

# 2022



**2022 Annual Report  
(2020 Data)**

**[www.ag.ks.gov/scdrb](http://www.ag.ks.gov/scdrb)**



**KANSAS  
ATTORNEY GENERAL  
DEREK SCHMIDT**

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# Kansas Attorney General Derek Schmidt



September 30, 2022

Dear Fellow Kansans:

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

This report compiles and evaluates information collected from 2020, the most recent year for which data is available. It provides analysis, context and “prevention points” – recommendations for action that can help prevent similar deaths in the future. It also makes several public policy recommendations intended by the Board to reduce child mortality.

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

Best wishes,

A handwritten signature in black ink that reads "Derek". The signature is written in a cursive, slightly stylized font.

Derek Schmidt  
Kansas Attorney General

# Executive Summary

Since 1994, the Board has reviewed 12,393 child deaths. In 2020, Kansas had 365 child fatalities. The manners of death are classified into one of the following five categories:

**Natural** – death brought about by natural causes such as prematurity, congenital conditions, cancer, and disease. Natural death remains the category with the most deaths: 197 in total. Of those cases, 45% were due to prematurity, 28% were due to congenital anomalies, and 5% were due to cancer.

- **COVID-19** – Two children were positive for COVID-19 at the time of death. One had no symptoms of illness and other possible contributing factors, including an unsafe sleep environment, which resulted in the Board classifying the death as an Undetermined - Sudden Unexpected Infant Death. The other death was classified as Natural due to complications of COVID-19.

**Unintentional Injury** – death caused by incidents such as motor vehicle crashes, drowning or fire, which were not the result of an intentional act. In 2020, there were 63 total unintentional injury deaths with the leading cause being motor vehicle crashes (MVC). Thirty-two children died because of an MVC. In only six of the MVC deaths, the decedent was the driver of a vehicle. While historically, the 15-17-year-old age group accounts for the majority of MVC deaths, the rate of death for this age group decreased significantly, from 21.1 deaths per 100,000 population in 2018 to 6.7 deaths per 100,000 occurring for this age group in 2019 and 2020. The board is particularly concerned about the increase in drug-related deaths, most of which fall into this category. We call attention to this in a new section of the board report.

**Homicide** – death due to an intentional act, unintentional act, or criminally negligent act leading to the death of another human being. There were 22 child homicides in 2020; six were the result of child abuse and three were the result of gang violence.

In three of the 22 homicides (14%), the board found there was sufficient additional information or evidence to classify the deaths as homicides even though they were not originally classified in that manner on the death certificate.

**Suicide** – death due to the intentional taking of one's own life. There were 26 suicide deaths, eight of which were age 14 or younger. Of the 26 youths who died by suicide, 85% were male and 15% were female. Furthermore, 54% communicated suicidal thoughts, actions or intent prior to taking their life. In eight of the suicide deaths, the Board determined that disruption in the youth's life related to the COVID-19 pandemic was a contributing factor in their death.

**Undetermined** – cases in which the manner of death could not be identified from the evidence collected. In 2020, 57 cases were classified as Undetermined, with 52 being further classified as a sleep-related Sudden Unexpected Infant Death (SUID). Of the deaths listed as undetermined, 79% were children less than 1 year of age.

# Legislative Priorities

The Board strongly encourages the members of the State Legislature to consider each of the Public Policy recommendations, beginning on page 79, during the 2023 legislative session. The two recommendations below are prioritized by the Board to strengthen the child welfare system and update child care licensing laws.

- 1. Improvement to Child Welfare System** – Through the review of more than 12,000 child fatalities since 1994, which includes the social circumstances of the lives of those 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. Adrian’s Law, a bill named for a 7-year-old Kansas City, Kansas, boy who died in 2015, was passed during the 2021 legislative session. Although it requires visual observation of an alleged victim of child abuse or neglect as part of an investigation by DCF or law enforcement officials, it does not address the need to assess for injuries not readily apparent to CPS investigators. It is not uncommon to find underlying injuries or evidence of neglect that are missed, or trauma for which the significance of the mechanism of injury is not recognized by a child protective service investigator. A training program has been developed for pediatricians to evaluate children with specific types of injuries when child abuse is a concern. Those pediatricians who meet specified qualifications are then eligible for reimbursement from the state. This program takes the load of the additional medical referrals off the limited number of board-certified child abuse pediatricians, who will continue to evaluate the more complex and hospitalized cases. The Board recommends the Legislature consider requiring a medical evaluation by a child abuse pediatrician or other pediatric health professional with specialized training in detecting and assessing potential child abuse injuries when there are allegations of child abuse. While the Legislature took steps to fund this program for 2022, having the program solidified in statute with a budget would ensure its long-term success.
- 2. Child Care Licensing Laws** – 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 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.

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# Acknowledgments

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

As a multi-disciplinary, multi-agency volunteer Board, we appreciate the support of our employers who allow us time to fulfill our responsibilities as Board members.

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## SCDRB SERVES AS A CITIZEN REVIEW PANEL

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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>

# Board Members

**Attorney General appointee**

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

**Director of Kansas Bureau of Investigation appointee**

Tony Weingartner, Assistant Director  
Kansas Bureau of Investigation, Topeka

**Secretary for Children and Families appointee**

Ann Goodall, 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**

Elizabeth H. Sweeney-Reeder, J.D.  
Miami County Attorney's Office, Paola

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## STAFF

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**Sara Hortenstine**, Executive Director

**Susan Croucher**, Administrative Specialist

**Evalinda Coria**, Program Consultant

**Robert Hutchison**, Acting Deputy Attorney General, General Counsel



# 2020 Overview

The State Child Death Review Board reviewed the deaths of 365 children, ages 0-17, who died in Kansas, or were Kansas residents who died outside of the state during the year 2020. The death rate calculated per 100,000 Kansas children increased in calendar year 2020. Despite the increase, the overall death rate shows a continued downward trend from previous years (Figure 1).

**Figure 1**

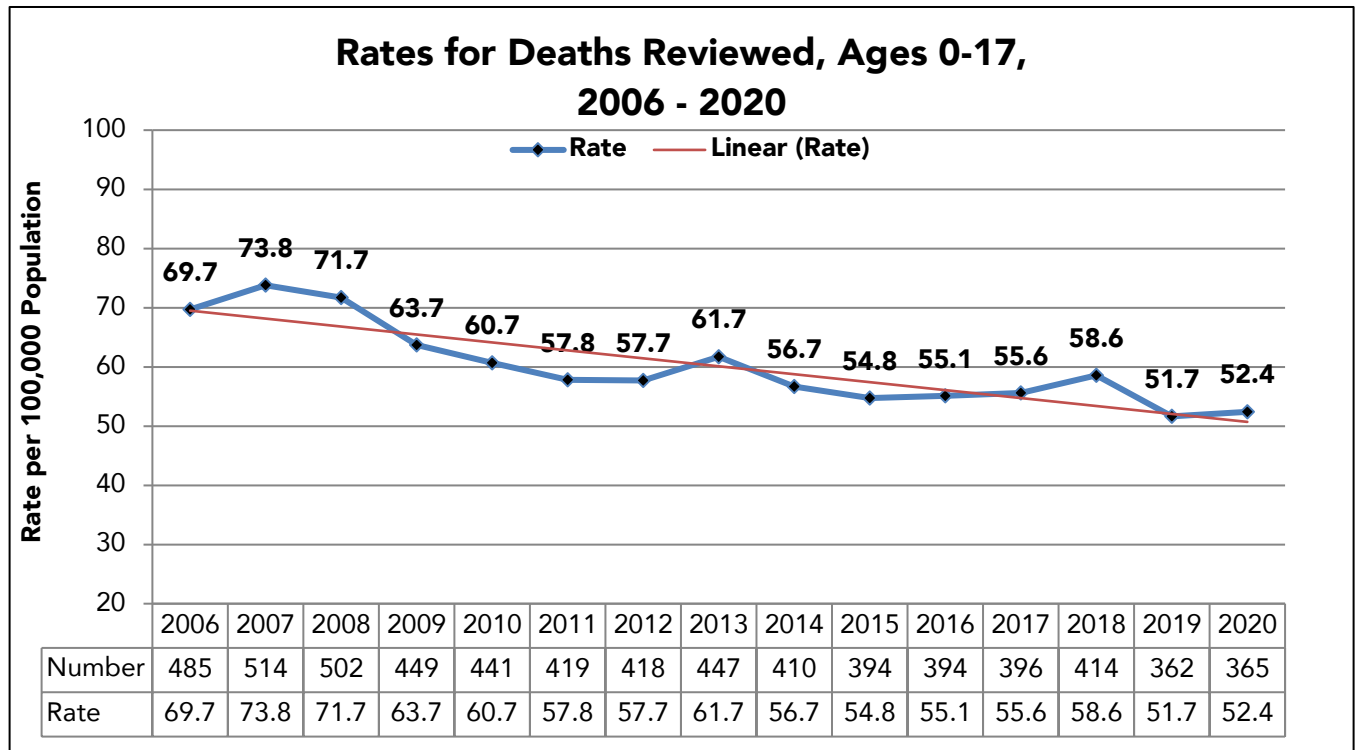


Figure 2

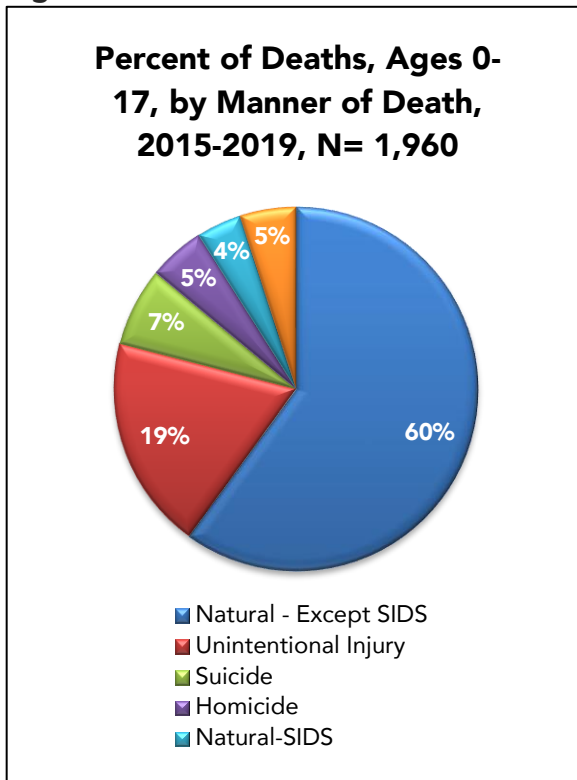
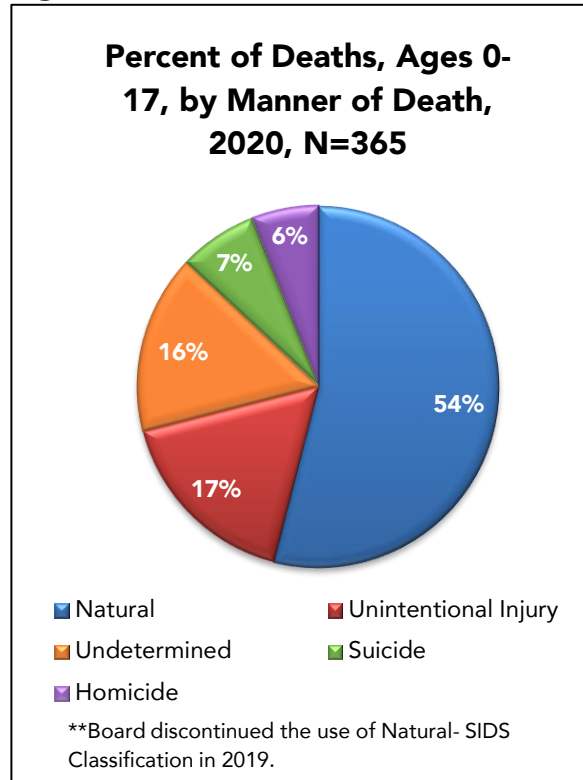


Figure 3



As shown in Figures 2 and 3, death by natural manner has accounted for the largest percentage of deaths for the previous five years as well as the current year. In 2020, death by natural manner claimed the lives of 197 Kansas children (Figures 3 and 4).

Of the total deaths in 2020, 17% were due to unintentional injuries, 16% were of undetermined manner, and 7% were due to suicide. The relative percentages of manners of death are all comparable to the previous five reporting years except infant deaths due to SIDS, which since 2019 is no longer a classification of death used by the Board. The deaths previously categorized as Natural-SIDS are categorized in subgroups of Sudden Unexpected Infant Deaths (SUID) within the Undetermined Manner, as explained in the [Sleep-Related, SUID Deaths](#) section of the report.

Males accounted for more deaths in nearly all age groups and comprised 59% of all child deaths in 2020 (Figures 4 and 5).

Figure 4

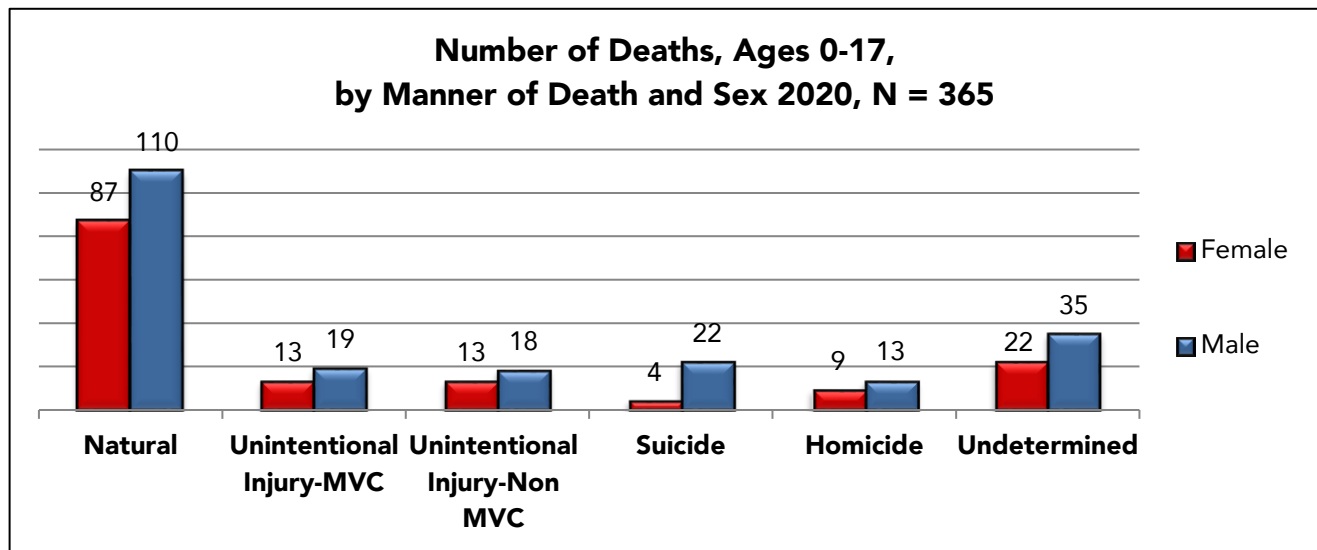
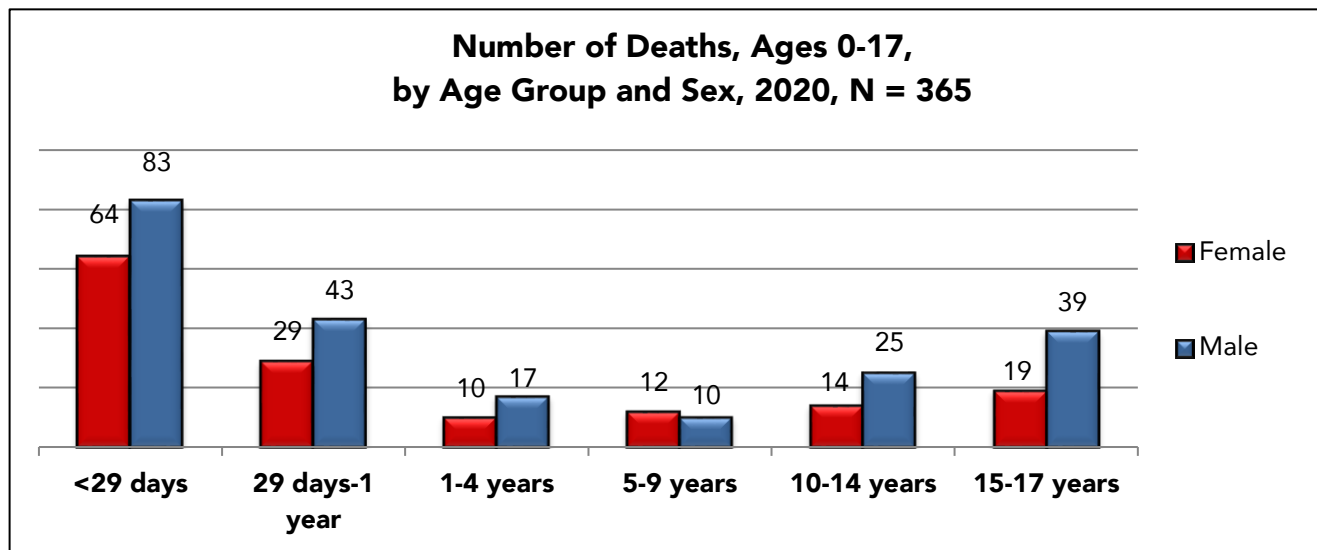


Figure 5



When looking at the percentage of child deaths by race, Figure 6 indicates that 69% of the child deaths age 0-17 were White children, 17% were Black and 10% were Multiracial. Figure 7 indicates that 24% of all races were Hispanic/Latino.

For comparison purposes, using estimates derived from the US Census data from 2020 as provided by the Kansas Department for Health and Environment (KDHE), the number of Kansas residents under the age of 18 was 696,746. In 2020 White, non-Hispanic/Latinos accounted for 65.73%, White, Hispanic/Latinos accounted for 16.30%, Black or African-Americans who were non-Hispanic/Latinos accounted for 6.14%, and multiracial individuals (two or more mixed races) accounted for 4.62%. This reference as well as others will be applicable in other sections of the report and can be found and described further in the [Methodology](#) section of the report.

Figure 6

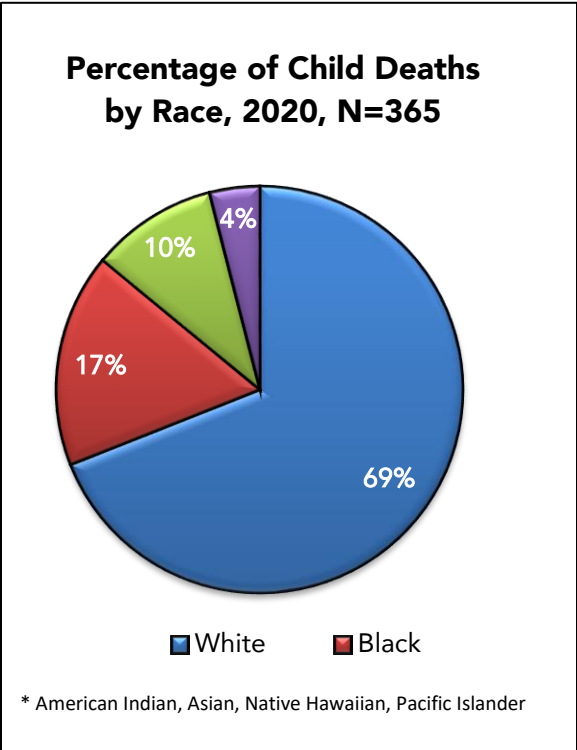
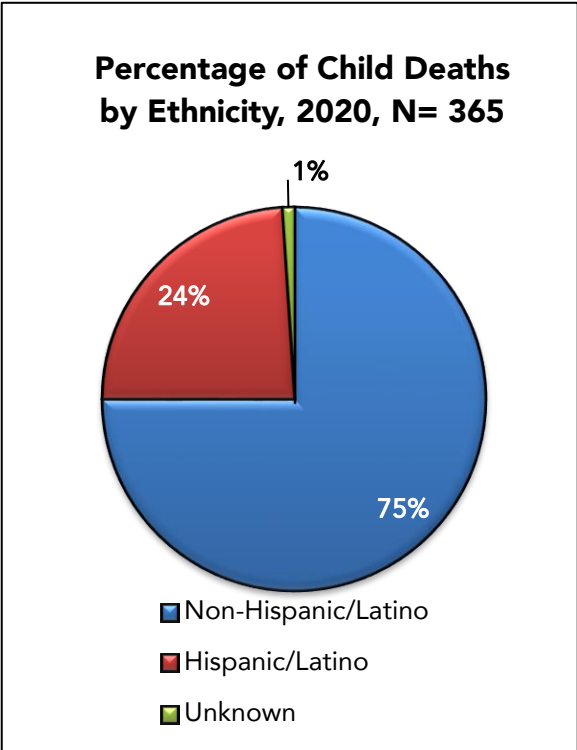


Figure 7



# 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 696,000 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 8, of the 727 child fatalities reviewed by the Board in 2019 and 2020, 266 had history with the child welfare system, specifically with Department for Children and Families (DCF) Division of Child Protective Services (CPS). Of the 266 cases with past CPS history, in 69 the decedent or a sibling had been removed from the home at some time prior to the death (Figure 9). Also noted in Figure 9 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 8**

Number of child deaths, All Cause and Manners, age 0-17 years, by involvement with Child Welfare System, 2019-2020, N=727						
	Total-All Ages	Age <1	Age 1-4	Age 5-9	Age 10-14	Age 15-17
<b>No Known CPS History</b>	452	310	28	32	31	51
<b>CPS History Prior to Death</b>	266	111	35	17	42	61
<b>Unknown</b>	9	1	1	2	2	3

**Figure 9**

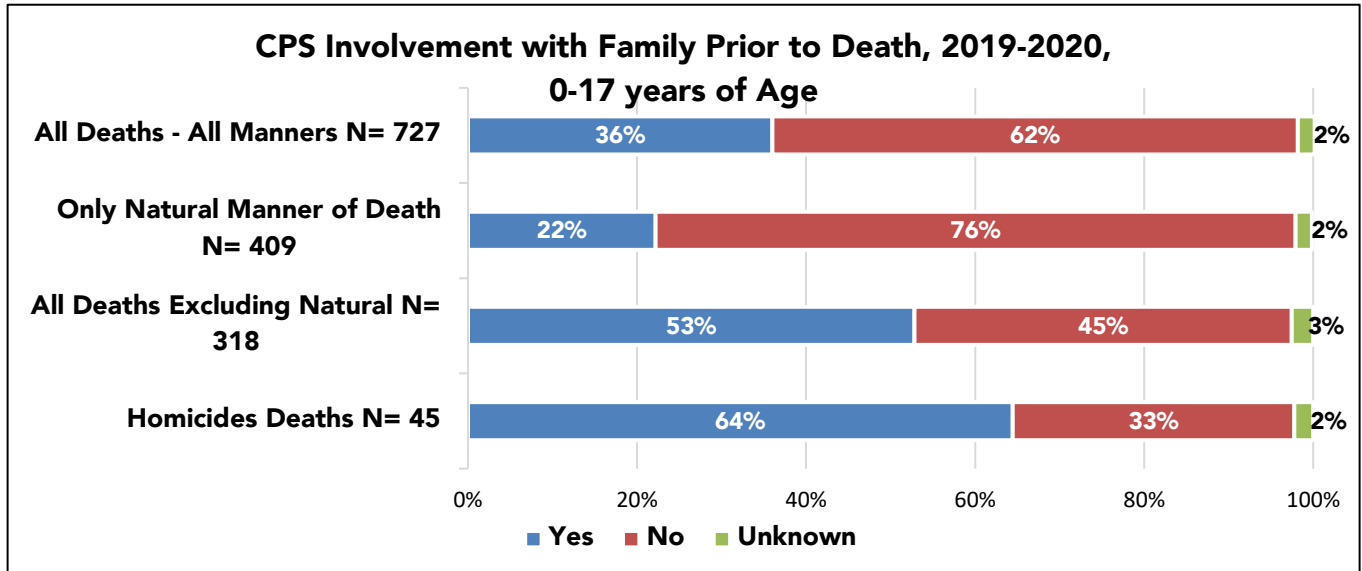
Type of case history when decedent had CPS history prior to death, Age 0-17, 2019-2020, N=266*						
*Categories are not exclusive as cases will overlap and equal more than 266						
	Total-All Ages	Age <1	Age 1-4	Age 5-9	Age 10-14	Age 15-17
<b>Removal of Sibling or Decedent Prior to Death</b>	69	30	7	3	10	19
<b>Open CPS at Time of Death</b>	39	16	9	3	6	5
<b>Decedent in Custody at Time of Death</b>	16	5	2	1	1	7
<b>Decedents with history not described in above categories</b>	171	71	23	10	28	39

Overall, 36% (259) of all decedents had CPS involvement prior to their death. As shown in Figure 10, for comparison, those children that died from a natural manner of death, only 22% (91) of the 409

## Child Welfare Overview

decedents had CPS involvement. When natural manner is excluded, the percentage of cases with CPS involvement increases, which is especially notable in the Homicide category where 64% (29) of the cases had prior CPS involvement.

Figure 10



In 2016, The Commission to Eliminate Child Abuse and Neglect Fatalities published a national report entitled, “Within our Reach,”<sup>1</sup> 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 supports 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.

As suggested in the [Legislative Priorities Section](#), 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.

## VIGNETTES

### DEATHS WITH CHILD WELFARE INVOLVEMENT

1. DCF had 31 previous reports on the family of a teenage suicide victim, many of which included allegations of physical, emotional, and sexual abuse. None of these prior cases were substantiated or affirmed, yet the board could find no events in which this child or the siblings had physical examinations by a healthcare provider to assess for injuries or other indications of abuse, which might have provided evidence needed to remove the children from their dangerous environment. This child had contacted DCF on multiple occasions in an attempt to improve their situation. The children reported they were bullied at school for smelling of urine and having dirty clothing. Because of a clogged drain, the children could not shower in their home; when able, they showered at school or a friend's home. This child provided pictures of the living situation to DCF after which the children were placed out of home. A little over a year later they were reintegrated with their mother. The last complaint was one year before this child's death when a report indicated the children were living in a dirty, cluttered home infested with fleas and cockroaches. DCF could not "get a hold of mom" and the case was unsubstantiated and closed. This is an example of where closer monitoring and effective communication with the school or other community resources, might have led to a better outcome.
2. A young child died of fentanyl intoxication while in the care of parents, who were subsequently charged with first-degree murder and aggravated child endangerment related to this death. In total, there were 18 reports about this child and siblings to DCF. The concerns included physical and emotional abuse, physical neglect, lack of supervision, and exposure to domestic violence. Other adults had reported the home as unsafe, and that the oldest child took on parental responsibilities for the younger siblings. DCF reported there was not enough evidence to remove the children or request court ordered services. The children remained in an environment of drugs, physical and emotional abuse, and poor supervision. After this child's death, the surviving children were briefly placed with relatives who allowed the parents to move in while continuing to test positive for drugs.
3. An infant died in an unsafe sleep environment. This infant was born to a mother with a history of substance use disorder. The mother's drug test at delivery was negative, and the baby was discharged from the hospital in mother's care; however, the baby was later placed into grandparent's care around three months of age. At the request of DCF, the grandparents provided documentation of a "safe sleep" environment as part of the placement safety plan. On the day of death, the baby was placed on an adult bed and left alone. The grandparent later returned to the room and found the baby unresponsive, wedged between the wall and the bed. Although the grandparents knew what a safe sleep environment should look like, they violated the safety plan and left the baby unattended in an unsafe sleep space.

# 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<sup>8</sup>. 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 10 years (2011-2020), there have been 38 child care deaths in Kansas with three of those occurring in 2020. Two of the three deaths in 2020 occurred in an unlicensed child care location. Children under the age of 1 have accounted for 32 of these deaths. Of those 32 deaths, 27 were sleep-related and all but three had unsafe sleep factors. The other five deaths that occurred to children under the age of 1 and were not sleep-related. This included two child abuse homicides and three deaths by natural causes.

Beginning in 2015, the Board recognized the need to track deaths of children that take place at the residence of the child when that residence is being used as a licensed or unlicensed child care home for other children. Since 2015, there has been one death that met these criteria.

## PREVENTION POINTS FOR PARENTS WHEN SELECTING CHILD CARE HOMES AND CENTERS

- Child care homes and centers must be licensed by KDHE<sup>2</sup>. 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.
- 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.kdheks.gov/bcclr/capp.htm>.
- Child care providers should develop a safe sleep policy 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.



# Mortality Affecting Infants

In Kansas, infant mortality (age less than 1 year) has been noted as an area in need of improvement. There were 219 infants who died in 2020. The infant mortality rate for Kansas was 6.4 deaths per 1,000 live births. Despite the death rate being higher in 2020 than 2019, the overall chart indicates a downward trend in annual infant mortality rates (Figure 11). 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.<sup>53</sup>

Figure 11

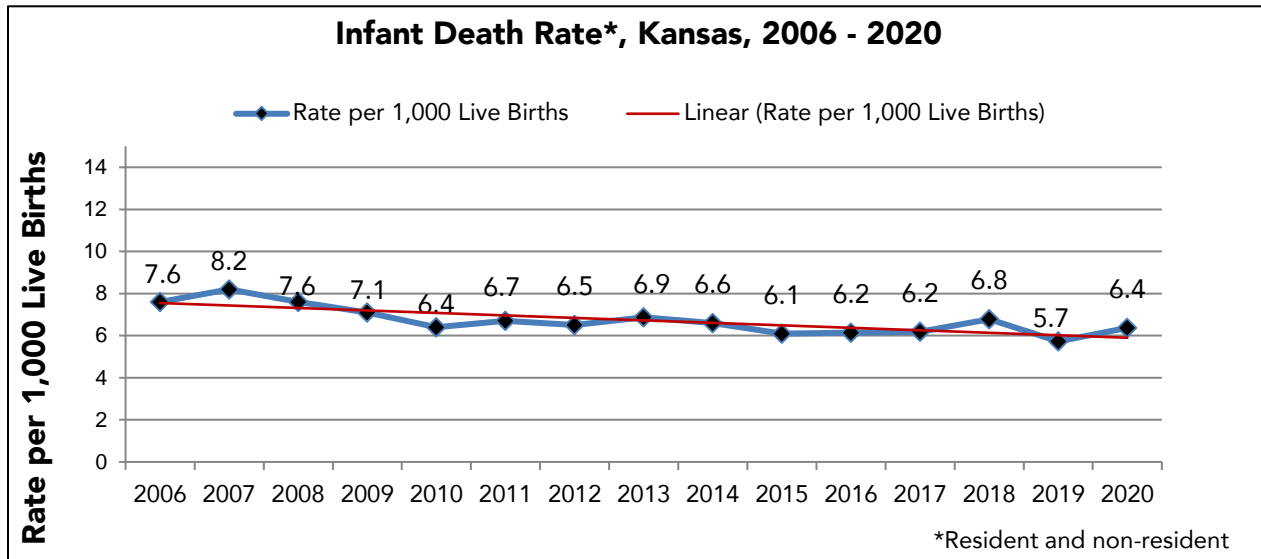
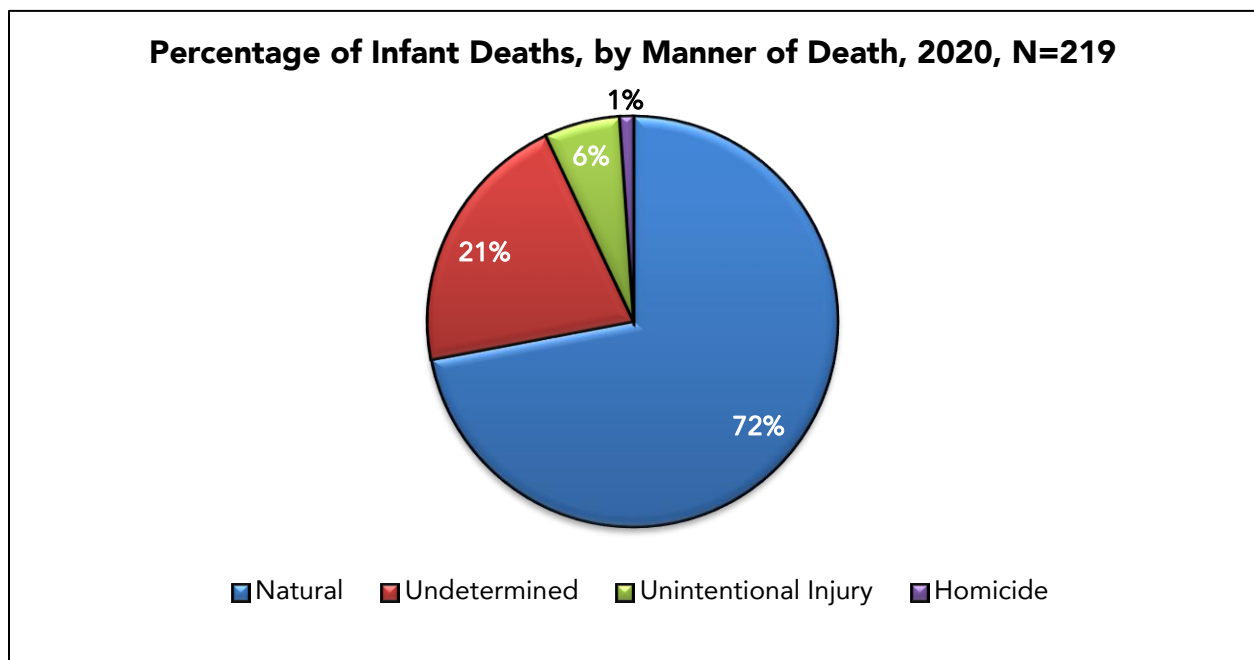


Figure 12



## Mortality Affecting Infants

Figure 13

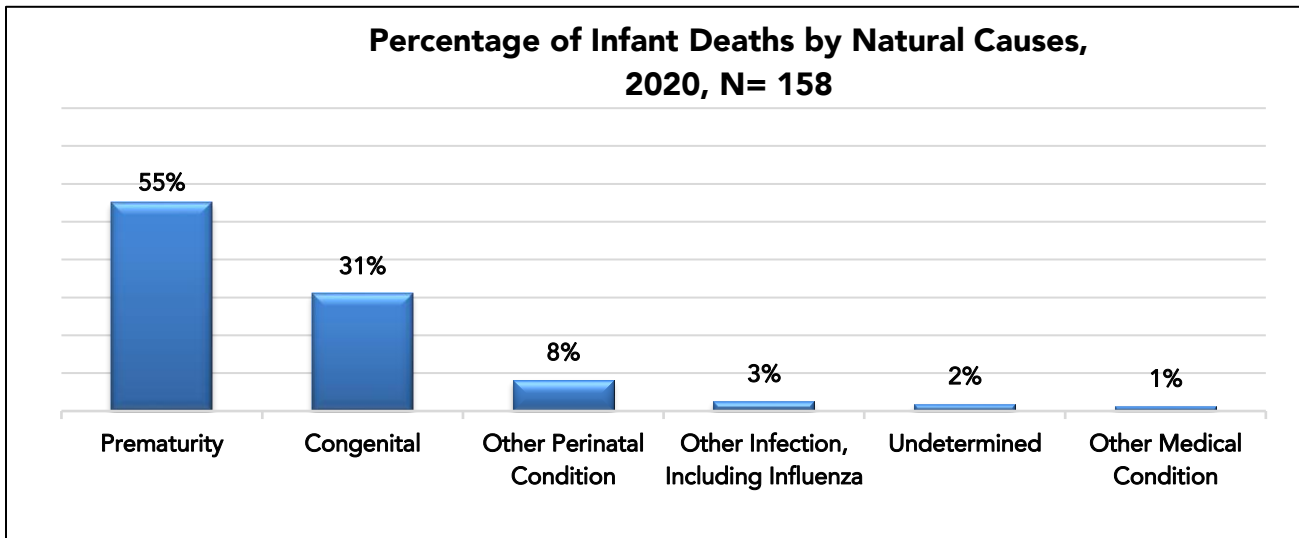
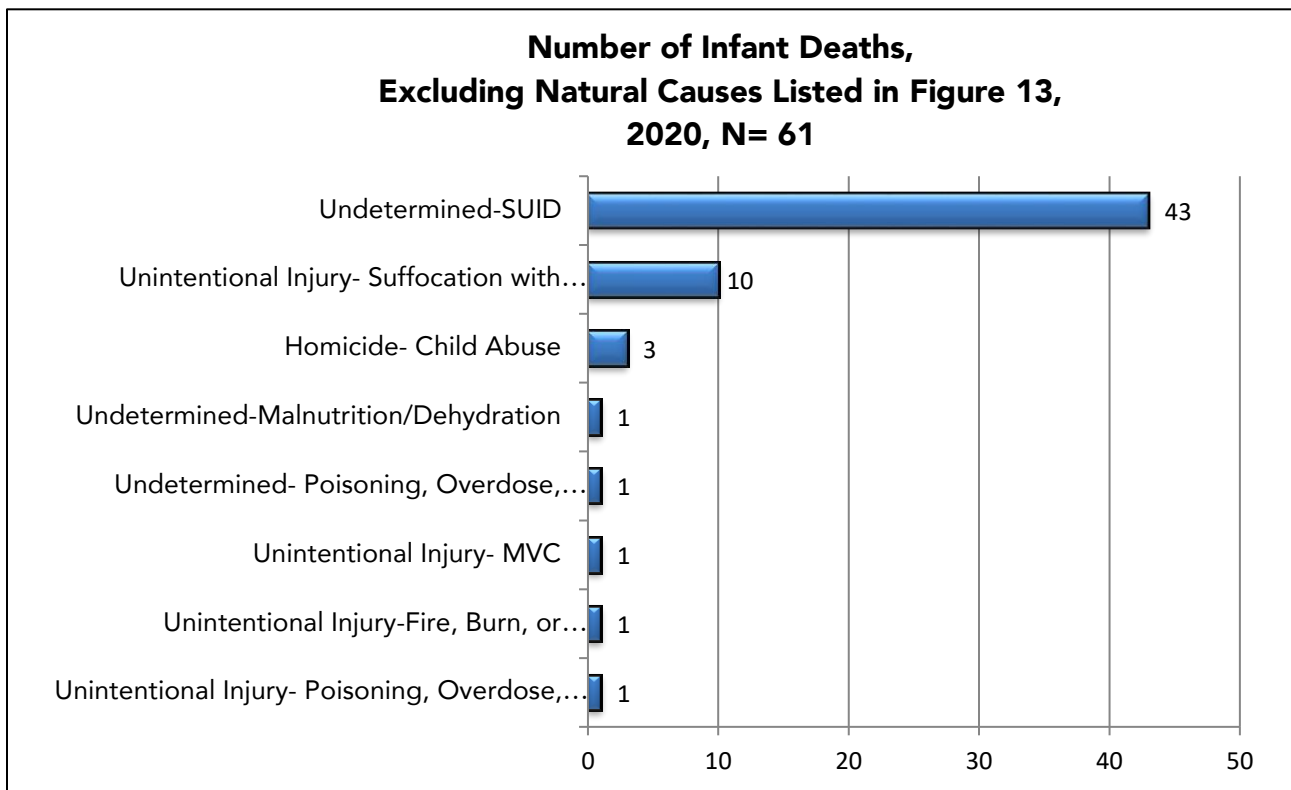


Figure 12 shows the percentage of infant deaths by manner. Figure 13 indicates that 158 infants were found to have died by natural causes with the leading causes being prematurity and congenital anomalies. Figure 14 describes all other infant deaths excluding natural causes.

Figure 14



Figures 15 and 16 indicate the percentage of infant deaths by race and ethnicity. More information can be found in the [Methodology](#) section of the report.

Figure 15

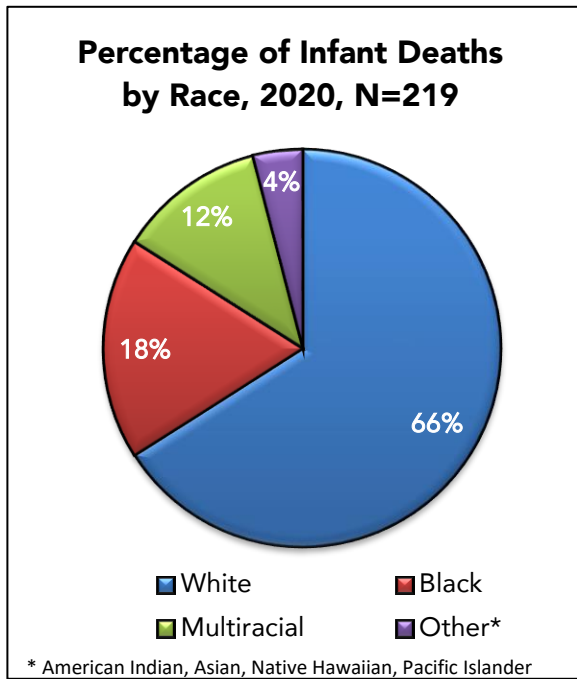
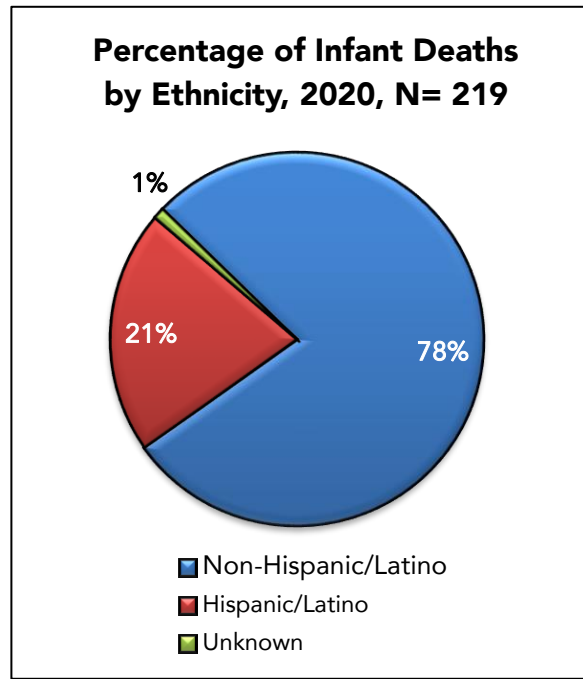


Figure 16



As shown in Figures 17 and 18, 59% of the infants who died from natural causes were born at 31 weeks gestation or earlier. 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. In addition to being a direct cause of death, prematurity is a significant risk factor for infant mortality from other causes.

Figure 17

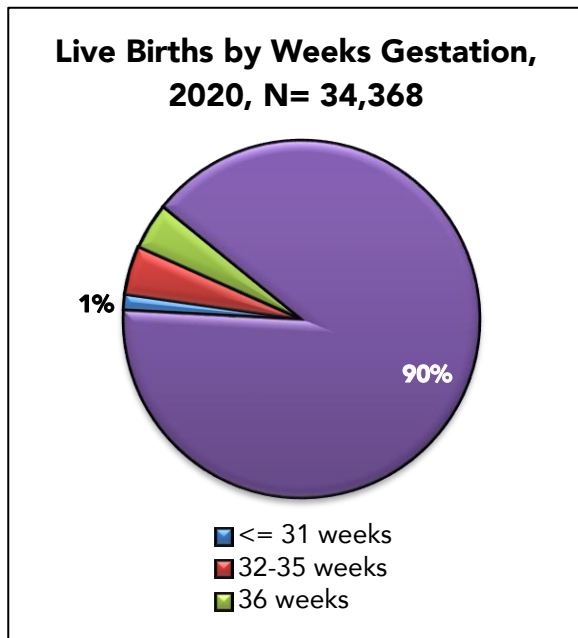
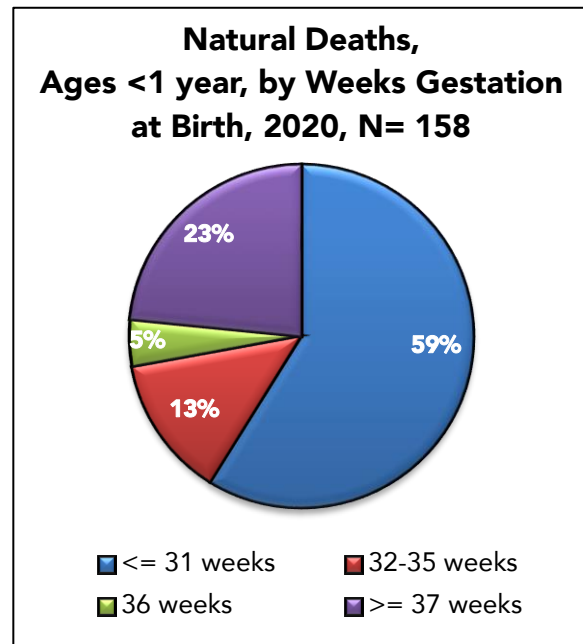


Figure 18



Source: Annual Summary of Vital Statistics Kansas, 2020, Kansas Department of Health and Environment.<sup>45</sup>

### 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.<sup>3</sup>
- **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.<sup>3</sup>
- **Drug Environments** – Children living in environments where they are exposed to drugs (including illicit drugs, prescription medication misuse) and alcohol abuse are at increased risk of abuse, neglect, or death. If caregiver substance abuse 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.<sup>4</sup>
- **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.<sup>5</sup>

# 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 19, 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/>.

In 2020, there were 52 sleep-related infant deaths. The classifications of these deaths are described below in Figure 19. The three deaths in the Unexplained/No Autopsy or Death Scene Investigation category were due to lack of a death scene investigation. 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 19**

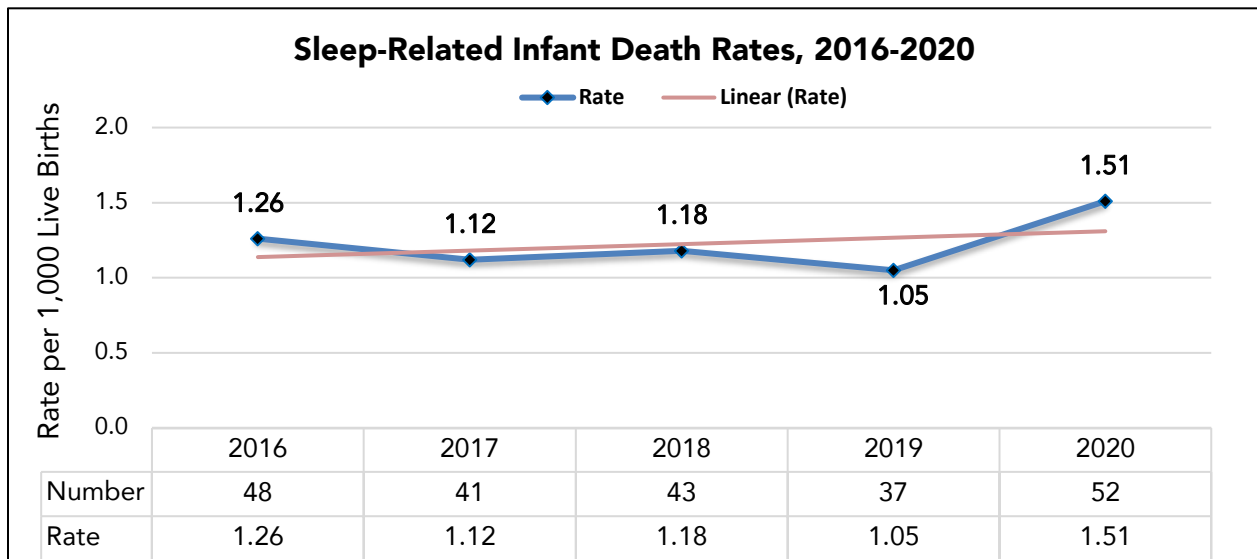
Sleep-Related Death Classifications for Infants 2019-2020			
Undetermined-SUID	Further Explanation	2019 Deaths	2020 Deaths
Unexplained: No autopsy or death scene investigation	Autopsy or death scene investigation not completed.	0	3
Unexplained: Incomplete case information	Incomplete case information pertinent to case review.	8	15
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
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
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
Unintentional Injury-Asphyxia	Further Explanation	2019 Deaths	2020 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
<b>Total Sleep Related Deaths</b>		<b>37</b>	<b>52</b>

## Sleep-Related, SUID Deaths

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>.

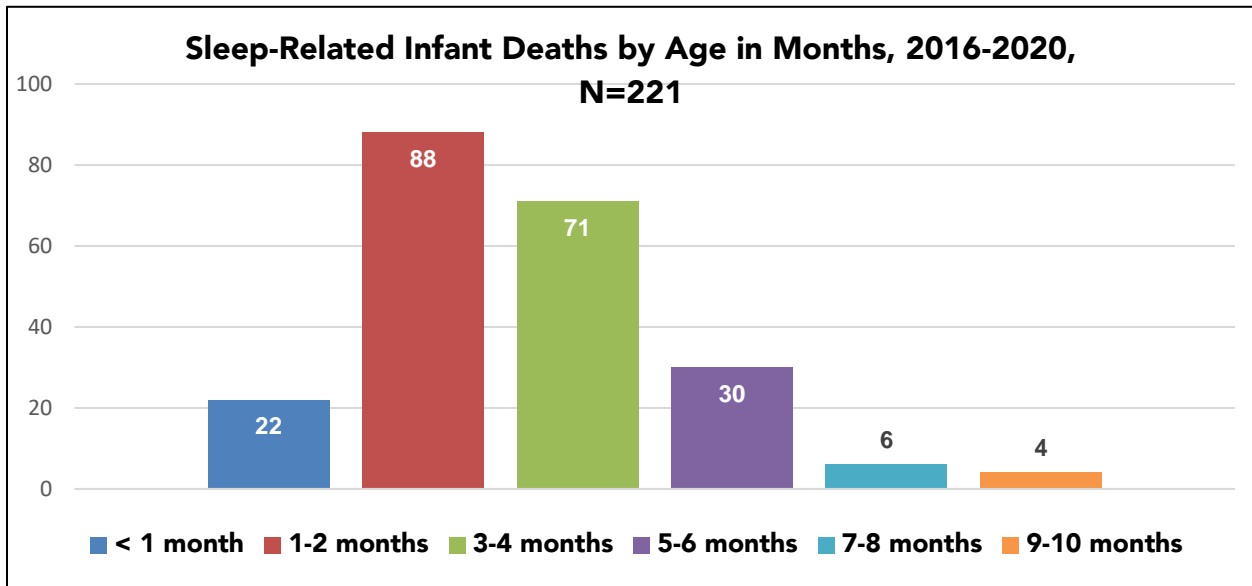
As shown in Figure 20, sleep-related infant death rates over the last five years have remained relatively stable. In 2020, the rate of infant deaths from sudden unexpected causes, which includes both Undetermined and Unintentional Injury-Asphyxia SUID deaths during sleep, increased to 1.51 infant deaths per 1,000 live births. This rate exceeds the target set by Healthy People 2020, of an infant death rate from these causes to less than 0.84 by 2020.<sup>6</sup>

**Figure 20**



Although by definition, sleep-related SUID deaths can occur at any time during an infant’s first year<sup>8</sup>, most SUID deaths occur in infants between 1 and 4 months of age as shown in Figure 21.

Figure 21



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 22). Safe sleep practices should occur at each sleep (naptime and nighttime) both in the home and when away from the home.

Figure 22

Incident Sleep Location* Infant Deaths, 2016-2020, N=221		
Location	Number	Percent
Child’s Home	177	80.1%
Relative’s Home	23	10.4%
Unlicensed Child Care	10	4.5%
Friend’s Home	4	1.8%
Other <sup>§</sup>	3	1.4%
Licensed Child Care	2	0.9%
Foster Care	1	0.45%
Unknown	1	0.45%

\*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 221 sleep-related deaths the Board reviewed from 2016 through 2020, only 19% of the infants were in a crib or bassinet (Figure 23). Also of concern was the 59% of infants who shared a sleep surface with one or more person(s) at the time of the incident (Figure 24).

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

## Sleep-Related, SUID Deaths

proximity to their parents (room sharing) but on a separate surface designed for infants without bed-sharing for at least the first six months of life.<sup>9</sup>

In 51 of the 52 sleep-related deaths reviewed by the Board in 2020, 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.<sup>44</sup>



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

Figure 23

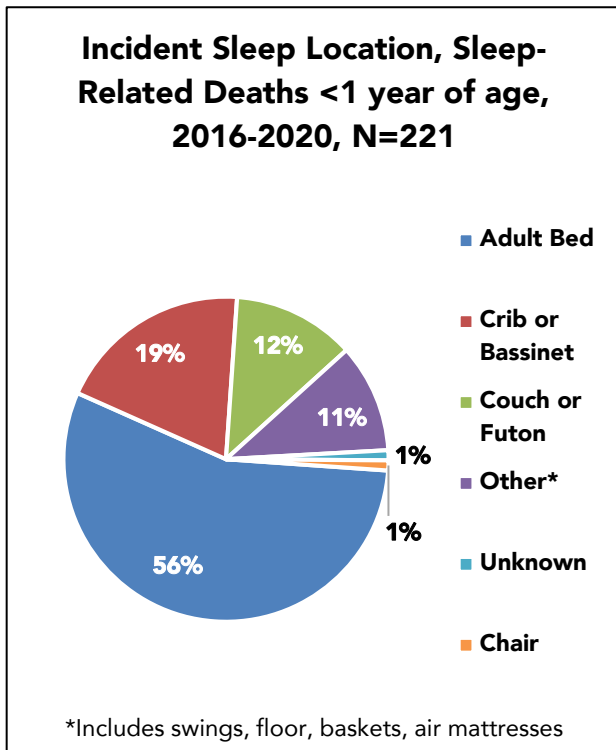
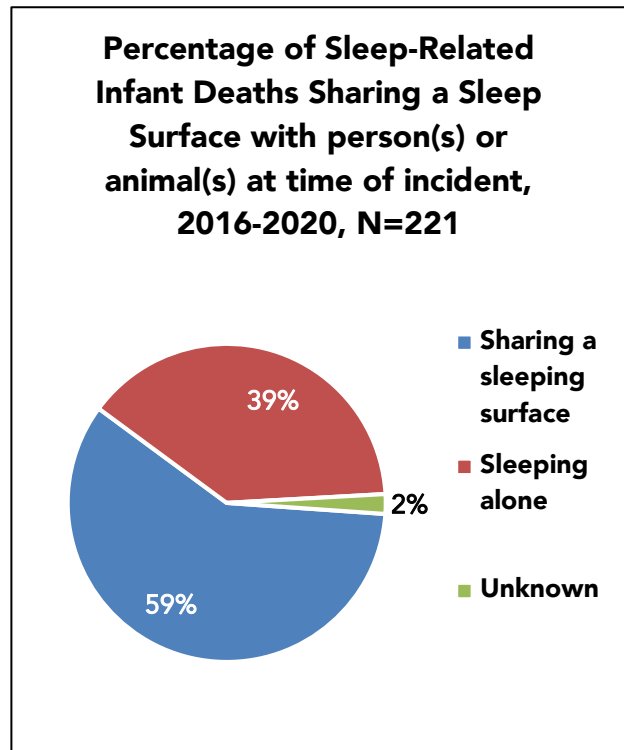


Figure 24



From 2016 through 2020 there have been 35 deaths in which the caregiver reportedly fell asleep while breast (21) or bottle (14) feeding the infant (Figure 25). As noted in the prevention points on page 21, 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 surface, crib or bassinet only, when the parent is ready to return to sleep.<sup>9</sup>

**Figure 25**

<b>Caregiver or Supervisor Fell Asleep While Feeding Infant, 2016-2020, N=221</b>		
<b>Caregiver or Supervisor Fell Asleep While Feeding Infant</b>	<b>Number</b>	
Yes	35	
If Yes, Feeding Type	Breast	21
	Bottle	14
No	176	
Unknown	10	

## Sleep-Related, SUID Deaths

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The Board stresses the importance of thorough investigations by law enforcement and medical personnel, along with properly conducted, complete autopsies. In 17 of the 52 sleep-related death investigations in 2020, the Board believed additional investigative information would have been helpful in more clearly determining the manner of death or the circumstances surrounding the death. The 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/SUIDRF.htm>

### Characteristics of the 52 Sleep-Related Infant Deaths, 2020

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- 98% 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 parental/caregiver alcohol or substance abuse 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.

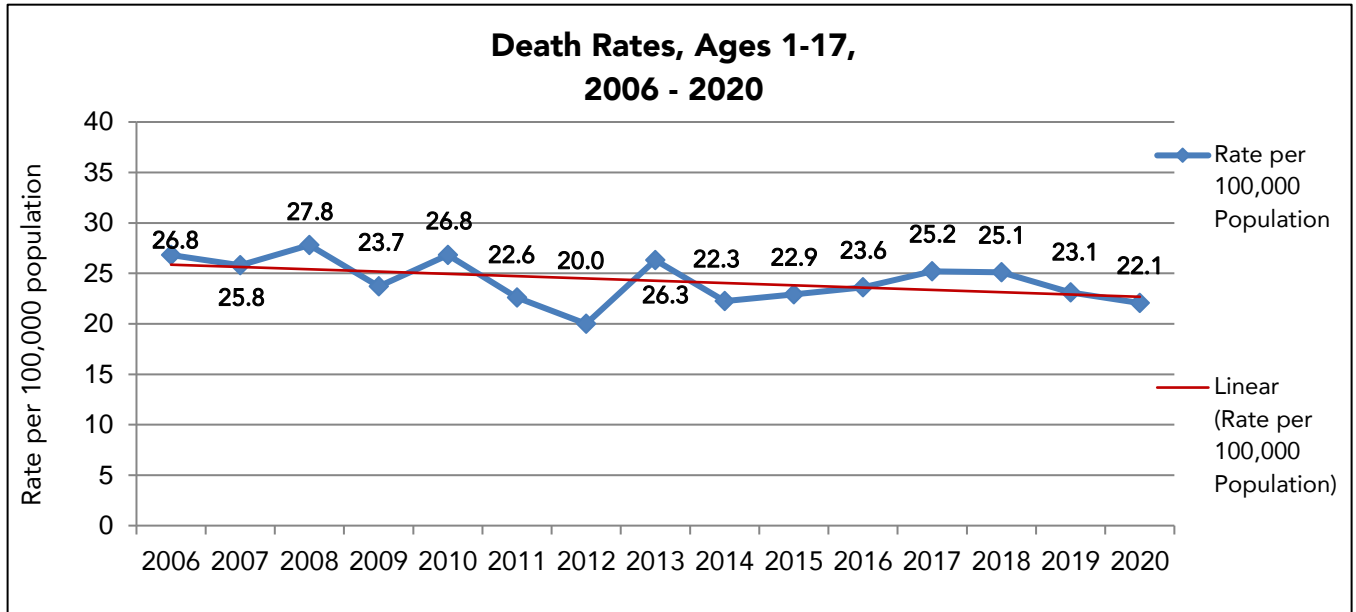
## PREVENTION POINTS

- 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.<sup>9</sup>
- A separate, but proximate sleeping environment is recommended. Bed-sharing with adults or other 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.<sup>9</sup>
- 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.<sup>9</sup>
- Smoking during pregnancy and in the infant's environment are risk factors and should be avoided.<sup>9</sup>
- 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.<sup>9</sup>
- 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 use of products such as sleep positioners or wedges.<sup>9</sup>
- 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/>.

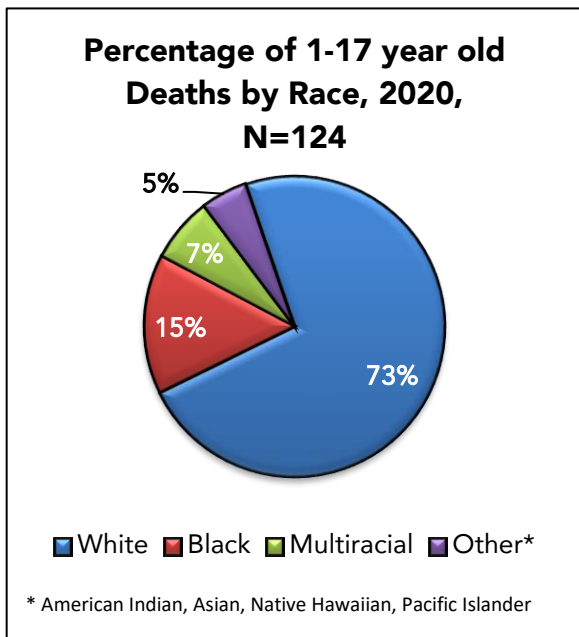
# Mortality Affecting Children Ages 1-17

The mortality rate for children ages 1-17 has remained relatively unchanged. However, the linear rate per 100,000 population over the past 15 years has continued to decline (Figure 26). There were 146 deaths in this age group in 2020.

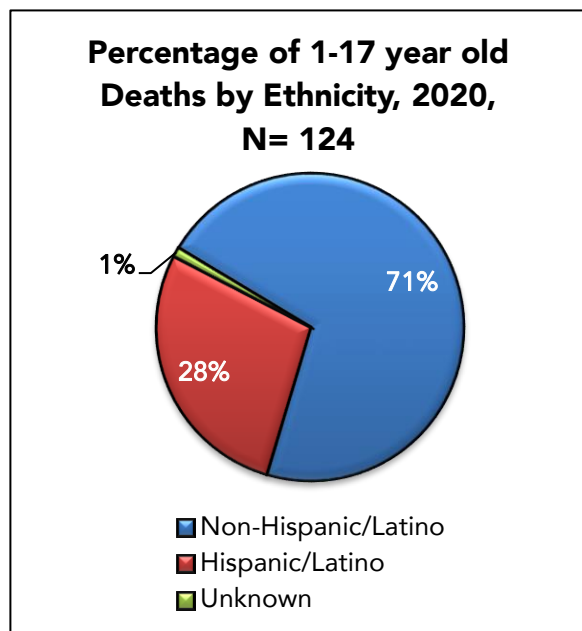
**Figure 26**



**Figure 27**



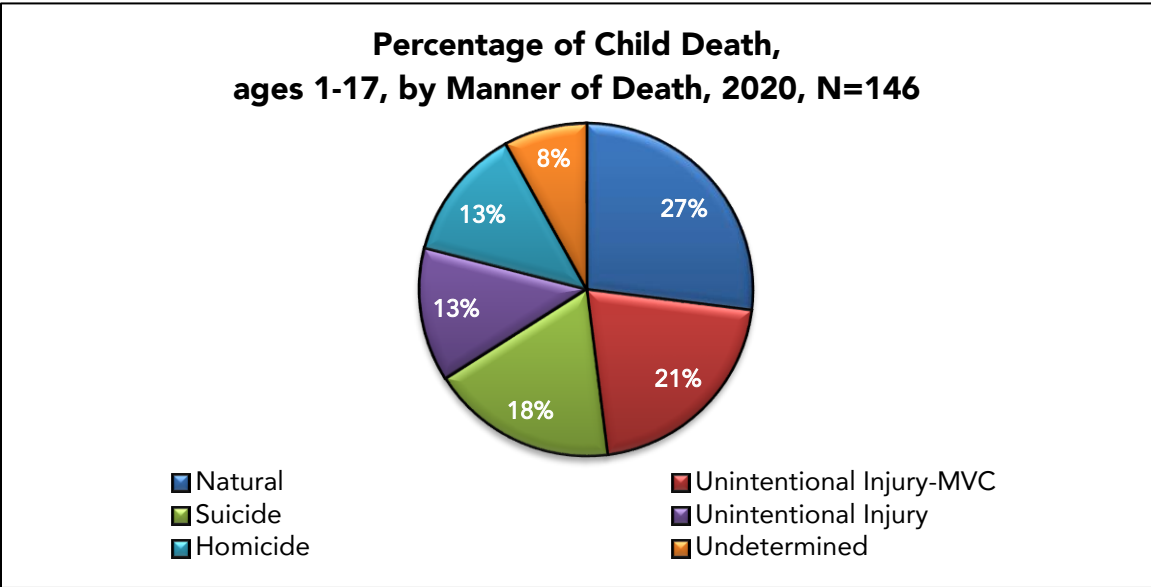
**Figure 28**



Shown in Figures 27 and 28 are the percentages of 1-17 year old deaths by race and ethnicity. More information can be found in the [Methodology](#) section of the report. Figure 29 shows the percentage of

child deaths age 1-17 based on the manner of death. Of all manners of death for this age group, natural deaths accounted for the largest percentage at 27%.

Figure 29



Figures 30 and 31 show relative percentages of death by non-natural causes in this age group for the five previous reporting years as compared to 2020. Unintentional Injury-MVC represents the largest percentage of non-natural deaths for the previous five reporting years as well as 2020.

Figure 30

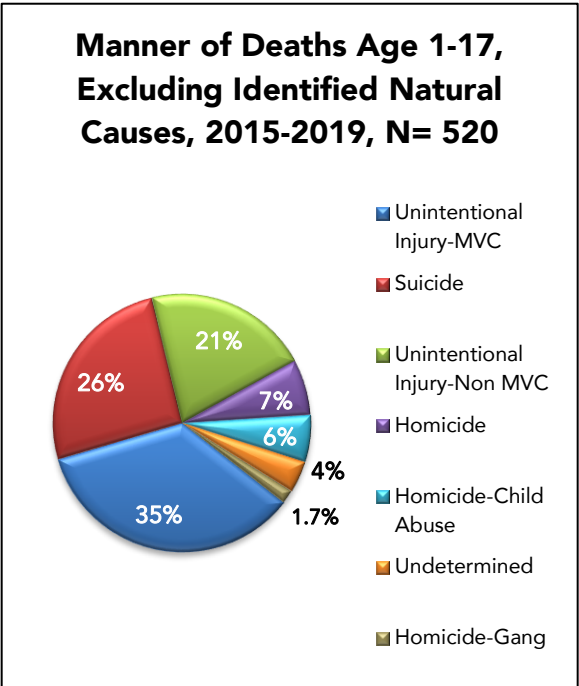
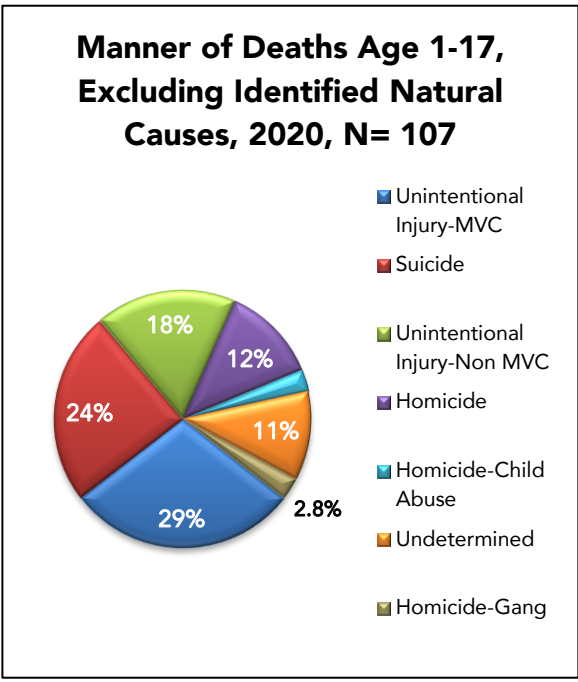


Figure 31



## Mortality Affecting Children Ages 1-17

Figure 32 shows the number of unintentional injuries by age classification for the most recent 5 years of reviews. When looking at the 1-17 age group, motor vehicle crashes (MVC) and other transportation-related deaths claimed the lives of 177 children and teens and was the primary cause of Unintentional Injury deaths in all age groups except infants. The second-leading cause of Unintentional Injury deaths for the 1-17 age group was drowning, with 36 deaths for this timeframe. Of the 16 Unintentional Injury deaths due to Fire, Burn, and Electrocution for this period, one death was due to electrocution and the other 15 the result of fires/burns.

**Figure 32**

Unintentional Injury by Cause and Age Classification, Age 0-17, 2016-2020, N=353					
	Age <1	Age 1-4	Age 5-9	Age 10-14	Age 15-17
<b>MVC and Other Transportation</b>	8	29	29	47	72
<b>Asphyxia</b>	60	9	2	1	0
<b>Drowning</b>	1	12	5	8	11
<b>Fire, Burn, Electrocution</b>	2	8	6	0	0
<b>Weapon, Including Body Part</b>	0	3	1	3	6
<b>Poisoning, Overdose or Acute Intoxication</b>	1	2	1	0	12
<b>Fall or Crush</b>	0	1	3	0	3
<b>Exposure</b>	1	2	0	0	0
<b>Other Causes</b>	1	1	0	1	1

Also shown in Figure 32 are the unintentional injury deaths due to weapon use which accounted for 13 deaths between 2016 and 2020. 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.<sup>13</sup>

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 influences 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.<sup>14</sup> 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.<sup>15</sup> One of those categories is Alcohol and Other Drug Use. In 2019, 16.2% of the youth in Kansas reported having taken “prescription pain medicine without a doctor’s prescription or differently than how a doctor told them to use it.” More information and data about this topic can be found at: <https://www.cdc.gov/healthyyouth/data/yrbs/index.htm>.

Figure 33

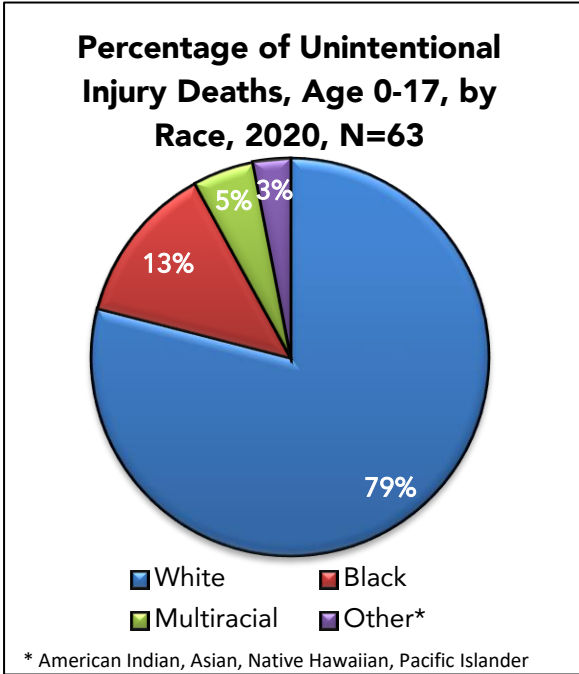
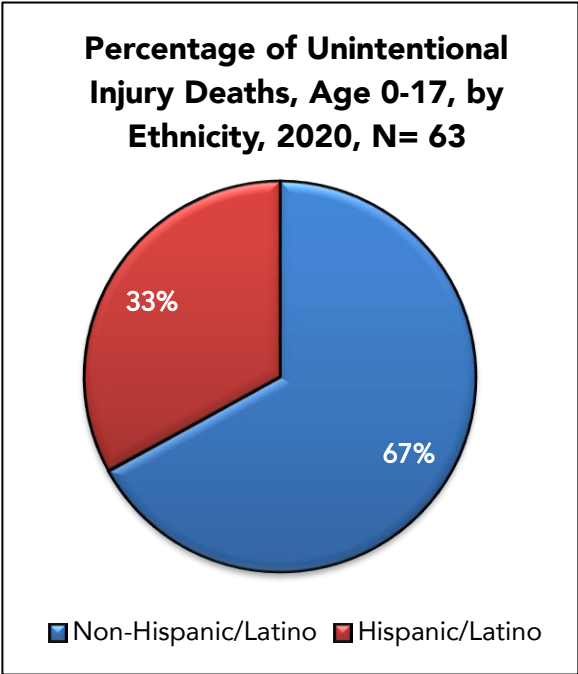


Figure 34



Shown in Figures 33 and 34 are the percentages of unintentional injury deaths by race and ethnicity for children age 0-17. More information can be found in the [Methodology](#) section of the report.

# Natural Deaths

The rate of deaths due to natural causes in children has declined in the last five years. Figure 35 indicates that in 2020 there were 197 natural deaths compared to 266 deaths in 2016. The rate of death has declined to 28.3 deaths per 100,000 population.

**Figure 35**

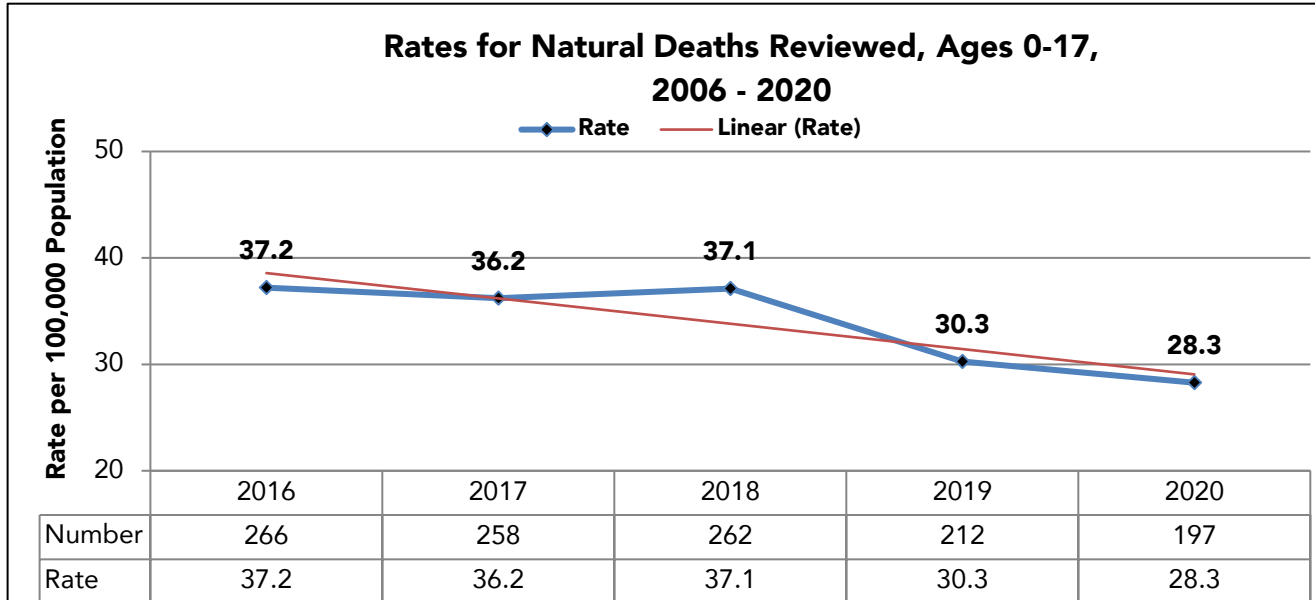


Figure 36 describes the number of natural deaths by age group and sex. Children who were less than one year of age accounted for 77% of natural deaths. Prematurity and congenital anomalies accounted for 73% of the causes of natural deaths for children ages 0-17. Cancer claimed the lives of 10 children and was the fifth-leading natural cause of death (Figure 37).

**Figure 36**

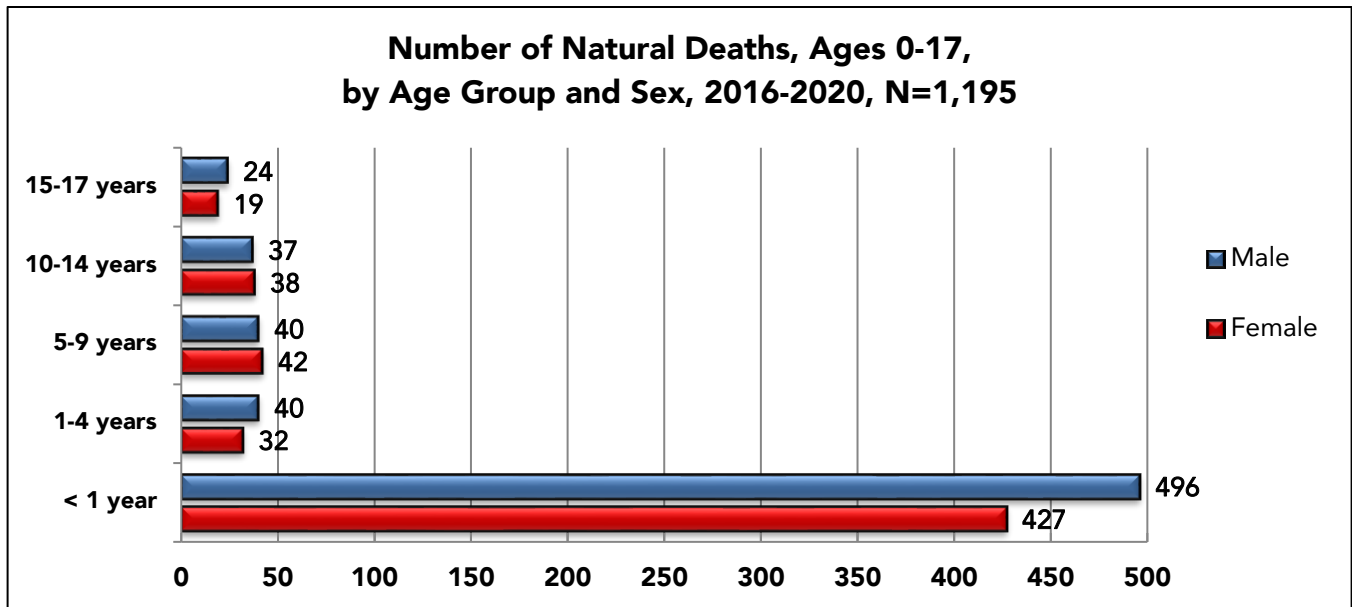




Figure 37

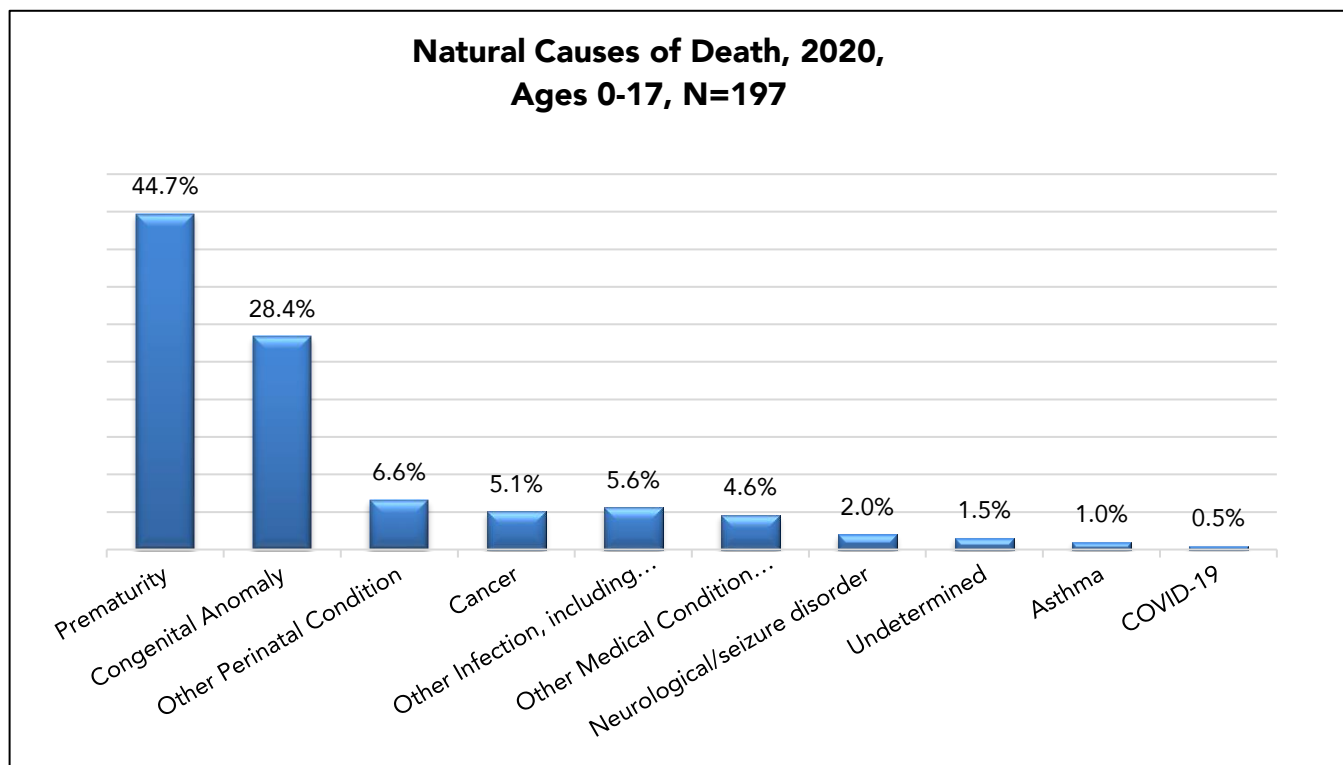


Figure 38

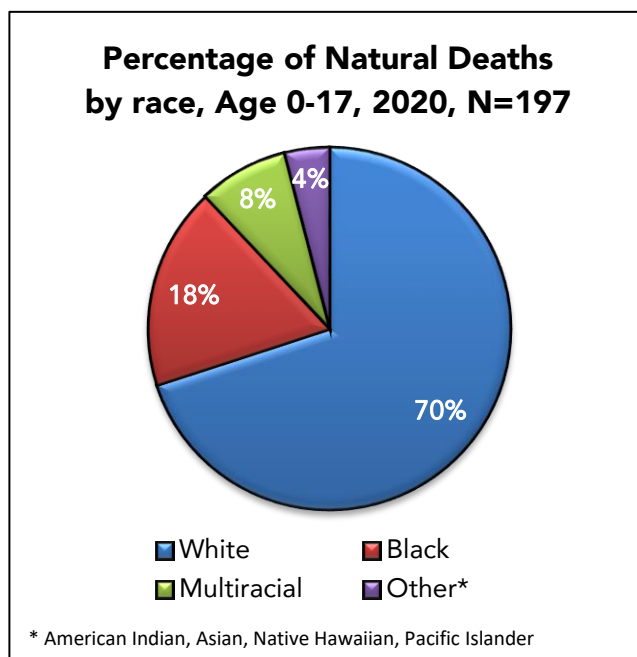
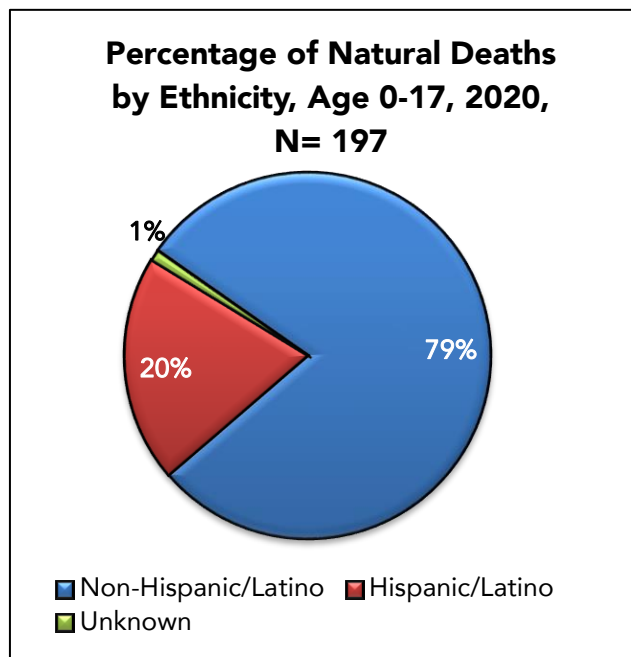


Figure 39



Shown in Figures 38 and 39 are the percentages of 0-17 year old natural deaths by race and ethnicity. More information can be found in the [Methodology](#) section of the report.

**ASTHMA**

In the last 11 years of SCDRB cases (2010-2020) there have been 25 child deaths due to asthma, two of which occurred in 2020. These deaths occurred in children from ages 1-14 with the majority of deaths occurring to children in the 10-14 age group. Although the number of deaths is small, even one death is too many since asthma is a treatable disease.

The numbers and rates of pediatric asthma hospitalizations are 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.<sup>10</sup> The Board is encouraged by the declining number of pediatric asthma hospitalizations as shown in Figure 40.

**Figure 40**

Numbers and Rates of Pediatric Asthma Hospitalizations* Kansas, 2010 - 2020		
Year	Number	Rate
2010	732	113.3
2011	700	108.5
2012	886	138.2
2013	600	93.5
2014	726	112.6
FFY 2015 **	554	86.2
2016 †	482	75.5
2017§	376	59.2
2018	425	67.4
2019	341	54.5
2020	214	32.0

\* 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

\*\* Calendar year rate cannot be calculated due to presence of ICD9CM and ICD10CM diagnoses. Federal fiscal year used.

† Rate calculated using ICD10CM diagnoses. Due to the difference in the coding methods, 2016 rate cannot be compared to prior years.

§ 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, 23 2022

Contact: [KDHE.HealthStatistics@ks.gov](mailto: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, tobacco smoke, air pollution and infections. It is estimated that one in 11 children have asthma, which makes it a common problem. Because it is common, parents and care providers often fail to understand that asthma is not a one-size-fits-all disease and may not appreciate how life threatening it can be if not treated quickly and appropriately.<sup>10</sup>

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.<sup>10</sup>

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.<sup>10</sup>
- **Education** – Teaching and reinforcement of self-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.<sup>10</sup>
- **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.<sup>10</sup>
- **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 published by the National Heart, Lung and Blood Institute of the NIH.<sup>10</sup>

### 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 severe environmental allergies, developed difficulty breathing after an exposure to allergens known to trigger the child’s asthma. After a trial of rescue medication prescribed for someone else, the child became unconscious. Despite emergency services, 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. DCF intakes were initiated due to concerns about the poor compliance with medical care, inability to get medications filled, exposure to cigarette smoke, and unacceptable living conditions. DCF services were provided in the home, but the family 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, random unannounced visits from child welfare are critical to 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.

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## COVID-19

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COVID-19 is caused by SARS-CoV-2, a coronavirus that emerged in December 2019. The first case in Kansas was identified March 7, 2020, with the first death reported March 11, 2020, both in adults. Older adults and individuals who have severe underlying medical conditions are at higher risk for developing more serious complications from COVID-19 illness. Children represent about 19% of all reported COVID-19 cases in the U.S. since the pandemic began. Research suggests disproportionately higher rates of COVID-19 infection in all Hispanic/Latino and non-Hispanic Black children than in non-Hispanic White children.

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 — become severely inflamed.<sup>12</sup>

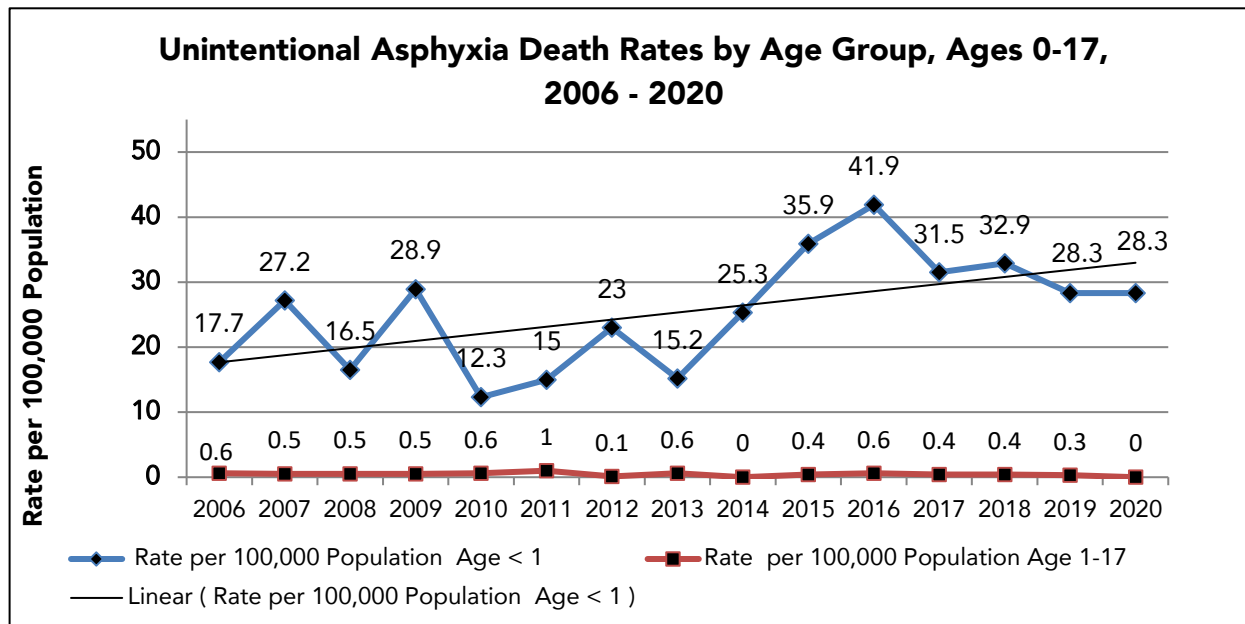
In 2020, there were two children who tested positive for COVID-19 at time of death. One child had no symptoms of COVID-19 and had other contributing factors including an unsafe sleep environment, which resulted in the Board classifying that case as an Undetermined- Sudden Unexpected Infant Death. The other death was classified as a natural death due to complications of COVID-19.

Information regarding natural causes of death due to COVID-19 involve reporting on death certificates, preferably after 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 – Asphyxia Deaths

Ten children between the ages of 0-17 died in 2020 due to unintentional asphyxia such as suffocation, strangulation or choking. Of the 10 child deaths due to unintentional asphyxia, all were under the age of one year and the result of unsafe sleeping conditions. As shown in Figure 41, the rate of death by unintentional asphyxia in children less than one year of age continues to trend upwards, although in comparison to historical data, the more recent annual rates appear to be stabilizing.

**Figure 41**



Unintentional asphyxia deaths most often affect very young children who have not yet developed the strength or motor skills to remove themselves from dangerous situations. Reviews from Kansas and across the nation show there are several common practices that increase the risk for these deaths. These include sleeping somewhere other than a crib 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. Of the 10 unintentional asphyxia deaths, all were sleep-related and included one or more of the above-described factors as a cause of the suffocation/asphyxia.

Some cribs, bassinets, playpens, and child beds have been recalled because of known or suspected risk of strangulation. Before caregivers purchase furniture for 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 the 10 Unintentional Asphyxia Deaths, 2020

- 100% of the deaths were sleep-related and occurred in children under the age of one year. All had elements of unsafe sleep.
- 60% occurred in the child’s home, 20% in a relative’s home, 20% in an unlicensed child care home.
- 20% had a history of DCF involvement with the family.
- 70% were sleeping in an adult bed, 20% on a couch, 10% in a crib.
- 50% were bed-sharing with an adult, child, or animal.
- 30% had a parent with a substance use disorder.

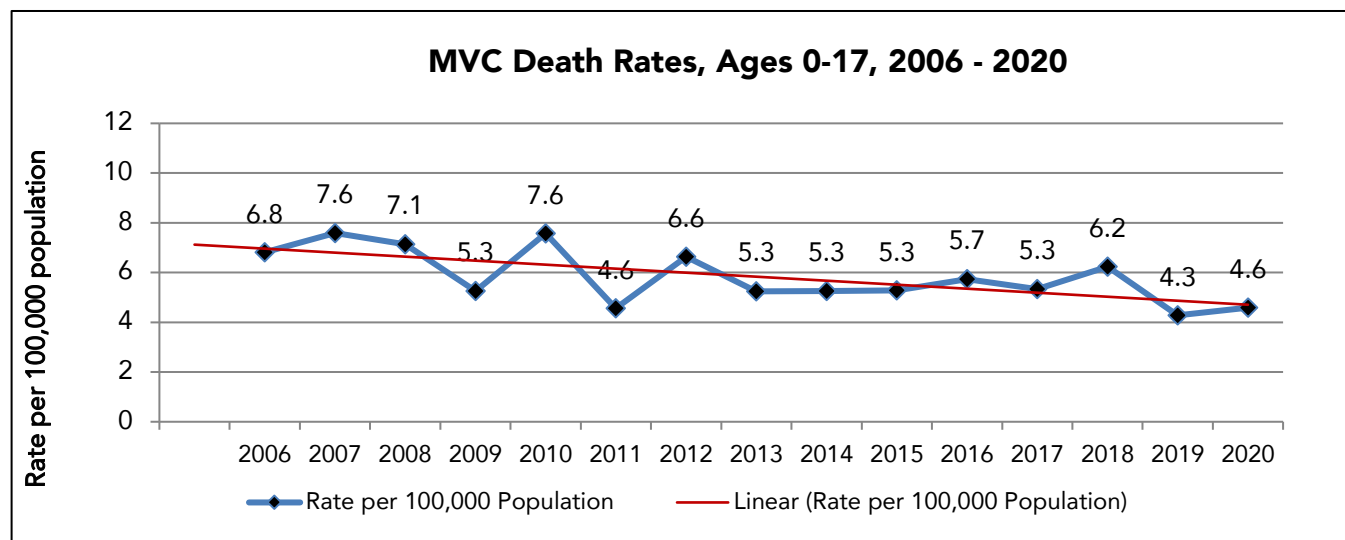
### PREVENTION POINTS

- **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.<sup>16</sup>
- **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, hanging cords or plastic bags, which may not be threats to adults, but can be deadly to children. Check play areas for hazards like protruding bolts that can catch clothing and strangle a child. Check playground equipment parts and handrails for spaces that may be large enough to allow a child’s body to slip through causing strangulation by trapping the head or neck.<sup>16</sup>
- **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.<sup>16</sup>
- **Choking Hazards** – Children under age four are most at risk for choking on food and small objects. In addition to small toys, balloons, coins and some foods can be a choking hazard for young children. Hot dogs, whole grapes, raw carrots, popcorn and other foods can become lodged in the child’s airway. Young children need supervision while eating and when playing with or near potential choking hazards.<sup>16</sup>

# Unintentional Injury – Motor Vehicle Crash Deaths

In 2020, 32 children died in Kansas due to unintentional injuries sustained in Motor Vehicle Crashes (MVC). Figure 42 shows the MVC death rate has continued to decline with 2019 having the lowest rate (4.3 deaths per 100,000 population) since the inception of the Board. In 2020, the rate of MVC deaths slightly increased to 4.6 deaths per 100,000 population.

**Figure 42**



In general, the likelihood of a child dying due to a motor vehicle crash increases as the child becomes older (Figures 43 and 44). Teens in the 15-17 age group typically account for the highest percentage of MVC deaths each year; however, in 2019 and 2020, this age group experienced a much lower rate of death compared to previous years (Figure 43).

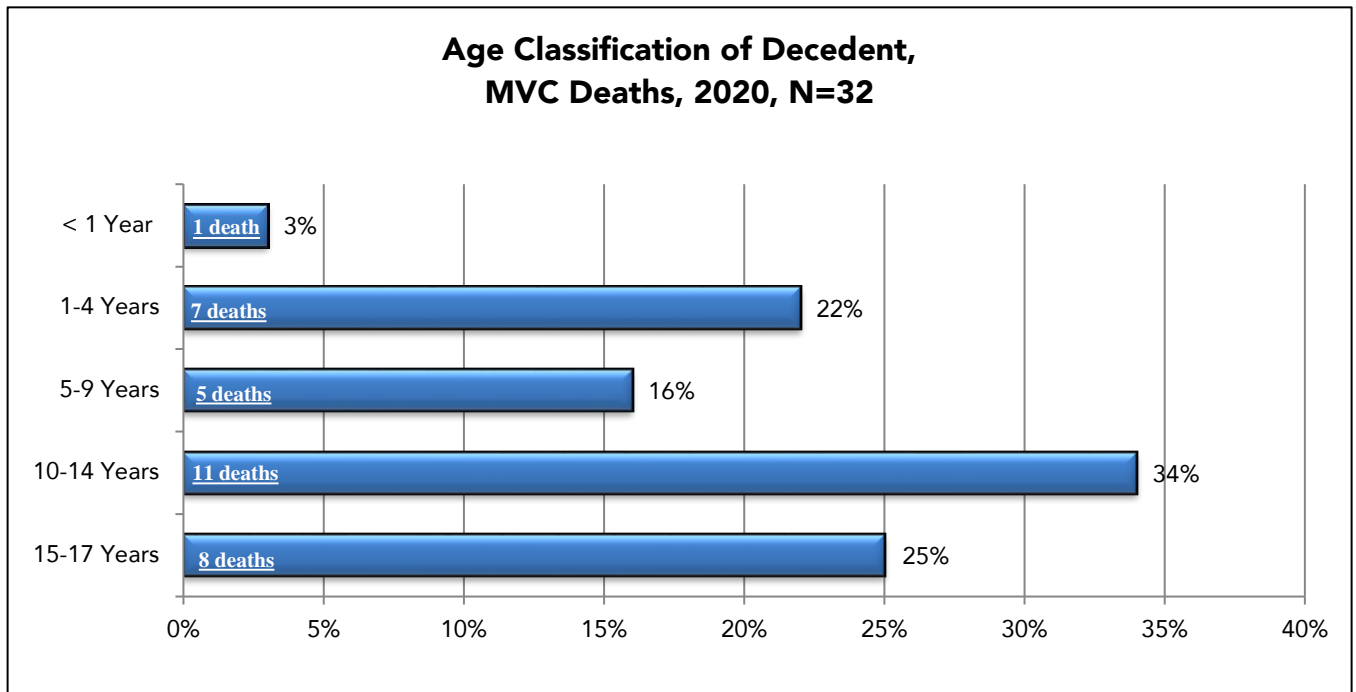
Of the 32 Motor Vehicle Deaths in 2020, 24 of the children were either the driver or a passenger of the vehicle. An additional six children were pedestrians, and two children were riding a bike.



Figure 43

MVC Death Rates per 100,000 Population by Age Group, Ages 0-17, 2006-2020					
	< 1 Year	Age 1-4	Age 5-9	Age 10-14	Age 15-17
2006	3.0	2.6	2.1	7.3	18.9
2007	3.0	5.1	1.1	6.9	23.2
2008	0.0	5.6	2.1	6.9	21.2
2009	4.0	4.3	1.0	1.6	18.9
2010	0.0	6.1	5.9	3.0	22.5
2011	2.5	4.9	3.5	3.5	8.4
2012	2.5	4.3	3.9	6.5	16.1
2013	2.8	2.5	2.9	4.5	15.2
2014	5.0	2.5	3.9	4.0	13.5
2015	2.6	2.5	5.4	3.0	13.3
2016	7.9	2.6	4.5	5.0	12.5
2017	0.0	3.9	3.0	5.0	13.4
2018	2.7	5.2	1.0	4.0	21.1
2019	8.5	2.7	3.6	4.0	6.7
2020	2.8	4.7	2.6	5.5	6.7
Average	3.2	4.0	3.1	4.7	15.4

Figure 44



It is important to note that there are multiple factors that can lead to a MVC death. Combined data for 2016-2020 includes 185 MVC fatalities. Of those fatalities, there were 408 combined factors that were reported as having contributed to those deaths. A list of those factors can be found in Figure 45.

## Unintentional Injury – Motor Vehicle Crash Deaths

Speeding, whether over the limit or unsafe for the conditions, was a contributing factor in 47% of the MVC deaths in 2016-2020. Driver inexperience accounted for another 29% of the MVC deaths. While 20% (37) of the MVC deaths during these five years had a contributing factor of alcohol or drug use, in 11 of these crashes, it was the underage decedent operating the vehicle while under the influence.

**Figure 45**

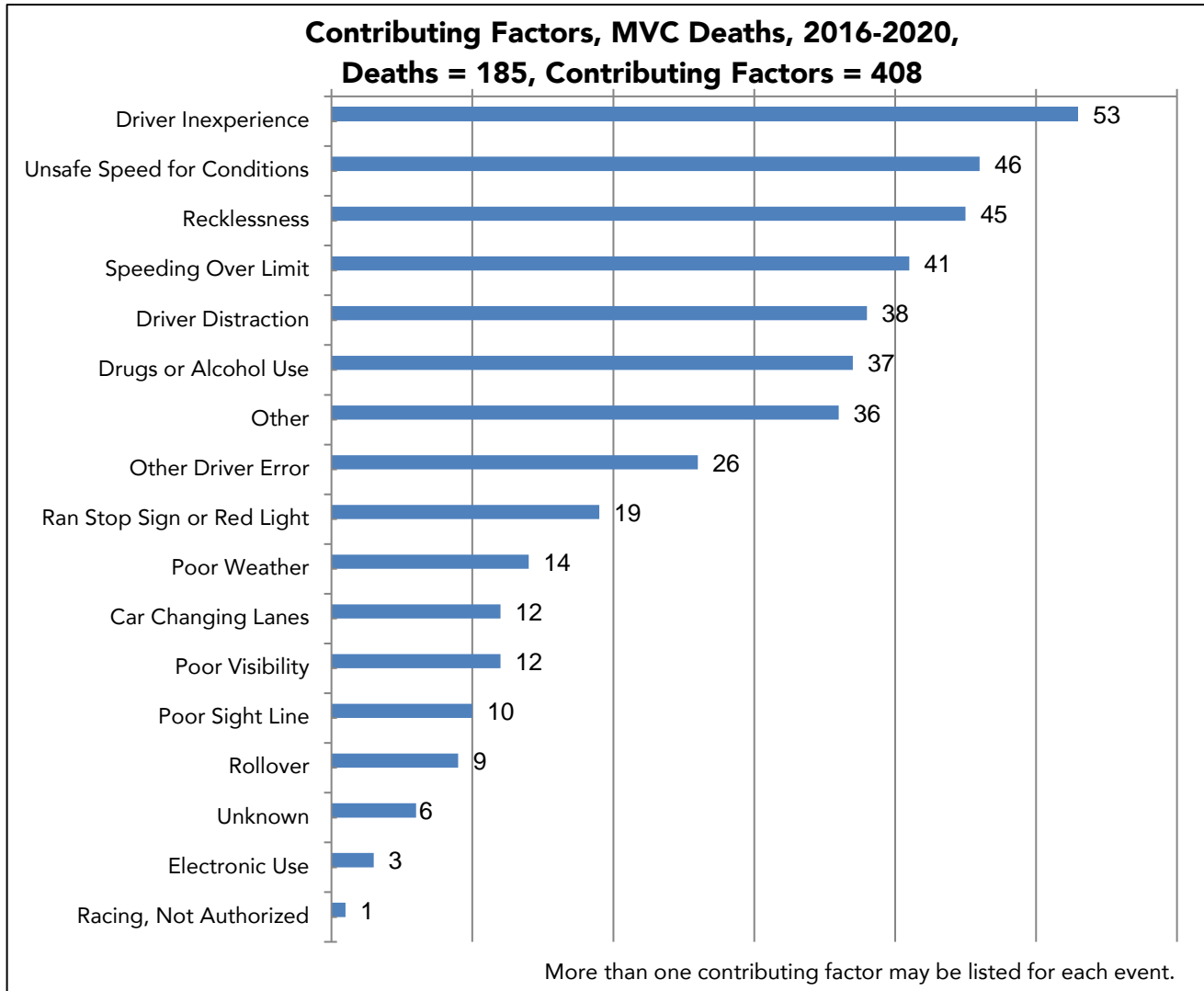


Figure 46

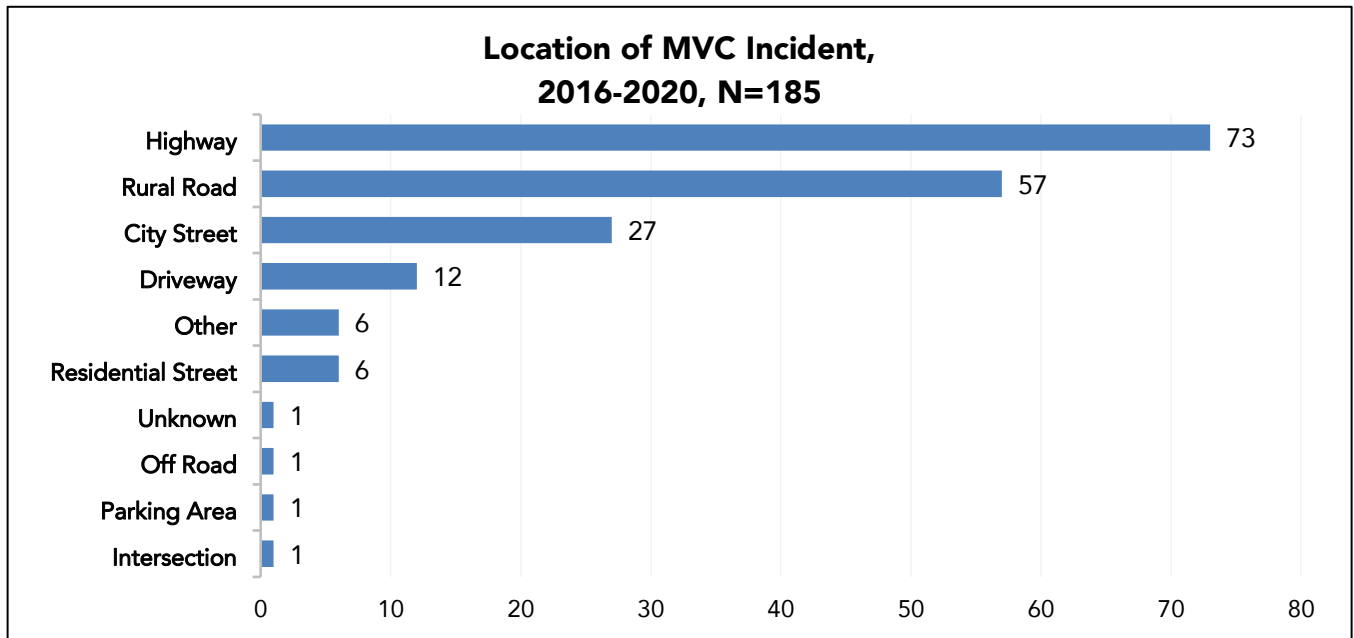


Figure 46 shows that 40% of motor vehicle crash deaths of Kansas children occurred on a highway and 31% on rural roads.

Figure 47

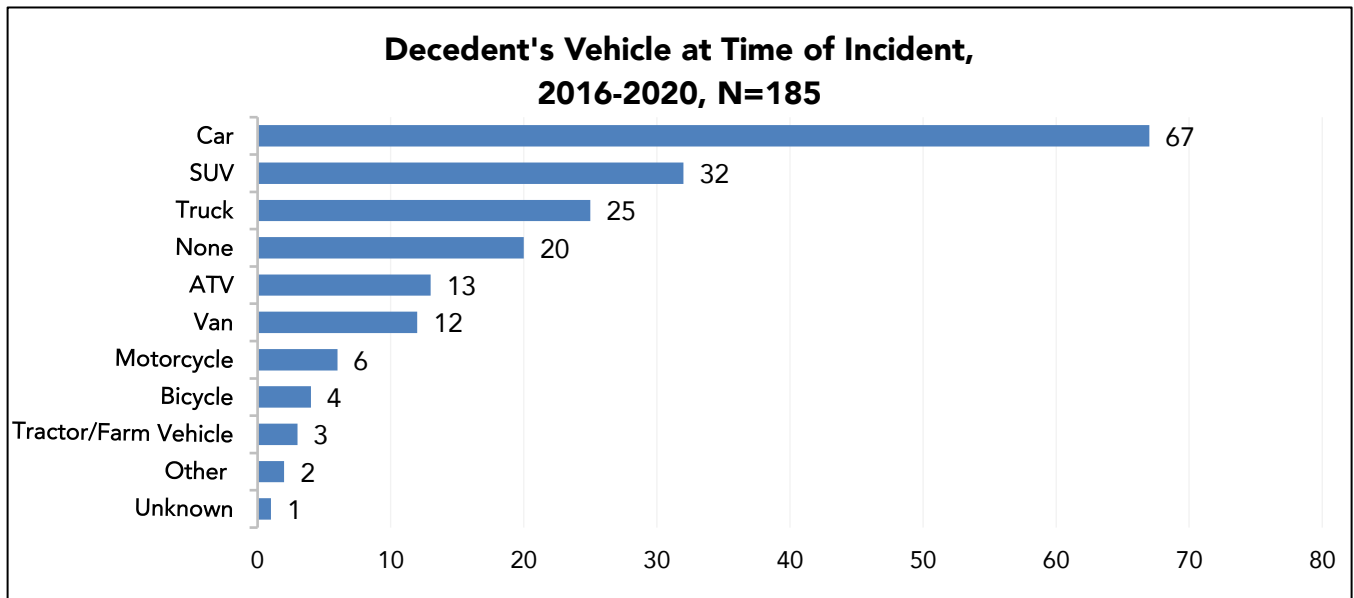


Figure 47 demonstrates the type of vehicle the decedent was driving or was a passenger in when the crash occurred. As shown above, 67 out of 185 instances or 36% of crashes occurred while the decedent was driving or riding in a car. This statistic is comparable to the National Highway and Traffic Safety Administration’s data, which says that in 2020, 32% of fatal accidents happened in a car.<sup>45</sup>

## Unintentional Injury – Motor Vehicle Crash Deaths

**Figure 48**

Restraint or Safety Measure Use by Decedent, 2018-2020, N= 88					
	Driver	Passenger Front Seat	Passenger Back Seat	Passenger Other*	Total
<b>Restrained, Correctly</b>	10	8	18	1	37
<b>Restrained, Incorrectly</b>	0	1	1	0	2
<b>Unrestrained</b>	10	7	18	1	36
<b>Unknown if Restrained</b>	2	1	0	3	6
<b>Other**</b>	3	0	0	4	7
<b>Total</b>	25	17	37	9	88

\*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 transport vehicles that did not have a typical restraint system. For example, motorcycle, airplane, tractor, etc.

Figure 48 displays whether a restraint or safety measure was used based on the location of the victim in the vehicle. Between the years of 2018 and 2020 there were 88 deaths of children due to MVCs. Of those deaths, 29% (25) of the decedents were the driver of a motor vehicle at the time of their death with only 40% (10) being properly restrained at the time of the crash. In total, when looking at safety restraint use, 44% of the decedents were either incorrectly restrained or unrestrained for all locations in the vehicle. Figure 48 does not include pedestrian deaths, bicycle death, or MVC related deaths in which the decedent was not in a motor vehicle at the time of the incident.

Kansas experienced 13 child deaths from All Terrain Vehicle (ATV) crashes in the five-year period from 2016 and 2020. According to the 2021 Annual Report of Deaths and Injuries Involving Off-Highway Vehicles published by the U.S. Consumer Product Safety Commission, in 2020, there were an estimated 112,300 ATV-related, emergency department-treated injuries in the United States. An estimated 26% of these involved children younger than 16 years of age.<sup>17</sup>

ATV use is popular in both recreation and agricultural work. This type of vehicle 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.<sup>18</sup>

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 2020, three children died in ATV crashes. 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.

### Characteristics of the 32 Motor Vehicle Crash Deaths, 2020

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- 19 decedents were male; 13 were female.
- 6 of the decedents were driving a vehicle at the time of their demise.
  - 3 were properly restrained.
- 8 decedents were pedestrians.
  - 2 were riding a bike, 6 were walking.

### 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.<sup>20</sup>
- **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, which are known risk factors.<sup>20</sup>
- **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.<sup>20</sup>
- **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.<sup>20</sup>
- **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.<sup>20</sup>

## CASE VIGNETTE

### 2020 CHILD DEATH DUE TO MOTOR VEHICLE CRASH

**Seat belts save lives** – Two children were passengers in a vehicle. At the time of the crash, the adult driver and the decedent were both unrestrained and ejected from the vehicle. The sole survivor of the crash was a properly belted child who sustained minimal injuries.

**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.<sup>20</sup>

## CASE VIGNETTE

### 2020 TEEN DEATH DUE TO MOTOR VEHICLE CRASH

**Alcohol and drug use while driving can be fatal** – A teen who died from injuries sustained in a motor vehicle crash was found at autopsy to have consumed a sufficient amount of alcohol and cocaine to be intoxicated. Reports indicated that the decedent had been drinking with friends prior to the 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:

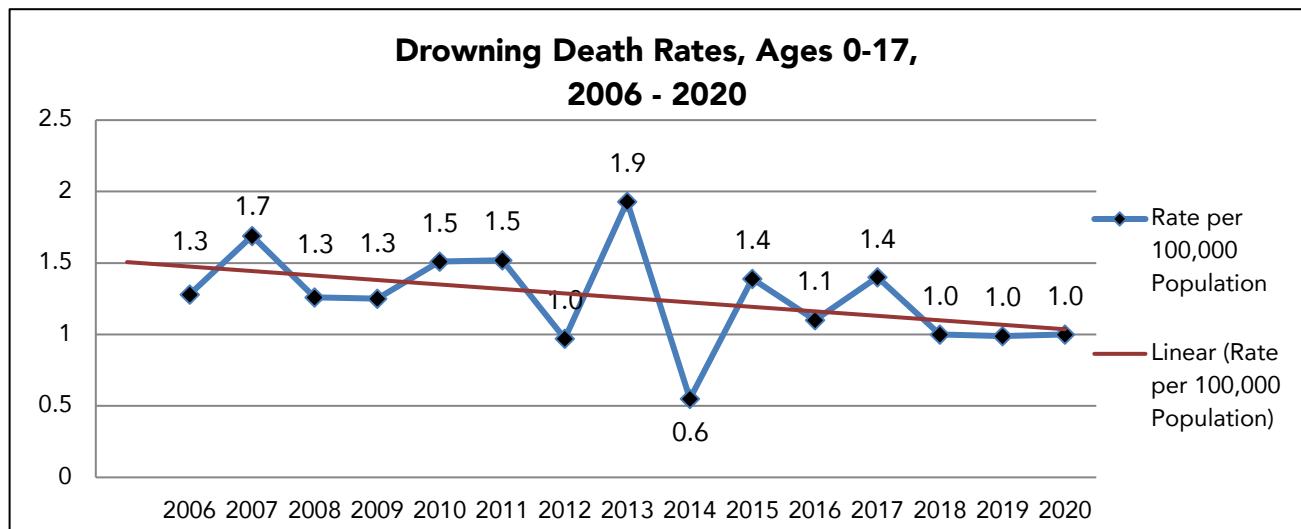
<https://www.cdc.gov/vitalsigns/teendrinkinganddriving/>.<sup>19</sup>

# Unintentional Injury – Drowning Deaths

In 2020, seven children died from unintentional drowning. Children are drawn to water. They like to splash and play in it, but this lure is deceptive and can lead to tragedy. Children can drown in minutes and in only a few inches of water. Figure 49 shows drowning death rates for all ages 0-17 combined over the last 15 years. Since 2006, the 1-4 year age group, on average, has accounted for the highest rate of deaths when compared to the other age groups (Figure 50).

Recently 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/>.<sup>21</sup>

**Figure 49**



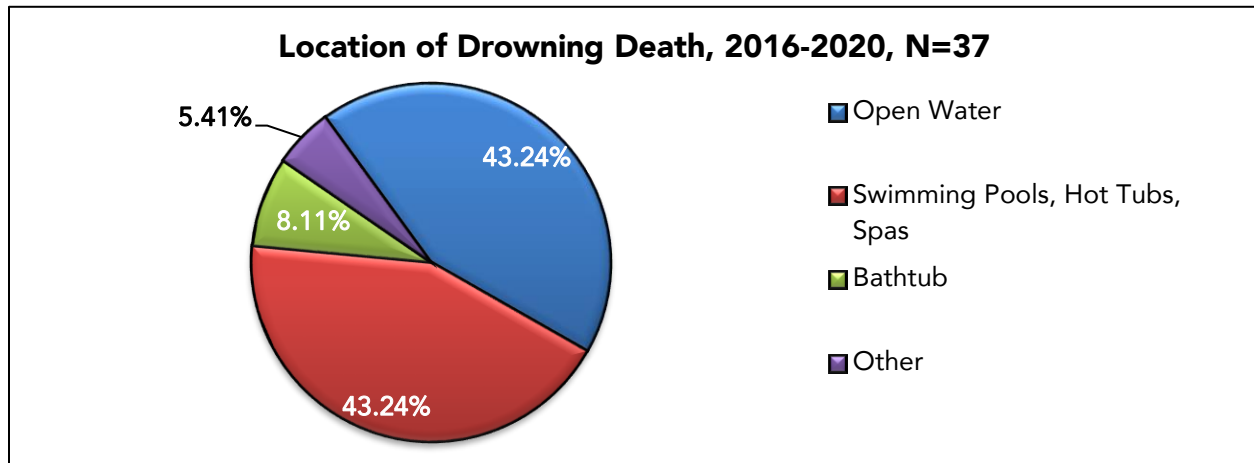
**Figure 50**

<b>Drowning Death Rates per 100,000 population by Age Group, Ages 0-17, 2006-2020</b>					
	< 1 Year	Age 1-4	Age 5-9	Age 10-14	Age 15-17
<b>2006</b>	1.0	2.6	0.5	0.0	2.0
<b>2007</b>	2.0	3.2	0.5	1.6	0.8
<b>2008</b>	0.0	4.4	0.5	0.0	0.8
<b>2009</b>	0.0	3.1	0.5	1.1	0.9
<b>2010</b>	0.0	3.6	1.5	1.0	0.0
<b>2011</b>	0.1	0.4	0.6	0.1	0.3
<b>2012</b>	0.0	2.4	1.0	0.5	0.0
<b>2013</b>	0.0	3.1	0.5	2.5	4.2
<b>2014</b>	0.0	1.9	0.0	0.0	0.8
<b>2015</b>	0.0	3.2	0.5	1.5	0.8
<b>2016</b>	0.0	1.3	0.0	0.5	2.5
<b>2017</b>	2.6	1.9	1.0	1.5	0.8
<b>2018</b>	0.0	2.0	0.5	0.5	1.7
<b>2019</b>	0.0	1.3	0.0	1.0	3.4
<b>2020</b>	0.0	1.4	1.0	1.0	0.8
<b>Average</b>	<b>0.4</b>	<b>2.4</b>	<b>0.6</b>	<b>0.9</b>	<b>1.3</b>

As shown in Figure 51, swimming pools and open water have been the primary location of child drownings in the last five years. Proper supervision and flotation devices for children of all ages are very important. Children are not only at risk during the summer when pools are mainly in use, but also when they are not in use and still accessible. Four-sided fencing of swimming pools, including soft-sided pools, on residential properties is an additional and necessary tool to prevent drownings.<sup>22</sup> Many of the same prevention points can be applied to swimming in locations of open water.<sup>23</sup> Open water, which includes rivers, lakes, and ponds, are popular areas for Kansas children to visit. 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.<sup>23</sup>



Figure 51



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.<sup>23</sup> Figure 51 shows that in 5% of the drowning deaths, “other” location of the drowning was listed. Toilets, buckets of water, washing machines, large puddles, etc. are all “other” locations that small children could encounter within their own home and that without proper supervision could endanger them. In 32 of the 37 unintentional drowning deaths between 2016 and 2020, poor/absent supervision or neglect was noted to be either the direct or contributing factor. Every minute counts in drowning situations. Proper supervision and appropriate personal flotation devices are critical prevention measures when children are near water.

Figure 52

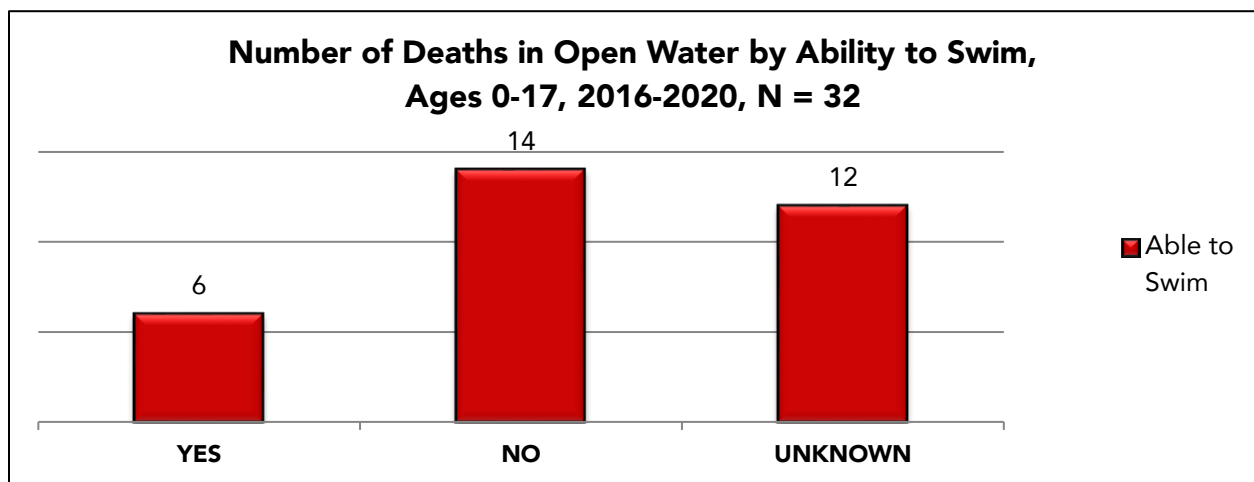
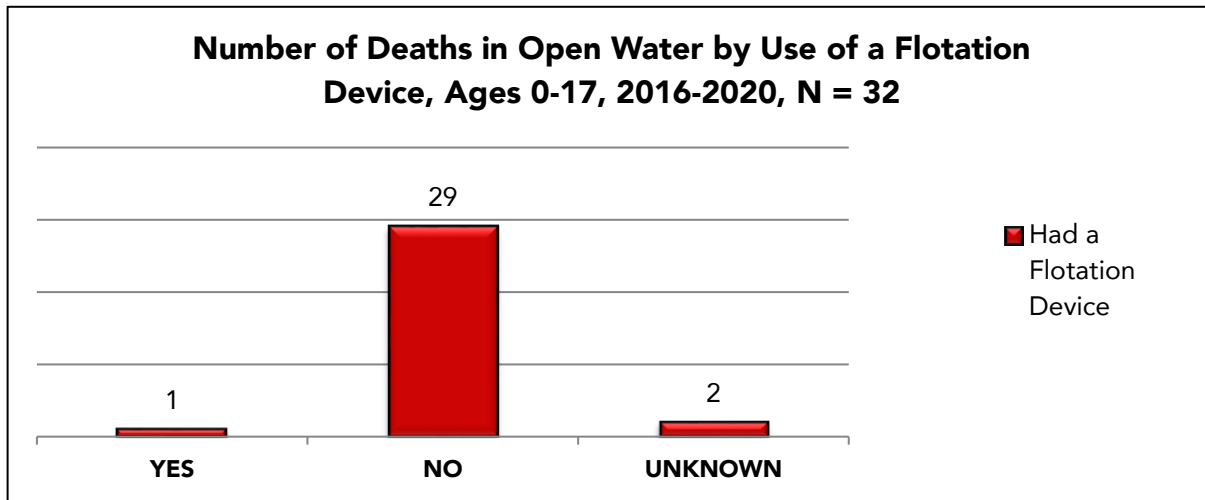


Figure 52 shows the number of deaths in open water based on the child’s ability to swim, for years 2016-2020. Less than 20% of children who died from drowning were reported to be able to swim. 44% were confirmed as not able to swim, and 38% had no documentation of swimming ability. The Board is hopeful that with the use of a standardized drowning investigation tool, thorough and accurate information will be collected to aid in understanding drowning deaths.

Figure 53



The use of personal flotation devices is essential for children of any age despite their ability to swim.<sup>23</sup> In 2020, none of the children who died due to unintentional drowning were wearing a flotation device. Figure 53 demonstrates the number of deaths that occurred in open water where the child was wearing a flotation device. Only one death from 2016-2020 was reported to be wearing a flotation device at the time of death and 90% had no flotation device. 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.<sup>23</sup>

### CASE VIGNETTE

#### CHILD DEATH DUE TO DROWNING

**Flotation devices are critical** – During a family gathering with several adults and children, a youth who was not a strong swimmer and was not wearing a flotation device fell off a raft in an open body of water.

**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.<sup>23</sup> It is essential that any child, despite age or ability to swim, use a personal flotation device when swimming in open bodies of water.<sup>22</sup>

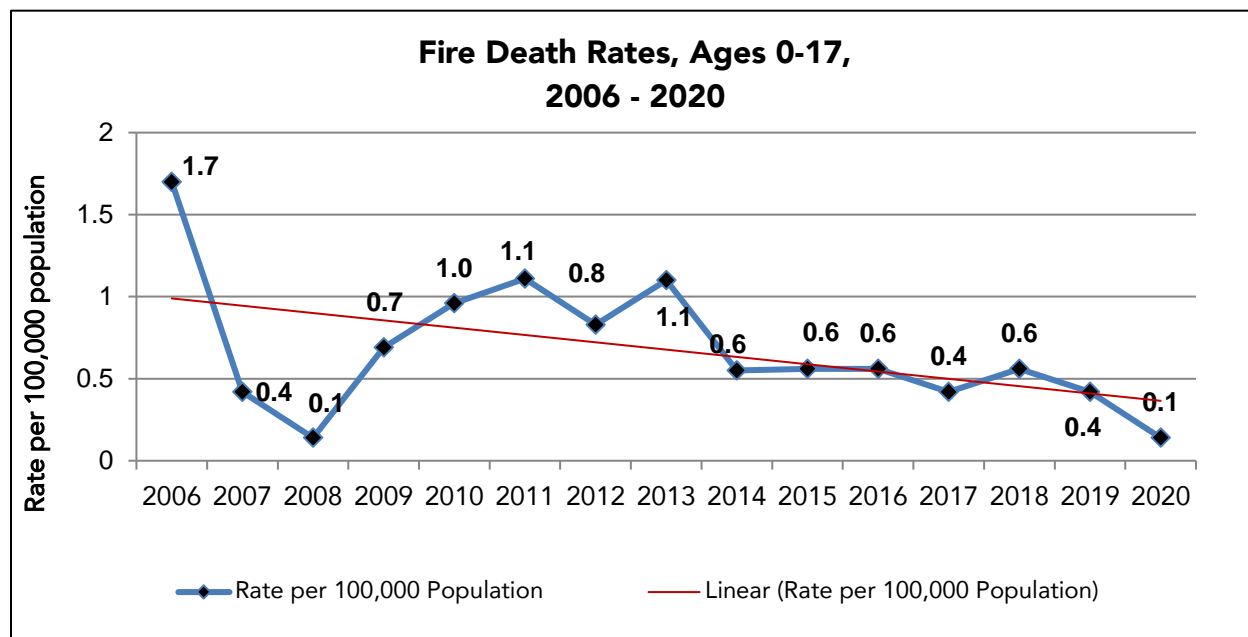
### PREVENTION POINTS

- **Home Safety** – Small children can drown after falling into buckets, toilets, washing machines or other containers holding water. In bathtubs, children can drown in only a few inches of water and seats designed to hold a baby’s head above water are no substitution for adult supervision. Caregivers should ensure that in addition to adequate supervision, creating barriers to areas or items in the home where water is accessible is important. Ways to prevent drowning deaths inside the home include keeping bathroom doors closed, adding locks to toilets, and ensuring buckets, coolers, and other containers are not stored with water.<sup>24</sup>
- **Proper Supervision** – An adult capable of responding to an emergency should always supervise children around water. The adult should actively watch and avoid distractions. Assigning swim “buddies” is recommended. Supervision also applies to other areas in the home including bathtubs, where children should never be left alone even for brief periods.
- **Pool Environment Safety** – Most cities/counties have ordinances regarding fencing around pools. A 5-foot fence with safety-latched gates completely encircling a pool or hot tub is recommended.<sup>23</sup>
- **Use of Safety Equipment** – When participating in water activities, children should always wear Personal Flotation Devices (PFDs) that are Coast Guard approved and suited for the proper weight of the child. PFDs should be checked for broken zippers and buckles. “Water wings” and other inflatable items are not adequate substitutes.<sup>22</sup>
- **Water Safety Education** – Children should have swimming lessons and water safety education. The American Academy of Pediatrics recommends waiting until age 4 to begin lessons. While this is vital, swimming ability alone does not relieve the need for adult supervision and PFDs.<sup>23</sup>
- **Water conditions** – Lakes, ponds and ditches often contain murky water and tangled branches or other items that pose danger to swimmers. Research and become familiar with possible dangers such as large rocks and underwater currents. Know water depth and underwater hazards before allowing children to enter any body of water. Parents and caregivers should educate children about the dangers of going out onto a frozen body of water for recreational purposes such as ice skating or fishing.<sup>22</sup>

# Unintentional Injury – Fire, Burn and Electrocution

In 2020, one Kansas child died in an unintentional fire, burn or electrocution incident. Figures 54 and 55 indicate death rates in this category for all children and by age group per 100,000 population for the past 15 years in Kansas.

**Figure 54**



**Figure 55**

Fire Death Rates per 100,000 population by Age Group, Ages 0-17, 2006-2020					
	< 1 Year	Age 1-4	Age 5-9	Age 10-14	Age 15-17
2006	5.3	2.7	0.6	2.2	0.8
2007	0	0.7	1	0	0
2008	0	0.7	1	0	0
2009	0	2	1	0	0
2010	0	2	1.6	0.5	0
2011	2.5	1.2	1.5	0.5	0.8
2012	0	1.8	1.5	0	0
2013	0	3.7	0.5	0.5	0
2014	0	0	1	0.5	0.8
2015	0	1.3	0	0.5	0.8
2016	0	1.3	0.5	0	0
2017	0	1.3	0.5	0	0
2018	2.7	1.3	0.5	0	0
2019	0	0.7	1	0	0
2020	2.8	0	0	0	0
<b>Average</b>	<b>0.9</b>	<b>1.4</b>	<b>0.8</b>	<b>0.3</b>	<b>0.2</b>

The fire-related death in 2020 occurred in a home that did not have working smoke alarms installed. Parents and caregivers must be diligent about having functional smoke alarms in all appropriate locations in the home.<sup>25</sup> Smoke alarms need to be installed on every level in the home and by each sleeping area. They should be tested once a month, have new batteries at least once a year, and be replaced every 10 years. Close supervision of children, safe storage of matches and lighters, and working smoke alarms in the home are critical.<sup>25</sup>

Fire is often started by children playing with matches or lighters. It is vital for parents and caregivers to keep all lighters, matches, and other igniting sources out of reach of children. They also need to educate children on the dangers of fire and practice escape routes in the event a fire does occur.<sup>16</sup>

### PREVENTION POINTS

- **Proper Supervision** – Young children must be watched closely. Leaving them unsupervised, especially if there are objects such as candles, lighters or matches within their reach, could result in a serious injury or death.<sup>16</sup>
- **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.<sup>16</sup>
- **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.<sup>25</sup>
- **Emergency Fire Plan** – Everyone in the house, including the children, should know all exits from the house in case of a fire. Ensure that gates or unnecessary clutter do not block exits. Designate a central meeting location outside of the home and have regular fire drills.<sup>25</sup>

# Unintentional Injury – Agriculture Related Deaths

The most recent census data from 2017 indicates there are likely more than 58,000 farms in Kansas, most of which are family-owned. 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.<sup>26</sup>

In the last five reporting years, Kansas has experienced nine agriculture-related deaths of children, two of which occurred in 2020. 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.<sup>18</sup>

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 (grades 1-6). This injury prevention program, available since 1950, is an effort to develop “safety-minded” youth. Educational materials and contest winners are accessible at <https://www.kfb.org/>.

## PREVENTION POINTS

- **Proper Supervision** – Parents and caregivers should not engage in farm work at the same time they are supervising young children. Caregiving requires undivided attention. As children learn how to assist with farm related tasks, supervision and guidance is critical to their safety until they can demonstrate the ability to safely perform tasks appropriate for their age and development.<sup>18</sup>
- **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.<sup>18</sup>
- **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.<sup>18</sup>
- **Safe Play Area** – Children should have a safe place to play where they are supervised and protected from potential hazards of farm life. The area should be away from roadways and areas where equipment is operated.<sup>18</sup>

# Drug-Related Deaths

In 2020, Kansas experienced 16 drug-related deaths in children ages 0-17. This is a sharp increase from 5 deaths in 2019. Figure 56 indicates that the rate of drug-related deaths tripled for children ages 0-17 to 2.3 deaths per 100,000 population.

Figure 56

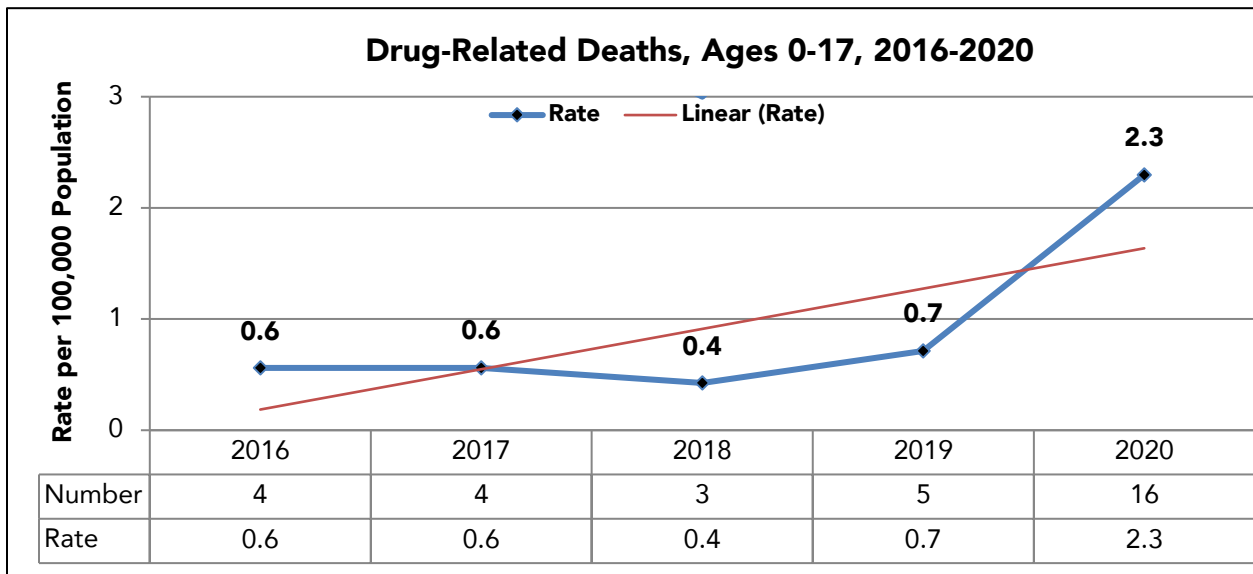


Figure 57 and 58 show the percentages of drug-related deaths by race and ethnicity. More information can be found in the [Methodology](#) section of the report.

Figure 57

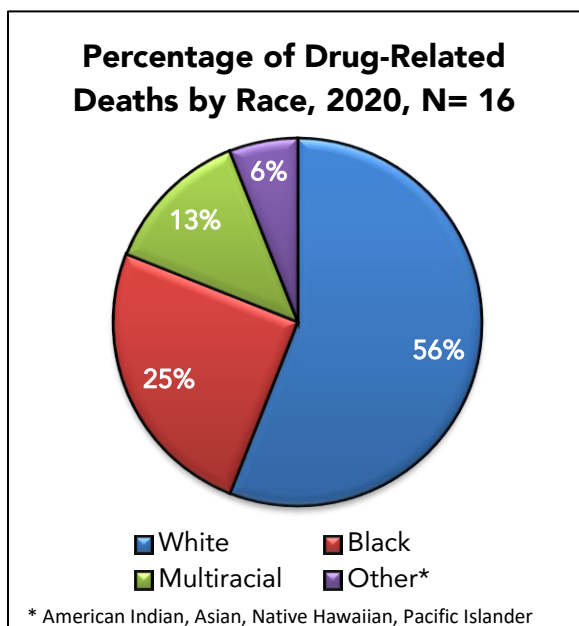
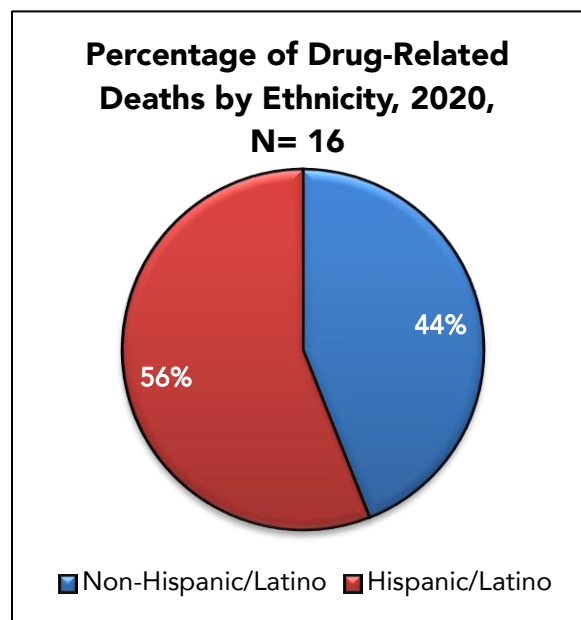


Figure 58



## Drug-Related Deaths

Figure 59

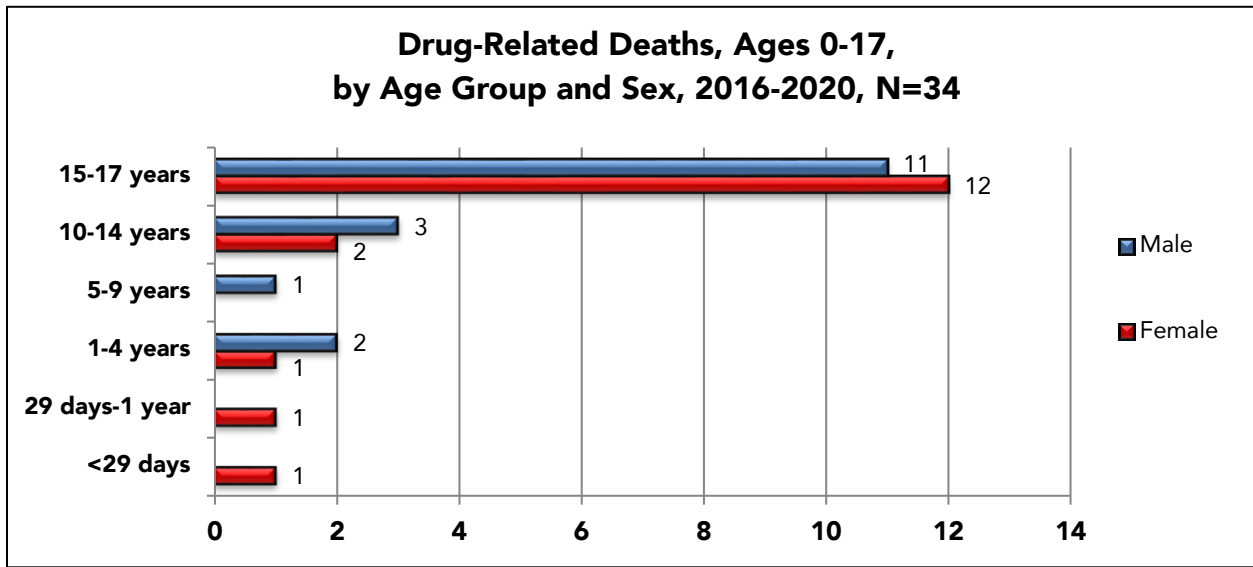


Figure 60

Number of Drug Deaths by Drug Class, 2020, N=16	
Illicit Drug	10
Prescription Medication	3
Combination of Illicit and Prescription Medication	3

Figure 61

Drug Deaths*	2016	2017	2018	2019	2020
<b>Illicit Drug Deaths</b>	0	1	1	3	13
Fentanyl	0	0	0	0	11
Methamphetamine	0	0	0	3	1
Cocaine	0	0	1	0	1
Ethanol	0	1	0	0	1
<b>Prescription Drug Deaths</b>	4	4	1	2	6
Methadone	1	1	0	1	0
Morphine	2	0	0	0	0
Oxycodone	0	2	1	0	2
<b>OTC Drug Deaths</b>	2	0	2	0	0
Diphenhydramine	1	0	2	0	0

\*Cases may be counted more than once, depending on the number of drugs detected.

Figure 60 shows the drug types involved in drug-related deaths in 2020. Ten deaths were attributed to illicit drugs alone, three deaths were due only to prescription medications, and three deaths were due to a combination of both illicit and prescription medications. Figure 61 shows the number of deaths due to the most common substances detected. 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. There were 11 fentanyl deaths in



2020, and no fentanyl deaths in the previous four years. There was one methamphetamine death in 2020, compared to three deaths in 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.<sup>27</sup> 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.<sup>28</sup>

Figure 62

Drug-Related Deaths, by Manner of Death, 2016-2020	
Manner of Death	2016-2020 Deaths
Accident	15
Undetermined	6
Suicide	10
Homicide	1
<b>Total</b>	<b>32</b>

## VIGNETTE

### DRUG-RELATED TEEN DEATH

**Children and teens should be warned of the dangers of fentanyl. Fentanyl can be disguised in other substances.** – A teen went to a party with friends where there was inadequate adult supervision. Although the teen did not appear to be under the influence of drugs when they returned home from the party, the teen was discovered unresponsive the next morning. The autopsy indicated that the teen died from a fentanyl overdose. It was assumed that the decedent, who had recently begun using other substances, was unaware that anything they consumed at the party contained fentanyl.

**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 so lethal, many youth and teens who died in Kansas due to drug overdoses most likely were unaware that the illicit drug 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.

### DRUG-RELATED DEATH PREVENTION POINTS

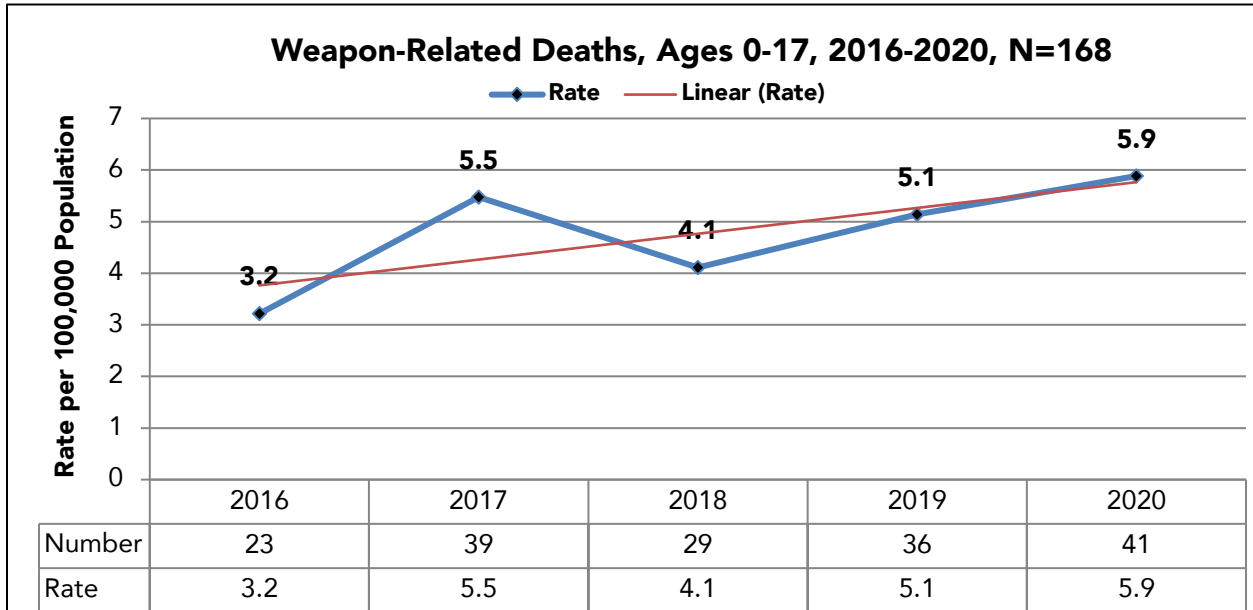
Young people are at high risk of substance use and overdose. These steps may help prevent teens from using alcohol and abusing prescription medications.

- **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 their medications with any other person, and not combine medications without being instructed to by a pharmacist or physician.<sup>29</sup>
- **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.
- **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.
- **Prescription medications should not be accessible to children.** Quantities of medications should be tracked and all medications kept in a locked cabinet.<sup>29</sup>
- **Discuss the dangers of alcohol use.** Underage use of alcohol, and the use of alcohol with medications can increase the risk of accidental overdose.<sup>14</sup>
- **The ability to order substances online is a risk factor for teens to access 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.<sup>29</sup>
- **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.<sup>29</sup>
- **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, some local jurisdictions have taken steps to repeal ordinances that allow prosecution for the possession of fentanyl test strips.

# Weapon-Related Deaths

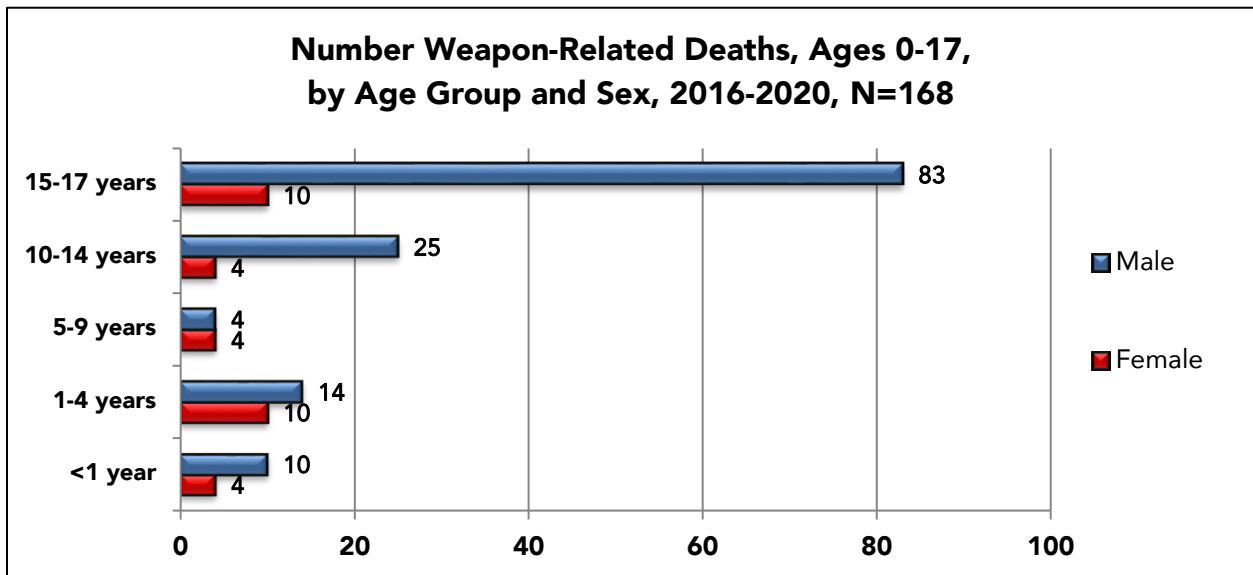
Between 2016 and 2020, Kansas experienced 168 weapon-related deaths in our children aged 0-17. Weapon, as defined for board review, includes firearms, knives, or other objects, including body parts. Figure 63 indicates a steady increase in the rate of weapon-related deaths over the last five years, with 5.9 deaths per 100,000 population in 2020.

**Figure 63**



Of the 168 weapon-related deaths from 2016-2020, 81% (136) were male and 19% (32) were female with a majority (55%) of the deaths occurring in the 15–17-year age group (Figure 64).

**Figure 64**



## Weapon-Related Deaths

Figure 65

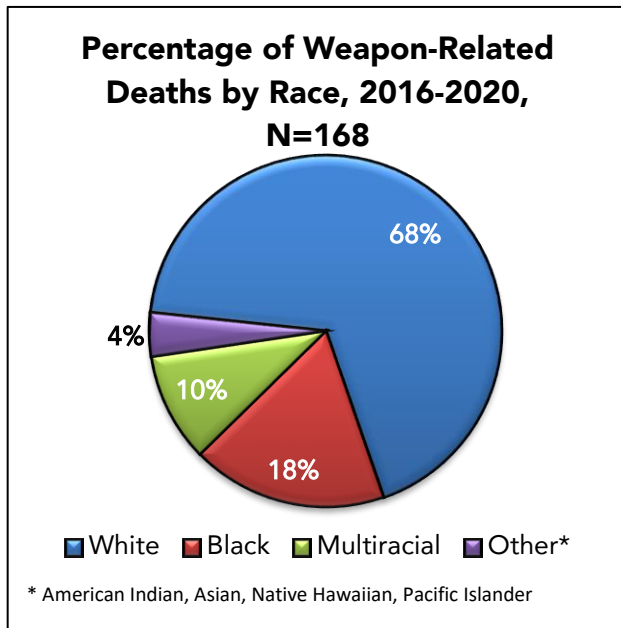


Figure 66

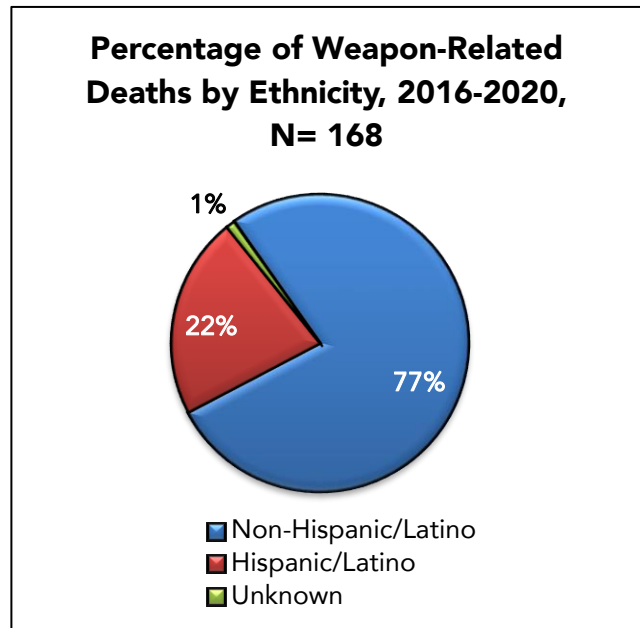


Figure 65 and 66 show the percentages of weapon-related deaths by race and ethnicity. More information can be found in the [Methodology](#) section of the report.

In Kansas, firearm deaths represented 74% (125) of all weapon-related deaths in the last 5 reporting years (Figure 67). Fatal firearm injuries can include Homicides, intentionally self-inflicted (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) as there is not enough information to know whether the injury was intentionally self-inflicted, unintentional, or an act of interpersonal violence.

Of the 125 firearm deaths reviewed over the last five years, the manners of death were as follows; 45 Homicide, 68 Suicide, 10 Accident, and two Undetermined (Figure 67).

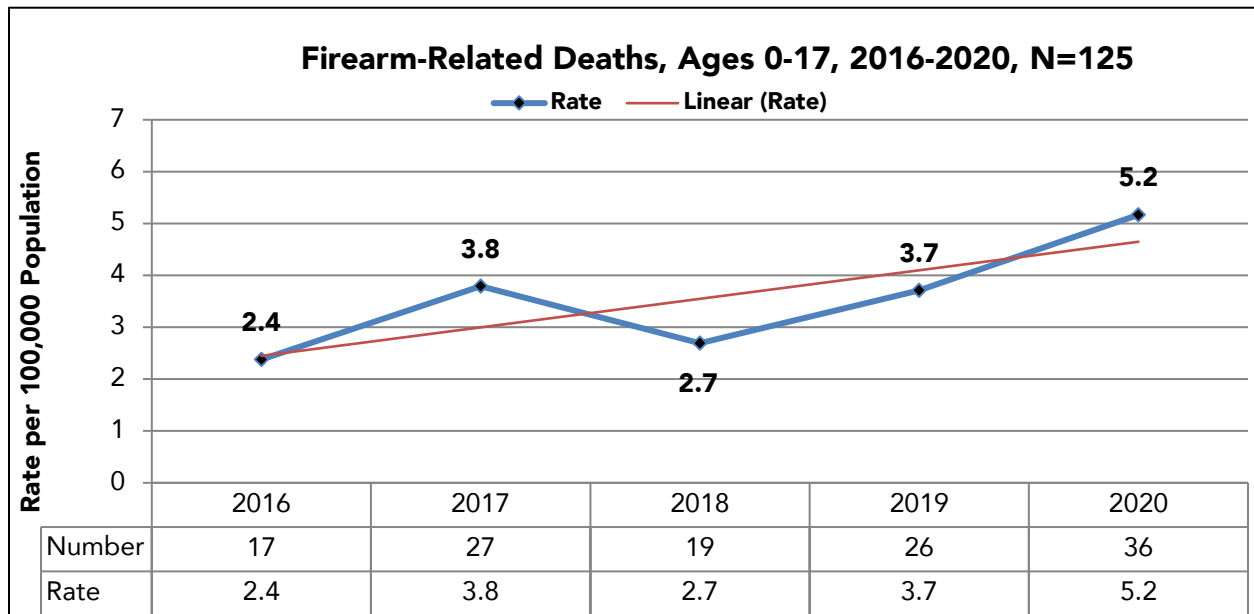
Figure 67

Weapon-Related Deaths by Weapon Used and Manner of Death, 2016-2020, N=168					
Weapon Used	Total Number	Homicide	Suicide	Accident	Undetermined
Firearm	125	45	68	10	2
Bodily Force	37	37	0	0	0
Knife, Sharp Object	4	4	0	0	0
Other	2	0	0	2	0
<b>Total</b>	<b>168</b>	<b>86</b>	<b>68</b>	<b>12</b>	<b>2</b>

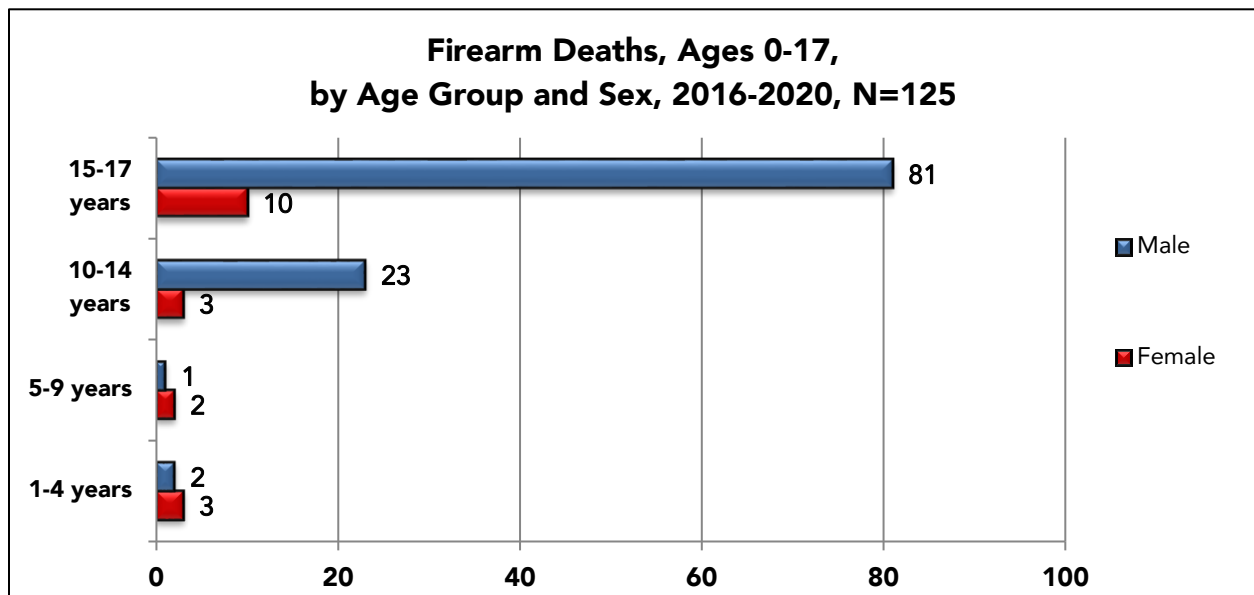
## FIREARM DEATHS

From 2011 through 2020, the U.S averaged 1,585 firearm deaths a year in children ages 0-17.<sup>46</sup> The rate of firearm deaths in Kansas has doubled over the last five reporting years. In 2020 more children died by firearms than in Motor Vehicle Crashes. Firearm deaths in children reached 5.2 deaths per 100,000 population according to figure 68.<sup>46</sup>

**Figure 68**



**Figure 69**



Of the 125 firearm deaths from 2016-2020, 86% (107) were male and 14% (18) were female with a majority (73%) of the deaths occurring in the 15-17 year age group as shown in Figure 69.

## Weapon-Related Deaths

In Kansas, the rate of firearm deaths, as a group, are most prevalent in counties with populations over 100,000. As demonstrated in Figure 70, between 2016 and 2020, firearm deaths in these five counties accounted for 76 of the 125 firearm deaths (61%) in Kansas.

The Board is encouraged by ongoing local efforts in several of these locations that are seeking to identify specific factors within these communities. Addressing the issues related to firearm deaths is a county-by-county initiative. Given the unique characteristics of these local 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.

**Figure 70**

Rate of Firearm Related Deaths, Age 0-17, by Counties with Population greater than 100,000 2016-2020											
	Population Age 0-17, 2016-2020	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
<b>Douglas</b>	111,087	1	-	-	1	-	0.00	0.00	0.90	0.00	0.90
<b>Shawnee</b>	209,375	10	5	4	1	-	2.39	1.91	0.48	0.00	4.78
<b>Wyandotte</b>	229,576	20	2	17	1	-	0.87	7.4	0.44	0.00	8.71
<b>Sedgwick</b>	661,177	27	12	12	1	2	1.81	1.81	0.15	0.30	4.08
<b>Johnson</b>	725,858	18	13	5	-	-	1.79	0.69	0.00	0.00	2.48

Figure 71

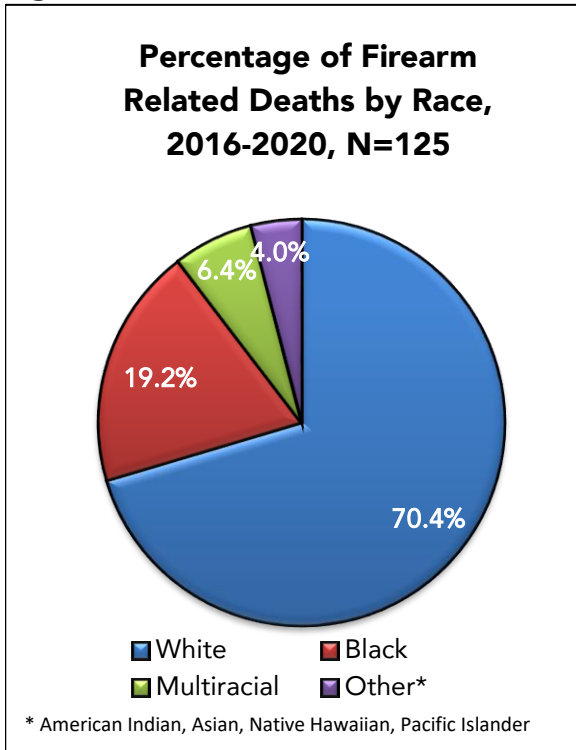


Figure 72

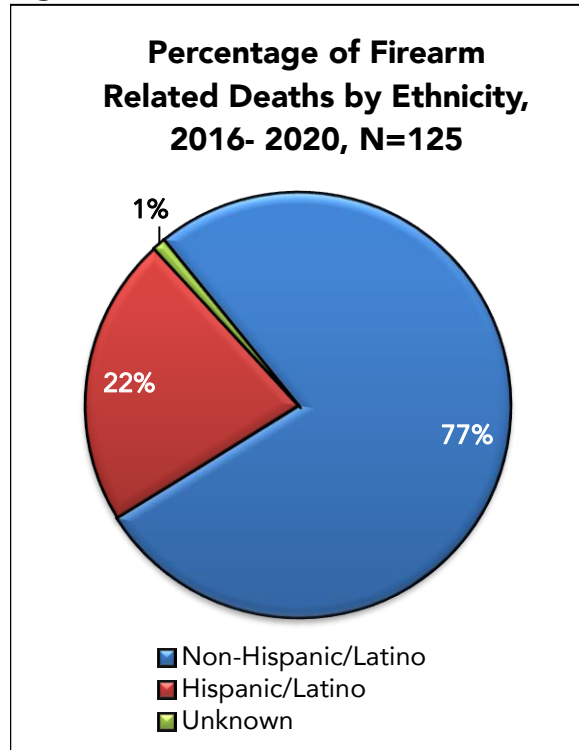


Figure 71 and 72 show the percentages of firearm related deaths by race and ethnicity. More information can be found in the [Methodology](#) section of the report.

# Homicide

In 2020 there were 22 child homicides. Figure 73 indicates rates per 100,000 population for the past 15 years. When examining child homicides, the average rate for infants is more than three times higher than other age groups. This difference is explained by the unique characteristics of the circumstances surrounding child abuse homicides that account for nearly all infant homicides.

**Figure 73**

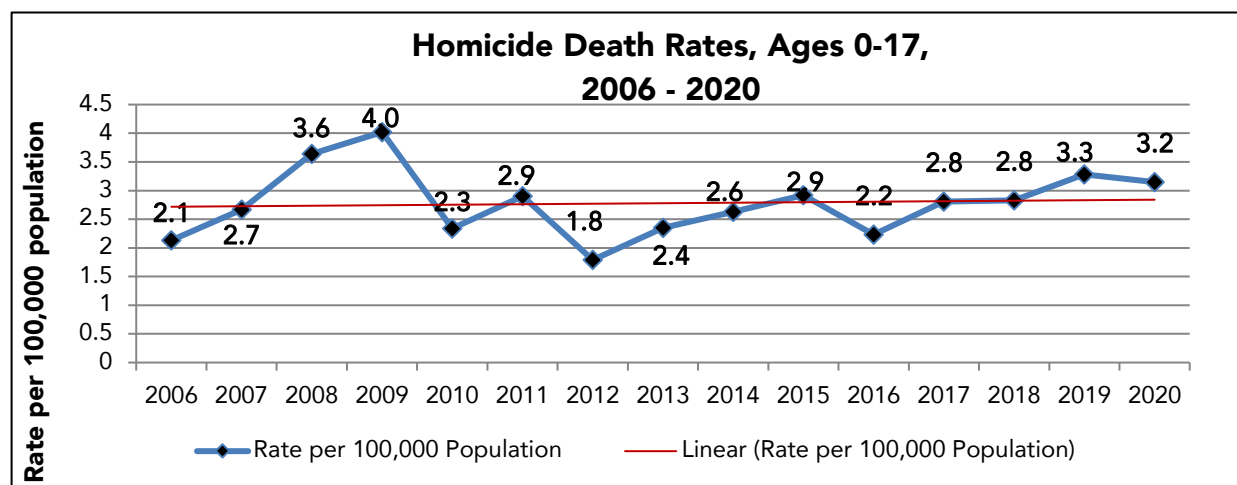


Figure 74 displays homicide rates per 100,000 population by age group. Very young children are not capable of defending themselves against an assault and are small enough to pick up and shake, throw or strike. Furthermore, their crying and unrealistic expectations for children’s behavior can create triggers for caregivers to harm children.<sup>7</sup> These factors are discussed in the [Homicide – Child Abuse](#) section.

**Figure 74**

Homicide Death Rates per 100,000 population by Age Group, Ages 0-17, 2006-2020					
	Age <1	Age 1-4	Age 5-9	Age 10-14	Age 15-17
2006	7.6	0.6	1.6	1.6	4.1
2007	14.8	3.2	0.0	0.5	5.8
2008	16.5	5.6	0.0	0.0	8.5
2009	19.3	3.7	1.0	3.7	5.2
2010	9.8	3.6	0.5	1.5	2.5
2011	12.5	3.6	0.5	1.5	2.5
2012	7.5	1.8	1.0	0.0	4.2
2013	12.6	2.4	1.5	1.0	1.7
2014	15.0	3.1	1.0	2.0	1.7
2015	23.1	3.2	1.0	0.0	4.2
2016	13.1	2.6	1.0	0.5	3.3
2017	10.5	5.2	0.0	0.0	6.7
2018	10.9	3.3	1.5	0.0	6.7
2019	5.7	4.0	1.5	1.5	7.6
2020	8.5	2.7	1.0	2.5	6.7
<b>Average</b>	<b>12.5</b>	<b>3.2</b>	<b>0.9</b>	<b>1.1</b>	<b>4.8</b>



Figure 75

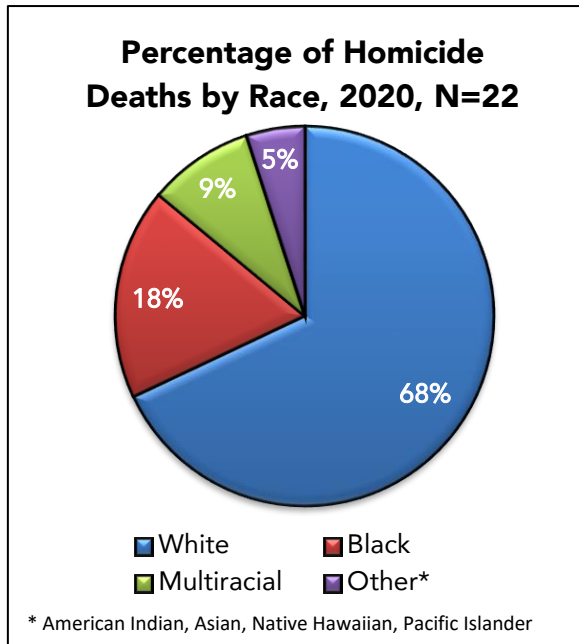


Figure 76

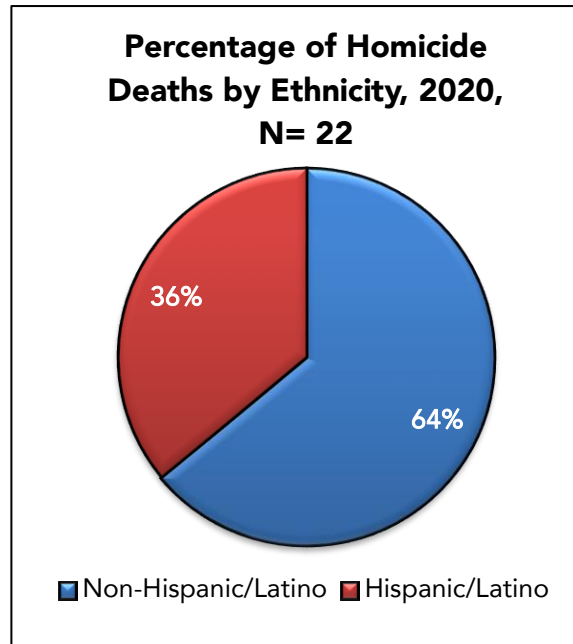


Figure 75 and 76 show the percentages of homicide deaths by race and ethnicity. More information can be found in the [Methodology](#) section of the report.

Each child homicide is categorized into one of the following groups: Child Abuse Homicides, Gang Homicides, and Other Homicides (Figures 77 & 78). 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 2020 (Figure 78), 27.3% (6) were due to child abuse and 13.6% (3) were related to gang violence. The remaining 59.1% (13), which did not meet the definition of gang violence or child abuse, were categorized as “other homicides.”

Figure 77

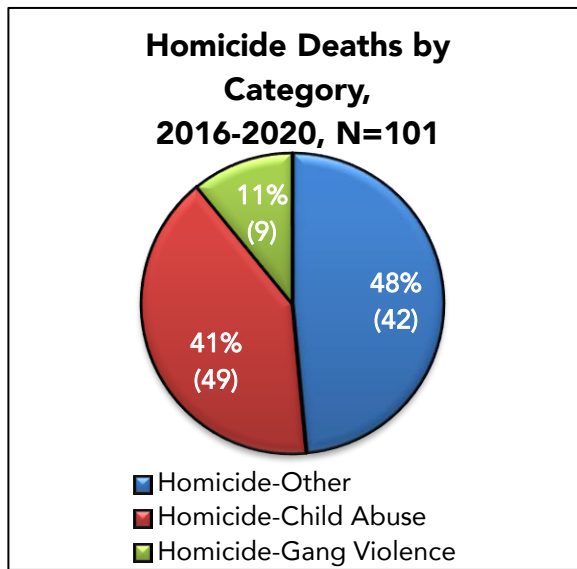
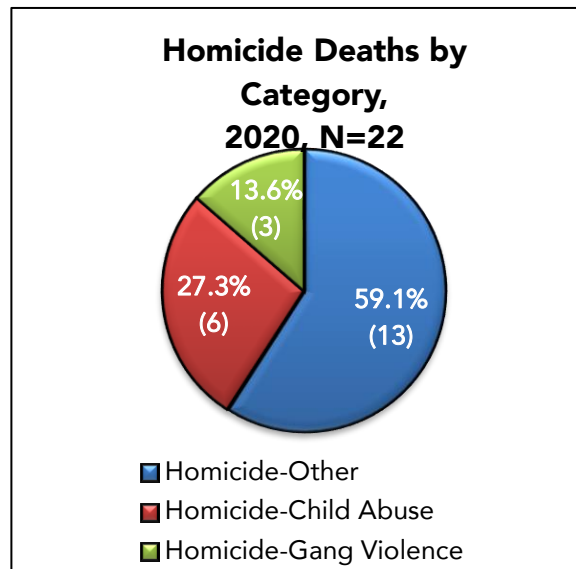


Figure 78



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## HOMICIDE – CHILD ABUSE

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The Board defines Child Abuse Homicide as resulting from abuse (inflicting injury with malicious intent, usually as a form of punishment or out of frustration with a child’s crying or perceived misbehavior) or neglect (failing to provide shelter, safety, supervision and nutritional needs) by caretakers. Child abuse is a complex problem that stems from a variety of factors including, but not limited to, financial stressors, domestic violence, substance abuse, mental illness and unreasonable expectations of children’s behaviors.<sup>7</sup>

The method of child abuse homicide can vary. In general, most occur as a result of blunt force trauma. The most prevalent form is Abusive Head Trauma (AHT), previously referred to as Shaken Baby or Shaken/Impact Syndrome. AHT occurs when an infant or toddler is severely or violently shaken resulting in serious injury and/or death. 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.<sup>7</sup>

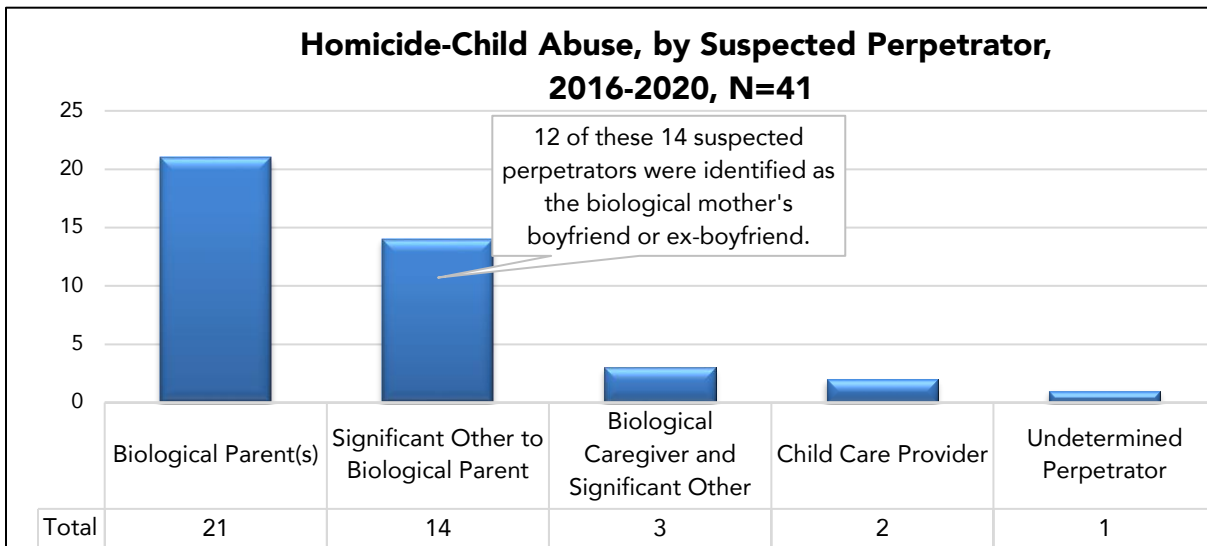
Caring for children can be overwhelming at times. Often parents and caregivers are facing multiple stressors and may have limited access to support. There are several risk factors associated with child abuse homicide including maternal risk factors (young age, less than 12 years of education, and being a single parent) and household risk factors (non-biological caregiver in the home, prior substantiation of child abuse and neglect, substance abuse, and low socioeconomic status). Many of the child abuse homicides occurred when the primary caregiver was away from the home. Often the child was in the care of the mother’s significant other<sup>†</sup> or by a relative who was not the primary caregiver.<sup>7</sup>

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

Figure 79 categorizes the suspected perpetrators in each of the child abuse homicides over the last five years. In 52% (21) of these deaths, the suspected perpetrator was a biological parent(s) of the child. Mother’s significant other was the suspected perpetrator in 30% (12) of the child abuse homicides. In 8% (3), a biological caregiver and his or her significant other were both responsible for the death. The child abuse homicide in which the perpetrator was listed as “undetermined” involved a case where the perpetrator could not be determined, due to more than one suspect in the case.

**Figure 79**



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, the majority of infant and young child homicides are the result of beating, shaking or strangulation by someone entrusted with caring for the child.<sup>7</sup>

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 include parent training and education about normal childhood behaviors and age-appropriate discipline, and information on how to select appropriate child caregivers. Educational interventions to identify abuse cases before they lead to severe injuries or death, and to teach skills for dealing with angry and impulsive responses to infant crying and frustrating behaviors are needed.<sup>7</sup>

## Homicide

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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.<sup>1</sup>

### CASE VIGNETTE

#### INFANT DEATH DUE TO HOMICIDE – CHILD ABUSE

**Risk factors and triggers leading to abuse** – An infant in the care of his father was reportedly found not breathing an hour after last being checked on. A call to 911 was made and medical care continued in an intensive care unit where the baby was found to have bilateral subdural hemorrhages, and skull and extremity fractures, some of which showed signs of healing. Despite maximal efforts to save the baby’s life, he succumbed to complications of the inflicted traumatic brain injuries several days later. Findings were confirmed on autopsy. The surviving sibling was examined at the time this child presented and was found to have facial and extremity bruising and an extremity fracture. After initially providing several explanations that were not plausible mechanisms for the injuries, father admitted being frustrated with the children crying and used blunt force to the head and extremities in an attempt to get them to “shut up.” The father agreed to a guilty plea, as charged, to murder in the 2nd degree and several counts of aggravated battery on the victim and the surviving sibling. Although neither parent was known to DCF for concerns as parents, the father had a history of abuse as a child and was known to use illicit substances.

**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. They had initially attempted to stagger their work hours to avoid using child care outside the home which created stress for the parents. Both parents carried a burden of abuse from childhood. The mother had been sexually abused as a child; the father had extensive DCF history as a child which included being in custody following physical abuse by his mother. There were additional concerns of physical and medical neglect of him and his siblings. Adverse childhood experiences (ACEs) can have a lasting impact on future violence victimization and perpetration. In situations such as these, parents can find education, assistance, and therapy through community agencies if their trauma history is revealed. Screening for ACEs and asking about child care plans during health encounters, referring for therapeutic services to mitigate the effects of adversity, and acknowledging to parents that raising children is hard work can open the door to conversations about parents’ needs for support and education in caring for their children. Additionally, this case points to the need for siblings to be examined when an index case of abuse is found, even if an initial assessment reports no evidence of trauma was found. The state has initiated a Kansas CARE (Child Abuse Review and Evaluation) program to provide in-depth training to pediatricians who will be qualified to provide reimbursed, thorough medical assessments in specified cases where child abuse or neglect is a concern.

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## HOMICIDE – GANG VIOLENCE

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The Board will categorize 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.<sup>30</sup>

Between the years of 2013 and 2020 there have been 14 homicides due to gang violence; in nine of the deaths a suspect was identified/charged with the murder. Gun violence was the cause of death in all 14 of these homicides. There were three homicides identified as gang-related in 2020.

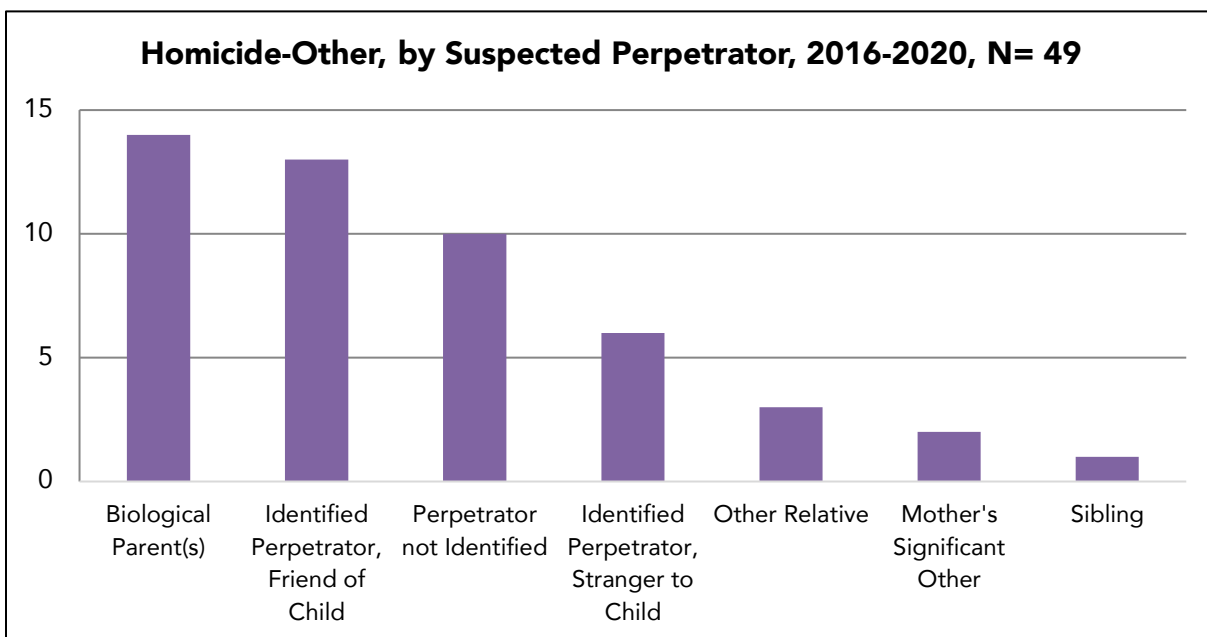
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## HOMICIDE – OTHER

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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.<sup>7</sup> 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. Figure 80 demonstrates that in 67% of the 49 deaths in this category over the last five years, the child victim knew the perpetrator. Of the deaths in which the perpetrator was a stranger to the victim or was unidentified, 94% involved gun violence. This contrasts with only 52% involving gun violence when the child victim knew the perpetrator.

**Figure 80**



### Characteristics of the 22 Child Homicides, 2020

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- Six children died from child abuse, three were under 1 year of age; two were between 1 and 4 years of age; and one was 5-9 years of age at the time of death.
  - 4 of the 6 child abuse homicide cases had current or past DCF child protective service involvement prior to the fatal incident.
- 13 of the 22 families of homicide victims had current or past DCF child protective service involvement initiated prior to the fatal incident.
- In 3 of the 23 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. Two of the deaths had been certified as accidents and one as a natural 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.<sup>1</sup>
- **Drug Environments** – Children living in environments where they are exposed to drugs (including illicit drugs, prescription medication misuse and alcohol abuse) are at increased risk of abuse, neglect or death. If substance use is suspected, the safety of the children should be addressed.<sup>1</sup>
- **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, combine unrealistic expectations for children’s behavior with a lack of appreciation for their vulnerability. Education should be provided at all points of contact with parents and caregivers, especially addressing positive ways to respond to infant crying and child discipline, supporting parents through stressful periods, and adjusting work policies to give parents quality time with their young children.<sup>1</sup>
- **Education about Signs of Child Abuse** – Most cases of child abuse can be suspected with attention to the characteristics of the injuries. Normal, active children get bruises and bumps from everyday play. These bruises are most often over bony areas such as the knees, elbows, and shins. 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.<sup>1</sup>
- **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.<sup>1</sup>

# Suicide

In 2020, 26 children in Kansas between the ages of 10-17 died by suicide; 22 were male and four were female. According to the Centers for Disease Control and Prevention, in 2020, suicide was one of the top nine causes of death for people ages 10-64 years, and was the second-leading cause of death among U.S. children 10-14.<sup>31</sup> In Kansas, consistent with national studies, adolescent females are more likely to attempt suicide, but adolescent males are more likely to complete it. Figures 81 and 82 show suicide rates per 100,000 population for children ages 0-17, and by age group for the last 15 years in Kansas. Figure 82 shows that the rate of suicide deaths in the 15-17 age category more than doubled between 2016 and 2017 and has remained high the past three reported years (2018-2020).

**Figure 81**

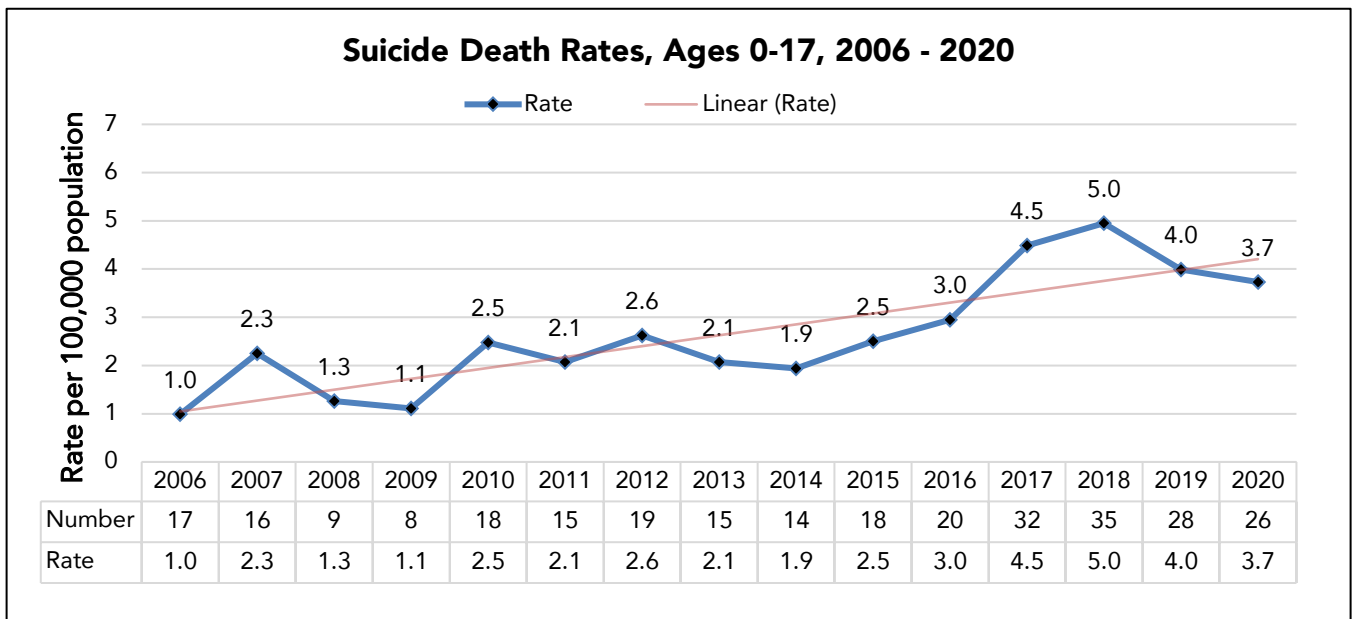


Figure 82

Suicide Death Rates per 100,000 age-related population, Ages 10-17, by Age Group, 2006-2020		
	Age 10-14	Age 15-17
2006	1.6	11.5
2007	2.6	9.1
2008	1.1	5.9
2009	2.7	3.5
2010	1.0	12.5
2011	1.5	10.1
2012	3.0	11.0
2013	2.0	9.3
2014	2.5	7.6
2015	3.0	10.0
2016	3.5	10.8
2017	3.5	21.0
2018	4.5	21.9
2019	3.0	18.5
2020	4.0	15.0
Average	2.6	11.8

Figure 83

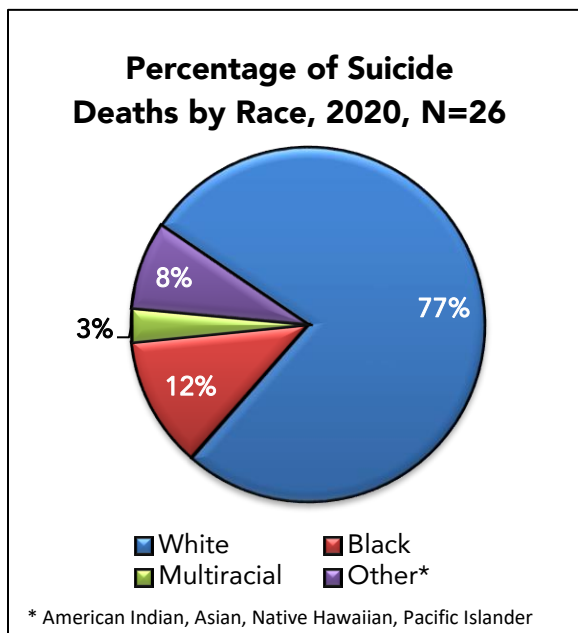
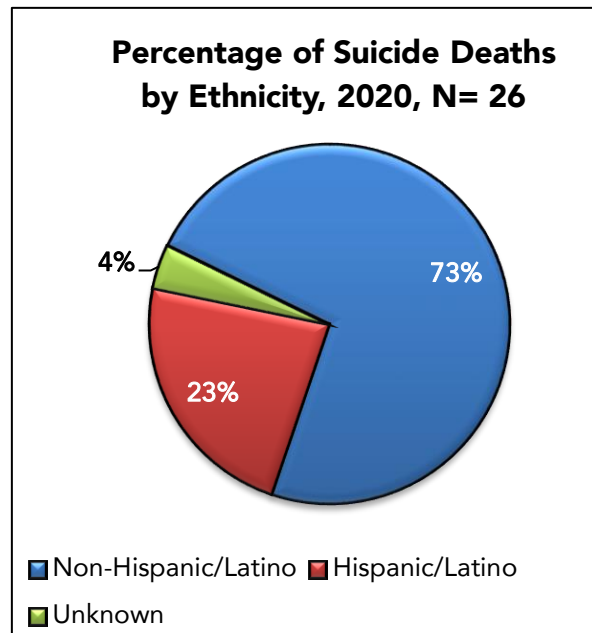


Figure 84



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 85 indicates the methods used by sex of the child over the last five years.



Figure 85

Suicides by Method and Sex, 2016-2020, N=141			
Method	Male	Female	Total
Firearm	61	7	68
Asphyxia	29	29	58
Poisoning, Overdose or Acute Intoxication	3	8	11
Fall or Crush	1	1	2
Undetermined	0	1	1
Other Transport*	1	0	1

\*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.<sup>32</sup> Precipitating factors include access to means, alcohol and drug use, exposure to suicide by friend or family including suicide attempts, social stress and isolation.<sup>33</sup> Well-identified examples of social stress include parental divorce or separation, ostracism due to gender identity and rejection due to sexual orientation, or the breakup of a significant relationship.<sup>33</sup> Young people who identify as LGBTQ+ reportedly have higher rates of suicidal thoughts and behavior compared to their peers who identify as heterosexual and cisgender. Bullying has also been identified as a risk factor, placing both bullies and victims at risk.<sup>33</sup>

Figure 86

Gender Identity in Suicides, Age 0-17, 2020, N=26		
Identity	Number	Percent
Male, not transgender	17	65.38%
Female, not transgender	4	15.38%
Male transgender	1	3.85%
Unknown	4	15.38%

## Suicide

**Figure 87**

Sexual Orientation in Suicides, Age 0-17, 2020, N=26		
Identity	Number	Percent
Straight/Heterosexual	7	26.92%
Gay/Lesbian	1	3.85%
Unknown	18	69.23%

“Data Collected in the KCTC 2022 SOGI Pilot shows patterns similar to published research. Responses from students included in the Kansas pilot who responded to the sexual orientation gender identity (SOGI) demographic questions are shown with the results of the Child Trends survey for which KCTC questions were modeled. Similar items asked on the Youth Risk Behavior Survey (YRBS), 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.”<sup>33</sup>

**Figure 88**

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

Figure 86 and 87 indicate the gender identity and sexual orientation for youth who died by suicide in 2020. It should be noted that the Board will rarely have information that would confirm a youth’s gender identity or sexual orientation. Figure 88 was included as a way to reflect how youth in Kansas are self-reporting their sexual orientation and gender identity. Figure 89 lists the recent personal crises associated with the suicides between 2016 and 2020. 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.<sup>33</sup> 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.<sup>33'</sup>

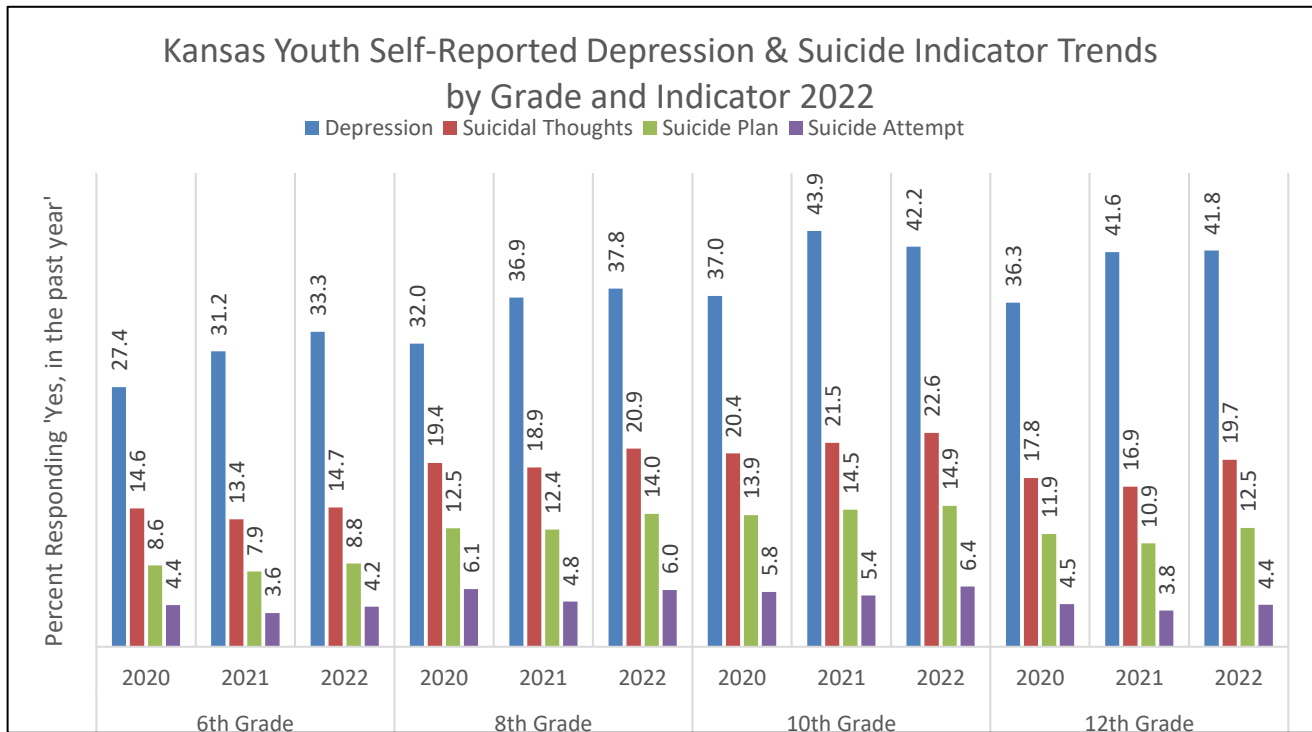
**Figure 89**

<b>Suicide Deaths Reviewed, 2016-2020,N=141</b>	
<b>Decedent History</b>	<b>Number</b>
History of maltreatment as a victim	50
Open CPS case at time of death	13
Child placed outside of home	18
History of mental health services	63
Child was currently receiving mental health services	46
History of substance use services	48
Child had history of delinquent or criminal activity	12
Child experienced suicidal behaviors/attempts	74
Child communicated any suicidal thoughts, actions or intents	89
Showed warning signs - Talked about or made plans for suicide	89
Showed warning signs - Expressed hopelessness about the future	70
Showed warning signs - Displayed severe/overwhelming emotional pain or distress	70
Showed warning signs - Expressed perceived burden on others	64
Showed warning signs - Worrisome behavioral cues or marked changes in behavior	66
Showed warning signs - None listed	32
Showed warning signs - Unknown	11
Child experienced known crisis	<b>59</b>

The findings of the Board are consistent with the Kansas Communities That Care (KCTC) Student Survey. The survey is administered annually, free of charge to all public and private schools in Kansas. Figure 90 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.<sup>34</sup>

These self-reported indicators parallel the preliminary data of the Board which show that the rate of Kansas children who died by suicide had not only increased in recent years, but includes children as young as elementary and middle school. Prevention efforts aimed at reducing youth suicide should be offered to children as early as elementary school.<sup>33</sup>

Figure 90



Source: Kansas communities that care (KCTC) student survey<sup>47</sup>

Due to ongoing concern about adolescent suicides, the Kansas Legislature passed SB323 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, 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 has continued to focus on collaboration and coordination between state agencies and community partners to strengthen and sustain the infrastructure that enables us to continue bettering 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. The national 988 suicide hotline is open to callers as of July 16, 2022. Furthermore, the YSPC assisted in drafting contracts with The Jason Foundation and DevDigital to

develop the youth suicide prevention phone app **Kansas- A Friend AsKS**. The app is free to download and use and will work alongside 988 as it will autofill “988” into a text message or phone call when a user clicks on ‘Need Help Now.’<sup>35</sup>

It is the Board’s hope that 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.

## IMPACT OF COVID-19 ON YOUTH SUICIDE

For nearly all children and adolescents, the COVID-19 pandemic represents their first experience with a wide-ranging community crisis. It is the first time that the government imposed the closure of schools, public parks, meeting places, and recreational and sport activities nationwide. Consequently, people experienced forced social isolation during the lockdown, and following that, the continuation of social distancing and the use of masks. These situations, and the fear of illness and death, can lead to psychological distress and depressive mood.<sup>36</sup>

The Centers for Disease Control and Prevention reports 1 in 3 children experienced hopelessness and sadness during the pandemic within the 30 days of responding to a national survey conducted between January-June 2021.<sup>37</sup>

In Kansas, lockdowns and school closures began March 21 of 2020 with considerable negative impact on children due to isolation, lack of contact with friends, cancelled school activities and frustration with processes used for remote learning. Depression and mental health issues were indicated in reviews of suicide events in children. As shown in Figure 91, there were 8 youth who experienced disruption in their life related to the COVID-19 pandemic that indirectly contributed to their death.

**Figure 91**

Characteristics of Youth Suicides Linked to the COVID-19 Pandemic	
Firearm	<ul style="list-style-type: none"> <li>3 youth</li> <li>All experiencing depression or other mental health issues</li> <li>2 were frustrated with remote learning; one experienced anxiety about returning to school</li> </ul>
Hanging	<ul style="list-style-type: none"> <li>3 youth</li> <li>All experienced depression or other mental health issues</li> <li>Described isolation due to lack of extracurricular activities</li> </ul>
Overdose	<ul style="list-style-type: none"> <li>2 youth</li> <li>Both medically fragile and indicated being bored without attending school</li> </ul>

### Characteristics of the 26 Suicide Deaths, 2020

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- 85% were male.
- 66% were currently receiving or previously had received mental health services.
- 54% communicated suicidal thoughts, actions or intents.
- 50% had current or past DCF history involving their immediate family.
- 38% had recent school problems (academic, behavioral, suspensions, conflicts with peers, truancy, etc.).
- 35% had a history of being in state custody or had a sibling in state custody prior to suicide.
- 31% were known to have attempted suicide previously.
- 19% of the decedents had a history of alcohol or substance use concerns.

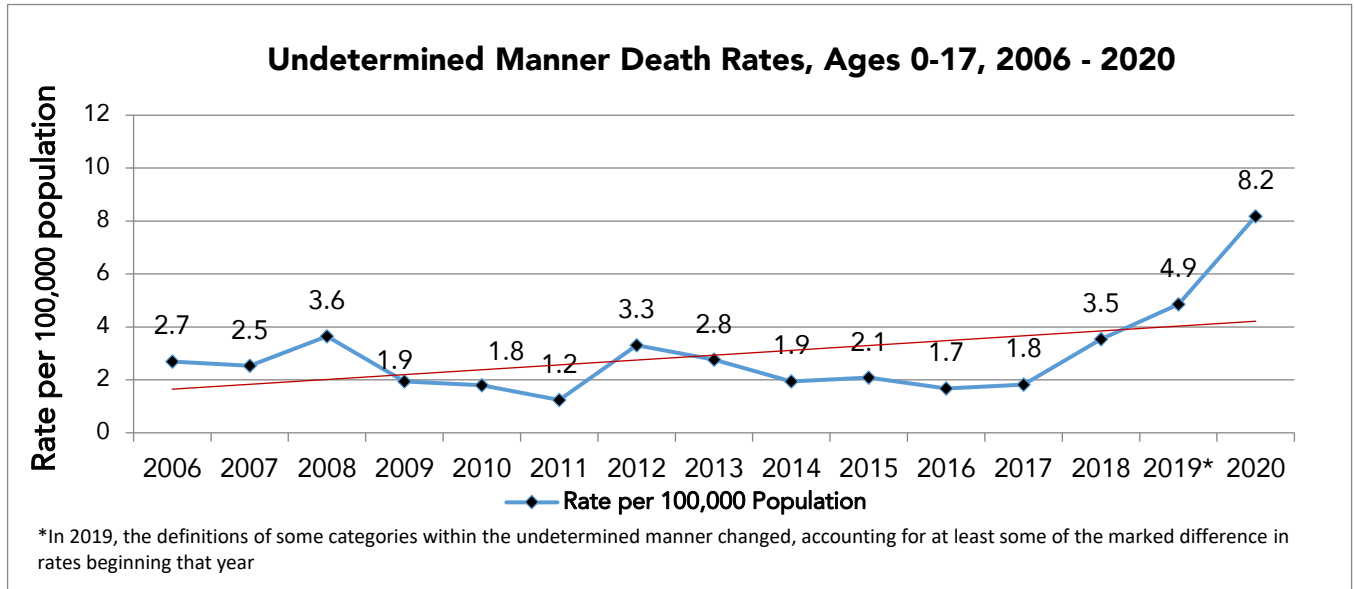
## PREVENTION POINTS

- **Early Diagnosis and Treatment of Mental Conditions** – Early involvement of mental health professionals may prevent suicide attempts. Special caution should be taken with children who are taking antidepressant medication as health officials have issued warnings that these medications might increase the risk of hostility, mood swings, aggression and suicide in children and adolescents.<sup>38</sup>
- **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.<sup>38</sup>
- **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.<sup>38</sup>
- **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 an increased risk for suicide following hospitalization.<sup>38</sup>
- **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.<sup>38</sup>
- **Talk About the Issue** – Bringing up suicide does not “give kids the idea” but rather gives them the opportunity to discuss their thoughts and concerns. This communication can be a significant deterrent.<sup>38</sup>
- **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.<sup>38</sup>
- **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.<sup>38</sup>

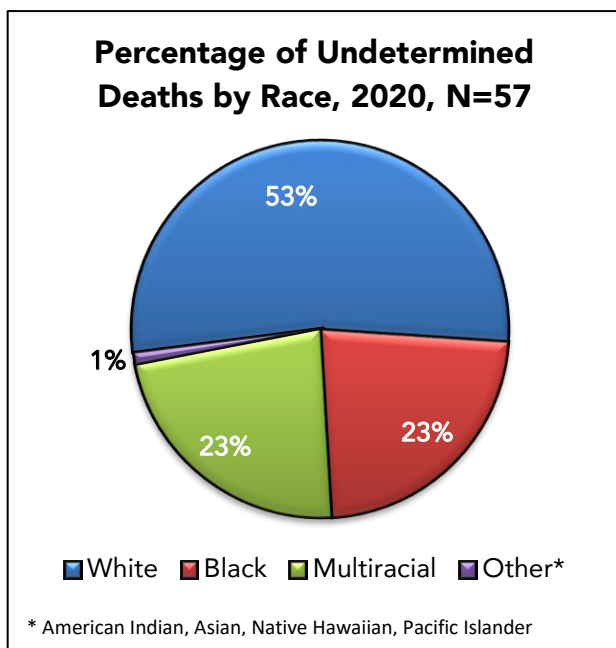
# Undetermined Manner

Unfortunately, the Board encounters cases where questions remain as to the cause or manner of the child's death. When there are multiple circumstances that may have contributed to the child's death or no identifiable cause is established, the Board will classify the death as undetermined. Figure 92 shows Undetermined Manner death rates for the last 15 years of case reviews.

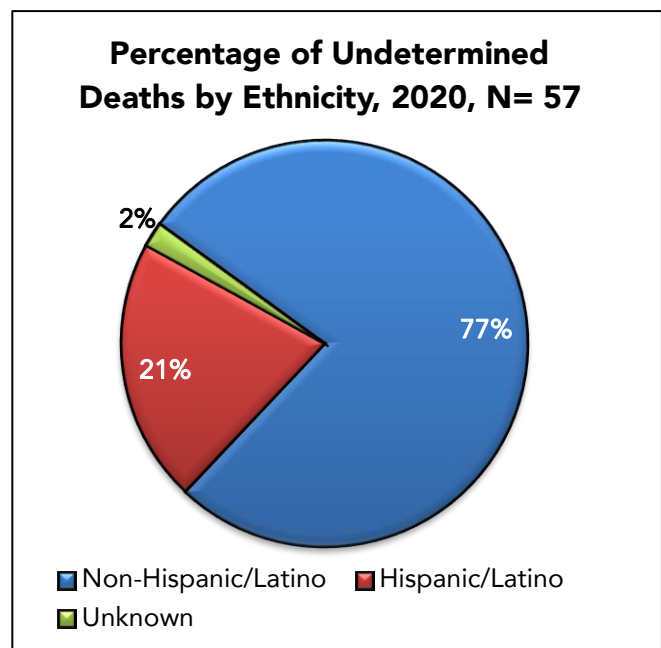
**Figure 92**



**Figure 93**



**Figure 94**





Historically, investigations in the undetermined 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.

The sharp increase in cases classified as undetermined since 2019 (Figure 92) is mainly due to reclassifications in sleep-related deaths, which are now being classified Undetermined–SUID instead of natural-SIDS.

In 2020, there were 57 undetermined deaths. Of those 57 deaths, 45 were Sudden Unexpected Infant Death (SUID). Of those 45 SUID deaths, 42 were sleep-related and are included in the [sleep-related death section](#).

In past years, some of the cases were classified as undetermined because of incomplete autopsies. This year all but one autopsy 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 needs 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 and interviews with caregivers. Due to the lack of information available for the Board to review, this case was finalized as a Sudden Unexpected Infant Death-Incomplete Case information.

**Board Reflection** – Law enforcement should utilize the Sudden Unexpected Infant Death Investigation Reporting Form (SUIDIRF) in each investigation of infant deaths. Completion of this form assists the board in determining accurate causes and circumstances around the death and guides investigators through their investigation to ensure that comprehensive and standardized information is collected regarding the incident.

Information regarding the SUIDIRF as well as a link to the fillable form can be found at: <https://www.cdc.gov/sids/SUIDRF.htm>

# Autopsy Examinations – All Manners of Death

In total, for all manners of death, there were seven child deaths in 2020 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:

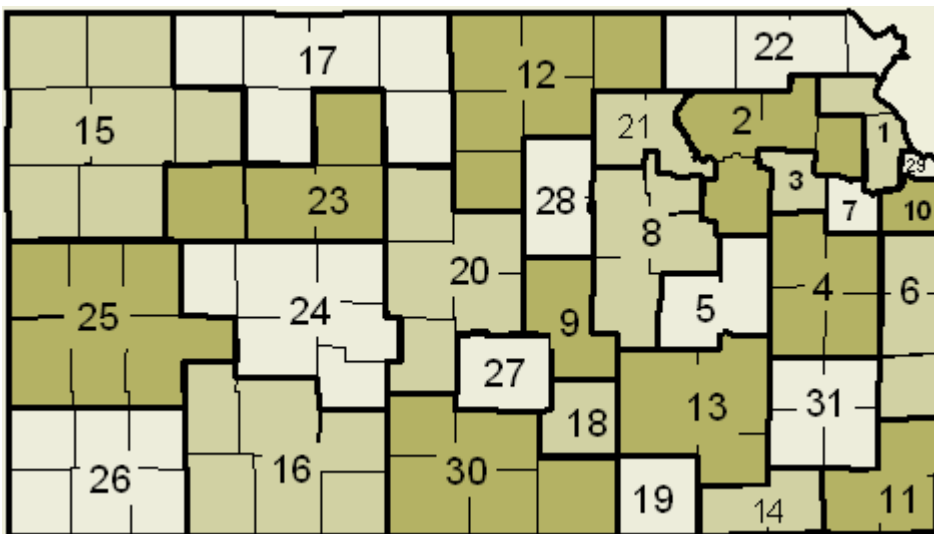
- Photographs of the child and of all external and pertinent internal injuries or findings.
- Examination of all clothing and items accompanying the body, preserving all materials for later examination by a crime lab.
- Documentation of evidence of therapy and resuscitation.
- Radiographs for a complete 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.<sup>39</sup> 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.<sup>39</sup> 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 seven Kansas cases in 2020 where the Board determined that an autopsy either should have been conducted, or was not properly conducted; those seven cases are noted by the judicial district that held jurisdiction of the death in Figure 95. As noted above, the Board has established protocols and guidelines for child autopsies.

### Kansas Counties by Judicial District



## Autopsy Examinations – All Manners of Death

Figure 95

District	Counties in District	# of child deaths not autopsied, despite guidelines		# of child deaths incompletely autopsied, despite guidelines	
		2015-2019	2020	2015-2019	2020
<b>District 1</b>	Atchison, Leavenworth	1	0	0	0
<b>District 8</b>	Dickinson, Geary, Marion, Morris	0	0	0	1
<b>District 10</b>	Johnson	1	0	2	0
<b>District 12</b>	Cloud, Jewell, Lincoln, Mitchell, Republic, Washington	6	0	0	0
<b>District 13</b>	Butler, Elk, Greenwood	1	1	0	0
<b>District 15</b>	Cheyenne, Logan, Rawlins, Sheridan, Sherman, Thomas, Wallace	2	0	4	1
<b>District 16</b>	Clark, Comanche, Ford, Gray, Kiowa, Meade	7	1	1	0
<b>District 17</b>	Decatur, Graham, Norton, Osborne, Phillips, Smith	0	0	1	0
<b>District 18</b>	Sedgwick	0	1	2	0
<b>District 19</b>	Cowley	1	1	0	0
<b>District 20</b>	Barton, Ellsworth, Rice, Russell, Stafford	2	1	5	0
<b>District 23</b>	Ellis, Gove, Rooks, Trego	3	0	4	0
<b>District 24</b>	Edwards, Hodgeman, Lane, Ness, Pawnee, Rush	0	0	1	0
<b>District 25</b>	Finney, Greeley, Hamilton, Kearny, Scott, Wichita	2	0	0	0
<b>District 27</b>	Reno	1	0	0	0
<b>District 28</b>	Ottawa, Salina	0	0	1	0
<b>District 29</b>	Wyandotte	1	0	1	0
<b>District 30</b>	Barber, Harper, Kingman, Pratt, Sumner	2	0	0	0

# SCDRB Public Policy Recommendations

The Board strongly encourages consideration of each of the following policy recommendations:

## **Recommendations to Prevent Child Abuse and Neglect Deaths**

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### **Increase Access to Affordable, High-Quality Child care**

Homicides, particularly of children under the age of three, continue to occur when children are left in the care of persons who are unprepared or unable to care for them.

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.<sup>2</sup>

### **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.<sup>40</sup>

### **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.

## **SCDRB Public Policy Recommendation**

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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**

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### **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 state agencies and mental health providers worked to increase the availability of community crisis responses for those in mental health distress. Additionally, the Legislature held hearings on the topic of mental health modernization and passed a bill that established certified community behavioral health clinics (CCBHC) as the model for providing behavioral health services in Kansas (HB 2208). CCBHCs are specifically designed to address the suicide crisis, prevention of overdose deaths, barriers to timely access to addiction and mental health treatment, delayed care, inadequate care for veterans, and overburdened jail and emergency departments; all of which affect the Kansas mental health system. At the time of this report, six Kansas community mental health centers (CMHC) are in the process of implementing the CCBHC model, and it is anticipated that all 26 licensed CMHCs will transition to CCBHCs over the next three years.<sup>41</sup>

The Board encourages community mental health centers, psychiatric treatment facilities, and other agencies providing mental health services to prepare for an increase in demand of their services following the youth application implementation.

### **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 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 other children if a peer has committed suicide. 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 YSPC 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 way to report suicidal thoughts or intent for themselves or their peers.

## **Recommendations to Prevent Motor Vehicle Deaths of Children and Youth**

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### **Strengthen All-Terrain Vehicle (ATV) Usage Laws**

Citizens and lawmakers should support efforts to impose a minimum age requirement of 16 years of age 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 2021 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 298 ATV-related fatalities of children under the age of 16, between January 1, 2016, and December 31, 2018. Almost half (48%) of all under-age-16 child fatalities occurred to children 12 and under. Kansas experienced three ATV-related child deaths in 2020.<sup>17</sup>

### **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 old 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 2018 and 2020, 44% of the children who died due to motor vehicle crashes were unrestrained or improperly restrained. In another 7% the restraint use of the victim was unknown. According to the State of Kansas Highway Safety Plan Federal Fiscal Year (FFY) 2022, “Children are much more likely to be buckled up if the driver is also belted. If the driver is belted, about 97% of the children are also belted. If the driver is not belted, only about 30% of the observed children were also belted.”<sup>20</sup> 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) 2022, “Distracted or inattentive driving is listed as a contributing circumstance for about 25% of all reported crashes in the state.”<sup>20</sup> 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**

Eleven decedents were teen drivers under the influence of drugs and/or alcohol at the time of their crash (2016-2020). Three of these fatalities occurred in 2020. 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 2020, Kansas experienced six pedestrian deaths of children, four of which took place in a driveway or farmyard. 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.<sup>42</sup> 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 would be to educate 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.<sup>43</sup> 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**

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### **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 regarding 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.<sup>44</sup>

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.<sup>44</sup> 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 2022 DCF workers were able to attend a two-day safe sleep instructor training provided by Kansas Infant Death and SIDS network that trained on how to implement safe sleep practices in instances of different cultural standards and for families with different mental health issues.

### **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 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**

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### **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 2016 and 2020, 43% 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 going forward. 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 and 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**

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### **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 and supervise contractors appropriately.

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 contracted 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 the contractor or 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.

A primary goal for Kansas is to reduce the need for foster care and the number of children in out of home placements by expanding prevention services to allow more children to remain in their homes if it is safe for them to do so. Increased access to trauma-informed, evidence-based prevention services is crucial to address the most common risk factors for abuse and neglect and to support families. The Board is encouraged by the implementation of Family First Prevention Services through DCF. With additional prevention services, it is anticipated the number of children able to remain safely in their homes will increase. Family First Prevention Services adds new programs, delivered by qualified clinicians, in the areas of mental health, substance use disorder and treatment services, as well as a kinship navigator and a parent skill-based program. Family First Prevention Services may be provided to families when at least one child in the home is at imminent risk for out-of-home placement. The Board recommends that similar services continue to be expanded so they are easily accessible to all at-risk families throughout the state regardless of geographic location.

### **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 the adoption 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 in instances where the reported abuse may be criminal in nature for law enforcement investigation. K.S.A. 38-2226 requires a joint investigation if there is a report of child abuse or neglect that indicates 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;

## **SCDRB Public Policy Recommendation**

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- 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.

## **Recommendation to Standardize County-Level Reviews of Child Fatalities**

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### **Consider Statutory Modifications to KSA 22a-243**

With passage of HB 2158 during the 2021 Legislative Session, the SCDRB is now permitted to share information with and support the work of Local Fatality Review Teams. As the Board has worked through the process to establish rules and regulations, it has become apparent that additional statutory modifications to KSA 22a-243 will be needed to ensure that local fatality teams have defined processes and goals, and are functioning within protective parameters as recommended by the State Child Death Review Board. The State Child Death Review Board believes that statutory changes should be made to ensure confidentiality of information is maintained.

## Appendix A: Deaths by County of Residence, 2016-2020

County	Population Age 0-17	Total Deaths*	Total Death Rate	Natural Deaths Excluding SIDS	Unintentional Injury-MVC	Unintentional Injury	SIDS	Homicide	Suicide	Undetermined
<b>Allen</b>	14,061	11	78.23	6	0	1	1	0	1	2
<b>Anderson</b>	9,951	6	60.30	2	1	1	0	0	1	1
<b>Atchison</b>	18,716	9	48.09	6	0	0	0	0	2	1
<b>Barber</b>	5,163	4	77.47	3	0	0	0	0	1	0
<b>Barton</b>	31,154	11	35.31	6	0	0	0	2	1	2
<b>Bourbon</b>	18,701	13	69.51	7	0	4	0	0	0	2
<b>Brown</b>	12,123	8	65.99	6	1	0	0	1	0	0
<b>Butler</b>	85,239	31	36.37	17	1	2	1	2	4	4
<b>Chase</b>	2,691	0	0.00	0	0	0	0	0	0	0
<b>Chautauqua</b>	3,387	1	29.52	1	0	0	0	0	0	0
<b>Cherokee</b>	23,084	9	38.99	5	2	0	0	0	1	1
<b>Cheyenne</b>	2,791	0	0.00	0	0	0	0	0	0	0

\*Data based on 20 or fewer deaths are not statistically valid for intervention planning.

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County	Population Age 0-17	Total Deaths*	Total Death Rate	Natural Deaths Excluding SIDS	Unintentional Injury-MVC	Unintentional Injury	SIDS	Homicide	Suicide	Undetermined
<b>Clark</b>	2,451	2	81.60	0	0	1	0	1	0	0
<b>Clay</b>	9,412	3	31.87	2	0	0	0	0	1	0
<b>Cloud</b>	10,088	9	89.21	4	1	2	1	0	0	1
<b>Coffey</b>	8,970	3	33.44	1	0	2	0	0	0	0
<b>Comanche</b>	2,121	2	94.30	2	0	0	0	0	0	0
<b>Cowley</b>	41,589	21	50.49	9	0	3	1	3	3	2
<b>Crawford</b>	42,557	21	49.35	15	1	2	0	0	1	2
<b>Decatur</b>	2,803	2	71.35	0	2	0	0	0	0	0
<b>Dickinson</b>	22,019	17	77.21	8	2	3	0	1	2	1
<b>Doniphan</b>	8,025	5	62.31	5	0	0	0	0	0	0
<b>Douglas</b>	111,087	48	43.21	28	1	7	4	1	1	6
<b>Edwards</b>	3,299	2	60.62	1	0	0	0	0	1	0
<b>Elk</b>	2,727	5	183.35	1	2	0	2	0	0	0
<b>Ellis</b>	30,719	14	45.57	10	1	1	0	0	1	1

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**Appendix A: Deaths by County of Residence, 2016-2020**

County	Population Age 0-17	Total Deaths*	Total Death Rate	Natural Deaths Excluding SIDS	Unintentional Injury-MVC	Unintentional Injury	SIDS	Homicide	Suicide	Undetermined
<b>Ellsworth</b>	5,643	2	35.44	1	0	1	0	0	0	0
<b>Finney</b>	55,468	24	43.27	14	2	3	0	1	1	3
<b>Ford</b>	50,814	34	66.91	18	6	3	1	0	6	0
<b>Franklin</b>	30,751	17	55.28	11	4	1	0	0	1	0
<b>Geary</b>	51,253	38	74.14	23	5	3	1	0	3	3
<b>Gove</b>	3,172	1	31.53	1	0	0	0	0	0	0
<b>Graham</b>	2,548	1	39.25	1	0	0	0	0	0	0
<b>Grant</b>	11,296	6	53.12	2	1	0	0	2	0	1
<b>Gray</b>	8,659	3	34.65	2	0	1	0	0	0	0
<b>Greeley</b>	1,612	1	62.03	1	0	0	0	0	0	0
<b>Greenwood</b>	6,443	7	108.65	4	2	0	0	1	0	0
<b>Hamilton</b>	3,674	3	81.65	2	0	0	0	0	1	0
<b>Harper</b>	6,835	3	43.89	1	1	0	0	0	0	1
<b>Harvey</b>	41,857	23	54.95	14	0	0	2	2	1	4

\*Data based on 20 or fewer deaths are not statistically valid for intervention planning.

## Appendix A: Deaths by County of Residence, 2016-2020

County	Population Age 0-17	Total Deaths*	Total Death Rate	Natural Deaths Excluding SIDS	Unintentional Injury-MVC	Unintentional Injury	SIDS	Homicide	Suicide	Undetermined
<b>Haskell</b>	5,640	3	53.19	2	1	0	0	0	0	0
<b>Hodgeman</b>	2,068	2	96.71	1	0	0	0	0	0	1
<b>Jackson</b>	16,605	11	66.25	4	2	1	2	0	0	2
<b>Jefferson</b>	21,652	7	32.33	2	2	2	0	0	1	0
<b>Jewell</b>	2,788	2	71.74	1	1	0	0	0	0	0
<b>Johnson</b>	725,858	239	32.93	145	15	17	8	8	35	11
<b>Kearny</b>	5,611	4	71.29	2	1	0	0	0	1	0
<b>Kingman</b>	7,962	2	25.12	0	0	0	1	0	1	0
<b>Kiowa</b>	2,824	1	35.41	0	1	0	0	0	0	0
<b>Labette</b>	23,776	12	50.47	5	1	3	1	1	1	0
<b>Lane</b>	1,742	0	0.00	0	0	0	0	0	0	0
<b>Leavenworth</b>	96,181	50	51.99	31	3	4	2	5	1	4
<b>Lincoln</b>	3,408	1	29.34	1	0	0	0	0	0	0
<b>Linn</b>	10,860	5	46.04	2	1	0	0	0	1	1

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**Appendix A: Deaths by County of Residence, 2016-2020**

County	Population Age 0-17	Total Deaths*	Total Death Rate	Natural Deaths Excluding SIDS	Unintentional Injury-MVC	Unintentional Injury	SIDS	Homicide	Suicide	Undetermined
<b>Logan</b>	3,353	1	29.82	0	1	0	0	0	0	0
<b>Lyon</b>	37,051	18	48.58	14	1	1	1	0	0	1
<b>Marion</b>	12,627	8	63.36	5	0	1	1	0	0	1
<b>Marshall</b>	11,593	5	43.13	3	0	2	0	0	0	0
<b>McPherson</b>	32,724	10	30.56	5	3	0	0	0	2	0
<b>Meade</b>	5,354	6	112.07	4	1	0	0	1	0	0
<b>Miami</b>	41,564	18	43.31	8	7	2	0	0	1	0
<b>Mitchell</b>	6,959	3	43.11	2	1	0	0	0	0	0
<b>Montgomery</b>	38,070	19	49.91	9	2	4	0	0	1	3
<b>Morris</b>	5,670	3	52.91	3	0	0	0	0	0	0
<b>Morton</b>	3,246	3	92.42	3	0	0	0	0	0	0
<b>Nemaha</b>	13,429	5	37.23	2	2	1	0	0	0	0
<b>Neosho</b>	19,655	16	81.40	7	4	1	0	0	0	4
<b>Ness</b>	3,063	3	97.94	2	0	0	0	0	1	0

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## Appendix A: Deaths by County of Residence, 2016-2020

County	Population Age 0-17	Total Deaths*	Total Death Rate	Natural Deaths Excluding SIDS	Unintentional Injury-MVC	Unintentional Injury	SIDS	Homicide	Suicide	Undetermined
<b>Norton</b>	5,128	3	58.50	2	0	1	0	0	0	0
<b>Osage</b>	18,400	8	43.48	5	2	0	1	0	0	0
<b>Osborne</b>	3,691	1	27.09	0	0	1	0	0	0	0
<b>Ottawa</b>	6,568	6	91.35	4	0	0	0	0	1	1
<b>Pawnee</b>	5,460	1	18.32	1	0	0	0	0	0	0
<b>Phillips</b>	6,023	1	16.60	1	0	0	0	0	0	0
<b>Pottawatomie</b>	35,079	11	31.36	6	0	1	1	0	1	2
<b>Pratt</b>	11,383	11	96.64	5	0	5	1	0	0	0
<b>Rawlins</b>	2,670	1	37.44	0	1	0	0	0	0	0
<b>Reno</b>	70,025	35	49.98	19	5	4	0	0	3	4
<b>Republic</b>	4,846	6	123.81	2	4	0	0	0	0	0
<b>Rice</b>	11,015	7	63.55	5	2	0	0	0	0	0
<b>Riley</b>	61,360	34	55.41	23	1	1	2	3	2	2
<b>Rooks</b>	5,583	3	53.73	2	0	0	0	0	1	0

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**Appendix A: Deaths by County of Residence, 2016-2020**

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<b>Rush</b>	3,083	1	32.44	1	0	0	0	0	0	0
<b>Russell</b>	7,519	1	13.30	0	0	0	0	1	0	0
<b>Saline</b>	63,615	32	50.30	21	1	3	1	4	1	1
<b>Scott</b>	6,479	0	0.00	0	0	0	0	0	0	0
<b>Sedgwick</b>	661,177	393	59.44	254	24	28	8	24	21	34
<b>Seward</b>	34,392	13	37.80	9	1	0	0	2	0	1
<b>Shawnee</b>	209,375	139	66.39	86	10	9	6	6	13	9
<b>Sheridan</b>	3,062	1	32.66	0	1	0	0	0	0	0
<b>Sherman</b>	7,093	5	70.49	1	0	0	0	1	1	2
<b>Smith</b>	3,632	2	55.07	2	0	0	0	0	0	0
<b>Stafford</b>	4,952	3	60.58	1	1	0	0	0	1	0
<b>Stanton</b>	2,786	2	71.79	0	1	1	0	0	0	0
<b>Stevens</b>	7,980	4	50.13	2	1	0	0	1	0	0
<b>Sumner</b>	28,016	18	64.25	12	2	2	0	1	1	0

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## Appendix A: Deaths by County of Residence, 2016-2020

County	Population Age 0-17	Total Deaths*	Total Death Rate	Natural Deaths Excluding SIDS	Unintentional Injury-MVC	Unintentional Injury	SIDS	Homicide	Suicide	Undetermined
<b>Thomas</b>	9,087	8	88.04	4	0	1	0	0	1	2
<b>Trego</b>	2,612	1	38.28	0	0	0	0	0	1	0
<b>Wabaunsee</b>	8,098	5	61.74	2	0	0	1	0	2	0
<b>Wallace</b>	1,915	1	52.22	0	0	0	0	0	0	1
<b>Washington</b>	6,189	4	64.63	2	1	0	0	0	1	0
<b>Wichita</b>	2,799	2	71.45	1	1	0	0	0	0	0
<b>Wilson</b>	10,217	6	58.73	2	1	1	0	0	2	0
<b>Woodson</b>	3,274	0	0.00	0	0	0	0	0	0	0
<b>Wyandotte</b>	229,576	168	73.18	91	11	19	6	22	4	15
<b>Out of State</b>	-	117	-	69	30	9	0	4	4	1
<b>Total</b>	<b>3,530,446</b>	<b>1,931</b>	<b>54.70</b>	<b>1,138</b>	<b>186</b>	<b>167</b>	<b>57</b>	<b>101</b>	<b>141</b>	<b>141</b>

\*Data based on 20 or fewer deaths are not statistically valid for intervention planning.

# Methodology

## Kansas State Child Death Review Board Process

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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.

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. In some instances, the SCDRB may determine that it is appropriate to refer a case to the county or district attorney in the county where the death occurred with recommendations for further action.

## Rates of Death

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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.

## Methodology

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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.

To determine the infant death rate per 1,000 live births in a specific year, the number of deaths is divided by the corresponding number of live births, and then multiplied by 1,000.

The KDHE Bureau of Epidemiology and Public Health Informatics (BEPHI) is the source for numbers of live births used as denominators in this report.

Example: Infant death rate, Kansas 2020 =

$$\left( \frac{219 \text{ (number of infant deaths that occurred in 2020, reviewed by the SCDRB)}}{34,368 \text{ (number of Kansas resident live births in 2020)}} \right) \times 1,000$$

= 6.4

To determine the death rate per 100,000 population for an age group for a given time period, the number of deaths is divided by the corresponding population, and then multiplied by 100,000. The KDHE BEPHI is the source for numbers of resident population data used as denominators in this report.

Example: Motor Vehicle Death Rate, age 15-17, Kansas 2020 =

$$\left( \frac{8 \text{ (number of MVC deaths age 15-17 that occurred in 2020, reviewed by the SCDRB)}}{119,327 \text{ (population of Kansas residents age 15-17 in 2020)}} \right) \times 100,000$$

= 6.7

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

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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. While the Board has included this information throughout the report, it should be noted that to understand disparities related to race and ethnicity, you must be able to compare percentages of death by race with percentage of population by race. One challenge the board faced was that the two most prominent sources for Kansas



population data (Kansas Department of Health and Environment and the U.S. Census Bureau) both collect and report race and ethnicity data differently and neither source collects or reports race and ethnicity the same as the State Child Death Review Board. For comparison purposes, using estimates derived from the US Census data from 2020, the number of Kansas residents under the age of 18 is 696,746. Figure 96 and Figure 97 indicate population information provided by the Kansas Department for Health and Environment (KDHE) which can be used as a reference to calculate both race and ethnicity for different age populations in Kansas.

**Figure 96**

Race and Ethnicity Percentages by Age Group, 2020, U.S. Census Bureau Population Estimates <sup>55</sup>									
Age	Total Population	White		Black		Multi		Other	
<b>0-1</b>	35,281	63.43%	15.77%	6.49%	0.86%	6.85%	1.08%	4.47%	1.06%
<b>0-17</b>	696,746	65.73%	16.30%	6.14%	0.76%	5.48%	0.97%	3.72%	0.90%
<b>1-17</b>	661,465	65.85%	16.33%	6.12%	0.76%	5.40%	0.96%	3.68%	0.89%

## Methodology

Figure 97

U.S. Census Bureau Population Estimates for selected age-groups and population groups, Kansas, 2020 <sup>55</sup>								
Age	White		Black		Multi		Other	
	Non-Hispanic	Hispanic	Non-Hispanic	Hispanic	Non-Hispanic	Hispanic	Non-Hispanic	Hispanic
<b>0</b>	22,379	5,563	2,289	302	2,417	380	1,576	375
<b>1</b>	22,833	5,818	2,439	345	2,120	386	1,391	382
<b>2</b>	23,580	5,950	2,440	356	2,093	398	1,343	445
<b>3</b>	24,118	6,142	2,319	322	2,126	391	1,325	372
<b>4</b>	25,236	6,207	2,302	282	2,171	334	1,447	410
<b>5</b>	25,495	6,028	2,428	277	2,047	355	1,394	365
<b>6</b>	25,667	6,147	2,392	273	2,017	357	1,488	382
<b>7</b>	25,756	6,163	2,412	267	2,147	352	1,466	385
<b>8</b>	25,784	6,197	2,306	273	2,111	375	1,439	404
<b>9</b>	25,942	6,363	2,417	307	2,112	330	1,474	415
<b>10</b>	26,046	6,777	2,354	289	2,253	418	1,418	314
<b>11</b>	25,773	6,748	2,384	307	2,214	416	1,314	275
<b>12</b>	26,384	6,838	2,497	288	2,198	426	1,392	301
<b>13</b>	26,563	6,730	2,400	339	2,216	418	1,394	298
<b>14</b>	26,353	6,629	2,454	280	2,142	396	1,434	336
<b>15</b>	26,476	6,497	2,355	276	1,942	336	1,445	282
<b>16</b>	26,606	6,398	2,269	256	1,969	358	1,633	286
<b>17</b>	26,948	6,402	2,324	267	1,867	323	1,546	266
<b>Totals Below:</b>								
<b>1-17</b>	435,560	108,034	40,492	5,004	35,745	6,369	24,343	5,918
<b>0-17</b>	457,939	113,597	42,781	5,306	38,162	6,749	25,919	6,293

## Gender Identity and Sexual Orientation

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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](#) section, 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 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](http://www.kctcdata.org).

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**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.**

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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](mailto:sara.hortenstine@ag.ks.gov)

# 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 death.

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