SECTION ONE:
Missouri Incident Fatalities

"A simple child,
That lightly draws its breath,
And feels its life in every limb,
What should it know of death?"

- William Woodsworth

In reviewing this report, the reader should be aware of some important definitions and details about how child deaths are reported and certified in Missouri, summarized here: (Please refer to Appendix 6, Definitions of Important Terms and Variables, for additional information.)

- **"Missouri Child Fatalities"** refers to all children age 17 and under, who died in Missouri, without regard to the state of residence or the state in which the illness, injury or event occurred. (For example, a child who is a resident of Kentucky, injured in a motor vehicle crash in Illinois and brought to a Missouri hospital, where he or she subsequently dies, would be counted as a "Missouri Child Fatality." This death would be reported to the Child Fatality Review Program on a Data Form 1, Section A only, as an out-of-state event and reported to Illinois.)

- **"Missouri Incident Fatality"** refers to a *fatal illness, injury or event,* which occurs *within the state of Missouri.* (This is not necessarily the county or state in which the child resided.) If the death meets the criteria for panel review, it is reviewed in the county in which the *fatal injury, illness or event* occurred.

- *Every* Missouri incident child fatality is required to be reviewed by the coroner or medical examiner and the chairperson for the county Child Fatality Review Panel. The findings of that review are reported on the Data Form 1.

- Any child death that is *unclear, unexplained, or of a suspicious circumstance, and all sudden, unexplained deaths of infants one week to one year of age* are required to be reviewed by a county-based Child Fatality Review Panel. Panel findings are reported on the Data Form 2. Panel members receive annual training on the investigation of child fatalities.

- **Multiple-Cause Deaths:** *Cause of death* is a disease, abnormality, injury or poisoning that contributed directly or indirectly to death. However, a death often results from the combined effect of two or more conditions. Because the Child Fatality Review Program is focused on the prevention of child fatalities, the precipitating events are of particular concern. Therefore, deaths are categorized according to the *circumstances of the death,* which may not be the immediate cause of death listed on the death certificate. (An example would be a child passenger in a car that runs off the road and lands in ditch full of water; the "immediate cause of death" is listed on the death certificate as "drowning," but the precipitating event was a motor vehicle accident. This death would be reported in the Motor Vehicle Fatalities section, with a footnote indicating that the death certificate lists "drowning" as the immediate cause of death.)

- The Child Fatality Review Program data management unit links data collected on the Data Forms 1 and 2 with Department of Health and Senior Services birth and death data. Every attempt is made to reconcile the two systems; however, in some cases, crucial data components are incomplete and are noted, as appropriate.
- All deaths included in this 2002 CFRP Annual Report occurred in calendar year 2002. Some of the cases reviewed may not have been brought before a county panel until the year 2003.
- In some cases, panels did not complete all of the information requested on the data form.
- Of the 491 Missouri Incident Fatalities reported on a Data Form 1 in 2002 with indication for review, 20 did not receive required CFRP panel review or panel findings were not submitted on a Data Form 2. These 20 fatalities are included in this 2002 CFRP Annual Report because the data, though incomplete, is useful and accurate within the limitations of the Data Form 1 information.
- In 2002, 43 Missouri Incident Fatalities were not reported on either a Data Form 1 or Data Form 2, but were reported to CFRP by death certificates from the Department of Health and Senior Services. From information provided by the death certificates, eighteen of these 43 fatalities (42%) had at least one indication for review. These fatalities are not included in the data for this annual report.

Summary of Findings, Missouri Incident Fatalities, 2002

In 2002, **1246** children age 17 and under died in Missouri. Of those deaths, **1080** were determined to be "Missouri incident fatalities" and, therefore, subject to review by the coroner or medical examiner. Of the 1080 deaths, **491** had an indication for review by a county Child Fatality Review Panel and of those **471** were reviewed and a Data Form 2 completed.

Figure 1. Missouri Child Fatalities vs. Missouri Incident Fatalities

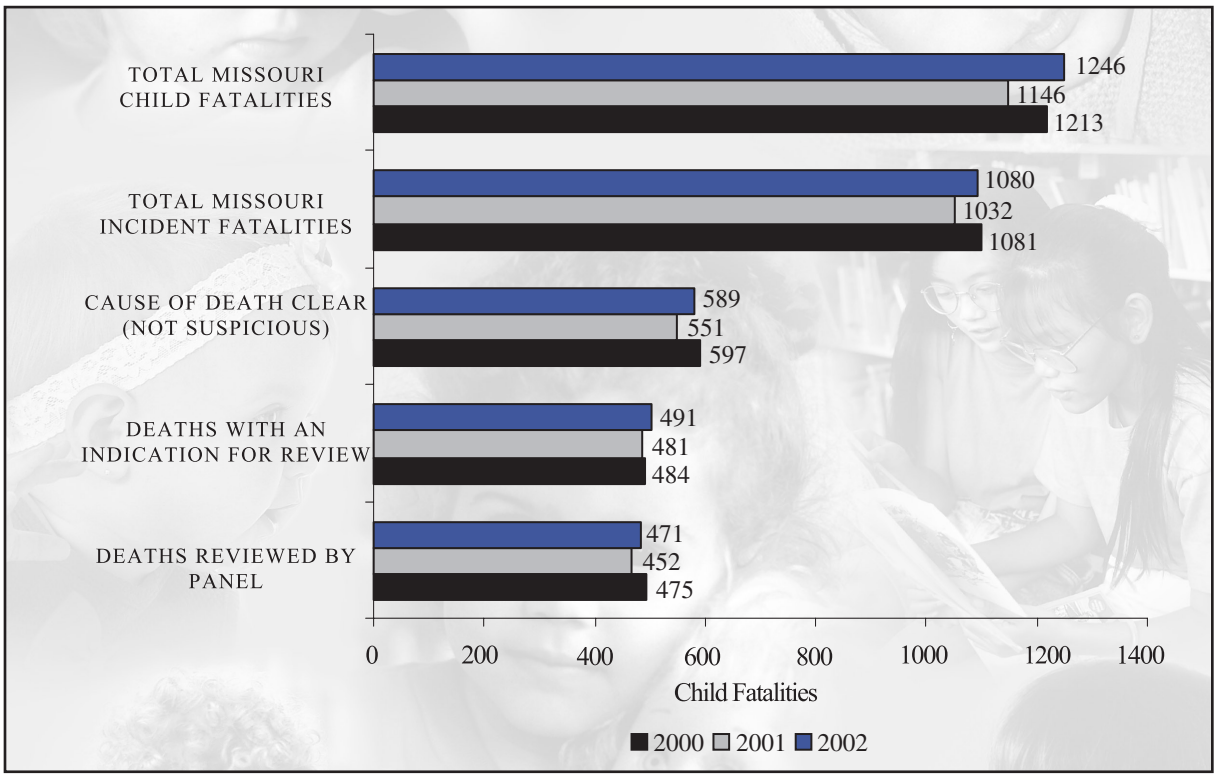
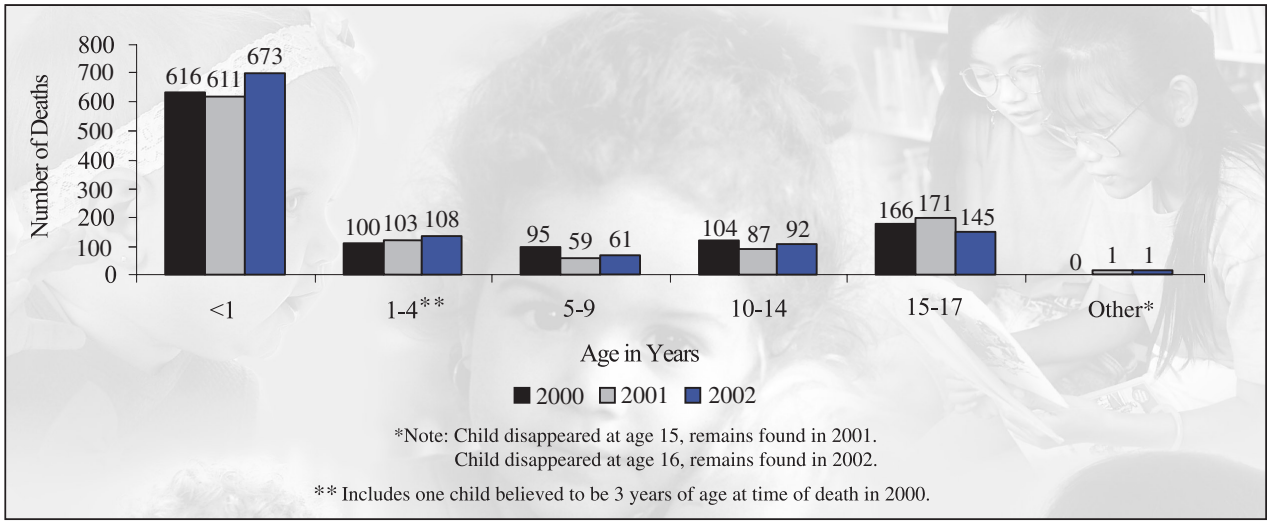


Figure 2. Missouri Incident Fatalities by Age



*Note: Child disappeared at age 15, remains found in 2001.
Child disappeared at age 16, remains found in 2002.

** Includes one child believed to be 3 years of age at time of death in 2000.

Figure 3. Missouri Incident Fatalities by Sex and Race

Sex	2000	2001	2002	Race	2000	2001	2002
Female	463	421	464	White	787	706	758
Male	618	611	616	Black	284	310	303
				Other	10	16	19
	1081	1032	1080		1081	1032	1080

Figure 4. Missouri Incident Fatalities by Manner

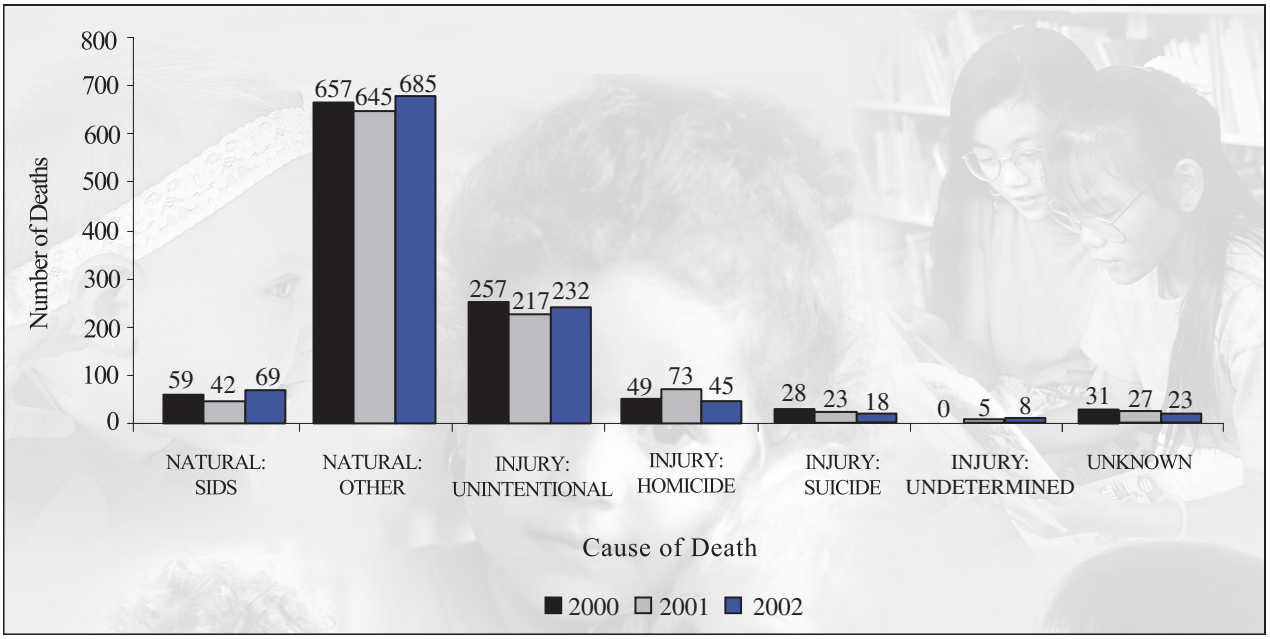
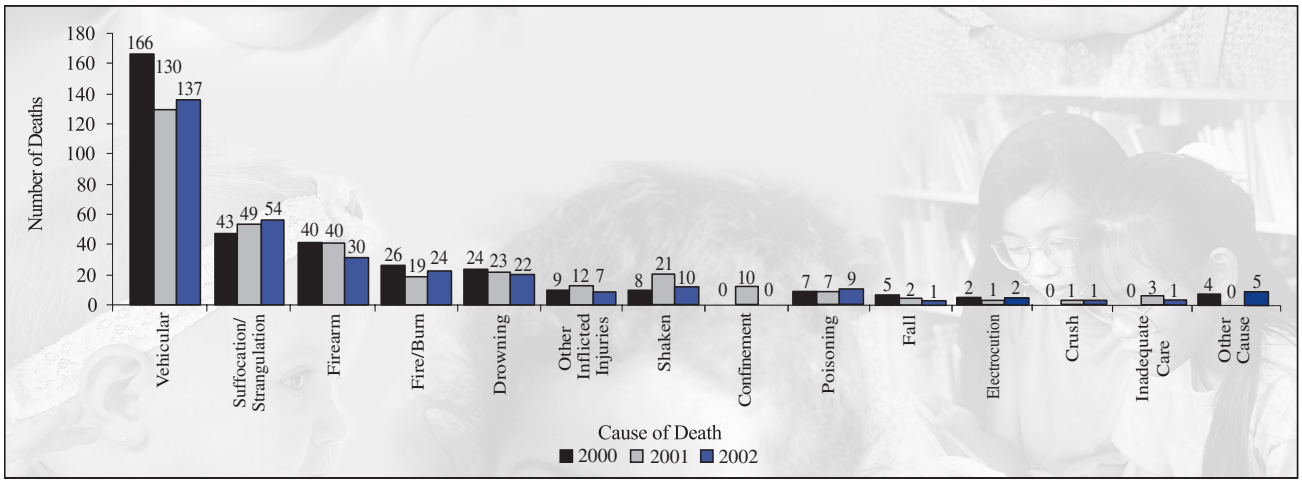


Figure 5. Leading Cause of Injury Deaths



Prevention Findings: The Final Report

"Injury is a problem that can be diminished considerably if adequate attention and support are directed to it. Exciting opportunities to understand and prevent injuries and to reduce their effects are at hand. The alternative is the continued loss of health and life to predictable, preventable and modifiable injuries."

-Dr. William Foege, Former Director of the Centers for Disease Control and Prevention

The difference between a fatal and nonfatal event is often only a few feet, a few inches, or a few seconds. In the past, most people believed that serious and fatal injuries were random or unavoidable events, or simply the result of individual carelessness. Fortunately, the science of injury prevention has moved away from this fatalistic approach to one that focuses on the environment and products used by the public, as well as individual behavior. Injuries are now widely recognized as understandable, predictable and preventable.

A *preventable child death* is defined as one in which awareness or education by an individual or the community may have changed the circumstances that lead to the death. Prior to August 2000, CFRP panels were asked to report their conclusions and prevention responses for each death reviewed on the Data Form 2. Legislation passed in 2000 now requires that the panel complete a Final Report, summarizing their findings in terms of circumstances, prevention messages, and community-based prevention initiatives.

The death of a child is a sentinel event that captures the attention of the community, creates a sense of urgency and a window of opportunity to respond to the question, "What can we do?" County-based prevention activities serve to raise awareness, educate parents and caretakers, influence public policy and involve the community in prevention initiatives that protect and improve the lives of children. In 2002, CFRP panels throughout our state reported their findings and prevention responses utilizing the Final Report. The initiatives highlighted below demonstrate how a few volunteer professionals have been able to measurably reduce or eliminate threats to the lives and well being of countless Missouri children.

Legislation, Law or Ordinance:

A newborn infant died during a home birth attended by a midwife. The panel suggested that the state should address standards and licensing of midwives in Missouri. The panel also wanted to find out the prevalence of midwife births and recommended legislative action.

Community Safety Project:

A 17-year-old boy was killed by rival gang members in a fight. The panel suggested that the community support efforts aimed at the prevention of gang-related activity, encourage parenting skills and parental involvement with adolescent children.

A 4-year-old girl and her family were killed in a house fire. There were no working smoke alarms in the home. The local CFRP panel worked with the local fire department to canvass the community with free smoke detectors and offered free installation for families that could not install the smoke detectors for themselves.

Public Forums:

A 16-year-old boy died of a self-inflicted gunshot wound to the head. The local panel participated in a public meeting with the schools and parents regarding suicide prevention. During the meeting, they discussed the need to identify students at risk and provide counseling for those who are having difficulties in school and the community.

A 2-year-old girl was killed by her mother's paramour. The panel and the local safety coalition suggested that the county health department and law enforcement distribute educational information about good childcare choices. They also wanted to inform the community regarding child abuse and neglect awareness.

Educational Activities in Schools:

A 13-year-old boy was struck by a pickup truck while he was crossing the street on his bicycle. The panel contacted area schools and asked that bicycle safety programs be brought into the schools.

A 17-year-old girl was killed in a motor vehicle accident. She was not wearing her seatbelt. The local panel drafted an article regarding effectiveness of seatbelts and submitted it to the local schools for distribution.

Educational Activities in the Media:

A 15-year-old boy was struck by a vehicle while riding his bike along the road. He was not wearing a helmet. The panel contacted the local television station and suggested a story on the importance of wearing helmets when riding bicycles.

A 6-month-old boy was found unresponsive by his babysitter after being put to sleep on a couch cushion. The local panel suggested that the media, both television and newspaper, run stories regarding the safe sleep practices for infants and the hazards of placing children to sleep in unsafe environments. They also asked that Safe Sleep brochures be given out at local health departments, clinics and Children's Division offices.

Consumer Product Safety:

A 10-month-old infant girl was found unresponsive in her crib with a blanket covering her face. The panel contacted the Consumer Product Safety Commission regarding a Safe Sleep campaign involving parent education in local hospitals.

News Services:

A 9-year-old girl died of acute carbon monoxide intoxication. The gas generator being used by the family was not properly ventilated. The panel approached the media about running an article regarding the proper use of gas generators and proper ventilation practices.

A 13-year-old girl died of an Oxy-Contin overdose. The local panel contacted the local television station to run a story on the dangers of Oxy-Contin and drug use in general.

Changes in Agency Practice:

A 1-year-old male was brought to the emergency room unresponsive and not breathing. The child's death was ruled homicidal asphyxiation by the medical examiner and his mother was charged with murder. The panel contacted the local hospitals asking that they encourage their emergency room staff to carefully evaluate for child abuse and neglect.

An 8-month-old boy was put to bed on his stomach and was found the next morning unresponsive. The panel contacted the local hospital to suggest that parents should be made aware of Safe Sleep practices before leaving the hospital.

A 3-year-old boy drowned after falling off a fishing dock. The local panel approached law enforcement about requiring handrails on the back part of main docks before dock permits could be issued or renewed.

Other Programs/Activities:

A 2-year-old girl and her mother died in an apartment fire. The panel discussed the possibility of having landlords cited for not insuring that smoke alarms were in working order at all times. The landlord in this case was cited for not having working smoke alarms in his properties.

A 4-year-old boy choked on an object lodged in his throat. The local panel suggested that the fire department provide a class for parents on the Hiemlich Maneuver and CPR.

"Alone we can do so little; together we can do so much."

-Helen Keller