Georgia Child Fatality Review Panel

Annual Report - Calendar Year 2016

C. LaTain Kell
Panel Chairman

Nathan Deal
Governor

The Child Fatality Review Panel Members

C. LaTain Kell – Panel Chair, Judge, Cobb County Superior Court

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

Vernon Keenan – Director, Georgia Bureau of Investigation

Mandi Ballinger – Member, Georgia House of Representatives

Kathleen Bennett – Retired Mental Health Specialist,
Central Savannah River Area Economic Opportunity Authority Head Start Program

Judy Fitzgerald – Commissioner, Department of Behavioral Health and Developmental Disabilities

Gloria Butler – Member, Georgia State Senate

Dr. Patrick O'Neal – Interim Commissioner, Department of Public Health

Robertiena Fletcher – Board Chair, Department of Human Services

Jay Neal – Chair, Criminal Justice Coordinating Council

Virginia Pryor – Director, Division of Family and Children Services

Tiffany Sawyer – Prevention Director, Georgia Center for Child Advocacy

Richard Hawk – Coroner, Coweta County

Paula Sparks – Investigator, Georgia Peace Officer Standards and Training Council

Dr. Jonathan Eisenstat – Chief Medical Examiner, Georgia Bureau of Investigation

Tom Rawlings – Director, Office of the Child Advocate

Ashley Wright – District Attorney, Augusta Judicial Circuit

Amy Jacobs – Commissioner, Department of Early Care and Learning

Vacant – Member, State Board of Education

Table of Contents

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).

Acknowledgments

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 level child fatality review committees;
- John T. Carter, Ph.D., M.P.H., Epidemiology Department, Rollins School of Public Health, Emory University.

This report was developed by the staff members of the Child Fatality Review Unit within the Georgia Bureau of Investigation. A special thanks to CFR Panel participants, Angela Boy, Tiffany Sawyer, Terri Miller, Lisa Dawson and Deb Ferrell for their assistance.

Letter from the CFR Panel Chair

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

We are honored to present the Annual Report of the Georgia Child Fatality Review Panel for data collected in calendar year 2016. This data has been reported to the Panel by the 159 county fatality review panels of the state pursuant to statutory requirements. As always, this information is provided to you as part of our mutual ongoing efforts to prevent and decrease child fatalities in Georgia. I thank you for the continuing partnership in this important effort.

The bank of data collected by the Panel during the past six years could have significant impact on predicting patterns for future child fatality prevention. A large-scale analysis of this data, together with data collected by other agencies, is needed. The Panel requests your assistance in securing the necessary resources to perform this analysis as soon as possible.

This year's spike in teenage suicides has caused the panel to focus attention and resources in the final quarter of 2017 and the coming year on significant prevention efforts. Members of the Panel from the Department of Education, the Department of Behavioral Health and Developmental Disabilities and the Department of Public Health along with Children's Healthcare of Atlanta and Voices for Georgia's Children are partnering in this effort.

Sleep-related infant deaths remain the leading cause of post-neonatal deaths in the 2016 data. We hope that increased education and public awareness efforts are beginning to have some effect. Efforts in the state's hospitals and neonatal units have continued to bring this topic to the attention of new mothers and families across the state. The panel will continue to work with both state and private partners to bring attention to this issue.

Maltreatment-related deaths continue to be a priority as well. Again this year, the panel staff has conducted statewide training to assist law enforcement, service providers and first responders in identifying the signs of maltreatment and the proper reporting of such maltreatment. The panel continues to emphasize the importance of maltreatment identification as a vital component of prevention.

The Georgia Bureau of Investigation and Director Keenan and his agents and staff continue to enhance their support of this Panel's mission. Their contributions are exceptional.

I greatly appreciate your attention to this report and its findings. Together, we hope to accomplish our mission to reduce and prevent child deaths in Georgia.

Sincerely,

Judge Tain Kell
Chairman, 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. Official Code of Georgia Annotated 19-15-1 thru -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.

Georgia Child Fatality Review Panel

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, and placed two additional members on the Panel: a member of the state Board of Education, and the commissioner of the Department of Early Care and Learning.

2015

- The Georgia Bureau of Investigation CFR Unit in partnership with the Division of Family and Children Services, and Department of Public Health, embarked on an aggressive campaign to prevent sleep – related deaths of infants in Georgia. This was the first law enforcement driven video designed to educate individuals and raise awareness to these tragic preventable deaths.
- GBI CFR was awarded a $200,000 grant from the Centers for Disease Control and Prevention (CDC) to help establish the Sudden Death in the Young (SDY) Registry. Nine other states received funding as well. The goals of the SDY registry are to a) establish the incidence of sudden death in the young in the United States using a population-based approach through state public health offices, and b) investigate the etiologies and risk factors for sudden death in the young, including sudden unexpected infant death (SUID), sudden cardiac death (SCD) and sudden unexpected death in epilepsy (SUDEP).

2016

- CFR began a campaign to prevent firearm-related deaths by participating in community events/forums around the state and distributed free cable locks for gun owners to promote safe storage of firearms.

Important Findings and Recommendations

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

1. Due to the ongoing problem of sleep-related deaths occurring in Georgia, new programs need to be developed to target high risk groups as identified through CFR data. It is highly recommended this be done as a joint effort with the Department of Public Health and Division of Family and Children Services.

2. School based health centers continue to be recommended to target students identified as "high risk" in an effort to reduce suicide related deaths. The partnership with CFRP and the Department of Education to continue awareness and education should be funded state-wide.

3. In partnership with the Governor's Office of Highway Safety, expand motor-vehicle safety educational efforts in schools and individual communities with an emphasis on the counties with the highest motor-vehicle fatalities among teen drivers.

Executive Summary

Child deaths are often viewed as an indicator of the health of the community in which they occur. While child death data provide an overall picture of child deaths by number and cause, it is the meticulous review of each child's death that we can learn how to best prevent future deaths. Each year the Georgia Child Fatality Review Panel (Panel) publishes an annual report detailing these tragic and often preventable deaths of children in Georgia.

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 patterns, prevention gaps and opportunities. We encourage all who are concerned about the welfare of Georgia's children, to use these data to make life-saving decisions for our children. In 2016, child fatality review committees reviewed 531 total child deaths.

Key Findings

MALTREATMENT

In 2016, child fatality review committees determined that maltreatment was the direct cause or contributing factor in 29 deaths (maltreatment includes abuse and neglect). An additional 142 deaths had a history of maltreatment but maltreatment was not identified as a direct cause or contributing factor.

SLEEP-RELATED INFANT

Child fatality review committees reviewed 152 sleep-related infant deaths in 2016. The number of reported sleep-related deaths (based on Vital Records death certificate data) has not demonstrated a significant change over the last 17 years (1999 – 2015). There was a peak of 196 in 2007, but the average over the 17 years is 158 deaths per year. Sleep-related infant deaths remain the leading cause of preventable post-neonatal deaths.

INJURIES

In 2016, child fatality review committees reviewed 293 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 174 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 119 deaths to children ages 0-17 from intentional causes – 68 homicides and 51 suicides.

PREVENTABILITY

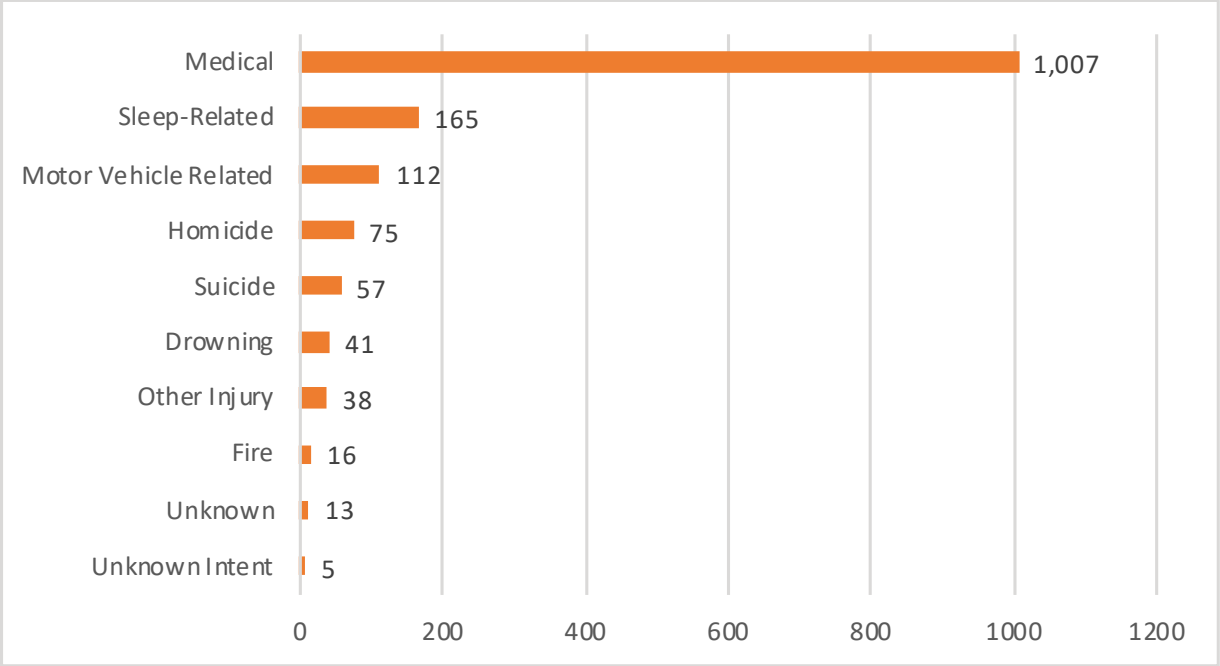
A primary function of the child fatality review process is to identify those deaths deemed to be preventable. Local CFR teams carefully reviewed each death in an effort to determine preventability. Preventability is best determined by evaluating If an individual or the community could reasonably have done something that would have changed the circumstances leading to a child's death. Child fatality review committees determined that 340 (79%) of the 430 reviewed child deaths with preventability data were definitely or possibly preventable (101 of the reviewed deaths did not have a preventability determination).

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 child deaths in Georgia. Death notifications are obtained from a variety of sources to include the coroner, medical examiner, Vital Records (VR) death certificates, law enforcement, 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. The death certificate records are the primary source for identifying cases to be reviewed by CFR teams. Figure 1 shows the number of reported infant/ child deaths by cause of death categories.

The information used in the preparation of this annual child fatality review report is primarily drawn from two "dynamic" data systems – death certificates submitted to the GA Vital Records Office and fatality reviews submitted to the National Child Death Review database. We have referred to these two systems as "dynamic" because new records are continuously entered into the systems (and previously entered records corrected or completed). Any cut-off or closure date for a given period of time (e.g. CY 2016) is arbitrary. The number of reported deaths (or reviews) on December 1 is likely to be greater than the count was on October 1. The process of comparing death data from the two data sources and adjusting both due to results of the comparison yields death counts slightly different from the GA results on the OASIS database.

Figure 1: Deaths to Children Under Age 18 in Georgia, All Causes based on Death Certificate, 2016 (n=1529)

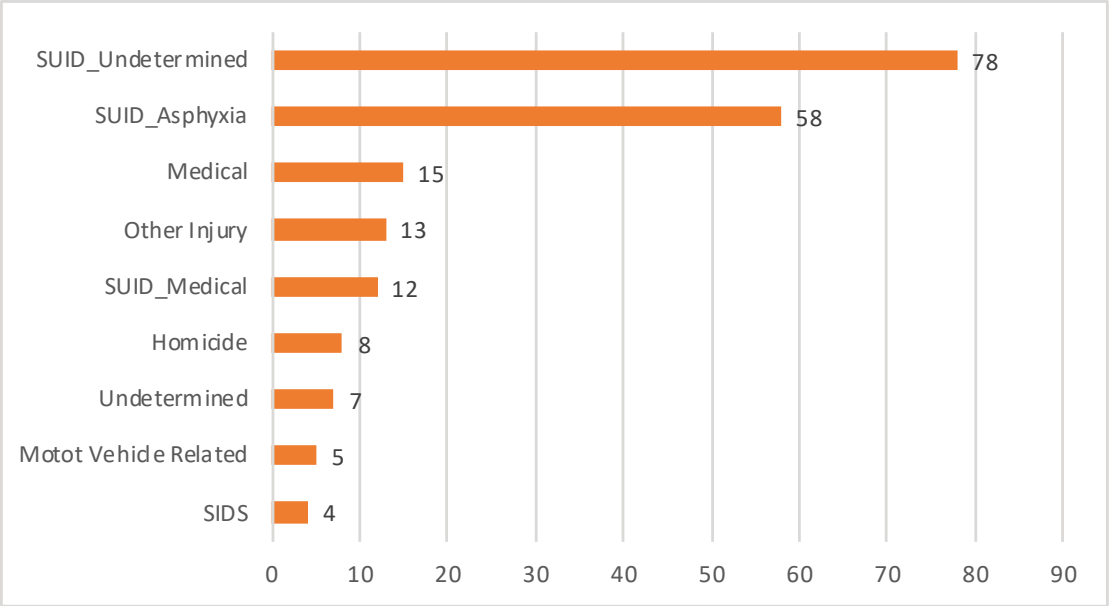


- The "Sleep-Related" category includes Sudden Infant Death Syndrome (SIDS), Sudden Unexpected Infant Death (SUID), and asphyxia (see the sleep-related infant section for more detailed information).
- The "unknown Intent" category includes deaths for which a definitive manner could not be determined.

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 interpretation of necessary prevention efforts and integration of services in order to solve the manifested problem year after year.

In 2016, 522 of the total 1,529 deaths met the eligibility criteria requiring review according to death certificate data. 438 of those were reviewed (84%). An additional 84 deaths with a medical cause identified on the death certificate were reviewed, and nine deaths were reviewed that did not have a death certificate identified. This report includes information from a total of 531 reviewed deaths.

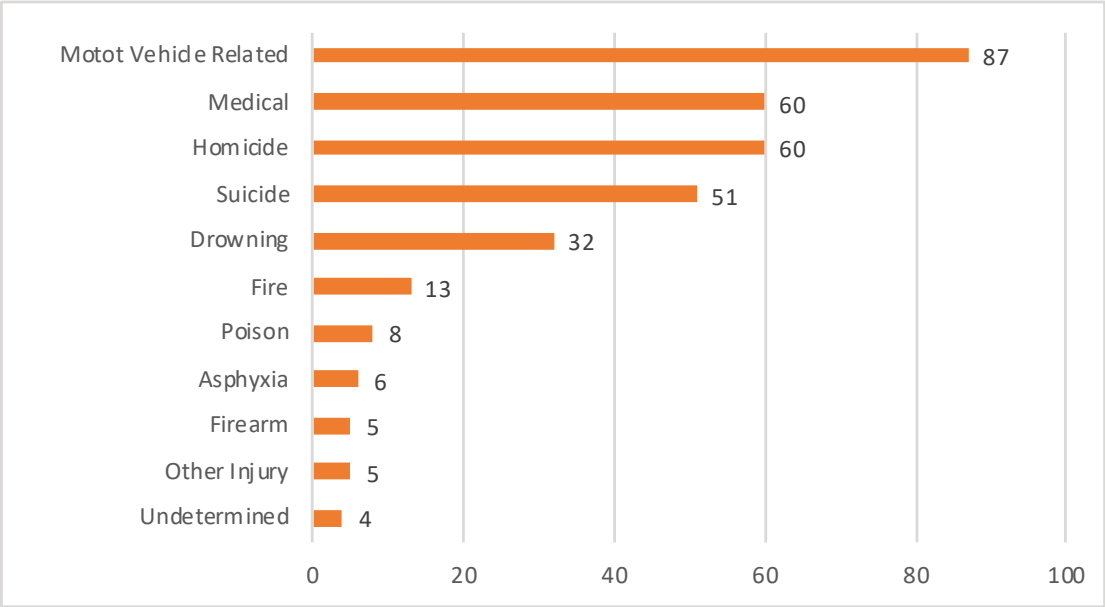
Figure 2: Number of Reviewed Infant Deaths by Cause, GA, 2016 (N=200)



*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 3: Number of Reviewed Child (ages 1-17) Deaths, By cause, GA, 2016 (N=331)



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

Figure 4: Demographics of All Reviewed Deaths, GA, 2016 (N=531)

	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total
White Male	37	21	8	14	39	119
White Female	32	16	6	12	15	81
African-American Male	59	22	19	11	40	151
African-American Female	51	15	11	7	20	107
Hispanic Male	12	3	3	5	11	33
Hispanic Female	6	7	0	5	4	26
Multi-Race Male	1	2	2	0	1	5
Multi-Race Female	1	0	2	0	1	2
Other Race Male	1	1	0	2	0	4
Other Race Female	0	0	1	0	3	3
Total	**200**	**87**	**54**	**56**	**134**	**531**

- 42% of all reviewed deaths had a caregiver who received social services.


HELP

Maltreatment

Child maltreatment fatalities occur in all communities but national trends show risk factors are greater in certain communities (low socioeconomic status in particular) for a variety of reasons. Local child fatality review teams conduct case-specific multi-disciplinary reviews of child fatalities. When they conduct these reviews, they discuss whether acts of omission or commission caused or contributed to the death. This review process allows committees to use a public health approach to assess whether prevention of the death was possible and determine areas of improvement for services and programs available to the family.

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). CFR is required to 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 5: GA 2016 CDR, Maltreatment Variables

Child had history of child maltreatment? Yes, 144

- The child had a reported history of maltreatment victimization at any point in their life (abuse and/or neglect), but that history was not related to the primary cause of death)

Poor Supervision? Yes, 49

- The committee determined the death to be related to poor supervision

Abuse or Neglect? Yes, 29

- Maltreatment (abuse or neglect) was the direct cause or contributing factor in the death

- Abusive head trauma (previously known as "Shaken Baby Syndrome") comprised 7 of the 29 deaths (5 infants, 2 older children) where maltreatment was the direct cause or contributing factor.

In 2016 there were a total of 157 cases with a history of child maltreatment. An identified history of child maltreatment puts a child at higher risk for future maltreatment so these families need additional support and monitoring. It is important to identify how the Division of Family and Children Services works with these families and how support is provided to a family on a continuing basis. Additional areas of focus for prevention efforts should center on educating parents about realistic expectations of children's development (particularly related to child behavior and toilet training). Inappropriate or excessive discipline can lead to injury or death so other prevention messaging should include information on other methods of discipline.

Poor and absent supervision is identified as a factor in 49 child deaths. These deaths are preventable through family support and education. For instance, when families have community supports for childcare, they are less likely to leave a child with an unsafe caregiver. In areas of the state where supports are lacking, efforts should focus on strengthening existing relationships between state agencies such as the Department of Public Health, the Department of Community Health, and the Department of Behavioral Health and Developmental Disabilities to leverage available resources for families to access. Prevention education should focus on child development (knowing what a child is capable of at different ages and stages and knowing when a child can be safely left unsupervised), safe storage of medications, firearms, etc. around the home, and safety around water sources (bathtubs, pools, lakes, etc.). Campaigns like the SPLASH Campaign run by the GA Department of Natural Resources are an example of a community-based program that provides drowning prevention resources.

Adverse childhood experiences (ACES) such as child maltreatment can have a permanent impact on the health and wellbeing of a child well into adulthood. This can pose a greater risk of substance use/abuse as adolescents, risk for bullying or dating violence, and suicidal ideation. Preventing child abuse and neglect can in turn prevent violence and future deaths from suicide and other chronic conditions.

Focus on Prevention: Maltreatment

Potential Prevention Opportunities Include:

- Increasing parental education programs to enhance practices and behaviors, such as age appropriate discipline, promoting positive parent child interactions and accessing community services and support systems.
- Early intervention that involves systems of services that help infants and toddlers with development delays and disabilities.
- Strengthening economic supports to families.
- Ensuring that DFCS case managers are well trained to thoroughly assess the safety and well-being of the children on their caseloads.
- Advocating a community approach to recognizing abuse and how to intervene appropriately to save a life.
- Ensuring access to mental health and substance abuse services for low income families who are not insured and/or not under the supervision of DFCS.

Current Prevention Efforts Include:

- DFCS Blue Print for Change is aimed at providing a comprehensive framework to help improve practices and outcomes, reduce maltreatment and recidivism rates and promote productive partnerships with external stakeholders. Since its implementation in 2014 there were 4,000 overdue investigations and there was a significant decrease to 407 in 2016.
- DFCS also implemented Solution Based Casework (SBC), an assessment tool that utilizes the family life cycle to frame and locate the "problem" that creates safety threats to the family in their daily functioning.

A 7 week old infant was found unresponsive. During the course of the investigation, she was found to have multiple small hemorrhages over her brain, internal bleeding, and multiple posterior rib fractures in various stages of healing, bilateral clavicle fractures consisting of three separate bones fractured on each shoulder and internal injuries. Both the mother and father were charged with murder; they were both drug impaired.

Disability and Chronic Disease

Developmental disability is a diverse group of chronic conditions that result in mental or physical impairments. These impairments affect language development, mobility, learning and other aspects of functioning. According to the American Academy of Pediatrics, early identification of developmental disorders is critical to the well-being of children and their families and can lead to further evaluation, diagnosis, and treatment.

Children with established developmental disorders often benefit from referrals to community-based family support services such as respite care, parent-to-parent programs, and advocacy organizations. Some children may qualify for additional benefits such as supplemental security income, public insurance, waiver programs, and state programs for children and youth with special health care needs (Title V). Parent organizations, such as Family Voices, and condition-specific associations can provide parents with information and support.

In 2016, there were a total of 531 reviewed deaths. Of these, 132 were identified as having a disability or chronic disease. 35 had no record of prior agency involvement which could be due to cultural, economic or social factors that prevented these children and their families from obtaining adequate resources and assistance. Early intervention programs can be particularly valuable when a child is first identified to be at high risk of delayed development because these programs often provide an array of services that include developmental therapies, service coordination, family training, counseling, and home visits.

Georgia Child Fatality Review Panel

Figure 6: Demographics of Reviewed Child Deaths with Developmental Disability or Chronic Diseases, GA, 2016 (N=132)

	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total
African-American Male	11	9	8	4	3	35
African-American Female	9	6	6	1	8	30
White Male	8	4	2	6	10	30
White Female	9	3	2	4	3	21
Hispanic Male	1	1			2	4
Hispanic Female	1	2		1	1	5
Multi-Race Male		2				2
Multi-Race Female	1				1	2
Other Male	1			1		2
Other Female					1	1
Total	**41**	**27**	**18**	**17**	**29**	**132**

- Males accounted for slightly over half (55%) of the total reviewed deaths identified with developmental disability and chronic disease.
- African-American males ranked the highest with 34 reviewed deaths.

16 year old adolescent black female with a history of muscular dystrophy and scoliosis became unresponsive while a passenger on her school bus. She was transported to a local hospital. Resuscitation and therapeutic efforts were unsuccessful.

Sleep-Related Infant Deaths

Sleep-related deaths are the leading cause of post-neonatal (after 27 days of life) infant death. The term "sleep-related" is relatively new and includes – but expands – deaths attributed to SIDS. The sleep related case definition includes infants found unresponsive in a sleep environment and other present risk factors for SIDS in that environment.

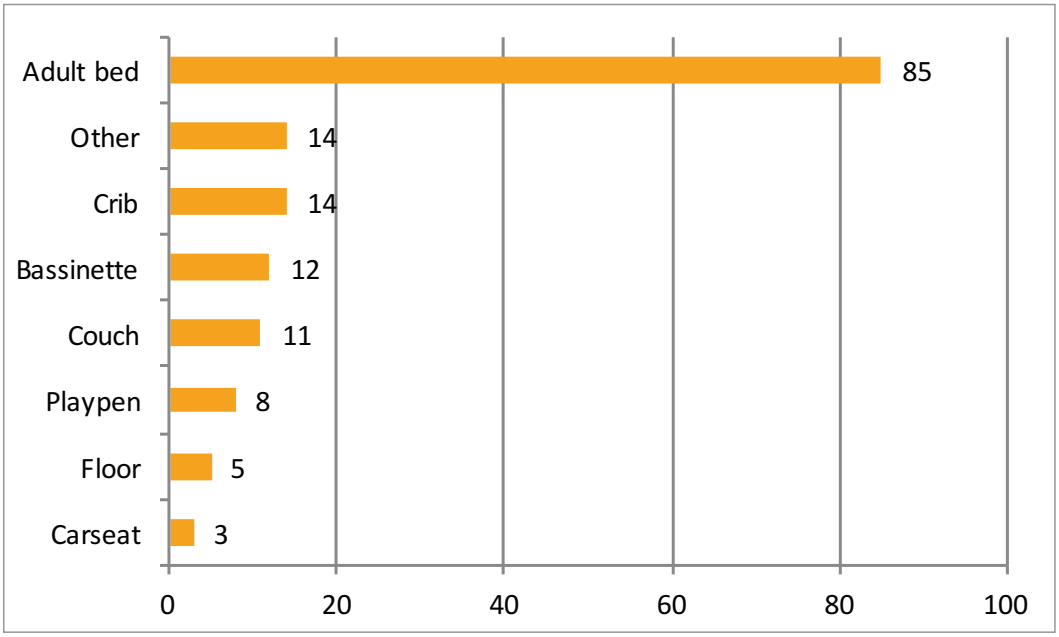
The Child Fatality Review process investigates the unexpected deaths of infants to examine the potential cause through a review of the infant's medical history, a death scene investigation and, autopsy. There is a subjective component to the classification of sleep-related deaths. The CFR typology includes four (rather than the three DC) categories. The additional category for the CFR (SUID, Medical) includes unexpected deaths where there is an underlying medical issue.

There has been an average of 160 sleep-related deaths (based on DC data) in GA per year over the last 10 years.

There were a total of 152 reviewed sleep-related infant deaths for the year 2016. 58 were SUID related to asphyxia and 78 were SUID undetermined. 12 were SUID with an underlying medical condition and 4 were SIDS. The deaths related to asphyxia are considered preventable and many of the undetermined deaths, also have indicators of possible asphyxiation and prevention efforts may impact these numbers as well.

SIDS can only be selected when, after a full review, there is no apparent explanation for the infant's death. Many deaths are labeled "undetermined" after an investigation, autopsy, and medical review because a definitive cause of infant death can be difficult to conclusively determine due to the events often occurring with no witnesses and incomplete information from the death scene investigation.

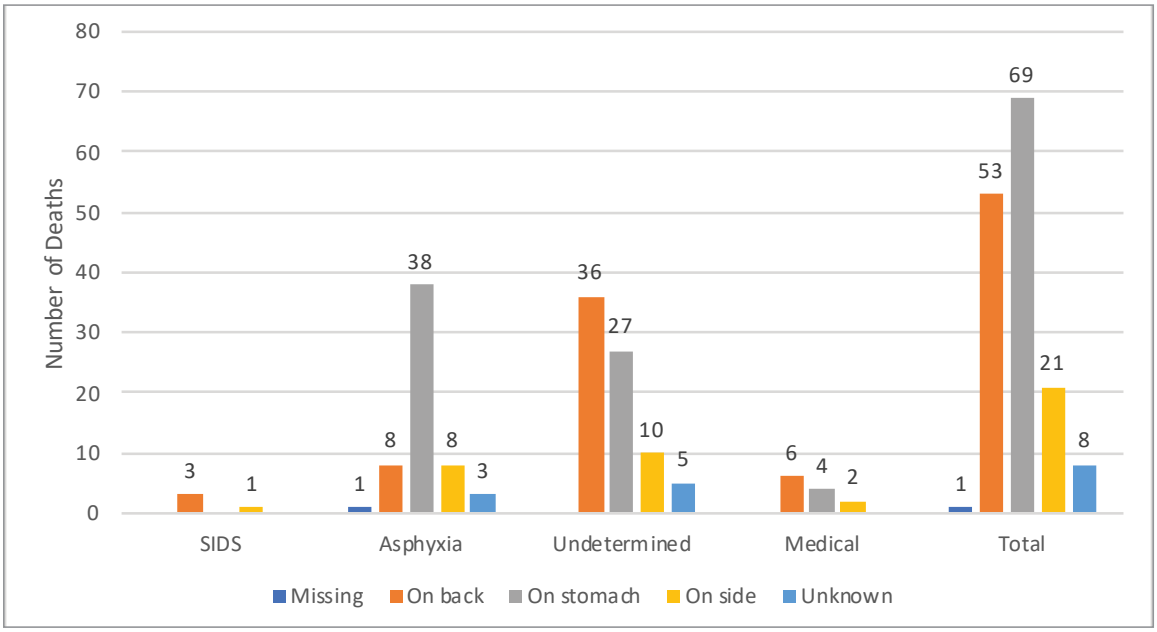
Figure 7: Sleep-Related Infant Deaths by Sleep Location, 2016 (N=152)



- The infant was found in an adult bed for majority (56%) of the sleep related deaths in 2016.
- 79 of the infants were sharing the surface with an adult (and an additional 4 were sharing with another child); 20 of the 79 also had another child on the surface.
- Within the "other" category, eight of the infants were on a person or in their arms at the time of death.
- Cribs and bassinets account for 17% of the locations of infant deaths.

The updated 2016 safe infant sleep recommendations from the American Academy of Pediatrics suggest room sharing as opposed to bed sharing and also providing a safe sleep environment that includes a firm, flat surface that is free of soft objects such as crib bumpers, pillows and blankets.

Figure 8: Sleep Position when Found, by Sleep-Related Death Category, 2016 (N=152)



- Stomach and side sleeping is a risk factor for all sleep-related infant deaths. The vulnerability of the developing infant is a major factor for deaths related to SIDS, SUID, and asphyxia due to the lack of muscle strength and coordination to remove themselves from a dangerous situation.

3 month old black female infant was found unresponsive prone on a sofa on which she had been placed to sleep. She was transported to a local children's hospital where she was pronounced dead approximately 45 minutes after arrival. The sofa was the usual sleep location for the infant. The parents only had one crib in the home and it was used for her 15 month old sibling.

Focus on Prevention: Safe Sleep

Potential Prevention Opportunities Include:

- Collaboration with pediatricians to promote safe sleep messaging at well checks.
- Targeted messaging geared toward the breast feeding community.
- Collaborating with local fire and police departments to incorporate safe sleep messaging into their first responder training to enhance their ability to assess unsafe sleep conditions.
- Continue to provide educators, caregivers, and community members with consistent and accurate information on safe infant sleep through as many avenues as possible.

Current Prevention Efforts Include:

- Statewide distribution of scene re-enactment dolls and the GBI safe sleep video.
- This Side Up campaign is currently implemented in birthing hospitals throughout the state.
- Continued partnership with Safe Kids throughout the state.

Statewide Partners

The CFRP continues to partner with other agencies 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 Division of Family and Children Services
- Georgia Obstetrical and Gynecological Society
- Georgia Connection Partnership
- Voices for Georgia's Children
- Safe Kids Georgia

Motor-Vehicle Related Deaths

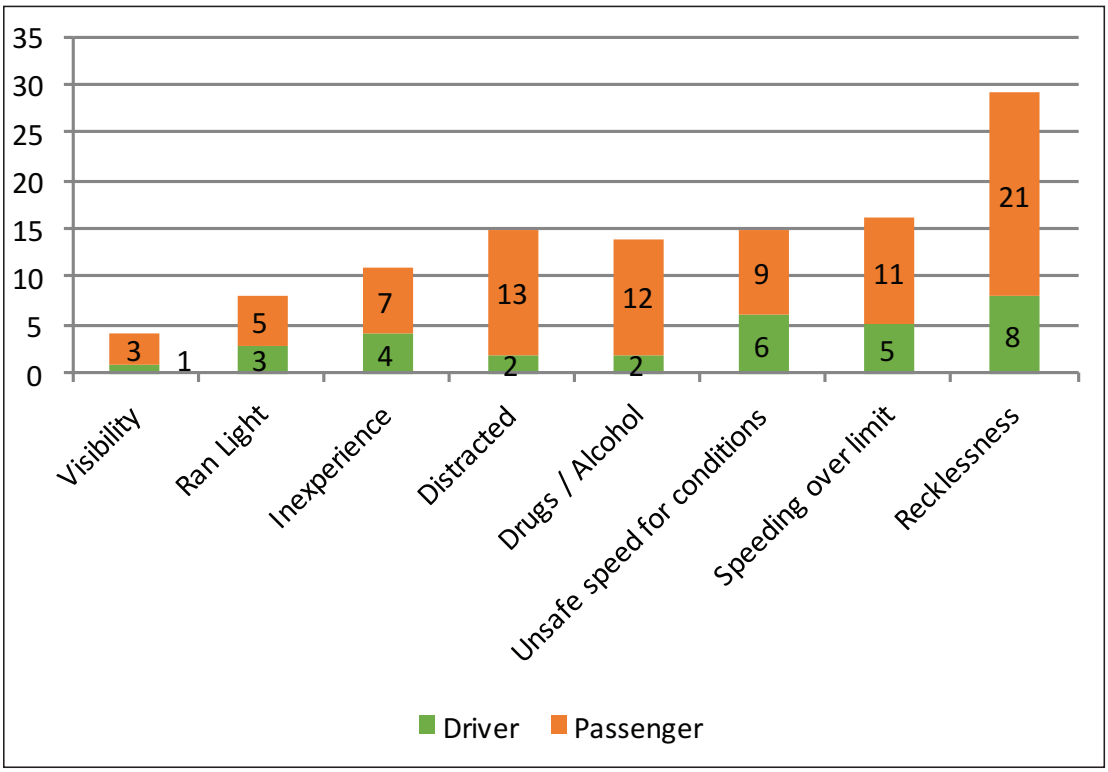
In the United States, motor-vehicle related fatalities are among the top five causes of death in children. In Georgia, specifically in 2012-2016, motor-vehicle related injuries were the leading cause of death in children ages 5-19. Among the 1-4 age group, MVC related injuries were the second leading cause of death during the same time frame.

Figure 9: Demographics of Reviewed Motor-Vehicle Related Deaths, 2016 (N=92)

	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total
White Male		1	3	6	14	**24**
White Female	1	6		5	5	**17**
African-American Male	3	3	7	4	6	**23**
African-American Female	1	2	3	2	5	**13**
Hispanic Male		1	2	1	4	**8**
Hispanic Female		2	2	2	1	**7**
Total	**5**	**15**	**17**	**20**	**35**	**92**

- Males comprised 60% of all reviewed MVC deaths (n=55).
- Fatalities among the 15 to 17 year old group are significantly higher than any other age group; this age group is likely to be inexperienced at driving and likely to engage in risky behaviors.

Figure 10: Reviewed Motor-Vehicle-Related Death Incident Causes, GA, 2016



- The most frequently cited causes for reviewed motor-vehicle related deaths were recklessness, speed, and distracted driving. National data shows that any distraction while driving increases the risk of a crash two-fold. Cellphone use leads to a more than three times greater risk of a crash[1].

Georgia law specifies that all children under one year must ride in a rear-facing seat in the back seat of a vehicle. Best practices from advocacy groups like the American Academy of Pediatricians and the Centers for Disease Control and Prevention recommend rear-facing until age 2 or until they reach the maximum height and weight for the seat. In older children, it is recommended that they remain in a five-point harness seat until they reach the maximum height and weight limit of the seat as a forward-facing seat with a harness is safer than a booster. Booster seats should be used by children until they are big enough (weight and height) to fit in a seatbelt properly. Proper use of a lap belt means it lies snugly across the upper thighs not the stomach. Similarly, the shoulder belt must lie across the shoulder and chest, not across the neck or face.

While these safety measures are widely known, they are not routinely practiced by parents and caretakers of all demographics. Schools and other youth-serving organizations are in a great position to impact proper restraint usage by including information, reminders, and random checks in their routine practice. Medical facilities (hospitals and pediatric practices in particular) should routinely screen parents/caregivers for restraint usage and provide education on proper use and information on community resources where proper car seats and boosters can be obtained and installed or checked.

1 Distracted Driving Presentation to the House Distracted Driving Study Committee by Lisa Dawson from DPH

Distracted driving significantly increases the risk of a motor-vehicle crash thereby increasing the risk for fatalities. Research has shown that age-specific cellphone bans are not effective in reducing injuries and fatalities but a total ban (inclusive of all drivers) was effective at reducing fatalities by 8%. This also decreases the risk of pedestrian fatalities. Prevention efforts should focus on increasing awareness of distracted driving via mass media campaigns and school-based instructional programs.

Focus on Prevention: Motor-Vehicle

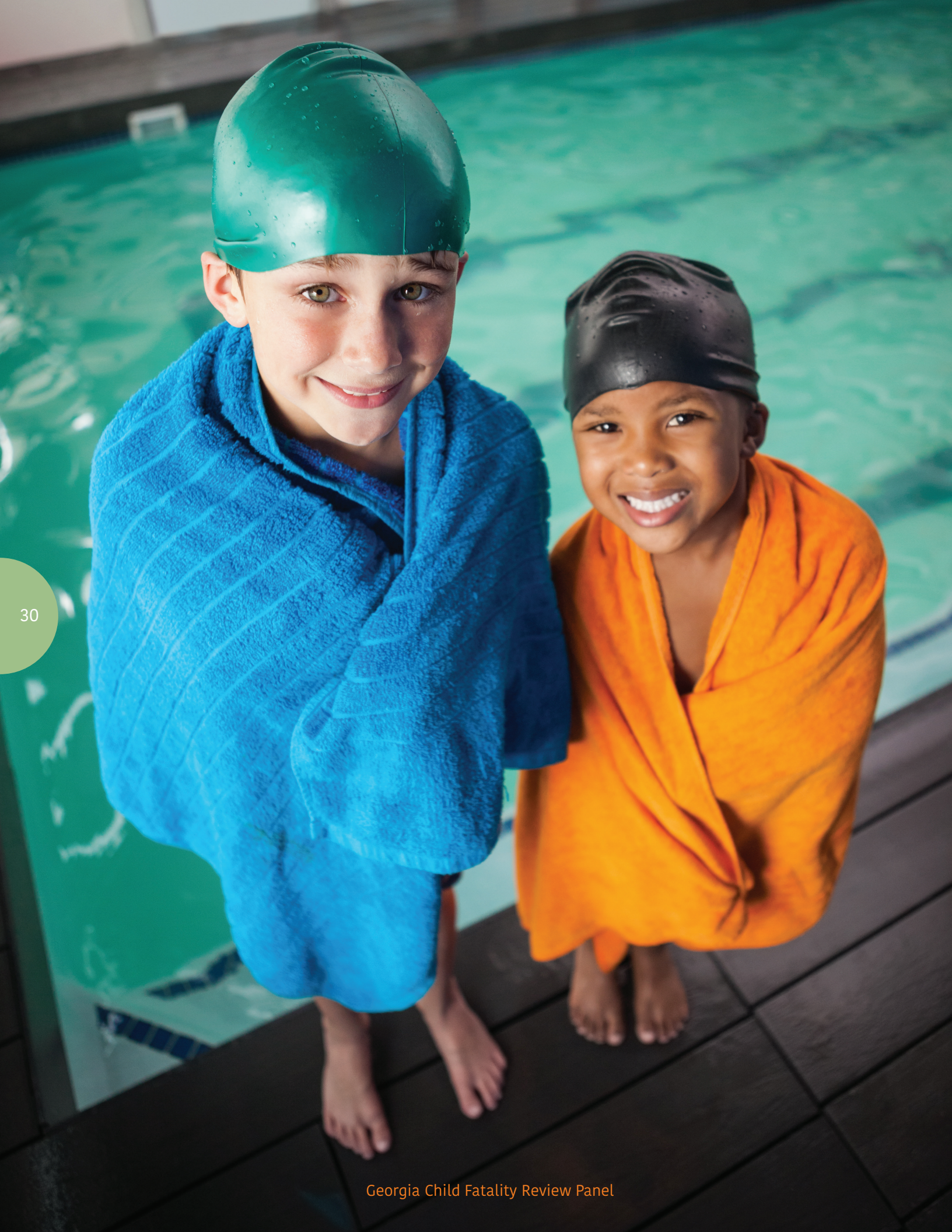
Potential Prevention Opportunities Include:

- To maximize safety, keep your child in a car seat as long as the child fits within the manufacturer's height and weight requirements.
- Keep your child in the back seat at least through age 12.
- Teach children not to play in or around cars.
- Make sure to look behind you while backing up slowly in case a child dashes behind your vehicle unexpectedly.
- Roll down your windows while backing out of your driveway or parking space so that you'll be able to hear what is happening outside of your vehicle.
- Start the Conversation Early: Talk to your teens about safe driving early and often before they reach driving age but don't stop there. Have conversations with the parents of your teen's friends and compare notes.
- Spell out the Rules: No cell phones, no passengers, no speeding, no alcohol, no driving when tired, and always buckle up. These rules could help save your teen's life.

Current Prevention Efforts Include:

- The Older Drivers Task Force comprised of multi- disciplinary partners throughout the state developed the Older Driver Safety program serviced by the Georgia Department of Public Health Injury Prevention program. It is designed to maintain the mobility and safety of older drivers while making the roadways safer for all road users.
- The Georgia Youth Adult Program through the Governor's Office of Highway Safety promotes education for young adults about highway safety issues.
- Hands Across the Border is a multi-state enforcement campaign which includes Georgia, Alabama, Florida, North Carolina, South Carolina and Tennessee. This campaign focuses on arresting impaired drivers during the Labor Day holiday.

The parents of the 4 year old male decedent were meeting at a bus yard to drop off the children. The children were going from the father's vehicle to the mother's vehicle. The decedent ran after the truck and the father ran over the child. He was dragged approximately 29 feet before the father realized he had run over something. He was on life support for 2 days until his parents decided to withdraw care.



Drowning Deaths

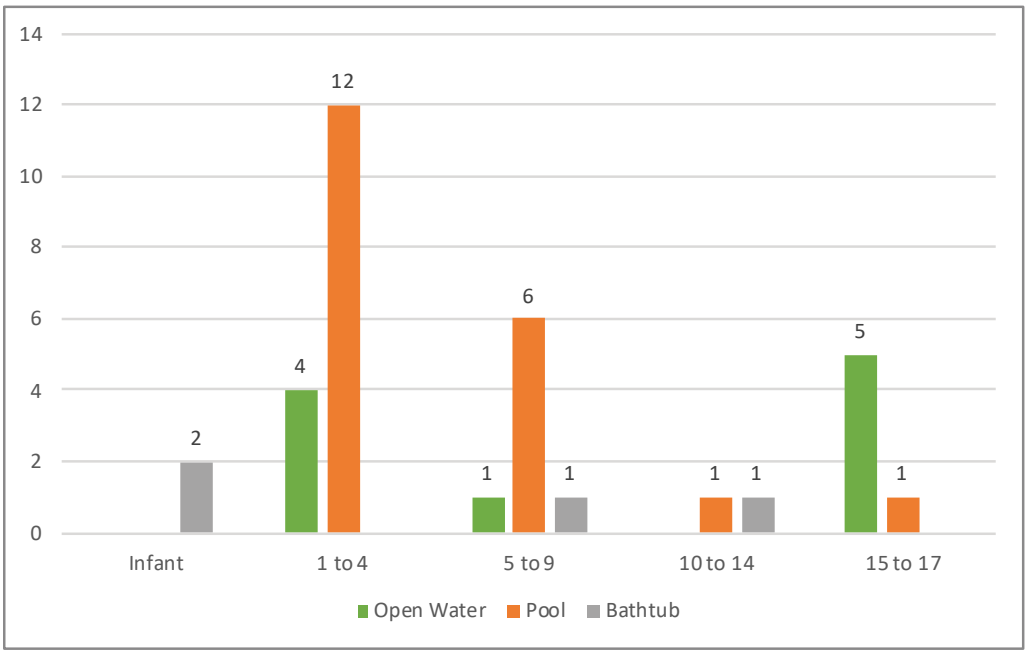
According to Center for Disease Control, from 2005-2014, there were an average of 3,536 fatal unintentional drownings (non-boating related) annually in the United States, about ten deaths per day. Drowning is a leading cause of injury-related death in children and it continues to be a public health problem affecting some of our most vulnerable groups of the population. In Georgia, there were a total of 34 reviewed drowning deaths in 2016.

Figure 11: Demographics of Reviewed Drowning Child Deaths, GA, 2016 (N=34)

	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total
African-American Male	0	4	4	2	4	14
African-American Female	0	1	1	0	0	2
White Male	0	10	2	0	1	13
White Female	1	1	0	0	0	2
Hispanic Male	0	0	0	0	1	1
Hispanic Female	1	0	1	0	0	2
Total	**2**	**16**	**8**	**2**	**6**	**34**

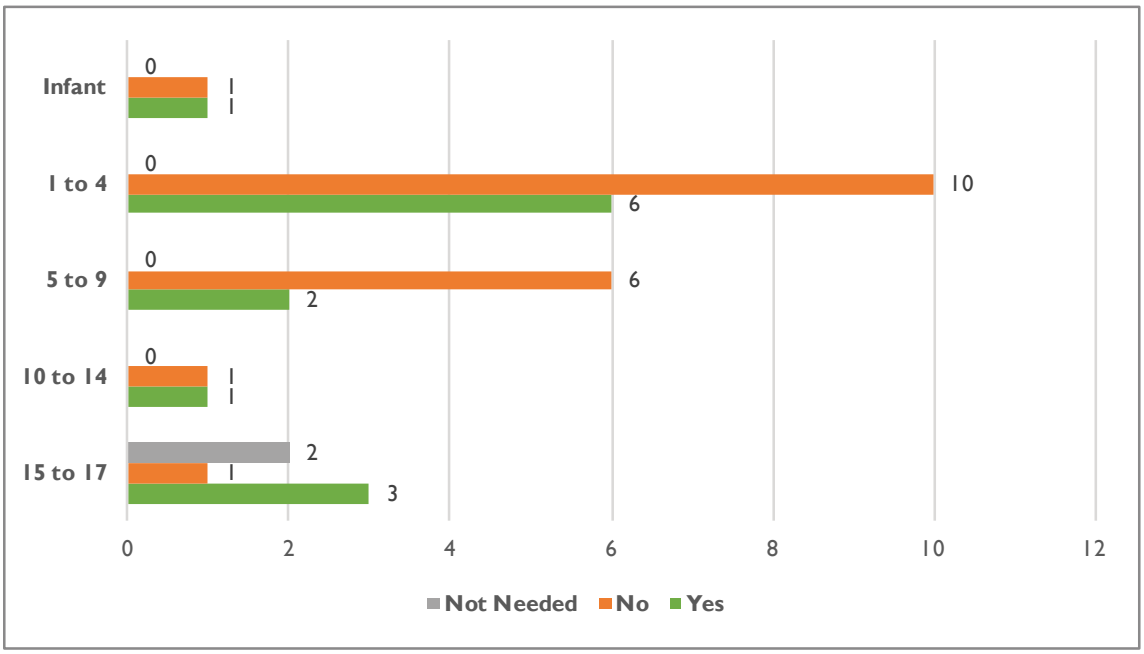
According to Center for Disease Control, from 2005-2014, there were an average of 3,536 fatal unintentional drownings (non-boating related) annually in the United States about ten deaths per day. Drowning is a leading cause of injury-related death in children, and it continues to be a public health problem affecting some of our most vulnerable groups of the population.

Figure 12: Drowning Fatalities by Age and Location, 2016, GA (N=34)



According to the American Academy of Pediatrics (AAP), most infant drownings occurs in bathtubs and buckets. Toddlers between one and four years most commonly drown in swimming pools. However, many children in this age group drown in ponds, rivers, and lakes. Children older than five years old are most likely to drown in rivers and lakes, but this varies from one area of the country to another.

Figure 13: Supervision at Drowning Incident, GA, 2016 (N=34)



Lack of supervision was cited as a factor for two-thirds of the toddler (1 to 4) and young child (5 to 9) drowning deaths..

Focus on Prevention: Drowning

Potential Prevention Opportunities Include:

- Teaching CPR skills in school as part of health education requirements.
- Increasing use of life jacket loaner boards across the state.
- Promote swimming lessons in daycare centers for younger children.

Current Prevention Efforts Include:

- The Department of Natural Resources developed the SPLASH campaign which is a water safety initiative aimed at reducing drowning deaths through water safety education and community outreach.

A 16 year old male was swimming with friends when he became tired and started to panic. He then went under the water; one of his friends tried to help bring him up to the surface but was unsuccessful. The local EMA Dive team responded to the scene and recovered the body of the male approximately three hours after initial incident. His body was recovered 100 feet from shore and approximately 22 feet under the water.

Homicide

According to 2015 CDC Data, homicide was the third leading cause of death among 1-4 year olds and 4th leading cause of death among 5-9 and 10-14 year olds. It is also the third leading cause of death among adolescents (ages 15-24). Our state level data shows similar trends to the national data.

Figure 14: Demographics of Reviewed Homicide Deaths, GA, 2016 (N=68)

	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total
White Male	2	1	1	0	3	**7**
White Female	2	1	1	0	3	7
African-American Male	2	5	1	0	19	**27**
African-American Female	1	6	2	2	9	**20**
Hispanic Male	0	1	0	0	0	1
Hispanic Female	1	1	0	1	0	3
Multi-Race Male	0	0	1	0	1	2
Other Male	0	1	0	0	0	**1**
Total	8	16	6	3	35	68

- African-American children accounted for 69% of all reviewed homicides (47).
- African-American males were disproportionately more impacted by homicidal violence, representing more than a quarter of the homicides occurring in this population, particularly 15-17 year olds. This highlights the need for work around community violence prevention.

The number and proportion of homicide deaths among teens ages 15 to 17 has increased the past two years. From 2009 through 2014 there was an average of 19 deaths per year (teens, 15 to 17), and that was about 1/3 of the total child homicide deaths. The number in that population doubled for 2015/16 (37 per year), and the proportion increased to 48%. (GA death certificate data)

Focus on Prevention: Homicide

Potential Prevention Opportunities Include:

- Increasing programs that address community deterioration (e.g alcohol abuse, gun safety, nonviolent coping skills) can also help prevent youth violence.
- Continued messaging around the importance of keeping weapons out of the reach of small children and storing in a safe and secure place.
- Ensuring proper supervision of children at all times when outside of the home.

Current Prevention Efforts Include:

- Distribution of gun locks within the community.
- Continued messaging around gun safety.

This 16 year old male and some of his friends were in his living room when one of the friends was playing with a loaded gun. He pointed it at the decedent and shot him. The friend stated that it was an accident and he didn't know that a bullet was in the weapon. The decedent tested positive for marijuana and it was reported that both the decedent and his friend owned a gun.

Suicide

According to the Center for Disease Control (CDC), suicide is the second leading cause of death for youth 15-19 years old and the third leading cause of death for youth ages 10-14 years old. Suicides in Georgia continue to trend upwards with 51 reviewed youth suicides in 2016.

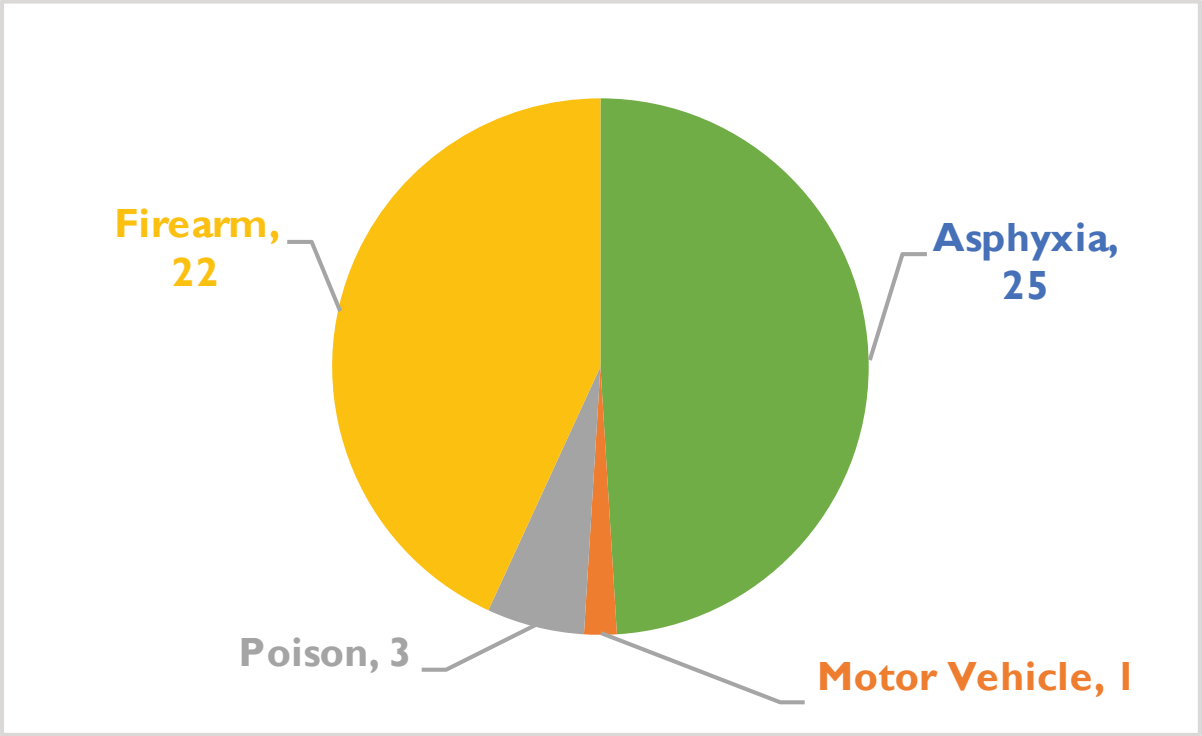
Many youth die by suicide due to depression that is triggered by several negative life experiences such as the death of a loved one, family discord, issues at school and, drug and/or alcohol abuse and bullying (CDC, 2011). Adolescence can be a tumultuous time for many young people and some experiences can be very confusing and difficult to handle. In reviewing the cases, it is clear that many of our youth lack the ability to cope with life stressors.

Figure 15: Demographics of Reviewed Suicide Deaths, GA, 2016 (N= 51)

	5 to 9	10 to 14	15 to 17	Total
White Male	0	2	16	18
White Female	0	4	3	7
African-American Male	1	2	5	8
African-American Female	0	1	0	1
Hispanic Male	0	3	5	8
Hispanic Female	0	2	2	4
Multi-Racial Female	0	0	1	1
Other Male	0	1	0	1
Other Female	0	0	3	3
Total	**1**	**15**	**35**	**51**

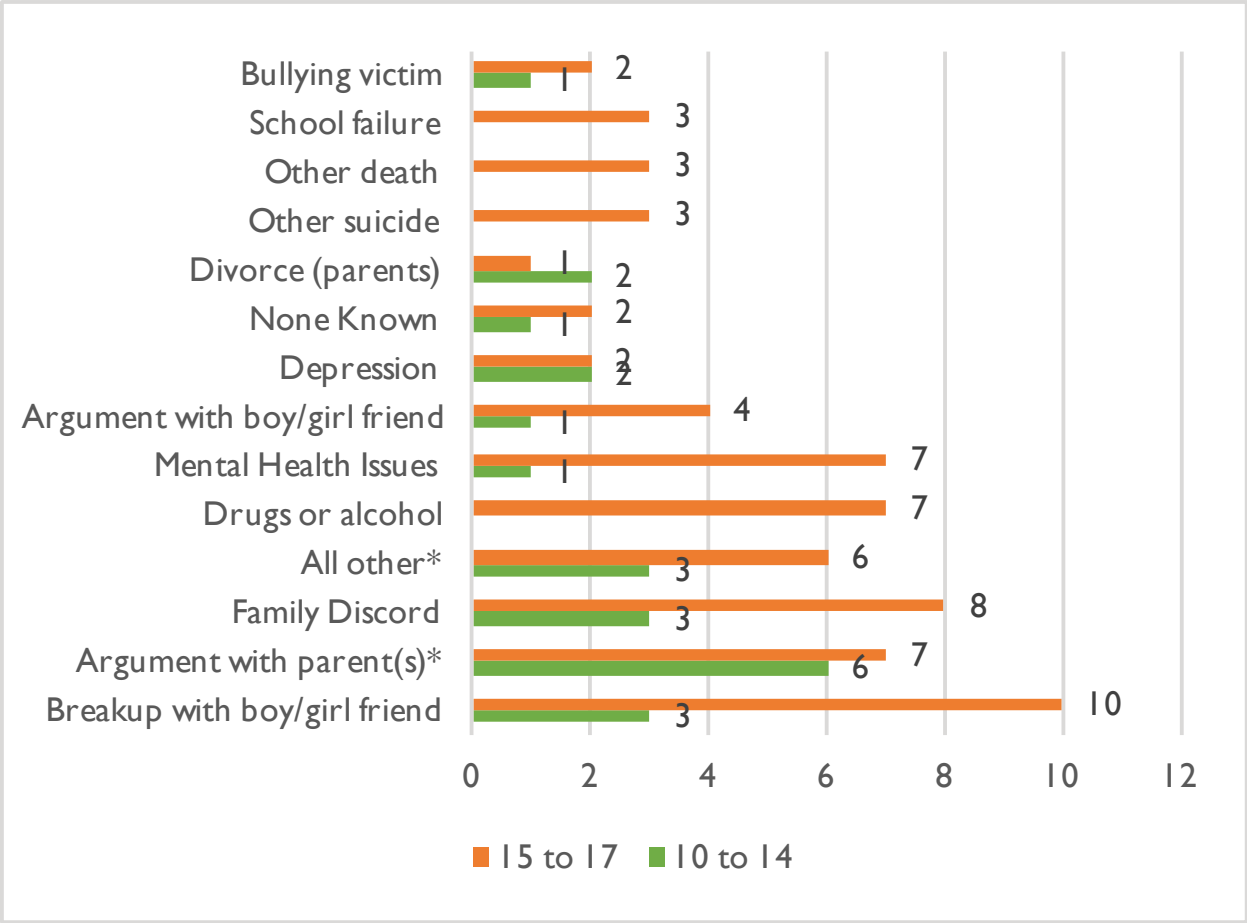
- 69% of reviewed suicide deaths were males.
- Youth between the ages of 15 to 17 years old made up two thirds of completed suicides in 2016.

Figure 16: Reviewed Suicide Deaths, by Mechanism, GA, 2016 (N= 51)



- 45% of reviewed suicide deaths resulted from the use of a firearm.
- Historically, the most frequent mechanisms for youth suicide is asphyxia and firearms (CDC). In Georgia, firearms and asphyxia accounted for 47 reviewed suicide deaths (92%).

Figure 20: Reported Risk Factors for Reviewed Suicide Deaths, GA 2016



- The history reported for a child can include multiple actions for each death; therefore the total is greater than the number of suicide deaths.
- The category "breakup with boy/girlfriend" accounted for the highest numbers among youth ages 15 to 17 years old and argument with parents accounted for the highest numbers among ages 10 to 14 years old.

Focus on Prevention: Suicide

Potential Prevention Opportunities Include:

- Increase targeted education for youth in elementary, middle, and high school to help them understand the risk factors and warning signs of suicide.
- Continue training school staff on identification of at risk students and how to effectively respond to crisis at school.
- Restrict access to lethal means of suicide in the household including firearms and lethal medications.

Current Prevention Efforts Include:

- As a recommendation of the Jason Flatt Act, the Department of Education and several state agencies have completed a series of suicide prevention summits around the state.
- Georgia Bureau of Investigation and Child Fatality Review Unit along with other stake-holders has formed a suicide prevention task force. The first project completed was a Peer to Peer public service announcement (PSA). This PSA is aimed at youth empowering other youth to get help.
- The suicide prevention task force with the GBI and DOE have distributed resources statewide, provided prevention training, and launched several press releases.

This 14 year old adolescent male was found in his room with a gunshot wound of the head. He was transported to a hospital where he was pronounced dead two days later. The father reported that he had recently given his son a lecture about his grades and chores. He admitted to yelling and treating him more harshly than usual. The father woke up around 9:00 am to the sound of a "pop". He went downstairs and noticed the child's bathroom shower was running. He entered his son's room and noticed he was lying on the bed with his eyes rolled back into his head and his head and face were bloody; he was making breathing noises. There was no suicide note left and this was completely unexpected.

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)

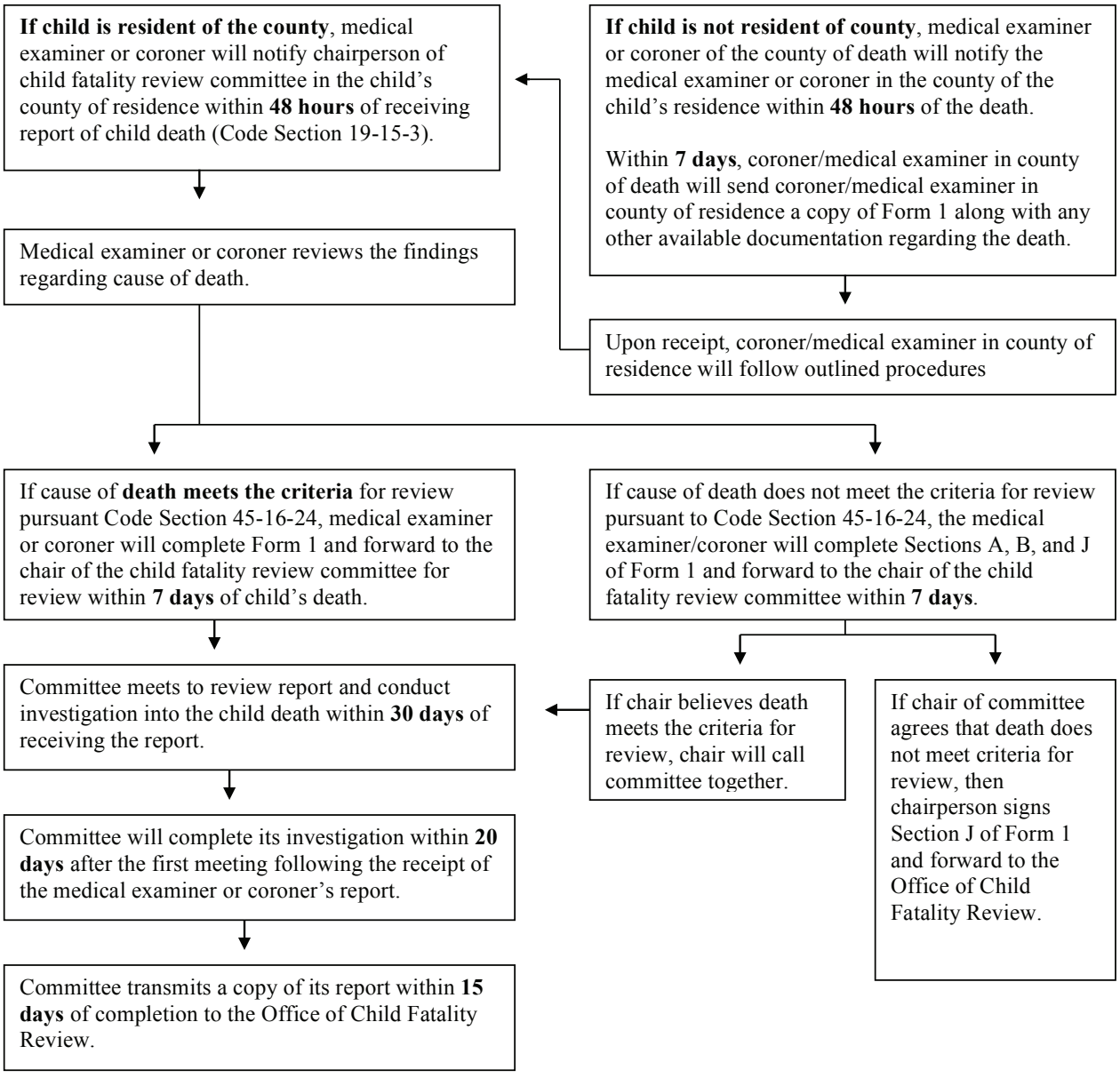
Georgia General Assembly Legislation (www.legis.ga.gov)

Prevent Child Abuse America (www.preventchildabuse.org)

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

Appendix A

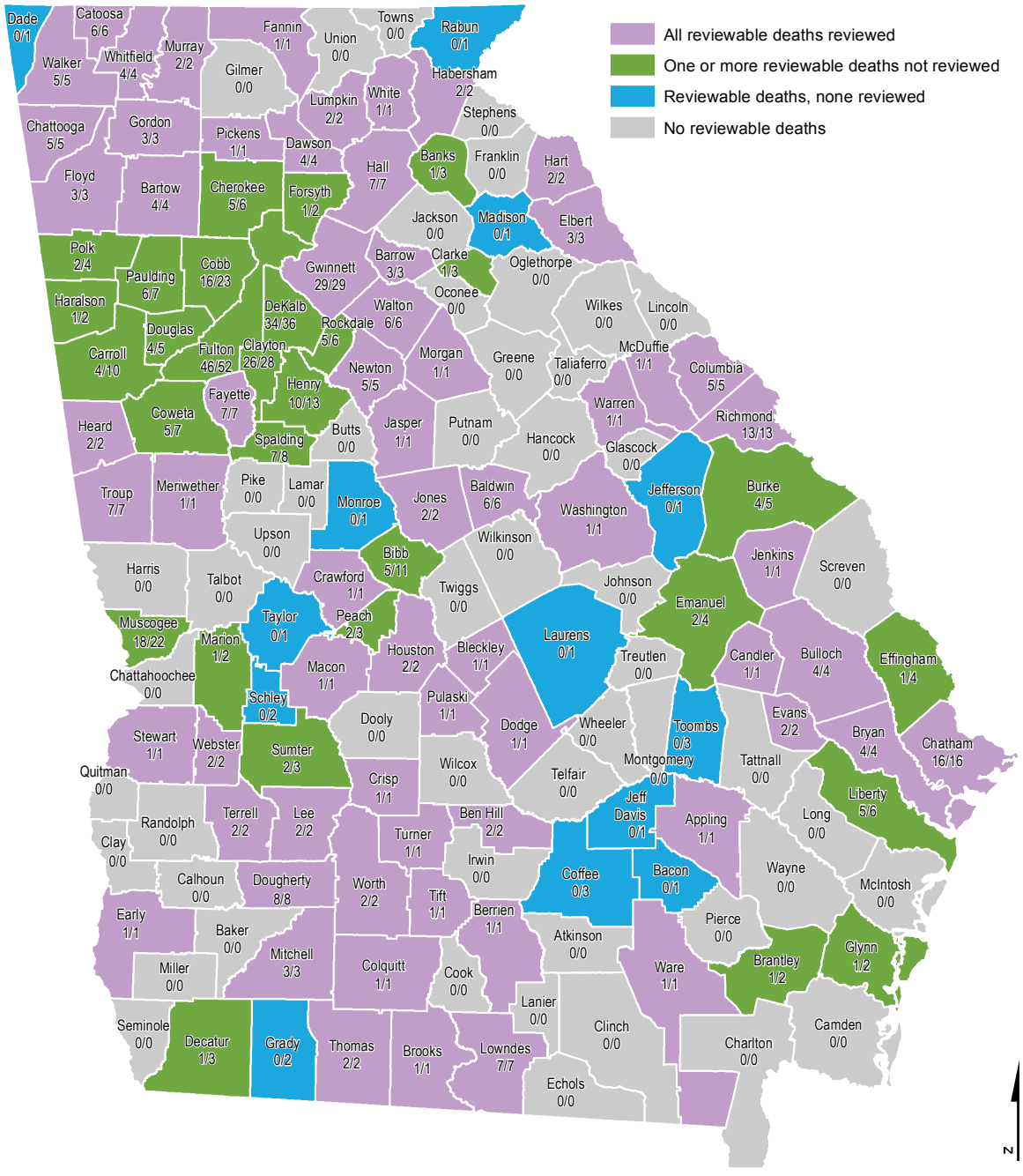
Child Fatality Review Committee Timeframes and Responsibilities



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

Number of Reviewable Deaths Reviewed / Number of Reviewable Deaths, 2016



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 2016 Deaths GA Residents, Age < 18 Years					Reviewable 2016 Deaths					Reviewable 2016 Deaths Reviewed					All 2016 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	Infant	1 to 4	5 to 9	10 to 14	15 to 17
Appling	2					1					1									
Atkinson	1																			
Bacon	2			1					1											
Baker																				
Baldwin	5	1		3	2	3			1	2	3			1	2	3			1	2
Banks	3	2	1	1	1		1		1	1		1					1			
Barrow	1	1		1	1		1		1	1		1		1	1		1		1	1
Bartow	8	2			4		1			3		1			3	1	1			3
Ben Hill	4				1	1				1	1				1	1				1
Berrien	2			1					1					1					1	
Bibb	22	6	1		4	4	3	1		3	3	1			1	1	1			1
Bleckley	1					1					1					2				
Brantley	1				2					2					1					1
Brooks	1		1					1					1					1		
Bryan	4	2	1	1	1	1	1		1	1	1	1		1	1	1	1		1	1
Bulloch	5	1	1	1	1	2		1	1		2		1	1		4		1	1	
Burke	3	1	1		2	2	1			2	2				2	3				2
Butts	1															1				
Calhoun					1															
Camden	6	1																		
Candler		1	1		1					1					1					1
Carroll	7	2	2	2	5	2	2	1	1	4	1		1		2	1		2		2
Catoosa	4	3			4		3			3		3			3		1			3
Charlton																				
Chatham	29	6	5	4	6	6	3	1	1	5	6	3	1	1	5	7	4	2	1	5
Chattahoochee	1																		1	
Chattooga	3	2	3			1	2	2			1	2	2			1	2	2		
Cherokee	16	2	1	3	3	2			2	2	2			1	2	1		1	1	2
Clarke	7	2		2		1			2		1					1				
Clay																				
Clayton	41	3	6	7	9	9	3	4	4	8	9	2	3	4	8	10	2	5	4	11
Clinch																				
Cobb	58	11		7	8	7	6		4	6	4	5		2	5	4	6		2	5
Coffee	6			1	1	2				1										
Colquitt	5	1	1		1					1					1					1
Columbia	21			5	2	1			3	1	1			3	1	1			4	2
Cook																				
Coweta	8			4	2	3			3	1	3			1	1	3	1		2	2
Crawford				1					1					1					1	
Crisp	2			1		1					1					1				

	All 2016 Deaths GA Residents, Age < 18 Years					Reviewable 2016 Deaths					Reviewable 2016 Deaths Reviewed					All 2016 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	Infant	1 to 4	5 to 9	10 to 14	15 to 17
Dade	2					1										1				
Dawson	3			1	2	1			1	2	1			1	2	1			1	2
Decatur	4	1		1	2		1		1	1		1				2	1			1
DeKalb	73	10	8	4	17	14	4	1	1	16	13	4	1	1	15	14	6	2	1	16
Dodge	3				1					1					1	1				1
Dooly	1																			
Dougherty	20	2	3	1	1	3	2	2	1		3	2	2	1		3	2	3	1	
Douglas	12	2	1		3	2	1			2	1	1			2	1	3			2
Early					1					1					1					1
Echols		1																		
Effingham	8	1	2			3		1			1					1	1			
Elbert	1	1			2		1			2		1			2		1			2
Emanuel	2	1	1	2	2	1		1	1	1			1		1			1		1
Evans	1		1		1			1		1			1		1			1		1
Fannin	3			1					1					1					1	
Fayette	5	1	3	1	3	1	1	3	1	1	1	1	3	1	1	2	1	3	1	2
Floyd	10	1			3	1				2	1				2	3	1			2
Forsyth	6		1	2	1				1	1					1			1	1	1
Franklin	1			1	2															
Fulton	81	12	12	6	21	20	6	4	4	18	19	6	3	4	14	29	9	4	5	15
Gilmer	1	2																		
Glascock																				
Glynn	9	1			1	2					1					1				
Gordon	6	2		3	1		1		2			1		2		1	1		2	
Grady	3			1	2	1			1											
Greene		1	1														1	1		
Gwinnett	91	9	8	8	10	11	3	6	6	3	11	3	6	6	3	13	4	7	7	4
Habersham	3	2			1	1				1	1				1	2	2			1
Hall	11	3	2	1	3	2	1	1		3	2	1	1		3	2	2	1		3
Hancock																				
Haralson	4		1			2					1					2				
Harris	2				1															1
Hart	2				1	1				1	1				1	1				1
Heard	3	1				1	1				1	1				1				
Henry	19	5	2	4	4	5	2	1	2	3	3	1	1	2	3	2	1	1	2	1
Houston	13			1	1	1				1	1				1	1				1
Irwin	1	1																		
Jackson	7																			
Jasper	3			1		1					1					2			1	
Jeff Davis	4	1				1														
Jefferson	1	1					1													

	All 2016 Deaths GA Residents, Age < 18 Years					Reviewable 2016 Deaths					Reviewable 2016 Deaths Reviewed					All 2016 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	Infant	1 to 4	5 to 9	10 to 14	15 to 17
Jenkins	1				2					1					1					2
Johnson	1																			
Jones	1	1		1			1		1			1		1		1	1		1	
Lamar																				
Lanier																				
Laurens	5				1	1														
Lee	3		3	1	1			1	1				1	1				1	1	
Liberty	14					6					5					6				
Lincoln	1																			
Long	2				1															
Lowndes	22	1	2	1	1	5		1		1	5		1		1	5		1		1
Lumpkin		2					2					2					2			
Macon	1					1					1					1				
Madison	5					1														
Marion	3					2					1					1				
McDuffie	2		1					1					1					1		
McIntosh	1																			
Meriwether	1	1				1					1					1				
Miller																				
Mitchell	4	1			1	2				1	2				1	2	1			1
Monroe	2	1	1			1														
Montgomery																				
Morgan	1				1					1					1					1
Murray	1	1	2			1	1				1	1				1	1			
Muscogee	31	5	5	2	9	7	4	3	1	7	7	2	3	1	5	7	2	3	1	7
Newton	8	1	3		2	1		3		1	1		3		1	2	1	3		2
Oconee	1																			
Oglethorpe																				
Paulding	14	3	1	3	1	3	2		1	1	3	2		1		3	2	1	2	
Peach	3	1			2		1			2		1			1		1			1
Pickens	2					1					1					1				
Pierce																				
Pike																				
Polk	6	1		1	2	1	1		1	1		1			1		2			1
Pulaski		1			1					1					1		1			1
Putnam																				
Quitman																				
Rabun	1				1	1														
Randolph	1																			
Richmond	33	10	2	4	1	7	5		1		7	5		1		9	5		1	1
Rockdale	10	1		1	2	3			1	2	3				2	3				2

	All 2016 Deaths GA Residents, Age < 18 Years					Reviewable 2016 Deaths					Reviewable 2016 Deaths Reviewed					All 2016 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	Infant	1 to 4	5 to 9	10 to 14	15 to 17
Schley	1				2					2										
Screven	4																			
Seminole	1			1																
Spalding	9	1	2		3	4		2		2	4		2		1	3		2		2
Stephens	1															1				
Stewart		1					1					1					1			
Sumter	4	1	2	1			1	1	1			1		1			1		1	
Talbot																				
Taliaferro																				
Tattnall	2			2																
Taylor	1				1					1										
Telfair																				
Terrell			1		1			1		1			1		1			1		1
Thomas	5				1	2					2					2				1
Tift	4	1			1					1					1	1	1			1
Toombs	4	1	2			1	1	1												
Towns	1																			
Treutlen																				
Troup	12	1		2	1	5			1	1	5			1	1	5			1	1
Turner				1					1					1					1	
Twiggs	1																			
Union	2																			
Upson	1																			
Walker	4	2	1			2	2	1			2	2	1			3	3	1		
Walton	9	3	1	1	1	3	1		1	1	3	1		1	1	4	1		1	1
Ware	4	1	2			1					1					1				
Warren					1					1					1					1
Washington	1	1		1					1					1					1	
Wayne	2																			
Webster				1	1				1	1				1	1				1	1
Wheeler	1																			
White		2					1					1					1			
Whitfield	6	2				2	2				2	2				2	3			
Wilcox	4																			
Wilkes																				
Wilkinson																1				
Worth	2		1			1		1			1		1			1		1		

All 2016 Child Deaths (N = 1,599)								
		White		African-American		Other Race		Total
AgeCat	Cause	Male	Female	Male	Female	Male	Female	
Infant	Drown				1			966
	Fire		2					
	Homicide	2	3	2	2			
	Medical	160	149	231	206	19	9	
	MVC		2	3	1			
	OthInjury	1	1	1				
	SIDS	20	17	30	29	3		
	Suff_Bed	9	5	11	6		1	
	Suff_Oth	2		2				
	Unk Intent	1		1				
	Unknown	10	8	6	10			
Ages 1 – 4	Drown	10	1	6	2			160
	Fire	1	3		1			
	Firearm	2						
	Homicide	2	1	5	6	1		
	Medical	26	14	20	19	1	2	
	MVC	4	8	5	3			
	OthInjury	2			2			
	Poison			3				
	Suff_Oth		1	1				
	Unk Intent				1			
	Unknown	2	3	1	1			
Ages 5 – 9	Drown	2	1	4	3			103
	Fire	1	2		2			
	Firearm	1						
	Homicide	1		1	2	1		
	Medical	10	16	12	14		3	
	MVC	6	1	6	5			
	OthInjury			2	2			
	Suff_Oth				1			
	Suicide			1				
	Unk Intent	1		1				
	Unknown		1					

All 2016 Child Deaths (N = 1,599) (continued)								
		White		African-American		Other Race		Total
AgeCat	Cause	Male	Female	Male	Female	Male	Female	
Ages 10 – 14	Drown	1	1	3				109
	Fire		1					
	Firearm	1						
	Homicide	2	1	1	3			
	Medical	13	7	11	13		1	
	MVC	8	8	5	2			
	OthInjury	1		2	1			
	Poison	1						
	Suff_Oth	1						
	Suicide	8	7	2	2	1		
	Unknown			1				
Ages 15 – 17	Drown	2		4				191
	Fire				3			
	Firearm	1						
	Homicide	4	2	24	9			
	Medical	19	9	8	12		3	
	MVC	20	10	10	4		1	
	OthInjury	3			1			
	Poison	2						
	Suicide	20	6	7			3	
	Unknown	1		3				
Total		**384**	**291**	**436**	**369**	**26**	**23**	

County Totals						
County	All Deaths	Reviewable	Rvbl Rvwd	All Reviewed	Label	Category
Appling	2	1	1	0	1/1	4
Atkinson	1	0	0	0	0/0	1
Bacon	3	1	0	0	0/1	2
Baker	0	0	0	0	0/0	1
Baldwin	11	6	6	6	6/6	4
Banks	8	3	1	1	1/3	3
Barrow	4	3	3	3	3/3	4
Bartow	14	4	4	5	4/4	4
Ben Hill	5	2	2	2	2/2	4
Berrien	3	1	1	1	1/1	4
Bibb	33	11	5	3	5/11	3
Bleckley	1	1	1	2	1/1	4
Brantley	3	2	1	1	1/2	3
Brooks	2	1	1	1	1/1	4
Bryan	9	4	4	4	4/4	4
Bulloch	9	4	4	6	4/4	4
Burke	7	5	4	5	4/5	3
Butts	1	0	0	1	0/0	1
Calhoun	1	0	0	0	0/0	1
Camden	7	0	0	0	0/0	1
Candler	3	1	1	1	1/1	4
Carroll	18	10	4	5	4/10	3
Catoosa	11	6	6	4	6/6	4
Charlton	0	0	0	0	0/0	1
Chatham	50	16	16	19	16/16	4
Chattahoochee	1	0	0	1	0/0	1
Chattooga	8	5	5	5	5/5	4
Cherokee	25	6	5	5	5/6	3
Clarke	11	3	1	1	1/3	3
Clay	0	0	0	0	0/0	1
Clayton	66	28	26	32	26/28	3
Clinch	0	0	0	0	0/0	1
Cobb	84	23	16	17	16/23	3
Coffee	8	3	0	0	0/3	2
Colquitt	8	1	1	1	1/1	4
Columbia	28	5	5	7	5/5	4
Cook	0	0	0	0	0/0	1
Coweta	14	7	5	8	5/7	3
Crawford	1	1	1	1	1/1	4
Crisp	3	1	1	1	1/1	4
Dade	2	1	0	1	0/1	2
Dawson	6	4	4	4	4/4	4
Decatur	8	3	1	4	1/3	3
DeKalb	112	36	34	39	34/36	3

County Totals						
County	All Deaths	Reviewable	Rvbl Rvwd	All Reviewed	Label	Category
Dodge	4	1	1	2	1/1	4
Dooly	1	0	0	0	0/0	1
Dougherty	27	8	8	9	8/8	4
Douglas	18	5	4	6	4/5	3
Early	1	1	1	1	1/1	4
Echols	1	0	0	0	0/0	1
Effingham	11	4	1	2	1/4	3
Elbert	4	3	3	3	3/3	4
Emanuel	8	4	2	2	2/4	3
Evans	3	2	2	2	2/2	4
Fannin	4	1	1	1	1/1	4
Fayette	13	7	7	9	7/7	4
Floyd	14	3	3	6	3/3	4
Forsyth	10	2	1	3	1/2	3
Franklin	4	0	0	0	0/0	1
Fulton	132	52	46	62	46/52	3
Gilmer	3	0	0	0	0/0	1
Glascock	0	0	0	0	0/0	1
Glynn	11	2	1	1	1/2	3
Gordon	12	3	3	4	3/3	4
Grady	6	2	0	0	0/2	2
Greene	2	0	0	2	0/0	1
Gwinnett	126	29	29	35	29/29	4
Habersham	6	2	2	5	2/2	4
Hall	20	7	7	8	7/7	4
Hancock	0	0	0	0	0/0	1
Haralson	5	2	1	2	1/2	3
Harris	3	0	0	1	0/0	1
Hart	3	2	2	2	2/2	4
Heard	4	2	2	1	2/2	4
Henry	34	13	10	7	10/13	3
Houston	15	2	2	2	2/2	4
Irwin	2	0	0	0	0/0	1
Jackson	7	0	0	0	0/0	1
Jasper	4	1	1	3	1/1	4
Jeff Davis	5	1	0	0	0/1	2
Jefferson	2	1	0	0	0/1	2
Jenkins	3	1	1	2	1/1	4
Johnson	1	0	0	0	0/0	1
Jones	3	2	2	3	2/2	4
Lamar	0	0	0	0	0/0	1
Lanier	0	0	0	0	0/0	1
Laurens	6	1	0	0	0/1	2
Lee	8	2	2	2	2/2	4

County Totals						
County	All Deaths	Reviewable	Rvbl Rvwd	All Reviewed	Label	Category
Liberty	14	6	5	6	5/6	3
Lincoln	1	0	0	0	0/0	1
Long	3	0	0	0	0/0	1
Lowndes	27	7	7	7	7/7	4
Lumpkin	2	2	2	2	2/2	4
Macon	1	1	1	1	1/1	4
Madison	5	1	0	0	0/1	2
Marion	3	2	1	1	1/2	3
McDuffie	3	1	1	1	1/1	4
McIntosh	1	0	0	0	0/0	1
Meriwether	2	1	1	1	1/1	4
Miller	0	0	0	0	0/0	1
Mitchell	6	3	3	4	3/3	4
Monroe	4	1	0	0	0/1	2
Montgomery	0	0	0	0	0/0	1
Morgan	2	1	1	1	1/1	4
Murray	4	2	2	2	2/2	4
Muscogee	52	22	18	20	18/22	3
Newton	14	5	5	8	5/5	4
Oconee	1	0	0	0	0/0	1
Oglethorpe	0	0	0	0	0/0	1
Paulding	22	7	6	8	6/7	3
Peach	6	3	2	2	2/3	3
Pickens	2	1	1	1	1/1	4
Pierce	0	0	0	0	0/0	1
Pike	0	0	0	0	0/0	1
Polk	10	4	2	3	2/4	3
Pulaski	2	1	1	2	1/1	4
Putnam	0	0	0	0	0/0	1
Quitman	0	0	0	0	0/0	1
Rabun	2	1	0	0	0/1	2
Randolph	1	0	0	0	0/0	1
Richmond	50	13	13	16	13/13	4
Rockdale	14	6	5	5	5/6	3
Schley	3	2	0	0	0/2	2
Screven	4	0	0	0	0/0	1
Seminole	2	0	0	0	0/0	1
Spalding	15	8	7	7	7/8	3
Stephens	1	0	0	1	0/0	1
Stewart	1	1	1	1	1/1	4
Sumter	8	3	2	2	2/3	3
Talbot	0	0	0	0	0/0	1
Taliaferro	0	0	0	0	0/0	1
Tattnall	4	0	0	0	0/0	1

County Totals						
County	All Deaths	Reviewable	Rvbl Rvwd	All Reviewed	Label	Category
Taylor	2	1	0	0	0/1	2
Telfair	0	0	0	0	0/0	1
Terrell	2	2	2	2	2/2	4
Thomas	6	2	2	3	2/2	4
Tift	6	1	1	3	1/1	4
Toombs	7	3	0	0	0/3	2
Towns	1	0	0	0	0/0	1
Treutlen	0	0	0	0	0/0	1
Troup	16	7	7	7	7/7	4
Turner	1	1	1	1	1/1	4
Twiggs	1	0	0	0	0/0	1
Union	2	0	0	0	0/0	1
Upson	1	0	0	0	0/0	1
Walker	7	5	5	7	5/5	4
Walton	15	6	6	7	6/6	4
Ware	7	1	1	1	1/1	4
Warren	1	1	1	1	1/1	4
Washington	3	1	1	1	1/1	4
Wayne	2	0	0	0	0/0	1
Webster	2	2	2	2	2/2	4
Wheeler	1	0	0	0	0/0	1
White	2	1	1	1	1/1	4
Whitfield	8	4	4	5	4/4	4
Wilcox	4	0	0	0	0/0	1
Wilkes	0	0	0	0	0/0	1
Wilkinson	0	0	0	1	0/0	1
Worth	3	2	2	2	2/2	4
Total	**1529**	**522**	**438**	**531**		

All Reviewed 2016 Infant / Child Deaths (N = 531)								
		White		African-American		Other Race		Total
AgeCat	Cause	Male	Female	Male	Female	Male	Female	
Infant	Asphyxia	1		1				200
	Drown		1		1			
	Fall/Crush			1				
	Fire		2					
	Homicide	2	3	2	1			
	Medical	5	1	5	4			
	MVC		1	3	1			
	OtherCause		1	1	1			
	Poison		1	1				
	SIDS	1	1	1	1			
	SUID_Asph	12	11	19	15	1		
	SUID_Med	2	2	3	4		1	
	SUID_Undet	20	11	21	22	3	1	
	Undetermined	1		3	3			
	Weapon					1		
Ages 1 – 4	Asphyxia	1	1	1				87
	Drown	10	1	4	1			
	Exposure	1						
	Fire	1	3		1			
	Homicide	1	1	5	6	2	1	
	Medical	4	5	5	4	2		
	MVC	2	7	2	2	1	1	
	Other Cause		1					
	Poison			3	1		1	
	SUDC	1	1					
	Undetermined			1				
	Weapon	2						
Ages 5 – 9	Asphyxia			1	2			54
	Drown	2	1	4	1			
	Fire	1	2		2			
	Homicide		1	1	2	1		
	Medical	1	4	5	4			
	MVC	5	1	7	3		1	
	Other Cause	1						
	Suicide			1				

All Reviewed 2016 Infant / Child Deaths (N = 531) (continued)								
		White		African-American		Other Race		Total
AgeCat	Cause	Male	Female	Male	Female	Male	Female	
Ages 10 – 14	Drown			2				56
	Exposure			1				
	Fire		1					
	Homicide	2			2		1	
	Medical	3	2	1	1	1		
	MVC	6	6	4	2	1	1	
	Poison	1						
	Suicide	4	5	2	1	2	1	
	Undetermined			1				
	Weapon	1			1			
Ages 15 – 17	Bite	1						134
	Drown	1		4		1		
	Fire				2			
	Homicide	2	3	19	9	1		
	Medical	3	3	5	4		1	
	MVC	17	6	6	5	1		
	Poison	2						
	Suicide	19	4	5		2	5	
	Undetermined		1	1				
	Weapon			1				
Total		**139**	**95**	**153**	**109**	**20**	**15**	

Reviewed Deaths with Maltreatment Cause or History (N = 171)								
		White		African-American		Other Race		Total
AgeCat	Cause	Male	Female	Male	Female	Male	Female	
Infant	Homicide	1	3	2	1			36
	Medical				1			
	Other Cause				1			
	Poison		1					
	SIDS	1			1			
	SUID_Asph	1		3	3			
	SUID_Med		1					
	SUID_Undet	3	2	3	5	1	1	
	Undet				1			
Ages 1 to 4	Asphyxia			1				39
	Drown	4	1	2	1			
	Fire	1	1					
	Homicide	1	1	5	6	2	1	
	Medical	1	1	3	3	2		
	MVC					1		
	Poison				1			
Ages 5 to 9	Asphyxia				1			24
	Drown	2		1				
	Fire	1	2					
	Homicide		1	1	2	1		
	Medical		2	3				
	MVC	2		3	1			
	Other Cause	1						
Ages 10 to 14	Drown			1				22
	Fire		1					
	Homicide	1					1	
	Medical	1	1	1				
	MVC	4	2	3				
	Suicide	1	3	1				
	Undetermined			1				
Ages 15 to 17	Drown	1		1				50
	Fire				1			
	Homicide	1		7	8	1		
	Medical	2		1	2		1	
	MVC	6	1	1				
	Poison	1						
	Suicide	9	2	1			3	
Total		**46**	**26**	**45**	**39**	**8**	**7**	

Preventability of Reviewed Deaths with No Maltreatment Cause or History (N = 360)			
	Death Preventable?		
Cause	No, probably not	Yes, probably	Could not determine
Asphyxia	1	3	2
Bite		1	
Drown		17	3
Exposure		2	
Fall/Crush			1
Fire		7	1
Homicide	3	16	2
Medical	30	4	14
MVC	2	62	4
Other Cause	1	2	
Poison		6	1
SIDS	1		1
SUDC		1	1
Suicide	8	16	7
SUID_Asph	1	39	11
SUID_Med	4	4	3
SUID_Undet	5	40	18
Undetermined	2	4	3
Weapon		6	

Preventability Determination, All Reviewed 2016 Deaths				
CauSummary	**No**	**Yes**	**?**	**% Preventable***
Asphyxia	1	5	2	
Bite		1		
Drown		30	4	
Exposure		2		
Fall/Crush			1	
Fire		12	3	
MVC	3	84	5	
OtherCause	2	2	1	
Poison		8	2	
Weapon		6		
Unintentional Subtotal	6	150	18	96.2
Homicide	7	56	5	88.9
Suicide	15	25	11	62.5
Sleep-Related Subtotal	15	97	40	86.6
SIDS	3		1	
SUID_Asph	3	43	12	
SUID_Med	4	4	4	
SUID_Undet	5	50	23	
SUDC		1	1	
Undetermined	2	4	5	
All Reviewable Subtotal	45	333	80	88.1
Medical	45	7	21	13.5
All Reviewed	90	340	101	79.1

1 = No, probably not

2 = Yes, probably

3 = Team could not determine

*Calculation of % Preventable excludes deaths for which the team could not determine preventability.

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.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