Georgia Child Fatality Review Panel Annual Report

CALENDAR YEAR 2022

Brian Kemp
Governor

Thomas B. "Britt" Hammond
Panel Chair

The Child Fatality Review Panel Members

Thomas Britt Hammond – Panel Chair, Judge, Toombs Judicial Circuit Superior Court

Carolyn Altman – Panel Vice-Chair, Judge, Paulding County Juvenile Court

Mike Register – Director, Georgia Bureau of Investigation

Mandi Ballinger – Member, Georgia House of Representatives

Kevin Tanner – 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

Trina Wilson- Social Worker, LIFE Counseling and Assessment Center

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Richard Hawk – Coroner, Coweta County

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

Dr. Geoffrey Smith – 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

Lisa Kinnemore – Fourth Congressional District Representative, 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 injury fatalities in the state. This mission is accomplished by promoting accurate identification and reporting of child fatalities, evaluating the prevalence and circumstances of both child maltreatment 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 O.C.G.A. § 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
- Alayna White, DPH Injury Prevention Intern, Georgia State University

The 2022 annual report was developed and written in collaboration with DPH Injury Prevention, and the staff members of the Child Fatality Review Unit within the Georgia Bureau of Investigation.

Letter from CFR Panel Chair

Thomas B. "Britt" Hammond
Judge of Superior Courts
Toombs Judicial Circuit

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December 15, 2023

The Honorable Brian P. Kemp
Governor of Georgia
206 Washington Street
Suite 203, State Capitol
Atlanta, Georgia 30334

RE: Georgia Child Fatality Review Panel's 2022 Annual Report

Dear Governor Kemp,

The Georgia Child Fatality Review Panel (CFR) submits the following annual report in compliance with Georgia law (O.C.G.A. § 19-15-4(a)&(i)). This report includes the most comprehensive data that we have been able to collect from participating local child fatality review committees. As in years past, we continue to struggle to obtain 100% participation from all local committees (26 of Georgia's 159 counties did not review any of their reviewable deaths in 2022). Conclusions and included prevention recommendations are therefore limited to our review of the data collected.

On behalf of the CFR Panel, I would like to thank you and the members of the General Assembly for your commitment to our goal of preventing child fatalities in Georgia.

Sincerely and respectfully yours,

Thomas B. "Britt" Hammond
Chairman, Child Fatality Review Panel

TBH/sw
Cc: Honorable Burt Jones, Lieutenant Governor of Georgia
Honorable John G. Burns, Speaker of Georgia House of Representatives
Honorable Brian Strickland, Chairman of the Senate Judiciary Committee
Honorable Stan Gunter, Chairman of the House Judiciary Committee

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Background and History

The Child Fatality Review (CFR) 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's 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. The governing statutes have been amended over the years, adding even more structure, definition, and members to the process. Through the State Panel and the work of the local committees, we can provide recommendations to communities, individuals, and legislators to prevent child deaths. Agencies and organizations working together at the state and local level offer the greatest potential for effective prevention and intervention strategies.

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.

How to Read this Annual Report

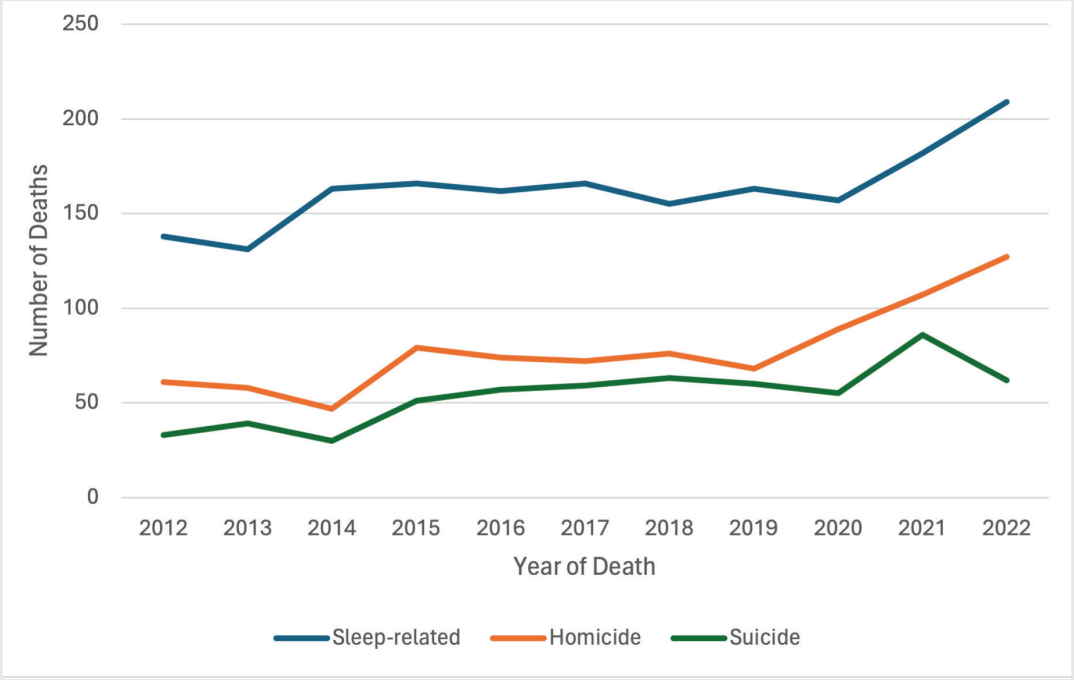
This report utilizes both CFR data as well as death and birth certificate data from vital records. Efforts are made to link birth and death certificates to the reviewed cases. When reading about each injury/death mechanism topic, you will see both death certificate and reviewed data which is clearly noted in the title of each graph. The death certificate data will typically have more deaths noted than the reviewed death data since not every death is reviewed by the local CFR teams.

Data with selected variables will be displayed for each of the injury/death mechanisms followed by a summary. Summaries will be followed by a high-level listing of shared risk and protective factors. To pull as much information from the local CFR teams reviews as possible, the report narratives were read to collect the most common themes. These themes are found under, "The main themes of the child death reviews included". This is followed by evidence-based recommendations for prevention that are listed, "for Individuals, for Communities and for Policy Makers". The Georgia CFR Panel and authors of the report took care to include themes from all the child fatality review narratives describing the circumstances surrounding each death and all the CFR local team's recommendations for prevention.

Trends in Cause of Death for Georgia Infants and Youth

Trends in child death are important to identify to help discern whether any yearly changes in a number are due to any significant increase or decrease in deaths or a random yearly difference. Trends can also help to spot unusual or unexpected changes in death data.

Figure 1. Infant and Child Deaths, Death Certificate Records, Georgia, 2012-2022



This graph shows the number of sleep-related infant deaths, youth homicide, and youth suicide from 2012-2022 based on Death Certificate data. Sleep-related infant deaths and youth homicide deaths have experienced a sustained increase since 2019. Youth suicide deaths had an increase in 2020 but then returned to numbers typically seen in the past by 2022. Within this report, trend data will be included, when relevant, to assist readers with understanding current data in relation to historical data.

Community

The local CFR team reviews the individual deaths, enters data abstracted from the review into a GA (and national) database, and develops recommendations

Georgia

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

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.

Introduction

2022 Georgia Child Fatality Review Process

Child Fatality Review (CFR) is the multidisciplinary review of individual child deaths to help communities understand why children die and equip them to effectively prevent future fatalities. In 2022, there were 657 deaths deemed reviewable (i.e. a non-medical sudden, unexpected, and/or unexplained death of a child).

Table A. Reviewed GA Resident Deaths, Ages <18, 2022

	Age in Years					
Cause of Death	**<1**	**1 to 4**	**5 to 9**	**10 to 14**	**15 to 17**	**Totals**
MVC	3	16	14	18	35	86
Drown	1	15	4	3	3	26
Poison	1	2		1	18	22
Weapon		6	2	3	6	17
Asphyxia	4	4	4	2		14
Fire		4		4	3	11
Fall/Crush	1	1	1		2	5
Other Cause	2	2				4
Unintentional Subtotal	12	50	25	31	67	185
Homicide	8	9	6	8	65	96
Suicide				13	35	48
Medical	27	15	11	12	5	70
SIDS	2					2
SUID_Asphyxia	41					41
SUID_Medical	5					5
SUID_Undetermined	105					105
Sleep-Related Subtotal	153					153
Undetermined	3	3			1	7
Total Reviewed	**203**	**77**	**42**	**64**	**173**	**559**

There were 46 of the 159 GA counties that had no reviewable deaths in 2022. Sixty-two counties were able to review all reviewable deaths while 26 counties did not review any of their reviewable deaths.

Table B. 2022 GA Reviewable Deaths by Review Status			
	Reviewed?		
Cause of Death	**No**	**Yes**	**% Reviewed**
Medical (non-reviewable)	856	65	7.1
MVC	23	79	77.5
Other Unintentional	38	90	70.3
Sleep-Related	60	149	71.3
Homicide	36	91	71.7
Suicide	13	49	79.0
Unknown Intent	3	14	82.4
Unknown (Age > 0)	8	4	33.3
Reviewable Total	181	476	72.5

The percentage of reviewable deaths reviewed by the local child fatality review teams has been declining over the last few years with 2022 having the lowest percentage in the last 5 years.

A further examination of the 2022 review process by Judicial Districts and Circuits reveals lower review rates for two Districts – the First (eastern/coastal) and the Fifth (Atlanta). Their review proportions were under 35%, and the aggregate rate for the remaining eight districts was 83%. Both Districts had a decline in reviewing cases over the past three years.

Table C. 2022 Review Status by District				
Judicial	Reviewed?		Total Reviewable	Reviewed/ Reviewable
District	No	Yes		
First	53	**28**	**81**	**28/81**
Second	9	38	47	38/47
Third	6	55	61	55/61
Fourth	18	44	62	44/62
Fifth	38	**20**	**58**	**20/58**
Sixth	12	69	81	69/81
Seventh	16	58	74	58/74
Eighth	6	34	40	34/40
Ninth	9	66	75	66/75
Tenth	14	64	78	64/78

Reviewing child deaths is important for prevention and to make recommendations on policy and organizational changes. CFR reviews are also beneficial for counties and local jurisdictions to assess how their agencies respond to a child death and whether consistent investigations and protocols are in place to ensure thorough investigations. Reviews also assess if there are adequate protocols being routinely followed to ensure the safety of other children in the home. Finally, these reviews can also find gaps in resources or education that may exist in the community; for example, referrals for grief support after the death of a child.

2022 Reported Infant and Child Deaths

According to Georgia Vital Records, in 2022 there were 126,001 births in Georgia and 1,578 reported infant and child deaths. Of these deaths, 904 were of infants (children under the age of 1 year) and 674 were all other ages up to the age of 18 years. There were 657 deaths identified for inclusion in the CFR process. The mechanisms of death, identified from the death certificate file were: Drowning, Fire, Homicide, Motor Vehicle Crashes/Incidents, Other injuries, Medical, Poison, Sudden Unexpected Infant Death (which includes SIDS, Suffocation in Bed, Other Suffocation and Unknown for Infant) Suicide, Unknown Intentional, and General Unknown. Below, they are listed, broken down by cause and age group.

Table D. 2022 Deaths, GA Residents Ages <18

	Age in Years					
Death Certificate Cause	**<1 year**	**1 to 4**	**5 to 9**	**10 to 14**	**15 to 17**	**Totals**
Drowning	3	18	5	5	3	34
Fall	1	1	1			3
Fire		5	1	5	3	14
Firearm*		8	2		3	13
MVC	2	14	17	25	44	102
Other Cause	4	7	6	2	7	26
Poison				1	19	20
Suffocation	4	5	5	3	1	18
Other (SUID)	2					2
Sudden Infant Death Syndrome SIDS	125					125
Suffocation in Bed	44					44
Unknown (ages <1 year)	38					38
Homicide	11	17	7	10	82	127
Suicide			1	17	44	62
Medical**	666	73	52	63	67	921
Unknown Intent	4	5	1	3	4	17
Unknown		8		1	3	12
Totals	**904**	**161**	**98**	**135**	**280**	**1,578**

2022 Deaths Georgia Residents, Ages <18
*Firearm deaths not included in homicide, suicide or other
** Typically, not included in child fatality review

In 2022, 666 infant deaths were excluded from the review process. The graph below shows the general age of the infant at the time of death. Black non-Hispanic infants have a disproportionately higher number of deaths than other races and ethnicities. The March of Dimes is one group that works to improve maternal and infant health. (For more information on statistics in Georgia and the Nation, visit the March of Dimes website.) Additionally, the Healthy Mothers Healthy Babies Coalition of Georgia works to advocate for infant and maternal health to reduce disparities as well as these types of medical deaths.

ABOUT HEALTHY MOTHERS, HEALTHY BABIES COALITION OF GEORGIA

Over the past forty years, HMHBGA has worked to improve access to prenatal and preventive healthcare for thousands of women, children and families in Georgia through direct service, collaborative advocacy and community education. Disclaimer: Healthy Mothers, Healthy Babies Coalition of Georgia does not support or oppose any candidate for federal, state or local elected office.

Table E. 2022 Georgia, Number of Deaths by Age

		Number of Deaths by Age				
Race and Ethnicity	**Year**	**< 1 Day**	**1 Week**	**1 Month**	**1 Year**	**Total**
Black non-Hispanic	2022	114	67	57	99	337
White non-Hispanic	2022	79	59	37	41	216
Hispanic	2022	34	21	17	23	95
Other non-Hispanic	2022	9	1	2	6	18

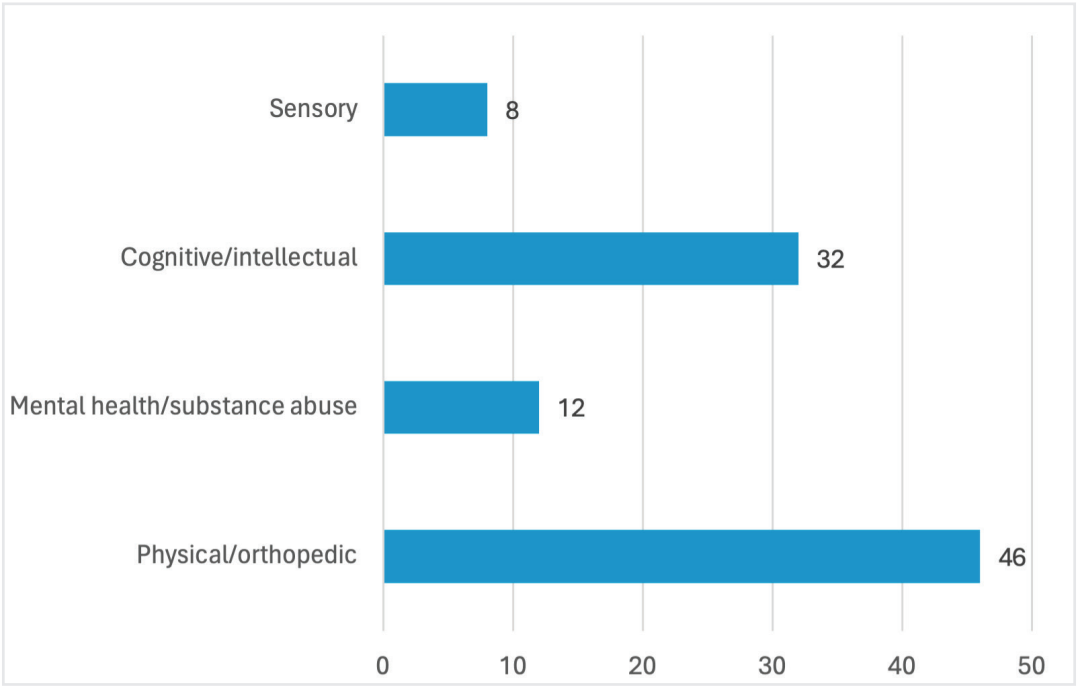
While no single solution will improve maternal and infant health, there are key policy opportunities to consider that are highlighted below:

- Medicaid Extension
- Medicaid Expansion
- Paid Family Leave
- Doula Reimbursement Policy
- Maternal Mortality Review Committee
- Fetal and Infant Mortality Review
- Perinatal Quality Collaborative

Children and Youth with Special Healthcare Needs (CYHCN)

In the CFR Report Form, question #13 in the "Information" section of the review form is: "Did child have prior disability or chronic illness?" Follow-up questions identify the category(ies) of the illness or disability, and whether the child was: "Receiving Children's Special Health Care Needs Services". The use of these questions allowed for infants and children to be identified in reviewed 2022 deaths as having a chronic illness or disability. Of the 476 reviewed cases, 81 decedents (17%) were identified by the initial question, and 18 (of the 81) were reported as CYSHCN service recipients.

Figure 2. Reviewed Deaths with Chronic Illness or Disability, Georgia, 2022



Children and youth that are identified as having special healthcare needs can be recipients of programs designed to provide support to both the parents and the child. Communities and those working with families are encouraged to utilize Children 1st.

Children 1st is the single point of entry for all Department of Public Health (DPH) Child Health programs and services for children, birth – 5 years old, and links eligible children to early intervention services, as well as other public health programs and community-based resources. All referrals made to DPH Child Health programs including Babies Can't Wait (BCW), Children's Medical Services (CMS), Early Hearing Detection and Intervention (EHDI), and 1st Care must be made through Children 1st.

Maltreatment Cases in Reviewed Deaths

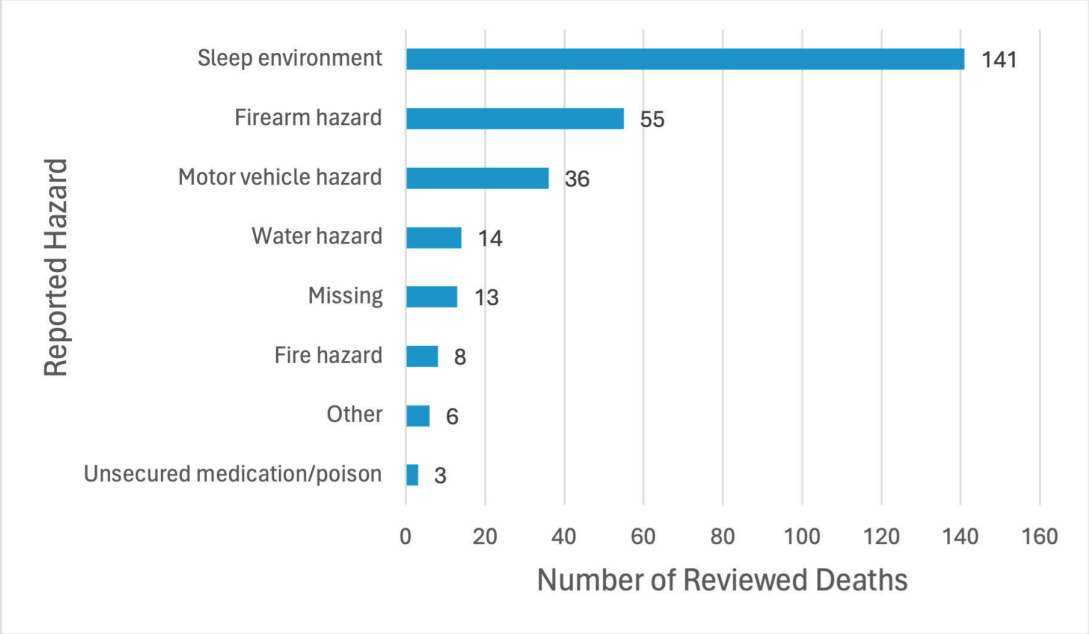
Supervision and hazard exposure are risk factors that are amenable to prevention efforts – usually directed at specific causes or ages. In addition to the possible contribution of poor supervision to the death, there is a question: “Did child have supervision at time of the incident leading to death?” If the response was “No, but needed” that death was added to the maltreatment supervision count. That increased the count of 2022 deaths with supervision issues to 130. Drowning deaths stand out for the proportion with supervision problems (73%). Although the count is small, 14 of the 19 are toddlers, identifying caregivers of young children as a population for prevention education.

Table G. Reported Maltreatment by Cause Category, 2022 Reviewed Deaths

Cause Category	Cause or Contribute		History		Supervision	Exposure to Hazard	None	Total	Cause/ History Proportion
	Abuse	Neglect	Abuse	Neglect					
MVC		7	4	5	10	33	27	86	18.6
Other Unintentional	1	4	9	16	27	27	15	99	30.3
Homicide	12	2	7	18	5	25	27	96	40.6
Suicide	1	1	6	3	1	6	30	48	22.9
Sleep-Related		4	3	3	18	108	17	153	6.5
Medical		7	5	4	2	2	50	70	22.9
Undetermined		2			1	1	3	7	28.6
Total	**14**	**27**	**34**	**49**	**64**	**202**	**169**	**559**	**22.2**

Exposure to hazards was identified as a risk factor for 276 of the reviewed deaths. There were 141 reviews (135 infants) where the sleep environment was identified as a hazard, with 128 of the 135 being sleep-related. Firearms were the second hazard, with teens, 15 to 17 years, accounting for 29 out of 55 reviewed that had a reported firearm hazard.

Figure 3. Hazards, Reviewed Deaths, Georgia, 2022



Risk Factors	Protective Factors
1. Parental Substance Abuse: Substance abuse by parents can impair judgment and increase the risk of child maltreatment.	1. Parental Resilience: A parent's ability to bounce back from stress and challenges can protect against maltreatment.
2. Mental Health Issues: Untreated mental health problems in parents can contribute to abusive behavior.	2. Access to Mental Health Services: Timely access to mental health services can help address and manage parental mental health issues.
3. Domestic Violence: A home environment with domestic violence may expose children to abuse.	3. Parental Education: Education on effective parenting practices and child development can be protective.
4. Social Isolation: Families with limited social support may face higher risks, as there are fewer external eyes on the well-being of the child.	4. Social Support: Having a strong support network, whether from family, friends, or community services, can provide assistance and guidance.
5. Poverty: Economic stressors can contribute to heightened tension in families, potentially leading to maltreatment.	5. Community Resources: Communities with accessible resources, such as childcare services and parenting classes, can contribute to child safety.
6. Parental Stress: High levels of stress in parents can contribute to a decreased ability to cope with parenting challenges.	6. Strong Parent-Child Relationships: Positive and nurturing relationships between parents and children can serve as a protective buffer.

It is important to note that these factors are interconnected and addressing them collectively is crucial for the prevention of child maltreatment deaths. Early intervention, community support, and education play key roles in creating a safer environment for children.

Prevention Recommendations

For Individuals

- Get involved, some examples include:
  - Prevent Child Abuse Georgia
  - Georgia Family Connections
  - Resilient Georgia
  - VOICES for Georgia's Children

For Communities

- Develop and promote incentives for expanding childcare access in underserved communities.
- Expand programs and practices aimed at parents who are "returning citizens" (i.e., formerly incarcerated adults).
- Increase access to low-/no-cost community-based behavioral-health services for low-income families (e.g., substance abuse recovery groups).
- Integrate practices that are designed to strengthen caregiver–child attachment relationship along the child-development continuum (e.g., Home visiting, positive behavioral interventions and supports).
- Promote trauma-informed training for all school personnel (e.g., trauma-informed care, addressing implicit bias, empathy, prejudices, attribution).
- Use data to inform the development of prevention practices, programs, and strategies (including child death review data). Preventing Adverse Childhood Experiences.

For Policy Makers

- Expand access to affordable childcare for parents who are working or in school (e.g., tax breaks for companies that offer on-site or subsidized childcare), especially for lower-income and hourly-wage-earning families.
- Promote and expand the participation of families in the Planning for Healthy Babies (P4HB) waiver program.
- Expand eligibility to Georgia's Childcare and Parent Services (CAPS).
- Expand efforts to develop safe and decent affordable housing for families.
- Increase access to family-support services in emergency rooms and urgent-care facilities.

Summary of All Causes

Motor Vehicle-Related Deaths (Includes all vehicles and pedestrian)

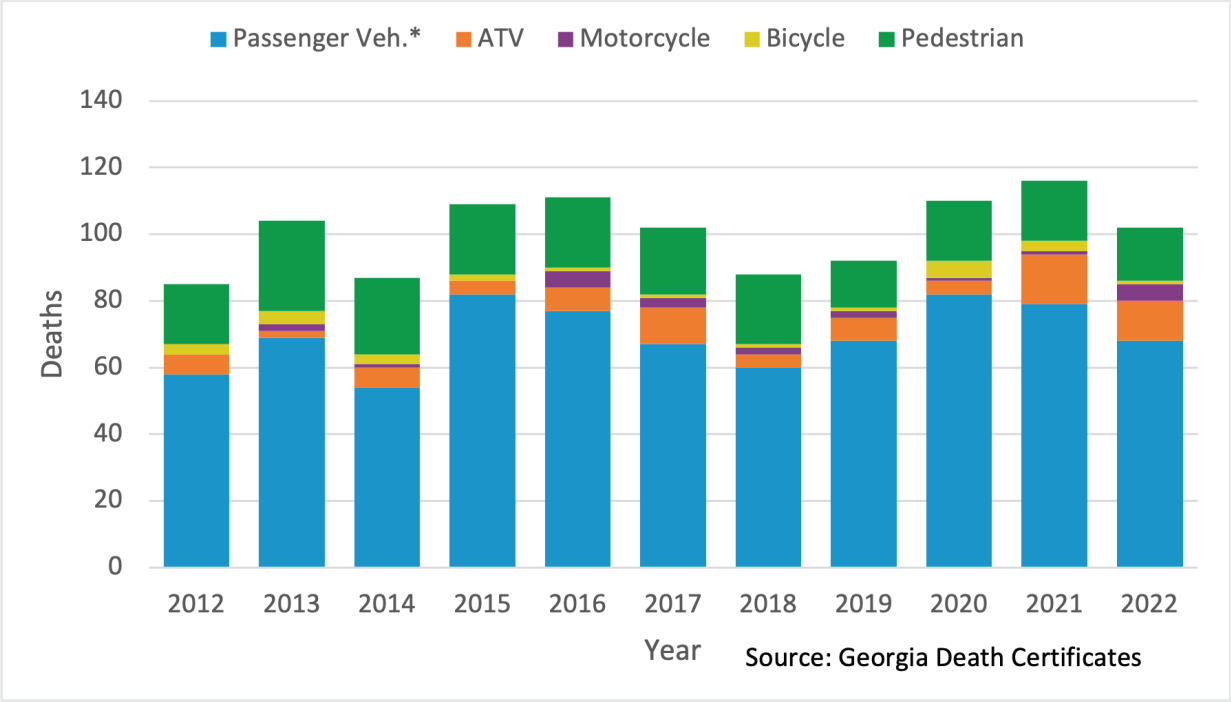
Of the 2022 motor vehicle-related death certificate data, there were a total of 102 child deaths due to all motor vehicle types. 68 deaths were due to “other vehicles” which include cars, trucks, SUVs and vans. 33 of these 68 (49%) were youth between the ages of 15-17 years. According to the CDC, factors that contribute to teen driver or passenger motor vehicle crash death include inexperienced drivers, distraction, high rates of speed, lack of seatbelt use, and substance use. (For more information on young driver motor vehicle safety, please review Young Drivers Georgia Traffic Safety Fact Sheet.)

Table H. Reviewed 2022 Motor Vehicle Deaths, by Involved Vehicle

Motor Vehicle Type	Infant < 1 year	1 to 4 years	5 to 9 years	10 to 14 years	15 to 17 years	Totals
Other Vehicle*	2	7	11	15	**33**	68
ATV		2	1	6	3	12
Motorcycle				1	4	5
Bicycle				1		1
Pedestrian		5	5	2	4	16

Figure **. 2022 Motor Vehicle Crash (MVC) Deaths, Death Certificate, Georgia
*Other vehicles include car, truck, SUV and van

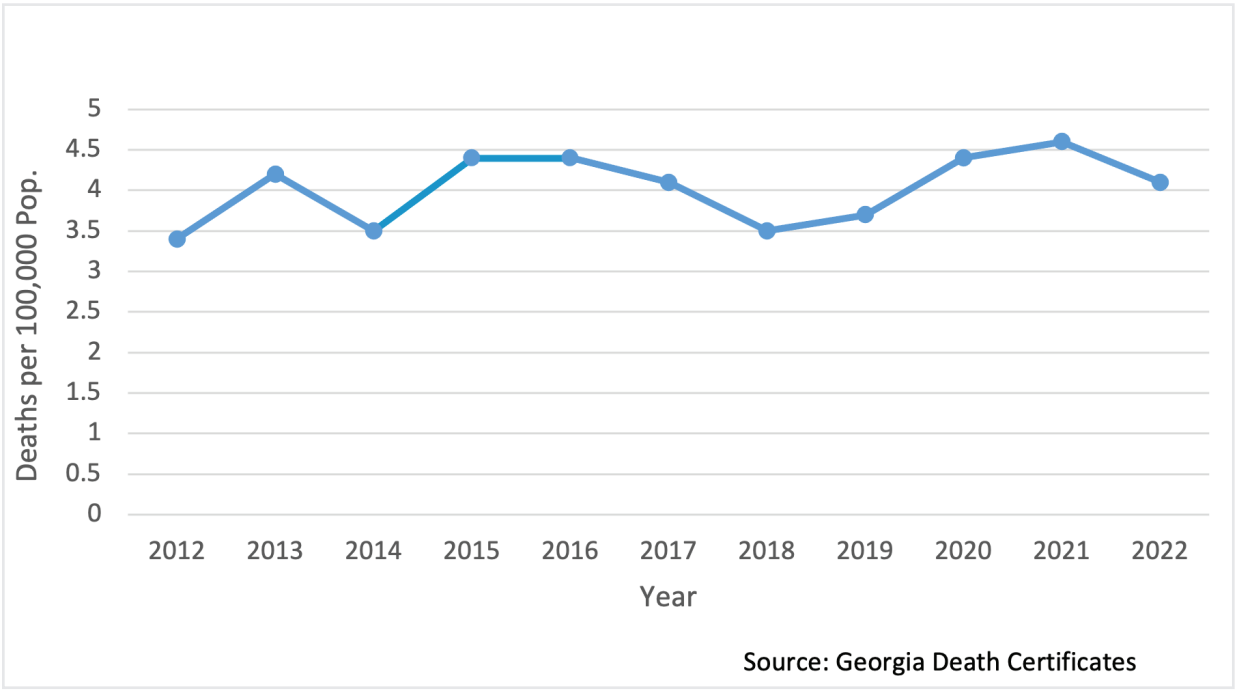
Figure 4. Motor Vehicle Crash Related Deaths by Mode, Ages <18, Georgia, 2012-2022



*Passenger vehicles include cars, trucks, SUVs, and vans

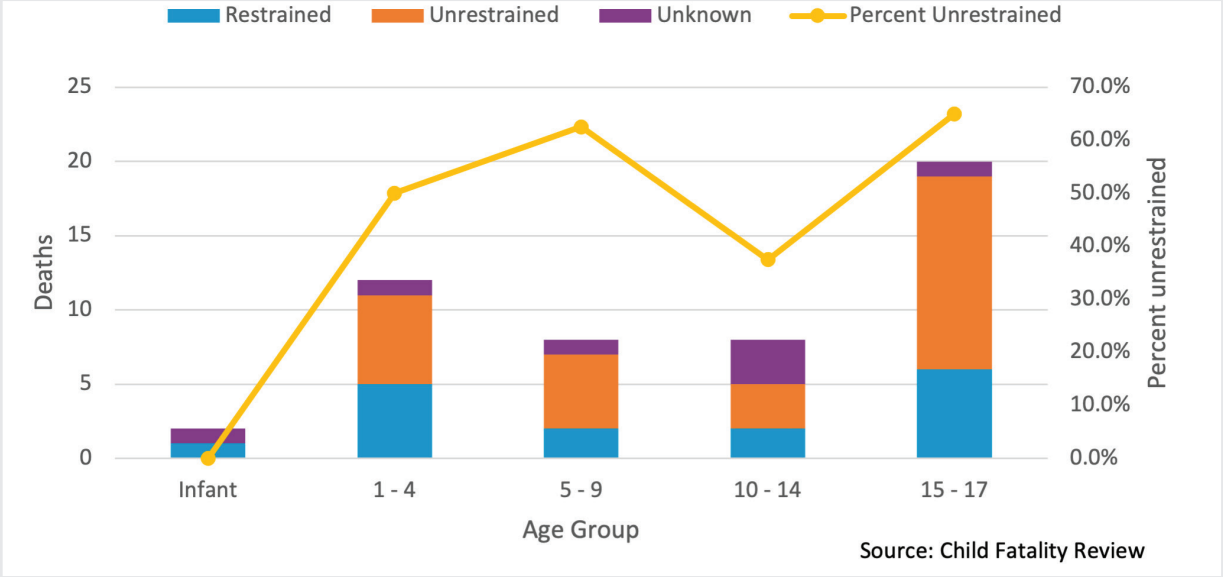
The majority of MVC Deaths in Georgia's youth from 2012-2022 occurred among passenger vehicles occupants (69.1%) followed by pedestrians (19.6%). MVC fatality rates increased sharply in 2020 and have not declined fully to pre-pandemic levels.

Figure 5. MVC Death Rates, Ages <18, Georgia, 2012-2022



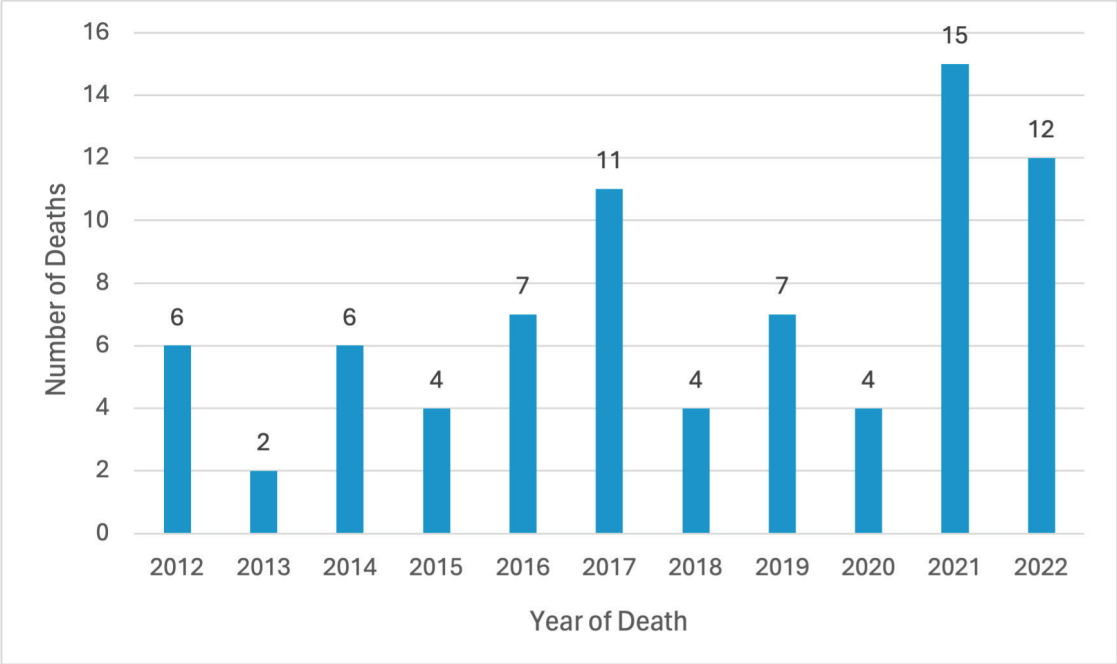
In 2022 reviewed child fatalities among passengers in motor vehicle crashes, more than half (54.0%) were unrestrained at the time of the crash. Passenger fatalities age 15-17 years had the highest rate of being unrestrained (65%), followed by ages 5-9 years (62.5%). This highlights the importance of consistent restraint use.

Figure 6. Restraint Use Among Reviewed MVC Passenger Deaths, Ages <18, Georgia, 2022



In 2021 and 2022, the number of youth deaths attributed to all-terrain vehicles (ATV) and utility vehicles increased. Factors contributing to ATV injury deaths included lack of protective gear, inexperience, unsafe speed, substance use, and improper positioning. The main factors contributing to utility vehicle deaths included fatigue, unsafe speed, and substance use.

Figure 7. Youth Deaths by ATV, Death Certificate, Georgia, 2012-2022



Summary: Shared risk and protective factors for motor vehicle crashes include:

Risk Factors	Protective Factors
1. Speeding	1. Obeying traffic laws
2. Distracted Driving	2. Utilizing seatbelts/child restraints
3. Impaired Driving	3. Avoiding distractions
4. Lack of seatbelt use	4. Practicing defensive driving
5. Adverse weather conditions	5. Graduated driver's licenses

The main themes of the child death reviews included: Concern over inexperienced drivers, substance misuse, improperly installed child safety seats, seatbelts not worn and, cases with other issues of neglect towards children present.

Prevention Recommendations

For Individuals

- Visit Child Safety Seat Fitting Stations across the state with certified Child Passenger Safety Technicians.
- Visit local car seat inspections that are offered throughout the state.
- Drivers Education – utilizing resources from Safe Kids or Georgia Highway Safety on the most up to date recommendations for child safety.
- Always wear safety restraints and model safe motor vehicle behavior for children and young drivers.
- Become familiar with the National Highway Traffic Safety Administration recall list and register all car seats to be informed of any recalls.

For Communities

- Encourage seat belt and safety restraint enforcement.
- Participate in the local Mini-Grant program to provide education and distribute car seats for qualified caregivers. Email Injury@dph.ga.gov for more information.

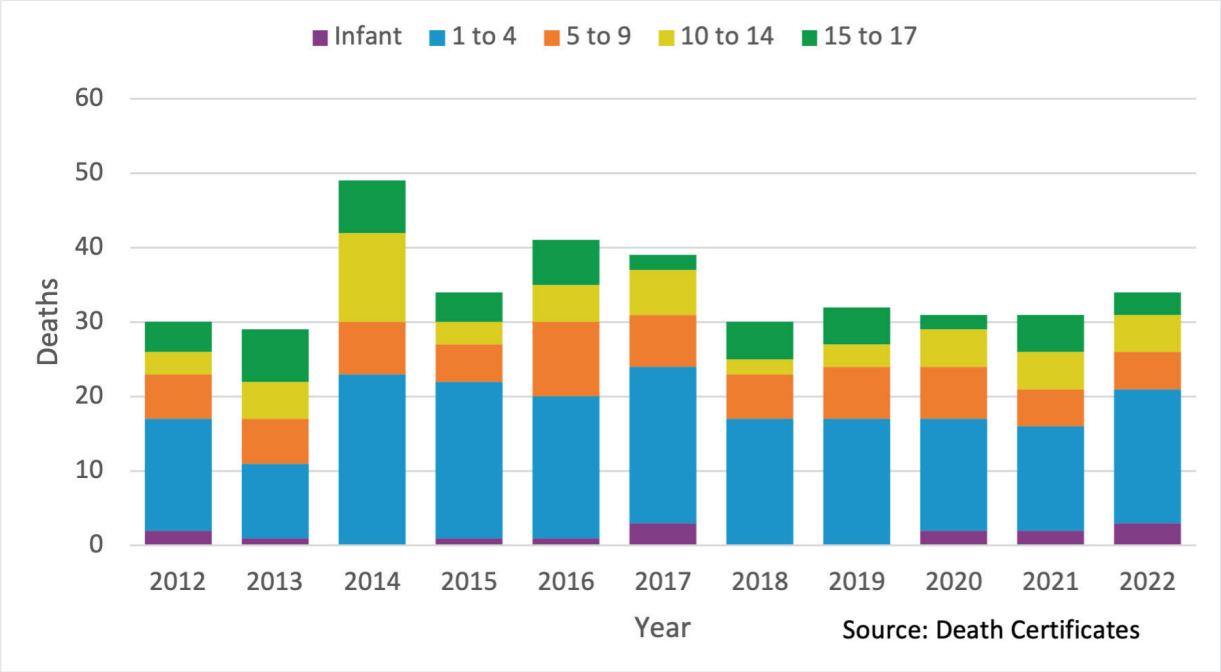
For Policy Makers

- Increase teen driver safety measures.
- Create policy for procedures to follow during pick up of children/youth from events or centers.
- Advocate for expansion of sidewalks and pedestrian crossings.
- Use available Georgia Traffic Safety fact sheets when advocating for motor vehicle safety.

Unintentional Cause: Drowning

The common themes of reviewed child deaths by drowning in 2022 were lack of supervision and lack of CPR training and understanding. In 2022 there were 34 child deaths by drowning and most of the deaths occurred in ages 1 to 4 years.

Figure 8. Drowning Deaths by Age Group, Ages <18, Georgia, 2012-2022



In analyzing CFR data from 2012 to 2022, different patterns in drowning deaths emerge based on the age of the child. Almost all (92.3%) infant drownings occurred in bathtubs, and 76.9% of infants were not supervised when they fatally drowned. Children aged 1 to 4 years, the age group with the highest rate of fatal drowning, were mostly likely to drown in swimming pools (69.9%), and 53.8% were unsupervised at the time of drowning. Older children (age 5 to 17 years) were most likely to drown in open water (49.7%) followed by swimming pools (40.0%), with 55.5% of older children unsupervised at the time of drowning. Of the CFR drowning deaths reviewed data between 2012-2022, only 1 out of 167 toddlers were confirmed to know how to swim.

Figure 9. Proportion of Drownings by Location and Age, Age <18, Georgia 2012-2022

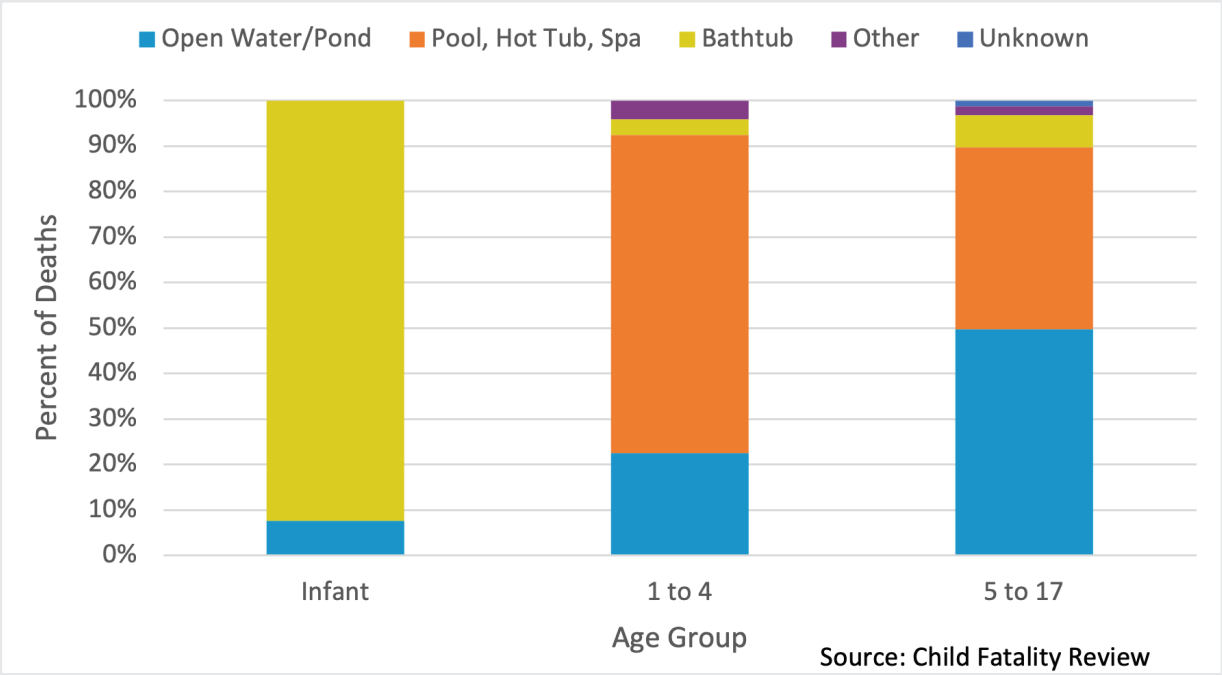
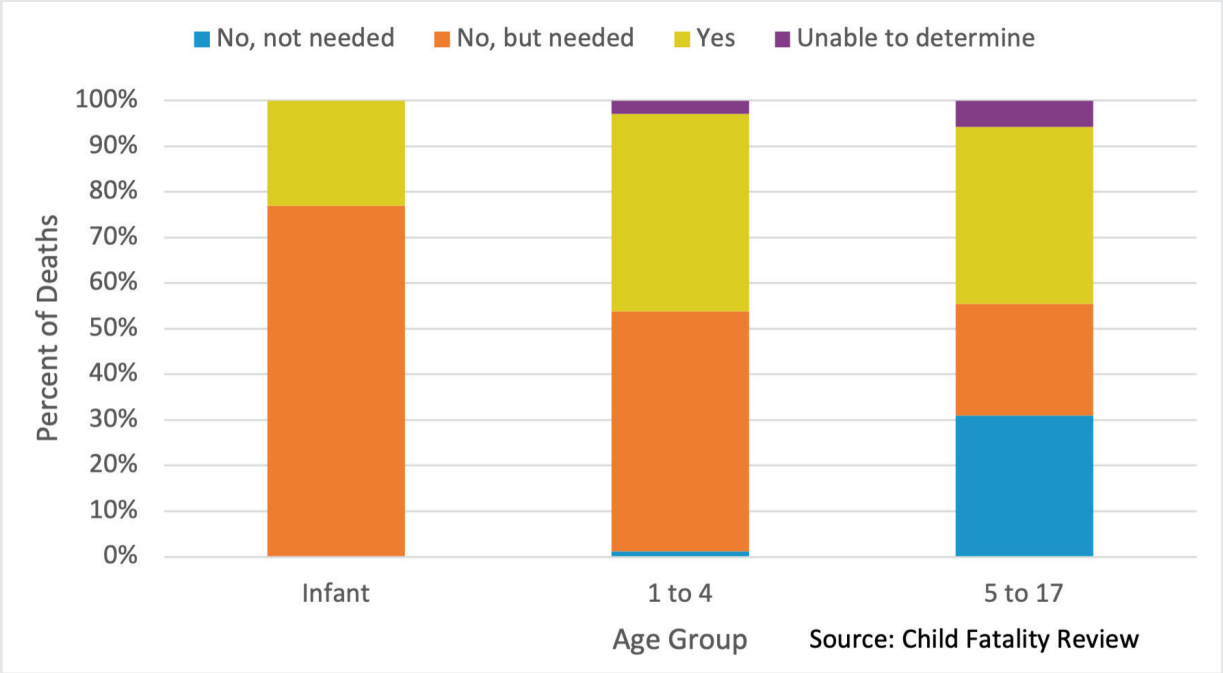


Figure 10. Supervision Status During Drowning Deaths, Age <18, Georgia, 2012-2022



Summary: The common shared risk and protective factors around drowning prevention include:

Risk Factors	Protective Factors
1. Lack of supervision.	1. Proper (consistent, undistracted, sober) supervision.
2. Access to bodies of water - including tubs, buckets, lakes, etc.	2. Swim lessons for all ages.
3. Absence of barriers like fences	3. Secure barriers, consistently utilized.
4. Inadequate swimming skills.	4. Restricted access to water.

The main themes of the child death reviews included: Minimal water safety education, lack of supervision, access to bodies of water, lack of CPR training, and inadequate swimming skills.

Prevention Recommendations

For Individuals

- Always supervise children when in or around any body of water, even when lifeguards are present.
- Learn to swim and ensure children also know how to swim. Understand what to look for in a good swim program.
- Learn CPR.
- Always wear a life jacket and ensure others do as well when on open, natural water sources.
- Designate a "water watcher" and use the buddy system whenever using a pool.
- Avoid alcohol or other substances when in or around bodies of water. Substances can impair judgement, balance, and coordination.
- Take additional precautions for medical conditions and consider the effects of medication. Medication side effects such as dizziness or low blood pressure can increase risk for drowning.

For Communities

- Incorporate water safety into school curricula. It is important for school-age children to understand basic swimming, water safety, and safe rescue skills.
- Ensure barriers such as fences and lockable gates are installed around local or community pools.
- Offer CPR training to community members.
- Support educational drowning prevention campaigns.

For Policy Makers

- Support local and state water safety laws.
- Advocate for water safety laws and policies.

Unintentional Infant and Sleep-Related Deaths

Infant deaths – Non-Medical Causes

In 2022, death certificate files show 17 infants died from non-medical causes of deaths. Sleep-related deaths were not included in this number and are discussed in detail in the following pages.

Table I. Deaths to GA Residents, CY2022, Selected Causes, <1 Year of Age (OASIS)							
Age <1 year	MVC	Falls	Drowning	Poisoning	Suicide	Homicide	Totals
	2	1	3	0	**0**	11	**17**

Summary: The main cause of non-medical death for infants (other than sleep-related deaths) is homicide. See maltreatment section (above) and homicide section (below) for more data and information on prevention.

Sudden Unexpected Infant Death (sleep-related infant death)

There were a total number 209 sleep-related infant deaths by death certificate in Georgia for 2022. This is an increase from previous years and 153 of these deaths were reviewed by local CFR teams.

Figure 11. Sleep-Related Infant Deaths, Georgia, 2012-2022

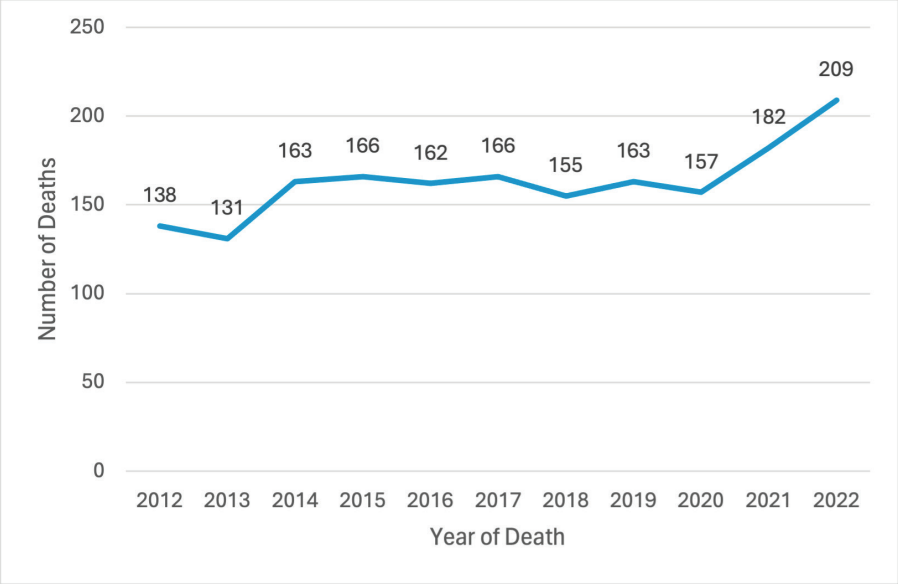
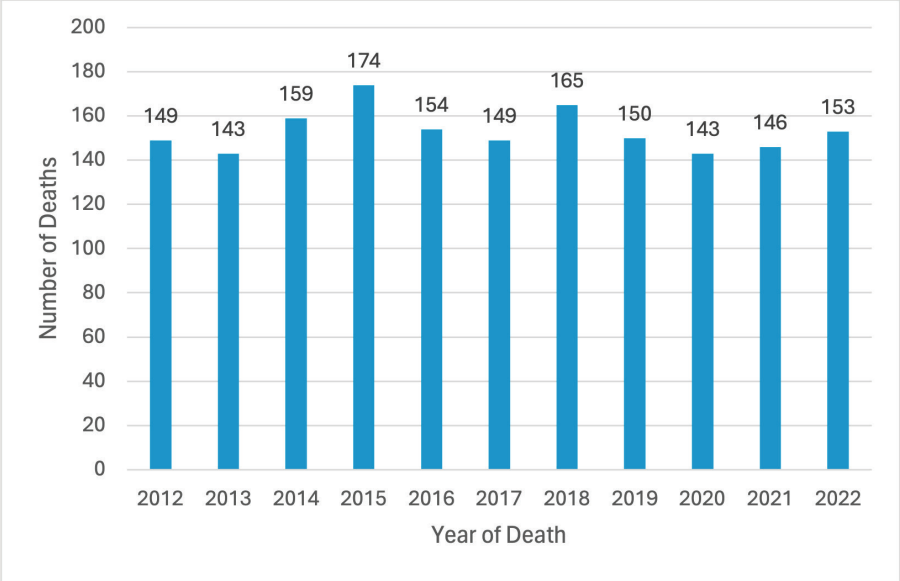


Figure 12. Reviewed, Sleep-Related Infant Deaths, Georgia, 2012-2022



Surface sharing (previously referred to as bed sharing) remains a leading risk factor. In 2022, as well as previous years, the adult bed is the leading location where the infant was found at the time of death. There were 92 (60%) infants found in the adult bed.

Figure 13. Reviewed Sleep-Related Deaths by Place Found, 2022, Georgia

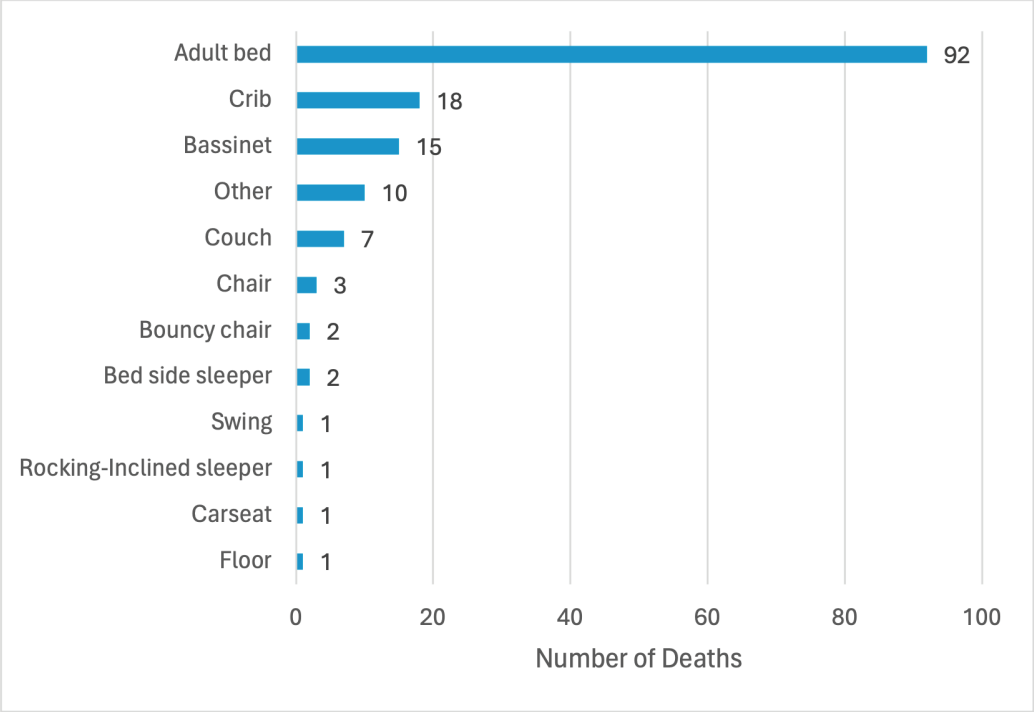
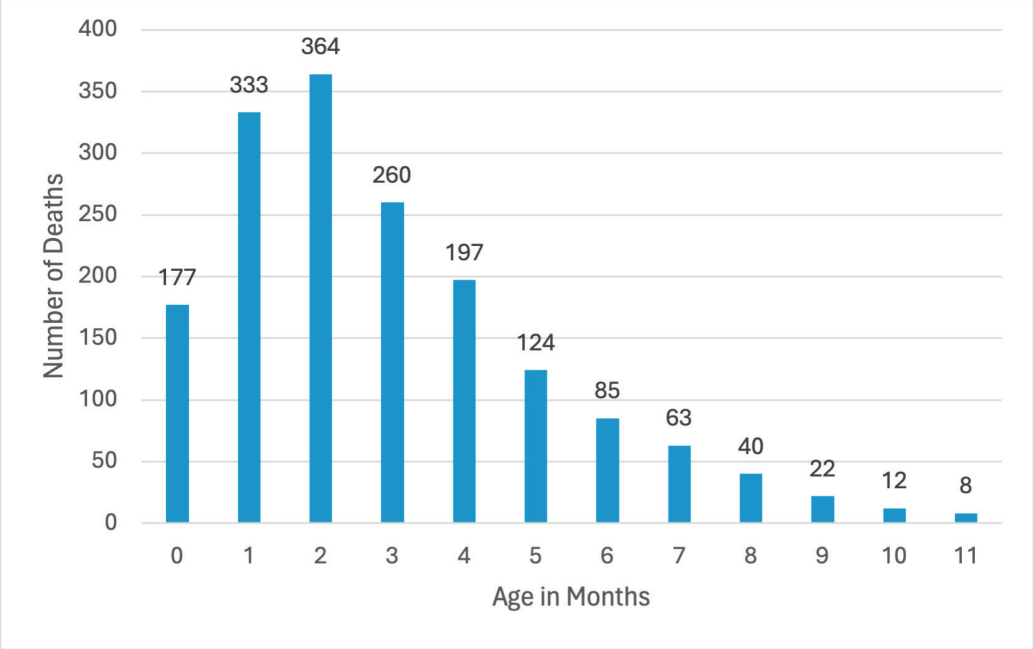


Figure 14. Reviewed Sleep-Related Deaths by Age in Months, 2012-2022. Georgia



The crib was the second highest location, followed by a bassinet. Education is provided to families on the need to place infants on a firm, flat surface free of soft bedding and other items. It was reported that 60 of the decedent infants with a reported crib in the home, still were sleeping in an adult bed or on another soft surface. Infants are reportedly being brought into the bed after or during feeding, so the parent can rest.

Surface sharing involves any surface that is being shared by the infant as well as an adult, child or even pet. 34 reviewed cases had 1 or more children reported as surface/bed sharing with the infant at the time of death. Recent efforts have included stressing the risk of co-sleeping siblings or other children when one of the children is less than 1 year old.

In addition to location, the age of the infant at the time of death is also a risk factor. It was determined that 90-95% of all infant sleep-related deaths occur from birth to 6 months of age with the highest risk occurring between 1 –3 months of age. Infants at this age are at a very vulnerable stage of life. They are rapidly developing, establishing sleeping, and eating patterns, learning to regulate their body temperature, and more. Infants also require to be fed on a regular basis and every couple of hours, which can be exhausting for caregivers.

It is important for caregivers to follow safe sleep guidelines and create a safe sleep environment to reduce the risk of SUID. Regular checkups and communication with healthcare providers can also play a crucial role in infant safety. Other risk factors include maternal tobacco usage or any substance misuse by caregivers of the infant.

Summary: The data from the reviewed cases supports the prevention efforts typically endorsed for prevention of sleep-related infant deaths, most notably, those that involve suffocation and the mechanisms of soft objects, overlay, and entrapment.

Risk Factors	Protective Factors
1. Sleeping Position: Infants placed on their stomachs or sides for sleep are at higher risk.	1. Back Sleeping Position: Placing infants on their backs to sleep is a key protective measure.
2. Sleeping Environment: Soft bedding, loose objects, and overheating in the sleep environment increase the risk.	2. Firm Sleep Surface: Providing a firm and flat sleep surface, free of soft bedding and toys.
3. Maternal Smoking: Exposure to maternal smoking during pregnancy and after birth increases the risk of SUID.	3. Avoiding Smoking: Pregnant women and caregivers should avoid smoking to reduce SUID risk.
4. Premature Birth or Low Birth Weight: Preterm and low birth weight infants may face higher risks.	4. Regular Prenatal Care: Adequate prenatal care can contribute to a healthier pregnancy.
5. Multiple Births: Twins or higher-order multiples may be at increased risk.	5. Breastfeeding: Feeding of Human milk is associated with a reduced risk of SUID.
6. Excessive Bedding or Overheating: Overdressing the infant or keeping the room too warm can be a risk factor.	6. Room Sharing: Having the infant sleep in the same room as the parent (but not the same bed) is protective.
	7. Pacifier Use: Offering a pacifier at naptime and bedtime is considered protective.

For a comprehensive list of the American Academy of Pediatrics recommendations for safe infant sleep, follow this link: https://publications.aap.org/pediatrics/article/150/1/e2022057990/188304/Sleep-Related-Infant-Deaths-Updated-2022?autologincheck=redirected.

The main themes of the child death reviews included: Soft items in the sleep space contributing to suffocation, exhausted parent/fussy infant, suffocation while breastfeeding, and sleeping on the same surface (after parent fell asleep), entrapment between a soft surface and hard surface i.e. mattress and a wall, overlay from a caregiver while surface sharing, young children providing care to infants, families with many stressors such as limited housing; multiple children but no regular childcare, substance or alcohol use, untreated mental health concerns, unstable housing.

Examples of Unsafe Sleep:

- *1 month old infant placed on the couch to sleep with pillows surrounding them. When parent checked on the infant, their face was in the cushion of the couch and child was unresponsive.*
- *Parent left infant in care of an older sibling while the parent went to work. The sibling gave the infant a pacifier and laid infant on their side, on a pillow, on the adult bed. Parent found infant with their face pressed into the pillow, unresponsive.*
- *Parent laid to sleep with infant on their chest. Infant was stated to enjoy physical contact to fall asleep. Parent woke to find infant unresponsive. The infant had slipped sideways off the parent's chest and was entrapped between the mattress and parent.*

Mechanisms related to suffocation in bed:

Prevention Recommendations

For Individuals

- All individuals should attend a safe infant sleep class. Everyone knows or will know someone with an infant (family member, coworker, etc.) and the more individuals who know about safe sleep the more people are available to help support parents with infants.
- Join a Safe Kids coalition to have the opportunity to participate in community awareness events.

For Communities

- Ensure equal access to adequate, safe, and affordable childcare.
- Provide ongoing, easily accessible safe infant sleep education. Combining safe sleep education with relevant information on milestones, typical eating, crying, and sleeping routines of infants, will help parents be prepared for their infant and lessen stress.
- Provide outreach to local OB-GYN offices, pediatricians, daycare providers (licensed and unlicensed) to encourage consistent and accurate education on safe sleep and why it is important.
- Support substance abuse prevention for families (especially when documented issues are present).
- Promote tobacco cessation programs including the GA Quit Line.

For Policy Makers

- Provide economic support for families.
- Improve housing stability initiatives.
- Increase access to mental health and substance abuse treatment (upstream approach).
- Increase access to free parenting and prenatal classes.
- Increase home visiting and doula programs.
- Support Centering Pregnancy and other programs designed to support new parents.

Intentional Cause: Homicide

Infants and older teens age 15 to 17 years are the most at risk of dying by homicide in Georgia. Since 2020, rates of child homicide death have continued to increase, driven primarily by increases in the number of older teens dying by homicide. In 2022, according to death certificate records, 127 children died by homicide while 96 were reviewed by local CFR teams. There was a total of 78 male and 18 female homicides. Of the 47 of the 96 (49%) reviewed homicide deaths, they were Black males ages 15 to 17 years.

Figure 15. Homicide Deaths and Rates, Age <18, Georgia, 2012-2022

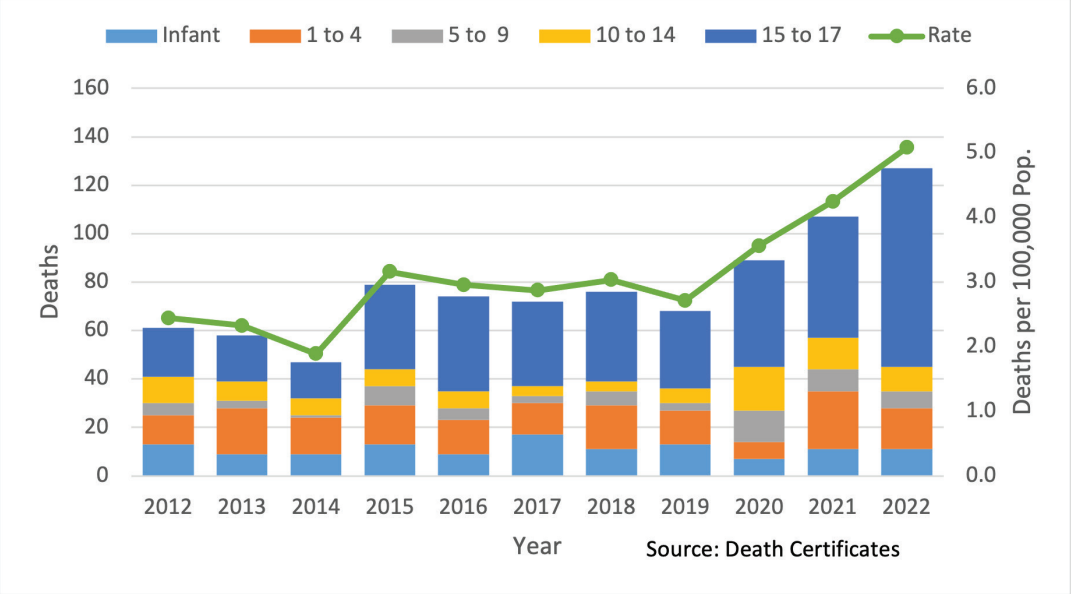


Table J. Reviewed GA Resident Homicide Deaths, Ages 0 – 17, 2022

	Black, non-Hispanic		White, non-Hispanic		Other non-Hispanic		Hispanic		Totals		
Age Group	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	All
Infant	2	2			1	1	1	1	4	4	**8**
1 - 4	6		1	2					7	2	**9**
5 - 9	3	2						1	3	3	**6**
10 - 14	4		2	2					6	2	**8**
15 - 17	**47**	6	3		2		6	1	58	7	**65**
Total	**62**	**10**	**6**	**4**	**3**	**1**	**7**	**3**	**78**	**18**	**96**

The main mechanisms of injury in child homicide deaths differ by age group. Infants and children aged 1-4 years are most likely to die by blunt force trauma (64.2% and 49.7% respectively). The vast majority of homicide deaths in older teens age 15-17 years (93.4%) are committed with firearms. These differences in mechanisms point to distinct situations which tend to lead to a child's death.

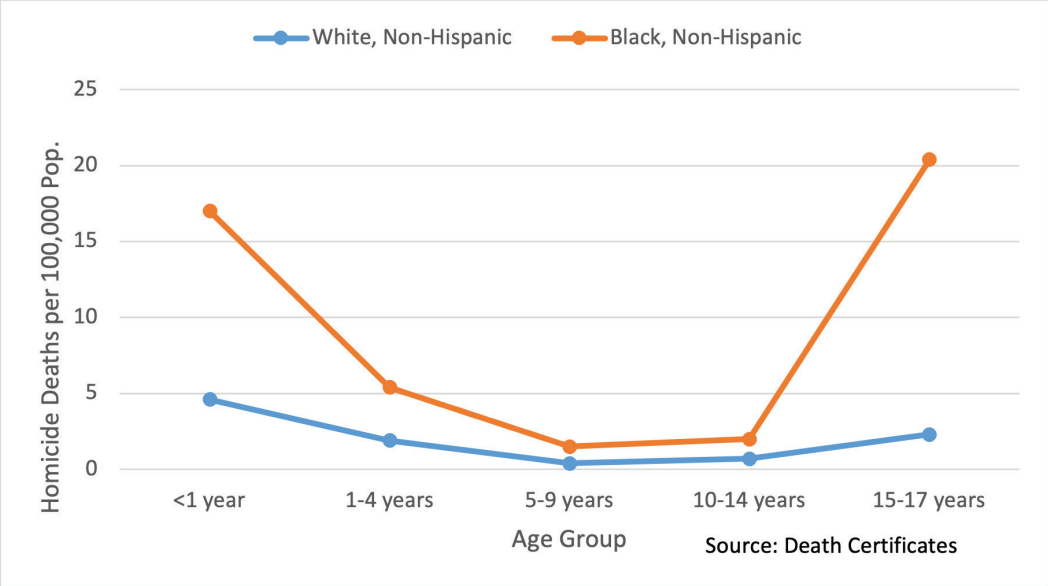
Table K. Homicide Mechanism by Age Group, Georgia, 2012-2022, Death Certificate

	Decedent Age (Years)					
Mechanism	**Infant**	**1 - 4**	**5 - 9**	**10 - 14**	**15 - 17**	**Total**
Firearm	5	31	38	74	**381**	**529**
Blunt Force Trauma	**79**	**84**	13	7	6	**189**
Poison	13	11	0	0	0	**24**
Knife	2	7	6	9	15	**39**
Strangulation	5	12	2	2	3	**24**
Malt	4	8	0	1	1	**14**
Drowning	3	3	1	1	1	**9**
All Other	4	8	2	1	0	**15**
Unspecified	8	5	1	0	1	**15**
Total	**123**	**169**	**63**	**95**	**408**	**858**

In 2022, 64 of the 65 reviewed homicide deaths for 5–17-year-olds involved firearms. Eight of the 17, infant to 4-year-old homicide deaths were due to blunt force trauma. Non-Hispanic Black and African American youth die by homicide at disproportionate rates compared to white, non-Hispanic youth. Among all children under the age of 18, there are 6.6 homicides per 100,000 population in black youth, 4.7 times the rate of death by homicide in white, non-Hispanic youth (1.4 per 100,000).

This disparity is greatest in black infants and older teens. Black infants under the age of one die by homicide at 3.7x the rate of White infants. (17 per 100,000 vs 4.6 per 100,000). There are 20.4 homicide deaths among Black teens age 15-17, 8.9 times the rate at which White teens die (2.3 per 100,000).

Figure 16. Homicide Death Rates by Age Group, Age <18, Georgia, 2012-2022



Summary: Youth homicide (a part of youth violence) and suicide often share many shared risk and protective factors.

Risk Factors	Protective Factors
1. Poverty: Growing up in economically disadvantaged neighborhoods can be associated with higher rates of youth violence.	1. Strong Family Support: Positive and supportive family relationships can act as a protective buffer.
2. Gang Involvement: Youth involved in gangs may be at an increased risk of involvement in violent activities.	2. Community Resources: Access to community programs and resources that provide positive alternatives for youth.
3. Access to Firearms: Easy access to firearms increases the risk of lethal violence among youth.	3. Effective Law Enforcement: Enforcing laws and regulations aimed at reducing access to firearms and curbing criminal activities.
4. Drug and Alcohol Use: Substance abuse, particularly involving drugs and alcohol, can contribute to violent behavior.	4. Mental Health Support: Adequate mental health support and intervention can address underlying issues contributing to violence.
5. Family Violence: Exposure to domestic violence or child abuse within the family can be a risk factor.	5. Youth Engagement: Engaging youth in positive activities, such as sports or arts, can divert their focus from violence.
6. School Environment: High levels of violence or bullying at school may contribute to youth violence.	6. Access to Education: Educational opportunities and positive school environments can contribute to a lower risk of violence.
7. Connection: Lack of connection to peers or caring adult supports.	7. Positive Peer Relationships: Positive relationships with peers who do not engage in violent behavior.

Addressing both risk and protective factors through a combination of community, family, and individual interventions is crucial for preventing youth homicide and promoting the well-being of young individuals. For a more comprehensive explanation of these factors, follow this link: https://vetoviolence.cdc.gov/apps/main/home

The main themes of the child death reviews included: Conflict between individuals, gang involvement and rivalry, drive-by shootings, illicit drugs, lack of parental supervision, improper gun storage, lack of gun safety awareness, speculation of suicidal ideations from close friends and family, and social media and cyberbullying.

Prevention Recommendations

For Individuals

- Learn about Adverse Childhood Experiences (ACEs) and how to help prevent them.
- Find Parenting classes with anger management. Learn about conflict resolution and bullying prevention.
- Learn about cyber bullying and things to watch for young people.

For Communities

- Incorporate street outreach programs to reduce community violence through conflict resolution and gun safety education.
- Increase educational programs on gang and violence prevention awareness that cover conflict resolution and problem-solving skills, financial literacy, and healthy relationships by way of parenting classes and in-school curriculum.
- Address social determinants of health such as economic stability and food security.
- Support a multi-sectoral collaboration and coordination between government agencies, the private sector, non-profit organizations, and community groups that incorporates restorative practices, increases community members' sense of belonging through community programming, and creates a holistic approach to violence prevention.
- Increase community-based out-of-school youth development programming which could include job skills and compensation for their time.
- Improve protocols by providing interpersonal violence screenings wherever possible, therapeutic services, and other follow-up measures for witnesses of community or interpersonal violence.

For Policy Makers

- Utilize the public health approach to preventing firearm injuries.
- Provide economic support for families.
- Require conflict resolution classes, gun safety classes, and lock boxes for gun purchases.
- Improve CPS follow-up procedures when referrals are made (lack of supervision, lack of school attendance).
- Increase communication between DFCS and schools.
- Improve housing stability initiatives.
- Increase access to mental health and substance abuse treatment (upstream approach).

Intentional Cause: Youth Suicide

It was found in death certificate data that 62 Georgia youth were listed as dying by suicide on death certificates in 2022. Of those 62 deaths, 49 were reviewed, but a team determined that one DC suicide was a homicide.

The reviews provide information on the risk factors associated with the individual deaths. The most common mechanism of youth death by suicide was firearm, followed by hanging. Of the reviewed cases, 25 youth (52%) died by firearm, and 17 youth (35%) died by hanging.

Table L. Reviewed 2022 Suicides, GA, Ages < 18

Race/Ethnicity		Male	Female	Total
Non-Hispanic	White	19	6	**25**
	Black	6	7	**13**
	Other	3		**3**
Hispanic		4	3	**7**
All Race/Ethnicity		32	16	**48**

		Age Category		
	Mechanism	10 to 14	15 to 17	Total
	Firearm	6	19	25
	Hanging	5	12	17
	Poison	2	2	4
	Drowning		1	1
	Motor Vehicle		1	1
	Total	**13**	**35**	**48**

White males die by suicide at a higher rate than other races and ethnicities. The rate of death is 8.6 per 100,000. Black males have the second highest rate of death at 4.9 per 100,000. Combined White males and White females still have the highest rates of death due to suicide at 6.1 per 100,000 compared to 3.6 for Black youth and 3.3 for Hispanic youth.

Prior to 2015 (2012 – 2014), teen (ages < 18) suicides averaged 34 per year. The number of suicides increased in 2015 and has averaged 62 per year over the following eight years (2015 – 2022). The suicide rates are higher among males and in the White, non-Hispanic population.

Table M. Suicide Rates, 2012 - 2022, Ages 1 to 17, OASIS				
		Deaths per 100,000 Population		
		Total	Male	Female
Non-Hispanic	Black	3.6	4.9	2.3
	White	6.1	8.6	3.4
Hispanic	All Races	3.3	4.2	2.4

In the 2022 reviewed cases, 6 youth reported being bullied, with 1 of the 6 specifying cyber bullying. 12 youth had a history of self-harm and 5 were known to have talked about suicide prior to their deaths. These are risk factors for youth suicide, and individuals and communities can learn to recognize the signs as well as what to do if they recognize signs in a young person.

When children and youth are bullied, this behavior can increase the risk of suicidal thoughts. Bullying does not always increase suicidality but, for those already at risk, it is a large concern. Bullying in schools has remained an issue that youth face, however the use of social media and cell phones has exacerbated bullying.

Summary: It is important to note that suicide risk is complex and often involves a combination of factors. Early intervention, destigmatizing mental health, and fostering supportive environments are critical components of suicide prevention efforts for youth. The shared risk and protective factors for youth suicide are listed below:

Risk Factors	Protective Factors
1. Mental Health Disorders: Conditions like depression, anxiety, and bipolar disorder increase the risk of suicide.	1. Mental Health Treatment: Access to mental health services and effective treatment for underlying disorders.
2. Previous Suicide Attempts: Individuals with a history of suicide attempts are at a higher risk.	2. Strong Support System: Positive relationships with family, friends, and community provide crucial support.
3. Family History of Suicide: A family history of suicide or mental health disorders can contribute to risk.	3. Connectedness: Feeling connected to school and community can be protective.
4. Bullying: Persistent bullying, both in person and online, can elevate the risk of suicide.	4. Effective Coping Skills: Teaching and developing healthy coping mechanisms and problem-solving skills.
5. Substance Abuse: Drug and alcohol abuse can impair judgment and increase vulnerability.	5. Crisis Intervention: Effective crisis intervention and follow-up care after a suicide attempt.
6. Access to Lethal Means: Easy access to firearms or other lethal objects.	6. Access to Supportive Resources: Encouraging access to helplines, support groups, and mental health resources.
7. Isolation: Social isolation and lack of supportive relationships can contribute to vulnerability.	7. Youth Engagement: Engaging youth in positive activities, such as sports or arts, can focus attention on positive experiences.

The main themes of the child death reviews included:

Bullying, sexual assault prior to suicide attempt, mental health – untreated, depression, anxiety, relocation from another country, family members who have previously attempted or committed suicide, missed a significant amount of school or no longer in school, medical conditions, and sexually transmitted infections (STIs)

Prevention Recommendations

For Individuals

- Understand the common warning signs and symptoms of suicide and how they may manifest in youth versus adults.
- Utilize lethal means safety techniques such as:
  - Safe storage
  - Lock boxes
  - Safe public storage at gun ranges or at police departments
  - Gun locks
- Dispose of unused medication using Deterra Drug Deactivation and Disposal System.
- Receive education on mental health.
  - NAMI youth focused mental health classes
  - Mental Health First Aid for youth
- Challenge stigma/stereotypes.
- Attend two-generational mental health awareness forums.
- Provide a supportive environment utilizing:
  - Safe spaces
  - Safety plans
  - Non-judgmental listening

For Communities

- Promote mental health awareness at common meeting places such as schools, gyms, or malls.
- Provide access to consistent, affordable in-person and online mental health treatment targeting youth.
- Provide inclusive and culturally competent mental health treatment.
- Increase access to safe recreational areas such as public parks, trails, basketball courts or swimming pools.
- Strengthen mental health programs by utilizing a comprehensive approach to suicide prevention.
- Promote mental health and suicide prevention in refugee resettlement programs.
- Provide mental health education in ESOL classes.
- Offer mental health services to youth receiving STI/STD treatment.

For Policy Makers

- Allocate more funding and resources for mental health services, crisis intervention and support services, and culturally informed research for youth suicide prevention.
  - Promote GCAL and other suicide crisis hotline numbers and resources.
  - Key topics for research may include understanding of suicide, recognition of suicide risk, causes of suicide, suicide prevention interventions, postvention efforts, stigma surrounding suicide and mental health, and lethal means prevention and access restriction.
- Support a multi-sectoral collaboration and coordination between government. Agencies, private sector, non-profit organizations, and community groups to create a holistic approach to suicide prevention.
- Encourage testing and spread of innovative delivery models, including digital innovations, that expand access. For example, expand telehealth services for mental health care to reach a wider pool of populations.
- Promote prioritization of accessible, evidence-based suicide prevention efforts in a wide range of settings, including specialty behavioral health care, primary care, justice/corrections, and education.
- Address disparities in suicide risk by expanding access to mental health services and suicide screening for youth within the school, child welfare and justice systems.
- Implement age restrictions for social media consumption.
- Increase safe message campaigns surrounding suicide prevention.

General:

- Expand additional peer norm and gatekeeper programs for youth.
- Increase educational programs on suicide prevention awareness that cover common risk factors, protective factors, warning signs, intervention strategies.
- Provide community open forums and workshops to discuss topics on mental illnesses prevention, common barriers to mental health and suicide prevention, especially on cultural stigma.

Unintentional Cause: Poisoning

There were 20 deaths due to poisoning in 2022 according to the Death Certificate data. Of those 20 deaths, 19 of them occurred in the age of 15-17 years.

Of the reviewed cases, deaths due to poisoning were more prevalent in White non-Hispanics. Over half of the deaths due to poisoning were attributed to toxic effects of fentanyl. According to the Centers for Disease Control, Fentanyl and other synthetic opioids are the most common drugs involved in overdose deaths. Even in small doses, it can be deadly. Over 150 people die every day from overdoses related to synthetic opioids like fentanyl. Death Certificate data shows that from 2019-2022 deaths due to poisonings has significantly increased in Georgia.

Summary: Preventing child deaths due to poisoning involves creating a safe environment, securing toxic substances, educating caregivers, and promoting awareness of potential hazards. The shared risk and protective factors listed below are specific to preventing accidental overdose due to high number of youth poisoning related to drug misuse.

Risk Factors	Protective Factors
1. Substance Abuse: Individuals with a history of substance abuse are at a higher risk of accidental overdose.	1. Treatment for Substance Abuse: Access to treatment programs for individuals struggling with substance abuse.
2. Polypharmacy: Taking multiple medications simultaneously, especially without proper medical supervision.	2. Medical Supervision: Proper medical supervision and regular check-ins with healthcare providers for medication management.
3. Prescription Medication Misuse: Using prescription medications in ways other than prescribed, such as taking higher doses or combining them with other substances.	3. Monitoring and Support: Having a support system that monitors and aids in managing medications.
4. Lack of Awareness: Not being aware of the potential risks and interactions of medications or substances being used.	4. Education: Understanding the proper use of medications, including dosage and potential interactions.
5. Previous Overdose: Individuals who have previously experienced an overdose may be at increased risk of a recurrence.	5. Safe Storage: Keeping medications securely stored and away from unauthorized access.
6. Mental Health Issues: Co-occurring mental health disorders can contribute to a higher risk of accidental overdose.	6. Naloxone Availability: Having access to naloxone, an opioid overdose reversal medication, in case of accidental opioid overdose.
	7. Mental Health Treatment: Adequate treatment and support for underlying mental health issues.
	8. Awareness of Risky Behaviors: Being aware of the risks associated with combining substances and engaging in preventive behaviors.

The main themes of the child death reviews included: The rates of unintentional poisoning exposures and deaths are increasing primarily because of drug misuse and abuse.

Prevention Recommendations

For Individuals

- Keep medicines and toxic products, such as cleaning solutions, in locked or childproof cabinets.
- Put the nationwide poison control center phone number, 1-800-222- 1222, on or near every telephone in your home, or post in a prominent place.
- Follow label directions and read all warnings on products.

For Communities

- Educate the public about poisonings, including how to prevent them as well as what to do if one occurs.
- Education for health providers, including first responders the dangers of about poisoning.
- Training of health professionals with expertise in toxicology.
- Implementation of clinical standards and protocols for responding to individuals who are poisoned.
- Join CDC drug free community coalitions to prevent youth substance use.
- Participate in Drug Take-Back Days.

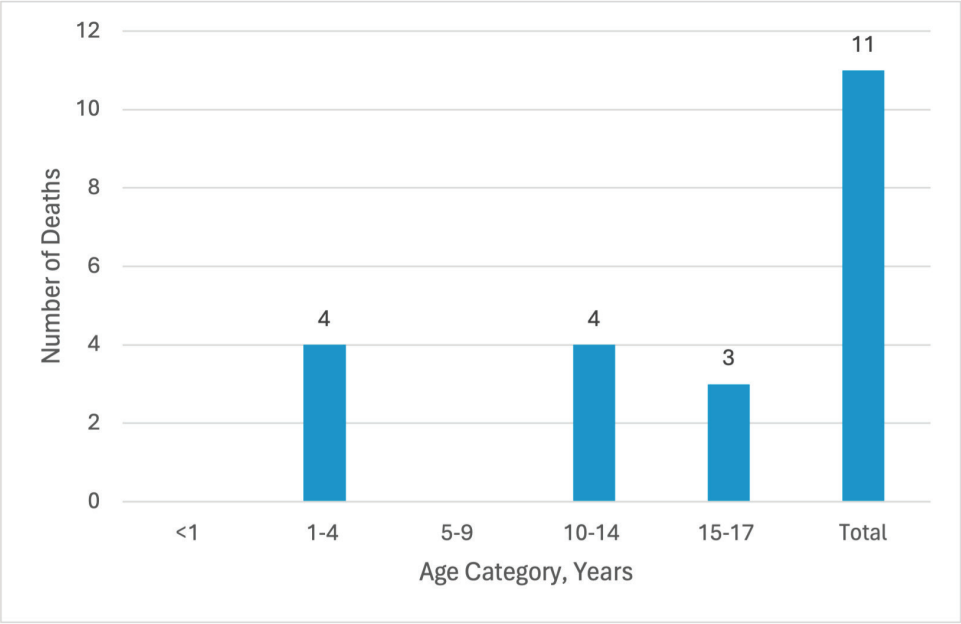
For Policy Makers

- Increase access to lifesaving naloxone products
- Advocate for safe storage of medications and other medical equipment.
- Learn more prevention strategies from the CDC

Unintentional Cause: Fire

Of the reviewed child deaths in 2022, there were 11 deaths caused by fire and smoke exposure. Children ages 1-4 and 10-14 years had 4 deaths due to fire and smoke exposure. 3 fire deaths were of youth aged 1-17 years.

Figure 17. Reviewed Fire-Related Deaths, Ages <18, Georgia, 2022



In 2022, the were 290 emergency room visits of Georgia youth, ages 0-17 years of age due to fire and smoke exposure. Children under the age 4 accounted for 108 and 134 youths between the ages of 5 and 14 years of age accounted for emergency room visits. There was a total of 48 emergency room visits for youth ages 15-17 years of age.

Summary: The increasing severity of home fires due to modern building contents and open space configurations makes it crucial that caregivers and youth understand the dangers of fire and importance of fire safety. The National Fire Protection Association (NFPA) estimates that in the United States one home fire-related injury occurs every 53 minutes and one home fire-related death occurs every 3 hours and 14 minutes. According to the U.S. Fire Administration, children ages 0-4 have a higher relative risk of dying in a fire compared to older children.

The shared risk and protective factors for fire injury and death are listed below. These factors play a crucial role in preventing child fire deaths and promoting a safe living environment.

Risk Factors	Protective Factors
1. Unsupervised Access to Fire Sources: Children with easy access to matches, lighters, or other fire-starting materials.	1. Supervision: Close supervision reduces the likelihood of children engaging in unsafe behaviors related to fire.
2. Lack of Fire Safety Education: Insufficient knowledge about fire safety measures and the dangers of playing with fire.	2. Fire Safety Education: Teaching children about the dangers of fire and how to respond appropriately in case of a fire.
3. Absent Smoke Alarms: Homes without working smoke alarms increase the risk of delayed response to a fire emergency.	3. Working Smoke Alarms: Installing and maintaining functional smoke alarms throughout the home.
4. Poorly Stored Flammable Materials: Keeping flammable items within reach of children, increasing the risk of accidental fires.	4. Secure Storage: Storing matches, lighters, and other fire-related items securely out of children's reach.
5. Inadequate Escape Plans: Lack of a well-practiced fire escape plan in case of emergencies.	5. Emergency Preparedness: Having a well-thought-out fire escape plan and practicing it regularly with the family.
	6. Parental/Adult Awareness: Being aware of and addressing potential fire hazards in the home environment.

The main themes of the child death reviews included: Lack of or minimal fire safety education, lack of or minimal supervision, and lack of fire safety equipment such as smoke detectors and/or sprinkler systems.

Fire Safety Education: Reviewed deaths included household electrical space heaters were placed near flammable objects (clothing, paper products, etc.).

Lack of Supervision: Reviewed deaths included child(ren) who were unsupervised and had access to matches and/or lighters.

Lack of Fire Safety Equipment: Reviewed deaths included caregiver(s) and child(ren) who were in homes without operable smoke detectors or sprinkler systems. Lack of fire safety equipment contributed to the delayed evacuation time.

Marietta Fire Department, School Fire & Safety Education - Marietta, GA

Prevention Recommendations

For Individuals

Fire Safety Education:

- Create a fire safety plan and practice twice a year. Ensure each household member knows two ways to escape each room. Determine a family meeting spot outdoors. Emphasize “get out, stay out”. Do not re-enter a home or building that is on fire, even if other family members, pets or possessions remain inside.
  - Fire Safety Plan Template
  - Establish a family emergency communications plan and ensure that all household members know who to contact in case of a fire emergency.
- Understand safeguards in home against fires including home heating sources that are clean and in good order, have electrical wiring inspected yearly, and keep stove area clean.
- Educate children on STOP, DROP and ROLL method if clothes should catch on fire.
- Educate children on the importance of fire safety.

Supervision and Proper Storage of Fire Hazards:

- Closely supervise children and educate them on the hazards of matches, lighters, and fire. Keep fire hazards out of reach of children (lighters, matches, lighter fluid, or other flammable materials). Ensure understanding that these tools should only be used by adults to start controlled fires.

Install Fire Safety Equipment:

- Install smoke detectors on each level of the home, inside bedrooms and outdoor sleeping areas. Test smoke detectors once a month and replace batteries once a year.

For Communities

- Promote and participate in a Community Risk Reduction Program.
- Support fire departments participating in community or school events to educate children and caregivers on fire safety practices and prevention measures.

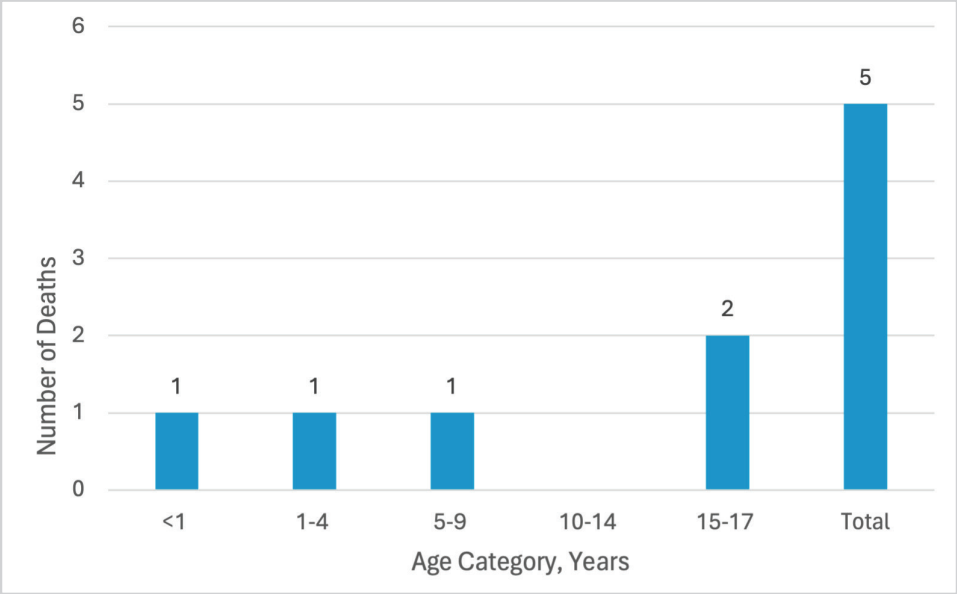
For Policy Makers

- Support programs that provide fire safety educational resources to parents and children.
- Support laws and policies that require regular fire drills, evacuation plans, fire extinguishers, and sprinklers systems in community spaces.

Unintentional Cause: Fall

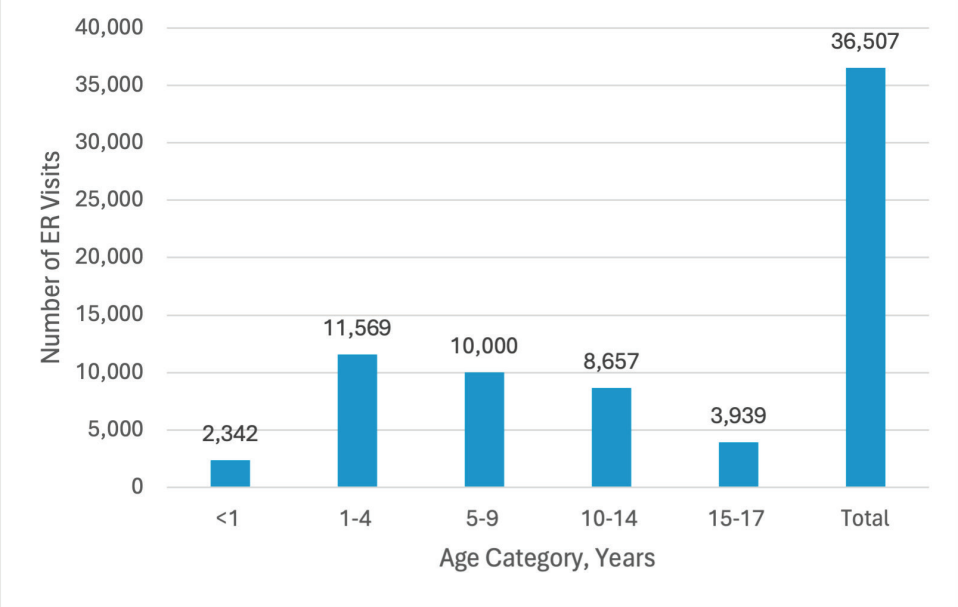
Of the reviewed deaths in Georgia, in 2022 there were a total of 5 injury deaths caused by a fall or crush. There were 2 deaths caused by a fall in children under the age of 4 years. There were 2 injury deaths due to a fall/crush for youth ages 15-17 years of age.

Figure 18. Reviewed Fall/Crush Deaths, Ages <18, Georgia, 2022



Falls are a leading cause of injury-related ER visits and hospitalizations in Georgia, as well as the leading cause of traumatic brain injury in the state.

Figure 19. Fall-Related ER Visits, <18, Georgia, 2022 (OASIS)



In Georgia, in 2022 there were a total of 36,508 emergency room visits caused by a fall among youth under the age of 17 years of age. 13,911 emergency room visits were for children under the age of 4 years. 10,000 emergency room visits were children between the ages of 5 and 9 years. Youth between the ages of 10-17 years of age visited the emergency room 12,596 times due to a fall.

Summary: A fall is defined as an event which results in a person coming to rest inadvertently on the ground or floor or other lower level. Falls have their greatest impact on children aged 0–4 years old. According to the CDC, unintentional injuries including those caused by a fall continue to be the leading cause of death among children in the United States. In Georgia, unintentional falls were listed in the top 10 causes of unintentional injury death among children and youth ages 1-24.

Falls are the most common cause of injury visits to the emergency room for young children, resulting in more open wounds, fractures, and brain injuries than any other cause.

The shared risk and protective factors for fall and death are listed below. These factors play a crucial role in preventing child fall and promoting a safe living environment.

Risk Factors	Protective Factors
1. Presence of external hazards (Stairs, open windows, playground equipment)	1. Install safety gates on stairs and window guards
2. Child inability to assess risk (lack of motor skills and coordination)	2. Provide a soft-landing surface below playground equipment
3. Social and demographic factors (age, gender, socioeconomic status)	3. Use proper safety equipment when playing or participating in sports (knee pads, elbow pads, helmets, etc.)
	4. Close supervision of children near fall hazards (playgrounds, outdoors, near stairs/windows)
	5. Removing fall hazards when possible (rugs, toys, etc.)

The main themes of the child death reviews included:

Minimal Supervision: Reviewed deaths included unintentional fall injury and death due to minimal supervision of child. Child(ren) left residence and an unintentional fall occurred outside residence.

Lack of Safety Equipment: Reviewed deaths included unintentional fall injury and death due to lack of safety equipment. Child(ren) left residence to play in areas without safety equipment present.

Worksite Accident: Reviewed deaths were of unintentional falls/crushes of youth working at industrial work sites.

Prevention Recommendations

For Individuals

- Supervision: Always closely supervise young children when at playgrounds or participating in outdoor activities. A serious fall can happen in a matter of seconds. As a rule of thumb, if environmental hazards increase, supervision should also increase; environmental hazards may include outdoor play, play near stairs or windows, or participating in sports.
- Protective Equipment: Use resources provided by Safe Kids Worldwide to ensure fall prevention measures are implemented in the home and outdoors.
  - Install window guards and safety gates around stairs.
  - Ensure all furniture a child may climb on is sturdy and heavy or mounted to the wall.
  - Always wear a helmet and other protective gear (elbow pads, knee pads, wrist guards) when playing a sport or riding a bike.
  - Play at parks with soft-landing spaces.

For Communities

- Educate youth and caregivers on the importance of wearing a helmet to prevent a Traumatic Brain Injury (TBI); especially when riding a bike, skateboard, roller blades or scooter as well as other motorized vehicles (ATVs, dirt bikes, hoover boards, snowmobile, electric scooter, etc.).
- Educate parents or caregivers on how to prevent falls for young children and youth. Fall prevention strategies, resources, and programs can apply to all ages.
- Use the CDC Heads Up Campaign as a guide for educating youth, caregivers, sports coaches, and academic teachers.

For Policy Makers

- Support programs that provide educational resources to parents and children.
- Support Return to Play and other concussion policies.
- Support safe working environment policies and laws regarding age.

Conclusion and Policy Recommendations

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 requires 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 implementing 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:

Georgia Bureau of Investigation Child Fatality Review

Unit 3121 Panthersville Rd Decatur, GA 30034

Phone: (404) 270-8715

ChildFatalityReview@gbi.ga.gov

Resources

Georgia Department of Public Health Injury Prevention Strategic Plan
https://dph.georgia.gov/document/document/2016-2018-georgia-injury-prevention-strategic-plan/download

Georgia Office of Vital Records
https://dph.georgia.gov/VitalRecords

March of Dimes
https://www.marchofdimes.org/

Healthy Mothers Healthy Babies
https://www.hmhbga.org/

Children 1st
https://www.p2pga.org/roadmap/diagnosis/children-at-risk/the-mission-of-children-1st/?gclid=EAIaIQobChMI4L-v31c2VgwMVngAGAB2TtwlrEAAYASAAEgLoj_D_BwE

Georgia Department of Public Health-Babies Can't Wait
https://dph.georgia.gov/babies-cant-wait

Planning for Healthy Babies (P4HB)
https://medicaid.georgia.gov/programs/all-programs/planning-healthy-babies

Georgia Department of Public Health Children Medical Services
https://dph.georgia.gov/CMS

1st Care
https://www.sehdph.org/services/perinatal-case-management/1st-care/

Georgia Childcare and Parent Services (CAPS)
https://caps.decal.ga.gov/en/

Prevent Child Abuse Georgia
https://preventchildabuse.org/chapters/georgia/

Georgia Family Connections Partnership
https://gafcp.org/

Resilient Georgia
https://www.resilientga.org/

VOICES for Georgia Children
https://georgiavoices.org/

American Academy of Pediatrics-Safe Infant Sleep
https://publications.aap.org/pediatrics/article/150/1/e2022057990/188304/Sleep-Related-Infant-Deaths-Updated-2022?autologincheck=redirected

Georgia Governor's Office of Highway Safety- Georgia Traffic Safety Fact Sheet
https://www.gahighwaysafety.org/georgia-traffic-safety-facts/

Georgia Governor's Office of Highway Safety- Child Safety Seat Fitting
https://www.gahighwaysafety.org/child-safety-seat-fitting-locations/

Safe Kids Georgia- Car Seat Safety Guide
https://safekidsgeorgia.org/carseats/

Youth Drivers Georgia Traffic Safety Fact Sheet
National Highway Traffic Safety Administration
https://www.nhtsa.gov/

YMCA- Water Safety and Swimming
https://www.ymca.org/what-we-do/healthy-living/water-safety

Safe Kids Georgia
https://www.safekids.org/coalition/safe-kids-georgia

Georgia Department of Public Health- Ready to Quit
https://dph.georgia.gov/readytoquit

Georgia ACEs Connection Community- Adverse Childhood Experiences
https://abuse.publichealth.gsu.edu/adverse-childhood-experiences/

Georgia Department of Education- Bullying Prevention
https://www.gadoe.org/wholechild/Pages/Bullying-Prevention.aspx

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

Prevent Suicide Georgia
https://preventsuicidega.org/

Georgia Department of Education- Suicide Prevention
https://www.gadoe.org/wholechild/Pages/Suicide-Prevention.aspx

Project Child Safe- Firearm Safety and Education
https://projectchildsafe.org/

National Alliance on Mental Illness (NAMI)
https://www.nami.org/home?gad_source=1&gclid=EAIaIQobChMIz6ui4dSVgwMV259aBR02eAMsEAAYASAAEgK_P_D_BwE

National Council for Mental Wellbeing
https://www.mentalhealthfirstaid.org/take-a-course/find-a-course/

Mental Health First Aid (MHFA)
https://www.augusta.edu/ahec/mental-health-first-aid.php

Georgia Crisis and Access Line (GCAL) 1-800-715-4225 Available 24 hours a day/7 days a week
https://www.georgiacollaborative.com/providers/georgia-crisis-and-access-line-gcal/

National Prescription Drug Take Back Day
https://www.deadiversion.usdoj.gov/drug_disposal/takeback/

United States Drug Enforcement Administration- Take Back Day
https://www.dea.gov/takebackday

Office of Commissioner of Insurance- Fire Safety
https://oci.georgia.gov/safety-fire-reporting-education/fire-safety-tips

CDC Injury Center- Heads Up Program
https://www.cdc.gov/headsup/index.html

Attachments

Table A. Counties with 2022 Reviewable Deaths Not Reviewed

Counties (26) with No Reviewable Death Reviewed

County	Count	County	Count
Appling	2	Hart	1
Baker	1	Johnson	1
Banks	1	Liberty	6
Ben Hill	4	Long	1
Bryan	7	McIntosh	2
Camden	5	Peach	3
Catoosa	1	Rabun	1
Chatham	23	Stephens	2
Chattooga	2	Stewart	1
Clarke	1	Tattnall	3
Dooly	1	Tift	3
Grady	2	Walker	4
Habersham	2	Wayne	2

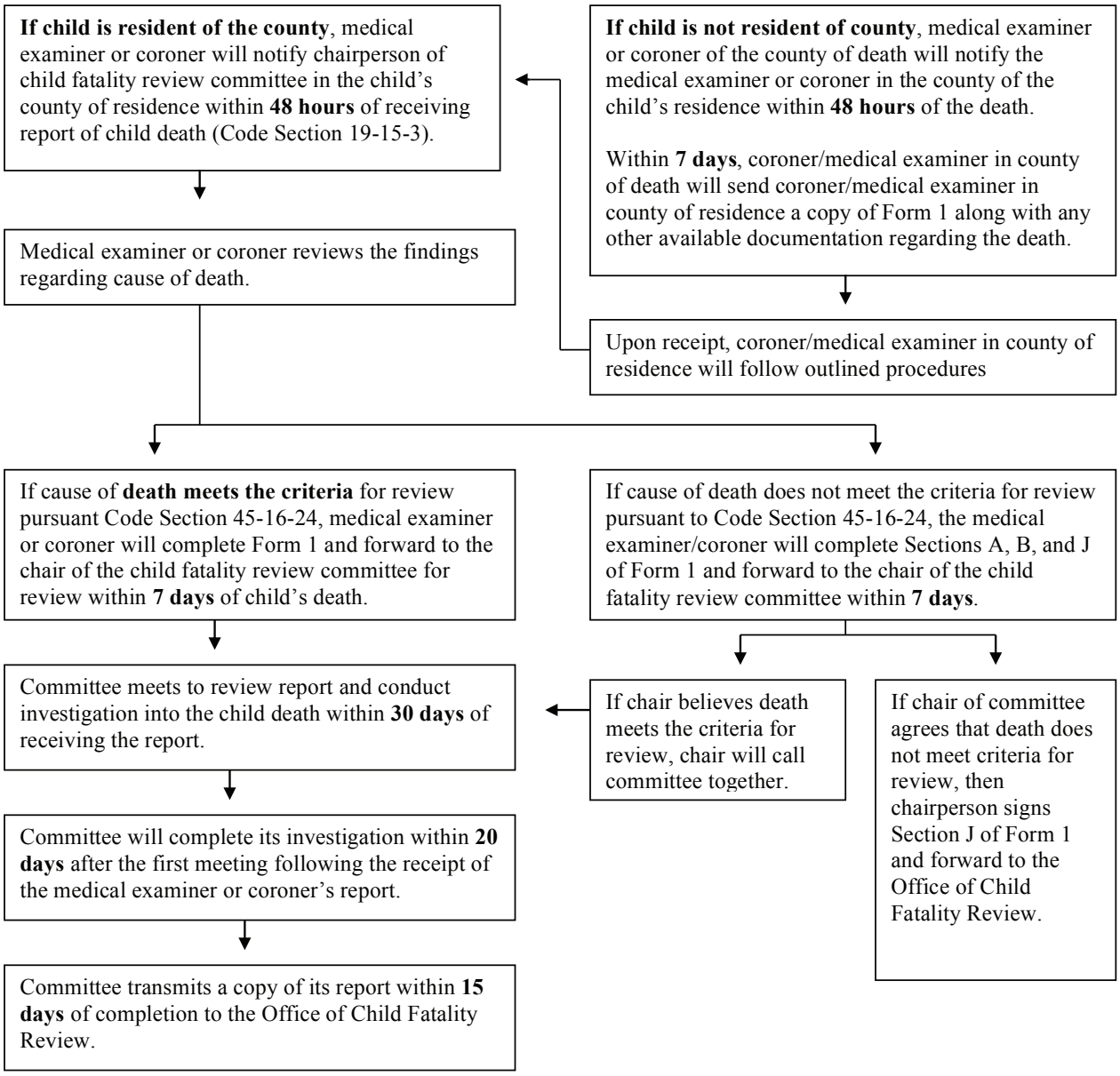
Counties (25) with Some Reviewable Death Reviewed

County	Review Status		County	Review Status	
	No	Yes		No	Yes
Irwin	1	1	Spalding	2	3
Jeff Davis	1	1	Newton	2	5
Haralson	1	2	Dougherty	2	10
Rockdale	1	2	Clayton	2	18
Heard	1	4	Richmond	2	25
Whitfield	1	4	Coweta	3	3
Bartow	1	5	Cobb	3	22
Douglas	1	5	Henry	4	13
Glynn	1	6	Gwinnett	4	36
Jackson	1	7	Columbia	6	2
Bibb	1	21	DeKalb	17	42
Muscogee	1	22	Fulton	38	20
Floyd	2	1			

Table B. Child Fatality Review Team Determination of Preventability: 2022 Reviewed Deaths				
	Could the death have been prevented?			
Cause of Death	No, probably not	Yes, probably	Undetermined	% Preventable
Unintentional				
Motor Vehicle Crash	4	82		95.3
Drowning	2	24		92.3
Other Unintentional	4	62	7	93.9
Intentional				
Homicide	7	86	3	92.5
Suicide	11	31	6	73.8
Sleep-Related	16	119	18	88.1
Medical	39	16	17	29.1
Undetermined	1	4		
Total	**84**	**424**	**51**	**83.5**

Appendix A

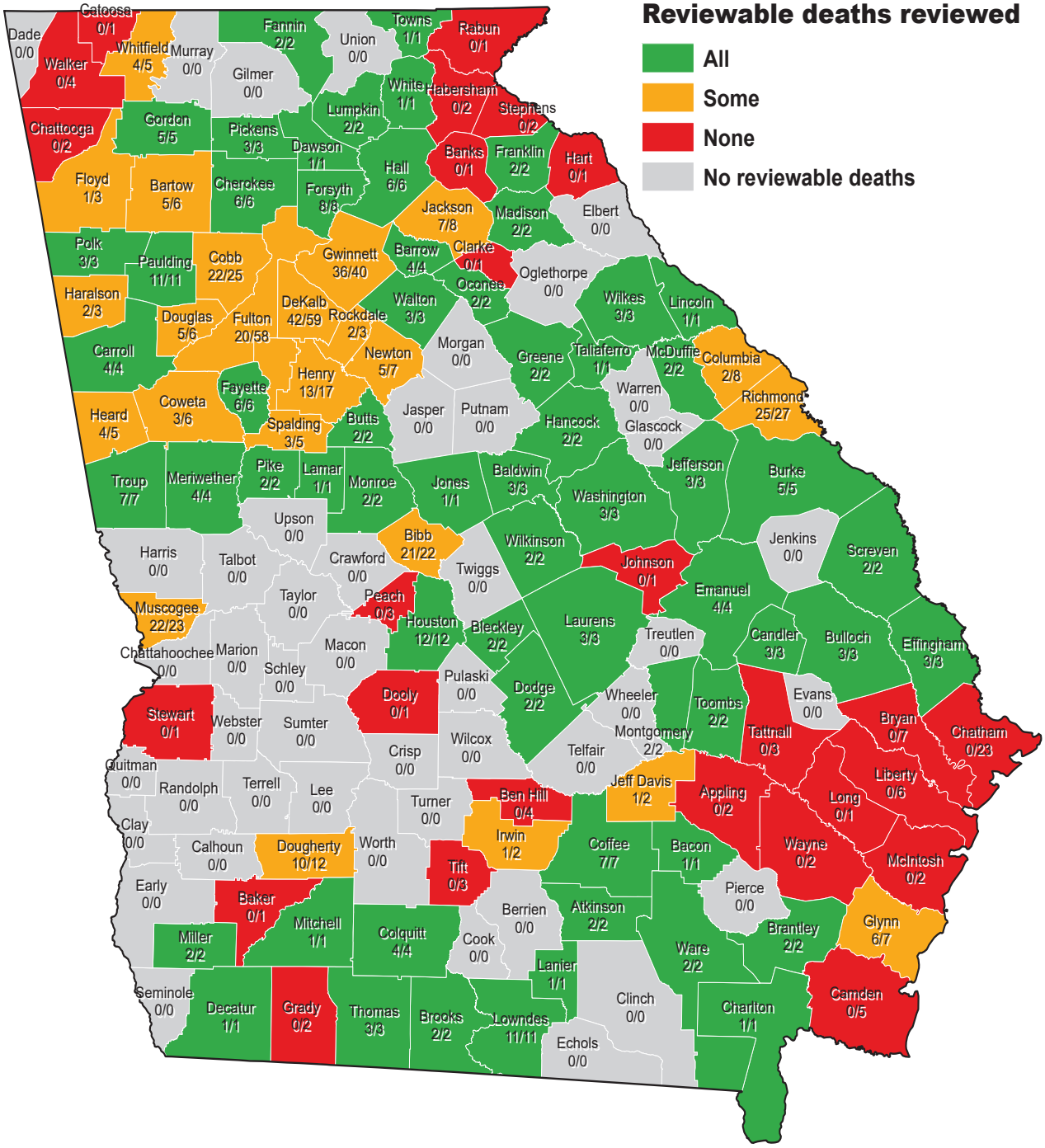
Child Fatality Review Committee Timeframes and Responsibilities



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

Reviewable Deaths / Reviewable Deaths Reviewed, 2022



Georgia Child Fatality Review Panel Annual Report

CALENDAR YEAR 2022