STATE CHILD DEATH REVIEW BOARD

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2012 ANNUAL REPORT OVERVIEW
(2010 Data)

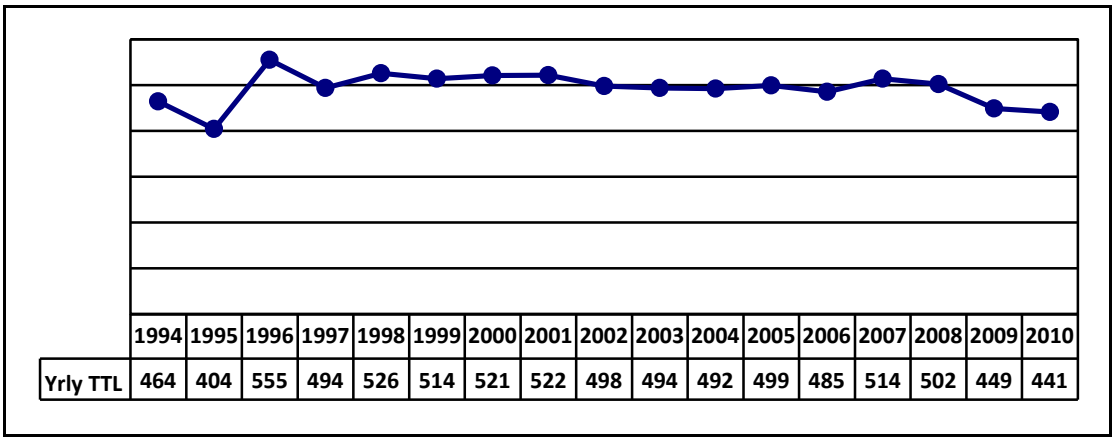
The State Child Death Review Board (SCDRB) was created by the Kansas Legislature in 1992, and is administered by the Office of the Kansas Attorney General. The Board's membership is comprised of ten-volunteer members whose appointments are outlined in K.S.A. Supp. 22a-241 et seq. They meet monthly to review cases and discuss pertinent issues related to child safety and death.

The Board examines the circumstances surrounding the deaths of Kansas children ages birth through 17, as well as children who are not residents, but die in the state. The purpose of the Board is to determine the number of Kansas children who die annually and the manner in which they died.

The manners of death are classified into one of the following 6 categories:

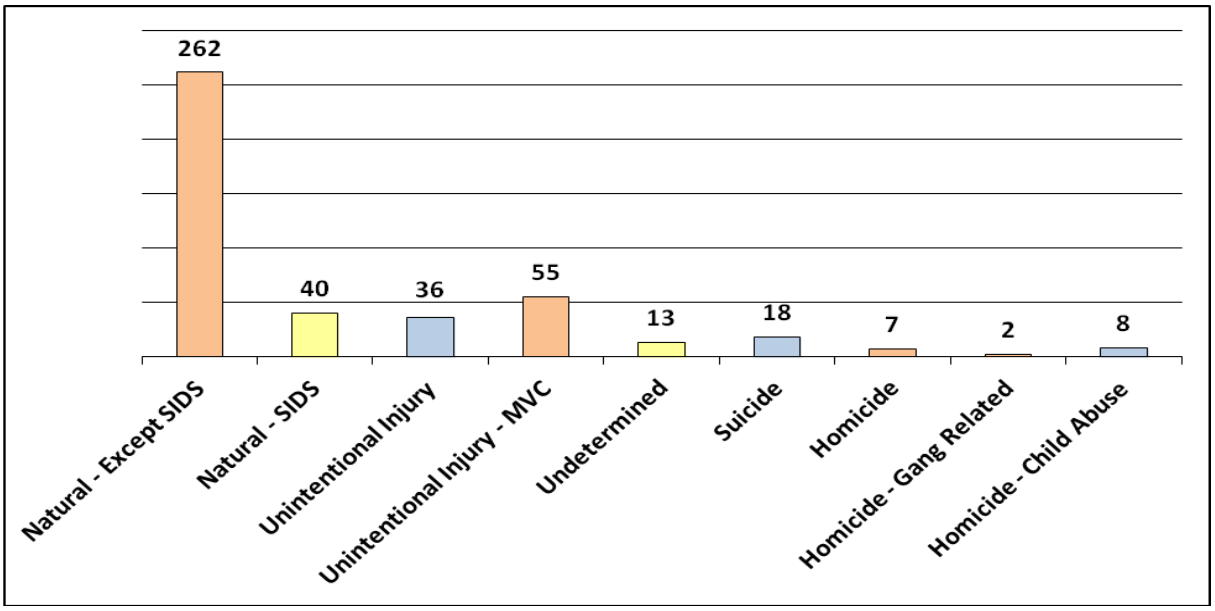
- **Natural-Except Sudden Infant Death Syndrome (SIDS)** - death brought about by natural causes such as prematurity, congenital conditions, and disease.
- **Natural-SIDS** - children who die prior to age one, and display no discoverable cause of death. Kansas statute requires that an investigation and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

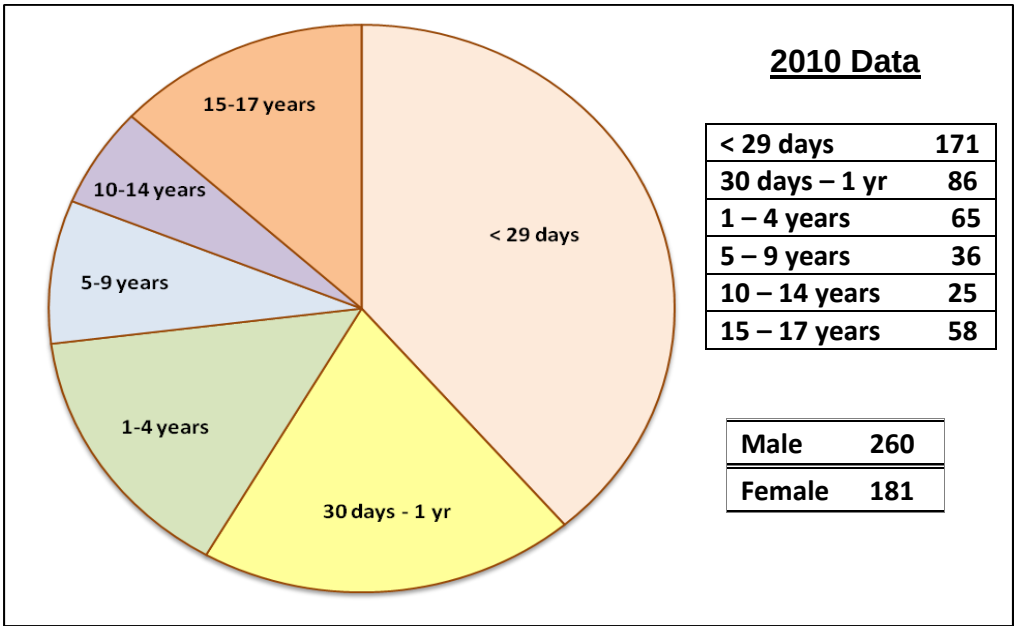
Since its inception, the Board has reviewed 8,374 cases. The Kansas child fatality rate is the lowest it has been since 1995.



	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Yrly TTL	464	404	555	494	526	514	521	522	498	494	492	499	485	514	502	449	441

In 2010, there were 441 fatalities of children under the age of 18. The majority (68%) were from natural causes, with one-fifth (21%) from unintentional injury. The board was unable to determine a cause of death for three percent of the total deaths.





2010 Data

< 29 days	**171**
30 days – 1 yr	**86**
1 – 4 years	**65**
5 – 9 years	**36**
10 – 14 years	**25**
15 – 17 years	**58**

Male	**260**
Female	**181**

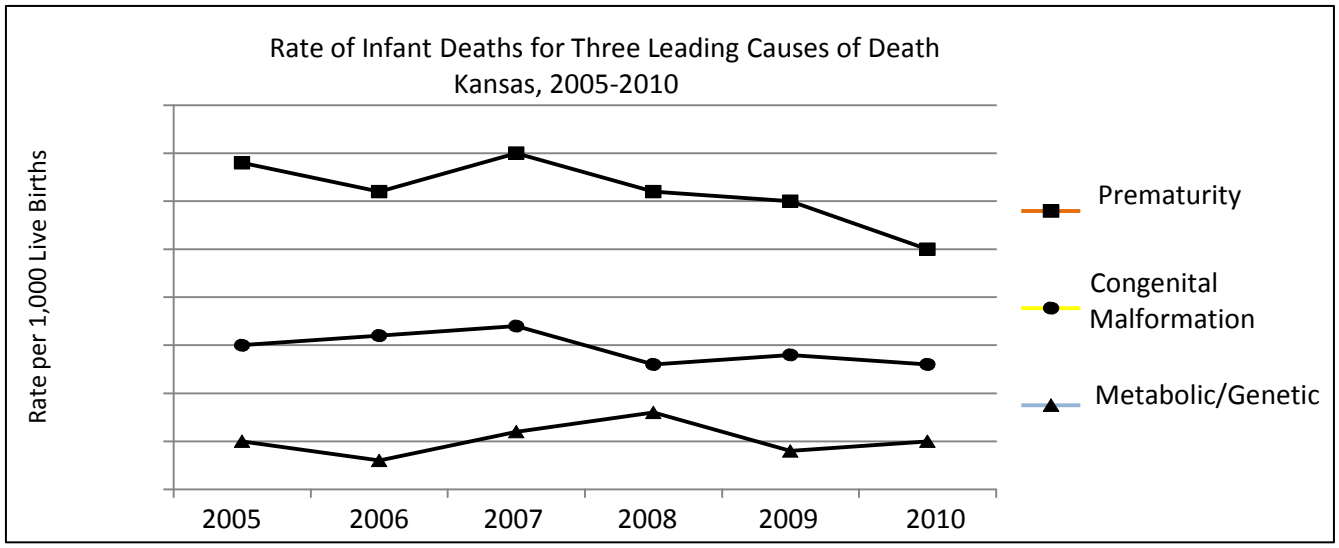
Emphasis has been placed on infant mortality (age less than one-year) as an area in need of improvement. Although the rate of infant deaths per 1,000 live births decreased to 6.4 in 2010, after reaching 8.2 in 2007, it is still above the national 6.0 goal as defined by the U.S. Department of Health and Human Services Healthy People 2020 target.

It is worth noting that 39% of the total fatalities in 2010 were less than 29 days old; 58% of the total was less than 1 year old. The majority of the fatalities were males.

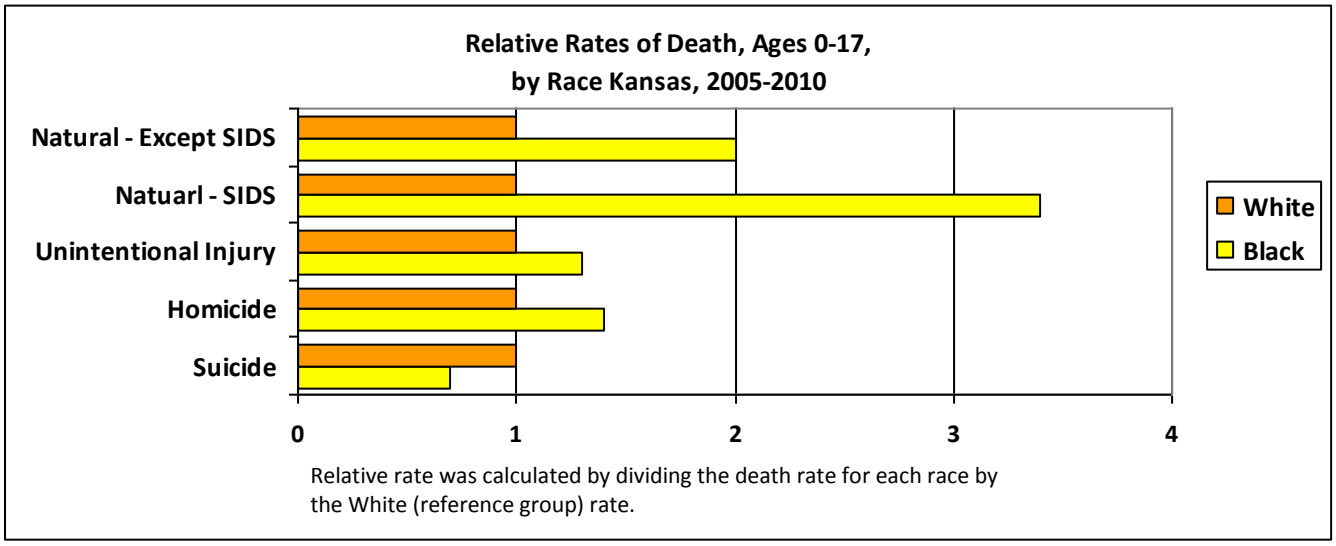
When reviewing the last five years of natural deaths by weeks gestation at birth of children who died less than one year of age, the majority (64%) were less than 32 weeks of age. Here is a breakdown by weeks gestation (page 9 of 2012 Annual Report):

Weeks Gestation	2006	2007	2008	2009	2010
<32 weeks	147	171	150	145	120
33 – 34 weeks	14	15	13	6	10
35 – 36 weeks	17	15	20	14	25
>= 37 weeks	51	50	59	55	47
Not listed	1	0	2	2	0

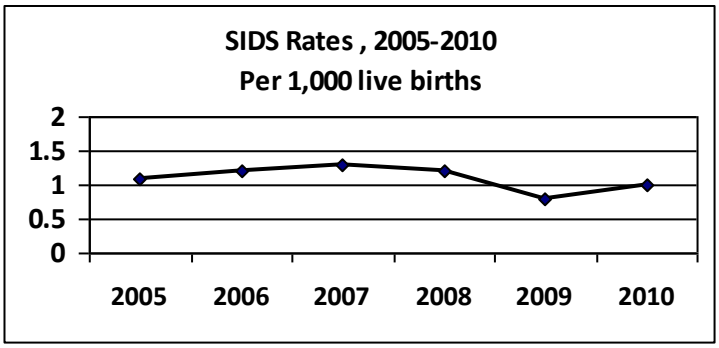
Since 2007, deaths from prematurity have steadily decreased. However, prematurity remains the highest cause of natural deaths. In 2010, it comprised 40% of the total natural deaths. Congenital malformation was the second highest cause (22%) followed by metabolic/genetic disorders (12%). The State of Kansas Genetics Plan released August 19, 2010, notes that "genetics expertise in the state is currently insufficient to meet clinical and patient needs" and calls for continuing education for primary care physicians to enable them to discuss the impact of genetics on health outcomes. For the entire genetics plan, visit http://www.kdheks.gov/newborn_screening/download/State_Genetics_Plan.pdf.

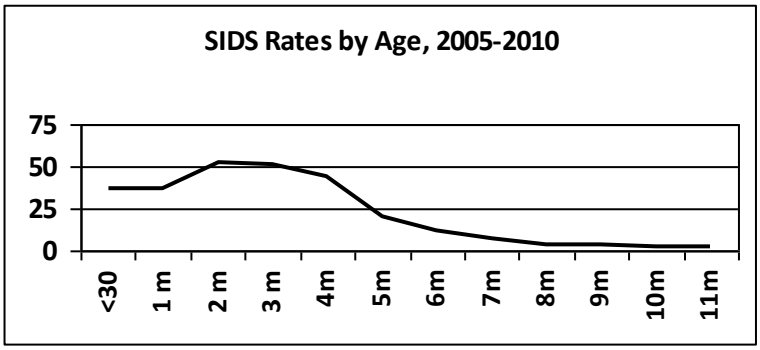


Death rates for Black children were higher than for White children for each manner of death except Suicide, with the greatest discrepancy in the SIDS category.



There were 40 Sudden Infant Death Syndrome (SIDS) cases in Kansas in 2010. The majority (78%) were less than 3 months of age. Eighty percent of the fatalities occurred at the decedent's residence with 10% occurring in a daycare. It was reported that 50% were placed to sleep on their back and 38% were placed in a crib to sleep. Since 2005, the SIDS fatality rate had remained moderately steady with a slight decrease in 2009.





The Board follows the CJ Foundation's definition of SIDS and sub-classifications when making a SIDS determination. For more information visit http://www.cjsids.org/ .

2010 SIDS Classification

6 = SIDS IA: Two of the six infants were placed and found prone; three were placed prone and found supine, and placement in one case was unknown, but was found prone.

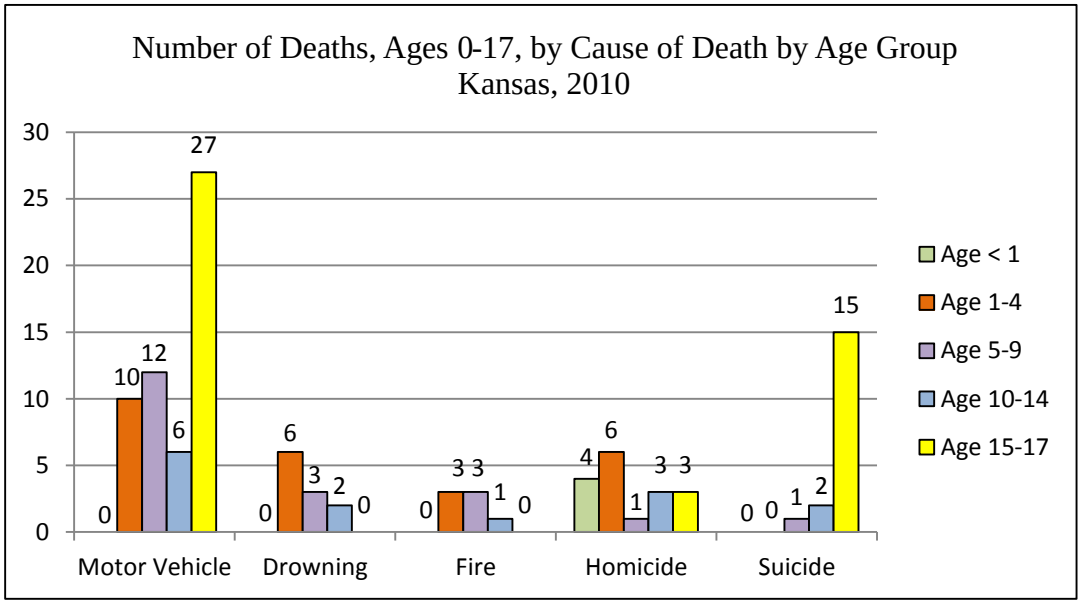
1 = SIDS IB: The scene investigation was inadequate as it did not contain information about how the infant was placed to sleep or the sleeping environment.

33 = SIDS II: In all of these cases, the possibility of an overlay or mechanical asphyxia could not be ruled out.

1 = USID: The Board classified this case as Undetermined because the child was embalmed prior to autopsy.

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

Overall death rates for children ages 1-17 have shown a slight decline from 1994 to 2010. There were 183 deaths in this age group in 2010 and the below chart outlines the manners in which they died.



Although the number of child homicides dropped from preceding years in 2010, they continue to remain a concern. The lowest number of homicide deaths (12) occurred in 2005. In 2006, they steadily increased until peaking in 2009, and then dropped to 17 in 2010. Between the years of 2005 – 2010, there were a total of 118 homicides, and over half of those were children under the age of four. Forty percent of the total 118 involved a firearm and 45% were the result of Abusive Head Trauma (AHT) commonly referred to as Shaken Baby Syndrome. In 2010, the majority of homicides were child abuse related.

Year	Weapon	Asphyxia	Fire/Burn	AHT/Child Abuse	Other
2005	4	0	0	8	0
2006	5	1	1	7	1
2007	8	1	0	7	3
2008	10	1	0	13	2
2009	16	2	0	10	1
2010	6	1	1	8	1

In 2010, the SCDRB recommended the following Public Policy Recommendations to lower child fatalities:

- Improve preconception health;
- Increase awareness of Pertussis vaccinations for all caregivers;
- Strengthen partnerships to improve public education purposes;
- Enact laws pertaining to children left unattended in vehicles;
- Improve All Terrain Vehicle (ATV) usage laws;
- Strengthen laws regarding the Farm Permit driving license; and
- Continue comprehensive investigations of child deaths.