GEORGIA CHILD FATALITY REVIEW PANEL

Executive Summary Report, Calendar Year 2010

Velma Tilley
Chairperson

Nathan Deal
Governor

November 2011

Georgia Child Fatality Review Panel

Executive Summary Report

Calendar Year 2010

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 the other 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 Child Fatality Review Committee of the year and the Coroner of the year, 2010 for their support and dedication to this office and the children of Georgia:

Bill Thrower, Coroner, Muscogee County

Fulton County Child Fatality Review Committee

This report was developed and written by the Office of the Child Advocate via the Child Fatality Review Division staff:

Cynthia Cartwright, Crystal Dixon, Wende Parker, Arleymah Raheem, and Malaika Shakir

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Georgia Child Fatality Review Panel

Dear Governor Deal and Members of the Georgia General Assembly:

As I step down from leadership and from membership on the Georgia Child Fatality Review Panel, it is my privilege to both present to you the 2010 report on child deaths occurring in Georgia and to address you this last time from this position on this important topic. This year I want to call to your attention the national issue of inaccuracy in the counting of child maltreatment deaths. The National Child Abuse & Neglect Data System (NCANDS) is based on a voluntary state report to the Department of Health and Human Services. Accordingly, many have questioned whether this report is an accurate collection of the number of deaths due to maltreatment. Factors such as lack of evidence and inconsistent interpretations of maltreatment may play a role in the accuracy of reporting of child maltreatment deaths. Research on the quality of maltreatment data is underway nationally. This panel has been actively engaged on this topic at its recent meetings.

On the positive side, as the members of the General Assembly may recall from a previous report, in 2009, Georgia was one of 5 states selected by the Centers for Disease Control and Prevention to participate in a three year pilot project on Sudden Unexpected Infant Death. The pilot project is specifically for the purpose of prevention and/or reduction of infant deaths in a sleep environment. Our data collection has been well received by the CDC and we attribute improvements in death scene investigations and autopsy timeliness to the work within this grant.

It has been a privilege to serve on this panel for some seven and a half years with many dedicated public officials. The staff serving the panel are dedicated, hardworking public servants who are committed to the task of making Georgia's children safer. The work must go on because children will always need our protection. Ongoing financial support for the Child Fatality Review Division of OCA will continue to strengthen the improvement of the reporting of child maltreatment deaths, infant deaths due to unsafe sleeping environments, and all child deaths through systemic changes in policy and protocol.

Sincerely,

Velma C. Tilley

Judge Velma Cowen Tilley, Chair

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PRACTICAL APPLICATION 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 Georgia's children. CFR data can be provided in 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, and general education. Education for agency staff, policy makers, and general public can be an important tool when you are trying to seek funding sources, partnerships, and volunteer support. Some ways the data in this report can be shared with others include:

- 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 advocate needed policy changes
- Education of students by including information on specific risk factors in curricula, including prevention of risks
- Facilitate discussions of safety habits in civic groups, agencies, public forums, and other places
- Realize opportunities for prevention and education are all around you such as: educating others on the trends in child deaths, creating support groups for families suffering from a loss, and creating public announcements about preventable deaths

If you would like for 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.

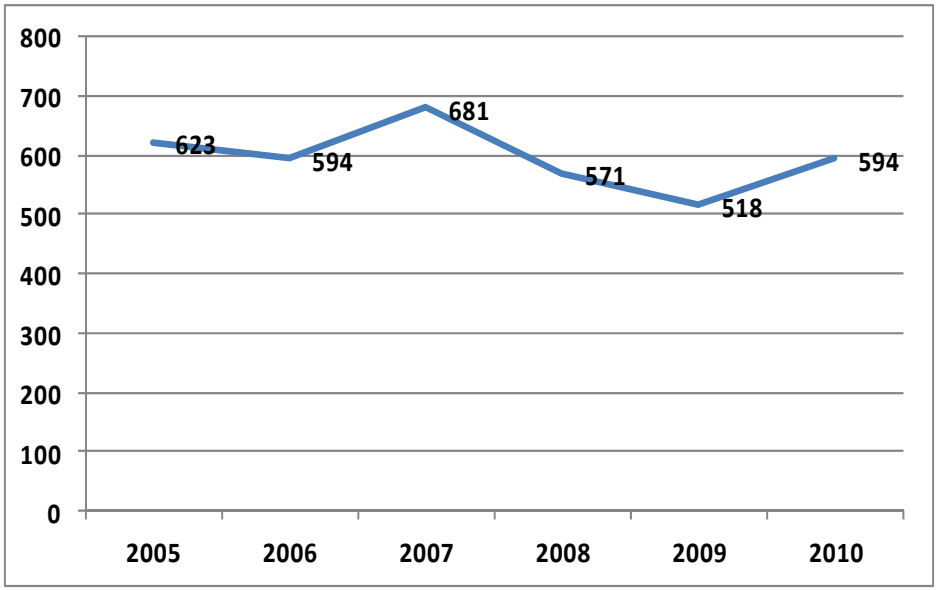
EXECUTIVE SUMMARY

Each year, the Georgia Child Fatality Review Panel (Panel) publishes a report detailing the circumstances of death for children under age 18 in Georgia. Child deaths are generally identified through death certificates filed by the Office of Vital Records of the Department of Public Health, with supplemental notifications provided by other agency sources. Local CFR committees convene a review meeting only for those deaths that are considered eligible for review by CFR legislation; that is, those deaths that are unexpected, unexplained, or due to suspicious circumstances. The circumstances of each death are recorded on a standardized surveillance form which is the basis for the data analyses presented in the annual report. The purpose of CFR in Georgia is to use the multidisciplinary review process to identify opportunities for prevention of future child deaths.

Throughout the report, there are vignettes of circumstances reported by CFR committees. These brief narratives are included to assist the reader in understanding some details of these cases, and also to consider real and necessary avenues for prevention.

In recent years, the Office of Vital Records has not been able to provide the death certificates within the required timeframe for the Panel to produce its annual data report, so the findings of this Annual Report are based solely on the deaths identified by CFR committees in 2010, which represents 594 reviewed deaths.

Figure 1: All Reviewed Deaths, GA CFR, 2005-2010



The overall number of reviewed deaths is lower in 2010 than it was in 2005, but that does not necessarily mean that the number of total child deaths was reduced, or even that the rate of child deaths (a more accurate measure because it is based on population size) was reduced. It is impossible to attribute this change over time to any single prevention policy or practice, because of the multitude of possible variables that could have also contributed to the observed decline during this period (from individual characteristics within families and communities, social programs, and policy, educational, or cultural changes).

PREVENTABILITY AND PREVENTION RECOMMENDATIONS

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 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 that would have changed the circumstances of the death. Many deaths to children are predictable, understandable, and therefore preventable.

Figure 2: Preventability Determination by Cause of Death, 2010 (N= 594)

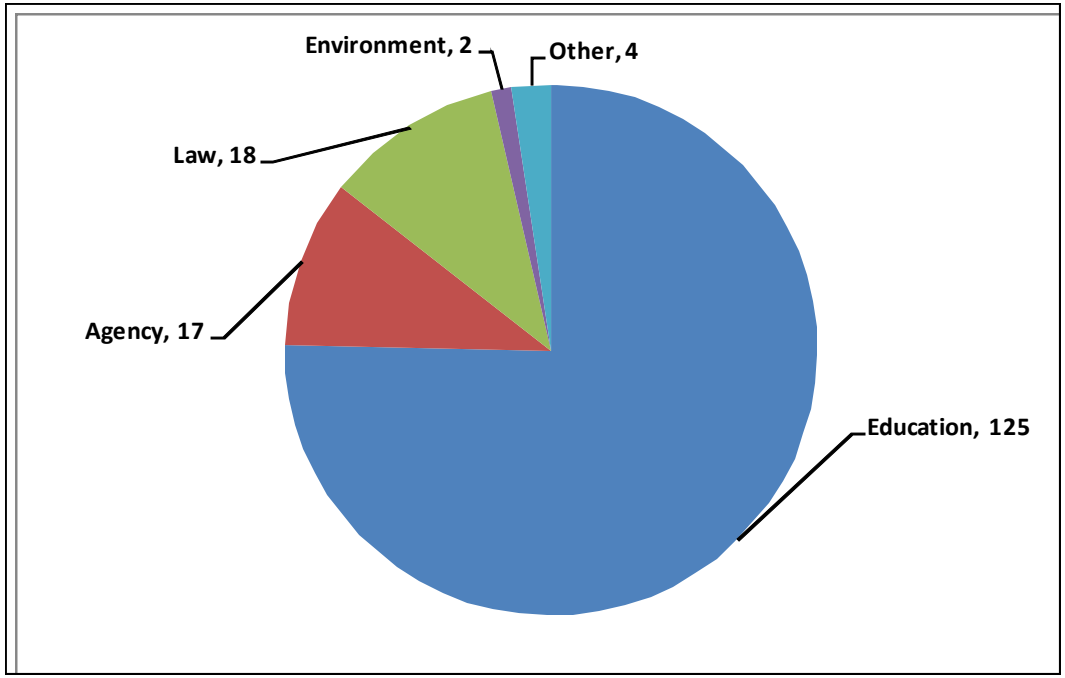
CAUSE	Missing/blank	No, probably not	Yes, probably	Team could not determine
All Unintentional	3	12	184	7
Homicide	2	6	54	5
Suicide	1	6	17	6
SIDS		10	3	7
Sleep-related Asphyxia	3	1	31	1
SUID	6	19	76	36
Medical	2	55	13	17
Undetermined	2	2	1	6

SIDS = Sudden Infant Death Syndrome

SUID = Sudden Unexplained Infant Death

Based on the retrospective review, if the death could have been prevented, the committees are also asked to make prevention recommendations to reduce future deaths. Each recommendation can have multiple components, if the committee determines that multiple agencies or policies could be effective in preventing deaths. In 2010, there were 135 deaths where the committees made a prevention recommendation for at least one area (e.g. education, law/policy, environment, etc). In 374 cases, the committee did not recommend any preventive action.

Figure 3: Prevention Recommendations by Topic,2010 (N=135)



- Of the "education" recommendations, committees most often suggested media campaigns, school programs, parent education, and community safety projects
- Of the "agency" recommendations, committees most often identified revising policies, creating new programs, and expanding services
- Of the "law" recommendations, committees most often identified enforcing laws and ordinances

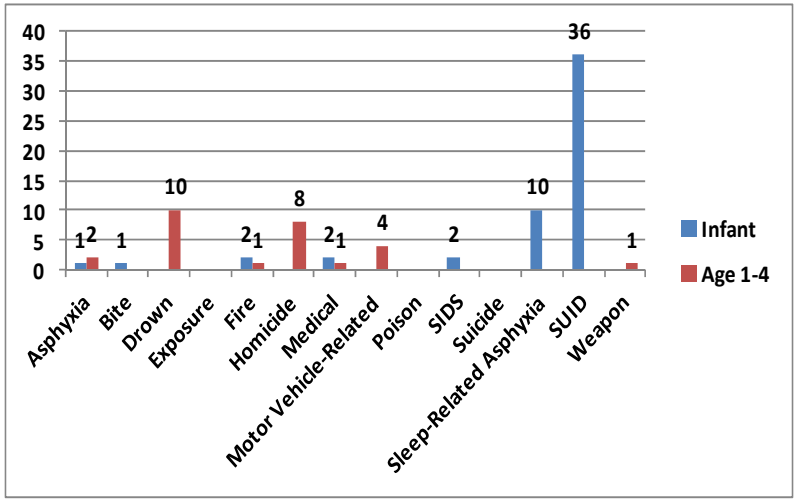
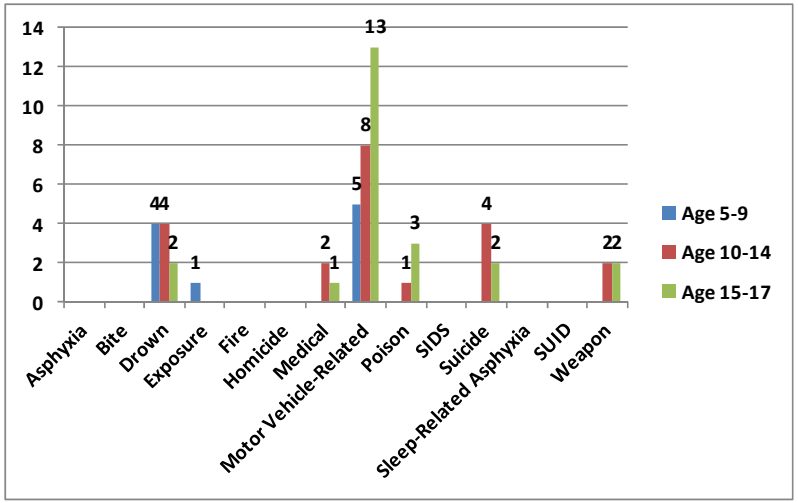


Figure 4: Prevention Recommendations for Children Age <5, 2010 (N=81)

- CFR Committees most often made prevention recommendations for young children (age <5) in the areas of sleep-related deaths, drowning, and homicide



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

Figure 5: Prevention Recommendations for Children age >5, 2010 (N=54)

ALL REVIEWED DEATHS

In Georgia, all 159 counties are legislatively mandated to convene a CFR committee which is comprised of a multi-agency, multi-disciplinary approach to understanding the circumstances surrounding every preventable child death. During this process, CFR committees utilize vital information gleaned from multiple sources (e.g. autopsies, coroner and medical examiner investigative reports, and child protective services historical documentation). Most often, the cause and manner of death is clearly identifiable, but occasionally, a constellation of factors make it difficult to definitively assign an accurate cause and manner of death. In such instances, multiple systems (e.g. the medical examiner's office, the coroner's office, and law enforcement entities) render a death **undetermined** based on inconclusive information, underscoring the importance of continuously enhancing scene investigation and data collection processes.

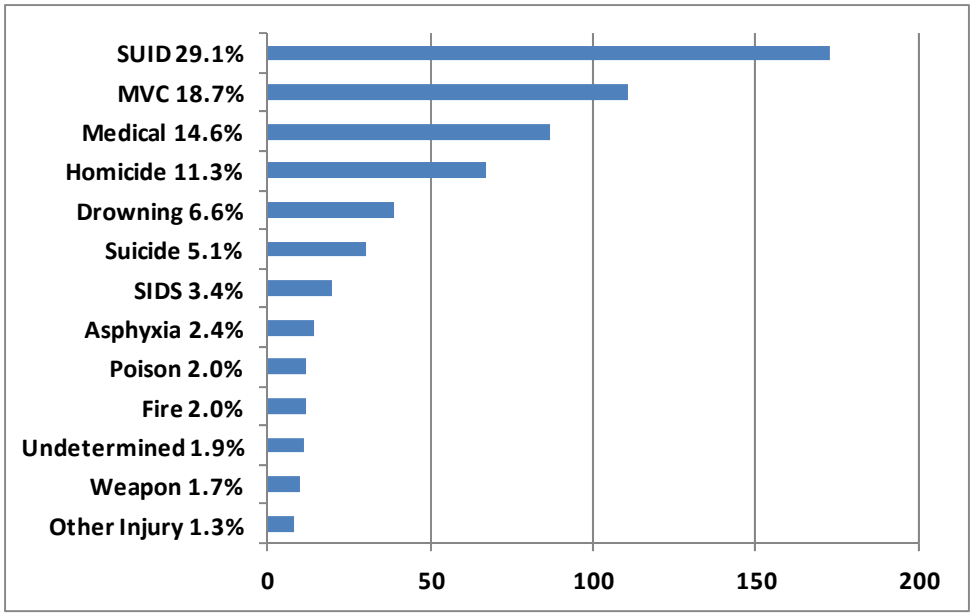
In 2010, CFR committees reviewed 594 child deaths which is a slight increase compared to 518 reviewed in 2009. Each year the Child Fatality Review Division links child death data collected by local CFR committees with the Office of Vital Records data to ensure a comprehensive and accurate account of all deaths. However, the full vital records data file was not available prior to completion of this report. Therefore, the information contained in this report is solely based on CFR data .

		Number	Percent
Age	Infant	244	41.1
	1 to 4	113	19
	5 to 9	54	9.1
	10 to 14	73	12.3
	15 to 17	110	18.5
Race/Ethnicity/	White Male	158	26.6
	White Female	96	16.2
	African-American Male	178	30
	African-American Female	108	18.2
	Hispanic Male	28	4.7
	Hispanic Female	16	2.7
	Multi-Race Male	4	0.7
	Multi-Race Female	1	0.2
	Asian Male	3	0.5
	Asian Female	2	0.3

Figure 6: Demographics of All Reviewed Deaths, 2010 (N=594)

- Infant deaths account for 41% of all reviewed deaths and exceed the total number of reviewed deaths for ages 1 through 14

Figure 7: All Reviewed Deaths by Cause, 2010 (N=594)



- Thirty-seven percent of reviewed deaths were due to unintentional or undetermined causes
- Thirty-two percent of reviewed deaths were due to sleep-related circumstances among infants
- The “other injury” category includes four fall/crush deaths, three exposure deaths resulting from being left in a vehicle, and one death resulting from an animal bite
- Sixteen percent of reviewed deaths were due to intentional injury (homicide and suicide)

SPOTLIGHT ON MALTREATMENT

The inaccurate account of child maltreatment deaths is prevalent across the United States. The National Child Abuse & Neglect Data System (NCANDS) is based on a voluntary state report to the Department of Health and Human Services (HHS). Many have questioned whether this report is an accurate collection of the number of child deaths due to maltreatment. There are several factors that play a role with inconsistent reporting of maltreatment deaths including "lack of evidence and inconsistent interpretations of maltreatment" (GAO, 2011). As part of the Child Abuse and Prevention Treatment Act, the Chairman of the House Ways and Means Committee requested the Government Accountability Office to research the quality of maltreatment data. As part of this research, the National Center for Child Death Review's (NCCDR) data was analyzed.

In 2009, Georgia CFR transitioned to the NCCDR death reporting system in an effort to collect more data and be a part of the national systemic CFR process for data collection. Since this time, CFR committees have been trained on the data collection process and have been taught to focus on the maltreatment section of the tool. The CFR reporting system collects information on maltreatment specific to acts of omission (child neglect) and commission (child abuse).

Of the 594 child deaths reviewed in 2010, CFR committees identified 80 children as victims of maltreatment (13%). Maltreatment is defined as having a positive response to one or more of the following variables:

- 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

Thirty- six reviews revealed that the child had a history of maltreatment as a victim. In 57 cases, the investigation found evidence of prior abuse. When cause of maltreatment was known (N=73)., there were 42 cases (58%) where child abuse reportedly caused/ contributed to the child's death, and in 31 cases (43%), child neglect reportedly caused/contributed to the child's death .

Of the maltreatment deaths, 32 cases were homicides (40%), 17 were infant sleep-related (21%), eight were medical (10%), and seven were motor vehicle crashes (9%). Children under age five represented 55 cases (69%) of maltreatment deaths. The demographic breakdown of maltreatment cases is provided in the table below.

CFR committees identified an additional 261 cases 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.

Figure 8: Demographics of All Reviewed Maltreatment Deaths, 2010 (N=80)

		Number	Percent
Age	Infant	29	36.3
	1 to 4	26	32.5
	5 to 14	13	16.3
	15 to 17	12	15
Race/Ethnicity/Gender	White Male	16	20
	White Female	16	20
	African-American Male	18	22.5
	African-American Female	17	21.3
	Hispanic Male	7	8.8
	Hispanic Female	5	6.3
	Multi-Race Male	1	1.3

AGENCY INVOLVEMENT

Agency involvement continues to be a reminder of opportunities for education, prevention, and risk reduction counseling with each agency visit or staff interaction with a family. CFR committees identified 286 (48%) cases where the decedent or his/her family had contact with a public agency. Some of these agencies include mental health, social services, law enforcement, and juvenile detention. The agency breakdown is as follows:

- 21 cases (7%) were receiving Children's Special Healthcare Services
- 15 cases (5%) received prior mental health services and of those, 11 were currently receiving services
- 32 (11%) children had an open Child Protective Services case with the Department of Families and Children's Services at the time of death and 16 (50%) of those had a history of child maltreatment
- 34 (12%) children had a delinquent or criminal history
- 10 (4%) children had spent time in juvenile detention
- 247 (86%) caregivers were receiving social services at the time of the child's death (e.g., WIC, Medicaid, TANF, Food Stamps, or other)
- 49 (17%) children had a history of maltreatment

MEDICAL DEATHS

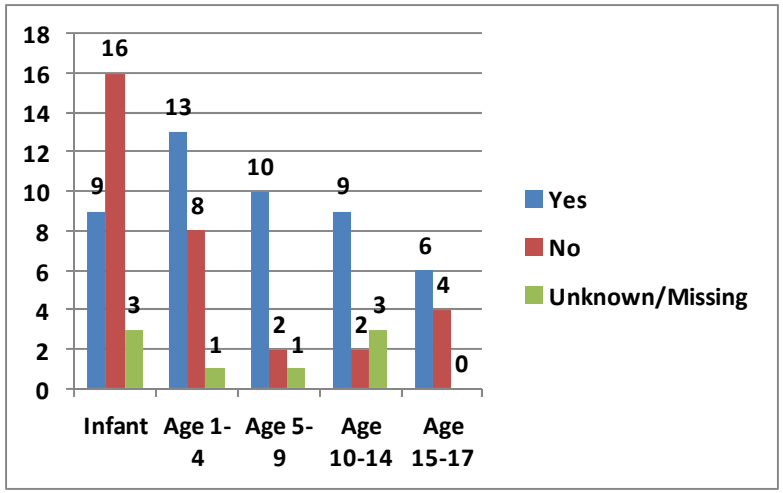
CFR Committees review medical deaths when the death is determined to be unexpected, suspicious, or under unusual circumstances. Reviewed medical deaths vary by cause and by decedent's age, but many deaths are due to seizure disorders, congenital abnormalities, asthma, or prematurity.

Figure 9: Demographics of All Reviewed Medical Deaths, 2010

		Number	Percent
Age	Infant	28	32.2
	1 to 4	22	25.3
	5 to 14	27	31
	15 to 17	10	11.5
Race/Ethnicity/Gender	White Male	8	9.2
	White Female	21	24.1
	African-American Male	31	35.6
	African-American Female	20	23
	Hispanic Male	3	3.4
	Hispanic Female	3	3.4
	Asian Female	1	1.1

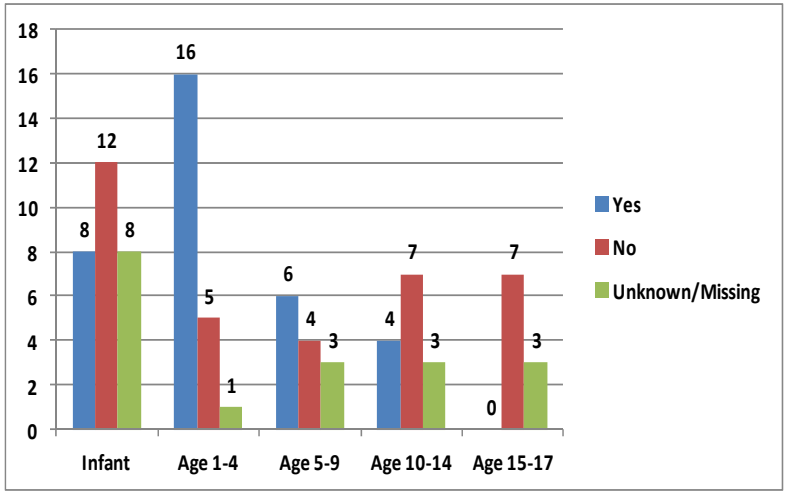
Having health insurance coverage is often considered a method to improve access to health care and reduce the severity of medical issues. In 42 cases, health insurance coverage was unknown, 26 decedents were covered by Medicaid, ten had private coverage, and four were covered by other sources. In five deaths, the decedent had no health insurance.

Figure 10: Reviewed Medical Deaths with History of Disability or Chronic Illness, 2010 (N=87)



- Deceased toddlers (age 1 to 4) were over 50% more likely to have had a reported disability, chronic illness or acute illness prior to death, compared to infants
- In 12 cases, the decedent had received special health care services

Figure 11: Reviewed Medical Deaths with History of Acute Illness, 2010 (N=87)



SLEEP-RELATED INFANT DEATHS

CFR Committees determine the cause of infant sleep-related deaths by reviewing multiple factors associated with the sleep environment, 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 contributing 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, or health issues).

Figure 12: Demographics of All Reviewed Sleep-Related Deaths, 2010 (N=193)

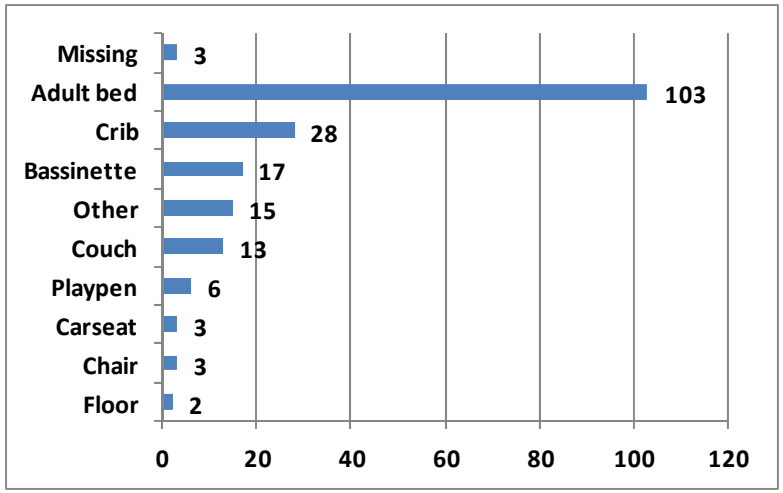
Race/Ethnicity/Gender	SIDS		Asphyxia		SUID		Total	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
White Male	5	25	9	25	39	28.5	53	27.5
White Female	3	15	4	11.1	19	13.9	26	13.5
African-American Male	5	25	8	22.2	41	29.9	54	28
African-American Female	6	30	11	30.6	27	19.7	44	22.8
Hispanic Male	1	5	1	2.8	7	5.1	9	4.7
Hispanic Female			1	2.8	2	1.5	3	1.6
Multi-Race Male			1	2.8	2	1.5	3	1.6
Multi-Race Female			1	2.8			1	0.5

*All Race/Ethnicity/Sex Categories except Hispanic are Non-Hispanic

- While not indicative of population rates, the race/gender groups with the highest percentage of reviewed infant deaths due to sleep-related circumstances were African-American males and non-Hispanic White males. However, population rates should be considered when determining priority for prevention programs and services

The American Academy of Pediatrics (AAP) expanded their recommendations for prevention of SIDS and other sleep-related infant deaths in October 2011, and stated: "Infants may be brought into the bed for feeding or comforting but should be returned to their own crib or bassinet when the parent is ready to return to sleep. Because of the extremely high risk of SIDS and suffocation on couches and armchairs, infants should not be fed on a couch or armchair when there is a high risk that the parent might fall asleep."

Figure 13: Sleep Location, Sleep-Related Infant Deaths, 2010 (N=193)



- Of the 183 sleep-related deaths when "sharing a sleep surface" was known to the committees, 57% of the decedents were sharing a sleep surface at time of death
- Ninety-two were bed-sharing with an adult, and 32 were bed-sharing with a child (the total exceeds the 104 known case total because there were several cases where the decedent was sharing a surface with both an adult and another child)
- The highest percentage of sleep-related deaths occurred in an adult bed (53%), while 23% occurred in a crib/bassinette

The AAP does not recommend any specific bed-sharing situations as safe, including bed-sharing when the infant is younger than three months. The AAP suggests that it is prudent to provide separate sleep areas and avoid co-bedding for twins and higher-order multiples in the hospital and at home.

The decedent's father was taking care of him while the mother rested. The father took the decedent to the bedroom and lay next to him on the bed. He placed the infant prone, despite the mother repeatedly instructing him to place the infant on his back to sleep. When the father woke about 2 hours later, he discovered his arm on top of the infant, weighing him down, and the infant's face pressed down into the bedding.

The following data give clarification for the specific sleep location and circumstances reported among reviewed infant sleep-related deaths.

Figure 14: Reviewed Sleep-Related Deaths and Bed-Sharing, when known (N=183)

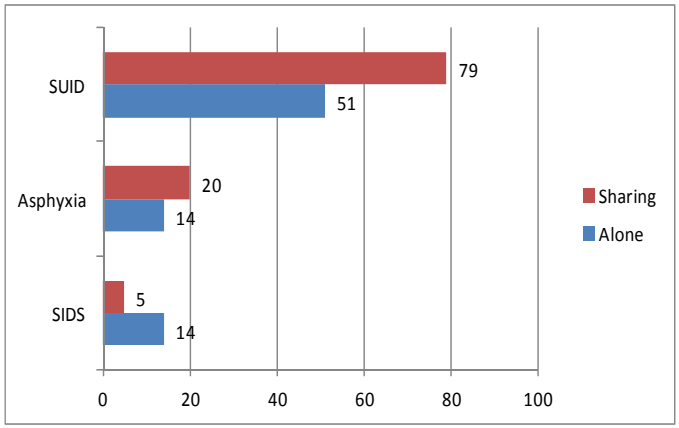
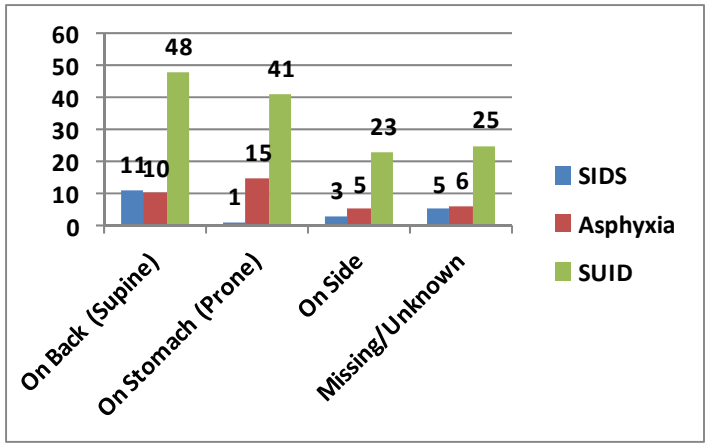


Figure 15: Placed Position of Reviewed Sleep-Related Deaths, 2010



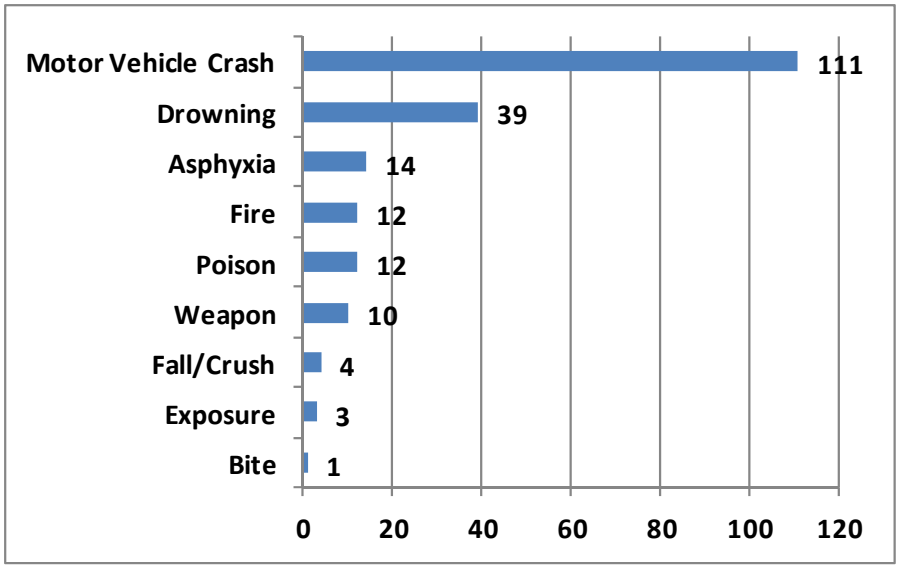
- Of the 15 SIDS deaths when "placed position" was known, 73% of decedents were placed to sleep on their back
- Of the 142 SUID/Asphyxia deaths, (position known) 40% were placed on their back

- The AAP recommends "back to sleep" for every sleep. To reduce the risk of SIDS and other sleep-related deaths, infants should be placed for sleep in a supine position (wholly on the back) for every sleep by every caregiver until one year old
- Side sleeping is not safe and is not advised

UNINTENTIONAL INJURY-RELATED DEATHS

Unintentional injury-related deaths are the leading cause of reviewed death to children between the ages of one and 18 years of age. Unintentional injuries can be fatal at times due to the severity of the injury and also the age of the child. In this section, several injuries will be highlighted.

Figure 16: Reviewed Unintentional Injury-Related Deaths by Mechanism, all ages, 2010 (N=206)



- There are eight injuries included in this section where CFR committees could not determine the manner of death, and left it as undetermined, after reviewing inconclusive autopsies and scene investigations. These included three from poisoning, 3 from weapons, and 2 from asphyxia
- Motor vehicle-related deaths accounted for more than half (54%) of all reviewed unintentional injury deaths
- Drowning continues to be the second leading cause of reviewed unintentional deaths
- For all unintentional injuries, the age groups vary in regards to the common causes of deaths investigated. The table below represents the type of injury by age group

Figure 17: Reviewed Unintentional Injury-Related Deaths by Mechanism

	Infant	1 to 4	5 to 9	10 to 14	15 to 17	TOTAL
Motor Vehicle Crash	0	27	19	25	40	111
Drowning	2	15	9	7	6	39
Asphyxia	2	7	2	1	2	14
Fire	2	5	3	0	2	12
Poison	2	1	1	3	5	12
Weapon	0	1	1	3	5	10
Fall/Crush	0	2	0	0	2	4
Exposure	0	2	1	0	0	3
Bite	1	0	0	0	0	1

- Older teens represented 36% of motor vehicle-related deaths

Figure 18: Reviewed Unintentional Injury-Related Deaths by Mechanism of Injury and Race/Ethnicity of Victim, 2010 (N=206)

	Asphyxia	Bite	Drowning	Exposure	Fall/	Fire	MVC	Poison	Weapon	TOTAL
MALE										
White	5	0	12	0	1	3	39	5	6	71
African-American	5	0	13	1	0	3	25	2	1	50
Hispanic	0	0	5	0	1	0	4	0	0	10
Other Race	0	0	1	0	0	0	2	0	0	3
FEMALE										
White	1	0	4	2	1	3	24	4	0	39
African-American	3	1	3	0	0	3	14	1	3	28
Hispanic	0	0	1	0	1	0	3	0	0	5
Other Race	0	0	0	0	0	0	0	0	0	0

- Two-thirds of unintentional injury related deaths occur among males (65%)

MOTOR VEHICLE INJURY-RELATED DEATHS

Motor Vehicle-Related deaths are the leading cause of all reviewed deaths for children ages one to 18 years. They also accounted for more than half (54%) of all the reviewed unintentional injury-related deaths. According to the Centers for Disease Control and Prevention (CDC), seatbelts reduce the risk for serious injury or death by 50% (CDC, 2009) and teen drivers are at the highest risk for death from motor vehicle crashes. There are four high risk areas to consider with teen driving which include: driving at night, newly licensed drivers, driving with other teen passengers and being male. The following graphs represent an overview of the data from the CFR committees.

Figure 19: Demographics of Reviewed Motor Vehicle-Related Deaths, 2010 (N=111)

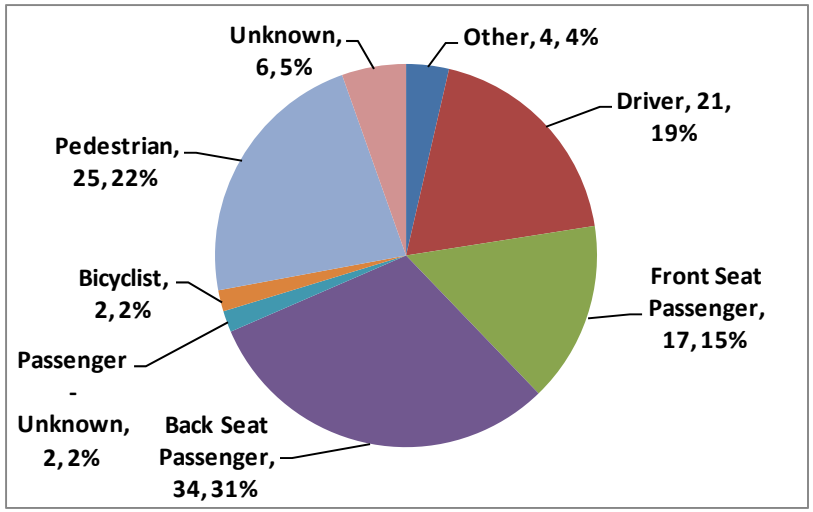
		Number	Percent
Age	1 to 4	27	24.3
	5 to 9	19	17.1
	10 to 14	25	22.5
	15 to 17	40	36
Race/Gender	White Male	39	35.1
	White Female	24	21.6
	African-American Male	25	22.5
	African-American Female	14	12.6
	Other Male	2	1.8
	Other Female	0	0
	Hispanic Male	4	3.6
	Hispanic Female	3	2.7

- Males represented 63% of all motor vehicle-related deaths
- While not indicative of population rates, the race/gender groups with the highest percentage of reviewed deaths due to motor vehicle-related injuries were non-Hispanic White males and African-American males. However, population rates should be considered when determining priority for prevention programs and services
- According to CFR committees, 58% of children ages 5 to 9 years died while riding in seatbelts instead of being in a booster seat. Additionally, 33% of this age group was riding unrestrained

The National Highway Traffic Safety Administration recommends children should stay in a booster seat until he or she is big enough to fit in a seat belt properly. For a seat belt to fit properly the lap belt must lie snugly across the upper thighs, not the stomach. The shoulder belt should lie snug across the shoulder and chest and not cross the neck or face. They also advise keeping children in the back seat through age 12 years. Georgia was fortunate to pass a revised booster seat law where children under age eight, with some exceptions, must ride in an approved child restraint system. For more details on this law, go to http://www.gohs.state.ga.us/seatbeltlaw.htm

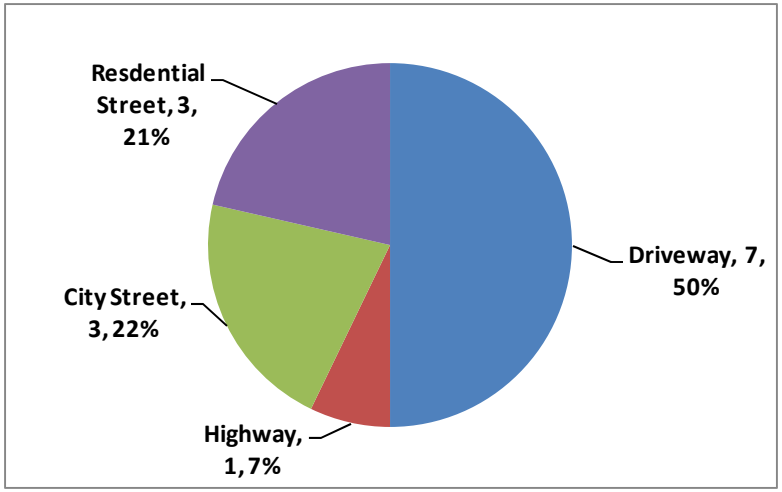
Toddler deaths in/around motor vehicles accounted for 24% of the total deaths in this category with 26% of those being killed as a pedestrian, outside of the vehicle. Most of these deaths occurred while a toddler was playing outside in their yard or near the roadway. Other common scenarios included children darting outside when a loved one drove up and they were run over unexpectedly.

Figure 20: Reviewed Motor Vehicle-Related Deaths by Location at Injury, 2010 (N=111)



- Of the 18 teens age 15-17 that died while driving, 50% were 16 years of age
- Passengers between the ages of 15-17 (N=22) were not re-strained in 45% of the cases and in 29% of the 10-14 year olds (N=14), when restraint use was known
- "Other" category includes all-terrain vehicles (ATV)

Figure 21: Location of Reviewed Motor Vehicle-Related Pedestrian Deaths, Ages 1 to 4, 2010 (N=14)



- CFR committees reported more than 90% of toddlers were supervised at the time of their death

DROWNING

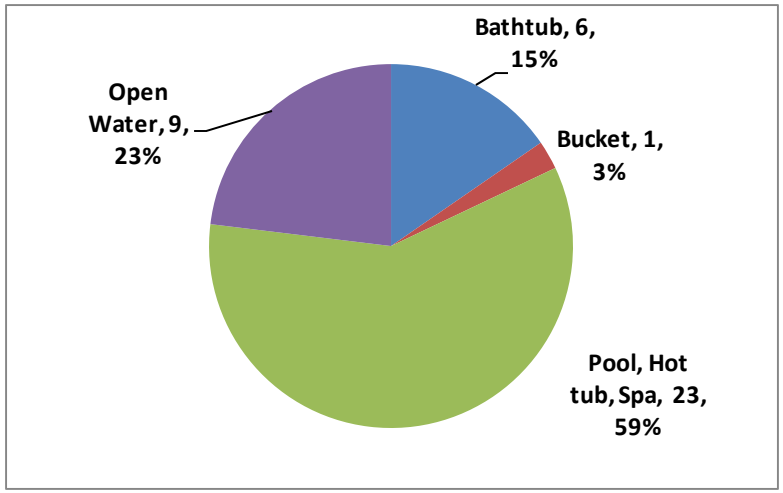
Each year, the number of drowning deaths continue to be alarming, specifically with the toddler age group. CFR committees reported 53% of the toddlers who drowned had supervision, 40% did not and 6% could not be determined. With the increase risk of distractions and busy schedules, caregivers and supervisors must be reminded that active supervision of children is critical for their overall safety.

Figure 22: Demographics of Reviewed Drowning Deaths, 2010 (N=39)

		Number	Percent
Age	Infant	2	5.1
	1 to 4	15	38.5
	5 to 9	9	23.1
	10 to 14	7	17.9
	15 to 17	6	15.4
Race/Ethnicity/Gender	White Male	12	30.8
	White Female	4	10.3
	African-American Male	13	33.3
	African-American Female	3	7.7
	Other Male	1	2.6
	Other Female	0	0
	Hispanic Male	5	12.8
	Hispanic Female	1	2.6

- Males accounted for 80% of all reviewed drowning deaths
- Drowning is the second leading cause of reviewed unintentional injury-related death

Figure 23: Drowning Location of Reviewed Drowning Deaths, 2010 (N=39)



- All of the bathtub drowning deaths revealed the children were left unattended and all but one were under the age of five years
- All but one of the deaths in open water occurred to children between 10-17 years of age

Toddler was in a neighborhood pool and was being watched by her sister. Her sister went back inside and thought the grandmother was watching the toddler. When the sister came back to the pool, they found the child on the bottom of the pool.

OTHER UNINTENTIONAL INJURY-RELATED DEATHS HIGHLIGHT

FIRE:

Fire-related deaths to children in Georgia continue to remain lower than in years past. When supervision was known, CFR committees identified 100% of the children were not being supervised.

Figure 24: Demographics of Reviewed Fire-Related Deaths, 2010 (N=12)

		Number	Percent
Age	Infant	2	16.7
	1 to 4	5	41.7
	5 to 9	3	25.0
	10 to 14	0	0.0
	15 to 17	2	16.7
Race/Ethnicity/Gender	White Male	3	25.0
	White Female	3	25.0
	African-American	3	25.0
	African-American	3	25.0

- 42% of deaths occurred to toddlers
- Causes of the fire deaths ranged from space heaters (2), lightning strikes (3), stove/cooking (2), and others (e.g., combustibles, playing with lighter)

Children left home alone inside bedroom with door closed and a small space heater which was running inside the room. Heater was overturned by one of the children and a fire started. Mother came home and found smoke coming from the bedroom.

POISON: According to the CDC, unintentional poisoning deaths are on the rise in the United States. Poisoning deaths rose 145% from 1999-2007and 93% were a result of drug overdose. CFR Committees have seen similar increases. The breakdown of reviewed poisoning deaths is as follows:

2006 – 7
2007 – 15
2008 – 14
2009 - 4
2010 - 12

- All of these poisonings are related to prescription drug overdoses
- Three of the poisoning deaths had an 'undetermined' manner by CFR committees after a thorough scene investigation and autopsy review, meaning that the committees were unable to determine if the death was due to intentional or unintentional actions

Figure 25: Demographics of Reviewed Poisoning Deaths, 2010 (N=12)

		Number	Percent
Age	Infant	2	16.7
	1 to 4	1	8.3
	5 to 9	1	8.3
	10 to 14	3	25
	15 to 17	5	41.7
Race/Ethnicity/Gender	White Male	5	41.7
	White Female	4	33.3
	African-American Male	2	16.7
	African-American Female	1	8.3

WEAPON: In the National Child Death Reporting System, the reporting form includes a "weapon" section. This section allows for the cause of death to be captured when a weapon is used. A weapon can be defined as a blunt/sharp instrument, rope, pipe, biological agent, firearm, explosive or a person's body part. The chart below identifies reviewed cases in Georgia where the decedent died from unintentional weapon use.

Figure 26: Demographics of Reviewed Unintentional Weapon Deaths, 2010 (N=10)

		Number	Percent
Age	1 to 4	1	10.0
	5 to 9	1	10.0
	10 to 14	3	30.0
	15 to 17	5	50.0
Race/Ethnicity/Gender	White Male	6	60.0
	White Female	0	0.0
	African-American Male	1	10.0
	African-American Female	3	30.0

- Firearms represented 90% of unintentional weapon-related deaths
- Of the firearms, 67% were handguns (6) and 33% were shotguns or hunting rifles (3)
- Three of the deaths were listed as 'undetermined' manner by CFR committees after a thorough scene investigation and autopsy, meaning that the committees were unable to determine if the death was due to intentional or unintentional actions

HOMICIDE

For many, the topic of child homicide elicits images of a malicious stranger taking the life of a child. But in reality, the top sources of mortality for American children are much closer to home: unintentional injuries, homicide and abuse at the hands of someone they know. Homicide is actually ranked second or third, depending on the age group analyzed, among the three leading causes of childhood mortality. And while deaths resulting from unintentional injuries, congenital defects, and infectious diseases have fallen over the past 30 years, homicides of children have increased (U.S. Department of Justice, 2008).

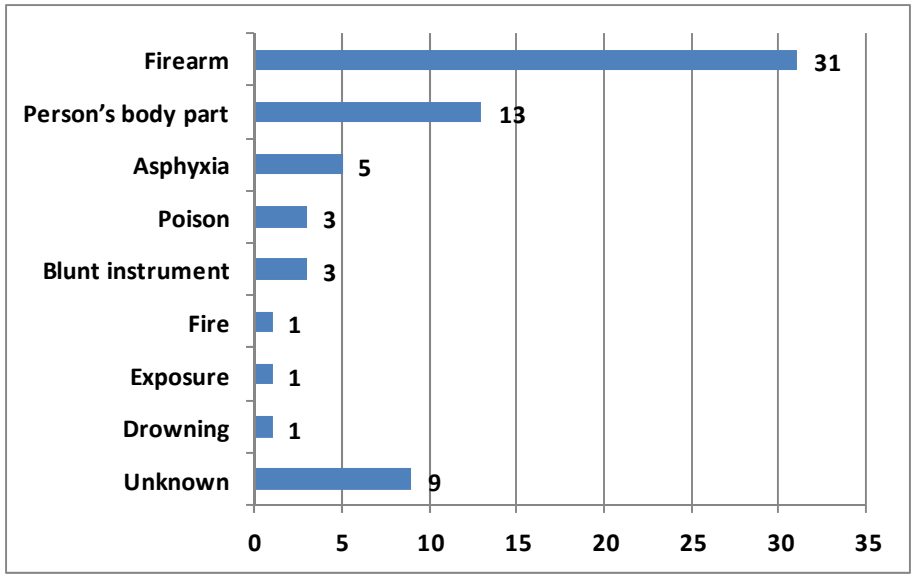
Figure 27: Demographics of Reviewed Homicide Deaths, 2010

		Number	Percent
Age	Infant	10	15.0
	1 to 4	24	36.0
	5 to 9	5	7.0
	10 to 14	8	12.0
	15 to 17	20	30.0
Race/Ethnicity/Gender	White Male	9	13.0
	White Female	4	6.0
	African-American Male	33	49.0
	African-American Female	11	16.0
	Hispanic Male	5	8.0
	Hispanic Female	4	6.0
	Other Male	1	2.0
	Other Female	0	0

- Young children and infants under age four accounted for just over half of reviewed homicide deaths, 51%
- While not indicative of population rates, the race/gender groups with the highest percentage of reviewed homicide deaths were African-American males and African-American females. However, population rates should be considered when determining priority for prevention programs and services

Eleven year old was asleep in bed when an unknown subject came to the location, pulled out a gun and began firing striking the child in the back of the head. The shooting was a retaliation of the victim's older brother who was involved in a previous crime.

Figure28: Reviewed Homicide Deaths by Mechanism, 2010 (N=67)



- When known (58 cases), firearms were involved in over half of all homicide deaths, 53%
- Sixty-one percent of the firearm-related homicide deaths involved older teens ages 15-17

SUICIDE

According to research carried out by the Commission for Children and Young People and Child Guardian in 2009, 42% of all youth suicides are completed by young people who have lost someone of influence or significance to them to suicide. The Commission terms this suicide contagion and makes several recommendations as to the importance of safe guarding young people and communities from suicide contagion. Such research has found that young people who feel connected, supported and understood are less likely to complete suicide and supports the notion that connectedness, a sense of being supported and respected are protective factors for young people at risk of suicide (Commission for Children and Young People and Child Guardian, 2009).

Figure 29: Demographics of Reviewed Suicide Deaths, 2010 (N=30)

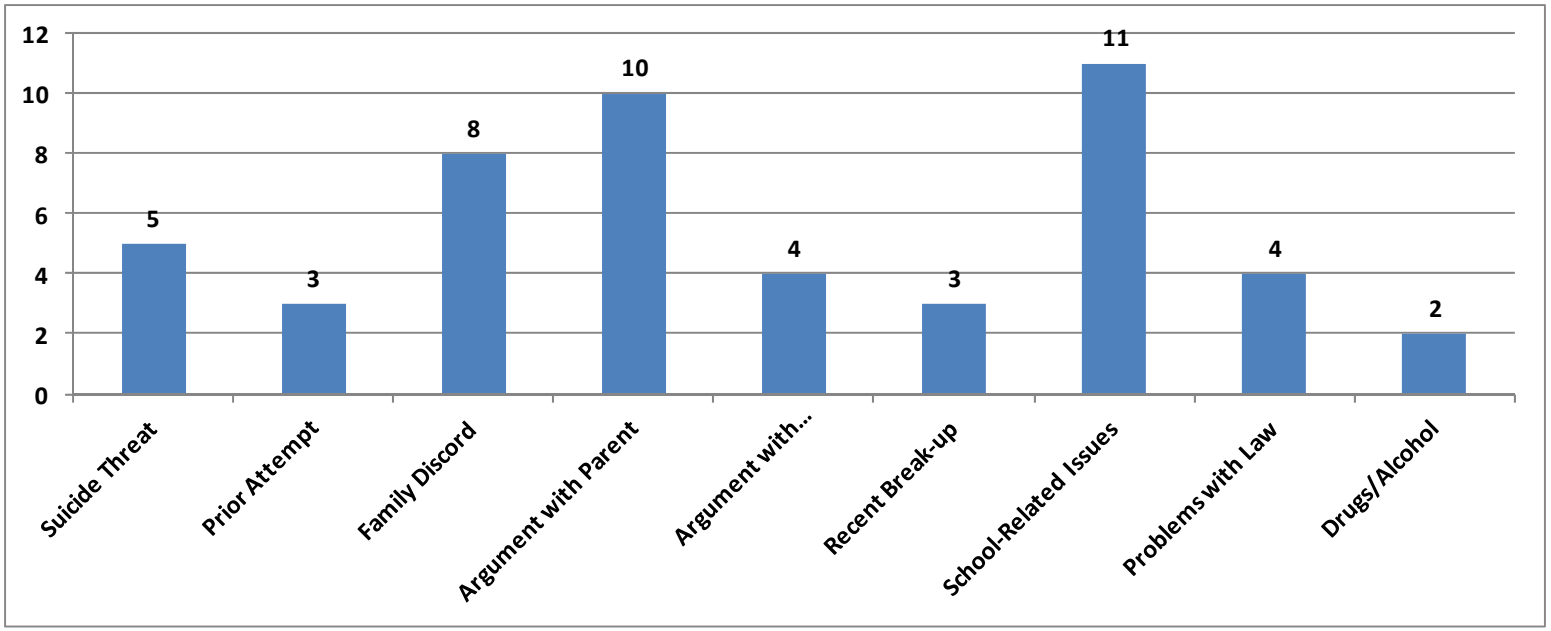
		Number	Percent
Age	10 to 14	12	40.0
	15 to 17	18	60.0
Race/Ethnicity/Gender	White Male	15	50.0
	White Female	5	17.0
	African-American Male	7	23.0
	African-American Female	1	3.0
	Hispanic Female	1	3.0
	Asian Female	1	3.0

- While not indicative of population rates, the race/ gender groups with the highest percentage of reviewed suicide deaths were non-Hispanic White males and African-American males. However, population rates should be considered when determining priority for prevention programs and services

- Fifty-three percent of reviewed suicide deaths involved firearms, (N=16); 37% involved hanging, (N=11)

Early identification of behavioral indicators and potential risk factors can serve as opportunities for effective intervention. Strengthening communities, enhancing social support, and improving the specific skills of youth and their parents are all part of an overall effort to promote the well-being of all youth (Center for Disease Control, 2009).

Figure 30: Suicide Deaths and Reported Risk Factors, when known, 2010



13 year-old died from a self inflicted gunshot wound to the head. He was a popular, well-liked student athlete with no major school related issues. He recently learned that his girlfriend was pregnant and believed that his life was over because he could not handle the responsibility of raising a child.

DISPROPORTIONATE DEATHS

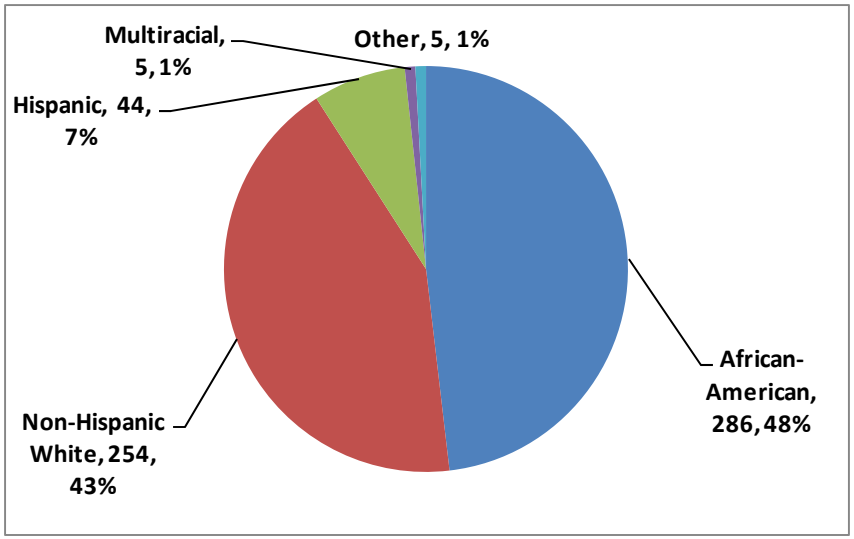
There are many state and national agencies and organizations dedicated to promoting health equity and social justice initiatives, to explore *why* certain populations bear a disproportionate burden of disease and mortality and what health departments and others can do to better address the causes of these inequities. In 2001, Congress authorized a National Healthcare Disparities Report by the Agency for Healthcare Research and Quality (AHRQ). The AHRQ, in tandem with the Institute of Medicine, identified key issues for study related to health disparities for racial and ethnic minorities in the U.S.—the role of socioeconomic status, access to care, quality of services, and geography.

The urgency behind the federal mandate is based on these facts:

- The gap between African-Americans and Whites in (age-adjusted) death rate from all causes has decreased only slightly from 1950 to 2000
- Minority racial and ethnic groups are less likely than Whites to have a usual source of health care
- Infant mortality among African-Americans is more than twice that of Whites
- Teen pregnancy rates among minorities are higher than for Whites
- Minorities tend to receive lower-quality health care than Whites even when insurance status, income, age, and severity of conditions are comparable. The initial National Healthcare Disparities Report defined “quality” as the degree to which health services consistent with current professional knowledge increases the desired health outcomes

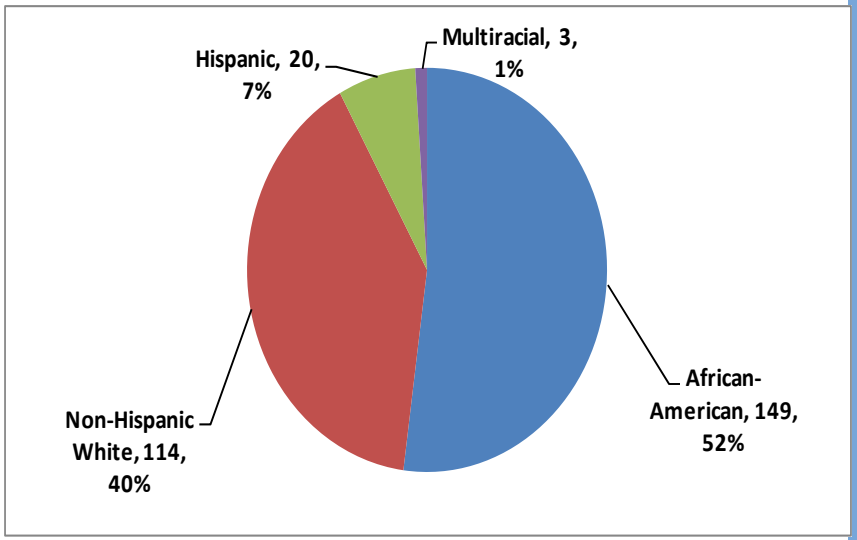
For the successful prevention of deaths among children, it is imperative to consider the fact that many racial and ethnic groups are fewer in number within the population as a whole. In contrast, many circumstances of injury and death demonstrate a higher percentage within these racial and ethnic groups. Their death rates are not proportionate to their representation within the population as a whole. For this reason, we must consider the specific social and ecological circumstances that are unique to each racial group, and identify prevention programs and services that are tailored to their needs.

Figure 31: Number and Percentage of All Reviewed Deaths by Race/ Ethnicity, 2010 (N=594)



- African-Americans represent 48% of the reviewed child deaths in 2010, but according to the 2010 U.S. Census, the population of African-Americans in Georgia was around 30.5%
- Non-Hispanic Whites represent 43% of the reviewed deaths, but the 2010 U.S. Census states the Georgia population was around 56%

Figure 32: Number and Percentage of Decedents with Prior Agency Involvement by Race/Ethnicity, 2010 (N=286)



Activities that can reduce the disproportionate burden of injury and deaths among minority populations can be found within the Department of Health and Human Services (HHS) Action Plan to Reduce Racial and Ethnic Health Disparities ("HHS Disparities Action Plan") at www.minorityhealth.hhs.go. Because racial and ethnic minorities often receive poorer quality of care than non-Hispanic Whites, they face more barriers in seeking care including preventive care, acute treatment, or chronic disease management, and are more likely to report experiencing poorer quality patient-provider interactions (a disparity particularly pronounced among the 24 million adults with limited English proficiency), the CDC's Racial and Ethnic Approaches to Community Health (REACH) program has empowered residents to seek better health, helped change local healthcare practices, and mobilized communities to implement evidence-based public health programs to reduce health disparities across a broad range of health conditions.

RECOMMENDATIONS

1. OCA will continue to utilize the public health surveillance programs that collect and report vital statistics data on births and deaths in Georgia so those agencies and organizations that depend on these data for programs and service delivery can maintain their operations.
2. OCA will educate coroners, first responders, and other death scene investigators on the importance of accurate data collection while at the scene to assist the GBI and local area Medical Examiners' offices in their efforts to improve timelines for completing autopsies and maintain the National Association of Medical Examiner (NAME) standards. Improvements can also be achieved by supporting outsourcing toxicology and improving in-house systems.
3. Counties should broaden who learns about death investigation to include other professionals such as Emergency Medical Services (EMS), nurses, public health, DFCS, and other first responders.
4. Develop and implement community engagement, education, and outreach initiatives by expanding the roles of local CFR committees to host bi-annual public forums providing an opportunity for the broader community to attain de-identified generalized child death data for their respective localities. These forums will serve to enhance public awareness and promote strategizing for effective intervention and prevention ideas for addressing child injury and fatality at a grassroots level.
5. OCA will attend conferences, educate agency staff, and assist with data collection for statewide campaigns and all agency initiatives that aim to educate Georgians on the leading causes of child death, the recognition and reduction of risk factors, and opportunities to promote protective capacities of individuals and communities for the prevention of child deaths.
6. OCA will continue to provide local CFR committees with resources available to them for child passenger safety equipment and advocate for continuation of the provision of child safety seats and booster seats at the local level through state occupant safety programs through the Governor's Office of Highway Safety and the Department of Public Health.

HIGHLIGHTS

The CDC Sudden Unexplained Infant Death (SUID) Case Registry Pilot Project was fully implemented in Georgia in 2010, providing enhanced training to committees on infant death scene investigation, review procedures, and reporting. In addition, CFR Division staff implemented several activities to improve the accuracy and timeliness of infant death reporting. As a result, the completeness rate of many data variables necessary for the prevention of infant deaths were improved by more than 50 percent, and in some cases, almost 100 percent. This project has allowed staff to provide the following:

- Detailed training for coroners on infant death scene investigation and doll reenactment;
- Distribution of death scene support equipment to include reenactment dolls, laptops, and digital cameras;
- Training for CFR committees on data analysis which identified areas to improve, as well as death scene investigation and doll reenactment;
- Presentation at conferences concerning death scene investigations and the promotion of quality data for prevention use. Some of the conferences the staff has participated in included:
    - GA EMS-C Regional Conference in Gainesville and Savannah
    - American Public Health Association
    - Maternal and Child Health Association Conference
    - Georgia Association for Young Children
    - Northwest Georgia Child Abuse Conference

RESOURCES

American Academy of Pediatrics (AAP) revised recommendations for infant safe sleep, October 2011

http://aappolicy.aappublications.org/cgi/content/full/pediatrics;128/5/e1341

Centers For Disease Control and Prevention, Vital Signs

http://www.cdc.gov/vitalsigns/SeatBeltUse/index.htm

http://www.cdc.gov/features/dsTeenDriving/

Commission on Children and Young People and Child Guardians

www.ccypcg.qld.gov

Department of Health and Human Services (HHS) Action Plan to Reduce Racial and Ethnic Health Disparities ("HHS Disparities Action Plan")
www.minorityhealth.hhs.gov

Georgia Governor's Office of Highway Safety

http://www.gohs.state.ga.us/seatbeltlaw.htm

National Healthcare Disparities Report by the Agency for Healthcare Research and Quality (AHRQ)

http://www.ahrq.gov/qual/qrdr10.htm

National Highway Traffic and Safety Administration

www.nhtsa.dot.gov

U.S. Department of Justice

www.justice.gov

U.S. Government Accountability Office, Strengthening National Data on Child Fatalities Could Aid in Prevention, 2011

http://www.gao.gov/products/GAO-11-599

APPENDIX A: REVIEWABLE DEATHS BY COUNTY

The following table represents the status of county level reporting compliance for 2010. 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 our 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 our office was aware of through a variety of sources (i.e., vital records, GBI, 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	# Reviewable Deaths Known	# CFR Reports Submitted	# CFR Reports Not Submitted
Atkinson	1	1	0
Bacon	0	0	0
Baker	0	0	0
Baldwin	2	2	0
Banks	1	1	0
Barrow	3	2	1
Bartow	5	5	0
Ben Hill	2	2	0
Berrien	0	0	0
Bibb	15	15	0
Bleckley	0	0	0
Brantley	2	2	0
Brooks	1	1	0
Bryan	0	0	0
Bulloch	6	5	1
Burke	1	1	0
Butts	1	0	1
Calhoun	1	0	1
Camden	6	6	0
Candler	0	0	0
Carroll	8	7	1
Catoosa	7	7	0
Charlton	2	2	0
Chatham	15	15	0
Chatooga	5	4	1
Chattahoochee	0	0	0
Cherokee	13	13	0
Clarke	3	3	0
Clay	0	0	0
Clayton	23	23	0
Clinch	5	5	0
Cobb	30	30	0
Coffee	4	4	0
Colquitt	5	5	0
Columbia	7	7	0
Cook	2	2	0
Coweta	4	4	0
Crawford	0	0	0
Crisp	1	1	0
Dade	2	2	0

COUNTY	# Reviewable Deaths Known	# CFR Reports Submitted	# CFR Reports Not Submitted
Dawson	1	1	0
Decatur	4	4	0
Dekalb	43	43	0
Dodge	2	2	0
Dooly	1	1	0
Dougherty	12	12	0
Douglas	12	12	0
Early	3	2	1
Effingham	5	5	0
Elbert	1	1	0
Emanuel	3	0	3
Evans	1	1	0
Fannin	1	1	0
Fayette	6	5	1
Floyd	7	7	0
Forsyth	3	3	0
Franklin	3	3	0
Fulton	51	51	0
Gilmer	2	2	0
Glascock	0	0	0
Glynn	8	8	0
Gordon	3	3	0
Grady	3	0	3
Greene	3	3	0
Gwinnett	32	32	0
Habersham	4	4	0
Hall	15	15	0
Hancock	0	0	0
Haralson	2	2	0
Harris	3	3	0
Hart	0	0	0
Heard	1	1	0
Henry	14	12	2
Houston	10	9	1
Irwin	0	0	0
Jackson	6	2	4
Jasper	0	0	0
Jeff Davis	4	3	1
Jefferson	2	0	2
Jenkins	0	0	0
Johnson	2	2	0

COUNTY	# Reviewable Deaths Known	# CFR Reports Submitted	# CFR Reports Not Submitted
Jones	2	2	0
Lamar	1	0	1
Lanier	0	0	0
Laurens	2	2	0
Lee	6	4	2
Liberty	5	5	0
Lincoln	0	0	0
Long	4	0	4
Lowndes	6	6	0
Lumpkin	1	1	0
Macon	1	0	1
Madison	3	3	0
Marion	0	0	0
McDuffie	5	0	5
McIntosh	1	0	1
Meriwether	2	2	0
Miller	1	1	0
Mitchell	1	0	1
Monroe	3	3	0
Montgomery	0	0	0
Morgan	1	1	0
Murray	3	2	1
Muscogee	15	15	0
Newton	6	6	0
Oconee	3	2	1
Oglethorpe	0	0	0
Paulding	4	3	1
Peach	0	0	0
Pickens	2	2	0
Pierce	5	5	0
Pike	3	2	1
Polk	4	3	1
Pulaski	1	1	0
Putnam	0	0	0
Quitman	0	0	0
Rabun			
Randolph	1	1	0
Richmond	22	22	0
Rockdale	3	3	0
Schley	0	0	0
Screven	1	0	1

COUNTY	# Reviewable Deaths Known	# CFR Reports Submitted	# CFR Reports Not Submitted
Seminole	1	1	0
Spalding	6	6	0
Stephens	0	0	0
Stewart	1	0	1
Sumter	2	0	2
Talbot	0	0	0
Taliaferro	0	0	0
Tattnall	3	2	1
Taylor	3	3	0
Telfair	1	1	0
Terrel	1	0	1
Thomas	3	3	0
Tift	4	4	0
Toombs	1	0	1
Towns	1	1	0
Treutlen	1	1	0
Troup	9	9	0
Turner	1	1	0
Twiggs	0	0	0
Union	2	2	0
Upson	3	3	0
Walker	1	1	0
Walton	5	5	0
Ware	1	1	0
Warren	1	0	1
Washington	0	0	0
Wayne	4	4	0
Webster	0	0	0
Wheeler	0	0	0
White	2	2	0
Whitfield	2	2	0
Wilcox	5	5	0
Wilkes	1	1	0
Wilkinson	0	0	0
Worth	0	0	0
	639	587	