GEORGIA CHILD FATALITY REVIEW PANEL

Annual Report - Calendar Year 2011

C. LaTain Kell, Sr.
Chairman

Nathan Deal
Governor

DECEMBER 2012

Georgia Child Fatality Review Panel
Annual Report
Calendar Year 2011

Nathan Deal, Governor

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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 acknowledges the following people and entities whose enormous commitment, dedication, and unwavering support to child fatality review have made this report possible:

- 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, M.P.H., Maternal and Child Health Program Epidemiologist, Georgia Department of Public Health;
- All public and private agencies that have so willingly collaborated with The Office of the Child Advocate and provided support; and
- All the public and private entities dedicated to the safety and well-being of children.

We would also like to thank the 2011 Child Fatality Review Committee of the Year and the 2011 CFR Coroner of the Year for their support and dedication to the children of Georgia:

Coroner of the year: Nickie Stockel – Deputy Coroner, Forsyth County
County CFR Committee of the year: Gwinnett County Child Fatality Review Committee

This report was developed and written by staff members of the Office of the Child Advocate: Arleymah Raheem Gray, Malaika Shakir, Tomia White, Crystal Dixon, Ryan Sanford, and Ken Perrin.

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Georgia Child Fatality Review Panel

Honorable Governor Nathan Deal and Members of the Georgia General Assembly:

On behalf of the Georgia Child Fatality Review Panel, it is my honor to present to you the 2011 Annual Report. This report summarizes the Panel's analysis of child deaths occurring in Georgia during the past calendar year.

The Panel takes seriously its statutory duty of promoting effective prevention measures and reviewing child deaths in the state with the primary focus on prevention. With the assistance of the Office of the Child Advocate and its talented and capable staff, the Panel has reviewed case files and has analyzed trends for future recommendations.

As in past years, the Panel has continued to focus on preventable child deaths in the areas of 1) unrestrained child passengers, 2) accidental child shootings, 3) child drownings, and 4) co-sleeping deaths. Future programs will continue to emphasize these areas. In addition, child maltreatment-related deaths and accuracy in the reporting of such deaths continue to be a priority with the Panel and with agencies and entities associated with the Panel.

Thank you for your review of this report and for your continuing interest in this critical work. Your ongoing support is essential to the task of reducing the number of preventable child deaths in Georgia in the coming year and in years to come.

We ask for your continued support for funding that is so essential to the work of this Panel and for the accurate collection and analysis of the data that are so vital to its function. With your help, the Child Fatality Review Division of the Office of the Child Advocate will continue its work strengthening the policies and protocols that will reduce child deaths in Georgia.

Sincerely,

Judge Tain Kell, Chair

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Practical Applications For This Report

Suggestions for Data Use:

Child Fatality Review (CFR) data can be very helpful for everyone. It is our hope that as you review the state level data summary, that it will encourage you to seek out opportunities to educate others about the continual need we have to protect our children. CFR data can be broken down to the state, regional, or county levels and be an effective means to educate others. The data can be used for summary reports, overall disposition of child deaths, policy informational briefs, or general education. Education for agency staff, policy makers, and general public can be an important too when you are trying to seek out funding sources, partnerships, and volunteer support. Some of the ways the data in this report can be shared with others:

- Develop talking points for your local media outlets, agency newsletters, or bulletins
- Share specific risk factors with your staff or colleagues who serve children, to raise their awareness of the issues
- Encourage your local leaders to read the report and address any needed policy changes
- Support the education of students by including information on specific risk factors in curricula, and facilitate regular discussions of safety habits
- Realize opportunities for prevention and education are all around you, and many people may not be aware of the trends in child deaths

If you would like the Office of the Child Advocate to prepare specific data for your county or area of expertise, please contact us so we may begin working with you. You are a critical partner in our mission to protect Georgia's children.

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Executive Summary

The Georgia Child Fatality Review Panel publishes a report each year that details the circumstances of death for children under the age of 18 that are deemed reviewable based on established standards in Georgia. Child deaths are identified through death certificates that are filed by the Office of Vital Records of the Department of Public Health. Supplemental notifications are also provided by other agency sources.

The deaths that are eligible for review are deaths that are unexpected, unexplained or are due to suspicious circumstances. The deaths are reviewed on the local level by Child Fatality Review Committees. In accordance with O.C.G.A § 19-15-3 (b), these committees are comprised of the county medical examiner or coroner, the district attorney, a representative of the Division of Family and Children Services, a local law enforcement representative, the sheriff or county police chief, a juvenile court representative, a county board of health representative and a county mental health representative.

Committee members represent agencies that may have been involved in some manner with the deceased child or the family of the deceased child. The expertise of the members of the committee are vital to conducting a thorough investigation of the circumstances surrounding the child's death.

The circumstances of each death are recorded using a standard surveillance form. The staff members of the Office of the Child Advocate along with the Georgia Child Fatality Review Panel use the data collected in this process to identify opportunities for prevention of future child deaths. The Office of the Child Advocate has one full-time staff member who is solely dedicated to prevention of future child deaths. The prevention specialist works with all counties throughout the State of Georgia.

Due to the fact that the Office of Vital Records did not have a complete data set for 2011 deaths available at the time of publication of this report, the information contained in this report is based solely on the 495 deaths that were reviewed by the CFR committees.

All Reviewed Child Deaths

The death of a child is a devastatingly tragic loss not only for families and loved ones but for the broader community as well. Every unfortunate loss leaves behind a story and far too many of these stories tell of mistakes made and opportunities missed. These stories guide us on the path to saving lives by helping us better understand how we can improve as parents, caregivers, policy makers, practitioners, advocates and legislators. In Georgia, local committees are commissioned with the extraordinary task of reviewing each of these child deaths so that we can work collectively to ensure the health and safety of our youngest citizens.

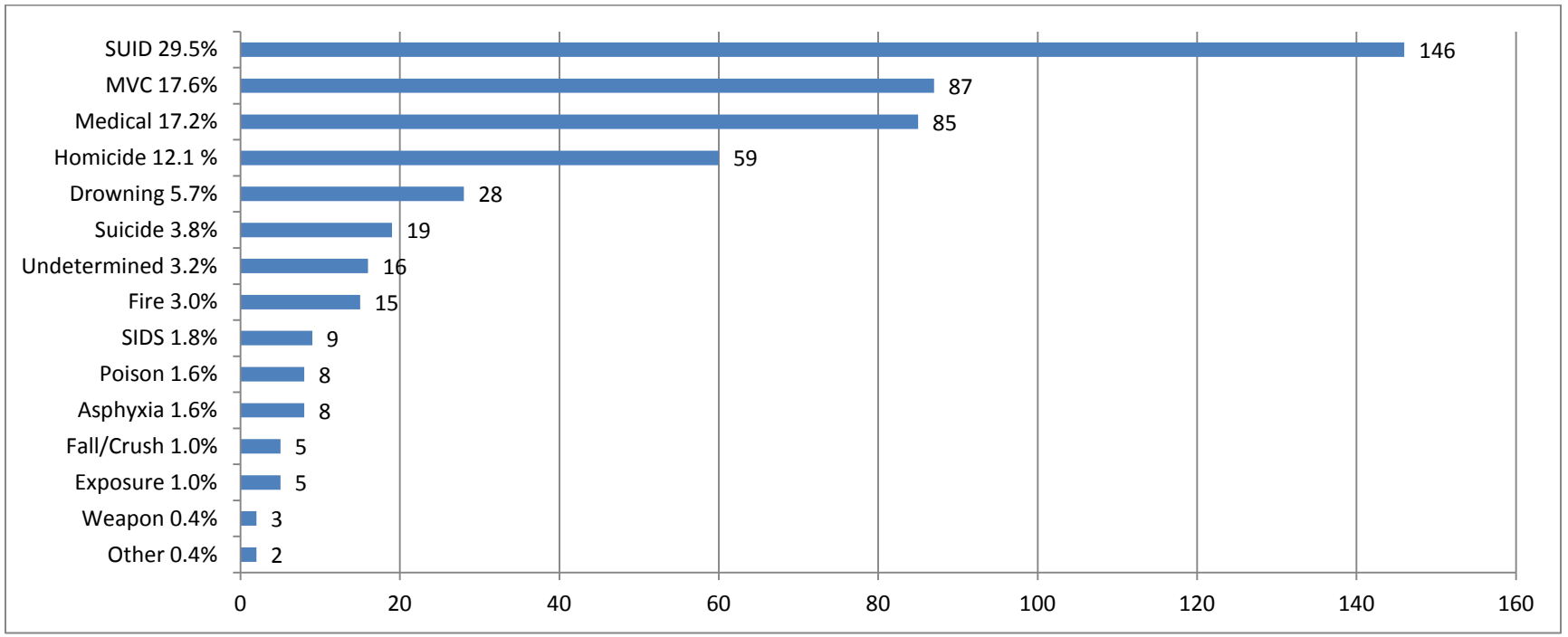
In 2011, Child Fatality Review committees reviewed 495 child deaths which is a significant decline when compared to 594 child deaths reviewed in 2010. These committees are comprised of professionals from various disciplines convening for the purpose of reviewing preventable child deaths. A child's death is eligible for review when the death is sudden, unexpected, unexplained, suspicious, or attributed to unusual circumstances. Death notifications are gleaned from a myriad of sources, including reports from county coroner/medical examiner offices, Vital Records (VR), Georgia Bureau of Investigations (GBI), and Department of Family and Children Services (DFCS). This death data is linked with Vital Records data to ensure a comprehensive and accurate account of all deaths. However, the full vital records data file was not available prior to completion of this report.

Figure 1: Demographics of All Reviewed Deaths, 2011 (N=495)

		Number	Percent
Age	Infant	219	44.2
	1 to 4	85	17.2
	5 to 9	44	8.9
	10 to 14	57	11.5
	15 to 17	90	18.2
Race/Ethnicity	White Male	134	27.1
	White Female	85	17.2
	African-American Male	129	26.1
	African-American Female	112	22.6
	Hispanic Male	20	4.0
	Hispanic Female	8	1.6
	Multi-Race Male	3	0.6
	Multi-Race Female	1	0.2
	Asian Male	2	0.4
	Asian Female	1	0.2

Please note that 557 deaths were deemed reviewable based on CFR criteria. However, there are 495 deaths for which a review was conducted and a report was submitted by local CFR committees. The information contained in this report is solely based on data attained from these 495 child death reports.

Figure 2: All Reviewed Deaths by Cause, 2011 (N=495)



- The "Sudden Unexpected Infant Death" (SUID) category is comprised of 116 SUID deaths and 30 sleep-related infant asphyxial deaths (146).
- In 2011, there were eight asphyxial deaths. The "Asphyxia" category represents deaths involving children over the age of one (e.g. choking on food particles)
- The "Other"category represents two tornado-related deaths; the Weapon category represents three unintentional firearm deaths
- Forty percent of all Motor vehicle deaths (MVC) involved older teens ages 15 to 17

- Half of all drowning deaths involved toddlers ages 1 to 4 (14) which is equivalent to all other age categories combined (14)

❖ Please note that the “Asphyxia” category depicted in **figure 2** does not include sleep-related infant asphyxial deaths. These deaths are included in the “SUID” category

Prevention and Preventability

In addition to conducting a thorough review of each death, CFR Committees are also asked to determine if the death was preventable. **Preventability** is defined for CFR Committees as a death in which, with retrospective analysis, it is determined that a reasonable intervention (e.g., medical, educational, social, psychological, legal, or technological) could have prevented the death. In other words, a child's death is preventable **if the community or an individual could reasonably have done something, at any point, that would have changed the circumstances leading up to the death**. Many deaths to children are predictable, understandable, and therefore preventable.

Figure 3: Preventability Determination by Cause of Death, 2011 (N=495)

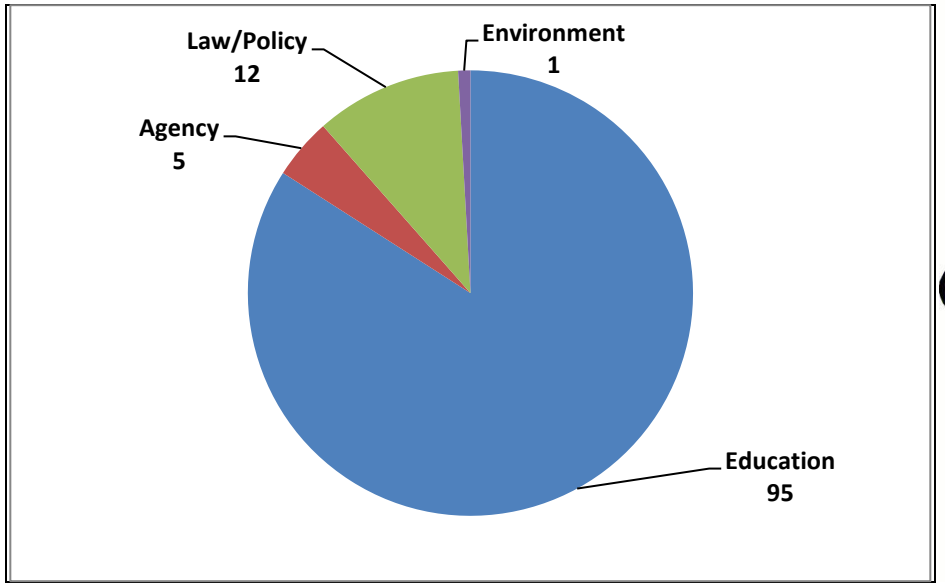
CAUSE	Missing/Blank	No, Probably Not	Yes, Probably	Team could not determine	% Preventable*
All Unintentional	2	18	134	10	88.2
SIDS	--	6	--	2	n/a
Sleep-Related Asphyxia	1	2	21	4	91.3
SUID	6	15	61	26	80.3
Homicide	4	5	48	3	90.6
Suicide	--	3	16	--	84.2
Undetermined	--	4	3	7	n/a
Medical	9	49	17	19	25.8

SIDS = Sudden Infant Death Syndrome
SUID = Sudden Unexplained Infant Death
**% Preventable* calculated excluding "missing/blank" and "team could not determine"*

Based on the retrospective review process, if the committees believe that the death could have been prevented, the committees are also asked to make prevention recommendations to reduce future deaths to children from similar circumstances. Each recommendation can have multiple components, if the committee feels that multiple domains, agencies, or policies could be effective in prevention.

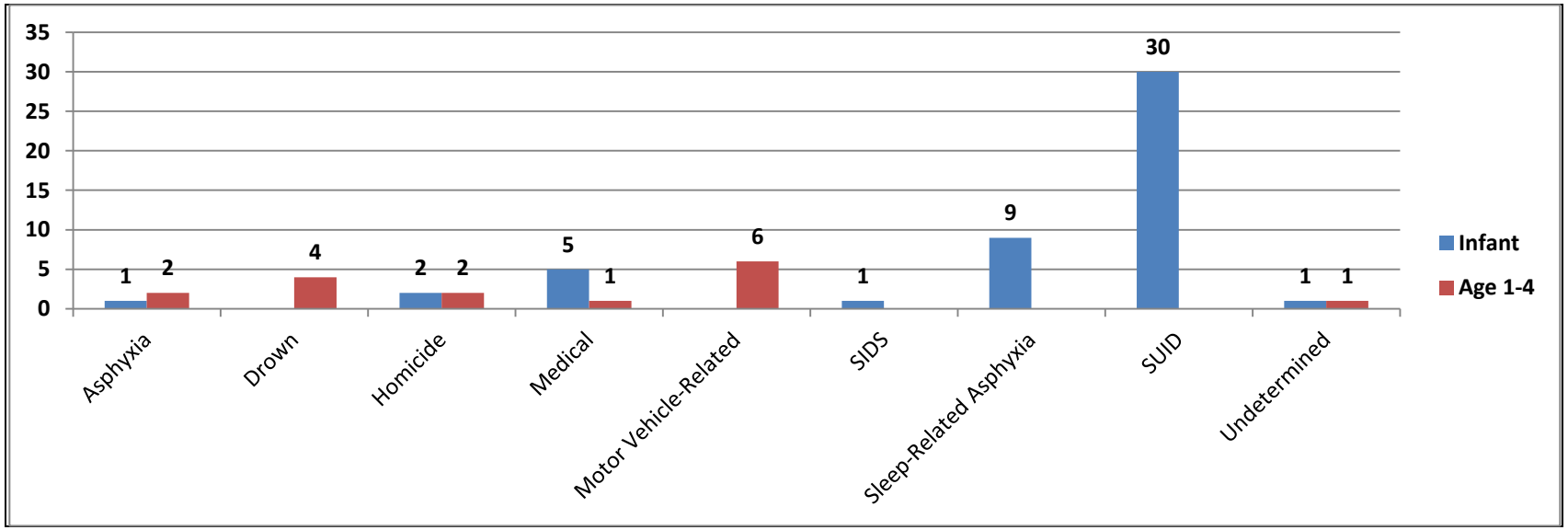
Committees can choose multiple recommendation areas in each death, because there are many ways that prevention efforts can be delivered to parents, caregivers, communities, providers, and policymakers. In 2011, there were 104 deaths (21%) where the committees made a prevention recommendation for at least one area (e.g. education, law/policy, environment, etc). In 391 cases, the committee did not recommend any preventive action.

Figure 4: Prevention Recommendations by Topic, 2011 (N=104)



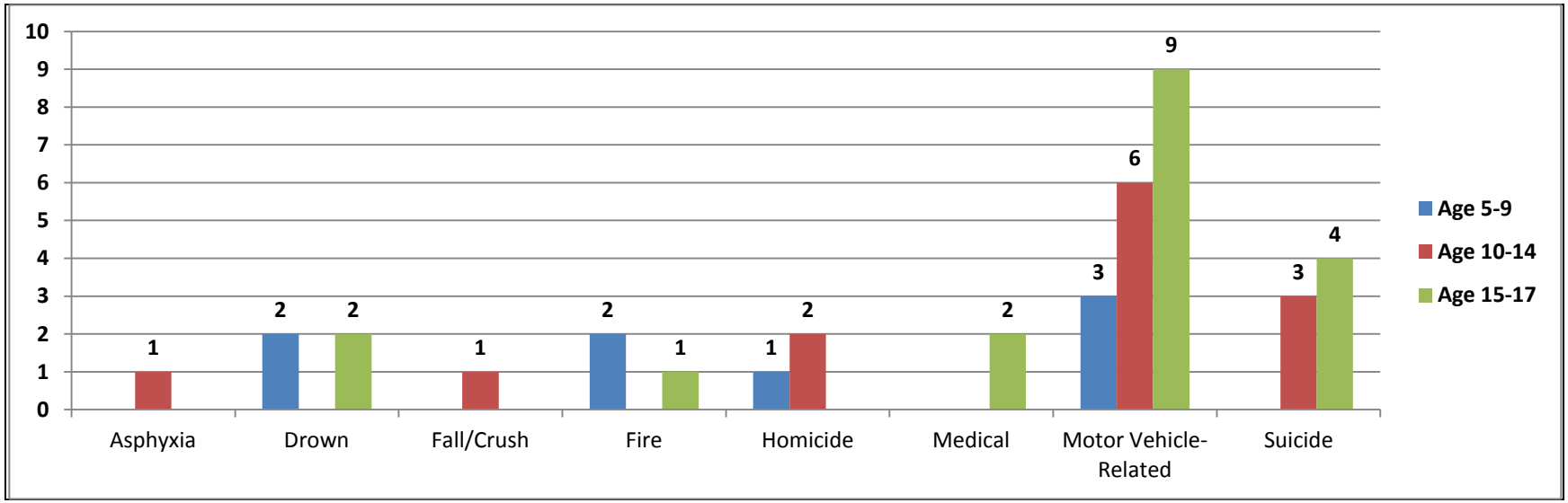
- Of the 227 “education” recommendations reported in 95 deaths, committees most often suggested media campaigns, school programs, parent education, and community safety projects
- Of the 12 “law” recommendations reported in 12 deaths, committees most often identified enforcing existing laws and ordinances
- Of the six “agency” recommendations reported in five deaths, committees most often identified revising policies, creating new programs, and expanding services

Figure 5: Prevention Recommendations for Children Age <5, 2011 (N=65)



CFR Committees most often made prevention recommendations for young children (age <5) in the areas of sleep-related deaths (62%), motor vehicle-related deaths (9%), and medical deaths (9%)

Figure 6: Prevention Recommendations for Children Age >5, 2011 (N=39)



CFR Committees most often made prevention recommendations for older children (age 5-17) in the areas of motor vehicle-related deaths (46%), suicide (18%), and drowning (10%)

PREVENTION RESOURCES FOR PARENTS, CAREGIVERS, AND PROVIDERS

Successful prevention efforts will encompass multiple areas and have overlapping impact. The Office of the Child Advocate suggests using the *Spectrum of Prevention* model, and addressing each of these six areas with prevention programming or policies:

1. Strengthening individual knowledge and skills
2. Promoting community education
3. Educating providers
4. Fostering coalitions and networks
5. Changing organizational practice

6. Influencing policy and legislation

Specific resources will be mentioned in each of the following sections of this report, relating to the singular cause and/or manner of death in each chapter. However, there are several national and state-level resources available that address multiple areas of child injury and fatality, and have materials or trainings available upon request. The Office of the Child Advocate encourages parents, caregivers, providers, and policymakers to utilize these and other resources and incorporate prevention as often as possible.

- Safe Kids USA (www.safekids.org)
- Prevent Child Abuse America (www.preventchildabuse.org)
- National Institute of Child Health and Human Development (www.nichd.nih.gov/sids)
- Suicide Prevention Resource Center (www.sprc.org)
- Centers for Disease Control and Prevention (www.cdc.gov/injury)
- Children's Healthcare of Atlanta, Child Protection Center (www.choa.org/childrens-hospital-services/child-protection-center)

Spotlight on Maltreatment

The Centers for Disease Control and Prevention (CDC) defines child maltreatment as any form of abuse or neglect of a child under the age of 18 by a parent, caregiver, or a person in a custodial role such as a coach or a teacher. The four common forms of abuse are:

- Physical Abuse: the use of intentional physical force, such as hitting, kicking, shaking, burning or other show of force against a child.
- Sexual Abuse: engaging a child in sexual acts including fondling, rape, and exposing a child to other sexual activities.
- Emotional Abuse: engaging in behaviors that harm a child's self-worth or emotional well-being such as name calling, shaming, rejection, withholding love, and threatening.
- Neglect: the failure to meet a child's basic need including housing, food, clothing, education, and access to medical care.

Although many incidents of child abuse and neglect are unreported, in 2011 Child Protective Services identified 681,000 children as victims of maltreatment in the United States. 48.6% of the victims of abuse and neglect were male and 51.1% were female. 1545 of these children died as a result of abuse and neglect.

Neglect was the most common form of maltreatment suffered by children in the United States and more children died as a result of neglect than abuse. 81.6% of the children who died due to abuse and neglect were under the age of 4. 86.5% of the children who died as a result of abuse and neglect were African American (28.2%), Hispanic (17.8%) and White (40.5%).

Of the 495 child deaths in Georgia reviewed in 2011, the CFR Committees identified 76 children as victims of maltreatment (15.3%). This number was identified by a positive response by the CFR Committees to one of these four variables:

- The deceased child had a history of maltreatment as a victim
- The investigation found evidence of prior abuse
- Child abuse caused or contributed to the death
- Child neglect caused or contributed to the death

Among the more frequent causes of death of maltreatment victims identified by the CFR Committees was homicide which represented 29 cases (38.1%) , sleep related infant death which represented 14 cases (18.4%), deaths related to a medical cause which represented 10 cases (13.1%) and deaths involving motor vehicles which represented 7 cases (9.2%).

36 children were White, 31 children were African American and 9 children were Hispanic. Children under the age of 5 represented 47 cases (61.8%) where children were victims of maltreatment. Children in the next three age groups represented between 9-10 cases each for a total of 29 cases (38.2%).

CFR teams identified 47children that had a ***history of maltreatment as a victim***.

In 42 (89.3%) of those 47 cases an act, omission or commission of maltreatment was a direct cause of the child's death. 30 of those 42 were children were under the age of 5. Child abuse was the most frequent cause of death in those 42 cases where an act, omission or commission of maltreatment was a direct cause of the child's death.

The CFR Committees identified an additional 185 cases where some form of act or omission occurred and was a contributing cause of death. Examples of these contributing causes include poor supervision and other forms of negligence

Figure 7: Causes of Death for All Reviewed Maltreatment Deaths, 2011 (N=76)

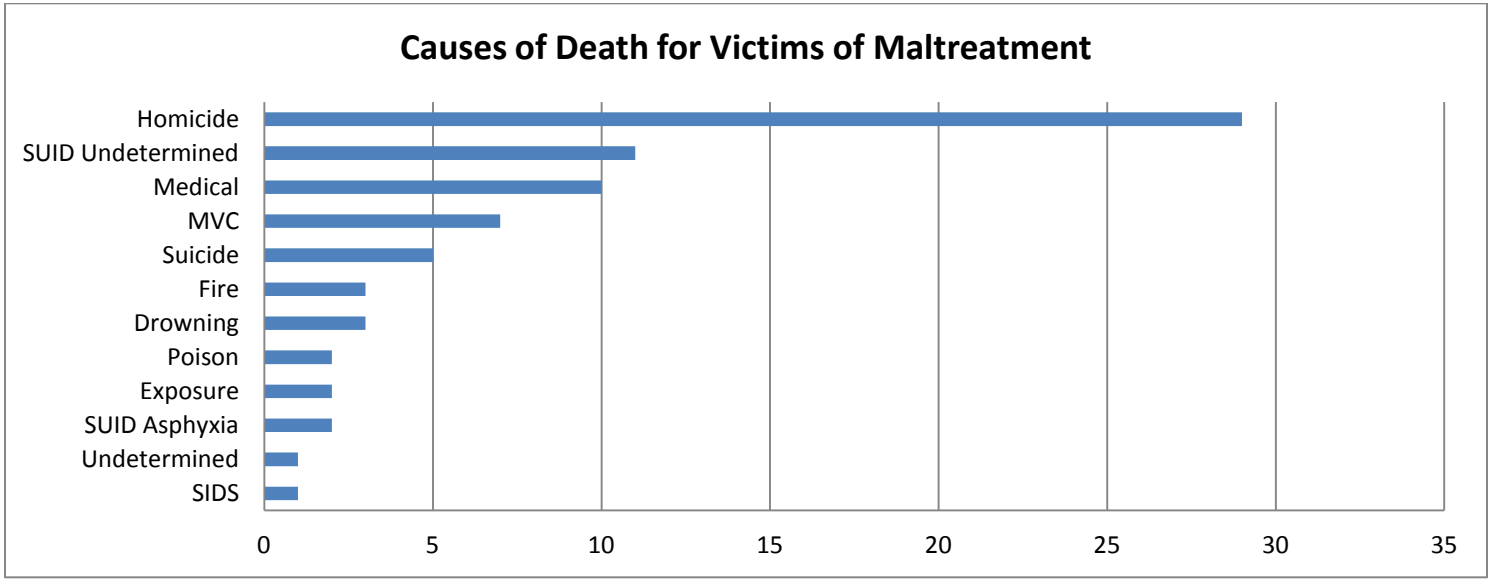


Figure 8: Demographics of All Reviewed Maltreatment Deaths, 2011 (N=76)

		Number	Percent
Age	Infant	29	38.2
	1 – 4	18	23.7
	5 - 9	10	13.2
	10 - 14	9	11.8
	15 - 17	10	13.2
Race/Ethnicity/Gender	White Male	19	25
	White Female	17	22.4
	African-American Male	17	22.4
	African-American Female	14	18.4
	Hispanic Male	4	5.3
	Hispanic Female	5	6.6

Agency Involvement

The CFR Committees were asked to identify the number and type of agencies that provided a service of some kind to the deceased child or the child's family. Child Fatality Review Teams identified 252 cases (50.9%) where a public agency had contact with a deceased child or the child's family. The agencies that had involvement in these cases include but are not limited to mental health, law enforcement, juvenile detention and social services. Each agency visit or staff intervention with a family represents an opportunity for prevention, education and risk reduction counseling for Georgia's families.

- 23 children were receiving services through Children with Special Health Care Needs for a disability or a chronic illness.
- 19 children had received prior mental health services at one time. 10 of these children were receiving mental health services at the time of their death.
- 26 children had an open Child Protective Services case at the time of their death.
- 20 children had a criminal or delinquent history.
- 5 children spent time in juvenile detention prior to their death.
- Child Fatality Review Teams reported that caregivers received some social service assistance (e.g Medicaid, TANF, Food Stamps, WIC) in 246 cases.

Of the 26 cases where there was an open Child Protective Services case:

- There were 5 cases of sleep related infant death. All five of these cases involved African American children.
- 7 children were found to have been the victim of a homicide. 5 of those seven children were Hispanic.

Of the 20 cases where children had a criminal or delinquent history:

- 9 children were the victim of a homicide.
- 5 of these children were between the ages 15-17 and 4 of these children were between the ages 10-14.
- 8 of these 9 children were African American.

Of the 23 children who received services through Children with Special Health Care Needs for a disability or a chronic illness, 15 children died of a medical cause. Examples of the medical conditions identified by CFR teams in these cases are:

- Complications related to a seizure disorder
- Complications related to cerebral palsy
- Complications related to prematurity
- Cardio facial feature disorder
- Hirschstrings disease
- Asthma
- Charge syndrome
- Failure to thrive
- Bacterial pneumonia
- Group B streptococcus sepsis
- Sleep apnea
- Staph infection
- Leukemia

9 of these children were under the age of 5.

11 of these children were African American.

7 of these 11 African American children were under the age of 5.

Medical-Related Deaths

A child medical death is reviewable when the death occurs unexpectedly, unexplained, unattended by a physician, or in a suspicious or unusual manner. Examples of reviewable child medical deaths are those from medical illnesses that do not normally cause death in otherwise healthy children, and can be successfully managed with proper medical care and treatment (i.e. asthma or seizure disorders).

In 2011, there were 495 child deaths reviewed by the CFR Committees. Out of those 495 child deaths, 85 were medical related, the third largest cause of deaths among children in Georgia.

Figure 9: Demographics of All Reviewed Medical Deaths, 2011

		Number	Percentage
Age	Infant	31	35.6
	1 to 4	16	18.4
	5 to 9	10	11.5
	10 to 14	12	13.8
	15 to 17	16	18.4
Race/Ethnicity/Gender	White Male	17	19.5
	White Female	12	13.8
	African American Male	27	31.0
	African American Female	24	27.6
	Hispanic Male	3	3.4
	Hispanic Female	1	1.1
	Asian Female	1	1.1

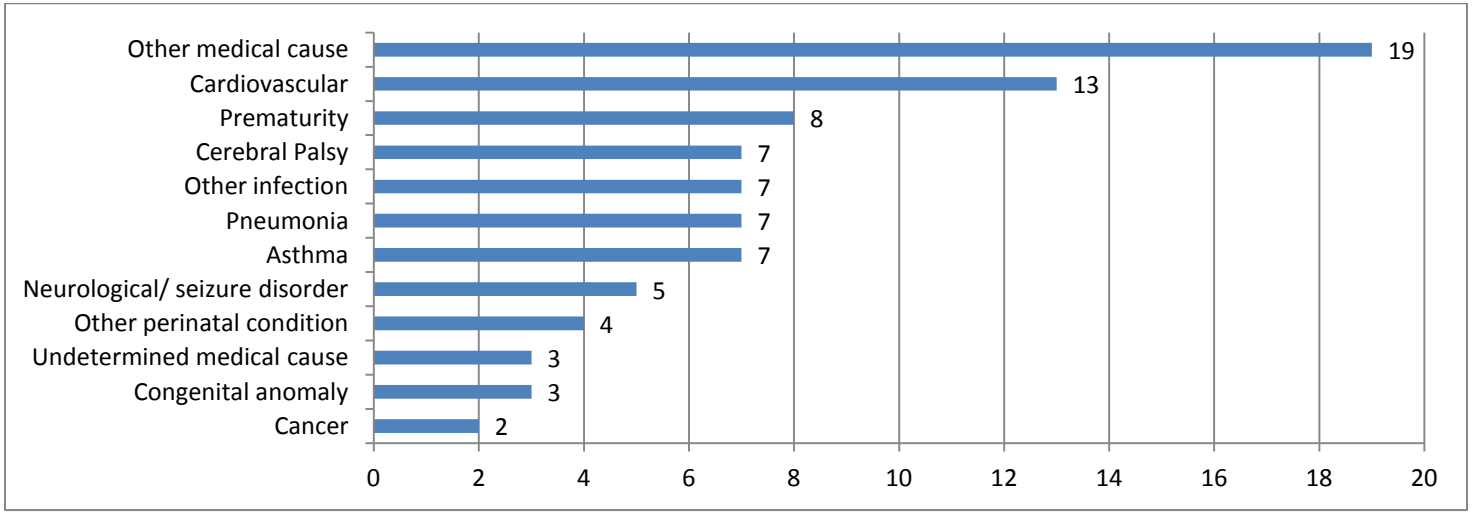
Findings:

- Thirty-six percent of all medical deaths involved infants, almost twice as many deaths in the first year of life than there are in the next 13 years
- Out of 31 infant deaths, 20 had a reported gestational age of less than 39 weeks

Facts:

- According to the March of Dimes, one in eight babies is born prematurely in the United States
- More than half of under-five child deaths are due to diseases that are preventable and treatable through simple, affordable interventions.

Figure 10 : Causes of Medical Related Deaths Reviewed in 2011, (N=85)



Medical related deaths can result from one of many serious health conditions. Examples of these medical conditions are congenital anomalies, cancers, cardiovascular and cerebral problems; respiratory disorders, and neurological disorder.

Many medical related deaths are not believed to be preventable. However, deaths attributed to conditions such as asthma, pneumonia, infectious diseases and some genetic disorders can oftentimes be prevented. There are many treatments for asthma, certain infectious diseases, and other medical conditions and they are generally effective.

In 2011, Twenty-two percent of all medical-related deaths were due to "other medical" causes which include conditions such as charge syndrome, Zellweger syndrome, severe combined immunodeficiency and 4q deletion syndrome.

The American Accreditation Healthcare Commission says that the cause of most infant deaths is associated with prematurity. Death due to prematurity frequently results from a lack of prenatal care.

PREVENTION POINTS:

Prenatal Care is Important!

- Healthy Babies are Worth the Wait is a comprehensive initiative by the March of Dimes to prevent preventable preterm birth, with a focus on reducing elective deliveries before 39 weeks gestation.
- Some birth defects cannot be prevented. However, some conditions may be diagnosed during pregnancy. Such conditions, when recognized, may be prevented or treated while the baby is still in the womb or immediately upon birth.
- Evaluation may include genetic screening of the parents, parental medical histories and childbearing history
- Most state health departments have programs that provide prenatal care to mothers, whether or not they have insurance or able to pay

Sleep-Related Deaths

CFR Committees determine the cause of infant sleep-related deaths by reviewing multiple factors associated with the sleep environment, the infant's medical history, and autopsy findings. A death is determined to be Sudden Infant Death Syndrome (SIDS) when the infant is considered to be in the safest possible sleep environment and no other potential risk factors are identified. A death is determined to be asphyxia when there is evidence of suffocation, wedging, or overlay during sleep. The Sudden Unexplained Infant Death (SUID) cases are determined when there is evidence of an unsafe sleep environment and/or other factors that could possibly have contributed to the death (e.g. bed-sharing, over bundling, prone positioning, or existing health issues).

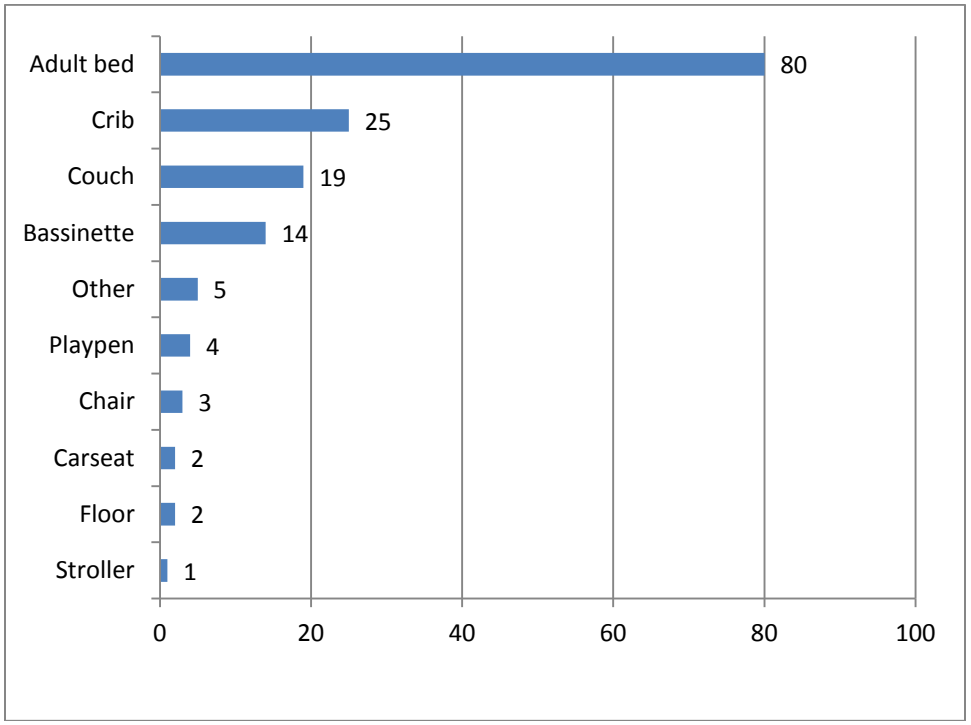
Figure 11: Demographics of All Reviewed Sleep-Related Infant Deaths, 2011 (N=155)

	SIDS		Asphyxia		SUID		Total	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
White Male	2	22.2	6	20.0	25	21.6	33	21.3
White Female	1	11.1	9	30.0	22	19.0	32	20.6
African-American Male	5	55.6	4	13.3	27	23.3	36	23.2
African-America Female			11	36.7	37	31.9	48	31.0
Hispanic Male	1				3	2.6	4	2.6
Hispanic Female					1	0.9	1	0.6
Multi-Race Female					1	0.9	1	0.6
Total	9		30		116		155	

*All Race/Ethnicity/Sex categories are non-Hispanic, except the Hispanic category

- While not indicative of population rates, the race/sex categories with the highest percentage of reviewed infant deaths due to sleep-related circumstances were African-American females (31.0%) and African-American males (23.2%). However, population rates should be considered when determining priority for prevention programs and services.

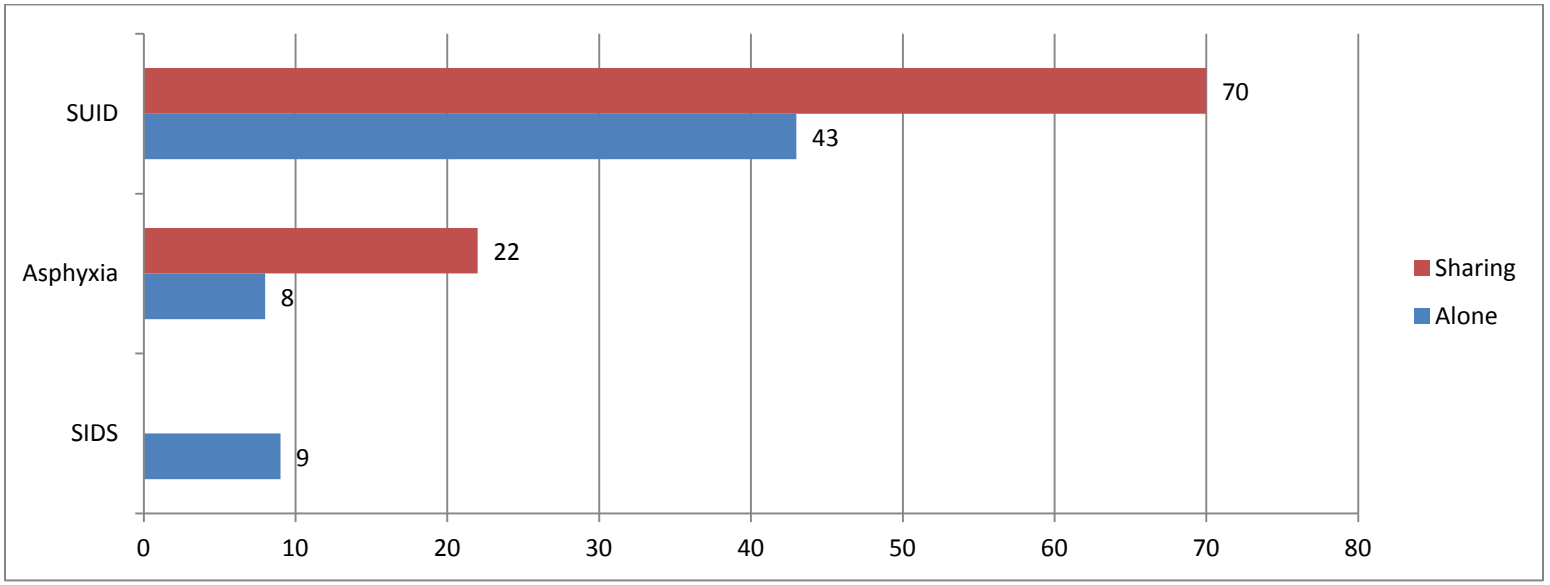
Figure 12: Sleep Location, Sleep-Related Infant Deaths, 2011 (155)



- Of the 155 infant sleep-related deaths reviewed in 2011, just over half of the deaths occurred in an adult bed (52%). The safest place for an infant to sleep is in a safety-approved crib, without blankets, bumper pads, or soft objects that can pose a suffocation hazard

- Twenty-five percent of the deaths occurred in a crib/bassinette; Although a crib or bassinette is a very appropriate sleep location for an infant, there were several incidents where soft or fluffy materials were placed in the crib, or the infant was placed in a prone position, which possibly contributed to the death

Figure 13: Reviewed Sleep-Related Deaths and Bed-Sharing, when known (N=152)



- Of the 70 SUID cases where bedsharing was a factor, 63 were sharing with an adult and 21 were sharing with a child (the total is greater than 70 because in several instances, the infant was sharing a sleep surface with both an adult and a child)
- Of the 22 sleep-related asphyxia cases where bedsharing was a factor, 17 were sharing with an adult and 8 were sharing with a child (the total is greater than 22 because in several instances, the infant was sharing a sleep surface with both an adult and a child)
- Scientific evidence shows that bed-sharing is not safe for children under the age of one. Scientific evidence shows that bed-sharing increases the risk for SIDS, as well as the risk of suffocation. Infants can be overlain by the parent, they can get entrapped between the mattress and the box spring or under the pillow, or they can be suffocated by heavy bedding

Sleeping in a supine position – on the back – is considered the safest position for an infant to sleep until their first birthday. Even when the infant is able to roll over on his own, caregivers are still encouraged to place the infant to sleep on his back. “Tummy time” is encouraged for play, when the infant is supervised by a caregiver, to avoid developing positional plagiocephaly (i.e. “flat head”)

- Of the 59 sleep-related deaths where the infant was placed on their back to sleep (supine), 49 deaths (83%) were determined to be SUID, eight were determined to be asphyxia (14%), and two were SIDS (3%)
- Of the 44 sleep-related deaths where the infant was placed on their stomach to sleep (prone), 33 were determined to be SUID (75%), 8 were determined to be asphyxia (18%), and 3 were SIDS (7%)

Prevention Recommendation

The U.S. national campaign to reduce the risk of sudden infant death syndrome has entered a new phase and will now encompass all sleep-related, sudden unexpected infant deaths. The National Institutes of Health (NIH) “Safe to Sleep” campaign recommends placing infants to sleep in their own safe sleep environment and not on an adult bed, without any soft bedding such as blankets or quilts. “Safe to Sleep” also emphasizes breast feeding infants when possible, which has been associated with reduced SIDS risk, and eliminating such risks to infant health as overheating, exposure to tobacco smoke, and a mother’s use of alcohol and illicit drugs. (www.nichd.nih.gov/sids)

In addition, the national Text4Baby initiative, launched in 2010, provides free weekly text messages to registered mobile phone users promoting safe and healthy behaviors for pregnant women and infants. This service includes information to reduce sleep-related deaths, such as tobacco cessation, accessing prenatal care, and making sleep arrangements prior to the birth. Text4Baby messages are also available to registered users through the infant’s first year.

CFR committees are promoting safe sleep environments for infants in their communities, by educating parents and caregivers to place infants to sleep on their backs, use a firm, tight-fitting mattress, and not add extra padding, blankets, pillows, or comforters in the sleep space.

First Lady's Children's Cabinet

Ensuring all of Georgia's children are educated, healthy, safe, and productive members of society

The First Lady's Children's Cabinet coordinates policies and resources to improve outcomes for children and families. The Cabinet provides unique leadership on child welfare and juvenile justice issues in Georgia by identifying the state's strategic priorities, then developing initiatives in response.

The First Lady of Georgia, Sandra Deal, who is the Chairwoman of the Georgia Children's Cabinet, launched the Safe Sleep Campaign on October 9th, 2012. The First Lady knows the critical importance of educating all parents and caregivers of babies about SIDS and the risk factors that contribute to it. The campaign highlights the actions that can be taken to help prevent SIDS and sleep related deaths.

Helpful resources for safe sleep:

DJJ Information on Safe Sleep: http://www.djjnewsandviews.org/safesleep/

DPH Information on Safe Sleep: http://health.state.ga.us/programs/sids/index.asp

Department of Health and Human Services: http://dfcs.dhs.georgia.gov/news-archives
http://dhs.georgia.gov/sites/dhs.georgia.gov/files/safesleepingrev2.pdf

Office of the Child Advocate: http://oca.georgia.gov/documents/safe-sleep-infants

The safest sleep environment is:

Alone—do not share a bed
Back——place infants to sleep on their backs, not tummy or side
Crib—-use a safety-approved sleep place such as a crib or bassinet

Motor Vehicle Injury-Related Deaths

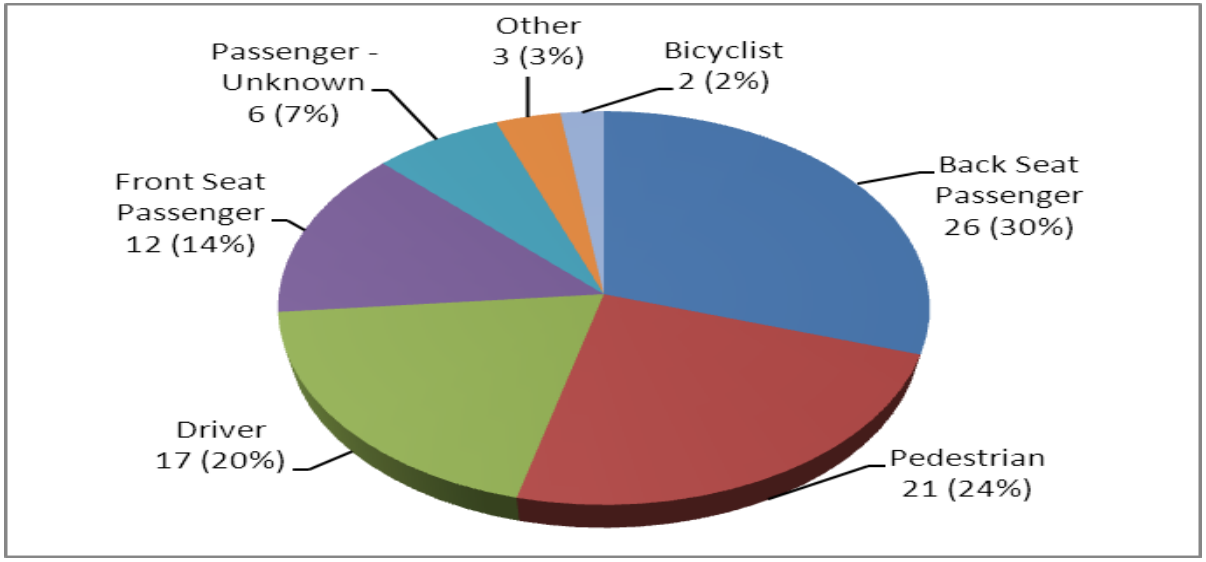
During 2011, motor vehicle related crashes were the second leading cause of all reviewed deaths. Motor vehicle injury-related deaths accounted for a total of 87 out of 161 total reviewed unintentional injury-related deaths. A total of 87 deaths in 2011 is a decrease from the total of 111 deaths that occurred in 2010. According to the National Highway Traffic Safety Administration, young drivers, ages 15 to 20 years old, are especially vulnerable to death and injury on our roadways - traffic crashes are the leading cause of death for teenagers in America.

Figure 14: Demographics of Reviewed Motor Vehicle-Related Deaths, 2011 (N=87)

	Category	Number	%
Age	Infant	4	4.6%
	1 to 4	17	19.5%
	5 to 9	13	14.9%
	10 to 14	19	21.8%
	15 to 17	34	39.1%
Race/Gender	White Male	33	37.9%
	White Female	17	19.5%
	African-American Male	15	17.2%
	African-American Female	15	17.2%
	Hispanic Male	5	5.7%
	Hispanic Female	2	2.3%

- Males represented 53% of all motor vehicle-related crashes.
- In regards to race/gender, the largest number of deaths occurred with white males.
- Teenagers age 15 to 17 had the largest number of deaths

Figure 15: Reviewed Motor Vehicle-Related Deaths by Location at Injury, 2011 (N=87)



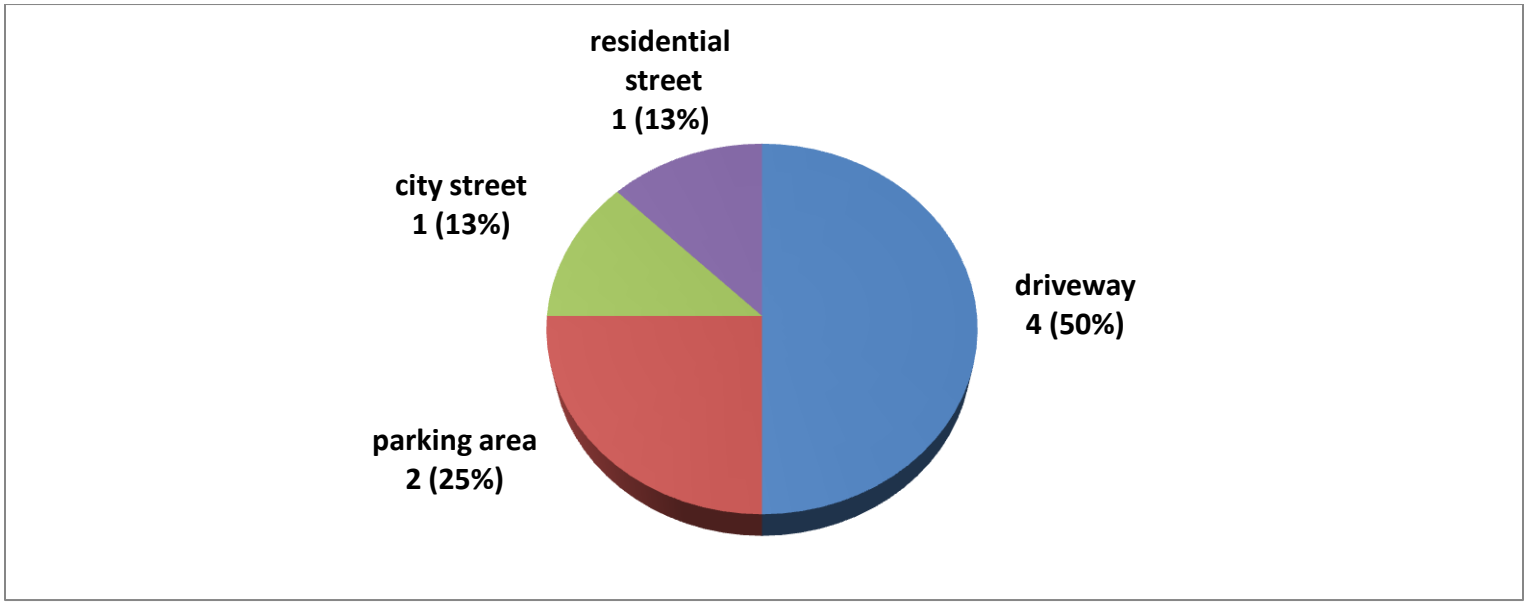
The largest type of Motor Vehicle-Related crashes (26) was as a result of passengers who rode in the back seat of the car. This is not indicating the back seat as a danger zone for passengers. Three out of a total of eight accidents occurred where passengers were not being restrained by a seatbelt between the ages of 10 to 14. Only one out of six known accidents occurred in teens 15 to 17 where the decedent was not restrained. However, one report indicated a child being restrained in a car seat. The accident was caused by a driver in another vehicle.

Information regarding the new Child Passenger Safety Restraint Law in Georgia is documented by Children's Healthcare of Atlanta. "During the 2011 state legislative session, Children's successfully advocated for an increase in the state required age for a child to be restrained in a booster seat when riding in a motor vehicle. On May 9, 2011, Governor Nathan Deal signed the legislation at Scottish Rite.

Effective as of July 1, 2011, all children **under 8 years old** must be properly secured in an approved car seat or booster seat while riding in a car, van, SUV or pickup truck.

A few findings were documented as a result of reviewable deaths reported for 2011. In one accident, a child, between the ages of 1 to 4, was properly restrained in a car seat when the car was hit by another vehicle. The child died in a hospital two days later. Another accident, occurring with a child between ages 5 to 9, found the child in the back seat behind the driver and was not wearing a seatbelt. Ultimately, a strong recommendation is to continue to enforce the restraint law in Georgia to prevent child deaths as a result of motor vehicle related crashes.

Figure 16: Location of Reviewed Motor Vehicle-Related Pedestrian Deaths, Ages 1 to 4, 2011 (N=8)



- A total of eight motor vehicle-related crashes occurred involving pedestrian children ages 1 to 4. The most prevalent location (50 %) was in a driveway.
- Two deaths occurred where the children darted out into the path of a car. One death was a result of the child not being seen by the driver of the car. The other death involved the driver not having time to stop when the child darted out in the path of the vehicle.
- One method of prevention is increasing close adult supervision of children in this age group

PREVENTION POINTS:

Below are a few guidelines for parents regarding child passenger safety. They are recommended by The Committee on Injury, Violence, and Poison Prevention. (www.cdc.gov)

- Use a seat belt on every trip, no matter how short. This sets a good example.
- Make sure children are properly buckled up in a seat belt, booster seat, or car seat, whichever is appropriate for their age, height and weight.
- All children younger than 13 years should ride in the back seat. Airbags can kill young children riding in the front seat. Never place a rear-facing car seat in the front seat or in front of an air bag.
- Place children in the middle of the back seat when possible, because it is the safest spot in the vehicle.

Drowning-Related Deaths

Figure 17: Demographics of Reviewed Drowning Deaths, 2011 (N=28)

	Category	Number	%
	1 to 4	14	50.0%
	5 to 9	7	25.0%
	10 to 14	3	10.7%
	15 to 17	4	14.3%
Race/Gender	White Male	12	42.9%
	White Female	5	17.9%
	African-American Male	6	21.4%
	African-American Female	1	3.6%
	Other Male	3	10.7%
	Other Female	1	3.6%

In general, drowning deaths decreased from a total of 39 in 2010 to 28 deaths in 2011. Fifty percent of all reviewed drowning deaths in 2011 occurred in children ages 1 to 4. All deaths occurred as a result of or due to careless safety measures. In some cases, there were two adults watching a child. But, they both left the child alone in a pool or bathtub for a few minutes. When they returned, the child was found unresponsive in the water.

PREVENTION POINTS:

According to the Centers for Disease Control and Prevention, the following prevention tips can be implemented:

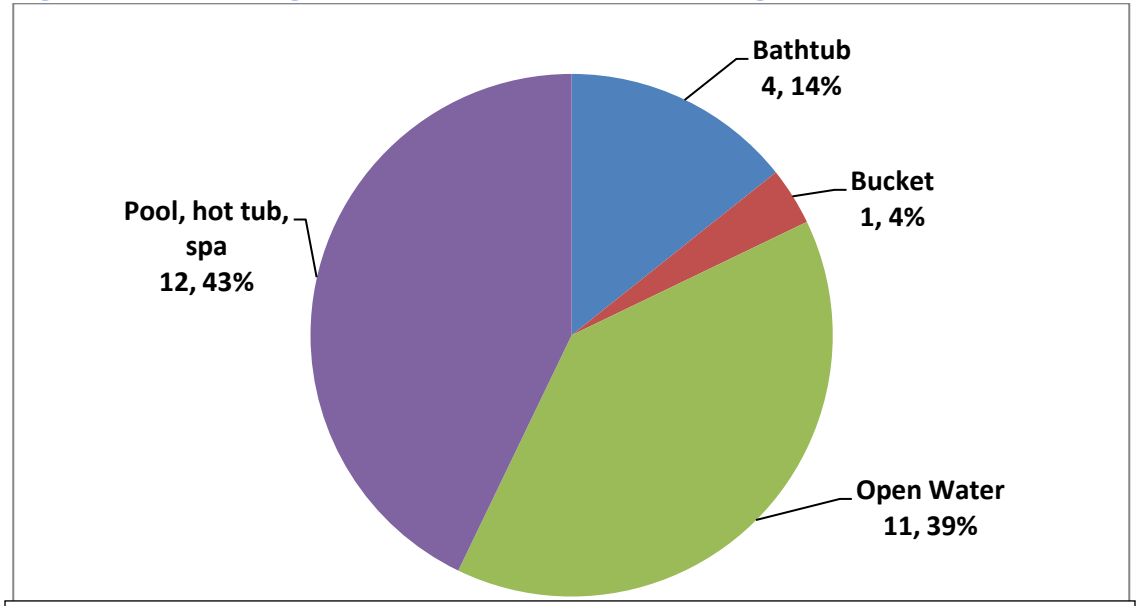
Learn life-saving skills. Everyone should know the basics of swimming (floating, moving through the water) and cardiopulmonary resuscitation (CPR).

Fence it off. Install a four–sided isolation fence, with self–closing and self–latching gates, around backyard swimming pools. Fences can help keep children away from the area when they aren't supposed to be swimming. Pool fences should completely separate the house and play area from the pool.

Make life jackets a "must." Make sure kids wear life jackets in and around natural bodies of water, such as lakes or the ocean, even if they know how to swim. Life jackets can be used in and around pools for weaker swimmers too.

Be on the lookout. When kids are in or near water, including bathtubs, closely supervise them at all times. Adults watching kids in or near water should avoid distracting activities like playing cards, reading books, talking on the phone, and using alcohol or drugs.

Figure 18: Drowning Location of Reviewed Drowning Deaths, 2011 (N =28)



- The largest percentage of reviewed drowning deaths occurred in a pool, hot tub or spa
- In general, CFR Committees reported evidence of children being unsupervised and left alone in unattended pools.
- The second highest location of drowning deaths occurred in open water.
- Reports also showed that children were unsupervised while playing with other siblings.
- Two teen deaths were ruled accidental.

Fire-Related Deaths

Nationally, deaths from fires and burns are the third leading cause of fatal home injury. Over one-third (37%) of home fire deaths occur in homes without smoke alarms and smoking is the leading cause of fire deaths (CDC, 2010). All too often, tragic fires occur when young children are left unattended, for even short periods. Even though they have a natural curiosity about fire, children may become frightened and confused in a fire and hide rather than escape to safety. Children are often found hiding in closets or under beds where they feel safe. Therefore, it is imperative that parents and caregivers hold fire drills in the home at least twice a year to let them practice the right things to do in a fire emergency (U.S. Fire Administration, 2009).

In Georgia, Fire-related deaths have fluctuated over the past several years

- 19 deaths in 2006
- 15 deaths in 2007
- 11 deaths in 2008
- 24 deaths in 2009
- 12 deaths in 2010
- 15 deaths in 2011

Figure 19: Demographics of Reviewed Fire-Related Deaths, 2011 (N=15)

	Category	Number	%
Age	Infant	2	13.3%
	1 to 4	4	26.7%
	5 to 9	6	40.0%
	15 to 17	3	20.0%
Race/Gender	White Male	4	26.7%
	White Female	3	20.0%
	African-American Male	5	33.3%
	African-American Female	3	20.0%

- Of the total 15 fire-related deaths, the source of fire originated from a heating stove (4 deaths) space heater (3 deaths), cigarette (1 death), surge protector (1 death), faulty electrical wiring (1 death) and unknown sources (5 deaths)
- Eighty-Seven percent of fire-related deaths occurred in single home structures
- In the majority of cases, it is unknown whether smoke detectors and fire extinguishers were present and operable at the time of incident. This underscores the importance of increased participation of fire scene investigators in the local child fatality review process.

Homicide Deaths

Homicide is one of the leading causes of child deaths. Child homicide victims account for 8% to 14% of all homicide victims. More often than not, most homicides occur by mechanism of injury. These injuries include but not limited to: shaken baby, fire, firearm, drowning, motor vehicle-related, poisoning, asphyxia, inflicted injury (being kicked, struck, stabbed or bitten) or other injury (crushed, heatstroke, etc).

Nationally, homicide accounts for one in five injury-related deaths among infants (less than one year of age). Infants are most likely to be killed by their mother during the first week of life, but thereafter are more likely to be killed by a male (usually their father or stepfather). The risk of infant homicide is highest on the day of birth, and half of all infant homicides occur by the fourth month of life. Homicide risk is greater in the first year of life than in any other year of childhood before age 17.

Research studies of infant death data drawn from multiple agencies (such as police or social service records) indicate the actual rate of deaths attributable to abuse or neglect of infants and children up to four years old is more than twice as high as the official rates reported in death certificate data. Studies have also indicated that a substantial but uncertain number of unreported infant homicide deaths, may occur among very young infants, particularly those infants for whom no birth or death certificates are found, such as those who are born with no trained attendants and not in a clinical setting.

Key risk factors associated with infant homicides include the circumstances surrounding the birth of the child. Among homicides occurring on the first day of life, 95% of the victims were not born in a hospital. Other important maternal risk factors include a second or subsequent infant born to an unmarried teenage mother (19 years of age or younger); no prenatal visit before the sixth month of pregnancy or no prenatal care; a history of maternal mental illness; a mother with 12 or fewer years of education; and premature birth (gestation of less than 28 weeks). Studies suggest that male caretakers (fathers or mother's intimate partners), often acting impulsively, are the perpetrators of the majority of infant homicides. However, there is generally less information (including potential risk factors for infant homicides) on biological fathers than there is on mothers, because of the frequency with which birth certificates are missing paternal data.

Between 1970 and 2000, the official infant homicide rate more than doubled; from 4% to 9% infant deaths per 100,000 children under age one. Between 2000 and 2002, the rate declined to 7% and has since fluctuated between 7% and 8%. The rate was 8% in 2010.

In 2010, for example, the infant homicide rate for boys was 8% for children under age one and 6% for girls. And as for race and ethnicity, African-American infants are substantially more at risk for homicide than are other infants. In 2009, the homicide rate for African-American infants was 17%, while Hispanics and Whites had rates of 6% and 5%, respectively.

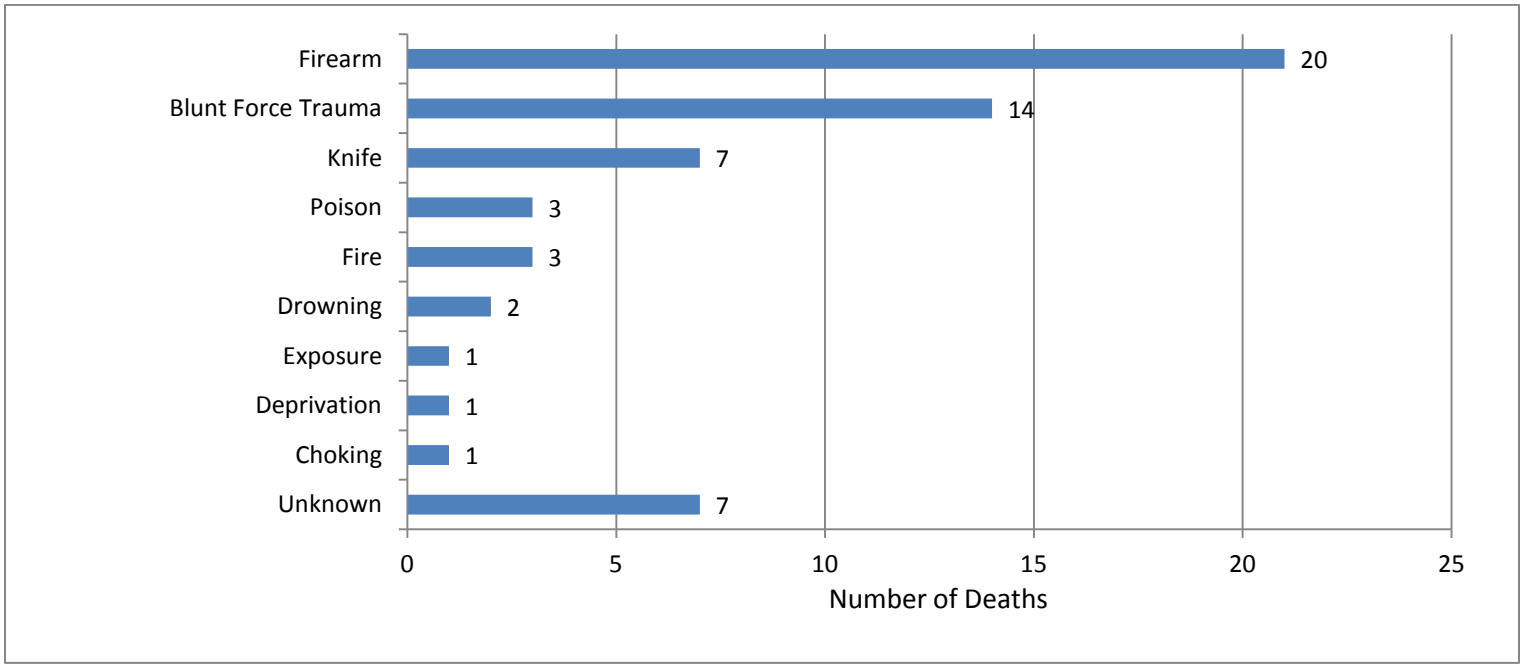
Homicide is the second leading cause of death among teens ages 15 to 19, after unintentional injury. Although other teens are the perpetrators of many of the homicides of teens below age 18, two-thirds of the murderers are eighteen or older.

Males ages 15 to 19 are 6 times more likely to die from homicide (14% and 2% respectively in 2010). As for race, in 2010, the national homicide rate for African-American teens was 52%, more than 22 times higher than the rate for White male teens (2%). Rates for other groups were 18% for Hispanic males, 11% for American Indian males, and 3% for Asian and Pacific Islander males.

Although the rate of homicide increased between 2004 and 2006, to 10.7 deaths per 100,000, it has since decreased. In 2010, the homicide rate was 8%, the lowest it has been since before 1980.

Georgia's homicide story is a vastly different one than previously reported in the past because Georgia's homicide rate has also decreased. In 2011, there were a total of 59 homicides.

Figure 21: Reviewed Homicide Deaths, by Mechanism, 2011
(N = 59)



Infant child deaths were listed at 23%, while children ages 1 to 4 were listed at 28%. For children ranging from ages 5 to 9 was 10% and ages 10 to 14 was 15%. The last remaining group, ages 15 to 17 was 22%.

Out of these deaths, racially, 10% were White males and 10 % were White females. However, African-American males had the highest death rate of 45%, while African-American females came in second with 16%. The Hispanic male death rate was 12%, while Hispanic females were only 5%.

Over 50% of child deaths that occurred were intentional injury related. The intentional injury deaths were by the hands of either both the father and mother, the mother or the father. This type of homicide is known as filicide (killing of your own child by a biological parent). The other injuries occurred by abuse, neglect (E.g., two cases where children drowned because their whereabouts were unknown and they were not being properly supervised), fire (e.g., a case where the mother and father were operating a crystal meth or methamphetamine lab out of their home, which blew up, killing two of their own children), or blunt force trauma. Oftentimes the biological parent themselves are either socially, mentally or emotionally unstable. Consequently, the child killings are a reflection of the parent's overall disposition.

Georgia continues to focus on homicide prevention by criminalizing firearm possession by minors, prosecuting minors as adults in criminal court or holding adults responsible for the actions of minors when there are multiple incidents of serious injuries upon others. However, these prevention methods may only curtail some of the homicidal occurrences. More thorough prevention efforts need to address early signs of potential maltreatment or homicidal tendencies. Georgia is steadily increasing its preventive measures by 1) developing stronger communications with local and regional Department of Family and Children Services units and 2) through each Child Fatality Review Committee, examining possible patterns that stem from various causes such as lack of resources or bare living necessities. Stronger communication with the Department of Family and Children Service units allows the Office of the Child Advocate to intervene in possible issues that may later result in death (such as a parent's psychological well being) Likewise, the Child Fatality Review Committees submit data and reports indicating information that signal common occurrences that may be stopped once the issues are addressed. For example, child dying because of the lack of knowledge of properly strapping a child in a car seat. By focusing on both of these measures, Georgia is able to further ensure the safety of its children.

Suicide Deaths

Suicide is the third-leading cause of death for 15 to 24 year-olds, according to the Centers for Disease Control and Prevention (CDC), after accidents and homicide. It is also thought that at least 25 attempts are made for every completed teen suicide. The risk of suicide increases dramatically when kids and teens have access to firearms at home, and nearly 60% of all suicides in the United States are committed with a gun. Therefore, guns kept in the home should be unloaded, locked, and kept out of the reach of children and teens. Overdose using over-the-counter, prescription, and non-prescription medicine is also a very common method for both attempting and completing suicide. It is important for parents and caregivers to carefully monitor all medications in the home and to be aware that teens will "trade" different prescription medications at school and carry them, or store them, in their locker or backpack (CDC, 2010).

Figure 22: Demographics of Reviewed Suicide Deaths, 2011 (N=19)

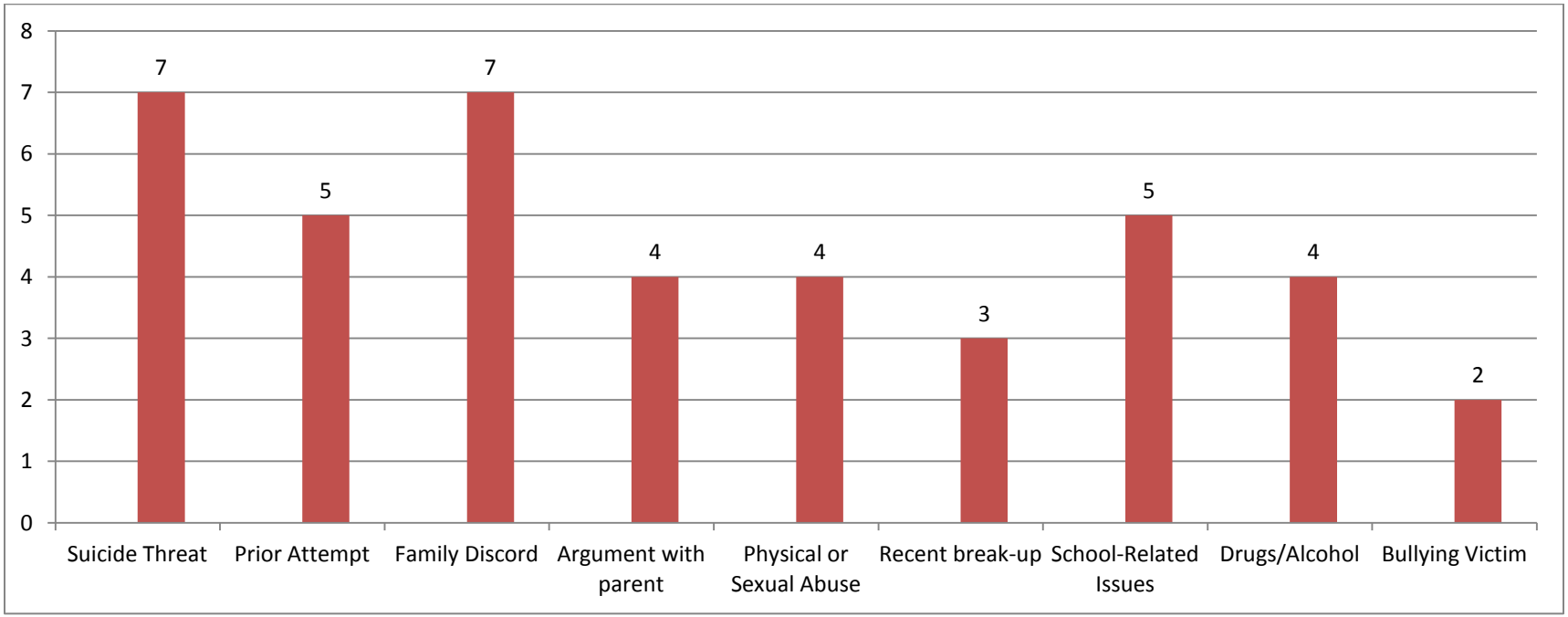
		Number	Percent
Age	10 to 14	7	36.8
	15 to 17	12	63.2
Race/Ethnicity/Gender	White Male	12	63.2
	White Female	2	10.5
	African-American Male	2	10.5
	African-American Female	2	10.5
	Asian Male	1	5.3

- White males accounted for over half of all reviewed suicide deaths (63%)

- Forty-seven percent of all reviewed suicide deaths involved hanging (9); thirty-seven percent involved firearms (7)

- Nationally, suicide rates differ between boys and girls. Girls think about and attempt suicide about twice as often as boys, and tend to attempt suicide by overdosing on drugs or cutting themselves. Yet boys die by suicide about four times as often as girls, perhaps because they tend to use more lethal methods, such as firearms, hanging or jumping from heights.

Figure 23: Suicide Deaths and Reported Risk Factors, when known, 2011

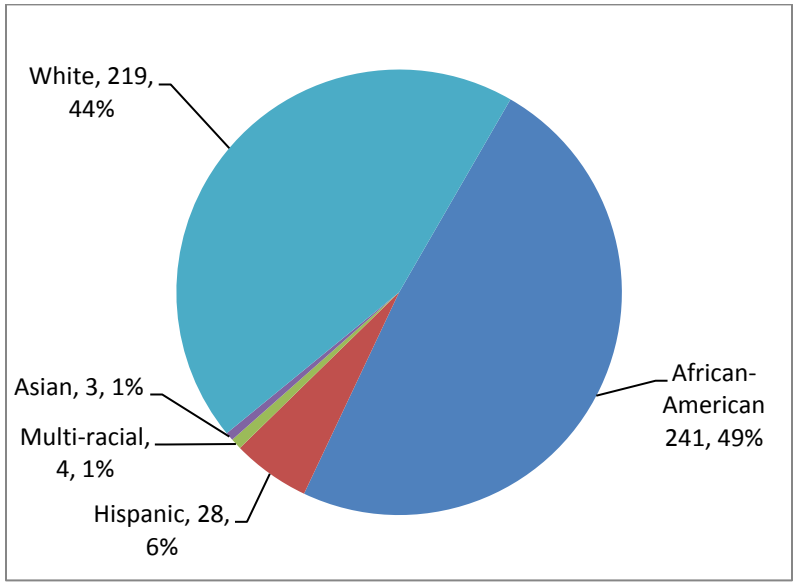


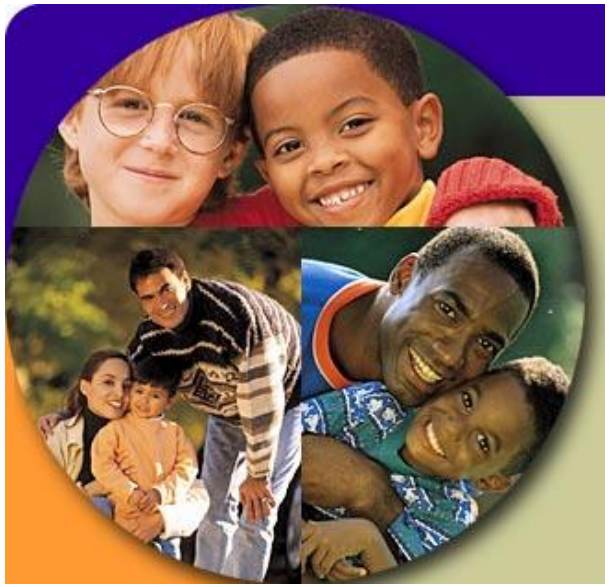
- **Early identification of behavioral indicators and potential risk factors can serve as opportunities for effective prevention (CDC, 2009)**

Disproportionate Deaths

According to the United States Census, the racial makeup of Georgians in 2011 was 63% White, 31% African-American, 9% Hispanic, and 3% Asian. However, the racial makeup of reviewed child fatalities in 2011 did not reflect the general population. African-Americans were disproportionately represented in the reviewed deaths (49%), while proportionally fewer deaths occurred among Whites (44%) and Hispanics (6%), relative to their percentage within the state's population.

Figure 24: Number and Percentage of All Reviewed Deaths by Race/Ethnicity, 2011 (N=495)





According to the Georgia Department of Public Health, Online Analytical Statistical Information System (OASIS), the death rate for African-American infants due to sleep-related circumstances in Georgia was almost twice that of White infants for many years. However, the death rates for other external causes of injury, with the exception of motor vehicle crashes, are nearly identical between African-American children and White children. The death rate for child homicides is five times higher among African-Americans compared to Whites.

Figure 25: Proportion of Reviewed Deaths with Prior Agency Involvement, by Race/Ethnicity and Age, 2011

Proportion of Reviewed Deaths with Prior Agency Involvement, by Race/Ethnicity

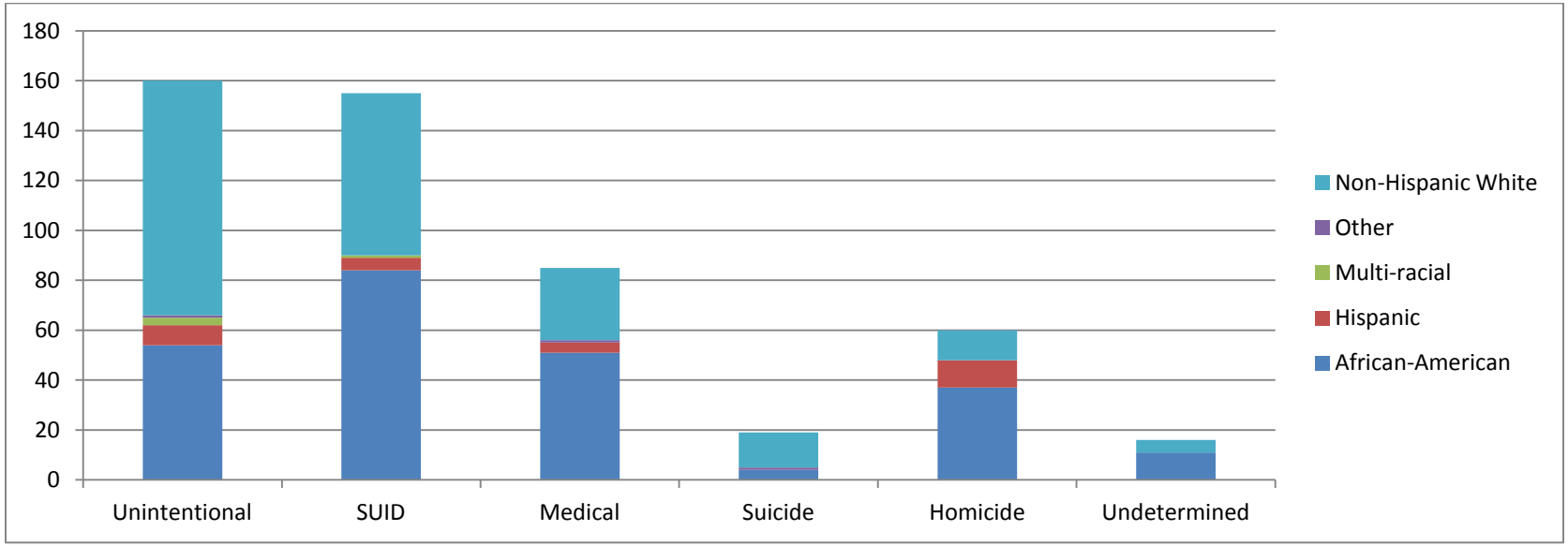
	Number	Percent
White	101	46.1
African-American	140	58.1
Hispanic	17	60.7

Proportion of Reviewed Deaths with Prior Agency Involvement, by Age

Infant	150	68.5
1 to 4	39	45.9
5 to 9	18	40.9
10 to 14	20	35.1
15 to 17	34	37.8

Minorities and infants were more likely to have agency involvement prior to their death.

Figure 26: Causes of Death by Race



It is evident that certain populations bear a disproportionate burden of injury or death. Many state and local agencies are working to identify the causes of the disproportionate deaths and how we can address them. For prevention efforts to be successful, we must consider the unique social and ecological circumstances for all racial and ethnic groups within communities, and tailor prevention programs and services to meet their specific needs. The Office of the Child Advocate remains committed to working with communities through the local CFR committees to develop specific and appropriate prevention plans.

Resources

- Safe Kids USA (www.safekids.org)
- Prevent Child Abuse America (www.preventchildabuse.org)
- National Institute of Child Health and Human Development (www.nichd.nih.gov/sids)
- Suicide Prevention Resource Center (www.sprc.org)
- Centers for Disease Control and Prevention (www.cdc.gov/injury)
- Children's Healthcare of Atlanta, Child Protection Center (www.choa.org/childrens-hospital-services/child-protection-center)
- www.cdc.gov/ViolencePrevention/childmaltreatment/
- www.cdc.gov/ViolencePrevention/pdf/CM_Factsheet2012-a.pdf
- U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. Child Maltreatment 2011 (www.acf.hhs.gov/sites/default/files/cb/cm11.pdf)
- The American Accreditation Healthcare commission
- March of Dimes (www.marchofdimes.com)
- Healthy Babies are Worth the Wait

- Governor's Office of Highway Safety (www.gahighwaysafety.org)
- Georgia Department of Public Health (www.health.state.ga.us)
- Georgia Traffic Injury Prevention Institute (www.ridesafegeorgia.org)
- Georgia Family Connection Partnership (www.gafcp.org)
- Governor's Office for Children and Families (www.children.georgia.gov)
- Safe Kids Georgia (www.safekidsgeorgia.org)
- Prevent Child Abuse Georgia (www.preventchildabusega.org)

- The National Institutes of Health (NIH) "Safe to Sleep" campaign (www.nichd.nih.gov/sids) Text4Baby
- U.S. Fire Administration (www.usfa.fema.gov)
- Statistics from the National Highway Traffic Safety Administration *(www.nhtsa.gov)*
- Children's Healthcare of Atlanta *(www.choa.org)* documentation for Child Passenger Safety Restraint Law in Georgia
- Prevention Tips from Centers for Disease Control and Prevention *(www.cdc.gov)*
- The American Accreditation Healthcare commission

- Data for 2001-2010: Centers for Disease Control and Prevention. Web-based Injury Statistics Query and Reporting System (WISQARS) [Online]. (2012) http://webappa.cdc.gov/sasweb/ncipc/mortrate10us.html

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Reviewable Deaths By County

The following table represents the status of county level reporting compliance for 2011. Please note that the total number of CFR reports does not correspond with the total number of reviewed deaths indicated in this report for a host of reasons. Some committees submitted data online without convening a CFR meeting while others submitted insufficient data to be deemed complete by reporting standards. Also, many committees convened CFR meetings but the data was not submitted online. Some committees were not notified of deaths that occurred within their county and did not have sufficient time to conduct a review at the time of this report. This information is reflected below in the following three categories:

Number of Reviewable Deaths Known

- This is the number of deaths that the Office of the Child Advocate was aware of through a variety of sources (i.e., vital records, Georgia Bureau of Investigations, local medical examiner offices, coroners, and others)

Number of CFR Reports Submitted

- This is the number of completed child death reports submitted via the online reporting system

Number of CFR Reports Not Submitted

- This is the number of reviewable deaths for which a completed report was not submitted via the online reporting system

COUNTY	# OF KNOWN REVIWABLE DEATHS	# OF CFR REPORTS SUBMITTED	# OF CFR REPORTS NOT SUBMITTED
Appling	3	1	2
Atkinson	0	0	0
Bacon	0	0	0
Baker	0	0	0
Baldwin	1	1	0
Banks	0	0	0
Barrow	0	0	0
Bartow	3	3	0
Ben Hill	1	1	0
Berrien	1	1	0
Bibb	8	8	0
Bleckley	0	0	0
Brantley	2	2	0
Brooks	0	0	0
Bryan	2	0	2
Bulloch	4	4	0
Burke	2	2	0
Butts	4	3	1
Calhoun	0	0	0
Camden	3	3	0
Candler	1	0	1
Carroll	6	6	0
Catoosa	6	6	0
Charlton	1	1	0
Chatham	12	10	2
Chatooga	5	5	0
Chattahoochee	0	0	0
Cherokee	9	9	0
Clarke	6	6	0

COUNTY	# OF KNOWN REVIWABLE DEATHS	# OF CFR REPORTS SUBMITTED	# OF CFR REPORTS NOT SUBMITTED
Clay	0	0	0
Clayton	17	17	0
Clinch	1	1	0
Cobb	17	17	0
Coffee	6	5	1
Colquitt	1	1	0
Columbia	13	13	0
Cook	3	3	0
Coweta	9	9	0
Crawford	0	0	0
Crisp	2	2	0
Dade	1	1	0
Dawson	1	1	0
Decatur	2	2	0
DeKalb	39	36	3
Dodge	1	1	0
Dooly	1	1	0
Dougherty	12	12	0
Douglas	8	8	0
Early	1	1	0
Effingham	9	9	0
Elbert	2	2	0
Emanuel	1	0	1
Evans	1	1	0
Fannin	2	2	0
Fayette	3	3	0
Floyd	11	11	0
Forsyth	6	5	1
Franklin	0	0	0

COUNTY	# OF KNOWN REVIWABLE DEATHS	# OF CFR REPORTS SUBMITTED	# OF CFR REPORTS NOT SUBMITTED
Fulton	56	50	6
Gilmer	1	1	0
Glascock	0	0	0
Glynn	7	0	7
Gordon	7	7	0
Grady	1	0	1
Greene	0	0	0
Gwinnett	35	35	0
Habersham	0	0	0
Hall	6	2	4
Hancock	2	2	0
Haralson	1	1	0
Harris	0	0	0
Hart	2	0	2
Heard	2	2	0
Henry	14	12	2
Houston	10	10	0
Irwin	0	0	0
Jackson	1	0	1
Jasper	4	4	0
Jeff Davis	4	2	2
Jefferson	0	0	0
Jenkins	1	1	0
Johnson	0	0	0
Jones	2	2	0
Lamar	0	0	0
Lanier	1	1	0
Laurens	3	1	2
Lee	2	2	0

COUNTY	# OF KNOWN REVIWABLE DEATHS	# OF CFR REPORTS SUBMITTED	# OF CFR REPORTS NOT SUBMITTED
Liberty	3	2	1
Lincoln	2	0	2
Long	2	0	2
Lowndes	9	9	0
Lumpkin	1	1	0
Macon	0	0	0
Madison	4	4	0
Marion	0	0	0
McDuffie	2	1	1
McIntosh	5	0	5
Meriwether	0	0	0
Miller	0	0	0
Mitchell	2	2	0
Monroe	4	4	0
Montgomery	0	0	0
Morgan	2	2	0
Murray	6	6	0
Muscogee	14	14	0
Newton	11	9	2
Oconee	1	1	0
Oglethorpe	0	0	0
Paulding	4	4	0
Peach	2	2	0
Pickens	0	0	0
Pierce	1	1	0
Pike	1	0	1
Polk	5	4	1
Pulaski	0	0	0
Putnam	0	0	0

COUNTY	# OF KNOWN REVIWABLE DEATHS	# OF CFR REPORTS SUBMITTED	# OF CFR REPORTS NOT SUBMITTED
Quitman	1	1	0
Rabun	2	2	0
Randolph	0	0	0
Richmond	13	12	1
Rockdale	4	4	0
Schley	0	0	0
Screven	0	0	0
Seminole	0	0	0
Spalding	3	3	0
Stephens	1	0	1
Stewart	0	0	0
Sumter	0	0	0
Talbot	0	0	0
Taliaferro	0	0	0
Tattnal	2	0	2
Taylor	0	0	0
Telfair	0	0	0
Terrel	2	2	0
Thomas	1	1	0
Tift	2	2	0
Toombs	2	0	2
Towns	0	0	0
Treutlen	0	0	0
Troup	3	3	0
Turner	1	1	0
Twiggs	0	0	0
Union	2	2	0
Upson	3	3	0
Walker	2	2	0

COUNTY	# OF KNOWN REVIWABLE DEATHS	# OF CFR REPORTS SUBMITTED	# OF CFR REPORTS NOT SUBMITTED
Walton	4	4	0
Ware	3	3	0
Warren	0	0	0
Washington	6	5	1
Wayne	2	2	0
Webster	0	0	0
Wheeler	0	0	0
White	2	2	0
Whitfield	3	3	0
Wilcox	0	0	0
Wilkes	0	0	0
Wilkinson	0	0	0
Worth	1	0	1
Total	557	495	62