Georgia Child Fatality Review Panel

Annual Report - Calendar Year 2019

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Acting Panel Chairman

Brian Kemp
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Mission

The mission of the Georgia Child Fatality Review Panel is to provide the highest quality of child fatality data, training, technical assistance, investigative support services, and resources to any entity dedicated to the well-being and safety of children to prevent and reduce child abuse and fatality in the state. The 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 Child Fatality Review Committees
- John T. Carter, PH.D., M.P.H., Emeritus Assistant Professor, Rollins School of Public Health, Emory University

The report was developed and written by the staff members of the Child Fatality Review Unit within the Georgia Bureau of Investigation.

Letter from the CFR Panel Chair

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

We present the Annual Report of the Georgia Child Fatality Review Panel for data collected in the calendar year of 2019. This data has been reported to the Panel by the 159 county fatality review panels of the state pursuant to statutory requirements. This information is provided to you as part of our ongoing efforts to prevent and decrease child fatalities in Georgia. Thank you for the continuing partnership in this important effort.

This report used multi-year data to analyze specific topics related to Georgia's 1,450 child deaths in 2019. Many of these deaths do not meet criteria for review as these are deaths of infants on the first day of life and in the first month thereafter arising from medical complications related to prematurity and congenital defects. Certainly, this significant number of deaths points to Georgia's need to support access to medical care for pregnant women and maternal health.

There were 468 reviewable deaths for 2019 with 429 reviews completed. Child Fatality Review focuses upon unintentional deaths (28%) and intentional deaths (20%). Areas of concern include sleep related deaths of infants and toddlers; motor vehicle related accidents particularly among teens 15 to 17 years of age; suicide of children who are young, preteens and adolescents; and homicides of children.

We must educate and promote public awareness of our consistent messaging on the ABC's of safe sleep (Alone, on the Back, in a Crib) in every contact with families throughout our State. Our efforts to promote safe driving among our teens as well as use of child safety seats and booster seats, proper installation of child safety seats, and avoidance of distracted driving must continue. We must also engage communities on implementation of Georgia's suicide prevention plan to support our children who need additional support with stressors and the difficulties of social and emotional regulation. We also have an opportunity to plan prevention strategies by regions as the Division of Family and Children Services implements Georgia's new Prevention Plan.

This report indicates the need for parental training and support particularly in identifying family stressors and providing necessary connections to address stressors to decrease maltreatment of children and intentional deaths of children. Additionally, emphasizing safe storage of firearms is necessary to decrease both suicides of children and intentional deaths of children. Teaching firearm safety to adults and children is vital given the number of deaths that are firearm related. We must continue to stress that the impulsiveness of youth and access to firearms is a deadly combination. We as adults are responsible for the safety of our children and must take the necessary steps to secure all firearms to protect our children, and we must be held responsible when we fail to do so.

The Georgia Bureau of Investigation and Director Victor Reynolds, his agents and staff continue to enhance support for this Panel's mission. Their contributions are vital to the important work of preventing child deaths throughout the State.

Thank you for your attention to this report and its findings. Together, we shall accomplish our mission to reduce and prevent child deaths in Georgia.

Sincerely,

Judge Peggy H. Walker
Acting Chair for 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 in 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 level 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 identify specific policy recommendations to reduce child deaths in Georgia.

The product of the review process is a description of trends and risk factors for child deaths in Georgia. The local CFR Teams and the Georgia CFR Panel use the review information to identify prevention strategies. The Georgia CFR Panel includes 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 Panel allow an in-depth analysis of both contributory and preventative factors for child deaths. This report identifies specific policy recommendations to reduce child deaths in Georgia.

Executive Summary

The Georgia Child Fatality Review Panel publishes an annual report on the deaths of infants and children in Georgia. The Report uses death certificate data provided by the Office of Vital Records within the Division of Public Health to document all deaths to the population under 18 years of age. The CFR process involves a review of a subset of deaths that are unexpected or are due to unintentional or intentional injuries. The review process provides for the systematic collection of "risk factor" data on deaths that are potentially preventable. These child death data are useful in revealing recurring patterns and to indicate prevention gaps and opportunities.

The Georgia trends in infant / child deaths over the last 10 years have been unremarkable. The child death rates tend to vary slightly from year to year, but there has not been any apparent trend. The infant death rate has declined from 7.8 deaths per 1,000 births in 2015 to 7.0 in 2019. Both rates remain slightly higher than the National rate.

There were 1,450 reported (Death Certificate) infant and child (< 18 years) deaths in 2019. Four hundred sixty-eight (468) of those deaths were considered as "reviewable", and 429 of the 468 were reviewed (92%). The county review teams also reviewed 117 of the 982 "medical" deaths and 11 deaths that were reported as non-GA residents or were missing a death certificate. This yields a total of 557 reviewed deaths, and the analysis of reviewed deaths includes all 557.

Table A. Reviewable 2019 Georgia Infant and Child Deaths, Proportion Reviewed

Major Cause of Death Categories	All Deaths	Reviewed	% Reviewed
Unintentional Injuries	169	148	87.6
Intentional Injuries	128	120	93.8
Sleep-Related (Infants)	156	148	94.9
Unknown / Unknown Intent	15	13	86.7
Total	**468**	**429**	**91.7**

The CFR teams determined that 45 of the 557 reviewed deaths (8%) had maltreatment (abuse or neglect) reported as a cause or contributing factor for the death. An additional 113 deaths (20%) reported a history of maltreatment. Child maltreatment is a valuable factor for identifying populations at risk for child deaths, and agencies serving children need appropriate access to maltreatment information.

The CFR teams agree that these reviewable deaths could have been prevented – 346 of the 374 (92%) of the reviewed deaths (non-medical cause, with a preventability determination) could "Probably" have been prevented. This result highlights the importance of the CFR process for identifying risk factors and contributing to the design of prevention strategies.

Racial disparities in the rates of infant and child deaths have been well documented, and the Georgia data (death certificate and Fatality Review) confirm the disparity. In 2019, 286 White, non-Hispanic infants died (a rate of 5.2 per 1,000 births). The rate was 10.7 (468 deaths) for Black/African-American, non-Hispanic infants. Overall African-American children were more likely to die a violent death. The disparity varies by cause of death; prevention targets or activities must account for both racial differences as well as differences in cause of deaths.

The National Center for Fatality Review and Prevention (NCFRP) data system is now a source for eight years of GA fatality review data. We are using this multi-year data to conduct analyses on specific topics related to Georgia infant and child deaths. The topics will address demographic characteristics (age, race, and sex), specific causes of death (sleep-related, suicide, homicide, and motor vehicle crashes), and/or cross-cutting subjects (maltreatment, supervision). Completed and documented analyses will be released and posted on the CFR website.

Reported Child Deaths in Georgia

In 2019, there were a total of 1,450 infant/child deaths in Georgia. Of those 1,450 deaths, 468 deaths met the eligibility criteria for county level Child Fatality Review. Of the 468 deaths that met the review criteria, 429 were reviewed (91.7%).

Any infant or child death is loss to society and a tragedy for the immediate family. The child fatality review (CFR) process was developed to provide a way to learn from these deaths so that future deaths could be prevented. A “learning process” can take place at three levels:

1

Community (county): A local CFR team reviews the individual deaths, enters data abstracted from the review into a GA (and National) database, and develops recommendations f or action at the community level.

2

Georgia: The GA CFR Panel – through work by staff from the GA Child Fatality Review – reviews the analysis of the state-wide CFR data and prepares recommendations (legislation, education, and environmental) designed to reduce childhood injury and associated death.

3

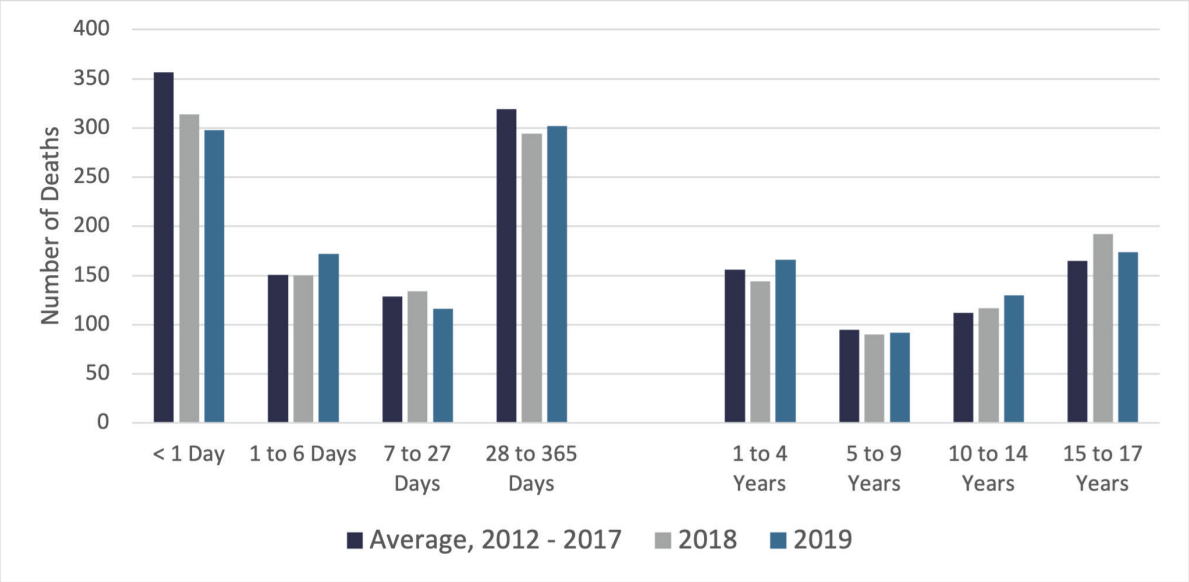
Nation: The National Center for the Review and Prevention of Child Deaths (NCFRP) maintains the national database and provides an opportunity for research on child deaths at the national level.

This annual CFR Report indicates trends in child deaths, summarizes the GA CFR 2019 activities, and provides a synthesis of the local CFR teams' prevention recommendations. The CFR Panel serves as one of the citizen review panels for the GA Child Abuse Prevention and Treatment Act (CAPTA), so one section explicitly addresses child maltreatment.

2019 Child Deaths:

A majority of these 1,450 reported deaths were infant deaths (888, or 61%), and 298 of the infant deaths occurred in the 1st day of life (Figure 1). An additional 288 occur within the 1st month and these three age categories define "neonatal deaths". These neonatal deaths are generally associated with prematurity and congenital defects, and they are not usually a subject for CFR. The sleep-related infant deaths are the largest category of post-neonatal deaths, and they are reviewed.

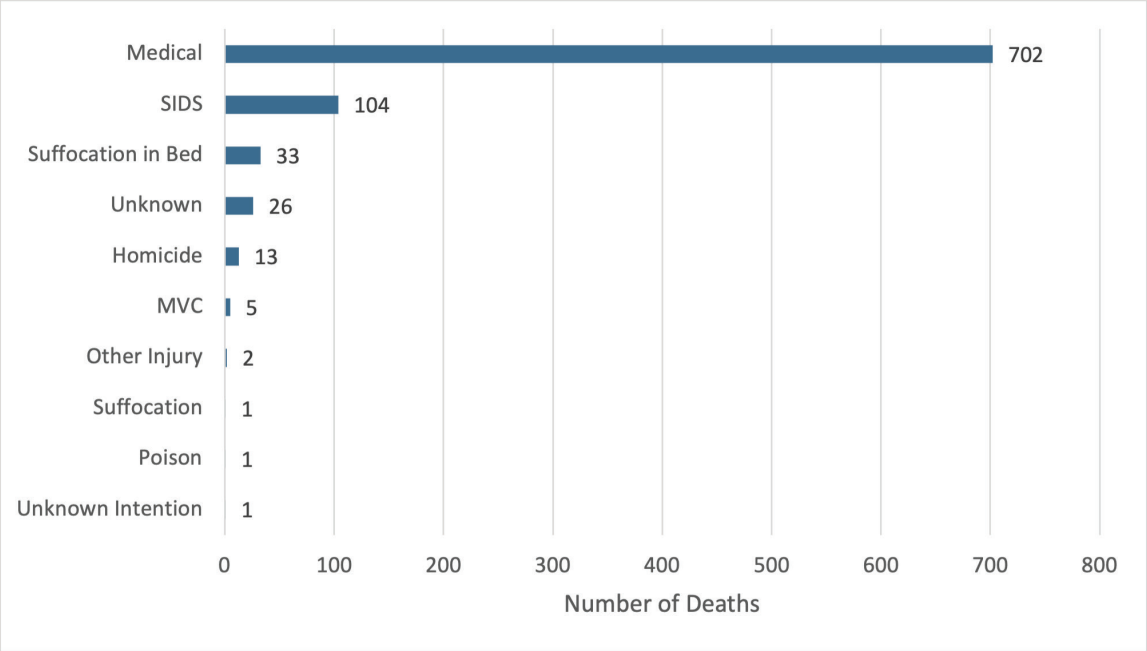
Figure 1. Age Distribution, GA Infant and Child Deaths



The 2019 NCHS data (NCHS Data Brief No. 395, December 2020) showed a U.S. infant mortality rate of 5.6 per 1,000. The GA Oasis rate was 7.0. Toddlers (1 to 4) and children (5 to 14) death rates were 23.3 and 13.4 per 100,000 for the U.S. and 30.9 and 15.8 for GA in 2019. Georgia's rate for all these mortality measures is slightly higher than the National rate.

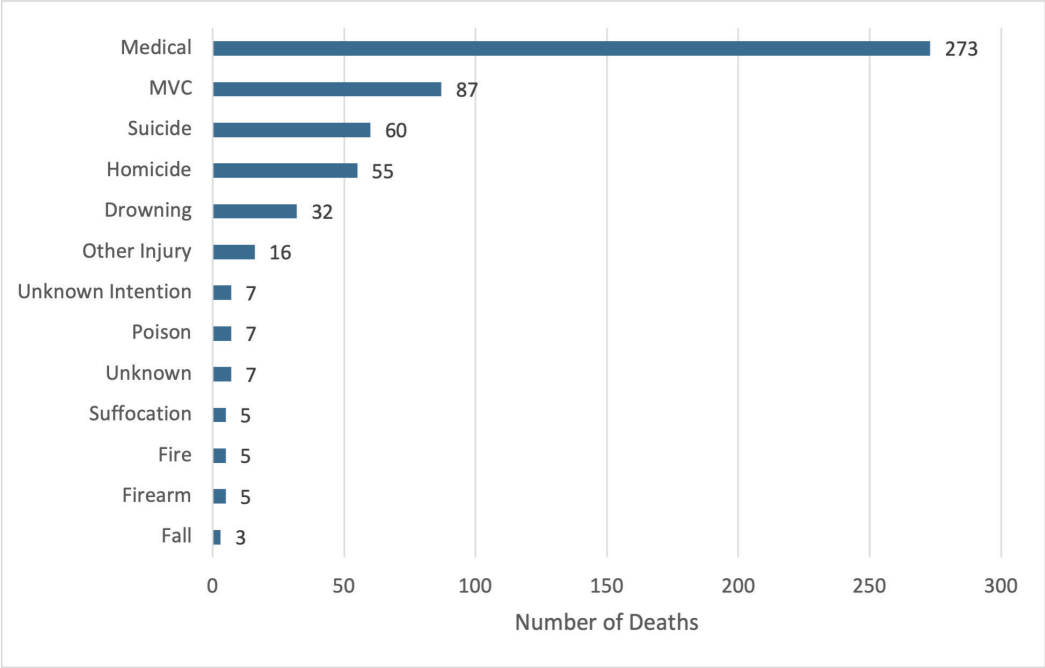
The 2019 infant deaths (Figure 2) are dominated by "medical" causes (79% of all infant deaths). The three next largest causes – SUID, suffocation in bed, and unknown – comprise the combined category of "sleep-related" deaths and account for 18% of all infant deaths. However, these sleep-related deaths made up 48% of all post-neonatal infant deaths.

Figure 2. 2019 Georgia Infant Deaths, by Cause



The estimated population of children ages 1 through 17 in 2019 was 2,378,228, and there were 562 deaths in that population in 2019. Deaths are more common among toddlers and teens, and these age differences are associated with specific causes of death. Deaths attributed to medical causes continue to be the largest category of death for ages 1 through 17 years (49%), but Figure 3 shows the significant number of deaths from unintentional (28%) and intentional (20%) injuries.

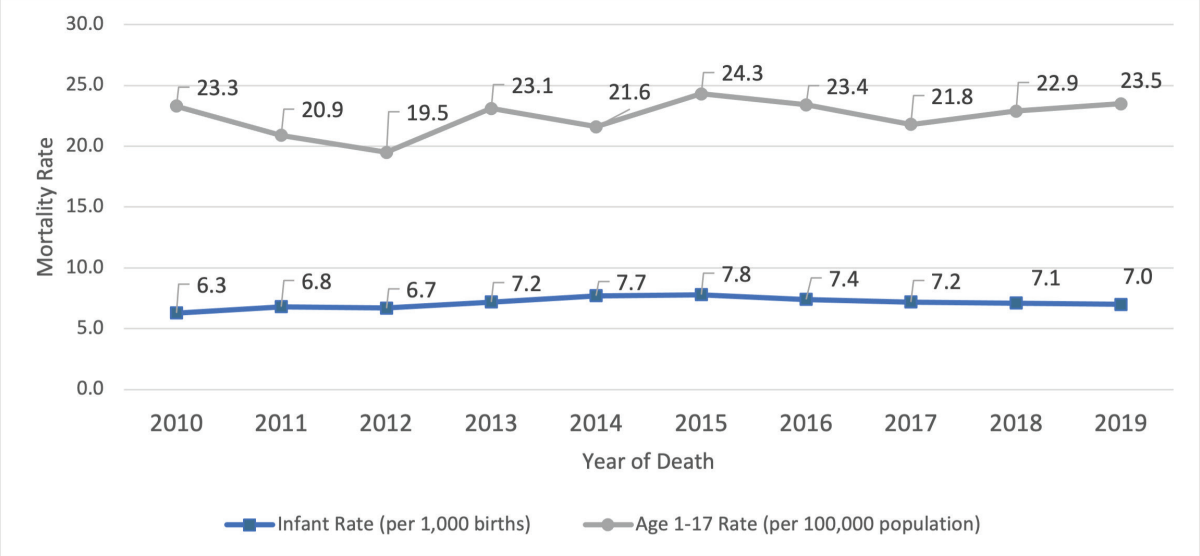
Figure 3. 2019 Georgia Deaths, Ages 1 - 17, by Cause



Trends in Georgia Infant and Child Deaths:

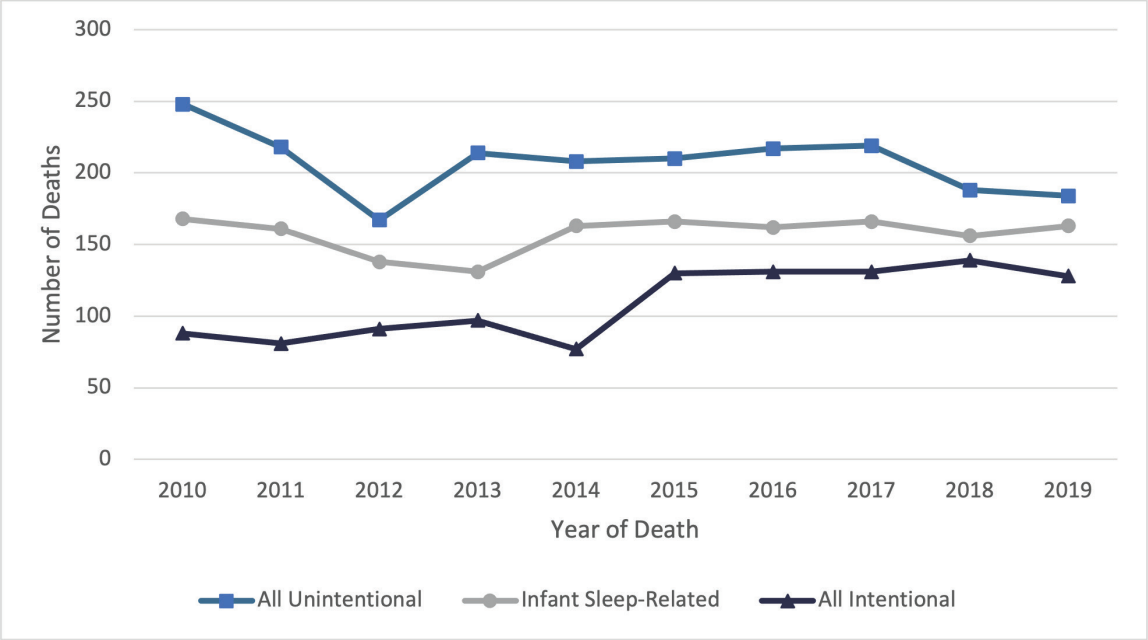
The total (all causes and ages) mortality rates obscure any of the age/cause differences, but they provide an overview of deaths for the past ten years (Figure 4). The infant rate shows an increase between 2010 and 2014/5 and then a decrease the last four years. The 1 – 17 rate appears to fluctuate more from year to year, but there is no obvious trend. The 2019 rate (23.5 per 100,000) is only slightly higher than the average rate (22.3) for the preceding nine years.

Figure 4. Georgia Infant and Child Death Rate Trends, 2010 - 2018



A brief examination of cause of death numbers over time shows a significant increase in the intentional deaths in 2015 (Figure 5), and deaths remained at the higher level for the next four years. These increases in homicides and suicides will be examined in subsequent analysis using the multi-year death certificate and CFR data.

Figure 5. Count of Georgia Deaths, Ages 0 - 17, Selected Categories, 2010 - 2019



Child Deaths Reviewed

The GA CFR process has been in place and operating since 1991. Over these past 28 years the GA CFR and the county teams have worked diligently to complete reviews and enter the reviews into the state (now national) CDR database. The proportion of "reviewable deaths" reviewed has been as high as 95%; however, after decreasing for six years, the teams have reviewed 91% of the reviewable deaths for the last two years. That effort returns the reviewed proportion to the 2012 level. The extent of county team participation (in an unfunded mandate) after 28 years is very commendable, and it is important to acknowledge and encourage that local effort.

A child fatality review is required for deaths that are sudden, unexpected, unexplained, suspicious, or attributed to unusual circumstances, but the legislation does not provide a specific case definition for reviewable deaths. Historically, any non-medical cause death (defined by the ICD code for the underlying cause of death) has been defined as reviewable. Certain medical deaths (unexpected, decedent not under the care of a physician) are appropriately reviewed and are addressed in the annual report, however they are not included in either denominator or numerator when calculating the proportion of reviewable deaths reviewed. (A change this year in the case definition for sleep-related deaths is addressed in the section on those deaths.) Using the "non-medical cause" criterium for reviewable deaths (with the sleep-related change), there were 468 reviewable 2019 deaths.

The death certificate (DC) and Child Death Review (CDR) databases are linked (using dates of birth and death, decedent and parent names, and street address). The linked files are used to calculate the CDR performance metric – percent of "Reviewable Deaths" reviewed – and to provide data quality review. Seven of the 557 reviewed death records did not link with a DC. This list has been provided to GA Vital Records for follow-up. Four of the remaining 550 records linked with a DC for a non-GA resident. Five hundred forty-six (546) of the completed CFR records were linked with a death certificate for a GA resident.

These 546 records are used for the calculation of the proportion of reviewable deaths reviewed (Table 1). However, all 557 completed reviews are included in the analysis of reviewed deaths.

Table 1. Percent of 2019 GA Reviewable Deaths Reviewed

Cause of Death (DC)	All Deaths	Reviewed	% Reviewed
MVC	92	78	84.8.0
Drowning	32	31	96.9
Other Injury	45	39	86.7
Unintentional Injury Total	**169**	**148**	**87.6**
Homicide	68	64	94.1
Suicide	60	56	93.3
Sleep-Related Total (Infants)	**156**	**148**	**94.9**
Unknown	7	6	85.7
Unknown Intent	8	7	87.5
Reviewable Total	**468**	**429**	**91.7**
Medical	982	117	11.9
All Deaths	**1,450**	**546**	**37.7**

The map in Appendix B displays counts by county for the number of reviewable deaths and the number of reviewable deaths reviewed. Eighty-three of the 159 GA counties reviewed all of their reviewable deaths (Table 2).

Table 2. Summary of 2019 Review Categories

Definition	Category	Counties	Reviewable Deaths	Reviewed
All reviewable deaths reviewed	4	83	328	328
One or more reviewable deaths not reviewed	3	11	119	101
Reviewable deaths, none reviewed	2	9	21	
No reviewable deaths	1	56		
Total			**468**	**429**

Maltreatment

The Role of Maltreatment in Reviewed Child Deaths

The World Health Organization defines child maltreatment as the abuse and neglect that occurs to children under 18 years of age. It includes all types of physical and/or emotional ill-treatment, sexual abuse, neglect, negligence and commercial or other exploitation, which results in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power. Exposure to intimate partner violence is also sometimes included as a form of child maltreatment.

2019 Reviewed Deaths with Maltreatment Reported

The purpose of this section is to document maltreatment as a reported cause of death and to describe deaths where there was a reported history of maltreatment. The National Child Death Review (NCDR) form captures maltreatment information (related specifically to the decedent) in various sections. Table 3 presents the maltreatment results (2019 reviewed deaths) from a derived summary variable which assigns an order to the maltreatment / contributing act categories. (The "de-duplication" works from the top down. For example, if abuse and neglect were both identified as causing the death, that death is reported as "Cause, Abuse". Twenty-four deaths had neglect identified as a cause, but five of those deaths also had abuse identified. Those five deaths are not counted in the "Un-Duplicated" "Cause, Neglect" entry.)

Table 3. Maltreatment Reports, GA, 2019 Reviewed Deaths			
		All Reports	Un-Duplicated
Cause/Contribute	Abuse	26	26
	Neglect	24	19
History	Abuse	60	45
	Neglect	76	68
Maltreatment Total			**158**
Poor Supervision		137	86
Exposure to Hazard(s)		262	145

The sum of the un-duplicated counts for the four cause / history maltreatment categories (Table 3) is 158 (26+19+45+68). The "descriptive epidemiology" of these maltreatment-related deaths first addresses three basic variables – age, sex, and race-ethnicity. The purpose of the analysis is to determine whether the apparent proportion of reviewed deaths with reported maltreatment changes with these three variables. (i.e., Is a male decedent more likely than a female to have experienced maltreatment?)

Most of the reviewed death victims are male (58%), and a disproportionate number are Black/African-American (47%). Infants account for over one-third of all reviewed deaths, but three-quarters of the infant deaths are sleep-related (Table 4).

Thirty percent of the reviewable deaths over the prior four years (2015 – 2018) had a history of maltreatment or had maltreatment as a cause of the death. The proportions (of deaths with maltreatment) fluctuate across the age / race / sex strata over time, but the maltreatment risk is evenly distributed across strata.

Table 4. 2019 Reviewed Deaths with Maltreatment Reported (by Demographic Variables)					
	Reviews with Maltreatment				
	All Reviewed	Percent	Count	Percent	%, '15 - '18
Sex					
Male	323	58.0	95	29.4	30.0
Female	234	42.0	63	26.9	31.0
Total	**557**		**158**	**28.4**	**30.4**
Race/Ethnicity					
Black	263	47.2	85	32.3	29.4
White	189	33.9	53	28.0	31.1
Hispanic	69	12.4	14	20.3	27.6
Multi-race	17	3.1	4	N/A	52.9
Other	19	3.4	2	N/A	
Age (Years)					
Infants	209	37.5	50	23.9	22.6
1 - 4	103	18.5	37	35.9	41.9
5 - 9	47	8.4	14	29.8	36.4
10 - 14	69	12.4	16	23.2	37.3
15 - 17	129	23.2	41	31.8	29.2

Table 5 shows all reviewed child deaths by cause of death with a cause or history of maltreatment. It reveals a disturbing number (21) of homicides with abuse as the cause. Over 60% of homicide related deaths has a history or reported maltreatment cause.

Table 5. Maltreatment Category by Cause of Death: GA, 2019 Reviewed Deaths

	Maltreatment Cause		Maltreatment History		% Reviewed w/ Maltreatment
Cause of Death	Abuse	Neglect	Abuse	Neglect	
MVC	1	3	6	13	27.4
Drowning		3	3	5	35.5
Other Unintentional	0	0	1	10	32.4
Homicide	21	2	8	12	63.2
Suicide	1	3	6	3	22.0
Sleep-Related	0	4	10	14	18.4
Medical	0	4	8	11	20.2
Undetermined	3		3		40.0
All Reviewed	26	19	45	68	28.4
Duplicated Counts	26	24	60	76	

Summary of Selected Causes

If we exclude infant deaths – which are dominated by medical causes associated with the birth – then the three leading causes of death (over the last five years) for all children ages 1 through 17 are motor vehicle crashes (479), homicide (305), and suicide (289). (Source: OASIS, GA, 2015 – 2019) These three causes accounted for 211 of the 557 (38%) reviewed deaths in 2019; and sleep-related infant deaths (152) comprised the largest category of reviewed deaths. This section of the Annual Report provides an overview of the demographics for these four causes, the prevention implications of selected risk factors identified in the review process, and suggestions for data quality improvements.

Motor Vehicle Crash (includes pedestrian and bicycle): In 2019, there were a total of 84 reviewed motor vehicle deaths in Georgia, an increase from the 77 reviewed motor vehicle-related deaths in 2018.

Table 6. Reviewed Motor Vehicle Crash Deaths, GA, 2019

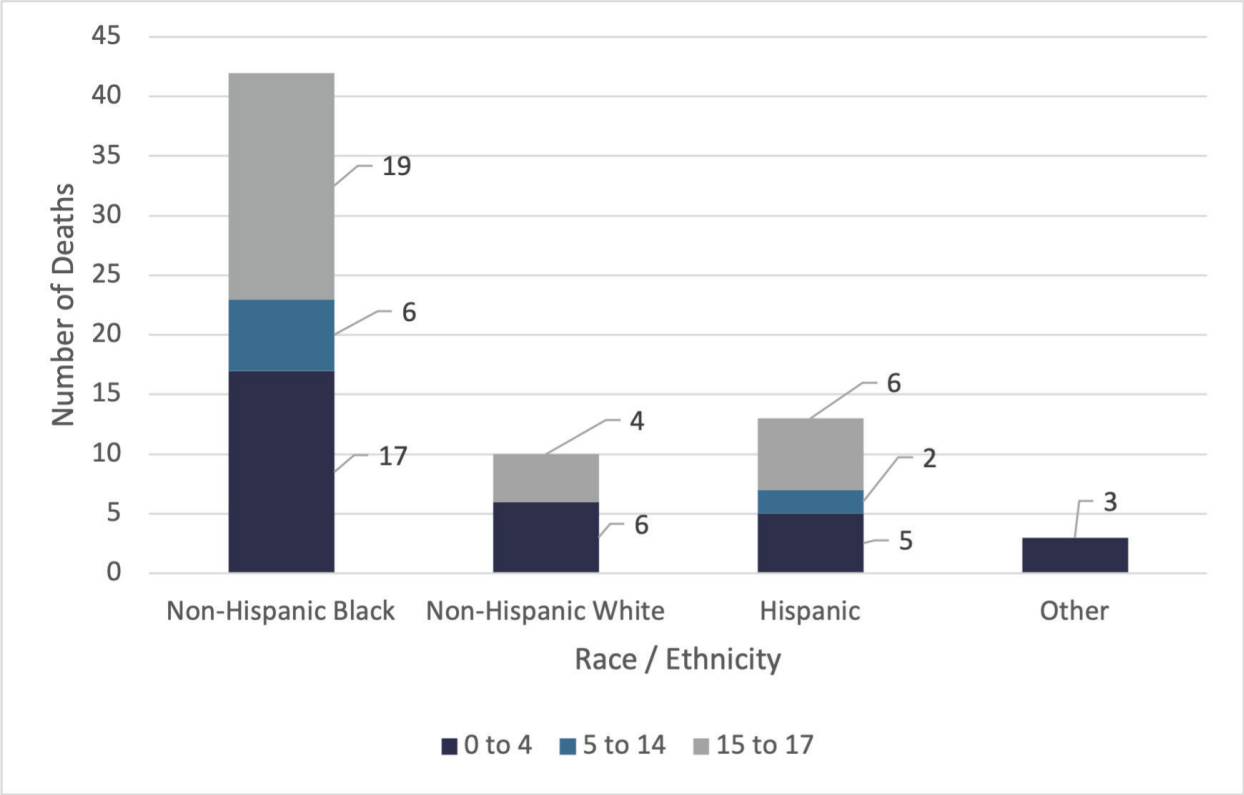
	White, Non-Hispanic		Black, Non-Hispanic		Hispanic & Other Race		
	Male	Female	Male	Female	Male	Female	Total
Infant	2	2	1				5
1 - 4	3	1		5	1	4	14
5 - 9	4	2	5	1	1	1	14
10 - 14	5	4	4	3	2	1	19
15 - 17	10	6	6	1	6	3	32
Total	**24**	**15**	**16**	**10**	**10**	**9**	**84**

- 46% (39/84) of the victims were White, non-Hispanic; and 60% were male.
- The decedent was the driver in 17 of the motor vehicle deaths and was determined to be responsible for the incident in 14 of the 17 deaths. Three of the deaths were children (ages 8, 10, and 12) driving a four-wheeler / ATV. Two of the 12 drivers aged 15 to 17 were reported as impaired, and three were on a graduated license.

Intentional Injuries (Homicide and Suicide): Intentional injuries provide three distinct populations for prevention efforts.

- Thirty-one of the 68 reviewed homicide deaths were infants (14) or toddlers (17) (Figure 6). The most common cause of death was "blunt force trauma", and the perpetrator was a parent or other caregiver. Three of the 31 deaths were due to firearm use by the male companion of the decedent's mother during an altercation. Potential prevention actions include parent training, identification of family stressors with appropriate support services, and coordination (sharing information) among different service providers.
- Twenty-six of the 37 remaining homicide deaths (ages five through 17) were Black or Hispanic males by firearm. (Only two White males were firearm homicide victims, and six females.) Impulsive adolescent behavior and access to firearms combine to produce lethal encounters. Although these deaths are defined as homicide, many are a result of careless handling of the firearm with no intent to harm. Ten of the shooters were reported as a friend (5), an acquaintance (4) or sibling (1).
- Prevention strategies include training in firearm storage (for parents and other caregivers), and firearm safety training for children and teens.

Figure 6. Homicides, Ages 0 to 17, GA, 2019: by Race and Age Category



- The increase in teen suicide in 2015 continued in 2019 with 59 deaths – 42 were males and 39 were ages 15 through 17 (Table 7). Suicide is a rare cause of death in which the White rate is higher than the Black/African-American rate, although the risk ratio (White rate / Black rate) is decreasing. In 2019, White teens were 20% more likely to commit suicide than Black teens; prior to 2018 the White teens were almost twice as likely as Black teens to commit suicide. Firearms account for 60% of the male suicides, but only 35% of female suicide – although all cells in the table are < 6 except for the White males.

Table 7. Reviewed 2019 GA Suicide Deaths, Ages 10 - 17

		Black Non-Hispanic			
	Mechanism	**White**	**Black**	**Hispanic**	**Other**
Male					
	Fall	1	1		
	Firearm	13	4	4	4
	Hanging	5	4	3	3
Female					
	Firearm	2	2	1	1
	Hanging	1	5	2	
	Poison	1	1	1	

Sleep-Related Infant Deaths: Sleep-related deaths are a persistent and frustrating problem. The Teams reviewed 152 sleep-related deaths in 2019 – slightly lower than the average number reviewed (156) over the preceding seven years (Table 8). The distribution of deaths by race/ethnicity and sex is consistent with the distribution over the five-year period (2015 – 2019). Black infants are twice as likely to suffer a SIDS death compared to white infants (OASIS: SIDS deaths, 2015 – 2019). The SIDS deaths do not include the infant deaths attributed to suffocation in bed or unknown cause.

Table 8. Reviewed Sleep-Related Deaths by SUID Category, GA, 2019						
	Black Non-Hispanic		White Non-Hispanic		Hispanic/Other Race	
SUID Category	Male	Female	Male	Female	Male	Female
Asphyxia	13	9	9	8		4
Medical	2	3	1			
Undetermined	25	32	23	12	4	7
Total	**40**	**44**	**33**	**20**	**4**	**11**

- Fifty-six percent (85/152) of the deceased infants were reported as sleeping on an adult bed (six more were on a mattress on the floor or a twin/bunk bed).
- Supervision information was ambiguous: 51 deaths had "Poor/absent supervision" indicated as a contributing factor, but reported the child had supervision.

The CDR database includes many variables that may be risk factors or indicators for sleep-related deaths. The Safe Infant Sleep program (in the DPH Office of Injury Prevention) is working with Georgia State University on an analysis of sleep-related death risk factors. The OCFR has prepared and provided a data set of selected CDR variables for deaths from 2012 through 2019. A GSU research faculty member will geocode the locations of the deaths and use spatial analysis methodology to examine the associations among the individual-level factors, ecological variables, and sleep-related deaths. Once the risk factors are examined, the researcher will overlay access to resources to investigate if a lack of resources is associated with higher SUID.

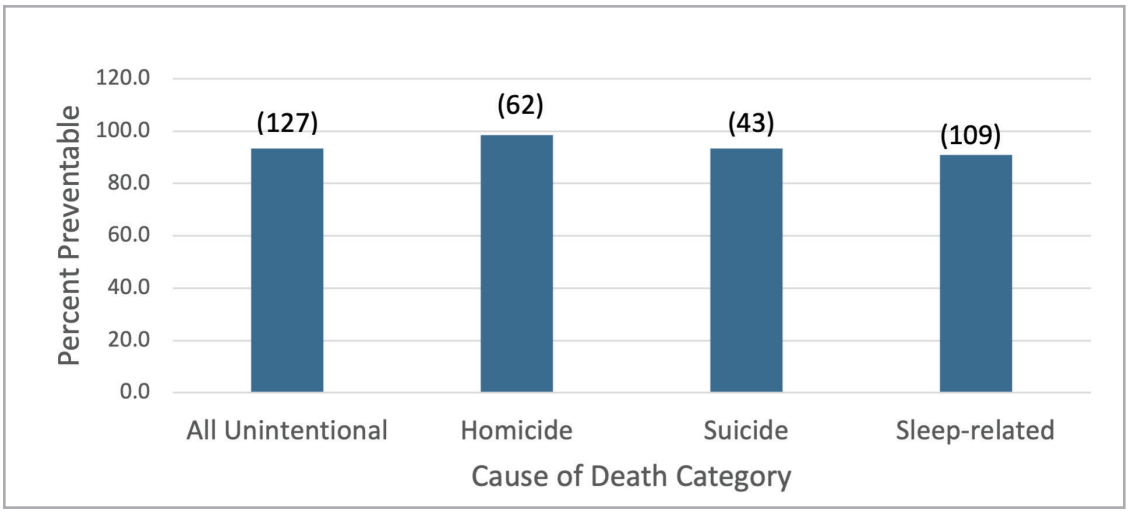
This collaborative effort on sleep-related death provides a good model for additional research on selected causes of child death. The GBI Office of Child Fatality Review and the CFR Panel are committed to initiating and supporting data sharing and multi-agency research to address identified issues related to the well-being of Georgia's children.

Preventability and Prevention Findings

There is strong consensus among the review teams that the non-medical (violent) deaths can be prevented. Ninety-two percent of non-medical deaths with a preventability determination (" No, probably not" or "Yes, probably") had "Yes, probably" reported. Over 93% of deaths due to unintentional injuries, 91% of sleep-related deaths, 98% of homicide deaths, and 93% of suicide deaths were considered preventable (Figure 7).

The CDR process encourages local teams to consider possible interventions that could have prevented the death. The review form has a prevention section (L. Prevention Initiatives Resulting from the Review) designed to capture suggestions or implemented actions in the areas of agency policies and services, education, legal system changes, or environmental factors. Several "open-ended" questions provide opportunities for narrative on recommendations. These narratives are of significant value – when they are completed. Most CDR cases have thoughtful recommendations regarding prevention steps; however, Section L comes near the end of the form, form, and detailed comments are the exception. The prevention review does not stop with the local CFR team. The CFR staff is responsible for summarizing / synthesizing the prevention input from the teams and providing that data and / or draft recommendations to the CFR Panel. The Panel then develops the final recommendations for the Annual Report.

Figure 7. 2019 Reviewed Deaths, % Preventable (Number Preventable)



Preventability of Reviewed Deaths

Determining why a death occurred and utilizing the information to prevent future deaths is the focus of each CFR team. It is also important to review preventability of reviewed deaths. In 2018, over 90% of non-medical deaths (with a preventability determination) — 346 of 374 reviewed — could have been prevented. As shown in Table 9, the CFR teams also determined that every (non-medical) cause of death category had a prevention percentage of over 80%.

Table 9: CDR Team Determination of Preventability: 2019 Reviewed Deaths					
	Could the death have been prevented? (PRV prevented)				
Cause of Death	Missing	No, probably not	Yes, Probably	Undetermined	% Prev*
Drowning		1	27	3	96.4
MVC		6	75	3	92.6
Other, Unintentional		2	25	7	92.6
Homicide	2	1	62	3	98.4
Suicide		3	43	13	93.5
SUID_Asphyxia			43		100.0
SUID_Medical		2	2	2	N/A
SUID_Undetermined		9	64	30	87.7
Medical	2	66	12	30	15.4
SUDC		1	2	1	N/A
Undetermined		3	3	9	50.0
Total	**4**	**94**	**358**	**101**	**79.2**
Non-Medical	**2**	**28**	**346**	**71**	**92.5**

Supervision: The CDR form addresses supervision of the decedent in three sections. The "Circumstances" section has a question: "CAN, poor supervision or exposure to hazards cause or contribute to death?" (Table 10). If the answer is "Yes", then "Poor/absent supervision" is one of the possible responses to describe the action. In Section J (Person Responsible), the first question is: "Did person(s) cause/contribute to death?". There are follow-up questions for up to two persons to identify the type of action, and "Poor/absent supervision" is one of the responses. Poor supervision is indicated if it is selected in one or more of these three variables.

In Section D (Supervisor Information), the initial question is: "Did child have supervision at time of the incident leading to death?"; and valid responses are:

1. No, not needed given developmental age or circumstances

2. No, but needed

3. Yes

4. Unable to determine

The sleep-related deaths provide an opportunity to check on the consistency of reporting of these two "supervision" variables. There were 51 deaths that had "Poor/absent supervision" indicated as a contributing factor, but reported the child had supervision. This suggests issues with the form design and review team training.

Table 10. Supervision and Sleep-Related Death

	Poor/absent Supervision	
Supervision at Time	**Yes**	**No/Unknown**
No, not needed	2	1
No, but needed	9	**8**
Yes	**51**	72
Unable to determine	1	8

The relationship between supervision and drowning deaths is stronger for accidental deaths (such as drowning), and there is less discordance in the two supervision variables. Both variables indicated a supervision issue for 15 of the 31 drowning deaths (and 11 out of 16 for toddlers ages < 5). There were three deaths (all <5) where poor supervision was reported but they were "supervised at the time" (Table 11).

Table 11. Supervision and Drowning Death

	Poor/absent Supervision	
Supervision at Time	**Yes**	**No/Unknown**
No, not needed	2	3
No, but needed	15	
Yes	3	3
Unable to determine	4	1

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)

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)

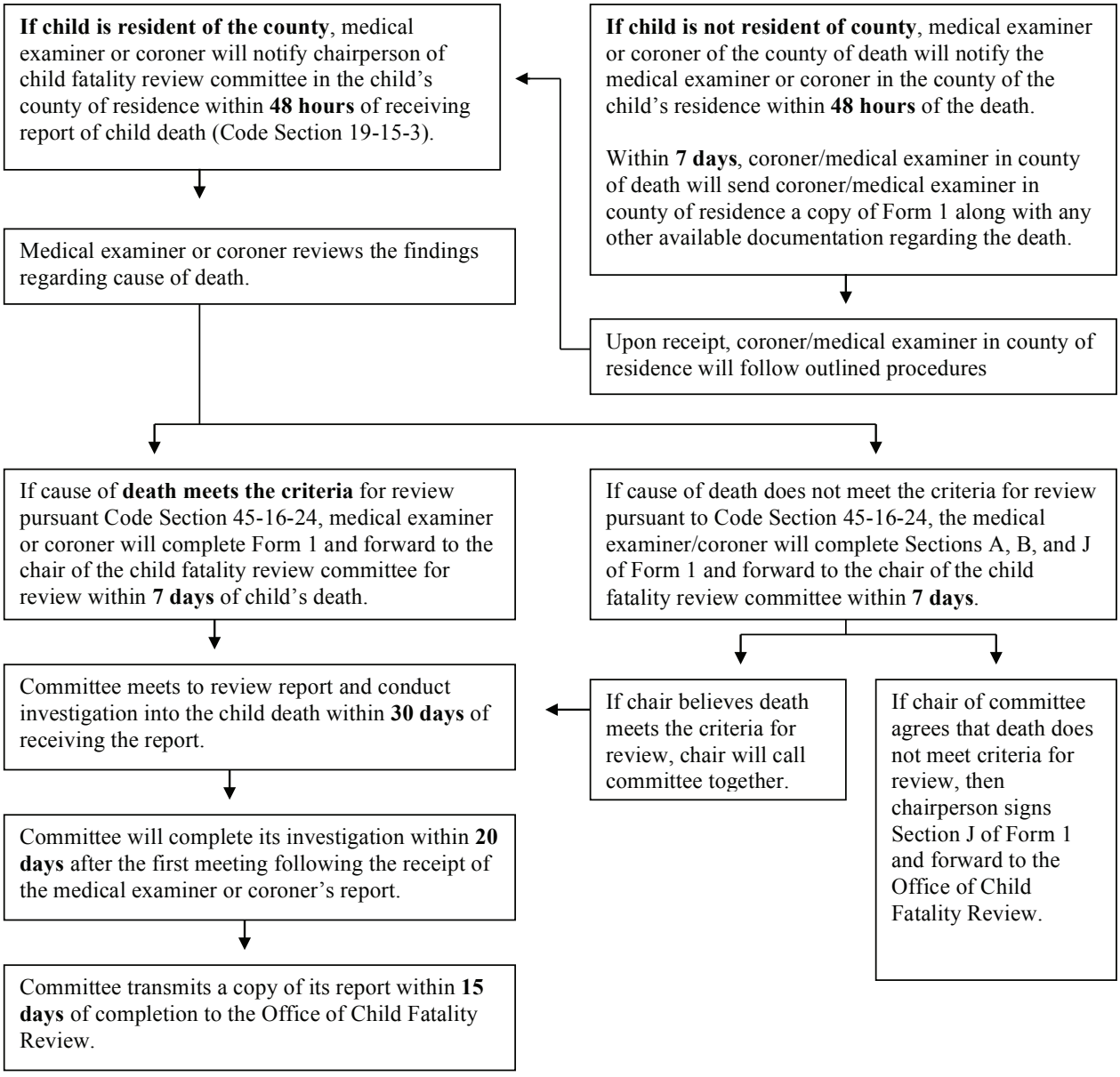
The Jason Foundation (www.jasonfoundation.com) Suicide Awareness Voices of Education (www.save.org)

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

Prevent Child Abuse America (www.preventchildabuse.org)

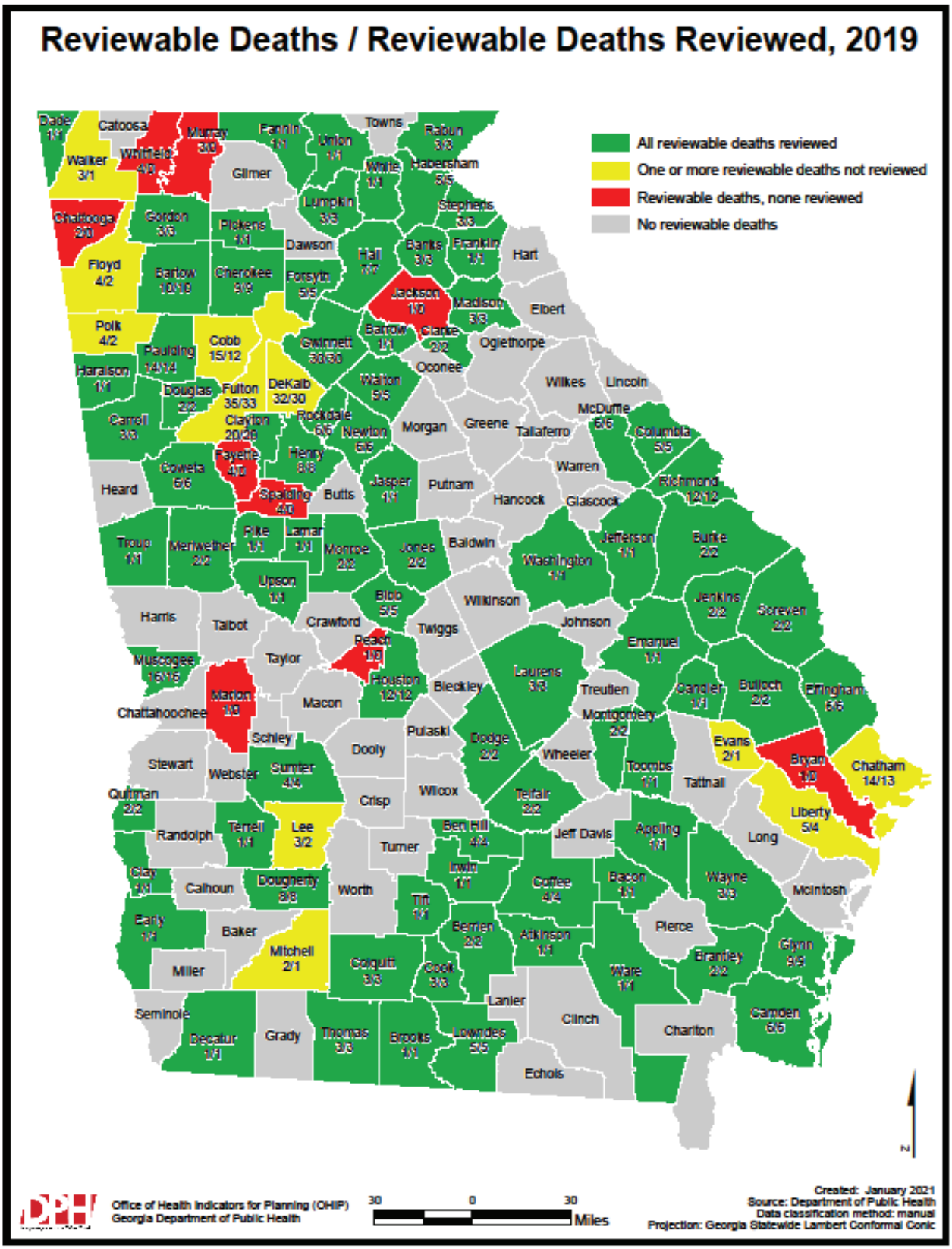
Appendix A

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 – 2019 Compliance Map



Georgia Child Fatality Review Panel

Annual Report - Calendar Year 2019