

Georgia Child Fatality Review Panel

# 2004 - 2008 TREND REPORT

**Georgia Child Fatality Review Panel  
Trend Report  
Calendar Years 2004 - 2008**



**Nathan Deal, Governor**

**Office of the Child Advocate for the Protection of Children  
Tonya C. Boga, Director**

**270 Washington Street, Suite 8101  
Atlanta, Georgia 30334  
Phone: (404) 656-4200  
Fax: (404) 656-5200  
[www.oca.georgia.gov](http://www.oca.georgia.gov)**

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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, Department of Public Health
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- 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.

## GEORGIA CHILD FATALITY REVIEW PANEL

### MEMBERS

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Judge, Bartow County Juvenile Court

#### Co-Chairperson

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Coroner, Catoosa County

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#### Tonya C. Boga

Child Advocate for the Protection of Children<sup>3</sup>

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Safe Kids Georgia Director

Child Injury Prevention Advocate

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Chief Medical Examiner,

Georgia Bureau of Investigation

#### LaTain Kell

Judge, Cobb County Superior Court

#### J. David Miller,

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Southern Judicial Circuit

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Emory School of Medicine

Child Abuse Prevention Advocate

#### Brenda Fitzgerald, M.D.

Commissioner, Department of Public Health<sup>3</sup>

#### Gloria Butler

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Chair, Criminal Justice Coordinating Council<sup>3</sup>

#### Frank Shelp, M.D., MPH

Commissioner, Department of Behavioral Health and Developmental Disabilities

#### Rachelle Carnesale

Director, Division of Family & Children Services<sup>3</sup>

### STAFF

#### Wende Parker

Program Manager

#### Arleymah Raheem

Prevention Specialist

#### Malaika Shakir

Program Manager

#### Cynthia Cartwright

Assistant Child Advocate

#### Tomia White

Data Support Analyst

#### Crystal Dixon

Data Specialist

The Georgia Child Fatality Review Panel is an appointed body of 17 representatives that oversees the county child fatality review process, reports to the governor annually on the incidence of child deaths, and recommends prevention measures based on the data.

Two year appointments are made by the governor except as otherwise noted.

<sup>1</sup>Appointed by the Lieutenant Governor

<sup>2</sup>Appointed by the Speaker of the House of Representatives

<sup>3</sup>Ex-Officio

# Preface

## 2004-2008 CFR Trend Report on Maltreatment

In 1993, the federal Child Abuse Prevention and Treatment Act (CAPTA) required states to include information on child death review in their program plans. In the 1996 reauthorization of CAPTA, Congress required states to establish at least three citizen review panels, and mandated that at least one of them review child maltreatment deaths and near deaths. In the 2003 reauthorization of CAPTA, Congress recognized that there may be a duplication of efforts in states with both Child Death Review and Citizen Review Panels, and thus changed from mandatory to permissive the requirement of Citizens Review Panels to study child fatalities and near fatalities. Fourteen states reported that their child death review teams serve a dual function as a CAPTA Citizen Review Panel for child fatalities.

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.

This report of the Georgia Child Fatality Review Panel summarizes the child deaths from 2004-2008, with a focus on maltreatment. The Centers for Disease Control and Prevention (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, such as a parent or other caregiver. The maltreatment focus of this report is intended to show readers how prevalent maltreatment is among Georgia children, and to empower readers to support and maintain prevention efforts. Many types of deaths could be prevented with community and agency involvement. With the data reported, the Georgia Child Fatality Review Panel wants to emphasize the need for a collaborative, coordinated, and comprehensive approach to raise awareness and education on child abuse and neglect. The Georgia Child Fatality Review Panel and staff encourage everyone to take action and help protect the life of a child today and everyday.

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This report was developed and written by the Child Fatality Review Division staff: Crystal Dixon, Wende Parker, Arlymah Raheem, Malaika Shakir, and Tomia White.



## Recommendations for Prevention

A retrospective review report is an opportunity to observe trends over time, and to monitor how the activities, policies, and practices of Child Fatality Review (CFR) committees and partners may have impacted these preventable deaths. For 18 years, the Georgia Child Fatality Review Panel has made recommendations to impact the overall safety of Georgia's children. There have been great successes in implementing many of these recommendations, which have led to a safer and healthier Georgia for our children. The Panel is very proud to provide this summary of recommendations that have been successfully implemented over the past decade.

### Motor Vehicle Safety

1. Georgia Code has been modified to require seat belts and child restraints in vehicles.
2. Law enforcement officers have been directed to cite those who break the seat belt and/or child restraint laws, even if that is the only offense.
3. Legislation was passed for a graduated driver's license system for teenagers under the age of 18. Legislation was strengthened to incorporate a restriction on driving hours and limitation on passengers in the vehicle.
4. Continued enforcement of the Teenage and Adult Driver Responsibility Act.
5. Seat belt law was amended to increase the age for children to be transported in a child restraint system to now under the age of eight years.

### **Autopsy/Investigation-Related**

1. Statute regarding the definition of a “medical examiner’s inquiry” was amended to require a scene investigation in the unexpected or unexplained deaths of children.
2. Developed multi-disciplinary training to promote and improve fatality reviews and investigations.
3. Required that autopsies of children under the age of 18 be considered a priority, including completion of all related written reports.
4. Required an autopsy, including toxicology studies, for every death of a child under age seven with the exception of children who are known to have died of a disease process while attended by a physician.
5. Expanded training for the Georgia Coroners Association to include improved death scene investigations for any child death that is suspicious, unexpected, and/or unexplained, and preparing timely autopsy reports.

### **Committee Training/Improvements**

1. Provide funding for ongoing training and technical assistance to CFR committees by CFR staff.
2. Improved the quality of data being collected by local CFR subcommittees.
3. OCGA § 19-15-2 was amended to include coroners as members of CFR.
4. Provide funding for no fewer than three regional trainings annually for child fatality review team members.

### **DFCS/Child Maltreatment-Related**

1. Modified Division of Family and Children’s Services policy regarding response times and initial assessment procedures for reports alleging child maltreatment so that all investigations of children under the age of one are considered “high risk” and thus requiring a 24 hour response time.

2. All cases of newborns whose mothers have a positive drug screen should be referred to juvenile court. Currently, DFCS policy now states that a Substance Abuse Assessment must be made and depending on resulting recommendations, and the mother’s response, understanding and willingness to address her substance abuse; and her willingness to understand how it may impact her ability to care for her child, a determination is made in regards to taking the case to juvenile court.
3. When a child dies due to a parent’s or a caretaker’s neglect or maltreatment, ongoing efforts should be made to visit the surviving children in the home to assess the safety and well-being of the children and enable voluntary referrals to appropriate services.
4. Improved the protection of case managers on field assignments by providing them with cellular phones.

### **CFR Committees and CFR Panel Activities**

1. Improved child fatality reporting compliance by local CFR committees.
2. Provided funding for ongoing training and technical assistance to CFR committees by CFR staff.

### **Public Health/Mental Health**

1. Increased efforts of the public awareness campaign regarding safe sleeping environments, and include risk factors associated with co-sleeping.
2. Implemented a statewide campaign that promotes safe infant sleep environments, and explicitly describes dangers posed to infants in bed-sharing and other unsafe sleep environments.
3. Vital Records provides monthly death certificate reports to the CFR Panel to facilitate a timely review of child deaths in each county.

### **Pools/Firearms/Fire Safety/Schools**

1. Required fences and gates in public and private swimming pools statewide.
2. Required local units of government to adopt and enforce regulations requiring smoke alarm installation and maintenance in rental properties.
3. Provided sufficient funding to state Fire Marshal’s Office to offer fire safety education for young children.



# Spotlight on Maltreatment: Sleep-Related Infant Deaths

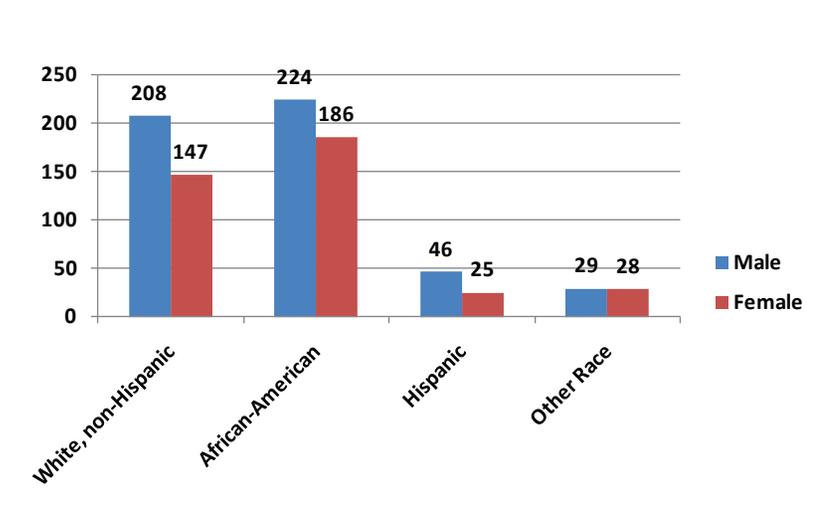
From 2004 to 2008, there were 893 sleep-related infant deaths reviewed by the CFR committees. Of those, 359 were determined to be Sudden Infant Death Syndrome (40%), 356 were determined to be Sudden Unexplained Infant Death (40%), and 178 were asphyxia/suffocation (20%).

According to the Centers for Disease Control and Prevention (CDC), Sudden Infant Death Syndrome (SIDS) is defined as the sudden death of an infant less than one year of age that cannot be explained after a thorough investigation is conducted, including a complete autopsy, examination of the death scene, and review of the clinical history. SIDS is the leading cause of death among infants under 12 months of age, and is the third leading cause overall of infant mortality in the United States.

For a medical examiner or coroner to determine the cause of the death, a thorough case investigation including examination of the death scene and a review of the infant's clinical history must be conducted. A complete autopsy needs to be performed, ideally using information gathered from the scene investigation. Even when a thorough investigation is conducted, it may be difficult to separate SIDS from other types of sudden unexpected infant deaths (SUID), especially accidental suffocation in bed. SUID is determined to be a sudden and unexplained death when certain environmental and physical risk factors are present (e.g., excessive bedding, bedsharing, or prone position).

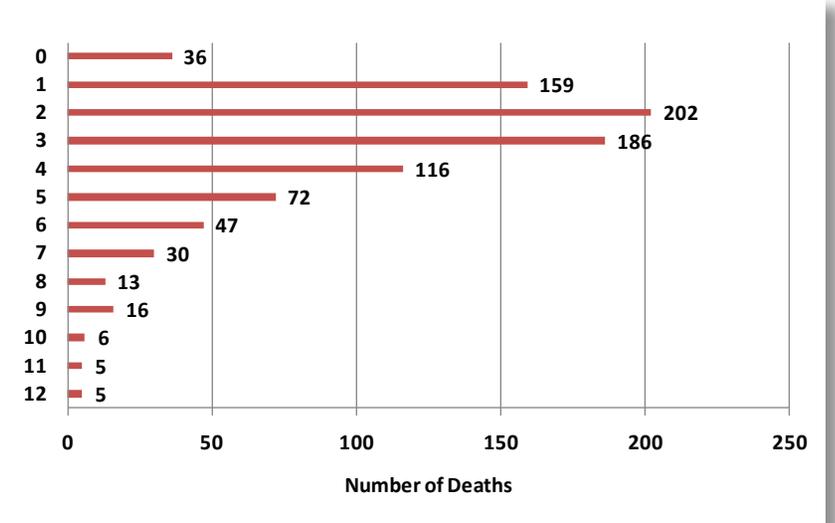


**Figure 1: Race/Sex/Ethnicity of Reviewed Sleep-Related Infant Deaths, 2004 - 2008 (N = 893)**



- Of the 893 sleep-related deaths reviewed during this period, 46% were African-American infants, 40% were White, eight percent were Hispanic, and six percent were infants of another race
- Although the overall rate of SIDS/sleep-related deaths in the United States has declined by more than 50% since 1990, rates for non-Hispanic African-American and American Indian/Alaska Native infants remain disproportionately higher than the rest of the population. It is believed that different cultural practices contribute to the varying incidence rate. Infants born to African-American families and to families living in some urban areas are more likely to be placed to sleep on their stomachs, the position that confers the highest risk. Sleeping on soft bedding and bed sharing, two practices that increase risk, are more common among minority populations
  - The Georgia Pregnancy Risk Assessment Monitoring System (PRAMS) data from 2004-2008 show that 31.4% of African-American mothers and 30.9% of Hispanic mothers reported that their infant “always” sleeps in the bed with them or someone else, compared to 8.6% of non-Hispanic White mothers, and 24.6% of mothers in other racial/ethnic groups

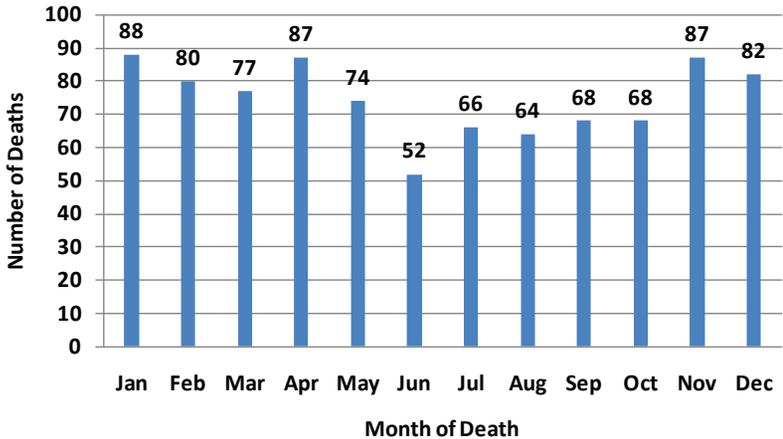
**Figure 2: Reviewed Sleep-Related Infant Deaths by Age in Months, 2004 - 2008 (N=893)**



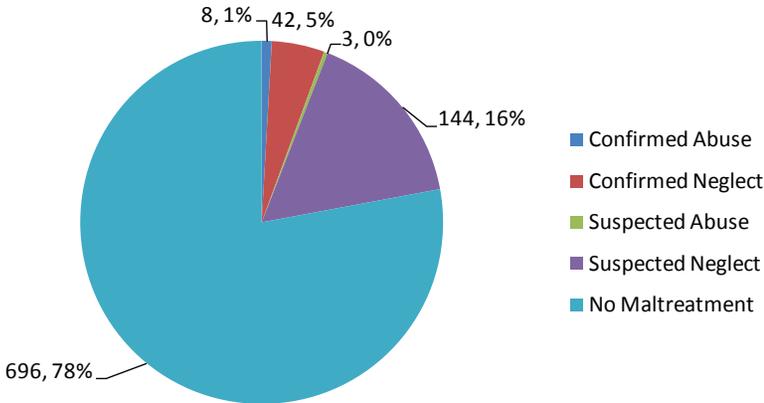
- The greatest risk of death occurs between two and four months of age. There were 504 reviewed deaths where the child was 2-4 months old (56%). There were 818 deaths (92%) that occurred within the first six months of life



**Figure 3: Reviewed Sleep-Related Infant Deaths, by Month of Death, 2004 - 2008 (N = 893)**



**Figure 4: Reviewed Sleep-Related Infant Deaths and Reported Maltreatment, 2004-2008 (N=893)**

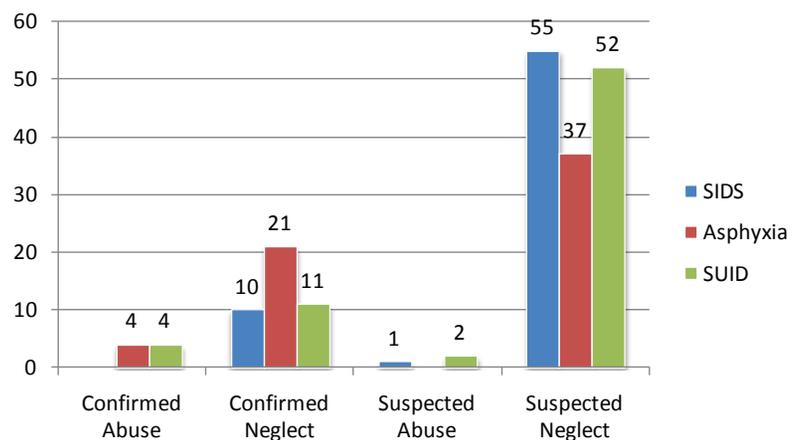


- Sleep-related deaths tend to occur more often in colder months. According to the National Institutes for Child Health and Human Development (NICHD), experts think the higher incidence of SIDS and sleep-related deaths in the colder months may be attributable to the greater risk of infection that infants face during this time or the “over-bundling” and “overheating” of infants. The overheating of an infant can cause the child to sleep more deeply, potentially making it more difficult to awaken when short of breath
- An infant born during the spring months is less likely to die from SIDS. The reason is because the infant’s first six months of life, which is when 90% of SIDS occurs, takes place during the spring and summer months. Age is a critical factor among infants who are under six months of age during the winter months. This seasonal risk occurs because of the association with cold weather, viral illness, and overdressing.

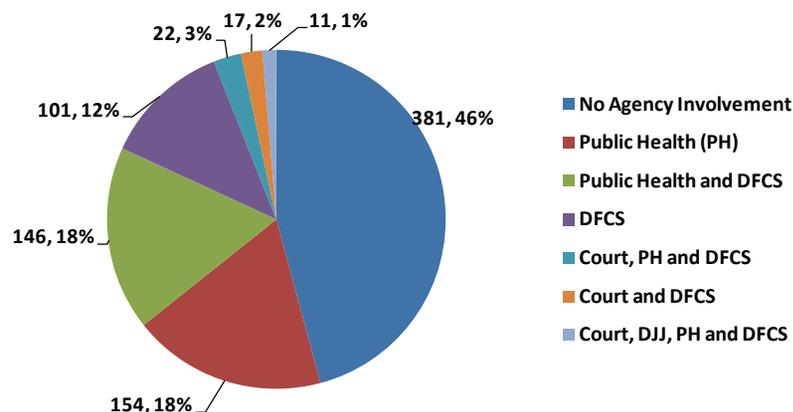
A 2001 report on SIDS examined the significance of the temperature, and found that infants who died of SIDS during the winter months were more likely to be overdressed. They also found that parents tended to overdress their infant because they believed that warming the infants reduced the risk for viral infections (Evolutionary Aspects of Sudden Infant Death Syndrome (SIDS), A. Fafalios; [www.webpub.alleggheny.edu/](http://www.webpub.alleggheny.edu/))

- In the majority of sleep-related infant deaths reviewed (78%), the CFR committees found no evidence of maltreatment. In 16% of deaths, the committee suspected some kind of abuse or neglect, but did not have confirmation by a physician, law enforcement officer, or CPS report. In six percent of deaths, the committees had evidence of confirmed maltreatment (abuse or neglect), as reported by DFCS, law enforcement, or a physician

**Figure 5: Reviewed Sleep-Related Infant Deaths by Cause of Death with Maltreatment, 2004-2008 (N=197)**

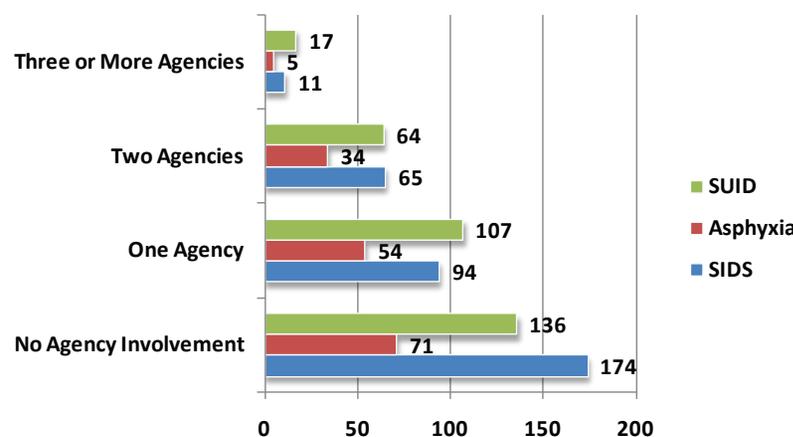


**Figure 6: Reviewed Sleep-Related Infant Deaths and Prior Agency Involvement, when Known, 2004-2008 (N=832)**

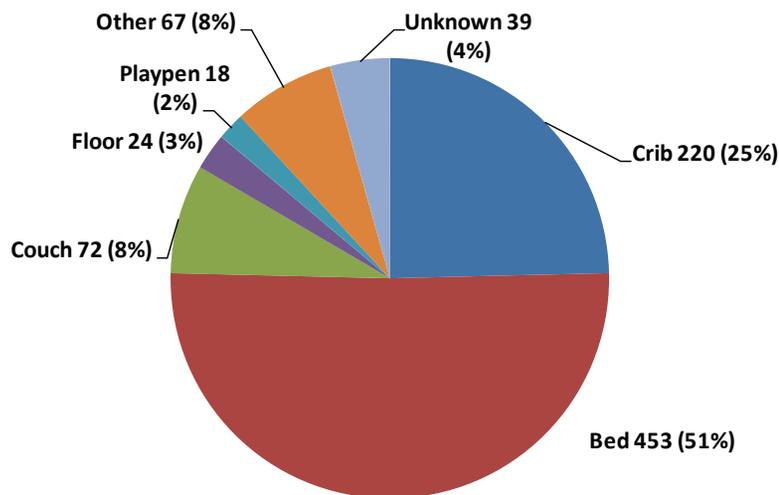


- The Children’s Bureau, Office on Child Abuse and Neglect, has developed a training manual that can be used by first responders to distinguish SIDS from child maltreatment. Some of the criteria that may lead to a finding of maltreatment include: the family’s and child’s histories are not typical of SIDS, have discrepancies, or are unclear; there is evidence of malnutrition, neglect, or fractures; there was little or no prenatal care; the child received little or no well-baby care, including immunizations; or the child was described as hard to care for or discipline

**Figure 7: Reviewed Sleep-Related Infant Deaths with Prior Agency Involvement by Cause of Death, when Known, 2004-2008 (N=832)**

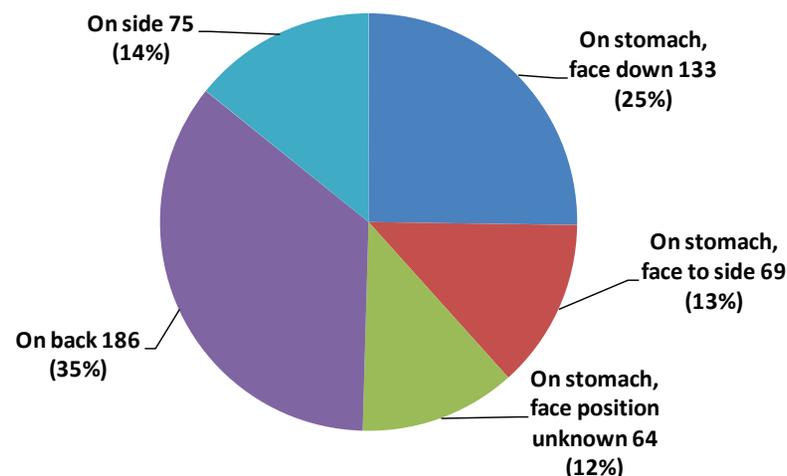


**Figure 8: Sleep Location at Time of Death for Reviewed Sleep-Related Infant Deaths, 2004-2008 (N=893)**



- Half of the infant deaths reviewed (51%) were found sleeping in a bed, while 25% were sleeping in a crib
  - Of the 359 SIDS deaths, 117 were found in a crib (33%) and 160 in a bed (45%). Of the 356 SUID deaths, 74 were found in a crib (21%) and 193 were found in a bed (54%). Of the 178 suffocation deaths, 29 were found in a crib (16%) and 100 were found in a bed (56%)
- The American Academy of Pediatrics (AAP) recommends using a firm sleep surface. Soft materials or objects such as pillows, quilts, comforters, or sheepskins should not be placed under a sleeping infant. A firm crib mattress, covered by a sheet, is the recommended sleeping surface. The AAP also found growing evidence that bed sharing, as practiced in the United States and other Western countries, is more hazardous than the infant sleeping on a separate sleep surface and, therefore, recommends that infants not bed share during sleep

**Figure 9: Position in Which Discovered, Sleep-Related Infant Deaths with Known Position (N = 527)**



- The back is recommended as the safest position for an infant to sleep, but only 35% of the infants were found sleeping on their back at the time of death. Half of the infants (50%) were discovered on their stomach
- The AAP recommends placing infants on their back to sleep. Infants should be placed for sleep in a supine position (wholly on the back) for every sleep. Side sleeping is not as safe as supine sleeping and is not advised
  - Georgia PRAMS data from 2004-2008 show that 48.6% of African-American mothers and 35.4% of mothers in other racial/ethnic groups reported that their infant sleeps on the stomach or side position, compared to 32.4% of non-Hispanic White mothers, and 29.9% of Hispanic mothers

**Resources:**

- Centers for Disease Control and Prevention ([www.cdc.gov/SIDS/](http://www.cdc.gov/SIDS/))
- National Institute for Child Health and Development ([www.nichd.nih.gov/](http://www.nichd.nih.gov/))
- The Child Welfare Information Gateway ([www.childwelfare.gov/](http://www.childwelfare.gov/))
- American Academy of Pediatrics ([www.aap.org](http://www.aap.org))
- Georgia Department of Public Health, Pregnancy Risk Assessment Monitoring System (<http://health.state.ga.us/epi/prams/>)

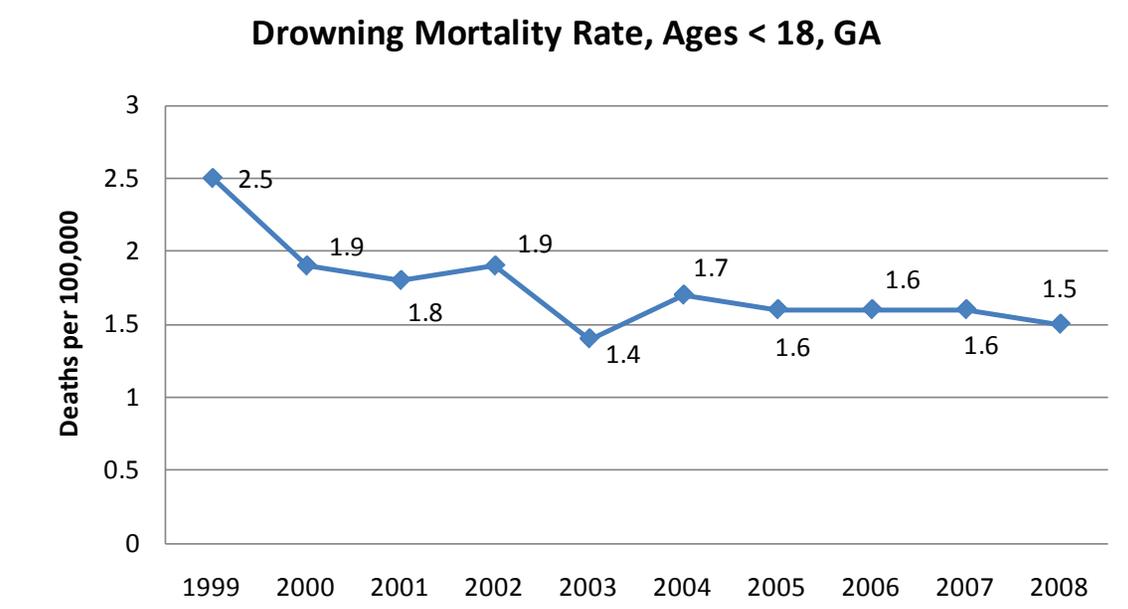


# Spotlight on Maltreatment: Drowning Deaths

## Drowning Deaths

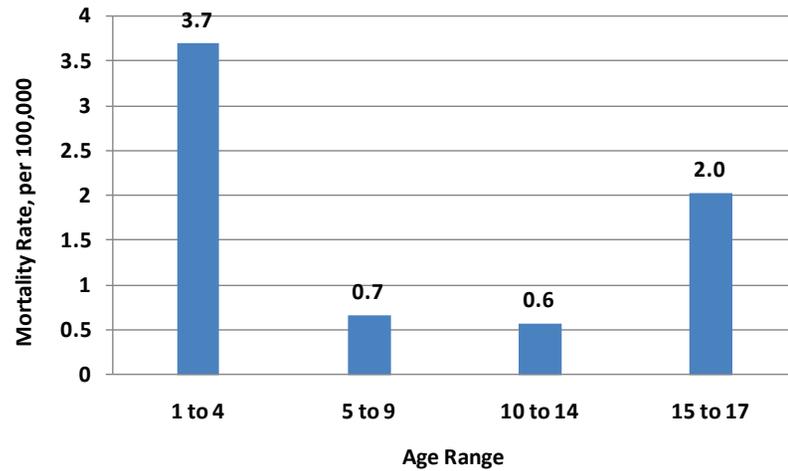
Child Fatality Review committees have been reviewing drowning deaths for more than fifteen years. Drowning remains a leading unintentional injury death for children under 18 years of age. Drowning affects all age groups around the world and has been recognized as a “global burden of disease” by the World Bank and World Health Organization. From 2004 to 2008, there were 199 drowning deaths for children 0-17 years of age in Georgia. The majority of the drowning deaths took place in public or private swimming pools (46%, 91) and natural bodies of water (42%, 43). Private pools alone accounted for 39% (77) of all drowning deaths, which included four wading pools. Toddlers represented 53% (106) of all drowning deaths while older teenagers, ages 15-17 years, accounted for 20% (39). More than half of the toddlers drowned in private pools with the mean age being two years.

Figure 10: Child Drowning Rate per 100,000 population, 1999-2008



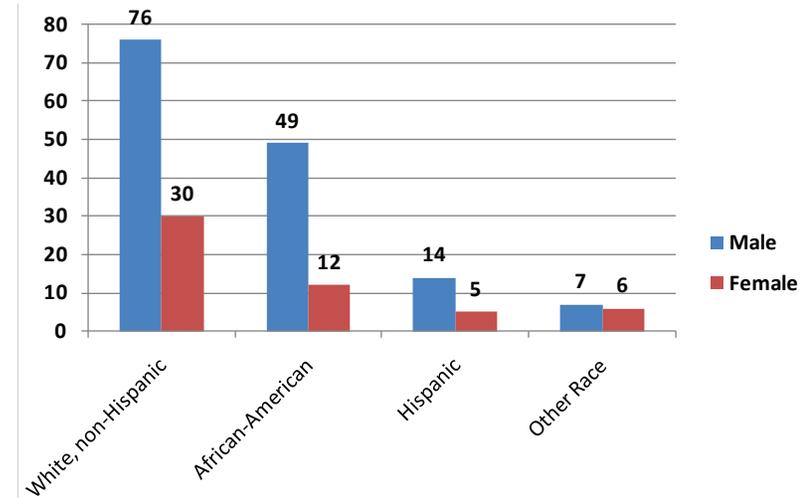
- When looking at child drowning, it appears that the number of deaths might be increasing very slightly. The rate of deaths appears to remain steady since 2006. When the vital records drowning data were evaluated from 2004-2008, calculations were made based on counties with more than four drowning deaths during that period. Georgia counties with the highest rate of drowning deaths (per 100,000 population) from 2004-2008 include:
  1. Floyd County – 6.9
  2. Troup County – 5.9
  3. Chatham County – 2.3
  4. Hall County – 2.1
  5. Clayton County – 2.0

**Figure 11: Reviewed Child Drowning Mortality Rate (per 100,000), death certificate, 2004-2008**

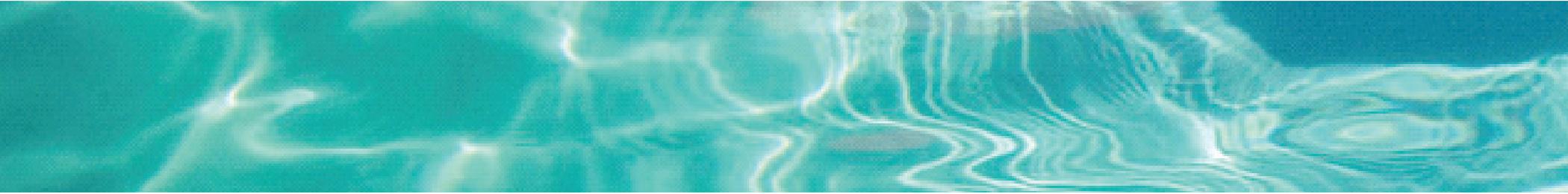


- The drowning rate for toddlers is about 75% higher than the rate for teens

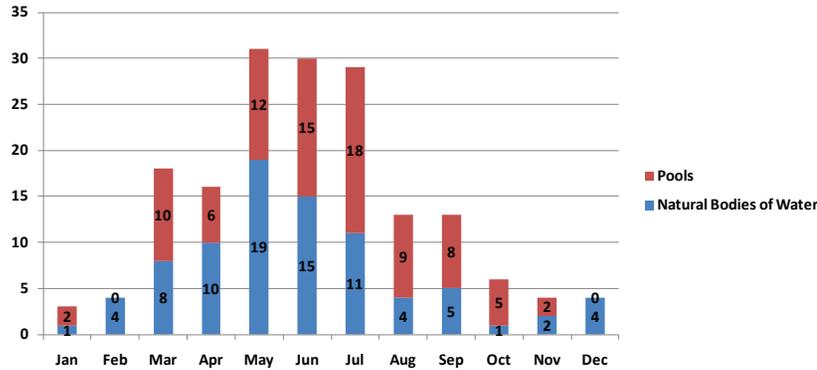
**Figure 12: Reviewed Drowning Deaths by Race/Ethnicity and Sex, 2004-2008 (N=199)**



- Of the 199 drowning deaths reviewed during this period, 53% were White, 31% were African-American, 10% were Hispanic, and seven percent were children of another race (e.g., Asian, Pacific Islander, Native American)
- Males in all age groups had a higher risk of drowning than females
- Males were three times more likely to drown than females

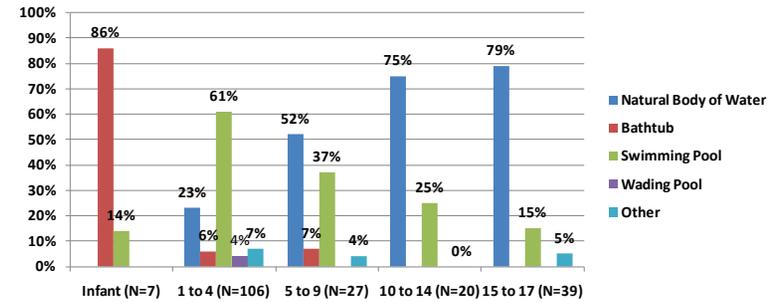


**Figure 13: Reviewed Drowning Deaths by Location and Month of Occurrence, 2004-2008 (N=175)**



- According to the Centers for Disease Control and Prevention (CDC), for every child who dies from drowning, another four children receive injuries from submersion in water. The risk for drowning increases greatly when there are no safety measures in place. The CDC reports an 83% reduction in the risk of childhood drowning when a four-sided isolation fence is in place around the swimming pool, as compared to a three-sided fence

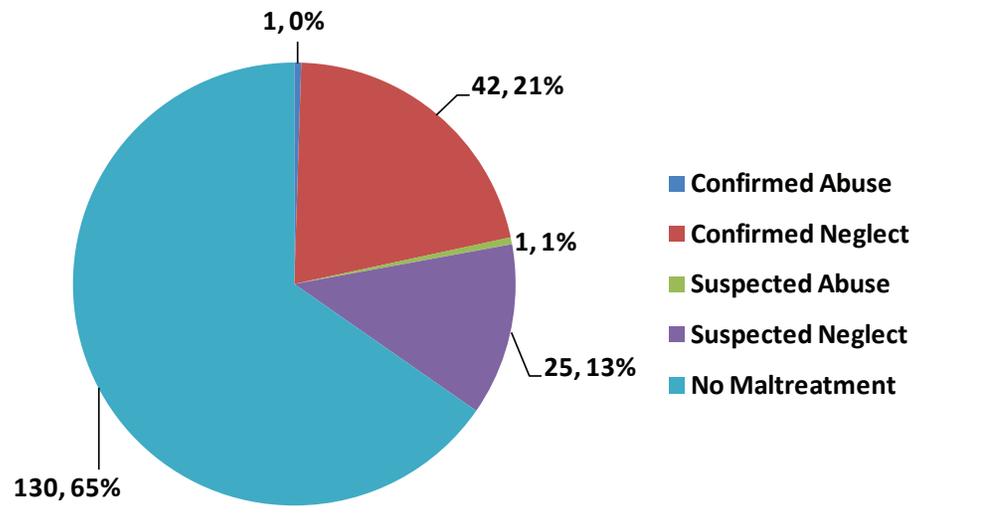
**Figure 14: Reviewed Drowning Deaths by Location and Age, 2004-2008 (N=199)**



- Older youth tend to drown more in natural bodies of water, while toddlers are more often found in a swimming pool

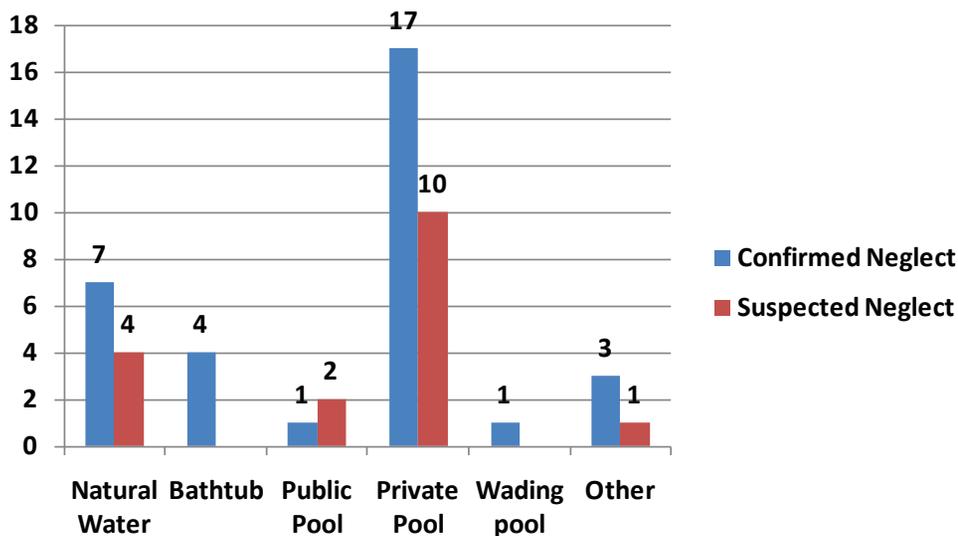
Drowning is often related to lack of active or “hands on” supervision. During the 2004-2008 reporting period, Child Fatality Review committees identified 35% of the drowning cases where maltreatment was a factor in the death. Maltreatment is defined as having confirmed or suspected abuse or neglect. CFR committees reported 78% of toddlers who drowned had inadequate supervision. Twenty-one percent of all maltreatment related drowning deaths had confirmed neglect. Alcohol and drugs were a factor in less than one percent of all 199 drowning deaths reported.

**Figure 15: Reviewed Drowning Deaths with Maltreatment, 2004-2008 (N=199)**



- In the majority of drowning deaths reviewed (65%), the CFR committees found no evidence of maltreatment. However, 35% had suspected or confirmed abuse or neglect
- Seventy-five percent of toddlers experienced maltreatment with almost half (50, 47%) being confirmed or suspected neglect

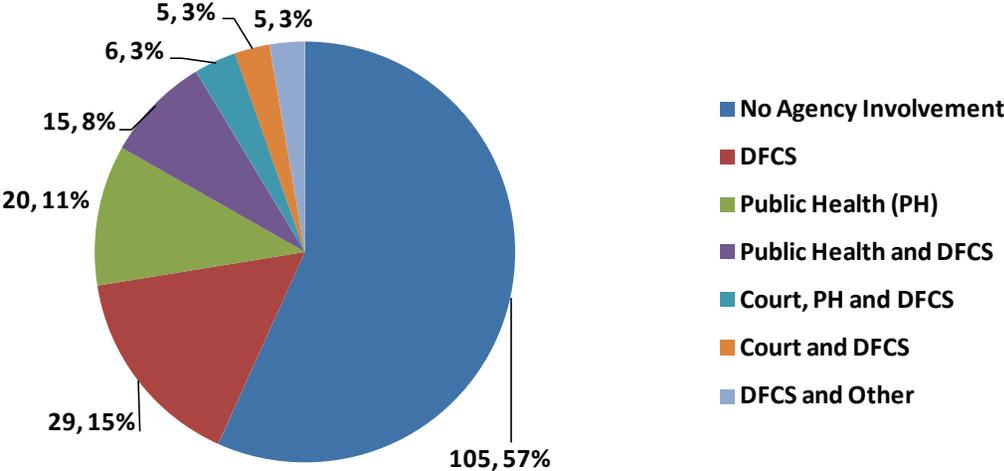
**Figure 16: Reviewed Drowning Deaths of Toddlers with Reported Maltreatment and Drowning Location, 2004-2008 (N=33)**



- 31% of toddlers were found to have experienced maltreatment during their death

Forty-seven percent of all drowning had prior involvement with agencies including the court system, Department of Juvenile Justice, Public Health, Division of Family and Children Services, Mental Health, or other agencies. Prior agency involvement breakdown is listed below:

**Figure 17: Reviewed Drowning Deaths with Reported Prior Agency Involvement, 2004-2008 N=183 (involvement with less than 3 occurrences not included N=14)**



**Resources:**

The Child Welfare Information Gateway ([www.childwelfare.gov/](http://www.childwelfare.gov/))  
 Centers for Diseases Control and Prevention ([www.cdc.gov](http://www.cdc.gov))  
 Bulletin of the World Health Organization, November 25, 83 (1)

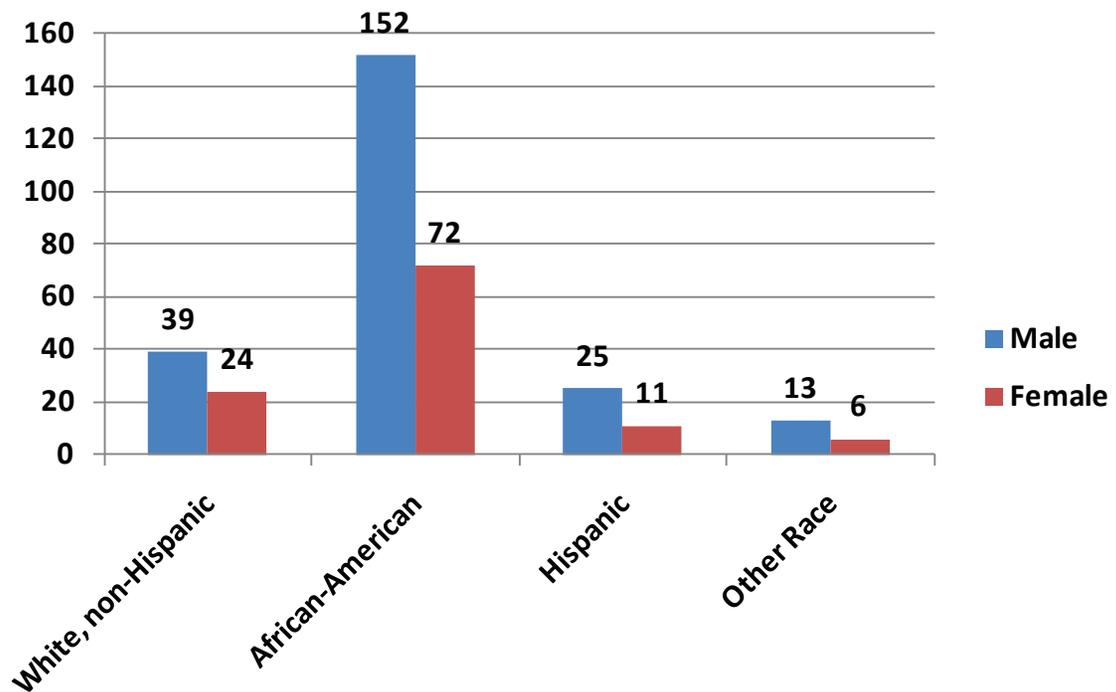


# Spotlight on Maltreatment: Homicide Deaths

## HOMICIDE

In the United States, the world is a frightening, often dangerous place for far too many children. Unfortunately, the greatest threat to the lives of children and adolescents is not disease, starvation or abandonment, but the terrible reality of violence. There is a growing “culture of violence” and its devastating impact has reached epidemic proportions within our society. A closer look at child homicides shows how critical it is that committees and child abuse prevention advocates work collectively to build a legacy of health and safety for our young people.

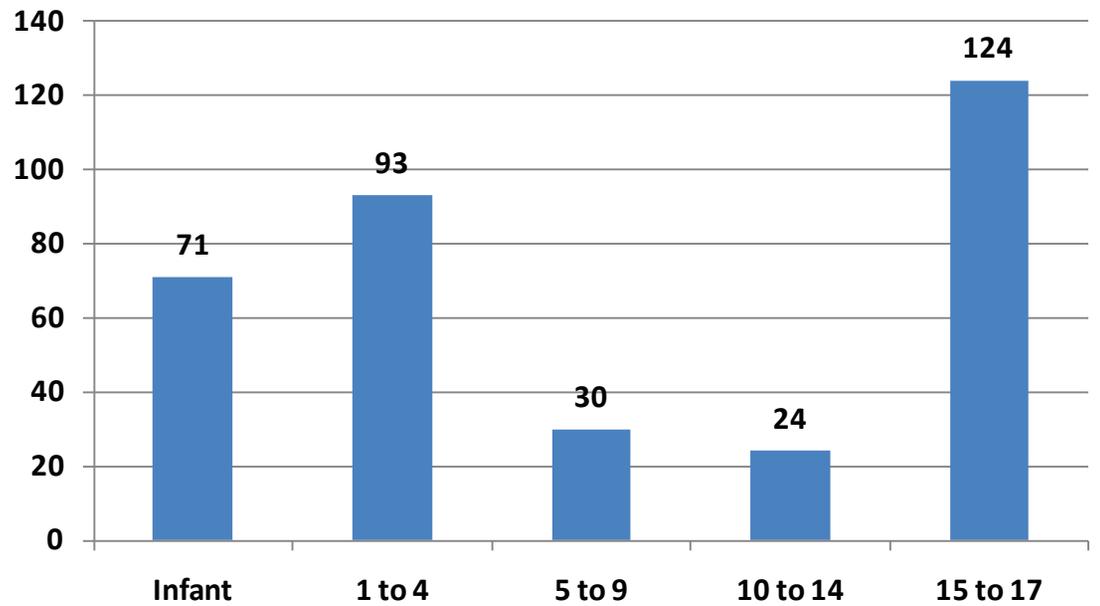
**Figure 18: Reviewed Homicide Deaths by Race/Ethnicity and Sex, 2004-2008 (N=342)**



- Homicide were highest among African-Americans who accounted for 65% of all homicide deaths
- African-American males represented 44% of all homicide deaths, exceeding all other race, ethnicity, and gender categories

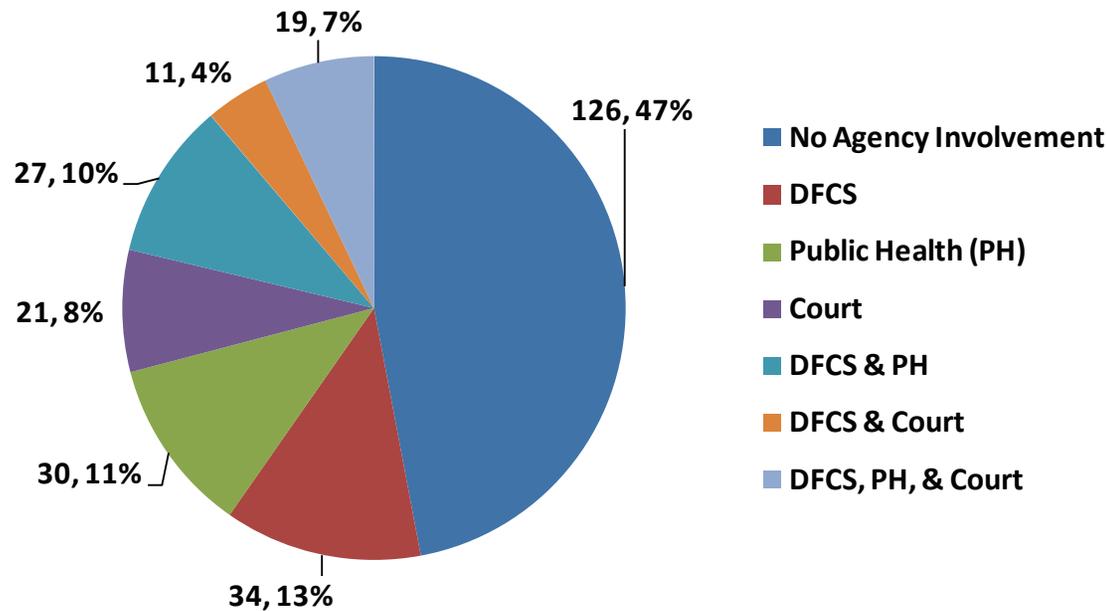
For nearly all teenagers in the U.S., accidents are the most common cause of death. Yet for African-American males, ages 12 to 19 years old, homicide eclipses accidents as the leading cause of death. Nationally, the homicide rate for African-American male teens is 16 times higher than the rate for non-Hispanic White male teens, and two times higher than the rate for Hispanic male teens (U.S. Centers for Disease Control and Prevention study, 2010).

**Figure 19: Reviewed Homicide Deaths by Age, 2004-2008 (N=342)**



- Homicide deaths of older teens, ages 15-17, accounted for more than one-third of all homicides
- Children, ages 10-14, represented the lowest percentage of homicide deaths (seven percent)

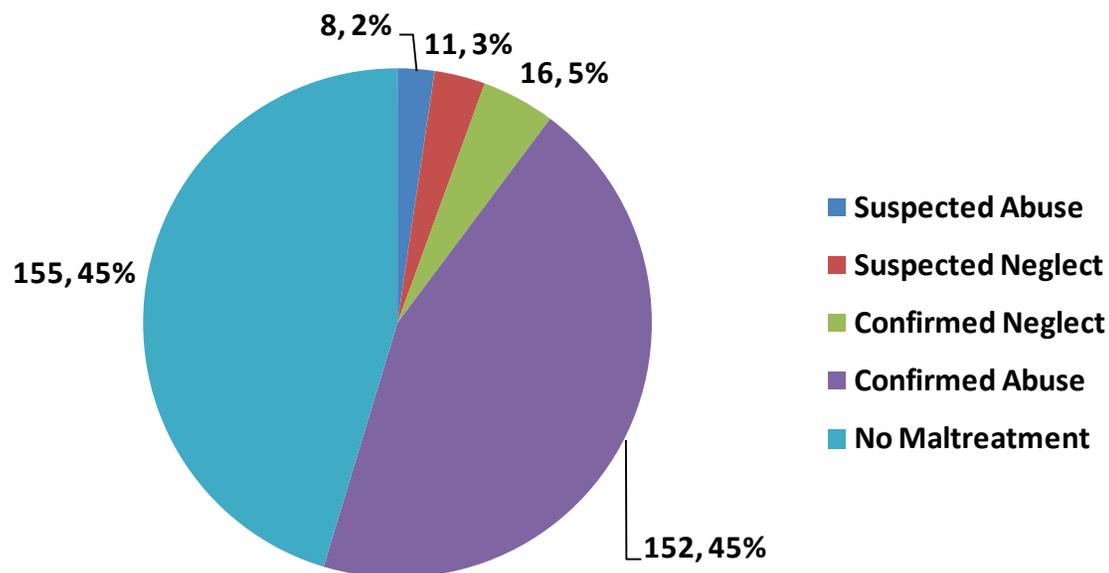
**Figure 20: Reviewed Homicide Deaths with Prior Agency Involvement, 2004-2008 (N=342)**



- From 2004 to 2008, in 37% of all homicide deaths there was no personal (direct) or familial (indirect) involvement with public service agencies
- In 10% of all homicide deaths, there was some level of involvement with the Department of Family and Children Services and nine percent had involvement with Public Health. Agency involvement did not always occur within close proximity of the child's death, but may have occurred at any period prior to the death, and with any member of the child's family

Child Fatality Review committees reviewed the circumstantial information of each death to determine whether there is sufficient evidence to suspect or confirm child maltreatment. The committees are not investigative entities. However, each local committee is comprised of a myriad of agencies responsible for making such determinations.

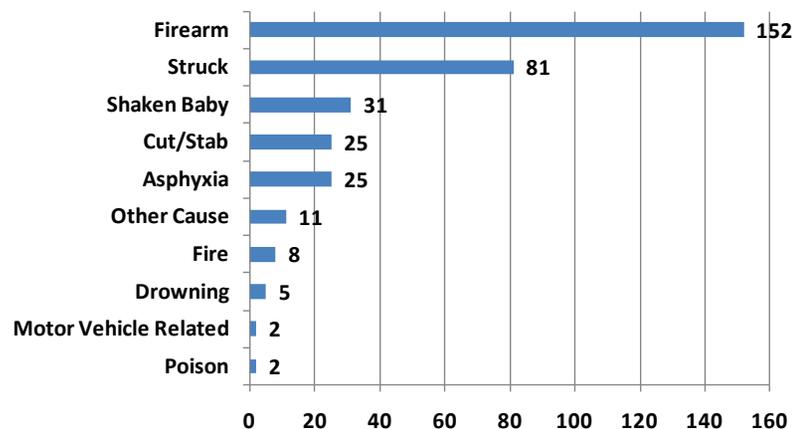
**Figure 21: Reviewed Homicide Deaths with Reported Maltreatment, 2004-2008 (N=342)**



- In 45% of the homicide deaths from 2004-2008, there were no maltreatment findings. In 45% of the homicide deaths, abuse was confirmed by the committee

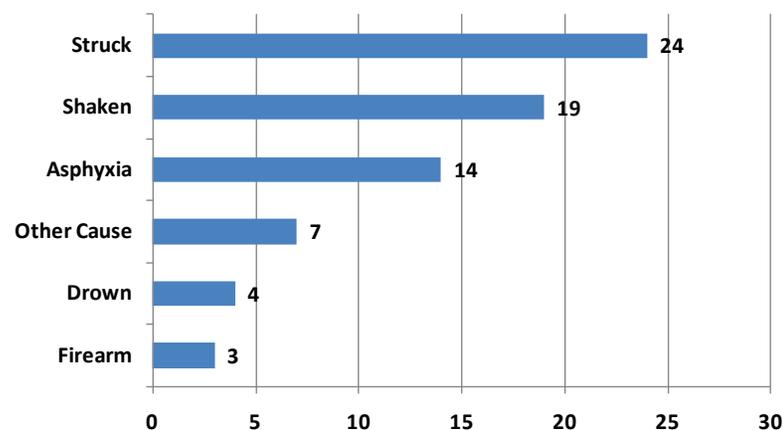
Nationally, a report of child abuse is made every ten seconds and more than five children die every day as a result of child abuse. It is estimated that between 50-60% of child fatalities due to maltreatment are not recorded as such on death certificates, underscoring the vital importance of accurate reporting and coding practices. Children who experience child abuse and neglect are 59% more likely to be arrested as a juvenile, 28% more likely to be arrested as an adult, and 30% more likely to commit violent crime. About 30% of abused and neglected children will later abuse their own children, continuing the horrible cycle of abuse. The estimated annual cost of child abuse and neglect in the United States for 2007 was \$104 billion (Child Help, 2009).

**Figure 22: Reviewed Homicide Deaths by Mechanism of Injury, 2004-2008 (N=342)**



- Firearms caused 44% of the 342 homicide deaths between 2004 and 2008. Older teens, ages 15 to 17, accounted for 68% of the firearm deaths. Males accounted for 87% of these deaths

**Figure 23: Reviewed Homicide Deaths of Infants by Mechanism of Injury, 2004-2008 (N=71)**



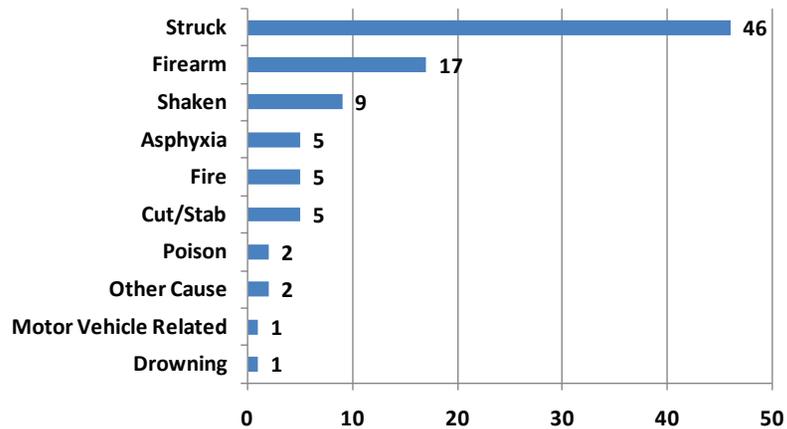
- Thirty-four percent (24) of the 71 homicide deaths of infants were the result of being struck by a blunt object or a “weapon of opportunity,” such as a hand or foot
- Six of the seven “Other Cause” infant homicide deaths were due to hyperthermia (elevated body temperature) or hypothermia (lowered body temperature) resulting from being left in an overheated vehicle or extremely cold climatic conditions

Nationally, males are significantly more likely than females to die violently. In 2007, males, ages 15 to 19, were four times more likely to commit suicide, six times more likely to be victims of homicide, and eight times more likely to be involved in a firearm-related death than were females of the same age (Child Trends Data Bank, 2007).

Seventy-five percent of the infant homicide perpetrators were natural parents, 44% were natural fathers and 31% were mothers. Twenty-four percent of the infant homicide perpetrators were under the age of 21 and 89% were under age 30.



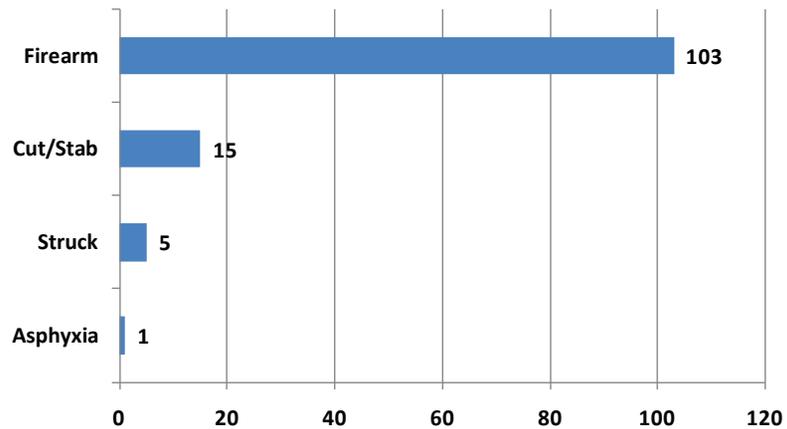
**Figure 24: Reviewed Homicide Deaths of Toddlers age 1 to 4 by Mechanism of Injury, 2004-2008 (N=93)**



- Almost half of all toddler (ages 1 to 4) homicide deaths resulted from being struck (49%). Fifty-seven percent of these deaths occurred after 4:00pm
- Natural fathers and mothers' significant others accounted for 52% of the identified perpetrators
- Natural mothers were the third leading identified perpetrator, and accounted for 16% of perpetrators

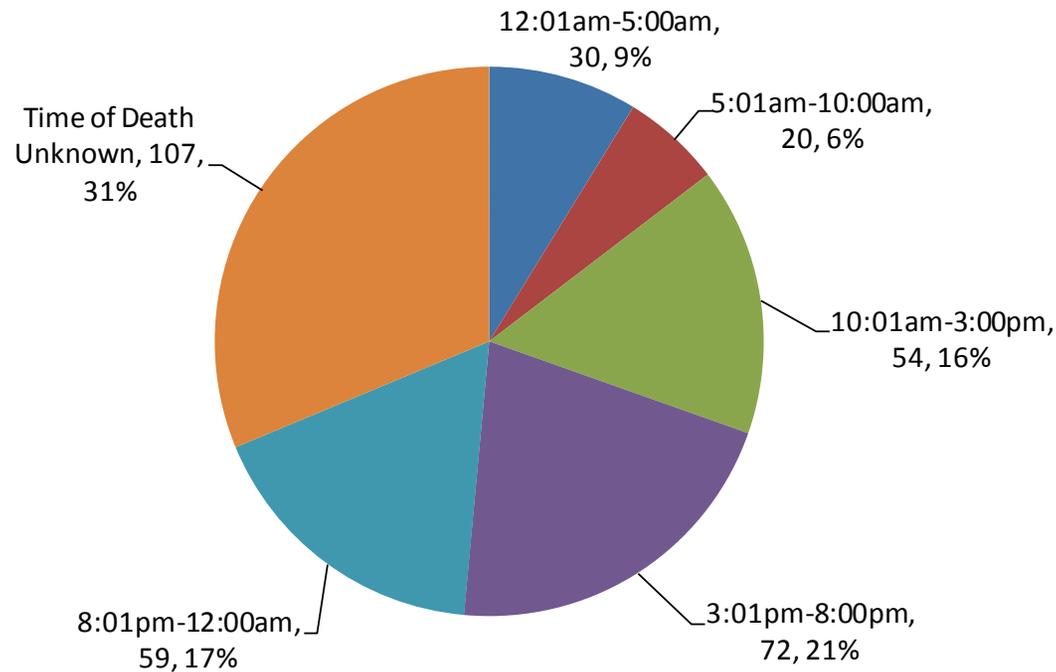
Many children ages 1 to 4 are seriously injured and/or killed as a result of accidentally soiling his/her clothing or expressing independence by repetitively uttering the word "no". The toddler stage, including what is commonly referred to as "terrible twos") is a critical phase of development characterized by the acquisition of new skills, such as toilet training and a growing sense of autonomy, oftentimes perceived as defiance and misbehaving. This can serve as a trigger for inexperienced caregivers who lack patience and child developmental knowledge and skills especially caregivers who additionally lack a close attachment and/or bond to the child, such as a parents' significant other.

**Figure 25: Reviewed Homicide Deaths of Teens (Age 15 to 17) by Mechanism of Injury, 2004-2008 (N=124)**



- Eighty-three percent of older teen (ages 15-17) homicide deaths were caused by firearms. The highest number of occurrences took place between 8:00pm-11:00pm (29%)
- Forty-five percent of the identified perpetrators were strangers. Friends and acquaintances combined also accounted for 45% of the identified perpetrators

**Figure 26: Reviewed Homicide Deaths by Time of Occurrence, 2004-2008 (N=235)**



- When the time of occurrence was known, more homicide deaths occurred between 3:00pm and 8:00pm. Substantially more homicide deaths 166 (71%) occurred in the afternoon and evening hours (from 12:01pm and 11:59pm) compared to 69 (29%) which occurred in the morning hours (from 12:00am and 11:59am)
- Two more deaths occurred within the single hour from 7:00 to 7:59pm (22 deaths, 9.4%), followed by 20 deaths (8.5%) from 11:00pm to 11:59pm

**Resources:**

National Center for Victims of Crime <http://www.ncvc.org>

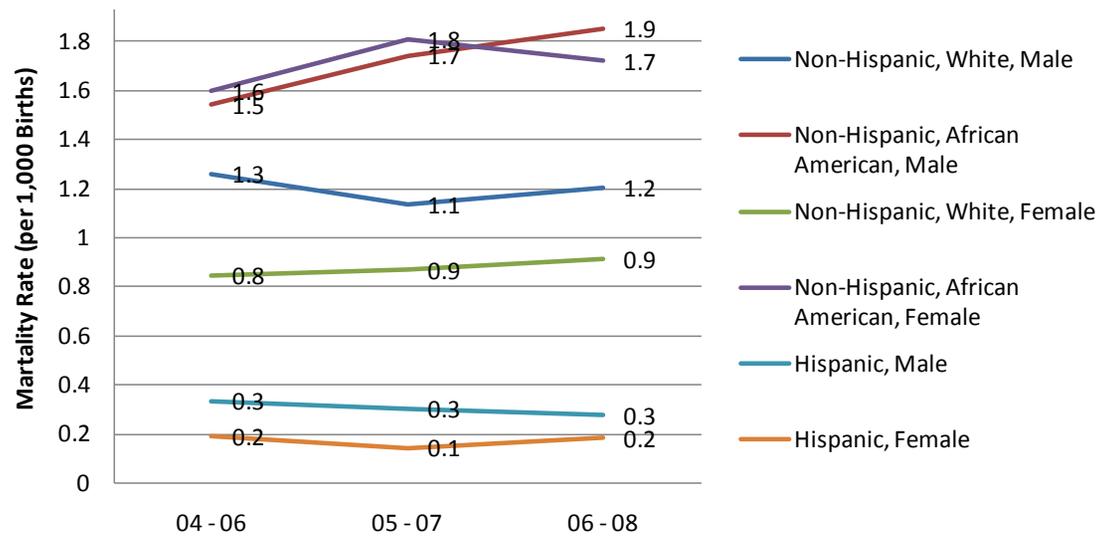
National Center for Injury Prevention and Control (NCIPC) <http://www.cdc.gov/ncipc/>

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

U.S. Census Bureau <http://www.census.gov>

## Disproportionate Death

**Figure 27: Mortality Rates for Infant Sleep-Related Deaths, 3-Yr Moving Average, 2004 – 2008**



- From 2004 to 2008, rates of deaths due to SIDS and sleep-related circumstances were highest among African-American males and females, and lowest among Hispanic males and females
- Epidemiologic studies have demonstrated prone position to be a major risk factor for SIDS and other sleep-related infant deaths. Studies have consistently demonstrated an increased rate of prone positioning in African-American infants, but very little is known about the reasons why African-American parents use the prone position more often than other racial and ethnic groups. No studies have taken advantage of the observed socioeconomic status associated variability in SIDS and prone sleeping within the African-American community. By examining within-group differences, it is possible to move beyond comparative racial descriptions, i.e. comparisons of White and African-American, to identification of potentially modifiable factors that might respond to culturally acceptable interventions within a disadvantaged group

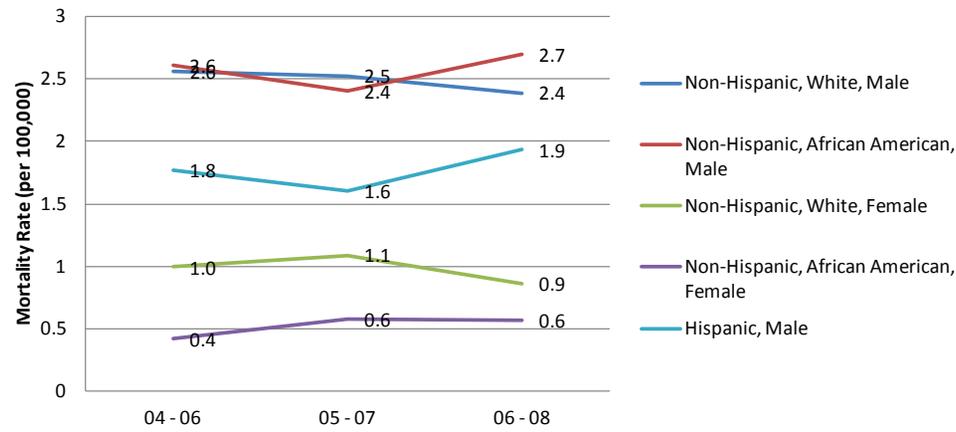
## Prevention Opportunity:

Encourage back-sleeping position for infants among all parents and families, especially for those infants in higher risk circumstances, i.e. environmental tobacco exposure, lower gestational age, or lower birth weight



*A 2008 study commissioned by USA Swimming, and including interviews with children and parents in several cities, revealed that the biggest barrier to a child's swimming proficiency isn't a lack of pools and instructors, but parents' fear of water*

**Figure 28: Mortality Rates for Drowning Deaths, 3-Yr Moving Average, 2004 – 2008**

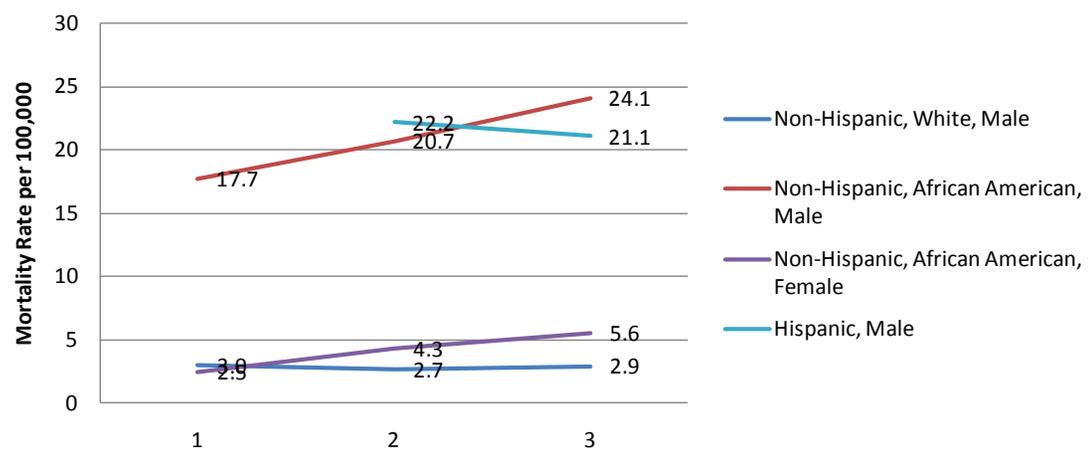


### Prevention Opportunity:

- Despite the proven efficacy of cardiopulmonary resuscitation (CPR), only a small fraction of the population knows how to perform it. As a result, rates of a bystander performing CPR are low, particularly within the African-American community. Successful development of a simplified approach to CPR training, for example video self-instruction (VSI), produces CPR skills comparable in quality to traditional training methods, which could boost rates of a bystander performing CPR and save lives
- Increasing supervision and environmental barriers to water are recommended as appropriate prevention measures for child drowning
- Although improving swimming ability is a possible preventative measure, there is no clear evidence that drowning rates are higher in poor swimmers. Increased swimming proficiency might lead to an increase in drowning rates through increased exposure to water. For example, among older children and adults, better swimmers are likely to participate in more water-related activities and may feel confident enough to swim in higher-risk settings, such as remote natural bodies of water with no lifeguards present

- From 2004 to 2008, rates of deaths due to drowning and submersion injuries were highest among non-Hispanic White males and African-American males, and lowest among non-Hispanic White females and African-American females
- Since 2004, the rate of drowning for African-American Females (rate of 0.4 to 0.6) has increased 50% over time and decreased by 10% for White Females (rate of 1.0 to 0.9)
- The American Academy of Pediatrics (AAP) 2003 report on drowning states that among females, drowning rates peak at one to two years of age and decrease after that. Among males, there are peaks in both the toddler and adolescent age groups. For all ages combined, drowning rates vary inversely with per capita income. In other words, higher drowning rates occur among lower-income families. Racial disparities in childhood drowning rates are higher beyond age five. For example, among males five to 19 years of age, drowning rates are higher among American Indian/Alaska Native, African-American, and Asian/Pacific Islander males than among White males. One study, which examined the site of drowning by age and race, found that White and African-American adolescent males were most likely to drown in natural bodies of freshwater, e.g., rivers and lakes. However, much of the increased risk among African-American males was attributable to high rates of drowning in swimming pools
- According to the CDC, African-Americans between the ages of five and 19 are six times as likely to fatally drown in pools as Whites or Hispanics. Factors such as access to and use of swimming pools and lessons, and a combination of social and cultural issues, may contribute to the racial differences in fatal drowning rates. If rates could be determined by actual participation in water-related activities, the disparity in minorities' fatal drowning rates compared to Whites would be much greater

**Figure 29: Mortality Rates for Homicide Deaths among Older Teens (Age 15 to 17), 3-Yr Moving Average, 2004 – 2008**



- From 2004 to 2008, rates of teen death due to homicide were highest among African-American and Hispanic males, and lowest among White males and African-American females
- African-American males, age 15-17, continue to have the highest rate of death from homicide with a 36% increase over the five year reporting period, moving from 17.7 to 24.1 per 100,000 population
- African-American females show a 124% increase in homicide death rates, rising from 2.5 to 5.6 per 100,000 population
- According to the CDC, the majority of homicides of children younger than 10 years are perpetrated by family members, particularly parents or guardians, and represent the most severe form of child maltreatment. Homicide among children aged 10-19 years is unlikely to be perpetrated by a caregiver and more likely to involve a weapon. Certain risk factors include poor behavioral control, a history of early aggressive behavior, substance abuse, exposure to family violence, poor parental monitoring and supervision, low academic performance, and involvement in gang activity. Poverty, living environment, parental characteristics, and other socio-demographic factors also play a role

### Prevention Opportunity:

- Protective factors include involvement in social activities, commitment to school, and being connected to family or other caring adults. Because the age of onset for aggressive and violent behavior might vary considerably, prevention efforts across developmental periods also are needed. In addition, risks and protective factors for youth violence operate at multiple levels of social influence. Interventions that address multiple domains of influence on behavior (e.g., peers, families, schools, and community environments) are likely to have a greater effect than those that focus on a single risk factor
- In 2005, a systematic review by the Task Force for Community Preventive Services indicated that well-designed and well-implemented home visitation programs might reduce reported child maltreatment by 40%

## Services Offered at time of Death:

Georgia families have many services and resources available to them should they or someone they know lose a child unexpectedly. Getting a family member engaged in bereavement services is very important in assisting them with their grieving process. In Georgia, many of the Child Fatality Review committee member agencies reach out to a family during this time; so many opportunities exist to offer resources. A summary of resources provided to families is listed below.

**Figure 30: Proportion of Parents Offered Services, by Type of Service and Decedent Age**

Services Offered to Parents	Infant	1 to 4	5 to 9	10 to 14	15 to 17	All < 18
Bereavement Counseling	40.9	42.6	42.6	44.5	37.9	41
Economic Support	6.9	11	11.7	9.1	5.3	7.9
Funeral Arrangements	24.3	27	22.3	23.7	21.9	24
Emergency Shelter	1	4.4	2.6	2.8	0.8	1.9
Mental Health Services	7.7	9.5	7.9	9.5	5.8	7.8
Social Services	17.5	17.8	14	13.6	9.2	14.9
HealthCare	3.3	4.8	3.8	3.8	1.4	3.2
Legal Services	1.4	3.4	1.5	2.2	1.6	1.9
No Services	13.4	15.4	12.8	13.6	17.7	14.7
Unknown	32.4	29.5	32.1	33.4	35.1	32.6
Other	4.2	6.4	9.1	6	7	5.8

Each number in the chart is the proportion (percentage) of decedent families in that age range that received the indicated service. The final column represents the proportion for the entire 0-17 age range, and is not a cumulative average of proportions across age ranges because the number of deaths in each age range are not the same.

The percentages shown in the chart, which represent services offered to the family after a child death, do not show any appreciable pattern or trend within categories or across age groups. This shows that all families received similar offers of support, regardless of the age of the decedent.

Some of the “Other” services noted include referral for chaplains, military life choices, substance abuse assistance, victim’s compensation, and SIDS resources.

Because membership on the CFR Committees includes coroners, who are often employed in the county funeral home, these individuals are often the first resource for families to learn about assistance for funeral arrangements for their child as well as grief counseling opportunities.

Because of the high percentage of funeral home staff and coroners in CFR committees, these two services are most often reported by the committees as “services provided to the families”. DFCS is also a member of the CFR committee, and when they respond to the death, their staff is able to quickly provide resources and information on social services to the family. The Victim Witness Advocate of the county District Attorney’s office is often a participating member of the committee, and is able to provide information to the family on economic support and legal services, if needed.

**Recommendations:**  
**Counties should create a county response protocol for an unexpected child death crisis and grief that incorporates the standards of services recommendations for professionals, developed by the Association of SIDS and Infant Mortality Programs. The standards include recommendations for first-responders, hospital emergency department personnel, investigators, coroners, medical examiners, and spiritual or funeral advisors. The recommendations also encourage peer support and crisis calls to families within 24 to 48 hours after a death.**

### Resources:

The Unexpected Death of an Infant or Child: Standards for Services to Families. (2004), Association of SIDS and Infant Mortality Programs, [http://www.asip1.org/images/ASIP\\_Standards.pdf](http://www.asip1.org/images/ASIP_Standards.pdf)



# Spotlight on Other Causes: Medical Deaths

CFR committees identify and review unexpected medical deaths each year. During 2004-2008, 429 medical deaths were evaluated for unusual circumstances, preventability, and maltreatment. Sixty-seven percent of these deaths had a pre-existing condition. For infants, the primary pre-existing conditions were congenital abnormalities, prematurity, and cardiac conditions. For children over age one, conditions included asthma, seizures, diabetes, flu or stomach complaints, and cardiac conditions.





### Prevention Opportunity:

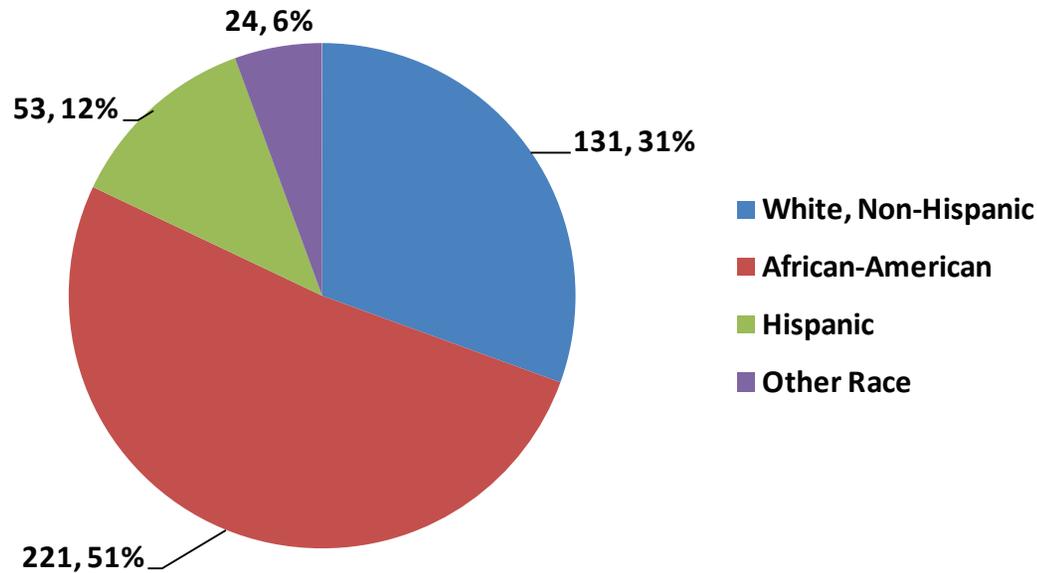
- The March of Dimes campaign for prevention and research regarding preterm birth is a great resource for prevention programs. Identifying the risks and protecting women before and during pregnancy is a critical issue. For older children, deaths associated with asthma, diabetes and heart conditions can sometimes be prevented by following proper medical recommendations and getting routine physicals to determine overall health.

**Figure 31: Reviewed Medical Deaths by Age**

Age	Number of Deaths	Percent of Total Reviewed
Infant	169	39%
1 to 4	93	22%
5 to 9	42	10%
10 to 14	64	15%
15 to 17	61	14%

Unexpected medical deaths carry some ambiguity with them because there are many questions raised regarding the circumstances under which the child died. It is difficult to represent child maltreatment in mortality statistics unless specific answers are sought out. In 93% of the medical related deaths, there was no maltreatment identified. CFR committees identified 32 cases (seven percent) indicating maltreatment was a component in the medical death. As referenced by the National Society for the Prevention of Cruelty to Children, good data collection tools were not always available to report on maltreatment related deaths. However, the National Child Death Review Reporting system changed this. Georgia adopted the NCCDR reporting system in 2009 and has been submitting reports reflecting maltreatment-related death data since that time.

**Figure 32: Reviewed Medical Deaths by Race/Ethnicity**



- Males represented 55% of all reviewed medical deaths
- Within the infant age category, males represented 61% of medical deaths

Low- birth-weight infants are at an increased risk of experiencing serious health problems. While some infants grow up to be very healthy, others are not as lucky and experience great medical difficulties.

Other considerations for the medical deaths:

- CFR committees determined that 44% of the medical deaths were preventable - either possibly preventable (41%) or definitely preventable (three percent)
- When looking at all reviewed deaths over the 2004-2008 period, next to motor vehicle crashes, medical deaths were the leading cause of reviewed death in children 5-14 years of age

**Resources:**

March of Dimes  
[www.marchofdimes.com](http://www.marchofdimes.com)

National Society for the Prevention of Cruelty to Children (NSPCC) [http://www.nspcc.org.uk/Inform/research/findings/relationshipbetweenchilddeathandmaltreatment\\_wda48256.html](http://www.nspcc.org.uk/Inform/research/findings/relationshipbetweenchilddeathandmaltreatment_wda48256.html)



# Spotlight on Other Causes: Unintentional Injury-related Deaths



## Unintentional Injury-Related Deaths

Unintentional injuries are the leading cause of morbidity and mortality among children in the United States. This report provides an overview of unintentional injuries related to motor vehicle accidents, poisoning, asphyxia (> age 1), fires, firearms and other injuries (electrocution and hypothermia) during the review period 2004-2008.

### *What is an unintentional injury?*

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

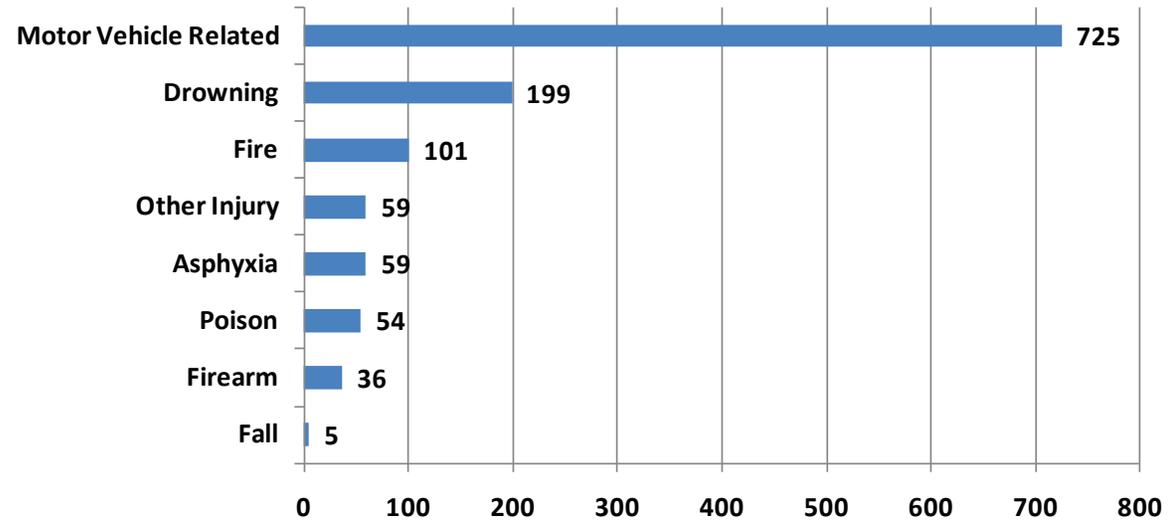
On average, there are over 12,000 children 0 to 18 years of age that die each year in the U.S. from an unintentional injury. Males have higher injury death rates than females. The death rate for males is almost two times the rate for females, and males have a higher injury death rate compared to females in all childhood age groups. Injuries due to transportation are the leading cause of death for children. The highest death rates are among occupants of motor vehicles in traffic. There are also a substantial number of pedestrian and pedal cyclist deaths among children. Combining all unintentional injury deaths among those between 0 and 18 years, motor vehicle traffic-related deaths are the leading cause.

## Prevention Opportunities:

### Medicines

- Follow directions on the label when you give or take medicines, and read all warning labels. Some medicines cannot be taken safely when you take other medicines or drink alcohol.
- Turn on a light when you give or take medicines so you know you have the correct amount of the right medicine.
- Never share or sell your prescription medicines.
- Keep all prescription medicines, especially opioid pain medications, such as those containing methadone, hydrocodone, or oxycodone; , over-the-counter medicines, including pain or fever relievers and cough and cold medicines; vitamins and herbals in a child safe place that can only be reached by people who take or give them.

**Figure 33: Reviewed Unintentional Injury Deaths, by Cause, 2004 - 2008, (N=1,338)**

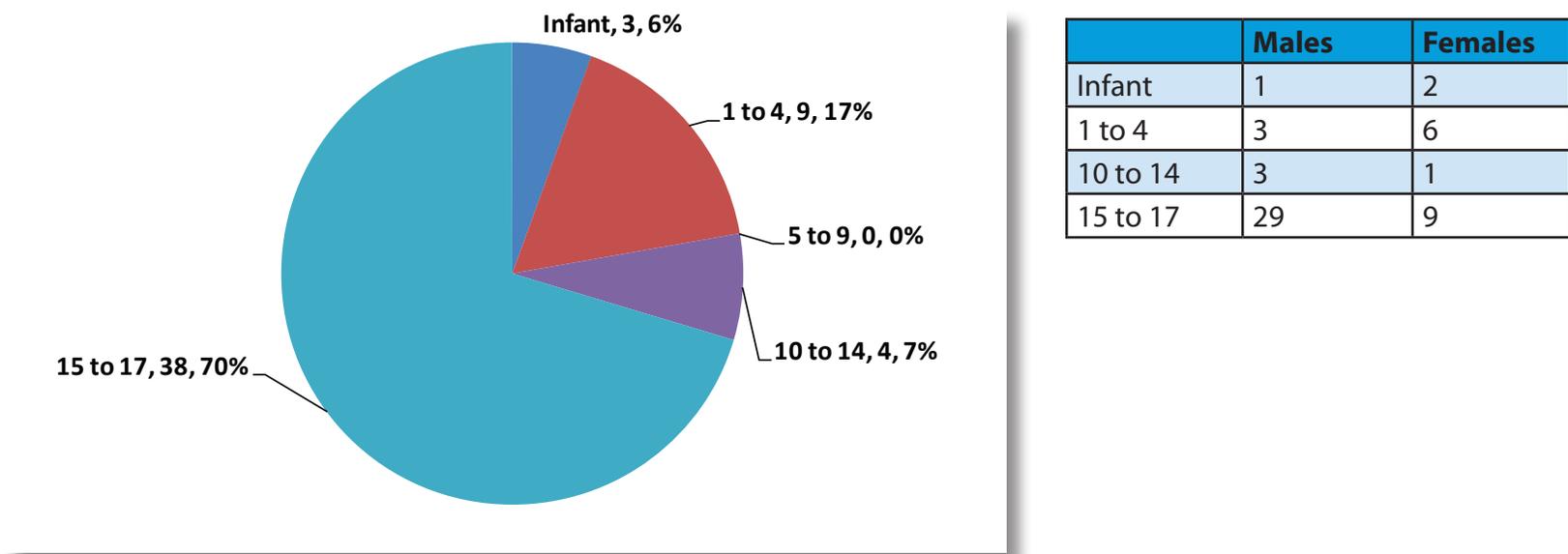


### Poison

A poison is any substance that is harmful to your body when ingested (eaten), inhaled, injected or absorbed through the skin. Any substance can be poisonous if too much is taken. Poisonings are either intentional or unintentional. If the person taking or giving a substance did not mean to cause harm, then it is an unintentional poisoning.

Among children, emergency room visits for medication poisonings are most common in children younger than six years of age. One out of every 180 two-year olds visits an emergency department for medication poisoning.

**Figure 34: Reviewed Poisoning Deaths by Age, 2004-2008 (N=54)**



	Males	Females
Infant	1	2
1 to 4	3	6
10 to 14	3	1
15 to 17	29	9

Poisoning was the cause of a total of 54 deaths between 2004-2008 for ages infant to 17. There were no reported deaths in the 5-9 age group.

The largest trend was present within males from age 15-17. However, among all children age 15-17 (N=38), 58% died as a result of prescription drug use. In addition, a total of 82% of teens died from over the counter and prescription drug use. Out of the same 15-17 age group (N=38), 92% of the decedents were white males.

**Resources:**

The CFR staff gives specific resources to CFR committees regarding poison prevention. These resources are used to support the CFR committees individually in their counties.

The Georgia Poison Center (GPC) serves as a resource for prevention. Since 1970, it has operated the 24-hour poison emergency treatment information service, providing assistance and expertise in the medical diagnosis and management of human and animal poisonings.

The GPC provides free, timely advice and information to parents, child care providers, pharmacists, nurses and doctors, and plays a significant role in reducing the cost of treatment and the severity of poisonings when time is of the essence. The GPC is a training site for healthcare professionals and serves Georgia by coordinating outreach and education programs to increase awareness of poison prevention and first aid.

(Source: [www.georgiapoisoncontrol.org](http://www.georgiapoisoncontrol.org))

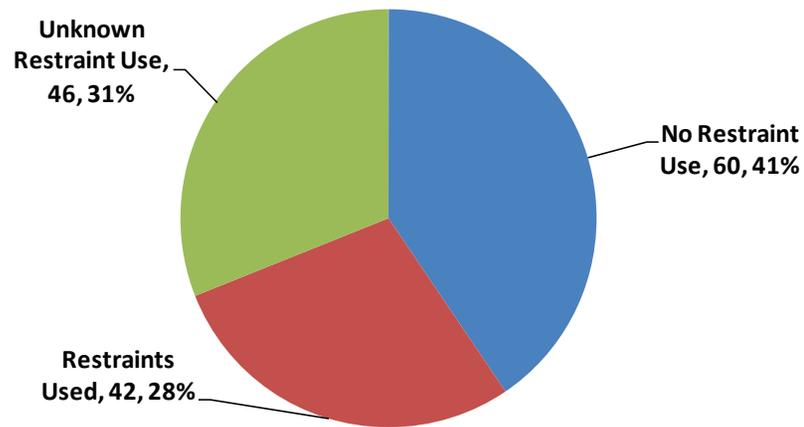


### **Motor Vehicle Incidents**

Motor vehicle crashes are the leading cause of death for U.S. teens. In 2009, about 3,000 teens in the United States ages 15 to 19 were killed, and in 2008 more than 350,000 were treated in emergency departments for injuries suffered in motor vehicle crashes. In one year alone, crash-related injuries and deaths among teens ages 15 to 19 cost \$14 billion in medical care and productivity losses. Teen motor vehicle crashes are preventable. There are proven policies to improve the safety of young drivers on the road. (Source: [www.childrenssafetynetwork.org](http://www.childrenssafetynetwork.org))

In Georgia, there were 725 motor vehicle related deaths from 2004-2008. Forty-six percent (N=337) of deaths were among 15-17 year olds. Forty-four percent were actual drivers of the vehicle, 39% were passengers, and six percent of the 15-17 year olds were killed as pedestrians.

**Figure 36: Reviewed Motor Vehicle-Related Deaths among Teen Drivers Age 15-17, 2004-2008 (N= 148)**

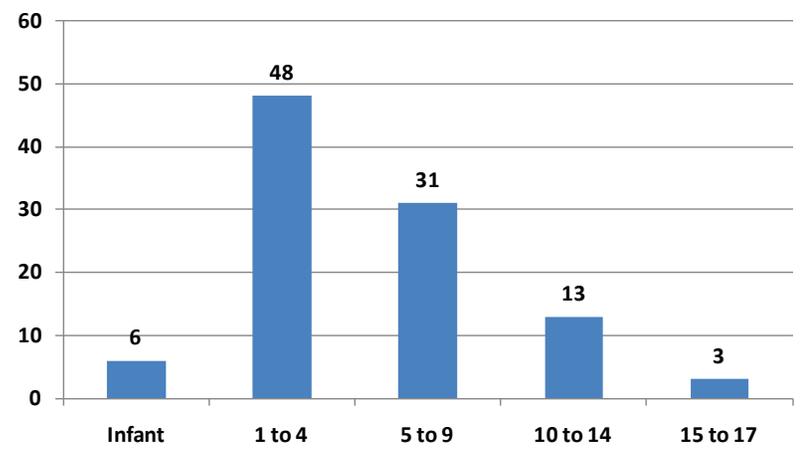


Within the 15-17 year age group, the highest percentage of deaths occurred as a result of teens not wearing seatbelts. The lowest percentage of deaths were teens impaired, or driving under the influence, and not wearing seatbelts.



## Unintentional Deaths Due To Fire

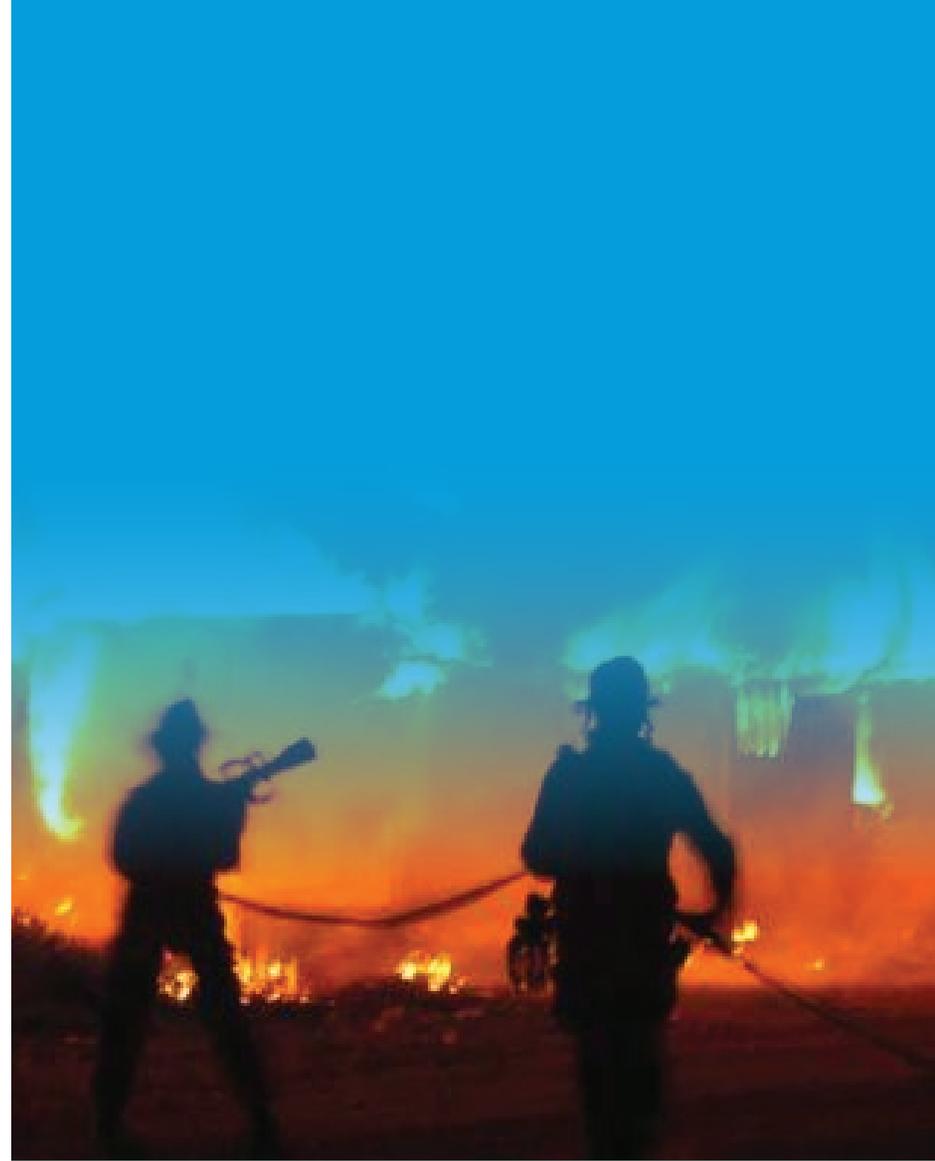
**Figure 37: Reviewed Fire-Related Deaths by Age, 2004-2008, (N=101)**



A total of 101 child deaths due to fire occurred from 2004-2008. There were 63 males and 38 females that died. Of the fire-related deaths, 32% were White and 68% were African-American. Of the 48 fire-related deaths that occurred among children ages 1 to 4, 50% were caused by the child playing with matches or lighters. Fire alarms were present in 33% of the homes.

Deaths from fires and burns are the third leading cause of fatal home injury (Runyan 2004). The United States' mortality rate from fires ranks eighth among the 25 developed countries for which statistics are available (International Association for the Study of Insurance Economics 2009).

Although the number of fatalities and injuries caused by residential fires has declined gradually over the past several decades, many residential fire-related deaths remain preventable and continue to pose a significant public health problem (Source: [www.cdc.gov](http://www.cdc.gov)).



### Prevention Opportunities:

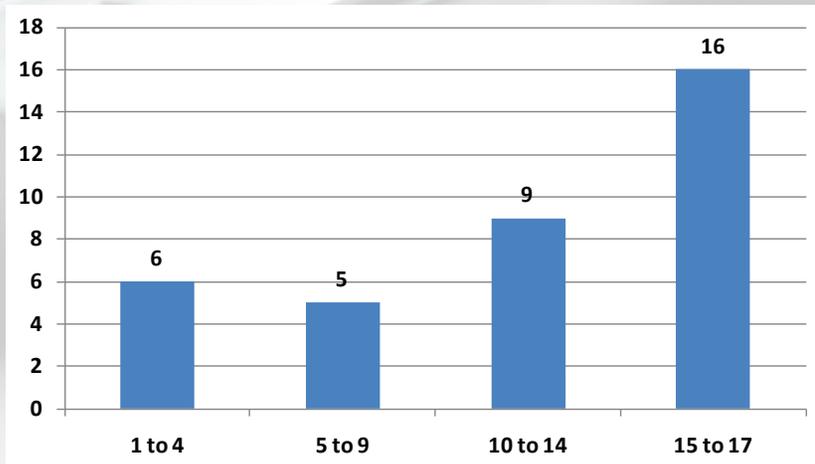
The CFR staff offers resources to CFR committees to aid in fire prevention. This information supports the committees and their counties.

### Firearm Related Injuries/Deaths

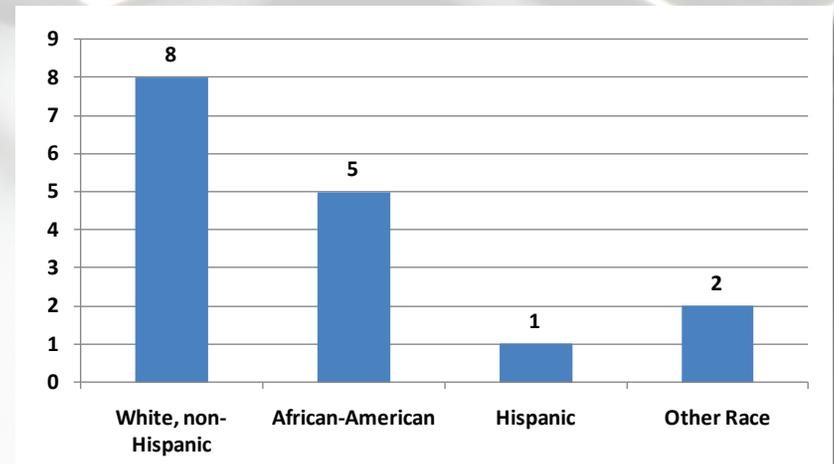
In the United States, almost nine children and teens die every day by gunfire—one every two hours and 45 minutes. After a decade of decline, the number of firearm deaths among children and teens increased for the second year in a row. According to data from the Centers for Disease Control and Prevention (CDC), a total of 3,184 children and teens died from gunfire in the United States in 2006, a six percent increase from 2005. A preschooler was killed by a firearm every six days in 2006. Among children, the greatest increase in firearm deaths was among those under age 10. And 17,451 children and teens were victims of non-fatal firearm injuries in 2006, a 7 percent increase from 2005. (Source: www.childrensdefense.org)

Firearm deaths were more prevalent within the 15-17 age group. Sixty-nine percent were killed with handguns, 19% with rifles, six percent with assault rifles, and six percent with shotguns.

**Figure 38: Reviewed Unintentional Firearm Deaths by Age, 2004-2008 (N=36)**



**Figure 39: Reviewed Unintentional Firearm Deaths among Older Teens (Age 15 to 17) by Race/Ethnicity, 2004-2008 (N=16)**



### Prevention Opportunities:

- Educate the public, parents and caregivers on firearm-related deaths and injuries among children.
- Promote safe firearm storage, trigger locks, and other safety features to reduce easy access by children.
- Promote violence-prevention programs for youth.
- Promote improved data collection of firearm-related deaths among children.

## Asphyxia

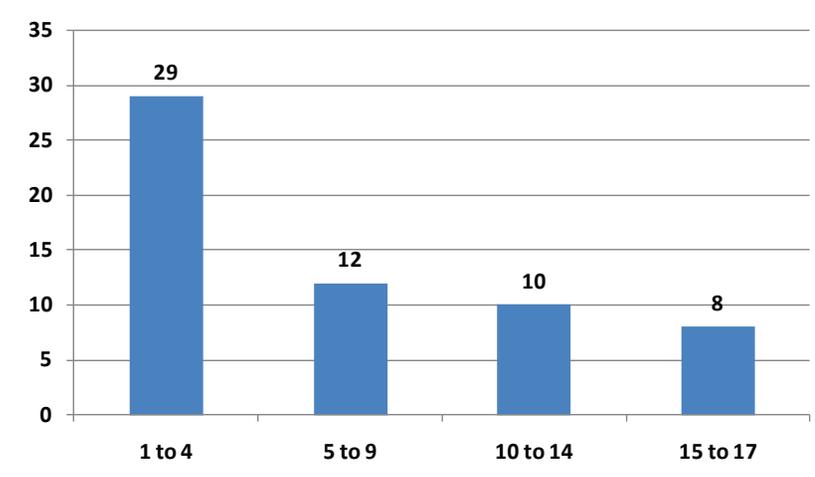
Asphyxia causes generalized hypoxia, which primarily affects the tissues and organs. It can be caused by improper ventilation, smothering, suffocation, compression, choking, or oxygen deficiency.

Asphyxia leads to an inability to breathe, which can then lead to loss of consciousness and death.

There are a number of risk factors associated with asphyxia. Infant sleep-related asphyxia deaths are addressed in an earlier section, so this section addresses only those deaths not attributed to a sleeping environment.

The largest percentage of deaths due to asphyxia occurred within the 1 to 4 year old age group. Within this group, 38% (N=29) of children died as a result of choking, some cases involved choking on small objects or toys. As a major precaution, it is imperative that small children are never left unsupervised by an adult. Supervision is also needed for older children up to age 13, depending on the child's maturity level. Within the 5 to 9 year old age group (N=12), 33% of those deaths occurred as a result of accidental hanging.

**Figure 40: Reviewed Asphyxia Deaths among Children >Age 1, 2004-2008 (N=59)**



### Prevention Opportunities:

As a major precaution, it is imperative that small children are never left unsupervised by an adult. Supervision is also needed for older children.

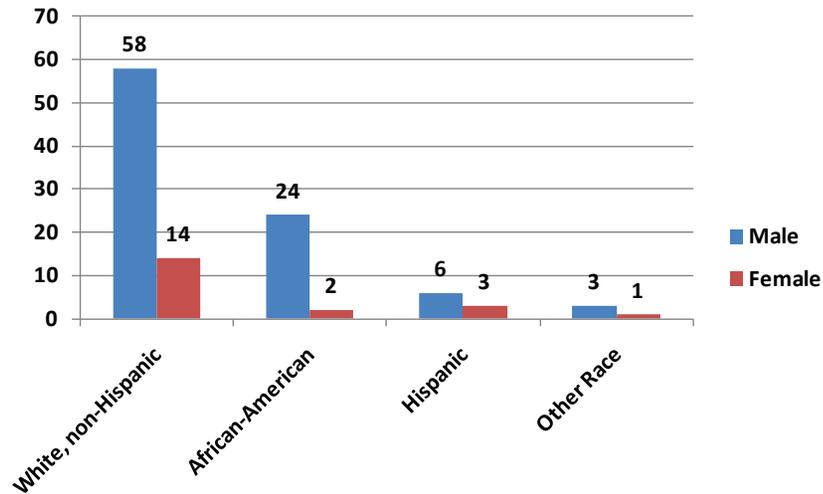
# Spotlight on Other Causes: Suicide Deaths

In the United States, suicide is the third leading cause of death among young people, resulting in about 4,400 deaths per year (Center for Disease Control, 2009). For every suicide among young people, there are at least 100 suicide attempts. Over 14% of high school students have considered suicide, and almost seven percent have attempted it. More than four times as many male youth die by suicide, but females attempt suicide more often and report higher rates of depression.

In recent years, a series of bullying-related suicides in the United States and across the globe have drawn attention to the connection between bullying and suicide. Though many adults still see bullying as “just part of being a kid,” it is a serious problem that can lead to many negative effects for victims, including suicide. According to a recent Yale University study, nearly 30% of students are either bullies or victims of bullying, and 160,000 children stay home from school every day because of fear of bullying. Bullying victims are between two to nine times more likely to consider suicide than non-victims (Center for Disease Control, 2009).



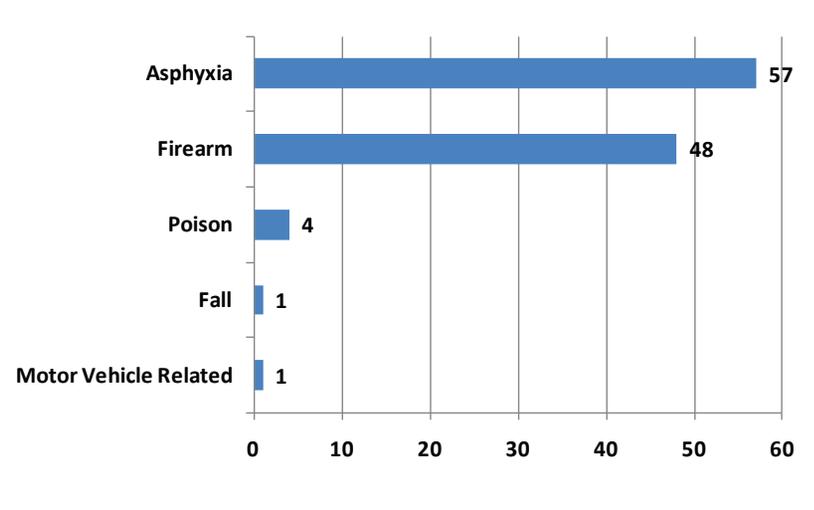
**Figure 41: Reviewed Suicide Deaths by Race/Ethnicity and Sex, 2004-2008 (N=111)**



- Whites accounted for 65% of all suicide deaths (72)
- White males remain approximately three times more likely than all other teens to commit suicide. Whites had a 2.5 times higher rate of suicide compared to African-Americans (1.5 versus 0.6 deaths per 100,000 population).



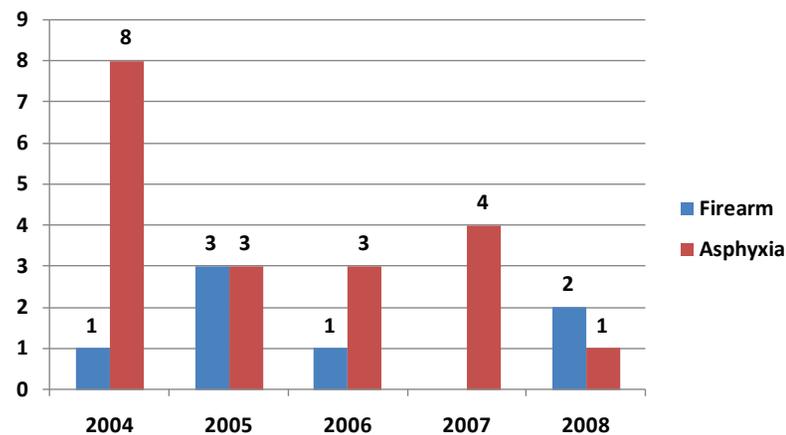
**Figure 42: Reviewed Suicide Deaths by Mechanism of Injury, 2004-2008 (N=111)**



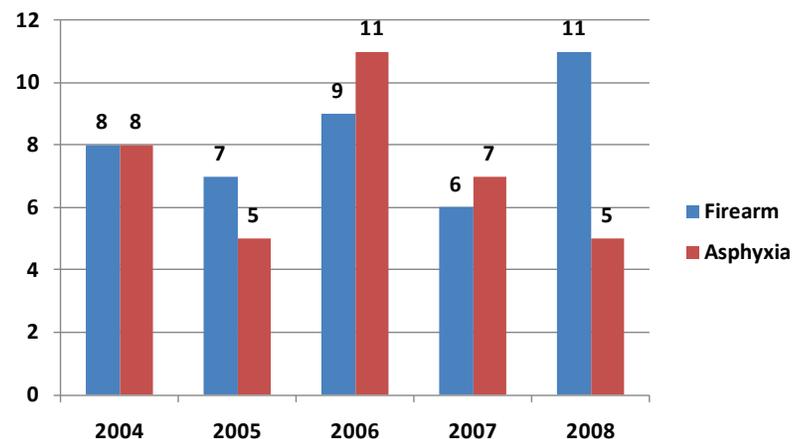
- In 63% of all suicide deaths, there was prior agency involvement with at least one service entity (71). Of these, 11 suicide deaths had documented prior involvement with mental health (16%), 45 had court involvement (63%), and 24 had Department of Family and Children Services (DFCS) involvement (34%)
- Based on the information provided during the county child fatality reviews, 12 previously attempted suicide, 29 talked about committing suicide, 24 were receiving mental health treatment at the time of death, and 20 previously received mental health treatment

Nationally, over 90 percent of youth who die by suicide had at least one psychiatric illness at the time of death; in about half such cases, the psychiatric illness was present, although often unrecognized, for two years or more. The most common diagnoses among youth are depression, substance abuse and conduct disorders (American Foundation for Suicide Prevention, 2008).

**Figure 43a: Reviewed Suicide Deaths by Mechanism among Children (Age 10 to 14), 2004-2008 (N=26)**



**Figure 43b: Reviewed Suicide Deaths by Mechanism among Older Teens (Age 15 to 17), 2004-2008 (N=77)**



- Children under age 15 are most likely to kill themselves by hanging and children ages 15 years and older most commonly commit suicide with a firearm
- Firearm-related suicide deaths among 15-17 year olds have increased from 2004 to 2008
- Conversely, suffocation (hanging) deaths among 15-17 year olds have decreased from 2004-2008. Suffocation deaths among 10-14 year olds were much lower in 2008 compared to 2004

Stressful life events often precede a suicide and/or suicide attempt. Such stressful life events include getting into trouble at school or with a law enforcement agency; fighting or breaking up with a boyfriend or a girlfriend; and fighting with friends. They often act as precipitating factors in the lives of young people.

**Resources:**

- Georgia Suicide Prevention Plan <http://georgiasuicidepreventionplan.org>
- Suicide Prevention Action Network <http://www.spanusa.org/GSSP.html>
- American Foundation for Suicide Prevention <http://www.afsp.org>



## Display and Comparison of Cause-Specific, County-Level Data

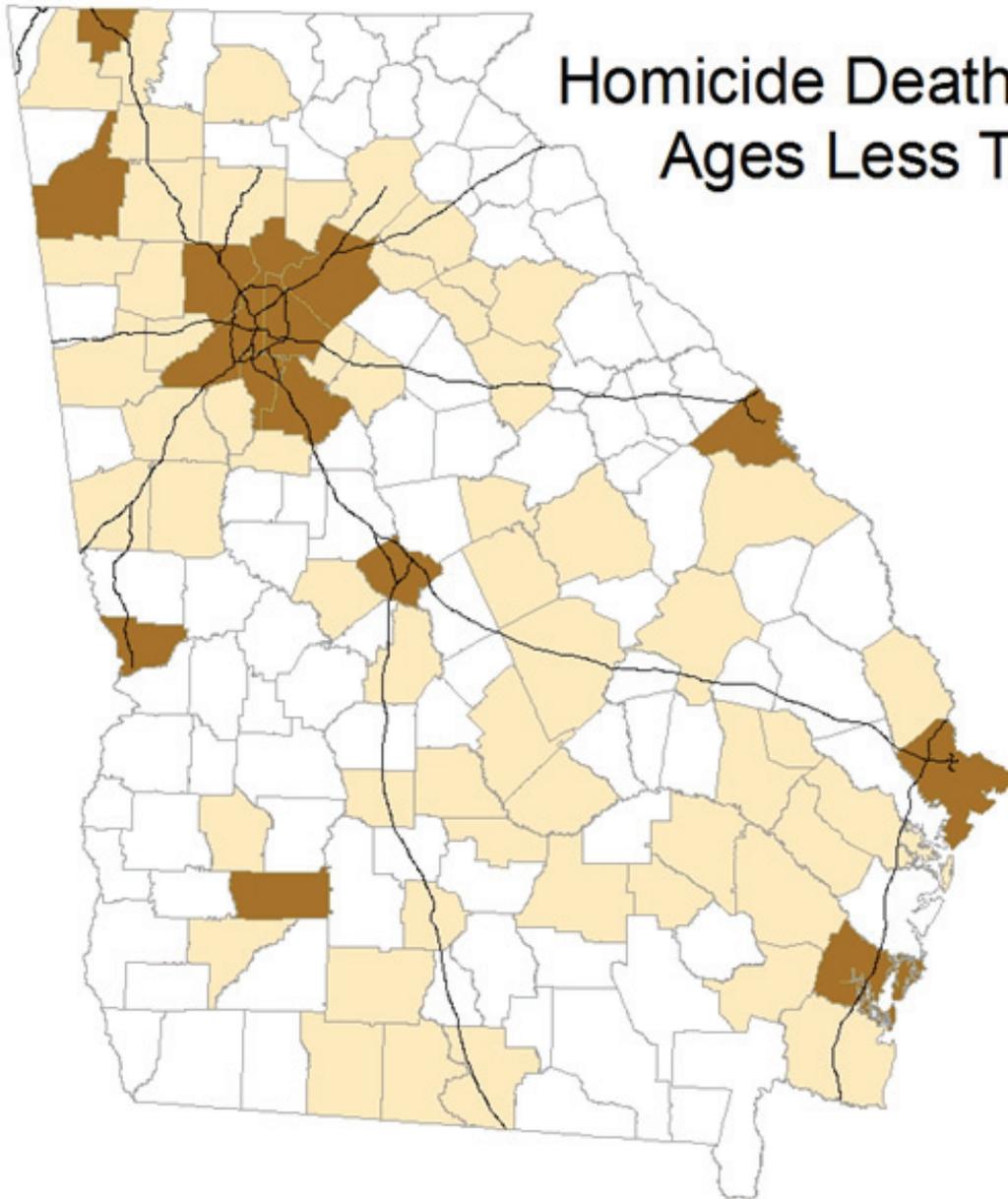
There are two issues associated with the interpretation of child death data at the county level – small numbers and rate calculations. A rate calculation requires two numbers – the number of events (deaths) and the population in which the event occurs. The population at risk for infant sleep-related deaths includes infants born during a specific time period, usually a calendar year. The event of interest is the death of an infant, born in the birth year of interest, within one year of birth. The rate of interest is the number of deaths divided by the number of births. The reported infant mortality rate is usually “per 1,000 births”, so the calculated rate is multiplied by 1,000.

The “small number problem” relates to large variations in rate calculations where there are very few events. If a county has 50 deaths one year and 49 the next, then that represents about a 2% change in the calculated rate, assuming the population does not change. However, if another county only has 4 deaths one year, a change to 3 deaths represents a 25% rate reduction. For this reason, rates based on fewer than five events during the time period of interest were not calculated.

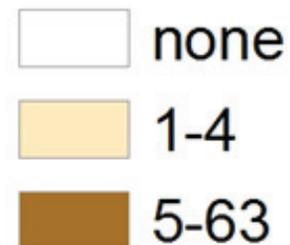
The second issue is associated with the calculation of a “rate” based on reviewed deaths. Although the intent of the Georgia CFR process is to review every accidental or violent death and every death classified as due to unknown cause, some deaths are not reviewed. Since the count of, for example, reviewed drowning deaths may not include all drowning deaths that actually occurred; the measure is referred to as a ratio rather than rate. Most (>80%) of the deaths of interest are reviewed, so the ratio will be close to the Georgia mortality rate, as found on the Department of Public Health’s Online Analytical Statistical Information System (OASIS), but neither the count nor the rate will be identical.

The three maps present data for the five-year period to try to ameliorate the small number problem. The sleep-related deaths map presents infant death ratios for the 48 counties with more than four deaths over the five-year period. However, there are relatively few drowning (199) or homicide (342) deaths that the numbers of deaths have only been identified on those maps. A table is provided with the ratio calculation for counties with more than four deaths for those causes.

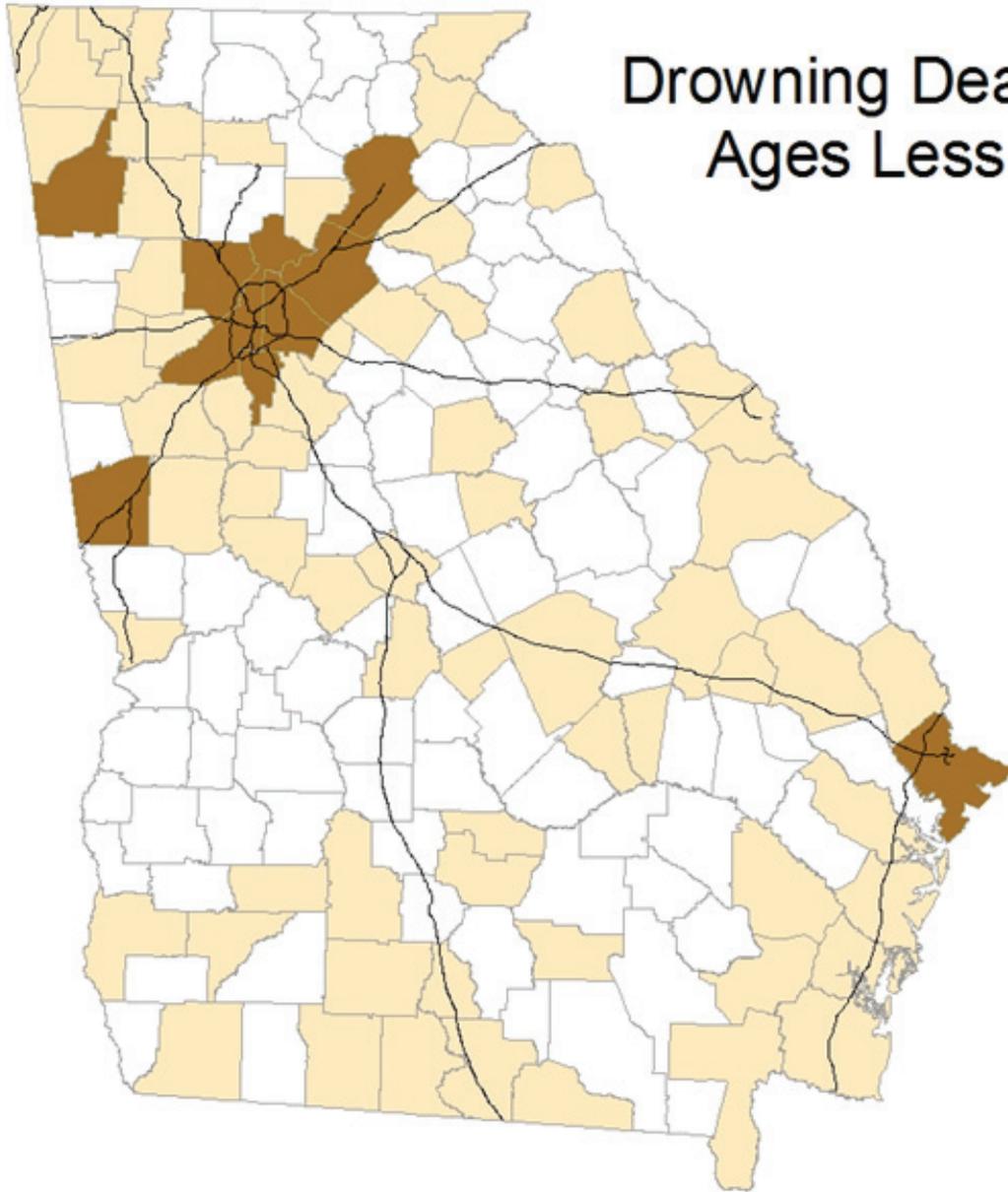
## Homicide Deaths, 2004 - 2008, Ages Less Than 18, GA



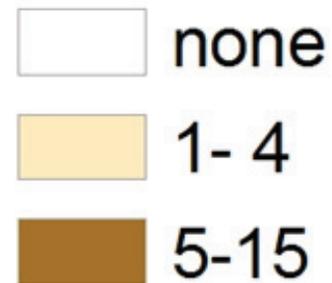
COUNTIES WITH HIGHEST HOMICIDE RATE	RATE PER 100,000 POPULATION
CLAYTON	8.0
MUSCOGEE	6.7
CATOOSA	6.6
FULTON	5.4
DOUGHERTY	5.4



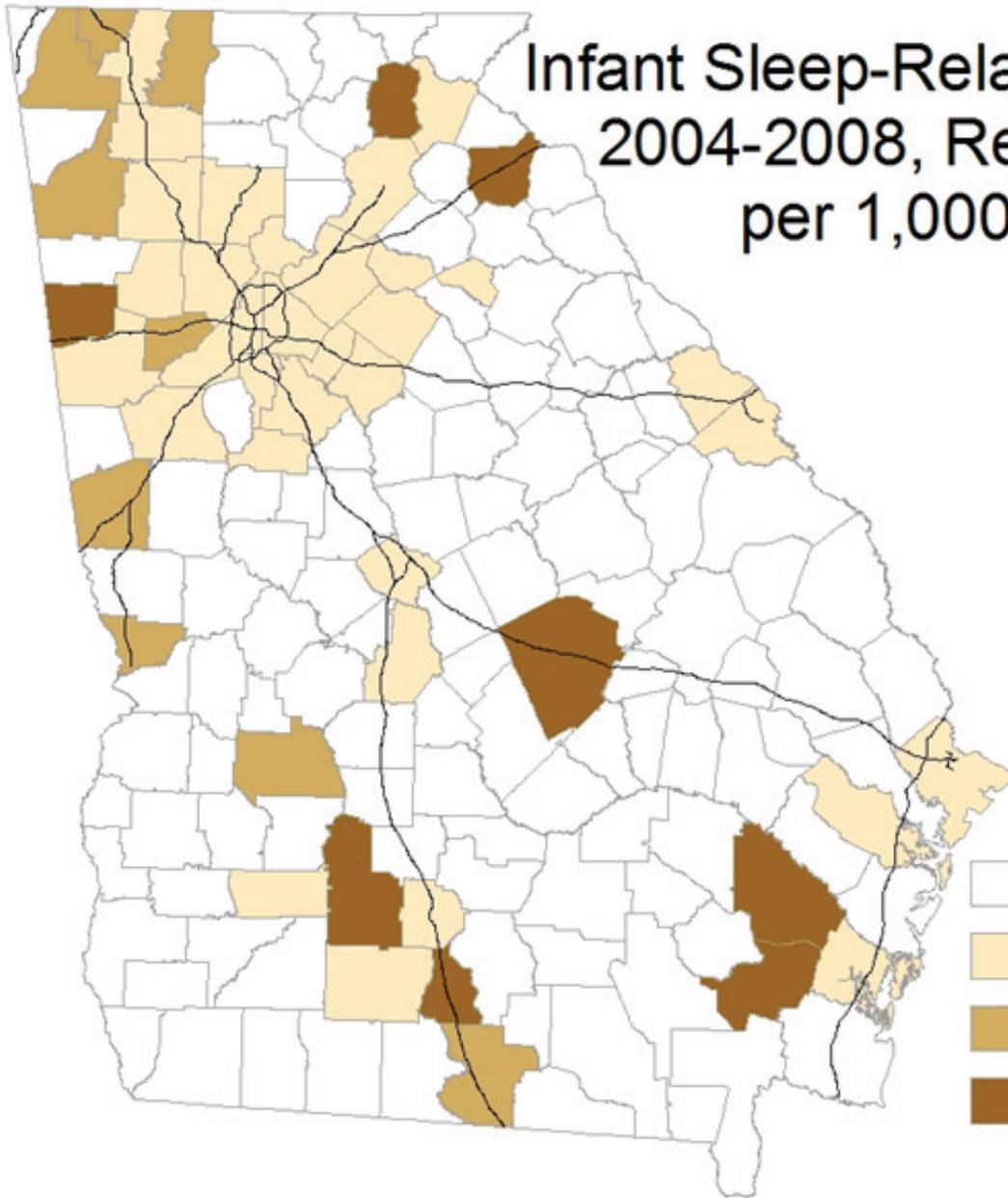
## Drowning Deaths, 2004-2008, Ages Less Than 18, GA



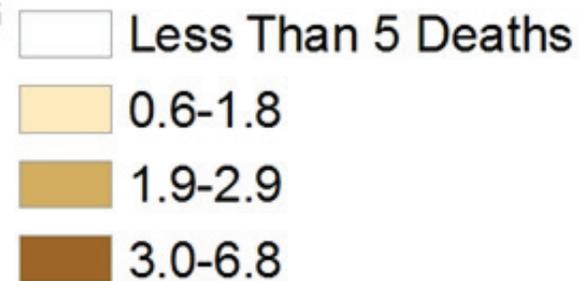
COUNTIES WITH HIGHEST DROWNING RATE	RATE PER 100,000 POPULATION
FLOYD	6.9
TROUP	5.9
CHATHAM	2.3
HALL	2.1
CLAYTON	2.0



## Infant Sleep-Related Death Ratios, 2004-2008, Reviewed Deaths per 1,000 Births, GA



COUNTIES WITH HIGHEST SLEEP-RELATED DEATH RATE	RATE PER 1,000 LIVE BIRTHS
FRANKLIN	6.8
BRANTLEY	5.3
COOK	3.7
WORTH	3.5
WHITE	3.4



# CRITERIA FOR CHILD DEATH REVIEWS

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

## "Eligible" Deaths or Deaths to be Reviewed by Child Fatality Review Committees

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

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



## Glossary of Terms

**AA** - African American

**CDC** – the federal Centers for Disease Control and Prevention agency

**Child Abuse and Neglect** – an act, or failure to act, on the part of a parent or caretaker that results in serious physical or emotional harm, sexual exploitation, or death of a child.

**Child Abuse Protocol Committee** - County level representatives from the office of the sheriff, county department of family and children services, office of the district attorney, juvenile court, magistrate court, county board of education, office of the chief of police, office of the chief of police of the largest municipality in county, and office of the coroner or medical examiner. The committee is charged with developing local protocols to investigate and prosecute alleged cases of child abuse.

**Child Fatality Review Report** - A standardized form required for collecting data on child fatalities meeting the criteria for review by child fatality review committees.

**Child Fatality Review Committee** - County level representatives from the office of the coroner or medical examiner, county department of family and children services, public health department, juvenile court, office of the district attorney, law enforcement, and mental health, and prevention advocate.

**Drowning Deaths** – Deaths that occur from water-related submersion and suffocation.

**Eligible Death** - Death meeting the criteria for review including death resulting from SIDS, unintentional injuries, intentional injuries, medical conditions when unattended by a physician, or any manner that is suspicious or unusual.

**Firearms** – any weapon that fires a high-velocity projectile, and includes rifles, pistols, revolvers, shotguns, handguns, and BB guns.

**Fire-Related Death** – Death resulting from fire or burn-related injuries sustained in a fire, and includes deaths from smoke inhalation.

**Form 1** - A standardized form required for collecting data on all child fatalities by coroners or medical examiners.

**Georgia Child Fatality Review Panel** - An appointed body of 17 representatives that oversees the county child fatality review process, reports to the governor annually on the incidence of child deaths, and recommends prevention measures based on the data.

**Injury** - Refers to any force whether it be physical, chemical (poisoning), thermal (fire), or electrical that resulted in death.

**Intentional** - Refers to the act that resulted in death being one that was deliberate, willful, or planned. It includes homicide and suicide.

**Medical Cause** - Refers to death resulting from a natural cause other than SIDS.

**Motor Vehicle-Related Death** – incidents that include the occupants of a vehicle, pedestrians struck by motor vehicles, bicycles, and occupants or riders of any other form of transportation (ATV, go-carts, etc.).

**Natural Cause** - Refers to death resulting from an inherent, existing condition. Natural causes include congenital anomalies, diseases of the nervous system, diseases of the respiratory system, other medical causes and SIDS.

**NICHHD** – the National Institute for Child Health and Human Development, supporting research on health issues for pregnancy and throughout the life course

**OASIS** – the Online Analytical Statistical Information System provided by the Department of Public Health

**“Other” Race** - Refers to those of Asian, Pacific Islander, or Native American origin.

**“Other” as Category of Death** - Includes deaths from poisoning and falls (unless otherwise indicated).

**PRAMS** – the Pregnancy Risk Assessment and Monitoring System, a statewide, ongoing, population-based survey that collects information on women who give birth in Georgia, maintained by the Department of Public Health

**Perpetrator** - Person(s) who committed an act that resulted in the death of a child.

**Preventable Death** - One in which with retrospective analysis it is determined that a reasonable intervention could have prevented the death. Interventions include medical, social, educational, legal, technological, or psychological.

**Reviewed Death** - Death which has been reviewed by a local child fatality review committee and a completed Child Fatality Review Report has been submitted to the Georgia Child Fatality Review Panel.

**Risk Factor** - Refers to persons, things, events, etc. that put an individual at an increased likelihood of dying.

**Sleep-Related Infant Death** – all deaths to infants that occur while sleeping but have no medical cause. Included are SIDS, SUIDS, and all suffocation/asphyxia deaths related to a sleep environment.

**Sudden Infant Death Syndrome (SIDS)** - The sudden death of an infant under one year of age which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene and review of the clinical history. In this report, SIDS is not considered a “medical” cause.

**Sudden Unexplained Infant Death (SUID)** - is a category used by child fatality review committees for deaths that appear to be SIDS but have other risk factors that could have contributed to the infant’s death.

**Trend** - Refers to changes occurring in the number and distribution of child deaths. In this report, the actual number of deaths for each cause is relatively small for the purpose of statistical analysis, which causes some uncertainty in estimating the risk of death.

**Unintentional Death** - Refers to the act that resulted in death being one that was not deliberate, willful, or planned.

