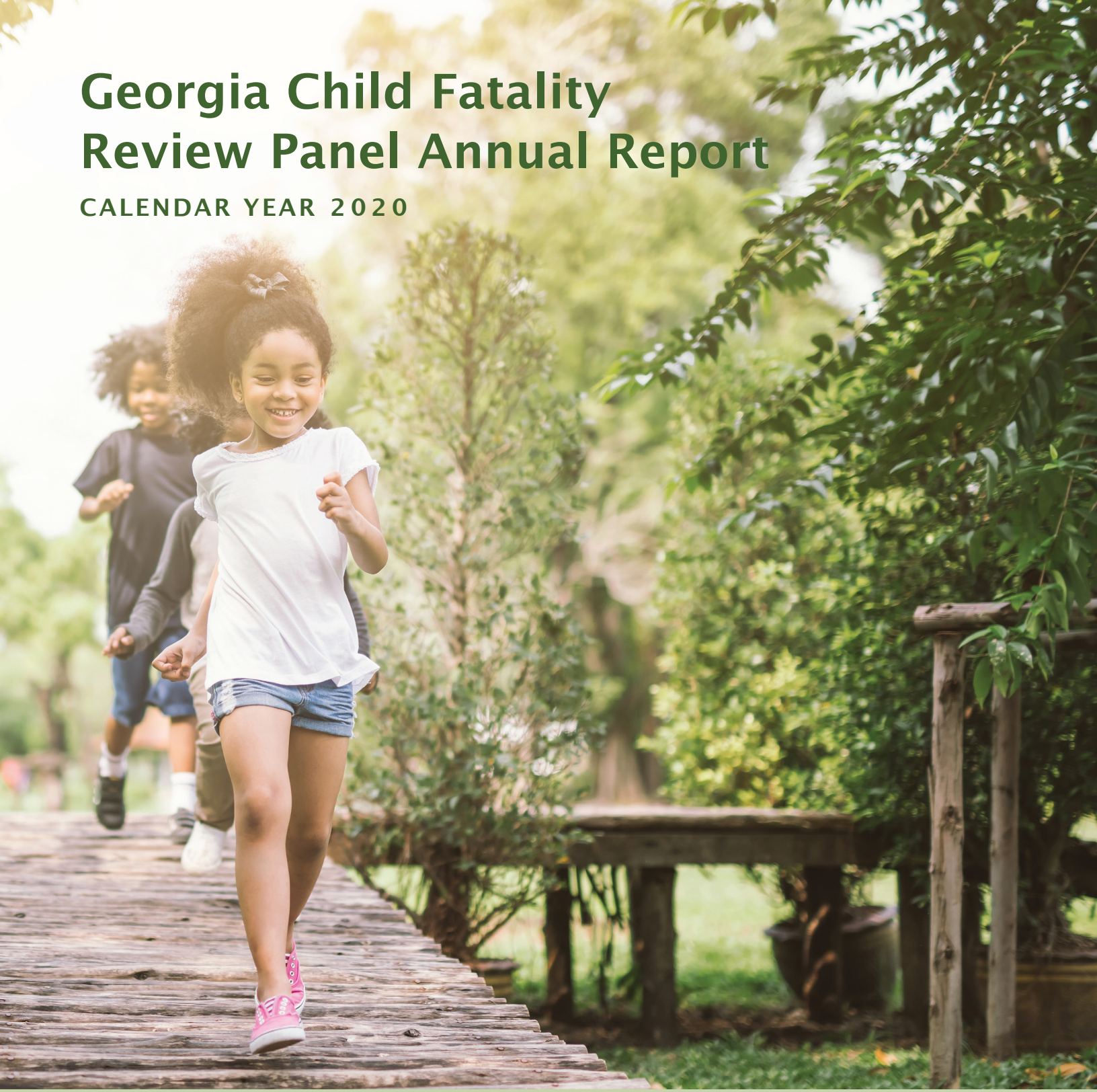
Georgia Child Fatality Review Panel Annual Report

CALENDAR YEAR 2020



Peggy Walker
Acting Panel Chairman

Brian Kemp
Governor

The Child Fatality Review Panel Members

Peggy Walker – Panel Acting Chair, Judge, Douglas County Juvenile Court

Vacant – Panel Vice-Chair,

Vic Reynolds – Director, Georgia Bureau of Investigation

Mandi Ballinger – Member, Georgia House of Representatives

Kathleen Bennett – Retired Mental Health Specialist

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

Gloria Butler – Member, Georgia State Senate

Kathleen Toomey – Commissioner, Department of Public Health

Robertiena Fletcher – Board Chair, Department of Human Services

Jay Neal – Director, Criminal Justice Coordinating Council

Tom Rawlings – Director, Division of Family and Children Services

Tiffany Sawyer – Prevention Director, Georgia Center for Child Advocacy

Richard Hawk – Coroner, Coweta County

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

Dr. Jonathan Eisenstat – Chief Medical Examiner, Georgia Bureau of Investigation

Rachel Davidson – Director, Office of the Child Advocate

Vacant – Member, District Attorney

Amy Jacobs – Commissioner, Department of Early Care and Learning

Vacant – Member, State Board of Education

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Mission

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

The Georgia Child Fatality Review Panel, each county-level review committee, their functions and membership requirements are established in Georgia statute (19-15-1 through -6).

Acknowledgments

The Georgia Child Fatality Review Panel acknowledges the following people and entities whose enormous commitment, dedication, and unwavering support to Child Fatality Review (CFR) have made this report possible:

- All the members who serve on each of the County Child Fatality Review Committees
- John T. Carter, PH.D., M.P.H., Emeritus Assistant Professor, Rollins School of Public Health, Emory University

The report was developed and written by the staff members of the Child Fatality Review Unit within the Georgia Bureau of Investigation.

Letter from the CFR Panel Vice-Chair

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

We are honored to present the Annual Report of the Georgia Child Fatality Review Panel for child death data composed in calendar year 2020. This data, representing sudden and unexpected child fatalities of Georgia residents, is compiled by 159 local child fatality review committees pursuant to statutory requirements. The Panel commends local committees for their continued compliance in this work. Thank you for the ongoing partnership and support in the Panel's mission to collect child death data and execute prevention efforts throughout our state.

The 2020 Annual Report uses multi-year data to highlight the leading reviewable causes of death in Georgia's children. There were 537 reviewable deaths for 2020 with 450 eligible reviews completed by local committees. Barriers cited for not completing reviews include turnover with mandated members, lack of knowledge regarding statutory requirements, and COVID-19 restrictions. To enhance compliancy, the Panel will continue to teach, communicate with, and support committee members in the child fatality review process.

Sleep-related infant deaths (SIDS, SUID, and sleep-related asphyxia) remain the leading post-neonatal reviewable cause of death, accounting for nearly one-third of all cases reviewed. We must continue efforts to educate and promote the Georgia Safe to Sleep Campaign and echo the message to the public during their interactions with the medical, public health, public safety, and prevention community. Furthermore, thorough investigation and documentation of these deaths is critical for review, prosecution, and prevention. Law enforcement, coroner, first responder, and other public safety personnel should receive coordinated and consistent instruction for investigating sleep-related infant deaths.

For purposes of this report, deaths not eligible for review are expected natural deaths or deaths due to congenital defects. Those medical deaths eligible for review are cases where children die suddenly and unexpectedly due to natural disease, or the death wasn't expected from the diagnosed medical condition. There were 95 medical deaths reviewed in 2020. Specific concentration should focus on plan and medication compliance as well as access to medical care. The Panel recognizes opportunities for prevention, especially in rural counties with limited medical care.

Child homicides account for the fourth leading reviewable cause of death in 2020, marking a 31% increase from the year prior. There were 89 juvenile homicides in 2020 with teens ages 15-17 comprising 49% of the reported deaths. With the COVID-19 pandemic, most school systems converted from in-person to virtual learning, a new, unexpected, and unchartered territory for families and communities. Coupled with inadequate supervision and unsecured access to firearms, the Panel recognizes the ramifications of the pandemic related to child maltreatment and intentional deaths. We support Georgia's Child Abuse and Neglect Prevention Plan (CANPP), which provides overarching goals for families, society, and systems/governments to ensure all of Georgia's children and families have equitable opportunities to grow and thrive in safe, stable, connected, and nurturing communities where they live, learn, work, and play.

The Panel commends Director Reynolds, the Child Fatality Review staff, Agents, and medical examiner office personnel at the Georgia Bureau of Investigation for their daily work to investigate, review, prosecute, and prevent the deaths of our most vulnerable residents, our children. Thank you for your attention, commitment, and support of the Panel and our Annual Report. Together, we shall continue our mission to reduce and prevent child deaths in Georgia.

Sincerely,
Elizabeth Andrews
Vice-Chair, Child Fatality Review Panel

Background and History

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

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

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

The product of the review process is a description of trends and risk factors for child deaths in Georgia. The CFR local teams and the Georgia CFR Panel use the review information to identify prevention strategies. The Georgia CFR Panel includes experts in the fields of child abuse prevention, mental health, family law, death investigation, and injury prevention. The variety of disciplines involved, and the depth of expertise provided by the Panel allow an in-depth analysis of both contributory and preventative factors for child deaths. This report identifies specific policy recommendations to reduce child deaths in Georgia.

Executive Summary

The Georgia Child Fatality Review Panel publishes an annual report on the deaths of infants and children in Georgia. The Report uses death certificate data provided by the Office of Vital Records within the Division of Public Health to document all deaths to the population under 18 years of age. The CFR process involves a review of a subset of deaths that are unexpected or are due to unintentional or intentional injuries. The review process provides for the systematic collection of "risk factor" data on deaths that are potentially preventable. These child death data are useful in revealing recurring patterns and to indicate prevention gaps and opportunities.

The Georgia trends in infant / child deaths over the last 10 years have been unremarkable. The child death rates tend to vary slightly from year to year, but there has not been any apparent trend. The infant death rate has declined from 7.8 deaths per 1,000 births in 2015 to 7.0 in 2019 and 6.3 in 2020. All the rates remain slightly higher than the National rate.

There were 1,358 reported (Death Certificate) infant and child (< 18 years) deaths in 2020. Five hundred thirty-seven (537) of those deaths were considered as "reviewable", and 450 of the 537 were reviewed (84%) (Table 1). The county review teams also reviewed 95 of the 821 "medical" deaths and 17 deaths that were reported as non-GA residents or were missing a death certificate. This yields a total of 562 reviewed deaths, and the analysis of reviewed deaths includes all 562.

Table 1. Reviewable 2020 Georgia Infant and Child Deaths, Proportion Reviewed

Major Cause of Death Categories	All Deaths	Reviewed	% Reviewed
Unintentional Injuries	211	176	83.4
Intentional Injuries	144	123	85.4
Sleep-Related (Infants)	157	129	82.2
Unknown / Unknown Intent	25	22	88.0
Total	**537**	**450**	**83.8**

The CFR local teams determined that 44 of the 562 reviewed deaths (8%) had maltreatment (abuse or neglect) reported as a cause or contributing factor for the death. An additional 111 deaths (20%) reported a history of maltreatment. Child maltreatment is a valuable factor for identifying populations at risk for child deaths, and agencies serving children need appropriate access to maltreatment information.

The CFR local teams agree that most of these reviewable deaths could have been prevented – 353 of the 400 (88%) of the reviewed deaths (non-medical cause, with a preventability determination) could "Probably" have been prevented. This result highlights the importance of the CFR process for identifying risk factors and contributing to the design of prevention strategies.

Racial disparities in the rates of infant and child deaths have been well documented, and the Georgia data (death certificate and Fatality Review) confirm the disparity. In 2020, 269 White, non-Hispanic infants died (a rate of 5.1 per 1,000 births). The rate was 9.6 (406 deaths) for Black/African American, non-Hispanic infants. The rate was 4.1 for Hispanics (76 deaths) which was down from 5.4 in 2019. Overall Black children were more likely to die a violent death. The disparity varies by cause of death; prevention targets or activities must account for both racial differences as well as differences in cause of deaths.

The National Center for Fatality Review and Prevention (NCFRP) data system is now a source for nine years of GA fatality review data. We are using this multi-year data to conduct analyses on specific topics related to Georgia infant and child deaths. The topics will address demographic characteristics (age, race, and sex), specific causes of death (sleep-related, suicide, homicide, and motor vehicle crashes), and/or cross-cutting subjects (maltreatment, supervision). Completed and documented analyses will be released and posted on the CFR website.

Reported Child Deaths in Georgia

In 2020, the COVID-19 pandemic was a challenge for all the U.S., and the Child Fatality Review process in Georgia was also affected. Due to the many demands on local health departments and other community organizations because of COVID-19, some county CFR local teams were not able to complete all the reviews. The number of reported child deaths decreased while the total number of deaths (all ages) increased by 20 percent. COVID-19 accounts for 9,446 of the 17,473 additional deaths, but that still leaves a 9% increase associated with other causes. The 2020 death certificates only reported six (6) COVID-19 deaths among children less than 18 years of age. However, the number of reviewable deaths increased by almost 15% (from 468 to 537) (Table 2).

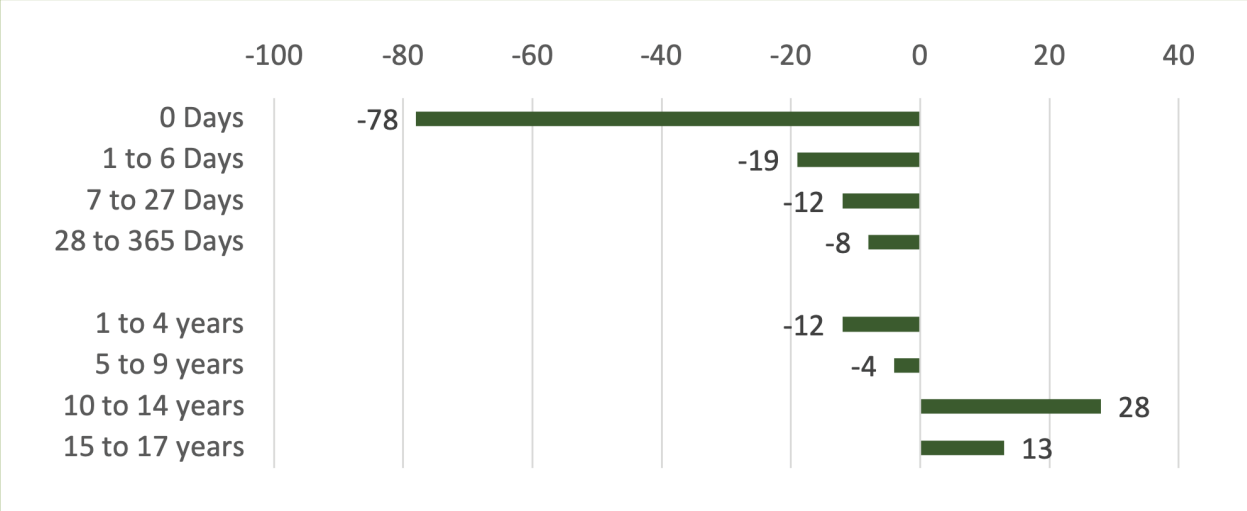
Table 2. 2019-2020 Georgia Infant/Child Deaths

	2019	2020
Total Number of Deaths	1,450	1,358
Reviewable Deaths	468	537
Reviewable Deaths Reviewed	429	450
% Reviewable Deaths Reviewed	91.7	83.8
Total Deaths Reviewed	**557**	**562**

The decrease in number of deaths (2019 to 2020) was not uniform across age categories. The infant mortality rate (deaths per 100,000 births) decreased from 7.0 in 2019 to 6.3 in 2020, corresponding to 117 fewer deaths in 2020. (The 3% drop in births would account for 27 of the 117 fewer infant deaths.) Most of the reduction

in infant deaths was due to the decrease (from 298 to 220) in number of infants dying at birth (within the first day of life). There were small decreases in deaths among children 1 through 9, and the 10 through 17-year-old children experienced an increase in deaths (Figure 1).

Figure 1. Change in Number of Deaths, 2019-2020



In 2020, there were a total of 1,358 infant/child deaths in Georgia. Of those 1,358 deaths, 537 deaths met the eligibility criteria for county level Child Fatality Review. Of the 537 deaths that met the review criteria, 450 were reviewed (83.8%).

Any infant or child death is loss to society and a tragedy for the immediate family. The child fatality review (CFR) process was developed to provide a way to learn from these deaths so that future deaths could be prevented. A "learning process" can take place at three levels:

1

Community (county): A local CFR team reviews the individual deaths, enters data abstracted from the review into a GA (and National) database, and develops recommendations for action at the community level.

2

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

3

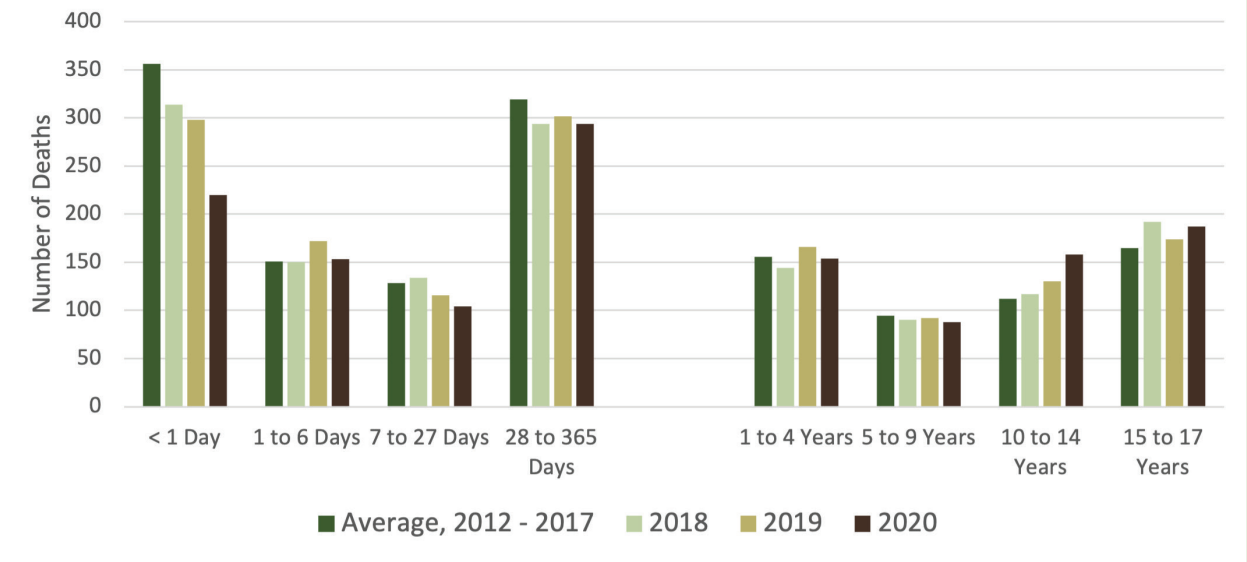
Nation: The National Center for the Review and Prevention of Child Deaths (NCFRP) maintains the national database and provides an opportunity for research on child deaths at the national level.

This annual CFR Report indicates trends in child deaths, summarizes the GA CFR 2020 activities, and provides a synthesis of the CFR local teams' prevention recommendations. The CFR Panel serves as one of the citizen's review panels for the GA Child Abuse Prevention and Treatment Act (CAPTA), so one section explicitly addresses child maltreatment.

2020 Child Deaths:

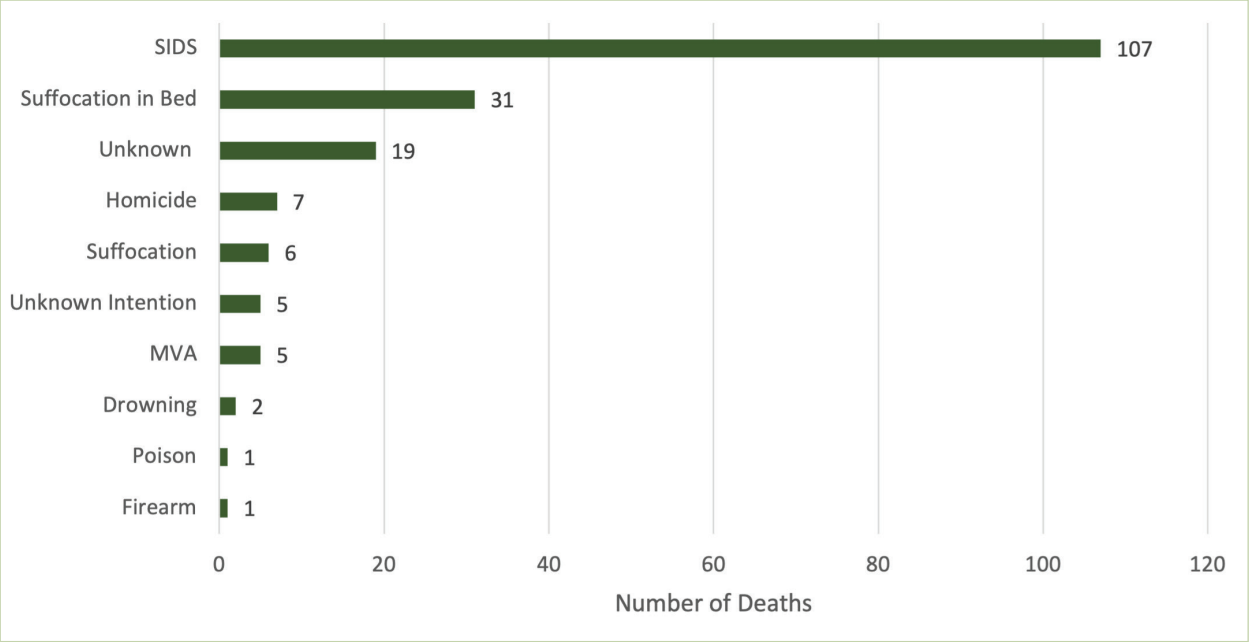
A majority of these 1,358 reported deaths were infant deaths (771, or 57%), and 220 of the infant deaths occurred in the 1st day of life (Figure 2). An additional 257 occur within the 1st month and these three age categories define "neonatal deaths". These neonatal deaths are generally associated with prematurity and congenital defects, and they are not usually a subject for CFR. The sleep-related infant deaths are the largest category of post-neonatal deaths, and they are reviewed.

Figure 2. Age Distribution, Georgia Infant and Child Deaths



The 2020 mortality data (https://www.macrotrends.net/countries/USA/united-states/infant-mortality-rate) showed a U.S. infant mortality rate of 5.68 per 1,000 births. The GA Oasis rate (6.3 per 1,000) is higher than the U.S. rate but represents a "statistically significant" decrease from the 2019 GA rate (7.0 per 1,000). Toddlers (1 to 4) and children (5 to 14) death rates (2019) were 23.3 and 13.4 per 100,000 for the U.S. and the corresponding GA 2020 rates were 29.6 and 17.3. Georgia's rate for all these mortality measures is slightly higher than the National rate.

Figure 3. 2020 Georgia Non-Medical* Infant Deaths, by Cause



*Infant deaths attributed to "Medical" causes=587

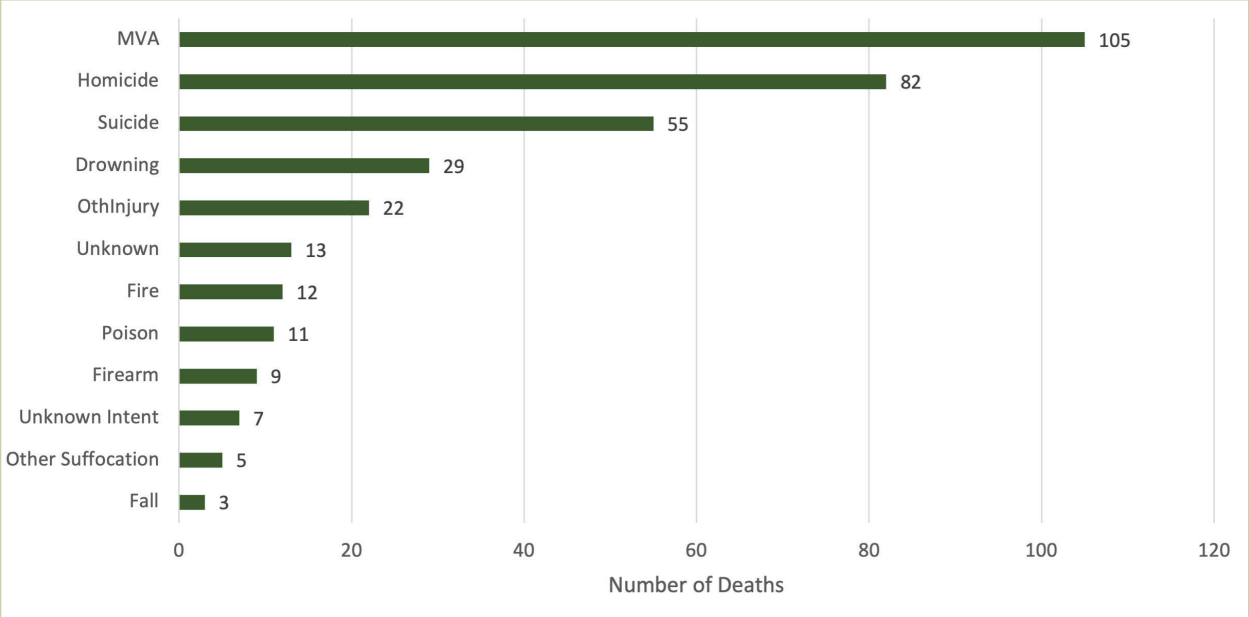
The 2020 infant deaths (Figure 3) are dominated by "medical" causes (76% of all infant deaths). The three next largest causes – SUID, suffocation in bed, and unknown – comprise the combined category of "sleep-related" deaths and account for 20% of all infant deaths. However, these sleep-related deaths made up 49% of all post-neonatal infant deaths (Table 3).

Table 3. Age Distribution for Infant Deaths, Georgia, 2020

	Infant Age Categories (days)				
	< 1 day	**1 to 6**	**7 to 27**	**28 to 365**	**Total < 1 Year**
SUD Categories					
SIDS			7	100	107
Suffocation in Bed		2		29	31
Unknown	1	1	1	16	19
All Other Causes	219	150	96	149	614
			Sleep-related proportion	**49.3**	**20.4**

The estimated population of children ages 1 through 17 in 2020 was 2,372,144, and there were 587 deaths in that population in 2020. Deaths are more common among toddlers and teens, and these age differences are associated with specific causes of death. Deaths attributed to medical causes continue to be the largest category of death for ages 1 through 17 years (42%), but Figure 4 shows the significant number of deaths from unintentional (33%) and intentional (23%) injuries.

Figure 4. 2020 Georgia Non-Medical* Deaths, Ages 1-17, by Cause

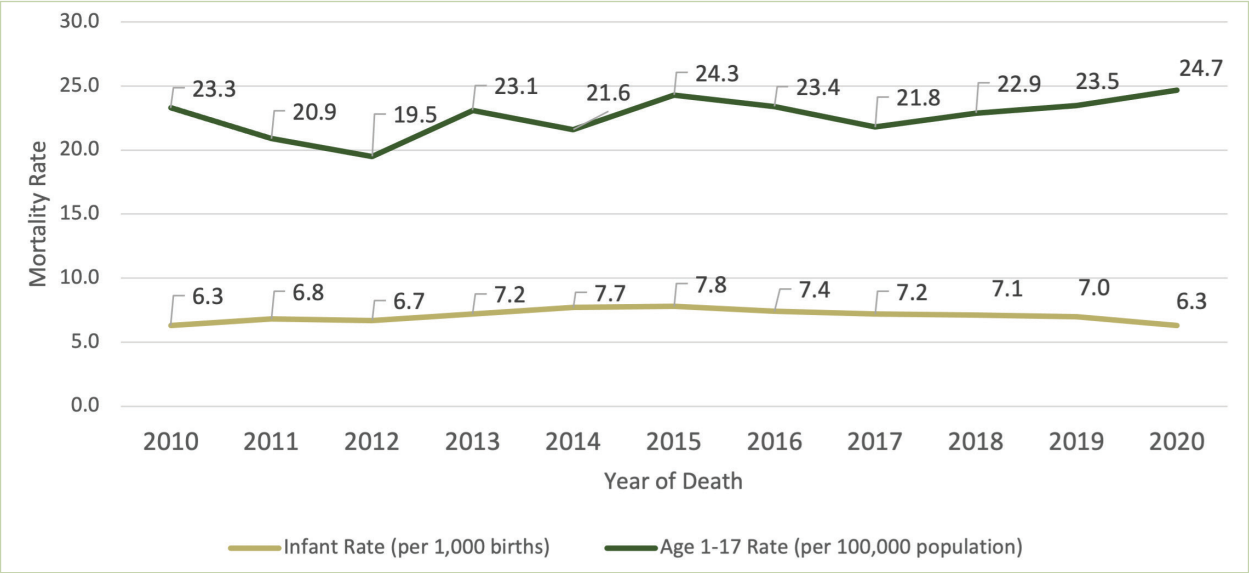


*Child (ages 1 to 17) deaths attributed to "Medical" causes=234

Trends in Georgia Infant and Child Deaths:

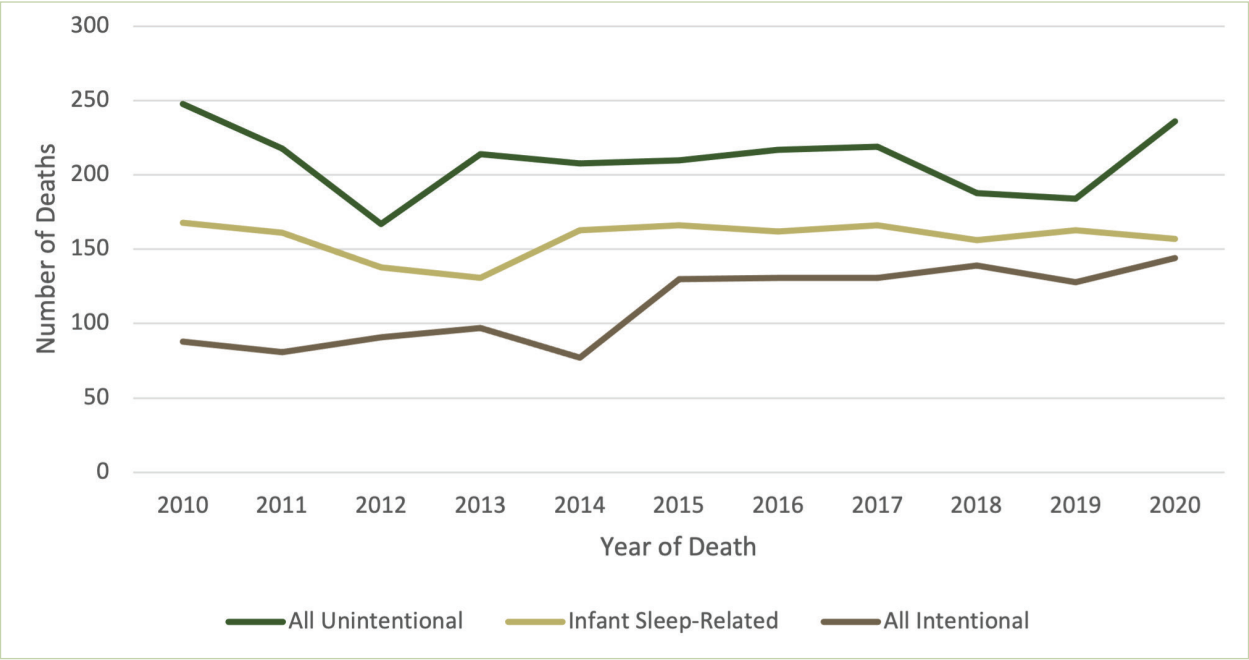
The total (all causes and ages) mortality rates obscure any of the age/cause differences, but they provide an overview of deaths for the past ten years (Figure 5). The infant rate shows an increase between 2010 and 2014/5 and then a decrease the last five years. The 1 – 17 rate appears to fluctuate more from year to year, but there is no obvious trend. The 2020 rate (24.7 per 100,000) is lightly higher than the average rate (22.4) for the preceding ten years.

Figure 5. Georgia Infant and Child Death Rate Trends, 2010-2020



A brief examination of cause of death numbers over time shows a significant increase in the intentional deaths in 2015 (Figure 6), and deaths remained at the higher level for the next five years. These increases in homicides and suicides will be examined in subsequent analysis using the multi-year death certificate and CFR data.

Figure 6. Georgia Deaths, Ages 0-17, Selected Categories, 2010-2020



Child Deaths Reviewed

The Georgia CFR process has been in place and operating since 1991. Over these past 29 years the Georgia CFR and the county teams have worked diligently to complete reviews and enter the reviews into the state (now national) CDR database. The proportion of "reviewable deaths" reviewed has been as high as 95%; however, after decreasing for six years, the teams have reviewed 91% of the reviewable deaths for 2018 & 2019 and 84% in 2020. The extent of county team participation (in an unfunded mandate) after 29 years is very commendable, and it is important to acknowledge and encourage that local effort.

A child fatality review is required for deaths that are sudden, unexpected, unexplained, suspicious, or attributed to unusual circumstances, but the legislation does not provide a specific case definition for reviewable deaths. Historically, any non-medical cause death (defined by the ICD code for the underlying cause of death) has been defined as reviewable. Certain medical deaths (unexpected, decedent not under the care of a physician) are appropriately reviewed and are addressed in the annual report, however they are not included in either denominator or numerator when calculating the proportion of reviewable deaths reviewed. Using the "non-medical cause" criterium for reviewable deaths, there were 537 reviewable 2020 deaths.

The death certificate (DC) and Child Death Review (CDR) databases are linked (using dates of birth and death, decedent and parent names, and street address). The linked files are used to calculate the CDR performance metric – percent of "Reviewable Deaths" reviewed – and to provide data quality review. Seventeen of the 562 reviewed death records did not link with a DC. This list has been provided to Georgia Vital Records for follow-up. Five hundred forty-five (545) of the completed CFR records were linked with a death certificate for a Georgia resident.

The 450 records (reviews of reviewable deaths) are used for the calculation of the proportion of reviewable deaths reviewed (Table 4). However, all 562 completed reviews (which includes the 95 reviews of medical deaths and the 17 with no DC) are included in the analysis of reviewed deaths.

Table 4. Percent of 2020 Georgia Reviewable Deaths Reviewed			
Cause of Death (DC)	**All Deaths**	**Reviewed**	**% Reviewed**
MVC	110	95	86.4
Drowning	31	22	71.0
Other Injury	70	59	84.3
Unintentional Injury Total	**211**	**176**	**83.4**
Homicide	89	74	83.1
Suicide	55	49	89.1
Sleep-Related Total (Infants)	**157**	**129**	**82.2**
Unknown Intent	12	11	91.7
Unknown	13	11	84.6
Reviewable Total	**537**	**450**	**83.8**
Medical	821	95	11.6
All Deaths	**1,358**	**545**	**40.1**

The map in Appendix B displays counts by county for the number of reviewable deaths and the number of reviewable deaths reviewed. Eighty-five of the 159 Georgia counties reviewed all their reviewable deaths (Table 5).

Table 5. Summary of 2020 Review Categories					
Definition	**Category**	**Counties**	**Reviewable Deaths**	**Reviewed**	**No Review**
All reviewable deaths reviewed	4	85	303	303	
One or more reviewable deaths not reviewed	3	17	209	147	62
Reviewable deaths, none reviewed	2	15	25		25
No reviewable deaths	1	42			
Total			**537**	**450**	**87**

Maltreatment

Understanding the Role of Maltreatment in Reviewed Child Deaths

According to the World Health Organization (WHO), child maltreatment is the abuse and neglect that occurs to children under the 18 years old. This includes all types of physical and/or emotional ill-treatment, sexual abuse, neglect, negligence and commercial or other exploitation, which results in actual or potential harm to the child's health, survival, development, or self-identity in terms of a relationship of authority, trust, or power.

The Child Abuse Prevention and Treatment Act (CAPTA) was enacted in federal law January 31, 1974 and has been amended several times. It was established in federal law to address child maltreatment through its prevention, assessment, guidance to states, prosecution, and treatment initiatives. CAPTA also provides grants to public and nonprofit organizations which includes Indian Tribes and Tribal organizations for demonstration programs and plans.

2020 Reviewed Deaths with Maltreatment Reported

The focus of this section is to highlight maltreatment as a reported cause of death and describe deaths with a reported history of maltreatment. The information is captured in the National Child Death Review (NCDR) for maltreatment as it relates to the decedent. Table 6 represents the maltreatment results (2020 reviewed deaths) from a derived summary variable which assigns an order to the maltreatment/ contributing act categories. (The "de-duplication" works from the top down. For example, if "Cause/Contribute" and "History" were both identified, that death is reported under "Cause/Contribute". Fifty-seven deaths had a history of abuse identified, but 13 of those deaths also had "Cause/Contribute" identified. Those 13 deaths are not counted in the "Un-Duplicated" "History, Abuse" xcccccentry.)

Table 6. Maltreatment Reports, Georgia, 2020 Reviewed Deaths

		All Reports	Un-Duplicated
Cause/Contribute	Abuse	22	22
	Neglect	22	22
History	Abuse	57	44
	Neglect	90	67
		Maltreatment Total	**155**
Poor Supervision		82	58
Exposure to Hazard(s)		279	189
No Reported Maltreatment, Poor Supervision, or Hazard Exposure			**160**

The sum of the un-duplicated counts for the four cause / history maltreatment categories (Table 6) is 155 (22+22+44+67). The "descriptive epidemiology" of these maltreatment-related deaths first addresses three basic variables – age, sex, and race-ethnicity. The reason for the analysis is to determine whether the apparent proportion of reviewed deaths with reported maltreatment changes with these three variables. (i.e., Is a male decedent more likely than a female to have experienced maltreatment?)

Of the reviewed death victims, most are male (61.4%), and a disproportionate number are Black/African American (50.9%) (Table 7). The proportions (of deaths with maltreatment) change across the age/race/sex strata over time, but the maltreatment risk is evenly distributed across strata.

Table 7. 2020 Reviewed Deaths with Maltreatment Reported (by Demographic Variables)

	All Reviewed		Reviews with Maltreatment		
	Count	Column Percent	Count	Percent with Maltreatment	Percent 2016-2019
Sex					
Male	345	61.4	84	24.3	30.2
Female	217	38.6	71	32.7	29.7
Total	**562**		**155**	**27.6**	**30.0**
Race/Ethnicity					
Black	286	50.9	87	30.4	30.3
White	194	34.5	50	25.8	31.2
Hispanic	65	11.6	16	24.6	24.0
Multi-race	12	2.1	2	N/A	42.1
Other	5	0.9		N/A	17.5
Age (Years)					
Infants	190	33.8	39	20.5	23.5
1 - 4	87	15.5	26	29.9	39.8
5 - 9	47	8.4	20	42.6	34.3
10 - 14	101	18.0	35	34.7	35.3
15 - 17	137	24.4	35	25.5	29.3

Table 8 shows all reviewed child deaths by cause of death with a cause or history of maltreatment. It exhibits an alarming number (20) of homicides with abuse as the cause. Over 50.6% of homicide related deaths has a history or reported maltreatment cause.

Table 8. Maltreatment Category by Cause of Death: Georgia, 2020 Reviewed Deaths

	Maltreatment Cause		Maltreatment History		% Reviewed w/ Maltreatment
Cause of Death	Abuse	Neglect	Abuse	Neglect	
MVC		1	6	14	20.2
Drowning			1	4	20.8
Other Unintentional	1	2	11	5	31.7
Homicide	20	4	8	8	50.6
Suicide		3	8	6	34.0
Sleep-Related		3	5	17	17.5
Medical		7	5	13	28.7
Undetermined	1	2			
All Reviewed	22	22	44	67	27.6
Duplicated Counts	22	22	57	90	

Summary of Selected Causes

If we exclude infant deaths – which are dominated by medical causes associated with the birth – then the three leading causes of death (over the last five years) for all children ages 1 through 17 are motor vehicle crashes (480), homicide (322), and suicide (294). (Source: OASIS, GA, 2016 – 2020) These three causes accounted for 218 of the 372 (59%) reviewed deaths (ages 1 to 17) in 2020. Sleep-related infant deaths (143) comprised the largest category of reviewed deaths (all ages). This section of the Annual Report provides an overview of the demographics for these four causes, the prevention implications of selected risk factors identified in the review process, and suggestions for data quality improvements.

Motor Vehicle Crash (includes pedestrian and bicycle)

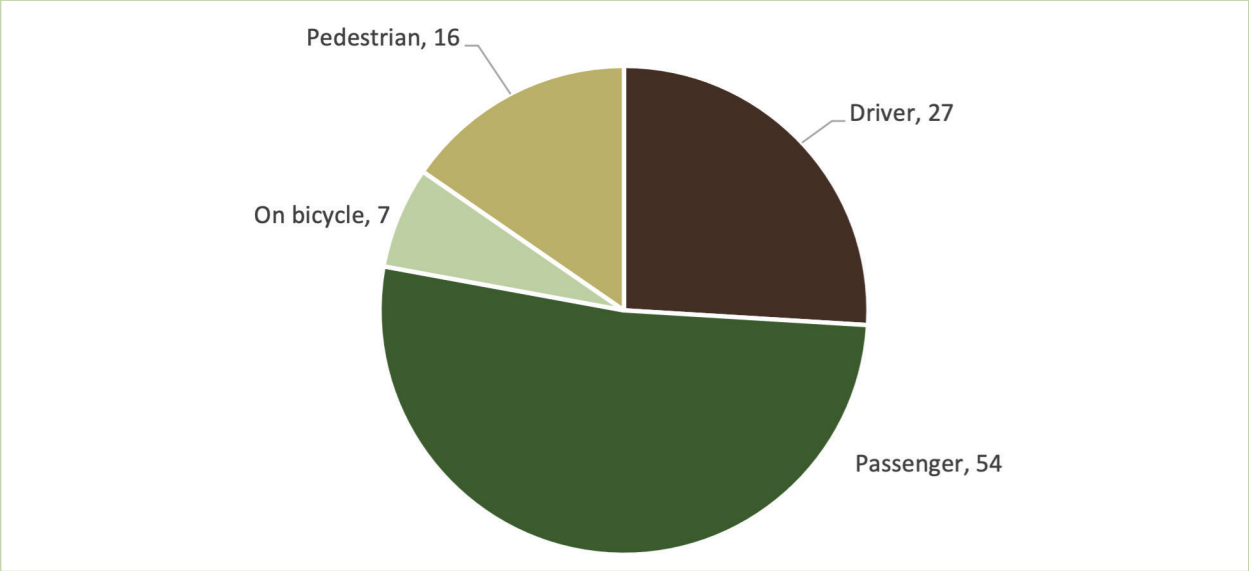
In 2020, there were a total of 104 reviewed motor vehicle deaths in Georgia, an increase from the 84 reviewed motor vehicle-related deaths in 2019 (Table 9).

Table 9. Reviewed Motor Vehicle Crash Deaths, Georgia, 2020

	White, Non-Hispanic		Black, Non-Hispanic		Hispanic & Other Race		
	Male	Female	Male	Female	Male	Female	Total
Infant			1	3			4
1 - 4	5	2	4	5		1	17
5 - 9	4	1	3	2	1	1	12
10 - 14	8	2	6	3	2		21
15 - 17	18	6	7	7	11	1	50
Total	**35**	**11**	**21**	**20**	**14**	**3**	**104**

- 44% (46/104) of the victims were White, non-Hispanic; and 67% were male.
- 48% (50/104) of the victims were between the ages of 15-17.
- 42% (21/50) of the children between the ages 15-17 were the reported drivers.

Figure 7. Reviewed 2020 Motor Vehicle Deaths, by Position



Intentional Injuries

The number of intentional injury (homicide and suicide) deaths in the population ages less than 18 is small – compared to all such deaths – but troubling (Table 10). We need to do a better job of protecting our children from intentional injuries and violent deaths. The following discussion uses death certificate (DC) data to identify trends in homicide and suicide deaths, and multi-year child death review (CDR) data to identify risk factors and target populations for intervention.

Table 10. Georgia 2020 Intentional Injury Deaths

	Number of Deaths		Mortality Rate*	
	All Ages	**< 18**	**15 to 17**	**18 to 24**
Suicide	1,488	55	7.1	19.2
Homicide	1,091	89	10.3	24.5
Cause				
Sum	**2,579**	**144**		

Rate*: Deaths per 100,000 population
Source: OASIS Mortality Query

Suicides and homicides have recognized racial differences in distribution. A White, non-Hispanic teen is about twice as likely to die by suicide as a Black, non-Hispanic teen (Table 11). The racial disparity for teen homicides is much more striking, with an eight-fold increased risk for Black teens compared to White teens.

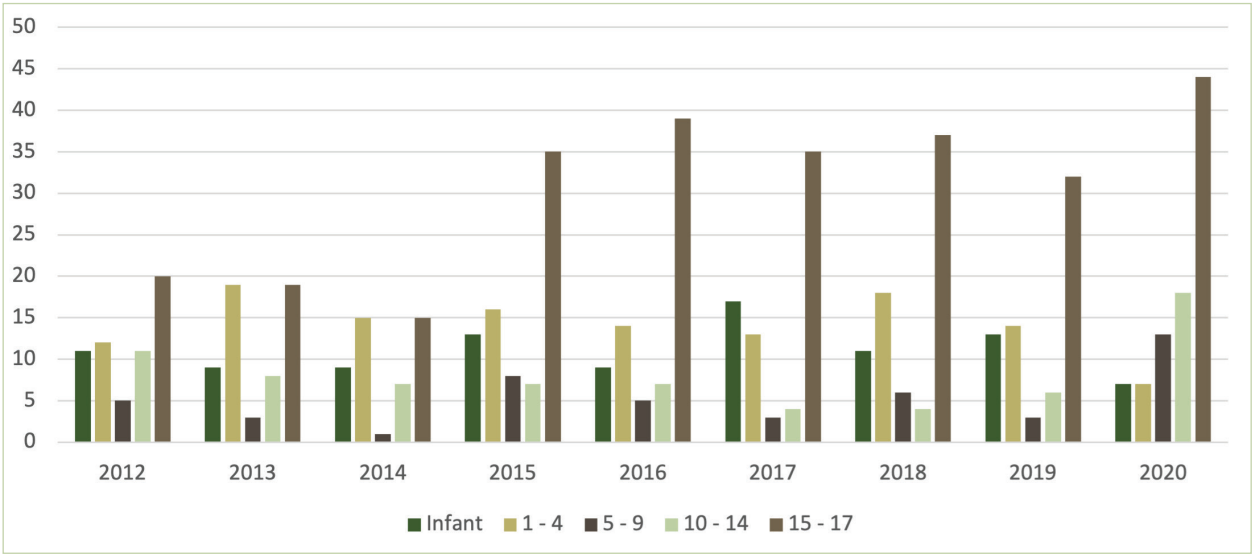
Table 11. Georgia Mortality Rate (per 100,000), Homicide and Suicide: 2016-2020, Ages 15-17

	Non-Hispanic		
	Black	**White**	**Black/White Relative Risk**
Suicide	5.3	11.4	0.5
Homicide	20.7	2.5	8.3

Homicide Deaths

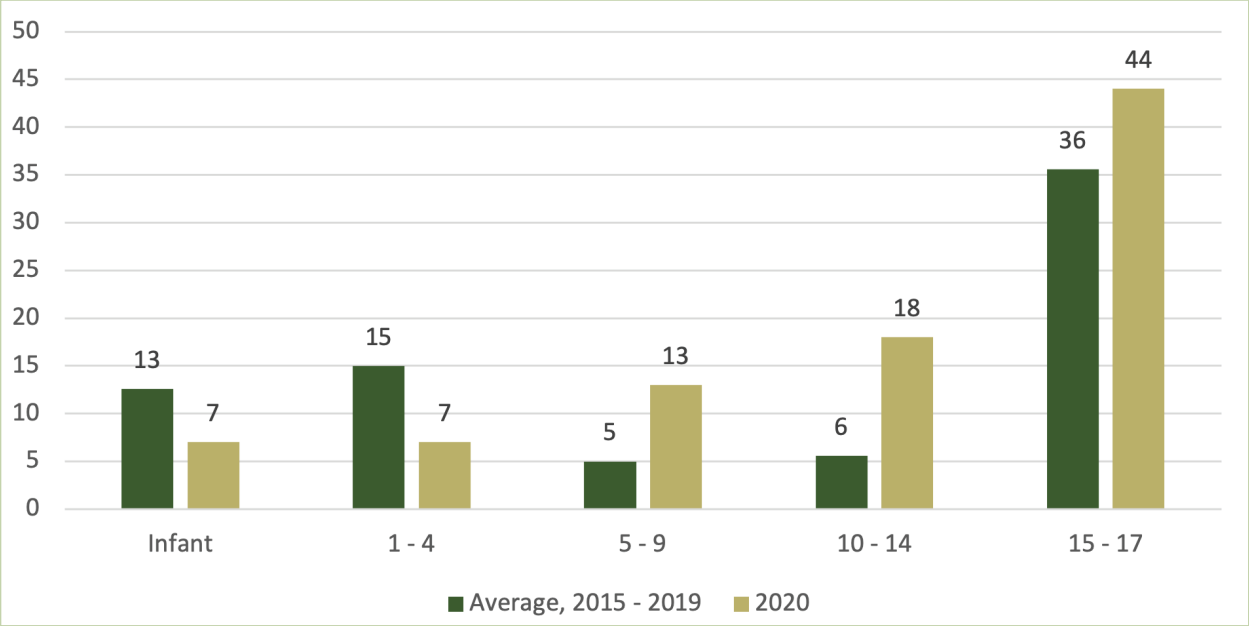
Death Certificate Trends: The homicide trend (based on Death Certificate data) showed an increase in 2015 from an average of 55 per year (2012 – 2014) to 76 (2015 – 2019). The increase was concentrated in the 15- to 17-year-old teens (Figure H1).

Figure H1. Homicide Deaths by Year of Death, by Age: Georgia, 2012-2020



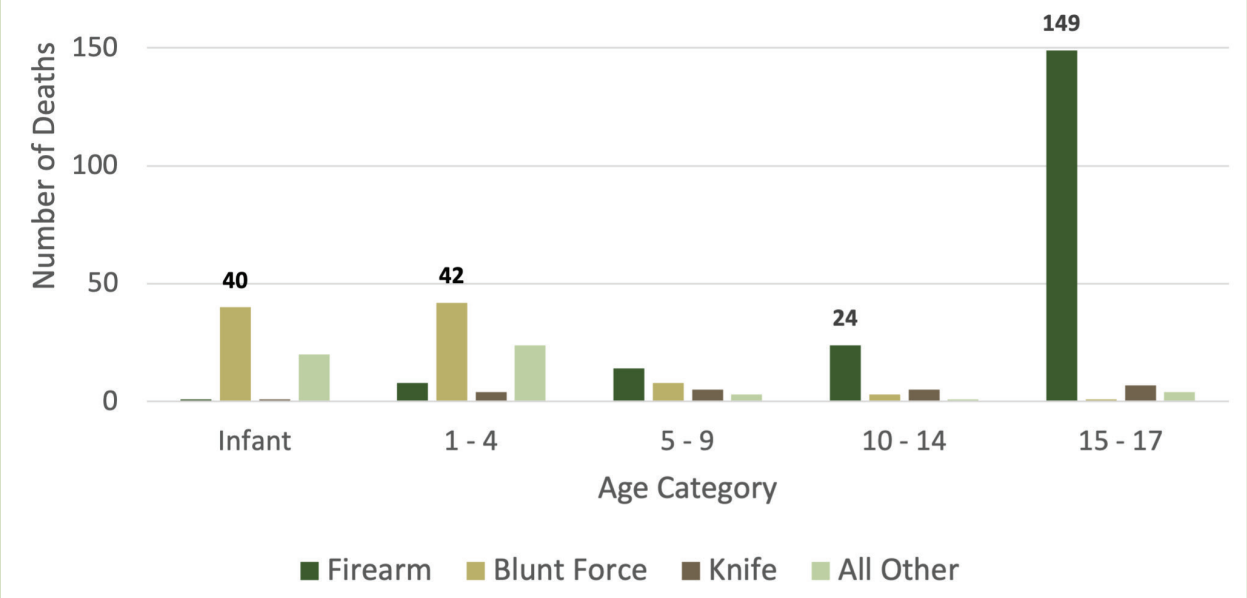
The 2020 homicides (ages < 18) appear to represent another change – perhaps associated with the COVID-19 pandemic. The infant and toddler age categories had fewer homicides than in any of the preceding eight years; and the other three age categories had more homicides. (Figure H2)

Figure H2. 2020 Change in Georgia Homicides, Ages < 18



CDR Results: The most recent five years of CDR data include 364 homicide deaths. The distribution of deaths by age category and mechanism of death (Figure H3) indicates two distinct populations with associated mechanisms: infants and toddlers / blunt force trauma and teens (15 to 17) / firearms.

Figure H3. Reviewed Homicide Deaths by Mechanism and Age, Georgia, 2016-2020



The identified responsible person for a majority of the 140 infant and toddler homicides was the biological mother (53) or father (33), or the mother's partner (21). Eighty-two (82%) percent of the blunt force (BFT) homicides were attributed to one of the three categories, and 76% of all infant/toddler homicides had one of the three. This suggests parents / partners as the intervention target population. A prior history of maltreatment should also serve as a risk factor, and 49% of the BFT victims had prior history reported (Table H1). (Fourteen victims had an open Child Protective Services ({CPS} case.)

Table H1. Blunt Force Trauma Victims with Maltreatment History, 2016-2020

	Ages in Years			
Maltreatment History	**Infant**	**1-4**	**5-9**	**Total < 10 Years**
Yes	16	20	8	44
No	24	**22**		**46**
Total	**40**	**42**	**8**	**90**
% w/ History	40.0	47.6		48.9

The teen firearm homicides present a greater challenge in identifying prevention populations or messages. There were 48 reviewed firearm homicides (all ages) in 2020, but there was no "responsible person type" classification for 28 of the perpetrators. Based on the review narrative, seven of the homicides appear to have been gang-related, six were "drive-by" shootings, and ten involved drug/firearm/cell phone sales. Four other deaths classified as homicides appear to have been unintentional and caused by mishandling of the weapon.

Looking at 2020 Homicide deaths in children in Georgia alone, 89 homicide deaths were reported, and 83.1% of those were reviewed by the local team. Sixty-one of the reviewed homicide deaths (ages 0 through 17) were non-Hispanic Black (Figure 6). That is a staggering 77% of all homicide deaths in children in Georgia in 2020. In that same category 58% were Black non-Hispanic males, and 19% were Black non-Hispanic females compared to 6% of White, non-Hispanic males, and 6% non-Hispanic females. Homicide deaths in children ages 0-17 is the 3rd leading highest non-medical cause of deaths in children in Georgia. In all age categories, children ages 15 through 17 ranked the highest number of homicide deaths in 2020 (Table H2). According to the local review team 90% of all reviewed homicides deaths in 2020 could have been prevented.

Table H2. Homicides, Ages 0-17, Georgia 2020: Race and Category						
Non-Hispanic	**White**		**Black**		**Other**	
Age Category	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
Infants			5	2		
1 to 4		2	1	3		
5 to 9	1	1	1	7		
10 to 14	4	2	9			
15 to 17	3	1	34	5		
Total	**8**	**6**	**50**	**17**		
Hispanic	**White**		**Black**		**Other**	
Infants						
1 to 4	1					
5 to 9	1	1	1			
10 to 14	1		1		1	
15 to 17			1			
Total	**3**	**1**	**3**		**1**	

Prevention strategies for infants and toddlers should focus on two distinct target populations:

1. Prevention strategies targeting parents/caregivers

- Educating parents and caregivers on the gun safety, proper use of firearms. In addition, parents and caregivers should also be educated on the proper storage of firearms in the home, as well as having access to affordable approved gun storage gear in the homes. This will likely decrease the occurrence of firearms related incidents at home by parents/caregivers, hence decrease firearms gun related death of infants and toddlers in Georgia.
- Prevention strategies should also aim at identifying family stressors, especially families with young children. Focusing on finding appropriate support services, with the emphasis on free or low-cost community activities for children and these families. In addition, coordination (sharing information) among different service providers, will help identify maltreatment risks factors for both perpetrators and the victim child early on which will decrease the occurrence of firearms related deaths in infants and toddlers.

2. Prevention strategies targeting teens

- Educating teens on the firearms safety will increase awareness of firearms related injuries in the community. Prevention should also focus on identifying age-appropriate community support programming aim at fostering positive social involvement and deterrence of gang involvement. Activities such as (Boys & Girls Club, YMCA). Hence will decrease gangs' violence amongst teens within the community.

Suicide Deaths

Death Certificate Trends: Georgia teen suicides increased almost 90% from the 2010 – 2014 period (30.6 average per year) to 58.0 for 2015 – 2019. This increase paralleled the observed increase in infant/child homicides. The 2020 suicide count (ages 10 to 17) was down slightly to 55, and the total suicide count (all ages) was also down from 1,582 in 2019 to 1,488 in 2020.

White, non-Hispanic youth account for 56% of all youth (< 18) suicides, and males account for 69% (Table S1). The male proportion is higher for the 15- to 17-year-old teens (74%) than for the 10 to 14 ages (61%).

Table S1. Youth Suicides by Age, Sex, Race, Ethnicity: Georgia, 2016 - 2020

		Non-Hispanic			Hispanic	
Age (yrs)	**Sex**	**White**	**Black**	**Other**		**Total**
5 to 9						
	Male		1		1	**2**
10 to 14	Male	32	20	4	9	**65**
	Female	19	17		6	**42**
15 to 17	Male	87	29	9	12	**137**
	Female	27	11	4	6	**48**
	Total	**165**	**78**	**17**	**34**	**294**

In 2020, local CFR committees reviewed 50 child deaths as the result of suicide. There were 34 males and 16 females. The two most common reviewed mechanisms were firearm (23) and hanging (23) which accounted for 92% of the reviewed suicide child deaths. Mechanisms of suicides due to poison was the least common (4).

Table S2: Reviewed 2020 Georgia Suicide Deaths, Ages 10 - 17					
		Non-Hispanic			
	Mechanism	White	Black	Hispanic	Other
Male					
	Firearm	12	6	2	
	Hanging	10	1		2
	Poison	1			
Female					
	Firearm	2	1		
	Hanging	3	4	3	
	Poison	1	1	1	

CDR Results: The CDR suicide data includes information on risk factors that are potentially useful for planning / developing / implementing prevention activities. There are a series of questions that address possible "early warning" signs:

1. Behavioral history (Question I6a): running away, anxiety, explosive anger, or head injury. Sixty-six of the 271 reviewed deaths had one of these behaviors reported.

2. Diagnosed disorders (I6b): anxiety, depression, bipolar, and others. Twenty-eight decedents had one or more diagnosed disorders.

3. Prior suicidal behavior/attempts (I6c): reported for 18 decedents.

4. Warning signs within 30 days of death (I6h): talking about suicide, expressing hopelessness, and others. 106 of the decedents had displayed at least one of the warning signs.

According to 2020 suicide data, Whites ages 10 through 17 ranked the highest with 29 reviewed suicide deaths in 2020, compared to 13 Blacks, 6 Hispanics, and 2 others. (Table S2). This high number is seen across all age category for whites with 46% males and 12% females. White males maintain the highest number for both mechanisms used combined. Twelve (12) firearms and 10 hangings compared to 7 firearms and 5 hangings amongst Black males and females. However, Black females have a higher rate of suicide by hanging.

86% of 2020 suicide deaths were reviewed by the team in which they found 37 to be "yes, probably" preventable, 7 Undetermined, and 6 "No, probably not".

One hundred ninety-three of the 271 suicide victims (71%) had responses in at least one of the four areas (plus two additional questions on communication of suicidal thoughts {I6d} and self-harm {I6g}).

Firearms were the mechanism for 130 of the 271 reviewed suicide deaths (2016–2020) (Table S3). The storage and safety precautions associated with these weapons provides another area for prevention action. The following section on firearms provides information on storage and safety derived from the CDR firearm data.

Table S3: Suicide Mechanism by Age: 2016-2020, Age in Years

	5-9	10-14	15-17	Total
Fall		2	6	8
Firearm	1	38	91	130
Hanging	1	52	64	117
Poison		6	10	16
Total	**2**	**98**	**171**	**271**

Suicide prevention strategies targeting teens should be a multi faced collaboration amongst different agencies serving the community. That should involve the school system, mental health services, primary care physicians as well as community support programming, especially those serving teens during after school hours. In addition, education parents and caregivers on intensifying changes in behavior as well as appropriate services within the community. Prevention strategies should also focus on improving community relationship between schools, community services, parents, and caregivers.

As noted above in the CDR results section, many risks factors were identified in most of the 2020 suicide cases, however there seemed to have had no follow ups on those identified risks factors, Evidenced by the number of unknown responses in the CDR reports. Due to the lack of participations from mental health providers within the CFR team. In addition, there needs to be more focus on the county level regarding suicide prevention. This will provide opportunities for intervention and community integration.

CFR team across the state felt higher level of supervision of teenagers and adolescent should be instituted, especially around social media interactions. Immaturity and impulsive adolescent behavior combine with easy access to firearms is a lethal combination for disaster. It was also determined that 50.6% of the reviewed homicides had a direct correlation with maltreatment (maltreatment being the cause or had a history of maltreatment).

Firearm Deaths

Firearms are the major mechanism associated with intentional injury deaths. They are involved in 54% of the homicides and 48% of the suicides (Table F1). An additional seven deaths per year (5-yr average) are attributed to careless handling of firearms.

Table F1. Reviewed Firearm Deaths: Georgia, 2016 - 2020

	Year of Death					
Manner of Death	**2016**	**2017**	**2018**	**2019**	**2020**	**5-Yr Total**
Homicide	40	33	38	37	48	**196**
Suicide	23	26	27	31	23	**130**
Unintentional	5	6	9	4	10	**34**
Total	**68**	**65**	**74**	**72**	**81**	**360**

Most of the CDR data regarding firearm storage and handling is missing for the homicide deaths, and 40% of the Suicide / Unintentional deaths have missing storage information (Table F2).

Table F2. Reported Firearm Storage: 2016-2020 Suicide/Unintentional Deaths

Where Stored	Suicide	Unintentional
Missing	1	
Not stored	12	12
Locked cabinet	5	
Unlocked cabinet	9	1
Glove compartment	5	1
Under mattress/pillow	4	
Other	42	7
Unknown	52	13
% Unknown	40.0	38.2

An inspection of the "Narrative" entry for the reviews with "Other" reported as the storage location revealed that the weapon was generally in an unsecured location in the decedent's home – closet, nightstand, basement. Several of the weapons were in the possession of the decedent. The narratives support the need for gun safety education for any gun owner, and for more attention to warnings of mental/emotional disturbance from teens.

Sleep-Related Infant Deaths

Sleep-Related Infant Deaths: Sleep-related deaths continue to be a disappointing issue. The local CFR committees reviewed 157 sleep-related deaths in 2020 – slightly lower than the average number reviewed over the preceding seven years (Table 12). The distribution of deaths by race/ethnicity and sex is consistent with the distribution over previous the five-year period (2016 – 2020). Black infants are twice as likely to suffer a SIDS death compared to White infants (OASIS: SIDS deaths, 2019- 2020). The SIDS deaths do not include the infant deaths attributed to suffocation in bed or unknown cause.

Table 12. Reviewed Sleep-Related Deaths by SUID Category, Georgia 2020

	Black Non-Hispanic		White Non-Hispanic		Hispanic/Other Race	
SUID Category	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
Asphyxia	13	7	7	9	5	1
Medical	3	3			1	
Undetermined	26	33	17	10	5	3
Total	42	43	24	19	11	4
Column Percent	29.4	30.1	16.8	13.3	7.7	2.8
2015-2020	28.8	26.3	17.0	15.5	6.4	5.9

- Sixty-four percent (92/143) of the deceased infants were reported as sleeping on an adult bed. Nine more were in other locations including an air mattress on the floor, sofa chair, bassinet mattress on an adult bed, twin bunk bed, pack n' play and in mother's arms while being breastfed.
- Seven infant deaths reported supervision was needed at the time of the incident and 103 reported to have had supervision.

The CDR database includes many variables that may be risk factors or indicators for sleep-related deaths. The OCFR continues to support a collaboration between the Safe Infant Sleep program (in the DPH Office of Injury Prevention) and Georgia State University on an analysis of sleep-related death risk factors.

This collaborative effort on sleep-related death provides a good model for additional research on selected causes of child death. The Georgia Bureau of Investigation/ Child Fatality Review State office and the CFR Panel are committed to initiating and supporting data sharing with multi-agencies to identify issues related to the well-being of Georgia's children.

Preventability and Prevention Findings

There is substantial agreement among the review teams that non-medical (violent) deaths can be prevented. Eighty-eight percent of non-medical deaths with a preventability determination ("No, probably not" or "Yes, probably") had "Yes, probably" reported. Ninety percent (90%) of deaths due to unintentional injuries, 85% of sleep-related deaths, 90% of homicide deaths, and 86% of suicide deaths were considered preventable (Table 13).

The CFR local teams are encouraged to discuss possible interventions and to note it in the CDR form of how child death can be prevented (Figure 8). There is also a section in the review form dedicated to prevention (L. Prevention Initiatives Resulting from the Review) designed to capture suggestions or implemented actions in the areas of agency policies, services, education, legal system changes, or environmental factors. Several "open-ended" questions provide opportunities for narrative on recommendations. When these areas are completed, they add significant value to identifying intervention/prevention opportunities. Many of the CDR cases have recommendations regarding prevention measures; however, with Section L near the end of the form, and in-depth comments are not the norm. The prevention review process does not stop with the CFR local team. CFR state office are responsible for summarizing / synthesizing the prevention input from the teams and providing that data and/or draft recommendations to the CFR Panel.

Figure 8. 2020 Reviewed Deaths, % Preventable (Number Preventable)

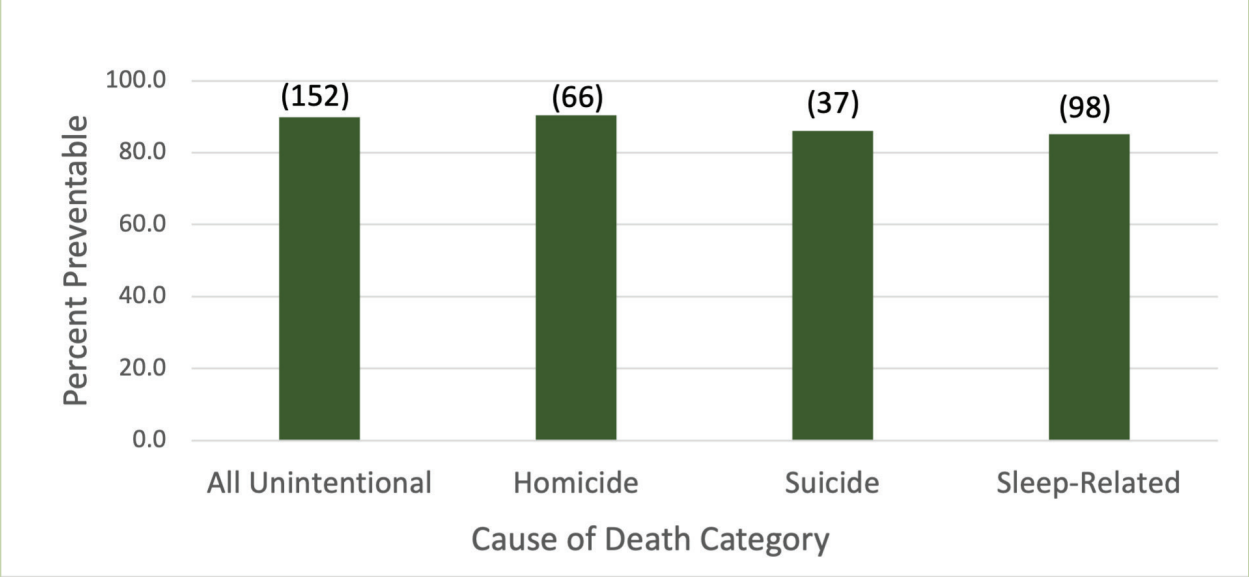


Table 13: CDR Team Determination of Preventability: 2020 Reviewed Deaths
Could the death have been prevented?

Cause of Death	Missing	No, probably not	Yes, Probably	Undetermined	%Prev
Unintentional					
Motor Vehicle Crash	1	9	86	8	90.5
Drowning		1	18	5	94.7
Other Unintentional	1	7	48	4	87.3
Intentional					
Homicide	1	7	66	5	90.4
Suicide		6	37	7	86.0
Sleep-Related	1	17	98	27	85.2
Medical	3	52	13	19	20.0
Undetermined	1	3	3	8	50.0
All Reviewed Deaths	8	102	369	83	78.3
All Non-Medical	5	50	356	64	87.7
		47	353		88.25

Supervision: The CDR form addresses supervision of the decedent in three sections. The "Circumstances" section has a question: "CAN, poor supervision or exposure to hazards cause or contribute to death?" (Table 14). If the answer is "Yes", then "Poor/absent supervision" is one of the possible responses to describe the action. In Section J (Person Responsible), the first question is: "Did person(s) cause/contribute to death?". There are follow-up questions for up to two persons to identify the type of action, and "Poor/absent supervision" is one of the responses. Poor supervision is indicated if it is selected in one or more of these three variables.

In Section D (Supervisor Information), the initial question is: "Did child have supervision at time of the incident leading to death?"; and valid responses are:

1. No, not needed given developmental age or circumstances
2. No, but needed
3. Yes
4. Unable to determine

The sleep-related deaths provide an opportunity to check on the consistency of reporting of these two "supervision" variables. There were 14 deaths that had "Poor/absent supervision" indicated as a contributing factor, but reported the child had supervision (Table 14). This suggests issues with the form design and review team training.

Table 14. Supervision and Sleep-Related Death, 2020

	Poor/absent supervision	
Supervision at Time	**Yes**	**No/Unknown**
No, not needed		1
No, but needed	8	7
Yes	14	103
Unable to determine	3	7

The relationship between supervision and drowning deaths is stronger for accidental deaths (such as drowning), and there is less discordance in the two supervision variables (Table 15). Both variables indicated a supervision issue for 3 of the 24 drowning deaths.

Table 15. Supervision and Drowning Death, 2020

	Poor/absent supervision	
Supervision at Time	**Yes**	**No/Unknown**
No, not needed	2	1
No, but needed	3	1
Yes	3	11
Unable to determine	2	1

Conclusion

This report summarizes the data collected regarding the circumstances related to each child death. It is intended to be a vehicle to share the findings with the community to engage others in concerns about these and other risks.

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

We encourage partners and local resources to assist in developing recommendations and implement policies, programs, and practices that can have a positive impact in reducing the risks and improving the lives of Georgia's children. It is our hope that you will utilize the information in this annual report and share it with others who can influence changes for the betterment of children.

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

Georgia Bureau of Investigation

Child Fatality Review Unit

3121 Panthersville Rd
Decatur, GA 30034

Phone: (404) 270-8715 | ChildFatalityReview@gbi.ga.gov

Resources

Prevent Child Abuse America (www.preventchildabuse.org)

Georgia Center for Child Advocacy (georgiacenterforchildadvocacy.org)

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

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

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

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

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

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

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

American Red Cross (www.redcross.org)

United States Consumer Product Safety Commission (www.cpsc.gov)

American Academy of Pediatrics (www.aap.org)

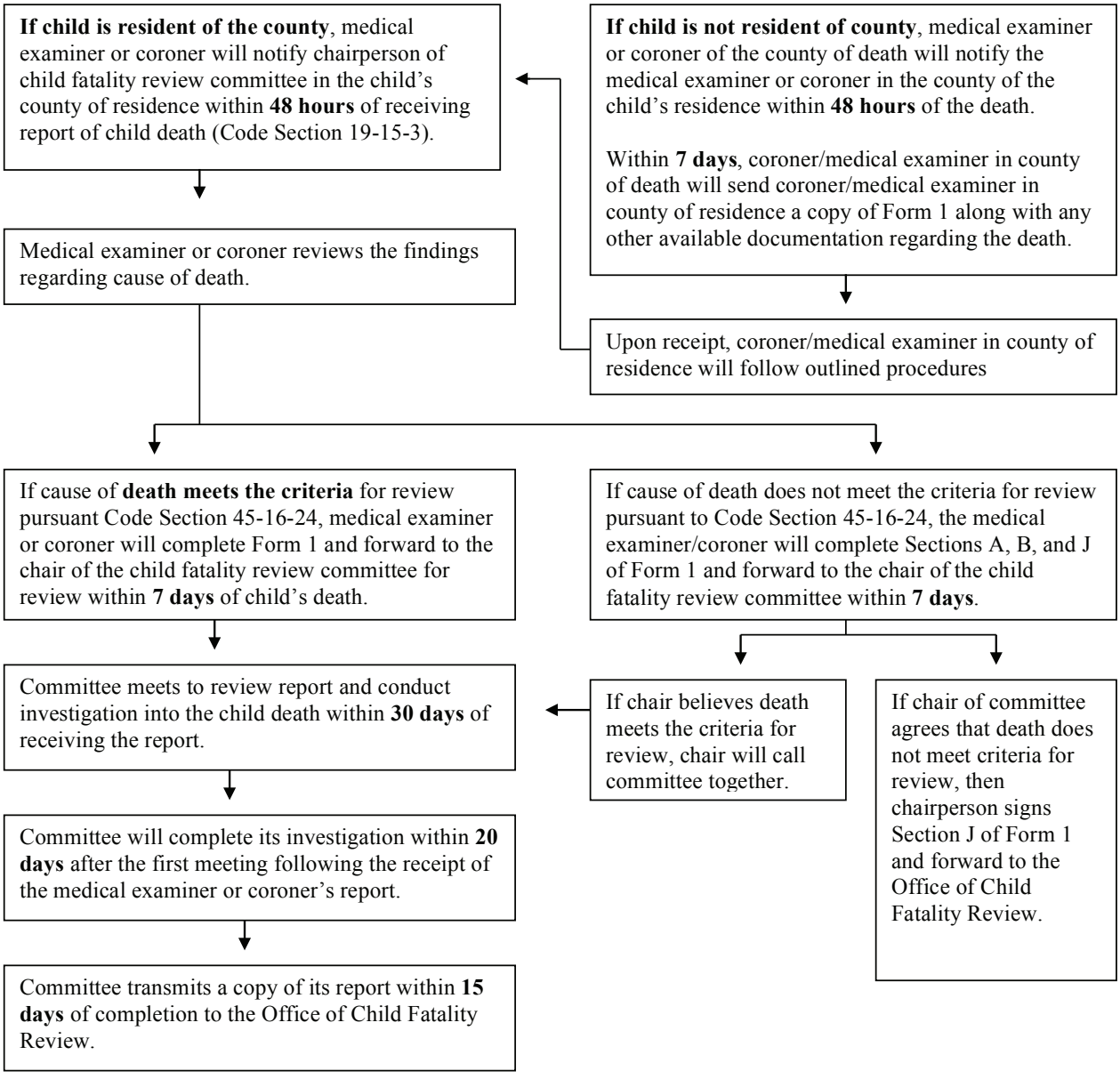
Centers for Disease Control and Prevention, Injury Prevention & Control:
Division of Violence Prevention (www.cdc.gov/violenceprevention)

Georgia Department of Public Health, Youth Risk Behavior Surveillance System
(www.dph.georgia.gov/YRBS)

Georgia General Assembly (www.legis.ga.)

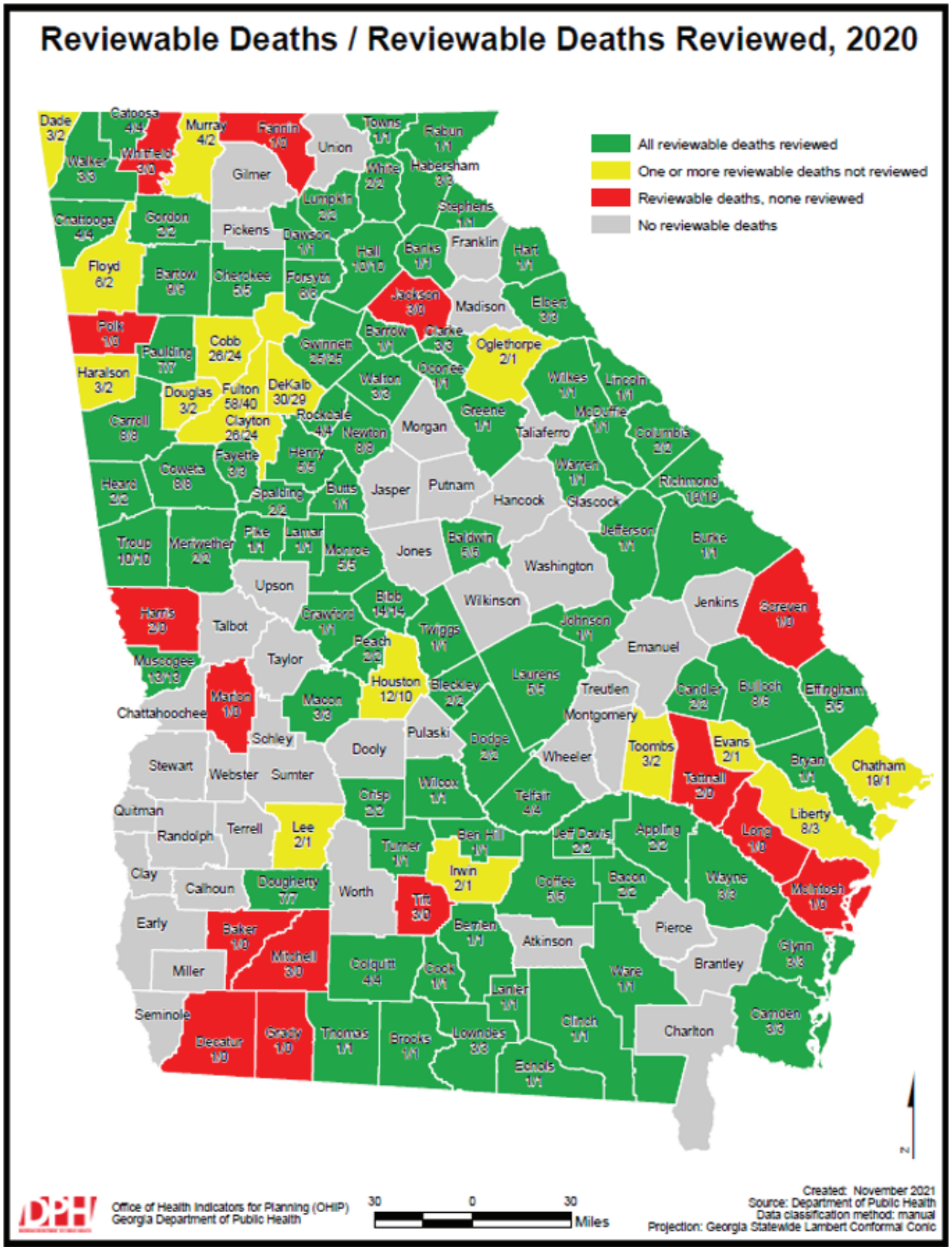
Appendix A

Child Fatality Review Committee Timeframes and Responsibilities



Send copy of the report within **15 days** to district attorney of the county in which the committee was created if the report concludes that the death was a result of: SIDS without confirmed autopsy report; accidental death when death could have been prevented through intervention or supervision; STD; medical cause which could have been prevented through intervention by agency involvement or by seeking medical treatment; suicide of a child under the custody of DHR or when suicide is suspicious; suspected or confirmed child abuse; trauma to the head or body; or homicide.

Appendix B – 2020 Compliance Map



Notes

Georgia Child Fatality Review Panel Annual Report

CALENDAR YEAR 2020