Georgia Child Fatality Review Panel Annual Report

CALENDAR YEAR 2021

Elizabeth Andrews
Panel Chair

Brian Kemp
Governor

The Child Fatality Review Panel Members

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Vacant – Panel Vice-Chair,

Vic Reynolds – Director, Georgia Bureau of Investigation

Mandi Ballinger – Member, Georgia House of Representatives

Kathleen Bennett – Retired Mental Health Specialist

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

Gloria Butler – Member, Georgia State Senate

Kathleen Toomey – Commissioner, Department of Public Health

Robertiena Fletcher – Board Chair, Department of Human Services

Jay Neal – Director, Criminal Justice Coordinating Council

Candice Broce – Commissioner, 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

Jerry Bruce – Director, Office of the Child Advocate

Randy McGinley – District Attorney, Alcovy Judicial Circuit

Amy Jacobs – Commissioner, Department of Early Care and Learning

Vacant – Member, State Board of Education

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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 CFR Panel Chair

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

We are honored to present the Annual Report of the Georgia Child Fatality Review Panel for child death data composed in calendar year 2021. This data, representing sudden and unexpected child fatalities of Georgia residents, is compiled by 159 local child fatality review committees pursuant to statutory requirements. This report could not be assembled without the continued diligence and contributions of the local child fatality review committees. On behalf of the Panel, I extend my utmost appreciation for every local committee member's participation in the investigation, prosecution, review, and prevention process. At the Panel's annual retreat, the following local teams/members were recognized for their exceptional service:

CFR Committee of the Year: Clayton County

CFR Community Prevention Efforts of the Year: Macon Judicial Circuit

Coroner of the Year: Leon Jones, Bibb County

Medical Examiner of the Year: Dr. Karen Sullivan, Fulton County

CFR Rookie of the Year: Jeffery Kujawa, Houston County

District Attorney Timothy Vaughn with the Oconee Judicial Circuit was also honored, marking 37 years of faithful service. Congratulations to all the awardees for their excellence, commitment, and compliance in collecting child death data and executing prevention efforts throughout our state.

Within the past year, great strides have been accomplished in partnering with those involved in child death investigation, review, and prevention. Our partnership with The National Center for Fatality Review and Prevention continues with the launch of the Drowning Death Scene Investigation and Child Death Review (CDR) Project. This initiative collects data from pediatric drownings with the intent to create a standardized death scene investigation (DSI) form utilized by first responders in their response to such fatalities. Support and involvement in events surrounding safe sleep and suicide awareness as well as fire, motor vehicle, and gun safety marked a record year for prevention initiatives. The work of the Panel has just begun; we must continue our mission to increase the effectiveness of county-based child death reviews and improve state and community response with increased coordination among agencies. Let us proactively utilize this report to facilitate community education and prevention in efforts to reduce child fatalities.

The Panel commends Director Register, the Child Fatality Review Managers, Agents, and medical examiner office personnel at the Georgia Bureau of Investigation for their commitment to our most vulnerable residents, our children. We thank Governor Kemp and Members of the Georgia General Assembly for their attention to the Panel's Annual Report. Together, we shall continue our mission to reduce and prevent child fatality in Georgia.

Elizabeth Andrews

Sincerely,
Elizabeth Andrews
Chair, Child Fatality Review Panel

Background and History

The child fatality review process was initiated in Georgia in 1990 as an amendment to an existing statute for child abuse protocol committees. The legislation provided that each county child abuse protocol committee establish a subcommittee to systematically 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 identifies 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 CFR local 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.

Introduction

2021 Infant and Child Deaths

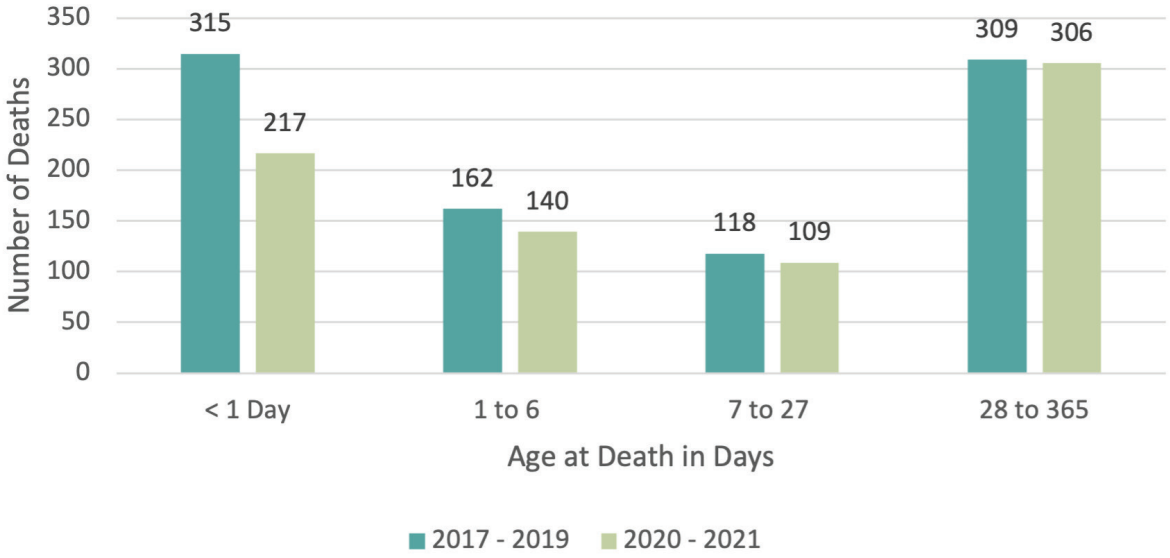
There were 1,440 reported deaths of infants and children in Georgia during calendar year 2021. The count by age group may be an undercount due to an (anecdotally reported) issue with medical examiner staffing and delays in autopsy completion and reporting. There were 48 infant deaths reported as cause of death “unknown” (ICD10 code R99). These deaths are classified as “sleep-related” and are counted as “reviewable” for Child Fatality Review (CFR) purposes.

Table A. 2021 Georgia Infant and Child Deaths

	Age in Years					
DC_Cause	**Infant**	**1 to 4**	**5 to 9**	**10 to 14**	**15 to 17**	**Totals**
MVA	8	19	17	26	46	116
Other Unintentional	7	30	15	19	32	103
Homicide	11	24	9	13	50	107
Suicide			1	29	56	86
Sleep-Related	182					182
Medical	562	86	47	72	55	822
Unknown Intent	2	1	1	1	1	6
Unknown (>1 Yr)		8	1	5	4	18
Total	**772**	**168**	**91**	**165**	**244**	**1,440**

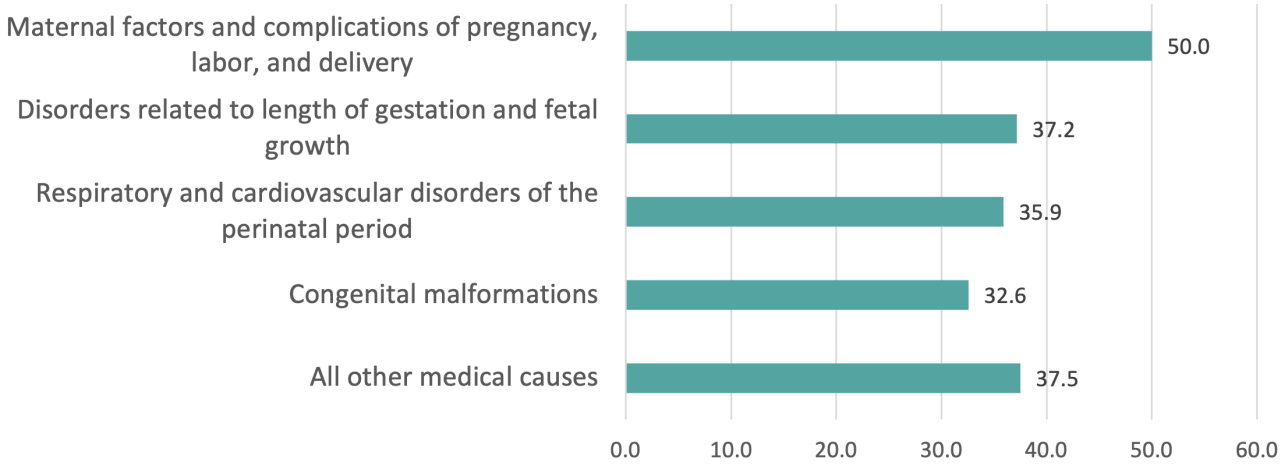
The impact of the COVID-19 pandemic on number of reported child deaths is probably also underestimated. The 2021 death certificates only reported 21 COVID-19 deaths among children less than 18 years of age (an increase from six in 2020). However, there are issues with case definition (COVID-19 not identified as associated with the death) and indirect effects of pandemic-associated stress. The decrease in number of infant deaths (2019 to 2020) reported last year continued into 2021 (772 deaths). The infant mortality rate (deaths per 100,000 births) had decreased to 6.3 in 2020 and continued to decrease slightly to 6.2 in 2021. Most of the reduction in infant deaths was due to the decrease (from 298 to 214) in number of infants dying of medical causes at birth (within the first day of life). (See Attachments, Table A for age and race/ethnicity detail.)

Figure 1. Average Infant Annual Deaths, by Age in Days



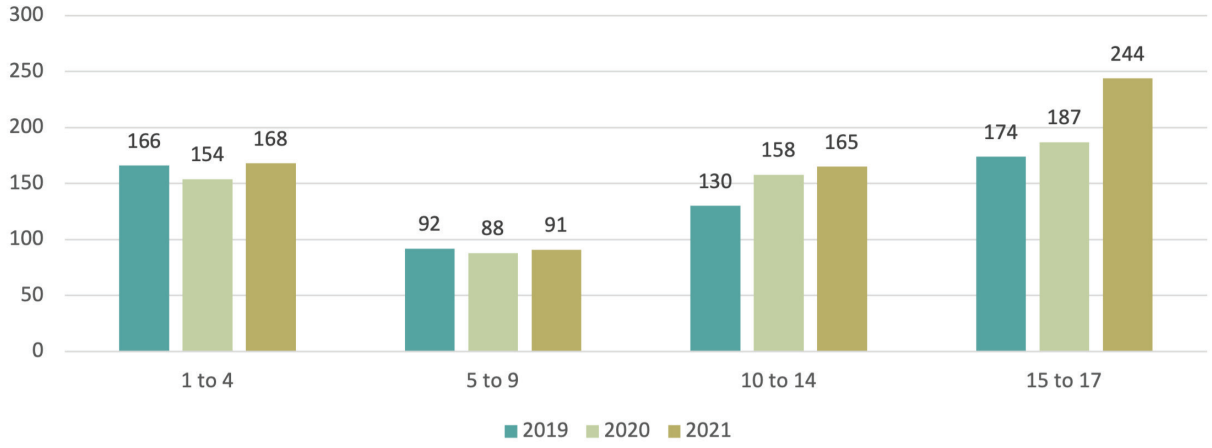
An examination of the race distributions showed that most of the "1 day" decrease was in the Black Non-Hispanic population. (Appendix, Table B.) The total decrease was 39.1% compared to 11.7% for the White Non-Hispanic infants. The decrease was consistent across major categories for cause of death.

Figure 2. % Decrease in Black Non-Hispanic Infant Deaths, Age < 1 Day



The number of deaths of youth ages 10 through 17 increased during the two pandemic years from 304 in 2019 to 409 in 2021. This increase is associated with specific cause of death categories – primarily intentional (homicide and suicide).

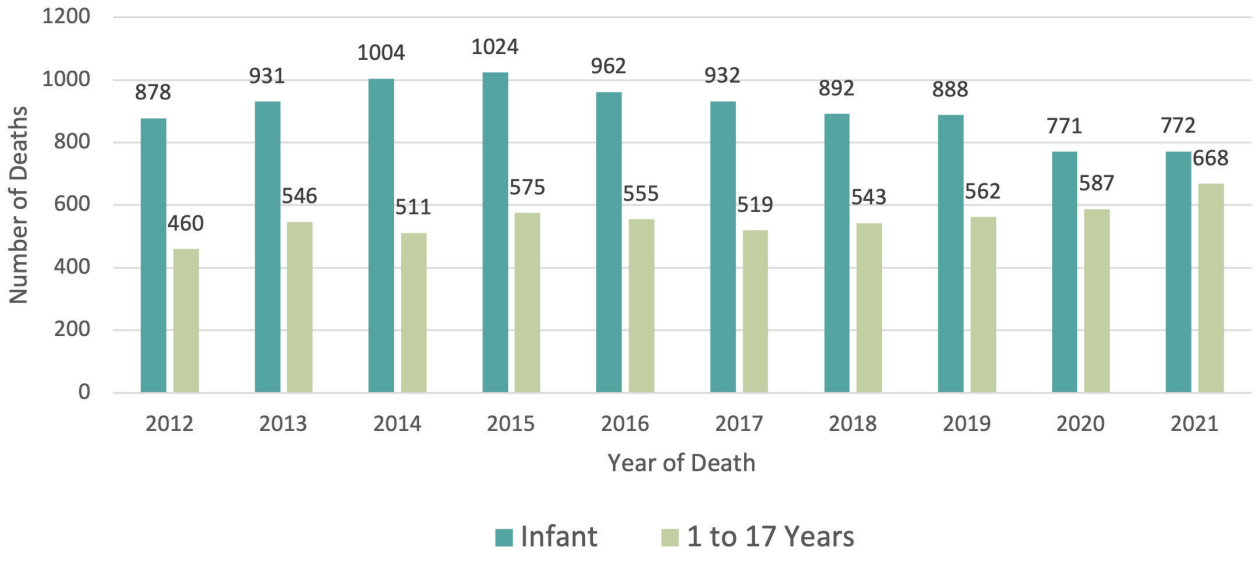
Figure 3. Number of Child Deaths, GA, 2019-2021, by Age Category



Trends in Cause of Death for Georgia Infants and Youth (< 18 years of age)

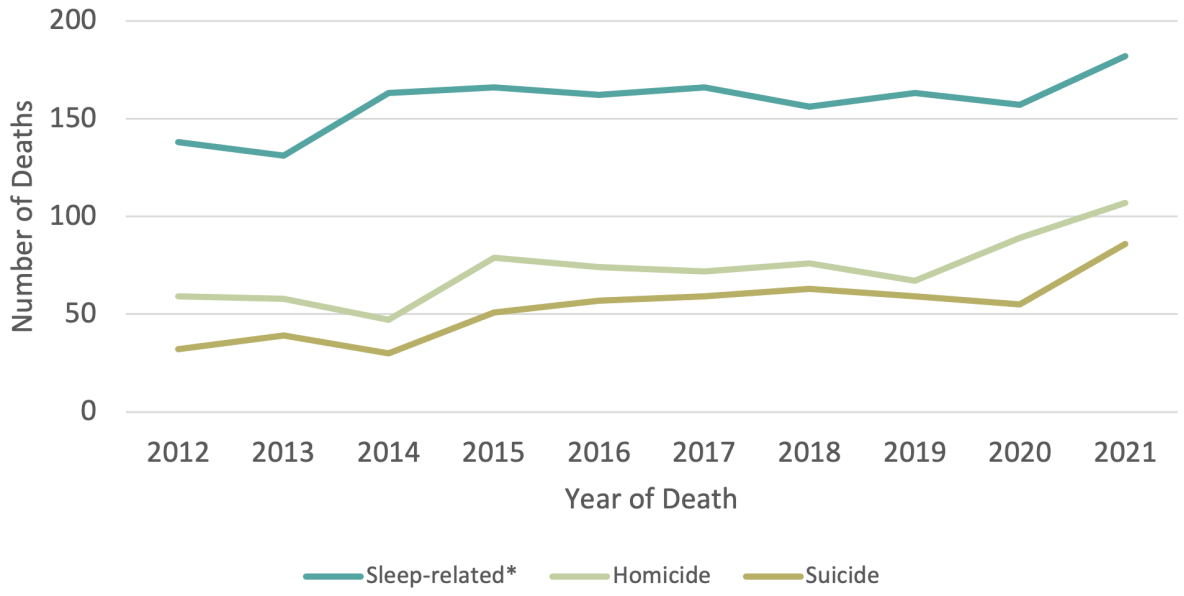
The recent changes in infant and child deaths represent a discontinuity in the longer-term trends (last ten years). The number of infant deaths (and the mortality rate) have been decreasing since 2015, but the rate in 2020 was lowest in 10 years and represented the largest one-year change. A preliminary review of the literature does not reveal an explanation of the decrease in the infant mortality rate. The Georgia low birthweight and premature birth rates have not decreased over the past two years, and they are strong risk factors for infant mortality.

Figure 4. GA Infant and Child Deaths, Ages < 18



The ten-year trend data shows an increase in 2021 in intentional deaths (homicide and suicide) and sleep-related deaths of infants. Forty-four of the “Unknown” cause of death infants were reviewed and 22 were determined to be sleep-related. The 22 non-sleep-related deaths would account for most of the observed increase in the death certificate data. (19 unknown infant deaths in 2020 and 48 in 2021.)

Figure 5. GA Infant and Child Deaths, 2012-2021



2021 Georgia Child Death Review Process

The Child Death Review (CDR) is the multidisciplinary review of individual child deaths to help communities understand why children die and equip them to effectively prevent future fatalities. The COVID-19 pandemic continued to adversely affect the CFR (Child Fatality Review) process in 2021. The proportion of reviewable deaths reviewed dropped an additional 3 percentage points (83.8 to 80.9) after an eight-percentage point decrease between 2019 and 2020. The review rates and changes were consistent across cause categories. (Deaths with a "Medical" cause are not defined as "Reviewable", although a review team may decide that a specific death should be reviewed. In 2021, 100 "medical" deaths were reviewed – perhaps because the death was unexpected or did not occur while the decedent was in the care of a physician.)

Table B. Proportion of Reviewable Deaths Reviewed, 2021

	Reviewed?		
Death Certificate Cause	**No**	**Yes**	**% Reviewed**
Medical (non-reviewable)	722	100	12.2
MVC	19	97	83.6
Other Unintentional	24	79	76.7
Sleep-Related	36	146	80.2
Homicide	22	85	79.4
Suicide	12	74	86.0
Unknown Intent	1	5	83.3
Unknown (Age > 0)	4	14	77.8
Reviewable Total	**118**	**500**	**80.9**

Reviewable deaths (based on death certificate non-medical deaths) in 2021 were distributed across 121 Georgia counties. Thirty-eight counties had no reported reviewable deaths, and 84 counties with a total of 366 reviewable deaths reviewed all deaths. Attachment Table C provides individual county review data.

Table C. Review Summary, 2021 Georgia Child Fatality Review				
Category	**Description**	**#Counties**	**#Deaths**	**Not Reviewed**
1	All Reviewable Deaths Reviewed	84	366	
2	Some Reviewable Deaths Reviewed	20	214	80
3	No Reviewable Deaths Reviewed	17	38	38
4	No Reviewable Deaths	38		

Maltreatment

Action or Failure to Act that Contributes to a Death

Fortunately, an overt act that directly causes a child's death is a rare event. Thirty Infants and toddlers were killed in 2021 by parents and other caregivers; and abuse was identified as the cause for 15 of those 30 deaths. Abuse was reported as the cause for only 22 deaths (all ages under 18) in 2021. The CFR form has questions addressing the role (if any) of maltreatment in causing or contributing to a death. Other questions address any history of maltreatment for the decedent and whether poor supervision or exposure to hazards may have contributed to the death. These various maltreatment questions were used to define a summary maltreatment variable that assigns a single maltreatment-related value to each death. (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 deaths had neglect identified as a cause, but one of those deaths also had abuse identified. That single death is not counted in the Total for the "Cause, Neglect" entry.)

Table D. Maltreatment Summary, 2021 Reviewed Deaths

	Cause or Contribute		History					Cause/ History
Cause Category	**Abuse**	**Neglect**	**Abuse**	**Neglect**	**Supervision**	**Exposure to Hazard**	**None**	**Proportion**
Motor Vehicle Crash		5	11	12	17	38	23	26.4
Other Unintentional	0	3	8	9	21	20	19	25.0
Homicide	18	3	11	14	13	14	15	52.3
Suicide			13	4	3	22	34	22.4
Sleep-Related	1	4	13	13	26	82	9	20.9
Medical	1	2	11	16		1	65	31.3
Undetermined	2	2	1		2	4	8	26.3
Total	**22**	**19**	**68**	**68**	**82**	**181**	**173**	**28.9**
Duplicated Totals	**22**	**20**	**85**	**119**	**109**	**280**		

About 29% of all reviewed deaths had maltreatment identified as causing or contributing to the death or had a reported history of maltreatment. That proportion has increased slightly over the last ten years (from 26.6% for 2012-2016 to 28.9, 2017-2021). The five-year comparison shows a doubling in the number of deaths with neglect reported as causing or contributing to the death and 150% increase in deaths with reported exposure to hazard. We do not know how much of these increases is associated with increased sensitivity to these risks by the review teams.

Table E. Reported Maltreatment, Five-Year Comparison

		Average	
		2012-2016	**2017-2021**
Cause or Contribute	Abuse	25	27
	Neglect	11	24
History	Abuse	66	76
	Neglect	37	37
	Poor Supervision	57	73
	Exposure to Hazard	56	146
	None	274	184
Percent	Cause/History	26.6	28.9
	Any	48.1	67.6

Supervision and Exposure to Hazards

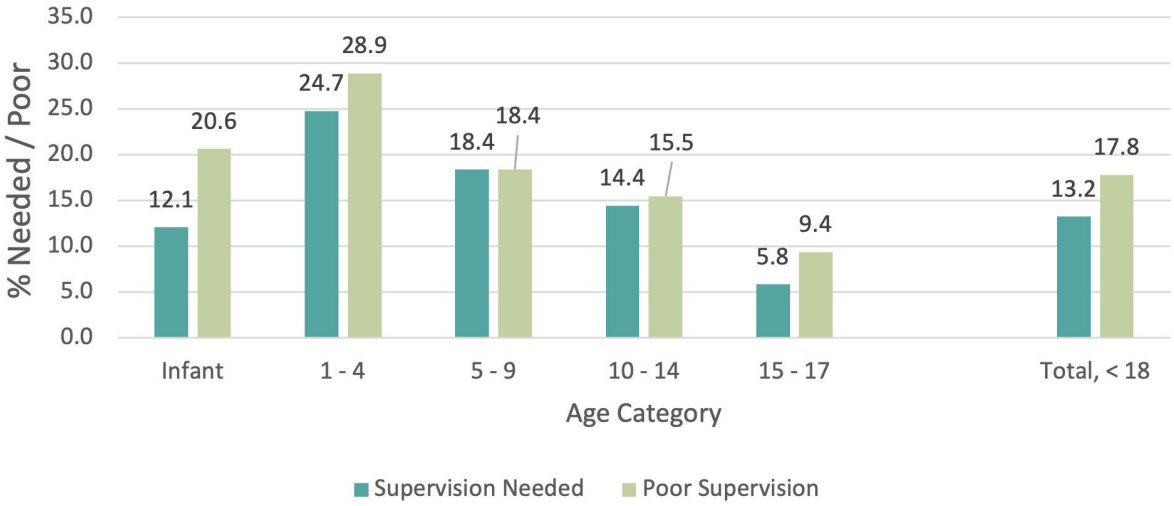
These two topics (supervision and exposure to hazards) were introduced in the preceding section on maltreatment because they indicate possible "lack of action" that may have contributed to a child's death. These three parameters (variables/risk factors) are not independent, but they can be used to examine prevention opportunities for specific cause of death / age populations. A subsequent report section on selected causes of death illustrates this "prevention planning" approach.

Supervision: The CDR form addresses supervision of the decedent in three sections. 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

Eighty-one (81) of the 613 reviewed deaths (13.2%) reported "No but needed". The two supervision measures show similar age distributions, but the second measure addresses deaths where poor supervision is a contributing factor.

Figure 6. Percent Reviewed Deaths with Supervision Issues, GA 2021



The possible contribution of poor supervision to the death is captured by three variables. The "Circumstances" section has a question: "Child abuse or neglect, poor supervision or exposure to hazards cause or contribute to death?". 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. The CFR teams determined that poor supervision was involved in 109 of the 613 reviewed deaths (17.8%).

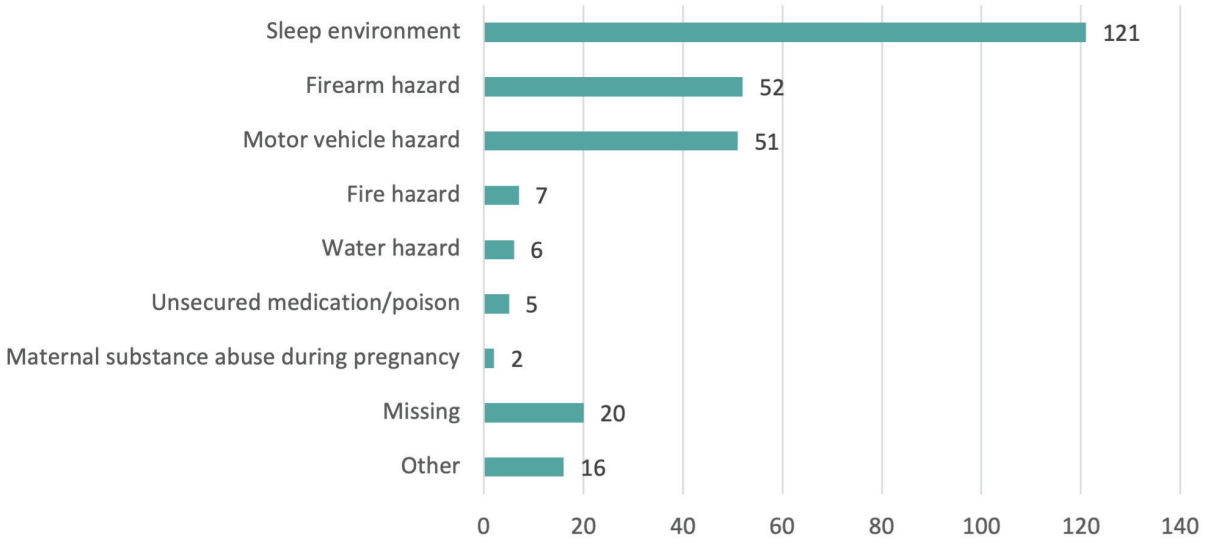
Exposure to Hazards is defined using the same variables as Poor Supervision, with a value for Hazard (4) replacing the Poor Supervision value (3). A total of 280 reviewed deaths had "Hazard" checked for at least one of the three variables. Infants accounted for half of the indicated presence of a hazard. Approximately one-third of the child (ages 1 – 17) deaths had "Hazard" reported.

Table F. Reviewed Deaths with Hazard Indicated

	Hazard Reported		
Age Category	**Yes**	**No**	**Percent**
Infant	141	58	70.9
1 - 4	29	68	29.9
5 - 9	18	31	36.7
10 - 14	32	65	33.0
15 - 17	60	111	35.1
Total, < 18	**280**	**333**	**45.7**

The CDR form has a follow-up question regarding the type of hazard. There was a response for 260 of the 280 deaths that indicated a hazard. The "Sleep environment" response explains the large number of infants exposed to a hazard.

Figure 7. Identified Hazards, GA CDR 2021

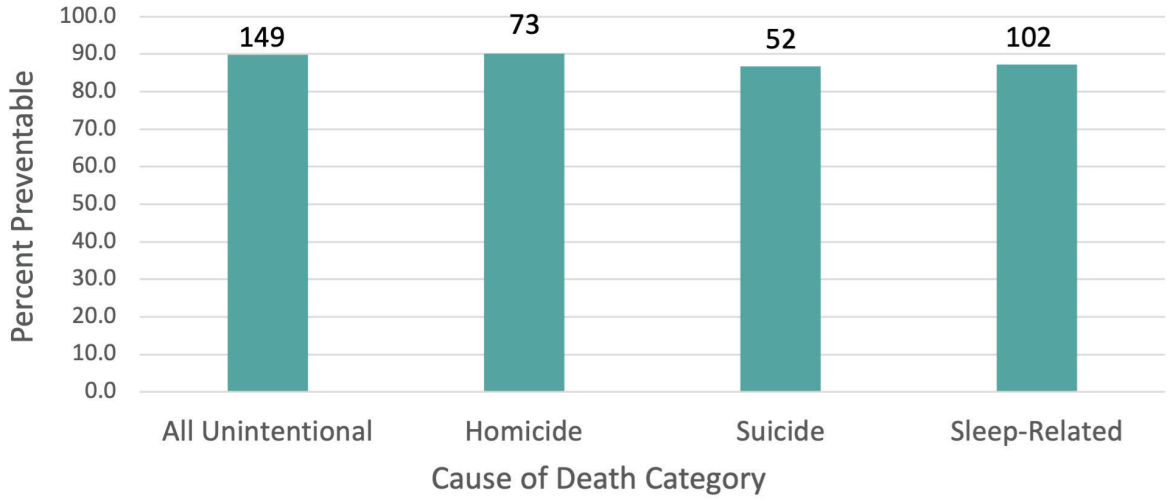


Summary of Selected Causes

Selected Cause of Death Categories: Prevention Target Populations

The county Child Fatality Review (CFR) teams determined that 80% or more of reviewed deaths could probably have been prevented. The central mission of the CFR process is to reduce the number of infant/child deaths; and the intent of the following "cause-specific" discussion is to provide information for use by GA legislators, the CFR Panel, Panel subcommittees, and concerned agencies/organizations.

Figure 8. 2021 Reviewed Deaths, % Preventable (# Preventable)



Unintentional Injuries

There were 186 reviewed unintentional deaths in Georgia in 2021, with motor vehicle-related events (including pedestrians and bicyclists) accounting for 57 percent (106) of the deaths. Drowning – the second-leading cause – accounted for 24 deaths (13%).

Table G. Reviewed 2021 Unintentional Injury Deaths, GA

	Age in Years					
Cause	**Infant**	**1 to 4**	**5 to 9**	**10 to 14**	**15 to 17**	**Totals**
Asphyxia	2	4		1		7
Drowning	2	11	3	3	5	24
Fall/Crush			1	1		2
Fire		7	5	1	1	14
MVC	8	19	15	24	40	106
Other Cause	4	2			2	8
Poison		1		1	14	16
Weapon		2	1	3	3	9
Totals	**16**	**46**	**25**	**34**	**65**	**186**

The white toddlers are 2.2 times more likely to drown than a black toddler; but the black 5- to 17-year-old is 3.8 times more likely to drown than a white child.

Drowning

An average of 35 GA children die each year due to drowning. There has not been any consistent trend over time in drowning deaths (although the average number of annual deaths has dropped to 31 for the past four years, compared to 37 for the preceding six years), so the following discussion addresses the total deaths over the 10-year period. This aggregation of years provides a sufficient sample to look for age and race differences.

There were 346 reported deaths of youth under the age of 18 in GA between 2012 and 2021. County CFR teams reviewed 285 of those deaths (82.4%). (Appendix Table E) The age and race/ethnicity data indicate two distinct populations – toddlers ages one through four, and children/teens ages five through 17.

Figure 9. GA Drowning Deaths, Ages 1 to 17, 2012-2021

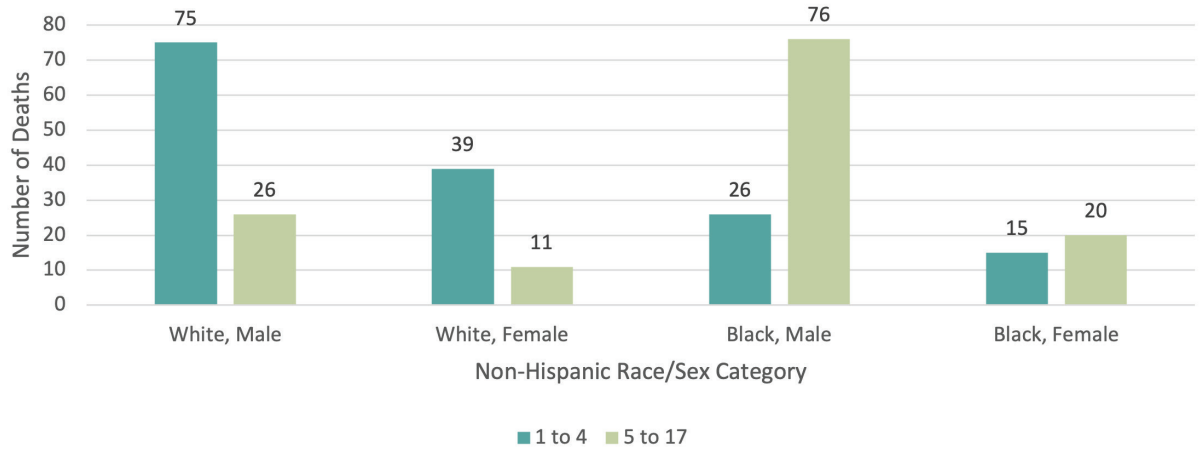
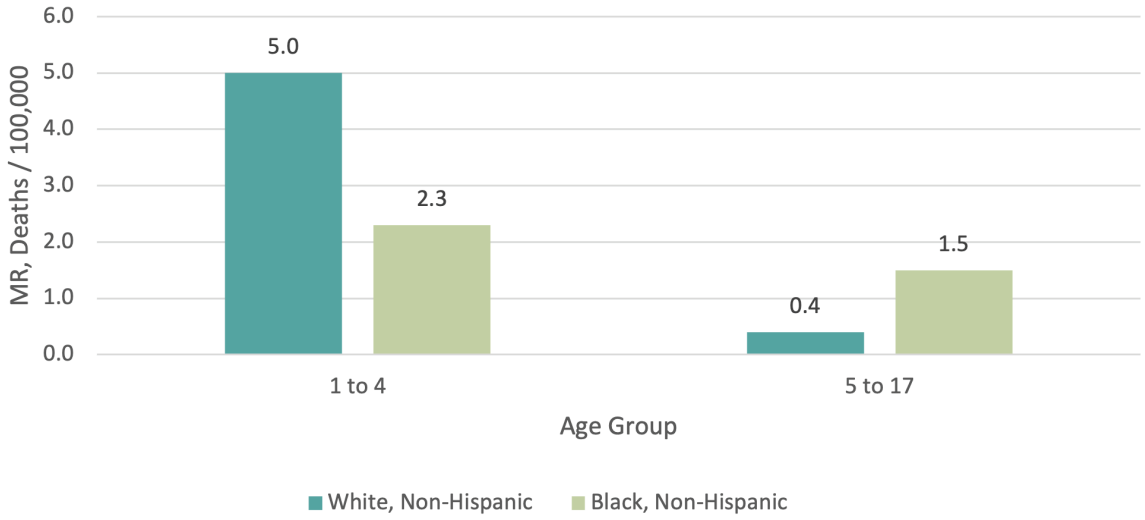


Figure 10. Drowning Mortality Rates by Age Group and Race



The fatality reviews provide information regarding the circumstances of the death and risk factors. Supervision is a factor described under the Responsibility section questions “Did person(s) cause/contribute to death?” and “What act caused/contributed to death?” “Poor supervision” is one of the options for the second question, and it was reported for 84% of the reviewed toddler (ages 1 to 4) deaths and 43% of the youth (ages 5 to 17) deaths.

An ability to swim is important for all children, and a racial disparity was noted in reviewed drowning deaths. The higher drowning risk for Black/African American youth (referenced in the discussion of death certificate data) may be partially explained by a racial disparity in swimming skills. Over 70% of the Black youth drowning victims were reported as unable to swim, compared to less than 40% of the White youth.

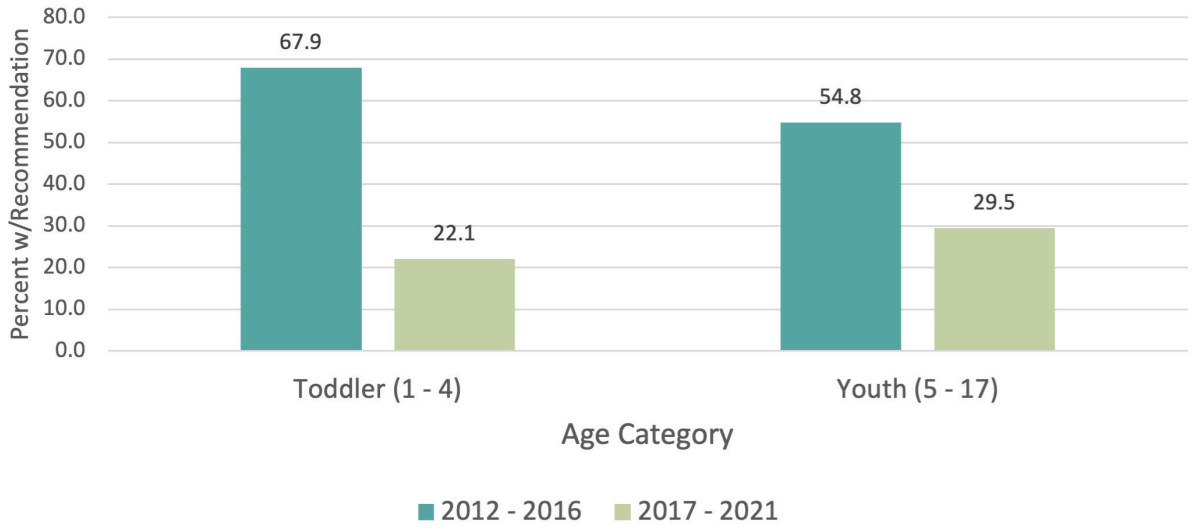
Table H. Racial Disparity in Swimming Skills

	Child able to swim? (DROchswim)			
Race (Non-Hispanic)	**Yes**	**No**	**Unknown**	**% Non-Swimmer***
White	16	10	9	38.5
Black	15	40	28	72.7

* Excludes “Unknown”

The prevention section of the CDR form provides an opportunity for team recommendations. The 10-year data shows a decrease in the responses to the question: “Recommendations and/or initiatives that could be implemented to prevent future deaths”.

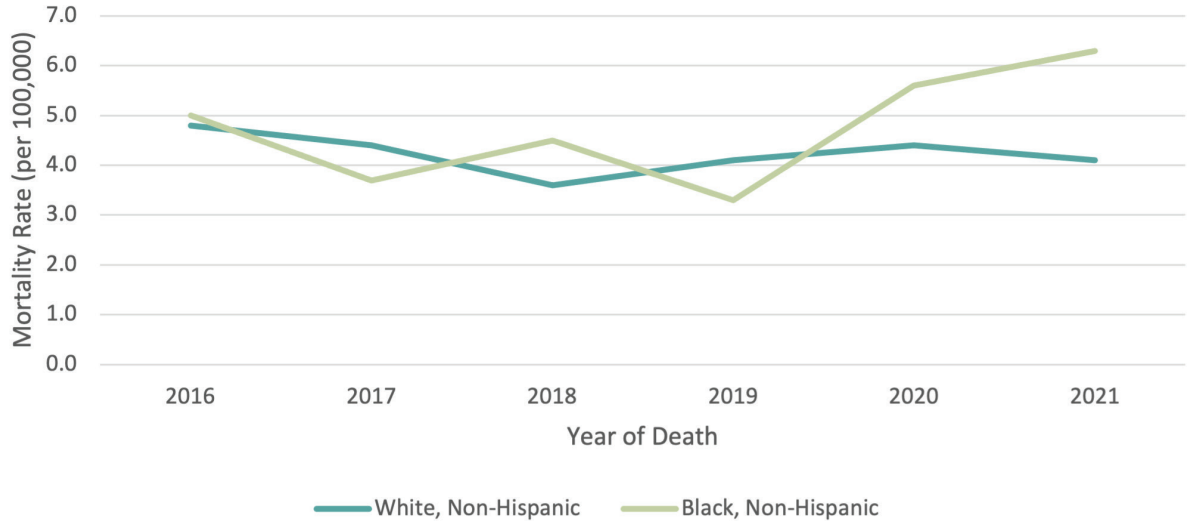
Figure 11. Proportion of Drowning Reviews with Recommendation



Motor Vehicle Incidents

Reported deaths (ages < 18) associated with MV incidents vary from year to year, but the average number is approximately 100 per year. There has been an increase in Black/African American deaths during the first two years of the COVID19 pandemic. The White deaths stayed at about 4 per 100,000, but Black deaths increased to over 6/100,000 in 2021.

Figure 12. Georgia Motor Vehicle Mortality Rate, Ages < 18



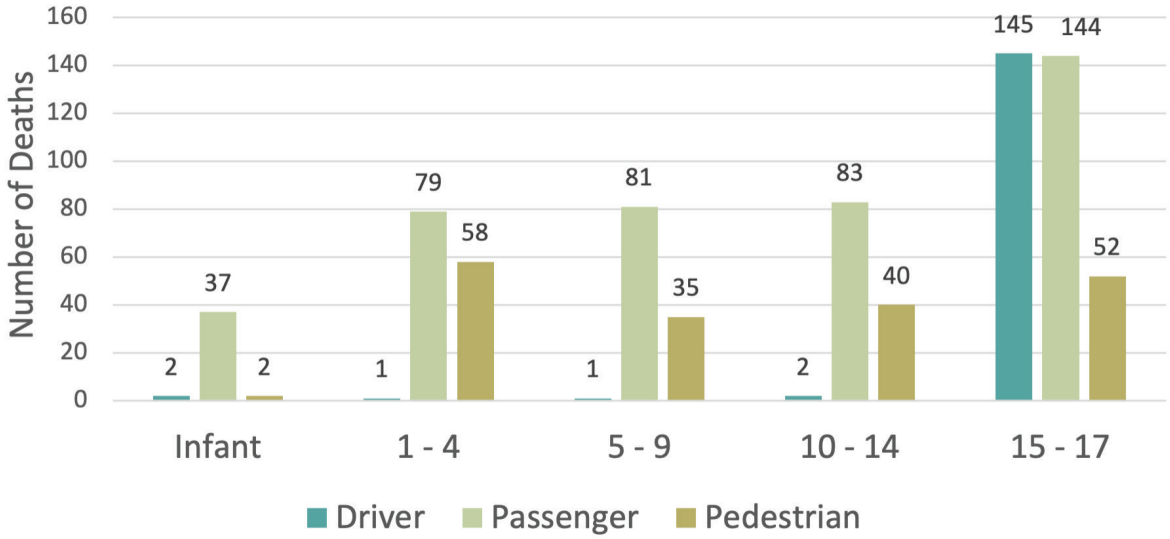
Child Fatality Review (CFR) teams reviewed 106 motor vehicle related deaths in 2021. The majority of the 106 incidents in 2021 were related to cars, vans, SUVs, or trucks, accounting for 58% (61) of these deaths. The 15-17 age group has largest number of deaths in this category with 27, accounting for 44%.

Table I. Reviewed 2021 Motor Vehicle Deaths, by Involved Vehicle

	Age in Years					
Child's Vehicle	**Infant**	**1 to 4**	**5 to 9**	**10 to 14**	**15 to 17**	**Totals**
ATV		1	4	3	4	12
Bicycle				2		2
Car, van, SUV, truck (driver)					17	17
Car, van, SUV, truck (passenger)	7	10	10	7	10	44
Motorcycle					1	1
Pedestrian	1	6	1	6	3	17
Other/Unknown		2		6	5	13
Totals	**8**	**19**	**15**	**24**	**40**	**106**

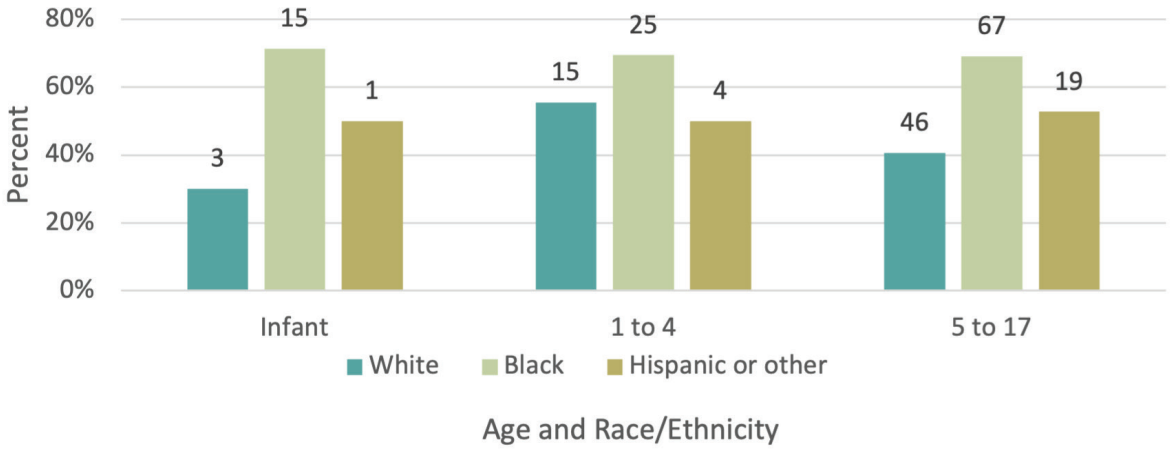
Assuming no significant trends over time, the 10-year set of reviewed data was used to describe the MVC victim population and examine risk factors. Passengers (of car, van, SUV, or truck) comprised the largest population by position (424 out of 938) – 45%.

Figure 13. Position of MVC Decedent by Age, GA 2012-2021



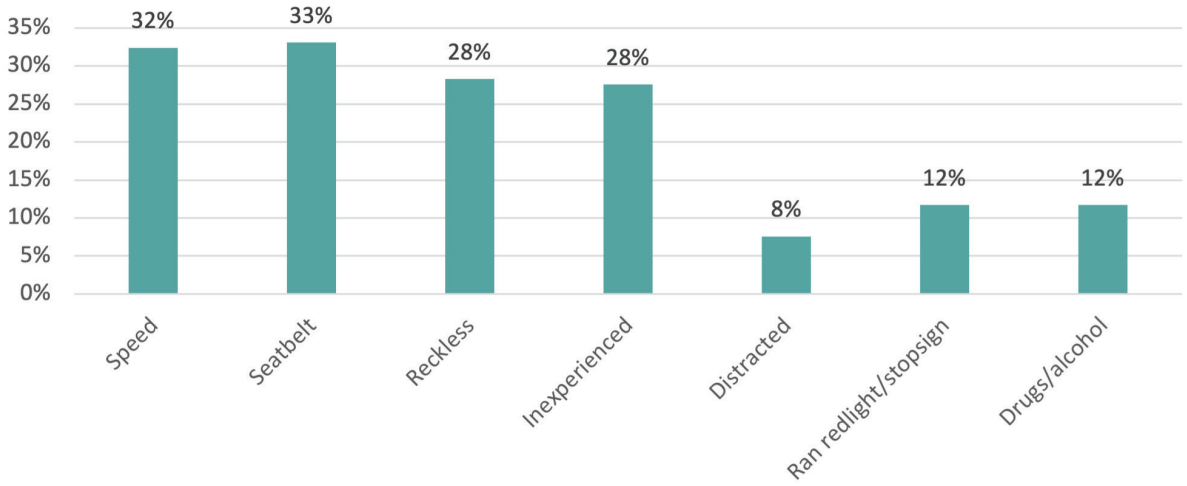
A primary prevention objective for passengers is availability and use of appropriate restraint systems. Over half of reviewed fatalities for children <18 who were passengers in a car, van, SUV, or truck were either not restrained or improperly restrained. Black children accounted for almost 80% of the unrestrained/improperly restrained infants, while they were 57% and 51% of the 1- to 4-year-olds and the 5-to-17-year-olds respectively.

Figure 14. Children who were Passengers in a Car, Van, SUV or Truck and were Unrestrained or Improperly Restrained (Percent and Number)



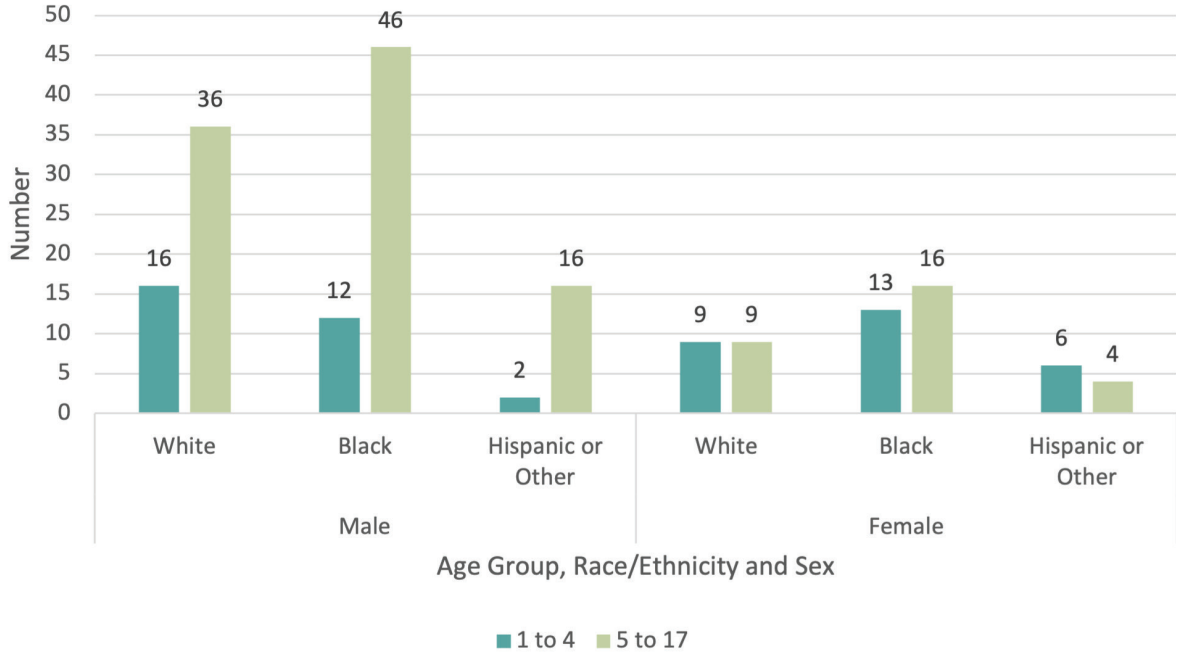
The teenage drivers are a second target population for prevention. There were 145 reviews of deaths of teen drivers from 2012 to 2021. Ninety percent of the time the teen driver was determined to be at fault in the motor vehicle incident. Males were involved in single vehicle accidents twice as often as females (66% of the time versus 32%). Speed, lack of seatbelt use, recklessness and inexperience were top contributing factors to motor vehicle incidents involving teen drivers.

Figure 15. Contributing Factors in Reviewed Fatal Crashes Involving Teen (15 to 17) Drivers, GA, 2012-2021



Pedestrian deaths are distributed across all age groups and represent a prevention challenge. For the 15 to 17 age group, 85% of reviewed pedestrian deaths were male, and 75% of the 10 to 14 age group were male. The toddlers represent a supervision issue, and the older children/youth need education in awareness of their environment.

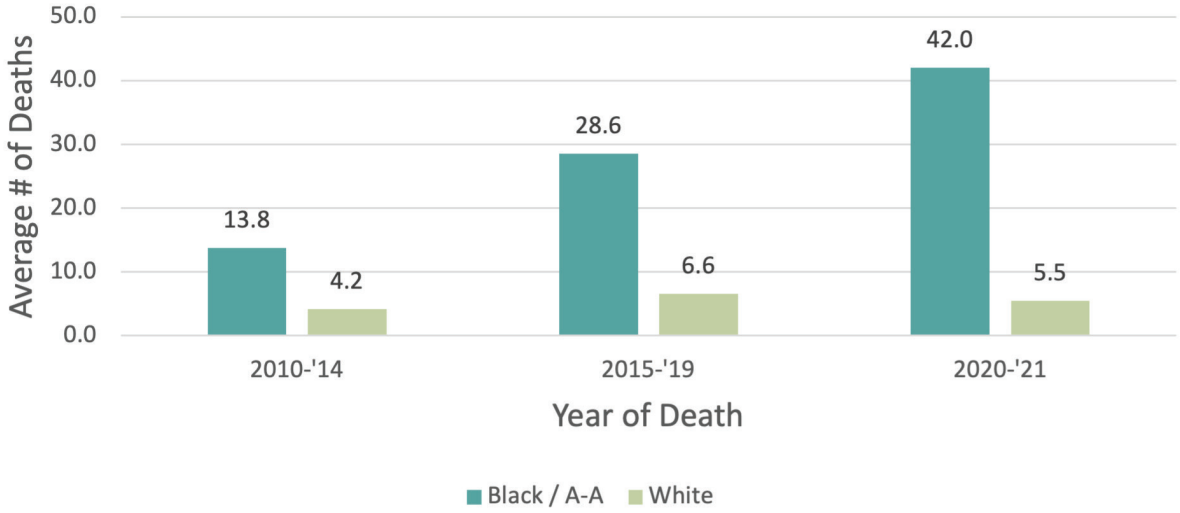
Figure 16. Number of Reviewed Pedestrian Deaths by Race/Ethnicity, Sex and Age Group, 2012-2021

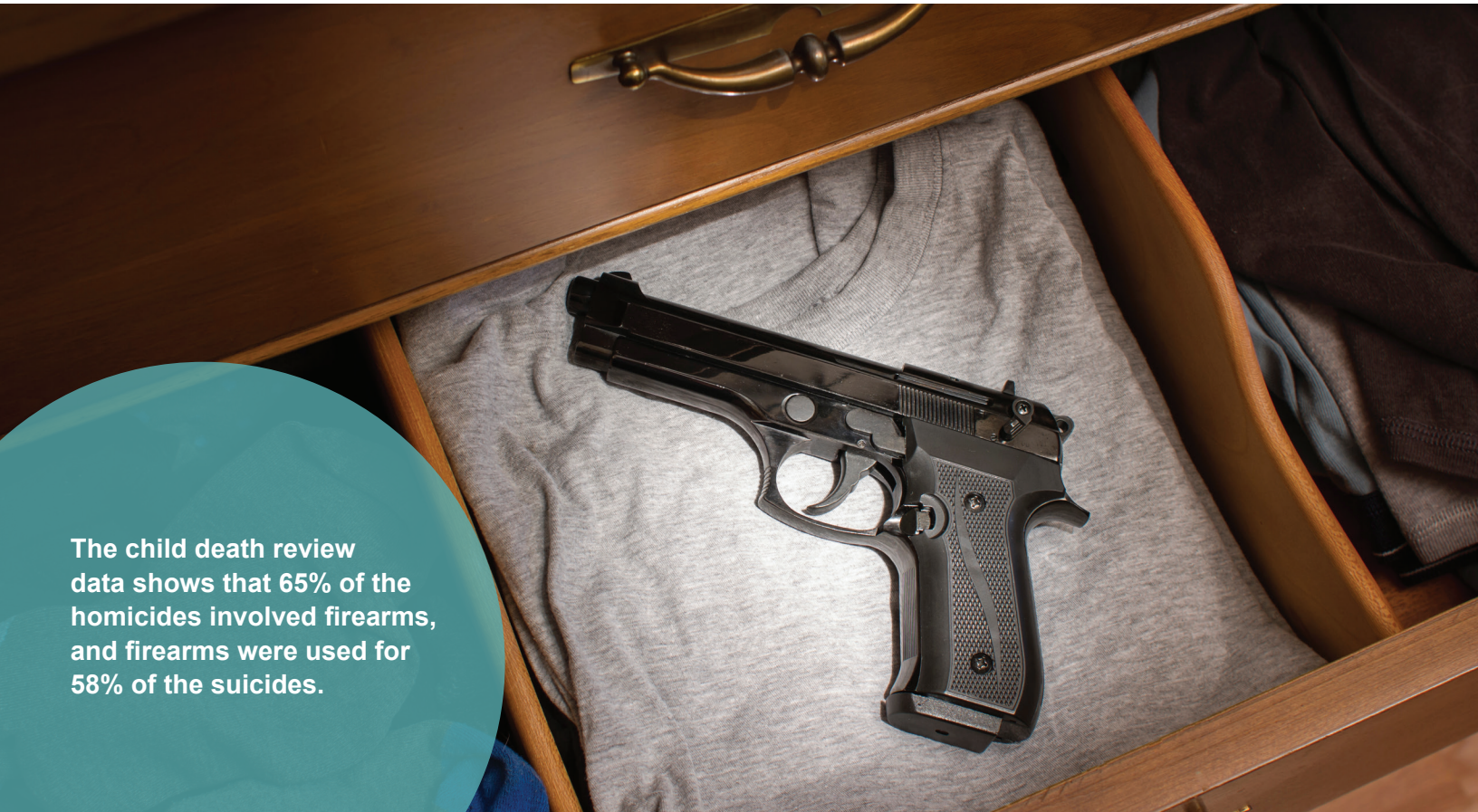


Intentional Injuries

Homicides continued an increase that started in 2020, and suicides (death certificate reports) increased from an average of 59 per year over the previous five years to 86 in 2021. The homicide increase has been associated with an increase within the Black/A-A population ages 15 to 17. The number doubled starting in 2015, and there has been another 50% increase over the past two years.

Figure 17. Average Annual Homicides, GA, Ages 15-17





The child death review data shows that 65% of the homicides involved firearms, and firearms were used for 58% of the suicides.

Table J. Reviewed Intentional Deaths by Mechanism, GA Residents, 2021							
		Age Category (yrs.)					
	Mechanism	Infant	1 - 4	5 - 9	10 - 14	15 - 17	Total
Homicide							
	Blunt Force Trauma	5	9	1			15
	Firearm		3	2	10	42	57
	Hanging		1				1
	Heat	1					1
	Knife		1		1		2
	Maltreatment	1	2	1			4
	Motor Vehicle		1				1
	Poison	1	5				6
	Suffocation					1	1
Total		**8**	**22**	**4**	**11**	**43**	**88**
Suicide							
	Firearm				13	31	44
	Hanging			1	13	14	28
	Poison				2	2	4
Total				**1**	**28**	**47**	**76**

The 10-year review data provides information on risk factors associated with deaths among defined (cause of death, age, race/ethnicity, and mechanism of death) populations. Appendix, Table F has the aggregate homicide and suicide breakout for the period for all four variables. The following table shows some of the disparities in homicide and suicide deaths for ages < 18. Toddlers account for 38% of the Black, non-Hispanic homicides compared to 56% for White, NH. This difference is a result of the large racial disparity in teen homicides. Many of the toddler homicides (approximately 60% for Black and White, NH) are attributed to blunt force trauma. The teen homicides are firearm-related (93% for Black, NH and 76% for White, NH), and over 80% of the firearm homicide victims were male.

Table K. Age and Race/Ethnicity Distributions, GA Intentional Injuries, 2012 - 2021						
Age Distribution (Count)				**Racial Distribution (Percent)**		
		Homicide	Suicide		Homicide	Suicide
Years		**NH Black**		Non-Hispanic		
1 to 4	Toddler	179		Black	68.6	25.8
5 to 14	Child	73	59	White	18.4	57.5
15 to 17	Teen	222	69	Other	4.5	5.8
		NH White		Hispanic		
1 to 4	Toddler	71		All Races	8.5	10.9
5 to 14	Child	22	90			
15 to 17	Teen	34	195			

The described age, race, and mechanism distributions highlight areas for additional risk factor investigation. The toddler homicides raise questions regarding the child's supervision and status of caregivers - responsible person(s). The firearm deaths (including accidental deaths) highlight questions regarding access to firearms.

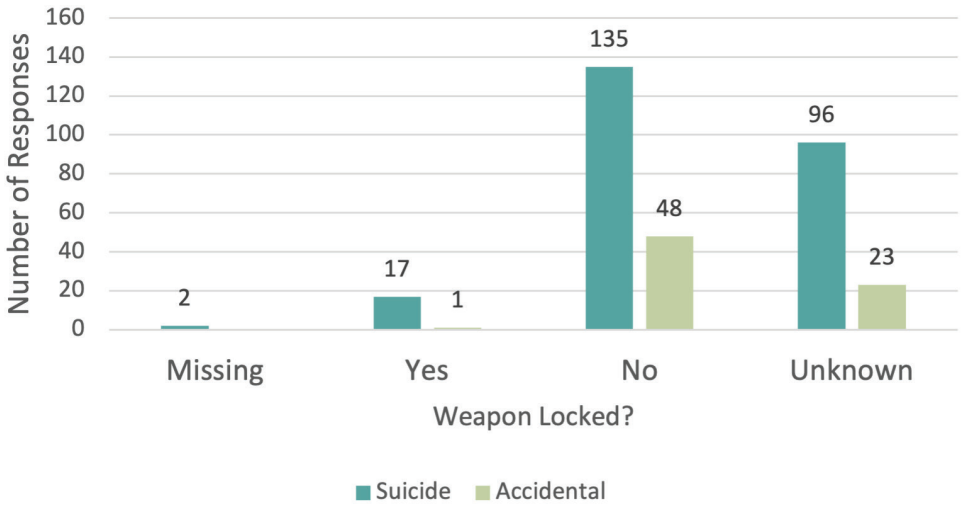
The New York Times reported (12/15/2022) that: "Guns are now the No. 1 cause of deaths among American children and teens, ahead of car crashes, other injuries and congenital disease." Access to firearms and firearm safety are major challenges for public health prevention. Further analysis of CFR firearm-related data will be a priority for future work.

A biological parent or the mother's partner was identified as the person responsible for the death for over 80% of the toddler homicides. The most common mechanism was "blunt force trauma" (59% of the homicides).

Table L. Relationship of Person Responsible for Toddler Homicides		
Description	**Homicide**	**BFT**
Missing	30	10
Biological mother	97	43
Biological father	63	45
Mother's partner	52	49
All Other	50	26
Total	**292**	**173**
% Biological Parent or Partner	80.9	84.0

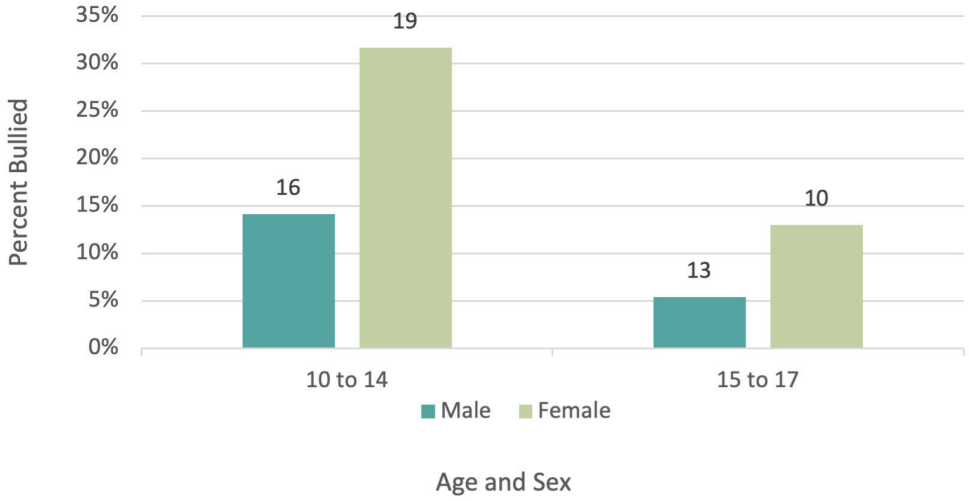
There are a series of questions regarding the firearm used in the deaths, but there are many "Missing" responses. Only 17 out of 152 suicides with a Yes/No response indicated the weapon was locked.

Figure 18. "Was the weapon locked?"



Access to firearms is a serious concern related to suicides, but the mental health of the young person is a major contributing factor. Bullying in school has always been a problem, but the expanded use of social media means that a child is never out of reach of a bully. Younger teen and female suicide victims are more likely to have been bullied (including cyber bullying) than older teens or males. Thirty-two percent of females ages 10 to14 were reported to have been bullied.

Figure 19. Reviewed Suicide Deaths with Reported Bullying, GA, 2012-2021



Of reviewed deaths of children who died by suicide, 29 percent had some form of abuse or neglect at some point in their lives and 56% communicated suicidal thoughts or intentions or talked about suicide.

Sleep-related deaths (Sudden Unexpected Infant Death – SUID):

Sleep-related deaths continue to resist efforts to address recognized risk factors. Safe sleep campaigns have promoted “back-to-sleep” positioning for infants and avoidance of soft bedding and other items in the crib, but the annual number of deaths has remained steady. The GA death certificates reported an average of 162 sleep-related deaths each year from 2014 through 2020. (The increase in 2021 to 182 is suspected to be a reporting anomaly.)

Table M. Reviewed SUID Deaths, GA Residents, 2021

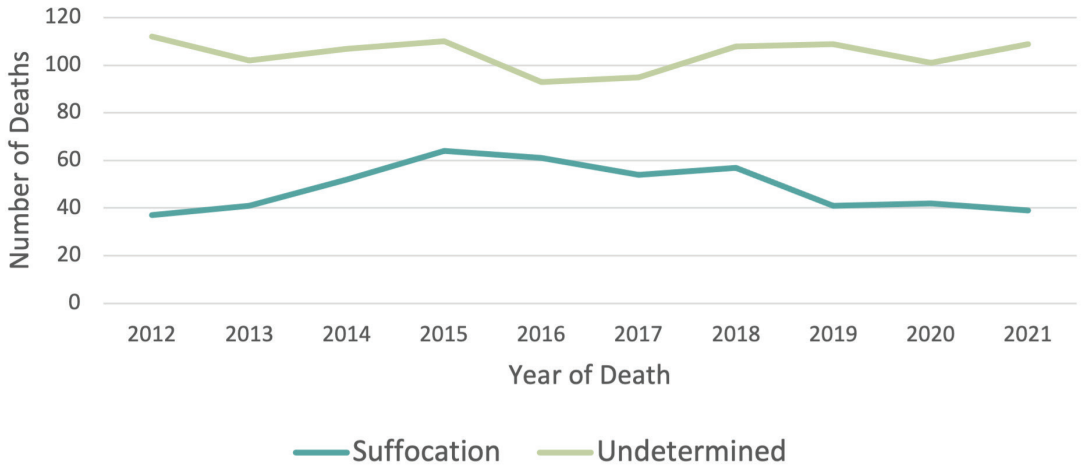
	SUID Category				
	Asphyxia		Undetermined		
Race/Ethnicity	Male	Female	Male	Female	Total
White	7	6	23	10	46
Black	15	6	41	27	89
Hispanic	1	1	1	3	6
Multi-Race	1	2	1	3	7
Total	**24**	**15**	**66**	**43**	**148**

Estimated mortality rates show that Black, non-Hispanic infants were about 2.5 times more likely to die from a sleep-related event than White, NH infants. (“Estimated” rate because not all deaths are reviewed – yielding an underestimate for the mortality rate.) Male infants are also at a slightly higher risk and comprise 61% of SUID deaths.

Fatality review teams determined that 148 reviewed deaths in 2021 were sleep-related.

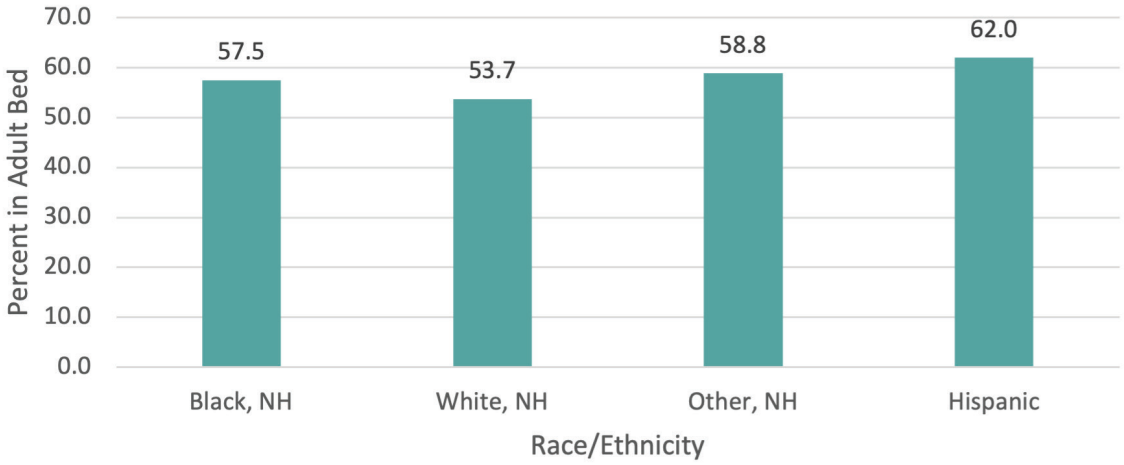
The review process for sleep-related deaths yields four categories for the deaths of infants in a sleep environment. If soft bedding is involved and suffocation is suspected, the cause is considered SUID-Asphyxia (suffocation). The three other SUID categories (SIDS, SUID-Medical, and Undetermined) are combined in "Undetermined" in the following graphic. SUID-Medical indicates that there was some underlying medical condition, but the condition was not determined to be the cause of death. There is some year-to-year fluctuation in SUID, but the count has averaged 153 per year.

Figure 20. Reviewed GA SUID Deaths, by Category, 2012-2021



The risk factors of concern include sleeping position (on back is recommended), sleeping surface (adult bed, crib, other surface), sleeping alone, and soft surfaces/objects on the surface. Over 55% of decedents were reported as sleeping in an adult bed, and the proportion did not vary significantly by race/ethnicity. The presence of a crib in the home (of an infant reported sleeping in an adult bed) was reported for 67% of the Black, NH deaths and 80% of the White, NH deaths.

Figure 21. Proportion of Decedents in Adult Bed, by Race/Ethnicity: Reviewed Deaths



Co-sleeping is a recognized risk factor for sleep-related death – a roll-over, or even a large arm, can block an airway or constrict an infant's chest and compromise breathing. The 10-year review data indicated 74% of the deaths on an adult bed and 57% on other surfaces had a co-sleeping adult. Only 38% of decedents were reported as sleeping alone.

Sleeping on their back has been aggressively promoted for over a generation, but over 60% of decedents were found on their stomach or side. (Fifty-eight percent of decedents were reported as having been put to sleep on their back.) Over 50% of all infants had unsafe sleep surface/bedding reported for each of the three listed variables. Twenty-nine percent were reported with all three of the unsafe conditions.

Summary

There has been a change in the age and cause of death distributions for Georgia infants and youth (<18 years of age) associated with the COVID19 pandemic. The infant mortality rate dropped by 10% from 2019 to 2020, and the rate remained at that low level (6.2 deaths per 1,000 births) in 2021. Most of that decrease was due to a drop in reported deaths in the first day of life for Black / African American newborns. The child (ages 1 through 17) deaths increased during the past two years – from 562 in 2019 to 668 in 2021. The number of deaths defined as "Reviewable" (for Child Fatality Review {CFR}) increased from 480 (2018-2019) to 600 (2020-2021). (All non-medical deaths are considered reviewable.)

Table N. Possible Pandemic-Associated Changes in Number of GA Infant/Child Deaths

		Year of Death			
Cause of Death	**Age Category**	**2018**	**2019**	**2020**	**2021**
Medical	Infant	711	702	587	562
Motor Vehicle	15 to 17	41	33	52	46
Intentional					
Homicide	10 to 14	4	6	18	13
Homicide	15 to 17	37	32	44	50
Suicide	15 to 17	38	41	31	56
Sleep-Related					
SIDS	Infant	104	104	107	101
Suffocation in Bed	Infant	27	33	31	31
Unknown	Infant	22	26	19	48

The medical infant deaths are not generally subject to review, but the CFR teams are charged with the review of all other deaths. Eighty-one percent of reviewable 2021 deaths were reviewed by CFR teams, with 84 teams reviewing all reviewable deaths in their county. The multi-year CFR data base was used to describe the pandemic associated changes noted and to examine risk factors for age, race/ethnicity, and sex for selected cause of death categories. The following provides highlights from those descriptive analyses:

Drowning: The drowning deaths did not show any trends over time, but the multi-year data distinguished two populations with different risk factors and racial distributions. The white toddlers are 2.2 times more likely to drown than black toddlers; but the black 5- to 17-year-old is 3.8 times more likely to drown than a white child. Access to pools and ability to swim may explain some of the observed racial differences.

Motor vehicle incidents: There has been an increase in Black/African American deaths during the first two years of the COVID19 pandemic. The White deaths stayed at about 4 per 100,000, but Black deaths increased to over 6/100,000 in 2021. There are (at least) three distinct prevention target populations:

1. Appropriate restraint use is an issue for passengers of all ages. Over half of passenger decedents in a car, van, SUV, or truck were either not restrained or improperly restrained.

2. Speed, lack of seatbelt use, recklessness and inexperience were top contributing factors to motor vehicle incidents involving teen drivers (about two-thirds male).

3. Pedestrian deaths are distributed across all age groups, with 69% male and 47% Black/African American. Prevention priorities need to be appropriate supervision for the toddlers and awareness of their environment for older youth.

Intentional Injuries: The increase in homicides among Black, 15- to 17-year-old males has been documented. The average number has increased from 14 to 42 per year since 2014. Reduced access to firearms needs to be a prevention priority, but other social/behavioral interventions must be implemented. Infants and toddlers are a different prevention population with biological parents (or caretaker) responsible and blunt force trauma as the mechanism. Prevention approaches include improvement of social support systems, access to parenting training, and more communication among agencies with contact with the infant/toddler.

Black and White youth suicides have displayed similar trends – an increase in 2015, a plateau through 2020, and another increase in 2021. Whites have a higher suicide rate, but the racial difference has narrowed. Prevention needs to address increased sensitivity to warning signs (56% of victims had communicated suicidal thoughts/plans), access to firearms (17 of 152 guns were locked), and use of social media (bullying).

Table O. Average Number of Youth (< 18) Suicides, 2012 - 2021 (GA Death Certificate)			
	2012 - 2014	2015 - 2020	2021
Non-Hispanic			
Black	7.7	15.7	25.0
White	24.0	32.8	48.0
White/Black Ratio	3.1	2.1	1.9

Sleep-Related Deaths: Sudden unexpected infant deaths (SUID) have remained relatively steady over the 10-year period. (The increase in the "Unknown" category in 2021 is suspected to be a reporting anomaly.) Data from the reviewed deaths indicates a high prevalence of recognized risk factors:

Table P. Prevalence of Risk Factors for Sleep-Related Deaths	
	Percent
Stomach or Side Sleep Position	61.1
Sleeping on Adult Bed	56.5
Co-sleeping with Adult	53.1
Soft bedding*	56.0
All 3	29.0

* Pillow and/or Comforter

Maltreatment: Child maltreatment - identified as abuse or neglect causing or contributing to the death, or a reported history of maltreatment – was identified in 29% of the reviewed deaths. The five-year comparison shows a doubling in the number of deaths with neglect reported as causing or contributing to the death and 150% increase in deaths with reported exposure to hazard. We do not know how much of these increases is associated with increased sensitivity to these risks by the review teams. The frequency of a history of maltreatment again highlights the importance of communication among involved agencies. The large increase in reported exposure to hazards (and poor supervision) indicates the need for parent/caregiver education.

Resources

Prevent Child Abuse America (www.preventchildabuse.org)

Georgia Center for Child Advocacy (georgiacenterforchildadvocacy.org)

Child Abuse and Neglect Prevention Plan (CANPP) https://abuse.publichealth.gsu.edu/canpp/

Department of Behavioral Health and Developmental Disabilities Suicide Prevention
https://dbhdd.georgia.gov/bh-prevention/suicide-prevention

Georgia Crisis and Access line (GCAL) 1-800-715-4225 available 24/7

The Trevor Project (LGBTQ) Trevor Lifeline 1-866-488-7386, 24/7, 365
or text 678-678-

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

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

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

American Red Cross (www.redcross.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.)

Attachments

Table A. Age and Race/Ethnicity Distribution, GA Deaths Ages < 18, 2019 - 2021						
		Hispanic	Non-Hispanic			
	Age (Yrs)		Black	White	Other	Total
2019	Infant	100	470	286	32	888
	1 to 4	24	76	58	8	166
	5 to 9	8	42	35	7	92
	10 to 14	15	63	50	2	130
	15 to 17	26	68	73	7	174
2020	Infant	76	406	269	20	771
	1 to 4	22	74	54	4	154
	5 to 9	14	47	24	3	88
	10 to 14	23	74	54	7	158
	15 to 17	21	85	78	3	187
2021	Infant	81	400	257	34	772
	1 to 4	20	84	51	13	168
	5 to 9	13	44	33	1	91
	10 to 14	16	81	59	9	165
	15 to 17	34	123	84	3	244
	2021 Totals	164	732	484	60	1,440

	Infant Deaths					
		Hispanic	Non-Hispanic			
	Age (Days)		Black	White	Other	Total
2019	0	40	156	92	10	298
	1 to 6	20	86	60	6	172
	7 to 27	10	60	43	3	116
	28 to 365	30	168	91	13	302
2020	0	23	111	77	9	220
	1 to 6	12	87	49	5	153
	7 to 27	11	51	40	2	104
	28 to 365	30	157	103	4	294
2021	0	30	111	68	5	214
	1 to 6	17	51	51	7	126
	7 to 27	9	58	40	7	114
	28 to 365	25	180	98	15	318

Table B. Infant Mortality Decrease, Age < 1 Day, 2018/'9 to 2020/'1				
	Black Non-Hispanic		**White Non-Hispanic**	
	2018-2019	2020-2021	2018-2019	2020-2021
PregProb	74	37	22	20
IUG	191	120	69	48
Resp	39	25	19	20
Cong	43	29	47	48
Other	16	10	6	8
Totals	363	221	163	144
% Decrease		39.1		11.7
	Other Non-Hispanic		**Hispanic**	
	2018-2019	2020-2021	2018-2019	2020-2021
PregProb	4	1	12	7
IUG	8	7	32	25
Resp	1		5	5
Cong		4	13	10
Other		2	3	6
Totals	13	14	65	53
% Decrease				18.5

Cause Category Definitions		
Label	ICD10 Range	Description
PregProb	P00 - P04	Maternal factors and complications of pregnancy, labor, and delivery
IUG	P05 - P08	Disorders related to length of gestation and fetal growth
Resp	P20 - P29	Respiratory and cardiovascular disorders of the perinatal period
Cong	Q00 - Q99	Congenital malformations
Other		All other medical causes

Table C. Counties with Un-Reviewed Deaths, 2021								
		Reviewable		Not Reviewable				
County	All Reviewable	Reviewed	Not Reviewed	Reviewed	Not Reviewed	CoFIPS	Label*	Category
Fulton	58	28	30	4	72	13121	58/28	2
DeKalb	49	43	6	7	50	13089	49/43	2
Cobb	22	15	7	1	46	13067	22/15	2
Chatham	19	11	8	1	22	13051	19/11	2
Glynn	11	1	10		3	13127	11/1	2
Troup	7	6	1		8	13285	7/6	2
Bulloch	6	5	1		3	13031	6/5	2
Camden	5	3	2		3	13039	5/3	2
Floyd	5	2	3		5	13115	5/2	2
Douglas	4	3	1	2	12	13097	4/3	2
Habersham	4	3	1		2	13137	4/3	2
Pike	4	3	1			13231	4/3	2
Burke	3	2	1	1		13033	3/2	2
Decatur	3	2	1	2	2	13087	3/2	2
Tift	3	1	2	1	5	13277	3/1	2
Walker	3	2	1	1	4	13295	3/2	2
Catoosa	2	1	1	1	6	13047	2/1	2
Chattooga	2	1	1		1	13055	2/1	2
Murray	2	1	1		5	13213	2/1	2
Sumter	2	1	1		1	13261	2/1	2
Liberty	7	0	7		9	13179	7/0	3
Fayette	5	0	5		7	13113	5/0	3
Baldwin	4	0	4	1	2	13009	4/0	3
Greene	4	0	4		1	13133	4/0	3
Bryan	3	0	3			13029	3/0	3
Grady	2	0	2		1	13131	2/0	3
Morgan	2	0	2			13211	2/0	3
Putnam	2	0	2			13237	2/0	3
Baker	1	0	1			13007	1/0	3
Coffee	1	0	1		5	13069	1/0	3
Evans	1	0	1		3	13109	1/0	3
Jasper	1	0	1			13159	1/0	3
Long	1	0	1		2	13183	1/0	3
McIntosh	1	0	1			13191	1/0	3
Mitchell	1	0	1		1	13205	1/0	3
Towns	1	0	1			13281	1/0	3
Wayne	1	0	1		2	13305	1/0	3

Label* = All Reviewable / Reviewable Reviewed

Table D. Child Fatality Review Team Determination of Preventability: 2021 Reviewed Deaths						
		Could the death have been prevented?				
	Cause of Death	Missing	No, probably not	Yes, probably	Undetermined	%Preventable
Unintentional						
	Motor Vehicle Crash		9	87	10	90.6
	Drowning		1	23		95.8
	Other Unintentional		7	39	10	84.8
Intentional						
	Homicide	1	8	73	6	90.1
	Suicide		8	52	16	86.7
	Sleep-Related	1	15	102	30	87.2
	Medical		63	9	24	12.5
	Undetermined		2	10	7	81.8
	Total		**113**	**395**		**77.8**

Table E. GA Resident Drowning Deaths, Ages 0 – 17, 2012 – 2021

		White, Non-Hispanic		Black, Non-Hispanic		Other Non-Hispanic		Hispanic		
Age Group		Male	Female	Male	Female	Male	Female	Male	Female	Totals
No Review										
	Infant		1		1		1			3
	1 - 4	15	4	3	2		1		1	26
	5 - 9	1	1	6	3		1	2		14
	10 - 14		1	4	2			3		10
	15 - 17	1	1	4	1				1	8
	Total	17	8	17	9		3	5	2	61
Reviewed										
	Infant	4	1	2	1				1	9
	1 - 4	60	35	23	13	2		10	3	146
	5 - 9	10	5	23	7	2		1	4	52
	10 - 14	5	3	21	7	1		2		39
	15 - 17	9		18		1		11		39
	Total	**88**	**44**	**87**	**28**	**6**		**24**	**8**	**285**
	% Reviewed	**83.8**	**84.6**	**83.7**	**75.7**			**82.8**		**82.4**

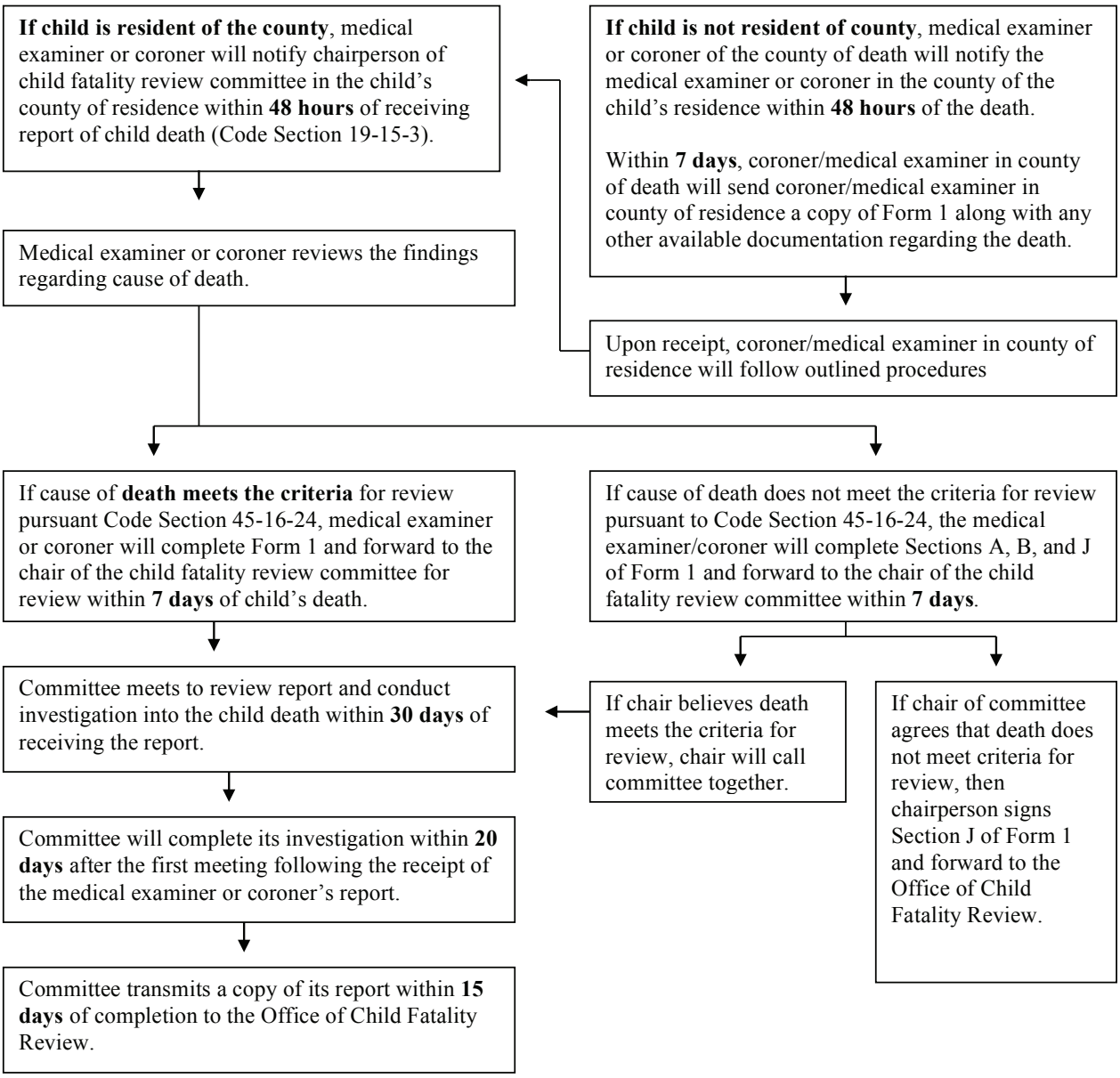
Table F. Reviewed Motor Vehicle Crash Deaths (Ages < 18), GA Residents, 2021

	White, Non-Hispanic		Black, Non-Hispanic		Hispanic & Other Race			
	Male	Female	Male	Female	Male	Female	Total	%Male
Infant	1		2	3	1	1	8	
1 - 4	4	3	5	4	2	1	19	57.9
5 - 9	8		5	1	1		15	93.3
10 - 14	5	6	6	4	2	1	24	54.2
15 - 17	9	6	11	6	6	2	40	65.0
Total	**27**	**15**	**29**	**18**	**12**	**5**	**106**	**64.2**

Table G. Reviewed GA Intentional Injury Deaths, 2012 - 2021: by Race/Ethnicity, Age Category, and Mechanism							
		Black, Non-Hispanic			White, Non-Hispanic		
	Mechanism	Toddler	Child	Teen	Toddler	Child	Teen
Homicide							
	Blunt Force Trauma	107	10	3	44	3	1
	Burns	1			1		
	Drowning	3	2		2		1
	Fire	1					
	Firearm	14	54	206	5	15	26
	Hanging	2			1		
	Heat	1					
	Knife	7	4	8		2	4
	Maltreatment	13	2	1	1		
	Medical Neglect		1		1		
	Motor Vehicle	2					1
	Other				2		
	Poison	10			6		
	Strangulation	10		2	4	1	1
	Suffocation	1		1	2		
	Undetermined	7		1	2	1	
	Total	179	73	222	71	22	34
Suicide							
	Fall		1	1			6
	Fire						1
	Firearm		19	46		47	107
	Hanging		34	19		40	68
	Poison		5	3		3	13
	Total		**59**	**69**		**90**	**195**

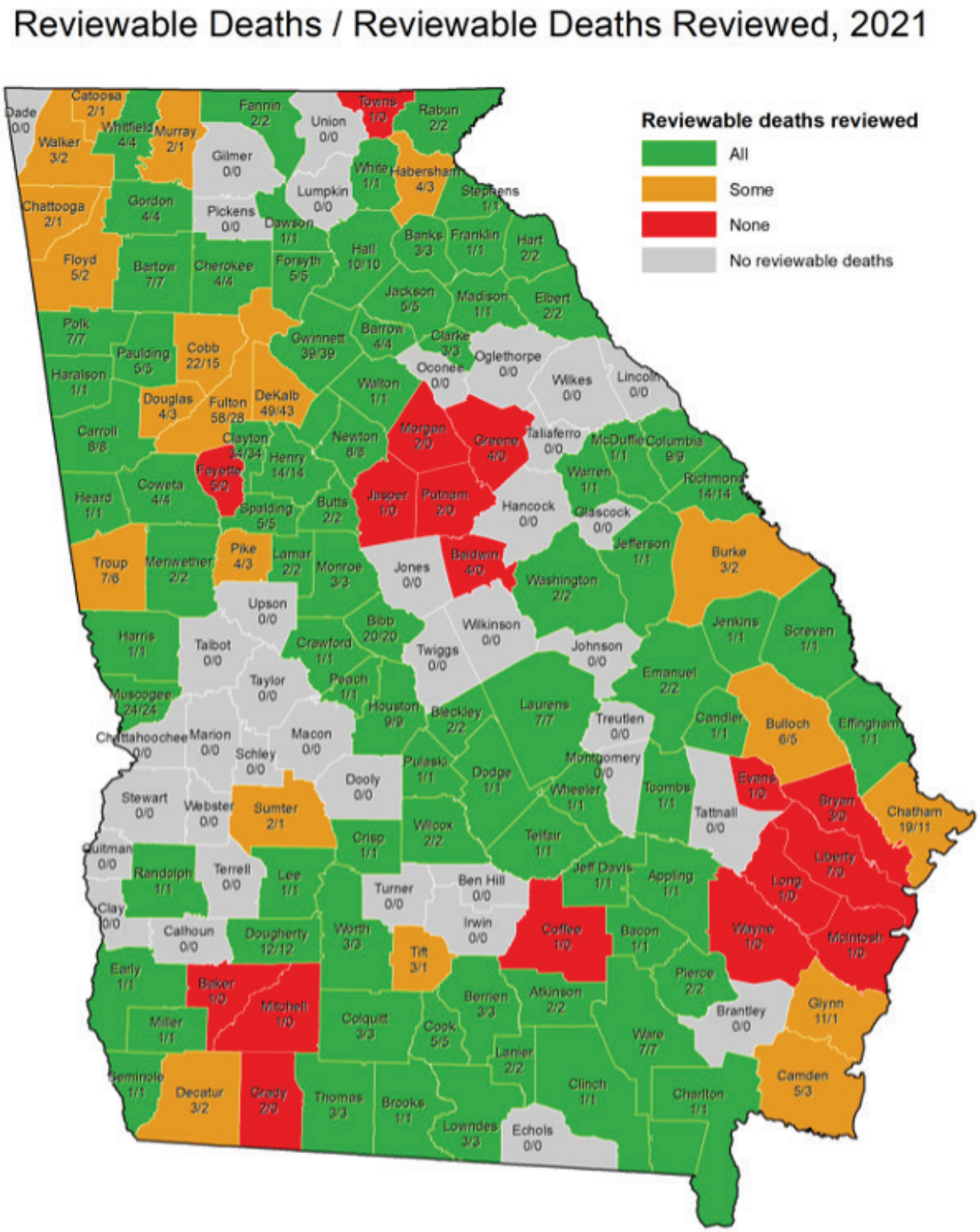
Appendix A

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 - 2020 Compliance Map



Conclusion

We are committed to preventing child deaths in Georgia. The preventable death of a child is an unimaginable tragedy for a family. While there is no way to predict most child deaths, we can identify some groups of children who are at greater risk of death. Identifying trends require analysis of the causes of fatalities, which begins with accurate vital statistics/data provided by local CFR teams.

This report summarizes the data collected regarding the circumstances related to each child death. It is intended to be a vehicle to share the findings with the community to engage others in concerns about these and other risks. We encourage partners and local resources to assist in developing recommendations and implement policies, programs, and practices that can have a positive impact in reducing the risks and improving the lives of Georgia's children. It is our hope that you will utilize the information in this annual report and share it with others who can influence changes for the betterment of children.

For more information on this report or the Child Fatality Review Unit, please contact:

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Georgia Child Fatality Review Panel Annual Report

CALENDAR YEAR 2021