Georgia Child Fatality Review Panel

Annual Report - Calendar Year 2015

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Panel Chairman

Nathan Deal
Governor

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Peggy Walker, Panel Vice-Chair – Judge, Douglas County Juvenile Court

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Frank Berry – Commissioner, Department of Behavioral Health and Developmental Disabilities

Gloria Butler – Member, Georgia State Senate

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TABLE OF CONTENTS

Mission and Acknowledgements 4

Letter from the CFR Panel Chair 5

Background of Child Fatality Review in Georgia 6

Key Findings 11

All Reviewed 12

Disparities in Reviewed Deaths 18

Prevention and Preventability 21

Sleep-related Deaths 23

Medical-related Deaths 29

All Unintentional Reviewed Deaths 31

Motor vehicle-related Deaths 33

Drowning Deaths 35

All Firearm Deaths 38

Homicide Deaths 40

Suicide Deaths 44

Opportunities for Prevention 49

Resources 51

Appendix A - Child Fatality Review Committee Timeframe and Responsibilities 52

Appendix B - Map - Reviewable Deaths Reviewed 53

Appendix C - Table - Reviewable Deaths Reviewed 54

Appendix D - Glossory of Terms 70

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.

The Georgia Child Fatality Review Panel, each county-level review committee, their functions and membership requirements, are established in Georgia statute (§19-15-1 through -6).

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 T. Carter, Ph.D., M.P.H., Epidemiology Department, Rollins School of Public Health, Emory University

We would also like to thank the 2014 Child Fatality Review Committee of the Year, the 2014 CFR Coroner of the Year, and the 2014 CFR Prevention Committee of the Year for their exceptional support and dedication to the children of Georgia:

- CFR Coroner/Medical Examiner of the Year: Mark Alcarez, Douglas County
- CFR Committee of the Year: Northern Circuit. The Northern Circuit includes the following counties: Madison, Franklin, Hart, Elbert, Oglethorpe
- CFR Prevention Committee of the Year: Cherokee County

This report was developed and written by Wende R. Parker with the support of the CFR staff, Panel members, and John T. Carter.

LETTER FROM THE CFR PANEL CHAIR

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

I am proud to present this Annual Report of the data collected by the Georgia Child Fatality Review Panel for calendar year 2015. This report reflects the work carried out by the 159 local fatality review panels of the state as required by law. We hope that this essential data will assist you in furthering our mutual efforts to prevent and decrease child fatalities in Georgia in the coming year.

As you will see from the enclosed summaries, the Panel continues to place emphasis on education, training and public awareness in the area of sleep-related deaths. Sleep-related infant deaths remain the leading cause of post-neonatal deaths, with an average of 158 such deaths reviewed each year. This unfortunate statistic reflects a national trend that is both disturbing and frustrating, because these deaths are largely preventable. The Panel will continue to work with both State and private partners to attack this issue.

The Panel has also placed a priority on the identification and prevention of maltreatment-related deaths. Hundreds of law enforcement, service providers and first responders have been trained on spotting the signs of maltreatment and the proper reporting of maltreatment. Working with community partners, the Panel continues to emphasize the importance of linking maltreatment with prevention.

The Panel has collected a body of data over the past five years that will be critical in predicting patterns for future child fatality prevention. An in-depth analysis of this data, together with other relevant data collected by other agencies, is essential. The Panel requests your assistance in securing the necessary resources to perform this analysis in the coming year.

I would be remiss if I did not once again acknowledge the significant contributions of the Georgia Bureau of Investigation to this Panel. The support of Director Keenan and his agents and staff has contributed greatly to the Panel's mission. Their assistance is acknowledged and much appreciated.

I greatly appreciate your review of this report and its findings. It is always the desire of this Panel to work with you and our community and State to continue to reduce and prevent child deaths in Georgia.

Sincerely,

Judge Tain Kell
Chair, Child Fatality Review Panel

BACKGROUND AND HISTORY

The child fatality review process was initiated in Georgia in 1990 as an amendment to an existing statute for child abuse protocol committees. The legislation provided that each county child abuse protocol committee establish a subcommittee to systematically and collaboratively review child deaths that were sudden, unexpected, and/or unexplained, among children younger than 18 years of age.

The Child Fatality Review committees became a statewide, multidisciplinary, multi-agency effort to prevent child deaths. Georgia Code section 19-15-1 through -6 has been amended over the years, adding even more structure, definition, and members to the process. Members now form a stand-alone committee instead of a subcommittee, which has added emphasis to the importance of the function. Through the State Panel and the work of the local committees, we have the opportunity to learn from tragedy, prevent deaths, and give a new generation hope. Agencies and organizations working together at the state and local levels offer the greatest potential for effective prevention and intervention strategies.

The purpose of these reviews is to describe trends and patterns of child deaths in Georgia and to identify prevention strategies. As mandated in statute, this report identifies specific policy recommendations to reduce child deaths in Georgia.

The members of the Georgia Child Fatality Review Panel are experts in the fields of child abuse prevention, mental health, family law, death investigation, and injury prevention. The variety of disciplines involved and the depth of expertise provided by the State Review Panel results in comprehensive prevention recommendations, allowing for a broad analysis of both contributory and preventive factors of child deaths.

THE HISTORY OF CHILD FATALITY REVIEW IN GEORGIA

1990 - 1993

- Legislation established the Statewide Child Fatality Review Panel with responsibilities for compiling statistics on child fatalities and making recommendations to the Governor and General Assembly based on the data. It established local county protocol committees and directed that they develop county-based written protocols for the investigation of alleged child abuse and neglect cases. Statutory amendments were adapted to:
    - Establish a separate child fatality review team in each county and determine procedures for conducting reviews and completing reports
    - Require the Panel to:
        - Submit an annual report documenting the prevalence and circumstances of all child fatalities with special emphasis on deaths associated with child abuse
        - Recommend measures to reduce child fatalities to the Governor, the Lieutenant Governor, and the Speaker of the Georgia House of Representatives
        - Establish a protocol for the review of policies, procedures and operations of the Division of Family and Children Services (DFCS) for child abuse cases

1996 - 1998

- The Panel established the Office of Child Fatality Review (OCFR) with a full-time director to administer the activities of the Panel
- Researchers from Emory University and Georgia State University conducted an evaluation of the child fatality review process. The evaluation concluded that there were policy, procedure and funding issues that limited the effectiveness of the review process. Recommendations for improvement were made to the General Assembly
- Statutory amendments were adopted to:
    - Identify agencies required to be represented on child fatality review teams, and establish penalties for nonparticipation
    - Require that all child deaths be reported to the coroner/medical examiner in each county

1999 - 2001

- Child Fatality Investigation Teams (CFIT) were initially developed in four judicial circuits as a pilot project, with six additional teams later added. Teams assumed responsibility for conducting death scene investigations of child deaths that met established criteria within their judicial circuit
- Statutory amendments were adopted which resulted in the Code section governing the Child Fatality Review Panel, child fatality review committees, and child abuse protocol committees being completely rewritten. This was an attempt to provide greater clarity and a more comprehensive, concise format
- The Panel's budget was increased

2002 – 2005

- The Panel published and distributed a child fatality review protocol manual to all county committee members
- Statutory amendments were adopted which resulted in the following:
  - Appointment of District Attorneys to serve as chairpersons of local committees in their circuits
  - Authority of the Superior Court Judge on the Panel to issue an order requiring the participation of mandated agencies on local child fatality review committees. Failure to comply would be cause for contempt
  - Authority of the Panel to compel the production of documents or the attendance of witnesses pursuant to a subpoena
  - Director of the Department of Behavioral Health and Developmental Disabilities added as a member of the Panel
- Funding was secured and an on-line reporting system was established for both the child fatality review report and the coroner/medical examiner report
- A collaboration was established between the OCFR and the National Center for Child Death Review (NCDR)
- The Georgia Child Fatality Investigation Program was established through a partnership between OCFR, DFCS and the Georgia Bureau of Investigation. A director was hired to advance a multi-disciplinary approach to child death investigation through development and training of local teams
- Conducted the first statewide Prevention Readiness Assessment, to evaluate resources and stakeholders available in counties to implement and sustain prevention efforts
- A Statewide Model Child Abuse Protocol was developed and distributed to all Protocol committee members
- A Prevention Advocate was added, by policy, to all child fatality review committees Statewide training was conducted for all prevention advocate members
- A quarterly newsletter was created and distributed to all child fatality review members
- Annual awards were established for the Child Fatality Review Coroner of the Year and Child Fatality Review County Committee of the Year. Awards were presented at the annual Child Fatality and Serious Injury Conference sponsored by the Panel, DHS, GBI and the Office of the Child Advocate
- A sub-committee of the Panel was formed to begin working on a Statewide Prevention Plan

2006-2008

- The Child Fatality Review (CFR) committee protocol was revised and updated to reflect best practices
- The Protocol was presented to all county committee members and is also available online
- The Panel subcommittee on prevention completed the Statewide Child Fatality Prevention Framework. The Framework was presented to the Governor's Office and other agency partners
- An annual award was established for the Outstanding Investigator/Team of the Year for death investigation cases
- The CFIT Program expanded to address all types of multi-disciplinary child abuse investigations, including sex abuse, physical abuse and neglect as well as homicides
- The Panel added a Prevention Specialist staff position to assist the local efforts in child fatality prevention
- Annual CFR Coroner of the Year and CFR Committee of the Year winners were recognized by the Georgia Senate honoring their work
- The Office of Child Fatality Review merged with the Office of the Child Advocate

2009-2013

- Adopted National Center for Child Death Review online reporting form for all child deaths, allowing Georgia child death data to be captured on a nationally standardized surveillance tool
- Included as one of five states to participate in three-year CDC pilot project to improve investigation, review and reporting of sudden and unexpected infant deaths
- Expanded CFIT program to include a child abuse investigation training academy
- Continued involvement with the Southeast Coalition on Child Fatalities, providing support to other CFR programs within the southeastern states
- Conducted second Prevention Readiness Assessment of counties, to determine the local resources and stakeholders available to implement and sustain prevention efforts
- Created and maintained a CFR Panel subcommittee to address infant sleep-related deaths; the Georgia Infant Safe Sleep Coalition (GISSC) serves as a strong resource for state and local partners, providing evidence-based best practice for prevention and implementation assistance

2014

- Senate Bill 365 was signed by the Governor, moving oversight of the CFR Panel from the Office of the Child Advocate to the GBI. The bill also added language including "child abuse" as one of the criteria for determining a reviewable death, and1placed two additional members to the Panel: a member of the state Board of Education, and the commissioner of early care and learning

CHILD FATALITY REVIEW PANEL AREAS OF PRIORITY

The Georgia Child Fatality Review Panel has determined that injuries and fatalities among children can be reduced if the following recommendations to policymakers are adopted and implemented:

1. Work with the Department of Early Care and Learning to look at the groups that apply for child care subsidy. Do more consumer education to explore how to educate families including children ages 0-12. Possible future discussion will include: Re-envisioning the child care assistance program, more outreach/ training, DECAL and DFCS to do joint monitoring and GBI exploring data sharing. CACDES system that follow children starting at birth; which will be tracked through DPH.

2. School based health centers provide great opportunity on the prevention side. Incorporate a child abuse registry, and create a committee to review the registry.

3. Data analysis needed to create a five-year trend report for the integration of child health data for purposes of enhancing prevention.

4. Continue safe sleep as a priority. Importance of home visiting program for both at risk and low risk. Disparities and needs assessment for high risk areas will be important.

EXECUTIVE SUMMARY

Every year the Georgia Child Fatality Review Panel (Panel) publishes an annual report chronicling the tragic, preventable deaths of children in Georgia. These deaths are identified through death certificate data provided by the Office of Vital Records within the Division of Public Health. Local child fatality review committees examine child deaths that are sudden, unexpected, or unexplained (“eligible”), and complete a standardized form detailing the circumstances of the deaths. These child death data are useful in revealing recurring patterns and indicating prevention gaps and opportunities. We encourage parents, communities, organizations, and policymakers to use these data to make life-saving decisions for Georgia’s children. In 2015, child fatality review committees reviewed 561 total child deaths.

KEY FINDINGS

MALTREATMENT

In 2015, child fatality review committees determined that maltreatment was the direct cause or contributing factor in 234 deaths (maltreatment includes abuse, neglect, and poor supervision).

SLEEP-RELATED INFANT

Child fatality review committees reviewed 170 sleep-related infant deaths in 2015. The number of reported sleep-related deaths (death certificates) in Georgia has not demonstrated any consistent trend over the last 17 years (1999 – 2015). There was a peak of 197 in 2007, but the average over the 17 years is 162 deaths per year. Sleep-related infant deaths remain the leading cause of post-neonatal deaths, and they are the leading cause for all reviewable deaths.

INJURIES

In 2015, child fatality review committees reviewed 300 deaths that resulted from injuries either intentional (inflicted) and unintentional (accidental). ** Note that sleep-related infant asphyxia deaths have been excluded from the injury category; these deaths are included in the sleep-related infant category.

Unintentional Injuries: Child fatality review committees reviewed 177 deaths attributed to unintentional injuries among children ages 0-17. Child fatality review data indicated the three leading causes of death related to unintentional injury for this age group as: motor vehicle-related, drowning, and fire.

Intentional Injuries: Child fatality review committees reviewed 123 deaths to children ages 0-17 from intentional causes – 73 homicides and 50 suicides.

PREVENTABILITY

A primary function of the child fatality review process is to identify those deaths deemed to be preventable. Child fatality review committees determined that 80% of the reviewed child deaths with preventability determination (455) were definitely or possibly preventable.

ALL REVIEWED

In Georgia, every county is legislatively required to convene a Child Fatality Review committee. This committee is comprised of professionals from multiple disciplines that analyze the critical aspects of child deaths to aid in reducing preventable injuries and deaths in Georgia. Death notifications are obtained from a variety of sources to include coroner/medical examiner reports, Vital Records (VR) death certificates, Georgia Bureau of Investigation (GBI), Medical Records, EMS, Law Enforcement, Schools, Mental Health and Public Health and the Division of Family and Children Services (DFCS). Death data are linked with Vital Records data to ensure a comprehensive and accurate representation of all child deaths in the state of Georgia.

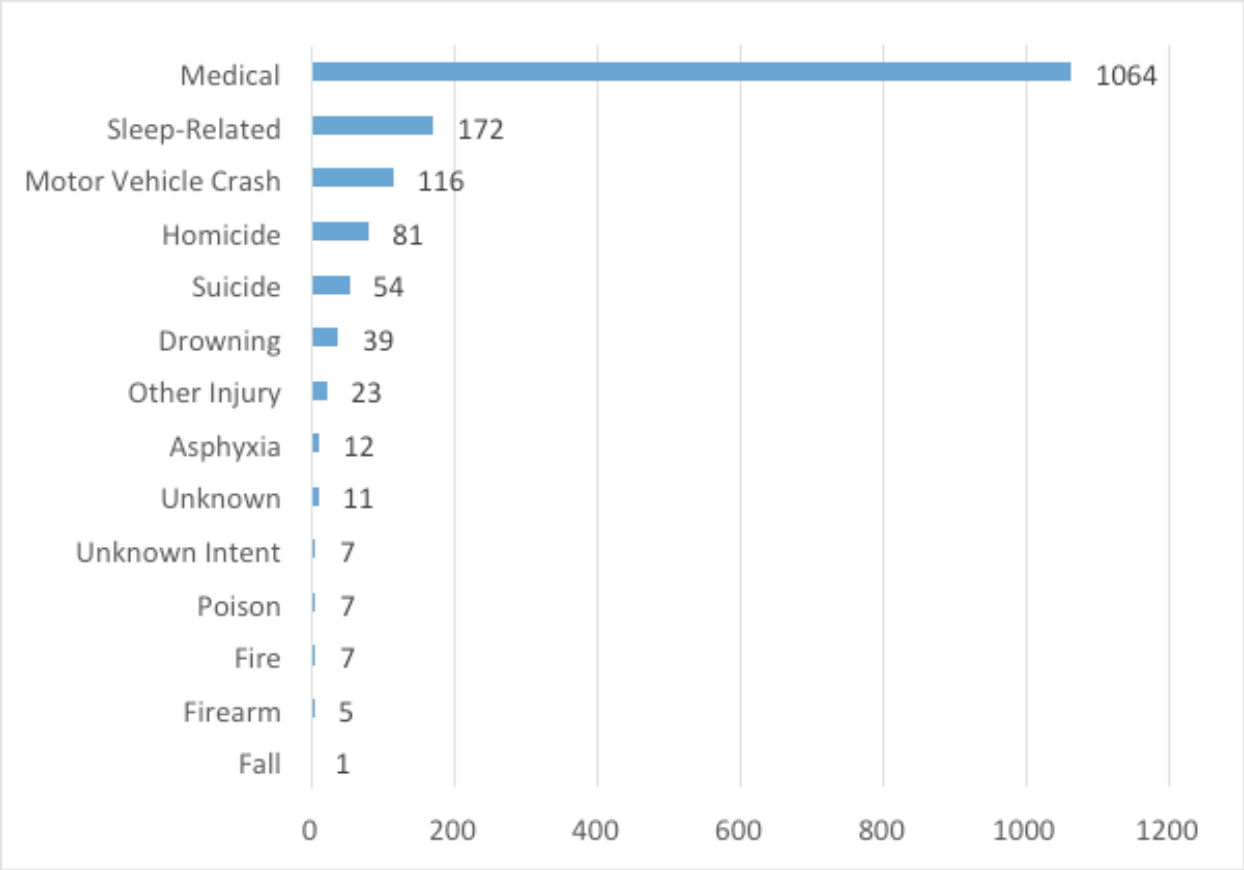
In 2015, 535 of the total 1,599 met the eligibility criteria requiring review according to death certificate data. Child Fatality Review committees reviewed an additional 26 deaths, and the total number of cases reviewed in 2015 was 561. CFR committee compliance for review was 85% in 2015. Of the reviewed deaths, the following information is of interest to assist with prevention:

- 60% of all reviewed deaths had prior agency involvement
- 39% were on Medicaid
- 24% were identified as having maltreatment identified at time of death
- 18% had been identified as having a chronic disease or disability and 27% of those were involved with the Children with Special Healthcare Needs Services program

A child's death is eligible for review when the death is sudden, unexpected, unexplained, suspicious, or attributed to unusual circumstances. The data included in this report are based on information attained from these reviews. The child death review reporting form provides details regarding the decedent's involvement with local agencies, maltreatment, neglect, prior history of medical conditions and a multitude of detailed data collection criteria to help uncover the reason why children die. It is the hope that this report will assist the reader with an understanding of necessary prevention efforts and integration of services in order to solve the manifested problem year after year.

***Note that there is a slight difference in the numbers and types of deaths reported between death certificate data and "all reviewed" CFR data. This difference is due to the additional information on the circumstances of the death that are obtained and reviewed by local CFR committees. This information sometimes leads to more comprehensive findings and accuracy in determining cause/manner that the death certificate does not specify, underscoring the value and importance of CFR data.**

Figure 1: Deaths to Children Under Age 18 in Georgia, All Causes based on Death Certificate, 2015 (n=1599)

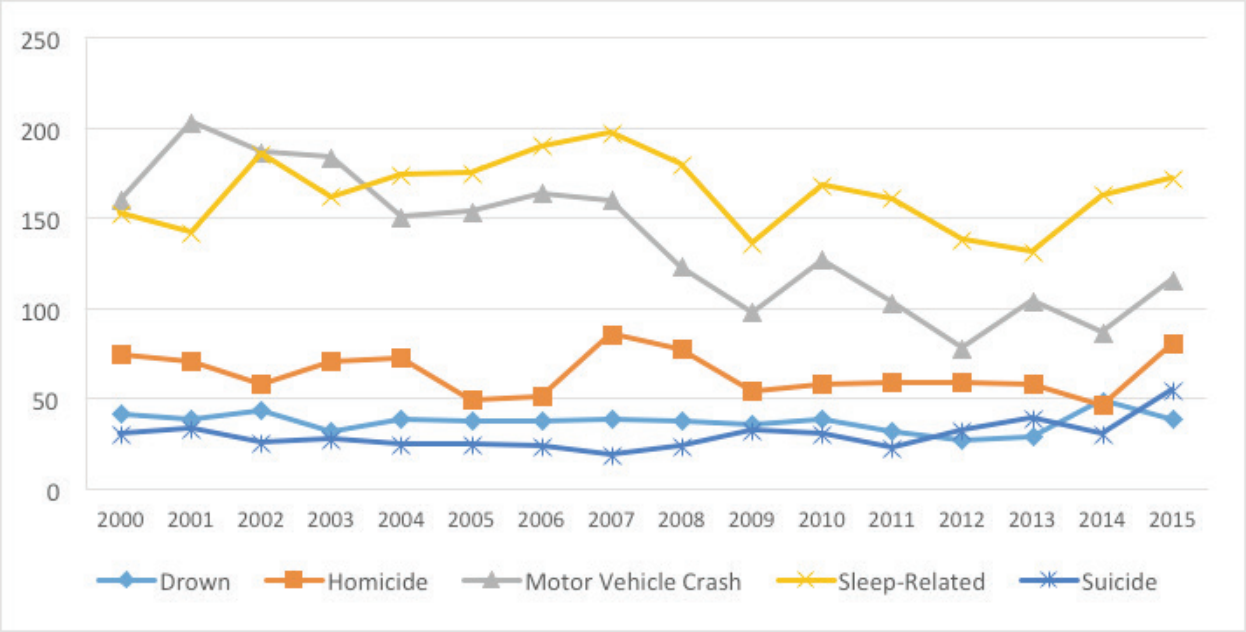


*Sleep-Related includes SIDS and infant asphyxia on a sleep surface

- The "unknown" category includes Sudden Unexpected Infant Death (SUID), sleep-related infant deaths with at least one prominent risk factor (see sleep-related infant section for more detailed information)
- The "unknown Intent" category includes deaths for which a definitive manner could not be determined
- Neonatal infant deaths (deaths in the first 27 days of life) account for almost two-thirds (63%) of all infant deaths, and 40% of all deaths to ages less than 18 years. They are usually attributed to prematurity, congenital malformations, and "other conditions originating in the perinatal period". A fetal-infant mortality review (FIMR) is the appropriate mechanism for reviewing these deaths.

The CDR data is linked to the GA vital records death certificate (DC) file to provide the data for this annual report. Thirteen of the 561 reviewed deaths did not link to a DC. These 13 deaths were reviewed by the OCFR and the Vital Records Office, and the absence of the DC remains unexplained. The chart below demonstrates the trends of child deaths in Georgia for the past 15 years.

Figure 2: Child Death Trends, Selected Causes, GA, 2000-2015



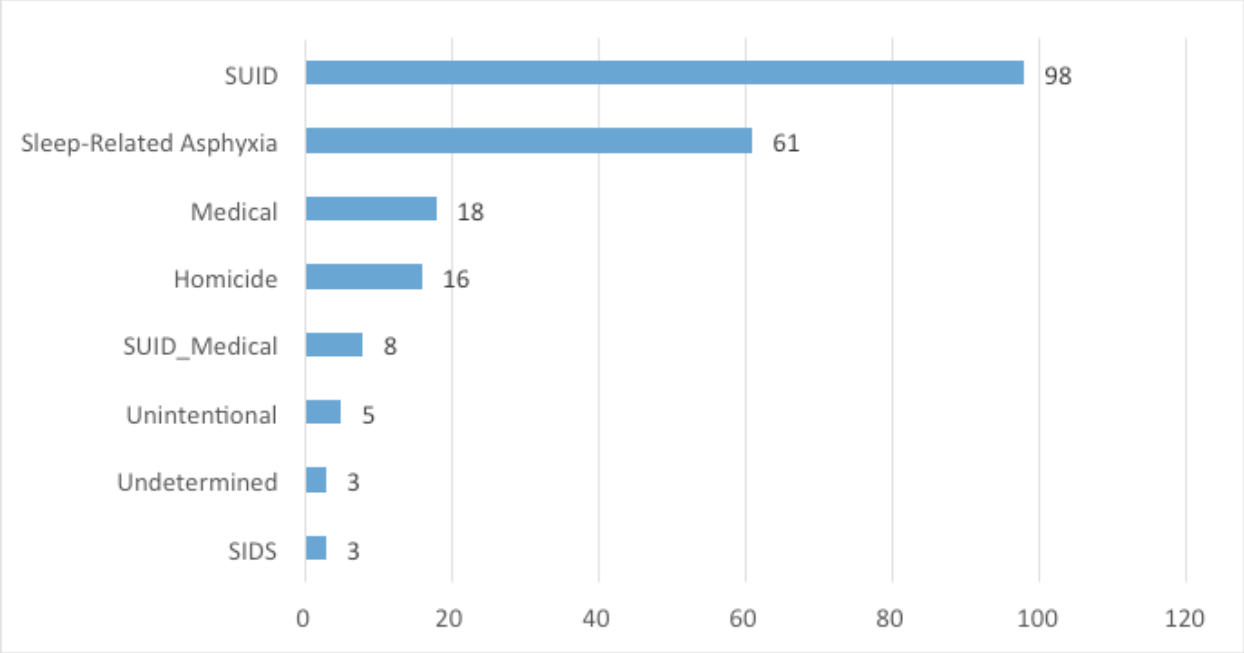
- Child deaths in Georgia increased in 2015 and significant reductions have occurred in the motor vehicle-related cause of death in the past five years

Figure 3: Demographics of All Reviewed Deaths, GA, 2015 (N=561)

Infant	1 to 4	5 to 9	10 to14	15 to 17	Totals	
White Male	30	20	10	24	43	127
White Female	35	17	3	9	25	89
African-American Male	61	31	17	15	46	170
African-American Female	71	14	11	9	13	118
Hispanic Male	6	6	3	4	11	30
Hispanic Female	3	3	0	1	3	10
Multi-Race Male	3	0	0	0	1	4
Multi-Race Female	2	2	0	0	1	5
Other Race Male	1	2	0	0	0	3
Other Race Female	0	0	1	0	4	5
Totals	212	95	45	62	147	561

- The African-American population comprised 51% of child deaths in 2015
- The White population comprised 39% of child deaths in 2015

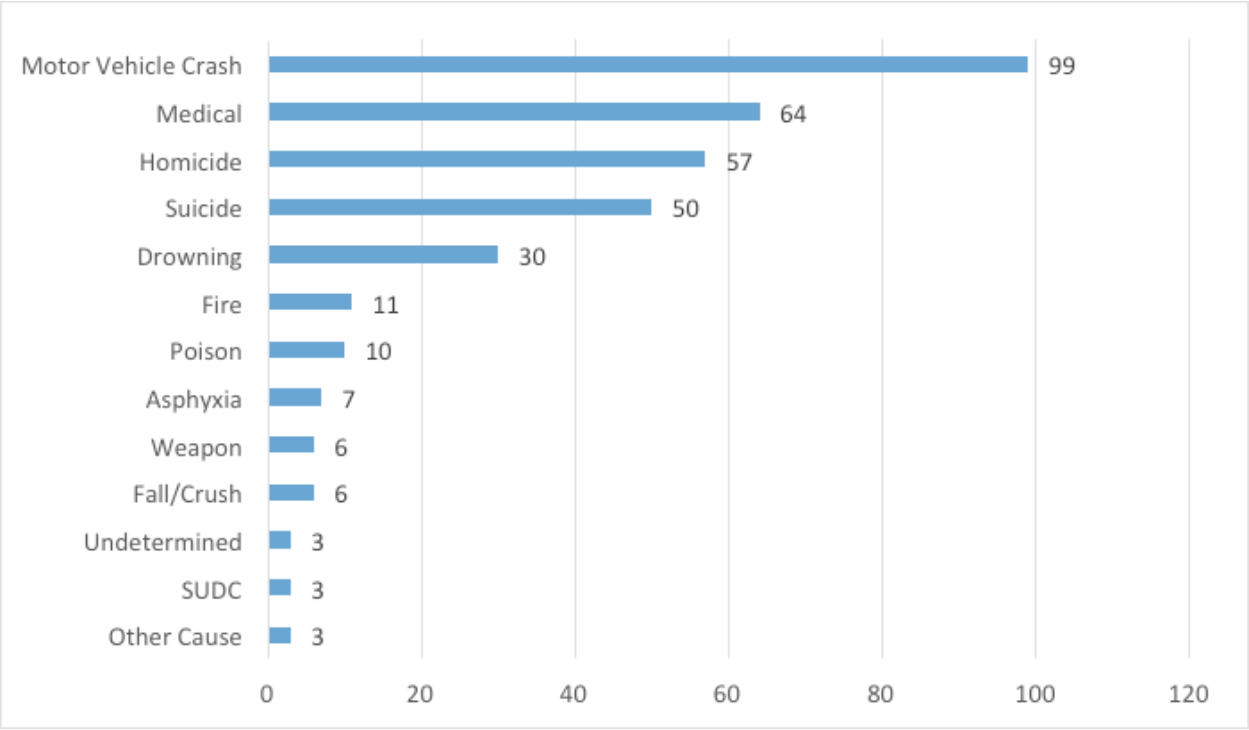
Figure 4: Number of Reviewed Infant Deaths by Cause, GA, 2015 (N=212)



*SUID = Sudden Unexplained Infant Death; SIDS = Sudden Infant Death Syndrome (more information on these types of deaths can be found in the "Sleep Related" section)

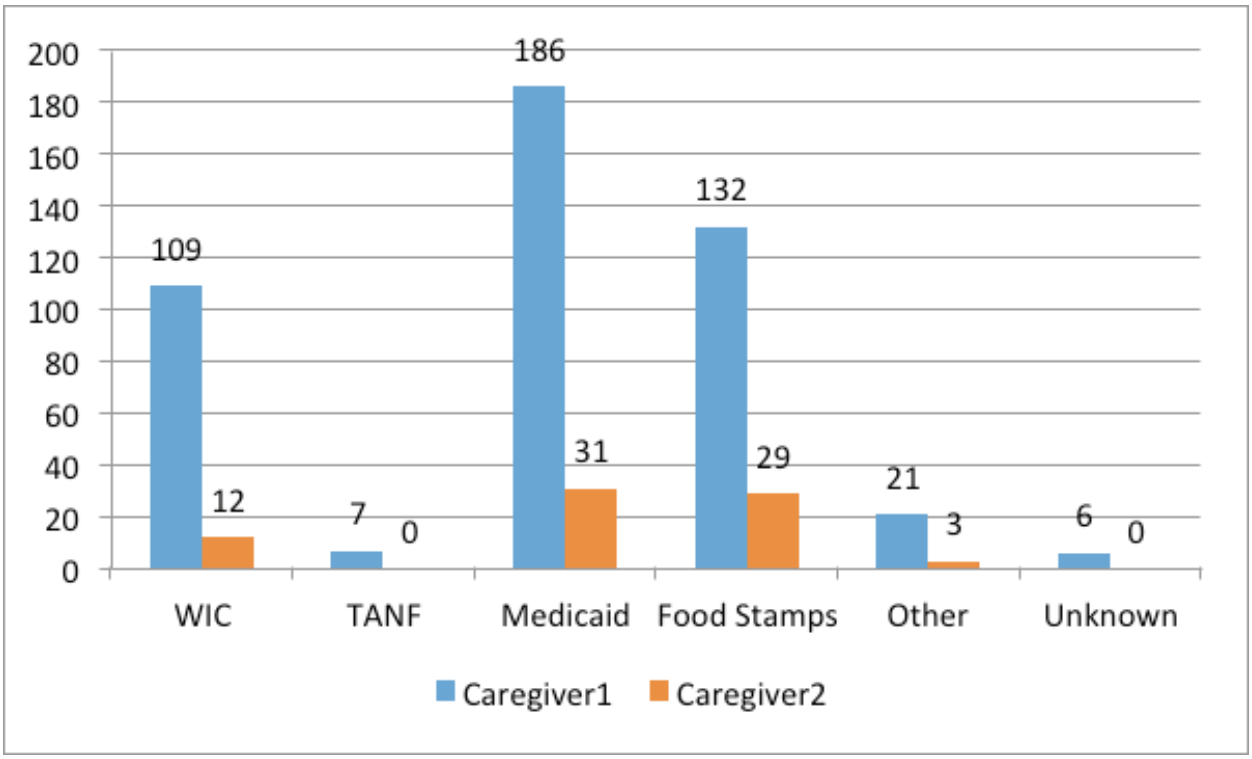
- The SUID_Medical category refers to an infant death with a medical cause and manner but the infant was placed in an unsafe sleep environment that likely exacerbated the medical condition(s)

Figure 5: Number of Reviewed Child (ages 1-17) Deaths, By Cause, GA, 2015 (N=349)



- The "undetermined" category refers to cases for which there is no definitive cause of death

Figure 6: Number of cases where a caregiver was receiving social services at time of child's death, GA, 2015



- 44% of deaths had a caregiver receiving social services which includes WIC, Temporary Assistance for Needy Families (TANF), Food Stamps/Supplemental Nutrition Assistance Program (SNAP), Housing Assistance, Free/Reduced Lunch
- As per the CFR reporting form, caregivers can be mother, father, sibling, partners, grandparents, or other

SPOTLIGHT ON MALTREATMENT:

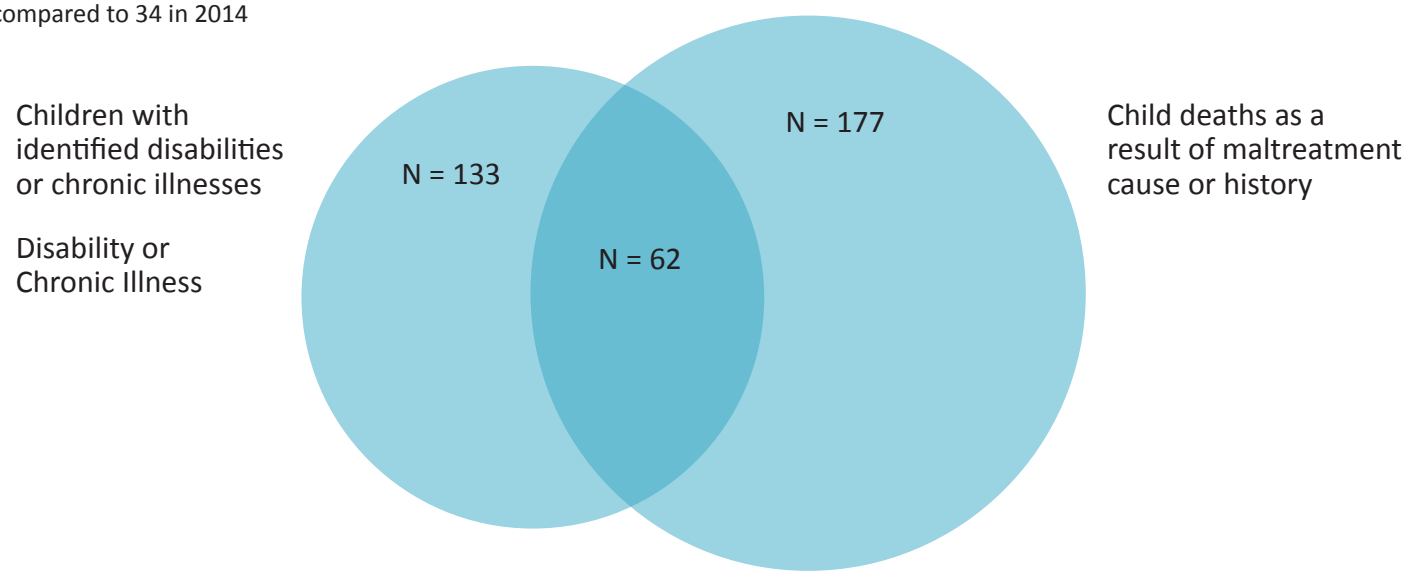
Child maltreatment is influenced by a number of factors, including lack of knowledge of child development, substance abuse, forms of domestic or intimate partner violence, and mental illness. Although maltreatment occurs in families at all economic levels, abuse, and especially neglect are more common in poor families than in families with higher incomes (Child Trends Data Bank). The CFR committee members are asked to collectively decide, using available information, if they believe that any human action or inaction caused (i.e., directly) and/or substantially contributed (i.e., indirectly) to the death of the child. The direct cause of death refers to an act that was the primary event leading directly to the death. The contributing cause of death refers to an act that played a role, but not the primary role, in the child's death. Fatalities classified as maltreatment by CFR committees are not necessarily reflective of official counts of abuse and neglect as reported by the state Division of Family and Children Services (DFCS). Not all CFR-identified maltreatment deaths had been known or reported to DFCS prior to the fatality occurring, or the maltreatment was not the direct cause of death. The CFR committees are not identifying only the "substantiated" maltreatment, but the deaths where maltreatment was indicated based on a review of the circumstances known to the committee. In 2015, one-third of the reviewed child deaths, there was a reported history of maltreatment, or maltreatment was identified as a direct cause or contributing factor.

The adverse consequences of child maltreatment affect all aspects of life, including physical and emotional health as well as social and economic wellbeing, and continue well after the maltreatment ends. The Adverse Childhood Experiences (ACE) Study links ACE to various risk factors that may lead to social and individual health consequences from conception to death. An ACE score is used to assess the total number of stresses a child experiences including child maltreatment; an increase in a child's ACE score is associated with a strong and graded increase in the following health behaviors/conditions: depression, elevated risk of intimate partner violence, chronic health problems, and suicide attempts.

The CFR Panel is one of three panels designated to serve as Georgia's Citizen Review Panels to fulfill the obligation of the Child Abuse Prevention and Treatment Act (CAPTA). To that end, CFR must report on child fatalities related to abuse or neglect, evaluate the extent to which state and local child protection agencies are effectively discharging their child protection responsibilities, and make recommendations to improve the system.

Figure 7: Child Deaths with Identified Disability/Chronic Illness and Maltreatment, GA, 2015

*62 children with identified disabilities or chronic illnesses died as a result maltreatment or had a history of maltreatment compared to 34 in 2014



DISPARITIES IN DEATHS

In 2015, there were 2,705,668 children age birth to 17 years of age in Georgia (GA Department of Public Health, OASIS data). Disparities in deaths exist due to the influence of social determinants that play a role in the lives of Georgia's children. Some of these determining factors include race, ethnicity, family income, education level, and health insurance coverage. Obviously, there are some risk factors that cannot be changed, but for the ones that can, it is imperative more be done to decrease the mortality rates. The following tables provide population data by age group as well as the 2015 mortality rates for each group.

Figure 8: Infant Population Estimates (OASIS), GA, 2015

Infant <1	Total Births	Hispanic
All Races	131,333	17,789
White	69,529	10,053
African-American	44,781	667
Other	8,852	556
Unknown	8,171	6,513

Figure 9: Infant Mortality Rates, GA, 2015, OASIS

Infant Mortality Rates		
	Total Births	Hispanic
All Races	7.8	5.7
White	5.8	7.9
African-American	13.1	27.0
Other	3.8	9.0

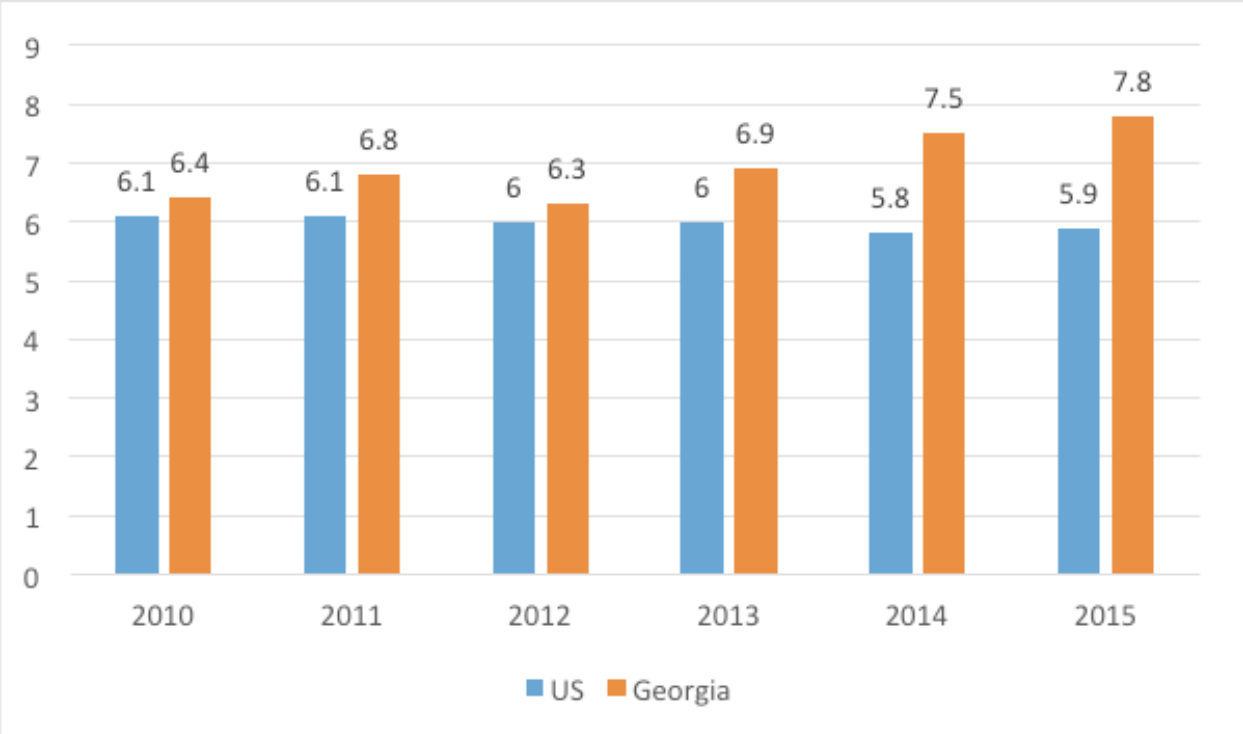
*National Target is 6 deaths per 1,000 live births according to Healthy People 2020

The infant mortality rate (IMR)is an estimate of the number of infant deaths for every 1,000 live births. Why is this important? The IMR can be used as an indicator to measure the health and well-being of the state. The reason this is separated by race and ethnicity is because there are some differences in infant mortality when reviewed this way. For example, the following demonstrates some obvious difference in demographics in Georgia in regards to the infant mortality rate.

- The rate of infant mortality in African-American infants is more than twice that of White non-Hispanic infants
- White, Hispanic infants had a higher mortality rate than White, non-Hispanic

In Georgia, there are preventive services available for families. Perinatal health programs in Georgia focus on preterm birth (birth before 37weeks) in order to ensure mothers and babies have access to comprehensive healthcare services. Preterm birth is a serious health problem affecting the outcomes of infants every day.

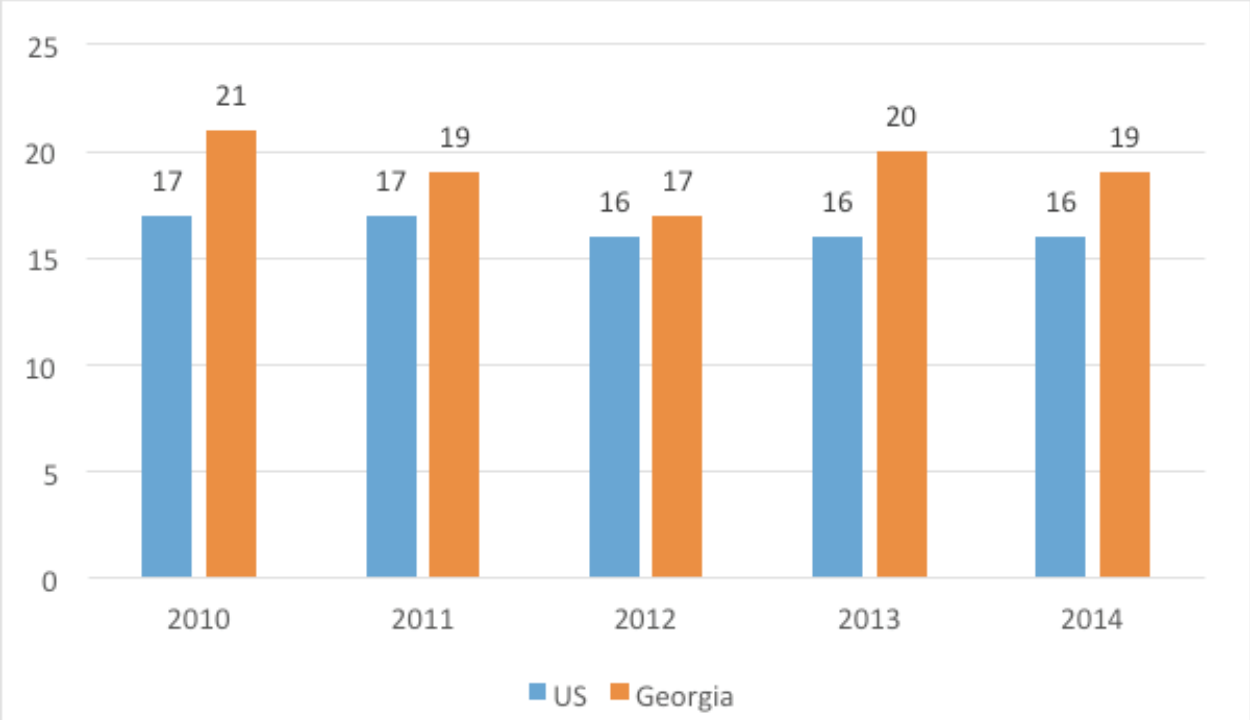
Figure 10: Infant Mortality Rates (deaths per 1,000 births), US and GA, 2010-2015



*Sources:
2010 - 2014, AECF Kids Count (NCHS Public Use Files), 2015 U.S., NCHS Data Brief No.267, 2015 GA, GA Vital Statistics, OASIS Web Site

- Georgia's infant mortality rate remains higher than that national rate

Figure 11: Child (ages 1-14 years) Mortality Rates (death per 100,000 population), US and GA, 2010-2014



*Source: 2010 - 2014, AECF Kids Count (NCHS Public Use Files)
*Child mortality death rate data is not available for 2015

- National child mortality death rate data is not available for 2015
- Georgia's child death rate is slightly higher than the national rate
- Neither in GA, nor nationally, are there any apparent trends in child death rates

PREVENTION AND PREVENTABILITY

After reviewing the child fatality information from 2015, it is apparent, more than ever, that everyone, especially state leadership must continue to advocate for children to have the protection they need to stay safe and also put policies and laws in place to assist with preventing these tragedies each year. Additionally, it is important for parents, caregivers, school personnel, childcare providers, families and healthcare workers to have knowledge of resources so they can provide support and help. Without integration of all prevention related services in a community, children will continue to be at risk for injury and death. For CFR purposes, **Preventability** is defined as a death in which, with retrospective analysis, it is determined that a reasonable intervention (e.g., medical, educational, social, psychological, legal, or technological) could have prevented the death.

The Child Fatality Review committees are asked to develop actionable prevention recommendations following every reviewed child death. Many of their recommendations have been put forth to agency leadership and legislators, and progress has been made over the years. This section is designed to provide the reader with some of the prevention recommendations provided by the committees, as well some additional resources for reference. Additionally, several CFR committees also recommended engaging social media platforms to connect with parents and caregivers (like FaceTime and Skype).

Figure 12: Child Fatality Review Committee Prevention Recommendations

Cause of Death	Prevention Recommendation Suggestions
DROWNING	1. Local ordinances should be reviewed for pool barriers and the consequences for removing barriers 2. Statewide campaign regarding drowning prevention to include all forms of media 3. Prominent signs warning of swimming in open water areas such as rivers, ponds, lakes 4. Children must learn to swim
MOTOR VEHICLE CRASHES	1. Education and awareness campaigns to teach youth about consequences of risky behaviors and poor decisions 2. Consistent driving education courses made available throughout the state
SLEEP-RELATED	1. Continue media awareness of sleep related dangers 2. Expand safe sleep education into all aspects of the family life
HOMICIDE	1. Gang prevention in elementary schools 2. Continue to address gun violence prevention to youth and incorporate the growing concern and fascination with gun play 3. Provide prevention messages at alternative schools 4. Continue to reinforce to all that no level of criminal involvement will result in a positive outcome 5. Community forums and programs for families to educate and teach how to resolve conflict without violence. Additional topics can include gun safety, peer accountability, anger management, bullying, and other selected topics related to prevention of child deaths
SUICIDE	1. Continue providing the Sources of Strength curriculum to school personnel 2. Increase resources for mental health trainings and recognition of signs/symptoms of depression 3. Statewide campaign to alert everyone of this problem 4. Reduce access of guns in the home

Figure 13: Determination of Preventability, GA, 2015 (N=561)

	Missing	No, probably not	Yes, probably	Team could not determine	Percent Preventable*
All Unintentional	0	12	157	8	92.9
Homicide	0	6	62	5	91.2
Suicide	0	6	35	9	85.4
SIDS/SUID	3	17	99	51	85.3
Medical	1	48	10	23	17.2
SUDC	1	0	1	1	N/A
Undetermined	0	2	4	0	N/A
All Reviewed	5	89	366	101	80.4

Committees determined that 366 of the 561 reviewed deaths were 'probably preventable'. Committees were then tasked with determining which factors could have been modified to prevent the death, and what measures they would recommend to prevent future similar deaths in their communities. In 184 cases where the death was preventable, the committees recommended at least one type of prevention strategy – law/policy, environment/consumer product, agency program/service, or education.

SLEEP-RELATED INFANT DEATHS

Each year in the U.S., more than 3,500 infants, without prior known illness or injury, die suddenly and unexpectedly from sleep-related causes. In 2015, Georgia averaged three infant deaths per week due to sleep-related causes, which are mostly preventable. Georgia's rate of infant deaths continues to be higher than the national average.

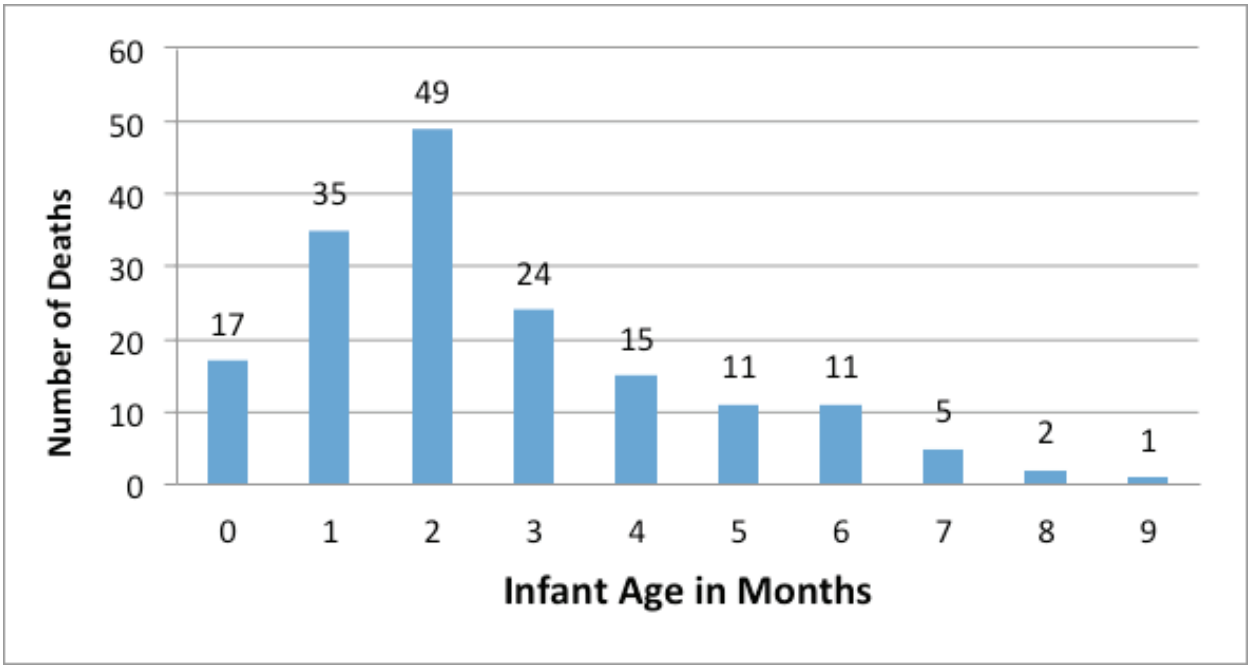
The American Academy of Pediatrics (AAP) recently released their 2016 updated recommendations for safe infant sleep. The recommendations remained relatively the same but, had some clarifications and expansions based on new scientific research. This new research continues to support the original recommendations and offer clearer insight in how best to prevent sleep-related infant deaths such as SIDS and SUID. The information that Georgia has on how, when, and where, the infant sleep-related deaths are occurring corresponds directly with the recommendations for prevention. Following the AAP recommendations and ensuring that parents, caregivers, and all professionals are aware of the recommendations and understand how to incorporate them into practice, will help reduce sleep-related infant deaths in Georgia.

CFR committees reviewed 170 sleep-related deaths. Of these deaths, 71.8% were identified as having prior agency involvement. Maltreatment was reported in 19 of the 170 sleep related deaths. Additionally, committees determined that poor supervision was a direct cause (3) or contributing factor (26) in the 17% (29 cases) of deaths. An additional 5 deaths had a response of "No, but needed" to the question about supervision at the time of the incident

Figure 14: Demographics of Reviewed Sleep-Related Deaths, GA, 2015 (N=170)

	SIDS	SUID Asphyxia	SUID Medical	SUID Undetermined	Totals
White Male	0	13	1	15	29
White Female	0	9	3	19	31
African-American Male	0	15	0	33	48
African-American Female	3	22	4	29	58
Other Male	0	2	0	2	4
Other Female	0	0	0	0	0
Totals	3	61	8	98	170

Figure 15: Reviewed Sleep-Related Deaths by Age, GA 2015



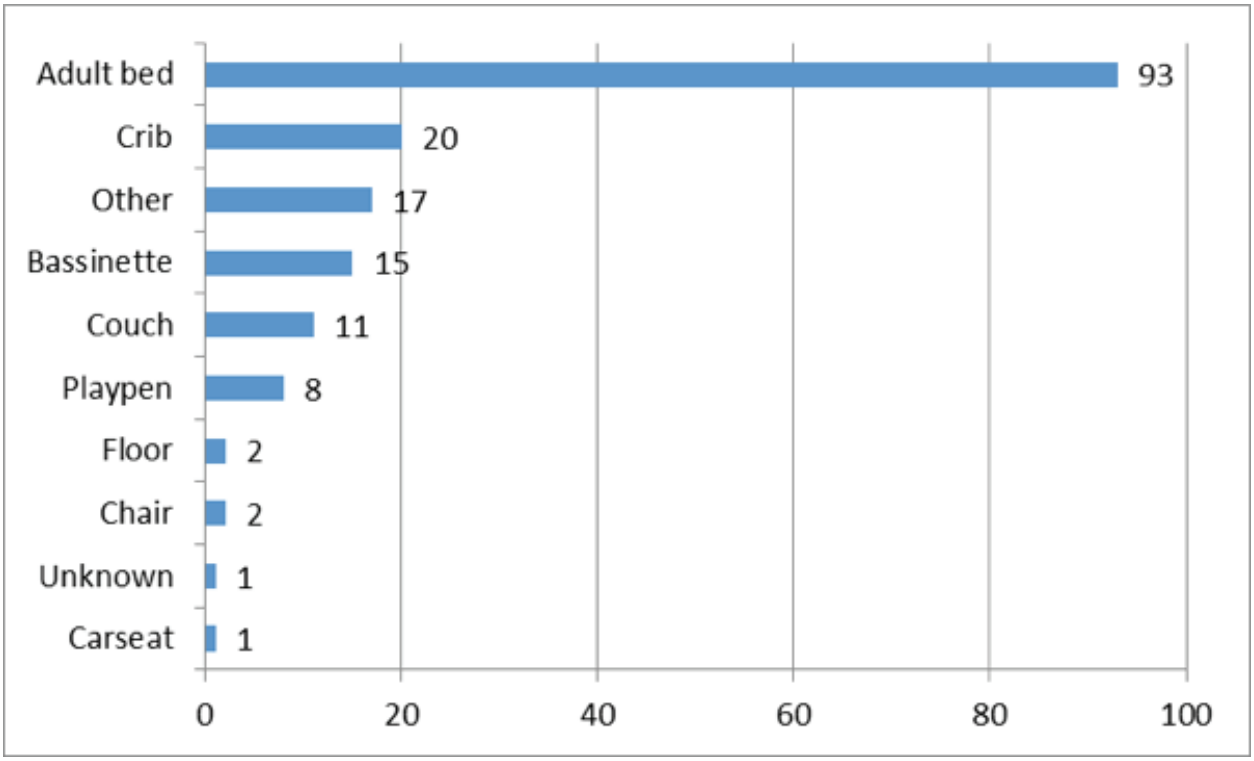
- 95% of sleep-related deaths occur from birth to 6 months. This has been a consistent trend for many years, both nationally and in Georgia

Infants vary in their ability to roll over and also, when they sit up on their own. The majority of infants will learn to sit on their own between 4 to 7 months. This is linked to the higher number of sleep-related deaths in children younger than 6 months. Without the muscle development to lift their heads and turn them aside and away from a soft item that is restricting their air flow the infant stays in the same place or "roots" him or herself further into the suffocating material. For example, if they become entrapped, between couch cushions, they are unable to alert caregivers or get out of the position.

"There is evidence that sleeping in the parents' room but on a separate surface decreases the risk of SIDS by as much as 50%. In addition, this arrangement is most likely to prevent suffocation, strangulation, and entrapment that may occur when the infant is sleeping in the adult bed. Couches and armchairs are extremely dangerous places for infants. Sleeping

on couches and armchairs places infants at extraordinarily high risk of infant death, including SIDS, suffocation through entrapment or wedging between seat cushions, or overlay if another person is also sharing this surface" (AAP, 2016).

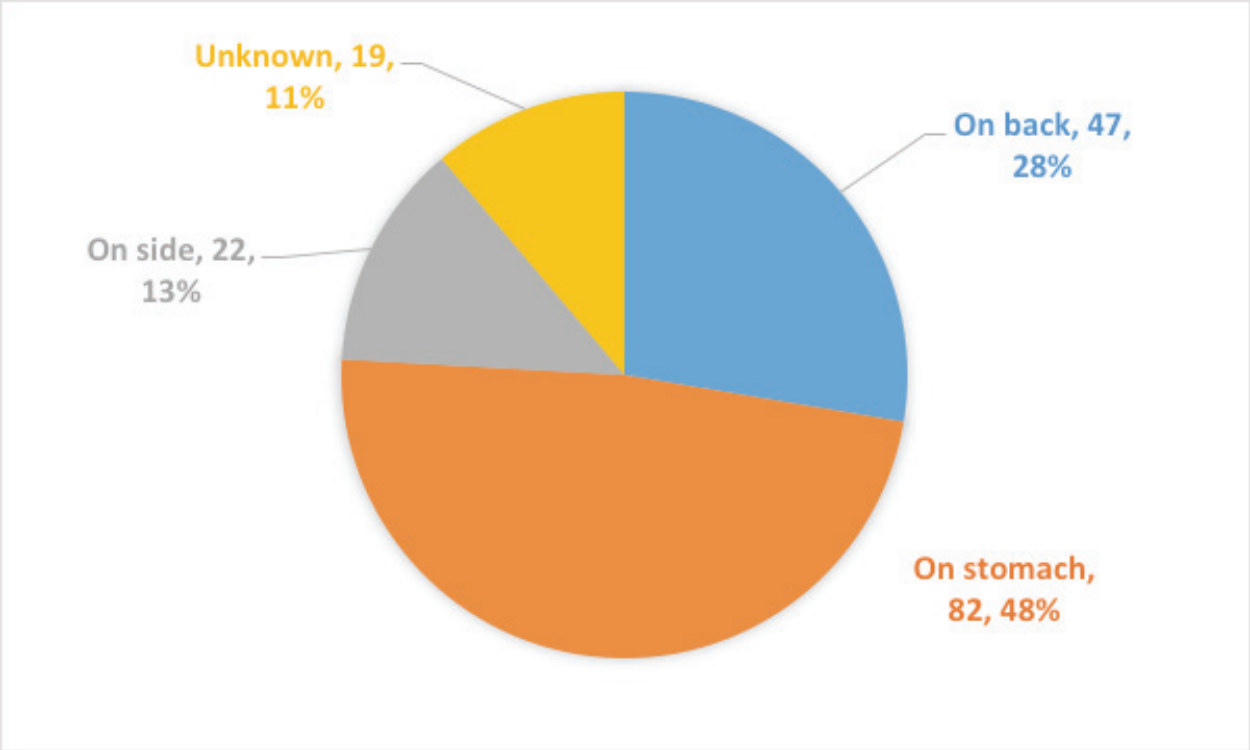
Figure 16: Location of Sleep-Related Deaths



- 55% of sleep-related infant deaths occurred within an adult bed
- 75 infants were bed sharing with an adult at the time of death, and 24 of these cases also had another child in the sleep environment
- The other category included: 5 on an air mattress, 7 lying on someone's arms or chest, and the remaining 5 were located in a 'bouncer', swing, pillow, or a sofa bed
- Adult beds are inherently unsafe for infants due to their very design, which is to provide a soft place for sleep. Additionally, if the adult bed is shared with others, including siblings, the risk of suffocation is increased through entrapment, suffocation and, overlay. The tendency to focus solely on bed sharing however, can be conflicting because the second highest death location is the crib. Merely using a crib or bassinet will not protect the child from suffocation if the crib is filled with soft suffocation hazards (pillows, crib bumpers, stuffed toys) and, strangulation hazards (cords, plastic bags), etc.

The 2016 AAP Policy Statement states: "It is important to note that a large percentage of infants who die of SIDS are found with their head covered by bedding. Therefore, no pillows, sheets, blankets, or any other items that could obstruct infant breathing or cause overheating should be in the bed." Additionally, "sitting devices, such as car seats, strollers, swings, infant carriers, and infant slings, are not recommended for routine sleep in the hospital or at home, particularly for young infants. Infants who are younger than 4 months are particularly at risk, because they may assume positions that can create a risk of suffocation or airway obstruction or may not be able to move out of a potentially asphyxiating situation".

Figure 17: Infant Position When Found, GA, 2015



- Almost half of all infants who died were found on their stomachs

Back sleeping reduces the risk of a sleep-related infant death. "To reduce the risk of SIDS, infants should be placed for sleep in a supine position (wholly on the back) for every sleep by every caregiver until the child reaches 1 year of age. Side sleeping is not safe and is not advised (AAP, 2016).

For those deaths that occur while the infant is on his or her back, suffocation/asphyxia from bedding, overlay or entrapment are contributing factors to the death. "The best evidence suggests that infants should continue to be placed supine until 1 year of age. Once an infant can roll from supine to prone and from prone to supine, the infant can be allowed to remain in the sleep position that he or she assumes. Because rolling into soft bedding is an important risk factor for SUID after 3 months of age, parents and caregivers should continue to keep the infant's sleep environment clear of soft or loose bedding." (AAP, 2016)

Known barriers to following the back to sleep recommendation include: fear of the infant choking (especially with reflux), better infant sleep when prone and, family tradition of prone sleeping.

Addressing these misperceptions and misunderstanding within the general population, as well as with health professionals, will help to increase the number of infants sleeping supine. The AAP does not recommend elevating a child's sleep surface to address reflux." The supine sleep position does not increase the risk of choking and aspiration in infants, even those with gastroesophageal reflux, because infants have airway anatomy and mechanisms that protect against aspiration. The American Academy of Pediatrics (AAP) concurs with the North American Society for Pediatric Gastroenterology and Nutrition that "the risk of SIDS outweighs the benefit of prone or lateral sleep position on GER [gastroesophageal reflux]; therefore, in most infants from birth to 12 months of age, supine positioning during sleep is recommended (AAP 2016)."

Recommendations:

All agencies and partners should work to increase outreach to all caregivers, including fathers and grandparents, teen and young parents as well as, all physicians, nurses and health care professionals. Maintaining initiatives which include birthing hospitals, special care nurseries, pediatrician offices, local health departments and local child health organizations while also, utilizing and implementing innovative programs such as faith-based initiatives, First Responder initiatives and other partnerships are highly recommended to assist in ensuring that families will have many points of contact with consistent and accurate information. Behavior change is a process and the more times that a family has access to information the better the likelihood that positive behavior change will occur.

Any outreach "should specifically include strategies to increase breastfeeding while decreasing bed-sharing, and eliminating tobacco smoke exposure. Recommendations should be introduced before pregnancy and ideally in secondary school curricula to both males and females and incorporated into courses developed to train teenaged and adult babysitters. The importance of maternal preconception health, infant breastfeeding, and the avoidance of substance use (including alcohol and smoking) should be included in this training" (AAP, 2016).

Link to the Technical Report:
http://pediatrics.aappublications.org/content/pediatrics/early/2016/10/20/peds.2016-2940.full.pdf

Link to the Policy Statement:
http://pediatrics.aappublications.org/content/pediatrics/early/2016/10/20/peds.2016-2938.full.pdf

Georgia leaders have come together to combat this issue by introducing the Georgia Safe to Sleep campaign, a statewide initiative designed to raise awareness about sleep-related infant deaths and evidence-based sleep practices.

Campaign Goals

The Georgia Safe to Sleep campaign will provide tools and resources that strengthen policy, provide consistent education and change infant sleep environments in an effort to achieve four primary objectives:

- Prevent infant sleep-related deaths in Georgia
- Empower professionals in multiple disciplines to educate parents about safe sleep environments and ensure they see proper sleeping practices modeled in hospitals
- Disseminate accurate and consistent messages that empower families to make informed decisions about infant sleep
- Increase access to resources that support behaviors that protect infants from sleep-related deaths

Statewide Partners

This campaign brings together the expertise of state agencies, associations and local organizations working together to extend the reach of this initiative including:

- Georgia Children's Cabinet under the leadership of First Lady Sandra Deal
- Georgia Department of Public Health
- Georgia Hospital Association
- Georgia Chapter of the American Academy of Pediatrics
- Georgia Bureau of Investigation
- Georgia Obstetrical and Gynecological Society
- Georgia Connection Partnership
- Voices for Georgia's Children
- Safe Kids Georgia

Promoting Safe Sleep for Every Sleep

The Georgia Safe to Sleep campaign is based on the evidence-based recommendations for safe sleep set forth by the American Academy of Pediatrics, commonly referred to as the ABCs of safe sleep:

- Alone – Babies should sleep alone in their own sleep space, close to but separate from their caregiver. Parents and caregivers are encouraged to share a room with the baby, but avoid sleeping in the same bed with the infant.
- Back – Babies should be placed on their back to sleep. Studies show that placing infants on their back for all sleep times, including naps and at night, reduces the risk of SIDS.
- Crib – Babies should sleep in a crib or bassinet that meets standards set forth by the Consumer Products Safety Commission. The mattress should be firm and covered with a tight-fitting bottom sheet made specifically for the crib. No blankets, quilts, crib bumpers, toys or any objects should be in baby's sleeping space.

Hospital-Based Safe to Sleep Program

Aligning with the campaign's goal to ensure parents see safe sleep practices modeled in hospitals, the Georgia Safe to Sleep campaign established a Hospital-Based Safe to Sleep program for Georgia's birthing centers.

Participating hospitals pledge to educate new parents and caregivers on proper infant sleeping practices. They were also provided with several resources to support new parents such as a one-year supply of "This Side Up" infant gowns, board books and a supply of travel bassinets for our most at-risk families.

To learn more about the Georgia Safe to Sleep campaign or join the Hospital-Based Safe to Sleep program, visit www.georgiasafetosleep.org

MEDICAL DEATHS

Child Fatality Review definition of chronic illness or disability incorporates physical, mental and sensory aspects of health. This definition includes: learning disabilities, ADD or ADHD, depression, anxiety problems, autism, developmental delay, speech problems, asthma, diabetes, Tourette syndrome, epilepsy or seizure disorder, hearing problems, vision problems, bone or joint problems and brain injury or concussion (National Survey of Children's Health).

Medical deaths are reviewed by the Child Fatality Review committees if the death was unexpected, suspicious or unusual, unattended by a physician, or unexplained. Deaths that occur while in hospice care are considered to be "expected" and are not reviewable by Child Fatality Review committees. Medical deaths could also be reviewed if the child had a terminal illness but died sooner than expected, or under suspicious circumstances. CFR committees reviewed 82 medical deaths to children under 18 years in 2015.

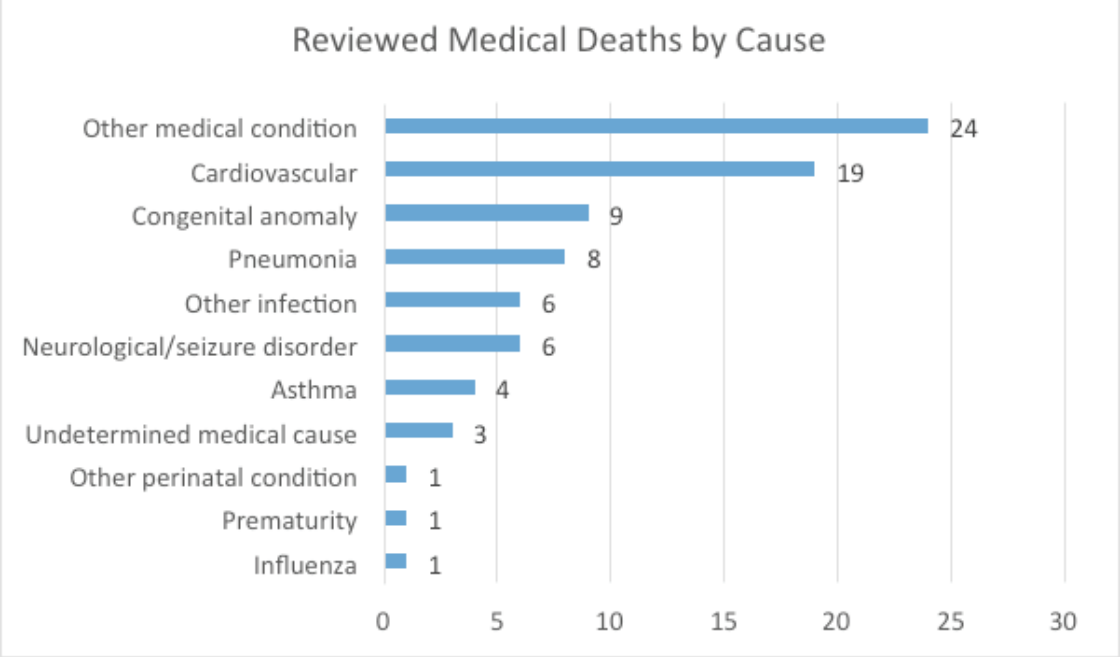
Figure 18: Demographics of Reviewed Medical Deaths, GA, 2015 (N=82)

	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Totals
White Male	2	1	3	2	4	12
White Female	5	1	0	2	0	8
African-American Male	4	11	2	4	3	24
African-American Female	5	7	1	5	5	23
Hispanic Male	1	2	1	1	2	7
Hispanic Female	1	3	0	0	1	5
Multi-Race Female	0	1	0	0	0	1
Other Race Male	0	2	0	0	0	2
Totals	18	28	7	14	15	82

- Of the 82 reviewed medical deaths, 56% were under age five
- For the children under age 5, medical conditions included cardiovascular, pneumonia, and other conditions
- African-American children accounted for 57% of all medical deaths compared to all others races and ethnicities

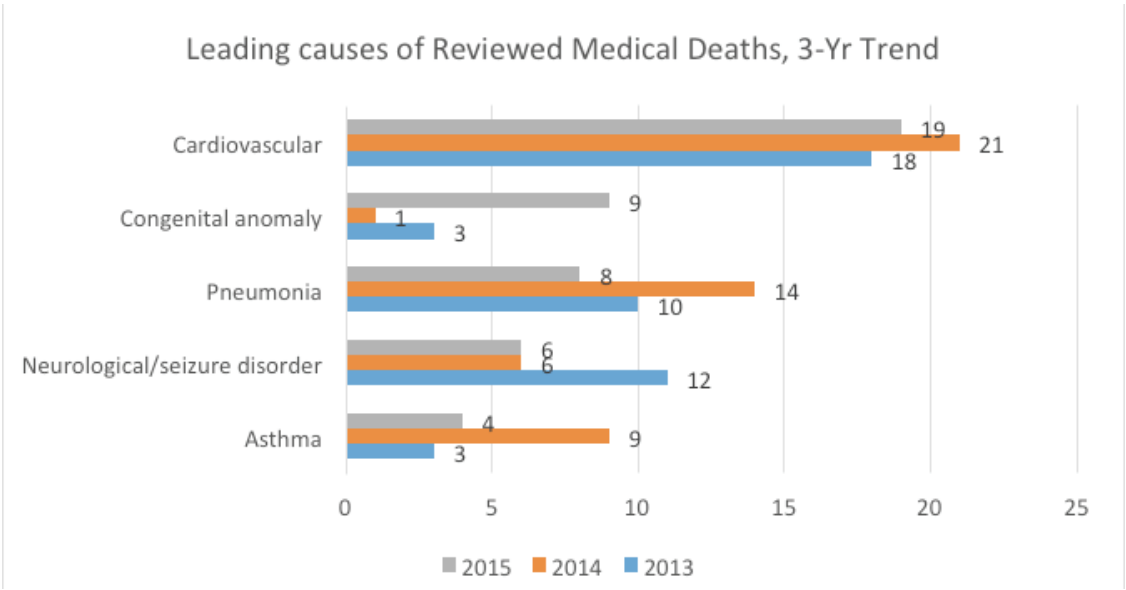
CFR committees reported that 30 cases had one or more caregivers receiving social services at time of death which includes services such as TANF, WIC, food stamps, or Medicaid. Forty-four of the decedents were receiving healthcare, with six listed as being non-compliant with medical plan (e.g., not following physician's prescribed medial instructions). CFR committees determined 17% of the medical deaths were preventable. The information regarding the number of decedents who were receiving social services can help with prevention efforts by working with the entire healthcare team to ensure caregivers understand the medical conditions and the importance of following care plans.

Figure 19 : Leading Causes of Reviewed Medical Deaths in Georgia, 2015 (N=82)



- Sixty-three percent of medical deaths were identified as having a chronic condition or disability
- Twenty-four deaths were categorized as other medial and include conditions such as: sickle cell, non-trauma anoxic brain injury, respiratory, complications from surgery, herpes encephalopathy, distress and multiple combined medical conditions

Figure 20: Leading Causes of Reviewed Medical Deaths, 3-Year Trend



- Neurological/seizure disorder related deaths increased in 2015
- Cardiovascular related deaths continue to be the second highest cause of death in this category with

UNINTENTIONAL REVIEWED DEATHS

Unintentional injury-related deaths remain a leading cause of death for children ages 1 to 17 years in Georgia and nationwide. This summary provides information on all causes of unintentional deaths but also outlines the two leading causes of death in order to assist with prevention efforts currently in place. CFR committees felt that 89% of these deaths could have been prevented. CFR committees also determined that six of the deaths were caused by poor supervision; it contributed to an additional 38 deaths; and five more deaths had "No, but needed" for the supervision question. Unintentional injury deaths make up 31% of all reviewed deaths, and of all reviewed deaths, they are the leading cause of death for all children ages 1 to 17 years. Unintentional injuries accounted for 24% of all deaths where maltreatment was identified as a contributing factor to the child's death.

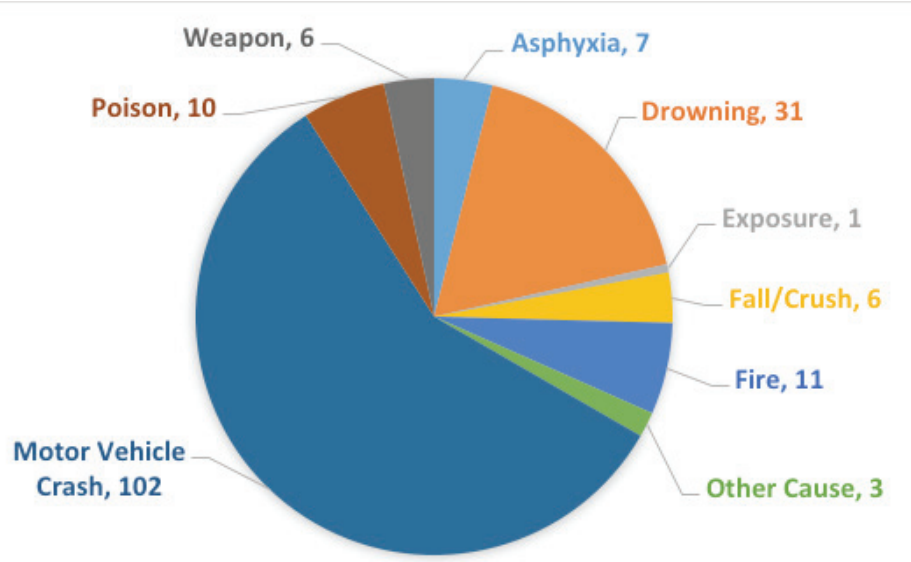
Figure 21: Demographics, All Reviewed Unintentional Injury-Related Deaths, GA (N = 177)

	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Totals
White Male	1	15	4	15	22	57
White Female	1	11	3	2	13	30
African-American Male	1	13	12	7	16	49
African-American Female	2	6	8	2	2	20
Hispanic Male	0	4	2	1	8	15
Hispanic Female	0	0	0	0	1	1
Multi-Race Male	0	0	0	0	1	1
Other Race Female	0	0	1	0	3	4
Totals	5	49	30	27	66	177

- Seventy percent of unintentional injury deaths occur in males
- Thirty-seven percent of these deaths occurred in the 15 to 17-year age group

Figure 22: Reviewed Unintentional Injury Deaths, by Cause, all ages, 2015 (N=177)

- Motor vehicle-related crashes continue to be the leading cause of unintentional injury-related death
- Drowning is the second leading cause



POISON

There were 10 unintentional poison-related deaths in 2015. Sixty-percent of these were directly attributed to accidental overdose of a prescription medication. Regarding prescription medication and overdosing, there were four youth ages 15 to 17 years who were using prescription medications and died. Children of all ages had a variety of issues surrounding medication usage that were related to their death (e.g., allergy, Fentanyl & Oxycodone accessibility). Fifty percent of poisoning deaths revealed lack of supervision and there were two toddler deaths who accidentally ingested medication from adults.

FIRE

Fire-related deaths include those attributed to fires, burns and electrocutions. In 2015, CFR committees reviewed 11 fire-related deaths. Of these 11, 64% occurred in children ages 10 to 14 years of age and causes were related to electrocution and residential fires. Six of the fire-related death cases had a history of maltreatment, including neglect or abuse in 3 cases.

ASPHYXIA

There were seven asphyxia-related deaths to children with 5 occurring in the 1 to 4-year population. Of these, the cause of asphyxia was widespread from choking on toys to having an object tangled around the neck. Three asphyxia deaths had reported maltreatment (abuse or neglect) identified.

FIREARM

In specific regards to unintentional firearms, there were three toddlers and one aged 5 to 9 years who found guns in the home or vehicle. Two deaths between 10-17 years were reported as playing around with the gun with a friend at time of discharge.

MOTOR VEHICLE RELATED DEATHS

In the United States, injuries from motor vehicle crashes far exceed those who die from them and the economic impact is significant. Both deaths and injuries to children in motor vehicle related crashes are preventable. There are multiple layers of prevention specifically targeted to all children in order to ensure they are safe in vehicles, whether as passengers or drivers. In Georgia, preventive measures have been in place for a long time and despite having child safety seat inspection stations, statewide educational campaigns for child safety seats and general seatbelt safety, as well as a multi-faceted teen driving law, motor vehicle crashes remain the leading cause of death for ages 1 to 17.

MVC related crashes continue to plague the state of Georgia. While a statewide initiative called 'Toward Zero Deaths' encourages an overall reduction of deaths for all ages by recommending zero deaths and injuries due to motor vehicle crashes. More than 50% of these deaths in GA are attributed to no restraint use. For purposes of this report, motor vehicle related deaths include all vehicles, including off road/all-terrain (e.g., four wheelers), bicycles, and pedestrians.

In 2015, MVC-related deaths were the leading cause of unintentional injury-related deaths and they accounted for more than half (58%) of 177 reviewed unintentional injury-related deaths in Georgia.

Figure 23 : Demographics of Reviewed Motor Vehicle-Related Deaths, GA, 2015 (N=102)

	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Totals
White Male	0	3	4	9	18	34
White Female	0	3	2	1	12	18
African-American Male	1	7	5	1	13	27
African-American Female	2	4	2	2	0	10
Hispanic Male	0	1	2	0	6	9
Multi-Race Male	0	0	0	0	1	1
Other Female	0	0	0	0	3	3
Totals	3	18	15	13	53	102

- Children ages 15 to 17 accounted for 52% of all reviewed MVC deaths
- Males comprised 70% of all reviewed MVC deaths
- In the 15 to 17-year age group, males die 2.5 times more than females
- White males and females accounted for more deaths than other races (51%)

Figure 24: Reviewed Motor Vehicle-Related Deaths by Position of Decedent, GA, 2015 (N=102)

- The "driver" category involves standard vehicles (cars, SUVs, trucks), motorcycles, and ATVs
- Of the 29 drivers who died in a car, truck, SUV or van, 79% were ages 16 or 17 years of age
- Fifty-three percent of pedestrian deaths were found in the 15 to 17-year age group

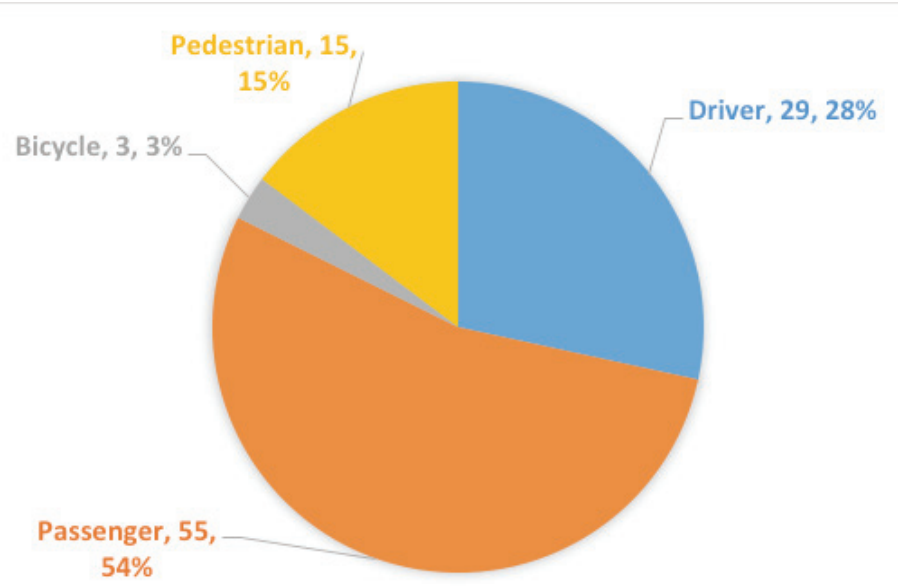
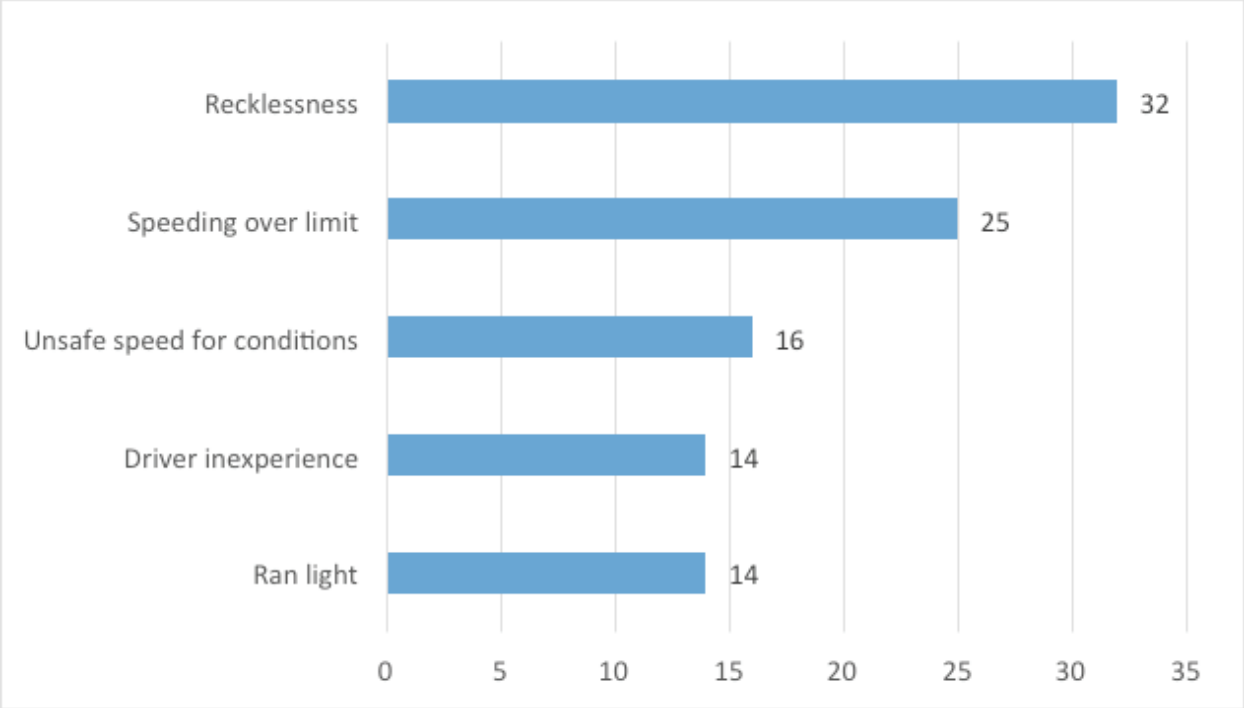


Figure 25: Reviewed Motor Vehicle-Related Death Incident Causes, When Known, GA, 2015



**Note that some deaths have multiple causes identified e.g. one death was attributed to recklessness, driver inexperience and speed

- The most frequently cited causes for reviewed motor-vehicle related deaths were recklessness, speed, and drugs/alcohol. This chart refers to all vehicle operators, not only those where the decedent was operating the vehicle

DROWNING DEATHS

Drowning continues to be a concern for all partners involved in family outreach, public health programming and death/injury prevention initiatives and continues to be the second leading cause of unintentional injury-related death every year. Without increased public awareness to address this problem, Georgia will continue to report these numbers and struggle with the questions of why children drown.

Nationally, there is documented evidence of prevention for drowning in children; especially toddlers ages 1 to 4 years (e.g., rescue equipment, fences and locked gates around pools, active supervision, and personal flotation devices or lifejackets). Prevention interventions incorporate behavior change with responsibility for all caregivers and those in charge of supervision. Caregivers and supervisors of children must be observant, aware, and present at all times, especially when children are young. The following information is presented to assist the reader with designing awareness & marketing strategies geared to prevent future drownings or to provide information to help save children from drowning.

In 2015, CFR committees reviewed 31 drowning deaths. Of these 31 children, the majority of deaths included 18 toddlers (58%) ages 1 to 4 years, and seven children between 10 to 17 years of age.

Figure 26: Demographics of Reviewed Drowning Deaths, GA, 2015 (N=31)

	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total
White Male	0	8	0	0	1	9
White Female	1	6	0	0	1	8
African-American Male	0	3	4	2	2	11
African-American Female	0	0	1	0	0	1
Hispanic Male	0	1	0	1	0	2
Total	0	18	5	3	4	31

- While there is no distinct racial disparity noted among drownings, 70% of drownings occur in males

CFR committees reported that 100% of all children ages 1 to 4 years who died from drowning were either not supervised or poorly supervised at time of death. Additionally, death investigations revealed that 65% of all drowning death cases listed the supervisors as being impaired. Some of these drownings occurred by a young child wandering away from a home or gathering. A supervisor impairment was described as follows:

Figure 27: Supervisor Impairment at time of Child's Death

- Many times parents or caregivers were engaged in other distracting activities such as caring for multiple children, talking on phone, reading, or socializing with others

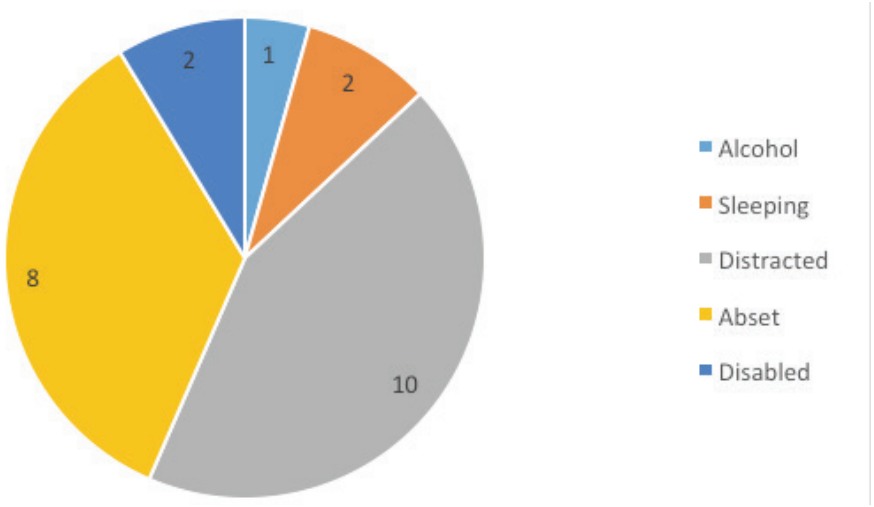
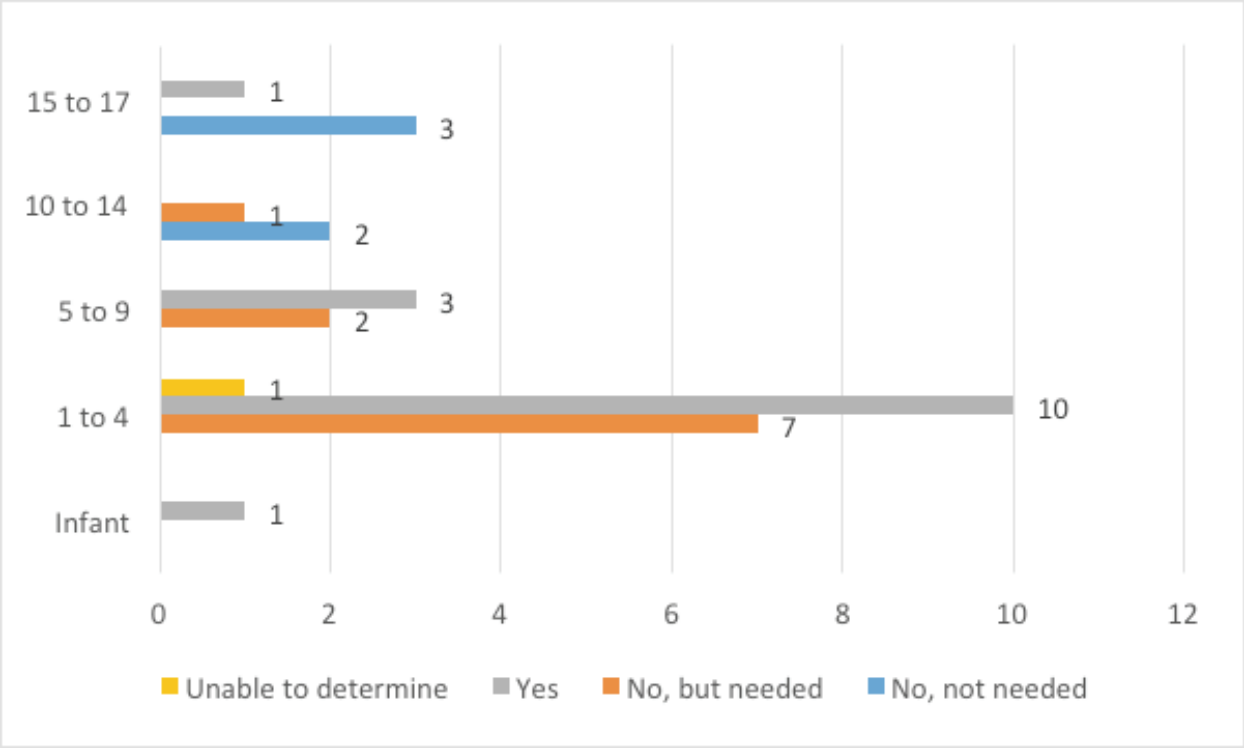
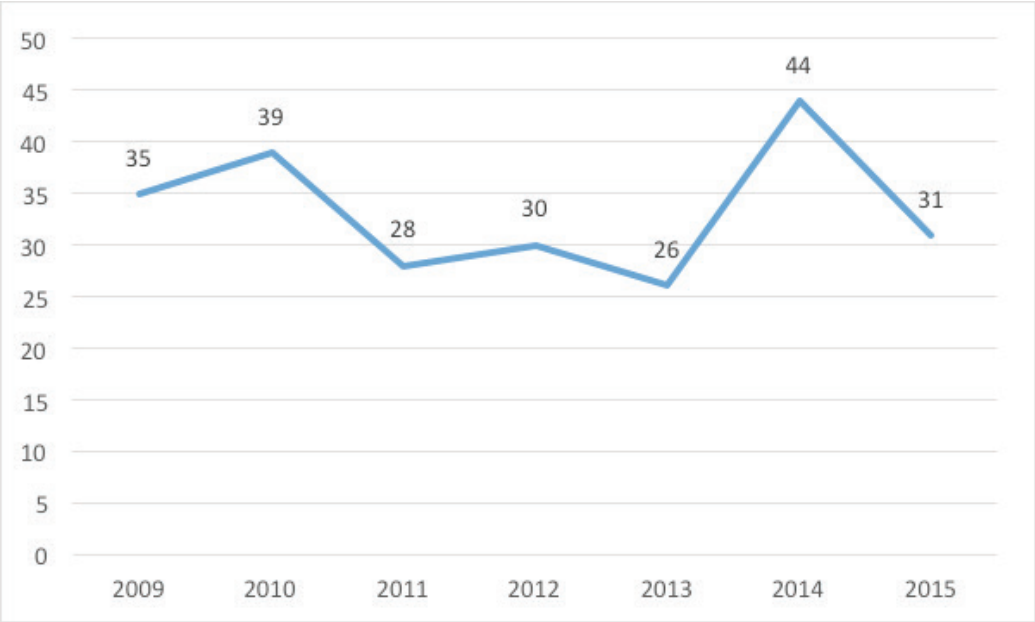


Figure 28: Adequacy of Supervision, Drowning Deaths, GA 2015



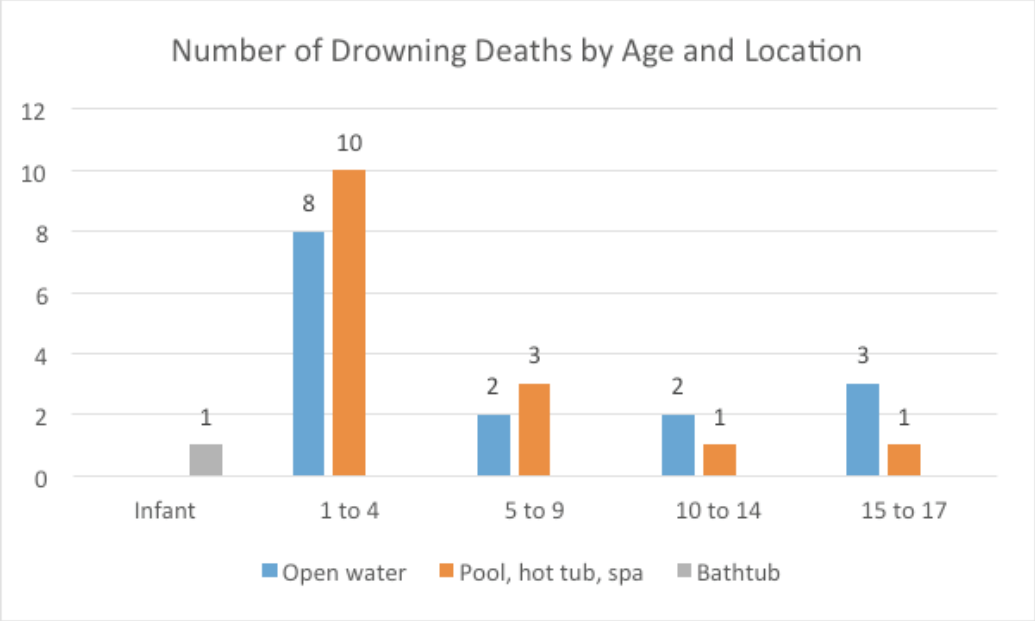
Active supervision is a critical component of ensuring children are safe at home and at play. Based on the CFR committee reports, some specific details at the time of death revealed caregivers were taking naps, distracted, or at gatherings where young children disappeared and drowned. Important to also note is that for toddlers who drowned, seven died in non-summer months, which reinforces the importance of supervision at all times. For children ages 5 to 14 years of age, they were swimming unsupervised at their time of death.

Figure 29: Reviewed Drowning Deaths by Year



- Every year in Georgia, drowning remains a leading cause of unintentional injury-related deaths
- Drowning deaths are sporadic when compared from 2013 to 2015, with a decrease of 30 percent in 2015

Figure 30 : Reviewed Drowning Deaths by Age and Location, GA, 2015 (N=31)



*Open water includes oceans, rivers, lakes and ponds

- Eight toddlers died in open water such as ponds and lakes without supervision
- All toddlers who died in pools were not actively supervised
- For the 15 to 17-year age group, there were a variety of situations that contributed to the death (e.g., ocean, river crossing, pool)
- Several of the drowning cases involving a pool indicated that gates and locks were broken

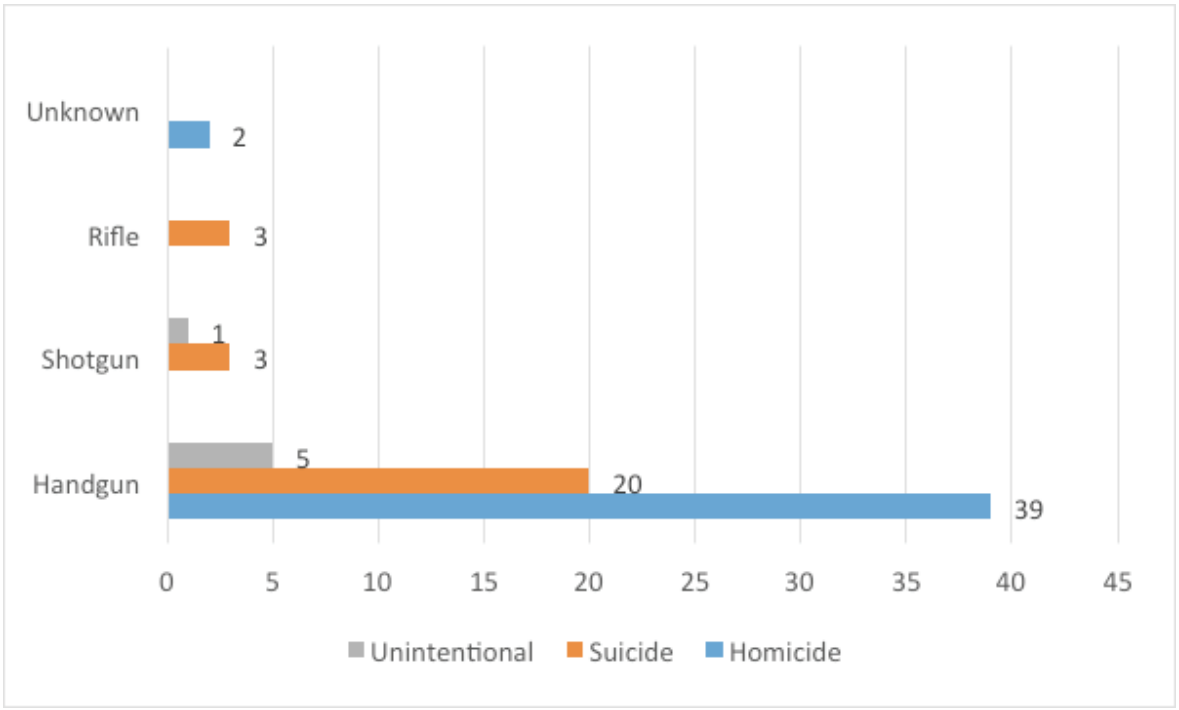
FIREARMS

In 2015, GA CFR committees reviewed a total of 73 firearm deaths. Of these, there were 41 homicides, 26 suicides, and six unintentional shootings.

Figure 31: Demographics of All Reviewed Firearm-Related Deaths, GA 2015 (N=73)

Homicide	1 to 4	5 to 9	10 to 14	15 to 17	Total
White Male	1	3	1	3	8
White Female	0	0	1	0	1
African-American Male	1	2	2	19	24
African-American Female	0	2	1	3	6
Other Male	0	0	0	1	1
Other Female	0	0	0	1	1
Total	2	7	5	27	41
Suicide	**1 to 4**	**5 to 9**	**10 to 14**	**15 to 17**	**Total**
White Male	0	0	4	10	14
White Female	0	0	1	4	5
African-American Male	0	0	1	5	6
African-American Female	0	0	0	1	1
Total	0	0	6	20	26
Unintentional Firearm	**1 to 4**	**5 to 9**	**10 to 14**	**15 to 17**	**Total**
White Male	2	0	1	1	4
White Female	0	0	0	0	0
African-American Male	1	0	0	0	1
African-American Female	0	1	0	0	1
Total	3	1	1	1	6

Figure 32: Type of Firearm Used, All Reviewed Deaths, GA, 2015



Of all firearms used, 16 were not stored away and most common storage places included nightstands, unlocked drawers, closet shelves, and under the mattress. In regards to unintentional firearms, some of the children who died found guns in the home or vehicle. Two deaths between 10-17 years were reported as playing around with the gun with a friend at time of discharge.

HOMICIDE

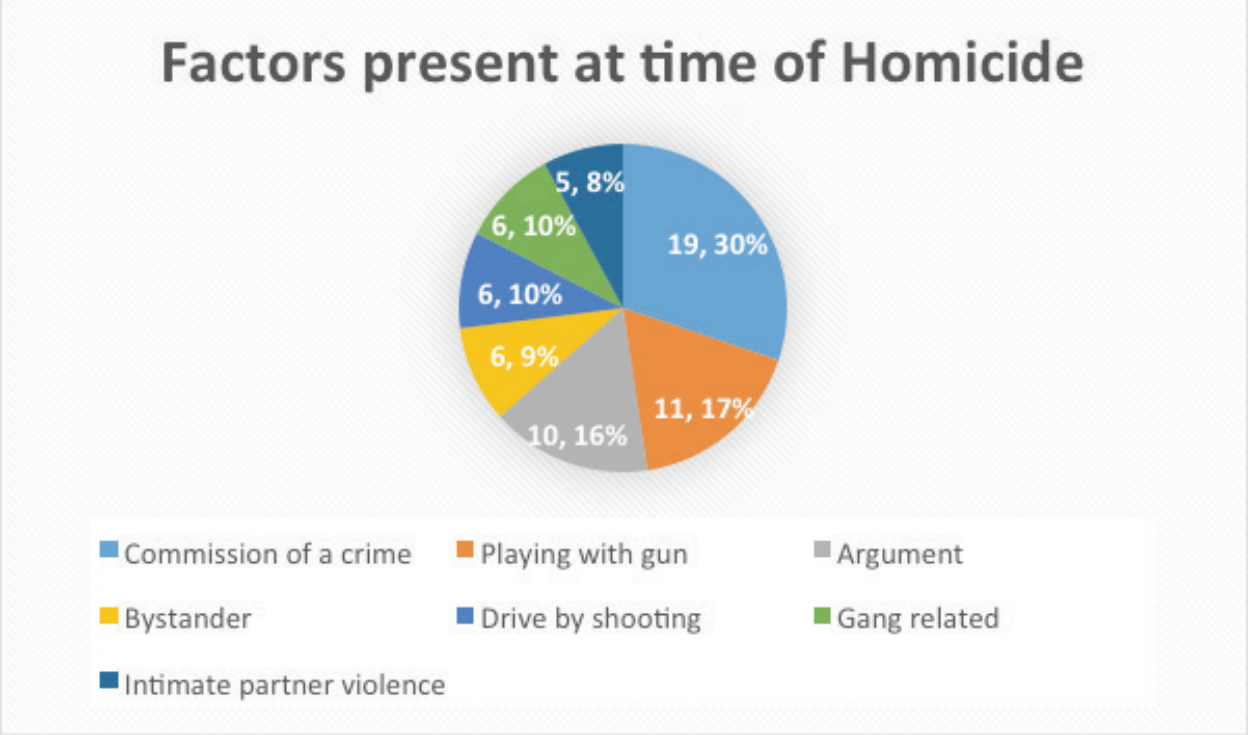
Every year in Georgia, children die due to acts of intended violence. Homicide is the third leading cause of death for children ages 1 to 17 years and is the leading cause of death for African-American teenagers 15 to 17 years in GA, based on CFR reports. In 2015, CFR committees reviewed 73 child deaths from homicides in Georgia. In 2014, there were 47 homicides reviewed. Of the 73 homicides, 28 cases had maltreatment identified and of those, 27 had maltreatment as a direct cause, only one was listed as a contributing factor. Six homicides were identified as having an open child protective services case and a history of maltreatment at the time of death. Of those, the ages varied: two were 15 to 17 years, two were 1 to 4 years, and two were infants (under age 1).

Figure 33: Demographics of Reviewed Homicide Deaths, GA, 2015 (N=73)

Homicide	1 to 4	5 to 9	10 to 14	15 to 17	Totals
White Male	1	3	1	3	8
White Female	0	0	1	0	1
African-American Male	1	2	2	19	24
African-American Female	0	2	1	3	6
Other Male	0	0	0	1	1
Other Female	0	0	0	1	1
Totals	2	7	5	27	41
Suicide	**1 to 4**	**5 to 9**	**10 to 14**	**15 to 17**	**Totals**
White Male	0	0	4	10	14
White Female	0	0	1	4	5
African-American Male	0	0	1	5	6
African-American Female	0	0	0	1	1
Totals	0	0	6	20	26
Unintentional Firearm	**1 to 4**	**5 to 9**	**10 to 14**	**15 to 17**	**Totals**
White Male	2	0	1	1	4
White Female	0	0	0	0	0
African-American Male	1	0	0	0	1
African-American Female	0	1	0	0	1
Totals	3	1	1	1	6

- Seventy percent of homicide victims were male. Of the 51 male victims, 73% were African-American (AA males comprise 51% of all reviewed homicide deaths)

Figure 34: Contributing Factors Present at Time of Homicide Death, GA, 2015

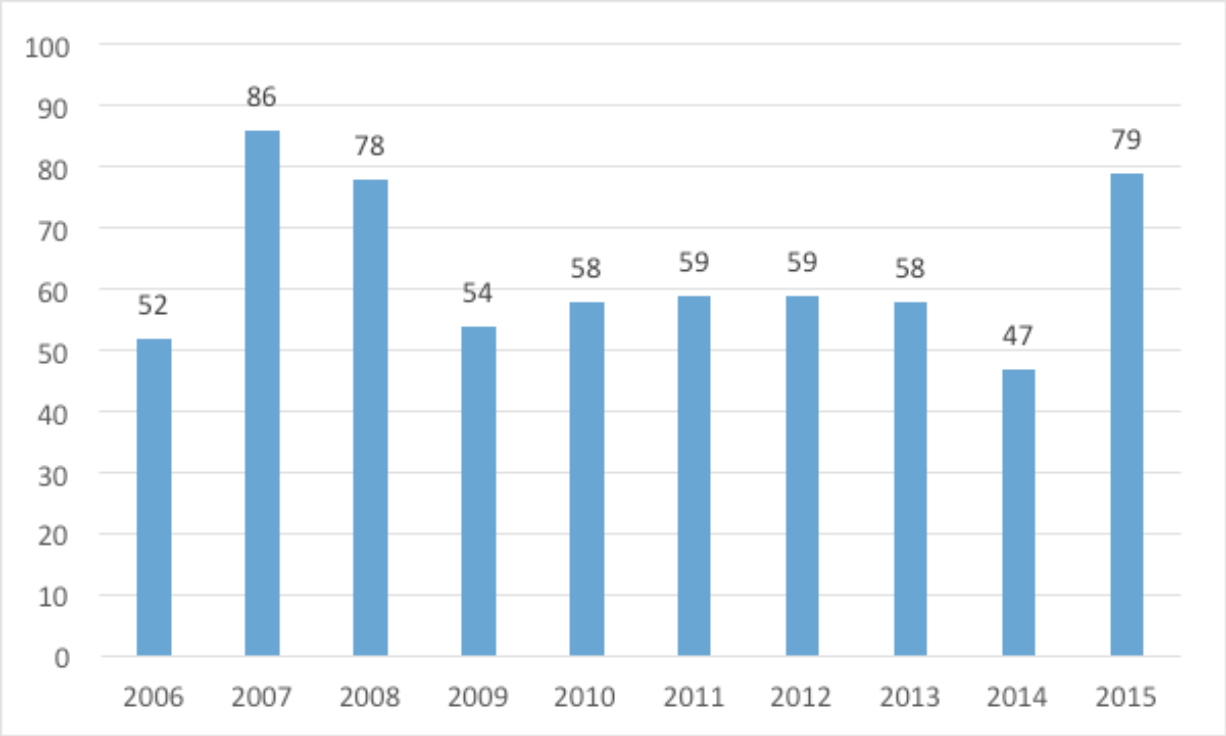


CFR committees are able to provide contributing factors in child deaths and for use of a weapon, the categories can provide great details and committees can select multiple factors for one case.

The Georgia Youth Risk Behavior Survey (YRBS) revealed the following information from 2013:

- Twelve-percent of high school students had experienced violence by a boyfriend or girlfriend
- Eighteen-percent reported carrying a weapon of some sort to school, while 7.8% specifically reported carrying a gun
- Twenty-one percent reported being in a physical fight in the last 12 months

Figure 35: Comparison of Homicides by Year, GA, 2006-2015 (GA OASIS)



- Homicide rates have remained steady for the past four years, until 2015

Figure 36: Ten-Year Homicide Rate (per 100,000), by Age

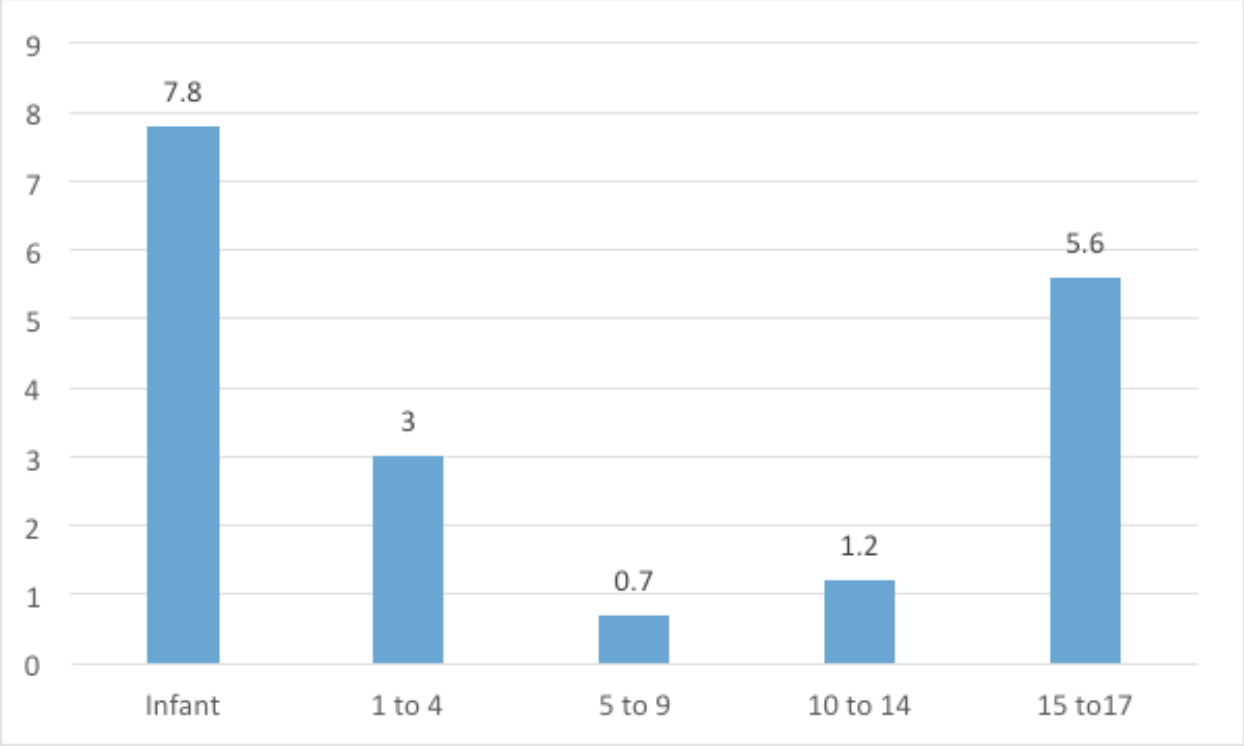
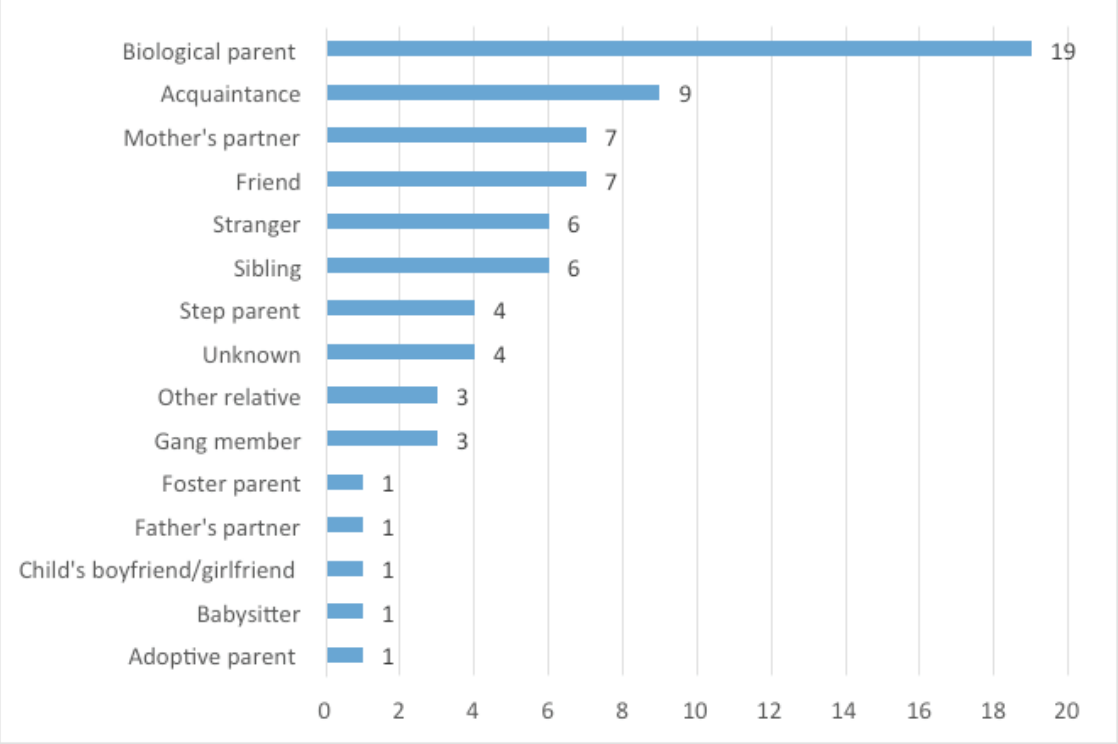
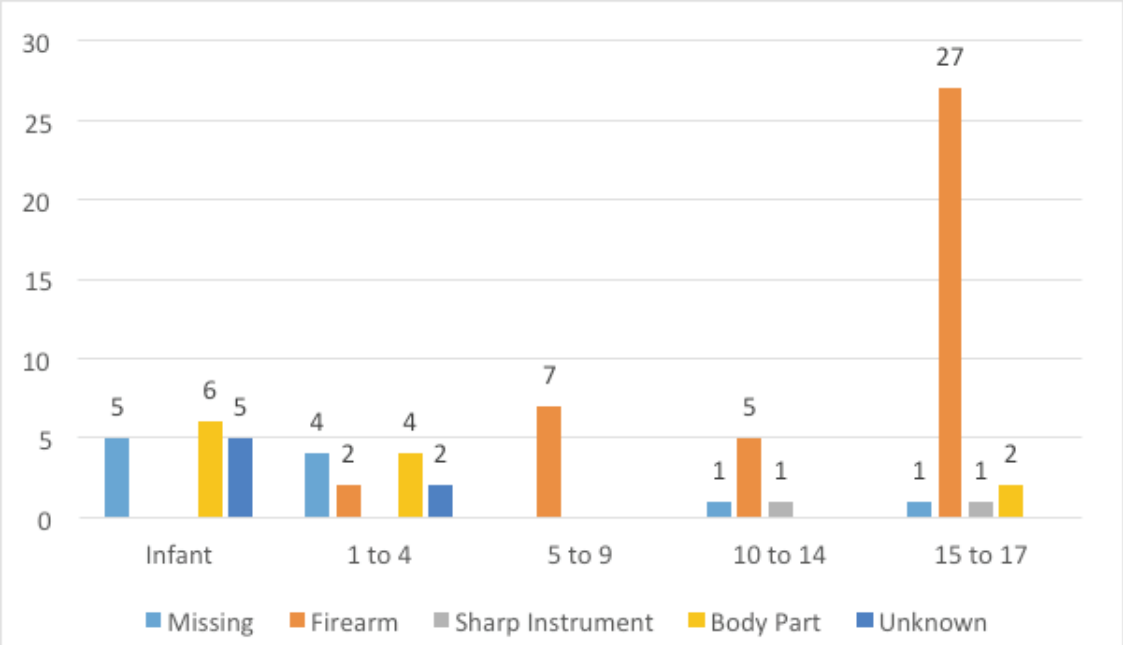


Figure 37: Homicide Perpetrators, GA, 2015 (N=73)



- 27 of the youth ages 15 to 17 years were killed by a firearm, with 12 of the perpetrators being an acquaintance or friend
- Twenty percent of homicides revealed some form of substance abuse was a direct cause of the act/homicide

Figure 38: Mechanism of Homicide Deaths, by age, 2015



- Firearms accounted for 75% of the weapons used, when the weapons were known

SUICIDE

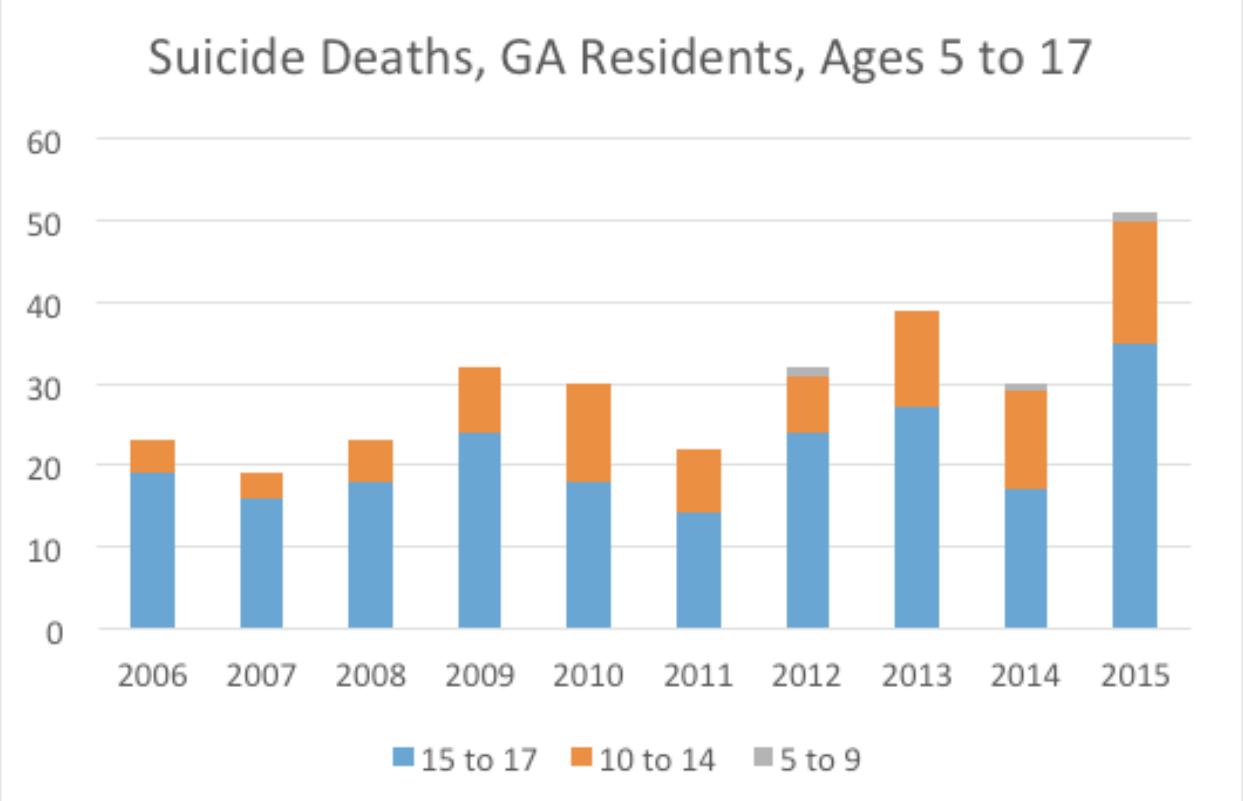
Youth suicides in Georgia have reached an all-time high with an alarming 50 suicides being reported by CFR committees in 2015. In 2013, there were 40 and in 2014, there were 28 suicide deaths. Even more significant, suicide is the second leading cause of death for Georgia's youth ages 15 to 17 years.

Figure 39: Demographics of Reviewed Suicide Deaths, GA, 2015 (N=50)

	5 to 9	10 to 14	15 to 17	Total
White Male	0	5	14	19
White Female	0	5	9	14
African-American Male	1	2	7	10
African-American Female	0	1	3	4
Hispanic Male	0	1	0	1
Hispanic Female	0	0	1	1
Other Female	0	0	1	1
Total	1	14	35	50

- White males and females committed more than half of the suicides in 2015

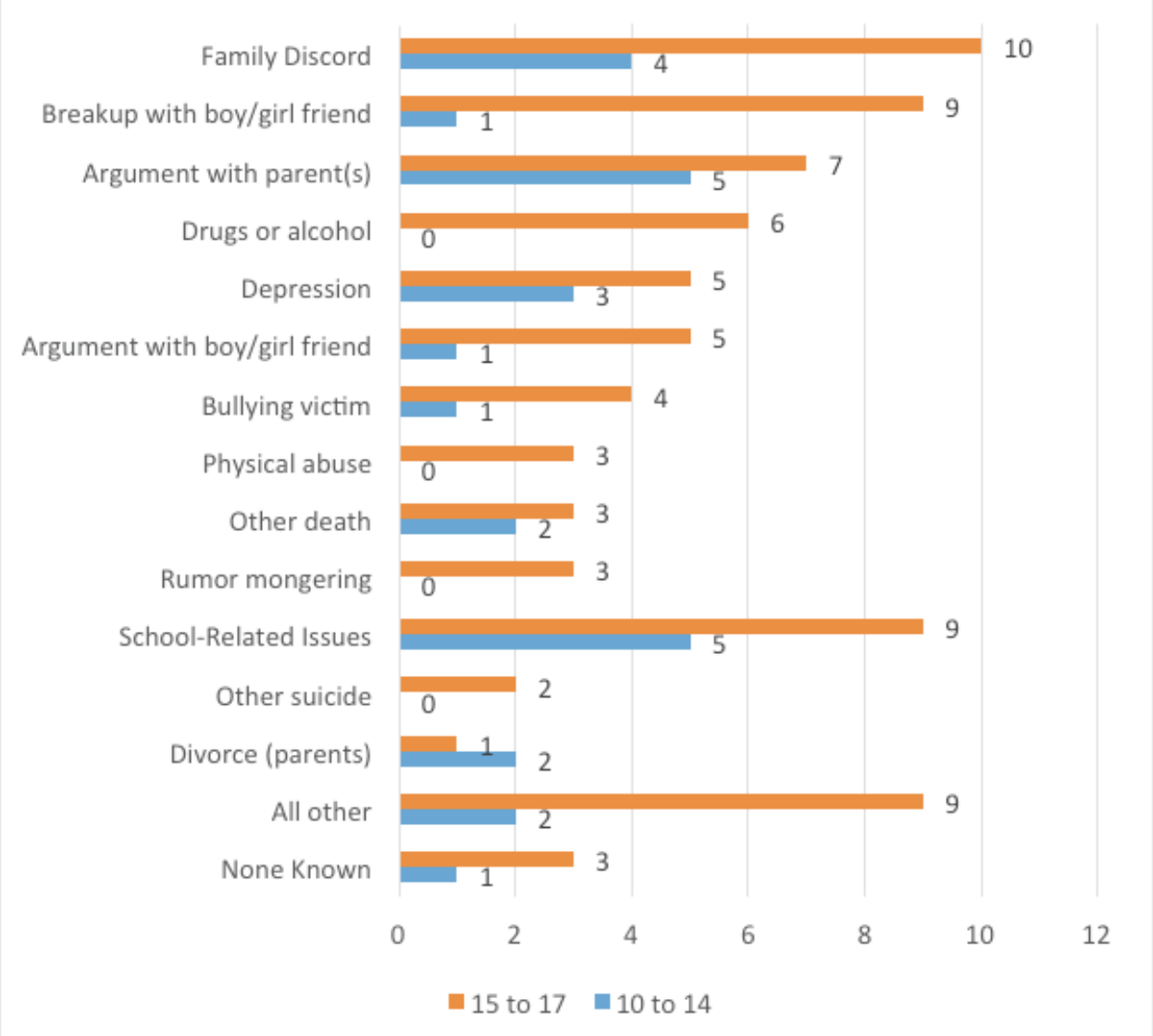
Figure 40: Suicide Death Trends, 2006-2015, GA (GA OASIS)



- In 2015, GA saw the highest number of youth suicides in the past ten years

The CFR Committees identified several factors present in these victims lives, including prior state agency involvement, history of mental illness, and issues with family and school. The following table provides some cross tabulations in regards to prior agency involvement and the child suicide deaths. The purpose of providing this information is for the reader to make some determinations regarding the possible connections where some lives might be saved in the future.

Figure 41: Reported Risk Factors for Reviewed Suicide Deaths, GA, 2015



*Note that in several cases, CFR committees have identified multiple risk factors for a child

- The other category included 8 child deaths where depression was cited as a contributing factor. Five of these were ages 15 to 17 years
- Arguments with family, family discord were the most commonly cited risk factors in the 15 to 17-year age group

Figure 42: Suicide Deaths with Prior Agency Involvement

Suicide Deaths and Prior Agency Involvement	5to9	10to14	15to17	Missing or Unknown
Prior Mental Health	1	4	15	9
Current Mental Health Services	0	2	8	13
Delinquent or Criminal History	0	3	5	6
Time in Juvenile Detention	0	1	3	6

- The ten victims who were currently receiving mental health services, also had prior agency involvement as well
- Two suicide victims had an open CPS case and history of maltreatment at time of death

The 2013 Georgia Youth Risk Behavior Survey (YRBS) revealed the following information from 2013: (2014 or 2015 YRBS data not available at time of this report)

Middle School

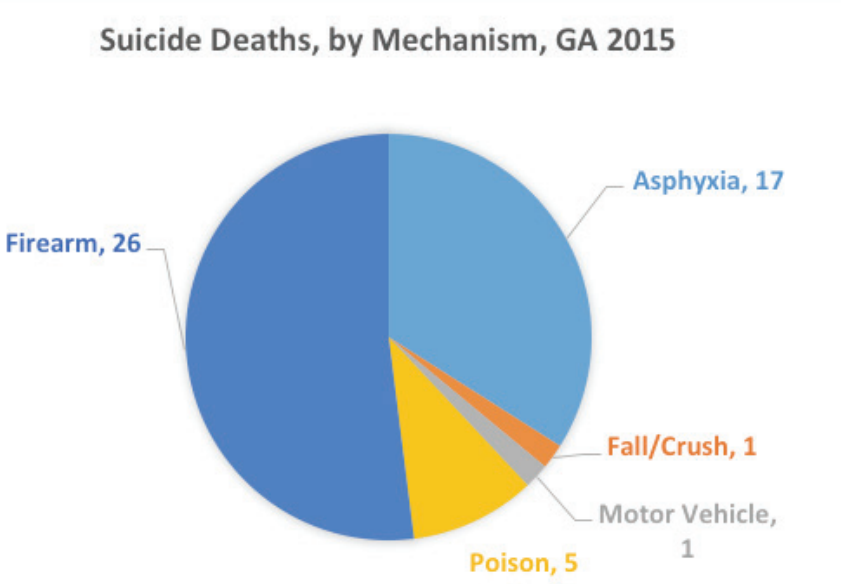
- Eighteen-percent had seriously thought about killing themselves in the past 12 months
- Eight percent had attempted suicide

High School

- Fourteen-percent had seriously thought about killing themselves in the past 12 months
- Nine-percent had attempted suicide
- Twenty-eight percent felt so sad or hopeless

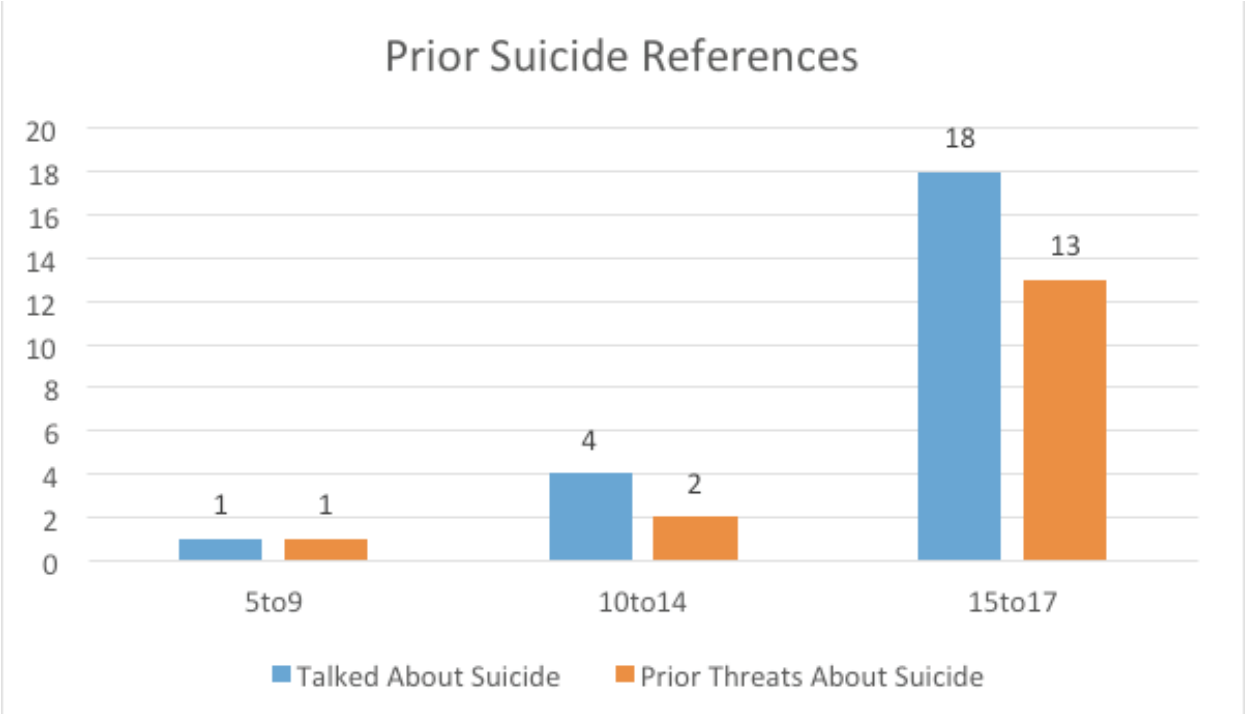
Figure 43: Mechanism of Injury in Reviewed Suicide Deaths, GA, 2015 (N=50)

- Historically, the most frequent mechanisms for suicide in youth are from asphyxia or firearms (CDC)
- For the 10 to 14-year age group, asphyxia was the mechanism for seven cases, and weapon was the cause in six
- In the 15 to 17-year age group, weapons (firearms) accounted for 20 of the suicides



When reviewing other history in the child death investigations, the following information was revealed:

Figure 44: Prior Suicide References, GA, 2015



- When this data variable was known, more than half of the victims had previously referenced suicide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OPPORTUNITIES FOR PREVENTION

- Georgia law specifies that all children under the age of one year must ride in a rear-facing seat in the back seat of the vehicle. Best practice recommendation from the American Academy of Pediatrics states that parents should "…keep their toddlers in rear-facing car seats until age two, or until they reach the maximum height and weight for their seat" (CDC)
- Children who have graduated from a rear-facing seat to a forward-facing seat with a harness should continue to use it until they reach the maximum height or weight limit of the seat, as a forward-facing seat with a harness is safer than a booster. They must remain seated in the back seat of the vehicle
- After outgrowing a forward-facing seat with a harness, a child may utilize a belt positioning booster seat and still must remain in the back seat. A booster seat should be used until a child until a child "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. If you are not sure if your child needs a booster seat, you can take the 5-step test developed by Safety Belt Safe U.S.A. at www.carseat.org
- Once a child transitions to a seat belt, the best practice recommendation from the AAP states that a child should remain in the back seat until at least 13 years of age
- According to the CDC, drunk driving accounted for 3,699 fatalities from 2003 to 2012 in Georgia and nationwide about one in three motor vehicle deaths involves a drunk a driver. Effective strategies used to curtail these activities in adult and young drivers are impaired driving laws, sobriety checkpoints, mass media campaigns, and school-based instructional programs
- Drivers are encouraged to minimize as many distractions as possible when on the road, as distracted driving has also become an issue for occupant safety. According to the CDC, "every day more than nine people are killed and more than 1,153 people are injured in crashes that are reported to involve a distracted driver." Using a cell phone, texting, and eating are all instances of distracted driving. Additional risk factors are driver age (younger, less experienced drivers are more at risk), state of impairment, and the type of distracting activity. Interventions such as media awareness campaigns and laws limiting or prohibiting the use of electronic devices while driving are being utilized to address this issue
- Drowning can happen quickly and silently. Therefore, active supervision of children in or around open water is critical. Children should never be left alone near open bodies of water such as bathtubs, spas, swimming pools, ponds, lakes, rivers or oceans. Additionally, it is extremely important to know the basics of swimming (floating and moving through the water) and how to perform Cardiopulmonary Resuscitation (CPR) while supervising children in or around open water
- When supervising toddlers, an adult should always be within arm's reach of the child. Active supervision of older children should be free of distractions such as telephone usage, socializing, tending to house chores, consuming alcohol or using drugs and any other activities that may cause distraction or impairment. Close supervision by a responsible adult is the best way to prevent drowning in children
- The U.S. Consumer Product Safety Commission program, Pool Safely, suggests a designated "Water Watcher". Water Watchers are important to have especially in water environments where there are large volumes of people such as parties. Oftentimes, the attendees are swimming, eating and laughing and it is assumed with there being so many adults present, there is someone supervising the children near and in the water. Water Watchers are designated to protect children from drowning and to keep children in sight at all times. Water Watchers should not be distracted and they should never leave a child alone in or near open water, even for a moment. The only time when a Water Watcher will leave the area is when there is another adult is available to replace them

- The National Drowning Prevention Alliance (NDPA) recommends the use of multiple strategies and layers of protection simultaneously to prevent child deaths from drowning. Strategies include learning to swim, learning CPR and rescue techniques and having an emergency action plan. Layers of protection include fencing, gates, safety covers and alarms helps to prevent access to open water areas when caregivers are not aware
- The Pool Safety program provides steps to keep children safe in and around water:
- Fences should be four sided and at least four feet high or taller. It should have no footholds or handholds that could help a young child climb in. Most chain link fencing is not suitable for pool fencing
- Gates should open out from the pool and should be self-closing and self-latching. The latch should be out of a child's reach
- Pools and spas should be kept covered when not in use. Lockable safety covers are a good option
- Safety covers should withstand the weight of two adults and a child to allow a rescue if an individual falls onto the cover. The pool cover should also be able to be easily and swiftly removed from the water to respond to emergencies
- Doors and pool and gate alarms should sound when there is unauthorized access or if something goes wrong around the pool
- With the implementation of HB 198, the state has demonstrated a strong community commitment to Georgia's children through suicide prevention. Piloting the goal of suicide safe schools, involvement is sought from teachers, administrators, students, support personnel, caregivers, and community volunteers. In conjunction with the Suicide Prevention Coordinator, school systems will develop model protocol and prevention trainings in their administration.
- It is also recommended that CFR committees have an annual review of the YRBS to target suicide prevention services in schools where suicidal ideation and/or attempts are known. CFR committees can also coordinate development of a protocol for intervention in schools where a suicide has occurred; this response protocol can be vital to prevention of additional attempts and suicides. Youth Mental Health First Aid Training is a potential resource raise awareness among agency professionals and families. Local Family Connections collaboratives can be a partner in developing a community plan for both prevention and intervention.
- Linking Education and Awareness of Depression and Suicide (LEADS) is a recognized evidence-based program in which educators implement a provided curriculum to students over three days, both inside and outside the classroom. The program addresses suicide warning signs and symptoms as well as provides prevention resources while promoting assistance-seeking behavior. Increased knowledge is gained and students feel empowered to address suicide issues for themselves and others
- By cultivating and maintaining multiple initiatives, suicide risks will decrease while positive behaviors increase. Furthermore, forming relationships with behavioral health providers as well as community resources will strengthen the collaboration in suicide prevention and awareness both for affected children and their families (CDC)
- By increasing support programs, parent education, affordable medical care, and public awareness of maltreatment, the community invests in children's' successful development
- Improving areas for children to play and providing supervised activities
- Programs that address community deterioration (e.g. alcohol abuse, gun safety, non-violence coping skills, and economic issues) can also help to prevent youth violence.

Resources

Centers for Disease Control and Prevention, Injury Prevention and Control (www.cdc.gov)

US Department of Transportation, Federal Highway Administration (www.fhwa.dot.gov)

National Highway Traffic Safety Administration (www.nhtsa.gov)

Georgia Department of Driver Services (www.dds.ga.gov)

Georgia Governor's Office of Highway Safety (www.gohs.state.ga.us)

American Red Cross (www.redcross.org)

Centers for Disease Control and Prevention (www.cdc.gov)

Children's Safety Network (www.childrensafetynetwork.org)

United States Consumer Product Safety Commission (www.cpsc.gov)

American Academy of Pediatrics (www.aap.org)

American Association of Suicidology (www.suicidology.org)

Centers for Disease Control and Prevention, Injury Prevention & Control: Division of Violence Prevention (www.cdc.gov/violenceprevention)

Georgia Department of Public Health, Youth Risk Behavior Surveillance System (www.dph.georgia.gov/YRBS)

Georgia General Assembly (www.legis.ga.gov)

The Jason Foundation (www.jasonfoundation.com)

Suicide Awareness Voices of Education (www.save.org)

Centers for Disease Control and Prevention, Injury Prevention & Control: Division of Violence Prevention (www.cdc.gov/violenceprevention)

Georgia Department of Public Health, Youth Risk Behavior Surveillance System (www.dph.georgia.gov/YRBS)

Georgia General Assembly Legislation (www.legis.ga.gov)

Prevent Child Abuse America (www.preventchildabuse.org)

Children's Safety Network (www.childrenssafetynetwork.org)

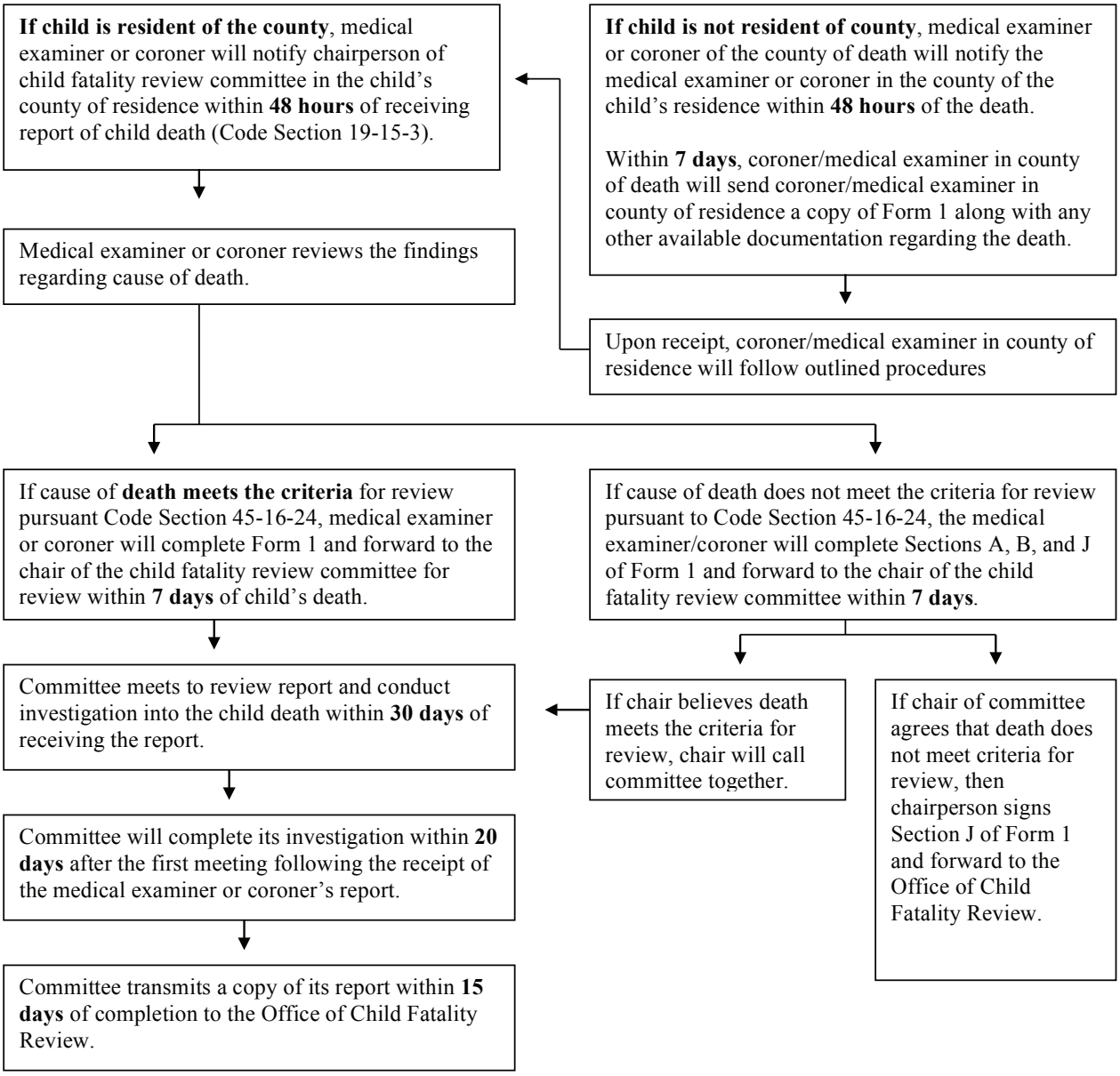
CDC: Whole School, Whole Childe, Whole Community:

https://www.cdc.gov/healthyyouth/wscc/index.htm

https://www.cdc.gov/violenceprevention/pdf/ssnrs-for-parents.pdf

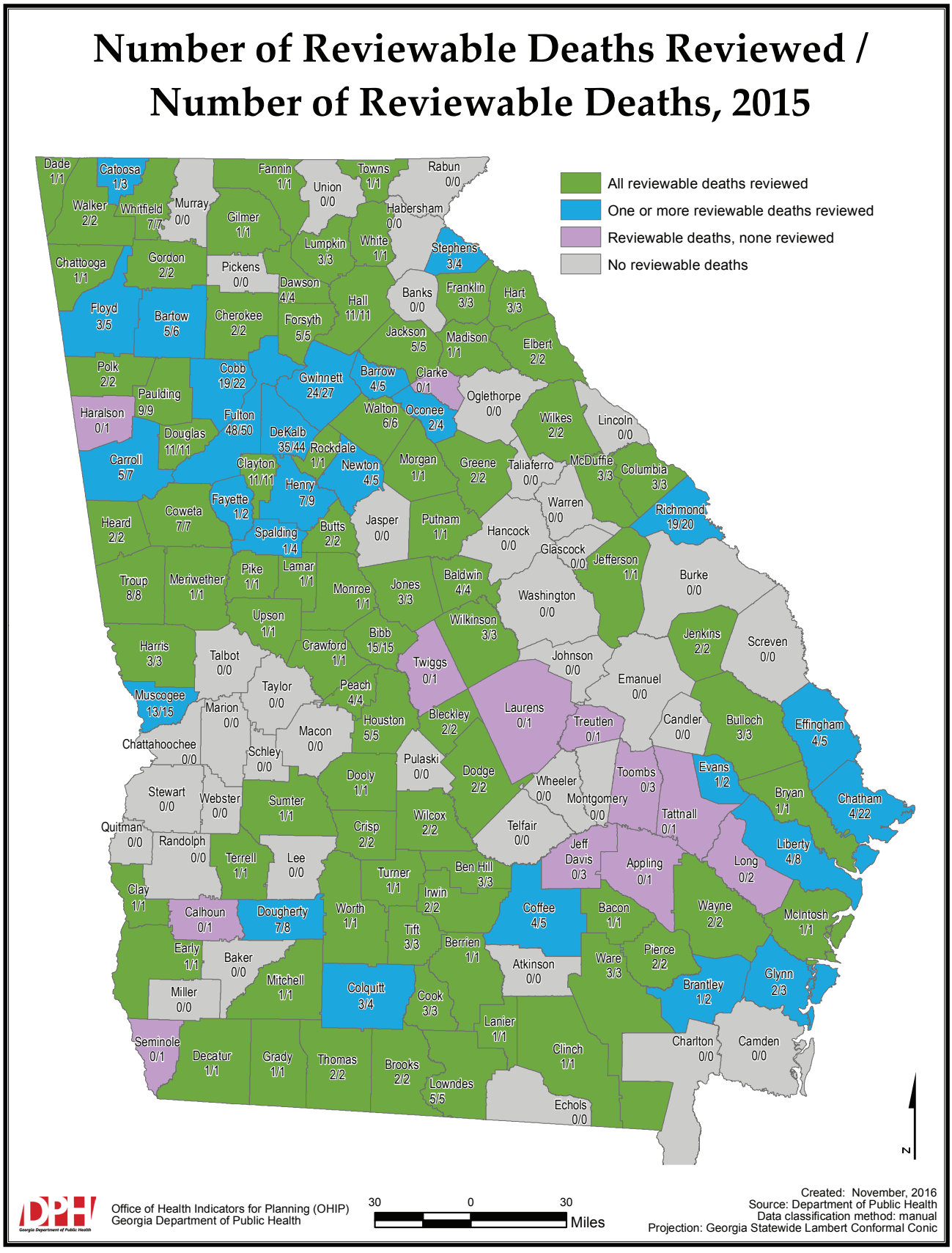
APPENDIX A

Child Fatality Review Committee Timeframes and Responsibilities



Send copy of the report within **15 days** to district attorney of the county in which the committee was created if the report concludes that the death was a result of: SIDS without confirmed autopsy report; accidental death when death could have been prevented through intervention or supervision; STD; medical cause which could have been prevented through intervention by agency involvement or by seeking medical treatment; suicide of a child under the custody of DHR or when suicide is suspicious; suspected or confirmed child abuse; trauma to the head or body; or homicide.

APPENDIX B - MAP – REVIEWABLE DEATHS REVIEWED



APPENDIX C - TABLE – REVIEWABLE DEATHS REVIEWED

** Note that there may be a difference in the numbers of cases deemed reviewable (see "All Reviewed" section of this Report for reviewability criteria) and the number of cases that were reviewed by each county committee

	All 2015 Deaths GA Residents, Age < 18 Years					Reviewable 2015 Deaths					Reviewable 2015 Deaths Reviewed				
County	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Infant	1 to 4	5 to 9	10 to 14	15 to 17
Appling	1		1			1									
Atkinson	1														
Bacon	1		1					1					1		
Baker	1														
Baldwin	6	1	1	1		2	1		1		2	1		1	
Banks	2														
Barrow	8			2	2	3				2	3				1
Bartow	18	1		2		4	1		1		3	1		1	
Ben Hill	5	1				2	1				2	1			
Berrien	1				1					1					1
Bibb	38	5	2	2	2	6	4	2	2	1	6	4	2	2	1
Bleckley	3				2					2					2
Brantley	2	1				1	1					1			
Brooks	1	2					2					2			
Bryan	1		1	2					1					1	
Bulloch	9	1			1	2				1	2				1
Burke	4				1										
Butts	2	1				1	1				1	1			
Calhoun	2	1				1									
Camden	1		1												
Candler	2				1										
Carroll	8	1	1	4	2	3			2	2	2			2	1
Catoosa	2	3	1		2	1	1			1					1
Charlton				1											
Chatham	37	10	6	4	7	8	5	2		7	2				2
Chattahoochee															
Chattooga	1				1	1					1				
Cherokee	9	3	2	2		1	1				1	1			
Clarke	8				1	1									
Clay			1					1					1		
Clayton	35	6	2	3	2	6	3	1		1	6	3	1		1
Clinch	6			1		1					1				
Cobb	66	5	5	7	9	10	2		2	8	8	2		2	7
Coffee	8		1	1	1	2		1	1	1	2		1	1	
Colquitt	4	2			3		1			3					3
Columbia	14	1		2	2	2				1	2				1
Cook		1			2		1			2		1			2

Category Codes

1 No reviewable deaths
2 Reviewable deaths, none reviewed
3 Some reviewable deaths reviewed
4 All reviewable deaths reviewed

	All 2015 Deaths Reviewed					County Totals					
County	Infant	1 to 4	5 to 9	10 to 14	15 to 17	All Deaths	Reviewable	Rvlb_Rvd	All Rvd	"Rvlb_RVD" / "Reviewable"	Categories
Appling						2	1	0	0	0/1	2
Atkinson						1	0	0	0	0/0	1
Bacon	1		1			2	1	1	2	1/1	4
Baker						1	0	0	0	0/0	1
Baldwin	2	1		1		9	4	4	4	4/4	4
Banks						2	0	0	0	0/0	1
Barrow	1				1	12	5	4	2	4/5	3
Bartow	3	1		1		21	6	5	5	5/6	3
Ben Hill	2	1				6	3	3	3	3/3	4
Berrien	1	1			1	2	1	1	3	1/1	4
Bibb	9	6	1	2	1	49	15	15	19	15/15	4
Bleckley					2	5	2	2	2	2/2	4
Brantley		1	1			3	2	1	2	1/2	3
Brooks		1				3	2	2	1	2/2	4
Bryan			1	1		4	1	1	2	1/1	4
Bulloch	2	2			1	11	3	3	5	3/3	4
Burke					1	5	0	0	1	0/0	1
Butts	1	1				3	2	2	2	2/2	4
Calhoun						3	1	0	0	0/1	2
Camden						2	0	0	0	0/0	1
Candler						3	0	0	0	0/0	1
Carroll	2			2	1	16	7	5	5	5/7	3
Catoosa					1	8	3	1	1	1/3	3
Charlton						1	0	0	0	0/0	1
Chatham	3	1		2	2	64	22	4	8	4/22	3
Chattahoochee						0	0	0	0	0/0	1
Chattooga	1				1	2	1	1	2	1/1	4
Cherokee	3	2				16	2	2	5	2/2	4
Clarke						9	1	0	0	0/1	2
Clay			1			1	1	1	1	1/1	4
Clayton	8	4	1		3	48	11	11	16	11/11	4
Clinch	1			1		7	1	1	2	1/1	4
Cobb	10	3	1	2	7	92	22	19	23	19/22	3
Coffee	2		1	1		11	5	4	4	4/5	3
Colquitt					2	9	4	3	2	3/4	3
Columbia	3	1			1	19	3	3	5	3/3	4
Cook		1		1	1	3	3	3	3	3/3	4

	All 2015 Deaths GA Residents, Age < 18 Years					Reviewable 2015 Deaths					Reviewable 2015 Deaths Reviewed				
County	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Infant	1 to 4	5 to 9	10 to 14	15 to 17
Coweta	8		2	2	2	4			1	2	4			1	2
Crawford			1					1					1		
Crisp	10	1		1		1			1		1			1	
Dade	2	1			1					1					1
Dawson				3	1				3	1				3	1
Decatur	2	1					1					1			
DeKalb	83	11	12	5	12	17	6	6	3	12	17	3	3	1	11
Dodge	3					2					2				
Dooly	3					1					1				
Dougherty	16	7		2	3	2	4			2	2	4			1
Douglas	18	3	4		2	4	2	3		2	4	2	3		2
Early	1		1					1					1		
Echols															
Effingham	11	1	1	1	3	1	1			3	1	1			2
Elbert	2					2					2				
Emanuel					1										
Evans		1	1		1		1			1					1
Fannin	2				1					1					1
Fayette	7		1	1	2				1	1				1	
Floyd	9	1		1	4	2				3	1				2
Forsyth	7	2	3	3	2	1		2		2	1		2		2
Franklin	3	1			2		1			2		1			2
Fulton	91	14	8	14	18	22	5	5	4	14	21	5	5	3	14
Gilmer	2				1					1					1
Glascock															
Glynn	9		1	1		2			1		1			1	
Gordon	2	2	1				1	1				1	1		
Grady	1	2					1					1			
Greene			2					2					2		
Gwinnett	80	9	6	11	14	12	3		5	7	9	3		5	7
Habersham	4														
Hall	13	2	2	1	4	2	2	2	1	4	2	2	2	1	4
Hancock															
Haralson	3		1	1					1						
Harris	1	2				1	2				1	2			
Hart	3	1	1		2	1	1			1	1	1			1
Heard				1	1				1	1				1	1

	All 2015 Deaths Reviewed					County Totals					
County	Infant	1 to 4	5 to 9	10 to 14	15 to 17	All Deaths	Reviewable	Rvlb_Rvd	All Rvd	"Rvlb_RVD" / "Reviewable"	Categories
Coweta	4			2	2	14	7	7	8	7/7	4
Crawford			1			1	1	1	1	1/1	4
Crisp	2			2		12	2	2	4	2/2	4
Dade					1	4	1	1	1	1/1	4
Dawson				3	1	4	4	4	4	4/4	4
Decatur		1				3	1	1	1	1/1	4
DeKalb	16	6	4	3	11	123	44	35	40	35/44	3
Dodge	2					3	2	2	2	2/2	4
Dooly	1					3	1	1	1	1/1	4
Dougherty	4	5		1	2	28	8	7	12	7/8	3
Douglas	5	2	3		2	27	11	11	12	11/11	4
Early			1			2	1	1	1	1/1	4
Echols						0	0	0	0	0/0	1
Effingham	2	1			2	17	5	4	5	4/5	3
Elbert	3					2	2	2	3	2/2	4
Emanuel						1	0	0	0	0/0	1
Evans					1	3	2	1	1	1/2	3
Fannin					1	3	1	1	1	1/1	4
Fayette				1		11	2	1	1	1/2	3
Floyd	2	1			3	15	5	3	6	3/5	3
Forsyth	1		2		2	17	5	5	5	5/5	4
Franklin		1			2	6	3	3	3	3/3	4
Fulton	28	7	4	4	15	145	50	48	58	48/50	3
Gilmer					1	3	1	1	1	1/1	4
Glascock						0	0	0	0	0/0	1
Glynn	1			1		11	3	2	2	2/3	3
Gordon		2	1			5	2	2	3	2/2	4
Grady		1				3	1	1	1	1/1	4
Greene			2			2	2	2	2	2/2	4
Gwinnett	11	9	2	7	10	120	27	24	39	24/27	3
Habersham	1					4	0	0	1	0/0	1
Hall	4	2	2	1	4	22	11	11	13	11/11	4
Hancock						0	0	0	0	0/0	1
Haralson						5	1	0	0	0/1	2
Harris	1	2				3	3	3	3	3/3	4
Hart	1	1	1		1	7	3	3	4	3/3	4
Heard				1	1	2	2	2	2	2/2	4

	All 2015 Deaths GA Residents, Age < 18 Years					Reviewable 2015 Deaths					Reviewable 2015 Deaths Reviewed				
County	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Infant	1 to 4	5 to 9	10 to 14	15 to 17
Henry	21	2	1	7	4	1	1	1	3	3	1	1	1	1	3
Houston	15	2	1	2	2	2		1	1	1	2		1	1	1
Irwin	1	1				1	1				1	1			
Jackson	2	1		1	4		1			4		1			4
Jasper	1														
Jeff Davis	4	1	1			2	1								
Jefferson	1		1			1					1				
Jenkins	2			1	1				1	1				1	1
Johnson					1										
Jones	1	1			2		1			2		1			2
Lamar	2		1			1					1				
Lanier				1					1					1	
Laurens	4					1									
Lee				1	1										
Liberty	16				2	6				2	4				
Lincoln															
Long		3					2								
Lowndes	19	1			2	2	1			2	2	1			2
Lumpkin	2	1	1		1		1	1		1		1	1		1
Macon	2		1												
Madison	2				1					1					1
Marion															
McDuffie	4				2	1				2	1				2
McIntosh					1					1					1
Meriwether	3	1					1					1			
Miller															
Mitchell	2			2					1					1	
Monroe	6				1					1					1
Montgomery	1														
Morgan					1					1					1
Murray															
Muscogee	35	4		1	8	5	2		1	7	5	1		1	6
Newton	4	1	2	2	2	2		1	1	1	2			1	1
Oconee	4				1	3				1	1				1
Oglethorpe															
Paulding	16	2	1	2	5	1	1	1	1	5	1	1	1	1	5
Peach	4			1	1	2			1	1	2			1	1

	All 2015 Deaths Reviewed					County Totals					
County	Infant	1 to 4	5 to 9	10 to 14	15 to 17	All Deaths	Reviewable	Rvlb_Rvd	All Rvd	"Rvlb_RVD" / "Reviewable"	Categories
Henry	2	1	2	2	4	35	9	7	11	7/9	3
Houston	2			1	2	22	5	5	5	5/5	4
Irwin	1	1				2	2	2	2	2/2	4
Jackson		1			4	8	5	5	5	5/5	4
Jasper						1	0	0	0	0/0	1
Jeff Davis						6	3	0	0	0/3	2
Jefferson	1					2	1	1	1	1/1	4
Jenkins				1	1	4	2	2	2	2/2	4
Johnson						1	0	0	0	0/0	1
Jones		1			2	4	3	3	3	3/3	4
Lamar	1					3	1	1	1	1/1	4
Lanier				1		1	1	1	1	1/1	4
Laurens						4	1	0	0	0/1	2
Lee						2	0	0	0	0/0	1
Liberty	4					18	8	4	4	4/8	3
Lincoln						0	0	0	0	0/0	1
Long						3	2	0	0	0/2	2
Lowndes	3				3	22	5	5	6	5/5	4
Lumpkin	1	1	1		1	5	3	3	4	3/3	4
Macon			1			3	0	0	1	0/0	1
Madison					1	3	1	1	1	1/1	4
Marion						0	0	0	0	0/0	1
McDuffie	1				2	6	3	3	3	3/3	4
McIntosh					1	1	1	1	1	1/1	4
Meriwether						4	1	1	0	1/1	4
Miller						0	0	0	0	0/0	1
Mitchell				1		4	1	1	1	1/1	4
Monroe					1	7	1	1	1	1/1	4
Montgomery						1	0	0	0	0/0	1
Morgan	1				2	1	1	1	3	1/1	4
Murray						0	0	0	0	0/0	1
Muscogee	7	1		1	6	48	15	13	15	13/15	3
Newton	3	1		2	2	11	5	4	8	4/5	3
Oconee					1	5	4	2	1	2/4	3
Oglethorpe						0	0	0	0	0/0	1
Paulding	3	1	1	1	5	26	9	9	11	9/9	4
Peach	2		1	1	1	6	4	4	5	4/4	4

	All 2015 Deaths GA Residents, Age < 18 Years					Reviewable 2015 Deaths					Reviewable 2015 Deaths Reviewed				
County	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Infant	1 to 4	5 to 9	10 to 14	15 to 17
Pickens	3														
Pierce		2			1		1			1		1			1
Pike	2	1	2			1					1				
Polk	3				1	1				1	1				1
Pulaski	1														
Putnam	2				1					1					1
Quitman															
Rabun	1														
Randolph															
Richmond	38	8	4	3	6	8	5	3	1	3	8	5	3	1	2
Rockdale	10				1	1					1				
Schley															
Screven	1														
Seminole	2					1									
Spalding	15	1	2	2		1		2	1		1				
Stephens	3		1	1	1	2			1	1	1			1	1
Stewart															
Sumter	1			1	2					1					1
Talbot															
Taliaferro															
Tattnall	4	1					1								
Taylor															
Telfair															
Terrell	1					1					1				
Thomas	6	2				1	1				1	1			
Tift	5	1	1	2	2				2	1				2	1
Toombs	5	1		1	1	2				1					
Towns	1				1					1					1
Treutlen		1					1								
Troup	7	1	1		2	4	1	1		2	4	1	1		2
Turner	1					1					1				
Twiggs	2			1					1						
Union					1										
Upson	3				1					1					1
Walker	5			1		2					2				
Walton	3	2		2	4	2			2	2	2			2	2
Ware	4	2	1		2		1	1		1		1	1		1

	All 2015 Deaths Reviewed					County Totals					
County	Infant	1 to 4	5 to 9	10 to 14	15 to 17	All Deaths	Reviewable	Rvlb_Rvd	All Rvd	"Rvlb_RVD" / "Reviewable"	Categories
Pickens	1					3	0	0	1	0/0	1
Pierce		2			1	3	2	2	3	2/2	4
Pike	1	1				5	1	1	2	1/1	4
Polk	1				1	4	2	2	2	2/2	4
Pulaski	1					1	0	0	1	0/0	1
Putnam					1	3	1	1	1	1/1	4
Quitman						0	0	0	0	0/0	1
Rabun						1	0	0	0	0/0	1
Randolph						0	0	0	0	0/0	1
Richmond	9	6	3	1	2	59	20	19	21	19/20	3
Rockdale	3					11	1	1	3	1/1	4
Schley						0	0	0	0	0/0	1
Screven						1	0	0	0	0/0	1
Seminole						2	1	0	0	0/1	2
Spalding	2					20	4	1	2	1/4	3
Stephens	1			1	1	6	4	3	3	3/4	3
Stewart						0	0	0	0	0/0	1
Sumter					1	4	1	1	1	1/1	4
Talbot						0	0	0	0	0/0	1
Taliaferro						0	0	0	0	0/0	1
Tattnall						5	1	0	0	0/1	2
Taylor						0	0	0	0	0/0	1
Telfair						0	0	0	0	0/0	1
Terrell	1					1	1	1	1	1/1	4
Thomas	1	1				8	2	2	2	2/2	4
Tift				2	1	11	3	3	3	3/3	4
Toombs						8	3	0	0	0/3	2
Towns					1	2	1	1	1	1/1	4
Treutlen						1	1	0	0	0/1	2
Troup	4	1	1		2	11	8	8	8	8/8	4
Turner	1					1	1	1	1	1/1	4
Twiggs						3	1	0	0	0/1	2
Union						1	0	0	0	0/0	1
Upson					1	4	1	1	1	1/1	4
Walker	2			1		6	2	2	3	2/2	4
Walton	3	1		2	2	11	6	6	8	6/6	4
Ware	1	1	1		2	9	3	3	5	3/3	4

	All 2015 Deaths GA Residents, Age < 18 Years					Reviewable 2015 Deaths					Reviewable 2015 Deaths Reviewed				
County	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Infant	1 to 4	5 to 9	10 to 14	15 to 17
Warren	1														
Washington	2														
Wayne	1	2	1				1	1				1	1		
Webster															
Wheeler	1														
White					1					1					1
Whitfield	9	5	1	1	3	2	2	1	1	1	2	2	1	1	1
Wilcox				1	1				1	1				1	1
Wilkes	1				1	1				1	1				1
Wilkinson			1	2				1	2				1	2	
Worth	2	1		1			1					1			
	1023	160	99	122	195	198	84	46	55	152	166	67	38	47	133
					1599					535					451

	All 2015 Deaths Reviewed					County Totals					
County	Infant	1 to 4	5 to 9	10 to 14	15 to 17	All Deaths	Reviewable	Rvlb_Rvd	All Rvd	"Rvlb_RVD" / "Reviewable"	Categories
Warren	1					1	0	0	1	0/0	1
Washington						2	0	0	0	0/0	1
Wayne		2	1			4	2	2	3	2/2	4
Webster						0	0	0	0	0/0	1
Wheeler						1	0	0	0	0/0	1
White					1	1	1	1	1	1/1	4
Whitfield	2	3	1	1	1	19	7	7	8	7/7	4
Wilcox				1	1	2	2	2	2	2/2	4
Wilkes	1				1	2	2	2	2	2/2	4
Wilkinson			1	2		3	3	3	3	3/3	4
Worth		1				4	1	1	1	1/1	4
	212	95	45	62	147						
					561						

All 2015 Child Deaths (N = 1,599)							
		White		African-American / AA		Other Race	
AgeCat	Cause	Male	Female	Male	Female	Male	Female
1Infant	Drown		1				
1Infant	Homicide			7	7		
1Infant	Medical	178	153	258	206	15	15
1Infant	MVC		1	2	2		
1Infant	OthInjury	1			1		
1Infant	OthSID		1				
1Infant	SIDS	21	20	34	30		
1Infant	Suff_Bed	7	6	10	16		2
1Infant	Suff_Oth	2			1	1	
1Infant	Unknown	7	4	6	7	1	
2_1to4	Drown	14	6	2			1
2_1to4	Firearm	2		1			
2_1to4	Homicide	3	4	6	3		
2_1to4	Medical	13	13	26	19	4	1
2_1to4	MVC	6	3	8	4		
2_1to4	OthInjury	1		2	1		
2_1to4	Suff_Oth	2	1	2			
2_1to4	UnkInt		2		1		
2_1to4	Unknown	1	4	3	1		
3_5to9	Drown			4	1	1	
3_5to9	Fire			2			
3_5to9	Firearm				1		
3_5to9	Homicide	4		2	2		
3_5to9	Medical	19	15	10	6	1	2
3_5to9	MVC	6	3	5	4	1	
3_5to9	OthInjury			1	2		
3_5to9	Poison			1	1		1
3_5to9	Suff_Bed				1		
3_5to9	Suff_Oth		1				
3_5to9	Suicide			1			
3_5to9	UnkInt				1		

All 2015 Child Deaths (N = 1,599) Continued							
		White		African-American / AA		Other Race	
AgeCat	Cause	Male	Female	Male	Female	Male	Female
4_10to14	Drown		1	3			
4_10to14	Fire	2		3			
4_10to14	Homicide	3		3	2		
4_10to14	Medical	17	18	12	19		1
4_10to14	MVC	8	1	1	2		
4_10to14	OthInjury	4	1		2		
4_10to14	Poison			1			
4_10to14	Suff_Oth	1					
4_10to14	Suicide	6	5	3	1		
4_10to14	Unknown	1			1		
5_15to17	Drown	2		3			
5_15to17	Fall		1				
5_15to17	Firearm	1					
5_15to17	Homicide	4	3	24	4		
5_15to17	Medical	17	3	13	8	1	1
5_15to17	MVC	26	13	14	1	2	3
5_15to17	OthInjury	2	2		2	1	
5_15to17	Poison	2		1			
5_15to17	Suicide	15	10	8	4		1
5_15to17	UnkInt	3					

All 2015 Child Deaths (N = 561)							
		White		African-American / AA		Other Race	
AgeCat	Cause	Male	Female	Male	Female	Male	Female
1Infant	Drown		1				
1Infant	Exposure	1					
1Infant	Homicide	1		8	5		2
1Infant	Medical	2	6	4	5	1	
1Infant	MVC			1	2		
1Infant	SIDS				3		
1Infant	SUID_Asph	13	9	15	22	2	
1Infant	SUID_Med	1	3		4		
1Infant	SUID_Undet	15	19	33	29	2	
1Infant	Undet	2					
1Infant	Undetermined				1		
2_1to4	Asphyxia	1	1	2		1	
2_1to4	Drown	8	6	3		1	
2_1to4	Fall/Crush	2					
2_1to4	Homicide	3	2	5	1		1
2_1to4	Medical	3	3	11	7	2	2
2_1to4	MVC	3	3	7	4	1	
2_1to4	OtherCause				1		
2_1to4	Poison		1		1		
2_1to4	SUDC		2	1			
2_1to4	Undet	1	1	1			
2_1to4	Weapon	2		1			
3_5to9	Asphyxia		1				
3_5to9	Drown			4	1		
3_5to9	Fall/Crush				2		
3_5to9	Fire			2	1		
3_5to9	Homicide	3		2	2		
3_5to9	Medical	4		2	1		
3_5to9	MVC	4	2	5	2	2	
3_5to9	Poison			1	1		1
3_5to9	Suicide			1			
3_5to9	Weapon				1		

All 2015 Child Deaths (N = 561) Continued							
		White		African-American / AA		Other Race	
AgeCat	Cause	Male	Female	Male	Female	Male	Female
4_10to14	Asphyxia	1					
4_10to14	Drown	1		2			
4_10to14	Fire	3	1	3			
4_10to14	Homicide	2	1	3	1		
4_10to14	Medical	2	2	5	5		
4_10to14	MVC	9	1	1	2		
4_10to14	OtherCause	1					
4_10to14	Poison			1			
4_10to14	Suicide	5	5	2	1	1	
4_10to14	Weapon	1					
5_15to17	Drown	1	1	2			
5_15to17	Fall/Crush				1		1
5_15to17	Fire	1					
5_15to17	Homicide	3	3	20	3	1	1
5_15to17	Medical	5		3	5	1	1
5_15to17	MVC	18	12	13		7	3
5_15to17	OtherCause				1		
5_15to17	Poison	1		1		2	
5_15to17	Suicide	14	10	7	3		1
5_15to17	Weapon	1					

Reviewed Deaths with Maltreatment Cause or History (N = 177))							
		White		African-American / AA		Other Race	
AgeCat	CauSummary	1WM	2WF	3BM	4BF	5OM	6OF
1Infant	Homicide	1		8	4		2
1Infant	Medical		1		2		
1Infant	SUID_Asph	3	2	2	2	1	
1Infant	SUID_Med				1		
1Infant	SUID_Undet	1	4	5	6	1	
1Infant	Undet	1					
2_1to4	Asphyxia	1	1	1			
2_1to4	Drown	3	4	1		1	
2_1to4	Fall/Crush	1					
2_1to4	Homicide	1	1	5	1		1
2_1to4	Medical	1	1	4	2		1
2_1to4	MVC	1	1	1			
2_1to4	OtherCause				1		
2_1to4	Poison		1				
2_1to4	SUDC		1	1			
2_1to4	Undet	1	1	1			
2_1to4	Weapon	1					
3_5to9	Asphyxia		1				
3_5to9	Drown			1	1		
3_5to9	Fire			2	1		
3_5to9	Homicide	2		1	1		
3_5to9	Medical	1		1	1		
3_5to9	MVC	1		1		1	
3_5to9	Suicide			1			
3_5to9	Weapon				1		
4_10to14	Drown	1					
4_10to14	Fire	1	1	1			
4_10to14	Homicide	2		2			
4_10to14	Medical	1		2	2		
4_10to14	MVC	4					
4_10to14	Suicide	1	1	1		1	
5_15to17	Fall/Crush						1
5_15to17	Homicide		2	10		1	1
5_15to17	Medical				3		
5_15to17	MVC	3	5	4		2	1
5_15to17	OtherCause				1		
5_15to17	Poison	1					
5_15to17	Suicide	3	5	3	2		
5_15to17	Weapon	1					

Preventability of Reviewed Deaths with Maltreatment Cause or History (N = 177)				
CauSummary	0	1	2	3
Asphyxia		1	3	
Drown		1	11	
Fall/Crush			2	
Fire			5	1
Homicide		5	37	4
Medical		9	6	8
MVC		2	22	1
OtherCause			1	1
Poison			2	
SUDC	1		1	
Suicide		2	15	1
SUID_Asph			7	3
SUID_Med		1		
SUID_Undet		1	6	10
Undet			2	2
Weapon			3	

Preventability of Reviewed Deaths with No Maltreatment Cause or History (N = 384)				
CauSummary	0	1	2	3
Asphyxia		1	2	
Drown		1	18	
Exposure			1	
Fall/Crush		2	2	
Fire			5	
Homicide		1	25	1
Medical	1	39	4	15
MVC		4	70	3
OtherCause			1	
Poison			6	2
SIDS		3		
SUDC				1
Suicide		4	20	8
SUID_Asph	1	2	41	7
SUID_Med	1	4	2	
SUID_Undet	1	6	43	31
Undet				1
Undetermined				1
Weapon			3	

Cause: IIf([ACTcauwhat] Between 2 And 3 Or [ACTconwhat] Between 2 And 3,1,0)

History: IIf([INFmalvic]=1 Or [INVabuse]=1,1,0)

APPENDIX D

Glossary of Terms

Asphyxia – Oxygen starvation of tissues. Asphyxia is a broad cause of death that may include more specific causes, such as strangulation, suffocation, or smothering.

Autopsy – Medical dissection of a deceased individual for the purpose of determining or confirming an official manner and cause of death.

Birth Certificate – Official documentation of human birth.

Cause of Death – The effect, illness, or condition leading to an individual's death: Medical Condition or External Cause (Injury). A different classification from Manner of Death.

Child Maltreatment – Intentional injury of a child, involving one or more of the following: neglect, physical harm, sexual abuse or exploitation, or emotional abuse.

Circumstances – Situational findings.

Commission (Act of) – Supervision that willfully endangers a child's health and welfare.

Congenital anomaly – A medical or genetic defect present at birth.

Contributing Factors – Behavioral actions that may elevate the potential risk of fatality.

Coroner – Jurisdictional official charged with determining the manner and cause of death for individuals perishing in sudden, violent, or suspicious circumstances. Performs much the same function as a Medical Examiner, but may or may not be a physician.

CPS (Child Protective Services) – Social service system engaged in protecting children from maltreatment.

Death Certificate – Official documentation of an individual's death, indicating the manner and cause of death.

Exposure – Cause of death directly related to environmental factors; typically death from hyper- or hypothermia.

External – Categorization of non-medical manners of death: i.e., accident, homicide, or suicide.

Full-term – A gestation of 37 or more weeks.

Homicide – Death perpetrated by another with the intent to kill or severely injure.

Hyperthermia – High body temperature.

Hypothermia – Low body temperature.

Infant – Child under one year of age.

Manner of Death – The intent of a death, i.e. whether a death was caused by an act carried out on purpose by oneself or another person(s): Natural, Accident, Suicide, Homicide, or Undetermined.

Medical Examiner – Physician charged with determining the manner and cause of death for individuals perishing in sudden, violent, or suspicious circumstances.

Missing – Case information or data that has not been included.

Natural – Categorization of deaths indicating a medical cause, such as congenital conditions, illness, prematurity, or SIDS.

Neglect – Failure to provide basic needs, such as food, shelter, and medical care.

Omission (Act of) – Supervision entirely absent or inadequate for the age or activity of the child.

Pending – Indication that an official manner of death awaits further investigation.

Preterm – Birth occurring at a gestation of less than 37 weeks.

Preventability – Indicates the likelihood that a death could have been averted with reasonable efforts on the part of an individual or community.

Sudden Infant Death Syndrome (SIDS) – An exclusionary manner of death for children less than one year of age, indicating that all evidence (including an autopsy, death scene investigation, and review of the medical record) has failed to yield the specific cause of a natural death.

Supervisor – Individual charged with the care of a child at the time of his or her death.

Undetermined – Default manner of death when circumstances and/or investigation fail to reveal a clear determination.

Unknown – Case information or data that is unattainable or unavailable after review.

Georgia Child Fatality Review Panel

Annual Report - Calendar Year 2015