2026

Kansas

State Child Death Review Board

2026 Annual Report

(2024 Data)

www.ag.ks.gov/scdrb

KRIS KOBACH

ATTORNEY GENERAL OF KANSAS

We acknowledge and honor the children and families represented in this report, remembering their lives and experiences with respect and reverence.

KANSAS ATTORNEY GENERAL KRIS KOBACH

September 30, 2026

Dear Fellow Kansans,

The death of a child is a profound loss, not only for the family, but also for the community and our state. For more than 30 years, the Kansas State Child Death Review Board has examined these deaths to better understand the circumstances surrounding them and identify steps that may help protect other children. This work requires careful judgement, professional expertise, and a willingness to confront difficult issues. I am grateful to the Board members who continue to take on that responsibility.

This report presents the Board's review of child deaths occurring in 2024. While the data allows us to recognize patterns over time, the significance of this work extends well beyond numbers. Each case represents an individual child, and each review deepens our understanding of where children remain vulnerable, as well as where changes may prevent another family from experiencing the same loss.

The value of this report will ultimately be measured by what we do with its findings. I encourage policymakers, professionals, and communities across Kansas to carefully consider the information and recommendations presented here. When a child's death reveals an opportunity to improve a policy, strengthen a response, or prevent a similar tragedy, we have a responsibility to act.

Sincerely,

Kris W. Kobach
Kansas Attorney General

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EXECUTIVE SUMMARY

Mission Statement

The Kansas State Child Death Review Board (SCDRB) works to understand how and why children die in Kansas to help prevent future injuries and deaths through a comprehensive, multidisciplinary review.

Background

Created by the Kansas Legislature in 1992 pursuant to K.S.A. 22a-243 and administered by the Office of the Kansas Attorney General, the SCDRB is the only entity in Kansas that comprehensively reviews each child death. The information collected is maintained confidentially and is used to review and analyze the circumstances of each child's death.

Data Summary and Report Overview

Since its inception, the SCDRB has reviewed 13,879 child deaths. The 2026 Annual Report examines five years of child mortality data (2020-2024), while highlighting findings from 2024, the most recent year for which complete data are available.

Key Highlights from the Report:

- **In 2024, 387 Kansas children died before reaching their 18th birthday**
  - 215 were infants under age one; 172 were children ages 1-17
  - Of the 186 children who received toxicology testing at the time of death, 23% (43) tested positive for alcohol or illicit substances
- **From 2020-2024, the SCDRB reviewed 1,848 child deaths**
  - The Kansas child death rate increased in 2024. While rates fluctuated over the five-year period, they remained consistently higher than the U.S. rate
  - Among the 1,848 child deaths reviewed, 997 resulted from natural causes. The remaining deaths were classified as unintentional injuries (353), undetermined causes (239), suicide (130), and homicide (129)
  - More infants died from sleep-related Sudden Unexpected Infant Deaths (SUIDs, N=236) than from any other non-natural cause across all age groups
  - Fentanyl was responsible for 55 child deaths during this period, compared with none from 2016 to 2019
  - Motor vehicle crashes (MVCs) were the leading cause of unintentional injury deaths among children over the age of one
  - There were 36 child homicides resulting from abuse or neglect
  - The child welfare system, including the Kansas Department for Children and Families (DCF) Division of Child Protective Services (CPS), had prior involvement with 716 children (39%) over the five-year reporting period, including:
    - 42 children who were in state custody at the time of death
    - 100 children were part of an open CPS case as either an alleged victim (AV) or the sibling of an AV; 38 of which were infants under age one

LEGISLATIVE PRIORITIES

The SCDRB strongly encourages the Kansas State Legislature to consider each of the proposed Public Policy Recommendations during the 2027 legislative session. The SCDRB has prioritized the following recommendations as needing immediate attention to address and prevent child fatalities in Kansas.

1. **Expand Information Sharing Between the SCDRB and the Office of the Child Advocate -** The SCDRB recommends that the Kansas Legislature amend K.S.A. 22a-244 and K.S.A. 75-7604 to authorize the SCDRB and the Office of the Child Advocate (OCA) to exchange relevant case information when necessary to carry out their respective statutory duties. Improved information sharing would strengthen each entity's ability to fulfill its statutory responsibilities, identify concerns involving the child welfare system, and support efforts to improve the safety and well-being of Kansas children.

2. **Strengthen Safety Assessments for Newborns and Infants with Significant Child Welfare Concerns -** The SCDRB recommends that the Kansas Legislature require DCF to conduct a comprehensive, in-person safety assessment when a report concerning the safety or well-being of a newborn or infant is accepted for assessment, regardless of whether the report is assigned as abuse or neglect or as a Family in Need of Assessment (FINA). The assessment should address the infant's immediate safety and evaluate current and prior concerns involving caregiver stability, substance use, and the home environment. Significant child welfare history, including prior termination of parental rights, removal of other children, serious prior maltreatment, prenatal substance exposure involving the infant or a sibling, or prior determinations that a caregiver or home was unsafe, should be verified and meaningfully evaluated as part of the assessment. When these or other serious safety concerns are identified, DCF should be required to document the concerns, how they were addressed, and the specific protections in place to ensure the infant's safety. When identified concerns cannot be adequately addressed to ensure the infant's safety, DCF should consider additional intervention, including multidisciplinary involvement or court intervention when appropriate.

3. **Expand the definition of "Violent Offender" Under the Kansas Offender Registration Act (KORA) to Include Child Abuse -** To strengthen child protection and promote public safety, the SCDRB recommends the Kansas Legislature amend K.S.A. 22-4902(e) by adding subsection (J): Abuse of a Child, as defined in K.S.A. 21-5602. This proposed amendment would ensure that individuals convicted of child abuse are subject to the same registration requirements and public disclosure provisions as other violent offenders under KORA, including placement on the KBI Registered Offender Website.

4. **Require Training and Continuing Education for Kansas Coroners** - The SCDRB recommends that the Kansas Legislature amend K.S.A. 22a-226 to require all district coroners, including those appointed to serve an individual county, to complete training in medicolegal death investigation within 180 days of appointment and at least 10 hours of continuing education annually thereafter. Training requirements would be established by the secretary of health and environment and include appropriate training related to the investigation of child deaths. These requirements would establish a minimum level of training for Kansas coroners and improve the quality and consistency of death investigations across the state.

ACKNOWLEDGMENTS

The review of each child death in Kansas could not be accomplished without the invaluable commitment of many people across the state. The SCDRB remains grateful for the significant contributions of the Office of the Attorney General, county coroners, law enforcement agencies, the Kansas Department for Children and Families (DCF), the Kansas Department of Health and Environment (KDHE), physicians, hospitals, child advocates, county and district attorneys, and others who help supply the information necessary for reviews.

As a multidisciplinary, multiagency volunteer board, we appreciate the support of our employers who allow us the time to fulfill our responsibilities as SCDRB members.

SCDRB SERVES AS A CITIZEN REVIEW PANEL

The Federal Child Abuse Prevention and Treatment Act (CAPTA) requires each state to establish citizen review panels in order to receive federal funding for child abuse prevention services. The purpose of the citizen review panels is to determine whether state and local agencies are effectively discharging their child protection responsibilities. The SCDRB 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

SCDRB MEMBERS

Attorney General appointees

Corey Kenney, J.D., (Chairperson)
Office of the Kansas Attorney General, Topeka

Jennifer Slagle (Advocacy Group)
Office of the Kansas Attorney General, Topeka

Director of Kansas Bureau of Investigation appointee

Doug Younger, Special Agent in Charge
Kansas Bureau of Investigation, Topeka

Secretary for Children and Families appointee

Kimberly Davis, CAPTA/CJA Program Administrator,
Kansas Department for Children and Families, Wichita

Secretary of Health and Environment appointee

Grace Harvey, Program Manager (*August 2026-Present)*
Kansas Department of Health and Environment, Topeka

Jeff Wilhelm, Program Manager *(January 2024-June 2026)*
Kansas Department of Health and Environment, Topeka

Commissioner of Education appointee

Brian K. Dempsey, J.D.
Kansas Department of Education, Lawrence

State Board of Healing Arts appointees

Harley Schainost, M.D. (Forensic Pathologist Member)
Deputy Coroner/Medical Examiner, Sedgwick County

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

Katherine Melhorn, M.D. (Pediatrician Member)
Clinical Professor of Pediatrics, Emeritus, KU School of Medicine, Wichita

Stephanie Kuhlmann, D.O. (Pediatrician Member)
Clinical Professor of Pediatrics, KU School of Medicine, Wichita

Kansas County and District Attorneys Association appointee

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

SCDRB STAFF - Office of the Kansas Attorney General

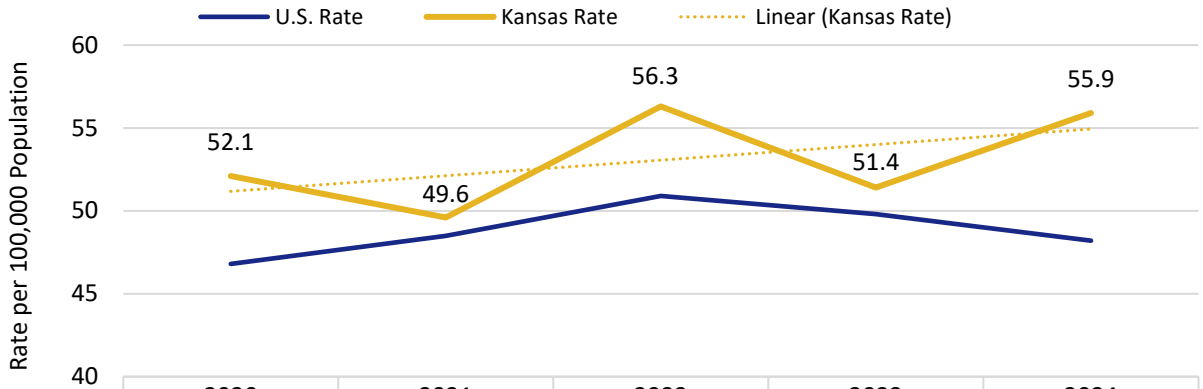
Sara Hortenstine, Executive Director
Caroline Rodriguez, MPH, Epidemiologist
Susan Croucher, Program Consultant
Yalexia Ramirez, Program Consultant
Robert Hutchison, J.D., General Counsel

2024 OVERVIEW

The Kansas SCDRB reviewed the deaths of 387 children, ages 0-17, who died in Kansas or were Kansas residents who died outside of the state in 2024. Despite fluctuations over the past five years, Kansas' child death rate has increased overall and remained higher than the U.S. rate each year (Figure 1).

Figure 1

Kansas and U.S. Child Mortality Rate, Ages 0-17, 2020-2024



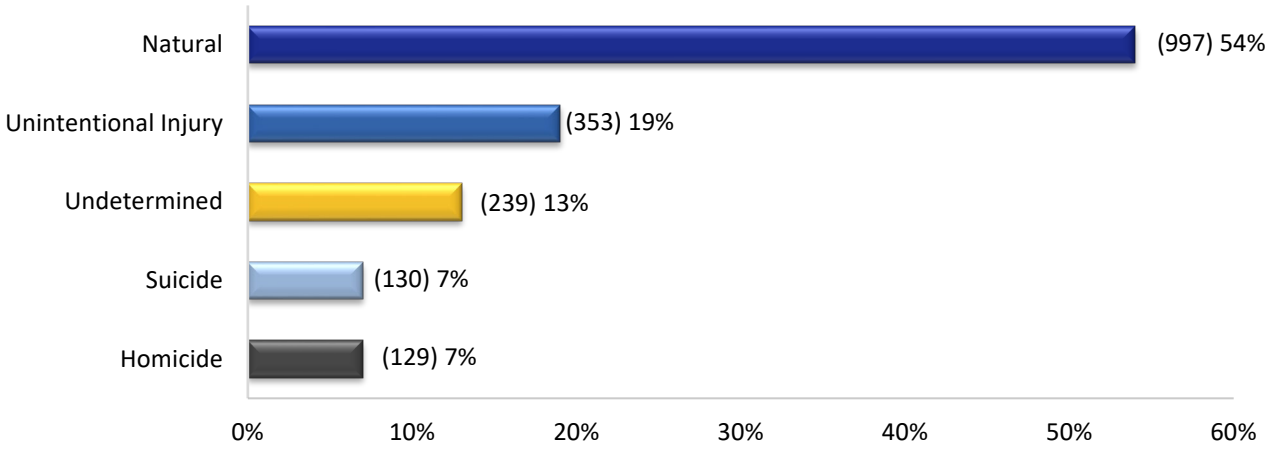
	2020	2021	2022	2023	2024
U.S. Rate	46.8	48.5	50.9	49.8	48.2
Kansas Rate	52.1	49.6	56.3	51.4	55.9
Kansas Number	363	349	389	360	387

*Kansas rate includes resident and non-resident deaths

From 2020 through 2024, more than half (54%) of child deaths were classified as natural, followed by unintentional injury (19%) and undetermined (13%) manners of death. Suicide and homicide each accounted for 7% of deaths during the five-year period (Figure 2).

Figure 2

Manner of Death, Kansas, Ages 0-17, 2020-2024, N=1,848



From 2020 through 2024, males accounted for more child deaths than females overall. The largest differences were among suicide deaths, where males accounted for 78% of deaths, and among youth ages 15-17, where males accounted for 71% of deaths. Males accounted for more deaths in every age group except ages 5-9. Natural causes were the most common manner of death for both males and females (Figures 3 and 4).

Figure 3

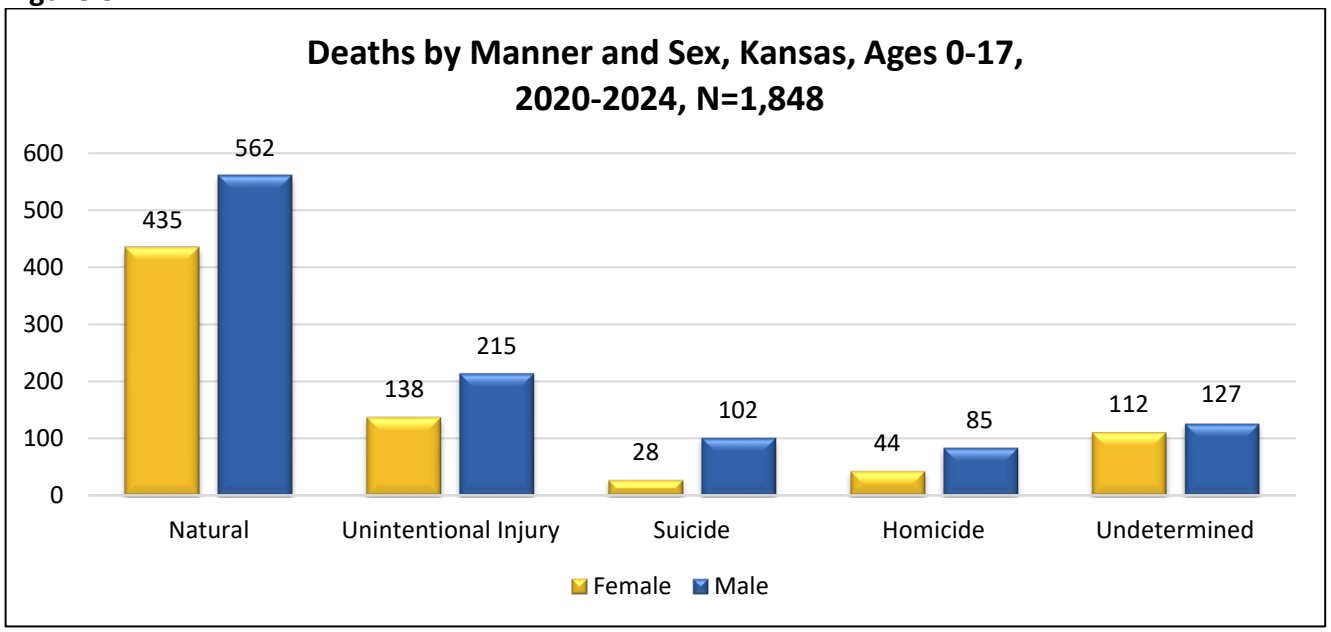
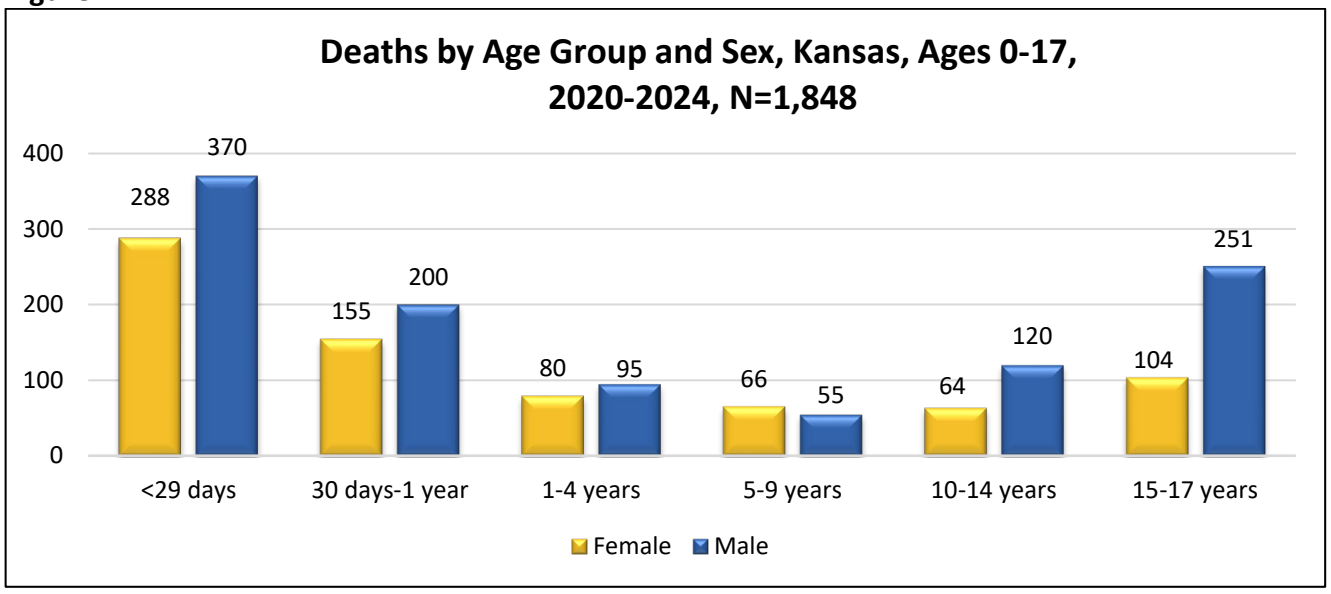


Figure 4



Of the 387 child deaths in Kansas in 2024, toxicology testing was completed in 48% (186) of deaths. Among infant deaths, toxicology was performed in 34% (74). In other age groups, the following percentages had toxicology testing: ages 1-4, 66% (27); ages 5-9, 29% (6); ages 10-14, 59% (19); and among teens ages 15-17, 77% (60) were tested. Of the 186 children who received toxicology testing, 23% (43) tested positive for alcohol or illicit substances at the time of death.

Marijuana was the most commonly detected substance, found in 27 children, followed by fentanyl and alcohol, each detected in nine children, and methamphetamine/amphetamine detected in seven children. Some children tested positive for more than one substance (Figure 5).

Figure 5

Toxicology Findings Related to Child Deaths, Kansas, Ages 0-17, 2024, N=387

Age Group	Child Deaths (N)	Toxicology Performed on Child (N)	Toxicology Positive for Alcohol or Illicit Drugs (N)	Alcohol or Illicit Substances Detected
<1	215	74	8	Methamphetamine (5), Marijuana (3)
1-4	41	27	2	Fentanyl (2)
5-9	21	6	1	Marijuana (1)
10-14	32	19	3	Marijuana (2), Oxycodone (1)
15-17	78	60	29	Marijuana (21), Fentanyl (7), Alcohol (9), Methamphetamine/Amphetamine (2), Cocaine (2)
Total	**387**	**186**	**43**	Marijuana (27), Fentanyl (9), Alcohol (9), Methamphetamine/Amphetamine (7), Cocaine (2), Oxycodone (1)

Notes: The "Toxicology Performed" column reflects the number of child deaths in which toxicology testing was completed at the time of death. The number of illicit substances detected may exceed the number of children with positive results because some children tested positive for more than one substance.

The SCDRB remains concerned about the number of child deaths in which alcohol or illicit substances were detected. Recognizing the serious implications of these findings, the SCDRB has emphasized the importance of prevention and has made several public policy and prevention recommendations throughout the report aimed at reducing substance-related harm among children and youth in Kansas.

Figure 6 shows rates of death by race and ethnicity for infants and children ages 0-17 from 2020 through 2024. Black/Non-Hispanic children had death rates above the overall Kansas rate in every category for which a rate was reported. Higher rates were also seen among several other racial and ethnic groups, although some rates are not reported due to small numbers.

Death rates in Figure 6 were calculated using population and birth data provided by KDHE.[3] For more information regarding rate of death or definitions regarding race and ethnicity, please refer to the Methodology Section.

Figure 6

Kansas Rate of Death by Race/Ethnicity, 2020-2024, Infant Mortality Rate per 1,000 Live Births and Mortality Rate for Ages 1-17 per 100,000 Population							
	KS Rate All Races	**White/Non-Hispanic**	**Black/Non-Hispanic**	**American Indian/Non-Hispanic**	**Asian/Non-Hispanic**	**Multiple Race/Non-Hispanic**	**Hispanic - Any Race**
2020-2024 - All Manners of Deaths, Ages <1 (Infant)	5.9	4.7	12.2	*	3.6	16.1	7.1
2020-2024 - All Manners of Deaths, Ages 0-17	53.1	42.5	123.8	64.0**	34.2	72.8	62.0
2020-2024 - All Manners of Deaths, Ages 1-17	25.3	20.1	63.8	47.4**	15.9**	30.1	29.8
2020-2024 - Natural Deaths, Ages 0-17	28.7	24.0	54.4	*	24.7	35.6	34.3
2020-2024 - Unintentional Injury Deaths, Age 0-17	10.2	8.6	22.0	*	*	10.5	12.1
2020-2024 - Homicide Deaths, Ages 0-17	3.7	1.6	20.6	*	*	6.8**	4.9
2020-2024 - Suicide Deaths, Ages 0-17	3.7	3.4	7.0**	*	*	*	3.4
2020-2024 - Undetermined Deaths, Ages 0-17	6.9	4.9	19.7	*	*	15.2	7.4

*Death count of 9 or less, suppressed
**Death count of 10-19, which should be used with caution

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 more than 690,000 Kansas children 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 13,000 child fatalities since 1994, including the social circumstances surrounding these deaths, the SCDRB has gained an increased understanding of the connection between the child welfare system and opportunities to prevent child fatalities in Kansas. The SCDRB continues to identify opportunities to improve outcomes for children and families.

As shown in Figure 7, 39% (716) of the 1,848 child fatalities reviewed from 2020 through 2024 involved a child and/or family with prior involvement with the child welfare system, including the Kansas Department for Children and Families (DCF) Division of Child Protective Services (CPS).

Figure 8 provides additional information about the type of child welfare involvement in these 716 cases. In 178 cases, the child who died and/or a sibling had previously been removed from the home. At the time of death, 100 children had an open CPS case and 42 were in state custody. These categories are not mutually exclusive, as some children had more than one type of child welfare involvement.

Figure 7

Child Deaths by Prior Child Welfare System Involvement, All Causes & Manners, Kansas, Ages 0-17, 2020-2024, N=1,848						
	Total - All Ages	**Age <1**	**Ages 1-4**	**Ages 5-9**	**Ages 10-14**	**Ages 15-17**
No Known Child Welfare History	**1128**	761	83	63	74	147
Child Welfare History Prior to Death	**716**	252	91	57	109	207
Unknown	**4**	0	1	1	1	1

Figure 8

Type of Child Welfare Involvement Prior to Death, Kansas, Ages 0-17, 2020-2024, N=716						
	Total - All Ages	**Age <1**	**Ages 1-4**	**Ages 5-9**	**Ages 10-14**	**Ages 15-17**
Removal of Sibling or Decedent Prior to Death	**178**	55	18	18	32	55
Open CPS at Time of Death	**100**	38	20	6	16	20
Decedent in Custody at Time of Death	**42**	5	11	3	7	16
Decedents with History Not Described in Above Categories	**491**	177	63	36	68	147
*Categories are not mutually exclusive; therefore, totals may exceed 716						

Further review of the 716 child deaths with prior CPS involvement identified parental substance use as a common factor. As shown in Figure 9, nearly 50% of these cases included a documented history of parental substance use, while 11% had no known history, and in 40% the history was unknown. Among infants with prior CPS involvement, 61% had a documented concern of previous or current parental substance use. Among these infants, 31% had documented prenatal exposure to illicit drugs and/or alcohol.

Figure 9

Parental Substance Use Among Children with Prior CPS Involvement, Kansas, Ages 0-17, 2020-2024, N=716				
Category (Children with CPS History Prior to Death)	**Total CPS-Involved Deaths (N=716)**		**Infants <1 with CPS Involvement (N=252)**	
	Deaths	**%**	**Deaths**	**%**
Parental Substance Use Concern	352	49%	153	61%
No Known Parental Substance Use History	77	11%	32	13%
Parental Substance Use History Unknown	287	40%	67	27%
Prenatal Exposure to Illicit Drugs or Alcohol* (Subset for Infants Only)	-	-	78	31%
*Prenatal exposure refers specifically to illicit drugs or alcohol used by the biological mother during pregnancy				

Findings from Figure 9 highlight the prevalence of parental substance use among children with prior CPS involvement, particularly infants. Notably, in 35% (27) of cases where infants were prenatally exposed, either the decedent or a sibling had previously been removed from the home prior to the infant's death.

Additional evidence from recent research further highlights how prenatal substance exposure may increase vulnerability to unsafe sleep environments and impaired supervision. Using the Sudden Death in the Young Registry, a study examining sleep-related sudden unexpected infant deaths (SUIDs) from 2015 to 2020 found that 14% of infants who died in sleep-related incidents were prenatally exposed to substances. These infants faced a disproportionate number of hazards in their sleep environments: more than half (52%) of the sleep-related deaths of prenatally exposed infants occurred in adult beds or involved surface sharing with an adult (53%), and supervisors of prenatally exposed infants were twice as likely to be impaired at the time of death compared to nonexposed infants (34% vs. 16%). The study identified statistically significant associations between prenatal exposure and family vulnerability factors, including child welfare involvement, intimate partner violence, lack of insurance, and barriers to health care.[32]

These findings demonstrate that infants who are prenatally substance-exposed not only face heightened risks in their immediate environment (e.g., unsafe sleep conditions and impaired supervision) but are also more likely to experience broader social vulnerabilities.

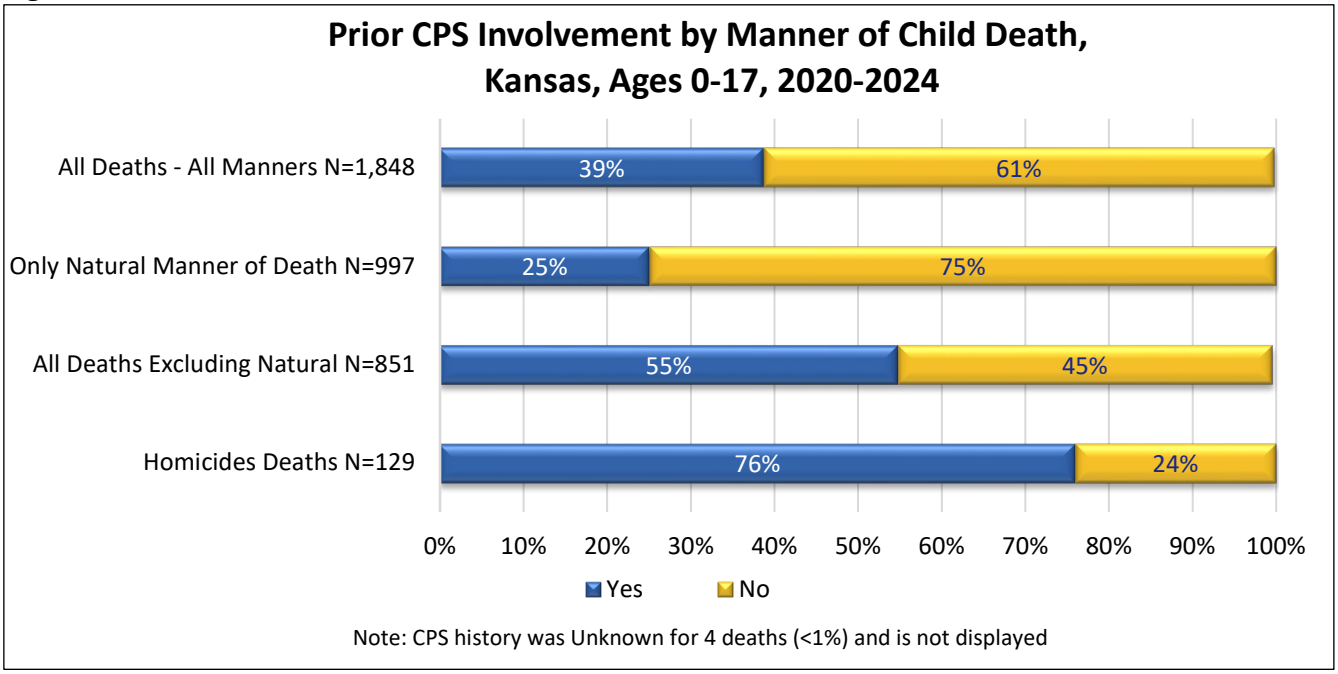
SCDRB case reviews have also identified concerns involving newborns who were discharged to the care of parents, and infants who remained with parents or caregivers, despite significant prior or current child welfare involvement. In some cases, known family circumstances included prior removal of other children from the home, prior termination of parental rights, ongoing child welfare involvement with siblings, repeated substance-exposed newborns, or continued concerns regarding caregiver substance use.

Current DCF policy provides expedited response times for reports involving infants, including same-day response for allegations of abuse or neglect involving a child under age one and for Family in Need of Assessment (FINA) reports involving an infant born positive for substances. However, response time alone does not ensure that significant historical factors are verified and fully considered or investigated before an infant is discharged from the hospital or placed in a caregiver's home. Additionally, policies for FINA assessments do not require the same in-person safety determinations that are required in an abuse or neglect assessment, and generally require parental or caregiver permission for contact with the child.

For infants, who are entirely dependent upon their caregivers and particularly vulnerable to serious injury and death, significant prior child welfare history should prompt a more comprehensive assessment of current safety and caregiver stability. Prior termination of parental rights, removal of other children, serious prior maltreatment, repeated substance-exposed newborns, or other significant child welfare history should not automatically result in removal of a new infant. However, these circumstances should be verified and meaningfully considered when determining whether an infant can safely be placed with or remain in the care of a parent or caregiver. When multiple or serious concerns remain unresolved, additional multidisciplinary or court oversight may be necessary to ensure the infant's safety.

While these concerns are particularly significant for infants, prior CPS involvement is prevalent across non-natural child deaths reviewed by the SCDRB. Overall, 39% (716) of the 1,848 child deaths reviewed from 2020 through 2024 involved a child or family with prior CPS involvement. As shown in Figure 10, prior CPS involvement was identified in 25% (250) of the 997 natural deaths. When natural deaths were excluded, the percentage with prior CPS involvement increased to 55%. Prior CPS involvement was highest among homicide deaths, at 76% (98).

Figure 10



Note: CPS history was Unknown for 4 deaths (<1%) and is not displayed

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

- Infants and toddlers are at 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, public health agencies, and other professionals working with children and families is vital to child safety. Well-coordinated interagency efforts are essential in ensuring timely and accurate communication and effective family services.
- The importance of child protection workers having access to real-time information about families cannot be overstated.
- It is critical to have an accurate count of child protection related fatalities. Better data allow us to better understand what works and how to best use resources and guide research.

The SCDRB believes that additional improvements to the child welfare system are needed in Kansas to reduce the number of child deaths. The most vulnerable children are infants and toddlers who cannot speak for or protect themselves and are fully dependent on caregivers in the home. The SCDRB has proposed several Public Policy Recommendations to address identified concerns within the Kansas child welfare system.

CHILD WELFARE CASE VIGNETTE

Cumulative History Must Be Considered When Assessing Child Safety

A Kansas infant died in the care of a mother with CPS involvement for substance use and mental health concerns. At the time of the infant's birth, the mother did not have custody of her four older children. Hospital providers documented and reported serious concerns about the infant being discharged into the mother's care. A home assessment was completed and the infant was initially discharged to the maternal grandmother before later returning to the mother's care.

The family had an extensive history with DCF involving 23 reports with concerns related to maternal substance use, mental health, lack of supervision, failure to adhere to medical recommendations, and the safety of the infant's siblings.

On the day of the infant's death, law enforcement responded multiple times to concerns regarding the mother's mental health. During one response, law enforcement located the infant inside the apartment after the mother initially stated that the infant was with someone she trusted. The infant was observed sleeping in a car seat but not further examined or assessed. The mother declined services, and responders left with a plan to contact DCF for follow-up.

Later that day, individuals who encountered the mother and infant became concerned that the infant appeared floppy and cold and reported that the mother smelled strongly of alcohol. Law enforcement was contacted for another welfare check. When officers returned, the infant was unresponsive. CPR was initiated and the infant was transported to the hospital, where resuscitation efforts were unsuccessful. After autopsy and limited investigation, the manner of death was classified as Undetermined.

SCDRB REFLECTION

This case highlights the importance of considering the cumulative history of a family when assessing the safety of an infant or young child. Individual reports viewed separately may not always meet the threshold for removal or other intervention; however, repeated reports involving substance use, serious mental health concerns, lack of supervision, missed medical care, and the removal of other children can demonstrate a pattern of risk that should indicate a higher level of intervention.

When a parent does not have custody of multiple older children, the circumstances surrounding those prior removals should be carefully considered when determining whether a newborn can safely remain in that parent's care. A home assessment alone may not adequately address concerns related to caregiver functioning, substance use, mental health, or the parent's demonstrated inability to safely care for a child.

This case also demonstrates the need for a careful assessment of children when law enforcement, social workers, or other professionals respond to a caregiver experiencing an acute mental health or substance-use crisis. When an infant appears unusually lethargic, limp, cold, or otherwise unwell, an immediate medical evaluation should be obtained. A coordinated response that considers both the caregiver's condition and the child's immediate safety is critical when multiple risk factors are present.

CHILD WELFARE CASE VIGNETTE

Safety Plans Must Adequately Address Caregiver Substance Use

A Kansas infant died while co-sleeping with the mother who had a history of alcohol use during pregnancy and received substance use treatment and services both during and after her pregnancy.

Less than three weeks before the infant's death, the mother was involved in a motor vehicle crash while driving under the influence of alcohol. The infant was properly restrained and uninjured but was admitted to the hospital because the mother was significantly impaired and unable to safely care for herself and the infant at that time. A report to DCF was substantiated for lack of supervision. Prior to discharge, the mother agreed to a safety plan requiring that another adult be present with her and the infant at all times.

On the day prior to the infant's death, law enforcement received another report regarding the mother caring for the infant while intoxicated in public. Later that day, the mother and infant stayed overnight in the office of a business. A portable crib was available at the location; however, the mother placed the infant to sleep with her on a large, soft couch. When she awoke several hours later, the infant was unresponsive. Numerous alcohol containers were found at the scene and the mother's preliminary breath test indicated a high level of alcohol intoxication.

The death was classified by the SCDRB as a Sudden Unexpected Infant Death with unsafe sleep factors.

SCDRB REFLECTION

This case highlights the challenges of relying on a safety plan when a caregiver has ongoing substance use that significantly impairs the ability to make appropriate decisions and safely care for an infant. A safety plan is only effective when the identified protections can be consistently maintained and there is appropriate follow-up to ensure compliance.

When caregiver substance use results in serious incidents involving an infant or young child, including impaired driving or an inability to safely provide care, the child's safety should be reassessed before remaining in or being returned to that caregiver's care. Continued substance use following such an incident should prompt consideration of whether a voluntary safety plan provides sufficient protection or whether additional court intervention is necessary.

Caregiver impairment also increases the risks associated with unsafe infant sleep. Parents and caregivers should never share a sleep surface with an infant whether or not they are impaired by alcohol or drugs. When substance use and unsafe sleep occur together, interventions should address both risk factors and ensure that a sober, responsible caregiver is available to provide safe care for the infant.

CHILD WELFARE CASE VIGNETTE

Prior Drug Exposure Requires Thorough Assessment and Intervention

A young Kansas child died from fentanyl ingestion after being found unresponsive in the family home. An investigation following the death revealed fentanyl powder, counterfeit pills, marijuana, and drug paraphernalia throughout the home, much of which was easily accessible to children.

Five months prior to the death, the child was taken to an emergency department after being found with THC/CBD gummies belonging to the mother. Although the child was not experiencing symptoms, urine testing was positive for cannabinoids and fentanyl. The parents denied fentanyl use or knowledge of fentanyl in the home. Law enforcement responded to the hospital and a report was made to DCF. After an observation period and parental education regarding naloxone availability and use, the child was discharged home.

Following the DCF intake, attempts were made over several months to locate the family at the address provided by the hospital. Multiple home visits and telephone calls were unsuccessful in locating the family. The case was closed without an assessment of the current home environment or parental substance use.

At the time of the fatal incident, the child's hospital drug screen was again positive for fentanyl. During the investigation, the father acknowledged fentanyl was present in the home, including fentanyl in edible THC products and counterfeit pills. Both parents were convicted of criminal offenses related to the child's death.

SCDRB REFLECTION

This case highlights the need for thorough assessment and intervention when a young child has been exposed to illicit substances in the home. A previous ingestion resulting in a positive fentanyl screen provided an opportunity to identify ongoing substance use and unsafe conditions before the subsequent exposure resulted in this child's death.

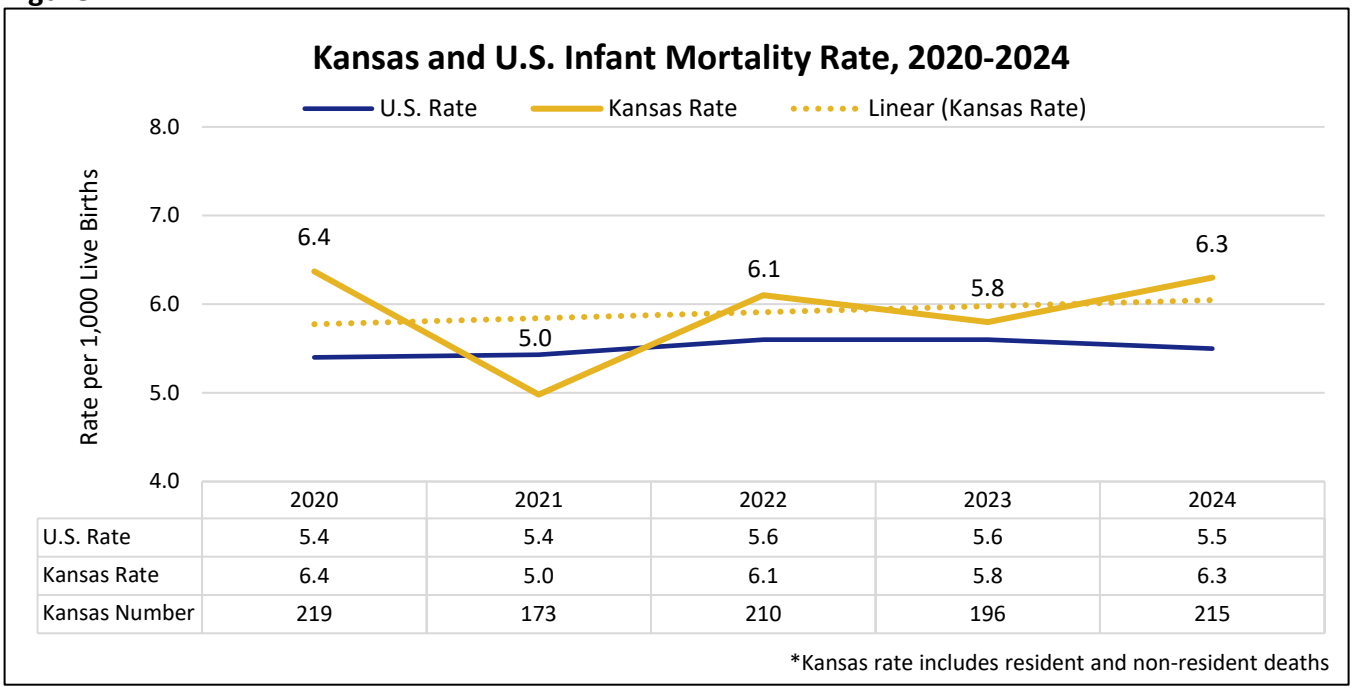
When an infant or young child is exposed to substances in utero or experiences an ingestion in the home, the child's safety should be assessed before the child is returned to or remains in that environment. This should include an assessment of parental substance use and an inspection of the child's current home to identify accessible drugs, drug paraphernalia, or other hazards. This safety assessment should have been performed prior to this child being released from the hospital.

When a family cannot be located following a serious drug exposure, additional efforts and coordination among child welfare, law enforcement, healthcare providers, and other available agencies should be undertaken before the case is closed. Young children are especially vulnerable to unintentional ingestions and cannot protect themselves from dangerous substances in their environment. A known exposure to fentanyl or other illicit drugs should prompt a coordinated response focused on ensuring the child's home is safe and addressing caregiver substance use.

MORTALITY AFFECTING INFANTS

In Kansas, infant mortality (age less than 1 year) has been noted as an area in need of improvement. In 2024, 215 infants died before their first birthday, resulting in an infant mortality rate of 6.3 deaths per 1,000 live births, compared to the U.S. rate of 5.5 (Figure 11). While Kansas has maintained a relatively stable infant mortality rate over the past five years, it continues to exceed both the national average and the Healthy People 2030 target of 5.0 deaths per 1,000 live births by the year 2030.[2]

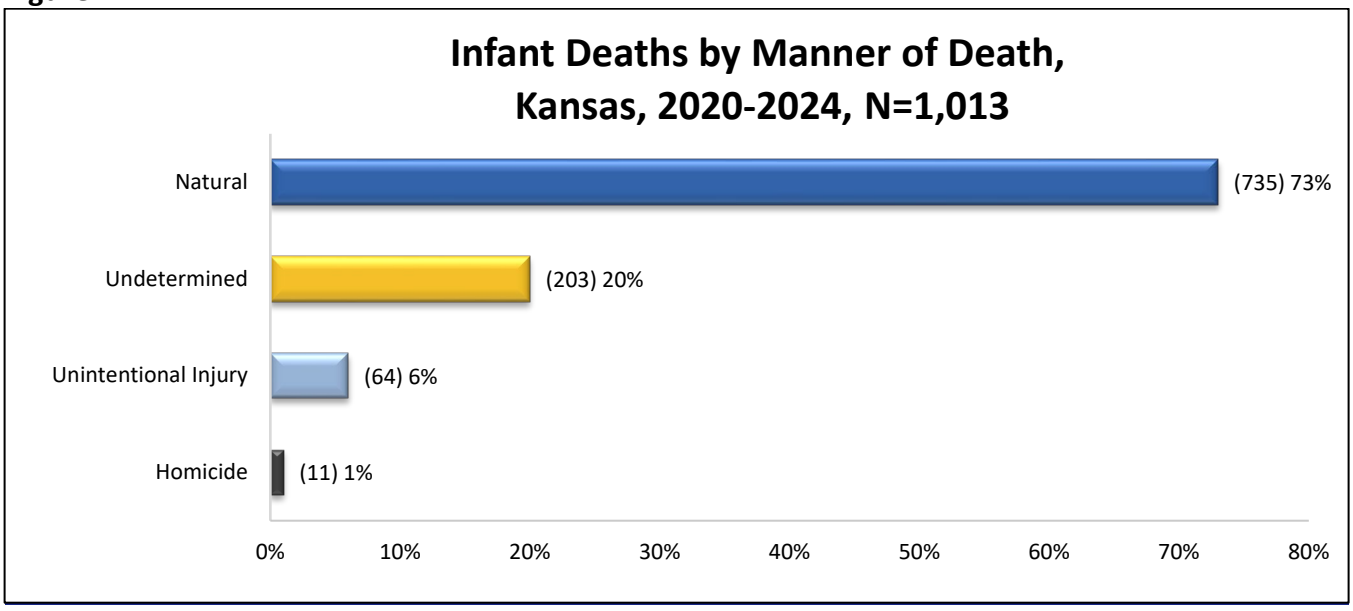
Figure 11



	2020	2021	2022	2023	2024
U.S. Rate	5.4	5.4	5.6	5.6	5.5
Kansas Rate	6.4	5.0	6.1	5.8	6.3
Kansas Number	219	173	210	196	215

*Kansas rate includes resident and non-resident deaths

Figure 12



From 2020 through 2024, 1,013 infants died in Kansas, with the majority (73%) attributed to natural causes (Figure 12).

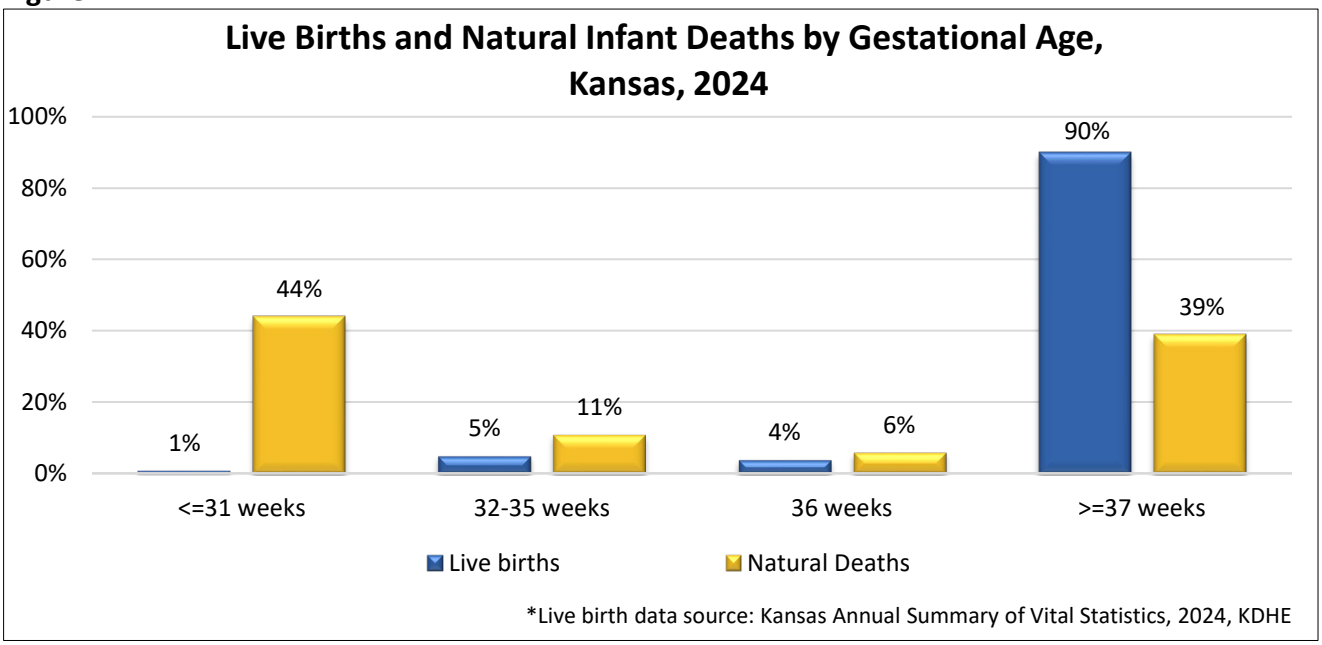
Figure 13 provides further detail on the specific natural and non-natural causes of death. Among natural deaths, prematurity and congenital anomalies were the leading causes. Among non-natural deaths, the two most frequent causes were related to unsafe sleep environments: Sudden Unexpected Infant Death (SUID) and suffocation with unsafe sleep. Together, these accounted for 84% of all non-natural infant deaths, underscoring the continued risk posed by unsafe sleep environments.

Figure 13

Infant Deaths by Natural and Non-Natural Cause of Death, Kansas, 2020-2024, N=1,013	
Natural Causes	**N=735**
Prematurity	398
Congenital Anomalies	237
Perinatal Complications	48
Infection (Including Pneumonia and Influenza)	36
Other Medical Condition	8
Undetermined Medical Condition	5
COVID-19	3
Non - Natural Causes	**N=278**
Undetermined	**203**
Sudden Unexpected Infant Death (Sleep-Related)	190
Sudden Unexpected Infant Death (Not Sleep-Related)	6
Poisoning, Overdose, Acute Intoxication	4
Other Undetermined Cause	2
Asphyxia	1
Unintentional Injury	**64**
Asphyxia (Sleep-Related Suffocation)	44
Complications of Maternal Substance Abuse During Pregnancy	7
Motor Vehicle Crash	5
Fire/Burn	2
Drowning	2
Gunshot Wound	1
Hyperthermia (Hot Car Death)	1
Complication of Medical Error at Birth	1
Methamphetamine Intoxication at Birth	1
Homicide - Child Abuse	**11**

Although 90% of infants are born at or after 37 weeks gestation, natural infant deaths were disproportionately associated with infants born before 37 weeks gestation. As shown in Figure 14, 44% of infants who died from natural causes were born at or before 31 weeks gestation, compared with that gestational age group accounting for only 1% of live births. In addition to being a direct cause of death, prematurity is a significant risk factor for infant mortality from other causes.

Figure 14



CHARACTERISTICS OF INFANT DEATHS, 2020-2024, N=1,013

- Kansas infant mortality rates have remained relatively stable over the past five years but continue to exceed the U.S. rate and the Healthy People 2030 target
- 73% of infant deaths were due to natural causes
    - 44% of infants who died from natural causes in 2024 were born at or before 31 weeks gestation
- 27% of infant deaths were due to non-natural causes
    - 84% of non-natural infant deaths were due to SUID or suffocation in an unsafe sleep environment
- 25% had caregivers with current or prior involvement with child protective services (DCF). Among these:
    - 61% had parental substance use history
    - 31% had documented prenatal exposure to illicit drugs or alcohol

PREVENTION POINTS

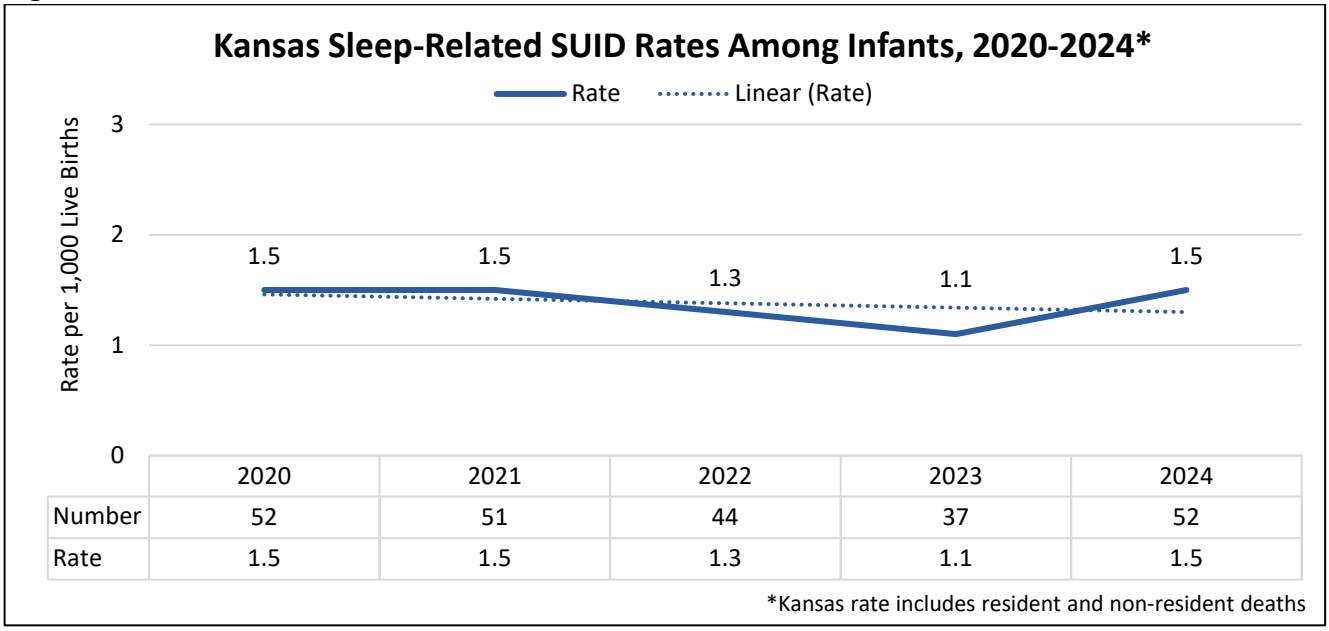
- **Prenatal Care -** Medical care during a pregnancy can identify risk factors and health problems, allowing for early treatment and improved outcomes. Proper nutrition is vital to a pregnancy. Iron and folic acid supplements, along with other physician prescribed regimens, can help ensure a healthy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

Sleep-Related Sudden Unexpected Infant Deaths (SUIDs)

According to the CDC, Sudden Unexpected Infant Death (SUID) is a term used to describe the sudden and unexpected death of a child less than 1 year old in which the cause is not obvious before investigation. These deaths usually occur during sleep or in the child's sleep area. In 2024, there were approximately 3,400 SUIDs in the U.S.[29]

In Kansas, sleep-related SUID rates remained relatively stable from 2020 through 2024. In 2024, 52 sleep-related SUIDs occurred, representing a rate of 1.5 deaths per 1,000 live births, comparable to rates in the previous four years (Figure 15).

Figure 15



	2020	2021	2022	2023	2024
Number	52	51	44	37	52
Rate	1.5	1.5	1.3	1.1	1.5

*Kansas rate includes resident and non-resident deaths

From 2020 through 2024, there were 236 sleep-related SUIDs in Kansas. Figure 16 shows the classifications of these deaths for the five-year period and for 2024 alone. Both unexplained categories with unsafe sleep factors may also include cases in which there were other potentially fatal findings, concerning conditions, or competing causes of death. How, or to what degree, these factors contributed to the death is uncertain.

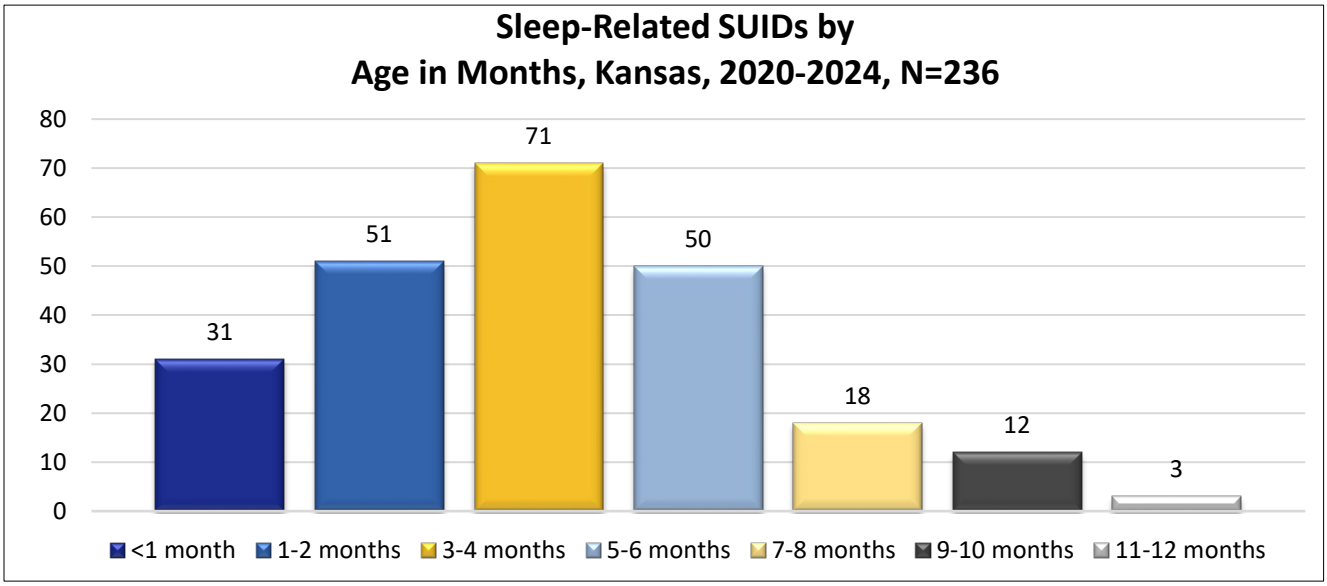
The SCDRB uses the SUID Case Registry Decision-Making Algorithm to classify sleep-related SUIDs. The classifications are shown in Figure 16. More information regarding the SUID Case Registry can be found at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4311566/.

Figure 16

Sleep-Related SUID Classifications for Infants, Kansas, 2020-2024, N=236			
Undetermined SUID	**Description**	**2024 Deaths**	**2020-2024 Deaths**
No autopsy or death scene investigation	Autopsy or death scene investigation not completed.	0	6
Incomplete case information	Case information pertinent to case review was not collected or documented during the investigation.	12	49
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	3
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.	20	106
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.	8	27
Unintentional Injury Asphyxia	**Description**	**2024 Deaths**	**2020-2024 Deaths**
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.	11	45
Total Sleep-Related SUIDs		**52**	**236**

Figure 17 shows the age distribution of sleep-related SUIDs. Deaths were most common during the first six months, peaking among infants ages 3-4 months and declining substantially after 6 months of age.

Figure 17



While most sleep-related SUIDs occurred in the child's home, 17% (39) occurred outside of the child's home (Figure 18). Safe sleep practices should be consistent at each sleep, including naps and nighttime, both in the home and away from home.

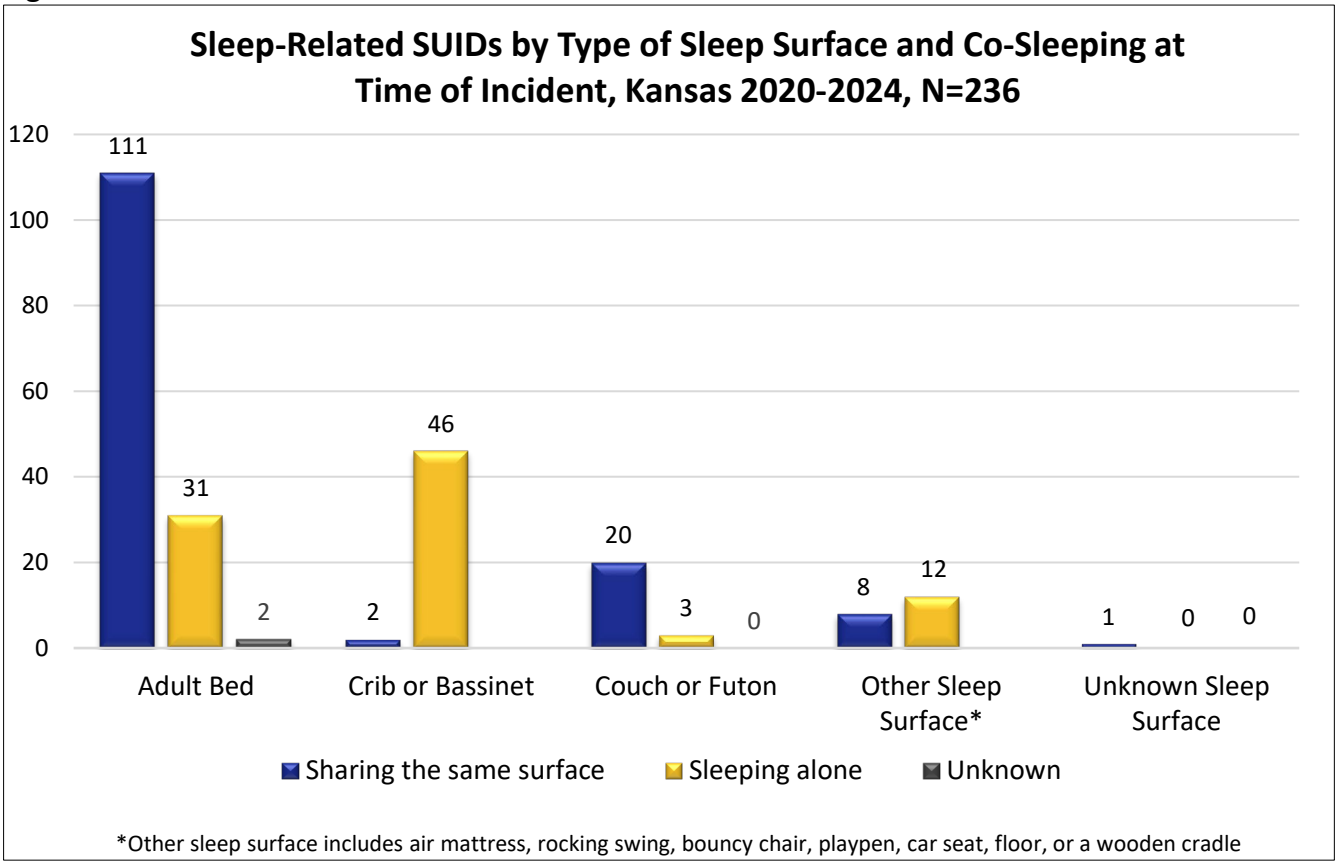
Figure 18

Sleep-Related SUIDs by Location of Incident, Kansas, 2020-2024, N=236	
Location of Incident	**Number**
Child's Home	201
Relative's Home	18
Unlicensed Child Care	6
Friend's Home	5
Licensed Child Care	4
Foster Home	2
Hotel or Motel	2
Other	2

*Multiple responses are appropriate for some circumstances regarding incident location; therefore, the sum could be greater than the total number of sleep-related SUIDs

Out of the 236 sleep-related SUIDs reviewed by the SCDRB between 2020 and 2024, only 20% of infants were placed in a crib or bassinet at the time of the death. Additionally, 60% of the infants were found to have been sharing a sleep surface with one or more individuals at the time of the incident. More than half (61%) of the deaths occurred while the infant was sleeping on an adult bed. Of those, 77% involved co-sleeping with one or more individuals (Figure 19).

Figure 19

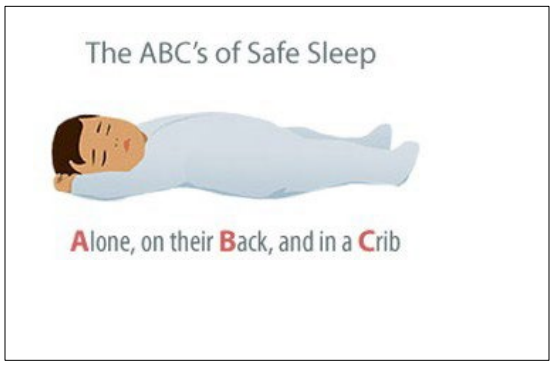


Among the 236 sleep-related SUIDs reviewed by the SCDRB from 2020 through 2024, over 98% (233) involved evidence of one or more unsafe sleep practices.

The American Academy of Pediatrics (AAP) recommends that infants be placed on a firm, flat, non-inclined sleep surface, such as a safety-approved crib, bassinet, or portable crib with an approved mattress and fitted sheet, with no other bedding or objects in the sleep area. Infants should sleep in close proximity to their parents (room sharing), but on a separate sleep surface designed for infants without bed-sharing **.[6]

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

The images below depict a safe sleep environment in which the infant is placed **A**lone, on their **B**ack, and in a **C**rib. Parents and caregivers should ensure the **ABC**s of safe sleep, for every sleep.[6]



Photos Credits: KIDS Network *http://www.kidsks.org/*

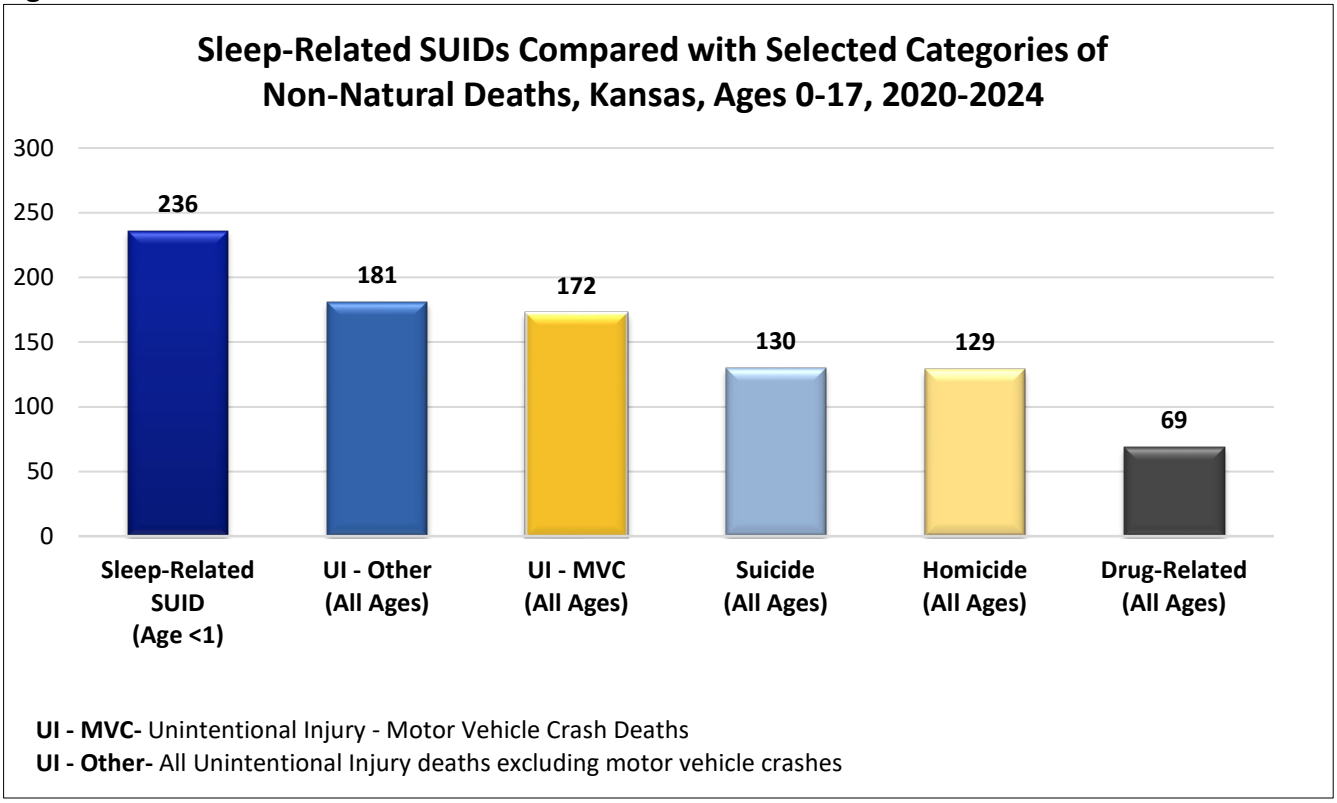
From 2020-2024, 21 sleep-related SUIDs occurred after a caregiver reportedly fell asleep while feeding the infant, including 15 while breastfeeding and 6 while bottle-feeding (Figure 20).

Mothers should be encouraged and supported to breastfeed safely and provided education about safe sleep practices and the risks associated with falling asleep while breastfeeding. This education should also be provided to parents and caregivers who bottle-feed infants. If an infant is brought into an adult bed for feeding, the infant should be returned to a separate, safe sleep surface when the parent or caregiver is ready to return to sleep.[6]

Figure 20

Caregiver or Supervisor Fell Asleep While Feeding Infant, Sleep-Related SUIDs, Kansas, 2020-2024, N=236		
Caregiver or Supervisor Fell Asleep While Feeding Infant?		**Number**
Yes		**21**
If Yes, Feeding Type	Breast	15
	Bottle	6
No		**200**
Unknown		**15**

Figure 21



From 2020 through 2024, more infants under age 1 died from sleep-related SUIDs than children ages 0-17 died in any single comparison category shown in Figure 21. The 236 sleep-related SUIDs exceeded the number of deaths from UI - Other, which includes unintentional injury deaths such as drowning, fire, and falls; UI - MVC, which is shown separately to distinguish motor vehicle crash deaths; Suicide, Homicide, and Drug-Related causes, despite these categories including deaths across the entire child population. This comparison underscores the significant impact of sleep-related SUIDs on infant mortality and the continued importance of safe sleep prevention efforts.

The SCDRB stresses the importance of thorough investigations by law enforcement and medical personnel, along with complete autopsies. In 2024, 12 sleep-related SUID investigations lacked information necessary to fully assess factors related to unsafe sleep or suffocation.

To improve the quality of data surrounding sleep-related SUIDs, the SCDRB recommends that investigations include photographed scene recreations or doll re-enactments, detailed witness interviews with follow-up interviews as necessary after autopsy completion, quality scene photographs, and documentation of important environmental factors, including room temperature, crib availability, and bed size.

Use of the Center for Disease Control and Prevention's Sudden Unexpected Infant Death Investigation Reporting Form (SUIDIRF) is the expected standard in all investigations and if used consistently and as designed would aid in obtaining critical information at the scene and from interviews.

SLEEP-RELATED CASE VIGNETTE

Unsafe Sleep Environment

A Kansas infant regularly slept with the parents when fussy or was having difficulty sleeping in the crib. On the night of the death, the infant was placed to sleep between both parents on an air mattress.

Several hours later, a family member checked on the infant and found the infant unresponsive. Despite resuscitation efforts, the infant was pronounced deceased at the scene. The death was classified as a sudden unexpected infant death with an unsafe sleeping environment.

SCDRB REFLECTION

The ABCs of safe sleep should be followed for every sleep. Infants should sleep Alone, on their Back, and in a safety-approved Crib with a firm, flat surface. This includes naps, nighttime sleep, and times when an infant is fussy or difficult to settle.

Unsafe sleep may occur repeatedly without harm, but each time an infant sleeps in an unsafe environment, there is a risk of suffocation or other sleep-related death. A sleep arrangement should not be considered safe simply because an infant has slept there previously without incident.

Air mattresses pose a high risk for suffocation because they are soft and flexible and can shift or compress under the weight of an infant or another person. This can cause an infant to roll toward a caregiver, become wedged against another person, or sink into the surface where the nose and mouth may become obstructed. Infants should never sleep on an air mattress, either alone or with another person.

When an infant is difficult to settle, caregivers should continue to return the infant to a separate, safety-approved crib rather than bringing the infant into an adult bed. Safe sleep practices are important for every infant, every caregiver, and every sleep.

CHARACTERISTICS OF SLEEP-RELATED SUIDs, 2020-2024, N=236

- Sleep-related SUIDs surpass all other non-natural categories of death across all age groups
- Over 98% had evidence of one or more unsafe sleep practices
- 80% occurred when the infant was sleeping in a place other than a crib or bassinet
    - 61% were placed to sleep on an adult bed, and 10% were on a couch or futon
- 60% were sharing a sleep surface with an adult, another child, or a pet animal
- 46% had parents or caregivers with a history of substance use, with 21 of the caregivers under the influence of alcohol or drugs at the time of the sleep-related event
- 44% had caregivers with current or prior involvement with child protective services (DCF)
- 23% of the investigations lacked information that would normally be expected in a child death investigation
- 21% were put to sleep on their stomach, side, or a position other than the recommended supine placement (on their back)
- For cases in which it was known whether or not a parent fell asleep while feeding an infant, 9.5% had fallen asleep while either breastfeeding or bottle feeding the infant

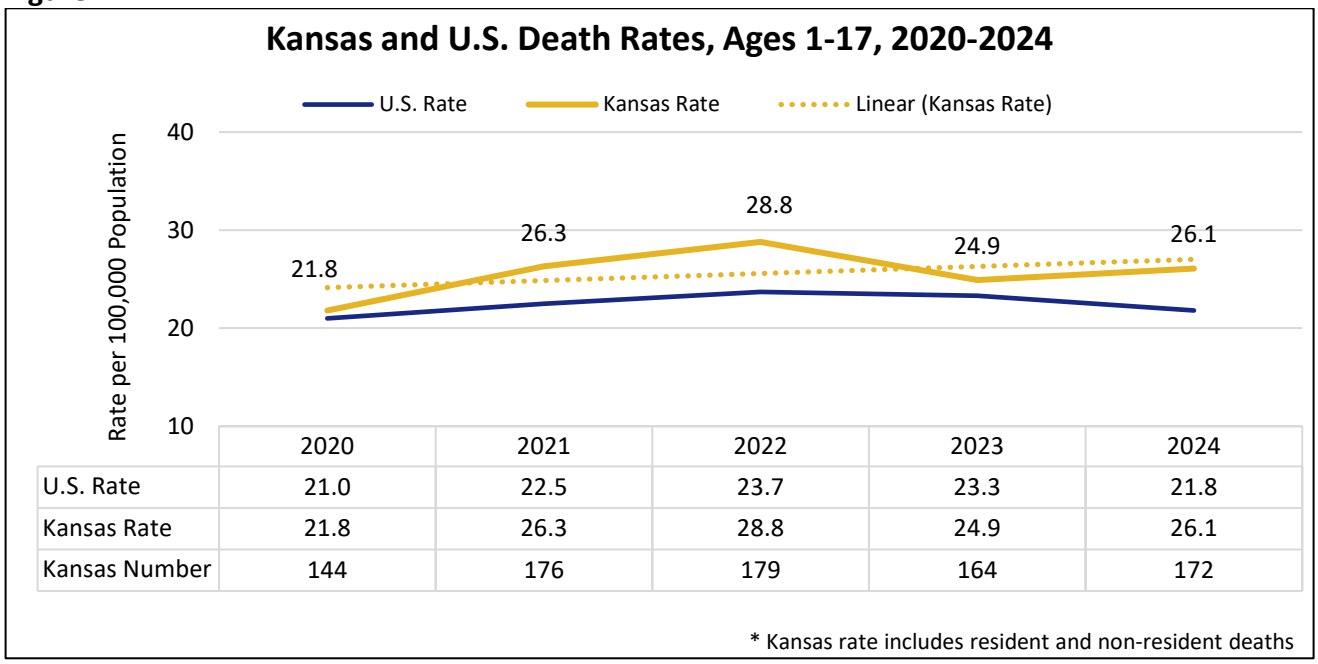
PREVENTION POINTS

- **Supine Sleep -** Infants should be placed to sleep on their backs. Side sleeping is not as safe as supine sleeping and is not advised. Infants should always be placed on their backs to sleep during every sleep period, including naps. Sleep position should be consistent each time and at every location. When babies who usually sleep on their backs are placed to sleep on their stomachs, they are at a significantly increased risk of sudden death.[6]
- **Sleeping Alone -** A separate but proximate sleeping surface is recommended. Bed-sharing with adults or siblings is not safe. A firm, flat, non-inclined sleep surface should be used. Soft materials such as pillows, quilts, comforters, or sheepskins should not be placed in the crib with the infant.[6]
- **Correct Clothing -** 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, block their airway, cover the infant's head, or cause entrapment. Avoid overheating the infant's room.[6]
- **Nicotine Prevention -** Smoking and/or vaping during pregnancy or in the infant's environment are risk factors for mortality and should be avoided.
- **Nursing -** Mothers should be encouraged and supported to breastfeed, not only for the known nutritional value but as a protective factor against sudden unexpected infant deaths. Infants brought to the adult bed for nursing should be returned to a separate safe surface (i.e., crib or bassinet) when the parent is ready to return to sleep.[6]
- **Devices Don't Prevent SUIDs -** Devices promoted to reduce "SIDS" have not been proven to reduce the incidence of sudden unexpected infant deaths. They should not be used unless prescribed for a specific disorder.[9]
- **Stay Informed -** Consistent messaging and modeling throughout state agencies and hospitals about research-based safe sleep recommendations is critical. For more information on safe sleep, visit these websites: AAP at http://www.aap.org/, or Kansas Infant Death and SIDS Network at http://www.kidsks.org/.

MORTALITY AFFECTING CHILDREN AGES 1-17

In 2024, there were 172 deaths of Kansas children ages 1-17, representing a rate of 26.1 deaths per 100,000 population. From 2020 through 2024, the Kansas death rate increased overall and remained higher than the U.S. rate each year (Figure 22).

Figure 22



	2020	2021	2022	2023	2024
U.S. Rate	21.0	22.5	23.7	23.3	21.8
Kansas Rate	21.8	26.3	28.8	24.9	26.1
Kansas Number	144	176	179	164	172

* Kansas rate includes resident and non-resident deaths

Of the 835 deaths among children ages 1-17 from 2020 through 2024, 62% were males. Children ages 15-17 accounted for 43% of all deaths during this period (Figure 23).

Figure 23

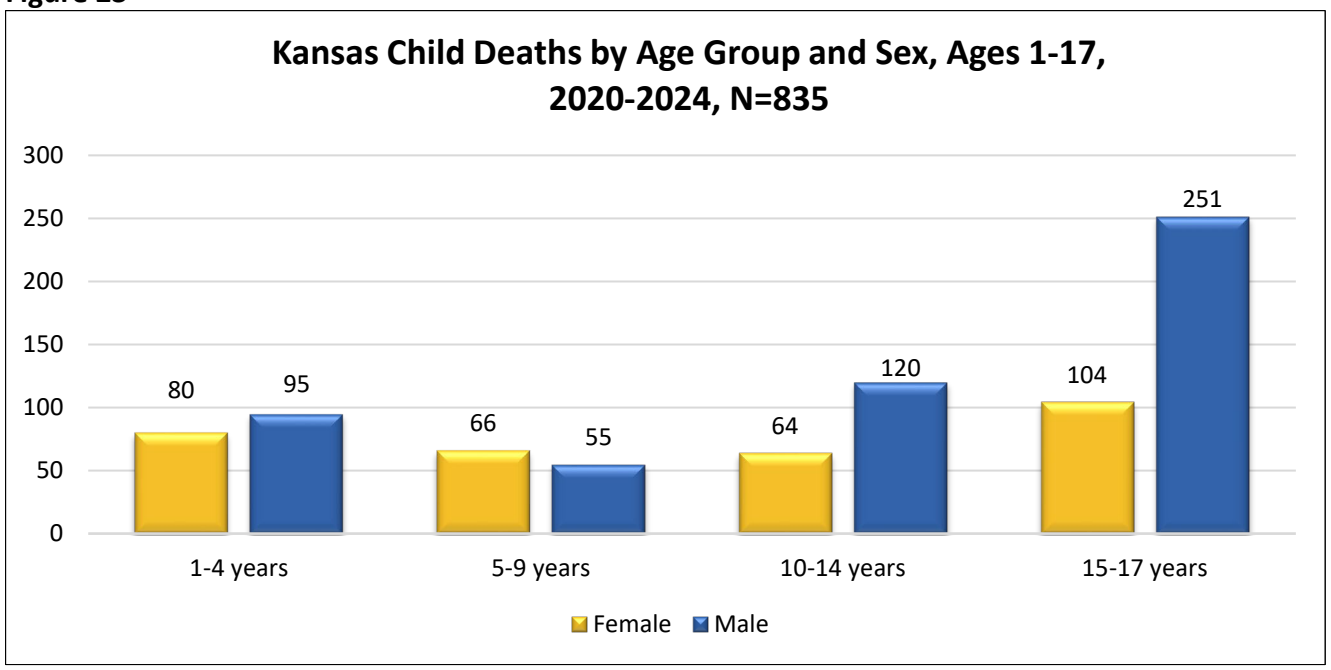
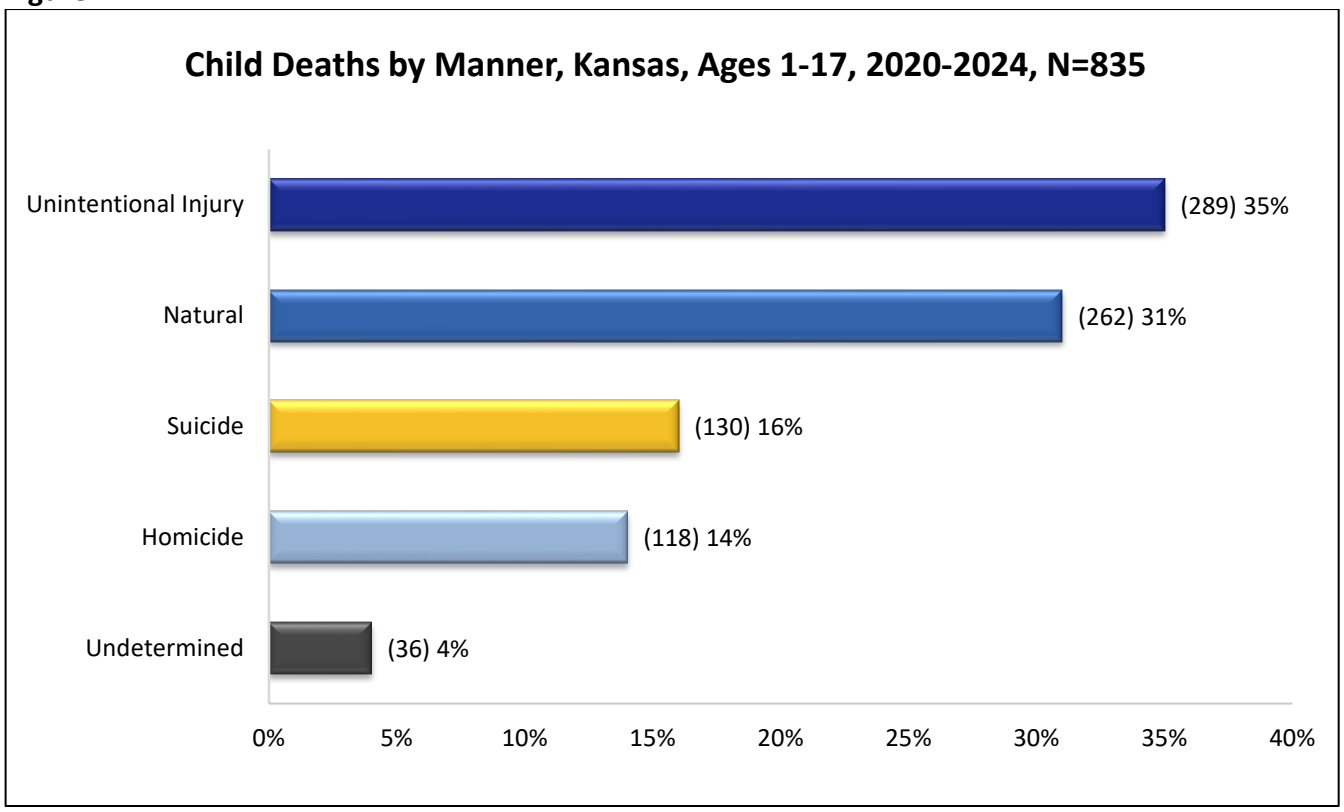


Figure 24



From 2020-2024, unintentional injury was the most frequent manner of death among Kansas children ages 1-17, accounting for 35% of deaths. Natural deaths accounted for 31%, followed by suicide (16%), homicide (14%), and undetermined deaths (4%) (Figure 24).

Figure 25 provides a more detailed breakdown of the causes of natural and non-natural deaths. Of the 262 natural deaths, congenital anomalies (84) and cancer (65) were the most frequent causes, followed by infections, including influenza and pneumonia (34).

The remaining 573 deaths were due to non-natural causes. Unintentional injuries accounted for 289 deaths, with motor vehicle crashes (167) the most frequent cause, followed by poisoning, overdose, or acute intoxication (52) and drowning (31). Firearms were the leading cause of suicide deaths (78), followed by asphyxia (39). Among homicide deaths, 25 were attributed to child abuse and 11 were gang-related. Of the 36 deaths with an undetermined manner, 16 also had an undetermined cause.

Figure 25

Deaths by Natural and Non-Natural Cause of Death, Kansas, Ages 1-17, 2020-2024, N=835	
Natural Causes	**N=262**
Congenital Anomalies	84
Cancer	65
Infection (Including Influenza and Pneumonia)	34
Other Medical Conditions	20
Cardiovascular	17
Neurological, Seizure Disorder	14
COVID-19	10
Asthma	8
Complications of Prematurity	7
Diabetes	3
Non-Natural Causes	**N=573**
Unintentional Injury	**289**
Motor Vehicle Crash	167
Poisoning, Overdose, or Acute Intoxication	52
Drowning	31
Fire, Burn, or Electrocution	10
Other Injury	9
Asphyxia	8
Firearm/Gunshot Wound	7
Fall/Crush	5
Suicide	**130**
Firearm	78
Asphyxia	39
Motor Vehicle Crash	5
Drug Overdose	4
Fall/Crush	3
Drowning	1
Homicide	**118**
Other	82
Child Abuse	25
Gang-Related	11
Undetermined	**36**
Undetermined Cause	16
Poisoning, Overdose, Acute Intoxication	9
Firearm	5
Fire, Burn, or Electrocution	2
Asphyxia	2
Drowning	1
Motor Vehicle Crash	1

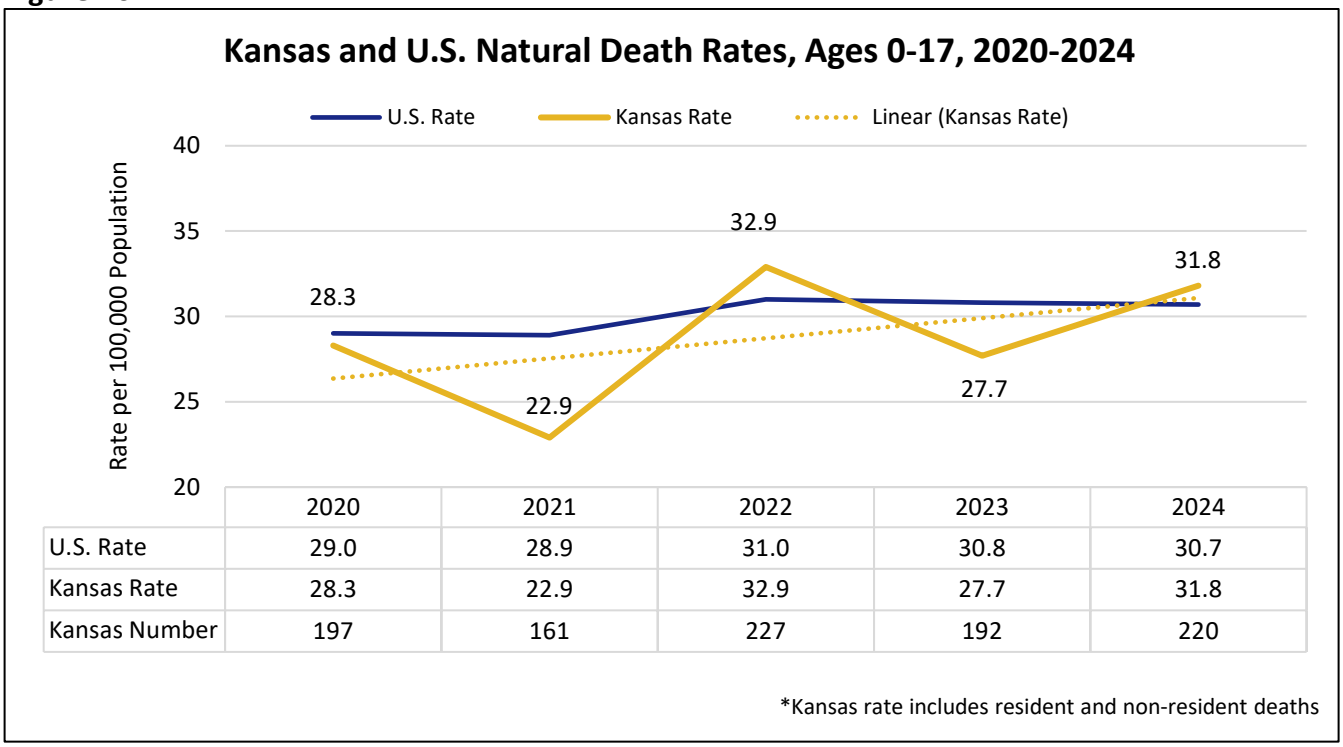
CHARACTERISTICS OF DEATHS, AGES 1-17, 2020-2024, N=835

- In Kansas, the death rate for this age group has exceeded the national rate in each of the past five reporting years
- 69% of deaths were due to non-natural causes; the three most frequent were motor vehicle crashes (167), firearms (103), and poisoning, overdose, or acute intoxication (61)
- 62% were male
- 56% had caregivers with current or prior involvement with child protective services (DCF)
- 43% of deaths were among youth ages 15-17, the largest proportion of any age group
- 35% of deaths were due to unintentional injuries, the most frequent manner of death
- 31% of deaths were due to natural causes; the three most frequent were congenital anomalies (84), cancer (65), and infections, including influenza and pneumonia (34)
- 29% (168) of the 588 children ages 1-17 who had toxicology testing performed at the time of death tested positive for alcohol or illicit drugs

NATURAL DEATHS

Natural deaths include those resulting from medical conditions such as prematurity, congenital conditions, cancer, and infections. In 2024, 220 Kansas children died from natural causes, representing a rate of 31.8 deaths per 100,000 population. As shown in Figure 26, Kansas natural death rates remained similar to U.S. rates between 2020 and 2024, while showing an upward trend.

Figure 26

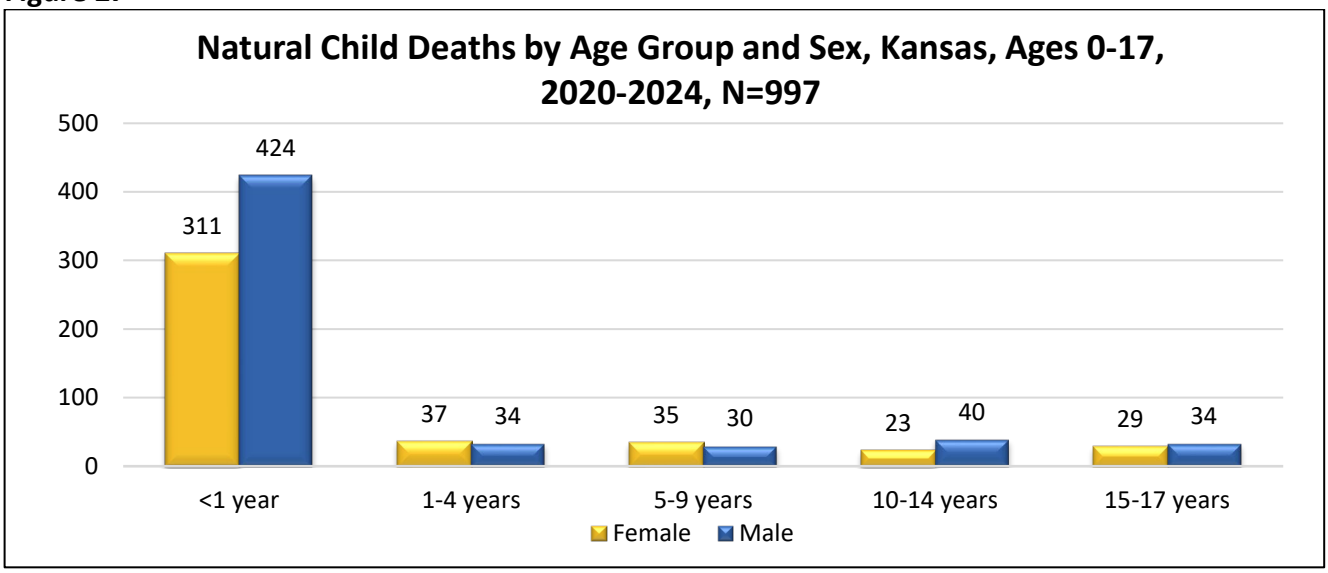


	2020	2021	2022	2023	2024
U.S. Rate	29.0	28.9	31.0	30.8	30.7
Kansas Rate	28.3	22.9	32.9	27.7	31.8
Kansas Number	197	161	227	192	220

*Kansas rate includes resident and non-resident deaths

Figure 27 shows natural deaths by age group and sex. Children under one year of age accounted for 74% of all natural deaths between 2020 and 2024. Overall, males accounted for 56% of all natural deaths.

Figure 27



Prematurity and congenital anomalies accounted for 73% of all natural deaths. Cancer claimed the lives of 65 children as the third-leading natural cause of death over the five-year period (Figure 28).

Causes such as prematurity, congenital anomalies, cancer, cardiovascular conditions, and other perinatal conditions are typically less preventable, though some risk factors and outcomes may be reduced through prenatal care, early diagnosis, and treatment.

Other causes such as influenza, pneumonia, certain infections, and asthma can be prevented or treated and in most cases are not expected to lead to death. Asthma accounted for 8 deaths between 2020 and 2024, with one recorded in 2024. While severe asthma can be life threatening, with quality medical care, and an asthma management plan that includes rescue inhalers, preventative medications, and asthma education, nearly all asthma deaths are preventable.

Figure 28

Natural Causes of Death, Kansas, Ages 0-17, 2020-2024, N=997						
Cause of Death	**2020**	**2021**	**2022**	**2023**	**2024**	**Total**
Prematurity	88	66	79	97	75	**405**
Congenital Anomaly	56	50	81	53	81	**321**
Cancer	10	11	16	7	21	**65**
Other Perinatal Condition	13	9	7	10	14	**53**
Other Infection	8	6	12	9	15	**50**
Other Medical Condition	4	7	2	4	2	**19**
Cardiovascular	5	2	7	1	2	**17**
Pneumonia	0	1	7	3	4	**15**
Neurological, Seizure Disorder	4	0	5	4	1	**14**
COVID-19	1	5	3	2	2	**13**
Undetermined Medical Condition	3	1	2	1	1	**8**
Asthma	2	2	3	0	1	**8**
Influenza	3	0	1	0	1	**5**
Diabetes	0	1	1	1	0	**3**
Malnutrition, Dehydration	0	0	1	0	0	**1**
Total	**197**	**161**	**227**	**192**	**220**	**997**

CHARACTERISTICS OF NATURAL DEATHS, AGES 0-17, 2020-2024, N=997

- While U.S. natural death rates remained relatively stable, Kansas rates fluctuated with an overall increasing trend and exceeded the U.S. rate in 2022 and 2024
- 74% of natural deaths occurred among infants under one year of age
- 73% were due to prematurity or congenital anomalies, the two leading natural causes of death
- 56% were male
- 25% had caregivers with current or prior involvement with child protective services (DCF)

PREVENTION POINTS

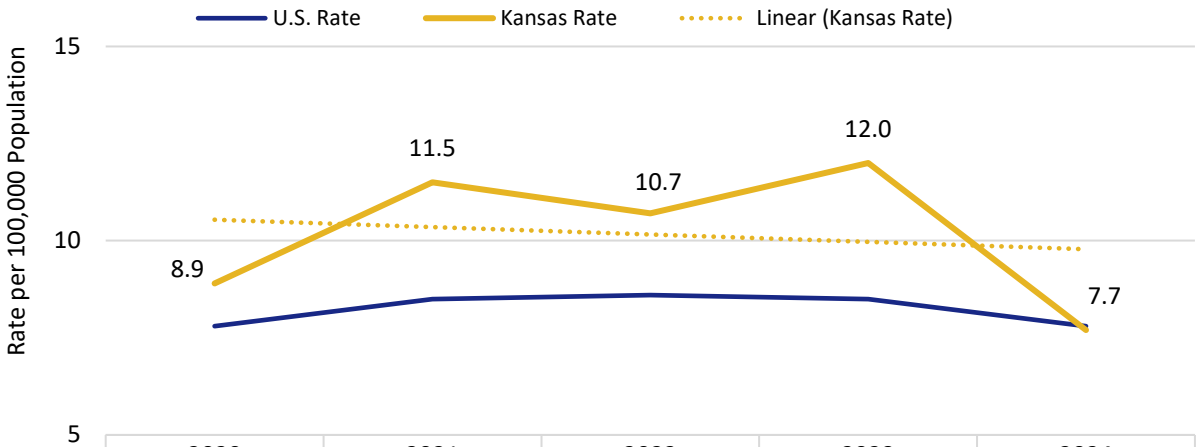
- **Early and Adequate Prenatal Care -** Comprehensive prenatal care is critical for reducing risks related to prematurity and congenital anomalies. Early and regular screenings, treatment of maternal conditions, and timely interventions can improve pregnancy and neonatal outcomes.
- **Education and Support for Expectant Families -** Healthcare providers should guide parents throughout the stages of pregnancy, including clarification of how current medical conditions may impact the pregnancy, education on vaccines necessary for a healthy mother and baby, and review of family health history as it relates to the pregnancy and children born to those parents.[7]
- **Immunizations -** Ensuring children receive recommended vaccines, including influenza, RSV, pneumococcal, and COVID, reduces the risk of infectious diseases that can lead to serious complications such as pneumonia and death. Decisions about which immunizations are appropriate should be made collaboratively between parents and their pediatrician, considering each child's individual health needs.
- **Early Diagnosis and Management of Chronic Conditions -** Conditions such as asthma, diabetes, and seizure disorders require timely diagnosis and ongoing management to prevent complications. Routine health assessments and access to specialized medical care are essential.
- **Assessment and Monitoring for Asthma Patients -** Asthma is highly variable over time. Periodic, scheduled monitoring by health care providers familiar with standardized and evidence-based care is essential, even if the patient and family feel the child is doing well.[8]
- **Asthma Education -** Teaching and reinforcement of disease monitoring, use of a written asthma action plan, correct use of medications and devices, and avoidance of asthma triggers in the environment are areas of knowledge to adapt and integrate into all points of a child's care.[8]
- **Asthma Medications -** Medications and devices must meet a child's needs. Insurance companies must provide flexibility in approval of medications based on a child's ability to use a particular device and the clinical response to prescribed medications. An evidence-based approach to therapy adjustments is outlined in Guidelines for the Diagnosis and Management of Asthma as well as the 2020 Focused Updates to the Asthma Management guidelines both published by the National Heart, Lung and Blood Institute of the NIH.

UNINTENTIONAL INJURY DEATHS

Unintentional injury deaths are those caused by incidents such as motor vehicle crashes, drowning, or fire, which are not the result of an intentional act. In 2024, the unintentional injury death rate of 7.7 deaths per 100,000 population reflects the first time in this 5-year span where the Kansas rate is below the national rate (Figure 29).

Figure 29

Kansas and U.S. Unintentional Injury Death Rates, Ages 0-17, 2020-2024



	2020	2021	2022	2023	2024
U.S. Rate	7.8	8.5	8.6	8.5	7.8
Kansas Rate	8.9	11.5	10.7	12.0	7.7
Kansas Number	62	81	74	83	53

*Kansas rate includes resident and non-resident deaths

Figure 30 shows the causes of unintentional injury deaths by age classification from 2020-2024. Motor vehicle crashes (MVCs) and other transportation-related incidents were the leading cause of unintentional injury death overall, accounting for 172 deaths, and were the leading cause among children ages 1-17. Asphyxia was the second most frequent cause overall and occurred predominantly among infants, with most related to unsafe sleep environments. Sleep-related asphyxia deaths are discussed further in the Unintentional Injury-Asphyxia Deaths section of this report.

Figure 30

Unintentional Injury Deaths by Cause and Age Classification, Kansas, 2020-2024, N=353						
Cause of Death	**Age <1**	**Ages 1-4**	**Ages 5-9**	**Ages 10-14**	**Ages 15-17**	**Total**
MVC and Other Transportation Related	5	22	31	35	79	**172**
Poisoning, Overdose, or Acute Intoxication	1	6	0	3	43	**53**
Asphyxia	44	5	0	2	1	**52**
Drowning	2	16	4	5	6	**33**
Other Causes	9	5	0	1	3	**18**
Fire, Burn, and Electrocution	2	4	4	0	2	**12**
Firearm	1	3	0	3	1	**8**
Fall/Crush	0	0	3	0	2	**5**
Total	**64**	**61**	**42**	**49**	**137**	**353**

As shown in Figure 30, poisoning, overdose, or acute intoxication was the second leading cause of unintentional injury deaths. Youth ages 15-17 accounted for 81% (43) of the 53 deaths in this category. Further information regarding drug-related deaths can be found in the Drug-Related Deaths section of this report. The environment in which youth are raised may influence whether they try drugs or other substances. At home, school, and in the community, caregivers and educators should address the dangers of drugs and alcohol and the risk of lethality from misuse or abuse.

Drowning accounted for 33 unintentional injury deaths, with 48% (16) occurring among children ages 1-4. Fire, burn, and electrocution accounted for 12 deaths, firearm injuries resulted in eight deaths, and fall or crush injuries in five deaths.

The “Other Causes” category in Figure 30 included 18 deaths resulting from injuries such as hyperthermia or environmental exposure, anaphylaxis, injuries sustained during the birth process or related to in utero substance exposure, ingestion of a foreign object, and mechanical equipment injury. Half (9) of these deaths occurred among infants under age one. Of these nine infant deaths, seven resulted from complications directly related to maternal alcohol or drug use during pregnancy, one resulted from injuries sustained during the birth process, and one resulted from hyperthermia after the infant was left in a vehicle. Overall, three children died from hyperthermia after being left in a vehicle.

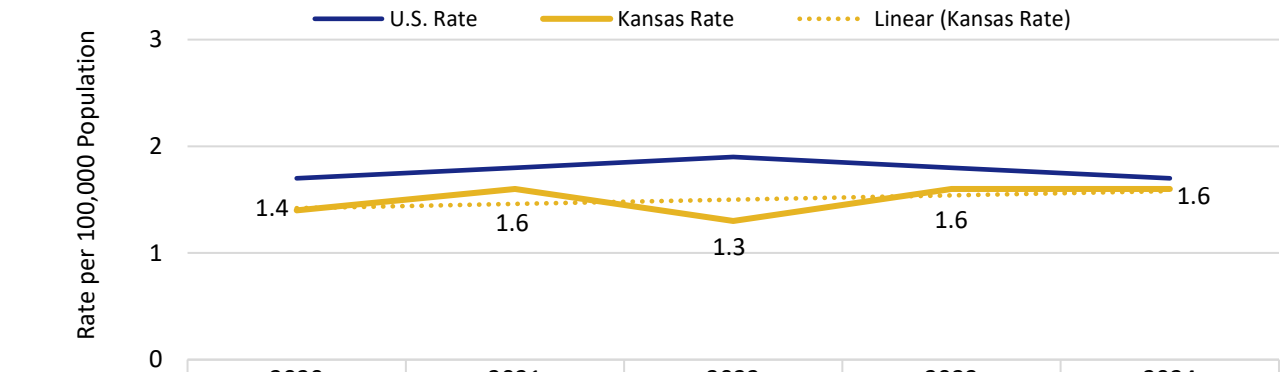
Unintentional Injury - Asphyxia Deaths

Asphyxia occurs when the body is deprived of oxygen because normal breathing is interrupted. Unintentional asphyxia deaths can result from circumstances such as suffocation, strangulation, or choking and may include sleep-related and non-sleep-related incidents.

From 2020-2024, asphyxia was the second-leading cause of unintentional injury deaths among Kansas children ages 0-17 and the leading cause among infants. During this period, 52 children died from unintentional asphyxia, including 44 infants and eight children over age one. As shown in Figure 31, the Kansas asphyxia death rate remained relatively stable from 2020-2024 and was below the U.S. rate each year.

Figure 31

Kansas and U.S. Unintentional Injury - Asphyxia Death Rates, Ages 0-17, 2020-2024



	2020	2021	2022	2023	2024
U.S. Rate	1.7	1.8	1.9	1.8	1.7
Kansas Rate	1.4	1.6	1.3	1.6	1.6
Kansas Number	10	11	9	11	11

*Kansas rate includes resident and non-resident deaths

Unintentional asphyxia deaths most often affected very young children who may not have developed the strength or motor skills to remove themselves from dangerous situations. From 2020-2024, 44 (85%) of the 52 children who died from unintentional asphyxia were infants. Overall, 46 (88%) of asphyxia deaths were sleep-related, including 44 infants and two children over age one.

These deaths illustrate the risks associated with unsafe sleep environments. Sleep practices that can increase the risk of suffocation include placing an infant somewhere other than a crib or bassinet, placing an infant in a cluttered sleep area or on a soft surface, and bed-sharing with parents, siblings, or other individuals.

Although most unintentional asphyxia deaths were sleep-related, asphyxia deaths also occurred in circumstances unrelated to sleep. Figure 32 describes the 52 unintentional asphyxia deaths from 2020-2024 by sleep-related status. Of these, 46 (88%) were sleep-related and six (12%) were non-sleep-related. All six non-sleep-related deaths involved children over age one. Four resulted from strangulation, one from choking on food, and one from failure of a medical device.

Figure 32

Unintentional Injury - Asphyxia Deaths by Sleep-Related Status, Kansas, Ages 0-17, 2020-2024, N=52		
Circumstances	**Deaths**	**Percentage**
Sleep-Related	**46**	**88%**
Not Sleep-Related	**6**	**12%**
Strangulation	4	-
Choking	1	-
Other	1	-

Strangulation can occur when children become entangled in cords, window-blind cords, straps, ropes, or other objects around the home or play environment. Young children should be closely supervised, and areas where children live and play should be routinely checked for potential strangulation or entanglement hazards.

Strangulation deaths may also occur among older children or adolescents as a result of intentional risk-taking behaviors involving self-induced asphyxia. These behaviors can result in loss of consciousness, serious injury, or death and should be recognized and discussed as a significant safety risk.

Young children are also at increased risk for choking and should be supervised while eating and when playing with or near small objects. Foods such as hot dogs, whole grapes, raw carrots, and popcorn can become lodged in a child's airway and should be prepared appropriately for the child's age. Small toys, balloons, coins, and other objects that can obstruct the airway should be kept out of reach of young children.

CHARACTERISTICS OF UNINTENTIONAL INJURY - ASPHYXIA DEATHS, 2020-2024, N=52

- Kansas asphyxia death rates remained relatively stable from 2020-2024 and were below U.S. rates each year
- 88% of deaths were sleep-related asphyxia; 44 were infants and 2 were over one year of age
- 85% of deaths occurred among infants under age one
- 56% had caregivers with current or prior involvement with child protective services (DCF) including:
    - 15% in which the child who died or a sibling had been in state custody prior to the death
    - 4% involved children who were in state custody at the time of their death
- 35% had caregivers with a history of substance use; in at least five deaths, a caregiver was under the influence of alcohol or drugs at the time of the asphyxia event

PREVENTION POINTS

- **Proper Supervision -** Young children should be watched attentively. Leaving them alone for even a few minutes allows opportunities for unintentional injuries. Child-specific training in CPR and other emergency responses can help prevent death.
- **Safe Environments -** Areas where children live, sleep, and play should be routinely inspected for dangers such as chests, coolers, cords, hanging materials, or plastic bags, which can be deadly to children. Check play areas for hazards like protruding bolts that can catch clothing. Playground equipment parts and handrails should be checked for spaces that are large enough to allow a child's body to slip through, trapping the head or neck. Children playing with rope swings and swing sets should be supervised at all times.
- **Infant Sleeping Arrangements -** The safest sleeping arrangement for an infant is alone, on their back, in a crib, bassinet, or other approved sleep surface. Babies should not sleep in adult beds and should not be placed in bed with others. The sleep surface should be firm, flat, and free of soft bedding and other objects that might create a risk for suffocation or entanglement, including blankets, bumper pads, pillows, stuffed animals, or infant supplies.[6]
- **Choking Hazards -** Children under age four are most at risk for choking on food and small objects. In addition to small toys, balloons, and coins, some foods can be a choking hazard for young children. Hot dogs, whole grapes, raw carrots, popcorn, and other foods can become lodged in a child's airway. Young children need supervision while eating and when playing with or near potential choking hazards.[11]

SLEEP-RELATED ASPHYXIA CASE VIGNETTE

Unsafe Sleep Poses Serious Risk for Suffocation

A Kansas infant was born at term following a pregnancy with limited prenatal care and concerns regarding unstable housing. During the newborn hospitalization, the father was found sleeping with the infant on a couch. Hospital staff moved the infant to a bassinet and provided safe sleep education. Following discharge, several medical appointments were missed, resulting in multiple attempts by medical providers, law enforcement, and child welfare professionals to locate the family and ensure the infant received follow-up care.

Several weeks later, the infant was staying with the father in a relative's home. The father reported routinely sleeping with the infant as there was no crib or other separate sleep space in the home. After feeding the infant and taking prescribed medications, the father placed the infant on their side in a king-sized bed and covered the infant with a fleece blanket before going to sleep next to the infant. The bed had a soft, lumpy mattress topper, multiple loose blankets, and pillows.

The father reported waking many hours later and finding the infant face down and unresponsive. Other adults in the home reported hearing the infant awake and crying at different times during the day, although the father did not recall waking or caring for the infant. The investigation indicated the infant was found face down with the nose and mouth obstructed by bedding. The infant's cause of death was determined to be asphyxia associated with an unsafe sleep environment.

SCDRB REFLECTION

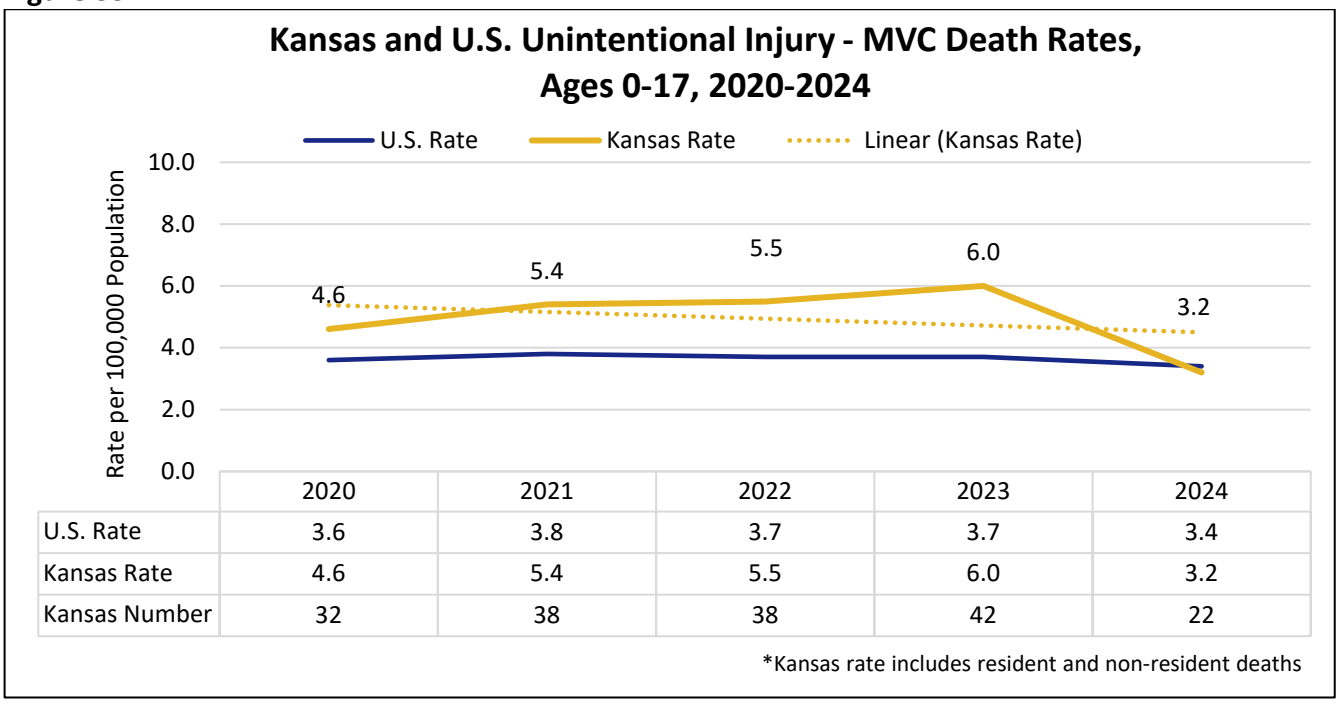
This death highlights the importance of providing infants with a safe sleep environment for every sleep. Infants should be placed on their backs on a firm, flat sleep surface in their own crib, bassinet, or portable crib without blankets, pillows, mattress toppers, or other soft items. Bed-sharing increases the risk of suffocation, particularly when a caregiver has taken medications or other substances that may impair alertness.

Unintentional Injury - Motor Vehicle Crash Deaths

Motor vehicle crashes (MVCs) were the leading cause of unintentional injury deaths among Kansas children from 2020-2024, accounting for 172 deaths. In 2024, 22 children died in MVCs, a 48% decrease from 42 deaths in 2023.

Figure 33 compares Kansas and U.S. MVC death rates from 2020-2024. Kansas experienced a steady increase in MVC death rates from 2020-2023, with rates exceeding the U.S. each year. In 2024, the Kansas rate declined substantially and fell below the U.S. rate.

Figure 33

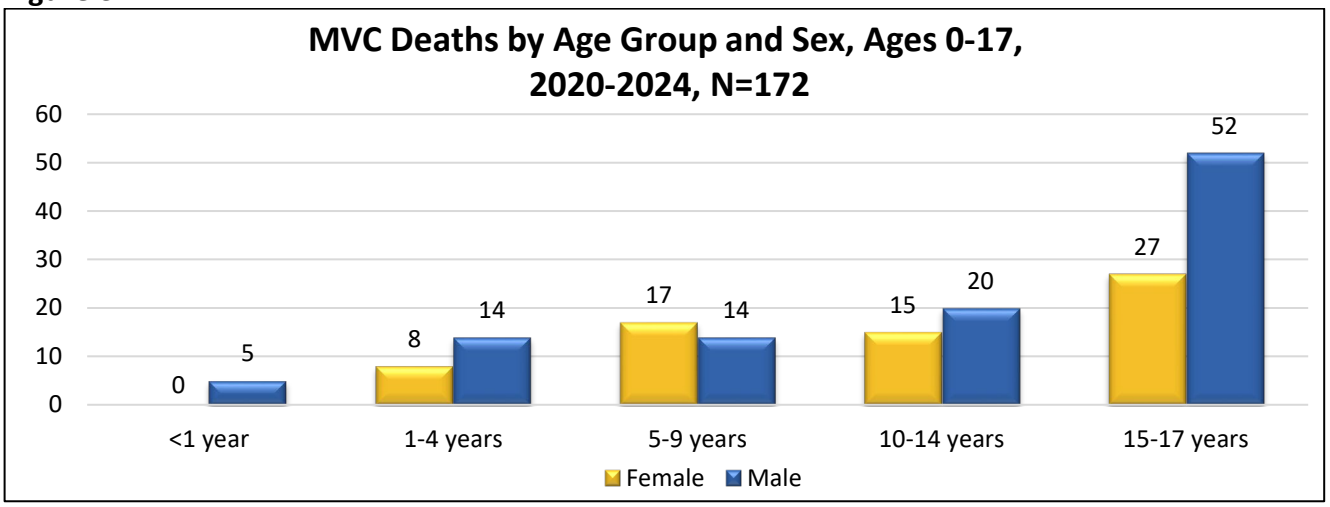


	2020	2021	2022	2023	2024
U.S. Rate	3.6	3.8	3.7	3.7	3.4
Kansas Rate	4.6	5.4	5.5	6.0	3.2
Kansas Number	32	38	38	42	22

*Kansas rate includes resident and non-resident deaths

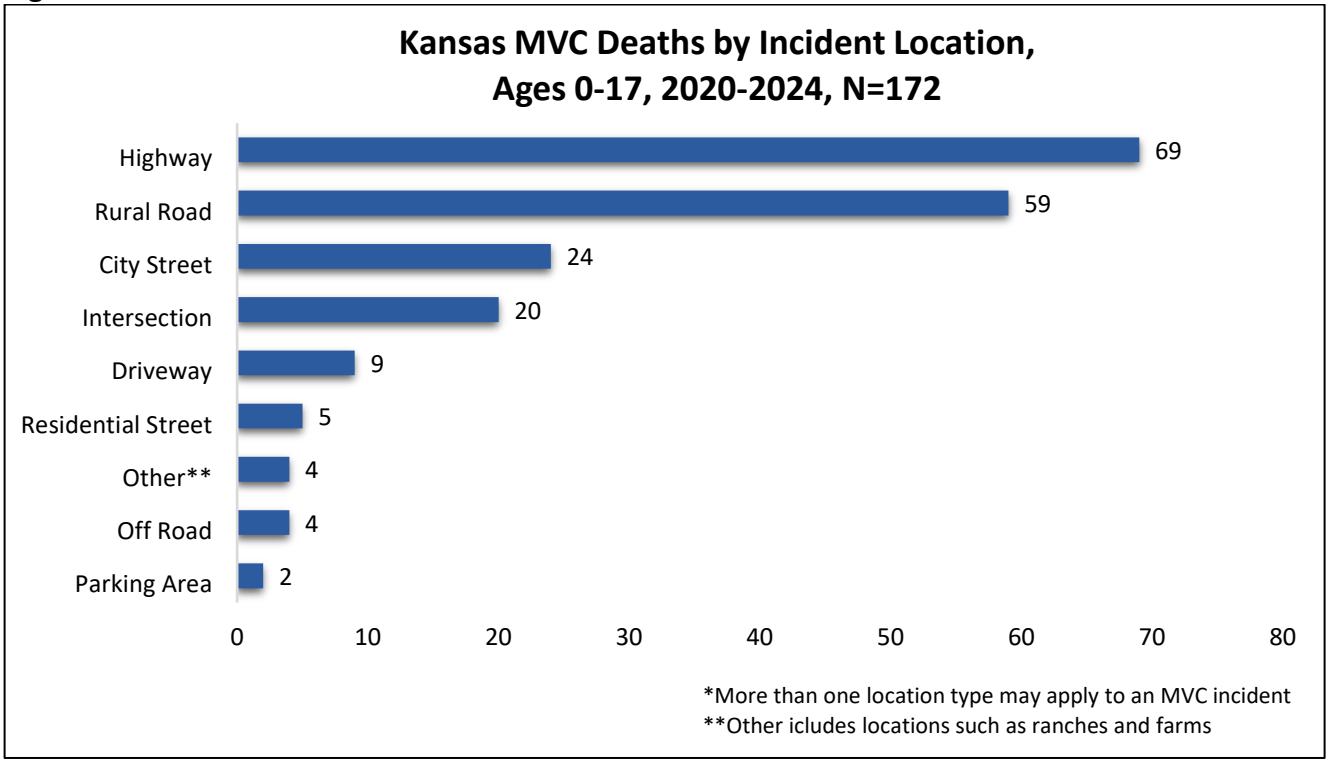
Figure 34 shows that 66% of MVC deaths occurred among children ages 10-17, with youth ages 15-17 accounting for nearly half (46%) of all MVC deaths. Males accounted for 61% of MVC deaths, compared with 39% among females.

Figure 34



The location of where a crash occurs can significantly influence its severity. Road type often determines the speed of travel, availability of safety infrastructure, and emergency response times. Figure 35 shows that nearly three-quarters (74%) of MVC deaths occurred on highways or rural roads, with 40% (69) occurring on highways and 34% (59) on rural roads. Many Kansas highways and rural roads have higher speed limits and often lack safety features such as guardrails, rumble strips, or divided lanes. These conditions may increase the likelihood of a fatal outcome when a crash occurs.

Figure 35



MVC deaths are rarely the result of a single factor. Instead, they often involve a combination of circumstances that together lead to fatal outcomes. Understanding the risk factors most commonly associated with these deaths is essential for shaping prevention strategies and educational efforts targeting both drivers and passengers of vehicles. Figure 36 identifies leading contributing risk factors among the 172 MVC deaths from 2020-2024. Recklessness or carelessness was identified in 58% (99) of deaths, followed by lack of proper seat restraint use in 41% (70), driver impairment from alcohol or drugs in 35% (61), and excess speed in 33% (57).

Figure 36

Leading Contributing Factors in MVC Deaths, Kansas, Ages 0-17, 2020-2024, N=172		
Contributing Risk Factor*	**Number**	**Percent**
Recklessness or Carelessness	99	58%
Lack of Proper Seat Restraint Use (Seat Belts, Car Seats, and Booster Seats)	70	41%
Impairment (Alcohol and/or Drugs)	61	35%
Excess Speed (Over the Limit or Unsafe for Conditions)	57	33%
Inexperienced Driver	40	23%
Distracted Driver (Including Electronic Device Use)	28	16%
Helmet Not Used**	25	15%
Poor Visibility and/or Sight Lines	22	13%
Rollover	19	11%
Ran Stop Sign or Red Light	18	10%
Driver Error	17	10%
Changing Lanes	11	6%
Weather Conditions	6	3%
Unauthorized Racing	6	3%
Road Hazard	5	3%
Fatigued Driver	3	2%

*More than one contributing risk factor may have been identified in each death
**Helmet use applies to off-road vehicle, motorcycle, and bicycle deaths only; percentage shown is based on all MVC deaths

One notable area of concern is the inconsistent use of helmets. Among the 172 MVC deaths, 28 children were operating or riding on off-road vehicles (12), motorcycles (11), or bicycles (5), where helmet use was applicable. Of these 28 children, 89% (25) were not wearing a helmet at the time of the crash. Only three children were wearing helmets, all of whom were on motorcycles. None of the children on off-road vehicles or bicycles were wearing helmets. Kansas law requires individuals under age 18 to wear a helmet when operating or riding on a motorcycle or motorized bicycle; however, Kansas does not have a comparable statewide helmet requirement for children riding off-road vehicles or bicycles.

Findings from Figure 36 reinforce the need to consider legal requirements for helmet use among children, as well as stronger safety education and prevention strategies that promote consistent helmet use, safe driver behavior, and child passenger safety.

Figure 37 examines restraint use among the 130 children who had access to a safety restraint at the time of the crash. Among the 47 children who were driving, 38% (18) were restrained, compared with 44% (15) of front-seat passengers and 62% (29) of back-seat passengers. Overall, only 48% (62) of the 130 children were known to be restrained at the time of the crash that led to their deaths. Consistent and appropriate use of seat belts, car seats, and booster seats is a critical component of reducing the risk of serious injury and death when a crash occurs.

Figure 37

MVC Deaths by Restraint Use and Position in Vehicle, Kansas, Ages 0-17, 2020-2024, N=130*					
Restraint Use	**Driver**	**Front-Seat Passenger**	**Back-Seat Passenger**	**Unknown Position Passenger**	**Total**
Restrained	18	15	29	0	**62**
Unrestrained	27	19	17	1	**64**
Restraint Use Unknown	2	0	2	0	**4**
Total	**47**	**34**	**48**	**1**	**130**

*Does not include deaths in which the decedent was a pedestrian, was not in a vehicle with a safety restraint system (e.g., a motorcycle), or deaths in which the child was in or on a vehicle where the safety restraint could not be accessed (truck beds, rear cargo areas, in-utero, etc.)

Figure 38 describes characteristics associated with 27 pedestrian deaths from 2020-2024. Of these, five children were riding bicycles, while the remaining 22 were walking, standing, or otherwise in the vicinity of vehicle travel when they were struck. None of the five children riding bicycles were wearing a helmet. More than half (56%) of the 27 deaths involved poor or absent supervision, and 22% involved a driver who was impaired by alcohol or drugs.

Figure 38

Characteristics of Pedestrian Deaths, Kansas Ages 0-17, 2020-2024, N=27		
Characteristics	**Number**	**Percentage**
Poor/Absent Supervision Contributed to Death	**15**	**56%**
Vehicle Frontover or Backover	**10**	**37%**
Frontover	5	19%
Backover	5	19%
Driver of the Vehicle impaired by Drugs and/or Alcohol	**6**	**22%**
Decedent was Biking Without Helmet	**5**	**19%**

Among the 27 pedestrian deaths, 37% (10) occurred in frontover or backover incidents in which a driver moving forward or in reverse unintentionally struck or drove over a child. All 10 children who died in these incidents were ages 1-4 years, and 70% were struck by a van, SUV, truck, or farm machinery. Vehicle size and design can increase the risk of serious or fatal injury to pedestrians. According to KidsAndCars.org, vehicles with hood heights over 40 inches were approximately 45% more likely to cause pedestrian fatalities than lower vehicles with sloped front ends.[12]

In recent years, advances in vehicle safety technology have included sensor-based alert systems, backup cameras, and 360-degree or "bird's-eye view" camera systems that improve visibility around vehicles. Further advancements in automatic emergency braking systems to detect pedestrians during low-speed vehicle movements, particularly very young children, could help prevent these deaths. Public education should continue to encourage drivers to walk completely around their vehicles before moving, check areas that may not be visible from the driver's seat, and ensure children are properly supervised and secured before moving the vehicle.

Kansas experienced 12 child deaths from off-road vehicle (ORV) crashes from 2020-2024 (Figure 39). According to the U.S. Consumer Product Safety Commission's 2025 Annual Report of Deaths and Injuries Involving Off-Highway Vehicles with More Than Two Wheels, an estimated 113,000 ORV-related injuries were treated in U.S. emergency departments in 2024. Children younger than age 16 accounted for an estimated 28% of these injuries, including nearly 14% involving children younger than age 12.[13]

Figure 39

Kansas Off-Road Vehicle Deaths by Age Group and Driver/Passenger Status, Ages 0-17, 2020-2024, N=12			
Age Group	**Driver**	**Passenger**	**Total**
Ages 0-9	3	2	**5**
Ages 10-14	1	2	**3**
Ages 15-17	3	1	**4**
Total	**7**	**5**	**12**

ORVs are popular for both recreational and agricultural use. Their size, maneuverability, and versatility make them useful and enjoyable to operate. However, these same features, including short wheelbases and a high center of gravity, can make ORVs susceptible to rollovers, particularly when turning at high speeds or driving on uneven terrain. Newer models with power steering and other advanced features may make operation easier, but they can also contribute to overcorrection or loss of control, especially for inexperienced or young drivers.

While there were no ORV-related child deaths in 2024, the number of young children operating these vehicles continues to raise concern. From 2020-2024, seven (58%) of the 12 children who died were operating the ORV at the time of the crash, including three drivers under age 10. ORVs can be dangerous, particularly when operated by children who lack the age, experience, and training to safely control them.

Most concerning, none of the 12 children who died in ORV crashes were using a helmet or safety restraint at the time of the crash. This represents a significant and preventable gap in safety practices. Prevention efforts should emphasize age-appropriate use, driver and rider education, and adult supervision. Policies establishing a minimum operator age of 16 should also be considered to reduce the risks associated with young children operating ORVs. At a minimum, all ORV users should wear helmets, eye protection, and protective clothing and use appropriate safety restraints when riding in or operating an ORV.

Figure 40 describes toxicology findings related to 172 child deaths from MVCs in Kansas from 2020-2024. Toxicology testing and findings varied based on the child's role in the crash and the individual tested. Among child drivers, 84% (47) received toxicology testing, and 30% (14) of those tested had positive toxicology findings. Among child passengers, 73% (65) received toxicology testing, and 15% (10) of those tested had positive toxicology findings. When the child was a passenger, 81% (72) of the drivers of the child's vehicle received toxicology testing, and 44% (32) of those tested had positive toxicology findings.

Testing information for drivers of other vehicles involved in fatal crashes was not consistently available; however, 11 drivers had confirmed positive toxicology findings. Across all individuals with positive toxicology findings, the substances most frequently detected were alcohol (43), marijuana (28), benzodiazepines (9), and amphetamine/methamphetamine (6).

Figure 40

Toxicology Findings in Child MVC Deaths, Kansas, 2020-2024, N=172

Child's Role	Toxicology Subject	Child Deaths	Toxicology Testing	Positive Toxicology Findings	Substances Detected
Driver	Child Driver	56	47	14	Marijuana (9), Alcohol (6), Cocaine (1), Benzodiazepines (1)
Passenger	Child Passenger	89	65	10	Alcohol (8), Marijuana (3), Benzodiazepines (1)
Passenger	Driver of Child's Vehicle	89	72	32	Alcohol (19), Marijuana (12), Benzodiazepines (5), Amphetamine/Methamphetamine (4), Opioids (3), Ketamine (3), Cocaine (1)
Driver, Passenger, or Pedestrian	Driver of Other Vehicle	172	Not Available	11	Alcohol (10), Marijuana (4), Benzodiazepines (2), Amphetamine/Methamphetamine (2), Opioids (1)

Notes: "Child Deaths" refers to children ages 0-17 who died as a result of an MVC. "Toxicology Testing" indicates the number of toxicology subjects who were tested, and "Positive Toxicology Findings" indicates the number of those tested who had confirmed positive results. When the toxicology subject was the driver of the child's vehicle or the driver of another vehicle, that individual may not have died in the crash. Substance counts may exceed the number of individuals with positive toxicology findings because some individuals tested positive for more than one substance.

The SCDRB highlights the need to strengthen prevention efforts and evaluate penalties related to impaired driving to ensure Kansas roadways are safe for children. Comprehensive fatal crash investigations should include toxicology testing of deceased children and all drivers involved. When alcohol or drug use by a minor is identified, investigations should also determine how the substances were obtained, with appropriate enforcement of laws prohibiting individuals or establishments from supplying alcohol or drugs to minors. Prevention efforts should continue to emphasize the dangers of impaired driving and the responsibility of adults to ensure children are transported by sober drivers.

MVC DEATH CASE VIGNETTE

Young Drivers and Farm Permit Restrictions

A 15-year-old Kansas youth died from injuries sustained in a head-on motor vehicle crash on a rural highway during the early morning hours. The youth was driving alone when, for an unknown reason, the vehicle crossed the centerline and collided with a semitruck. The youth was properly restrained but sustained extensive injuries and died several days later.

Less than one year prior to the fatal crash, the youth had been involved in another single-vehicle crash while driving. In that incident, the vehicle fishtailed and rolled several times. The youth was restrained and sustained only minor injuries.

At the time of the fatal crash, the youth had a valid Kansas farm permit. Based on the youth's age and the time and circumstances of the crash, it is likely the youth was driving outside of the restrictions of the permit. However, this could not be confirmed with the limited investigative information provided.

SCDRB REFLECTION

This case highlights the importance of restrictions placed on young and inexperienced drivers. Farm permits allow youth to begin driving at an earlier age for specific purposes and under specific conditions. These restrictions are intended to reduce the risks associated with limited driving experience while still allowing youth to drive when necessary for farm-related activities and other permitted purposes.

Parents and caregivers play an important role in ensuring young drivers understand and follow the restrictions associated with their permit, including when and where they are permitted to drive. Previous crashes involving a young driver should also lead parents and caregivers to reassess the youth's driving skills, reinforce safe driving practices, and determine whether additional supervision or driver education is needed.

Additionally, Kansas should consider whether the current minimum age and requirements for obtaining a farm permit provide adequate safeguards for young drivers, including whether additional training, supervision, or driving experience should be required before youth are permitted to drive independently.

MVC DEATH CASE VIGNETTE

Impaired Driving and Restraint Use

A Kansas youth was driving with another youth as a passenger when the vehicle left the county road and was involved in a rollover crash. The passenger reported that the driver appeared drowsy and became unresponsive while driving. The passenger attempted to take control of the vehicle, but the vehicle struck a post and rolled. The driver and the passenger were not wearing seat belts. The driver was ejected from the vehicle, resulting in fatal injuries. During the investigation, a vape pen containing THC was located near the driver's door and identified as belonging to the youth. Toxicology testing identified Delta-8 THC in the youth's blood.

SCDRB REFLECTION

This death highlights the dangers of impaired driving and youth access to THC products. THC products, including Delta-8, can impair attention, reaction time, coordination, and judgment, creating serious risks when driving. Investigations into MVC deaths involving youth and THC should examine not only the circumstances of the crash, but also how and where intoxicating products were obtained by minors. Parents, caregivers, retailers, law enforcement, and other community stakeholders all play a role in limiting youth access to THC products and educating teens about the dangers of driving after using marijuana or other impairing substances.

This death also highlights the importance of consistent seat belt use. Neither the driver nor the passenger was restrained. The passenger survived; however, the driver was ejected from the vehicle and sustained fatal injuries. Although outcomes can differ among occupants in the same crash, traveling without a seat belt significantly increases the risk of ejection and serious or fatal injury. Seat belts should always be used, regardless of distance, roadway, or seating position.

CHARACTERISTICS OF UNINTENTIONAL INJURY - MVC DEATHS, 2020-2024, N=172

- Kansas MVC death rates exceeded U.S. rates from 2020-2023 but fell below the U.S. rate in 2024
- 61% were male
- 49% were unrestrained drivers or passengers in a vehicle
    - Only 38% of the 47 drivers in vehicles with restraint systems available were restrained
- 46% were ages 15-17, 20% were ages 10-14, 18% were ages 5-9, and 16% were under age five
- 35% involved the use of drugs or alcohol at the time of the crash
- 33% (56) were driving a vehicle at the time of the crash
- 16% (27) were pedestrian deaths
    - Five were riding a bicycle at the time of the incident; none were wearing a helmet
    - Ten resulted from a vehicle frontover or backover
- 8% were front-seat passengers age 12 or younger
- 7% were ORV-related deaths; none were using helmets or safety restraints

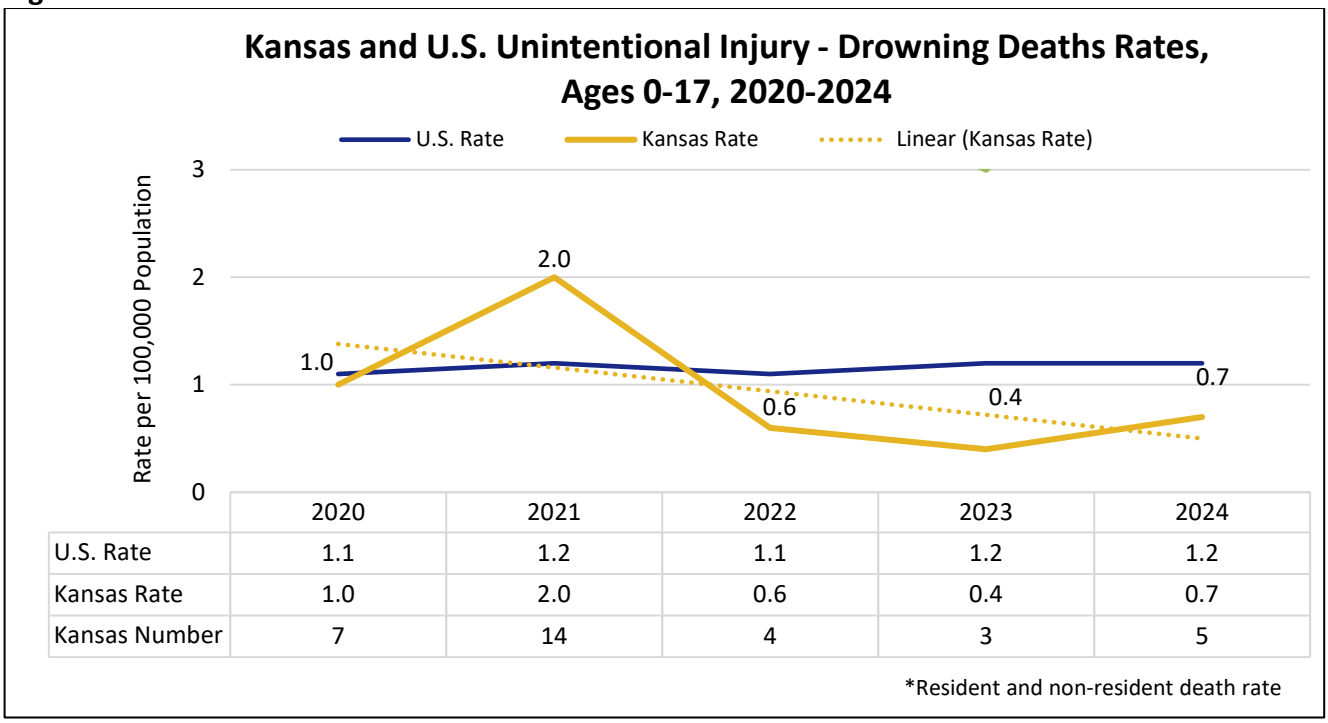
PREVENTION POINTS

- **Use Proper Safety Restraints -** Seat belts and appropriate child safety restraints prevent serious injury and death. According to the National Highway Traffic Safety Administration (NHTSA), it is best to keep children in rear-facing car seats as long as possible, until they reach the seat's maximum height or weight limit. Children should then transition to a forward-facing car seat with a harness and later a belt-positioning booster seat. Caregivers should refer to their specific car seat manuals for guidance on height and weight requirements for car seat transitions. Car seats of any kind should always remain in the back seat.[14]
- **Front Seat Passengers -** Recommendations suggest that children 12 and under should ride in the back seat. Front seat airbags may cause injury to smaller children. If a child must ride in front, disable the front airbag when appropriate and move the seat as far back as possible.[14]
- **Frontover and Backover Deaths -** The Kids and Cars safety organization recommends safeguarding outside doors and using door alarms to prevent children from leaving the home unnoticed. Children should also be supervised and visible before a vehicle is put in gear.[15]
- **Attentive Driving -** Avoid distractions such as cell phones, navigation devices, or eating. Novice drivers should limit passengers and nighttime driving, both known risk factors for crashes.[16,17]
- **Avoid Alcohol or Drug Use -** Driving after consuming alcohol or using narcotics or mood-altering substances is never safe. Children must be educated about not driving under the influence and how to avoid riding with anyone suspected of being under the influence of drugs or alcohol.
- **Driving Experience -** Driving requires practice, focus, and good judgment. Young drivers should be accompanied by an experienced adult and avoid complex driving situations. Kansas' graduated driver's license system requires significant supervised driving before full driving privileges are granted at age 17.[17]
- **Stay Alert -** Pedestrians should remain visible to drivers and alert to their surroundings, especially when crossing streets. Cell phones, headphones, and other distractions can make it difficult to see or hear approaching hazards.
- **Off-Road Vehicle (ORV) Safety -** Children should only operate ORVs that are appropriate for their age and size. Policies requiring a minimum operator age of at least 16 should be considered to help prevent injuries and deaths. All ORV users should wear helmets, eye protection, protective clothing, and use proper seat restraints.[13]

Unintentional Injury - Drowning Deaths

In 2024, there were five unintentional drowning deaths of children in Kansas. Figure 41 presents the drowning death rates for children ages 0-17 between 2020 and 2024. Kansas rates fluctuated during this period but were generally at or below the U.S. rate, with the exception of 2021. In Kansas, children ages 1-4 years accounted for the highest number of drowning deaths from 2020 through 2024, with males accounting for 73% of drowning deaths overall (Figure 42).

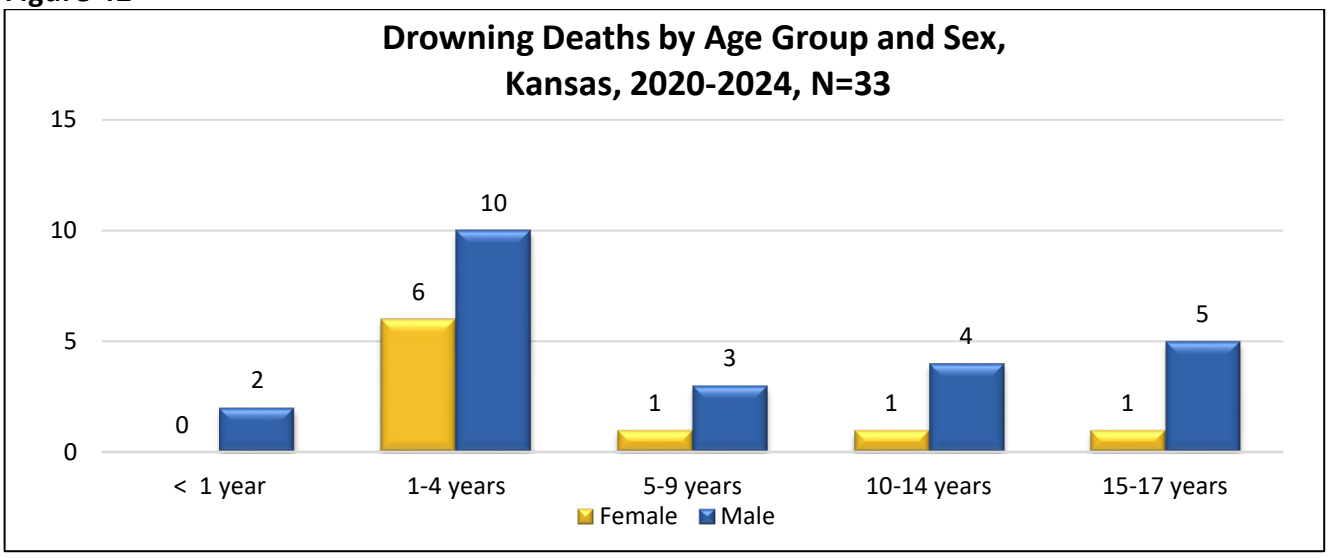
Figure 41



	2020	2021	2022	2023	2024
U.S. Rate	1.1	1.2	1.1	1.2	1.2
Kansas Rate	1.0	2.0	0.6	0.4	0.7
Kansas Number	7	14	4	3	5

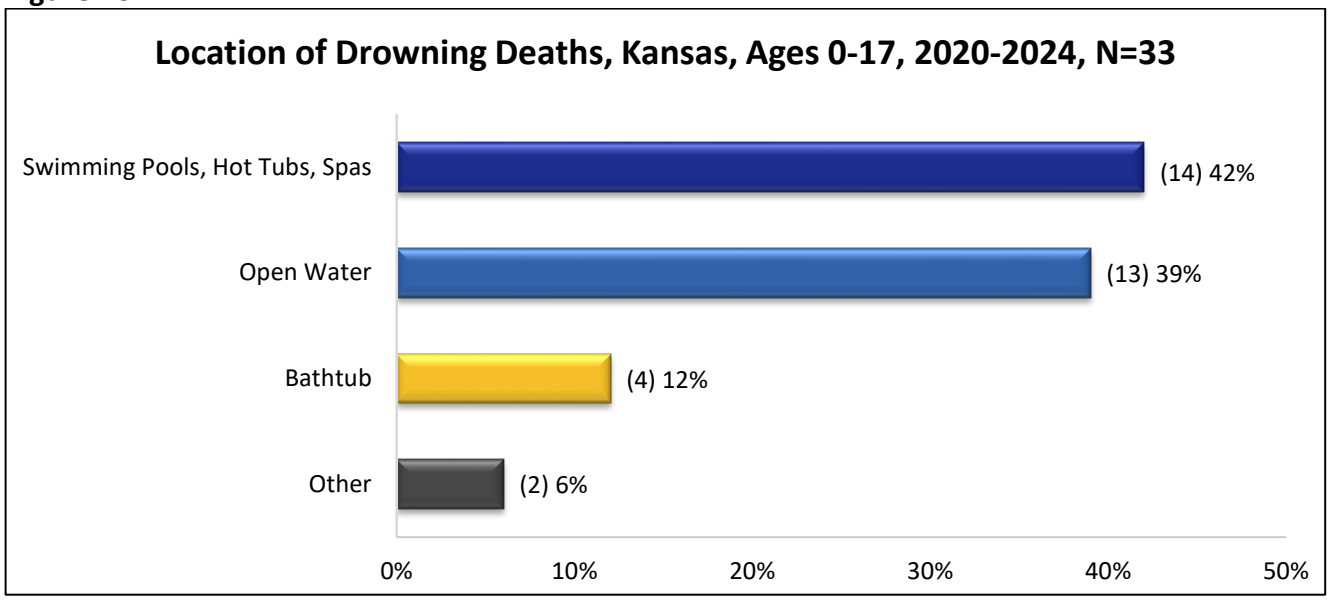
*Resident and non-resident death rate

Figure 42



As shown in Figure 43, swimming pools and open water are the primary locations of child drownings. Proper supervision and use of flotation devices for children of all ages are critical prevention measures. Children are not only at risk during the summer when pools are mainly in use, but also when not in use and still accessible. Fencing of swimming pools, including soft-sided pools, on residential properties is an additional and necessary tool to prevent drownings. Creating more "layers" of protection between children and water can prevent tragedies from taking place.[19] Many of the same prevention points can be applied to swimming in open water locations.

Figure 43



Because drownings can occur in only a few minutes and with only a few inches of water present, young children are vulnerable to drowning in locations that most caregivers would not see as a threat. Figure 43 shows that in two of the drowning deaths, "other" location of the drowning was listed. Toilets, buckets of water, washing machines, and large puddles are examples of locations that small children can encounter and that without proper supervision, can endanger them.

In 73% (24) of unintentional drowning deaths between 2020 and 2024, poor or absent supervision was noted to be either the direct or contributing factor. Proper supervision and appropriate personal flotation devices are critical prevention measures when children are near water.

Figure 44

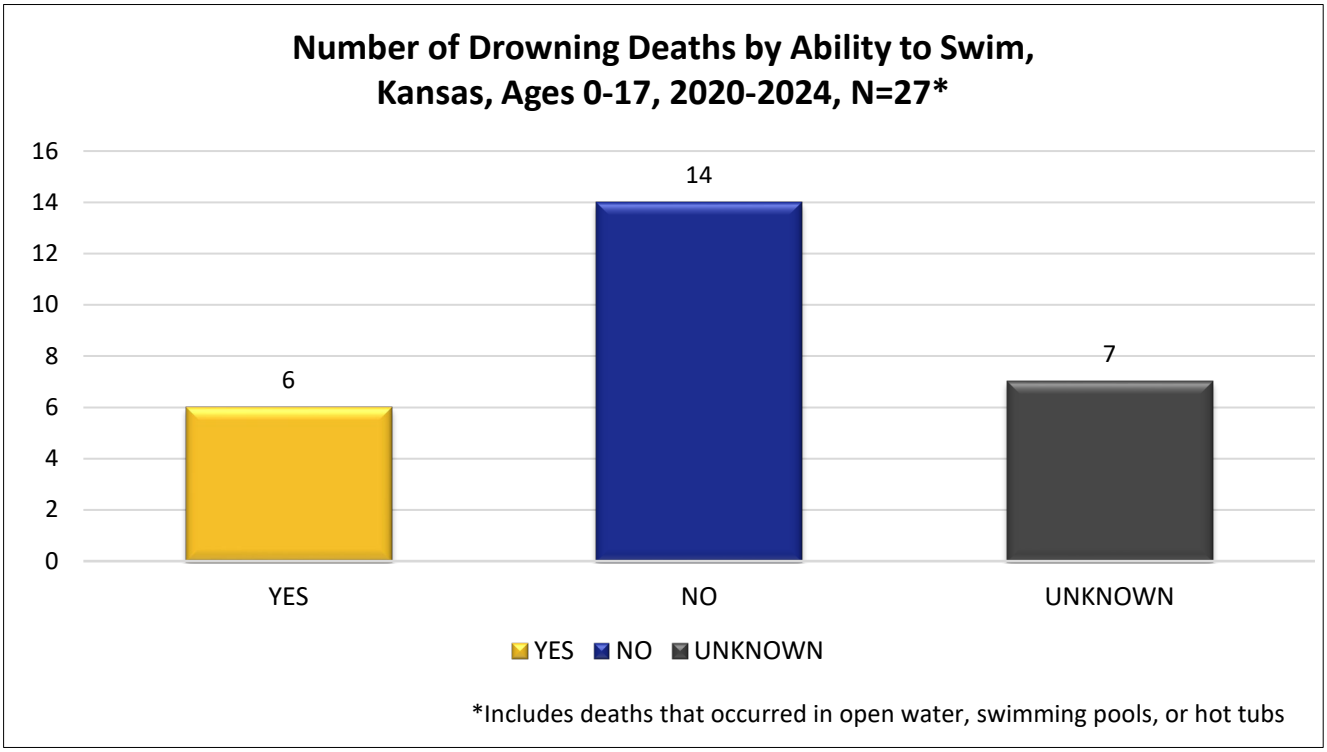
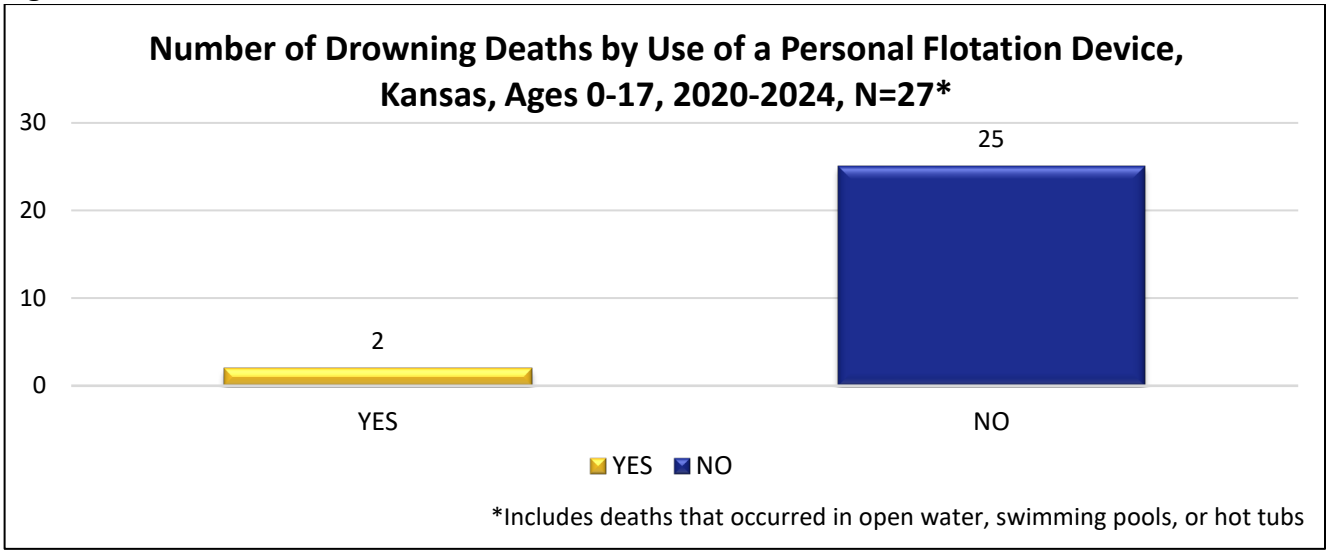


Figure 44 shows the number of deaths in open water, swimming pools, or hot tubs, based on the child's ability to swim. Only 22% of children who died from drowning in these water sources were reported to be able to swim, 52% were confirmed as not able to swim, and 26% had no documentation of swimming ability.

The use of personal flotation devices is essential for children of any age despite their ability to swim. Figure 45 documents the number of deaths associated with the use of a personal flotation device in open water, swimming pools, and hot tubs. Only two of the drowning deaths from 2020-2024 were reported to be wearing a personal flotation device at the time of death; both occurred in open water in 2021. While many children use inflatable floats, toys and foam noodles, the CDC recommends using only well-fitting Coast Guard-approved personal flotation devices.[20]

Figure 45



In 2022, the SCDRB 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.[18] 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 and ensure that all drowning deaths are investigated thoroughly.

The SCDRB is hopeful that with the use of a standardized investigation tool, thorough and accurate information will be collected to aid in understanding and preventing drowning deaths.

CHARACTERISTICS OF UNINTENTIONAL INJURY - DROWNING DEATHS, 2020-2024, N=33

- Kansas death rates declined during this reporting period and were consistently at or below the U.S. rate, with the exception of 2021 when the Kansas rate was higher
- 93% were not wearing a flotation device at the time of the drowning
- 76% had poor/absent supervision or neglect noted to be either a direct or contributing factor in the drowning
- 73% were male
- 48% were ages 1-4 years
- 29% of drowning deaths in pools lacked appropriate barriers to prevent access to the water

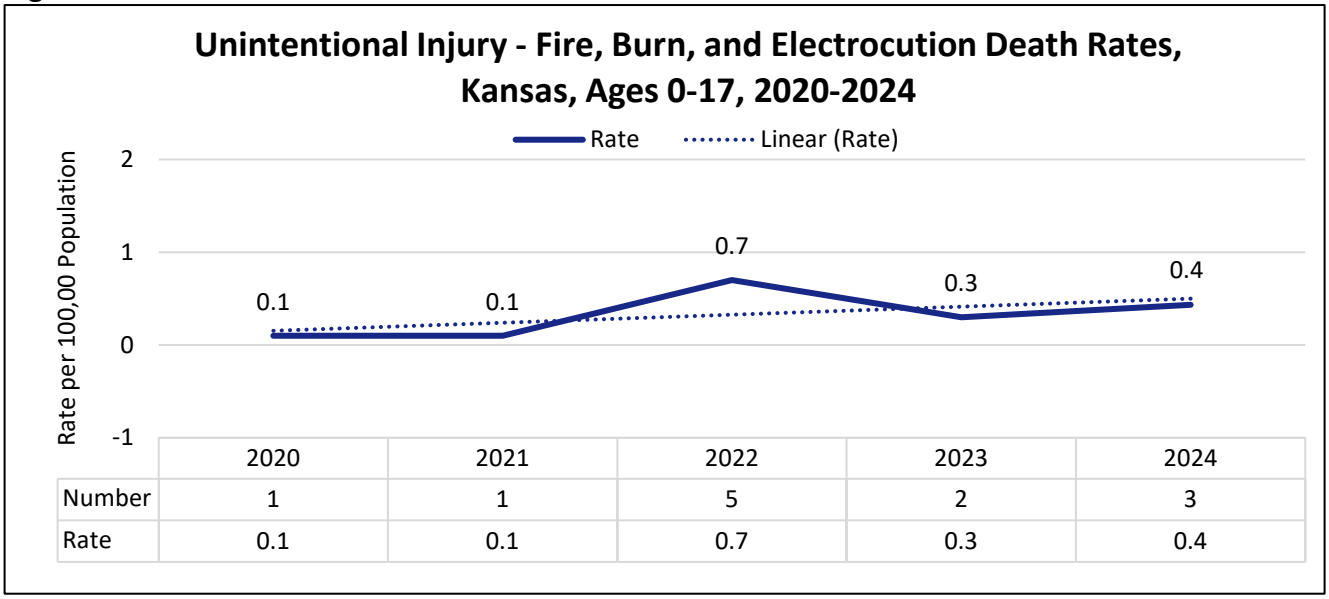
PREVENTION POINTS

- **Proper Supervision -** An adult should be designated to closely and constantly supervise any children who are in or near water, including bathtubs. Adults who are supervising must avoid distractions such as using phones, electronic devices, or reading.[19]
- **Learn Basic Swimming and Water Safety Skills -** Formal swimming lessons can reduce the risk of drowning and can be beneficial for children as early as age 1.[19]
- **Restriction/Barriers to Water -** Pools need to be enclosed on all four sides by a wall, fence, or barrier. Gates and locks should be utilized and there should be no gaps that children can slip through, or barriers low enough to climb over.[19]
- **Wear a Personal Flotation Device -** Personal flotation devices that are Coast Guard evaluated and approved reduce the risk of drowning and should be used by children around open water, regardless of their activity.[20]
- **Learn CPR -** Adults and caregivers should learn CPR. Immediate resuscitation can be the difference between life and death in a drowning situation, as every minute counts. Organizations such as the American Red Cross and the American Heart Association offer CPR courses.[19]

Unintentional Injury - Fire, Burn, and Electrocution Deaths

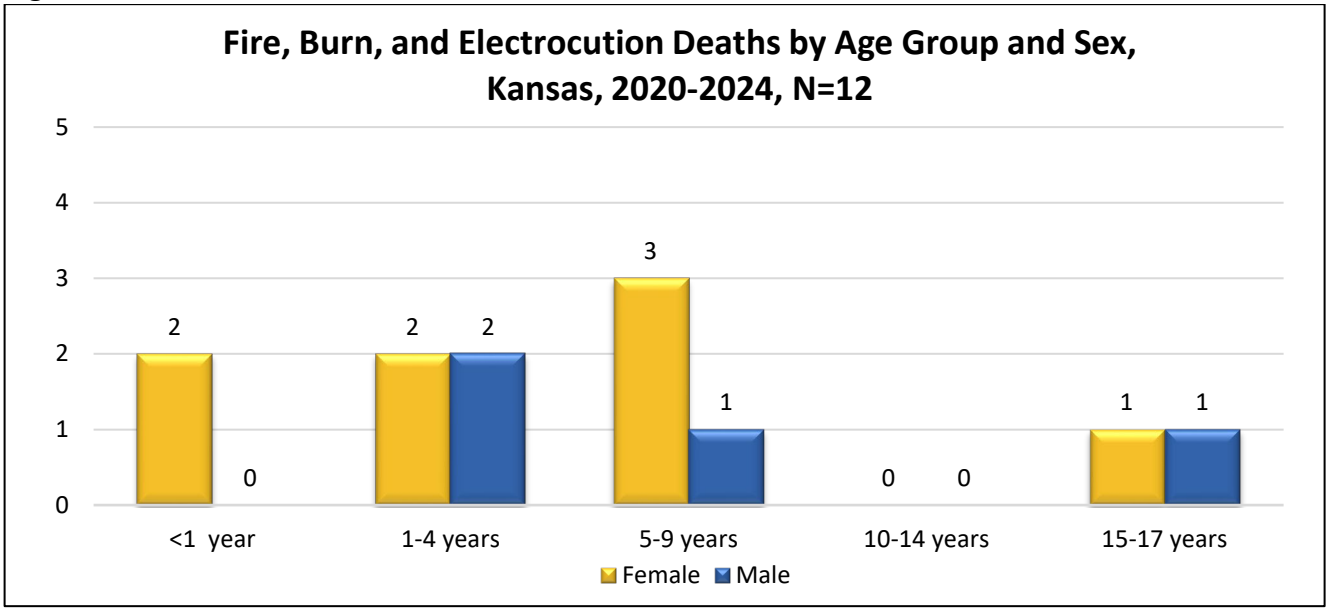
In 2024, there were three child deaths in Kansas due to unintentional fire, burn, or electrocution incidents. Death rates remained relatively low from 2020 through 2024, with some year-to-year fluctuation (Figure 46). Most deaths during the five-year period occurred among children under age 10, who accounted for 83% of deaths (Figure 47).

Figure 46



	2020	2021	2022	2023	2024
Number	1	1	5	2	3
Rate	0.1	0.1	0.7	0.3	0.4

Figure 47



Of the 12 deaths from 2020 through 2024, 10 were fire-related, one resulted from injuries sustained from a scald burn, and one resulted from electrocution. Figure 48 provides additional detail on smoke alarm presence in the 10 fire-related deaths. A working smoke alarm was confirmed in only 20% (2) of these incidents.

Figure 48

Prevalence of Smoke Alarms in Fire Deaths, Kansas, 2020-2024, N=10		
Was smoke alarm present?		**Number**
Yes		**2**
If yes, was it working properly?	Yes	2
	No	0
No		**6**
Unknown		**2**

CHARACTERISTICS OF UNINTENTIONAL INJURY - FIRE, BURN, AND ELECTROCUTION DEATHS, 2020-2024, N=12

- Kansas death rates have remained relatively stable over the last five reporting years
- Most deaths (83%) were fire-related; one death resulted from a scald burn and one from electrocution
- Among the 10 fire-related deaths
    - 80% occurred without a confirmed working smoke alarm
    - 60% had barriers to a safe exit identified at the location of the fire

PREVENTION POINTS

- **Proper Supervision -** Young children must be supervised closely. Leaving them unsupervised, especially if objects such as candles, lighters, or matches are within their reach, could result in a serious injury or death.
- **Prevent Access to Fire-Starting Materials -** Matches, lighters, candles, and other fire-starting materials should be kept away from children. Do not assume a young child cannot operate a lighter or match.
- **Working Smoke Alarms -** Install smoke alarms inside each bedroom, outside each sleeping area, and on every level of the home, including the basement. Test smoke alarms regularly to ensure they are working properly.
- **Emergency Fire Plan -** Everyone in the house, including the children, should know all exits from the house in case of a fire. Ensure that gates or clutter do not block exits. Designate a central meeting location outside of the home and have regular fire drills.
- **Electrical Safety -** Keep children away from electrical hazards, including outlets, cords, appliances, and downed or low-hanging power lines. When working around electrical equipment or high-voltage power lines, appropriate training, supervision, and clearly understood safety instructions are essential.

Unintentional Injury - Agriculture Deaths

The most recent census data from 2022 indicates there are likely more than 55,000 farms in Kansas, most of which are family owned.[22] 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 injuries and fatalities.

In the last five reporting years, Kansas experienced four agriculture-related child deaths. Although these deaths are few, agriculture-related injuries and deaths are largely preventable. In two cases, children ages 1-4 wandered into areas where heavy equipment was being operated and were struck or crushed by equipment whose operators were unaware the children were nearby. The other deaths involved children ages of 5-9 who were operating farm equipment or an ORV while participating in farm-related activities. These deaths highlight the importance of keeping young children separated from active farm work areas, providing close and consistent supervision, restricting the operation of farm equipment and vehicles to children who are developmentally capable and appropriately trained, and using recommended safety equipment, including helmets when operating ORVs.

It is vital for parents, caregivers, and children to understand the potential dangers present on a farm and take steps to prevent injury. Kansas Farm Bureau provides agriculture and farm safety education materials for all ages. For 75 years, Kansas Farm Bureau sponsored a Safety Poster Program for students in Grades 1-6 designed to help develop "safety-minded" youth.[22] Although the program concluded in 2025, educational materials and past contest winners remain accessible on their website. Pictured below is the 2025 Division III (5th and 6th grade), first-place poster, submitted by a student in Labette County.

Photo source: https://www.kfb.org/ArticleFile/file/c11f6ee9-9748-475c-b48b-f4131e422a6c/D3%201%20Shilo%20Herold.jpg

CHARACTERISTICS OF AGRICULTURE DEATHS, 2020-2024, N=4

- All involved farm equipment, vehicles, or ORVs
- All were male
- 50% were ages 1-4, and 50% were ages 5-9
- 50% were backover deaths involving children under age of 5

PREVENTION POINTS

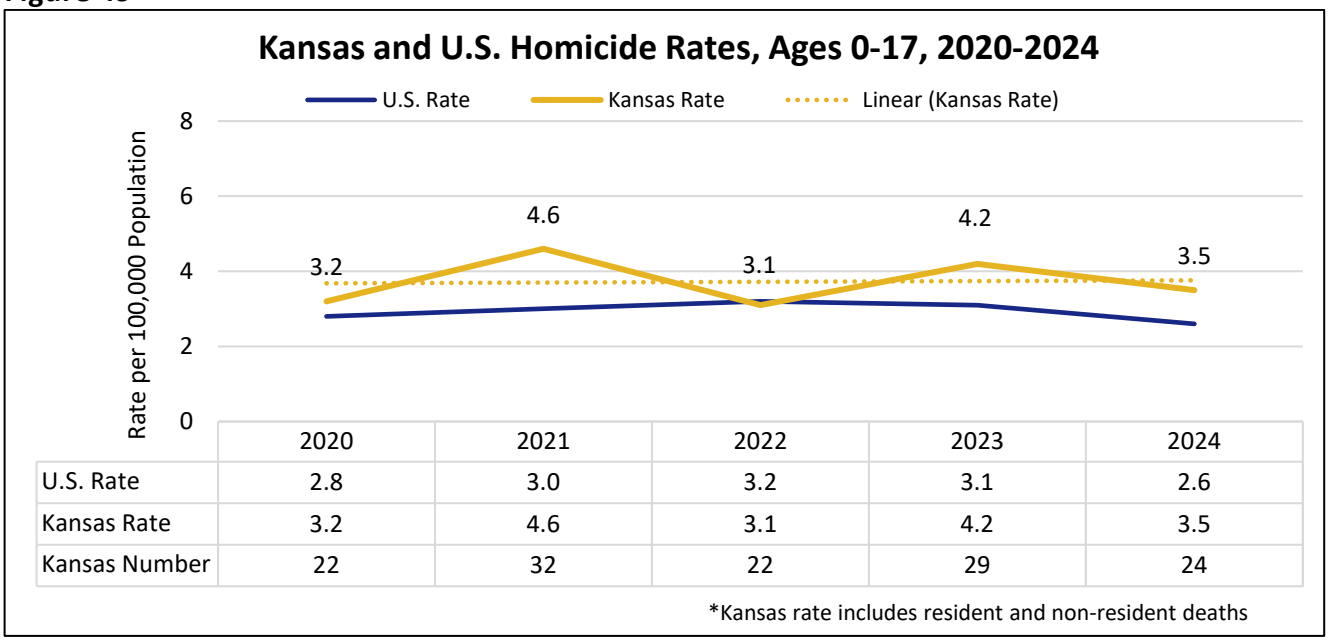
- **Proper Supervision -** Parents and caregivers should provide undivided attention and not engage in farm work while supervising young children. As children learn to assist with farm-related tasks, supervision and guidance are critical until they demonstrate the ability to safely perform tasks appropriate for their age and development.[21]
- **Preventing Backovers -** Before moving farm equipment or vehicles, operators should check the area around the vehicle and confirm that children are in a safe location. Young children should be kept away from areas where tractors, trucks, and other equipment are being operated.
- **Safety Around Power Take-Off (PTO) -** Injuries and fatalities have been reported from entanglement in PTOs. Safety shields should always be in place and in good working condition. Furthermore, children should never step on or jump over a PTO, as clothing can become entangled in moving parts. PTOs should be disengaged when not in use.[21]
- **Equipment Safety -** Children should not operate machinery such as lawn mowers, tractors, or ORVs until they are appropriately trained and developmentally capable of safely operating the equipment. Drivers and riders of ORVs and other farm equipment should use appropriate safety equipment, including helmets, eye protection, and protective clothing.[21]
- **Safe Play Area -** Children should have a safe place to play where they are supervised and protected from potential hazards, and away from roadways and areas where equipment is operated.[21]

HOMICIDES

Homicides are due to an intentional, unintentional, or criminally negligent act leading to the death of another human being. From 2020-2024, there were 129 child homicides in Kansas, including 24 in 2024.

Figure 49 compares Kansas and U.S. homicide rates from 2020-2024. Kansas homicide rates remained relatively stable during this period, with rates exceeding the U.S. each year except 2022.

Figure 49

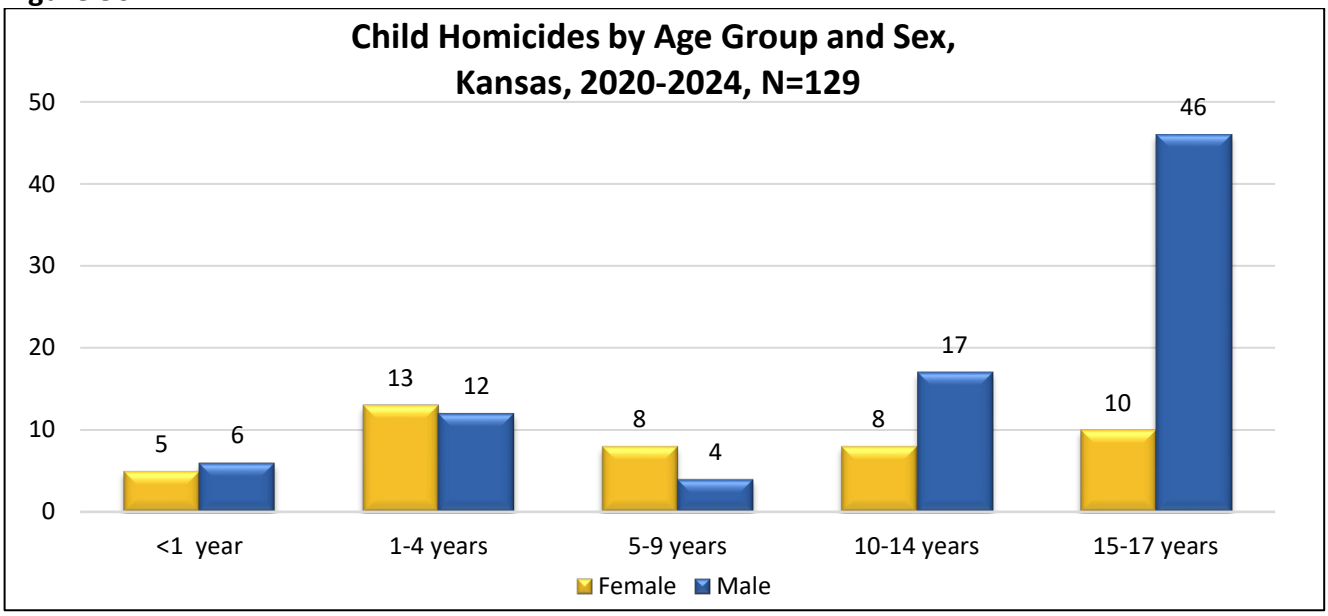


	2020	2021	2022	2023	2024
U.S. Rate	2.8	3.0	3.2	3.1	2.6
Kansas Rate	3.2	4.6	3.1	4.2	3.5
Kansas Number	22	32	22	29	24

*Kansas rate includes resident and non-resident deaths

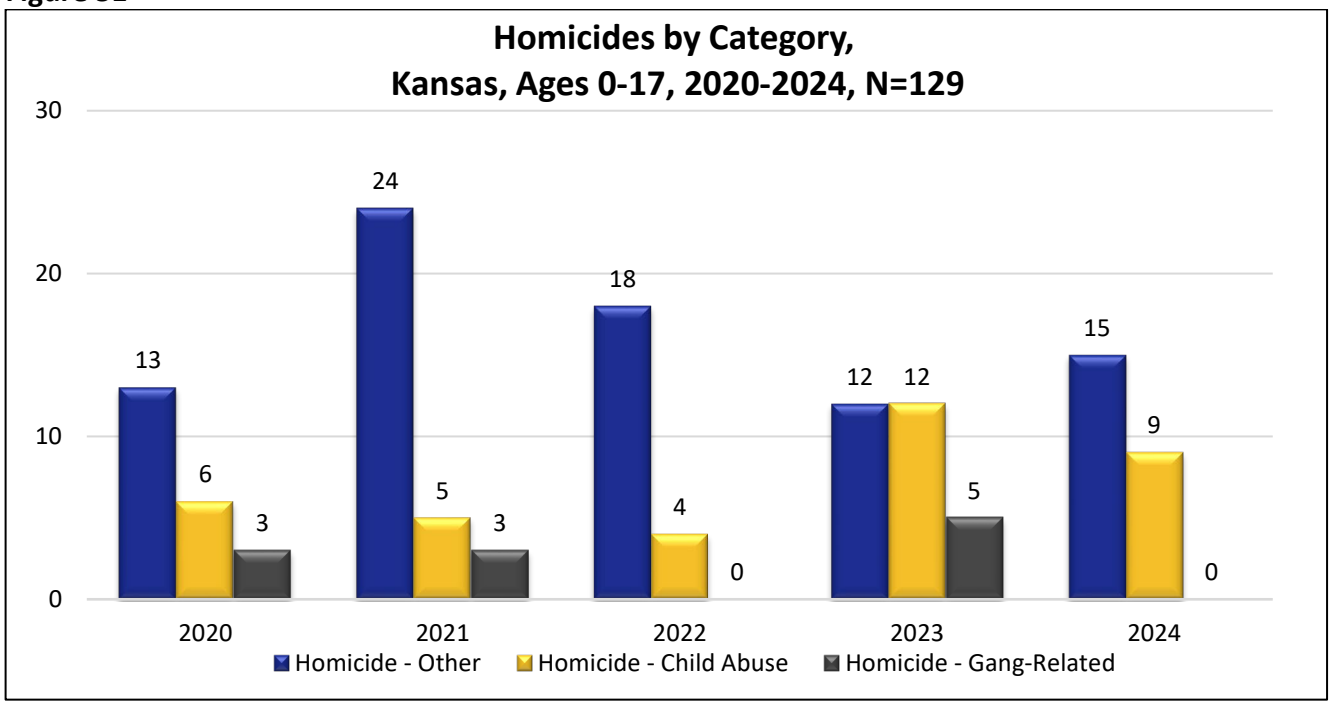
Figure 50 shows homicides by age and sex. The 15-17 age group accounted for 43% of homicides, while the lowest percentage, 9%, were infant deaths. Additionally, males were disproportionately affected, accounting for 66% of homicide victims, compared with 34% for females.

Figure 50



Each child homicide is categorized into one of three categories: child abuse homicides, gang-related homicides, and other homicides. These categories allow the SCDRB to examine circumstances and risk factors specific to each type of homicide. Each category is further described and examined in the subsections that follow.

Figure 51



Of the 129 homicides from 2020-2024, 28% (36) were categorized as child abuse homicides and 9% (11) as gang-related homicides. The remaining 64% (82), which did not meet the definition of child abuse or gang-related homicide, were categorized as "other homicides".

CHARACTERISTICS OF HOMICIDES, 2020-2024, N=129

- Between 2023 and 2024, the child homicide death rate decreased by 17% but remains high relative to previous years
- 76% had caregivers with current or prior involvement with child protective services (DCF)
- 66% were male
- 34% (44) were related to interpersonal violence or domestic violence
    - 6 of these deaths resulted from a murder-suicide; in 3, the perpetrator was identified as the biological father of the decedent, 2 were the biological mother of the decedent, and 1 was the mother's significant other
- 33% of decedents had toxicology findings positive for alcohol and/or illicit drugs at death, including, marijuana (41), alcohol (7), opioids (5), amphetamine/methamphetamine (3), and cocaine (2); some tested positive for multiple substances
- 13% occurred when the decedent was either the buyer, dealer, or victim of retaliation during a drug transaction
- 12% (16) were found by the SCDRB to have sufficient evidence to classify the manner of death as homicide, although the death certificate classified the death differently
    - 1 had been certified as a natural death, 4 as unintentional injuries, and 11 as undetermined

PREVENTION POINTS

- **Family Violence -** The safety of children living in homes where domestic violence occurs needs to be addressed by child protective services (DCF) and law enforcement when visits are made to the home. Children living in such environments are at increased risk of abuse, neglect, or death.
- **Drug Environments -** Children living in environments where they are exposed to caregivers with substance use disorders (including illicit drugs, prescription medications, and alcohol) are at increased risk of abuse, neglect, or death. If substance use in the home is suspected, the safety of the children must be addressed. Furthermore, youth who buy or sell drugs are at an increased risk of death from homicide.
- **Education for Caregivers of Young Children -** The victims of child abuse homicide are most often younger ages. Frustrated caregivers with minimal parenting training, who have unrealistic expectations for children's behavior and a lack of appreciation for the vulnerability of small children, create a high-risk situation. Education should be provided at all points of contact with parents and caregivers, especially addressing positive ways to respond to infant crying and child discipline, supporting parents through stressful periods, and adjusting work policies to give parents quality time with their young children.
- **Education about Signs of Child Abuse -** Active children are expected to have bruises and bumps from everyday play. These bruises are most often over bony areas such as the knees, elbows, and shins. If a child has injuries on areas such as the cheeks, ears, mouth, stomach, buttocks, or thighs, the possibility that the child is being abused must be considered. Bruises in these areas, human bite marks, round burns the size of a cigarette, or larger poorly explained burns seldom come from everyday activities. Young children who are not crawling or walking rarely sustain bruises. Any bruises noted on a child less than 9 months of age, especially if recurrent, patterned, or in unusual locations on the body, should be evaluated for the possibility of abuse.
- **Report any Concerns for Child Abuse and Neglect -** If there is suspicion a child is being abused or neglected, a report should be made to the Kansas Protection Report Center at 1-800-922-5330 (toll-free) or 911 if the child is in imminent danger.

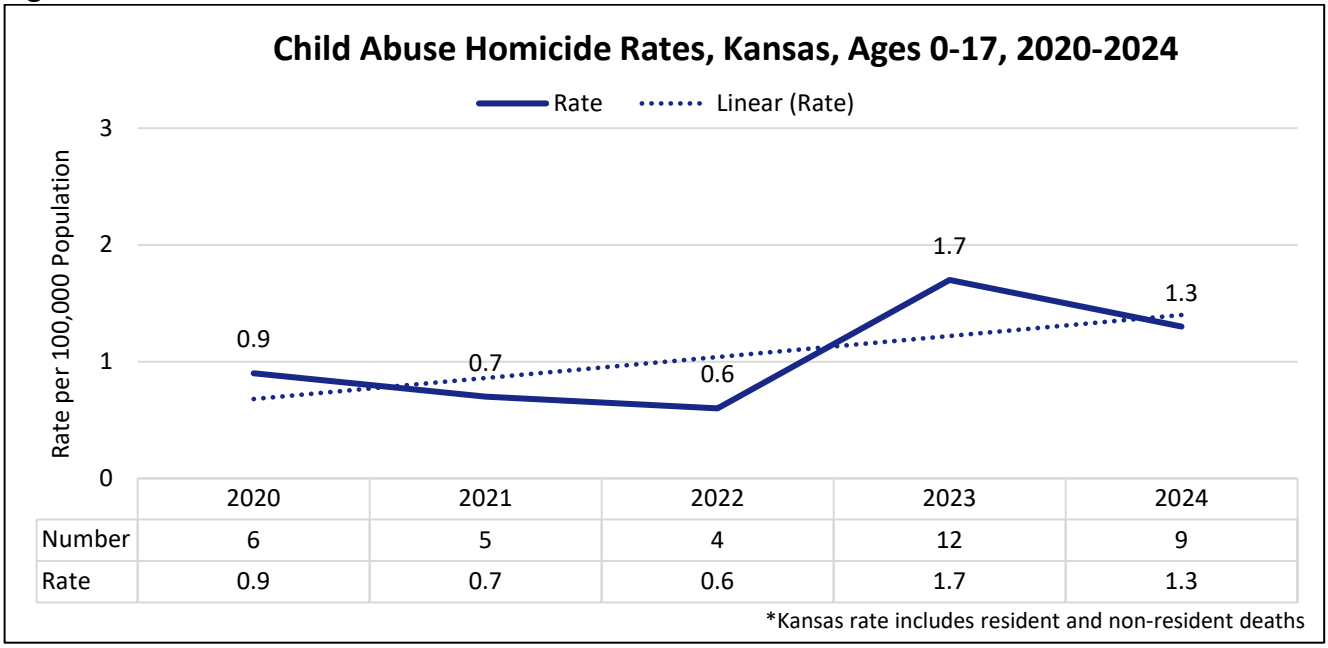
Homicide - Child Abuse

From 2020-2024, 36 homicides were attributed to child abuse, including 9 deaths in 2024. The SCDRB defines child abuse homicide as a death resulting from either:

- **Abuse**: the intentional infliction of injury, often as a form of punishment or in response to frustration with behaviors such as crying or perceived misbehavior.
- **Neglect**: the failure of a caretaker to provide basic needs such as safety, supervision, nutritional, or medical care.

Figure 52 shows the Kansas child abuse homicide rate from 2020-2024. Of particular concern is that, after declining from 2020 through 2022, the rate increased sharply in 2023 and remained relatively elevated in 2024.

Figure 52



	2020	2021	2022	2023	2024
Number	6	5	4	12	9
Rate	0.9	0.7	0.6	1.7	1.3

*Kansas rate includes resident and non-resident deaths

Child abuse is a complex and multifaceted issue often stemming from factors such as caregiver history of childhood trauma, financial stress, domestic violence, substance use, mental illness, and unrealistic expectations of child behavior. Very young children are especially vulnerable because they are dependent on caregivers, unable to protect themselves, and may exhibit developmentally normal behaviors, such as frequent crying, that can trigger frustration in overwhelmed caregivers.

SCDRB data reflect characteristics of child abuse homicides identified in research from other states. Younger children are at disproportionately high risk of child abuse fatalities, and these deaths often have characteristics that differ from homicides among older youth. Research indicates that infant homicides are most often perpetrated by someone in a caregiving role, with many perpetrators under age 25. More than 80% occur in the child's home, and in more than half of cases, there are suspicions of prior abuse of the victim by the perpetrator or another person, or prior abuse of another child by the perpetrator. In sharp contrast to homicides among older youth, where the majority involve weapons, most infant and young child homicides result from beating, shaking, or strangulation by someone entrusted with the child's care.[23]

Figure 53

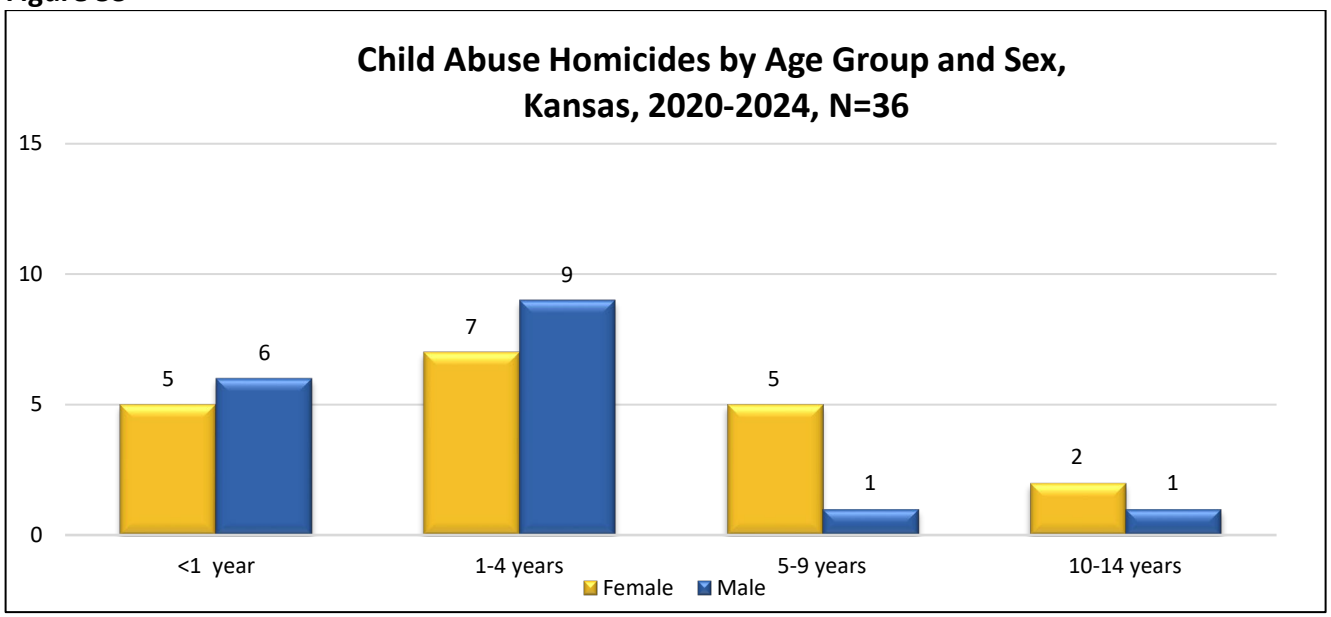


Figure 53 shows that 75% (27) of child abuse homicides occurred among children under age 5, including 31% (11) among infants under age one and 44% (16) among children ages 1-4. Children ages 5-9 accounted for 17% (6) of deaths, while 8% (3) occurred among children ages 10-14, with no deaths among youth ages 15-17. Two of the deaths among children ages 10-14 were the delayed result of abuse injuries sustained in infancy.

Overall, females accounted for 53% (19) of child abuse homicides and males accounted for 47% (17). Males accounted for more deaths among children under age 5, while females accounted for most deaths among children ages 5-14.

Figure 54 provides characteristics of the 36 child abuse homicides, including characteristics of physical abuse and neglect and triggering events associated with physical abuse. The mechanisms of injury in child abuse homicides are of varied types. In general, most occur as a result of blunt force trauma. The most prevalent form is Abusive Head Trauma (AHT), which occurs when an infant or toddler is severely or violently shaken or struck, resulting in serious injury to the brain and/or death. It is important to note that it is common for children who die from AHT to have autopsy evidence of blunt force injuries without visible external evidence of impact. Among the 32 physical abuse homicides, 84% (27) involved AHT, 44% (14) involved shaking, and 34% (11) involved beating or kicking.

Figure 54

Characteristics of Child Abuse and Neglect Homicides, Kansas, Ages 0-17, 2020-2024		
Child Physical Abuse Characteristics	**N=32**	**Percentage**
Abusive Head Trauma	27	84%
Child Shaken	14	44%
Beating/Kicking	11	34%
Chronic Battered Child Syndrome	9	28%
Scalding/Burning	3	9%
Strangulation/Suffocation	2	6%
Sexual Assault	1	3%
Child Neglect Characteristics	**N=4**	**Percentage**
Deprivation of Necessities (Food/Water)	3	75%
Medical Neglect	2	50%
Triggering Events Among Physical Abuse Homicides	**N=32**	**Percentage**
Unknown	18	56%
Crying	12	38%
Other (includes interrupting video gaming, not sleeping, and normal toddler behavior)	5	16%
Feeding Problems	2	6%
Toilet Training	2	6%
Disobedience	1	3%
Domestic Violence	1	3%
Note: Child physical abuse/neglect characteristics and triggering events are not mutually exclusive; more than one may be identified in a single death. Therefore, percentages within each section may total more than 100%. Triggering events are reported only for physical abuse homicides		

Caring for children can be overwhelming at times. Parents and caregivers may face multiple stressors with limited access to support. Risk factors associated with child abuse homicides include maternal risk factors such as young age, less than 12 years of education, and single-parent status, as well as household risk factors such as a non-biological caregiver in the home, prior substantiation of child abuse and neglect, substance use disorders, and low socioeconomic status. [1] Consistent with these known risk factors, SCDRB data identified biological parents and a mother's significant other† as the most frequently identified suspected perpetrators of child abuse homicides (Figure 55).

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

Figure 55 categorizes the suspected perpetrators identified in child abuse homicides from 2020-2024. More than one suspected perpetrator may be identified in a single death; therefore, the number of suspected perpetrators exceeds the 36 child abuse homicides. Biological parents were the most frequently identified suspected perpetrators, including 16 biological fathers and 9 biological mothers. A mother's significant other was identified in 8 deaths.

Figure 55

Child Abuse Homicides, by Suspected Perpetrator, Kansas, Ages 0-17, 2020-2024, N=36		
Perpetrator(s) Relationship to Child	**Number**	**Percentage**
Biological Father	16	44%
Biological Mother	9	25%
Mother's Significant Other	8	22%
Father's Significant Other	3	8%
Biological Parent's Acquaintance or Friend	3	8%
Sibling	2	6%
Adoptive Parents	1	3%
Unlicensed Child Care Provider	1	3%
Note: More than one suspected perpetrator may be identified in a single death; therefore, categories are not mutually exclusive, counts may total more than N=36, and percentages may total more than 100%		

Child abuse homicides call for attention aimed at prevention. Effective methods for preventing child abuse involve programs that enhance parenting skills for at-risk parents. Examples include home visits by nurses who provide information on quality childhood programs, coaching in parenting skills which includes parent training and education about normal childhood behaviors and age-appropriate discipline, and information on how to select appropriate child care providers. Educational programs to identify abuse cases before they lead to severe injuries or death, and to teach skills for dealing with angry and impulsive responses to infant crying and frustrating behaviors are needed.[1]

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

If there is suspicion a child is being abused or neglected, a report should be made to the Kansas Protection Report Center at 1-800-922-5330 (toll-free) or 911 if the child is in imminent danger.

CHILD ABUSE CASE VIGNETTE

Severe Neglect and Malnutrition

A Kansas toddler had normal growth and development through six months of age, with weight consistently between the 40th and 50th percentiles. By the nine-month well-child visit, the child had lost nearly a pound and dropped to the 1st percentile for weight. The feeding history provided by the mother did not explain the significant weight loss. The mother was asked to keep a food diary and return for close weight monitoring. During this period, the child gained more than a pound, demonstrating an ability to gain weight when adequate nutrition was provided. At the 12-month visit, the child's weight had improved to the 8th percentile and the next visit was scheduled for 15 months. Approximately one month before that appointment, the child was found unresponsive at home and pronounced deceased at the scene. At autopsy, the child weighed approximately 1½ pounds less than at the 12-month medical visit. Skin injuries were consistent with insect activity and probable physical abuse.

The death investigation revealed extremely poor conditions throughout the home, including accumulated trash and food, cockroach and bed bug infestation, and a heavily soiled playpen used as the child's crib. Responders observed insects on and around the child. Marijuana was found in multiple areas of the home, including in a small bag underneath the child's body. The home was extremely hot, with the living area where the child slept measuring approximately 96 degrees. The mother reported giving the child pediatric nutritional drinks to assist with weight gain but stated the family had been without them for several days. Subsequent drug testing of the mother was positive for methamphetamine.

DCF became involved following the death and observed the conditions of the home during the joint DCF and law enforcement investigation. The surviving sibling was placed in police protective custody. Physical neglect allegations were affirmed. The family subsequently received preservation services and assistance from community and family resources to address the infestation and obtain new beds, furniture, and bedding.

SCDRB REFLECTION

Young children experiencing significant growth faltering require close follow-up to determine the cause and ensure improvement is sustained. When a child gains weight during periods of increased oversight but loses weight in periods of decreased monitoring, healthcare providers should ask for a DCF assessment of the family's environment and resources, initiate more frequent follow-up, and refer to appropriate community services.

It is also important to distinguish poverty from neglect. Limited financial resources alone do not constitute neglect. Families experiencing poverty should be connected with services and supports to help meet their children's needs. In this case, however, the concerns extended beyond a lack of financial resources and included severe malnutrition and dehydration, hazardous and unsanitary living conditions, extreme heat, insect infestation, accessible marijuana, caregiver substance use, and unmet medical needs. The assistance provided to the family following the death also demonstrates the importance of identifying needs and connecting families with available community resources before conditions place a child at serious risk. Caregiver functioning and the ability of all adults in the home to consistently provide adequate nutrition, medical care, supervision, and a safe living environment should be considered when assessing the safety of a young child.

CHARACTERISTICS OF CHILD ABUSE HOMICIDES, 2020-2024, N=36

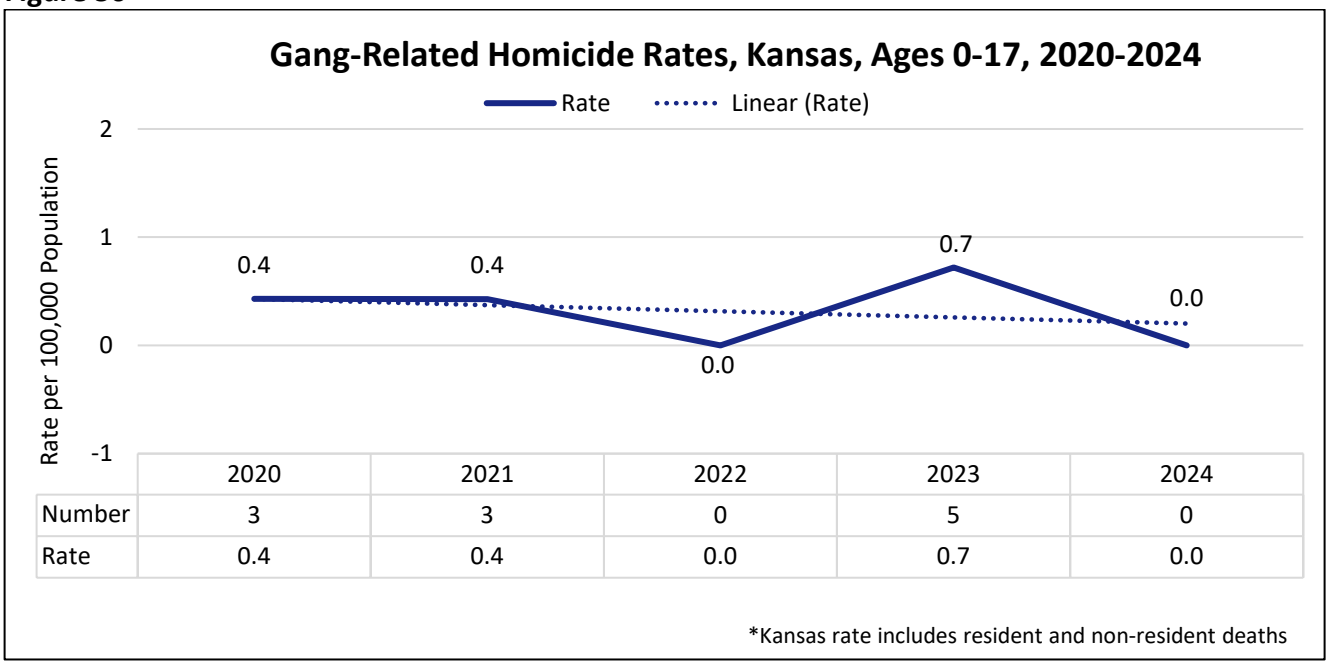
- After a steady decline from 2020-2022, the Kansas child abuse homicide death rate increased sharply in 2023 and remained relatively elevated in 2024
- 86% had caregivers with current or prior involvement with child protective services (DCF)
- 84% of physical abuse homicides involved abusive head trauma
- 81% had evidence of prior abuse
- 75% occurred among children under age 5
- 67% had caregivers with a history of substance use
- 61% of child abuse homicides involved a biological parent as a suspected perpetrator
- 38% of physical abuse homicides identified crying as a triggering event
- 31% involved prior removal of the decedent or a sibling from the home
- 17% had an open child protective services (DCF) case at the time of death

Homicide - Gang-Related

The SCDRB categorizes a homicide as the result of gang violence when there is evidence to support the child died from direct or indirect actions carried out by known or suspected gang members. In many of the cases reviewed, children were at the "wrong place at the wrong time" and were the unintentional victims of gang violence. This can occur while a 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 are members of a gang and die during disputes related to gang activity.

Figure 56 shows the rate of homicides due to gang violence over the last five reporting years. Between the years of 2020 and 2024 there have been 11 gang-related homicides, with 0 occurring in 2024.

Figure 56

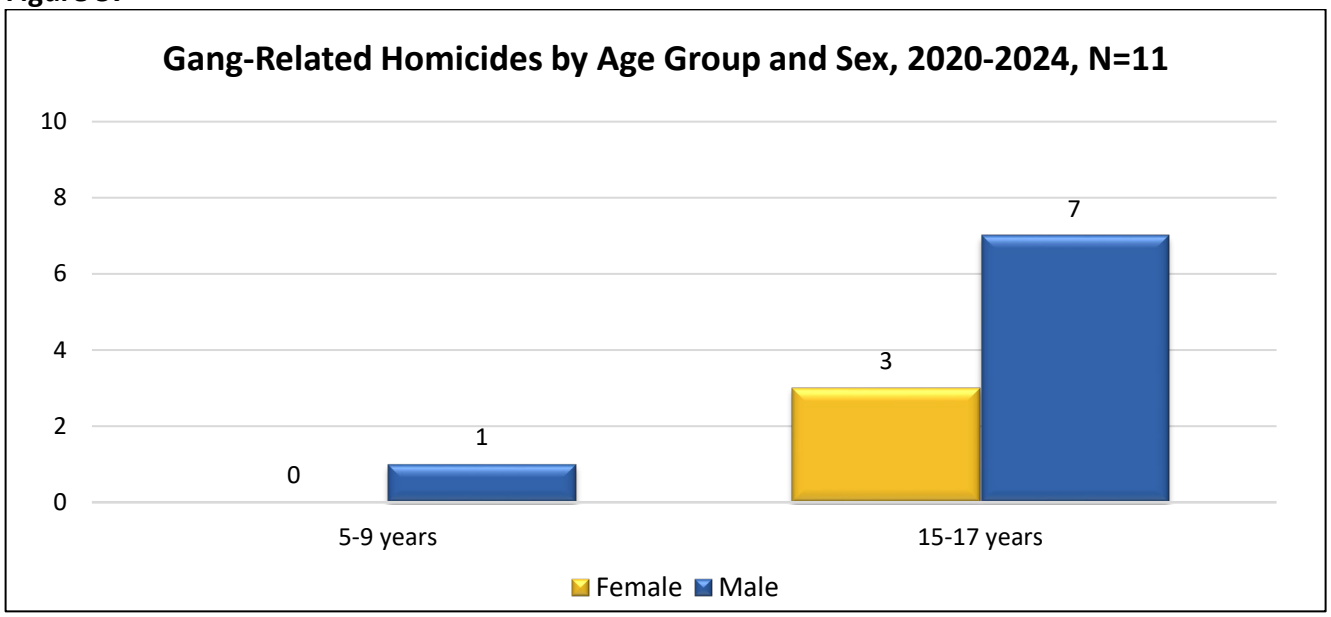


	2020	2021	2022	2023	2024
Number	3	3	0	5	0
Rate	0.4	0.4	0.0	0.7	0.0

*Kansas rate includes resident and non-resident deaths

Figure 57 describes the age group and sex of the 11 gang-related homicides over the last five reporting years. Of the victims identified, 73% were male, and all but one were ages 15-17. Gang-related violence can have devastating consequences for innocent children, including unintended targets, such as the child under the age of 9.

Figure 57



CHARACTERISTICS OF GANG-RELATED HOMICIDES, 2020-2024, N=11

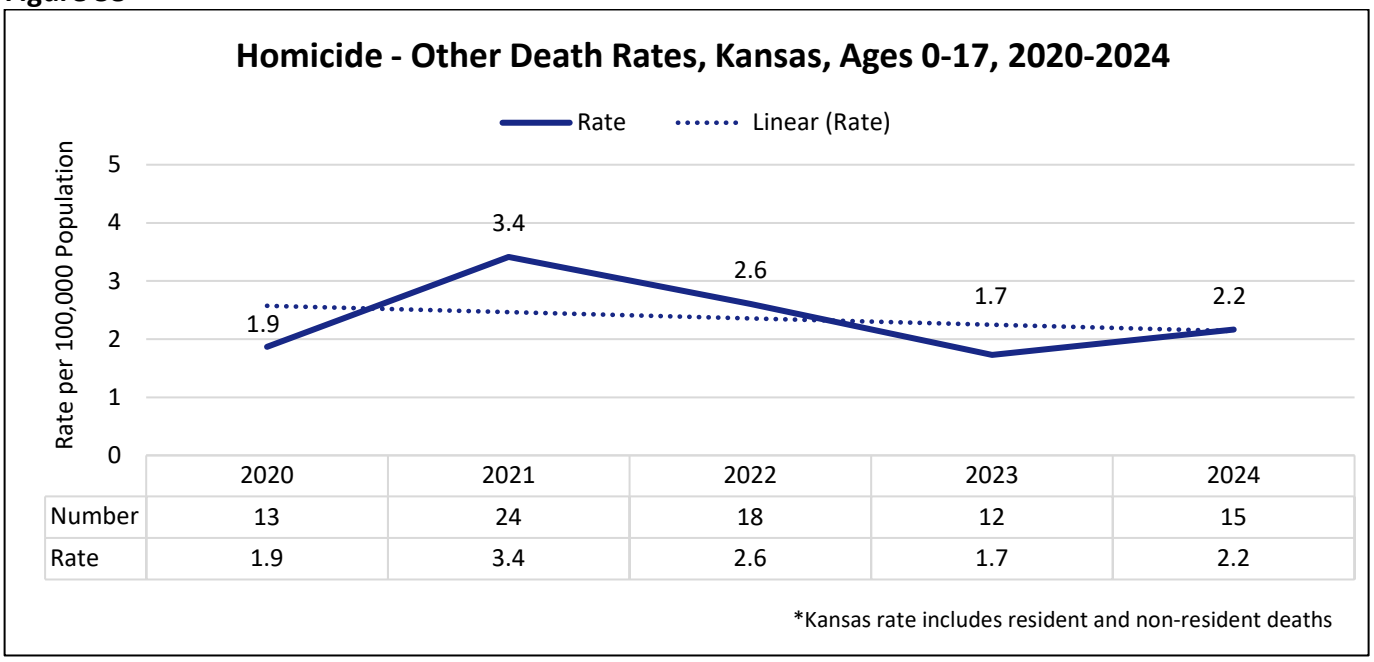
- 100% involved a firearm
- 91% were ages 15-17 years old
- 73% of victims were male
- 55% had caregivers with current or prior involvement with child protective services (DCF)
- 36% of decedents had positive toxicology findings for alcohol and/or illicit drugs

Homicide - Other

Homicides that do not meet the SCDRB definition of child abuse or gang-related homicide are categorized as Homicide - Other. These deaths encompass a wide range of circumstances. In some cases, the circumstances or motivation for the homicide may be unclear, while in others, the reason for the violence is known but is unrelated to child abuse or gang-related activity. Homicide - Other deaths may include interpersonal or domestic violence, drug-related incidents, retaliation, and other acts of violence. From 2020-2024, 82 child homicides were categorized as Homicide - Other, including 15 deaths in 2024.

Figure 58 presents Homicide - Other death rates for Kansas children ages 0-17 from 2020-2024. Following a peak in 2021, rates generally trended downward through 2024, despite an increase between 2023 and 2024.

Figure 58



	2020	2021	2022	2023	2024
Number	13	24	18	12	15
Rate	1.9	3.4	2.6	1.7	2.2

*Kansas rate includes resident and non-resident deaths

CHARACTERISTICS OF HOMICIDES - OTHER, 2020-2024, N=82

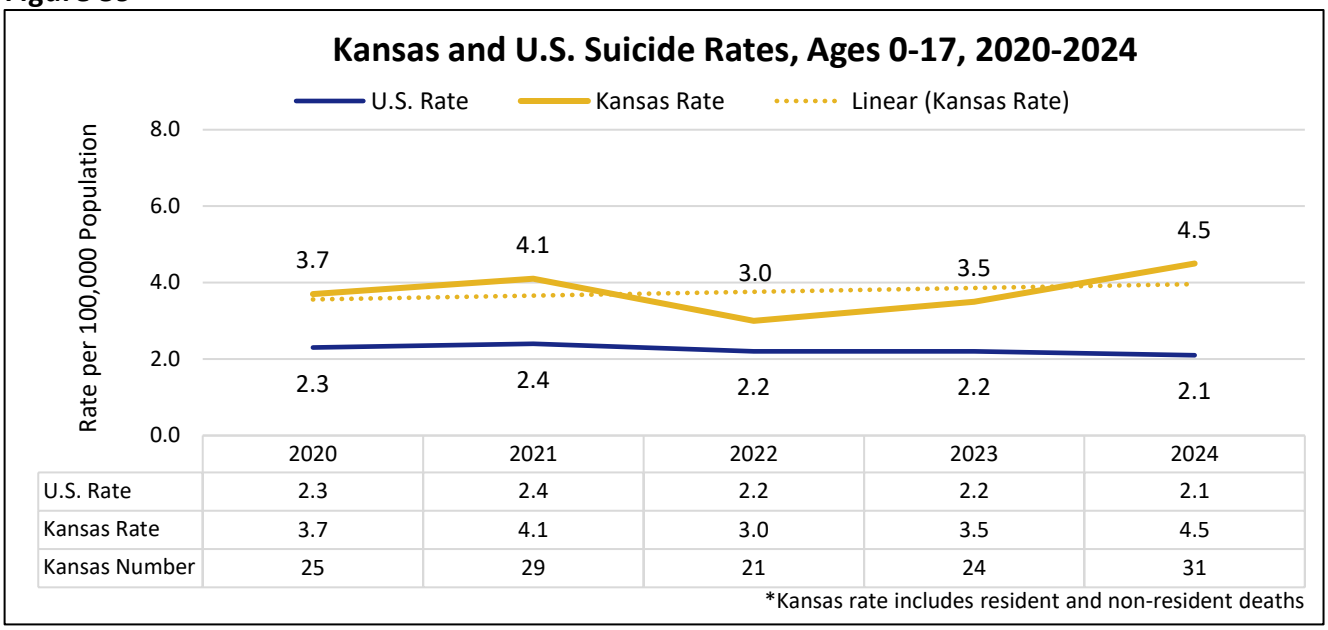
- 87% died from a firearm injury
- 74% had caregivers with current or prior involvement with child protective services (DCF)
- 70% involved interpersonal violence
- 56% were ages 15-17, 27% were ages 10-14, 11% were ages 1-4, and 6% were ages 5-9
- 24% occurred in connection with a drug or gun transaction, including deaths in which the decedent was a buyer, seller, or the victim of retaliation related to the transaction
- 18% involved domestic violence
- 12% resulted from an unintentional shooting while a firearm was being handled, played with, or shown to others
    - These deaths, although unintentional in nature, are ruled as homicides due to a criminally negligent act leading to the death of a person
- 7% involved a murder-suicide

SUICIDES

Suicide is the intentional taking of one's own life. According to the CDC, in 2024, suicide was the second leading manner of death for children ages 10-14 and the third leading manner of death for youth ages 15-19, after unintentional injury and homicide.[29]

Figure 59 compares Kansas and U.S. suicide rates among children ages 0-17 from 2020-2024. Kansas suicide rates exceeded U.S. rates in each of the five reporting years. In 2024, the Kansas suicide rate increased to the highest rate during the five-year period and more than twice the U.S. rate.

Figure 59



	2020	2021	2022	2023	2024
U.S. Rate	2.3	2.4	2.2	2.2	2.1
Kansas Rate	3.7	4.1	3.0	3.5	4.5
Kansas Number	25	29	21	24	31

*Kansas rate includes resident and non-resident deaths

Figure 60 shows suicide deaths in Kansas by age group and sex from 2020-2024. Of the 130 suicide deaths, 78% (101) were male and 70% (91) occurred among youth ages 15-17. National research indicates that adolescent females are more likely to attempt suicide, while adolescent males are more likely to die by suicide.

Figure 60

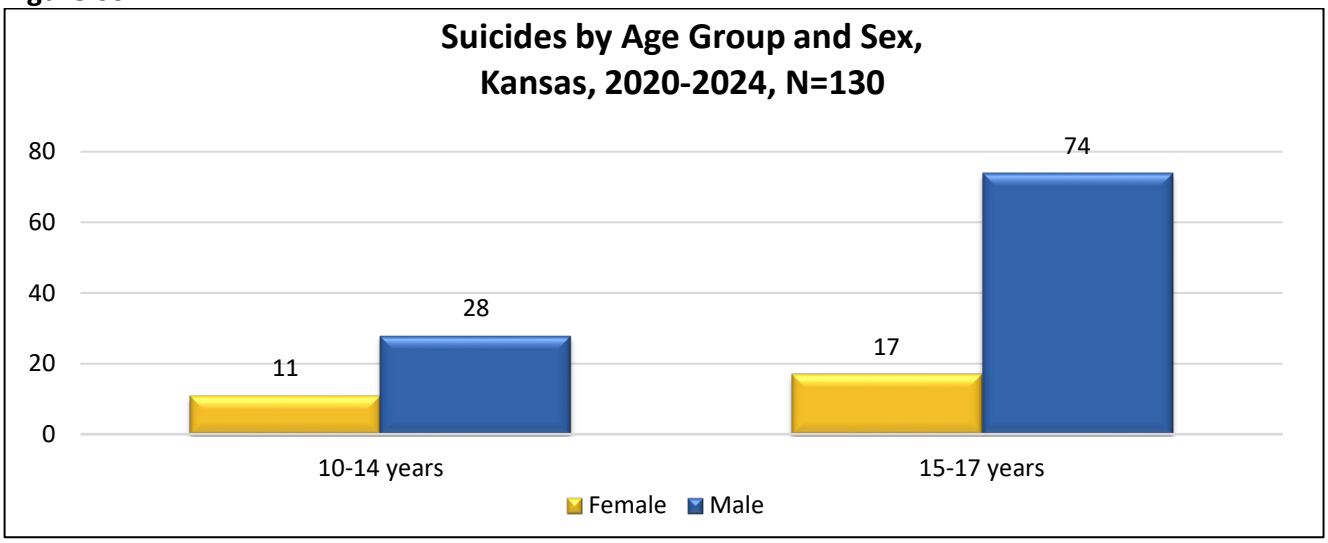


Figure 61 shows the methods of suicide by sex among Kansas youth from 2020-2024. Firearms were the most common method, accounting for 60% (78) of the 130 suicide deaths, followed by asphyxia at 30% (39). Among males, firearms were the most common method of suicide, while firearm and asphyxia deaths occurred equally among females.

Many suicide attempts, as well as suicides reviewed by the SCDRB, occur when a child is experiencing a short-term crisis. It is important for parents and caregivers to prevent access to lethal means, particularly during periods of increased risk for suicide or self-harm.

Figure 61

Suicides by Method and Sex, Kansas, 2020-2024, N=130			
Method	**Male**	**Female**	**Total**
Firearm	66	12	**78**
Asphyxia	27	12	**39**
Other Transport (Train or MVC)	4	1	**5**
Overdose	1	3	**4**
Fall or Crush	3	0	**3**
Drowning	1	0	**1**
Total	**102**	**28**	**130**

While there were only four suicide deaths by overdose, toxicology testing at the time of death revealed that 29% (38) of the 130 youth who died by suicide had positive toxicology findings for alcohol and/or illicit drugs at the time of death. Among those with positive toxicology findings, 55% (21) were positive for marijuana, 26% (10) for alcohol, and 11% (4) for opioids. A smaller proportion tested positive for cocaine, methamphetamine, or ketamine, and some tested positive for more than one substance at the time of death.

Figure 62 presents contributing risk factors identified in suicide deaths among Kansas youth ages 10-17 from 2020-2024, organized into five categories: relationship stressors, problems in school, trauma, mental health, and suicidal ideation. These categories demonstrate how risk can emerge across different areas of a youth's life.

Relationship stressors included family discord, breakups, and bullying. Although not all cases are investigated as thoroughly as others, in those where risk factors were known, nearly one-third of youth, 32% (42), had recent family discord, including arguments with a parent or caregiver. Additionally, 12% (16) were victims of bullying, including four cases involving cyberbullying. Problems in school included academic difficulties, behavioral concerns, and truancy, with 28% (37) experiencing academic difficulties and 27% (35) having behavioral concerns.

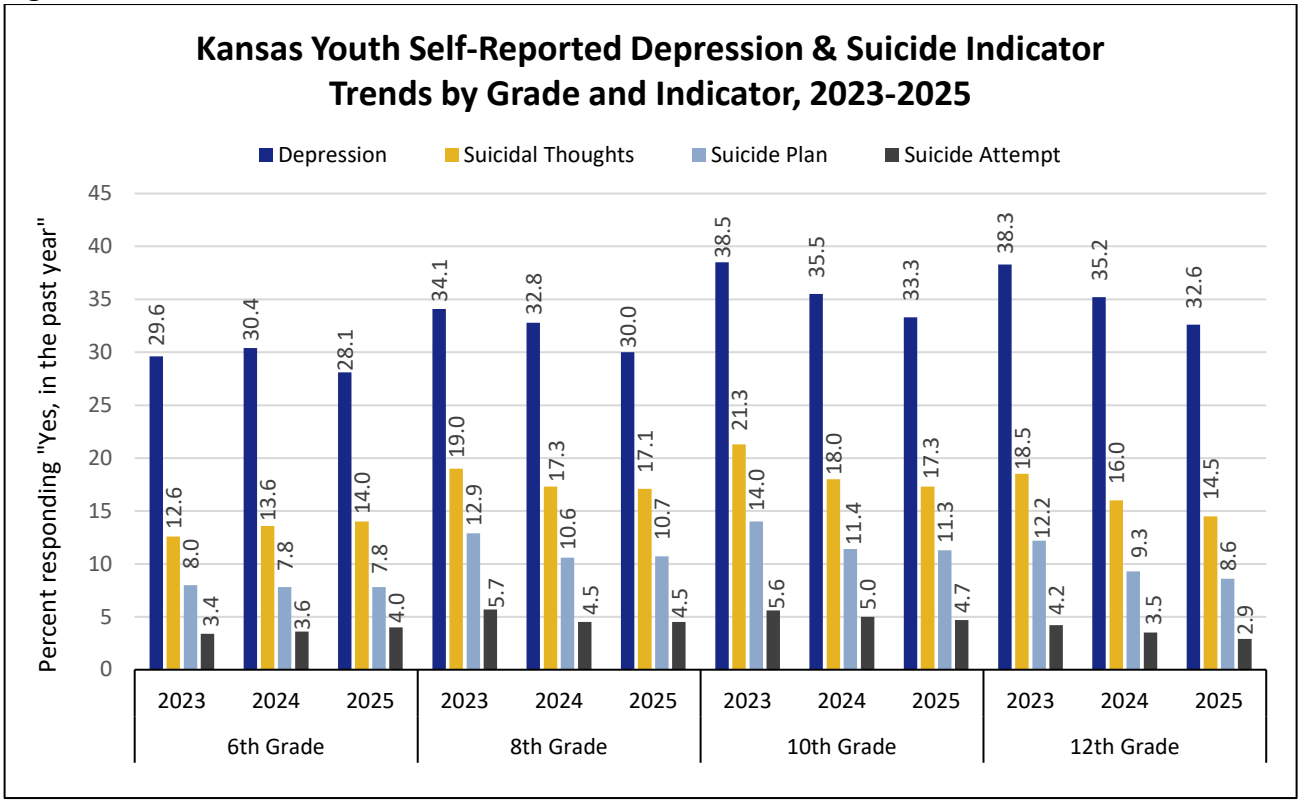
Trauma included experiences such as child welfare system involvement, maltreatment, parental substance use, and exposure to crises or loss. More than half of youth, 58% (75), had past or current family involvement with child protection services, and 39% (51) experienced a known crisis within 30 days of their death. Mental health factors included prior or current mental health services, substance use, self-harm, and barriers to accessing care. More than half of youth, 52% (67), had previously received mental health services, while 35% (45) were receiving services at the time of their death. Suicidal ideation included warning signs such as communicating suicidal thoughts or intentions and prior attempts. More than half of youth, 54% (70), communicated suicidal thoughts or intentions prior to their death, and 43% (56) showed warning signs.

Figure 62

Contributing Risk Factors Identified in Suicides, Kansas, Ages 10-17, 2020-2024, N=130		
Relationship Stressors	**Number**	**Percent**
Family Discord/Argument with Parents or Caregivers	42	32%
Breakup with Significant Other	25	19%
Parents' Divorce or Separation	20	15%
Isolation	19	15%
Bullying as Victim	16	12%
Argument with Significant Other	9	7%
Bullying as Perpetrator	7	5%
Argument with Friends	6	5%
Problems in School	**Number**	**Percent**
Academic	37	28%
Behavioral	35	27%
Truancy	21	16%
Suspensions	14	11%
Trauma (Past or Present)	**Number**	**Percent**
Family History with Child Protective Services	75	58%
Experienced a Known Crisis Within 30 days of Death	51	39%
History of Maltreatment	47	36%
Parental Substance Use/Abuse	26	20%
Domestic Violence in the Home	7	5%
Rape or Sexual Assault	6	5%
Death of Peer, Friend, or Family Member to Suicide	5	4%
Mental Health	**Number**	**Percent**
Prior Mental Health Services	67	52%
Current Mental Health Services	45	35%
History of Substance Use	40	31%
History of Self Harm	24	18%
Issues or Barriers Preventing Access to Mental Health Care	23	18%
Mental Health Hospitalization in Previous 12 months	12	9%
Suicidal Ideation	**Number**	**Percent**
Communicated Suicidal Thoughts or Intentions with Others	70	54%
Showed Warning Signs	56	43%
Prior Suicide Attempt	26	20%
Child had a Suicide Safety Plan	12	9%
Suicide Cluster, Pact, or Imitation	5	4%
*More than one contributing risk factor may have been identified in each death; not all identified risk factors are listed		

The circumstances surrounding each youth suicide are complex, and often there is no singular reason a youth may take their own life. It is essential for youth to know they are loved, valued, and that support is available regardless of the challenges they may be facing. Awareness of risk factors and warning signs can help parents, caregivers, educators, and peers recognize when a youth may need support and encourage earlier intervention. Promoting protective factors such as strong family support, access to mental health services, and connectedness with peers and the community can help reduce the risk of suicide among youth.

Figure 63



Source: Kansas Communities That Care (KCTC) student survey[30]

The Kansas Communities That Care (KCTC) student survey is administered annually, free of charge to students in grades 6, 8, 10, and 12 at public and private schools in Kansas. Figure 63 represents a recent enhanced survey that measures youth depression and suicidal thoughts, plans, and attempts. Youth as young as sixth grade are reporting depression as well as suicidal thoughts, plans, and attempts. Understanding these factors helps schools, communities, and policymakers identify trends and develop prevention strategies to support the well-being of Kansas youth.

In response to concerns surrounding youth suicide in Kansas, the legislature created the position of Youth Suicide Prevention Coordinator (YSPC) within the Office of the Kansas Attorney General. The YSPC focuses on collaboration and coordination among state agencies and community partners to strengthen Kansas youth suicide prevention efforts. The YSPC participates as a partner in several statewide suicide prevention initiatives and also serves as the advocacy group appointee on the Kansas SCDRB, contributing expertise on youth suicide and informing prevention strategies.

In partnership with the Jason Foundation, the Kansas Attorney General's Office released Kansas - A Friend AsKS, a free youth suicide prevention app, in September 2022. The bilingual app serves as a tool to assist youth in finding resources to help themselves or a friend experiencing a mental health crisis or suicidal thoughts. Through the app, users can connect to 988, the Suicide & Crisis Lifeline. Continued state, local, and individual efforts are critical to addressing and reducing youth suicide in Kansas.

SUICIDE CASE VIGNETTE

Alcohol, Firearm Access, and Responding to Suicidal Statements

A Kansas youth with a history of depression and suicidal thoughts died by suicide with a firearm. Approximately one month before the death, the youth attempted suicide in a motor vehicle crash after consuming alcohol and marijuana. The youth was hospitalized for mental health treatment following the attempt.

On the night of the death, the youth was drinking alcohol at a gathering with friends and family and made statements about suicide. Friends talked with the youth and believed the immediate crisis had passed. The youth later left the gathering and was found with a fatal gunshot wound. Family and friends did not know the youth had access to a firearm or where it had been obtained. Toxicology indicated alcohol intoxication.

SCDRB REFLECTION

This case highlights the increased risk when suicidal thoughts, alcohol use, and access to firearms occur together. Alcohol can impair judgment and increase impulsivity, particularly among youth already experiencing mental health concerns.

A previous suicide attempt is an important warning sign for continued risk. When a youth expresses suicidal thoughts, particularly following a recent suicide attempt, connecting them with a trusted adult and appropriate support can help ensure continued safety and access to care, even after the immediate crisis appears to have passed.

Access to firearms increases the likelihood that a suicidal crisis will result in death. Continued prevention efforts should educate youth and families about the risks of alcohol use, recognizing and responding to suicidal statements, and preventing access to firearms and other lethal means for youth at increased risk.

CHARACTERISTICS OF SUICIDE, 2020-2024, N=130

- Kansas youth suicide rates exceeded U.S. rates each year from 2020-2024, and in 2024, the Kansas rate was more than twice the U.S. rate
- 78% were male
- 60% died by firearm; among firearm suicides, 42% used a firearm owned by a parent or caregiver
    - 35% of firearms used were not stored in a locked location; of those, 41% were also loaded
- 54% communicated suicidal thoughts or intentions to others prior to their death
- 54% had caregivers with current or prior involvement with child protective services (DCF)
    - 7% had an open CPS case at the time of death
- 52% had previously received mental health services, and 35% were receiving mental health services at the time of death
- 39% experienced a known crisis within 30 days of their death
- 29% had positive toxicology findings for alcohol and/or drugs
    - Among those with positive findings, 55% were positive for marijuana and 26% for alcohol

PREVENTION POINTS

- **Early Diagnosis and Treatment of Mental Health Disorders -** Early involvement of mental health professionals may prevent suicide attempts. Children taking antidepressant medications should be monitored for hostility, mood swings, aggression, and suicidal ideation.
- **Evaluation of Suicide Threats or Ideation -** Never ignore statements about suicide, even if they seem casual or insincere. The months following a suicide attempt or severe depression are a time of increased risk, regardless of how well the child appears to be functioning.[24]
- **Transition of Treatment -** The transition from inpatient to outpatient behavioral health care is a critical time for patients with a history of suicide risk. Youth discharged from an inpatient care setting are at increased risk for suicide following hospitalization.[24]
- **Limit Access to Lethal Agents -** Firearms, other weapons, and prescription or over-the-counter medications should be securely stored and inaccessible to youth. Limiting access to lethal means provides additional time for intervention during a suicidal crisis.[24]
- **Talk About the Issue -** Discussing concerns of suicide does not introduce the idea of suicide. It gives youth an opportunity to share their thoughts and alerts caregivers when support is needed.
- **Impact of Parental Mental Health on Children -** Research indicates that children whose primary caregiver reports poor mental health are four times more likely to have poor general health and twice as likely to have mental, behavioral, or developmental disorders.[27]
- **Monitor High-Risk 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 are imperative.
- **Social Isolation and Lack of Connection -** Social connections may serve as protective factors against suicide. Evidence suggests that loneliness, social isolation, and inadequate social support are associated with an elevated risk of self-harm and suicidal ideation. Enhancing meaningful social connections can play a crucial role in mitigating the risk of self-harm and suicide.[24]
- **Don't Keep Suicide Threats a Secret -** If a friend or loved one is considering suicide, promising to keep it a secret can delay help and put a life at risk. Young people should be counseled to tell an adult about the threats, and assure the friend that help is available.

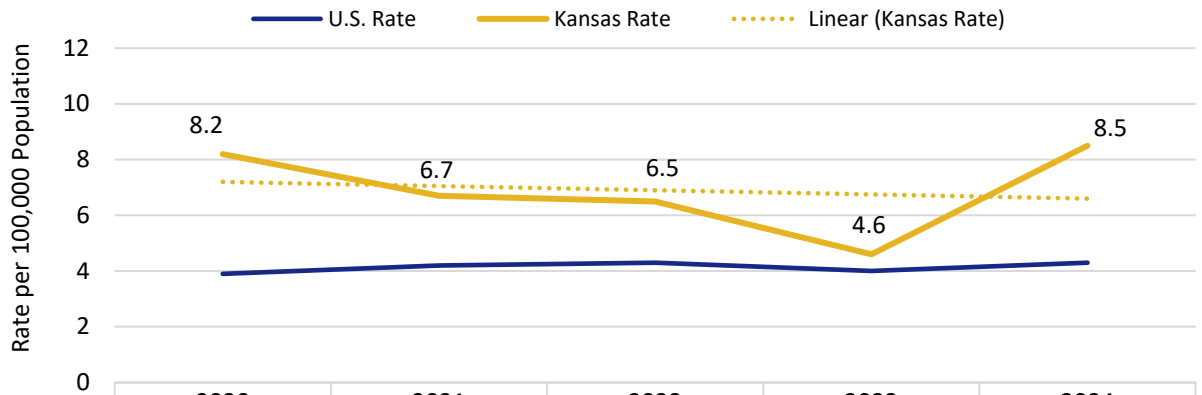
UNDETERMINED DEATHS

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

Figure 64 compares Kansas and U.S. undetermined manner of death rates from 2020-2024. Kansas rates fluctuated during the five-year period and exceeded U.S. rates each year. In 2024, there were 59 Kansas deaths of undetermined manner, including 43 sleep-related SUIDs, which are discussed in the Sleep-Related Sudden Unexpected Infant Deaths section.

Figure 64

Kansas and U.S. Undetermined Manner Death Rates, Ages 0-17, 2020-2024

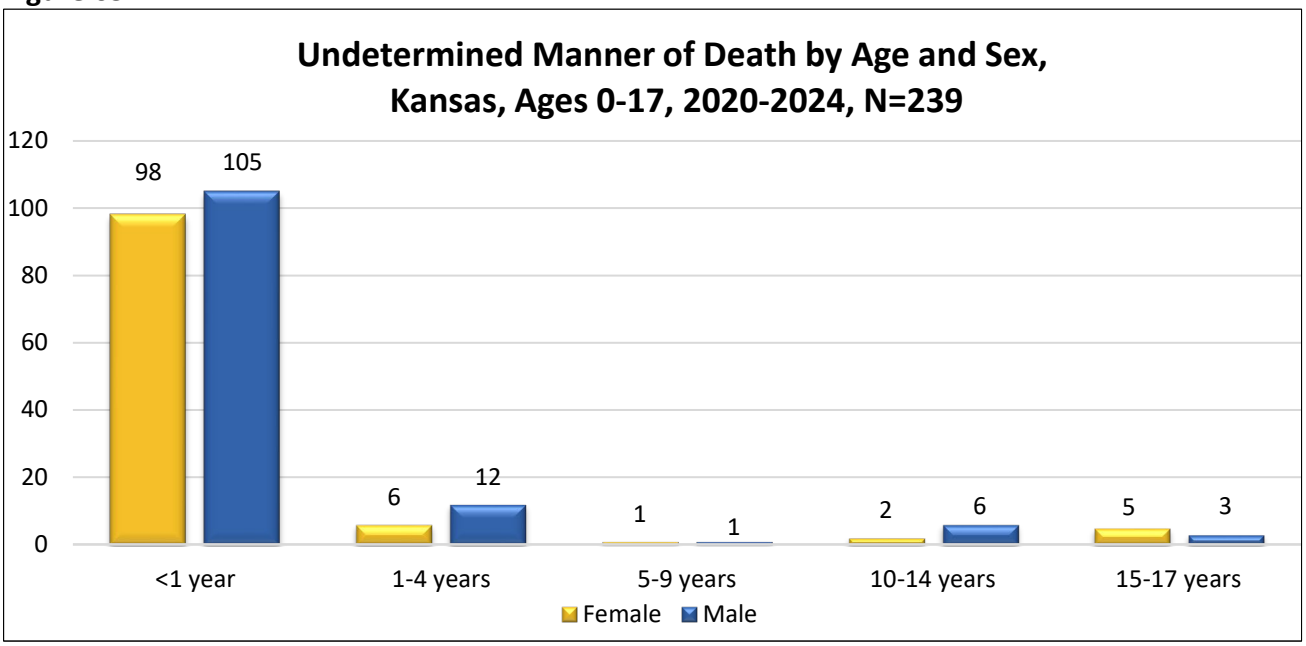


	2020	2021	2022	2023	2024
U.S. Rate	3.9	4.2	4.3	4.0	4.3
Kansas Rate	8.2	6.7	6.5	4.6	8.5
Kansas Number	57	47	45	32	59

*Kansas rate includes resident and non-resident deaths

Figure 65 displays undetermined manner of death by age group and sex. Of the 239 deaths with undetermined manner between 2020-2024, 85% (203) occurred among infants under age one. Males accounted for 53% (127) of deaths overall.

Figure 65



Historically, investigations in cases of undetermined manner have varied significantly. In some instances, although every effort was made to determine why a death occurred, the cause and manner of death could not be ascertained. Other cases had incomplete investigations because law enforcement agencies were not informed of the death and therefore did not conduct an investigation; occasionally, law enforcement agencies conducted only an abbreviated, incomplete investigation. In other instances, autopsies were not ordered, were incomplete, or toxicology testing on the victim was not performed, even though the circumstances warranted testing.

All non-natural child deaths should be exhaustively investigated. The circumstances and family situation should not affect the detail of the inquiry. Hospitals must establish protocols to ensure that law enforcement is informed whenever a child dies from causes other than expected natural causes, or when a child is admitted to the hospital with a life-threatening event of unknown origin that is considered likely to be fatal.

CHARACTERISTICS OF UNDETERMINED MANNER, 2020-2024, N=239

- Kansas death rates have remained higher than U.S. death rates each year
- 85% (203) were infants
    - 91% (191) of infant deaths were noted to have missing law enforcement information or other components of the death investigation that would have been helpful in the review. These included:
        - 5 deaths in which scene photographs were not taken
        - 7 deaths that had no law enforcement investigation
        - 49 deaths without scene recreations or doll re-enactments completed
        - 129 deaths in which a CDC SUIDI reporting form, or equivalent, was not completed
- 54% (13) were deaths due to poisoning, overdose, or acute intoxication that were classified as undetermined manner due to incomplete investigations and/or lack of information. Two of those deaths occurred in 2024
- 46% had caregivers with current or prior involvement with child protective services (DCF)

UNDETERMINED SLEEP-RELATED CASE VIGNETTE

Thorough and Timely Infant Death Investigations

A Kansas infant died while sharing a sleep surface with parents and siblings. The infant was placed to sleep on a soft pillow that was covered with a fleece blanket in an adult bed containing multiple pillows, blankets, and other items. The baby was swaddled within another blanket. A bassinet was available in the home but was being used to store clothing and other baby items.

Law enforcement completed the Centers for Disease Control and Prevention Sudden Unexpected Infant Death Investigation Reporting Form (CDC-SUIDIRF) more than six weeks after the death. Numerous questions regarding the circumstances and sleep environment were unanswered or documented as unknown, including information that may have been available had caregivers been interviewed using the form at the time of the investigation.

SCDRB REFLECTION

Thorough and timely scene investigations are critical to understanding why an infant died and identifying factors that may prevent future deaths. The CDC-SUIDIRF provides investigators with a standardized method for obtaining important information about the infant, caregiver, and sleep environment.

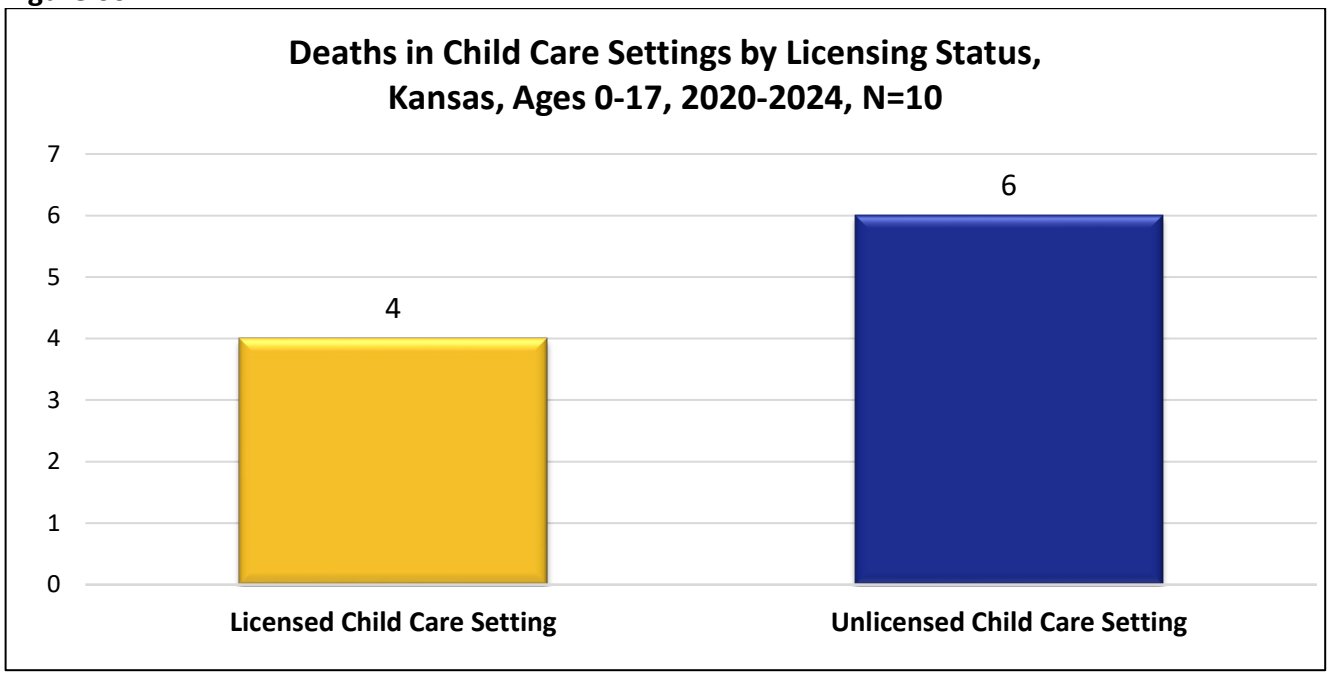
The SCDRB recommends use of the SUIDIRF and a doll re-enactment during the initial investigation of all sudden unexpected infant deaths. Delayed or incomplete investigations can result in important information not being collected, and may limit the ability of pathologists, law enforcement, and the SCDRB to accurately understand the circumstances surrounding an infant's death.

DEATHS IN KANSAS CHILD CARE SETTINGS

Many Kansas infants and young children, particularly those who are not yet school-age, spend a significant portion of their day in child care settings. Licensed child care provides important safety protections, including required training, background checks, and regulatory oversight that are not required in unlicensed child care settings. Licensed providers receive training in safe sleep practices to reduce the risk of sleep-related infant deaths, and comprehensive background checks to help reduce the risk of abuse or neglect in child care settings.

From 2020-2024, there were 10 Kansas deaths among children ages 0-17 who died while in a child care setting. Six deaths occurred in unlicensed child care settings and four occurred in licensed child care settings (Figure 66). Of the four deaths in licensed settings, two occurred in settings that were operating in violation of their license. One of the four involved an infant who resided in the licensed child care home where the death occurred.

Figure 66



All 10 of these deaths occurred among infants under age one. Among these infant deaths, 90% (9) were associated with an unsafe sleep environment. The remaining death was classified as a child abuse homicide. Many sleep-related deaths occur when infants are placed prone (on their stomachs) to sleep, or when they are placed on an adult bed or another unsafe sleep surface.

Unlicensed providers and other caregivers such as babysitters and family members who provide occasional or regular care of an infant may not be aware of the importance of supine (back) sleeping and other safe sleep practices. In licensed child care settings, adherence to safe sleep guidelines, including appropriate sleep positions and environments, is required to reduce the risk of infant death. Ensuring safe sleeping arrangements and compliance with state safety regulations at every child care site is critical. Parents should discuss safe sleep practices with all caregivers, including family members, babysitters, and child care providers.

In 2025, Kansas lawmakers passed HB 2045, establishing the Kansas Office of Early Childhood. Effective July 1, 2026, the Office assumed responsibility for several early childhood programs previously administered by other state agencies, including child care licensing, child care subsidies, and home visiting programs.

While the consolidation of early childhood programs provides opportunities to improve coordination of services for Kansas families, HB 2045 also expanded an exemption from child care licensure that raises safety concerns for infants and children. Under the expanded exemption, a provider may care for up to four children unrelated to the provider, with no more than two children under 18 months of age, for up to 35 hours per week per child. Previously, this exemption allowed care for up to two children for no more than 20 cumulative hours per week.

While the law maintains certain health and safety requirements for licensed child care settings, providers operating under the expanded licensure exemption are not subject to the same licensing requirements, regulatory oversight, or routine inspections as licensed providers. This distinction is particularly important for infants and young children, who may be more vulnerable to unsafe sleep environments, inadequate supervision, and other safety risks.

Licensed providers in Kansas are required to meet important safeguards that unlicensed providers are not required to follow. Licensed providers must:

- Complete certified first aid and CPR training, as well as training in child health and safety topics, including safe sleep practices
- Undergo Kansas Bureau of Investigation criminal history and child abuse/neglect background checks for all individuals living, working, or volunteering in the child care setting
- Meet fire safety requirements before receiving approval to operate
- Be inspected at least every 12 months to ensure compliance with health, safety, and well-being standards

When child care providers operate without a license, these safeguards are not assured. The SCDRB continues to recommend licensing requirements and enforcement of penalties for noncompliance, as described further in the Legislative Priorities and Public Policy Recommendations sections of this report.

For more information about child care licensing requirements and safety standards in Kansas, please visit the Kansas Office of Early Childhood website.

The Kansas SCDRB supports efforts to reduce barriers for families to obtain high-quality and affordable child care but has significant concerns regarding the expanded allowance of unlicensed child care. Parents and caregivers are encouraged to learn and understand the differences between licensed and unlicensed child care settings and consider licensing status, training, background checks, inspection history, and other safety information when selecting care for their children.

CHARACTERISTICS OF DEATHS IN CHILD CARE SETTINGS 2020-2024, N=10

- All were infants under the age of one
- 90% of the deaths occurred while the infant was sleeping in an unsafe sleep environment
- 60% occurred in an unlicensed child care setting
- Of the deaths that occurred in licensed child care settings, 50% occurred in a setting where the provider was in violation of their license
- One death was classified as a child abuse homicide

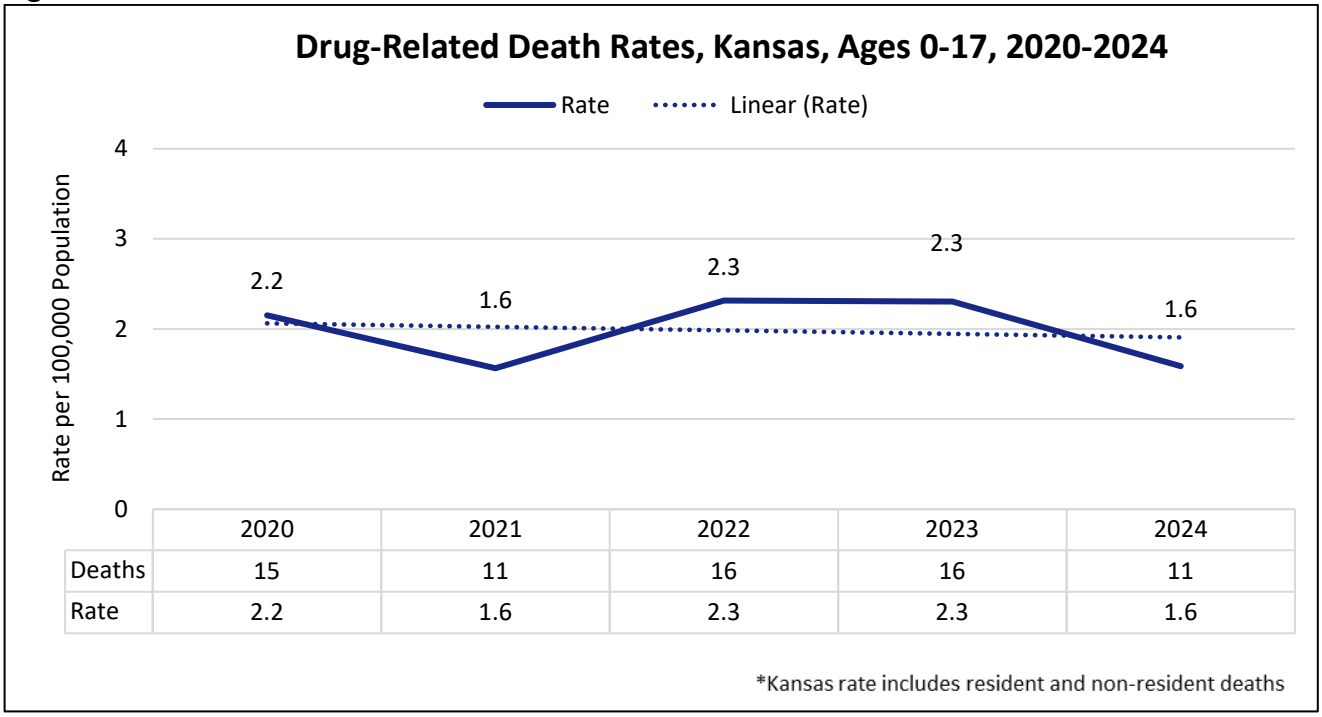
PREVENTION POINTS

- **Accessing Child Care -** Child Care Aware of Kansas partners with a network of Child Care Resource & Referral agencies to connect families across Kansas to child care in their area. Parents and caregivers can visit their website or call toll-free 877-678-2548 to find a list of licensed child care providers in their area.
- **Check Licensing and Compliance History -** Before selecting a child care provider, parents and caregivers should verify that the provider is currently licensed and review available licensing and compliance information, including inspection findings and identified violations. The Kansas Office of Early Childhood provides an online search of child care facility inspection and compliance reports. For assistance, contact Child Care Licensing at 785-296-1270.
- **Ask About Training and Background Checks -** Parents and caregivers should ask whether child care providers and other individuals in the child care setting have completed background checks and training in first aid, CPR, safe sleep practices, and other child health and safety topics. These protections are required in licensed child care settings but may not be required in settings exempt from licensure.
- **Safe-Sleep Practice -** Child care providers should follow safe sleep guidelines, including placing infants on their backs to sleep, using approved sleep surfaces, and maintaining a safe sleep environment free from hazards. Providers should have a written safe sleep policy and discuss it regularly with parents to ensure consistency between home and child care settings.
- **Report Concerns -** Parents and caregivers should report concerns about the health or safety of children in a child care setting, including suspected licensing violations, to the Kansas Office of Early Childhood.

DRUG-RELATED DEATHS - ALL MANNERS

In 2024, Kansas experienced 11 drug-related deaths among children ages 0-17. Drug-related deaths are classified as such when the decedent's death was due to an overdose or toxicity of illicit substances, prescription medications, or over-the-counter medications. Figure 67 shows that drug-related death rates have remained relatively stable over the past five years, ranging from 1.6 to 2.3 deaths per 100,000 population. Despite this stability, rates remain elevated compared with the years preceding 2020, when rates were typically below 1.0 per 100,000 population.

Figure 67



	2020	2021	2022	2023	2024
Deaths	15	11	16	16	11
Rate	2.2	1.6	2.3	2.3	1.6

*Kansas rate includes resident and non-resident deaths

Of the 69 drug-related deaths occurring between 2020 and 2024, a majority (72%) were unintentional/accidental. For 13 deaths, the manner of death was undetermined because available information was insufficient to determine whether the ingestion was intentional or unintentional, or the circumstances surrounding the ingestion remained unclear despite investigation (Figure 68).

Figure 68

Drug-Related Manner of Deaths, Kansas, Ages 0-17, 2020-2024, N=69						
Manner of Death	**2020**	**2021**	**2022**	**2023**	**2024**	**2020-2024 Combined**
Accident	8	8	13	13	8	**50**
Undetermined	6	1	2	1	3	**13**
Suicide	1	1	1	1	0	**4**
Homicide	0	1	0	1	0	**2**
Total	**15**	**11**	**16**	**16**	**11**	**69**

Youth ages 15-17 accounted for 71% of drug-related deaths between 2020 and 2024, and males accounted for 62%. Of particular concern, 13 deaths (19%) occurred among children under age 5 (Figure 69). Most of these deaths resulted from young children gaining access to illicit drugs or medications, including two deaths classified as homicides in which the child was given an illicit drug or medication not prescribed to them. One death involved an infant who died shortly after birth with a lethal amount of methamphetamine in their system. Fentanyl was involved in nine (69%) of the 13 drug-related deaths among children under age 5.

Figure 69

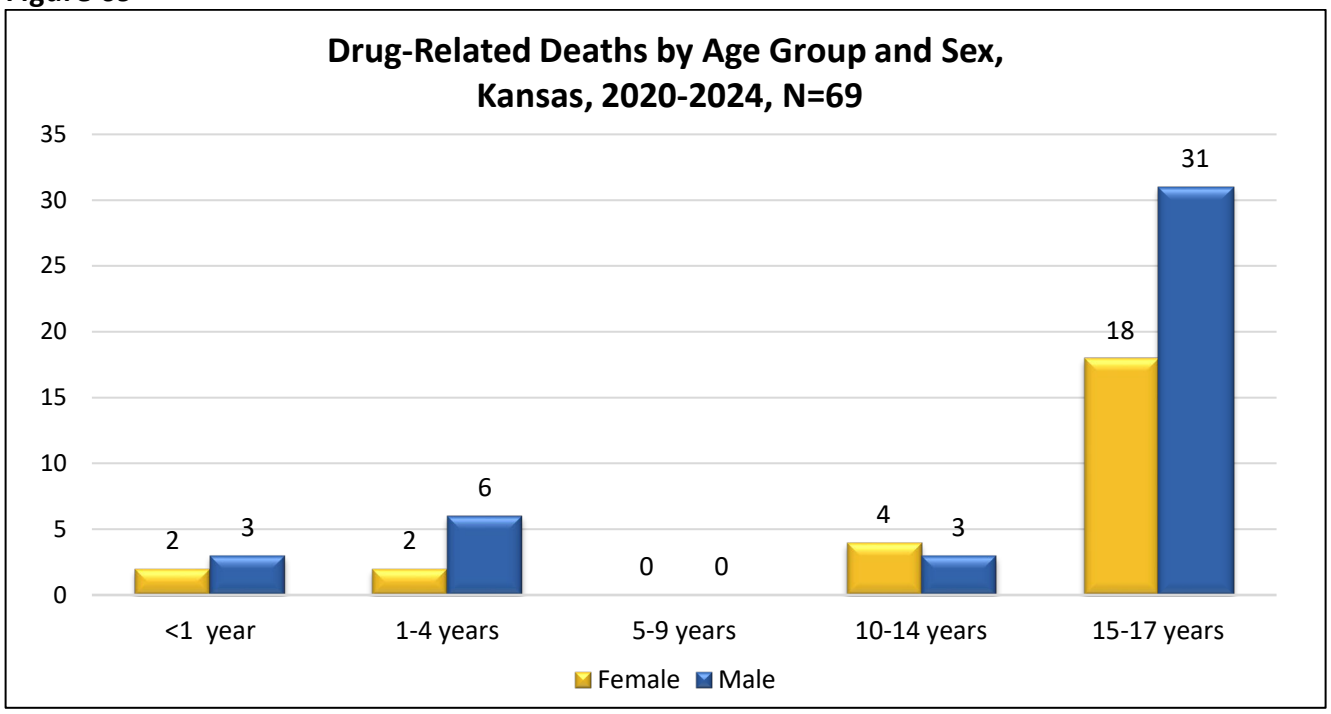


Figure 70 shows the types of substances involved in drug-related deaths between 2020 and 2024. Of the 69 deaths, 47 (68%) involved only illicit drugs, while 12 (17%) involved a combination of illicit drugs, prescription medications, and/or over-the-counter medications.

Figure 70

Drug-Related Deaths by Drug Classification, Kansas, Ages 0-17, 2020-2024, N=69	
Classification	**Deaths**
Illicit Drugs	**47**
Combination of Illicit, Prescription, or Over-the-Counter Medication	**12**
Prescription Medication	**8**
Over-the-Counter Medication	**2**
Total	**69**

Figure 71 shows the illicit drugs, prescription medications, and over-the-counter (OTC) medications that contributed to drug-related deaths between 2020 and 2024. Ethanol is classified as an illicit drug for the purposes of this report because alcohol consumption is illegal for persons younger than 21 years of age. Fentanyl was the most frequently identified substance, contributing to 55 (80%) of the 69 drug-related deaths during this period, compared with 0 fentanyl-related deaths between 2016 and 2019.

Figure 71

Drug-Related Deaths by Type of Substance, Kansas, Ages 0-17, 2020-2024, N=69						
	2020	2021	2022	2023	2024	**Total**
Illicit Drugs						
Fentanyl	11	9	13	15	7	**55**
Methamphetamine	1	1	2	1	1	**6**
Cocaine	1	1	1	0	2	**5**
Flubromazolam	3	0	1	0	0	**4**
Ethanol	1	0	0	1	1	**3**
Bromazolam	0	0	0	1	0	**1**
Prescription Medication						
Oxycodone	2	0	1	0	1	**4**
Alprazolam	0	0	3	1	0	**4**
Hydroxyzine	0	0	0	1	2	**3**
Tramadol	0	1	1	0	0	**2**
Citalopram/Escitalopram	0	0	0	1	1	**2**
Pregabalin	0	0	0	1	0	**1**
Duloxetine	0	0	0	1	0	**1**
Promethazine	0	0	0	1	0	**1**
Fluoxetine	0	0	0	1	0	**1**
Clonazepam	0	0	0	1	0	**1**
Buprenorphine	0	0	0	0	1	**1**
Quetiapine	0	0	0	0	1	**1**
Trazodone	0	0	0	0	1	**1**
Over-the-Counter Medication						
Diphenhydramine	0	0	2	1	1	**4**
Dextromethorphan	0	0	0	1	0	**1**

*More than one substance may have contributed to a single death; therefore, categories are not mutually exclusive and totals may exceed 69

Figure 72 describes drug-related deaths by the child's county of residence. The five counties shown separately each had a child population greater than 100,000 during the five-year period. Two drug-related deaths involved children who were not Kansas residents and are excluded from this figure only.

Drug-related deaths occurred across Kansas, affecting both urban and rural communities. However, deaths were more frequently concentrated in the state's larger population centers. Wyandotte County had the highest drug-related death rate among children (6.6 per 100,000), followed by Sedgwick County (3.1). When combined, the five most populous counties had a drug-related death rate among children of 2.4 per 100,000, compared with 1.3 for all other Kansas counties combined. Therefore, the five most populous counties experienced an 85% higher drug-related death rate among children than the rest of the state (Figure 72). The SCDRB is encouraged by ongoing local efforts to identify specific risk factors within these communities.

Figure 72

Drug-Related Deaths by County of Residence in Counties with a Population > 100,000, Kansas Residents, Ages 0-17, 2020-2024, N=67			
County	**Population Ages 0-17 (2020-2024)**	**Total Drug-Related Deaths**	**Drug-Related Deaths Death Rate†**
Douglas	105,524	2	1.9*
Shawnee	203,667	1	0.5*
Wyandotte	226,137	15	6.6*
Sedgwick	653,448	20	3.1
Johnson	721,325	8	1.1*
Combined Totals			
Five Most Populous Counties Combined	1,910,101	46	2.4
All other Kansas Counties Combined	1,567,456	21	1.3
†Rate per 100,000 population *Rate of death for death counts <20, should be used with caution			

From a national standpoint, the CDC reported 81,776 drug overdose deaths among all age groups in 2024, a 22% decrease from 105,007 deaths in 2023.[25] Despite this decline, synthetic opioids such as fentanyl remain a significant concern nationally and in Kansas. While fentanyl is available as a prescription drug, it is also manufactured illegally. Fentanyl is 50 to 100 times more potent than morphine, making even small amounts potentially deadly. Illicitly manufactured fentanyl is frequently incorporated into counterfeit pills or mixed with other substances, often without the knowledge of the person using them.[25]

The Drug Enforcement Administration (DEA) has issued a public safety alert about the dangers of counterfeit prescription pills containing fentanyl. The alert supports the DEA's "One Pill Can Kill" campaign which educates the public about the risks associated with counterfeit pills.[28] In Kansas, the Attorney General reinforced this message through a statewide "One Pill Can Kill" public service announcement.

DRUG-RELATED DEATH CASE VIGNETTE

Adrian's Law

An infant was left in the care of the father after the mother was incarcerated on drug-related charges. The father was known to law enforcement as a methamphetamine user and dealer and lacked stable housing, moving with the infant between friends' homes, motels, and his vehicle. The family also had significant child welfare history, including the abuse-related death of the mother's older child several years earlier.

During the weeks preceding the infant's death, multiple individuals had concerns about the infant's safety. Witnesses saw the father use methamphetamine while caring for the infant and described concerning behavior toward the child, including yelling at the infant and handling the infant aggressively. Several people offered to care for the infant because of their concerns. Law enforcement received requests to conduct welfare checks but had difficulty locating the father and infant.

One week before the death, a report was made to DCF regarding the father's treatment of the infant and his substance use while providing care. DCF opened a case and attempted to meet with the father but was unable to obtain his cooperation. Law enforcement requested the assistance of another jurisdiction where father was later residing. They found his car and noted he was not living in it; however, the infant was not observed, the infant's living environment was not assessed, and the infant was not taken for a medical evaluation.

Seven days after the DCF report, the father called 911 after waking to find the infant unresponsive. Drug paraphernalia was located in the room and the diaper bag. The father acknowledged using methamphetamine the previous day and methamphetamine was present in the infant's toxicology testing. The death was attributed to methamphetamine intoxication in an unsafe sleep environment.

SCDRB REFLECTION

This case demonstrates the importance of considering the totality of circumstances when assessing the safety of a vulnerable child. This family had significant child welfare history, a caregiver known for methamphetamine use, unstable living arrangements, a DCF report from an individual concerned for the child's safety, and unsuccessful welfare checks. Despite these cumulative concerns, the infant was never visually observed or taken for evaluation after being located before the death.

Kansas law, specifically K.S.A. 38-2226(h), commonly known as Adrian's Law, establishes requirements for visual observation of an alleged victim of child abuse or neglect as part of an investigation. Infants are most vulnerable as they are completely dependent on adults for their care and safety. Based on the concerns reported in this case, the SCDRB determined the report should have been assigned for a physical harm assessment and the infant should have been visually observed with a CARE referral initiated in accordance with Adrian's Law and CARE requirements. Child welfare and law enforcement professionals should receive continued education regarding Adrian's Law and CARE referrals and recognize when repeated reports, unsuccessful welfare checks, caregiver substance use, and significant family history warrant an escalated response to ensure a child is located and assessed.

CHARACTERISTICS OF DRUG-RELATED DEATHS, 2020-2024, N=69

- Drug-related death rates remained elevated from 2020-2024 compared with the years immediately preceding 2020
- Most drug-related deaths (72%) were unintentional/accidental
- Youth ages 15-17 accounted for 71% of drug-related deaths, and males accounted for 62%
- Thirteen (19%) of drug-related deaths occurred among children under age 5; fentanyl was involved in nine (69%) of these deaths
- Illicit drugs were involved in 59 (86%) of drug-related deaths, either alone or in combination with prescription and/or over-the-counter medications
- Fentanyl contributed to 55 (80%) of the 69 drug-related deaths from 2020-2024, compared with no fentanyl-related deaths from 2016-2019
- The five most populous Kansas counties had an 85% higher drug-related death rate among children than the rest of the state
- Nearly three-fourths (74%) of children had a history of involvement with child protective services (DCF). Among those with prior involvement, 37% had experienced a prior removal, and 14% were in state custody at the time of the incident
- In 42% of the drug-related deaths, marijuana was positive on toxicology testing despite it not being a contributing cause of death

PREVENTION POINTS

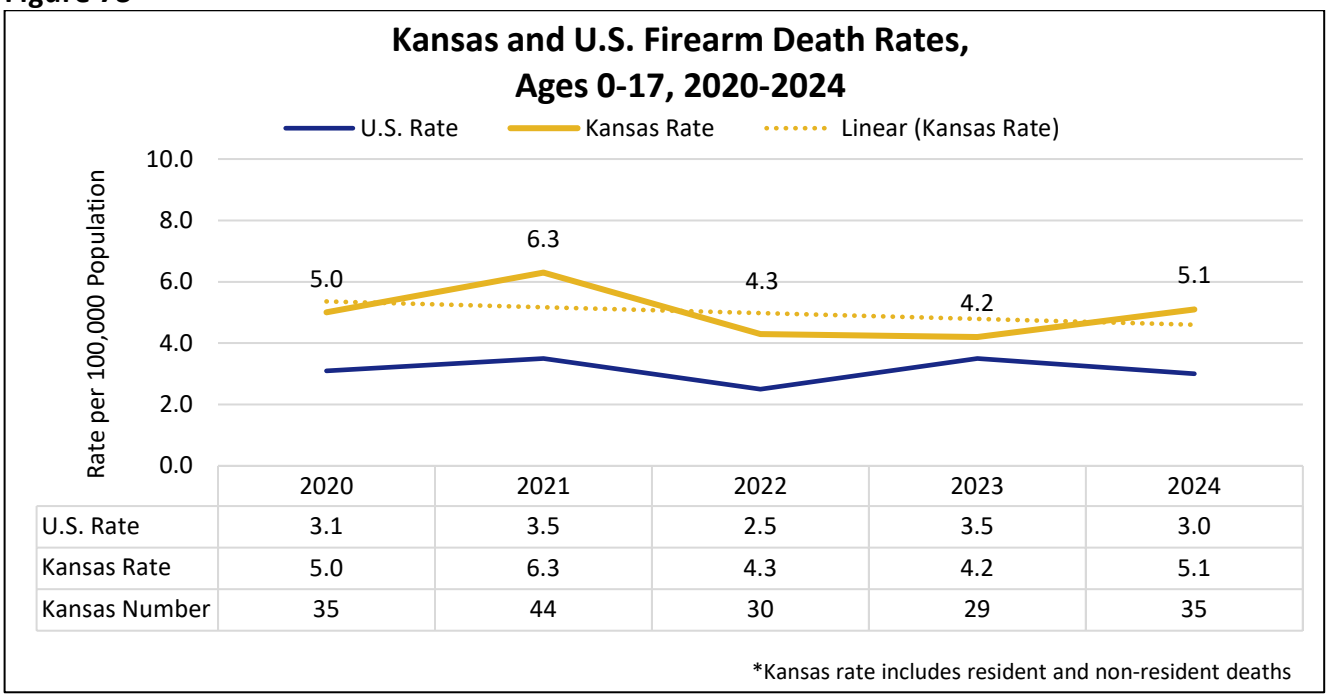
- **Medication Safety -** Medications are prescribed by physicians for specific patients and specific purposes. The fact that they are prescribed does not make them safe for others. Children and youth should take only medications prescribed to them, never share medications, and never combine them unless directed by a physician.[25]
- **Positive Parental Involvement -** Positive relationships between parents and children are a protective factor, offsetting the risk of substance use. Parental involvement is also needed for youth activities and social media use.[25]
- **Prescription Medications Should Not Be Accessible to Children -** Quantities of medications should be tracked and all medications kept in a locked cabinet.[25]
- **The Dangers of Alcohol Use -** Underage use of alcohol and the use of alcohol with medications can increase the risk of accidental overdose.
- **Ordering Substances Online -** Some websites sell counterfeit and dangerous drugs and chemicals. Internet use should be monitored and caregivers should ensure youth are not accessing drugs, whether at home, through friends, or outside sources.[25]
- **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.
- **Overdose Reversal Medication Availability -** Naloxone (commonly known as Narcan) is a medication which can temporarily reverse the life-threatening effects of an opioid overdose. It should be accessible in homes, schools, and community settings where youth may be at risk. Caregivers, educators, and peers should be aware of how to obtain and use these products in an emergency and how to access medical services following use.
- **Prevent Exposure to Fentanyl and Other Illicit Drugs -** Infants and young children are at risk of death if they come in contact with even trace amounts of fentanyl. Any substances, including illicit drugs, should be kept completely inaccessible to children.

FIREARM DEATHS - ALL MANNERS

A firearm death is a fatal injury caused by a bullet or other projectile fired from a weapon, such as a handgun, rifle, or shotgun. According to the CDC, 12,222 firearm deaths occurred among children ages 0-17 in the U.S. from 2020-2024.[29] Of these, 173 were Kansas children.

Figure 73 compares Kansas and U.S. firearm death rates from 2020-2024. Throughout this period, the Kansas firearm death rate remained higher than the U.S. rate each year. In 2024, 35 Kansas children died from firearm injuries, with the Kansas rate remaining relatively stable over the five-year period.

Figure 73



	2020	2021	2022	2023	2024
U.S. Rate	3.1	3.5	2.5	3.5	3.0
Kansas Rate	5.0	6.3	4.3	4.2	5.1
Kansas Number	35	44	30	29	35

*Kansas rate includes resident and non-resident deaths

Fatal firearm injuries can be the result of several manners of death, including homicide, suicide, unintentional injury, and undetermined manner. Unintentional firearm deaths can occur when a child is playing with a firearm or when someone discharges a firearm without intent to cause harm. In some cases, older children handling firearms in an unsafe manner have caused the deaths of others. Although the act may be unintentional, the death may be classified as a homicide due to criminal negligence. There are also circumstances in which firearm deaths are the result of interpersonal violence, such as domestic violence, or legal intervention by law enforcement.

Despite investigation, there are cases in which it remains unknown whether the firearm injury was intentionally self-inflicted, unintentional, or the result of interpersonal violence. When the intent cannot be determined, the death will be classified as undetermined manner.

Figure 74 shows the manner of death for the 173 firearm deaths among children ages 0-17 in Kansas from 2020-2024. Together, homicide and suicide accounted for 92% (160) of all firearm deaths, with 47% (82) classified as homicide and 45% (78) as suicide. Unintentional firearm injuries accounted for 5% (8) of deaths, while the remaining 3% (5) were classified as undetermined manner.

Figure 74

Firearm Deaths by Manner of Death, Kansas, Ages 0-17, 2020-2024, N=173		
Manner of Death	**Number**	**Percent**
Homicide	82	47%
Suicide	78	45%
Unintentional Injury/Accident	8	5%
Undetermined	5	3%
Total	**173**	**100%**

From 2020-2024, 82% (142) of the 173 firearm deaths occurred among males and 18% (31) among females. Youth ages 15-17 accounted for the largest proportion of deaths at 66% (114). Among both males and females, firearm deaths increased with age (Figure 75).

Figure 75

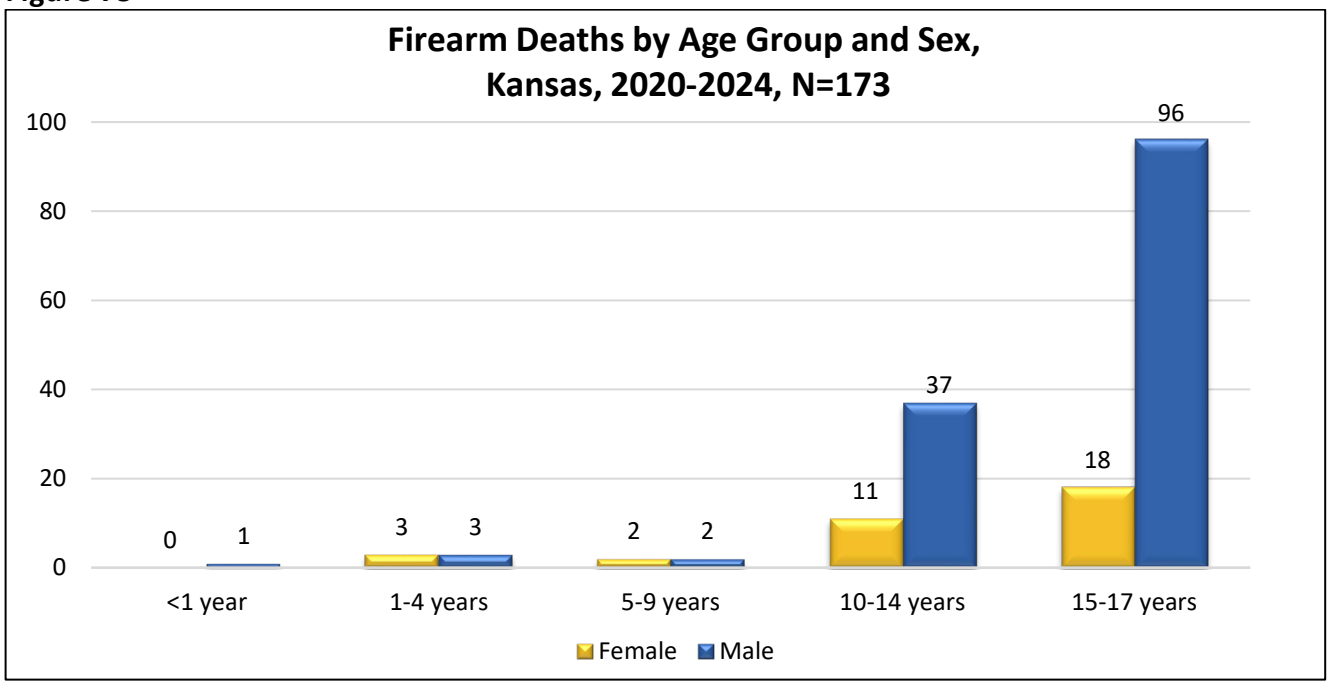


Figure 76 shows firearm deaths among children ages 0-17 who resided in each of the five most populous Kansas counties from 2020-2024, with all other Kansas counties combined for comparison. Nine non-residents who died from firearm injuries in Kansas are excluded from the analysis.

The five most populous counties had a combined firearm death rate of 5.5 deaths per 100,000 population, 45% higher than the rate of 3.8 among all other Kansas counties combined. Among the five counties, Wyandotte County had the highest firearm death rate at 10.2 deaths per 100,000 population, followed by Shawnee County at 7.9 and Sedgwick County at 7.3.

Differences were also seen in the manner of firearm deaths. Homicides were more common in urban counties such as Sedgwick and Wyandotte, while suicides accounted for more firearm deaths across the remaining counties, most of which are rural.

Figure 76

Firearm Deaths and Rates by County, Kansas Residents, Ages 0-17, 2020-2024, N=164							
County	**Population Ages 0-17 (2020-2024)**	**Total Firearm Deaths**	**Firearm Deaths by Manner**				**Firearm Death Rate†**
			Suicide	**Homicide**	**Accident**	**Undetermined**	
Wyandotte	226,137	23	3	18	1	1	**10.2**
Shawnee	203,667	16	5	7	3	1	**7.9***
Sedgwick	653,448	48	14	31	1	2	**7.3**
Douglas	105,524	6	1	4	1	-	**5.7***
Johnson	721,325	12	9	3	-	-	**1.7***
Combined Totals							
Five Most Populous Counties Combined	1,910,101	105	32	63	6	4	**5.5**
All Other Kansas Counties Combined	1,567,456	59	46	11	1	1	**3.8**

†Rate per 100,000 population
*Rates calculated with death counts <20 should be used with caution

The SCDRB is encouraged by ongoing local efforts to identify and address firearm-related risk factors within their communities. Differences across counties highlight the importance of locally informed prevention efforts. The SCDRB will continue to evaluate available data and research to determine whether more specific recommendations can be made in the future.

CHARACTERISTICS OF FIREARM DEATHS, 2020-2024, N=173

- During this period, the Kansas firearm death rate remained higher than the U.S. rate each year.
- Overall, only 8% of firearms were securely locked; 39% were left unlocked; and for 53% the status of the gun security was unknown
- Of the 39% left unlocked, 53% were also loaded, emphasizing a need for safe firearm storage
- 78% of the firearms involved in these deaths were handguns
- 66% of victims were ages 15-17, with males accounting for 84% of those fatalities
- 64% had caregivers with current or prior involvement with child protective services (DCF)
- 47% were homicides and 45% were suicides
- 50% of the unintentional injury deaths occurred to children under the age of 5
- 38% of the firearms used in these incidents were owned by the child's parent or caregiver

PREVENTION POINTS

- **Use Gun Safety Devices -** Encourage the use of gun locks, safes, and other safety devices even when guns are stored securely, to add extra layers of protection.[31]
- **Promote Safe Firearm Education for Parents and Caregivers -** Provide education on safe firearm storage and handling practices to adults in the home, emphasizing their responsibility in preventing injuries and deaths.
- **Engage Healthcare Providers -** Encourage pediatricians and other healthcare providers to discuss firearm safety with families during routine visits.
- **Community Awareness and Advocacy -** Support community programs and policies that promote firearm safety and prevent unauthorized access to guns by children.[31]
- **Address Media and Cultural Influences -** Educate families about the impact of media, video games, and cultural attitudes toward guns and violence on children’s perceptions of violence.[31]
- **Encourage Safe Transportation -** Remind families to securely store firearms when transporting them, to prevent accidental exposure to children.[31]
- **Firearm Safety Programs for Youth -** Support educational programs or information sharing in schools, community centers, or youth organizations that teach children and youth about the risks of firearms, safe handling practices, and the importance of never touching guns without adult supervision. These programs should emphasize awareness and safety while reinforcing responsible behaviors and decision-making.[31]

DEATH INVESTIGATION AND AUTOPSY EXAMINATIONS

The Kansas SCDRB relies significantly on law enforcement, death investigators, and forensic pathologists to ascertain not only the causes of child fatalities in Kansas but also to provide comprehensive details from their investigations. This information is crucial for the SCDRB to understand the underlying factors contributing to these deaths and to develop strategies for prevention.

In the review of over 13,000 deaths of children in Kansas, the SCDRB has found multiple areas in which death investigations in Kansas, including autopsies of children, could be improved. Suggestions for improvement in our state include:

- **Following Child Autopsy Guidelines and Recommendations -** The Kansas SCDRB has issued comprehensive guidelines concerning the autopsies of children under coroner jurisdiction. These guidelines specify that postmortem examinations of children be conducted by a forensic pathologist. The guidelines also stipulate rigorous standards for the procedure, including a thorough examination of all organs, including the brain, as well as the incorporation of toxicological analysis and radiographic imaging. These protocols ensure the highest standard of investigation and accuracy in the determination of cause and manner of death. Child Autopsy Guidelines created by the SCDRB can be found at: Child Autopsy Guidelines.
- **Effective Investigations of SUIDs -** Accurate investigations of SUIDs are vital for determining the cause and circumstances surrounding these tragic events. Utilizing the Sudden Unexpected Infant Death Investigation (SUIDI) reporting form is essential in this process as it standardizes data collection and ensures comprehensive documentation. A thorough SUID investigation requires:
    - **Scene Recreation and Doll Re-enactments:** These techniques provide critical insights into conditions leading to the death that may not be apparent from interviews or at autopsy.
    - **Witness Interviews:** Conducting detailed interviews helps gather contextual information about the infant's environment and circumstances. Follow-up interviews may be needed after autopsy.
    - **Diagnostic Procedures:** Utilizing x-rays, toxicology, and other autopsy testing along with the examination by a forensic pathologist ensures a thorough medical investigation.
- **Improving Drug-Related Death Investigations -** When a child dies from an overdose, regardless of the manner of death, it is crucial to thoroughly investigate and gather information to understand how the child obtained the drugs and identify those responsible. This includes interviewing friends, family, and others who may provide insights into risk factors and the source of the drugs. Comprehensive information is needed not only to understand the broader context of drug access and usage but also to pursue prosecution of individuals who provide illicit substances to children.

  Investigations should also include assessment of parent or caregiver substance use, with drug testing conducted when indicated, and coordination with DCF to ensure the safety of other children in the home if there is suspected drug activity or other evidence of an unsafe home. Incorporating these methods along with the SUIDI reporting form facilitates a structured and consistent investigation process, enhancing the accuracy of findings and contributing to better prevention strategies. For additional guidance, the CDC has published resources for death investigators at CDC SUID Training Materials. Additionally, the National Center for Fatality Review offers a free 10-module series on various aspects of death scene investigation, with a focus on SUID, available at NCFRP Child DSI Learning Series.

- **Improving Youth Suicide Investigations -** Although most youth suicides in Kansas are investigated, the SCDRB often lacks sufficient information from law enforcement reports to accurately document these deaths and to provide specific prevention efforts that could save lives. Investigations should include interviews with family, friends, and others who have regular interaction with the child. Investigations should also include the collection and analysis of electronic devices such as cell phones and computers. These steps in death investigation are critical for identifying whether external factors, such as sextortion or encouragement to commit suicide, both of which are criminal under Kansas law, played any role in the death. Other states have addressed this issue by using standardized suicide death investigation forms. Standardized collection of information in suicide investigations ensures consistent, well-documented information is obtained to help identify risk factors and guide prevention efforts. A standardized process also supports unbiased data collection. The Colorado Department of Public Health & Environment provides a model form at https://cdphe.colorado.gov/suicide-prevention/suicide-investigation-form. In addition, Kansas coroners must ensure that autopsies or, at a minimum, external examinations as well as toxicology testing are ordered. The National Association of Medical Examiners (NAME) emphasizes that these medical examinations are essential for accurately interpreting the cause and circumstances of death, particularly in cases of youth suicide.

- **Improving Motor Vehicle Death Investigations-** The SCDRB's review of child deaths involving motor vehicle crashes has identified inconsistencies in how these deaths are investigated and documented. For the SCDRB to identify trends and develop meaningful recommendations and prevention strategies, thorough and consistent investigation of each fatal crash is necessary.

  Fatal motor vehicle crash investigations could be improved with the use of standardized guidelines similar to those used in other types of child death investigations. Relevant state and local stakeholders should work together to establish consistent standards based on best practices, recognizing that not every crash requires the same level of investigation or every investigative tool or technique. A thorough investigation should identify and document key factors that may have contributed to the crash, including:

  - **Impairment:** Toxicology should be obtained from drivers involved in fatal motor vehicle crashes. When alcohol or drugs are identified or suspected, the source should also be investigated when relevant.
  - **Distraction:** Investigations should consider evidence from cell phones and other pertinent electronic devices, vehicle infotainment systems, and possible passenger-related distractions.
  - **Speed:** Available evidence may include airbag control modules, other vehicle data, and calculations obtained through crash reconstruction.
  - **Driver License Status and Restrictions:** Investigations involving young drivers should document license status, applicable restrictions, and whether the driver was in compliance with those restrictions.
  - **Seat Belts and Safety Equipment:** Investigations should identify required safety equipment for drivers and passengers and document whether it was present and used properly.
  - **Scene Documentation:** Scene photography should be consistently used to document the crash scene and relevant physical evidence.
  - **Route and Circumstances of Travel:** When relevant, investigators should document where the child and driver were last seen, the route of travel, expected destination, and other circumstances preceding the crash.

- **Other Contributing Factors:** Investigations should document other relevant factors, including drowsy driving and reckless driving.

Impaired driving remains a significant factor in fatal motor vehicle crashes. Universal toxicology testing of all drivers involved in fatal crashes would provide important information about whether alcohol, drugs, or other substances contributed to the crash. While this may be addressed through changes to investigative procedures and practices, legislation may be necessary to ensure consistent application.

The SCDRB also recognizes the importance of training and education for law enforcement officers responsible for fatal motor vehicle crash investigations. Even when a full crash reconstruction is not indicated, basic crash reports should meet consistent standards for timeliness, accuracy, and completeness. Experience or training requirements for officers responsible for child fatality crash investigations would improve the consistency and quality of information available for review.

Kansas laws related to fatal motor vehicle crashes should also be reviewed to determine whether they adequately address behaviors that contribute to fatal crashes and appropriately reflect the serious nature of crashes resulting in death.

- **Enhance Training for Coroners and Law Enforcement in Child Death Investigations -** In Kansas, coroners must be licensed physicians, but many do not have specialized training in medicolegal death investigation. Similarly, law enforcement officers tasked with investigating child deaths often have limited formal training. To address these gaps, it is crucial that newly appointed coroners and relevant law enforcement personnel receive timely, comprehensive training, supported by ongoing professional development on best practices and emerging trends. In other states, certification by the American Board of Medicolegal Death Investigators (ABMDI) is a requirement for coroners, deputy coroners, and death investigators. Implementing standardized investigation procedures and nationally recognized data collection protocols will improve the overall quality, consistency, and reliability of child death investigations throughout Kansas. More information about ABMDI can be found at: https://abmdi.org/.

The Kansas Coroner and Medicolegal Death Investigator Conference was held on August 19, 2026. This event brought together professionals from law enforcement, coroners, forensic pathologists, and related fields to enhance their expertise in forensic toxicology, drug-related death certification, and the investigation of SUID cases. Attendees gained critical knowledge on the complexities involved in infant and child death investigations and received training on the sensitive use of doll re-enactments, a valuable technique to aid in understanding SUID cases. Participants were also provided with SUID Investigation Kits, distributed by the Kansas SCDRB and the Office of the Kansas Attorney General. Since these yearly trainings have been implemented, there has been a noticeable increase in the use of doll re-enactments and the SUIDI reporting form.

PUBLIC POLICY RECOMMENDATIONS

The SCDRB strongly encourages consideration of the following public policy recommendations to enhance child death investigations, improve data quality, and prevent future child deaths in Kansas.

Public Policy Recommendations	
Recommendation	**Proposed Action**
Expand Information Sharing Between the Kansas State Child Death Review Board (SCDRB) and the Office of the Child Advocate (OCA)	• Amend K.S.A. 22a-244 and K.S.A. 75-7604 to authorize the SCDRB and OCA to exchange relevant case information when necessary to carry out their respective statutory duties. Improved information sharing would strengthen each entity's ability to fulfill its statutory responsibilities, identify concerns involving the child welfare system, and support efforts to improve the safety and well-being of Kansas children.
Expand the Definition of "Violent Offender" Under the Kansas Offender Registration Act (KORA) to Include Child Abuse	• Amend K.S.A. 22-4902(e) by adding subsection (J): Abuse of a Child, as defined in K.S.A. 21-5602. This proposed amendment would ensure that individuals convicted of child abuse are subject to the same registration requirements and public disclosure provisions as all other violent offenders under KORA, including placement on the KBI Registered Offender Website.
Improve Reporting of Child Abuse and Neglect	• Launch public service campaigns to educate all Kansans on when, how, and why they should report concerns of child abuse or neglect. • Regularly train mandated reporters regarding reporting laws and the process for reporting concerns accurately, appropriately, and in a timely manner.
Strengthen Safety Assessments for Newborns and Infants with Significant Child Welfare History	• Ensure that significant prior child welfare history prompts a comprehensive assessment of the infant's current safety and caregiver stability, including when concerns are assigned as a Family in Need of Assessment (FINA). Prior termination of parental rights, removal of other children, serious prior maltreatment, prenatal substance exposure involving the infant or a sibling, and other significant history should be verified and meaningfully considered. These circumstances should not automatically result in removal but should inform whether the infant can safely be placed with or remain in the care of a parent or caregiver. • Reconsider DCF policies which allow newborns and infants to be placed with parents or caregivers whose homes were previously deemed unsafe for the reintegration of older children or with caregivers who are actively using substances without evidence of treatment or stability. • When multiple or serious concerns remain unresolved, additional multidisciplinary involvement and court oversight should be considered to ensure the infant's safety.

Recommendation	Proposed Action
Strengthen Safety Protocols for Infants and Young Children with Substance-Using Caregivers	• Review and revise DCF policies for Family in Need of Assessment (FINA) reports involving substance-exposed infants to ensure that significant prior history and current safety concerns prompt a comprehensive, in-person assessment of the infant, caregiver stability, and home environment. Establish an escalated response when the family cannot be located or when caregivers refuse access necessary to complete a safety assessment. • Require thorough safety planning when an infant or young child will be placed with or remain in the care of a parent or caregiver with substance use concerns. Safety planning should consider the home environment, the substance use and stability of each caregiver who will provide care, prior and current child welfare history, and whether identified protections can be consistently maintained. • Delay hospital discharge of newborns when healthcare providers believe there are serious safety concerns that have not been adequately addressed prior to DCF clearance for release to the parent. Law enforcement, child advocacy center multidisciplinary team, or prosecuting attorney could be requested to review the placement concerns before the infant is discharged. • Ensure pregnant women, parents, and caregivers with substance use concerns receive timely referrals for assessment, treatment, and appropriate support services, with ongoing monitoring to confirm engagement and completion. When substance use continues, serious safety concerns remain unresolved, or a voluntary safety plan does not provide sufficient protection, coordinate among healthcare providers, DCF, law enforcement, and other appropriate partners and consider court oversight before the child is released to, returned to, or remains in the caregiver's care.
Ensure Compliance with Adrian's Law and CARE Referrals	• Continue comprehensive and ongoing training for DCF employees and law enforcement officers regarding the requirements of K.S.A. 38-2226(h), commonly known as Adrian's Law, and K.S.A. 38-2226(i), concerning Child Abuse Review and Evaluation (CARE) referrals. • Ensure DCF employees involved in investigations of physical abuse receive training regarding appropriate agency responses and substantiation findings based on CARE evaluation outcomes, and that all investigations subject to Adrian's Law are reviewed for compliance.
Enhance Training and Information Access for Child Welfare Professionals	• Ensure DCF employees and contracted agency staff receive ongoing, high-quality training on best practices in child welfare and safety assessments, with effective DCF oversight of contracted agency staff to support consistent practice. • DCF and partner agencies should obtain and share medical records, law enforcement reports, and other relevant investigative information with all professionals responsible for child safety assessments. Medical providers reporting suspected abuse or neglect should provide complete records pertinent to the investigation.

Recommendation	Proposed Action
Ensure Objective and Comprehensive Evaluation of Child Abuse Investigations	• Ensure DCF caseloads allow investigators to perform high-quality, thorough assessments of all abuse and neglect allegations in a timely manner. • Objectively evaluate all evidence in DCF investigations, including law enforcement reports, related judicial proceedings, and prior DCF investigations. A parent's uncorroborated denial must not override other credible evidence when determining substantiation of child abuse. • Require additional, targeted training or disciplinary action for workers who fail to consistently conduct adequate investigations.
Improve Coordination and Communication Between DCF and Law Enforcement During Joint Investigations	• Immediately notify law enforcement for investigation in instances where the abuse reported to DCF may be criminal in nature. K.S.A. 38-2226 requires a joint investigation if there is a report of child abuse or neglect that indicates serious physical harm or sexual abuse and that action may be required to protect the child. Law enforcement receiving a report of abuse or neglect should assure that a DCF intake is made and that a visual inspection of the child is performed by an investigator with experience in injury assessment, including a CARE referral for children ages 5 and under. • Provide education to DCF and health care providers, including hospitals, about reporting any unwitnessed, unexplained or suspicious death or near death of a child to law enforcement for investigation. The investigations should be a coordinated effort by DCF and law enforcement to ensure thorough investigations and the safety of surviving children. • Review and adopt a best practice approach for DCF and law enforcement investigations of all allegations of abuse and neglect. Once adopted, training should be conducted with all employees including contracted staff to ensure they understand the scope and extent of investigation necessary in all allegations of abuse and neglect. Standards for investigation should be carried out consistently.
Perform Unannounced Inspections of Programs Serving Children	• Implement regular unannounced inspections of residential placements including but not limited to residential centers, group homes, Qualified Residential Treatment Programs, transitional living programs, emergency shelters, and secure care programs to ensure compliance with safety, staffing, and care standards. Inspections should review the physical environment, staffing ratios, care plans, medication administration, and any safety or abuse concerns. • Implement regular unannounced inspections of youth substance abuse treatment centers to evaluate the quality and consistency of care. Kansas Department for Aging and Disability Services (KDADS) inspections should focus on treatment program fidelity, implementation of individualized care plans, and the therapeutic environment, in addition to standard safety and staffing requirements.

Recommendation	Proposed Action
Reassess Implementation of the 2019 Child Welfare System Task Force Recommendations	• Review the recommendations proposed by the Child Welfare System Task Force in their 2019 report to determine progress on recommendations that have not yet been fully implemented. Priority should be given to implementation of the following recommendations: ○ **Data Infrastructure -** Continue development and implementation of the Kansas Comprehensive Child Welfare Information System (CCWIS), including the cross-system information-sharing capabilities envisioned by the 2019 Task Force. The completed system should support timely and efficient sharing of relevant information among DCF and other agencies and stakeholders serving children and families. ○ **Immediate Response -** Continue efforts to fully implement a statewide 24/7 response to reports of child abuse and neglect. While Kansas provides 24/7 access to the child abuse and neglect hotline and has expanded requirements for timely responses, additional efforts should ensure trained DCF investigators are available to respond after hours, on weekends, and on holidays when an immediate response is warranted.
Require Licensing for All Home-Based Child Care Providers and Establish Stricter Penalties for Unlicensed Providers	• Address the serious safety concerns related to the licensing exemption in HB 2045 (2025 session), which allows individuals to provide child care for fewer than 35 hours a week for up to four children (including up to two infants) without a license. Addressing these concerns will help uphold the quality and safety of child care in Kansas. • Update K.S.A. 65-514 to modernize penalties associated with providing unlicensed child care, including increasing fines from a minimum of $50 per day to $200 per day, reclassifying violations from an unspecified misdemeanor to a Class A nonperson misdemeanor, and establishing enhanced penalties of a severity level 7 person felony for second or subsequent convictions or when a child is harmed. • Issue immediate cease-and-desist orders and timely public warnings regarding unlicensed care operations.
Increase Family Friendly Workplaces in Kansas	• Increase efforts to promote Kansas workplaces that offer flexible work schedules, paid parental leave, child care, breastfeeding support, and livable wages. The Kansas Power of the Positive (KPoP) is a statewide coalition focused on preventing adverse childhood experiences and promoting safe, stable, nurturing relationships and environments for Kansas children. Their efforts to promote family-friendly workplaces are a valuable component of this work and should receive continued support at the state level.[26]
Increase Accessibility to Mental Health & Crisis Services for Youth	• Expand Community Mental Health Center outreach to increase awareness of available mental health and crisis services for youth, including how to access urgent and ongoing support.

Recommendation	Proposed Action
Increase Awareness of Youth Suicide Prevention Tools and Supports	• Ensure collaboration between the Youth Suicide Prevention Coordinator and schools, communities, and state agencies to increase awareness of Kansas-A Friend AsKS, a youth suicide prevention app, and 988, the National Suicide Prevention Lifeline. Outreach efforts should ensure youth, as well as parents, caregivers, educators, and other community members, are familiar with these resources and understand how to use them to report suicidal thoughts for themselves or concerns about their peers.
Strengthen Harmful Online Content to Minors Law	• Strengthen K.S.A. 21-6402 to include websites that promote or encourage suicide. While current law requires websites providing harmful content to minors to implement age verification or face penalties for noncompliance, it does not explicitly cover websites that promote or encourage suicide.
Expand Education and Availability of Naloxone	• Support implementation of the naloxone requirements enacted through 2026 HB 2534 and ensure school personnel, students, and families understand how to recognize a suspected opioid overdose and access naloxone in an emergency. • Continue expanding naloxone availability in homes, accredited nonpublic schools, and community settings where youth may be at risk. Caregivers, educators, and peers should receive information about how to obtain and administer naloxone in an emergency. • Encourage Kansas schools to implement school-wide education for middle and high school students to raise awareness about the risks of fentanyl and opioids, using free resources provided by D.A.R.E. America.
Promote Firearm Safety Education and Secure Storage	• Support educational programs and information sharing in schools, community centers, and youth organizations that teach children and youth about firearm risks, safe behavior, and the importance of never handling a firearm without adult supervision. [31] • Encourage the use of gun locks, safes, and other safety devices and support initiatives establishing secure-storage requirements in households with minors or other vulnerable individuals. [31]
Prohibit All Retail Sales and Possession of THC and Kratom Products	• Increase law enforcement action to identify and seize illegal products, investigate the sources and supply chains through which children obtain these substances, and enforce penalties against individuals or businesses responsible for distributing them.
Increase Education and Enforcement of Child Passenger Safety Laws	• Promote public awareness and enforce compliance with child passenger safety laws, including seat belt use, car seat and booster seat requirements, and ensuring that children under the age of 13 do not ride in the front passenger seat.

Recommendation	Proposed Action
Increase Education on Safe Sleep for Parents and Caregivers	• Continue hospital policies and practices regarding safe sleep of infants while hospitalized, and education of all parents prior to discharge from the hospital. The board supports these policies and practices, and encourages hospitals to include statistics on sleep-related deaths and provide regular monitoring of practices and messaging in the hospitals to assure accuracy and consistency in supporting the **ABCs** of safe sleep: **A**lone on their **B**acks in a **C**rib. • 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.
Improve the Quality of Law Enforcement Investigations for Infant Deaths	• Expand the knowledge and training of specialized investigators involved in child abuse and neglect cases. Law enforcement and other death investigators should expand their knowledge of child fatality investigations through high-quality training including implementation of the Center for Disease Control's Sudden Unexpected Infant Death Investigation Reporting Form (SUIDIRF) and Sudden Death in the Young (SDY) protocols, and the use of scene recreation and photography. • Adopt procedures based on best practices for child abuse, neglect, and child death investigations. Require a portion of each law enforcement officer's annual training to address child physical abuse, 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. These standards should be applied consistently by all officers and across all jurisdictions.
Improve the Quality of Prosecutorial Decision-Making Regarding Infant Deaths	• Ensure that all prosecutors tasked with reviewing infant death cases have specialized knowledge and experience in child death investigations and child abuse/neglect or consult with other prosecutors with such specialized knowledge and experience 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. • Collaborate with local law enforcement agencies, DCF, and child advocacy centers to assure a coordinated effort toward using a best practices approach to the investigation and prosecution of all allegations of abuse and neglect.
Require Training and Continuing Education for Kansas Coroners	• Amend K.S.A. 22a-226 to require all district coroners, including those appointed to serve an individual county, to complete training in medicolegal death investigation within 180 days of appointment and at least 10 hours of continuing education annually thereafter. Training requirements should be established by the secretary of health and environment and include appropriate training related to the investigation of child deaths.

Recommendation	Proposed Action
Improve the Quality of Forensic Investigations and Autopsies of Child Deaths	• Require that forensic pathologists who perform autopsies of children 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. • Ensure that coroners and/or medicolegal death investigators respond to all unexpected child death scenes and coordinate their investigation with law enforcement. • Perform doll re-enactments with appropriate photo documentation in investigations of sleep-related deaths. • Perform autopsies in cases of unexpected natural child deaths unless the child has a known terminal condition or the death is one in which a child with a chronic debilitating disorder was under the care of a physician who had no concerns about the child's care or circumstances. • Follow Child Autopsy Guidelines and Recommendations. The Kansas SCDRB has issued comprehensive guidelines concerning the autopsies of children and adolescents under coroner jurisdiction. These guidelines specify that postmortem examinations of children be conducted by a forensic pathologist. The guidelines also stipulate rigorous standards for the procedure, including a thorough examination of all organs, including the brain, as well as the incorporation of toxicological analysis and radiographic imaging. These protocols ensure the highest standard of investigation and accuracy in the determination of cause and manner of death.
Standardize and Strengthen Suicide Death Investigations	• Enhance suicide investigations to include comprehensive information on a youth's social, mental health, and medical history. Investigations should address family stressors, prior trauma, suicide attempts, mental health services, and relevant online and social media activity. Investigations should also include analysis of electronic devices. These steps are critical to identifying whether external factors, such as sextortion or encouragement of suicide, both of which are criminal under Kansas law, played a role in the death. • Develop standardized training and protocols for law enforcement and coroner investigators, including a suicide death scene investigation form to guide collection of relevant information and interviews with family, friends, and other relevant contacts.
Implement Mandatory Physician Reporting of Medically Impaired Drivers for Conditions Involving Lapses of Consciousness	• Mandate reporting by any physician or licensed medical provider who diagnoses or becomes aware of a patient with a condition likely to impair safe vehicle operation through episodic loss of consciousness or motor control, to the Kansas Department of Motor Vehicles. Conditions that should be reported include, but are not limited to, uncontrolled seizure disorders, unstable diabetes, and neurological or cognitive disorders, such as dementia.

Recommendation	Proposed Action
Strengthen Investigations of Fatal Motor Vehicle Crashes Involving Children	• Relevant state and local stakeholders should work together to establish consistent standards based on best practices for investigating fatal motor vehicle crashes involving children. These standards should address impairment, distraction, speed, driver license or permit status and restrictions, restraint and safety-equipment use, scene photography, the route and circumstances of travel, drowsy driving, and reckless driving. • Require that all MVC child fatalities include thorough investigations with toxicology testing performed on the deceased child as well as all drivers involved. When alcohol or drug use by a minor is identified, investigations should determine how the substances were obtained, with strong enforcement of penalties for individuals or establishments that illegally supply alcohol or drugs to minors. • Establish minimum standards for complete and accurate fatal-crash reports and provide appropriate training for law enforcement officers responsible for investigating fatal crashes involving children, even when a full crash reconstruction is not warranted.
Strengthen Graduated Driver Licensing and Farm Permit Requirements	• Review K.S.A. 8-296 to determine whether the current minimum age and requirements for obtaining a farm permit provide adequate safeguards for young and inexperienced drivers. Consider requiring additional driver education, supervised driving experience, or demonstrated driving competency before a farm permit holder under age 16 is permitted to drive independently. • Ensure that young drivers and their parents or caregivers receive clear information regarding farm permit restrictions, including when, where, and for what purposes independent driving is permitted. A previous crash or serious traffic violation involving a young driver should prompt reassessment of the youth's driving skills and consideration of additional education or supervised driving before independent driving continues.
Strengthen Off-Road Vehicle (ORV) Usage Laws	• Impose a minimum age requirement of 16 years to operate an ORV within this state. • Require that operators and passengers under the age of 18 wear helmets, eye protection, and protective clothing, similar to the provisions of K.S.A. § 8-1598. • Require seat belt use in ORVs with originally equipped restraint systems. Examples include work-site utility vehicles (UTV), micro utility trucks, and golf carts.
Update Rear-Facing Car Seat Requirements	• Amend Kansas law to require all children from birth to two years of age be secured in a vehicle back seat in a rear-facing child passenger restraint system until the child exceeds the height or weight limit allowed by the manufacturer of the child restraint being used. Only car seats that meet federal standards should be used.

Recommendation	Proposed Action
Legislate Rear-Seat Age Requirement	• Update Kansas law to require all children under the age of 13 to ride in the rear seat of a vehicle when available and impose penalties for noncompliance. Even at age 13, children under 4 feet, 9 inches tall, or weighing less than 80 pounds, are safer in the back seat.
Decrease Distracted Driving	• Engage citizens and lawmakers in supporting efforts to promote and encourage individuals to reduce the use of hand-held devices while operating a motor vehicle. 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.
Establish Child Helmet Safety Requirements	• Require all children under the age of 16 to wear a properly fitted helmet when riding bicycles, scooters, or skateboards. • Require all children under the age of 18 to wear a properly fitted helmet and eye protection when riding motorized bicycles, electric-assisted bicycles, or electric-assisted scooters. • Provide educational materials and ensure helmets are affordable and accessible for all families.
Strengthen Personal Flotation Device Requirements for Children	• Extend Kansas law to require children 12 years of age and younger to wear a U.S. Coast Guard approved personal flotation device not only while aboard or being towed by a vessel on public waters, but also when swimming or wading in lakes, rivers, or other navigable public waters in Kansas.

GOALS AND HISTORY

The Kansas 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 SCDRB works to identify patterns, trends, 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 SCDRB 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 certificates, death certificates, 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 SCDRB to assist other agencies in prioritizing education and prevention efforts. The SCDRB members and staff collaborate with other agencies on child safety issues, testify on pertinent legislation, conduct trainings, and serve on committees and task forces to support efforts to protect 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 established pursuant to K.S.A. 22a-243. Membership includes: one member each representing 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; four members appointed by the State Board of Healing Arts: a district coroner, a physician specializing in pathology, and two physicians specializing in pediatrics; 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 multidisciplinary 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 provided the information necessary to examine the circumstances that led to the deaths of children. By understanding how children are dying, the SCDRB is able to propose ways of reducing the number of preventable deaths.

METHODOLOGY

PROCESS - KANSAS STATE CHILD DEATH REVIEW BOARD

The SCDRB meets monthly to review the deaths of all Kansas children up to age 17, including non-residents who died in Kansas. 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.

As a rule, the SCDRB is notified of a death when a death certificate, matched with its corresponding birth certificate, is received from KDHE'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 SCDRB and share birth and death records as allowed.

Upon receiving a death certificate, SCDRB staff creates a file and gathers key records for review and analysis. These include coroner and autopsy reports, medical and law enforcement records, scene and autopsy photos, DCF and school records, media reports, obituaries, and other relevant materials. All SCDRB information is confidential except as allowed by K.S.A. 22a-243(k).

After collecting all records, SCDRB staff assigns cases to SCDRB members for review. Members enter information about each case into the National Fatality Review Case Reporting System (NFR-CRS). At monthly meetings, members present completed cases, discuss each child's death, agree on and approve the cause and manner of death, and then finalize the case. After finalizing all cases for the year, data from the NFR-CRS is analyzed to identify trends and inform prevention recommendations. The analysis is compiled into the annual report, which informs policymakers, stakeholders, and the public about child mortality in Kansas and guides future prevention.

RATES OF DEATH

It should be noted that the numbers and rates in this report may not be the same as those reported in the KDHE Annual Summary of Vital Statistics, which only monitors deaths of Kansas residents. Case file information may not be available to the coroner when the cause of death is determined, resulting in incomplete information about the circumstances of the death. After review, the classification of the cause or manner of death may be different from that determined by the coroner or what was listed on the death certificate.

The current reporting of data follows the custom of presenting death rates for infants per 1,000 live births and death rates for all other age groups per 100,000 population. The exception to this rule is when rates for infants and older children are compared in the same graph. In such instances, infant mortality is expressed as deaths per 100,000 of the infant population. Several figures throughout this report contain data based on small numbers. Rates and percentages based on small numbers can be unreliable due to random error and should be used with caution.

Unless otherwise noted, all U.S. death rates cited in this report are derived from the CDC WONDER Online Database (Centers for Disease Control and Prevention, National Center for Health Statistics, 2024) which is cited within the References section of this report.[29]

RACE AND ETHNICITY

The following race/ethnicity groups are used in the report: American Indian (including Alaska Native), Asian (including Pacific Islander), Black (including African American), Hispanic (including Latino), and White (including Caucasian). Multiple Race indicates two or more Non-Hispanic races. Death rates for some groups have been suppressed due to small, potentially unreliable numbers.

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. Generative artificial intelligence tools were used on a limited basis to assist with proofreading, grammar, clarity, and writing fluency. All content, data, analyses, findings, and conclusions were reviewed and verified by SCDRB staff. Artificial intelligence was not used to generate or analyze the data presented in this report.

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 email: Sara.Hortenstine@ag.ks.gov.

APPENDIX A - RESIDENT COUNTY OF DEATH, 2020-2024, N=1,848								
County	**Population, Ages 0-17, 2020-2024**	**Total Deaths, Ages 0-17, 2020-2024**	**Natural**	**Unintentional Injury**	**Homicide**	**Suicide**	**Undetermined**	**Rate of Death per 100,000, 2020-2024**
Allen	13,880	5	4	1	0	0	0	*
Anderson	9,957	2	0	1	0	0	1	*
Atchison	17,783	12	6	2	0	2	2	67.5**
Barber	4,781	3	2	0	0	1	0	*
Barton	30,086	20	9	3	1	1	6	66.5
Bourbon	18,700	6	1	2	0	1	2	*
Brown	11,774	2	0	1	1	0	0	*
Butler	83,760	37	15	10	2	4	6	44.2
Chase	2,562	1	1	0	0	0	0	*
Chautauqua	3,648	2	1	1	0	0	0	*
Cherokee	21,878	9	5	1	0	0	3	*
Cheyenne	2,908	3	0	1	0	1	1	*
Clark	2,310	1	0	0	1	0	0	*
Clay	9,332	4	2	0	0	2	0	*
Cloud	10,341	7	3	0	0	1	3	*
Coffey	8,804	3	0	2	0	1	0	*
Comanche	1,947	1	1	0	0	0	0	*
Cowley	40,358	22	12	2	1	5	2	54.5
Crawford	42,906	20	12	2	0	2	4	46.6
Decatur	2,823	2	0	1	0	1	0	*
Dickinson	21,189	13	4	5	0	1	3	61.4**
Doniphan	7,909	3	2	1	0	0	0	*
Douglas	105,524	44	25	7	4	3	5	41.7
Edwards	3,101	1	0	0	0	0	1	*
Elk	2,806	1	1	0	0	0	0	*
Ellis	29,268	9	4	2	0	2	1	*
Ellsworth	5,549	1	1	0	0	0	0	*
Finney	55,810	22	10	8	0	2	2	39.4
Ford	50,443	35	20	5	3	4	3	69.4
Franklin	29,873	16	9	5	1	1	0	53.6**

County	Population, Ages 0-17, 2020-2024	Total Deaths, Ages 0-17, 2020-2024	Natural	Unintentional Injury	Homicide	Suicide	Undetermined	Rate of Death per 100,000, 2020-2024
Geary	55,348	45	29	5	1	2	8	81.3
Gove	3,414	2	1	0	0	1	0	*
Graham	2,480	1	0	0	0	0	1	*
Grant	10,758	6	2	2	1	0	1	*
Gray	8,277	6	5	1	0	0	0	*
Greeley	1,650	3	1	1	0	0	1	*
Greenwood	6,300	6	2	3	0	1	0	*
Hamilton	3,426	2	0	2	0	0	0	*
Harper	6,812	2	1	0	0	1	0	*
Harvey	39,825	25	16	3	1	0	5	62.8
Haskell	4,953	2	2	0	0	0	0	*
Hodgeman	2,012	4	1	2	0	0	1	*
Jackson	16,668	9	4	2	0	1	2	*
Jefferson	20,170	9	4	2	1	2	0	*
Jewell	3,014	3	0	1	0	1	1	*
Johnson	721,325	203	131	30	8	22	12	28.1
Kearny	5,585	1	1	0	0	0	0	*
Kingman	8,046	6	2	1	0	2	1	*
Kiowa	2,880	1	1	0	0	0	0	*
Labette	23,865	11	2	3	0	1	5	46.1**
Lane	1,806	0	0	0	0	0	0	*
Leavenworth	97,597	46	23	6	4	4	9	47.1
Lincoln	3,201	3	2	0	1	0	0	*
Linn	10,658	6	2	1	0	0	3	*
Logan	3,402	0	0	0	0	0	0	*
Lyon	35,805	13	5	6	0	0	2	36.3**
Marion	12,306	8	3	4	1	0	0	*
Marshall	11,872	3	2	0	0	1	0	*
McPherson	32,907	13	7	5	0	1	0	39.5**
Meade	5,178	4	3	1	0	0	0	*
Miami	40,993	14	9	4	1	0	0	34.2**

County	Population, Ages 0-17, 2020-2024	Total Deaths, Ages 0-17, 2020-2024	Natural	Unintentional Injury	Homicide	Suicide	Undetermined	Rate of Death per 100,000, 2020-2024
Mitchell	6,907	1	0	1	0	0	0	*
Montgomery	36,182	17	7	4	0	2	4	47.0**
Morris	5,534	3	2	1	0	0	0	*
Morton	3,146	2	0	0	0	1	1	*
Nemaha	13,503	4	0	2	0	1	1	*
Neosho	19,032	15	10	1	1	0	3	78.8**
Ness	2,949	2	2	0	0	0	0	*
Norton	5,092	1	0	1	0	0	0	*
Osage	17,991	9	4	4	1	0	0	*
Osborne	3,865	1	0	0	0	0	1	*
Ottawa	6,705	4	2	0	0	0	2	*
Pawnee	4,799	2	1	0	1	0	0	*
Phillips	5,409	2	2	0	0	0	0	*
Pottawatomie	37,342	21	12	3	0	1	5	56.2
Pratt	10,913	6	2	2	0	0	2	*
Rawlins	2,847	0	0	0	0	0	0	*
Reno	67,205	38	19	8	0	4	7	56.5
Republic	5,080	4	0	2	1	1	0	*
Rice	10,863	8	5	2	0	0	1	*
Riley	58,345	22	11	4	2	0	5	37.7
Rooks	5,256	3	1	1	0	1	0	*
Rush	2,897	2	2	0	0	0	0	*
Russell	7,388	3	1	2	0	0	0	*
Saline	60,641	28	20	7	0	0	1	46.2
Scott	6,476	4	2	1	0	1	0	*
Sedgwick	653,448	401	213	65	42	27	54	61.4
Seward	33,162	15	8	3	0	0	4	45.2**
Shawnee	203,667	128	63	25	17	7	16	62.8
Sheridan	2,996	1	0	1	0	0	0	*
Sherman	6,940	3	1	0	1	0	1	*
Smith	3,608	0	0	0	0	0	0	*

County	Population, Ages 0-17, 2020-2024	Total Deaths, Ages 0-17, 2020-2024	Natural	Unintentional Injury	Homicide	Suicide	Undetermined	Rate of Death per 100,000, 2020-2024
Stafford	4,786	1	0	1	0	0	0	*
Stanton	2,787	3	1	2	0	0	0	*
Stevens	7,439	5	3	1	0	1	0	*
Sumner	26,943	12	9	0	1	1	1	44.5**
Thomas	9,418	7	4	2	0	0	1	*
Trego	2,593	0	0	0	0	0	0	*
Wabaunsee	8,013	1	1	0	0	0	0	*
Wallace	2,054	1	1	0	0	0	0	*
Washington	6,625	3	1	0	0	1	1	*
Wichita	2,870	1	1	0	0	0	0	*
Wilson	10,060	3	0	2	0	0	1	*
Woodson	3,101	2	2	0	0	0	0	*
Wyandotte	226,137	143	65	26	20	5	27	63.2
Out of State	-	152	108	31	9	1	3	-
Total	**3,477,557**	**1848**	**997**	**353**	**129**	**130**	**239**	**-**

*Death count of 9 or less, suppressed **Death count of 10-19, which should be used with caution

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