KENTUCKY

CHILD FATALITY REVIEW SYSTEM

2003 and 2004 Annual Child Fatality Review Report

Cabinet for Health and Family Services
Department for Public Health

Table of Contents

Message from the Commissioner	**ii**
Acknowledgements	**iii**
Child Fatality Review in Kentucky	**1**
Map of Kentucky Counties with Local CFR Team	**3**

2003 Child Fatality Review Report

Executive Summary				**4**
Summary Table				**5**
I.	**Infant Mortality**			**6**
II.	**Natural Cause Infant Fatalities**			**9**
	A.	**Congenital Anomalies**		**12**
		a.	**Anencephaly**	**12**
		b.	**Trisomy 13**	**13**
		c.	**Trisomy 18**	**14**
	B.	**Prematurity and Low Birth Weight**		**16**
	C.	**Sudden Infant Death Syndrome**		**18**
III.	**Natural Cause Child Fatalities**			**21**
IV.	**Injury Related Fatalities**			**25**
	A.	**Unintentional Injuries**		**27**
		a.	**Transportation Fatalities**	**27**
		b.	**Suffocation/Strangulation Fatalities**	**30**
		c.	**Drowning Fatalities**	**33**
		d.	**Smoke/Fire Fatalities**	**38**
	B.	**Intentional Injuries**		**41**
		a.	**Child Abuse and/or Neglect**	**41**
		b.	**Homicide Fatalities**	**49**
		c.	**Suicide Fatalities**	**52**

2004 Child Fatality Review Report

Executive Summary				**56**
Summary Table				**57**
I.	**Infant Mortality**			**58**
II.	**Natural Cause Infant Fatalities**			**61**
	A.	**Congenital Anomalies**		**64**
		a.	**Anencephaly**	**64**
		b.	**Trisomy 13**	**65**
		c.	**Trisomy 18**	**66**
	B.	**Prematurity and Low Birth Weight**		**68**
	C.	**Sudden Infant Death Syndrome**		**70**

III. Natural Cause Child Fatalities 73

IV. Injury Related Fatalities 77
- **A. Unintentional Injuries** 78
  - **a. Transportation Fatalities** 79
  - **b. Suffocation/Strangulation Fatalities** 82
  - **c. Drowning Fatalities** 85
  - **d. Smoke/Fire Fatalities** 90
- **B. Intentional Injuries** 93
  - **a. Child Abuse and/or Neglect** 93
  - **b. Homicide Fatalities** 100
  - **c. Suicide Fatalities** 101

Technical Notes and Data Sources 107

References 109

MESSAGE FROM THE COMMISSIONER
Cabinet for Health and Family Services
Department for Public Health

This report summarizes child fatality causes in Kentucky for children under the age of 18 and stresses related risk factors and prevention measures. This report's information is based on Kentucky 2003 and 2004 vital statistics data.

Infant deaths have been declining steadily in the Commonwealth. However, congenital anomalies continue to remain the leading cause of infant deaths in Kentucky as well as the Nation. Deaths due to prematurity/low birth weight is another cause of infant deaths. During recent years many dedicated health care providers have steadfastly promoted and practiced initiatives to provide better access to prenatal care, reduce drug, alcohol and tobacco use, increase folic acid use, and have encouraged proper nutrition and physical exercise in women of child bearing age. We are very grateful for these efforts that are contributing to the improvement of the health of Kentucky mothers and their babies. In order to improve health outcomes, we must continue with these and other prevention measures as we strive to achieve a standard of excellence regarding infant health and survivability.

Similarly to infant deaths, child fatalities have been steadily decreasing in Kentucky since 1997 with 720 deaths compared to 631 deaths in 2004. Injury related deaths continue to remain the most preventable types of child death and in an effort to reduce these types of deaths, education and awareness of child safety and injury prevention is imperative. Transportation related injuries continue to be the predominant cause of Kentucky injury related child deaths between one through 17 years of age. A significant number of child transportation related injuries and deaths may be avoided by increasing booster seat usage among children ages four through eight, increasing seat belt usage for children older than eight and improving safe driving habits among our young and inexperienced drivers. In 2006, the Kentucky Graduated Driver's License Bill was signed into law with the goal to decrease the overall number of crashes involving teenage drivers.

All individuals and communities are encouraged to diligently practice injury prevention methods proven to make a significant difference in reducing child injury and fatality. The future of Kentucky's children depends on assuring a safe and quality community life for them and their families. It is hopeful that the information contained within this report will be helpful to strengthen communities and families and will help improve the lives of children across the state.

Sincerely,

William D. Hacker, MD, FAAP, CPE
Commissioner
Department for Public Health

ACKNOWLEDGEMENTS

The development of the 2003 and 2004 Kentucky Child Fatality Review (CFR) Annual Report was completed by the Department for Public Health staff. The Department for Public Health is indeed grateful for the time and effort contributed toward this annual CFR report by all individuals involved.

This report was prepared by:

Tina M. Hembree, MPH
Epidemiologist
Maternal & Child Health Branch
Division of Adult & Child Health Improvement

Tracey D. Jewell, MPH
Division Epidemiologist
Division of Adult & Child Health Improvement

A special thank you for document review go to the following individuals:

William D. Hacker, MD, FAAP, CPE
Commissioner
Department for Public Health

James S. Davis, MD
Deputy Commissioner
Department for Public Health

Ruth A. Shepherd, MD, FAAP, CPHQ
Director
Division of Adult & Child Health Improvement

Linda Lancaster, RN, MPA
Manager
Maternal & Child Health Branch
Division of Adult & Child Health Improvement

Kentucky Child Fatality Review State Team Members

Questions concerning this report should be directed to:

Tina M. Hembree
Maternal and Child Health Branch
275 East Main Street, HS2GW-A
Frankfort, KY. 40621
Phone: 502-564-2154

This report may be viewed at the following web address:
http://chfs.ky.gov/dph/ach/childfatality.htm

Child Fatality Review in Kentucky

KRS 211.680 was passed by the Kentucky General Assembly in 1996 to create a system for the purpose of reducing the number of child fatalities. The system was charged to establish priorities and develop child death prevention programs that require:

- Accurate determination of the cause and manner of death;
- Cooperation and communication among agencies responsible for the investigation of child fatalities; and
- Collection and analysis of data to:
  1. Identify trends, patterns, and risk factors; and to
  2. Evaluate the effectiveness of prevention and intervention strategies.

With passage of this legislation, the Kentucky Department for Public Health was approved to establish a state child fatality review team. The establishment of a state team is not a requirement but as a voluntary body is requested by legislation to assume certain inclusive duties such as the:

- Development and distribution of model protocols for direction of local child fatality review teams that investigate child fatalities;
- Facilitation of local child fatality review team development that may include but is not limited to the provision of joint training opportunities and technical assistance;
- Review and approval of locally prepared and submitted child fatality review team protocols;
- Analysis of received data regarding child fatalities to identify trends, patterns, and risk factors;
- Evaluation of the effectiveness of adopted prevention and intervention strategies; and to
- Make recommendations regarding state programs, legislation, administrative regulations, policies, budgets, and treatment and service standards that may facilitate development of strategies for prevention and reduction of the number of child deaths.

The Kentucky Child Fatality Review State Team was organized in 1997 and has been functioning regularly since in an advisory capacity to the Department for Public Health. One of the earliest projects of the state team was to develop the Kentucky Child Fatality Review System Handbook that is referenced as the standards of practice for a local child fatality review team. The Handbook may be accessed at http://chfs.ky.gov/dph/ach/childfatality.htm.

The fostering of local child fatality review team development and continuation is one of the most important infrastructure building responsibilities of the Department for Public Health in partnership with the state team to assure a strong child injury and fatality review and prevention system throughout Kentucky. The local team composition, similar to that of the state

team, includes multidisciplinary representation from the medical, legal, social and child protection services, law enforcement, mental health counseling, consumer and other key community organizations focusing on child safety issues. For example, local health department representative participation on a local child fatality review team offers a unique opportunity for the health department participant to assess the high-risk health and life threats regarding the community's children. In return, the coroner and other team members have the opportunity to partner with their local health department in sharing, discussing and prioritizing child health and life risk factors for team participation in various community prevention projects.

Kentucky Counties with Child Fatality Review Team (Shown in Grey)

as of July 28, 2008

Source: Local Health Departments 2008