

# GEORGIA CHILD FATALITY REVIEW PANEL



Annual Report - Calendar Year 2013

LaTain Kell Panel Chairman, **Nathan Deal** Governor



JANUARY 2015





## THE CHILD FATALITY REVIEW PANEL MEMBERS

LaTain Kell, Panel Chairman – Judge, Cobb County Superior Court

Peggy Walker, Panel Vice-Chair – Judge, Douglas County Juvenile Court

Rep. Paul Battles – Georgia House of Representatives

Kathleen Bennett – Central Savannah River Area Economic Opportunity  
Authority Head Start Program

Dr. Frank Berry – Commissioner, Department of Behavioral Health and  
Developmental Disabilities

Sen. Gloria Butler – Georgia State Senate

Dr. Brenda Fitzgerald – Commissioner, Department of Public Health

Robertiena Fletcher – Board Chairperson, Department of Human Services

Charles Fuller – Chairperson, Criminal Justice Coordinating Council

Bobby Cagle – Director, Department of Family and Children Services

Vernon Keenan – Director, Georgia Bureau of Investigation

Tiffany Sawyer – Prevention Director, Georgia Center for Child Advocacy

E.K. May – Coroner, Washington County

Paula Sparks – SafePath Children's Advocacy Center

Dr. Kris Sperry – Chief Medical Examiner, Georgia Bureau of Investigation

Ashley Willcott – Office of the Child Advocate

Ashley Wright – District Attorney, Augusta Judicial Circuit

Amy Jacobs – Commissioner, Department of Early Care and Learning

Vacant – Member, State Board of Education

## Mission / Acknowledgements

### Mission

The mission of the Georgia Child Fatality Review Panel is to provide the highest quality child fatality data, training, technical assistance, investigative support services, and resources to any entity dedicated to the well-being and safety of children in order to prevent and reduce incidents of child abuse and fatality in the state. This mission is accomplished by promoting more accurate identification and reporting of child fatalities, evaluating the prevalence and circumstances of both child abuse and child fatalities, and developing and monitoring the statewide child injury prevention plan.

### Acknowledgements

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., Epidemiology Department, Rollins School of Public Health, Emory University

We would also like to thank the 2013 Child Fatality Review Committee of the Year, the 2013 CFR Coroner of the Year, and the 2013 CFR Prevention Committee of the Year for their exceptional support and dedication to the children of Georgia:

- CFR Coroner of the Year: Buddy Bryan, Muscogee County
- CFR Committee of the Year: Cherokee County
- CFR Prevention Committee of the Year: Cherokee County

This report was developed and written by the staff members of the Child Fatality Review Unit within the Georgia Bureau of Investigation: SAC Trebor Randle, Arleymah Gray, Malaika Shakir, and Crystal Dixon.





**Chairperson:**

**Honorable LaTain Kell**  
Judge,  
Cobb County Superior Court

**Co-Chair:**

**Peggy Walker**  
Judge,  
Douglas County Juvenile Court

**Members:**

**EK May**  
Washington County Coroner

**Andrew Fuller**  
Board Chair  
Criminal Justice Coordinating Council

**Robertiena Fletcher**  
Board Chair  
Georgia Dept. of Human Services

**Kathleen Bennett**  
Disabilities and Mental Health Specialist  
CSRAEO Head Start

**Paul Battles**  
Member, Georgia House of  
Representatives

**Vernon M. Keenan**  
Director  
Georgia Bureau of Investigation

**Bobby Cagle**  
Division of  
Family & Children Services

**Frank Berry**  
Commissioner, Department of Behavioral  
Health and Developmental Disabilities

**Ashley Wright, J.D.**  
District Attorney  
Augusta Judicial Circuit

**Ashley Willcott, J.D.**  
Child Advocate for the  
Protection of Children

**Kris Sperry, M.D.**  
Chief Medical Examiner  
Georgia Bureau of Investigation

**Gloria Butler**  
Member, Georgia Senate

**Brenda Fitzgerald, M.D.**  
Commissioner  
Department of Public Health

**Tiffany Sawyer**  
Director of Prevention Services  
Georgia Center for Child Advocacy

**Paula Sparks**  
County Law Enforcement

**Amy Jacobs**  
Commissioner, Department of Early  
Care and Learning

## **Georgia Child Fatality Review Panel**

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

It is my sincere honor to present to you the Georgia Child Fatality Review Panel's 2013 Annual Report. This report summarizes the analyses of child deaths occurring in Georgia conducted by the Panel during 2013.

In the wake of legislation moving the administrative oversight of the Panel and its staff to the Georgia Bureau of Investigation, the investigative and analytical capabilities of the Panel continue to be enhanced. Cooperation of the various agencies gathering data concerning child deaths and prevention also improved this year, increasing the quality of the information the Panel has reviewed.

The data compiled from each of the 159 local review panels across Georgia continues to be the central tool used by the Panel to focus resources and efforts to prevent child deaths. As you will see from the Annual Report, new and better data regarding child fatalities in Georgia continue to be the emphasis of the Panel in order to carry out its statutory duties.

Significant areas of concern are highlighted in this report, along with specific recommendations for addressing many of these concerns. These issues include the high incidence of sleep-related deaths for infants in Georgia, the disproportionate number of motor vehicle related deaths of children over age nine, the increases in maltreatment, motor vehicle and fire-related deaths and the continuing problem of teen suicides. Special emphasis will be devoted to these areas again in the coming year. We hope that you will consider carefully each of the critical areas outlined in the Panel's recommendations.

The Panel continues to refine the scope of data gathered from agencies and local panels in an effort to develop prevention programs, legislation and other recommendations for action.

I would like to extend my special thanks to Special Agent in Charge Trebor Randle, and staff members Arleymah Gray, Malaika Shakir and Crystal Dixon for their extraordinary efforts in organizing the Child Fatality Review Unit within the Georgia Bureau of Investigation and making this Annual Report possible. I would also like to acknowledge the efforts of Dr. John Carter for his exemplary assistance in this report.

We appreciate your continued assistance in preventing and reducing child fatalities in Georgia. Your support is critical in accomplishing the goals and objectives highlighted in this report. The Panel and I thank you for all that you continue to do for the children of Georgia.

Sincerely,

Judge Tain Kell, Chair

3121 Panthersville Rd. • Decatur, GA 30034  
(404) 270-8715 office • (404) 270-8720 fax





## Table of Contents

Background of Child Fatality Review in Georgia	6
Important Findings	10
All Reviewed	11
Disparities in Reviewed Deaths	15
Prevention and Preventability	17
Agency Involvement	23
Maltreatment-Related Deaths	25
Sleep-Related Infant Deaths	30
Reviewed Medical Deaths	41
All Unintentional Reviewed Deaths	45
Motor Vehicle-Related Deaths	48
Drowning Deaths	59
Asphyxia Deaths	65
Fire-Related Deaths	67
Homicide Deaths	70
Suicide Deaths	75
Appendices	81

# Background of Child Fatality Review in Georgia

## Background and History

The child fatality review process was initiated in Georgia in 1990 as an amendment to an existing statute for child abuse protocol committees. The legislation provided that each county child abuse protocol committee establish a subcommittee to systematically and collaboratively review child deaths that were sudden, unexpected, and/or unexplained, among children younger than 18 years of age.

Georgia Code section (O.C.G.A.) 19-15-1 through 6 has been amended over the years, adding even more structure, definition, and members to the process. Members now form a stand-alone committee instead of a subcommittee, which has added emphasis to the importance of the function. The Child Fatality Review committees became a statewide, multidisciplinary, multi-agency effort to prevent child deaths. Through the State Panel and the work of the local committees, we have the opportunity to convert tragedy into hope. Agencies and organizations working together at the state and local levels offer the greatest potential for effective prevention and intervention strategies.

The purpose of these reviews is to describe trends and patterns of child deaths in Georgia and to identify prevention strategies. As mandated in statute, this report identifies specific policy recommendations to reduce child deaths in Georgia.

The members of the Georgia Child Fatality Review Panel are experts in the fields of child abuse prevention, mental health, family law, death investigation, and injury prevention. The variety of disciplines involved and the depth of expertise provided by the State Review Panel results in comprehensive prevention recommendations, allowing for a broad analysis of both contributory and preventive factors of child deaths.

## The History Of Child Fatality Review In Georgia

### 1990 - 1993

- Legislation established the Statewide Child Fatality Review Panel with responsibilities for compiling statistics on child fatalities and making recommendations to the Governor and General Assembly based on the data. It established local county protocol committees and directed that they develop county-based written protocols for the investigation of alleged child abuse and neglect cases. Statutory amendments were adapted to:
  - Establish a separate child fatality review team in each county and determine procedures for conducting reviews and completing reports
  - Require the Panel to:
    - Submit an annual report documenting the prevalence and circumstances of all child fatalities with special emphasis on deaths associated with child abuse
    - Recommend measures to reduce child fatalities to the Governor, the Lieutenant Governor, and the Speaker of the Georgia House of Representatives
    - Establish a protocol for the review of policies, procedures and operations of the Division of Family and Children Services for child abuse cases



# Background of Child Fatality Review in Georgia

## 1996 - 1998

- The Panel established the Office of Child Fatality Review with a full-time director to administer the activities of the Panel
- Researchers from Emory University and Georgia State University conducted an evaluation of the child fatality review process. The evaluation concluded that there were policy, procedure and funding issues that limited the effectiveness of the review process. Recommendations for improvement were made to the General Assembly
- Statutory amendments were adopted to:
  - Identify agencies required to be represented on child fatality review teams, and establish penalties for nonparticipation
  - Require that all child deaths be reported to the coroner/medical examiner in each county

## 1999 - 2001

- Child death investigation teams were initially developed in four judicial circuits as a pilot project, with six additional teams later added. Teams assumed responsibility for conducting death scene investigations of child deaths that met established criteria within their judicial circuit
- Statutory amendments were adopted which resulted in the Code section governing the Child Fatality Review Panel, child fatality review committees, and child abuse protocol committees being completely rewritten. This was an attempt to provide greater clarity and a more comprehensive, concise format
- The Panel's budget was increased

## 2002 - 2005

- The Panel published and distributed a child fatality review protocol manual to all county committee members
- Statutory amendments were adopted which resulted in the following:
  - Appointment of District Attorneys to serve as chairpersons of local committees in their circuits
  - Authority of the Superior Court Judge on the Panel to issue an order requiring the participation of mandated agencies on local child fatality review committees. Failure to comply would be cause for contempt
  - Authority of the Panel to compel the production of documents or the attendance of witnesses pursuant to a subpoena
  - Director of the Division of Mental Health added as a member of the Panel
- Funding was secured and an on-line reporting system was established for both the child fatality review report and the coroner/medical examiner report
- A collaboration was established between the Office of Child Fatality Review and the National Center for Child Death Review

## Background of Child Fatality Review in Georgia

- The Georgia Child Fatality Investigation Program was established through a partnership between OCFR, DFCS and the Georgia Bureau of Investigation. A director was hired to advance a multi-disciplinary approach to child death investigation through development and training of local teams.
- Conducted the first statewide Prevention Readiness Assessment, to evaluate resources and stakeholders available in counties to implement and sustain prevention efforts
- A Statewide Model Child Abuse Protocol was developed and distributed to all Protocol committee members
- A Prevention Advocate was added, by policy, to all child fatality review committees. Statewide training was conducted for all prevention advocate members
- A quarterly newsletter was created and distributed. The newsletter is sent to all child fatality review members and contains useful information about the process as well as prevention
- Annual awards were established for the Child Fatality Review Coroner of the Year and Child Fatality Review County Committee of the Year. Awards are presented at the annual Child Fatality and Serious Injury Conference sponsored by the Panel, DHR, GBI and the Office of the Child Advocate
- A sub-committee of the Panel was formed to begin working on a Statewide Prevention Plan. The sub-committee also includes outside agencies working in the prevention field

### **2006 - 2008**

- The Child Fatality Review committee protocol was revised and updated to reflect best practices
- The Protocol was presented to all county committee members and is also available online
- The Panel subcommittee on prevention completed the Statewide Child Fatality Prevention Framework. The Framework was presented to the Governor's Office and other agency partners
- An annual award was established for the Outstanding Investigator/Team of the Year for death investigation cases
- The CFIT Program expanded to address all types of multi-disciplinary child abuse investigations, including sex abuse, physical abuse and neglect as well as homicides
- The Panel added a Prevention Specialist staff position to assist the local efforts in child fatality prevention
- Annual CFR Coroner of the Year and CFR Committee of the Year winners were recognized by the Georgia Senate honoring their work
- The Office of Child Fatality Review merged with the Office of the Child Advocate for the Protection of Children



# Background of Child Fatality Review in Georgia

## 2009 - 2013

- Adopted National Center for Child Death Review online reporting form for all child deaths, allowing Georgia child death data to be captured on a nationally standardized surveillance tool
- Included as one of five states to participate in three-year CDC pilot project to improve investigation, review and reporting of sudden and unexpected infant deaths
- Expanded CFIT program to include a child abuse investigation training academy
- Continued involvement with the Southeast Coalition on Child Fatalities, providing support to other CFR programs within the southeastern states
- Conducted second Prevention Readiness Assessment of counties, to determine the local resources and stakeholders available to implement and sustain prevention efforts
- Created and maintained a CFR Panel subcommittee to address infant sleep-related deaths; the Georgia Infant Safe Sleep Coalition (GISSC) serves as a strong resource for state and local partners, providing evidence-based best practice for prevention and implementation assistance

## How To Read This Report

Throughout this report, you will find INFOGRAPHICS. These images are placed within each topic section to support the data presented, and also to assist the reader in understanding the scope of the issue. Please feel free to print those infographics that are helpful to you and use them in presentations, trainings, or other venues where you can share information on the causes of deaths to children. While these infographics do not represent the specific data from reviewed Georgia child fatalities, Georgia CFR presents these materials as a helpful tool to the reader, and fully endorses the sources where these documents were created.

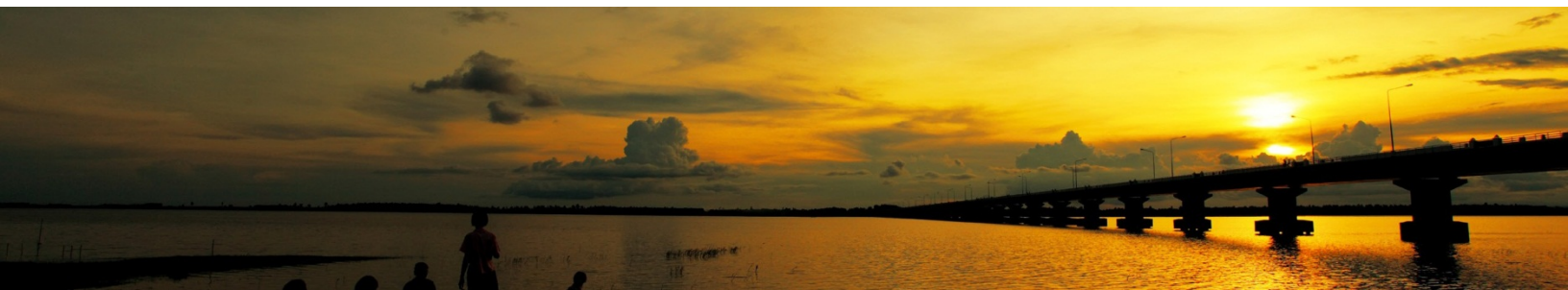


### Important Findings And Recommendations

- The infant mortality rate in Georgia continues to be higher than the national rate, and the rate for African-Americans continues to be higher than the state rate
- Sleep-related deaths continue to be the leading cause of death for infants in Georgia
- Motor vehicle crashes continue to be the leading cause of death for children over age one
- African-Americans continue to have higher incidence of deaths compared to other race/ethnic groups
- The number of deaths due to maltreatment, motor vehicles, and fire/burns has increased
- CFR committees reported that most reviewed deaths were preventable

The Child Fatality Review Panel determined that child fatalities can be reduced in Georgia if the following recommendations to policymakers are adopted and implemented:

1. Create a consistent and coordinated campaign regarding infant safe sleep to better align with the American Academy of Pediatrics safe sleep recommendations (*published online October 2011*)
2. Continue to enforce the Teenage and Adult Driver Responsibility Act (TADRA) to enhance young driver education and reduce risk associated with newly licensed drivers. Encourage parents and caregivers to model appropriate driving behavior – no texting, eating, applying makeup, or other distractions while operating a motor vehicle (<http://gahighwaysafety.org/highway-safety/tadra/>)
3. Increase funding for the Suicide Prevention Program to implement the following activities: 1) expand the program's statewide community grant program to more counties and at higher funding levels; 2) expand the implementation and evaluation of means restriction education training at hospitals statewide; and 3) expand implementation and evaluation of school-based suicide prevention programs that promote resilience and positive youth development as protective factors from suicide statewide (<http://dbhdd.georgia.gov/suicide-prevention>)
4. Require newly licensed K-12 educators and special service providers (nurses, school psychologists, school counselors and social workers) to complete suicide prevention trainings
5. Incorporate infant safe sleep education and how to address safety concerns related to infant safe sleep practices as part of the training and continuing education for child welfare professionals, early childhood education providers, health care providers, and home visitors
6. Support the activities of Safe Kids Georgia, and encourage development of Safe Kids coalitions in every county (<http://safekidsgeorgia.org/>)
7. Encourage availability of affordable childcare for all families in every community



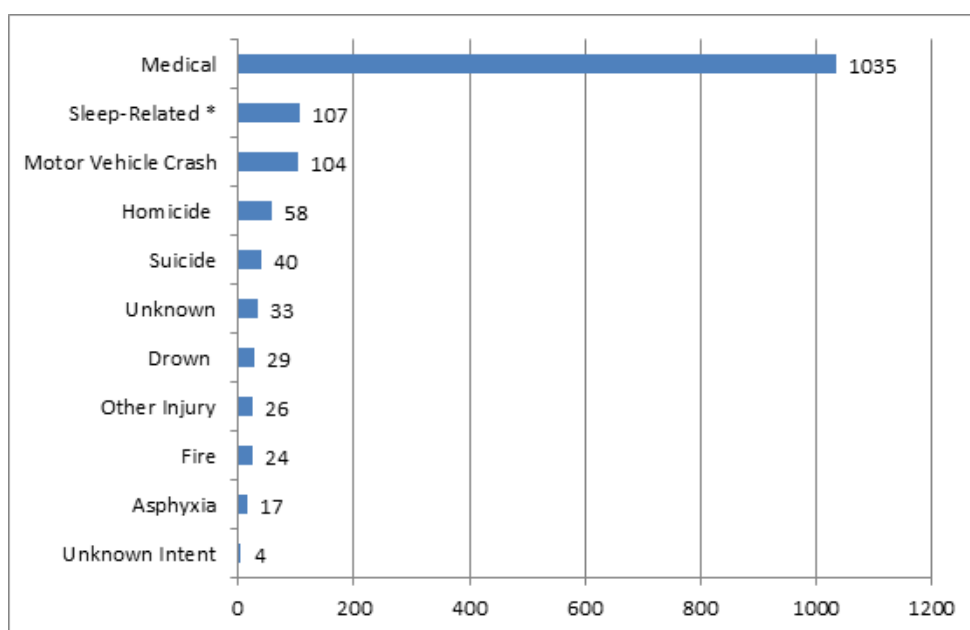


### All Reviewed

In 2013, a total of 540 child deaths were deemed reviewable by death certificate data. A child's death is eligible for review when the death is sudden, unexpected, unexplained, suspicious, or attributed to unusual circumstances. Ninety-Three percent of these deaths were reviewed (502) by local CFR committees. These committees are comprised of professionals from multiple disciplines that analyze the critical aspects of child deaths to aid in reducing preventable injuries and child deaths in Georgia. Death notifications are attained from a variety of sources to include coroner/medical examiner reports, Vital Records (VR) death certificates, Georgia Bureau of Investigations (GBI), and Department of Family and Children Services (DFCS). These death data are linked with Vital Records data to ensure a comprehensive and accurate representation of all child deaths in the state of Georgia. The data included in this report are based on information attained from these reviews.

### All Child Deaths in Georgia, 2013

Figure 1: Deaths to Children under Age 18 in Georgia, All Causes based on Death Certificate, 2013 (N=1,477)



\*Sleep-Related includes SIDS and infant suffocation in bed

- Infants make-up 26 percent(267) of all medical deaths
- "Unknown" category includes Sudden Unexpected Infant Death (SUID), sleep-related infant deaths with at least one prominent risk factor(see sleep-related infant section for more detailed information)
- "Unknown Intent" includes deaths for which a definitive manner could not be determined

## All Reviewed

\*Note that there is a slight difference in the numbers and types of death reported between death certificate data and "all reviewed" CFR data. This difference is due to the additional information on the circumstances of the death that are obtained and reviewed by local CFR committees. This information sometimes leads to more comprehensive findings and accuracy in determining cause/manner that the death certificate does not report, underscoring the value and importance of CFR data.

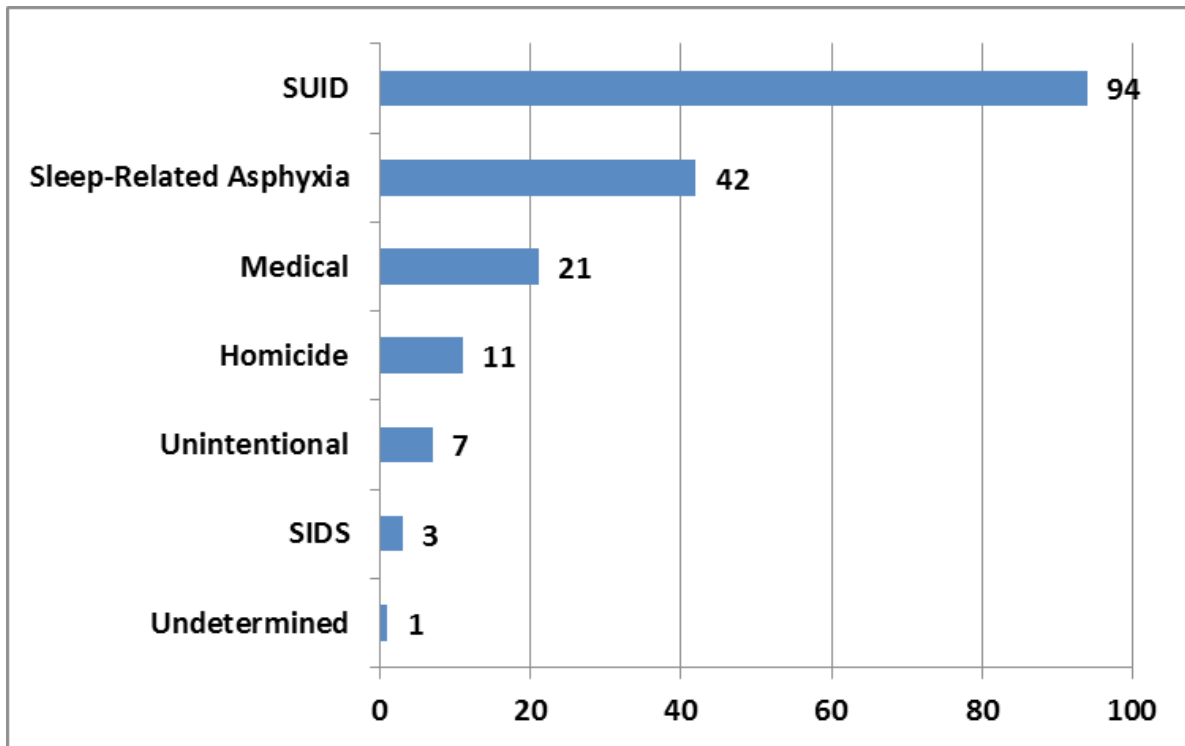
**Figure 2: Demographics of All Reviewed Deaths, GA, 2013 (N=502)**

	<u>Infant</u>	<u>1 to 4</u>	<u>5 to 9</u>	<u>10 to 14</u>	<u>15 to 17</u>	<u>Total</u>
White Male	35	26	7	15	48	131
White Female	31	11	5	10	18	75
African-American Male	52	28	14	18	35	147
African-American Female	43	26	8	12	12	101
Hispanic Male	6	2	3	2	7	20
Hispanic Female	7	4	1	1	1	14
Multi-Racial Male	2				1	3
Multi-Racial Female	2	2				4
Other Race Male	1	1	2	1		5
Other Race Female		2				2
Total	179	102	40	59	122	502





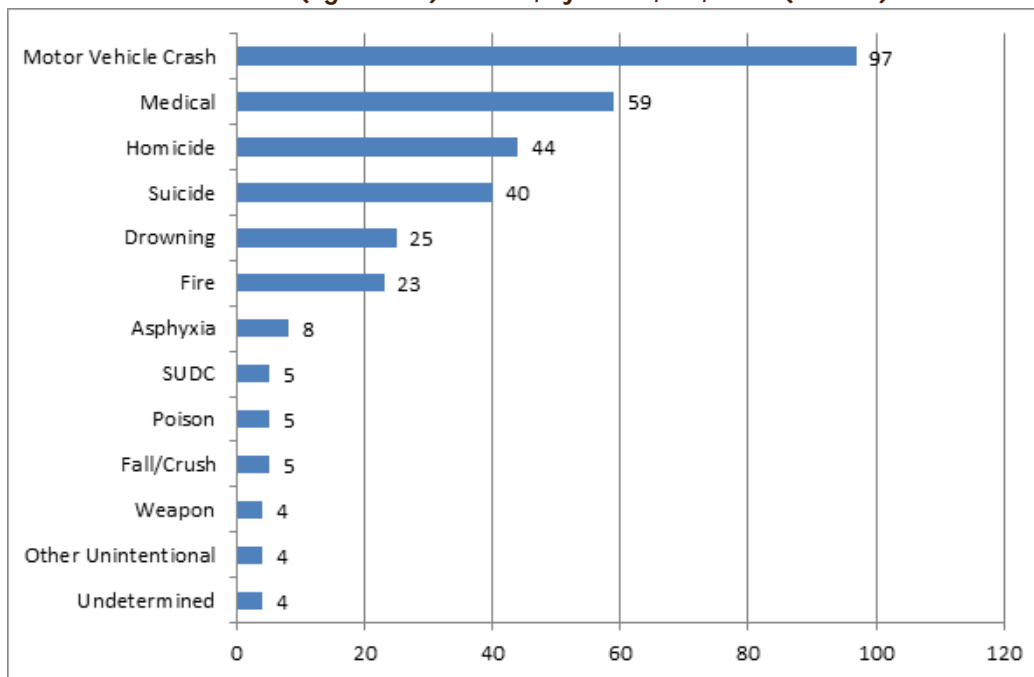
Figure 3: Number of Reviewed Infant Deaths by Cause, GA, 2013 (N=179)



- SUID = Sudden Unexplained Infant Death; SIDS = Sudden Infant Death Syndrome (more detail on these types of deaths can be found in the "Sleep Related" section)
- The "Unintentional" category includes five motor vehicle deaths, one drowning death, and one fire death
- The "Undetermined" death involves a non-sleep-related sudden infant death



Figure 4: Number of Reviewed Child (ages 1-17) Deaths, By cause, GA, 2013 (N=323)



- The “Other Unintentional” category includes deaths due to circumstances such as dog bites, sports-related head injuries, et cetera
- The “SUDC” category refers to Sudden Unexplained Death in Childhood cases that resemble SIDS or SUID in circumstances (e.g. unexplained cause after full investigation and autopsy), but the child is over the age of one



## Disparities in Reviewed Deaths

### Disparities in Reviewed Deaths

The 2013 child population up to age 17 in Georgia was 2,492,428 (GA Dept of Public Health, OASIS data). The racial and ethnic makeup of the child population was:

- White, non-Hispanic – 45.8%
- African-American, non-Hispanic – 33.5%
- Multiracial – 3.3%
- All other races (Asian, Pacific Islander, Native American) – 3.7%
- Hispanic, all races – 13.6%

**Figure 4: All Infant (<1) and Child (1-17) Deaths, Population, and Mortality Rates, GA death certificate data, 2013**

	<u>Deaths</u>		<u>Population</u>		<u>IMR</u>	<u>1 to 17 MR</u>
	<u>≤1</u>	<u>1 to 17</u>	<u>≤1</u>	<u>1 to 17</u>	(Per 1,000)	(Per 100,000)
White	352	231	72,613	1,347,126	4.8	17.1
African-American	478	232	45,424	823,698	10.5	28.2
Multi-Racial	82	64	7,145	87,495	11.5	73.1
Hispanic	83	41	22,094	317,661	3.8	12.9
Total		546		2,360,962		23.1

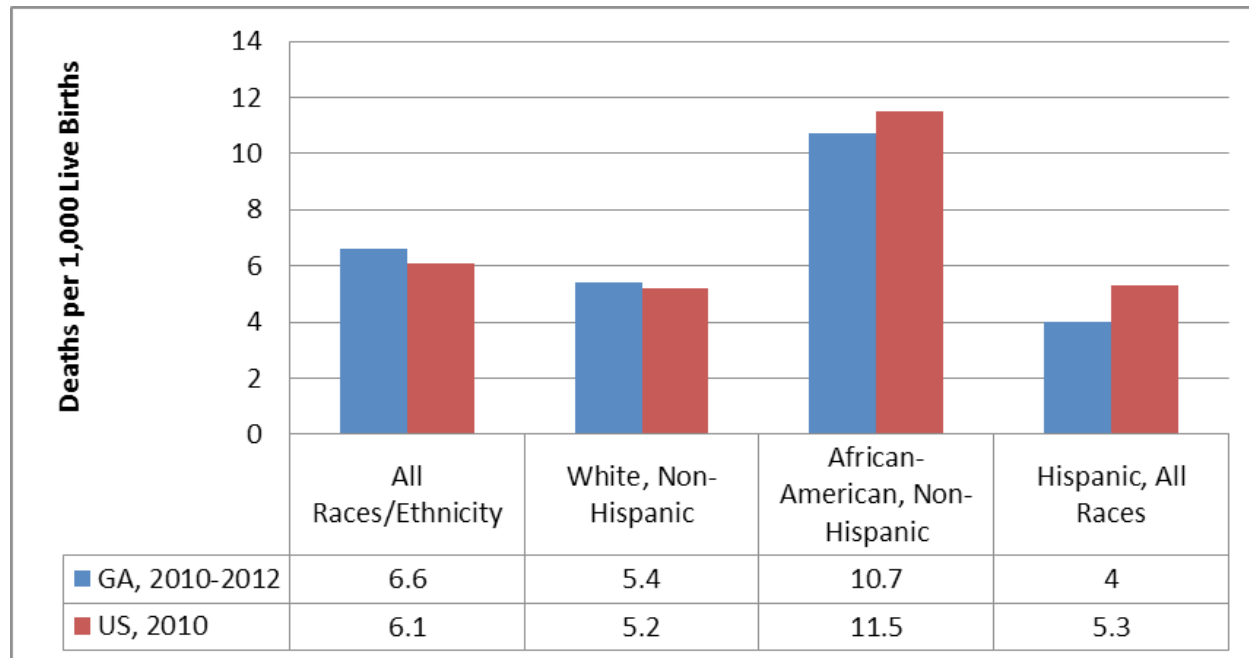
The *infant mortality rate* (IMR) is an estimate of the number of infant deaths for every 1,000 live births. This rate is often used as an indicator to measure the health and well-being of a nation, because factors affecting the health of entire populations can also impact the mortality rate of infants. There are obvious differences in infant mortality by age, race, and ethnicity; for instance, the mortality rate for non-Hispanic African-American infants is more than twice that of non-Hispanic white infants.

The child death rate (age 1-17) for Georgia in 2013 was 23.1 per 100,000. Georgia's infant mortality rate for 2013 was 7.1 per 1,000. This is higher than the national average of 6.0 per 1,000. However, the IMR for White, non-Hispanic infants and Hispanic infants was lower than the state and national average (4.8 and 3.8, respectively). The IMR for African-Americans was 10.5 per 1,000. This great disparity in the infant death rate should mobilize agencies and communities to determine what factors are negatively impacting the health of mothers and infants in the African-American community, and take action to reduce the deaths in these communities. As a result, we can also lower the overall Georgia IMR to meet the national standard. According to the CDC, the majority of infant deaths are due to serious birth defects, low birth weight (born too small), prematurity (born too early), sleep-related infant death, or maternal complications of pregnancy.



## Disparities in Reviewed Deaths

Figure 5: Infant Mortality, Georgia/US Comparison, by Race/Ethnicity



According to the GA Department of Public Health, Online Analytical Statistical Information System (OASIS), the death rate for African-American infants due to sleep-related circumstances in Georgia has been almost twice that of White infants for many years. However, the death rates for other external causes of injury, with the exception of motor vehicle crashes, are nearly identical between African-American children and White children. The death rate for child homicides is five times higher among African-Americans compared to Whites.



## Prevention and Preventability

### Prevention and Preventability

In addition to conducting a thorough review of each death, Child Fatality Review committees are also asked to determine if the death was preventable. CFR committees determine preventability through a retrospective analysis of factors. **Preventability** is defined for CFR committees as a death in which, with retrospective analysis, it is determined that a reasonable intervention (e.g., medical, educational, social, psychological, legal, or technological) could have prevented the death. In other words, **a child's death is preventable if the community or an individual could reasonably have done something, at any point, that would have changed the circumstances leading up to the death.** Many deaths to children are predictable, understandable, and therefore preventable.

Figure 6: Determination of Preventability, GA, 2013 (N=502)

	Missing/ Blank	No, probably not	Yes, probably	Team could not determine	Percent Preventable *
All Unintentional		8	159	11	95.2
Homicide	1	1	53		98.1
Suicide		5	29	6	85.3
SIDS/SUID		18	86	35	82.7
Medical	2	35	22	20	38.6
Sudden Unexplained Death in Childhood (SUDC)		1	1	3	N/A
Undetermined		3	2	1	N/A
All Reviewed Deaths	3	71	352	76	83.2

*% Preventable calculated excluding "missing/blank" and "team could not determine"*

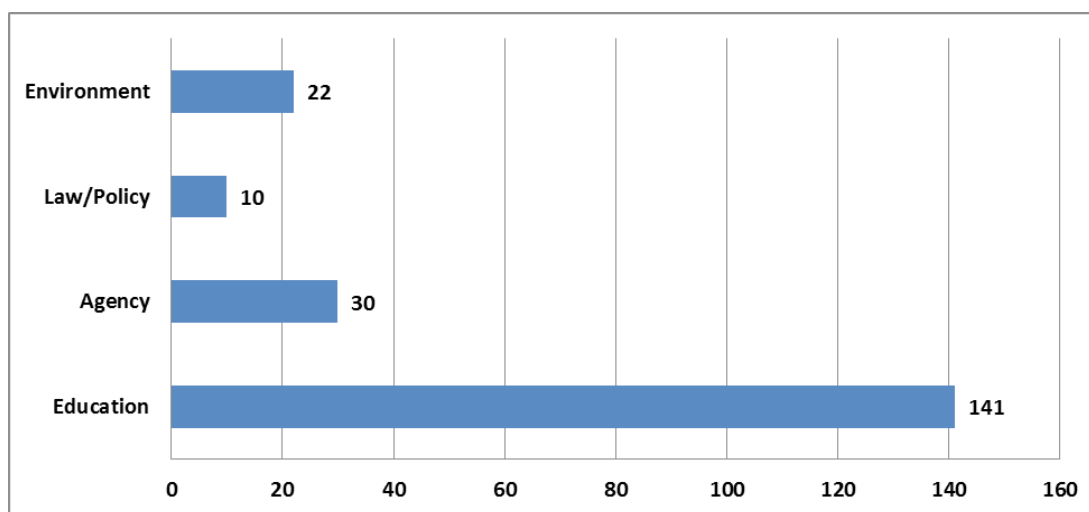
Since 2012, the 'percent preventable' increased for several categories, perhaps due to greater awareness among local review teams on the definition of preventability and/or the availability of resources to address the identified issues.

- "all unintentional" increased slightly from 92.9%
- "homicide" increased slightly from 96.2%
- "suicide" increased 18 percentage points from 66.7%
- "SIDS/SUID" remained constant
- "medical" increased 26 percentage points from 12.1%

## Prevention and Preventability

Committees determined that 352 of the 502 reviewed deaths could have been prevented. Committees were then tasked with determining which factors could have been modified to prevent the death, and what measures they would recommend to prevent similar deaths in their communities. In 141 cases where the death was preventable, the committees recommended at least one type of prevention strategy – education, law/ordinance, agency policy/program, or environment/consumer product. A total of 203 prevention recommendations were documented (some casereports had multiple recommendations).

**Figure 7: Prevention Recommendations Identified by CFR Committees, 2013**



Prevention of child deaths is the primary goal of child fatality review in Georgia. Prevention relies on a broad and inclusive population-based approach, focusing efforts upstream to change the agent and the environment, and creating a user-friendly, easily understood system of policies, programs, and tools that makes it easier to live safely and without injury or death. All members of a society – in every age and income group – can contribute to prevention by promoting protective factors (i.e. strengths, resources, and skills) and reducing risk factors (i.e. barriers, stressors, and dangerous or negligent behaviors).





## Prevention and Preventability

Some recommendations made by local CFR committees:

Topic/Cause of Death	Recommendations made by the local CFR committees	Recommendations from the Community Preventive Services Task Force (TheCommunityGuide.org)
Safe Sleep	<p>Safe sleep education for health care providers, parents and caregivers</p> <p>Media campaigns; continue PSA's and education on back to sleep positioning of infants to include a safe sleep environment and the use of a pacifier</p> <p>Education on safe sleep while on vacation or visiting homes where a crib may not be available</p> <p>County Safe Sleep program should initiate contact with all parents through social services including social security and health records department to provide live personnel to provide sleep education to parents</p>	None available
Motor Vehicle	<p>Car seat safety classes for all parents and caregivers; parent education regarding the proper placement and positioning of children in child safety seats</p> <p>School programs for elementary students on seat belt usage and crossing the street</p> <p>Teen driving classes in schools</p> <p>Bus Monitors and Seat Belts on all school buses</p>	<p>Child Safety Seats: Interventions that use distribution and education programs based on strong evidence of their effectiveness in increasing child safety seat use.</p> <p>Seat Belt Use: Enhanced enforcement programs are added to normal enforcement practices and include publicity. They fall into two categories: (1) those that increase citations along with increasing the number of officers on patrol (supplemental), and (2) programs that promote more citations during an officer's normal patrol (targeted).</p>

## Prevention and Preventability

<b>Fire</b>	Provide smoke alarms for all homes, and enforce code violations for older homes	None available
<b>Drowning</b>	<p>Increase signage at rivers where no lifeguard is present and water conditions may be dangerous</p> <p>Require fencing for private ponds and pools, to restrict access to water</p> <p>Provide pool safety signage in several languages</p> <p>Schools should have swimming pools and lessons for students</p>	None available
<b>Homicide</b>	<p>Education on Russian Roulette</p> <p>Promote gun safety</p> <p>Provide gun locks and safe storage options</p> <p>Provide programs for teens on consequences of poor choices and criminal activity – target delinquent youth and young offenders</p>	Universal, school-based programs on the basis of strong evidence of effectiveness in preventing or reducing violent behavior. Universal school-based programs to reduce violence are designed to teach all students in a given school or grade about the problem of violence and its prevention or about one or more of the following topics or skills intended to reduce aggressive or violent behavior: emotional self-awareness, emotional control, self-esteem, positive social skills, social problem solving, conflict resolution, or team work.
<b>Suicide</b>	<p>Suicide education for parents and schools</p> <p>Improve communication between parents, mental health providers, and schools to monitor at-risk kids</p> <p>Bring mental health providers into schools</p> <p>Incorporate suicide prevention into parent aid classes</p> <p>Educate parents on dangers of having firearms and other weapons in the home with a child who exhibits depression or suicidal behavior</p>	None available

## Prevention and Preventability

<b>Maltreatment</b>	Increase community education on domestic violence and child abuse	Early childhood home visitation programs based on strong evidence of their effectiveness in reducing child maltreatment among high-risk families.
<b>Medical</b>	<p>Specialized health exams for student-athletes, beyond the traditional sports physicals, which could detect certain heart conditions</p> <p>Educate parents of children with health conditions on proper, safe ways to perform daily activities and compliance with care regimens</p> <p>Provide information to parents on medical tests they can request, even if not suggested by a doctor</p> <p>Schools and recreational leagues should improve the types of physicals required to play sports; there should be a consensus between the Georgia High School Association and local recreational leagues on the requirements for the extent that a physical to play sports should cover</p>	None available
<b>Other</b>	<p>Provide information on contacting emergency services for non-English speakers</p> <p>Mandatory CPR training for all school personnel</p> <p>Media campaigns and awareness programs to secure TVs and other electronics in the home</p> <p>Adult medication should be stored out of reach of children</p>	None available

CFR committees also identified several agencies and organizations which could champion these recommendations, including:

- Department of Juvenile Justice (DJJ)
- county Health Departments
- local school systems
- local law enforcement and School Resource Officers (SROs)
- mental health providers and Community Service Boards (CSBs)
- fire departments
- hospitals
- Safe Kids chapters
- Family Connection Collaboratives



## Prevention and Preventability

Reviewing the circumstances of each death helps committees focus on the specific factors that caused the death or made the child more susceptible to harm. Once the committee has identified these factors, the committee should decide which factors they believe they can modify or impact. Not all risk factors are easy to impact; some may require long term, systemic change. Thus, the prevention of risk may be simple or it may be complicated and long term.

Once individuals understand the risk factors for their community, they can bring together other interested individuals (i.e. “Stakeholders”) and develop an **action plan for prevention**.

### Resources

#### State:

Georgia’s Framework for Childhood Injury Prevention Planning ([www.oca.georgia.gov](http://www.oca.georgia.gov))

Safe Kids Georgia ([www.SafeKidsGeorgia.org](http://www.SafeKidsGeorgia.org))

Prevent Child Abuse Georgia ([www.PreventChildAbuseGA.org](http://www.PreventChildAbuseGA.org))

Children’s Healthcare of Atlanta, Stephanie V. Blank Center for Safe and Healthy Children ([www.choa.org/childrens-hospital-services/child-protection-center](http://www.choa.org/childrens-hospital-services/child-protection-center))

Georgia Department of Public Health, Injury Prevention Program ([www.health.state.ga.us](http://www.health.state.ga.us))

Georgia Governor’s Office of Highway Safety ([www.gahighwaysafety.org](http://www.gahighwaysafety.org))

Georgia KidsCount Data Center, Family Connection Partnership ([www.gafcp.org/count](http://www.gafcp.org/count))

#### National:

National Institute of Child Health and Human Development ([www.nichd.nih.gov/sids](http://www.nichd.nih.gov/sids))

Suicide Prevention Resource Center ([www.sprc.org](http://www.sprc.org))

Centers for Disease Control and Prevention ([www.cdc.gov/injury](http://www.cdc.gov/injury))

The Community Guide (<http://www.thecommunityguide.org/index.html>)

The Child Welfare Information Gateway (<https://www.childwelfare.gov/>)



## Agency Involvement

- In 2013, CFR committees reported that 256 of the 502 total deaths reviewed (51%) had some evidence of prior agency involvement. Involvement is defined as the provision of some form of service to the deceased child or the child's family. The agencies that had involvement in these cases include but are not limited to public health, mental health, law enforcement, juvenile detention and social services. Each agency visit or staff intervention with a family represents an opportunity for prevention, education and risk reduction counseling for Georgia's families.
- There were 172 decedents (34%) where the child's caregiver(s) had received some type of social service assistance in the past 12 months, such as WIC, TANF, Medicaid, or food stamps
- There were 73 (15%) decedents with a reported disability or chronic illness; of those 73 decedents, 18 were receiving services through Children with Special Health Care Needs (CSHCN) at the time of death (25%)
- There were 25 decedents (5%) who had received mental health services at some point prior to their death; there were 12 decedents who were receiving mental health services at the time of their death
- There were 89 decedents (18%) with a reported history of child maltreatment as a victim, due to either abuse or neglect, at some point during their lifetime; there were 24 decedents (5%) who had an open CPS case at the time of death
- There were 33 decedents (7%) who had reported delinquent or criminal history, due to assaults, robbery, drugs, or other charges; in eight cases, the child had spent some time in juvenile detention

**Figure 8: Decedents with Prior Agency Involvement, GA, 2013**

	Social Services	Disability or Chronic Illness	Children with Special Health Care Needs (CSHCN)	Mental Health (prior or current)	Maltreatment history or open CPS	Delinquent history
Male	104	44	9	22	57	26
Female	68	29	9	4	40	7
Infant	97	27	4		24	
Age 1-4	36	14	7	1	23	
Age 5-9	16	6	2	1	11	
Age 10-14	6	9	3	4	10	2
Age 15-17	17	17	2	20	29	31
Agency Totals	172	73	18	26	97	33

## Agency Involvement

Figure 9: Age of Decedents with Prior Agency Involvement, GA, 2013 (N=256)

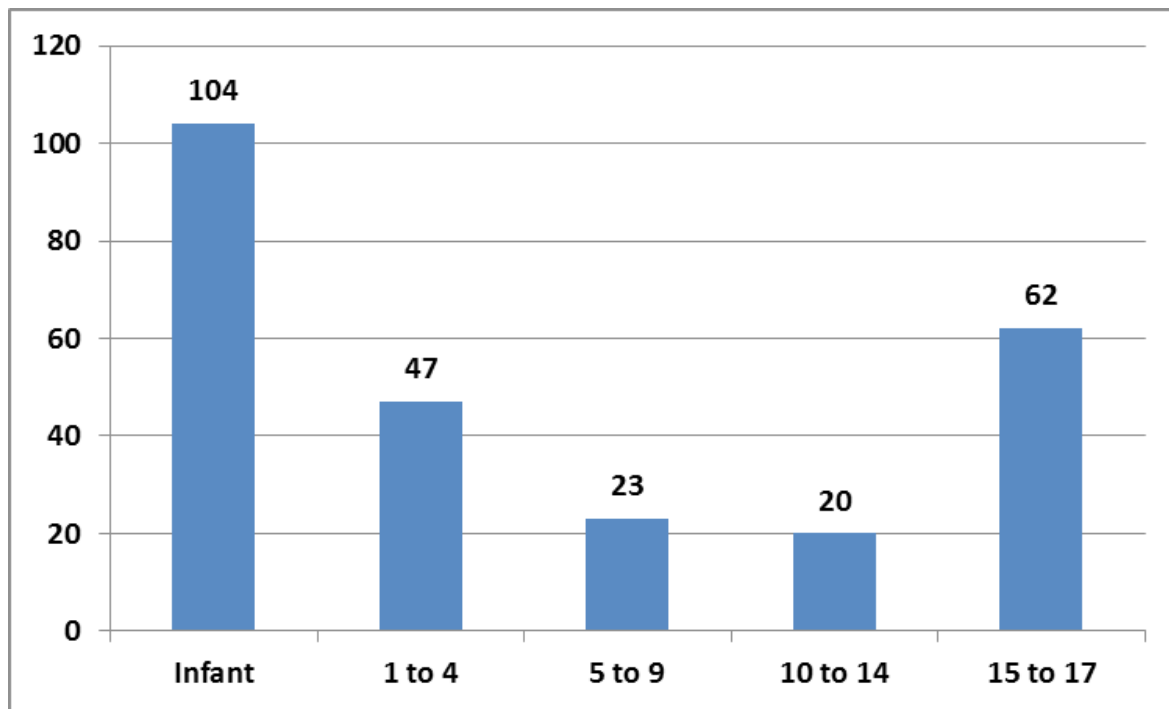


Figure 10: Number of Deaths with Prior Agency Involvement by Cause, GA, 2013 (N=256)

	Prior Agency History	All Reviewed	Percent
Unintentional	72	178	40.4
Sleep-Related	80	139	57.6
Suicide	24	40	60.0
Homicide	38	55	69.1
Medical	37	79	46.8
Undetermined	5	11	45.5
Total	256	502	51.0



## Maltreatment-Related Deaths

Georgia CFR committees are asked to report on the number and types of death related to maltreatment – child abuse and neglect. The committees also report on those deaths related to poor supervision and negligence.

CFR committees identified 123 child deaths with evidence of maltreatment in the child's history or as the direct cause of death (54 were abuse and 46 were neglect). In 23 cases, the committees reported an unknown type of maltreatment (unsure if abuse or neglect was a factor).

- In 103 cases, the decedent had a past history of maltreatment as a victim (compared to 60 cases in 2012, and 47 in 2011), but the maltreatment was not the direct cause of the death
- In 39 cases, the maltreatment was the direct cause or contributing factor in the death (compared to 37 cases in 2012, and 29 in 2011)
- For 19 decedents, both "reported maltreatment history" and "abuse/neglect as cause" were identified (compared to 14 in 2012, and 11 in 2011)
- "Poor/absent supervision" was reported to be a factor in 58 deaths. "Other negligence" was reported to be a factor in 84 deaths

Georgia code section 19-7-5 defines child abuse as "Physical injury or death inflicted upon a child by a parent or caretaker thereof by other than accidental means; provided, however, that physical forms of discipline may be used as long as there is no physical injury to the child".

Child neglect is defined in Georgia Code 49-5-180: "neglect or exploitation of a child by a parent or caretaker thereof if said neglect or exploitation consists of a lack of supervision, abandonment, or intentional or unintentional disregard by a parent or caretaker of a child's basic needs for food, shelter, medical care, or education as evidenced by repeated incidents or a single incident which places the child at substantial risk of harm...".

**Figure 11: Decedents with Maltreatment History, GA, 2013 (N= 123)**

	<u>Infant</u>	<u>Age 1-4</u>	<u>Age 5-9</u>	<u>Age 10-14</u>	<u>Age 15-17</u>	<u>Total</u>
White Male	12	6	2	0	11	31
White Female	5	4	1	4	2	16
African-American Male	9	5	3	5	12	34
African-American Female	7	10	4	4	3	28
Hispanic Male	2	1	2	1	1	7
Hispanic Female	0	1	0	0	1	2
Multi-Racial Male	2	0	0	0	1	3
Multi-Racial Female	0	2	0	0	0	2

## Maltreatment-Related Deaths

National research suggests that the following groups are higher risk populations:

- Infants
- Males
- African-Americans
- Caregivers with alcohol abuse, drug abuse, or intimate partner violence in the home

National statistics provided in the Child Maltreatment 2012 report, developed by the Administration for Children and Families (ACF) Children's Bureau, National Child Abuse and Neglect Data System (NCANDS), states that younger children were the most vulnerable to death as the result of child abuse and neglect. Nearly three-quarters (70.3%) of all child fatalities reported in 2012 were younger than three years and in general, the child fatality rate decreased with age. Children who were younger than one year old died from abuse and neglect at a rate of 18.83 per 100,000 children in the population younger than one year. This is nearly three times the rate of children who were one year old (6.46 per 100,000 children in the population of the same age). Children who were older than five years died at a rate of less than 1.00 per 100,000 in the population. Additionally, males had a higher child fatality rate than females; 2.54 per 100,000 males in the population, compared to 1.94 per 100,000 females in the population.



## Maltreatment-Related Deaths

Figure 12: Causes of death where the maltreatment was the direct cause or contributing factor, GA, 2013 (N=39)

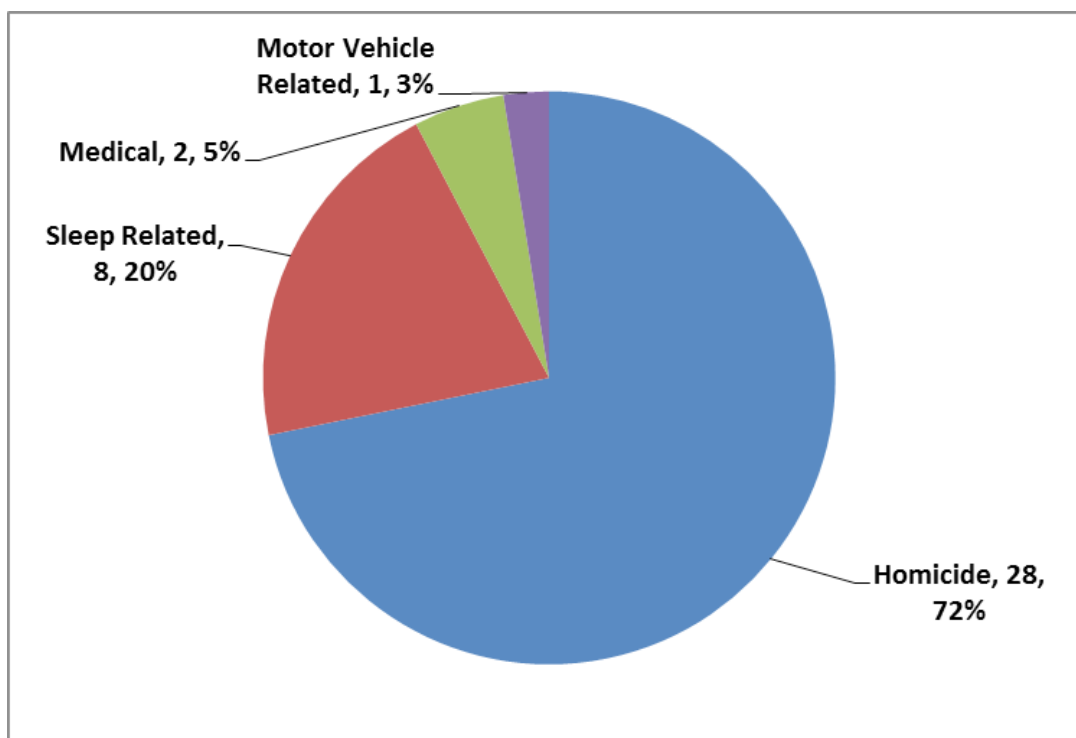
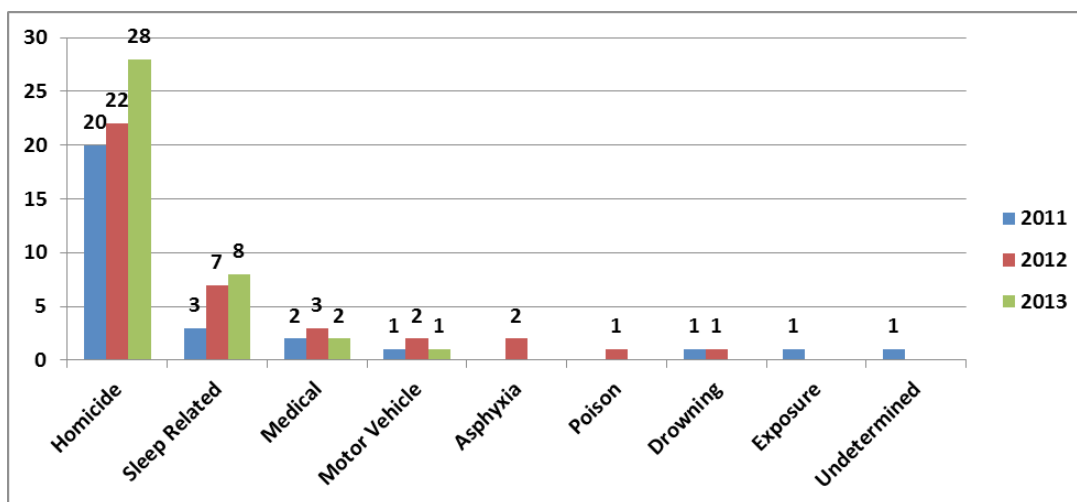


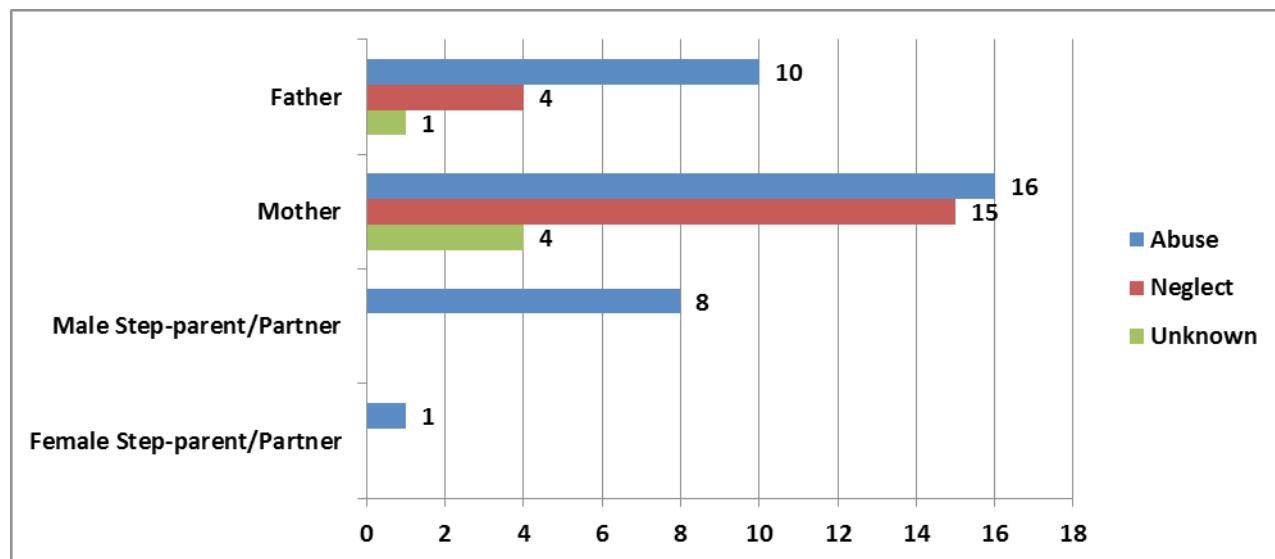
Figure 13: Causes of Death where the maltreatment was the direct cause or contributing factor, three-year trend, GA, 2011-2013



- Homicide was the leading cause of reviewed maltreatment-related death, followed by sleep-related and medical
- The number of maltreatment-related deaths shows an increase from 2011 to 2013

## Maltreatment-Related Deaths

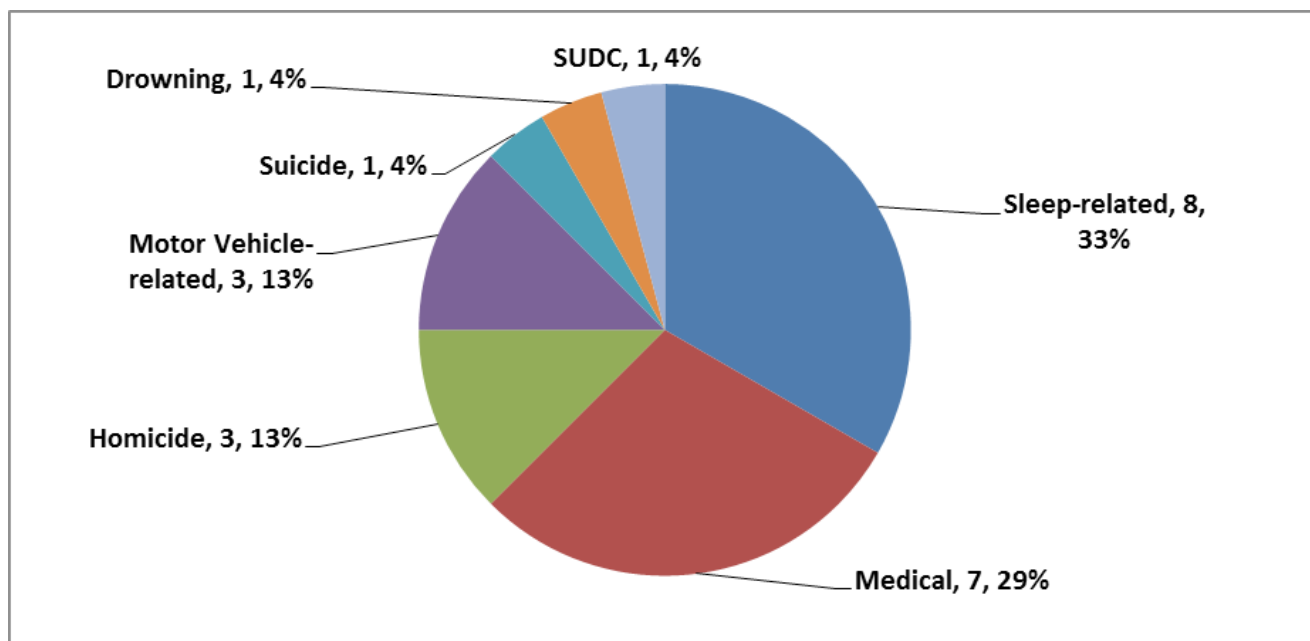
Figure 14: Parental perpetrators of deaths where maltreatment was the direct cause or contributing factor, GA, 2013



\*\* in several cases, both parents, or parent and partner, were identified as perpetrators of the death

CFR committees reported on 24 decedents who had an open CPS case at the time of death. Nearly two-thirds of those deaths were due to medical or sleep-related circumstances

Figure 15: Causes of death for decedents with an open CPS case, GA, 2013 (N=24)





## Maltreatment-Related Deaths

### Opportunities for Prevention:

The Child Welfare Information Gateway has published “Child Neglect: A Guide for Prevention, Assessment, and Intervention”. According to the Guide, the current theory on maltreatment views neglect from a social-ecological perspective in which multiple factors contribute to child abuse and neglect. From this perspective, it is recommended that we should consider not only the parent’s role, but also the societal and environmental variables contributing to the parent’s inability to provide for the basic needs of the child. This model is valuable because it recognizes the shared responsibility among individuals, families, communities, and society, thereby enabling a more constructive approach and targeting interventions on multiple levels. [www.childwelfare.gov/pubs/usermanuals/neglect/neglect.pdf](http://www.childwelfare.gov/pubs/usermanuals/neglect/neglect.pdf)

PCA Georgia, a state chapter of Prevent Child Abuse America, provides statewide direction to promote healthy children and develop strong families through:

- **Prevention Network** – Building a statewide network of individuals, families, agencies, and communities dedicated to preventing child abuse and neglect in all its forms.
- **Public Awareness** – Increasing public awareness about child abuse and neglect prevention through training and education, information dissemination, and statewide events.
- **Prevention Programs** – Encouraging the development and implementation of innovative prevention programs using research-based models.
- **Research** – Conducting and disseminating academic and community-based research to guide the development of policies, programs and services which will enhance the health and well-being of Georgia’s children and their families.
- **Advocacy Activities** – Informing public policy, programs, and practices that strengthen families and protect children by regularly imparting information regarding child abuse prevention research, initiatives, legislation, and campaigns.

PCA Georgia also maintains the 1-800-CHILDREN Helpline - open weekdays from 8 a.m. to 6 p.m. 1-800-CHILDREN is a referral line for Georgians concerned about the healthy development of children and the prevention of child abuse and neglect. Parents, families, professionals, or anyone else who seeks child abuse prevention resources can call the Helpline and speak with a knowledgeable information and referral specialist.

Please join us in our efforts to protect Georgia’s children. Anything you do to support kids and parents can help reduce the stress that often leads to abuse and neglect. [www.PreventChildAbuseGA.org](http://www.PreventChildAbuseGA.org)



## Sleep-Related Infant Deaths

CFR Committees determine the cause of infant sleep-related deaths by reviewing multiple factors associated with the sleep environment, the infant's medical history, and autopsy findings. A death is determined to be **Sudden Infant Death Syndrome (SIDS)** when the infant is considered to be in the safest possible sleep environment and no other potential risk factors are identified. A death is determined to be **Sleep-related Asphyxia** when there is forensic evidence of suffocation, wedging, positional asphyxia, or overlay during sleep. The **Sudden Unexplained Infant Death (SUID)** cases are those when the cause of death is truly undetermined, because there is evidence of an unsafe sleep environment and/or other factors that could possibly have contributed to the death (e.g. bed-sharing, over bundling, prone positioning, or existing health issues). **Sleep-related Medical deaths** are those when an infant has a serious medical condition, but was also placed in an unsafe sleep environment, which exacerbated the medical issues and contributed to the death (these deaths are also reported in the Medical section of this report, in order to highlight opportunities for prevention among children with serious medical concerns).



## Sleep-Related Infant Deaths

Figure 16: Demographics of Reviewed Sleep Related Infant Deaths, GA, 2013 (N=139)

	SIDS		Sleep Related Asphyxia		SUID		Total	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent
White Male	1		8	19.0	17	18.1	26	18.7
White Female			5	11.9	21	22.3	26	18.7
African-American Male	2		14	33.3	24	25.5	40	28.8
African-American Female			13	31.0	23	24.5	36	25.9
Hispanic Male			1	2.4	3	3.2	4	2.9
Hispanic Female					4	4.3	4	2.9
Multi-Racial Male					1	1.1	1	0.7
Multi-Racial Female			1	2.4	1	1.1	2	1.4
<b>Total</b>	<b>3</b>		<b>42</b>		<b>94</b>		<b>139</b>	

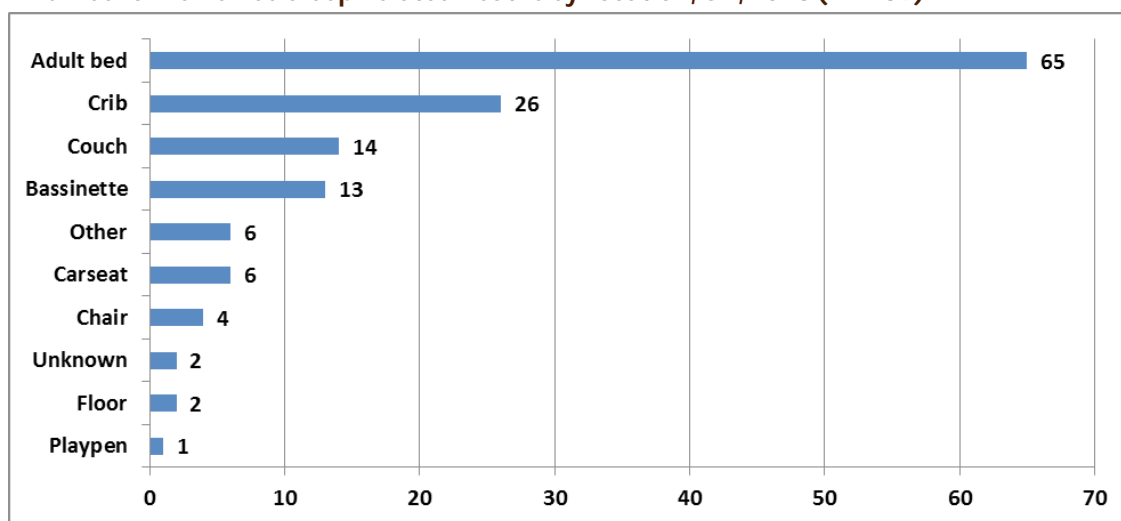
- Thirty percent of the sleep related deaths were determined to be asphyxia, and 68% were SUID. Only two percent of deaths were determined to be SIDS. Utilization of the appropriate language during prevention and awareness campaigns is crucial in effectively communicating the true nature of sleep related infant deaths. The burden of death to infants in Georgia is not primarily related to SIDS, which many view as unpreventable, but is attributable to SUID and other sleep related deaths which are highly preventable. Parents and caregivers should be empowered with the knowledge and education of simple, yet effective, prevention steps as well as the understanding of the true risk for infant death.
  - CFR committees reviewed 139 sleep-related infant deaths in 2013
  - Of those, 55% were African-Americans, 37% were non-Hispanic Whites, and six percent were Hispanic
  - The majority of sleep-related infant deaths had one or more risk factors present (sleep environment, location, and/or position)





## Sleep-Related Infant Deaths

Figure 17: Number of Reviewed Sleep Related Deaths by Location, GA, 2013 (N=139)



- Sleep environment continued to be a critical issue in the reviewed deaths
- Nearly half of the deaths occurred in an adult bed (47%), but this is a slight decrease from 2012, when 58% of sleep related deaths occurred in an adult bed
- Nineteen percent of deaths occurred in a crib, and 10% occurred on a couch/sofa
- Of the 79 deaths that occurred on an adult bed or couch, 57 were sleeping with an adult at the time of death (72%)

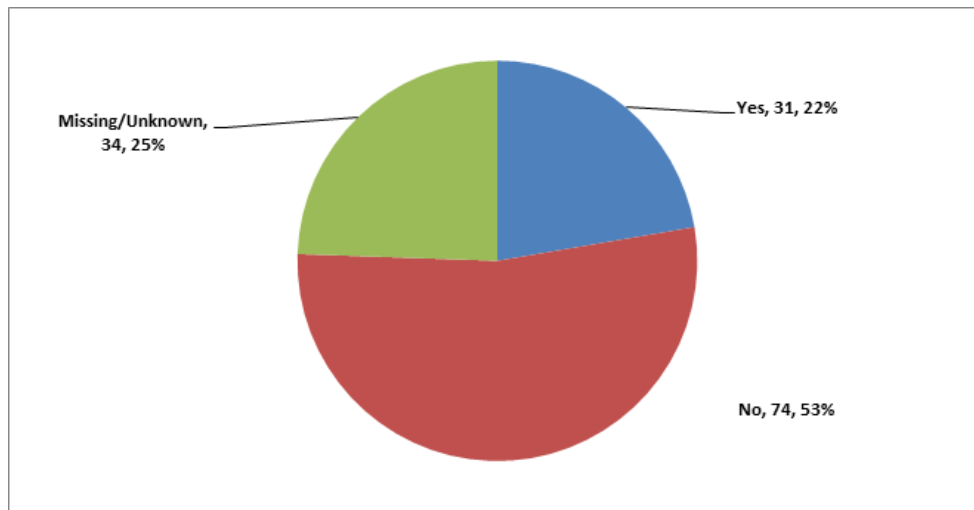




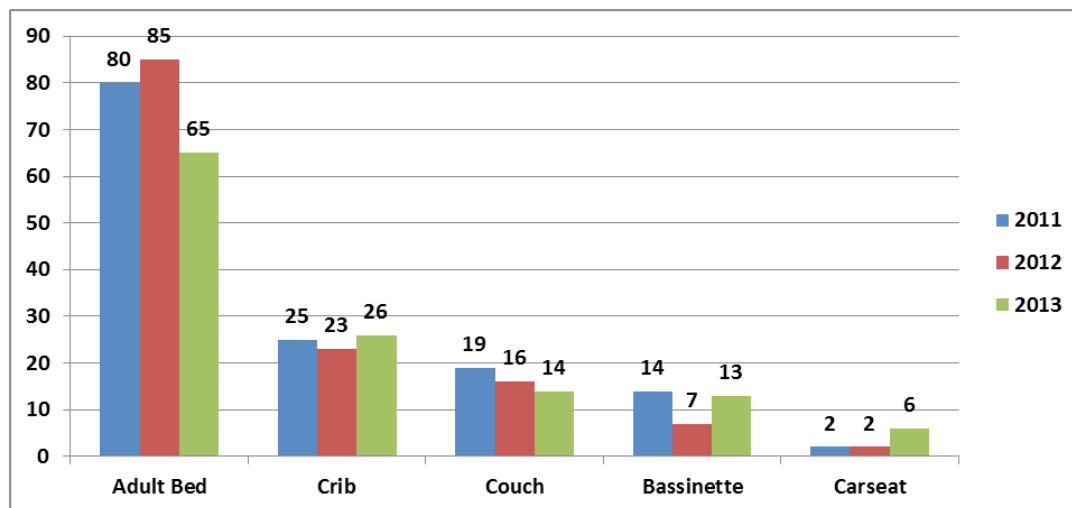
## Sleep-Related Infant Deaths

- 22% of deaths had a scene re-enactment performed with a doll by a law enforcement officer, coroner, or medical examiner investigator. CFR staff have distributed scene re-enactment dolls since 2009, with CDC grant funding support, as part of an effort to improve death scene investigations and CFR reporting quality

**Figure 18: Scene Re-enactment with Doll Performed, GA, 2013 (N=139)**



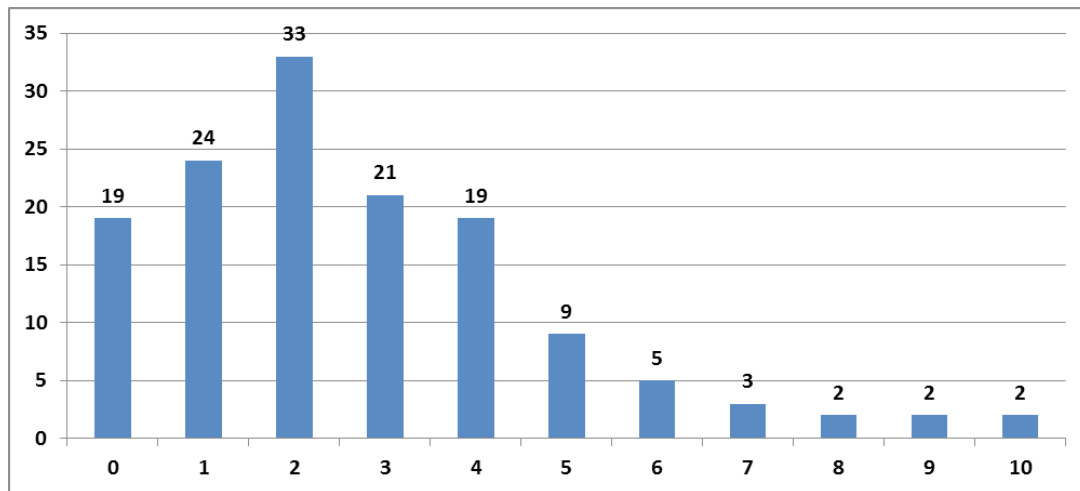
**Figure 19: Trend of Top Five Locations for Sleep Related Deaths, GA, 2011-2013**



- The number of reviewed sleep related infant deaths has not decreased significantly, from 155 in 2011 to 139 in 2013, despite multiple efforts by state and local agencies to provide prevention education, programs, and services to parents and caregivers. We should continue to work collaboratively and raise awareness of the issue with consistent messaging across the state. Evidence shows that coordinated and sustained efforts at the state level are able to provide necessary information to families and caregivers that enable them to make informed decisions in regards to safe sleep.

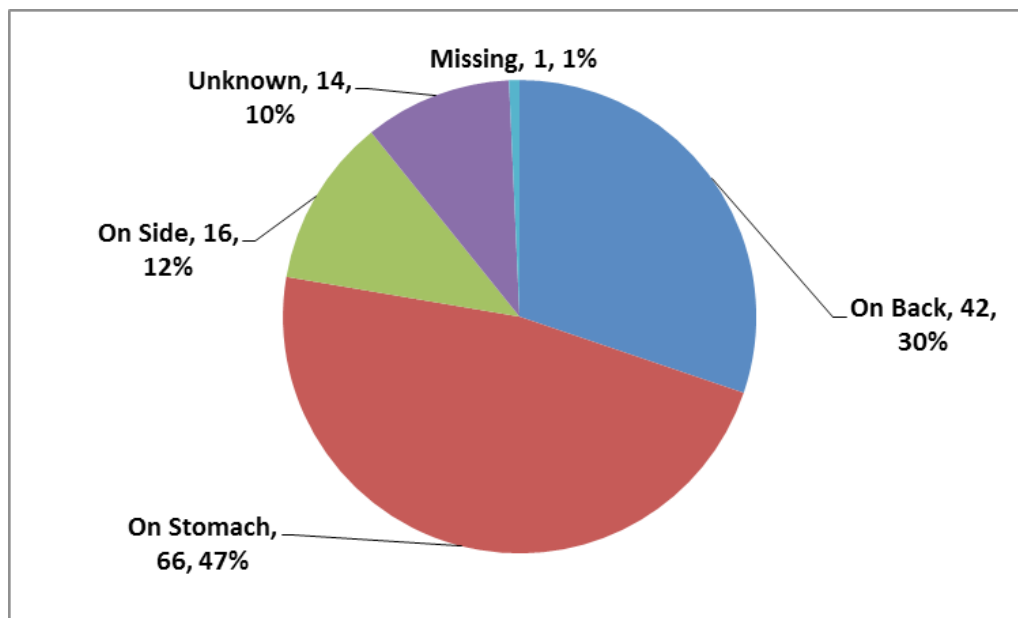
## Sleep-Related Infant Deaths

Figure 20: Sleep Related Deaths by Age in Months, GA, 2013 (N=139)



- Eighty-three percent of the deaths occurred among infants younger than five months. This reinforces the need for consistent and continuous education for parents as well as their supportive caregivers, both prior to the birth and in the first few months after the child is born

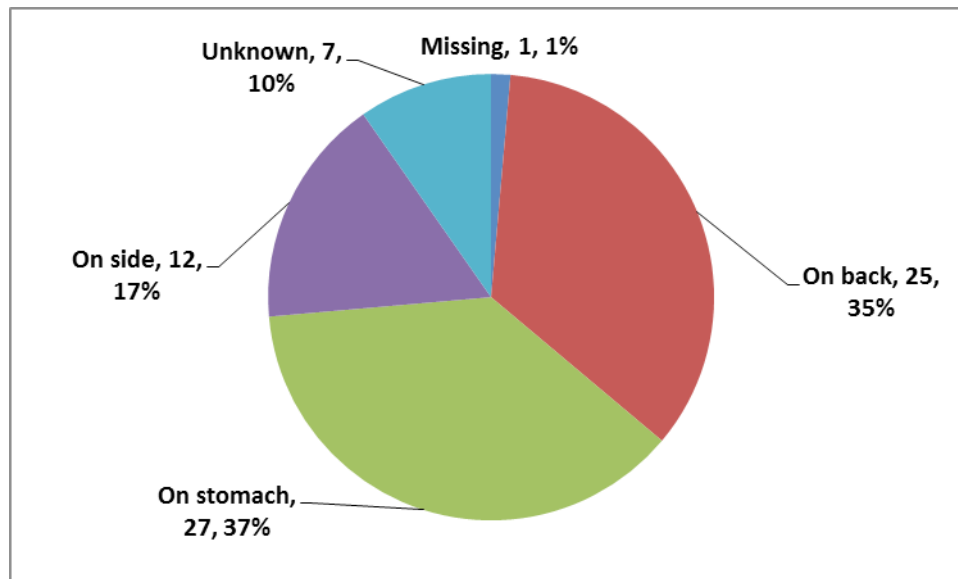
Figure 21: Sleep Related Deaths by Position when Found, GA, 2013 (N=139)



- Of the 139 sleep related infant deaths, 64 were reportedly placed supine – on their back – to sleep (46%), compared to 56 placed prone - on their stomach – or side (40%)
  - o However, when the infant was found unresponsive, 42 were on their back (30%) and 82 were found on their stomach or side (59%). The remainder had an “unknown” position

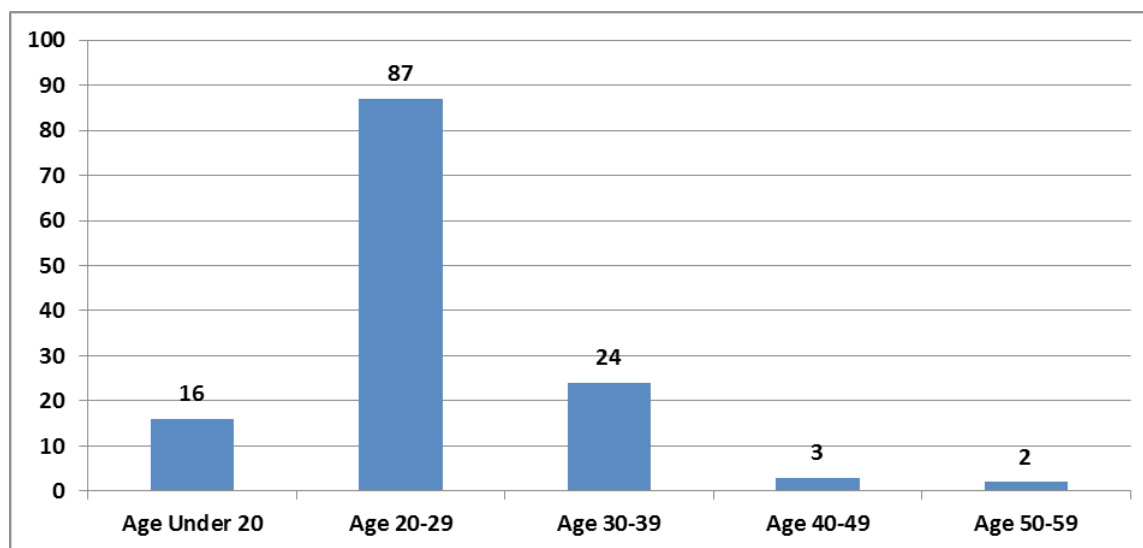
## Sleep-Related Infant Deaths

Figure 22: Sleep Related Deaths with Reported Bed Sharing, by Position when Found, GA, 2013 (N=72)



- Infants who were reported as “bed sharing” were sharing a sleep surface, such as a bed, couch, chair, or crib, with at least one other person at the time of death

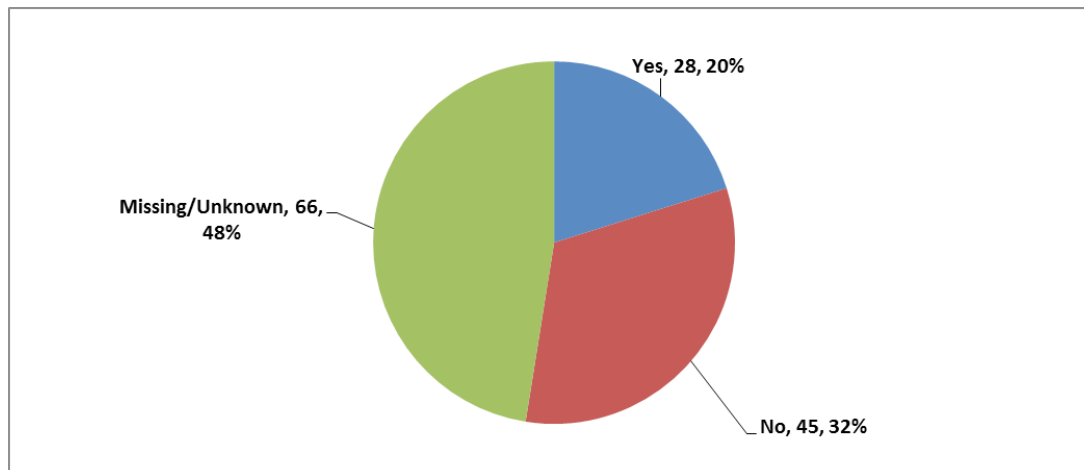
Figure 23: Age of Caregiver for Sleep Related Infant Deaths, when known, GA, 2013 (N=132)



- In 74% of reviewed sleep related deaths, the caregiver was between the ages of 14 and 29. This reinforces the need for infant safe sleep education for teenagers while still in high school
- In 102 cases, the biological parent was the supervisor at the time of death, but in 17 cases (12%), a grandparent, other relative, or babysitter was caring for the infant

## Sleep-Related Infant Deaths

Figure 24: Caregiver Substance Abuse Reported for Sleep Related Infant Deaths, GA, 2013 (N=139)



- In 20% of the reviewed sleep related infant deaths the caregivers were reported to have a history of substance abuse; 32% had no reported history, and 45% were unknown





## Sleep-Related Infant Deaths

Successful “Safe Sleep” programs in Georgia should aim to increase the adoption of safe infant sleep behavior among infant caregivers by activating champions of these protective behaviors within systems that intersect with families at risk. An infant caregiver is defined as the individual who puts a baby down for sleep and could be a parent, grandparent, other family members, child care provider or other guardian. Examples of systems that serve infant caregivers include, but are not limited to:

1. Home visiting programs
2. Food and nutrition programs
3. Community-based organizations such as Healthy Start
4. Housing assistance authorities
5. Child care
6. Hospitals and birthing centers
7. Community health clinics
8. Health care provider networks such as pediatricians, family physicians and obstetricians



## Sleep-Related Infant Deaths

Providers who serve at-risk families in the delivery of health care, public health and social services have an opportunity to educate and empower infant caregivers to adopt safe infant sleep behavior. However, promoting the latest evidence-based recommendations is more complex than the original “Back to Sleep” campaign message, which focused solely on infant sleep position. To be successful, providers must be supported by organizational policies, practices and resources to enhance their efforts to translate the modern safe infant sleep message to action among infant caregivers. Some resources do exist to support these provider networks. ([www.nichd.nih.gov/sts](http://www.nichd.nih.gov/sts))

While all populations are impacted, African-American and American Indian/Alaskan Native families have a significantly higher risk to suffer the loss of an infant due to sleep-related circumstances. Infant caregivers face barriers to implementing safe infant sleep behavior, which can conflict with cultural and familial norms about sleep habits, or even compete with caregiver needs related to sleep deprivation. The American Academy of Pediatrics (AAP) has summarized the state of scientific evidence surrounding these behaviors and identified the following description of a safe sleep environment: placing the infant to sleep on the back, in the infant’s own crib without blankets or soft items or bed-sharing, and breastfeeding. ([www.healthychildcare.org/sids.html](http://www.healthychildcare.org/sids.html))

Agency and organizational leadership in Georgia should provide the framework for successful safe sleep programming by establishing, facilitating, and coordinating a safe infant sleep prevention effort with the purpose of integrating safe sleep promotion throughout systems that serve families, with a particular emphasis on reaching communities at higher risk for SUID. Activities should include strategic planning, identifying and convening multi-disciplinary stakeholders, ensuring representation from safe sleep promotion experts, including researchers and public health professionals with experience designing and implementing educational interventions, breastfeeding advocates, and leadership of key systems serving families. Representatives from the communities at increased risk for SUID can heighten the success of the program by providing feedback about the reality of barriers that infant caregivers face when considering safe sleep as a practice. The safe sleep effort should also include coordinating the development of resources such as training modules, model policy templates or health promotion materials, to facilitate the attainment of goals related to safe infant sleep promotion at the national and local levels.

### **National Resources:**

National Action Partnership to Promote Safe Sleep [www.nappss.org](http://www.nappss.org)

National “Safe to Sleep” Public Education Campaign [www.nichd.nih.gov/sts](http://www.nichd.nih.gov/sts)

Healthy Child Care America, a program of the American Academy of Pediatrics [www.healthychildcare.org/sids.html](http://www.healthychildcare.org/sids.html)

Centers for Disease Control and Prevention [www.cdc.gov/sids/](http://www.cdc.gov/sids/)

National Center for Education in Maternal and Child Health Library [www.mchlibrary.info/suid-sids/trainingtoolkit.html](http://www.mchlibrary.info/suid-sids/trainingtoolkit.html)

First Candle [www.firstcandle.org/new-moms-dads](http://www.firstcandle.org/new-moms-dads)

### **State Resources:**

Georgia Children’s Cabinet [www.children.georgia.gov](http://www.children.georgia.gov)

Georgia Infant Safe Sleep Coalition

### Create a **Safe Sleep** Environment for Baby

Did you know that the features of your baby's sleep area can affect his/her risk for **Sudden Infant Death Syndrome (SIDS)** and other sleep-related causes of infant death, such as suffocation?

**Reduce the risk** of SIDS and other sleep-related causes of infant death by **creating a safe sleep environment** for your baby.

How can you make a **safe sleep environment**?



- ▶ Always place baby **on his or her back** to sleep for all sleep times, including naps.



- ▶ Have the baby **share your room, not your bed**. Your baby should not sleep in an adult bed, on a couch, or on a chair alone, with you, or with anyone else. Try room sharing—keeping baby's sleep area in the *same* room next to where you sleep.



- ▶ Use a **firm sleep surface**, such as a mattress in a safety-approved\* crib, covered by a fitted sheet.



- ▶ Keep soft objects, toys, pillows, crib bumpers, and loose bedding **out of your baby's sleep area**.



- ▶ Dress your baby in **no more than one layer of clothing more than an adult would wear** to be comfortable, and leave the blanket out of the crib. A one-piece sleeper or wearable blanket can be used for sleep clothing. Keep the room at a temperature that is comfortable for an adult.



**Safety-approved\* portable play yards** can also provide a safe sleep environment for your baby. When using a portable play yard, always place baby to sleep on his or her back and keep toys, pillows, and blankets out of the play yard. These actions help reduce the risk of SIDS and other sleep-related causes of infant death.

\*Visit the U.S. Consumer Product Safety Commission website for more information about safety-approved baby sleep areas: <http://www.cpsc.gov/en/Safety-Education/Safety-Education-Centers/cribs/>



Eunice Kennedy Shriver National Institute  
of Child Health and Human Development



Learn more about ways to reduce the risk of SIDS and other sleep-related causes of infant death at

<http://safetosleep.nichd.nih.gov>



### 3 KEY WAYS DADS CAN HELP BABY

# Sleep Safe



**Dads today spend triple the time caring for their children as dads did 50 years ago.**

Making sure dads with infants know how to reduce the risk of **Sudden Infant Death Syndrome (SIDS)** and other sleep-related causes of infant death is more important than ever.

**Dads everywhere** can keep baby safe during sleep in the following ways.

## 1

**Always place your baby on his or her back for sleep—both for naps and at night.**

This is the most effective way to protect a sleeping baby from SIDS and other sleep-related causes of death.

Babies are not more likely to choke if placed on their backs to sleep, even if they throw up or drool while sleeping.



## 2

**Share your room, not your bed.**

Your baby should sleep in your room, but in his or her own separate sleep area. Baby should not sleep in an adult bed, on a couch, or in a chair alone, with you, or with anyone else.

Room sharing without bed sharing may reduce the risk of SIDS by as much as 50% and helps prevent accidental suffocation.



## 3

**Use a firm sleep surface—such as a mattress in a safety-approved\* crib—covered by a fitted sheet.**

Remove all bumpers, blankets, loose bedding, and soft toys from the sleep area.

Do not use car seats, strollers, baby carriers, swings, and other sitting devices as baby's routine sleep area.



Learn more about what dads can do to create a safe sleep environment for babies at <http://safetosleep.nichd.nih.gov>.

\*For information about crib safety, visit: <http://www.cpsc.gov/Safety-Education/Safety-Education-Centers/cribs/>



**20<sup>th</sup>**  
**Anniversary**  
**SAFE TO SLEEP**



Eunice Kennedy Shriver National Institute  
of Child Health and Human Development





## Reviewed Medical Deaths

All children will likely develop some types of different health issues throughout infancy and childhood, even into their teenage years. For the most part, these health issues vary and usually do not interfere with their everyday life and development. On the other hand, there are a variety of medical conditions that can last for a long time, affect the child's daily activities, require extensive medical care, and in many cases, result in the death of a child. Medical deaths are reviewable by the Child Fatality Review committee if the death occurs unexpectedly, is unexplained, unattended by a physician, or in suspicious or unusual manner.

Many medical deaths may not be reviewed by committees if the death occurred in a hospital, or was not reported to the local coroner/ medical examiner. Deaths that are not reviewed by the Child Fatality Review committee are deaths that occur while in hospice and/or under a physician's care. These are considered "expected" deaths.

In 2013, there were 79 deaths reviewed due to medical related causes. Medical related deaths were highest among infants and toddlers (age 1-4), followed by older teens, and adolescents.

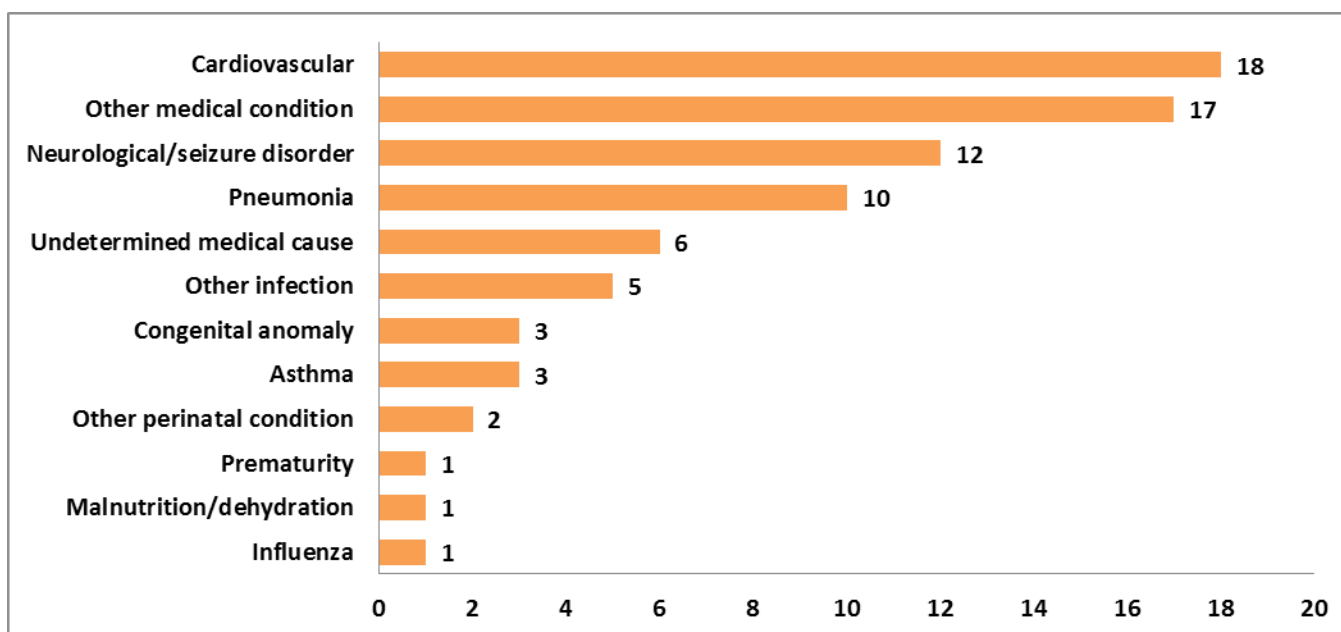


## Reviewed Medical Deaths

Figure 25: Demographics of Reviewed Medical Deaths, GA, 2013 (N=79)

	<u>Infant</u>	<u>1 to 4</u>	<u>5 to 9</u>	<u>10 to 14</u>	<u>15 to 17</u>	<u>Total</u>
White Male	4	6	2	2	4	18
White Female	4	4		1	2	11
African-American Male	6	5	3	4	5	23
African-American Female	3	6	1	4	5	19
Hispanic Male	1					1
Hispanic Female	2	2		1		5
Multi-racial Female		1				1
Other Male			1			1
	20	24	7	12	16	79

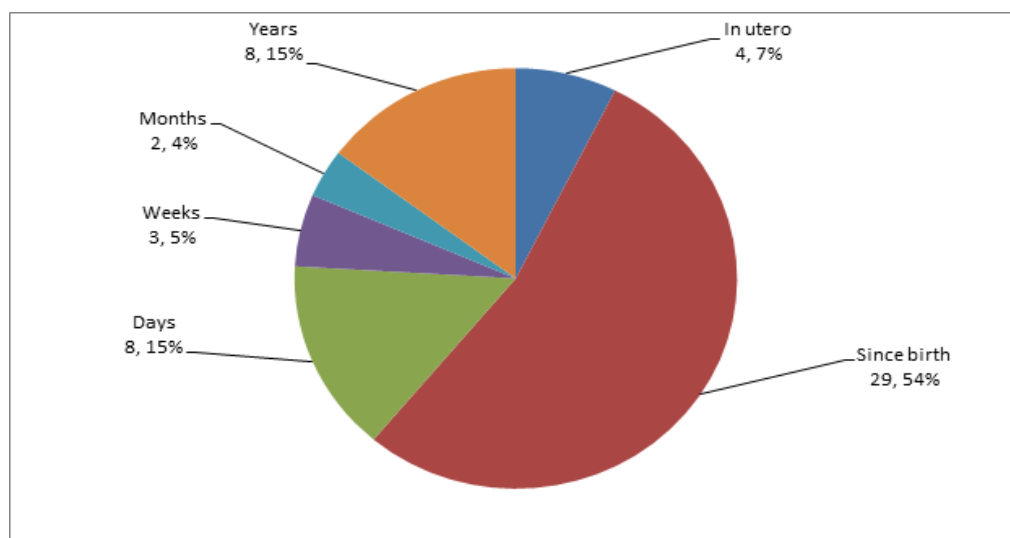
Figure 26: Medical Causes of Reviewed Deaths, GA, 2013 (N=79)



- The leading causes reported by CFR committees were cardiovascular, neurological, and pneumonia
- The category "other infection" includes respiratory infections, appendicitis, peritonitis, necrosis and chorioamnionitis

## Reviewed Medical Deaths

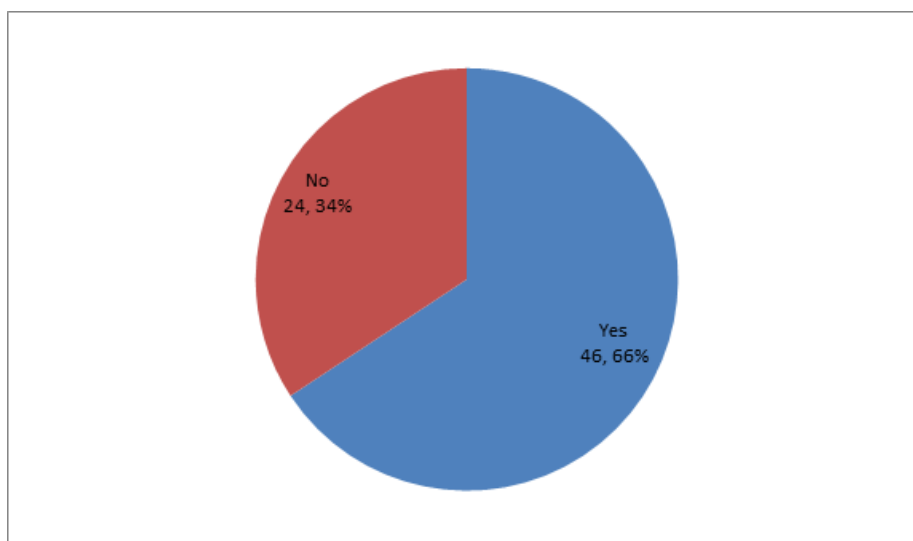
**Figure 27: Length of time child had medical condition, when known, GA, 2013 (N=54)**



In 54 cases, the committees reported the length of time the child had the medical condition.

- Just over half (54%) of decedents had been living with their medical conditions since birth
- Fifteen percent had received the diagnosis within days of the death

**Figure 28: Child receiving health care for medical condition, when known, GA (N= 70)**



“Receiving health care” includes attending medical appointments, taking medications and following a prescribed plan for the medical condition.

- Forty-six decedents were reported to have been receiving health care for their medical condition (66%)



## Reviewed Medical Deaths

### Prevention Opportunities

- Make certain to get early and comprehensive prenatal health care and nutrition
- Encourage healthy nutrition at an early age
- Introduce and integrate physical activity when children are young into their daily lives to prevent a sedentary lifestyle
- Be attentive and enable early diagnosis of developmental delays or mental illness to improve access to care designed to help
- Make it a priority to get regular medical care for children to increase the chances of detecting chronic diseases and get them treated early
- School based health centers should be implemented and made available to those who do not have a primary care provider. This could ensure that more children are appropriately screened for potential chronic illnesses including cardiovascular and neurological disorders
- Enhancement should be made to youth school sports physical requirements
- Improve the health care system to make it high quality, comprehensive, affordable, and accessible for everyone

### Resources

American Academy of Pediatrics ([www.aap.org](http://www.aap.org))

Asthma and Allergy Foundation of America ([www.aaafa.org](http://www.aaafa.org))

Centers for Disease Control and Prevention ([www.cdc.gov](http://www.cdc.gov))

Healthy Children ([www.healthychildren.org](http://www.healthychildren.org))

Georgia Department of Public Health (<http://dph.georgia.gov/>)





## All Unintentional Reviewed Deaths

In 2013, CFR committees reviewed 179 unintentional injury-related deaths. An unintentional injury-related death may also be called an “accident”, but very often the types of circumstances that lead to these deaths are predictable – and therefore, preventable. According to the Centers for Disease Control and Prevention (CDC) 2012 Vital Signs report, death rates from unintentional injuries among children and adolescents from birth to age 19 declined by nearly 30 percent from 2000 to 2009. Although rates for most causes of child injuries have been dropping, poisoning death rates did increase, with a 91 percent increase among teens aged 15-19, largely due to prescription drug overdose. Suffocation rates are on the rise, with a 54 percent increase in reported suffocation among infants less than one year old.

The most common cause of death from unintentional injury for children in the United States is motor vehicle crashes; other leading causes include suffocation, drowning, poisoning, fires, and falls. Across the United States, every four seconds, a child is treated for an injury in the emergency department, and every hour, a child dies as a result of an injury (CDC).

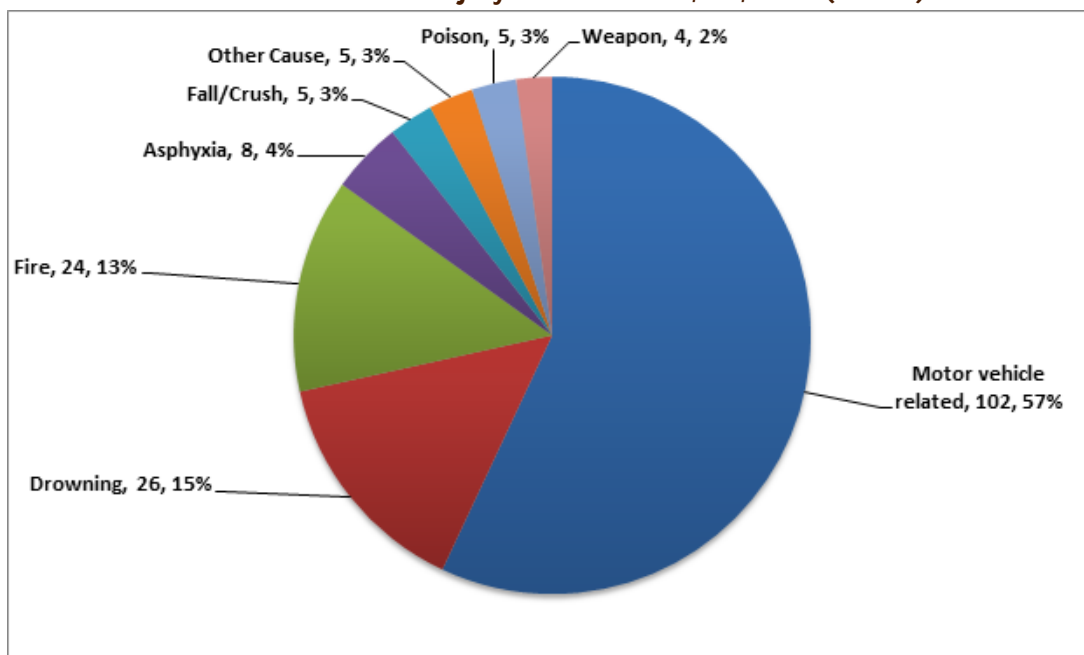
**Figure 29: Demographics of Reviewed Unintentional Injury-related Deaths, GA, 2013 (N=179)**

<u>Cause</u>	<u>Infant</u>	<u>1 to 4</u>	<u>5 to 9</u>	<u>10 to 14</u>	<u>15 to 17</u>	<u>Total</u>
Motorvehicle-related	5	19	16	16	46	102
Drowning	1	8	5	4	8	26
Fire	1	11	8	4		24
Asphyxia		6	2			8
Fall/Crush		4			1	5
Other Cause	1	3			1	5
Poison				1	4	5
Weapon		1		1	2	4
Total	8	52	31	26	62	179

- Motor vehicle crashes accounted for more than half of all unintentional injury-related deaths of children (57%). Relevant policies and programs to address injury prevention and fatality should be data-driven, and geared toward the identified risk factors
- Drowning and fire-related deaths together accounted for nearly a third of unintentional injury related deaths (28%). These types of incidents often claim the lives of multiple individuals, often due to the rescue attempts made by caregivers or bystanders, which leads to additional fatalities. Prevention efforts should include safe rescue techniques for the general public
- Other injury deaths that were reviewed include accidental overdoses, television falls, and accidental firearm shootings

## All Unintentional Reviewed Deaths

Figure 30: Causes of Reviewed Unintentional Injury-related Deaths, GA, 2013 (N=179)



According to the CDC, unintentional injury is the leading cause of death for Americans age 1-44. For infants younger than 12 months, unintentional injury is the 5<sup>th</sup> leading cause of death. The following chart breaks down the specific causes of injury in the United States by age group.



## All Unintentional Reviewed Deaths

### 10 Leading Causes of Injury Deaths by Age Group Highlighting Unintentional Injury Deaths, United States – 2012

Rank	Age Groups										Total
	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	
1	Unintentional Suffocation 965	Unintentional Drowning 415	Unintentional MV Traffic 339	Unintentional MV Traffic 407	Unintentional MV Traffic 6,910	Unintentional Poisoning 7,737	Unintentional Poisoning 7,899	Unintentional Poisoning 10,340	Unintentional Poisoning 5,431	Unintentional Fall 24,190	Unintentional Poisoning 36,332
2	Homicide Unspecified 170	Unintentional MV Traffic 357	Unintentional Drowning 141	Suicide Suffocation 195	Homicide Firearm 3,931	Unintentional MV Traffic 5,949	Unintentional MV Traffic 4,620	Unintentional MV Traffic 5,359	Unintentional MV Traffic 4,543	Unintentional MV Traffic 6,378	Unintentional MV Traffic 34,935
3	Unintentional MV Traffic 68	Homicide Unspecified 153	Unintentional Fire/Burn 74	Homicide Firearm 124	Unintentional Poisoning 3,175	Homicide Firearm 3,427	Suicide Firearm 2,924	Suicide Firearm 4,113	Suicide Firearm 3,747	Suicide Firearm 4,796	Unintentional Fall 28,753
4	Homicide Other Spec., Classifiable 43	Unintentional Suffocation 138	Homicide Firearm 67	Unintentional Drowning 109	Suicide Firearm 2,218	Suicide Firearm 2,760	Suicide Suffocation 2,054	Suicide Suffocation 2,029	Unintentional Fall 2,168	Unintentional Unspecified 4,664	Suicide Firearm 20,666
5	Unintentional Drowning 43	Unintentional Fire/Burn 101	Unintentional Suffocation 34	Suicide Firearm 104	Suicide Suffocation 1,882	Suicide Suffocation 2,085	Homicide Firearm 1,887	Suicide Poisoning 1,974	Suicide Poisoning 1,485	Unintentional Suffocation 3,403	Homicide Firearm 11,622
6	Undetermined Suffocation 41	Unintentional Pedestrian, Other 98	Unintentional Other Land Transport 24	Unintentional Suffocation 45	Unintentional Drowning 540	Suicide Poisoning 852	Suicide Poisoning 1,251	Unintentional Fall 1,344	Suicide Suffocation 1,172	Unintentional Poisoning 1,655	Suicide Suffocation 10,088
7	Homicide Suffocation 26	Unintentional Struck by or Against 52	Unintentional Poisoning 21	Unintentional Other Land Transport 43	Homicide Cut/Pierce 386	Undetermined Poisoning 557	Undetermined Poisoning 640	Homicide Firearm 1,181	Unintentional Suffocation 677	Adverse Effects 1,639	Suicide Poisoning 6,729
8	Undetermined Unspecified 26	Homicide Other Spec., Classifiable 46	Homicide Unspecified 18	Unintentional Fire/Burn 36	Suicide Poisoning 364	Homicide Cut/Pierce 437	Unintentional Fall 458	Undetermined Poisoning 881	Homicide Firearm 589	Unintentional Fire/Burn 1,021	Unintentional Suffocation 6,238
9	Unintentional Natural/Environment 19	Homicide Firearm 45	Unintentional Pedestrian, Other 18	Unintentional Poisoning 30	Undetermined Poisoning 247	Unintentional Drowning 433	Unintentional Drowning 370	Unintentional Drowning 533	Unintentional Fire/Burn 493	Suicide Poisoning 799	Unintentional Unspecified 5,915
10	Unintentional Fire/Burn 17	Unintentional Natural/Environment 39	Unintentional Struck by or Against 17	Unintentional Firearm 22	Unintentional Fall 218	Unintentional Fall 319	Homicide Cut/Pierce 351	Unintentional Suffocation 451	Undetermined Poisoning 467	Suicide Suffocation 667	Unintentional Drowning 3,551

Data Source: National Center for Health Statistics (NCHS), National Vital Statistics System.  
Produced by: National Center for Injury Prevention and Control, CDC using WISQARS™.



Centers for Disease  
Control and Prevention  
National Center for Injury  
Prevention and Control





## Motor Vehicle-Related Deaths

“Motor vehicle-related” include injury related deaths involving motor vehicles and other forms of transportation, including public transport, farm equipment, recreational vehicles, bicycles, scooters, and skateboards.

In 2013, motor vehicle-related deaths were the leading cause of unintentional injury-related deaths. Motor vehicle-related deaths accounted for 102 out of 178 reviewed unintentional injury-related deaths (57%) in Georgia. Reviewed motor vehicle-related deaths have increased in the past two years, from 82 motor vehicle related deaths in 2012, and 87 in 2011.

**Figure 31: Demographics of Reviewed Motor Vehicle-Related Deaths, GA, 2013 (N=102)**

	<u>Infant</u>	<u>1 to 4</u>	<u>5 to 9</u>	<u>10 to 14</u>	<u>15 to 17</u>	<u>Total</u>
African-American Male	1	5	6	1	12	25
African-American Female	1	6	3	3	5	18
White Male	2	5	3	6	16	32
White Female			1	6	12	19
Hispanic Male		1	2		1	4
Hispanic Female	1	1	1			3
Other Race Female		1				1
	5	19	16	16	46	102

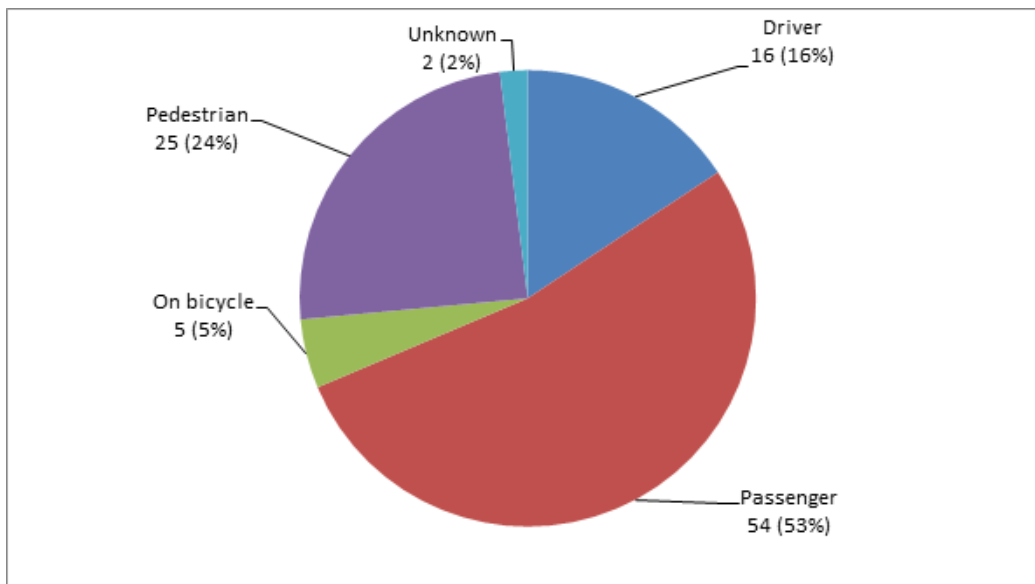
The number of motor vehicle-related deaths has increased for teenagers (ages 15-17) from 31 in 2012 and 34 in 2011. This group had the largest number of reviewed motor vehicle-related fatalities. According to the Centers for Disease Control and Prevention, motor vehicle crashes are the leading cause of death in the United States for teenagers. According to the National Highway Traffic Safety Administration (NHTSA), teenagers are involved in three times as many fatal crashes as all other drivers, on the basis of miles driven. Distracted driving is a concern for this age group, as well as distracted walking, often leading to injury and death.





## Motor Vehicle-Related Deaths

Figure 32: Reviewed Motor Vehicle-Related Deaths by Position of Decedent, 2013 (N=102)

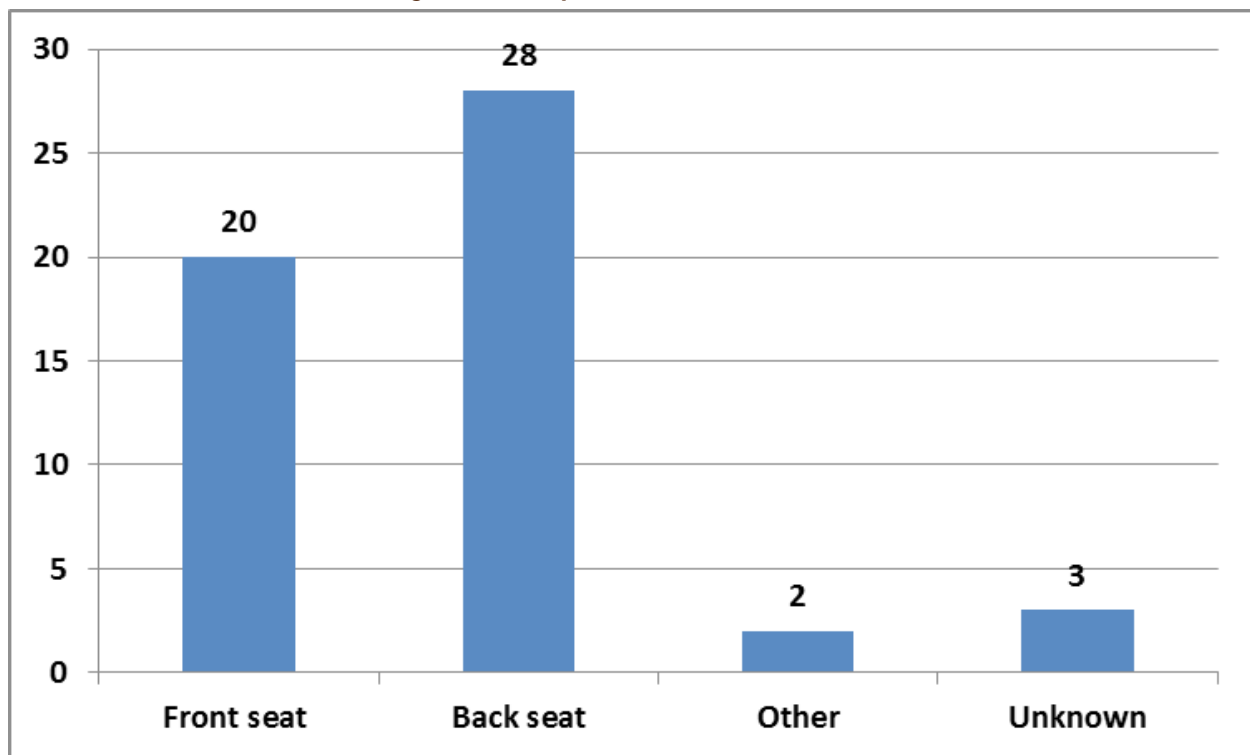


- The "Driver" category includes 15 teens (age 15-17) and a nine-year-old operating an ATV
- Occupant information was unknown for two (2%) of the motor vehicle-related deaths reviewed by the CFR committees. Unknown occupancy usually occurs when multiple decedents are ejected from the vehicle and there is no indication of the child's position (i.e. driver or passenger) prior to the crash



## Motor Vehicle-Related Deaths

Figure 33: Position of Child as Passenger, when reported, GA, 2013 (N=53)



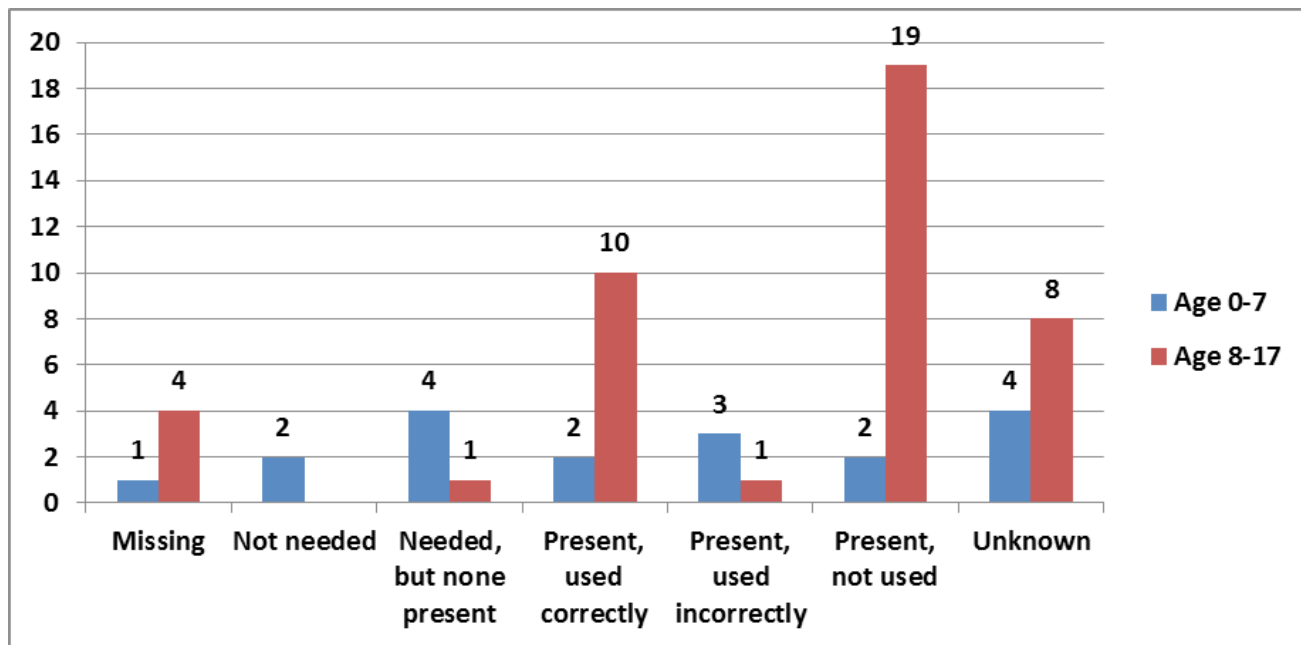
CFR committees reported 54 motor vehicle passengers who died as a result of a motor vehicle related injury.

- There were 28 children who were located in the back seat of the vehicle (including a school bus)
- Twenty were reported to occupy the front passenger seat
- Two cases reported the child's position as "other". The "Other" category includes circumstances such as horseback rider, and car surfing
- The positions of three of the passengers were unknown



## Motor Vehicle-Related Deaths

Figure 34: Occupant Restraint Usage (drivers and passengers), 2013 (N=61)



- Of the 61 motor vehicle occupants, 18 were under the age of eight, and 43 were age 8-17
- There were nine infants/young children who were improperly restrained (or completely unrestrained) in a child safety seat
- There were 21 adolescents/teens who were improperly restrained (or completely unrestrained) in a seat belt

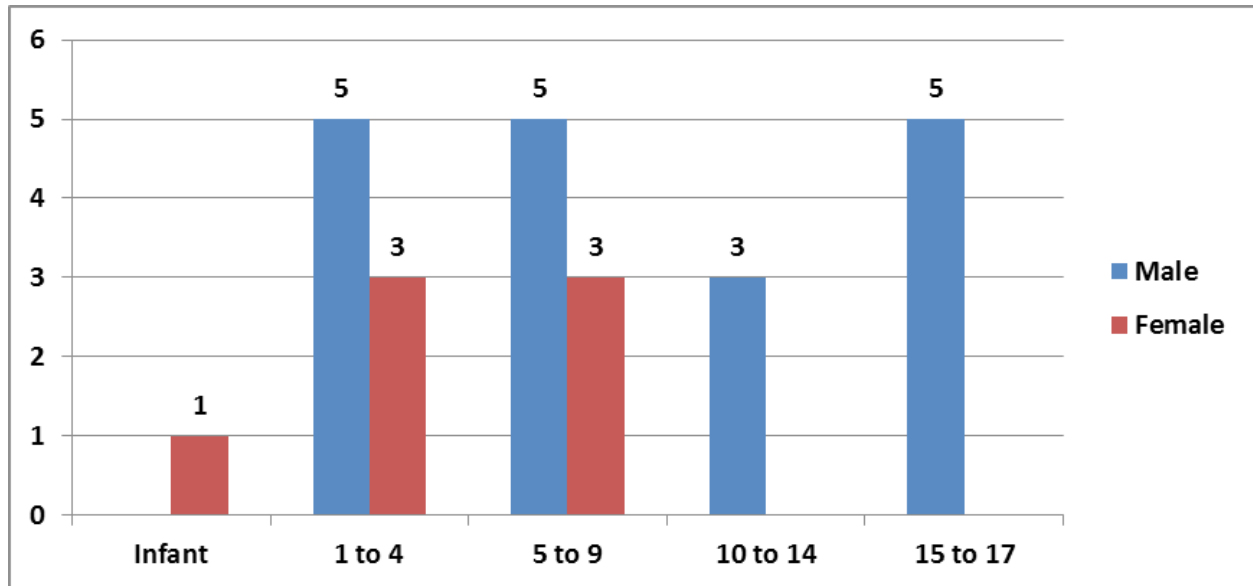
Child restraint systems should be used until the child reaches the upper weight or height limit of the seat. A child should remain rear-facing until age two, if possible. Never place rear-facing car seats in the front with an active airbag.

Children age two and older should use a forward-facing car seat with a harness until they reach the upper weight or height limit of the seat. Before transitioning to a seat belt, a child should use a booster seat. Before allowing a child to use a seat belt, make sure it fits properly with the lap belt across the upper thighs and not on the stomach and the shoulder belt across the chest and collar bone and not the neck or face. Georgia law requires that children under age 8 use a child restraint system. Often, children eight and older are not ready for a safety belt. Consider using a booster until the child is at least 57" tall. All children under age 13 should always ride in the back seat.



## Motor Vehicle-Related Deaths

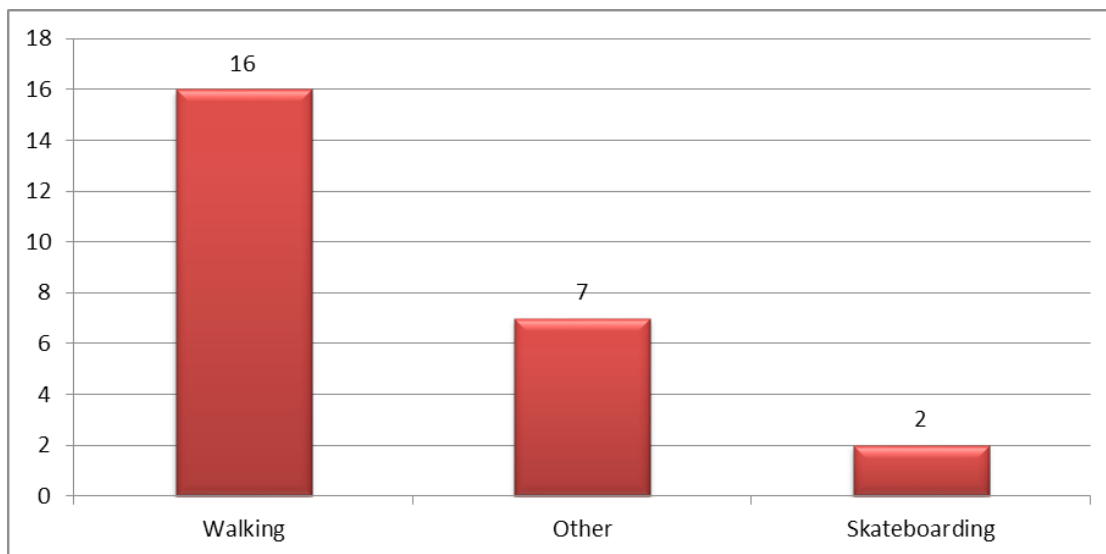
Figure 35: Pedestrian Deaths by Age and Sex, GA, 2013 (N=25)





## Motor Vehicle-Related Deaths

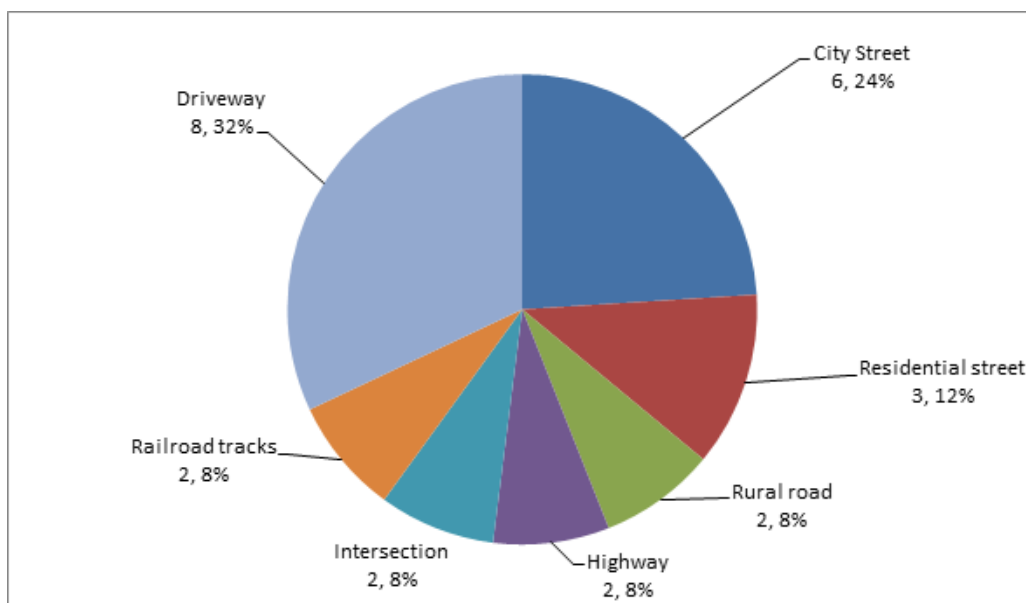
Figure 36: Activity of Child as Pedestrian, GA, 2013 (N=25)



In 2013, there were 25 children who died from a motor vehicle-related injury while pedestrians.

- The "Other" category includes activities such as playing on train tracks and playing/standing in a driveway

Figure 37: Location of Reviewed Motor Vehicle-Related Pedestrian Deaths, GA, 2013 (N=25)



- Six of the eight "driveway" location deaths involved toddlers ages 1-4
- The "city street" was the most common location for children ages 5 to 9
- "The residential street" and "railroad tracks" locations were more common among teens ages 15-17

## Motor Vehicle-Related Deaths

### Passenger Prevention

Always use proper restraints on every trip! Children should be buckled in car seats, booster seats, or seat belts no matter the length of time of the trip. Before transitioning the child from the booster seat to the safety belt alone, make sure that the lap belt fits properly across the upper thighs and not on the stomach and the shoulder belt fits across the chest and not the neck or face. Children often model adult behavior, so parents and caregivers should ride restrained on every trip as well.

### Operator Prevention

Driving is a very complex task that requires processing and accurately estimating risk on roadways, cultivating appropriate reactions to minimize risks and gaining experience to predict what actions others may take on the road. Georgia has a Graduated Driver's License law, called TADRA (Teenage and Adult Driver Responsibility Act), which was designed to enhance skill-building for new drivers. TADRA is a graduated driver's license program for young drivers ages 15 to 18. It was established in Georgia by a collaborative effort of highway safety advocates, legislators, law enforcement officials, educators, businesses and media in the wake of a high number of fatal vehicle crashes involving young, inexperienced drivers. TADRA has significantly changed the way young motor vehicle operators earn and maintain driving privileges by developing a controlled means for new drivers to improve driver experience and reducing high risk driving situations. It is additionally important for teen drivers to adhere to the minimum legal drinking age and zero blood-alcohol laws.



## Motor Vehicle-Related Deaths

### Pedestrian Death Prevention

Safer environments separate people from cars, slow traffic in areas most traveled by pedestrians, and improve street crossings. Law enforcement can play an important role to ensure that traffic laws are designed to protect pedestrians. Positioning speed bumps and specialized crosswalks have been shown to reduce the risk of motor vehicle-related deaths.

It is extremely important to always know where children are before moving the vehicle. Make sure that children are moved away from the vehicle, are in full view, and that another adult is properly supervising children before moving the car. Some research suggests using rear-view cameras and sensors to prevent child deaths in driveways and parking areas. There are several vehicle manufacturers that currently provide such devices. Additionally, teach children to not play in, around or behind parked vehicles.

### National Resources

Centers for Disease Control and Prevention, Injury Prevention and Control ([www.cdc.gov](http://www.cdc.gov))

US Department of Transportation, Federal Highway Administration ([www.fhwa.dot.gov](http://www.fhwa.dot.gov))

National Highway Traffic Safety Administration ([www.nhtsa.gov](http://www.nhtsa.gov))

### State Resources

Georgia Department of Driver Services ([www.dds.ga.gov](http://www.dds.ga.gov))

Georgia Governor's Office of Highway Safety ([gahighwaysafety.org](http://gahighwaysafety.org))

Georgia Injury Prevention Program, Department of Public Health ([www.health.state.ga.us](http://www.health.state.ga.us))

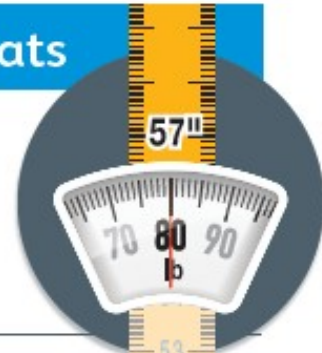




### What to Know about Booster Seats

Booster seats protect children who are too big for a car seat but too small for a seat belt.

Seat belts don't fit children properly until they are **at least 57" (4'9") tall and weigh between 80 and 100 pounds.**



Motor vehicle crashes are the second-leading cause of death for children 4 to 10 years old.

**340 children** this age died in motor vehicle crashes in 2012.



**1/3** of these children were riding without a restraint that could have saved their lives.

Although seat belts are safer than nothing at all, children who should be in booster seats but wear only seat belts are at risk of **severe abdominal, head and spinal injuries** in the event of a crash.



Booster seats can **reduce the risk** of serious injury by 45 percent compared to seat belts alone.



Safe Kids Worldwide surveyed 1,000 parents of 4 to 10 year olds. The study found **seven in ten parents do not know** that a child should be at least 57 inches (4'9") to ride in a car using a seat belt without a booster seat.



The study revealed 9 out of 10 parents move their child from a booster seat to seat belt **before their child is big enough.**



One in five parents whose children carpool say they **"bend the rules"** when driving, letting children ride without seat belts and without the car seat or booster seat they would normally use.



And **61 percent of parents say they notice other carpool drivers** bending the rules.

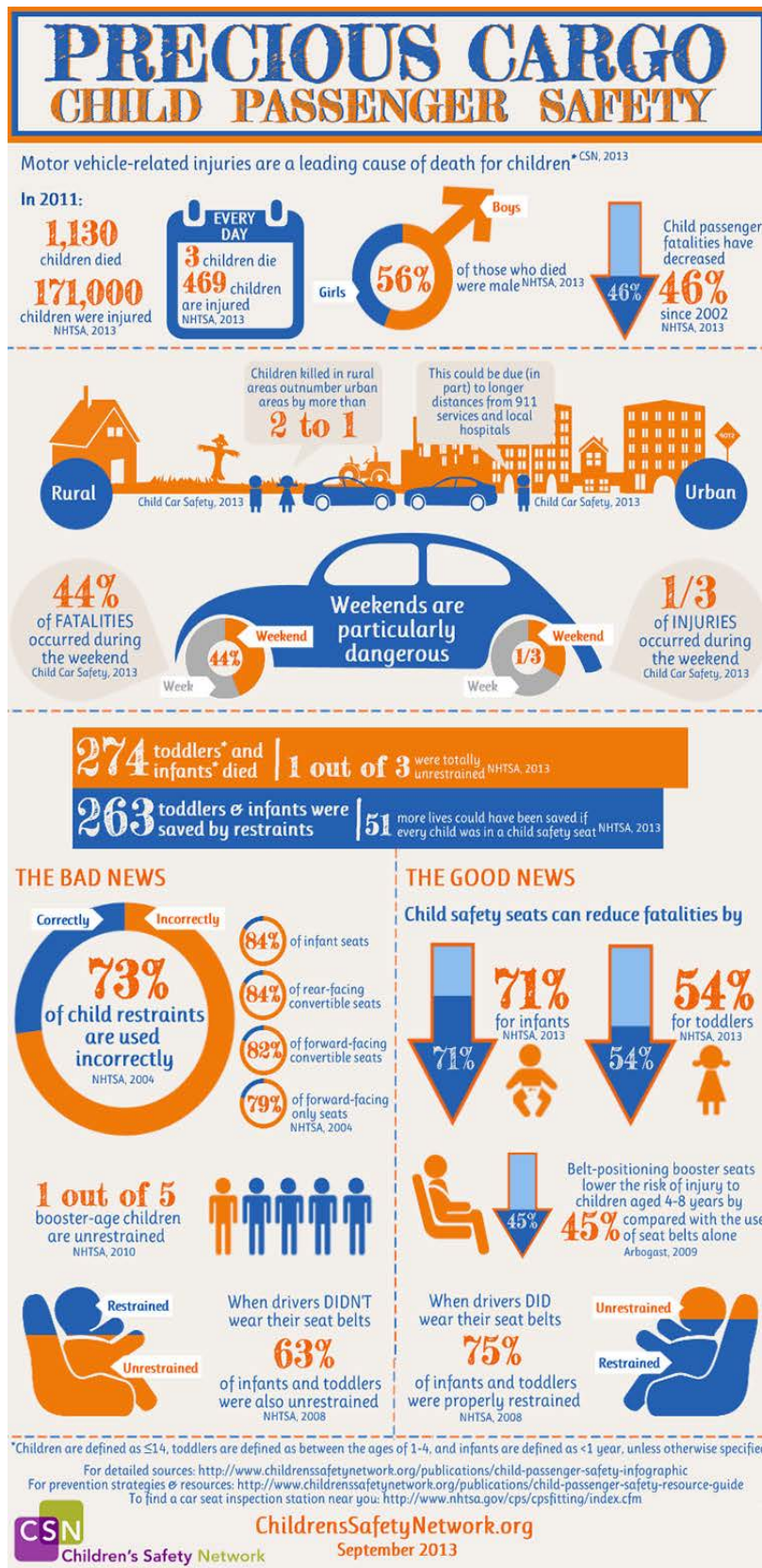
**Buckle up every ride, every time, in the right seat.**

REMEMBER: A child needs to be at least 57" tall (4'9") and weigh between 80 and 100 pounds to ride with just a seat belt.

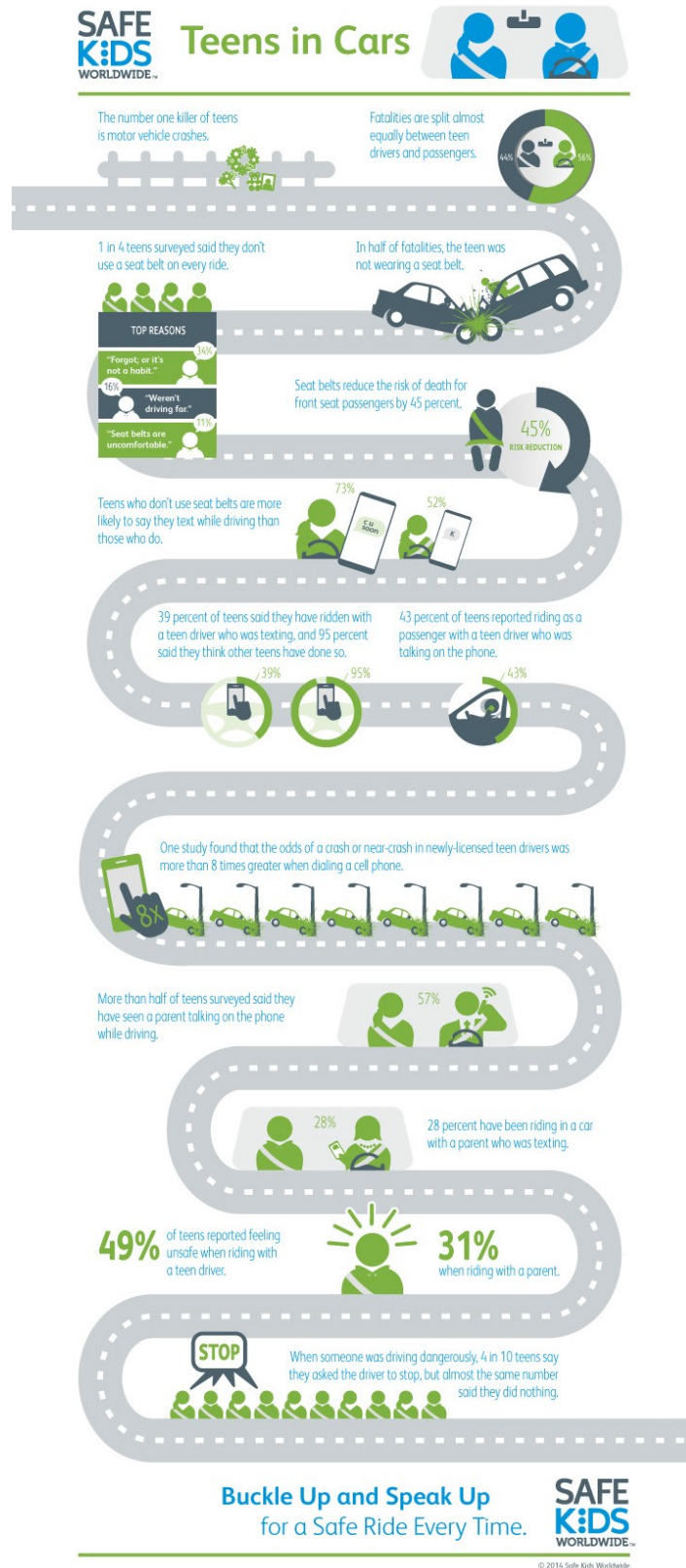
**SAFE  
KIDS**  
WORLDWIDE™

Learn more at [www.safekids.org](http://www.safekids.org)





# Motor Vehicle-Related Deaths



## Drowning Deaths

Children of all ages love the water. Drowning can occur quickly and quietly. According to the National Drowning Prevention Alliance, drowning is the leading cause of unintentional injury related deaths for children ages one to four. Additionally, drowning is the second leading cause of unintentional injury deaths for children five to nine years of age.

In 2013, 26 children died from drowning in Georgia. Drowning deaths accounted for 26 of 179 unintentional injury related child deaths (15%). Male children had the largest percentage of drowning deaths (77%). The American Academy of Pediatrics (AAP) 2010 Policy Statement on the Prevention of Drowning states that rates of drowning death vary with age, gender, and race. Age groups at greatest risk are toddlers and male adolescents. After one year of age, male children are at greater risk than are female children. African-American and American Indian/Alaska Native children have higher drowning fatality rates than do White and Asian American children. From 2000 to 2006, the highest death rates were seen in White males less than four years of age and African-American male teens 15 to 19 years of age.

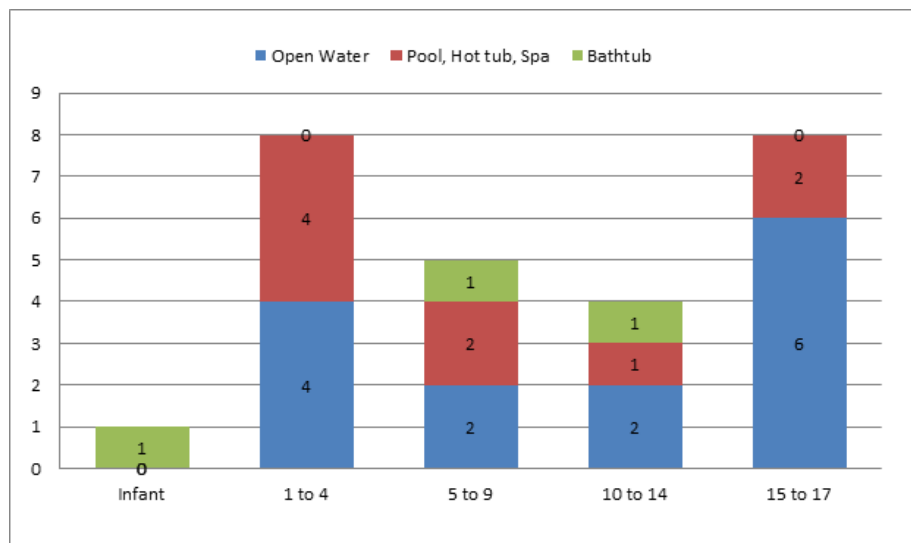
**Figure 38: Demographics of Reviewed Drowning Deaths, 2013 (N=26)**

	<u>Infant</u>	<u>1 to 4</u>	<u>5 to 9</u>	<u>10 to 14</u>	<u>15 to 17</u>	<u>Total</u>
White Male		5			2	7
White Female			2			2
African-American Male		1	3	3	3	10
African-American Female	1	1		1		3
Hispanic Male					3	3
Other Female		1				1
Total	1	8	5	4	8	26



## Drowning Deaths

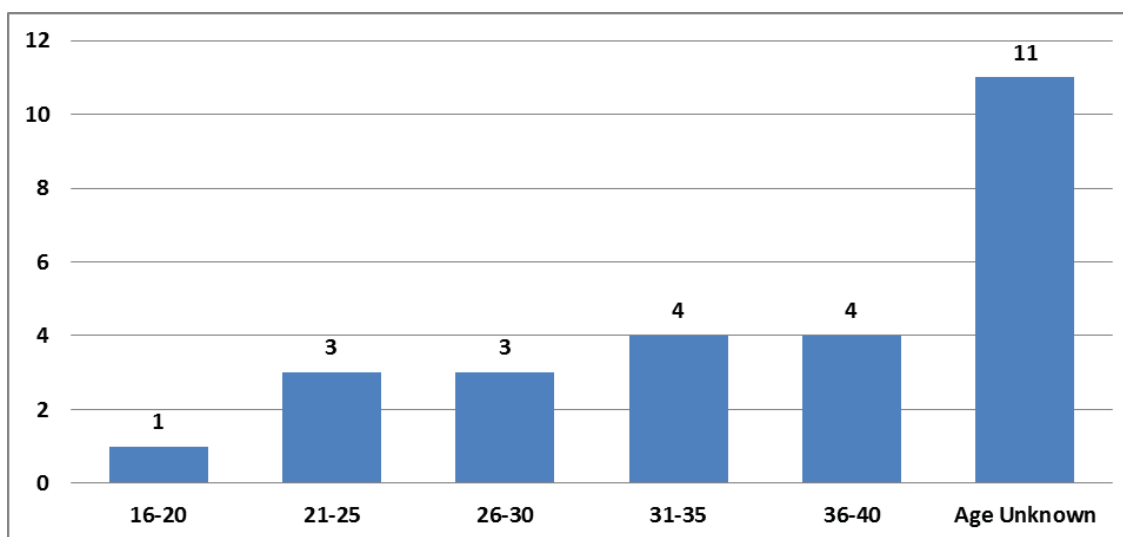
Figure 39: Drowning Fatalities by Age and Location, GA 2013 (N=26)



Location plays a major role in drowning. In 2013, there were 14 decedents who drowned in open water (54%) such as oceans, rivers, lakes and ponds. There were nine decedents who drowned in a pool, hot tub, or spa (35%) and three decedents who drowned in a bathtub.

**Supervise with your eyes!** Children need constant supervision around water whether it's in a bathtub, home pool, pond, beach, or lake. Many drowning deaths occur when a supervisor is distracted for a brief moment or leaves the area for a short period of time.

Figure 40: Supervisor's age for Reviewed Drowning Deaths, GA, 2013 (N=26)

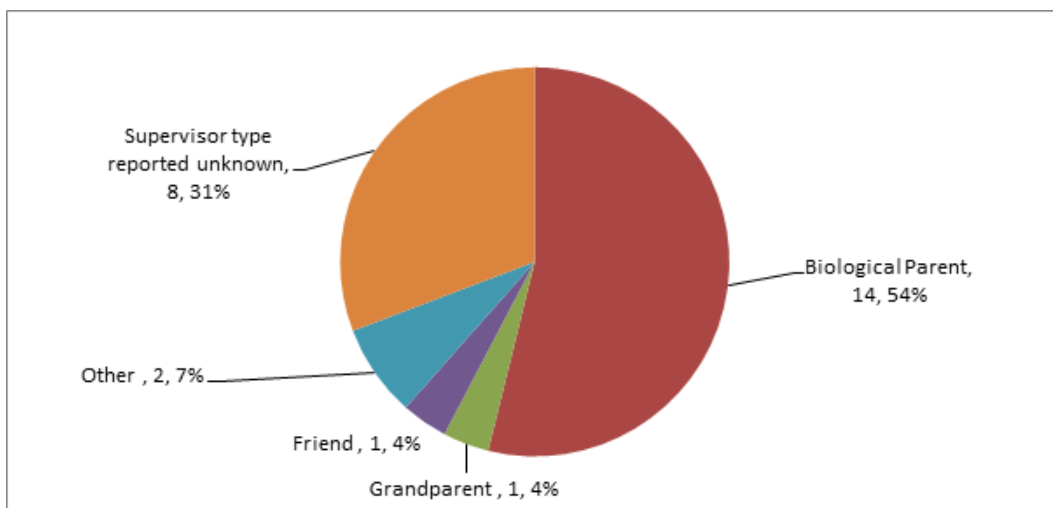


- In 11 cases (42%), the CFR committee did not know the age of the supervisor responsible for the decedent at the time of death



## Drowning Deaths

Figure 41: Supervisor's relationship to child for Reviewed Drowning Deaths, GA , 2013 (N=26)



- Biological parents were the reported supervisors for 14 decedents (54%)
- Many times, parents and caregivers were engaged in other distracting activities like caring for multiple children, talking or texting on cell phones, reading, eating, or socializing with others



# Drowning Deaths

## Drowning Prevention

The level of supervision is essential for prevention of child drowning deaths. It is highly recommended to give children undivided attention and distraction free supervision around any type of water. Supervisors should always be within an arm's reach when watching young children in water. Younger children should be supervised using "touch supervision" while in the bathtub, swimming pool or playing in or around water.

Multilayered protection for young children that include effective pool barriers should be put into place. These include the use of perimeter fencing around pools, self-closing/self-latching gates, and alarms on doors leading directly to pools. Tables, chairs and other items that can be used for climbing to gain access to water should be removed and secured away from the pool area. For hot tubs and spas, specialty covers that support the weight of adults should be used to secure these areas when not in use.

Proper swimming instruction and water survival skills for all children and supervisors are highly recommended. All supervisors of children around water should have CPR training and be first aid certified and have knowledge of proper rescue techniques. Young children and children who don't know how to swim should always wear U.S. Coast Guard approved personal flotation devices or life jackets around any type of open water. Always have rescue equipment and a phone on hand near water.

For children with seizure disorders, the Centers for Disease Control and Prevention suggest the child take showers rather than using the bathtub for bathing. Additionally, one-on-one supervision and the use of flotation devices should be provided for children with medical conditions such as seizure disorders.

## National Resources

Centers for Disease Control and Prevention ([www.cdc.gov](http://www.cdc.gov))

Children's Safety Network ([www.childrenssafetynetwork.org](http://www.childrenssafetynetwork.org))

National Drowning Prevention Alliance ([www.ndpa.org](http://www.ndpa.org))

Pool Safely ([www.poolsafely.org](http://www.poolsafely.org))

## State Resources

Safe Kids of Georgia ([www.safekidsgeorgia.org](http://www.safekidsgeorgia.org))

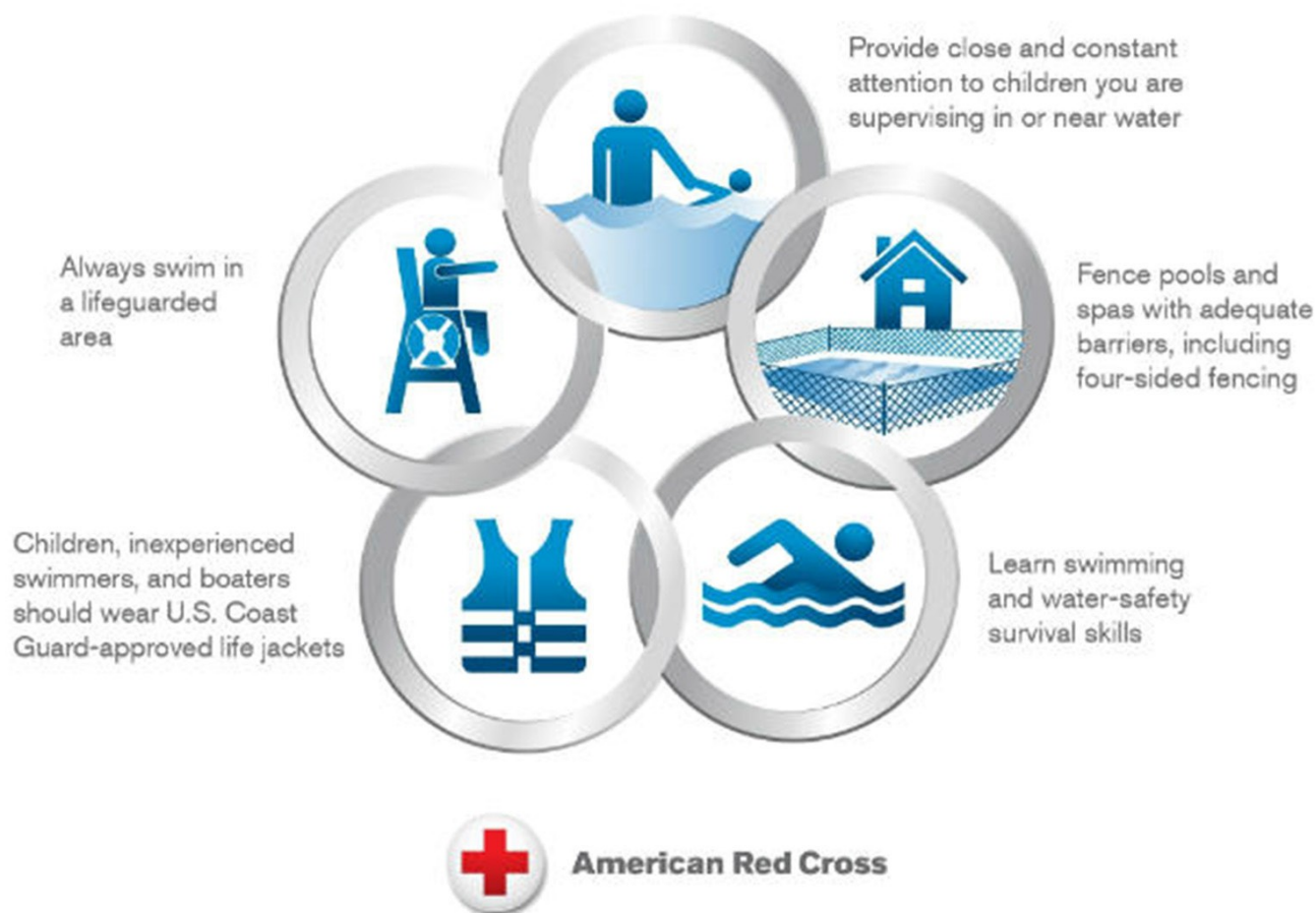
Georgia Children's Cabinet ([www.children.ga.gov](http://www.children.ga.gov))

Georgia Department of Natural Resources, Wildlife Division (<http://www.georgiawildlife.com>)



### Circle of Drowning Prevention

Layers of protection are essential to help prevent drowning.  
Plan ahead for aquatic activities:





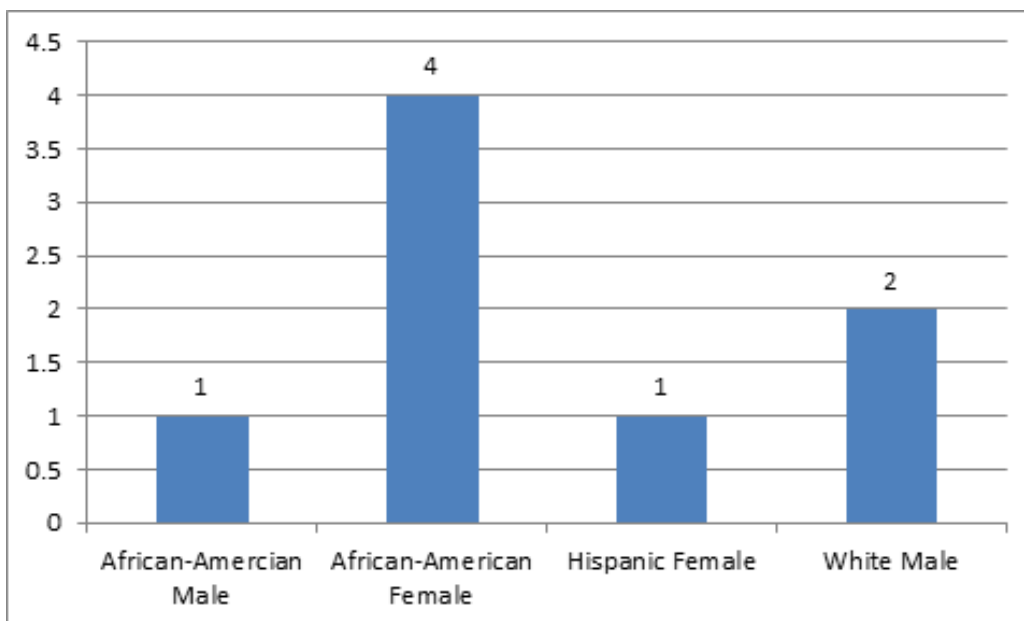
## Asphyxia Deaths

Suffocation/asphyxia is the fourth leading cause of unintentional child death. Toddlers and preschool aged children are those most at risk for choking and strangulation. Their increased activity puts them at risk of choking on food or small objects. According to a study conducted by the National Center for Child Death Review, most unintentional suffocation occurs due to the following factors:

- Overlay: When a person with whom the child is sleeping rolls onto and smothers the child
- Positional asphyxia: A child's face becomes trapped in soft bedding or wedged into a tight place, as between a mattress and wall
- Covering of the face or chest: When an object prevents the child from breathing by covering the mouth or compressing the chest, e.g., plastic bags, heavy bedding or furniture
- Choking: When a child chokes on an object such as food or a small toy
- Confinement: When a child becomes trapped in an airtight place such as a refrigerator or toy chest
- Strangulation: When a rope, cord, hands or other object strangles a child

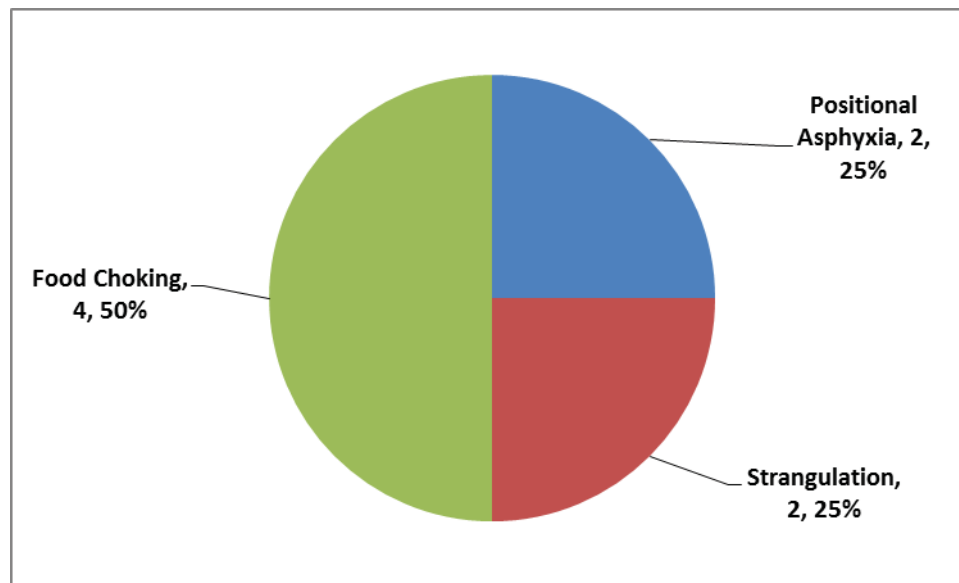


**Figure 42: Reviewed Asphyxia Deaths by Race/Ethnicity, 2013 (N=8)**



## Asphyxia Deaths

Figure 43: Reviewed Asphyxia Deaths by Mechanism, 2013 (N=8)



- Seventy-Five percent (6) of reviewed asphyxia deaths involved children age one to four; the remaining two deaths involved children age five to nine
- Proper supervision is a prominent factor in preventing non-sleep asphyxia deaths among infants and toddlers

### Opportunities for Prevention

- Infants and toddlers should be closely supervised to ensure that they remain safe
- Keep small objects such as deflated balloons, small toy parts, window blind cords, and rope out of the reach of small children
- Small children should be watched closely during mealtime and all food objects should be chopped or ground into small chewable pieces to prevent choking

Safe Kids Georgia

[www.safekids.org](http://www.safekids.org)

The National Center for Child Death Review

[www.childdeathreview.org](http://www.childdeathreview.org)



## Fire-Related Deaths

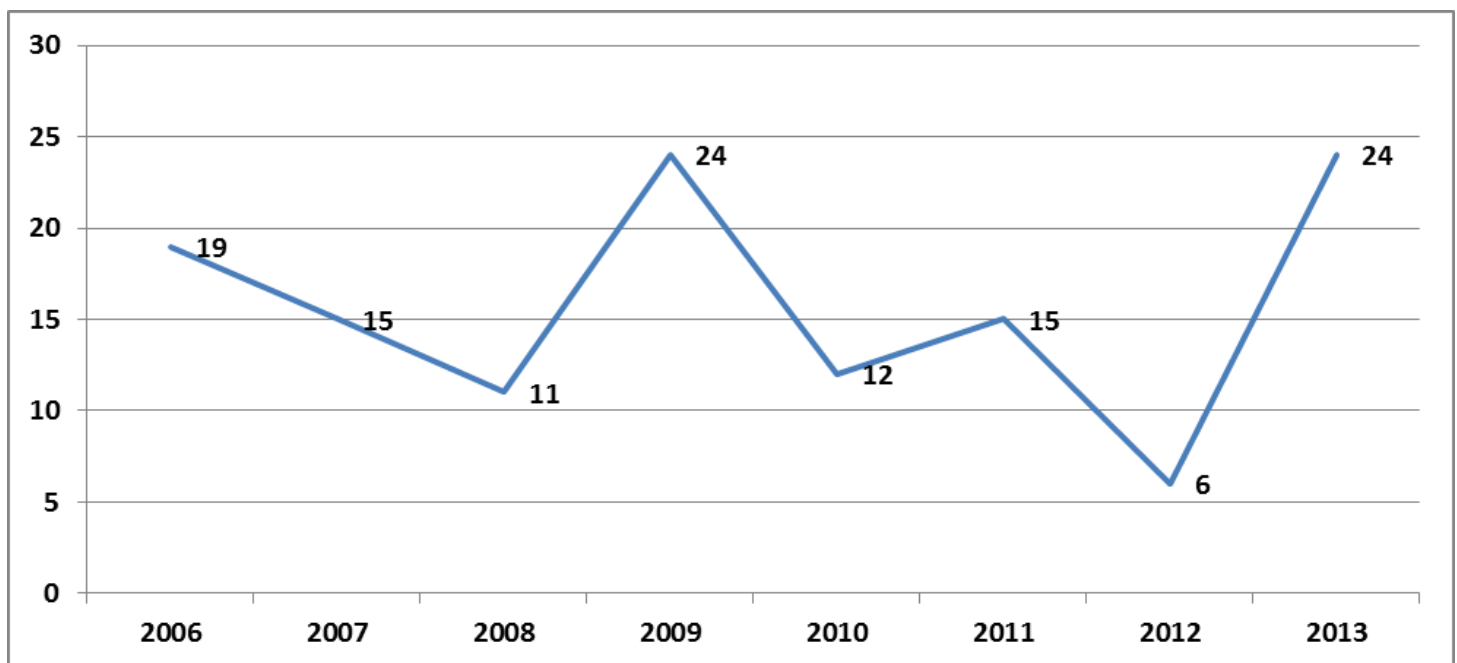
According to the National Fire Protection Association (NFPA), fires and burns are the third leading cause of unintentional death among children 14 and under. Forty percent of children ages 14 years and younger who die in home fires in the United States are under the age of five. Most fires occur in the home and cooking equipment is the leading cause of home fires and home fire injuries. More home fires start in the kitchen than in any other place in the house and more than two-thirds of home fire deaths occur in homes without smoke detectors or inoperable smoke detectors (NFPA, 2011).



In Georgia, there were 24 fire-related deaths in 2013. Of these, 13 occurred in single family homes (57%) and seven occurred in duplexes (30%). The fire source breakdown is as follows:

- 7 cigarette lighter/matches
- 3 electrical outlet/wiring
- 2 cooking stove
- 1 space heater
- In 11 cases, the fire source was unknown

**Figure 44: Reviewed Fire-Related Deaths, 2006-2013, GA (N=24)**



Nationally, the number of fatalities and injuries caused by residential fires has declined gradually over the past several decades (CDC 2012). However, in Georgia, fire-related deaths have fluctuated over the past several years; the current number of fire-related deaths (24) has quadrupled in the last year (6) which underscores the importance of enhancing our efforts toward reducing the incidence of fire-related child deaths in Georgia.



## Fire-Related Deaths

Figure 45: Demographics of Reviewed Fire-Related Deaths, 2013 (N=24)

	<u>Infant</u>	<u>1 to 4</u>	<u>5 to 9</u>	<u>10 to 14</u>
White Male		1	1	
White Female		3	2	3
African-American Male	1	3	2	
African-American Female		4	3	1

- Children under the age of five are at increased risk for fire-related deaths and injuries.

General risk factors for fire and burn-related deaths can be attributed to the child and the caregiver. According to research findings (Alnababtah, Khan, & Ashford, 2014), there are several parent/caregiver risk factors which can increase the opportunity for fire/burn injuries:

- Lack of first aid knowledge
- Poor supervision
- Living in rented housing
- Low income family
- Single-parent family
- Smoking in the home/in bed

Risk factors that increase opportunity for fire/burn injuries among children are:

- Children younger than 5
- Males have higher risk of burns than females
- African-American children have higher risk of burns
- Children with disabilities, such as seizure disorders

### Opportunities for Prevention:

- Make sure that there are working smoke detectors on every level of your home and test each alarm monthly to ensure that it is working properly
- Fire extinguishers should be kept in high risk areas, such as the kitchen, and all adults in the home should know how to use it correctly
- Create a fire escape plan with every member of your family (to include small children) and practice it regularly (at least four times each year)
- Keep matches, lighters and other fire sources out of the reach of small children
- Adult smokers should do so outside and make sure that smoking materials are properly extinguished

National Fire Protection Association

[www.nfpa.org](http://www.nfpa.org)

U.S. Fire Administration

[www.usfa.fema.gov](http://www.usfa.fema.gov)

Georgia Office of Insurance and Safety Fire Commissioner/Fire Marshal


[www.oci.ga.gov](http://www.oci.ga.gov)

# FIRE SAFETY


### WHAT YOU SHOULD KNOW

**Every day at least one child dies in a home fire.**

And every day, 293 children are injured by fire and burns.




**90%**

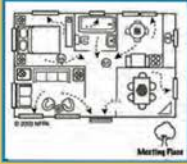


**Home fires account for nearly 90 percent of all fire-related fatalities.**


**Working smoke alarms reduce the chance of dying in a home fire by half.**




**77%** of families have **not** developed and practiced a home fire escape plan, one of the most important components to surviving a home fire.



**Fire can spread rapidly through a home, leaving a family as little as two minutes to escape safely once the alarm sounds.**



**HAVE WORKING SMOKE ALARMS.  
PRACTICE AN ESCAPE PLAN.**



## Homicide Deaths

According to the CDC, homicide disproportionately affects persons aged 10–24 years in the United States and consistently ranks in the top three leading causes of death in this age group, resulting in approximately 4,800 deaths and an estimated \$9 billion in lost productivity and medical costs in 2010. Nationally, youth homicides represent the greatest proportion of all firearm deaths. Each day in the U.S., there are an average of 10 children and teen firearm-related deaths, even though the number of firearm-related teen deaths has dropped by 35% in the past four years. In 1999, the Youth Risk Behavior Surveillance Survey reported that almost one-fifth of the 10th and 12th graders indicated that they had carried a firearm within the previous 30 days for self-defense or to settle disputes.

Youth homicide is a serious problem in large urban areas, especially among African-American males. Homicides are the number one cause of death for African-American and Hispanic teens. Yet when socio-economic status is held constant, differences in homicide rates by race become insignificant. Major contributing factors in addition to poverty include easy access to handguns, involvement in drug and gang activity, family disruption and school failure. These homicides usually occur in connection with an argument or dispute. They are often committed by casual acquaintances of the same gender, race and age, using inexpensive, easily acquired handguns.

Violence prevention research has demonstrated that strategies are most effective when they identify high-risk children in their earliest years and intervene at multiple levels through collaborative community partnerships.

### Major Risk Factors

- Youth active in drug and gang activity, with a prior history of early school failure, delinquency and violence
- Easy availability of and access to firearms
- Youth living in neighborhoods with high rates of poverty, social isolation and family violence
- Youth with little or no adult supervision
- Prior witnessing of violence

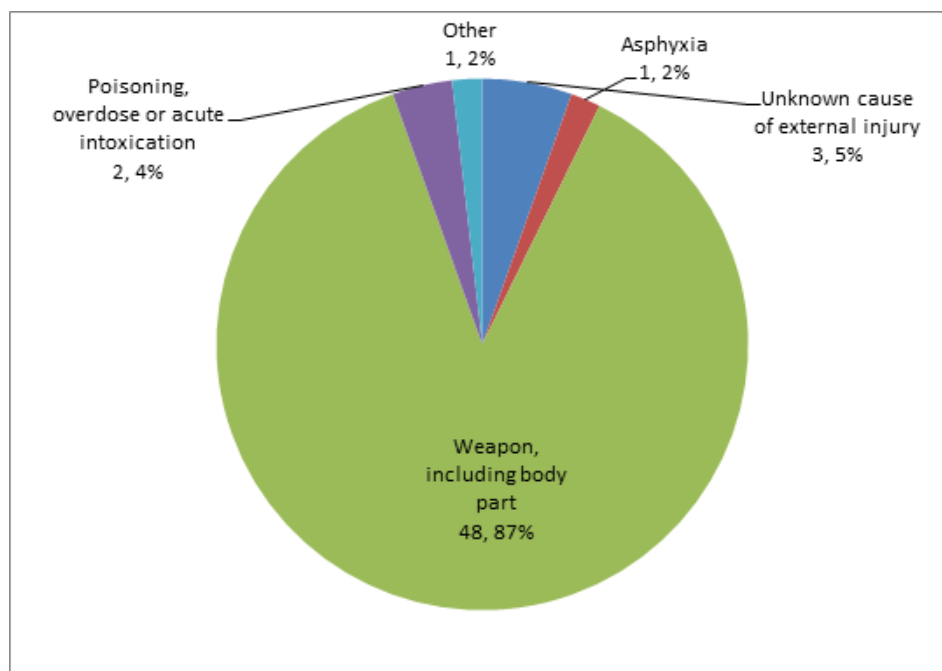
Figure 46: Demographics of Reviewed Homicide Deaths, GA, 2013 (N=55)

	<u>Infant</u>	<u>1 to 4</u>	<u>5 to 9</u>	<u>10 to 14</u>	<u>15 to 17</u>	<u>Total</u>
White Male	3	5			5	13
White Female		2				2
African-American Male	3	5		4	8	20
African-American Female	2	5		1	1	9
Hispanic Male	1	1	1	2	1	6
Multi-Racial Male	1					1
Multi-Racial Female		1				1
Other Male	1		1	1		3
TOTAL	11	19	2	8	15	55

## Homicide Deaths

- In 2013, 55 children were victims of homicide in Georgia. Homicides were the 4th leading cause of death in children age 14 and under, while it is the 3rd leading cause of death among teens age 15 to 17. A third of all reviewed homicide deaths were among African-American males (36%). Homicides involving males were more than three times the number of females reported.

**Figure 47: Homicides among Children by Mechanism, Georgia, 2013 (N=55)**



- Weapons, including body parts, were the mechanism in 48 deaths (87%)
- The mechanism for the cause of the external injury was unknown in three homicides (5%)
- Poisoning, overdose or acute intoxication was the mechanism of injury in two homicides (both decedents were under the age of five)

**Figure 48: Mechanism of Injury for Reviewed Homicide Deaths by age groups, GA, 2013 (N=55)**

	<u>Infant</u>	<u>1 to 4</u>	<u>5 to 9</u>	<u>10 to 14</u>	<u>15 to 17</u>
Asphyxia		1			
Poisoning, overdose or acute intoxication	1	1			
Missing/Unknown	1	2			
Other				1	
Weapon, including body part	9	15	2	7	15



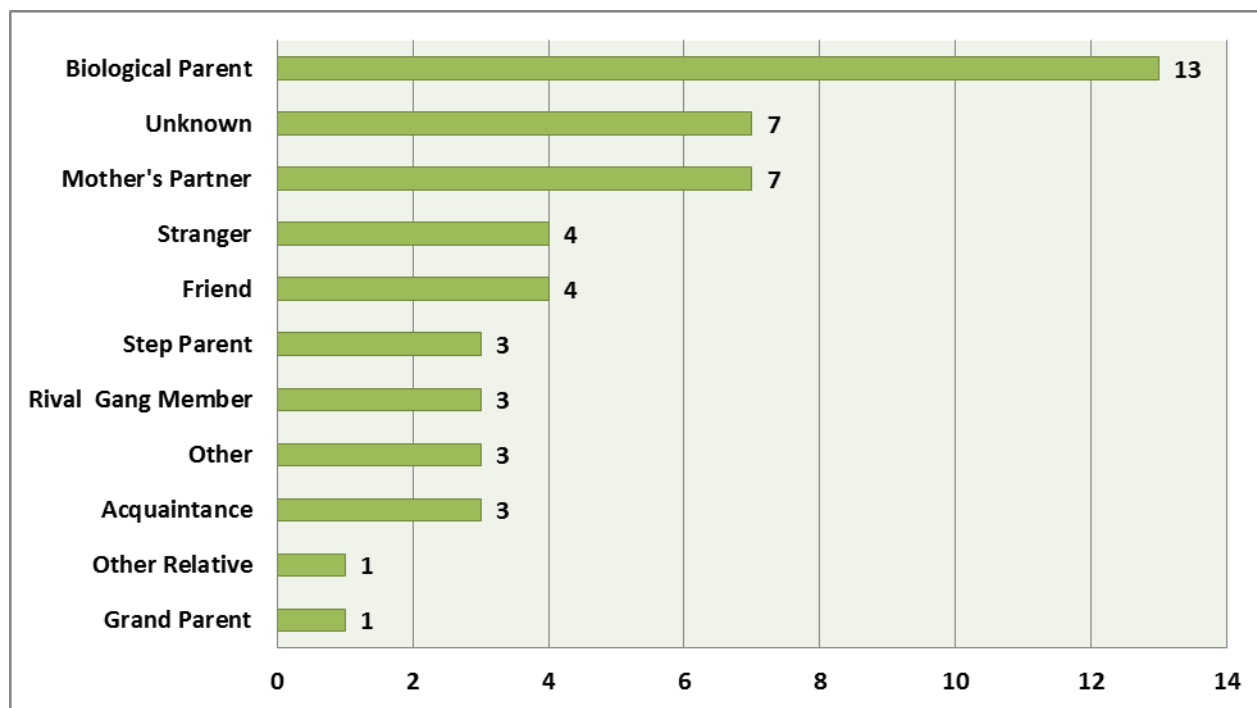
## Homicide Deaths

Figure 49: Type of Weapon for Reviewed Homicide Deaths, GA, 2013 (N=55)

	<u>Infant</u>	<u>1 to 4</u>	<u>5 to 9</u>	<u>10 to 14</u>	<u>15 to 17</u>	<u>Total</u>
Blunt Instrument		1				1
Body Part	8	11	1	3		23
Firearm		2		3	14	19
Missing/Unknown	3	4		1		8
Sharp Instrument		1	1	1	1	4
<b>Total</b>	<b>11</b>	<b>19</b>	<b>2</b>	<b>8</b>	<b>15</b>	<b>55</b>

- Deaths caused by body parts were the highest among infants and toddlers (age 1-4). When "body part" is reported, the circumstances generally involve beating, dropping, pushing, biting, shaking, strangling and throwing
- Homicides by firearms were highest among teens (age 15-17). These circumstances were generally due to gang violence and altercations with acquaintances, friends, strangers and family

Figure 50: Homicides among Children by Perpetrator, when reported, GA, 2013 (N=49)



- In 23 cases, the perpetrator was the parent/step-parent/parent's partner (47%)
- In ten cases, the perpetrator was a peer of the decedent (i.e. acquaintances, rival gang member, friend) (20%)

## Homicide Deaths

### Homicide Prevention

It is important to have patience and take extra care with younger children. Likewise, it is important to recognize and familiarize yourself with child abuse. Many of the victims of homicide are often younger than age five, and fatally injured by a parent or caregiver's direct abuse. In many cases the caregivers are frustrated, have little parental training and/or unrealistic expectations of child behavior and development. Classes are available for parents and caregivers to educate themselves on child behaviors and to enhance their parenting skills.

Teens ages 15 to 17 also had higher numbers of homicide deaths due to firearms. Risk factors include domestic disputes, attempting to commit a crime, and gang related activities. Prevention efforts, starting with parental involvement, are critical in this age group. The most common age for youth to join a gang is between ages 13 to 15.

Community partnerships are available to assist in reinforcing the strengths of families and communities. The reinforcement from communities and families build stronger relationships with parents, teachers and peers and enhance healthier relationships and lifestyle choices. Supportive groups such as teen mentoring and tutoring programs help teens as they go through challenging life transitions. These programs have shown to improve behaviors, interpersonal skills, self-esteem and self-confidence, and encourage higher educational aspirations.

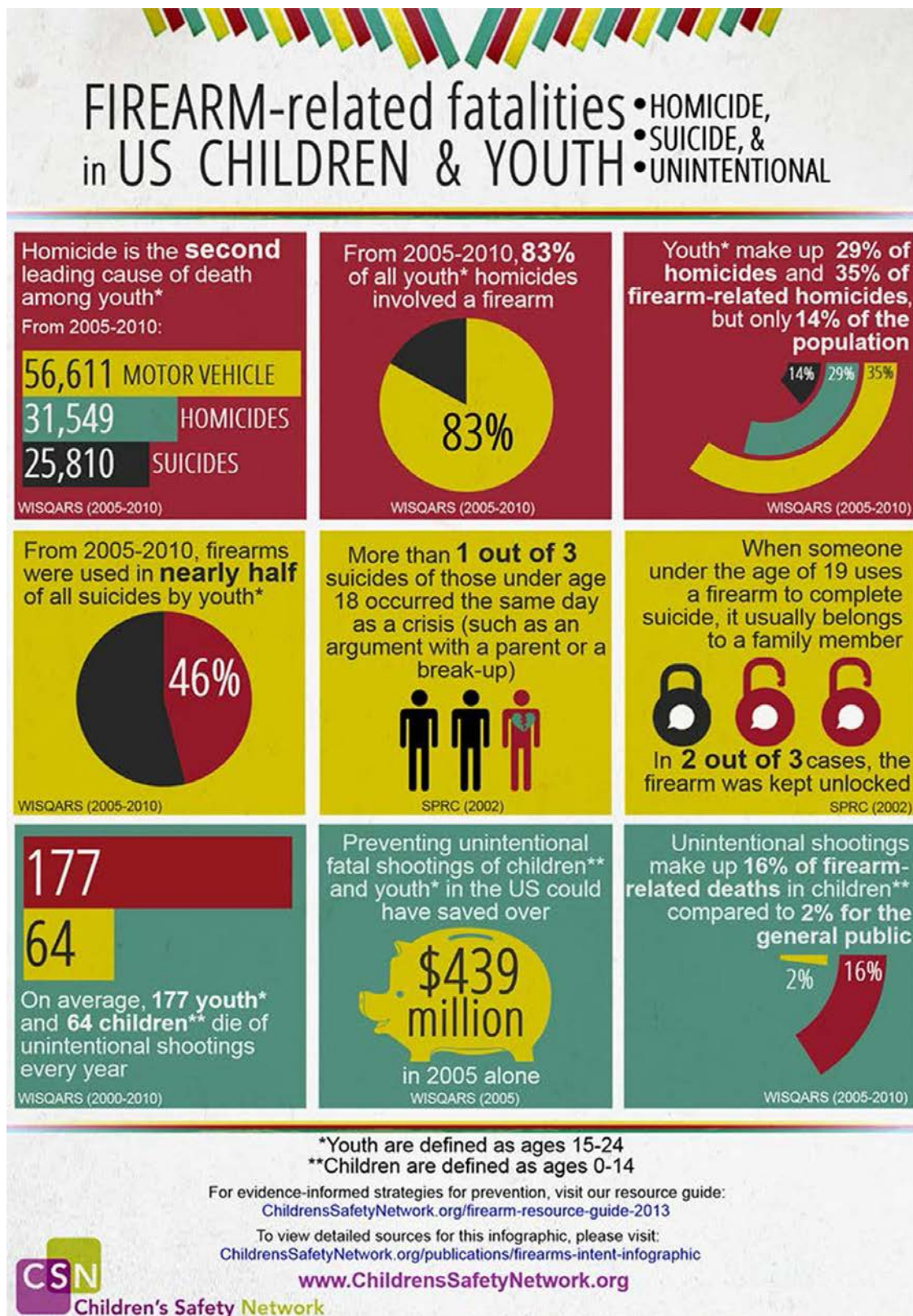
### National Resources

National Vital Statistics System  
(<http://www.cdc.gov/nchs/nvss.htm>)  
National Center for Health Statistics  
([www.cdc.gov/nchs](http://www.cdc.gov/nchs))

### State Resources

Georgia Criminal Justice Coordinating Council ([www.cjcc.georgia.gov](http://www.cjcc.georgia.gov))  
Georgia Family Connection Partnership ([www.gafcp.org](http://www.gafcp.org))  
Prevent Child Abuse Georgia ([www.preventchildabusega.org](http://www.preventchildabusega.org))  
Georgia Department of Public Health, Violent Death Reporting System  
([www.health.state.ga.us](http://www.health.state.ga.us))







## Suicide Deaths

Suicide is the third leading cause of death among young people in the United States between the ages of 10 and 19. Although the percentage of U.S. high school students who considered suicide fell by nearly half between 1991 to 2009 (from 29 percent to 14 percent), this percentage has increased slightly in recent years. In 2012, roughly one in every six high school students considered suicide.

Research suggests that at least 75 percent of the people who complete suicide are depressed; for this reason, preventing teen suicide means treating teen depression. There is some concern that many young people are not receiving much needed screening and treatment for mental health issues. While youth can face a range of barriers to accessing mental health care, reducing the stigma around mental illness is also key to ensuring more adolescents seek help and that peers, parents, and school personnel are aware of warning signs and effective intervention strategies.

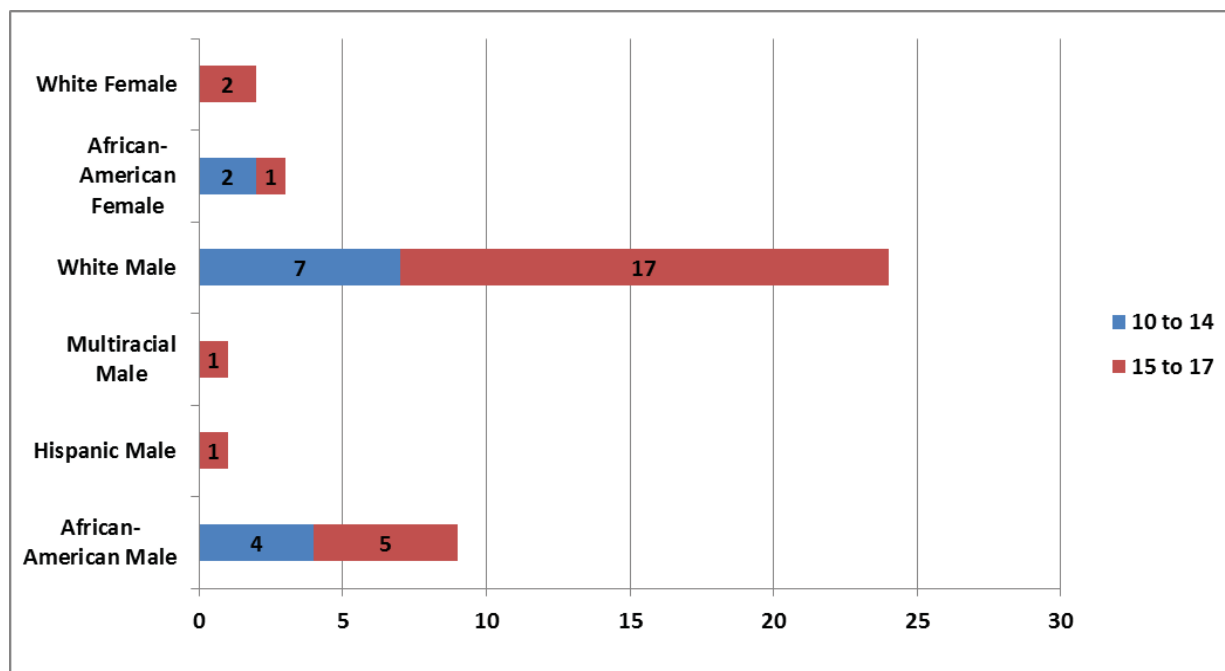
Some public health researchers advocate for paying greater attention to “means reduction” in suicide-prevention efforts—focusing on suicidal youths’ access to highly lethal means of completing suicide, such as a parent’s gun. Indeed, as we continue to debate the future of gun control laws, it’s worth noting that firearms are used in 40 percent of teen suicides (ChildTrends, 2012).





## Suicide Deaths

Figure 51: Demographics of Reviewed Suicide Deaths, GA, 2013 (N=40)

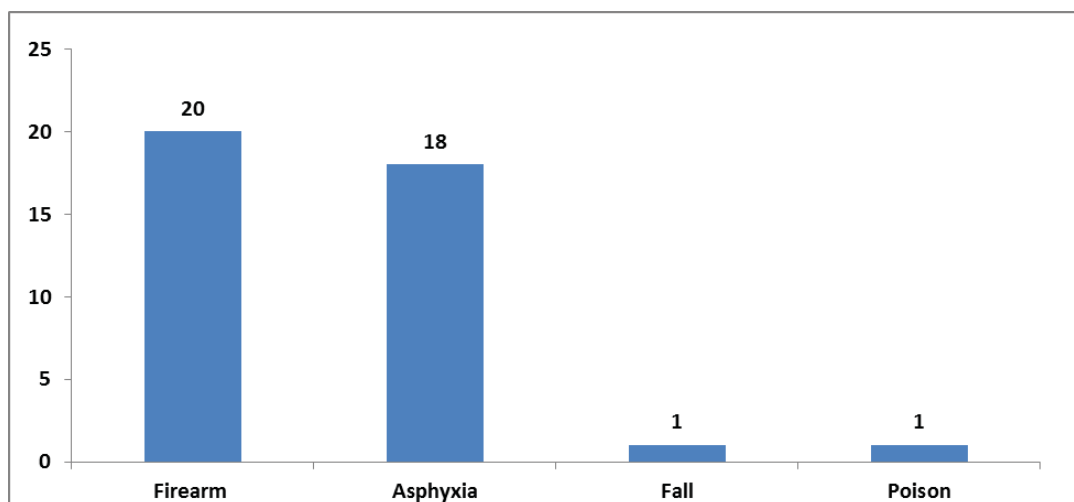


- Eighty-Eight percent of reviewed suicide deaths were males
- Nationally, a third of teenage suicide victims have made a suicide attempt. If a male teen has attempted suicide, he is more than 30 times more likely to complete suicide in a subsequent attempt, while a female with a previous attempt has about three times the risk to complete suicide
- Research suggests that positive community support, family and peer connectedness, school connectedness, and positive relationships can help youth build resiliency and reduce the risk that the child will attempt suicide



## Suicide Deaths

Figure 52: Mechanism of Injury in Reviewed Suicide Deaths, GA, 2013 (N=40)

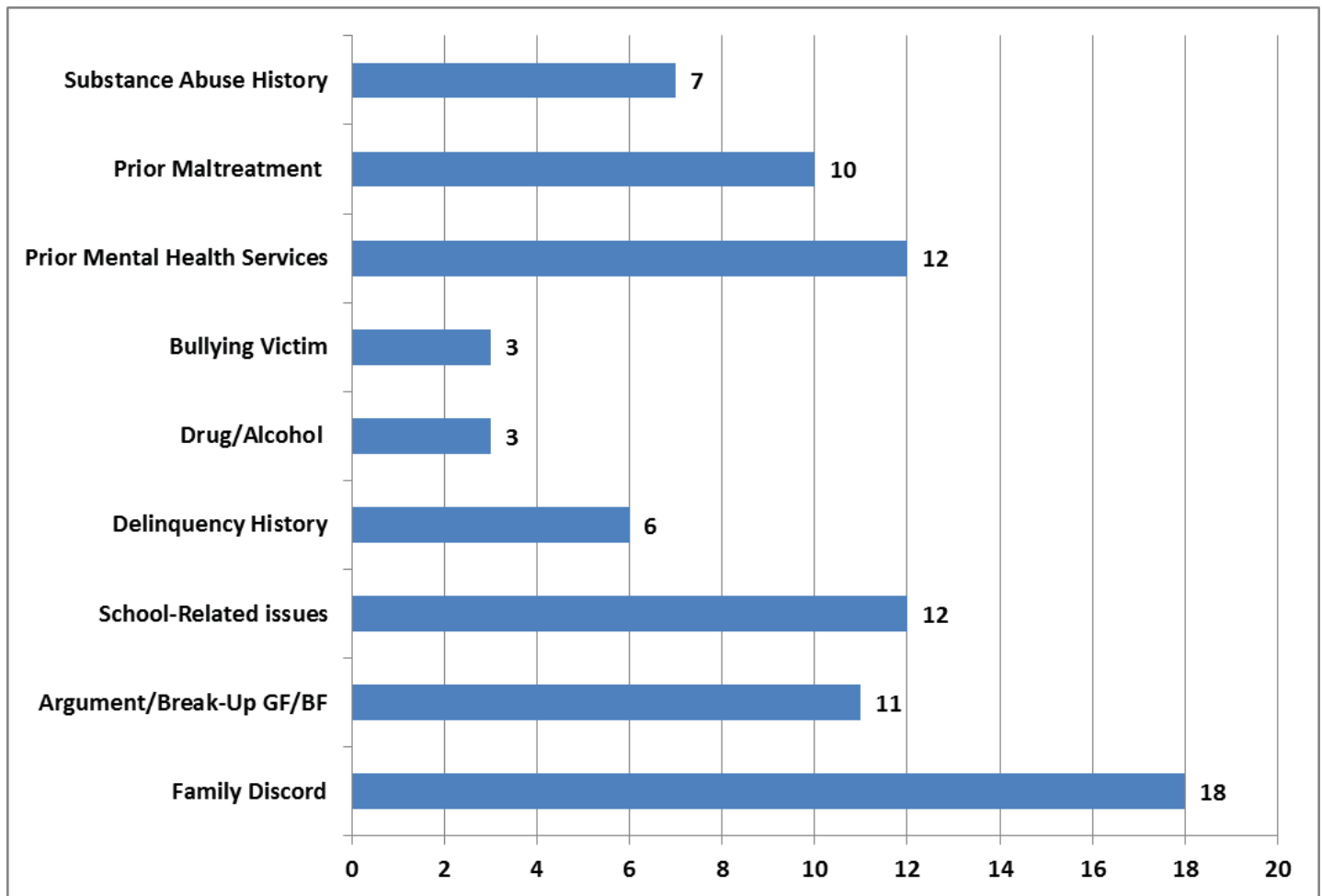


- Half of the suicide deaths involved use of a firearm (handgun, hunting rifle, or shotgun)
- The risk of suicide increases dramatically when children and teens have access to firearms at home, and nearly 60% of all suicides in the United States are committed with a gun
- Restricting access to lethal means is one of the most effective strategies to prevent youth suicides. It is critically important that parents who are concerned that their child might be feeling suicidal reduce easy access to lethal means, including firearms, medications, and alcohol



## Suicide Deaths

Figure 53: Reported Risk Factors for Reviewed Suicide Deaths, GA, 2013



- The history reported for a child can include multiple actions for each death, therefore the total is greater than the number of suicide deaths
- The "Family Discord" category includes relational issues with parents, recent argument with parent(s) and/or sibling(s)



## Suicide Deaths

### Opportunities for Prevention:

- Address how changing technology and social media landscape affects teens' experience with bullying and mental health issues
- Increase awareness of suicide warning signs and encourage parents, school personnel, counselors, health care providers and other community agents who interact with youth to take prompt action when these signs are recognized
- Increase accessibility and availability of mental health services to children, youth and families
- Advocate for safe and secure storage of firearms

Georgia Suicide Prevention Information Network ([www.gspin.org](http://www.gspin.org))

Georgia Department of Behavioral Health and Developmental Disabilities ([www.dbhdd.georgia.gov](http://www.dbhdd.georgia.gov))

The Centers for Disease Control and Prevention ([www.cdc.gov](http://www.cdc.gov))

Child Trends ([www.childtrends.org](http://www.childtrends.org))





### WARNING SIGNS

Please call 911 or the National Suicide Prevention Lifeline at 1-800-273-8255 now if you identify with any of the signs below or know someone who exhibits these signs.



Talking about killing themselves



Drug or alcohol abuse



Uncontrollable anger or sadness



Irrational mood swings



Feeling worthless & without purpose



Feeling hopeless, desperate or trapped



Loss of interest in things they enjoyed



Withdrawal from loved ones



Anxiety & depression



Change in sleep & eating habits



Neglecting personal hygiene & care



Self-injury or reckless behavior



Communicating unusual thoughts



Giving away prized possessions

### CRITICAL WARNING SIGNS



Has a weapon & is threatening to cause themselves harm



Talking about killing themselves & acting anxious

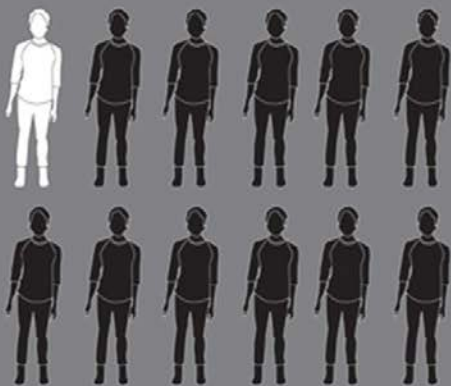


Talking about death or suicide while drunk or high

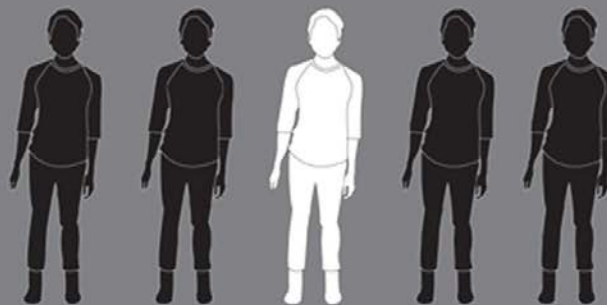


Seeking methods to kill themselves

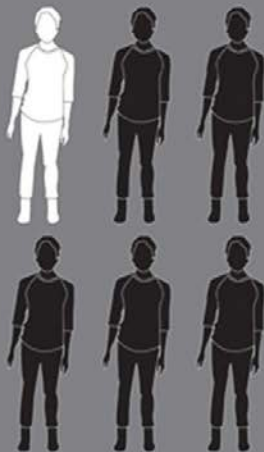
# YOUTH SUICIDE IN THE UNITED STATES



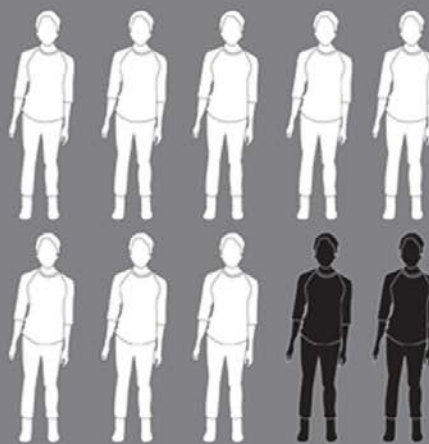
1 IN 12 HIGH SCHOOL STUDENTS HAVE  
ATTEMPTED SUICIDE



1 OUT OF 5 HIGH SCHOOL STUDENTS  
CONSIDERED SUICIDE

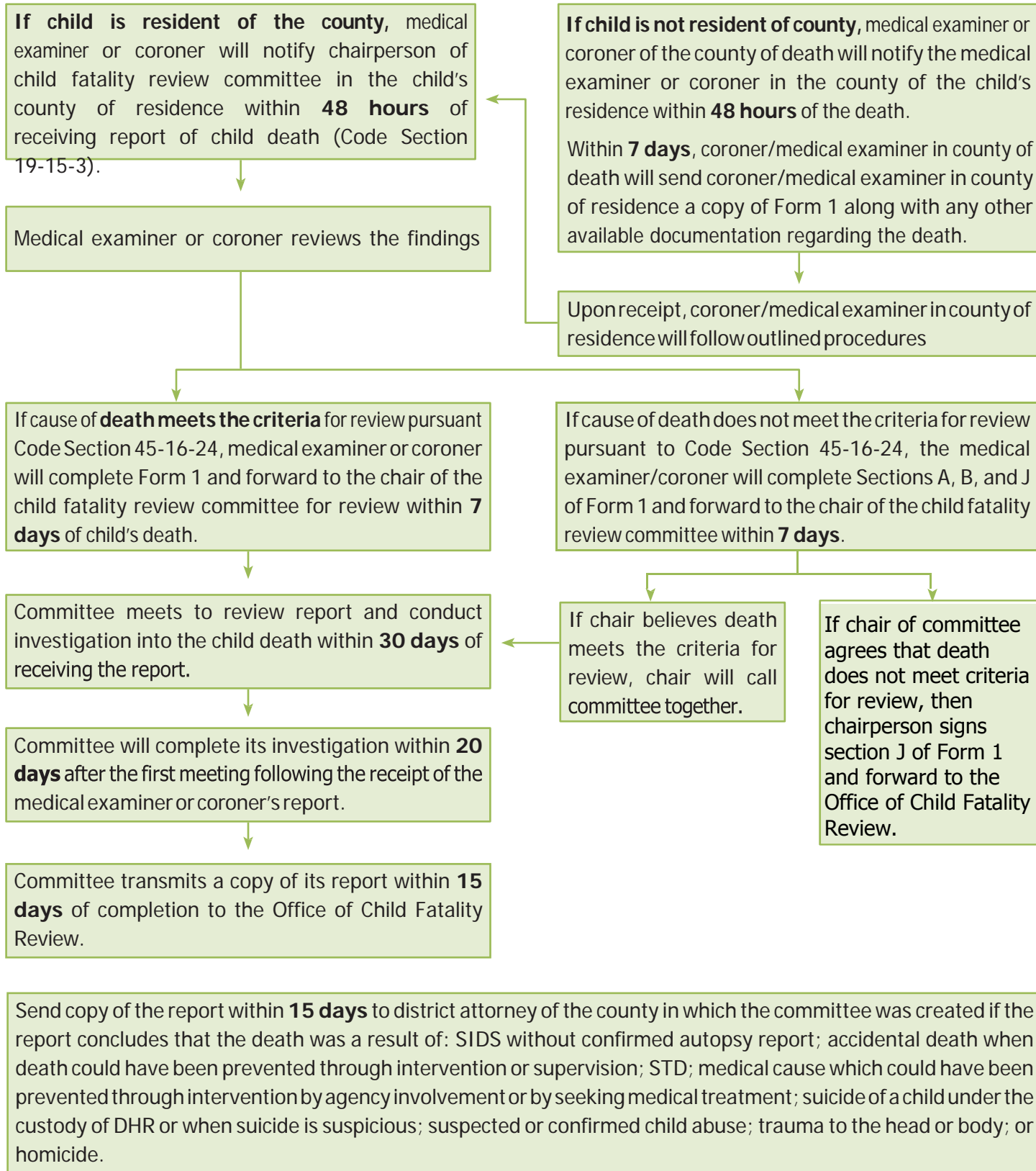


1 IN 6 HIGH SCHOOL STUDENTS MADE PLANS TO  
ATTEMPT SUICIDE



8 OUT OF 10 ASK FOR SOME WAY OF HELP  
BEFORE COMMITTING SUICIDE

## Appendix A: Child Fatality Review Committee Timeframes and Responsibilities



## Appendix B – Reviewable Deaths Reviewed

Reviewed/ Reviewable	County Chattahoochee	All Infant/Child Deaths						All Reviewable Deaths						All Reviewable Deaths Reviewed						All Reviewed Deaths					
		Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total
1/1	Appling	1	1			1	3					1	1					1	1					1	1
2/2	Atkinson					2	2					2	2					2	2					2	2
1/1	Bacon	1					1	1					1	1					1	1					1
0/0	Baker						0						0						0						0
4/4	Baldwin	6	2		1		9	2	1		1		4	2	1		1		4	2	1		1		4
0/0	Banks						0						0						0						0
3/4	Barrow	7	1			2	10	3	1				4	2	1				3	2	1				3
2/2	Bartow	8	1				9	2					2	2					2	2					2
1/1	Ben Hill	2	1				3	1					1	1					1	1					1
2/2	Berrien	2	1			1	4	1	1				2	1	1				2	1	1				2
15/17	Bibb	19	2	5	6	3	35	5	1	4	4	3	17	3	1	4	4	3	15	4	2	4	5	3	18
0/0	Bleckley	1					1						0						0						0
2/2	Brantley				1	1	2				1	1	2				1	1	2				1	1	2
2/2	Brooks	2	3			1	6		2				2		2				2		1				1
0/4	Bryan	5	1	3	1		10		1	2	1		4						0						0
2/2	Bulloch	6	1		1		8	1			1		2	1			1		2	1			1		2
0/0	Burke	3	1				4						0						0						0
0/0	Butts	1	1				2						0						0						0
0/0	Calhoun						0						0						0						0
1/1	Camden	6				1	7					1	1					1	1					1	1
0/0	Candler	1					1						0						0						0
3/3	Carroll	4	1	1	4	2	12	1		1		1	3	1		1		1	3	1	1	1		3	6
2/2	Catoosa	2		1		1	4			1		1	2			1		1	2			1		1	2
0/0	Charlton	1					1						0						0						0
15/15	Chatham	32	8	1	5	4	50	7	2	1	2	3	15	7	2	1	2	3	15	9	3	1	3	3	19
0/0	Chattahoochee	3	1				4						0						0						0
2/2	Chattooga	2	1	1	2		6			1	1		2			1	1		2	1		1	1		3
6/6	Cherokee	15	3			5	23	1				5	6	1				5	6	1	2			5	8
1/1	Clarke	10	1	1	1		13		1				1		1				1		1				1
1/1	Clay				1		1				1		1				1		1				1		1
14/14	Clayton	30	6		3	8	47	3	3		2	6	14	3	3		2	6	14	9	6		4	6	25
0/0	Clinch						0						0						0						0
19/19	Cobb	60	14	7	6	5	92	8	5	1	2	3	19	8	5	1	2	3	19	13	7	2	2	4	28
3/4	Coffee	6	4			1	11	1	2			1	4	1	1			1	3	1	3			1	5
4/4	Colquitt	10	2		1		13	3	1				4	3	1				4	3	2				5
6/6	Columbia	11	2	1	4	2	20	1			3	2	6	1			3	2	6	1	1		4	2	8
1/1	Cook	4	1				5		1				1		1				1	1	1				2
6/6	Coweta	5	5	1		3	14		4	1		1	6		4	1		1	6		5	1		1	7
1/1	Crawford	1					1	1					1	1					1	1					1
3/3	Crisp	4		1			5	2		1			3	2		1			3	3		1			4



## Appendix – Reviewable Deaths Reviewed

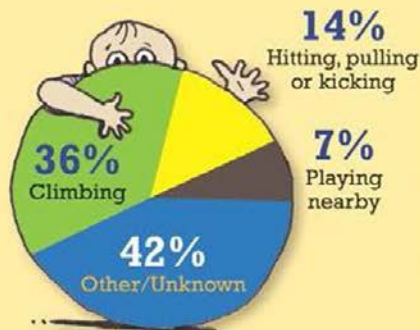
Reviewed/ Reviewable	County Chattahoochee	All Infant/Child Deaths						All Reviewable Deaths						All Reviewable Deaths Reviewed						All Reviewed Deaths					
		Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total
1/1	Dade	2		1			3	1					1	1					1	1					1
3/3	Dawson	3			1	1	5	2				1	3	2				1	3	2				1	3
0/0	Decatur	3					3						0						0	1					1
25/26	DeKalb	81	19	3	5	10	118	10	5	2	2	7	26	9	5	2	2	7	25	12	7	3	2	6	30
1/1	Dodge	5					5	1					1	1					1	1					1
1/1	Dooly		1			1	2					1	1					1	1					1	1
5/6	Dougherty	23	4	1		2	30	2	2	1		1	6	2	2	1			5	3	1	1			5
7/7	Douglas	15	2	1		3	21	2	2	1		2	7	2	2	1		2	7	2	2	1		2	7
1/1	Early	2		1	1		4	1					1	1					1	1					1
0/0	Echols	1					1						0						0						0
5/5	Effingham	4	3			2	9	1	2			2	5	1	2			2	5	1	3			2	6
0/0	Elbert	4		1	1		6						0						0			1			1
5/6	Emanuel	7		1		4	12	2		1		3	6	2		1		2	5	2		1		2	5
0/0	Evans	2					2						0						0						0
1/3	Fannin	2			1	1	4	1			1	1	3					1	1	1				1	2
2/2	Fayette	4				2	6					2	2					2	2					2	2
4/4	Floyd	5	2	1	1	3	12	1	1	1		1	4	1	1	1		1	4	1	2	1		2	6
8/8	Forsyth	10	2	1	1	3	17	4	1			3	8	4	1			3	8	5	1		1	3	10
2/3	Franklin	2	1		3	1	7	1			1	1	3	1			1		2	2	1		1		4
41/42	Fulton	86	12	8	8	19	133	14	5	4	6	13	42	14	5	4	5	13	41	20	11	6	5	17	59
1/1	Gilmer		1				1		1				1		1				1		1				1
1/1	Glascok					1	1					1	1					1	1						0
4/4	Glynn	6	1	1	1	1	10	1	1	1		1	4	1	1	1		1	4	2	1	1	1	1	6
4/4	Gordon	3	1	1	1	2	8	1			1	2	4	1			1	2	4	1			1	2	4
0/2	Grady	4	1				5	1	1				2						0						0
0/0	Greene	1			1	1	3						0						0				1		1
20/21	Gwinnett	61	18	4	10	12	105	5	7	1	2	6	21	5	6	1	2	6	20	5	6	1	4	9	25
3/3	Habersham	5		1		1	7	3					3	3					3	3				1	4
6/6	Hall	11	1	2	3	1	18	3		1	1	1	6	3		1	1	1	6	3		1	2	1	7
0/0	Hancock	1					1						0						0						0
0/1	Haralson	5					5	1					1						0						0
0/0	Harris			1			1						0						0						0
2/2	Hart	2	1		1		4		1		1		2		1		1		2				1		1
4/4	Heard	1	1		1	2	5	1			1	2	4	1			1	2	4	1	1		1	1	4
6/6	Henry	9	1	2	3	2	17	1		1	2	2	6	1		1	2	2	6	2		1	2	2	7
6/7	Houston	19	2	1	2	2	26	4	1			2	7	4				2	6	5	1			2	8
0/0	Irwin						0						0						0						0
1/3	Jackson	7	2		2		11	1	1		1		3		1				1		1				1
0/0	Jasper						0						0						0		1				1
2/2	Jeff Davis	3			1		4	2					2	2					2	2					2

## Appendix – Reviewable Deaths Reviewed

Reviewed/ Reviewable	County Chattahoochee	All Infant/Child Deaths						All Reviewable Deaths						All Reviewable Deaths Reviewed						All Reviewed Deaths					
		Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total
1/1	Jefferson	2				1	3					1	1					1	1					1	1
0/0	Jenkins						0						0						0						0
0/0	Johnson			1			1						0						0						0
3/3	Jones	4	2	1	1		8		2		1		3		2		1		3		2		1		3
0/1	Lamar					1	1					1	1						0						0
0/0	Lanier	1					1						0						0						0
2/3	Laurens	8				1	9	2				1	3	1				1	2	1				1	2
1/2	Lee	4				1	5	2					2	1					1	1					1
3/5	Liberty	8	2	1	2		13	3	2				5	2	1				3	3	1		1		5
0/0	Lincoln	1					1						0						0						0
1/1	Long	2			1		3				1		1				1		1				1	1	2
4/4	Lowndes	12	1	1	3	1	18	1	1		1	1	4	1	1		1	1	4	1	2		1	1	5
0/0	Lumpkin	1					1						0						0						0
0/0	Macon						0						0						0						0
0/0	Madison	2					2						0						0		1				1
0/0	Marion	2					2						0						0						0
0/0	McDuffie	2			1		3						0						0						0
0/0	McIntosh						0						0						0						0
1/1	Meriwether	2			1	1	4					1	1					1	1				1	1	1
0/0	Miller						0						0						0						0
0/0	Mitchell	2					2						0						0						0
2/2	Monroe				2		2				2		2				2		2				1		1
0/0	Montgomery	3					3						0						0						0
1/1	Morgan	1					1	1					1	1					1	1					1
4/4	Murray	2	1	1	1	4	9					4	4					4	4					4	4
12/12	Muscogee	39	6	1	2	3	51	7	3		1	1	12	7	3		1	1	12	10	4		1	3	18
4/4	Newton	13	1	2	2		18	2	1		1		4	2	1		1		4	3	1	1	1		6
2/2	Oconee				1	1	2				1	1	2				1	1	2				1	1	2
0/0	Oglethorpe	1					1						0						0						0
2/2	Paulding	4	4	1		1	10		2				2		2				2		1		1	1	3
1/1	Peach	2					2	1					1	1					1	1					1
0/0	Pickens	5		1		1	7						0						0						0
1/1	Pierce		1				1		1				1		1				1		1				1
1/1	Pike					2	2					1	1					1	1				1	1	1
1/2	Polk	5	1	1			7	1		1			2			1			1			1			1
0/0	Pulaski	1					1						0						0						0
1/1	Putnam	3	1				4	1					1	1					1	1					1
2/2	Quitman		2				2		2				2		2				2		2				2
0/0	Rabun						0						0						0						0
0/0	Randolph		1				1						0						0		1				1

## Appendix – Reviewable Deaths Reviewed

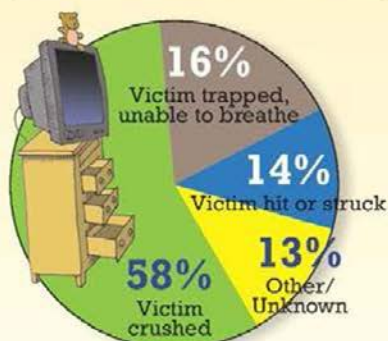
Reviewed/ Reviewable	County Chattahoochee	All Infant/Child Deaths						All Reviewable Deaths						All Reviewable Deaths Reviewed						All Reviewed Deaths					
		Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total
9/11	Richmond	24	9	3	2	3	41	3	4	2		2	11	2	4	2		1	9	3	4	2	1	2	12
7/8	Rockdale	19	1	4			24	3	1	4			8	3	1	3			7	3	1	3			7
1/2	Schley				2		2				2		2				1		1				1		1
2/2	Screven	2		4			6			2			2			2			2			2			2
0/0	Seminole						0						0						0						0
1/1	Spalding	2	2	2	1		7	1					1	1					1	1					1
1/1	Stephens	5					5	1					1	1					1						0
1/1	Stewart	1					1	1					1	1					1	1					1
1/2	Sumter	2			1	1	4	1				1	2					1	1				1		1
0/0	Talbot						0						0						0						0
0/0	Taliaferro						0						0						0						0
0/1	Tattnall	3	1		1	1	6		1				1						0	1				1	2
0/0	Taylor	2					2						0						0						0
0/1	Telfair	3				1	4	1					1						0						0
0/0	Terrell	2					2						0						0		1				1
0/0	Thomas	5					5						0						0						0
0/1	Tift	5		1		1	7	1					1						0						0
0/0	Toombs	4	1				5						0						0						0
0/0	Towns				1		1						0						0	1					1
2/2	Treutlen	1			1	1	3				1	1	2				1	1	2				1	1	2
6/6	Troup	12	4	1	1	4	22	2	1			3	6	2	1			3	6	2	1			4	7
0/0	Turner					1	1						0						0						0
0/0	Twiggs		1				1						0						0						0
1/1	Union	1					1	1					1	1					1				1		1
0/0	Upson	1				1	2						0						0						0
2/4	Walker	5		1	2	5	13	1				3	4					2	2					2	2
3/3	Walton	9	1	1		1	12	1	1			1	3	1	1			1	3	1	1	1		1	4
2/2	Ware	5		1		1	7	1				1	2	1				1	2	1				1	2
0/0	Warren						0						0						0					1	1
1/1	Washington	2		1		1	4	1					1	1					1	1				1	2
1/1	Wayne	2		1			3	1					1	1					1						0
0/0	Webster						0						0						0						0
0/0	Wheeler						0						0						0						0
1/1	White	1					1	1					1	1					1	1					1
1/1	Whitfield	6					6	1					1	1					1	2					2
0/0	Wilcox		1				1						0						0						0
1/1	Wilkes	2					2	1					1	1					1	1					1
0/0	Wilkinson	1					1						0						0						0
2/2	Worth	2			1		3	1			1		2	1			1		2	1			1		2



**Why**  
does it happen?



**Where**  
does it happen?



**How**  
do victims die?



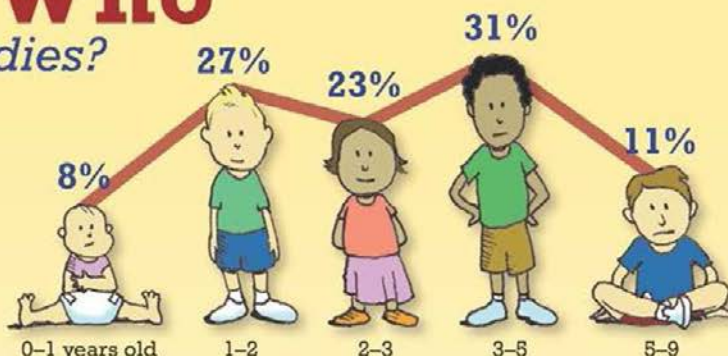
NSN 10-4

# 1 CHILD DIES EVERY 2 WEEKS

When a TV, furniture or appliance falls on him or her

## Who

dies?



## What

falls on them?



Televisions  
and furniture

70%



Furniture:  
dressers, tables

26%



Appliances, etc.

4%

**Injuries:** about 3 per hour 71  
per day 2,117 per month 25,400 per year

These tragedies can be prevented by  
taking low-cost steps to stabilize TVs,  
furniture and appliances.

# ANCHOR IT AND PROTECT A CHILD

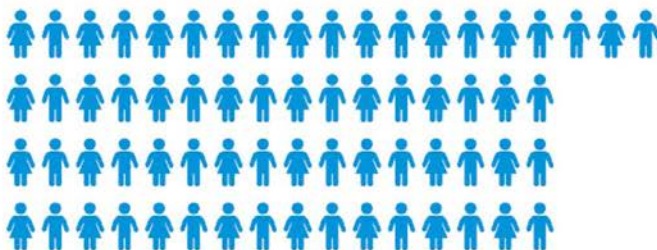


## The Facts about Kids and Medication Safety

Every parent knows it's important to store medicine up and away from children, but every year more than

**500,000 parents**

and caregivers call a poison control center because a child got into medicine or because they were given the wrong dose of medicine. That's one call every minute of every day.

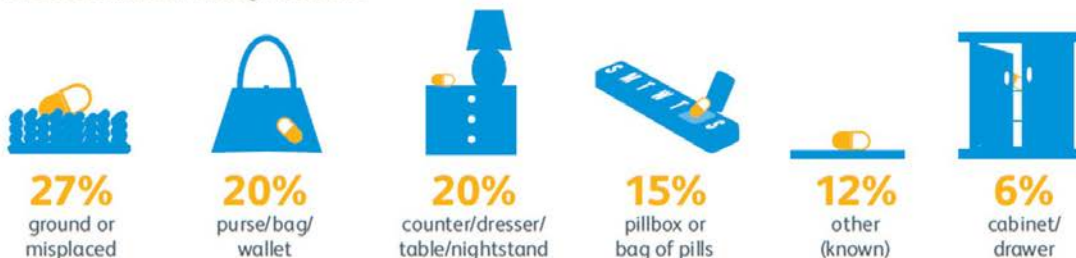


In 2011, more than **67,000 kids** were treated in an emergency room for medicine poisoning. That's one child every 8 minutes.

 = 1,000



Where are children finding medicine?



(2011 emergency room visits; of the 14% of cases known.)

**86%** of emergency room visits for medicine poisoning were due to the child getting into adult medicine.



(Of the 24% of cases known.)

Put your medicines up and away every time you use them and put the poison control center number in your phone:

**1-800-222-1222**

TO FIND OUT MORE ABOUT MEDICINE SAFETY VISIT [SAFEKIDS.ORG](http://SAFEKIDS.ORG)



**SAFE  
KIDS**  
WORLDWIDE™

© 2013 Safe Kids Worldwide

## KIDS AND UNINTENTIONAL MEDICATION OVERDOSES IN THE U.S.

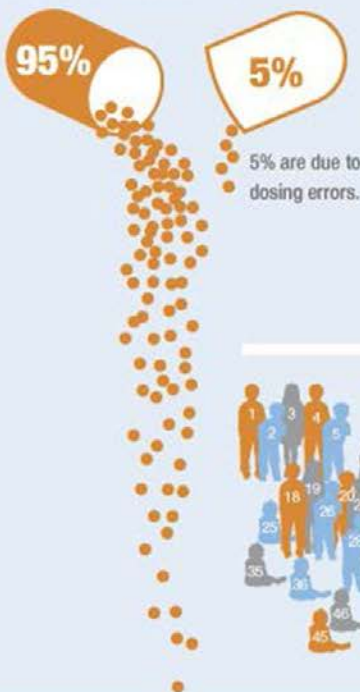
### BY THE NUMBERS

While the death rate among children from poisoning has been cut in half since the late 1970s, medication deaths as a percentage of all child poisoning deaths have nearly doubled.



POISON HOTLINE **1-800-222-1222**

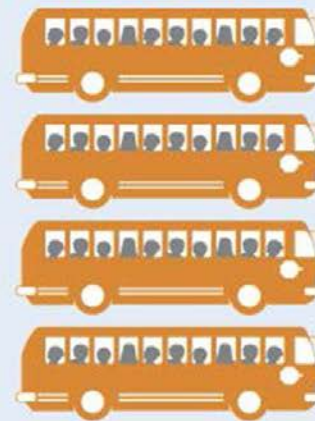
95 percent of medication-related ER visits among children under age 5 are due to a child ingesting medication while unsupervised.



165 young children per day (roughly four busloads) are brought to the ER after taking medications on their own.

**60,000**

young children are treated in the ER due to accidental unsupervised medication ingestions each year.



**56** children ages 14 and under die each year from unintentional medication overdoses.



**PREVENTABILITY:**

**100%**

# INJURY

The #1 killer of children in the US



For every 1 child that dies there are...

25 hospitalizations

925 treated in ER

Many more treated in doctors' offices



In 2005, injuries that resulted in death, hospitalization or an ER visit cost nearly \$11.5 billion in medical expenses.

SOURCE: Wakefield Injury Statistics Query and Reporting System (WISQRS), CDC, 2005.  
National Health Interview Survey, 2008 data release, CDC, National Center for Health Statistics.

## Global view

The US child (0-14 years) injury death rate ranks among the worst of all high-income countries

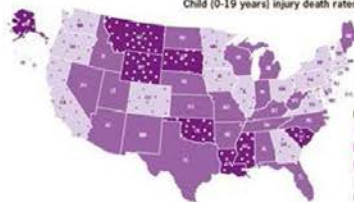
The US child injury death rate is 4 times that of countries with the lowest rates.

SOURCE: Global Health Observatory Data Repository, Mortality and burden of disease, injury and risk factors estimates, 2008, by sex and age.



## State view

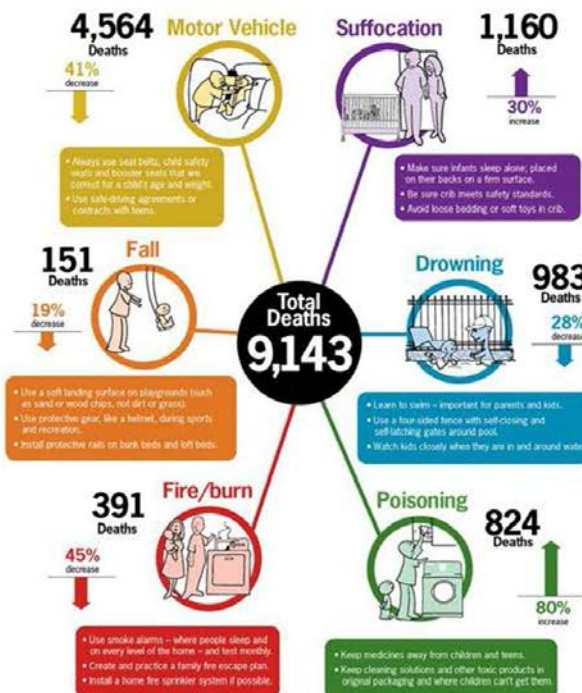
Child (0-19 years) injury death rates vary by state



In 2009, more than 5,700 children's lives would have been saved if the lowest state death rate was achieved nationally.

SOURCE: Wakefield Injury Statistics Query and Reporting System (WISQRS), CDC, 2009.

## Causes of child injury and prevention tips



Percentages show changes in death rates from 2000 to 2009. Deaths are from 2009. Total deaths exclude 1,070 from other causes.



U.S. Department of Health and Human Services  
Centers for Disease Control and Prevention

[www.cdc.gov/vitalsigns](http://www.cdc.gov/vitalsigns)  
Your Source for Credible Health Information