Approved: 3-18-94
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE

The meeting was called to order by Chair Sandy Praeger at 10:00 a.m. on March 8, 1994 in Room 526-S of the Capitol.

All members were present except:

Committee staff present: Norman Furse, Revisor of Statutes
William Wolff, Legislative Research Department
Emalene Correll, Legislative Research Department
Jo Ann Bunten, Committee Secretary

Conferees appearing before the committee:

Nancy Lindberg, Chairperson, State Child Death Review Board, Attorney General's Office
Jim McHenry, Kansas Children's Service League
Elsie Wolters, Oberlin

Others attending: See attached list

Hearing on SB 782 - Child death review board staffing and office

Nancy Lindberg, AG's office, addressed the Committee in support of **SB 782** and noted the Child Death Review Board was established by the 1993 legislature. As Chairperson of the Board, Ms. Lindberg stated that she spends two to three days a week working on the Board, and the remaining members serve as volunteers with no reimbursement from the state for their travel or time. The majority of the expenses incurred by the Board has been borne by the Attorney General's office. **SB 782** would require the Board to establish a permanent office in Topeka, appoint an executive director, support staff and a medical investigator. Ms. Lindberg recommended deleting language in the bill on page 2, lines 37 to 42 that made reference to hiring a medical investigator. The cost for two staff positions was estimated to be $55, 418, plus operating and travel expenses, for a total of $97,018. All but the $10,000 start up costs would be ongoing expenditures in future fiscal years. Ms. Lindberg also provided the Committee with the 1993 annual report of the State Child Death Review Board. (Attachment 1)

Ms. Lindberg noted that it has never been difficult to obtain Board members to serve without compensation, and that there is not a sunset provision in the statute. Committee discussion related to language dealing with appropriations and justifying the cost associated with the Board. Ms. Lindberg felt that an educational program in prevention of accidents should be emphasized, and that it would be beneficial and appropriate to have some sort of time line in the statute regarding notification of death from coroners.

James McHenry, KCDR Board member and Associate Executive Director of the Kansas Children's Service League, appeared before the Committee in support for **SB 782** as well as providing written testimony from Katherine J. Melhorn, M.D., and member of the Kansas Child Death Review Board. Mr. McHenry noted that as a Board, they have discovered cases in which the information on the death certificate differed from the information on the autopsy, and that medical members on the Board have called to their attention instances where appropriate blood screens and oncology tests - things that normally would have been expected - have for some reason been omitted. He also noted prevention strategy and early detection have become more prevalent, and that firearm related deaths among children are rapidly surpassing deaths from traffic accidents. It was pointed out by Mr. McHenry that the new KDHE data base will generate important information from the Board's reviews. (Attachment 2)

During Committee discussion, it was pointed out that as the bill is now written, the Board would be a free standing entity, and suggestion was made that the Board be under the umbrella of the Attorney General's office.

Elsie I. Wolters, Oberlin, expressed concern with some of the language in **SB 782** and told of the death of her daughter in which no autopsy was done. Ms. Wolters felt the Board should research the history and genealogy of children who have a family history of various diseases. (Attachment 3)

It was pointed out by staff that the Committee may want to consider rules and regulations that would set the guidelines of when the coroner must do an autopsy. The Chair noted that additional information would be obtained on this issue, that language be drafted to specify authority for the oversight of the Child Death Review Board by the Attorney General's office be retained, and delete the reference to the medical investigator as noted in the bill.

Action on SB 748 - Pharmacy authorized ratio of supportive personnel to licensed pharmacists

After Committee discussion and input from staff, Senator Jones made a motion that an amendment be adopted that clarifies that the Board of Pharmacy has the authority to extend the pharmacy ratio, and that **SB 748 as amended**, be recommended favorably for passage, seconded by Senator Salisbury. The motion carried.

The meeting was adjourned at 11:00 a.m.

The next meeting is scheduled for March 9, 1994.

GUEST LIST

COMMITTEE: SENATE PUBLIC HEALTH & WELFARE DATE: 3-8-94

NAME	ADDRESS	COMPANY/ORGANIZATION
Cecil Bothwell	KC	Health Midwest
J D Wolters	Oberlin	
Frances Kastner	Topeka	Ks Food Dealers Assn
Joe Fujosic	Topeka	KCA
Jon Pj Fleeson	Topeka	Att'y Gen Off.
Harold Riegel	Topeka	KAHM
Margaret Lindeen	Columbia	Boehringer Ingelheim
David E. Jill	Dallas	Zeneca
Donald Wisot	Wamego	Child Death Board
Nancy Lindberg	Topeka	Att'y Gen
Wayne E Thomas	Topeka	Coroner
Lorna R. Phillips	Topeka	KAHF
Jim McHenry	Topeka	KCSL
Chris Wolters	Oberlin KS	Parent
Bob Williams	Topeka	KS. Pharmacists Assoc.
Chip Wheeler	Topeka	Ks Medical Soc.
Sandy Constant	Denver Co	Syntex

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Testimony of
Nancy Lindberg
Chairperson, State Child Death Review Board
Before the Senate Public Health and Welfare Committee
RE: Senate Bill 782
March 8, 1994

Chairperson Praeger and Members of the Committee:

Thank you for this opportunity to appear before you today on behalf of the State Child Death Review Board. I am Assistant to Attorney General Bob Stephan and serve as his appointment to the board and as the chairperson of the State Child Death Review Board.

The Kansas Legislature created the State Child Death Review Board in the 1992 legislative session for the purpose of identifying how children are dying in Kansas and evaluating what can be done, if anything, to prevent those deaths. Appointments to the board were made in the fall of 1992 and the first meeting was held in January, 1993. At first the board met frequently in order to set our purpose, goals and protocols for the various professionals associated with the board. (See Appendix A in annual report.)

From the beginning, no appropriation was made for the State Child Death Review Board. Those of us who are state employees are appointments of the various agency heads and have added the work to our other responsibilities. The remaining members serve as volunteers on the board with no reimbursement from the state for their travel or time. The majority of the expenses incurred by the board (mainly printing and postage) has been borne by the attorney general's office.

In July, 1993, the State Child Death Review Board began meeting monthly and was ready to begin identifying each child's death from the ages of 0 through 17. The form we have asked coroners to complete (see annual report) along with law enforcement and social service information provides the necessary data for us to identify the circumstances of a child's death.

Senate PH&W
attachment #1
3-8-94

In the first six months (July through December, 1993) we reviewed 72 of the 215 child deaths. Some of the concerns we have discovered include:

1. We've had one case (93-033) where a death was declared SIDS without an autopsy. Our coroner member on the board followed up and discovered that the physician in question had no copy of the relevant statutes and was unaware that the state will pay up to five hundred dollars for a SIDS-related autopsy.

Conclusion: There is a need for further education within the Kansas medical community regarding current Kansas law governing SIDS.

2. We've had several cases, including 93-022, where one board member drew attention to the fact that blood screens need to be done as well as urine screens. Another board member noted on case 93-040 that no blood screens were taken on the mother and child involved.

Conclusion: More attention needs to be paid to "best practice" in follow-up medical tests in child deaths.

3. A number of cases, including 93-030, 038 and 039 have involved youth whose lives might have been saved had they been wearing seat belts or restraints.

Conclusion: A public safety seat-belt awareness campaign aimed at adolescents appears to be a good idea.

4. We've seen at least one case, 93-050, where medical neglect contributed significantly to a child's death.

Conclusion: Education efforts should encourage the filing of Child in Need of Care (CINC) petitions in cases where medical neglect could prove fatal.

5. We've reviewed one case, 93-042, where SRS had prior reports of child abuse. It was noted that the mother was involved in alcohol/drug abuse treatment.

Conclusion: Evidence of significant alcohol/drug abuse by immediate caregivers should be treated as grounds for intense scrutiny and possible intervention by sanctioned state entities.

6. We've reviewed a number of cases involving children who have been killed in bicycle accidents.

Conclusion: The matter of a lack of appropriate parental supervision has arisen during the board's discussion of some cases. In general, public safety campaigns stressing the value of bike helmets for children and other elements of bicycle safety seem warranted.

Our first annual report was issued October 1, 1993. By statute, K.S.A. 22a-243(e), we are to "include the findings of the board regarding reports of child deaths, the board's analysis and the board's recommendations for improving child protection, including recommendations for modifying statutes, rules and regulations, policies and procedures."

Senate Bill 782 is our recommendation to you. I am submitting an amendment that we would propose. After some discussion at our last meeting, the board decided to recommend deleting on page 2, lines 37 to 42, the request for a medical investigator. We recognize the value of having such a person on staff to assist the counties that do not have a medical investigator, but we believe that the other two positions we recommend, the executive director and a secretary, are more important to the work of the board at this time. If money was not a problem, we would stand by our request for all three positions. The estimated cost for the two staff positions, including salary and benefits, is $55,418.

There are now 37 states with some form of child death review teams. In checking with several states we found that Colorado's board has one staff position. In Arizona there is a coordinator and a half-time clerical staff. Our neighbor Missouri probably has the most staff with seven.

Also included in this bill are the annual operating expenses estimated as follows: board travel and subsistence -- $5,400; rent of office space -- $11,200; other operating costs -- $15,000; first year startup costs --$10,000. The total of these expenses along with salaries is $97,018. All but the $10,000 startup costs would be ongoing expenditures in future fiscal years.

Finally, included in our bill is the deletion of the 24-hour timeline as set forth in K.S.A. 22a-242(c). Because the board does not have investigative power, the board does not believe the 24 hour notification is necessary.

In a recent national teleconference for child death review teams, Attorney General Janet Reno talked with us and said that "no child should be laid to rest before answering how and why he or she died". The members of the state child death review team are working hard to find these answers, but we need help. We are behind in the number of cases we are reviewing, we need to provide information and training for the professionals involved, and we must begin identifying prevention strategies that then can be implemented. There is so much we can do with the information we are gathering, but we can not do it without staff assistance. Kansas has made a good beginning by forming an active State Child Death Review Board, but we can't stop there. I ask for your support of Senate Bill 782.

STATE CHILD DEATH REVIEW BOARD

Attorney General appointment:

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KBI
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Secretary of SRS appointment:

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Secretary
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Secretary of Health and Environment appointment:

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Commissioner of Education appointment:

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State Board of Healing Arts appointments:

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Attorney General appointment to represent advocacy groups:

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Kansas County and District Attorneys Association appointment:

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* * * * *

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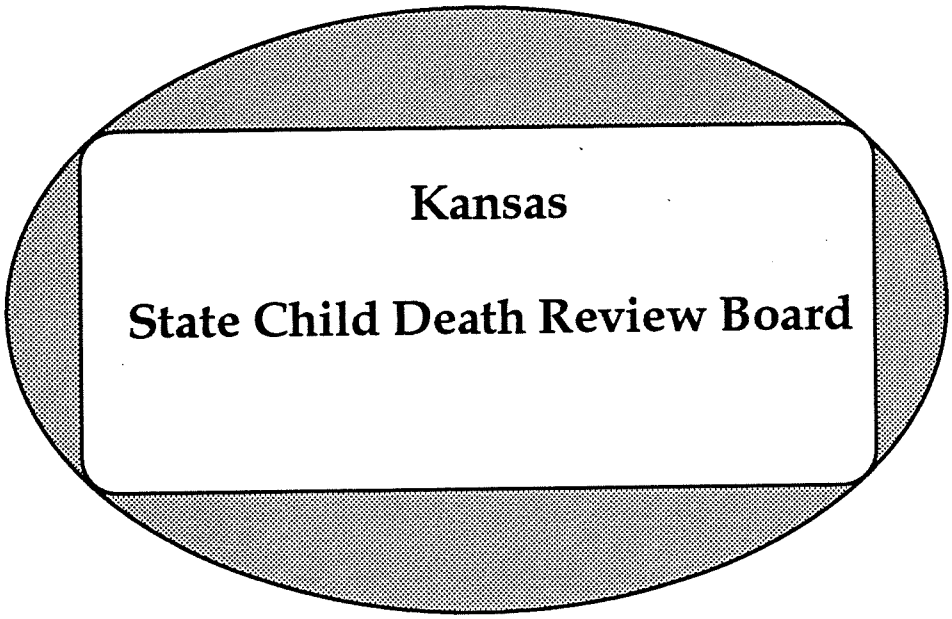

Annual Report
1993

INTRODUCTION

As required by K.S.A. 22a-243(1)(e) the State Child Death Review Board shall submit an annual report to the governor and the legislature on or before October 1 of each year. Such report shall include the findings of the board regarding reports of child deaths, the board's analysis and the board's recommendations for improving child protection, including recommendations for modifying statutes, rules and regulations, policies and procedures.

The first meeting of the State Child Death Review Board was held on January 21, 1993. The board was formed as a result of action taken by the 1992 Legislature.

It is recognized that a number of children are dying in Kansas. The time has come to determine why children die and to evaluate whether these deaths were preventable. The State Child Death Review Board is beginning to collect statistics of documented data as to why children in Kansas are dying.

The KDHE has established a data system that will include all data elements defined as necessary by the board. Analysis of the data and reports will be generated from this data base by the KDHE, Office of Research and Analysis. However, only aggregate data will be publicly released.

PROFESSIONALS INFORMED

At first the State Child Death Review Board met every two weeks. During these initial meetings the board members developed a purpose and goals; roles for each board member; protocols for law enforcement, coroners, physicians and SRS area directors; a form for coroners to complete on all child deaths; a form for the board to complete on all child deaths; a law enforcement summary sheet; an SRS Case Information Summary Sheet; and outlined the process for the State Child Death Review Board. A complete set of materials developed by the board is included in this report (Appendix A).

On July 1, 1993, the State Child Death Review Board sent letters and information to:

♦ coroners (265 pieces) — included the coroners protocol, statute and the form to be completed on all child deaths;

♦ police chiefs and sheriffs (425 pieces) — included the law enforcement protocol, statute and a summary sheet to be completed upon request on any child death;

♦ area SRS directors, social service chiefs — included the protocol and an SRS case information summary sheet;

♦ county and district attorneys (105 pieces) — included the statute and the county/district attorney role on the board.

The board also requested the Kansas Hospital Association include in their newsletter information on the State Child Death Review Board. In their July 16, 1993, Current Report, an article was included along with the board's instruction sheet for physicians (Appendix B).

CORONER REPORTS TO DATE

Since the forms were completed and the appropriate professionals informed, the State Child Death Review Board set July 1, 1993, as the beginning date to require all child deaths to be reported. The board is now meeting the third Monday of each month reviewing the coroner forms that have been completed. The forms are coming in slowly.

In August four coroner forms were reviewed; 20 death certificates for July had been received by the Department of Health and Environment. In those four deaths one was due to natural causes, one was reported as a SIDS death and two children died as a result of accidents. Reminder notices for information on the remaining 16 deaths were sent to coroners.

In September (July and August deaths) ten deaths were reviewed; 38 death certificates for July and August had been received by the Department of Health and Environment. Of these ten deaths reviewed by the board, three were due to natural causes, one was reported as a SIDS death, four children died as a result of accidents, one was a suicide and the reason for one child death was undetermined at the time of reporting. Again, reminder notices were sent to the coroners for information on the remaining 31 deaths.

RESEARCH INFORMATION

The board reviewed information collected over the past several years in Kansas and nationwide. The information included studies on children's deaths in Kansas and the results of other state's child death review boards. Since it is too early for the board to have findings of our own, we have provided Appendix C as a summary of the information we examined. This will provide you an example of what the board would like to offer in future reports.

PROBLEMS/CONCERNS/LEGISLATIVE RECOMMENDATIONS

1. The board needs two full time staff, operating expense and travel reimbursement for board members.

When the State Child Death Review Board was formed in 1992, no funding was provided. The members have served as volunteers with no travel expenses paid. The State Child Death Review Board members have spent an significant amount of volunteer time in setting up procedures and materials for the board.

The coroner forms reporting the child deaths are being completed by some coroners and submitted to the board. With no staff assistance the board will not be able to adequately review the forms submitted to the board; with no staff assistance the board will not be able to keep up with notifications to coroners who are not completing forms; and with no staff assistance the board will not be able to evaluate the information.

The Office of Attorney General Bob Stephan has absorbed the costs of mailings and underwritten the costs of providing materials for the board members. The time of a staff member in the attorney general's office has reached two to three days a week and she is not able to do many of the things that is needed for the board to properly function. This is an additional workload that will not be able to continue because of other responsibilities. In addition to the added work in the attorney general's office, individuals in other state agencies have had to absorb additional work responsibilities. This includes KDHE and SRS. By having State Child Death Review Board staff, many projects could be done so that the board members could limit their time commitment to the board work and so that the work of the board can be done to best meet the intent of the legislation.

Most states with state child death review boards have funding. For example, the newly formed Arizona Child Fatality State Team has two staff—one program manager and one clerical person. Arizona funded their program by increasing the death certificate fee $1.00 ($5.00 to $6.00) which generated $220,000. Besides funding this program, the balance of the increased fee goes to a Child Abuse Prevention Fund which funds programs such as Healthy Start. Arizona also provides travel expenses for board members.

THE BOARD RECOMMENDS A PROFESSIONAL STAFF PERSON (LEVEL 26, STEP A) AND A SECRETARY III (LEVEL 17, STEP A). THE BOARD FURTHER RECOMMENDS AN OFFICE AND OPERATIONAL EXPENSES. THIS PROGRAM COULD BE SET UP SIMILAR TO THE CRIME VICTIMS' COMPENSATION BOARD.

THE BOARD RECOMMENDS THE REIMBURSEMENT OF TRAVEL EXPENSES OF THE BOARD MEMBERS.

2. The board has limited enforcement power to require coroners to submit information on child deaths.

Except for subpoena power and the ability to report coroners to the Board of Healing Arts, the board has little power to get coroners to file a report on a child death to the board. The board has heard

from several coroners who are not willing to voluntarily comply with the board's request for information.

The coroners are asked to complete the form on each child death within one month of the death. In the two months since the board required the information from coroners, only 14 forms have been received for the 58 child deaths that have occurred. If all coroners do not participate, then the statistics will be incomplete and meaningless.

THE BOARD RECOMMENDS THE LEGISLATURE ENCOURAGE COUNTIES TO HIRE A MEDICAL INVESTIGATOR FOR THEIR COUNTY OR DISTRICT. THE BOARD ALSO RECOMMENDS THE STATE HIRE AN ADDITIONAL STAFF MEMBER FOR THE STATE CHILD DEATH REVIEW BOARD WHO IS A MEDICAL INVESTIGATOR TO WORK IN COUNTIES OR DISTRICTS WHERE THE LOCAL STAFF ARE NOT ABLE TO COMPLY WITH THE STATUTE.

3. A timeline as set forth in the statute is needing to be changed.

In K.S.A. 22a-242(c) - "If, after investigation and an autopsy, the coroner determines that the death of a child includes any suspicious circumstance or unknown cause ... the coroner shall, within 24 hours, notify the chairperson of the state review board and the county or district of the county where the death of the child occurred." Because the board does not have investigative power, the board does not believe the 24 hour notification is necessary. Also, a phone line with an answering machine would be needed to fully comply.

THE BOARD RECOMMENDS DELETING THE 24 HOUR NOTIFICATION REQUIREMENT.

4. Increased funding for additional autopsies will be needed by KDHE.

The new law generates a significant number of autopsies. Prior to the passage of this statute, KDHE was paying for SIDS autopsies. The legislature has changed the definition on which autopsies are required, thereby requiring KDHE to pay for more autopsies.

THE BOARD RECOMMENDS INCREASING THE APPROPRIATION TO KDHE TO COVER THE ADDITIONAL COSTS OF MANDATED AUTOPSIES.

5. Implementation of local review teams.

Based on experiences in other states, local review teams are a valuable addition to the work of state child death review teams.

THE BOARD RECOMMENDS THE LEGISLATURE ENCOURAGE THE ORGANIZING OF LOCAL REVIEW TEAMS.

IN SUMMARY

Although it is too soon for the State Child Death Review Board to recognize any trends and patterns of child deaths, the board has established a procedure and materials that will provide the necessary information needed for future reports. It is also too early to begin developing prevention strategies to avoid child deaths in Kansas.

The State Child Death Review Board has accomplished much in a short amount of time. The members of the board have volunteered their time and expertise to help get the work started. And now the legislature must decide what financial assistance it can provide to assist the board members in accomplishing the mandates as set forth in state statute. Without the funding, the work that the board feels needs to be accomplished cannot be completed. We believe that what you want us to do by statute is appropriate and necessary but must be funded. We appreciate your support of the State Child Death Review Board and encourage you to pass these recommendations in the 1994 legislative session.

APPENDIX A

PURPOSE AND GOALS OF THE STATE CHILD DEATH REVIEW BOARD

Background Statement

Child death review teams have been formed across the country as more attention is focused on fatal child abuse and neglect. It is apparent in many state jurisdictions, including Kansas, that a failure to identify cases of fatal child abuse exists. This is the result of several problems. For example, cause of death coding on death certificates fails to accurately identify abuse or neglect as contributors to death. Additionally, communication barriers between law enforcement, child protective services and reporting agencies allows for delayed and/or inadequate investigations of suspicious child deaths.

As child death teams developed experience, a broader scope of inquiry was found to be beneficial. Many preventable deaths obviously are not the result of child abuse. For example, the increased morbidity and mortality of preterm infants delivered in rural areas vs. a tertiary treatment center is a recognized problem. Referral centers can identify cases of unrecognized preterm labor, or delayed referral, resulting in a newborn death. Additionally, motor vehicle accidents, in which the child was unrestrained, cause preventable child deaths. Drownings, burn deaths, suicides, and other potentially preventable deaths also are of concern to the board.

Therefore, the Child Death Review Board, as a multidisciplinary, multiagency team, established by the Kansas Legislature with duties as described in the 1992 House Bill 3056, Secs. 33 and 34, has made a collaborative commitment to establish a systematic mechanism for intervention in and prevention of child fatalities.

Goals

1. To describe trends and patterns of child deaths (ages 0 through 17) in Kansas, identifying risk factors in the population.

2. To improve sources of data and communication between 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 should occur at the individual case level and at the local and state level.

3. To develop prevention strategies including community education and mobilization, professional training, and needed changes in legislation, public policy and/or agency practices.

STATE CHILD DEATH REVIEW BOARD

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Secretary of SRS appointment:

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Secretary
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Secretary of Health and Environment appointment:

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State Board of Healing Arts appointments:

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(913) 354-2607 (beeper)

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Attorney General appointment to represent advocacy groups:

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Kansas County and District Attorneys Association appointment:

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* * * * *

General Counsel:

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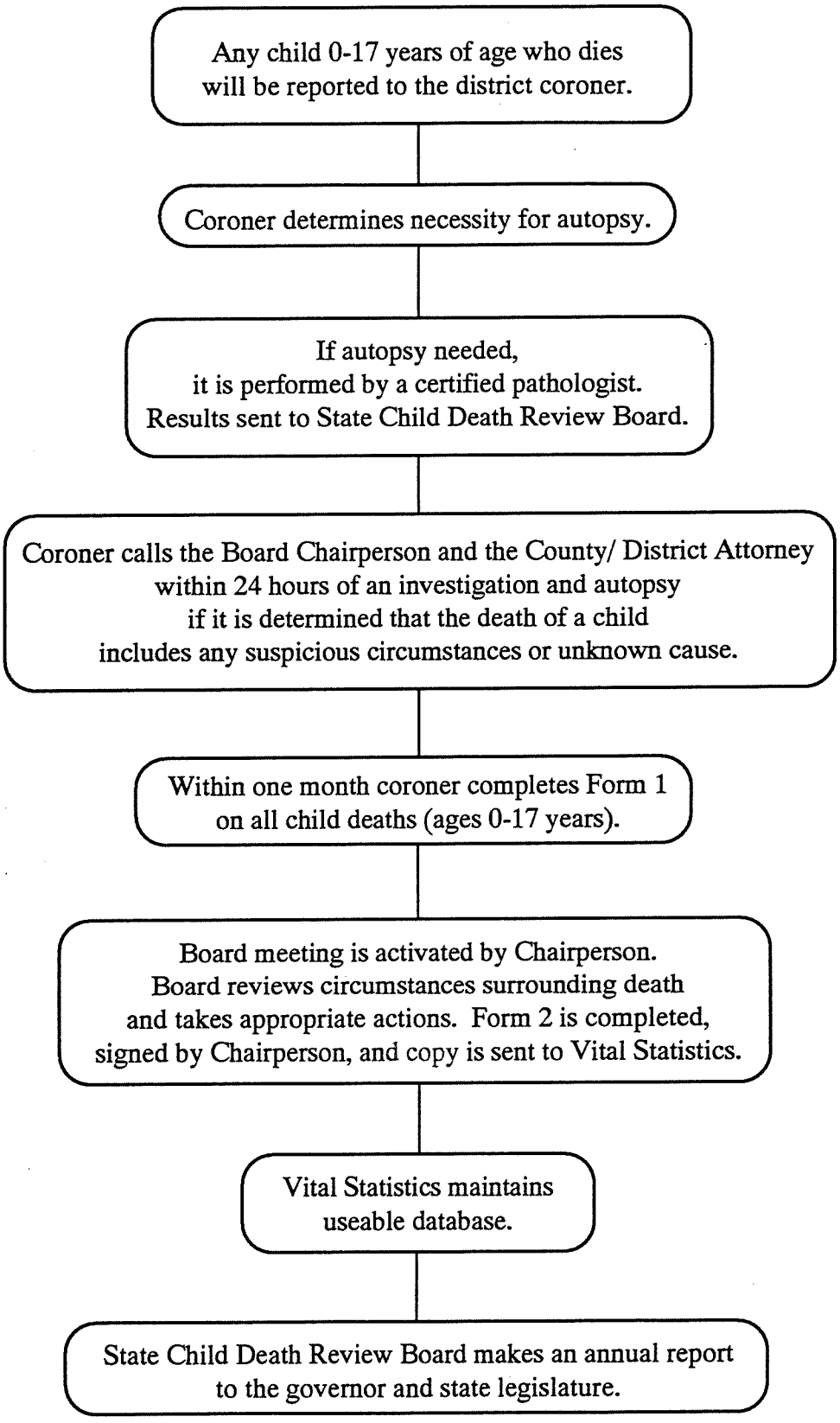
Process for State Child Death Review Board



vessel as defined by K.S.A. 82a-802 and amendments thereto.

(2) "Alcohol concentration" has the meaning provided by K.S.A. 8-1005 and amendments thereto.

(b) When an accident involves an air, land or watercraft and results, within four hours, in the death of the operator of such craft or a person not a passenger in a craft, the district coroner, or a person designated by the district coroner, shall withdraw blood or another bodily substance from the deceased for the purpose of determining the alcohol concentration and presence of drugs in the deceased's blood. The withdrawal shall occur within eight hours after death.

(c) The forensic laboratory of the Kansas bureau of investigation shall analyze the blood or other bodily substance withdrawn under this section to determine the alcohol concentration or presence of drugs in the deceased's blood. The results of the analysis shall be reported by the district coroner to the state registrar of vital statistics on a form provided by the secretary of health and environment. Such form shall not disclose the identity of the deceased person.

(d) The results of the analysis required by this section may be used by state and local officials only for statistical purposes that do not reveal the identity of the deceased person.

(e) This section shall not require withdrawal of blood or any other bodily substance from a person less than 14 years of age at the time of death unless such person was the operator of an air, land or watercraft involved in the accident.

History: L. 1988, ch. 39, § 1; L. 1990, ch. 226, § 9; July 1.

22a-238.

History: L. 1988, ch. 103, § 2; Repealed, L. 1992, ch. 312, § 41; July 1.

22a-239, 22a-240. Reserved.

CHILD DEATH REVIEW BOARD

22a-241. **Definitions.** As used in K.S.A. 1992 Supp. 22a-241 through 22a-244, and amendments thereto:

(a) "Child" means a person less than 18 years of age.

(b) "Pathologist" means a forensic pathologist, if available. Otherwise, "pathologist" means a physician licensed to practice medicine and surgery and qualified to conduct an autopsy.

(c) "State review board" means the state child death review board established by K.S.A. 1992 Supp. 22a-243.

(d) "Suspicious circumstances" includes, but is not limited to, abuse or neglect.

History: L. 1992, ch. 312, § 31; July 1.

22a-242. **Child death, notification of coroner; autopsy; notification of state review board; notification of parent or guardian; SIDS death; fee for autopsy.** (a) When a child dies, any law enforcement officer, health care provider or other person having knowledge of the death shall immediately notify the coroner of the known facts concerning the time, place, manner and circumstances of the death. If the notice to the coroner identifies any suspicious circumstances or unknown cause, as described in the protocol developed by the state review board under K.S.A. 1992 Supp. 22a-243, the coroner shall immediately: (1) Investigate the death to determine whether the child's death included any such suspicious circumstance or unknown cause; and (2) direct a pathologist to perform an autopsy.

(b) If, after investigation and an autopsy, the coroner determines that the death of a child does not include any suspicious circumstances or unknown cause, as described in the protocol developed by the state review board under K.S.A. 1992 Supp. 22a-243, the coroner shall complete and sign a nonsuspicious child death form.

(c) If, after investigation and an autopsy, the coroner determines that the death of a child includes any suspicious circumstance or unknown cause, as described in the protocol developed by the state review board under K.S.A. 1992 Supp. 22a-243, the coroner shall, within 24 hours, notify the chairperson of the state review board and the county or district attorney of the county where the death of the child occurred.

(d) The coroner shall attempt to notify any parent or legal guardian of the deceased child prior to the performance of an autopsy pursuant to this section and attempt to notify any such parent or legal guardian of the results of the autopsy.

(e) A coroner shall not make a determination that the death of a child less than one year of age was caused by sudden infant death syndrome unless an autopsy is performed.

(f) The fee for an autopsy performed under this section shall be the usual and reasonable fee and travel allowance authorized under

1-16

K.S.A. 22a-233 and amendments thereto and shall be paid from moneys available therefor from appropriations to the department of health and environment. The reasonableness of all claims for payment of a fee for an autopsy under this section shall be determined by the secretary of health and environment.

History: L. 1992, ch. 312, § 32; July 1.

22a-243. State child death review board; membership; development of protocol; annual report; confidentiality of records. (a) There is hereby established a state child death review board, which shall be composed of:

(1) One member appointed by each of the following officers to represent the officer's agency: The attorney general, the director of the Kansas bureau of investigation, the secretary of social and rehabilitation services, the secretary of health and environment and the commissioner of education;

(2) three members appointed by the state board of healing arts, one of whom shall be a district coroner and two of whom shall be physicians licensed to practice medicine and surgery, one specializing in pathology and the other specializing in pediatrics;

(3) one person appointed by the attorney general to represent advocacy groups which focus attention on child abuse awareness and prevention; and

(4) one county or district attorney appointed by the Kansas county and district attorneys association.

(b) The chairperson of the state review board shall be the member appointed by the attorney general to represent the office of the attorney general.

(c) The state review board shall meet at least annually to review all reports submitted to the board. The chairperson of the state review board may call a special meeting of the board at any time to review any report of a child death.

(d) The state review board shall develop a protocol to be used by the state review board. The protocol shall include written guidelines for coroners to use in identifying any suspicious deaths, procedures to be used by the board in investigating child deaths, methods to ensure coordination and cooperation among all agencies involved in child deaths and procedures for facilitating prosecution of perpetrators when it appears the cause of a child's death was from abuse or neglect.

(e) The state review board shall submit an annual report to the governor and the legislature on or before October 1 of each year, commencing October 1993. Such report shall include the findings of the board regarding reports of child deaths, the board's analysis and the board's recommendations for improving child protection, including recommendations for modifying statutes, rules and regulations, policies and procedures.

(f) Information acquired by, and records of, the state review board shall be confidential, shall not be disclosed and shall not be subject to subpoena, discovery or introduction into evidence in any civil or criminal proceeding, except that such information and records may be disclosed to any member of the legislature or any legislative committee which has legislative responsibility of the enabling or appropriating legislation, carrying out such member's or committee's official functions. The legislative committee, in accordance with K.S.A. 75-4319 and amendments thereto, shall recess for a closed or executive meeting to receive and discuss information received by the committee pursuant to this subsection.

History: L. 1992, ch. 312, § 33; July 1.

22a-244. Same; activation of board to investigate; access to records; subpoena power; report issued; disclosure of conclusions. (a) Within 72 hours after receipt of notification from a coroner pursuant to K.S.A. 1992 Supp. 22a-242, the chairperson of the state review board may activate the board to investigate and make a written report regarding the death.

(b) The state review board shall have access to all law enforcement investigative information regarding the death; any autopsy records and coroner's investigative records relating to the death; any medical records of the child; and any records of the department of social and rehabilitation services or any other social service agency which has provided services to the child or the child's family within three years preceding the child's death.

(c) The state review board may apply to the district court for the issuance of, and the district court may issue, a subpoena to compel the production of any books, records or papers relevant to the cause of any death being investigated by the board. Any books, records or papers received by the board pursuant to the subpoena shall be regarded as confidential and privileged information and not subject to disclosure.

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(d) The state review board's report shall contain the circumstances leading up to the death and cause of death; any social service agency involvement prior to death, including the kinds of services delivered to the dead child or the child's parents, siblings or any other children in the home; the reasons for initial social service agency activity and the reasons for any termination of agency activities if involvement was terminated; whether court intervention had ever been sought and, if so, any action taken by the court; and recommendations for prevention of future death under similar circumstances.

(e) Within 15 days of its activation pursuant to this section, the state review board shall complete and transmit a copy of its written report to the county or district attorney of the county in which the child's death occurred. If the death of the child occurred in a different county than where the child resided, a copy of the report shall be sent to the county or district attorney of the county where the child resided or, if the child resided in another state, to the child protective services agency of that state.

(f) The state review board shall maintain permanent records of all written reports concerning child deaths.

(g) The state review board may disclose its conclusions regarding a report of a child death but shall not disclose any information received by the board which is not subject to public disclosure by the agency that provided the information to the board.

(h) Information, documents and records otherwise available from other sources are not immune from discovery or use in a civil or criminal action solely because they were presented during proceedings of the state review board. A person who presented information before the board or who is a member of the board shall not be prevented from testifying about matters within the person's knowledge.

History: L. 1992, ch. 312, § 34; July 1.

CHAIRPERSON'S ROLE ON STATE CHILD DEATH REVIEW BOARD

1. Arrange to have the necessary information from investigative reports, medical records, autopsy reports or other items made available to members of the board.

2. Receive the coroner form and provide copies for each State Child Death Review Board member.

3. Schedule and notify the board members of an upcoming State Child Death Review Board meeting.

4. Chair the meeting of the State Child Death Review Board.

5. Serve as a liaison with other agencies as well as other child death review teams.

6. Ensure that the State Child Death Review Board report to the governor and legislature is made on or before October 1 of each year.

7. Make sure the form to be completed by the State Child Death Review Board is completed and a copy sent to the county or district attorney of the county is which the child's death occurred.

8. Receive the 24 hour notification from the coroner who determines after an investigation and an autopsy that the death of a child includes any suspicious circumstances or unknown cause.

LAW ENFORCEMENT'S ROLE ON STATE CHILD DEATH REVIEW BOARD

1. Obtain suspect identity, biographical and criminal history information.

2. Obtain information from the suspect's statement, if one was given by the suspect.

3. Obtain crime scene information.

4. Obtain law enforcement information about the injuries noted on the victim and evidence collected from the body.

5. Determine toxicology/drug screen/blood alcohol test results, if collected.

6. Obtain information gathered from any witness.

7. Serve as liaison with other Kansas law enforcement agencies.

8. Educate/inform Kansas law enforcement agencies about the purpose and needs of the Board.

9. Conduct other investigations/inquiries as requested by the Board.

10. Complete the Law Enforcement Summary report with the above information and present it to the Board.

STATE CHILD DEATH REVIEW BOARD

Law Enforcement Summary

1. Victim's Full Name _____ Race _____ Sex _____ DOB _____

   Address _____ City/County _____

2. Time and date of death _____

3. Location where death occurred (be specific) _____

   _____

4. Was a crime scene investigation done? ☐ Yes ☐ No

5. Was an autopsy done? ☐ Yes ☐ No

   Name of doctor _____

6. Was manner of death: ☐ natural ☐ accident ☐ suicide ☐ homicide ☐ unknown

7. Immediate cause of death _____

   _____

   Any contributing factor(s) ☐ Yes ☐ No

   Specify _____

8. Was a toxicology/drug screen done? ☐ Yes ☐ No Results _____

9. Was a blood alcohol taken? ☐ Yes ☐ No Results _____

10. Who was in charge/responsible for victim at the time of the death, and what was his/her relationship?

    _____

11. Who had legal custody of the victim at the time of death? _____

12. Was the above person(s) (10 & 11) under the influence of alcohol/drugs when the death occurred? ☐ Yes ☐ No

    If yes, whom _____

13. Information about persons living in the residence with the victim. (If related, specify if relationship is natural, step, adopted, or foste

Name	Race/Sex	Age	Relationship
1.			
2.			
3.			
4.			
5.			

14. Did anyone (other than suspect) witness the injury/death? ☐ Yes ☐ No ☐ Unknown

15. W information (if applicable):

Witness Name	Sex	Est. Age	Address	Phone No.	In Charge of Vi
1.	M F				Yes No
2.	M F				Yes No
3.	M F				Yes No

16. How much time elapsed from the time the victim was last seen - until the time of death?

Hours_____ Minutes_____ Unknown_____

17. Was the person in charge of victim's care at the time of the incident asleep at the time?
☐ Yes ☐ No ☐ Unknown ☐ N/A

18. Approximate distance between the victim and the person in charge of the victim when injury/death occurred.

Distance_____ ☐ Unknown ☐ N/A

19. Did victim have any prior known history of sexual/physical abuse? ☐ Yes ☐ No ☐ Unknown

If yes, what agency would have the information?_____

20. Did victim have any prior known history of neglect/negligence? ☐ Yes ☐ No ☐ Unknown

If yes, what agency would have the information?_____

21. Have there been any other child fatalities associated with victim's family? ☐ Yes ☐ No ☐ Unknown

SUSPECT INFORMATION

Name_____ Race_____ Sex_____ DOB_____

Address_____ City_____ State_____

Was a drug screen done? ☐ Yes ☐ No Results_____

Was a blood alcohol done? ☐ Yes ☐ No Results_____

What was the relationship of the suspect with the victim? (If related - specify if the relationship is natural, step, adopted, or foster).

_____

Was the suspect arrested? ☐ Yes ☐ No

What was the suspect charged with?_____

Comments:_____

_____

_____

_____

Please Print

Agency Case or File Number _____
Name of Agency _____
Address _____
Phone Number _____
Name/title officer completing form _____

STATE CHILD DEATH REVIEW BOARD

Office of Attorney General
2nd Floor Judicial Center
301 W. 10th
Topeka, KS 66612
(913) 296-2215

Information and Instructions for Law Enforcement

The State Child death Review Board was formed by the 1992 Kansas Legislature (K.S.A. 22a-241 - 244). The Board consists of ten members: one each from the offices of the Attorney General, the Kansas Bureau of Investigation, Social and Rehabilitation Services, Health and Environment, and the Department of Education; three appointed by the State Board of Healing Arts, specifically, a district coroner, a pathologist and a pediatrician; one representative of a child advocacy group; and one county or district attorney.

It is the responsibility of the law enforcement representative of the Board to contact the law enforcement agency who investigated the death of a child.

Beginning July 1, 1993, the Board will be reviewing the deaths of children from ages 0-17. All information will be kept strictly confidential.

For your information, enclosed is a copy of the Law Enforcement Summary which will be filled out by the investigating agency at the request of the State Child Death Review Board.

A. It is recommended that an officer who is familiar with the particular investigation complete this form.

B. If additional victims or suspects need to be listed, either use another form or add to the back of the page.

C. Please attach a copy of the required Kansas Incident Based Report form (IBR), making this information available also.

D. The information on this form will be used by the law enforcement representative on the Board to assist the Board in their review.

Thank you for your cooperation. If there are any questions, please contact:

Special Agent Don Winsor
Kansas Bureau of Investigation
1620 SW Tyler
Topeka, Kansas 66612
(913) 232-6000

SRS'S ROLE ON STATE CHILD DEATH REVIEW BOARD

1. Educate/inform local SRS area staff concerning the purpose and needs of the Board.

2. Provide records and information of previous or present services involving the child and family.

3. Assist in the analysis of data and preparation of Board reports.

4. Identify strategies to prevent child deaths and serious injuries.

5. Serve as liaison to other social service agencies.

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
Office of the SECRETARY

M E M O R A N D U M

TO: Area Directors
Social Service Chiefs

DATE: JULY 1, 1993

FROM: Donna L. Whiteman

SUBJECT: Child Death Review Board

The Kansas Child Death Review Board was formed by the 1992 Legislature. The Board consists of ten members from a variety of professional backgrounds and from various agencies. The Board will be reviewing selected cases involving the death of children from ages 0-17. District Coroners will be gathering information concerning these deaths and reporting to the Board. As the representative for SRS on the Board I want you to be aware of it's existance and the possibility that you may be required to provide information to the District Coroner or to me for presentation to the Board. This information will remain confidential and K.S.A. 38-1507 has been modified to authorize disclosure for this purpose.

The purpose of the Child Death Review Board is:

1. To describe trends and patterns of child deaths in Kansas, identifying risk factors in the population.
2. To improve sources of data and communication between 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 should occur at the individual case level and at the local and state level.
3. To develop prevention strategies including community education and mobilization, professional training, and needed changes in legislation, public policy or agency practices.

The role of the Department of Social and Rehabilitation Services representative on the Board is to:

1. Educate/inform local SRS area staff concerning the purpose and needs of the board.
2. Provide records and information of previous or present services involving the child and family.
3. Assist in the analysis of data and preparation of board reports.
4. Identify strategies to prevent child deaths and serious injuries.
5. Serve as liaison to other social service agencies.

* * * * *

In order to obtain information necessary to the work of the Child Death Review Board, the SRS representative or the CDRB may require local SRS offices to complete the case summary form. A copy of the form is attached for your review.

DLW:RSM/clh

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
Youth and Adult Services

STATE CHILD FATALITY REVIEW BOARD
CASE INFORMATION SUMMARY

NAME OF DECEASED CHILD:
DOB: DOD: GENDER: RACE/ETHNICITY:
CAUSE OF DEATH:
PLACE OF DEATH:

FAMILY INFORMATION:

SUMMARY OF SRS INVOLVEMENT PRIOR TO CHILD DEATH:

SUMMARY OF SRS INVOLVEMENT IN INVESTIGATION OF DEATH:

SUMMARY OF SRS INVOLVEMENT SUBSEQUENT TO DEATH:

OTHER INFORMATION IN CASE FILE:

DEPARTMENT OF HEALTH AND ENVIRONMENT'S ROLE ON STATE CHILD DEATH REVIEW BOARD

1. Develop and maintain useable database.

2. Assist in the analysis of data and preparation of any board reports.

3. Provide death and birth certificates and other vital statistic records where applicable.

4. Work with other states in obtaining out-of-state birth certificates.

5. Liaison with local and state health services.

EDUCATION MEMBER'S ROLE ON STATE CHILD DEATH REVIEW BOARD

1. Assist in educating and informing public educational institutions of the purpose and functioning of the State Child Death Review Board.

2. Assist in the analysis of data presented to the Board.

3. Assist in the preparation of Board reports.

4. Inform the Board of information regarding the education of children.

5. Assist in the identification of strategies to prevent child death and serious injury.

6. Serve as a liaison between the Board and public educational institutions.

PHYSICIAN'S ROLE ON STATE CHILD DEATH REVIEW BOARD

1. Provide expertise in the processes of normal infant and childhood growth and development.

   A. Interpret the findings of cases in the context of normal growth and development.

   B. Assist in the identification of cases where findings are inconsistent with normal growth and development.

2. Provide expertise in the expected course of disease and medical conditions of infancy and childhood and assist in the interpretation of case findings in this context.

3. Provide expertise in the expected outcome and complications of various treatments and interpret case findings in this context.

4. Provide expertise in the area of community standards of medical care.

5. Serve as a liaison with the medical community. Contact the child's primary care provider (if known) regarding fatality review.

6. Provide the committee with current pertinent information from the medical literature.

7. Assist in the discovery and review of previous health care/medical records.

8. Identify strategies to prevent further child deaths and serious injuries.

STATE CHILD DEATH REVIEW BOARD

Office of Attorney General
2nd Floor Judicial Center
301 W. 10th
Topeka, KS 66612
(913) 296-2215

Information and Instructions for Medical Professionals

The State Child Death Review Board was formed by the 1992 Kansas Legislature (K.S.A. 22a-241 - 244). The Board consists of ten members: one each from the offices of the Attorney General, the Kansas Bureau of Investigation, Social and Rehabilitation Services, Health and Environment, and the Department of Education; three appointed by the State Board of Healing Arts, specifically, a district coroner, a pathologist and a pediatrician; one representative of a child advocacy group; and one county or district attorney.

The purpose of the State Child Death Review Board is to conduct a full examination of each death of a child ages 0 through 17. The following goals have been established:

1. To describe trends and patterns of child deaths (ages 0 through 17) in Kansas, identifying risk factors in the population.

2. To improve sources of data and communication between 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 should occur at the individual case level and at the local and state level.

3. To develop prevention strategies including community education and mobilization, professional training, and needed changes in legislation, public policy and/or agency practices.

To assure a coordinated response that fully addresses all systemic concerns surrounding child fatality cases, the Kansas Legislature gave the State Child Death Review Board authority to obtain all records concerning each child. K.S.A. 22a-244(b) provides that the Board shall have access to any medical records of the child. All records provided to the Board remain confidential. If the Board requires documents which a medical professional possesses, the Board will make its request in writing.

If you have questions concerning the Board, or if you have suggestions which may assist the Board in carrying out its function, please contact board member Dr. Katherine Melhorn, (316) 688-3110, or the board chairperson Nancy Lindberg, (913) 296-2215.

1-30

CORONER'S ROLE ON STATE CHILD DEATH REVIEW BOARD

1. Provide interpretation of cause and manner of death.

2. Provide interpretation of autopsy report including microscopic examination and toxicology.

3. Provide information regarding correlation of circumstances of death with cause and manner of death.

4. Provide information regarding accidental trauma versus non-accidental trauma and natural disease versus abuse or neglect.

5. Provide guidance for further investigation, if needed.

6. Act as liaison with local coroners.

7. Work with others on the State Child Death Review Board to formulate strategies for prevention of child deaths and injuries.

STATE CHILD DEATH REVIEW BOARD

Office of Attorney General
2nd Floor Judicial Center
301 W. 10th
Topeka, KS 66612
(913) 296-2215

July 1, 1993

Dear District Coroner:

As a District Coroner you are an integral part of the child death review process which is now being set up in Kansas under K.S.A. 22a-241 - 244. Enclosed is a copy of the statute. The State Child Death Review Board was formed by the 1992 Legislature. The Board consists of ten members from a variety of professional backgrounds and from various agencies. The Board will be reviewing the death of children from ages 0-17. All information will be kept strictly confidential. The participation of the Coroners is crucial to the success of this process. The State Child Death Review Board welcomes your comments and suggestions during this formative period and at any time.

Enclosed is a copy of Form 1 which is to be filled out on every child death beginning July 1, 1993. In deaths which are natural, very little information is needed. In deaths which are non-natural (accident, suicide, homicide, undetermined), much more information is needed. The local investigative agencies, such as the police and SRS, should be able to help you gather this detailed information. This form should then be sent to the State Child Death Review Board.

Also, enclosed is the District Coroner's Protocol in Child Deaths. Your comments and suggestions are welcomed.

If you have any questions pertaining to the Coroner's role, please call Dr. George Thomas, Shawnee County Coroner and member of the State Child Death Review Board, at (913) 266-2240. Other questions should be directed to the Board.

Please respond with questions, comments or suggestions to me at your earliest convenience.

Sincerely,

Nancy Lindberg

Nancy Lindberg
Chairperson
State Child Death Review Board

enclosures

DISTRICT CORONER'S PROTOCOL IN CHILD DEATHS

1. Take report of child death (ages 0-17) from law enforcement personnel, health care provider or other person having knowledge of the death.

2. Record facts of the death including time, place, manner and circumstances of death.

3. Determine necessity for autopsy and/or further investigation.

4. If an autopsy is needed, it is performed by a certified pathologist. A copy of the autopsy report including microscopic examination and toxicology results are sent to the State Child Death Review Board.

5. Call the State Child Death Review Board Chairperson within 24 hours if investigation and/or autopsy determines that the death involved suspicious (i.e., non-natural) circumstances or unknown cause.

6. Notify appropriate local investigative agencies (police, SRS, etc.) as indicated for further investigation and appropriate action.

7. Complete Form 1 within one month on all child deaths (ages 0-17). Use local investigative agencies (police, SRS, etc.) when necessary to gather detailed information to complete form.

8. Send completed Form 1 to the Chairperson of the State Child Death Review Board.

9. Participate in local child death review activities if such activities are available.

10. Whenever indicated, provide comments and/or suggestions to State Child Death Review Board regarding the child death review process.

CHILD ADVOCATE'S ROLE ON STATE CHILD DEATH REVIEW BOARD

1. Provide information and assistance regarding prevention issues by focusing on prevention and potentially preventable incidents. Assist with the prevention portion of the Board's annual report.

2. Provide advocacy and assistance in order to secure adequate funding to support the Board's performance of its mandated responsibilities.

3. Assist in addressing the Board's training and research needs as well as training services for selected groups.

4. Serve as a community resource specialist by furnishing resource information and service options for families if such information is pertinent to selected cases coming before the Board.

5. Assist with the Board's public information needs, representing the Board at public functions if requested to do so.

6. Assist with the establishment and maintenance of working relationships with other child death review boards/teams in our region. Serve as liaison with the National Committee to Prevent Child Abuse.

7. Provide leadership with reference to public policy changes or actions recommended by the Board, particularly those requiring legislative attention.

COUNTY OR DISTRICT ATTORNEY'S ROLE ON STATE CHILD DEATH REVIEW BOARD

1. Provide legal definitions and explanations.

   a. Answer questions about specific cases and the likelihood of involvement in the criminal justice system.

   b. Define legal terminology that may impact what is identified/described as suspicious vs. abuse.

   c. Evaluate and assess cases to ascertain if they reach the threshold for the commission of a crime.

2. Provide assistance/guidance for further investigation. This may include:

   a. Provide assistance to any of the participating agencies.

   b. Determine if there is any pending criminal investigation.

3. Assist in communication between participating agencies.

   a. Serve as liaison with other County and District Attorneys within the state and nationwide.

   b. Serve as a liaison with other legal aspects of death review (e.g., City Attorney, County Counsel).

   c. Provide training pertaining to legal issues.

4. Provide feedback on child death review cases that are entered into the criminal justice system. (Track case through system.)

5. Identify strategies to prevent further child deaths and serious injuries.

STATE CHILD DEATH REVIEW BOARD

Office of Attorney General
2nd Floor Judicial Center
301 W. 10th
Topeka, KS 66612
(913) 296-2215

The State Child Death Review Board was formed by the 1992 Kansas Legislature (K.S.A. 22a-241 - 244). The Board consists of ten members: one each from the offices of the Attorney General, the Kansas Bureau of Investigation, Social and Rehabilitation Services, Health and Environment, and the Department of Education; three appointed by the State Board of Healing Arts, specifically, a district coroner, a pathologist and a pediatrician; one representative of a child advocacy group; and one county or district attorney. I have enclosed a copy of the County or District Attorney's Role on the State Child Death Review Board.

The purpose of the State Child Death Review Board is to conduct a full examination of each death of a child ages 0 through 17. The following goals have been established:

1. To describe trends and patterns of child deaths (ages 0 through 17) in Kansas, identifying risk factors in the population.

2. To improve sources of data and communication between 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 should occur at the individual case level and at the local and state level.

3. To develop prevention strategies including community education and mobilization, professional training, and needed changes in legislation, public policy and/or agency practices.

To assure a coordinated response that fully addresses all systemic concerns surrounding child fatality cases, the Kansas Legislature gave the State Child Death Review Board authority to obtain all records concerning each child. K.S.A. 22a-244(b) provides that the Board shall have access to any medical records of the child. Coroners are to fill out a form on each child death. All records provided to the Board remain confidential.

If you have questions concerning the Board, or if you have suggestions which may assist the Board in carrying out its function, please contact board member Rod Symmonds, (316) 342-4950 ext. 263, or the board chairperson Nancy Lindberg, (913) 296-2215.

KANSAS STATE CHILD DEATH REVIEW BOARD

CORONER REPORT

To Be Completed for All Child Deaths (Age 0-17 Years)

For SCDRB Use (
No. _____

A. IDENTIFICATION OF THE VICTIM

1. NAME (LAST, FIRST, MI)

2. BIRTH DATE (MO/DAY/YR) / /

3. DEATH DATE (MO/DAY/YR) AND TIME (MILITARY) / /

4. COUNTY OF RESIDENCE

5. COUNTY OF INJURY/ILLNESS

6. COUNTY OF DEATH

7. SEX AND RACE /ETHNICITY

B. MANNER OF DEATH

Note: If death due to natural cause, answer only Sections B, F (if other circumstances apply) and G on page 2.

☐ 8. Natural (except SIDS) Specify: _____
☐ 9. SIDS ☐ 10. Accident ☐ 11. Suicide ☐ 12. Homicide ☐ 13. Pending Investigation ☐ 14. Undetermined

C. SOCIAL INFORMATION

Mark all that apply:

15. Persons living in residence of victim:
- a. ☐ Natural Father
- b. ☐ Adoptive Father
- c. ☐ Step Father
- d. ☐ Foster Father
- e. ☐ Natural Mother
- f. ☐ Adoptive Mother
- g. ☐ Step Mother
- h. ☐ Foster Mother
- i. ☐ Minor(s) living in residence
- j. ☐ Parent's male paramour
- k. ☐ Parent's female paramour
- l. ☐ Other: _____
- m. ☐ Unknown

16. Children including victim under 18 years living in residence: #_____

17. Children living in residence - age (use: "<1" if less than one year):
- a. _____ yrs c. _____ yrs e. _____ yrs
- b. _____ yrs d. _____ yrs f. _____ yrs

18. Persons in charge of victim at time of fatal illness or injury event:
- a. ☐ Natural Father
- b. ☐ Adoptive Father
- c. ☐ Step Father
- d. ☐ Foster Father
- e. ☐ Natural Mother
- f. ☐ Adoptive Mother
- g. ☐ Step Mother
- h. ☐ Foster Mother
- i. ☐ Child(ren)
- j. ☐ Parent's male paramour
- k. ☐ Parent's female paramour
- l. ☐ No one in charge
- m ☐ Other: _____
- n. ☐ Unknown

19. If child(ren) in charge -- ages: a. ☐ N/A
b. _____ yrs c. _____ yrs d. _____ yrs

20. Were one or more persons in charge intoxicated or under influence of drugs at time of fatal illness/injury event?
a. ☐ Yes b. ☐ No c. ☐ Unknown

21. Who had legal custody of the victim at the time of the fatal illness/injury?
- a. ☐ Natural Father
- b. ☐ Adoptive Father
- c. ☐ Step Father
- d. ☐ Foster Father
- e. ☐ Natural Mother
- f. ☐ Adoptive Mother
- g. ☐ Step Mother
- h. ☐ Foster Mother
- i. ☐ Other (specify): _____

22. If two persons are described as having legal custody, they are:
- a. ☐ Currently married
- b. ☐ Never married
- c. ☐ Divorced
- d. ☐ Separated
- e. ☐ Unknown

23. Have there been any other child fatalities associated with any of the above? a. ☐Unknown
b. ☐ Yes c. ☐ No If yes, explain:
_____
_____

D. LOCATION AND WITNESSES

Mark all that apply:

24. Scene of illness or injury event:
- a. ☐ Highway
- b. ☐ City street
- c. ☐ Rural road
- d. ☐ Farm
- e. ☐ Body of water
- f. ☐ Public driveway
- g. ☐ Private driveway
- h. ☐ Other private prop.
- i. ☐ Resid. of victim
- j. ☐ Other residence
- k. ☐ Other: _____
- l. ☐ Unknown

If illness, skip to Section E.

25. Date of injury event (mo/day/yr):
_____/_____/_____

26. Time of injury event:
a. _____ ☐ a.m. ☐ p.m.
b. Between_____ and _____
c. ☐ Unknown

27. Did anyone (other than person(s) who inflicted the injury) witness the injury event?
a. ☐ Yes b. ☐ No c. ☐ Unknown
If YES, skip to #30 below.

28. How much time elapsed from the time the victim was last seen until the time of the incident?
a. ☐ Known _____hrs. _____mins.
b. ☐ Unknown c. ☐ N/A

29. Was the person in charge of child's care at the time of the injury event asleep at the time?
a. ☐ Yes b. ☐ No c. ☐ Unknown
d. ☐ N/A

30. Provide information about person(s) who witnessed the injury event (other than person(s) who inflicted the injury).

Witness	Sex	Estimated Age	Person in Charge of Victim?
a. ☐ #1	M F	_____	☐ Yes ☐ No
Name/phone #: _____			
b. ☐ #2	M F	_____	☐ Yes ☐ No
Name/phone #: _____			
c. ☐ #3	M F	_____	☐ Yes ☐ No
Name/phone #: _____			

31. Approximate distance between victim and person in charge of the victim at time of fatal injury event:
_____(Number of)
- a. ☐ Feet
- b. ☐ Blocks
- c. ☐ Yards
- d. ☐ Miles
- e. ☐ Not applicable
- f. ☐ Unknown

DIRECTIONS

Coroner: **Within 30 days of date of death** complete form to the best of your ability and file original along with a copy of autopsy report and Report of Death form with the State Child Death Review Board. Send to:

State Child Death Review Board
Office of Attorney General
2nd Floor, Judicial Center
301 W. 10th
Topeka, Kansas 66612
(913) 296-2215

Coroner Protocol

1. Take report of child death (ages 0-17) from law enforcement personnel, health care provider or other person having knowledge of the death.
2. Record facts of the death including time, place, manner and circumstances of death.
3. Determine necessity for autopsy and/or further investigation.
4. If an autopsy is needed, it is performed by a certified pathologist. A copy of the autopsy report including microscopic examination and toxicology results are sent to the State Child Death Review Board.
5. Call the State Child Death Review Board Chairperson, Nancy Lindberg, within 24 hours if investigation and/or autopsy determines that the death involved suspicious (i.e., non-natural) circumstances or unknown cause.
6. Notify appropriate local investigative agencies (police, SRS, etc.) as indicated for further investigation and appropriate action.
7. Complete Form 1 within one month on all child deaths (ages 0-17). Use local investigative agencies (police, SRS, etc.) when necessary to gather detailed information to complete form.
8. Send completed Form 1 to the Chairperson of the State Child Death Review Board.
9. Participate in local child death review activities if such activities are available.
10. Whenever indicated, provide comments and/or suggestions to State Child Death Review Board regarding the child death review process.

E. BRIEF DESCRIPTION OF CIRCUMSTANCES AND OTHER COMMENTS

Note: Complete this section or attach Report of Death form.

F. PRIMARY CAUSE AND CIRCUMSTANCES OF THE DEATH

Mark all applicable cause categories and specific circumstances to describe the fatality, based on information presently available. More than one cause may be indicated.

32 ☐ DEATH DUE TO NEGLECT

A. Cause of Death:
1. ☐ Malnutrition/dehydration
2. ☐ Delayed medical care
3. ☐ Known illness: _____
4. ☐ Other: _____
5. ☐ Unknown

33 ☐ VEHICULAR INJURY

A. Status of victim:
1. ☐ Occup. of vehicle 3. ☐ Pedestrian
2. ☐ Driver of vehicle 4. ☐ Other

B. Type of vehicle:
1. ☐ Car 6. ☐ Pick-up/Van
2. ☐ Farm tractor 7. ☐ Other farm vehicle
3. ☐ All-terrain vehicle 8. ☐ Riding mower
4. ☐ Bicycle 9. ☐ Motorcycle
5. ☐ Bus/Truck 10. ☐ Other: _____

C. Road condition:
1. ☐ Normal 3. ☐ Loose gravel
2. ☐ Wet 4. ☐ Ice/snow
5. ☐ Other: _____
6. ☐ Not applicable

D. Safety restraint (seatbelt, infant seat, etc.):
1. ☐ Used 3. ☐ Not used
2. ☐ None in vehicle 4. ☐ Unknown
5. ☐ Not applicable

E. Deceased was wearing helmet:
1. ☐ Yes 2. ☐ No 3. ☐ Not applicable

F. Operator of occupant vehicle:
1. ☐ DUI 2. ☐ BAT _____
3. ☐ Drug screen
4. ☐ Speed/recklessness:
(est. speed _____ mph)
(speed limit _____ mph)
5. ☐ Other violation
6. ☐ Brake failure
7. ☐ No operator
8. ☐ Other mechanical failure
9. ☐ Other: _____
10. ☐ None of the above

G. Operator of non-occupant vehicle:
1. ☐ DUI 2. ☐ BAT _____
3. ☐ Drug screen
4. ☐ Speed/recklessness:
(est. speed _____ mph)
(speed limit _____ mph)
5. ☐ Assault with vehicle
6. ☐ Other violation
7. ☐ Brake failure
8. ☐ No operator
9. ☐ Other mechanical failure
10. ☐ Other: _____
11. ☐ None of the above

H. ☐ CIRCUMSTANCES UNKNOWN

34 ☐ DROWNING

A. Place of drowning
1. ☐ Swimming pool 3. ☐ Bathub
2. ☐ Wading pool 4. ☐ Bucket
5. ☐ Creek/river/pond/lake
6. ☐ Well/cistern/septic tank
7. ☐ Other: _____

B. Location prior to drowning:
1. ☐ Boat 2. ☐ Water edge
3. ☐ Other: _____

C. Wearing flotation device:
1. ☐ Yes 2. ☐ No 3. ☐ Unknown

D. ☐ CIRCUMSTANCES UNKNOWN

35 ☐ POISONING OR OVERDOSE

A. Name of drug or chemical:
_____

B. ☐ CIRCUMSTANCES UNKNOWN

36 ☐ FIRE, BURN (non-arson)

A. Source of ignition/fire:
1. ☐ Matches 3. ☐ Lighter
2. ☐ Lit cigarette 4. ☐ Furnace
5. ☐ Space heater
6. ☐ Explosion of oven/stove
7. ☐ Cooking appliance used as heating source
8. ☐ Explosives/fireworks
9. ☐ Electrical wire
10. ☐ Other: _____

B. Source of non-fire burn:
1. ☐ Hot water (bath, etc.)
2. ☐ Appliance
3. ☐ Other: _____

C. Did a person start the fire?
1. ☐ Yes 2. ☐ No 3. ☐ Unknown
If yes: Age of person: _____ years
Activity of person:
1. ☐ Playing 2. ☐ Smoking
3. ☐ Cooking
4. ☐ Other: _____

D. ☐ CIRCUMSTANCES UNKNOWN

37 ☐ FIREARM INJURY

A. Person handling firearm was:
1. ☐ The victim 2. ☐ Other person
3. ☐ Unknown

B. Firearm involved was:
1. ☐ Handgun 2. ☐ Rifle
3. ☐ Shotgun
4. ☐ Other: _____

C. Age of person handling firearm:
_____ years

D. Use of firearm at time of injury:
1. ☐ Cleaning 3. ☐ Loading
2. ☐ Hunting 4. ☐ Playing
5. ☐ Target shooting
6. ☐ Assault
7. ☐ Other: _____

E. ☐ CIRCUMSTANCES UNKNOWN

38 ☐ ELECTROCUTION

A. Cause of electrocution:
1. ☐ Appliance defect
2. ☐ Appliance-water contact
3. ☐ Tool defect
4. ☐ Tool-water contact
5. ☐ Electrical wire defect
6. ☐ Outlet defect
7. ☐ Other electrical hazard
8. ☐ Other: _____

B. ☐ CIRCUMSTANCES UNKNOWN

39 ☐ SUFFOCATION/STRANGULATION

A. Was suffocation/strangulation by another person?
1. ☐ Yes 2. ☐ No 3. ☐ Unknown

B. Object impeding breath:
_____

C. Object strangulating:
_____

D. Did the injury occur in a bed, crib, or other sleeping arrangement?
1. ☐ Yes 2. ☐ No 3. ☐ Unknown
If yes, check:
1. ☐ Crib, functioning properly
2. ☐ Crib, malfunctioning
3. ☐ Bed
4. ☐ Other sleeping arrangement
(specify: _____)
5. ☐ Unknown

E. ☐ CIRCUMSTANCES UNKNOWN

40 ☐ FALL INJURY

A. Deceased fell from:
1. ☐ Stair, steps (in baby walker)
2. ☐ Stair, steps (other)
3. ☐ Open window
4. ☐ Natural elevation
5. ☐ Furniture
6. ☐ Other: _____

B. Describe composition of landing surface (type):
_____

C. Height of fall:
_____ feet

D. ☐ CIRCUMSTANCES UNKNOWN

41 ☐ CRUSH INJURY (non-vehicular)

A. Explain: _____
_____

B. ☐ CIRCUMSTANCES UNKNOWN

42 ☐ CONFINEMENT

A. Place of confinement:
1. ☐ Refrigerator/appliance
2. ☐ Chest/box/foot locker
3. ☐ Motor vehicle
4. ☐ Room, building
5. ☐ Other: _____

B. ☐ CIRCUMSTANCES UNKNOWN

43 ☐ OTHER INFLICTED INJURY

A. Site:
1. ☐ Head 2. ☐ Abdomen
3. ☐ Other: _____

B. Type of inflicted injury:
1. ☐ Shaken 3. ☐ Struck
2. ☐ Thrown 4. ☐ Cut/Stabbed
5. ☐ Sexually assaulted
6. ☐ Immersed in water
7. ☐ Suffocated/strangulated
8. ☐ Other: _____

C. Who inflicted the injury?
1. ☐ Self 3. ☐ Unknown
2. ☐ Other person

D. With what was the injury inflicted?
1. ☐ Hands/feet 3. ☐ Fire/arson
2. ☐ Firearm 4. ☐ Poison
5. ☐ Body (overlying)
6. ☐ Sharp object (knife, scissors,etc.)
7. ☐ Blunt object (hammer, bat, etc.)
8. ☐ Vehicle (assault with vehicle)
9. ☐ Hot liquid or other substance
10. ☐ Object used for suffocation or strangulation (specify): _____
_____
11. ☐ Unknown

E. ☐ CIRCUMSTANCES UNKNOWN

44 ☐ OTHER CAUSE

Describe what is known:
_____
_____
_____
_____
_____
_____

45 ☐ UNKNOWN CAUSE

Describe:
_____
_____
_____
_____
_____
_____

G. CORONER (Print or type name) **DATE (MO/DAY/YR)** / /

Coroner Signature

DATE SCDRB NOTIFIED, IF APPLICABLE: / /

Source(s) of Information: (Name/Agency/Phone Number)

1-38

KANSAS STATE CHILD DEATH REVIEW BOARD

BOARD REPORT

For SCDRB Use Only
No. _____

A. IDENTIFICATION OF THE VICTIM

1. NAME (LAST, FIRST, MI)
2. BIRTH DATE (MO/DAY/YR) / /
3. DEATH DATE (MO/DAY/YR) AND TIME (MILITARY) / /
4. COUNTY OF RESIDENCE
5. COUNTY OF INJURY/ILLNESS
6. COUNTY OF DEATH
7. SEX AND RACE/ETHNICITY

B. MANNER OF DEATH

Note: If death due to natural cause, answer only Section B and Page(s) 3 and 4 (if applicable).

☐ 8. Natural (except SIDS)Specify: _____
☐ 9. SIDS ☐ 10. Accident ☐ 11. Suicide ☐ 12. Homicide ☐ 13. Pending Investigation ☐ 14. Undetermined

C. SOCIAL INFORMATION

Mark all that apply:

15. Persons living in residence of victim
a. ☐ Natural Father e. ☐ Natural Mother
b. ☐ Adoptive Father f. ☐ Adoptive Mother
c. ☐ Step Father g. ☐ Step Mother
d. ☐ Foster Father h. ☐ Foster Mother
i. ☐ Minor(s) living in residence
j. ☐ Parent's male paramour
k. ☐ Parent's female paramour
l. ☐ Other: _____
m. ☐ Unknown

16. Children including victim under 18 years living in residence: # _____

17. Children living in residence - ages (use: "<1" if less than one year):
a. _____ yrs c. _____ yrs e. _____ yrs
b. _____ yrs d. _____ yrs f. _____ yrs

18. Persons in charge of victim at time of fatal illness or injury event:
a. ☐ Natural Father e. ☐ Natural Mother
b. ☐ Adoptive Father f. ☐ Adoptive Mother
c. ☐ Step Father g. ☐ Step Mother
d. ☐ Foster Father h. ☐ Foster Mother
i. ☐ Child(ren)
j. ☐ Parent's male paramour
k. ☐ Parent's female paramour
l. ☐ No one in charge
m ☐ Other: _____
n. ☐ Unknown

19. If child(ren) in charge -- ages: a. ☐ N/A
b. _____ yrs c. _____ yrs d. _____ yrs

20. Were one or more persons in charge intoxicated or under influence of drugs at time of fatal illness/injury event?
a. ☐ Yes b. ☐ No c. ☐ Unknown

21. Who had legal custody of the victim at the time of the fatal illness/injury?
a. ☐ Natural Father e. ☐ Natural Mother
b. ☐ Adoptive Father f. ☐ Adoptive Mother
c. ☐ Step Father g. ☐ Step Mother
d. ☐ Foster Father h. ☐ Foster Mother
i. ☐ Other (specify): _____

22. If two persons are described as having legal custody, they are:
a. ☐ Currently maried
b. ☐ Never married d. ☐ Separated
c. ☐ Divorced e. ☐ Unknown

23. Have there been any other child fatalities associated with any of the above? a. ☐ Unknown
b. ☐ Yes c. ☐ No If yes, explain: _____

D. LOCATION AND WITNESSES

Mark all that apply:

24. Scene of illness or injury event:
a. ☐ Highway f. ☐ Public driveway
b. ☐ City street g. ☐ Private driveway
c. ☐ Rural road h. ☐ Other private prop.
d. ☐ Farm i. ☐ Resid. of victim
e. ☐ Body of water j. ☐ Other residence
k. ☐ Other:
l. ☐ Unknown

If illness, skip to Section E.

25. Date of injury event (mo/day/yr): ____/____/____

26. Time of injury event: a. _____ ☐ a.m. ☐ p.m.
b. Between _____ and _____
c. ☐ Unknown

27. Did anyone (other than person(s) who inflicted the injury) witness the injury event?
a. ☐ Yes b. ☐ No c. ☐ Unknown

If YES, skip to #30 below.

28. How much time elapsed from the time the victim was last seen until the time of the incident?
a. ☐ Known _____hrs. _____mins.
b. ☐ Unknown c. ☐ N/A

29. Was the person in charge of child's care at the time of the injury event asleep at the time?
a. ☐ Yes b. ☐ No c. ☐ Unknown
d. ☐ N/A

30. Provide information about person(s) who witnessed the injury event (other than person(s) who inflicted the injury).

Witness	Estimated Age	Person in Charge of Victim?
a. ☐ #1 M F	_____	☐ Yes ☐ No
Name/phone #: _____		
b. ☐ #2 M F	_____	☐ Yes ☐ No
Name/phone #: _____		
c. ☐ #3 M F	_____	☐ Yes ☐ No
Name/phone #: _____		

31. Approximate distance between victim and person in charge of the victim at time of fatal injury event:
_____ (Number of)
a. ☐ Feet d. ☐ Miles
b. ☐ Blocks e. ☐ Not applicable
c. ☐ Yards f. ☐ Unknown

E. REVIEW PANEL FINDINGS

Mark all that apply:

32. SCDRB review meeting(s):
a. Date of first meeting (mo/day/yr): ___/___/___
b. Total # of meetings held: _____
c. No meeting (explain): _____

33. Autopsy:
a. ☐ Not performed
b. ☐ Performed by (specify): _____

34. Toxicology:
a. ☐ Not performed
b. ☐ Performed by (specify): _____

35. Death scene investigation:
a. ☐ Not conducted
b. ☐ Conducted by coroner
c. ☐ Conducted by law enforcement
d. ☐ Conducted by fire investigator
e. ☐ Conducted by other (specify): _____

36. Law enforcement investigation:
a. ☐ Not conducted
b. ☐ Conducted-no arrest
c. ☐ Conducted-arrested for: _____

37. Health department/medical record inquiry:
a. ☐ Not conducted
b. ☐ Conducted-no action
c. ☐ Conducted-action taken: _____

38. SRS inquiry:
a. ☐ Not conducted
b. ☐ Conducted-no action
c. ☐ Conducted-action taken: _____

39. Prosecutor action:
a. ☐ Pending or in progress
b. ☐ Case closed, no charge(s) filed
c. ☐ Suspected perp., but no arrest or charge
d. ☐ Charge(s) filed (specify): _____

F. PERSON(S) ARRESTED OR CHARGED (If no arrest or charge was made, skip to Section G.)

40. Number of persons arrested or charged:
a. ☐ One b. ☐ Two c. ☐ More

41. Was the person(s) arrested or charged caring for or in charge of the victim at the time of the fatal illness or injury event?
a. ☐ Yes b. ☐ No c. ☐ Unknown

Code for race/ethnicity:
(1) White
(2) Black
(3) Native American
(4) Asian/Pacific Islands
(5) Other Nonwhite
(6) Other
(9) Unknown

42. Person #1 arrested or charged:
a. ☐ Natural father e. ☐ Natural mother
b. ☐ Adoptive father f. ☐ Adoptive mother
c. ☐ Step father g. ☐ Step mother
d. ☐ Foster father h. ☐ Foster mother
i. ☐ Child living in residence
j. ☐ Other living in residence (specify): _____
k. ☐ Parent's paramour
l. ☐ Unrelated person-known to victim
m. ☐ Unrelated person-not known to victim
n. Sex of person: ☐ Male ☐ Female
o. Age of person (approx.): _____ yrs.
p. Race (see box at left): ☐

43. Person #2 arrested or charged: ☐ N/A
a. ☐ Natural father e. ☐ Natural mother
b. ☐ Adoptive father f. ☐ Adoptive mother
c. ☐ Step father g. ☐ Step mother
d. ☐ Foster father h. ☐ Foster mother
i. ☐ Child living in residence
j. ☐ Other living in residence (specify): _____
k. ☐ Parent's paramour
l. ☐ Unrelated person-known to victim
m. ☐ Unrelated person-not known to victim
n. Sex of person: ☐ Male ☐ Female
o. Age of person (approx.): _____ yrs.
p. Race (see box at left): ☐

CONTINUE ON PAGE 2

G. SR MATION

Mark all that apply:

44. Was a case opened as a result of the child's death or were services provided the child or child's family prior to the death?
a. ☐ Yes b. ☐ No
If no, stop here.

45. Services provided:

		Prior to death
a.	Cash Assistance	☐
b.	Medical Services	☐
c.	Food Services	☐
d.	Child Support Enforcement	☐
e.	Mental Health & Rehabilitation Services	☐
f.	Alcohol and Drug Abuse Services	☐
g.	Youth & Adult Services	☐
h.	Vocational Rehabilitation	☐

46. Status of assessment (check one):
a. ☐ Assessment conducted
b. ☐ Assessment in progress
c. ☐ Assessment completed
If completed, check one:

47. Findings from assessment (deceased child only):
a. ☐ Case unconfirmed
b. ☐ Case confirmed - physical abuse
c. ☐ Case confirmed - sexual abuse
d. ☐ Case confirmed - physical neglect
e. ☐ Case confirmed - medical neglect
f. ☐ Case confirmed - inadequate supervision
If confirmed:

48. How many confirmed perpetrators?
a. ☐ One b. ☐ Two c. ☐ More than 2

49. Person #1 (case substantiated against):
a. ☐ Natural Father e. ☐ Natural Mother
b. ☐ Step Father f. ☐ Step Mother
c. ☐ Adoptive Father g. ☐ Adoptive Mother
d. ☐ Foster Father h. ☐ Foster Mother
i. ☐ Parent's paramour
j. ☐ Child living in residence
k. ☐ Other relative living in residence (specify): _____
l. ☐ Non-relative living in residence (specify): _____
m. Sex of person: ☐ Male ☐ Female
n. Age of person (approx.): _____ yrs.
o. Race/ethnicity (see code below): ☐

50. Person #2 (case substantiated against).
a. ☐ Natural Father e. ☐ Natural Mother
b. ☐ Step Father f. ☐ Step Mother
c. ☐ Adoptive Father g. ☐ Adoptive Mother
d. ☐ Foster Father h. ☐ Foster Mother
i. ☐ Parent's paramour
j. ☐ Child living in residence
k. ☐ Other relative living in residence (specify): _____
l. ☐ Non-relative living in residence (specify): _____
m. Sex of person: ☐ Male ☐ Female
n. Age of person (approx.): _____ yrs.
o. Race/ethnicity (see code below): ☐

51. Other service (specify): _____

Code for race/ethnicity: (1) White; (2) Black; (3) Native American; (4) Asian/Pacific Islands; (5) Other Nonwhite; (6) Other; (9) Unknown.

H. RESULTS OF SRS INVESTIGATION

CONTINUE ON PAGE 3

I. PRIMARY CAUSE AND CIRCUMSTANCES OF THE DEATH

Mark applicable cause categories and specific circumstances to describe the fatality, based on information presently available. More than one cause may be indicated.

52. ☐ DEATH DUE TO NEGLECT

A. Cause of Death:
1. ☐ Malnutrition/dehydration
2. ☐ Delayed medical care
3. ☐ Known illness: _____
4. ☐ Other: _____
5. ☐ Unknown

53. ☐ VEHICULAR INJURY

A. Status of victim:
1. ☐ Occup. of vehicle
2. ☐ Driver of vehicle
3. ☐ Pedestrian
4. ☐ Other

B. Type of vehicle:
1. ☐ Car
2. ☐ Farm tractor
3. ☐ All-terrain vehicle
4. ☐ Bicycle
5. ☐ Bus/Truck
6. ☐ Pick-up/Van
7. ☐ Other farm vehicle
8. ☐ Riding mower
9. ☐ Motorcycle
10. ☐ Other: _____

C. Road condition:
1. ☐ Normal
2. ☐ Wet
3. ☐ Loose gravel
4. ☐ Ice/snow
5. ☐ Other: _____
6. ☐ Not applicable

D. Safety restraint (seatbelt, infant seat, etc.):
1. ☐ Used
2. ☐ None in vehicle
3. ☐ Not used
4. ☐ Unknown
5. ☐ Not applicable

E. Deceased was wearing helmet:
1. ☐ Yes 2. ☐ No 3. ☐ Not applicable

F. Operator of occupant vehicle:
1. ☐ DUI 2. ☐ BAT_____
3. ☐ Drug screen
4. ☐ Speed/recklessness:
(est. speed _____mph)
(speed limit _____mph)
5. ☐ Other violation
6. ☐ Brake failure
7. ☐ No operator
8. ☐ Other mechanical failure
9. ☐ Other _____
10. ☐ None of the above

G. Operator of non-occupant vehicle:
1. ☐ DUI 2. ☐ BAT_____
3. ☐ Drug screen
4. ☐ Speed/recklessness:
(est. speed _____mph)
(speed limit _____mph)
5. ☐ Assault with vehicle
6. ☐ Other violation
7. ☐ Brake failure
8. ☐ No operator
9. ☐ Other mechanical failure
10. ☐ Other: _____
11. ☐ None of the above

H. ☐ CIRCUMSTANCES UNKNOWN

54. ☐ DROWNING

A. Place of drowning
1. ☐ Swimming pool
2. ☐ Wading pool
3. ☐ Bathub
4. ☐ Bucket
5. ☐ Creek/river/pond/lake
6. ☐ Well/cistern/septic tank
7. ☐ Other: _____

B. Location prior to drowning:
1. ☐ Boat
2. ☐ Water edge
3. ☐ Other: _____

C. Wearing flotation device:
1. ☐ Yes 2. ☐ No 3. ☐ Unknown

D. ☐ CIRCUMSTANCES UNKNOWN

55. ☐ POISONING OR OVERDOSE

A. Name of drug or chemical:
_____

B. ☐ CIRCUMSTANCES UNKNOWN

56. ☐ FIRE, BURN (non-arson)

A. Source of ignition/fire:
1. ☐ Matches
2. ☐ Lit cigarette
3. ☐ Lighter
4. ☐ Furnace
5. ☐ Space heater
6. ☐ Explosion of oven/stove
7. ☐ Cooking appliance used as heating source
8. ☐ Explosives/fireworks
9. ☐ Electrical wire
10. ☐ Other: _____

B. Source of non-fire burn:
1. ☐ Hot water (bath, etc.)
2. ☐ Appliance
3. ☐ Other: _____

C. Did a person start the fire?
1. ☐ Yes 2. ☐ No 3. ☐ Unknown
If yes: Age of person: _____years
Activity of person:
1. ☐ Playing
2. ☐ Smoking
3. ☐ Cooking
4. ☐ Other: _____

D. ☐ CIRCUMSTANCES UNKNOWN

57. ☐ FIREARM INJURY

A. Person handling firearm was:
1. ☐ The victim
2. ☐ Other person
3. ☐ Unknown

B. Firearm involved was:
1. ☐ Handgun
2. ☐ Rifle
3. ☐ Shotgun
4. ☐ Other: _____

C. Age of person handling firearm:
_____ years

D. Use of firearm at time of injury:
1. ☐ Cleaning
2. ☐ Hunting
3. ☐ Loading
4. ☐ Playing
5. ☐ Target shooting
6. ☐ Assault
7. ☐ Other: _____

E. ☐ CIRCUMSTANCES UNKNOWN

58. ☐ ELECTROCUTION

A. Cause of electrocution:
1. ☐ Appliance defect
2. ☐ Appliance-water contact
3. ☐ Tool defect
4. ☐ Tool-water contact
5. ☐ Electrical wire defect
6. ☐ Outlet defect
7. ☐ Other electrical hazard
8. ☐ Other: _____

B. ☐ CIRCUMSTANCES UNKNOWN

59. ☐ SUFFOCATION/STRANGULATION

A. Was suffocation/strangulation by another person?
1. ☐ Yes 2. ☐ No 3. ☐ Unknown

B. Object impeding breath:
_____

C. Object strangulating:
_____

D. Did the injury occur in a bed, crib, or other sleeping arrangement?
1. ☐ Yes 2. ☐ No 3. ☐ Unknown
If yes, check:
1. ☐ Crib, functioning properly
2. ☐ Crib, malfunctioning
3. ☐ Bed
4. ☐ Other sleeping arrangement (specify: _____)
5. ☐ Unknown

E. ☐ CIRCUMSTANCES UNKNOWN

60. ☐ FALL INJURY

A. Deceased fell from:
1. ☐ Stair, steps (in baby walker)
2. ☐ Stair, steps (other)
3. ☐ Open window
4. ☐ Natural elevation
5. ☐ Furniture
6. ☐ Other: _____

B. Describe composition of landing surface (type):
_____

C. Height of fall:
_____ feet

D. ☐ CIRCUMSTANCES UNKNOWN

61. ☐ CRUSH INJURY (non-vehicular)

A. Explain: _____
_____

B. ☐ CIRCUMSTANCES UNKNOWN

62. ☐ CONFINEMENT

A. Place of confinement:
1. ☐ Refrigerator/appliance
2. ☐ Chest/box/foot locker
3. ☐ Motor vehicle
4. ☐ Room, building
5. ☐ Other: _____

B. ☐ CIRCUMSTANCES UNKNOWN

63. ☐ OTHER INFLICTED INJURY

A. Site:
1. ☐ Head
2. ☐ Abdomen
3. ☐ Other: _____

B. Type of inflicted injury:
1. ☐ Shaken
2. ☐ Thrown
3. ☐ Struck
4. ☐ Cut/Stabbed
5. ☐ Sexually assaulted
6. ☐ Immersed in water
7. ☐ Suffocated/strangulated
8. ☐ Other: _____

C. Who inflicted the injury?
1. ☐ Self
2. ☐ Other person
3. ☐ Unknown

D. With what was the injury inflicted?
1. ☐ Hands/feet
2. ☐ Firearm
3. ☐ Fire/arson
4. ☐ Poison
5. ☐ Body (overlying)
6. ☐ Sharp object (knife, scissors, etc.)
7. ☐ Blunt object (hammer, bat, etc.)
8. ☐ Vehicle (assault with vehicle)
9. ☐ Hot liquid or other substance
10. Object used for suffocation or strangulation (specify): _____
_____
11. ☐ Unknown

E. ☐ CIRCUMSTANCES UNKNOWN

64. ☐ OTHER CAUSE

Describe what is known:
_____
_____
_____
_____
_____
_____

65. ☐ UNKNOWN CAUSE

Describe:
_____
_____
_____
_____
_____
_____

CONTINUE ON PAGE 4

J. CHILD'S NAME

K. CORONER'S BRIEF DESCRIPTION OF CIRCUMSTANCES AND OTHER COMMENTS

L. MAIN CONCLUSIONS

M. FOLLOW-UP REQUESTED

N. RECOMMENDATIONS

O. SOURCES OF REPORT

Yes	No	Explain:
☐	☐	Medical Records
☐	☐	Autopsy report
☐	☐	Report of death
☐	☐	Death certificate
☐	☐	Birth certificate
☐	☐	Law enforcement report
☐	☐	SRS reports
☐	☐	Court reports
☐	☐	Public health/medical record reports
☐	☐	Education reports
☐	☐	Press clippings

P. DIRECTIONS

Q. SIGNATURE

CHAIR DATE (MO/DAY/YR)

____/____/____

KANS. ASSOCIATION

APPENDIX B

Volume 21
Number 29

Current Report

July 16, 1993

STATE UPDATE

NEW DEATH REPORTING RULES . . . Hospitals must now report every death of a child age 0 to 17 to the District Coroner, according to the State Child Death Review Board. Previous law only required unnatural deaths to be reported. If the coroner decides to perform an autopsy, the Board has the authority to investigate the death and access all of the child's medical records.

The State Child Death Review Board was formed by the 1992 Kansas Legislature to identify fatal child abuse and to discover general trends or patterns of child deaths in Kansas. The Board intends to collect information and make an annual report to the governor and state legislature.

Please share the enclosed copy of the Board's instructions for medical professionals with your staff. If you have questions concerning the Board, you may contact board member Dr. Katherine Melhorn, 316/688-3110, or chairperson Nancy Lindberg, 913/296-2215.

TABLE OF CONTENTS

KHA CLOSEUP

DON'T FORGET TO NOMINATE THOSE TRUSTEES . . . The deadline for submitting nominees for the 1993 KHA Award for Trustee Excellence is August 11. Nomination forms were sent to each hospital in June. If you're planning to nominate someone, please make sure you get the process started as soon as possible. Nominations received after the deadline will not be accepted. If you need another nomination packet, contact Anne Humphrey at the KHA office, 913/233-7436.

APPENDIX C

The State Child Death Review Board wishes to acknowledge the important research on child deaths in Kansas that has occurred in recent years. Particularly noteworthy is the work of Patricia Schloesser, M.D., who summarized some significant findings in an article coauthored with Dr. John Poertner and John Pierpont from the University of Kansas School of Social Welfare. (See "Active Surveillance of Child Abuse Fatalities," Schloesser, Pierpont and Poertner, Child Abuse and Neglect, Vol. 15, pp. 3-10, 1992.) Years included in the study were 1975-78 and 1983-88.

Dr. Schloesser and her colleagues concluded that "monitoring abuse related deaths of infants and young children yields information necessary to the formulation of sound public policy ... Active surveillance decreases the possibility of misidentifying abuse related deaths as accidental, and allows state agencies to follow abuse fatalities, collecting pertinent information and adjusting policy accordingly ... States and nations may monitor success in preventing child abuse fatalities just as they now use infant mortality to monitor progress in public health, thus creating a stable and reliable standard for measuring progress in eliminating one type of abuse."

The study's specific findings serve as points of reference as the State Child Death Review Board moves forward with its work:

♦ "Although the cases examined ranged in age from birth to age four, 85% of the children who died were under the age of two and more than 65% were under the age of one ..." It is (also) of interest that more than 60% of the deaths were girls. (p. 5)

♦ "Nearly 15% of the infants whose birth weight was known were classified as low birth weight (under 5.5 pounds)." By contrast, only 6% of all infants born in the state are of low birth weight, suggesting that infants who die are two times more likely to be of low birth weight. (p. 5)

♦ "In nearly 90% of the cases the cause of death was discovered or confirmed by an autopsy." (p. 5)

♦ Other significant findings include: "very young age of parents at the first pregnancy; high rate of single parenthood; significantly lower educational achievement of victims' mothers; late, inadequate prenatal care and complications during pregnancy." (abstract, p. 3)

♦ ... we found that the perpetrator was male in nearly 57% of all cases, representing fathers, stepfathers, and live-in boyfriends. When the perpetrator was a male, the death was more likely to be from head or abdominal injuries. Mothers were more frequently implicated in infanticide by asphyxiation, drowning, strangulation or neglect." (p. 6)

♦ "Legal action was taken in 56% of the cases." (p. 6)

♦ "Of the deaths that occurred in this study, 60% took place in four metropolitan communities representing 46% of the state's population (Sedgwick, Shawnee, Johnson, and Wyandotte). This demonstrates the positive value of targeting these four communities for intensive prevention programs." (p. 9)

♦ "The relationship of substance abuse to child fatalities was not examined ... Information regarding substance abuse might add appreciably to our understanding of the phenomenon of fatal abuse and should be a routine part of Active Surveillance." (p. 7)

Prior to the publication of Dr. Schloesser's research, several other studies of child deaths in Kansas highlighted trends worthy of continuing attention. For instance, a document authored by Donovan Rutledge, et al., studied child deaths known to SRS Youth Services. Rutledge and his colleagues reviewed 22 confirmed deaths, noting that in 73% of the cases, a biological parent was implicated as at least one of the perpetrators of child abuse or neglect leading to a child death. (See unpublished paper by Donovan Rutledge, et al., "Analysis of Child Deaths in Kansas Related to Intra-Familial Child Abuse and Neglect, January 1986-June 1987.")

In March, 1989, SRS and the Kansas Department of Health and Environment released a detailed report entitled "Children's Deaths in Kansas, 1985-87." This study found that "children in low-income households in Kansas are dying at a significantly higher rate than children in non-low-income households for virtually all causes of death." Moreover, the second leading cause of death among low-income children was found to be "death relating to symptoms, signs and ill-defined conditions." Not surprisingly, the ten leading causes of death for low and non-low-income children were found to be dissimilar, "with deaths associated with poor medical care and unsafe environmental conditions affecting low-income children more frequently than non-low-income children."

More recent child death information from KDHE for the years 1987-1991 establishes that 48.5% were under the age of four and 34.9% were under the age of one. The most common causes of death were motor vehicle accidents (38.6%) and SIDS (28%), followed by gunshot wounds (12.7%). Of the children under one year of age (335), 80% were classified as SIDS, followed by suffocation (10.7%) and accidental (8.1%). Child battering, criminal neglect or striking accounted for seven deaths for all children under the age of four.

A separate KDHE document entitled "Childhood Injury in Kansas: Preventable Injury is the Leading Single Killer of Kansas Children" (1993) reports that during 1988-90, half of the 271 deaths which occurred among Kansas children ages 5-14 resulted from preventable injury. Information of this nature is useful to the State Child Death Review Board since it helps establish a baseline that can be monitored as the board reviews cases.

Also, of benefit are the reports from the neighboring states of Missouri and Colorado, both of which have active child death review systems in place. An analysis of Missouri's statistics gathered from January to September, 1992, found that "the children most at risk appear to be black males, infants to four years old, living with young single mothers who have not finished high school who may be abusing alcohol or drugs." The interim report also noted that "... the statewide child fatality review project has identified lack of supervision as a big problem." In response to this finding, the report continued, some communities are now working with local churches to set up parenting classes and crisis nurseries, where caretakers in trouble can drop off their children. (See "Tracking Abused Kids: Missouri Leads in Investigating Child Deaths," City and State, June 7, 1993.)

Alinda W. Dennis, chairperson of the Jackson County board in Missouri summarized her team's finding as follows: "... the themes we have observed include a high number of perpetrators who are adolescents as well as a concern regarding young male babysitters. We have seen the shaken baby

syndrome and we are taking a very careful look at oral water intoxication in infants. Finally, we have observed that several of the mothers of the deceased children were themselves victims of child abuse as children." (See Alinda W. Dennis to Senator August Bogina, Jr., March 16, 1992.)

In a meeting with the State Child Death Review Board, Ms. Dennis stated that SIDS is the leading cause of child deaths their board reviews and homicide is second. Sixty-eight percent of SIDS deaths reviewed were flagged as suspicious. The board found that in some instances where child deaths were classified as SIDS, the actual cause could be traced to inappropriate sleeping arrangements or shaken baby syndrome. (See minutes of the State Child Death Review Board, February 4, 1993.)

It is beneficial for the State Child Death Review Board to be aware of these trends in neighboring states. Also, of significance is the assessment of Michael Durfee, M.D., one of the nation's leading experts on child death review teams.

In reviewing the experience of teams in Oregon and California, Dr. Durfee concluded: "A state level team in Oregon has evaluated suspicious child deaths since 1985. The Oregon statistics are consistent with California findings of an increase in criminal actions and an increase in the ability of agencies to coordinate actions for protective service for surviving siblings as a result of team review."

By drawing on past studies of child deaths in Kansas and the experience of supportive colleagues in other states, the State Child Death Review Board has constructed a useful frame of reference. The board will require adequate staff support, however, if it is to complete the demanding tasks outlined for it by the Kansas Legislature.

Kansas
Children's
Service League

Testimony in Support of SB 782
Senate Committee on Public Health and Welfare
March 8, 1994

The Kansas Children's Service League endorses the intention of SB 782, which would enable the Kansas Child Death Review Board to fulfill the responsibilities established for it by the Kansas Legislature.

I have had the honor of representing child advocacy groups as a member of the Board. I have been impressed by the skill and dedication shown by my fellow Board members in tackling a difficult, often emotionally draining, but very essential task. Attached to my testimony are the observations of board member Dr. Katherine Melhorn, who could not be here today because of medical school teaching obligations. I believe you will find her remarks helpful in assessing the importance of SB 782.

My special interest lies in finding ways to translate the Board's findings into prevention strategies. To illustrate the point, let me highlight three trends we've noted in our first year of case review:

1. The number of children dying in firearm-related instances is increasing steadily. While deaths traceable to gang involvement exist, many more are accidental, as demonstrated by several recent tragedies here in Topeka.

2. We are seeing a rise in infant deaths where there is reason to suspect alcohol and drug involvement on the part of the mother. In these cases the Board performs a public service by flagging these cases to the attention of SRS since other siblings are frequently also at risk.

3. There are a significant number of adolescent deaths that could have been prevented by the use of automobile seatbelts.

The Board's work has been sustained in the first year by the extraordinary efforts of chairman Nancy Lindberg and the support of Attorney General Stephan and his staff. Dr. Lorne Phillips and his staff at KDHE have assisted the Board in creating a new data base that will generate important information from the Board's reviews. Other Board Members have contributed generously of their time and talents. This dedication to task will continue; however, some basic staff support will be essential if the Board is to complete the tasks assigned to it.

We encourage you to approve SB 782, with the amendments proposed in Nancy Lindberg's testimony.

Presented by: James McHenry, Ph.D., Assoc. Ex. Dir.

Senate PH&W
Attachment #2
3-8-94

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913-232-0858 (FAX)

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2600 S.E. 23RD
TOPEKA, KS 66605
913-234-5424
913-234-8316 (FAX)

EMERGENCY CHILDREN'S
SHELTER
802 BUCHANAN
TOPEKA, KS 66606
913-232-8282
913-232-4142 (FAX)

CHILD ABUSE
PREVENTION
715 W. 10TH STREET
TOPEKA, KS 66612
913-354-7738
913-354-7739 (FAX)

100 YEARS
OF SERVICE
TO CHILDREN

To: Committee on Public Health and Welfare

From: Katherine J. Melhorn, M.D., Member, Kansas Child Death Review Board

Re: Senate Bill No. 782

In a review of State Child Death Review Teams in this country, that I wrote in 1993 for the Kansan Pediatrician, the newsletter of the KS Chapter of the American Academy of Pediatrics, I detailed the outcomes of studies which clearly identify the need for Child Death Review Boards. To summarize:

First, data from any one reporting agency are not adequate to determine accurate causes of deaths. It is not until information is shared between agencies that we can capture all the contributing factors to child deaths and correctly identify a cause in each case. Already, we have two cases for which we feel the cause of death was incorrectly classified. One child abuse death was not classified as such by the local physician. This would not have been noted without our systematic review. On follow-up we were able to provide essential information to law enforcement involved in the case.

Second, data from other states have pointed to areas of concern that can be addressed by policy changes in agencies, legislative changes, professional and public education. In our review of Kansas child deaths we have found that evaluations and investigations by involved agencies varies considerably. In some cases, the evaluations were felt to be inadequate or even in conflict with the law. In one case a death was declared due to Sudden Infant Death Syndrome without an autopsy being performed. The involved physician was unaware of the state statute that requires an autopsy. We have had several cases of motor vehicle accidents involving adolescent driver fatalities that were unwitnessed. Again, autopsies, drug toxicologies, and blood alcohol tests are not obtained in a significant number of these cases. Protocols will be necessary to help professionals evaluate child deaths. This will likely include such things as defining suspicious deaths, suggesting autopsy standards, death scene investigation protocols, and evidence collection standards for emergency medical services, hospitals, and law enforcement.

Third, Kansas is now one of 34 states with a multiagency review team at the state or local level. We have found many areas to target for prevention. Nearly all the teenage deaths involved unrestrained victims. We have reviewed several cases involving children on bicycles. Others were the direct result of inadequate supervision by a caretaker. As these types of patterns develop, we can work on public education programs for prevention.

Currently, the CDRB members have served as volunteer members and are committed to the process as it has been established. The chairperson of the board is spending two to three days a week on board-related activities. I personally, am spending approximately 15 hours a month reviewing cases and tracking down related information. Multiplied by the other board members this is a significant amount of time for people who have full-time responsibilities in their own agencies.

Up to this point we have barely been able to keep up with timely reviews of the child deaths. Our goals include improving the sources of data and using trends and patterns of causes of deaths, as described above, to identify risk factors, improve system responses and develop prevention strategies. In order to follow through on these goals we will need, at a minimum, an office and staff assistance.

2-2

11/18/93

NATIONAL CHILD DEATH REVIEW TEAMS

Michael Durfee M.D.

Multiagency Child Death Review Teams exist at the state and/or local level in 35 states covering over half the total U.S. population. Teams cover total populations from 30 million in California to 600,000 in Vermont, to counties with a few thousand people. A combined military team has begun meeting.

A national team has been planned and exists today informally. Ontario Canada has a team covering over 1/3 of Canada's population. This will bring us the question of international cooperation.

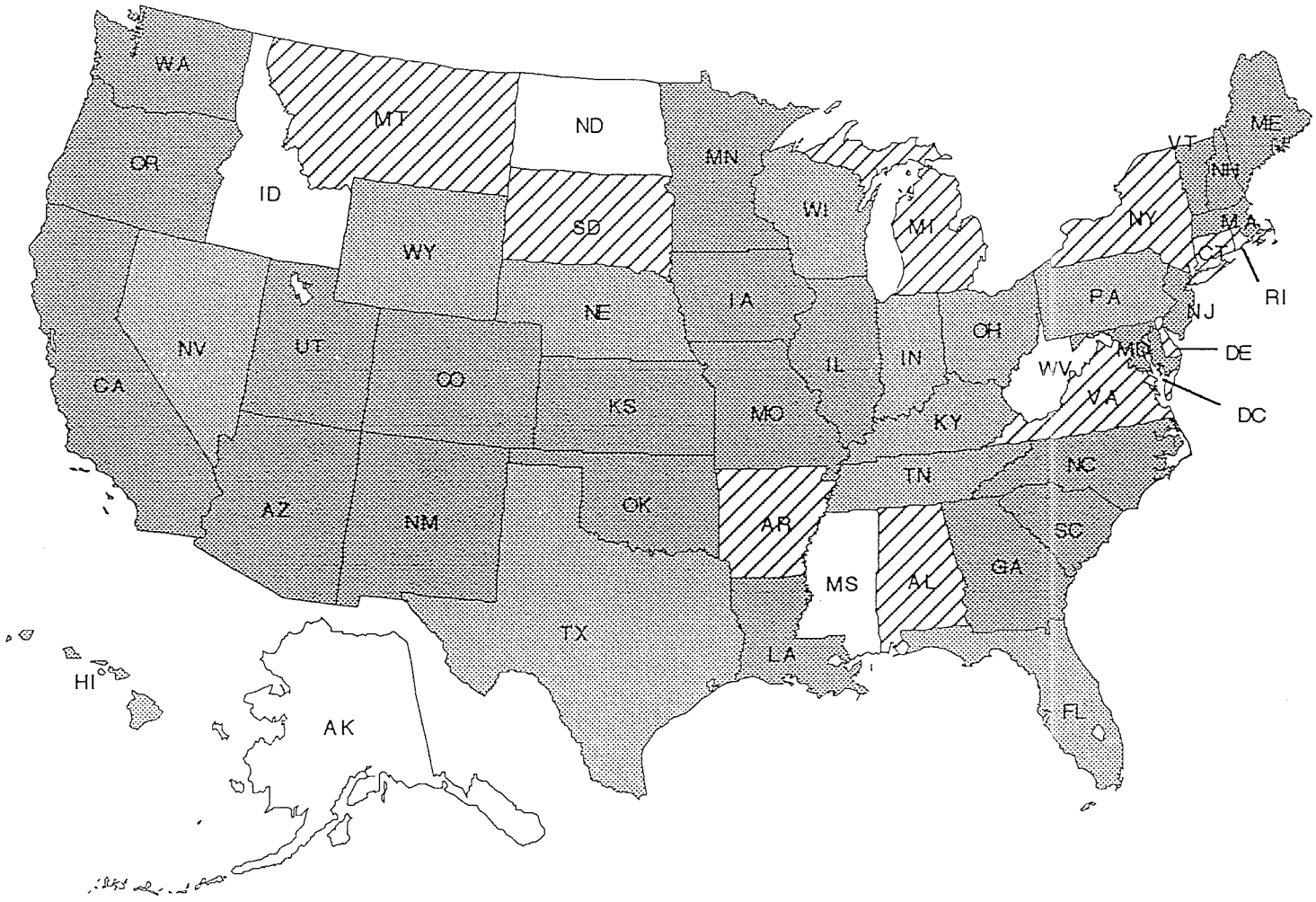
States may begin with state level teams or local teams. The trend is towards state and local teams. Ten states and the District of Columbia have formal planning underway. Over half of the 50 largest counties have teams. Counties and states are gathering in clusters with ties across geographic boundaries to share resources and to serve families that cross those lines.

Core team members include the coroner/medical examiner, law enforcement, prosecuting attorney, child protective services and health. Health may include a local pediatrician and/or public health nurse. Additional members may include, schools, preschools, probation. parole, mental health, child advocates, fire department, emergency medical technicians, and emergency room staff.

Cases are chosen from coroner's records or public health records. Some teams have joined public health based fetal infant mortality review to consider all child and fetal deaths. Most child abuse/neglect deaths are of the very young with 40-50% of the victims under one year of age. The most common cause of child death by a caretaker is head trauma followed by a mixture of smothering, drowning, abdominal trauma, burns, poisoning, and weapon deaths including guns and knives.

The multiagency peer review of all potentially suspicious deaths makes the team more vigorous and more accountable. The interagency cooperation that develops provides a framework for more competent case management with nonfatal cases and a framework for future multiagency prevention programs.

Dept. Health Services, 241 N. Figueroa, Los Angeles, Calif. 90012



MULTIAGENCY CHILD DEATH REVIEW TEAMS*

(Ontario Canada has a team*)

***TEAMS INCLUDE:**

- Criminal Justice, Social Services, Health
- Multiagency, Sytematic, Peer Review
- Case Selection From Coroner or Health

CHILD DEATH REVIEW TEAMS

- State Team*
- Local Team* Only
- Formal Planning
- No Team*

Survey - Michael Durfee M.D. - November 18, 1993

MAR. 8 1994

Phone (913)475-3946
Testimony & Presentation on Public Health & Welfare
Senate Bill No. 782
By Elsie L. Wolters who lost a SPECIAL child 17 years ago.

Madam Chairman, Sandy Preger, Committee Members and guests:

I am here to let you know my concern with various parts of the "Death Review Board."

1. In regard to Section 1-K.S.A. 1993-Supp-22a-242. I believe that the process should be in the very beginning on suspicious deaths. That should be done by a certified Pathologist, forensic Pathologist, and certified Toxicologist and certified or a qualified law enforcement officer. They should all be working together to find the cause of death.

2. Having true facts in the very beginning make for a better factual investigation, as well as being cheaper in the long run.

3. I lost a very (SPECIAL) daughter some 17 years ago. If we would have had qualified coroners and county attorneys I wouldn't have to be here this many years later. Our family has had many added problems because of such.

4. If Kansas gets the death penalty it is imperative to me that they have a state medical examiner, or else it is like getting the cart before the horse!

5. Kansas is one of 16 states who do NOT have medical examiners. Some 34 other states do!

6. It would be inexcusable to send an innocent person to the death chamber.

7. There were laws passed in the 1960's that stated that any suspicious death should have an autopsy done. In 1976 the coroner and the county attorney chose NOT to to do one. So what does that tell you about coroners? A coroner may be a doctor or may be a funeral director, etc. What does that tell you in regard to qualifications. I believe that Forensic Pathologist have 5 extra years of training in said field.

8. In our loss of our child, NO autopsy was done, No clean blood samples were drawn, and NO law official were present. Records were lost, others were misplaced for some 4-8 years, some were destroyed. Our daughter had NO life support or taken to the hospital. She was taken to the morgue and we were never notified where she was taken. We thought she was going to the hospital!

9. Many attorneys are NOT able to prosecute the offenders because lack of evidence, if you do NOT have the facts, many go FREE.

10. It is my understanding that the budget for 1995 has been set for 9.3 million dollars for indigent people who can NOT afford an attorney, many are offenders or even killers. (If) moneys is scarce- start gradual; but get started as soon as possible, for a state medical examiner!

11. In regard to K.S.A. Section-2-1993-Supp-22a243(j). I believe that NO board should have more rights than the parents or guardians of minor children. unless it is an investigative record or special technique used to determine the cause for death. No one else should have that right unless the parent signs for such. Parents should sign a release before the board is allowed to get the records. Oppose Opponent

12. It is my sincere wish that what happened to our family will NEVER be allowed to happen to another family or human being! That is the reason I am here .

It would be nice if the death review board would research the history and genealogy on children who have a family history of various diseases, for example--certain cardiac conditions, diabetes, etc. Prevention of such diseases would be better than finding the cause of death.

Senate PHW
Attachment #3
3-8-94

302 No. Wolf Street
Oberlin, KS 67749
April 6, 1991

Dear Kansas Ways & Means Committee:

Let it be known that you are changing a portion of the Senate Bill No. 405 by amending K.S.A. 22a-233 and repealing the existing section. Please consider the following to be included in this amendment, as this is very important and is the only satisfactory way to protect the victim and their family of an unattended death!

It is very important that this particular portion of the bill become MANDATORY unless the victim of the unattended death has a CHRONIC condition or the cause of death can be determined by CLEAN, ADEQUATE BLOOD SAMPLES!

The bill needs to require the following:

(1)--The actual TESTS that must be made with each AUTOPSY. (Consult experts! for the type of tests that need to be established.)

(2)--Record of the results of each TEST made a part of each AUTOPSY.

(3)--Record of deposition of SPECIMENS TAKEN FOR TESTS.

(4)--Record as to size/volume, such as CCs, MLs, etc.

(5)--A record of examiners' conclusions based upon TESTS. Record to be in a safe place, such as the BUREAU OF VITAL STATISTICS or the COUNTY CLERK.

I personally had the experience of an unattended death with our 17-year-old daughter. The coroner did NOT find it necessary, NOR did the county attorney find it necessary to have an autopsy or CLEAN BLOOD SAMPLES of our beloved daughter.

I have had some 14 years of HELL wondering what really happened to our daughter; this is worse than the DEATH itself!

That is why it is necessary for that part of the bill to be MANDATORY in an unattended death.

Please let me know when the hearing will be held on this bill for presentation by myself.

Sincerely yours,

Elsie L. Wolters
(913) 475-3946

For better laws for protection!

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