

# STATE OF SOUTH CAROLINA



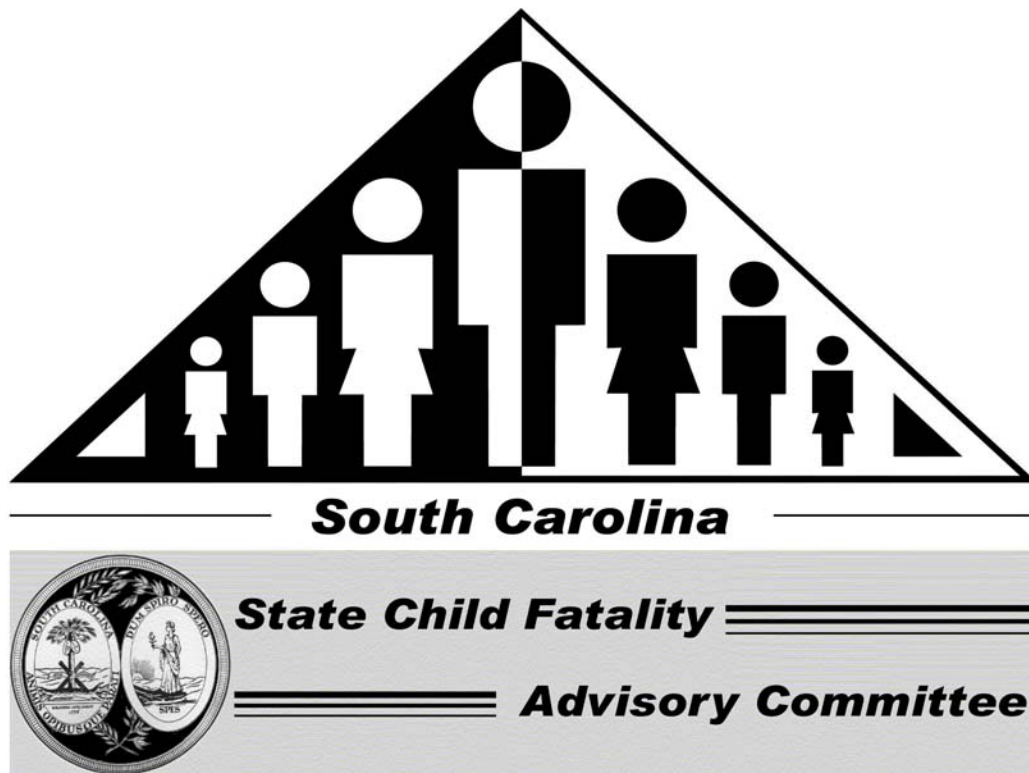
## STATE CHILD FATALITY ADVISORY COMMITTEE 2002 ANNUAL REPORT

Child Fatality Data provided by the South Carolina Law Enforcement Division Department of Child Fatalities. All opinions and recommendations are those of the State Child Fatality Advisory Committee. This publication was supported by Award Number U17/CCU422396-02 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 Megan Weis at 803-898-0441 or Tahelia Wardlaw at 803-896-7033



Honorable Mark C. Sanford

Governor of the State of South Carolina  
and the 116<sup>th</sup> 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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## EXECUTIVE SUMMARY

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. The Committee does not review motor vehicle crashes except as related to injuries on private property or as a pedestrian. The South Carolina Department of Public Safety (SCDPS) investigates motor vehicle 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 239 cases during 2003. A manner of death determination places each fatality into one of five main categories: natural, unintentional injury, homicide, suicide, and undetermined. Of the 2002 child fatalities reported to SLED, there were 87 natural deaths, 62 unintentional injury deaths, 23 homicides, 10 suicides and 17 undetermined deaths. There are 6 cases that have pending investigations.

Of the 205 reportable deaths that occurred in 2002, the two largest categories of South Carolina child fatalities continue to be natural and unintentional injury. Together, they account for 72.6% of child fatalities, with natural deaths representing 42.4% and unintentional injury representing 30.2%. These categories were followed by homicide (11.2%), undetermined (8.3%) and suicide (4.9%). Cases with investigations pending represent 2.9% of total deaths.

Within the category of natural deaths, SIDS represents 37.9% of natural deaths. Overall, SIDS represents 16.1% of total fatalities. In many cases the Committee noted in review that unsafe sleeping arrangements were present at the time of death, similar to those noted in unintentional suffocation deaths. Additionally, concerns 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 SCFAC continues to advocate a team approach to child death investigations, including the importance of law enforcement as well as coroners being on the scene of a child's death and the importance of strengthening relationships between local law enforcement, medical community, and different agencies involved in the death of a child.

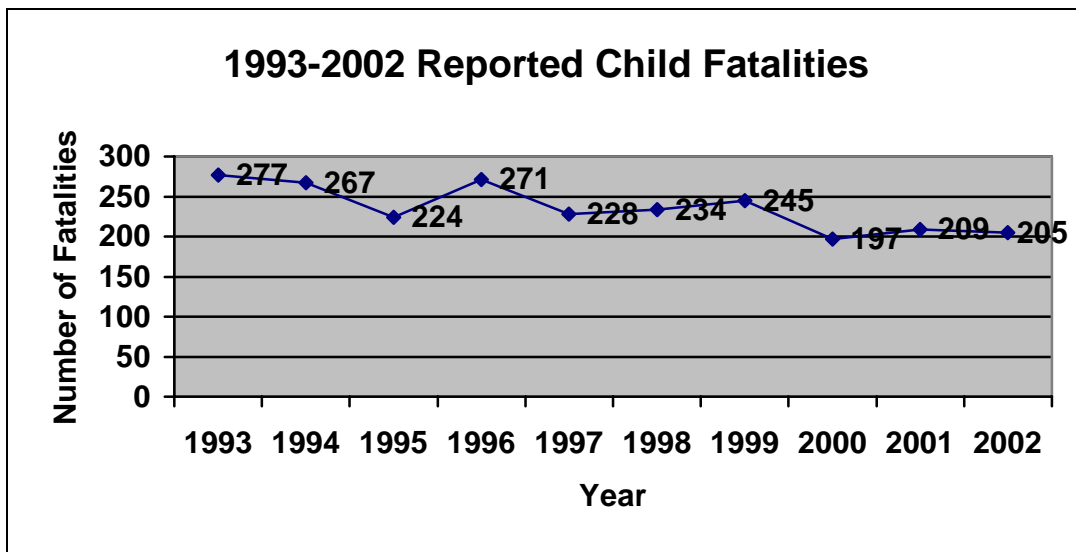
The SCFAC continues to support building partnerships among agencies and organizations dedicated to the welfare of children. A SCFAC representative joined the board of SC SAFE KIDS, an organization dedicated to prevention of unintentional injuries of children; the Committee is a grant partner with the Department of Health and Environmental Control Division of Injury and Violence Prevention for the National Violent Death Reporting System

(NVDRS), a violent death surveillance system including a special module for child fatality; and continued support for local child death review and formation of Children's Health and Safety Councils.

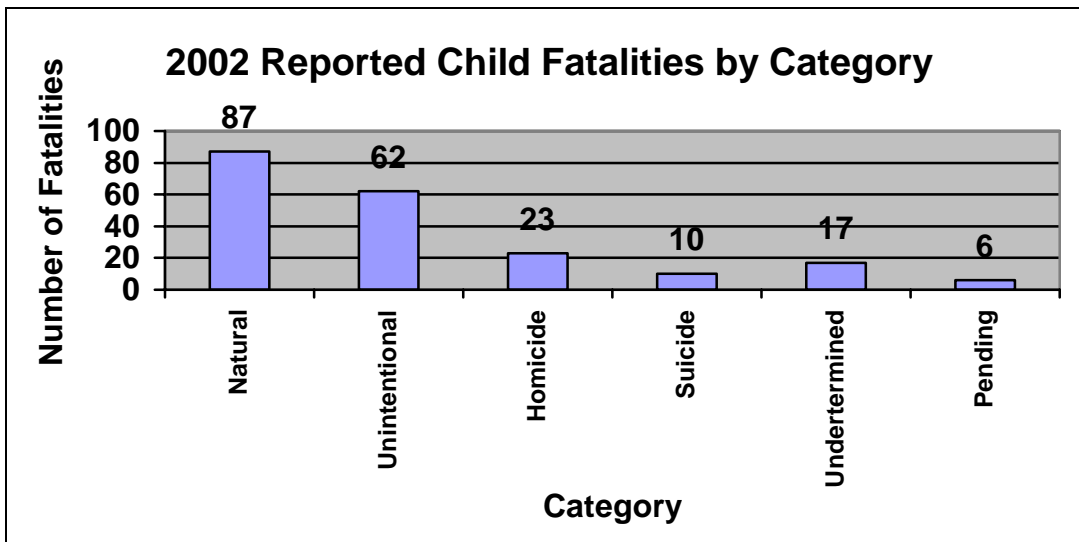
***2002 SLED DEPARTMENT OF CHILD  
FATALITIES DATA***

# OVERALL CHILD FATALITIES

In 2002, 205 child fatalities were reported.

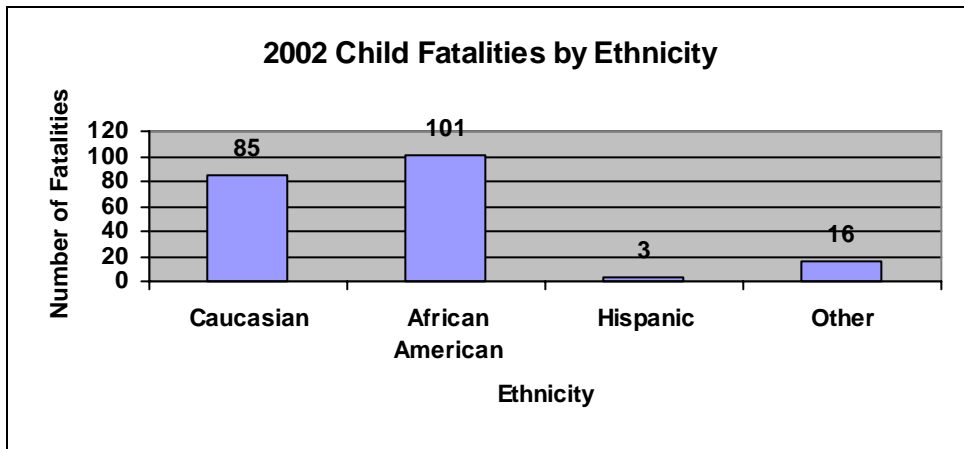


42.4% of fatalities were classified as natural deaths. This was followed by unintentional injuries (30.2), homicide (11.2%), undetermined (8.3%), suicide (4.9%) and pending (2.9%).

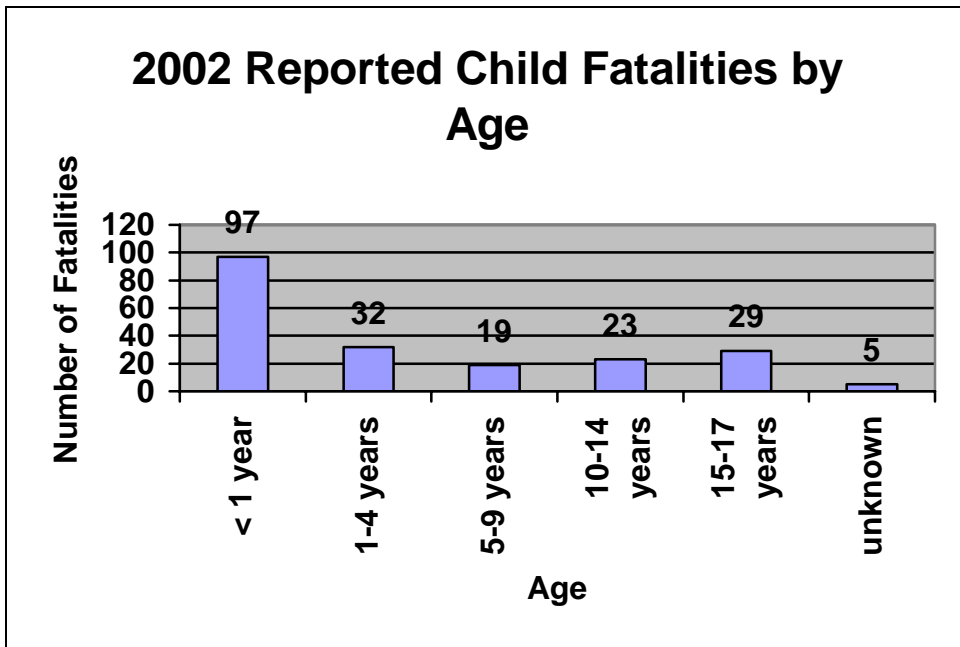


African Americans accounted for 49.3% of fatalities. Caucasians account 41.5%. Other ethnicities, including Middle Eastern and Asian represent 7.8% of child fatalities. Hispanics represent 1.5% of child fatalities.





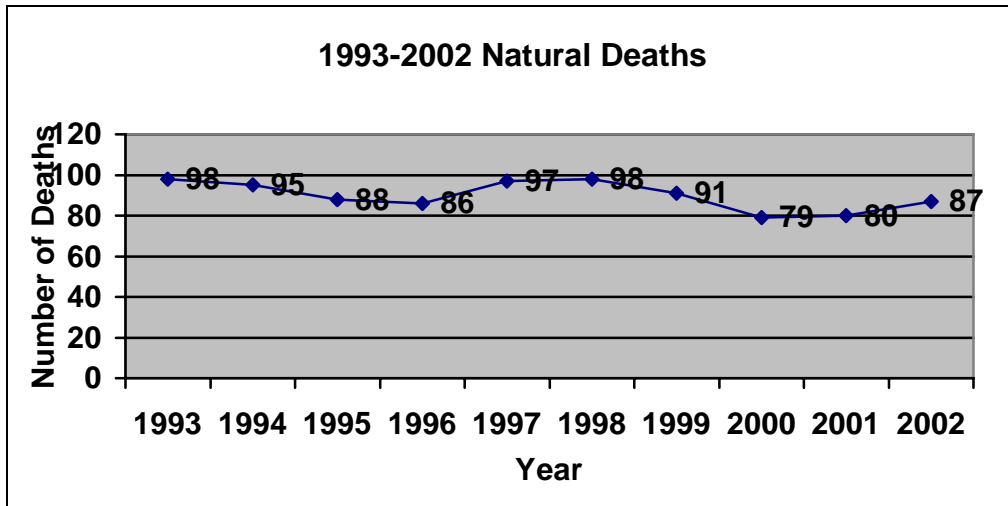
The majority (47.3%) of child fatality victims are under the age of 1 year. This is followed by children between the ages 1-4 years (15.6%), 15-17 years (14.1%), 10-14 years (11.2%), and 5-9 years (9.3%). In 2.4% of cases the age of the child was unknown.



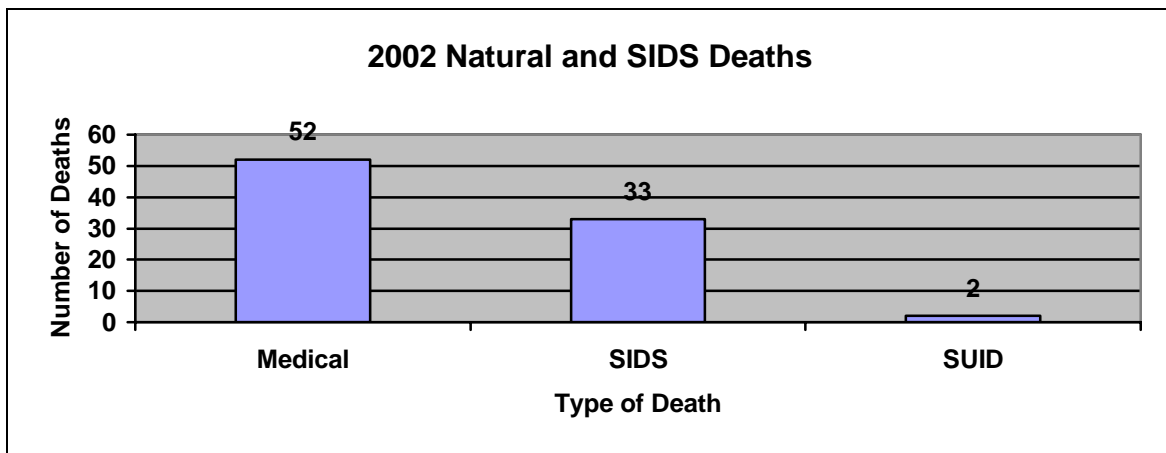
# NATURAL DEATHS / SUDDEN INFANT DEATH SYNDROME

In 2002, 87 children died of natural deaths in cases reviewed by the Department of Child Fatalities. This represents an 11.3% increase from 2001.

Natural deaths include natural diseases such as cardiac arrhythmia, meningitis, myocarditis, and pneumonia.

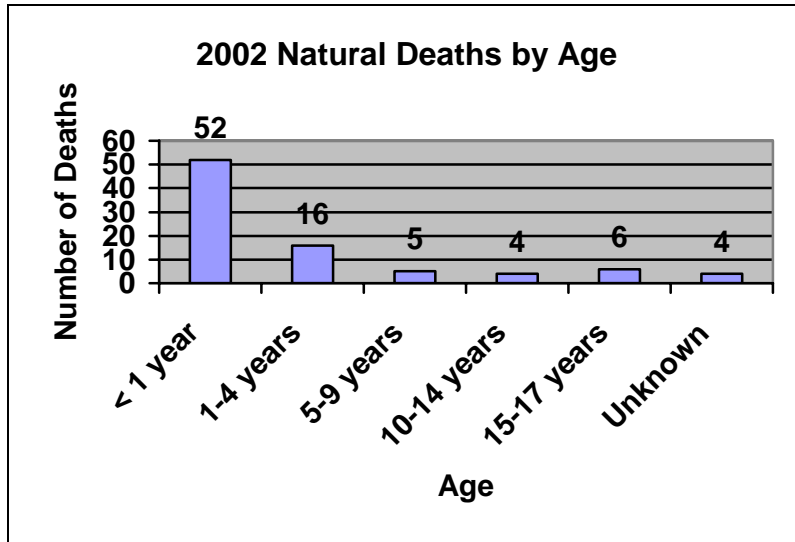


59.8% of natural deaths investigated are classified as medical. 37.9% are classified as Sudden Infant Death Syndrome (SIDS).



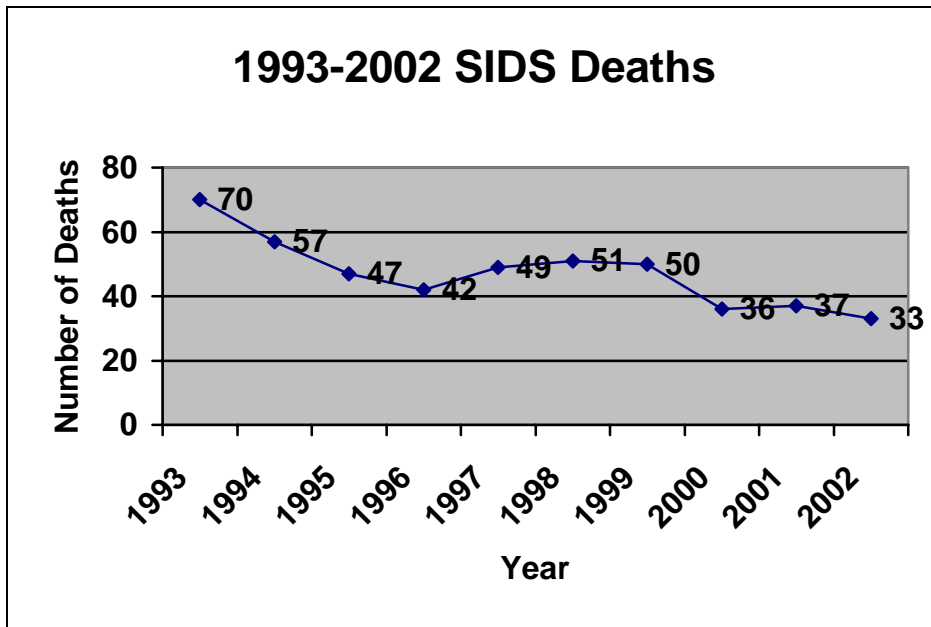
58.6% of natural deaths are males, while African Americans represented 47.1% of natural deaths.

59.8% of natural deaths are of children less than the age of 1 year.

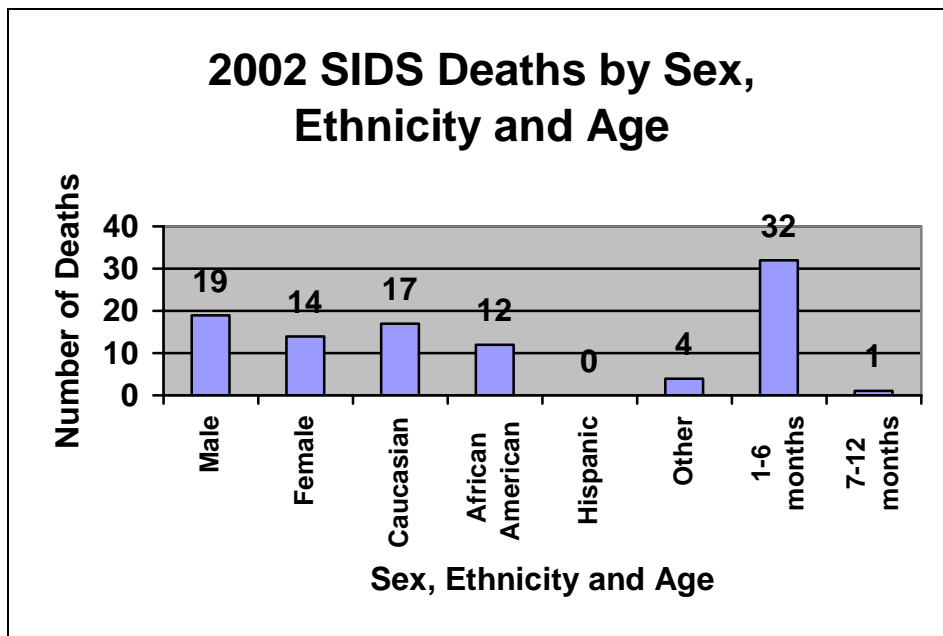


## SUDDEN INFANT DEATH SYNDROME (SIDS)

In 2002, 33 SIDS deaths were investigated. This continues a downward trend in reported SIDS deaths.

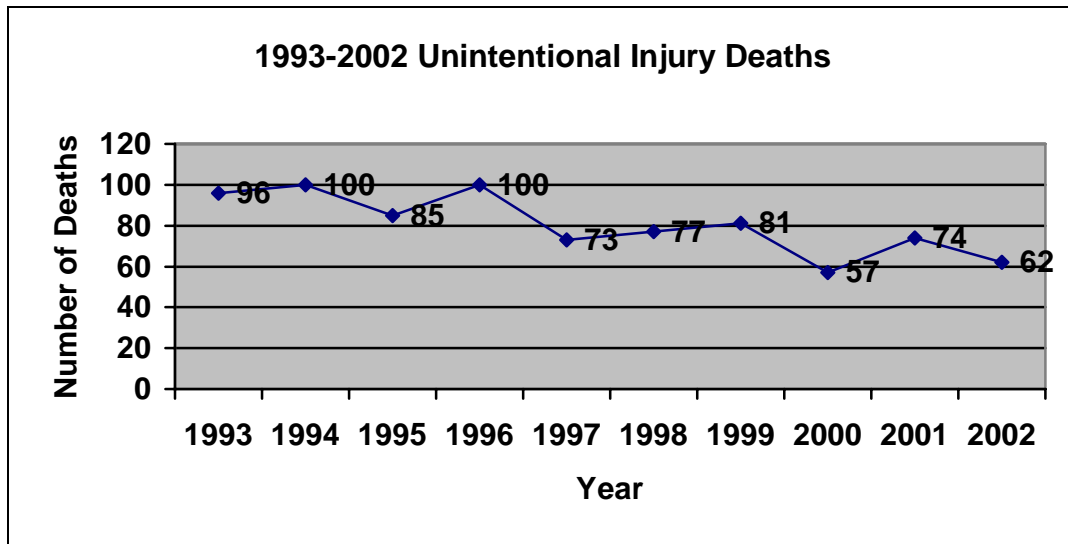


57.6% of SIDS victims were male. 51.5% of victims were Caucasian, and 97% were under the age of 6 months.

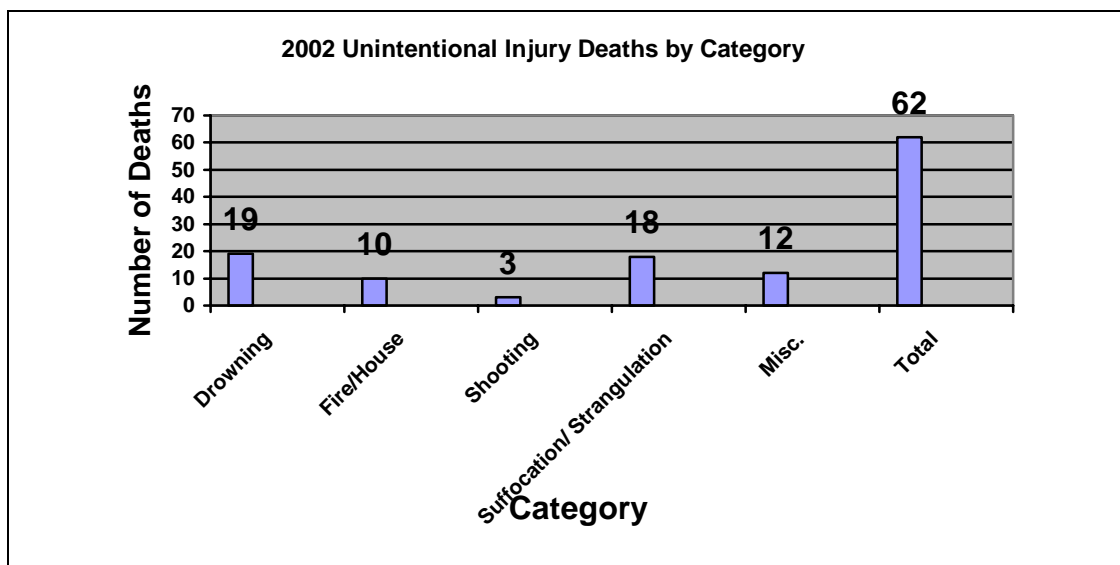


# UNINTENTIONAL INJURIES

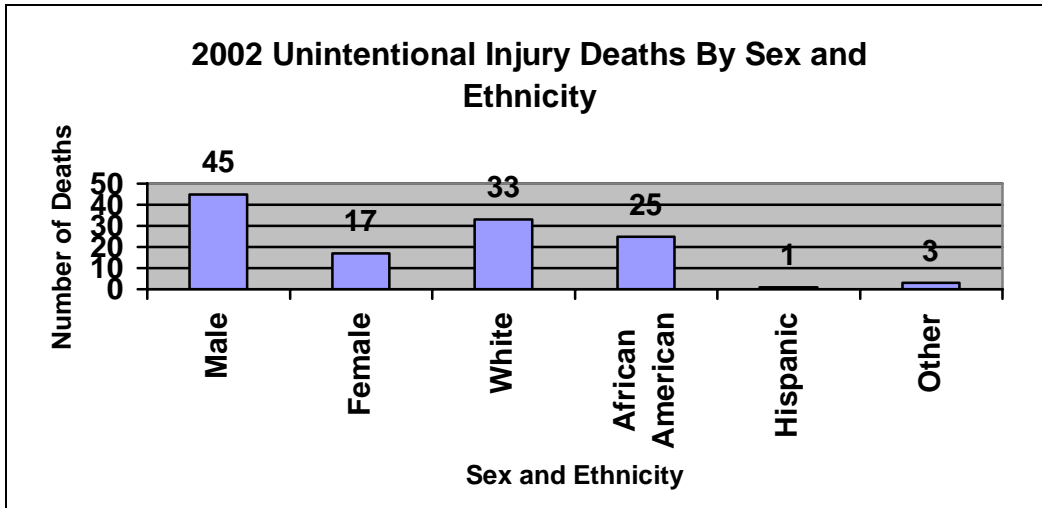
In 2002, 62 children died from unintentional injuries. This continues an overall downward trend in the number of unintentional injury deaths to South Carolina's children.



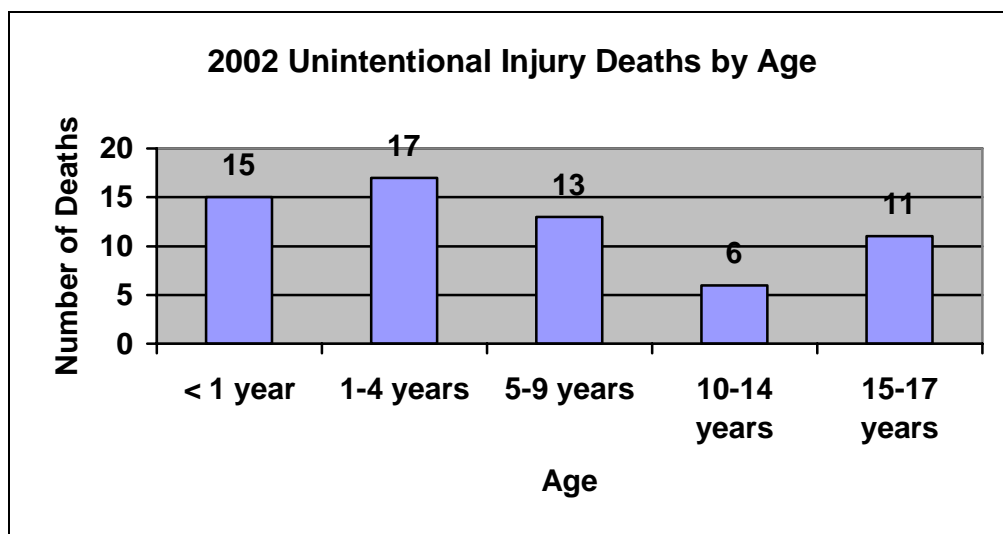
Five categories are used to define unintentional injury deaths: drowning, fire/house, shooting, suffocation/strangulation, and miscellaneous. Year 2002 unintentional miscellaneous deaths include collisions, falls, electrocutions, exsanguination, blow to chest, boating, crushing, drug overdose, striking with an object, and traffic. As in past years, drownings accounted for the largest percentage of unintentional deaths (30.6%). Drownings were closely followed by suffocation/strangulation (29%), miscellaneous (19.4%), fire/house (16.1%), and shooting (4.8%) deaths.



Males accounted for 72.6% of victims, and Caucasians 53.2% of victims.

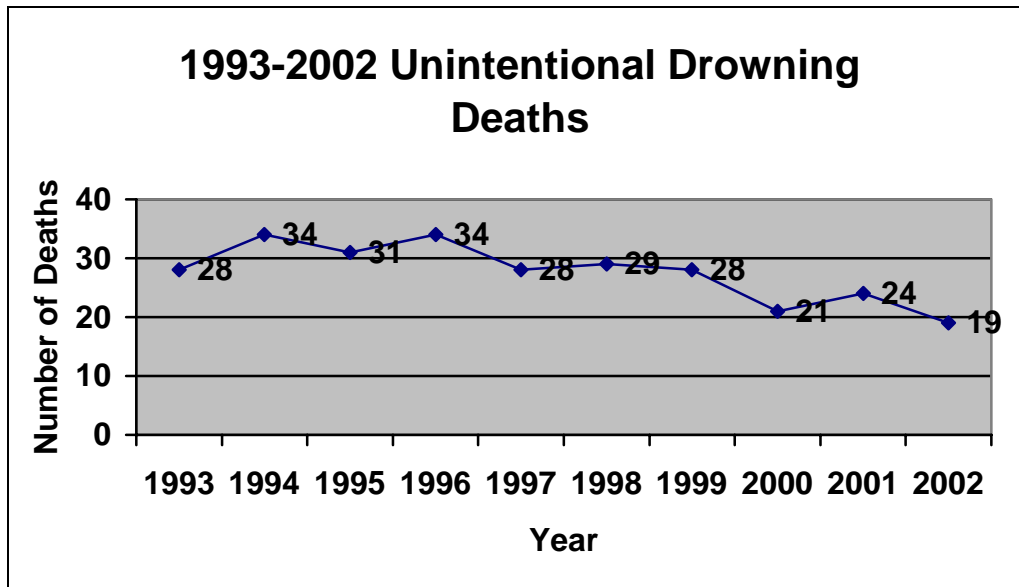


The majority of unintentional deaths are to children under the age of 10 years (72.6%). Most deaths are to children between the ages of 1 and 4 years (27.4%).

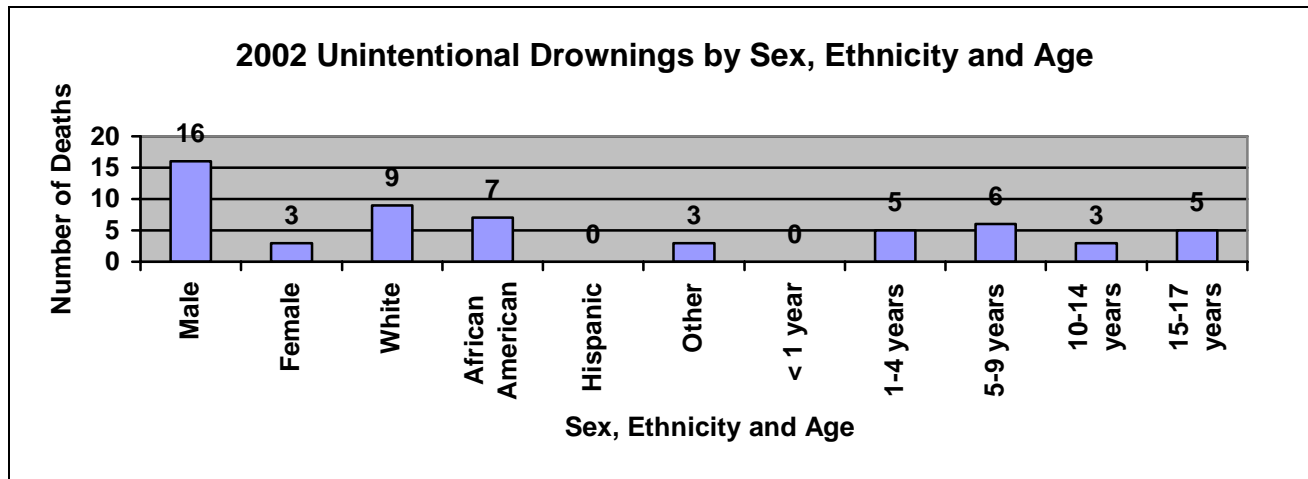


## UNINTENTIONAL DROWNINGS

In 2002, 19 drowning deaths occurred. This represents the lowest number of unintentional drownings in the past ten years.



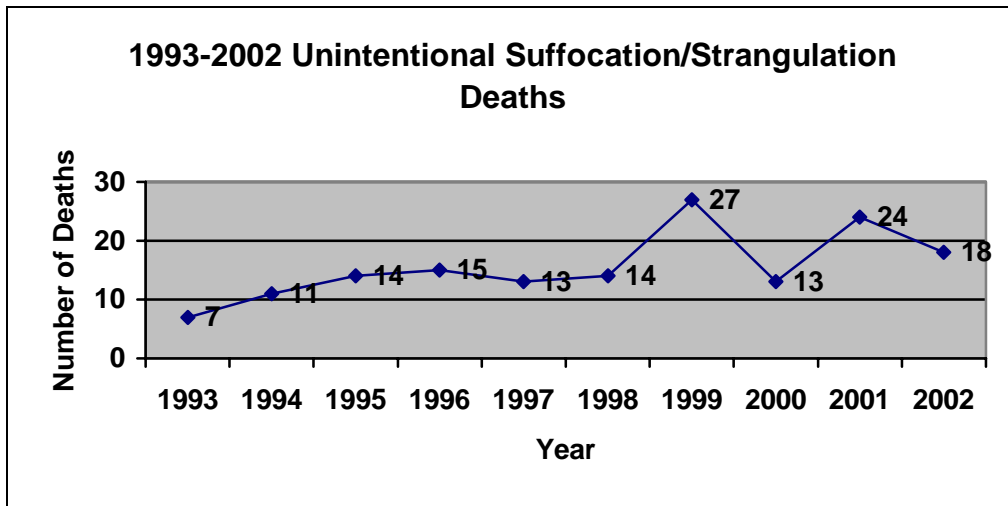
Of the 19 deaths, 84.2% of the deaths were male, and 47.4 % were Caucasian. 57.9% of drowning victims were under the age of ten years.



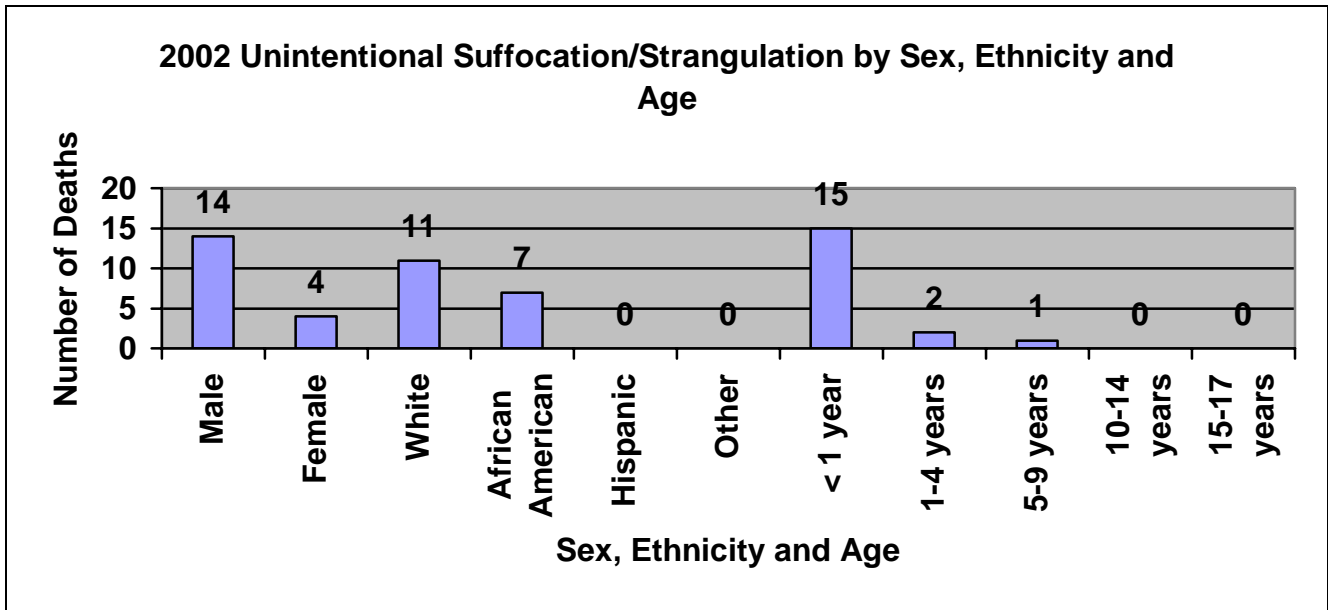
6 deaths occurred at a residential or neighborhood pool. 11 deaths occurred in a creek, river, or pond. 2 deaths occurred in a bathtub.

## UNINTENTIONAL SUFFOCATION/STRANGULATION

In 2002, 18 deaths occurred from unintentional suffocation/strangulation. This is a 25% decrease from 2001.



Of the 18 deaths, 77.8% were male, and 61.1% were Caucasian. 83.3% of deaths occurred in children under the age of 1 year.

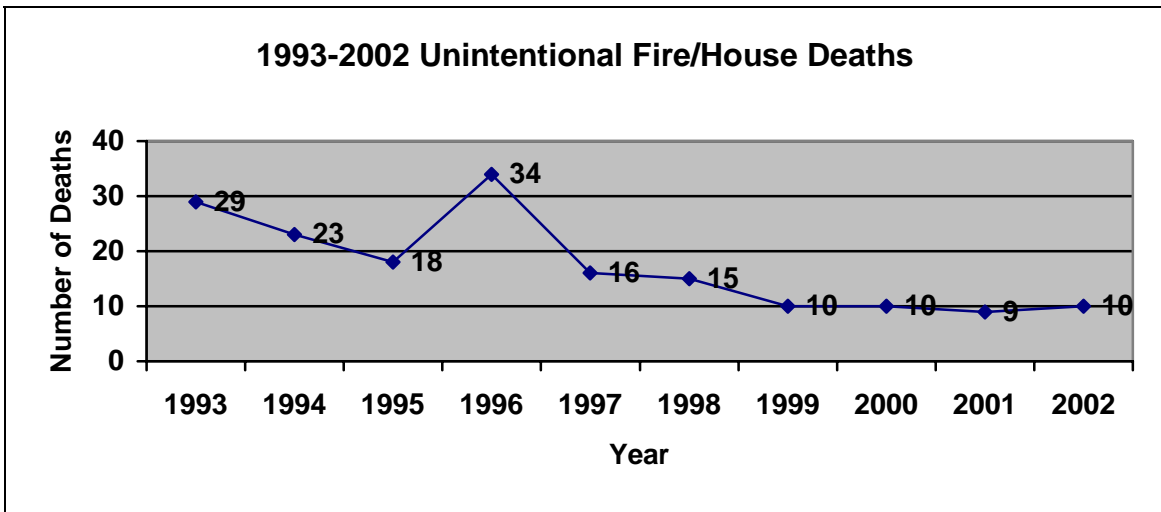


9, or 50%, of the deaths were due to overlay.

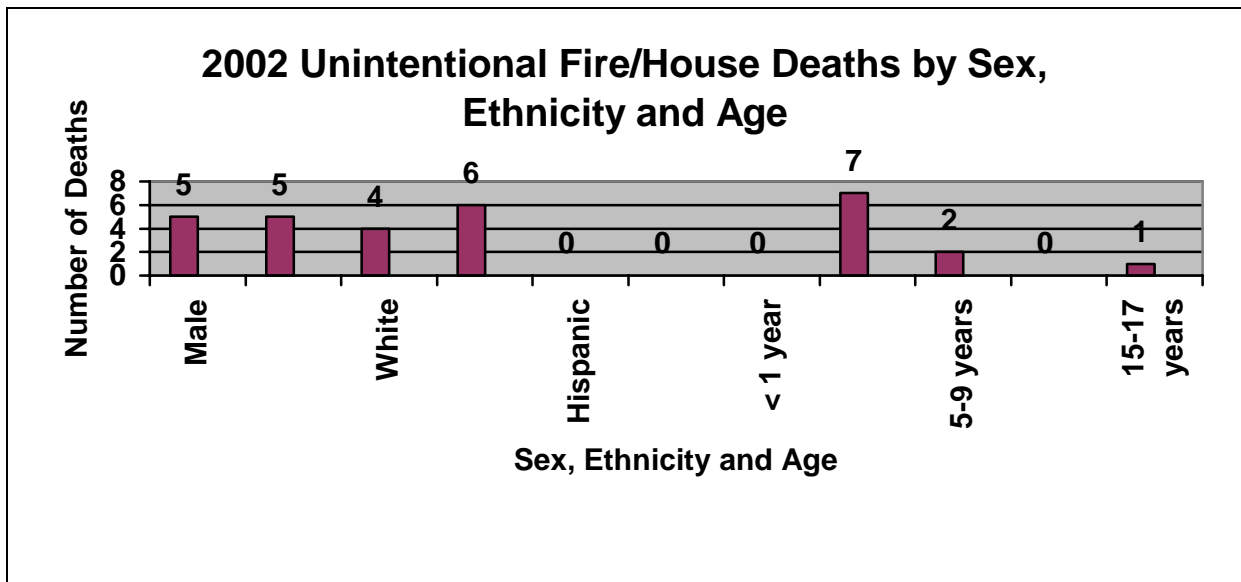


## UNINTENTIONAL FIRE/HOUSE

In 2002, 10 children were victims of fire in a house or residence. This number has remained steady for the past 4 years.



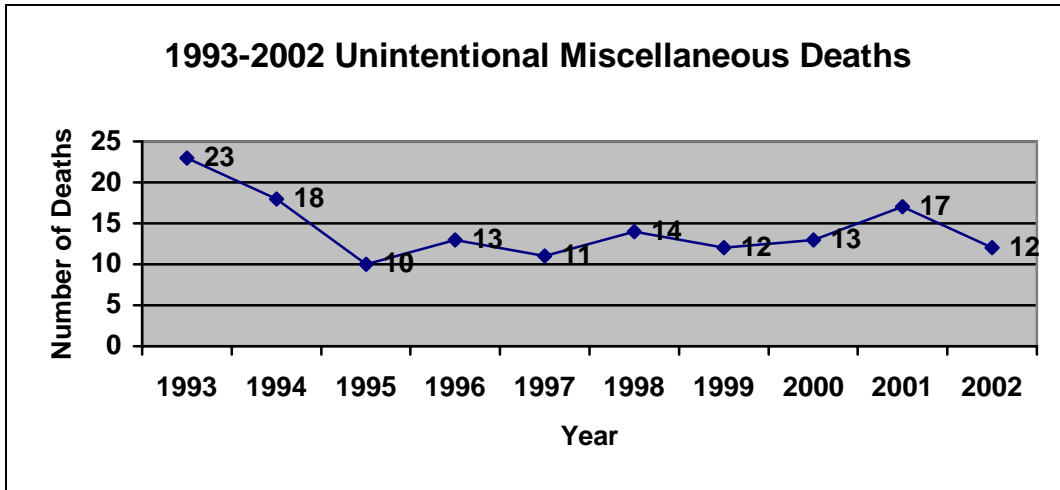
Fire/House victims are evenly divided between males and females. Each represents 50% of deaths. African Americans represent 60% of deaths, and children under the age of 10 years represent 70%.



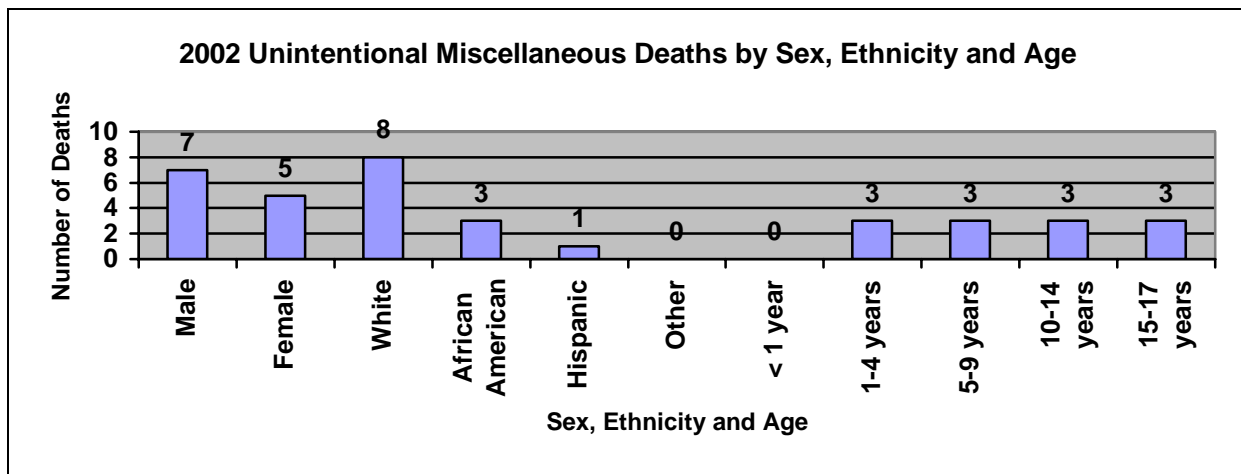
All fire deaths occurred in the child's primary residence or residence of a friend.

## UNINTENTIONAL MISCELLANEOUS

In 2002, 12 children were victims of miscellaneous unintentional injuries. These 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. With the exception of a spike in 2001, the number of miscellaneous unintentional deaths has remained within a small range for the past 7 years.

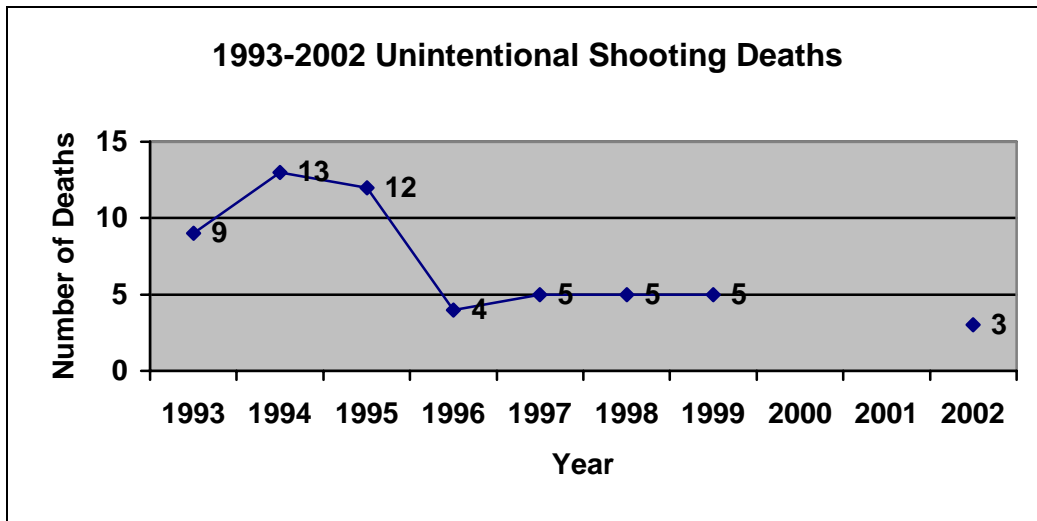


Males accounted for 58.3% and Caucasians 66.6% of unintentional miscellaneous deaths in 2002. Deaths were evenly distributed across the 1-4 years, 5-9 years, 10-14 years and 15-17 years age groups, with each representing 25% of deaths.

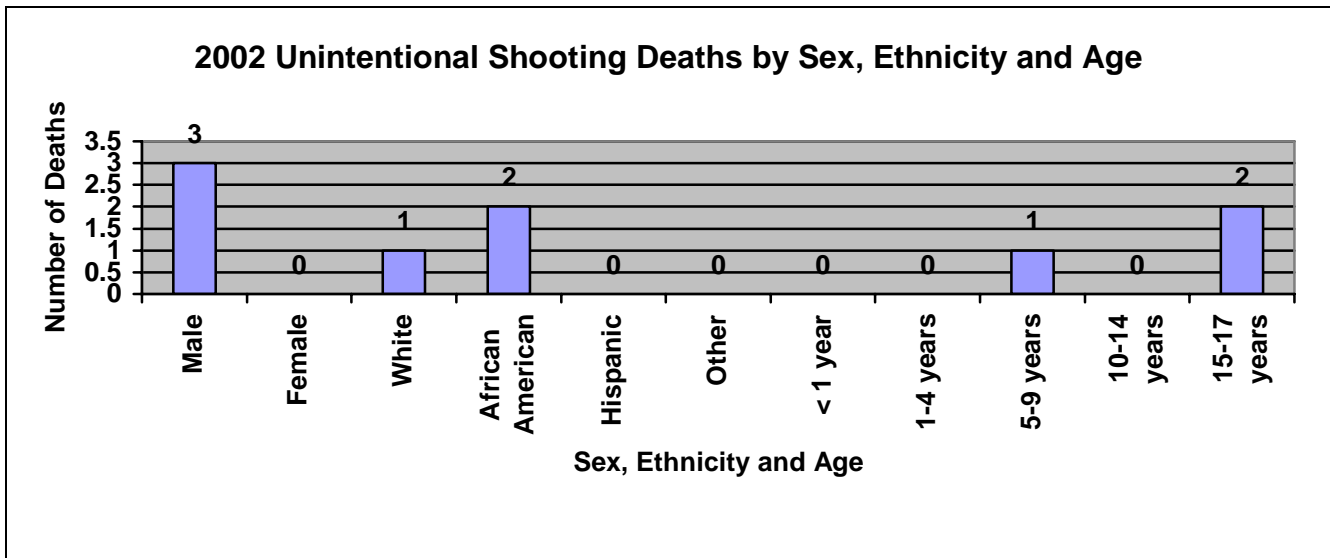


## UNINTENTIONAL SHOOTING

In 2002, 3 children died from unintentional shootings. This is an increase from the 0 deaths in 2000 and 2001.



Males accounted for 100% of unintentional shooting deaths, and African Americans 66.6%. 66.6% of deaths were of children between the ages of 15 and 17 years.



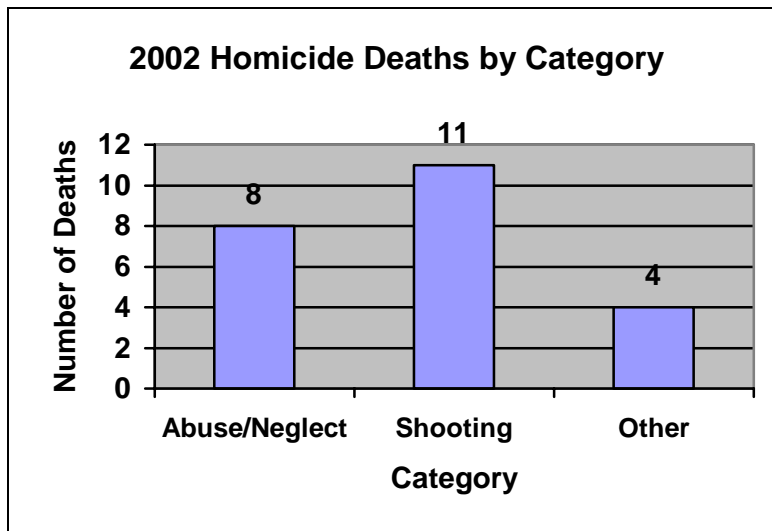
The unintentional shooting took place while playing with a firearm, playing Russian roulette, and by dropping the firearm. In two cases, the firearm belonged to a parent. The owner of the weapon in 1 incident is unknown.

# HOMICIDE

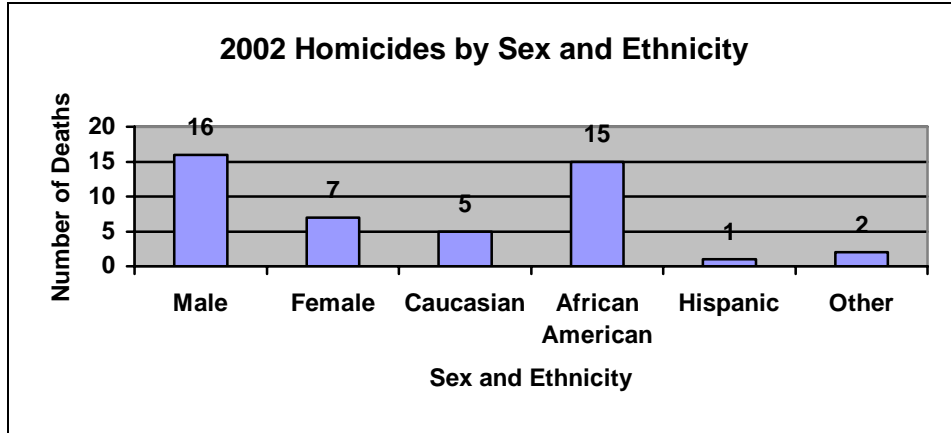
In 2002, 23 child deaths from homicide occurred. This is the lowest number of child homicides since the creation of the Department of Child Fatalities, and continues a downward trend in homicide numbers.



Homicides are classified by 3 categories: Abuse/Neglect, Shooting and Other. This year, "other" includes homicide by beating, fire/house, and poisoning. 47.8% of the homicides were shootings.



69.6% of homicide victims were male. 30.4% of homicide victims were female.

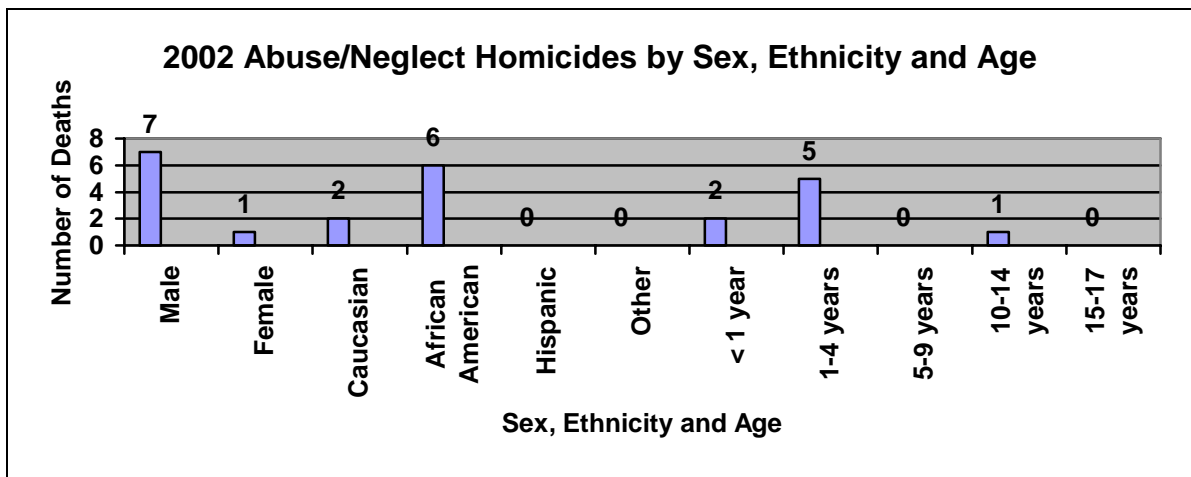


34.8% of homicide victims were between the ages of 1 and 4 years. 56.5% were between the ages of 10 and 17 years. However, most deaths by abuse/neglect were of victims in the 1-4 years of age group. Shooting victims are represented in the 10-17 years of age group.



### HOMICIDE BY ABUSE/NEGLECT

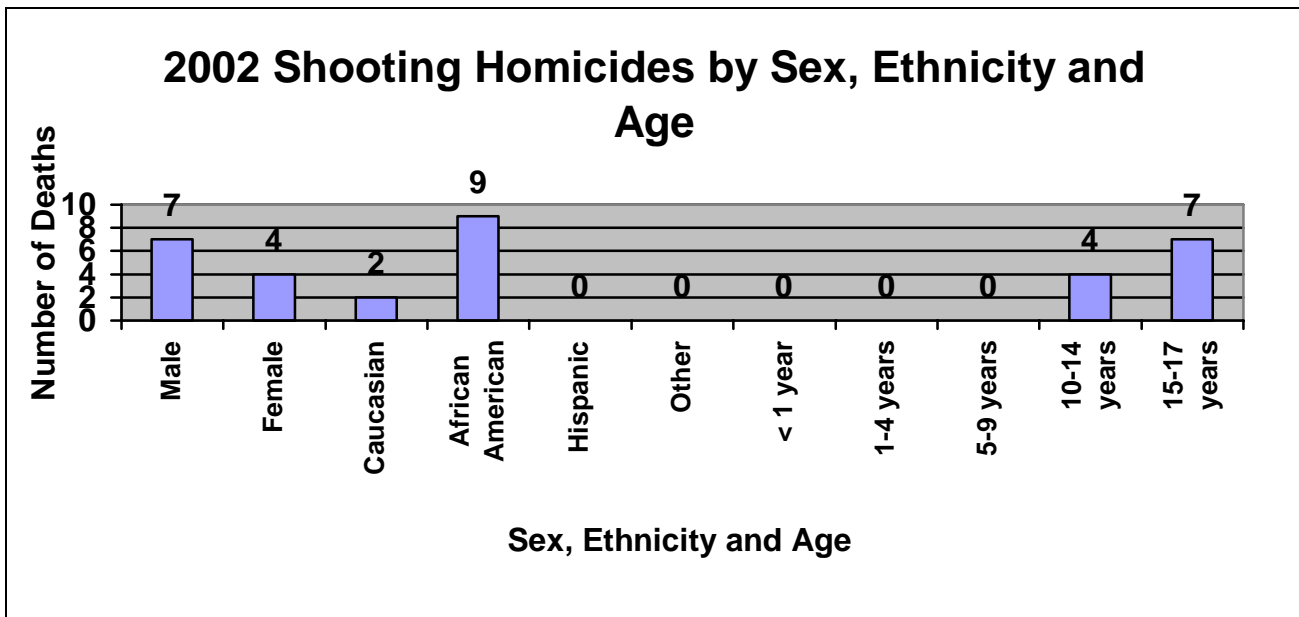
87.5% of abuse/neglect homicide victims were male. 75% of abuse/neglect homicide victims were African American, and 62.5% were between the ages of 1 and 4 years.



Their parent, relative or other caregiver killed all victims.

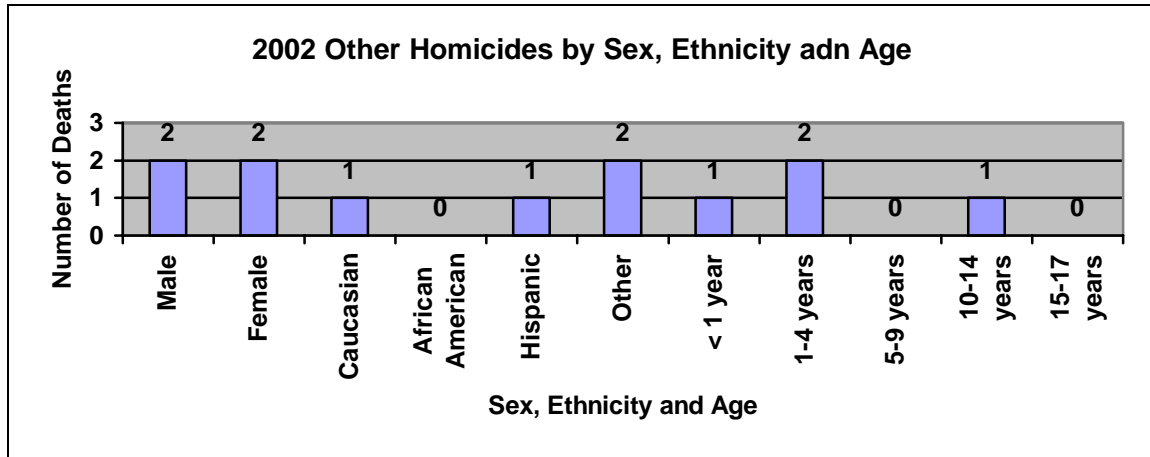
### HOMICIDE BY SHOOTING

63.6% of shooting homicide victims were male. 81.8% of shooting homicide victims were African American, and 63.6% of victims were between the ages of 15-17 years.



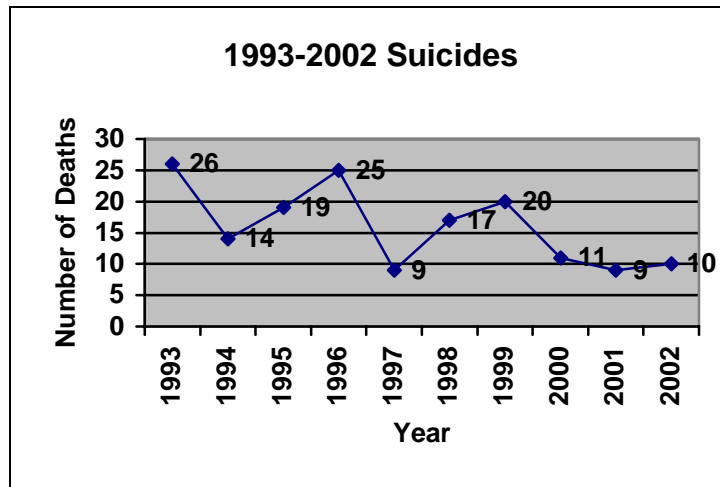
## HOMICIDE BY OTHER METHOD

“Other” homicide deaths in 2002 include beating, fire/house, and poisoning. Deaths were evenly divided between males and females, with each sex representing 50% of deaths. 50% of other homicides were to children between the ages of 1 and 4 years.

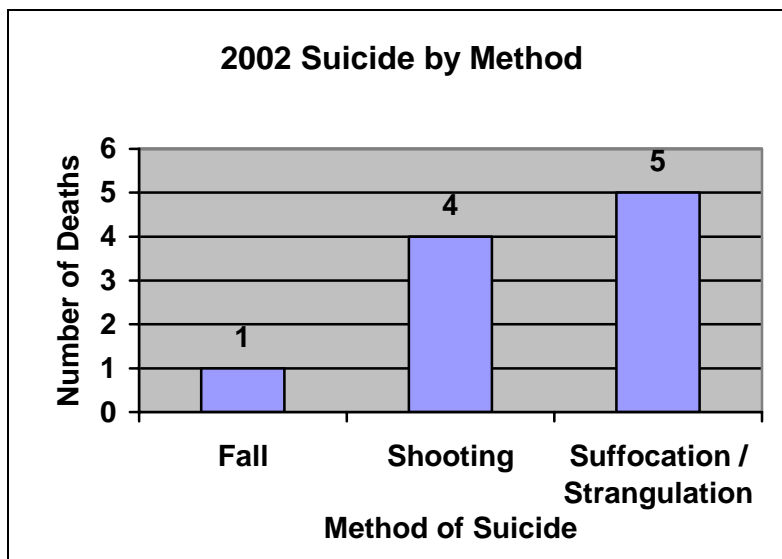


# SUICIDE

In 2002, 10 children died from suicide.

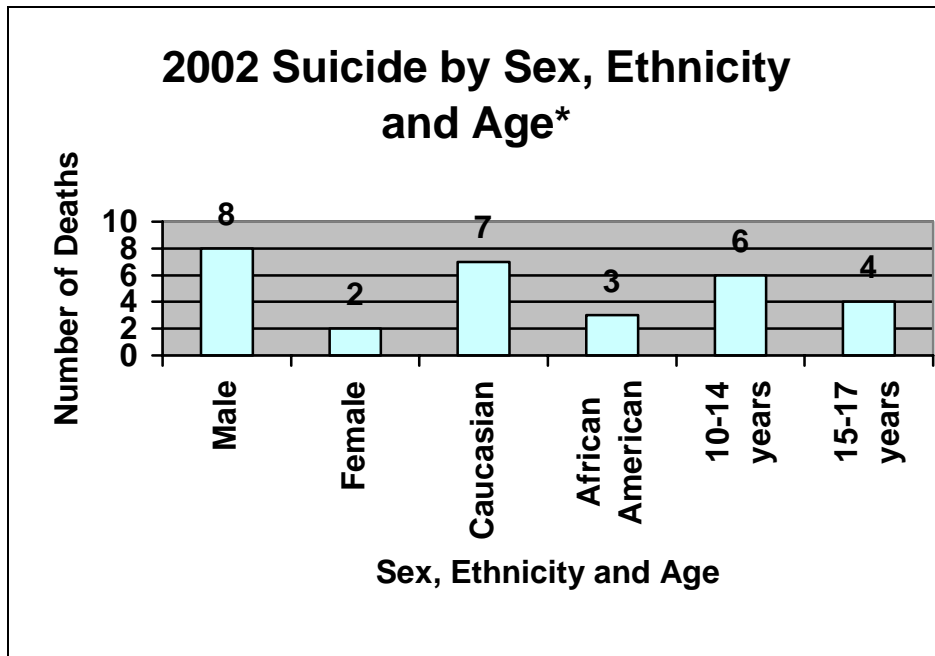


In 2002, three methods of suicide are represented: falls (10%), shooting (40%), and suffocation/strangulation (50%).

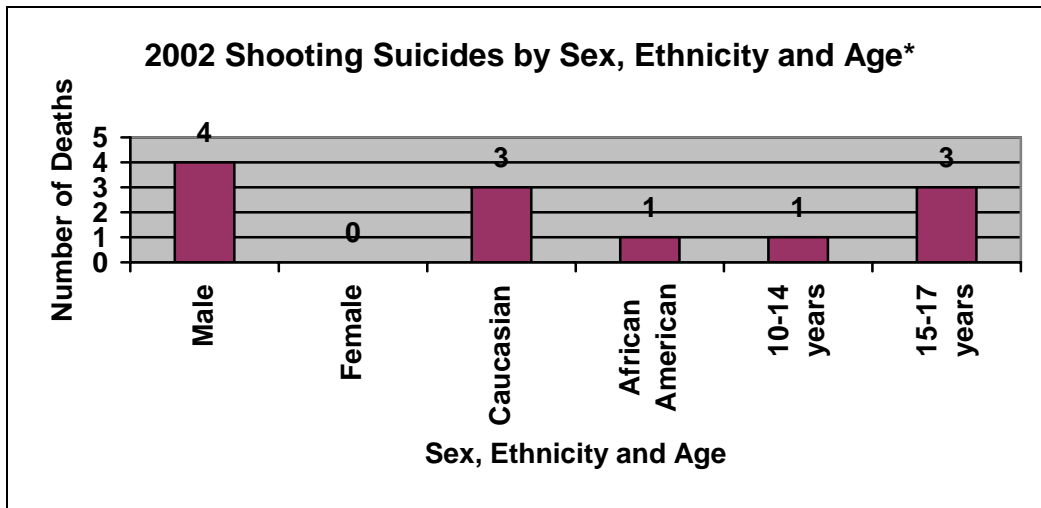


80% of suicides were completed by males, 70% by Caucasians, and 60% by children between 10-14 years of age.

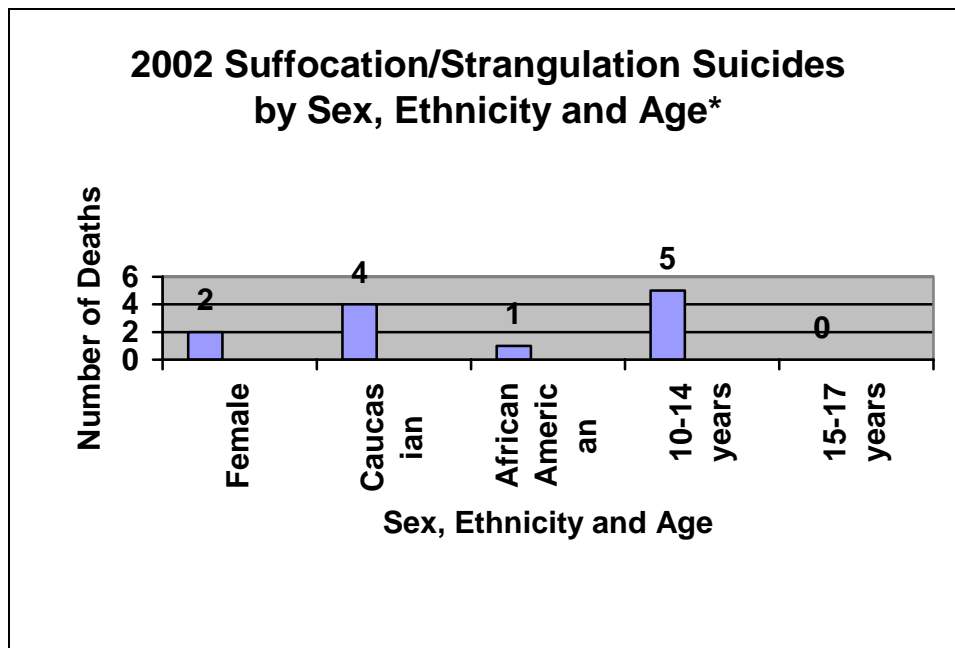




100% of shooting suicides were completed by males, and 75% were Caucasian. Individuals 15-17 years of age comprised 75% of the victims.



Males completed 60% of suffocation/strangulation suicides. 80% of suicides were completed by Caucasians, and 100% by children between the ages of 10-14 years.



Methods numbering 1 victim will not be analyzed to protect confidentiality.

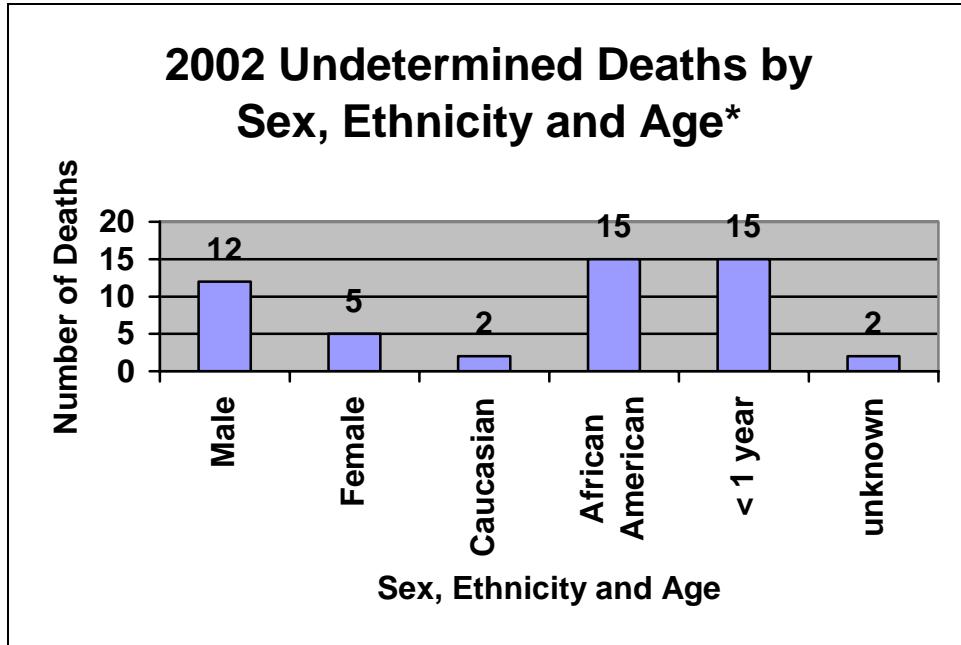
50% of suicides were completed in the victim's residence, with other locations being a bridge, behind a barn, in the forest/woods and at a country club.

In each suicide shooting, the firearm used belonged to the victim's father and stored in the home.

\*Ethnicity or age groups not represented on chart number as "0" deaths.

## UNDETERMINED

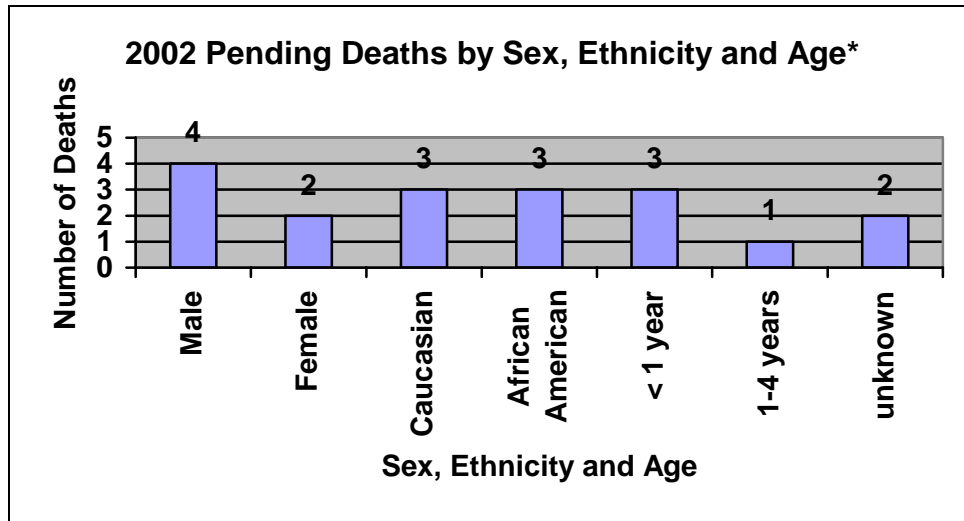
The *Undetermined* category includes cases that have been investigated but a manner of death cannot be determined based on the available information. In 2002, 17 child deaths are in this category. 70.6% of undetermined deaths are male. 88.2% of pending deaths are African American. 88.2% of pending deaths were less than 1 year of age.



\*Ethnicity or age groups not represented on chart number as "0" deaths.

## PENDING

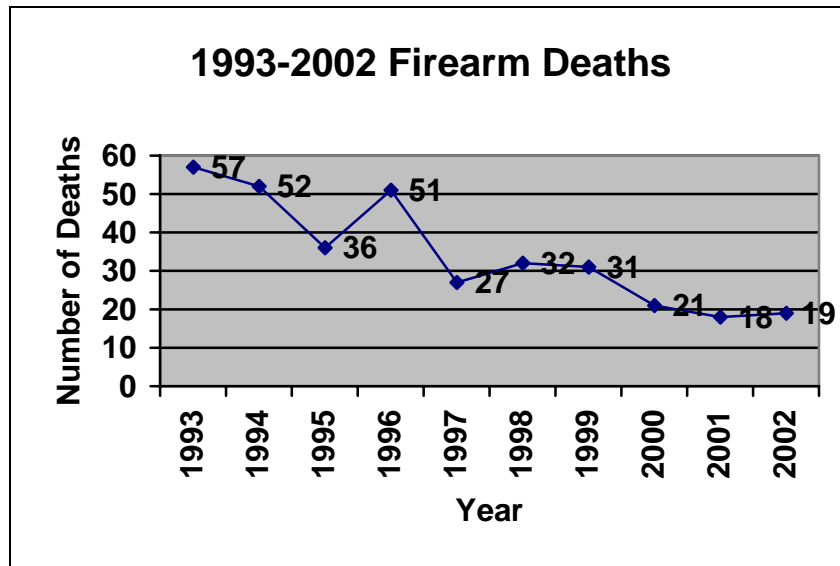
6 deaths occurring in 2002 are pending investigations to determine cause and manner of death. 66.6% of these are of male children. Pending deaths are evenly split between Caucasian and African American, with each group representing 50% of pending deaths. 50% of pending deaths are of children less than 1 year of age.



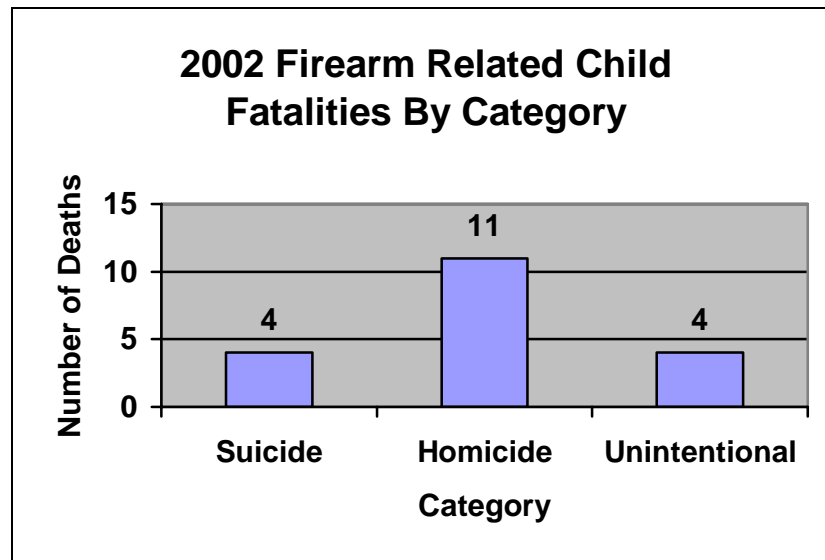
\*Ethnicity or age groups not represented on chart number as "0" deaths.

## FIREARM RELATED CHILD FATALITIES

In 2002, 19 firearm related child fatalities occurred. This is a 5.6% increase from 2001.

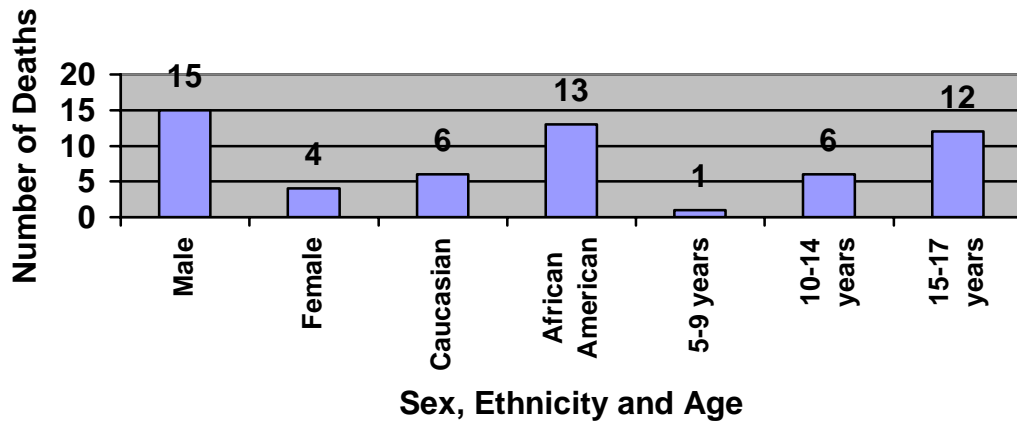


57.9% of firearm related child fatalities were homicide.



79.8% of victims were male. 68.4% of victims were African American. 63.2% of victims were between the ages of 15 and 17 years.

## 2002 Firearm Related Child Fatalities by Sex, Ethnicity and Age



## CHILD FATALITIES PER COUNTY

County	Number of Child Fatalities
Abbeville	0
Aiken	5
Allendale	0
Anderson	7
Bamberg	2
Barnwell	1
Beaufort	3
Berkeley	3
Calhoun	0
Charleston	16
Cherokee	5
Chester	3
Chesterfield	2
Clarendon	2
Colleton	1
Darlington	4
Dillon	2
Dorchester	1
Edgefield	0
Fairfield	1
Florence	12
Georgetown	5
Greenville	18
Greenwood	2
Hampton	0
Horry	8
Jasper	1
Kershaw	3
Lancaster	5
Laurens	8
Lee	0
Lexington	14
Marion	0
Marlboro	2
McCormick	0
Newberry	0
Oconee	2
Orangeburg	5
Pickens	4
Richland	19
Saluda	1
Spartanburg	21
Sumter	7
Union	1
Williamsburg	4
York	5

***STATE CHILD FATALITY ADVISORY  
COMMITTEE ACTIVITIES &  
RECOMMENDATIONS***



## 2003 State Child Fatality Advisory Committee Activities

The State Child Fatality Advisory Committee (SCFAC) continued a bi-monthly meeting schedule in 2003. The six meetings took place on the first Wednesday of February, April, June, August, October and December. The February meeting covered the agenda of the December 2002 meeting, which was postponed due to weather. Throughout the year 72 previously reviewed cases continued to be reported on for clarification on questions raised during the initial review. 239 new cases were reviewed. As a result of the reviews, follow-up to cases included letters to pathologists requesting information from autopsies, communication with the South Carolina Department of Natural Resources in regards to a dangerous boat landing, and continued monitoring of needed family services.

Changes in SCFAC membership and leadership occurred in 2002. New representatives from the South Carolina Department of Alcohol and Other drug Abuse Services, the South Carolina Department of Juvenile Justice and the Sixteenth Circuit Solicitor's Office joined the Committee. The vacancy for an attorney with experience in prosecuting crimes against children awaits appointment by the Governor. Additionally, a new program coordinator began working with the SCFAC. The term of Mr. Bill Billingsley as chair ended, and Dr. Clay Nichols was elected chair for the next two-year term. Dr. Gratin Smith continues to serve as Vice-Chair.

The SCFAC engaged in many activities throughout the year.

On April 8, 2001, the 2001 Annual Report was presented to the Governor at the Rotunda of the State House. Prevent Child Abuse South Carolina allowed SCFAC to share in their event. Issues the Committee highlighted in 2002 include 1) safe and unsafe sleeping arrangements, 2) inconsistency in sentencing for people who abuse children and 3) arson investigation. The SCFAC supports the position that an arson death team should be available to investigate all fire related child deaths.

Building partnerships with other organizations dedicated to the welfare of children exists as a continuing goal of the SCFAC. Several steps were taken to enhance and build relationships during the past year. SC SAFE KIDS is dedicated to preventing unintentional injuries, fatal and non-fatal, of South Carolina's children. Unintentional injury has consistently proved to be the leading category of child fatality reviewed by the SCFAC. Through working together the efforts of both groups are enhanced. As part of this partnership, the Chair of the SCFAC is now a member of the SC SAFE KIDS board. Other partnerships include participation with the YWCA Week Without Violence Campaign. The SCFAC is also represented on a task force to review child death review in South Carolina brought together by the South Carolina Department of Social Services.

Throughout 2003 the SCFAC continued its support of local Children's Health and Safety Councils and local child death review (CDR) teams. The SCFAC program coordinator provides technical assistance upon request and acts as a facilitator of communication between local Councils and the SCFAC. An editorial stating the position of the SCFAC was submitted to *The State* newspaper, but was unfortunately not published. A copy of the submitted editorial may be found in Appendix G. As a retrospective review board, the SCFAC is positioned to view statewide trends in child fatality and act as child advocates at the state level through identifying and recommending systemic and legislative changes that would protect children if

enacted. Local Councils and CDR teams are able to provide concurrent review that may affect investigation and immediately impact any services that need to be provided to surviving family members.

Local CHSC and CDR teams are also in a unique position to directly impact change within the community and environment to prevent future child deaths. For example, as a result of a bike/auto crash, the Greenwood CHSC convinced a private property owner to erect a fence to keep children from cutting through the property into the street. Lancaster CHSC realized through CHSC meetings that valuable information about child and infant deaths was being lost during initial emergency response. As a result, Lancaster developed a form to be filled out by EMS at the scene of a home death of an infant or child. This form collects the information needed to adequately review the death and determine how future deaths may be prevented (Appendix H). Additionally, many CHSCs, such as Richland, fly Memorial flags in the event of a preventable death of a child. The SCFAC supports Children's Living Memorial flags in many counties by procuring the flags and providing them at cost to interested groups.

The SCFAC recognizes that the current status of SC's CHSC system can be improved to better serve the children of SC. In order to build on the groundwork that has been laid, local teams must be supported so that the number of counties participating can be expanded across the state. Additional technical assistance will be needed along with legislation to acknowledge and support the role of the local review process. Confidentiality provisions will need to be formally established for the local teams as well. The framework for statewide child death review is in place and may be enhanced with stronger support from the state level.

In addition to stating continuing support for building partnerships among those interested in saving children's lives and Children's Health and Safety Councils and local child death review, the SCFAC would like to emphasize several issues in the following year:

- 1) The importance of law enforcement as well as coroners being on the scene of a child's death. Without the presence of law enforcement critical evidence pertaining to a child's death may be lost.
- 2) The need to strengthen relationships between local law enforcement and medical community and different agencies involved - Until all involved caring for children and investigating their premature death communicate effectively, the ability to conduct effective child death review will be hampered.
- 3) Unsafe sleeping – This is a disturbing trend observed by the SCFAC. In many unintentional injury and SIDS cases, unsafe sleeping practices are observed. These include inappropriate bedding (blankets, pillows, comforters), multiple family members in the same bed and infants placed to sleep on their stomachs.

# State Child Fatality Advisory Committee Recommendations

## Sudden Infant Death Syndrome:

- ◆ Communicate the importance of placing infants on their backs when putting them down for sleeping or naps. Parents and caregivers should be made aware of the risk factors related to SIDS through public awareness campaigns, publications and training.
- ◆ Provide safe sleeping arrangements for newborns and young children who may be accidentally asphyxiated from soft mattresses, the bodies of other siblings or parents, and excessive bedding or improperly fitted crib mattresses.
- ◆ Intensify public education campaigns to recognize the risk for SIDS such as sleep position

## Unintentional Drownings:

All children should be taught how to swim! Local schools, community agencies and/or local recreational safety commissions take the leadership in assuring that every community has a water safety program available to every child. Emphasize adult supervision of children around any body of water. Provide warning signs around lakes, ponds and river areas that are popular attractions for swimming/boating activities. Stress responsible safety measures to private pool owners, especially in regard to adequate fencing/barriers around pools.

- ◆ Educate the public that living near a body of water is **NOT** the only risk of drowning.
- ◆ Recognize any container of water as a potential source of drowning such as 5-gallon buckets, mop buckets.
- ◆ Supervise children in the bathroom – tubs and toilets are sources of drowning.
- ◆ CPR, life-saving techniques, and life vests do not replace supervision. Most drowning of young children happens during a momentary interval of non-supervised time.
- ◆ Teach children to swim at a very young age.
- ◆ Mandate all pools should be fenced and gated to limit access by children.

**Unintentional Suffocations/Strangulations:** The Committee recommends that state agencies involved in home visitation programs provide training in home safety as part of their services to parents and caregivers. Training should include risks of unsafe sleeping arrangements for infants and toddlers, proper feeding procedures, warnings regarding foods most likely to choke children and basic CPR techniques. A public information campaign should be initiated to educate the community on unsafe sleeping/bedding arrangements for children – including discouraging parents/caregivers from sleeping with infants, especially while under the influence of drugs/alcohol, dangers of improper bedding, risk of placing an infant face down for sleeping and allowing infants to sleep in adult beds.

- ◆ Educate the public on choking the hazards of latex balloons, nuts, hard candy and hot dogs.
- ◆ Provide safe sleeping arrangements for newborns and young children who may be accidentally asphyxiated from soft mattresses, the bodies of other siblings or parents, and excessive bedding or improperly fitted crib mattresses.

**Unintentional Fire/House:** Encourage public awareness of the importance of fire prevention and maintaining functional smoke detectors and fire alarms

- ◆ Require all fire deaths involving children to be investigated by a certified arson investigation team (if one is not available to be investigated then the SLED Arson Unit is available to investigate any child death from a fire).
- ◆ Develop an escape plan and practice with children at least once a year.
- ◆ Require functioning smoke alarms and fire extinguishers in all residences.
- ◆ Restrict children's access to lighters, candles and matches.

### **Unintentional Miscellaneous:**

- ◆ Restrict access to golf carts, 4-wheelers, motorcycles and lawnmowers to young children.
- ◆ Educate children to avoid all unfamiliar animals.
- ◆ Hold pet owners accountable for unrestrained animals.
- ◆ Supervise young children when near the highway as well as the residential driveway.

**Homicide – Child Abuse/Neglect:** Provide awareness education to teachers, day care providers, pediatric workers and other people in the community in the area of identification and detection of child abuse and neglect. Stress greater inter-agency communication between law enforcement agencies, Departments of Social Services, Mental Health, Education (school counselors) and the pediatric community.

- ◆ Legislate and enforce stronger Child Endangerment laws
- ◆ Provide training for DSS workers who perform and document home visits in child protective service cases and supervisors who determine case action

**Suicide:** Educate parents, teachers, coaches and other child-care workers on the “warning signs” associated with suicide. Identifying potential warning signs and recognizing at-risk children can initiate proper assistance and guidance through professional services.

- ◆ Restrict access to firearms and weapons
- ◆ Use informative posters to heighten awareness at schools how peers can recognize and report friends exhibiting suicidal warning behaviors
- ◆ Educate public that professional help should be sought immediately
- ◆ Support public awareness and campaigns about recognizing children at risk for suicide and the importance of seeking intervention for these children.

**Firearm Related Child Fatalities:** Decrease the accessibility and availability of handguns to children and promote gun safety programs through the Departments of Education, Natural Resources and Public Safety. Also partner with other organizations such as Boy Scouts and Girl Scouts, National Rifle Association, Ducks Unlimited and law enforcement agencies. The emphasis should be on responsible storage and security of firearms in the home, proper use of firearms while hunting with a responsible adult and educating young people on the tragic consequences of inadequate gun safety measures.

- ◆ Support legislation for gun responsibility and firearm safety laws.
- ◆ Mandate gun safety legislation
- ◆ Support public campaigns and parenting education that focus on prevention of violence-related deaths, including firearm safety and suicide prevention measures.
- ◆ Enforce existing firearm laws prohibiting persons under the age of 18 years from purchasing or illegally possessing a firearm.

- ◆ Teach children to stay away from guns and to report immediately to an adult that they have seen/found a gun.
- ◆ Keep guns and ammunition out of the reach of children.

## **APPENDICES**

Appendix A: Membership – State Child Fatality Advisory Committee

Appendix B: Flowchart – State Child Fatality Advisory Committee

Appendix C: Flowchart – Child Fatality Investigation and Review

Appendix D: Child Death Investigations

Appendix E: State Coroners by Region/County

Appendix F: Child Fatality Coroner Protocol

Appendix G: Editorial

Appendix H: Lancaster County EMS Child/Infant Fatality Form

Appendix I: Data Sources and Acknowledgements



**STATE CHILD FATALITY ADVISORY COMMITTEE  
MEMBERSHIP**

**BILL BILLINGSLEY**

*SC Department of Education*

**DENNIS BURDETTE**

*South Carolina Department of Juvenile Justice*

**JENNIFER BUSTER**

*SC Department of Disabilities and Special Needs*

**ROBERT EDGE**

*S. C. Coroner's Assoc./Horry County Coroner*

**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**

*South Carolina Department of Health &  
Environmental Control*

**DR. CLAY NICHOLS**

*Richland Memorial Hospital/Dept. of Pathology*

**EMILY REINHART LT.**

*South Carolina Law Enforcement Division*

**DR. GRATIN SMITH**

*South Carolina Academy of Pediatrics*

**SHANNON WILEY**

*Sixteenth Circuit Solicitor's Office*

**HARRIET WILLIAMS**

**MARY WILLIAMS**

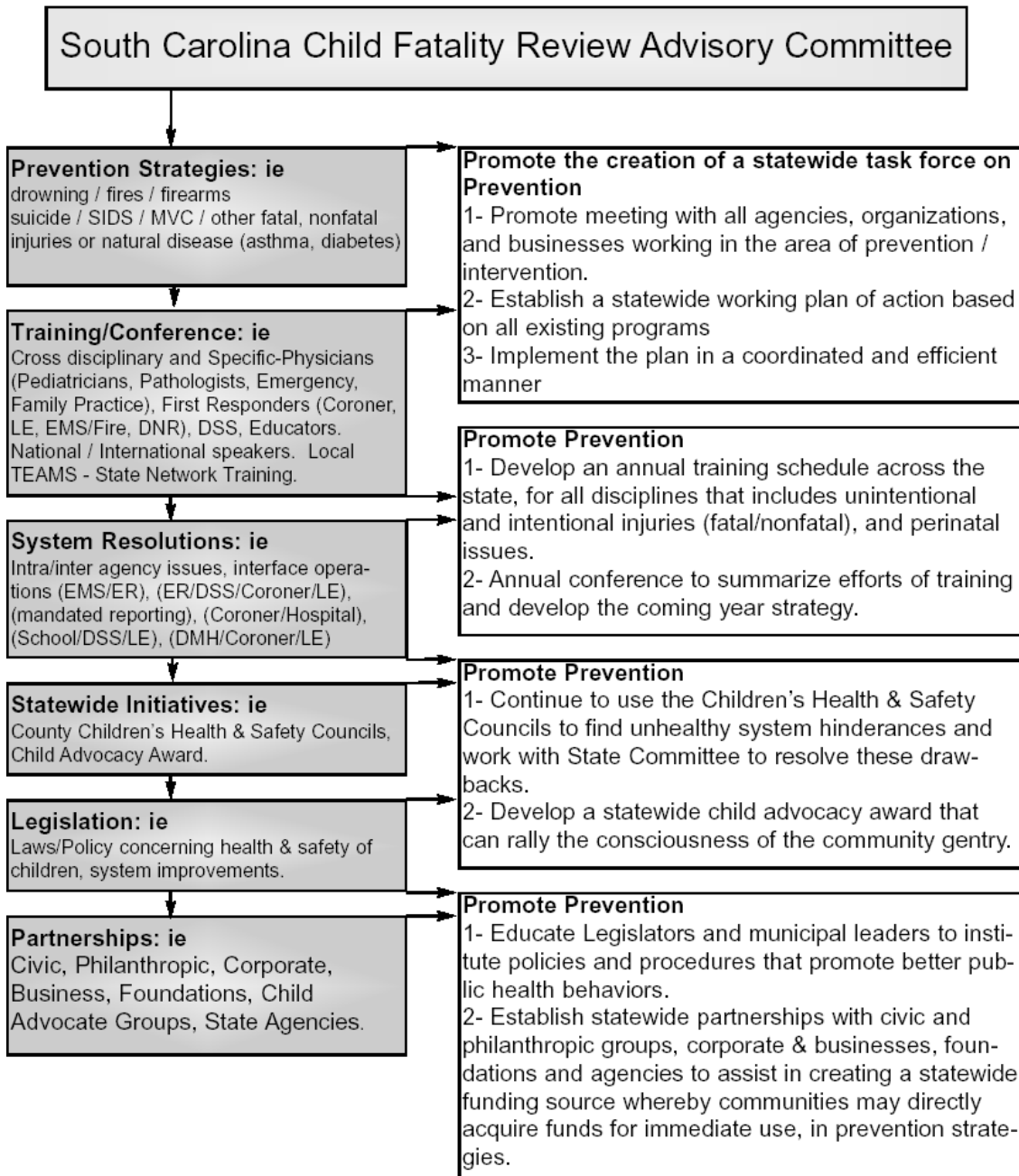
*Dept. of Alcohol & Other Drug Abuse Services  
South Carolina Department of Social Services*

**RITA YARBOROUGH**

*SC DPS Criminal Justice Academy*

**VACANT**

*Governor's Appointment - Attorney*



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



## 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

County Coroner / Medical Examiner:  
Death Scene Investigation, orders Autopsy, completes Coroner Protocol

*Regional SLED Office:* assigns Case to Special Agent  
*Special Agent:* contacts County Coroner / Medical Examiner within five days, to inform them of assigned case

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.

## 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.

## **STATE CORONERS BY REGION/COUNTY:**

### **Low Country**

Allendale	Elaine Poston
Bamberg	Willard Duncan
Barnwell	Lloyd Ward
Beaufort	Curt Copeland
Berkeley	Glenn Rhoad
Calhoun	Donnie Porth
Charleston	Susan Chewing
Colleton	Richard M. Harvey
Dorchester	Chris Nisbet
Hampton	Gordon Rhoden, Sr
Jasper	L. Martin Sauls, III
Orangeburg	Samuetta Marshall

### **Midlands**

Aiken	Watson E. Wright
Chester	Thurmond Burnett
Edgefield	Joseph Silvia
Fairfield	John B. Fellers, III
Kershaw	Michael Morris
Lancaster	Harry Harmon
Lexington	Faye L. Puckett
McCormick	Gary Watts
Richland	Keith Turner
Saluda	

### **Pee Dee**

Chesterfield	Donald Baker
Clarendon	Ranny Stephens
Darlington	J. Todd Hardee
Dillon	Dan Grimsley
Florence	M. G. "Bubba" Matthews
Georgetown	Kenneth Johnson
Horry	Robert Edge, Jr.
Lee	Alford Elmore
Marion	Jerry Richardson
Marlboro	Timothy Brown
Sumter	Verna Moore
Williamsburg	Harrison McKnight, Jr.

### **Piedmont**

Abbeville	Ronnie Ashley
Anderson	Greg Shore
Cherokee	Harley Vinesette
Greenville	Parks Evans
Greenwood	James T. Coursey
Laurens	F. G. "Nick" Nichols
Newberry	James Smith
Oconee	Karl E. Addis
Pickens	James R. Mahanes, MD
Spartanburg	James Burnett
Union	William Holcombe
York	Douglas P. McKown



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: \_\_\_\_\_

Deceased: Last \_\_\_\_\_, First \_\_\_\_\_ Race Sex: Age:  
DOB: \_\_ / \_\_ / \_\_  
(If more than one child death @ same time, photocopy 1<sup>st</sup> 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: \_\_\_\_\_

Mother: \_\_\_\_\_ Race: Sex: Age: DOB: \_\_\_\_\_ SSN \_\_\_\_\_

Father: \_\_\_\_\_ Race: Sex: Age: DOB: \_\_\_\_\_ SSN \_\_\_\_\_

Other Family Members Living with Child:

	<u>Race</u> :	<u>Sex</u> :	<u>DOB</u> :	<u>SSN</u> :
_____	_____	_____	__ / __ / __	____ : ____ : _____
_____	_____	_____	__ / __ / __	____ : ____ : _____
_____	_____	_____	__ / __ / __	____ : ____ : _____

Decedent

Name: \_\_\_\_\_

Witnesses: \_\_\_\_\_

Caregiver(s) \_\_\_\_\_ Race: \_\_\_\_\_ Sex: \_\_\_\_\_ Age \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_ DOB: \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ SSN: \_\_\_\_\_

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: \_\_\_\_\_



## Editorial Submitted to *The State* Newspaper

The editorial regarding the child death review system in South Carolina brings much needed attention to the plight of many children in our state and the need for a coordinated response to all threats to children's safety. Although the editorial portrays the concept of local child death review as a new initiative, it is actually an established initiative that is in need of new energy and broader support.

State law created the State Child Fatality Advisory Committee in 1993 to assist the newly created Department of Child Fatalities in the State Law Enforcement Division. The Committee is comprised of representatives of state agencies as well as representatives from law enforcement, coroners, pediatricians, pathologists, child advocates and solicitors. The Committee meets every other month with the Department of Child Fatalities to review specific cases of unexplained and unexpected deaths of children under the age of 18 years and the circumstances involved.

The Committee reviews approximately 200 cases each year. Each case is reviewed and analyzed to determine whether further investigation is necessary, and whether a response is needed from an agency involved with the case. If the case indicates that immediate action is needed, a member of the Committee is assigned to follow-up. Statistics are compiled annually into a report that includes recommendations for preventing child fatalities. In some cases agencies identify and address gaps in services or needed changes in policies or protocols. By reviewing deaths and examining trends, the Committee is able to identify and recommend systemic and legislative changes that would protect children if enacted. The Committee agrees a thorough review of child fatalities should exist and more importantly effective responses to the findings are vital.

The Committee strongly supports the concept of local teams. Through our annual reports, submitted each year to the governor and legislature, we have pointed out the need for the support and establishment of local teams. In 1997, through the leadership of the Department of Social Services and the Department of Health and Environmental Control, the Committee recommended the establishment of local Children's Health and Safety Councils (CHSC). The purpose of the councils is to "review all local deaths and injuries." DSS and DHEC provided grant funds to hire a program coordinator to work with our Committee. The program coordinator provides technical support to local groups to help get their local review teams started.

As a result of these efforts and the enthusiastic response of many local communities, Councils were formed and began operating. Though there has been no state funding provided to finance these local initiatives, sixteen communities have made an effort to establish local health and safety teams. Child death reviews have occurred and preventive steps have been taken to protect the well being of children as a result of their efforts. For example, as a result of a bike/auto crash, the Greenwood CHSC convinced a private property owner to erect a fence to keep children from cutting through the

property into the street. Many CHSCs, such as Richland, fly Memorial flags in the event of a preventable death of a child.

The Committee recognizes that the current status of SC's CHSC system can be improved to better serve the children of SC. In order to build on the groundwork that has been laid, local teams must be supported so that the number of counties participating can be expanded across the state. Additional technical assistance will be needed along with legislation to acknowledge and support the role of the local review process. Confidentiality provisions will need to be formally established for the local teams as well. Our committee will again ask the General Assembly to pass legislation this year to codify local Children's Health and Safety Councils with confidentiality procedures. The framework for statewide child death review is in place and may be enhanced with stronger support from the state level.





## Data Sources and Acknowledgements

### The following agencies and organizations provided data in this Annual Report:

All child fatality data –

- ◆ South Carolina Law Enforcement Division, Dept. of Child Fatalities

Collaborating and cross-referencing data –

- ◆ Department of Health and Environmental Control, Public Health Statistics and Information Systems
- ◆ State Budget and Control Board, Office of Research and Statistics
- ◆ South Carolina Coroners
- ◆ Department of Social Services, Child Protective Services

### Acknowledgements:

The State Child Fatality Advisory Committee 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.

- ◆ Department of Health and Environmental Control:
  - Jo Ann S. Gooding, Director – Division of Vital Records
  - Mary Hill Glover, Statistical and Research Analyst – Division of Biostatistics and Health GIS
- ◆ Department of Social Services:
  - Beth Williams, Assistant Director of Family Preservation and Child Welfare Services
  - Cookie Schakle

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