Georgia Child Fatality Review Panel

Executive Summary Report
2005 Calendar Year

Judge Edward Lukemire
Chairperson

Honorable Sonny Perdue
Governor

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Preface

In the United States, our social, economic, and political climates indicate that we are a nation in crisis. Divorce rates, unemployment, poverty, political scandals, and violence in homes, schools, and communities are all indicators of the crisis we face.

Georgians have not gone unscathed by the challenges occurring in our nation. We too are faced with poverty, single-parent households, domestic violence, child maltreatment, school violence, and lack of adequate health care. Too often, child fatality review teams witness the fallout of families in crisis—child deaths. Children are most vulnerable to societal ills and least able to protect themselves.

Healthy People 2010[1] is a Federal initiative aimed at improving the health and safety of families (see Appendix A). Some of the Healthy People 2010 Objectives are relevant to the work of child fatality review teams, and include:

- Increase the number of States where 100 percent of deaths to children aged 17 years and under that are due to external causes are reviewed by a child fatality review team
- Reduction of infant deaths related to preterm, sudden infant death syndrome and unexpected deaths
- Reduction of child deaths related to injuries, specifically the top three causes: motor vehicle crashes, drowning, and fires/burns
- Reduction of adolescent deaths related to injuries, specifically motor vehicle crashes, homicides and suicides
- Reduce maltreatment and maltreatment fatalities of children

These reductions aimed at protecting children must not involve intervention alone. Protecting children means creating environments that are not charged with everyday crises. Real protection means prevention. The spectrum of prevention provides us with tools to change organizational practices and influence policy and legislation. The collection of more complete and accurate data by child fatality review teams will allow for prevention efforts that are more population specific and goal oriented. We can do better. We must do better.

Summary

Each year, the Georgia Child Fatality Review Panel (Panel) publishes a report detailing the circumstances of death for children in Georgia. Child deaths are identified through death certificates filed by the Bureau of Vital Records of the Division of Public Health. Local Child Fatality Review (CFR) committees convene a review only for those deaths that are considered eligible for review by legislation, that is, those deaths that are unexpected, unexplained, or due to suspicious circumstances. The circumstances of each death are recorded on a standardized form which is the basis for the data analyses presented in the annual report. Analyses of these data create opportunities for identifying prevention strategies which, if implemented, could significantly reduce the number of children injured or killed each year.Death certificate data indicated a total of 1,723 deaths to children under the age of 18 in 2005.

Of those deaths:

- 529 met the criteria requiring review
- 479 of the 529 were reviewed by local child fatality review committees (91%)
- Committees reviewed an additional 144 child deaths with circumstances that were felt to warrant additional investigation
- Of those 144 additional deaths reviewed, 26 had no death certificate available
- In total, local CFR committees reviewed 623 child deaths that occurred in 2005

FINDING:

- Local CFR Committees determined that 82% of all reviewed child deaths were definitely or possibly preventable

Table 1: Preventability, All Reviewed Infant/Child Deaths, Georgia, 2005 (N=623)

	N	%
Definitely Preventable	265	42.7%
Possibly Preventable	245	39.5%
Not Preventable	110	17.7%
Missing information	3	
Total	623	

All Child Deaths

The number of child deaths in Georgia continues to show a slight decline from previous years.

1,794 deaths in 2003
1,760 deaths in 2004
1,723 deaths in 2005

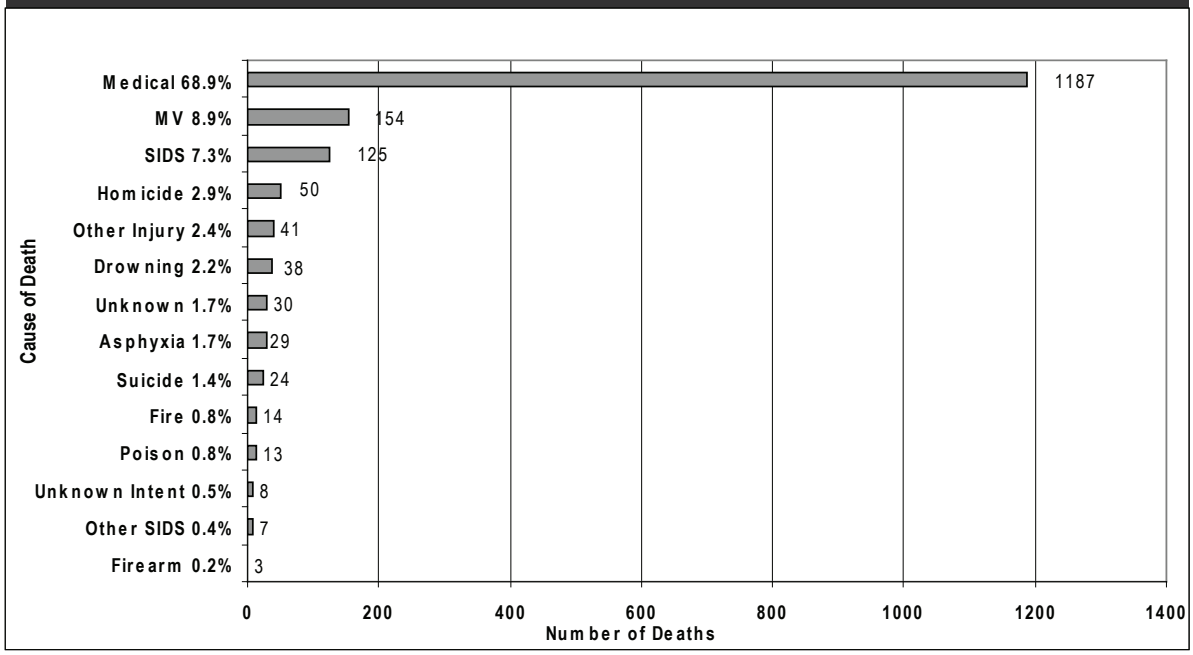
However, Georgia's child death rate of 73.2 (deaths per 100,000 children) continues to be higher compared to children living in other regions of the country.

According to an article in the December 2005 edition of the Pediatrics journal[2] (see Appendix A), the reasons for these regional disparities are complex and may be related to social, economic, political and other factors which affect poverty, quality early education, income disparities, homelessness, and access to quality nutrition and critical health services.

Death certificate data indicate a total of 1,723 child deaths in Georgia in 2005.

Of those:
- 65% were infants (1,124)
- Teens ages 15-17 accounted for the second largest age group of deaths (216)
- 860 were White children
- 793 were African-American children
- 70 were children of "Other" race

Figure 1: Deaths to Children Under Age 18 in Georgia, All Causes Based on Death Certificate, Georgia, 2005 (N=1723)



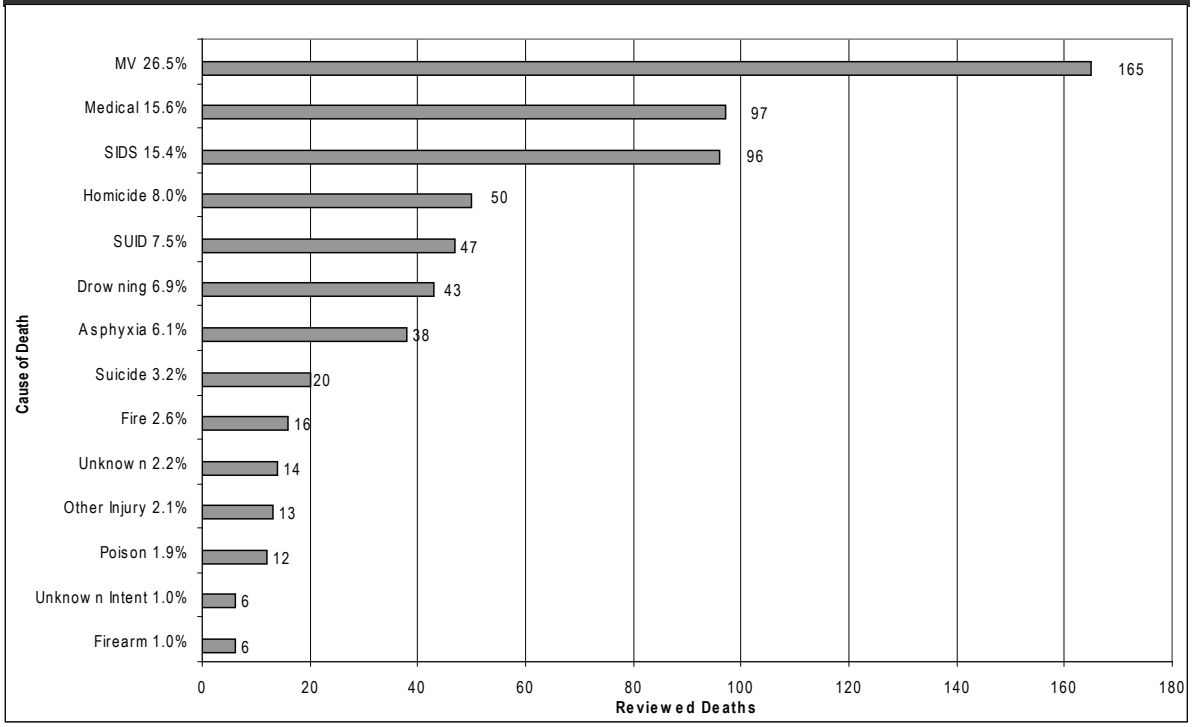
FINDINGS:
- 69% of all child deaths were due to medical causes (infants accounted for 78% of all medical deaths)
- Motor vehicle incidents were the second leading cause of death (154)

All Reviewed Child Deaths

The purpose of the child fatality review process is to analyze all aspects of a child's death using a multidisciplinary, multi-agency approach in a confidential forum. Local CFR committees reviewed a total of 623 child deaths that occurred in 2005.

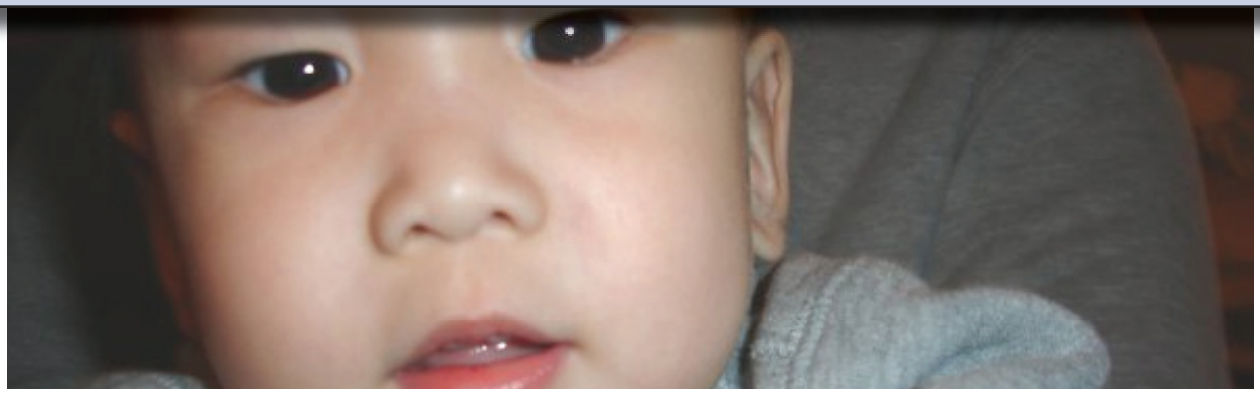
- More than one-third (231) of the total reviewed deaths were infants (younger than one)
- Teens ages 15-17, accounted for the second-largest age group of deaths (163)

Figure 2: Cause of Death, All Reviewed Infant/Child Deaths, Georgia, 2005 (N=623)



FINDINGS:

- Motor vehicle related incidents remain the leading cause of reviewed deaths for children
- Reviewed medical deaths increased in 2005, representing 15% of all reviewed deaths



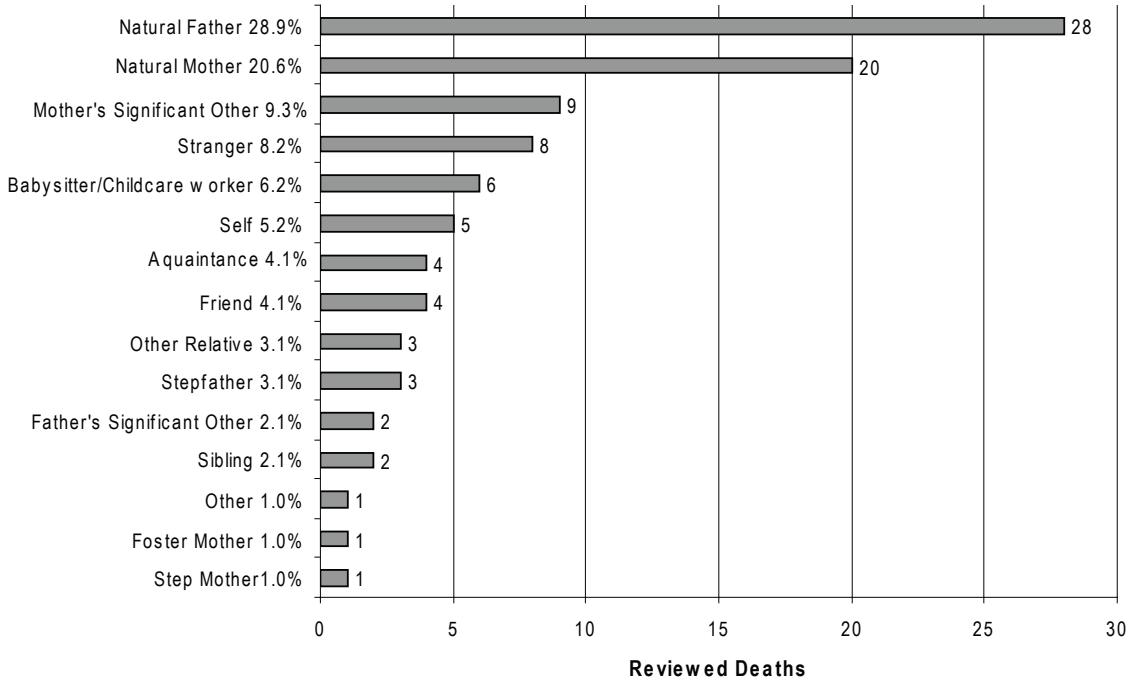
Child Abuse / Neglect Child Deaths

There are generally four recognized forms of child maltreatment: neglect, physical abuse, sexual abuse, and psychological or emotional maltreatment. Most victims of maltreatment are very young, with almost three-fourths being younger than 5 years old. Males and infants are more likely to be victims of abuse or neglect. Committees reviewed 136 deaths with abuse or neglect findings.

Of those:

- 85 were males and 51 were females
- 57 were infants
- 46 were toddlers ages 1 to 4
- 22 were youth/adolescents ages 5 to 14
- 11 were teens ages 15 to 17

Figure 3: Relationship of Perpetrator to Decedent in Reviewed Deaths with Abuse/Neglect Findings, Georgia, 2005



FINDINGS:

- 48 parents were identified as perpetrators in deaths with suspected or confirmed child abuse/neglect
- The mother's significant other (e.g., boyfriend or romantic partner) represented the third largest category of perpetrators

Child Abuse / Neglect Child Deaths (con't)

Table 2: Infant/Child Deaths with Prior Agency Involvement, by Abuse / Neglect Status*				
	Abuse and/or Neglect			
Agency	No	%	Yes	%
Court	64	13.2	20	14.7
Dept. of Juvenile Justice	39	8.0	11	8.1
Public Health	153	31.5	57	41.9
Dept. of Family & Children Svcs	155	31.9	72	52.9
Other	34	7.0	22	16.2

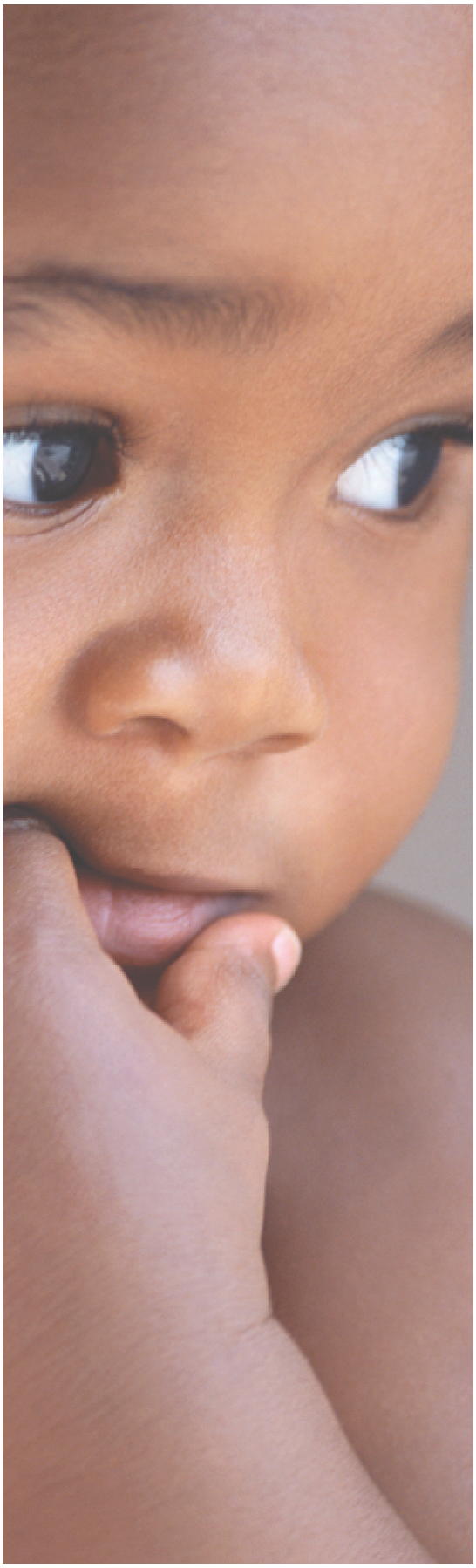
*A child or family was often involved with more than one agency; therefore, the number of involvements children/families had with agencies exceeded the number of abuse/neglect-related child deaths.

FINDINGS:

- 75% of children with abuse/neglect related deaths had prior agency involvement (an increase from 65% in 2004)
- 53% had involvement with DFCS
- 42% had involvement with Public Health

Opportunities for Prevention - Child Abuse/Neglect

1. Promote the less considered but critically important resources for child protection, such as faith-based communities, extended families, friends and neighbors, and other community resources that support families and guide parents in the proper care and nurturance of their children
2. Increase access and availability of substance abuse treatment programs. National research shows that nearly one-half of substantiated cases of child abuse and neglect are associated with parental alcohol or drug abuse



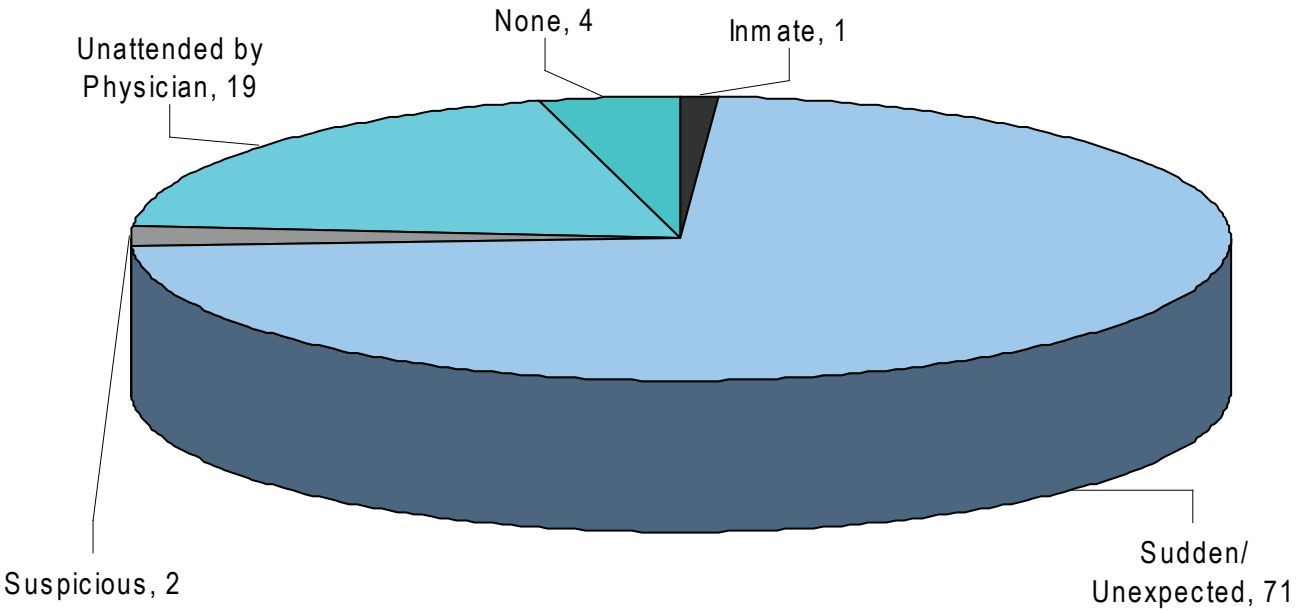
Reviewed Medical / Natural Child Deaths

Medical deaths are reviewable by child fatality review teams if the death occurs while unattended by a physician, in a suspicious or unusual manner, or occurs to an otherwise healthy child. There were 97 medical deaths reviewed by committees.

Of those:

- One-third of the reviewed medical deaths occurred among infants (32)
- Ages 5-14 were the second largest age group of deaths in this category (26)
- There were 51 reviews for White children
- 42 reviews for African- American children
- 4 reviews for children of "Other" races

Figure 4: Medical Deaths Reviewed by Review Criteria, Georgia 2005 (N=97)



FINDINGS:

- 73% of reviewed medical deaths were determined to be "sudden/unexpected"
- Of the 97 medical deaths, 19 died while in the hospital, and 8 died after being treated by a physician and released

Opportunities for Prevention - Reviewed Medical

1. Children should have regular visits with a health-care provider to check for any illnesses or abnormalities in wellness and development
2. School systems should enhance the quality and frequency of youth sports physicals to ensure more children are fully screened for potentially life-threatening conditions

Sudden Infant Death Syndrome (SIDS)
Sudden Unexplained Infant Death (SUID)

Infant mortality from SIDS (death of an infant that remains unexplained after an investigation, autopsy, and review of clinical history) has declined over the past few years, however SIDS, and now the use of the term SUID (a death that appears to be SIDS, but has possible contributing factors present), continue to be important issues to research, because they continue to be the number one cause of reviewed infant deaths in Georgia.

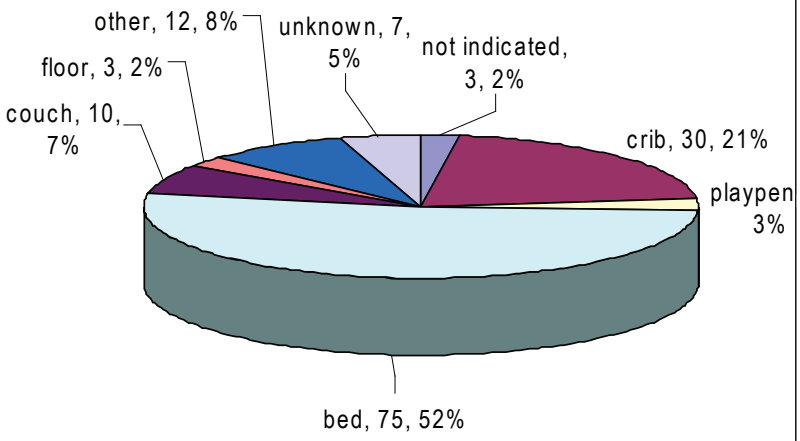
From a national perspective, SIDS occurs most often between 2 and 4 months and then declines, whereas in Georgia, SIDS deaths remain highest between 1 and 4 months of age. While we do not know the cause of SIDS, we do know that by eliminating known risk factors, we may increase the rate of infant survival. Risk factors include maternal smoking, illegal drug exposure, soft bedding, overheating, and sleeping on stomach.

In Georgia, sleep-related deaths are the number one cause of reviewed deaths to infants. During 2005, 143 infants died from SIDS or SUID, and included:

- 34% White males (49)
- 24% African-American males (35)
- 19% White females (27)
- 19% African-American females (27)
- < 1% children of "Other" races (5)

FINDING:
- The majority of infants who died were not sleeping in a crib, which is considered the safest sleep environment for infants

Figure 5: Location at Time of Death for Infants who Died of SIDS/SUID, 2005 (N=144)



Opportunities for Prevention - SIDS/SUID

1. Consider sleeping in the same room with the infant (co-sleeping) instead of in the same bed (bed-sharing), and promote the use of "co-sleepers" (infant beds designed to be attached to parents' beds while protecting the child's sleep safety). 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 (American Academy of Pediatrics Task Force on SIDS, 2005)
2. Avoid smoking during pregnancy

Unintentional Injury Related Child Deaths

Despite tremendous progress toward the reduction in unintentional injury-related child deaths, these types of injuries continue to remain the number one cause of death for children over age one, regardless of gender, race, or economic status. Each age groups exhibits unique characteristics which present different levels of risk and are associated with deaths to children.

- Infants were at higher risk of death from asphyxia
- 1-4 year olds were at higher risk of death from drowning and motor vehicle incidents
- 5-17 year olds were at higher risk of death from motor vehicle incidents

Unintentional injury-related death occurs among children of all ages and is often related to a child's developmental abilities as well as a parent's belief of their child's risk and actual ability (Safe Kids, 2003). Awareness and supervision by parent or caregiver is critical for young children to be safe and free from injury.

In this report, we have classified unintentional injury-related deaths into the following categories:

Motor Vehicle Incidents	Fire/Burn/Smoke Inhalation
Drowning	Other Injury
Asphyxia	Poisoning/Overdose
	Firearm

Motor Vehicle Related Child Deaths

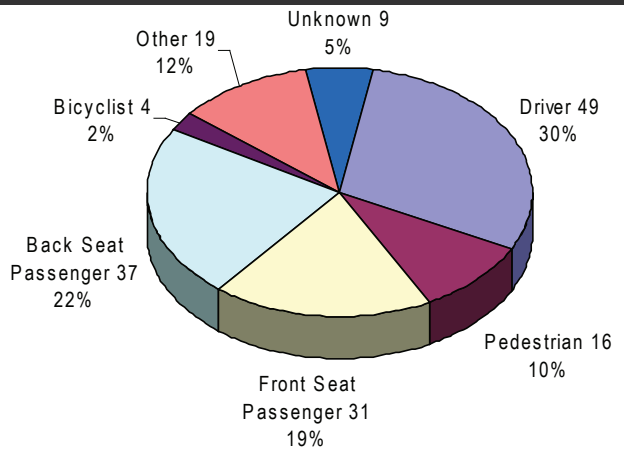
Motor vehicle related injuries account for the majority of deaths in children ages 1 to 17. In Georgia, motor vehicle related injuries claimed the lives of 165 children in 2005.

Of those:

- 89 were in the 15-17 age group (54%)
- 45 were in the 5-14 age group (27%)
- White males represented 42%
- White females represented 27%

We have done a good job reducing infant deaths in motor vehicles, but research shows more work is needed for older children. For children who were killed while outside of a vehicle, more deaths occurred as pedestrians (e.g., in a driveway) than as bicyclists. Though reduction of such injuries is challenging, it is possible with stricter legislation, enforcement, and public education.

Figure 6: Reviewed Motor Vehicle-Related Deaths by Location at Injury, 2005 (N=165)



FINDINGS:

- The most common vehicle location for children who died in motor vehicle incidents was the driver/operator position (30%)
- Some examples of "Other" motor vehicle incident locations include: back of a pick-up truck, back of a motorcycle, skateboard, and sitting on the lap of another person

Table 3: Demographics of Reviewed Motor Vehicle Crash Deaths, 2005 (N = 165)

	Category	Number	%	Rate (per 100,000)
Age	Infant	5	3.0%	3.5
	1 to 4	26	15.8%	4.7
	5 to 14	44	26.7%	3.4
	15 to 17	90	54.5%	23.3
Race/ Gender	White Male	70	42.4%	9.5
	White Female	45	27.3%	6.5
	African-American Male	24	14.5%	5.8
	African-American Female	15	9.1%	3.7
	Other Male	6	3.6%	10.6
	Other Female	5	3.0%	9.3

FINDINGS:

- Older adolescents ages 15-17 had the highest rate of motor vehicle related deaths (23%); they were almost 7 times more likely to have a motor vehicle related death than the age group of the lowest rate (5-9 year olds)
- White children made up 70% of all motor vehicle related deaths involving children
- Males made up 61% of motor vehicle related child deaths

Opportunities for Prevention - Motor Vehicle

1. Pedestrian safety must incorporate proper supervision, overall education for children and immediate caregivers, and environmental changes incorporating sidewalks on heavily traveled roadways
2. Continue state-supported child safety seat distribution programs to help families in need
3. Aggressive fines for teenage drivers who do not buckle up and for parents of unrestrained children
4. Advocate for residential speed bumps

Drowning Related Child Deaths

In 2005, 43 children died from drowning, which continues to be the second leading cause of unintentional injury death for all children older than one year. Drowning deaths occurred as frequently as motor vehicle related deaths in children ages 1 to 4 years. Most drowning related child deaths occurred when children were unsupervised momentarily and have access to bodies of water (inadequate barriers). Of the 43 drowning related child deaths:

- 19 occurred in private pools
- 18 occurred in natural bodies of water
- 3 occurred in bathtubs
- 3 occurred in other locations

Table 4: Demographics of Reviewed Motor Vehicle Crash Deaths, 2005 (N = 165)

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Race/ Gender	White Male	70	42.4%	9.5
	White Female	45	27.3%	6.5
	African-American Male	24	14.5%	5.8
	African-American Female	15	9.1%	3.7

FINDINGS:

- 61% of drowning deaths occurred among children 1-4 years of age
- Committees determined that in 18 of the 26 drowning deaths for 1-4 year olds, the children were inadequately supervised (suggesting that 8 children who drowned were properly supervised at the time of death)

Opportunities for Prevention - Drowning

- Increase environmental health staffing positions to provide inspections on residential and commercial pools for fencing violations in order to comply with local ordinances that require fences and gate locks
- Mandate that all pools, including hot tubs, be installed with a safety device such as a water motion sensor as part of the pool inspection process, furnish all pool owners with the proper replacement drain covers in order to help prevent entrapment

Unintentional Asphyxia Related Child Deaths

In Georgia, 38 children died from unintentional asphyxia related deaths. Most unintentional asphyxia related child deaths are caused by overlay, positional asphyxia, choking, confinement, or strangulation. For infants, asphyxia may occur during bed sharing if another person rolls over on the infant or if the infant is sleeping on a surface where they may get wedged and cannot breathe. For older children, asphyxia related deaths occur commonly with choking games, strangulations, and/or unintentional hangings. These types of deaths are definitely preventable and can be decreased through education of younger children who may be unaware of potential risks, improvement of infant sleep environments, and encouraging open communication with older teenagers.

Table 5: Demographics of Reviewed Asphyxia Deaths, 2005 (N = 38)

	Category	Number	%	Rate (per 100,000)
Age	Infant	28	73.7%	19.6
	1 to 4	5	13.2%	0.9
	5 to 14	5	13.2%	0.4
Race/ Gender	White Male	9	23.7%	1.2
	White Female	6	15.8%	0.9
	African-American Male	10	26.3%	2.4
	African-American Female	10	26.3%	2.5
	Other Male	3	7.9%	-

FINDINGS:

- Infants were most at risk for asphyxia related deaths
- African-American children accounted for more than 50% of all asphyxia related child deaths, and had higher rates than the other race/gender groups
- 58% of asphyxia related child deaths occurred among males

Opportunities for Prevention – Unintentional Asphyxia

1. More consistent and widely-disbursed safe sleep messages
2. Infants should be placed to sleep in a safety approved crib with a firm mattress and tightly fitted sheet
3. Children and parents should be educated regarding the dangers associated with any games that restrict the intake of oxygen

Fire Related Child Deaths

During 2005, 16 children died in Georgia from fire related deaths, including burns and smoke inhalation. Fire related deaths accounted for 40 child deaths in 2004, almost 2.5 times higher than in 2005.

In the last decade, fire related child deaths have been as high as 53 in 1996 and as low as 10 in 1999. While one fire related child death is too many, Georgia has begun doing great work in the area of prevention in fire related deaths. One such effort involved a grant received by Safe Kids Georgia from the Federal Emergency Management Agency to help assess and conduct a smoke alarm installation program in four counties to analyze specific geographic areas of risks for residential fire related deaths. Also, Georgia's DHR Injury Prevention Section received a grant from CDC to coordinate residential fire safety prevention programs in 25 areas across the state and 5000 homes were visited to provide information on proper installation of smoke alarms.

Table 6: Demographics of Reviewed Fire Deaths, 2005 (N = 16)

	Category	Number	%	Rate (per 100,000)
Age	Infant	2	12.5%	1.4
	1 to 4	8	50.0%	1.5
	5 to 14	6	37.5%	0.5
Race/ Gender	White Male	1	6.3%	0.1
	White Female	4	25.0%	0.8
	African-American Male	10	62.5%	2.4
	African-American Female	1	6.3%	0.2

FINDINGS:

- More African-American males died from fire related incidents than any other race/gender group (63%), and had the highest rate compared to the other race/ gender groups
- Although toddlers aged 1 to 4 accounted from 50% of the fire related deaths, their risk of fire related death was equivalent to that of infants (rates of 1.5 and 1.4, respectively)
- There were no reviewed fire-related deaths for 15-17 year olds

Opportunities for Prevention - Fire

1. Address known risk factors, such as non-working smoke alarms and lack of a fire escape plan
2. Store matches and lighters out of children's reach and supervise use of candles

Intentional Injury Related Child Deaths

Younger children are more often intentionally injured at home or during domestic violence incidents between their parents/caregivers, while older children and teens are more often injured outside of the home during arguments with siblings or peers (acquaintances), or may injure themselves as a result of depression or recent difficulties. Males are more likely to be both perpetrators and victims of intentional injury (homicide and suicide). Females are more likely to threaten or attempt injury to themselves or others but less likely to become victims or perpetrators. Firearms are most often used as the mechanism of intentional injury, partly due to their easy access among children

Homicide Child Deaths

The U.S. has the highest homicide rate for children of any industrialized nation in the world. In Georgia, homicide is the leading cause of injury-related death for infants (67% higher than the number of motor vehicle deaths to infants). Young children are generally murdered via abandonment, starvation, asphyxia, drowning, strangulation, or beating. They are more likely to die at the hands of parents, siblings, friends or acquaintances, or other family members, rather than strangers. Older children and teens are more likely to be killed by friends, acquaintances, and strangers. While gang violence is less prevalent in smaller towns, it remains a problem in urban areas and is usually attributed to fear and retaliation, often involving unidentified assailants. While school-related homicides have received substantial attention in the media, they still remain relatively rare events.

Table 7: Demographics of Reviewed Homicide Deaths, 2005 (N = 50)

	Category	Number	%	Rate (per 100,000)
Age	Infant	8	16.0%	5.6
	1 to 4	15	30.0%	2.7
	5 to 14	7	14.0%	0.5
	15 to 17	20	40.0%	5.2
Race/ Gender	White Male	9	18.0%	1.2
	White Female	4	8.0%	0.6
	African-American Male	30	60.0%	7.3
	African-American Female	7	14.0%	1.7

FINDINGS:

- Of the 50 child homicides reviewed, 40% were among older teens (20). Infants and 5-14 year olds had the lowest percentage of homicides (16% and 14%, respectively)
- There were 30 homicides among African-American males (60%), and only 4 homicides (8%) among White females
- Of the highest-risk group of homicides (African-American males), 50% occurred among older teens (15). There were no reviewed homicides among children of Other races
- Firearms were used in 23 of the 50 homicides reviewed

Opportunities for Prevention - Homicides

1. Make efforts to address and reduce risk factors that increase the likelihood of child homicide, including: child abuse and/or neglect, domestic violence, poverty, inequality, unemployment, criminal activity, the use of drugs and/or alcohol, and the availability of weapons
2. Teach conflict resolution and anger management to young children, teens, and parents to reduce the likelihood of violent or deadly confrontations

Suicide Child Deaths

In the United States, more than four times as many male youth die by suicide, but females attempt suicide more often and report higher rates of depression. Youth are much more likely to think about and attempt suicide if they are depressed. Younger children may be less likely to complete suicide because they do not have the cognitive ability to plan and carry out a suicide attempt, but research also suggests that the increase in suicide rates among younger children may be due to increased exposure to critical risk factors, such as serious depression, drugs and alcohol. Studies have found that for younger children exposed to such risk factors, the suicide rate is similar to that for older teens.

Table 8: Demographics of Reviewed Suicide Deaths, 2005 (N = 20)

	Category	Number	%	Rate (per 100,000)
Age	5 to 14	6	30.0%	0.5
	15 to 17	14	70.0%	3.6
Race/ Gender	White Male	12	60.0%	1.6
	White Female	1	5.0%	0.1
	African-American Male	6	30.0%	1.5
	African-American Female	1	5.0%	0.2

FINDINGS:

- Of the 20 child suicides reviewed, 70% were among older teens (14). Five to 14 year olds made up the other 30% of reviewed suicides (6)
- Males were at higher risk for suicide than females
- Of the highest-risk group of suicides (White males), 50% occurred among the 15-17 year old age group (10)
- There were no reviewed suicides among children of Other races

Opportunities for Prevention - Suicide

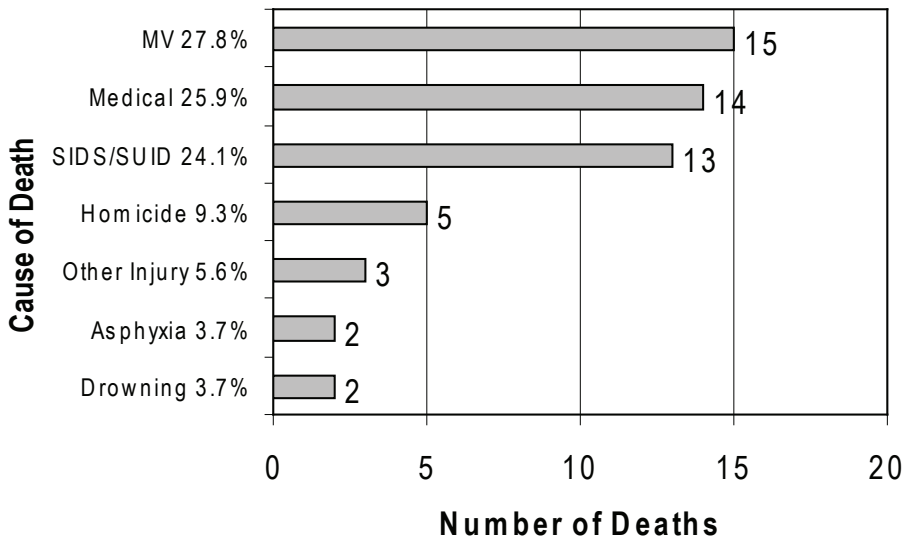
1. Become aware of risk factors of suicide: impulsive or aggressive behavior, use of alcohol or drugs, family instability or significant family conflict, talk of suicide, and exposure to another suicide
2. Open talk and genuine concern are a source of relief and key elements in preventing the immediate danger of suicide. Talking about suicide does not create or increase risk; it actually reduces it
3. Provide affordable mental health care for youth

Child Deaths Among Hispanic Population

Children's health depends on a wide range of factors, including the family's economic circumstances, access to health care, and knowledge of children's health care needs and how to address them. The correlation between a family's socio-economic status and child health and development is well documented.

The 2005 Kids Count Data Book reports that African-American and Hispanic children are more likely to live in poverty than are White children. In 2005, 29% of Hispanic and 36% of African American children were living in families with incomes below the Federal poverty level, compared to 11% of White children.

Figure 7: Reviewed Hispanic Deaths by Cause of Death, 2005 (N=54)



FINDING:

- Among deaths eligible for review, motor vehicle incidents were the leading cause of deaths for Hispanic children

Opportunities for Prevention - Hispanic Population

1. Make English language classes more accessible at health and human service sites (i.e., Health Departments and Family and Children Services) to facilitate teaching relevant health and safety information

Georgia Child Fatality Investigation Program

The Georgia Child Fatality Investigation Team (CFIT) Program, administered through the Georgia Child Fatality Review Panel, in collaboration with the Georgia Bureau of Investigation and the Department of Family and Children Services, was founded 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. These teams immediately respond and share information from the point of the child's death.

In 2005, 623 child deaths were reviewed by Child Fatality Review teams. Fifty of those deaths were deemed to be homicides by Review Teams. Therefore, given that nearly 1 child a week is a victim of homicide in Georgia, the need for the best quality in investigations seems apparent.

Members of a team recently participated in a multi-agency advanced training after noting serious problems within the jurisdiction with multi-agency communication. Data were kept over a three-year period in the jurisdiction and reflected that in 2005, the district attorney was only notified timely in one of seven deaths in which the team should have been activated. The problem continued in 2006, with the district attorney's office being notified timely of only one death out of eight. Subsequent to the group's re-training late in 2007, which included law enforcement, representatives of the district attorney's office and DFCS, team members reported that they felt more comfortable communicating with one another and found it useful to specifically address issues with the team approach in their jurisdiction. They further noted an appreciation for hearing the perspectives of team members from different disciplines. Subsequent to the training, this team reported timely notification of the district attorney on a case involving a surviving victim of potentially lethal abuse.

Utilizing 2005 CFR data from two jurisdictions, one employing a team approach, and one employing the traditional approach, participation in scene investigation was reviewed. An interview of the member jurisdiction was also performed by the CFIT program. The data gleaned from the report and interview revealed that in the jurisdiction employing a team approach, the team activated and then continued to communicate in every case of child death encompassed by their protocol, a total of thirteen cases in 2005. In the jurisdiction utilizing a traditional approach only law enforcement was the only agency reporting to every scene. By including the district attorney early in investigations, team-based jurisdictions can benefit from expert legal advice as well as practical information on securing a conviction beyond making an arrest. By including DFCS, teams can benefit from the family histories already available with the agency from prior contact in many cases. Further, DFCS investigators are uniquely qualified to interview surviving siblings and collaterals. A multi-disciplinary team approach facilitates better communication, more thorough information gathering, and a more complete investigation.

For more detailed information, please visit our website (after January 1, 2008) at:

www.gacfr.dhr.georgia.gov

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Appendix A
References & Glossary

References

1. U.S. Department of Health and Human Services. *Healthy People 2010*. 2nd ed. *With Understanding and Improving Health and Objectives for Improving Health*. 2 vols. Washington, DC: U.S. Government Printing Office, November 2000
2. Jeffrey Goldhagen, MD, MPH, et al. *The Health Status of Southern Children: A Neglected Regional Disparity*. PEDIATRICS Vol. 116 No. 6 December 2005

Glossary

CDC – Centers for Disease Control and Prevention

CFIT – Child Fatality Investigation Team, a collaboration among agencies involved with the Georgia Child Fatality Investigation Program

DHR – Georgia Department of Human Resources

SIDS - The sudden death of an infant under 1 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

SUID – sudden, unexplained death of an infant under 1 year of age, in which investigation, autopsy, medical history review, and appropriate laboratory testing fails to identify a specific cause of death

We would like to thank Our Partners…

Local Child Fatality Review Committee Members in all 159 Counties

Department of Human Resources (DHR)
- The Office of Health Information Policy (OHIP)
- The Division of Family and Children Services (DFCS)
- The Office of Vital Records
- The Public Health Injury Prevention Section
- The Public Health Epidemiology Section

Emory University
Rollins School of Public Health
Department of Epidemiology
Dr. John T. Carter, Chief Epidemiologist

RECOMMENDATIONS

For Policy Makers

1. Provide sufficient funding to the Georgia Child Fatality Review Panel to fulfill statutory requirements which include annual statewide training, providing sufficient informational technologies for data analyses and sharing among state agencies, child death report reviews, and consultation with counties as indicated
2. Require an autopsy, including toxicology analysis, for every death of a child under the age of seven with the exception of a child who is known to have died of a disease process while attended by a physician. Further, require complete skeletal X-ray (following established pediatric and radiological protocol) of the bodies of children who died before their second birthday. Fully fund aforementioned requirements
3. Require local units of government to adopt and enforce pool-fencing regulations
4. Require local units of government to adopt and enforce regulations requiring smoke alarm installation and maintenance in rental properties
5. Provide sufficient funding to state Fire Marshals Office to offer fire safety education for young children at the local level
6. Amend current Graduated Driver Licensing to place restrictions on the number of passengers under the age of 21 allowed in vehicles driven by teens during the first two years of licensure
7. Enhance the Safe Place for Newborns Act to allow for increased accessibility, improved publicity and marketing, and elimination of the identification requirement
8. Require more comprehensive physical exams for all youth athletes, and enhanced the mental health services for all youth

For Parents and Caregivers

1. Supervise all children under ten years of age in and around cars at all times
2. Infants should be placed to sleep on their backs and in a safety approved crib with a firm mattress
3. Install smoke alarms on every floor and outside all sleeping areas of your home
4. When you are near any body of water, always designate one responsible adult to keep sight of the children at all times
5. Make sure all guns are stored locked and unloaded at all times

For Agencies

1. **DFCS:** Make ongoing visits to the surviving children in a home after a child had died due to parental or caretaker neglect or aggression. Ongoing visits for a minimum of three months can help assess their safety and well-being, and enable referrals to appropriate services
2. **Public Health:** Continue the statewide campaign to promote awareness and practice of safe infant sleep environments, specifically the crib matching program and culturally appropriate media initiative
3. **Coroners and Medical Examiners:** Continue conducting death scene investigations for any child death that is suspicious, unexpected, and/or unexplained