2023

2023 Annual Report
(2021 Data)

www.ag.ks.gov/scdrb

KANSAS ATTORNEY GENERAL

KRIS W. KOBACH

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Kansas Attorney General Kris Kobach

September 30, 2023

Dear Fellow Kansans,

Since 1992, the Kansas Child Death Review Board has diligently worked to review the causes of child deaths in Kansas. The multi-agency, multi-jurisdictional board annually reviews hundreds of child deaths in order to compile meaningful data that can be used to make our children safer.

The task is grim but necessary in order to prevent future child deaths and reduce child mortality. I am grateful for the work of members of the Child Death Review Board, and I'm hopeful the information in this report provides meaningful analysis and context that can be used to protect Kansas children in the future.

On behalf of the Child Death Review Board, I present you this report. My hope is that policymakers will find it to be a valuable tool in the arsenal we use to promote the health and safety of Kansas kids.

Sincerely,

Kris W. Kobach

Kris W. Kobach
Kansas Attorney General

CONTENTS

Letter from Kansas Attorney General Kris Kobach 2
Executive Summary 3
Legislative Priorities 4
Acknowledgments 5
Goals and History 6
Board Members 7
2021 Overview 8
  Child Welfare Overview 11
Mortality Affecting Infants 14
  Sleep-Related, SUID Deaths 18
Mortality Affecting Children Ages 1-17 25
Natural Deaths 27
  Asthma 29
  COVID-19 32
Unintentional Injury Deaths 33
  Unintentional Injury- Asphyxia Deaths 35
  Unintentional Injury- Motor Vehicle Crash Deaths 37
  Unintentional Injury- Drowning Deaths 43
  Unintentional Injury- Fire, Burn and Electrocution 47
  Unintentional Injury- Agriculture Related Deaths 49
Homicide Deaths 51
  Homicide- Child Abuse 55
  Homicide- Gang Violence 58
  Homicide- Other 59
Suicide Deaths 60
Undetermined Deaths 69
Deaths in Non-Relative Child Care Homes and Centers 72
Drug- Related Deaths- All Manners 74
Weapon-Related Deaths- All Manners 79
  Firearm Deaths 82
Autopsy Examinations- All Manners of Death 85
Public Policy Recommendations 88
Methodology 97
Appendix A- Resident County of Death 2017-2021 99
References 103

EXECUTIVE SUMMARY

Since 1994, the Board has reviewed 12,742 child deaths. In 2021, Kansas had 349 child fatalities. The manners of death are classified into one of the following five categories: Natural, Unintentional Injury (Accident), Homicide, Suicide, and Undetermined. The following are several significant highlighted elements of the report.

- The overall rate of death for children ages 0-17 has shown a decline in the last five years with the rate of death for 2021 being 49.6 deaths per 100,000 population. When looking at specific manners or mechanisms of death:
  - Rate of death due to natural causes has shown a downward trend with more than 100 fewer children dying of natural causes in 2021 compared to 2018.
  - Rate of death due to unintentional injuries (accidents) has remained stable the past 5 reporting years.
  - Rate of death due to homicide was relatively stable from 2017-2020 but showed a fairly significant increase in 2021 when there were 32 child homicides. This is compared to only 22 child homicides in 2020.
  - Rate of death due to suicide has shown a downward trend since 2018 when both the Kansas and the U.S. rate of youth suicides peaked.
  - Undetermined rate of deaths has shown an increase since 2019 mainly due to reclassification in sleep-related deaths which previous to 2019 had largely been classified as natural deaths.
  - Drug-related deaths have shown a significant increase in the past two years with 20 times more deaths from Fentanyl in 2020 and 2021 than there were in the three years prior combined.
  - Weapon-related deaths, specifically firearm deaths has nearly doubled over the last five reporting years. In 2021 there were 44 firearm deaths, which means that more children died from firearms than from injuries sustained in motor vehicle crashes.
- Males accounted for more deaths in nearly all age groups and comprised 60% of child deaths in 2021. This is consistent with past reporting years.
- Rate of death by race/ethnicity for multiple groupings of deaths in the combined years of 2017-2021 indicated Black/Non-Hispanic children had a rate of death higher than the Kansas rate in all categories except for suicides. Disparities are seen in all race/ethnicity groups except for White/Non-Hispanic children who died at a rate lower or the same than the Kansas overall rate.
- Of the 1074 child fatalities reviewed by the Board between 2019 and 2021, 392 children (36%) had history with the child welfare system, specifically with the Department for Children and Families (DCF) Division of Child Protective Services (CPS).
  - In 115 of the deaths with CPS involvement, the decedent or a sibling had been removed from the home at some point prior to the death, with 28 of them being in state custody at the time of death.
  - There were 61 children who had an open CPS case at the time of death, 24 were infants under the age of 1.

LEGISLATIVE PRIORITIES

The Board strongly encourages the members of the State Legislature to consider each of the Public Policy Recommendations, beginning on page 88 during the 2024 legislative session. The following recommendations below are prioritized by the Board as needing immediate attention in order to address and prevent child fatalities in Kansas.

1.) **Statutory Modifications to K.S.A 22a-243 State child death review board; executive director; development of protocol; annual report; confidentiality of records; exceptions for disclosure; rules and regulations.** Language should be modified to allow:
   - The SCDRB to produce publications and share data outside of what is produced in the annual report submitted on or before October 1st of each year.
   - The Board to consult with content experts on cases in which an advanced review of the death by such expert may result in a better understanding or more accurate documentation of data surrounding child fatalities. These experts could include professionals knowledgeable in specific areas of study such as pediatrics, toxicology, pathology, environmental and mental health disorders.
   - Expansion of local level prevention work for judicial jurisdictions who have an interest in partnering with the SCDRB to become a certified Community Action Team (CAT). Community Actions Teams would need to be established and approved by the SCDRB in order to receive aggregate data and information related to child fatalities in their area by the SCDRB. Certified CATs would need to meet criteria outlined by the SCDRB and would use information provided to lead local level prevention efforts surrounding child fatalities in their jurisdiction.

2.) **Statutory Modifications to K.S.A 22a-242- Child death, notification of coroner; autopsy; notification of state review board; notification of parent or guardian; SIDS death; fee for autopsy.** Language should be modified to:
   - Remove requirement for nonsuspicious child death form as it is currently not in use.
   - Remove required notification to the chairperson of the SCDRB within 30 days of the death.

3.) **Child Care Licensing Laws –** Each year, the Board finds instances of children dying in the care of unlicensed child care providers or providers that are not in compliance with their license requirements. K.S.A. 65-501 requires persons maintaining a child care facility for children under 16 be licensed. If someone is found to be out of compliance after remedial measures have been attempted, the current Kansas statute authorizes the person to be prosecuted by the County Attorney for an unclassified misdemeanor. If the provider is found guilty, the current penalty is between $5 and $50 each day they are out of compliance. Through enhanced monitoring, enforcement, higher fines and increased prosecution, the Board hopes that the quality of child care available to Kansas children will be improved.

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 reviews.

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.

More information regarding the Citizen Review Panels in Kansas can be found at:
http://www.dcf.ks.gov/services/PPS/Pages/CitizenReviewPanel.aspx

GOALS AND HISTORY

The State Child Death Review Board (SCDRB) 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 findings. 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.

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; and
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, the Department for Children and Families, the Kansas Department of Health and Environment, 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.

This multi-disciplinary volunteer Board meets monthly to examine circumstances surrounding the deaths of Kansas children. 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 agencies around the state, 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.

BOARD MEMBERS

Attorney General appointee

Jane Weiler, J.D., Chairperson
Office of the Kansas 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

Jennifer Slagle, CAPTA/CJA Program Administrator,
Kansas Department for Children and Families, Topeka

Secretary of Health and Environment appointee

Elizabeth W. Saadi, Ph.D., State Registrar (Retired)
Kansas Department of Health and Environment, Topeka

Commissioner of Education appointee

Kim Jones, RN, BSN, School Nurse
Kansas Department of Education, Topeka

State Board of Healing Arts appointees

Christine James, D.O. (Forensic Pathologist Member),
Deputy Medical Examiner/Coroner, Johnson County

Diane C. Peterson, M.D. (District Coroner Member),
Chief Medical Examiner/Coroner, Johnson County

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

Melissa G. Johnson, J.D.
Montgomery County Attorney, Independence

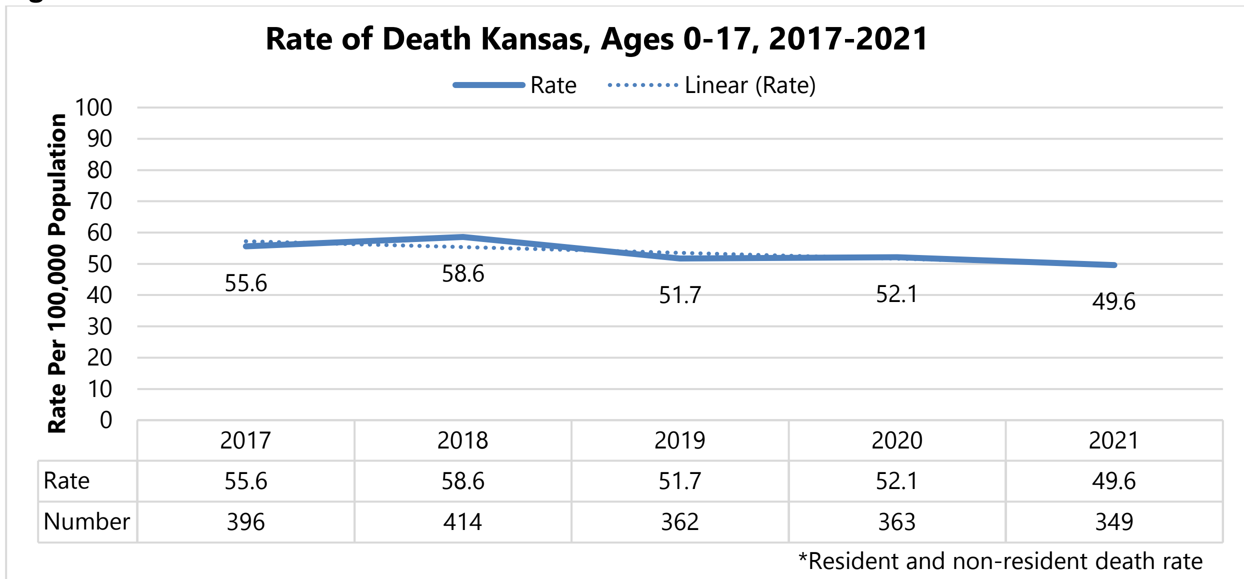
STAFF

Sara Hortenstine, Executive Director
Susan Croucher, Program Consultant
Evalinda Coria, Program Consultant
Robert Hutchison, Deputy Attorney General, General Counsel

2021 OVERVIEW

The State Child Death Review Board reviewed the deaths of 349 children, ages 0-17, who died in Kansas, or were Kansas residents who died outside of the state during the year 2021. The death rate calculated per 100,000 Kansas children decreased in calendar year 2021. The overall death rate shows a continued downward trend from previous years (Figure 1).

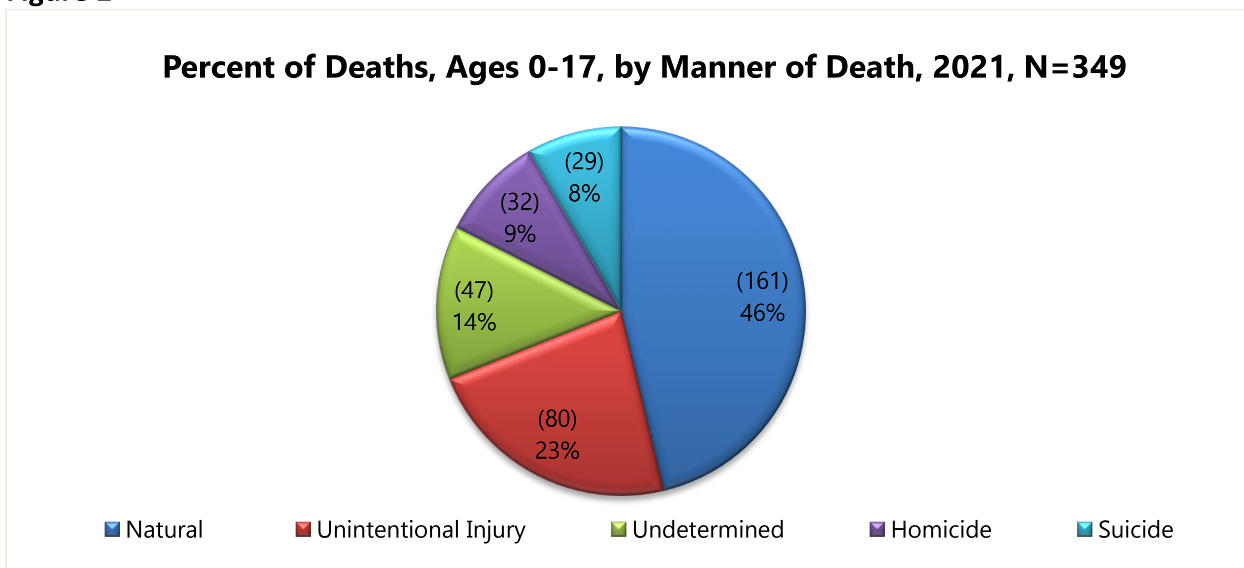
Figure 1



	2017	2018	2019	2020	2021
Rate	55.6	58.6	51.7	52.1	49.6
Number	396	414	362	363	349

*Resident and non-resident death rate

Figure 2



As shown in Figure 2, of the total deaths in 2021, 23% were due to unintentional injuries, 14% were of undetermined manner, 9% were homicides and 8% were due to suicide. Natural manner of death accounted for the largest percentage, at 46% of all deaths in 2021.

Males accounted for more deaths in nearly all age groups and comprised 60% of all child deaths in 2021 (Figures 3 and 4).

Figure 3

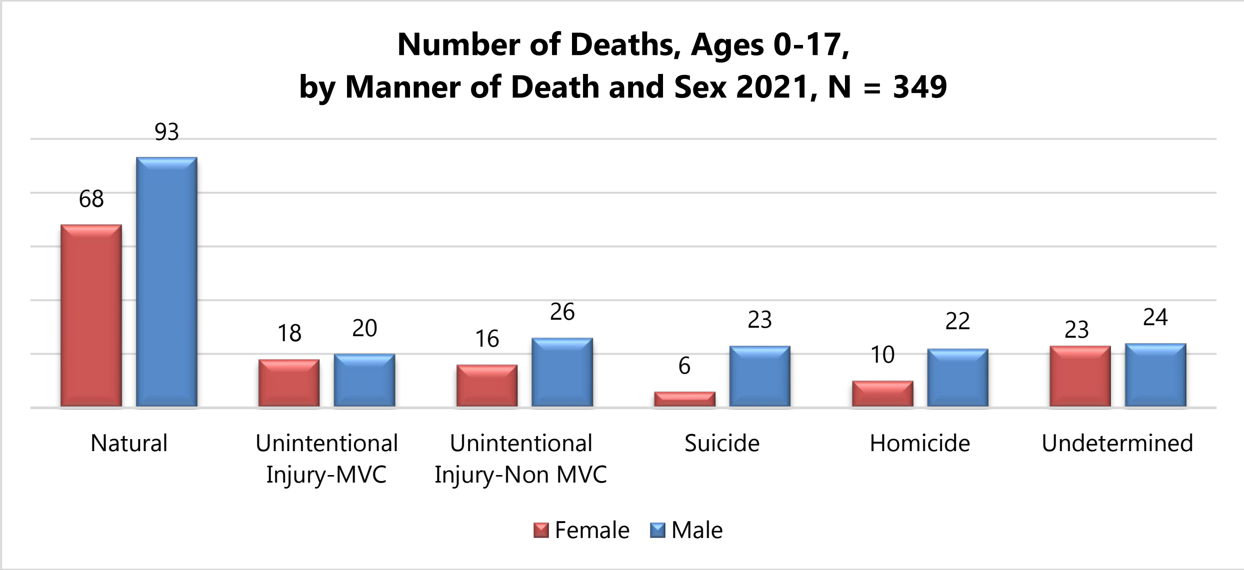


Figure 4

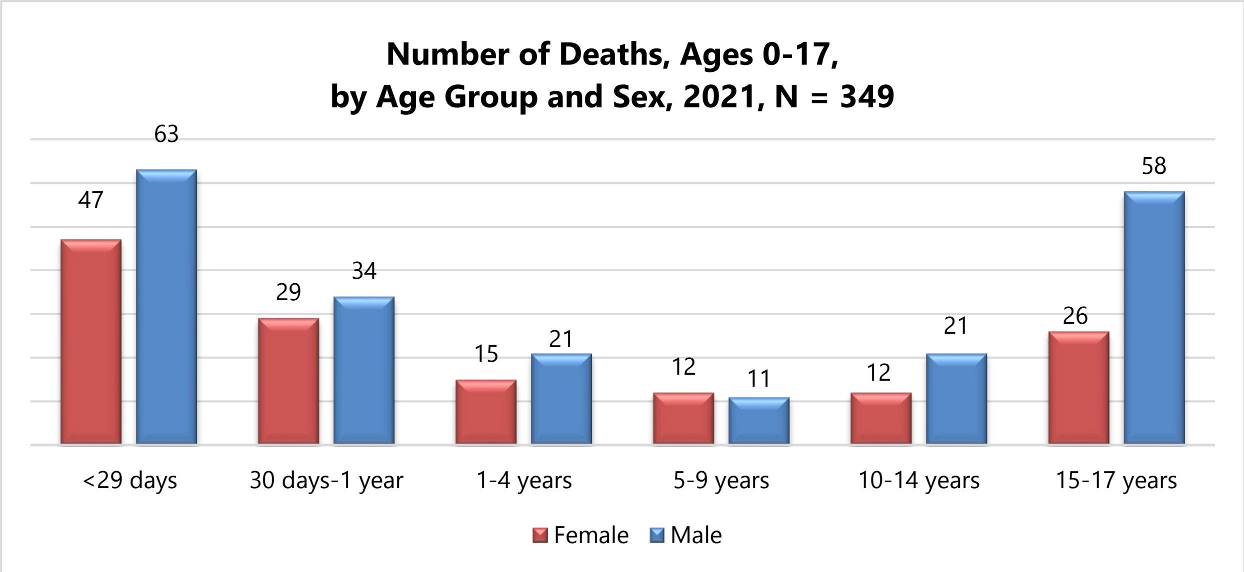


Figure 5 shows the rate of death by race/ethnicity for multiple groupings of deaths in the combined years of 2017-2021. Black/Non-Hispanic children had a rate of death higher than the Kansas rate in all categories except for suicides which are not displayed due to low numbers. Disparities are seen in all race/ethnicity groups except for White/Non-Hispanic children which died at a rate lower or the same than the Kansas overall rate.

Figure 5

Rate of Death by Race/Ethnicity, 2017-2021 Infant death rate per 1,000 live births, Age 0-17 death rate per 100,000 population							
	Kansas Rate All Races	White/ Non-Hispanic	Black/ Non-Hispanic	American Indian/ Non-Hispanic***	Asian/ Non-Hispanic	Multiple Race/ Non-Hispanic	Hispanic- Any Race
2017-2021- All Manners of Deaths, Age<1 (Infant)	6	4.6	11.6	*	3.8	16	8.1
2017-2021- All Manners of Deaths, Age 0-17	52	42.3	114.2	*	41.2	68.2	66.2
2017-2021- All Manners of Deaths, Age 1-17	24.5	21.5	51.5	*	19.4**	19.2	28.7
2017-2021- Natural Deaths, Age 0-17	30.1	24.9	63.1	*	29.4	36.0	38.1
2017-2021- Unintentional Injury Deaths, Age 0-17	9.7	8.4	18.6	*	*	10.0**	13
2017-2021- Homicide Deaths, Age 0-17	3.3	1.6	14.9	*	*	6.1**	5
2017-2021- Suicide Deaths, Age 0-17	4.1	4.1	*	*	*	*	4.4
2017-2021- Undetermined Deaths, Age 0-17	4.9	3.4	14.4	*	*	12.7	5.8

*Denotes suppressed rates of death due to value of 9 or less
**denotes rates of death with value of 10-19 which should be used with caution
***American Indian as defined in the methodology section of this report has been suppressed as the value is too small to report in all categories

Rates for Figure 5 were calculated using population and birth data provided by the Kansas Department for Health and Environment (KDHE). For more information regarding rate of death or definitions regarding race and ethnicity, please refer to the Methodology section.

CHILD WELFARE OVERVIEW

While there is an expectation for all caseworkers, providers and administrators serving in our child welfare system to be highly trained, dedicated professionals, we cannot expect each of them to be an expert in every area of involvement with families. Ensuring the safety of the more than 700,000 children in Kansas is a shared responsibility that extends to law enforcement, public health, medical and mental health professionals, educators, child care providers, and private citizens.

Through the review of more than 12,000 child fatalities since 1994, which includes the social circumstances of the lives of these children, there is an ever-increasing awareness that our social welfare system is directly connected to the potential prevention of child fatalities in our state. The Board sees opportunities in this area to improve the outcomes for our children.

As shown in Figure 6, of the 1074 child fatalities reviewed by the Board between 2019 and 2021, 392 had history with the child welfare system, specifically with Department for Children and Families (DCF) Division of Child Protective Services (CPS). Of the 392 cases with past CPS history, in 115 of them, the decedent or a sibling had been removed from the home at some time prior to the death (Figure 7). Also noted in Figure 7 are the ages of children in state's custody at the time of their death as well as those in which there were open CPS cases at the time death.

Figure 6

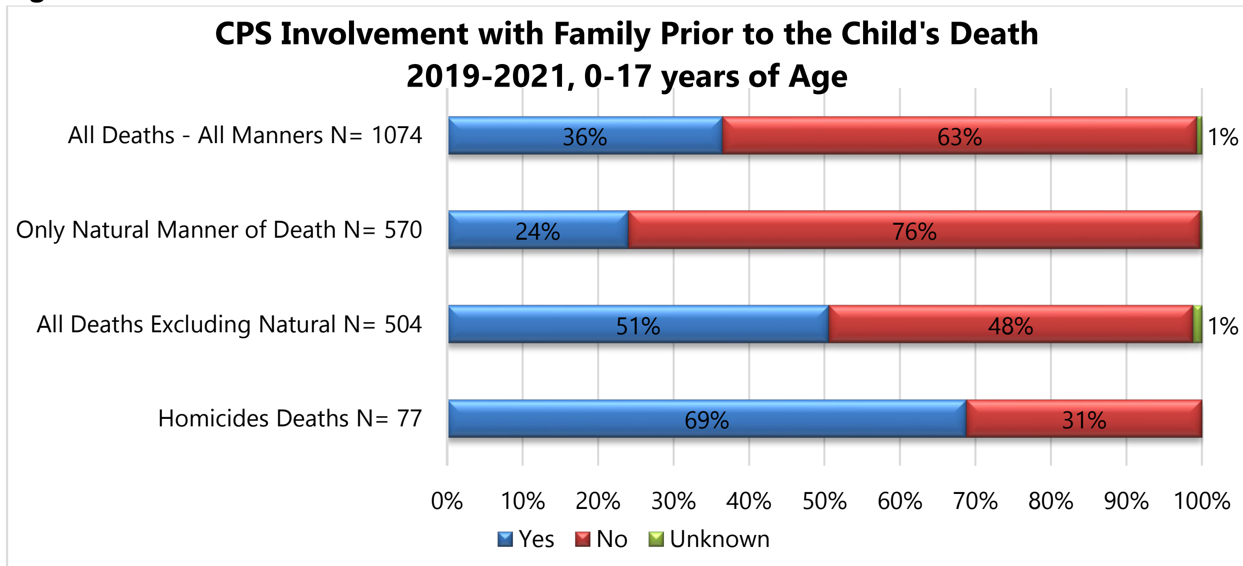
Number of child deaths, All Cause and Manners, age 0-17 years, by involvement with Child Welfare System, 2019-2021, N=1074						
	Total-All Ages	Age <1	Age 1-4	Age 5-9	Age 10-14	Age 15-17
No Known CPS History	675	445	47	48	46	89
CPS History Prior to Death	392	149	52	24	60	107
Unknown	7	1	1	2	2	1

Figure 7

Type of case history when decedent had CPS history prior to death, Age 0-17, 2019-2021, N=392* *Categories are not exclusive as cases will overlap and equal more than 392						
	Total- All Ages	Age <1	Age 1-4	Age 5-9	Age 10-14	Age 15-17
Removal of Sibling or Decedent Prior to Death	115	46	14	6	15	34
Open CPS at Time of Death	61	24	13	5	7	12
Decedent in Custody at Time of Death	28	6	7	2	1	12
Decedents with history not described in above categories	252	91	33	16	42	70

Overall, 36% (392) of all decedents had CPS involvement prior to their death. As shown in Figure 8, for comparison, of those children that died from a natural manner of death, only 24% (137) of the 570 decedents had CPS involvement. When natural manner is excluded from the total deaths with CPS involvement, the percentage of cases with CPS involvement increases, which is especially notable in the Homicide category where 69% (53) of the cases had prior CPS involvement.

Figure 8



In 2016, The Commission to Eliminate Child Abuse and Neglect Fatalities published a national report entitled, "Within our Reach,"[1] which focused on child welfare system changes that could lead to prevention of child abuse and neglect deaths. Consistent with the Commission's research and findings, data from the SCDRB support the following:

- Infants and toddlers are at a higher risk of abuse or neglect fatalities compared to other age groups.
- A call to a child protection-reporting center, regardless of the disposition, is the best predictor of a later child abuse or neglect fatality. This highlights the importance of how decisions are made to screen in reports. Screening out a report risks leaving children in unseen situations where there may be a high risk for later fatality or serious injury.
- Involvement of health care and public health agencies and professionals is vital to safety for children. Well-coordinated interagency efforts are essential in ensuring timely and accurate communication and effective family services.
- The importance of child protection workers' access to real-time information about families cannot be overstated.
- It is critical to have an accurate count of child protection fatalities. Better data allows us to better understand what works and how best to use resources and guide research.

The Board believes that additional child welfare improvement is needed in Kansas to reduce the number of child abuse and neglect deaths. Additional recommendations include timely referrals for drug and alcohol assessments and treatment when parental use is suspected, consistent and regular monitoring of cases, and effective communication with other community agencies providing services to families known to the child welfare system.

VIGNETTE

Deaths with Child Welfare Involvement

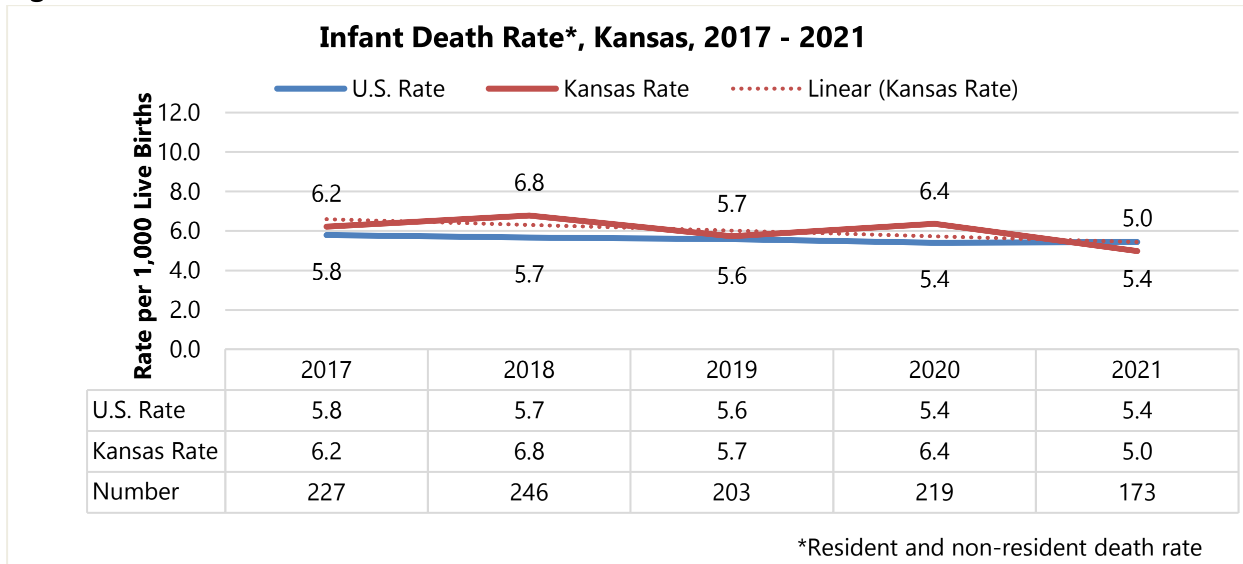
1. DCF had 25 previous intakes on the family of an infant who was born substance exposed. The mother of the infant tested positive for methamphetamine, amphetamine, and THC during her pregnancy. Despite the mother not having custody of her other 6 children due to state removal, and the known maternal substance use disorder, the infant was discharged home with the mother without services in place. Safe sleep information was provided to the mother both in the hospital and at the infant's first health visit. On the date of the incident the mother indicated she fell asleep with the infant in an adult bed and woke to find the infant unresponsive. Drug paraphernalia was noted at the scene and the mother admitted she rolled over on the infant. The Board ruled the death as a suffocation related to an unsafe sleep environment. The DCF history reviewed by the Board included previous reports for exposure to illicit drug use, lack of supervision, physical abuse including a strangulation event, unlivable home environment, threats of harm and abandonment, and more. The removal of the other children due to the unsafe environment occurred only 2 years prior to the birth and subsequent death of this infant. Given the findings of this case as well as others that are similar in nature, DCF should adopt or modify policies to ensure that families with prior removals have adequate oversight and a safe environment prior to a new infant being placed in their care.

2. A young child's death was ruled a child abuse homicide. For the first few months of life, the child was in foster care due to concerns for safety. Six months prior to the death of this child, the caregiver regained custody and was receiving aftercare services with a contracted DCF agency. Three months prior to the death, DCF received a report with allegations of emotional abuse of this child, which included descriptions of the caregiver screaming at, cursing at, and threatening the child. During the DCF investigation, the caregiver admitted telling the young child to "shut the fuck up" but justified the actions by reporting they would also say "nice things" to the child. That case was unsubstantiated. Twelve days prior to the death, another intake was made when the caregivers were requesting assistance. Before this intake could be addressed, the child died of abusive head trauma. Additional older injuries were noted at the hospital and in the autopsy. In total, DCF had 23 intakes on this family. Eleven were assessed but not investigated, seven were related to the caregiver's drug use, the death of another child in their care, and domestic violence with children in the home. The remaining five intakes were investigated, two for emotional abuse due to a child witnessing domestic violence, one of which was affirmed with the sibling placed in custody, one was unsubstantiated for suspected physical abuse of a sibling, and one was noted above as the emotional abuse to this child due to the caregiver's verbal berating. The last report DCF received was at the death of this child. Despite previous removal and aftercare services, this caregiver continued to display signs of abusive behaviors which were triggered by the child's expected developmental activities.

MORTALITY AFFECTING INFANTS

In Kansas, infant mortality (age less than 1 year) has been noted as an area in need of improvement. There were 173 infants who died in 2021. The infant mortality rate for Kansas was 5.0 deaths per 1,000 live births. Over the last five years, Kansas has experienced a downward trend in annual infant mortality rates (Figure 9). According to "The Healthy People 2030," the national goal for infant mortality is 5.0 infant deaths per 1,000 live births by the year 2030.[2]

Figure 9



	2017	2018	2019	2020	2021
U.S. Rate	5.8	5.7	5.6	5.4	5.4
Kansas Rate	6.2	6.8	5.7	6.4	5.0
Number	227	246	203	219	173

*Resident and non-resident death rate

Figure 10

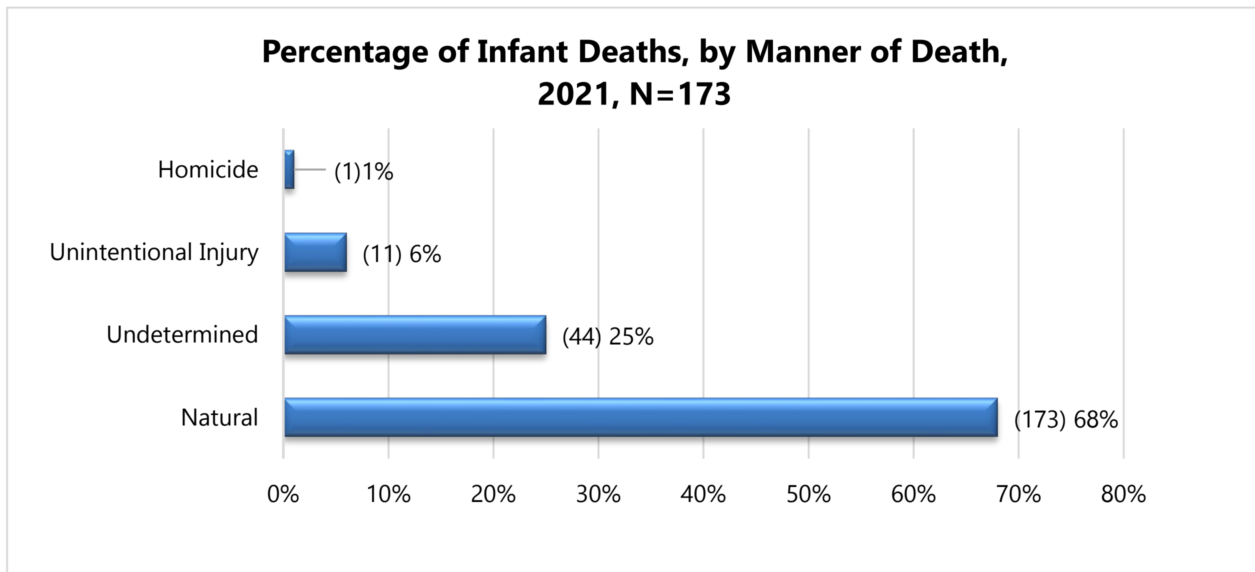


Figure 11

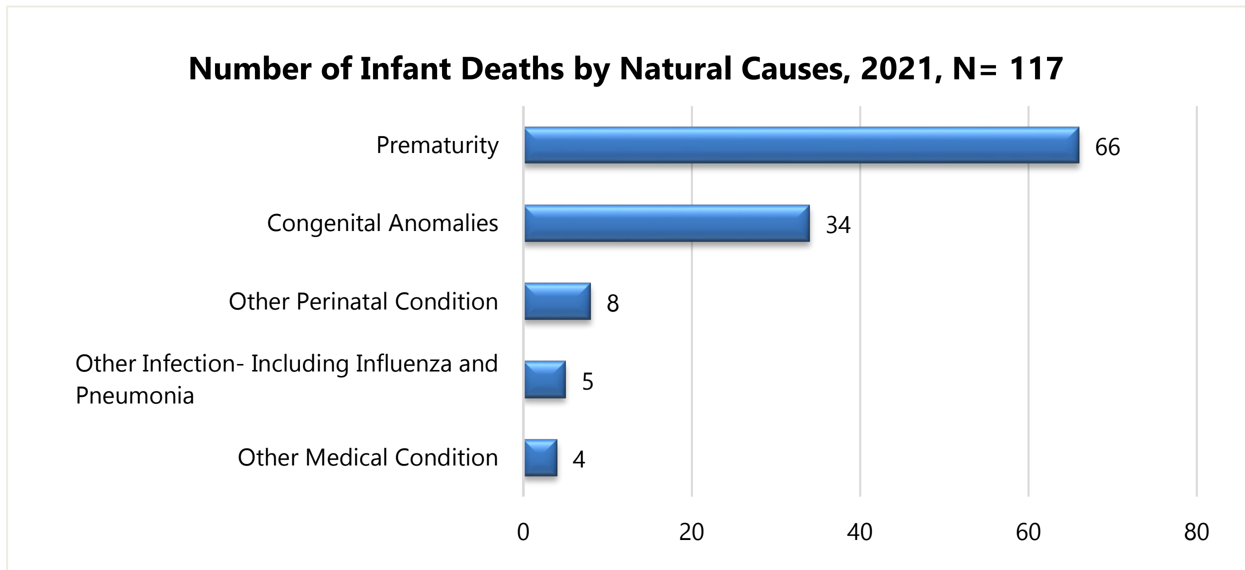


Figure 10 shows the percentage of infant deaths by manner. Figure 11 indicates that 117 infants were found to have died by natural causes with the leading causes being prematurity and congenital anomalies. Figure 12 describes all other infant deaths excluding natural causes.

Figure 12

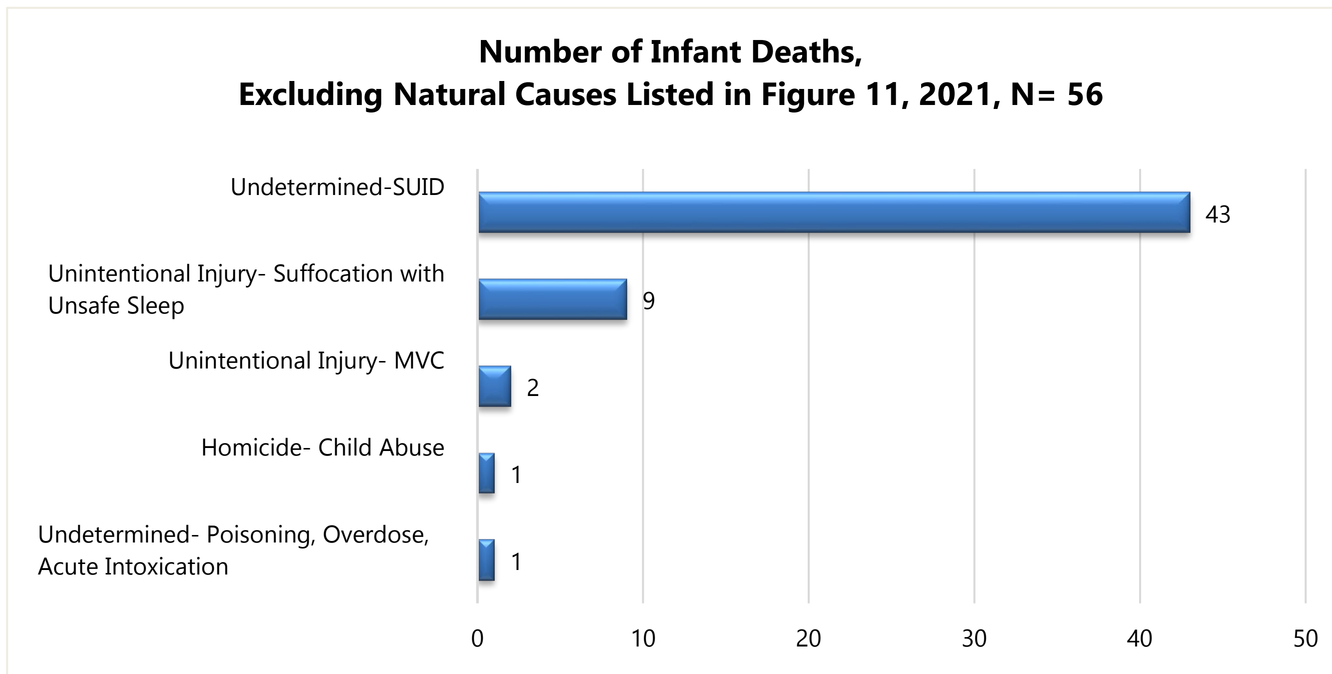


Figure 13

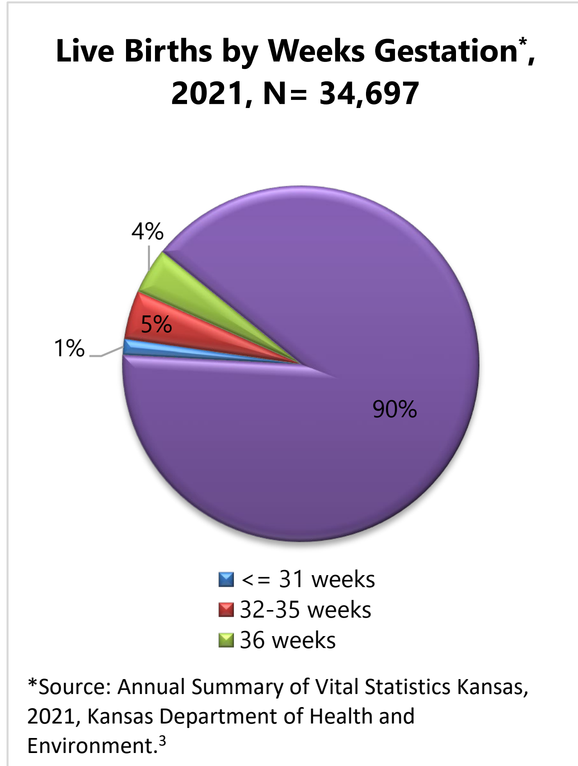
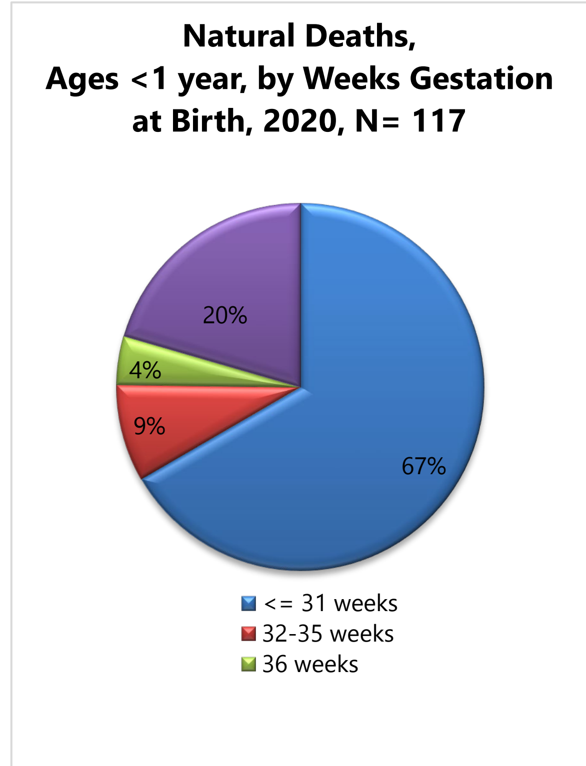


Figure 14



Though the majority (90%) of infants are born at or after 37 weeks gestation, deaths are disproportionately associated with those born prior to 37 weeks gestation. As shown in Figures 13 and 14, 67% of the infants who died from natural causes were born prior to or at 31 weeks gestation. In addition to being a direct cause of death, prematurity is a significant risk factor for infant mortality from other causes.

Figure 15 shows that the rate of death per 1,000 live births by race/ethnicity for infants was the lowest for Asian/Non-Hispanic and White/Non-Hispanic infants. The other race/ethnicity groups listed all had a rate of death higher than the Kansas rate of death when all races are combined.

Figure 15

Rate of Death per 1,000 live births by Race/Ethnicity, Age <1, 2017-2021							
	Kansas Infant Mortality Rate All Races	White/ Non-Hispanic	Black/Non-Hispanic	American Indian/Non-Hispanic	Asian/ Non-Hispanic	Multiple Race/ Non-Hispanic	Hispanic-Any Race
2017-2021	6.0	4.6	11.6	*	3.8	16.0	8.1
*Denotes suppressed rates of death due to value of 9 or less							

PREVENTION POINTS

- **Prenatal Care** – Medical care during a pregnancy can identify risk factors and health problems, allowing for early treatment and improved 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 must be avoided during pregnancy. These elements are known to cause serious health problems and increase the risk for death in newborns and infants.
- **Drug Environments** – Children living in environments where they are exposed to drugs (including illicit drugs and prescription medication misuse) and alcohol abuse are at increased risk of abuse, neglect, or death. If caregiver substance use disorder is suspected or identified at birth, the safety of the infant and other children should be assessed by DCF, and the family provided drug treatment and medical and mental health services in a closely monitored, supportive, trauma-informed system to reduce potential harm.
- **Diagnose and Manage Chronic Health Conditions** – Medical care for infants and children with chronic 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.[4]
- **Home Visitation** – A study by Cincinnati Children's Hospital compared infants whose families received regular home visits with a control group that did not. The visits were provided by nurses, social workers and paraprofessionals through the "Every Child Succeeds" program. The study found that infants who did not receive home visitation services were 2.5 times more likely to die in infancy. These findings are consistent with prevention efforts that support the role of intensive home visiting in reducing the risk of infant death. [5]

SLEEP-RELATED, SUID DEATHS

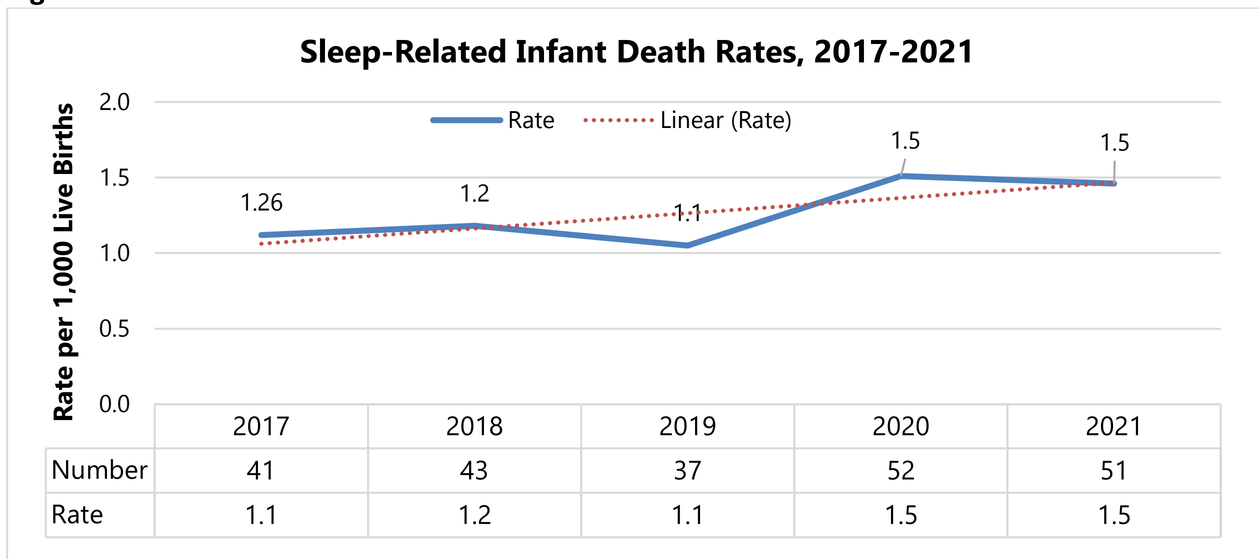
Prior to 2019, sleep-related deaths of infants (less than 1 year of age) were classified in one of three manners of death depending on the circumstances and the cause of death.

1.) Natural-Sudden Infant Death Syndrome (SIDS)
2.) Unintentional Injury-Asphyxia
3.) Undetermined

To standardize the categorization of Sudden Unexpected Infant Deaths (SUID) consistent with practices in other states, beginning with the review of the 2019 infant sleep-related fatalities, the SCDRB is using the SUID Case Registry Decision-Making Algorithm. These categories of SUID cases, as listed in Figure 17, have replaced the previous categories of Sudden Infant Death Syndrome used in the review of cases prior to 2019. More information regarding the SUID case registry and its application can be found at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4311566/.

Sleep-related infant death rates over the last five years have remained disappointingly stable. In 2021, the rate of infant deaths from sudden unexpected causes, which includes both Undetermined and Unintentional Injury-Asphyxia SUID deaths during sleep, remained at 1.5 infant deaths per 1,000 live births, which contributes to the overall increasing trend (Figure 16).

Figure 16



	2017	2018	2019	2020	2021
Number	41	43	37	52	51
Rate	1.1	1.2	1.1	1.5	1.5

In 2021, there were 51 sleep-related infant deaths. The classifications of these deaths are described in Figure 17. Both of the unexplained categories with unsafe sleep factors may also include cases in which there are other potentially fatal findings, concerning conditions, or competing causes of death; however, how these factors contributed to the death is uncertain.

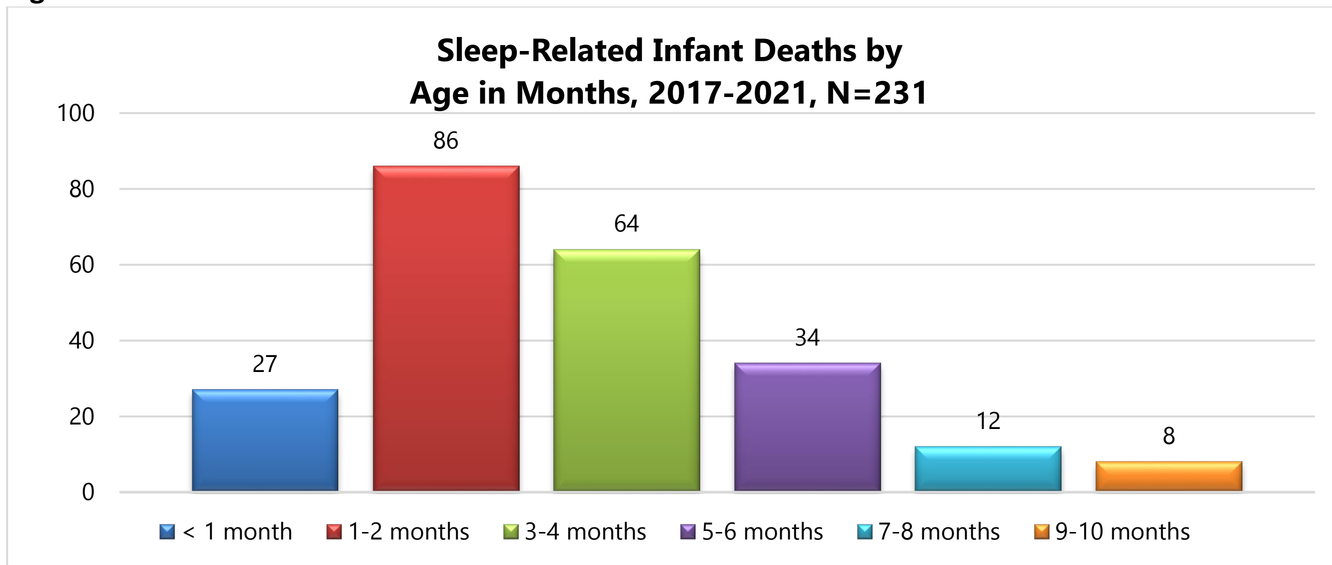
Figure 17

Sleep-Related Death Classifications for Infants 2019-2021				
Undetermined-SUID	Further Explanation	2019 Deaths	2020 Deaths	2021 Deaths
Unexplained: No autopsy or death scene investigation	Autopsy or death scene investigation not completed.	0	3	2
Unexplained: Incomplete case information	Incomplete case information pertinent to case review.	8	15	4
Unexplained: No unsafe sleep factors	Cases in which infant was placed alone on their back on a sleep surface recommended for an infant without any soft or loose objects in the sleep area.	1	1	0
Unexplained: Unsafe sleep factors	Cases in which the infant's sleep environment had one or more unsafe sleep factors (e.g., not in a crib, on a shared sleep surface, not supine) but evidence of airway obstruction was not present.	13	18	29
Unexplained: Possible Suffocation with unsafe sleep factors	Cases in which unsafe sleep factors were present and evidence of what caused at least partial obstruction of the airway is known but does not meet the criteria of the explained suffocation below.	6	5	7
Unintentional Injury-Asphyxia	Further Explanation	2019 Deaths	2020 Deaths	2021 Deaths
Explained: Suffocation with unsafe sleep factors	Cases with a non-conflicting account of placed and found position, no other potentially fatal findings or conditions from autopsy, age and developmental stage that made a suffocation event possible, evidence to visualize how the airway obstruction occurred and strong evidence of external obstruction of the airway.	9	10	9
	Total Sleep- Related Deaths	**37**	**52**	**51**

Due to the change in classifications, the Board will no longer classify deaths as Natural-SIDS. Historical information about SIDS related deaths may be accessed in previous annual reports at: https://ag.ks.gov/media-center/annual-reports/child-death-review-board-annual-reports.

Although by definition, sleep-related SUID deaths can occur at any time during an infant's first year, most SUID deaths occur in infants between 1 and 4 months of age as shown in Figure 18.

Figure 18



While most sleep-related SUID deaths occur in the child's home, nearly 20% of the sleep-related fatalities occurred in a location outside the child's home (Figure 19). Safe sleep practices should be consistent at each sleep (naptime and nighttime) both in the home and when away from the home.

Figure 19

Incident Sleep Location* Infant Deaths, 2017-2021, N=231		
Location	Number	Percent
Child's Home	190	81.9%
Relative's Home	22	9.9%
Unlicensed Child Care	10	3.9%
Friend's Home	4	1.7%
Other§	3	0.4%
Licensed Child Care	2	0.9%
Foster Care	2	0.4%
*Multiple responses are appropriate for some circumstances regarding incident location; therefore, the sum could be greater than the total number of infants who died of sleep-related causes.		
§Other includes hotel rooms, shelters, etc.		

In the 231 sleep-related deaths the Board reviewed from 2017 through 2021, only 21% of the infants were in a crib or bassinet (Figure 20). Also of concern was the 58% of infants who shared a sleep surface with one or more person(s) at the time of the incident (Figure 21).

Figure 20

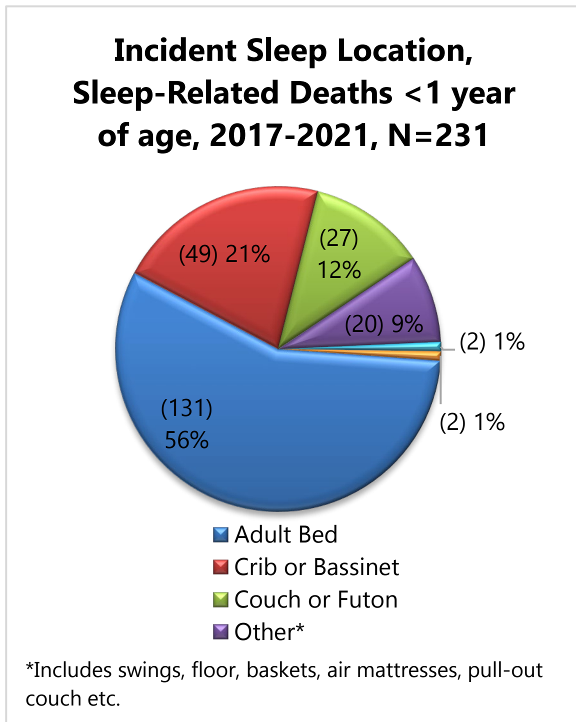
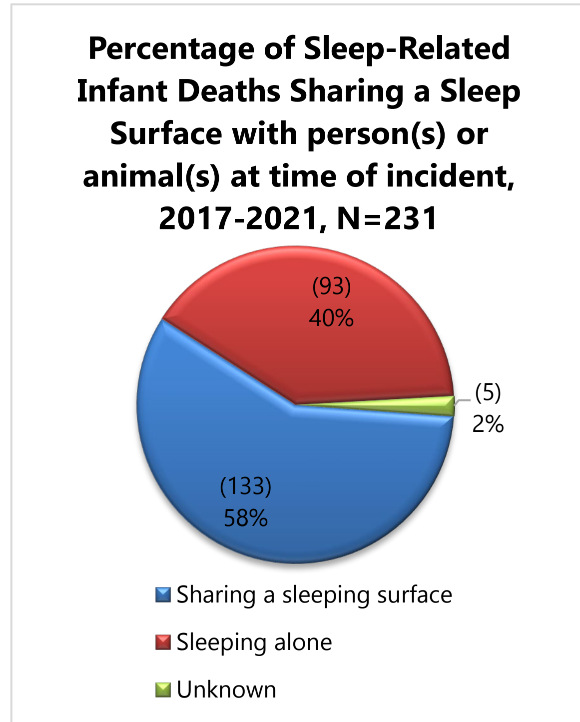


Figure 21



As recommended by The American Academy of Pediatrics (AAP), infants should be placed on a firm, flat, non-inclined sleep surface (e.g., a safety-approved crib and mattress) covered by a fitted sheet with no other bedding or soft objects in the crib. It is also recommended that infants sleep in close proximity to their parents (room sharing) but on a separate surface designed for infants without bed-sharing. [6]

In all of the sleep-related deaths reviewed by the Board in 2021, there was evidence of one or more unsafe sleep practices. The images below depict a safe sleep environment in which the infant is placed Alone, on their Back, and in a Crib. Parents and caregivers should ensure the ABCs of safe sleep, for every sleep. [6]

Photo Credit-KIDS Network *http://www.kidsks.org/*

From 2017 through 2021 there have been 34 deaths in which the caregiver reportedly fell asleep while breast (21) or bottle (13) feeding the infant (Figure 22). As noted in the prevention points on page 24, mothers should be encouraged and supported to breastfeed safely. Education about how to safely breastfeed in bed and counseling about risk factors and prevention is critical. Parents should be reminded that if infants are brought to an adult bed for a feeding (breast or bottle), they should be returned to a separate safe crib or bassinet when the parent is ready to return to sleep.[6]

Figure 22

Caregiver or Supervisor Fell Asleep While Feeding Infant, 2017-2021, N=231		
Caregiver or Supervisor Fell Asleep While Feeding Infant		**Number**
Yes		34
If Yes, Feeding Type	Breast	21
	Bottle	13
No		186
Unknown		11

Figure 23

Sleep- Related Rate of Death per 1,000 live births by Race/Ethnicity, Age <1, 2017-2021							
	Kansas Rate All Races	**White/ Non-Hispanic**	**Black/Non-Hispanic**	**American Indian/Non-Hispanic**	**Asian/ Non-Hispanic**	**Multiple Race/ Non-Hispanic**	**Hispanic-Any Race**
2017-2021	1.3	0.9	2.8	*	*	5.0	1.5
*Denotes suppressed rates of death due to value of 9 or less							

Figure 23 shows the rate of infant sleep-related deaths in Kansas by race. Black/Non-Hispanic infants are nearly three times more likely and Multiple Race/Non-Hispanic infants are nearly five times as likely to die from a sleep-related death as White/Non-Hispanic infants.

The Board stresses the importance of thorough investigations by law enforcement and medical personnel, along with properly conducted, complete autopsies. In 2021 there were two deaths in which a death investigation was not conducted and an additional four that lacked pertinent information necessary to determine factors for unsafe sleep or suffocation.

Board recommendations include using photographed scene recreations and re-enactments with dolls, additional witness interviews, improving the quality of scene photographs, and documenting room temperature, the availability of a crib, and the size of the bed. Use of the Center for Disease Control's Sudden Unexpected Infant Death Investigation Form is the expected standard in all investigations and would aid in obtaining critical information at the scene and from interviews: https://www.cdc.gov/sids/pdf/SUIDI_Fill_Under_508.pdf. A Sudden Unexpected Infant Death Investigation (SUIDI) form was not completed in 33 of the 51 sleep-related deaths in 2021.

CHARACTERISTICS OF 2021 SLEEP-RELATED, INFANT DEATHS

- 88% had evidence of one or more unsafe sleep practices
- 81% occurred when the infant was sleeping in a place other than a safe crib or bassinet
- 49% (18) had current or past DCF child protective services (CPS) involvement with the family
- In 39% of these families (7 cases), either the decedent or sibling(s) were placed into state custody at some time prior to the death
- 56% were bed or couch-sharing
- 40% were put to sleep on their back and 29% were put to sleep on their stomach
- 58% were put to sleep on an adult bed, and 12% were put to sleep on a couch
- 27% had caregiver alcohol or substance use disorder concerns prior to or at the time of death
- 33% of the investigations lacked information that would normally be expected in a child death investigation

PREVENTION POINTS

- Infants should be placed to sleep in a supine position. 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.[6]
- A separate, but proximate sleeping environment is recommended. Bed-sharing with adults or siblings should be avoided.
- A firm, flat, non-inclined sleep surface should be used. Soft materials such as pillows, quilts, comforters, or sheepskins should not be placed in the crib with the infant.[6]
- Sleep clothing, such as wearable blankets designed to keep the infant warm, should be used instead of blankets and quilts that could overheat the infant, cover the baby's head, or cause entrapment. Avoid overheating the infant's room.[6]
- Smoking during pregnancy and in the infant's environment are risk factors and should be avoided.
- Mothers should be encouraged and supported to breastfeed, not only for the known nutritional value but as a protective factor against sudden unexpected infant deaths. Infants brought to the adult bed for nursing should be returned to a separate safe surface (i.e., crib or bassinet) when the parent is ready to return to sleep.[6]
- Many devices promoted to reduce "SIDS" have not been proven to reduce the incidence of sudden unexpected infant deaths. Obtain an evaluation/recommendation from a medical professional before the use of products such as sleep positioners or wedges.
- For more information on safe sleep, visit these websites: SCDRB at http://ag.ks.gov/scdrb, the AAP at http://www.aap.org/, or Kansas Infant Death and SIDS Network at http://www.kidsks.org/.

CASE VIGNETTE

Sleep-Related Infant Death

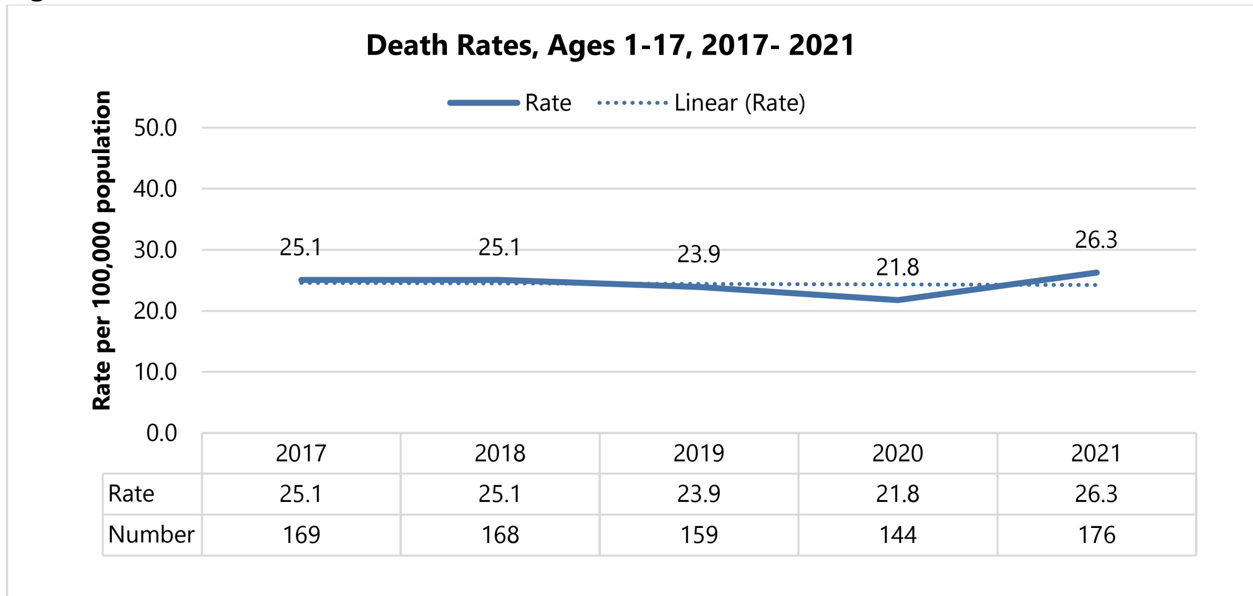
Safe Sleep Surfaces- A young mother fell asleep while breastfeeding her infant in an adult size bed. When the mother awoke the next morning, she found the infant unresponsive. This death was classified as a suffocation due to unsafe sleep factors. The infant's bassinette was found in the same room as the adult bed but was not used on the night of the incident.

Board Reflection – Parents should be reminded that if infants are brought to an adult bed for a feeding (breast or bottle), the infant should be returned to a separate safe crib or bassinet when the parent is ready to return to sleep.

MORTALITY AFFECTING CHILDREN AGES 1-17

The mortality rate for children ages 1-17 had been on a downward trend until 2021 when a spike in deaths occurred for this population (Figure 24). There were 176 deaths for this age group in 2021.

Figure 24



	2017	2018	2019	2020	2021
Rate	25.1	25.1	23.9	21.8	26.3
Number	169	168	159	144	176

Figure 25 shows the percentage of child deaths age 1-17 based on the manner of death. All non-natural manners of death accounted for 75% percent of the total deaths in this age group. These non-natural deaths are described in Figure 26. Natural deaths in this age group are discussed on page 27.

Figure 25

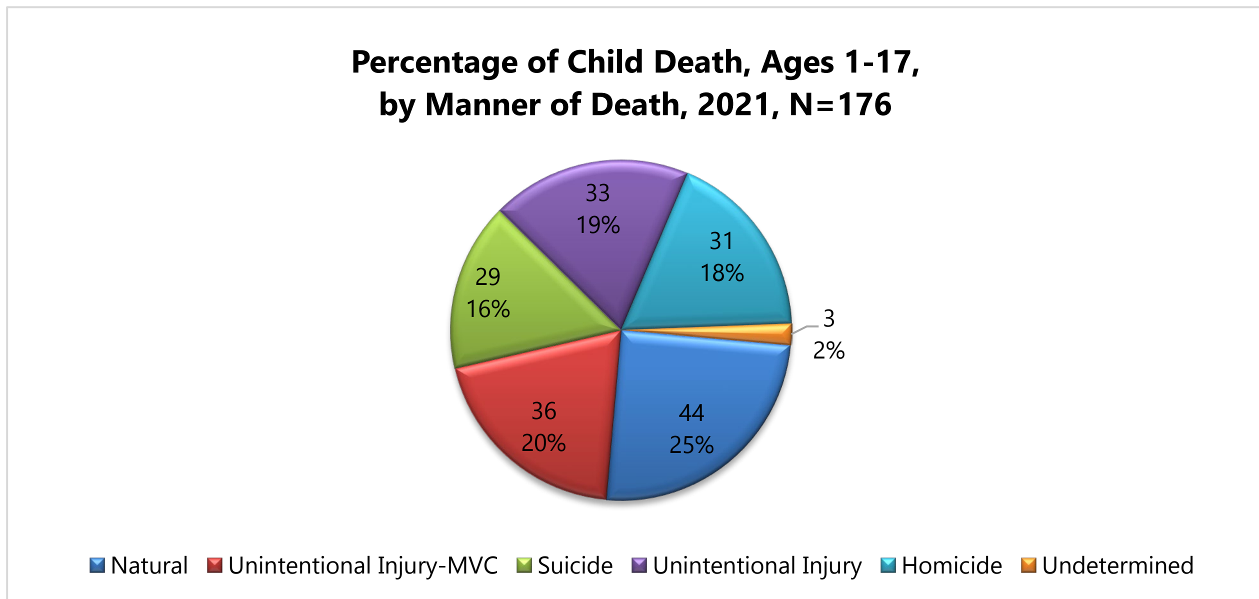


Figure 26

Non-Natural Deaths Age 1-17, 2021, N=132	
	Total
Unintentional Injury	**69**
Asphyxia	2
Drowning	14
Fall/Crush	2
Fire, Burn, Electrocution	1
Motor Vehicle Crash	36
Other Injury	3
Poisoning, Overdose, or Acute Intoxication	9
Weapon	2
Homicide- All Causes	**31**
Suicide- All Causes	**29**
Undetermined- All Causes	**3**
Total	**132**

Figure 27

Rate of Death by Race/Ethnicity, Age 1-17, 2017-2021							
	Kansas Rate All Races	**White/ Non-Hispanic**	**Black/Non-Hispanic**	**American Indian/Non-Hispanic**	**Asian/ Non-Hispanic**	**Multiple Race/ Non-Hispanic**	**Hispanic-Any Race**
2017-2021	24.5	21.5	51.5	*	19.4**	19.2	28.7

*Denotes suppressed rates of death due to value of 9 or less
**denotes rates of death with value of 10-19 which should be used with caution

Figure 27 shows the rate of death per 100,000 population for children ages 1-17 in Kansas by race. Black/Non-Hispanic children in this age group are more than twice as likely to die as White/Non-Hispanic children.

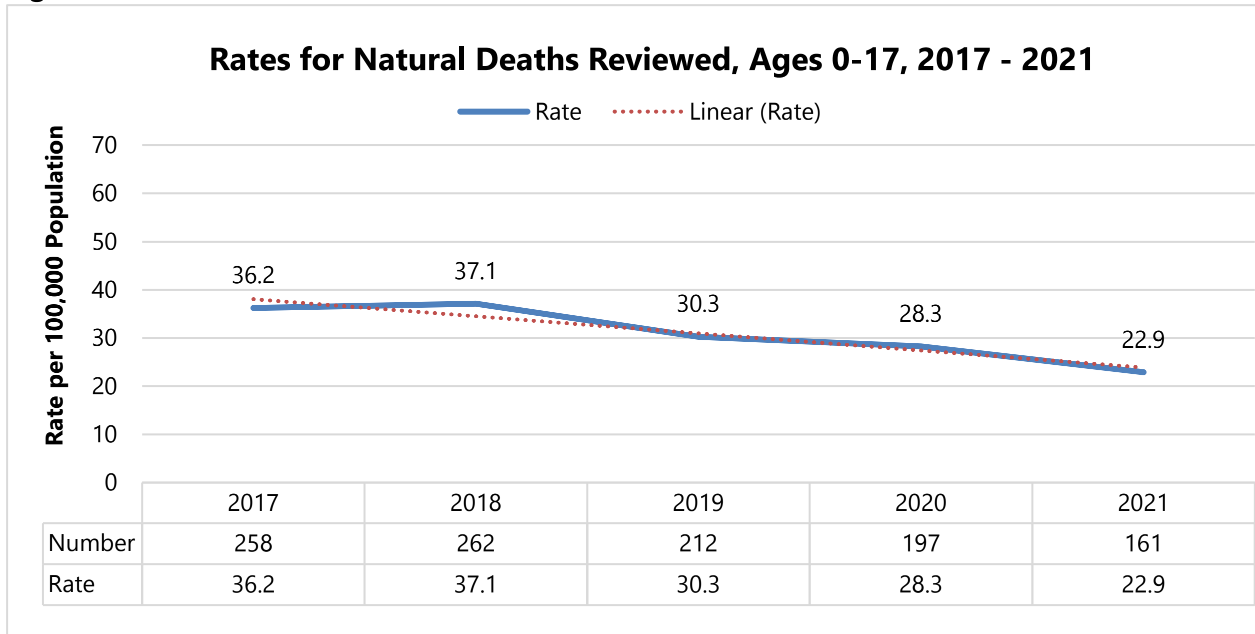
CHARACTERISTICS OF DEATHS AGE 1-17, 2021

- Rate of death for this age group increased by 4.5 deaths per 100,000 population between 2020 and 2021
- 75% of the deaths in this age group were from non-natural causes
- 63% were male
- 50% (88) had current or past DCF child protective services (CPS) involvement with the family

NATURAL DEATHS

Natural deaths are those brought about by natural causes such as prematurity, congenital conditions, cancer, and other diseases. Figure 28 indicates that in 2021 there were 161 natural deaths. The rate of death due to natural causes in children has declined over the last five years to 22.9 deaths per 100,000 population. Figure 29 shows the Kansas child death rates for natural manners of death by race.

Figure 28



	2017	2018	2019	2020	2021
Number	258	262	212	197	161
Rate	36.2	37.1	30.3	28.3	22.9

Figure 29

Rate of Death, Natural Manner by Population Group, Age 0-17, 2017-2021							
	Kansas Rate All Races	White/ Non-Hispanic	Black/Non-Hispanic	American Indian/Non-Hispanic	Asian/ Non-Hispanic	Multiple Race/ Non-Hispanic	Hispanic-Any Race
2017-2021	30.1	24.9	63.1	*	29.4	36.0	38.1
*Denotes suppressed rates of death due to value of 9 or less							

Figure 30 describes the number of natural deaths by age group and sex. Children who were less than one year of age accounted for 76% of natural deaths between 2017 and 2021. In 2021, for children ages 0-17, prematurity and congenital anomalies led to 72% of the natural deaths. Cancer claimed the lives of 11 children as the third-leading natural cause (Figure 31).

Figure 30

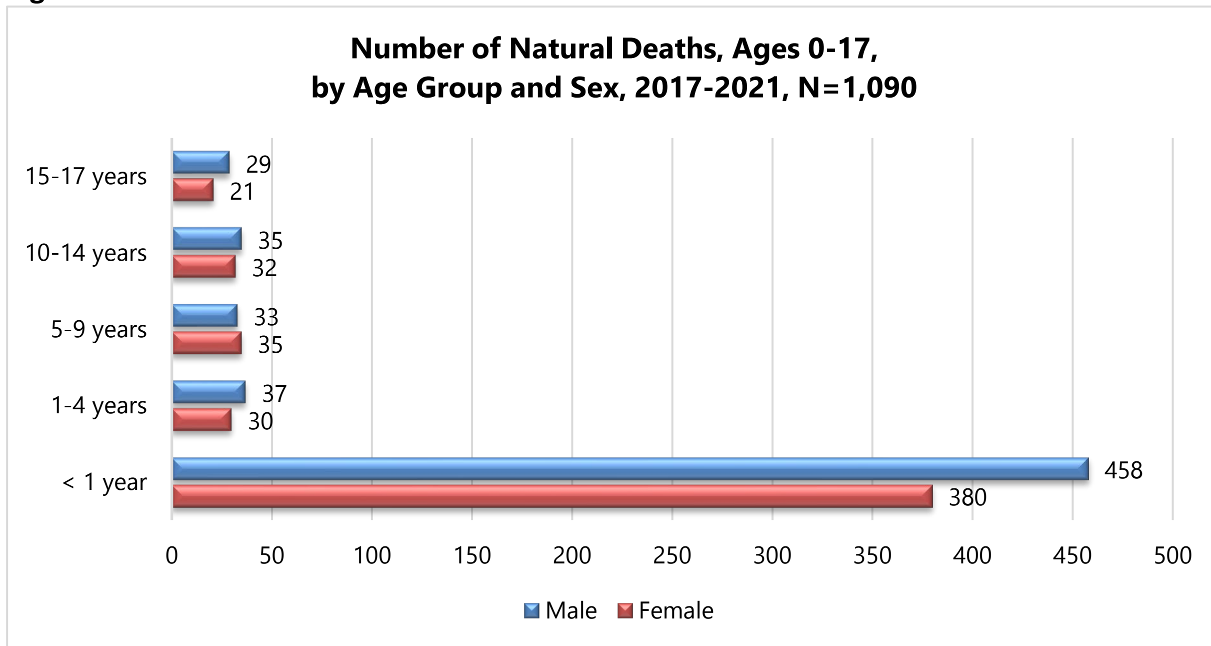
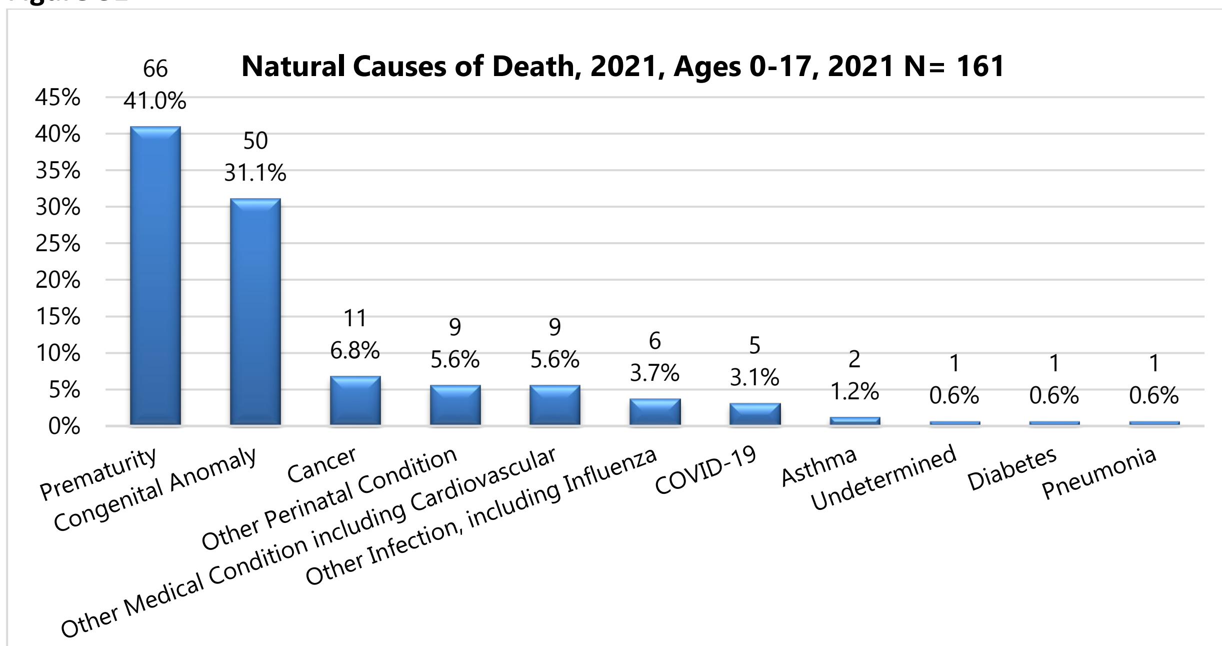


Figure 31



CHARACTERISTICS OF NATURAL DEATHS AGE 0-17

- Deaths due to natural causes are decreasing
- Infants represent 76% of all natural deaths (2017-2021)
- 54% were male (2017-2021)
- 24% (39) had DCF child protective services (CPS) involvement with the family (2021)
- The rate of death for Black/Non-Hispanic children was 63.1 per 100,000, compared to 24.9 for White/Non-Hispanic (2017-2021)

In the last five years (2017-2021) there have been 11 child deaths due to asthma, two of which occurred in 2021. These deaths occurred in children from ages 1-17 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. As shown in Figure 32, asthma hospitalizations have shown an overall decline; however, the number increased in 2021 which warrants continued caution and demonstrates the need for continued education.

Figure 32

Numbers and Rates of Pediatric Asthma Hospitalizations*
Kansas, 2017-2021

Year	Number	Rate
2017§	376	59.2
2018	425	67.4
2019	341	54.5
2020	214	32.0
2021	331	49.4

* Admissions with a principal diagnosis of asthma per 100,000 population, ages 2 through 17 years. Excludes cases with a diagnosis code for cystic fibrosis and anomalies of the respiratory system, obstetric admissions, and transfers from other institutions
§ This value was revised due to an updated methodology and better reflects the true rate of pediatric asthma hospitalizations.
Residence Data
Source data: Kansas Hospital Association
Calculated using Agency for Healthcare Research and Quality Pediatric Quality Indicator software. Prepared by: Kansas Department of Health and Environment
Bureau of Epidemiology and Public Health Informatics
Created: August 11, 2023
Contact: KDHE.HealthStatistics@ks.gov

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 controlled through quality medical care with a management plan that includes rescue inhalers, preventive medications and asthma education. This also includes the ability to recognize and avoid each child's specific triggers such as allergens, exercise, cigarette smoke, air pollution and infections. It is estimated that one in 12 children have asthma, which makes it a common problem.[7] Because it is common, parents and care providers often fail to understand that asthma is not a one-size-fits-all disease and may not appreciate how life threatening it can become 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, child care facilities and schools to improve the lives of children with asthma and prevent asthma related deaths. Child care 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.[8]
- **Education** – Teaching and reinforcement of disease monitoring, 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.[8]
- **Control of Environmental Factors and Comorbid Conditions** – Avoidance of cigarette smoke and other allergen exposures, consideration of immunotherapy if indicated, management of co-morbid factors, and annual use of influenza vaccine are important in asthma control.[8]
- **Medications** – Medications and devices must meet a child's needs. An evidence-based approach to therapy adjustments is outlined in Guidelines for the Diagnosis and Management of Asthma as well as the 2020 Focused Updates to the Asthma Management guidelines both published by the National Heart, Lung and Blood Institute of the NIH.

CASE VIGNETTE

Youth Death Related to Complications of Asthma

Access to treatment and medication must be readily available – A Kansas youth, previously diagnosed with moderate persistent asthma and environmental allergies, had a history of noncompliance with medical appointments and medication use. The child had not had an influenza vaccine for 7 years. A DCF report for medical neglect made two years prior to the death resulted in the mother being uncooperative with the investigation and declining services. The child had recently been discharged from a hospitalization and developed trouble breathing at home. Mother started a breathing treatment but did not seek emergency services until the child became unresponsive. Despite a rapid emergency response and resuscitation, the child died from complications of asthma.

Asthma deaths are rare but preventable with appropriate monitoring and intervention – This child was previously hospitalized multiple times for asthma exacerbations and the family had received extensive education from the medical providers. DCF intakes were initiated due to concerns about the poor compliance with medical care, inability to get medications filled, exposure to cigarette smoke, and poor living conditions. Although the mother responded to the immediate DCF concerns, she declined on-going services and failed to maintain a safe environment. Close communication between child welfare workers and medical providers about the status of a case and the child's disease process is critical to assure continued health and safety.

Board Reflection – Asthma is a common chronic disorder. Because symptoms vary and are dependent on genetic and environmental factors, families may not understand asthma can unexpectedly become life threatening. Education should focus on the need for rescue medications to be readily available, keeping prescriptions filled, and avoiding known triggers, even if the child is doing well. Asthma action plans provide critical directions to caregivers about assessment and treatment of asthma based on severity of symptoms. This child was allowed to be chronically exposed to allergens that could easily have been removed from the home. When a home is known to be hazardous, unannounced visits from child welfare are critical for accurate assessments and maintaining safety. Additionally, with family education and support from child welfare and health care case managers, there should be no reason for a child to be without medication.

COVID-19

COVID-19 is caused by SARS-CoV-2, a coronavirus that emerged in December 2019. The first Kansas death was an adult, reported in January 2020. While children may be as likely to get COVID-19 as adults, they are less likely to become severely ill. Up to 50% of children and adolescents might have COVID-19 with no symptoms. However, some children with COVID-19 need to be hospitalized, treated in the intensive care unit, and/or placed on a ventilator to help them breathe. Of greater concern is multisystem inflammatory syndrome in children (MIS-C), a serious condition in which some parts of the body — such as the heart, lungs, blood vessels, kidneys, digestive system, brain, skin or eyes — develop severe inflammatory damage.[9]

In 2021, there were five children who died from COVID- 19. This is an increase from the two deaths experienced in 2020. There were an additional two deaths in which the decedents tested positive for COVID-19 at autopsy, but the death was not classified as being caused by COVID-19. One of those deaths was an asymptomatic infant who died in an unsafe sleep environment; the other was a teen who died of an accidental overdose.

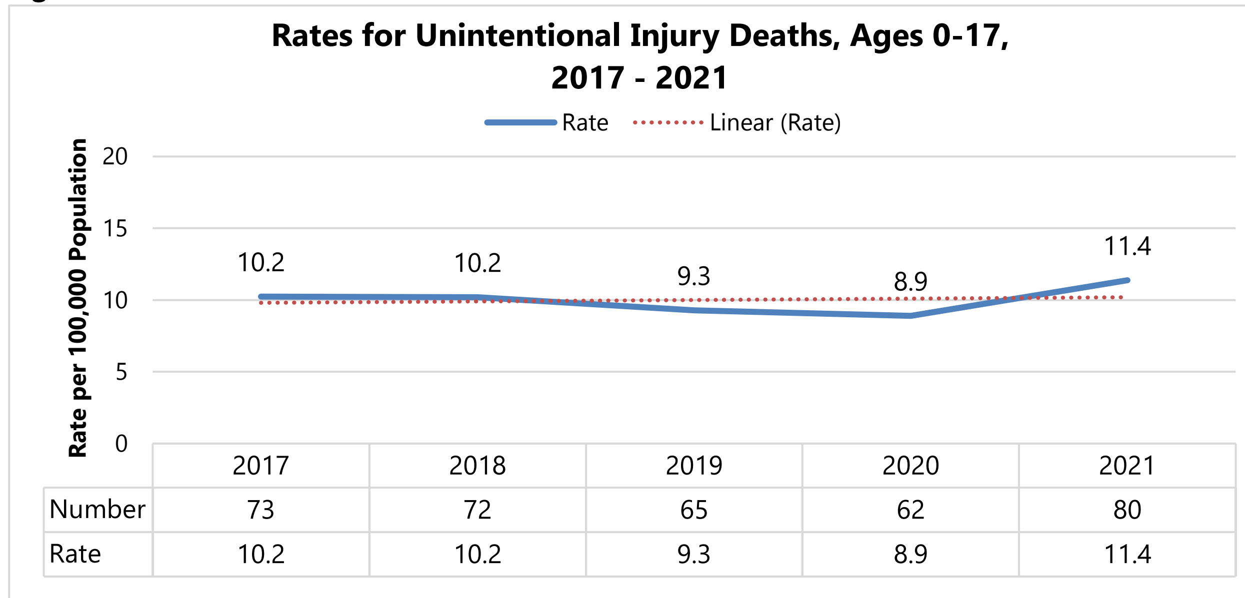
In addition to the natural deaths that were directly caused by COVID-19, there were 14 cases in which issues related to the COVID-19 pandemic may have contributed to the death. These indirect deaths include, but are not limited to, the following factors found through the board case reviews of the deaths: parent, caregiver, or decedent reluctance or fear of seeking medical attention, lack of availability of medical care in their area, mental health effects of isolation during school and activity closures, and financial challenges. The Board recognizes there may be additional contributing factors in COVID-19-related deaths that were not captured on review.

Information regarding natural causes of death due to COVID-19 should be reported on death certificates, preferably confirmed by a positive test result. Guidance for physicians for reporting these cases is found at Guidance for Certifying Deaths Due to Coronavirus Disease 2019 (COVID–19) https://www.cdc.gov/nchs/data/nvss/vsrg/vsrg03-508.pdf .

UNINTENTIONAL INJURY DEATHS

Unintentional Injury deaths are those caused by incidents such as motor vehicle crashes, drowning or fire, which were not the result of an intentional act. In 2021, the rate of death increased to 11.4 deaths per 100,000 population (Figure 33).

Figure 33



	2017	2018	2019	2020	2021
Number	73	72	65	62	80
Rate	10.2	10.2	9.3	8.9	11.4

Figure 34 shows the number of unintentional injuries by age classification between 2017 and 2021. Motor vehicle crashes (MVC) and other transportation-related deaths claimed the lives of 182 children and teens and were the primary cause of Unintentional Injury deaths in children over the age of one. The second and third highest numbers of Unintentional Injury deaths in the 1-17 age group were drownings and the category of poisoning/overdose/acute intoxication, respectively. Asphyxia causes of death accounted for the second highest number of Unintentional Injury deaths overall, but are seen in younger children, especially those less than 1 year of age, many of which are sleep-related, and are discussed in the Unintentional Injury-Asphyxia Deaths, section of the report.

Figure 34

Unintentional Injury by Cause and Age Classification, Age 0-17, 2017-2021, N=352

	Age <1	Age 1-4	Age 5-9	Age 10-14	Age 15-17	Total
MVC and Other Transportation	7	30	29	43	73	182
Asphyxia	53	8	2	0	0	63
Drowning	1	17	7	8	12	45
Poisoning, Overdose or Acute Intoxication	1	3	1	0	18	23
Fire, Burn, Electrocution	2	6	4	0	1	13
Weapon, Including Body Part	0	2	1	4	4	11
Fall or Crush	0	0	5	0	3	8
Other Causes	2	4	0	0	1	7
Total	66	70	49	55	112	352

Also shown in Figure 34 are the unintentional injury deaths due to weapon use which accounted for 11 deaths for ages 0-17 between 2017 and 2021. Weapon, as defined for board review, includes guns, knives, or other objects, including body parts. Guns should be stored unloaded in a locked location out of a child's reach and sight. Leaving guns where they are accessible to children, such as in or on dressers or nightstands, can lead to injury or death.

It should not go unnoticed that the second leading cause of unintentional injury death for teens aged 15-17 was poisoning, overdose, or acute intoxication. The environment in which our youth are raised may influence whether they will try drugs or other substances. At home, school and in the community, caregivers and school educators should address the dangers of drugs and alcohol and the risk of lethality from misuse or abuse. The Centers for Disease Control and Prevention (CDC) measures the prevalence of risk behaviors for students in grades 9-12 through the national Youth Risk Behavior Surveillance System (YRBSS). YRBSS monitors six categories of priority health-risk behaviors among youth and young adults. One of those categories is Alcohol and Other Drug Use. In 2021, 10.6% of the youth in Kansas reported having taken prescription pain medicine without a doctor's prescription or differently than how a doctor prescribed it to be used.[10] More information and data about this topic can be found at: https://www.cdc.gov/healthyyouth/data/yrbs/index.htm. Further information regarding drug-related deaths can be found in the Drug-Related Death section of this report.

There were 8 children who died from Unintentional Fall or Crush injuries. Half of these injuries were due to falls from heights typically associated with an expected poor outcome. The remainder were deaths due to crush injuries sustained from an object falling on or entrapping the child. In 3 of the 4 deaths from crush injuries, the use or misuse of farm equipment led to the fatal injury.

Seven children died from Unintentional Injuries-Other Causes, which includes deaths from exposure or hyperthermia, 3 of which were left in hot cars, and 4 other injury deaths that do not meet the criteria explained in other cause of death injuries referenced in Figure 34.

Figure 35

Rate of Death, Manner-Accident/Unintentional Injury by Race/Ethnicity, Age 0-17, 2017-2021

	Kansas Rate All Races	White/ Non-Hispanic	Black/Non-Hispanic	American Indian/Non-Hispanic	Asian/ Non-Hispanic	Multiple Race/ Non-Hispanic	Hispanic-Any Race
2017-2021	9.7	8.4	18.6	*	*	10.0**	13

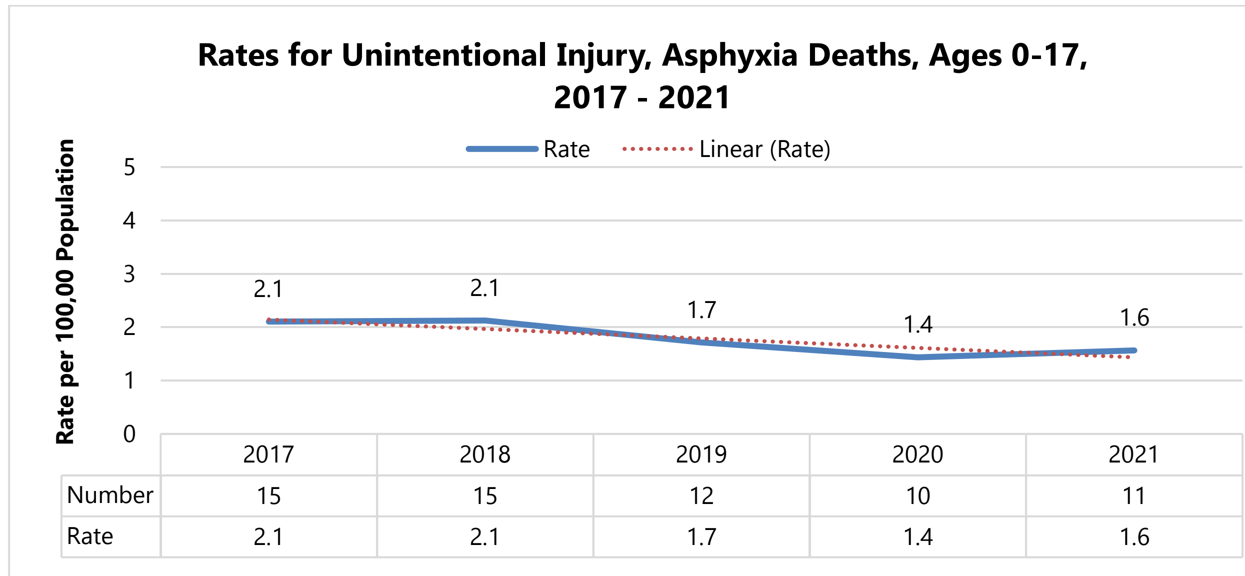
*Denotes suppressed rates of death due to value of 9 or less
**denotes rates of death with value of 10-19 which should be used with caution

Figure 35 shows the death rates for Unintentional Injury/Accidental manners of death in Kansas by race. Black/Non-Hispanic children in this age group are more than twice as likely to die from unintentional injuries as White/Non-Hispanic children.

UNINTENTIONAL INJURY- ASPHYXIA DEATHS

As shown in the previous section, asphyxia was the leading cause of unintentional injury deaths in infants between 2017 and 2021. In 2021, eleven children between the ages of 0-17 died due to unintentional asphyxia such as suffocation, strangulation or choking. Figure 36 indicates a downward trend between 2017 and 2021 with a rate of 1.6 deaths per 100,000 population in 2021.

Figure 36



	2017	2018	2019	2020	2021
Number	15	15	12	10	11
Rate	2.1	2.1	1.7	1.4	1.6

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.

Of the 11 child deaths due to unintentional asphyxia in 2021, nine were under the age of one and the result of unsafe sleeping conditions. 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 or bassinet, sleeping in a cluttered area, being placed on a soft surface such as an air mattress, pillow or quilt, and bed-sharing** with parents or siblings.

In May of 2022, the Safe Sleep for Babies Act of 2021 was signed into law.[11] This bill makes it unlawful to manufacture, sell, or distribute crib bumpers or inclined sleepers, both of which are unsafe for infant sleep and have been linked to deaths. Additionally, some cribs, bassinets, playpens, and child beds have been recalled because of known or suspected risk of asphyxia. Before caregivers purchase furniture or other infant equipment for their children, 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.

** Bed Sharing- A type of sleeping practice in which the sleeping surface (e.g., bed, couch or armchair, or some other sleeping surface) is shared between the infant and another person.

CHARACTERISTICS OF UNINTENTIONAL ASPHYXIA DEATHS, 2021, N=11

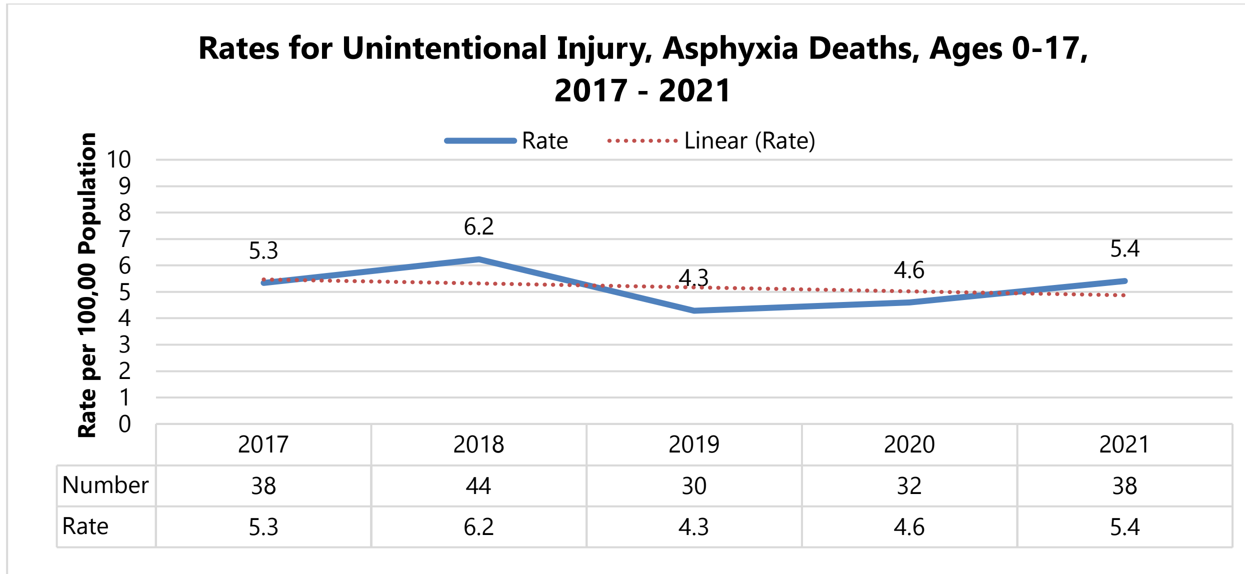
- 81% (9) of the deaths were sleep-related suffocation deaths and occurred in children under the age of one year. All had elements of unsafe sleep
- The remaining two deaths were in children age 1-4 and were not sleep-related
- 63% had a history of DCF involvement with the family
- 45% involved a prior removal of decedent or sibling into state custody prior to the incident
- 45% involved a concern of parental substance use

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 a child's size, curiosity and motor ability. Living, sleeping, and playing areas should be routinely inspected for dangers such as chests, coolers, cords, hanging materials, or plastic bags, which 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 handrails for spaces that may be large enough to allow a child's body to slip through, trapping the head or neck, and supervise children playing with rope swings and swing sets.
- **Infant Sleeping Arrangements** – The safest sleeping arrangement for an infant is alone in an approved crib, on their 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 in the crib 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.[6]
- **Choking Hazards** – Children under age four are most at risk for choking on food and small objects. In addition to small toys, balloons and coins, some foods can be a choking hazard for young children. Hot dogs, whole grapes, raw carrots, popcorn and other foods can become lodged in a child's airway. Young children need supervision while eating and when playing with or near potential choking hazards.[12]

In 2021, 38 children died in Kansas due to unintentional injuries sustained in Motor Vehicle Crashes (MVC). Figure 37 shows the MVC death rate between 2017 and 2021. In 2019 Kansas recorded the lowest rate (4.3 deaths per 100,000 population) since the inception of the Board. Since then, the rate of MVC deaths has increased to 5.4 deaths per 100,000 population in 2021.

Figure 37



	2017	2018	2019	2020	2021
Number	38	44	30	32	38
Rate	5.3	6.2	4.3	4.6	5.4

In general, the likelihood of a child dying from a motor vehicle crash increases after the age of 10 years when children take on more responsibility for using restraints and have less time under adult supervision. Overall, teens in the 15-17 age group have the highest rate of MVC deaths (Figure 38).

Of the 38 Motor Vehicle Deaths in 2021, 30 of the children were either the driver or a passenger of the vehicle. An additional six children were pedestrians, one child was on a bicycle, and one was in-utero at the time of the crash and succumbed to the injuries after birth.

Figure 38

MVC Death Rates per 100,000 Population by Age Group, Ages 0-17, 2017-2021

	< 1 Year	Age 1-4	Age 5-9	Age 10-14	Age 15-17
2017	0	3.87	3.00	4.99	13.41
2018	2.74	5.23	1.01	3.99	21.09
2019	8.48	2.67	3.56	4.00	6.74
2020	2.83	4.74	2.57	5.50	6.70
2021	5.98	3.46	4.62	2.90	12.94
Average	**4.01**	**3.99**	**2.96**	**4.28**	**12.18**

It is important to note there are multiple factors that can lead to a MVC death. Combined data for 2017-2021 includes 182 MVC fatalities. Related to those fatalities, there were 405 combined factors reported as having contributed to those deaths. A list of those factors are found in Figure 39.

Speeding, whether over the limit or unsafe for the conditions, was a contributing factor in 49% (90) of the MVC deaths in 2017-2021. Driver inexperience accounted for another 23% (42) of the MVC deaths. During this five-year period, 19% (36) of the MVC deaths had a contributing factor of alcohol or drug use. In 10 of these crashes, it was the underage decedent operating the vehicle while under the influence.

Figure 39

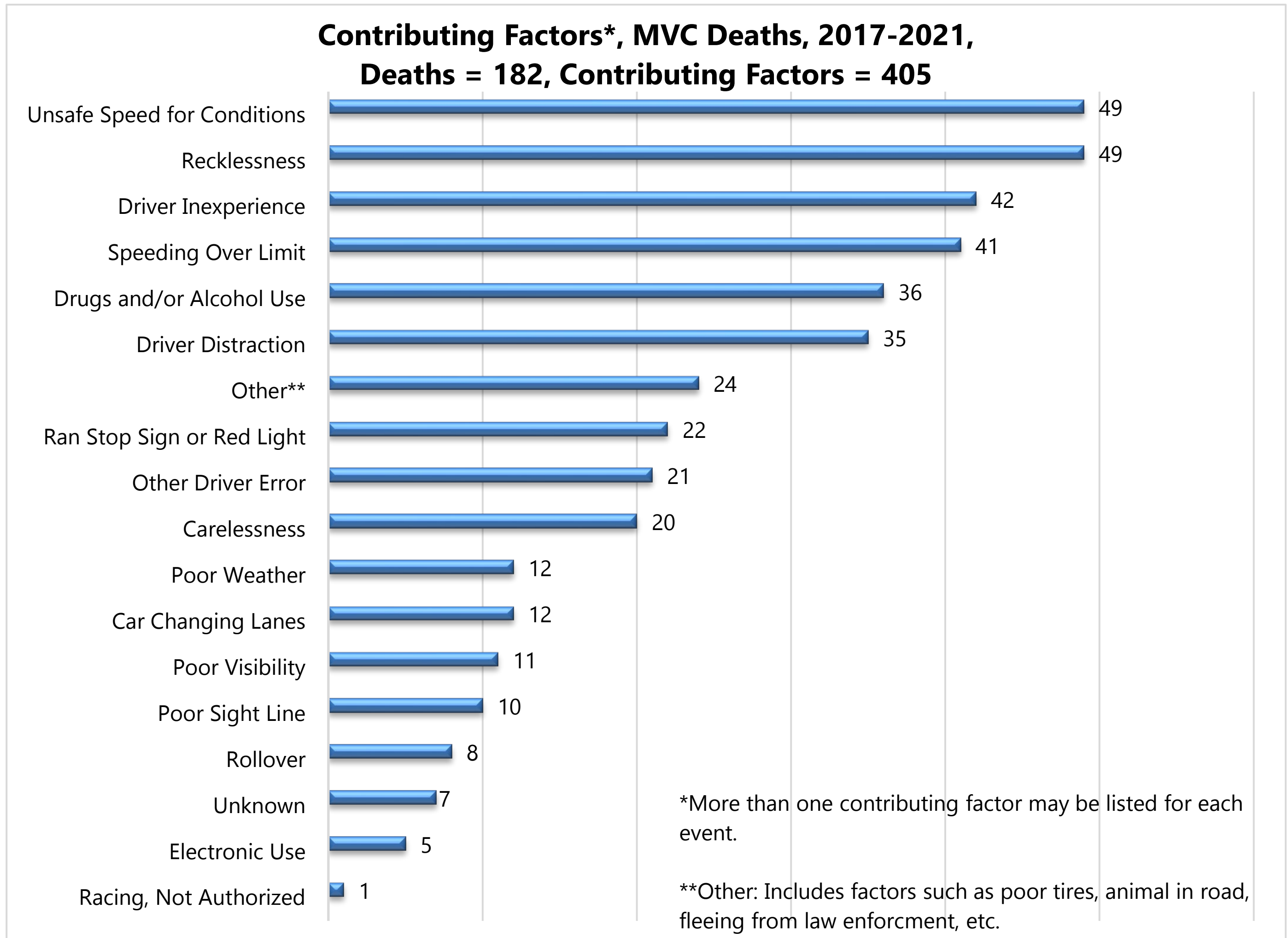


Figure 40

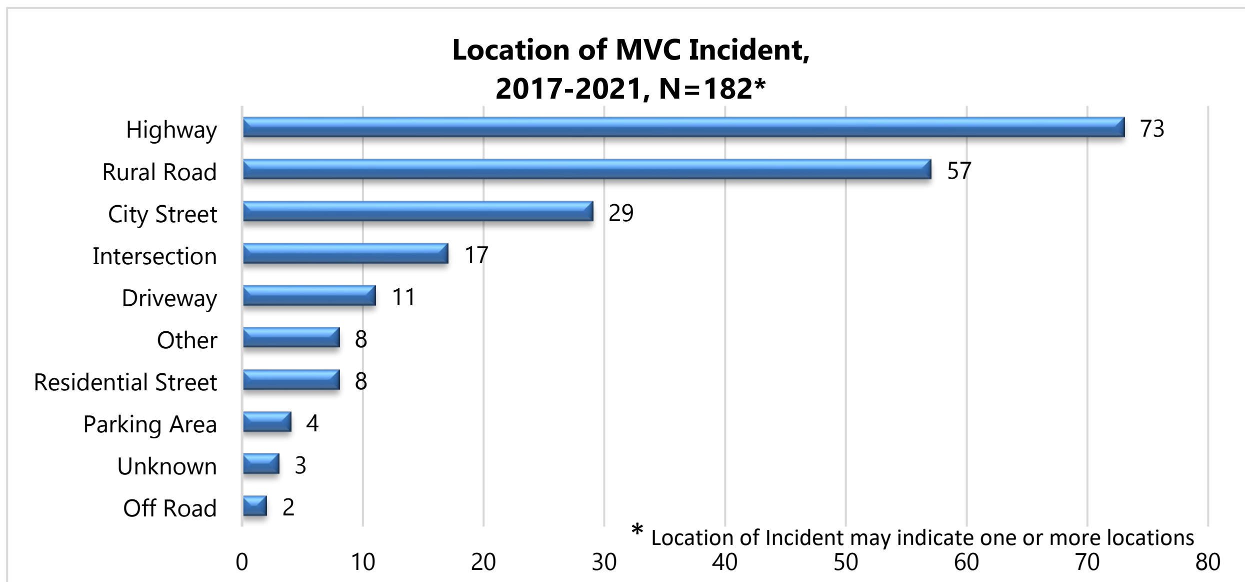


Figure 40 shows that 40% (73) of motor vehicle crash deaths of children in Kansas occurred on a highway and 31% (57) on rural roads.

Figure 41

Restraint or Safety Measure Use by Decedent, 2017-2021, N= 182						
	Pedestrian Death	Driver	Passenger Front Seat	Passenger Back Seat	Passenger Other*	Total
Restrained, Correctly	-	19	18	34	2	73
Unrestrained	-	20	17	29	4	70
Unknown if Restrained	-	1	0	2	1	4
Other**	32	2	0	0	1	35
Total	32	42	35	65	8	182

*Passenger Other is used to categorize passengers on motorcycles, planes, farm equipment, or when the decedent was in-utero at the time of the crash.
**Other is used to categorize situations in which the decedent was in a transport vehicle without a typical restraint system; for example, motorcycle, airplane, tractor, etc.

Figure 41 displays whether a restraint or safety measure was used based on the location of the victim in the vehicle. Between the years of 2017 and 2021 there were 182 deaths of children due to MVCs. Of those deaths, 23% (42) of the decedents were the driver of a motor vehicle at the time of their death with only 45% (19) being properly restrained at the time of the crash. In total, when looking at safety restraint use, 46% of the decedents were unrestrained for all locations in the vehicle (pedestrian deaths excluded).

Also reflected in Figure 41, there were 32 pedestrian deaths of children between 2017 and 2021. Of those 32 deaths, seven were either riding a bicycle, skateboarding or roller-blading at the time of the incident. Of the 32 pedestrian deaths, 46% (15) occurred when the driver of the vehicle was backing up and unintentionally drove over or struck the pedestrian. Deaths such as these are called backover deaths. According to KidsAndCars.org, at least 50 children are backed over every week in the United States because a driver did not see the child.[13] Public campaigns to encourage drivers to "look before you leave" should be promoted and drivers should be encouraged to walk completely around their vehicle and ensure children are secured prior to backing up their vehicle.

Kansas experienced 11 child deaths from All Terrain Vehicle (ATV) crashes in the five-year period from 2017 and 2021. According to the 2022 Annual Report of Deaths and Injuries Involving Off-Highway Vehicles published by the U.S. Consumer Product Safety Commission, in 2021, there were an estimated 103,500 ATV-related, emergency department-treated injuries in the United States. An estimated 27% of these involved children younger than 16 years of age.[14]

ATVs are popular in both recreational and agricultural use. The ATV size, maneuverability and durability makes it extremely versatile and fun to ride. Drivers of ATVs often use roadways not designed for ATV travel and often drive at unsafe speeds.[14]

Since the board began reviewing child deaths in 1994, the largest number of ATV-related child fatalities has been in the 10-14 year age range. In 2021, one child died in an ATV crash. Young riders lack the size and strength to safely control an ATV. Operating or riding in an ATV carries a substantial risk of serious injury or death. Due to the risk associated with operating ATVs, laws requiring a minimum operator age of at least 16 should be considered as a way to prevent future ATV-related deaths in children. At a minimum, all ATV users should wear a helmet, eye protection, and protective clothing, and use appropriate restraints when riding in or operating an ATV.

CASE VIGNETTE
Teen Death Due to Motor Vehicle Crash

Alcohol and drug use while driving can be fatal – A teen died from injuries sustained after being ejected from the vehicle at the time of the crash. Reports indicated that the decedent and multiple teen passengers in the same vehicle had been drinking with friends and were all under the influence of alcohol at the time of the crash. Multiple teen passengers were unrestrained and the vehicle was traveling at a high rate of speed prior to crash.

Board Reflection – In recent years, several preventable motor vehicle fatalities were teen drivers who were under the influence of alcohol or drugs at the time of the crash. The Board feels it is critical for MVC investigations to identify the source of the illegal alcohol or other substances associated with the MVC. Minimum legal drinking age and zero-tolerance laws in every state make it illegal to sell alcohol to anyone under age 21, and for those under age 21 to drive after drinking any alcohol. Research has shown that enforcement of these laws and using alcohol retailer compliance checks have reduced drinking and driving crashes involving teens. Parental involvement, with a focus on monitoring and restricting what teen drivers are allowed to do, helps keep teens safe as they learn to drive. Parents should consider a parent-teen driving contract with their teens, including consequences for noncompliance. More information about teen drinking and driving can be found at: https://www.cdc.gov/vitalsigns/teendrinkinganddriving/.

CASE VIGNETTE
Child Death Due to Motor Vehicle Crash

Seat belts save lives – A child under the age of 10 was a rear passenger in a vehicle that was involved in a crash. The child was ejected from the vehicle and pronounced on scene. At the time of the crash, the adult driver and the decedent were both unrestrained. There were multiple people injured in the crash, but those that were properly restrained had less severe injuries and survived the crash.

Board Reflection – Parents and caregivers should require seat belt use long before their children are able to drive or ride in vehicles with others. One way to reinforce the habit is for caregivers to belt themselves and insist that occupants in the car do so as well.

CHARACTERISTICS OF THE 38 MOTOR VEHICLE CRASH DEATHS, 2021

- 20 decedents were male; 18 were female
- One death was the result of an ATV crash
- 42% were ages 15-17, 15% were age 10-14, 23% were age 5-9, 18% were age birth to 4
- 38% were unrestrained drivers or passengers in a vehicle
- 23% involved the use of drugs or alcohol at the time of the crash
- Eight were driving a vehicle at the time of the crash
    - Only 3 were restrained at the time of the crash
- Seven were pedestrian deaths
    - 1 riding a bicycle, 4 walking, 2 standing or sitting near vehicle/road
    - 2 were backover deaths

PREVENTION POINTS

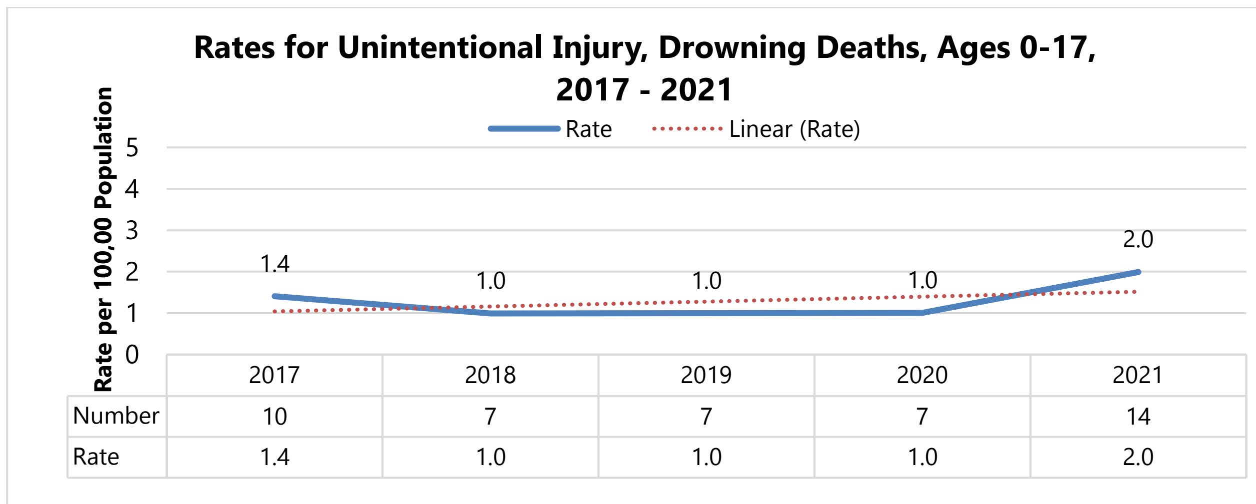
- **Use of Proper Safety Restraints** – Wear seat belts. Seat belts and appropriate child safety restraints consistently prevent serious injury and death. According to the National Highway Traffic Safety Administration, parents who buckle up are more likely to use safety restraints for their children. Children under 4 years of age should be placed in a child safety seat firmly secured in the backseat. Children between the ages of four and eight should be in belt-positioning booster seats in the back seat. Parental seatbelt use as an example to children and passengers is invaluable.[15]
- **Front Seat Passengers** – General guidance and recommendations suggest that children 12 and under should ride in the back seat. Front seat airbags are designed to cushion full-sized adults in the in the event of a crash and may cause injury to smaller children. If a child must ride in the front seat, it is recommended to disable the front air bag and/or slide the seat back as far as possible.[15]
- **Backover Deaths**- Drivers should "look before you leave" which includes walking completely around the vehicle and ensuring that children are supervised and secure prior to backing up a vehicle.[13]
- **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 of which are known risk factors.[16]
- **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.[17]
- **Stay Alert**- Pedestrians need to be visible to drivers at all times and stay in well-lit areas, especially when crossing the street. While distractions such as cell phones and headphones are a daily part of youth's lives, they are dangerous to pedestrians who are looking down or unable to hear what is going on in their surroundings.

UNINTENTIONAL INJURY- DROWNING DEATHS

In 2021, 14 children died from unintentional drowning which is double the number in 2020. 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 minutes and in only a few inches of water. Figure 42 shows drowning death rates for all ages 0-17 over the last 5 years. On average, the 1-4 age group accounts for the highest rate when compared to the other age groups (Figure 43).

In 2022, the Board contracted with the National Center for Fatality Review and Prevention to participate in a pilot project with six other sites to test a Drowning Death Scene Investigation tool. The immediate goal is to standardize drowning death scene investigations and enhance data collection for the national database. The ensuing goal is to prevent future drownings, lower the racial and economic disparities in child drownings and assure that all drowning deaths are investigated thoroughly. The drowning case registry website is: https://ncfrp.org/cdr/drowning-case-registry/ [18]

Figure 42



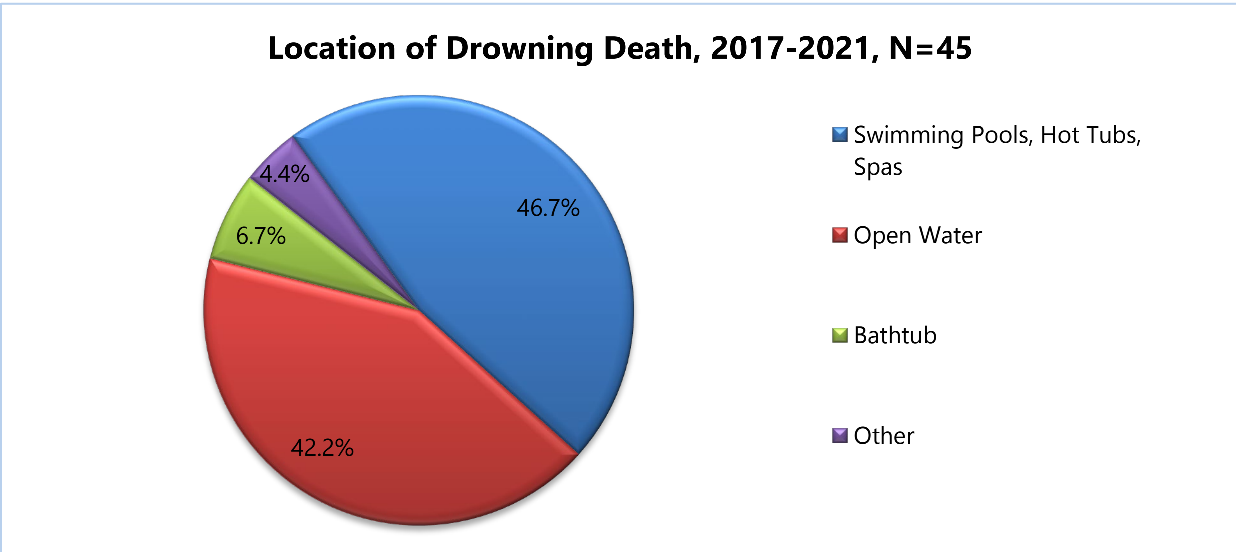
	2017	2018	2019	2020	2021
Number	10	7	7	7	14
Rate	1.4	1.0	1.0	1.0	2.0

Figure 43

Drowning Death Rates per 100,000 population by Age Group, Ages 0-17, 2017-2021					
	< 1 Year	Age 1-4	Age 5-9	Age 10-14	Age 15-17
Average 2017-2021	**0.53**	**2.28**	**0.71**	**0.80**	**1.99**

As shown in Figure 44, swimming pools and open water are the primary locations of child drownings. Proper supervision and use of flotation devices for children of all ages are critical. Children are not only at risk during the summer when pools are mainly in use, but also when not in use and still accessible. Fencing of swimming pools, including soft-sided pools, on residential properties is an additional and necessary tool to prevent drownings.[19] Many of the same prevention points can be applied to swimming in locations of open water.

Figure 44



Because drownings can occur in only a few minutes and with only a few inches of water present, young children can become vulnerable to drowning in locations that most caregivers would not see as a threat. Figure 44 shows that in 4.4% of the drowning deaths, "other" location of the drowning was listed. Toilets, buckets of water, washing machines, large puddles, etc. are locations that small children could encounter within the home and that without proper supervision could endanger them. In 28 of the 45 unintentional drowning deaths between 2017 and 2021, poor/absent supervision or neglect was noted to be either the direct or contributing factor. Proper supervision and appropriate personal flotation devices are critical prevention measures when children are near water.

Figure 45

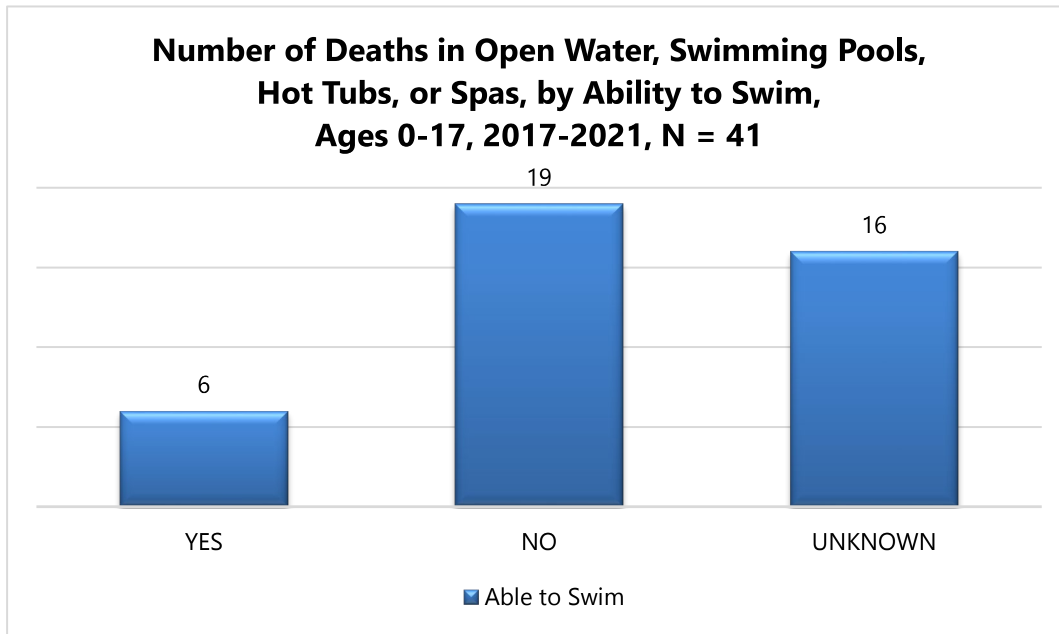
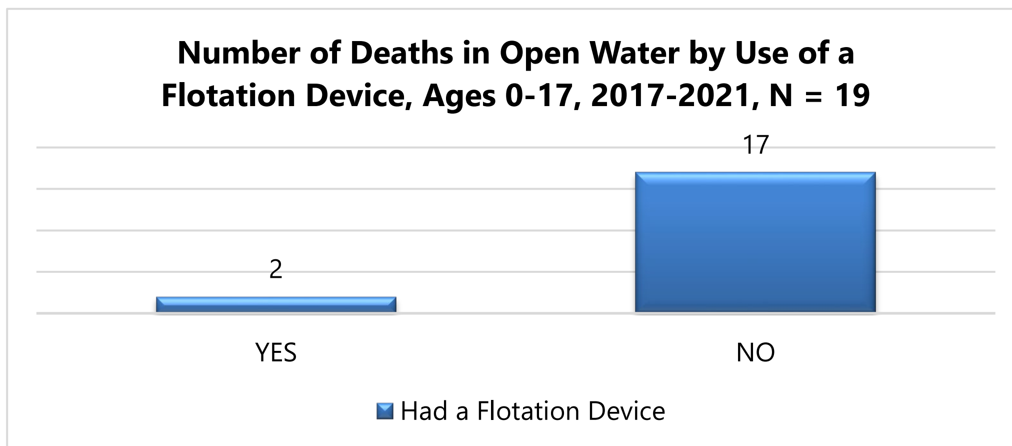


Figure 45 shows the number of deaths in open water, swimming pools, hot tubs, or spas based on the child's ability to swim, for years 2017-2021. Only 14% of children who died from drowning in these water sources were reported to be able to swim, 46% were confirmed as not able to swim, and 39% had no documentation of swimming ability. The Board is hopeful that with the use of a standardized investigation tool, thorough and accurate information will be collected to aid in understanding drowning deaths.

Figure 46



The use of personal flotation devices is essential for children of any age despite their ability to swim. Figure 46 documents the number of deaths where the child was wearing a flotation device in open water. Only two of the 45 drowning deaths from 2017-2021 were reported to be wearing a flotation device at the time of death, both occurred in open water in 2021. While many children like to use air-filled toys and foam noodles, the CDC recommends using only well-fitting Coast Guard-approved life jackets for flotation assistance.

CASE VIGNETTE
Teen Death Due to Drowning

Flotation devices are critical – A group of teens went swimming at a lake in a residential area. Despite the ability to swim, the decedent began to struggle in the water and yelled for help. Other teenagers attempted to assist the decedent but were unable to do so as the decedent was pulling them under during their rescue attempt. Despite the efforts of the friends, the decedent was not able to be pulled from the water in time. The decedent nor the other teenagers were using life jackets or other floatation devices.

Board Reflection – Despite the ability to swim, swimming in open water is more challenging than in a pool. Children and youth can tire quickly and if they go under water, the murky water and currents can make it difficult for even the best swimmer to be seen and rescued. It is essential that any child, despite age or ability to swim, use a personal flotation device when swimming in open bodies of water.

CHARACTERISTICS OF 14 DROWNING DEATHS, 2021

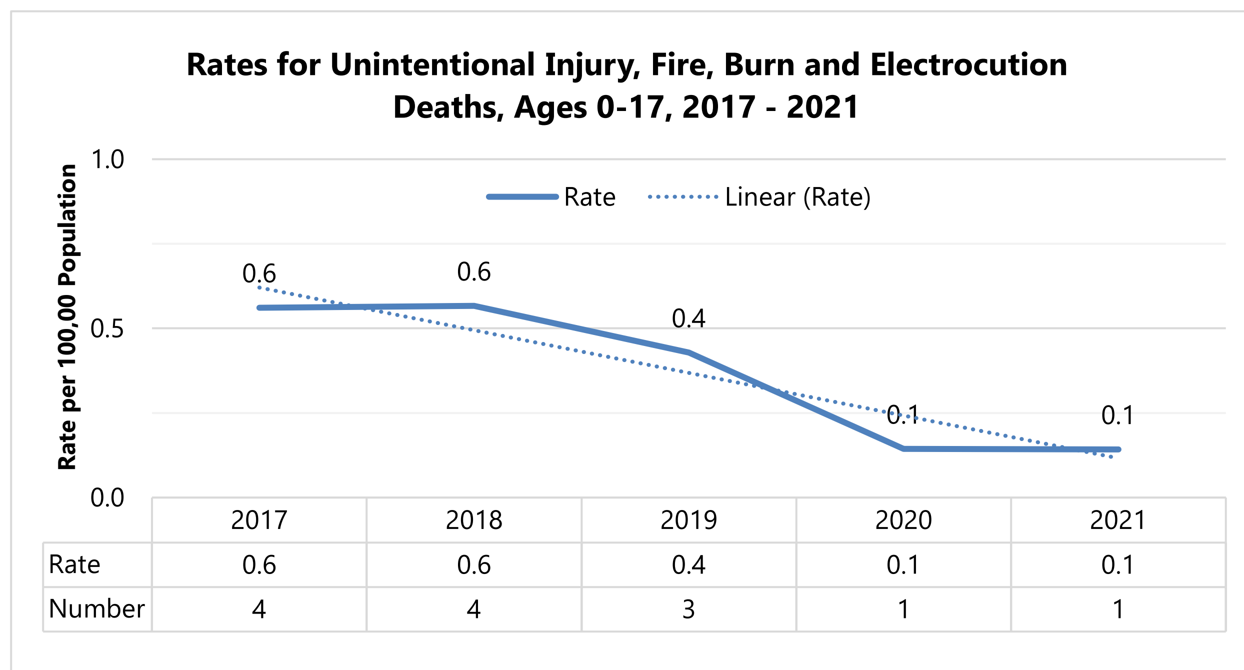
- The rate of children drowning deaths doubled from 2020 to 2021
- 10 were male, 4 were female
- 85% were not wearing a flotation device at the time of the drowning
- 50% were in the 1-4 age group
- 50% had poor/absent supervision or neglect noted to be either a direct or contributing factor in the drowning

PREVENTION POINTS

- **Supervision-** An adult should be designated to closely and constantly supervise any children who are in or near water, including bathtubs. Adults who are supervising should avoid distractions such as using their phone, watching TV, or reading.[20]
- **Learn Basic Swimming and Water Safety Skills-** Formal swimming lessons can reduce the risk of drowning and can be beneficial for children as early as age 1.[20]
- **Restriction/Barriers to Water-** Pools need to be enclosed on all four sides by a wall, fence, or barrier. Gates and locks should be utilized and there should not be gaps that children could slip through, or barriers low enough a child could climb over.[20]
- **Wear a Life Vest**- Life jackets reduce the risk of drowning and should be used by children regardless of their activity in or near water.[20]
- **Learn CPR-** Adults and caregivers of children should invest in learning CPR. Immediate resuscitation can be the difference between life and death in a drowning situation – every minute counts. Organizations such as the American Red Cross and American Heart Association offer CPR courses. [20]

In 2021, one Kansas child died in an unintentional fire, burn or electrocution incident. Figures 47 and 48 indicate death rates in this category for all children and by age group per 100,000 population for the past 5 years in Kansas.

Figure 47



	2017	2018	2019	2020	2021
Rate	0.6	0.6	0.4	0.1	0.1
Number	4	4	3	1	1

Figure 48

Fire, Burn and Electrocution Death Rates per 100,000 population by Age Group, Ages 0-17, 2017-2021					
	< 1 Year	Age 1-4	Age 5-9	Age 10-14	Age 15-17
Average 2017-2021	**1.1**	**0.7**	**0.4**	**0**	**0.16**

Between 2017-2021 there were 12 unintentional injury deaths due to fire or burns and one death that was due to electrocution. Figure 49 describes the use of smoke alarms in the 12 fire deaths between 2017 and 2021. In only 16% (2) of the fire related deaths was a working smoke alarm present.

Figure 49

Smoke Alarms in Unintentional Injury Fire Deaths, 2017-2021, N=12		
Was a smoke alarm Present?		Number
Yes		6
If Yes, was it working properly?	Yes	2
	No	4
No		6

CHARACTERISTICS OF FIRE, BURN, AND ELECTROCUTION DEATHS, 2017-2021

- 12 deaths due to fire, one death due to electrocution
- Rate of death in the last five years of reporting shows a downward trend
- Only 12% of deaths due to fire had a working smoke alarm present
- Cigarette lighters were the ignition source in 33% of the fire deaths
- 50% of the deaths occurred in children ages 1-4

PREVENTION POINTS

- **Proper Supervision** – Young children must be watched closely. Leaving them unsupervised, especially if objects such as candles, lighters or matches are 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 Alarms** – Smoke alarms should be placed inside and outside of each sleeping area and on every level of the house, including the basement. Smoke alarms 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 clutter do not block exits. Designate a central meeting location outside of the home and have regular fire drills.

The most recent census data from 2017 indicates there are likely more than 58,000 farms in Kansas, most of which are family owned.[21] Unlike other industries, the farm includes an intermingling of home and worksite activities for Kansas families. As a result, children can be exposed to agricultural hazards that lead to unintentional injury and fatalities.

In the last five reporting years, Kansas has experienced ten agriculture-related deaths of children, one of which occurred in 2021. A majority of agriculture-related child deaths in Kansas within that period involved a motor vehicle such as a tractor, ATV, or other heavy machinery. While lack of supervision was a primary contributor in many of these fatalities, failing farm equipment or equipment void of safety features also contributed to several of the deaths.

Kansas Farm Bureau provides education materials for all ages specific to agriculture and farm safety. In addition, Kansas Farm Bureau sponsors a "Safety Poster Program" offered to students in Kansas in grades 1-6. This injury prevention program, available since 1950, is an effort to develop "safety-minded" youth.[22] Educational materials and contest winners are accessible at https://www.kfb.org/. Pictured below is the 2023 Division II (3rd and 4th grade), 1st place safety poster submitted by a student in Jackson County. It is vital for parents, caregivers, and children to understand the potential dangers on a farm.

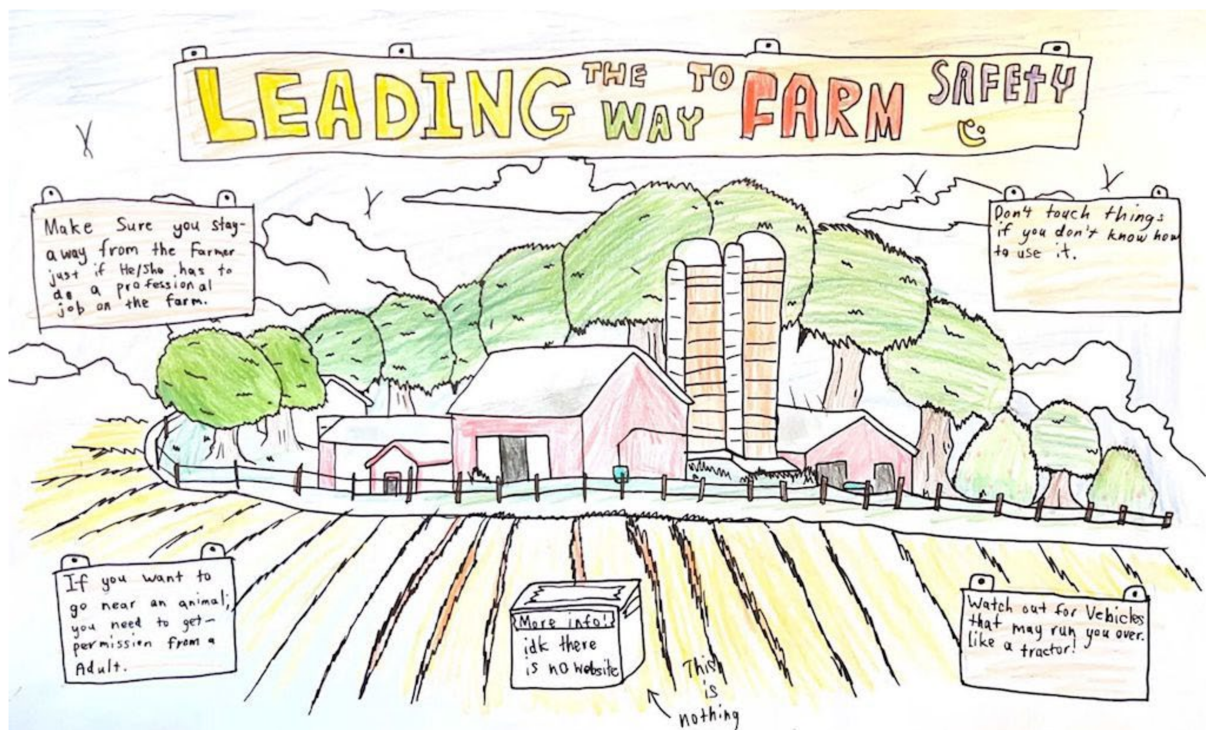


Photo source: https://www.kfb.org/ArticleFile/file/986bb804-9881-48ab-b8fb-97aa5dc96e10/D2-1st-Jackson.jpg

CHARACTERISTICS OF AGRICULTURE RELATED DEATHS, 2017-2021

- 100% of the deaths during this time period were males
- 50% were children ages 5-9
- 20% were backover deaths in children under the age of 5
- 20% involved ATV usage

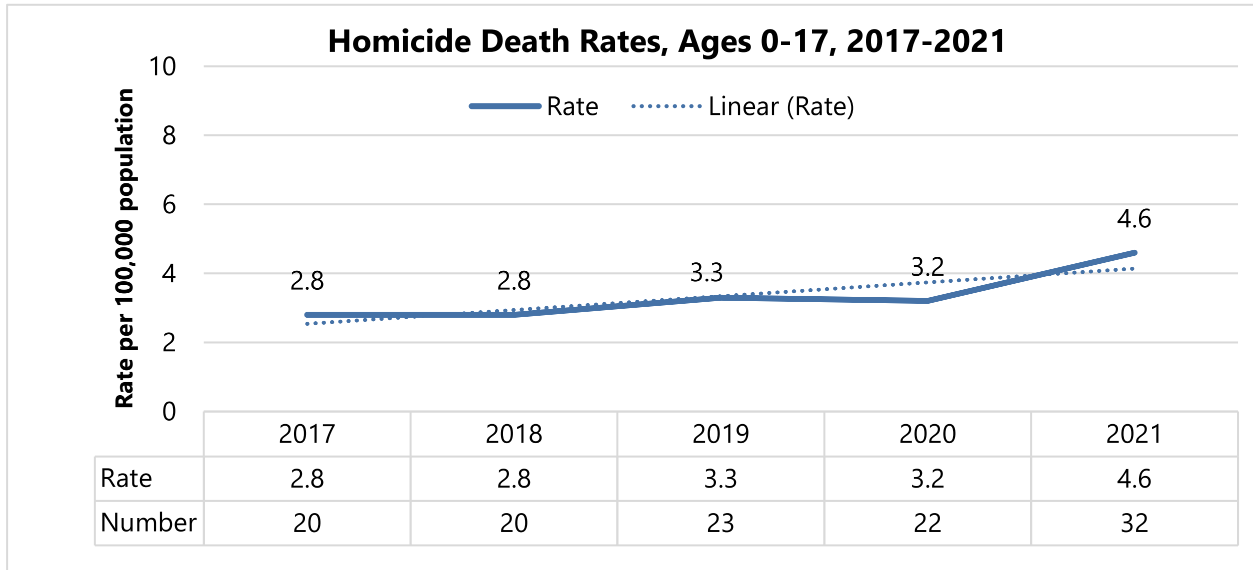
PREVENTION POINTS

- **Proper Supervision** – Parents and caregivers should provide undivided attention and not engage in farm work at the same time they are supervising young children. As children learn how to assist with farm related tasks, supervision and guidance are critical to their safety until they can demonstrate the ability to safely perform tasks appropriate for their age and development.[21]
- **Safety Around Power Take-Off (PTO)** – Many injuries and fatalities have been a result of entanglement in PTOs. Safety shields should be in place and in good working condition. Furthermore, children should be reminded to never step or jump over a PTO as clothing can become entangled in the moving parts. PTOs should be disengaged when idle or not in use.[21]
- **Equipment Safety** – Children should not operate machinery such as lawn mowers, tractors, or ATVs until they are trained and can safely be trusted to do so. Steps should be taken to ensure that riders and drivers of ATVs and other farm equipment use helmets and protective gear.[21]
- **Safe Play Area** – Children should have a safe place to play where they are supervised and protected from potential hazards, and away from roadways and areas where equipment is operated.[21]

HOMICIDE DEATHS

Homicide deaths are those that are due to an intentional act, unintentional act, or criminally negligent act leading to the death of another human being. In 2021 there were 32 child homicides. The rate of death increased to 4.6 deaths per 100,000 population, the highest rate in the last 5 reporting years (Figure 50).

Figure 50



	2017	2018	2019	2020	2021
Rate	2.8	2.8	3.3	3.2	4.6
Number	20	20	23	22	32

Figure 51 displays homicide rates per 100,000 population by age group. In 2021, the rate of homicide deaths in the 15-17 year old age group was significantly higher than in past reporting years. Historically children under the age of 5 are more likely to be victims in homicides, particularly child abuse homicides.

Figure 51

Homicide Death Rates per 100,000 population by Age Group, Ages 0-17, 2017-2021					
	Age <1	Age 1-4	Age 5-9	Age 10-14	Age 15-17
2017	10.5	5.1	0.0	0.0	6.7
2018	10.9	3.3	1.5	0.0	6.8
2019	5.7	4.0	1.5	1.5	7.6
2020	8.5	2.7	1.0	2.5	6.7
2021	2.9	2.8	1.0	2.4	16.18
Average	**7.7**	**3.6**	**1.0**	**1.3**	**8.8**

Each child homicide is categorized into one of the following groups: Child Abuse Homicides, Gang Homicides, and Other Homicides (Figures 52 & 53). By categorizing homicides in this way, the Board is able to look in depth at specific issues pertaining to each category. Of the total homicides in all categories for 2021 (Figure 53), 16% (5) were due to child abuse and 9% (3) were related to gang violence. The remaining 75% (24), which did not meet the definition of gang violence or child abuse, were categorized as "other homicides." In comparison to Figure 52 which shows 5 years of homicide data by category, the largest increase in 2021 homicides is seen in the "other" category, while gang-related and child abuse homicides remained the same or were fewer in number.

Figure 52

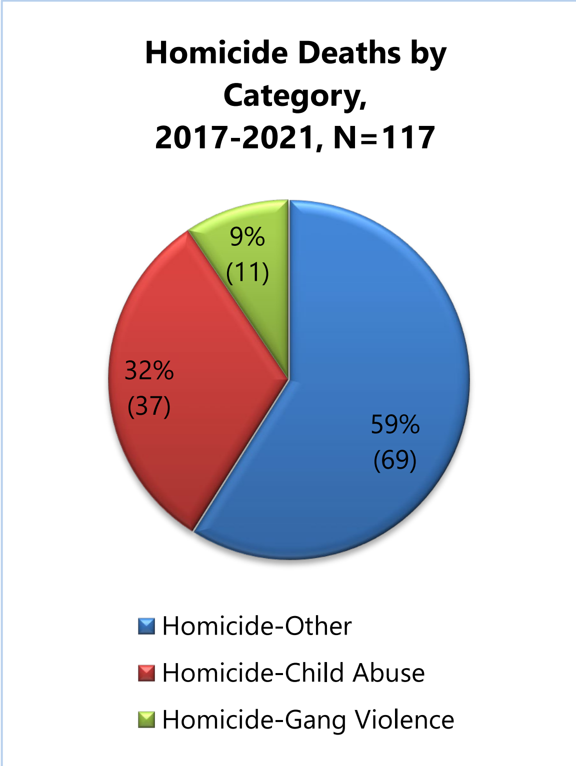


Figure 53

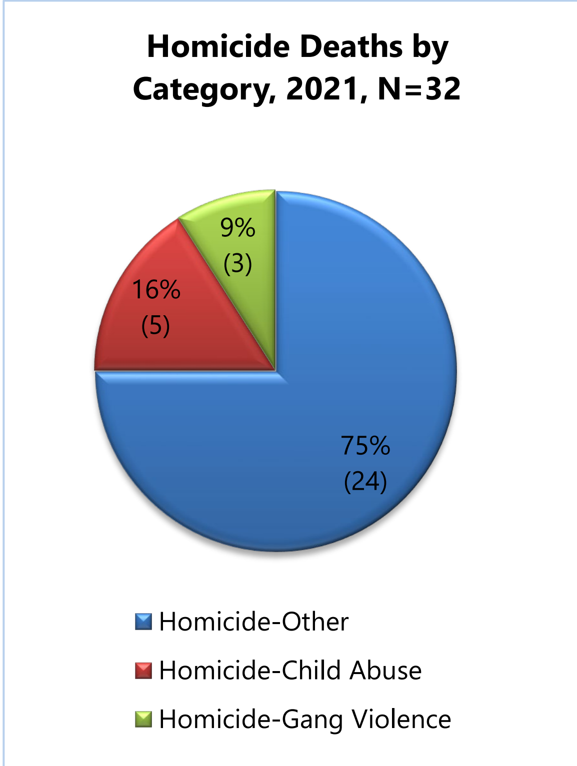


Figure 54 shows the rate of death for homicides by race/ethnicity. Homicide deaths of Black/Non-Hispanic children occurred at a rate of 14.9 deaths per 100,000 population compared to a rate of 1.6 deaths per 100,000 population for White/Non-Hispanic children.

Figure 54

Rate of Death, Manner- Homicide, by Race/Ethnicity, Age 0-17, 2017-2021							
	Kansas Rate All Races	**White/ Non-Hispanic**	**Black/Non-Hispanic**	**American Indian/Non-Hispanic**	**Asian/ Non-Hispanic**	**Multiple Race/ Non-Hispanic**	**Hispanic-Any Race**
2017-2021	3.3	1.6	14.9	*	*	6.1**	5.0
*Denotes suppressed rates of death due to value of 9 or less **denotes rates of death with value of 10-19 which should be used with caution							

CHARACTERISTICS OF CHILD HOMICIDES, 2021 N=32

- Homicide death rate increased to 4.6 deaths in 2021 compared to a rate of 3.2 deaths per 100,000 population in 2020
- Males accounted for 71% of the child homicides
- Black/Non-Hispanic children died at a rate of 14.9 deaths per 100,000 population compared to the Kansas death rate of 3.3 per 100,000 children, when all races/ethnicities were combined
- 23 of the 32 families of all homicide victims had current or past DCF child protective service involvement prior to the fatal incident
- 4 of the 5 child abuse homicide cases had current or past DCF child protective service involvement prior to the fatal incident
- Five children died from child abuse, one was under 1 year of age; three were between 1 and 4 years of age; and one was 5-9 years of age at the time of death
- Three deaths were classified as gang-related homicides
- In 4 of the 32 homicides, the Board found sufficient evidence, after thorough review, to classify the deaths as homicides even though they were not originally classified in that manner. One of the deaths had been certified as an accident and three as undetermined manner of death

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 caregivers with substance use disorders (including illicit drugs, prescription medications and alcohol) are at increased risk of abuse, neglect or death. If substance use in the home is suspected, the safety of the children should be addressed. Furthermore, youth who engage in buying or selling of drugs are at an increased risk of death due to homicide.
- **Education for Caregivers of Young Children –** The victims of child abuse homicide are most often in the younger age categories. Frustrated caregivers, often without any parenting training have 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 and child discipline, 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. Active children are expected to have bruises and bumps from everyday play. These bruises are most often over bony areas such as the knees, elbows, and shins. 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 must 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. Young children who are not crawling or walking rarely sustain bruises – "if you don't cruise, you don't bruise." Any bruises noted on a child less than 9 months of age, especially if recurrent, patterned, or in unusual locations on the body should be evaluated for the possibility of abuse.
- **Report any Concerns for Child Abuse and Neglect** – 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 if the child is in imminent danger.

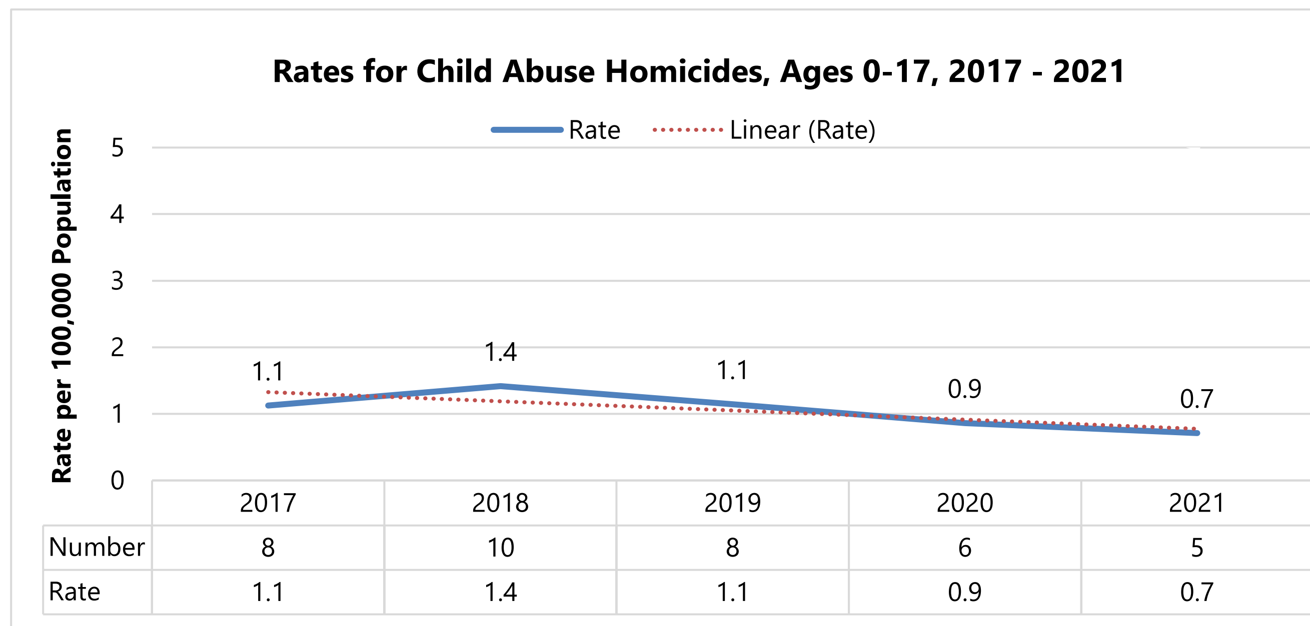
HOMICIDE- CHILD ABUSE

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 financial stressors, domestic violence, substance abuse, mental illness and unreasonable expectations of children's behaviors.

Very young children are not capable of defending themselves against an assault and are small enough to pick up and shake, throw or strike. Furthermore, their behaviors can create triggers for caregivers to harm them.

Figure 55 indicates a slight downward trend in child abuse homicides since 2017. In the last 5 years there have been 37 child abuse homicides, 5 of which occurred in 2021.

Figure 55



	2017	2018	2019	2020	2021
Number	8	10	8	6	5
Rate	1.1	1.4	1.1	0.9	0.7

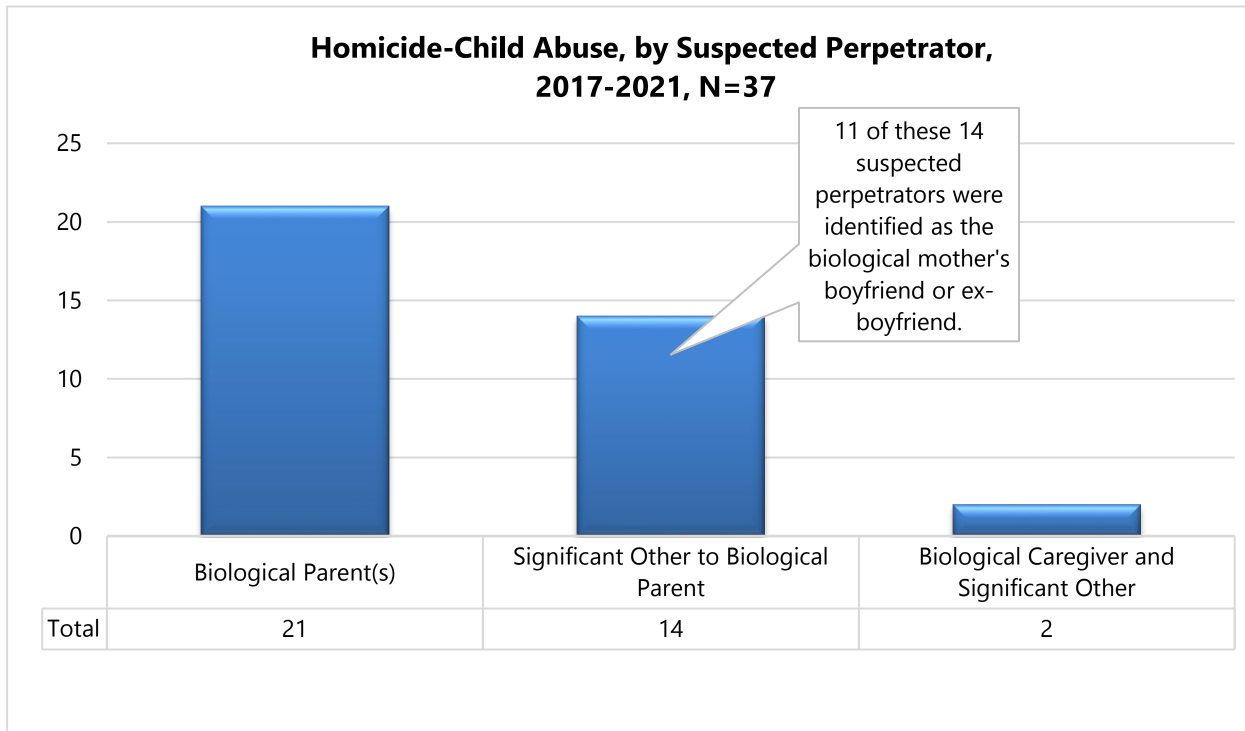
The method of child abuse homicide can vary. In general, most occur as a result of blunt force trauma. The most prevalent form is Abusive Head Trauma (AHT), which occurs when an infant or toddler is severely or violently shaken resulting in serious injury and/or death. It is important to note that it is common for children who die from AHT to have autopsy evidence of impact injuries without visible external evidence of trauma.

Caring for children can be overwhelming at times. Parents and caregivers are often 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 (non-biological caregiver in the home, prior substantiation of child abuse and neglect, substance use disorders, and low socioeconomic status). Many of the child

abuse homicides occurred when the primary caregiver was away from the home, with the child in the care of the mother's significant other† or a relative who was not the primary caregiver.[1]

Figure 56 categorizes the suspected perpetrators in each of the child abuse homicides over the last five years. In 56% (21) of these deaths, the suspected perpetrator was a biological parent(s) of the child. Mother's significant other was the suspected perpetrator in 29% (11) of the child abuse homicides. In 5% (2), a biological caregiver and his or her significant other were both responsible for the death.

Figure 56



SCDRB data reflects characteristics of child abuse homicides from studies in other states. Child abuse 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 are perpetrated by someone in a caregiving role and who is less than 25 years of age. More than 80% 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, most infant and young child homicides are the result of beating, shaking or strangulation by someone entrusted with caring for the child.[23]

Child abuse 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 includes parent training and education about normal childhood behaviors and age-appropriate

† Significant Other- Used to reference a current or previous non-marriage relationship with no biological relationship to the child.

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 and frustrating behaviors are needed.[1]

It is crucial that all citizens of Kansas help support families and protect children by reporting all suspicions of abuse or neglect. Children rely on those around them to speak up for their well-being when they are unable to do so themselves. 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 if the child is in imminent danger.

CASE VIGNETTE
Child Death Due to Homicide- Child Abuse

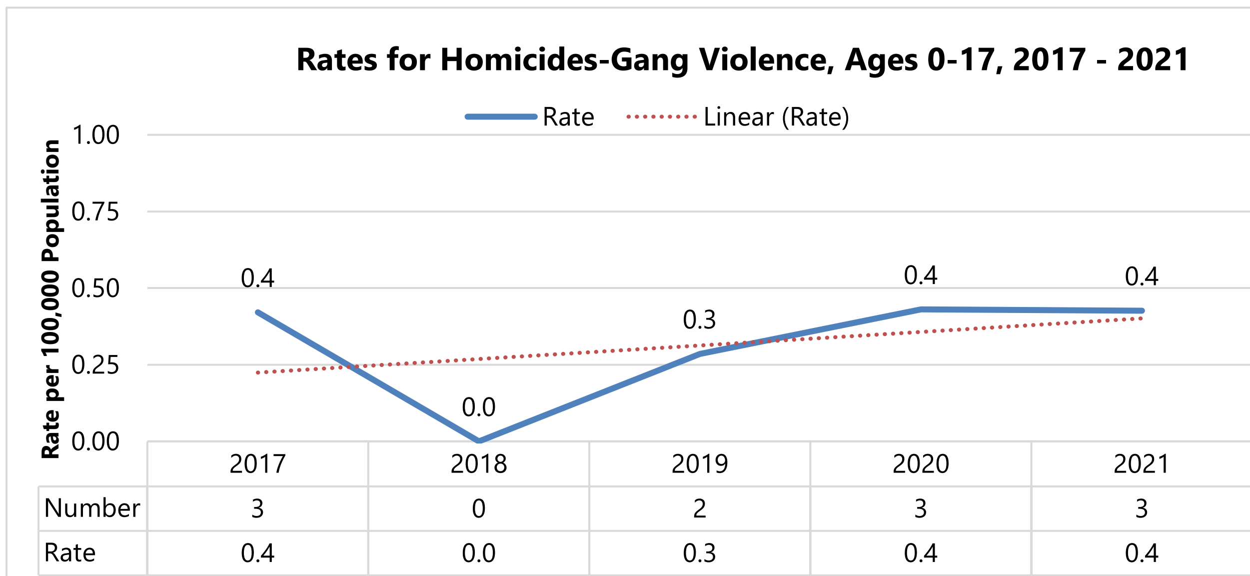
Risk factors and triggers leading to abuse – An infant with young parents was healthy at birth. At 1 month of age the baby was seen for a primary care health visit. A small bruise on the abdomen was noted and explained by a caregiver as resulting from a near-fall in which the caregiver grabbed the baby to stop the fall. No intervention was ordered by the provider. At that visit, and the 2 month visit, the baby was described as not sleeping well and crying “a lot.” On the day of the incident, the mother left for work and father was caring for the baby alone. He reported a “choking” event, after which the baby was limp and unresponsive. Emergency services were contacted. At the hospital the baby was found to have multiple bilateral rib fractures in various stages of healing, subdural hemorrhages, and extensive brain swelling, all of which are indicative of abusive head trauma. Despite intensive care, the baby was later determined to be brain dead. Father admitted to law enforcement officers that he had shaken the baby out of frustration on at least two occasions, the most recent was the day of the event that led to the death.

Board Reflection – Statistically, a parent or someone close to the parent is most frequently the perpetrator of abuse. In this case, the mother had returned to work and father was staying home with the children. He was frustrated with the baby’s fussiness and crying, which is the most common trigger for abuse. There are resources for parents who need help with handling child behaviors. Knowledge of these resources, such as Period of Purple Crying, is imperative for health care providers who see infants. Additionally, this baby had a sentinel injury – bruising to the abdomen – that would not be explained by the mechanism father described. This should have triggered further evaluation for other injuries and consideration of physical abuse. Because not all medical providers have the expertise, nor are they able to devote the time to completing forensic medical evaluations, the state has initiated a Kansas CARE (Child Abuse Review and Evaluation) program to provide in-depth training to interested pediatricians. Those pediatricians, who are reimbursed by the state, are able to provide thorough medical assessments in specified cases where child abuse or neglect is a concern. Also, a DCF Medical Resource Center has been initiated for DCF investigators to refer cases for review by child abuse pediatricians, who help determine whether a medical assessment is needed and to what level of medical expertise the case should be referred. It is hopeful these additional resources and trainings will increase knowledge and awareness across the state

HOMICIDE- GANG VIOLENCE

The Board categorizes a homicide as the result of gang violence when there is evidence to support the child died from direct or indirect 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 unintentionally caught in the gang violence. This can occur while the child is outside playing or even in the safety of his or her own home. A child living in a location with gang activity or in a home that has other household members with gang associations is at significant risk for injury or death. In other circumstances, the children killed are members of a gang and die during disputes related to gang activity.

Figure 57



	2017	2018	2019	2020	2021
Number	3	0	2	3	3
Rate	0.4	0.0	0.3	0.4	0.4

Figure 57 shows the rate of Homicides due to gang violence over the last 5 reporting years. Between the years of 2017 and 2021 there have been 11 homicides due to gang violence; in seven of the deaths a suspect was charged with the murder and an additional case has charges pending. A gunshot wound was the cause of death in all 11 of these homicides.

CHARACTERISTICS HOMICIDE- GANG VIOLENCE, 2017-2021 N=11

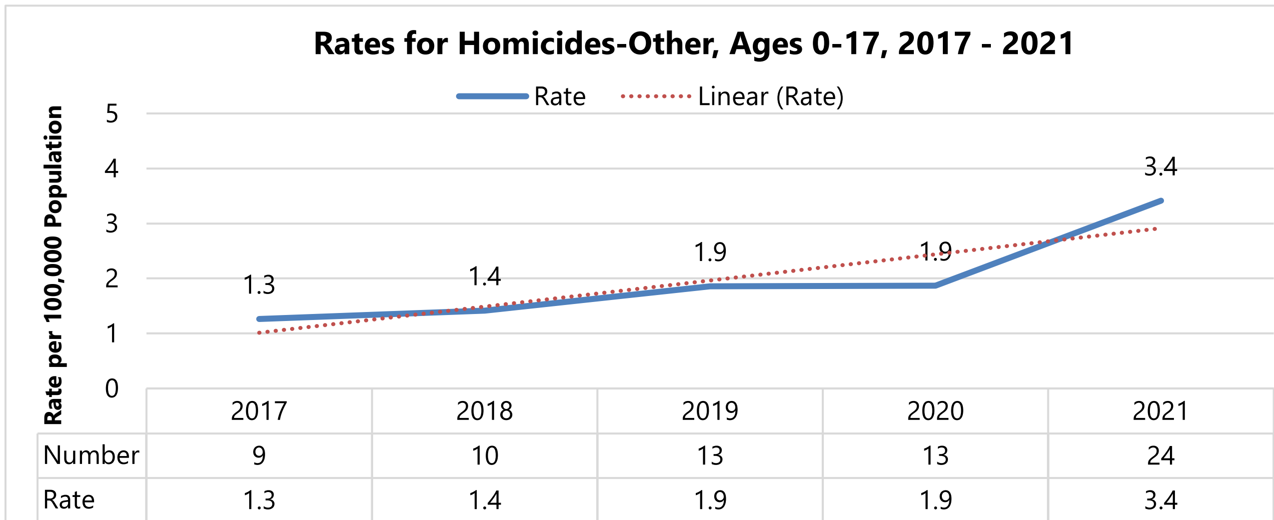
- 100% were age 15-17
- 100% involved a firearm
- 81% were male
- 63% of cases have a suspect who is charged with the death

HOMICIDE- OTHER

Any death not categorized as Homicide-Child Abuse or Homicide-Gang Violence is categorized as Homicide-Other. In many of these deaths, the act of violence against the child is more random in nature and a clear explanation for why the murder occurred 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. Between 2017 and 2021 there were 69 Homicides that fell into this category, with 24 of them occurring in 2021.

As shown in Figure 58, the rate of death due to Homicide-Other, showed a significant increase in 2021, bringing the rate of death to 3.4 per 100,000 population.

Figure 58



	2017	2018	2019	2020	2021
Number	9	10	13	13	24
Rate	1.3	1.4	1.9	1.9	3.4

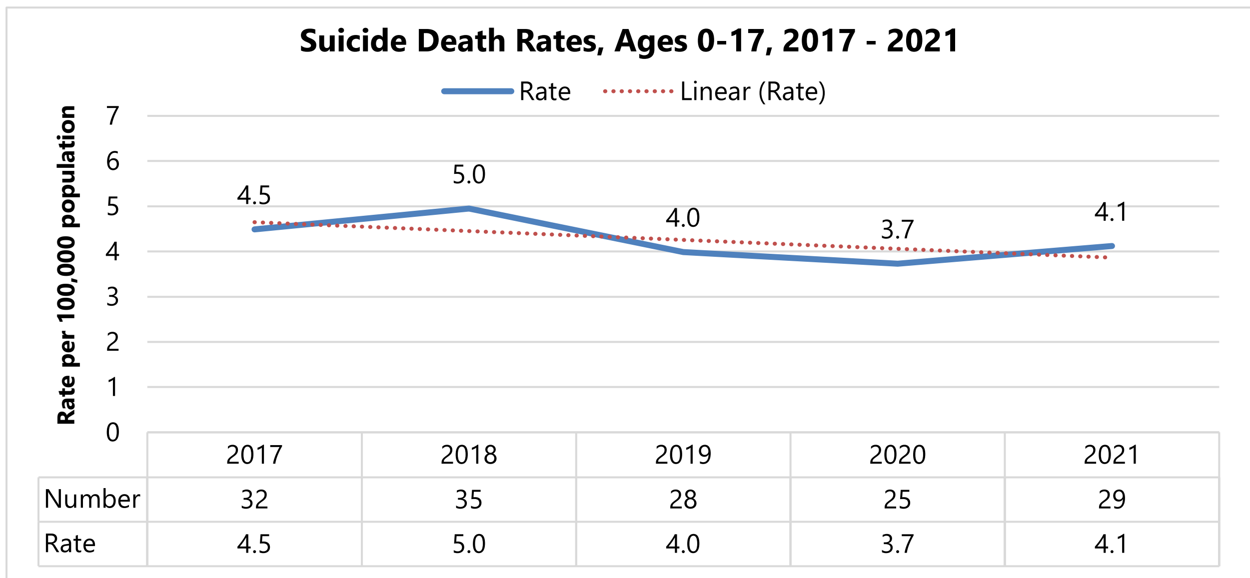
CHARACTERISTICS OF HOMICIDE-OTHER DEATHS, 2017-2021 N=69

- 78% died from a firearm injury
- 20% occurred when the decedent was either the buyer, dealer, or a victim of retaliation during a drug transaction
- 13% were related to domestic violence, which includes deaths in which the child was murdered prior to the perpetrator taking their own life
- 11% were the result of an unintentional shooting while the gun handler was either playing with or showing the weapon. These deaths, although unintentional in nature are ruled as homicides due to a criminally negligent act leading to the death of a person
- 30% of the identified perpetrators were a friend or acquaintance of the decedent
- In 21% the perpetrator was identified as a biological parent
- In 15% of the cases, a perpetrator was unable to be identified

SUICIDE DEATHS

Suicide deaths are those that are due to the intentional taking of one's own life. In 2021, 29 children in Kansas between the ages of 10-17 died by suicide; 23 were male and six were female. According to the Centers for Disease Control and Prevention, in 2020, suicide was the second leading cause of death for children ages 10-17.[24] Consistent with national studies, adolescent females are more likely to attempt suicide, but adolescent males are more likely to complete it. Figures 59 and 60 show suicide rates per 100,000 population for children ages 0-17, and by age group for the last 5 years in Kansas.

Figure 59



	2017	2018	2019	2020	2021
Number	32	35	28	25	29
Rate	4.5	5.0	4.0	3.7	4.1

Figure 60

Suicide Death Rates per 100,000 Age-Related Population, Ages 10-17, by Age Group, 2017-2021		
	Age 10-14	Age 15-17
2017	3.5	21.0
2018	4.5	21.9
2019	3.0	18.5
2020	4.0	14.3
2021	4.8	15.4
Average	**4.0**	**18.2**

Due to small numbers, the rate of suicide deaths for Non-Hispanic Black, American Indian, Asian, and Multiple Race population groups was unable to be reported regarding suicides. White/Non-Hispanic and Hispanic racial groups had the highest number of suicide deaths in 2017-2021 when compared to other racial groups.

Figure 61

Rate of Death, Manner- Suicide, by Race/Ethnicity, Age 0-17, 2017-2021							
	Kansas Rate All Races	**White/ Non-Hispanic**	**Black/Non-Hispanic**	**American Indian/Non-Hispanic**	**Asian/ Non-Hispanic**	**Multiple Race/ Non-Hispanic**	**Hispanic-Any Race**
2017-2021	4.1	4.1	*	*	*	*	4.4
*Denotes suppressed rates of death due to value of 9 or less							

Various methods are used by children and adolescents who die by suicide. The most common method of suicide for males is the use of a firearm; 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. Many suicide attempts, as well as suicides reviewed by the Board, occur when the child is in short-term crisis. It is important for parents and caregivers to prevent access to lethal means during periods of increased risk of suicide or self-harm. Figure 62 indicates the methods used by sex of the child over the last five years.

Figure 62

Suicides by Method and Sex, 2017-2021, N= 149			
Method	Male	Female	Total
Firearm	67	8	75
Asphyxia	30	27	57
Poisoning, Overdose or Acute Intoxication	2	7	9
Fall or Crush	2	1	3
Undetermined	0	1	1
Other Transport*	3	1	4
*Train, Motor Vehicle Crash			

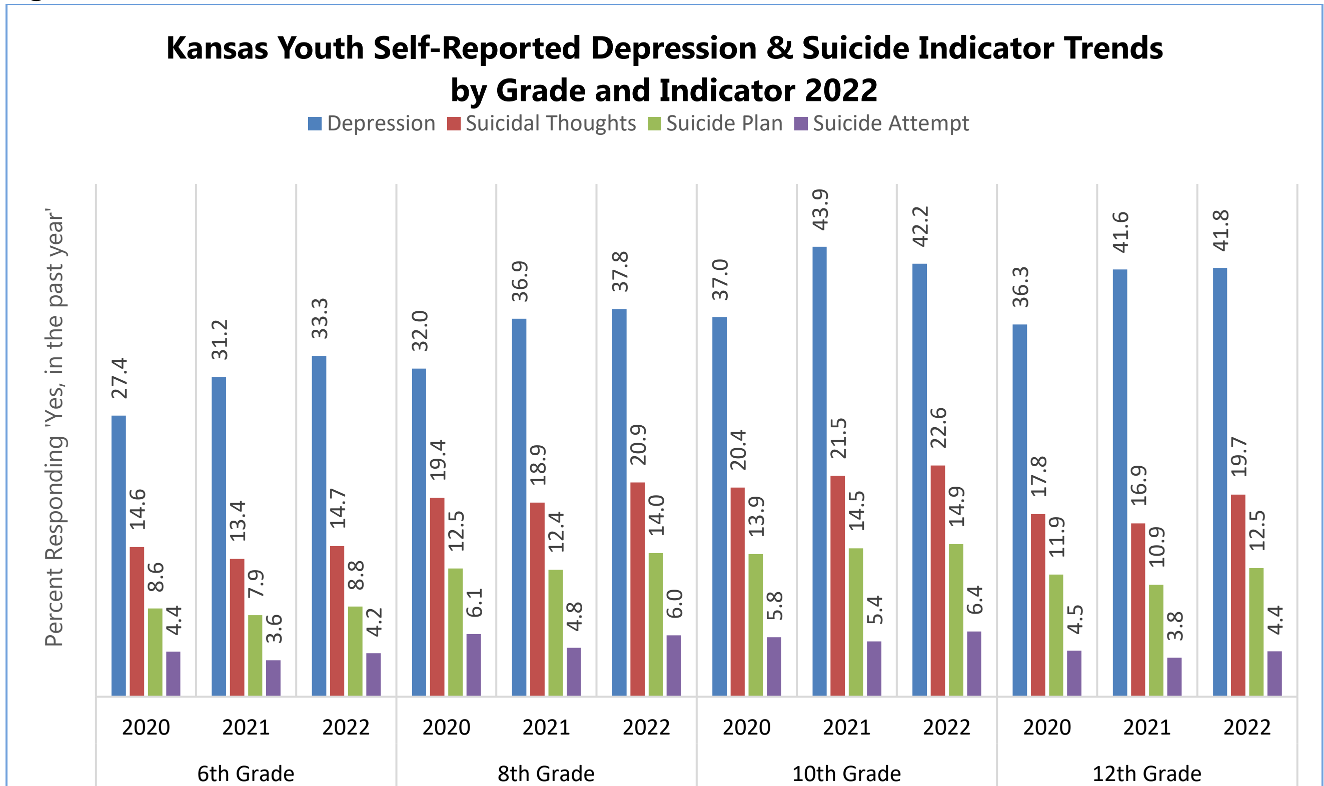
Risk factors for adolescent suicide are categorized as predisposing and precipitating factors. Predisposing factors include mental health problems and psychiatric disorders, previous suicide attempts, family history of suicide, history of physical or sexual abuse, and exposure to violence. Precipitating factors include access to means, alcohol and drug use, social stress, isolation, and exposure to suicide by friend or family including suicide attempts. Well-identified examples of stressors include parental divorce or separation, ostracism or rejection, gender identity, sexual orientation, or the breakup of a significant relationship. Young people who identify as LGBTQ+ reportedly have higher rates of suicidal thoughts and behavior compared to their peers. Bullying has also been identified as a risk factor, placing both bullies and victims at risk.

Figure 63 lists the recent personal crises associated with the suicides between 2017 and 2021. Reasons for suicide can be complex and challenging to identify, however some suicides can be prevented. Parents, caregivers, friends, school personnel, and others need an awareness of warning signs to identify those who may be considering harming themselves. There are many protective factors that can buffer individuals from suicidal thoughts and behaviors, including clinical care for mental health and substance use, family and community support, and promoting skills in problem solving and conflict resolution.

Figure 63

Suicide Deaths, Victim Histories, 2017-2021, N=149	
Decedent History	Number
History of maltreatment as a victim	51
Open CPS case at time of death	13
Previous out of home placement	16
History of mental health services	67
Child was currently receiving mental health services	47
History of substance use services	46
Child had history of delinquent or criminal activity	13
Child experienced suicidal behaviors/attempts	49
Child communicated any suicidal thoughts, actions or intents	94
Showed warning signs - Talked about or made plans for suicide	85
Showed warning signs - Expressed hopelessness about the future	64
Showed warning signs - Displayed severe/overwhelming emotional pain or distress	66
Showed warning signs - Expressed perceived burden on others	60
Showed warning signs - Worrisome behavioral cues or marked changes in behavior	66
Showed warning signs - None listed	34
Showed warning signs - Unknown	16
Child experienced known crisis	58

Figure 64



Source: Kansas communities that care (KCTC) student survey [36]

The Kansas Communities That Care (KCTC) Student Survey is administered annually, free of charge to students in grades 6th, 8th,10th, and 12th at public and private schools in Kansas. Figure 64 represents a recent enhancement to the survey which measures youth depression and suicide thoughts, plans and attempts. Youth as young as sixth grade are reporting thoughts, plans and attempts of suicide. Each grade surveyed has shown an increase in self-reported depression between 2020 and 2022.[36]

These self-reported indicators parallel the preliminary data of the Board which show that the rate of Kansas children who die by suicide has not only increased in recent years but includes children as young as elementary and middle school age. Prevention efforts aimed at reducing youth suicide should be offered to children as early as elementary school.

Figure 65 and 66 indicate the gender identity and sexual orientation for youth who died by suicide between 2017 and 2021. It should be noted that information that would verify a youth's gender identity or sexual orientation is not readily available in many cases. Figure 67 is included as a way to reflect how youth in Kansas are self-reporting their sexual orientation and gender identity.

Figure 65

Gender Identity in Suicides, Age 0-17, 2017-2021, N= 149		
Identity	Number	Percent
Male, not transgender	80	53.7%
Female, not transgender	32	21.5%
Male transgender	4	2.7%
Female transgender	0	0.0%
Unknown	33	22.1%

Figure 66

Sexual Orientation in Suicides, Age 0-17, 2017-2021, N=149		
Identity	Number	Percent
Straight/Heterosexual	51	34.2%
Gay/Lesbian	6	4.0%
Bisexual	3	2.0%
Questioning	2	1.3%
Unknown	87	58.4%

Figure 67

Comparison of percentage of student-reported SOGI demographics from KCTC Pilot, Child Trends, and YRBS				
	Response Option	Child Trends 2017	YRBS 2019 (High School Only)	KCTC Student Survey SOGI Pilot 2022
Sexual Orientation	Straight	82.0	86.0	76.8
	Lesbian or Gay	2.0	2.7	3.0
	Bisexual	7.0	7.3	9.4
	Something else	2.0	--	4.4
	I'm not sure yet	7.0	4.0	6.4
Gender Identity	Cisgender	96.0	94.4	92.8
	Transgender	1.0	1.8	1.5
	Nonbinary; I do not identify as either male or female	1.0	--	2.9
	I'm not sure yet	1.0	1.6	2.8

Figure 67 references data collected in the Kansas Communities That Care (KCTC) 2022 SOGI (sexual orientation gender identity) Pilot. Responses from 6th, 8th, 10th, and 12th grade students included in the Kansas pilot who responded to the SOGI demographic questions are shown with the results of the Child Trends survey on which KCTC questions were modeled. Similar items surveyed on the Youth Risk Behavior Survey (YRBS), which was administered by the Centers for Disease Control (CDC) in 2019, are also shown for comparison. It is important to note that the YRBS presents SOGI demographics questions only to high school students."[25]

Due to ongoing concern about adolescent suicides, the Kansas Legislature passed SB 323 in 2016. This legislation requires suicide prevention training for school district personnel and a building crisis plan be developed for each school that includes steps for recognizing suicide ideation, appropriate methods of intervention, and a crisis recovery plan. This law is modeled after the Jason Flatt Act, making Kansas the 19th state to pass similar legislation since 2007. More information regarding the Jason Flatt Act can be found at http://jasonfoundation.com/.

In further response to the increased rate of youth suicide, former Kansas Attorney General Derek Schmidt and the Tower Mental Health Foundation formed the Youth Suicide Prevention Task Force in June 2018, to survey efforts that were currently underway in Kansas to reduce the incidence of youth suicide. In 2019, the Kansas Legislature adopted several of the task force recommendations by passing the conference committee report on HB 2290 that led to the creation of a Youth Suicide Prevention Coordinator (YSPC) position. More information regarding the Youth Suicide Prevention Task Force and their report can be found at http://ag.ks.gov/ysptf.

The YSPC continues to focus on collaboration and coordination between state agencies and community partners to strengthen and sustain the infrastructure that enables us to improve the response to youth suicide in Kansas. The YSPC participates as a dynamic partner in several statewide suicide prevention organizations including the Inter-Agency Suicide Awareness Committee, KDHE's Zero Suicide Initiative, the 988 advisory implementation group and the Kansas Suicide Prevention Coalition. In partnership with the Jason Foundation and DevDigital, a free youth suicide prevention app, **Kansas – A Friend AsKS** was released by the Kansas Attorney General's Office in September 2022. The dual language app serves as a tool to assist youth in finding resources to aid themselves, or a friend experiencing a mental health crisis or thoughts of suicide. Through the app, users can connect to 988, the national suicide and crisis lifeline.

It is the Board's hope there will be continued state, local, and individual responses to the alarming youth suicide epidemic. It is through these actions that we can continue to address, reduce, and potentially eliminate youth suicide in Kansas.

CHARACTERISTICS OF SUICIDE DEATHS 2017-2021

- Despite a downward trend from 2018, when Kansas recorded the highest rate of death for youth suicides, there was an increase in both the number and rate of suicide deaths in 2021
- Between 2017 and 2021, 69% of youth suicides were males. In 2021, males represented 79% of the youth suicides
- 63% communicated suicidal thoughts, actions, or intents
- 48% had recent school problems (academic, behavioral, suspensions, conflicts with peers, truancy, etc.)
- 44% had prior involvement with mental health services, 31% were currently receiving mental health services
- 38% experienced a known crisis within 30 days of the suicide
- 16% of the decedents had a history of alcohol or substance use concerns
- 10% of the decedents had barriers preventing them from receiving mental health services. These included: lack of insurance, not scheduling appointments, in-person therapy not available during the pandemic, child refusing to participate or attend therapy and parental concern that a DCF report would be made if child attended therapy

PREVENTION POINTS

- **Early Diagnosis and Treatment of Mental Health Disorders –** 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.[26]
- **Observation of Behaviors –** Changes in a young person's psychological state (increase in rage, anxiety, depression or hopelessness), withdrawal, reckless behavior or substance use indicate a need for intervention.[26]
- **Evaluation of Suicide Threats or Ideation – Do not ignore statements about suicide, even if they seem casual or fake.** The months following a suicide attempt or severe depression are 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. [26]
- **Transition of Treatment** – The transition from inpatient to outpatient behavioral health care is a critical time for patients with a history of suicide risk. Youth discharged from an inpatient care setting are at increased risk for suicide following hospitalization. [26]
- **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 more difficult it is for children to put their hands on these items, the more time they have to rethink their intentions, or to allow someone to intervene.[26]
- **Talk About the Issue –** Discussing concerns about suicide does not introduce the idea of suicide for children, but rather gives them the opportunity to share their thoughts and concerns. This communication can be a significant deterrent.
- **Monitor Difficult Situations –** A child's response to parental separation, a relationship breakup, or a peer suicide may include signs or symptoms of depression or hopelessness. Counseling and support to address depression or situational difficulties is imperative.
- **Don't Keep Suicide a Secret –** If a friend or a loved one is considering suicide, promising to keep it a secret delays help and puts a life at risk. Young people should be counseled to tell a friend that help is available. Education about sharing concerns, and how to reach out to a trusted adult, school counselor, or a suicide prevention hotline must be in the hands of all youth.
- **Resources for Youth-** Kansas – A Friend AsKS is a free youth suicide prevention app that can connect users to 988, the national suicide and crisis lifeline. When calls, texts or chats are received by trained crisis counselors at 988 call centers, callers are supported and directed to local mental health services.

CASE VIGNETTE
Youth Death due to Suicide

Reported concerns or attempts of suicide should be taken seriously - Following an argument with parents, a teen broke into the family's safe and recovered a handgun to take their life. The parents were unaware that the safe could be accessed and because the argument was relatively minor, felt the suicide was completely unexpected. In the law enforcement interview with a sibling, it was learned that the youth had shared thoughts of taking their life. The information had not been shared with the parents or other support person. The youth left behind a suicide note.

Board Reflection – In many youth suicides, it is learned after the fact that the youth was considering suicide and had shared those thoughts with a close friend or family member. When a youth is considering suicide, even what seems to be an insignificant trigger can end in a fatality when coupled with access to lethal means.

In August of 2023, SCDRB staff attended the Kansas Legislature's Special Committee on Mental Health where data surrounding youth suicide and mental health concerns were shared. Members of the legislature questioned "why" youth were taking their lives, and inquired if the content of the suicide notes left behind could shed light on areas for prevention.

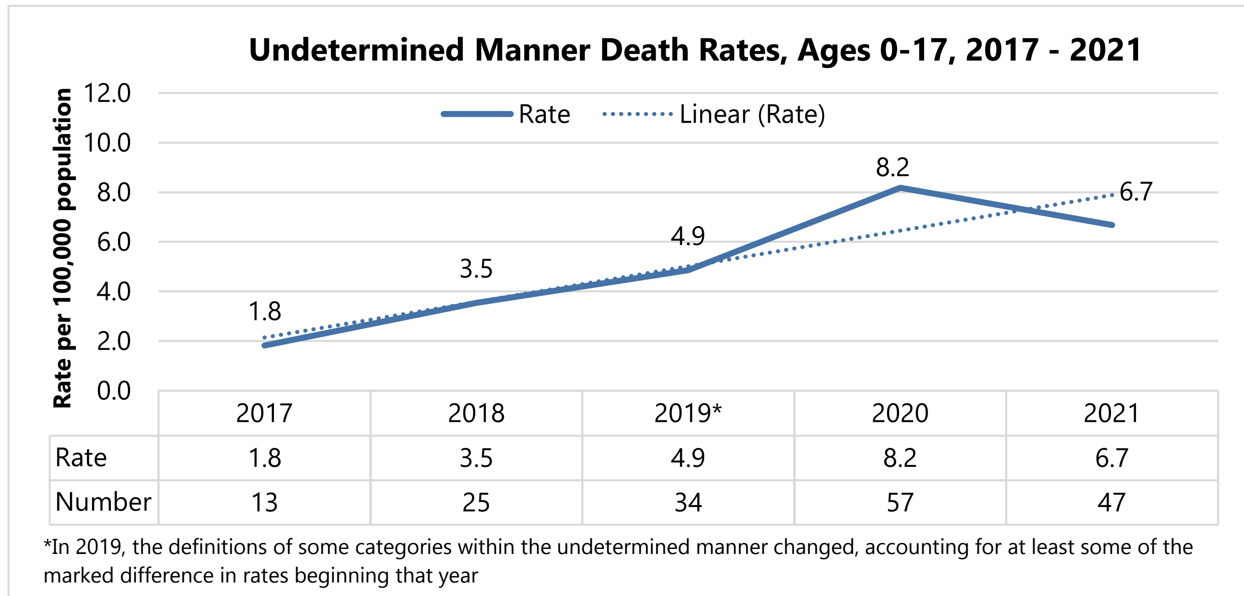
As the SCDRB is the only entity in Kansas that reviews all youth suicides, we find that there are rare occasions when a note might provide specifics of the "why" that led that particular youth to end their life. Overwhelmingly, the Board finds that the suicide notes share such things as the burden the youth felt they were to others, how they felt the world would be better without them, and how they love those around them and hope they will not miss them when they are gone. There is not a singular answer to "why" a youth ends their life. What has been learned from these letters is that youth need to know they are loved despite any shortcomings, and they are of value to someone. Youth need to hear a message that there is help for whatever challenges or problems they are facing.

UNDETERMINED DEATHS

Undetermined deaths are those in which the manner of death could not be identified from the evidence collected. When there are multiple circumstances that may have contributed to the child's death or no identifiable cause is established, the Board will classify the death as undetermined.

Figure 68 shows Undetermined Manner death rates for the last 5 years of case reviews. The increase in cases classified as undetermined since 2019 is mainly due to reclassifications in sleep-related deaths, which are now being classified Undetermined–SUID instead of Natural-SIDS. In 2021, there were 47 undetermined deaths. Of those 47 deaths, 42 were Sleep-Related Sudden Unexpected Infant Death (SUID) and are included in the Sleep-Related, SUID Deaths Section.

Figure 68

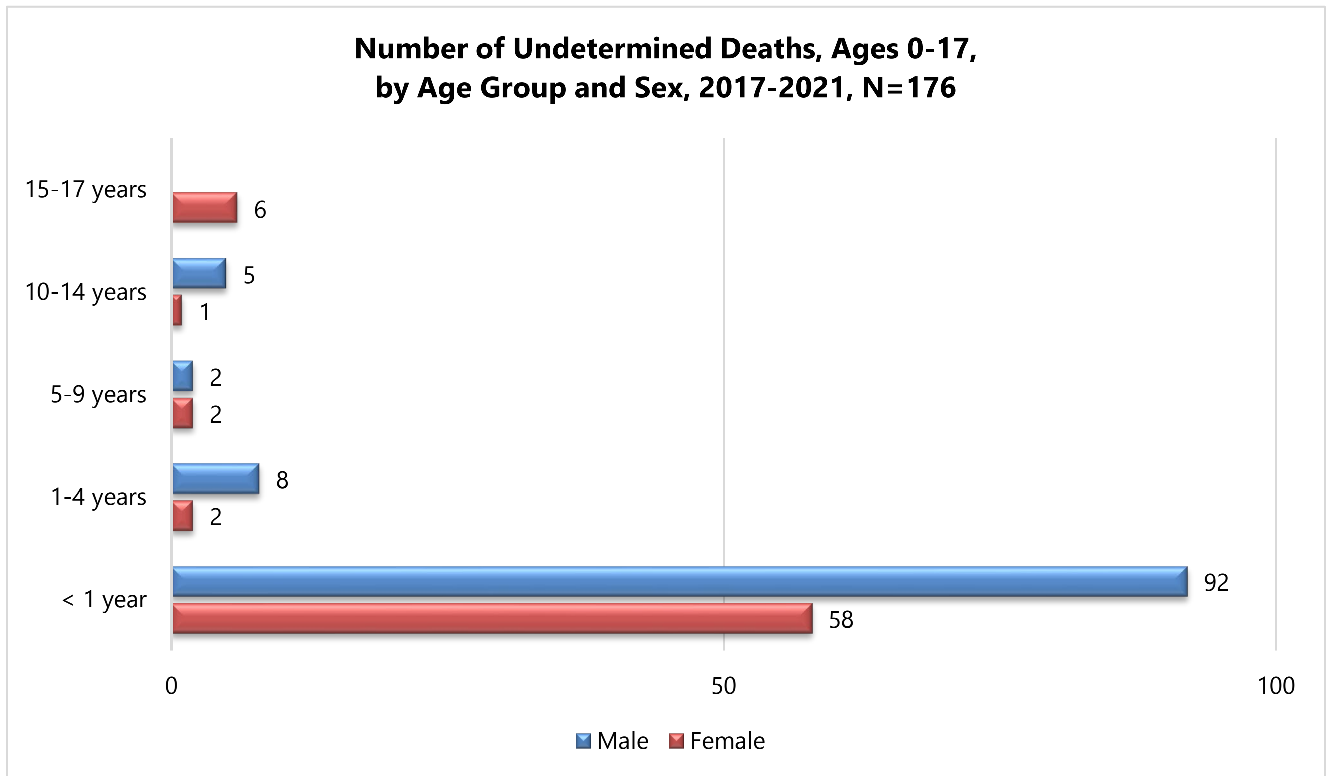


	2017	2018	2019*	2020	2021
Rate	1.8	3.5	4.9	8.2	6.7
Number	13	25	34	57	47

*In 2019, the definitions of some categories within the undetermined manner changed, accounting for at least some of the marked difference in rates beginning that year

Figure 69 displays the breakdown of undetermined deaths by age group and sex. Of the 176 deaths with undetermined manner, males represented 60% for all ages, and infants (age <1) represented 85% of all deaths age 0-17.

Figure 69



The rate of undetermined deaths for all race/ethnicity groups in Kansas between 2017 and 2021 was 4.9 deaths per 100,000 population. Black/Non-Hispanic children showed the largest rate of death for this category with a rate of 14.4 deaths (Figure 70).

Figure 70

Rate of Death, Undetermined Manner, by Population Group, Age 0-17, 2017-2021							
	Kansas Rate All Races	White/ Non-Hispanic	Black/Non-Hispanic	American Indian/Non-Hispanic	Asian/ Non-Hispanic	Multiple Race/ Non-Hispanic	Hispanic-Any Race
2017-2021	4.9	3.4	14.4	*	*	12.7	5.8
*Denotes suppressed rates of death due to value of 9 or less							

Historically, investigations in Undetermined Manner cases have 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 had incomplete investigations, or law enforcement agencies were not informed of the death. In some, autopsies were not ordered or were incomplete, or toxicology testing on the victim was not performed even though the circumstances warranted testing.

In 2021, all but two autopsies performed on cases within the undetermined category met basic standards. All non-natural child deaths should be exhaustively investigated. The circumstances and family situation should not affect the detail of the inquiry. Hospitals must 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 a life-threatening event of unknown etiology that is likely to be fatal.

CASE VIGNETTE
Infant Death Due to Undetermined Manner

Every case requires a thorough and coordinated investigation – An infant was placed to sleep on an unsafe sleep surface. When the caregiver awoke, the infant was found to be unresponsive and later pronounced deceased. The investigation completed by law enforcement was minimal and lacked information regarding the circumstances of the death including the sleep position. In addition, the autopsy was not performed in accordance with guidelines, as the cranial vault was not examined, the body was not weighed, and toxicology and imaging were not performed. Due to the inadequate information available for the Board to review, this case was finalized as a Sudden Unexpected Infant Death-Incomplete Case information.

Board Reflection – Use of the CDC Sudden Unexpected Infant Death Investigation Reporting Form (SUIDIRF) would aid law enforcement in obtaining appropriate and thorough information in the investigation of infant deaths. The Board recommends using this in all infant death investigations. Autopsies should be conducted in accordance with guidelines and by pathologists with training and experience in child deaths. Additional information regarding Autopsy Guidelines can be found on page 85.

CHARACTERISTICS OF UNDETERMINED MANNER OF DEATH 2017-2021

- Rates of undetermined manner of death have increased over the last five reporting years
- Infants represent 85% of the deaths age 0-17 with an undetermined manner of death
- Males represent 60% of these deaths
- 45 of the 47 undetermined deaths had a complete autopsy that met guidelines
- Undetermined manner of death is three times higher in the Non-Hispanic Black and Multiple Race child populations than in the White/Non-Hispanic child population

DEATHS IN NON-RELATIVE CHILD CARE HOMES AND CENTERS

Since many infants and children spend a significant portion of their time in child care 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 child care providers.

Many Sudden Unexpected Infant Deaths (SUID) have been associated with the child being prone, especially when the infant is accustomed to sleeping on his or her back. Babysitters and family members who provide periodic care for infants may not be aware of the importance of supine sleeping and other safe sleeping arrangements. In licensed child care settings, it is expected that safe sleep environments and sleep position recommendations be followed. When child care homes are found to be operating without a license, enforcement of the law and penalties should be considered. For general information regarding the basis and purpose of child care licensing, please visit: https://www.kdhe.ks.gov/374/Child-Care-Facility-Requirements.

In the last 5 years (2017-2021), there have been 17 deaths of children that occurred while child was in a non-relative child care home or center (Figure 71)

Figure 71

Type of Child Care Setting for Deaths Age 0-17, 2017-2021 N=17	
	Number of Deaths
Unlicensed	12
Licensed	4
Licensed- In violation of license	1

As discussed in the Legislative Priority Section of this report, the Board has found instances of children dying in the care of unlicensed child care providers or providers that are not in compliance with their license requirements. K.S.A. 65-501 requires persons maintaining a child care facility for children under 16 be licensed. If someone is found to be out of compliance after remedial measures have been attempted, the current Kansas statute authorizes the person to be prosecuted by the County Attorney for an unclassified misdemeanor. If the provider is found guilty, the current penalty is between $5 and $50 each day they are out of compliance. Through enhanced monitoring, enforcement, higher fines and increased prosecution, the Board hopes that the quality of child care available to Kansas children will be improved.

CHARACTERISTICS OF DEATHS IN NON- RELATIVE CHILD CARE HOMES AND CENTERS 2017-2021, N=17

- 82% (14) were infants under the age of 1
- 71% (12) of the deaths occurred when the infant or child was sleeping
  - 10 of the 12 sleep-related deaths occurred in an unlicensed child-care location; all had one or more factors for unsafe sleep
  - One death occurred in a licensed child-care location that was in violation of license requirements and had one or more unsafe sleep factors present
  - One death occurred in a licensed child care location in which no unsafe sleep factors were present
- 29% (5) were not sleep-related
  - Of the 5 deaths that were not sleep-related, three were children ages 1-4 and two were infants
  - 3 of the 5 deaths were due to natural causes
  - The remaining two deaths were unintentional injury deaths due to asphyxia

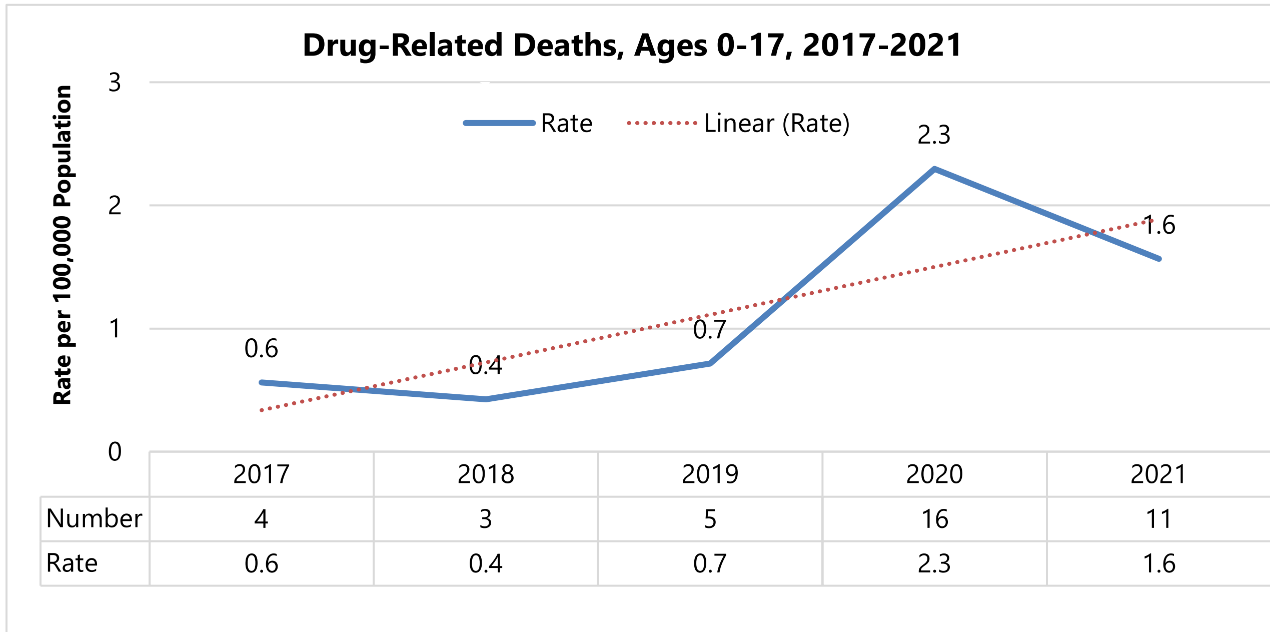
PREVENTION POINTS FOR PARENTS WHEN SELECTING CHILD CARE HOMES AND CENTERS

- **Child care homes and centers must be licensed by KDHE**. Parents should ask to see the license or certificate as it documents the license type and maximum number of children allowed to be enrolled in that home or center.
- **Check compliance history-** The compliance history of a child care 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://www.kdhe.ks.gov/280/Child-Care-Licensing.
- **Safe sleep practice -** Child care providers should develop a safe sleep practice that is discussed with parents. Child care providers and parents should communicate frequently to assure they understand safe sleep and that these practices are followed at home and in child care. Safe sleep recommendations are listed with the Sleep-Related Deaths prevention points.

DRUG-RELATED DEATHS- ALL MANNERS

In 2021, Kansas experienced 11 drug-related deaths in children ages 0-17. Drug-related deaths are classified as such when the decedent's death was due to an overdose of illicit substances, prescription or over the counter medications. Figure 72 indicates that the rate of drug-related deaths per 100,000 population has shown a significant increase in the last two reported years.

Figure 72



	2017	2018	2019	2020	2021
Number	4	3	5	16	11
Rate	0.6	0.4	0.7	2.3	1.6

Of the drug-related deaths occurring between 2017 and 2021, a majority (54%) are unintentional in nature. Of the 7 deaths that were of Undetermined manner, the board had inadequate information for a determination, or despite thorough investigation, the source or intent of the ingestion could not be determined (Figure 73).

Figure 73

Drug-Related Deaths, by Manner of Death, 2017-2021	
Manner of Death	2017-2021 Deaths
Accident	21
Undetermined	7
Suicide	9
Homicide	2
Total	**39**

Teens aged 15-17 represented 69% of the drug-related deaths, and males accounted for 59% (Figure 74).

Figure 74

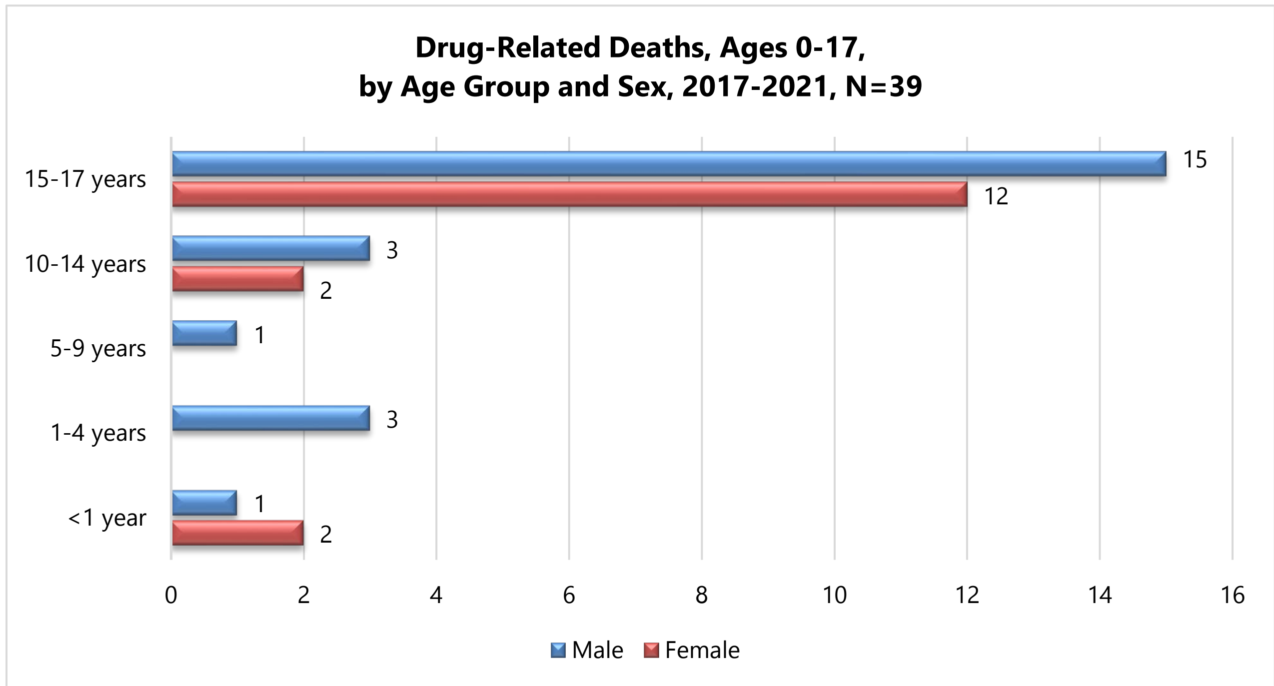


Figure 75 shows the types of substances involved in drug-related deaths during the years of 2017-2021. A majority (26) involved illicit drug use with 22 ingesting only an illicit substance and four using a combination of illicit substances, prescription and/or over-the-counter medications.

Figure 75

Number of Drug Deaths by Drug Class, 2017-2021, N=39	
Illicit Drugs	22
Prescription Medication	12
Combination of Illicit, Prescription and or Over the Counter Medication	4
Over the counter	1

Figure 76 shows the number of deaths due to the most common substances detected during the same period. Ethanol is classified as an illicit drug for the purposes of this report as alcohol is illegal for persons younger than 21 years of age to consume. There were 11 fentanyl deaths in 2020 and another 9 in 2021. This is compared to no fentanyl deaths from 2017-2019.

From a national standpoint, the CDC reported nearly 500,000 people of all ages died from overdoses involving both illicit and prescribed use of opioids from 1999-2019.[27] In recent years, both nationally and in Kansas, the data has shown an increase in the use of synthetic opioids like fentanyl. While fentanyl is a prescription drug, it is also manufactured illegally. Compared to morphine, fentanyl is 50 to 100 times more powerful, making even a small amount deadly. Fentanyl is frequently incorporated into illicitly manufactured pressed pills and mixed with other substances without the knowledge of the end user.[28]

The Drug Enforcement Administration (DEA) added a public safety alert, warning Americans of the increase in the lethality and availability of fake prescription pills containing fentanyl. The public safety alert coincides with the launch of the DEA's "One Pill Can Kill" public campaign to educate people of the dangers of counterfeit pills.[32] More information about this campaign can be found at https://www.dea.gov/onepill/social-media.

Figure 76

Drug-Related Deaths*	2017	2018	2019	2020	2021
Illicit Drug Deaths	**1**	**1**	**3**	**13**	**9**
Fentanyl	0	0	0	11	9
Methamphetamine	0	0	3	1	1
Cocaine	0	1	0	1	1
Flubromazolam	0	0	0	3	0
Ethanol	1	0	0	1	0
Prescription Drug Deaths	**4**	**1**	**2**	**6**	**2**
Methadone	1	0	1	0	0
Oxycodone	2	1	0	2	0
OTC Drug Deaths	**0**	**2**	**0**	**0**	**0**
Diphenhydramine	0	2	0	0	0
*Cases may be counted more than once, depending on the number of drugs detected.					

Figure 77 describes drug-related deaths by the child's resident county, highlighting counties with populations of children greater than 100,000 in the five-year period. Resident status of the five most populous counties accounted for 71% (27) of the drug-related deaths in Kansas. Of note, there was one drug-related death during this period that was not a Kansas resident, which is excluded from this chart only. The Board is encouraged by ongoing local efforts to identify specific risk factors within these communities.

Figure 77

Resident Rate of Drug-Related Deaths, Age 0-17, by Counties with Population > 100,000, 2017-2021 N=38			
	Combined Population Age 0-17, 2017-2021	Total Drug-Related Deaths by Resident County of Decedent	Total Rate of Drug-Related Deaths
Douglas	109,812	1	0.9
Shawnee	208,049	2	1.0
Wyandotte	229,603	9	3.9
Sedgwick	659,697	10	1.5
Johnson	725,919	5	0.7
All Kansas Counties Excluding Those Listed Above	1,933,080	11	0.6

VIGNETTE
Drug-Related Teen Death

Children and teens should be warned of the dangers of fentanyl which can be disguised in other substances. – A teen was discovered unresponsive the morning following a night out with a friend. Reports indicate the teen had obtained and taken a pill which they believed to be a prescription pain pill that was safe. The teen died from a fentanyl overdose.

Board Reflection – Fentanyl is increasingly being incorporated into illicitly manufactured drugs. This is most often done without the knowledge of the end user. Because fentanyl is highly lethal, many children and teens who died in Kansas due to drug overdoses most likely were unaware that the substance they were taking contained fentanyl. Parents and caregivers need to ensure that youth are aware that any medication that is not prescribed by a doctor is not safe to take.

CHARACTERISTICS OF DRUG-RELATED DEATHS 2017-2021, N=39

- Death rates have shown a significant increase in the past two years
- Resident status of the five most populous counties accounted for 71% (27) of the drug-related deaths in Kansas
- There were 20 times more deaths from Fentanyl in 2020 and 2021 then there were in the three years prior combined
- Teens aged 15-17 represented 69% of the drug-related deaths, and males accounted for 59%

DRUG-RELATED DEATH PREVENTION POINTS

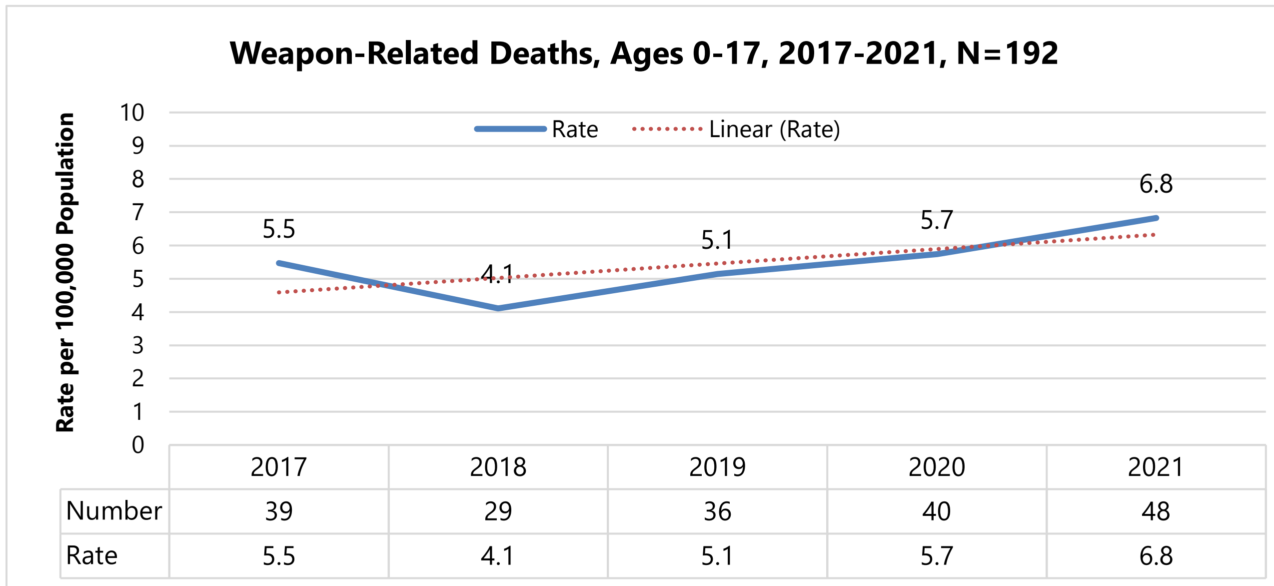
Young people are at high risk of substance use and overdose. These steps may help prevent teens from using alcohol and illicit substances, and from abusing prescription medications.

- **Discuss the dangers and rules of taking medications.** Medications are prescribed by physicians 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 only take medications that are prescribed for them, never share medications with another person, and not combine medications unless instructed to by a physician.[28]
- **Consider alternatives to narcotic use.** Many people believe opioids work best for pain, but recent studies show that non-opioid medicines such as ibuprofen and naproxen, as well as other non-medical approaches can be just as effective. Discuss alternatives to opioids with a physician. [28]
- **Positive parental involvement in children's lives.** Positive relationships between parents and adolescents can serve as a protective factor, offsetting the risk of substance use. Youth and teens need parental involvement, and their activities and social media use should be monitored. [28]
- **Prescription medications should not be accessible to children.** Quantities of medications should be tracked and all medications kept in a locked cabinet. [28]
- **Discuss the dangers of alcohol use.** Underage use of alcohol, and the use of alcohol with medications can increase the risk of accidental overdose.
- **The ability to order substances online is a risk factor for teens to obtain and use them inappropriately.** Some websites sell counterfeit and dangerous drugs and chemicals. Internet use should be monitored, and caregivers should assure teens are not accessing drugs through friends or outside sources.[28]
- **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.
- **No street drug can be trusted to be what the seller says it is.** Any drug obtained illegally can contain any number of ingredients in unknown doses that could be fatal. The crisis caused by fentanyl being added to "oxycodone" tablets and marijuana laced with fentanyl, has resulted in a devastating number of deaths. To address this issue, SB 174 which decriminalizes Fentanyl test strips, was signed into law in early 2023.

WEAPON-RELATED DEATHS- ALL MANNERS

Between 2017 and 2021, Kansas experienced 192 weapon-related deaths in children aged 0-17. Weapons, as defined for Board review, include firearms, knives, or other objects, including body parts. Figure 78 indicates a steady increase in the rate of weapon-related deaths over the last five years, with 6.8 deaths per 100,000 population in 2021.

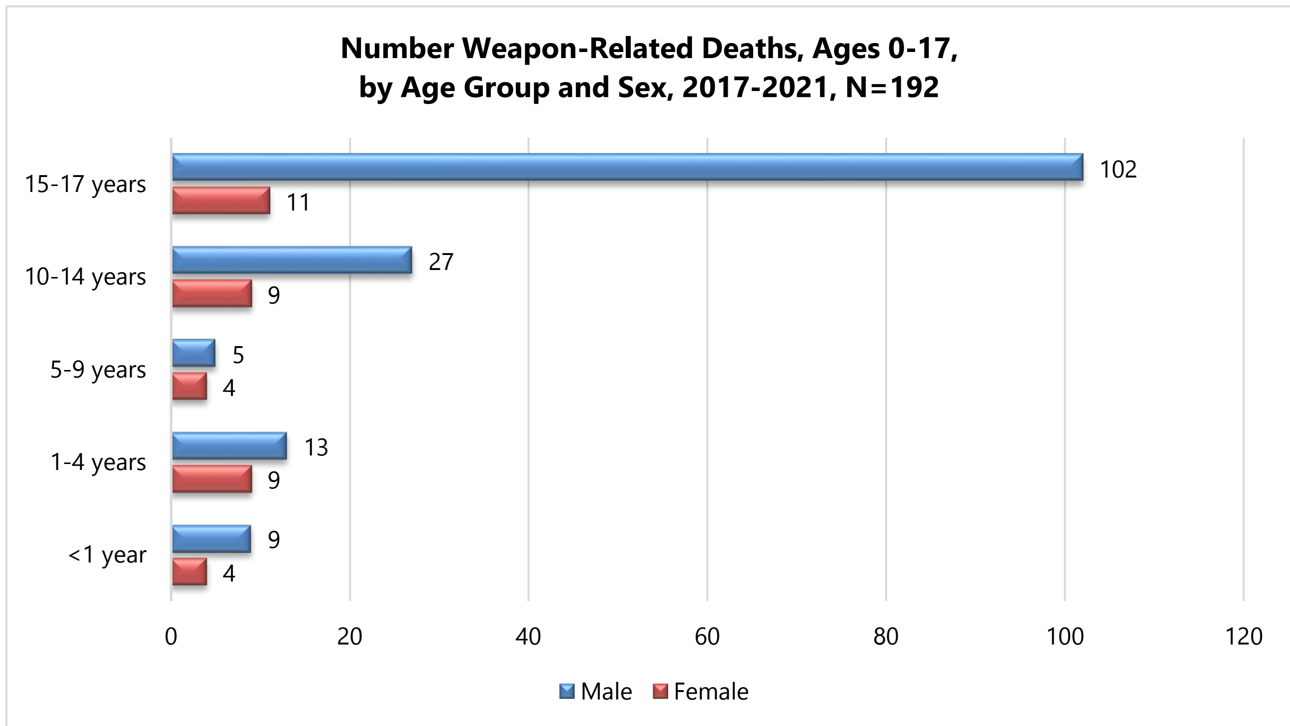
Figure 78



	2017	2018	2019	2020	2021
Number	39	29	36	40	48
Rate	5.5	4.1	5.1	5.7	6.8

Of the 192 weapon-related deaths from 2017-2021, 81% (155) were male and 19% (37) were female with a majority (58%) of the deaths occurring in the 15–17-year age group (Figure 79).

Figure 79



In Kansas, firearm deaths represented 78% (151) of all weapon-related deaths in the last 5 reporting years (Figure 80). Due to the large number of firearm fatalities, they are discussed in the Firearm Deaths section of the report.

Figure 80

Weapon-Related Deaths by Weapon Used and Manner of Death, 2017-2021, N=192					
Weapon Used	Total Number	Homicide	Suicide	Accident	Undetermined
Firearm	151	65	75	8	3
Bodily Force	32	31	0	1	0
Knife, Sharp Object	1	1	0	0	0
Other	8	6	0	2	0
Total	**192**	**103**	**75**	**11**	**3**

CHARACTERISTICS OF WEAPON- RELATED DEATHS 2017-2021, N=192

- The rate of firearm deaths in Kansas has nearly doubled over the last five reporting years
- 80% of all weapon-related deaths were male
- 58% of all weapon-related deaths were age 15-17
- 50% were suicides, 43% were homicides, and 5% were unintentional injuries
- 31 of the 32 bodily force deaths were homicides
    - 30 of the 31 bodily force homicides were child abuse homicides
- 60% of all firearm deaths occurred in Shawnee, Wyandotte, Johnson, Sedgwick, or Douglas County

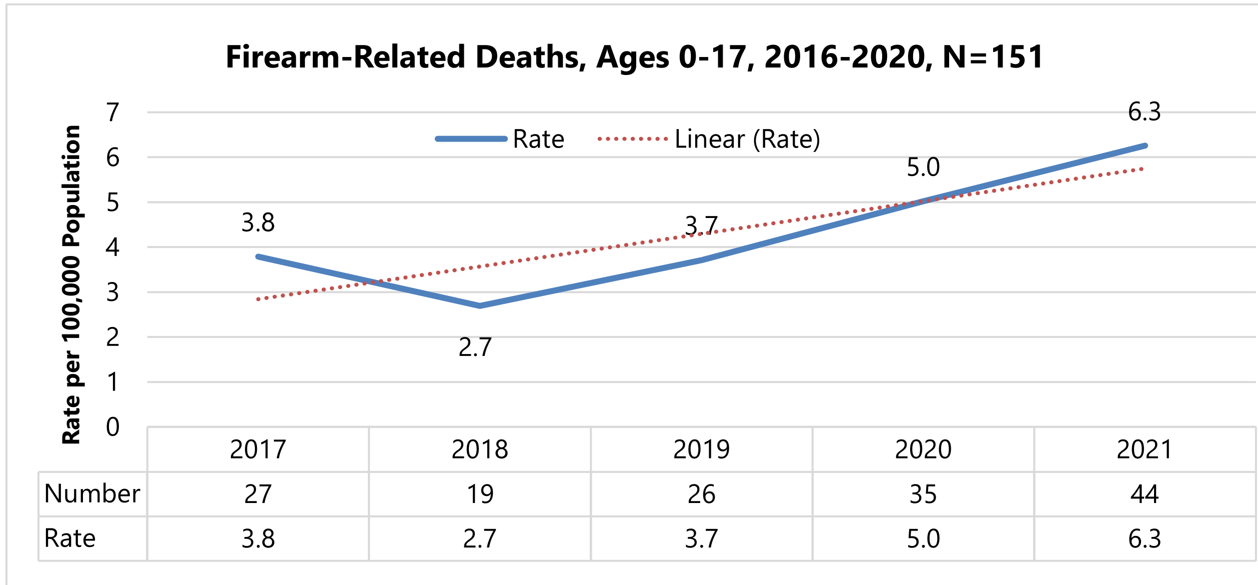
WEAPON RELATED DEATHS PREVENTION POINTS

- Keep guns out of reach and out of sight of children by storing them securely. This means storing them unloaded, locked, and separate from ammunition. Leaving guns unsecured or in a place where a child could gain access can lead to injury or death.
- Teach children that if they see or find a gun to immediately tell an adult. Urge them not to touch it.
- If a youth or member of the household is in crisis and could be a risk to themselves or to others, consider removing firearms from the home. Such crises can involve people who are depressed, suicidal, or who are abusing drugs or alcohol.

FIREARM DEATHS

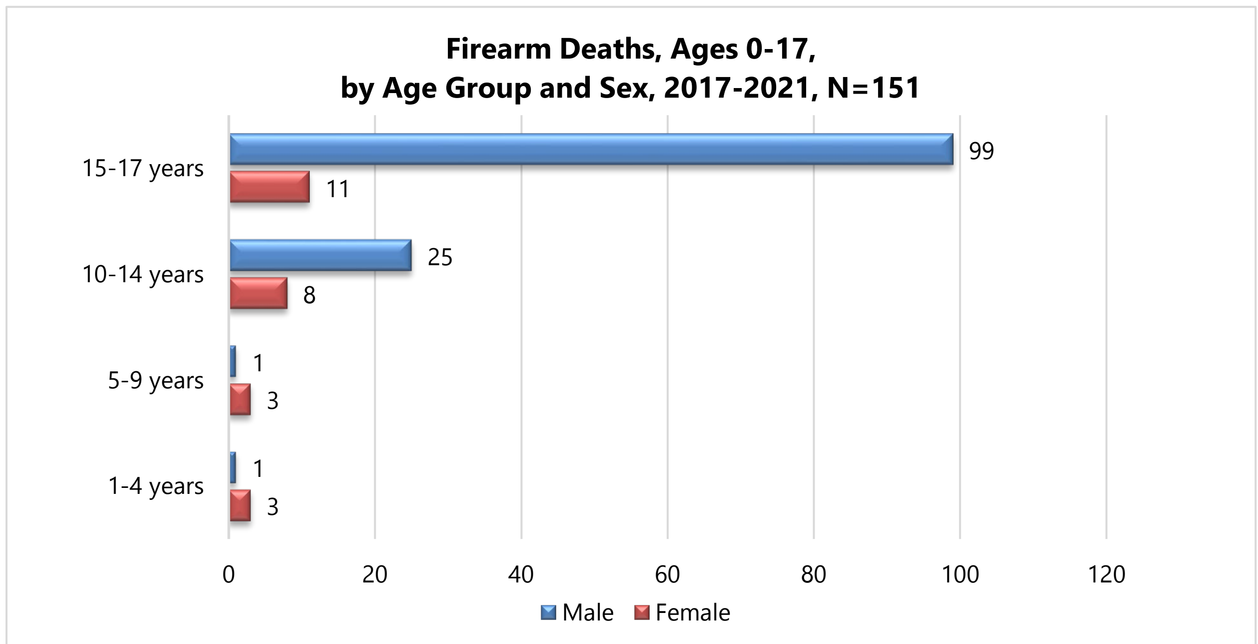
From 2011 through 2020, the U.S averaged 1,585 firearm deaths a year in children ages 0-17.[33] The rate of firearm deaths in Kansas has nearly doubled over the last five reporting years. In 2021 more children died by firearms than in Motor Vehicle Crashes. Firearm deaths in children reached 6.3 deaths per 100,000 population according to Figure 81.

Figure 81



	2017	2018	2019	2020	2021
Number	27	19	26	35	44
Rate	3.8	2.7	3.7	5.0	6.3

Figure 82



Of the 151 firearm deaths from 2017-2021, 83% (126) were male and 16% (25) were female with a majority (72%) of the deaths occurring in the 15-17 year age group. (Figure 82)

Fatal firearm injuries can include Homicides, Suicides, or Unintentional Injury (Accident) deaths which could occur if a child is playing with a firearm, or someone discharges a firearm without evidence of intentional harm. There are also circumstances in which firearm deaths are the result of interpersonal violence such as domestic violence, or legal intervention by law enforcement. Other times the intent of the firearm use cannot be determined (Undetermined Manner) because despite investigation, it remains unknown if the injury was intentionally self-inflicted, unintentional, or an act of interpersonal violence.

Of the 151 firearm deaths reviewed over the last five years, the manners of death were as follows; 65 Homicide, 75 Suicide, eight Accident, and three Undetermined (Figure 83).

Figure 83 shows resident and non-resident numbers of deaths by manner of death.

Figure 83

Firearm-Related Deaths, by Manner of Death, 2017-2021 N=151	
Manner of Death	2017-2021 Deaths
Accident	8
Undetermined	3
Suicide	75
Homicide	65
Total	**151**

In Kansas, the rate of firearm deaths, as a group, are most prevalent in counties with populations over 100,000. As demonstrated in Figure 84, between 2017 and 2021, firearm deaths of residents in the five counties below accounted for 60% of the firearm-related deaths in the state. Not included in Figure 84 are the five out of state residents who died from firearm injuries in Kansas.

Figure 84

Rate of Firearm- Related Deaths, Age 0-17, by Counties with Population greater than 100,000 2017-2021 N=146 with only resident of Kansas deaths included											
County	Population Age 0-17, 2017-2021	Total Firearm Related Deaths	Suicide Firearm	Homicide Firearm	Unintentional Injury Firearm	Undetermined Manner Firearm	Rate of Suicide Firearm	Rate of Homicide Firearm	Rate of Unintentional Injury Firearm	Rate of Undetermined Manner Firearm	Total Rate of Firearm Related Deaths
Douglas	109,812	2	-	-	2	-	-	-	1.8	-	1.8
Shawnee	208,049	13	5	6	2	-	2.4	2.9	1.0	-	6.2
Wyandotte	229,603	21	2	18	1	-	0.9	7.8	0.4	-	9.1
Sedgwick	659,697	34	12	20	-	2	1.8	3.0	-	0.3	5.2
Johnson	725,919	17	11	6	-	-	1.5	0.8	-	-	2.3
All other KS counties combined	1,933,080	59	44	11	3	1	2.3	0.6	0.2	0.1	3.0

The Board is encouraged by ongoing local efforts in several of these locations to identify specific risk factors within these communities. Addressing issues related to firearm deaths is a county-by-county initiative. Given the unique characteristics of these communities, as well as the plethora of available research related to firearm deaths of children, the Board will continue to evaluate additional data to determine if more specific recommendations can be made in the future.

AUTOPSY EXAMINATIONS- ALL MANNERS OF DEATH

In total, for all manners of death, there were five child deaths in 2021 for which the Kansas coroner or pathologist either did not order or complete an autopsy when the Board felt one was warranted by the circumstances, or did not meet the minimum expectations for the autopsy components. All natural child deaths should proceed to autopsy, unless the child has a known terminal condition, or the death was not unexpected due to a known chronic debilitating condition.

Child Autopsy Guidelines established by the SCDRB indicate that in addition to a thorough investigation, the standards for an autopsy as it relates to an unexplained child death 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 or findings.
- Examination of all clothing and items accompanying the body, preserving all materials for later examination by a crime lab.
- Documentation of evidence of therapy and resuscitation.
- Radiographs for a complete survey of the skeletal structures, especially in children less than two 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 use as an adjunct to toxicology or if metabolic or hydration status could be a concern.
- 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, or if otherwise indicated by gross findings, 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 less than two 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.

Child Autopsy Guidelines created by the Board can be found at: https://ag.ks.gov/scdrb.

Combined with thorough 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. Kansas is in need of improvements in the coroner system to include standards for medicolegal death investigation, procedures, and appropriate filing of causes of deaths. Reimbursement opportunities are available for child autopsies through the District Coroner's fund managed by KDHE. More information is available at the SCDRB's website: https://ag.ks.gov/scdrb.

There were five Kansas cases in 2021 where the Board determined that an autopsy either should have been conducted, or was not properly conducted; those five cases are noted by the judicial district that held jurisdiction of the death in Figure 85. As noted above, the Board has established protocols and guidelines for child autopsies.

Kansas Counties by Judicial District

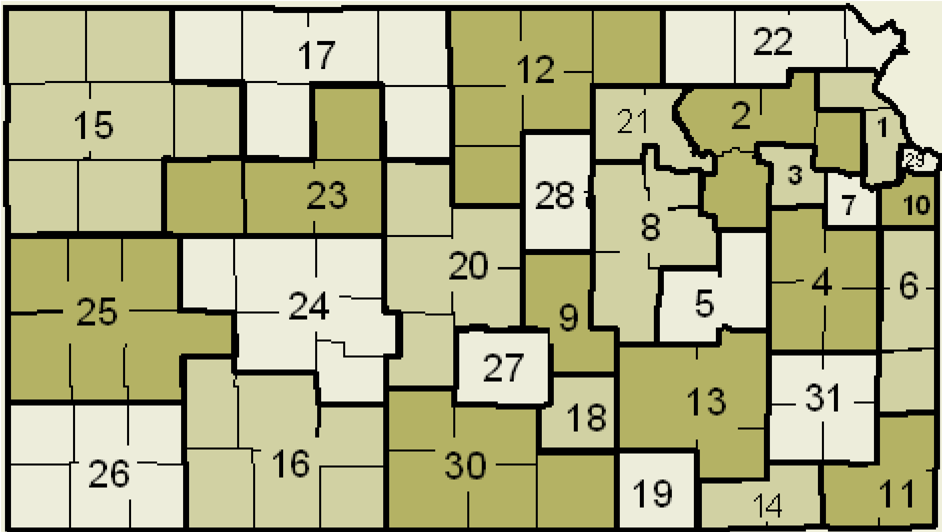


Figure 85

District	Counties in District	# of child deaths not autopsied, despite guidelines		# of child deaths incompletely autopsied, despite guidelines	
		2017-2020	2021	2017-2020	2021
District 8	Dickinson, Geary, Marion, Morris	0	0	1	0
District 10	Johnson	0	0	1	0
District 12	Cloud, Jewell, Lincoln, Mitchell, Republic, Washington	4	0	0	0
District 13	Butler, Elk, Greenwood	1	1	1	0
District 15	Cheyenne, Logan, Rawlins, Sheridan, Sherman, Thomas, Wallace	1	0	2	0
District 16	Clark, Comanche, Ford, Gray, Kiowa, Meade	7	0	0	0
District 17	Decatur, Graham, Norton, Osborne, Phillips, Smith	1	0	0	1
District 18	Sedgwick	1	0	1	0
District 19	Cowley	2	0	0	0
District 20	Barton, Ellsworth, Rice, Russell, Stafford	2	0	2	1
District 21	Riley, Clay	0	1	0	1
District 23	Ellis, Gove, Rooks, Trego	0	0	3	0
District 25	Finney, Greeley, Hamilton, Kearny, Scott, Wichita	2	0	0	0
District 27	Reno	1	0	0	0
District 29	Wyandotte	1	0	1	0
District 30	Barber, Harper, Kingman, Pratt, Sumner	2	0	0	0

PUBLIC POLICY RECOMMENDATIONS

The Board strongly encourages consideration of each of the following policy recommendations to prevent child deaths in Kansas.

RECOMMENDATIONS TO PREVENT CHILD ABUSE AND NEGLECT DEATHS

INCREASE ACCESS TO AFFORDABLE, HIGH-QUALITY CHILD CARE

KDHE and DCF should continue working towards ensuring families have access to high quality and affordable child care. Children, and particularly young children, should be cared for by persons who are experienced and have reasonable expectations for children and their behaviors. Access to affordable, high-quality child care is associated with reduced parental stress and maternal depression, both of which are also risk factors for child abuse and neglect.

INCREASE FAMILY FRIENDLY WORKPLACES IN KANSAS

The Kansas Power of the Positive (KPoP) is a statewide coalition working to assure that all Kansas children grow up in safe, stable, nurturing relationships and environments. Their efforts to promote family friendly workplaces to support Kansas parents is a valuable and critical component of their work, and should receive continued support at the state level. Efforts to ensure that more Kansas families are employed at places that offer flexible work schedules, paid parental leave, child care, breastfeeding support, and livable wages support families in a way that can reduce risk factors for child physical abuse and neglect.[29]

ADOPT AND CONSISTENTLY FOLLOW A BEST-PRACTICES APPROACH IN THE INVESTIGATION OF ALL ALLEGATIONS OF ABUSE AND NEGLECT

The Board was encouraged by House Sub. For SB 126 (2017) which directed the Secretary for Children and Families to establish a Child Welfare System Task Force to study the child welfare system in Kansas. The Child Welfare System Task Force proposed several recommendations in their report to the 2019 Kansas Legislature, which align with recommendations proposed by the SCDRB over the last several reporting years. Information regarding The Child Welfare System Task Force and their report can be found at: http://www.dcf.ks.gov/Agency/CWSTF/Pages/default.aspx

While the Board acknowledges the financial limitations faced by all agencies and branches of government, until appropriate resources are available to provide a thorough, consistent and adequate investigation of all allegations of abuse and neglect, Kansas children will continue to be at risk. The deaths of several children in recent years have been widely reported in the media due to concerns about DCF actions or inactions; those deaths are not isolated examples. It is a continuing concern of the Board that all investigations of abuse and neglect be thorough and fact based, and that any confidentiality restrictions placed on DCF that prevent them from investigating collateral sources be removed. Additionally, K.S.A. 38-2226 requires a joint investigation between law enforcement and DCF in cases of serious physical harm to or sexual abuse of a child. It is important that both the law enforcement and social work perspective are present in all such investigations.

DCF and law enforcement should review and adopt a best practice approach for the investigation of all allegations of abuse and neglect. Once adopted, training should be conducted with all employees to ensure they understand the scope and extent of investigation necessary in all allegations of abuse and neglect. Those standards for investigation should be carried out consistently among workers, law enforcement officers and among regions of the state. Caseloads must be manageable to ensure investigators have adequate time to investigate and follow up on allegations of abuse and neglect. Additionally, funding should be adequate to allow for the hiring of qualified, experienced investigators to perform those investigations.

All investigative information obtained should be evaluated in an objective manner. An uncorroborated denial by a parent, in and of itself, should never be grounds for unsubstantiating a claim of abuse or neglect when there is other credible evidence to support such a finding. DCF should also consider any other information collected through law enforcement investigations and any prior or related judicial proceedings in evaluating whether an adult should be substantiated for purposes of the child abuse registry. Workers who consistently fail to conduct adequate investigations should receive additional training to correct those deficiencies or have disciplinary action taken if necessary. Prior history and investigations should be reviewed before placement decisions are made. DCF and collaborative providers should also develop a reliable system to ensure they have all relevant and necessary information for children in their custody in order that the child’s health and well-being does not rely on the child or a relative to provide necessary information to DCF. A child’s safety should not be compromised because the case decision-maker did not have access to relevant information when making placement decisions.

The Board is encouraged by the implementation of the Kansas CARE Program, a grant which was awarded to Children’s Mercy Hospital (CMH) for FY22. The program was piloted in Johnson and Wyandotte Counties. The purpose is to ensure young children who may have been victims of physical abuse/neglect receive an expert medical assessment to aid in the determination of whether abuse has resulted in injury and/or if there are safety risks that require intervention. The goal of involving experts in child abuse pediatrics is to improve accurate assessments related to child maltreatment, improve the provision of targeted services to families and improve child safety outcomes. When DCF has assigned an investigation for a child under 6 years of age with allegations of physical abuse and/or physical neglect, the assigned specialist completes a medical referral form with basic information about the allegations, which is then reviewed by a child abuse pediatrician who provides recommendations regarding the need for medical evaluation or detailed case review. On 6/1/2023, the pilot program ended, and the Kansas CARE program was implemented statewide, with medical referrals assessed by child abuse pediatricians from CMH and KU Pediatrics-Wichita.

ENHANCE TRAINING AND ACCESS TO APPROPRIATE INFORMATION FOR CHILD WELFARE PROFESSIONALS

Kansas DCF should continue to develop and provide enhanced training for both their employees as well as employees of all contracted agencies. It is imperative that every employee of each agency charged with the investigation of abuse and neglect or assessing the continued risk of children under their supervision or custody have current, high quality training regarding child abuse and neglect as well as other topics related to safety assessment.

Through privatization of many components of the state child welfare system, additional issues have developed regarding the flow of information to all persons involved with decision-making for the

children and families being served. In reviewing DCF records in situations where children and their families were receiving services, it is apparent that workers who had frequent interaction with the families were unaware of additional information DCF had regarding a particular family. Each report should be looked at not as an individual incident, but with all available information reviewed in its entirety to look for repeated reports of similar behavior prior to developing case plans or making recommendations regarding a child.

Kansas DCF cannot address allegations and concerns of abuse or neglect without thorough historical and investigative information that is comprehensive and easily accessible. Medical histories and law enforcement investigative information about the child is critical for DCF assessments regarding the safety and well-being of a child. Medical providers who report suspicions of abuse or neglect must provide medical information and records appropriate to the case investigation.

IMPROVE REPORTING OF CHILD ABUSE AND NEGLECT

In Kansas, mandated reporters are required to report child abuse or neglect as directed by Kansas law (K.S.A. 38-2223). Concerned citizens who suspect child abuse or neglect are also encouraged to report concerns to DCF.

Public policy campaigns should be launched to educate all Kansans on when, how, and why they must report concerns of child abuse or neglect. Additionally, mandated reporters need continued trainings regarding reporting laws and the process to report concerns accurately, appropriately and in a timely manner. There are several instances each year where mandated reporters and concerned citizens had information that could have saved the life of a child had the information been reported prior to the death.

RECOMMENDATIONS TO PREVENT YOUTH SUICIDES

INCREASE ACCESSIBILITY TO CRISIS SERVICES AND MENTAL HEALTH SERVICES FOR YOUTH WITHIN KANSAS COMMUNITIES

Community Mental Health Centers should continue to increase outreach to raise awareness of available mental health services for children and youth, and to ensure parents, caregivers, educators, and other community members are aware of the resources in their community and the state.

The Board is pleased to recognize some steps taken to address the accessibility of crisis and mental health services for all Kansans. This past year the Special Committee on Mental Health recognized the need for additional beds and services for individuals who require inpatient care for mental health crisis treatment. Multiple recommendations were made and include opening a new state hospital, opening additional mental health locations in Sedgwick County, the review of Mental Health provider certifications and workforce protocol, hospital reimbursement pilot programs and the review and evaluation of mental health care provided through telehealth technology.[35]

INCREASE THE DEPTH OF SUICIDE INVESTIGATIONS

Law enforcement should increase the depth of suicide investigations to include social, mental health and medical histories of the child. Information regarding family stressors, history of past physical and

emotional trauma, previous suicide attempts, involvement in mental health services, and relevant social media information should be included. The Board recommends initiating a policy of standardized training for law enforcement and coroner investigators that includes the use of a protocol for suicide investigations and a suicide death scene investigation form to assist in collecting all pertinent information. By better understanding the contributing factors and precipitating events leading to youth suicide, Kansas will be better equipped to determine the best approaches to prevention.

ENSURE TRAINING OF EDUCATION PROFESSIONALS REGARDING THE PREVENTION, ASSESSMENT, AND INTERVENTION OF SUICIDE

All public school personnel must comply with required annual training that provides practical guidance and best practices on the proactive development and implementation of programs to assess risk of suicide and intervene effectively. Educators and school personnel are in a position to best identify at-risk children as well as support peers when a suicide occurs. This is particularly crucial as deaths due to suicide have increased and include more children of younger ages.

PROMOTE SAFE REPORTING AND MESSAGING ABOUT YOUTH SUICIDE

Through multiple coordination and communication efforts, the Youth Suicide Prevention Coordinator of Kansas should continue to engage with schools, communities and state agencies to promote **Kansas - A Friend AsKS,** a youth suicide prevention app, as well as **988**, the national suicide prevention lifeline. The familiarity with and use of these two resources among youth, and those that work with them, can effectively ensure that Kansas youth have a safe and effective way to report suicidal thoughts or intent for themselves or their peers.

RECOMMENDATIONS TO PREVENT MOTOR VEHICLE DEATHS

STRENGTHEN ALL-TERRAIN VEHICLE (ATV) USAGE LAWS

Citizens and lawmakers should support efforts to impose a minimum age requirement of 16 years to operate an ATV. Furthermore, requirements that both operators and passengers wear a helmet and be properly restrained should be explored.

ATV use in Kansas continues to increase, as does the risk for serious injury and death when operated by young children. According to the *2022 Report of Deaths and Injuries Involving Off-Highway Vehicles with More than Two Wheels,* published by the U.S. Consumer Product Safety Commission, there were 283 ATV-related fatalities of children under the age of 16 between January 1, 2017, and December 31, 2019. Almost half (47%) of all under-age-16 child fatalities occurred to children 12 and under.[14] The one ATV-related child death in 2021 is added to a total of 11 such deaths in the last 5 reporting years.

STRENGTHEN SEAT BELT USAGE

Citizens and lawmakers should support efforts in Kansas that aim to increase the use of seat belts and proper restraints by drivers and child passengers. Two considerations being requested are:

- Children from birth to two years of age must be secured in a rear-facing child passenger restraint system, which meets federal standards, in the rear vehicle seat until the child exceeds the height or weight limit allowed by the manufacturer of the child restraint being used.
- Children who are younger than 13 must be transported in the rear seat of the vehicle, when available.

Between 2017 and 2021, 46% of the children who died due to motor vehicle crashes were unrestrained. According to the State of Kansas Highway Safety Plan Federal Fiscal Year (FFY) 2023, "Children are much more likely to be buckled up if the driver is also belted. If the driver is belted, about 96.5% of the children in the vehicle are also belted. If the driver is not belted, only about 28% of the observed children were also belted."[30] 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. The Board is hopeful that additional legislation will help decrease the number of Kansas children who are unrestrained.

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. According to the State of Kansas Highway Safety Plan Federal Fiscal Year (FFY) 2023 "Distracted or inattentive driving is listed as a contributing circumstance for about 25% of all reported crashes in the state."[30] Furthermore, according to the State of Kansas Strategic Highway Safety Plan 2020-2024, between 2014-2018, the percentage of fatal and serious injury crashes involving distracted driving with teen drivers was 31%, as compared to all drivers being 27% for distracted or inattentive driving.[31] Ordinances, promotional materials, public service announcements and enforcement of current laws can all be effective ways to encourage Kansas drivers to avoid distractions while driving.

IMPROVE INVESTIGATIONS AND STRENGTHEN PENALTIES FOR PROVIDING ALCOHOL TO MINORS

Ten decedents were teen drivers under the influence of drugs and/or alcohol at the time of their crash (2017-2021). One of these fatalities occurred in 2021. Thorough investigations of social hosting, as well as increased penalties for providing alcohol to children and teens will help deter adults from providing alcohol to children and decrease alcohol-related motor vehicle crashes and deaths. The public should be aware of the dangers of teen drinking.

INCREASE PUBLIC AWARENESS REGARDING PEDESTRIAN DEATHS IN KANSAS

In 2021, Kansas experienced seven pedestrian deaths of children, two of which were backover deaths. According to KidsAndCars.org, at least 50 children are backed over every week in the United States because a driver did not see the child.[13] Public campaigns to encourage drivers to "look before you leave" should be promoted and drivers should be encouraged to walk completely around their vehicle and ensure children are secured prior to backing up their vehicle.

Other efforts that could reduce the number of pedestrian deaths in Kansas include education of children of all ages about the dangers of walking while distracted. According to the Safe Kids

Worldwide publication, *Alarming Dangers in School Zones,* published in October 2016, there are five teen pedestrian deaths every week in the United States.[34] Walking while distracted by technology, such as cell phones, earbuds, and headphones, increases the risk of pedestrian injury and should be avoided. Furthermore, reminders to children and youth to look both ways before crossing a road, and to avoid foot or bike travel at night could aid in preventing pedestrian deaths.

RECOMMENDATIONS TO PREVENT SLEEP-RELATED DEATHS

INCREASE EDUCATION ON SAFE SLEEP FOR PARENTS AND CAREGIVERS

Hospitals with obstetrical services in Kansas have adopted policies regarding safe sleep of infants while hospitalized, and education of all parents prior to discharge from the hospital. The board supports these policies and practices, and encourages hospitals to include statistics on sleep-related deaths and provide regular monitoring of practices and messaging in the hospitals to assure accuracy and consistency in supporting the ABCs of safe sleep: **A**lone on their **B**acks in a **C**rib.

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. Parents and caregivers should always comply with the ABCs of safe sleep at every sleep time and place. Enhanced education and provision of consistent messages about safe sleep is critical for primary care physicians, child care providers and at-risk populations in the state, including low-income and adolescent parents.

Required training for DCF investigators and support workers regarding safe sleep should be considered since home visits are an additional educational opportunity for at risk parents. The Board is encouraged that DCF continues to take steps to train workers in safe sleep practices. In fiscal year 2023, DCF held 15 safe sleep courses with the goal to have all DCF workers trained in safe sleep education.

INCREASE EDUCATION AND ENFORCEMENT OF SAFE SLEEP PRACTICES IN LICENSED CHILD CARE SETTINGS

While reviewing child fatalities each year, the Board has found instances of children dying in the care of unlicensed child care providers or providers that are not current on their license requirements. K.S.A. 65-501 requires persons maintaining a child care facility for children under 16 to be licensed. If someone is found to be out of compliance after remedial measures have been attempted, the current Kansas statute authorizes the person to be prosecuted by the County Attorney for an unclassified misdemeanor. If the provider is found guilty, the current penalty is between $5 and $50 per day they are out of compliance. Through enhanced monitoring, enforcement, higher fines and increased prosecution, the Board hopes that the quality of child care available to Kansas children will be improved.

RECOMMENDATIONS TO PREVENT UNINTENTIONAL INJURY DEATHS

STRENGTHEN REQUIREMENTS FOR PERSONAL FLOTATION DEVICE USE IN PUBLIC WATERS

Citizens and lawmakers should support efforts to establish a minimum requirement that any person age 12 or under who is on board any watercraft in the waters of Kansas or who is wading or

swimming in navigable public waters shall wear a personal flotation device that is approved by the United States Coast Guard. Between the years of 2017 and 2021, 37% of the drowning deaths of children in Kansas occurred in open water where personal flotation devices were not used. Ensuring that Kansas children are able to swim and are properly outfitted with personal flotation devices will save lives.

PROMOTE THE USE OF STANDARDIZED DROWNING INVESTIGATION TOOL

In 2022, the Kansas Child Death Review Board entered into agreement with the National Center for Fatality Review and Prevention to become one of the seven pilot states participating in the Drowning Case Registry Project. This project seeks to standardize drowning death scene investigations by creating an easy-to-use tool referred to as the DSI or Drowning Death Scene Investigation form. Kansas's participation will require collaboration between law enforcement and coroners to collect information using the DSI form. From there, the SCDRB will ensure a timely review of the death and work towards providing feedback for prevention efforts. The project goals are to address the lack of a nationally standardized drowning investigation process and to collect data to help lower the poor outcomes overall and the disparities that have been observed in past reviews. Use of the DSI form should be used in all drowning deaths of children.

RECOMMENDATIONS TO IMPROVE THE QUALITY OF INVESTIGATIONS AND PROSECUTION OF CHILD DEATHS AND NEAR FATALITIES

IMPROVE THE QUALITY OF LAW ENFORCEMENT INVESTIGATIONS FOR INFANT DEATHS

Referrals made to law enforcement regarding child abuse and neglect should be investigated by trained and experienced investigators. Law enforcement and other death investigators should expand their knowledge of child fatality investigations through high quality training including implementation of the Center for Disease Control's Sudden Unexpected Infant Death Investigation Reporting Form (SUIDI) and Sudden Death in the Young (SDY) protocols, and the use of scene recreation and photography. Each year the Board 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.
The Board recommends that Kansas law enforcement adopt procedures based upon best practices regarding the investigation of child abuse or neglect and child death investigations and that a portion of each law enforcement officer's annual training include training on child physical abuse and neglect and sexual abuse. Once adopted, training should be conducted with all law enforcement officers to ensure they understand the scope and extent of the investigation necessary in all infant deaths. Those standards for investigation should be carried out consistently among officers in all jurisdictions.

IMPROVE THE QUALITY OF PROSECUTORIAL DECISION-MAKING REGARDING INFANT DEATHS

All prosecutors tasked with reviewing infant death cases should have specialized knowledge or should consult with other prosecutors with such specialized knowledge to assist in reviewing evidence in cases where criminal conduct is suspected. Particularly, child abuse homicide cases require a heightened level of knowledge and experience in order to reach informed, well-reasoned decisions that are consistent throughout the state.

Prosecutors should also work with local law enforcement agencies and DCF to assure a coordinated effort toward using a best practices approach to the investigation of all allegations of abuse and neglect.

IMPROVE COORDINATION AND COMMUNICATION BETWEEN DCF AND LAW ENFORCEMENT

Kansas DCF should immediately notify law enforcement for investigation in instances where the reported abuse may be criminal in nature. K.S.A. 38-2226 requires a joint investigation if there is a report of child abuse or neglect that indicates serious physical harm or sexual abuse and that action may be required to protect the child. Law enforcement receiving a report of abuse or neglect should assure that a DCF intake is made.

DCF and health care providers, including hospitals, should report any unwitnessed, unexplained or suspicious death or near death of a child to law enforcement for investigation. The Board has reviewed many cases in which law enforcement was either not contacted, or not notified in a timely manner, thus impeding the ability of law enforcement to conduct a thorough investigation. The investigations should be a coordinated effort by DCF and law enforcement to ensure thorough investigations and the safety of surviving children.

IMPROVE THE QUALITY OF FORENSIC INVESTIGATIONS AND AUTOPSIES OF CHILD DEATHS

Forensic investigation currently occurs at the county level, which often leads to inconsistency in the way cases are investigated and autopsied. Kansas should consider coordinated oversight of forensic investigations at a state level. Until that capacity is established, the State Child Death Review Board recommends new and existing coroners be required to receive adequate continuing education regarding the capacity of their duties and to ensure consistency in investigations and declarations of child death determinations.

Forensic pathologists who perform autopsies of children should continue to use the most up-to-date best practices as established by accreditation agencies, such as the standards published by the National Association of Medical Examiners. 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. Coroners and/or medicolegal death investigators should respond to all unexpected child death scenes and coordinate their investigation with law enforcement. A doll re-enactment should be completed for any sleep-related death of an infant with appropriate photo documentation. All natural child deaths should proceed to autopsy, unless the child has a known terminal condition or the death was not unexpected due to a known chronic debilitating condition. An external examination may be sufficient in cases of obvious fatal injury.

The Coroner/Medical Examiner 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 unusual or suspicious circumstances;
- Deaths of children or youth in custody;
- Deaths known or suspected to involve diseases constituting a threat to public health; or
- 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; or
- Death is unexpected, including those that are sports related, suicides, possible cardiac related and motor vehicle crashes.

METHODOLOGY

PROCESS- KANSAS CHILD DEATH REVIEW BOARD

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 as well as Kansas specific birth and death records as available for deaths occurring in Kansas. For deaths occurring out of state, The Kansas Office of Vital Statistics works with the Missouri Vital Records office to provide birth and death records to the SCDRB for deaths occurring in Missouri. For all other out-of-state deaths, the SCDRB is reliant on each individual state to report the death to the Board and share birth and death records as allowed. The reporting of all deaths of Kansas residents, whether occurring in Kansas or in another state is essential for cases to be consistently reviewed by the SCDRB.

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, with exceptions outlined in K.S.A 22a-243(j).

After all records have been collected, cases are assigned for review and assessment. During the SCDRB's monthly meetings, members present their completed cases orally and discuss the circumstances leading to the death. 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.

RATES OF DEATH

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 that determined by the coroner or what was listed on the death certificate.

The current reporting of data 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.

Several figures throughout this report contain data based on small numbers. Rates and percentages based on small numbers can be unreliable due to random error and should be used with caution.

RACE AND ETHNICITY

During the 2022 legislative session, it was requested from members of the Legislature that information related to race and ethnicity be included in future reports when appropriate. Figures throughout the report will refer to the following race/ethnicity groups: American Indian, Asian, Black, Hispanic, and White. However, please note, American Indian includes Alaska Native, Asian includes Pacific Islander, Black includes African American, White includes Caucasian and Hispanic includes Latino. Multiple Race indicates two or more races that were Non-Hispanic. Rate of death for some race/ethnicity groups have been suppressed based on small numbers that can be unreliable.

Racial Disparities: While sections of the report show progress in reducing child deaths in Kansas overall, racial disparities in the death data presented still remain or in some cases have increased in recent years. Further investigation of these disparities can lead to evidence-based interventions to improve death rates for children.

GENDER IDENTITY AND SEXUAL ORIENTATION

Also, during the 2022 legislative session, it was requested from members of the Legislature that information related to gender identity and sexual orientation be included in future reports where appropriate. While the Board has included this information within the Suicide Deaths section of the report, it should be noted that sexual orientation and gender identity are not consistently reported or provided within the records that are reviewed by the Board. Given that this information can often be kept confidential, unknown, or assumed incorrectly, the information provided in this annual report should be used with caution. As indicated within the suicide death section of this report, more information related to gender identity and sexual orientation as self-reported through the Kansas Communities that Care (KCTC) can be found at: www.kctcdata.org.

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.

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

APPENDIX A- RESIDENT COUNTY OF DEATH 2017-2021

County	Population Age 0-17 2017-2021	Total Deaths Age 0-17 2017-2021	Natural Deaths	Unintentional Injury Motor Vehicle	Unintentional Injury	Natural SIDS	Homicide	Suicide	Undetermined
Allen	13,909	11	7	0	1	1	0	0	2
Anderson	10,015	5	2	0	1	0	0	1	1
Atchison	18,594	10	5	0	0	0	0	3	2
Barber	5,060	4	3	0	0	0	0	1	0
Barton	30,707	13	7	1	0	0	2	1	2
Bourbon	18,737	11	5	0	4	0	0	0	2
Brown	12,148	6	4	1	0	0	1	0	0
Butler	84,992	32	16	1	4	1	3	3	4
Chase	2,660	0	0	0	0	0	0	0	0
Chautauqua	3,423	2	1	0	1	0	0	0	0
Cherokee	22,719	8	5	1	1	0	0	0	1
Cheyenne	2,796	2	0	1	0	0	0	1	0
Clark	2,432	2	0	0	1	0	1	0	0
Clay	9,386	1	0	0	0	0	0	1	0
Cloud	10,136	9	5	0	1	1	0	0	2
Coffey	8,883	4	1	0	3	0	0	0	0
Comanche	2,035	1	1	0	0	0	0	0	0
Cowley	41,130	28	13	0	4	1	4	4	2
Crawford	42,464	17	12	0	2	0	0	1	2
Decatur	2,814	2	0	2	0	0	0	0	0
Dickinson	21,686	15	8	2	2	0	0	1	2
Doniphan	8,049	5	5	0	0	0	0	0	0
Douglas	109,812	49	25	2	9	4	0	2	7
Edwards	3,244	2	1	0	0	0	0	1	0
Elk	2,774	3	2	1	0	0	0	0	0
Ellis	30,474	11	8	0	0	0	0	2	1

County	Population Age 0-17 2017-2021	Total Deaths Age 0-17 2017-2021	Natural Deaths	Unintentional Injury Motor Vehicle	Unintentional Injury	Natural SIDS	Homicide	Suicide	Undetermined
Ellsworth	5,631	2	1	0	1	0	0	0	0
Finney	55,579	28	16	3	3	0	1	2	3
Ford	50,742	37	19	7	3	1	0	6	1
Franklin	30,569	17	11	5	0	0	0	1	0
Geary	51,674	35	22	3	2	0	0	4	4
Gove	3,258	0	0	0	0	0	0	0	0
Graham	2,512	2	0	0	0	0	0	0	1
Grant	11,052	8	2	1	0	0	3	0	2
Gray	8,515	3	2	0	1	0	0	0	0
Greeley	1,652	1	1	0	0	0	0	0	0
Greenwood	6,437	6	4	2	0	0	0	0	0
Hamilton	3,586	2	1	0	0	0	0	1	0
Harper	6,768	4	1	1	0	0	0	1	1
Harvey	41,301	26	16	0	1	2	2	1	4
Haskell	5,504	2	1	1	0	0	0	0	0
Hodgeman	2,033	1	0	0	0	0	0	0	1
Jackson	16,624	8	3	1	2	0	0	0	2
Jefferson	21,379	9	4	3	1	0	0	1	0
Jewell	2,853	1	0	0	0	0	0	0	1
Johnson	725,919	235	141	14	17	6	9	35	13
Kearny	5,625	4	2	1	0	0	0	1	0
Kingman	7,959	5	0	1	0	1	0	2	1
Kiowa	2,843	2	1	1	0	0	0	0	0
Labette	23,876	8	2	1	3	0	1	1	0
Lane	1,733	0	0	0	0	0	0	0	0
Leavenworth	96,399	42	25	2	4	2	5	1	3
Lincoln	3,306	2	1	0	0	0	1	0	0
Linn	10,750	5	1	1	0	0	0	1	2
Logan	3,373	1	0	1	0	0	0	0	0
Lyon	36,671	19	12	3	1	1	0	0	2

County	Population Age 0-17 2017-2021	Total Deaths Age 0-17 2017-2021	Natural Deaths	Unintentional Injury Motor Vehicle	Unintentional Injury	Natural SIDS	Homicide	Suicide	Undetermined
Marion	12,460	7	5	0	1	0	0	0	1
Marshall	11,693	6	3	0	2	0	0	1	0
McPherson	32,926	7	3	2	0	0	0	2	0
Meade	5,306	4	3	1	0	0	0	0	0
Miami	41,530	18	7	7	3	0	0	1	0
Mitchell	6,897	2	1	1	0	0	0	0	0
Montgomery	37,616	17	5	2	3	0	0	3	4
Morris	5,640	2	2	0	0	0	0	0	0
Morton	3,209	5	3	0	0	0	0	1	1
Nemaha	13,502	7	1	4	1	0	0	1	0
Neosho	19,542	16	8	3	1	0	0	0	3
Ness	3,008	2	1	0	0	0	0	1	0
Norton	5,098	2	1	0	1	0	0	0	0
Osage	18,278	9	6	2	0	0	1	0	0
Osborne	3,702	1	0	0	1	0	0	0	0
Ottawa	6,527	5	3	0	0	0	0	1	1
Pawnee	5,227	1	1	0	0	0	0	0	0
Phillips	5,824	3	3	0	0	0	0	0	0
Pottawatomie	35,707	14	9	0	1	0	0	1	3
Pratt	11,256	13	5	0	6	1	0	0	1
Rawlins	2,707	1	0	1	0	0	0	0	0
Reno	68,996	36	19	4	5	0	0	4	4
Republic	4,894	6	1	4	1	0	0	0	0
Rice	10,851	7	5	1	1	0	0	0	0
Riley	60,775	34	22	3	1	0	2	2	4
Rooks	5,493	3	1	1	0	0	0	1	0
Rush	3,077	0	0	0	0	0	0	0	0
Russell	7,493	1	0	0	0	0	1	0	0
Saline	62,846	25	19	0	2	0	3	1	0
Scott	6,534	2	1	0	1	0	0	0	0

County	Population Age 0-17 2017-2021	Total Deaths Age 0-17 2017-2021	Natural Deaths	Unintentional Injury Motor Vehicle	Unintentional Injury	Natural SIDS	Homicide	Suicide	Undetermined
Sedgwick	659,697	376	225	23	26	3	35	22	42
Seward	33,960	14	9	2	0	0	1	0	2
Shawnee	208,049	127	78	9	8	2	8	12	10
Sheridan	3,113	1	0	1	0	0	0	0	0
Sherman	7,115	4	1	0	0	0	1	1	1
Smith	3,671	1	1	0	0	0	0	0	0
Stafford	4,918	3	1	1	0	0	0	1	0
Stanton	2,806	2	1	1	0	0	0	0	0
Stevens	7,856	6	2	2	0	0	1	1	0
Sumner	27,757	18	12	1	2	0	2	1	0
Thomas	9,153	6	3	0	1	0	0	1	1
Trego	2,597	0	0	0	0	0	0	0	0
Wabaunsee	8,036	4	2	0	0	1	0	1	0
Wallace	1,956	1	0	0	0	0	0	0	1
Washington	6,258	3	1	1	0	0	0	1	0
Wichita	2,765	2	1	1	0	0	0	0	0
Wilson	10,221	6	2	1	1	0	0	2	0
Woodson	3,212	0	0	0	0	0	0	0	0
Wyandotte	229,603	165	79	12	20	4	23	4	23
Out of State		121	76	27	8	0	6	2	2
Total	3,518,559	1,884	1,058	182	170	32	117	149	176

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