Georgia Child Fatality Review Annual Report

Supplemental Analysis: Sudden Unexpected Infant Deaths in Georgia

2012–2024

Brian Kemp
Governor

Thomas B. “Britt” Hammond
Panel Chair

The Child Fatality Review Panel Appointments and Attendees (2023 and 2024)

This section outlines the authorized appointments and regular attendees of the Georgia State Child Fatality Review Panel, including mandated members, designees, ex officio participants, and standing non-voting attendees.

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

VACANT – Commissioner, Department of Behavioral Health and Developmental Disabilities

Derek Mallow – Member, Georgia State Senate

Kathleen Toomey – Commissioner, Department of Public Health

Jay Neal – Director, Criminal Justice Coordinating Council

Candice Broce – Commissioner, Department of Human Services & Director, Division of Family & Children Services

Trina Wilson – Social Worker, LIFE Counseling and Assessment Center

Jinger Robins – CEO, SafePath Children's Advocacy

Richard Hawk – Coroner, Coweta County

VACANT – Law Enforcement Official

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

Nicholas Ellis – State Board of Education

Standing Attendees (2023 and 2024)

April Rogers – Director of Policy & Enforcement for Child Care Services, Department of Early Care and Learning

Angie Boy – Program Manager, Prevention and Training, Children's Healthcare of Atlanta

Nicole McDougald – Commissioner, Department of Human Services

Terri Miller – Program Manager, Safe Sleep & Bullying Prevention, Department of Public Health

John T. Carter – Emeritus Assistant Professor, Rollins School of Public Health, Emory University

Michelle DiMarco – Associate Medical Examiner, Georgia Bureau of Investigation

Scott Dutton – Assistant Director, Georgia Bureau of Investigation

Ashley Garrish – Director of Medical Operations, Georgia Bureau of Investigation

Tiffany Sawyer – Director of Prevention & Education, Georgia Center for Child Advocacy

Polly McKinney – Advocacy Director, Georgia Voices

Table of Contents

This Annual Report is issued during the transition to Georgia's two-year Child Fatality Review reporting model and includes a supplemental statewide analysis of Sudden Unexpected Infant Deaths (SUID) spanning calendar years 2012–2024.

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 individuals and entities whose commitment, dedication, and ongoing support of the Child Fatality Review process made this report possible:

- All members who serve on the County Child Fatality Review Committees across Georgia
- John T. Carter, PhD, MPH, Emeritus Assistant Professor, Rollins School of Public Health, Emory University, whose analytic support was essential to the development of this report

This annual report was developed collaboratively by the staff of the Child Fatality Review Unit within the Georgia Bureau of Investigation, including the GBI Medical Examiner's Office, whose administrative and programmatic support was essential to the development of this report, and the Georgia Department of Public Health, for its continued collaboration and partnership in injury prevention and health communications.

Letter from CFR Panel Chair and Co-Chair

December 2025

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

We are honored to present the Georgia Child Fatality Review Panel Annual Report.

Infant deaths comprise 60% of all child fatalities in Georgia. Sudden Unexpected Infant Death is the leading (non-medical) cause of death among infants. Data collected through the Child Fatality Review process highlights risk factors associated with SUID, most notably co-sleeping with an adult, tobacco use by a caregiver, and the presence of soft bedding (pillows and blankets) in a child's sleep environment.

This report provides a detailed review of Georgia SUID fatalities from 2012-2023. The report concludes with recommendations for policy makers to increase public awareness through training and education, to develop consistent messaging about safe sleep practices, as well as giving practical aid to families.

The Panel thanks 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 most vulnerable children

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

Thomas "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

Executive Summary

The Georgia State Child Fatality Review (CFR) Panel is responsible for improving the identification, reporting, and prevention of child fatalities across the state. In calendar year 2025, the Panel conducted a review of its processes to strengthen data quality and ensure continued alignment with its mission. This review identified the timing of the annual report release as a key area for improvement. Increasing complexity of child death investigations, a national shortage of medical examiners, and Georgia's population growth have made it more difficult for local Child Fatality Review committees to complete reviews within existing timelines, particularly for deaths requiring extended investigation such as sudden unexplained infant deaths, homicides, and potential neglect cases. These challenges increased the risk that annual reports could reflect incomplete trend information.

To address these limitations, the CFR Panel adopted a two-year reporting model. Annual reports will continue to be released each year but will include deaths that occurred two calendar years prior, allowing sufficient time for investigations to be completed and cases to be thoroughly reviewed. This change is intended to ensure that statewide findings are based on more complete and reliable data. Because this model was recently implemented, some deaths that occurred in 2023 and were previously excluded from the 2023 Annual Report (released December 30, 2024) due to incomplete investigations could not be included in this report, as local review teams shifted focus to newer 2024 cases before completing all outstanding 2023 reviews.

Beginning with this transition, each annual report also includes a supplemental in-depth analysis focused on a priority topic identified through the CFR process. The supplemental analysis in this report examines Sudden Unexpected Infant Deaths (SUID) in Georgia.

Sudden Unexpected Infant Death (SUID) includes all sudden and unexpected deaths of infants under one year of age, regardless of whether a specific cause is identified. This report examines SUID trends in Georgia from 2012 through 2024, using death certificate data, linked birth and infant death records, and Child Fatality Review data. From 2014 through 2020, SUID deaths remained relatively stable at approximately 160 deaths per year, followed by an increase from 2021 through 2023, driven in part by a rise in deaths classified as having an unknown cause. In 2024, SUID deaths declined to levels consistent with the earlier seven-year period. While ICD-10 coding provides standardized public health surveillance, medical examiners face challenges applying categories such as Sudden Infant Death Syndrome (SIDS) and SUID in complex investigations, which can affect how deaths are classified and reported.

Linked birth–death data allow for analysis of individual-level risk factors associated with SUID. Analysis of a five-year cohort of infants born in Georgia (2019–2023) shows higher SUID risk among infants with low birth weight, short birth intervals, younger mothers, and lower maternal educational attainment. Socioeconomic indicators, including Medicaid-funded births and WIC participation, were also strongly associated with elevated SUID risk, reflecting underlying structural and environmental factors rather than insurance status itself.

Most SUID cases identified through death certificate data are referred to county CFR teams, with approximately 83% reviewed statewide from 2012–2023, although review rates declined in recent years. CFR reviews provide critical case-level information that enhances understanding of infant sleep environments and circumstances surrounding these deaths. Findings consistently identify the sleep environment as a primary area of risk. Most SUID cases involved sleeping on adult beds or couches, frequently with co-sleeping, and soft bedding was present in more than half of reviewed cases. Although the proportion of infants placed to sleep on their backs has increased over time, many infants were found in different positions.

Collectively, these findings reinforce national evidence that unsafe sleep environments, particularly bed-sharing and the presence of soft bedding, remain significant contributors to sleep-related infant deaths. Analysis of CFR data also identifies persistent gaps in prevention, including inconsistent safe sleep education across prenatal and postpartum settings, limited public awareness of SUID, and structural barriers faced by families with fewer resources. The report underscores the continued need for coordinated, evidence-based prevention strategies, including standardized and repeated safe sleep education, integration of tobacco cessation and postpartum support, expanded public awareness efforts, and improved access to safe sleep resources such as crib distribution programs, to reduce preventable infant deaths and improve outcomes for Georgia's children.

Key Findings

- Sudden Unexpected Infant Deaths (SUID) in Georgia remained relatively stable from 2014–2020, increased from 2021–2023, and declined in 2024 to levels consistent with earlier years; recent increases were driven in part by deaths classified as having an unknown cause.
- Linked birth–death data show higher SUID risk among infants with low birth weight, short birth intervals, younger mothers, and lower maternal educational attainment.
- Socioeconomic indicators, including Medicaid-funded births and WIC participation, are strongly associated with elevated SUID risk, reflecting underlying structural and environmental factors rather than insurance status itself.
- Approximately 83% of SUID cases were reviewed by county Child Fatality Review teams from 2012–2023, although review rates declined in recent years.
- CFR reviews consistently identify the sleep environment as a primary area of risk; most SUID cases involved sleeping on adult beds or couches, often with co-sleeping, and soft bedding was present in more than half of reviewed cases.
- While more infants are being placed to sleep on their backs, many are later found in different positions, increasing risk.

Key Recommendations

- Standardize safe infant sleep education across prenatal, hospital, pediatric, home visiting, and child welfare settings to ensure consistent, evidence-based messaging.
- Expand repeated safe sleep education throughout pregnancy and the postpartum period, with attention to caregiver fatigue, mental health, and real-world barriers.
- Integrate tobacco cessation support into prenatal and postpartum care, given its disproportionate presence in SUID cases.
- Increase access to safe sleep resources, including formalized crib and bassinet distribution programs paired with education.
- Strengthen public awareness efforts through coordinated statewide media campaigns focused on SUID and safe sleep.
- Leverage CFR and vital records data for ongoing monitoring, accountability, and targeted prevention strategies.

Sudden Unexpected Infant Deaths (SUID) in Georgia, 2012–2024

The sudden (and unexplained) death of an infant has always been a tragedy for parents and communities. Even though we did not, and still do not understand the causes of many of these deaths, the sudden infant death syndrome (SIDS) was defined and given a code (798.0) in the 9th version of the World Health Organization (WHO) International Classification of Diseases (ICD). "In ICD–9, SIDS was treated as an ill-defined condition and ignored in the presence of other better-defined conditions. In ICD–10, SIDS is not considered to be ill-defined." The identification of possible SIDS risk factors and the on-going analysis of these sudden infant deaths led to the development of a new category – sudden unexpected infant death (SUID). (See Appendix A. SUID Case Definition for summary and references.)

The Georgia Office of Child Fatality Review (OCFR) in the Georgia Bureau of Investigation uses three data sources to describe the continuing SUID problem in Georgia:

1. The death certificate provides a population-based record on all deaths within individual states. The core death certificate variables are consistent across states and enable a standardized accounting of deaths, by cause of death, across the United States. (https://www.cdc.gov/nchs/data/dvs/death11-03final-acc.pdf)

2. The linked birth and infant death data provide a population-based denominator to calculate exposure risks for SUID. (https://www.cdc.gov/nchs/nvss/linked-birth.htm)

3. Georgia participates in the National Child Fatality Review Program (NCFRP: https://ncfrp.org/), which documents the state/county review of unexpected infant/child deaths.

Access to the GA birth and death data (and the referenced linkages) is provided through the Georgia Department of Public Health, Office of Health Indicators for Planning (OHIP). The OASIS website (https://oasis.state.ga.us/) provides public access to aggregate GA vital records data.

The following discussion provides a summary of SUID trends and analyses identified and prepared using the three data sources.

SUID Definitions: Medical Examiner's Office Perspective

While the uniform classification of deaths into ICD-10 codes is necessary to enable standardization of death certificates and public health tracking throughout the country, definitions of causes of death like SIDS and SUID may be more nuanced in the setting of a medicolegal death investigation. Increasingly, medical examiners are reluctant to list "SIDS" (ICD-10 code R95) on death certificates, as doing so requires the exclusions of all other possible causes or risk factors for possible asphyxia. As infant death investigations can be complex and ongoing, some feel there is no point at which one can determine that all other alternative causes have been thoroughly investigated and ruled out. Additionally, some doctors may use "SUID/SUDI" as "sudden unexplained infant death/death in infancy" while others used "SUID" as "sudden unexpected infant death." Some medical examiners may use these two terms interchangeably, while others define each as a different type of death. As there is no ICD-10 code for "SUID," deaths labeled as "SUID" or "SUDI" will be classified under ICD-10 code R95 for "SIDS."

While the data presented in this report is largely based around ICD-10 classifications pulled from vital statistics records, the Georgia Child Fatality Review Panel has begun a more in-depth examination of the limitations of these classification codes and their impact on a comprehensive review of child deaths.

Georgia Death Certificate Sleep-Related Deaths (SUID)

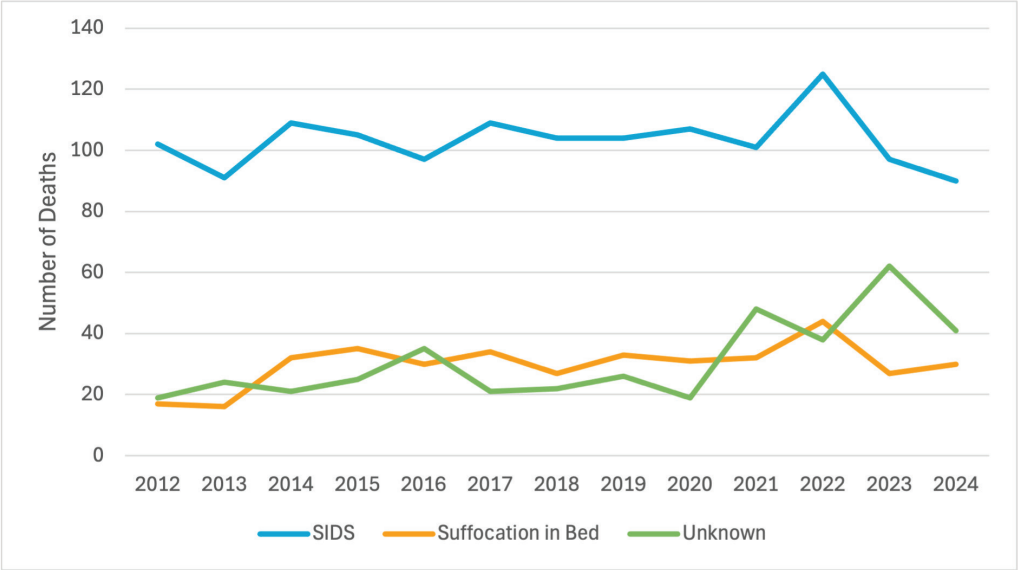
The currently accepted case definition for Sudden Unexpected Infant Death (SUID) includes infant deaths with one of three ICD-10 codes for the underlying cause of death in the death certificate. (See Appendix A. SUID Case Definition for summary and references.)

Table 1: SUID Definitions Based on ICD-10 Codes

ICD-10 Code	Code Definition
R 95	SIDS
R 99	Unknown cause
W 75	Accidental suffocation or strangulation in bed

The following figure provides the trends for the three ICD-10 codes over the past 13 years. The number of SUID was stable (160 per year) between 2014 and 2020, but there were fluctuations and an overall increase from 2021 through 2023. Some of that three-year increase was associated with an increase in the number of deaths with "Unknown" cause. The 2024 deaths decreased back to the earlier seven-year period (160).

Figure 1. GA Sudden Unexpected Infant Deaths, Death Certificate 2012-2024

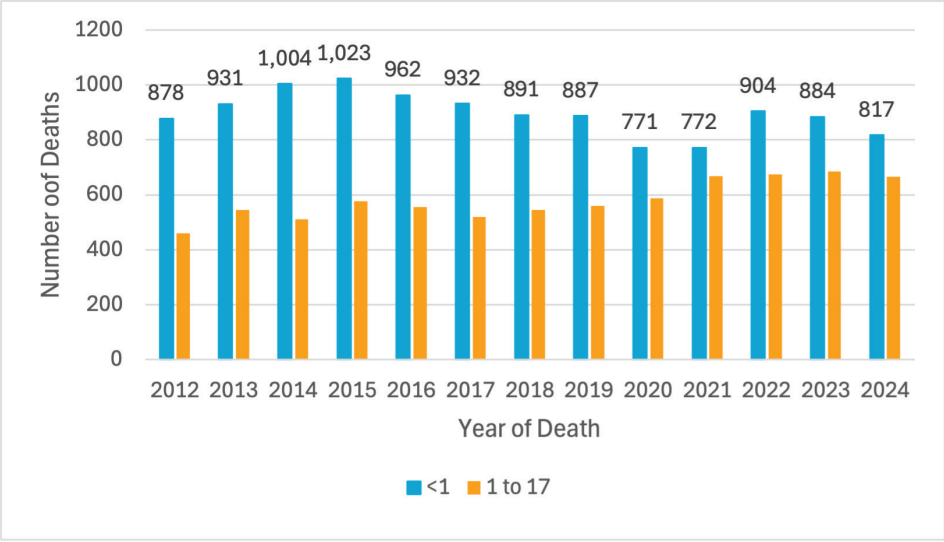


In addition to providing trend information, the death certificate and population (county, Census tract) data can be used to prepare area-specific death rates by cause and demographic variables.

A Context for Sudden Unexpected Infant Deaths (SUID)

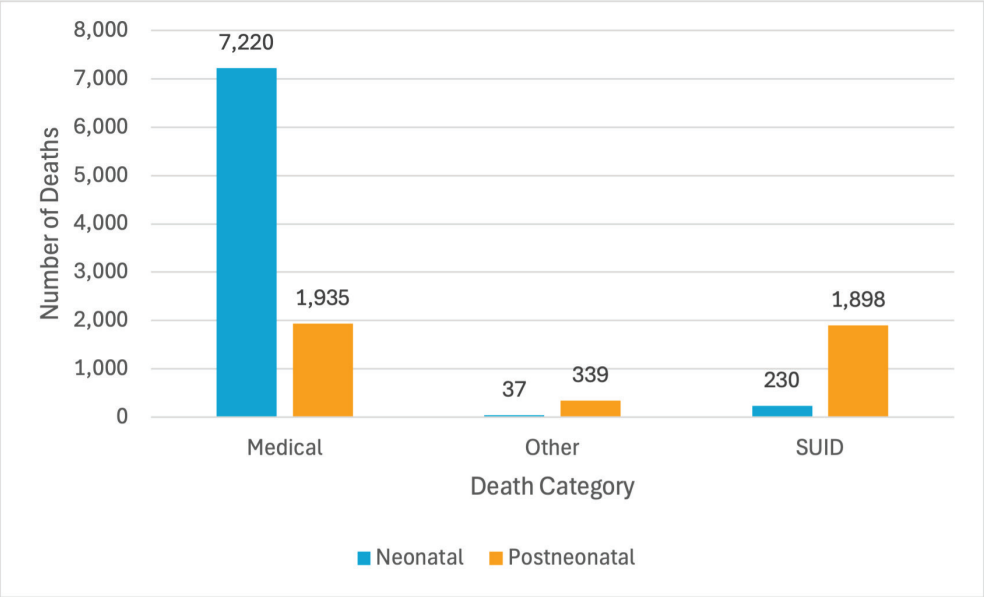
Georgia resident infants and children (ages 0 through 17) account for an average of 1,477 deaths each year (2012–2024). The infant deaths have decreased slightly over the 13 years with an unexplained significant drop for 2020 and 2021. The number of child deaths has increased with much of that increase attributable to teen homicide and suicide. The following SUID discussion is limited to the infant deaths.

Figure 2. Georgia Infant and Child Deaths



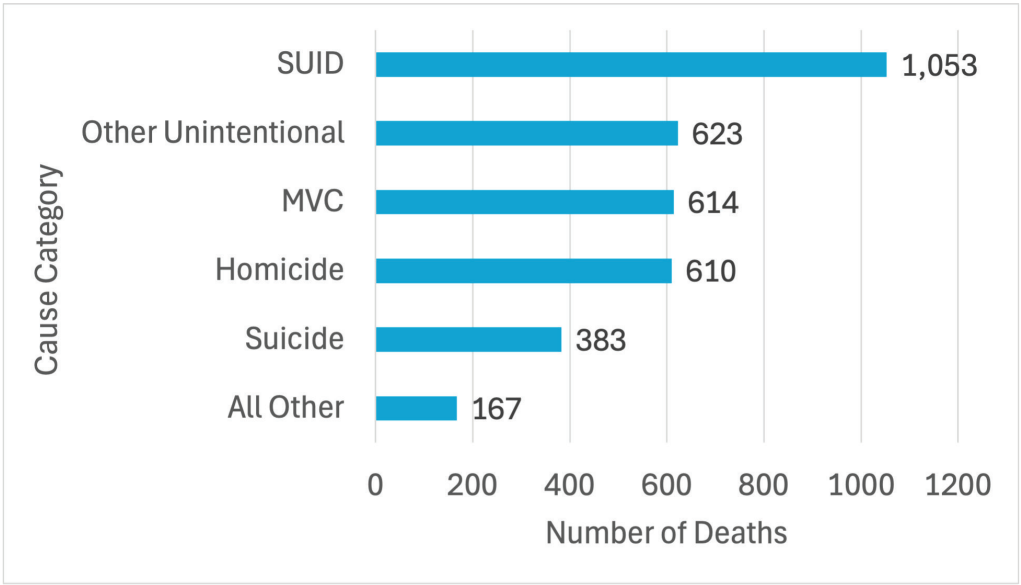
Infant deaths comprise 60.7% of all deaths 0 through 17 years of age. Neonatal deaths (infant age less than 28 days) make up 64.2% of all infant deaths. The non-medical deaths are the primary focus of the child fatality review process. The SUID category includes most of the non-medical post-neonatal (28 through 365 days of age) deaths. The “Other” death category includes intentional and unintentional injuries.

Figure 3. Cause of Death Categories by Infant Age: 2012-2024



SUID is the largest category for all reviewable deaths, accounting for 1,053 of the 3,450 (30.5%) reviewable deaths over the last six years. SUID makes up 86% of all reviewable infant deaths during the six-year period.

Figure 4. Reviewable Deaths (Ages<18),2019-2024 Totals



GA Linked Birth-Death Records, Infants Born in Georgia

The death certificate database provides a count of SUID by time, geographic location, and demographic characteristics (age, race, sex, ethnicity). This is useful for the description of the scope of SUID, but it does not provide for the assessment of risk factors. Birth and / or population data provide denominators for the calculation of rates, but linked infant birth-death data allows the analysis of risk factors (captured in the birth certificate) for SUID.

All GA resident infant deaths from 2019 through 2024 were linked with all births for 2019 through 2023 to prepare a five-year birth cohort database. (Note that some 2019 infant deaths were 2018 births (94) and some 2024 deaths were 2024 births (716) – and both sets are excluded from the cohort. See following table.)

Table 2. Cohort Table, 2019-2024 Infant Deaths, Year of Birth by Year of Death

	Year of Death					
Year of Birth	2019	2020	2021	2022	2023	2024
2018	**94**					
2019	794	105				
2020		666	112			
2021			660	134		
2022				770	128	
2023					756	101
2024						**716**

4,226 Birth Cohort Deaths

A total of 4,226 deaths of infants born between 2019 and 2023 were identified from the 2019 to 2024 death certificates. (See following table) Seventy-nine of these deaths (1.9%) were not linked to a GA death certificate. The five-year birth cohort includes 623,606 births and 4,147 linked infant deaths – of which 847 are SUID (as defined by the three DC ICD-10 codes – R95, R99, W75). The SUID death rate slightly underestimates the “true” rate due to the small number of unlinked SUID. {The five-year cohort SUID mortality rate is 1000*847/623,606 = 1.36 deaths per 1,000 births. The Vital Records SUID IMR is 1.43 for the same five-year period. (Some SUID deaths are not linked with the birth certificate, and the death counts are different - SUID deaths during the five-year period versus SUID deaths of infants born during the five years.)

Table 3. Number of GA Infant Deaths, by Year of Birth and Cause of Death Category						
	Year of Birth					
Death Category	2019	2020	2021	2022	2023	5-Yr Cohort
All Infant Deaths						
Medical	708	579	590	663	666	3,206
Other	29	27	34	24	25	139
SUID	162	172	170	211	166	881
Totals	899	778	794	898	857	4,226
Deaths with Birth Certificate Link						
Medical	700	577	585	654	650	3,166
Other	28	27	32	23	24	134
SUID	**157**	**168**	**165**	**201**	**156**	**847**
Totals	885	772	782	878	830	4,147
Births	**126,250**	**122,379**	**123,971**	**126,001**	**125,005**	**623,606**
Cohort Infant Mortality Rate	7.1	6.4	6.4	7.1	6.9	6.8

The following cohort analysis excludes multiple (twin, etc.) births. This eliminates 21,294 infants and 52 SUID deaths. They are excluded because their distribution of birth outcomes (birth weight, gestational age, and mortality) differs from the distributions for singletons. The resulting analysis database includes 602,312 births with 3,654 linked deaths (795 SUID).

Table 4. Five-Year Singleton Birth Death Categories by Year of Birth						
	Five-Year Singleton Birth Death Categories by Year of Birth					
Death Category	2019	2020	2021	2022	2023	5-Yr Cohort
Medical	585	502	511	565	569	2,732
Other	25	26	32	22	22	127
SUID	148	155	156	186	150	795
Survive	120,998	117,565	119,119	120,817	120,159	598,658
Singleton Birth Totals	**121,756**	**118,248**	**119,818**	**121,590**	**120,900**	**602,312**

The linked birth-death file allows the analysis of individual-level data to calculate and compare SUID rates associated with birth variables. For example, the SUID risk for a low birth weight (LBW) infant (birth weight is reported in the birth certificate) can be compared to the risk for a normal birth weight (NBW) infant. A low birth weight infant is three times more likely to suffer a SUID than a normal (2500+gram) infant. (See following table)

Table 5. Birth weight/SUID Association, 2019-2023 GA Singleton Cohort			
Birth weight / SUID Association, 2019-2023 GA Singleton Birth Cohort			
Birth weight (grams)	Births	SUID	SUID Rate (/1000)
< 500	982	6	6.1
500 to 1499	7,701	39	5.1
1500 to 2499	42,127	129	3.1
2500+	551,502	621	1.1
Totals	602,312	795	1.3
LBW Subtotal (<2500)	50,810	174	3.4

Race and ethnicity are documented risk factors for low birth weight infants (Black/White LBW relative risk = 2.2), so the LBW/SUID association should be stratified by race/ethnicity. The Black, African American infant is at a higher risk for SUID for both weight categories, but the SUID relative risk associated with birth weight decreases for Black, A-A.

Table 6. SUID Rates (Deaths per 1,000 Births)			
SUID Rate (Deaths per 1,000 Births) (2019-2023 GA Singleton Birth Cohort)			
	Birth weight Category (grams)		LBW / NBW
	< 2500	2500+	Relative Risk
Non-Hispanic			
White	3.3	1.0	3.3
Black, African-American	4.1	1.8	2.4

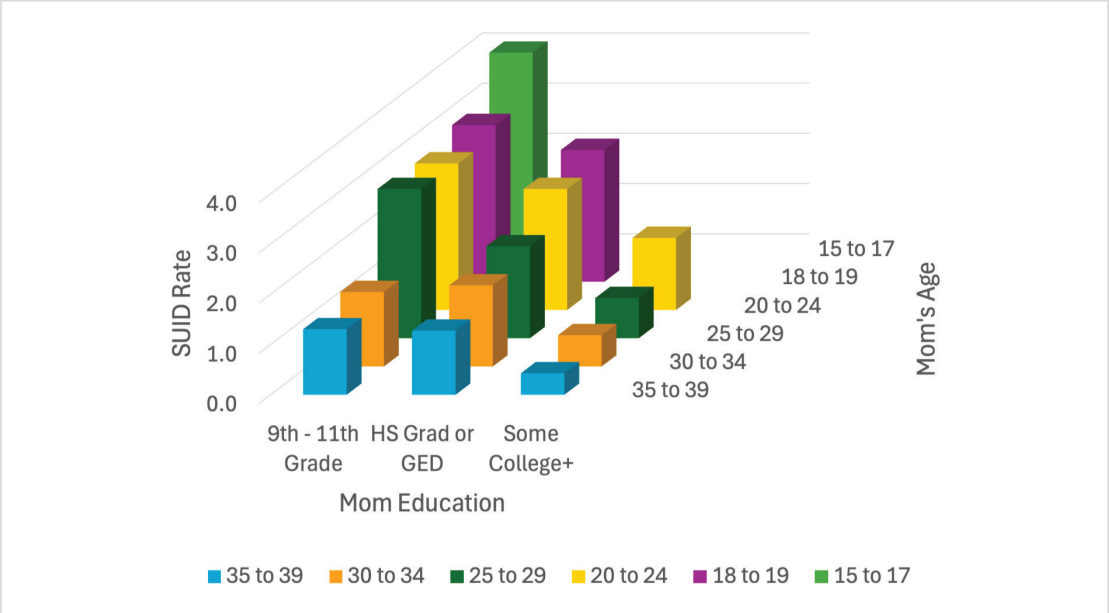
Birth interval (time between sequential live births) is associated with birth outcomes, so the association between birth interval and SUID was examined. Infants born with less than a two-year interval since the last live birth were twice as likely to have a SUID as an infant with more than a two-year interval. An infant with no prior sibling had the lowest risk. Similar two-fold relative risks occurred for both White and Black infants.

Table 7. SUID Risk by Birth Interval, Singleton Birth Cohort, 2020-2023			
SUID Risk by Birth Interval, Singleton Birth Cohort, 2020 - 2023			
	Birth Interval (Yrs)		
	< 2	No PLB*	2+
SUID	190	190	267
All Births	72,363	199,027	209,166
SUID Risk	2.6	1.0	1.3

PLB* No previous live birth (1st birth)

The mother's age and educational level provide a demographic/socio-economic combination that has an association with SUID. Younger age is associated with higher SUID rates, and higher education relates to lower SUID rates. The two variables are related, and the following figure illustrates their interaction.

Figure 5. SUID Rate by Mother's Age and Education Level



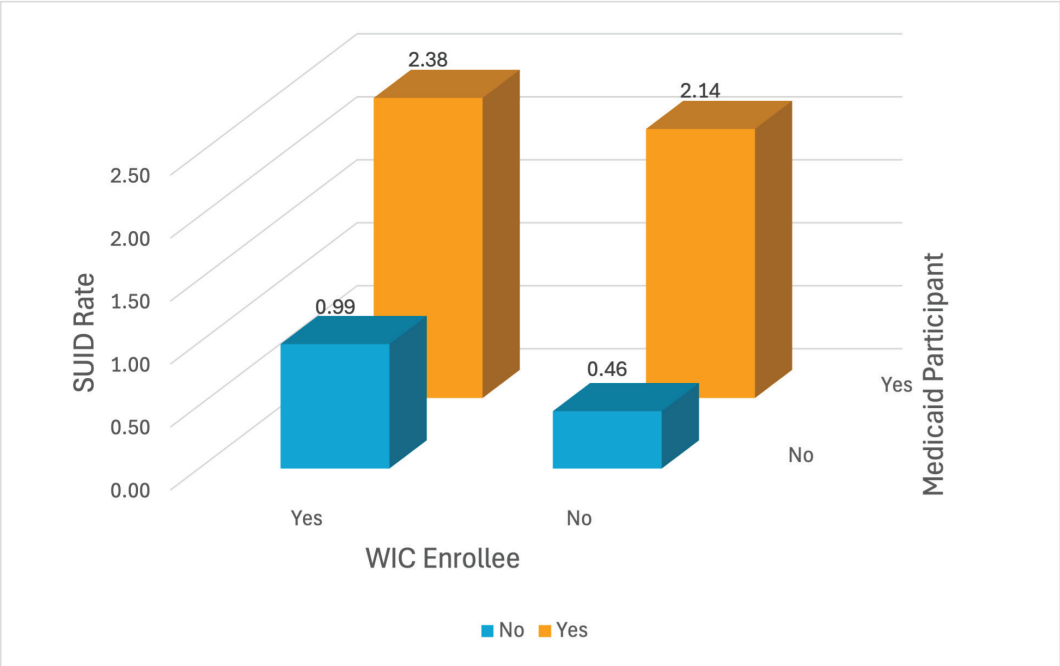
The role of socio-economic variables in influencing birth outcomes is recognized but not well understood. The birth certificate has two variables – WIC participation by the mother and Medicaid funding for the prenatal care and birth – that can serve to indicate lower income status. The following table summarizes the associations between these two variables and SUID in the singleton birth cohort. The SUID mortality rate for infants with reported Medicaid funding for their birth was 2.26 deaths per 1,000 live births (singleton births, 2019–2023). That rate is over four times the rate for infants with births covered by private insurance (0.47 deaths per 1,000 live births). WIC participation during pregnancy also carries an increased risk, but the association is not as strong as with Medicaid (approximately a two-fold increase).

Table 8. Insurance Coverage and WIC Participation, GA Singleton Births, 2019-2023				
Insurance Coverage and WIC Participation, GA Singleton Births, 2019 - 2023				
			SUID	
Insurance Payor	Births	Percent	Count	Rate*
Medicaid	277,196	46.1	626	2.26
Private Insurance	245,761	40.9	115	0.47
Self-Pay	40,096	6.7	20	0.50
All Other	38,362	6.4	31	0.81
“Known” Subtotal	601,415			
Unknown	767		3	
Missing	130		0	
WIC Participation				
Unknown	5,239		11	
Non-Participant	420,348	70.4	418	0.99
WIC Enrollee	176,725	29.6	366	2.07
“Known” Subtotal	597,073			
Payor/WIC Composit				
Medicaid and WIC	137,236	22.8	327	2.38
Medicaid Only	139,960	23.2	299	2.14
WIC Only	39,489	6.6	39	0.99
Neither	285,627	47.4	130	0.46
Total	602,312			

Rate* SUID per 1,000 Singleton Births

Medicaid and WIC participation appear to identify a population at elevated risk for SUID, not because of the insurance type itself, but because Medicaid enrollment often reflects underlying socioeconomic and structural factors that influence infant sleep safety. Families enrolled in Medicaid are more likely to experience conditions such as housing instability, crowded sleep environments, inconsistent access to prenatal and postpartum care, and limited availability of safe sleep equipment. These challenges can increase the likelihood of unsafe sleep practices and reduce opportunities for ongoing reinforcement of safe sleep guidance. For this reason, the increased SUID risk associated with Medicaid coverage was a key consideration in the design of Georgia’s “Safe to Sleep” hospital-based program (2016-2018), including the provision of portable bassinets to Medicaid-enrolled birthing parents. Using Medicaid enrollment as a marker helps ensure that prevention resources are directed to families facing the greatest structural barriers to safe sleep.

Figure 6. SUID Risks by Medicaid and WIC Status



GA Child Fatality Review SUID/Sleep-Related Deaths

The SUIDs defined by the death certificate ICD-10 coding are referred to the county Child Fatality Review (CFR) teams, and 83% of these deaths (2012–2023) were reviewed by the CFR teams. (Only 63% were reviewed in 2023.) The review process provides additional data on the decedent, their family, and the circumstances associated with the death. This additional data can be used to describe risks that may be related to the death. CFR teams may determine that a SUID according to the death certificate (DC) has another cause or determine that a non-SUID death (DC) should be considered a SUID. The table following provides the definitions for the CDR sleep-related death categories. The variable definitions are in Appendix C.

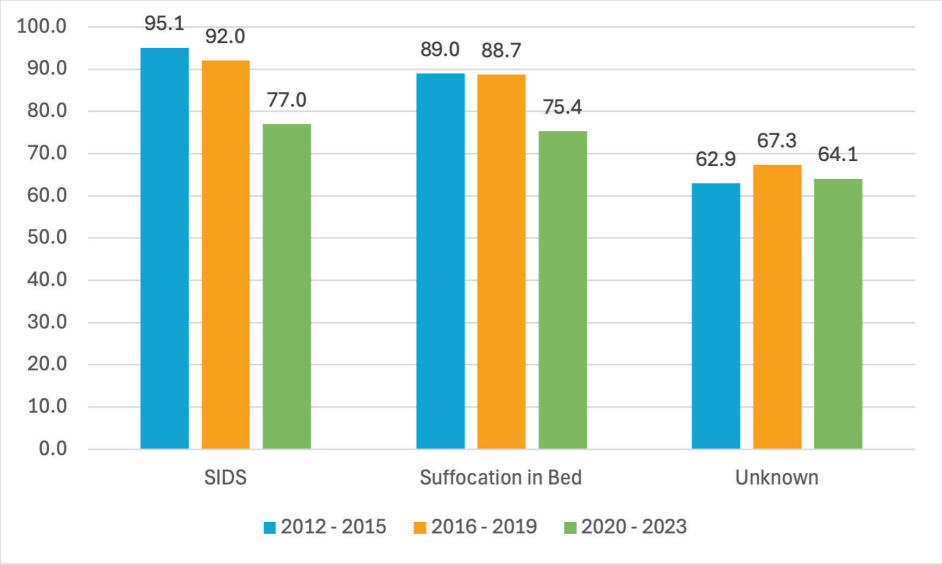
Table 9. Child Death Review Sudden Unexpected Infant Death (SUID) Classification

Child Death Review Sudden Unexpected Infant Death (SUID) Classification						
	Relevant Variables					
SUID Category	**CAUcausedth**	**CAUmanner**	**CAUextinjury**	**CAUmedcond**	**CIRdeath sleepenv**	**Age (yrs)**
SUID_Asphyxia	External cause	Accident	Unintentional asphyxia		1 = Yes	0
SUID_Undetermined	Undetermined	Undetermined			1 = Yes	0
SIDS	Medical	Natural		SIDS		0
SUID_ Medical	Medical	Natural			1 = Yes	0

Note: CDR variable descriptions are provided in Appendix

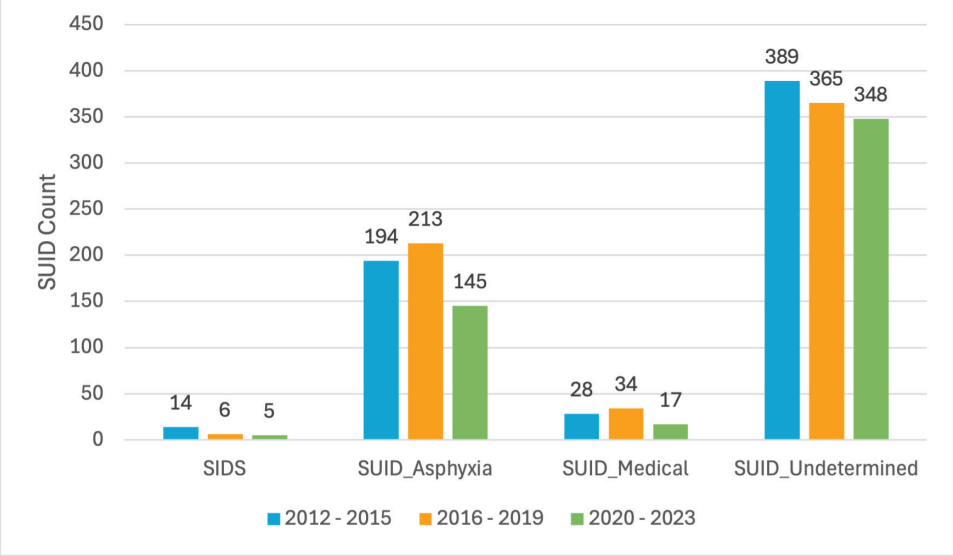
Deaths coded as SIDS or Suffocation in Bed show a lower proportion reviewed for Suffocation in Bed, and both categories show a drop in proportion reviewed for 2020–2023 (which includes the COVID-19 years). The deaths identified as Unknown have a lower proportion that is reviewed across all three time periods. There has been an increase in the number of infant deaths with an unknown (R99) cause of death over the past three years (average of 49 per year) compared to an average of 24 over the prior nine years.

Figure 7. Percent of Death Certificate of SUIDs Reviewed by Category and Four-Year Period



There was a significant drop in the number of sleep-related deaths reviewed in 2023 (73) compared to the average count for the prior 11 years (153).

Figure 8.CFR Sleep-Related Deaths, by SUID Category, by Four-Year Period

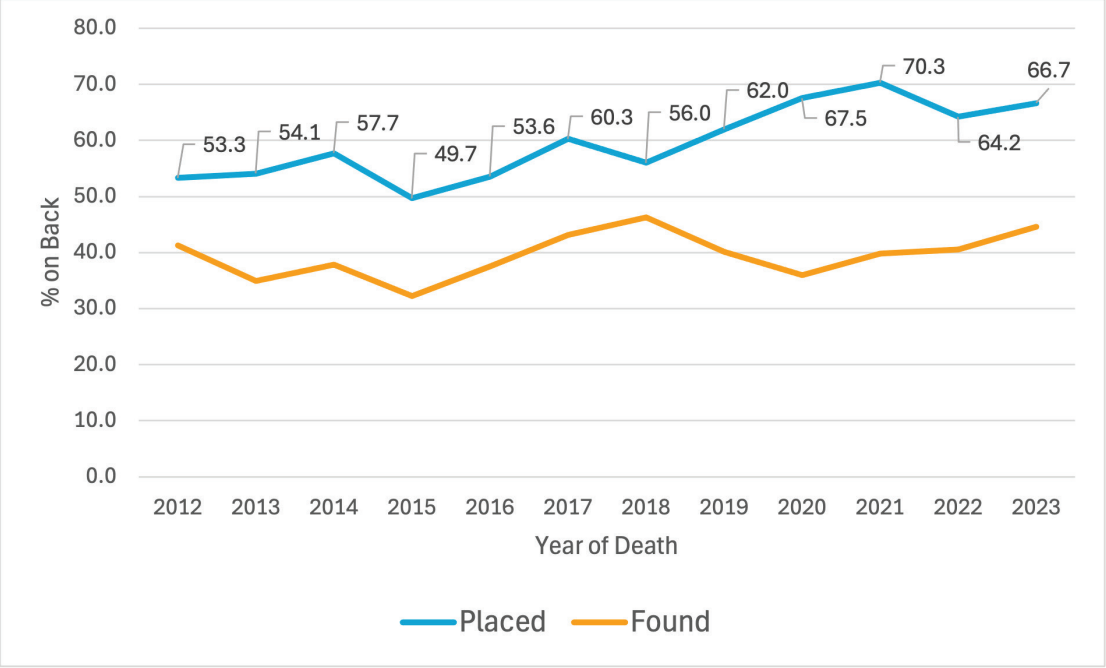


The CFR review process attempts to capture data from a death scene investigation and review of documentation on the decedent's life history and involvement with relevant agencies. A persistent area of concern for SUID has been the infant's sleep environment, and the following discussion addresses bed/surface sharing, sleep position, sleep surface, and items in the bed (on the sleep surface). These are factors associated with asphyxia deaths, and they appear in the "SUID_Undetermined" category as well as the "SUID_Asphyxia".

More than thirty years ago, in 1994, the NICHD launched the "Back to Sleep" campaign in response to the 1992 release of the American Academy of Pediatrics (AAP) recommendations for safe infant sleep. The AAP recommended a supine infant sleep position because the prone sleep position was associated with SIDS. The campaign yielded an initial sharp reduction in SIDS, but the decrease did not continue, and the SIDS/SUID rates have remained steady, with year-to-year fluctuations. (https://www.cdc.gov/sudden-infant-death/data-research/data/sids-deaths-by-cause.html) In 2011, NICHD rebranded the campaign to "Safe to Sleep" to reflect the updated and expanded AAP recommendations, which were meant to address the increases in suffocation and strangulation in bed deaths.

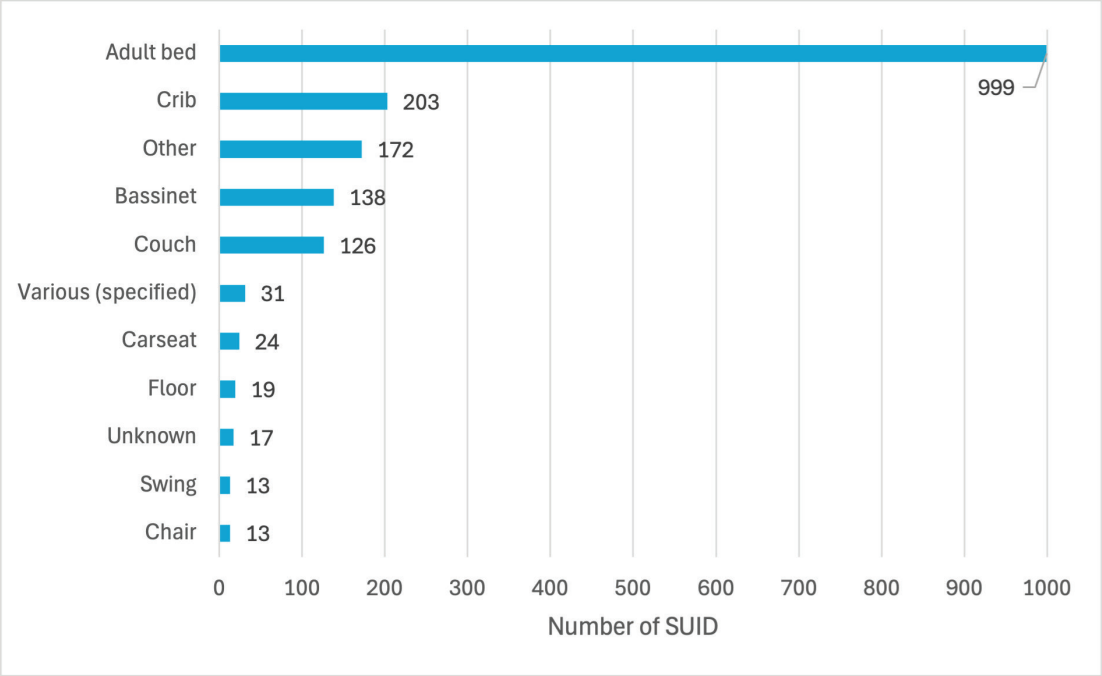
The average reported proportion of SUID infants placed to sleep on their back has increased over the last 12 years from 53.7% (201 –2016) to 66.2% (2019–2023). The proportion reported as found on their back has increased slightly (37% to 40%).

Figure 9. Sleep Location on Back by Year of Death



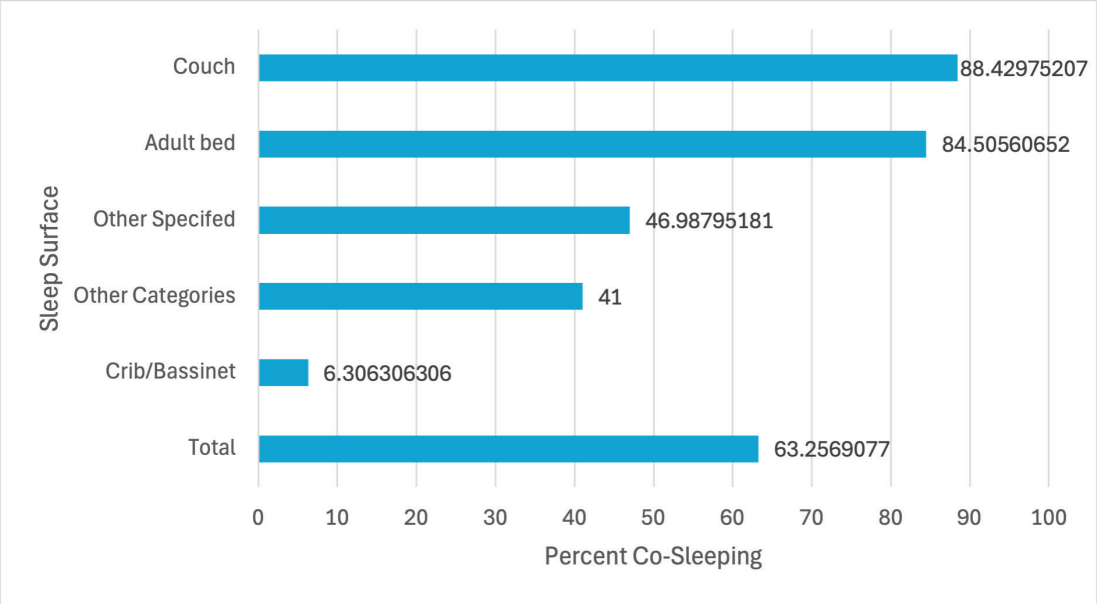
The most common reported sleeping surface for SUID infants is an adult bed (999 out of 1755). A crib or bassinet - the recommended surface - was only reported for 341 SUID. The "Other" category with 172 SUID includes sleep surfaces that could be recoded to existing categories or added as new categories (52 of the 172 specified playpen/other). Further analysis could use the specified sleeping place and the death narrative for recoding. Sleeping on an adult bed is a SUID risk factor, but we do not know for certain what proportion of all infants sleep on that surface. Research consistently demonstrates that while a portion of families intentionally bed/surface share, unintentional or occasional bed-sharing is frequent. The AAP confirms that infants who sleep in a separate room, e.g., nursery, are 2.75 to 11.5 times more likely to die suddenly and unexpectedly than infants who are room-sharing and on a separate sleep space (without bed-sharing). Additionally, when all circumstances are included in meta-analyses, the risk of SUID when bed/surface sharing is almost 3 times higher than room-sharing without bed-sharing. When considering certain circumstances, such as parent smoking, infants under 4 months of age, loose bedding, etc., this risk can increase by 10 times (American Academy of Pediatrics, 2022)

Figure 10. Sleeping Place, SUID, 2012-2023



Sleeping surface and position may be secondary risks when compared to the presence of people, animals, and other objects. The CDR form has a section regarding "Objects in child's sleep environment..." which includes separate responses for "Adult(s)", "Child(ren)", and "Animal(s)". The following question asks, "Child sleeping on same surface with person(s) or animal(s)?" and has the three separate responses. These two variables usually agree, but there are some inconsistencies. The following results on co-sleeping are based on the shared surface variables. A total of 1,125 SUID were reported as sleeping on an adult bed or couch, and over 85% (of the 1,125) were reported as co-sleeping.

Figure 11. Percent of SUID Co-Sleeping, by Sleep Surface



Over 53% of SUID (936) were infants co-sleeping on an adult bed or couch; 22%(333) were infants sleeping in a crib or bassinet; and only 6% of those were reported as co-sleeping, generally with another child.

Table 10. Co-Sleeping on Adult Bed

	4-Year Intervals		
Shared Surface	2012 - 2015	2016 - 2019	2020 - 2023
Yes	268	288	273
No	64	52	36
Unknown	8	4	6
Total (on Adult Bed)	340	344	315
All Deaths	623	618	514
% Sharing Adult Bed	**43.0**	**46.6**	**53.1**

The proportion of SUID reported as sharing an adult bed has increased over the past 12 years.

In addition to the suspected co-sleeping risk, the presence of soft bedding is considered a risk factor for infant asphyxia. The CDR data on the presence of soft items on the infant sleep surface indicates over 55% of SUID reported a comforter and/or pillow on the sleep surface. There is some variation among the GA health districts, but eleven of the 18 reported between 51 and 61% of SUID had a pillow and/or comforter on the sleep surface.

Table 11. Reviewed SUID, 2012 - 2023, Items on Sleep Surface by Health District					
	Presence of Comforter and/or Pillow on Sleep Surface				
Health District	Comforter	Pillow	Both	Neither	% Neither
Missing	1	5	5	15	
Clayton County Health District (Jonesboro)	14	10	30	45	45.5
Coastal Health District (Savannah)	25	18	23	44	40.0
Cobb/Douglas Health District	16	9	18	52	54.7
DeKalb Health District	20	12	34	56	45.9
District 4 Public Health	20	11	39	66	48.5
East Central Health District (Augusta)	31	9	41	50	38.2
Fulton Health District	32	16	45	60	39.2
Gwinnett, Newton and Rockdale	20	15	43	58	42.6
North Central Health District (Macon)	20	12	35	56	45.5
North Georgia Health District (Dalton)	5	3	11	15	44.1
North Health District (Gainesville)	12	15	47	20	21.3
Northeast Health District (Athens)	5	3	19	31	53.4
Northwest Health District (Rome)	13	9	42	42	39.6
South Central Health District (Dublin)	4	3	10	10	37.0
South Health District (Valdosta)	8	8	21	26	41.3
Southeast Health District (Waycross)	11	6	26	29	40.3
Southwest Health District (Albany)	12	4	16	54	62.8
West Central Health District (Columbus)	14	8	15	47	56.0
Totals	**283**	**176**	**520**	**776**	**44.2**

Prevention Recommendations

Analysis of the Child Fatality Review data highlights persistent gaps and missed opportunities in safe infant sleep education, reinforcement, and support across systems that interact with families during pregnancy, birth, and the postpartum period. While awareness exists of safe sleep recommendations, inconsistent messaging, uneven training expectations, and limited structural supports undermine prevention efforts. The following recommendations are informed by the SUID-specific findings presented above and emphasize the need for standardized, repeated, and developmentally appropriate education; cross-sector accountability; and policies that address both individual behaviors and the broader social and environmental factors influencing infant sleep practices.

Summary:

- Safe sleep education is delivered inconsistently across prenatal, hospital, and postpartum settings.
- Tobacco use is disproportionately represented in SUID cases.
- Families with fewer resources face structural barriers to creating a safe sleep environment.
- Postpartum health, caregiver fatigue, and mental health are under-addressed in prevention efforts.
- Public awareness of SUID remains limited.

Recommendations:

1. Standardize Safe Infant Sleep Training Across Systems

Establish standardized, evidence-based training requirements on safe infant sleep for healthcare professionals, home visitors, child welfare staff, public health employees, and other professionals who interact with expectant and new families. Training should include current recommendations, risk factors for SUID, culturally responsive communication strategies, and guidance on addressing caregiver fatigue and real-world barriers. Standardization ensures consistent messaging and reduces conflicting information provided to families.

2. Establish Clear Expectations for When Safe Sleep Education Occurs

Develop and implement policies that define when safe infant sleep education should be delivered across the perinatal continuum, including during prenatal care, hospital stays, pediatric visits, home visits, and other routine points of contact. Repeated exposure to consistent messaging for all caregivers is critical for reinforcing safe sleep practices. Leadership support is essential to ensure these expectations are integrated into workflows and sustained over time.

3. Integrate Tobacco Cessation Resources Throughout Pregnancy and Postpartum Care

Ensure that tobacco cessation screening, counseling, and referral to evidence-based cessation resources are provided early in pregnancy and reinforced throughout the prenatal and postpartum periods. Tobacco use is disproportionately represented in SUID cases, and sustained cessation support should be a core component of comprehensive prevention efforts.

4. Align Breastfeeding and Safe Sleep Messaging

Provide breastfeeding education alongside safe infant sleep guidance using mutually supportive, non-conflicting messaging. Policies should encourage providers to address both topics together, emphasizing strategies that support infant feeding goals while maintaining a safe sleep environment.

5. Expand Public Awareness Through Coordinated Media Efforts

Increase public awareness of SUID and safe infant sleep recommendations through coordinated media campaigns. Limited media coverage contributes to low public visibility of SUID as a preventable cause of infant death. Agencies should partner with media outlets to disseminate clear, consistent, and evidence-based messaging statewide.

6. Strengthen Access to Prenatal Education

Ensure access to affordable, high-quality prenatal education that helps parents understand infant developmental needs, normal sleep patterns, and safe sleep practices. Education should be accessible across geographic regions and tailored to meet the needs of diverse families, including those with limited resources.

7. Expand Access to Fourth-Trimester Education and Support

Promote access to fourth-trimester education and care that addresses the physical and emotional health needs of the birthing parent while supporting infant care. Policies should recognize the role of postpartum recovery, mental health, and fatigue in shaping infant sleep practices and incorporate these factors into safe sleep education.

8. Formalize and Promote Crib Distribution Programs

Formalize statewide or local crib distribution programs to ensure families with limited resources have access to a safe sleep environment. Crib distribution should be paired with education on safe infant sleep location, positioning, and environment. Clear referral pathways and promotion of program availability are needed to ensure eligible families are reached.

9. Leverage Data for Continuous Improvement and Accountability

Use Child Fatality Review and SUID data to inform ongoing policy decisions, identify missed opportunities for intervention, and provide feedback to healthcare systems and community partners. Regular dissemination of aggregate findings can support accountability, guide resource allocation, and strengthen prevention strategies over time.

History of Child Fatality Review in Georgia

Atlanta, GA - November 1, 1990 (JOEY IVANSCO/ The Atlanta Journal-Constitution staff)

1990–1992

- Legislation established the Statewide Child Fatality Review (CFR) Panel, charged with compiling child fatality statistics and making recommendations to the Governor and General Assembly.
- Local county protocol committees were created and directed to develop written protocols for investigating alleged child abuse and neglect.
- Statutory provisions outlined the Panel's responsibility to submit annual reports, emphasize abuse-related deaths, and review DFCS policies and practices related to child abuse cases.

1993–1995

- Statutory amendments strengthened the CFR framework by:
  - Requiring a child fatality review team in every county or jurisdiction.
  - Establishing standardized procedures for conducting reviews and completing reports.

1996–1998

- The Office of Child Fatality Review (OCFR) was established with a full-time director to administer Panel activities.
- Emory University and Georgia State University conducted an evaluation of the CFR process, identifying policy, procedural, and funding challenges and issuing recommendations to the General Assembly.
- Statutory amendments:
  - Defined required agency representation and penalties for non-participation.
  - Required all child deaths to be reported to the county coroner or medical examiner.

1999–2001

- Child Fatality Investigation Teams (CFIT) were piloted in four judicial circuits and later expanded to additional circuits.
- Statutory provisions governing CFR, child fatality review committees, and child abuse protocol committees were comprehensively rewritten for clarity and consistency.
- The Panel's budget was increased.

2002–2004

- A statewide Child Fatality Review Protocol Manual was developed and distributed to county committees.
- Statutory amendments:
  - Appointed District Attorneys as chairs of local CFR committees.
  - Authorized Superior Court judges to compel participation by mandated agencies.
  - Granted subpoena authority to the Panel.
  - Added the Director of the Department of Behavioral Health and Developmental Disabilities to the Panel.
- An online reporting system was established for CFR and coroner/medical examiner reports.
- Collaboration began with the National Center for Child Death Review (NCDR).
- The Georgia Child Fatality Investigation Program was launched in partnership with OCFR, DFCS, and GBI.
- The first Prevention Readiness Assessment was conducted.
- A Statewide Model Child Abuse Protocol was developed.

2005–2007

- CFR committee protocols were revised to reflect best practices and made available statewide.
- The Panel's Prevention Subcommittee completed the Statewide Child Fatality Prevention Framework.
- Annual awards were established to recognize excellence in death investigation and CFR committee performance.
- CFIT expanded to include multidisciplinary investigations of all forms of child abuse.
- A Prevention Specialist position was added to support local prevention efforts.

2008–2010

- The Office of Child Fatality Review merged with the Office of the Child Advocate.
- Georgia adopted the national CDR online reporting system, enabling standardized data collection.
- Georgia was selected as one of five states to participate in a CDC pilot project to improve investigation and reporting of sudden unexpected infant deaths.
- The CFIT program expanded to include a child abuse investigation training academy.

2011–2013

- A second Prevention Readiness Assessment was conducted.
- A CFR Panel subcommittee addressing infant sleep-related deaths was established.
- The Georgia Infant Safe Sleep Coalition (GISSC) was formed to support evidence-based prevention and implementation statewide.

2014–2016

- Senate Bill 365 transferred oversight of the CFR Panel to the Georgia Bureau of Investigation (GBI) and expanded the Panel's membership.
- GBI CFR launched a statewide sleep-related infant death prevention campaign, including a law-enforcement-driven educational video.
- GBI CFR received a CDC grant to establish the Sudden Death in the Young (SDY) Registry.
- CFR expanded prevention efforts related to firearm safety, distributing free cable locks statewide.

2017–2019

- CFR partnered with the Georgia Department of Education, Department of Public Health, and Children's Healthcare of Atlanta to launch a statewide youth suicide prevention campaign.
- Statewide maltreatment identification and reporting training was conducted for first responders and service providers.
- CFR transitioned to multi-year analytic reporting focused on priority topics, including sleep-related deaths, suicide, and drowning.
- Collaborative research initiatives were expanded with DPH, Georgia State University, and GBI to analyze sleep-related infant death risk factors.

2020–2022

- The COVID-19 pandemic disrupted CFR operations statewide, limiting review completion in some counties.
- Reporting of child deaths declined while overall mortality increased.
- CFR continued data sharing and multi-agency research commitments.
- Partnership with the National Center for Fatality Review and Prevention (NCFRP) launched the Drowning Death Scene Investigation Project, supporting standardized data collection.
- Prevention initiatives expanded across safe sleep, suicide awareness, fire safety, motor vehicle safety, and firearm safety.

2023–2025

- The CFR Panel conducted an internal process review and adopted a two-year reporting model to improve the timeliness, completeness, and accuracy of annual reports in response to increasing investigation complexity, workforce constraints, and population growth; annual reports will continue to be released each year and now include a supplemental in-depth analysis, with the initial focus on sleep-related infant deaths.
- The Georgia Bureau of Investigation (GBI) created a CFR Program Manager position within the GBI Medical Examiner's Office to strengthen program capacity and support statewide child fatality review operations.
- A mini-grant was approved to support a partnership between CFR, Emory University, and Morehouse College on the "Fathers Matter" project, a nine-month initiative focused on strengthening father engagement to reduce child maltreatment. CFR contributes data from child fatality review narratives and reports to assess father involvement in the child's life and in fatal incidents, supporting prevention-focused research.

Appendix A: The evolution of a SUID case definition

SIDS (Sudden Infant Death Syndrome): The term sudden infant death syndrome (SIDS) was first proposed in 1969 to focus attention on a subgroup of infants with similar clinical features whose deaths occurred unexpectedly in the postnatal period. Today, the definition of SIDS refers to death in a seemingly healthy infant younger than 1 year of age whose death remains unexplained after a thorough case investigation, including a complete autopsy, review of medical and clinical history, and death scene investigation. SIDS is typically associated with a sleep period, with death presumed to have occurred during sleep itself or in the transition between sleep and waking. The term SIDS was only accepted as an official diagnosis on death certificates in 1971, with the term "Sudden Infant Death" being allocated a separate code (coding number 798.0) in the World Health Organization's International Classification of Diseases (ICD) in 1979. (Duncan and Byard 2018)

SUID (Sudden Unexpected Infant Death): From this larger group, the authors identified causes of death, which constituted most United States SUID cases (ICD 9/10 codes: SIDS (795.0/R95), unknown cause (799.9/R99), and accidental suffocation or strangulation in bed (E913/W75). In 2015, the CDC's National Center for Health Statistics (NCHS) recognized the value of grouping codes and began using these three codes to track SUID trends by cause of death more consistently. This same group of codes is used to define SUID for the United States Healthy People 2020 initiative, where SUID is among the health indicators measured. (Shapiro-Mendoza, Parks, and Lambert, 2018)

Sudden Unexpected Infant Death is the sudden and unexpected death of a baby aged younger than 1 year. For these deaths, there is no apparent cause before investigation. SUID cases often happen during sleep or in the baby's sleep area. (CDC, 2024)

State SUID Data: The state SUID data come from the following sources: the Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics (NCHS), the National Vital Statistics System, and the Mortality Files. The rates are calculated via CDC WONDER.

A "WONDER" generated map shows SUID rates by state for 2018–2022 years combined. Rates varied by state from 2018 to 2022 among the 50 states and the District of Columbia. From 2018 to 2022, 23 states or jurisdictions had rates above the U.S. average (94.8 per 100,000 live births). The GA rate for the five years was 137.4

Relevant Dates:

1969: The term Sudden Infant Death Syndrome (SIDS) was first proposed.

1971: The term SIDS was accepted as an official diagnosis on death certificates (ICD-9 = 798.0).

1988: Medical societies in the Netherlands begin recommending against babies sleeping on their stomachs to help reduce SIDS risk.

1994: The National Institute of Child and Human Development (NICHD) launches the Back to Sleep campaign with several collaborating groups.

1999: ICD-10 (SIDS = R95)

It's important to note that in ICD–9, SIDS was treated as an ill-defined condition and ignored in the presence of other better-defined conditions. In ICD–10, SIDS is not considered to be ill-defined. (Anderson, Miniño, Hoyert, and Rosenberg, 2001)

2005: The American Academy of Pediatrics (AAP) Task Force on SIDS revises its policy statement about ways to reduce the risk of SIDS. The new recommendations reinforce exclusive use of the back sleep position for every sleep, a firm sleep surface with no loose bedding or blankets, and a separate sleep area for the baby. The recommendations also warn against letting the baby get too warm during sleep and suggest that using a pacifier can reduce the risk of SIDS.

2012: The NICHD and its collaborators launch Safe to Sleep®, an expansion of the Back to Sleep campaign that addresses safe sleep environments, as well as back sleeping.

2015: Researchers reviewed the vital statistics data to create a grouping of codes to more consistently track trends in SUID in the United States. The ICD-9/10 codes that were selected are listed below:

- SIDS (795.0/R95)
- Unknown cause (799.9/R99)
- Accidental suffocation or strangulation in bed (E913/W75)

This same group of codes is used to define SUID for the United States Healthy People 2020 initiative, where SUID is among the health indicators measured. (Shapiro-Mendoza, Parks, and Lambert, 2018).

2016: The Georgia Department of Public Health launched the Georgia Safe to Sleep Hospital Initiative, providing hospitals with safe infant sleep information and educational materials to be distributed to families and newborns (Walcott, Salm Ward, Ingels, Llewellyn, Miller, Corso, and 2018).

References:

Anderson RN, Miniño AM, Hoyert DL, Rosenberg HM. Comparability of cause of death between ICD–9 and ICD–10: Preliminary estimates. National vital statistics reports; vol 49 no. 2. Hyattsville, Maryland: National Center for Health Statistics. 2001

Center for Disease Control and Prevention. (2024, September 17). About SUID and SIDS. Sudden Unexpected Infant Death and Sudden Infant Death Syndrome. https://www.cdc.gov/sudden-infant-death/about/index.html

Hunt, Carol E., et al. "Assigning Cause for Sudden Unexpected Infant Death." Forensic Science, Medicine, and Pathology, vol. 11, no. 2, 2015, pp. 283–288. Springer, https://doi.org/10.1007/s12024-014-9650-8.

Shapiro-Mendoza CK, Parks S, Lambert AE, et al. The Epidemiology of Sudden Infant Death Syndrome and Sudden Unexpected Infant Deaths: Diagnostic Shift and other Temporal Changes. In: Duncan JR, Byard RW, editors. SIDS Sudden Infant and Early Childhood Death: The Past, the Present and the Future. Adelaide (AU): University of Adelaide Press; 2018 May. Chapter 13. Available from: https://www.ncbi.nlm.nih.gov/books/NBK513373/

Sudden Infant Death Syndrome: An Overview. In: Duncan JR, Byard RW, editors. SIDS Sudden Infant and Early Childhood Death: The Past, the Present and the Future. Adelaide (AU): University of Adelaide Press; 2018 May. Chapter 2. https://www.ncbi.nlm.nih.gov/books/NBK513399/#:~:text=Introduction,death%20scene%20investigation%20(2).

Walcott RL, Salm Ward TC, Ingels JB, Llewellyn NA, Miller TJ, Corso PS. A Statewide Hospital-Based Safe Infant Sleep Initiative: Measurement of Parental Knowledge and Behavior. J Community Health. 2018 Jun;43(3):534-542. doi: 10.1007/s10900-017-0449-x. PMID: 29188464; PMCID: PMC5919986.

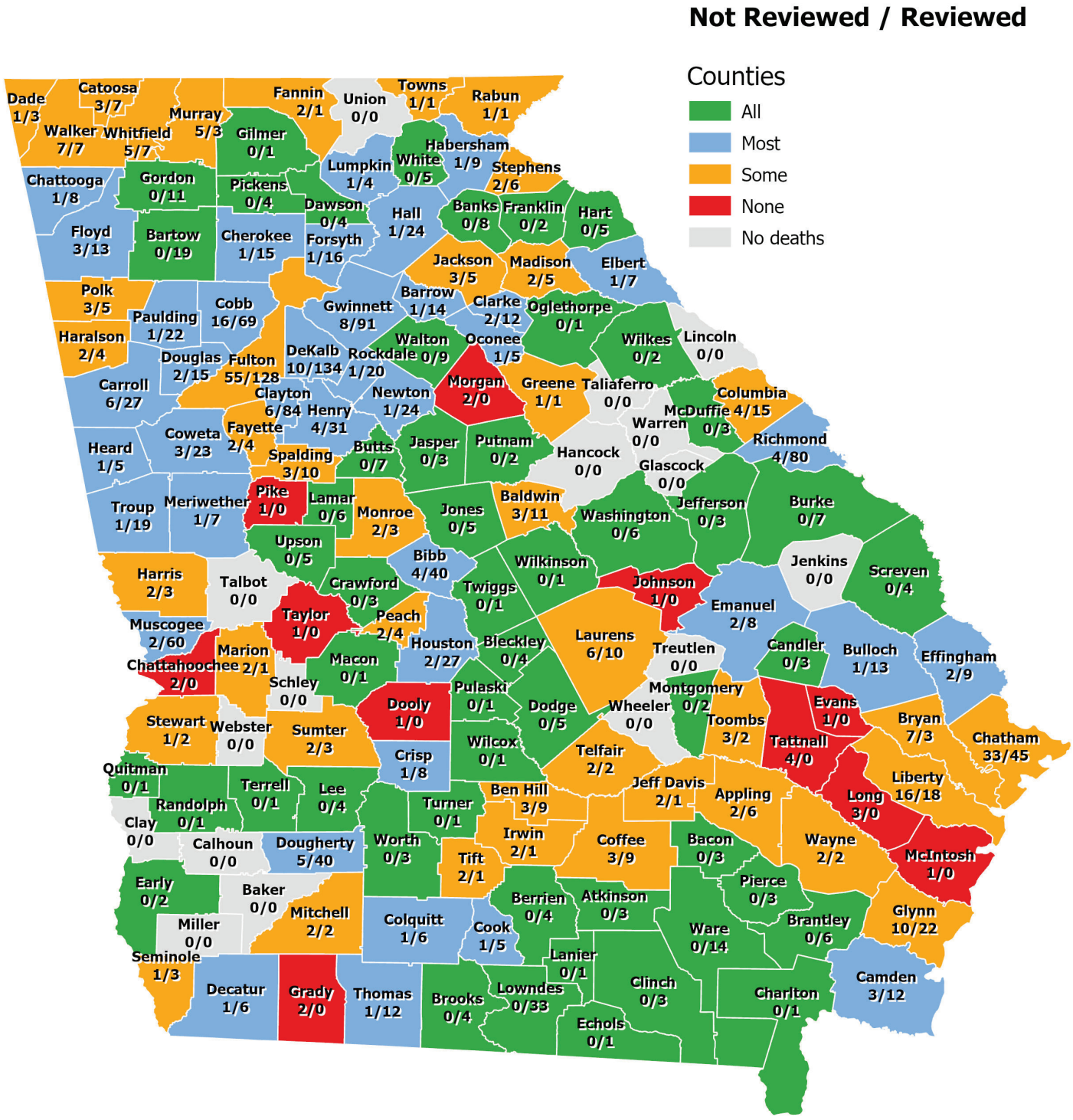
Appendix B. Distribution of SUID Reviews

There were 1,969 SUID deaths (death certificate) from 2012 through 2023. The CFR teams reported 1,633 of those deaths (82.8%).

Review Summary, 2012-2023 Georgia SUID					
Category	**Description**	**# Counties**	**# Deaths**	**Not Reviewed**	
All	All Reviewable Deaths Reviewed	52	233		
Most	80 to 99% Reviewed	39	1,129	105	
Some	30 to 79% Reviewed	41	588	212	
None	No Reviewed Deaths	11	19	19	
No Deaths	No Reviewable Deaths	16			
					% Reviewed
	Totals	159	1,969	336	82.9

The following map displays the 12-year review results for the counties. Fifty-two county review teams reviewed all the reported SUID deaths of infants residing in the county that occurred during the twelve-years. These 52 counties averaged less than five SUID over the 12 years. The numbers on the counties in the map indicate the number of SUID “Not Reviewed” and the number “Reviewed”. For example, the Gwinnett label (8/91) indicates that eight SUID were not reviewed and ninety-one were reviewed. That placed Gwinnett in the “Most” category – color blue.

Review Status, 2012-2023



Appendix C. Definitions for Selected Child Death Review Variables

Child Death Review Variables Used in SUID Determination			
Variable Name	**Description**	**Categories**	
CAUcausedth	Primary cause of death	1 = From an external cause of injury	
		2 = From a medical condition	
		3 = Undetermined if injury or medical	
		9 = Unknown	
CAUmanner	Official manner of death from DC	1 = Natural	5 = Undetermined
		2 = Accident	6 = Pending
		3 = Suicide	9 = Unknown
		4 = Homicide	default to 0
CAUextinjury	From an injury cause	1 = Motor vehicle and other transport	7 = Fall or crush
		2 = Fire, burn, or electrocution	8 = Poisoning, overdose or acute intoxication
		3 = Drowning	10 = Undetermined
		4 = Asphyxia	11 = Other
		5 = Bodily force or weapon	99 = Unknown
CAUmedcond	From a medical cause	1 = Asthma/respiratory	10 = Pneumonia
		2 = Cancer	11 = Prematurity
		3 = Cardiovascular	12 = SIDS
		4 = Congenital anomaly	13 = Other infection
		5 = HIV/AIDS	14 = Other perinatal condition
		6 = Influenza	15 = Other medical condition
		7 = Low birth weight	16 = Undetermined medical cause
		8 = Malnutrition/dehydration	17 = Diabetes
		9 = Neurological/seizure disorder	18 = COVID-19
			99 = Unknown
CIRdeathsleepenv	Was the death related to sleeping or the sleep environment?	1 = Yes	
		2 = No	
		9 = Unknown	

Child Death Review Sudden Unexpected Infant Death (SUID) Classification						
	Relevant Variables					
SUID Category	CAUcausedth	CAUmanner	CAUextinjury	CAUmedcond	CIRdeathsleepenv	Age (yrs)
SUID_Asphyxia	External cause	Accident	Unintentional asphyxia		1 = Yes	0
SUID_Undetermined	Undetermined	Undetermined			1 = Yes	0
SIDS	Medical	Natural		SIDS		0
	Medical	Natural			1 = Yes	0

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 sudden unexpected infant deaths in Georgia between 2012 and 2023. 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:

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Child Fatality Review Unit

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ChildFatalityReview@gbi.ga.gov

https://dofs-gbi.georgia.gov/departments/medical-examiners-office/child-fatality-review-unit

Resources

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

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

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

Children 1st
https://www.p2pga.org/roadmap/diagnosis/children-at-risk/the-mission-of-children-1st/?gclid=EAIaIQobChMI4Lv31c2VgwMVngAGAB2TtwlrEAAYASAAEgLoj_D_BwE

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

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

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

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

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

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

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

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

OASIS (Online Analytical Statistical Information System) https://oasis.state.ga.us/

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

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

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

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

Georgia Child Fatality Review Annual Report

Supplemental Analysis: Sudden Unexpected Infant Deaths in Georgia

2012–2024