SOUTH CAROLINA
STATE CHILD FATALITY
ADVISORY COMMITTEE

Annual Report

2023

DEDICATION

This report reflects the work of numerous dedicated professionals from communities throughout the State of South Carolina who have committed themselves to gaining a better understanding of how and why children die. Their work is driven by a desire to protect and improve the lives of young South Carolinians. Each child's death represents a tragic loss for the family and the communities they impacted.

We dedicate this report to the memory of these children and to their families.

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HISTORY AND MISSION

When a child dies unexpectedly, the response by the state and the community to the death must include an accurate and complete determination of the cause of death, including 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.

The State Child Fatality Advisory Committee (SCFAC) was enacted in 1993. S.C. Code 63-11-1950 mandates that the State Child Fatality Advisory Committee (SCFAC) review completed investigations of deaths involving children aged 17 years and younger that are unexpected, unexplained, suspicious, or criminal in nature. Since its enactment, the committee has completed review of 3,409 cases as of December of 2023.

The committee is composed of twenty (20) members including law enforcement, legal, medical, state agencies working with children, legislators, and two members from the general public. A full list of committee members can be found on page 2.

The SCFAC meets every other month and, using a system mapping approach, reviews cases by manner of death. Prior to 2023, the committee had reviewed 42 cases of various causes and manners of death at each meeting. These cases reviews were conducted at an individualized case level, leading to missed opportunities for systemic improvement.

In 2023 the SCFAC made a commitment to review cases in a systemic manner, leveraging experts from the National Partnership for Child Safety (NPCS) to systems map cases by manner of death. Systems mapping facilitates collaboration at all levels of systemic influence, considering how family factors, community factors, professional factors, agency factors, as well as legislative factors contribute to child deaths in South Carolina. This collaboration serves to implement changes and initiate action within agencies represented on the committee and to propose changes in statutes, regulation, policies, and procedures to ultimately prevent and reduce the number of child deaths in South Carolina.

It is our vision to prevent future deaths of children by developing an understanding of how and why children die in the State of South Carolina.

HISTORY AND MISSION

SECTION 63-11-1950. Purpose and duties of committee.

(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.

MESSAGE FROM THE CHAIR

Thank you for reviewing the State Child Fatality Advisory Committee's 2023 Annual Report. This past year has not been business as usual for the State Child Fatality Advisory Committee (SCFAC). When I accepted the role as Chair of the committee in the Fall of 2022, committee members shared with me that they wanted the committee's work to truly make a difference for South Carolina's children. Another goal was to become more current with reviews and address the backlog of fatality reviews for the committee to complete. In an effort to be more focused and intentional in its mission to decrease incidences of preventable child deaths, the committee decided in late 2022 to explore a different approach to its review processes.

The National Partnership for Child Safety has used safety science to build a body of knowledge about what works in preventing child maltreatment and fatalities. Facilitated by DSS in 2022, members of the SCFAC met as a workgroup, applied the approach, and found the results to be helpful. The committee voted to incorporate safety science mapping for its state-level child death reviews beginning in 2023. This included a significant change to the agendas.

The committee's agenda historically was established based on the assigned SLED agent and included causes and manners of death from different years. The committee traditionally reviewed 42 cases at each meeting with a goal of reviewing 200 fatalities each year. Committee members voted to modify the approach for 2023 to create agendas based on manner of death (homicide, suicide, accidental, natural or undetermined). These changes allowed the committee to identify trends in causation and system involvement and to pull representative samples and themes to map. In addition, the committee reviewed 402 child deaths in 2023, which is more than twice as many fatality reviews as the prior year, despite not making quorum (and thus not being able to review any fatalities) in October of 2023.

The committee engaged in training, collaboration, and technical assistance. **SLED Captain Trista Baird** presented Child Death Investigations Task Force Training 101 regarding the task force's investigatory processes and the roles of coroners, law enforcement, and other entities in child death investigations. **Assistant U.S. Attorney Stacey Haynes** shared the USOA's leadership role with the Project Safe Neighborhoods program which is designed to reduce gun and gang-related violence. **Ellen Weaver, State Superintendent of Education**, shared important information about the role of schools in child fatality prevention and the committee's access to education data.

In addition to its regular schedule in 2023, the committee had two business meetings. **Dr. Mike Cull** of the University of Kentucky provided committee members with different approaches to fatality reviews and how other systems have improved outcomes. **Christina Rosato** of the University of Kentucky led the committee through a Lean Six Sigma exercise to map the SCFAC's current processes and future goals. The current-state and future-state mapping identified actionable steps to improve the committee's effectiveness. With focused agendas, cross-agency training and collaboration, and safety science mapping, the committee is better equipped to communicate and strategize fatality prevention recommendations and initiatives. We are looking forward to building on these efforts in 2024.

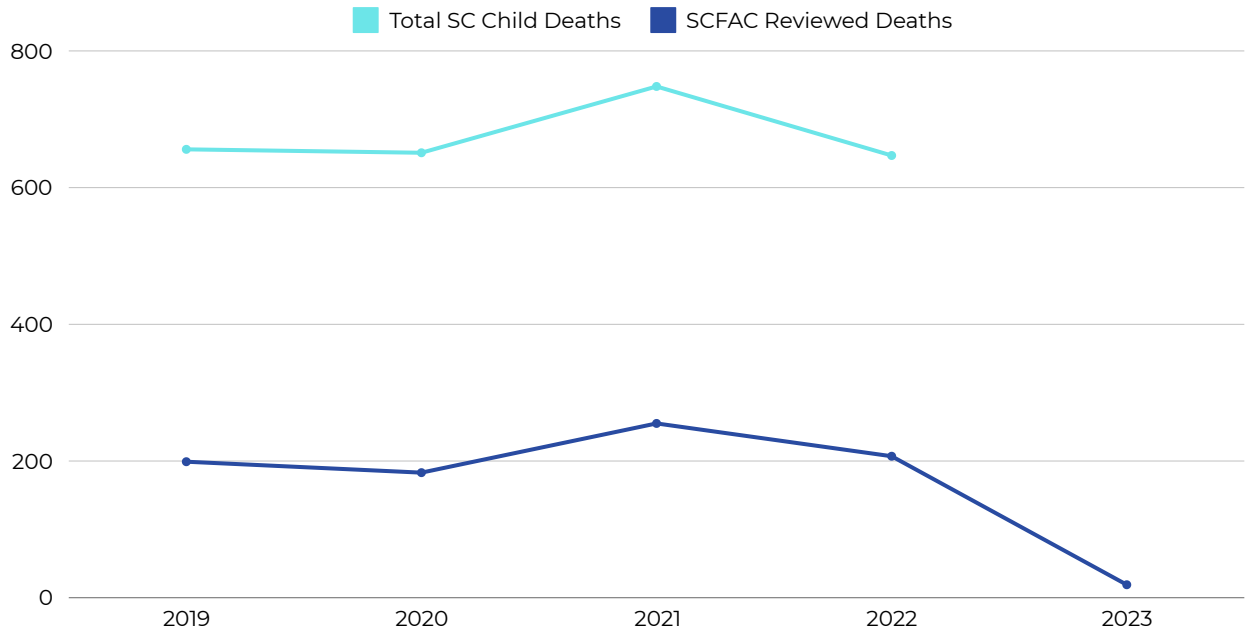
Thank you again,
Amanda F. Whittle, J.D., CWLS
State Child Advocate and Director of the S.C. Dept. of Children's Advocacy

State Child Fatality Advisory Committee Chair (2022-2024)

ANNUAL REPORT SUMMARY

The committee does not review all child deaths in South Carolina, so it is important to consider the committee's reviews alongside South Carolina's mortality data.

Mortality data provides an overall picture of child fatalities by number and cause of death. As a committee, we work to identify patterns in child fatalities that will guide efforts by agencies, communities, and individuals to decrease the number of preventable child deaths .The chart below shows a comparison of the total number of child deaths in South Carolina by year compared with the number of deaths assigned to the committee and reviewed by the committee by year of death.

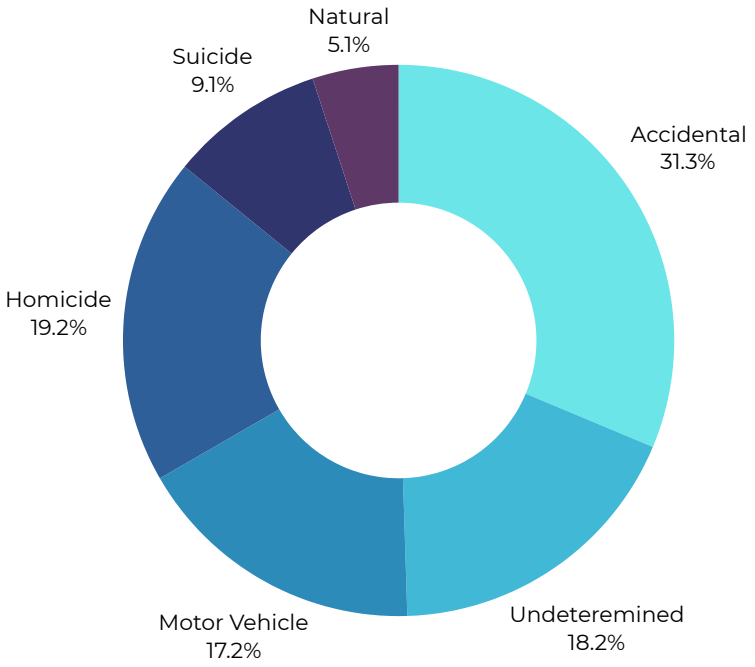


**DHEC has not released the total number of child fatalities for the calendar year 2023.*

Of all child deaths reported by DHEC, approximately 31% have been reviewed by the State Child Fatality Advisory Committee (SCFAC), based on the criteria established by legislative mandate of unexpected and unexplained deaths. Cases eligible for review involve preventable deaths of children age 17 years and younger that are unexpected, unexplained, suspicious, or criminal in nature.

ANNUAL REPORT SUMMARY

This report reflects the findings from the 478 cases reviewed by the committee during the time period of December 2022 through December 2023 [1]. The 478 cases included in this report are comprised of deaths occurring between 2019 – 2023. Of the 478 cases reviewed, 31% were ruled accidental, 18% undetermined, 9% suicide, 19% homicide, and 17% were motor vehicle accidents[2]. An additional 5% were determined to be natural deaths during the course of review.



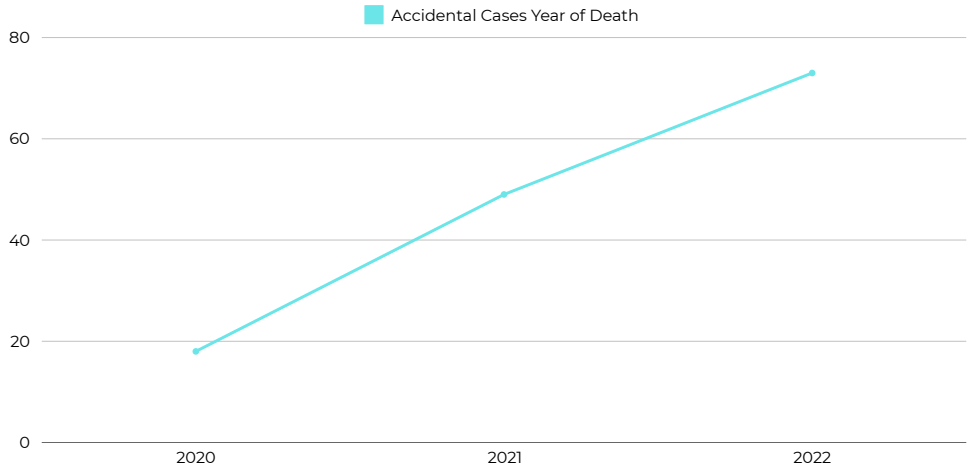
1. Going forward the SCFAC Annual Report will cover efforts by the SCFAC over the calendar year. To avoid a lapse in data, the 2023 SCFAC Annual Report includes cases reviewed during December 2022 as these cases were not included in the 2022 SCFAC Annual Report.

2. Motor vehicle deaths are presented by the SC Highway Patrol and are reviewed separate by the SCFAC from other accident types. Most motor vehicle deaths are ruled accidental.

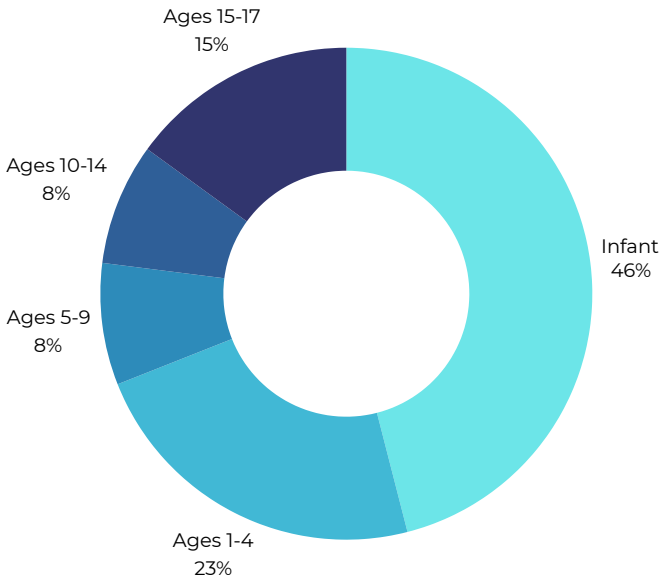
CASE REVIEW FINDINGS

ACCIDENTAL

Of the 478 cases reviewed, 150 were ruled as accidental manners of death (31%)



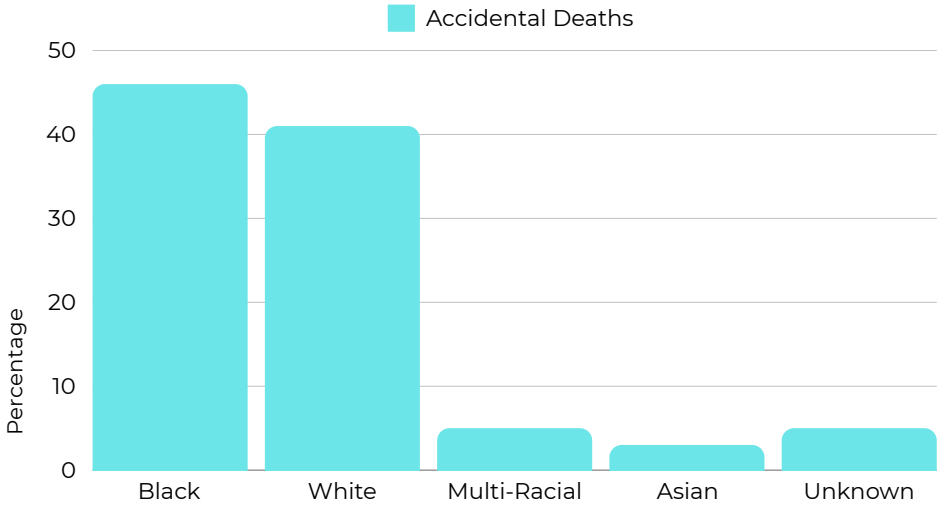
Infant deaths represent the highest population by age, with 46% of accidental deaths reviewed being infants under the age of 1. The next highest age category is children ages 1 – 4 years (23%), followed by ages 15 – 17 years (15%), and ages 5 – 9 and 10 – 14 years both representing 8%.



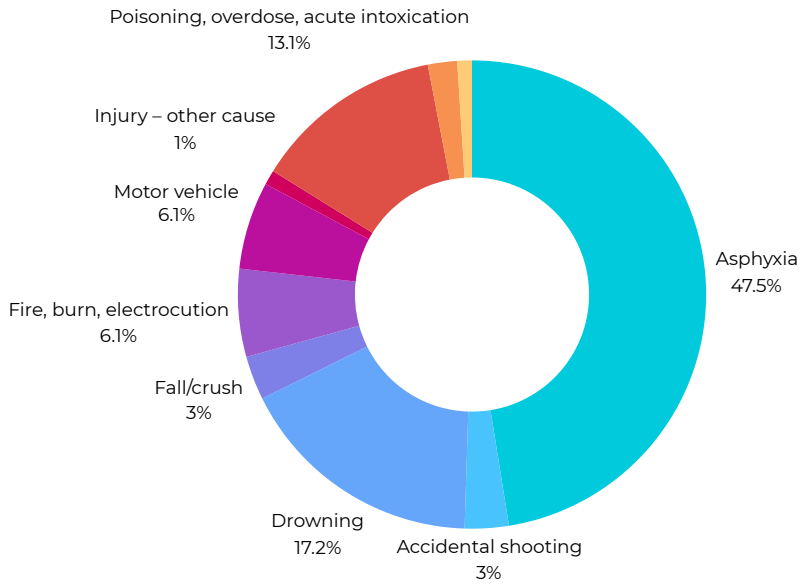
CASE REVIEW FINDINGS

ACCIDENTAL CONT.

By race, Black children accounted for 46% of accidental cases reviewed, 41% were white, 5% were multi-racial, 3% were Asian, and 5% were of unknown race.



Accidental deaths include numerous causes. The most frequently reviewed cause of accidental deaths was asphyxia, often related to infant sleep-related deaths. Asphyxia death accounted for 47% of accidental deaths reviewed, followed by drownings (17%), and accidental poisoning, overdoses, and acute intoxications (13%).

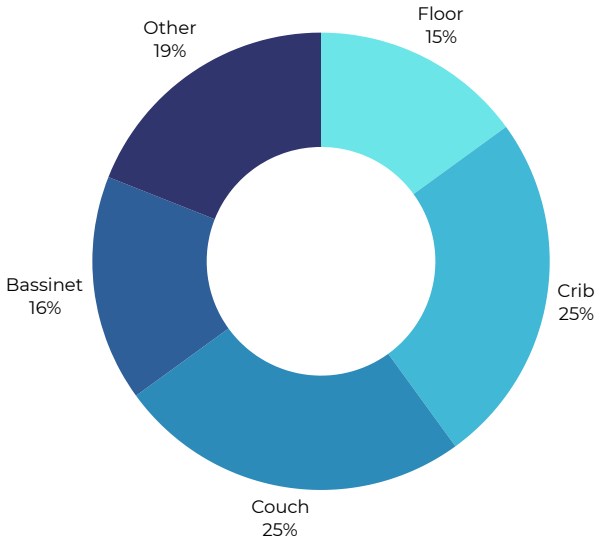


CASE REVIEW FINDINGS

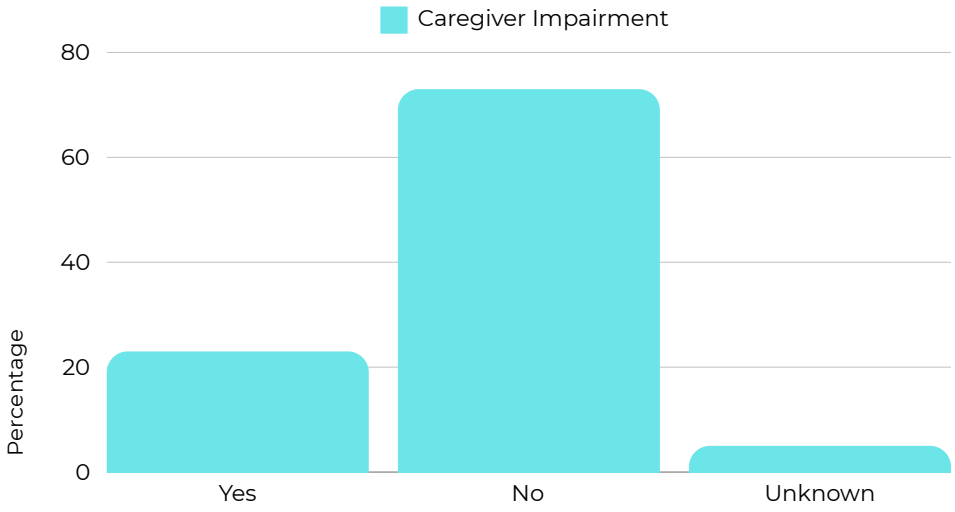
ACCIDENTAL CONT.

INFANT SLEEP RELATED DEATHS

Of the 71 asphyxia deaths reviewed, 62 were infants under the age of 1 and all were sleep-related. Infant sleep-related deaths are most often ruled accidental or undetermined, dependent upon the information learned during the investigation. Of the 62 sleep related deaths, 68% were deaths occurring in a co-sleep environment within an adult bed.



Of the caregivers who gave biological samples, impairment was noted as a contributing factor in 23% of the accidental infant sleep-related deaths reviewed. Of the 14 deaths involving caregiver impairment, 8 involved drugs, 5 involved alcohol, and 1 involved both drugs and alcohol.

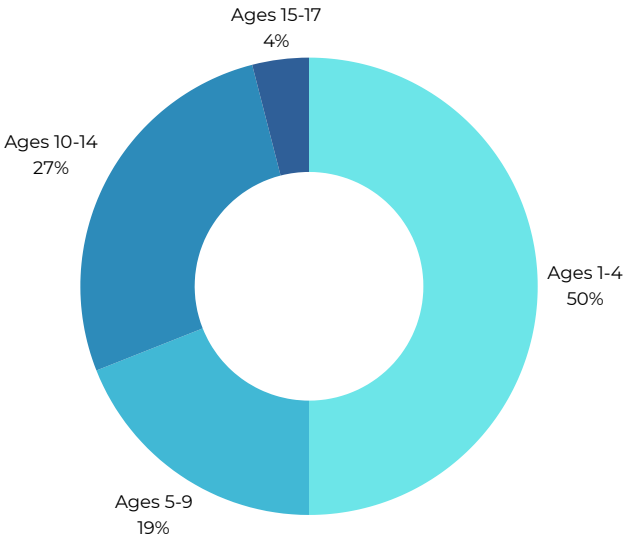


CASE REVIEW FINDINGS

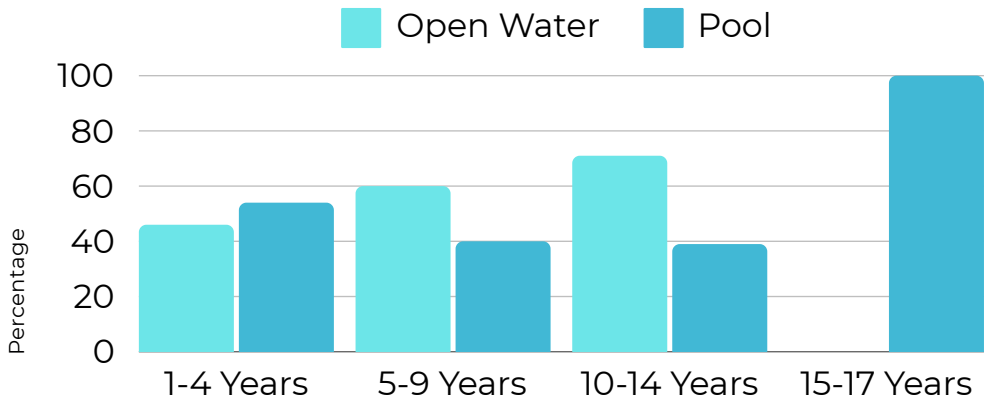
ACCIDENTAL CONT.

DROWNING DEATHS

Drowning deaths accounted for the next highest cause of accidental deaths reviewed. Of the 150 accidental deaths reviewed by SCFAC, 26 were drowning deaths (17%). By age, children ages 1 – 4 years were the highest population of drowning deaths, representing 50% of drownings reviewed.



Of the 26 drowning cases reviewed, 14 (54%) occurred in open water. This may include ponds, lakes, oceans, rivers, drainage areas, creeks, etc. Pool drownings represented 12 of the 26 drownings (46%). Of the 12 pool drownings, 8 (67%) did not have a barrier preventing access to the pool. There is some variation by age and location, with younger children most frequently drowning in pools and older children most frequently drowning in open water.



CASE REVIEW FINDINGS

ACCIDENTAL CONT.

POISONINGS, OVERDOSES, AND ACUTE INTOXICATIONS

The third most frequent cause of accidental deaths reviewed were accidental poisonings, overdoses, and acute intoxications, accounting for 19 of the 150 total accidental deaths reviewed (13%). The majority of these cases were teenagers, with 15 of the 19 being over the age of 13 (79%). Most frequently these cases were the result of a drug overdose.

Of the 19 overdose, poisoning, and acute intoxication deaths reviewed, 14 involved a fentanyl overdose (74%). ALL of the teenage deaths in this cause category involved fentanyl, whether alone or in combination with another substance. Of the 14 fentanyl related deaths, 29% noted mixed drug toxicity on the death certificate.

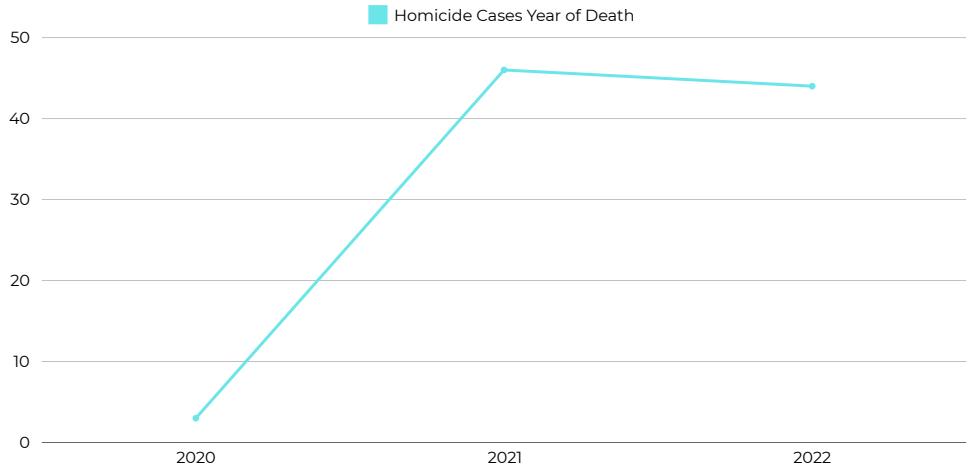
100% *Of teenage deaths in the poisonings, overdoses, and acute intoxications category involved fentanyl*

The SCFAC examines the involvement of agencies represented on the committee with the deaths reviewed. In this analysis it was noted that 50% of the cases reviewed of teenage overdoses involved youth who had received prior DAODAS treatment services. Of the youth who had received services, 7% had received services within the year leading up to their death. The SCFAC does not have access to private provider treatment records, so it is very possible this is an underrepresentation of the actual percentage of youth who had received prior treatment services. Additionally, 43% of teenage overdose deaths had prior history as a victim of maltreatment with the Department of Social Services. Although prior agency involvement is more likely to be seen with older youth, simply given the fact that they are older and have had more years to have had agency involvement, these particular data points stand out in comparison to other causes of death and agency involvement.

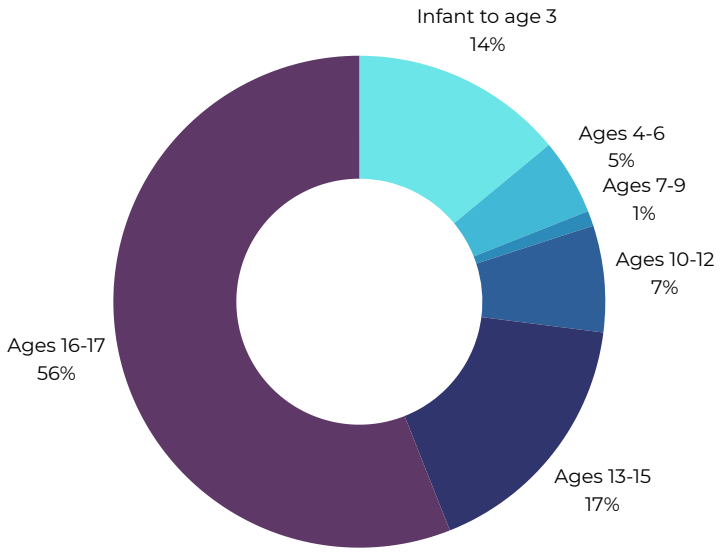
CASE REVIEW FINDINGS

HOMICIDE

Of the 478 cases reviewed by the SCFAC, 93 (19%) were homicides. Most of the homicide cases reviewed by SCFAC were deaths occurring in 2021 and 2022.



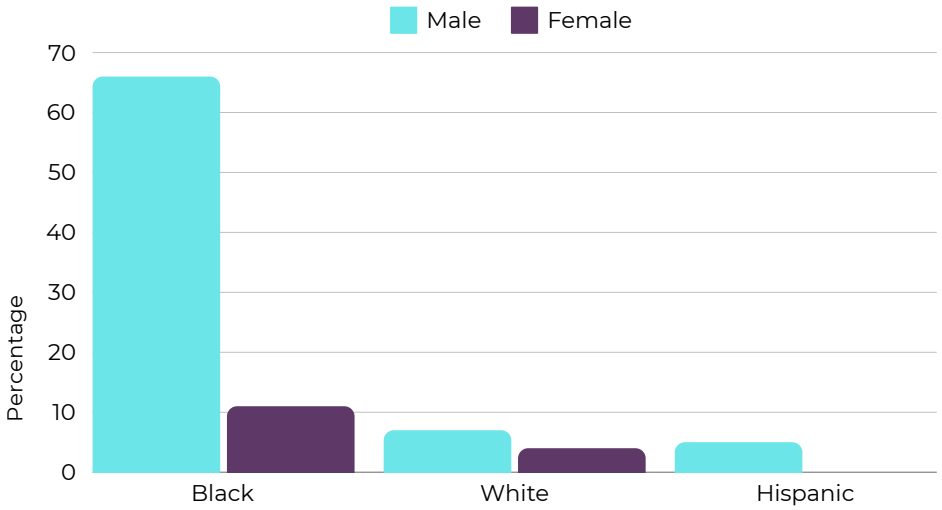
Of the homicide deaths reviewed during this reporting period, 13% (12 children) were one year of age or younger, 1 child was 2 years of age, 3% (3 children) were 4 years of age, 2% (2 children) were 5 years of age, 1 child was 8 years of age, 3% (3 children) were 11 years of age, 3% (3 children) were 12 years of age, 3% (3 children) were 13 years of age, 4% (4 children) were 14 years of age, 9% (9 children) were 15 years of age, 25% (23 children) were 16 years of age, and 31% (29 children) were 17 years of age.



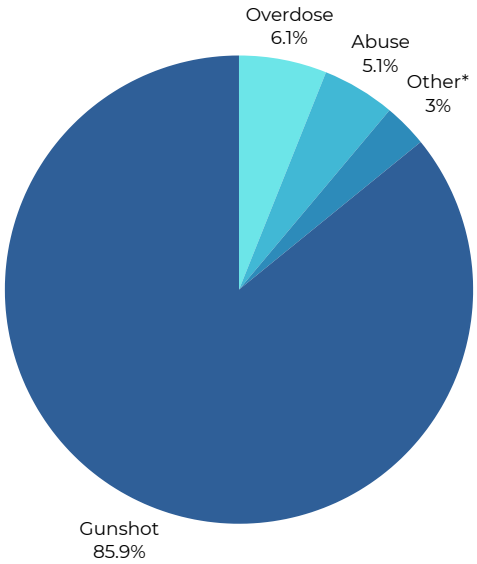
CASE REVIEW FINDINGS

HOMICIDE CONT.

Black children/youth of both sexes accounted for 71% of all homicide deaths. By sex, males of all races account for 84% of homicides reviewed. Further analysis reveals 71% of the homicides reviewed were black males, 12% were black females, 8% were white males, 4% were white females, 5% were Hispanic males, and 0% were Hispanic females



The majority of homicide deaths were the result of gunshots, accounting for 85% of homicides reviewed. Overdoses accounted for 6% of homicides reviewed, physical abuse accounted for 5%, and 3% were classified as other.



** Includes other causes including but not limited to suffocation, medical neglect, and house fires.*

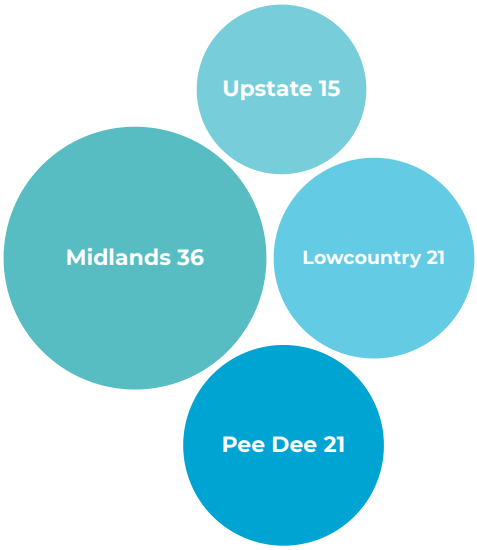
CASE REVIEW FINDINGS

HOMICIDE CONT.

The majority of homicides deaths reviewed by SCFAC occurred in the Midlands region[1], accounting for 39% of homicides reviewed. The Low Country region accounted for 23%, as did the Pee Dee region. The Upstate accounted for 16% of homicides reviewed.

Arrests were made in all five cases that were determined Homicide by Physical Abuse. All five were charged with Murder or Homicide by Child Abuse. Of the five arrests, one was found guilty of Homicide by Child Abuse and sentenced to 40 years; one pled guilty to Voluntary Manslaughter and was sentenced to 10 years; and charges are pending for the other three. Additional information regarding deaths by child abuse can be found at DSS's Child Fatalities Dashboard .

Of note, 47% of the Midlands homicides were from Richland County alone.



1. *Midlands*: York, Chester, Lancaster, Fairfield, Kershaw, Richland, Lexington, Saluda, Edgefield, McCormick, Aiken, Barnwell, Bamberg
Upstate: Oconee, Pickens, Greenville, Spartanburg, Cherokee, Union, Newberry, Laurens, Anderson, Abbeville, Greenwood
Pee Dee: Chesterfield, Marlboro, Dillon, Marion, Horry, Darlington, Florence, Lee, Sumter, Clarendon, Williamsburg, Georgetown
Low Country: Calhoun, Orangeburg, Berkeley, Dorchester, Charleston, Colleton, Allendale, Hampton, Jasper, Beaufort

CASE REVIEW FINDINGS

HOMICIDE CONT.

Through the course of reviewing these cases, the SCFAC compiled the below noteworthy data points:

71%

of homicide deaths were black males

9/10

Were homicide due to gun violence

13%

of homicides were related to drug transactions that resulted in murder

52%

of homicides had prior involvement with child protective services

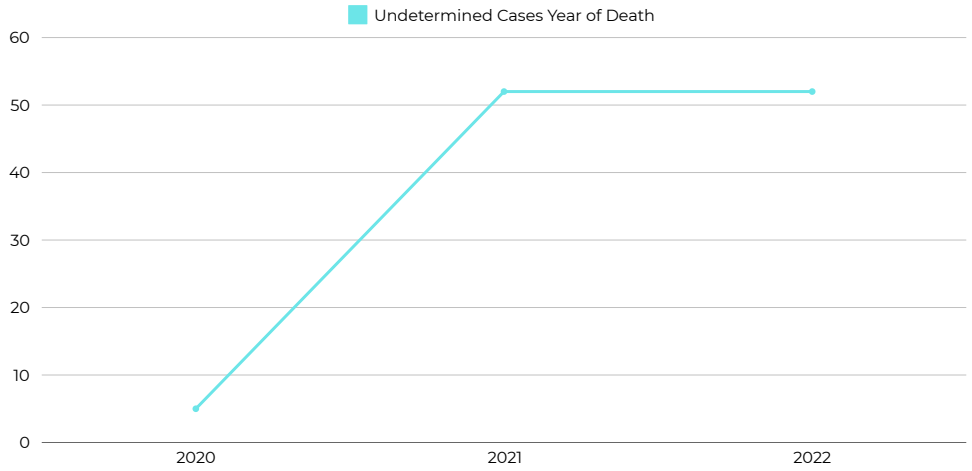
25%

of homicides involved children/youth who had prior or ongoing involvement with the Department of Juvenile Justice

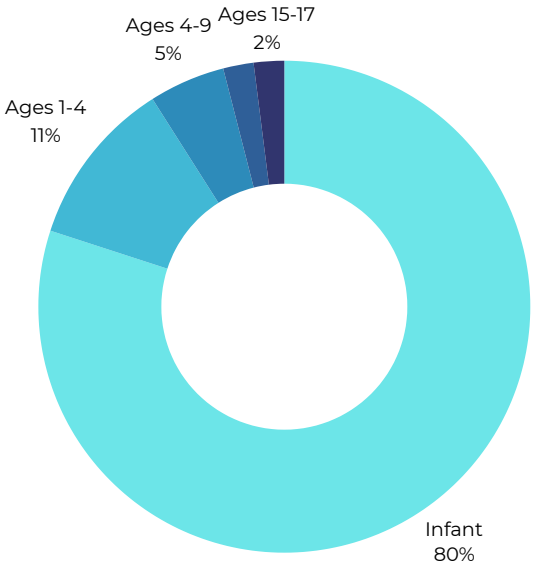
CASE REVIEW FINDINGS

UNDETERMINED

Of the 478 cases reviewed, 88 were ruled as undetermined manners of death (18%).



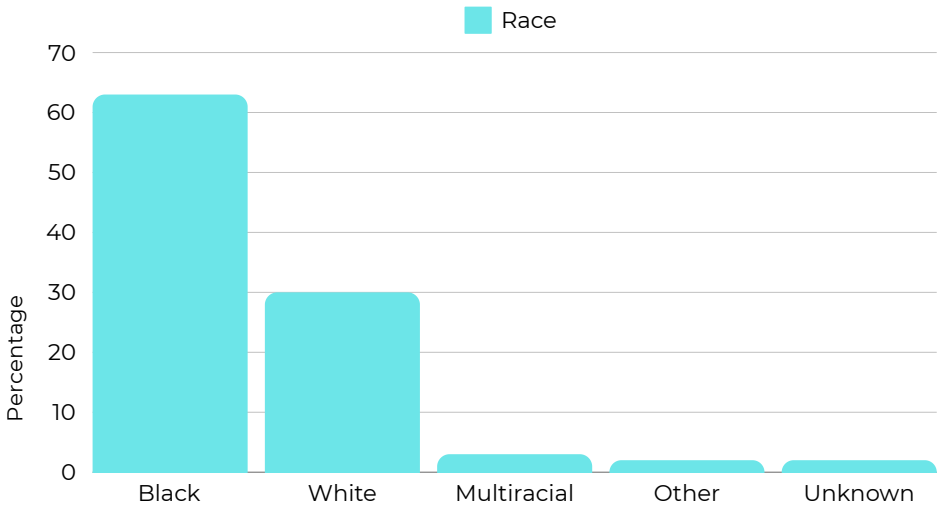
Similar to accidental deaths, the vast majority of undetermined deaths reviewed involved infants under the age of 1. Of the 88 undetermined deaths reviewed, 70 were infants (80%). The next highest age category is children ages 1 – 4 years (11%), followed by ages 5 - 9 years (5%), and ages 10 – 14 years and 15 – 17 years both representing 2%.



CASE REVIEW FINDINGS

UNDETERMINED CONT.

By race, Black children accounted for 63% of undetermined cases reviewed, 30% were white, 3% were multi-racial, 2% were from other races, and 2% were of unknown race. Given South Carolina's population composition is approximately 68% white and 27% Black, the rate of black undetermined deaths is quite high.



By sex, males were most frequently seen in the reviewed undetermined deaths, with 52 of the 88 (59%) involving male children, and 36 of the 88 (41%) involving female children.

The majority of undetermined deaths reviewed were infant sleep-related, representing 74%. The next highest category were deaths ruled with an undetermined cause and undetermined manner (15%). A small percentage of undetermined cases reviewed were shooting deaths (5%), other injuries (3%), and drownings (3%). These other causes are frequently ruled undetermined if the investigation is unable to clearly decipher whether the death was accidental, suicide, or homicide.

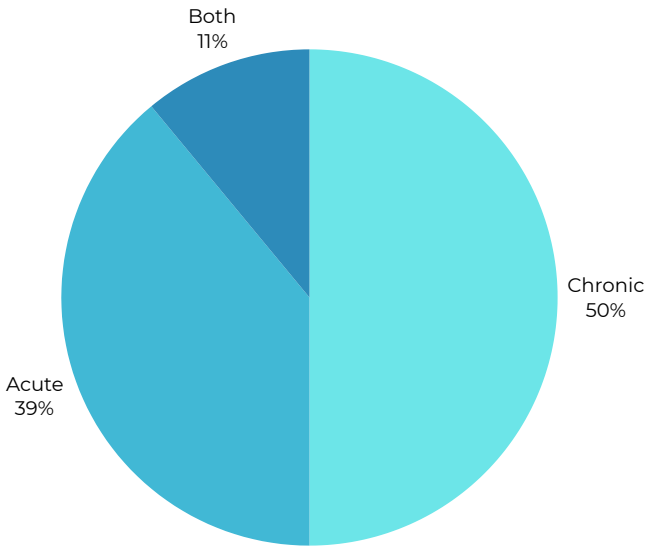
CASE REVIEW FINDINGS

UNDETERMINED CONT.

74% *of undetermined deaths were infant sleep-related*

Of the 70 undetermined infant deaths reviewed, 90% were sleep-related. The common unsafe sleep factors of sleeping surface, cosleep, bedding, and/or position were seen in nearly all of these deaths. Of these 70 deaths, 14% involved a case in which no safe sleep surface was available. Often these were situations where the family was traveling and staying in a hotel, or the child was with a caregiver or relative who did not have a safe sleep environment for the child (crib, bassinet, pack-n-play, etc.).

Of the 70 undetermined infant deaths, 26% (18 cases) had a noted medical condition. Upper respiratory infections were the most frequently occurring medical condition, accounting for 40% of all noted medical conditions. Chronic conditions ranged from cardiovascular, metabolic, endocrine, failure to thrive, and/or in-utero diagnoses



CASE REVIEW FINDINGS

MOTOR VEHICLE (HIGHWAY PATROL)

The South Carolina Highway Patrol is typically the lead investigatory agency for motor vehicle deaths occurring on public roadways. Although most of these accidents are ruled accidental, the SCFAC reviews Highway Patrol investigated deaths separate from accidental deaths that are presented by SLED. Analysis of the Highway Patrol cases reviewed by SCFAC shows two main categories of deaths: unrestrained children and driving age teenagers.

UNRESTRAINED YOUNG CHILDREN

Of the cases reviewed during the reporting timeframe, the SCFAC reviewed 81 motor vehicle accidents investigated by the Highway Patrol. Of these 81 cases, 16 (20%) were under the age of 6. Children in this age group typically require a car seat or booster seat in order to ride safely in a vehicle. Of the 16 children in this age group, 7 (44%) were unrestrained. Of note, over half of these unrestrained children were under the age of 4. All children under the age of 4 should be restrained in an appropriate child restraint seat.

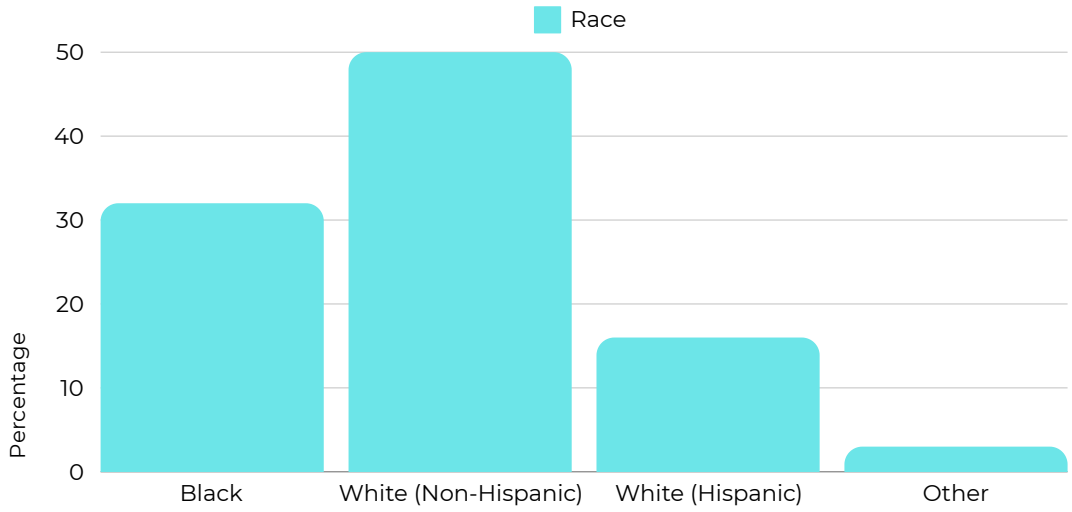
There are a number of reasons why a young child may be unrestrained in a vehicle. Often parents are not aware of the guidance for car seats or booster seats after their child outgrows the infant car seat. Additionally, car seats can be quite expensive and not all families have the resources to purchase additional restraint systems past the infant car seat. This becomes especially challenging when children are riding in the car with relatives, babysitters, or other caregivers who may not have a proper car seat for the child.

CASE REVIEW FINDINGS

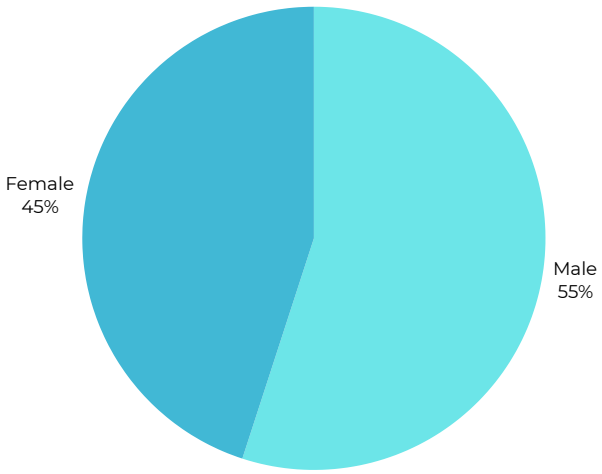
MOTOR VEHICLE (HIGHWAY PATROL) CONT.

DRIVING AGE DEATHS (15 YEARS AND OLDER)

Nearly half of the reviewed Highway Patrol cases were teenagers of driving age (ages 15 and up). Of the 81 cases reviewed, 38 (47%) fell within this age group. By race, 50% of the deaths reviewed were white children, 32% were Black, 16% were Hispanic, and 3% were of another race.



By sex, more males were reviewed than females, with 55% of cases involving male victims and 45% female.

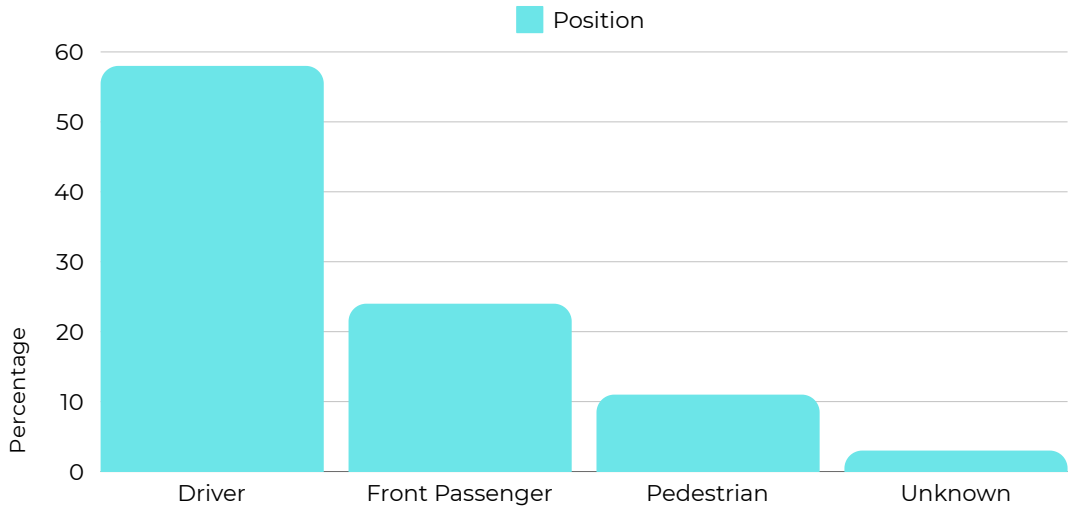


CASE REVIEW FINDINGS

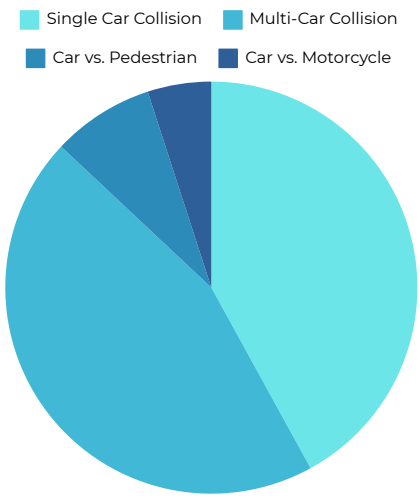
MOTOR VEHICLE (HIGHWAY PATROL) CONT.

DRIVING AGE DEATHS (15 YEARS AND OLDER) CONT.

Analysis of driving age Highway Patrol deaths reviewed by their position during the accident shows 58% were driving, 24% were passengers, 11% were pedestrians hit by a vehicle, and 3% were unknown.



Teenage Highway Patrol deaths were of varying accident types, although single and multi-car collisions accounted for the vast majority of the cases reviewed. The high rate of single car collisions may be reflective of distracted driving, resulting in inexperienced drivers running off of the road.

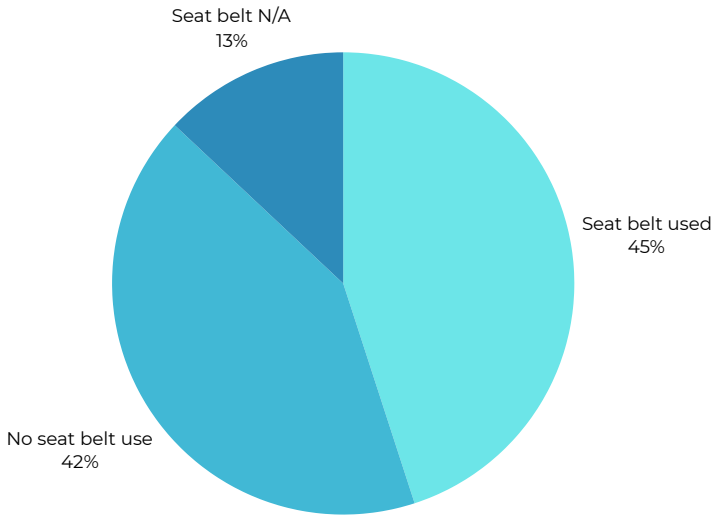


CASE REVIEW FINDINGS

MOTOR VEHICLE (HIGHWAY PATROL) CONT.

DRIVING AGE DEATHS (15 YEARS AND OLDER) CONT.

The cases reviewed shows a high rate of unrestrained teenage deaths, with 42% having no seat belt. Seat belts were in use for 45% of the cases, and seat belts were not applicable in 13% of cases. Cases in which a seat belt would be not applicable include pedestrians and motorcycles.



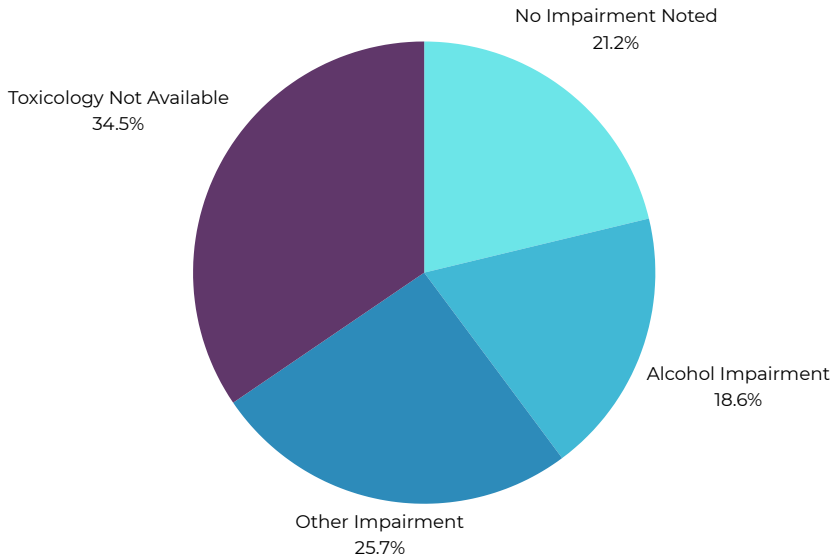
Airbag deployment was also analyzed by the SCFAC, which showed in 16% of these deaths there was no airbag deployment. This equates to 6 cases. In all 6 of these cases there was also no seat belt use present and furthermore, 4 of the 6 (67%) were deaths in which the victim was completely ejected from the vehicle.

There was a relatively high rate of impairment noted in these deaths, which is likely under representative of the actual value given the high rate of toxicology not being available for review. Of the cases reviewed, 21% noted driver alcohol impairment, and 29% noted other substance impairment. This includes marijuana, opiates, and amphetamines. The Committee believes it would be helpful to have a breakdown of the 29% which are combined as “Other Impairment.”

CASE REVIEW FINDINGS

MOTOR VEHICLE (HIGHWAY PATROL) CONT.

DRIVING AGE DEATHS (15 YEARS AND OLDER) CONT.



The total of these percentages exceeds 100% due to some cases involving multi-substance impairment.

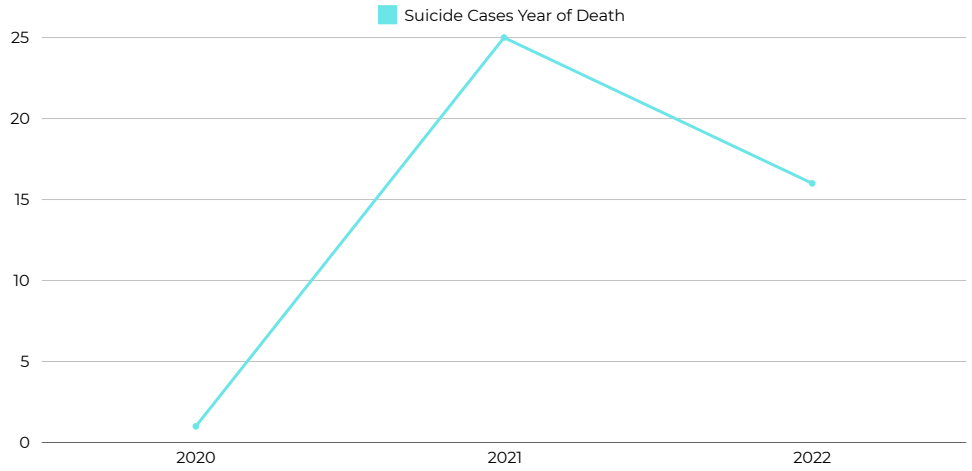
There were a variety of other factors discussed as it relates to teenage motor vehicle deaths. Many cases involved speeding, distracted, and/or reckless driving. The high percentage of single car collisions indicates some level of distraction occurring, whether that be cell phone usage or driving with friends in the car. Combined with impulsivity often seen in teenagers and lack of driving experience, the SCFAC is concerned this puts teenage drivers at a higher risk of running off the road or hitting another vehicle.

The SCFAC discussed numerous systemic factors that may be contributing to these deaths including access to driver's education programs, as well as trauma prevention programs. While there are trauma prevention programs across the state, they are often concentrated in metropolitan areas, limiting exposure to these programs in more rural areas. Additionally, the SCFAC discussed it may be of value to review states with lower rates of teenage motor vehicle deaths to compare the laws around initial licensure and regulations as it pertains to permits and restricted licenses.

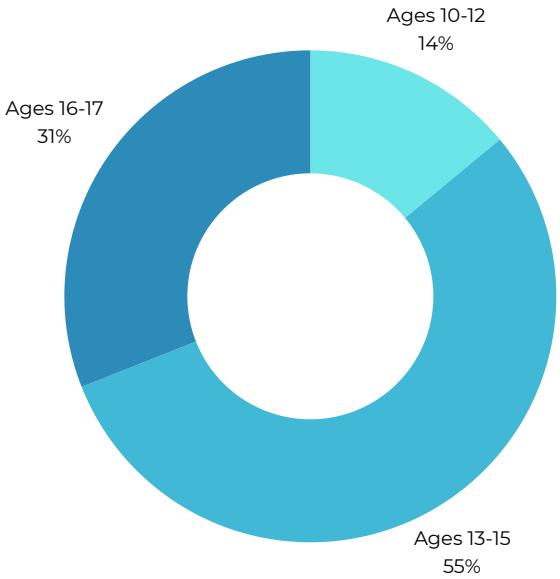
CASE REVIEW FINDINGS

SUICIDE

Of the 478 cases reviewed by the SCFAC, 42 (9%) were suicides. Most of the suicide cases reviewed by SCFAC were deaths occurring in 2021 and 2022



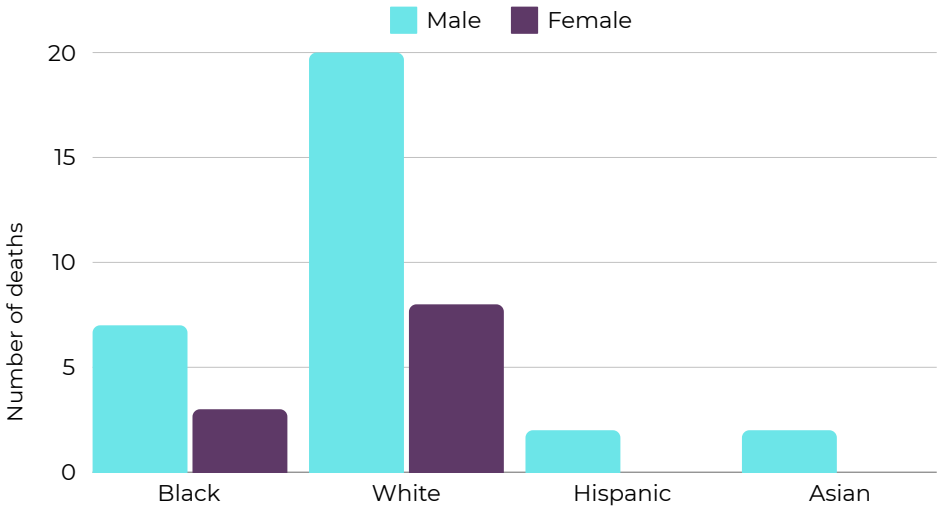
Of the suicide deaths reviewed during this reporting period, 1 child was 10 years of age, 1 child was 11 years of age, 10% (4 children) were 12 years of age, 12% (5 children) were 13 years of age, 19% (8 children) were 14 years of age, 24% (10 children) were 15 years of age, 10% (4 children) were 16 years of age, and 21% (9 children) were 17 years of age.



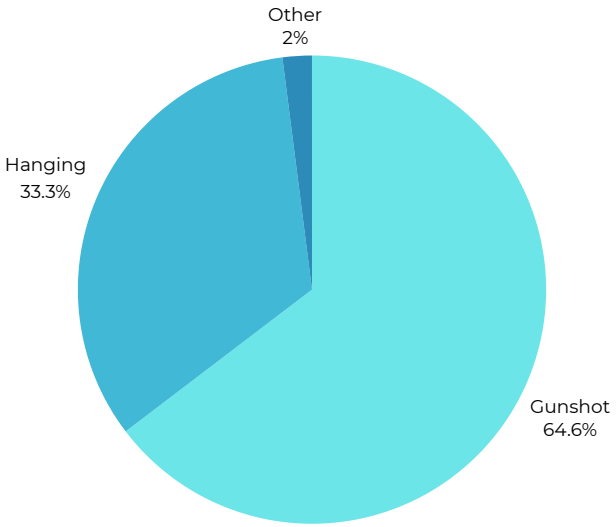
CASE REVIEW FINDINGS

SUICIDE CONT.

By race, white children/youth accounted for 67% of suicide cases reviewed, 24% were black children/youth, 5% were Hispanic, and 5% were Asian. Males across all races accounted for 74% of suicides reviewed, with white males accounting for 48% of all suicides reviewed.



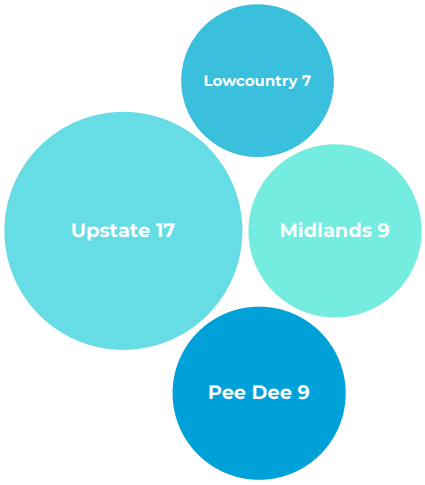
Gunshots were the most commonly reviewed cause of suicide cases, representing 64% of suicides reviewed. Hanging deaths represented 33%, and 2% were classified as other.



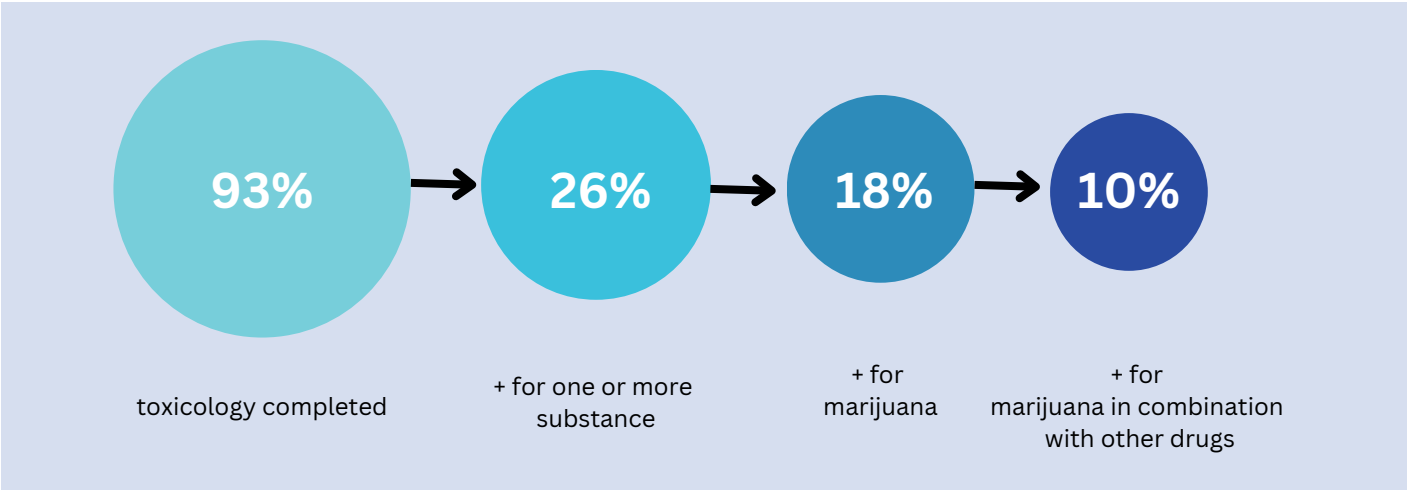
CASE REVIEW FINDINGS

SUICIDE CONT.

Analysis by region reveals 40% of suicides reviewed were from the Upstate, 21% from the Midlands, 21% from the Pee Dee, and 17% from the Low Country.



Analysis of toxicological findings for suicide deaths showed 39 of the 42 suicides had a toxicology completed at the time of death (93%). Of those that received a toxicological evaluation, 26% were positive for one or more substance. Of these 10, 7 were positive for marijuana and 4 were positive for marijuana in combination with other drugs.



SCFAC CURRENT AND FUTURE STATE MAPPINGS

LOCAL CHILD FATALITY REVIEWS

Issue: Local Child Death Reviews (LCDRs), by necessity, focus on the investigation of the death and the determination of the cause and manner of death. Coroners, law enforcement, and DSS/CPS discuss the initial response and investigation and may include reviewing the death reenactment, interviews with the caregivers and/or perpetrators, and assessment of safety and risk of other children in the home. Many data points are not collected at this point, and the involvement of other agencies is not consistently discussed until a fatality review is held at the state level.

Mapping: Through the mapping process, the committee determined it would be helpful to have a secondary or supplemental LCDR process input information which would be available to the SCFAC. The committee acknowledged that additional resources would be necessary to lead the work. Our committee discussed piloting a process to create capacity for a more robust or supplemental LCDR process.

DATA ENTRY COLLABORATION

Issue: For many years, committee members have discussed county level data-entry into the National Centers Case Reporting System to consistently provide the committee with additional data points from all counties in the state, but there are logistical challenges. Coroners have been funded to ensure the county reviews occur, but some coroners do not have sufficient staff and resources to enter data for every child fatality in addition to the statutorily-required death reviews and investigations.

Mapping: Through the mapping process, the committee recommended the need for additional capacity, and DHEC (now the Department of Public Health) was suggested as a possible partner to explore who and how to support the data upload. Thereafter, DHEC (now DPH) Director Dr. Ed Simmer and his team welcomed additional thought and conversation regarding what they described as an amazing public health opportunity.

CAMPAIGNS

At the requests of DSS and Children's Trust South Carolina, Governor Henry McMaster issued a proclamation designating April as Child Abuse Prevention Month. Members and contributing individuals of the committee partnered with other agencies to raise awareness regarding child abuse prevention in April and mental health awareness in May.

The Department of Children's Advocacy purchased billboard ads to raise awareness about the availability of 988 for suicide and crisis support. DCA also had billboard ads regarding safe sleep, the importance of properly restraining children in cars, and DHEC's "look before you lock" campaign concerning leaving children in cars.

SCFAC Chair Amanda Whittle worked with Department of Motor Vehicles Director Kevin Schwedo to digitally display Department of Children's Advocacy posters in county DMV offices encouraging drivers to properly restrain their children in cars with "Buckle Up, Buttercup" images.

CAMPAIGNS

DAODAS has a current prevention campaign to increase awareness of the dangers posed by counterfeit pills which contain Fentanyl but are produced to mimic common prescription medications. The campaign Just Plain Killers highlights the risk of prescription pain medications.

DAODAS has an active prevention campaign #openconversationSC to encourage parents to talk to children about the dangers of alcohol, tobacco, and other drugs. The campaign website offers support for ways to start the dialogue.

RECOMMENDATIONS FOR FATALITY PREVENTION

In the cases of accidental deaths (2021-2023) reviewed by the SCFAC, the number of unsafe sleep deaths of infants and young children was *alarming*. During 2023, the committee recommended support for evidence-based, voluntary home visiting programs through Children's Trust of South Carolina, the state's recipient of the federal home visiting grant. These programs work one-on-one with new parents to help them learn how to give their babies a strong start in life, including how to keep their babies healthy and safe while they sleep.

During the Committee's reviews, sleep-related issues were noted in the causes of death across the various manners of death. The Committee is concerned that the prevalence of sleep-related deaths is under-reported and under-analyzed. The committee plans to continue to be focused and intentional in tracking sleep conditions as a contributing factor within each manner of death and with identifying recommendations that align with child fatality prevention in South Carolina.

DSS, DHEC, Children's Trust, and DAODAS have led a collaborative for many years to address safe sleep. Beginning in 2022, SCFAC Chair Amanda Whittle has requested a proclamation for October as Safe Sleep Awareness Month, and Governor Henry McMaster issued a proclamation to raise awareness about the importance of safe sleep.

More intentional work is needed to prevent child deaths related to unsafe sleep. The committee recommends that the General Assembly provide an FTE to be designated as the South Carolina Safe Sleep Coordinator with funding to the agency that should lead this work.

The committee will continue to identify initiatives that align with its recommendations regarding motor vehicle safety, child abuse prevention, alcohol and substance use disorders, suicide prevention, safe sleep, and gun safety. The Committee seeks input from all agencies which are represented on the Committee.

RECOMMENDATIONS FOR FATALITY PREVENTION

Data and information from the agencies represented on the committee is relevant and necessary for the Committee to conduct reviews, analyze information, and formulate recommendations to the Governor, General Assembly, and to agencies and organizations for the prevention of child fatalities.

During this reporting year, information from the Department of Education and Department of Juvenile Justice was insufficient. The Committee recommends consistent contributions to the Committee's work by these agencies.

The Committee reviews child fatalities that are the result of motor vehicle accidents. As noted in the report, 29% of drivers who were determined to be impaired were noted as "Other Impairment." This includes marijuana, opiates, and amphetamines. The Committee believes it would be helpful to have a breakdown of the 29% which are combined as "Other Impairment."

ACKNOWLEDGEMENTS

The 2023 Annual Report was prepared by:
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Amanda Whittle of the South Carolina Department of Children's Advocacy
Trista Baird of the State Law Enforcement Division
Laura Hudson of the South Carolina Victim Assistance Network
Sarah Knox of Children's Trust of South Carolina

The 2023 Annual Report was Edited by:
The State Child Fatality Advisory Committee members

All opinions and recommendations are those of the SCFAC membership.

To review this report online, please visit the State Child Fatality Advisory Committee website: www.scfac-sc.org

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Confidentiality

Please note: Portions of the information and data contained in this report were compiled from records that are confidential and contain information which is protected from disclosure to the public, pursuant to the South Carolina Code 63-11-195.

QUESTIONS

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