GEORGIA CHILD FATALITY REVIEW PANEL

Calendar Year 2006

Edward Lukemire
Chairperson

Sonny Perdue
Governor

December 2008

GEORGIA CHILD FATALITY REVIEW PANEL

Annual Report
Calendar Year 2006

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Mission

The Mission of the Georgia Child Fatality Review Panel is to provide the highest quality child fatality data, training, technical assistance, investigative support services and resources to any entity dedicated to the well being and safety of children in order to prevent and reduce incidents of child abuse and fatality in the state. This mission is accomplished by promoting more accurate identification and reporting of child fatalities, evaluating the prevalence and circumstances of both child abuse and child fatalities, and developing and monitoring the statewide child injury prevention plan.

Acknowledgements

The Georgia Child Fatality Review Panel wishes to acknowledge those whose enormous commitment, dedication, and unwavering support to child fatality review have made this report possible. These include:

- All the members who serve on each of the county child fatality review committees
- John Carter, Ph.D. Epidemiology Department of Emory University, Rollins School of Public Health
- Katherine Kahn, MPH, Department of Epidemiology, Evaluation, and Health Information, Georgia Department of Human Resources
- Jimmy Clanton, Graphic Designer, Georgia Division of Public Health, Department of Human Resources
- All the other public and private agencies that have so willingly collaborated with this office and provided support

GEORGIA CHILD FATALITY REVIEW PANEL

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The Georgia Child Fatality Review Panel is an appointed body of 17 representatives that oversees the county child fatality review process, reports to the governor annually on the incidence of child deaths, and recommends prevention measures based on the data. Two year appointments are made by the governor except as otherwise noted.

1 Appointed by the Lieutenant Governor
2 Appointed by the Speaker of the House of Representatives
3 Ex-Officio

Georgia Child Fatality Review Panel

Dear Governor and Members of the Georgia General Assembly:

On behalf of the Georgia Child Fatality Review Panel, I am pleased to submit the 2006 Annual Report. As you know, one of the responsibilities of the Panel is to gather from local review committees information concerning child deaths. The Report is a compilation of that data as to the number and manner of child fatalities in this state for the designated period, as well as assessments regarding preventability. Also included are suggestions for prevention in each fatality category reviewed. We hope this Report will assist you as you seek to protect Georgia's children.

As always, we appreciate your efforts and your leadership in this very difficult task. You enable this Panel, local review committees and numerous participating agencies to continue the fight. Thank-you for that.

Sincerely,

Edward D. Lukemire
Chairperson, Georgia Child Fatality Review Panel

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Preface

An uncertain future awaits Georgians in these difficult economic times. There are constant news reports on job losses, personal savings losses, and budget cuts to public programs, in our state, and across the country. There is speculation that the current economic crisis could mirror the recession of the early 1980s. During that time, spending on children's programs suffered the most, with a 5.2% decrease in real total social welfare spending. Spending on children's programs has only slightly increased since that time, although the states have enjoyed several periods of growth and expansion.

States have primary oversight for children's welfare programs, not the federal government, which tends to make these programs more vulnerable to economic downturns. In a lean economy, many state program budgets are cut, leading to a greater number of children living in poverty. Spending on children's preventive health care, including health insurance, is frequently subjected to the instability of state budgets. Recent "across-the-board" funding cuts to critical safety net programs could lead to an increase in the number of children lacking the basic necessities of food, clothing, shelter, and preventive health care. While poverty and unemployment do not cause child maltreatment or neglect, the stress of living day to day under these conditions are risk factors for unhealthy pregnancies in women and for families not properly caring for their children. These are the times when children and families need more assistance, not less.

With so many families struggling just to provide food and keep their homes, how can we keep our focus on improving injury prevention and reducing child fatalities? A majority of child deaths in Georgia are the result of medical conditions. It is crucial to understand how to better protect children from preventable medical deaths while they go without medical coverage. A significant percentage of deaths occur among infants, so we must focus more of our attention on providing early and regular prenatal education to women, especially those who have difficulty accessing health care. We must also turn our attention to those direct service providers who work with pregnant women and families to ensure that they have the support and resources they need to continue delivering quality services in the community.

This year, the Office of Child Fatality Review has made significant changes to its structure in an effort to better serve the state. Through the addition of a Prevention Specialist, OCFR strengthens its efforts to provide dedicated support and guidance to communities developing local child fatality prevention projects. The merger of OCFR with the Office of the Child Advocate will facilitate a greater focus on research and program evaluation. A renewed sense of purpose among the CFR Panel brings a collaborative energy to the work of prevention. New partnerships with state and county-level agencies allow for OCFR to better understand the needs of families and children, and for communities to get more involved in the work of child fatality prevention.

It is not easy to find good news in this economic crisis about the future of children and families in Georgia, but we must persevere. These difficult times will bring out the best in all of us. The challenges that our state is facing will serve as a catalyst for people to get involved with the improvement of their communities – especially those who might not have considered the possibility before. OCFR strives to improve data collection, identify gaps in service, and train local committees on death scene investigation and fatality response. We are finding ways to work together and share our limited resources, creatively building bridges and strengthening partnerships. Individuals are motivated to help, and OCFR is working with many other agencies and organizations to provide outlets for interested communities and individuals to get involved. This economic crisis will make all of us stronger and more efficient as we protect the lives of children and families across Georgia.

Executive Summary

The Georgia Child Fatality Review Panel (Panel) publishes an annual report chronicling the tragic, preventable deaths of children in Georgia. Child deaths are identified through death certificate data provided by the Office of Vital Records within the Division of Public Health. Local child fatality review committees review only those deaths that are sudden, unexpected, or unexplained ("eligible"), and complete a standardized form detailing the circumstances of the deaths. That information is compiled and used in the Panel's report. The Panel is charged with tracking the numbers and causes of child deaths as well as identifying and recommending prevention strategies that could reduce the number of child deaths.

This year, the Panel is providing a report detailing the circumstances of child deaths occurring in 2006. Considering aggregated child death data year to year is useful in revealing recurring patterns and indicating prevention gaps and opportunities. We encourage parents, communities, organizations, and policymakers to use these data to make life-saving decisions for children.

Key Findings

Adjusted death certificate data from 2006 reported 1,825 child deaths in Georgia, of which 574 were reported as eligible for review. Child fatality review committees reviewed 459 (80%) of those deaths; however, the cause of death listed on death certificates and the cause of death determined by child fatality review committees sometimes differed due to cause of death coding systems for the death certificate data. Because child fatality review committees consider all aspects of the event to determine cause and manner of death, Vital Records sometimes uses the child fatality review data, which is believed to be more reliable, to adjust death certificate data in the state.

FATAL CHILD ABUSE/NEGLECT

Department of Family and Children Services reported that 64 children in Georgia died as a result of substantiated abuse or neglect in 2006. Those deaths were investigated by DFCS, and did not include deaths that were handled by law enforcement or the courts without DFCS involvement. Thirty-six children died as a result of inadequate supervision or of other forms of parental neglect, and another 28 children died from physical abuse. Of the 64 children, 40 had no current or prior history with Child Protective Services; 24 were from families that had been investigated at some time prior to the child's death.

Child fatality review committees determined that 116 child deaths resulted from both confirmed and suspected abuse/neglect (54 confirmed and 62 suspected). Children under the age of five accounted for 79% (92) of those abuse/neglect related deaths. Perpetrators were identified in 73 of the 116 abuse/neglect related deaths, as well as relationship of the perpetrator to the child. More than one perpetrator was identified in 13 child abuse/neglect deaths. Forty-nine percent (49%) of perpetrators in child abuse/neglect deaths were natural parents. Homicide was the cause of 26 confirmed abuse deaths.

NATURAL

Death certificate data indicated a total of 1,393 children under the age of 18 died of natural causes (medical or SIDS). Infants accounted for the vast majority (1,115) of those deaths. The leading causes of infant deaths continued to be congenital anomalies, low birth weight, and prematurity. There were 150 SIDS deaths – a 20% increase since 2005 (125).

Child fatality review committees reviewed 245 deaths from natural causes (medical or SIDS/SUID). One hundred sixty-three (163) of those deaths were reported as SIDS or SUID. (SUID – Sudden Unexplained Infant Death - is a term used for a death that appears to be SIDS, but has other factors that *could* have contributed to the death.) Committees are required to review all SIDS/SUID deaths, as well as medical deaths that are unexpected or unattended by a physician. Medical deaths reviewed included conditions related to asthma, spinal, or heart-related complications.

UNKNOWN

Death certificate data listed 51 child deaths that were determined to be of unknown cause. Thirty-one of those deaths were reported among infants. An unknown cause of death is reported on a death certificate when the information reported by the medical history and autopsy cannot conclusively determine what caused the death of the child.

Child fatality review committees reported 27 deaths due to unknown causes. Twelve of those deaths occurred among infants. An unknown cause of death is reported by review committees when the information gathered from the scene investigation, family circumstances, medical history and autopsy cannot conclusively determine what caused the death of the child.

INJURIES

Death certificate data listed 381 deaths to have resulted from known injuries, but nine of those deaths listed an unknown intent. Among infant deaths, there were 48 known injury deaths, including deaths from homicides, motor vehicles, and asphyxia. There were 333 deaths in children ages 1 – 17 resulting from injuries, either intentional (inflicted) or unintentional (accidental).

Unintentional Injuries

Death certificate data indicated that 77% (258) of all injuries in the 1 – 17 year age group resulting in death were unintentional (excludes intentional, unknown intent and unknown cause). The three leading single causes of unintentional injury-related deaths in this age group were:

- 147 motor vehicle incidents
- 37 drowning incidents
- 19 fire incidents

There was a one percent decrease in the number of deaths caused by known unintentional injuries to this age group from 261 in 2005. Motor vehicle-related deaths decreased slightly (from 149 in 2005), while fire-related deaths increased (from 13 in 2005). The number of drowning deaths remained the same from 2005.

There were 39 unintentional injury deaths to infants, and one injury death reported as unknown intent.

Child fatality review committees reviewed 213 deaths attributed to unintentional injuries among children age 1-17. Child fatality review data agreed with death certificate data on the three leading causes of death related to unintentional injury as seen below:

- 126 motor vehicle incidents
- 35 drowning incidents
- 19 fire incidents

Intentional Injuries

Death certificate data indicated 67 children age 1-17 died from injuries intentionally inflicted by themselves or by others. In 2006, there were 44 homicides and 23 suicides (similar to 2005 data, in which there were 44 homicides and 24 suicides).

There were eight intentional injury deaths among infants.

Child fatality review committees reviewed 73 deaths to children age 1-17 from intentional causes – 47 homicides and 26 suicides.

FIREARM DEATHS

Death certificate data indicated firearms were used in 41 child deaths. Twenty-five (25) of those firearm-related deaths were ruled homicides, and eight were suicides. In addition, there were five unintentional firearm-related deaths and three with unknown intent.

Child fatality review committees reviewed 38 firearm-related deaths. Eighty-seven percent (33) were intentional (23 homicides and 10 suicides). The type of firearm was identified in 35 of the 38 reviewed firearm-related deaths. Handguns were most frequently used (32 of the 35 deaths where type of firearm was identified).

PREVENTABILITY

A primary function of the child fatality review process is to identify those deaths believed to be preventable. The issue of preventability was addressed in each of the 594 child deaths reviewed.

Child fatality review committees determined that 80% (476) of the 594 reviewed child deaths with preventability data were definitely or possibly preventable. Of the 116 reviewed abuse/neglect deaths, 112 were determined to be definitely or possibly preventable (97%).

AGENCY INVOLVEMENT

Child fatality review committees reported that in 74 (64%) of the 116 child abuse/neglect related deaths, the child and/or family had prior involvement with at least one state or local agency. Committees are also asked to determine which of the total deaths reviewed with agency involvement could have been prevented and 18 deaths were identified. While not all of those 18 deaths had findings that identified abuse or neglect, eight of the 18 did have an abuse/neglect determination ("confirmed abuse" for four and "suspected neglect" for four).

Accomplishments, Recommendations, and Goals of the Georgia Child Fatality Review Panel 2005-2008

CFR Accomplishments

1. Continued co-sponsorship of the annual conference on serious injury and child fatality with Department Family Children Services, Office of Child Advocate, and Georgia Bureau of Investigations
2. Initiated legislative recognition of county efforts through "Coroner of the Year", and "County Committee of the Year" Senate resolutions
3. Published and distributed an updated "Child Fatality Review Policy and Procedures Manual" of best practices, also available online
4. Enhanced fatality surveillance and data collection with an improved online reporting tool
5. Delivered statewide training programs on the State Model Child Abuse Protocol
6. Continued partnerships providing training to committees and assistance to local prevention efforts, which included the Governor's Office of Highway Safety, Georgia Alliance for Drug Endangered Children, Criminal Justice Coordinating Council, Public Health, and GBI
7. Continued support of child fatality investigation teams with a multi-disciplinary approach in a total of 26 judicial circuits

On-going Legislative Recommendations

1. Require an autopsy, toxicology study, and complete skeletal x-ray (following established pediatric and radiological protocol) for every death of a child under the age of seven with the exception of children who are known to have died of a disease process while attended by a physician
2. In the Child Abuse Protocol annual report, the number of investigations using a multidisciplinary approach should be indicated
3. Expand the safe haven law to include abandonment protections for infants up to 90 days old, and anonymity for the mother

On-going Agency Recommendations

1. DFCS: The Panel recommends that when a child dies due to parental or caretaker neglect or aggression, the Child Death/Serious Injury Committee be empowered to provide resources and support to counties for bereavement and prevention
2. Public Health: The Panel recommends that Vital Records provide monthly death certificate reports to OCFR to facilitate a timely review of child deaths in each county
3. Coroner and Medical Examiner's Office: Expand funding for training on improved death scene investigations for any child death that is suspicious, unexpected, and/or unexplained, and timely autopsy reports
4. Department of Education: support infant care training and SIDS risk reduction into middle and high school curricula
5. Mental Health: Redirect a portion of crisis funding for children's mental health services to devote more resources to preventive care, especially for those identified as "at risk"

Recommendations That Have Been Implemented Statewide

1. DFCS and Public Health funded an expansion of home-based family support models that promote and enable appropriate parenting skills for prevention of child abuse and neglect (SafeCare and the Integrated Family Support programs)
2. The Legislature adopted national guidelines on pool safety (to require fences and gates in public and private swimming pools statewide) and fire safety (to require smoke detectors in all dwellings)
3. The Panel, with support from the CDC, collaborated with relevant organizations to develop a statewide child abuse/child injury prevention framework, which was presented to the Governor's Office for consideration
4. Public Health implemented a statewide crib-matching campaign to promote education and training on safe infant sleep environments

Information Sources and Inconsistencies

This annual report on calendar year 2006 infant and child fatalities in Georgia uses two related but independent sources of data – death certificate (DC) data collected by the Office of Vital Records and prepared by the Health Planning and Assessment Unit (HPAU), and the child fatality review data collected by the Office of Child Fatality Review. These two data sources do not always agree on the cause or manner of death. Child fatality review reports are the primary source of data for this report.

The death certificates provide the ICD-10 coding (International Classification of Diseases, Revision 10) for the cause of death, and are used to identify the set of "reviewable" infant and child deaths. For child fatality review purposes, the relevant ICD-10 codes include deaths due to unknown or undetermined cause, SIDS, and any death due to accident or violence. In addition, a medical examiner, coroner, or CFR committee may also determine that a death should be reviewed because of the circumstances of the death (e.g., the child was not under the care of a physician). Accordingly, the total number of reviewed deaths in a county may exceed the number of deaths identified as "reviewable" based on the death certificate.

Child fatality review reports detail the cause, manner and circumstance of death, supervision at time of death, prior history of abuse or neglect, others identified as causing or contributing to child deaths, and prior agency involvement. Reports also contain information regarding whether a death might have been prevented and what measures might be taken to lessen the likelihood of a similar death occurring in the future.

Although death certificate and child fatality review data do not always agree, the causes of death are generally consistent between the two sources. However, committees often have access to additional information, and may reach a different conclusion regarding the cause and/or manner of death. The system used in the coding of the causes of death on the death certificate, the ordering of reported codes to select the underlying cause, and the collapse of codes into categories all contribute to error in the classification of the death certificate "cause" of death. One of the values of the CFR process is that it provides a check on the death certificate coding of cause.

The CFR process for the 2006 child deaths was complicated by processing delays experienced in the Vital Records system and data quality issues with the final 2006 death certificate file. The DC file is used to identify deaths that are required to be reviewed, and delays in that identification made it more challenging for the county CFR committees to gather information and conduct the reviews. One hundred fifteen (115) of 574 "reviewable" CY2006 deaths were not reviewed (in contrast, only five were not reviewed in 2004). There were also 43 reviewed deaths that could not be matched to a death certificate. This is a much larger number than usual (compared to 14 in 2004) and may reflect closing the 2006 DC file before all deaths had been entered into the system.

Five hundred fifty-one CFR reports were linked with a death certificate, and the causes of death for each linked pair were compared. The largest mismatch was 101 DC SIDS deaths that were determined by CFR committees to be sudden, unexplained infant deaths (SUID). However, there is no ICD-10 coding for SUID, (the CFR SUID determination indicates that a risk factor, such as bed-sharing and soft bedding, was identified in the documentation examined by the review committee). An additional 68 deaths had other/different causes of death in the CFR and DC records.

Rates are not calculated for 2006 deaths due to the large number of deaths not reviewed. A rate calculated on the reviewed deaths would be inaccurate and skewed. Therefore, the *proportion* of deaths is presented throughout this report, in order to demonstrate the rate of deaths within the population of all reviewed deaths.

Georgia Child Fatality Investigation Program

The Georgia Child Fatality Investigation Team (CFIT) Program, administered through the Georgia Child Fatality Review Panel, was formed to promote the utilization of best practices in the area of the investigation of suspicious child deaths in Georgia. Recognizing the importance of an immediate and comprehensive response in such cases, experts around the country suggest the utilization of a multi-disciplinary team approach from the inception of such investigations. These teams utilize highly trained representatives from their own district attorney's offices, coroners, and/or medical examiners, local law enforcement agencies, and the Department of Family and Children Services (DFCS). These teams immediately respond and share information from the moment of notification of the child's death.

In 2006, there were 594 child deaths reviewed by child fatality review committees. Fifty-six of those deaths were determined to be homicides by CFR committees. Therefore, given that on average, at least one child a week is a victim of homicide in Georgia, the need for the best quality in investigations is apparent. The original judicial circuits involved in the pilot program included: Lookout Mountain, Middle, Douglas, Dougherty, Stone Mountain, Eastern, Rome, Northeastern, Alcovy, Southern, and Tifton. The following judicial circuits enrolled in the program between 2004 and 2008: Blue Ridge, Bell-Forsyth, Clarke, Rockdale, Gwinnett, Flint, Cobb, Clayton, Macon, Brunswick, Paulding, and Towaliga.

Beginning in 2006, the program emphasized working with existing teams to revitalize teams that had fallen victim to personnel turnover and attrition. In addition to the beginning training that was initially provided, the program began to offer an advanced curriculum that included local issues. Each time the training is provided, the discussion is tailored to address problems with current or recent cases occurring within the jurisdiction.

In addition to training team members in 2008 from 14 of the enrolled jurisdictions, child abuse professionals from non-member jurisdictions also received this training under the auspices of the DFCS training program, the Georgia Public Safety Training Center child abuse course and the Building Successful Teams conference. Several jurisdictions availed themselves of the case consultation/ assistance available through the program, receiving support in many different phases of child homicide cases, from autopsy to the preparation of criminal indictments. In many cases, the program director was able to serve as a liaison and facilitate dialog between the children's hospital, the medical examiner, DFCS, local law enforcement, and prosecution where communication had not yet been established or had broken down.

In 2007, the CFIT Program expanded to encourage and train jurisdictions to utilize a true multi-disciplinary approach in all child abuse investigations. In 2008, the merger of the Office of Child Fatality Review and the Office of the Child Advocate became an opportunity to expand the scope of the CFIT training program. In 2009, the program looks forward to launching a centralized multi-disciplinary training academy. Local teams will train in groups of three to five jurisdictions to enhance their local protocols, improve efforts as a team, and learn best practices in various areas of child abuse investigations - including sexual and physical abuse, child homicides, and neglect.

Among the 594 deaths that were reviewed in 2006, over 60% of both intentional and unintentional deaths were determined to be "Definitely Preventable" by the CFR committees and an additional 30% were "Possibly Preventable". The committees reported that 126 (54%) of the 235 "Definitely Preventable" had at least one risk factor identified prior to the death; and there had been some community action prior to the death for 109 (87%) of those 126 deaths.

Figure 1: Preventability as determined by committees by categories of death, 2006 (N=594)

	Not at All	Maybe	Definitely
All Reviewed	117	241	235
	19.7%	40.6%	39.6%
Unintentional Injuries	13	72	152
	5.5%	30.4%	64.1%
Intentional Injuries	6	24	52
	7.3%	29.3%	63.4%
Medical/SIDS/SUID/ Unknown	98	145	31
	35.8%	52.9%	11.3%

Figure 1 shows preventability of deaths as determined by committees

In response to the high percentage of preventable child deaths each year, the Office of Child Fatality Review recently began an innovative program to support the implementation and maintenance of child fatality prevention programs statewide. While we have consistently encouraged local CFR committees to focus on prevention in their work of reviewing and reporting fatality cases, there was often confusion and uncertainty around the steps required to do so.

In 2007, local CFR committees were asked to develop a specific prevention plan which would be used to drive all child fatality prevention efforts in the county for the upcoming years. Each committee was asked to outline their strategy, define action steps, and identify resources to help them in their objectives. The prevention plans gave OCFR insight into the needs and available resources of their communities. The project also allowed committees to network with each other and identify ways they could share resources while working toward the same goals. The prevention plans were revised and upgraded during the 2008 training season, and many committees have made significant progress since then.

We know that 30 counties and two judicial circuits want to direct their prevention attention to promoting infant safe sleep and reducing SIDS. Eight counties and two circuits are committed to improving child safety seat use in motor vehicles, while eleven counties, one circuit and one health district are choosing to focus their energies on teen driver safety. A handful of other counties want to focus on other injuries like drowning, gun safety, suicide, and farm injuries. Other issues that have been discussed in CFR prevention plans include newborn abandonment, poor birth outcomes, domestic violence and drug use. It is critical that we also address these types of social and developmental problems, because they can have a detrimental effect on the quality of life within a community, and can be directly linked to many child fatalities each year.

A barrier that is commonly identified in implementing a prevention program is lack of funding for personnel and program materials. OCFR is working to provide these necessary resources by applying for public and private program grants on behalf of the CFR committees. Several committees identified barriers such as a lack of awareness or participation in the community. OCFR is now working to mobilize community groups to provide in-kind support to the fatality prevention efforts, through parent organizations and service clubs. While speculating as to the attitudes of parents and families around the issue of fatality prevention, several committees indicated a need for focus groups to learn directly from parents their attitudes about the issues. OCFR has initiated focus group development in several counties, and is providing support and technical assistance for the data evaluation.

Prevention is an ongoing process, and requires the commitment of many individuals, agencies, and organizations. OCFR will continue to provide the highest quality data, training and technical assistance to all of our partners to achieve a reduction in the number of child deaths each year.

Child Deaths in Georgia

In 2006, Georgia lost 1,825 children ages birth-17 years to deaths due to medical conditions and intentional or unintentional injuries. The number of child deaths in Georgia has declined over the past few years; however there was a slight increase in 2006. Previous year information indicated the following:
1,794 deaths in 2003
1,760 deaths in 2004
1,723 deaths in 2005
1,825 deaths in 2006

The top three overall causes of death for individuals less than 18 years of age were medical, motor vehicle incidents, and Sudden Infant Death Syndrome (SIDS). Motor vehicle incidents continued to be the leading cause of death for children 15-17 years, with medical being the highest for all other age categories.

Figure 2: Deaths to Children Under Age 18 in Georgia, Death Certificate, 2006 (N=1825)

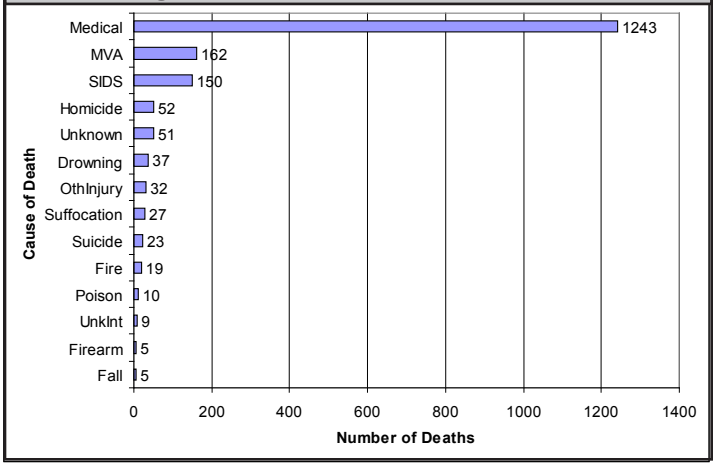


Figure 2 shows all child deaths by cause based on Georgia vital records

Findings:

- The number of child deaths has increased by six percent since 2005 (1,723)
- Although two-thirds of all child deaths were due to medical causes, infants accounted for 78% of those deaths
- Some examples of infant medical deaths included complications of prematurity, low birth weight, and respiratory distress syndrome
- The second leading cause of death overall was motor vehicle incidents

Figure 3: All Child Death Rates per 100,000 Children Age 0-17 by Race/Gender Categories, 2006 (N=1825)

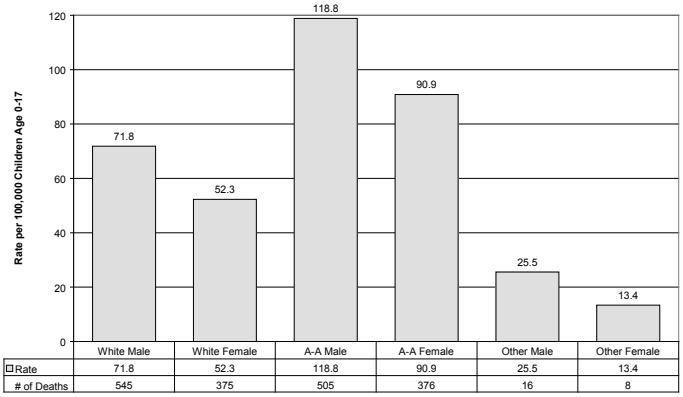


Figure 3 shows the rate and number of child deaths by race and gender groups

Findings:

- Child deaths occurred disproportionately among African-Americans. The rate for African-American males is 1.7 times higher than that of White males
- Males are more likely to die than females. Within each racial category, the rate for males is higher than that of females
- African-American female death rate is 1.7 times higher than that of White females

Figure 4: Leading Categories of Death by Age Group, Georgia, 2006

	Age Group in Years					
Rank	**<1 1,194 (65.4%)**	**1-4 193 (10.6%)**	**5-9 92 (5.0%)**	**10-14 115 (6.3%)**	**15-17 231 (12.7%)**	**All Deaths <18 1,825 (100%)**
1	Medical 965 (80.8%)	Medical 92 (47.7%)	Medical 45 (48.9%)	Medical 68 (59.1%)	Unintentional 110 (47.6%)	Medical 1243 (68.1%)
2	SIDS 150 (12.6%)	Unintentional 74 (38.3%)	Unintentional 37 (40.2%)	Unintentional 37 (32.2%)	Medical 73 (31.6%)	Unintentional 297 (16.3%)
3	Unintentional 39 (3.3%)	Intentional 16 (8.3%)	Intentional 4 (4.3%)	Intentional 6 (5.2%)	Intentional 41 (17.7%)	SIDS 150 (8.2%)
4	Unknown 31 (2.6%)	Unknown 10 (5.2%)	Unknown 3 (3.3%) Unknown Intent 3 (3.3%)	Unknown 3 (2.6%)	Unknown 4 (1.7%)	Intentional 75 (4.1%)
5	Intentional 8 (0.7%)	Unknown Intent 1 (0.5%)		Unknown Intent 1 (0.9%)	Unknown Intent 3 (1.3%)	Unknown 51 (2.8%)

Figure 4 shows the five most common categories of death for each age group, as well as the percent of all child deaths occurring within each age group

The total number of child fatalities based on death certificate data provides the following information:

Infants

- Sixty-six percent of all child deaths were to infants (less than one year old)
- Eighty-one percent of infant deaths were due to medical complications
- The second leading category of death for infants (13%) was SIDS

Ages 1-4 (Early Childhood)

- Eleven percent of all child deaths occurred to children between the ages of one and four years
- Majority of deaths were due to medical causes including, birth defects, respiratory diseases, and cancer (48%)
- The second leading category of death was due to unintentional injuries such as motor vehicle, drowning, and fire-related (38%)

Ages 5-14 (Middle Childhood)

- Eleven percent of all child deaths occurred to children between the ages of five and 14 years
- Majority of deaths were due to medical causes (55%) such as asthma and heart complications
- The second leading category of death was due to unintentional injuries such as motor vehicle, drowning, and fire-related (36%)

Ages 15-17 (Later Adolescence)

- Thirteen percent of all child deaths occurred to older teenagers
- Majority of deaths were related to unintentional injuries such as motor vehicle, drowning, and fire (48%)
- The second leading category of death resulted from medical conditions such as asthma and heart complications (32%)

All 2006 Reviewed Deaths

A child's death is eligible for review when the death is unexpected, unexplained, suspicious, or attributed to unusual circumstances (for more detail on deaths eligible for review, please see Appendix A). Child medical deaths are deemed reviewable if unexpected, suspicious, or unattended by a physician (i.e., unexpected heart failure). These deaths are reviewed by child fatality review committees which are comprised of local professionals who convene for the purpose of analyzing all circumstances of child deaths. This review process utilizes a multi-faceted approach to provide a comprehensive understanding of each child's death. Child Fatality Review is a critical component for enhancing our ability to galvanize community efforts toward the reduction of preventable child deaths.

In 2006, 574 of the total 1,825 child deaths met the eligibility criteria for review based on death certificate data. Committees submitted reports for 80% (459) of those deaths. Committees reviewed an additional 135 deaths. A total of 594 deaths were reviewed. Complete data on reviewed child deaths are available in Appendix C.2. The distribution of child deaths in Georgia is generally proportional to the county population.

- There were 12 counties with ten or more reviewable deaths in 2006. Those counties had 49% of the child population and accounted for 45% of all reviewable deaths. Those counties reviewed 77% (201) of their 260 reviewable deaths. They reviewed an additional 65 deaths
- There were 111 counties with less than ten reviewable deaths in 2006. Those counties accounted for 53% of all reviewable deaths and reviewed 82% (258) of their 314 reviewable deaths. They reviewed an additional 67 deaths
- Nine counties did not review any of their reviewable deaths. Of those, seven counties had one reviewable death, and two counties had two reviewable deaths
- Fourteen counties had no child fatalities in 2006, and 22 additional counties had no child fatalities that met criteria for review

Figure 5: Causes of Death, All Reviewed Infant/Child Deaths, Georgia, 2006 (N=594)

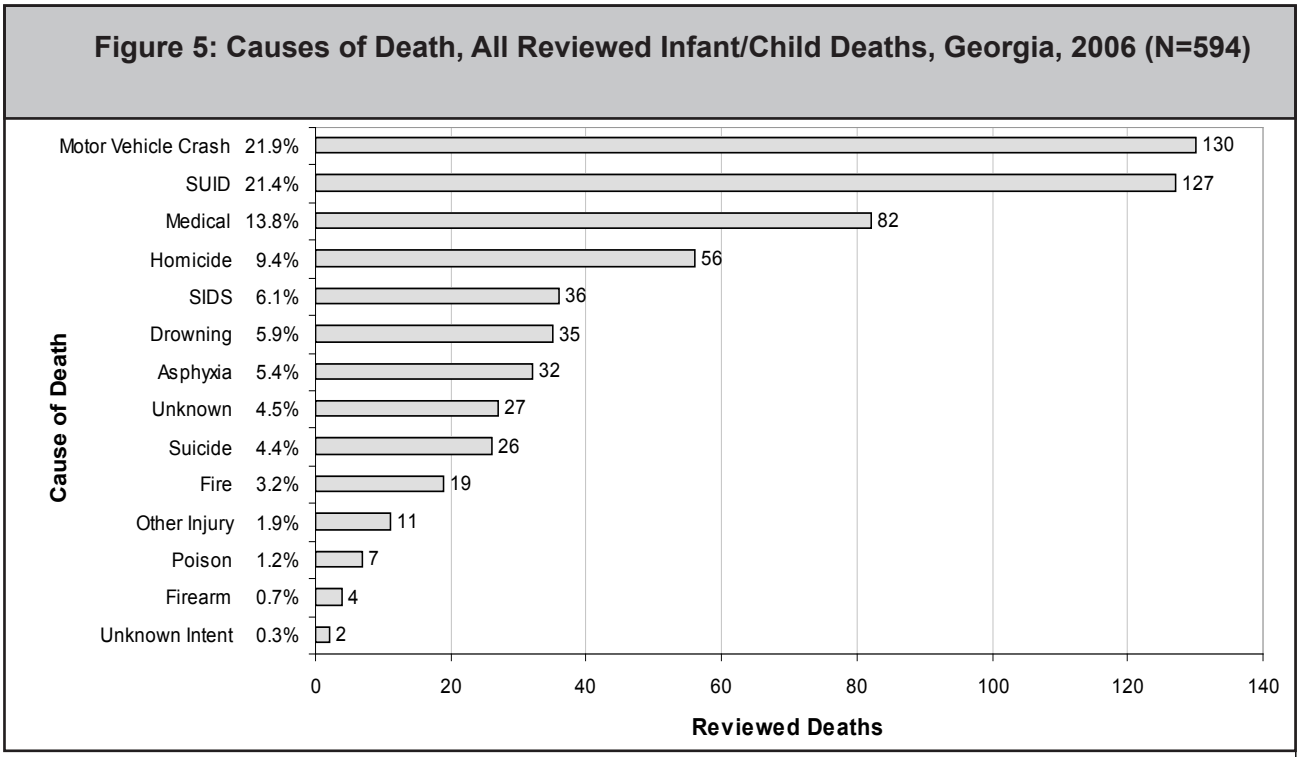


Figure 5 shows the cause of death for all 594 deaths reviewed by the child fatality review committees

Findings:

- Motor vehicle-related incidents continued to account for the leading cause of reviewed child deaths (22%)
- There was a 63% decrease in the number of SIDS deaths reviewed (from 96 in 2005), and a corresponding increase in the number of SUID deaths. This increase in SUID deaths reviewed is likely due to an enhanced awareness and identification of the risk factors possibly contributing to infant deaths
- Unknown deaths are deaths for which there was no definite cause identified after a review of the scene investigation, clinical history, and/or autopsy findings.
- Other injury includes accidental blunt head trauma, electrocution, lightning, falls, and heat-related deaths

Medical deaths are reviewable by child fatality review committees if the death occurs while unattended by a physician, occurs in a suspicious or unusual manner, or is unexpected (for more detail on deaths eligible for review, please see Appendix A). There were 82 medical deaths reviewed by CFR committees based on these criteria. More than 80% of those children had a pre-existing medical condition, such as asthma, prematurity, spinal and/or heart complications.

Figure 6: Medical Deaths Reviewed by Review Criteria, (N=82)

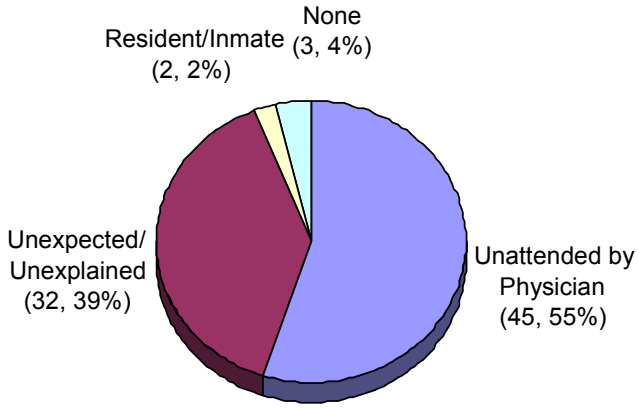


Figure 6 shows medical death reviewed based on criteria for review

Findings:

- Thirty-two percent of the medical deaths were unexpected or unexplained
- Two decedents (10-14 years of age) were residents of a hospital
- Fifty-five percent of the medical reviewable deaths were unattended by a physician, (i.e., a child experienced death as a result of a medical condition outside of a medical facility/physician's care). Examples included viral and undiagnosed heart conditions

Facts:

- According to the CDC, asthma is one of the leading causes of school absenteeism
- Based on the *School Health Profiles*, 51% of Georgia schools had one or more groups that guide and provide information for health topics in the school

Child was playing basketball and collapsed due to cardiac arrest

Opportunities for Prevention:

For Parents

- Ensure children have regular visits with a health-care provider to check for any illnesses or abnormalities in wellness and development

For Community Leaders and Policy Makers

- Consider creating a study committee to research improvements to the current school sport physical requirements. Such a committee should evaluate improvement suggestions against funding options and solutions

For Professionals

- Implementation of trainings to medical staff regarding childhood medical deaths and common conditions which have resulted in death over the past few years

Resources:
Centers for Disease Control and Prevention
www.cdc.gov/HealthyYouth

Preventability

When CFR committees investigate a child death, they also identify the degree to which that death could have been prevented. They specifically examine the circumstances of the child and the child's family *before* the event, *during* the event, and *immediately after* the event, in an effort to clearly recognize the level of intervention needed to prevent a similar death in the future. The review committees define "preventability" based on two criteria: if a death is identified through retrospective analysis to be foreseeable, or is the result of an absence of reasonable intervention.

Figure 7: Preventability, All Reviewed Infant/Child Deaths, 2006 (N=593)

	Number	Percent
Definitely Preventable	235	39.6%
Possibly Preventable	241	40.6%
Not Preventable	117	19.7%

Figure 7 shows the determination of preventability for all reviewed deaths (one reviewed death did not have preventability determination reported)

Finding:

- As in previous years, 80% of reviewed deaths were reported to be "definitely preventable" or "possibly preventable" by the review committees

Fact:

- One study determined that, if all child deaths in the United States were reviewed from a prevention/needs assessment perspective, targeted and data-driven recommendations for prevention could be developed for each community, and potentially 38% of all child deaths that occur after the first month of life could be prevented (Pediatrics, 2002)

Figure 8: Preventability, Unintentional and Intentional Injuries, 2006 (N=596)

	Not at All	Possibly	Definitely
Unintentional Injuries	13	72	152
	5.5%	30.4%	64.1%
Intentional Injuries	6	24	52
	7.3%	29.3%	63.4%

Figure 8 shows the committee determination of preventability by intent (one reviewed death did not have preventability determination reported)

Finding:

- Among the 594 deaths that were reviewed in 2006, over 60% of both intentional and unintentional deaths were determined to be "Definitely Preventable" by the CFR committees and an additional 30% were "Possibly Preventable"

Fact:

- About one third of all unintentional childhood injury deaths in the US are preventable. Among the relevant characteristics: higher education level of parents, lower gun ownership, higher population density that implies shorter distances traveled by cars, a better developed emergency medical system, and the existence of several injury prevention programs (*Injury Prevention*, *2004*)

Figure 9: Preventability by Cause, Reviewed Deaths, 2006 (N=593)

Cause of Death	Not at All	Possibly	Definitely
Medical	50	29	3
SIDS	19	17	0
SUID	25	78	24
Drowning	4	11	20
Fire	0	4	14
Firearm	1	0	3
Motor Vehicle	5	45	80
Other Injury	2	4	5
Poison	0	0	7
Asphyxia	1	8	23
Homicide	3	8	45
Suicide	3	16	7
Unknown Intent	0	1	1
Unknown	4	20	3

Figure 9 shows the preventability determination for each reviewed cause of death (one reviewed death did not have preventability determination reported)

Findings:

- Committees determined that 61% of medical deaths were not at all preventable
- There is inconsistency in the preventability determination for SUID, while SIDS is generally reported as "not preventable"

Fact:

- Most unintentional (accidental) and all intentional (inflicted) deaths are often considered to be preventable, using reasonable intervention procedures (e.g. educational, medical, social, behavioral, technological, or legal interventions)

While there are certain circumstances that are unforeseen and not reasonably preventable (i.e. certain medical situations), many injuries that are reviewed by CFR committees should be considered preventable based on the presence of awareness and education messages in the community. It is unlikely that any homicides, suicides, motor vehicle crashes, firearm or drowning deaths would be considered "not at all preventable".

The committees reported that 126 (54%) of the 235 "Definitely Preventable" deaths had at least one risk factor identified prior to the death. There had been some community action prior to the death for 109 (87%) of those 126 deaths.

Child Abuse and Neglect

Far too many children suffer at the hands of those entrusted to love, nurture, and care for them. Child abuse and neglect is a devastating epidemic that impacts not only the lives of maltreated children, but of everyone within our society.

According to Child Help USA, 80% of young adults who had been abused met the diagnostic criteria for at least one psychiatric disorder at the age of 21 (including depression, anxiety, eating disorders, & post-traumatic stress disorder). Children who experience child abuse and neglect are 59% more likely to be arrested as a juvenile, 28% more likely to be arrested as an adult, and 30% more likely to commit violent crime. Fourteen percent of all men in prison and 37% of all women in prison in the United States were abused as children.

What is included in the definition of "abuse and/or neglect"?

Child maltreatment is defined as any act or failure to act resulting in the imminent risk of serious harm, death, serious physical or emotional harm, sexual abuse, or exploitation of a child (under the age of 18). Fatal child abuse may involve repeated abuse over a period of time (e.g., battered child syndrome), or it may involve a single, impulsive incident (e.g., suffocating, or shaking an infant). In cases of fatal neglect, the child's death results not from anything the caregiver does, but from a caregiver's *failure to act*. The neglect may be chronic (e.g., extended malnourishment) or acute (e.g., an infant who drowns after being left unsupervised in the bathtub).

How does Georgia compare with the U.S. average?

According to the U.S. Department of Health and Human Services, in 2006 an estimated 906,000 children were victims of abuse and/or neglect in the U.S. (a rate of 12.3 per 1,000). In Georgia, 22,779 children were victims of abuse and/or neglect (a rate of 9.9 per 1,000). (GA DHR). In 2006, The National Child Abuse and Neglect Data System (NCANDS) reported an estimated 1,530 child abuse and/or neglect fatalities (a rate of 2.1 per 100,000). In Georgia, DFCS reported 64 child abuse and/or neglect fatalities in 2006 (a rate of 2.8 per 100,000). However, CFR committees identified 116 fatalities with associated abuse and/or neglect (suspected or confirmed).

Figure 10: Reviewed Deaths with Abuse/Neglect Findings, by Age, 2006 (N=116)

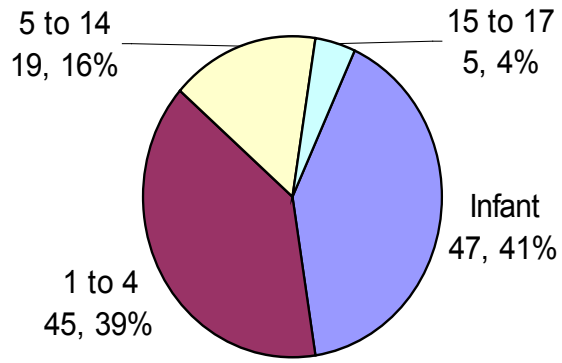


Figure 10 shows the percent of child abuse/neglect deaths for different age groups

Findings:

- Pre-school age children under five years of age comprised 80% of all abuse/neglect-related deaths in 2006
- The proportion of child abuse/neglect-related deaths decreased with age

Fact:

- Infants and younger children experience more abuse/neglect deaths because of their overall vulnerability and developmental stage, their dependency on caretakers for all personal needs, and their limited contact with mandated reporters

Figure 11: Causes of Death Among Reviewed Deaths with Abuse/ Neglect Findings, 2006, (N=238)

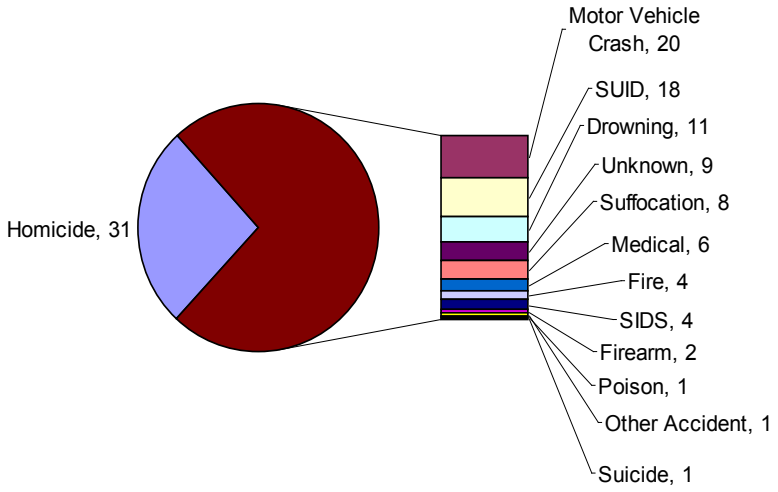


Figure 11 shows the causes of death when child abuse/neglect was suspected or confirmed

Findings:

- Twenty-seven percent of the 116 reviewed deaths with child abuse and neglect findings were homicides
- Total number of reviewed deaths with abuse or neglect findings has steadily declined over recent years from 166 in 2004 to 136 in 2005 to 116 in 2006

Fact:

- For infants under the age of one, studies indicate that the most common cause of fatal abuse is blunt head trauma which typically leaves no external signs of injury

Figure 12: Reviewed Unintentional Injury-Related Deaths by Cause, 2006 (N=238)

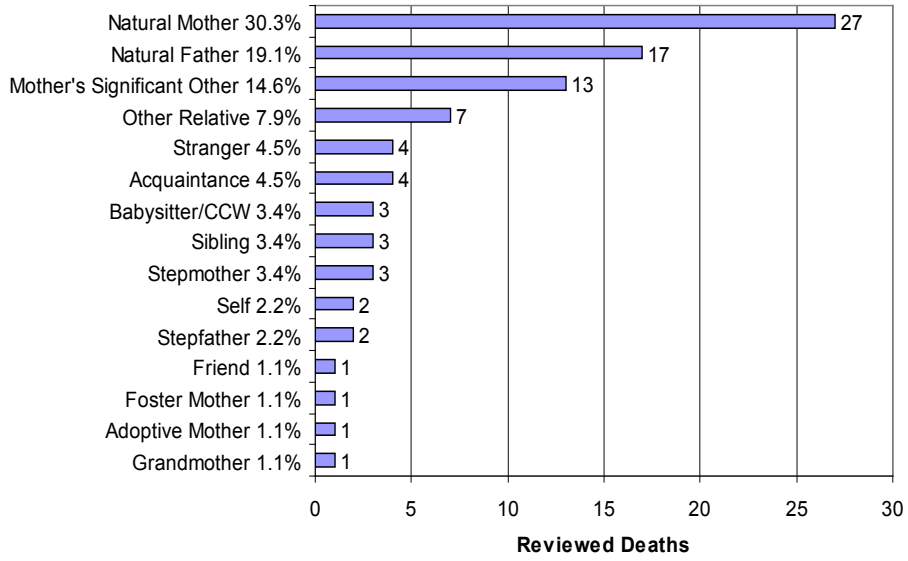


Figure 12 shows the relationship of the perpetrator to the child in suspected or confirmed child abuse/neglect related deaths. Some child abuse/neglect related deaths involved more than one perpetrator

Findings:

- Mothers represented the largest category of perpetrators (27) while fathers represented the second largest category (17). Mothers and fathers reversed leading roles when compared to 2005 data—fathers represented the largest category (28) while mothers represented (20) the second largest category
- The mother's significant other (e.g. boyfriend or paramour) represented the third largest category of perpetrators
- The "self" category refers to two suicides with abuse/neglect findings

Facts:

- A young child left with a male caregiver who lacks emotional attachment to him/her is at increased risk of abuse and/or neglect
- Most fatalities from physical abuse are caused by fathers and other male caretakers
- Mothers are most often held responsible for deaths resulting from child neglect
- Although there are a myriad of contributing risk factors commonly associated with child maltreatment, fatal abuse is interrelated with domestic violence, substance abuse, and poverty

Domestic Violence and Child Abuse

The concurrent incidence of domestic violence and child abuse within the same families is well-documented. The U.S. Advisory Board on Child Abuse and Neglect suggests that domestic violence may be the single major precursor to child abuse and neglect fatalities in this country (1995). Children from homes where domestic violence occurs are physically or sexually abused and/or seriously neglected at a rate 15 times the national average (McKay, 1994).

Alcohol, Substance Abuse, and Child Abuse
The U.S. Departmen0t of Health and Human Services estimates that 50 to 80 percent of all child abuse cases substantiated by Child Protective Services (CPS) involve some degree of substance abuse by the child's parents. Children in alcohol-abusing families were nearly four times more likely to be maltreated overall. They were almost five times more likely to be physically neglected and ten times more likely to be emotionally neglected than children in non-alcohol abusing families.

Poverty
The Third National Incidence Study of Child Abuse and Neglect conducted by Sedlak & Broadhurst found that family income was significantly related to incidence rates in nearly every category of maltreatment. Children whose families had annual incomes below $15,000 were more than 22 times more likely to experience maltreatment, more than 44 times more likely to be neglected, and more than 22 times more likely to be seriously injured by maltreatment than families with incomes of $30,000 or more. A number of problems associated with poverty may contribute to higher child maltreatment, including: transience in residence, poorer education, higher rates of substance abuse and emotional disorders, and less adequate support systems (U.S. Dept Health & Human Sciences).

Victim was killed by mother's boyfriend as a result of blunt force trauma to the head. In addition, there were multiple bruises on the child's body which were consistent with abuse

Opportunities for Prevention:

For Parents

- Participate in classes that teach effective coping strategies, developmental stages of children, and age-appropriate disciplinary practices
- Increase self-awareness to identify personal triggers and child behaviors that elicit anxiety and anger by understanding your individual response to stress
- Seek assistance and guidance from family members, friends, community members, and service providers

For Community Leaders and Policy Makers

- Train hospital emergency room staff in identifying fatalities related to child abuse and responsibility to report to the appropriate agencies
- Provide comprehensive training on the mandated reporting of child abuse and neglect to local human service agencies, hospitals, and physicians
- Develop a networking system with neighborhood associations, community centers, and faith-based centers

For Professionals

- Develop media campaigns to enlighten and inform the general public on known behaviors associated with child fatality, eg., violently shaking a child out of frustration
- Implement crisis nurseries to provide respite care for parents "on the edge" for a specified period of time, at no charge
- Provide intensive home visiting services to parents of at-risk infants and toddlers

Resources:
Georgia Department of Human Resources (DHR)
www.dhr.georgia.gov

Prevent Child Abuse Georgia
www.preventchildabusega.org

Child Help USA
www.childhelp.org

U.S. Department of Health and Human Sciences
www.hhs.gov

Prior Agency Involvement

Fifty-one percent (301) of the 594 CFR reports received for 2006 indicated that one or more community agencies had prior involvement with the deceased child and/or his/her family. The duration and degree of community agency involvement varied depending on individual circumstances. Oftentimes, a child or family was involved with more than one agency.

Figure 13: Proportion of Deaths (No Abuse/Neglect Indentified) with Prior Agency Involvement, 2006 (N=478)

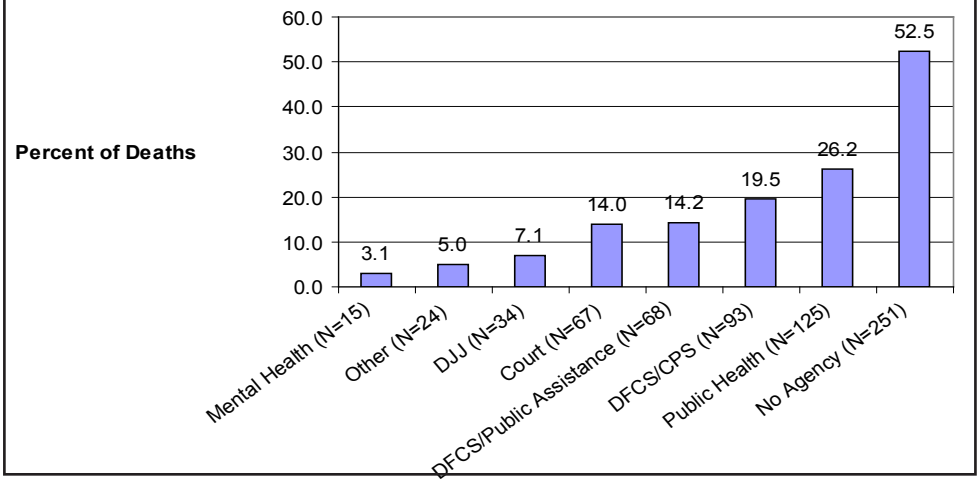


Figure 13 shows prior agency involvement for deceased children and their families without abuse or neglect findings. A significant number of children and/or their families were involved with more than one agency resulting in number of agency involvements exceeding number of deaths.

Findings:

- Fifty-three percent of deaths without abuse/neglect findings had no prior agency involvement
- Public Health represents the agency most often involved with families(26%) without abuse/neglect findings

Fact:

- Professionals who work with governmental and other public agencies are mandated to report suspected abuse and/or neglect

Figure 14: Proportion of Deaths (Abuse/Neglect Indentified) with Prior Agency Involvement, 2006 (N=116)

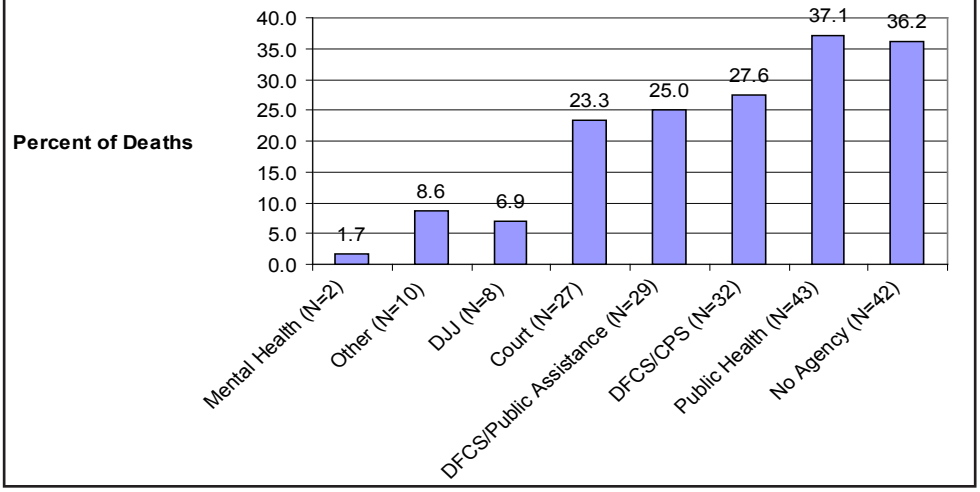


Figure 14 shows prior agency involvement for deceased children and their families with abuse or neglect findings. A significant number of children and/or their families were involved with more than one agency resulting in number of involvements exceeding number of deaths.

Findings:

- Sixty-four percent of children with abuse/neglect findings had prior involvement with at least one agency
- Thirty-six percent of children with abuse/neglect findings had no prior agency involvement

Fact:

- Mandated reporters are required to have specialized training for accurate identification of risk factors and signs of abuse/neglect

Opportunities for Prevention:

For community leaders and policy makers

- Educate the community about the importance of reporting child abuse/neglect
- Increase public awareness regarding the far reaching social and economic impact of child abuse/neglect

For professionals

- Participate in trainings, seminars, and workshops to learn how to recognize and report child abuse/neglect
- Collaborate with service providers and community advocates to promote child abuse/neglect reporting

Sleep-Related Infant Deaths

Sleep-related deaths include all deaths to infants that occur while sleeping, but have no identifiable medical cause. They are the leading cause of reviewed deaths in Georgia for children up to one year of age. According to the Centers for Disease Control and Prevention (CDC), more than 4,500 infants die each year with no obvious explanation. Almost all of these deaths occur during sleep.

What is included in the definition of sleep-related infant death?

SIDS (Sudden Infant Death Syndrome) is defined as the sudden death of an infant less than one year of age which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene, and review of the clinical history. Other infant sleep-related deaths are defined as Sudden Unexplained Infant Death (SUID), and appear to be SIDS, but have other factors present that could have contributed to the deaths. Sleep-related deaths may also result from sleep-related asphyxia (extreme decrease of oxygen in the body accompanied by an increase of carbon dioxide). Examples of sleep-related asphyxia include unintentional overlay by another, sleeping with head or face covered, or wedging.

Although many risk factors have been identified in association with SIDS and other sleep-related deaths, a primary cause has not been determined. Research suggests a complex combination of physiology and environmental stressors that contribute to SIDS. A death should only be determined as SIDS after careful investigation so that all other possibilities can be ruled out. The process is expensive, and many counties do not conduct such thorough investigations.

How does Georgia compare to the U.S.?

Sleep-related infant deaths in Georgia are comparable to national data. In the United States, Sudden Infant Death Syndrome (SIDS) is the most common cause of death in infants between the ages of one month and one year, affecting nearly one out of every 2,000 live births. Most deaths occur between two to four months of age. Consistently higher rates are found in African-American and American Indian/Alaska Native children (two to three times the national average).

The National Centers for Health Statistics in 2005 determined the SIDS mortality rate was roughly one death for every 2,000 live births -- or 0.5 percent (CDC, 2006). In contrast, the infant mortality rate for all causes of death was 6.8 (per 1,000 live births).

Findings:

- Sleeping position was known and reported for 116 of those infants who died of SIDS or SUID; position was unknown and/or unreported for 47 of SIDS/SUID infants (29%)
- There were 59 SIDS/SUID deaths where the infants were found laying on their stomachs; in 34 deaths, the infants were found on their backs

Facts:

- Infants who are accustomed to sleeping on their backs are 18 times more likely to die from SIDS when put down to sleep on their stomachs
- A recent study in a special supplement to the journal Pediatrics revealed that at three months of age, 25% of parents were still not following recommendations to put their infants to sleep on their backs, and one-third of parents were sharing a bed with their infants at that age, contrary to the NICHD and American Academy of Pediatrics (AAP) guidelines
- Infants who sleep on their stomachs or sides face the biggest danger: They have twice the risk of dying from SIDS as infants who sleep on their backs. When an infant's face is turned toward the bedding, he's in a position to re-breathe the carbon dioxide he exhales, which limits the amount of oxygen he takes in

Figure 15: Sleeping Position of Infants who Died of Reviewed SIDS, 2006 (N=28)

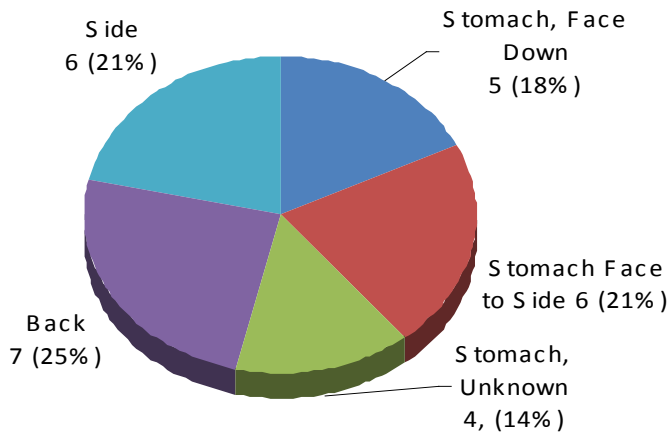


Figure 15 shows the reported sleeping position for those 28 infants who died of SIDS (when known)

Figure 16: Sleeping Position of Infants who Died of Reviewed SUID, 2006 (N=88)

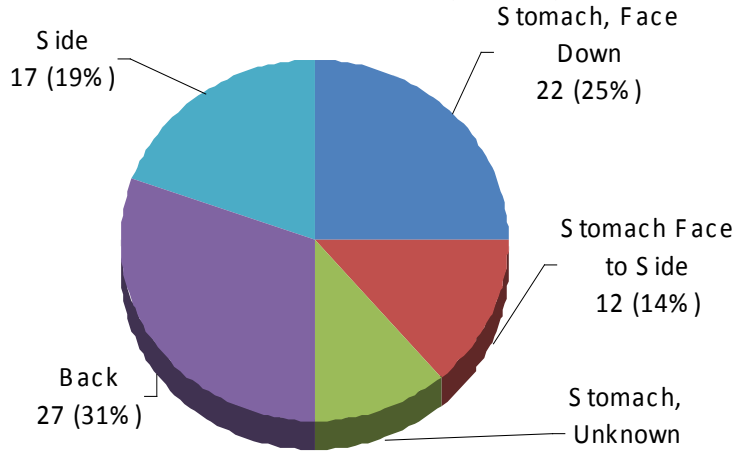


Figure 16 shows the reported sleeping position for those 88 infants who died of SUID (when known)

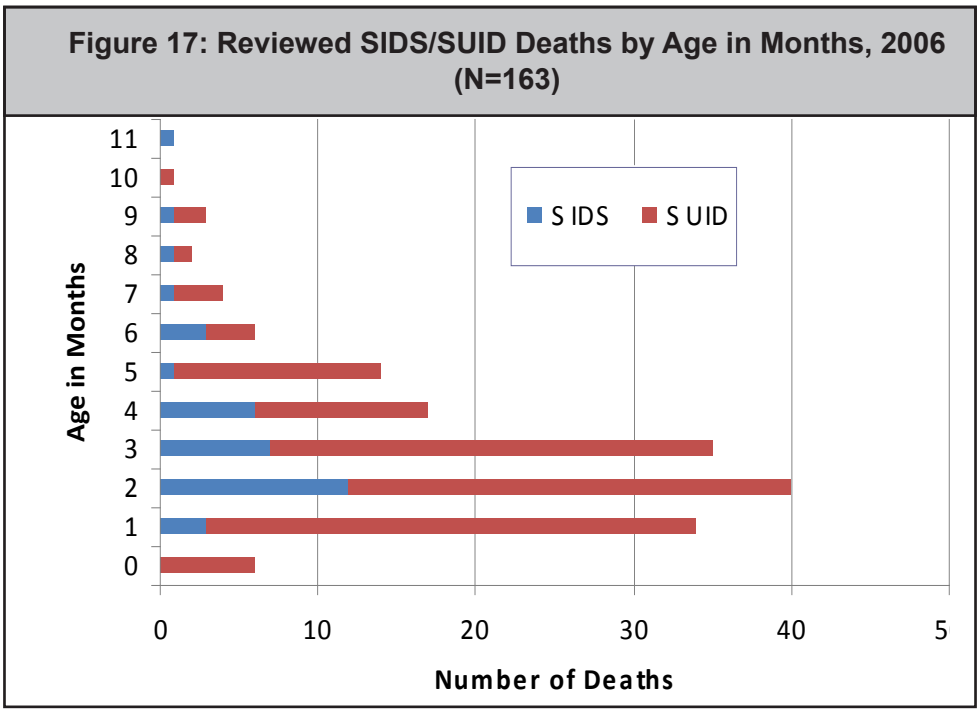


Figure 17 shows the age in months of reviewed deaths due to Sudden Infant Death Syndrome (SIDS) or Sudden Unexplained Infant Death (SUID) in 2006

Findings:

- Most SIDS /SUID deaths occurred to infants one to three months of age (n=109)
- Seventy-one percent of all SIDS/SUID occurred in infants younger than four months
- Only seven percent of all SIDS/SUID deaths occurred in infants older than six months

Fact:

- Generally, most infants who die from SIDS/SUID are between two and six months old. The risk of death declines dramatically after six months of age

Findings:

- Sleeping location was known and reported for 152 of those infants who died of SIDS or SUID; location was unknown and/or unreported for 11 of SIDS/SUID infants (seven percent)
- Of the 33 infants who died of SIDS, the most common location for sleep was a crib (55%)
- Fifty-two percent of the 119 SUID deaths occurred while the infant was in a bed
- An additional 11% of reviewed SIDS/SUID infant deaths occurred on couches

Figure 18: Location where Found for Infants who Died of Reviewed SUID, 2006 (N=119)

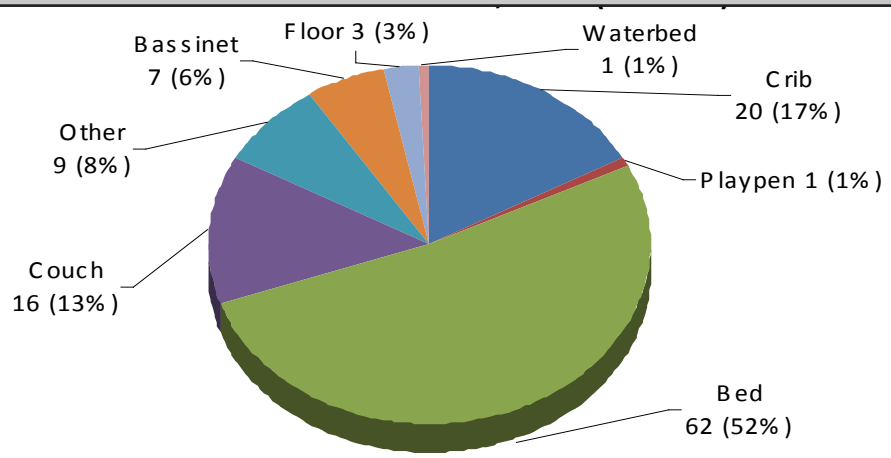


Figure 18 shows the sleeping locations for the infants who died of Reviewed SUID (when known)

Facts:

- According to the AAP, the risk of SIDS is higher when bed sharing occurs with young infants. Also, the risk of SIDS seems to be particularly high when there are multiple bed sharers and also may be increased when the bed sharer has consumed alcohol or is overtired. It is extremely hazardous when adults sleep with an infant on a couch
- There is growing evidence that room sharing (infant sleeping in the parent's room) without bed sharing is associated with a reduced risk of SIDS

Figure 19: Location where Found for Infants who Died of Reviewed SIDS, 2006 (N=33)

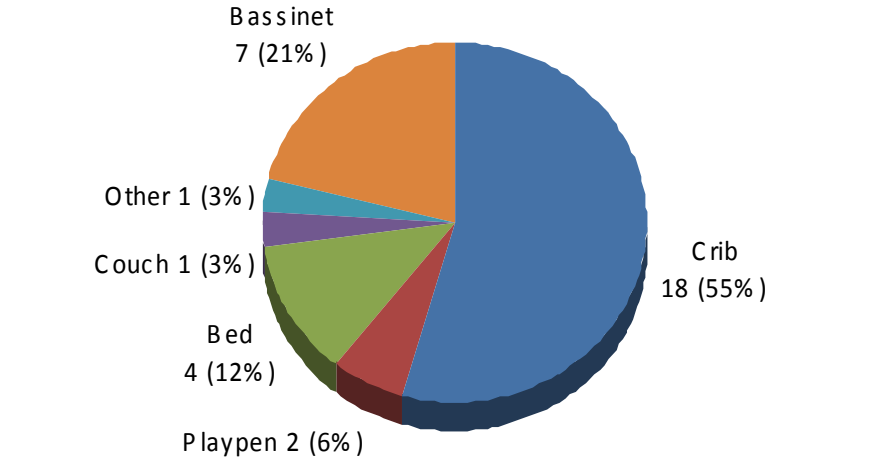


Figure 19 shows the reported location of death for those infants who died of Reviewed SIDS (when known)

Findings:

- In 83% of deaths (n=134), the infant was sleeping at their own home
- Five deaths (3%) occurred in a child-care facility, and 20 occurred in another caregiver's home (12%)

Facts:

- Many child care deaths have been associated with the prone sleep position, especially when the infant is not accustomed to being placed in that position. Unaccustomed prone sleep increases the risk of SIDS by as much as 18-fold. It is frequently a non-parental caregiver who places the infant in an unaccustomed prone position (AAP)
- Georgia's licensed child care centers are required to practice safe sleep for infants. Bright from the Start regulations state: "In order to reduce the risk of Sudden Infant Death Syndrome (SIDS), staff shall put an infant to sleep on the infant's back unless the center has been provided a physician's written statement authorizing another sleep position for that particular infant" (O.C.G.A20-1A-1 et.seq. and 50-13-4(a))

Figure 20: Place of Death for Infants who Died of SIDS/SUID, 2006 (N=163)

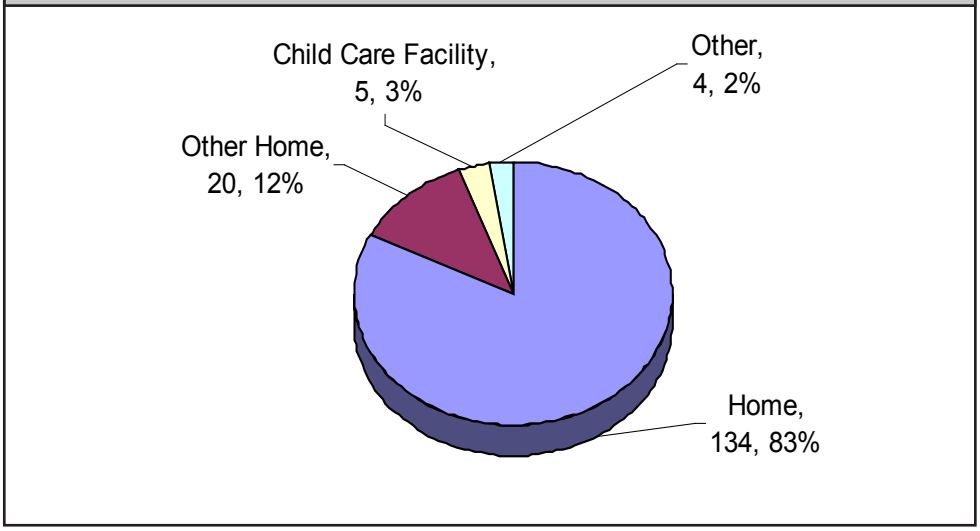


Figure 20 shows the place of death for the 163 reviewed SIDS/SUID deaths in 2006

Figure 21: Race/Gender Distribution of Reviewed SIDS and SUID Deaths, 2006 (N=163)

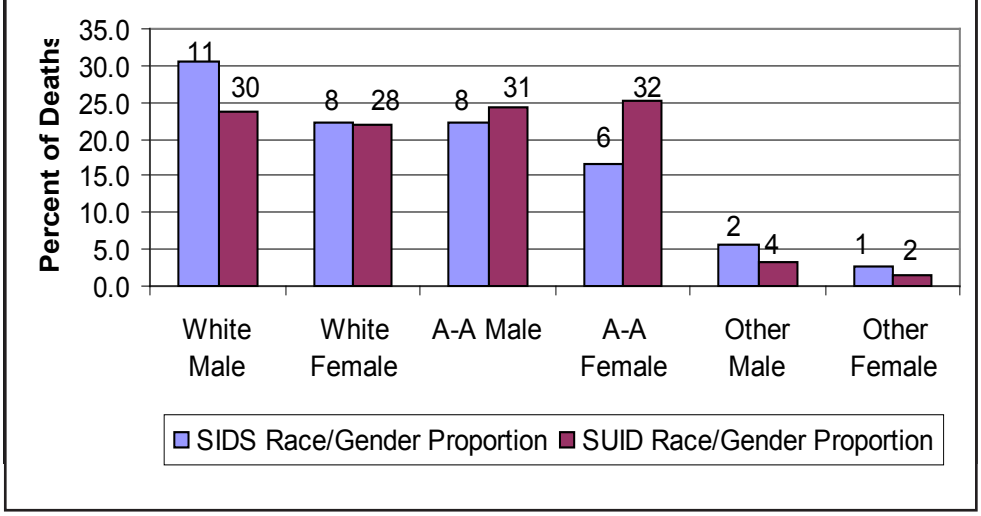


Figure 21 shows the demographic numbers and proportions for the 163 reviewed SIDS and SUID deaths in 2006

Findings:

- SIDS occurred more often, and had a higher proportion, among White males
- SUID occurred almost equally, and displayed a similar proportion, among White males and females, and African-American males and females

Facts:

- Data from the Center for Health Statistics show that nationally the SIDS rate among African-American infants remains more than twice the rate of White infants
- According to the CDC, many SUID cases are not investigated, and when they are, cause-of-death data are not collected and reported consistently. Inaccurate classification of cause and manner of death hampers prevention efforts and researchers are unable to adequately monitor national trends, identify risk factors, or evaluate intervention programs

Finding:

- Fifty-five percent (11) of the children who died from sleep-related asphyxia were three months old or younger

Fact:

- Sixty percent of infant asphyxia occurs in the sleep environment (Safe Kids, 2005). Infants in particular are at greater risk for asphyxia because of their inability to lift their heads or remove themselves from tight places

Figure 22: Reviewed Sleep-Related Infant Asphyxia Deaths, by Month of Age, 2006 (N=20)

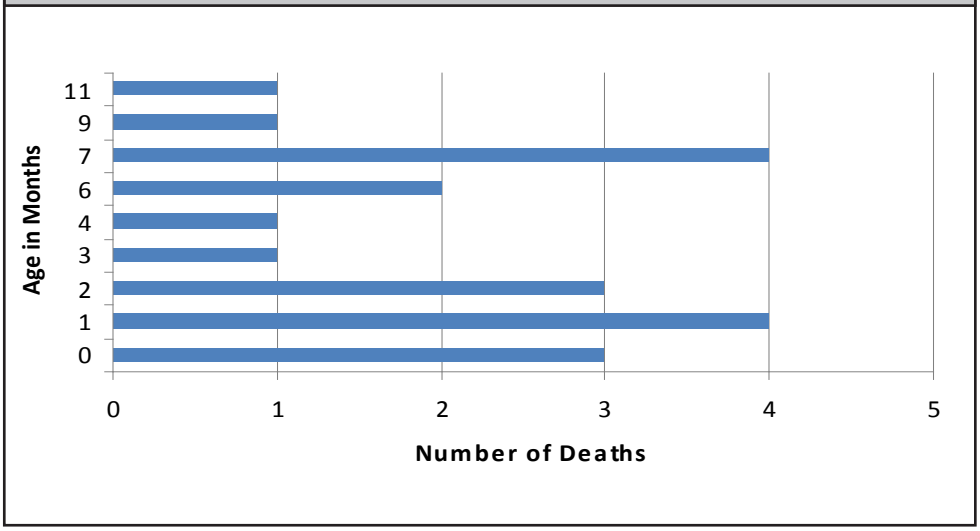


Figure 22 shows the age in months at death for the 20 infants with reviewed sleep-related asphyxia deaths in 2006

Finding:

- Almost three-fourths of the infants (70%) were sleeping with at least one other person at the time of death

Fact:

- Bed-sharing is particularly dangerous when the caregiver is overweight or under the influence of anything that might hamper a normal arousal response

Figure 23: Number of People Sleeping with Infants at Time of Death, 2006 (N=20)

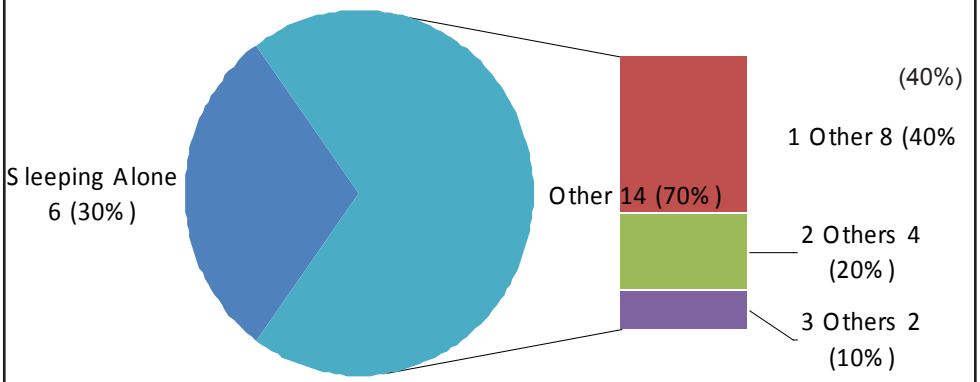


Figure 23 shows the number of people sleeping with the infant when the cause of death was asphyxia

Statewide Opportunities for Prevention:

For Parents:

- Get medical care early in pregnancy, preferably within the first three months, followed by regular checkups at the doctor's office or health clinic. Make every effort to maintain good nutrition and avoid stress. These measures can reduce the risk of premature birth, a major risk factor for SIDS
- Do not smoke during pregnancy: Maternal smoking during pregnancy has emerged as a major risk factor in almost every epidemiologic study of SIDS
- Breast-feed infants whenever possible. Breast milk decreases the occurrence of respiratory and gastrointestinal infections. Studies show that breast-fed infants have a lower SIDS rate than formula-fed infants
- Thoroughly discuss infant sleep safety with all caregivers and child care providers. If you take your infant to daycare or leave him/her with a sitter, provide a copy of the safe sleep recommendations to them and make sure they follow all recommendations
- Avoid exposing the infant to people with respiratory infections. Avoid crowds. Carefully clean anything that comes in contact with the infant. Have people wash their hands before holding or playing with your infant. SIDS often occurs in association with relatively minor respiratory (mild cold) and gastrointestinal infections (vomiting and diarrhea)
- Place infants to sleep in an infant bed with a firm mattress (not an adult bed, or a couch or chair). There should be nothing in the bed but the infant - no covers, no pillows, no bumper pads, no positioning devices and no toys. Soft mattresses and heavy covering are associated with the risk for SIDS

48-day old infant, premature and with heart monitor, was visiting dad and co-slept with dad on couch and never woke up. Heart monitor was going off but dad claimed he couldn't hear it

For Professionals and Policy-makers:

- Support establishing a population-based SUID case registry that can facilitate the understanding of the root causes, rates, and trends of SUID; support facilitating the collection, analysis, and dissemination of data by implementing a surveillance and monitoring system based on thorough and complete death scene investigation data, clinical history, and autopsy findings
- Support research to find the cause for SIDS and SUID
- *First responders and coroners:* Improve public reporting of surveillance and descriptive epidemiology of SUID to better understand the risks and associations of SUID with race and gender

For Agencies and Community Leaders:

- Train childbirth educators, lactation consultants, trainers for babysitter courses, WIC agencies, pediatricians, daycare providers, nurses and birth support staff to model SIDS risk-reduction techniques to ensure that families know how to reduce SIDS risk
- Encourage parents to keep the infant's crib in the parents' room until the infant is at least six months of age. Studies clearly show that infants are safest when their beds are close to their mothers

Resources:

American Academy of Pediatrics
www.healthychildcare.org

National Safe Kids Campaign
www.safekids.org

National Institute of Child Health and Human Development "Back to Sleep" Campaign
www.nichd.nih.gov/sids/sids.cfm

National SIDS and Infant Death Project Impact
www.sidsprojectimpact.com

Unintentional Injury-Related Deaths

Unintentional injuries caused the deaths of 238 children in 2006. Those types of injuries caused more deaths to children 1-17 years of age than any other reviewed category (e.g., medical or intentional injuries). Nationally, since 1987, there has been a 45% decrease in unintentional injury fatalities; yet despite this good news, they continue to be the leading category of death for American children (Safe Kids, 2008). CFR committees found 64% of all unintentional injury related deaths to be definitely preventable.

What is an unintentional injury?

Injury is damage to a person's body via mechanical, thermal, or chemical distribution. The intent of an injury is important to note as well. Unintentional injury is not deliberate, therefore these injuries (fatal or non fatal) are preventable. This category includes those injuries described as unintended regardless of whether the injury was inflicted by oneself or by another person. It does not include deaths whose intent was labeled as unknown, as during certain case review, intent was not able to be determined by CFR committees.

How does Georgia compare to the U.S. average?

The top three causes of unintentional injury-related fatalities in Georgia are the same on a national front. Specifically, motor vehicle, drowning, and asphyxia are most prevalent. According to the National Center for Injury Prevention and Control, in 2005, the United States unintentional injury fatality child death rate (birth-17 years) was 11.15 per 100,000 children, while Georgia's was 12.91.

Figure 24: Reviewed Unintentional Injury-Related Deaths by Cause, 2006 (N=238)

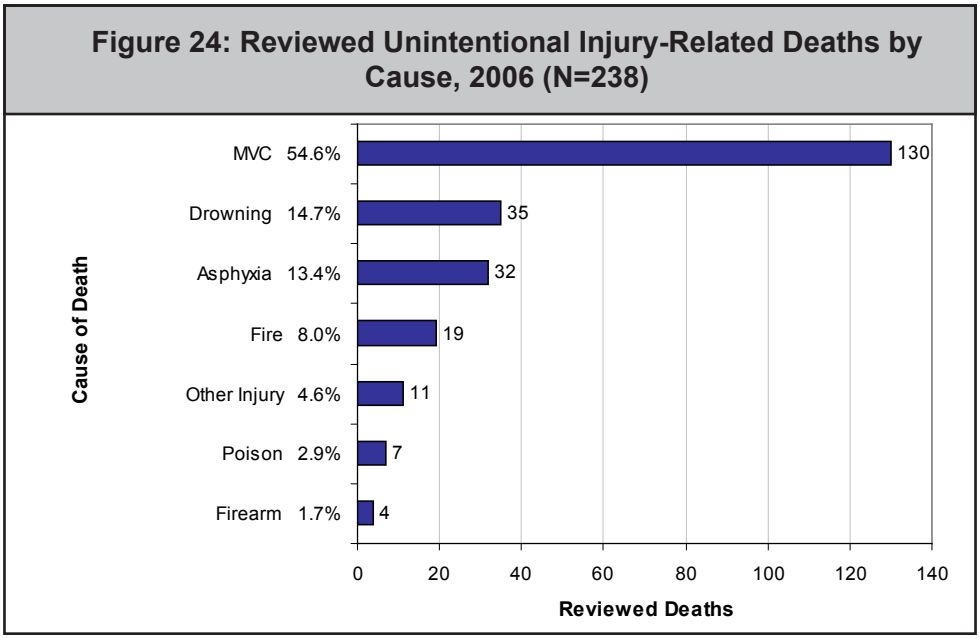


Figure 24 shows unintentional injury deaths by mechanism

Findings:

- Motor vehicle-related deaths accounted for the majority (55%) of unintentional injury deaths
- Motor vehicle-related, drowning, and asphyxia have remained the top three causes of unintentional injury fatalities for two years

Fact:

- CFR committees reviewed more unintentional injuries (40%) than intentional injuries (24%) or unexpected medical deaths (24%)

Motor vehicle-related injuries are the number one cause of death for children over age one. Many factors contribute to this public health problem including improper restraint use (lack of seatbelts, car seats, booster seats, and premature graduation to a seat belt), driver error, as well as active supervision of young children near roadways. The Governor's Office of Highway Safety reports that the Teenage and Adult Driver Responsibility Act (TADRA) that went into effect on July 1, 1997 was responsible for a "44.5% decline in teenage speed-related crashes in 18 months" (not specific to deaths). During 2006, CFR committees identified 27 youth ages 15-17 years who died while operating a vehicle. Eight out of nine older teens who died while riding in the back seat were not wearing a seatbelt, when restraint use was known.

Additionally, Georgia continues to see pedestrian deaths increase each year, warranting the continuation of recently added programs such as *Safe Routes to School* and others where the Department of Transportation and the Governor's Office have been instrumental with local community grants. In pedestrian-related motor vehicle deaths, toddlers were determined "not adequately supervised" 89% of the time, when supervision was reported. There were no pedestrian-related fatalities to children 5-9 years of age.

What is included in the definition of motor vehicle-related death?

Deaths attributed to motor vehicle-related incidents include the drivers and passengers of a vehicle, and occupants, riders or pedestrians impacted by any other form of transportation (bicycles, ATV, go-carts, motorized scooters, airplanes).

How does GA compare with the U.S. average?

On the national front, motor vehicle deaths are the leading cause of death to children ages 1-17 years. When parents were surveyed regarding their concerns and worries for their children, their top two concerns were motor vehicle crashes and pedestrian collisions (Safe Kids, 2008). According to NCIPC, the 2005 United States motor vehicle child death rate (birth-17 years) was 6.14 per 100,000 children while the CDC reported Georgia's rate was 7.00.

Figure 25: Related Deaths by Age, 2006 (N=130)

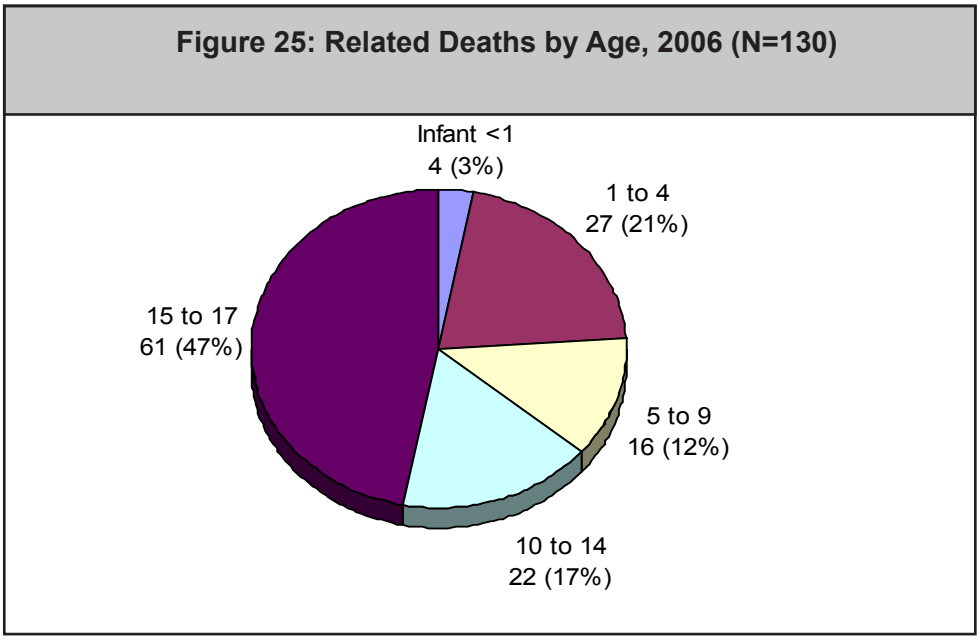


Figure 25 shows the age breakdown of motor vehicle related deaths

Findings:

- Teenagers ages 15-17 years accounted for 47% of the 130 deaths
- Toddlers accounted for 21% of all motor vehicle deaths, and 59% of those pedestrian-related deaths

Fact:

- In Georgia, if a child is riding unrestrained, the driver will receive a citation for each unrestrained passenger under 18 years of age

Findings:

- There were 61 deaths among the 15-17 year old age group; 34% were reported to not wear their seatbelt (when restraint use was known and applicable)
- There were 38 deaths among the 5-14 year old age group; 67% were reported to not wear their seatbelt (when restraint use was known and applicable)

Facts:

- Some death investigations reveal there is difficulty identifying if restraints were worn or not, leaving a high unknown category based on CFR committee reports
- Child restraint systems are extremely effective when properly installed and used in passenger cars. They reduce the risk of death by 71% for infants and 54% for children ages 1-4 years (Safe Kids, 2005)

Figure 26: Reviewed Motor Vehicle-Related Deaths by Restraint Use and Age, 2006 (N=130)

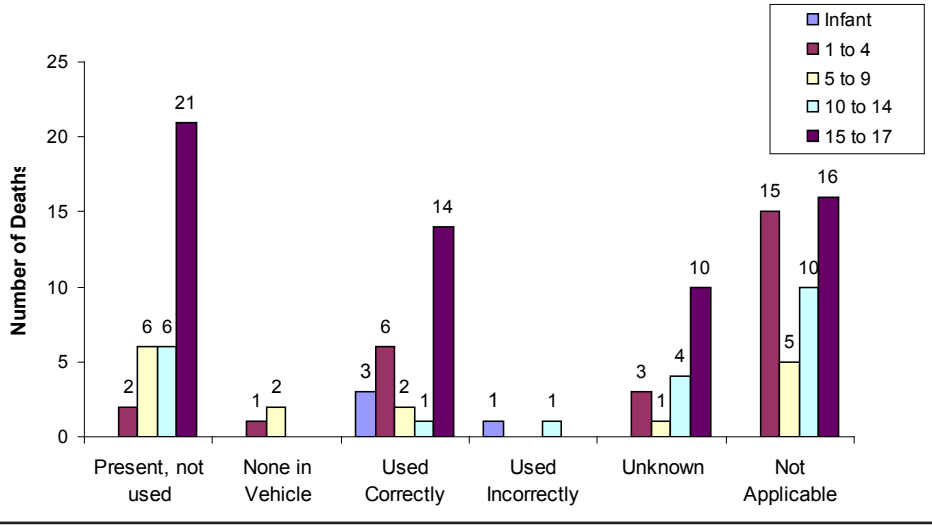


Figure 26 shows restraint use with age breakdown

Findings:

- White children are at a higher risk (67%) than African-American children (22%) of dying in a motor vehicle-related crash
- White males continue to have the highest proportion of deaths
- Across all racial groups, motor vehicle-related deaths among males occurred more often than for females

Facts:

- Nationally in 2006, it was reported that on any weekday, nearly once every two hours, a teen died in a traffic crash
- According to the Georgia Governor's Office of Highway Safety, contributing factors for young driver deaths included: losing control, unsafe speed, wrong side of the road, and failure to yield

Figure 27: Reviewed Motor Vehicle-Related Deaths by Race, Gender and Proportion, 2006 (N=130)

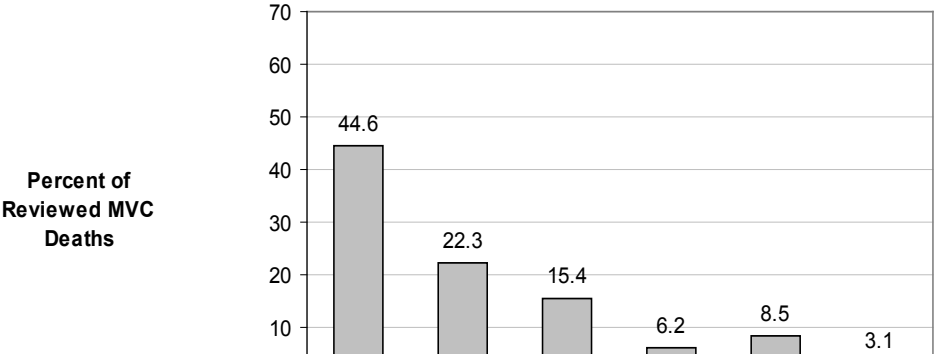


Figure 27 shows breakdown of motor vehicle deaths by Race, Gender and Proportion

Findings:

- Of the backseat passengers who died, older teenagers (15-17 years) accounted for the highest percentage of deaths
- The most common position for children who died in motor vehicle-related injuries was either as the operator or back seat passenger
- Forty-two percent of all back seat passengers were reported as not wearing a seat belt

Fact:

- The American Academy of Pediatrics recommends that all children younger than 13 years ride in the back seat

Figure 28: Motor Vehicle-Related Deaths by Position at Time of Injury, 2006 (N=130)

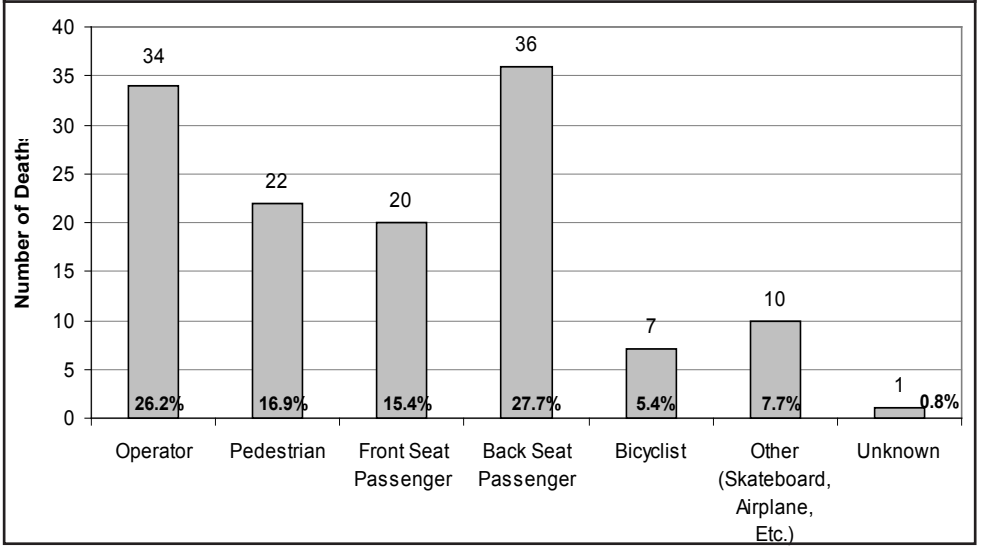


Figure 28 shows the position of the decedent at time of death

Findings:

- Fifty-nine percent of pedestrian related fatalities involved toddlers
- Teenagers ages 15-17 years had the second highest percentage of pedestrian-related deaths

Facts:

- Toddler deaths were attributed to being in a roadway unattended or in a driveway
- Pedestrian roadside safety education programs may influence children's behavior more than classroom education
- Pedestrian injury and death prevention programs must be multi-faceted with four factors that include the environment, vehicle, driver, and the supervisor (Schieber & Vegega, 2002)

Figure 29: Reviewed Motor Vehicle-Related Deaths Involving Pedestrian decedents by Age and Proportion, 2006 (N=20)

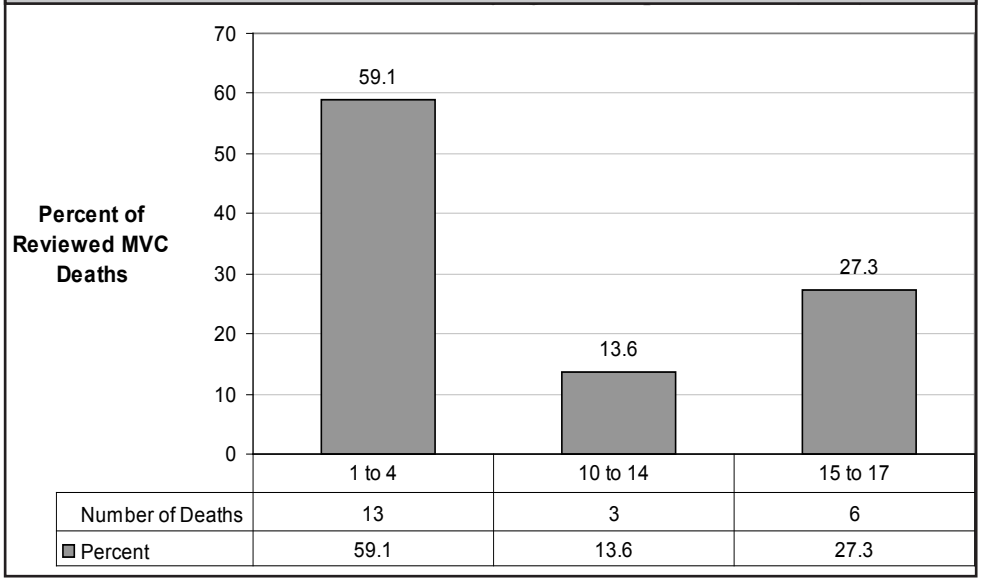


Figure 29 shows pedestrian deaths by age and proportion

17 y/o girl was operating a moped with an 11 y/o passenger and ran a red light; neither had helmets

Finding:

- There has been an overall decrease in motor vehicle-related deaths over the past five years

Facts:

- In Georgia, 43 children ages one to nine years died in 2006 from motor vehicle-related injuries. The National Highway Traffic and Safety Administration suggests that children grow up safe by following four steps:
  - Rear-facing car seats
  - Forward-facing car seats
  - Booster Seats
  - Seat Belts
- As of January 1, 2007, any 16 year old who obtains a Class D drivers license must have completed a driver education course and 40 hours of supervised driving

Figure 30: Motor Vehicle-Related Deaths Rates per 100,000 Teens Age 15-17, Three-Year Moving Average, 1994-2006 (OASIS)

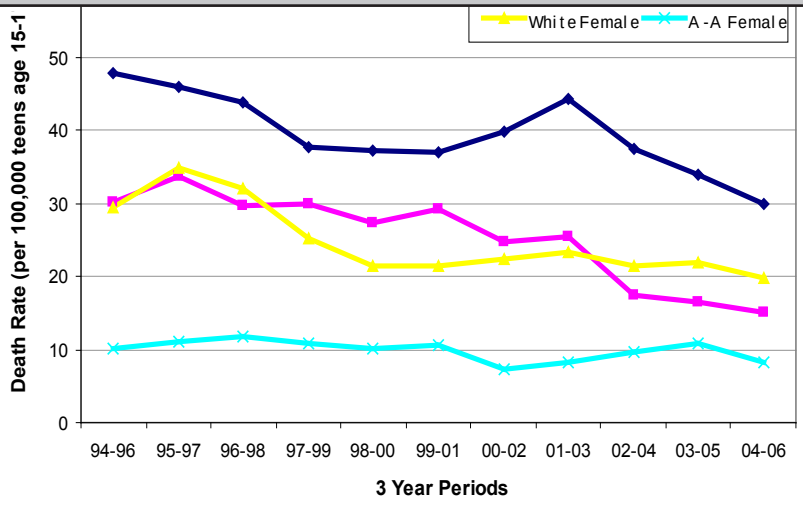


Figure 30 shows motor vehicle-related deaths since 1994

Opportunities for Prevention:

For Parents

- Support and demonstrate proper seat belt use on every ride
- Research and support the Graduated License program
- Set good examples in the vehicle by not speeding, talking on the cell phone, or eating while driving
- Set up a driver agreement with your teenager

For Young Drivers

- Do not consume alcohol or ride with someone who has
- Wear a seat belt every time you ride in a vehicle and enforce that passengers with you do the same
- Obey traffic rules and laws that govern everyone's safety

For Community Leaders and Policy-makers

- Support the work of groups such as the Young Adult Driver Task Team through the Georgia Strategic Highway Safety Plan (2007-2008)
- Support a progressive amendment to the current safety belt law by increasing the fine and points additions
- Support changes to the current child restraint law to increase booster seat use beyond six years of age
- Amend the current safety belt law to require safety belts be mandatory in pick-up trucks
- Continue to support and improve the Georgia Teenage and Adult Driver Responsibility Act (TADRA)

Resources:

American Academy of Pediatrics
www.aap.org

Georgia Governor's Office of Highway Safety
www.gohs.state.ga.us

www.gahighwaysafety.org

Georgia Young Adult Driver Task Team
http://extension.caes.uga.edu/gtipi/

National Highway Traffic Safety Administration
www.nhtsa.dot.gov

Schieber RA, Vegega ME (editors) *Reducing Childhood Pedestrian Injuries: Proceedings of a Multidisciplinary Conference.* Atlanta, GA: CDC, NCIPC, 2002
www.cdc.gov

Safe Kids USA
www.usa.safekids.org
www.preventinjury.org

Drowning Deaths

Drowning continues to be the second leading cause of unintentional deaths to children in Georgia. Most drowning deaths occurred to the toddler age group (60%) with the majority of deaths occurring in private pools. Teenagers 15-17 years of age accounted for the second highest group with 100% of deaths occurring in natural bodies of water. According to the CDC, for every child who dies from drowning, another four receive emergency care for nonfatal submersion injuries. Of the 1-4 year-old age group, CFR committees identified 95% of the children did not have adequate supervision based on death scene investigation reports containing this information.

There are many ways to prevent fatal and nonfatal drowning including deliberate and non negotiable supervision, pool barrier regulations and enforcement, parental diligence regarding door alarms, and locked access to pool areas. The statistics continue to show the need for diligence in ensuring our youth learn to swim and understand how to rescue someone from drowning. Specificity in life saving and strong swimming skills can save lives. Additionally, more prevention efforts should be aimed near natural bodies of water to include warning signs and life saving device stations (e.g., reach and throw poles and life jackets).

What is characterized as a drowning death?

Drowning deaths occur from water-related submersion and asphyxia, and include deaths involving public and private swimming pools, natural open water (rivers, lakes, oceans, and ponds), bathtubs, and other bodies of water. Occasionally, other areas may include drainage ditches and septic tanks.

How does GA compare to the U.S. average?

Across the United States, a swimming pool is the most common site for toddler drowning deaths, and males are four times more likely than females to die from unintentional drowning (CDC), which is the same for Georgia. Nationally, Southern states have the highest accidental drowning rates, while Western states are second highest. According to NCIPC, the 2005 United States' drowning child death rate was 1.33 per 100,000 children, while Georgia's was 1.74, in 2005.

Figure 31: Reviewed Drowning Deaths by Age, 2006 (N=35)

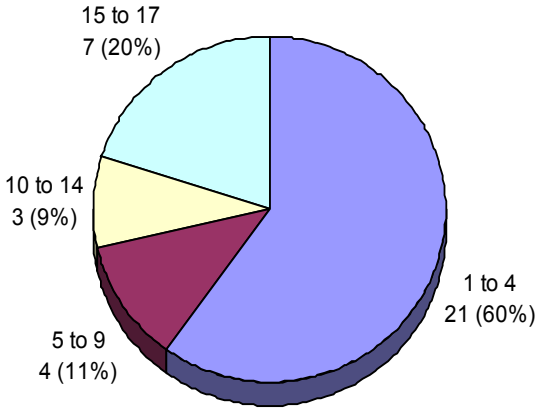


Figure 31 shows drowning deaths by age categories

Findings:

- Sixty percent of reviewed drowning deaths occurred among children ages 1 to 4 years
- Twenty percent of reviewed drowning deaths occurred among children ages 15 to 17 years

Facts:

- Drowning happens suddenly as children may slip into water very quickly without screaming or splashing around
- Active supervision is critical, especially for young children. According to Safe Kids (2008), a survey of parents in 2007 revealed the following:

  "When parents of a child under age five are the caregiver, only 15 percent said they can always physically reach their child. Forty-five percent overall said they usually know where their child is but are not always able to see or reach the child."
- Young child drowning deaths are often linked to lack of adequate supervision in Georgia

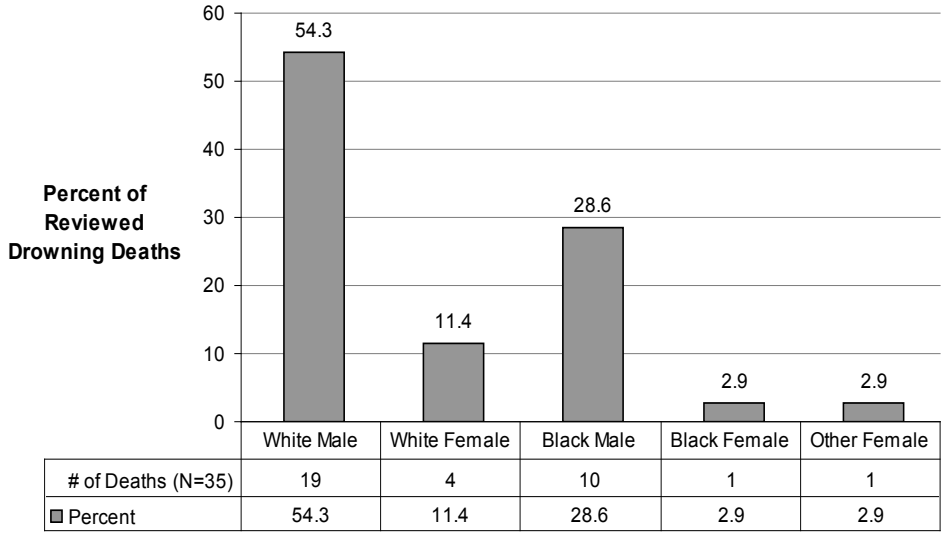
Finding:

- Overall, males accounted for 83% of all the drowning deaths, with White males comprising 54%

Fact:

- Nationally, the CDC reports that drowning rates are lower in White children when compared with African-American, American Indian and Alaskan Native children

Figure 32: Reviewed Drowning Deaths by Race, Gender and Proportion, 2006 (N=35)



	White Male	White Female	Black Male	Black Female	Other Female
# of Deaths (N=35)	19	4	10	1	1
Percent	54.3	11.4	28.6	2.9	2.9

Figure 32 shows proportion of child drowning deaths by Race and Gender

Findings:

- For children ages 1-4 years, 62% died in private swimming pools
- Natural bodies of water were the location for 100% of the 15-17 year old drowning deaths
- There were no deaths in public swimming pools or bathtubs during 2006

Facts:

- Toddlers do not have the cognitive ability to understand consequences of deep water or swimming without a life jacket or Personal Flotation Device (PFD)
- Arm floats or pool foam noodles are not life saving devices, yet some caregivers continue to use them on a regular basis
- Most young children who drowned in pools were last seen in the home, or had been out of sight less than five minutes

Figure 33: Reviewed Deaths Due to Drowning in Natural Bodies of Water and Private Swimming Pools by Month of Occurrence, 2006 (N=31)

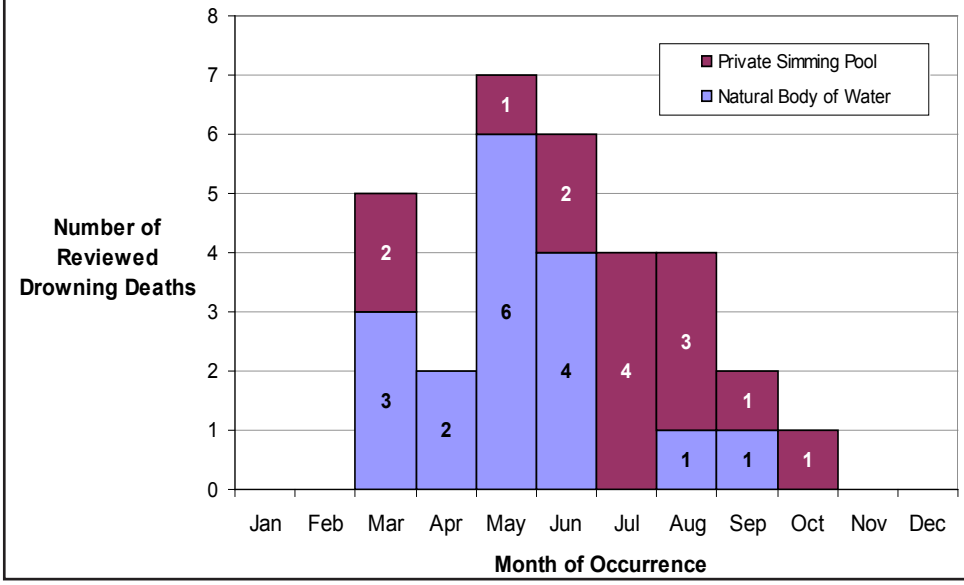


Figure 33 shows the number of deaths, month of occurrence, and location of drowning. Chart excludes four deaths occurring in other locations

Findings:

- Overall, drowning death rates are decreasing
- The drowning death rate for African-American males and females has decreased significantly
- The drowning death rate for White males has increased slightly, while the drowning death rate for White females has remained the same

Fact:

- Drowning remains the second leading cause of unintentional injury-related deaths to children ages 1-14 years, based on CDC research

Figure 34: Drowning Death Rates per 100,000 Children Age 0-17, Three-Year Moving Average, 1994-2006 (Based on OASIS Data)

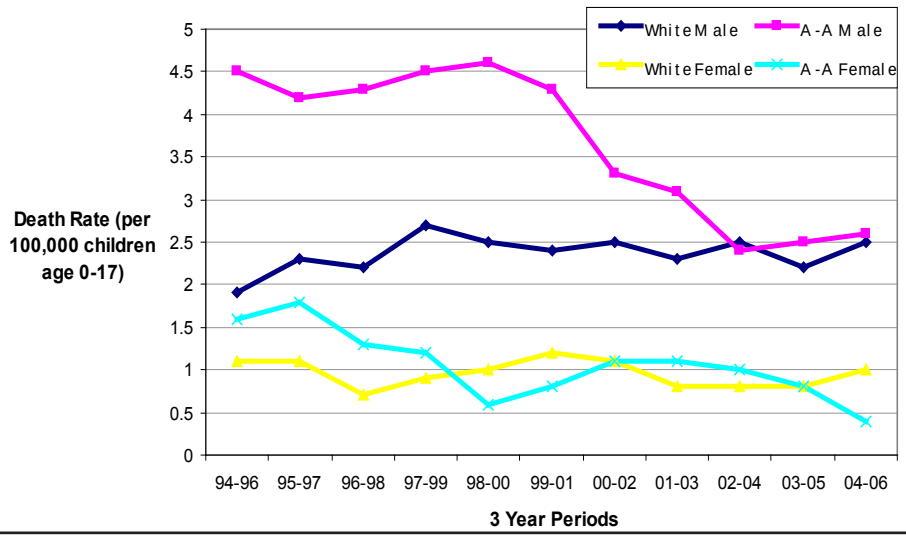


Figure 34 reveals drowning death trends since 1994

Opportunities for Prevention:

For parents

- Install a four-sided barrier around a private home pool with a four foot high vertical fence. Optimal barrier devices will separate the house and yard from the pool
- Never leave a child unsupervised around water. Children should not have immediate access to a water source without adult supervision. There is no substitute for diligent supervision
- Be familiar with other adults' perception of safety if they care for your child and they have a swimming pool or hot tub/spa
- Use layers of protection including active supervision, locked gates on all fencing, door alarms, and a safe pool environment where all the adults are aware of safety
- Do not drink alcohol while supervising children, especially around water
- Children should learn how to swim and personal water safety techniques
- Do not use arm floats/foam noodles as a measure of security in the water. Use Coast Guard approved PFDs (CDC, 2008)

For community leaders and policy makers

- Consider sponsoring community-wide swimming lessons/water safety instruction for children of all ages, but mostly for adolescents
- Empower, implement and enforce local ordinances requiring four-sided isolation fencing with self-closing, self-latching gates for private pools across the state. In January 2007, the state of Georgia adopted the international building code, Appendix G, requiring all private pools to have barrier devices. Enforcement of such codes is up to the local authorities to implement

For professionals

- Raise awareness of safety devices to help parents keep the home environment safe such as: door alarms for outside entrance, safety gates, toilet cover locks, door knob covers
- Support and raise awareness for reduced cost or free swimming lessons for youth
- Improve safety awareness at neighborhood pools and apartment/hotel pools so that all may be aware of the issue

Mother thought father was watching child and father thought mother was. Child had wandered into neighbor's backyard, jumped into pool and drowned

Resources:

CDC's National Center for Injury Prevention
www.cdc.gov/ncipc/

National Drowning Prevention Alliance
www.ndpa.org

Safe Kids USA
www.usa.safekids.org

U.S. Consumer Product Safety Commission
www.cpsc.gov

Fire-Related Deaths

Fire-related deaths are the fourth leading cause of unintentional injury-related deaths in Georgia. There were 19 reviewed fire-related child deaths in 2006. Since 2004 (when there were 40 reviewed fire deaths), fire-related deaths have continued to remain lower than in subsequent years reported.

The most common fire structure was wood frame (53%) and source was more often matches/lighters when known. Committees found 78% of fire deaths to be definitely preventable and 22% to be possibly preventable. In 2002, the CDC reported fire deaths to children to be the third leading cause of accidental death. Child fatality review data shows fire-related deaths as the fourth leading cause of unintentional deaths to children in Georgia.

Nationally, fire-related injuries or deaths are not perceived as a major problem, according to the United States Fire Administration (USFA). Across the United States, residential structures are inferior to the public building technology available. The USFA reports that the majority of fires occur in residential areas, where the knowledge of sprinkler systems and fire containment is not "widely used" like that in public facilities (USFA, 2007). The USFA suggests that safety built into homes and practicing safety behaviors is where we "fall short" (USFA, 2007). Across the U.S., the majority of fire deaths are caused by arson and smoking.

What is included in the definition of fire-related death?
A fire-related death is one resulting from fire or burn injuries sustained in a fire, and includes deaths from smoke inhalation.

How does GA compare with the U.S. average?
Fire deaths across the United States have declined by 20% since 1995; however, the fire death rate continues to be the fourth highest in the world according to the World Fire Statistic Centre. The annual costs associated with natural disasters are only a fraction of those associated with fires. Georgia's fire death rate in 2004 was 19.9 while the national rate was 13.6 (per million population. The USFA reported in 2007 that most of the southern states continued to have a fire death rate of 20 or more per million population. Georgia was not listed as one of the highest Southeastern states and our rate continues to decline. According to NCIPC, the United State's residential fire-related child death rate was 0.64 per 100,000, while Georgia's was 0.58, in 2005.

Figure 35: Reviewed Fire-Related Deaths by Age, 2006 (N=19)

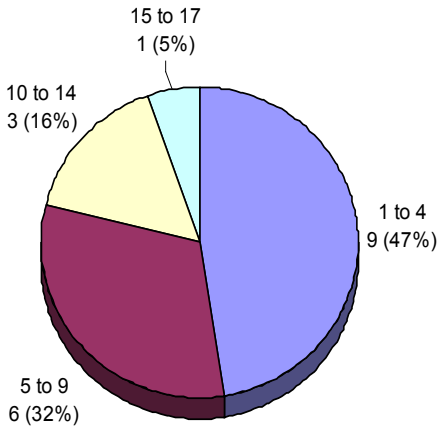


Figure 35 shows fire-related deaths by age and proportion

Findings:

- Toddlers account for the majority of child deaths due to fire
- Children ages 5-9 years account for the second highest age group

Facts:

- In the United States, children under the age of five are "more than twice as likely to die from a residential fire than the rest of the country's population" (USFA, 2003)
- A resident's risk of death from fire is cut in half with at least one working smoke alarm

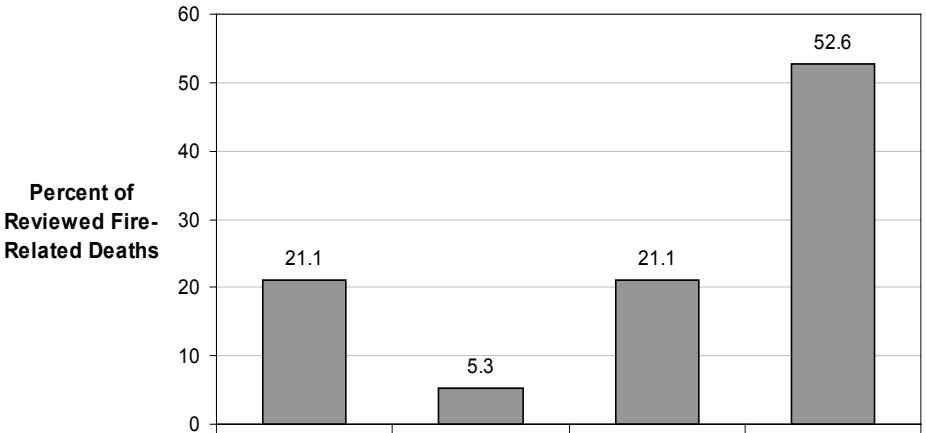
Finding:

- A higher percentage of fire-related deaths occurred among African-American children

Fact:

- In the U.S., African-Americans have higher fire-related death rates than the rest of the population

Figure 36: Reviewed Fire-Related Deaths by Race, Gender and Proportion, 2006 (N=19)



	White Male	White Female	A-A Male	A-A Female
# of Deaths (N=19)	4	1	4	10
Percent	21.1	5.3	21.1	52.6

Figure 36 shows proportions of fire deaths by Race and Gender

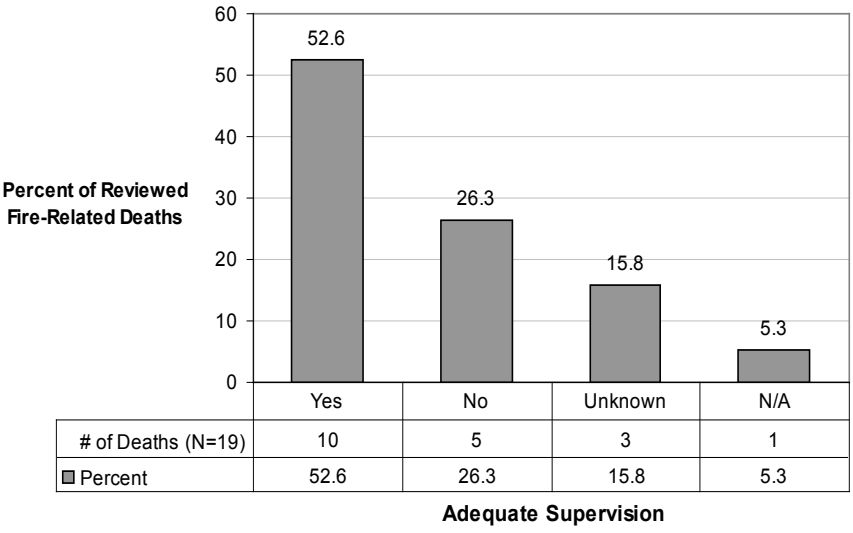
Finding:

- Fifty-three percent of children were determined to be supervised adequately at the time of the death

Fact:

- Active supervision of children around matches, lighters, open flames, and space heaters is critical for overall injury prevention

Figure 37: Reviewed Fire-Related Deaths by Adequate Supervision and Proportion, 2006 (N=19)



	Yes	No	Unknown	N/A
# of Deaths (N=19)	10	5	3	1
Percent	52.6	26.3	15.8	5.3

Figure 37 shows fire-related deaths by level of supervision

Mom worked the night shift and was napping in a room. Decedent and brother were in their bedroom playing with trigger lighter and caught some wrapping paper on fire

Figure 38: Fire-Related Death Rates per 100,000 Children Age 0-17, Three-Year Moving Average, 1994-2006 (Based on OASIS Data)

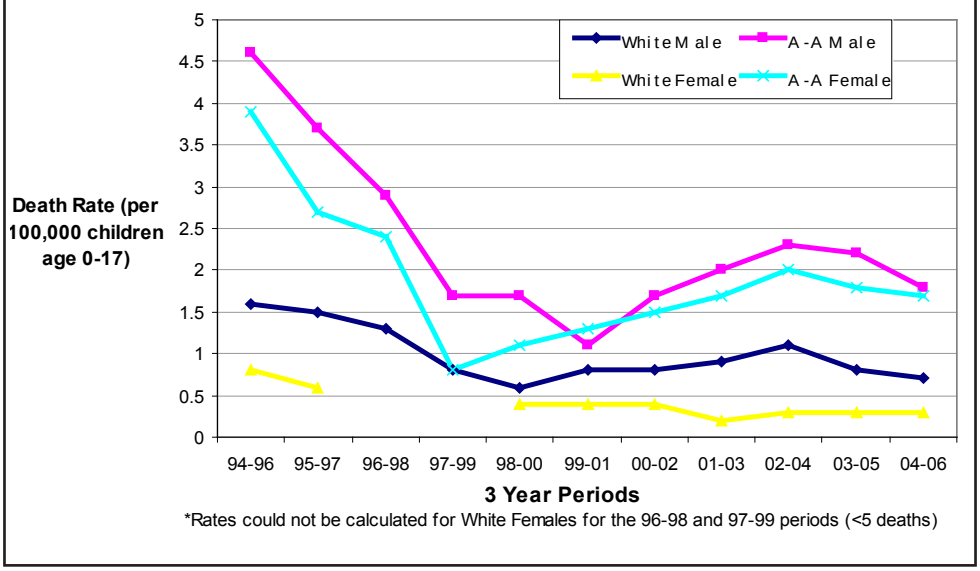


Figure 38 shows fire-related deaths since 1994

Findings:

- Fire deaths have shown an overall decline for all race/gender groups since 1994
- The average fire-related fatality rate for African-American males and females was less than two per 100,000 children in 2006, still more than twice as high as the average rates for White males and females

Fact:

- Through a partnership with the CDC, Georgia's Department of Human Resources reported that smoke alarms were provided to local fire departments for distribution across the state. Over the past five years, more than 20,000 detectors have been distributed, potentially saving 100 lives (GA DHR, 2006)

Opportunities for Prevention:

For parents

- Prepare and practice a fire escape route include teaching children: "once outside, stay outside"
- Have at least two working smoke alarms, one on every floor of the home if possible
- Decrease risk factors for possible fires including: alcohol consumption, smoking, especially in the bed, and fire activities during the winter months
- Educate older siblings to inform an adult if a young child has matches or lighters

For community leaders and policy makers

- Encourage local fire marshals to enforce home safety regulations for all types of dwellings
- Continue to provide funding sources for smoke detectors
- Provide funding for portable fire extinguishers

For professionals

- Continue to work with local fire departments and support smoke alarm distribution awareness programs

Resources:
Georgia Department of Human Resources
http://health.state.ga.us/programs/injuryprevention/firesafety.asp

U.S. Fire Administration / National Fire Data Center
www.usfa.dhs.gov/
www.usfaparents.gov/

Asphyxia Deaths

Unintentional asphyxia claims more infant lives each year than any other age group, occurring mostly during sleep. During 2006, there were 32 asphyxia deaths from children ages birth-17 years. In this section, the emphasis is on children older than age one (n=12), as infant asphyxia is discussed in the sleep-related death section. Toddlers accounted for 67% of asphyxia deaths for children ages 1-17 years, with food being the primary cause.

What is included in the definition of unintentional-related asphyxia?

Asphyxia occurs when there is an extreme decrease of oxygen in the body, accompanied by an increase in carbon dioxide, and usually caused by an interruption of breathing or suffocation. These types of death are definitely preventable and can be decreased through education of all age groups and proper adult supervision

How does GA compare with the U.S. average?

According to NCIPC, the United States unintentional asphyxia child death rate was 1.39 per 100,000 children, while Georgia's was 1.32 in 2005. Safe Kids reports that choking is a common cause of toy-related deaths and children are at risk from "hidden hazards" in the home. Asphyxia may also occur when children are running or playing while eating or if they are involved with activities such as the "choking game," where breathing is cut off momentarily to achieve a "high" without the effects of drugs or alcohol.

Findings:

- There were 12 asphyxia deaths among children ages 1-17 years; the majority were attributed to items in the mouth (i.e., choking)
- Unintentional hangings were reported in three children between the ages of 4 and 17 years old
- Asphyxia caused by food was determined only in the toddler age group. Items included a grape, pretzel, popcorn, and candy

Figure 39: Reviewed Asphyxia Deaths by Cause and Infant vs. Non-Infant, 2006 (N=32)

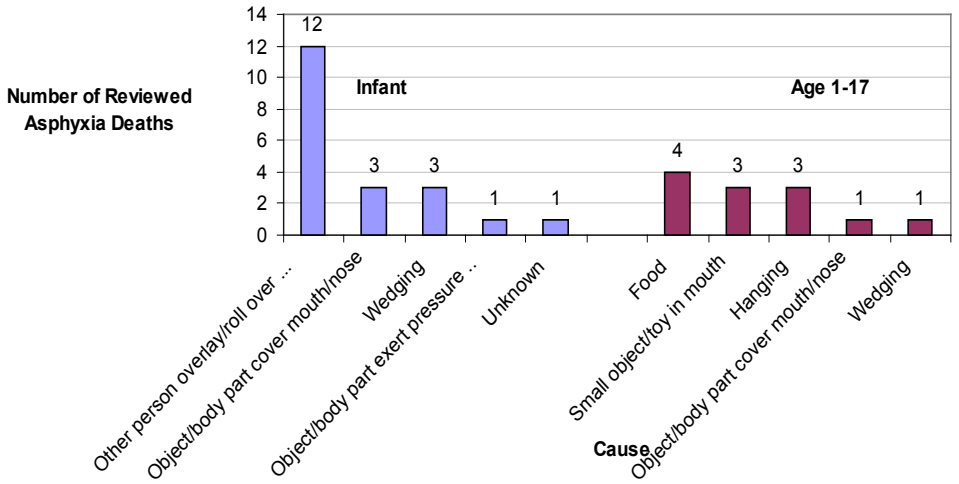


Figure 39 shows asphyxia deaths by cause, separating infant from other ages

Fact:

- Households with older children in the family may increase the risk of choking in young children because toys with small parts may be more accessible

Opportunities for Prevention:

For Parents

- Warn children about the "choking game" activity, because often they are unaware of the extreme lethal consequences
- Consider talking to your child's friend's parents, if you suspect your child has been experimenting with asphyxiation
- Keep small objects out of reach of toddlers and teach children not to run or play with food or small toys

For Community Leaders and Policy Makers

- Educate parents about warning signs associated with asphyxiation games
- Talk to children and adults who work with children regarding the consequences of choking games

For Professionals

- Engage schools with the DARE curriculum
- Implement and complete an official GASP trainer certified program

Resources:
Games Adolescents Shouldn't Play
www.stop-the-choking-game.com

Safe Kids USA
www.safekids.org

Intentional Injury-Related Deaths

Most child fatalities stem from medical causes or are the result of unintentional circumstances. However, every year a substantial number of children die as a result of intentional injuries. Intentional injuries are those which are purposely inflicted either by oneself or by another person. It also includes a willful, wanton, or reckless disregard for the safety of others during the course of action (for example, a child killed by a stray bullet).

Intentional injuries are separated into two major categories: Homicide and Suicide. In 2006, local committees reviewed 56 child homicides and 26 child suicides. When compared to 2005 data, there was a slight increase in both categories: child homicides (50), child suicides (20).

Homicide

According to global studies, the United States has the highest child homicide rate among developed countries. Additionally, in the U.S. homicide is the only major cause of childhood death that has increased in incidence during the past 30 years. While deaths of children resulting from accidents, congenital defects, and infectious diseases were declining, child homicides were increasing. More children 0-4 years of age in the U.S. die from homicide than from infectious diseases or cancer, and homicide claims the lives of more teenagers than any cause other than motor vehicle accidents (U.S. Census Bureau).

The Center for the Study and Prevention of Violence has reported that funding for violence "after the fact" (e.g., prisons) is higher than for a preemptive system to prevent violence in our communities. Basically, more money is allocated to *reacting* to national violence than is to *preventing* this public health problem. It is imperative that we reverse this trend in order to effectively address the devastating impact of violence in our society.

What is the included in the definition of homicide?
Homicide occurs when a person purposely, knowingly, recklessly, or negligently causes the death of another.

How does Georgia compare with the U.S. average?
According to the National Center for Injury Prevention and Control, the U.S. child homicide rate was 2.53 per 100,000, while Georgia's child homicide rate was 2.11 in 2005. This is a significant decrease in Georgia when compared to the state rate of 3.29 in 2004.

Figure 40: Reviewed Homicide Deaths by Mechanism of Injury, 2006 (N=56)

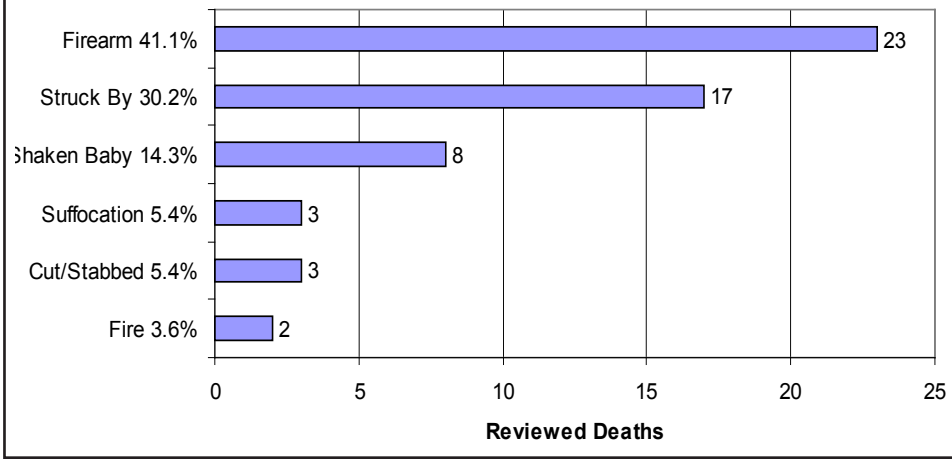


Figure 40 shows the mechanism of injury for the 56 children whose deaths were homicides in 2006

Findings:

- Firearms were determined to be involved in 23 (41%) of the 56 homicide deaths
- Seventeen homicide deaths (30%) were attributed to violent force or impact resulting from being struck by an object or a weapon of some sort

Fact:

- The homicides of young children are among the most difficult to document because they often resemble deaths that are unintentional and other causes. For example, a child who has been thrown or intentionally dropped may have injuries similar to those of one who died from an unintentional fall

Findings:

- Thirty-eight percent of reviewed child homicides occurred among 15-17 year olds
- Thirty-four percent of reviewed homicides occurred among 1-4 year olds

Fact:

- Homicide incidence among children significantly decrease between ages 5-14, particularly after reaching school age

Figure 41: Reviewed Homicide Deaths by Age, 2006 (N=56)

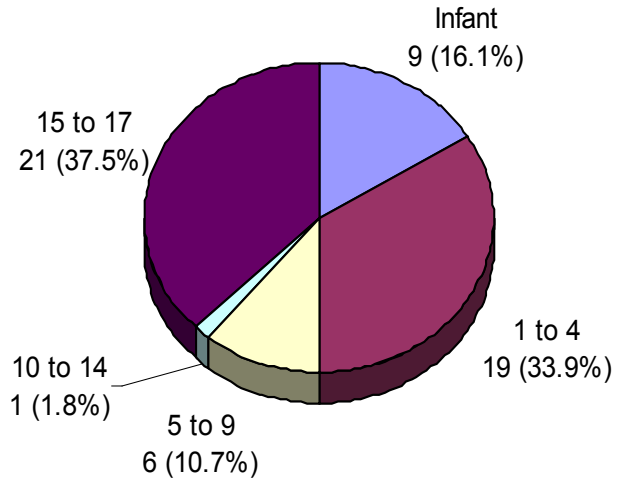


Figure 41 shows the number of deaths by age category for the 56 children whose deaths were homicides in 2006

Findings:

- African-American males continued to be the highest-risk group for homicides representing almost half (45%) of all homicide deaths
- The number and proportion of homicide deaths between African-American females and White males were equal

Fact:

- Studies indicate a disproportionate rise in the risk of homicide for non-White youth

Figure 42: Race/Gender Proportion for Reviewed Homicide Deaths, 2006, (N=56)

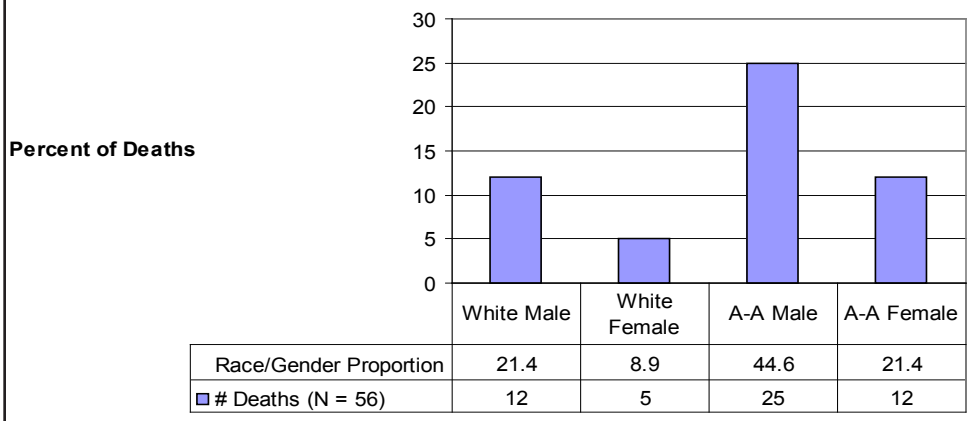


Figure 42 shows race and gender proportions for the 56 children whose deaths were homicides in 2006

Findings:

- Natural fathers are identified as perpetrators in three of the nine infant homicides
- Head of household data suggest that the fathers who perpetrated these homicides lived in the home with the child at the time of death

Fact:

- The majority of fatal injury deaths among infants is due to abusive head trauma, also known as Shaken Baby/ Shaken Impact Syndrome, which occurs when an infant is violently shaken or thrown against a hard surface

Figure 43: Number of Infant Homicide Deaths with Perpetrator Identified, 2006 (N=9)

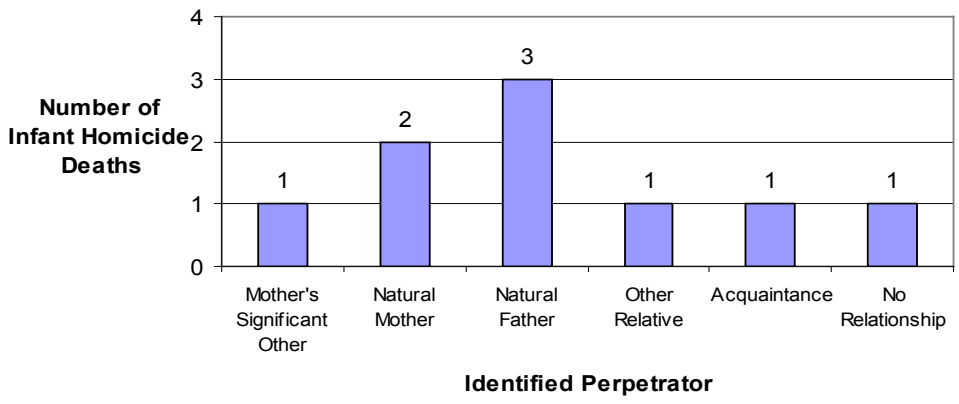


Figure 43 depicts identified perpetrator in infant homicides

Findings:

- Mothers' significant others were identified as perpetrators in seven of the nineteen homicides of 1-4 year olds
- Natural fathers were identified as perpetrators in six of the nineteen homicides of 1-4 year olds

Fact:

- A significant number of homicides involving young children are labeled "altruistic killings." Between 15 percent and 30 percent of homicides of children under age ten are related to adult suicides. The parent decides to commit suicide, and can't bear to leave the child behind (UCI, 1999)

Figure 44: Reviewed Homicide Deaths by Age, 2006 (N=56)

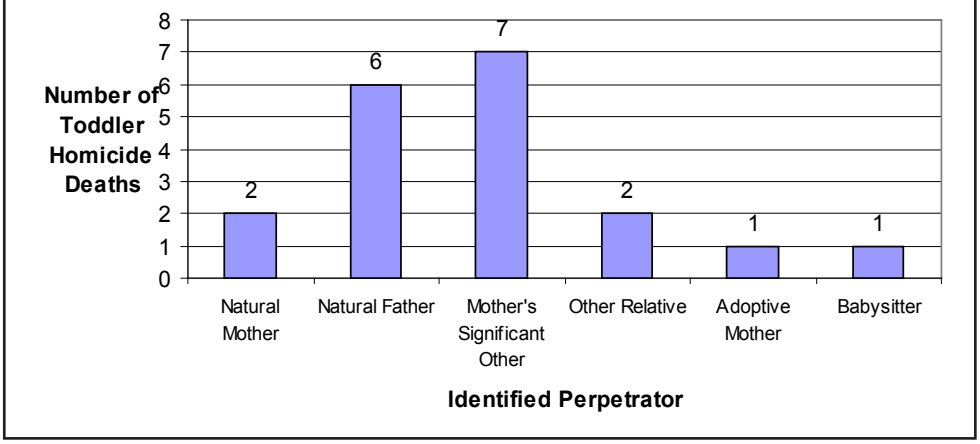


Figure 44 depicts identified perpetrators for toddler homicides

Findings:

- Unlike homicides of children under age 12, relatively few teen homicides are committed by relatives
- A high percentage of teen homicides are perpetrated by other teens

Fact:

- The dramatic increase in the number of older teen homicides has been attributed to various factors, including the rise in child poverty, expansion of gang activity, prevalent drug use, and increased accessibility of firearms (OJJDP, 2001)

Figure 45: Number of 15-17 year old Homicide Deaths with Perpetrator Identified, 2006 (N=21)

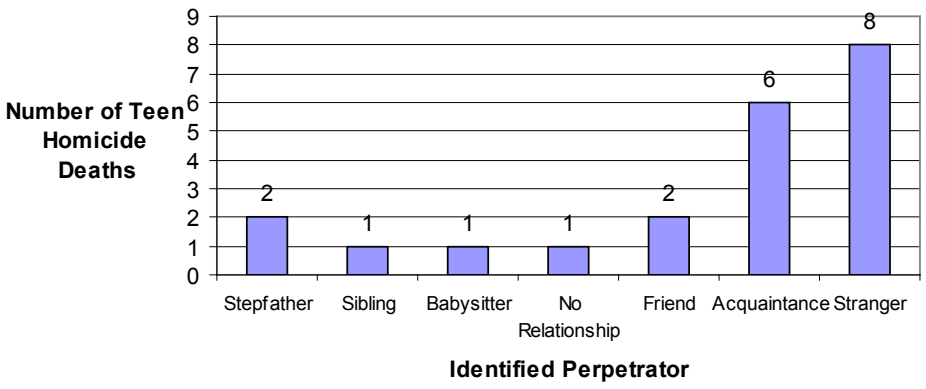


Figure 45 depicts identified perpetrator for older teenager homicides

Opportunities for Prevention

For Parents

- Increase self-awareness by recognizing personal stressors, anxieties, and triggers
- Seek assistance when feeling overwhelmed or stressed
- Reduce access to lethal weapons by securing firearms

For community leaders and policy makers

- Create incentives for parents to attain pre and post-natal parent training programs to avail them with the knowledge and skills to appropriately respond to child-related stressors
- Establish strong, positive community support networks that are comprised of faith –based entities, neighborhood associations, and local service agencies
- Increase public awareness of the warning signs of child maltreatment and encourage community members to report child maltreatment to child protective service agencies

For professionals

- Provide respite care to assist parents and caregivers who are overwrought with stress
- Increase support for violence prevention programs
- Promote firearm safety to ensure that guns are secured and inaccessible to children and youth
- Implement in-school and after-school programs designed to engage young child and teens in positive activities
- Link young parents with parent mentors for the purpose of developing and maintaining relationships rooted in modeling impulse control, anger and stress management, and other positive parenting behaviors

Resources:
National Center for Injury Prevention and Control (NCIPC)
http://www.cdc.gov/ncipc/

National Youth Violence Prevention Resource Center
http://www.safeyouth.org/

The parents were engaged in a domestic altercation. The mother fled the home and the father killed the children and himself.

Suicide

In the United States, suicide is the third leading cause of death for teens, according to the Centers for Disease Control and Prevention (CDC), surpassed only by unintentional injuries and homicide. Young children have a much lower incidence of suicide. The CDC also reports that about four children out of every 500,000 below the age of 12 commit suicide annually, according to the CDC. Commonly, teen and adult suicides begin with an idea, proceed with a plan, and end with action. Conversely, child suicide is more likely to be spontaneous and less connected to psychiatric disorders or aggression. Instead of hanging, cutting, or using a firearm, children tend to kill themselves by doing things their parents have warned them against, such as running into traffic or jumping out of a window. This makes it very difficult to distinguish between suicide and unintentional injuries. Consequently, this calls for a more extensive investigation by highly trained professionals to ensure accurate death coding.

What is included in the definition of Suicide?
Suicide is the act of voluntary and intentional self-harm (by asphyxia/suffocation, cutting, poisoning, firearms or falls), which results in death.

How does Georgia compare with the U.S. average?
According to the National Center for Injury Prevention and Control, the child death rate from suicide in Georgia (0.95) is comparable to the U.S. child suicide death rate (1.39) in 2005. Both have remained relatively constant over the past two decades. In 2006, there were 26 child suicides in Georgia which is a slight increase compared to 20 child suicides in 2005. Georgia's suicide death rates have fluctuated over the past few years with 30 child suicides in 2003, decreasing to 26 child suicides in 2004.

Figure 46: Reviewed Suicide Deaths by Method of Death, 2006 (N=26)

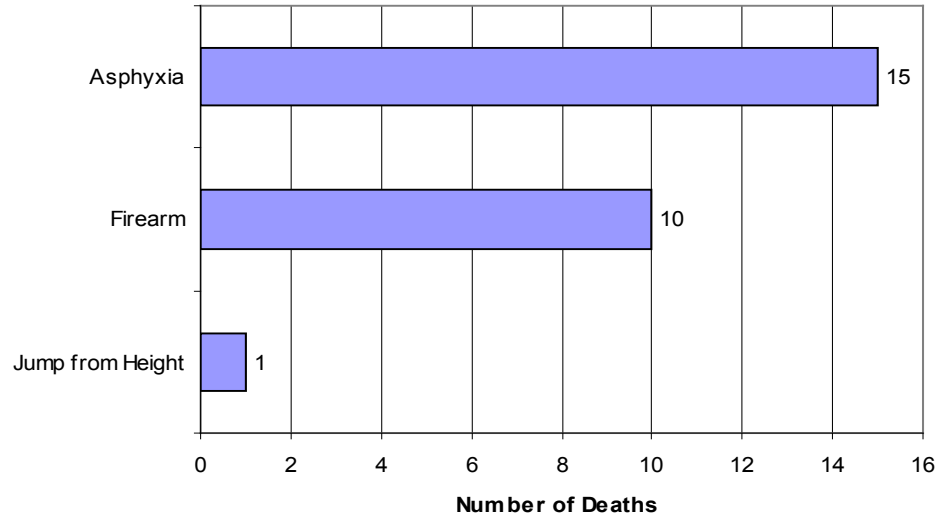


Figure 46 shows the mechanism of death for the 26 children who committed suicide in 2006

Findings:

- The highest number of child suicide deaths was due to asphyxia/suffocation by hanging (15)
- Firearms were determined to be involved in ten (38%) of the 26 suicide deaths which is comparable to 2005

Fact:

- The risk of suicide increases dramatically when children have access to firearms at home, and nearly 60% of all suicides in the United States are committed with a gun (Kids Health 2008)

Findings:

- Twenty-six suicide deaths occurred among older teens, an increase from 14 (70%) in 2005
- There were five suicide deaths among 10-14 year olds which has decreased (from six in 2005 and nine in 2004)

Fact:

- Experts estimate that 20-25% of teens admit to thinking about suicide at some point in their lives

Figure 47: Reviewed Suicide Deaths by Age, 2006 (N=26)

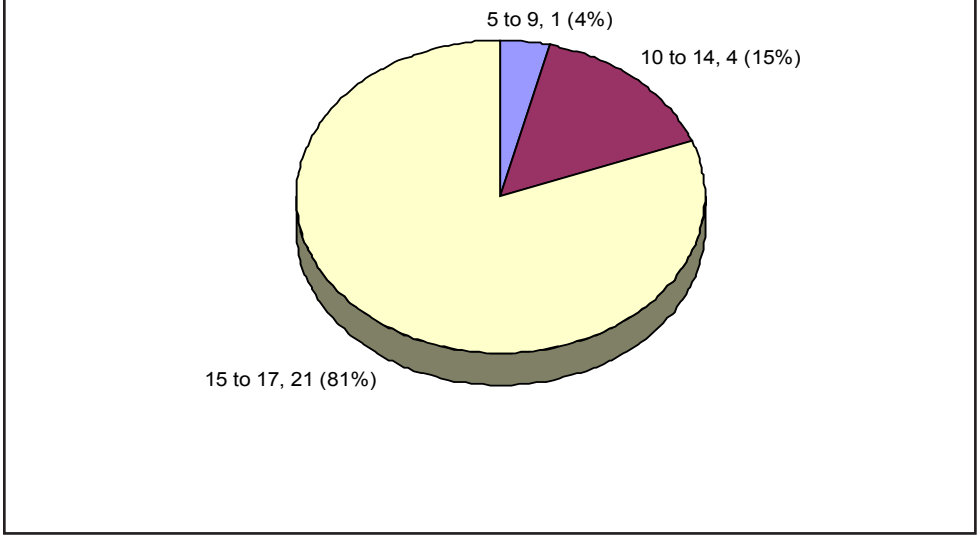


Figure 47 shows the age breakdown for the 26 children who committed suicide in 2006

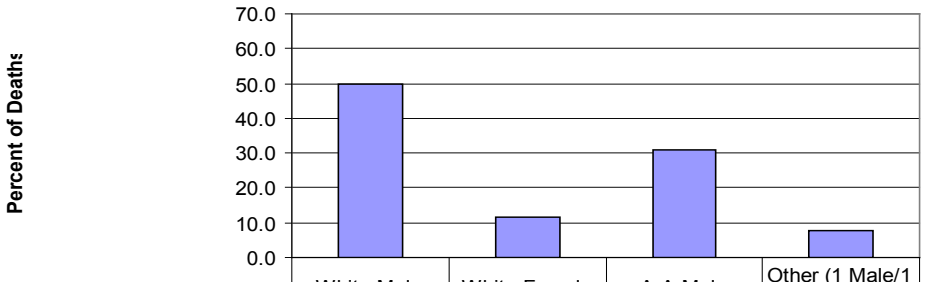
Findings:

- White males had the highest proportion of suicide deaths
- There were no reviewed suicides for African-American females

Fact:

- White males are four times more likely to commit suicide than other race/gender groups, but White females are more likely to attempt suicide

Figure 48: Race/Gender Proportion for Reviewed Suicide Deaths, 2006 (N=26)



	White Male	White Female	A-A Male	Other (1 Male/1 Female)
# Deaths (N = 26)	13	3	8	2
Race/Gender Proportion	50.0	11.5	30.8	7.7

Figure 48 shows the number and proportion of reviewed suicides by Race and Gender

Figure 49: Number of Reviewed Suicide Deaths with Risk Factors Identified, 2006 (N=26)

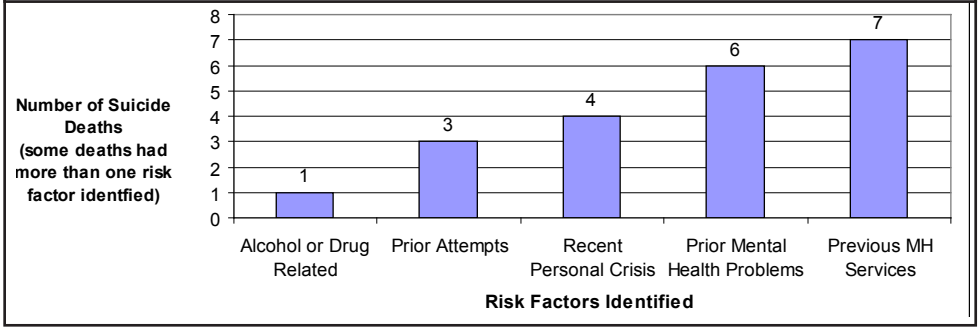


Figure 49 shows other contributing risk factors that were identified for reviewed suicide deaths (there were some suicide deaths with multiple risk factors reported, so the total number shown is higher than the number of suicide deaths)

Findings:

- In three of the four deaths where the victim had a recent personal crisis, they had also talked of suicide
- In each of the three cases where the victim had a prior suicide attempt, they had also received mental health services
- Only one suicide was determined to be alcohol or drug-related

Fact:

- Approximately one-third of teenage suicide victims have made a previous suicide attempt in the past

Opportunities for Prevention

For Parents

- Recognize the risk factors and warning signs for suicide
- Develop and maintain an open, understanding parent-child relationship that fosters communication and trust
- Closely monitor children for changes in behavior e.g., loss of interest in favorite things
- Seek professional help when signs of depression, anxiety, and suicidal thoughts have been detected

For community leaders and policy makers

- Promote youth suicide campaigns within local communities
- Provide suicide prevention and intervention training for school personnel, service providers, and parents

For professionals

- Provide support services so that youth feel comfortable seeking help coping with stress, depression, and/or suicidal thoughts
- Educate parents about the seriousness of youth suicide and the importance of recognizing behavioral indicators of suicide

Resources:
Georgia Suicide Prevention Plan
http://georgiasuicidepreventionplan.org/

The National Suicide Hotline
1-800-SUICIDE (1-800-784-2433)

National Institute of Mental Health (NIMH)
http://www.nimh.nih.gov

Victim was reprimanded by his grandmother and became upset. He said that he was going to hang himself. He went into the house and hung himself on a rope swing.

Firearm-Related Deaths

During 2006, firearms claimed the lives of 38 children in Georgia, with older teens represented in 71% of the deaths and younger children (ages one to nine), represented in 21% of the deaths. Males accounted for 89% of firearm-related deaths, with 55% of those African-American males. At the time of death, 68% of all firearm-related deaths occurred either at the child's home or at someone else's home.

What is included in the definition of firearms?
A firearm is any weapon that fires a high-velocity projectile, and includes rifles, pistols, revolvers, shotguns, handguns, and BB guns.

How does GA compare with the U.S. average?
According to NCIPC, the national child death rate due to firearms in 2005 was 2.03, per 100,000 children, while Georgia's rate was 1.80 in 2005. Nationally, more than 75% of guns used in youth suicide were found in the decedent's residence or another home. In Georgia, ten percent of youth suicides with a firearm occurred in another home and 90% occurred in the decedent's residence. Georgia is among five other Southern states with one of the weakest Child Access Prevention Laws in the nation (LCAV, 2008). Some states institute legislation that imposes criminal liability for negligent storage of a firearm and/or if a child gained access to the firearm regardless of injury or death. Georgia's CAP law prohibits persons from intentionally, knowingly, and/or recklessly providing handguns to children under 18 years and holds parents liable when "they know of a substantial risk that the minor will use the firearm to commit a crime" (LCAV, 2008) (O.C.G.A. 16-11-101.1). Georgia does not have legislation specific to a minimum age for rifles or shotguns.

Figure 50: Reviewed Firearm-Related Deaths by Age and Race, 2006 (N=38)

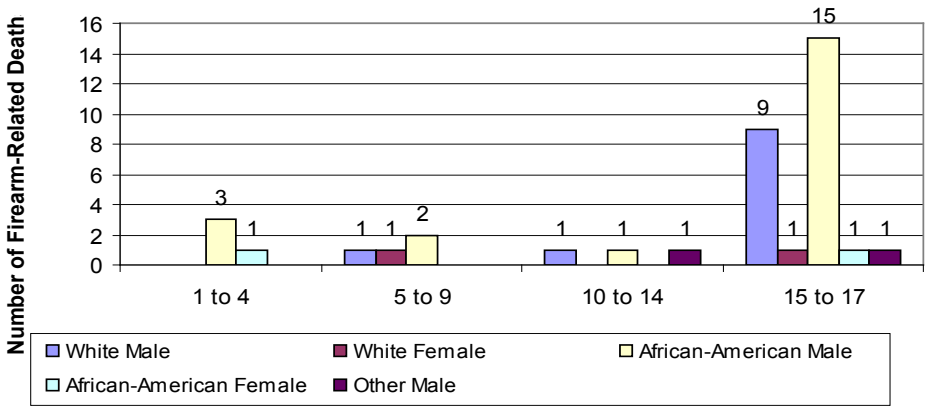


Figure 50 shows age and race breakdown of firearm-related deaths

Findings:

- African-American males represented the majority of firearm-related deaths (55%)
- Males outnumber females in firearm-related deaths, representing 89% of this category
- Ten youth committed suicide with a firearm (one was 10-14 years, nine were 15-17 years)
- Males of other races/ethnicities accounted for less than one percent of firearm-related deaths

Fact:

- Based on information from the Youth Risk Behavior Survey (CDC, 2000), male teens are more likely to possess firearms and nine percent of male students reported carrying a gun at least once during the past 30 days preceding the survey

Findings:

- Homicides account for the largest category of firearm-related deaths
- Unintentional firearm-related deaths have decreased from 2004 by 75%. There were 11 unintentional firearm deaths to children in 2004
- CFR committees reported teenagers 15-17 years accounted for 74% of homicide by firearm and only two deaths were known to be related to a gang - 24% were unknown for gangs

Figure 51: Reviewed Firearm-Related Deaths by Intent, 2006 (N=38)

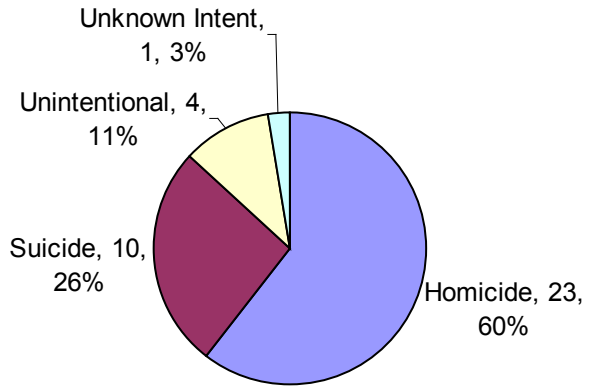


Figure 51 shows reported intention of firearm-related deaths

Facts:

- Gangs have emerged since the 1980s and there is a direct relationship between gangs and violence, which can impose greater drug use, delinquency rates, and violent offenses in communities (Center for the Study and Prevention of Violence, 2008)
- CFR committees found youth with prior state agency involvement accounted for 70% of homicide with a gun
- The U.S. Consumer Product Safety Commission recommends children under age 16 not use a BB gun or pellet gun
- The National Child Safety Lock Act of 2005 requires that as of April 2006, firearms should be sold with a safety locking device or secure gun storage. Across the nation, this applies to "any licensed importer, manufacturer, dealer to sell, deliver, or transfer any handgun to any person, other than another licensee" (U.S. Department of Justice, 2006).

Findings:

- More firearm-related deaths occurred in the decedent's own residence
- Ninety percent of youth suicides occurred in their own home
- Twenty-six percent of homicides with a firearm occurred in the decedent's home

Figure 52: Reviewed Firearm-Related Deaths, Based on Location, 2006 (N=38)

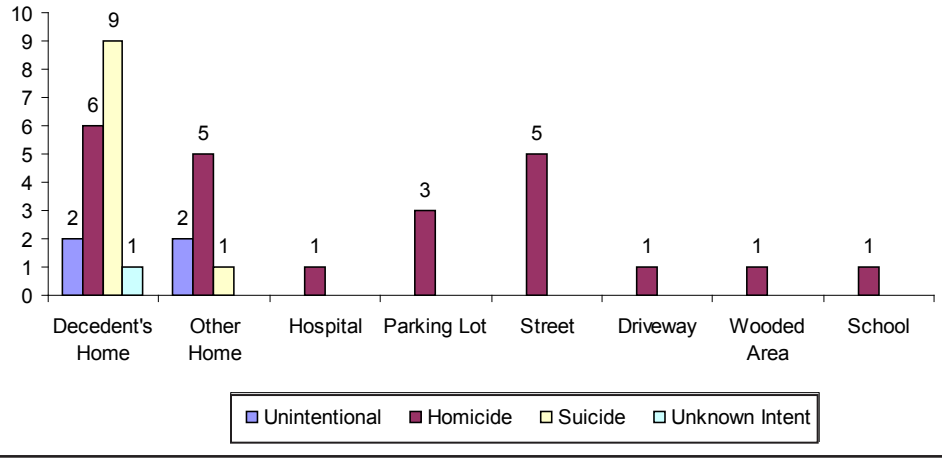


Figure 52 shows the reported location of decedent at time of death

Facts:

- In the U.S., 35% of homes with children under 18 years have firearms
- Firearm deaths occur primarily because of children having access to a firearm. More firearm deaths occur at a residence (66%) than anywhere else

Finding:

- Handguns were used in 84% of the firearm-related deaths

Facts:

- More than 50% of U.S. homes have one or more firearms in an unlocked location and 43% have unlocked firearms (meaning loaded, without a trigger or other safety lock mechanism (AJPH, 2000)
- In Georgia, more firearm deaths are due to handguns, which are specifically addressed in Georgia's law regarding child access to handguns

Figure 53: Reviewed Firearm-Related Deaths by Type of Firearm, 2006 (N=38)

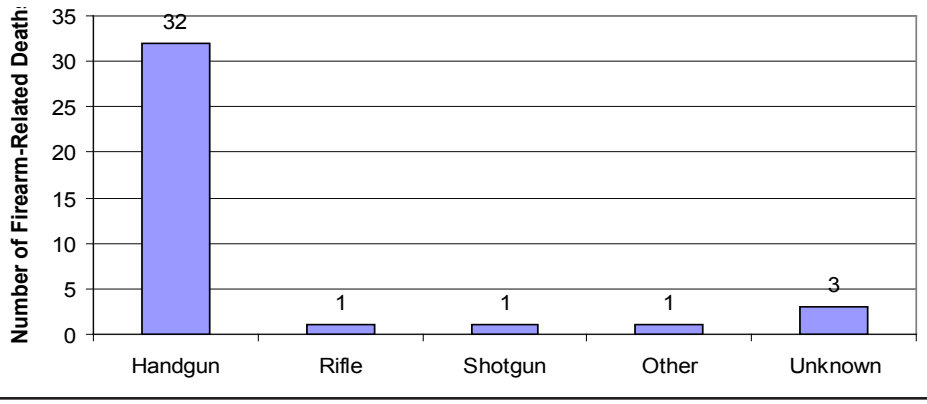


Figure 53 shows type of firearm used in reviewed firearm-related deaths

Opportunities for Prevention:

For parents

- Enroll youth in hunter education classes that support and promote the safe use of firearms at all times
- Remind youth how to transport guns safely while hunting or engaging in hunting sports
- Children may come in contact with a gun at a neighbor's house. It is important parents and caregivers teach children what to do if a gun is found at another home
- Store firearms responsibly, utilizing a safety locking device and/or secure storage

For community leaders and policy makers

- Support hunting education classes that teach youth respect and safety for all types of guns
- Develop school based firearm safety education classes to demonstrate how to reduce the risk of firearm deaths
- Consider support of improvements in the current Child Access Prevention Law to improve negligence penalties for inadequate firearm storage

For professionals

- Promote and train gun owners the use of firearm safety devices and how to keep them locked
- Teach conflict resolution skills to youth involved in state agency programs

Resources:

American Journal of Public Health
www.ajph.org/

Centers for Disease Control and Prevention
www.cdc.gov/ncipc/

Legal Community against Violence
www.lcav.org

National Child Safety Lock Act 2005
http://childsafetylockact.com/

University of Colorado's Center for the Study and Prevention of Violence
http://www.colorado.edu/cspv

Decedent was involved in a card game with a large group of people. An altercation broke out and the decedent was shot

In 2006, there were 73.7 million children under age 18 in the United States (25% of the U.S. population). This represents an increase in the child population of more than 50 percent since 1950. By the year 2030, that number is expected to grow to 85.7 million. The 2006 estimated population in Georgia was 9,342,080. The number of children in Georgia under age 18 was 2,291,227 representing approximately 25% of the total population of the state. Racial and ethnic diversity is greater in the adolescent population than in the U.S. population as a whole, and diversity among adolescents is increasing.

Georgia population estimates from 2006 suggest that African-American male children (age 0-17) made up about 17% of the child population, but 28% of all child deaths. In contrast, White males made up about 31% of the child population, and a proportional 30% of all child deaths. African-American females made up about 17% of the child population and 21% of all child deaths. White females were 29% of the child population, but 21% of all child deaths. Hispanic males made up five percent of the child population and a proportional five percent of all child deaths. Hispanic females also made up five percent of the child population but only two percent of all child deaths. Other racial and ethnic groups were combined (including Asian and American Indian/Alaska Natives) and males in this group made up three percent of the child population in 2006 and one percent of all child deaths. Females in this group made up two percent of the child population and less than one percent of all child deaths. This data suggest that certain subgroups of the population are significantly more (i.e. African-American males) or less (i.e. White females) vulnerable to fatalities when compared to the population as a whole. For this reason, it is important to note the specific circumstances that lead to identified racial disparities in child fatalities.

There are certain circumstances that are presented in other sections of this report that highlight the racial disparities seen in child fatalities-for example, infant mortality, homicide, and suicide. In 2006, infant mortality among African-Americans occurred at a rate of 14.1 deaths per 1,000 live births. This is more than twice the national average of 6.7 deaths per 1,000 live births. Additionally, infants born to African-American mothers are more than twice as likely to die in the first year of life as White infants -- 13.73 African-American infant deaths per 1,000 live births compared to 5.73 among Whites (Children's Defense Fund).

Suicide data show that Hispanic and White non-Hispanic adolescents were more likely than African-American non-Hispanic adolescents to have seriously considered suicide. African-American and Hispanic females have the lowest rates of suicide completion. Among 15-19 year old males, American Indians/Alaska Natives have the highest suicide rate - two to four times the rate of any other ethnic/racial group. Among adolescents age 15-19, males are five times more likely than females to become homicide victims. For young African-American males, homicide is the leading cause of death (Act for Youth, 2008).

There are a myriad of factors contributing to disparities among racial/ethnic populations. During these difficult times of economic turbulence, many of the disparities highlighted will worsen as the need for assistance will dramatically increase. Therefore, a collaborative approach to addressing these disparities should be implemented in an effort to mobilize communities to enhance the lives of our children and their families.

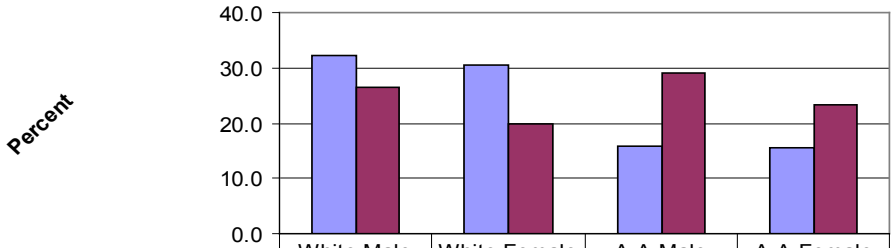
Finding:

- The percent of death are higher among males than females for both races, and the gender-specific differences (percent ratios) are slightly greater among White infants

Fact:

- The racial gap in infant mortality is nearly identical for medical and external causes of death, with the overall rate of infant mortality among African-Americans about 2.2 times higher than Whites

Figure 54: Deaths to Infants and Percent of Population in Georgia by Race and Gender, 2006 (Based on Death Certificates)



	White Male	White Female	A-A Male	A-A Female
% of Population	32.1	30.5	16.0	15.5
% of Deaths	26.5	19.8	29.1	23.2

Figure 54 shows the number of deaths to infants and percent of the population by race and gender

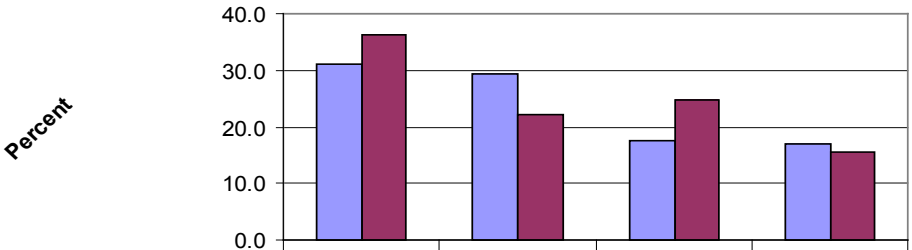
Finding:

- The racial disparities are not as pronounced for the 1-17 year old age group. Males are more likely to die than females, and the gender difference is greater among White youth than African-American youth

Fact:

- Age and race differences in adolescent death rates vary by cause of death, but child death rates have dropped dramatically since 1980

Figure 55: Deaths to Children 1-17 and Percent of Population in Georgia by Race and Gender, 2006 (Based on Death Certificates)



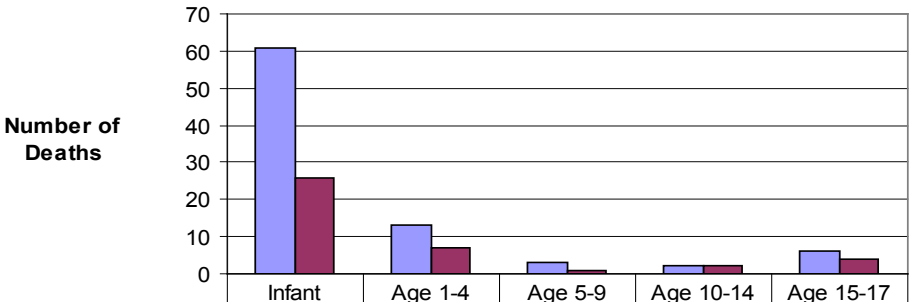
	White Male	White Female	A-A Male	A-A Female
% of Population	31.1	29.4	17.5	17.1
% of Deaths	36.3	22.2	24.7	15.5

Figure 55 shows the number of deaths to children age 1 -17 and percent of population by race and gender

Finding:

- The number of deaths among Hispanic males is significantly higher in the infant population than any other age group

Figure 56: Hispanic Deaths by Age and Gender, 2006 (N=125)



	Infant	Age 1-4	Age 5-9	Age 10-14	Age 15-17
Male	61	13	3	2	6
Female	26	7	1	2	4

Figure 56 shows the number of deaths among Hispanic children by age and gender

Opportunities for Prevention:

For Parents

- Learn about the importance of maintaining pre-natal health
- Seek information regarding effective parenting methods to ensure overall healthy child development

For Community Leaders and Policy Makers

- Develop and implement strategies for educating the community about racial/ethnic disparities
- Provide diversity training to service providers and community advocates

For Professionals

- Educate parents about the importance of maintaining healthy lifestyles
- Collaborate with community advocates to increase cultural awareness and sensitivity

Resources:

Act for Youth
www.actforyouth.org

Children's Defense Fund
www.childrensdefense.org

United States Department of Health and Human Services
www.os.dhs.gov

History of Child Fatality Review in Georgia

1990 - 1993

Legislation established the Statewide Child Fatality Review Panel with responsibilities for compiling statistics on child fatalities and making recommendations to the Governor and General Assembly based on the data. It established local county protocol committees and directed that they develop county-based written protocols for the investigation of alleged child abuse and neglect cases. Statutory amendments were adapted to:

- Establish a separate child fatality review committee in each county and determine procedures for conducting reviews and completing reports
- Require the Panel to:
  - Submit an annual report documenting the prevalence and circumstances of all child fatalities with special emphasis on deaths associated with child abuse
  - Recommend measures to reduce child fatalities to the Governor, the Lieutenant Governor, and the Speaker of the Georgia House of Representatives
  - Establish a protocol for the review of policies, procedures and operations of the Division of Family and Children Services for child abuse cases

1996 - 1998

- The Panel established the Office of Child Fatality Review with a full-time director to administer the activities of the Panel
- Researchers from Emory University and Georgia State University conducted an evaluation of the child fatality review process. The evaluation concluded that there were policy, procedure and funding issues that limited the effectiveness of the review process. Recommendations for improvement were made to the General Assembly
- Statutory amendments were adopted to:
  - Identify agencies required to be represented on child fatality review committees, and establish penalties for non-participation
  - Require that all child deaths be reported to the county coroner/medical examiner

1999 - 2001

- Child death investigation teams were initially developed in four judicial circuits as a pilot project, with six additional teams later added. Teams assumed responsibility for conducting death scene investigations of child deaths that met established criteria within their judicial circuit
- Statutory amendments were adopted which resulted in the Code section governing the Child Fatality Review Panel, child fatality review committees, and child abuse protocol committees being completely rewritten. This was an attempt to provide greater clarity and a more comprehensive, concise format
- The Panel's budget was increased

2002 – 2005

- The Panel published and distributed a child fatality review protocol manual to all county committee members
- Statutory amendments were adopted which resulted in the following:
  - Appointment of District Attorneys to serve as chairpersons of local committees in their circuits
  - Authority of the Superior Court Judge on the Panel to issue an order requiring the participation of mandated agencies on local child fatality review committees. Failure to comply would be cause for contempt
  - Authority of the Panel to compel the production of documents or the attendance of witnesses pursuant to a subpoena
  - Director of the Division of Mental Health added as a member of the Panel
- Funding was secured and an on-line reporting system was established for both the child fatality review report and the coroner/medical examiner report
- A collaboration was established between the Office of Child Fatality Review and the National Center for Child Death Review
- The Georgia Child Fatality Investigation Program was established through a partnership between OCFR, DFCS and the Georgia Bureau of Investigation. A director was hired to advance a multi-disciplinary approach to child death investigation through development and training of local teams.
- A Statewide Model Child Abuse Protocol was developed and distributed to all Protocol committee members

- A Prevention Advocate was added, by policy, to all child fatality review committees. Statewide training was conducted for all prevention advocate members
- A quarterly newsletter was created and distributed. The newsletter is sent to all child fatality review members and contains useful information about the process as well as prevention
- Annual awards were established for the Child Fatality Review Coroner of the Year and Child Fatality Review County Committee of the Year. Awards are presented at the annual Child Fatality and Serious Injury Conference sponsored by the Panel, DHR, GBI and the Office of the Child Advocate
- A sub-committee of the Panel (including several outside agencies) was formed to begin working on a Statewide Prevention Plan

2006-2008

- The Child Fatality Review committee protocol was revised and updated to reflect best practices. The Protocol was presented to all county committee members and is also available online
- The Panel subcommittee on prevention completed the Statewide Child Fatality Prevention Framework. The Framework was presented to the Governor's Office and other agency partners
- An annual award was established for the Outstanding Investigator/Team of the Year for death investigation cases.
- The CFIT Program expanded to address all types of multi-disciplinary child abuse investigations, including sex abuse, physical abuse and neglect as well as homicides
- The Panel added a Prevention Specialist staff position to assist the local efforts in child fatality prevention
- Annual CFR Coroner of the Year and CFR Committee of the Year winners were recognized by the Georgia Senate honoring their work
- The Office of Child Fatality Review merged with the Office of the Child Advocate for the Protection of Children

APPENDICES

CRITERIA FOR CHILD DEATH REVIEWS

Child Fatality Review Teams are required to review the deaths of all children under the age of 18 that meet the criteria for a coroner/medical examiner's investigation.

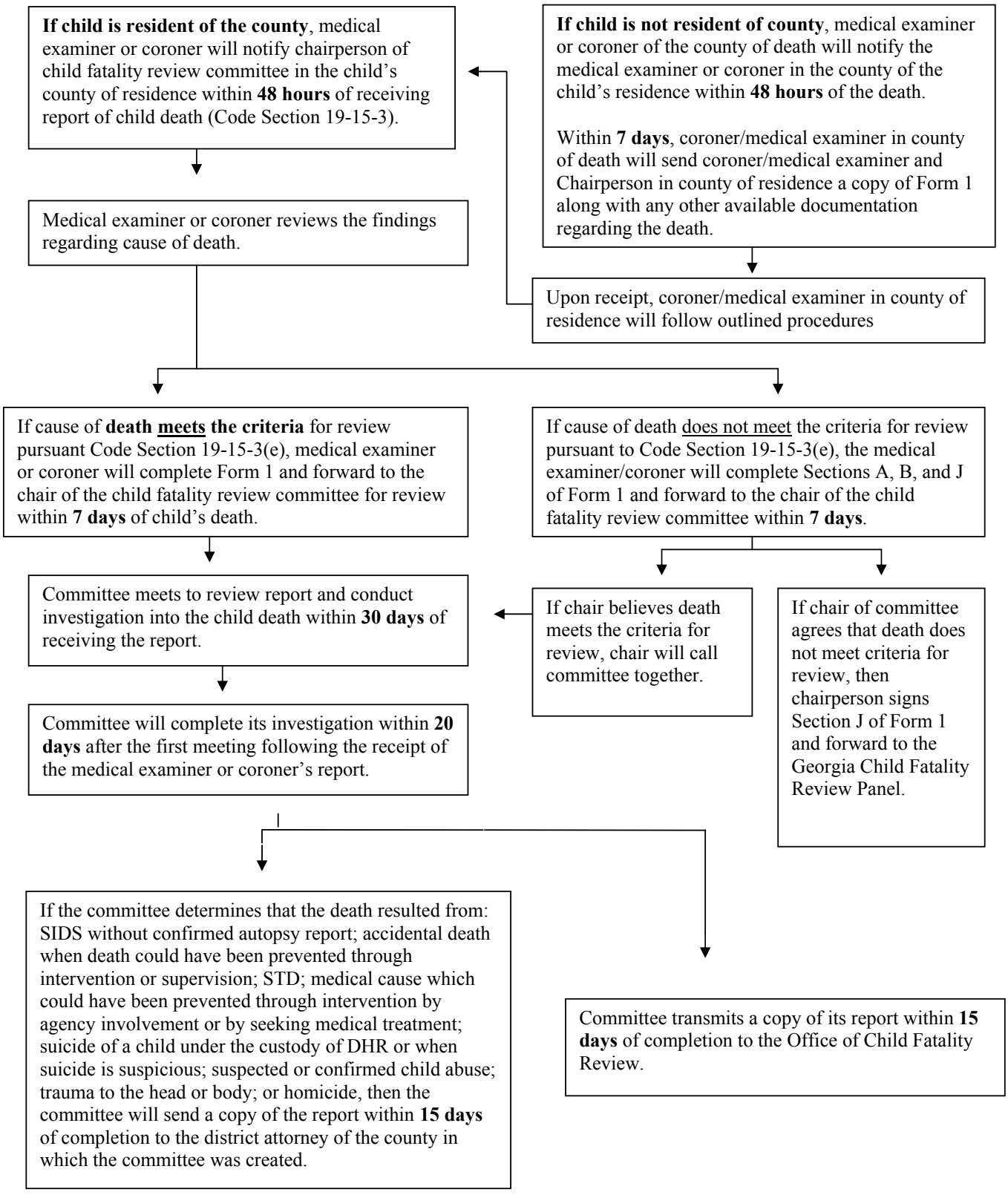
"Eligible" Deaths or Deaths to be Reviewed by Child Fatality Review Teams

The death of a child under the age of 18 must be reviewed when the death is ***suspicious, unusual, or unexpected***. Included in this definition are incidents when a child dies:

1. as a result of violence
2. by suicide
3. by a casualty (i.e. car crash, fire)
4. suddenly when in apparent good health
5. when unattended by a physician
6. in any suspicious or unusual manner, especially if under 16 years of age
7. after birth but before seven years of age if the death is unexpected or unexplained
8. while an inmate of a state hospital or a state, county, or city penal institution
9. as a result of a death penalty execution

APPENDIX B

Child Fatality Review Team Timeframes and Responsibilities



APPENDIX C1 -Total Child Fatalities Based on Death Certificate (N=1,825)								
Infant (Age<1)	Cause of Death	White Male	White Female	A-A Male	A-A Female	Other Male	Other Female	Total
	Fall	1	1		1			3
	Firearm		1					1
	Homicide	1	1	4	2			8
	Medical	251	186	290	226	9	3	965
	MVA	4	4	6	1			15
	OthInjury	1		2	1			4
	Poison	2						2
	SIDS	38	35	37	40			150
	Suffocation	6		2	5	1		14
	Unknown Intent	1						1
	Unknown	11	7	8	2	1	2	31
	Total	316	235	349	278	11	5	1194
Age 1 to 4	Cause of Death	White Male	White Female	A-A Male	A-A Female	Other Male	Other Female	Total
	Drowning	15	5	2				22
	Fire	3		4	3			10
	Firearm			1				1
	Homicide	2	2	7	5			16
	Medical	24	28	18	20	1	1	92
	MVA	13	7	7	1			28
	OthInjury	3			2			5
	Poison				1			1
	Suffocation	1	2	4				7
	Unknown Intent			1				1
	Unknown	3	3		4			10
	Total	64	47	44	36	1	1	193
Age 5 to 14	Cause of Death	White Male	White Female	A-A Male	A-A Female	Other Male	Other Female	Total
	Drowning	2		3				5
	Fall		1					1
	Fire		1	1	7			9
	Firearm	2						2
	Homicide	1	1	3	1			6
	Medical	32	23	34	24			113
	MVA	19	9	5	7	1		41
	OthInjury	7	3	1				11
	Poison	1						1
	Suffocation	1	1	1	1			4
	Suicide	2	1	1				4
	Unknown Intent			3	1			4
	Unknown	2	3		1			6
	Total	69	43	52	42	1	0	207
Age 15 to 17	Cause of Death	White Male	White Female	A-A Male	A-A Female	Other Male	Other Female	Total
	Drowning	3		7				10
	Fall	1						1
	Firearm			1				1
	Homicide	5	1	13	3			22
	Medical	21	19	17	15		1	73
	MVA	41	19	14	2	2		78
	OthInjury	6	3	2			1	12
	Poison	4	2					6
	Suffocation	1				1		2
	Suicide	11	4	4				19
	Unknown Intent	2		1				3
	Unknown	1	2	1				4
	Total	96	50	60	20	3	2	231

APPENDIX C2 -Total Reviewed Child Fatalities (N=594)								
Infant (Age<1)	Cause of Death	White Male	White Female	A-A Male	A-A Female	Other Male	Other Female	Total
	Homicide	1	1	3	3	1		9
	Medical	4	3	9	8	6		30
	MVA		1	2		1		4
	OthInjury			1				1
	SIDS	11	8	9	6	2	1	37
	Suffocation	4		5	7	4		20
	SUID	30	28	30	32	4	2	126
	Unknown	3	3	2	3		1	12
	Total	53	44	61	59	18	4	239
Age 1 to 4	Cause of Death	White Male	White Female	A-A Male	A-A Female	Other Male	Other Female	Total
	Drowning	16	3	1			1	21
	Fire	3		3	3			9
	Firearm			2				2
	Homicide	4	2	6	6		1	19
	Medical	3	4	4	6			17
	MVA	10	6	5	2	4		27
	OthInjury	1	1	1				3
	Suffocation	2	2	3	1			8
	Unknown	2	2	3	5	1		13
	Total	41	20	28	23	5	2	119
Age 5 to 14	Cause of Death	White Male	White Female	A-A Male	A-A Female	Other Male	Other Female	Total
	Drowning	2	1	3	1			7
	Fire		1	1	7			9
	Firearm		1			1		2
	Homicide	2	1	3	1			7
	Medical	4	3	8	6			21
	MVA	19	7	5	4	1	2	38
	OthInjury	2					1	3
	Poison	1						1
	Suffocation	1		2				3
	Suicide	2		3				5
	Unknown Intent				1			1
	Unknown		1					1
	Total	33	15	25	20	2	3	98
Age 15 to 17	Cause of Death	White Male	White Female	A-A Male	A-A Female	Other Male	Other Female	Total
	Drowning	1		6				7
	Fire	1						1
	Homicide	5	1	13	2			21
	Medical	2	2	6	4			14
	MVA	29	15	8	2	5	2	61
	OthInjury	2	1	1				4
	Poison	4	2					6
	Suffocation	1						1
	Suicide	11	3	5		1	1	21
	Unknown Intent	1						1
	Unknown		1					1
	Total	57	25	39	8	6	3	138

APPENDIX C3 - Reviewed Child Fatalities with Abuse/Neglect Findings (N=116)								
Infant (<1)	Cause of Death	White Male	White Female	Black Male	Black Female	Other Male	Other Female	Total
	Homicide	1	1	4	2	1		9
	Medical				2			2
	MVA		2	1				3
	OthInjury			1				1
	SIDS	1		3				4
	Suffocation	2		2	2	1		7
	SUID	3	3	6	5	1		18
	Unknown	1	1	2			1	5
	Total	8	7	19	11	3	1	49
Age 1 to 4	Cause of Death	White Male	White Female	Black Male	Black Female	Other Male	Other Female	Total
	Drowning	9	1					10
	Fire	2		1				3
	Firearm			2				2
	Homicide	3	3	5	5			16
	Medical	1						1
	MVA	4		3				7
	Suffocation	1						1
	Unknown		2	2				4
	Total	20	6	13	5	0	0	44
Age 5 to 14	Cause of Death	White Male	White Female	Black Male	Black Female	Other Male	Other Female	Total
	Drowning			1				1
	Fire		1					1
	Homicide		1	2	1			4
	Medical				2			2
	MVA	3	3	2	2			10
	Poison	1						1
	Total	4	5	5	5	0	0	19
Age 15 to 17	Cause of Death	White Male	White Female	Black Male	Black Female	Other Male	Other Female	Total
	Homicide		1	1				2
	Medical		1					1
	Suicide	1						1
	Total	1	2	1	0	0	0	4

APPENDIX C.4.A - Preventability for Reviewed Deaths with Suspected or Confirmed Abuse or Neglect (N=115)				
	Preventability			
Cause of Death	Not at All	Possibly	Definitely	Missing
Drowning		2	9	
Fire			3	1
Firearm			2	
Homicide	1	2	28	
Medical	2	3	1	
MVA		8	12	
OthInjury			1	
Poison			1	
SIDS		4		
Suffocation			8	
Suicide		1		
SUID		10	8	
Unknown		7	2	
Total	3	37	75	1

APPENDIX C.4.B - Preventability for Reviewed Deaths with No Suspected or Confirmed Abuse or Neglect (N=478)			
	Preventability		
Cause of Death	Not at All	Possibly	Definitely
Drowning	4	9	11
Fire		4	11
Firearm	1		1
Homicide	2	6	17
Medical	48	26	2
MVA	5	37	68
OthInjury	2	4	4
Poison			6
SIDS	19	14	
Suffocation	1	8	15
Suicide	3	15	7
SUID	25	67	16
UnkInt		1	1
Unknown	4	13	1
Total	114	204	160


Number of Reviewable Deaths 2006
Dade 0
Catoosa 5
Whitfield 5
Walker 5
Murray 5
Fannin 2
Union 2
Towns 0
Rabun 0
Gilmer 3
White 4
Habersham 5
Stephens 0
Lumpkin 2
Chattooga 3
Gordon 7
Pickens 2
Dawson 1
Banks 4
Franklin 1
Hart 2
Floyd 11
Bartow 2
Cherokee 7
Forsyth 7
Hall 8
Madison 0
Elbert 2
Jackson 6
Polk 3
Paulding 12
Cobb 33
Barrow 4
Gwinnett 33
Clarke 3
Oglethorpe 0
Haralson 2
Douglas 12
DeKalb 48
Fulton 43
Rockdale 5
Walton 2
Oconee 1
Wilkes 0
Lincoln 0
Carroll 9
Clayton 18
Newton 3
Morgan 1
Greene 2
Taliaferro 0
Columbia 4
Heard 0
Coweta 4
Fayette 2
Henry 6
Spalding 5
Butts 3
Jasper 0
Putnam 0
Warren 0
McDuffie 3
Richmond 15
Hancock 2
Glascock 0
Troup 4
Meriwether 0
Pike 0
Lamar 1
Monroe 2
Jones 4
Baldwin 2
Jefferson 0
Burke 5
Washington 1
Upson 1
Harris 1
Talbot 0
Crawford 0
Bibb 11
Twiggs 1
Wilkinson 0
Johnson 0
Jenkins 1
Screven 3
Taylor 1
Peach 2
Emanuel 4
Muscogee 11
Marion 1
Macon 1
Houston 8
Bleckley 2
Laurens 5
Treutlen 2
Candler 1
Bulloch 5
Effingham 5
Chattahoochee 0
Schley 0
Pulaski 1
Montgomery 1
Stewart 0
Webster 0
Sumter 1
Dooly 1
Dodge 1
Wheeler 1
Toombs 2
Evans 0
Bryan 1
Chatham 13
Wilcox 2
Tattnall 4
Quitman 0
Crisp 3
Telfair 1
Clay 1
Randolph 0
Terrell 1
Lee 4
Ben Hill 1
Jeff Davis 2
Appling 4
Long 2
Liberty 3
Turner 2
Calhoun 0
Dougherty 4
Worth 1
Irwin 1
Coffee 3
Bacon 1
Wayne 2
McIntosh 2
Tift 2
Early 1
Baker 2
Berrien 4
Atkinson 1
Pierce 1
Glynn 4
Miller 0
Mitchell 0
Colquitt 5
Cook 4
Ware 2
Brantley 0
Lanier 2
Seminole 0
Decatur 1
Grady 2
Thomas 2
Brooks 0
Lowndes 3
Clinch 0
Charlton 2
Camden 5
Echols 0

APPENDIX E

2006 Child Fatality Reviews, By County, By Age Groups

Appendix G presents county level data for the Child Fatality Review process in 2006. The data are presented for four age groups (infants less than one year old, children from 1 to 4 years of age, children 5 to 14, and teenagers 15 to 17 years). Four numbers are provided for each age group:

Total Deaths: The total number of deaths (all causes) for that age group. This number is generally based on Georgia death certificate data and only includes deaths to Georgia residents under the age of 18. This includes deaths of Georgia residents that occurred in other states and were reported back to Georgia Vital Records, but it does not include deaths of out-of-state residents that occurred in Georgia. The review committee of the child's county of residence has the responsibility of reviewing deaths. However, the residence determined by the committee may not match the residence reported on the death certificate. If the review committees identified any deaths that occurred to residents of other states and were coded as Georgia residents on the death certificates, then those deaths are not included in the child death statistics presented in this report.

Reviewable Deaths: The number of SIDS/SUID, unintentional, or violence-related deaths (reviewable deaths) according to the death certificate classifications. Although other deaths due to medical or natural causes may be eligible for review according to OCGA 19-15-3(e), SIDS deaths are explicitly required to be reviewed, and unintentional/violence related deaths should be reviewed as "sudden or unexpected deaths." Thus, this number represents a minimum number of deaths that should be reviewed. This is a subset of total deaths.

The death certificate is not a "perfect" determinant of reviewable deaths. For example, a death certificate may be filed with "R99" (undetermined) for the cause of death. The review committee may have autopsy or toxicology information that identifies a specific cause. If that is a medical cause, the review committee may not complete a review.

Reviewable Deaths Reviewed: The number of SIDS/SUID, unintentional, or violence-related deaths that were reviewed. This number is a measure of how well a county identified and reviewed the minimum number of appropriate deaths. This is a subset of the total "reviewable" deaths. However, there are several sources of error (or inconsistencies) in the county-level tables. The CFR committee may have access to additional information regarding the death, and the committee may reach a different conclusion regarding the cause of death.

Total Deaths Reviewed: This is the total number of child deaths in 2006 for which a Child Fatality Review Report was submitted. It includes deaths due to natural causes (other than SIDS) in addition to those deaths that were identified as eligible for review. This reflects the work of the committee within the county of residence identified from the death certificates.

One hundred fifteen (115) of 574 "reviewable" CY2006 deaths were not reviewed (in contrast, only five were not reviewed in 2004). There were also 43 reviewed deaths that could not be matched to a death certificate.

County	All Deaths					All Reviewable Deaths					Reviewable Deaths Reviewed					All Deaths Reviewed				
	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	To-tal
Appling	4		0	2	6	2		0	2	4	2		0	1	3	2		0	1	3
Atkinson	1		0		1	1		0		1	1		0		1	1		0		1
Bacon	1	1	0		2		1	0		1		1	0		1		1	0		1
Baker	1	1	0		2	1	1	0		2	1	1	0		2	1	1	0		2
Baldwin	3	2	1		6		2	0		2		1	0		1		1	1		2
Banks	2		2	1	5	2		1	1	4	2		1		3	2		2		4
Barrow	4	1	1	1	7	3		0	1	4	3		0	1	4	4	1	0	1	6
Bartow	10	2	0	4	16	1		0	1	2	1		0	1	2	3	3	0	1	7
Ben Hill	3		0		3	1		0		1	1		0		1	1		0		1
Berrien	3		1	1	5	2		1	1	4	2		1	1	4	2		1	1	4
Bibb	34	1	9	3	47	6		4	1	11	5		2		7	5		2		7
Bleckley		1	2		3			2		2			2		2		1	2		3
Brantley	1	1	0		2			0		0			0		0			0		0
Brooks	4		1		5			0		0			0		0			0		0
Bryan	1	1	2	1	5			0	1	1			0		0			0		0
Bulloch	4	2	2	1	9	1	1	2	1	5	1	1	2	1	5		2	2	1	5
Burke	6	2	2		10	2	2	1		5	2	2	1		5	3	2	2		7
Butts	4		1	1	6	2		0	1	3	2		0		2	2		0		2
Calhoun	1		0		1			0		0			0		0	1		0		1
Camden	5	3	1	1	10	2	2	0	1	5	2	2	0	1	5	3	2	0	1	6
Candler	1		0	1	2			0	1	1			0	1	1			0	1	1
Carroll	12	2	1	6	21	5	1	1	2	9	5	1	1	2	9	6	1	1	4	12
Catoosa	4	2	0	2	8	3	1	0	1	5	1	1	0	1	3	1	1	0	1	3
Charlton	4	1	0		5	1	1	0		2	1	1	0		2	1	1	0		2
Chatham	52	3	6	8	69	6	1	1	5	13	5	1	1	5	12	12	3	3	7	25
Chatta-hoochee	3		0		3			0		0			0		0			0		0
Chattooga	1		1	3	5			1	2	3			1	2	3			1	2	3
Cherokee	9	1	5	4	19	3		1	3	7	3		1	3	7	2		2	4	8
Clarke	7	2	0	1	10	1	1	0	1	3	1	1	0		2	4	1	0		5
Clay	1		0		1	1		0		1			0		0			0		0
Clayton	43	6	5	8	62	9	2	4	3	18	8	2	2	3	15	11	3	2	5	21
Clinch			0		0			0		0			0		0			0		0

County	All Deaths					All Reviewable Deaths					Reviewable Deaths Reviewed					All Deaths Reviewed				
Cobb	88	14	9	9	120	13	6	5	9	33	10	6	4	9	29	14	10	5	9	38
Coffee	10	2	0	1	13	1	2	0		3	1	2	0		3	3	2	0		5
Colquitt	7	1	1	3	12	2		0	3	5	2		0	3	5	1	1	0	4	6
Columbia	11	5	1	2	19	3		0	1	4	3		0		3	3	1	0		4
Cook	6		0	2	8	2		0	2	4	2		0	2	4	2		0	2	4
Coweta	9		3	1	13	1		2	1	4	1		2	1	4	2		2	1	5
Crawford			0		0			0		0			0		0			0		0
Crisp	4	1	0	1	6	2	1	0		3	2	1	0		3	2	1	0		3
Dade			0		0			0		0			0		0			0		0
Dawson			0	1	1			0	1	1			0	1	1			0	1	1
Decatur	2	1	1		4		1	0		1		1	0		1		1	1		2
DeKalb	76	20	16	17	129	14	11	9	14	48	11	7	7	9	34	14	9	9	12	44
Dodge	3		0	1	4	1		0		1	1		0		1	1		0	1	2
Dooly	1		0	1	2			0	1	1			0	1	1			0	1	1
Dougherty	18		1	2	21	2		1	1	4	2		1		3	5		1		6
Douglas	12	4	5	4	25	5	4	1	2	12	4	4	1	2	11	4	4	1	3	12
Early	2		1		3			1		1			1		1			1		1
Echols			0		0			0		0			0		0			0		0
Effingham	8	2	1	1	12	3	2	0		5	1	2	0		3	1	2	0		3
Elbert	2		2		4			2		2			2		2	1		3		4
Emanuel	4	1	1	4	10		1	1	2	4		1	1	2	4		1	1	2	4
Evans	1		0		1			0		0			0		0			0		0
Fannin		1	2		3		1	1		2		1	1		2		1	1		2
Fayette	2		1	2	5			0	2	2			0	2	2			1	2	3
Floyd	18	4	2	2	26	5	3	1	2	11	4	3	1	1	9	5	3	1	1	10
Forsyth	8	3	4	4	19		2	1	4	7		2	1	4	7		3	1	4	8
Franklin	2		0		2	1		0		1	1		0		1	1		0		1
Fulton	96	18	15	17	146	19	8	4	12	43	9	4	2	7	22	10	8	3	8	29
Gilmer	4	1	1	1	7	2		1		3	1		1		2	2		1		3
Glascock			0		0			0		0			0		0			0		0
Glynn	11	4	2	1	18		3	1		4		3	1		4		3	1		4
Gordon	8	1	2	1	12	3	1	2	1	7	1	1	2		4	2	1	2		5
Grady	2		1		3	1		1		2	1		1		2	1		1		2
Greene	3		0	2	5	1		0	1	2	1		0	1	2	2		0	2	4

County	All Deaths					All Reviewable Deaths					Reviewable Deaths Reviewed					All Deaths Reviewed				
Gwinnett	78	10	20	19	127	7	3	10	13	33	7	3	5	10	25	11	3	6	11	31
Habersham	5	1	1		7	3	1	1		5	3		0		3	3		0		3
Hall	21	2	1	5	29	1	2	0	5	8		1	0	2	3		1	1	2	4
Hancock	2		0	1	3	1		0	1	2	1		0		1	1		0		1
Haralson	4		1		5	2		0		2	2		0		2	2		0		2
Harris		1	0	1	2		1	0		1		1	0		1		1	0	1	2
Hart	2		2	1	5			1	1	2			1		1			1		1
Heard	2		0		2			0		0			0		0			0		0
Henry	12	4	4	6	26	2	2	1	1	6	2	2	1	1	6	2	2	2	2	8
Houston	18	3	2	4	27	2	2	2	2	8	2	2	1	2	7	3	2	1	2	8
Irwin	2		0		2	1		0		1			0		0			0		0
Jackson	10	3	2	1	16		3	2	1	6		3	2		5		3	2		5
Jasper	1		0		1			0		0			0		0			0		0
Jeff Davis	3		0		3	2		0		2	1		0		1	1		0		1
Jefferson	4	1	0		5			0		0			0		0			0		0
Jenkins	4		1		5			1		1			1		1	1		1		2
Johnson	1		0		1			0		0			0		0			0		0
Jones	4	1	1	2	8	2		0	2	4	2		0	2	4	2		0	2	4
Lamar	4		2		6	1		0		1	1		0		1	1		0		1
Lanier	1		2		3			2		2			2		2			2		2
Laurens	7	1	1	2	11	2	1	0	2	5	2	1	0		3	2	1	0		3
Lee	5		0	3	8	1		0	3	4	1		0	3	4	1		0	3	4
Liberty	14	2	1	1	18	1	1	0	1	3	1	1	0	1	3	1	2	0	1	4
Lincoln			0		0			0		0			0		0			0		0
Long	4		3		7			2		2			2		2			3		3
Lowndes	20	1	6	1	28	3		0		3	3		0		3	4		0		4
Lumpkin	1		1	1	3			1	1	2			1	1	2			1	1	2
Macon	3		0	1	4			0	1	1			0		0			0		0
Madison	3		0		3			0		0			0		0			0		0
Marion	1		0	1	2			0	1	1			0		0			0		0
McDuffie	4	1	0	1	6	1	1	0	1	3	1	1	0	1	3	1	1	0	1	3
McIntosh			1	1	2			1	1	2			1	1	2			1	1	2
Meriwether	1		0	2	3			0		0			0		0		1	0		1
Miller			0		0			0		0			0		0			0		0

County	All Deaths					All Reviewable Deaths					Reviewable Deaths Reviewed					All Deaths Reviewed				
Mitchell	2		0		2			0		0			0		0			0		0
Monroe	6		0		6	2		0		2	2		0		2	2		0		2
Montgomery	2		0	1	3	1		0	1	2			0	1	1			0	1	1
Morgan	1		0	1	2			0	1	1			0		0		1	0		1
Murray	4		1	1	6	3		1	1	5	3		1		4	3		1		4
Muscogee	46	4	3	2	55	6	1	2	2	11	6	1	1	2	10	12	1	1	2	16
Newton	20	2	2	3	27	2		0	1	3	2		0	1	3	3		1	1	5
Oconee	1		1		2			1		1			1		1			1		1
Oglethorpe			1		1			0		0			0		0			0		0
Paulding	18	6	1	5	30	4	5	0	3	12	4	5	0	3	12	4	6	1	2	13
Peach	5		2	1	8			1	1	2			1	1	2			1	1	2
Pickens	1		0	1	2	1		0	1	2			0		0			0		0
Pierce	5		0	2	7			0	1	1			0	1	1			0	1	1
Pike	3		0		3			0		0			0		0			0		0
Polk	4	1	2	1	8	1		2		3			2		2			2		2
Pulaski	1		1		2	1		0		1	1		0		1	1		1		2
Putnam	1		0		1			0		0			0		0			0		0
Quitman			0		0			0		0			0		0			0		0
Rabun			0		0			0		0			0		0			0		0
Randolph	1		0		1			0		0			0		0			0		0
Richmond	40	4	6	5	55	6	4	1	4	15	6	4	1	4	15	8	4	4	4	20
Rockdale	15		1	2	18	2		1	2	5	1		0	2	3	2		0	2	4
Schley			0		0			0		0			0		0			0		0
Screven	3	1	0		4	2	1	0		3	1		0		1	1		0		1
Seminole			0		0			0		0			0		0			0		0
Spalding	10		5		15	3		2		5	1		2		3	1		2	1	4
Stephens	2		0		2			0		0			0		0			0		0
Stewart	1	1	0		2			0		0			0		0			0		0
Sumter	4		2	1	7	1		0		1	1		0		1	2		1		3
Talbot	1	1	0		2			0		0			0		0		1	0		1
Taliaferro			0		0			0		0			0		0			0		0
Tattnall	7	1	3	2	13	3		0	1	4	2		0	1	3	2		0	1	3
Taylor		2	0		2		1	0		1		1	0		1		1	0		1
Telfair	6		0	1	7			0	1	1			0		0	1		0		1

County	All Deaths					All Reviewable Deaths					Reviewable Deaths Reviewed					All Deaths Reviewed				
Terrell	3		0		3	1		0		1	1		0		1	1		0		1
Thomas	8		0	1	9	1		0	1	2	1		0	1	2	1		0	1	2
Tift	7	1	0	1	9	1		0	1	2	1		0	1	2	1	1	0	1	3
Toombs	4	1	0	1	6		1	0	1	2			0		0			0		0
Towns			0		0			0		0			0		0			0		0
Treutlen	2		0		2	2		0		2	2		0		2	2		0		2
Troup	7	3	2	1	13	2		2		4	2		2		4	2		2	1	5
Turner	1	1	1	1	4			1	1	2			1		1			1		1
Twiggs	1		0		1	1		0		1	1		0		1	1		0		1
Union	4	1	0		5	1	1	0		2		1	0		1		1	0		1
Upson	4		0		4	1		0		1	1		0		1	2		0		2
Walker	10	1	3	2	16	4		0	1	5	2		0	1	3	2	1	0	1	4
Walton	6		1	2	9	1		0	1	2	1		0	1	2	1	1	0	1	3
Ware	6		1	2	9			1	1	2			1	1	2			1	1	2
Warren	1		0		1			0		0			0		0			0		0
Washington	1		1	1	3			0	1	1			0	1	1			0	1	1
Wayne	6	2	0		8		2	0		2		2	0		2		3	0		3
Webster	1		0		1			0		0			0		0			0		0
Wheeler			0	1	1			0	1	1			0	1	1			0	1	1
White	3	2	0	1	6	2	1	0	1	4	2	1	0	1	4	3	1	0	1	5
Whitfield	14	6	0	3	23	1	2	0	2	5		1	0	2	3		3	0	3	6
Wilcox	2	2	0		4	1	1	0		2	1	1	0		2	1	2	0		3
Wilkes			0		0			0		0			0		0			0		0
Wilkinson	1		0	1	2			0		0			0		0			0		0
Worth	4	1	0	1	6	1		0		1	1		0		1	1		0		1
Totals					1825					574					459					594
Percent Reviewable Deaths Reviewed = 80.0																				

Glossary of Terms

AA - African American
Asphyxia - the extreme condition caused by lack of oxygen and excess of carbon dioxide in the blood, produced by interference with respiration or insufficient oxygen in the air; suffocation.
Child Abuse and Neglect – an act, or failure to act, on the part of a parent or caretaker that results in serious physical or emotional harm, sexual exploitation, or death of a child
Child Abuse Protocol Committee - County level representatives from the office of the sheriff, county department of family and children services, office of the district attorney, juvenile court, magistrate court, county board of education, office of the chief of police, office of the chief of police of the largest municipality in county, and office of the coroner or medical examiner.
The committee is charged with developing local protocols to investigate and prosecute alleged cases of child abuse
Child Fatality Review Report - A standardized form required for collecting data on child fatalities meeting the criteria for review by child fatality review committees
Child Fatality Review Committee - County level representatives from the office of the coroner or medical examiner, county department of family and children services, public health department, juvenile court, office of the district attorney, law enforcement, and mental health, and prevention advocate
Drowning Deaths – Deaths that occur from water-related submersion and suffocation
Eligible Death - Death meeting the criteria for review including death resulting from SIDS, unintentional injuries, intentional injuries, medical conditions when unattended by a physician, while the child was an inmate or resident of a hospital or penal institution, or any manner that is suspicious or unusual
Firearms – any weapon that fires a high-velocity projectile, and includes rifles, pistols, revolvers, shotguns, handguns, and BB guns
Fire-Related Death – Death resulting from fire or burn-related injuries sustained in a fire, and includes deaths from smoke inhalation
Form 1 - A standardized form required for collecting data on all child fatalities by coroners or medical examiners
Georgia Child Fatality Review Panel - An appointed body of 17 representatives that oversees the county child fatality review process, reports to the governor annually on the incidence of child deaths, and recommends prevention measures based on the data
Homicide – A death caused by the intentional actions of another person
Injury - Refers to any force whether it be physical, chemical (poisoning), thermal (fire), or electrical that resulted in death
Intentional - Refers to the act that resulted in death being one that was deliberate, willful, or planned. It includes homicide and suicide
Medical Cause - Refers to death resulting from a natural cause other than SIDS.
Motor Vehicle-Related Death – incidents that include the occupants of a vehicle, pedestrians struck by motor vehicles, bicycles, and occupants or riders of any other form of transportation (ATV, go-carts, etc.)
Natural Cause - Refers to death resulting from an inherent, existing condition. Natural causes include congenital anomalies, diseases of the nervous system, diseases of the respiratory system, other medical causes and SIDS
"Other" Race - Refers to those of Asian, Pacific Islander, or Native American origin
"Other Injury" as Category of Death - Includes deaths from electrocution, heat-related injury, or the like (unless otherwise indicated)
Perpetrator - Person(s) who committed an act that resulted in the death of a child
Preventable Death - One in which with retrospective analysis it is determined that a reasonable intervention could have prevented the death. Interventions include medical, social, educational, legal, technological, or psychological actions
Reviewed Death - Death which has been reviewed by a local child fatality review committee and a completed Child Fatality Review Report has been submitted to the Georgia Child Fatality Review Panel
Risk Factor - Refers to persons, things, events, etc. that put an individual at an increased likelihood of dying
Sleep-Related Infant Death – all deaths to infants that occur while sleeping but have no medical cause. Included are SIDS, SUID, and all suffocation/asphyxia deaths resulting from a sleep environment
Suicide – Deaths that occur from the intentional taking of one's own life
Sudden Infant Death Syndrome (SIDS) - The sudden death of an infant under one year of age which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene and review of the clinical history. In this report, SIDS is not considered a "medical" cause of death
Sudden Unexplained Infant Death (SUID) - is a category used by child fatality review committees for deaths that appear to be SIDS but have other risk factors present that could have contributed to the infant's death
Trend - Refers to changes occurring in the number and distribution of child deaths. In this report, the actual number of deaths for each cause is relatively small for the purpose of statistical analysis, which causes some uncertainty in estimating the risk of death
Unintentional - Refers to an action that resulted in death which was not deliberate, willful, or planned


STATE OF GEORGIA
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