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 2003 CFRP Annual Report occurred in calendar year 2003. Some of the cases reviewed may not have been brought before a county panel until the year 2004.
- In some cases, panels did not complete all of the information requested on the data form.
- Of the 467 Missouri Incident Fatalities reported on a Data Form 1 in 2003 with indication for review, 34 did not receive required CFRP panel review or panel findings were not submitted on a Data Form 2. These 34 fatalities are included in this 2003 CFRP Annual Report because the data, though incomplete, is useful and accurate within the limitations of the Data Form 1 information.
- In 2003, 36 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, nine of these 36 fatalities (25%) 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, 2003

In 2003, **1186** children age 17 and under died in Missouri. Of those deaths, **1065** were determined to be "Missouri incident fatalities" and, therefore, subject to review by the coroner or medical examiner. Of the 1065 deaths, **467** had an indication for review by a county Child Fatality Review Panel and of those **433** were reviewed and a Data Form 2 completed.

Figure 1. Missouri Child Fatalities vs. Missouri Incident Fatalities

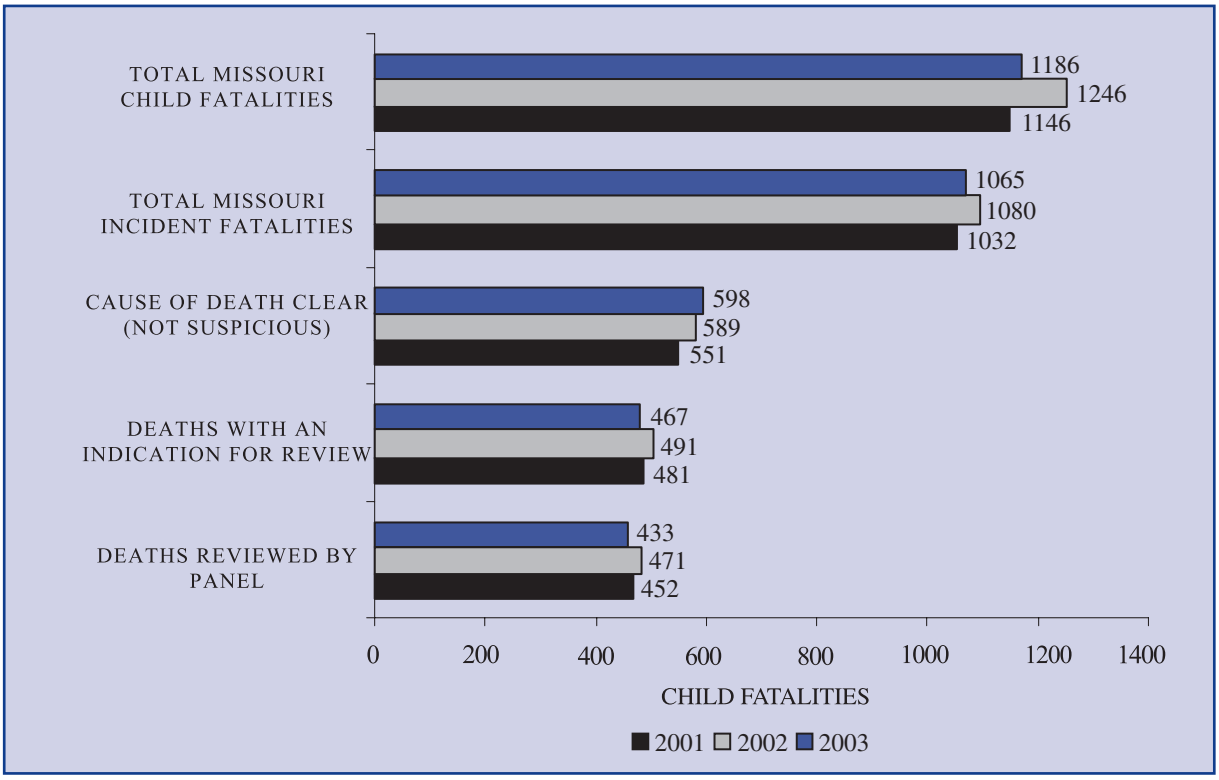
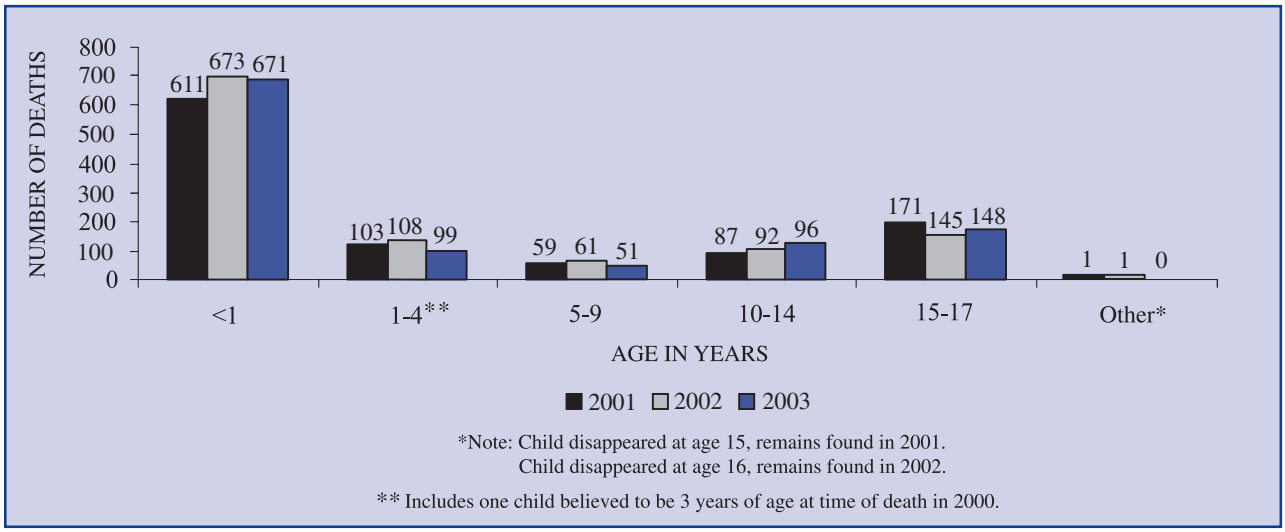


Figure 2. Missouri Incident Fatalities by Age



*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	2001	2002	2003	Race	2001	2002	2003
Female	421	464	456	White	706	758	779
Male	611	616	608	Black	310	303	267
Other			1	Other	16	19	19
	1032	1080	1065		1032	1080	1065

Figure 4. Missouri Incident Fatalities by Manner

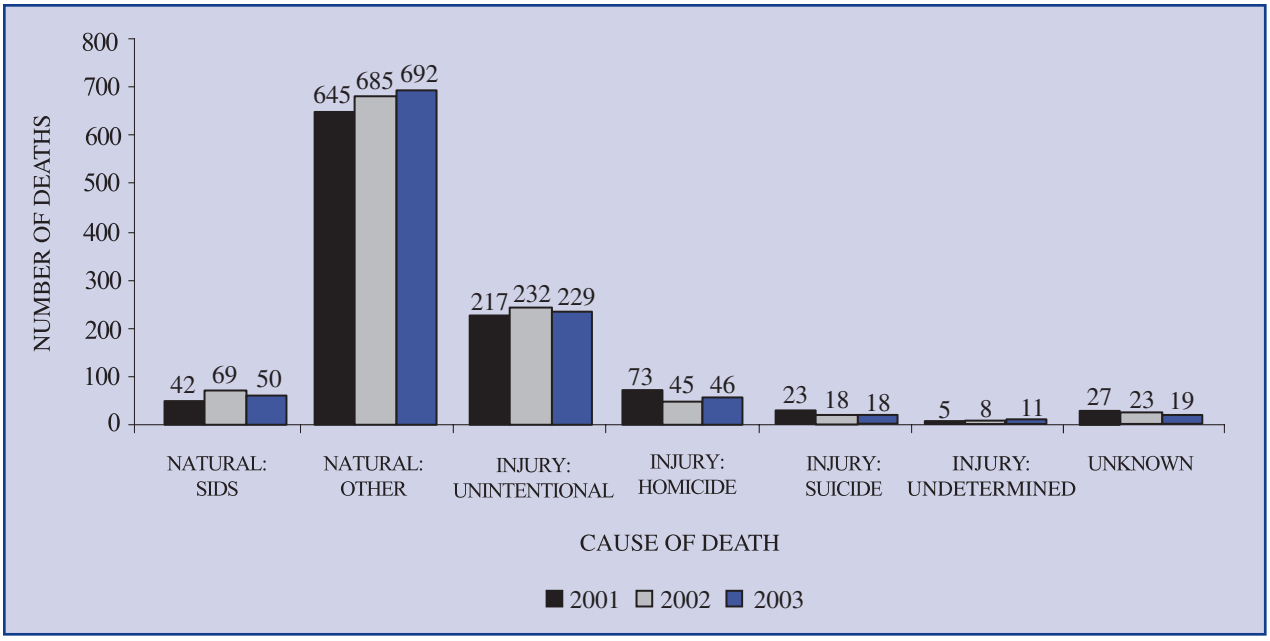
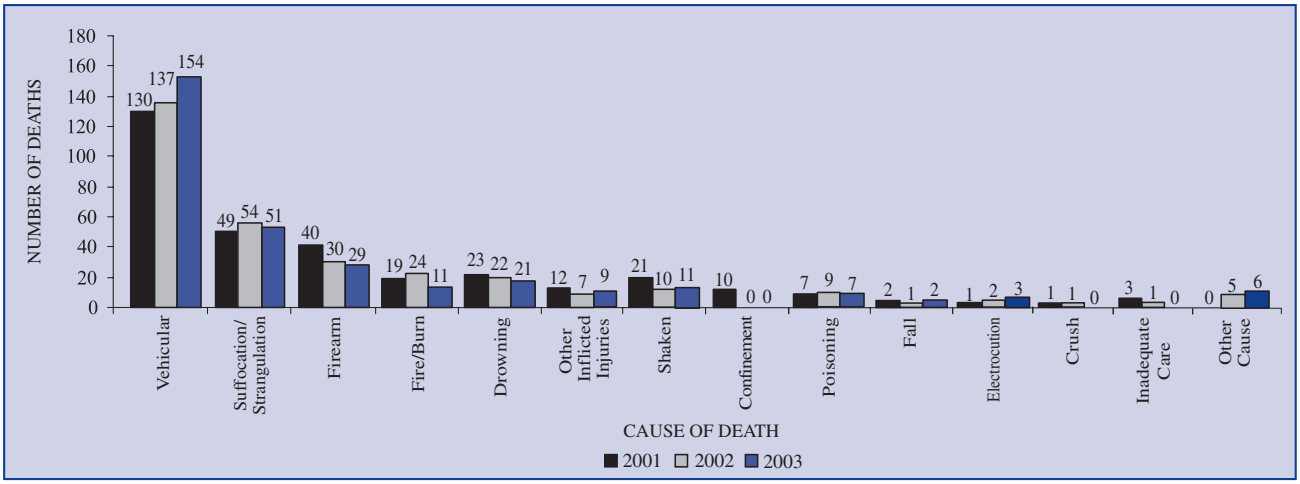


Figure 5. Leading Cause of Injury Death



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 2003, 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 after being born addicted to cocaine and heroin the mother used during her pregnancy. The panel suggested legislation be passed to help prosecute mothers who knowingly use illegal drugs during their pregnancy and refuse to seek treatment.

Community Safety Project:

A 6-year-old girl was killed in a motor vehicle accident. Her booster seat was not properly installed, causing her to be ejected from the car. The local panel contacted SAFE Kids about having a safety seat check in the community.

A 2-month-old infant was found lifeless on his stomach on the family room couch. The panel, with the assistance of the local hospital, provided a presentation for medical professionals, child protection professionals and the general public on safe sleep practices.

Public Forums:

A 15-year-old boy was killed when a train struck the vehicle he was riding in. The panel met and decided to approach the city council about placing railroad crossbars at the intersection and clearing the brush near the intersection to improve the line of sight for drivers.

A 3-year-old boy was found dead in a back bedroom from smoke inhalation and thermal injuries after an unattended candle caused a fire in his home. There was no working smoke alarms in the home. The local panel and fire department held a fire prevention day in the community where families could get information regarding fire prevention. Smoke alarms were also handed out to those in need.

Educational Activities in Schools:

A 17-year-old boy was killed in a motor vehicle crash. The local panel, along with the Missouri State Highway Patrol, begin showing the "Stop the Knock" video in the schools and sent letters home to parents suggesting they talk to their children about the use of safety belts and speeding.

A 14-year-old girl was found dead in her backyard with a self-inflicted gunshot wound to the head. At the request of the local panel, the sheriff's department spoke to students in the junior high and high schools about resources available to them if they are having trouble and about the finality of suicide.

Educational Activities in the Media:

A 4-month-old infant was found unresponsive and not breathing in her parent's bed. A member of the local panel made an appearance on a local radio station to talk about safe sleep environment and safe sleep position. The panel also had the health department make a press release on the dangers of sleeping with infants.

A 7-year-old girl was accidentally shot and killed while playing with a loaded gun she found in her home. The panel wrote a news story for the local paper regarding gun safety.

A 16-year-old boy died of alcohol poisoning, his blood alcohol content was .472. The Prosecuting Attorney, Sheriff, Police Chief and Director of Public Health (all panel members) held a press conference in an effort to draw public attention to underage drinking and parental apathy.

Consumer Product Safety:

A 7-month-old infant was placed in a baby swing for a nap. While unattended, the child slid down in the swing and suffocated when the chest strap became wrapped around its neck. The panel saw this as an opportunity to remind parents never to leave infants unattended and to always make sure that the child is properly placed in a swing.

News Services:

A one-month-old baby was found dead in her parent's bed. The panel approached the newspaper and other media sources about press releases regarding safe sleep environments, especially for small infants.

A 3-year-old girl was hit by a car and killed. The panel wrote an article for the local paper regarding supervision of young children while outdoors.

Changes in Agency Practice:

A 12-year-old girl died from an asthma attack. She had recently missed several doctor appointments regarding her asthma. The panel suggested that clinics need to be more aware when children are not showing up for follow-up visits on serious illnesses and contact the Child Abuse/Neglect Hotline to report these incidents. They also suggested penalties for parents, when medical neglect results in a child death.

A 2-month-old infant was found lifeless on his back in his mother's bed, sleeping alone. The panel approached the hospital Labor and Delivery staff about educating new parents on safe sleep practices before they are sent home.

Other Programs/Activities:

A 3-month-old boy died of undetected birth defects. The local panel suggested the family be referred to genetic specialists to prevent this or other similar defects in future pregnancies.

A 7-year-old boy was killed in a motor vehicle accident. The law enforcement representative on the panel noted that there had been 19 accidents in the same location in the past few years. The panel contacted the Missouri Department of Transportation and the Missouri State Highway Patrol to advise them of this and suggest a safety study be conducted.

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

-Helen Keller