Georgia Child Fatality Review Panel Annual Report

CALENDAR YEAR 2023

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

Chris Hosey – 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

Jinger Robins- CEO, SafePath Children's Advocacy

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

Table of Contents

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

The 2023 annual report was developed and written in collaboration with the staff members of the Child Fatality Review Unit within the Georgia Bureau of Investigation.

Letter from CFR Panel Chair

December 2024

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

We are honored to present the Georgia Child Fatality Review Panel Annual Report. The data within this report covers non-medical child fatalities during the calendar year of 2023.

The 2023 Annual Report uses multi-year data to highlight trends. Regrettably, child deaths continue to *increase* over the past three years, and the mortality rate is currently 20% higher than it was in 2017. The leading, non-medical, causes of death in Georgia's children continue to be: sleep-related infant deaths, homicide, suicide, and motor vehicle incidents.

We must strengthen our prevention efforts, education, and messaging in our communities.

Most of the local child fatality review committees continue to work diligently to review their community's child deaths. Some local committees are not in compliance and are not meeting, reviewing deaths, or reporting needed data. The local committees struggle to timely convene meetings and report the data due to lack of funding, lack of time, and turnover among the committee members. Less than two-thirds of the 601 reviewable child deaths in 2023 were completed. (See maps on page 10 and 11.)

The Panel is working with the GBI and the National Center for Fatality Review and Prevention to streamline collecting and reporting the data. The Child Fatality Review unit staff will also continue training and providing individualized support to the local committees.

The Panel commends Georgia Bureau of Investigation Director Chris Hosey, Assistant Director Scott Dutton, the Child Fatality Review unit staff, agents, and medical examiner's office for their daily work to investigate, document, analyze, prosecute, and prevent the deaths of our vulnerable children.

Thank you for your attention and continuing support to the Child Fatality Review Panel, its mission, and the local committees.

Thomas B. "Britt" Hammond, Judge
Superior Court Toombs Judicial Circuit
Chair, Child Fatality Review Panel

Carolyn Altman, Judge
Juvenile Court Paulding Judicial Circuit
Vice-Chair, Child Fatality Review Panel

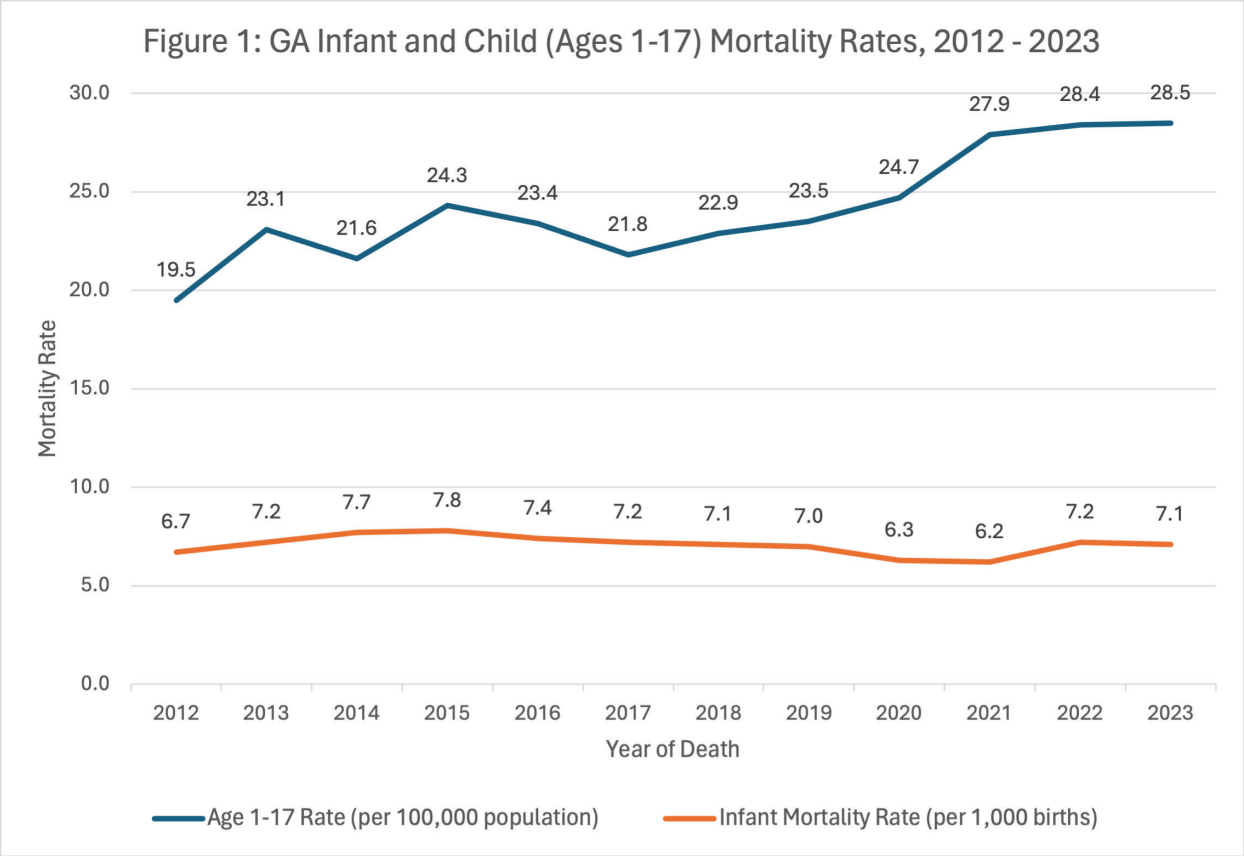
Introduction

This 2024 Georgia Child Fatality Review (CFR) Annual Report provides a summary of the deaths of infants and children (ages less than 18) that occurred in CY 2023. The goal of the CFR process is to reduce preventable child deaths. The GBI Office of Child Fatality Review (OCFR) supports that goal by:

- Describing trends in child deaths using GA Vital Records data – the death certificate data;
- Identifying potentially preventable deaths that should be reviewed by county CFR teams and supporting the Teams through training and other assistance;
- Implementing a quality assurance process for the collected CFR data;
- Providing a preliminary analysis of the annual DC and CFR data for consideration by the GA CFR Panel in developing recommendations and guiding Annual Report content; and
- Preparing an Annual Report including an assessment of the preceding year's review process and recommendations for prevention action.

2023 Child Deaths and Trends (Death Certificates)

Georgia death certificates are initially prepared by GA county coroners or medical examiners. They are submitted (electronically) to the Office of Vital Records, GA Department of Public Health and captured in the Georgia Vital Events Registration System (GAVERS). At some date (in June or later of the following calendar year) the annual death file is "closed" and is used by the Office of Health Indicators for Planning (OHIP) to compile annual statistics which are posted on the OASIS website. The OASIS data are based on the deaths in the "closed" file and represent official GA statistics.



GA infant deaths have shown some variation over the last 12 years (Figure 1): 2014 and 2015 were high and there was a significant drop in 2020 and 2021, but the average rate has been about 7.1 deaths per 1,000 births.

Child deaths (ages 1 – 17) have increased since 2017 and the average rate for the last three years is 20% higher than the rate for the preceding three years.

There were 1,569 reported deaths of GA residents ages less than 18 years in 2023. (Table 1)

Table 1: 2023 Deaths, GA Residents Ages < 18

	Age in Years						
Cause of Death	<1	1-4	5-9	10-14	15-17	2023 Totals	2022 Totals
Unintentional Injuries							
MVC	5	17	16	18	52	108	102
Drowning	4	19	5	8	8	44	34
Other Unintentional	5	17	6	5	24	57	94
Homicide	11	14	5	16	65	111	127
Suicide				15	40	55	62
Sleep-Related	188					188	209
Unknown Intent	1	4	4	3	2	14	17
Unknown (age>0)		11	3	1	9	24	12
Medical	670	89	66	71	72	968	921
Total Deaths	884	171	105	137	272	1,569	1,578
Reviewable (Non-Medical)	214	82	39	66	200	601	657

A majority (56%) of these deaths were infants and 670 of the 884 infant deaths were attributed to medical causes.

Sleep-related deaths are the largest cause of (non-medical) deaths for ages less than 18 years. The apparent increase in infant deaths attributed to unknown causes (Figure 2) may just be a reporting anomaly associated with death certificate reporting and coding delays.

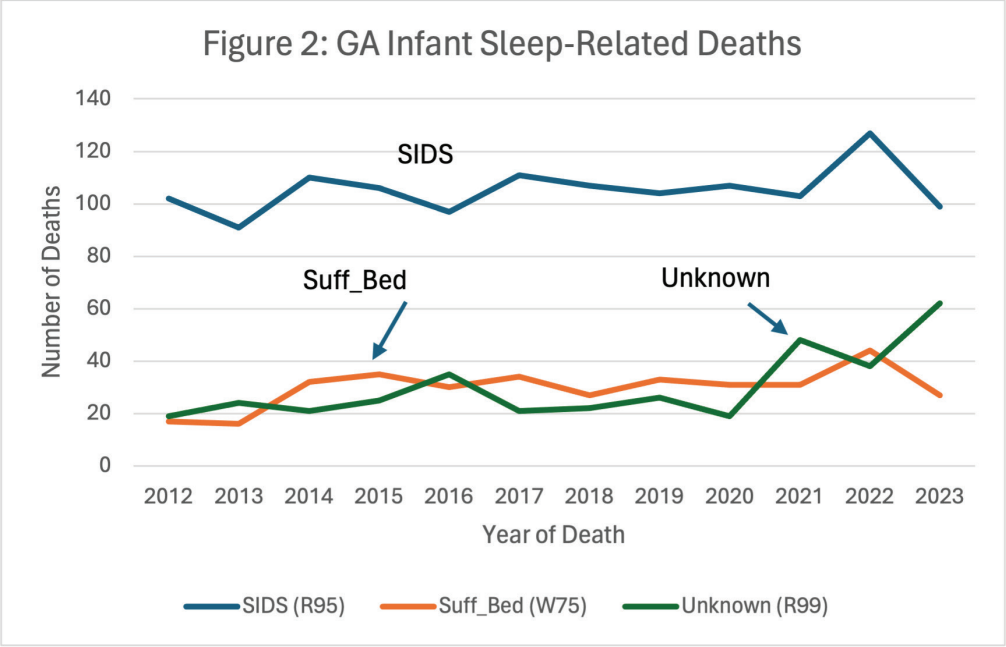
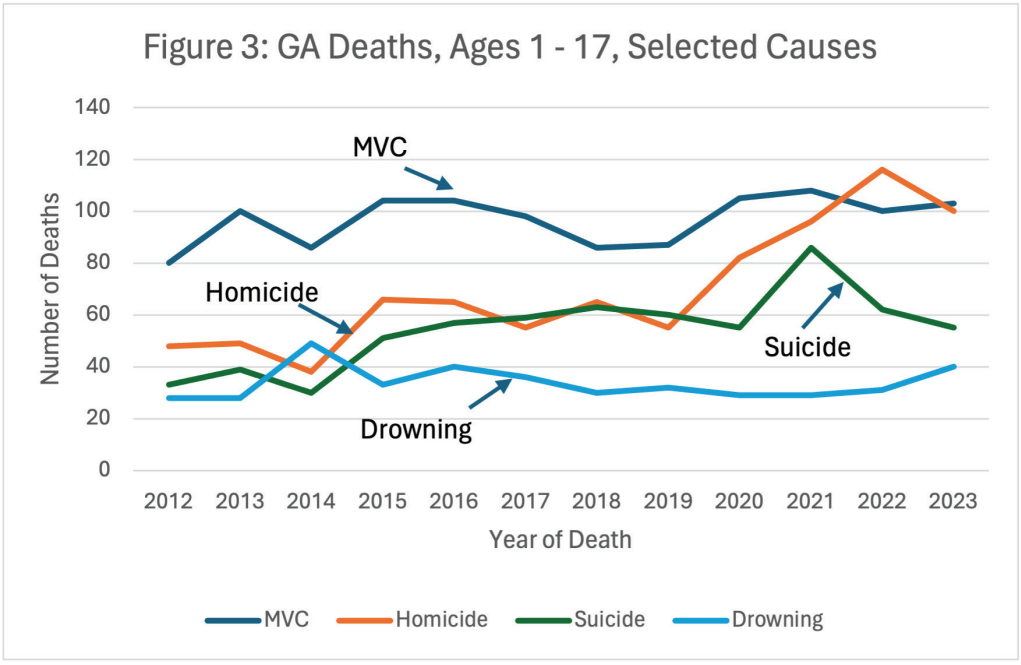


Figure 3 shows the trends over the past 12 years in major causes of non-medical deaths for children ages 1 through 17 years. The most apparent change was the increase in homicides beginning in 2020.



Child Fatality Review Process – Death Review and Data Entry

The county CFR teams have the responsibility for reviewing a subset of "potentially preventable" deaths. Teams are notified of deaths through death certificates and additional local sources including coroners, law enforcement, county and GBI medical examiners, and media reports. These local sources provide timely notification (DC submission can be delayed due to time required for toxicology analysis, autopsy reporting, and other investigations). The identified non-medical cause deaths are defined as "reviewable", and the county CFR team is responsible for conducting a review, completing the child death review (CDR) form, and entering the CDR form data into the National CDR database. The GBI OCFR is responsible for review of the submitted data and certifying the quality and completeness of the individual submissions. There are three critical variables (in the CDR database) that document this review and assurance process, (Table 2)

Table 2: CDR Database, Data Review Process Variables

Variable	Description
REVcomplete	Is review complete?
CMPdone	Data entry completed
CMPqa	Data quality assurance completed by state

There were 530 deaths with an entry in the GA 2023 CDR database. Seventy of these records were not certified by the OCRF (CMPqa = 0). The 2023 CDR database includes 460 deaths with 18 submitted after the extended submission deadline of July 15, 2024.

Table 3: 2023 GA Deaths with Complete CDR Record

	Age in Years					
Cause of Death	<1	1-4	5-9	10-14	15-17	Total
Unintentional Injuries (Total)	36	34	21	24	54	169
MVC	1	12	12	16	34	75
Drown	3	14	5	4	3	29
Asphyxia	21	3	1	1		26
Other Unintentional	11	5	3	3	17	39
Homicide	8	9	2	13	41	73
Suicide				10	28	38
Sleep Related	73					73
Undetermined	18	7			4	29
Medical	22	16	15	10	15	78
Non-Medical Total	135	50	23	47	127	382

Proportion of Reviewable Deaths Reviewed and Geographical Distribution

The proportion of reviewable deaths (determined by death certificate cause of death) that are reviewed (a certified CDR record – CMPqa = 1)) is a primary outcome measure for the GA CFR Program. The reviewed proportion is calculated using the linked DC and CDR records with the DC cause of death. (The DC and CDR do not always agree on cause of death.)

Table 4: Review Process Summary Statistic

2023 Deaths		
Reviewed?		
Review?	No	Yes
No	894	74
Yes	227	374
% Reviewable Reviewed		**62.2**

Less than two-thirds of 2023 reviewable deaths were reviewed. The review proportion has dropped steadily from over 90% in 2019 to 62% for the 2023 deaths. Four counties were responsible for 107 of the 227 deaths that had an incomplete or missing review.

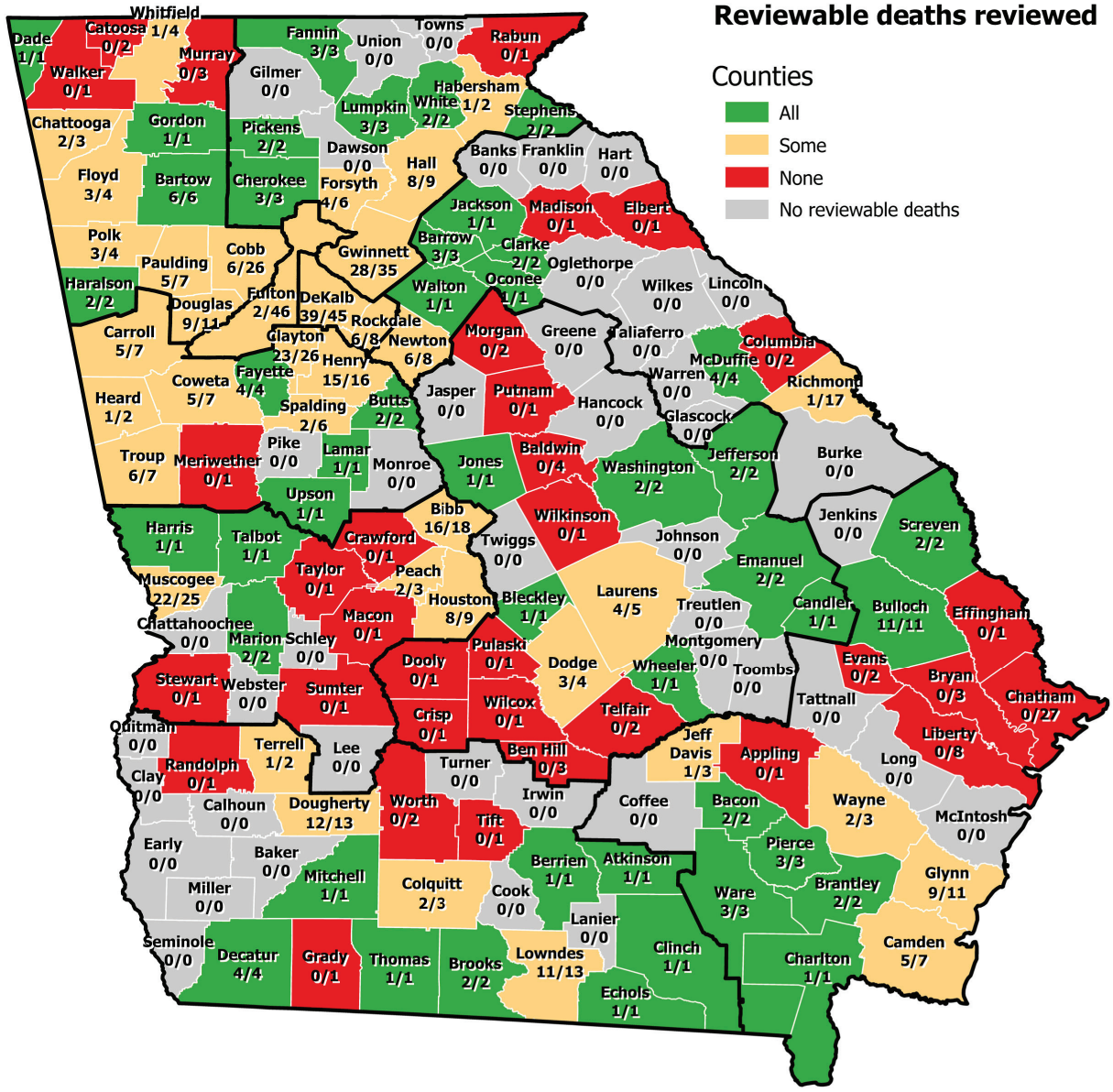
Table 5: Review Summary, 2023 Georgia Child Fatality Review

Category	Description	# Counties	# Deaths	Not Reviewed	Ave. Deaths/Co.
1	All Reviewable Deaths Reviewed	45	95		2.1
2	Some Reviewable Deaths Reviewed	37	425	146	11.5
3	No Reviewable Deaths Reviewed	33	81	81	2.5
4	No Reviewable Deaths	44			
	Totals	159	601	227	

The following two pages present maps of “Reviewed Deaths / Reviewable Deaths”. The first map provides county-level data which is also available in Appendix Table 1. The second map has the Judicial Circuits with the Judicial Districts. Appendix Table 2 has the data summary for the Districts and Circuits.

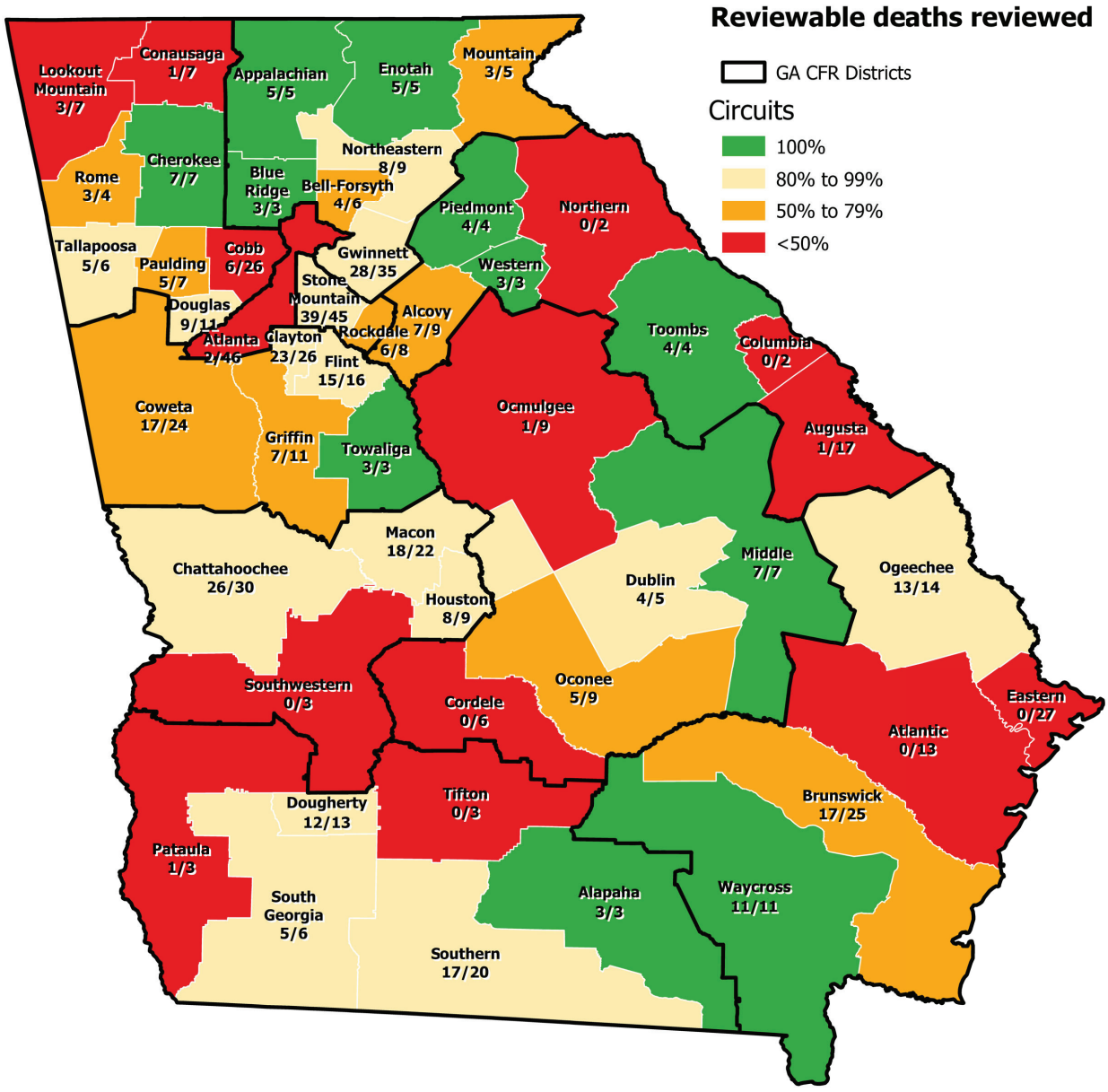
Reviewable Deaths Reviewed / Reviewable Deaths, 2023

By County



Reviewable Deaths Reviewed / Reviewable Deaths, 2023

By Judicial District and Circuit



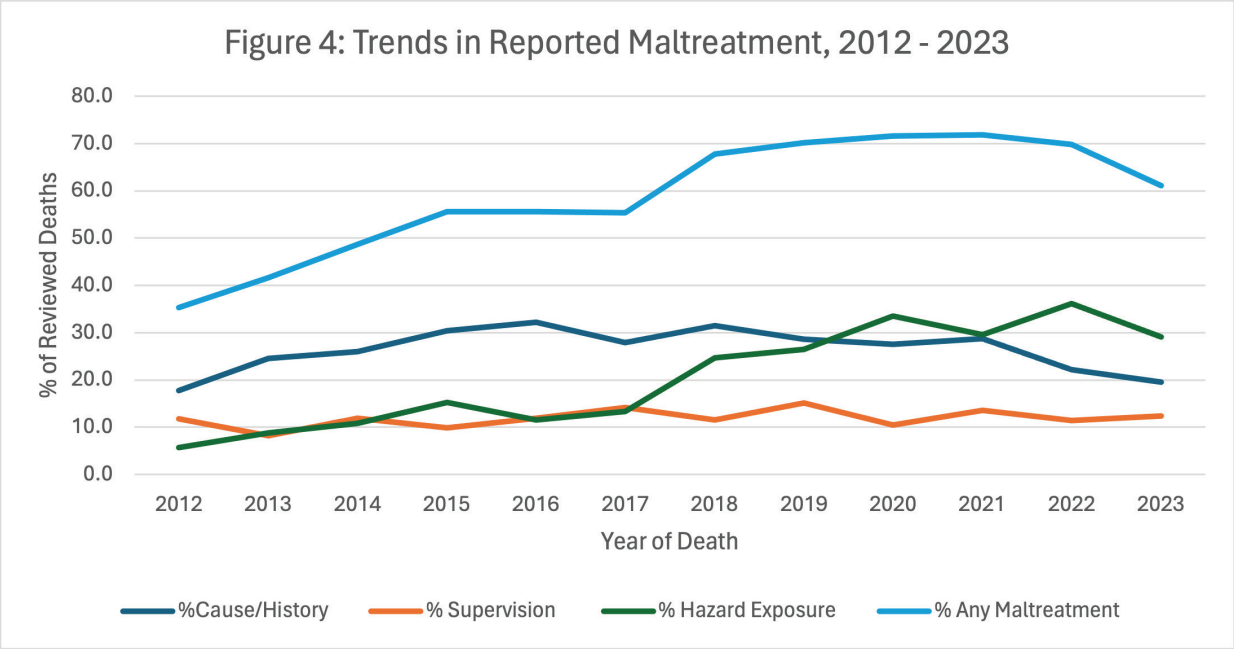
Maltreatment

Child maltreatment covers a wide range of caregiver action (or inaction). A disturbing number of infants and toddlers are victims of parental homicide, a situation in which the parent(s) action caused the death. In 2023 eight infant/toddler homicides were reported as caused by blunt force trauma inflicted by the biological father (2) or mother (3), or mother's partner. (Perpetrator type was unknown for two.) The maltreatment "spectrum" includes two other risk factor categories, "Hazard" and "Poor Supervision". The hazard category includes "unsafe sleeping environment" which was reported for 61 infants out of 73 with a sleep-related death. These various maltreatment categories 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, forty-four deaths had history of abuse identified, but eleven of those deaths also had abuse or neglect as a cause. Those eleven deaths are not counted in the History of Abuse category.)

Table 6: Reported Maltreatment, Historical Comparison

		Average			
		2012-2016	2017-2021	2022	2023
Cause or Contribute					
	Abuse	25	27	14	19
	Neglect	11	24	27	16
History					
	Abuse	66	76	34	33
	Neglect	37	37	49	22
Poor Supervision		57	73	64	57
Exposure to Hazard		56	146	202	134
	None	274	184	169	179
Percent					
	Cause/History	26.6	28.9	22.2	19.6
	Any	48.1	67.6	69.8	61.1

There have been fluctuations in the reported maltreatment by category, but no apparent trends. The identified maltreatment (as a cause or history) is lower in 2022 and 2023, but single year counts are small. Twenty-nine percent of reviewed deaths over the preceding five years had a history of maltreatment or identified it as causing or contributing to the death. The increase in the Hazard category is associated with the addition of that option to the CDR v.5 form (2018).



Supervision and hazard exposure are risk factors that are amenable to prevention efforts – usually directed at specific causes or ages.

Table 7: Reported Maltreatment by Cause Category, 2023 Reviewed Deaths

	Cause or Contribute		History		Supervision	Exposure to Hazard	None	Total	Cause/ History %	
	Abuse	Neglect	Abuse	Neglect					2023	2022
Cause Category										
MVC		1	3	2	8	26	35	75	8.0	18.6
Other Unintentional		2	10	9	18	33	22	94	22.3	30.3
Homicide	18		5	5	13	11	21	73	38.4	40.6
Suicide		1	5	2		7	23	38	21.1	22.9
Sleep-Related			3	2	15	47	6	73	6.8	6.5
Medical		8	7	2	2	3	56	78	21.8	22.9
Undetermined	1	4			1	7	16	29	17.2	
Total	19	16	33	22	57	134	179	460	19.6	22.2
With Duplicates	19	16	44	26	73	177				

In addition to the possible contribution of poor supervision to the death (included in the preceding maltreatment discussion), 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 would be added to the maltreatment Supervision count. Fifty-two of the 2023 deaths with supervision issues (125) were identified by this question. These 52 deaths are not included in the Supervision-related deaths in the preceding table (Table 7).

Table 8: Supervision Issue, by Cause of Death, 2023 Reviewed Deaths

	Supervision Problem			
	No	Yes	Rev Total	% Yes
MVC	55	20	75	26.7
Drown	6	23	29	79.3
Other Unintentional	44	21	65	32.3
Unintentional Subtotal	105	64	169	37.9
Homicide	44	29	73	39.7
Suicide	33	5	38	13.2
Intentional Subtotal	77	34	111	30.6
Sleep-Related Subtotal	54	19	73	26.0
Medical	75	3	78	3.8
Undetermined	24	5	29	17.2
All Reviewed	335	125	460	27.2

Drowning deaths stand out for the proportion with supervision problems (79%). Although the count is small, 14 drowning victims are toddlers, and 12 of the toddlers had a supervision risk, identifying caregivers of young children as a target prevention population.

Exposure to a hazard was identified as a risk factor for 276 of the reviewed deaths. There were 97 reviews (93 infants) where the sleep environment was identified as a hazard, with 61 of the 97 being sleep-related. Firearms were the 3rd hazard, with teens 15 to 17 accounting for 12 out of 22 reviewed that had a reported firearm hazard.

Child Death Review Prevention Findings

The goal of the Child Fatality Review process is to reduce preventable injury and death in the population under 18 years of age. The CDR form includes cause-specific sections that identify risk factors for the individual deaths. (For example, the Drowning section includes questions on the decedent's ability to swim and the use of flotation devices.) The county CFR team is asked to assess the preventability of a reviewed death and to identify possible prevention actions. Their conclusions and recommendations are captured in a Prevention section of the CDR form.

Table 9: Preventability Assessment and Presence of Recommendation(s), 2023 Reviewed Deaths

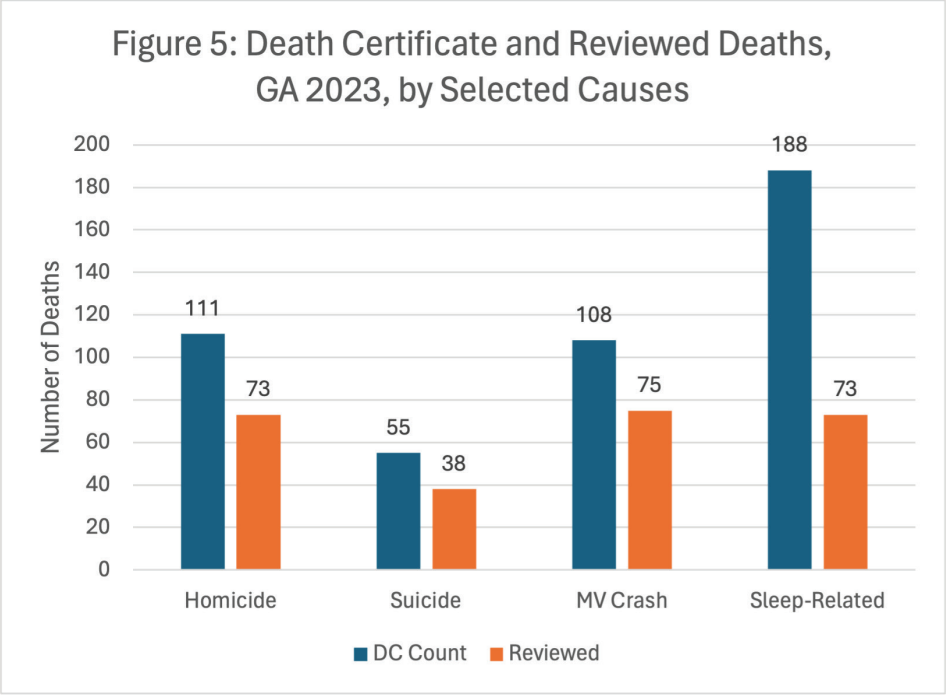
	PRVprevented				No Recommendation	
	No	Yes	Undetermined	% Preventable	Number	Percent
MVC	4	71		94.7	18	25.4
Drown		29		100.0	2	
Asphyxia		24	2	100.0	4	
Other	5	29	5	85.3	3	
Homicide	2	69	2	97.2	19	27.5
Suicide	3	31	4	91.2	3	
Sleep-Related	4	60	9	93.8	7	
Medical	46	16	16	25.8	4	
Undetermined	6	14	9	70.0	3	
Totals	70	343	47	83.1	*63	18.4
Unintentional Sub-total	9	153	7	94.4	27	17.6

*63 of the 343 had no entry for PRVrecsp

The CFR teams considered 83% of all reviewed deaths as preventable, with over 90% of unintentional, intentional, and sleep-related deaths reported as preventable. Eighty-two percent of the 343 preventable deaths had a response for the recommendation variable (PVRrecsp - *Recommendations and/or initiatives that could be implemented to prevent future deaths.*)

Drowning Example: There were 44 death certificate drowning deaths reported for 2023 GA infants and children; 28 of the 44 had a completed review. (One CFR "Drowning" death was reported on the death certificate as a "Medical" cause.) All 29 reviewed drowning deaths were reported as preventable, and 27 of those 29 had a prevention recommendation (PRVrecsp = "Yes"). Appendix 2 is a summary of selected prevention variables for one drowning case. The recommendation(s) (*Placing a fence or barrier around the pool to prevent young children from accessing them without any supervision. Being more accountable of your child's whereabouts*) address use of barriers for pools and supervision. This recommendation is representative of most of the entries – it defines problems (lack of barriers and poor supervision) – without identifying mechanisms for interventions (local ordinances, parental education).

Across the Child Fatality Review teams in state of Georgia, there is a consensus that non-medical deaths are largely preventable. In 2023, ninety four percent of unintentional deaths with a preventability determination (“no, probably not” or “Yes, probably) had “Yes, probably” reported in the preventability section of the CDR form. The leading causes of death for those under 18 in Georgia, are homicide, suicide, sleep-related, and motor vehicle-related incidents. Local teams considered most of these deaths preventable: 94% of deaths due to motor vehicle-related collisions, 93% of sleep-related deaths, 97% of homicides, and 91% of suicides were all reported to be avoidable.



The CDR process encourages local CFR teams to consider and discuss intervention and prevention efforts on a systemic level, rather than looking at a case-by-case basis. Previous prevention efforts that have come from data collected by CFR include graduated driver’s licenses for teens, standardized safe-sleep education messaging across all agencies, local traffic calming measures. Table 10 outlines recommended prevention strategies for the leading causes of death among individuals under 18 in Georgia.

Table 10: Prevention Recommendations, Selected Cause of Death Categories
Motor Vehicle Crashes
• enhanced programs to strengthen driver education in teens, • targeted campaigns focused on the importance of wearing seatbelts, • creation of youth focused road safety initiatives, • educate parents of teen drivers on the need to model safe driving behavior
Homicide
• community programs to address youth engagement, • implementing and enforcing gun safety laws, • violence interruption programs, • providing access to mental health resources and crisis intervention
Suicide
• increasing awareness about mental health, • providing access to 24/7 crisis hotlines, • training for community members (teachers, coaches, etc.) to recognize risk factors, • encouragement of collaboration with community partners for safety planning for those children at risk.
Sleep-Related Deaths
• wider distribution of free cribs, • strengthening healthcare provider education and support relating to safe-sleep messaging, • enforcing safe sleeping training in clinical and childcare settings, • enhancing the training for law enforcement and first responders so they can better identify safe sleep environments when in the field

Resources

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 Children 1st – Parent to Parent of Georgia

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 Sleep-Related Infant Deaths: Updated 2022 Recommendations for Reducing Infant Deaths in the Sleep Environment | Pediatrics | American Academy of Pediatrics

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/

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

Appendix A

2023 Infant/Child Death Review Status by County and Judicial District and Circuit										
		Judicial			Review Status					
County	CoFIPS	Circuit	District	All Rvbl	Complete	Incomplete	Late	No Review	Reviewed/ Reviewable	Category
Bulloch	13031	Ogeechee	First	11	11				11/11	1
Bartow	13015	Cherokee	Seventh	6	6				6/6	1
Decatur	13087	South Georgia	Second	4	4				4/4	1
Fayette	13113	Griffin	Sixth	4	1		3		4/4	1
McDuffie	13189	Toombs	Tenth	4	4				4/4	1
Cherokee	13057	Blue Ridge	Ninth	3	3				3/3	1
Fannin	13111	Appalachian	Ninth	3	3				3/3	1
Pierce	13229	Waycross	First	3	3				3/3	1
Ware	13299	Waycross	First	3	3				3/3	1
Barrow	13013	Piedmont	Tenth	3	3				3/3	1
Lumpkin	13187	Enotah	Ninth	3	3				3/3	1
Clarke	13059	Western	Tenth	2	2				2/2	1
Emanuel	13107	Middle	Eighth	2	2				2/2	1
Pickens	13227	Appalachian	Ninth	2	2				2/2	1
Screven	13251	Ogeechee	First	2	2				2/2	1
Stephens	13257	Mountain	Ninth	2	2				2/2	1
Washington	13303	Middle	Eighth	2	2				2/2	1
White	13311	Enotah	Ninth	2	2				2/2	1
Bacon	13005	Waycross	First	2	2				2/2	1
Brantley	13025	Waycross	First	2	2				2/2	1
Brooks	13027	Southern	Second	2	2				2/2	1
Butts	13035	Towaliga	Sixth	2	2				2/2	1
Haralson	13143	Tallapoosa	Seventh	2	2				2/2	1
Jefferson	13163	Middle	Eighth	2	2				2/2	1
Marion	13197	Chattahoochee	Third	2	2				2/2	1
Charlton	13049	Waycross	First	1	1				1/1	1
Clinch	13065	Alapaha	Second	1	1				1/1	1
Dade	13083	Lookout Mountain	Seventh	1	1				1/1	1
Echols	13101	Southern	Second	1	1				1/1	1
Talbot	13263	Chattahoochee	Third	1	1				1/1	1
Thomas	13275	Southern	Second	1			1		1/1	1
Upson	13293	Griffin	Sixth	1	1				1/1	1
Walton	13297	Alcovy	Tenth	1	1				1/1	1
Wheeler	13309	Oconee	Eighth	1	1				1/1	1
Atkinson	13003	Alapaha	Second	1	1				1/1	1
Berrien	13019	Alapaha	Second	1	1				1/1	1
Bleckley	13023	Oconee	Eighth	1			1		1/1	1
Candler	13043	Middle	Eighth	1	1				1/1	1
Gordon	13129	Cherokee	Seventh	1	1				1/1	1
Harris	13145	Chattahoochee	Third	1	1				1/1	1

2023 Infant/Child Death Review Status by County and Judicial District and Circuit (Continued)

		Judicial			Review Status					
County	CoFIPS	Circuit	District	All Rvbl	Complete	Incomplete	Late	No Review	Reviewed/ Reviewable	Category
Jackson	13157	Piedmont	Tenth	1	1				1/1	1
Jones	13169	Ocmulgee	Eighth	1	1				1/1	1
Lamar	13171	Towaliga	Sixth	1	1				1/1	1
Mitchell	13205	South Georgia	Second	1	1				1/1	1
Oconee	13219	Western	Tenth	1	1				1/1	1
Fulton	13121	Atlanta	Fifth	46	2	1		43	2/46	2
DeKalb	13089	Stone Mountain	Fourth	45	39	1		5	39/45	2
Gwinnett	13135	Gwinnett	Ninth	35	28	1		6	28/35	2
Clayton	13063	Clayton	Sixth	26	23	1		2	23/26	2
Cobb	13067	Cobb	Seventh	26	6	16		4	6/26	2
Muscogee	13215	Chattahoochee	Third	25	22			3	22/25	2
Bibb	13021	Macon	Third	18	16			2	16/18	2
Richmond	13245	Augusta	Tenth	17	1	9		7	1/17	2
Henry	13151	Flint	Sixth	16	15	1			15/16	2
Dougherty	13095	Dougherty	Second	13	12			1	12/13	2
Lowndes	13185	Southern	Second	13	11			2	11/13	2
Douglas	13097	Douglas	Seventh	11	9	1		1	9/11	2
Glynn	13127	Brunswick	First	11	8	1	1	1	9/11	2
Hall	13139	Northeastern	Ninth	9	8			1	8/9	2
Houston	13153	Houston	Third	9	8			1	8/9	2
Rockdale	13247	Rockdale	Fourth	8	6	1		1	6/8	2
Newton	13217	Alcovy	Tenth	8	3	2	3		6/8	2
Coweta	13077	Coweta	Sixth	7	5			2	5/7	2
Troup	13285	Coweta	Sixth	7	6			1	6/7	2
Camden	13039	Brunswick	First	7	3		2	2	5/7	2
Carroll	13045	Coweta	Sixth	7	5	1		1	5/7	2
Paulding	13223	Paulding	Seventh	7	5			2	5/7	2
Forsyth	13117	Bell-Forsyth	Ninth	6	3		1	2	4/6	2
Spalding	13255	Griffin	Sixth	6			2	4	2/6	2
Laurens	13175	Dublin	Eighth	5	4	1			4/5	2
Dodge	13091	Oconee	Eighth	4	2		1	1	3/4	2
Floyd	13115	Rome	Seventh	4	3			1	3/4	2
Polk	13233	Tallapoosa	Seventh	4	3			1	3/4	2
Whitfield	13313	Conausaga	Seventh	4	1	2		1	1/4	2
Chattooga	13055	Lookout Mountain	Seventh	3	2			1	2/3	2
Colquitt	13071	Southern	Second	3	2	1			2/3	2
Peach	13225	Macon	Third	3	1		1	1	2/3	2
Wayne	13305	Brunswick	First	3	2	1			2/3	2
Jeff Davis	13161	Brunswick	First	3	1			2	1/3	2
Terrell	13273	Pataula	Second	2	1			1	1/2	2

2023 Infant/Child Death Review Status by County and Judicial District and Circuit (Continued)

		Judicial			Review Status					
County	CoFIPS	Circuit	District	All Rvbl	Complete	Incomplete	Late	No Review	Reviewed/ Reviewable	Category
Habersham	13137	Mountain	Ninth	2	1	1			1/2	2
Heard	13149	Coweta	Sixth	2	1	1			1/2	2
Chatham	13051	Eastern	First	27		8		19	0/27	3
Liberty	13179	Atlantic	First	8				8	0/8	3
Baldwin	13009	Ocmulgee	Eighth	4				4	0/4	3
Ben Hill	13017	Cordele	Eighth	3				3	0/3	3
Bryan	13029	Atlantic	First	3				3	0/3	3
Murray	13213	Conausaga	Seventh	3				3	0/3	3
Columbia	13073	Columbia	Tenth	2		2			0/2	3
Evans	13109	Atlantic	First	2				2	0/2	3
Telfair	13271	Oconee	Eighth	2				2	0/2	3
Worth	13321	Tifton	Second	2				2	0/2	3
Catoosa	13047	Lookout Mountain	Seventh	2				2	0/2	3
Morgan	13211	Ocmulgee	Eighth	2				2	0/2	3
Crawford	13079	Macon	Third	1				1	0/1	3
Crisp	13081	Cordele	Eighth	1				1	0/1	3
Dooly	13093	Cordele	Eighth	1				1	0/1	3
Effingham	13103	Ogeechee	First	1				1	0/1	3
Elbert	13105	Northern	Tenth	1				1	0/1	3
Pulaski	13235	Oconee	Eighth	1				1	0/1	3
Putnam	13237	Ocmulgee	Eighth	1				1	0/1	3
Rabun	13241	Mountain	Ninth	1				1	0/1	3
Randolph	13243	Pataula	Second	1				1	0/1	3
Stewart	13259	Southwestern	Third	1				1	0/1	3
Sumter	13261	Southwestern	Third	1				1	0/1	3
Taylor	13269	Chattahoochee	Third	1				1	0/1	3
Tift	13277	Tifton	Second	1		1			0/1	3
Walker	13295	Lookout Mountain	Seventh	1				1	0/1	3
Wilcox	13315	Cordele	Eighth	1				1	0/1	3
Wilkinson	13319	Ocmulgee	Eighth	1				1	0/1	3
Appling	13001	Brunswick	First	1				1	0/1	3
Grady	13131	South Georgia	Second	1				1	0/1	3
Macon	13193	Southwestern	Third	1				1	0/1	3
Madison	13195	Northern	Tenth	1				1	0/1	3
Meriwether	13199	Coweta	Sixth	1				1	0/1	3
Chatta-hoochee	13053	Chattahoochee	Third	0					0/0	4
Clay	13061	Pataula	Second	0					0/0	4
Coffee	13069	Waycross	First	0					0/0	4
Cook	13075	Alapaha	Second	0					0/0	4
Dawson	13085	Northeastern	Ninth	0					0/0	4

2023 Infant/Child Death Review Status by County and Judicial District and Circuit (Continued)

		Judicial			Review Status					
County	CoFIPS	Circuit	District	All Rvbl	Complete	Incomplete	Late	No Review	Reviewed/ Reviewable	Category
Early	13099	Pataula	Second	0					0/0	4
Franklin	13119	Northern	Tenth	0					0/0	4
Pike	13231	Griffin	Sixth	0					0/0	4
Quitman	13239	Pataula	Second	0					0/0	4
Schley	13249	Southwestern	Third	0					0/0	4
Seminole	13253	Pataula	Second	0					0/0	4
Taliaferro	13265	Toombs	Tenth	0					0/0	4
Tattnall	13267	Atlantic	First	0					0/0	4
Toombs	13279	Middle	Eighth	0					0/0	4
Towns	13281	Enotah	Ninth	0					0/0	4
Treutlen	13283	Dublin	Eighth	0					0/0	4
Turner	13287	Tifton	Second	0					0/0	4
Twiggs	13289	Dublin	Eighth	0					0/0	4
Union	13291	Enotah	Ninth	0					0/0	4
Warren	13301	Toombs	Tenth	0					0/0	4
Webster	13307	Southwestern	Third	0					0/0	4
Wilkes	13317	Toombs	Tenth	0					0/0	4
Baker	13007	South Georgia	Second	0					0/0	4
Banks	13011	Piedmont	Tenth	0					0/0	4
Burke	13033	Augusta	Tenth	0					0/0	4
Calhoun	13037	South Georgia	Second	0					0/0	4
Gilmer	13123	Appalachian	Ninth	0					0/0	4
Glascock	13125	Toombs	Tenth	0					0/0	4
Greene	13133	Ocmulgee	Eighth	0					0/0	4
Hancock	13141	Ocmulgee	Eighth	0					0/0	4
Hart	13147	Northern	Tenth	0					0/0	4
Irwin	13155	Tifton	Second	0					0/0	4
Jasper	13159	Ocmulgee	Eighth	0					0/0	4
Jenkins	13165	Ogeechee	First	0					0/0	4
Johnson	13167	Dublin	Eighth	0					0/0	4
Lanier	13173	Alapaha	Second	0					0/0	4
Lee	13177	Southwestern	Third	0					0/0	4
Lincoln	13181	Toombs	Tenth	0					0/0	4
Long	13183	Atlantic	First	0					0/0	4
McIntosh	13191	Atlantic	First	0					0/0	4
Miller	13201	Pataula	Second	0					0/0	4
Monroe	13207	Towaliga	Sixth	0					0/0	4
Montgomery	13209	Oconee	Eighth	0					0/0	4
Oglethorpe	13221	Northern	Tenth	0					0/0	4
				601	358	54	16	173		

Appendix B

Judicial Circuit Review Summary (2023 Deaths)										
	Judicial			Review Status						
	District	Circuit	All Rvbl	Complete	Incomplete	Late	No Review	Reviewed/ Reviewable	Percent Reviewed	Category
1	First	Atlantic	13				13	0/13	0.0	4
1	First	Brunswick	25	14	2	3	6	17/25	68.0	3
1	First	Eastern	27		8		19	0/27	0.0	4
1	First	Ogeechee	14	13			1	13/14	92.9	2
1	First	Waycross	11	11				11/11	100.0	1
2	Second	Alapaha	3	3				3/3	100.0	1
2	Second	Dougherty	13	12			1	12/13	92.3	2
2	Second	Pataula	3	1			2	1/3	33.3	4
2	Second	South Georgia	6	5			1	5/6	83.3	2
2	Second	Southern	20	16	1	1	2	17/20	85.0	2
2	Second	Tifton	3		1		2	0/3	0.0	4
3	Third	Chattahoochee	30	26			4	26/30	86.7	2
3	Third	Houston	9	8			1	8/9	88.9	2
3	Third	Macon	22	17		1	4	18/22	81.8	2
3	Third	Southwestern	3				3	0/3	0.0	4
4	Fourth	Rockdale	8	6	1		1	6/8	75.0	3
4	Fourth	Stone Mountain	45	39	1		5	39/45	86.7	2
5	Fifth	Atlanta	46	2	1		43	2/46	4.3	4
6	Sixth	Clayton	26	23	1		2	23/26	88.5	2
6	Sixth	Coweta	24	17	2		5	17/24	70.8	3
6	Sixth	Flint	16	15	1			15/16	93.8	2
6	Sixth	Griffin	11	2		5	4	7/11	63.6	3
7	Seventh	Cherokee	7	7				7/7	100.0	1
7	Seventh	Cobb	26	6	16		4	6/26	23.1	4
7	Seventh	Conausaga	7	1	2		4	1/7	14.3	4
7	Seventh	Douglas	11	9	1		1	9/11	81.8	2
7	Seventh	Lookout Mountain	7	3			4	3/7	42.9	4
7	Seventh	Paulding	7	5			2	5/7	71.4	3
7	Seventh	Rome	4	3			1	3/4	75.0	3
7	Seventh	Tallapoosa	6	5			1	5/6	83.3	2
8	Eighth	Cordele	6				6	0/6	0.0	4
8	Eighth	Dublin	5	4	1			4/5	80.0	2
8	Eighth	Middle	7	7				7/7	100.0	1
8	Eighth	Ocmulgee	9	1			8	1/9	11.1	4
8	Eighth	Oconee	9	3		2	4	5/9	55.6	3
9	Ninth	Appalachian	5	5				5/5	100.0	1
9	Ninth	Bell-Forsyth	6	3		1	2	4/6	66.7	3
9	Ninth	Blue Ridge	3	3				3/3	100.0	1
9	Ninth	Enotah	5	5				5/5	100.0	1
9	Ninth	Gwinnett	35	28	1		6	28/35	80.0	2

Judicial Circuit Review Summary (2023 Deaths) (continued)

	Judicial			Review Status						
	District	Circuit	All Rvbl	Complete	Incomplete	Late	No Review	Reviewed/ Reviewable	Percent Reviewed	Category
9	Ninth	Mountain	5	3	1		1	3/5	60.0	3
9	Ninth	Northeastern	9	8			1	8/9	88.9	2
10	Tenth	Alcovy	9	4	2	3		7/9	77.8	3
10	Tenth	Augusta	17	1	9		7	1/17	5.9	4
10	Tenth	Columbia	2		2			0/2	0.0	4
10	Tenth	Northern	2				2	0/2	0.0	4
10	Tenth	Piedmont	4	4				4/4	100.0	1
10	Tenth	Toombs	4	4				4/4	100.0	1
10	Tenth	Western	3	3				3/3	100.0	1

Judicial District Review Summary (2023 Deaths)

		Review Status				
District	All Rvbl	Complete	Incomplete	Late	No Review	%Complete
First	90	38	10	3	39	45.6
Second	48	37	2	1	8	79.2
Third	64	51		1	12	81.3
Fourth	53	45	2		6	84.9
Fifth	46	2	1		43	4.3
Sixth	80	60	4	5	11	81.3
Seventh	75	39	19		17	52.0
Eighth	36	15	1	2	18	47.2
Ninth	68	55	2	1	10	82.4
Tenth	41	16	13	3	9	46.3
GA Total	**601**	**358**	**54**	**16**	**173**	**62.2**

Notes

Notes

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Georgia Child Fatality Review Panel Annual Report

CALENDAR YEAR 2023