Georgia Child Fatality Review Panel

Annual Report - Executive Summary - Calendar Year 2015

C. LaTain Kell
Panel Chairman

Nathan Deal
Governor

THE CHILD FATALITY REVIEW PANEL MEMBERS

C. LaTain Kell, Panel Chair – Judge, Cobb County Superior Court

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

Mandi Ballinger – Member, Georgia House of Representatives

Kathleen Bennett – Retired Mental Health Specialist, Central Savannah River Area Economic Opportunity Authority Head Start Program

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

Gloria Butler – Member, Georgia State Senate

Brenda Fitzgerald – Commissioner, Department of Public Health

Robertiena Fletcher – Board Chair, Department of Human Services

Charles Fuller – Chair, Criminal Justice Coordinating Council

Bobby Cagle – Director, Division 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 – Investigator, Georgia Peace Officer Standards and Training Council

Jonathan Eisenstat – Chief Medical Examiner, Georgia Bureau of Investigation

Ashley Willcott – Director, 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

THE CHILD FATALITY REVIEW PANEL STAFF

Trebor Randle – Special Agent in Charge

Shevon Jones – Prevention Specialist

Crystal Dixon – Program Manager

Malaika Shakir – Program Manager

Elizabeth Andrews – SDY Program Manager

EXECUTIVE SUMMARY

Every year the Georgia Child Fatality Review Panel (Panel) publishes an annual report chronicling the tragic, preventable deaths of children in Georgia. These deaths are identified through death certificate data provided by the Office of Vital Records within the Division of Public Health. Local child fatality review committees examine child deaths that are sudden, unexpected, or unexplained ("eligible"), and complete a standardized form detailing the circumstances of the deaths. These child death data are useful in revealing recurring patterns and indicating prevention gaps and opportunities. We encourage parents, communities, organizations, and policymakers to use these data to make life-saving decisions for Georgia's children. In 2015, child fatality review committees reviewed 561 total child deaths.

KEY FINDINGS

MALTREATMENT

In 2015, child fatality review committees determined that maltreatment was the direct cause or contributing factor in 234 deaths (maltreatment includes abuse, neglect, and poor supervision).

SLEEP-RELATED INFANT

Child fatality review committees reviewed 170 sleep-related infant deaths in 2015. The number of reported sleep-related deaths (death certificates) in Georgia has not demonstrated any consistent trend over the last 17 years (1999 – 2015). There was a peak of 197 in 2007, but the average over the 17 years is 162 deaths per year. Sleep-related infant deaths remain the leading cause of post-neonatal deaths, and they are the leading cause for all reviewable deaths.

INJURIES

In 2015, child fatality review committees reviewed 300 deaths that resulted from injuries either intentional (inflicted) and unintentional (accidental). ** Note that sleep-related infant asphyxia deaths have been excluded from the injury category; these deaths are included in the sleep-related infant category.

Unintentional Injuries: Child fatality review committees reviewed 177 deaths attributed to unintentional injuries among children ages 0-17. Child fatality review data indicated the three leading causes of death related to unintentional injury for this age group as: motor vehicle-related, drowning, and fire.

Intentional Injuries: Child fatality review committees reviewed 123 deaths to children ages 0-17 from intentional causes – 73 homicides and 50 suicides.

PREVENTABILITY

A primary function of the child fatality review process is to identify those deaths deemed to be preventable. Child fatality review committees determined that 80% of the reviewed child deaths with preventability determination (455) were definitely or possibly preventable.

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