

SOUTH CAROLINA  
STATE CHILD FATALITY  
ADVISORY COMMITTEE

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# Annual Report

2024-

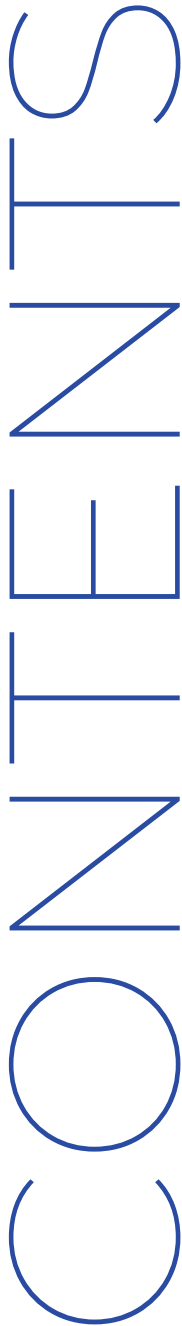
2025

# 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.***

# Table of Contents



## **Dedication**

page 1

## **Committee Membership**

pages 3-4

## **History and Mission**

pages 5-6

## **A Message from the Committee**

page 7

## **Annual Report Summary**

pages 8-9

## **Case Review Findings (Non-Motor Vehicle)**

pages 10-30

## **Unsafe Sleep and Gun Violence**

pages 26-29

## **Committee Findings (Motor Vehicle)**

pages 30-33

## **20 Year Comparison**

pages 34-38

## **Next Steps**

pages 39-40

## **Acknowledgements**

page 39

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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 investigations completed by SLED or SCHP 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 a review of 3,882 cases as of December of 2025.

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.

In 2024 Dr. Mary Fran Crosswell assumed the role of chair of the committee. Due to Hurricane Helene, and a lack of quorum, the committee was unable to meet three times in the report period. Due to this lack of meetings, this report will combine cases reviewed in 2024 and 2025.

For the first time, this report will also include a 20 year comparison, looking back at the 2003 report and comparing it to the 2023 report.

**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 COMMITTEE

On behalf of the South Carolina Child Fatality Advisory Committee, we present the 2024–2025 Annual Report with a continued sense of urgency, responsibility, and resolve. This year’s findings underscore a deeply troubling and persistent reality: unsafe sleep remains the leading cause of preventable infant death in South Carolina. Despite years of public education and clinical guidance, too many infants continue to die in sleep environments that are known to increase risk. These deaths are preventable, and their continued prevalence demands renewed commitment to consistent messaging, caregiver support, and systems-level interventions that ensure families receive clear, culturally responsive, and timely guidance.

The report also highlights that homicide is the third leading cause of preventable child death. Each of these deaths represents a profound failure to protect children from violence and underscores the critical importance of strengthening prevention strategies that address family stress, community safety, and early identification of risk. Preventing violence against children requires coordinated efforts across public health, child welfare, law enforcement, and community-based organizations.

Suicide remains a prevalent and devastating cause of death among South Carolina’s children and youth. These deaths remind us of the urgent need to prioritize mental health, expand access to services, reduce stigma, and ensure that young people and families can recognize warning signs and seek help before a crisis occurs.

While the data in this report are sobering, they also point us toward solutions. Evidence-based prevention strategies exist. Education works. Supportive services work. **When families have access to accurate information, stable resources, and responsive systems of care, lives can be saved.**

The Committee remains hopeful because prevention is possible—and because meaningful progress depends on sustained collaboration among policymakers, service providers, healthcare professionals, and communities across the state. **We urge continued investment in proven prevention efforts and a shared commitment to protecting South Carolina’s children.**

Every child death is one too many. Our collective responsibility is to act on what we know and to ensure that fewer families experience such preventable loss in the years ahead.

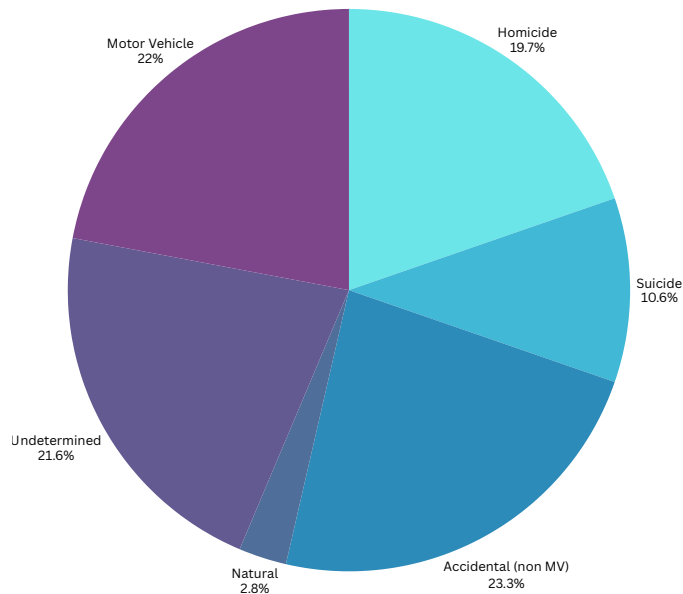
Sincerely,  
The South Carolina Child Fatality Advisory Committee

# ANNUAL REPORT SUMMARY

## INTRODUCTION

This report reflects the findings from 369 non-motor vehicle cases reviewed by the committee during 2024 and 2025 and 104 motor vehicle cases for a total of 473 cases. Of all cases reviewed by the CFAC during this period, non-motor vehicle accidental deaths were most common (23%), followed by motor vehicle accidental and undetermined deaths (22% each). Analysis showed:

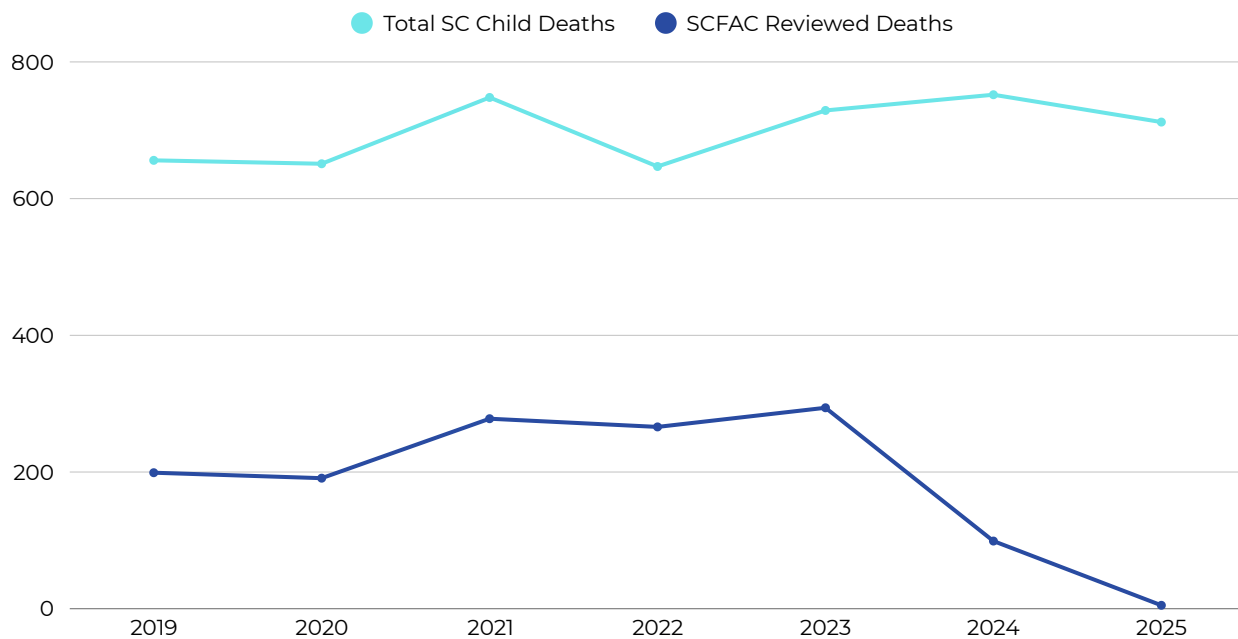
- 23% Non-Motor Vehicle Accidental
- 22% Undetermined
- 22% Motor Vehicle Accidental
- 20% Homicide
- 11% Suicide
- 2% Natural



# 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. Please note that cases are often reviewed 1-5 years after they occurred.



*\*Please note that 2024 and 2025 death totals from DPH are provisional and subject to change.*

Of all child deaths reported by DPH since 2019, approximately 27% 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.

# CASE REVIEW FINDINGS

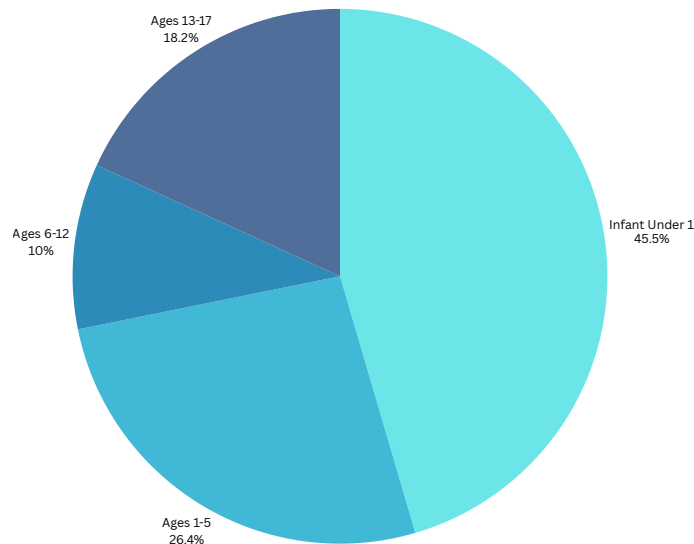
## ACCIDENTAL

Of the 473 cases reviewed, 110 were ruled as accidental (non-motor vehicle) manner of death.

## AGE

Infants under age 1 represented the largest age group.

- 51 (46%) were infants under the age of one.
- 28 (26%) were between the ages of 1-5
- 11 (10%) were between the ages of 6-12
- 20 (18%) were between the ages of 13-17



## RACE/ETHNICITY AND SEX

By race/ethnicity, Black children accounted for 46% of accidental deaths. White children accounted for 40% and multiracial children accounted for 7%.

Hispanic/Latino children accounted for 5%, and Asian children accounted for 2%

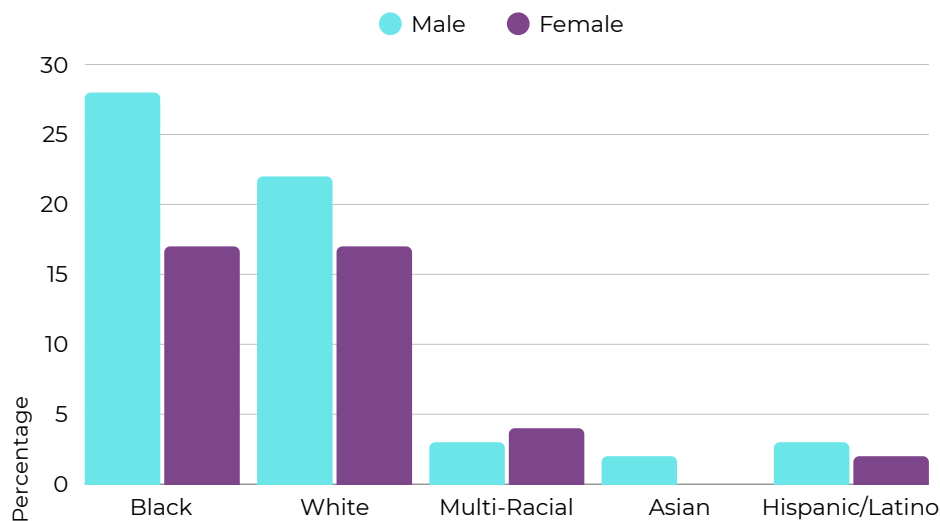
# CASE REVIEW FINDINGS

## ACCIDENTAL

### RACE/ETHNICITY AND SEX

Further analysis revealed that:

- 31 (28%) were Black males
- 25 (22%) were White males
- 19 (17%) were White females
- 19 (17%) were Black females
- 5 (5%) were multiracial females
- 3 (3%) were multiracial males
- 3 (3%) were Hispanic males
- 2 (2%) were Asian males
- 2 (2%) were Hispanic females



## TOXICOLOGY

Of the 110 cases marked as accidental (non-motor vehicle), toxicology reports were completed in 99 cases (90%). Of the cases where reports were completed, 16 (16%) were positive. Of those positives:

- 6 were positive for THC
- 6 were positive for fentanyl
- 5 were positive for other substances including: acephate, glipzide, alcohol, cocaine, and cotinine.

*Please note that several reports were positive for multiple substances.*

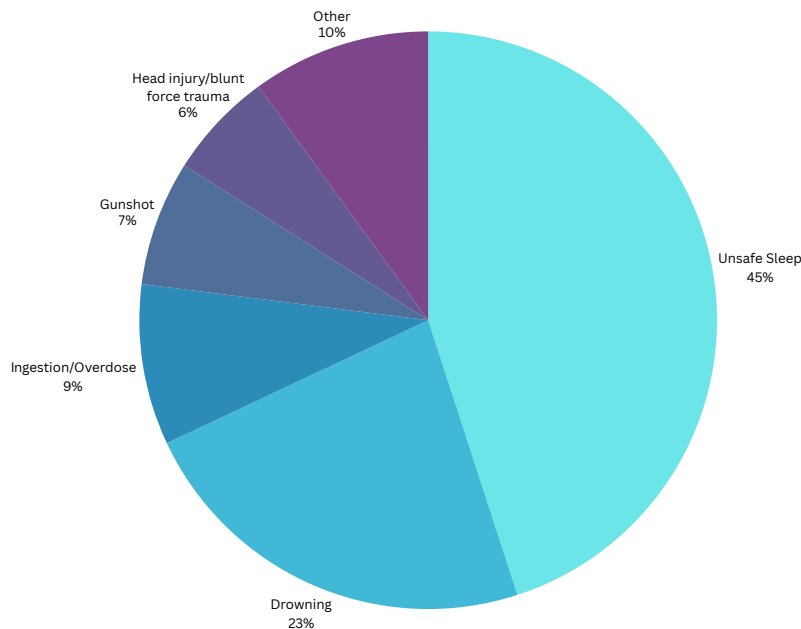
# CASE REVIEW FINDINGS

## ACCIDENTAL CAUSES OF DEATH

Accidental deaths include numerous causes. The most frequent cause of accidental death was related to unsafe sleep, which accounted for 45% of accidental deaths. This report will address unsafe sleep in a later section.

The next leading cause, with 23%, is drowning. Of the drownings, 61% of children were under the age of 5.

Accidental overdoses accounted for 9% of accidental deaths and most commonly involved fentanyl, particularly among older children and adolescents. Following overdoses and ingestions, accidental shootings accounted for 7%. Head injuries and blunt force trauma accounted for 6%. Other causes include smoke inhalation, plane crash, hyperthermia, hypothermia, hyperpyrexia, food aspiration, and accidental hanging.

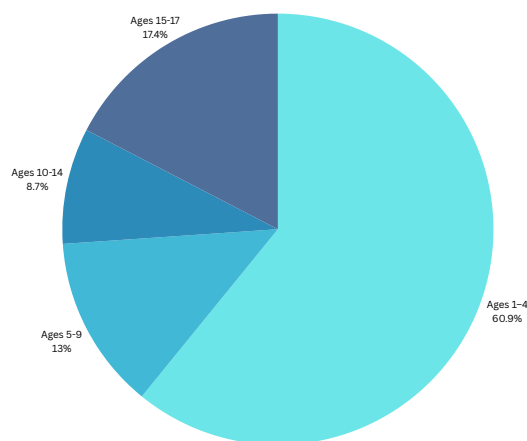


# CASE REVIEW FINDINGS

## ACCIDENTAL- CAUSES

### DROWNING DEATHS

Drowning deaths accounted for the second highest cause of accidental deaths reviewed. Of 110 accidental deaths, 25 were drowning deaths (23%). By age, children ages 1-4 years were the highest population of drowning deaths, representing 66% of drownings reviewed.



## PREVENTION

South Carolina has made prevention efforts to reduce the number of drowning deaths, including public awareness campaigns, The South Carolina Water Safety Coalition, low-cost swim lessons, and Life Jacket Loaner Boards by SCDNR. To further prevention efforts, low-cost swim lessons should be expanded across the state further into rural and underserved areas. Additionally, we recommend that every locality ensure proper signage is placed around public bodies of water to indicate if swimming is not allowed or if swimming is not recommended at that spot. To increase access to knowledge of water safety, curriculum can also be incorporated into physical education classes. Finally, increasing community-based CPR courses can empower community members to be equipped in the event of drowning, particularly in rural areas where a rapid response may be limited.

# CASE REVIEW FINDINGS

## ACCIDENTAL-CAUSES

### POISONINGS, OVERDOSES, AND ACUTE INTOXICATIONS

The third leading cause of accidental deaths reviewed were accidental poisoning, overdoses, and acute intoxications, accounting for 11 out of 110 deaths. 3 young children died from glipizide ingestion, pesticide ingestion, and carbon monoxide poisoning.

The remainder of overdose deaths (8) involved adolescents and opioids. ALL teen overdose deaths involved opioids. 6 out of 8 deaths were confirmed to have been caused by fentanyl. 1 overdose death was attributed to OxyContin, and the final overdose death was attributed to an unspecified opioid.

100%

*Of teenage deaths in the poisonings, overdoses, and acute intoxications category involved opioids*

## PREVENTION

Prevention efforts are necessary to decrease the number of children and adolescents who are dying from opioids. Prevention efforts should include education on the dangers of opioids and the effects of lacing substances with fentanyl. Many youth who consume substances do not know that the substance they are consuming has been laced with fentanyl. The state program to provide schools with Narcan and testing strips should be expanded.

# CASE REVIEW FINDINGS

## UNDETERMINED

The second leading cause of death (non-motor vehicle) reviewed during this period was undetermined. Of the 473 total cases reviewed, 102 were ruled as undetermined manners of death.

The vast majority ( 70%) of undetermined deaths were infant sleep-related deaths. Out of the 86 undetermined infant deaths, unsafe sleep was present in 73 (85.9%) of deaths.

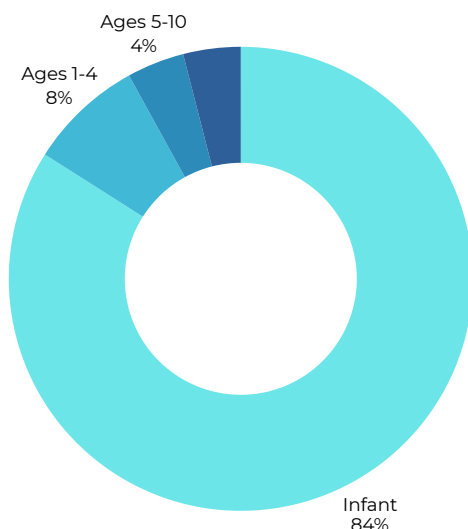
**70%**

*Of undetermined cases were infant sleep-related deaths.*

## AGE

The vast majority of undetermined deaths reviewed involved infants under the age of 1. Of the 102 undetermined deaths reviewed:

- 86 (83%) were infants under the age of 1
- 8 (8%) of the children were between the ages of 1-4
- 4 (4%) were between the ages of 5-10
- 4 (4%) were between the ages of 11-17.



# CASE REVIEW FINDINGS

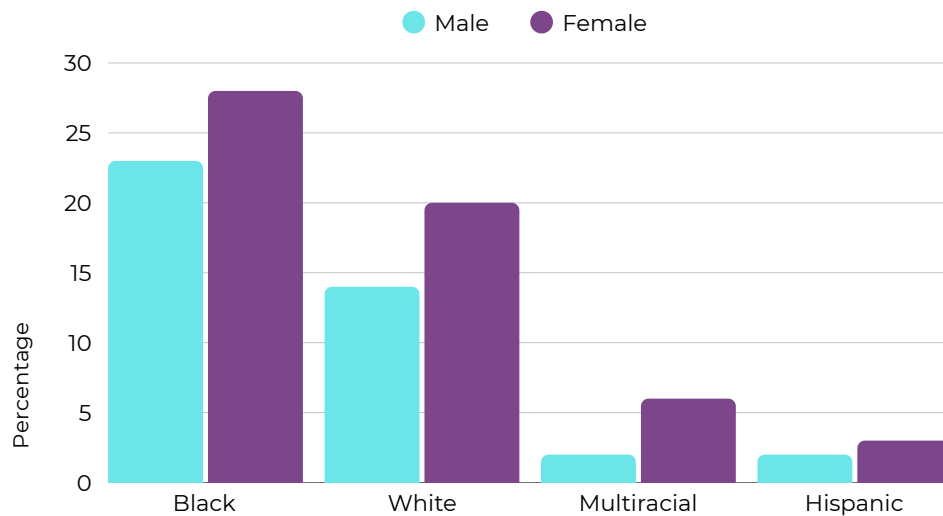
## UNDETERMINED

### RACE/ETHNICITY AND SEX

By race, Black children accounted for 50% of undetermined cases reviewed, 34% were White, 8% were multiracial and 7% were Hispanic.

By sex, there were 59 (57%) cases in this reporting period who were female and 44 (43%) were male. Further analysis revealed that:

- 29 (28%) were Black females
- 23 (23%) were Black males
- 20 (20%) were White females
- 15 (14%) were White males
- 6 (6%) were multiracial females
- 4 (4%) were Hispanic females
- 3 (3%) were Hispanic males
- 2 (2%) were multiracial males



# CASE REVIEW FINDINGS

## UNDETERMINED

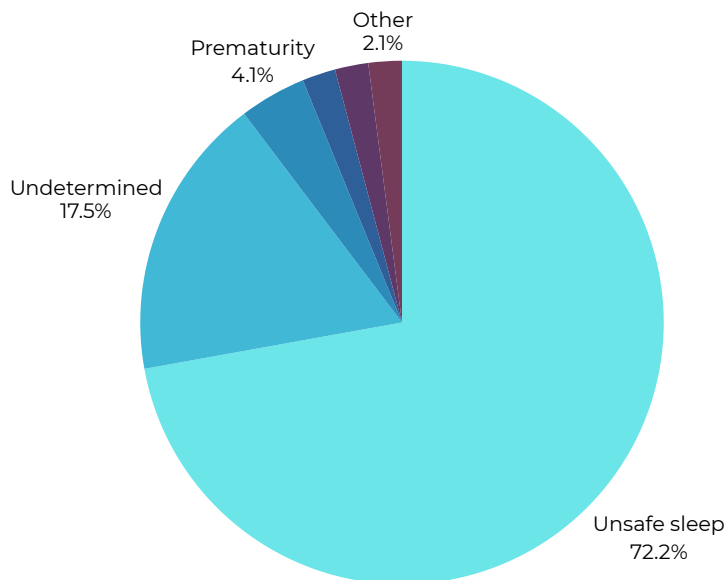
### TOXICOLOGY

Of the 102 undetermined cases, toxicology reports were taken in 91 (89%) of cases. Only 5 were positive, including one for fentanyl, one for THC, one for cocaine, one for oxycodone, and one for amphetamines and methamphetamines. As earlier noted, most of undetermined cases are infants under the age of one.

### CAUSES

The majority of undetermined deaths reviewed were infant sleep-related, representing 70%. Unsafe sleep will be addressed later in this report. Causes of death in the undetermined category include:

- 72 (70%) were related to unsafe sleep
- 18 (17%) had causes of death that could not be determined
- 4 (4%) were related to prematurity in birth or birthing complications
- 2 (2%) were gunshots
- 2 (2%) were overdose
- One case each of hanging and heart failure.



# CASE REVIEW FINDINGS

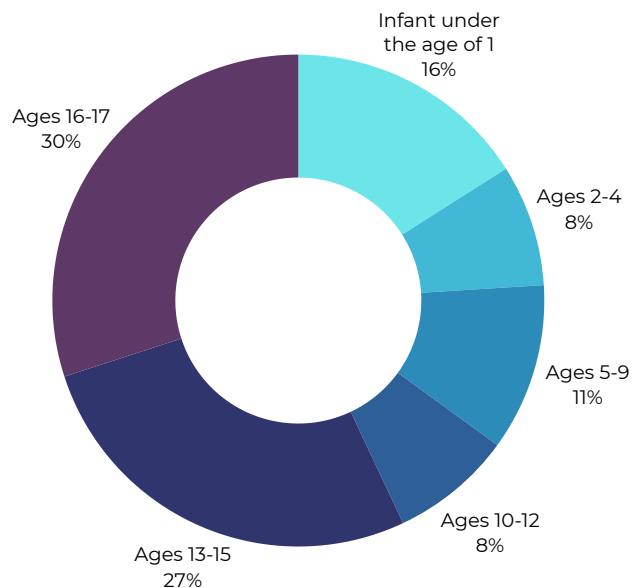
## HOMICIDE

Homicide is the third leading cause of child fatality (non-motor vehicle) in South Carolina. Of the 473 cases we reviewed, 93 were classified as homicide.

### AGE

Of the homicide deaths reviewed during this reporting period:

- 15 (16%) were under the age of 1,
- 7 (8%) were between the ages of 2-4,
- 10 (11%) were between the ages of 5-9,
- 7 (8%) were between the ages of 10-12,
- 26 (27%) were between the ages of 13-15,
- 28 (30%) were between the ages of 16-17.



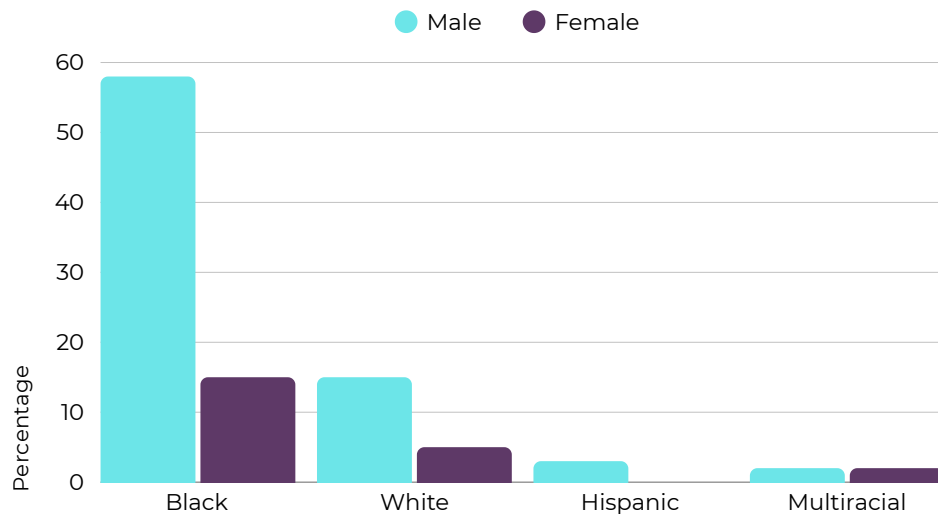
# CASE REVIEW FINDINGS

## HOMICIDE

### RACE/ETHNICITY AND SEX

Black children/youth of both sexes accounted for 72% of all homicide deaths. By sex, males of all races account for 77% of homicides reviewed. Further analysis reveals:

- 54 (58%) of the homicides reviewed were Black males,
- 14 (15%) were Black females
- 14 (15%) were White males
- 4 (5%) were White females
- 3 (3%) were Hispanic males
- 2 (2%) were multiracial males
- 2 (2%) were multiracial females.



# CASE REVIEW FINDINGS

## HOMICIDE

### TOXICOLOGY

Of the 93 cases marked homicide toxicology reports were taken in 84 (90%) cases. Of the reports taken, 44 (52%) were positive. Of the 44 positive:

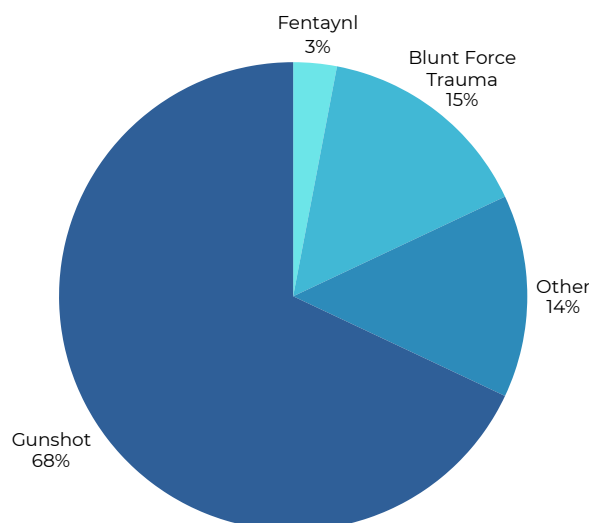
- 31 (70% of positives) were positive for THC.
- 9 (20% of positives) were positive for alcohol
- 6 (13% of positives) were positive for nicotine
- 4 (9% of positives) were positive for fentanyl
- 2 (4% of positives) were positive for methamphetamines
- 2 (4% of positives) were positive for amphetamines

*Please note that in many cases reports were positive for multiple substances.*

### CAUSES

The majority of homicide deaths were the result of gunshots, accounting for 68% of homicides reviewed.

- 63 (68%) were the result of a gunshot
- 14 (15%) were blunt force trauma
- 3 (3%) were due to fentanyl toxicity
- 13 (each 2% or less) were other including: medical neglect, stab wounds, smoke inhalation/burns, drowning, homicidal violence, and internal bleeding.



# CASE REVIEW FINDINGS

## HOMICIDE

### PREVENTION

Homicide continues to be one of the most urgent and preventable causes of child death in South Carolina. The majority of child homicides involve firearms, and disproportionately affect Black children and adolescents. These losses reflect deep inequities in exposure to violence, access to safe environments, and availability of prevention support in underserved communities.

South Carolina has taken meaningful steps to address community violence through the Department of Public Health's Community Violence Intervention and Prevention (CVIP) program, the Department of Juvenile Justice's prevention and diversion initiatives, and hospital-based programs such as MUSC's Turning the Tide Violence Intervention Program. However, these efforts remain concentrated in limited areas, and coordination across agencies and regions can be strengthened to ensure statewide reach.

Reducing homicide will require expanding and aligning existing prevention resources. Priorities include extending hospital- and community-based violence intervention programs to additional regions; enhancing early prevention through home visiting, after-school engagement, and trauma-informed care; as well as investing in underserved, impoverished communities.

# CASE REVIEW FINDINGS

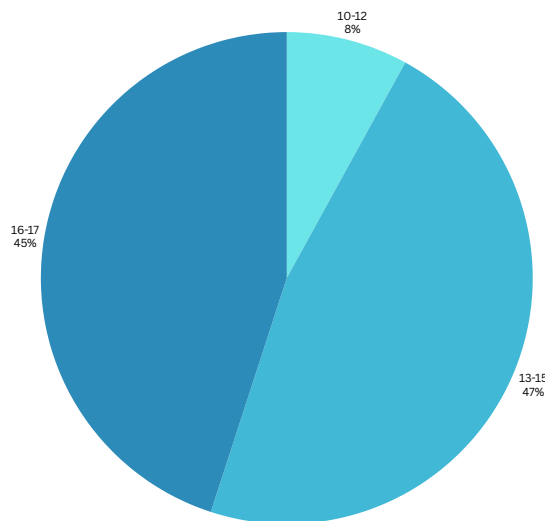
## SUICIDE

Of the cases reviewed by SCFAC, 50 were suicides.

### AGE

While the vast majority of children dying by suicide were 13 or older there were 4 cases of suicide under the age of 13.

- 4 (8%) were under the age of 13 (10, 11, and two 12 year old children)
- 24 (47%) were between the ages of 13-15
- 23 (45%) were between the ages of 16-17



### RACE/ETHNICITY AND SEX

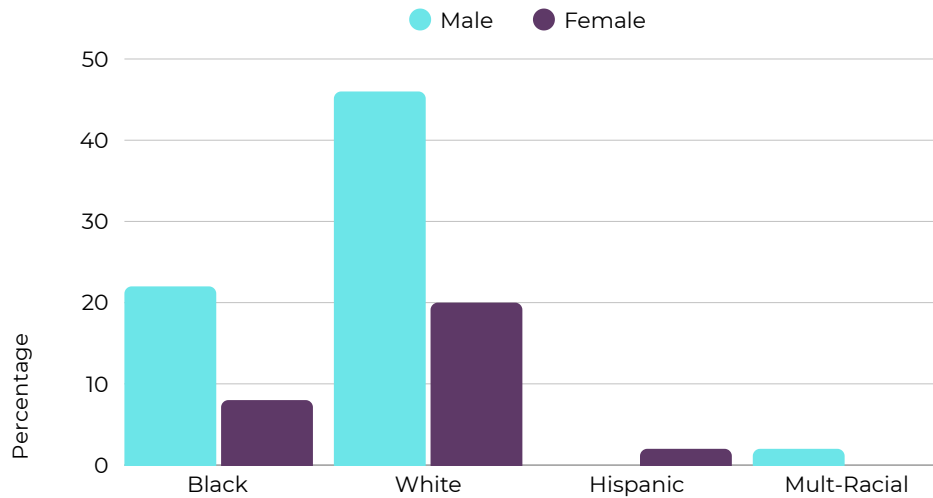
By race, White children accounted for 65% (33) of suicide cases reviewed. Males across all races accounted for 69% (35) of suicides. Further analysis revealed that:

- 23 (46%) were White males
- 11 (22%) were Black males
- 10 (20%) were White females
- 4 (8%) were Black females
- 1 (2%) was a Hispanic female
- 1 (2%) was a multiracial male

# CASE REVIEW FINDINGS

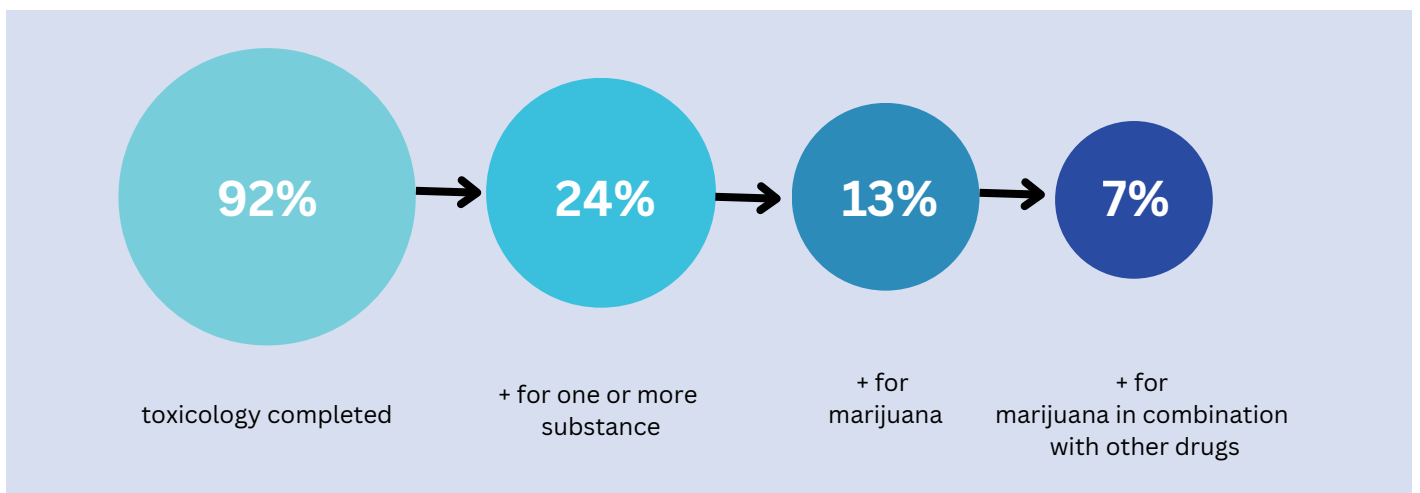
## SUICIDE

### RACE/ETHNICITY AND SEX



## TOXICOLOGY

Analysis of toxicological findings for suicide deaths showed 46 of the 50 suicides had a toxicology completed at the time of death (92%). Of those that received a toxicological evaluation, 24% were positive for one or more substance. Of these that were positive 6 were positive for THC and 3 were positive for THC in combination with other drugs.



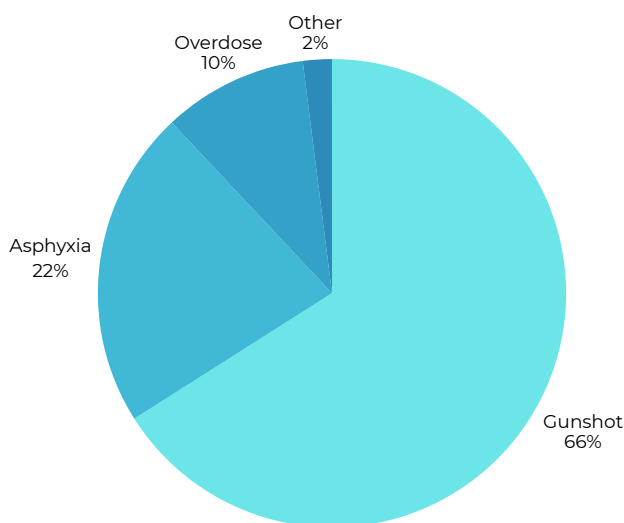
# CASE REVIEW FINDINGS

## SUICIDE

### CAUSE

Gunshots were the most commonly reviewed cause of suicide cases.

- 34 (66%) were related to gunshot
- 11 (22%) Asphyxia, including hanging and one unspecific case of suffocation,
- 5 (10%) were as a result of overdose
- 1 (2%) was from a fall or jump.



## PREVENTION

The youngest child to die by suicide was 10 years old. Developmentally appropriate suicide prevention and mental health messaging must be in schools, and early intervention and detection is key in identifying those who may be at risk. Research shows that contrary to popular belief, talking about suicide does not increase suicide rates, but rather reduces stigma and will provide South Carolina's children with connection to support. South Carolina has made efforts to address youth suicide through the Jason Flatt Act; mandating teachers receive mental health training. While it is important for adults in children's lives to be aware of the signs and symptoms of mental health and suicidality, it is also important to provide youth with the space, language, and resources to work through mental health challenges. Additionally, increased access to mental health services is necessary, including interagency coordination.

# CASE REVIEW FINDINGS

## **NATURAL**

Of the 473 cases reviewed in this reporting period 13 of them were classified as natural deaths. Cases under the purview of the committee must be unexpected, unexplained, suspicious, or criminal in nature and so often do not include natural deaths.

## **AGE**

Of the 13 deaths marked as natural and reviewed 7 (54%) were infants under the age of one and unsafe sleep was present in 5 of them. 3 cases were between the ages of 1-10 and 3 were between the ages of 10-17.

## **RACE/ETHNICITY AND SEX**

11 of the 13 cases were Black children of both sexes and 2 were White children of both sexes. Further analysis revealed:

- 4 (31%) were Black females
- 7 (54%) were Black males
- 2 (15%) were White males

## **TOXICOLOGY**

Toxicology reports were made in 10 of the 13 cases. All reports were negative.

## **CAUSE**

The causes of death in this category are varied. Unsafe sleep was present in 5 of the 13 cases. Additional causes include: hyperthyroidism, acute pneumonia, dehydration, malnutrition, epilepsy, and unexplained death.

# UNSAFE SLEEP IN SOUTH CAROLINA

## A CONTINUING CRISIS

During this review period, the committee noted 126 cases where elements of unsafe sleep were present. This represents 34% of all non-motor vehicle related cases that we reviewed in 2024-2025, making it the single largest factor related to preventable child death in South Carolina.

Unsafe sleep is present across all manners of death excluding suicide.

A comprehensive study completed by the State Law Enforcement Division (SLED) showed 95 unsafe sleep deaths in 2024, or roughly **one unsafe sleep death every four days in South Carolina.**

Unsafe sleep remains a pervasive problem in South Carolina. The 2003 Child Fatality Advisory Committee report showed that unsafe sleep was the leading cause of preventable child death and the number of unsafe sleep deaths today remains roughly the same as 20 years ago, adjusting for population growth.

Despite three decades of public awareness campaigns such as "Back to Sleep," the number of unsafe sleep deaths remains alarmingly high, highlighting the need for expanding more efforts to prevent these entirely avoidable tragedies.

Although unsafe sleep affects all races of infants, Black infants in South Carolina experience significantly higher rates of infant mortality, reflecting persistent gaps in pediatric health.

# UNSAFE SLEEP IN SOUTH CAROLINA

## **PREVENTING UNSAFE SLEEP DEATHS**

The committee has spent considerable time discussing and researching methods, practices, and policies to addressing unsafe sleep deaths. The following recommendations have been suggested:

### **EXPAND VOLUNTARY HOMEVISITING PROGRAMS**

Voluntary homevisiting programs, like those supported through the Maternal, Infant, and Early Childhood Homevisiting federal grant managed by Children’s Trust of South Carolina, are evidence based to prevent unsafe sleep deaths. Despite showing great results, less than 10% of the eligible population receive these critical services. A state investment in these programs could reduce the number of unsafe sleep deaths in South Carolina.

### **IMPROVE OUR MESSAGE AND OUR MESSENGERS**

The committee believes that incorrect information spread through social media is leading to the persistently high number of unsafe sleep deaths. We must combat this misinformation by creating a message that resonates with a younger generation and that we use trusted messengers to spread this information.

### **COLLECT BETTER DATA**

Across counties, unsafe sleep related factors are often treated differently. In order to get a full scope of the problem we must have consistency in our reporting on unsafe sleep.

### **ADDRESS DISPARITIES**

To address the alarming disparity in Black infant mortality in South Carolina, we recommend developing safe-sleep education initiatives tailored for Black parents and families. These messages should be created with input from Black parents and caregivers to ensure cultural relevance and effectiveness, and should incorporate a multi-generational approach that acknowledges the important role of extended family in infant care.

# GUN VIOLENCE IN SOUTH CAROLINA

## **A DISTURBING TREND OF GUN VIOLENCE**

During this reporting period, there were 106 cases (28% of all non-motor vehicle cases) of death caused by gunshots, making gun violence the second most common factor in the deaths the committee reviewed, after unsafe sleep

Gun violence shows up across all manners of death but shows up most frequently in homicide and suicide. 69% of homicides and 66% of suicides included gun violence.

## **DEMOGRAPHICS OF GUN VIOLENCE VICTIMS**

Across all manners of death, gun violence victims tend to be male teenagers. 86 cases, 81% of cases, had victims 13 years or older and 84% of cases had a male victim. The data also shows that Black children are more likely to be victims of gun violence with 64% of cases having Black child victims. In addressing prevention, it is important to note that prevention efforts should focus on these communities.

## **PREVENTION OF GUN RELATED DEATHS**

The committee has spent considerable time considering prevention strategies to lower the number of gun related deaths in South Carolina. The following recommendations have been made from the committee.

## **INCREASED FUNDING FOR PARENTING PROGRAMS**

There are evidence based programs like the Strengthening Families Program which are shown to strengthen family relationships, improve parenting practices, better child behavior and mental health, reduce substance use risk, and improve school outcomes. The committee believes all of these factors are associated with reductions in gun violence. The committee recommends more state funding for this program as well as the many other violence prevention programs across the state.

# GUN VIOLENCE IN SOUTH CAROLINA

## **MORE EDUCATION AROUND SAFE STORAGE OF WEAPONS**

In almost all cases we reviewed, the guns that were used were not stored in accordance with safe storage recommendations. Safe storage recommendations, at their strongest, encourage guns to be locked away with a key or code that children do not have access to and for ammunition to be locked away separately.

Recommendations that contemplate guns being kept by adults for home defense suggest keeping those guns locked in a quick-access safe with biometric or keypad systems to quickly unlock and retrieve the gun when needed. Additionally, there should be more promotion of programs like ones offered through the Department of Public Health which provide free gun locks.

## **IMPROVING ACCESS TO MENTAL HEALTH RESOURCES**

Finally, the committee recommends the state further investing in accessibility to mental health resources for children. We believe earlier access to mental health support would lower all gun violence related deaths across the state.

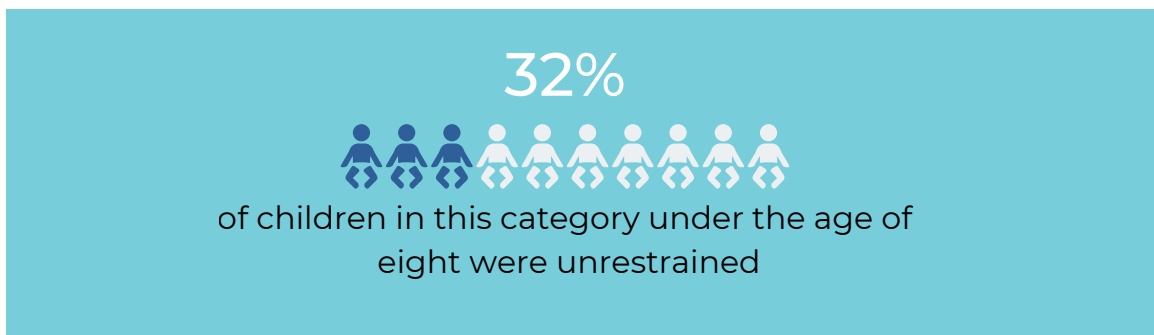
# CASE REVIEW FINDINGS

## 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 victims and driving age teenagers.

### UNRESTRAINED YOUNG CHILDREN

Of the cases reviewed during the reporting timeframe, the SCFAC reviewed 104 motor vehicle accidents investigated by the Highway Patrol. Of these 104 cases, 28 (27%) were under the age of 8, the legally required age range for child restraint systems in South Carolina. Of the 28 children in this age group, 9 (32%) were unrestrained. Of the 23 cases with children between the ages of 9-14, 10 (43%) were unrestrained.



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.

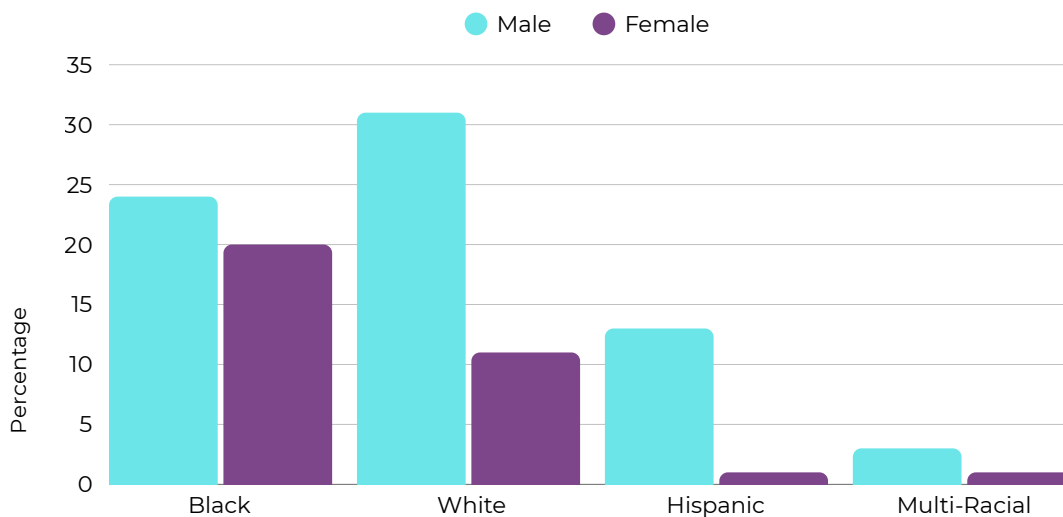
# CASE REVIEW FINDINGS

## MOTOR VEHICLE (HIGHWAY PATROL)

### DRIVING AGE DEATHS (15 YEARS AND OLDER)

Exactly half of the reviewed Highway Patrol cases were teenagers of driving age (ages 15 and up). Of the 104 cases reviewed, 53 (50%) 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. Further analysis revealed that:

- 31 (30%) were White males
- 24 (23%) were Black males
- 20 (19%) were Black females
- 13 (12%) were Hispanic males
- 11 (11%) were White females
- 3 (3%) were multiracial males
- 1 (1%) was a Hispanic female
- 1 (1%) was a multiracial female.

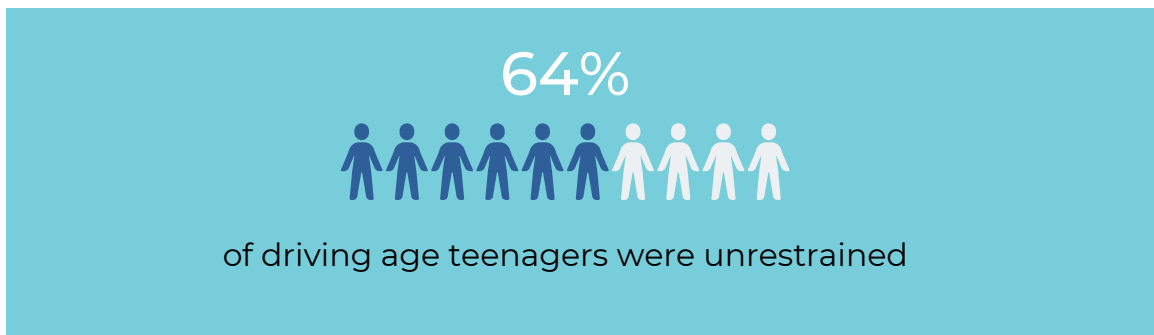


# CASE REVIEW FINDINGS

## MOTOR VEHICLE (HIGHWAY PATROL)

### DRIVING AGE DEATHS (15 YEARS AND OLDER)

As with young children, these cases reviewed show a high rate of unrestrained teenage deaths, with 64% of driving age teenagers unrestrained.



### TOXICOLOGY

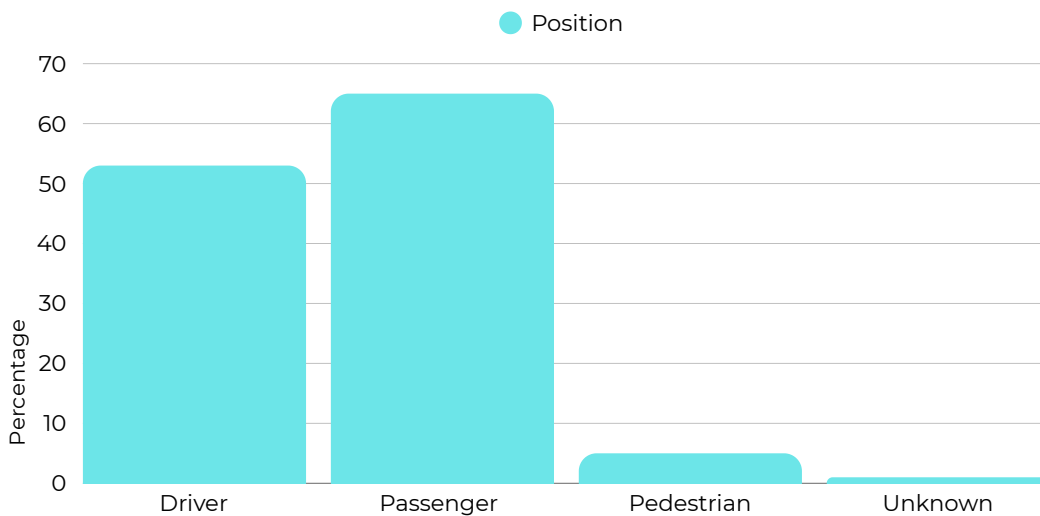
While toxicology reports are often taken of the drivers in these accidents the information given to the CFAC does not always include the toxicology of the child victims. In the 2024 period 59% of the victims who were drivers had toxicology reports completed and, of those completed, 50% were positive for alcohol. In the 2025 period 22 drivers, but not necessarily victims, had positive tox screens, most commonly for alcohol.

# CASE REVIEW FINDINGS

## MOTOR VEHICLE (HIGHWAY PATROL) CONT.

### POSITION

Analysis of driving age Highway Patrol deaths reviewed by their position during the accident showed that 65 (63%) were passengers 33 (32%) were drivers, 5 (4%) were pedestrians, and 1 was unknown.



# TWENTY YEAR COMPARISON

## INTRODUCTION

In the summer of 2024, the South Carolina Child Fatality Advisory Committee released its 2023 Annual Report. This analysis compares the findings of the 2023 report to those of the 2003 Annual Report, examining both areas of progress and those that require further attention.

It is important to note that the methods of reporting and reviewing child fatalities have evolved significantly over the last two decades. In 2003, the committee focused on deaths that occurred within a single calendar year. Today, deaths are reviewed by manner and may include cases spanning a three-year or more period to better capture trends.

To allow for a more accurate comparison, this analysis uses the average number of incidents in the 2023 report (over a three-year span) and compares it to the number of incidents in 2003. Additionally, motor vehicle-related deaths were not included in the 2003 report but are now reviewed, so those deaths have been added to the 2003 data for consistency.

## POPULATION CHANGES

From 2003 to the publication of the 2023 report South Carolina's population has grown by 27%, but this growth is primarily driven by adults moving to the state rather than an increase in the number of children. The number of children in South Carolina has only increased by 10% over this period.

# TWENTY YEAR COMPARISON

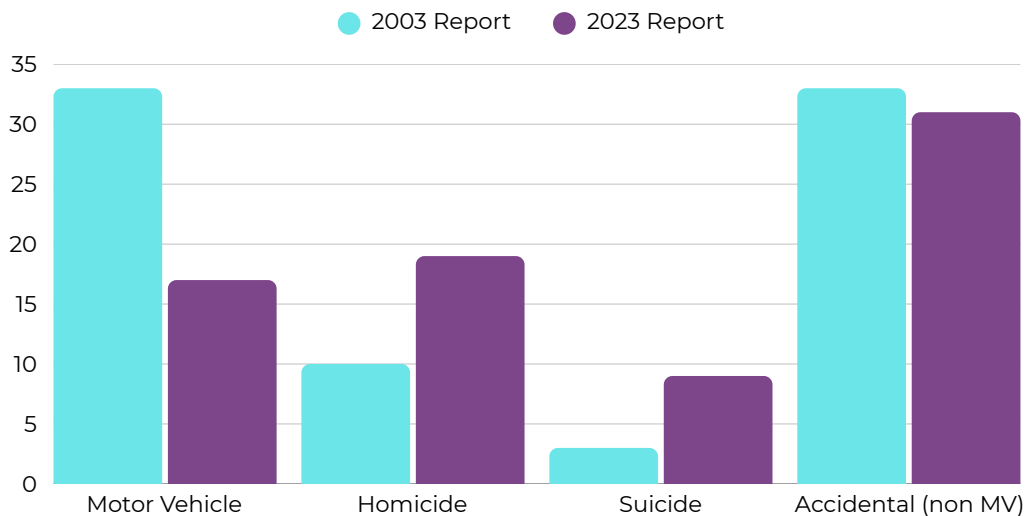
## OVERVIEW

In 2003, 647 children died in South Carolina. In the 2023 report, an average of 675 children died per year. Adjusted for population growth, this is a slightly lower number than what might have been expected if all factors had remained constant.

Most child deaths are not preventable and are not included in the committee's review. This report focuses on comparing the 283 preventable deaths in 2003 to the 478 preventable deaths (211 per year on average) included in the 2023 report. The data show that while motor vehicle deaths have decreased, other causes of death have remained stable or even increased, surpassing expected population growth.

## COMPARING CAUSES OF DEATH

- Motor vehicle deaths: 33% of deaths in the 2003 report, 17.2% in the 2023 report
- Homicides: 10% in 2003, 19.2% in 2023
- Suicides: 3% in 2003, 9.1% in 2023
- Accidental deaths: 33% in 2003, 31.3% in 2023



# TWENTY YEAR COMPARISON

## SUCCESSSES

The most notable success in reducing child fatalities over the past 20 years has been the significant decrease in motor vehicle-related deaths. In 2003, motor vehicle accidents were the leading cause of preventable child deaths. By 2023, they had dropped to the fourth leading cause, marking a 61% reduction. While it is difficult to attribute this entirely to any single factor, likely contributors include safer vehicles, improved child restraint systems, extensive public campaigns promoting their use, and the 2017 update to the state's child seat belt law.

Drowning and fire-related deaths have also declined, likely due to extensive public education campaigns on water and fire safety across the state.

## AREAS FOR IMPROVEMENT

### *UNSAFE SLEEP*

Unsafe sleep was the leading cause of accidental death in 2003, accounting for 48% of such fatalities, with the majority involving infants under the age of one. In 2003, Sudden Infant Death Syndrome (SIDS) and suffocation were classified separately; for the purpose of this analysis, they are combined, as we now understand that most SIDS cases are related to unsafe sleep environments.

- Unsafe sleep deaths (2003): 16% of all child fatalities
- Unsafe sleep deaths (2023): 27% of all child fatalities

The number of unsafe sleep deaths has increased slightly in total numbers. Unsafe sleep is now the leading cause of preventable deaths among infants in South Carolina. Despite three decades of public awareness campaigns such as "Back to Sleep," the number of unsafe sleep deaths remains alarmingly high, highlighting the need for continued efforts to prevent these entirely avoidable tragedies.

# TWENTY YEAR COMPARISON

## **HOMICIDES**

In 2003, 29 child deaths were classified as homicides. In the 2023 report, this number increased to an average of 45 per year, far exceeding expectations based on population growth.

On the positive side, homicides involving young children (ages 1-4) have significantly decreased. In 2003, nearly half (48%) of child homicides were of young children. In 2023, that figure dropped to just 13%, with the number of young children killed decreasing from 14 in 2003 to an average of less than six annually in 2023. Child abuse and neglect were the primary causes of child homicides in 2003, but homicides involving young children are no longer predominant, marking a win for the state.

However, the reduction in young child homicides has been offset by a troubling rise in homicides involving teens. In 2003, homicides of teens aged 15-17 made up just 28% of total homicides. By 2023, that figure has doubled to 56%. In total numbers, teen homicides increased from eight in 2003 to an average of 26 per year in 2023. Demographically, homicide victims have also shifted. In 2003, 59% of homicide victims were male, and 62% were Black. In 2023, 71% of homicide victims were Black children, and a staggering 84% were male.

Most of this increase is due to gun violence. In 2003, 41% of child homicides were gun-related. In 2023, that figure soared to 85%.

# TWENTY YEAR COMPARISON

## ***SUICIDES***

Suicide deaths among children and teens have grown dramatically over the past 20 years. In 2003, suicides accounted for less than 3% of child deaths, totaling eight cases. By 2023, that number had risen to 9%, with an average of 21 suicide cases per year.

The demographics of suicide victims have shifted slightly. In 2003, 88% of victims were male, and 62% were Black. While the proportion of Black youth suicides has declined to 24%, the actual number has remained consistent. In 2023, males accounted for 74% of suicide victims, with White males representing a significant increase to 48% of suicide deaths.

## ***DRUG OVERDOSES***

In 2003, the opioid crisis was in its early stages, and only two overdose deaths were reported among children, with no details about the substances involved. By 2023, overdoses accounted for 13% of accidental deaths among children, with fentanyl detected in all cases.

## ***FIREARM RELATED DEATHS***

The overall number of firearm-related deaths has increased. In 2003, firearms were involved in 7% (20) of preventable deaths. By 2023, that figure had risen to 23%, with an average of 48 firearm-related deaths per year.

## **CONCLUSION**

This 20-year comparison reveals both significant progress and emerging challenges in the effort to reduce child fatalities in South Carolina. While strides have been made in areas such as motor vehicle safety and reducing young child homicides, troubling increases in teen homicides, suicides, and drug overdoses and a stagnant but persistently high number of unsafe sleep deaths highlight the need for continued intervention and prevention efforts.

# NEXT STEPS FOR THE COMMITTEE

## **LOOKING TO THE FUTURE**

During the course of our reviews in 2024 and 2025 several recommendations came from the committee to improve our process, better understand the cases assigned to the committee, and to increase prevention efforts. Moving into 2026 the committee will take on the following initiatives.

### ***COMPILING MORE THOROUGH UNSAFE SLEEP DATA***

Safe sleep guidelines say that babies under the age of one should be placed to sleep, alone with no loose blankets or pillows, on their back, on a firm flat surface made for infant sleep like a crib or bassinet. The committee has been asked which of these safe sleep guidelines are most often not being followed in unsafe sleep deaths. To that end, the committee will be noting that information in future reviews so that prevention efforts can be targeted to prevent specific types of unsafe sleep practices. Additionally, the committee is committed to do a more thorough job of indicating when a caregiver has tested positive for legal or illegal substances in unsafe sleep cases when such data is available.

### ***UNDERSTANDING GANG RELATED ACTIVITY BETTER***

In the course of reviewing homicide and suicide deaths there is often mention of opposing friend group violence. Often these groups do not meet the legal definition of being referred to as gangs. To that end, the committee will receive a training in 2026 to better understand what constitutes a gang in South Carolina. The committee will also work to compile better data for future reports to show the prevalence of this type of violence in South Carolina.

# NEXT STEPS FOR THE COMMITTEE

## ***TRACKING PROCUREMENT OF ILLEGAL SUBSTANCES***

In many of the cases the committee reviews, minors are in possession of illegal substances. If law enforcement attempts to identify the source of illegal substances obtained by a minor, through a source investigation or a narcotics investigation focused on distribution, the committee will attempt to obtain that information, if it is known and made available.

## ***TRACKING STATUS OF FILED CHARGES***

The committee aims to, in 2026, track all cases where charges are filed so as to report on the status of those charges in the 2026 report.

# ACKNOWLEDGEMENTS

The 2024-2025 Annual Report was prepared by:  
Dr. Mary Fran Crosswell- Child Abuse Pediatrician  
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Laura Hudson of the South Carolina Victim Assistance Network

The 2024-2025 Annual Report was Edited by:  
The State Child Fatality Advisory Committee members

A special thanks to Kiley Huff (MSW) for her work in producing this report.

All opinions and recommendations are those of the SCFAC membership.

To review this report online, please visit the State Child Fatality Advisory Committee website: <https://www.scfacsc.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.

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## QUESTIONS

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