Preventing Child Deaths in Missouri:
The Missouri Child Fatality Review Program (CFRP) Annual Report for 2014
Executive Summary

INTRODUCTION

Fatality rates for infants, children and teens are widely recognized as valuable measures of child wellbeing. Realizing this, over twenty years ago, Missouri implemented the most comprehensive child fatality review system in the nation. Missouri law requires child fatalities to be reported to the coroner or medical examiner, regardless of the cause of death and if the death meets criteria, it is reviewed by a county-based panel of child protection professionals in the county of illness/injury/event. During the review process, CFRP panels collect standardized child fatality data which can be used immediately by the community to address needs for services and implement prevention best practices. Statewide data is used to identify spikes, trends and patterns of death requiring systemic solutions and prevention strategies to improve child wellbeing and ensure a safer environment for all Missouri children and families.

GENERAL SUMMARY

In 2014, **951** child fatalities were reported to the Missouri Child Fatality Review Program – a decrease of **28** deaths from 2013. This number includes children that died in Missouri, regardless of their state of residence or state in which the illness, injury or event occurred. (p. 6)

- **Eight hundred thirty-seven** child fatalities were the result of a fatal illness, injury or event that occurred within Missouri and were subject to determination of review by the coroner/medical examiner and the CFRP chairperson, based on established program criteria – a **41** death decrease from 2013. Demographically, 62% involved children age one and younger, 70% were white and 59% were male. (pp. 6, 7)

- **Four hundred forty-two** child fatalities had causes that were clear and not suspicious. The remaining **395** had indications for review by the CFRP panel, of which **385** deaths were reviewed and the panel information entered into the National Center for the Review and Prevention of Child Deaths – (NCRPCD) Case Reporting System. (p. 6)

- **Five hundred thirty-six** (64%) were of a natural manner; i.e., illness, prematurity, congenital anomalies, etc., including **13** Sudden Infant Death Syndrome (SIDS) deaths. The remaining **301** child fatalities were categorized by manner of death as injury-unintentional (**204**), injury-homicide (**47**), injury-suicide (**37**), injury-undetermined (**3**), and manner-undetermined (**10**). (p. 7)

NATURAL FATALITIES

Of the **536** Missouri incident fatalities due to illness or natural causes, **442** were clear and not suspicious. (pg 9, 17)

- **Four-hundred two** (77%) of the non-SIDS natural cause child fatalities occurred during the first year of life and were often related to prematurity or birth defects. (pg 9, 10)

- For infants who die suddenly and unexpectedly, a full autopsy, thorough investigation, social and medical review have allowed for more accurate determinations of cause of death, but for some the cause still remains unknown. These deaths are classified as Sudden Infant Death Syndrome (SIDS). The number of SIDS deaths in Missouri has decreased from **121** in 1992, to **69** in 2002, to only **13** in 2014. To reduce risk, continued public education and awareness concerning safe sleep practices for infants is needed. Of the **13** SIDS deaths, only one child was known to have been sleeping alone on its back, in a crib. (pg 17, 20)

- Cancer (34%), congenital anomalies (26%), neurological disorders (17%) and cardiac conditions (17%) were the leading natural causes of death for children one year of age and older. (pg 10)

INJURY FATALITIES

Of the **837** child fatalities reported to the CFRP in 2014, **291** (35%) were due to injury, of which **204** (70%) were unintentional. The two leading causes were unintentional suffocation (**85** deaths) and vehicular crashes (**77** deaths). (pg. 24)

- In 2014, **three** children died of injuries whose manner (intentional or unintentional) could not be determined. (pg. 80)

- Of the **104** total intentional and unintentional suffocation deaths, **85** (82%) were diagnosed as unintentional suffocation, and **75** (88%) of those were infants. **Forty seven** (63%) of the infant deaths were related to the infant sharing the same sleep surface with another person. (pg 26, 27)

- In comparison with total Missouri vehicular deaths, the percentage of children who died from vehicle crashes has decreased from **13.92%** in 2000, to **10.84%** in 2014. (pg 38)

- Of the **69** unintentional motor vehicle-related child fatalities involving child restraint issues, **30** were unrestrained, **two** child restraints were improperly used and **eleven** had unknown restraint use. (pg 32)

- Other leading causes of unintentional injury deaths were drowning, fire/burn, poisoning and firearm. (pg 24)

    - **Fifteen** children died from accidental drowning, of which **seven** were under age five. **Four** children drowned in swimming pools, **nine** were in open water locations. **None** were wearing personal flotation devices. Of the others, **one** drowned in a bathtub, and **one** at a water park. (pg 46, 47, 48)

    - Unintentional fire/burn injuries resulted in the deaths of **six** children, of which **three** were under five years of age. All **six** deaths involved residential structure fires, and **none** of the structures were known to have a working smoke detector. (pg 41, 42, 43)

    - **Nine** children died of unintentional poisoning, with **seven** being 15 years of age and over. **Three** died from prescription drugs, and **six** died from illegal drugs. (pg 50, 51, 52)

    - **Two** children died of unintentional firearm injuries, of which **both** were teens. **One** child was injured during a hunting accident and the other **one** was reported to be playing with the gun when it went off. **One** of the **two** unintentional firearm deaths involved a handgun and **one** involved a hunting rifle. (pg 54, 55)

HOMICIDES

- **Twenty-four** Missouri children were victims of homicide by non-caretakers. (pg 70)

    - **Nine** were related to youth violence by various causes. Of those, **seven** victims were directly involved in harmful behaviors and activities which put them at risk. Intentional firearm injuries accounted for **17** of the **24** non-caretaker homicide fatalities. (pg 71)

SUICIDES

- Suicide (intentional self-inflicted injury) was the cause of death of **37** children, age ranging from 10 to 17. The forms of suicide were suffocation/strangulation (**16** deaths), firearms (**17** deaths), poisoning (**2** deaths) and vehicular (**2** deaths). (pg 74, 75)

UNDETERMINED CAUSE AND MANNER

- In 2014, **10** children died in which the cause and manner could not be determined. (pg 81)

FATAL CHILD ABUSE AND NEGLECT (CAN)

Sixty child deaths involved fatal child abuse and neglect (CAN) by inflicted physical injury and/or grossly negligent treatment by a parent or caretaker, regardless of motive or intent. (pg 59)

- Homicide by caretaker/guardian was the manner of **23** child abuse deaths. (pg 62)

- The remaining **37** child neglect deaths were initially listed as an unintentional, natural, non-caretaker homicide or undetermined manner of death, but the CFRP panels believed that gross negligence by a parent or caretaker contributed to child's death. (pg 62)

- **Thirty four** (57%) of the total **60** CAN deaths were children under one year of age, **18** (30%) children were ages one to four. (pg 60)

    - The three leading causes of total **60** CAN fatalities were **21** deaths from suffocation/strangulation, **eight** deaths from abusive head trauma and **seven** deaths from vehicular crashes (impairment and lack of appropriate restraint). (pg 60)