STATE OF SOUTH CAROLINA

STATE CHILD FATALITY ADVISORY COMMITTEE

2022 Report

The Honorable Henry McMaster, Governor, State of South Carolina
The 125th South Carolina General Assembly

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State Child Fatality Advisory Committee (SCFAC) Membership

Susan Lamb, M.D., SCFAC Chairperson Until August 2022

Amanda Whittle, State Child Advocate, SCFAC Chairperson Effective October 2022

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Member of Public http://www.scvan.org/	Laura Hudson	laurahudson@sccvc.org P:803-413-5040

The following are additional Resources available to South Carolina children and families. This is by no means an all-inclusive list of resources available.

- Resource library provided by the SC Department of Children's Advocacy: https://childadvocate.sc.gov/resource-library
- Prevention program geographical search by the Children's Trust of South Carolina: https://scparents.org/

State Child Fatality Advisory Committee (SCFAC) History & Mission

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 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.

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 age 17 years and younger that are unexpected, unexplained, suspicious, or criminal in nature. Since its enactment, the committee has completed review of 3,007 cases as of October of 2022.

The SCFAC regularly meets every other month and has traditionally scheduled reviews of 42 cases at each meeting, completing approximately 200 case reviews annually. Each case is presented by the State Law Enforcement Division (SLED) Special Victims Unit and is reviewed by the committee to analyze and develop an understanding of the causes and various manners of child deaths. This collaboration serves as a means 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.

In addition to the SLED cases reviewed, the South Carolina Highway Patrol (SCHP) presents motor vehicle deaths at each meeting. The motor vehicle deaths reviewed are not exhaustive, limiting the data reporting by the committee for these fatalities. All motor vehicle traffic deaths are investigated by the South Carolina Department of Public Safety (SCDPS), who track and report data on these deaths separate from this report.

At the end of 2022, the committee adopted a new format to review fatalities beginning in 2023 to incorporate an AcciMap approach to reviewing and analyzing information about child deaths. This safety science method will be facilitated by the S.C. Department of Social Services.

The committee's collaboration serves as a means 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.

The mission of the committee is to decrease the incidence of preventable child deaths by:

- Developing an understanding of the causes and trends in 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.

The committee is composed of 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 3.

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.

Dedication and Acknowledgements

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 in which they impacted. We dedicate this report to the memory of these children and to their families.

Reported Edited by: Committee Members

Report Prepared by: Santana Jones and Chelsea Smith of the South Carolina Department of Social Services

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

Please direct any questions to the SCFAC Chair:
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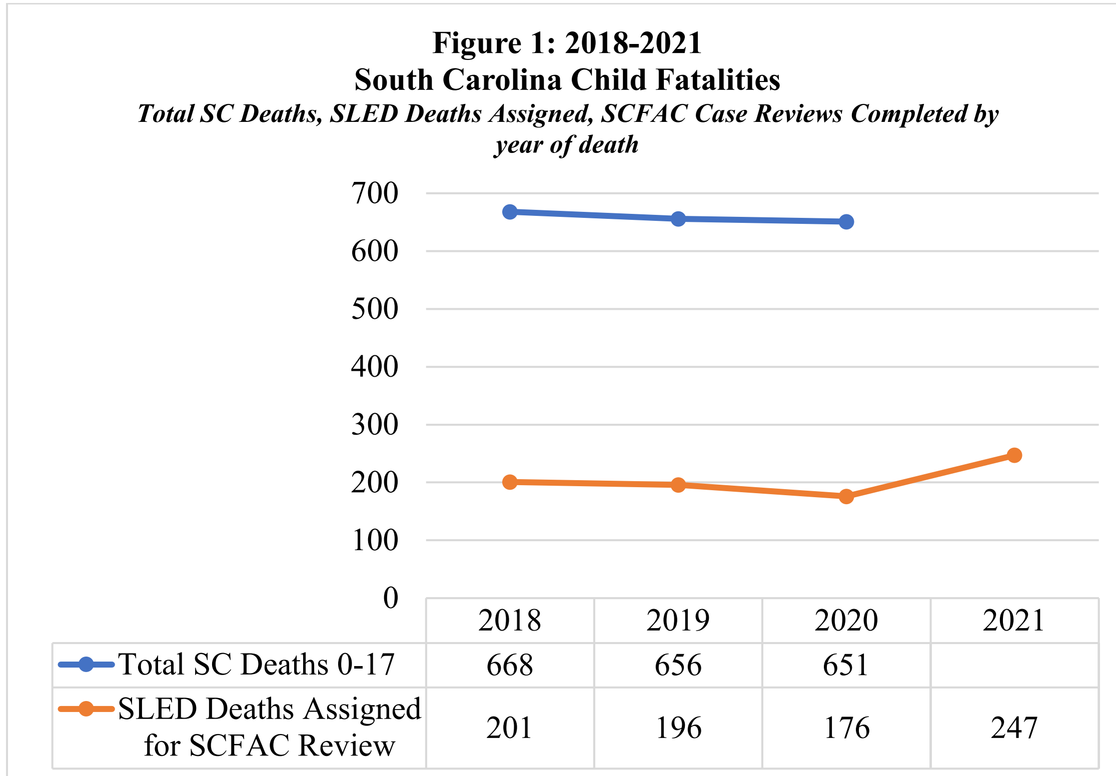
Confidentiality

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.

I. Executive Summary

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.



**DHEC has not released the total number of child fatalities for the calendar year 2021.*

The South Carolina Department of Health and Environmental Control (DHEC) reports there were 651 fatalities in South Carolina from the ages of 0-17 in the years 2020. Of these child fatalities, 176 (27% of deaths) were eligible for review 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. This report reflects the findings from the 602 completed cases occurring during the years 2018-2021 that have been reviewed by the committee. The 2022 SCFAC annual report covers SCFAC efforts during the time period of December of 2021 through October of 2022.

All opinions and recommendations are those of the SCFAC membership. This report includes the results of 602 completed case reviews for fatalities occurring during the years 2018-2021. Of these cases, approximately 20% were undetermined, 34% were accidental, 17% were suicides, 25% were homicides, and 3% were natural. These manners of deaths are reported based on what was recorded on the child's death certificate. Please note that the committee does not review non-preventable natural deaths. Deaths that are preventable (e.g., infant deaths in an unsafe

sleeping environment) and that are documented on the child's death certificate as natural are included with the undetermined case reviews for the committee.

Tables 1 - 3 provide a summary of the fatalities occurring in the years 2019-2021 that SCFAC has reviewed as of October of 2022. These competed case reviews are summarized by manner of death, gender, race, and ethnicity.

Table 1: 2019 Fatalities Manner of Death, Race, and Sex																		
SCFAC Case Reviews Completed																		
	African American			Hispanic			Non-Hispanic White			Other			Unknown			Totals		
Manner	M	F	Tot als	M	F	Totals	M	F	To tal s	M	F	Totals	M	F	Total s	M	F	Total s
Accidental	18	8	**26**	3	0	**3**	22	9	**31**	1	2	**3**	2	0	**2**	46	19	**65**
Homicide	17	7	**24**	3	0	**3**	10	4	**14**	1	0	**1**	0	0	**0**	31	11	**42**
Suicide	4	0	**4**	3	0	**3**	26	3	**29**	0	1	**1**	0	0	**0**	33	4	**37**
Undetermine d and Natural*	13	14	**27**	3	3	**6**	12	3	**15**	4	2	**6**	0	0	**0**	32	22	**54**
Totals	**52**	**29**	**81**	**12**	**3**	**15**	**70**	**19**	**89**	**6**	**5**	**11**	**2**	**0**	**2**	**142**	**56**	**198**

** The SCFAC does not review non-preventable deaths..*

Of the 198 SCFAC reviewed cases of child deaths occurring during 2019, the manner of death determination revealed 65 (33%) were accidental, 42 (21%) were homicide, 37 (19%) were suicide, and 54 (27%) were undetermined or preventable natural deaths. The cases reviewed revealed 81 (41%) were African American, 89 (45%) were non-Hispanic White, 15 (8%) were Hispanic, and 11 (6%) were categorized as Other (includes Native Americans, multi-racial, and/or Asian). There were 2 cases in which the race was unknown (1%).

Table 2: 2020 Fatalities Manner of Death, Race, and Sex																		
SCFAC Case Reviews Completed																		
	African American			Hispanic			Non-Hispanic White			Other			Unknown			Totals		
Manner	M	F	Totals	M	F	Totals	M	F	Totals	M	F	Totals	M	F	Totals	M	F	Totals
Accidental	15	11	**26**	6	0	**6**	14	10	**24**	2	1	**3**	0	0	**0**	37	22	**59**
Homicide	26	8	**34**	0	1	**1**	7	6	**13**	0	0	**0**	0	0	**0**	33	15	**48**
Suicide	3	0	**3**	1	1	**2**	16	4	**20**	0	0	**0**	0	0	**0**	20	5	**25**
Undetermined and Natural*	14	6	**20**	0	0	**0**	6	2	**8**	1	1	**2**	0	0	**0**	21	9	**30**
Totals	**58**	**25**	**83**	**7**	**2**	**9**	**43**	**22**	**65**	**3**	**2**	**5**	**0**	**0**	**0**	**111**	**51**	**162**

** The SCFAC does not review non-preventable deaths. Deaths classified as Natural on the death certificate are included in the Undetermined section of this report due to the low amount of cases.*

Of the 162 SCFAC reviewed cases of child deaths occurring during 2020, the manner of death determination revealed 59 (36%) were accidental, 48 (30%) were homicide, 25 (16%) were suicide, and 30 (19%) were undetermined or preventable natural deaths. The cases reviewed revealed 83 (51%) were African American, 65 (40%) were non-Hispanic White, 9 (6%) were Hispanic, and 5 (3%) were categorized as Other (includes Native Americans, multi-racial, and/or Asian).

Table 3: 2021 Fatalities Manner of Death, Race, and Sex																		
SCFAC Case Reviews Completed																		
	African American			Hispanic			Non-Hispanic White			Other			Unknown			Totals		
Manner	M	F	Totals	M	F	Totals	M	F	Totals	M	F	Totals	M	F	Totals	M	F	Totals
Accidental	9	2	**11**	0	0	**0**	4	4	**8**	1	1	**2**	0	0	**0**	14	7	**21**
Homicide	5	4	**9**	0	0	**0**	2	2	**4**	0	0	**0**	0	0	**0**	7	6	**13**
Suicide	0	0	**0**	0	0	**0**	2	1	**3**	0	1	**1**	0	0	**0**	2	2	**4**
Undetermined*	7	8	**15**	0	0	**0**	1	1	**2**	0	0	**0**	0	1	**1**	8	10	**18**
Totals	**21**	**14**	**35**	**0**	**0**	**0**	**9**	**8**	**17**	**1**	**2**	**3**	**0**	**1**	**1**	**31**	**25**	**56**

** The SCFAC does not review non-preventable deaths. Deaths classified as Natural on the death certificate are included in the Undetermined section of this report due to the low amount of cases.*

Of the 56 SCFAC reviewed cases of child deaths occurring during 2021, the manner of death determination revealed 21 (38%) were accidental, 13 (23%) were homicide, 4 (7%) were suicide, and 18 (32%) were undetermined or preventable natural deaths. The cases reviewed revealed 35 (63%) were African American, 17 (30%) were non-Hispanic White, 0 (0%) were Hispanic, and 3 (5%) were categorized as Other (includes Native Americans, multi-racial, and/or Asian).

Table 4 provides a summary of fatalities occurring from 2019-2021 that SCFAC has reviewed as of October of 2022 by county.

Table 4: SCFAC Completed Case Reviews by County for fatalities occurring 2019 - 2021					
County	**2019**	**2020**	**2021**	**Totals**	**% of Cases Reviewed**
Abbeville	1	0	0	1	0%
Aiken	4	3	2	9	2%
Allendale	1	1	0	2	0%
Anderson	8	7	3	18	4%
Bamberg	1	0	0	1	0%
Barnwell	2	0	0	2	0%
Beaufort	9	6	1	16	4%
Berkeley	6	7	0	13	3%
Calhoun	1	3	0	4	1%
Charleston	25	13	7	45	11%
Cherokee	1	1	0	2	0%
Chester	1	2	0	3	1%
Chesterfield	2	1	0	3	1%
Clarendon	1	1	1	3	1%
Colleton	2	3	0	5	1%
Darlington	1	0	1	2	0%
Dillon	2	2	1	5	1%
Dorchester	6	4	1	11	3%

Edgefield	0	0	0	0	0%
Fairfield	0	1	1	2	0%
Florence	6	3	1	10	2%
Georgetown	3	1	0	4	1%
Greenville	20	10	3	33	8%
Greenwood	1	1	0	2	0%
Hampton	3	2	1	6	1%
Horry	13	12	8	33	8%
Jasper	0	0	0	0	0%
Kershaw	0	4	1	5	1%
Lancaster	2	6	2	10	2%
Laurens	0	0	0	0	0%
Lee	2	1	0	3	1%
Lexington	10	10	2	22	5%
Marion	2	1	1	4	1%
Marlboro	2	0	0	2	0%
McCormick	0	0	0	0	0%
Newberry	2	2	2	6	1%
Oconee	5	2	1	8	2%
Orangeburg	2	3	3	8	2%
Pickens	3	2	0	5	1%
Richland	18	16	5	39	10%
Saluda	2	0	0	2	0%
Spartanburg	11	9	0	20	5%
Sumter	5	4	1	10	2%
Union	0	2	0	2	0%
Williamsburg	0	1	0	1	0%
York	8	10	7	25	6%

II. Leading Causes of Child Deaths

The following data is not representative of cases reviewed by the SCFAC; however, it is included to provide an overview of child mortality trends and data.

Mortality data is useful for identifying trends and prevention opportunities. The data included in this section is compiled from various sources including the Centers for Disease Control and Prevention (CDC) and the South Carolina Department of Health and Environmental Control (DHEC) and is intended to provide an overall picture of child mortality data in South Carolina.

The leading causes of death in children vary by age group. Mortality data from the CDC Injury Center is summarized in Table 5 to include the leading causes of death in South Carolina by age category and the leading causes of death nationally for the same age category.

Table 5: Leading Causes of Death by Age Category (2020)		
	South Carolina	National
Age Category	Leading Causes	Leading Causes
Infant (Less than 1)	1. Congenital Anomalies	1. Congenital Anomalies
	2. Short Gestation	2. Short Gestation
	3. Unintentional Injury	3. SIDS
	4. Maternal pregnancy complications	4. Unintentional Injury
	5. Placenta cord membranes	5. Maternal pregnancy complications
Ages 1-5	1. Unintentional Injury	1. Unintentional Injury
	2. Congenital Anomalies	2. Congenital Anomalies
	3. Homicide	3. Malignant Neoplasms
	4. Malignant neoplasms	4. Homicide
	5. Benign neoplasms	5. Heart Disease
Ages 6-10	1. Unintentional Injury	1. Unintentional Injury
	2. Malignant Neoplasms	2. Malignant Neoplasms
	3. Homicide	3. Homicide
	4. Chronic lower respiratory disease	4. Congenital Anomalies
	5. Benign neoplasms	5. Chronic Lower Respiratory Disease
Ages 11-15	1. Unintentional Injury	1. Unintentional Injury
	2. Suicide	2. Suicide
	3. Homicide	3. Homicide
	4. Malignant Neoplasms	4. Malignant Neoplasms
	5. Heart Disease	5. Congenital Anomalies
Ages 16-17	1. Unintentional Injury	1. Unintentional Injury
	2. Suicide	2. Homicide
	3. Homicide	3. Suicide
	4. Malignant Neoplasms	4. Malignant Neoplasms
	5. Diabetes Mellitus	5. Heart Disease

Data Source: CDC WISQARS, CDC, Injury Center [1]

Infant Mortality Summary

The leading causes of death in South Carolina from 2019-2020 for infants (less than one year) were congenital anomalies, short gestation, unintentional injuries, maternal pregnancy

complications, and SIDS.[1] Infant mortality considers deaths of an infant less than one year in age. Calculating infant mortality as a rate per 1,000 live births provides key information surrounding maternal and infant health and is considered an important marker of overall societal health. In 2019 and 2020, the Infant Mortality Rate (IMR) in South Carolina was 6.89 and 6.64.[2] South Carolina ranks as the 11th highest state in the United States for infant mortality according to the CDC's National Center for Health Statistics.[2]

The DHEC reports that racial disparity for infant mortality is a concern in South Carolina. According to DHEC's 2020 Infant Mortality report, infant mortality rates of births to White mothers was the lowest (4.5 deaths per 1,000 live births), while the infant mortality rate among births to Black women was more than twice as high (10.8 deaths per 1,000 live births).[3] The 2020 infant mortality rate among births to mothers of all races in South Carolina was 6.5 deaths per 1,000 live births. This is an improvement over the 2019 rate of 6.9 deaths per 1,000 live births.[2]

The SCFAC reviews infant death cases for preventable deaths, including those resulting from sudden unexplained infant death (SUID). SUID deaths include deaths from unknown or unexplained causes, sudden infant death syndrome (SIDS), and accidental suffocation in bed. South Carolina ranks 19th in SUID deaths with a rate of 1.11 per 1,000 live births from 2016-2020.[4]

Youth Injury Mortality Summary

Injury deaths are the leading cause of mortality in children over the age of 1. Causes of injury-related deaths include unintentional injuries, homicides, suicides, and those from undetermined intent. In 2020 the national youth injury-related death rate was 16.11 (age-adjusted). South Carolina ranks 41st with an age-adjusted rate of 23.3.[3]

In South Carolina, injury-related deaths in youth are most often unintentional. Data from the CDC Web-based Injury Statistics Query and Reporting System (WISQARS) reports that 58% of South Carolina youth injury deaths are unintentional, followed by 25% being homicides, and 18% being suicides.[5]

Unintentional Youth Injury Deaths

Unintentional injury fatalities account for the largest percentage of youth injury-related deaths in South Carolina. These deaths are the result of accidents such as motor vehicle and other transportation accidents, accidental discharge of firearms, drownings, falls, exposure to smoke and fire, and accidental poisonings.

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[1] "WISQARS Leading Causes of Death Reports," Centers for Disease Control and Prevention, accessed December 19, 2022, https://webappa.cdc.gov/sasweb/ncipc/leadcause.html.
[2] "Infant Mortality Rates by State," Centers for Disease Control and Prevention, https://www.cdc.gov/nchs/pressroom/sosmap/infant_mortality_rates/infant_mortality.htm.
[3] "WISQARS Fatal Injury Reports," Centers for Disease Control and Prevention, accessed December 19, 2022, https://webappa.cdc.gov/sasweb/ncipc/mortrate.html.

Table 6: Causes of Injury Deaths *Fatalities occurring 2019-2020* *Ages 0-17*		
Cause of Injury	**2019**	**2020**
Transportation accidents (motor vehicle, water, air, land)	57	62
Drowning	16	15
Accidental exposure to smoke, fire, and flames	1	5
Accidental discharge of firearm	3	6
Accidental poisoning	2	7
Other and unspecified non-transportation accidents	38	32
Falls	0	1

Source: SC DHEC SCAN [7]

Older youth experience a higher frequency of unintentional injury deaths related to transportation accidents and accidental poisonings than younger age groups. Drownings, exposure to smoke and fire, as well as accidental firearm discharge deaths occur more frequently in younger populations.

Table 7: Unintentional Injury Deaths
by Cause and Age
Fatalities occurring 2019 - 2020

Age	Transportation Accidents	Accidental discharge of firearm	Drowning	Exposure to smoke, fire and flames	Accidental poisoning	Falls	Other and unspecified nontransport accidents	Totals
0-1	6	0	3	0	0	0	51	**60**
1-4	18	4	11	4	0	0	11	**48**
5-9	16	2	7	1	0	1	1	**28**
10-14	18	1	2	1	1	0	3	**26**
15-17	61	2	8	0	8	0	4	**83**
Totals	**119**	**9**	**31**	**6**	**9**	**1**	**70**	**245**

Source: SC DHEC SCAN [7]

Motor vehicle accidents: During 2019-2020 there were 2,245 deaths from transportation accidents in South Carolina: motor vehicle accident fatalities (2,134) other land transportation accident fatalities (52), to include water, air, and other unspecified transportation accident fatalities (59). Of these transportation fatalities, approximately 5% (119 fatalities) involved

children ages 17 years and younger. Of the 119 transportation fatalities in youth reported by SC DHEC during 2019-2020, 61 were ages 15-17 (51%).[4]

Drownings: Nationally, drowning is the second leading cause of unintentional injury deaths in children ages 5-14. For every child who dies from drowning, another seven children receive emergency medical treatment for non-fatal or near drowning events.[5] Close supervision, effective barriers to pool or water access, and the use of life jackets are recommended strategies to reduce the occurrence of drowning deaths.

Drowning deaths occur most frequently in younger children. During 2019-2020 there were 31 drowning deaths occurring in ages 0-17 reported in SC DHEC SCAN data: ages 0 to 1 (3 deaths, 10%), ages 1 to 4 (11 deaths, 35%), ages 5 to 9 (7 deaths, 23%), ages 10 to 14 (2 deaths, 6%), ages 15 to 17 (8 deaths, 26%).

Of the 31 drowning fatalities that occurred in South Carolina youth from 2019-2020, 23 of the 31 were males (74%). Sixty-one percent of the 31 SC drowning fatalities occurred among White children (19 of 31) and 39% among African American children (12 of 31). Across all subgroups, White males account for the highest rate, representing 52% of all drownings.

Table 8: Accidental drowning and submersion fatalities
By sex and race, Ages 0-17, 2019-2020

Race	Male	Female	Selection Total
White	16	3	**19**
African American	7	5	**12**
Other	0	0	**0**
Totals	**23**	**8**	**31**

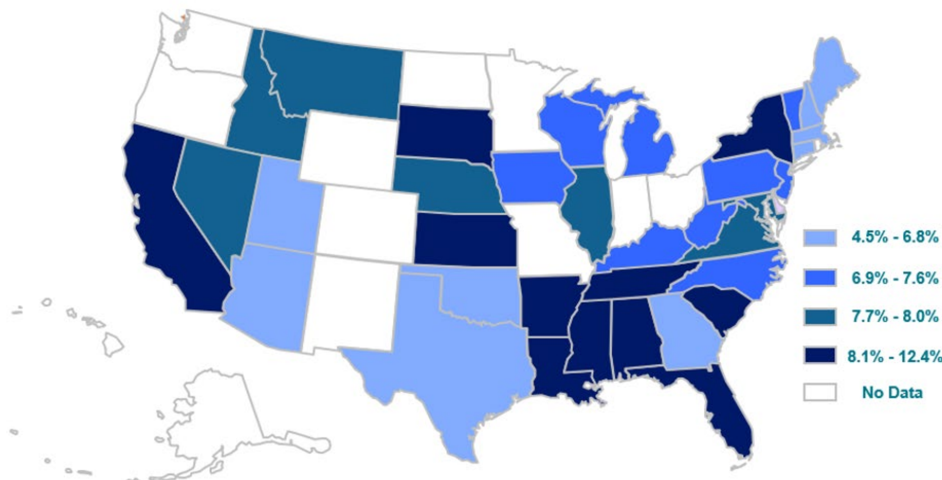
Source: SC DHEC SCAN [7]

Peer Violence: Homicide is a top three leading cause of death in South Carolina for adolescents and young adults, and the victim and offender(s) may be youth.

Disparities in age, race and gender related to youth violence are highlighted in the 2019 Youth Risk Behavior Survey (YRBS).[6] Nationally, 7.4% of high school students responding to the YRBS reported being threatened or injured with a weapon at school during the past year. More male students were threatened or injured with a weapon at school than female students. South Carolina students responding to this question reported a higher occurrence as evident by Figure 5.

[4] "DHEC SCAN Death Certificate Data," SCAN Death Tables (South Carolina Department of Health and Environmental Control), accessed December 19,2022, https://apps.dhec.sc.gov/Health/SCAN_BDP/tables/death2table.aspx.
[5] "Drowning Facts," Centers for Disease Control and Prevention, October 7, 2022, https://www.cdc.gov/drowning/facts/index.html.
[6] "High School YRBS: South Carolina 2019 and United States 2019 Results," Centers for Disease Control and Prevention, n.d., https://nccd.cdc.gov/Youthonline/App/Results.aspx?LID=SC

Figure 2: Percentage of High School Students Threatened or Injured with a Weapon on School Property



Source: 2019 YRBS [8]

Nationally, 21.9% of YRBS respondents reported being in a physical fight outside of school property in the prior year, including 28.3% of males and 15.3% of females. Thirty percent of African Americans, 33% of Hispanic, and 20% of White students reported being in a physical fight at least once during the prior year. Overall, 4.4% of YRBS respondents reported carrying a gun for reasons other than hunting or sport, including 7.1% of African American students, 5.6% of Hispanic students, and 3.3% of White students.

Homicide by a caregiver: Homicides resulting from abuse and/or neglect most often occur in young children when the child is in the care of a relative or someone that the child knows. According to the Children's Bureau, for FFY2020 a national estimate of 1,750 children died from abuse and neglect (rate 2.38 per 100,000). Of these, approximately 46% occurred in children younger than 1 year of age.[7]

Abusive head trauma (ABH), which includes shaken baby syndrome, is a term used to describe the physical abuse from violent shaking and/or blunt impact. The resulting injuries may include bleeding around the brain or at the back of the eyes and can cause serious, long-term health consequences or death. The CDC reports that abusive head trauma is a leading cause of physical abuse deaths in children under the age of five and that babies less than one year of age are at the greatest risk of abusive head trauma.[8] Abusive head trauma often happens when a parent or caregiver becomes frustrated with a child's crying and inconsolability.

The incidence of child abuse may be the result of abuse recurring over time or may be a result of a single incident in which a parent or caregiver becomes frustrated and reacts by harming the

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[7] "Child Maltreatment 2020" (ACF/Children's Bureau), https://www.acf.hhs.gov/sites/default/files/documents/cb/cm2020.pdf.
[8] "Preventing Abusive Head Trauma in Children," Centers for Disease Control and Prevention, April 6, 2022, https://www.cdc.gov/violenceprevention/childabuseandneglect/Abusive-Head-Trauma.html.

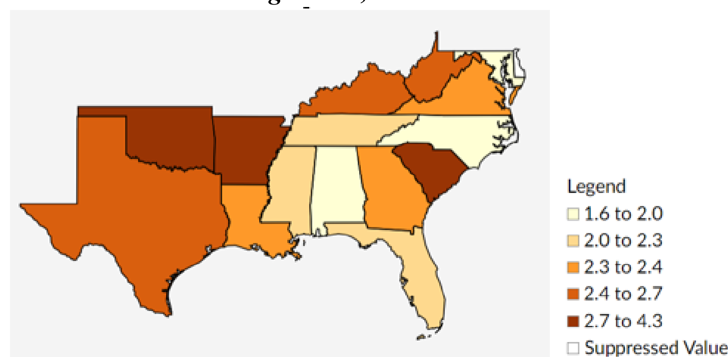
child. The CDC reports the incidence of child abuse appears associated with risk factors surrounding the individual, family, and community. Risk factors at the individual level include caregivers with substance abuse issues, mental health issues, a generational history of abuse or neglect, families with high levels of economic stress, and caregivers who do not understand children's needs or development. Risk factors at the family level include families with members incarcerated, families isolated from extended family, friends, or neighbors, domestic violence, and families with poor or negative communication styles to include high levels of conflict. At the community level, risk factors include communities with high rates of crime, poverty, and unemployment, few community activities for young people, unstable housing, and food insecurity.[9]

Youth Suicide

Suicide is one of the leading causes of death in youth ages 11-17. Adolescence is a time of tremendous growth and transitions involving education, employment, relationships, and living circumstances that can be difficult to navigate, leading to mental health challenges that can be associated with increased risk for suicide. It is reported that for every suicide death among young people, there may be 100 to 200 suicide attempts. The incidence of suicidal behavior is even higher amongst those involved in the child welfare and juvenile justice systems, those in the LGBTQ community, and American Indian/Alaskan Natives.[10] The CDC recommends prevention strategies aimed at increasing social connectedness, teaching coping skills, learning to recognize the signs of suicide and how to respond, along with limiting access to commonly utilized self-harm mechanisms such as medications and firearms to help prevent suicide attempts.[11] According to CDC WISQARS data, the national suicide rate of children ages 0-17 is 2.28 per 100,000 during 2019-2020. The Southern region has a slightly higher rate of 2.35. The suicide rate in South Carolina for ages 0-17 is 3.00.[5]

Figure 3: Regional Suicide Fatality Rates

Ages 0-17, 2019-2020



Source: CDC WISQARS, CDC, Fatal Injury Data [5]

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[9] "Risk and Protective Factors," Centers for Disease Control and Prevention, April 6, 2022, https://www.cdc.gov/violenceprevention/childabuseandneglect/riskprotectivefactors.html.

[10] Suicide prevention, accessed December 19,2022, https://youth.gov/youth-topics/youth-suicide-prevention.

[11] Ellen Yard et al., "Emergency Department Visits for Suspected Suicide Attempts among Persons Aged 12–25 Years before and during the COVID-19 Pandemic — United States, January 2019–May 2021," *MMWR. Morbidity and Mortality Weekly Report* 70, no. 24 (2021): pp. 888-894, https://doi.org/10.15585/mmwr.mm7024e1.

DHEC SCAN data reports 67 suicide deaths in South Carolina children ages 17 and younger during the years 2019-2020. These deaths occurred in ages 10-17, with ages 15 to 17 having the highest occurrence with 45 of the 67 deaths (67%). Of these 67 youth suicides, 56 were among White children (84%), 9 were among Black children (13%), and 2 were among other races (3%).[7]

Table 9: Suicide Fatalities *by age and race* *Ages 0-17, 2019-2020*			
	Male	**Female**	**Total**
White	47	9	**56**
Black	8	1	**9**
Other	1	1	**2**
Totals	**56**	**11**	**67**

Source: SC DHEC SCAN [7]

III. 2019-2021 Fatality Findings - SCFAC Case Reviews Completed

Note: Although incomplete (54 of 247 assigned cases completed) 2021 is included in the next sections, since it represents the most recent available data.

Homicide

Homicide is the act or instance of killing another human being, whether intentionally or unintentionally. In 2020 South Carolina had a total of 620 homicides, 50 of which were children 0 to 17 years of age.[5]

SCFAC Case Reviews – Homicide *Deaths occurring from 2019-2021*	
Cases Assigned	619
Cases Completed:	416
Homicide:	103
Percent of Completed Cases:	26%

Of the deaths occurring in 2019 through 2021, the committee has completed its review of 403 cases with 103 (26%) cases determined with a manner of homicide. Of these 103 cases, 67 (65%) were African American, 31 (30%) were White, 4 (4%) were Hispanic, and 1 (1%) was categorized as Other (includes Native Americans, Biracial, and/or Asian). Table 11 breaks down the completed cases by year of death and race and ethnicity.

Table 10: SCFAC Completed Cases: Homicide *by race and ethnicity* *Deaths occurring 2019-2021*				
	2019	**2020**	**2021**	**Totals**
Black	24	34	9	**67**
Non-Hispanic White	14	13	4	**31**
Hispanic	3	1	0	**4**
Other (Native Americans, multi-racial, and/or Asian)	1	0	0	**1**
Totals	**42**	**48**	**13**	**103**

Cases reviewed revealed that homicide cases for ages 0-4 were most often committed by the child's caregivers through acts of physical violence without an external weapon (i.e. beating and

suffocation). Middle childhood showed the fewest homicide cases across the age categories. Older youth homicide case reviews revealed most teenage homicide deaths involved a male victim. (Table 12)

Table 11: SCFAC Completed Cases: Homicide *by age category and sex* *Deaths occurring 2019-2021*									
	2019		**2020**		**2021**		**Totals**		
	Male	**Female**	**Male**	**Female**	**Male**	**Female**	**Total Male**	**Total Female**	**Total Combined**
Infant (less than 1 year of age)	4	3	3	3	1	1	8	7	**15**
Ages 1-4	7	3	2	5	0	2	9	10	**19**
Ages 5-9	3	2	2	3	1	1	6	6	**12**
Ages 10-14	3	3	6	1	0	1	9	5	**14**
Ages 15-17	14	0	20	3	5	1	39	4	**43**
Totals	**31**	**11**	**33**	**15**	**7**	**6**	**71**	**32**	**103**

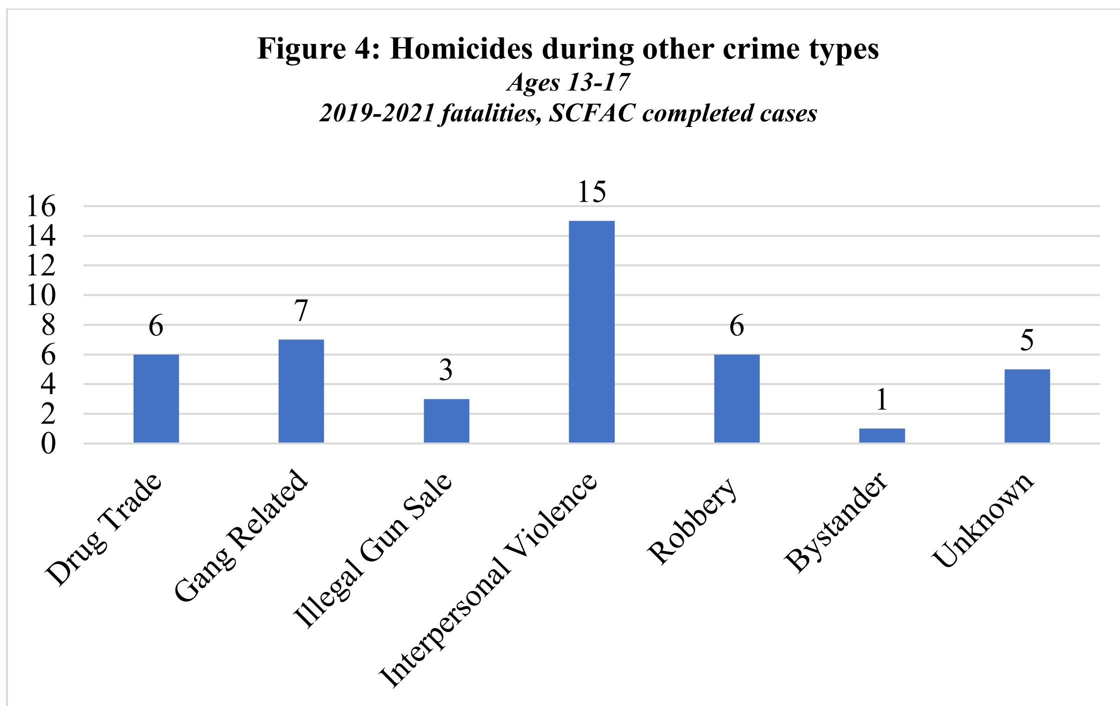
Homicide involving caregiver(s): Of all 403 cases reviewed, 83 cases (21%) showed evidence of child abuse and/or neglect surrounding the child's death. Not all of these cases are categorized as homicides. When a child dies, the immediate circumstances surrounding the death do not always indicate that a homicide has occurred. There are cases through thorough investigation and autopsy that other evidence is obtained to strongly suggest that the death is a homicide as a result of abuse and/or neglect. Some injuries are the result of a deliberate act to do harm whereas other injuries may have no external signs of trauma.

Of the 103 homicide cases reviewed by the committee, 39 (38%) included child abuse and/or neglect causing or contributing to the child's death. The ages of the children in these cases spanned from less than one to 13 years of age.

The incidence of child maltreatment is complex, involving many systems and family stressors. Efforts to reduce the occurrence of child maltreatment and maltreatment fatalities must take a systemic approach to family, community, and economic disparities.

Youth violence: Many of the reviewed homicide cases of older youth were male victims and involved peer violence. Of the 103 homicide cases reviewed, 52 (50%) were deaths of children ages 13-17. Of these 52 cases, the vast majority are the result of assaults by an individual not in a caregiving role to the child. One case was classified as child abuse, 3 were determined to be unintentional homicides due to accidental shootings, and 43 were acts of violence perpetrated by someone not serving as a caregiver to the child (i.e. acquaintance, friend, stranger). Of those, the majority of these homicides were the result of violence by an acquaintance, friend or person known by the victim child.

Many of the 13-17 year old homicide cases reviewed occurred during the commission of another crime (i.e., gang conflict, drug trade, robbery, and interpersonal violence). Many of these cases involved deaths as a result of interpersonal violence, which includes assaults stemming from an argument that escalated to violence resulting in death, assaults between undocumented gang affiliated groups, and other incidents of violence without an identifiable other crime occurring. A summary of cases in which the death occurring during the commission of other crimes is included in Figure 9.



There are numerous factors to consider when determining what puts youth at higher risk for engaging in risky behavior. These factors include mental health issues, substance abuse, delinquent behavior, experiencing maltreatment, and lack of community engagement and resources.

The committee includes representation from the State agencies supporting children and families, including the S.C. Department of Mental Health (DMH), S.C. Department of Social Services (DSS), S.C. Department of Juvenile Justice (DJJ), S.C. Department of Education (DOE), and the S.C. Department of Alcohol and Other Drug Abuse Services (DAODAS). Encounters that children and families have with these agencies are discussed through the case reviews and the data in the following section comes from state agency involvement with the children of these cases. This is noted because the committee does not have access to services that these children may have received through private means, such as private counseling or treatment.

Suicide

Suicide fatalities are a result of self-injury with the intent to die. Between 2019-2020 South Carolina had a suicide rate of 6.50 in children ages 10-17, which is above the regional rate of 5.13.[5]

SCFAC Case Reviews – Suicide *Deaths occurring from 2019-2021*	
Cases Assigned	619
Cases Completed:	416
Suicide:	65
Percent of Completed Cases:	16%

Of the deaths occurring in 2019 through 2021, the committee has completed its review of 416 cases with 65 (16%) cases determined with a manner of death as suicide. Of these 65 cases, 7 (11%) were African American, 51 (78%) were White, 5 (8%) were Hispanic, and 2 (5%) were categorized as Other (includes Native Americans, multi-racial, and/or Asian).

Table 12: SCFAC Completed Cases: Suicide
by race/ethnicity
Deaths occurring 2019-2021

	2019	2020	2021	Totals
African American	4	3	0	**7**
Non-Hispanic White	29	19	3	**51**
Hispanic	3	2	0	**5**
Other (Native Americans, multi-racial, and/or Asian)	1	0	1	**2**
Totals	**37**	**24**	**4**	**65**

Case reviews revealed that most suicide cases reviewed involved males, representing 55 (85%) of the 65 cases reviewed. Females represented 15% of the suicide cases reviewed. Analysis by age revealed 21 cases (32%) involved children ages 10 to 14 and 44 cases (68%) occurring in ages 15-17.

Table 13: SCFAC Completed Cases: Suicide
by age category and sex
Deaths occurring 2019-2021

	2019		2020		2021		Totals	
	Male	Female	Male	Female	Male	Female	Male	Female
Ages 10-14	13	1	5	1	1	0	19	2
Ages 15-17	20	3	15	3	1	2	36	8
Totals	**33**	**4**	**20**	**4**	**2**	**2**	**55**	**10**

Suicide remains a leading cause of death in late childhood and adolescence, resulting in not only the direct loss of young lives, but also having adverse impacts on psychosocial and socioeconomic effects. Having good insight into the risk factors contributing to youth suicides can help guide prevention efforts. In general, risk factors of adolescent suicide include, but are not limited to, mental disorders, previous suicide attempts, triggering psychosocial stressors, and availability of means of committing suicide.[12]

[12] Johan Bilsen, "Suicide and Youth: Risk Factors," *Frontiers in Psychiatry* 9 (2018), https://doi.org/10.3389/fpsyt.2018.00540.

The SCFAC's fatality reviews revealed that 40 (62%) of the 65 suicide cases reviewed involved children with a diagnosed mental health disorder including anxiety, depression, bipolar disorder, impulse control/conduct disorder, substance abuse disorder, eating disorders, and/or other mental health diagnoses. Of the 40 children with a mental health disorder, 24 were diagnosed with depression. Amongst the children reviewed 35 (54%) had a history of a previous suicide attempt or previous suicidal behaviors. These behaviors may include preparatory behavior, the child communicating suicidal thoughts or intentions, changes in behavior, displaying severe emotional distress, and/or expressing hopelessness.

Of the 65 suicide cases reviewed, toxicological testing was conducted on 59. Analysis of these cases revealed 17 positive toxicological results (29%).

Table 14: SCFAC Suicide Cases Toxicological Findings *Deaths occurring 2019-2021*		
	Frequency	**Percent**
Total Suicides	65	NA
Tox. Conducted	59	91%
Negative toxicological results	42	71%
Positive toxicological results	19	29.70%

The CDC reports alcohol, marijuana, and tobacco are the most commonly used substances by adolescents with approximately 66.7% of 12th graders having tried alcohol and approximately 50% of high school students reporting ever having used marijuana.[13] Of the 59 suicide cases reviewed by the SCFAC with a toxicology conducted, 12% were positive for marijuana, 8% were positive for alcohol, 5% were positive for prescription drugs in non-therapeutic levels, and 7% showed other toxicological findings. The other findings include over the counter medications exceeding therapeutic levels, methamphetamines, kratom, and excessive caffeine levels. These substances are grouped together due to limited findings for these substances and serves as a means to protect the identity of these children. Please note these drugs did not cause the death in all cases.

Table 15: SCFAC Suicide Cases, Toxicological Findings by Substance		
Substance	**Frequency**	**Percent (of 64 cases toxicological testing was conducted)**
Alcohol	5	8%
Marijuana	7	12%
Prescription medication (outside of prescribed purpose)	3	5%
Other findings[14]	4	7%

[13] "Teen Substance Use & Risks," Centers for Disease Control and Prevention (Centers for Disease Control and Prevention, February 10, 2020), https://www.cdc.gov/ncbddd/fasd/features/teen-substance-use.html.
[14] Includes over the counter drugs exceeding therapeutic levels, LSD, methamphetamine, and excessive levels of caffeine.

Accidental

SCFAC Case Reviews – Accidental *Deaths occurring from 2019-2021*	
Cases Assigned	619
Cases Completed:	416
Accidental:	146
Percent of Completed Cases:	35%

Deaths ruled as accidental are those caused by unintentional injuries as the result of accidents such as drownings, motor vehicle accidents, house fires, accidental overdoses, accidental weapons discharge, falls, and other accidental injuries resulting in death. All motor vehicle traffic deaths are investigated by the South Carolina Department of Public Safety (SCDPS). During 2022, the South Carolina Highway Patrol presented all motor vehicle deaths to the SCFAC. Prior to 2022, SLED's Special Victims Unit (SVU) did not investigate all private property or pedestrian fatalities, and their investigations were limited to those that SCHP did not investigate.

Infant deaths as a result of unsafe sleep are often classified as either accidental or undetermined manner of death. The majority of the cases reviewed by the committee in which the death was related to the sleeping environment were most often classified as an undetermined manner of death. Due to this, infant unsafe sleep deaths will be reported in more detail in the Undetermined section of this report.

Of the deaths occurring in 2019 through 2021, the committee has completed its review of 416 cases with 146 (35%) cases determined with a manner of accidental. Of these 146 cases, 63 (43%) were African American, 64 (44%) were White, 9 (6%) were Hispanic, and 10 (7%) were categorized as Other (includes Native Americans, multi-racial, and/or Asian).

Table 16: SCFAC Completed Cases: Accidents
by race/ethnicity
Deaths occurring 2019-2021

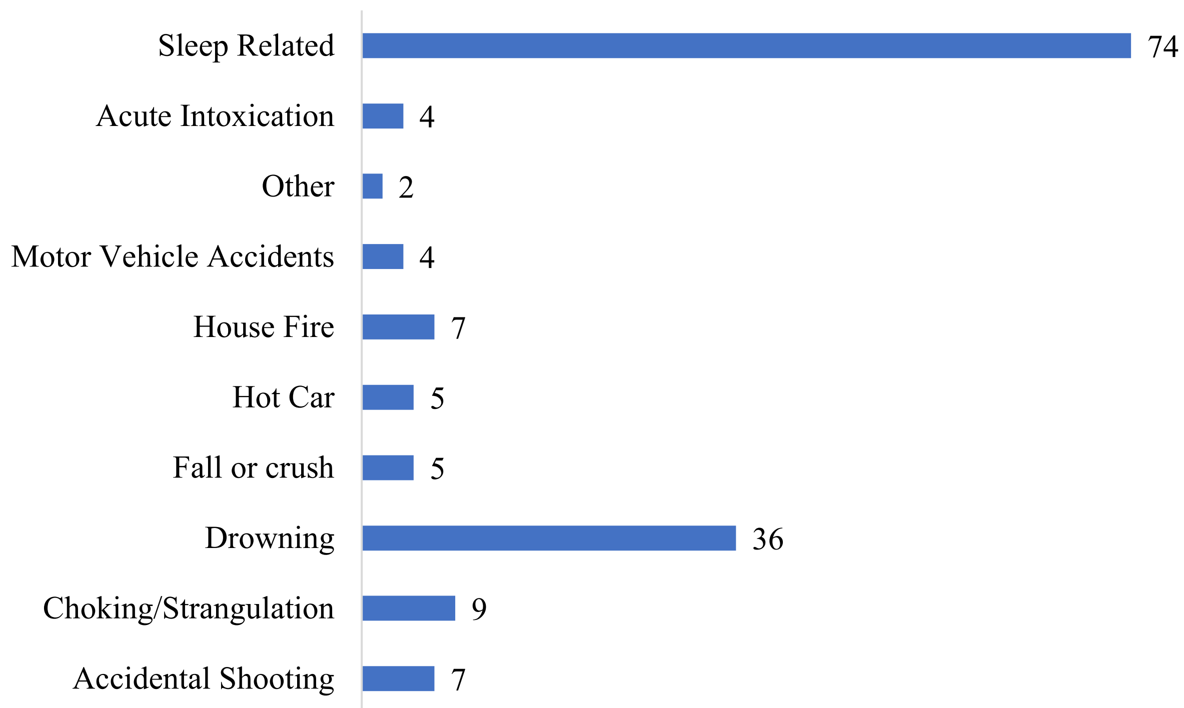
	2019	2020	2021	Totals
African American	26	26	11	**63**
Non-Hispanic White	32	24	8	**64**
Hispanic	3	6	0	**9**
Other (Native Americans, multi-racial, and/or Asian)	5	3	2	**10**
Totals	**66**	**59**	**21**	**146**

Analysis by age and sex reveals that 98 (67%) of the 146 accidental deaths involved male children, and 48 (33%) involved females. Infants had the highest percentage by age category, with 61 of the 146 cases, accounting for 42% of all accidental cases reviewed. Ages 1-4 had 36 cases of accidental deaths reviewed (25%), ages 5-9 had 12 cases of accidental deaths reviewed (8%), ages 10-14 had 12 cases of accidental deaths reviewed (8%), and ages 15-17 had 27 cases of accidental deaths reviewed (18%).

Table 17: SCFAC Completed Cases: Accidents *by age category and sex* *Deaths occurring 2019-2021*								
	2019		**2020**		**2021**		**Totals**	
	Male	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
Infant (less than 1 year of age)	24	9	11	13	2	2	37	24
Ages 1-4	11	6	9	4	2	2	24	12
Ages 5-9	4	1	4	1	2	0	10	2
Ages 10-14	4	1	3	0	3	1	10	2
Ages 15-17	4	2	10	4	5	2	19	8
Totals	**47**	**19**	**37**	**22**	**14**	**7**	**100**	**48**

The majority of accidental deaths reviewed by the committee were infant sleep related deaths, which are covered in more detail in the Undetermined section of this report. Drowning deaths accounted for the next highest amount of accidental fatalities reviewed, with 39 cases, or 26.7% of accidental deaths reviewed. Following drowning deaths, deaths as a result of overdosing, house fires, and accidental shootings were reviewed by the committee as frequent causes of accidental deaths.

Figure 5: Accidental Deaths, Mechanisms
2018-2020 Fatalities, SCFAC completed cases



Drownings: The committee reviewed 39 drowning deaths. These deaths account for 9.3% of total deaths reviewed, and for 26.7% of accidental deaths reviewed. Younger children,

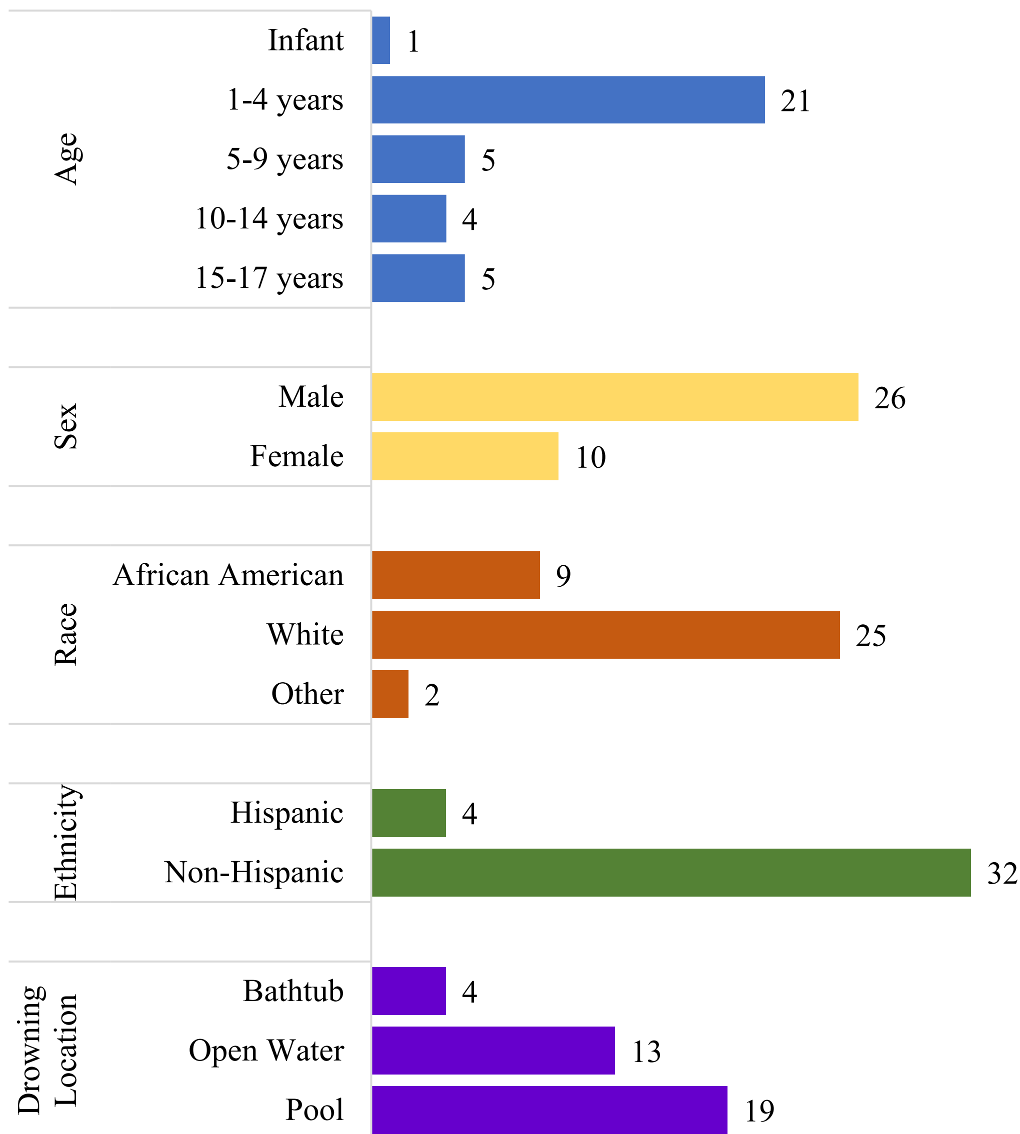
particularly ages 0-4 are at greatest risk for drowning. Of the 39 reviewed drowning deaths, 19 (48.7%) involved children younger than 5 years old.

Analysis of drowning cases revealed significantly more cases involved male children. Male children accounted for 29 of the 39 drowning cases reviewed (74.3%).

Of the 39 drowning cases reviewed, 18 (46.1%) children were White, 15 (38.4%) were African American, and 3 (7.6%) were categorized as Other (Native Americans, multi-racial, and/or Asian). The majority of drowning cases reviewed involved non-Hispanic children, with 36 (92.3%) of the 39 cases being non-Hispanic.

Figure 6: Drowning Deaths

2018-2020 Fatalities, SCFAC completed cases



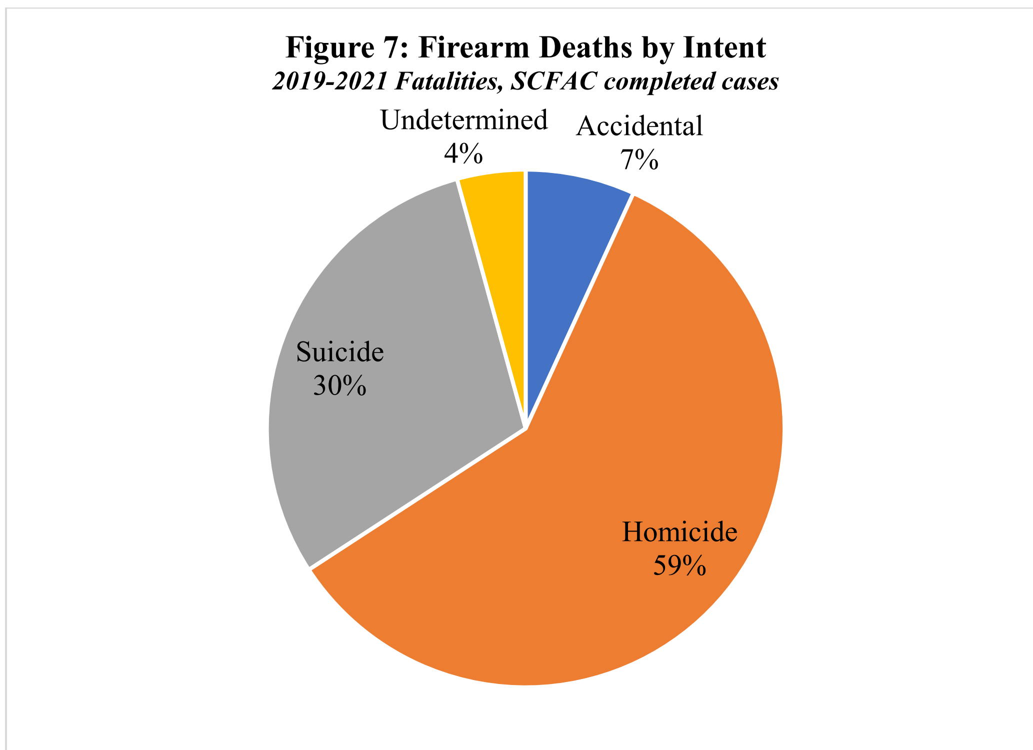
The drowning cases reviewed occurred evenly in pools and open water such as ponds. Pool drownings, including private and public pool locations, accounted for 17 (43.5%) of the 39 cases reviewed. Very few of these cases occurred at public pools. Many of the drowning cases reviewed involved a child gaining access to pools that did not have a barrier in place (i.e., no fence or gate around the pool), or in which the barrier to the water was not fully secured (i.e., unlocked doors, open gates, not fully fenced). Many of these cases involved children who were inside a home and who were able to venture outside and gain access to a pool, unknowing to the supervisor.

Open water drownings, such as in lakes or rivers, accounted for 17 (43.5%) of the 39 cases reviewed. Many of the open water drownings reviewed occurred while the child was playing in or around the water, who either entered the water unknowing to the supervisor, or who was swimming and ventured into water that was either deeper or swifter moving than the child's swimming ability could handle. These cases include those in which children were boating, or those who were jumping into deep water while not wearing a life jacket.

The main factors identified across the drowning cases reviewed include:

- Lack of swimming ability
- Lack of adequate barriers to prevent unsupervised water access
- Lack of close supervision while around water, including supervision while in the bath
- Failure to wear life jackets

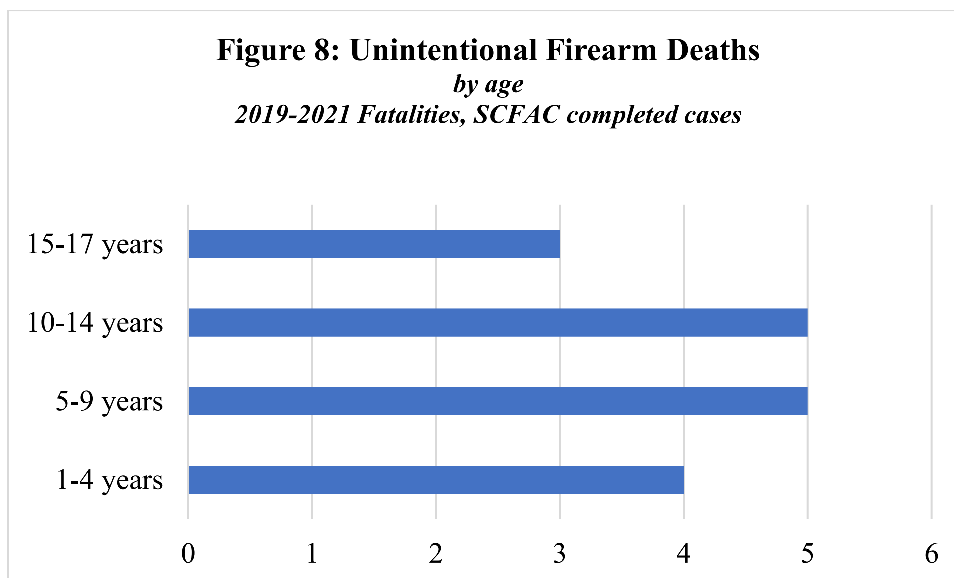
Unintentional firearm deaths: The committee reviewed a total of 117 deaths occurring between 2019-2021 that were the result of a firearm death. These 117 cases include suicides, intentional homicides, accidental shootings, and firearm deaths of undetermined intent.



Of these firearm deaths reviewed, 17 cases involved a child being unintentionally shot. These types of cases involve hunting accidents, target shooting, and those in which a child accidentally shoots themselves or another child. There is variation in the manner of death listed on the death certificates for these types of incidents with some documented as Accident and others as Homicide or Undetermined on the death certificate. The data included in this section is intended to inform of the factors related to the incident being unintentional, not necessarily the determination listed on the child's death certificate as Accident.

Of the 17 unintentional firearm deaths reviewed, 8 were self-inflicted, 6 were children who were shot by other children, and 3 were hunting or target shooting accidents. The 3 hunting/target shooting incidents were firearms shot by adults.

An analysis of age of the child in unintentional firearm deaths shows relatively equal distribution, with ages 5-9 and 10-14 years having the highest rate of cases at 5 deaths each.



Many cases involving younger children obtaining access to a gun and accidentally shot themselves, or another child, there is frequently a misunderstanding of a child's ability to gain access to and fire a gun, their ability to distinguish between real and toy guns, and their ability to make good judgements regarding gun handling and safety. Promoting the safe storage of firearms in the home to reduce their availability and accessibility is an important step in preventing unintentional firearm deaths among children.

Acute intoxication and accidental overdose: Nationally, there has been a significant increase of overdoses. Out of the 416 cases reviewed from the years of 2019-2021, 13 (3.1%) were caused by overdoses. The age group of 15-17 years old was the largest age group in overdoses which were 9 cases which made up 69.2% of the cases reviewed. Racial and gender breakdown for this age group includes 7 (77.7%) White females, 1 (1.1%) White males, 1 (1.1%) African American males, and 0 were reviewed for African American females nor Hispanic children.

Undetermined and natural classifications

SCFAC Case Reviews – Undetermined *Deaths occurring from 2019-2021*	
Cases Assigned	619
Cases Completed:	416
Undetermined:	103
Percent of Completed Cases:	25%

Deaths in which the manner is classified as Undetermined includes cases that have been investigated, but a manner of death could not be determined based on the available information surrounding the case. It may be that multiple causes of death are possible, but none can be conclusively proven (e.g., Sudden Unexpected Infant Death (SUID) vs. overlay vs. intentional suffocation). Many infant unsafe sleep deaths are categorized as Undetermined due to this. Other cases classified as Undetermined include those in older children in which an injury has caused the death, but the intent of the injury cannot be conclusively proven (accidental vs. suicide vs. homicide).

The committee only reviews preventable deaths. Deaths as a result of medical conditions as the only cause of death or that are determined to be of another natural cause that is not preventable are not reviewed by the committee. There are cases in which the official documenting the death certificate will classify some preventable deaths with a Natural manner of death. Deaths that are preventable (e.g., infant deaths in an unsafe sleeping environment) and that are documented on the child's death certificate as natural are included in the Undetermined case reviews for the committee.

Of the deaths occurring in 2019 through 2021, the committee has completed its review of 416 cases with 103 (24.7%) cases determined with a manner of undetermined, including those documented on the child's death certificate as natural. Of these 103 cases, 63 (61.1%) were African American, 27 (26.2%) were White, 6 (5.8%) were Hispanic, and 8 (7.7%) were categorized as Other (includes Native Americans, Biracial, and/or Asian).

Table 18: SCFAC Completed Cases: Undetermined
by race/ethnicity
Deaths occurring 2019-2021

	2019	2020	2021	Totals
African American	28	20	15	**63**
Non-Hispanic White	15	9	3	**27**
Hispanic	6	0	0	**6**
Other (Native Americans, multi-racial, and/or Asian)	5	2	0	**7**
Totals	**55**	**31**	**18**	**103**

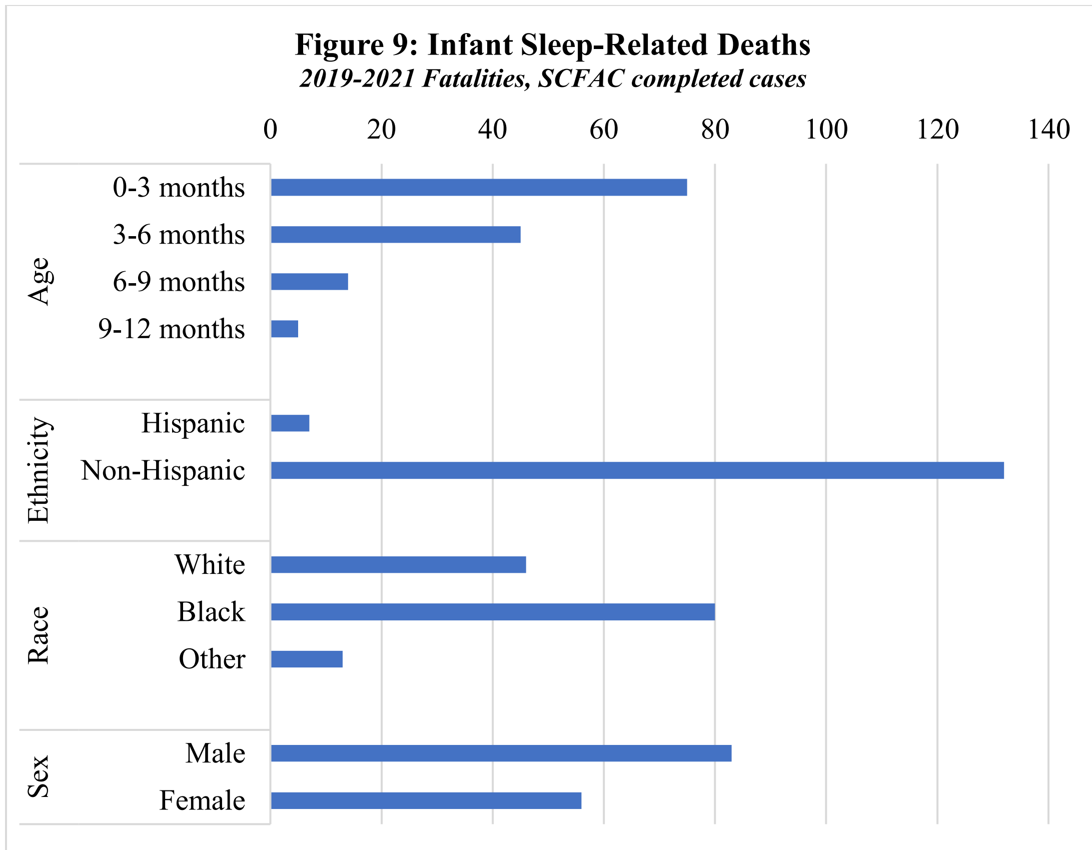
The majority of these cases were deaths occurring in infants less than one year of age. Of these cases, 83 of the 103 Undetermined or preventable natural deaths reviewed occurred in infants (80.5%). The next highest age category is ages 1 – 4, totaling 12 of the 103 cases reviewed (11.6%).

Table 19: SCFAC Completed Cases: Undetermined *by age category and sex* *Deaths occurring 2019-2021*								
	2019		**2020**		**2021**		**Totals**	
	Male	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
Infant (less than 1 year of age)	26	19	14	9	8	7	48	35
Ages 1-4	3	2	4	0	0	3	7	5
Ages 5-9	0	0	3	0	0	0	0	3
Ages 10-14	0	0	0	0	0	0	0	0
Ages 15-17	3	1	1	0	0	0	4	1
Totals	**32**	**23**	**22**	**9**	**8**	**10**	**59**	**44**

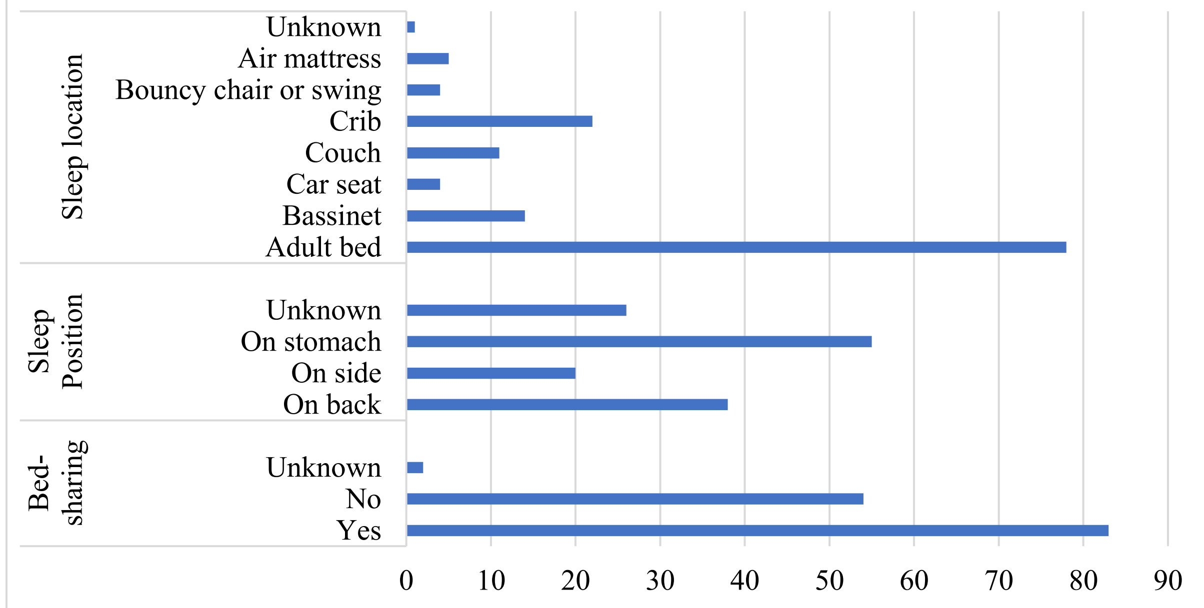
Infant Sleep-Related Deaths: The committee reviews a significant number of deaths of infants while sleeping. Sudden unexpected infant deaths (SUIDs) while sleeping may be diagnosed as sudden infant death syndrome (SIDS), while others are diagnosed as overlay, accidental suffocation, positional asphyxia, or undetermined. SIDS is a subset of SUID and is often used when the death of an infant occurs that remains unexplained after a complete investigation, autopsy, and review of the child's medical history.
Of the 416 total deaths reviewed by the committee, 139 were related to the infant sleeping environment (33% of cases reviewed). Of these 139 cases, 80 were Black (58%), 46 were White (33%), and 13 (9%) were categorized as Other (includes Native Americans, Biracial, and/or Asian).

Analysis of infant sleep deaths by age in months reveals the majority of the sleep related deaths reviewed by the committee occurred in infants less than 6 months. Of the 139 infant sleep deaths reviewed, 120 (86%) were infants less than 6 months of age. As infants age, the incidence of sleep related deaths declines, although sleep-related causes of infant death can occur until baby's first birthday.[15]

[15] "SIDS by Baby's Age," SIDS by Baby's Age § (n.d.), https://www.dhhs.nh.gov/dphs/bchs/mch/documents/sids-byage-infographic.pdf.



There are many risk factors attributed to infant sleep related deaths. The committee has identified bed sharing, unsafe sleeping location (i.e. not in a crib or bassinet) and infant sleeping position as three predominant factors in the infant sleep related deaths reviewed.



Of the 139 infant sleep related deaths reviewed, 83 (60%) reported bed-sharing at the time of the death. These cases include bed-sharing with adults and/or other children. Bed-sharing on its own is considered a risk factor of infant sleep deaths, with the incidence of death occurring when the adult bed-sharing with the child is impaired by drugs and/or alcohol increases the risks. Of the 33 bed-sharing deaths reviewed, 13 (9%) indicated the supervisor was impaired by drugs and/or alcohol at the time of the incident. Of note, not all supervisors were tested for drugs and/or alcohol.

Table 20: Bed-sharing Deaths
Caregiver Impairment Summary
Deaths occurring 2019-2021

	Frequency	Percent
Total Infant Sleep Deaths	139	NA
Cosleeping	83	60%
Caregiver impaired	13	9%
Caregiver impairment unknown	21	25%
Caregiver not impaired	49	59%

The only sleeping position considered safe for infants is on the back. When an infant is placed in another position for sleep, the occurrence of sleep related fatalities increases. Of the 139 infant sleep related deaths, 38 (27%) were cases in which the infant was in the safe sleep position, on their back. The remainder of the cases reviewed were of infants placed on their stomach, side, or cases in which the positioning is unknown or unavailable at the time of the committee review.

Safe sleep locations include cribs and/or bassinets, free from any bedding such as blankets, pillows, stuffed animals, cushions, etc. Of the 139 infant sleep related deaths reviewed, 103

(74%) were cases in which the infant was sleeping in a location other than a crib or bassinet. The majority of these cases (78 of 104, 75%) were infants sleeping in an adult bed. The next most frequently reviewed unsafe sleep location were cases in which the infant was sleeping on a couch (11 cases). The committee reviewed many other cases involving unsafe sleep locations including car seats, air mattresses, bouncy chairs, swings, and rockers.

While 36 of the 139 (26%) of the infant sleep related deaths reviewed occurred in a safe sleep location of a crib or bassinet, it is important to acknowledge that with these cases, many had other unsafe sleep factors of bedding. Infants should always be placed alone, flat on their backs, and in a crib or bassinet to sleep safely. Of the 36 infant deaths that occurred in cribs or bassinets, 15 (42%) were found on their stomachs.

IV. SCFAC Recommendations

Presenting the report ~ The committee's report should be formally presented by the Committee Chair or Chair Elect to the Governor and General Assembly to raise awareness about the committee's recommendations and concerns.

Communication ~ The committee's website has not been maintained for the past three years, and there are unmaintained social media accounts associated with the committee. The committee should identify committee members to be responsible for the committee's communication, and any barriers to establishing a consistent communication plan should be addressed in the next annual report and/or additional recommendations to the Governor and General Assembly.

Initiatives ~ During October of 2022, members and contributing individuals of the Committee partnered with other agencies for a Safe Sleep Summit. During Child Abuse Prevention Month in April and Mental Health Awareness Month in May, members and contributing individuals of the committee partnered with other agencies to raise awareness regarding child abuse prevention and mental health awareness. The committee should identify initiatives that align with its recommendations regarding motor vehicle safety; child abuse prevention; mental health awareness and advocacy; water safety; car safety; alcohol and substance use disorders; suicide prevention; safe sleep; and gun safety,

A more focused and intentional review process ~ In an effort to strengthen its advocacy concerning child fatality prevention, the Committee will engage in an Accimapping approach during 2023 to identify trends and solutions for preventing child fatalities. The agendas for the previous meetings have been established based on the assigned SLED agent and included multiple causes and manners of death from different years. Committee members voted to modify this approach for 2023 to create agendas based on manner of death (homicide, accident, suicide, unknown) in an effort to review fatalities in a more intentional and focused manner. During the December, 2023 meeting, the new review method will be assessed by the committee to determine if it should continue, or if the committee should resume the pre-2023 agendas based on the assigned agent. During 2023, Accimapping will be facilitated by Department of Social Services' representatives who have received training in this safety science approach.

Increased funding for home visiting programs ~ In the cases of accidental deaths (2021-2023) reviewed by the South Carolina Child Fatality Advisory Committee, the number of unsafe sleep deaths of infants and young children was alarming. As such, the committee recommends that the state invest in evidence-based, voluntary home visiting programs through Children's Trust of South Carolina, which is 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. In 2022, the federal government reauthorized the Maternal, Infant, and Early Childhood Home Visiting grant and included a new match component, which allows states to receive a three-to-one formula-funded match for home visiting programs. In 2024, a state investment of $250,000 to the Children's Trust of South Carolina for home visiting would allow an additional $750,000 in funding from the federal government to be allocated for South Carolina families to expand these much-needed programs.