South Carolina
State Child Fatality Advisory Committee

ANNUAL REPORT 2003

STATE OF SOUTH CAROLINA

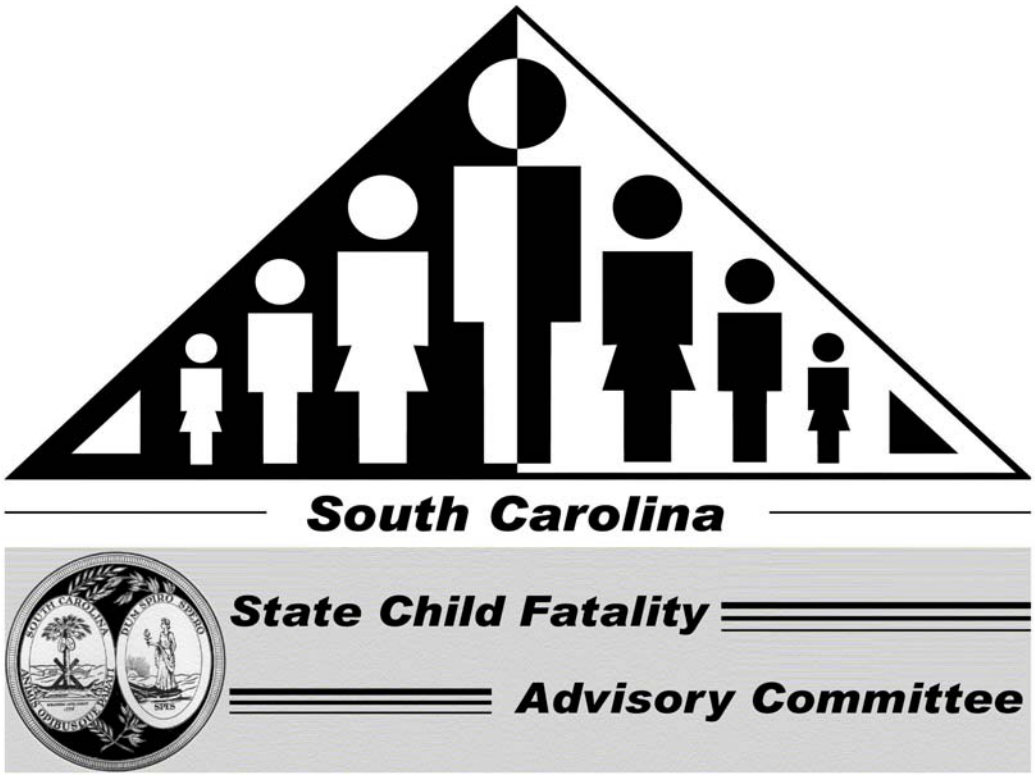
STATE CHILD FATALITY ADVISORY COMMITTEE

2003 ANNUAL REPORT

Child Fatality Data provided by the South Carolina Law Enforcement Division Department of Child Fatalities, Office of Research and Statistics, SC Budget and Control Board, and the SC Department of Health and Environmental Control. All opinions and recommendations are those of the State Child Fatality Advisory Committee. This publication was supported by Award Number U17/CCU422396-03 from the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers of Disease Control and Prevention. For additional copies, please contact Keisha Adams at 803-898-4153 or Megan Weis at 803-898-0441.

Honorable Mark C. Sanford

Governor of the State of South Carolina
and the 117th South Carolina General Assembly



Dr. Clay Nichols
Chairperson, State Child Fatality Advisory Committee

Mission Statement

To decrease the incidence of preventable child deaths by:

- Developing an understanding of the causes of child death
- Developing plans for implementing changes within the agencies represented
- Advising the Governor and the General Assembly on statutory, policy, and practice changes which will prevent child deaths

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ACKNOWLEDGMENTS

The members of the SC State Child Fatality Advisory Committee (SCFAC) recognize that without the participation and support of numerous organizations, agencies and individuals, SCFAC activities and reports would not be possible. These acknowledgements represent a small part of the unified effort in SC to protect the health and safety of children.

The SCFAC wishes to thank the following organizations and individuals for their assistance and cooperation in compiling this report by providing data, statistical analysis or other pertinent information and support.

Special acknowledgment is deserving of the **Department of Child Fatalities, SC Law Enforcement Division.** The dedicated work and provision of data by *Lt. Patsy Lightle, Special Agent David Belk and Tahelia Wardlaw*, make it possible for the SCFAC to fulfill its mission.

South Carolina Coroners: Provision of child death investigation information.

Local Children's Health and Safety Councils and Child Death Review Teams: Involved efforts in improving CDR in SC and the services to their communities

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Letter from the Chair

Clay Nichols, MD

Dear Children's Health and Safety Advocates,

Each year the South Carolina Child Fatality Advisory Committee (SCFAC) submits an annual report to the Governor, Legislature and South Carolina Public. Since 1993 the number of reviewed "unexplained and unexpected" child deaths has dropped from 277 to 191, a 31% decrease. This decrease is a great achievement for all of those who work to improve the health and safety of South Carolina's children.

While it is important to recognize our achievements, we must realize our work is far from complete. Children still die from preventable deaths. Additionally, South Carolina's youngest citizens suffer from countless preventable injuries, both unintentional and intentional.

This report contains data and information relating to reviewed deaths and vital statistical data on all child fatalities. Though the SCFAC does not review motor vehicle crashes (MVC), they continue to represent the number one cause of unintentional injury death to children.

In order to protect South Carolina's children, the SCFAC would like to highlight the following recommendations.

- ***State Legislation to Support Local Child Death Review Teams***
- ***Statewide Safe Sleeping Education***
- ***Additional Key Recommendations***
  - *Fire Death Prevention:* Each home should have properly placed, working smoke detectors.
  - *Drowning:* Proper signage and locked fences surrounding public and private pools.
  - *Firearms:* Proper storage of firearms.

Through partnership and dedicated work, we can reduce child fatalities in South Carolina.

Sincerely,

Clay Nichols, MD

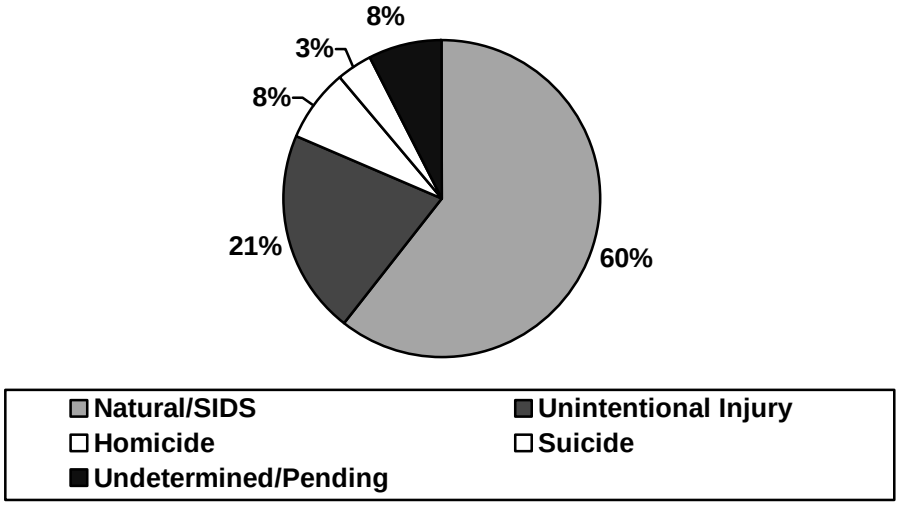
Executive Summary – 2003 SCFAC Annual Report

The State Child Fatality Advisory Committee (SCFAC) is mandated by S.C. Code 20-7-5920 to identify patterns in child fatalities that will guide efforts by agencies, communities and individuals to decrease the number of preventable child deaths. As defined by S.C. Code 20-7-5900 a "child" means a person less than eighteen years of age. Any child death under the age of 18 years is investigated when the death is unexpected and unexplained including, but not limited to, possible sudden infant death syndrome (SIDS), as a result of violence, when unattended by a physician and in any unusual or suspicious manner. **Though Motor Vehicle Crashes (MVC) are the number one cause of unintentional injury death among youth, the Committee does not review MVC except as related to injuries on private property or as a pedestrian.** The South Carolina Department of Public Safety (SCDPS) investigates MVC deaths.

When a child dies, the response by the State and the community to the death must include an accurate and complete determination of the cause of death to include a thorough scene investigation and a complete autopsy. Lack of adequate investigations of child deaths impedes the effort to prevent future deaths from similar causes. With the assistance of the State Law Enforcement Division (SLED) Department of Child Fatalities, **the Committee comprehensively reviewed 244 new cases and conducted follow-up reviews on 112 cases for a total of 356 reviews during 2004.**

A manner of death determination places each fatality into one of five main categories: Natural/ SIDS, unintentional injury, homicide, suicide, and undetermined/pending. The breakdown of cases reviewed in 2004 is as follows: 191 Natural/SIDS deaths (47 were SIDS), 66 unintentional injury, 24 homicides, 11 suicides and 24 undetermined/pending deaths.

SCFAC New Case Reviews (N=244), Year 2004

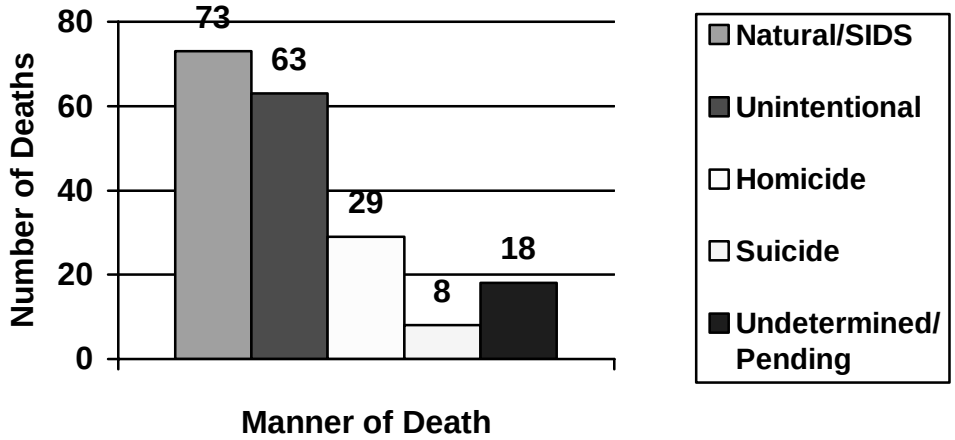


Cases are reviewed after a thorough law enforcement investigation has been completed. This results in the review of deaths from multiple years simultaneously. The majority of deaths reviewed occurred in years 2003-2005. In order to accurately identify trends and make recommendations, analysis must to be limited to year of death, not review. Additionally input from other data sources, such as vital statistics and behavioral surveys, add to the complete picture. **For consistency, therefore, in this report child fatalities are analyzed by year. Year 2003 deaths from the most recent completed database.**

According to DHEC vital records, 652 deaths of children aged 0-17 years occurred in 2003. Of these, 191 were "unexplained and unexpected," and therefore reportable to the Department of Child Fatalities, SC Law Enforcement Division (SLED) and subject to review by the SCFAC. This represents 2.93% of all child deaths in 2003. Of those *not* reviewed, the majority were due to congenital abnormalities and perinatal conditions. Ninety-two were due to motor vehicle crashes. The SCFAC recognizes that overall, MVC represent the largest injury cause of death to SC's children.

Of the 191 *reportable* deaths that occurred in 2003, the two largest categories of South Carolina child fatalities continue to be natural and unintentional injury. Together, they account for 71.2% of child fatalities, with natural deaths representing 38.2% and unintentional injury representing 33.0%. These categories were followed by homicide (15.2%), suicide (4.2%) and undetermined (7.3%). Cases with investigations pending represent 2.1% of total reviewed deaths.

Year 2003 Deaths (N=191) Reviewed by SCFAC



Within the category of natural deaths, the 30 SIDS deaths reviewed represents 41.1% of natural deaths reviewed. Overall, SIDS represents 15.7% of total reviewed fatalities.

SIDS deaths are included in a special section of the 2003 report – "Safe Sleeping for Infants." The SCFAC explores sleep associated deaths of infants less than one year of age. Sleep associated deaths are those diagnosed as Sudden Infant Death Syndrome (SIDS), Strangulation/Suffocation, or Undetermined in which sleep positional and/or environmental risk factors were present. Positional and environmental risk factors are addressed in the National Institutes of Health "Back to Sleep" campaign: side or stomach sleeping position, excess bedding (comforters, pillows, etc), soft sleep surface (adult bed, couch, etc) and bed sharing. While the exact mechanism is debated, sleeping on the stomach is widely recognized as a SIDS risk factor. Loose bedding, soft surfaces and the presence of an additional person in the bed may suffocate or obstruct the airway of the sleeping child.

In 2003, there were 45 sleep-associated deaths to infants aged 12 months or younger. This represents 23.7% of all reviewed deaths.

Parents and caregivers may reduce the risk of sleep-associated deaths through four simple steps:

Safe Sleeping Saves Lives

1) ***Safe Surfaces***
   Baby should sleep on a firm surface. Never place a baby on a couch or soft mattress.

2) ***Safe Surroundings***
   Baby's sleeping area should be free of pillows, blankets, sheepskins, bumpers, wedges and other materials. Ensure the baby cannot become trapped between the mattress and framework of the bed, a wall or other furniture.

3) ***Stay off Stomach:***
   Babies should be placed to sleep on their back.

4) ***Safe Snuggling***
   Babies should not share a bed with a parent or other caregiver. If mothers choose to share a bed in order to facilitate breastfeeding, the SCFAC urges mothers to reduce the risk by avoiding drugs and alcohol and following the other rules for safe sleeping.

Additionally, the SCFAC is concerned that some child deaths deemed “SIDS” do not meet the criteria for SIDS as defined by the American Academy of Pediatrics and continue to be misclassified. According to the American Academy of Pediatrics, SIDS is the “sudden death of an infant under one year of age which remains unexplained after a thorough case investigation including performance of a complete autopsy, examination of the death scene, and a review of the clinical history. SIDS should not be diagnosed if these criteria are not met.”

The key to recognizing the causes of and preventing child deaths is teamwork. The solution lies in the ability of diverse groups and individuals to work together to identify and implement effective prevention plans. One of the greatest successes of the SCFAC is showing that governmental agencies, non-profit organizations and child advocates can meet and work together for towards a common goal. The SCFAC challenges SC to rise to the challenge of protecting our greatest resource – our children.

State Child Fatality Advisory Committee Activities, Challenges and Successes

Strategic Planning for the Future:

The State Child Fatality Advisory Committee is in the process of reevaluating procedure in order to improve effectiveness. SCFAC members participated in a series of meetings with local and state child death review team members and stakeholders to determine the future course of child death review in SC.

The critical challenge facing child death review (CDR) in South Carolina is that the current structure of CDR inhibits the state team from more effectively fulfilling its mission. State and local participants agreed that legislative support of a local CDR teams and use of a comprehensive system of uniform data collection will greatly improve communication, reporting and, ultimately, effectiveness in planning and implementing prevention activities, changing systems and making recommendations to state and local leaders.

The "best practice" model in place in 37 states is one consisting of a state and several local (usually county level) teams. Local teams conduct intensive case reviews and the state team reviews the findings of local teams. Local teams are able to review deaths within days or weeks of the incident. The knowledge of the incident, community, environment and services held by local team members is critical to collecting meaningful data and enacting positive change. State teams may also review selected cases at a local teams request or as a representative sample of a particular issue. This structure allows for a more timely and intensive review of the death (that may include those involved with the case) and for the State team to focus on trends and issues for prevention and policy/legislative recommendations rather than review of *all* individual deaths.

Adoption of a uniform data reporting system aids this process. The SCFAC has adopted use of a data tool provided at no cost by the National Center on Child Death Review. The data tool is available to local teams and provides a way for the local team to summarize data and communicate it to the State team. The State team may then examine the local data in aggregate to share broader trends and findings back to the local level.

Adoption of New Data Tool:

The SCFAC has adopted the National Center on CDR data tool, a web-based reporting system, to improve team analysis of deaths and produce data that will be comparable to other states and the nation. Twelve (12) states, including SC, are participating in the pilot testing of the system.

2002 Annual Report Release:

The 2002 State Child Fatality Annual Report was presented to Representative Gilda Cobb-Hunter as part of the SC Violence Prevention Strategic Planning meeting in September 2004.

Law Enforcement Recognition Award:

The SCFAC awarded Lt. Jean Lee of the Berkeley County Sheriff's Office the 2004 Law Enforcement Recognition Award at the September 2004 SC Violence Prevention Strategic Planning Meeting. Lt. Lee has shown distinguished service in investigation of child deaths and promotes a conscious professional approach toward the investigation of child fatalities across the State of South Carolina.

Historically, Lt. Lee has methodically and completely investigated child homicides in the county of Berkeley. Additionally, Lt. Lee distinguished herself by taking a 4-wheeler to a trained mechanic to determine if this vehicle in any way contributed to the accidental death of the passenger. This detailed work help to determine that the vehicle indeed had mechanical problems that prevented the braking device from functioning properly. Though this seems minor, it is often the small details in child fatality cases that can make or break the case, and hopefully reduce the number of child fatalities in the state. Lt. Lee searches out the smallest details so that she can best determine the cause of the deaths she investigates, which in turn, helps the State Review Committee make recommendations to the Governor and General Assembly on how to prevent such deaths in the future.

Her accomplishments reflect uncommon ability and dedication and serve as a standard for all to emulate. Lt. Lee's achievements were in the finest law enforcement traditions and reflect great credit upon her and the Berkeley County Sheriff's Office.

Coroner Recognition Award:

The SCFAC awarded the Honorable Coroner Gary Watts the Coroner Recognition Award at the September 2004 SC Violence Prevention Strategic Planning Meeting. Coroner Watts rendered most distinguished and valuable service to the citizens of Richland County and the State of South Carolina. Under his leadership, the Richland County Coroner's Office has developed a zealous and professional approach toward the investigation of child fatalities within Richland County and has set high standards for such investigations.

Coroner Watts also serves as President to the South Carolina Coroner's Association. Under his leadership, this association has helped encourage quick reporting of child deaths within South Carolina so that the investigative process in put into motion before valuable time is forever lost. He has also been an

advocate for the South Carolina Child Fatality Review Committee and their continuing mission in reducing child death in South Carolina.

His leadership and accomplishments reflect uncommon ability and dedication and serve as a standard for all to emulate. Coroner Watts achievements were in the finest traditions of the honorable position of coroner and reflect great credit upon him and the Richland County Coroner's Office.

Partnerships:

The SCFAC has prioritized the development of partnerships with local, state and national groups to further the mission of the Team. To that end, the SCFAC is a member of the Southeast Coalition on Child Fatalities**.** South Carolina is an active member of the Southeast Coalition on Child Fatalities. The Coalition formed between Southeastern states to share strategies for prevention, child death review procedure, and support to member states as the southeastern region of the country shares many similar challenges and threats to the health and safety of children in the region.

SCFAC has also joined with a broad coalition of state and local agencies and groups to develop educational materials and planning regarding safe sleeping. These partners include, but are not limited to, Voices for South Carolina's Children, KidsCount South Carolina, Prevent Child Abuse South Carolina, SAFEKids South Carolina, member agencies of SCFAC, and local CDR teams. SCFAC is committed to working in concert with organizations sharing its goals.

Selected Local Team Highlights (alphabetical order):

Charleston County: The coroner's office conducts a child death review team meeting within. The Centers for Disease Control and Prevention (CDC) visited the Charleston County Coroner's Office for three days to make a training film on infant death investigations.

Dillon: A rural county, Dillon maximizes its resources by combining CDR, infant mortality review, and other meetings into one. The open communication and comparison of case information has resulted in changes to case management and methods.

Greenville: Greenville's CDR team meets monthly and has broad community participation. The team has a particularly strong partnership with SAFEKids Upstate, aiding SAFEKids Upstate in determining the most effective use of resources. Greenville volunteered to pilot test the National Center on Child Death Review's data tool.

Horry: Horry County's Children's Health and Safety Council, which includes a child death review team, volunteered to pilot test the National Center on Child Death Review's data tool. Horry is also pursuing becoming a SAFEKids coalition in order to increase support.

Lancaster County: The Lancaster Children's Health and Safety Council dedicated a Children's Memorial Garden in a moving ceremony including those who investigate child deaths and parents and loved ones of deceased children. The Garden is a place where those who have lost a child may morn and find comfort, as well as remind the community of the need to protect future children. Lancaster CHSC also produced a book of poems written by a community member dedicated to those who have lost a child.

Richland County: The Richland County Children's Health and Safety Council achieved non-profit organizational status in order to apply for grants for prevention activities and is developing a local safe sleeping campaign. Richland also volunteered to pilot test the National Center on Child Death Review's data tool.

York County: Following a period of inactivity, York County resumed child death review meetings in 2004. The Committee enjoys broad community support and has generated media coverage for its findings. Additionally, team members contributed to the development of a Children's Memorial Garden in cooperation with the local SAFEKids Coalition located at EMS headquarters."

Core Recommendations

1) State Legislation to Support Local Child Death Review Teams.

Support for creation, maintenance and participation of county level child death review teams and use of a statewide uniform data system will allow local team's findings, recommendations and actions to be communicated to the SCFAC, allowing the SCFAC to focus on its charge to make recommendations to the governor, legislature and state systems for improvement of children's health and safety.

As a result of a series of statewide meetings between local and state child death review team members, the SCFAC recognizes that a major critical challenge facing child death review (CDR) in South Carolina is that the current structure of CDR inhibits the state team from more effectively fulfilling its mission. Legislative support of a local CDR teams and use of a comprehensive system of uniform data collection will allow local communities and the SCFAC review deaths in a timely manner, analyze data for prevention purposes and formalize reporting and communication between state and local teams,

The "best practice" model in place in 37 states is one consisting of a state and several local (usually county level) teams. Local teams conduct intensive case reviews and the state team reviews the findings of local teams. Local teams are able to review deaths within days or weeks of the incident. The knowledge of the incident, community, environment and services held by local team members is critical to collecting meaningful data and enacting positive change. State teams may also review selected cases at a local teams request or as a representative sample of a particular issue. This structure allows for a more timely and intensive review of the death (that may include those involved with the case) and for the State team to focus on trends and issues for prevention and policy/legislative recommendations rather than review of *all* individual deaths.

Adoption of a uniform data reporting system aids this process. The SCFAC has adopted use of a data tool provided at no cost by the National Center on Child Death Review. The data tool is available to local teams and provides a way for the local team to summarize data and communicate it to the State team. The State team may then examine the local data in aggregate to share broader trends and findings back to the local level.

2) Statewide Safe Sleeping Education

As outlined in this report, unsafe sleeping practices contribute to the deaths of many of South Carolina's children each year. Through partnering with numerous state and local agencies and organizations (including, but not limited to, Voices for South Carolina's Children, Prevent Child Abuse South Carolina, Safe Kids SC, member agencies of SCFAC, and local CDR teams), the SCFAC is committed to producing an effective education materials and methods for caregivers, childcare professionals and the general public. Please join the effort. Only through partnership and cooperation will the number of deaths associated with unsafe sleeping arrangements decrease.

Please refer to the "Safe Sleeping for Infants" section for in depth discussion.

3) Additional Key Recommendations:

The SCFAC recognizes many trends through the review process. Though the Committee has chosen to focus on Safe Sleeping as the main focus for prevention in the coming year, other recommendations are commonly stressed at meetings. Three other common concerns/recommendations are:

Fire Death Prevention: Each home should have properly placed, working smoke detectors.
According to the National Fire Prevention Association, a working smoke alarm in the home can more than double the chances of an occupant surviving a residential fire. In most of the fire deaths reviewed by the SCFAC a smoke detector is not present or presence is unknown.

Drowning: Proper signage and locked fences surrounding public and private pools.
Pools are very attractive to children. A locked, gated fence surrounding the pool provides a physical barrier between the pool and an unattended child.

Firearms: Proper storage of firearms.
Firearms should be stored lock and unavailable to children. SCFAC reviews numerous firearm cases in which the weapon used was owned by the family of the deceased child.

Safe Sleeping for Infants

Safe Sleeping for Infants

"A *mother was sitting in a recliner around midnight Saturday when she fell asleep. When she awoke early Sunday morning with the baby, the baby was wedged between the mother and the arm of the recliner, unresponsive."*

"A 3 month and 3 week old baby was found face down on an adult sized bed between a foam mattress and the wall. The death was declared asphyxiation due to wedging."

"A 3 week old baby was sleeping between Mother and Father. The father rolled over baby."

"A 3 month old victim was sleeping in a waterbed with mother. Mother found infant on stomach in the waterbed unresponsive."

Above are examples of sleep associated death cases the SC State Child Fatality Advisory Committee (SCFAC) reviews at each meeting. The scenarios are representative of cases reviewed since the 1993 creation of the team. While all child deaths are tragic and heartbreaking, this year the SCFAC has chosen to focus on prevention of sleep associated deaths. As a team and individually, the SCFAC is heartbroken and frustrated by the process of reviewing numerous deaths each meeting in which unsafe sleeping is suspected to be a factor. By highlighting the dangers and joining a broad statewide coalition to produce an educational campaign, the SCFAC strives to educate families and caregivers to prevent future deaths.

Sleep associated deaths are those diagnosed as Sudden Infant Death Syndrome (SIDS), Strangulation/Suffocation (most likely due to wedging or overlay), or Undetermined in which sleep positional and/or environmental risk factors were present.

According to the American Academy of Pediatrics, SIDS "is the sudden death of an infant under one year of age, which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene, and review of the clinical history." SIDS is a diagnosis of exclusion of all other possible causes of death. Undetermined deaths are those in which the cause of death could not be conclusively determined based on available information (ex: SIDS versus Overlay). Sleep associated Suffocation/Strangulation deaths tend to be due to overlay or wedging between two objects (ex: mattress and wall).

Positional and environmental risk factors are addressed in the National Institutes of Health “Back to Sleep” campaign: side or stomach sleeping position, excess bedding (comforters, pillows, etc), soft sleep surface (adult bed, couch, etc) and bed sharing. While the exact mechanism is debated, sleeping on the stomach is widely recognized as a SIDS risk factor. Loose bedding, soft surfaces and the presence of an additional person in the bed may suffocate or obstruct the airway of the sleeping child.

State Child Fatality Advisory Committee Findings

From 1999-2003, 233 children less than one year of age died a sleep associated death in which risk factors were present.

In 2003, 45 sleep associated deaths to children less than one year of age occurred in South Carolina.

Almost all sleep associated deaths occur to children less than one (1) year of age, with the majority being less than six (6) months of age.

From 1999-2003, 220 infants 0-6 months of age died in sleep associated deaths with risk factors present. This represents 94.4% of Suffocation/Strangulation, SIDS and Undetermined deaths of children less than one year of age.

1999 - 2003
Suffocation/Strangulation, SIDS and Undetermined Deaths Associated w/ Unsafe Sleeping Arrangements*
Infants Less than One Year of Age
STATEWIDE NUMBERS BY RACE AND GENDER
Source: SC State Child Fatality Advisory Committee Records

	1999	2000	2001	2002	2003	Total
0-3 months	23	19	34	27	31	134
4-6 months	13	20	18	22	13	86
7-9 months	3	3	1	1	1	9
10-12 months	0	0	3	1	0	4
Total	39	42	56	51	45	**233**

Ninety-eight percent (98%) of suffocation/strangulation deaths of infants less than year of age are associated with positional and/or environmental risk factors.

The mechanisms of death include overlay and wedging. From 1999-2003 60 children less than one year of age died from suffocation/strangulation in which sleep associated risk factors were present. A total of 61 unintentional suffocation/strangulation deaths occurred during this time period.

1999 - 2003
Unintentional Injury-Suffocation/Strangulation Deaths Associated w/ Unsafe Sleeping Arrangements
Infants Less than One Year of Age
STATEWIDE NUMBERS BY RACE AND GENDER
Source: SC State Child Fatality Advisory Committee Records

	1999	2000	2001	2002	2003	Total
White Male	1	2	3	6	3	15
White Female	1	3	9	3	4	20
Non-White Male	1	4	6	5	0	16
Non-White Female	1	1	3	0	4	9
Total	4	10	21	14	11	**60**

1999 - 2003
Unintentional Injury-Suffocation/Strangulation Deaths Associated w/ Unsafe Sleeping Arrangements
Infants Less than One Year of Age
STATEWIDE NUMBERS BY AGE
Source: SC State Child Fatality Advisory Committee Records

	1999	2000	2001	2002	2003	Total
0-3 months	2	3	14	7	8	34
4-6 months	2	7	6	5	3	23
7-9 months	0	0	0	1	0	1
10-12 months	0	0	1	1	0	2
Total	4	10	21	14	11	**60**

During review the SCFAC identified positional and/or environmental risk factors present in 80.24% of SIDS deaths between 1999-2003.

1999 - 2003
SIDS Deaths Associated w/ Unsafe Sleeping Arrangements
Infants Less than One Year of Age
STATEWIDE NUMBERS BY RACE AND GENDER
Source: SC State Child Fatality Advisory Committee Records

	1999	2000	2001	2002	2003	Total
White Male	8	5	10	10	7	40
White Female	5	6	4	5	3	23
Non-White Male	6	7	10	4	11	38
Non-White Female	9	7	7	7	3	33
Total	28	25	31	26	24	**134**

1999 - 2003
SIDS Deaths Associated w/ Unsafe Sleeping Arrangements
Infants Less than One Year of Age
STATEWIDE NUMBERS BY AGE
Source: SC State Child Fatality Advisory Committee Records

	1999	2000	2001	2002	2003	Total
0-3 months	15	12	17	14	15	73
4-6 months	11	10	11	12	8	52
7-9 months	2	3	1	0	1	7
10-12 months	0	0	2	0	0	2
Total	28	25	31	26	24	**134**

1999 - 2003
SIDS Deaths Associated w/ Unsafe Sleeping Arrangements
STATEWIDE CASES ASSOCIATED WITH UNSAFE SLEEPING ARRANGEMENTS

Source: SC State Child Fatality Advisory Committee Records

	1999	2000	2001	2002	2003	Total
Number cases associated with unsafe sleeping	28	25	31	26	24	134
Total SIDS Cases	33	33	39	32	30	167
Percent associated with unsafe sleeping	84.85%	75.76%	79.49%	81.25%	80.00%	**80.24%**

Cases with unknown age information were left out of analysis

Protecting Infants – Safe Sleeping Saves Lives

The good news is that parents and caretakers can reduce the risk to infants by following four simple steps:

Safe Surfaces:

Baby should sleep on a firm surface. Never place a baby on a couch or soft mattress.

Safe Surroundings:

Baby's sleeping area should be free of pillows, blankets, sheepskins, bumpers, wedges and other materials. Ensure the baby cannot become trapped between the mattress and framework of the bed, a wall or other furniture.

Stay off Stomach:

Babies should be placed to sleep on their back. According to the South Carolina Pregnancy Risk Assessment Monitoring System (PRAMS), in 2003 only 57% of infants born to South Carolina mothers were placed to sleep "most often" on their back.

Safe Snuggling:

Bed sharing places a baby at risk. The SCFAC joins the Back to Sleep Campaign and the US Consumer Product Safety Commission as on record as opposing bed sharing by an infant and an adult, particularly if there is more than one adult in the bed. However, it is recognized that a significant portion of the population practices bed sharing between mother and infant as a strategy to facilitate breastfeeding and that the presence of the father in the bed will be common. If mothers choose to share a bed, the SCFAC urges mothers to reduce the risk by avoiding drugs and alcohol and following the other rules for safe sleeping.

Additional Safe Sleeping Resources:

US Consumer Product Safety Commission:
www.cpsc.gov/cpscpub/pubs/cribsafe.html
Provides information and materials in English and Spanish about crib and bedding safety for infants.

Back to Sleep Campaign:
www.nichd.nih.gov/sids
Provides information and English and Spanish materials about the Back to Sleep Campaign.

American Academy of Pediatrics:
www.aap.org
Provides a wealth of information on child development, health, and injury and violence prevention. Includes information about safe sleeping.

First Candle/SIDS Alliance:
www.firstcandle.org
Promotes infant health and survival during the prenatal period through two years of age. SIDS and Other Infant Death bereavement services are a critical component of their mission.

South Carolina Community Assessment Network
http://scangis.dhec.sc.gov/scan/
The South Carolina Community Assessment Network (SCAN) is an interactive data retrieval system for community assessment, planning and health practices. Data from the SC Pregnancy Risk Assessment Monitoring System (PRAMS) is available.

Year 2003 Cases Reviewed By SCFAC

Based on SLED Department of Child Fatalities Data

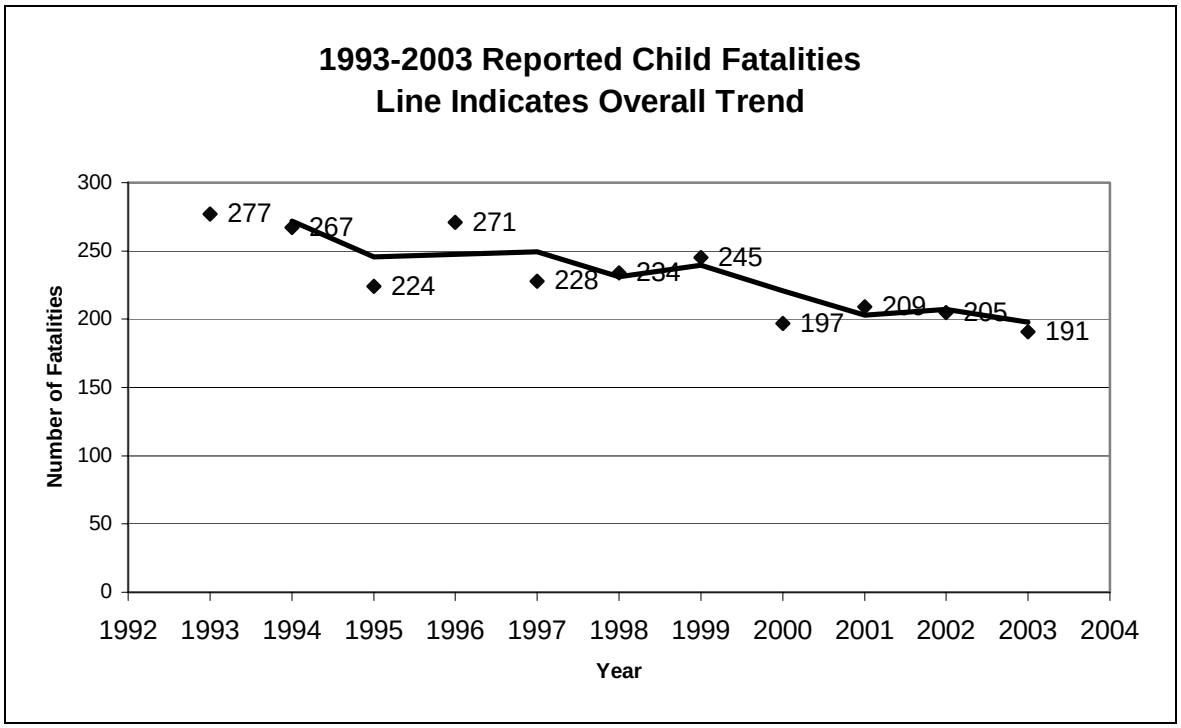
All Child Fatalities Reviewed in South Carolina – Year 2003 Deaths

Overview

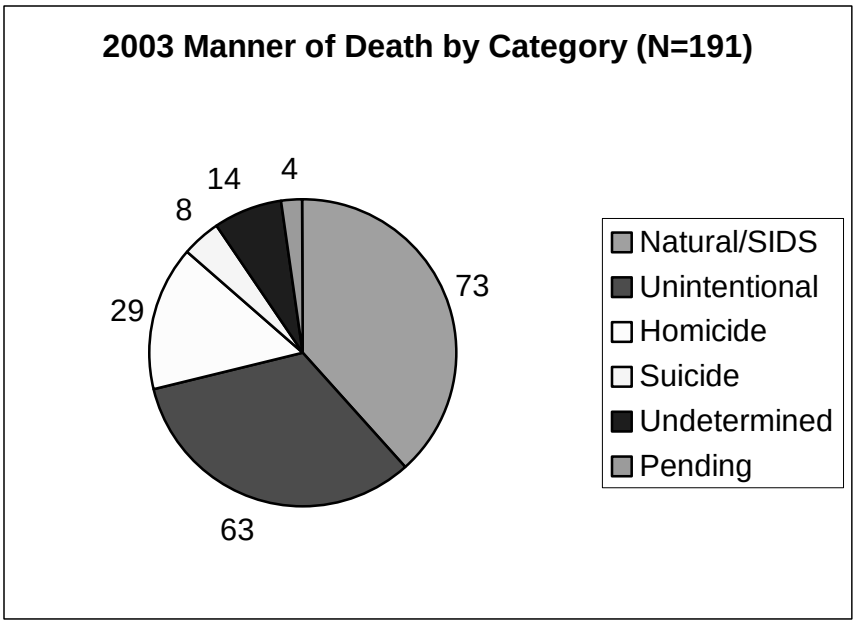
Mortality data provides an overall picture of child deaths (by number and cause). It is from a careful study of each and every child's death that we can learn how best to respond to a death and how to prevent another death from occurring. Child deaths are often regarded as an indicator of the health of a community.

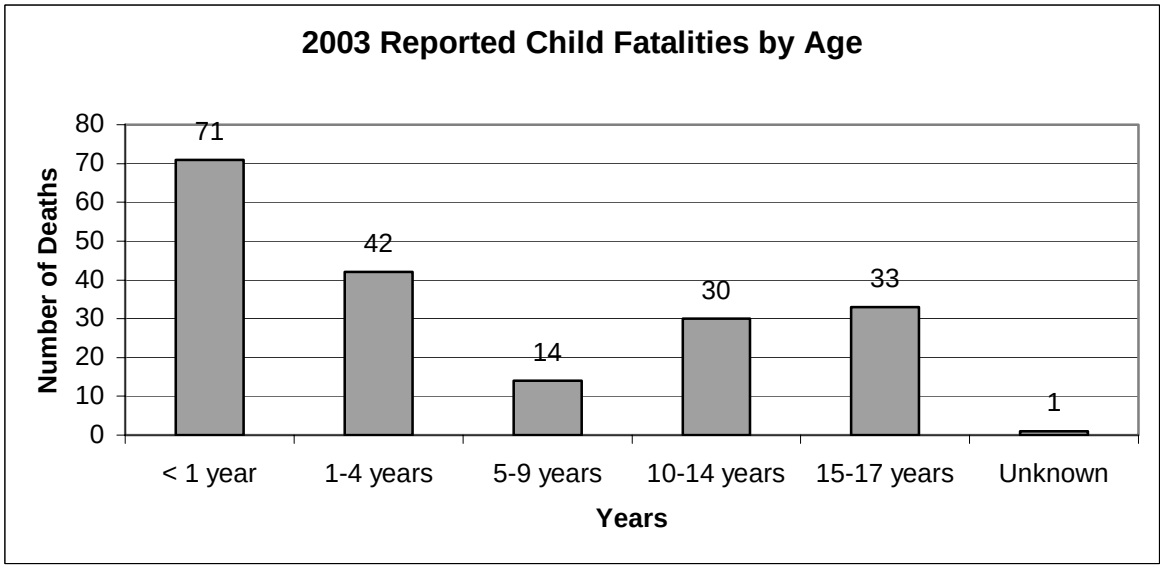
The State Child Fatality Advisory Committee (SCFAC) is mandated by S.C. Code 20-7-5920 to identify patterns in child fatalities that will guide efforts by agencies, communities and individuals to decrease the number of preventable child deaths.

Though Motor Vehicle Crashes (MVC) are the number one cause of unintentional injury deaths among youth, the Committee does not review MVC except as related to injuries on private property or as a pedestrian. The South Carolina Department of Public Safety (SCDPS) investigates MVC deaths.

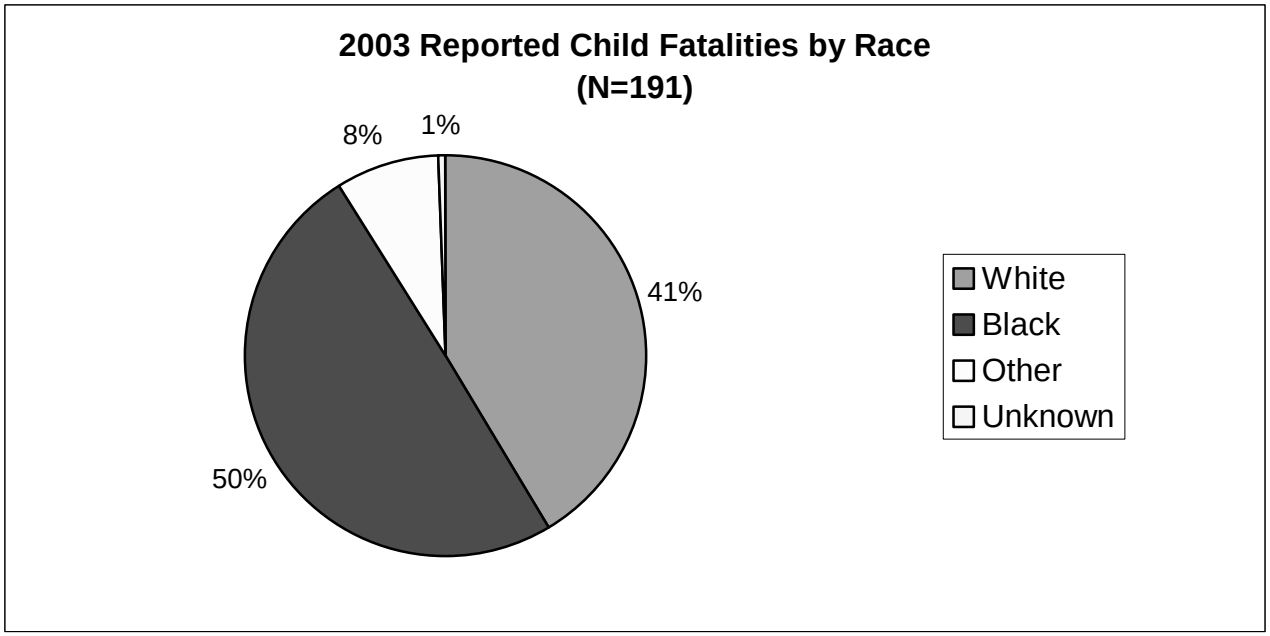


Since 1993, a steady decline in reviewed child fatalities has been reported. In 2003, **191** child fatalities were reported. Since 2002, a 7% decrease in the number of deaths has been reported and investigated.

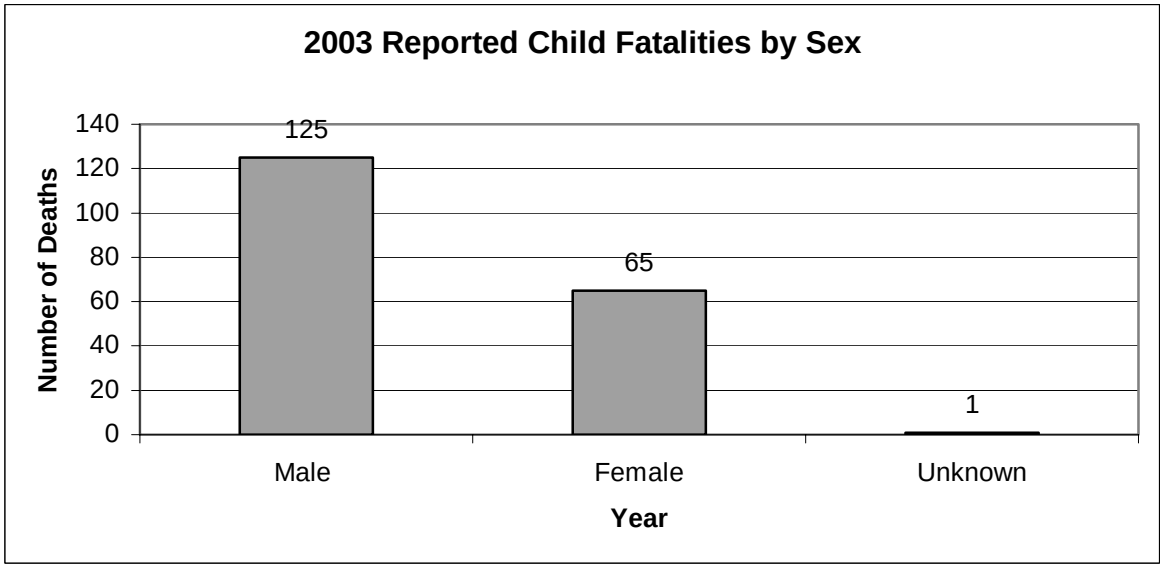




In 2003, 36% of child fatality victims were less than 1 year old. This is followed by children between the ages of 1-4 (21%), 15-17 years (17%), 10-14 years (15%), and 5-9 years (7%). Four percent of cases the ages of the child were unknown.



Blacks accounted for 95 of child fatalities. Whites accounted for 79 of deaths. One death was unknown.



* In some cases sex data is not available in the database used for analysis.

Males accounted for 65% of all child deaths. Females represented 34% of all child deaths. Only 1% of victims were unknown.

2003 Child Fatalities Annual Report – Rate Information

Child fatality data from SLED Dept. of Child Fatalities – Population data from DHEC Vital Records.
All rates per 100,000 population

1993-2003 South Carolina Child Fatality Rates

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
All child Fatalities	28.7	27.4	23.0	27.6	23.9	24.3	25.5	19.4	20.3	20.9	18.7
Natural Deaths	10.2	9.8	9.0	8.8	10.1	10.2	9.5	7.8	7.8	8.9	7.1
All Unintentional Injury Deaths	10.0	10.3	8.7	10.2	7.6	8.0	8.4	5.6	7.2	6.3	6.2
Drowning	2.9	3.5	3.2	3.5	2.9	3.0	2.9	2.1	2.3	1.9	1.6
Suffocation	0.7	1.1	1.4	1.5	1.4	1.5	2.8	1.3	2.3	1.8	1.9
Fire/house	3.0	2.4	1.8	3.5	1.7	1.6	1.0	1.0	0.9	1.0	1.5
Miscellaneous	2.4	1.8	1.0	1.3	1.2	1.5	1.2	1.3	1.6	1.2	1.1
Shooting	0.9	1.3	1.2	0.4	0.5	0.5	0.5	0.0	0.0	0.3	0.2
Homicides	5.0	5.3	2.6	4.8	3.3	3.5	3.4	3.8	3.0	2.3	2.8
Suicides	2.7	1.4	2.0	2.5	0.9	1.8	2.1	1.1	0.9	1.0	0.8
Firearm*	5.9	5.3	3.7	5.2	2.8	3.3	3.2	2.1	1.7	1.9	2.0

*Firearm deaths are part of the homicide, suicide and unintentional injury deaths.
**Pending and undetermined deaths are included in the total number of deaths.

2003 South Carolina Child Fatality Rates by Race

	White	Black/Other
All Child Fatalities	15.1	28.4
Natural Deaths	6.0	8.9
All Unintentional Injury Deaths	5.2	7.6
Drowning	1.4	1.8
Suffocation	2.1	1.5
Fire/house	0.5	3.0
Miscellaneous	1.0	1.3
Shooting	0.3	0.0
Homicides	1.6	4.8
Suicides	0.5	1.5
Firearm*	1.4	2.8

*Firearm deaths are part of the homicide, suicide and unintentional injury deaths.
**Pending and undetermined deaths are included in the total number of deaths.

2003 Child Fatalities Annual Report – Rate Information

Child fatality data from SLED Dept. of Child Fatalities – Population data from DHEC Vital Records.
All rates per 100,000 population

2003 South Carolina Child Fatality Rates by Age Group					
	<1 Yr	**1-4 Yr**	**5-9 Yr**	**10-14 Yr**	**15-17 Yr**
All Child Fatalities	122.7	18.5	5.2	9.6	18.5
Natural Deaths	74.0	4.1	1.8	3.0	5.2
All Unintentional Injury Deaths	25.3	7.7	2.6	5.0	5.2
Drowning	1.8	3.2	1.1	0.7	1.7
Suffocation	21.7	0.9	0.4	1.3	0.0
Fire/house	1.8	1.8	0.7	2.3	0.6
Miscellaneous	0.0	1.8	0.4	0.3	2.3
Shooting	0.0	0.0	0.0	0.3	0.6
Homicides	3.6	6.3	0.7	1.0	4.6
Suicides	0.0	0.0	0.0	0.7	3.5
Firearm*	0.0	0.5	0.7	1.7	6.9

*Firearm deaths are part of the homicide, suicide and unintentional injury deaths.
**Pending and undetermined deaths are included in the total number of deaths.

SCFAC - Total Number of Reviewed Deaths By County And Cause of Death – Year 2003	Naturals	SIDS	Homicide	Suicide	Drowning	Suffocation/Strangulation	Shooting	Fire/House	Traffic	Crushing	Overdose	Dog Bite	Pending	Undetermined	**TOTAL**
Abbeville			1			1									**2**
Aiken	1	2		1	1			1		1				1	**8**
Allendale															**0**
Anderson	1	1			1	4									**7**
Bamberg															**0**
Barnwell		1			1										**2**
Beaufort			1		1				1						**3**
Berkeley	4		4			1									**9**
Calhoun	1			1				1							**3**
Charleston	1		2	1	1	3		3					1	2	**14**
Cherokee			1												**1**
Chester	2								1						**3**
Chesterfield		2													**2**
Clarendon					1										**1**
Colleton						1								1	**2**
Darlington			1			1								1	**3**
Dillon	1	1			1				1						**4**
Dorchester	1	3													**4**
Edgefield			1												**1**
Fairfield															**0**
Florence		1	1												**2**
Georgetown															**0**
Greenville	6	2	3					1		1	1			1	**15**
Greenwood					1	1									**2**
Hampton								2							**2**
Horry	6	3		1		1	1								**12**
Jasper			1												**1**
Kershaw		1													**1**
Lancaster		2			1	1		2							**6**
Laurens		1	1	1											**3**

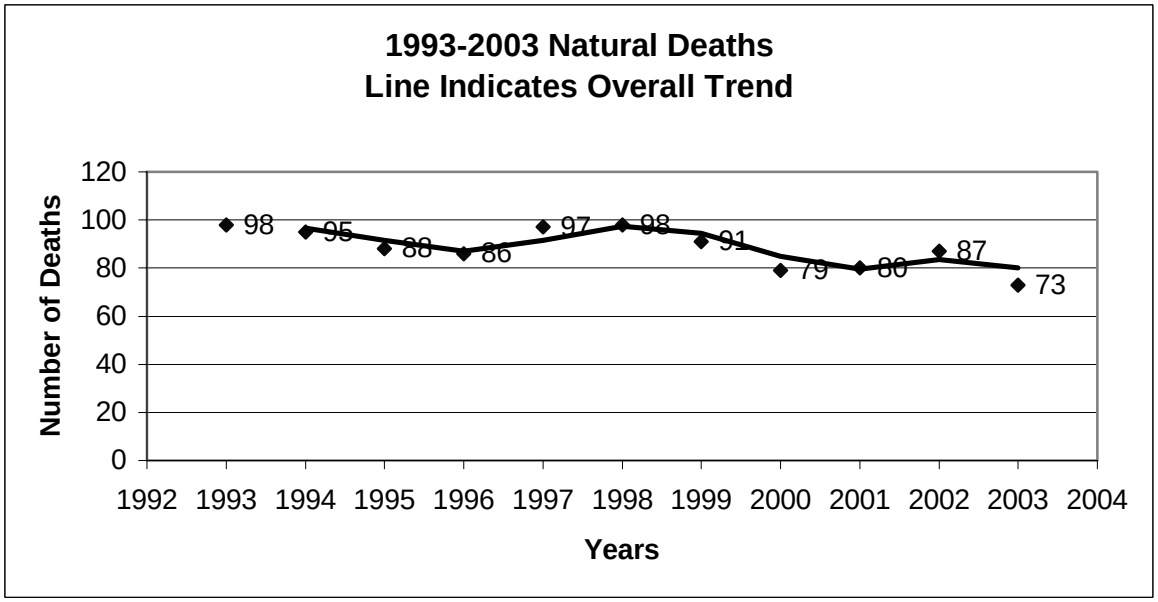
SCFAC - Total Number of Reviewed Deaths By County And Cause of Death – Year 2003	Naturals	SIDS	Homicide	Suicide	Drowning	Suffocation/Strangulation	Shooting	Fire/House	Traffic	Crushing	Overdose	Dog Bite	Pending	Undetermined	**TOTAL**
Lee		1													**1**
Lexington	1	1	2											4	**8**
Newberry	1														**1**
Oconee	1				1			1							**3**
Orangeburg	2			1	2										**4**
Pickens					2	1		2							**5**
Richland	7	3	3	1	1	1				2				1	**19**
Saluda															**0**
Spartanburg	2	1	2		1	2			1		1	1	2	2	**15**
Sumter	1	1	2											1	**5**
Union															**0**
Williamsburg															**0**
York	3	2	1	1		1									**8**
TOTAL	**43**	**30**	**29**	**8**	**16**	**19**	**2**	**15**	**4**	**4**	**2**	**1**	**4**	**14**	**191**

Natural Deaths/Sudden Infant Death Syndrome

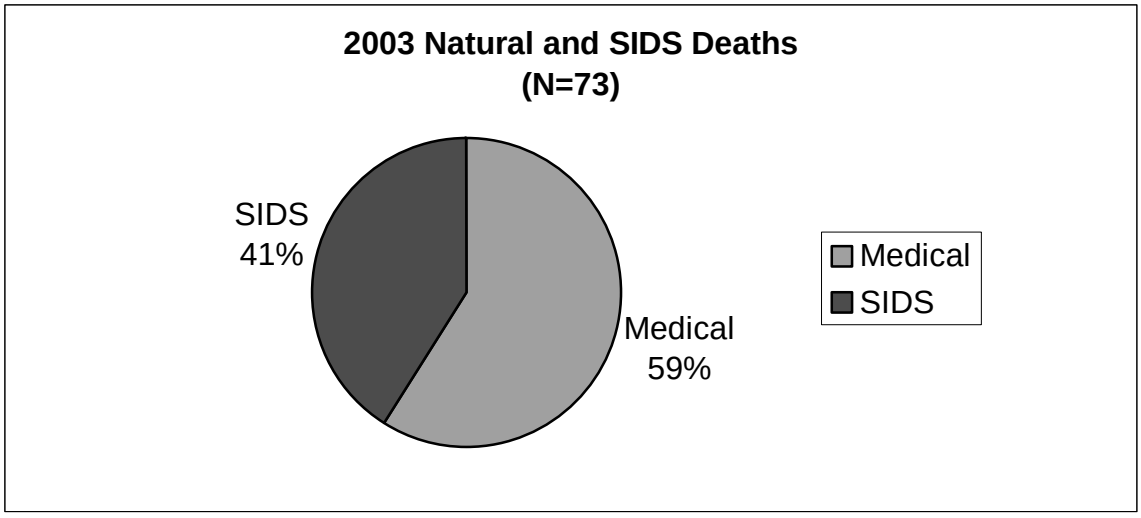
Natural Deaths were the cause of death for 73 reported children in South Carolina in 2003, representing 38.2% of the total reviewed deaths.

Overview

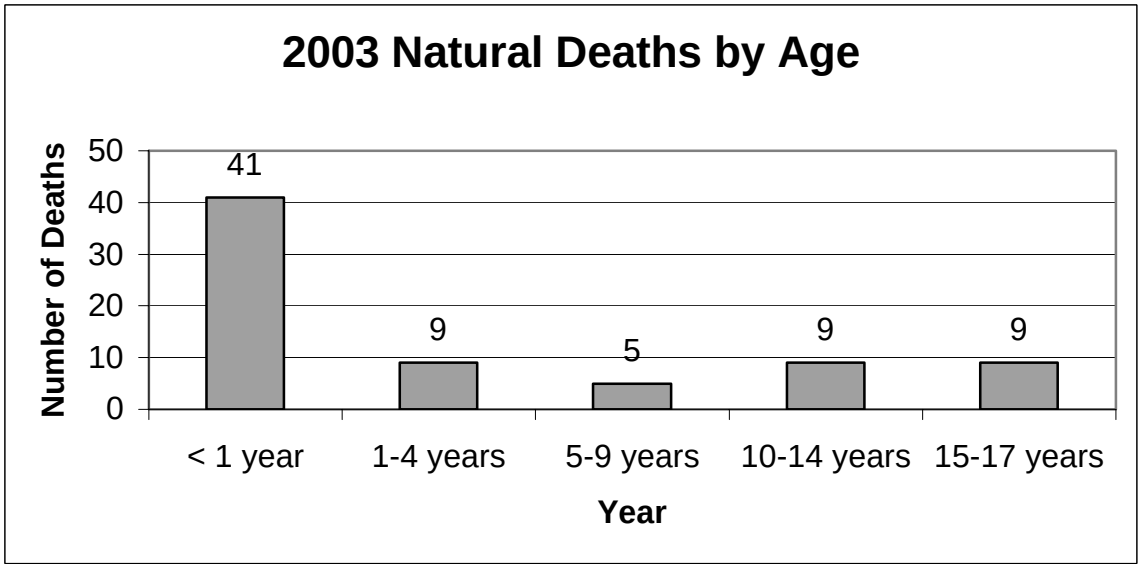
Natural Deaths include diseases and conditions such as cardiac arrhythmia, meningitis, myocarditis and pneumonia. Metabolic disorders also contribute to the cause of death among children. Many times the cause of death is undetectable until a thorough autopsy is performed.



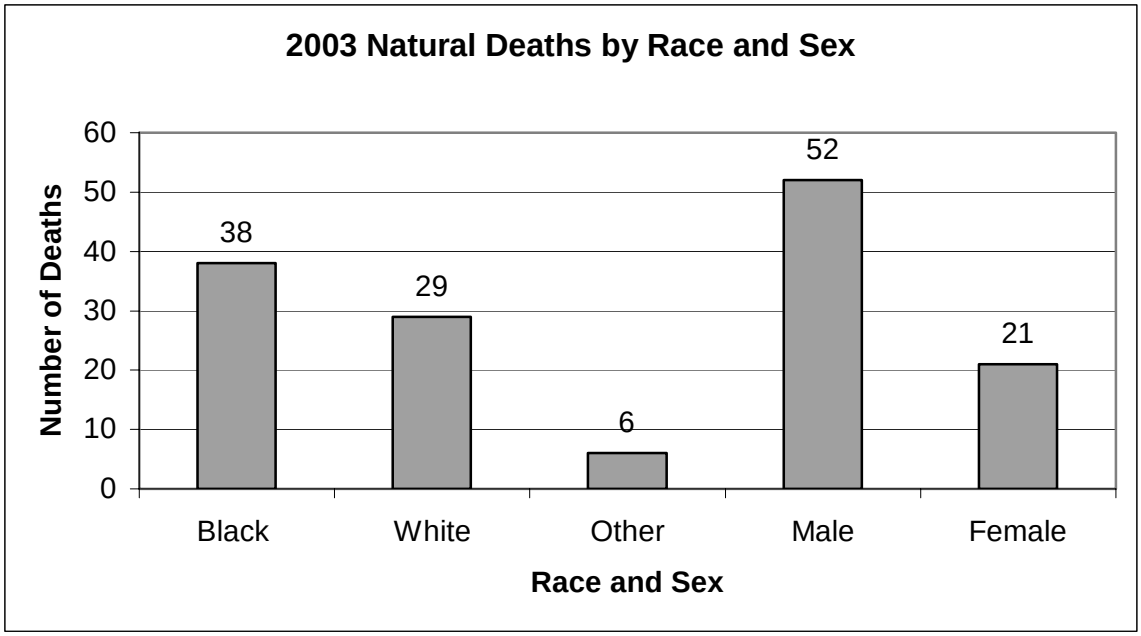
In 2003, 73 of the reviewed deaths were as a result of natural causes. This is a 16% decrease in the number of deaths in comparison to 2002.



There were 43 natural deaths that were investigated and classified as medical cause of death. The other 30 natural deaths were classified as Sudden Infant Death Syndrome (SIDS) after exclusion from any other possible cause of death.



Fifty-five percent (55%) of natural deaths are of children less than 1 year of age. Children from the age groups of 1-4 years, 10-14 years and 15-17 years of age each represent 12% of natural deaths.



Seventy percent (70%) of victims of natural deaths were males, while blacks represented 52% of natural deaths.

Sudden Infant Death Syndrome (SIDS)

Sudden Infant Death Syndrome (SIDS) was the cause of death of 30 infants in South Carolina in 2003, representing 41% of all natural deaths reviewed.

Overview

SIDS is the sudden death of an infant under one year of age which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene, and review of the clinical history.

SIDS is one the leading causes of death in infants between one month and one year of age. It is sudden and unexpected and even after an autopsy no cause of death is found. It strikes without warning, usually in seemingly healthy babies.

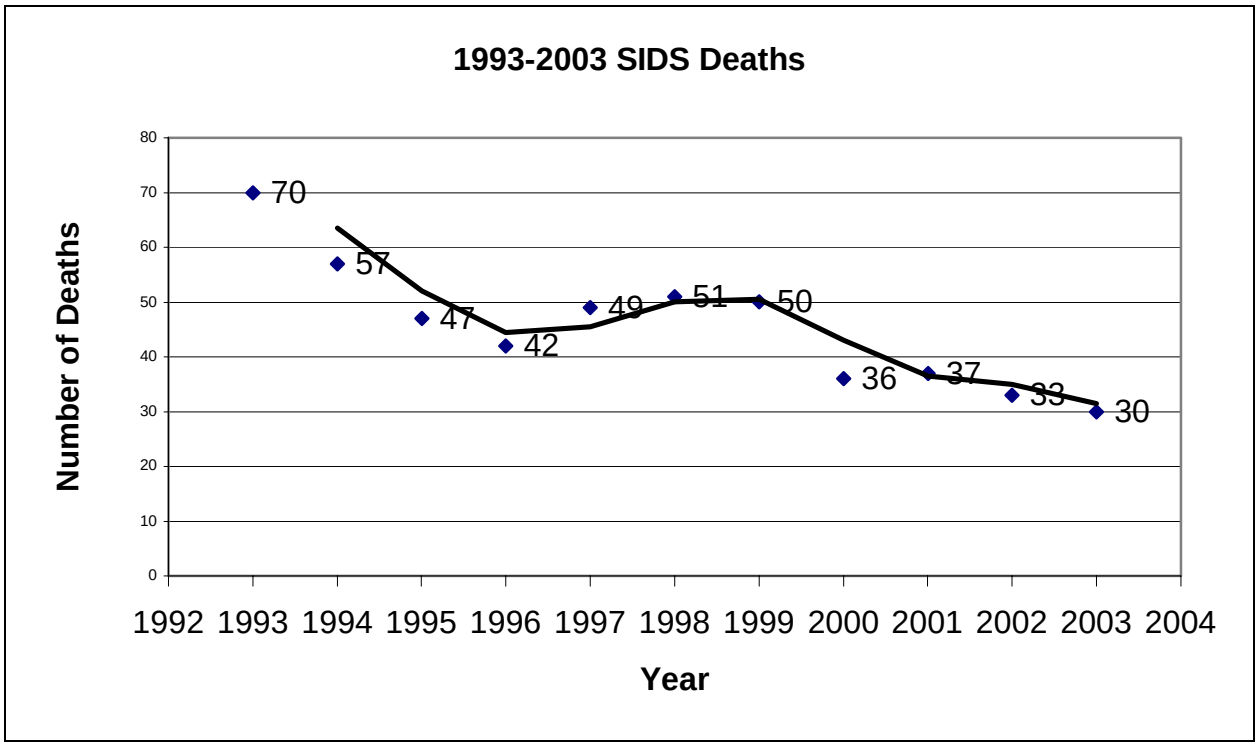
KEY FINDINGS:

- 29 SIDS deaths were investigated.
- 97% were under six months of age.
- 72% were males.
- 48% were black.
- 55% were on their back.
- 31% were on their stomach.

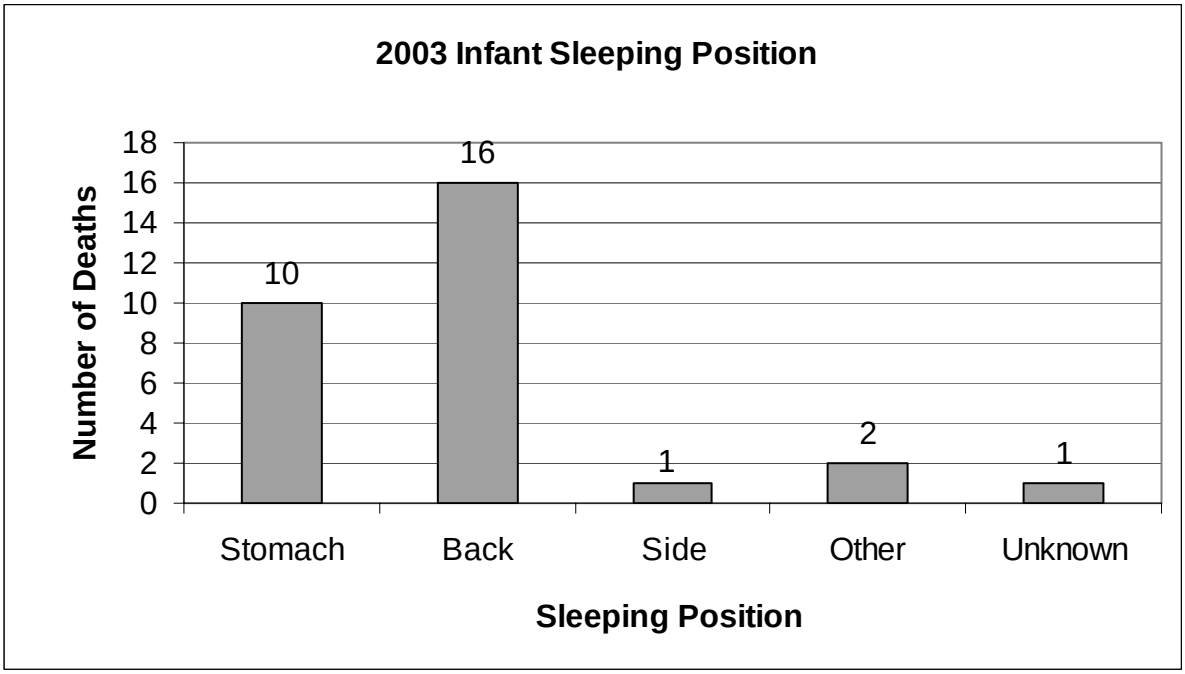
Several **RISK** factors for **SIDS** have been identified:

1. **Tummy (prone) or side sleeping**
   Infants who are put to sleep on their tummy or side.
2. **Soft sleep surfaces**
   Sleeping on a waterbed, couch, sofa, or pillows, or sleeping with stuffed toys.

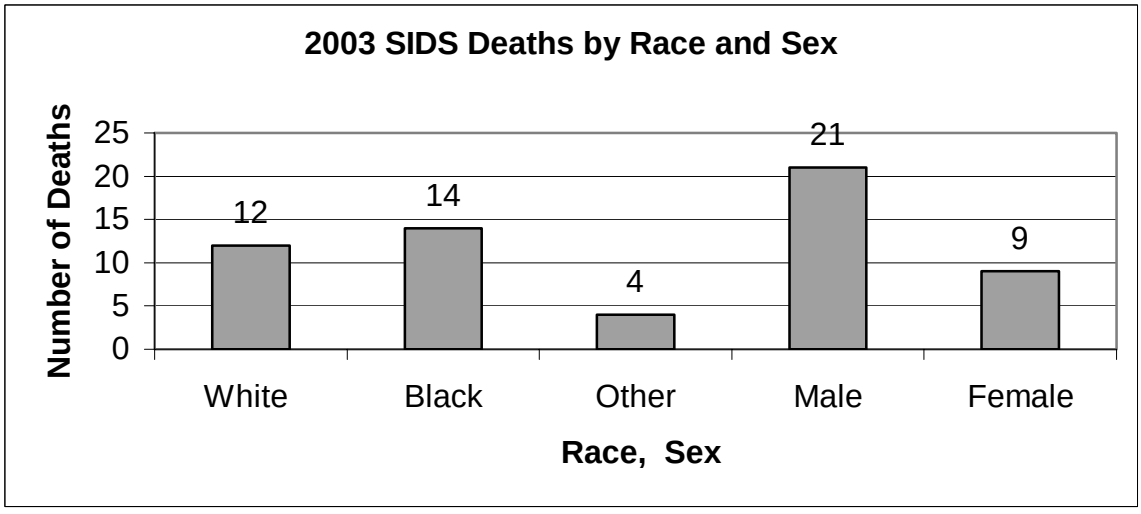
3. **Loose bedding**
   Sleeping with pillows or loose bedding such as comforters, quilts, and blankets.
4. **Overheating**
   Infants who overheat because they are overdressed, have too many blankets on, or are in a room that is too hot.
5. **Smoking**
   Infants born to mothers who smoke during pregnancy; infants exposed to smoke at home or at daycare.
6. **Bed sharing**
   Sharing a bed with anyone other than the parents or caregivers and with people who smoke or are under the influence of alcohol or drugs.
7. **Preterm and low birth weight infants**
   Infants born premature or low birth weight.



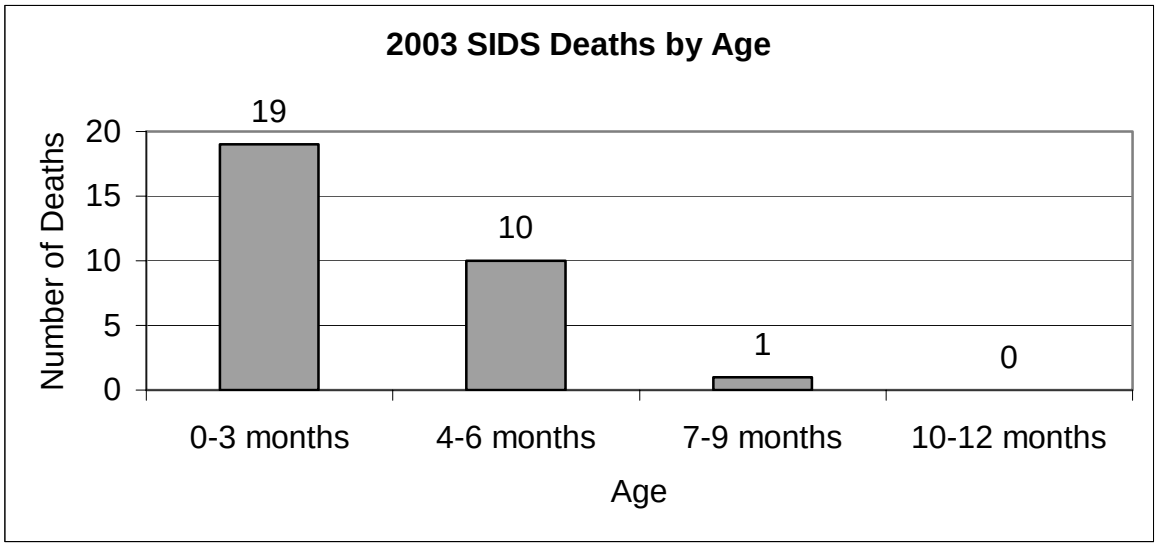
Thirty (30) SIDS deaths were investigated in 2003. This continues a downward trend in reported SIDS deaths. This represents a 9% decrease from 2002.



Fifty-five percent (55%) of infants were sleeping on the backs, while 31% of infants were sleeping on their stomachs.



Seventy-two percent (72%) of SIDS victims were male, while 48% of SIDS victims were black.



Sixty-two (62%) of SIDS deaths are of children less than 3 months of age.

Recommendations:

- Babies should sleep on a firm surface.
- Sleeping area should be free of pillows, toys, blankets, bumpers, and wedges.
- Babies should sleep on their backs.

Resources:

- SIDS Network – www.SIDS-network.org
- The Consumer Product Safety Commission – www.cpsc.gov
- American Academy of Pediatrics – www.aap.org

This practice (placing infants) on their backs must be applied across the board in all healthcare settings. This (campaign) is a tremendous opportunity when you think that 3,000 babies a year could live because of a simple, little intervention."

E. Stephen Edwards, Past President
American Academy

Unintentional Injury Related Deaths

Unintentional injuries were the cause of death for 63 children in South Carolina in 2003, representing 33% of the total deaths reviewed.

Overview

Unintentional injuries were once viewed as "freak incidents or "unavoidable accidents" that occurred regularly as part of everyday life. Like disease, they follow a distinct pattern based on age, sex, and race. Injuries, unlike accidents, do not happen by chance and more commonplace than previously perceived. Unintentional injuries can be prevented.

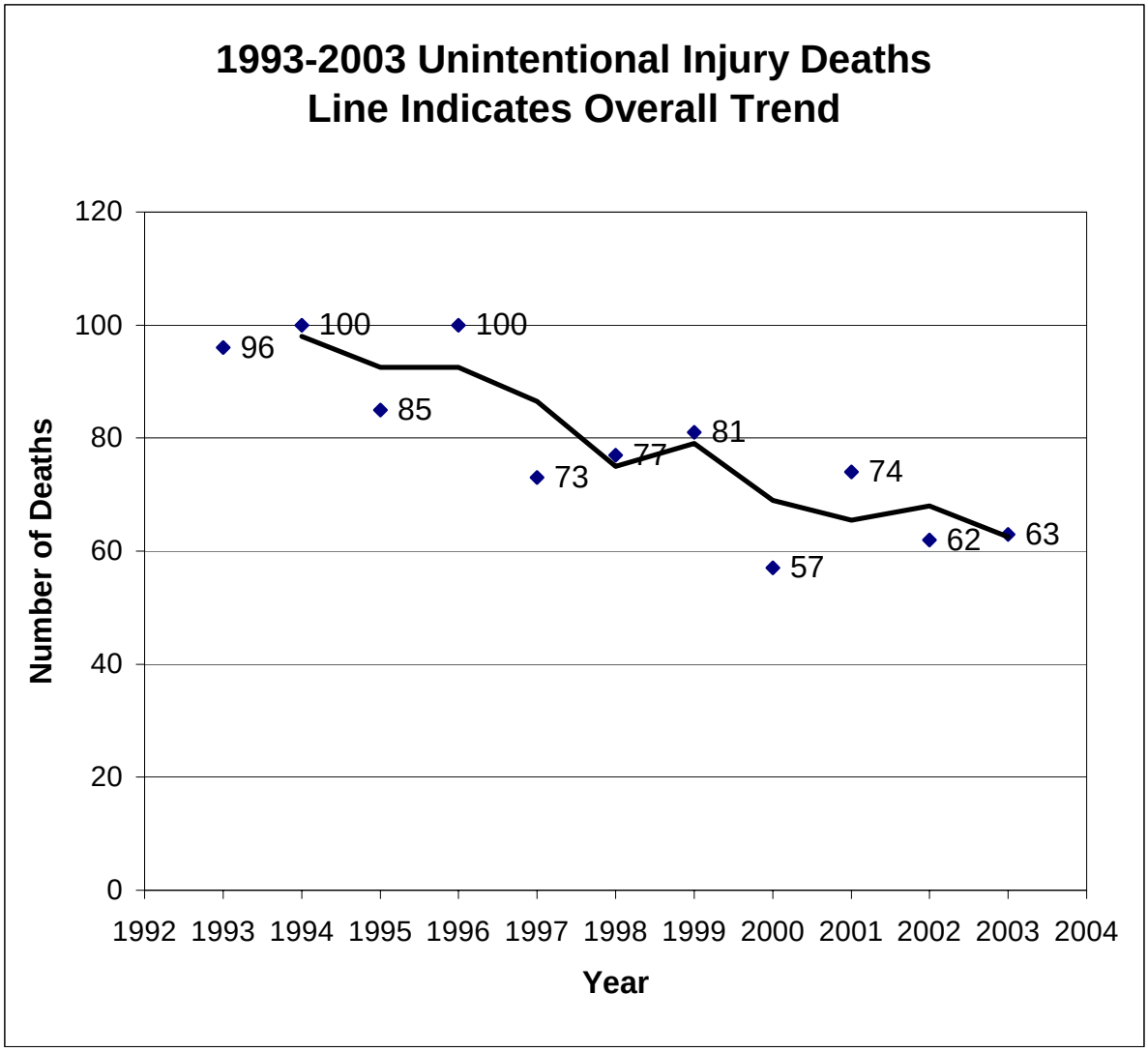
For each unintentional injury related death, there are even more hospitalizations, emergency room and healthcare providers visits, rehabilitation services, and preventative services. For this reason, it becomes more evident that child fatality data is a necessity along with numerous prevention campaigns and strategies to prevent future child deaths.

Key Findings:

- 60% of victims were less than 10 years of age.
- 27% of victims were in between 1-4 years of age.
- 65% of victims were male.
- 52% of victims were white.

"Injury is probably the most under recognized major public health problem facing the nation today."

– National Academy of Science

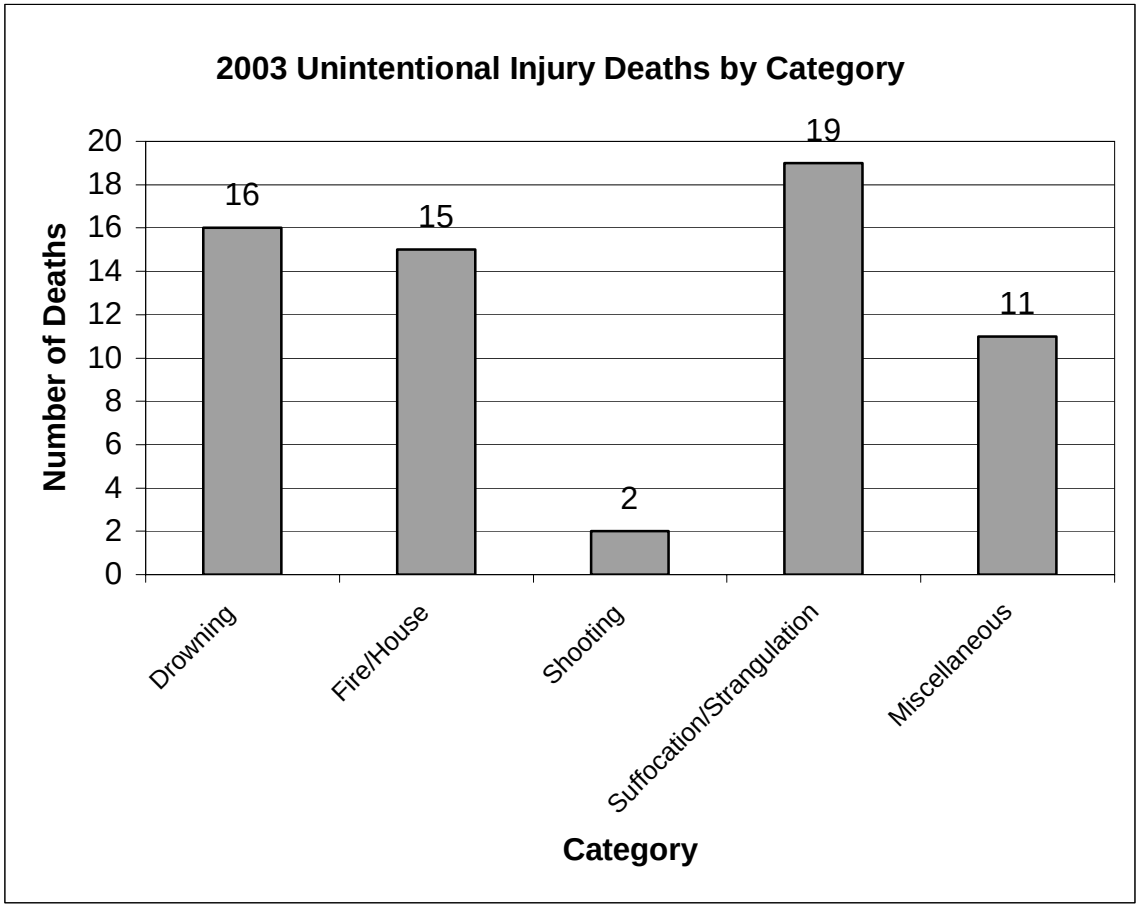


In 2003, there were 63 unintentional injury deaths. There is a 2% increase from 2002. The increase is represented by 1 death.

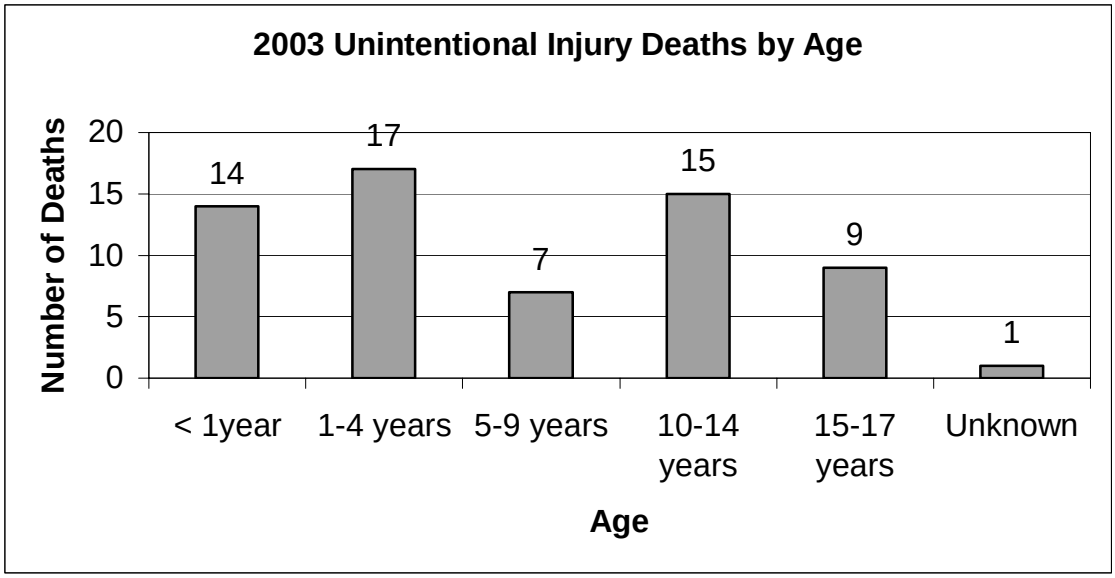
"If some infectious disease came along that affected children [in the proportion that injuries do], there would be a huge outcry and we would be told to spare no expense to find a cure and to be quick about it."

Surgeon General C. Everett Koop before the Subcommittee on Children, Family, Drugs, and Alcoholism, US Senate, February

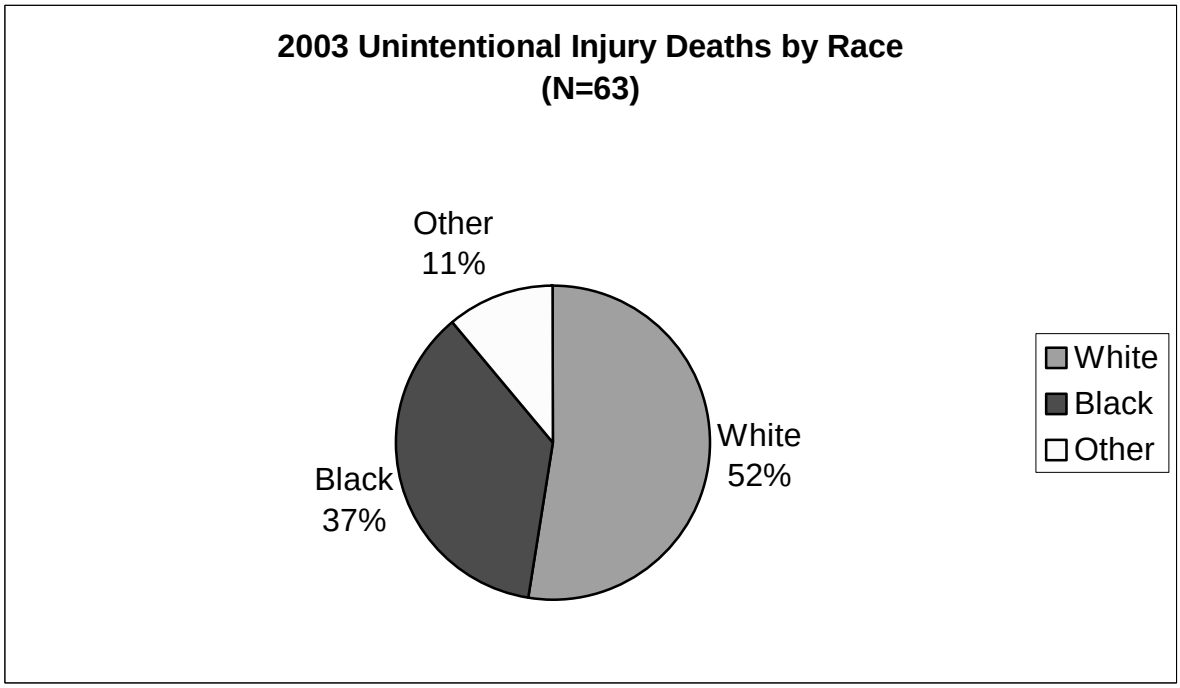
SCFAC uses five categories to define unintentional injury deaths: drowning, fire/house, shooting, suffocation/strangulation, and miscellaneous. Year 2003 unintentional miscellaneous injury deaths include drug overdose, ATV/Go-cart, dog bite and crushing.



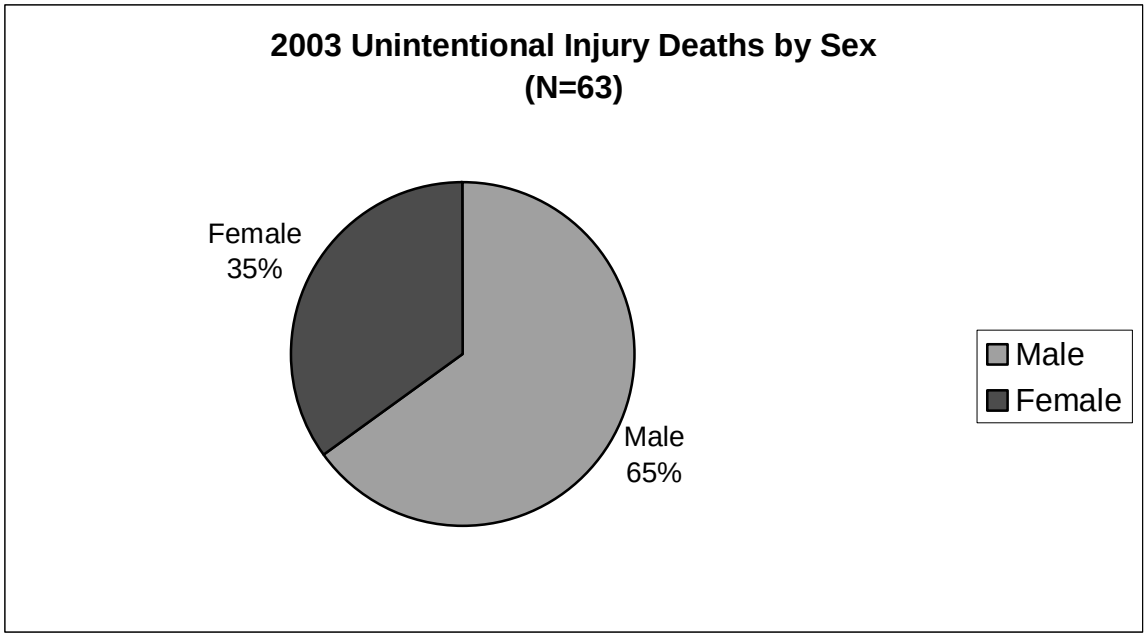
Suffocation/Strangulation accounted for the largest percentage of unintentional deaths (30.6%). Suffocation/Strangulations were followed closely by drownings (25%), fire/house (24%), miscellaneous (17.4%), and shootings (3%).



The majority of unintentional injury deaths are to children under 10 years of age (60%). 22% of the victims were less than 1 year of age. 27% of the victims were in between 1-4 years of age. 42% of the victims were between 10-14 years of age. 14% of victims were between 15-17 years.



There were 63 unintentional injury deaths. Of the 63 victims, 33 deaths were of white. The number remained constant from 2002. There was a slight decrease of black children that fell victim to unintentional injuries from 2002, which is an 8% decrease from 25 to 23 deaths. The other races include Latinos and East Indians, which represent 7 deaths. The number of deaths rose 43% from 2002.



Of the 63 victims of unintentional injury 41 were male and 22 were female. There was a 9% decrease in the number of male victims. There was an increase in the number of deaths of females, which rose 19% from 2002.

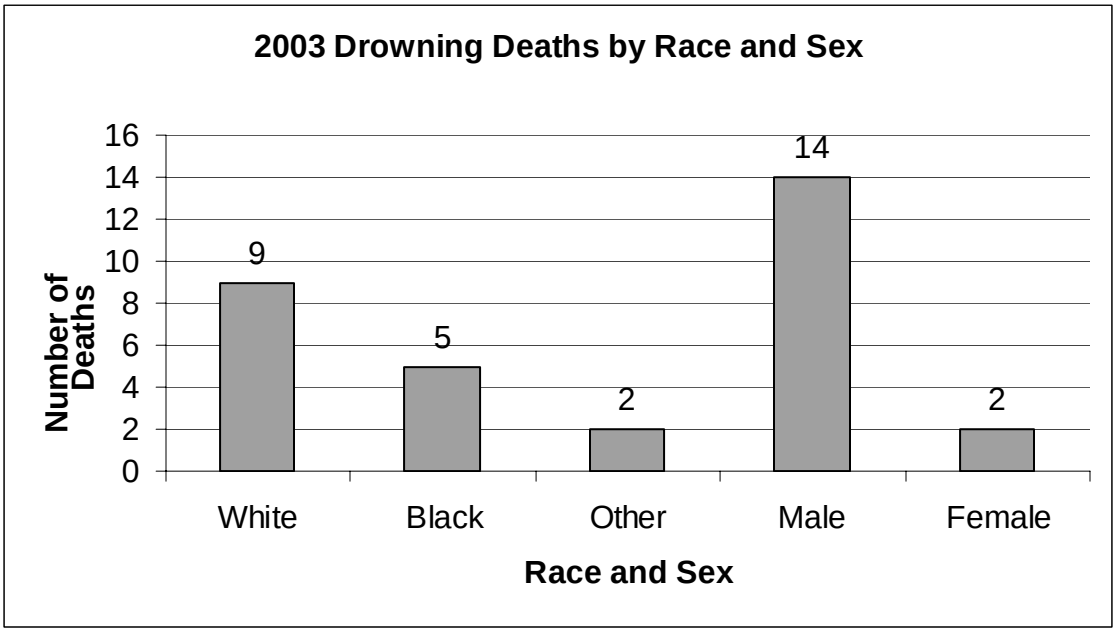
DROWNINGS

According to Safe Kids Worldwide, most drowning incidents occur in swimming pools; however, young children can drown in less than two inches of water. Adult supervision is the most effective prevention strategy. Fences, barriers and alarms add an extra layer of protection when used correctly at all times. Each year children drown in swimming pools, bathtubs, buckets, coolers, ponds, ditches, fountains, hot tubs, toilets, pet water bowls and wading pools. Most childhood drowning deaths occur when the parent or caregiver becomes distracted by the telephone, doorbell or chores around the home. Children can drown in a matter of seconds.

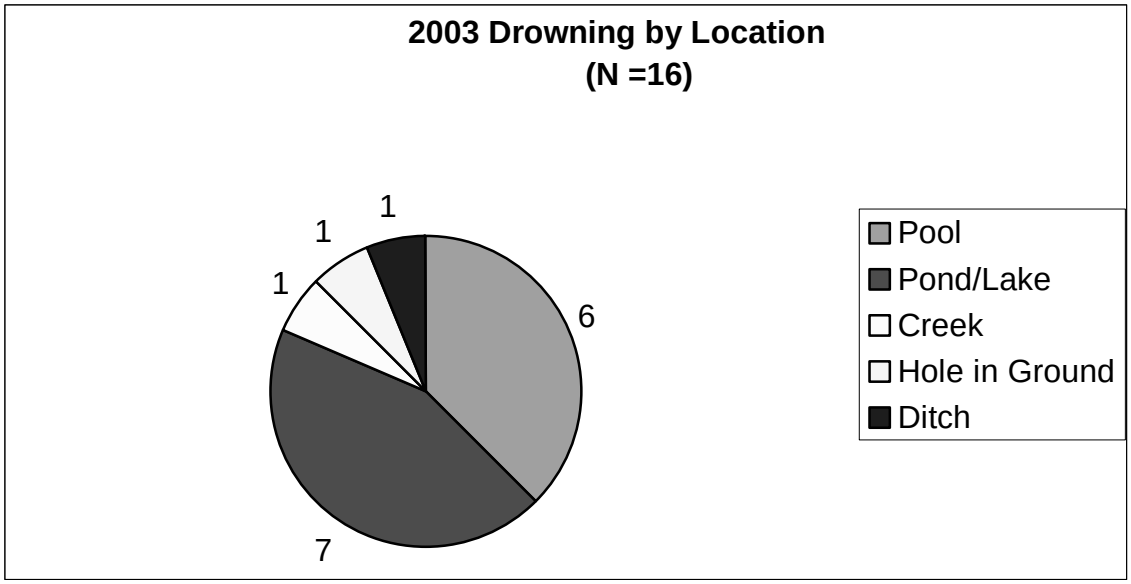
Key Findings:

- 16 children were victims.
- 16% decrease in deaths from 2002 to 2003.
- 44% of victims were between 1-4 years of age.

Age	Number of Deaths
< 1 year	1
1-4 years	7
5-9 years	3
10-14 years	2
15-17 years	3
Total	**16**



There were 16 victims of drowning. There was a 16% decrease in deaths from 2002 to 2003. Fifty-six percent of victims were white. Eighty-eight percent of victims were male.



Six victims (38%) drowned in a pool. Seven (44%) victims drowned in a pond or lake. Three other victims drowned in a creek, hole in the ground or a ditch, which represents a total of 18%.

Recommendations:

- Use barriers to keep children away from pools, ponds, and other bodies. of water.
- Always maintain constant supervision.
- Never leave a child alone near water.

Resources:

- Centers for Disease Control and Prevention – www.cdc.gov
- Safe Kids Worldwide – www.safekids.org
- American Academy of Pediatrics – www.aap.org
- American Red Cross – www.redcross.org

SUFFOCATION/CHOKING/STRANGULATION

According to Safe Kids Worldwide, airway obstruction injury (suffocation, choking, and strangulation) nationally is the one of the leading cause of unintentional injury-related death among children. These injuries occur when children are unable to breathe normally because food or objects block their internal airways (choking); materials block or cover their external airways (suffocation); or items become wrapped around their necks and interfere with breathing (strangulation).

Key Findings:

- 19 children were victims of suffocation/strangulation.
- 9% increase in suffocation/strangulation from 2002 to 2003.
- 68% (13) of victims were white.
- 47% (9) of victims were female.
- 63% (12) of victims were under one year of age.

Race		Sex	
White	13	Male	9
Black	4	Female	10
Other	2		
Total	**19**	**Total**	**19**

Age	Number of Deaths
< 1 year	12
1-4 years	2
5-9 years	1
10-14 years	4
15-17 years	-
Total	**19**

Recommendations:

- Improve safety in homes, especially in sleeping areas.
- Place baby on a firm flat surface without pillows, wedges, or toys.
- Place child on their back while sleeping or napping.
- Remove cords and drawstrings from child's clothing.
- Place all plastic bags or wrapping where children cannot reach them.
- Check floors for small objects like buttons, beads, marbles or coins.

Resources:

- Centers for Disease Control and Prevention – www.cdc.org
- American Academy of Pediatrics – www.aap.org
- U. S. Consumer Product Safety Commission – www.cpsc.gov
- National Safety Council – www.nsc.org

FIRE/HOUSE

The majority of child fire and burn deaths occur at home. The most common reasons are cooking, smoking, electrical malfunctions in products and house wiring. Young children are often involved with matches and lighters because of curiosity in most instances. Fire related injury deaths may be caused by damage to the lungs from smoke inhalation and asphyxiation.

Key Findings:

- 15 children were victims of fire in a house or residence.
- 17% increase from 2002 to 2003.
- 26% of fires were started by space heaters.
- Stoves or ovens started 26% of fires.
- Electrical wiring started 13% of fires.
- Faulty chimneys started 6% of fires.
- Wood stoves started 6% of fires.

Race		Sex	
White	3	Male	8
Black	11	Female	7
Other	1		
Total	**15**	**Total**	**15**

Age	Number of Deaths
< 1 year	1
1-4 years	4
5-9 years	2
10-14 years	7
15-17 years	1
Total	**15**

Recommendations:

- Install smoke alarms in your home on every floor even in bedrooms.
- Keep all flammable objects away from flames.
- Plan and practice an escape route.

Resources:

- United States Fire Administration – www.usfa.fema.gov
- Safe Kids Worldwide – www.safekids.org
- National Fire Prevention Association – www.nfpa.org
- Centers for Disease Control and Prevention – www.cdc.gov
- State Fire Marshall's Office – www.llr.state.sc.us

SHOOTINGS

According to Safe Kids Worldwide, exposure to guns and access to a loaded firearm increase the risk of unintentional firearm-related death and injury to children. Unrealistic perceptions of children's capabilities and behavioral tendencies with regard to guns are common. These include misunderstanding a child's ability to gain access to and fire a gun, distinguish between real and toy guns, make good judgments about handling a gun and consistently follow rules about gun safety. Promoting the safe storage of firearms in the home and reducing their availability and accessibility are important steps in preventing unintentional firearm-related death and injury among children.

Key Findings:

- 2 children were victims of unintentional shootings.
- 33% increase in unintentional shooting deaths from 2002 to 2003.
- 100% of victims' deaths were due to a shooting.
- 100% of victims were male.
- 100% of victims were white.

Recommendations:

- Store firearms unloaded.
- Store and lock ammunition in different location than firearm.
- Use quality gunlocks and lock boxes, or gun safes on every firearm.

Resources:

- Safe Kids Worldwide – www.safekids.org
- Project ChildSafe – www.projectchildsafe.org

MISCELLANEOUS

These unintentional injuries include blows to the chest, boating, collisions involving golf carts or ATVs, drug overdose, electrocution, exsanguinations, falls, striking with an object, crushing and traffic.

Key Findings:

- 11 children were victims.
- 8% decrease from 2002.
- 73% of victims were males.
- 55% of victims were white.
- 36% of victims were in between 1-4 years of age.
- 36% of victims were in between 15-17 years of age.

Manner of Death by Category	Number of Deaths
Overdose	2
ATVs/Go Cart	4
Crushing	4
Dog Bite	1
Total	**11**

Age	Number of Deaths
< 1 year	1
1-4 years	4
5-9 years	2
10-14 years	7
15-17 years	1
Total	**15**

Race		Sex	
White	3	Male	8
Black	11	Female	6
Other	1	Unknown	1
Total	**15**	**Total**	**15**

Homicide

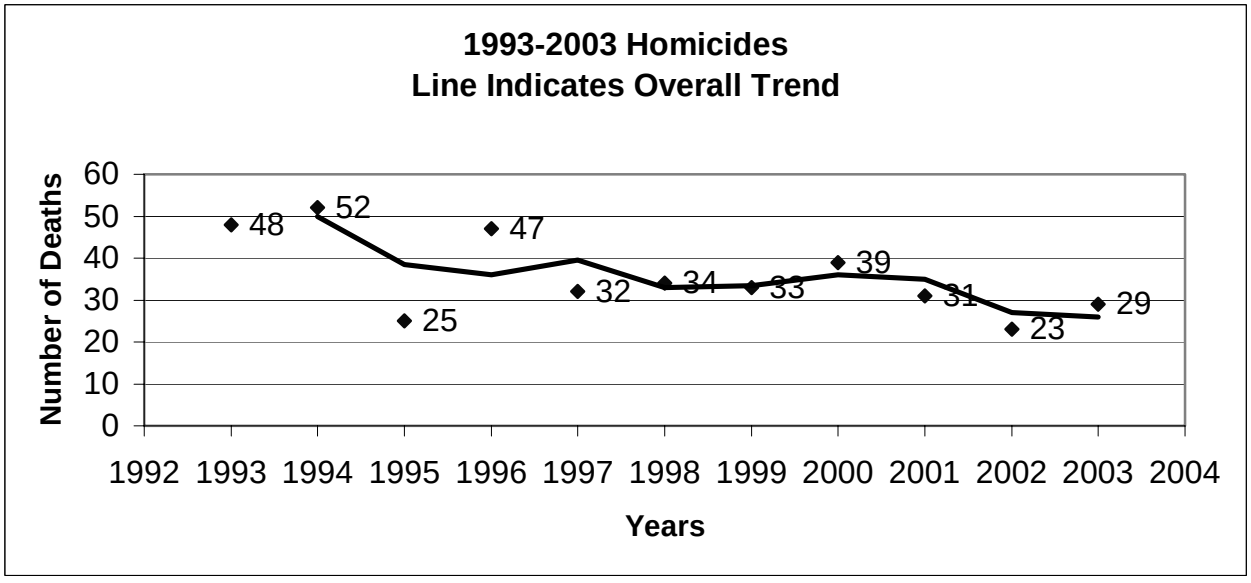
Homicides were the cause of death for 29 children in South Carolina in 2003, representing 15.2% of the total deaths reviewed.

Overview

Family members, through beating and suffocation, commit most homicides of young children. Middle childhood is a time when a child's homicide risk is relatively low. As the victims increase in age, the circumstances and manner of death change. Some cases are the result of child maltreatment, while others are a result of a conflict. Firearms become a more likely mechanism of death. Most homicide of teenagers involves male victims killed by male offenders using firearms.

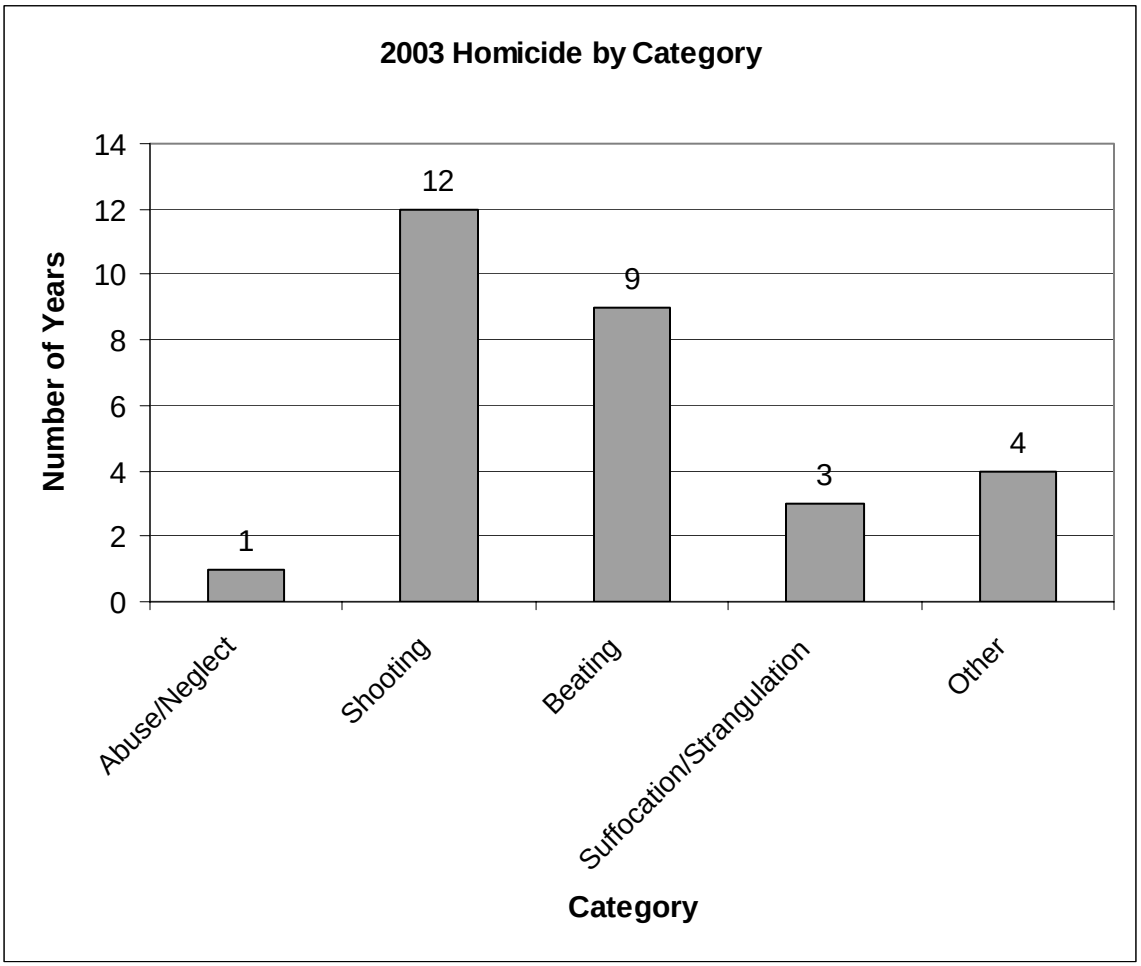
Key Findings:

- 21% of perpetrators were mothers of the victims.
- 7% of perpetrators were fathers of the victims.
- 41% of victims were killed by shootings.
- 48% of victims were between 1-4 years of age.
- 59% of victims were male.
- 62 % of victims were black.

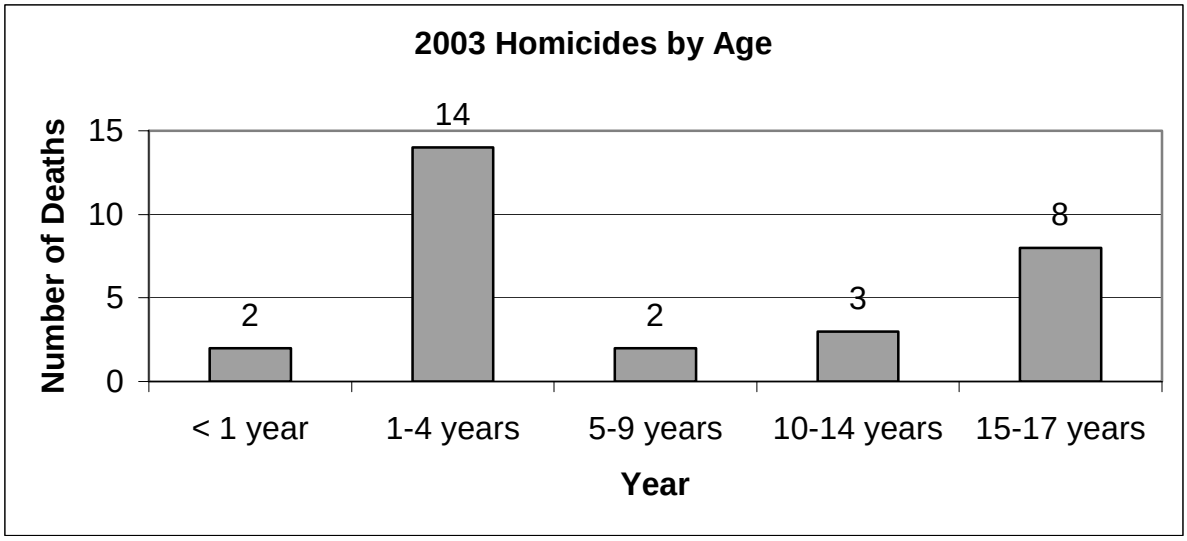


In 2003, 29 child deaths occurred from homicide. That is a 21% increase in the number of deaths from 2002.

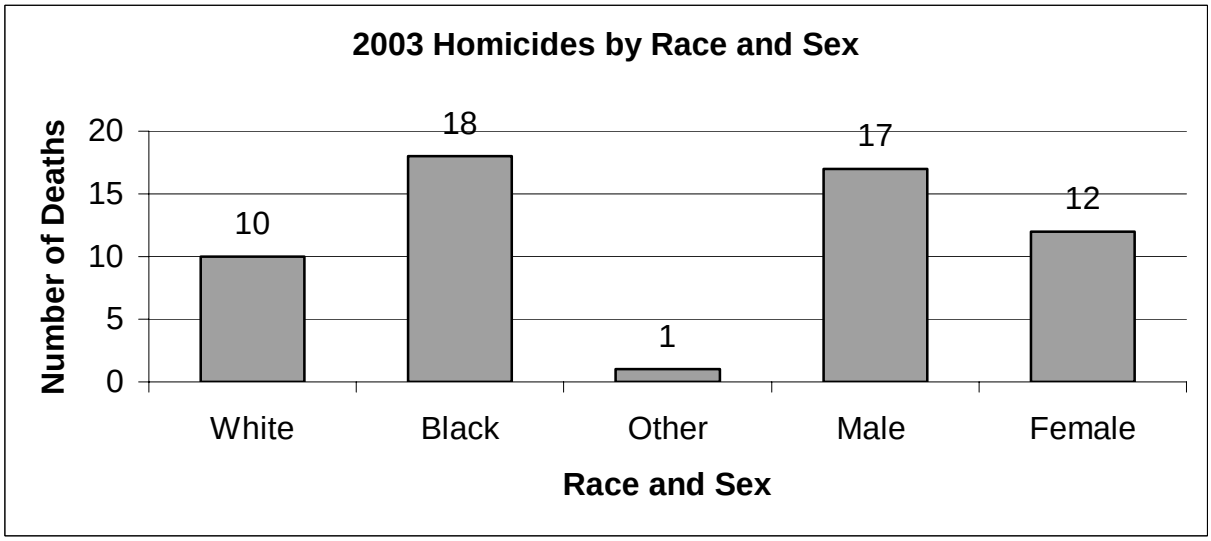
Homicides are classified by 5 categories: Abuse/Neglect, Shooting, Beating, Suffocation/Strangulation, and Other. "Other" includes mechanisms not included in the other categories, such as a drug overdose. This year "other" includes homicide by drug overdose, drowning and burns.



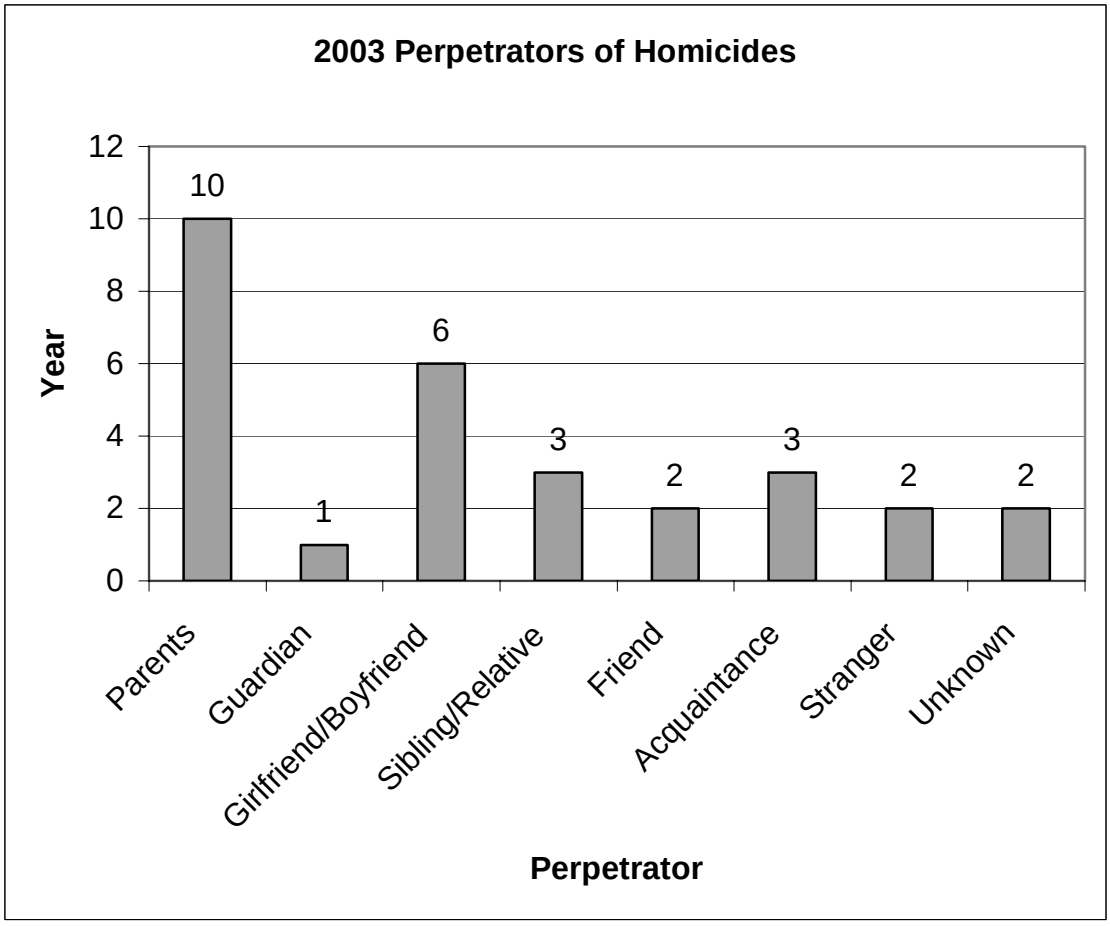
Homicides involving firearms represented 41% of deaths. Sixty-six percent (66%) of shooting victims were black. Eighty-three percent (83%) of shooting victims were male. Homicide by beating victims represented 31% of deaths. Fifty-five percent (55%) of beating victims were male and black.



Forty-eight percent (48%) of victims were between the ages of 1-4 years. Most of these represent victims of child abuse. Twenty-seven percent (27%) of victims were between the ages of 15-17 ages. However, shooting victims represent 21% in the 10-17 years of age group.



Sixty-two percent (62%) of homicide victims were black, while 59% of victims were male.



Thirty-four percent (34%) of perpetrators were parents of the victims. Twenty-one percent (21%) of perpetrators were either girlfriends or boyfriends of the parents. Ten percent (10%) of perpetrators were relatives or siblings of victims. Thirteen percent (13%) of perpetrators were strangers or unknown to the victim.

Resources:

- Office of Juvenile Justice and Delinquency Prevention – http://ojjdp.ncjrs.org or 1-800-851-3420
- Centers of Disease Control and Prevention – www.cdc.gov

There is a powerful consensus that youth violence is, indeed, our Nation's problem, and not merely a problem of the cities, or of the isolated rural regions, or any single segment of our society.

-Former Surgeon General David Satcher

Suicide

Suicides were the cause of death of 8 children in South Carolina in 2003, representing 4.2% of the total reviewed deaths.

Overview

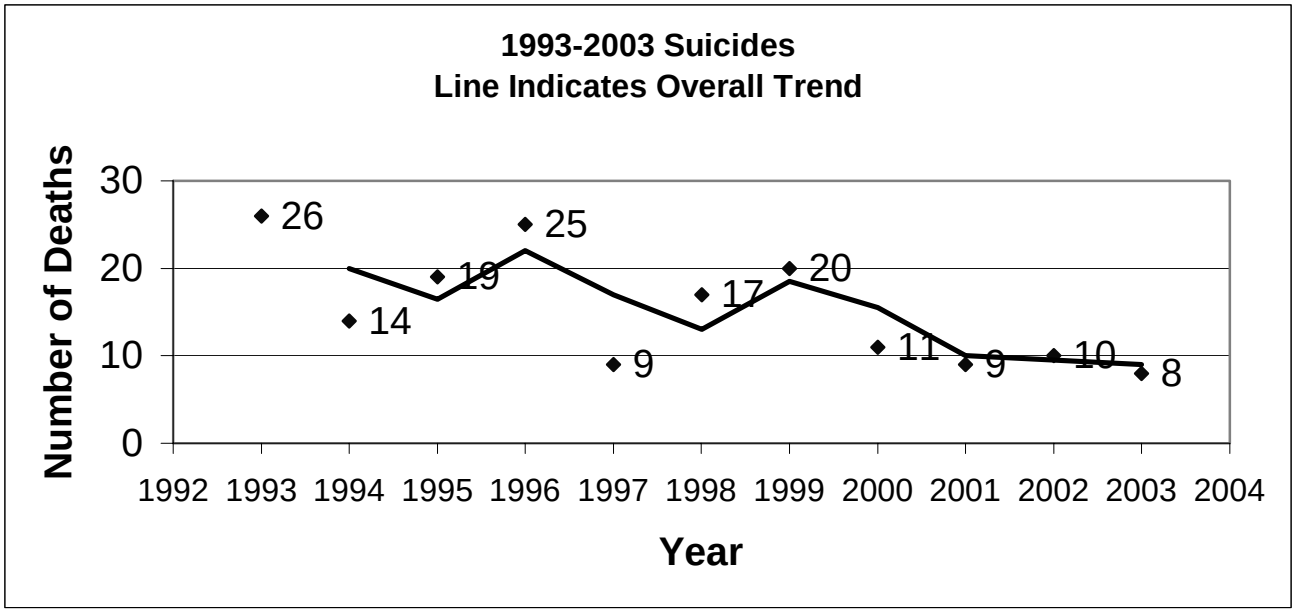
Suicide is often linked to clinical depression, bipolar disorders, and substance abuse. Suicides are more common than previously perceived. Many factors contribute to suicide. Children who experience violence, drug and alcohol addiction, poverty, and sexual, physical, and/or emotional abuse have a much higher risk for suicide. Despite the fact that research indicates more females attempt suicides, more males actually complete suicides.

Key Findings:

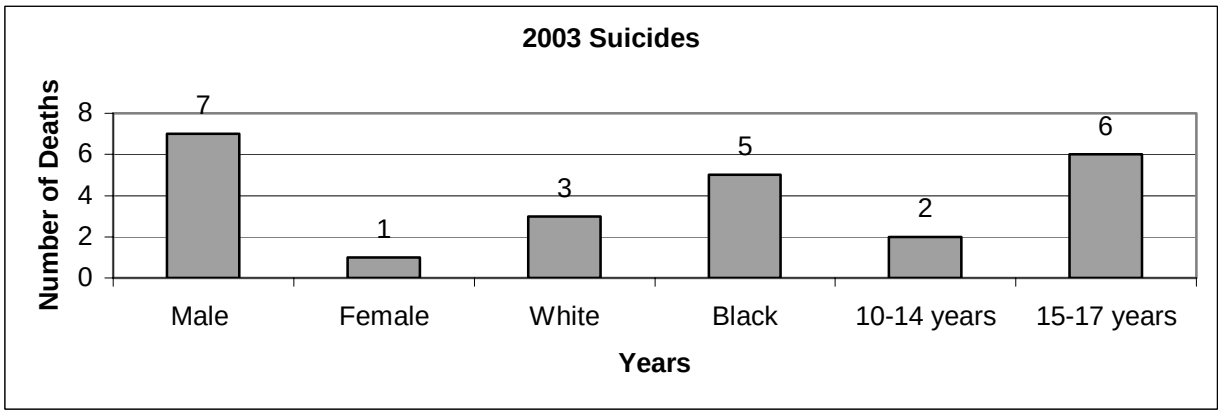
- 88% of victims were male.
- 63% of victims were black.
- 75% of victims were between 15-17 years of age.
- 63% of victims died by firearm.
- 25% of victims died by suffocation/strangulation.
- 13% of victims died by stabbing.

Young people who contemplate suicide don't want to die, they want an end to the incredible emotional pain they feel. Young people don't recognize **suicide is a permanent solution to a temporary situation.**

-Kids Under Twenty-One

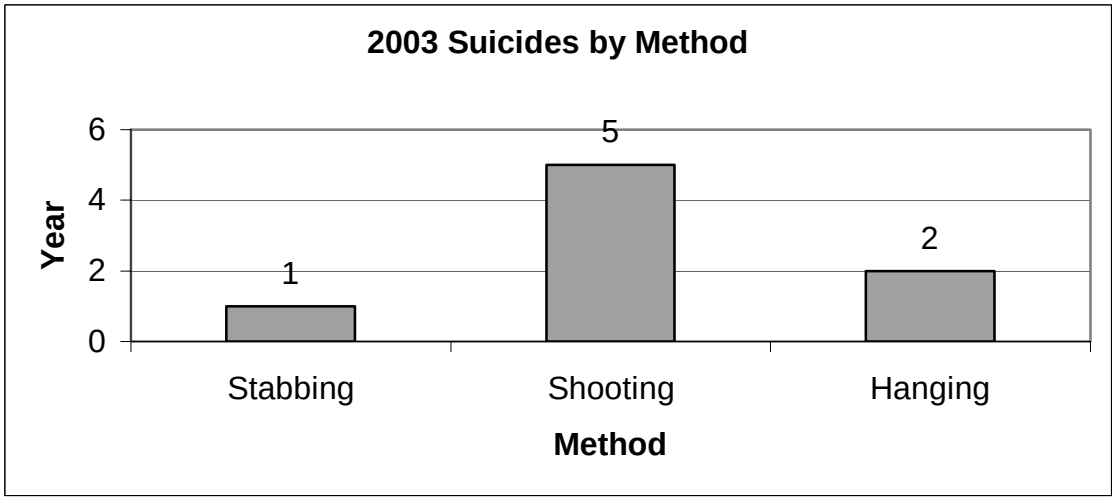


In 2003, 8 children completed suicide. This is a 20% decrease from 2002.



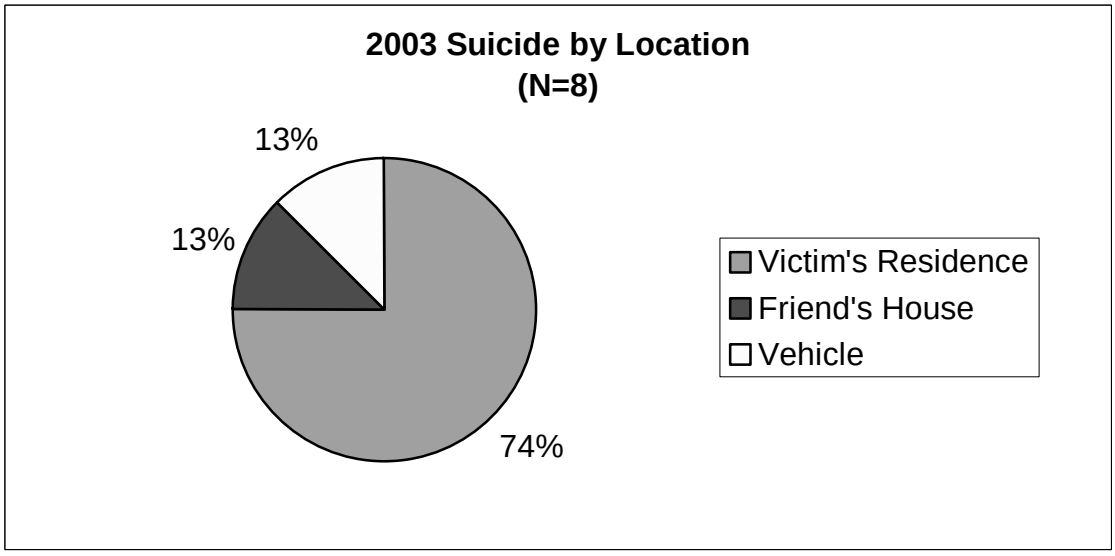
*Age groups or races not represented on chart had zero deaths.

Eighty-eight percent (88%) of victims were male. Sixty-three percent of victims were black. The total number of suicide deaths for children in between 15-17 years of age equals 75%.



Suicide by shooting represents 63% of suicides deaths. Eight percent of shooting victims were in between 15-17 years of age. Sixty percent of victims were black. Eighty percent of victims were male.

Suicides by hanging represent 25% of suicide deaths. One hundred percent hanging victims were in between the ages of 15-17 years of age.



Six (6) suicides were completed in the victim's residence. One (1) suicide was completed at a friend's house. One (1) suicide was completed in a vehicle.

Recommendations:

- Always take all suicidal behavior seriously.
- Raise awareness on childhood and adolescent depressive illness and suicide.
- Understand that early intervention is the key to successful treatment.

Resources:

- American Academy of Pediatrics - www.aap.org
- American Foundation of Suicide Prevention – www.afsp.org
- Youth Suicide Prevention Program – www.yspp.org
- Kids Under Twenty One – www.kuto.org
- American Association of Suicidology – www.suicidology.org
- KidsHealth – www.kidshealth.org
- Common Sense About Kids and Guns – www.kidsandguns.org

Firearm Related Deaths

Firearms were the cause of death of 20 children in South Carolina in 2003, representing 10% of the total reviewed deaths.

Overview

According to Safe Kids Worldwide, exposure to guns and access to a loaded firearm increase the risk of unintentional firearm-related death and injury to children. Unrealistic perceptions of children's capabilities and behavioral tendencies with regard to guns are common. These include misunderstanding a child's ability to gain access to and fire a gun, distinguish between real and toy guns, make good judgments about handling a gun and consistently follow rules about gun safety. Promoting the safe storage of firearms in the home and reducing their availability and accessibility are important steps in preventing unintentional firearm-related death and injury among children.

Key Findings:

- 20 children were victims of shootings.
- 2 children were victims of unintentional shootings.
- 5% increase in shooting deaths from 2002 to 2003.
- 100% of victims' deaths were result of the use of a firearm.
- 80% of victims were male.
- 55% of victims were black.

Age	Number of Deaths
< 1 year	0
1-4 years	1
5-9 years	2
10-14 years	5
15-17 years	12
Total	**20**

Recommendations:

- Store firearms unloaded.
- Store and lock ammunition in different location than firearm.
- Use quality gunlocks and lock boxes, or gun safes on every firearm.

Resources:

- Safe Kids Worldwide – www.safekids.org
- Project ChildSafe – www.projectchildsafe.org
- American Academy of Pediatrics – www.aap.org
- KidsHeath – www.kidshealth.org
- Common Sense About Kids and Guns – www.kidsandguns.org

Undetermined Deaths

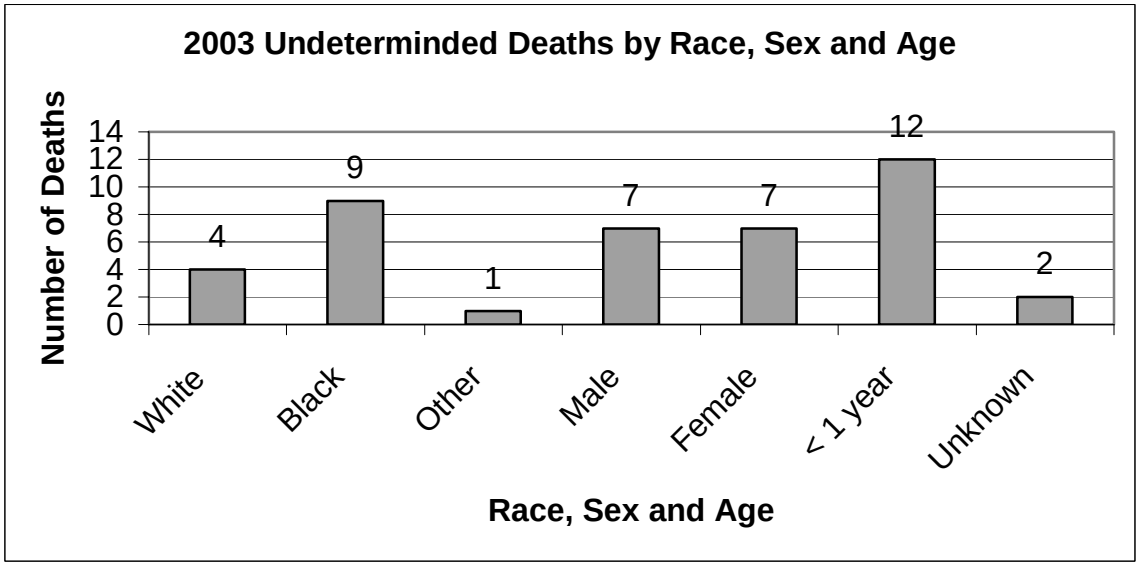
Undetermined deaths represent 7.3% of the total reviewed deaths.

Overview

The Undetermined category includes cases that have been investigated but a manner of death cannot be determined based on the available information surrounding each case. Often, two causes are possible, but neither can be conclusively proven (ex: SIDS vs. Overlay). SIDS is the sudden death of an infant under one year of age which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene, and review of the clinical history.

Key Findings:

- 14 undetermined child deaths were investigated.
- 50% of victims were male.
- 64% of victims were black.
- 85.7% of victims were less than 1 year of age.



* For age groups not represented on chart, there were zero deaths.

Pending

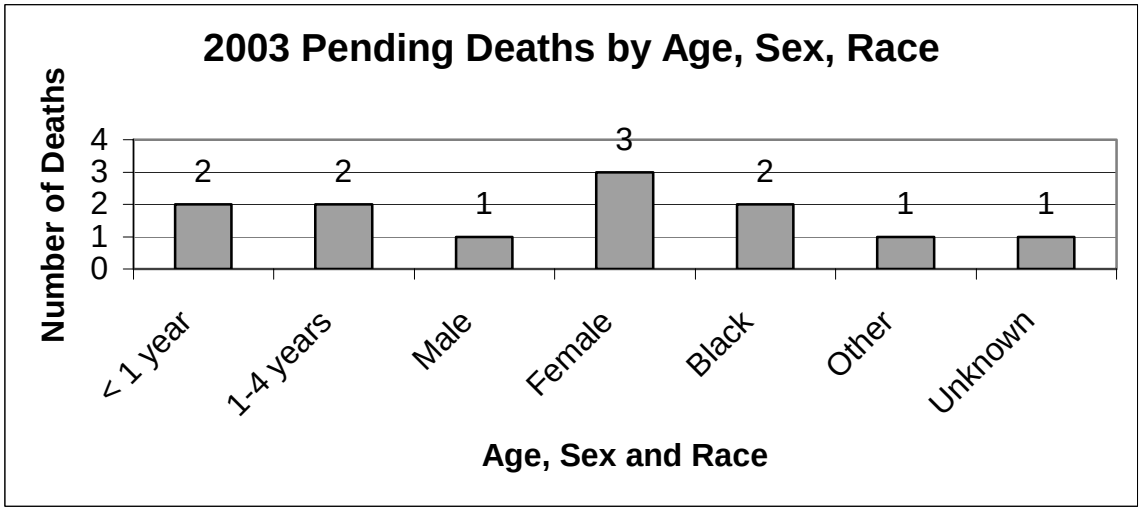
Pending investigations represent 2.1% of the total reviewed deaths.

Overview

Pending investigations are cases presently undergoing investigations that remain open until the cause and manner of death can be determined.

Key Findings:

- 4 cases are pending.
- 50% of victims are less than 1 year of age; the remaining victims are between the ages of 1 and 4 years of age.
- 75% of victims are female.
- 50% of victims are black.



* For race or age groups not represented on chart, there were zero deaths.

Recovered Cases

Recovered cases represent 8.3% of the total reviewed deaths.

Overview

Recovered cases are ones that were not submitted with a 24 hours time period required by law but have been review and investigated. Since 2001 there has been a drastic and steady decline in the number of recovered cases. There has been a 60% decrease in the number of recover cases from 40 in 2001 to 16 in 2003.

YEAR	NUMBER OF RECOVERED CASES
2001	40
2002	15
2003	16

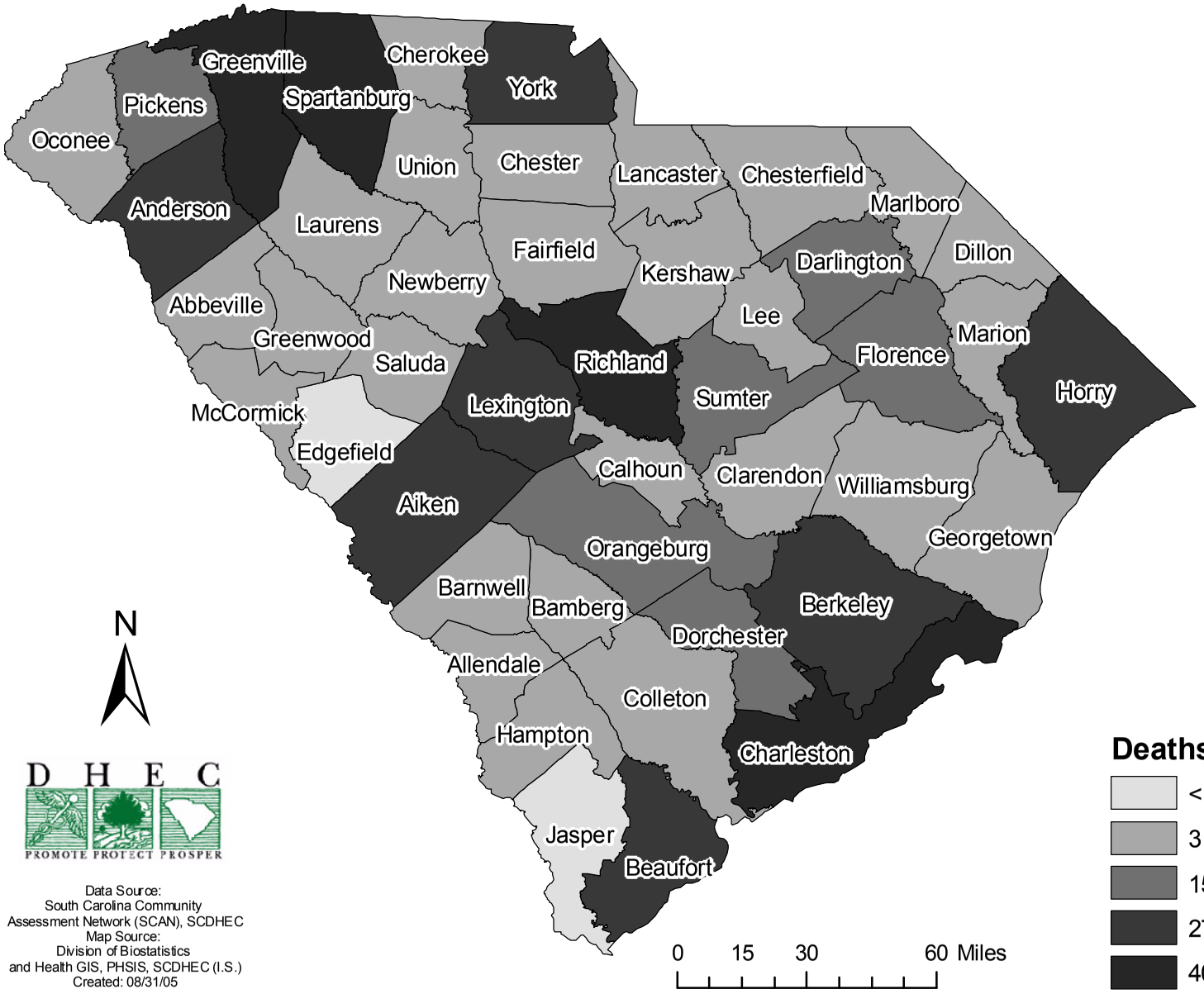
COUNTY	NUMBER OF CASES
Aiken	2
Anderson	1
Beaufort	1
Berkeley	1
Charleston	1
Clarendon	1
Dorchester	1
Greenville	1
Greenwood	1
Lee	1
McCormick	1
Orangeburg	1
Pickens	2
York	1
TOTAL	**16**

Vital Records Data

Additional state and county level data available by accessing the South Carolina Community Assessment Network:

http://scangis.dhec.sc.gov/scan

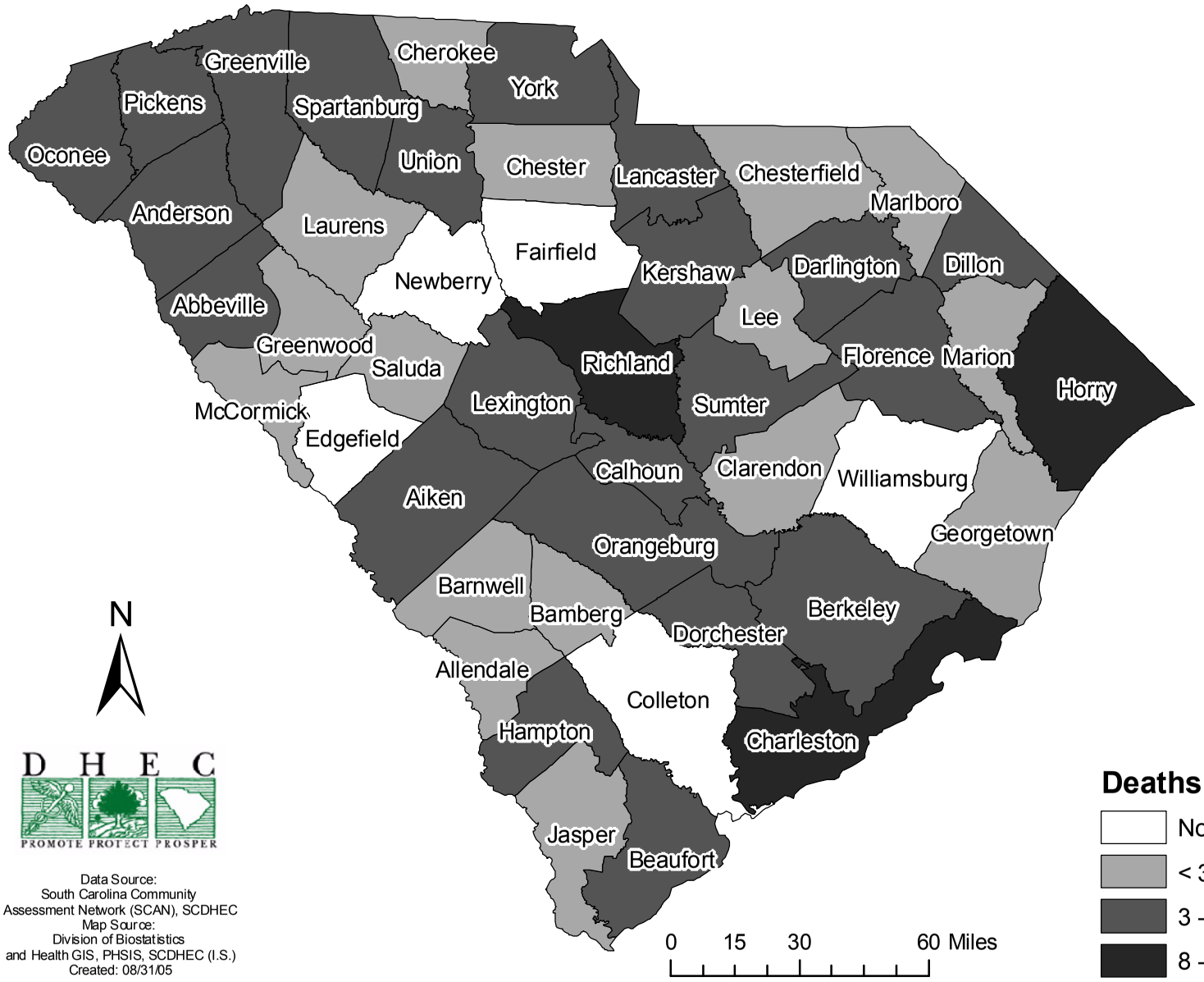
Mortality from All Causes Among Children Aged 0 - 17 Years
(South Carolina Resident Mortality Data, 2003)



D H E C
PROMOTE PROTECT PROSPER

Data Source:
South Carolina Community
Assessment Network (SCAN), SCDHEC
Map Source:
Division of Biostatistics
and Health GIS, PHSIS, SCDHEC (I.S.)
Created: 08/31/05

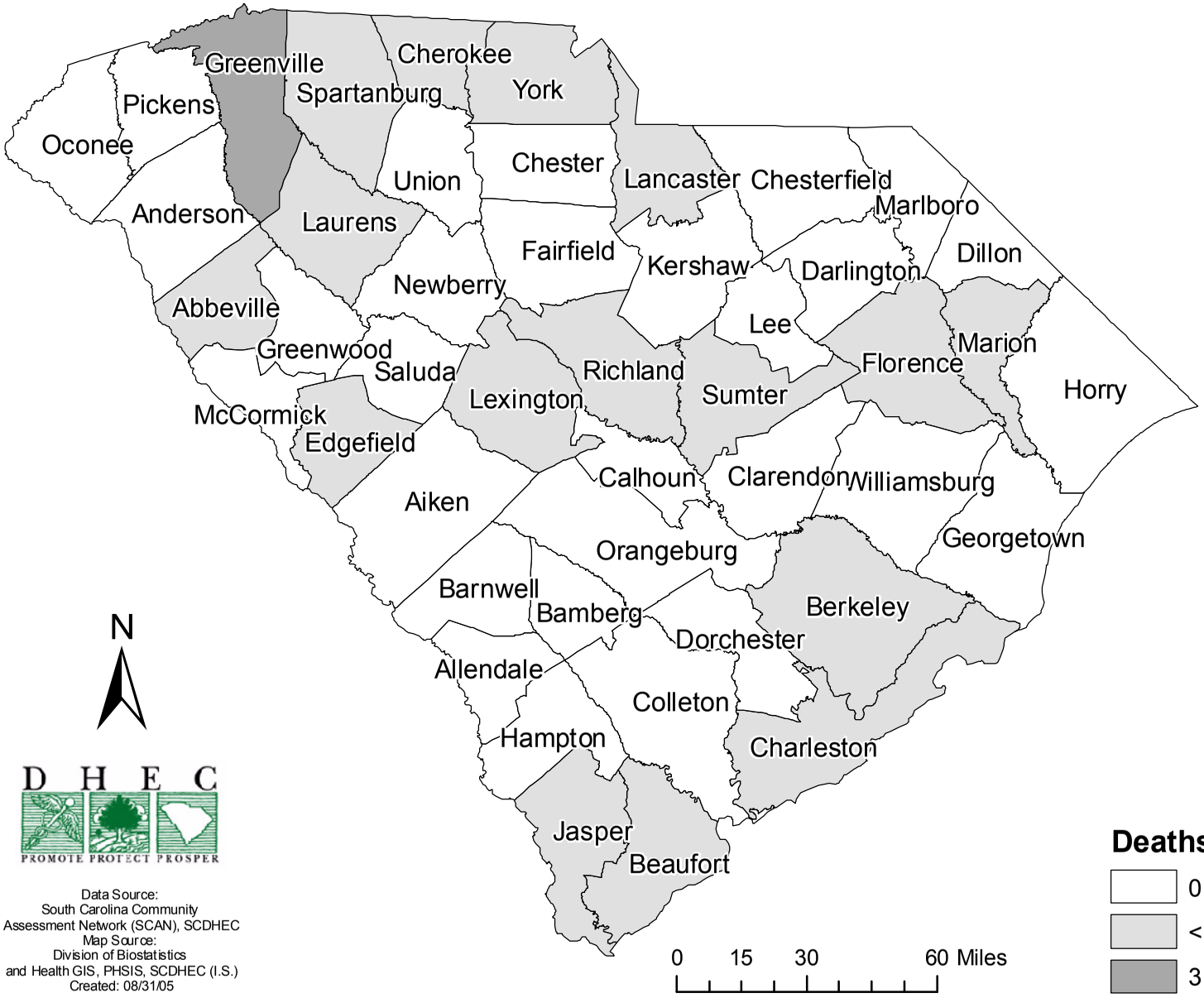
Accidental Deaths Among Children Aged 0 - 17 years
(South Carolina Resident Mortality Data, 2003)



D H E C
PROMOTE PROTECT PROSPER

Data Source:
South Carolina Community
Assessment Network (SCAN), SCDHEC
Map Source:
Division of Biostatistics
and Health GIS, PHSIS, SCDHEC (I.S.)
Created: 08/31/05

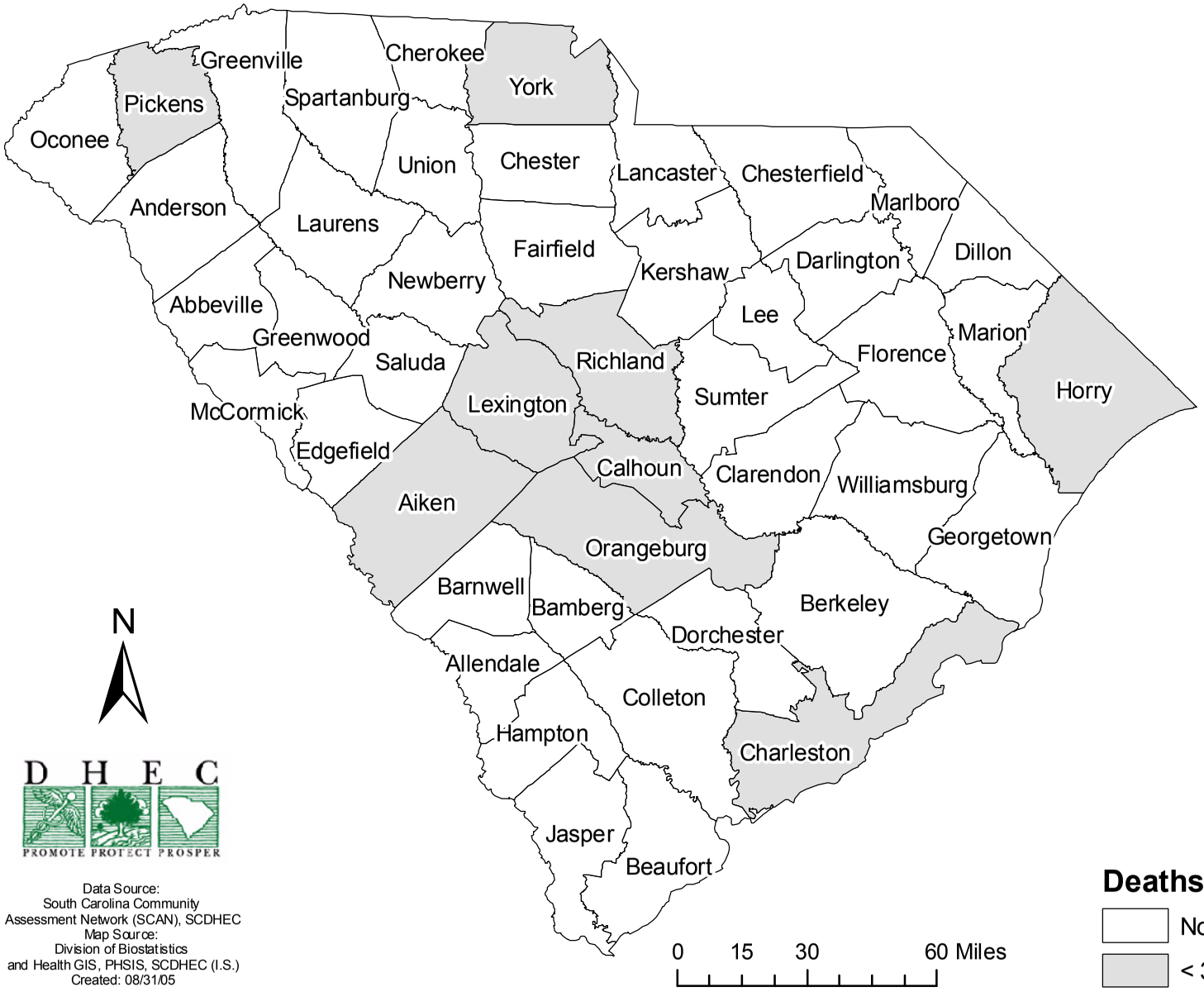
Homicidal Deaths Among Children Aged 0 - 17 Years (South Carolina Resident Mortality Data, 2003)



D H E C
PROMOTE PROTECT PROSPER

Data Source:
South Carolina Community Assessment Network (SCAN), SCDHEC
Map Source:
Division of Biostatistics and Health GIS, PHSIS, SCDHEC (I.S.)
Created: 08/31/05

Suicidal Deaths Among Children Aged 0 - 17 Years
(South Carolina Resident Mortality Data, 2003)



D H E C
PROMOTE PROTECT PROSPER

Data Source:
South Carolina Community
Assessment Network (SCAN), SCDHEC
Map Source:
Division of Biostatistics
and Health GIS, PHSIS, SCDHEC (I.S.)
Created: 08/31/05

Death Statistics for Residents of South Carolina														
Year(s): 2003														
Cause of Death: Accidents														
	Sex													
	Male						Female						Selection Total	
Race	White		Black		All		White		Black		All			
Age	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
0 to 1	4	22.6	0	0	4	14.1	5	29.6	4	40.7	9	33.2	13	23.5
1 to 4	12	17	4	9.9	17	15	5	7.4	5	12.7	10	9.2	27	12.2
5 to 9	10	11.5	4	7.9	14	10	4	4.9	2	4.1	6	4.5	20	7.4
10 to 14	8	8.6	9	15.3	17	11.1	8	9.1	5	8.7	13	8.8	30	10
15 to 17	29	52.4	12	37.4	42	47.3	21	41.1	5	15.6	26	30.8	68	39.2
Selection Total	63	19.5	29	15.1	94	17.9	43	14.1	21	11.2	64	12.8	158	15.4
Footnote	Rates per 100,000													
	Rates calculated with small numbers are unreliable and should be used cautiously													

Death Statistics for Residents of South Carolina														
Year(s): 2003														
Cause of Death: Motor vehicle accidents														
	Sex													
	Male						Female						Selection Total	
Race	White		Black		All		White		Black		All			
Age	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
0 to 1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1 to 4	1	1.4	2	4.9	4	3.5	1	1.5	2	5.1	3	2.8	7	3.2
5 to 9	8	9.2	1	2	9	6.4	2	2.5	2	4.1	4	3	13	4.8
10 to 14	3	3.2	3	5.1	6	3.9	7	8	1	1.7	8	5.4	14	4.6
15 to 17	23	41.6	10	31.2	33	37.2	20	39.1	5	15.6	25	29.6	58	33.5
Selection Total	35	10.8	16	8.3	52	9.9	30	9.8	10	5.4	40	8	92	9
Footnote	Rates per 100,000													
	Rates calculated with small numbers are unreliable and should be used cautiously													

Death Statistics for Residents of South Carolina														
Year(s): 2003														
Cause of Death: Water, air and space and other and unspecified transport accidents														
	Sex													
	Male						Female						Selection Total	
Race	White		Black		All		White		Black		All			
Age	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
0 to 1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1 to 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0
5 to 9	0	0	1	2	1	0.7	0	0	0	0	0	0	1	0.4
10 to 14	0	0	0	0	0	0	0	0	0	0	0	0	0	0
15 to 17	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Selection Total	0	0	1	0.5	1	0.2	0	0	0	0	0	0	1	0.1
Footnote	Rates per 100,000													
	Rates calculated with small numbers are unreliable and should be used cautiously													

Death Statistics for Residents of South Carolina														
Year(s): 2003														
Cause of Death: Falls														
	Sex													
	Male						Female						Selection Total	
Race	White		Black		All		White		Black		All			
Age	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
0 to 1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1 to 4	0	0	0	0	0	0	1	1.5	0	0	1	0.9	1	0.5
5 to 9	0	0	0	0	0	0	0	0	0	0	0	0	0	0
10 to 14	0	0	0	0	0	0	0	0	0	0	0	0	0	0
15 to 17	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Selection Total	0	0	0	0	0	0	1	0.3	0	0	1	0.2	1	0.1
Footnote	Rates per 100,000													
	Rates calculated with small numbers are unreliable and should be used cautiously													

Death Statistics for Residents of South Carolina														
Year(s): 2003														
Cause of Death: Accidental discharge of firearms														
	Sex													
	Male						Female						Selection Total	
Race	White		Black		All		White		Black		All			
Age	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
0 to 1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1 to 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0
5 to 9	0	0	0	0	0	0	0	0	0	0	0	0	0	0
10 to 14	1	1.1	0	0	1	0.7	0	0	0	0	0	0	1	0.3
15 to 17	1	1.8	0	0	1	1.1	0	0	0	0	0	0	1	0.6
Selection Total	2	0.6	0	0	2	0.4	0	0	0	0	0	0	2	0.2
Footnote	Rates per 100,000													
	Rates calculated with small numbers are unreliable and should be used cautiously													

Death Statistics for Residents of South Carolina														
Year(s): 2003														
Cause of Death: Accidental drowning and submersion														
	Sex													
	Male						Female						Selection Total	
Race	White		Black		All		White		Black		All			
Age	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
0 to 1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1 to 4	7	9.9	0	0	7	6.2	0	0	0	0	0	0	7	3.2
5 to 9	1	1.1	1	2	2	1.4	0	0	0	0	0	0	2	0.7
10 to 14	0	0	2	3.4	2	1.3	0	0	1	1.7	1	0.7	3	1
15 to 17	1	1.8	0	0	2	2.3	0	0	0	0	0	0	2	1.2
Selection Total	9	2.8	3	1.6	13	2.5	0	0	1	0.5	1	0.2	14	1.4
Footnote	Rates per 100,000													
	Rates calculated with small numbers are unreliable and should be used cautiously													

Death Statistics for Residents of South Carolina

Year(s): 2003

Cause of Death: Accidental exposure to smoke, fire and flames

	Sex													
	Male						Female						Selection Total	
Race	White		Black		All		White		Black		All			
Age	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
0 to 1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1 to 4	2	2.8	0	0	2	1.8	0	0	3	7.6	3	2.8	5	2.3
5 to 9	1	1.1	1	2	2	1.4	0	0	0	0	0	0	2	0.7
10 to 14	2	2.2	3	5.1	5	3.3	0	0	3	5.2	3	2	8	2.7
15 to 17	0	0	1	3.1	1	1.1	0	0	0	0	0	0	1	0.6
Selection Total	5	1.5	5	2.6	10	1.9	0	0	6	3.2	6	1.2	16	1.6
Footnote	Rates per 100,000													
	Rates calculated with small numbers are unreliable and should be used cautiously													

Death Statistics for Residents of South Carolina

Year(s): 2003

Cause of Death: Accidental poisoning and exposure to noxious substances

	Sex													
	Male						Female						Selection Total	
Race	White		Black		All		White		Black		All			
Age	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
0 to 1	0	0	0	0	0	0	0	0	1	10.2	1	3.7	1	1.8
1 to 4	0	0	0	0	0	0	1	1.5	0	0	1	0.9	1	0.5
5 to 9	0	0	0	0	0	0	0	0	0	0	0	0	0	0
10 to 14	0	0	0	0	0	0	0	0	0	0	0	0	0	0
15 to 17	2	3.6	1	3.1	3	3.4	1	2	0	0	1	1.2	4	2.3
Selection Total	2	0.6	1	0.5	3	0.6	2	0.7	1	0.5	3	0.6	6	0.6
Footnote	Rates per 100,000													
	Rates calculated with small numbers are unreliable and should be used cautiously													

Death Statistics for Residents of South Carolina

Year(s): 2003

Cause of Death: Other and unspecified nontransport accidents and their sequelae

	Sex													
	Male						Female						Selection Total	
Race	White		Black		All		White		Black		All			
Age	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
0 to 1	4	22.6	0	0	4	14.1	5	29.6	3	30.6	8	29.5	12	21.7
1 to 4	2	2.8	1	2.5	3	2.7	2	3	0	0	2	1.8	5	2.3
5 to 9	0	0	0	0	0	0	1	1.2	0	0	1	0.8	1	0.4
10 to 14	2	2.2	1	1.7	3	2	0	0	0	0	0	0	3	1
15 to 17	2	3.6	0	0	2	2.3	0	0	0	0	0	0	2	1.2
Selection Total	10	3.1	2	1	12	2.3	8	2.6	3	1.6	11	2.2	23	2.2
Footnote	Rates per 100,000													
	Rates calculated with small numbers are unreliable and should be used cautiously													

Death Statistics for Residents of South Carolina														
Year(s): 2003														
Cause of Death: Other land transport accidents														
	Sex													
	Male						Female						Selection	
Race	White		Black		All		White		Black		All			
Age	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
0 to 1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1 to 4	0	0	1	2.5	1	0.9	0	0	0	0	0	0	1	0.5
5 to 9	0	0	0	0	0	0	1	1.2	0	0	1	0.8	1	0.4
10 to 14	0	0	0	0	0	0	1	1.1	0	0	1	0.7	1	0.3
15 to 17	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Selection Total	0	0	1	0.5	1	0.2	2	0.7	0	0	2	0.4	3	0.3
	Rates per 100,000													
Footnote	Rates calculated with small numbers are unreliable and should be used cautiously													

Top Five Causes of Death for Residents of South Carolina by Age (Years)						
	Less than 1			1 to 4		
Rank	Cause of Death	Number	Rate	Cause of Death	Number	Rate
1	Certain conditions originating in the perinatal period	268	483.7	**Accidents**	27	12.2
2	Congential malformations, deformations and chromosomal abnormalities	71	128.1	**Homicide (Assault)**	9	4.1
3	**Accidents**	13	23.5	Diseases of heart	6	2.7
4	Diseases of heart	10	18	Septicemia	4	1.8
5	Septicemia	8	14.4	Tie between Cancer (Malignant neoplasms) and Influenza and pneumonia	2	0.9

	5 to 9			10 to 14		
Rank	Cause of Death	Number	Rate	Cause of Death	Number	Rate
1	**Accidents**	20	7.4	**Accidents**	30	10
2	Cancer (Malignant neoplasms)	5	1.8	Diseases of heart	7	2.3
3	Congential malformations, deformations and chromosomal abnormalities	4	1.5	Cancer (Malignant neoplasms)	6	2
4	Influenza and pneumonia	3	1.1	Tie between **Suicide (Intentional self-harm); Homicide (Assault)**; Chronic lower respiratory disease; and congenital malformations, deformations and chromosomal abnormalities	3	1
5	Tie between Diabetes mellitus; Diseases of heart; **Homicide (Assault)**; In situ neoplasms, benign neoplasms and neoplasms of uncertain or uknown behavior; and septicemia	1	0.4	Septicemia	2	0.7

	15 to 17		
Rank	Cause of Death	Number	Rate
1	**Accidents**	68	39.2
2	Tie between **Homicide (Assault); and** Cancer (Malignant neoplasms)	9	5.2
3	Diseases of heart	7	4
4	Suicide (Intentional self-harm)	6	3.5
5	Cerebrovascular disease	3	1.7

Injury Data

Death represents only a part of the picture of threats to health and safety of children. Injury is a valuable tool for determining needs of a community's children.

Presented here, courtesy of the Office of Research and Statistics, SC Budget and Control Board, is a summary of the top causes of injury for children 0-17 years of age in each South Carolina County.

2003 – South Carolina Injury Data

Children Age 0-17

Note: Rates per 10,000

Note: *Indicates rate is one standard deviation about the statewide average

Source: SC UB 92 Inpatient and Outpatient Billing Data

Reason	Rate
ALL UNINTENTIONAL INJURIES	**992.0**
Piercing or Cutting	74.2
Drowning/Near Drowning	0.2
Falls	72.6
Fire and Flame	18.5
Firearm and Airgun	3.7
Foreign Body Entering Eye or Other Opening	30.1
Agricultural, Industrial, Recreational Machinery	1.2
Motor Vehicle Crash	97
Motorcycle	2.2
Pedal Cyclist	1.3
Pedestrian	4.9
Nontraffic Transportation	5.1
Natural, Environmental Factors	58.4
Other Bites and Stings	40.0
Dog Bites	15.3
Poisoning	16.6
Pressurized and Explosive Materials	1.0
Sports and Recreation	103.3
Struck By/Against Person or Object in Sports	43.6
Pedal Cycle in Sports	31.0
Water Ski in Sports	0.1
Drowning/Near Drowning in Sports	0.4
Diving in Sports	0.3
Falls in Sports	25.1
Off Road Vehicles in Sports	10.0
Other Water Related in Sports	0.1
Animal Riding in Sports	1.8
Unpowered Aircraft in Sports	0.0
Other Vehicles in Sports	0.9
Struck By/Against Person/Object or Caught In/Between Objects	166.5
Suffocation/Near Suffocation	2.1
Electrical Current	0.7
Effects of Radiation	0.2
Adverse Effects of Therapeutic Drugs	7.6

2003 – South Carolina Injury Data

Children Age 0-17

Note: Rates per 10,000

Note: *Indicates rate is one standard deviation about the statewide average

Source: SC UB 92 Inpatient and Outpatient Billing Data

Reason	Rate
ALL INTENTIONAL INJURIES	**32.4**
Suicide/Attempted Suicide	5.6
Homicide/Attempted Homicide/Assault	26.7
Injury Due to Legal Intervention	0.2
TOTAL	**992.0**

2003 Top 5 Reasons for Injury by County

Rate of Children Age 0-17

Note: Rates per 10,000

Note: *Indicates rate is one standard deviation above the statewide average

Source: SC UB 92 Inpatient and Outpatient Billing Data

County	Reason	Rate
Abbeville	Struck By/Against Person/Object or Caught In/Between Objects	138.9
	Sports and Recreation	129.9
	Piercing or Cutting Object	88.1
	Natural Environmental Factors	83.6
	Motor Vehicle Crash	59.7
Aiken	Struck By/Against Person/Object or Caught In/Between Objects	93.3
	Sports and Recreation	85.5
	Motor Vehicle Crash	56.2
	Piercing or Cutting Object	47.7
	Falls	44.0
Allendale	Struck By/Against Person/Object or Caught In/Between Objects	290.8*
	Motor Vehicle Crash	158.6*
	Sports and Recreation	148.7*
	Natural Environmental Factors	95.8*
	Falls	92.5
Anderson	Struck By/Against Person/Object or Caught In/Between Objects	145.9
	Motor Vehicle Crash	109.2
	Sports and Recreation	95.3
	Piercing or Cutting Object	73.1
	Falls	67.8
Bamberg	Struck By/Against Person/Object or Caught In/Between Objects	163.8
	Piercing or Cutting Object	106.8*
	Falls	106.8
	Motor Vehicle Crash	83.1
	Sports and Recreation	68.9
Barnwell	Struck By/Against Person/Object or Caught In/Between Objects	238.0*
	Sports and Recreation	155.0*
	Falls	97.1
	Piercing or Cutting Object	95.5
	Motor Vehicle Crash	90.8
Beaufort	Struck By/Against Person/Object or Caught In/Between Objects	75.1
	Motor Vehicle Crash	56.0
	Sports and Recreation	51.5
	Piercing or Cutting Object	36.5
	Falls	32.7

Berkeley	Struck By/Against Person/Object or Caught In/Between Objects	217.7
	Motor Vehicle Crash	107.0
	Sports and Recreation	90.9
	Piercing or Cutting Object	85.1
	Falls	73.8
Calhoun	Struck By/Against Person/Object or Caught In/Between Objects	120.7
	Motor Vehicle Crash	90.5
	Sports and Recreation	71.3
	Falls	60.3
	Piercing or Cutting Object	57.6
Charleston	Struck By/Against Person/Object or Caught In/Between Objects	147.0
	Motor Vehicle Crash	93.7
	Piercing or Cutting Object	81.0
	Sports and Recreation	76.5
	Falls	73.2
Cherokee	Struck By/Against Person/Object or Caught In/Between Objects	239.6*
	Sports and Recreation	210.3*
	Motor Vehicle Crash	145.2*
	Piercing or Cutting Object	101.6
	Natural, Environmental Factors	85.1*
Chester	Struck By/Against Person/Object or Caught In/Between Objects	179.5
	Sports and Recreation	122.2
	Piercing or Cutting Object	110.1*
	Motor Vehicle Crash	81.5
	Falls	76.0
Chesterfield	Struck By/Against Person/Object or Caught In/Between Objects	146.6
	Sports and Recreation	76.3
	Motor Vehicle Crash	58.6
	Natural, Environmental Factors	52.3
	Piercing or Cutting Object	51.5
Clarendon	Struck By/Against Person/Object or Caught In/Between Objects	199.3
	Sports and Recreation	121.0
	Motor Vehicle Crash	103.9
	Piercing or Cutting Object	102.7
	Natural, Environmental Factors	90.5*
Colleton	Struck By/Against Person/Object or Caught In/Between Objects	255.7*
	Motor Vehicle Crash	161.6*
	Natural, Environmental Factors	111.2*
	Piercing or Cutting Object	110.2*
	Sports and Recreation	105.5

Darlington	Struck By/Against Person/Object or Caught In/Between Objects	191.8
	Motor Vehicle Crash	138.3*
	Sports and Recreation	114.2
	Piercing or Cutting Object	68.0
	Falls	66.4
Dillon	Struck By/Against Person/Object or Caught In/Between Objects	199.0
	Motor Vehicle Crash	144.3*
	Piercing or Cutting Object	138.5*
	Sports and Recreation	112.9
	Natural, Environmental Factors	101.3*
Dorchester	Struck By/Against Person/Object or Caught In/Between Objects	251.3*
	Sports and Recreation	122.1
	Motor Vehicle Crash	103.0
	Piercing or Cutting Object	88.7
	Falls	82.2
Edgefield	Sports and Recreation	114.0
	Struck By/Against Person/Object or Caught In/Between Objects	102.1
	Natural, Environmental Factors	54.5
	Motor Vehicle Crash	47.7
	Piercing or Cutting Object	44.2
	Falls	44.2
Fairfield	Struck By/Against Person/Object or Caught In/Between Objects	244.8*
	Sports and Recreation	165.4*
	Motor Vehicle Crash	147.5*
	Falls	97.3
	Piercing or Cutting Object	90.8
Florence	Struck By/Against Person/Object or Caught In/Between Objects	199.2
	Motor Vehicle Crash	128.3
	Sports and Recreation	103.9
	Falls	78.5
	Piercing or Cutting Object	76.7
Georgetown	Struck By/Against Person/Object or Caught In/Between Objects	257.6*
	Sports and Recreation	169.5*
	Motor Vehicle Crash	143.3*
	Piercing or Cutting Object	109.5*
	Falls	104.4
Greenville	Struck By/Against Person/Object or Caught In/Between Objects	189.1
	Sports and Recreation	128.6
	Piercing or Cutting Object	81.2
	Falls	80.8
	Natural, Environmental Factors	66.5

Greenwood	Struck By/Against Person/Object or Caught In/Between Objects	205.2
	Sports and Recreation	127.6
	Motor Vehicle Crash	114.9
	Piercing or Cutting Object	97.1
	Falls	74.7
Hampton	Struck By/Against Person/Object or Caught In/Between Objects	212.5
	Sports and Recreation	130.6
	Piercing or Cutting Object	125.4*
	Motor Vehicle Crash	114.9
	Falls	101.0
Horry	Struck By/Against Person/Object or Caught In/Between Objects	238.3*
	Sports and Recreation	136.4
	Motor Vehicle Crash	130.8
	Falls	92.2
	Piercing or Cutting Object	88.7
Jasper	Sports and Recreation	65.5
	Struck By/Against Person/Object or Caught In/Between Objects	63.6
	Motor Vehicle Crash	48.6
	Natural, Environmental Factors	41.2
	Falls	37.4
Kershaw	Struck By/Against Person/Object or Caught In/Between Objects	165.7
	Sports and Recreation	140.3
	Motor Vehicle Crash	120.7
	Falls	77.8
	Piercing or Cutting Object	70.5
Lancaster	Struck By/Against Person/Object or Caught In/Between Objects	204.8
	Motor Vehicle Crash	122.4
	Falls	84.4
	Piercing or Cutting Object	76.6
	Struck By/Against Person/Object in Sports	56.7
Laurens	Falls	261.8*
	Struck By/Against Person/Object or Caught In/Between Objects	225.0
	Motor Vehicle Crash	98.9
	Piercing or Cutting Object	92.2
	Natural, Environmental Factors	89.3*
Lee	Struck By/Against Person/Object or Caught In/Between Objects	147.2
	Motor Vehicle Crash	118.2
	Sports and Recreation	93.0
	Falls	63.9
	Piercing or Cutting Object	52.3

Lexington	Struck By/Against Person/Object or Caught In/Between Objects	125.5
	Motor Vehicle Crash	91.5
	Sports and Recreation	69.1
	Falls	52.4
	Piercing or Cutting Object	50.1
Marion	Struck By/Against Person/Object or Caught In/Between Objects	172.0
	Sports and Recreation	127.2
	Motor Vehicle Crash	86.5
	Piercing or Cutting Object	75.1
	Natural, Environmental Factors	65.7
Marlboro	Struck By/Against Person/Object or Caught In/Between Objects	147.3
	Sports and Recreation	102.7
	Motor Vehicle Crash	74.3
	Piercing or Cutting Object	71.6
	Natural, Environmental Factors	64.9
McCormick	Sports and Recreation	126.9
	Struck By/Against Person/Object or Caught In/Between Objects	115.9
	Motor Vehicle Crash	93.8
	Piercing or Cutting Object	77.3
	Falls	49.7
	Foreign Body Entering Eye or Other Opening	49.7*
	Natural, Environmental Factors	49.7
Newberry	Struck By/Against Person/Object or Caught In/Between Objects	185.9
	Sports and Recreation	139.7
	Motor Vehicle Crash	114.9
	Piercing or Cutting Object	111.5*
	Falls	82.2
Oconee	Struck By/Against Person/Object or Caught In/Between Objects	208.1
	Sports and Recreation	136.6
	Piercing or Cutting Object	105.3
	Falls	93.0
	Motor Vehicle Crash	92.3
Orangeburg	Struck By/Against Person/Object or Caught In/Between Objects	179.1
	Motor Vehicle Crash	128.0
	Piercing or Cutting Object	80.2
	Falls	77.7
	Sports and Recreation	74.8

Pickens	Struck By/Against Person/Object or Caught In/Between Objects	197.9
	Sports and Recreation	166.5*
	Piercing or Cutting Object	102.2
	Falls	84.1
	Motor Vehicle Crash	73.3
Richland	Struck By/Against Person/Object or Caught In/Between Objects	142.1
	Motor Vehicle Crash	87.9
	Sports and Recreation	86.5
	Piercing or Cutting Object	53.1
	Falls	44.8
Saluda	Motor Vehicle Crash	57.5
	Struck By/Against Person/Object or Caught In/Between Objects	53.3
	Sports and Recreation	53.3
	Falls	29.8
	Natural, Environmental Factors	27.7
Spartanburg	Struck By/Against Person/Object or Caught In/Between Objects	122.5
	Sports and Recreation	100.5
	Motor Vehicle Crash	91.9
	Falls	67.8
	Piercing or Cutting Object	66.8
Sumter	Struck By/Against Person/Object or Caught In/Between Objects	147.4
	Motor Vehicle Crash	119.7
	Sports and Recreation	97.5
	Piercing or Cutting Object	70.4
	Falls	63.8
Union	Struck By/Against Person/Object or Caught In/Between Objects	195.5
	Sports and Recreation	112.8
	Motor Vehicle Crash	90.2
	Falls	76.1
	Natural, Environmental Factors	62.0
Williamsburg	Struck By/Against Person/Object or Caught In/Between Objects	188.7
	Sports and Recreation	114.4
	Falls	76.3
	Motor Vehicle Crash	67.5
	Piercing or Cutting Object	65.5
York	Struck By/Against Person/Object or Caught In/Between Objects	85.5
	Falls	80.6
	Motor Vehicle Crash	64.3
	Sports and Recreation	56.4
	Piercing or Cutting Object	49.4

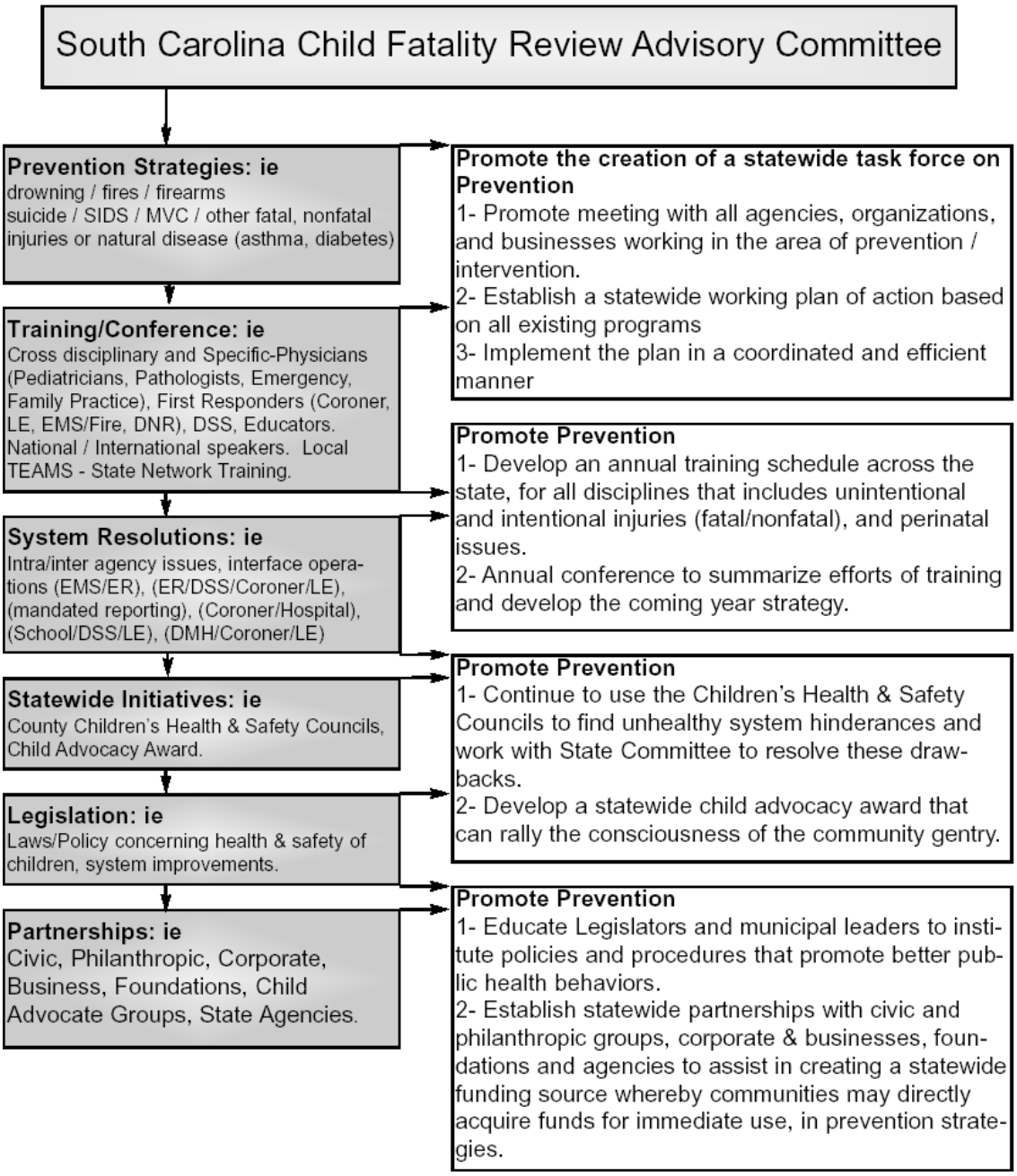
Appendices

APPENDICES

STATE CHILD FATALITY ADVISORY COMMITTEE

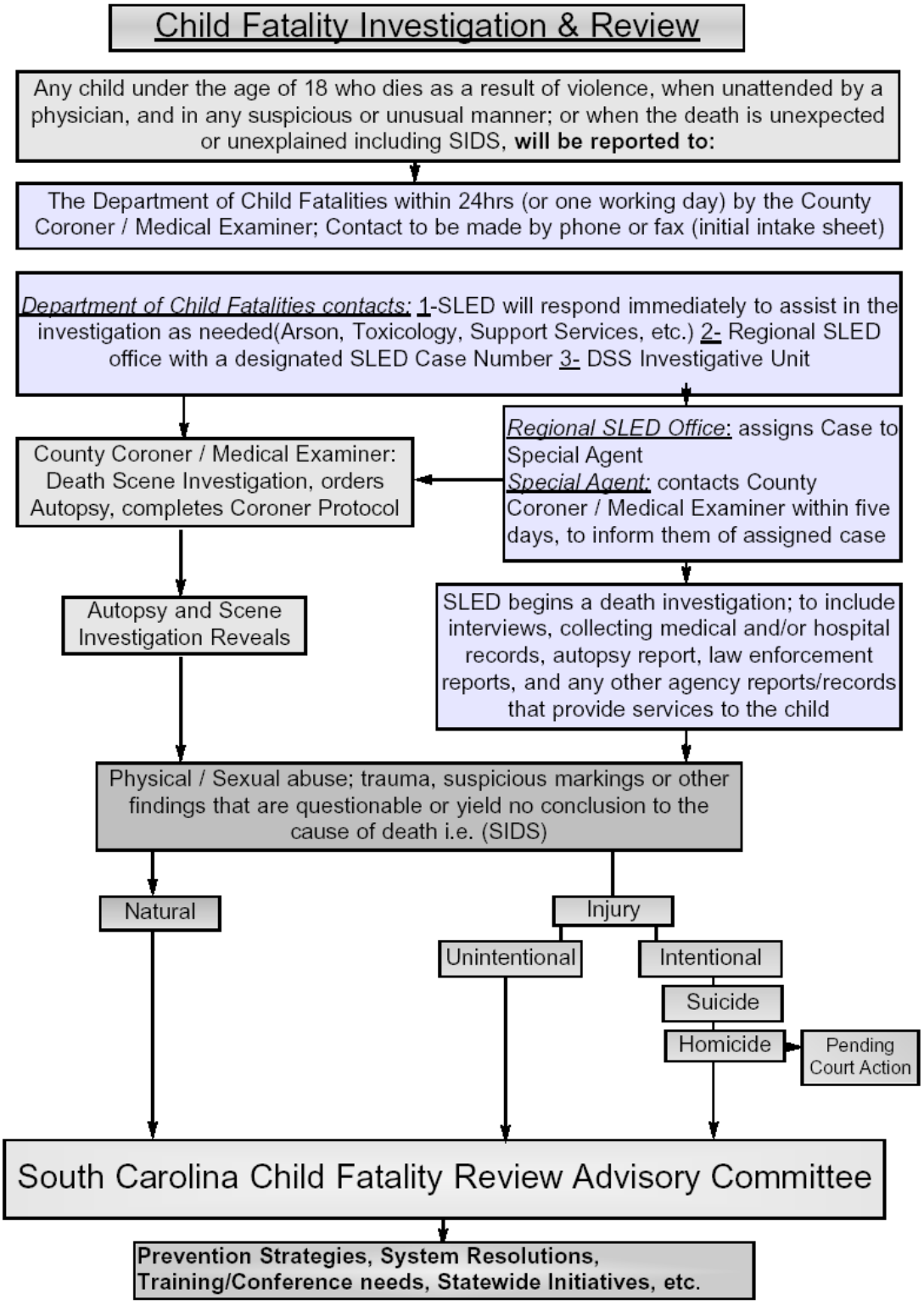
HANNAH BONSU	***Department of Alcohol & Other Drug Abuse Services***
DENNIS BURDETTE	***SC Department of Juvenile Justice***
JENNIFER BUSTER	***SC Department of Disabilities and Special Needs***
ROBERT EDGE	***SC Coroner's Association/Horry County Coroner***
CAROLYN EVATT	***SC Department of Social Services***
ANGELA FLOWERS	***SC Department of Mental Health***
LAURA HUDSON	***SC Victims Assistance Network***
CLARA S. JAMES (BEEBE)	***Coordinator of the Network of Children's Advocacy Centers Children's Law Office***
DR. HARVEY KAYMAN	***Director of the MCH Bureau Department of Health & Environmental Control***
JOHN METTERS	***Governor's Appointment - Attorney***
DR. CLAY NICHOLS	***Richland Memorial Hospital/Dept. of Pathology***
EMILY REINHART LT.	***SC Law Enforcement Division***
DR. GRATIN SMITH	***SC Academy of Pediatrics***
KIMBERLY W. SMITH	***Office of Safe Schools & Youth Services SC Department of Education***
RITA YARBOROUGH	***SC DPS Criminal Justice Academy***

Appendix A



BOTTOM LINE STRATEGY:::: Every child is entitled to live in safety & in health and to survive into adulthood.

Appendix B


Child Fatality Investigation & Review
Any child under the age of 18 who dies as a result of violence, when unattended by a physician, and in any suspicious or unusual manner; or when the death is unexpected or unexplained including SIDS, will be reported to:
The Department of Child Fatalities within 24hrs (or one working day) by the County Coroner / Medical Examiner; Contact to be made by phone or fax (initial intake sheet)
Department of Child Fatalities contacts: 1-SLED will respond immediately to assist in the investigation as needed(Arson, Toxicology, Support Services, etc.) 2- Regional SLED office with a designated SLED Case Number 3- DSS Investigative Unit
Regional SLED Office: assigns Case to Special Agent
Special Agent: contacts County Coroner / Medical Examiner within five days, to inform them of assigned case
County Coroner / Medical Examiner: Death Scene Investigation, orders Autopsy, completes Coroner Protocol
Autopsy and Scene Investigation Reveals
SLED begins a death investigation; to include interviews, collecting medical and/or hospital records, autopsy report, law enforcement reports, and any other agency reports/records that provide services to the child
Physical / Sexual abuse; trauma, suspicious markings or other findings that are questionable or yield no conclusion to the cause of death i.e. (SIDS)
Natural
Injury
Unintentional
Intentional
Suicide
Homicide
Pending Court Action
South Carolina Child Fatality Review Advisory Committee
Prevention Strategies, System Resolutions, Training/Conference needs, Statewide Initiatives, etc.

Appendix C

TITLE 20. DOMESTIC RELATIONS

CHAPTER 7. CHILDREN'S CODE

ARTICLE 26. DEPARTMENT OF CHILD FATALITIES

STATE CHILD FATALITY ADVISORY COMMITTEE

SECTION 20-7-5900. Definitions. [SC ST SEC 20-7-5900]

For purposes of this article:

(1) "Child" means a person under eighteen years of age.

(2) "Committee" means the State Child Fatality Advisory Committee.

(3) "Department" means the State Law Enforcement Division's Department of Child Fatalities.

(4) "Local child protective services agency" means the county department of social services for the jurisdiction where a deceased child resided.

(5) "Meeting" means both in-person meetings and meetings through telephone conferencing.

(6) "Preventable death" means a death which reasonable medical, social, legal, psychological, or educational intervention may have prevented.

(7) "Provider of medical care" means a licensed health care practitioner who provides, or a licensed health care facility through which is provided, medical evaluation or treatment, including dental and mental health evaluation or treatment.

(8) "Working day" means Monday through Friday, excluding official state holidays.

(9) "Unexpected death" includes all child deaths which, before investigation, appear possibly to have been caused by trauma, suspicious or obscure circumstances, or child abuse or neglect.

SECTION 20-7-5902. State policy. [SC ST SEC 20-7-5902]

It is the policy of this State that:

(1) Every child is entitled to live in safety and in health and to survive into adulthood;

(2) Responding to child deaths is a state and a community responsibility;

(3) When a child dies, the response by the State and the community to the death must include an

accurate and complete determination of the cause of death, the provision of services to surviving family members, and the development and implementation of measures to prevent future deaths from similar causes and may include court action, including prosecution of persons who may be responsible for the death and family court proceedings to protect other children in the care of the responsible person;

(4) Professionals from disparate disciplines and agencies who have responsibilities for children and expertise that can promote child safety and well-being should share their expertise and knowledge toward the goals of determining the causes of children's deaths, planning and providing services to surviving children and nonoffending family members, and preventing future child deaths;

(5) A greater understanding of the incidence and causes of child deaths is necessary if the State is to prevent future child deaths;

(6) Multi-disciplinary and multi-agency reviews of child deaths can assist the State in the investigation of child deaths, in the development of a greater understanding of the incidence and causes of child deaths and the methods for preventing such deaths, and in identifying gaps in services to children and families;

(7) Access to information regarding deceased children and their families by the Department of Child Fatalities is necessary to achieve the department's purposes and duties; and

(8) Competent investigative services must be sensitive to the needs of South Carolina's children and their families and not unnecessarily intrusive and should be achieved through training, awareness, and technical assistance.

SECTION 20-7-5905. Department of Child Fatalities established. [SC ST SEC 20-7-5905]

There is created within the State Law Enforcement Division (SLED) the Department of Child Fatalities which is under the supervision of the Chief of SLED.

SECTION 20-7-5910. Child Fatality Advisory Committee established; composition; officers; meetings; quorum; staff and administrative support. [SC ST SEC 20-7-5910]

(A) There is created a multi-disciplinary State Child Fatality Advisory Committee composed of:

(1) the Commissioner of the South Carolina Department of Social Services;

(2) the Commissioner of the South Carolina Department of Health and Environmental Control;

(3) the State Superintendent of Education;

(4) the Executive Director of the South Carolina Criminal Justice Academy;

(5) the Chief of the State Law Enforcement Division;

(6) the Commissioner of the South Carolina Commission on Alcohol and Drug Abuse;

(7) the Commissioner of the State Department of Mental Health;

(8) the Commissioner of the State Department of Mental Retardation;

(9) the Commissioner of the Department of Youth Services;

(10) an attorney with experience in prosecuting crimes against children;

(11) a county coroner or medical examiner;

(12) a pediatrician with experience in diagnosing and treating child abuse and neglect, appointed from recommendations submitted by the State Chapter of the American Academy of Pediatrics;

(13) a solicitor;

(14) a forensic pathologist; and

(15) two members of the public at large, one of which must represent a private nonprofit organization that advocates children services.

(B) Those state agency members in items (1)-(9) shall serve ex officio and may appoint a designee to serve in their place from their particular departments or agencies who have administrative or program responsibilities for children and family services. The remaining members, including the coroner or medical examiner and solicitor who shall serve ex officio, must be appointed by the Governor for terms of four years and until their successors are appointed and qualify.

(C) A chairman and vice-chairman of the committee must be elected from among the members by a majority vote of the membership for a term of two years.

(D) Meetings of the committee must be held at least quarterly. A majority of the committee constitutes a quorum.

(E) Each ex officio member shall provide sufficient staff and administrative support to carry out the responsibilities of this article.

SECTION 20-7-5915. Purpose and duties of Department of Child Fatalities. [SC ST SEC 20-7-5915]

(A) The purpose of the department is to expeditiously investigate child deaths in all counties of the State.

(B) To achieve its purpose, the department shall:

(1) upon receipt of a report of a child death from the county coroner or medical examiner, as required by Section 17-5-540, investigate and gather all information on the child fatality. The coroner or medical examiner immediately must request an autopsy if SLED determines that an autopsy is necessary. The autopsy must be performed by a pathologist with forensic training as soon as possible. The forensic pathologist must inform the department of the findings within forty-eight hours of completion of the autopsy. If the autopsy reveals the cause of death to be pathological or an unavoidable accident, the case must be closed by the department. If the autopsy reveals physical or sexual trauma, suspicious markings, or other findings that are questionable or yields no conclusion to the cause of death, the department immediately must begin an investigation;

(2) request assistance of any other local, county, or state agency to aid in the investigation;

(3) upon receipt of additional investigative information, reopen a case for another coroner's inquest;

(4) upon receipt of the notification required by item (1), review agency records for information regarding the deceased child or family. Information available to the department pursuant to Section 20-7-5930 and information which is public under Chapter 4, Title 30, the Freedom of Information Act, must be available as needed to the county coroner or medical examiner and county department of social services;

(5) report the activities and findings related to a child fatality to the State Child Fatality Advisory Committee;

(6) develop a protocol for child fatality reviews;

(7) develop a protocol for the collection of data regarding child deaths as related to Section 17-5-540 and provide training to local professionals delivering services to children, county coroners and medical examiners, and law enforcement agencies on the use of the protocol;

(8) study the operations of local investigations of child fatalities, including the statutes, regulations, policies, and procedures of the agencies involved with children's services and child death investigations;

(9) examine confidentiality and access to information statutes, regulations, policies, and procedures for agencies with responsibilities for children, including, but not limited to, health, public welfare, education, social services, mental health, alcohol and other substance abuse, and law enforcement agencies and determine whether those statutes, regulations, policies, or procedures impede the exchange of information necessary to protect children from preventable deaths. If the department identifies a statute, regulation, policy, or procedure that impedes the necessary exchange of information, the department shall notify the committee and the agencies serving on the committee and the committee shall include proposals for changes to statutes, regulations, policies, or procedures in the committee's annual report;

(10) develop a Forensic Pathology Network available to coroners and medical examiners for prompt autopsy findings;

(11) submit to the Governor and the General Assembly, an annual report and any other reports prepared by the department, including, but not limited to, the department's findings and recommendations;

(12) promulgate regulations necessary to carry out its purposes and responsibilities under this article.

SECTION 20-7-5920. Purpose and duties of Child Fatality Advisory Committee. [SC ST SEC 20-7-5920]

(A) The purpose of the State Child Fatality Advisory Committee is to decrease the incidences of preventable child deaths by:

(1) developing an understanding of the causes and incidences of child deaths;

(2) developing plans for and implementing changes within the agencies represented on the committee which will prevent child deaths; and

(3) advising the Governor and the General Assembly on statutory, policy, and practice changes which will prevent child deaths.

(B) To achieve its purpose, the committee shall:

(1) meet with the department no later than one month after the department receives notification by the county coroner or medical examiner pursuant to Section 17-5-540 to review the investigation of the death;

(2) undertake annual statistical studies of the incidences and causes of child fatalities in this State. The studies shall include an analysis of community and public and private agency involvement with the decedents and their families before and subsequent to the deaths;

(3) the committee shall consider training, including cross-agency training, consultation, technical assistance needs, and service gaps. If the committee determines that changes to any statute, regulation, policy, or procedure is needed to decrease the incidence of preventable child deaths, the committee shall include proposals for changes to statutes, regulations, policies, and procedures in the committee's annual report;

(4) educate the public regarding the incidences and causes of child deaths, the public role in preventing these deaths, and specific steps the public can undertake to prevent child deaths. The committee shall enlist the support of civic, philanthropic, and public service organizations in performing the committee's education duties;

(5) develop and implement policies and procedures for its own governance and operation;

(6) submit to the Governor and the General Assembly, an annual written report and any other reports prepared by the committee, including, but not limited to, the committee's findings and recommendations. Annual reports must be made available to the public.

SECTION 20-7-5930. Departmental access to information concerning child whose death is being investigated. [SC ST SEC 20-7-5930]

Upon request of the department and as necessary to carry out the department's purpose and duties, the department immediately must be provided:

(1) by a provider of medical care, access to information and records regarding a child whose death is being reviewed by the department, including information on prenatal care;

(2) access to all information and records maintained by any state, county, or local government agency, including, but not limited to, birth certificates, law enforcement investigation data, county coroner or medical examiner investigation data, parole and probation information and records, and information and records of social services and health agencies that provided services to the child or family, including information made strictly confidential in Section 20-7-650 concerning unfounded reports of abuse or neglect.

SECTION 20-7-5940. Subpoena power. [SC ST SEC 20-7-5940]

When necessary in the discharge of the duties of the department and upon application of the department, the clerks of court shall issue a subpoena or subpoena duces tecum to any state, county, or local agency, board, or commission or to any representative of any state, county, or local agency, board, or commission or to a provider of medical care to compel the attendance of witnesses and production of documents, books, papers, correspondence, memoranda, and other relevant records to the discharge of the department's duties. Failure to obey a subpoena or subpoena duces tecum issued pursuant to this section may be punished as contempt.

SECTION 20-7-5950. Confidentiality of meetings when discussing individual cases; applicability of Freedom of Information Act; violations and penalties. [SC ST SEC 20-7-5950]

(A) Meetings of the committee and department are closed to the public and are not subject to Chapter 4, Title 30, the Freedom of Information Act, when the committee and department are discussing individual cases of child deaths.

(B) Except as provided in subsection (C), meetings of the committee are open to the public and subject to the Freedom of Information Act when the committee is not discussing individual cases of child deaths.

(C) Information identifying a deceased child or a family member, guardian, or caretaker of a deceased child, or an alleged or suspected perpetrator of abuse or neglect upon a child may not be disclosed during a public meeting and information regarding the involvement of any agency with the deceased child or family may not be disclosed during a public meeting.

(D) Violation of this section is a misdemeanor and, upon conviction, a person must be fined not more than five hundred dollars or imprisoned not more than six months, or both.

SECTION 20-7-5960. Confidentiality of information, records, and meetings; statistical compilations and reports which lack identifying details; evidentiary privilege; exceptions; violations and penalties. [SC ST SEC 20-7-5960]

(A) All information and records acquired by the committee and by the department in the exercise of their purposes and duties pursuant to this article are confidential, exempt from disclosure under Chapter 4, Title 30, the Freedom of Information Act, and only may be disclosed as necessary to carry out the committee's and department's duties and purposes.

(B) Statistical compilations of data which do not contain information that would permit the identification of a person to be ascertained are public records.

(C) Reports of the committee and department which do not contain information that would permit the identification of a person to be ascertained are public information.

(D) Except as necessary to carry out the committee's and department's purposes and duties, members of the committee and department and persons attending their meeting may not disclose what transpired at a meeting which is not public under Section 20-7-5940 and may not disclose information, the disclosure of which is prohibited by this section.

(E) Members of the committee, persons attending a committee meeting, and persons who present information to the committee may not be required to disclose in any civil or criminal proceeding information presented in or opinions formed as a result of a meeting, except that information available from other sources is not immune from introduction into evidence through those sources solely because it was presented during proceedings of the committee or department or because it is maintained by the committee or department. Nothing in this subsection may be construed to prevent a person from testifying to information obtained independently of the committee or which is public information.

(F) Information, documents, and records of the committee and department are not subject to subpoena, discovery, or the Freedom of Information Act, except that information, documents, and records otherwise available from other sources are not immune from subpoena, discovery, or the Freedom of Information Act through those sources solely because they were presented during proceedings of the committee or department or because they are maintained by the committee or department.

(G) Violation of this section is a misdemeanor and, upon conviction, a person must be fined not more than five hundred dollars or imprisoned for not more than six months, or both.

Child Death Investigations

Any child death under the age of 18 is investigated when the death is unexpected and unexplained including, but not limited to, possible sudden infant death syndrome; as a result of violence, when unattended by a physician and in any suspicious or unusual manner. When a child dies, the response by the State and the community to the death must include an accurate and complete determination of the cause of death to include a thorough scene investigation and a complete autopsy. Lack of adequate investigations of child deaths impedes the effort to prevent future deaths from similar causes.

Multi-disciplinary and multi-agency reviews of child deaths can assist the State in the investigation of child deaths, in the development of a greater understanding of the incidence and causes of child deaths and the methods for preventing such deaths, and in identifying gaps in services to children and families. Law enforcement, coroners, public health officials, educators, medical personnel, social workers, and mental health providers must collaborate on child death investigations. This cooperation increases the ability to accurately identify the cause and manner of child fatalities.

The American Academy of Pediatrics describes an adequate death investigation as including a complete autopsy, investigation of circumstances of death, review of the child's medical and family history, and review of information from relevant agencies and health care professionals. Not all of the 205 child deaths in 2002 were autopsied. An autopsy is essential in order to determine the cause and manner of death, and toxicology samples are necessary to indicate the presence of drugs and/or alcohol. When an autopsy is not performed, it greatly limits the investigation and the SCFAC's ability to gain insight into the death to make recommendations to prevent future deaths. A thorough death scene investigation by law enforcement and the coroner is essential. Available are child death scene investigation protocols from various sources, coroner's protocols and initial intake sheets.

In the state of South Carolina, the State Law Enforcement Division provides, upon request, assistance in the sometimes-lengthy investigations of child deaths. Services include the assistance of experienced crime scene technicians that can assist local agencies in the gathering of evidence from a child death scene and/or autopsy. Local agencies can also request the use of the SLED Toxicology Department. Child Fatalities cases have preliminary testing completed within 48 hours (most are within 24 hours) and more comprehensive testing is completed within two weeks (unless further specialized testing is required). The 24 – 48 hours turn around time is provided on all Child Fatality cases that are visibly marked and noted as a child fatality case. The preliminary results will be called to the coroner upon request and these services are provided free of charge. The State Law Enforcement Division also can provide experienced investigators, specially trained in the investigation of child death, to assist in every step of the investigation from the initial scene to the final court date.

Appendix E

SOUTH CAROLINA CORONERS

Abbeville	Ronnie Ashley	**Greenwood**	James T. Coursey
Aiken	Tim Carlton	**Hampton**	Gordon L. Rhoden, Sr.
Allendale	Elaine Poston	**Horry**	Robert L. Edge, Jr.
Anderson	Greg L. Shore	**Jasper**	L. Martin Sauls, III
Bamberg	Willard H. Duncan	**Kershaw**	John B. Felders, III
Barnwell	Lloyd B. Ward	**Lancaster**	Michael Morris
Beaufort	Curt Copeland	**Laurens**	Francis G. Nichols, Jr.
Berkeley	Glenn Rhoad	**Lee**	Alford D. Elmore
Calhoun	Donnie B. Porth	**Lexington**	Harry O. Harman
Charleston	Susan J. Chewning	**Marion**	Jerry M. Richardson
Cherokee	Harley Joe Vinesett	**Marlboro**	Timothy E. Brown
Chester	Terry Tinker	**McCormick**	Faye L. Puckett
Chesterfield	Donald J. Baker	**Newberry**	James O. Smith
Clarendon	Hayes F. Samuels, Jr.	**Oconee**	Karl Addis
Colleton	Richard M. Harvey	**Orangeburg**	Samuetta Marshall
Darlington	J. Todd Hardee	**Pickens**	James R. Mahanes, M.D.
Dillon	Daniel Grimsley	**Richland**	Gary Watts
Dorchester	Christopher B. Nisbet	**Saluda**	B. Keith Turner
Edgefield	W. Thurmond Burnett	**Spartanburg**	Jim Burnett
Fairfield	Joseph A. Silvia	**Sumter**	Verna Moore
Florence	M. G. “Bubba” Matthews	**Union**	William E. Holcombe
Georgetown	Kenneth M. Johnson	**Williamsburg**	Harrison McKnight, Jr.
Greenville	B. Parks Evans, Jr.	**York**	Douglas McKown

Appendix F

Decedent Name:_____

The South Carolina Coroner's Association
The South Carolina Law Enforcement Division

Coroner Protocol ::: Child Fatality
(Mail to SLED Regional Office as soon as practical)

Coroner Case No. _____

Law Enforcement Case No. _____

SLED / Child Fatality Case No. 55___ - __ __ __

Coroner----------

County: _____ County # __ __

Office contacted: Date: ___ / ___ / ___ Time: __ __**:** __ __ (when Coroner's called)

By Whom: _____of what agency_____

Responding Coroner/ Deputy Coroner/ Investigator _____ Date: ___ / ___ / ___

Other Agencies Involved / Contacted: _____

Scene Investigation--------was onset of illness/trauma different from place of death Y / N

Place of Onset: _____

Race Sex: Age:

Deceased: Last _____ First _____ ____ ___ ____ DOB: __ / __ / __
(If more than one child death @ same time, photocopy 1st page & attach with initial report)

Birth Place: _____ Name of Hospital / Health Care Facility_____
City State

Death: Date: ___ / ___ / ___ Time: __ __ **:** __ __ Site of Death: Residence, Day Care, Lake, ER, HWY, ICU, Caregiver, Other

Place of Death: _____

Mother's Maiden Name: _____

	Race:	Sex:	Age:	DOB:	SSN
Mother: _____	___	___	___	__ /__ / __	_ _ _ : _ _ : _ _ _ _
Father: _____	___	___	___	__ /__ /__	_ _ _ : _ _ : _ _ _ _

Other Family Members Living with Child:

	Race:	Sex:	DOB:	SSN:
_____	___	___	__ / __ / __	___:__:____
_____	___	___	__ / __ / __	___:__:____
_____	___	___	__ / __ / __	___:__:____

Decedent Name: _____

Witnesses: _____

	Race:	Sex:	Age:	DOB:	SSN:
Caregiver(s) _____	____	____	___	__ / __ / __	___:__:____

Caregiver relationship: Mom /Dad /Relative /Acquaintance /Friend /Neighbor /Unknown /Sitter

Perpetrator(s): _____	____	____	___	__ / __ / __	___:__:____
(if applicable) _____	____	____	___	__ / __ / __	___:__:____

Perpetrator relationship: Mom /Dad /Relative /Acquaintance /Friend /Neighbor /Unknown /Sitter

Circumstances of Death::: Traffic (Child Pedestrian) / Fall / Electrocution / Medical / Farm / Train / GSW/ Poisoning / Knife-Stab / Boating / Other_____

Fire::: Cause_____ Smoke Detector: Y N CO Monitor: Y N Operable: Y N

Drowning::: Site_____ Public / Private Warning Signs: Y N Fence: Y N

Weapons Involved::: Type/Origin:_____

SIDS Related Factors::: Body position: back / side / stomach / wedged Other_____
Face position: face up / face to side / face down

Bedding Type: _____

Sleeping with / Alone: _____ Smokers in home (who): _____

Specify: mucous / blood / foam / food / foreign object seen at: nose / mouth / ears / other_____

Child Abuse / Neglect::: Abuse / Neglect: Yes □ No □ Unknown □

Hx of Prior Abuse / Neglect / Domestic Violence _____

Drugs Involved::: Type of Drugs: Prescription / Street Used By:_____
(Attach list of drugs found in home or @ scene in narrative section)

Autopsy □ **Autopsy Ordered** □

Suspected Cause: _____ Actual Cause: _____
Pathologist: Dr._____ Hospital: _____

Manner of Death: Accident / Homicide / Suicide / Natural / Undetermined / Pending Investigation - Toxicology

Decedent: Hx of Medical Problems: _____

Decedent's Doctor: Dr._____ Date Last Seen: __ __/ __ __/ __ __

Health Dept. Services Received by victim? Y / N County: _____

Decedent Name: _____

Pending Legal Actions::: Criminal Charges Y / N
_____
_____

Narrative::: If possible, please include-- facts leading up to death / last person to see decedent / past deaths of other children / home environment / appearance of child. **Are all other Live born Children of parents living?** Y / N
_____

_____

_____

_____

_____

_____

_____

_____

MAIL A COPY OF THIS FORM TO YOUR REGIONAL SLED OFFICE. Coroner retains original, submit copy to pathologist, submit copy to the SLED Regional Office (please include SLED Agent's name on envelope), and submit copy to SLED Toxicology along with body fluids/ tissues obtained during autopsy using the SLED Child Postmortem Kit.

CC: 1). Coroners (original) 2). Pathologist (copy) 3). Child Fatality (copy) 4). SLED Toxicology (copy)

Fact Sheet: Child Death Review

The Mission of Child Death Review

Through a comprehensive, multidisciplinary review of child deaths, we will better understand how and why children die, and use our findings to take action that can prevent other deaths and improve the health and safety of our children.

Child death review (CDR) is:

- A multidisciplinary, multi-agency process designed to examine the causes and circumstances of child deaths
- Collaborative
- Comprehensive and broad
- Leads to an understanding of risk factors
- Focus on prevention of other deaths and the health and safety of children
- Should lead to effective action

Objectives of CDR:

- Ensure accurate ID and uniform reporting of the cause and manner of death and establish a minimum dataset on causes on child deaths.
- Improve communication and linkages among local and state agencies and enhanced coordination of efforts.
- Improve agency responses to child deaths in the investigation of child deaths.
- Improve agency response to protect siblings of deceased children.
- Improve criminal investigations and the prosecution of child homicides.
- Improve delivery of services to children, families, providers and community members.
- ID specific barriers and systems issues involved in the deaths of the children.
- ID significant risk factors and trends in child deaths.
- ID needed changes in legislation, policy and practices, and expanded efforts in child health and safety to prevent child deaths.
- Increase public awareness of the issues that impinge on the health and safety of children.

Child Death Review Resources:

National Center on Child Death Review: www.childdeathreview.org
National Center on Child Fatality Review: http://www.ican-ncfr.org
Michigan Child Death Review Program: www.keepingkidsalive.org

Appendix H

Fact Sheet: SC State Child Fatality Advisory Committee

The State Child Fatality Advisory Committee (SCFAC):

In 1993 South Carolina Code 20-7-5920 mandated the creation of the SCFAC to ID patterns in child fatalities that will guide efforts by agencies, communities and individuals to decrease the number of preventable child deaths.

The Mission of the State Child Fatality Advisory Committee (SCFAC):

To decrease the incidence of preventable child deaths by:

- Developing an understanding of the causes of child death.
- Developing plans for implementing changes within the agencies represented.
- Advising the Governor and General Assembly on statutory, policy, and practice changes which will prevent child deaths

State Child Fatality Review Team Members:

The Committee is comprised of representatives of state agencies as well as representatives from law enforcement, coroners, pediatricians, pathologists, child advocates and solicitors.

Dept. of Social Services
Dept. of Health and Environmental Control
Dept. of Education
SC Criminal Justice Academy
SC Law Enforcement Division
Commission on Alcohol and Drug Abuse
Dept. of Mental Health
Dept. of Youth Services
Dept. of Disabilities and Special Needs
Coroners
Pathologists
Pediatricians
Child Advocates
Attorney

Appendix I

Deaths Reviewed:

The SCFAC meets every other month with SLED Department of Child Fatalities to review specific cases. Cases reviewed include:

- unexplained and unexpected deaths
- of children under the age of 18 years and the circumstances involved.

The SCFAC does not review motor vehicle crashes. The SC Department of Public Safety performs its own review.

Publications and Findings:

The SCFAC publishes an Annual Report featuring child fatality information and recommendations. Copies are available by contacting Keisha Adams (adamsks@dhec.sc.gov, 803-898-4153) or Megan Weis (weisma@dhec.sc.gov; (803-898-0441)