Georgia Child Fatality Review Panel

2009 ANNUAL REPORT

Georgia Child Fatality Review Panel
Annual Report
Calendar Year 2009

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Mission

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

Acknowledgements

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

- All the members who serve on each of the county child fatality review committees
- John Carter, Ph.D. Epidemiology Department of Emory University, Rollins School of Public Health
- Katherine Kahn, M.P.H. Maternal and Child Health Program Epidemiologist, Division of Public Health, Department of Community Health
- Jimmy Clanton, Graphic Designer. Georgia Division of Public Health, Department of Community Health

Georgia Child Fatality Review Panel

Dear Governor Perdue and Members of the Georgia General Assembly:

On behalf of the Georgia Child Fatality Review Panel, I present to you the 2009 Abridged Annual Report. This report provides a statistical overview of child deaths that occurred in Georgia during the 2009 calendar year. In accordance with our mission to accurately track the causes of unexpected deaths in Georgia's children and to promote effective prevention measures, the CFR Panel has launched the following initiatives:

In January 2009, the Child Fatality Review Panel transitioned to the National Center for Child Death Review (NCCDR) Case Reporting System, a more comprehensive web-based data tool which assists local committees in providing more thorough scene investigation and agency-specific information.

In July 2009, Georgia was one of five states selected by the Centers for Disease Control and Prevention (CDC) to participate in a three-year pilot project, the Sudden Unexpected Infant Death Case Registry. The purpose of this project is to enhance our understanding of circumstances surrounding unexplained infant deaths. The result of reliable data will ultimately be the development of prevention measures that will reduce such deaths from occurring. As a participant in this project, Georgia has been awarded grant funds which aid in providing vital resources to assist local committees in their diligent efforts to reduce infant mortality.

In October 2009, the Child Fatality Review Panel supported the Office of Vital Records by assisting staff with core functions necessary for accurate reporting of child deaths.

Thank you for your continued support of this vital work. The CFR Panel will continue to honor the memories of children unnecessarily lost by gathering and interpreting data to better equip communities with prevention strategies.

Sincerely,

Velma C. Tilley

Judge Velma C. Tilley, Chair

Georgia Child Fatality Review Panel

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Preface

The year 2010 marks the 20th anniversary of the existence of the Georgia Child Fatality Review Panel. Created through legislation with the ultimate purpose of preventing avoidable child deaths, the Panel is charged with collecting and interpreting local child-specific data. To this end, multi-disciplinary child fatality review committees in every county come together to share information and track the reviewable child deaths in the jurisdiction. Recognizing that Georgia's children are our most valuable resource and our most vulnerable population, the Panel has evolved and adapted to the logistical, economic and strategic challenges that have arisen over time.

Over the last two decades, the Panel has succeeded in dramatically improving the quality and quantity of data received from local committees. Georgia is now well-positioned to move decisively toward proven prevention measures that are data-driven and supported by evidence. However, progress is contingent on the continued momentum built through collaboration between the Panel and its partners in government and the community. As the Panel has seen progress, it has also faced disappointment. We continue to see that the number one cause of death in infants is related to sleep environment, despite the efforts of numerous governmental and private organizations. In the same vein, we continue to experience the greatest loss of young children through motor vehicle accidents. These forms of entirely preventable loss of precious life must become priorities statewide.

In this report, challenges to progress and resulting or needed systems changes are outlined, along with summaries of current data. It will become clear as you examine this report that action is desperately needed to improve capacity at the Office of Vital Records, an anchor for the process of Georgia child death review. To this end, the Panel and its partners are collaborating to determine how best to support a Vital Records system that is facing massive challenges.

For 20 years, the Panel has served as the only complete source for child death review information in Georgia. The Panel is now poised to collaborate and lead in the growing movement for prevention of needless child deaths in Georgia over the next decade. The time is now to provide Georgia's children with the safe, healthy environment they deserve.

Rachelle Carnesale

Rachelle Carnesale, J.D.
Acting Director
OCA/CFR

This report was developed and written by the CFR Division staff:
Arleymah Raheem, Wende Parker, Malaika Shakir
With essential support from Carri Cottengim and Sarah Stocker

History and Progression of Child Fatality Review in Georgia

In 1990, legislation established the Statewide Child Fatality Review Panel with responsibilities for compiling statistics on child fatalities and making recommendations to the Governor and General Assembly based on the data. It established local county protocol committees and directed that they develop county-based written protocols for the investigation of alleged child abuse and neglect cases. Statutory amendments were adapted to establish separate child fatality review committees in each county and determine procedures for conducting reviews and completing reports.

Deaths are eligible for review when the child is less than 18 years of age, and when the death meets the criteria for a coroner or medical examiner investigation. Legislation requires that the death of a child under the age of 18 must be reviewed when the death is suspicious, unusual, or unexpected. Included in this definition are incidents when a child dies: as a result of violence; by suicide; from an unintentional injury (e.g. car crash or fire); suddenly when in apparent good health; from any medical condition when unattended by a physician; in any suspicious or unusual manner, especially if the child is under 16 years of age; after birth but before seven years of age if the death is unexpected or unexplained; while an inmate of a state hospital or a state, county, or city penal institution; or as a result of a death penalty execution.

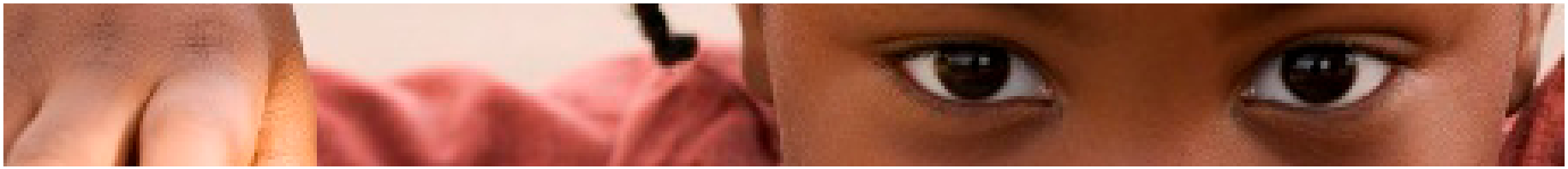
In 1996, researchers from Emory University and Georgia State University conducted an evaluation of the child fatality review process. The evaluation concluded that there were policy, procedure and funding issues that limited the effectiveness of the review process. In 2003, the Panel distributed its first child fatality review

protocol manual to all county committee members. An online reporting system was established for both the child fatality review report and the coroner/medical examiner report. A partnership was established between the Georgia Office of Child Fatality Review and the National Center for Child Death Review. The Georgia Child Fatality Investigation Team (CFIT) program was established through a partnership between CFR, the Department of Family and Children Services, and the Georgia Bureau of Investigation.

In 2004, the Prevention Advocate was added – by policy – to the child fatality review committee membership, the office quarterly newsletter was established and distributed to all members and agency partners, and a sub-committee of the Panel was formed to begin creating the Statewide Child Injury Prevention Plan. In 2006, the child fatality review protocol manual was revised and updated to reflect best practices. The CFIT program expanded to address all types of multi-disciplinary child abuse investigations, including sex abuse, physical abuse and neglect, as well as homicides. In 2008, the Office of Child Fatality Review was merged with the Office of the Child Advocate for the Protection of Children (OCA). Subsequent to the merger, the CFIT program expanded to include a statewide comprehensive training academy. The training academy faculty is comprised of subject matter experts in the fields of law, medicine, law enforcement, and child welfare. Additionally, the Statewide Child Injury Prevention Plan was completed and presented to the Governor's Office and other agency partners.

In 2009, child fatality review committee reports were submitted to a web-based reporting system developed and maintained by the National Center for Child Death Review. The system offers many benefits to staff and county review committees, including the capability for local committees to produce their local data reports in real time. The Child Fatality Review Division of the Office of the Child Advocate was awarded a three-year grant from the Centers for Disease Control and Prevention (CDC) to implement the Sudden Unexplained Infant Death (SUID) Case Registry pilot project.

The child fatality review process in Georgia has evolved and improved over the past twenty years. Due to the intense work and dedication of the CFR staff and partners, the success is evident in the effectiveness of the review committees. In the next few years, we will continue to work on improving data collection and reporting through the CDC SUID Case Registry project, continuing collaboration with the OCA Child Welfare Division staff activities, the Georgia Violent Death Reporting System, and the Office of Vital Records, and seeking out partnerships for prevention and health promotion. These activities will strengthen the position of CFR among agencies and communities, and support our mission of prevention and reduction of child abuse and fatality in our state.



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Clyde L. Reese, III, Esq., Commissioner Sonny Perdue, Governor

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The Office of Vital Records, in the Department of Community Health, Division of Public Health, works diligently to provide accurate records and data concerning vital events to Georgians and other stakeholders in an expeditious and friendly manner. Two of our primary tasks are to record and enter all occurrences of Georgia vital events into the vital records database (more than 200,000 records each year), and prepare certified copies of birth and death records (nearly 318,000 copies each year). The Child Fatality Review Division of the Office of the Child Advocate (OCA/CFR) has been very helpful in providing staff to assist us in completing this work.

In 2009 and 2010, OCA/CFR has been a strong partner in the effort to improve efficiencies in recording death certificates to the vital records electronic database. Death certificates are completed by funeral directors and certifying physicians, except in the case of coroner investigations where the coroner certifies the manner of death. The CFR Division staff has dedicated time to obtaining these necessary records when they were unavailable to us, which also supports their work in comparing CFR reports by committees to vital statistics data. Additionally, we have begun sharing birth certificate data with CFR to assist them in their CDC Sudden Unexplained Infant Death Investigation grant-related data collection activities. We welcome the opportunity to partner with CFR and look forward to a long and collaborative relationship.

Unfortunately, one of the problems with our death information is the lack of ICD-10 coding. The employee who was entering this information retired earlier this year and because NCHS indicated their intentions to assume this responsibility and that particular skill requires several months of training and approximately two years experience to become proficient, we have not attempted to replace her. We hope to work out the kinks in the processing of this data in the upcoming months.

We look forward to enhancing the mutual benefits of our relationship with CFR in the future. As of this date, over 40,000 2010 death records have been entered in our system by funeral homes, county registrars and OVR staff. The advantages of having this data readily available cannot be overrated.

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"The child fatality review process in Georgia has evolved and improved over the past twenty years. Due to the intense work and dedication of the CFR staff and partners, the success is evident in the effectiveness of the review committees. In the next few years, we will continue to work on improving data collection and reporting through the CDC SUID Case Registry project, continuing collaboration with the OCA Child Welfare Division staff activities, the Georgia Violent Death Reporting System, and the Office of Vital Records, and seeking out partnerships for prevention and health promotion. These activities will strengthen the position of CFR among agencies and communities, and support our mission of prevention and reduction of child abuse and fatality in our state."

All 2009 Reviewed Child Deaths

Child fatality review committees utilize a multidisciplinary approach to review all available circumstances surrounding the death, including any relevant history the family has had with public agencies. The resulting information provides a more accurate picture of what happened and helps to create more targeted prevention efforts. Greater knowledge of child deaths leads to more opportunities for the prevention of child deaths. In addition, comprehensive reviews can clarify trends in causes and show patterns of increasing or decreasing deaths.

CFR staff obtained initial records and death notifications from a variety of sources, including coroner/medical examiner reports, Vital Records (VR) death certificates, Georgia Bureau of Investigation (GBI), and Department of Family and Children Services (DFCS). While Vital Records death certificates generally provide a true and valid denominator of all deaths occurring in the state, several issues with VR reporting have resulted in an incomplete file of records for 2009. Therefore, CFR did not have a full and complete denominator of deaths for 2009, and no way to conclusively determine if all the deaths that were reviewed represented all the child deaths that occurred.

However, with the notifications that were received, staff were able to identify those deaths in need of review. CFR staff worked very closely with local CFR committees to ensure that those identified deaths were reviewed within a timely manner, and that the reports detailing the circumstances of death were thorough and accurately submitted to the office. The following data are based on those deaths that were reviewed and reported using the CFR web-based reporting form. The form can be viewed at http://childdeathreview.org/reports/CDRCaseReportForm2-1-11009.pdf.

In 2009, CFR committees reviewed 518 child deaths. Thirty-eight percent of these deaths (199) were among infants younger than 12 months. The following charts show the variation in causes of death between infants and children over the age of one. SUID (Sudden Unexplained Infant Death – usually occurring during sleep) was the leading cause of death among infants (134), followed by medical causes (32). For children over the age of one, unintentional injuries were the leading cause of reviewed deaths (165 – including motor vehicle, drowning, fire, asphyxia, and other circumstances), followed by medical causes (67). The greatest number of infant deaths was due to sleep-related circumstances, while the greatest number of child deaths was due to motor vehicle-related circumstances.

Figure 1 shows the number of all reviewed deaths of infants by cause in 2009 (N=199)

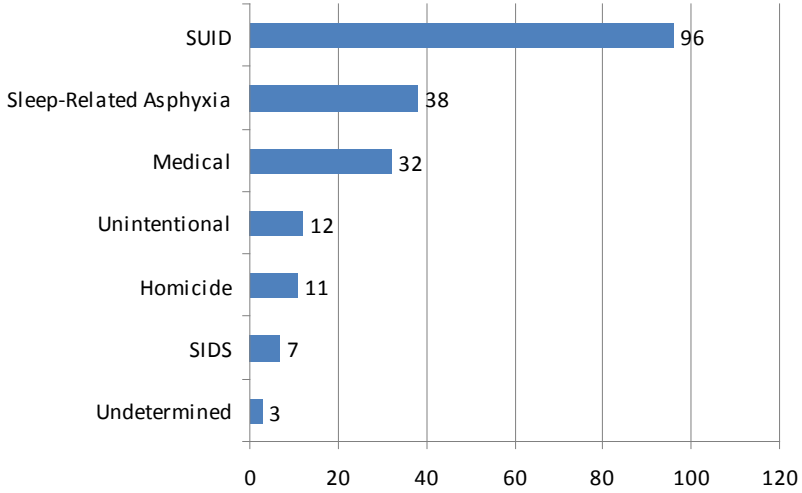
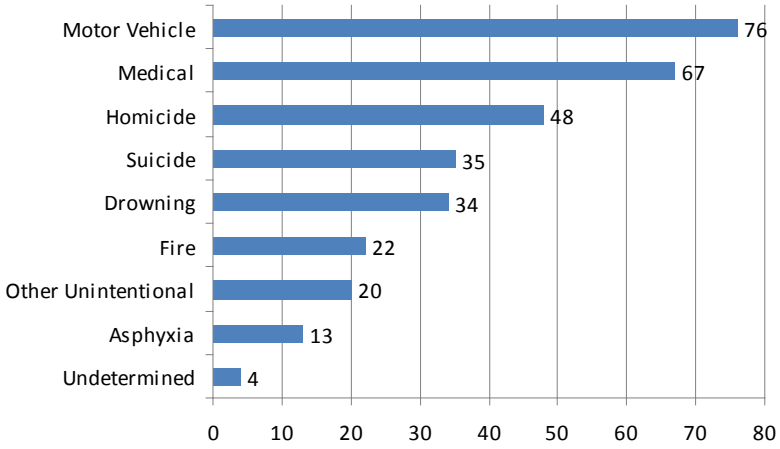


Figure 2 shows the number of all reviewed deaths of children ages 1-17 by cause in 2009 (N=319)



- African-Americans and Whites together were 88% of all reviewed deaths, while Hispanics were nine percent of the total
- Infants were 38% of the reviewed deaths, while older teens (15-17) and toddlers (1-4) together made up 40% of the total
- Consistent with previous years, males were 60% of the total reviewed deaths

The following charts show the race/ethnicity, gender, and age categories of the 518 deaths reviewed. All race categories reported are non-Hispanic, except where otherwise noted. The race/ethnicity of "Hispanic" includes any infant or child reported to be any race plus Hispanic ethnicity.

Figure 3 shows the race/ethnicity of all reviewed deaths in 2009 (N=518)

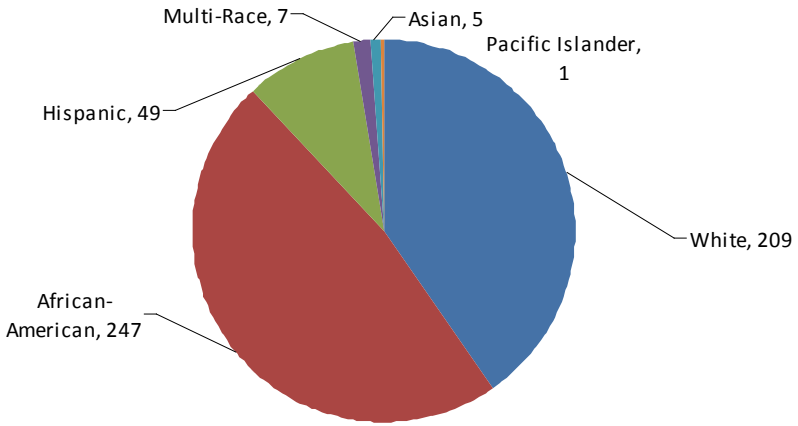


Figure 4 shows the age category of all reviewed deaths in 2009 (N=518)

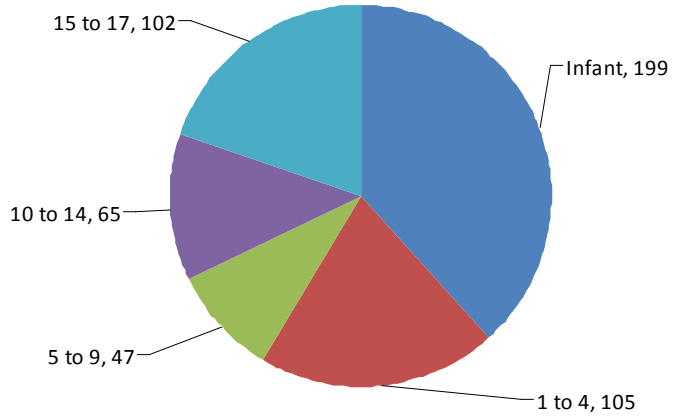
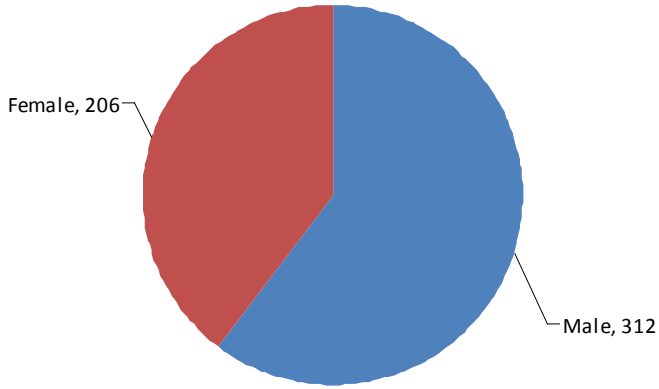


Figure 5 shows the gender of all reviewed deaths in 2009 (N=518)



Spotlight on Maltreatment

In 2006, the Georgia Child Fatality Review Panel was designated to serve as one of Georgia's three Child Abuse Prevention and Treatment Act (CAPTA) citizen review panels. As the recipient of a federal CAPTA grant, Georgia is required to maintain and support three independent citizen review panels whose purpose is to examine the policies, procedures, and practices of State and local agencies. The panels are further required to evaluate the extent to which they are effectively discharging their child protection responsibilities, which includes a review of maltreatment-related child fatalities and near fatalities. Based on their review, CAPTA citizen review panels make recommendations for system improvements in the prevention and treatment of cases of child maltreatment.

The CDC describes child maltreatment as emotional, physical, or sexual abuse (i.e. acts of commission) and/or neglect (i.e. acts of omission) to a child under the age of 18 years by a person in a custodial role to that child (i.e. parent or other caregiver). The CDC and other national organizations have long recognized the need for a consistent definition of child maltreatment. The Child Fatality Review reporting system collects information on maltreatment specific to acts of omission (child neglect) and acts of commission (child abuse). These descriptions of maltreatment, along with consistent data collection and investigation efforts at the local level, can produce a more thorough examination of child death trends for prevention.

Of the 518 child deaths in 2009, CFR committees identified 77 children as victims of maltreatment. This identification was based on a positive response to one or more of the following four variables:

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

Forty-five child death reviews revealed that the child had history of maltreatment as a victim. In 14 cases, the investigation found evidence of abuse. In 23 cases, child abuse reportedly caused/contributed to the child's death, and in three cases, child neglect reportedly caused/contributed to the child's death (N=26). Because four separate variables were used to determine maltreatment, there was some overlap with the reporting. There were 21 cases where the committees identified two of the four maltreatment variables, and two cases with three maltreatment variables identified. There were no cases where all four maltreatment variables were included in the report.

Of these 77 children with maltreatment identified, 34 were reported as homicide deaths (44%), 12 were medical deaths (16%), eight were suicide deaths (10%), and five were infant sleep-related deaths (six percent). Maltreatment reported by race/ethnicity identified 39 African-Americans (51%), 31 Whites (40%), six Hispanics (eight percent), and one Multi-racial child.

Children ages 0-4 represented 41 of the child deaths with maltreatment identified (53%), and 21 of the child deaths with maltreatment identified (27%) were teens (13-17).

CFR committees were able to identify an additional 179 children where some form of omission or commission occurred and was a contributing cause in the death. Examples of other contributing causes include poor supervision or other negligence. CFR has collected data on child maltreatment for many years, and the capacity to consistently collect the information relies upon the CFR committee approach and that all organizations work together to produce accurate and thorough case information.

Agency Involvement

Committees were asked to report on the number and type of agencies who had involvement with the child or the child's family at any point prior to the death. Involvement was generally defined as having provided services of some type (e.g. mental health, social services, law enforcement, disability services, etc.) to the child or the child's family. In many cases, multiple agencies were providing services to a single family. These represent opportunities for education, prevention, and risk reduction counseling with each agency visit or staff interaction.

- 15 children were receiving services through Children with Special Health Care Needs (CSHCN) for a disability or chronic illness
- 23 children had received mental health services at one time, and 13 of the 23 were currently receiving services at the time of death
- 32 children had an open CPS case at the time of death
- 26 children had prior court involvement for delinquent or criminal history
- 11 children had spent time in juvenile detention prior to their death
- 106 cases reported that a caregiver had received social services (e.g., WIC, food stamps, Medicaid, TANF) in the 12 months prior to death

Opportunities for Prevention

- Of the 11 children with juvenile court history, eight (73%) died from intentional injuries (six homicides and two suicides)
- Of the 32 children with open CPS cases, eight died from sleep-related causes, seven died from intentional injuries (homicide), and five died from medical causes
- Of the 23 with any mental health service history, 13 died from intentional injuries (nine suicides and four homicides), and five died from medical causes
- Of the 15 children receiving CSHCN services, seven (47%) died from medical causes

Death Scene Investigation

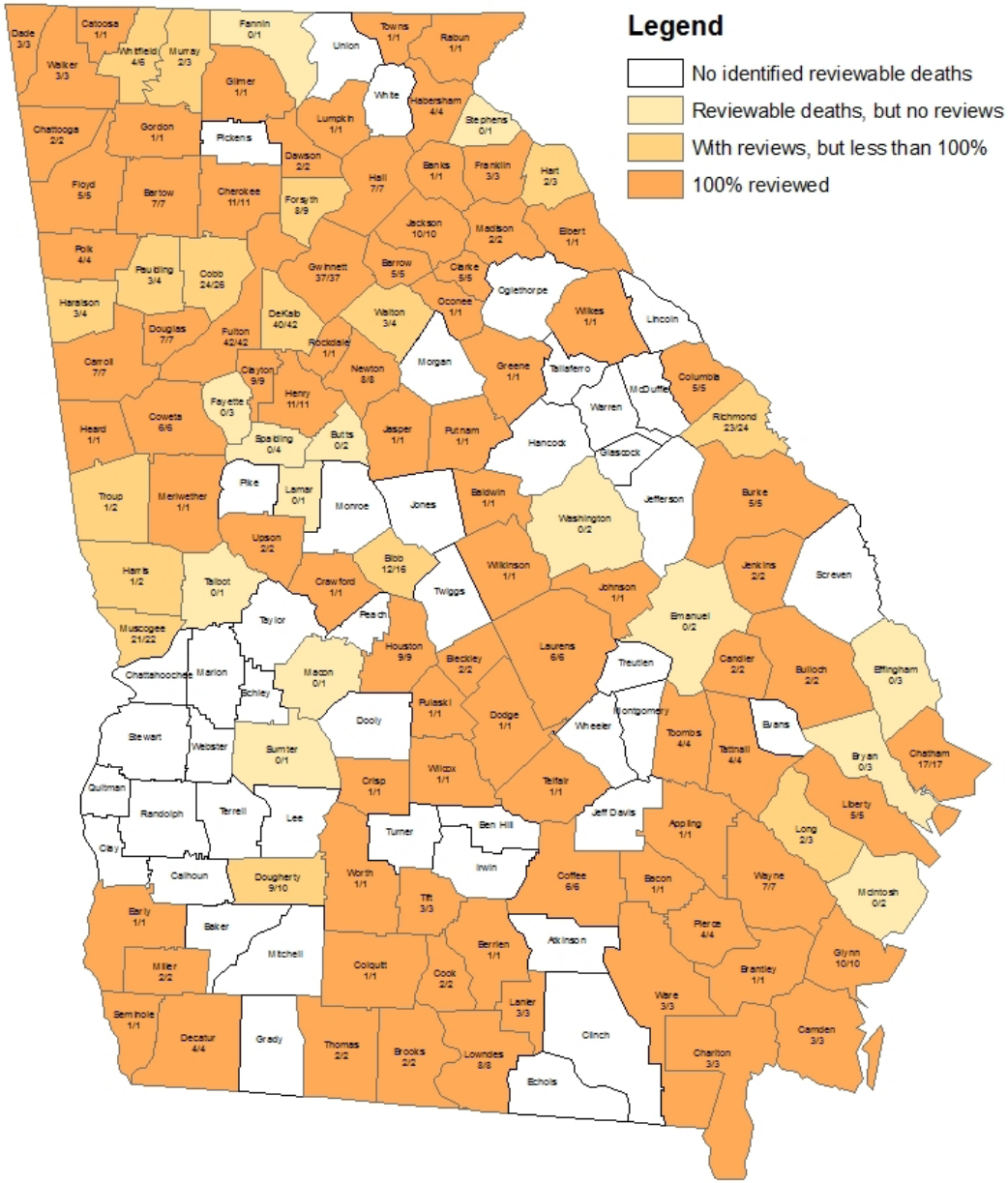
Committees reported that in 54 cases, there were no agencies involved in the death scene investigation. In the remaining 464 cases reviewed, there was at least one agency that participated in the death scene investigation

Agencies Involved	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total
0	22	9	7	8	8	54
1	34	19	9	13	19	94
2	62	35	16	18	36	167
3	65	29	13	15	31	153
4	11	10	0	7	7	35
5	5	1	2	4	1	13
6	0	1	0	0	0	1
7	0	1	0	0	0	1

- The average number of agencies involved in death scene investigation (DSI) is just over 2.1, and does not vary by age category

Child Fatality Reviews 2009

Numbers are number reviewed out of number reviewable



Sleep-Related Infant Deaths

A 4-week-old infant was placed on his back and in bed with his parents to sleep for the night. Their bed was very soft and had an egg-crate mattress on top of the queen mattress. Sometime during the night, the father got up and moved to another room. When he awoke later, he discovered that the infant was cold and not moving. EMS was called but the child was already deceased. When his body was sent for autopsy, the cause of death could not be determined due to the history of bed-sharing and possible overlaying. While this family did have some protective factors that could have reduced his risk of death (he was healthy at birth; full-term and normal birthweight; his mother did not have a history of smoking during pregnancy), there were other risk factors for this family: his mother was an older teenager with a high school education, and while his usual sleeping place was a bassinette, he was not placed there on this night.

Definitions

Sudden infant death syndrome (SIDS) is the sudden death of an infant under age one that cannot be explained after a thorough investigation has been conducted, including a complete autopsy, an examination of the death scene, and a review of the clinical history.

Sudden Unexplained Infant Death (SUID) is the sudden and unexpected death of an infant in which the manner and cause of death are not immediately obvious prior to investigation. SUID cases may sometimes appear to be SIDS at first glance, but a thorough and complete investigation reveals other contributing risk factors present.

Sleep-related asphyxia is reported when the circumstances of the death clearly show that the infant experienced suffocation during sleep (e.g. positional asphyxia, wedging, or strangulation). Infant sleep-related asphyxia deaths often occur while bed-sharing with another person.

This category of sleep-related infant deaths captures SIDS, SUID, and sleep-related asphyxia. How are SUID and SIDS different? SUID can be caused by undiagnosed metabolic disorders, possible hypothermia or hyperthermia, undetermined neglect or homicide, undetermined poisoning, or undetermined suffocation. Often the cause is unknown. Research by the Centers for Disease Control and Prevention (CDC) has found that the decline in SIDS since 1999 corresponds to an increase in SUID rates during the same period. This change in the classification of SUID can be explained by changes in how investigations are conducted and how SUID is diagnosed.

When residence location was reported for infant sleep-related deaths (N=124), 53 occurred in suburban counties (43%), 40 occurred in urban counties (32%), and 31 occurred in rural counties (25%)

Spotlight on Maltreatment

Of the 141 sleep-related infant deaths in 2009, five infants were reported to have evidence of maltreatment prior to or at the time of death. Four were reported as SUID and one was a sleep-related asphyxia. Two infants were White, two were African-American, and one was Multiracial.

Figure 6 shows the demographic data for reviewed sleep-related infant deaths, 2009 (N=141)

	SIDS	Asphyxia	SUID	All	%
White Male	1	9	23	33	23.4
White Female	1	9	19	29	20.6
African-American Male	1	13	26	40	28.4
African-American Female	2	3	18	23	16.3
Hispanic Male	1	2	3	6	4.3
Hispanic Female	0	1	4	5	3.5
Other Race Male	1	1	1	3	2.1
Other Race Female	0	0	2	2	1.4
Total	7	38	96	141	100.0

Figure 7 shows the reviewed sleep-related deaths by caregiver age (when known), 2009 (N = 119)

Caregiver Age	SIDS	Asphyxia	SUID	All	%
<20	0	6	12	18	15.1
20-29	3	23	53	79	66.4
30+	1	5	16	22	18.5
Missing/ Unknown	3	4	15	22	--

Smoking during pregnancy was reported for 31 infant sleep-related deaths. In 12 cases, the committees received evidence of prenatal smoking and in 19 cases, there was none.

Although two-thirds of the reviewed infant deaths were with caregivers between 20 and 29 years of age, sleep-related infant deaths are not directly related to a caregiver's or mother's age. Prevention education should target youth and adults of all ages, to ensure that all potential caregivers have the best information before taking on the responsibility of caring for an infant.
Risk Factors for SIDS, SUID, and sleep-related asphyxia include: bed-sharing, prone sleep position, tobacco exposure, and delayed prenatal care. According to the Department of Health and Human Services (DHHS), infants born to mothers who received no prenatal care are three times more likely to be born at low birth weight, and five times more likely to die, than those whose mothers received prenatal care. Georgia PRAMS (Pregnancy Risk Assessment Monitoring System), a statewide surveillance system, show the population estimates for maternal behaviors, including these risk factors. The most recent published PRAMS data are from women who delivered a live-born infant in Georgia between 2004 and 2006.

- PRAMS data show 78% of respondents reported entering prenatal care during their first trimester
  - The highest percentages of women who enter prenatal care during their first trimester are: non-Hispanic White women, women 30-39 years old, women whose highest level of education is completion of college, and women with a household income of $50,000 or higher
  - PRAMS data also show that 76-80% of women reported receiving prenatal care and counseling from an MD or HMO. Only 18-19% received prenatal care and counseling from a health department or hospital clinic. The highest reported barriers to care were appointment availability and cost

Figure 8 shows the reviewed sleep-related deaths by gestational age (when known), 2009 (N=76)

Gestational Age in Weeks	SIDS	Asphyxia	SUID	All
Moderate-Extreme Preterm, <34 weeks	1	3	4	8
Late Preterm, 34-36 weeks	0	1	16	17
Term, 37+ weeks	0	15	36	51
Missing/Unknown	6	19	40	--

- PRAMS data show 51% of respondents reported that their infant sleeps in the same bed with them or someone else
  - The highest percentages of women who report that their infant is bed-sharing are: African-American women, women younger than 20 years old, women whose highest level of education is completion of high school or less, Hispanic women, women with a household income of less than $15,000, non-married women, and women who delivered an infant weighing between 1,500 and 2,499 grams (3lbs 5oz – 5lbs 8 oz)
  - Infant bed-sharing appears to be increasing among women whose race is other than African-American or White, women 40 years or older, and women with a household income between $35,000 and $49,999

Of the 141 sleep-related infant deaths reviewed in 2009, 26 were reportedly low birthweight (<2,500 grams) and 45 were reportedly normal birthweight (>2,500 grams). This information was not provided for 70 of the deaths (50% missing/unknown).

- PRAMS data show 19% of respondents reported smoking a cigarette during the three months before pregnancy
  - The highest percentages of women who report smoking before pregnancy are: non-Hispanic White women, women 29 years or younger, non-married women, and women whose delivery was paid for by Medicaid
  - Pre-pregnancy maternal smoking appears to be increasing among women who delivered an infant weighing less than 1,500 grams (3lbs 5oz)

Figure 9 shows the reviewed sleep-related deaths by bed-sharing (when known), 2009 (N=110)

Sharing Sleep Surface	SIDS	Asphyxia	SUID	All	%
Yes	1	20	65	86	78.2
No	1	9	14	24	21.8
Missing/ Unknown	5	9	17	31	--

Figure 10 shows the reviewed sleep-related deaths by sleeping position when discovered (when known), 2009 (N = 106)

Sleep Position	SIDS	Asphyxia	SUID	All	%
On back	4	2	26	32	30.2
On stomach	0	26	31	57	53.8
On side	0	4	13	17	16.0
Missing/ Unknown	3	6	26	35	--

Opportunities for Prevention:

- Encourage crib use in families and communities. Use a crib that meets current safety standards. The mattress should be firm and fit snuggly in the crib. Cover the mattress with only a tight-fitting crib sheet. Portable cribs and play yard style cribs are also good choices
- Fewer than 20% of women in Georgia seek prenatal care from a health department or hospital. Support private health care providers by encouraging training and providing resources for counseling of new mothers. Support communities and providers by incorporating culturally and linguistically competent values, policies, structures and practices in SIDS/Infant Death-related programs.
- Support public health campaigns to promote healthy habits among parents expecting a child or caring for an infant to prevent child malnutrition (such as Text4Baby.org). Support medical research to better understand and prevent birth defects, premature birth and Sudden Infant Death Syndrome (SIDS) and to promote healthier growth and development

Prevention Success

A product recall was initiated for Amby Baby Motion Hammocks after a county review. A mother placed her infant in the hammock on her back after a feeding. When the mother checked on her infant around 3:00 am, the infant was found face down with her face in the mattress. Soon after this case was submitted, the Consumer Product Safety Commission issued a recall in December 2009. This county review was instrumental in the product recall

All Reviewed Medical Deaths

She was a 17-year-old high school student, and in school on this last day of her life. She had been in the hospital a few months before her death and diagnosed with severe hypertension. She was on four different medications for her high blood pressure. On this fateful day, she was crying and complaining of a severe headache. She asked a classmate to bring her to the school clinic. She admitted that she had not taken her medication that morning. Her blood pressure was extremely high and she became unresponsive. Her mother was contacted and EMS was called. She was transported to the hospital emergency department but they were unable to save her. Her final diagnosis: acute intracerebral hemorrhage – her brain functions had completely stopped. She was pronounced dead on that same day

Definitions

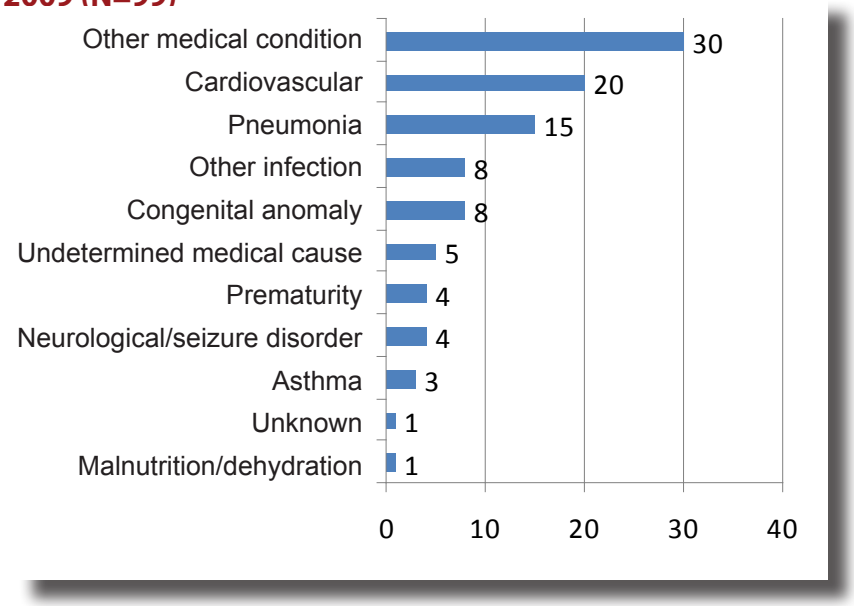
Medical deaths are eligible for review by committees when the death is referred to the coroner or medical examiner and meets CFR eligibility criteria (i.e. unexpected/unexplained/suspicious circumstances). Examples of reviewable medical deaths are those from medical illnesses that do not normally cause death in otherwise healthy children, and can be successfully managed with proper medical care and treatment (i.e. asthma or high blood pressure). However, many medical deaths may not be reviewed by committees if the death occurred in the hospital, or was not reported to the local coroner/medical examiner. [Note: deaths that occur while in hospice care are not considered reviewable by CFR, as they are considered “expected” deaths]

Figure 11 shows the demographic data for reviewed medical deaths, 2009 (N=99)

	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total
White	11	5	2	5	7	30
African-American	18	12	9	9	12	60
Hispanic	2	1	0	1	1	5
Multi-racial	1	1	0	0	1	3
Other Race/ Ethnicity	0	0	0	0	1	1
Total	32	19	11	15	22	99

A death due to a natural cause can result from one of many serious health conditions. Congenital anomalies, genetic disorders (such as cystic fibrosis), cancers, heart and cerebral problems, serious infections and respiratory disorders such as asthma can be fatal to children. Many of these conditions are not believed to be preventable in the same way in which accidents, homicides or suicides are preventable. But there are some illnesses, such as asthma, infectious diseases and some genetic disorders, in which under certain circumstances, fatalities can and should be prevented. Treatments for asthma, certain infectious diseases, and other medical conditions are numerous and generally very effective.

Figure 12 shows the causes of medical deaths reviewed in 2009 (N=99)



Spotlight on Maltreatment

There were 12 medical deaths reviewed with maltreatment findings. Six were African-American (50%), five were White (42%), and one was Hispanic. Of the 12 deaths, two were children younger than five years old, three were ages 5-9, and seven were ages 10-17. In all 12 cases, the committee did not determine that the prior abuse directly caused or indirectly contributed to the death. The committee noted in four of the cases, the child had been treated by a physician shortly before the death.

There were 99 medical deaths reviewed by committees in 2009. Of the 99 deaths reviewed, 41 children were reported to have a known physical disability or chronic illness at the time of death. Twenty-one had reported heart or lung disorders (including asthma, lung disease, and heart disease), and seven had reported seizure disorders. Several children had multiple illnesses reported. Thirty-five children had no known disability or chronic illness reported before death. Of these 35, eight deaths were determined to be due to pneumonia. Pneumonia can be caused by a variety of agents including bacteria, viruses, and mycoplasmas, among others. Pneumonia remains an important cause of morbidity and mortality in the United States as both a primary and secondary infection. The “other medical conditions” reported (30) consist of a variety of conditions that are not adequately represented in other named categories, such as necrotizing fasciitis, spontaneous pneumothorax, and pulmonary embolism.

Opportunities for Prevention:

- Regular health exams and tests can help find problems early, when the opportunities for treatment and cure are better
- Remove triggers that may cause asthma or other respiratory health problems. Triggers include smoke, dust mites, cockroaches, pets, and mold
- The most important thing that all people can do to help keep from getting sick is to wash hands, especially after coughing and sneezing, before preparing foods or eating, and after using the restroom. It is estimated that one out of three people do not wash their hands after using the restroom

Prevention Success

Due to an increase in asthma deaths in one community, an asthma prevention coalition was created. The coalition is now working closely with the school system to do research on air quality

Unintentional Injury-Related Deaths

A 14-year-old, accompanied by a teenage friend, lost control of an ATV. The teens crossed the highway, striking a parked car, a mailbox, rocks, and finally a tree. Both children were ejected from the vehicle and killed.

Definitions

Unintentional injury is damage to a person's body via mechanical, thermal, or chemical distribution. These injuries are not deliberate, therefore these injuries (fatal or non-fatal) can be considered preventable. This category includes those injuries where the manner of death was listed as unintentional by CFR committees.

In 2009, unintentional injury-related deaths were reported for 165 children over the age of one (52% of all deaths among children in this age group). While the overall number of reviewed unintentional injury-related (UI) deaths has decreased from previous years, there is an average of 3.4 child deaths each week due to unintentional circumstances such as motor vehicle, drowning, fire, poisoning, firearm, asphyxia, falls, dog bites, and exposure to the elements. UI deaths affect all children, regardless of race, gender, or age, but each year, children ages 1-4 years (i.e. toddlers) are at greatest risk. Deaths to children in this age group were 35% of all UI deaths. Toddlers represented the majority of drowning, fire, exposure, and asphyxia fatalities.

Figure 13 shows the reviewed unintentional injury-related deaths by mechanism of injury and age of victim, 2009 (N=177)

	Infant	1 to 4	5 to 9	10 to 14	15 to 17	TOTAL
Motor Vehicle	3	16	17	18	25	79
Drown	1	22	3	3	6	35
Fire	2	12	5	4	1	24
Asphyxia	3	7	3	3	0	16
Weapon	0	1	0	3	4	8
Fall/Crush	1	1	2	1	0	5
Exposure	1	3	0	0	0	4
Poison	1	0	1	0	2	4
Bite	0	1	1	0	0	2

The most common mechanisms of reviewed UI deaths were due to motor vehicle, drowning and fire (138). However, children died from other preventable incidents such as being exposed to space heaters, wedged between furniture, strangulated on high chair straps, firearm incidents, deprivation of oxygen due to the “choking game” and choking on grapes/other objects.

In 2009, the most common mechanisms of reviewed UI deaths were:

Infants	Asphyxia (25%) and Motor Vehicle- Related (25%)
1-4 years	Drowning (35%)
5-9 years	Motor Vehicle-Related (53%)
10-14 years	Motor Vehicle-Related (56%)
15-17 years	Motor Vehicle-Related (66%)

For all ages, males have a significantly higher risk of death than females

Research has shown that children from low-income homes are at increased risk for unintentional injuries (Safe Kids, 2004). Families with lower income may not have the resources to obtain the recommended safety equipment, may live in neighborhoods without safe play areas, or have inadequate supervision for children. When family income was reported (30), 19 families were reported to be living in a low income household (63%). Of those 19 families, 13 (68%) were receiving social services of various types (WIC, TANF, Food Stamps).

Spotlight on Maltreatment

CFR committees reported 15 unintentional injury-related deaths where the investigation revealed history of maltreatment. However, 21% of all unintentional injury-related deaths were associated with some form of maltreatment (child abuse and/or neglect), including poor supervision or other negligence. The majority of those cases involved motor vehicles (65%) or weapons (14%).

Figure 14 shows the reviewed unintentional injury-related deaths by mechanism of injury and race/ethnicity of victim, 2009 (N=177)

	Asphyxia	Bite	Drown	Exposure	Fall/ Crush	Fire	MVC	Poison	Weapon	TOTAL
MALE										
White	6	1	16	2	1	2	18	3	2	51
African-American	3	0	7	1	0	6	24	0	5	46
Hispanic	0	0	5	0	1	4	5	0	0	15
Other Race	0	0	1	0	0	0	0	0	0	1
FEMALE										
White	2	1	4	0	2	1	14	1	0	25
African-American	5	0	0	1	1	10	11	0	0	28
Hispanic	0	0	1	0	0	1	5	0	1	8
Other Race	0	0	1	0	0	0	2	0	0	3

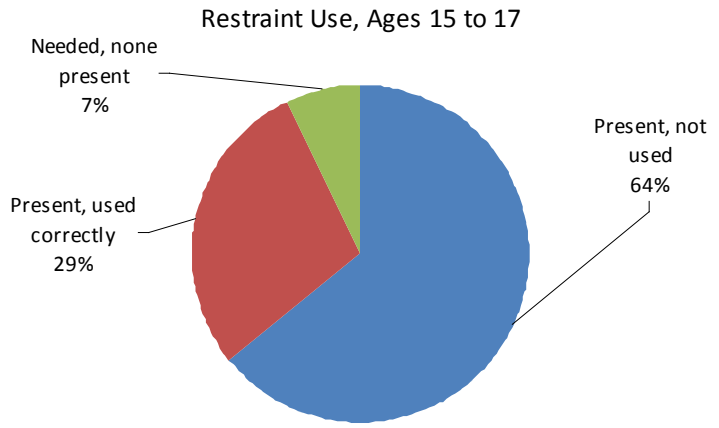
Motor Vehicle-Related Deaths

There were 79 motor vehicle-related deaths reviewed by committees in 2009. Motor vehicle-related deaths accounted for 45% of all unintentional injury-related deaths reviewed in 2009. Thirty percent of the motor vehicle-related deaths were pedestrian fatalities, which continue to be an important issue for all age groups. The number of these reviewed deaths has stayed about the same over the past several years. Prevention initiatives for pedestrian injuries have proven to be great successes in communities across Georgia, and the deaths associated with motor vehicle crashes are declining nationally. However, it remains a prominent focal point for unintentional injury professionals. The momentum must continue in order to see further reductions in motor vehicle-related deaths and injuries in Georgia.

The National Highway Traffic Safety Administration (NHTSA) recommends a booster seat be used until the child reaches a height of four feet nine inches tall or the vehicle seat belt system fits the child properly. CFR committees reported on 11 vehicle occupants ages 5-9 years; five (45%) of these children were riding unrestrained. CFR data variables specifically indicated that the restraint was “present, but not used” or “needed, but none present.”

CDC data indicate that teenagers most at risk for motor vehicle-related injuries and deaths include males, teen drivers with other teen passengers, and newly licensed drivers, particularly during their first year of driving. The data from CFR committees are consistent with this risk analysis. Reported causes of these crashes included driver inexperience, unsafe speeds, pulling out in front of other vehicles, and losing control. There was only one reported case where drugs or alcohol was a cause of the fatality. CFR committees identified 25 children ages 15-17 years who died from motor vehicle-related injuries; 19 were identified as "operators/drivers". Seven had more than two teen/young adult passengers (ages 14-21) riding with them.

Figure 15 shows motor vehicle restraint use for teens ages 15-17 (when known), 2009 (N=14)



Studies have shown that the majority of unintentional injuries occur during evening hours. Of the 155 UI deaths where time of death was known, CFR committees indicated that 55 UI deaths (35%) occurred between 5 and 10 pm

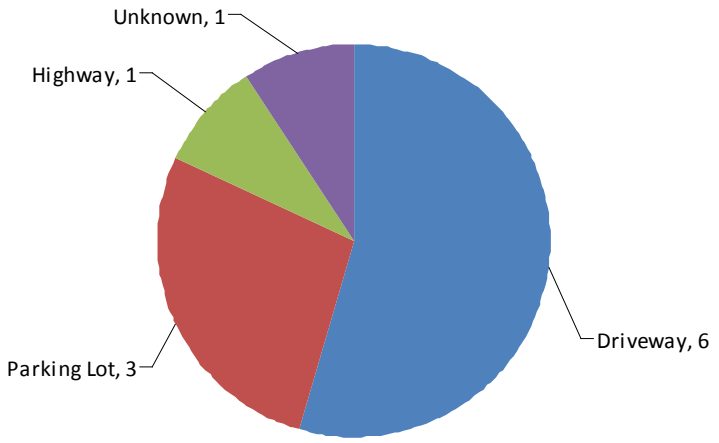
Restraint use has proven to save lives for children and adults of all ages. In Georgia, seat belt use is a primary enforcement law requiring everyone to ride with a seatbelt. Children must be in an approved child safety seat or booster seat until their sixth birthday

For children between the ages of 10-14 years, reported restraint use is very mixed. CFR committees reported 50% of youth to wear their seatbelt correctly, while the other 50% were unrestrained. There were also three deaths related to driving an All-Terrain Vehicle (ATV). All three children were 12-14 years of age. In each of the three cases, the driver reportedly lost control, which is often related to elevated speed or inexperience.

The age of a child can determine their mobility and independence, both of which can affect their risk of being hit by a car. Toddlers are generally less cognizant of surroundings and unknowingly put themselves in risky situations (e.g., playing in unsafe locations). Studies show that adults tend to supervise young males less vigilantly than young females, which can lead to more injuries and deaths. CFR committees reported 21 deaths to toddlers associated with motor vehicle-related injuries. Of these 21 deaths, 11 (52%) were pedestrian-related where the incident occurred outside of the car.

CFR committees reported that of the 10 toddler deaths when supervision was known, seven had adequate supervision at time of death. In 88% of those cases, the mother was the supervisor at the time of death.

Figure 16 shows locations of pedestrian-related fatalities for children ages 1-4 (when known), 2009 (N=11)



Opportunities for Prevention:

- Continue to support the Graduated Licensing of all teen drivers so that experience can be gained over time. Parents should continue to work through driver's education programs with their teen, such as the P.R.I.D.E. program provided by the Governor's Office of Highway Safety (www.ridesafegeorgia.org)
- Young children should be actively supervised at all times. Active supervision of toddlers in and around roadways, parking lots, and driveways is critical for their safety
- Children should ride in a booster seat until the vehicle seat belt system fits them correctly, and they are around four feet nine inches in height
- Parents, caregivers, family members, and friends can be role models. Everyone should wear a seatbelt to teach children and youth how this behavior can save lives

Drowning-Related Deaths

Drowning deaths occur from water-related submersion injuries and asphyxia, and include deaths involving public and private swimming pools, natural open water (e.g., rivers, lakes, oceans, and ponds), bathtubs, and other bodies of water. Drowning is the second leading cause of unintentional injury-related deaths to children over age one. The CDC reports that for every child who dies from drowning, another four children receive emergency care for submersion injuries.

Figure 17 shows the demographic data for reviewed drowning deaths, 2009 (N=35)

	Infant	1 to 4	5 to 9	10 to 14	15 to 17	TOTAL
White	0	15	2	1	2	20
African-American	1	2	0	2	2	7
Hispanic	0	4	1	0	1	6
Other Race	0	1	0	0	1	2
Total	1	22	3	3	6	35

Toddlers (children ages 1-4) continue to represent the majority of drowning deaths in Georgia (63%). The majority of toddlers were found in pools (50%) and open bodies of water (41%). Seventy-three percent of the pools had no barriers to prevent accessibility (such as fence or gates). CFR committees reported that children in this age group were supervised mostly by their biological parents (55%). The CDC recommends that active supervision of young children should be "touch supervision", where the supervisor should be able to touch the child at all times. The child should always be in sight of the supervisor. CFR committees also reported that 75% of the supervisors were distracted or absent at the time of death.

Children over age four accounted for 34% of the reviewed drowning deaths. The location of the drowning deaths varied, but the majority occurred in open water.

Figure 18 shows the number of children ages 1-4 with supervision at the time of drowning, 2009 (N=22)

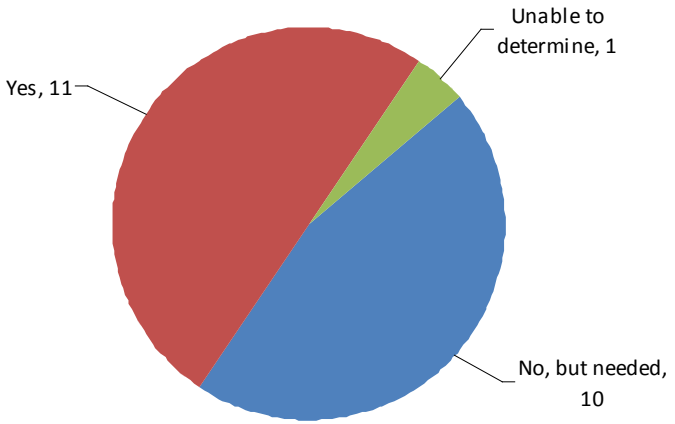
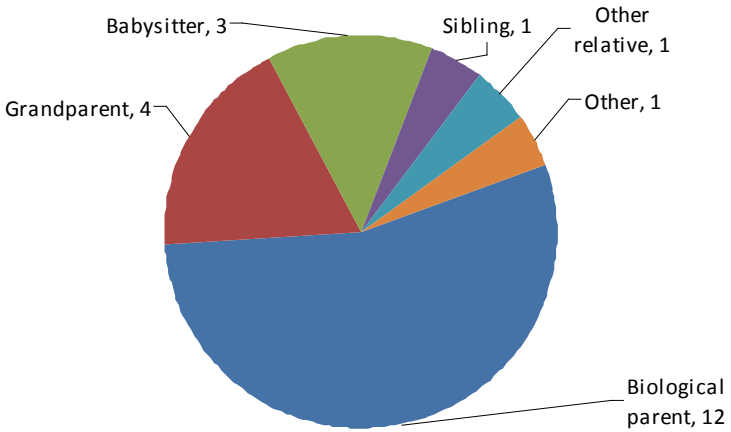
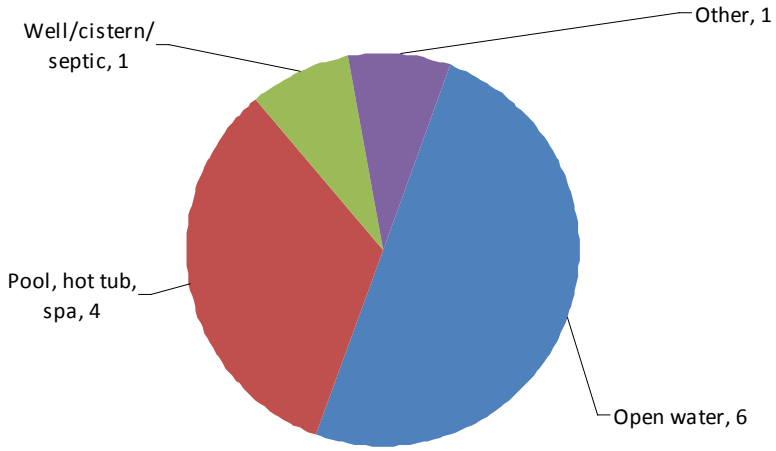


Figure 19 shows the type of supervisors to children ages 1-4 at time of drowning, 2009 (N=22)



CFR committees reported that CPR was initiated in 79% of the drowning deaths before EMS arrived

Figure 20 shows the location of drowning for children ages 5-17, 2009 (N=12)



Opportunities for Prevention:

- Active supervision of children around water is critical and often not practiced by caregivers
- All pools should be protected by a fence at least four feet tall and the pool should be separated from the play area, yard and house
- Older children should always swim with a buddy and should be taught to use extreme caution in open bodies of water. Teens need to be taught to swim and how to assess if the water is safe for swimming

Prevention Success

After a toddler drowned in a nearby public pond, a fence was put up to provide a barrier of accessibility to others

Intentional Injury-Related Deaths

He was an openly gay teen, having problems with classmates and with his family. He was at home with his parents when he said he was going to the basement to do laundry. Shortly after, his parents heard what they thought were firecrackers. His father went to the basement and found him with a self-inflicted gunshot wound to his head.

Definitions

While most child fatalities in Georgia are a result of medical causes or unintentional circumstances, many children also die as a result of intentional injuries. Intentional injuries are those which are deliberately inflicted by oneself (suicide), or by another person (homicide). This also includes a willful, wanton, or reckless disregard for the safety of others during the course of action (for example, a child killed while being disciplined by a parent or caregiver).

In 2009, local committees reviewed 59 child homicides and 35 child suicides. Reviewed child homicides have decreased from 87 in 2007 and 75 in 2008. However, there has been a substantial increase in reviewed child suicides from 19 in 2007 and 20 in 2008.

Mortality rates are higher among males than females in almost all species, including humans, at all ages and even before birth. Research suggests that there are biological as well as social, cultural, environmental, and behavioral reasons for the mortality differences between males and females

Figure 21 shows the demographic data for reviewed intentional injury deaths, 2009 (N=94)

	Suicide	Homicide	All	%
White Male	23	5	28	29.7
White Female	4	6	10	10.6
African-American Male	4	24	28	29.7
African-American Female	1	19	20	21.4
Hispanic Male	2	3	5	5.3
Hispanic Female	1	2	3	3.3
Total	35	59	94	100%

- Two thirds (66%) of all suicide deaths were White males; and 41% of homicide deaths were African-American

Spotlight on Maltreatment

Local committees identified 19 child homicide and eight child suicide cases that were associated with some form of maltreatment (child abuse and/or neglect). Additionally, there were six child homicide cases where prior history of maltreatment involving the parent or caregiver was documented (in these six cases, there was no documented history involving the child).

Homicide

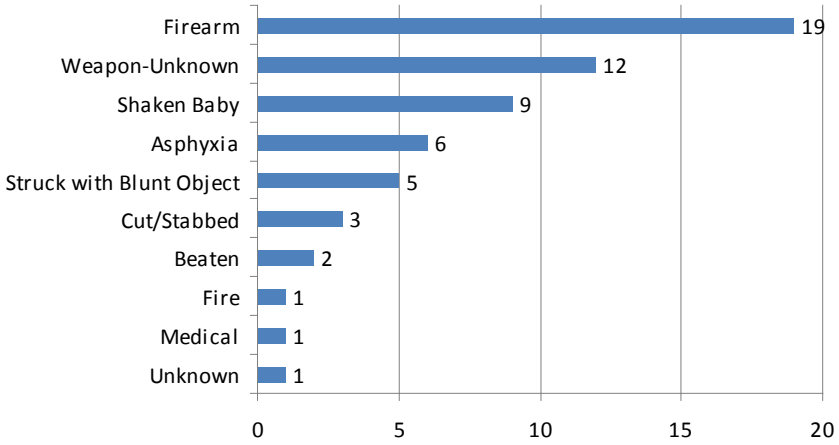
Homicide is the leading cause of injury deaths among infants under one year of age in the United States (15th leading cause of infant mortality from all causes). Males are generally more likely than females to be killed during the first year of life. Moreover, non-Hispanic African-Americans are at higher risk than children of other races to die of an intentional injury during their first year of life. Additionally, while overall homicide levels in the United States have fluctuated minimally in recent years, those involving young victims and perpetrators—particularly young African-American males—have surged. From 2002 to 2007, the number of homicides in the U.S. involving African-American male juveniles as victims rose by 31% and as perpetrators by 43%. Particularly, the number of homicides with firearms among this young population also increased dramatically. In 2009, African-American males accounted for almost half of all reviewed homicides (41%), which is disproportionately high compared to White males (nine percent). African-American females also had a disproportionately high number of reviewed homicides representing 32%, while White females accounted for 10% of all reviewed homicides. It is imperative that all parents, educators, legislators, and community advocates invest in children and families to address this growing epidemic of violence within society.

Figure 22 shows the demographic data for reviewed homicide deaths, 2009 (N=59)

	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total	%
White Male	0	2	2	1	0	5	8.5
White Female	1	4	0	0	1	6	10.2
African-American Male	4	4	1	7	8	24	40.7
African-American Female	5	8	0	1	5	19	32.2
Hispanic Male	0	1	1	0	1	3	5.1
Hispanic Female	1	0	0	0	1	2	3.4
Total	11	19	4	9	16	59	100%

After some decline during the 1990s, the percentage of homicides that involve a gun has increased since 2000, both among young White and African-American offenders. The percentage of gun homicides for young African-American offenders has reached nearly 85%

Figure 23 shows reviewed homicide deaths by mechanism, 2009 (N=59)



- In 14 of the 19 firearm-related homicides where weapon type was specified, there were nine handguns, two hunting rifles, one pellet gun, one shotgun, and one assault rifle
- Of the 19 firearm-related homicides, eight involved older teens ages 15-17 (42%), seven were children ages 10-14 (37%), three were young children ages 5-9 (16%), and one was a toddler
- There were eight reported homicides with “head shaking”; three were infants and five were children ages 1-4. Seven of the eight also had documented retinal hemorrhages

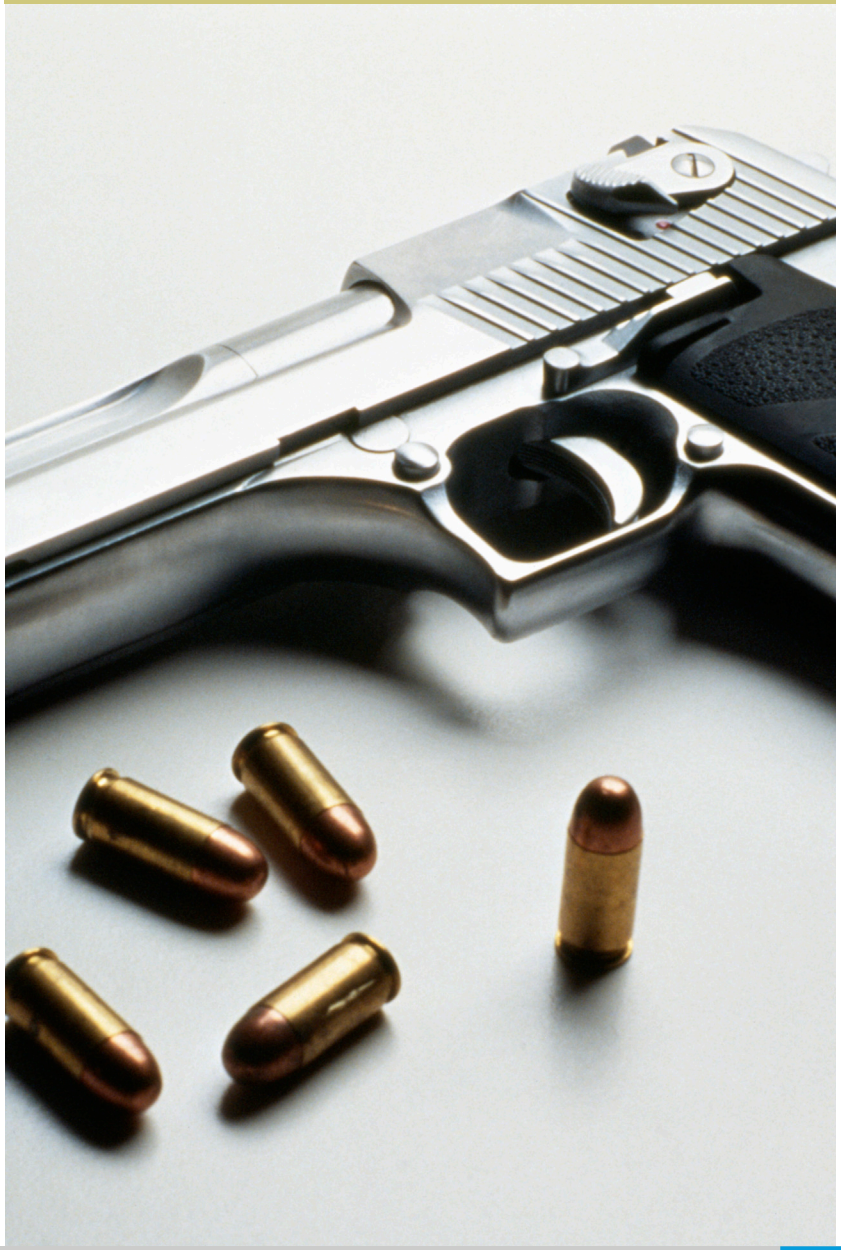
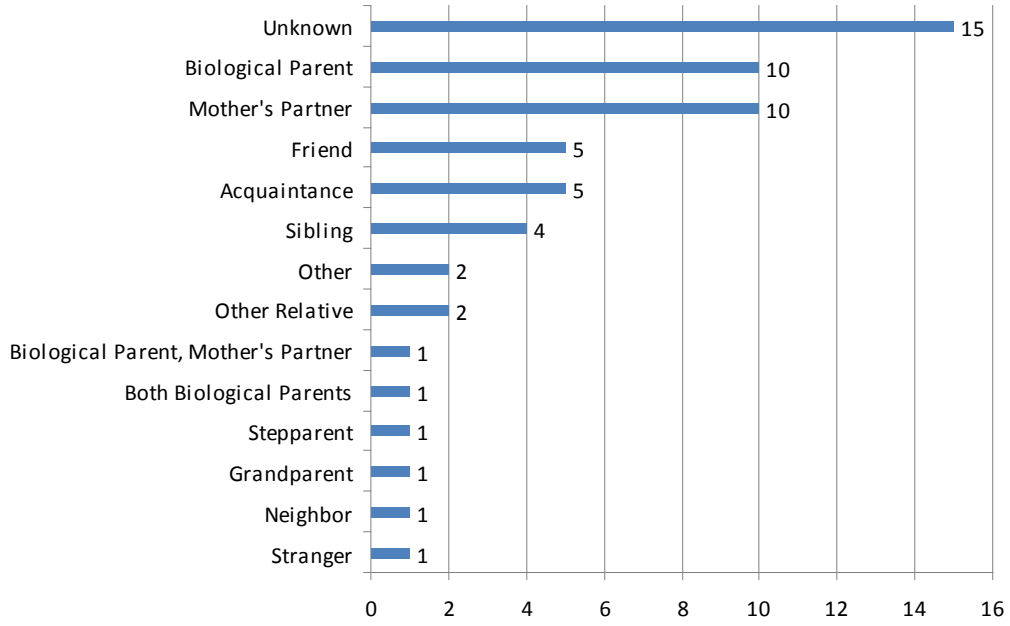


Figure 24 shows reviewed homicide deaths by person handling fatal weapon, 2009 (N=59)



- Seven infant homicides were committed by a biological parent (64%), while the majority of toddler homicides (10) were committed by the mother's partner (53%)
- Of the 10 homicide deaths committed by biological parents, two were mothers, seven were fathers, and one was gender unknown. "Other" includes a security guard and a babysitter
- When known, most homicides involving children ages 10-14 (four) and older teens ages 15-17 (five) were committed by friends or acquaintances within the same age cohort, illustrating the growing trend of youth on youth violence

On school days, the risk of violent crime victimization spikes during the after-school hours – the prime time for juvenile crime – while the late evening hours are the most problematic on non-school days, particularly summertime weekends

Homicide occurrence followed no appreciable pattern by time of day based on the 45 cases for which incident data was provided. The times when larger number of homicides occurred by age group was:

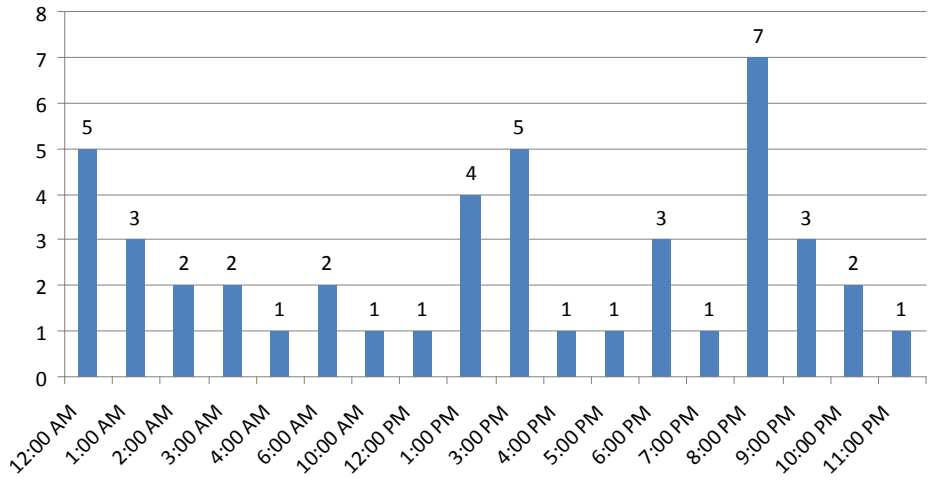
- Ages 15-17: 12midnight (four deaths) and 9pm-11pm (four deaths)
- Ages 10-14: 8pm-10pm (five deaths)

These data demonstrate the importance of ensuring that adolescents and youth are continuously engaged in positive activities throughout the day and some level of supervision is incorporated into their evenings.

Opportunities for Prevention:

- Direct state and federal government spending for after-school youth enrichment and violence prevention programs
- Implement child, parent, and family support networks to provide vital resources for healthy growth and development

Figure 25 shows the reviewed homicides by time of incident (when known), 2009 (N=45)



Suicide Deaths

The longing for approval, admiration, acceptance, and camaraderie accompanies us through every phase of life but is extremely crucial during adolescence. Many youth are overwhelmed by the competing need to feel accepted and embraced by their peers while struggling to cope with familial, educational, communal, and societal challenges they face. This can oftentimes be too much for many youth to handle as they grapple to develop effective coping mechanisms. The CDC reports that 60% of high school students say that they have thought about committing suicide, and nine percent say that they have attempted killing themselves at least once.

Fortunately, many youth display warning signs prior to attempting suicide which can offer a critical window of opportunity for effective intervention strategies. One of the most significant protective factors for youth is a caring relationship with an adult, thus illustrating the importance of parents, educators, and community advocates playing an active role in their lives. By maintaining healthy relationships, youth can develop positive coping strategies that will follow them into adulthood

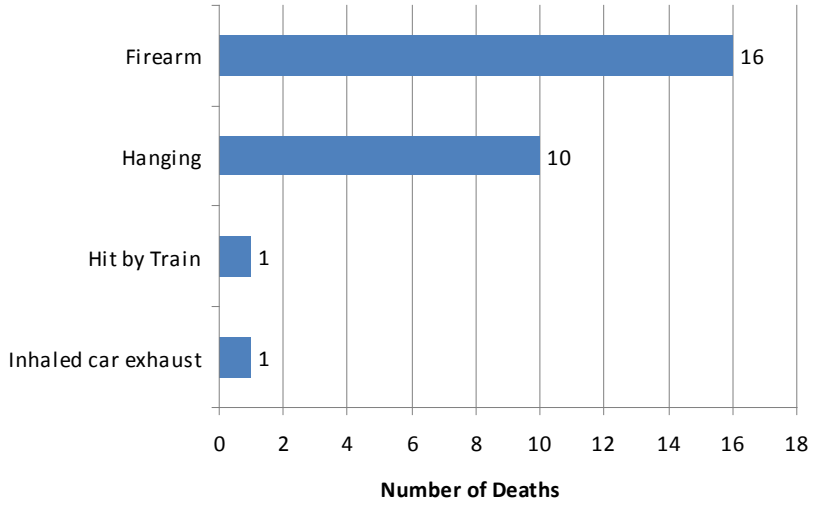
Figure 26 shows the demographic data for reviewed suicide deaths, 2009 (N=35)

	10 to 14	15 to 17	Total	%
White Male	3	20	23	66
White Female	1	3	4	11
African-American Male	1	3	4	11
African-American Female	1	0	1	3
Hispanic Male	2	0	2	6
Hispanic Female	1	0	1	3
Total	9	26	35	100%

Twenty-three of the 35 reviewed suicides (66%) had a “history of acute or cumulative personal crisis”, inclusive of such issues as family discord, school failure, legal problems, and others. There were six cases where the committee reported the child talked of suicide and threatened suicide. In three of those deaths, the committee reported that the child had made at least one suicide attempt prior to their death. Six of the children who committed suicide were currently receiving mental health services. Fourteen of the 35 reviewed suicides were “completely unexpected”.

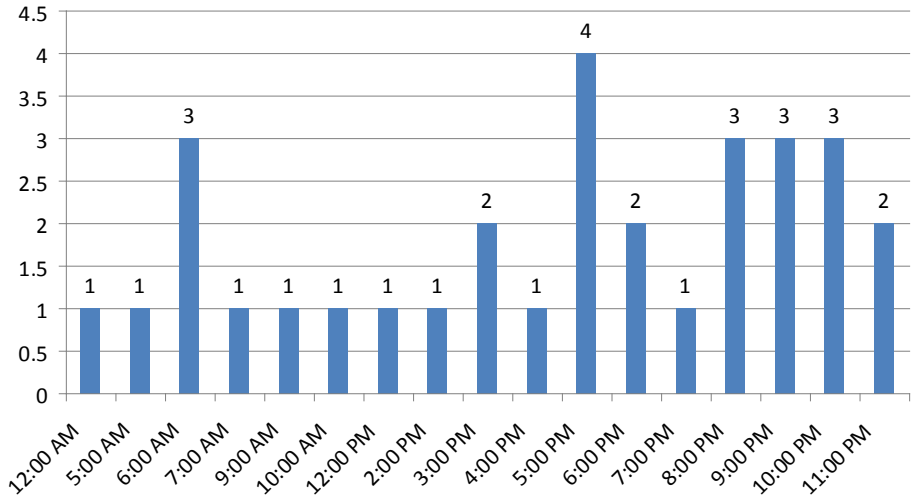
The risk of suicide increases dramatically when children and teens have access to lethal means at home, and nearly 60% of all suicides in the United States are committed with a firearm

Figure 27 shows the reviewed suicide deaths by mechanism of injury, 2009 (N=35)



- Of the 11 suicide deaths where information pertaining to weapon owner was reported, six weapons were owned by the biological parents, three by the victim, and one each by a friend and a stranger
- National data show that young females who attempt suicide are more likely to try overdosing on pills or cutting themselves. Young males are more likely to choose a more lethal method, such as guns or hanging, which is why they are more likely to complete a suicide

Figure 28 shows the reviewed suicide deaths by time of incident (when known), 2009 (N=31)



Suicide occurrence followed no appreciable pattern by time of day based on the 31 cases for which incident data was provided. The times when larger number of suicides occurred by age group was:

- Ages 15-17: 3pm-8pm (eight deaths – 31%)
- Ages 10-14: 3pm-8pm (eight deaths – 89%)

Opportunities for Prevention:

- Increase awareness of suicide warning signs, and promote prompt action when warning signs are recognized among parents, educators, caregivers, and communities
- Support extra-curricular and after-school programs that provide positive activities for children and youth
- Expand Question, Persuade and Refer (QPR), a three-step basic gatekeeper training within schools and community advocacy centers

Prevention Success

An anti-bullying bill was signed into law in 2010, requiring the state Department of Education to develop an anti-bullying policy for all students, kindergarten through 12th grade


Mizuno

Prevention

When CFR committees review a child death, they must also identify the "preventability" of the death. Preventability is based on two criteria: if a death is identified through retrospective analysis to be foreseeable, or is the result of an absence of reasonable intervention. The circumstances before the event, during the event, and immediately after the event are all considered in this determination.

Figure 29 shows all reviewed deaths by cause and preventability (when known), 2009 (N=506)

Cause of Death	Probably Not	Probably	Undetermined
Asphyxia	1	14	1
Bite	0	1	1
Drown	4	29	0
Exposure	0	4	0
Fall/Crush	0	4	1
Fire	2	19	2
Homicide	5	49	3
Medical	59	13	25
Motor Vehicle Crash	2	72	3
Poison	0	4	0
SIDS	4	0	3
Suicide	7	16	11
Sleep-Related Asphyxia	1	30	6
SUID	16	51	28
Undetermined	2	1	4
Weapon	1	7	0
Total	104 (21%)	314 (62%)	88 (17%)

Figure 30 shows the services identified by committees as offered or provided to families after a death (when known), 2009

Services Identified					
	Bereavement	Funeral	Mental	Health	Legal
Infant	80	50	20	6	2
1 to 4	50	37	14	6	3
5 to 9	23	17	4	1	1
10 to 14	25	18	9	1	3
15 to 17	33	30	5	1	0
Total	211	152	52	15	9

*78 records had both Bereavement and Funeral indicated

Prevention can often begin with services offered to a family after a death of a child. The education and support from these services can help families consider risk factors and behaviors that may prevent another death from happening in the future. Committees reported these services were offered or provided to families after a death was reviewed.

When prevention initiatives were recommended by committees after completing a child death review, these activities were most often mentioned: media campaigns (58), community safety projects (50), school programs (45), and public forums (19).

Examples of prevention recommendations by CFR committees:

- Coordinate health department, DFCS, and hospitals to provide sleep safety information to all new mothers
- Contact the Department of Transportation when street lights and pedestrian crosswalks are needed
- Provide counseling in schools to help students cope with death and prevent suicides; make students aware of counseling availability
- Develop media campaigns on private pool safety and risk factors; teach proper adult-to-child ratio for subdivision pools
- Encourage parental supervision around pools, vehicles and weapons

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

deaths each year. In 2007, local CFR committees were asked to develop a specific prevention plan, which would be used to drive all child fatality prevention efforts in their county for the upcoming years. Each committee was asked to outline their strategy, define action steps, and identify resources to help them in their objectives. The prevention plans gave CFR insight into the needs and available resources of the communities. The project also allowed committees to network with each other and identify ways they could share resources while working toward the same goals. The barriers that were commonly identified were lack of funding for personnel and program materials, and lack of awareness or participation in the community.

The CFR Panel and staff are actively working on several prevention projects to respond to these identified barriers. In 2008, the Panel supported the development of the first statewide childhood injury/fatality prevention plan, which uses data and best practice models to educate community members, leaders and professional agency staff. In 2009, staff convened a workgroup of agency representatives – including Injury Prevention, Behavioral Health, DFCS, Safe Kids Georgia, the Governor's Office for Children and Families, and Family Connection Partnership – to generate state and local support for the statewide prevention plan. This Panel workgroup is also creating a "prevention toolkit" for counties to use for developing, sustaining, and evaluating local prevention efforts. This toolkit uses results from a quantitative "readiness assessment" tool, together with the CFR committee prevention plans, to devise strategies specific to the needs and issues of each jurisdiction, and facilitate collaboration and partnerships in the prevention planning process. This collaborative effort is designed to address the specific barriers that each CFR committee faces, and provide targeted resources to reduce them.

The Panel and staff also work with other state agencies and coalitions to address specific prevention strategies, such as the Georgia Infant Safe Sleep Coalition, which is funding a safe sleep social marketing campaign; a Georgia State University/Emory University partnership to review 2005-2008 drowning data, including hospital and EMS records; the Child Injury Prevention & Control Policy Plan Advisory Group for child safety seat policies; and the Metropolitan Atlanta Violence Prevention Partnership. Financial assistance for medical, funeral, crime scene clean-up and mental health counseling expenses can be provided to victims of crime (and their families) through the state's Crime Victims Compensation Program (www.cjcc.ga.gov).

In support of prevention legislation, CFR contributed data and statistics for the hearings on the statewide law to ban hand-held cellphone use while driving, cellphone use for young or novice drivers, and texting while driving. CFR has also contributed a voice to the national policymakers, by submitting a letter of support for the Stillbirth and SUID Prevention, Education and Awareness Act of 2009. This bill would improve the collection of critical data to determine the causes of theses tragic deaths, increase education and awareness about how to prevent these tragedies in the future and expand support services for families who have experienced a stillbirth or SUID loss.

Opportunities for Prevention and Education in Communities:

Healthcare Providers / Hospital Staff

- Rates of medication errors and adverse drug events for hospitalized children were comparable to rates for hospitalized adults in a 2001 study in the Journal of the American Medical Association. However, the rate for potential adverse drug events was three times higher in children and substantially higher still for infants in neonatal intensive care units. But errors also happen when doctors and their patients have problems communicating. For example, a study supported by the Agency for Healthcare Research and Quality (AHRQ) found that doctors often do not do enough to help their patients make informed decisions. Uninvolved and uninformed patients are less likely to accept the doctor's choice of treatment and less likely to do what they need to do to make the treatment work. (www.ahrq.gov)
- Advocate for mandatory youth school physicals
- Advocate for a state-wide campaign for reducing prone sleeping (Back to Sleep)
- Parent pressure makes a difference. For pediatric care, a recent study showed that doctors prescribe antibiotics 65% of the time if they perceive parents expect them, and 12% of the time if they feel parents do not expect them. Parents should not demand antibiotics when a health care provider has determined they are not needed. Parents should talk with their health care provider about antibiotic resistance. (www.cdc.gov)

Parents and Caregivers

- It only takes a second for small children to get into something they shouldn't get into. To prevent injury, be aware of common causes of injury in the home, at school, and on the move
- Store all medicines, household products, personal care products, and other dangerous substances in locked cabinets that are out of reach of small children
- Ensure that everyone caring for a child (including family, friends, neighbors, day care, and schools) has all emergency contact information, knows what to do in case of an emergency, and has appropriate policies in place to handle problems. Determine if caregivers are screened and provided training
- Advocate for residential speed bumps and traffic calming measures in neighborhoods
- Require completion of an ATV driver safety course, use of helmets and restriction of child operators in all ATV operations

Coaches / Athletic Directors

- Encourage girls to participate in sports and athletic activities. Girls who play sports have higher levels of self-esteem, lower levels of depression, more positive body image, and higher states of psychological well being than girls and women who do not play sports
- Treat concussions seriously. A concussion is a brain injury. Concussions are caused by a bump or blow to the head, and can occur even when the blow appears to be minor. Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury. If a child reports any symptoms of concussion or if the symptoms are noticeable, seek medical attention right away

Mothers / Women

- Through prenatal care, health problems can be prevented, identified and treated early, or closely monitored. Persons with certain conditions or diseases can receive specialized care, which may lower the risk in the fetus or newborn of developing similar or other problems
- Insufficient folic acid (a B vitamin) in pregnant women can lead to spina bifida (spine defects) and anencephaly (brain defects) in infants. All women who could possibly become pregnant should take a vitamin with folic acid every day. Take 400 micrograms of folic acid daily both before pregnancy and during the first few months of pregnancy to reduce the risk of birth defects of the brain and spine

Legislators/Professionals

- Enhance the current child restraint law to protect children older than five years. Children need to ride in booster seats until adult seat belts fit them properly, somewhere around five feet tall
- Develop and pass legislation to protect unattended children in cars
- Pass a Child Access Prevention law to regulate child access and usage of firearms
- Revise the current child endangerment legislation allowing for prosecution under a felony charge instead of a misdemeanor
- Allocate funding for a mass media, statewide education and outreach campaign promoting Back to Sleep for infants

Online Resources and Information

For Infant Sleep-Related Deaths:
www.health.state.ga.us/epi/prams
Georgia PRAMS supplements birth certificate data by collecting information on women's attitudes, experiences, and behaviors before, during, and after they deliver a live-born infant
www.hhs.gov/news/factsheet/infant
The Department of Health and Human Services (HHS) supports a wide range of medical research to prevent and treat birth defects, premature birth, SIDS and other life-threatening conditions
www.sidscenter.org
The National Sudden and Unexpected Infant/Child Death Resource Center (Resource Center) serves as a central source of information on sudden infant death and on promoting healthy outcomes for infants from the prenatal period through the first year of life and beyond
www.firstcandle.org
First Candle's current priority is to eliminate Stillbirth, Sudden Infant Death Syndrome (SIDS) and other Sudden Unexpected Infant Deaths (SUID) with programs of research, education and advocacy
www.suid-im-projectimpact.org
An important focus of the Project IMPACT mission is providing technical support to state and local professionals regarding their efforts to address sudden unexpected infant death

For Medical Deaths:
www.hhs.gov
The Department of Health and Human Services is the principal agency for protecting the health of all Americans

For Child Maltreatment:
http://www.cdc.gov/ViolencePrevention/childmaltreatment/
CDC's research and programs work to understand the problem of child maltreatment and prevent it before it begins
http://www.acf.hhs.gov/programs/cb/pubs/cm08/
The Children's Bureau provides State and national data on adoption and foster care, child abuse and neglect, and child welfare. The Children's Bureau also funds research in collaboration with other organizations

For Unintentional Injuries:
http://www.safekids.org/our-work/research/fact-sheets/high-risk-fact-safety.html
Safe Kids sponsors programs and initiatives that combine education, awareness, environmental changes and safety device distribution to get communities more involved in child safety and keep families and children safer
www.cdc.gov/motorvehiclesafety
CDC's research and prevention efforts focus on improving car and booster seat and seat belt use, reducing impaired driving, and helping groups at risk: child passengers, teen drivers, and older adult drivers. CDC also works to prevent pedestrian and bicycle injuries
http://www.cdc.gov/HomeandRecreationalSafety/Water-Safety/waterinjuries-factsheet.html
The CDC produced the "Unintentional Drowning Fact Sheet" as part of their focus on the science behind making people safe – working to prevent leading causes of injuries, including drowning, falls, fires, and poisoning. CDC works to ensure that all people have safe and healthy homes and places to play

http://injuryprevention.bmj.com/content/8/suppl_1/i3.full.pdf
"Reducing Childhood Pedestrian Injuries" Injury Prevention June 2002, Vol 8, Supplemental I. The Injury Prevention Journal is an international peer-reviewed journal for health professionals and others in injury prevention. Free online access is available for issues printed prior to January 2006

www.safekidsgeorgia.org
Safe Kids Georgia, led by Children's Healthcare of Atlanta, is dedicated to preventing unintentional injury to children under 14 years of age

www.ridesafegeorgia.org
The Georgia Traffic Injury Prevention Institute is an education outreach program of the University of Georgia. Primary focus areas include child safety seats, safety belts, teen driving, and senior drivers

www.gohs.state.ga.us
The Georgia Governor's Office of Highway Safety is determined to keep people safe on the roads and highways throughout the state

For Homicide Deaths:

www.ojp.usdoj.gov
The Office of Justice Programs (OJP) in the US Department of Justice provides leadership to federal, state, local, and tribal justice systems, by sharing knowledge and best practices, and providing grants for strategy implementation. OJP works in partnership with the justice community to identify the most pressing crime-related challenges confronting the justice system and to provide information, training, coordination, and innovative strategies and approaches for addressing these challenges

www.childtrendsdatabank.org
Child Trends Data Bank is a nonprofit, nonpartisan research organization that works with federal and state officials and other researchers to improve the quality, scope, and use of data on children and their families. They provide technical assistance to public agencies and private organizations that develop, analyze, track, and use statistical indicators of child and youth well-being

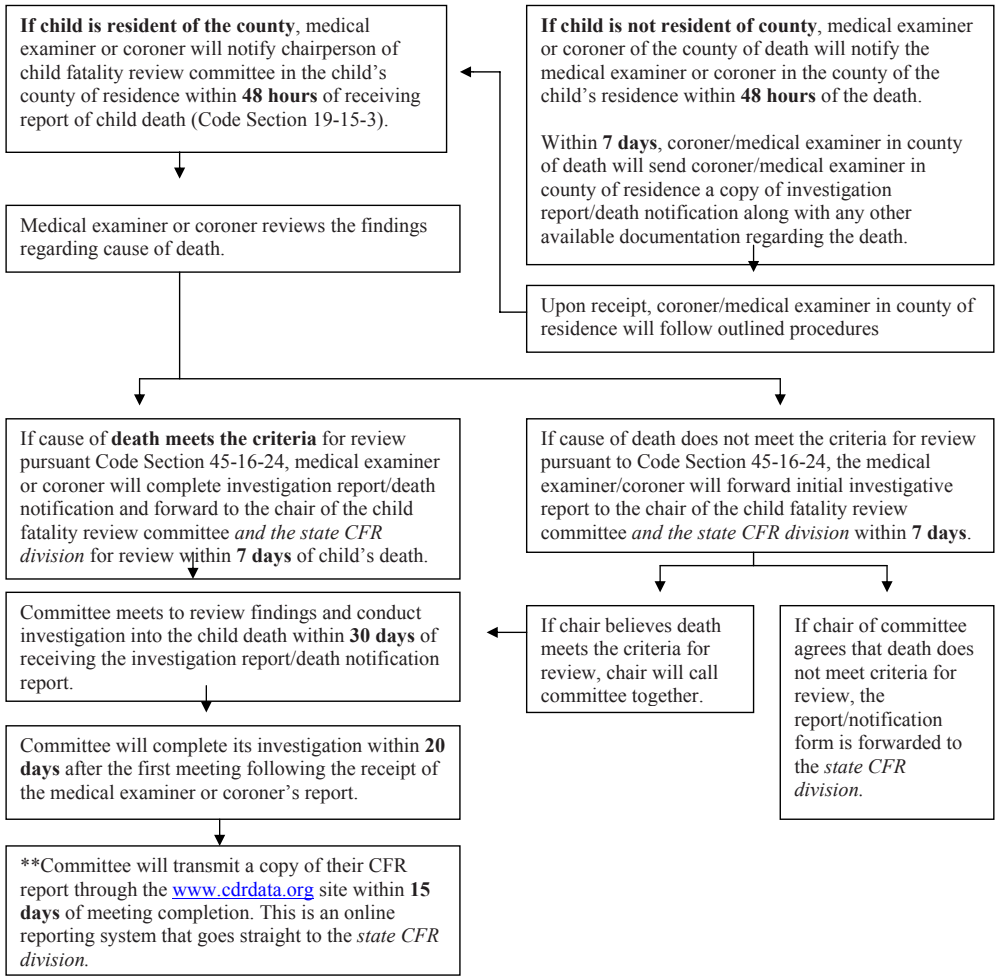
www.safeyouth.gov
STRYVE is a national initiative, led by the Centers for Disease Control and Prevention (CDC), which takes a public health approach to preventing youth violence before it starts. To support this effort, STRYVE Online provides communities with the knowledge and resources to be successful in preventing youth violence

For Suicide Deaths:

www.sprc.org
The Suicide Prevention Resource Center (SPRC) provides prevention support, training, and resources to assist organizations and individuals to develop suicide prevention programs, interventions and policies, and to advance the National Strategy for Suicide Prevention

www.save.org
The Suicide Awareness Voices of Education works to prevent suicide through public awareness and education, reduce stigma, and serve as a resource to those touched by suicide

Child Fatality Review Committee Timeframes and Responsibilities



**The District Attorney or his/her designee is responsible for completion of the CFR committee's report of findings online. All reviewable deaths should be considered in this process. Those deaths includes: SIDS/SUID without confirmed autopsy report; accidental death when death could have been prevented through intervention or supervision; STD; medical cause which could have been prevented through intervention by agency involvement or by seeking medical treatment; suicide of a child under the custody of DHS or when suicide is suspicious; suspected or confirmed child abuse; trauma to the head or body; or homicide.

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Total Reviewed Child Fatalities

		White		African-American		Hispanic		Multi-Race		Other Race/ Ethnicity		
Age	Cause	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Total
Infant												
	Homicide		1	4	5		1					11
	Medical	3	8	13	5	2		1				32
	SUID	33	29	40	23	6	5	2	2	1		141
	Undetermined		1			1	1					3
	Unintentional	2	2	7	1							12
	Total	38	41	64	34	9	7	3	2	1	0	199
1 to 4												
	Homicide	2	4	4	8	1						19
	Medical	2	3	8	4		1	1				19
	Undetermined	1	1	2								4
	Unintentional	19	10	9	11	10	3				1	63
	Total	24	18	23	23	11	4	1	0	0	1	105
5 to 9												
	Homicide	2		1		1						4
	Medical		2	4	5							11
	Unintentional	8	4	6	9	1	2				2	32
	Total	10	6	11	14	2	2	0	0	0	2	47
10 to 14												
	Homicide	1		7	1							9
	Medical	1	4	5	4		1					15
	Suicide	3	1	1	1	2	1					9
	Unintentional	12	6	8	5		1					32
	Total	17	11	21	11	2	3	0	0	0	0	65
15 to 17												
	Homicide		1	8	5	1	1					16
	Medical	4	3	7	5	1			1		1	22
	Suicide	20	3	3								26
	Unintentional	10	3	16	2	4	2			1		38
	Total	34	10	34	12	6	3	0	1	1	1	102

Reviewed Deaths with Maltreatment Identified

		White		African-American		Hispanic		
Age	Cause	Male	Female	Male	Female	Male	Female	Total
Infant								
	Homicide		1	4	3		1	9
	Unintentional			1				1
1 to 4								
	Homicide	2	4	2	5	1		14
	Unintentional			1				1
5 to 9								
	Unintentional			1				1
	Total	2	5	9	8	1	1	26