South Carolina
State Child Fatality Advisory Committee

SFY 2019 Report

The Honorable Henry McMaster, Governor, State of South Carolina
The 122nd South Carolina General Assembly

South Carolina
State Child Fatality
Advisory Committee

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

Acknowledgments

The members of the State Child Fatality Advisory Committee (SCFAC) recognize that without the participation and support of numerous organizations, agencies and individuals, committee activities and reports would not be possible. These acknowledgments represent a small part of the unified effort in South Carolina to protect the health and safety of children. The SCFAC membership 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:
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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 63-11-1950.

EXECUTIVE SUMMARY

When a child dies unexpectedly, the response by the state and the community about 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 investigation of child deaths impedes the effort to prevent future deaths from similar causes.

S.C. Code 63-11-1950 mandates that the State Child Fatality Advisory Committee (SCFAC) review completed investigations of deaths involving children age 17 years and younger that are unexpected, unexplained, suspicious or criminal in nature. Following an internal review, a relationship between the South Carolina Law Enforcement Division (SLED), and the Department of Health and Environmental Control (DHEC) Vital Records was developed to help ensure all cases meeting SCFAC criteria are reviewed.

This report is supported by the (SCFAC) and prepared in coordination with SLED, Department of Child Fatalities, Revenue and Fiscal Affairs Office, Division of Research and Statistics and DHEC.

Since the initiation of this report starting with the 2006 data year, SCFAC has been assigned 2,798 cases. Of those, 2,402 (85.8%) have been completed, leaving a balance of 396 cases to be completed. The SCFAC caseload balance is distributed as follows: 2006-2013 (0 cases), 2014 (5 cases), 2015 (1 cases), 2016 (0 cases) and 2017 (88 cases), 2018 (201 cases), and 2019 (101 cases) remaining to be reviewed and completed. This is not a summary of all child deaths occurring during the time period of 2006-2019.

The 2019 SCFAC Annual Report covers SCFAC efforts during the time-period of July 1, 2018 through June 30, 2019. Annual report development is funded by DSS. All opinions and recommendations are those of the SCFAC membership. This report includes only the results of the 234 completed case reviews. The SCFAC review determined the following manners of death: Accidental (95 cases), Homicide (52 cases), Natural (1 case), Suicide (17 cases), Unknown (6), and Undetermined (63 cases).

Summary of 2019 Recommendations Include:

Safe Sleep

The SCFAC recommends support of and identification of urban and rural community-based partners and existing grassroot efforts to provide safe sleep education through allocation of fiscal resources to fund evidence-based practices.

Caregiver DJJ History

The SCFAC recommends and supports interagency communication between the SC Department of Juvenile Justice (SCDJJ) and the SC Department of Social Service (SCDSS) for the purpose of child protection and juvenile justice.

Caregiver Substance Abuse

The SCFAC recommends and supports testing of caregivers when substance abuse presents itself as a probable cause of death in children four years or younger along with appropriate measures to provide opportunities for treatment in such cases.

METHODS

The SCFAC regularly schedules six review meetings each State Fiscal Year (SFY), which covers July 1st to June 30th. During these meetings, the committee reviews a selection of the total cases assigned for further review. SLED assigns cases to the SCFAC to review upon completion of their final investigations of child deaths which, before investigation, appear to have been caused by trauma, suspicious or obscure circumstances, or child abuse or neglect. As case investigations have been completed by SLED and assigned to the SCFAC, they are reviewed based upon assignment, rather than by date of death. While the SCFAC focuses on the deaths of children in South Carolina, they do not review every child death that occurs, such as deaths deemed to have resulted from natural causes.

The review of the SCFAC is vital in identifying patterns in child fatalities that will guide efforts by agencies, communities and individuals to decrease the number of preventable child deaths. Each agency representative has the opportunity to present additional relative circumstantial facts that may have impacted the outcome of the incidences which are imperative when identifying patterns.

Case findings are analyzed and used to guide the development of the Annual Report. Descriptive statistics are utilized to present a summary of the case findings to include demographics, leading causes of death by manner and age and by gender (where necessary). These statistics along with consideration of emerging health issues, guides the SCFAC in developing recommendations which target the outcomes and those specific health issues. Since the case selection only represents as portion of all child fatalities without correlation to a specific calendar year, tests for statistical significance are not done.

Within the State of South Carolina, manner of death is categorized as natural, homicide, suicide, accident, or undetermined. Cases in which the manner of death cannot be clearly identified after thorough investigation are categorized as undetermined. The cause of death refers to the medical condition or injury which directly leads to the death.

SCFAC SFY2019 RECOMMENDATIONS

Recomendation 1: Unsafe Sleeping Conditions 

SCENARIO: Adam's father had just gotten home from work and fell asleep with 6-month-old Adam while sitting on the recliner. Father woke up to mother screaming and found Adam wedged beside him on the recliner.

Unsafe sleep was the leading cause of death in children under 12 months of age; weapon including body part was the leading cause of death in children ages 1 to 4, children ages 11 to 14, and children ages 15 to 17. The leading cause of death for children ages 5 to 10 was fire, burn, or electrocution. In unsafe sleep cases, only 34.9% of children less than 12 months of age were put to sleep on their backs.

It is the intent of the SCFAC to help ensure that parents and caregivers of all infants receive evidence-based education on Safe Sleeping practices for infants to help them have a safe and healthy environment in which they can live, learn, travel, and play. Extensive efforts were given in 2018 to address the phenomenon of the number of infants deceased due to unsafe sleeping conditions. As the SC Child Fatality Review Committee reviewed these deaths it was determined that in most cases, safe sleep environments were available in the home (crib, bassinet, or portable crib) at the time of death, but were not in use. Additionally, not all deaths happened in the infant's home; some were while they were under the watch of other childcare providers.

SCFAC recommends that the S.C. General Assembly make unsafe sleep a legislative priority by allocating fiscal resources to support:

- Prevention strategies identifying community-based partners and existing grassroot efforts best able to provide safe sleep education within rural and urban communities, based on current evidence-based practices.
- Continued collaboration with DHEC to drive safe sleep efforts throughout SC through educational outreach. This would include purchasing of handouts, posters, brochures to be distributed.
- Continued collaboration with the South Carolina Birth Outcomes Initiatives (BOI).

Recomendation 2: Caregiver DJJ History Record Access

SCENARIO: 2-year-old Simon had been physically abused by his father and died from complications resulting from abusive head trauma. Prior to the death, DSS had an involvement due to homelessness of the parents. They ran a background check that was normal. After the death, a review of DJJ records, it was found that the 19-year-old father had an extensive criminal record as a juvenile to include numerous physical assault charges.

The SCFAC recommends the legislative support of SCDSS and SCDJJ's existing efforts to work together to create a portal for sharing information between the two agencies for the purpose of child protection and juvenile justice.

Recomendation 3: Caregiver Substance Abuse

SCENARIO: 6-month-old Mary was being breastfed at 2 a.m. by her mother when both fell asleep on the couch. Several hours later her mother awoke finding Mary wedged between her body and the couch back. After investigation it was found that Mary's mother was under the influence of multiple substances at the time of Mary's death.

Given that the State Child Fatality Advisory Committee (SCFAC) has found that 50 of 234 child fatalities were complicated by caregiver/parental current substance abuse (impairment at death) and in 83 of 234 child fatalities, the caregiver/parent had a history of substance abuse, the Committee recommends that when there is probable cause that events in a home or premises or the intoxication or impairment of the child's caregiver may have contributed to a child 4 or younger's death, that the coroner, medical examiner, or law enforcement officer be able to petition for a warrant from a magistrate, municipal judge or circuit court judge to perform tests of the blood or urine of the child's caregiver to determine the level of intoxication or impairment.

The Committee also recommends that the S.C. General Assembly make caregiver/parental substance use a legislative priority by allocating fiscal resources to support:

a) A coordinated multi-system involvement for referring caregivers/parents to substance use disorder (SUD) treatment and implementing a strategy to track SUD treatment engagement/ compliance post child fatality to mitigate future occurrences of impaired parenting.

b) Primary SUD prevention strategies designed to reach new mothers who test positive at birth, have a history of substance use, or are at risk for substance use and may engage in unsafe sleeping practices. This shall be accomplished by utilizing current evidence-based information on substance use and safe sleeping practices in collaboration with the Safe Sleep Coalition through the Children's Trust of South Carolina and the South Carolina Birth Outcomes Initiative.

SFY19 CASES REVIEWED AND COMPLETED

Section 1. Demographics

Highlights

- Of the 234 cases reviewed by the SCFAC, 101 (43.2%) were non-Hispanic Black, 114 (48.7%) were Non-Hispanic White, 18 (7.7%) were Hispanic, and 1 (0.4%) were categorized as other.
- In these cases, 151 (64.5%) of these were male and 83 (35.5%) were female.
- Almost half (48.7%) of these cases were less than 12 months of age. Cases for other age groups consisted of 38 for 1 to 4 year olds, 17 for 5 to 10 year olds, 20 for 11 to 14 year olds, and 45 for 15 to 17 year olds.

TABLE 1. Demographics

	Frequency	Percent (%)
Race		
Non-Hispanic Black	101	43.2
Non-Hispanic White	114	48.7
Hispanic	18	7.7
Other	1	0.4
Sex		
Male	151	64.5
Female	83	35.5
Age Group		
less than 12 months	114	48.7
1 to 4 years	38	16.2
5 to 10 years	17	7.3
11 to 14 years	20	8.6
15 to 17 years	45	19.2
Total	**234**	**100**

Section 2. Cause and Manner of Death

Highlights

- The most common primary cause of death was from an external cause of injury (75.7%), followed by undetermined if injury or medical cause (20.9%), and death from a medical condition (3.4%).
- The most common manner of death was accident (40.6%), followed by undetermined (26.9%), and homicide (22.2%).

TABLE 2. Primary Cause of Death

Cause of Death	Frequency	Percent (%)
External cause of injury[1]	177	75.7
Undetermined if injury or medical cause	49	20.9
From a medical condition	8	3.4
Total	**234**	**100.0**

Note:
[1] External cause of injury refers to any unintentional or intentional damage to the body resulting from acute exposure to thermal, mechanical, electrical or chemical energy that exceeds a threshold of tolerance in the body or from the absence of such essentials as heat or oxygen.

TABLE 3. SCFAC Manner of Death

Manner of Death	Frequency	Percent (%)
Accident	95	40.6
Undetermined	63	26.9
Homicide	52	22.2
Suicide	17	7.3
Unknown	6	2.6
Natural	1	0.4
Total	**234**	**100.0**

[1]National Center for Fatality Review and Prevention. Data Dictionary. Version 5.0. https://www.ncfrp.org/wp-content/uploads/NCRPCD-Docs/DataDictionary_v5.pdf

Section 2.1 Cause and Manner of Death in Infants Less than 12 Months of Age

Highlights

- In the 234 total cases reviewed by SCFAC, 114 involved children under the age of 12 months. The leading cause of death for children less than 12 months of age was unsafe sleep (72.8%).

TABLE 4. Cause of Death in Children Less than 12 Months of Age

	#	%
Unsafe Sleep	83	72.8
Undetermined	10	8.8
Weapon, including body part	8	7.0
Prematurity	3	2.6
Fire, burn, or electrocution	1	0.9
Asphyxia	1	0.9
Fall or Crush	1	0.9
Poisoning, overdose or acute intoxication	1	0.9
Other Infection	2	1.8
Other medical condition	1	0.9
Other	3	2.6
Total	**114**	**100.0**

Section 2.2 Cause and Manner of Death in Children Ages 1 to 4 Years

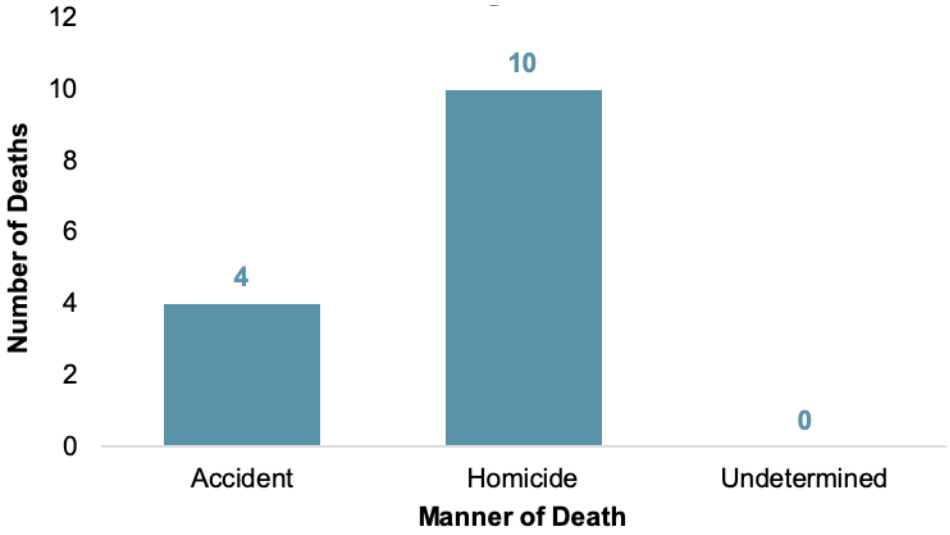
Highlights

- Of the 234 cases reviewed, 38 cases involved children between the ages of 1 to 4. The leading cause of death for children ages 1 to 4 is weapon. Of the 14 cases with this cause of death, 4 were due to accidents, and 10 were homicide.
- The second leading cause of death for children ages 1 to 4 was drowning. Drowning as the cause of death was identified for 10 of the total 38 cases for this age group.
- Asphyxia was the third leading cause of death for children ages 1 to 4. There were a total of 4 cases. Of these cases, 3 were accidental asphyxiation and 1 was identified as homicide.

TABLE 5. Cause and Manner of Death in Children Ages 1 to 4

	Accident		Homicide		Undetermined		Total	
	#	%	#	%	#	%	#	%
Weapon	4	18.2	10	76.9	0	0.0	14	36.8
Drowning	9	40.9	1	7.7	0	0.0	10	26.3
Asphyxia	3	13.6	1	7.7	0	0.0	4	10.5
Fire, burn, or electrocution	3	13.6	0	0.0	0	0.0	3	7.9
Undetermined	0	0.0	0	0.0	3	100.0	3	7.9
Fall or Crash	2	9.1	0	0.0	3	100.0	3	7.9
Unsafe Sleep	1	4.5	0	0.0	7.7	0	1	2.6
Poisoning, overdose or acute intoxication	0	0.0	1	7.7	0	0.0	1	2.6
Total	**22**	**100.0**	**13**	**100.0**	**3**	**100.0**	**38**	**100.0**

FIGURE 1. Weapon-Related Manner of Death in Children Ages 1 to 4



Section 2.3 Cause and Manner of Death in Children Ages 5 to 10 Years

Highlights

- Of the cases reviewed, 17 cases involved children ages 5 to 10. Fire, burn, or electrocution was the cause of death for over half (52.9%) of these cases. Two of these fire, burn, or electrocution cases were due to homicide, and 7 were accidents.
- Weapon, including body part was the second leading cause of death for children ages 5 to 10. Of these 5 cases, 1 was suicide, and 4 were homicide.
- The third leading cause of death for children ages 5 to 10 was drowning, with the 2 cases identified as accidents.

TABLE 6. Cause and Manner of Death in Children Ages 5 to 10

	Accident		Suicide		Homicide		Total	
	#	%	#	%	#	%	#	%
Fire, burn, or electrocution	7	70.0	0	0.0	2	33.3	9	52.9
Weapon	0	0.0	1	100.00	4	66.7	5	29.4
Drowning	2	20.0	0	0.0	0	0.0	2	11.8
Motor vehicle and other transport	1	10.0	0	0.0	0	0.0	1	5.9
Total	**10**	**100.0**	**1**	**100.0**	**6**	**100.0**	**17**	**100.0**

Section 2.4 Cause and Manner of Death in Children Ages 11 to 14 Years

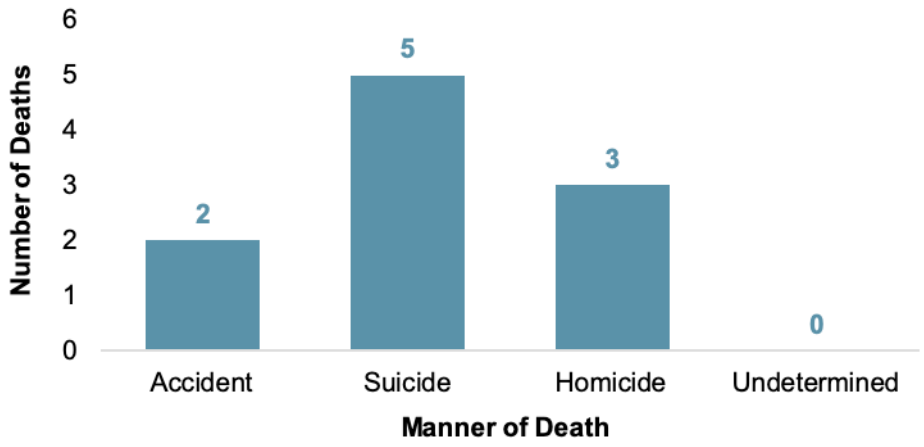
Highlights

- Of the 234 cases reviewed, 20 cases involved children ages 11 to 14. In this age group, the leading cause of death was weapon. There were 10 total cases (50%) due to this cause of death. 2 of these cases were accidents, 5 were suicide, and 3 were homicide.
- The second leading cause of death for this age group was fire, burn, or electrocution. All 3 of these cases were identified as accidents.
- Drowning was the third leading cause of death for children ages 11 to 14. There were 2 cases of drowning.

TABLE 7. Cause and Manner of Death in Children Ages 11 to 14

	Accident		Suicide		Homicide		Undetermined		Total	
	#	%	#	%	#	%	#	%	#	%
Weapon	2	25.0	5	100.0	3	100.0	0	0.0	10	50.0
Fire, burn, or electrocution	3	37.5	0	0.0	0	0.0	0	0.0	3	15.0
Drowning	1	12.5	0	0.0	0	0.0	1	25.0	2	10.0
Other	1	12.5	0	0.0	0	0.0	1	25.0	2	10.0
Poisoning, overdose or acute intoxication	0	12.5	0	0.0	0	0.0	1	25.0	1	5.0
Motor vehicle and other transport	1	12.5	0	0.0	0	0.0	1	25.0	1	5.0
Undetermined	1	0.0	0	0.0	0	0.0	1	25.0	1	5.0
Total	**8**	**100**	**5**	**100.0**	**3**	**100.0**	**4**	**100.0**	**20**	**100.0**

FIGURE 2. Weapon-Related Manner of Death in Children Ages 11 to 14



Section 2.5 Cause and Manner of Death in Children Ages 15 to 17 Years

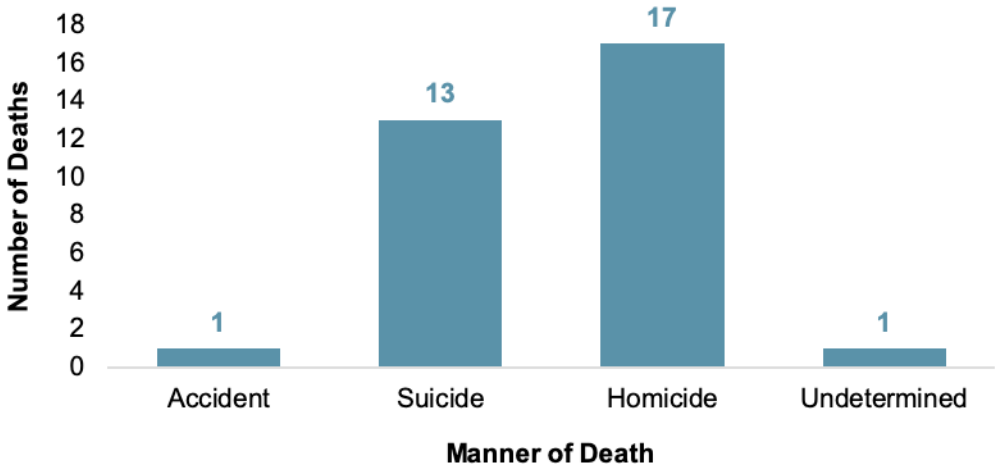
Highlights

- Of the 234 cases reviewed, 45 cases involved children ages 15 to 17. Of the 45 cases, 32 (71.1%) were due to weapon. Of the 32 cases involving weapons, 1 was an accident, 13 were suicide, and 17 were homicide.
- The second leading cause of death for children ages 15 to 17 was drowning. There were a total of 5 drowning cases, all of which were accidents.
- Poisoning, overdose or acute intoxication was the third leading cause of death for this age group. There were 5 total cases, 4 of which were accidents, and 1 was suicide.

TABLE 8. Cause and Manner of Death in Children Ages 15 to 17

	Accident		Suicide		Homicide		Undetermined		Total	
	#	%	#	%	#	%	#	%	#	%
Weapon	1	9.1	13	92.9	17	100.0	1	33.3	32	71.1
Drowning	5	45.5	0	0.0	0	0.0	0	0.0	5	11.1
Poisoning, overdose or acute intoxication	4	36.4	1	7.1	0	0.0	0	0.0	5	11.1
Undetermined	0	0.0	0	0.0	0	0.0	1	33.3	1	2.2
Neurological/ seizure disorder	1	9.1	0	0.0	0	0.0	0	0.0	1	2.2
Other medical condition	0	0.0	0	0.0	0	0.0	1	3.3	1	2.2
Total	**11**	**100.0**	**14**	**100.0**	**17**	**100.0**	**3**	**100.0**	**45**	**100.0**

FIGURE 3. Weapon-Related Manner of Death in Children Ages 15 to 17



Section 3. Details of Most Common Cause and Manner of Death

Section 3.1 Details of Unsafe Sleep-Related Deaths

Highlights

- Unsafe sleep was the most common cause of deaths in children less than 12 months of age. Of the 83 total cases, only 29 (34.9%) of infants were put to sleep on their backs and only 16 (19.3%) of infants were found on their backs.
- Over half, (61.5%) of unsafe sleep deaths occurred in an adult bed, while16.9% occurred in cribs, and 12.0% occurred on couches.
- Deaths related to unsafe sleep environments were attributed to co-sleeping in 55 cases, mattresses in 51 cases, pillows in 39 cases, and thin blankets or flat sheets in 33 cases.

TABLE 9. Child's Sleeping Position

	Child put to sleep		Child found	
	#	%	#	%
On back	29	34.9	16	19.3
On stomach	18	21.7	39	47.0
On side	13	15.7	12	14.5
Unknown	23	27.7	16	19.2
Total	**83**	**100**	**83**	**100**

FIGURE 4. Child Put to Sleep

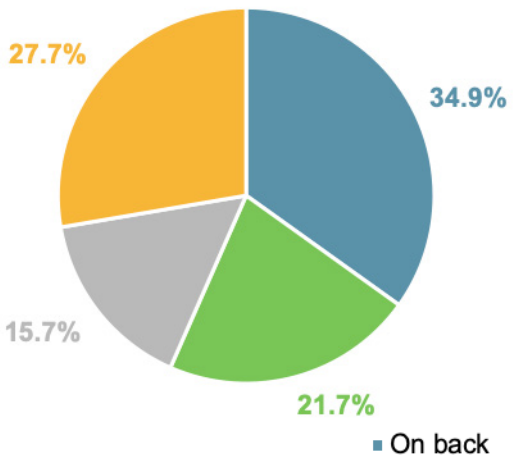


FIGURE 5. Child Found

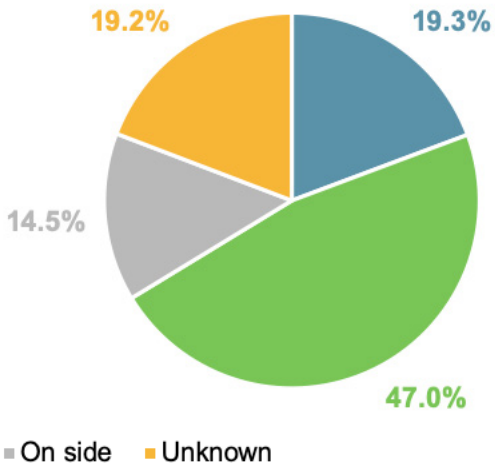


TABLE 10. Sleep Location at Time of Death

Sleep Place	Frequency	Percent (%)
Adult bed	51	61.5
Crib	14	16.9
Couch	10	12.0
Bassinette	3	3.6
Chair	2	2.4
Futon	1	1.2
Swing	1	1.2
Other	1	1.2
Total	**83**	**100**

FIGURE 6. Sleep Location at Time of Death

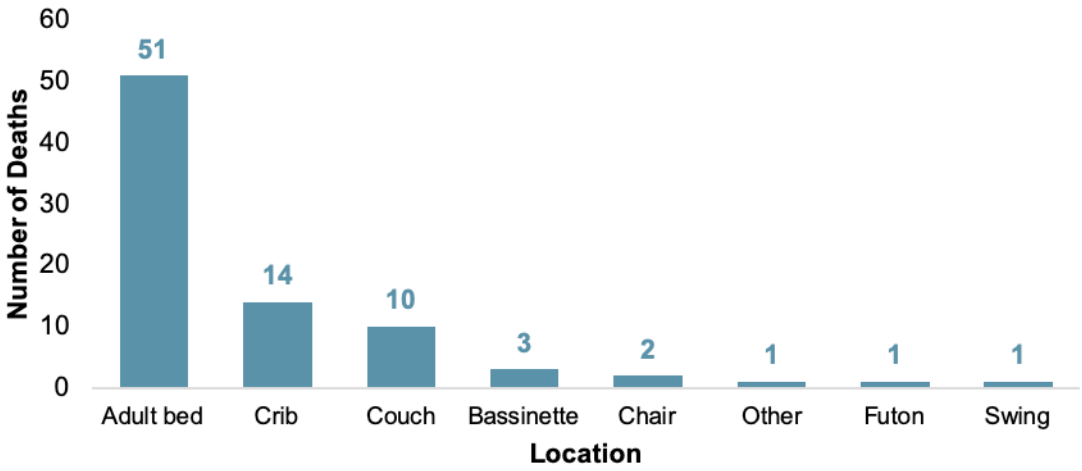


TABLE 11. Person/Object in Bed with Child

	Frequency	Cumulative Percent (%)
Adult(s)	55	66.3
Mattress	51	61.4
Pillow	39	47.0
Thin blanket/flat sheet	33	39.8
Comforter, quilt or other cover	32	38.6
Child(ren)	19	22.9
Cushion	13	15.7
Bobby or U-shaped pillow	5	6.0
Clothing	4	4.8
Toy(s)	3	3.6
Sleep Positioner	1	1.2
Bumper Pads	1	1.2
Wall	1	1.2
Other	7	8.4
Total	**83**	**100**

Section 3.2 Details of Weapon-Related Deaths

Highlights

- There were a total of 69 cases reviewed with the cause of death due to weapon. Of these cases, 42 involved a firearm. Firearms were identified as the manner of death in 7 accidents, 8 suicides, 26 homicides, and 1 undetermined.
- The most common type of firearm identified was handgun. Handgun was identified as the manner of death in 5 accidents, 6 suicides, and 21 homicides. Shotgun was identified as the manner of death in 1 accident, 2 suicides, and 2 homicides.

TABLE 12. Number of Deaths by Type of Weapon and Manner of Death

	Number				
Type of Weapon	**Accident**	**Suicide**	**Homicide**	**Undetermined**	**Total**
Firearm	7	8	26	1	42
Sharp instrument	0	0	2	0	2
Blunt instrument	0	0	1	0	1
Persons body part	0	0	12	0	12
Rope	0	3	0	0	3
Other	0	8	1	0	9
Total	**7**	**19**	**42**	**1**	**69**

TABLE 13. Number of Deaths by Type of Firearm and Manner of Death

	Number				
Type of Firearm	**Accident**	**Suicide**	**Homicide**	**Undetermined**	**Total**
Handgun	5	6	21	0	32
Shotgun	1	2	2	0	5
Hunting rifle	1	0	0	0	1
Unknown	0	0	3	1	4
Total	**7**	**8**	**26**	**1**	**42**

Section 3.3 Details of Drowning-Related Deaths

Highlights

- Of the 19 drowning cases, more than half (52.6%) occurred in children ages 1 to 4 years and 26.3% of drownings occurred in children ages 15 to 17.
- In the review of these cases, 31.6% owned a private pool and different pool barriers were utilized for protection. These methods consisted of fence (15.8%), gate (10.5%), and door (5.3%). Over half, (57.9%) had no protection or barriers for their pool.

TABLE 14. Drowning Victims by Age Group

Age Group	#	%
1 to 4 years	10	52.6
5 to 10 years	2	10.5
11 to 14 years	2	10.5
15 to 17 years	5	26.3
Total	**19**	**100.0**

FIGURE 7. Pool Location

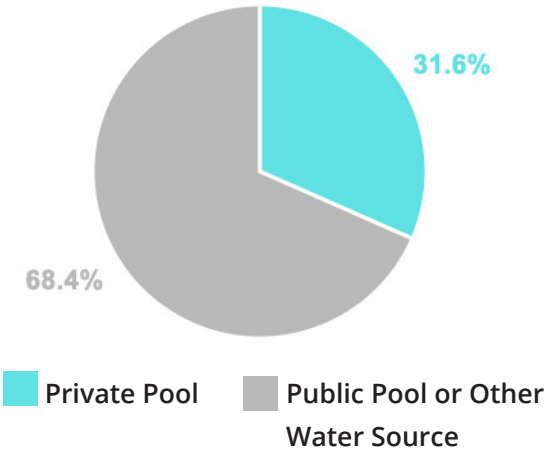
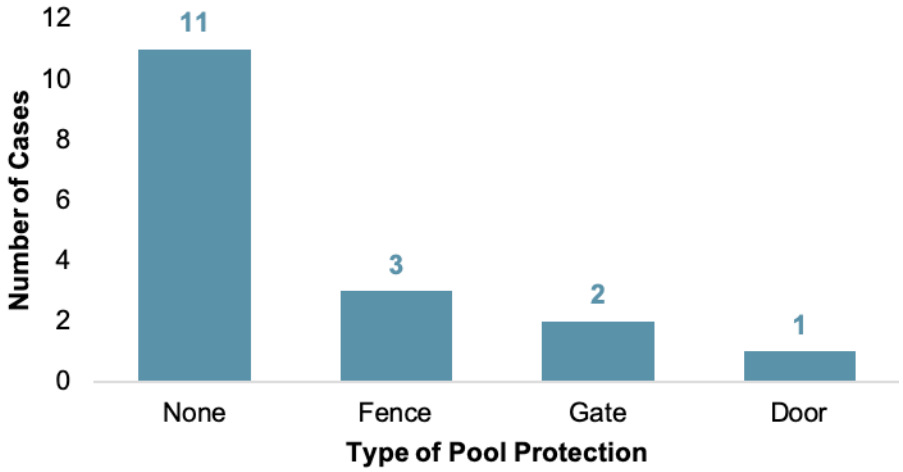


FIGURE 8. Pool Barriers and Location



Section 4. Circumstances Surrounding Deaths

Section 4.1 Details of Child Maltreatment

Highlights

- There was a DSS investigation in 136 (58.1%) of cases, and the child had DSS involvement in 73 (31.2%) of the total cases. At the time of death, there were open DSS cases in 25 (10.7%) cases.
- Poor supervision or exposure to hazard contributed to death in 145 (62%) of the 234 cases reviewed by SCFAC.
- In the 145 cases where maltreatment was identified as contributing to death, child neglect was the most common, occurring in 114 (78.6%) of cases, followed by child abuse in 25 (17.2%) of cases.
- The most common type of child abuse was abusive head trauma (64.0%), followed by other (52.0%), beating or kicking (16.0%), and lastly, Chronic Battered Child Syndrome (4.0%).
- DSS departments, whether CPS investigation or Community-based services, was involved in 58.1% of cases reviewed.

TABLE 15. Child Protective Services (CPS) Involvement

CPS Involvement in 234 Cases	Frequency #	Percent %
Ever had any CPS Involvement [2]	157	67.1
Was there a CPS Investigation [3]	136	58.1
Caregiver had CPS Involvement	74	31.6
Child had CPS Involvement	73	31.2
Caregiver 2 had CPS Involvement	33	14.1
Was there an open CPS case at time of death[4]	25	10.7

Note:
[2] SCDSS had prior involvement with the family
[3] SCDSS opened a CPS investigation in response to the child's death
[4] SCDSS had an open CPS case at the time of the child's death

TABLE 16. Child Maltreatment

Child Maltreatment	Frequency #	Percent %
Poor supervision or exposure to hazards caused or contributed to death[5]	145	62.0
Type of Act		
Child Neglect	114	78.6
Child Abuse	25	17.2
Poor/Absent Supervision	6	4.1
Total	**145**	**100.0**

Note:
[5] Intended to identify whether there were specific behaviors by a parent/caregiver/supervisor that caused or contributed to the child's death. A behavior that causes death is defined as a behavior that in and of itself led to the child's death.

FIGURE 9. Did Poor Supervision or Exposure to Hazard Contribute to Death

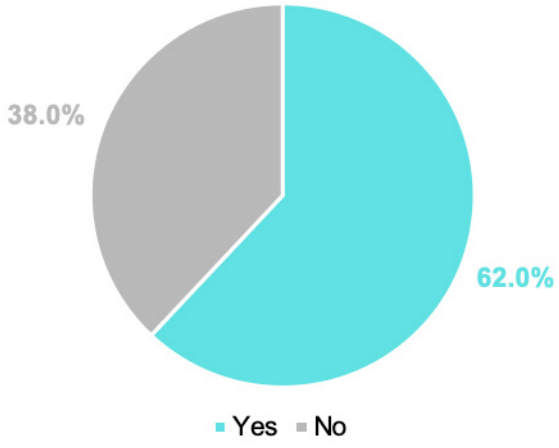
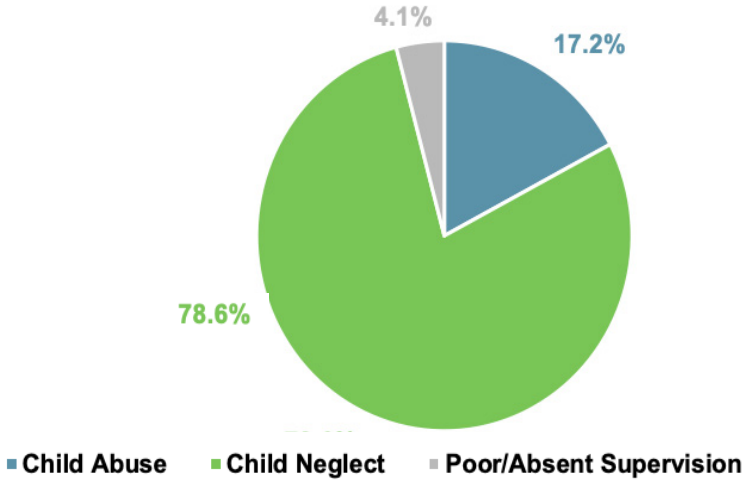


FIGURE 10. Type of Child Maltreatment

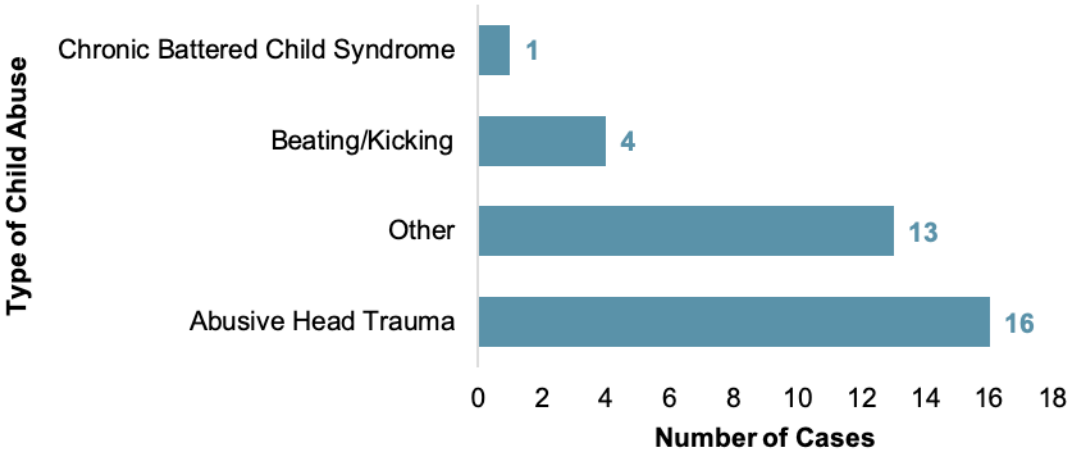


[2, 3, 4, 5] National Center for Fatality Review and Prevention. Data Dictionary. Version 5.0. https://www.ncfrp.org/wp-content/uploads/NCRPCD-Docs/DataDictionary_v5.pdf

TABLE 17. Child Abuse

Type of Child Abuse	#	%
Abusive head trauma	16	64.0
Beating/Kicking	4	16.0
Chronic Battered Child Syndrome	1	4.0
Other	13	64.0

FIGURE 11. Type of Child Abuse in SCFAC Reviewed Cases



Note: Total exceeds number of child abuse deaths as more than one type can be present.

Section 4.2 History of Substance Abuse

Highlights

- Of the 234 deaths reviewed, 25 (10.7%) of the deaths were associated with alcohol, and the caregiver had a history of alcohol use.
- Out of the 84 unsafe sleep cases, the death was associated with caregiver alcohol use in 14 (16.7%) of cases.
- Of the 234 cases reviewed by SCFAC, 69 cases had a cause of death due to weapon. Out of the 69 cases, 4 of them were associated with alcohol.
- Of the 234 total deaths, 16 were due to fire, burn, or electrocution. In 4 of the 16 fire, burn, or electrocution cases the death was associated with alcohol.
- The child's caregiver was impaired at the time of the incident in 50 (21.4%) of the total 234 cases investigated.
- The caregiver was alcohol-impaired in 15 cases and the caregiver was drug impaired in 26 cases.
- Caregivers had a history of substance abuse in 83 of the 234 cases investigated by SCFAC. Of the 83 cases, marijuana was the most common substance abused (67.5%), followed by alcohol (15.7%), methamphetamine (15.7%), and opiates (15.7%).
- Of the 234 cases reviewed, children ages 13 to 17 had a known history of substance abuse in 14 cases.

TABLE 18. Death Associated with Caregiver Alcohol Use

Cause of Death	#	%	Total Deaths
Unsafe Sleep	14	16.7	84
Weapon, including body part	4	5.8	69
Drowning	1	5.3	19
Fire, Burn, or electrocution	3	18.8	16
Poisoning, overdoes or acute intoxication	1	12.5	8
Undetermined	2	13.3	15
Total	**25**	**10.7**	**234**

FIGURE 12. Total Deaths and Deaths Associated with Alcohol

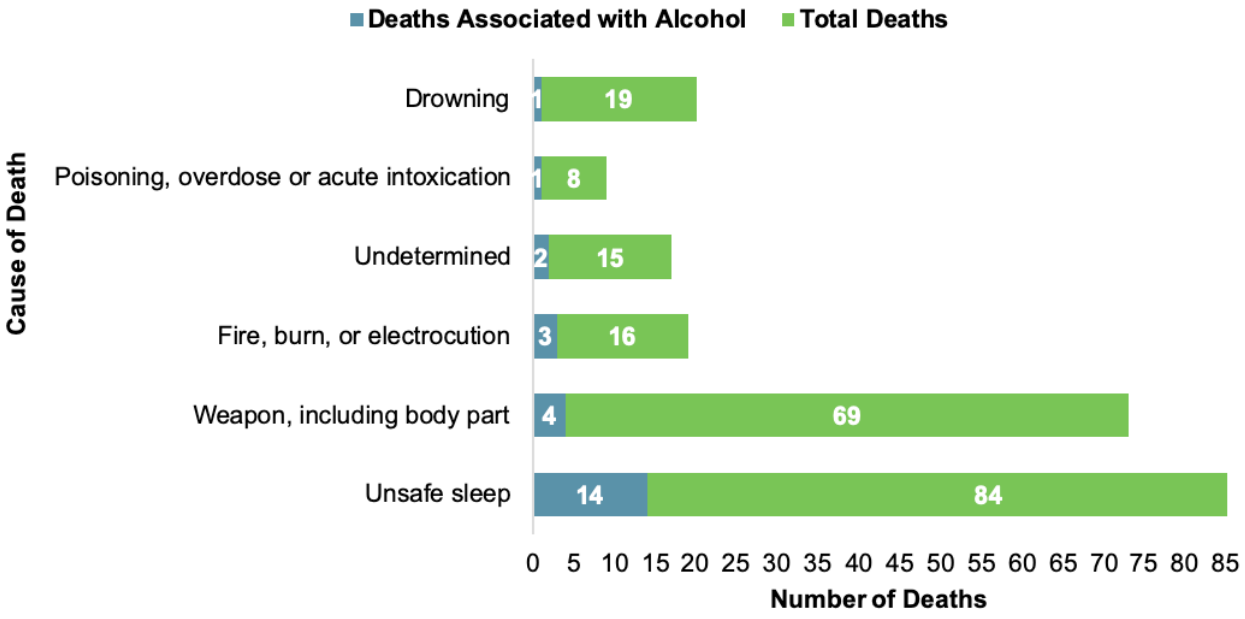


TABLE 19. Caregiver Impairment at Time of Incident

	#	%
At time of incident caregiver was impaired	50	21.4
Alcohol Impaired	15	6.4
Drug Impaired	26	11.1

FIGURE 13. Caregiver Impairment at Time of Incident

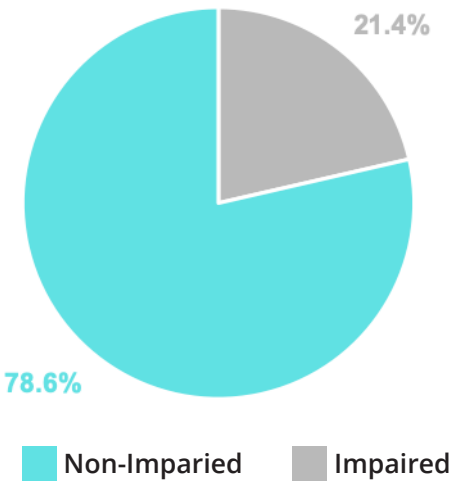


TABLE 20. Caregiver has History of Substance Abuse

Substance	#	%
Marijuana	56	67.5
Alcohol	13	15.7
Methamphetamine	13	15.7
Opiates	13	15.7
Cocaine	11	13.3
Prescription Drugs	10	12.0
Unknown	8	9.6

FIGURE 14. History of Substance Abuse in Caregivers

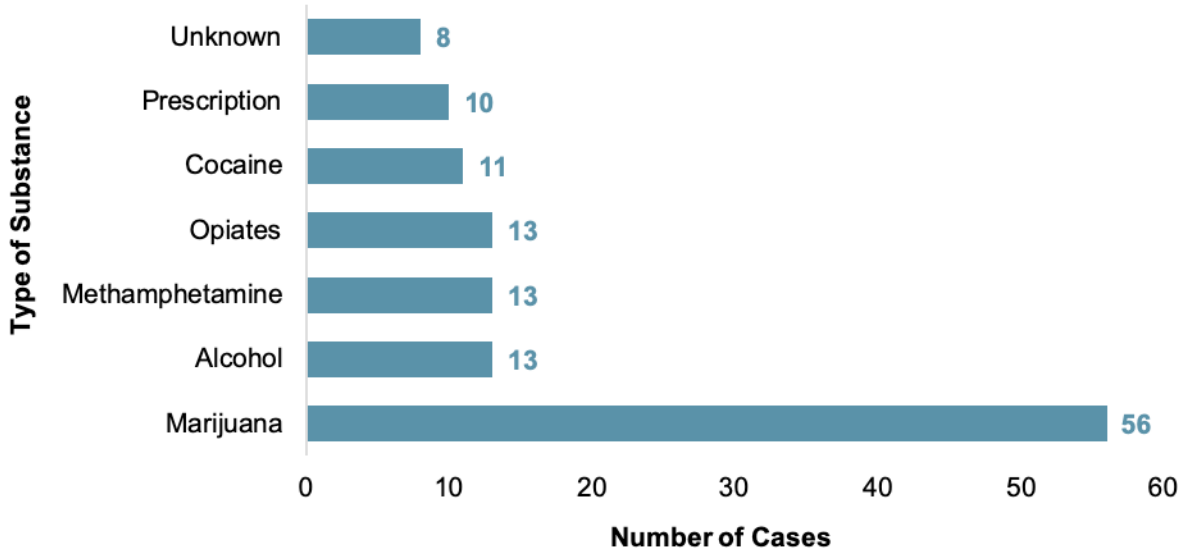


FIGURE 15. History of Substance Abuse in Children Ages 13 to 17