations in the home. Smoke detectors need to be installed on every level in the home and by each sleeping area. They need to be tested once a month, have new batteries at least once a year, and should be replaced every 10 years. Close supervision of children, safe storage of matches and lighters, and working smoke detectors in the home are critical.

Fire is often started by children playing with matches or lighters. It is vital for parents and caregivers to keep all lighters, matches, and other igniting sources out of reach of children. They also need to educate children on the dangers of fire and practice escape routes in the event a fire does occur.

Characteristics of the Four Fire-Related Deaths, 2015

- Of the 2 deaths that occurred in the 1-4 age group, both had barriers that prevented a safe exit; i.e. baby gate, cluttered space, locked door, etc.
- In only 1 of the 4 deaths was there a working smoke detector.
- Lack of supervision was a risk factor in only 1 death; the rest occurred during the night, while decedents were sleeping.

PREVENTION POINTS

- **Proper Supervision** - Young children must be watched closely. Leaving them unsupervised, especially if there are objects such as 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 inside each bedroom, outside each sleeping area and on every level of the house, including the basement. Smoke detectors should be 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. Ensure that gates or unnecessary clutter does not block exits. Designate a central meeting location outside of the home and have regular fire drills.

Asthma

In the last six years of SCDRB cases (2010 – 2015) there have been 13 deaths due to asthma. These deaths occurred in children from ages 1-14 with the majority of deaths occurring to children in the 10-14 age group. Although the number of deaths is small, even one death is too many since asthma is a treatable disease.

The numbers and rates of pediatric asthma hospitalizations is one indication of how well a state overall is managing asthma. If asthma is well controlled a child should rarely need to be hospitalized for the disease.

Numbers and Rates of Pediatric Asthma Hospitalizations*
Kansas, 2010-2015
Rate per 100,000 population ages 2 through 17 years

Year	Number	Rate
2010	732	113.3
2011	700	108.5
2012	886	138.2
2013	600	93.5
2014	726	112.6
FFY 2015†	554	86.2

* Admissions with principal diagnosis of asthma per 100,000 population, ages 2 through 17 yrs
† Calendar year rate cannot be calculated due to presence of ICD9CM and ICD10CM diagnoses. Federal fiscal year used. Excludes cases with a diagnosis code for cystic fibrosis and anomalies of the respiratory system, obstetric admissions, and transfers from other institutions.
Source: Kansas Hospital Association
Prepared by KDHE Bureau of Epidemiology and Public Health Informatics, 2017

Asthma is a chronic disease that affects the airways in the lungs. It is characterized by inflammation that restricts the ability to move air out of the lungs and leads to episodes of wheezing, coughing, shortness of breath and chest tightness. Severe asthma can lead to complete closure of the airways and is life threatening. There is no cure for asthma. It can be kept under control with a management plan that includes rescue inhalers and preventive medications through quality medical care and asthma education. This also includes the ability to recognize and avoid each child's specific triggers such as allergens, exercise, tobacco smoke, air pollution and infections. It is estimated that 1 in 11 children have asthma, which makes it a very common problem. Because it is common, parents and care providers often fail to understand that asthma is not a one-size-fits-all disease and do not appreciate how life threatening it can be if not treated quickly and appropriately.

It is imperative that children have access to medical providers who can effectively manage and control asthma, provide ongoing education and monitoring, and work with families, childcare facilities and schools to improve the lives of children with asthma and prevent asthma related deaths. Childcare providers and school personnel, including coaches and trainers, must have appropriate asthma

education and access to each child's asthma action plan and medications. Immediate access to medical providers who can provide direction in urgent situations is also important to those caring for children with asthma.

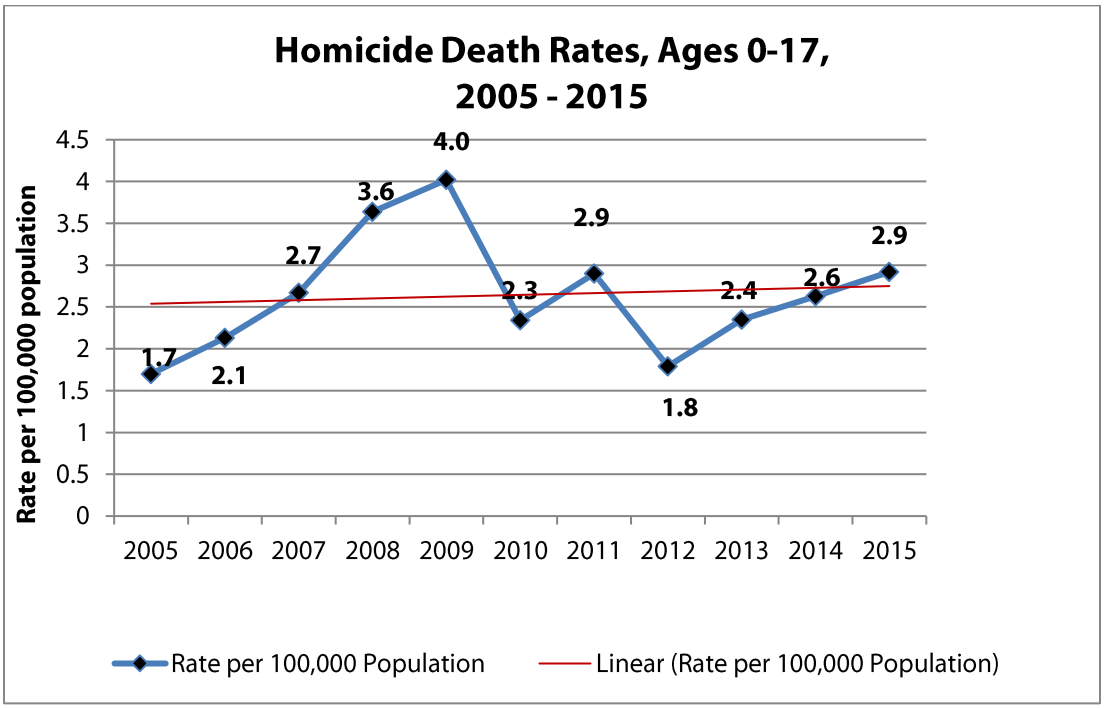
Efforts to improve asthma care and education are part of hospital quality improvement efforts across the state. Involving families and other care providers in education is also essential. Continued monitoring of Kansas asthma hospitalizations and deaths will help in our assessment of how well our state is caring for children with asthma.

PREVENTION POINTS

- **Assessment and Monitoring** - Asthma is highly variable over time. Periodic, scheduled monitoring by health care providers familiar with standardized and evidence-based care is essential, even if the patient and family feel the child is doing well.
- **Education** - Teaching and reinforcement of self-monitoring skills and devices, use of a written asthma action plan, correct use of medications and devices, and avoidance of asthma triggers in the environment are areas of knowledge to adapt and integrate into all points of a child's care.
- **Control of Environmental Factors and Comorbid Conditions** - Avoidance of cigarette smoke exposure, determining and reducing exposures to allergens, consideration of allergen immunotherapy if indicated, and management of obesity, gastroesophageal reflux, obstructive sleep apnea and infections (including annual use of influenza vaccine) are important steps in asthma control.
- **Medications** - Medications and delivery devices must meet the child's needs and circumstances. A stepwise approach with therapy adjustments based on the child's asthma control are outlined with evidence-based support in Guidelines for the Diagnosis and Management of Asthma published by the National Heart, Lung and Blood Institute of the National Institutes of Health. (http://www.nhlbi.nih.gov/health-pro/guidelines/current/asthma-guidelines/full-report)

Homicide

Homicide is defined as the death of one person resulting from an intentional act, unintentional act, or criminally negligent act leading to the death of another person. The Board reviewed 21 child homicides in 2015. The tables below indicate rates per 100,000 population for the past 11 years.



When examining child homicides, the rate for infants is more than five times higher than other age groups. This difference is explained by the unique characteristics of the circumstances surrounding child abuse homicides, which account for nearly all infant homicides, and the vulnerability of very young children who are not capable of defending themselves against an assault, are small enough to pick up and shake, throw or strike, and whose crying can be frustrating to caregivers. This is discussed in more detail in the Homicide – Child Abuse section on the next page.

Homicide Death Rates per 100,000 population, Ages 0-17, by Age Group, 2005-2015					
	Age < 1	Age 1-4	Age 5-9	Age 10-14	Age 15-17
2005	10.4	2.7	0.6	0.0	2.5
2006	7.6	0.6	1.6	1.6	4.1
2007	14.8	3.2	0.0	0.5	5.8
2008	16.5	5.6	0.0	0.0	8.5
2009	19.3	3.7	1.0	3.7	5.2
2010	9.8	3.6	0.5	1.5	2.5
2011	12.5	3.6	0.5	0.5	6.7
2012	7.5	1.8	1.0	0.0	4.2
2013	15.0	3.1	1.0	2.0	1.7
2014	15.0	3.1	1.0	2.0	1.7
2015	23.1	3.2	1.0	0.0	4.2
Average	14.1	3.2	0.8	1.2	4.5

Each child homicide was categorized into the following groups. By categorizing homicides in this way, the Board is able to look in depth at specific issues pertaining to each category.

Homicide – Child Abuse

The Board defines Child Abuse Homicide as resulting from abuse (inflicting injury with malicious intent, usually as a form of punishment or out of frustration with a child's crying or perceived misbehavior) or neglect (failing to provide shelter, safety, supervision and nutritional needs) by caretakers. Child abuse is a complex problem that stems from a variety of factors including, but not limited to, financial stressors, domestic violence, substance abuse and mental illness.

The method of child abuse homicide can vary. In general, most occur as a result of blunt force trauma. The most prevalent form is abusive head trauma (AHT), previously referred to as Shaken Baby or Shaken/Impact Syndrome. AHT occurs when an infant or toddler is severely or violently shaken resulting in serious injury and/or death. When infants are shaken or their heads sustain a severe impact, the brain moves back and forth within the skull. The blood vessels and brain tissue cannot tolerate the sheering force caused by the violent shaking. Blood vessels will break causing internal bleeding, and brain cells are damaged. Because of the internal head injuries, the child may encounter trouble breathing or lose consciousness, which can cause brain damage due to lack of oxygen. These injuries

lead to serious complications 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 who die from AHT to have autopsy evidence of impact injuries, but no visible external evidence of trauma.

Caring for children can be overwhelming at times. Often parents and caregivers are facing multiple stressors and may have limited access to support. There are several risk factors associated with child abuse homicide including maternal risk factors (young age, less than 12 years of education, and being a single parent) and household risk factors (male not related to the child in home, prior substantiation of child abuse and neglect, substance abuse, and low socioeconomic status). Many of the child abuse homicides occurred when the primary caregiver was away from the home. Often the child was being cared for by the mother's paramour or by a relative who was not the primary caregiver.

SCDRB data reflect what is found in studies of characteristics of infant homicides from other states. Infant homicide is proportionately greater and has findings that are different from those of other child homicides. Research indicates that the circumstances of infant homicides include a majority of them perpetrated by someone in a caregiving role and who is less than 25 years of age. More than 80 percent occurred in the child's home and in more than half there were suspicions of previous abuse of the victim by the perpetrator or another person, or previous abuse of another child by the perpetrator. In sharp contrast to teen homicides where the majority involve guns or knives, the majority of infant and young child homicides are the result of beatings, shakings and chokings by someone entrusted with caring for the child.

Infant homicides call for attention aimed at prevention. Effective methods for preventing child abuse involve programs that enhance parenting skills for at-risk parents. Examples include home visits by nurses who provide information on quality childhood programs; coaching in parenting skills which include parent training and education about normal childhood behaviors and age appropriate discipline; and information on how to select appropriate child caregivers. Educational interventions to identify abuse cases before they lead to severe injuries or death, and to teach skills for dealing with angry and impulsive responses to infant crying, especially for male caregivers, are necessary.

Homicide – Gang Violence

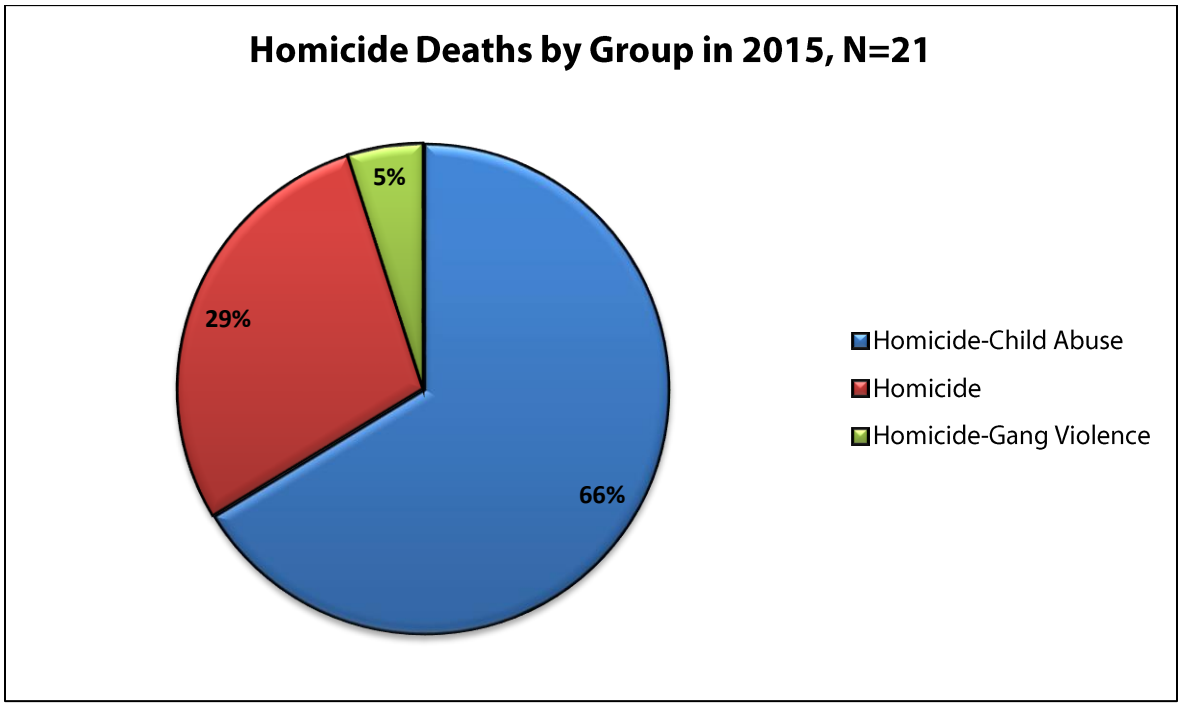
The Board will categorize a homicide as the result of gang violence when there is evidence to support the child died as a direct or indirect result of actions carried out by known or suspected gang members. In many of the cases reviewed, children are at the "wrong place, at the wrong time" and are caught up in gang violence. This can occur while the child is outside playing or even in the safety of his or her own home. In locations with gang activity, the child living in a home that has other members with gang associations is a significant risk factor. In other circumstances, the children killed are members of a gang and die during disputes related to gang activity.

Homicide

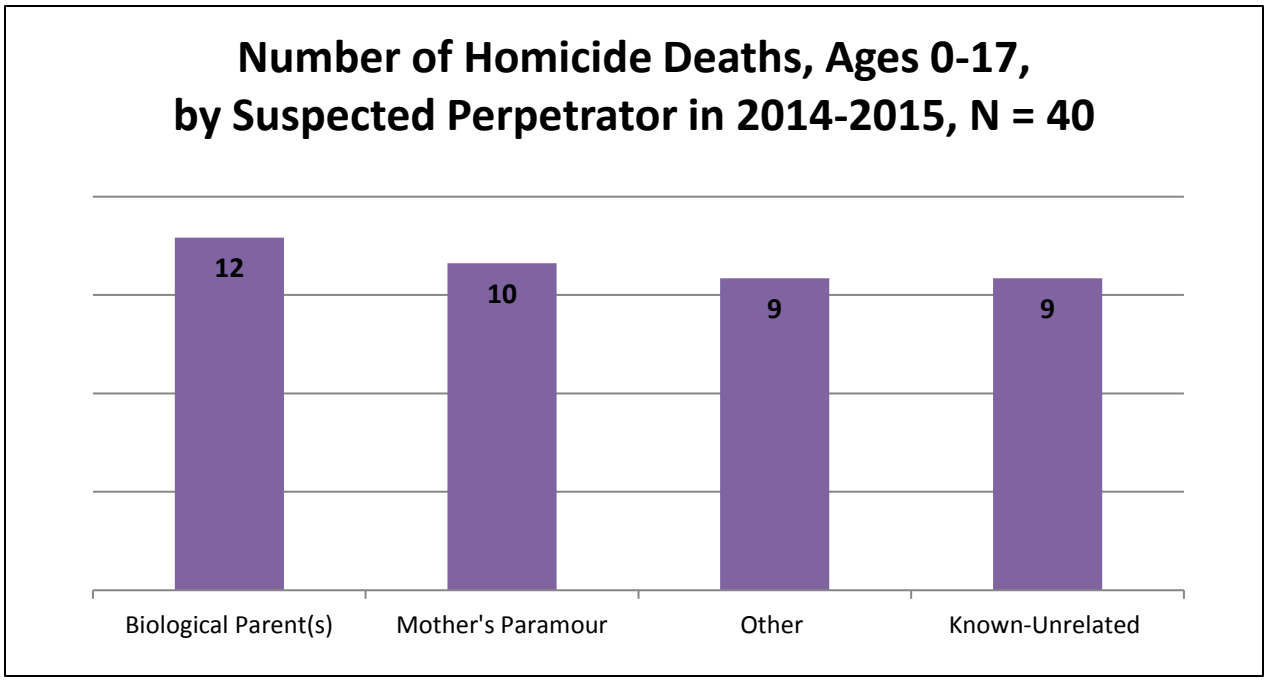
Any death not categorized as Homicide - Child Abuse or Homicide - Gang Violence is categorized as Homicide. In many of these deaths, the act of violence against the child is more random in nature and a

clear indication for the murder may not be evident. In other situations, there are clear indications why the child was killed, however the circumstances had nothing to do with child abuse or gang related violence.

The following graph indicates 2015 homicide deaths by category. Of the total homicides, 66 percent were due to child abuse and 5 percent were due to gang violence. The other 29 percent were attributed to deaths that did not fall under child abuse or gang violence definitions.



As shown in the chart below, in more than half of the homicides the suspected perpetrator was either a biological parent or the mother's paramour. The 9 homicides in which the perpetrator was listed as "other" involved cases where the perpetrator could not be determined due to more than one person having access to the child, charges not being filed, or when the suspected perpetrator was related to the decedent but not a biological parent. The remaining homicides categorized as "known-unrelated" are those in which the suspected perpetrator was identified, but not biologically related to the child.



Characteristics of the 21 Child Homicides, 2015

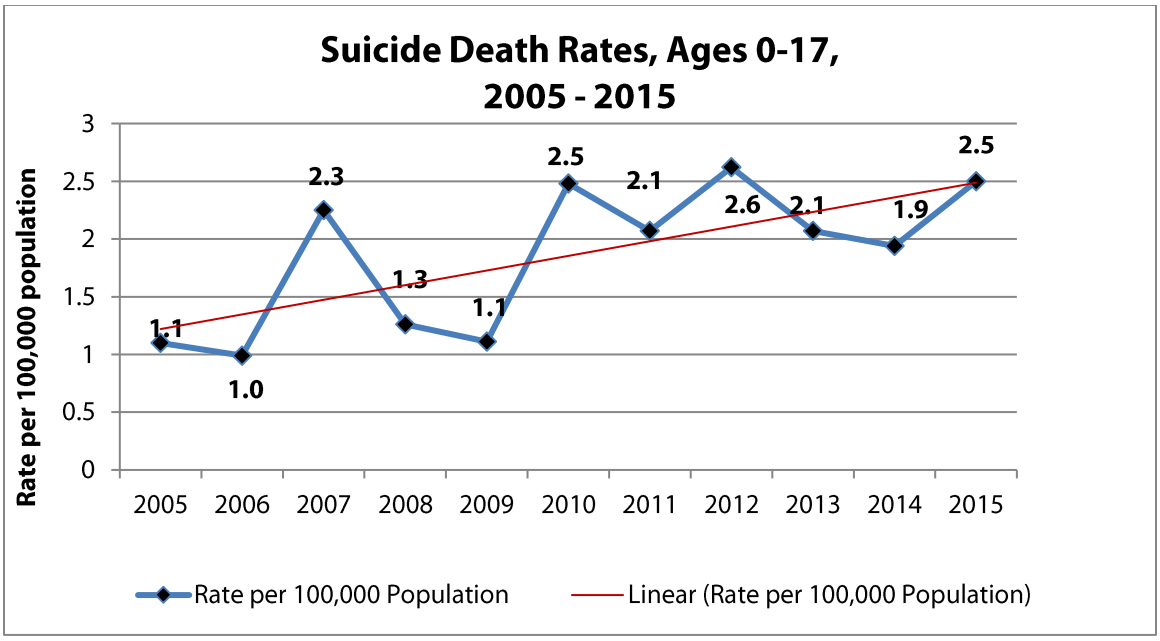
- Fourteen children died from child abuse, 8 of whom were under one year of age.
- Eight of the families had current or past DCF child protective service involvement.
  - Many of the cases without DCF history were child abuse/neglect deaths that occurred in the first year of life without other children in the home.
  - Many of the parental paramours caring for the victims had little experience with children prior to the incident.
- Twelve of the deaths occurred at the child's home.
- In 6 of the 7 non-abuse/neglect Homicides a firearm was used.
- Two of the deaths classified as homicides by the Board were listed as undetermined on the death certificate.

PREVENTION POINTS

- **Family Violence** –The safety of children living in homes where domestic violence occurs needs to be addressed by DCF and law enforcement when visits are made to the home. Children living in such environments are at increased risk of abuse, neglect or death.
- **Drug Environments –** Children living in environments where they are exposed to drugs (including illicit drugs, prescription medication and alcohol) are at increased risk of abuse, neglect or death. If drug use is suspected, the safety of the children should be addressed.
- **Education for Caregivers of Young Children –** The victims of child abuse homicide are more often in the younger age categories. Frustrated caregivers, often without any parental training, combine unrealistic expectations for children's behavior with a lack of appreciation for their vulnerability. Education should be provided at all points of contact with parents and caregivers, especially addressing positive ways to respond to infant crying, supporting parents through stressful periods, and adjusting work policies to give parents quality time with their young children.
- **Education about Signs of Child Abuse –** Most cases of child abuse can be suspected with attention to the characteristics of the injuries. Normal, active children get bruises and bumps from everyday play. These bruises are most often over bony areas such as the knees, elbows, and shins. However, if a child has injuries on areas such as the cheeks, ears, mouth, stomach, buttocks or thighs, the possibility that the child is being abused should be considered. Bruises in these areas, human bite marks, round burns the size of a cigarette, or larger poorly explained burns seldom come from everyday activities. If there is suspicion a child is being abused or neglected, a report should be made to the Kansas Protection Report Center at 1-800-922-5330 (toll-free), or 911 should be contacted if the child is in imminent danger.

Suicide

In 2015, 18 children in Kansas between the ages of 10-17 were identified as committing suicide. Of that number, 14 were male and 4 were female. This compares to females accounting for 50 percent of suicides in 2014. According to the Centers for Disease Control and Prevention, suicide is the third leading cause of death among U.S. children 10-14 and second leading cause among persons 15-34 years of age. Similar to national studies, suicides in Kansas indicate adolescent females are more likely to attempt suicide, but adolescent males are more likely to complete it. Suicide rates increase after puberty, and the rates of suicide vary according to race and ethnicity, with the adolescent suicide rate highest for white males. The tables below indicate rates per 100,000 population for the past 11 years.



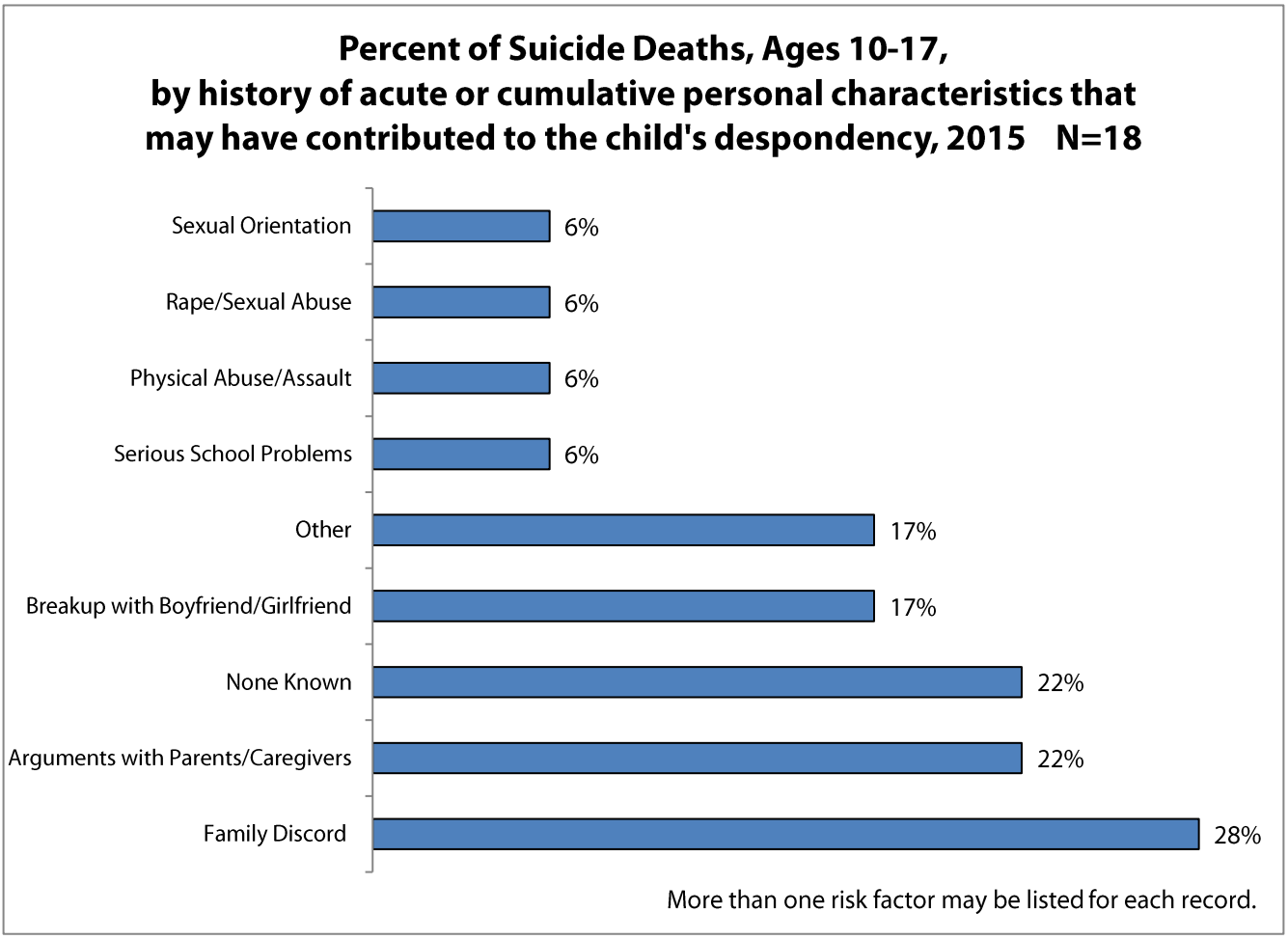
Suicide Death Rates per 100,000 age-related population, Ages 10-17, by Age Group, 2005-2015		
	10-14 Years Old	15-17 Years Old
2005	0.5	5.9
2006	1.6	11.5
2007	2.6	9.1
2008	1.1	5.9
2009	2.7	3.5
2010	1.0	12.5
2011	1.5	10.1
2012	3.0	11.0
2013	2.0	9.3
2014	2.5	7.6
2015	3.0	10.0
Average	2.0	8.8

Varied methods are used by children and adolescents committing suicide. The most common method for males is firearms; females more frequently use hanging, suffocation or drugs. While it is known there is a connection between suicide and vehicular crashes, the number of intentional crashes remains unidentified. The table below indicates the methods and number of occurrences over the past five years.

Suicides by Method and Gender, 2010-2015				
Ranking of Method (1 highest)	**Method**	**Male**	**Female**	**Total**
#1	**Suffocation/Strangulation**	**36**	**13**	**49**
#2	**Firearm**	**37**	**6**	**43**
#3	**Drug Overdose**	**1**	**4**	**5**
#4	**Fall***	**0**	**1**	**1**
	Other Transport-Train*	**0**	**1**	**1**
***denotes equal ranking**				

Risk factors for adolescent suicide are categorized as predisposing and precipitating factors. Predisposing factors include psychiatric disorders, previous suicide attempt, family history of suicide, history of physical or sexual abuse, exposure to violence and biological factors. Precipitating factors include access to means, alcohol and drug use, exposure to suicide and suicide attempts, social stress and isolation, and emotional and cognitive factors. Well-identified examples of social stress include parental divorce or separation, or the breakup of a significant relationship. Bullying has been identified as a risk factor, placing both bullies and victims at risk. Additionally, an increased risk for suicide for females has been correlated with a recent family move and an increased risk for males with the loss of a relationship.

In 2015, 10 of the 18 children who committed suicide were currently or previously receiving mental health services. Fifty percent of the children had a recent argument with a parent/caregiver, or recent family discord prior to taking their life. Of note, in 22 percent of the suicides, the family felt the death was completely unexpected as the child did not have or display any history of mental illness, suicidal ideation, or other risk factors associated with suicide. This is important to understand, as suicide is described as a "silent epidemic." In many cases reviewed by the Board, it is not known what could have been done to prevent the suicide. For that reason, the Board was unable to determine if any of the 18 suicides of 2015 could have been prevented.



Due to ongoing concern about adolescent suicides, the Kansas Legislature passed SB323 in the 2016 session, which requires suicide prevention training for school district personnel and the inclusion of steps for recognizing suicide ideation in the school building crisis plan. This law is modeled after the Jason Flatt Act making Kansas the 19th state to pass similar legislation since 2007.

Characteristics of the 18 Suicide Deaths, 2015

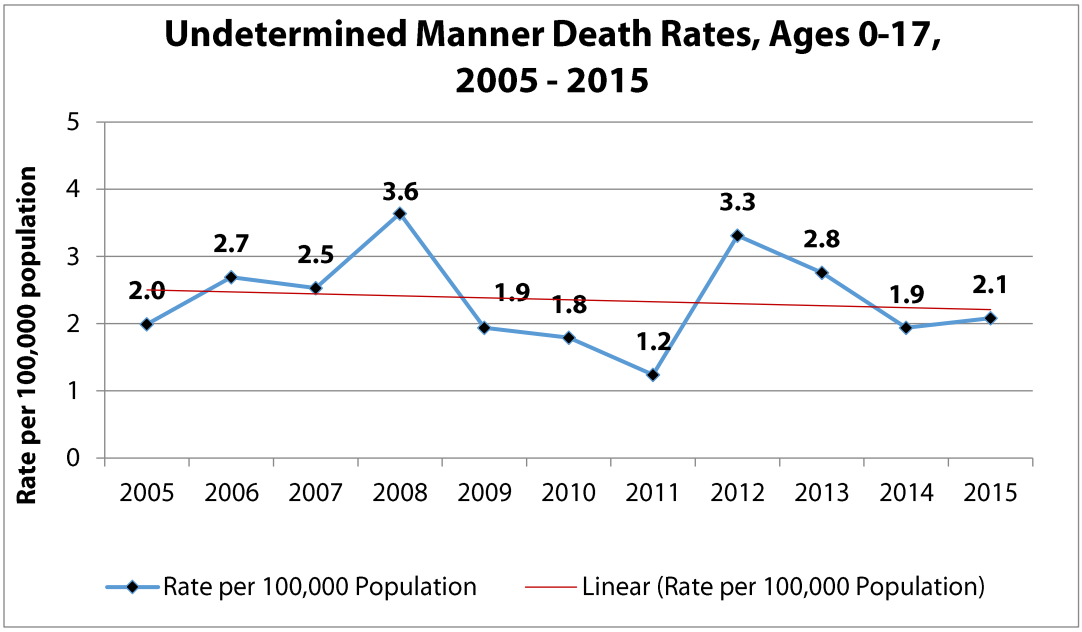
- 78% of the suicide cases reviewed were male.
- 66% of the suicides were completed by hanging, or other method of suffocation.
- 33% of the suicides were completed with a firearm.
- 22% of the decedents left a suicide note.
- In 56% of the cases the decedent had previously talked about suicide.
- In 50% of the cases the decedent had recent family discord or an argument with a parent or caregiver.

PREVENTION POINTS

- **Early Diagnosis and Treatment of Mental Conditions –** Early involvement of mental health professionals may prevent suicide attempts. Special caution should be taken with children who are taking antidepressant medication as health officials have issued warnings that these medications might increase the risk of hostility, mood swings, aggression and suicide in children and adolescents.
- **Observation of Behaviors –** Watch for changes in a young person's psychological state (increase in rage, anxiety, depression or hopelessness), withdrawal, reckless behavior or substance use.
- **Evaluation of Suicidal Thinking –** ***Do not ignore statements about suicide, even if they seem casual or fake.*** 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 functioning. This is a critical time for family interaction and securing family support systems.
- **Limit Access to Lethal Agents –** Easily obtained or improperly secured firearms and other weapons, and means such as prescription and over the counter medications, are often used in suicides. The harder it is for children 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 be a significant deterrent.
- **Pay Attention –** Pay close attention to a child's response to a parental separation or a relationship breakup. Provide counseling and support to address depression or situational difficulties.

Undetermined Manner

Periodically, the Board encounters a case where questions remain as to the cause or manner of the child's death. When there are multiple circumstances that may have contributed to the child's death and no identifiable cause is established, the Board will classify the death as undetermined. The SCDRB has classified 346 deaths as undetermined manner since the board began reviewing cases in 1994.



In 2015, there were 15 such deaths. Of the 15 deaths, four were Unclassified Sudden Infant Death (USID). As noted in the SIDS section of this report, USID includes deaths that do not meet the criteria for SIDS I or II and for which alternative diagnoses of natural or unnatural conditions are unclear. The four USID cases for 2015 were listed as such due to incomplete scene investigations, improperly conducted/ incomplete autopsies, or concern that the death may have been the result of intentional injuries or actions.

Of the 15 deaths classified as undetermined by the Board, six did not have an adequate autopsy completed. In total, there were 11 child deaths in which the Kansas coroner or pathologist did not complete an autopsy or did not meet the minimum expectation for the autopsy.

The minimum expectations for autopsies on children ages birth to 17 years with unexplained death suggest that in addition to a thorough investigation, an autopsy should include at a minimum, the following as appropriate for the age and circumstances of the child at death:

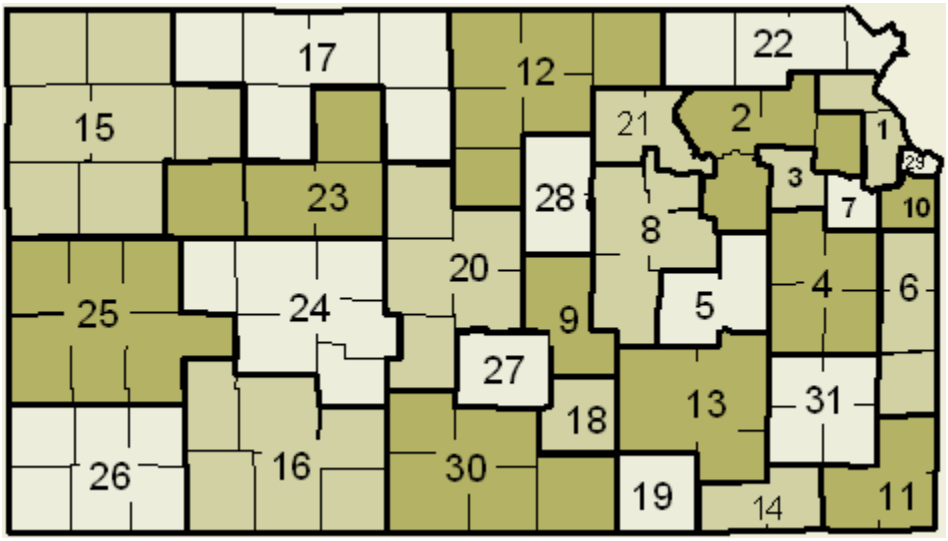
- Photographs of the child and of all external and pertinent internal injuries.
- Examination of all clothing and items accompanying the body, preserving all materials for later examination by a crime lab.
- Evidence of therapy and resuscitation.
- Radiographs for a complete survey of the skeletal structures, especially in children less than 2 years of age; films should be reviewed by a radiologist or physician experienced in child trauma whenever possible.

- Blood, urine and vitreous should be collected for possible use as an adjunct to toxicology or if metabolic or hydration status is an issue.
- Toxicological studies should include ethanol and common drugs of abuse, including cold medications, if being used; prescription drugs should be tested for based on history and scene investigation.
- The external examination should give consideration to and document the general appearance, cleanliness, nutrition (heights and weights compared to standard growth charts), dehydration, failure to thrive, congenital anomalies, evidence of abuse or neglect, evidence of sexual abuse; if not found, these should be recorded as essential negative findings.
- An autopsy should be performed on an unembalmed body and include in-situ examination of the brain, neck structures, thoraco-abdominal and pelvic organs with removal and dissection. Weights of organs should be documented. In suspected injury cases, lengthwise incisions through skin and subcutaneous tissues should document the depth of the hemorrhage. If there is no gross cause of death, microscopic examination should be conducted on the brain, heart, lungs, liver, kidneys and other organs as indicated. Stock tissue and paraffin blocks should be retained.
- DNA should be archived for genetic testing, if indicated.
- Metabolic screening results should be determined from the medical birth record. In cases where a metabolic condition is considered (e.g. preceding viral illness, period of starvation, nocturnal death, positive findings such as fatty liver), particularly in children under 2 years of age, further tissues should be preserved. A blood spot card should be prepared and retained in case autopsy findings suggest a metabolic disorder.

All non-natural child deaths should be exhaustively investigated. The circumstances and family situation should not affect the detail of the inquiry. Hospitals need to have protocols in place to ensure law enforcement is notified when a child dies from other than expected natural causes and when a child is admitted with what appears to be an apparent life-threatening event of unknown etiology that is likely to be fatal. Investigations in the undetermined cases varied significantly. In some instances, although every effort was made to determine why a death occurred, the cause of death could not be ascertained. Other cases revealed incomplete investigations or law enforcement agencies not being informed of the death. In some, autopsies were not performed or were incomplete, or toxicology testing on the victim was not performed.

The 11 cases below display instances in 2015 where the pathologist performing an autopsy did not follow standards of practice. The numbers are organized by the judicial district that held jurisdiction of the death. As shown on page 46, the SCDRB has established protocols and guidelines for when an autopsy should be completed. Furthermore, as described within Board recommendations, when these standards of practice are not followed, the SCDRB should have the ability to refer the case to the Board of Healing Arts for additional review.

Kansas Counties by District



District	Counties in District	# of child deaths not autopsied, despite guidelines	# of child deaths incompletely autopsied, despite guidelines
District 10	Johnson	1	0
District 15	Cheyenne, Logan, Rawlins, Sheridan, Sherman, Thomas, Wallace	1	0
District 16	Clark, Comanche, Ford, Gray, Kiowa, Meade	1	1
District 20	Barton, Ellsworth, Rice, Russell, Stafford	1	2
District 23	Ellis, Gove, Rooks, Trego	1	1
District 24	Edwards, Hodgeman, Lane, Ness, Pawnee, Rush	0	1
District 28	Ottawa, Salina	0	1

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, metabolic and toxicological studies. Coroners must be mindful of their statutory duties and should be aware of the autopsy reimbursement program through KDHE. More information is available at the SCDRB's website: http://ag.ks.gov/scdrb.

SCDRB Public Policy Recommendations

Recommendations to Prevent Child Abuse and Neglect Deaths

1.) Increase Access to Affordable, High-Quality Child Care

The Kansas Department for Children and Families and the Kansas Department of Health and Environment should continue working towards ensuring families have access to high quality and affordable childcare. Children, and particularly young children, should be cared for by persons who are experienced and have reasonable expectations for children and their behaviors. Having access to affordable, high-quality childcare could help decrease future child deaths.

2.) Enhance Training for Child Welfare Professionals

The Kansas Department for Children and Families should continue to develop and provide enhanced training for Child Welfare professionals regarding child abuse and neglect as well as other topics related to injury prevention.

Recommendations to Prevent Youth Suicides

1.) Increase Community Outreach Regarding Mental Health Services

Local Mental Health Coalitions should increase community outreach to raise awareness regarding available mental health services for children and youth.

2.) Increase the Depth of Suicide Investigations

Law Enforcement should increase the depth of suicide investigations to include social, mental and medical health histories of the child. Information regarding family stressors, past history of attempts, involvement in mental health services, and social media information that may be relevant should be included. By better understanding the precipitating events leading to youth suicide, our state is better equipped to understand these deaths and learn more to prevent them.

Recommendations to Prevent Motor Vehicle Deaths of Children and Youth

1.) Strengthen Seat Belt Usage

Citizens and lawmakers should support efforts in Kansas that aim to increase the use of seatbelts among drivers and child passengers. In 2015, 63 percent of the children who died due to motor vehicle accidents were unrestrained or improperly restrained. According to the State of Kansas Highway Safety Plan FFY 2016, "Children are much more likely to be buckled up if the driver is also belted. If the driver is belted, about 96 percent of the children are also belted. If the driver is not belted, only about 21 percent of the observed children were also belted." Efforts to increase the number of drivers who are properly restrained will also increase the likelihood that our children will be properly restrained. In 2017, legislation passed in Kansas increased the fine for those who are unrestrained. We are hopeful this legislation will help decrease the number of Kansas children who are unrestrained.

2.) Decrease Distracted Driving in Kansas

Citizens and lawmakers should support efforts in Kansas to promote and encourage individuals to reduce the use of hand-held devices while operating a motor vehicle. In 2015, 47 percent of the crashes involving child deaths listed a cause of the incident as driver inexperience and/or distracted driving. Ordinances, promotional materials and advertising can all be effective ways to encourage Kansas drivers to be less distracted while driving.

Recommendations to Prevent Sleep-Related Infant Deaths

1.) Increase Education on Safe Sleep for Parents and Caregivers

Delivery hospitals in Kansas should create or adopt policies regarding hospital safe sleep education for new parents prior to discharge from the hospital. The education should include statistics on sleep related deaths, as well as provide consistent messaging supporting the ABC's of safe sleep. Professionals should use sleep-related suffocation language to clarify for parents that in many cases of sleep related deaths, children do not die from unexplained reasons but due to overlay, positional asphyxia and other forms of suffocation/strangulation. Information on how to implement a hospital-based infant safe sleep program is at: http://www.cribsforkids.org/hospitalinitiative/.

Kansas communities should enhance education for primary care physicians, childcare providers and at-risk populations in the state, including low-income and adolescent parents, to provide consistent messages about safe sleep.

Recommendations to Improve the Quality of Investigations in Child Deaths and Near Fatalities

1.) Improve the Quality of Law Enforcement Investigations for Infant Deaths

Law Enforcement should increase investigators' knowledge of child fatality investigations through high quality training including the adoption of the Center for Disease Control's Sudden Unexpected Infant Death Investigation (SUIDI) protocols, and the use of scene recreation and photography. Each year the SCDRB reviews deaths of infants in which law enforcement did not collect adequate information in the investigation for the Board to determine a cause of death.

2.) Improve Coordination and Communication with Law Enforcement

The Kansas Department for Children and Families (DCF) should immediately notify law enforcement in instances where the reported abuse may be criminal in nature for law enforcement investigation. K.S.A. 38-2226 requires a joint investigation if there is a report of child abuse or neglect that indicates that there is serious physical harm and that action may be required to protect the child.

DCF and health care providers, including hospitals, should report any death or near death of a child to law enforcement for investigation. The SCDRB has reviewed many cases in which law enforcement was not contacted in a timely manner, which impeded the ability of law

enforcement to conduct their investigation. The investigations should be a coordinated effort by DCF and law enforcement to ensure thorough investigations and the safety of surviving children.

3.) Improve the Statutory Authority of the SCDRB

The SCDRB's ability to adequately review child fatalities is dependent on the investigation quality and performance of medical professionals, including pathologists. In 2015 alone, there were 11 child fatalities in which either an autopsy was not performed, or was performed in a manner that did not meet the minimum expectation for autopsies on children. It is imperative that SCDRB members and staff have the ability to comply with their professional responsibility to report medical misconduct or neglect.

Additionally there are certain circumstances in which the board reviews information that was not disclosed to the county or district attorney during the initial investigation of the child's demise. The information provided by the Board could assist in the prosecution of child deaths including those due to child abuse or neglect and cases where there is criminal activity.

Statutory Changes- K.S.A. 22a-243(j) should be clarified to indicate that State Child Death Review Board information may be disclosed to professional licensing organizations if members are under a professional responsibility to disclose that information to comply with their professional licensure. It should also be clarified to allow the release of information to the county or district attorney in the jurisdiction where the death occurred if it appears that the information is necessary for the county or district attorney to prosecute the perpetrator and the cause of the child's death was from abuse or neglect and cases where there is criminal activity.

4.) Improve the Quality of Forensic Investigations and Autopsies of Child Deaths

Thorough and complete investigations and autopsies are essential for proper death certification and eventual review and analysis of the circumstances of infant, child and adolescent deaths. The Kansas State Child Death Review Board recommends the following protocols as a guideline for a comprehensive investigation and pediatric autopsy.

A forensic pathologist should investigate all:

- Known or suspected non-natural deaths, including those due to violence, trauma, drugs or associated with police action;
- Unexpected or unexplained deaths of infants and children, including those with underlying or chronic illness;
- Deaths occurring under the unusual or suspicious circumstances;
- Deaths of children or youth in custody;
- Deaths known or suspected to involve diseases constituting a threat to public health;
- Deaths of persons not under the care of a physician.

A forensic pathologist should perform the autopsy when the:

- Death is known or suspected to have been caused by violence, trauma, drugs or associated with police action;
- Death occurs in custody of a local, state, or federal institution;
- Death is unexpected and unexplained in an infant or child;
- Death is due to acute workplace injury;
- Death is the result of a motor vehicle crash. Clinical judgment is recommended in the case of delayed deaths;
- Death is caused by or involves apparent injury, including but not limited to electrocution, fire, chemical exposure, intoxication by alcohol, drugs, or poison, unwitnessed or suspected drowning or fall;
- Body is unidentified and the autopsy may aid in identification;
- Death is unexpected, including those that are sports related, suicides, possible cardiac related and motor vehicle crashes.

Appendix: Death by County of Residence

County	Population Age 0-17	Total Deaths	Natural Deaths Except SIDS	Unintentional Injury Motor Vehicle	Unintentional Injury	Natural SIDS	Homicide	Suicide	Undetermined
Allen	2,889	3	2						1
Anderson	1,939	2	2						
Atchison	3,803	2	2						
Barber	1,094	0							
Barton	6,606	5	3		1				1
Bourbon	3,748	2	1				1		
Brown	2,467	0							
Butler	17,227	10	5			2			3
Chase	563	0							
Chautauqua	696	0							
Cherokee	4,920	2			2				
Cheyenne	563	0							
Clark	527	0							
Clay	1,975	3	2			1			
Cloud	2,047	0							
Coffey	1,862	2		1	1				
Comanche	455	1							1
Cowley	8,484	5	3		1		1		
Crawford	8,536	2	2						
Decatur	598	1						1	
Dickinson	4,652	3		1	1			1	
Doniphan	1,684	2	1	1					
Douglas	22,269	6	4	1	1				
Edwards	693	0							
Elk	541	2		2					
Ellis	6,325	5	2				1		2
Ellsworth	1,136	0							
Finney	11,510	10	7		1	1	1		
Ford	10,444	10	8					1	1
Franklin	6,321	5	2	1	2				
Geary	11,166	12	9			1	1	1	
Gove	635	1		1					
Graham	532	0							
Grant	2,462	1					1		
Gray	1,821	1	1						
Greeley	347	0							
Greenwood	1,313	1				1			
Hamilton	730	0							
Harper	1,424	0							
Harvey	8,839	3	3						

County	Population Age 0-17	Total Deaths	Natural Deaths Except SIDS	Unintentional Injury Motor Vehicle	Unintentional Injury	Natural SIDS	Homicide	Suicide	Undetermined
Haskell	1,191	1	1						
Hodgeman	416	1					1		
Jackson	3,348	3	1		1				1
Jefferson	4,440	3	3						
Jewell	557	0							
Johnson	145,597	51	37	4	4	2	2	2	
Kearny	1,174	2	2						
Kingman	1,707	2		2					
Kiowa	585	1	1						
Labette	4,852	4	3	1					
Lane	366	0							
Leavenworth	19,050	7	3	1	2	1			
Lincoln	716	1	1						
Linn	2,198	4	2	1	1				
Logan	649	0							
Lyon	7,410	6	3	1	2				
Marion	2,553	1				1			
Marshall	2,307	0							
McPherson	6,627	3	3						
Meade	1,163	0							
Miami	8,179	4		1	2			1	
Mitchell	1,391	0							
Montgomery	7,868	8	4	2	1	1			
Morris	1,173	0							
Morton	777	0							
Nemaha	2,673	2	1	1					
Neosho	4,044	2	1	1					
Ness	662	0							
Norton	1,068	0							
Osage	3,676	2	2						
Osborne	751	0							
Ottawa	1,414	0							
Pawnee	1,251	2	1						1
Phillips	1,256	0							
Pottawatomie	6,789	1	1						
Pratt	2,316	0							
Rawlins	487	0							
Reno	14,732	7	4	1	1			1	
Republic	943	1			1				
Rice	2,372	3	1	1	1				

Appendix: Death by County of Residence, continued

County	Population Age 0-17	Total Deaths	Natural Deaths Except SIDS	Unintentional Injury Motor Vehicle	Unintentional Injury	Natural SIDS	Homicide	Suicide	Undetermined
Riley	13,025	6	5	1					
Rooks	1,191	0							
Rush	611	0							
Russell	1,572	1		1					
Saline	13,420	4	1		1		1	1	
Scott	1,274	0							
Sedgwick	134,499	74	48	3	6	5	4	5	3
Seward	7,255	6	5		1				
Shawnee	43,262	26	15	2	2	2	2	2	1
Sheridan	593	0							
Sherman	1,426	1		1					
Smith	716	0							
Stafford	1,010	0							
Stanton	587	1	1						
Stevens	1,791	1	1						
Sumner	5,821	3	2		1				
Thomas	1,807	2	1					1	
Trego	545	0							
Wabaunsee	1,737	0							
Wallace	377	1			1				
Washington	1,250	1	1						
Wichita	577	0							
Wilson	2,100	0							
Woodson	651	2	2						
Wyandotte	45,889	27	15	3	2	4	3		
Out of State		14	7	2	1	1	2	1	
Total		**394**	**238**	**38**	**41**	**23**	**21**	**18**	**15**

Methodology

Kansas Child Death Review Board 2015 Data

The SCDRB meets monthly to examine the circumstances surrounding the deaths of all Kansas children aged birth through 17 years old, as well as children who are not residents but died in Kansas. As a rule, the SCDRB is notified of a death when a death certificate, matched with its corresponding birth certificate, is received from the Kansas Department of Health and Environment's Office of Vital Statistics. On a monthly basis, KDHE provides the SCDRB with a list of children whose deaths have been reported. The Office of Vital Statistics has a close working relationship with other state vital statistics departments per inter-jurisdictional agreement and receives death certificates from those departments when a Kansas child dies in another state. This provides relevant information about out of state deaths to the SCDRB for review.

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 sources of additional information necessary for a comprehensive review. Before a case can be reviewed, pertinent records that could provide circumstances that led to the child's demise are collected for the file. Such records may include coroner reports, autopsy reports and photos, medical records, law enforcement reports, scene photographs, DCF records, school records, media reports and obituaries, and other relevant documents. Information obtained by the SCDRB is confidential.

After all records have been collected, cases are assigned for review and assessment. 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. Upon agreement of the cause and manner of death, cases are finalized. In some instances, the SCDRB may determine that it is appropriate to refer a case to the county or district attorney in the county where the death occurred with recommendations for further action.

It should be noted that the numbers and rates in this report should not be expected to be the same as those reported in the KDHE Annual Summary of Vital Statistics, which monitors deaths of Kansas residents only. Case file information may not be available to the coroner when cause of death is determined, resulting in incomplete information about the circumstances of the death. After review by the Board, the classification of the cause or manner of death may be different from the coroner's. For example, an infant death suspicious for asphyxia may be called an undetermined death by the coroner, but after the Board reviews medical, law enforcement, and other pertinent reports, additional information may support the Board's classification of the death as Sudden Infant Death Syndrome, Category II or Unintentional Injury due to asphyxia depending on the review findings.

The current publication follows the custom of presenting death rates for infants per 1,000 live births, and death rates for all other age groups per 100,000 age-group population. The exception to this rule is when rates for infants and older children are compared in the same graph. In such an instance, infant mortality is expressed as deaths per 100,000 infant population. An example is the graph for Homicide death rates on page 31.

Methodology, continued

To determine the infant death rate per 1,000 live births in a specific year or the number of deaths is divided by the corresponding number of live births, and then multiplied by 1,000. The Kansas Department of Health and Environment (KDHE) Bureau of Epidemiology and Public Health Informatics (BEPHI) is the source for numbers of live births used as denominators in this report.

Example: Infant death rate, Kansas 2015 =

$$\left(\frac{237 \text{ (number of infant deaths that occurred in 2015, reviewed by the CDRB)}}{39{,}126 \text{ (number of Kansas resident live births in 2015)}} \right) \text{ X } 1{,}000$$

= 6.05

To determine the death rate per 100,000 population for an age group for a specific year or the number of deaths is divided by the corresponding population, and then multiplied by 100,000. The U.S. Census Bureau is the source for population denominators for this report.

Example: Motor Vehicle Death Rate, age 15-17, Kansas 2015=

$$\left(\frac{16 \text{ (number of MVC deaths age 15-17 that occurred in 2015, reviewed by the CDRB)}}{120{,}060 \text{ (population of Kansas residents age 15-17 in 2015)}} \right) \text{ X } 100{,}000$$

= 13.32

Any questions about this report or about the work of the SCDRB should be directed to Sara Hortenstine, Executive Director, at (785) 296-7970 or by e-mail at sara.hortenstine@ag.ks.gov.

The information and data contained in this report are compiled from multiple reporting sources and have been represented to be accurate as of the date of this report. The information and data contained herein are subject to later modification by the reporting sources.

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 old) 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 for Children and Families (DCF), 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 to examine circumstances surrounding the deaths of Kansas children (birth through 17 years old). Members bring a wide variety of experience and perspective on children's health, safety and maltreatment issues, which strengthen the decision-making of this body.

With assistance from law enforcement agencies, county and district attorneys, DCF, KDHE, physicians, coroners, and other medical professionals, the SCDRB is given necessary information needed to examine the circumstances that led 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, which improves comparison of data and trends related to child deaths.

References

1. Centers for Disease Control and Prevention (CDC). Web-Based Injury Statistics query and reporting system (WISQARS) (Online). (2013, 2011) National Center for Injury Prevention and Control, CDC (producer). Available from http://www.cdc.gov/injury/wisquars/index.html

2. Colvin, J.D., V. Collie-Akers, C. Schunn, and R. Y. Moon. "Sleep Environment Risks for younger and Older Infants." Pediatrics 134:2 (2014)

3. Fujiwara, T., Barber, C., Schaechter, J., and Hemenway, D., "Characteristics of Infant Homicides: Findings From a U.S. Multisite Reporting System." Pediatrics 124:2 (2009)

4. Kansas Department of Transportation, State of Kansas Highway Safety Plan FFY 2014, Bureau of Transportation Safety and Technology, 2016.

5. Oakley D, Crawford G, Savage C. 2015 Kansas Annual Summary of Vital Statistics. Topeka, KS: Kansas Department of Health and Environment, 2016.

State Child Death Review Board
120 SW 10th Ave, 2nd Floor
Topeka, KS 66612-1597

(785) 368-7376
(785) 296-7796 (Fax)
www.ag.ks.gov