South Carolina
LAW ENFORCEMENT DIVISION

SPECIAL VICTIMS UNIT
DEPARTMENT OF CHILD FATALITIES

ANNUAL REPORT

2024

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This report is dedicated to the memory of every child whose life was lost. May their stories inspire change and guide our work toward a better future.

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Introduction

The 2024 edition of the South Carolina Law Enforcement Division (SLED) Special Victims Unit (SVU) Department of Child Fatalities (DCF) Annual Report is designed to present a comprehensive, nonbiased analysis of the statistics and emerging trends related to child fatalities across the state. This report, which marks its inaugural release, will be submitted on an annual basis to the Governor and General Assembly of South Carolina, serving as a vital resource for understanding the gravity of child fatalities and the underlying factors contributing to such tragedies. The data presented within this report was meticulously gathered from investigations conducted by agents in SLED's SVU DCF. This report is written and submitted to the Governor and General Assembly in compliance with S.C. Code Ann. § 63-11-1940-(11).

SLED DCF is mandated by S.C. Cod Ann. § 63-11-1940 to investigate all deaths in the state involving children under the age of 18, to ensure an accurate, complete, and thorough investigation is conducted. *(Note: The terms deaths and fatalities are used synonymously throughout this report.)* Child deaths are investigated by DCF agents when the death is a result of violence, when the death occurs in any suspicious or unusual manner, or when the death is unexpected and unexplained. S.C. Code Ann. § 63-11-1910 further defines "unexpected death" to include, "all child deaths which, before investigation, appear possibly to have been caused by trauma, suspicious or obscure circumstances, or child abuse or neglect." DCF agents do not investigate deaths occurring during traffic collisions, unless the death occurred on private property or unless another investigating agency specifically requests the assistance of DCF agents. The DCF is also responsible for receiving coroner's intakes on all reportable child fatalities within the state, maintaining a statistical database, and reporting these findings to the State Child Fatality Advisory Committee (SCFAC) on a bi-monthly basis.

SLED DCF agents investigate child deaths as part of a multidisciplinary, multiagency team, known statewide as the Child Death Investigation Task Force (CDITF). Each county has a CDITF, which is comprised of local law enforcement, coroner's office personnel, solicitor's office personnel, representatives from the South Carolina Department of Social Services (DSS), a child abuse pediatrician, and emergency first responders (such as EMS and the Fire Department personnel). The CDITF works as a team to investigate all child deaths in a county. The team also investigates all child deaths in compliance with the South Carolina Child Abuse Response Protocol[1]. In 2024, agents provided 17 training sessions, with approximately 531 attendees, across the state on CDITF and child death investigations.

[1] https://www.cac-sc.org/protocol/

Overview

In 2024, the DCF received 488 intakes of child fatalities from coroner's offices throughout the state. Of these, 160 intakes did not meet the statutory requirements for an investigation as a child fatality. The DCF investigated 328 total child fatalities and opened 326 child fatality cases. There were 2 cases that involved multiple deaths but were classified as 1 incident/case number. DCF agents investigated an additional 25 allegations of child abuse or neglect (involving non-fatalities) that are not included in this report.

The DCF agents responded to 207 scenes to assist local law enforcement and/or the coroner.

The DCF provided 177 cases to the SCFAC. The SCFAC is mandated by S.C. Code Ann. § 63-11-1950 and is tasked to identify patterns in child fatalities that will guide efforts by agencies, communities, and individuals to decrease the number of preventable child deaths. SCFAC reviews completed DCF investigations of deaths involving children deemed to be unexpected, unexplained, or suspicious in nature.

While SLED DCF agents investigated 328 child deaths in 2024, this report reflects an analysis of 317 of those investigated deaths. Of the remaining 11 deaths, 7 were categorized as fetal deaths that occurred before delivery from the mother, and the remaining 4 deaths were investigated as fetal deaths but did not yield enough information to accurately categorize or report these deaths.

The deaths documented in this report encompass all deaths of children under the age of 18, whose deaths resulted from violence, occurred under suspicious or unusual circumstances, or were unexpected and unexplained.

Autopsies

S.C. Code Ann. § 17-5-520 states that coroners shall request an autopsy if a child's death occurs as a result of violence, in any suspicious or unusual manner, or when the death is unexpected and unexplained.

Of the 317 child deaths discussed in this report, autopsies were completed in 304 (95.9%) deaths.

Child Death Reviews

S.C. Code Ann. § 17-5-541 – 17-5-544 require that coroners rapidly and expeditiously review all child deaths. To achieve this, the coroner is required to schedule a local Child Fatality Review Team to perform a review of the case. The team may be comprised of the coroner (or their designee), local law enforcement, SLED DCF agents, a board-certified child abuse pediatrician, a representative from DSS, a forensic pathologist, and/or emergency first responders (such as EMS and the Fire Department). Typically, all CDITF members are present and participate in the child death review. It is an investigative tool used to ensure that all agencies involved in the investigation are sharing information and working together as a team to thoroughly and accurately investigate the child death.

In 2024, coroners hosted child death reviews in 282 (89%) of the 317 child deaths. Of the 35 deaths that did not have child death reviews, 11 (31.4%) were ruled as natural, 6 (17.1%) were ruled as accidents, 2 (5.7%) were ruled as suicides, 8 (22.9%) were ruled as homicides, and 8 (22.9%) were undetermined.

Department of Social Services (DSS) Involvement

DSS provides SLED DCF with a report on each child death that indicates the agency's involvement with the child, the child's family, and/or the child's household members. In 2024, DSS had an open investigation involving the child and their family at the time of the death in 11 (3.47%) deaths. DSS had some sort of involvement with 1 or more family member and/or household member prior to the child's death in 180 (56.8%) deaths.

Forensic Interviews

A forensic interview is the process by which a child (who is a victim or witness) is given an opportunity to make a statement, in a safe supportive environment, about what has happened to them or what they have witnessed. The child is questioned in a legally-sound, environmentally appropriate manner by a trained professional, most often in a Children's Advocacy Center.

In 2024, in compliance with the South Carolina Child Abuse Response Protocol, 42 children were forensically interviewed during the investigation of 27 child deaths.

5 Year Summary

YEAR	CHILD DEATHS INVESTIGATED	DCF RESPONSE TO SCENES	DCF RESPONSE TO DEATH SCENES
2024	328	207	184
2023	292	182	169
2022	321	177	161
2021	298	145	135
2020	237	88	84

In 2024, SLED DCF agents responded to 207 scenes. This included 23 scenes not reflected in the data in this report. Those 23 scenes include responses to cases of near-fatalities where the child survived, cases of child abuse (non-fatalities), and the 11 aforementioned fetal deaths. From 2023 to 2024, there was a 12.3% increase in child fatalities, and a 13.8% increase in the number of scenes responded to. Of the 317 deaths reflected in this report, SLED DCF agents responded to 184 (58%) child death scenes.

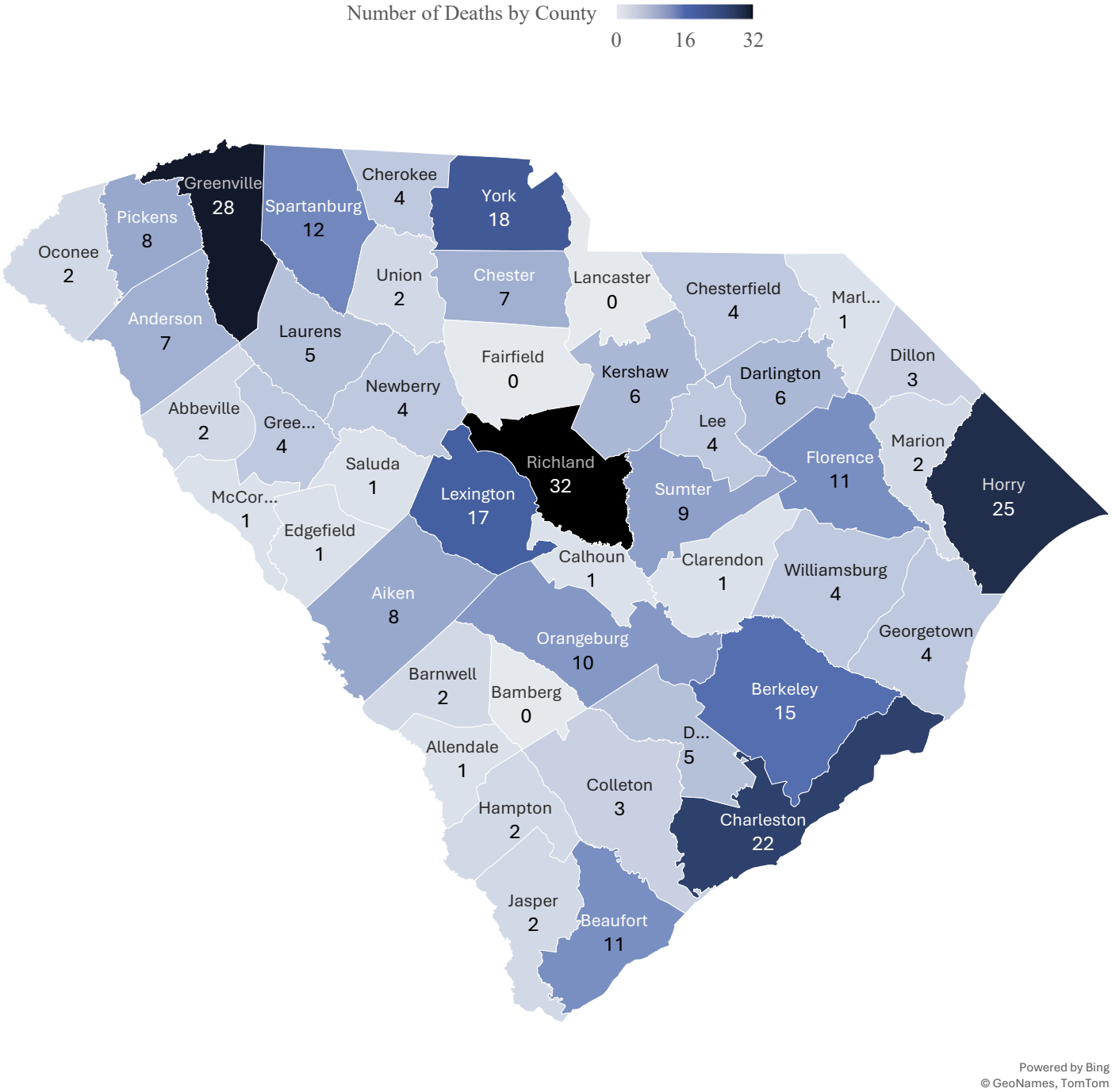
In 2023, SLED DCF agents responded to 169 child death scenes and 13 scenes that included near-fatalities where the child survived, cases of child abuse (non-fatalities), fetal deaths, 1 death of an 18-year-old, and 1 case of assault and battery.

In 2022, SLED DCF agents responded to 161 child death scenes and 16 scenes that included responses to near-fatalities where the child survived, cases of child abuse (non-fatalities), fetal deaths, and an ATV accident that occurred on a public roadway.

In 2021, SLED DCF agents responded to 135 child death scenes and 10 scenes that included responses to cases of child abuse (non-fatalities) and fetal deaths.

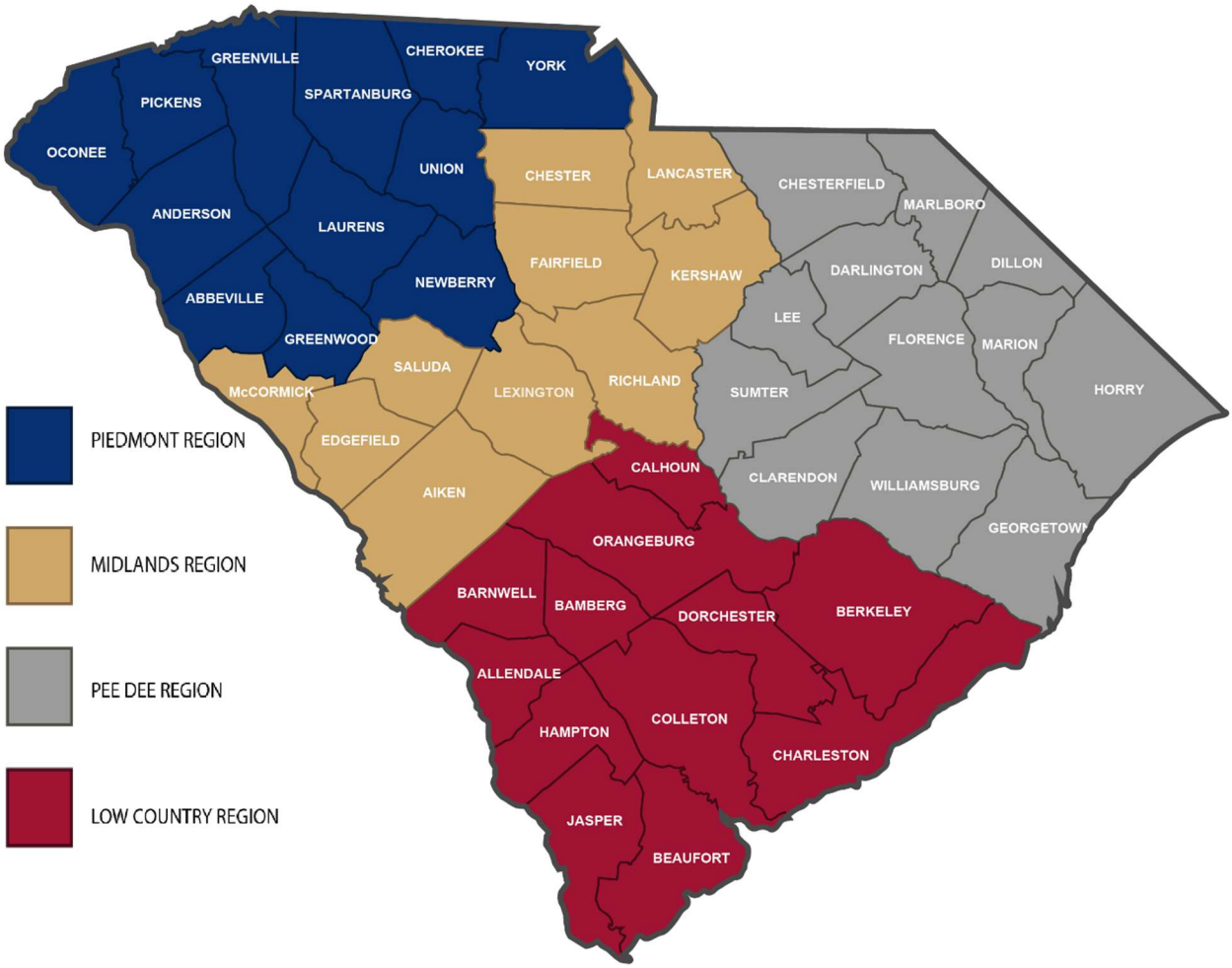
In 2020, SLED DCF agents responded to 84 child death scenes and 4 scenes that included responses to cases of child abuse (non-fatalities) and fetal deaths.

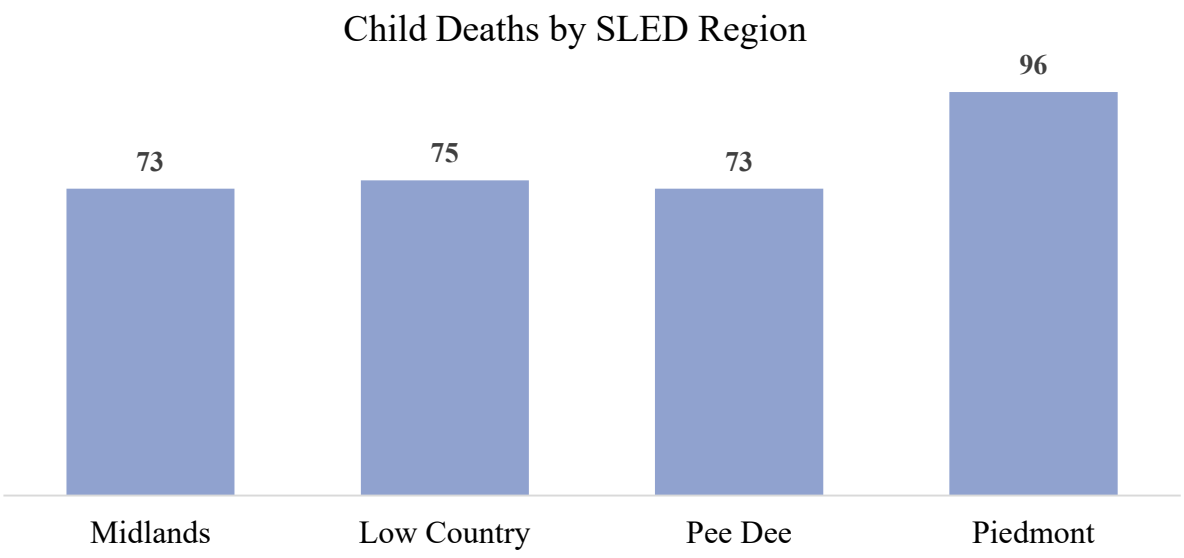
2024 Child Deaths by County

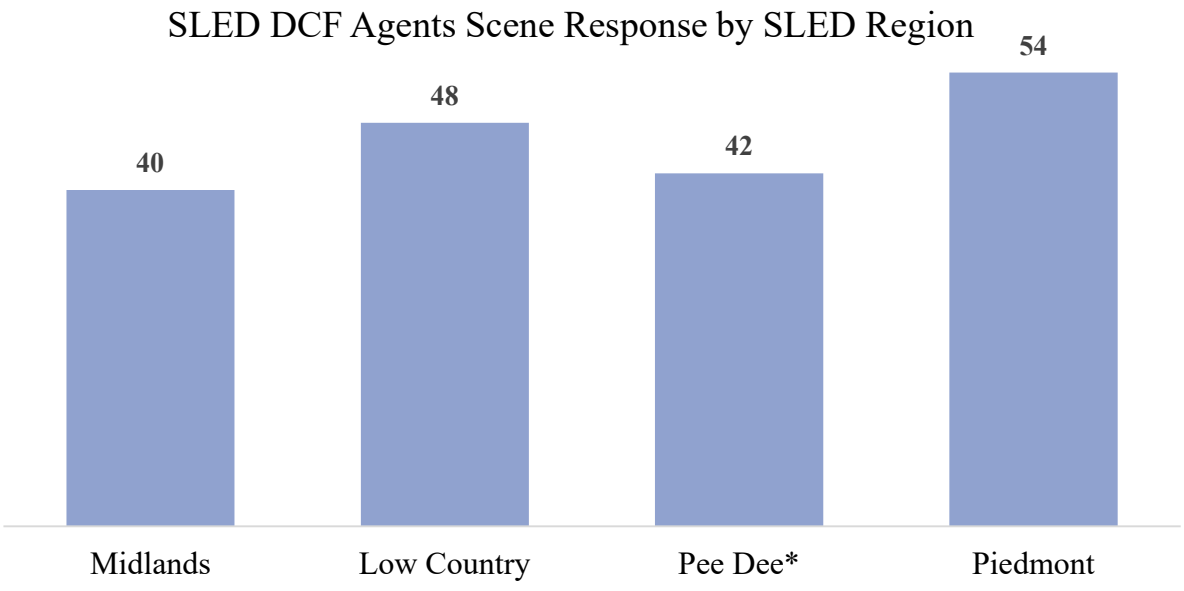


Child Deaths by Region

SLED Investigative Services Unit divides the state into 4 geographical regions: the Low Country, Midlands, Pee Dee, and Piedmont. The Low Country Region has 12 counties in the southern tip of the state, including Allendale, Bamberg, Barnwell, Beaufort, Berkeley, Calhoun, Charleston, Colleton, Dorchester, Hampton, Jasper, and Orangeburg. The Midlands Region includes 10 counties along the center of the state, including Aiken, Chester, Edgefield, Fairfield, Kershaw, Lancaster, Lexington, McCormick, Richland, and Saluda. The Pee Dee Region has 12 counties along the eastern corner of the state, including Chesterfield, Clarendon, Darlington, Dillon, Florence, Georgetown, Horry, Lee, Marion, Marlboro, Sumter, and Williamsburg. The Piedmont Region has 12 counties along the northwestern corner of the state, including Abbeville, Anderson, Cherokee, Greenville, Greenwood, Laurens, Newberry, Oconee, Pickens, Spartanburg, Union, and York Counties.





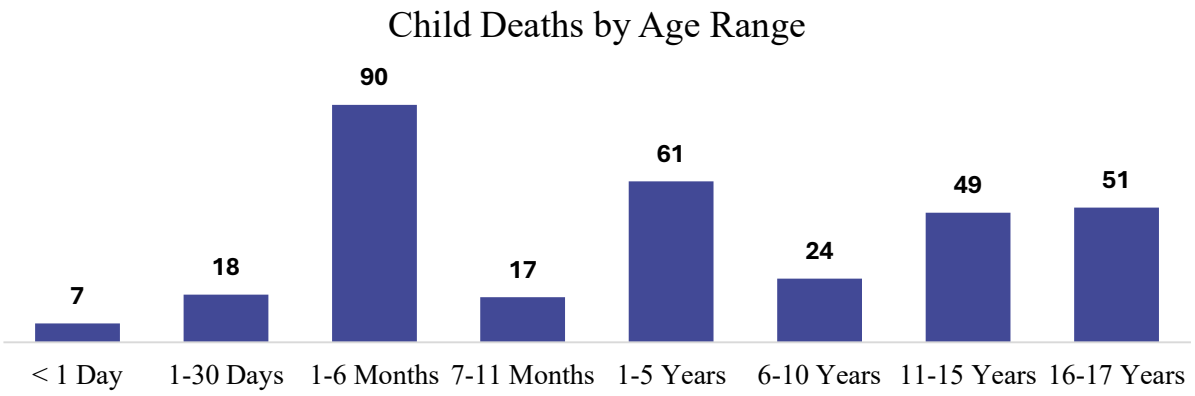


**1 Pee Dee response was for a multi-death incident.*

Demographic Information

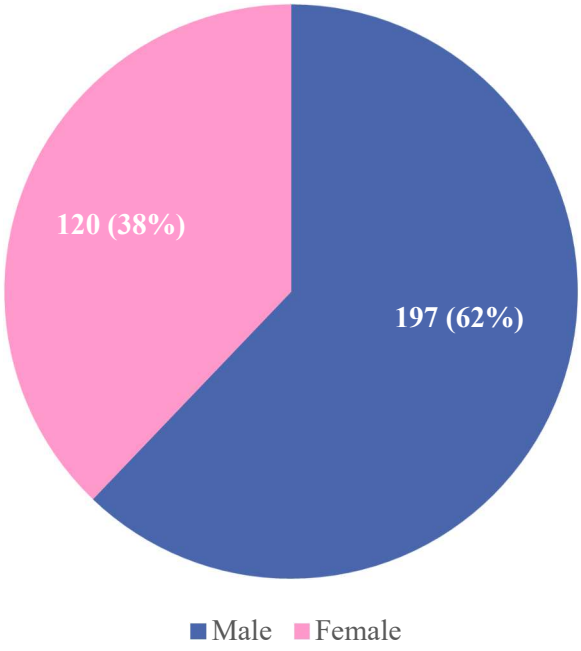
Demographic information for each child was obtained from the certified death certificate. The largest age group of children who died in 2024 was children under the age of 1 year old. 132 (approximately 42%) of the 317 child deaths involved children under the age of 1 year old.

The races of the children who died in 2024 were: 178 (approximately 56%) Black/African American, 106 (33%) White, 17 (5%) Hispanic, 13 (4%) Biracial, and 3 (just under 1%) classified as Other (Native American, Asian Indian, and Guamanian).

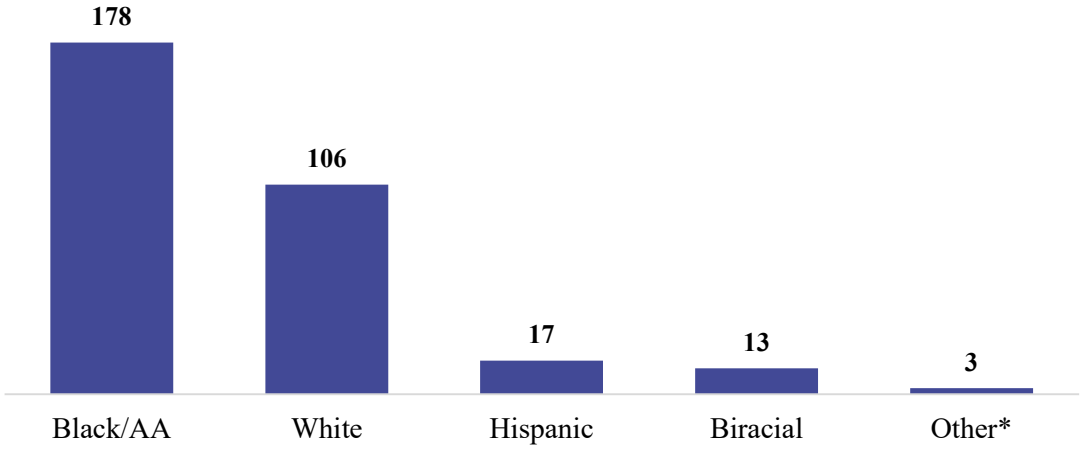


Child Age	Number of Child Deaths by Age
Less than 1 Year	132
1 Year	22
2 Years	10
3 Years	16
4 Years	8
5 Years	5
6 Years	8
7 Years	1
8 Years	4
9 Years	4
10 Years	7
11 Years	5
12 Years	4
13 Years	11
14 Years	12
15 Years	17
16 Years	24
17 Years	27

Child Deaths by Sex



Child Deaths by Race



**Other includes Native American, Asian Indian, and Guamanian in the 2024 data*

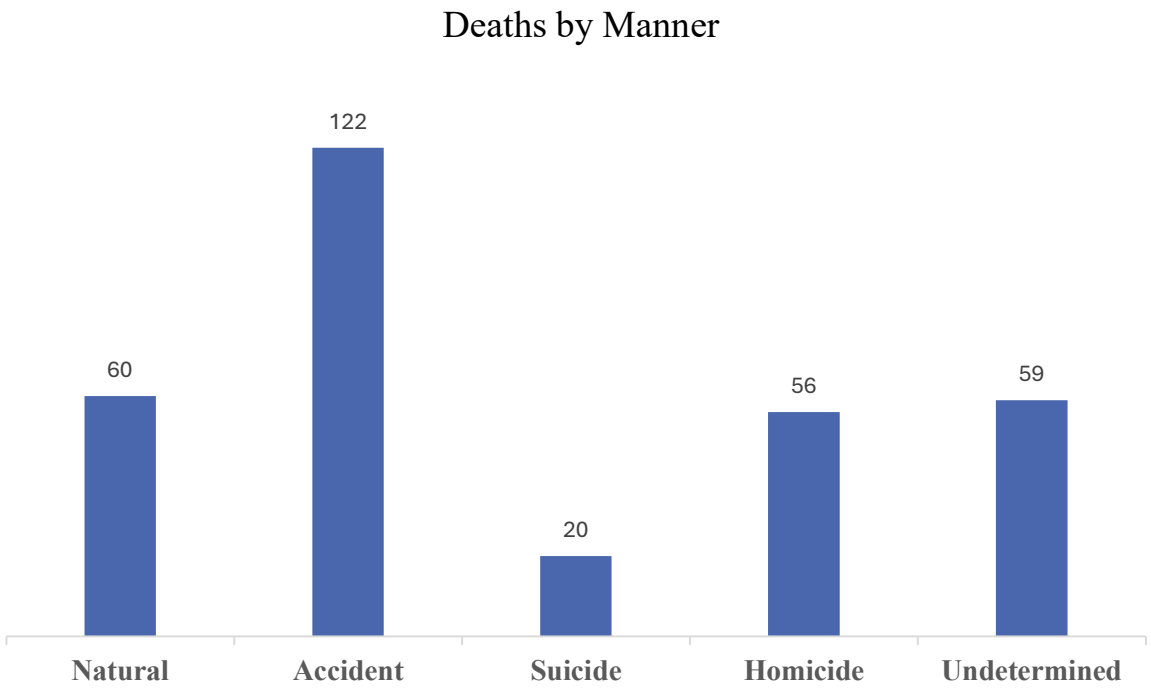
Cause and Manner of Death

The cause and manner of death are determined by the elected county coroner and are certified on the death certificate. This determination is finalized after a thorough investigation, which most often includes an autopsy.

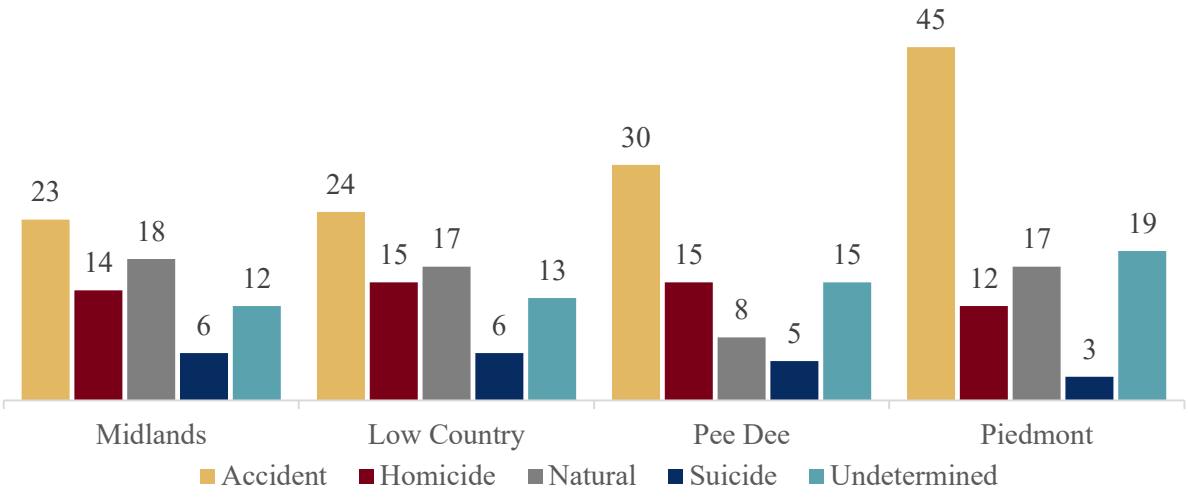
The cause of death is the disease or injury which directly led to the child's death. While the cause of death can be a multitude of findings specific to the death, there are only 5 manners of deaths. These include natural, accident, suicide, homicide, and undetermined.

Manners of Death:

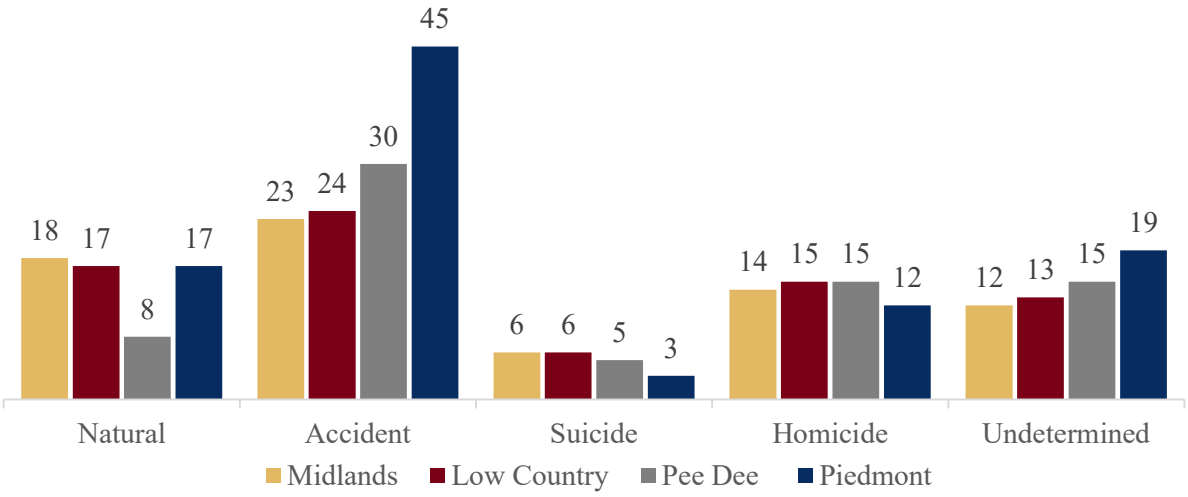
Natural	death resulting from disease process with no external factors
Accident	death resulting from an unintentional event
Suicide	death resulting from a deliberate self-inflicted act
Homicide	death caused by another's deliberate act
Undetermined	inconclusive; insufficient evidence to classify the death



SLED Region By Manner of Death



Manner of Death By SLED Region

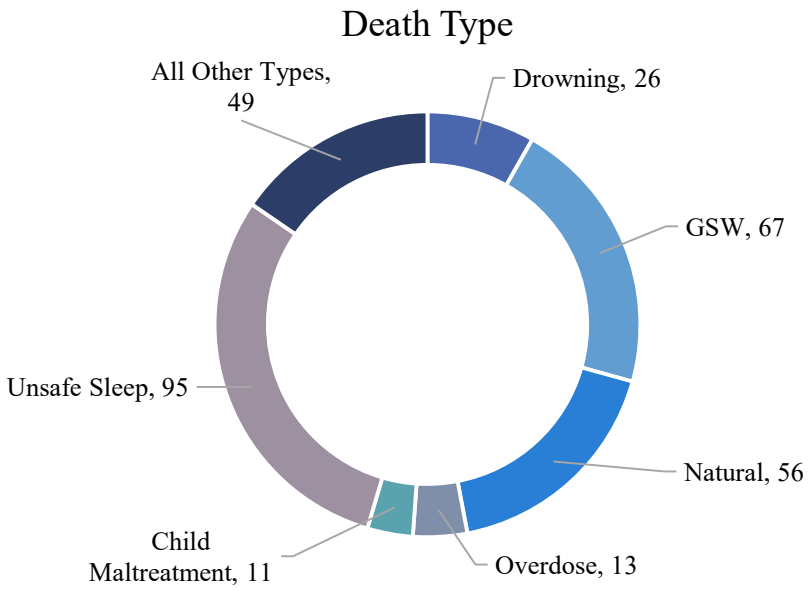


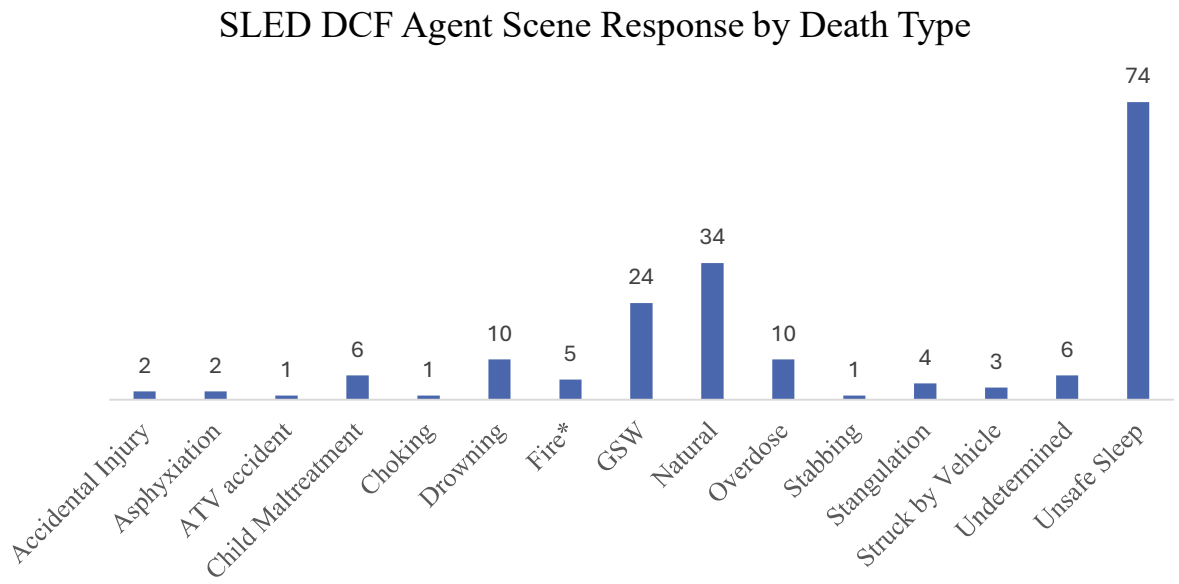
Type of Death

The cause of death can be influenced or categorized by a multitude of findings specific to the circumstances of each case. Therefore, the deaths represented in this report are classified into 17 categories by the type of death: accidental injury, asphyxiation, all-terrain vehicle (ATV) accident, child maltreatment, choking, drowning, fall, fire, gunshot wound (GSW), hyperthermia, natural, overdose, stabbing, strangulation, struck by vehicle, undetermined, and unsafe sleep.

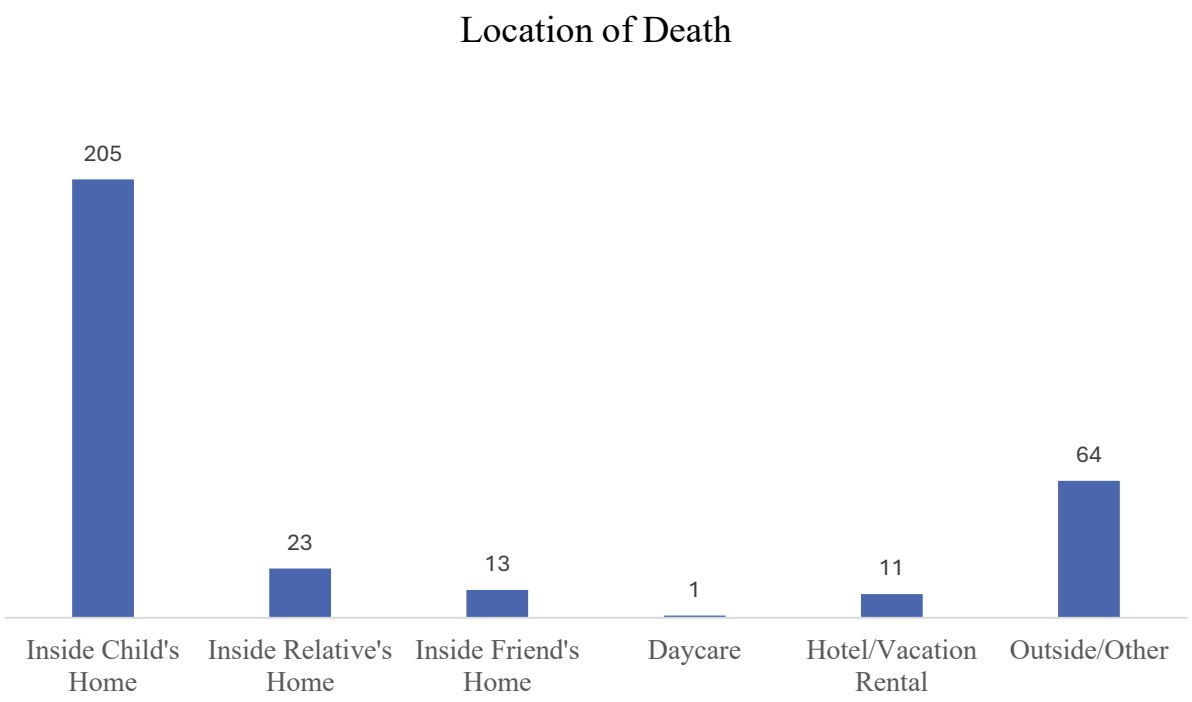
The 3 most common types of cases for 2024 deaths were unsafe sleep (30%), GSW (21.1%), and natural deaths (17.7%). The natural deaths included in this report are those that initially occurred under suspicious, unusual, unexpected, or unexplained circumstances, but were subsequently determined through investigation to be the result of natural causes. This report does not include all natural deaths of children in South Carolina in 2024.

Type of Death	Total Deaths	Midlands	Low Country	Pee Dee	Piedmont
Accidental Injury	5	1	0	1	3
Asphyxiation	2	0	0	1	1
ATV Accident	2	2	0	0	0
Child Maltreatment	11	4	2	1	4
Choking	2	0	1	1	0
Drowning	26	2	4	8	12
Fall	2	1	1	0	0
Fire	8	2	1	4	1
GSW	67	15	18	18	16
Hyperthermia	1	1	0	0	0
Natural	56	17	17	7	15
Overdose	13	2	4	2	5
Stabbing	1	0	1	0	0
Strangulation	8	1	1	3	3
Struck by Vehicle	5	1	1	1	2
Undetermined	13	3	2	5	3
Unsafe Sleep	95	21	22	21	31

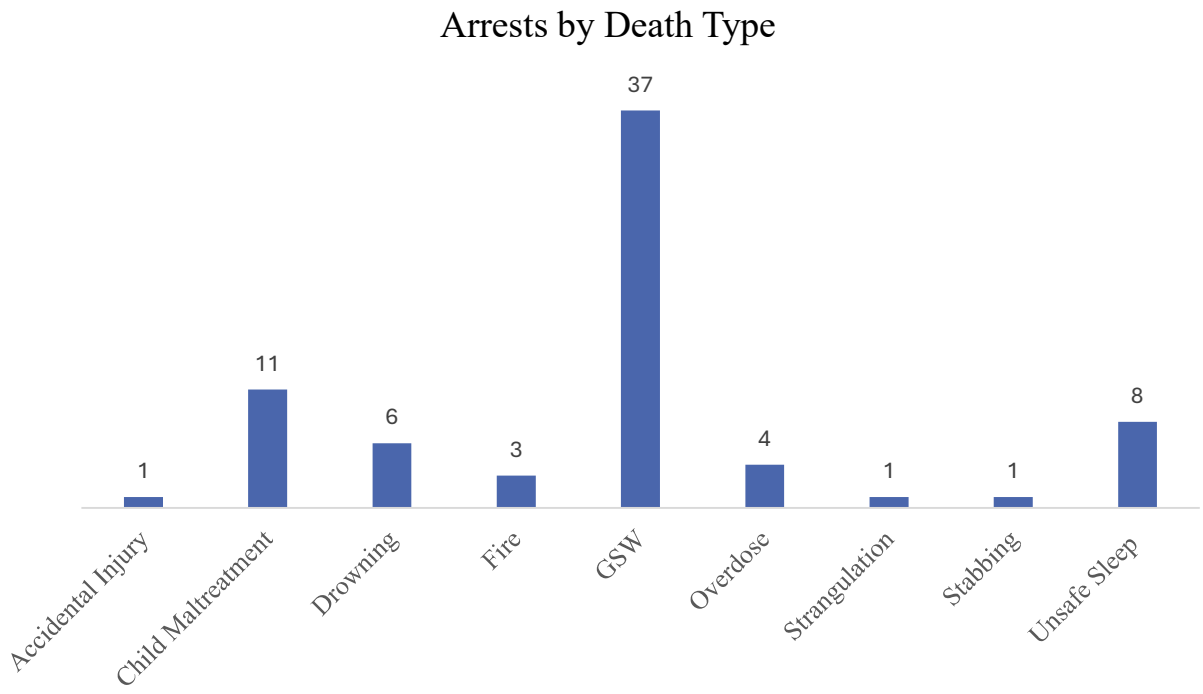




**SLED DCF responded to 5 fire death scenes; however, 1 scene was a multi-death incident.*

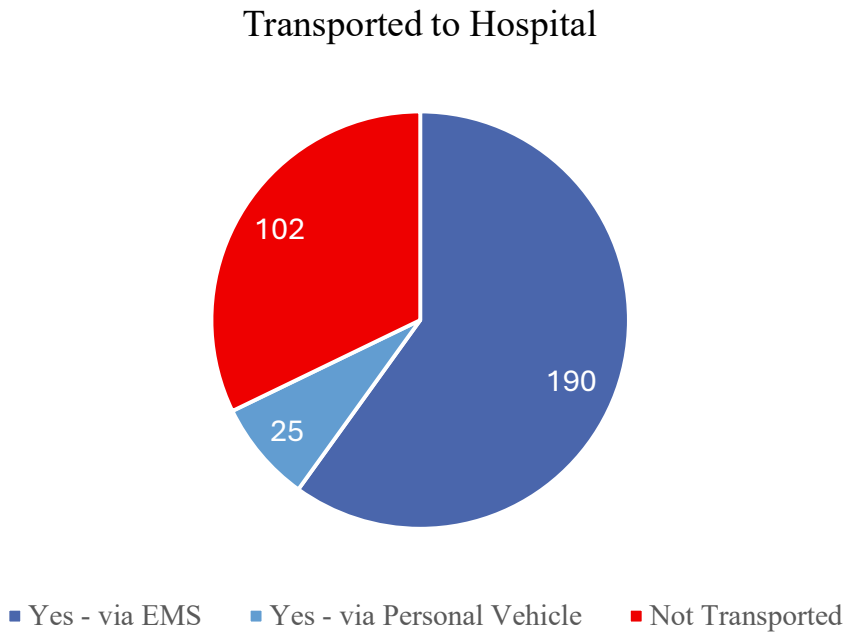


Of the 317 deaths in 2024, 205 (64.7%) occurred at the child's home, 23 (7.2%) occurred at a relative's home, 13 (4.1%) occurred at a friend's home, 1 (0.3%) occurred at a licensed daycare facility, and 11 (3.5%) occurred in a hotel or vacation rental. 64 (20.2%) occurred in locations outside or at other locations such as parking lots, wooded areas, natural bodies of water, parks, roadways, swimming pools, or yards.

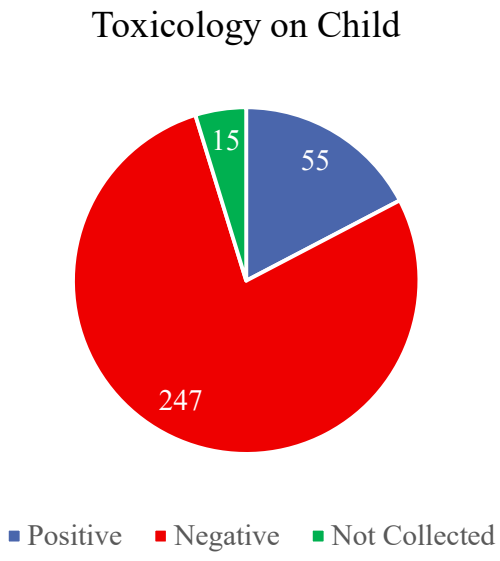


Arrests were made in 72 of the 317 child death investigations. 37 (51.4%) of the 72 deaths that resulted in an arrest were deaths resulting from gunshot wounds, 11 (15.3%) were deaths involving child maltreatment, and 8 (11.1%) were deaths involving unsafe sleeping conditions.

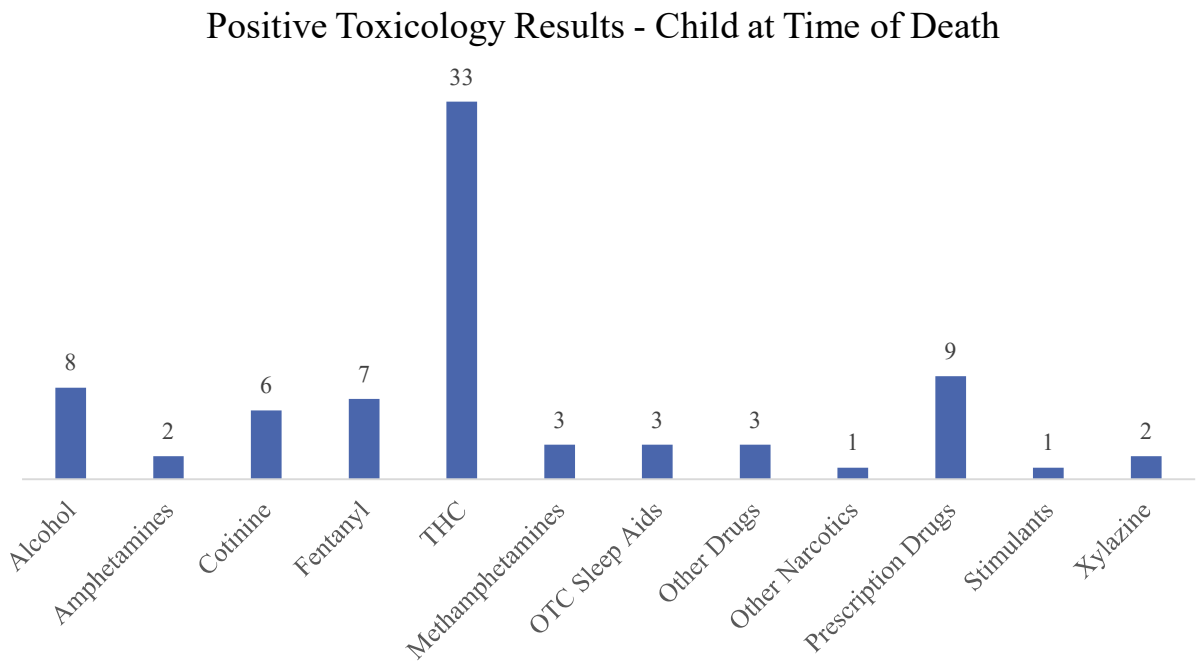
In 8 (2.52%) of the 317 deaths, the family had experienced a prior child death.

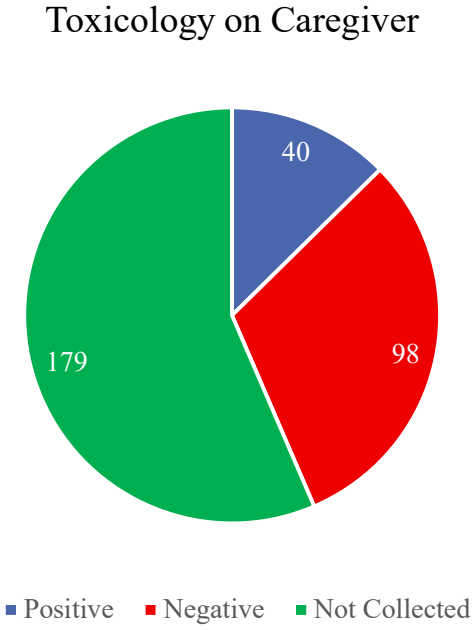


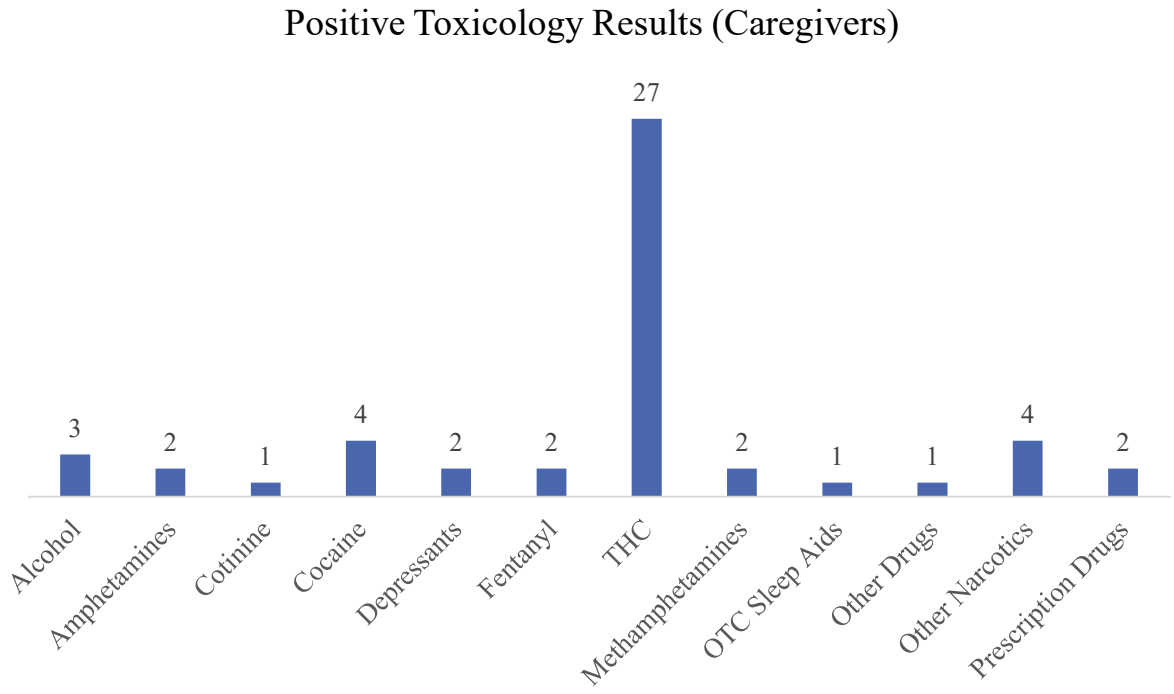
Of the 317 deaths in 2024, 215 (67.8%) were transported to a hospital prior to death, either by EMS or personal vehicle. 102 (32.2%) were pronounced deceased on scene without transport to a hospital.



There were 55 (17.3%) children that had substances in their systems at the time of their death. These were identified by toxicological analyses at the time of death. Of those 55, 18 (32.7%) were positive for multiple substances. The chart below illustrates the frequency that the substances were identified during analysis.



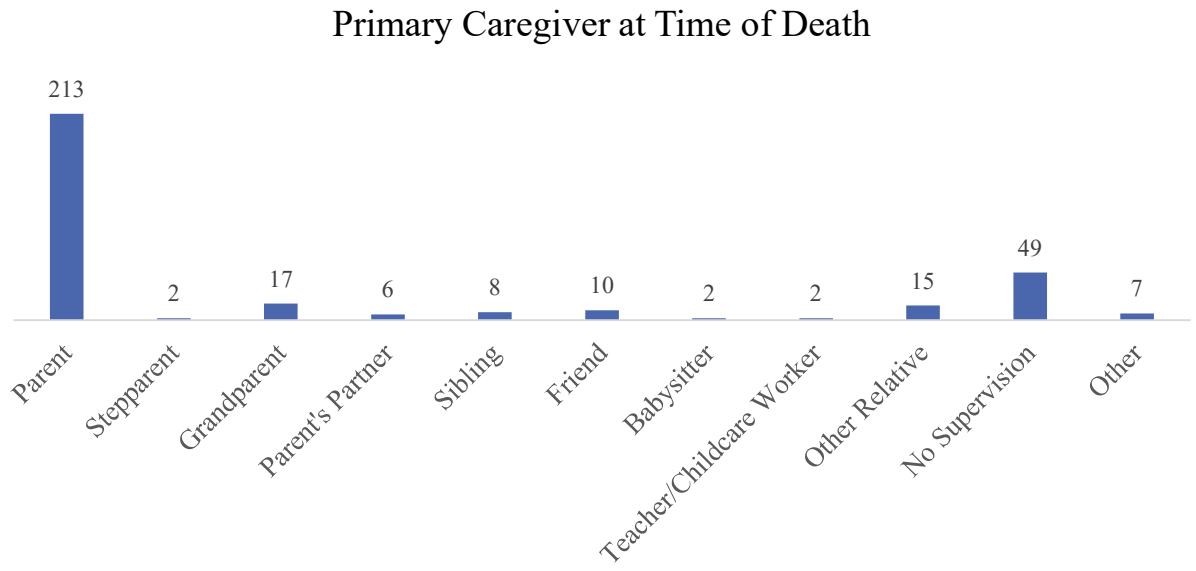




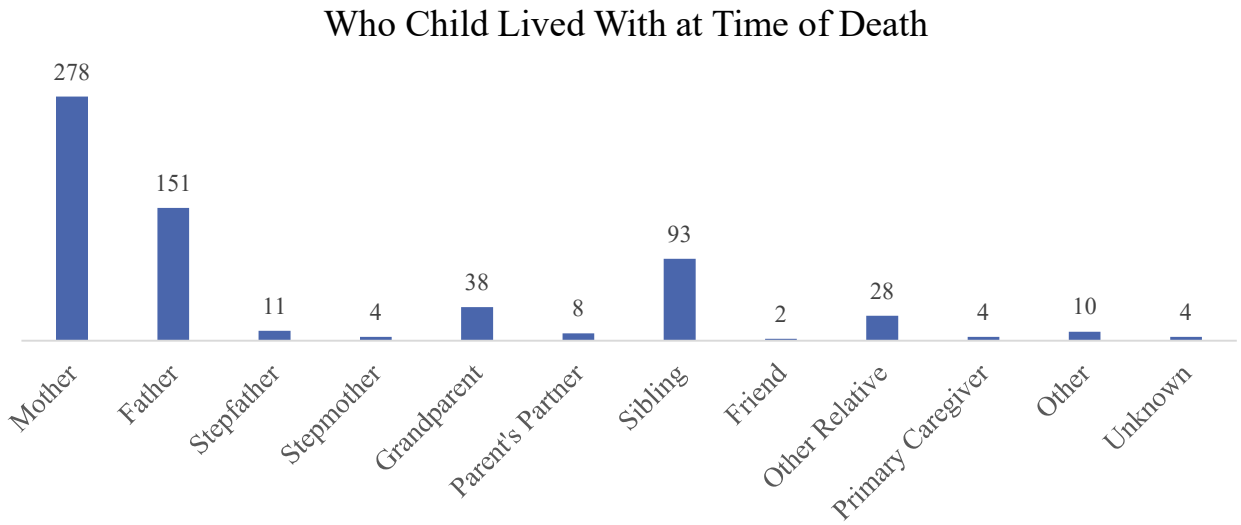
There were 40 (12.6%) caregivers that had substances identified in their toxicological analyses at the time of the child's death. Of those 40 caregivers, 8 (20%) were positive for multiple substances. The chart above illustrates the frequency that the substances were identified during analysis.

An area of concern for the DCF is the lack of consistency or uniformity in drug testing caregivers present during child deaths. The DCF encourages the collection of blood samples from caregivers at the time of the infant's death as a best practice. It is noteworthy that blood, urine, and/or hair samples are collected from caregivers at the time of the child's death (of any age) if any member of the CDITF has reason to believe the caregiver is under the influence of drugs and/or alcohol. This can be obtained through consent of the caregiver or, if probable cause exists, a search warrant by law enforcement. However, the sooner the collection, the better.

Of the 317 deaths in 2024, 213 (67.2%) children were in the care of their parent at the time of death, and 49 (15.5%) had no supervision at the time of their death. There were 14 (4.4%) children that were in the care of multiple people at the time of their death.



Of the 317 deaths in 2024, 137 (43.2%) children resided in a home with both biological parents, and 176 (55.5%) children lived in a home not shared by both biological parents. It is unknown with whom the child resided in 4 (1.3%) deaths.



Accidental Injury

There were 5 (1.6%) deaths that resulted from some type of injury that is not included in the other categories in this report. All 5 were ruled as accidental deaths. These included deaths by electrocution after stepping on a live power line, upper gastrointestinal hemorrhage after ingesting a button battery, and 3 deaths from blunt force trauma (being struck by a falling cement structure, a go-cart wreck, and an unrestrained child seat in a traffic collision[2]).

Asphyxiation

There were 2 (0.6%) children that died of asphyxiation in 2024. They were both accidental deaths of 3-year-old males. There was 1 that was the result of getting a plastic bag stuck on his head. The other got his neck stuck in a car window.

All-Terrain Vehicle (ATV) Accident

In 2024, 2 males, ages 10 and 11-years-old, died as a result of an ATV accident. In both cases, the children were ejected and pinned under the ATV. Both deaths were ruled as accidents.

Child Maltreatment

There were 11 (3.5%) deaths that resulted from child maltreatment in 2024. There was 1 death that resulted from medical neglect. A 3-year-old Hispanic male died as a result of not receiving the prescribed and necessary medication for his medical diagnosis. Both of his parents were charged with Homicide by Child Abuse.

There were 10 (90.1%) child deaths from physical abuse. All of them occurred at the child's home and were ruled as homicides. There were 9 (90%) of these deaths that were caused by blunt force trauma, 8 (88.9%) of which were injuries to the head. In 1 death, a blunt object was used as a weapon. In 8 (88.9%) deaths, personal weapons (body part of the aggressor) were used as a weapon. There was 1 death caused by non-accidental thermal injuries after the child was forced into a bathtub of hot water.

[2] SLED DCF typically does not investigate traffic fatalities that occur in the roadway. This specific death was included in this report because SLED DCF was requested to assist in the investigation of the death by the lead investigating law enforcement agency.

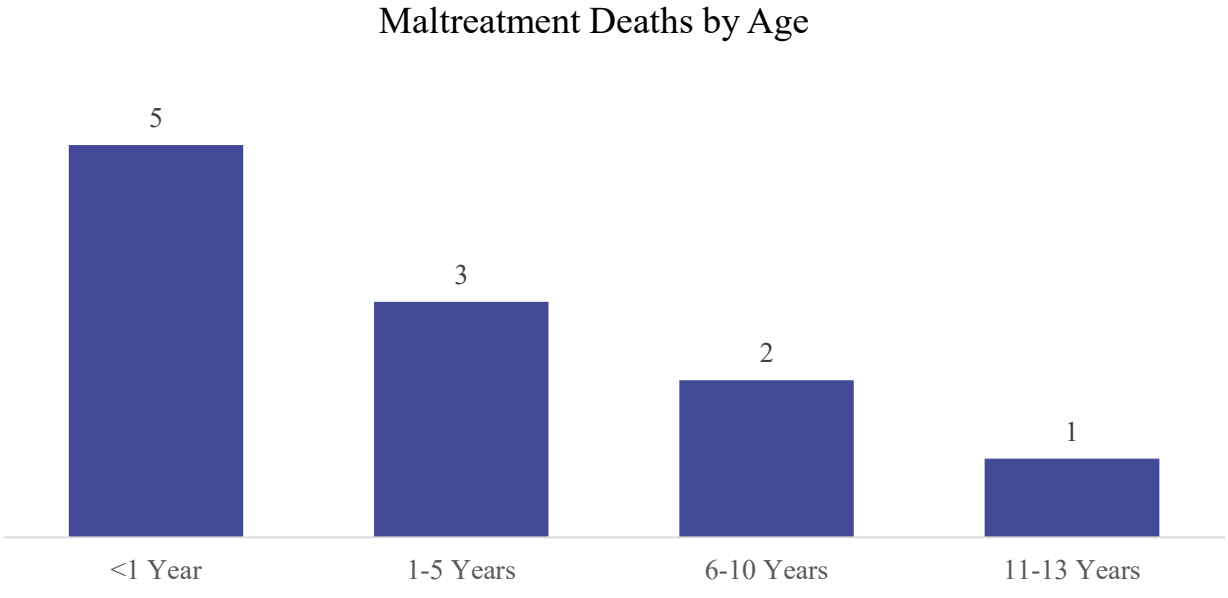
In 2 (18.2%) of these child maltreatment deaths, there was a delay in seeking medical attention for the child. The events that triggered the abuse were identified in 2 cases; those include toilet training accidents and the child crying.

There were 5 infants killed as a result of physical abuse. In 4 (80%) of these deaths, old and new injuries were identified at the autopsy. In 1 case, the infant was left home alone unsupervised with 6 other young children.

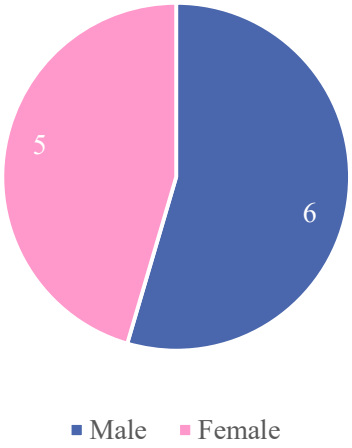
There were 2 caregivers in the child maltreatment deaths that had positive toxicological analyses; 1 was positive for tetrahydrocannabinol (THC), the primary psychoactive compound in cannabis/marijuana, and 1 was positive for a depressant.

There were 2 (18.2%) deaths (a 10-year-old and a 6-year-old) which were the result of prior injuries sustained by the child from physical abuse as infants. Both children died due to complications of non-accidental head trauma. In both cases, a parent was previously charged for inflicting the injuries. No additional charges were made after the deaths.

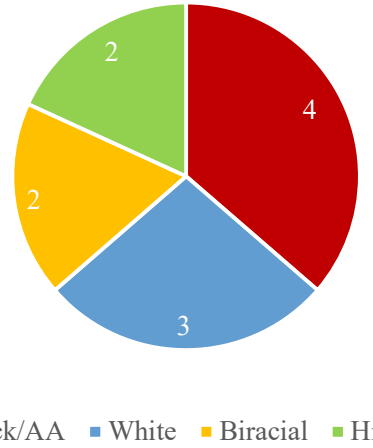
While numerous deaths involved some form of neglect by the caregiver at the time of the death, some of which are discussed in other areas of this report, the deaths included in this section only represent those deaths that occurred as a direct result of abuse and/or neglect by the caregiver.



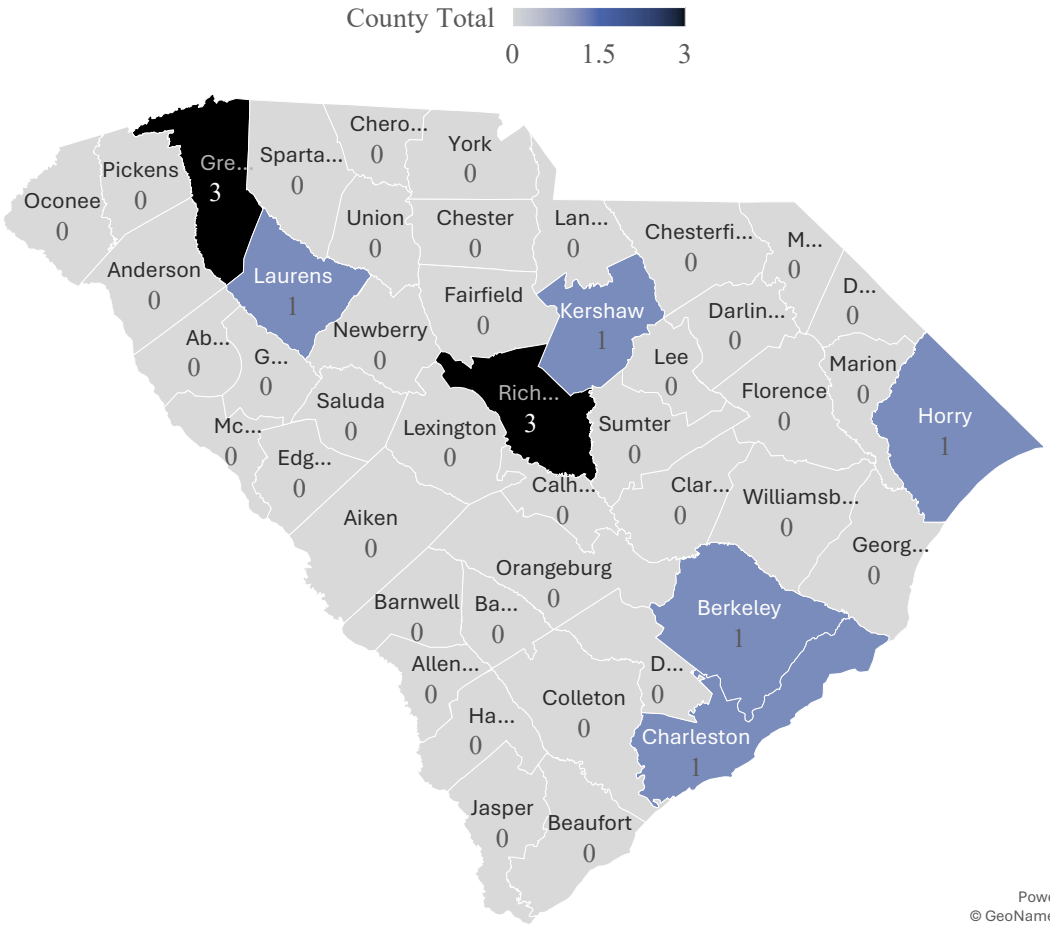
Maltreatment Deaths by Sex



Maltreatment Deaths by Race



Maltreatment Deaths by County



The chart below describes the age of the child, the exact cause of death, who was arrested and charged for the death, and the charges for 8 of the physical abuse cases. This chart does not include the 2 deaths from previous physical abuse injuries.

Child's Age	Cause of Death	Person(s) Arrested	Charge(s)*
1-month-old	Complications of blunt force injuries due to non-accidental trauma	Mother and Father	Homicide by Child Abuse
2-month-old	Inflicted head trauma	Father	Homicide by Child Abuse
2-month-old	Epidural, subdural, and subarachnoid hemorrhage due to blunt force trauma (head and trunk)	Father	Homicide by Child Abuse
7-month-old	Blunt head trauma	Mother and Father	Homicide by Child Abuse
8-month-old	Blunt force injuries to head	Mother	Unlawful Conduct Toward a Child (6 counts)
4-years-old	Diffuse anoxic brain injury following cardiac arrest due to thermal injuries	Mother and Father	Homicide by Child Abuse; Unlawful Conduct Toward a Child
4-years-old	Blunt force trauma of head	Mother's Boyfriend	Homicide by Child Abuse
13-years-old	Blunt head trauma	Mother's Boyfriend and Mother	Murder (mother's boyfriend); Unlawful Conduct Toward a Child (mother)

**Homicide by Child Abuse – S.C. Code Ann. § 16-3-85; Unlawful Conduct Toward a Child – S.C. Code of Ann. § 63-5-70, Murder – S.C. Code Ann. § 16-3-10*

Choking

There were 2 (0.6%) males, ages 8-months and 14-years-old, who died of choking in 2024. Choking is defined as the obstruction of the airway by a foreign body. Both deaths were ruled as accidents and were the result of choking while eating. Congenital conditions contributed to both children being at higher risk of choking during feeding.

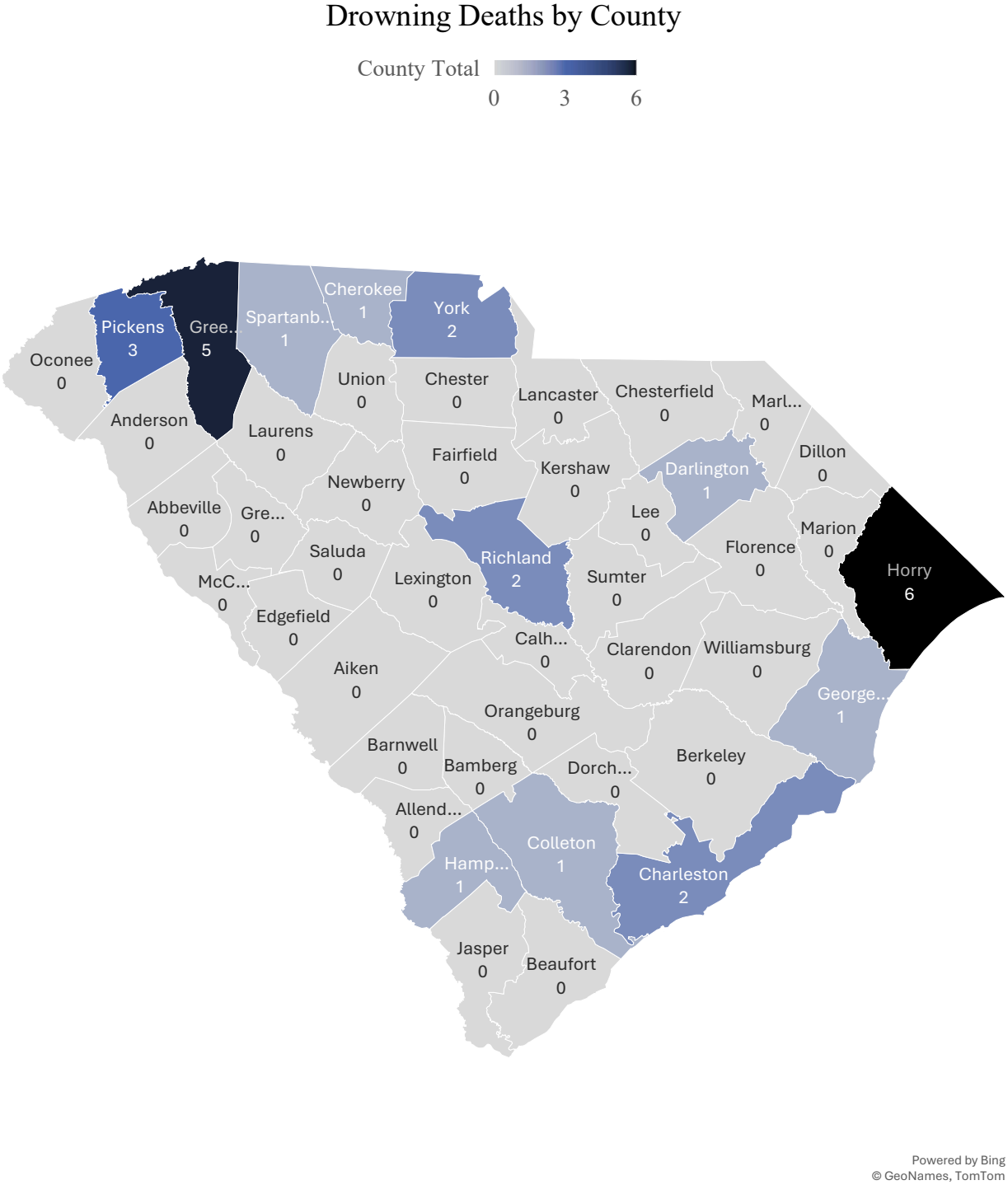
Drownings

In 2024, 26 (8.2%) children died by drowning. There were 25 (96.2%) that were ruled as accidents, and 1 was ruled undetermined. There were 2 deaths that occurred from the same incident involving children jumping from a bridge.

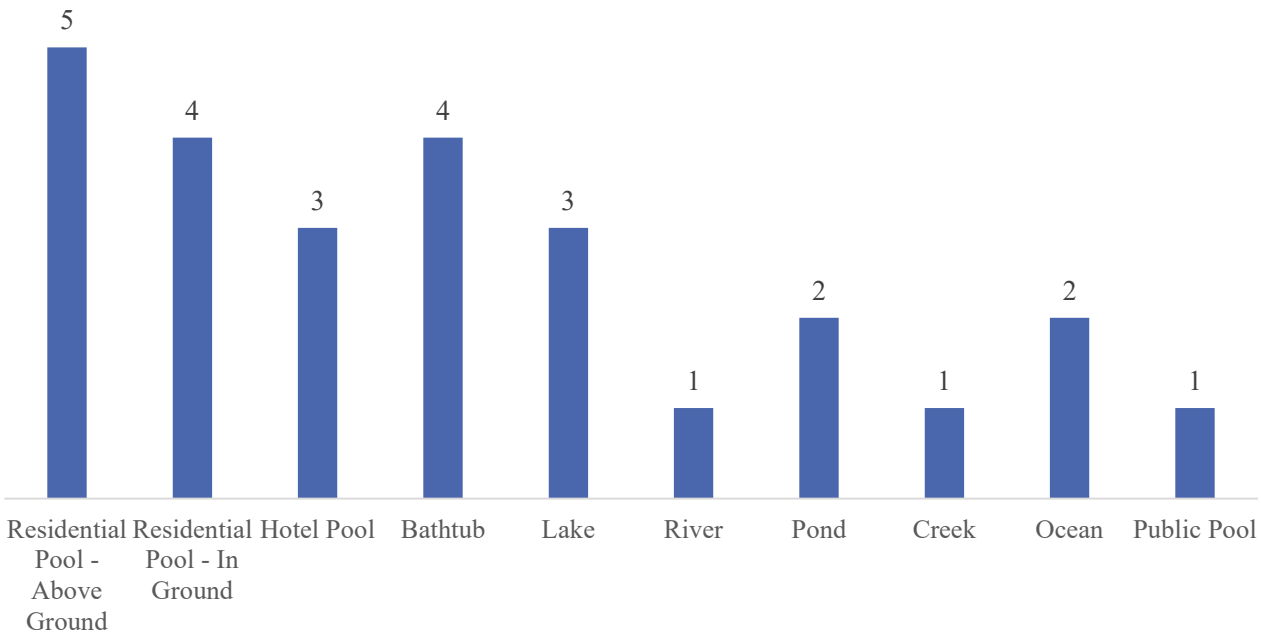
There were arrests made in 6 (2.3%) of these drowning deaths. In 3 deaths, parents were charged with Homicide by Child Abuse or Unlawful Conduct Toward a Child for leaving infants unattended in the bathtub prior to their drowning deaths. In 1 death, a mother was charged with Unlawful Conduct Toward a Child for leaving a young child unattended in a hotel pool prior to the drowning. In 2 deaths, parents or caregivers were charged with Homicide by Child Abuse or Unlawful Conduct Toward a Child for leaving young children unattended prior to the children leaving the residence and drowning in a nearby pool or creek. Other factors included deplorable living conditions, drug paraphernalia in the home, and/or the defendant having a positive toxicological analysis for THC.

In the deaths that involved swimming pools, at least 6 (60%) of them did not have adequate barriers or fences to prevent unsupervised water access. In the 3 deaths that occurred at a hotel, there was no lifeguard on duty at the time of the drowning. In at least 24 (92.3%) deaths, the child was not using a flotation device at the time of the drowning. In 4 (15.4%) of the cases, the child was reported as having adequate ability to swim. In 17 (65.4%) deaths, the child lacked the ability to swim. In the remaining 5 (19.2%) deaths, the child's level of swimming ability was unknown.

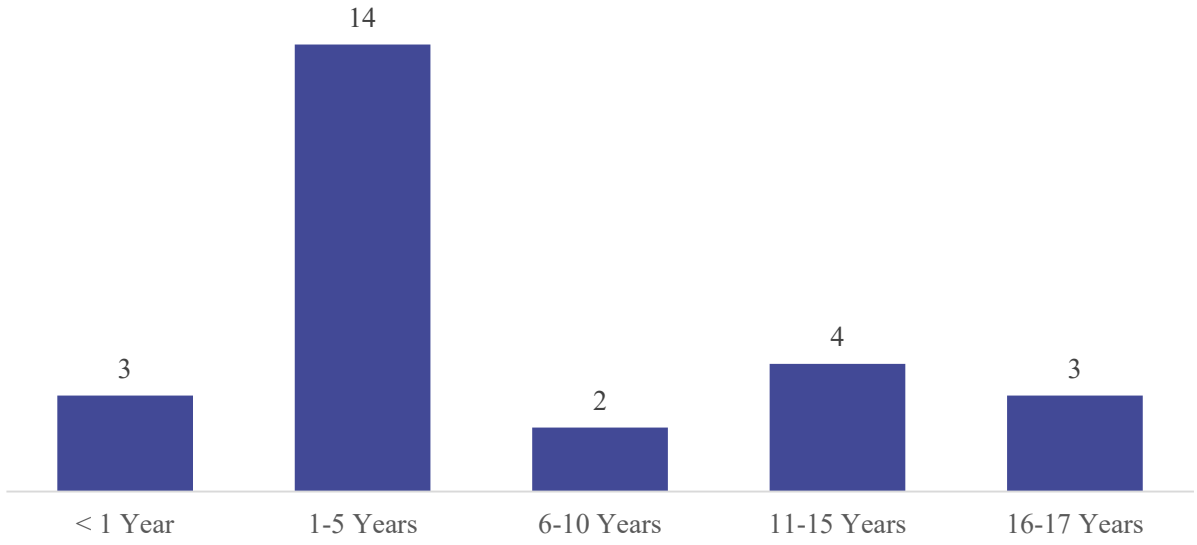
Drowning Deaths by County

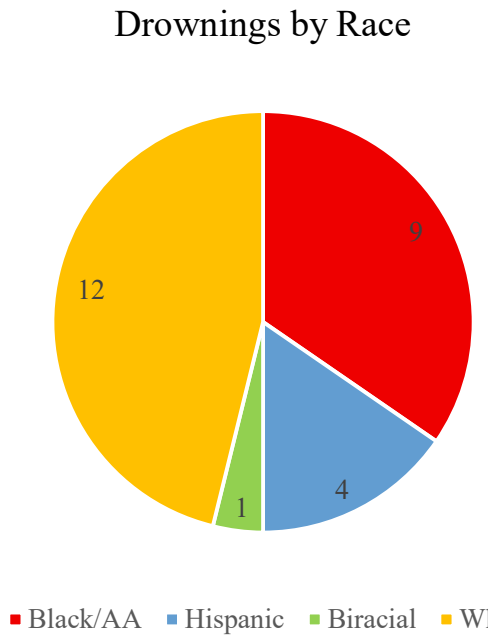


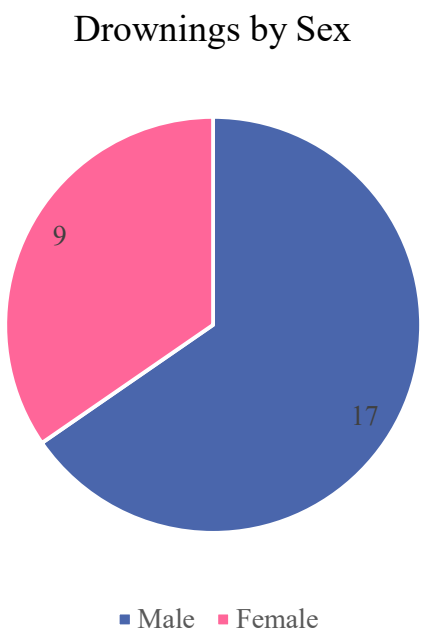
Location of Drowning

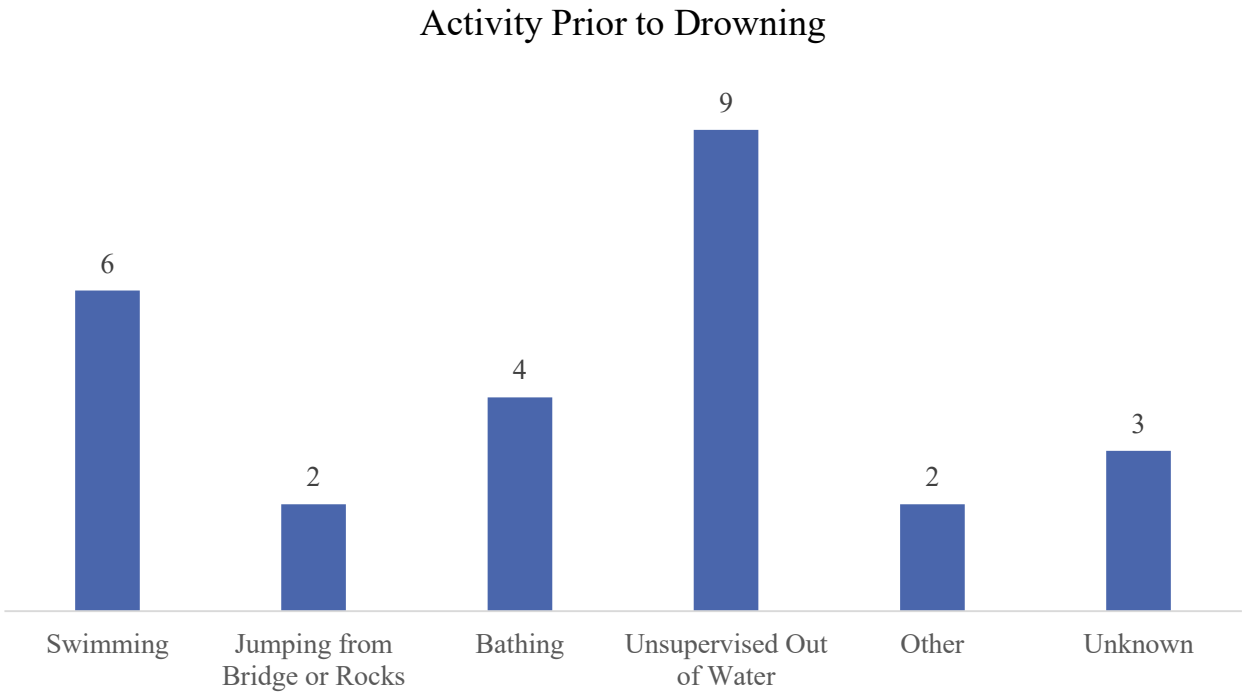


Drownings by Age Range









The 2 activities prior to drowning that are labeled as “other” in the chart above, include playing outside with older siblings and eloping from school.

Fall

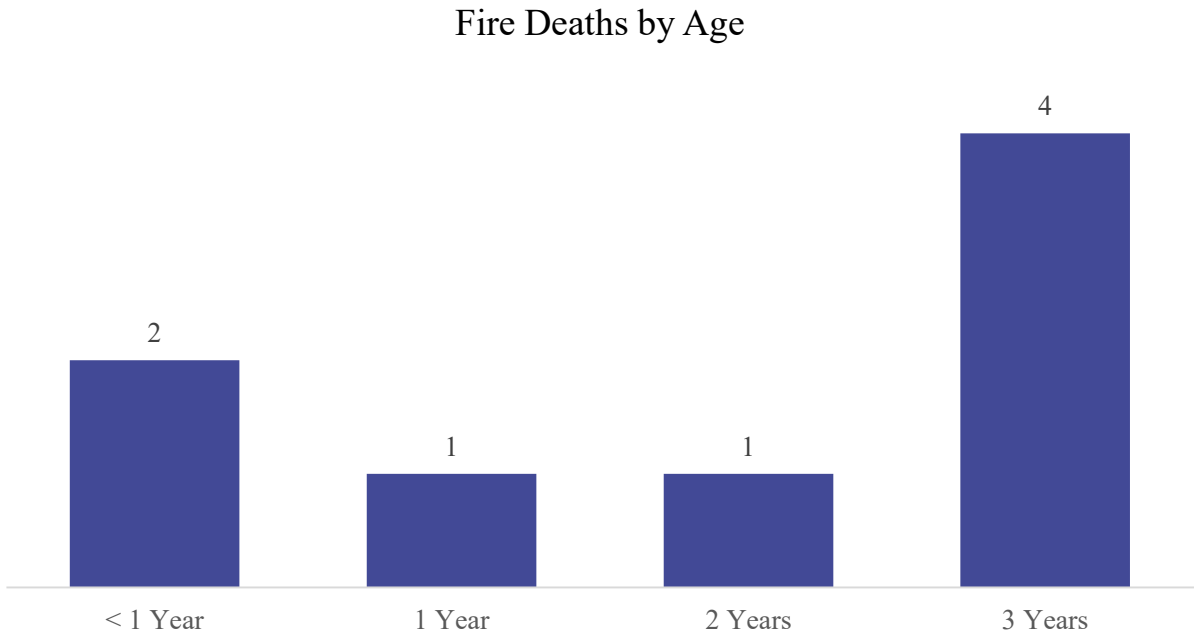
There were 2 (0.6%) females, ages 6 and 13-years-old, that died due to a fall in 2024. There was 1 death that was ruled an accident, and 1 was ruled a suicide. There was 1 fall that was from the bed of a pickup truck and onto a dirt road. The other fall was from a lake dam.

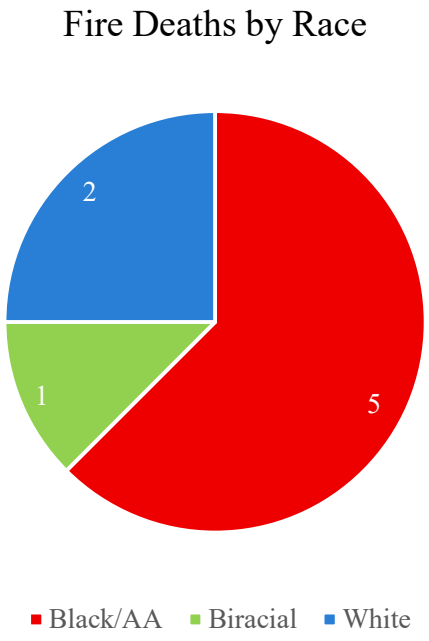
Fire

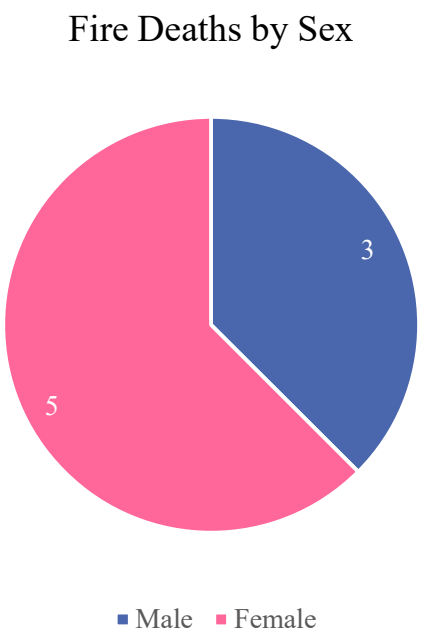
There were 8 (2.5%) children who died in fires in 2024. All 8 were ruled as accidents; 2 children died as the result of the same fire. Smoke detectors were present in 3 deaths. There were no smoke detectors present in 1 death. In 4 deaths, it was unknown if there were smoke detectors present.

There were 2 of these deaths that occurred in January, 2 that occurred in February, 1 in March, 1 in April, and 2 in December.

There were arrests made in 2 of the cases, that included 3 child deaths. Parents in these cases were charged with Unlawful Conduct Toward a Child or Homicide by Child Abuse for leaving young children home unattended during the time the fatal fires began.

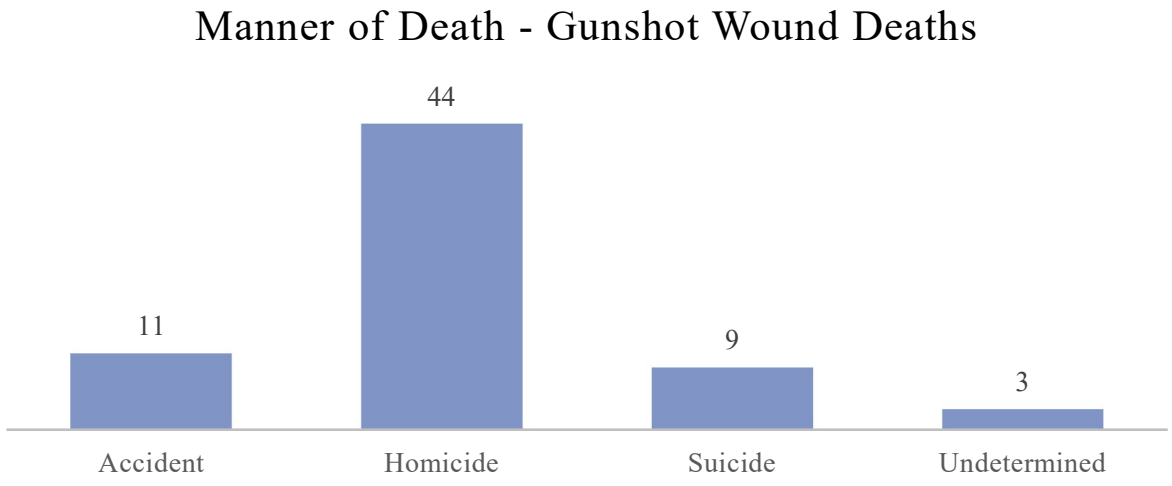




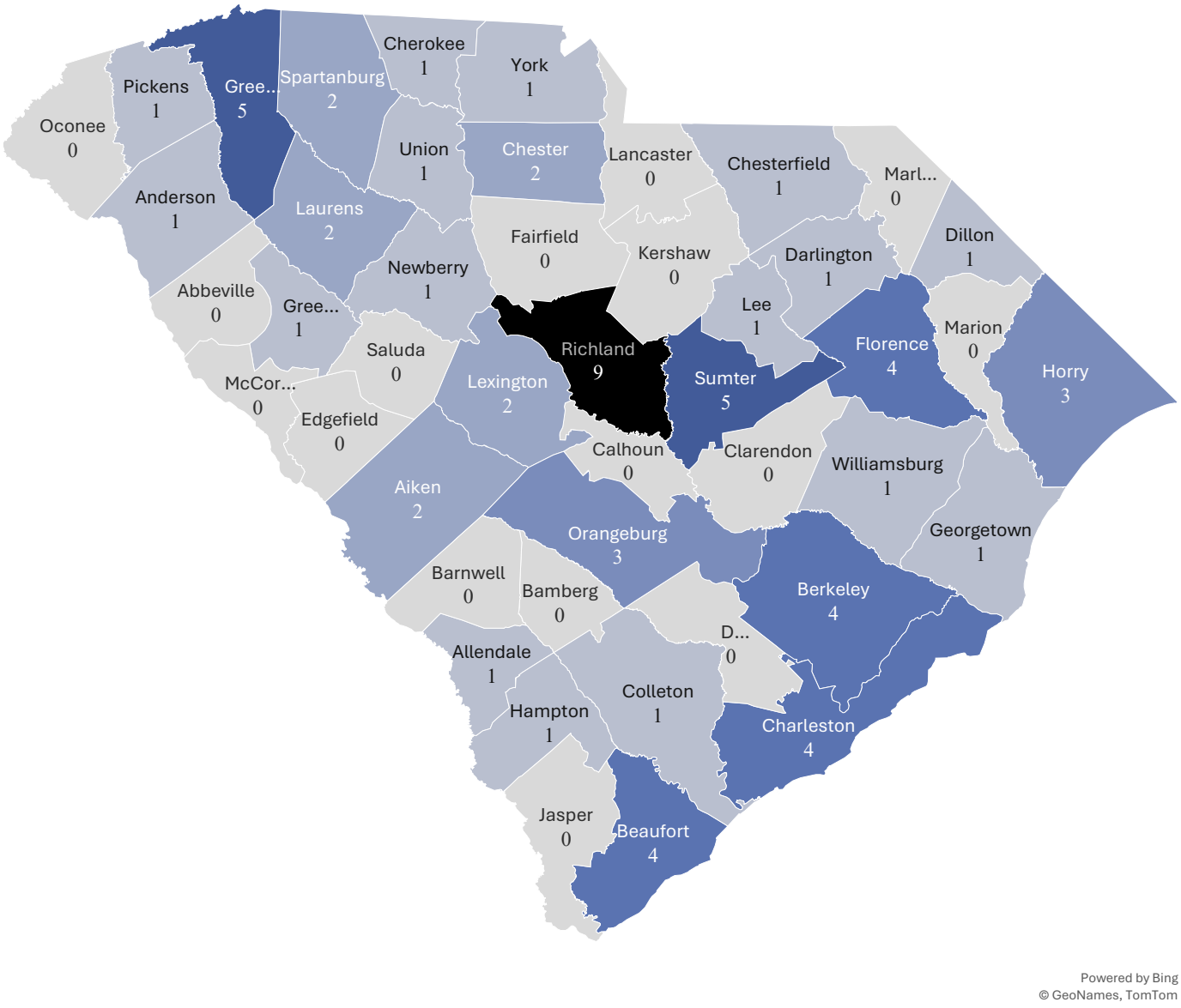


Gunshot Wound (GSW) Deaths

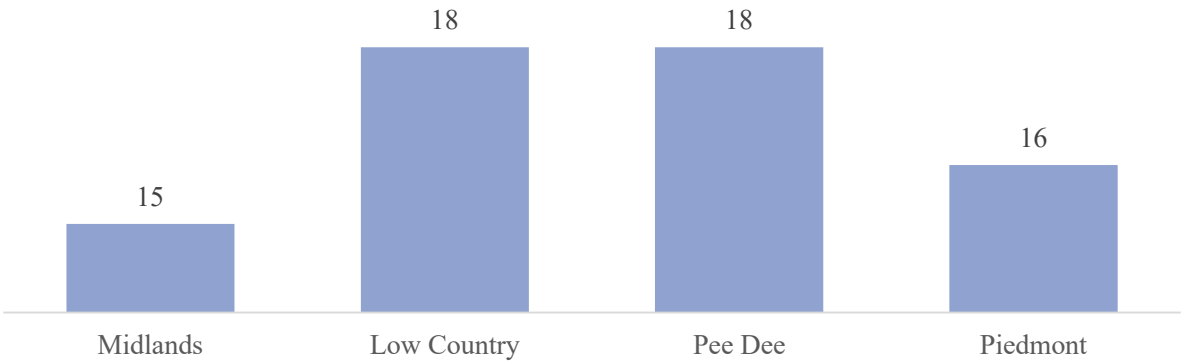
In 2024, there were 67 (21.1%) children of the 317 deaths discussed in this report, who died from causes related to injuries sustained from a gunshot wound (GSW). 44 (65.7%) GSW deaths were ruled as homicides, 11 (16.4%) were accidents, 9 (13.4%) were suicides, and 3 (4.5%) were undetermined.



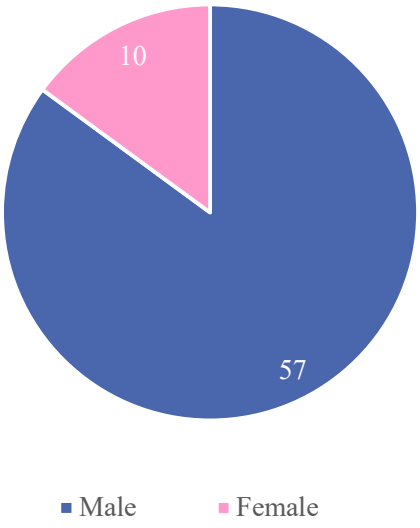
Gunshot Wound Deaths by County



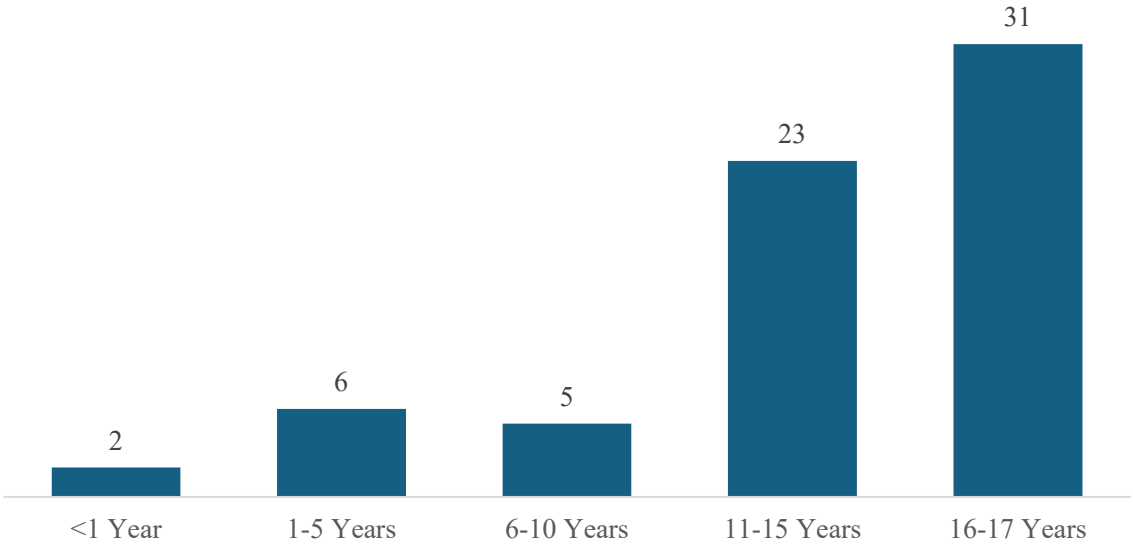
Gunshot Wound Deaths by SLED Region



Gunshot Wound Deaths by Sex

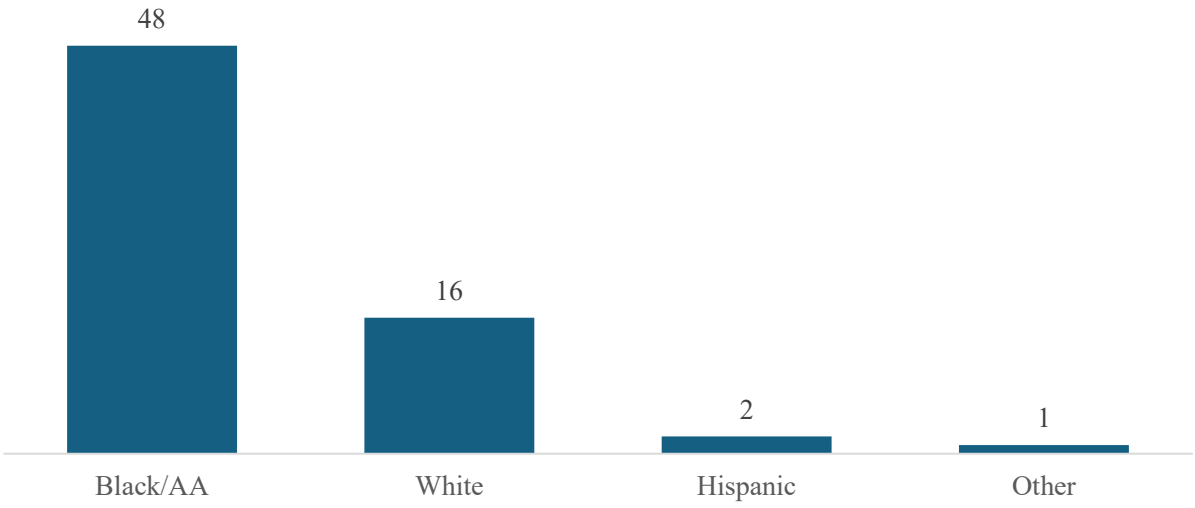


Gunshot Wound Deaths By Age



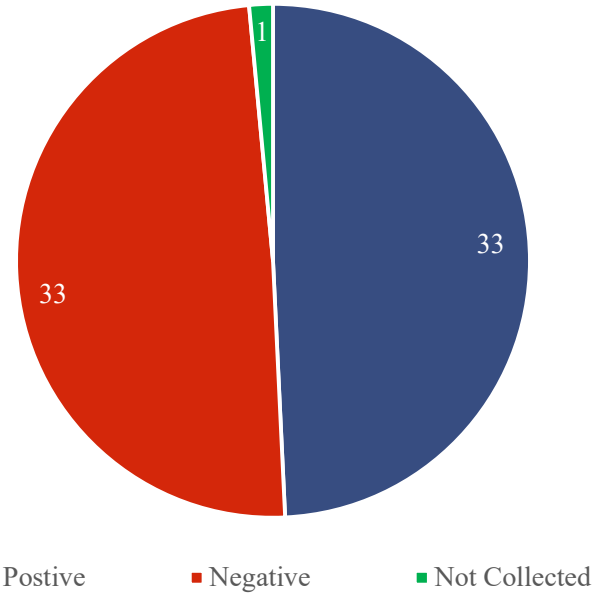
Of the 67 GSW deaths in 2024, 54 (80.5%) were between the ages of 11 and 17-years-old.

Gunshot Wound Deaths by Race

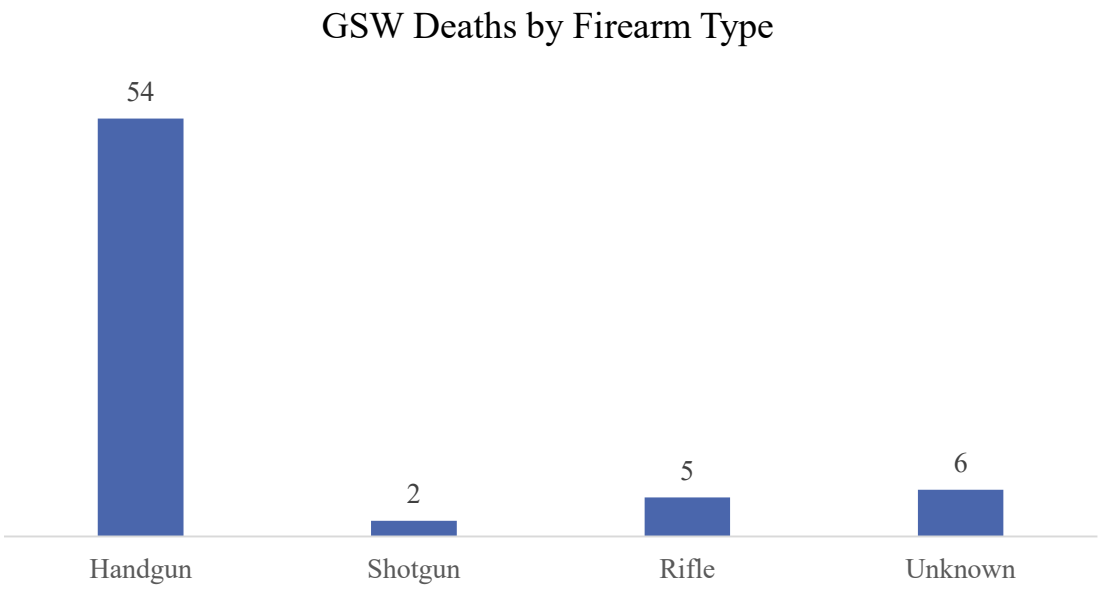


Over 71% of all GSW deaths in 2024 were Black/African American children. Of the 67 GSW deaths in 2024, 42 (62.7%) were Black/African American males.

Toxicology on Victim (Gunshot Wound Deaths)

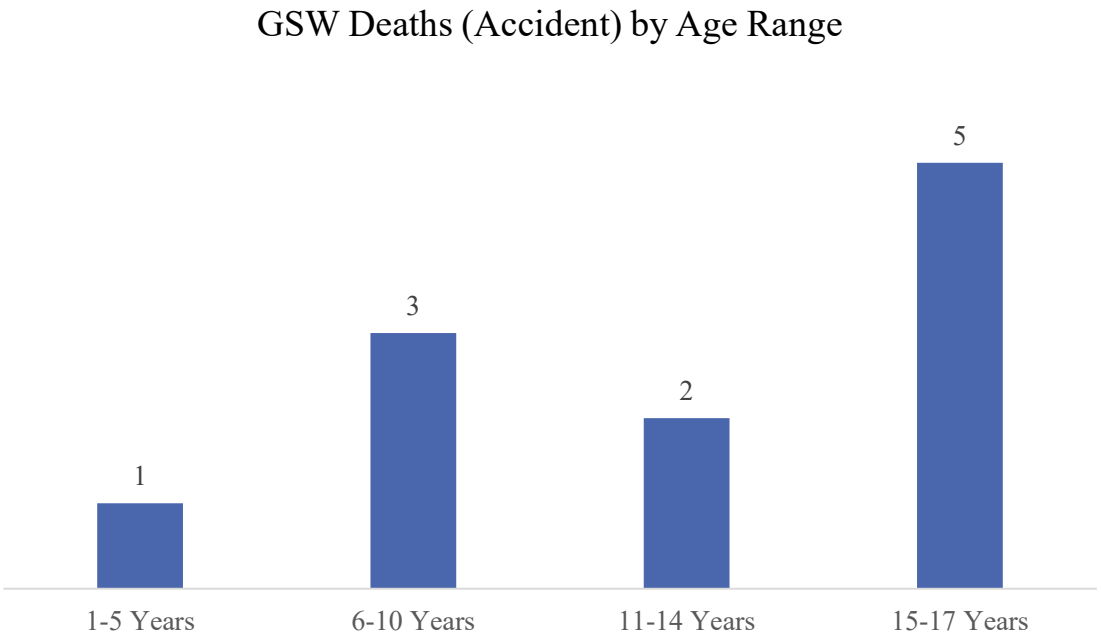


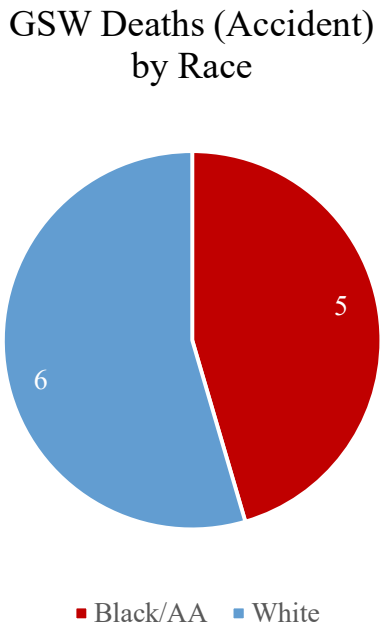
In the 67 GSW deaths in 2024, 33 (49%) of the victims were positive for an illicit substance at the time of their death. There were 26 (78.8%) victims who were positive for an illicit substance that were positive for THC, 7 (21.2%) were positive for alcohol, 5 (15.2%) were positive for cotinine (the chemical substance formed by the breakdown of nicotine in the body), 2 (6%) were positive for methamphetamine, 1 was positive for a prescription drug, 1 was positive for amphetamines, and 1 was positive for another stimulant.

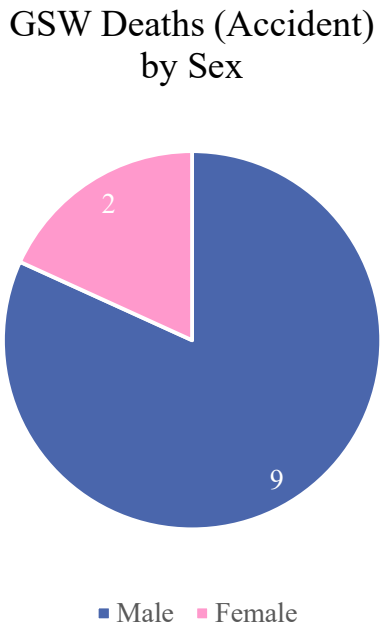


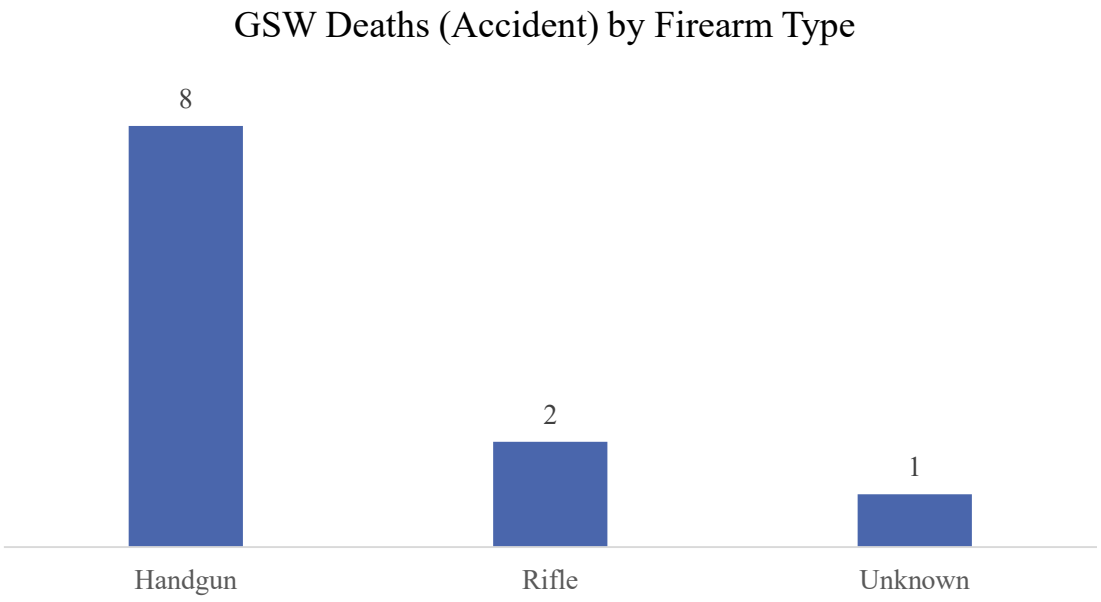
Gunshot Wound – Accident

There were 11 (16.4%) child deaths that were a result of GSW that were classified with the manner of death as accident.









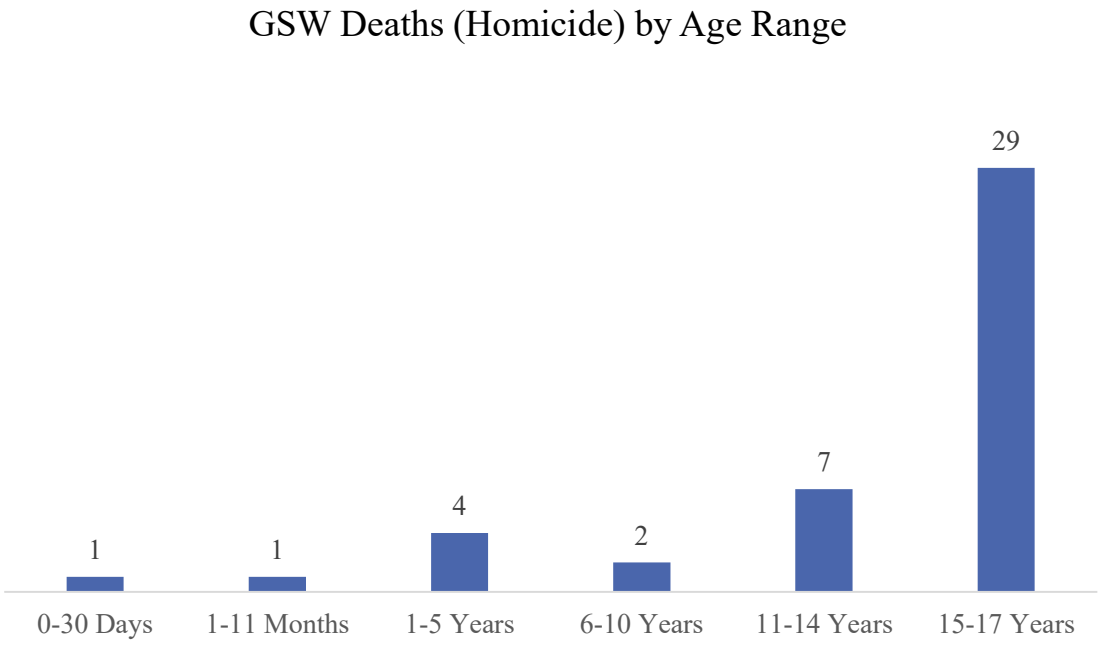
Of the 11 GSW deaths classified as accidents, 4 (36.4%) resulted in an arrest. Of the 11 deaths, 8 (72.8%) involved the use of a handgun, 2 (18.2%) involved a rifle, and 1 (9.1%) was unknown. In 9 (81.2%) of the deaths, the firearm was not properly secured by the owner.

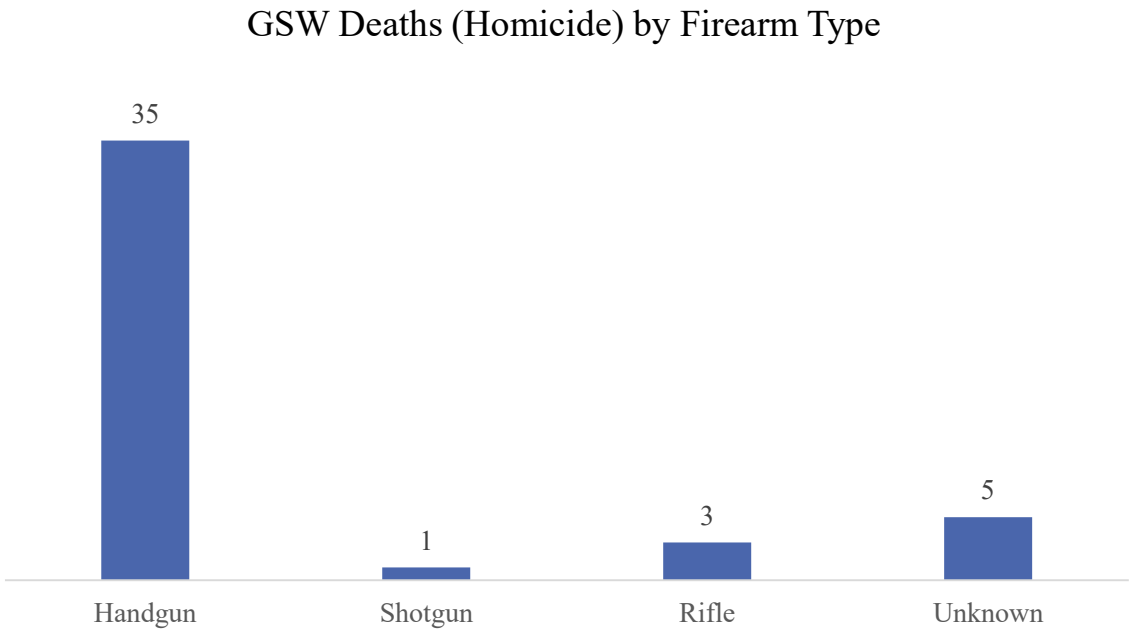
Of the 11 GSW deaths classified as accidents, 4 (36.4%) children had a toxicological analysis that revealed the presence of an illicit substance; 3 revealed the presence of THC, and 1 revealed the presence of a prescription drug.

In 2 (18.2%) cases, the firearm was being shown to others when the accidental discharge occurred, 1 (9.1%) was a hunting accident, in 6 (54.6%) cases the death was due to a self-injury due to lack of supervision of the child, and in 3 (27.3%) cases the victim was shot due to lack of supervision of the children. In 1 case, there were multiple circumstances that occurred during the incident.

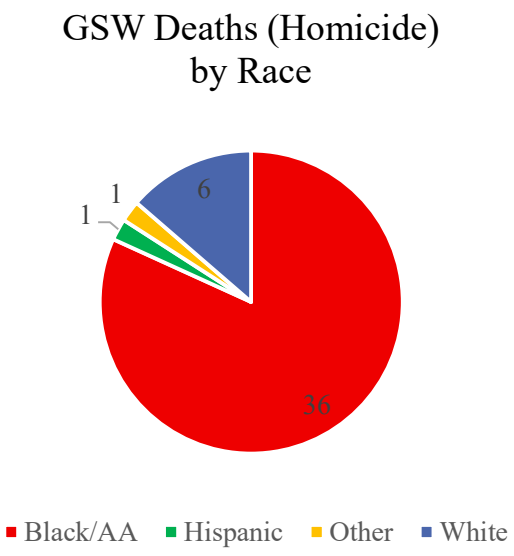
Gunshot Wound – Homicide

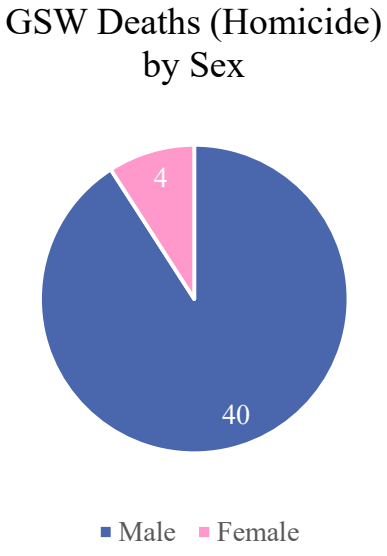
There were 44 (65.7%) GSW deaths that were ruled with the manner of death as homicide. Of the 44 GSW deaths that were classified as homicides, 32 (72.8%) resulted in arrest(s) – 10 of which resulted in murder charges. In at least 18 (41%) cases, the firearm was not stored properly by the owner.



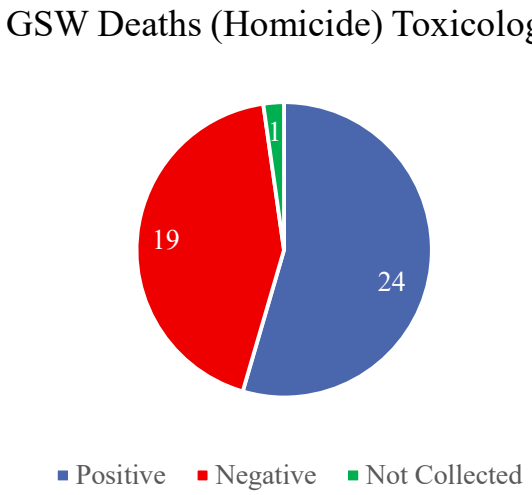


There were 35 (79.6%) deaths that were the result of GSWs from a handgun, 3 (6.8%) were from a rifle, 1 (2.3%) was from a shotgun, and in 5 (11.4%) deaths the type of gun was unknown.

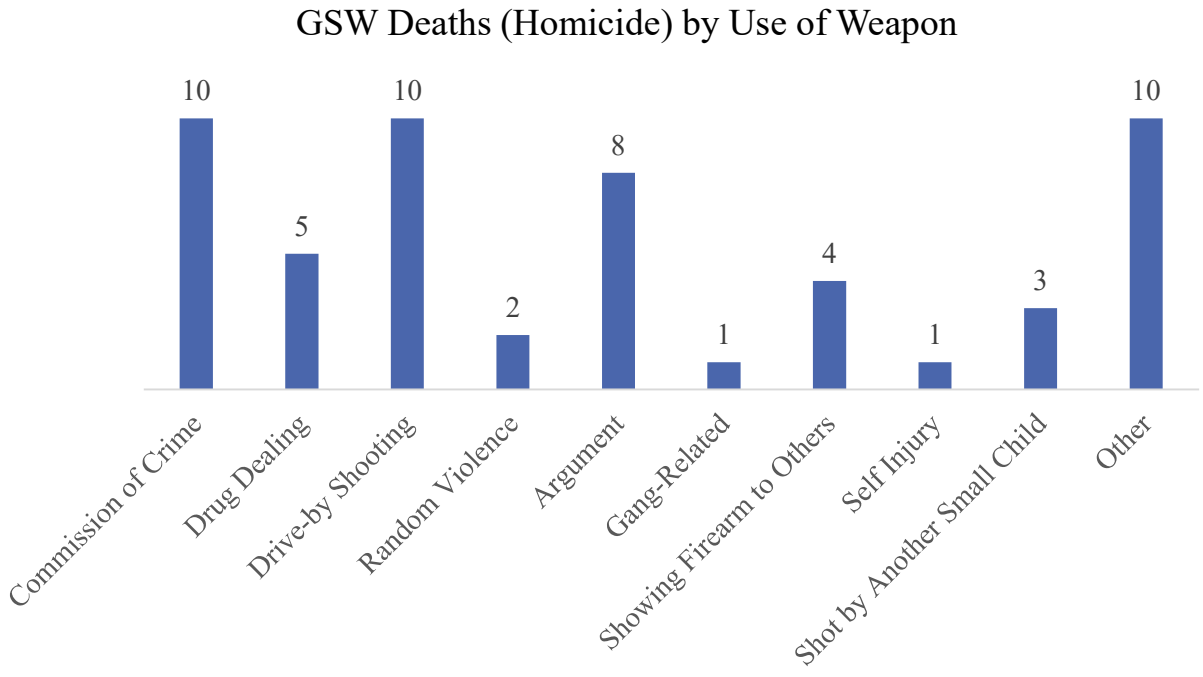




There were 33 (75%) of the 44 GSW deaths classified as homicides that involved a Black/African American male victim.



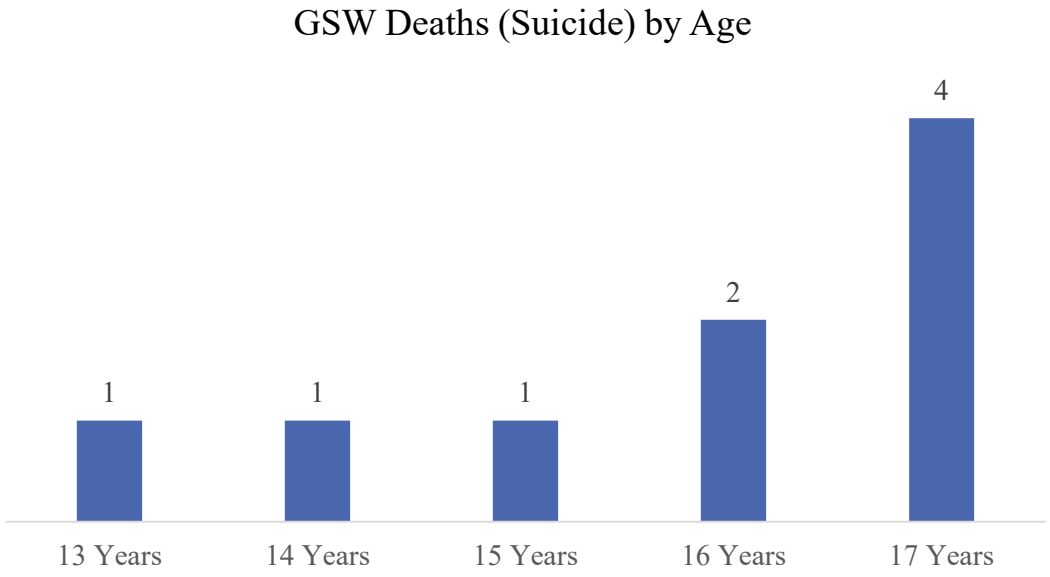
Of the 44 GSW deaths classified as homicides, 24 (54.6%) had a toxicological analysis that revealed the presence of an illicit substance. There were 20 (83.3%) of the 24 that were positive for THC, 5 (20.9%) were positive for alcohol, 5 (20.9%) were positive for cotinine, and 1 (4.2%) was positive for a stimulant.

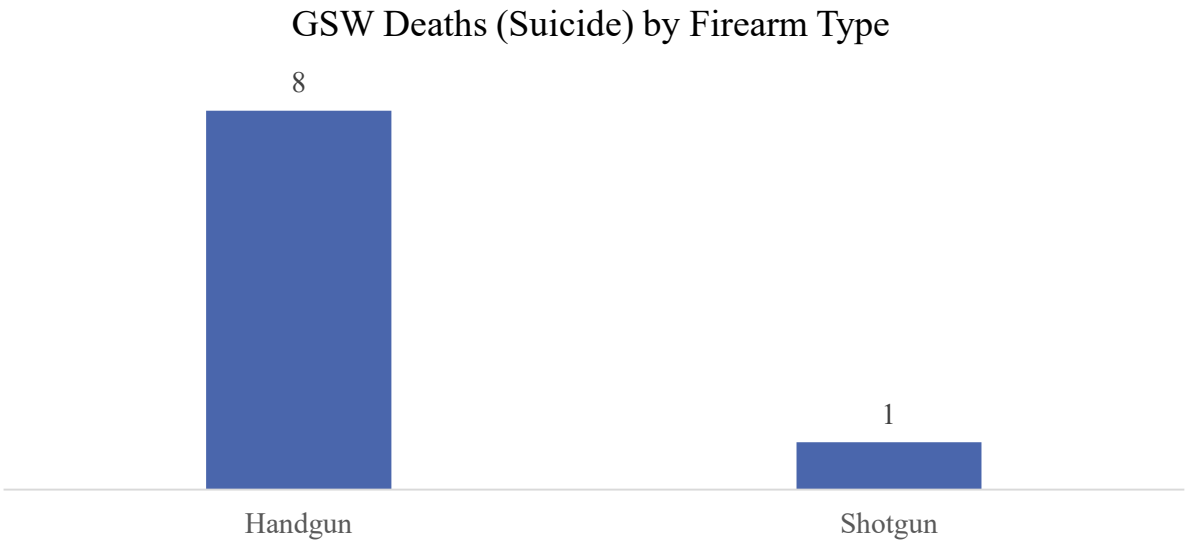


In the graphic above, some GSW (Homicide) deaths had multiple circumstances that contributed to the death.

Gunshot Wound – Suicide

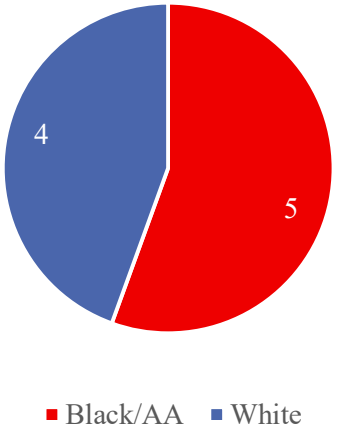
There were 9 (13.4%) GSW deaths that were classified as suicides. Of those, 3 (33.3%) occurred in Richland County, and 1 (11.1%) occurred in each of Aiken, Berkeley, Greenville, Hampton, Horry, and Sumter counties.



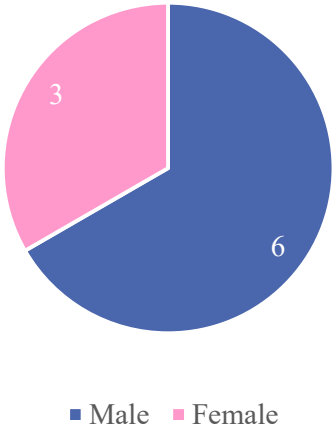


There were 8 (88.9%) GSW deaths that were classified as suicides that involved the use of a handgun, while 1 (11.1%) involved the use of a shotgun.

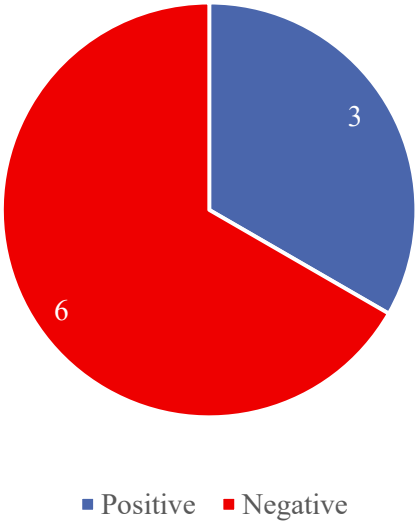
GSW Deaths (Suicide) by Race



GSW Deaths (Suicide) by Sex



GSW Deaths (Suicide) Toxicology



Of the 9 GSW deaths classified as suicides, 3 (33.3%) had a toxicological analysis that revealed the presence of an illicit substance. There were 2 (66.7%) that were positive for THC, 2 (66.7%) were positive for alcohol, and 1 (33.3%) was positive for methamphetamines. 2 (66.7%) children tested positive for multiple substances at the time of their death.

In 5 (55.6%) of the 9 GSW deaths classified as suicides, the firearm was not secured properly by the owner; in 1 (9.1%) death the firearm was secured properly, and in 3 (33.3%) deaths it was not known whether the firearm was secured properly.

Gunshot Wound – Undetermined

Of the 3 GSW deaths that were classified with the manner of death as undetermined, 1 (33%) was a 4-year-old, 1 (33%) was a 16-year-old, and 1 (33%) was a 17-year-old. 2 (66%) were Black/African American and 1 (33%) was Hispanic. 2 (66%) were male and 1 (33%) was female.

There were 2 children whose toxicological analysis revealed the presence of an illicit substance, which included amphetamines, methamphetamines, and THC.

In 2 (66%) of the cases, the firearm was not stored properly by the owner. All 3 deaths involved the use of a handgun.

1 death resulted in an arrest because the victim was shot by another child due to lack of supervision.

Hyperthermia

In 2024, 1 (0.3%) 3-year-old female died from hyperthermia after becoming trapped in a vehicle when the outdoor temperature was 88-degrees Fahrenheit. According to Omnicalculator.com, the expected temperature inside the vehicle after approximately 30 minutes is near 120-degrees Fahrenheit, after 60 minutes it is 130-derees Fahrenheit. The death was ruled an accident.

Natural

There were 56 (17.7%) deaths that were determined to be from natural causes. *(Note: There were 60 deaths that were classified with the manner of death as natural. This section discusses 56 of those cases. Of the remaining 4 deaths, 3 are categorized as Deaths Related to Unsafe Sleep Environment and 1 is categorized as Child Maltreatment after a thorough investigation and medical review with a Child Abuse Pediatrician.)*

SLED DCF investigated these deaths because they were initially thought to be suspicious or unusual, or they were unexpected or unexplained. Natural death may present as sudden, unexpected, or progressive, often resulting from an underlying condition that is not apparent to the child's parent or caregiver. In many instances, the cause of death is not identified until an autopsy is conducted.

The causes of death in these cases included 1 or more of the following natural causes. This is not a comprehensive list of all 56 causes of death; some of the deaths included 1 or more of the following contributing factors:

- Aspiration of amniotic fluid and meconium
- Complications due to:
    - bacterial and/or viral infection (adenovirus, bronchopneumonia, coronavirus, COVID-19, enterovirus, group A streptococcal infection, influenza, parainfluenza, pneumonia, respiratory syncytial virus, rhinovirus, upper respiratory viral infection)
    - asthma
    - cerebral palsy
    - congenital herpes simplex virus infection
    - morbid obesity
    - reactive airway disease
    - prematurity
    - sickle cell trait
    - tracheotomy dependence
- Congenital anomalies
- Heart related disease
- Meningoencephalitis
- Pneumonitis
- Post-operative complications following tonsillectomy
- Sepsis
- Sepsis and Systemic Inflammatory Response
- Sudden unexpected death in epilepsy

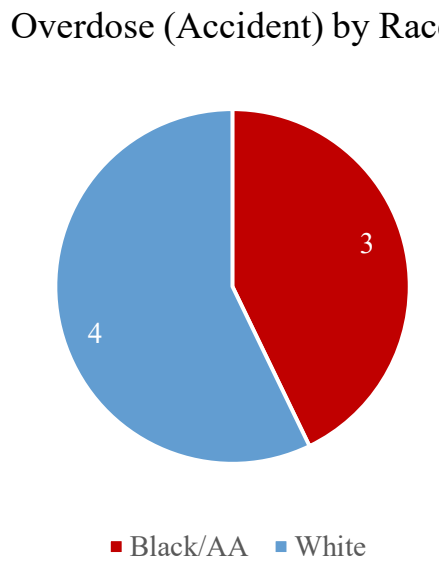
Overdose

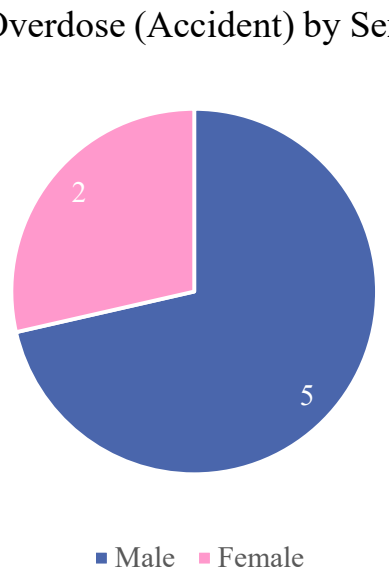
There were 13 (4.1%) overdose deaths in 2024. The manners of death included 7 (53.8%) accidents, 3 (23.1%) suicides, 1 (7.7%) homicide, and 2 (15.4%) undetermined.

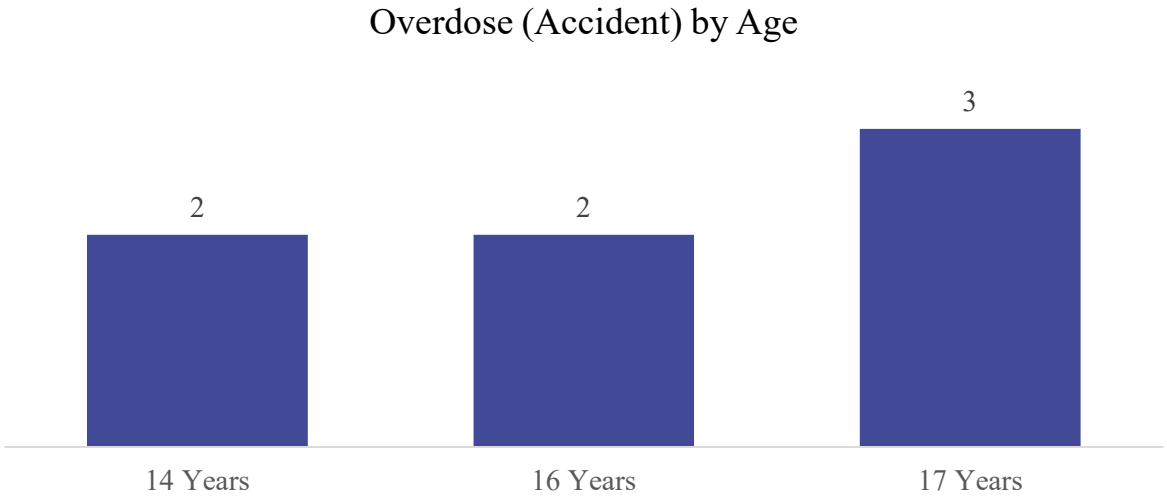
Overdose – Accident

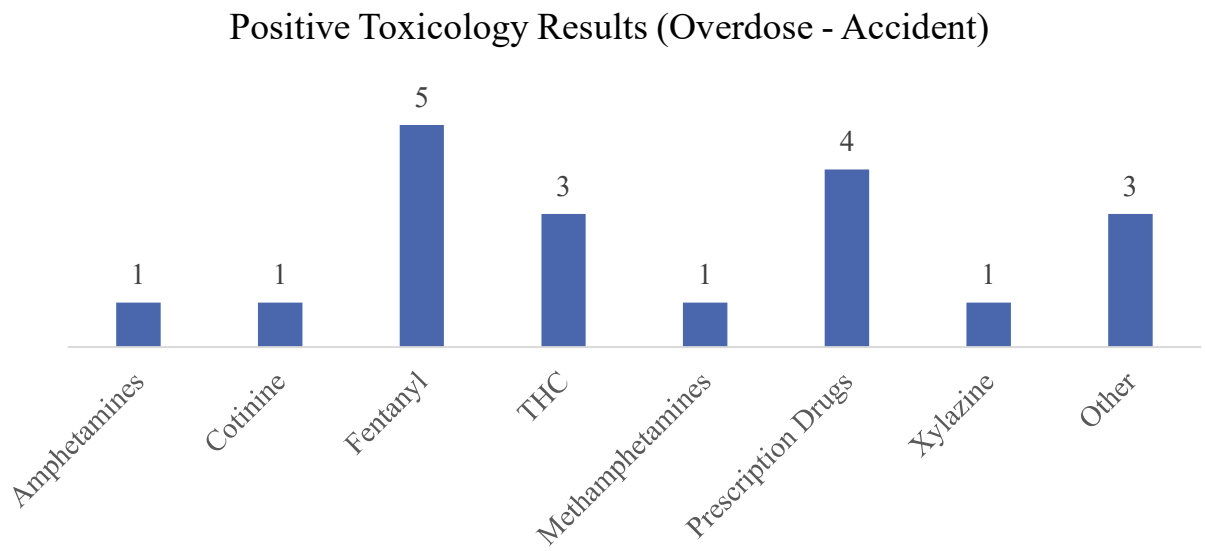
There were 7 overdose deaths that were ruled as accidents. They all occurred at the child's home. In 2 (28.6%) of the overdose deaths ruled accidental, the drugs were not secured properly. In 2 (28.6%) of the deaths, they were secured properly, and in 1 (14.3%) death, it was unknown.

In the accidental overdose death of a 14-year-old, whose toxicological analysis included the presence of MDMA (also known as ecstasy), amphetamines, methamphetamine, and THC, 4 adults in the home were arrested and charged: the mother (charged with Unlawful Conduct Toward a Child), a relative (charged with Possession of Marijuana with Intent to Distribute), a relative (charged with Possession of Marijuana), and a relative (3 counts of Unlawful Conduct Towards a Child).





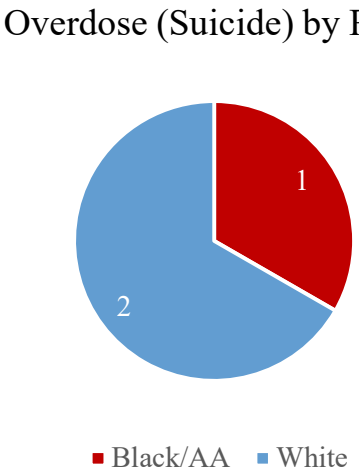


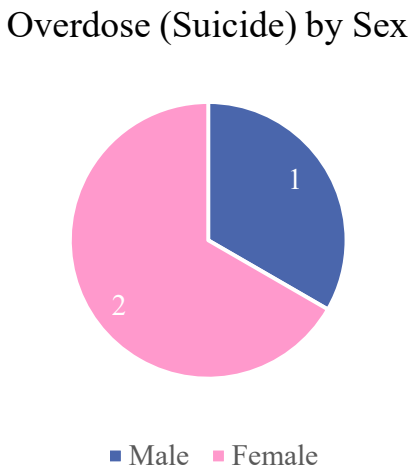


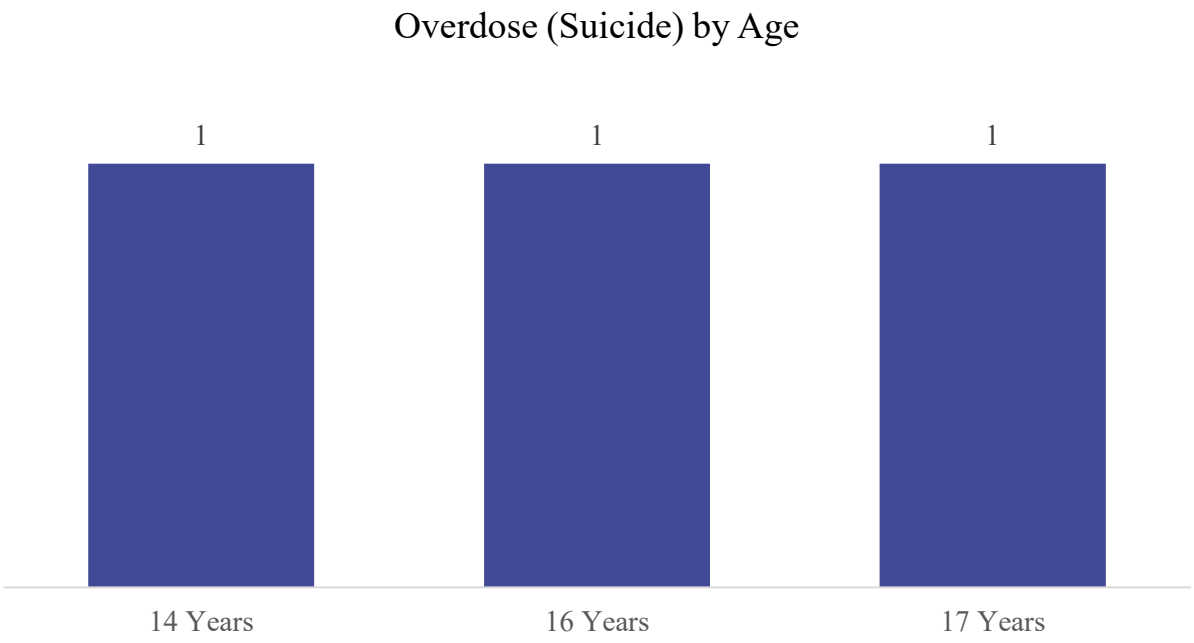
Of the 7 children who died by accidental overdose, 5 (71.4%) were positive for multiple substances. The chart above illustrates the frequency that the substances were identified during analysis.

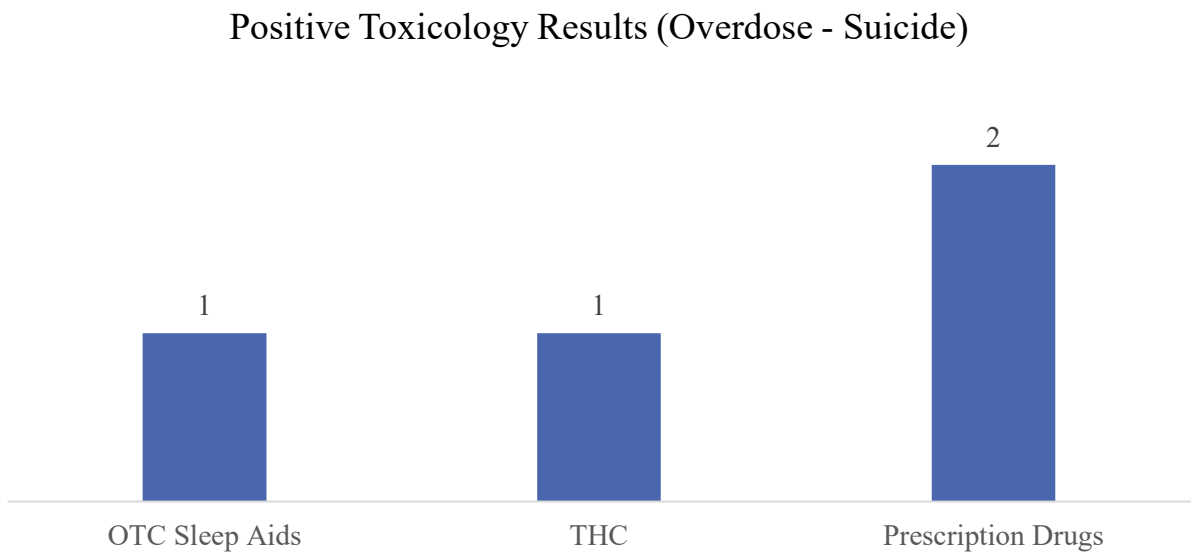
Overdose – Suicide

There were 3 overdose deaths that were ruled suicides. All 3 occurred in the Low Country Region and at the child's home.









Of the 3 children who completed suicide by overdose, 1 was positive for multiple substances. The chart above illustrates the frequency that the substances were identified during analysis.

Overdose – Homicide

In 2024, 1 biracial 10-month-old female died of the toxic effects of fentanyl while at her home. At the time of her death, both she and her mother had positive toxicological analyses for fentanyl. In addition, her mother also tested positive for cocaine. Infant formula, bottles, and a pacifier located on scene also tested positive for the presence of fentanyl. The mother was charged with Homicide by Child Abuse.

Overdose – Undetermined

The manner of death in 2 overdose deaths was unable to be determined. Both overdoses occurred at the child's home. In 1 death, a family member of the child was charged with Homicide by Child Abuse after admitting to using drugs in the home around the time of the child's death. The child was positive for fentanyl and xylazine (a tranquilizer) at the time of death.

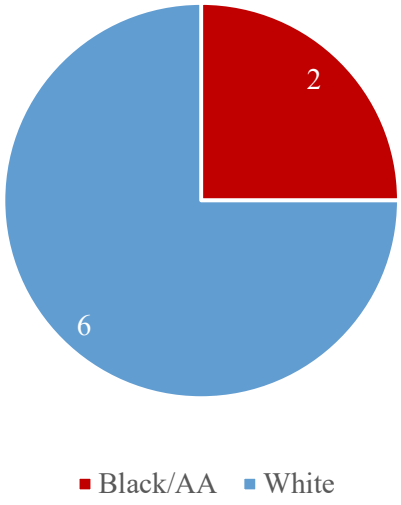
Stabbing

There was 1 (0.3%) child death that was the result of being stabbed. The victim was a 17-year-old black female who was pregnant at the time of the incident. The death was ruled a homicide. Her unborn child's death was also ruled a homicide. An acquaintance was charged with 2 counts of Murder.

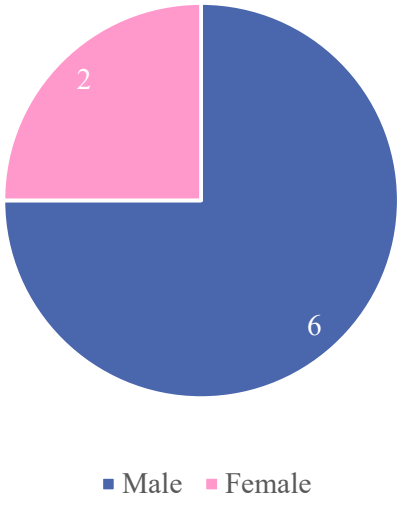
Strangulation

In 2024, there were 8 (2.5%) strangulation deaths. There were 7 (87.5%) ruled suicides, and 1 (12.5%) death was ruled as undetermined. The ligatures used in these deaths included a jacket, sweatshirt, bed sheet, rope, ID lanyard (used in 2 deaths), and belt (used in 2 deaths).

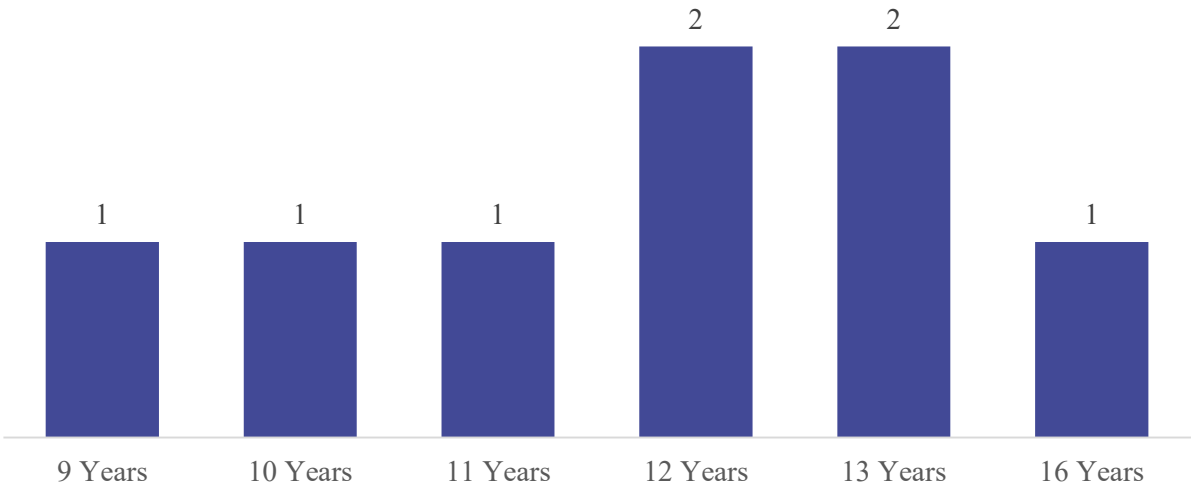
Strangulation Deaths by Race



Strangulation Deaths by Sex



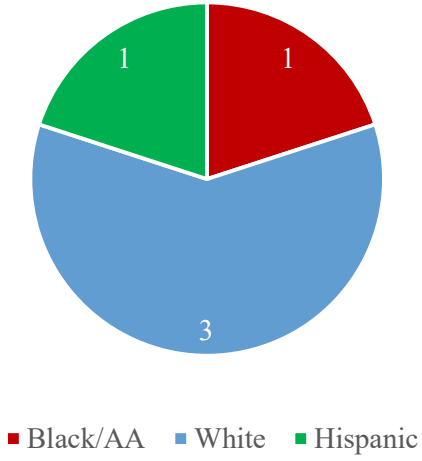
Strangulation Deaths by Age



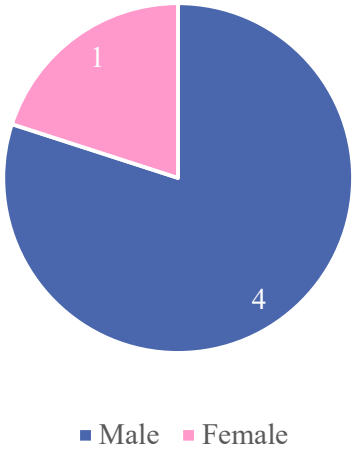
Struck by Vehicle

There were 5 (1.6%) children that died after being struck by a vehicle and sustaining blunt force head trauma in 2024. They were all ruled as accidental deaths. There were 4 (80%) of these deaths that occurred at the child's home or at a relative's home. There were 3 (60%) that occurred while the parent or relative was backing a vehicle in the driveway, and 1 (20%) occurred while the parent or relative was moving forward in the driveway. There was 1 (20%) death that occurred on the roadway when a semitruck struck a child who was riding a motorized minibike.[3]

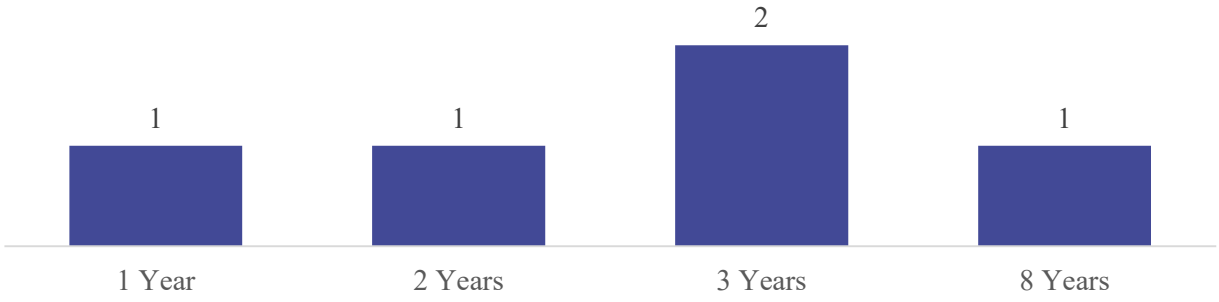
Struck by Vehicle Deaths by Race



Struck by Vehicle Deaths by Sex



Struck by Vehicle by Age



[3] SLED DCF typically does not investigate traffic fatalities that occur in the roadway. This specific death was included in this report because SLED DCF was requested to assist in the investigation of the death by the lead investigating law enforcement agency.

Undetermined

The undetermined category encompasses deaths that have been thoroughly investigated yet the cause and/or manner of death cannot be established based on the available information. In many of these deaths, multiple causes exist, but none can be confirmed with certainty. In 2024, 11 (3.5%) child deaths were best classified as undetermined causes and manners of death.

Of the undetermined deaths, 6 (54.5%) were Black/African American males, 3 (27.3%) were Black/African American females, 1 (9.1%) was a White female, and 1 (9.1%) was a Hispanic male. There were 6 (54.5%) were infants, 3 (27.3%) 1-year-olds, 1 (9.1%) 5-year-old, and 1 (9.1%) 17-year-old.

In the 6 undetermined infant deaths, factors such as congenital conditions, natural disease, unsafe sleep environment, prematurity, and/or maternal THC use during pregnancy contributed to the deaths, but a definitive cause of death was unable to be determined.

In the 3 1-year-olds, factors such as natural disease, congenital conditions, and/or body weight contributed to the death, but no definitive cause of death could be determined.

In the 5-year-old's death, insect killer marketed for outdoor use that was used inside the home could have contributed to the death.

The 17-year-old had a previous GSW to the head and chronic marijuana use that may have contributed to the death.

There was 1 death where the cause of death was determined, but the manner of death was undetermined. The cause of death was determined to be from chronic heart failure. The 1-year-old Black/African American male was born with fetal alcohol syndrome and fetal abstinence syndrome, along with positive toxicology for cocaine, opiates, THC, and ethanol at the time of his birth.

Deaths Related to Unsafe Sleep Environment

In 2024, there were 95 (30%) of the 317 deaths discussed in this report, who died from causes related to an unsafe sleep environment. Unsafe sleep environments include all sleep surfaces that deviate from the American Academy of Pediatrics (AAP) recommendations that includes "supine positioning; use of a firm, non-inclined sleep surface; room sharing without bed sharing; and avoidance of soft bedding and overheating."[4] Positional asphyxia (suffocation) occurs when an infant cannot get enough air to breathe due to the positioning of his/her body, such as where his/her mouth and nose are blocked or where his/her chest cannot fully expand.

Sudden Infant Death Syndrome (SIDS) is a cause of death assigned in infant deaths that cannot be explained after a thorough investigation, including a scene investigation, autopsy, and review of medical records. There were no deaths in 2024 with SIDS as the cause of death.

The cause and manner of death for deaths related to an unsafe sleep environment vary, depending on the factors of the case and how the county coroner chooses to certify the death certificate. Of the 95 unsafe sleep deaths in 2024, 53 (55.8%) were classified as accidents, 39 (41.1%) were classified as undetermined, and 3 (3.2%) were classified as natural deaths. Those that were certified as natural deaths by the county coroner generally had some element of natural disease that contributed to the death. The cause of death varied by specific circumstances of the case but generally included causes such as asphyxiation, hypoxia, overlaying, smothering, sudden unexpected death in infancy (SUDI), suffocation, undetermined, unsafe sleep conditions, and/or wedging.

Of these 95 deaths related to unsafe sleep environments, 75 (78.9%) infants were sharing a sleep surface (hereafter referred to as bed-sharing) at the time they were found unresponsive. In 6 (6.3%) cases, the caregiver fell asleep while feeding and thus created a bed sharing environment. There were 4 breastfeeding at the time and 2 were bottle-feeding. Of the 75 bed sharing deaths, 49 (65.3%) had a safe-sleep alternative that was not utilized.

The most common sleeping places for the 95 deaths related to unsafe sleep environments were adult beds (64 deaths or 67.4%). Others were on a couch (11 deaths or 11.6%), and bassinet (11 deaths or 11.6%). Other sleeping places included cribs, pack n' plays, bouncy chairs, air mattresses, floors, and a wicker basket.

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4 Rachel Y. Moon, Rebecca F. Carlin, Ivan Hand, The Task Force on Sudden Infant Death Syndrome and The Committee on Fetus and Newborn; Sleep-Related Infant Deaths: Updated 2022 Recommendations For Reducing Infant Deaths In The Sleep Environment. Pediatrics July 2022.

In 4 (4.2%) of the deaths involving unsafe sleep environments, infants were placed to sleep on or next to U-shaped pillows. In 1 death, the infant's head was placed on a neck pillow. In 1 death, a hands-free bottle-feeding device was being utilized.

In 84 (88.4%) unsafe sleep environment deaths, the death occurred at the child's home, 6 (6.3%) occurred at a relative's home, 2 (2.1%) at a friend's home, 2 (2.1%) at a hotel or vacation rental, and 1 (1.1%) at a babysitter's home.

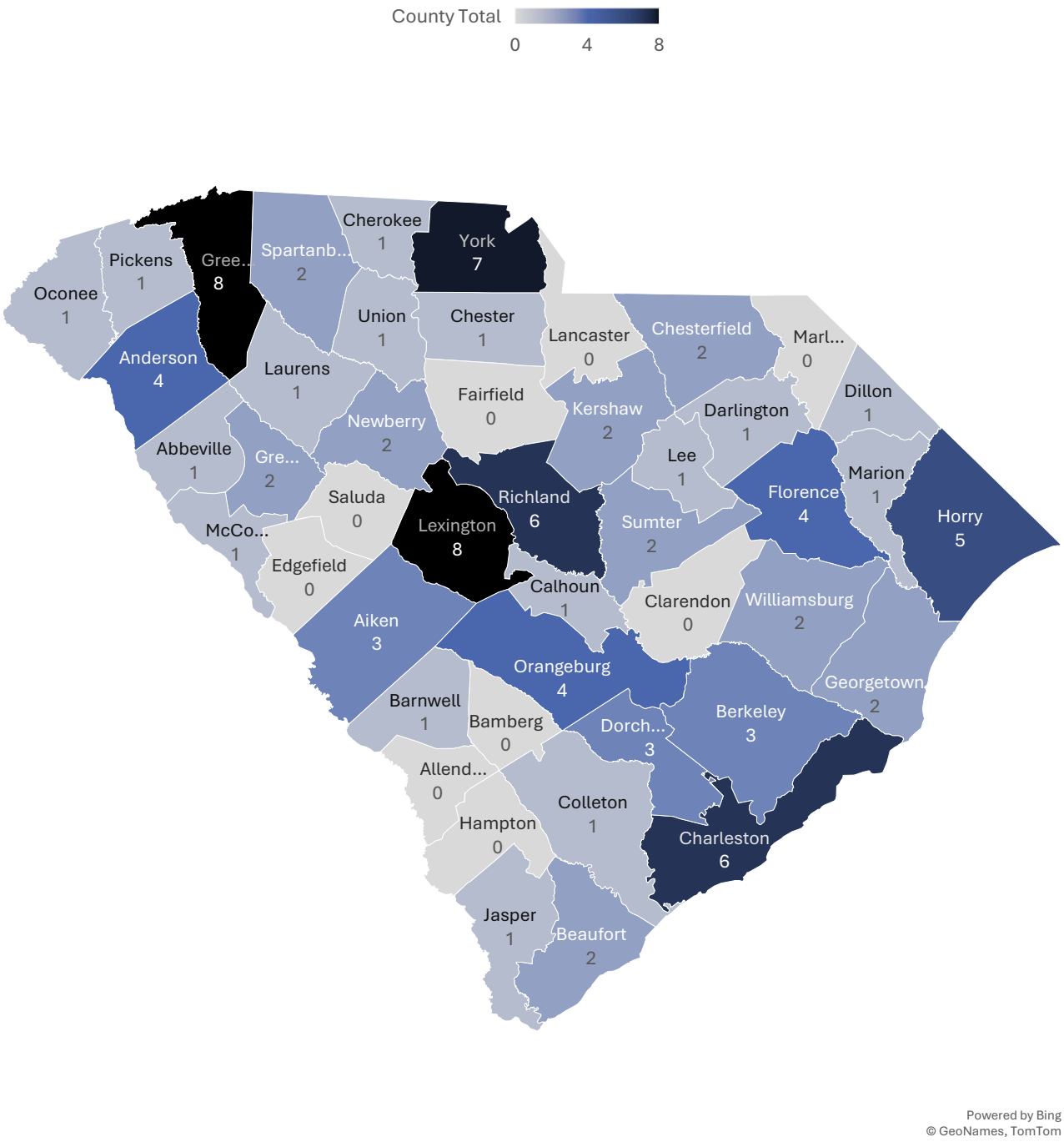
Typically, unsafe sleep deaths only involve infants, under the age of 1. This is because children over the age of 1 are able to move themselves out of an unsafe sleep environment that may cause asphyxiation. In 2024, 1 death was related to the sleep environment in children over the age of 1. In that case, prematurity and the presence of viruses contributed to the death after bed sharing with an adult and sibling.

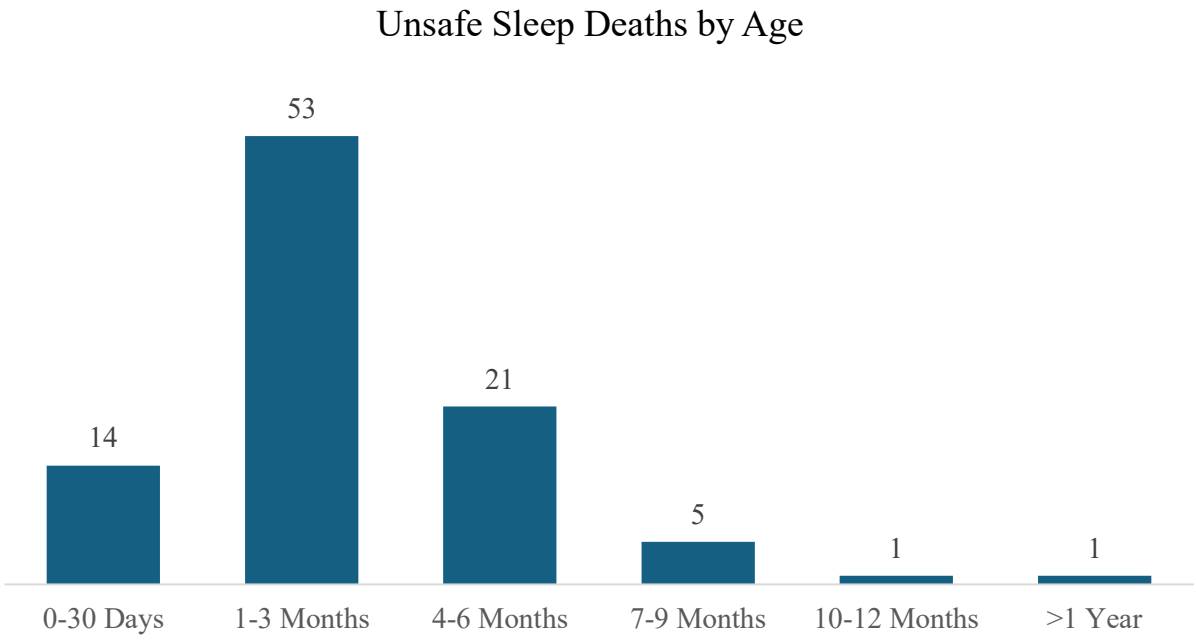
In 8 (8.4%) of the 95 deaths related to unsafe sleep, arrests were made. In 7 (87.5%) of these cases, the infant was sharing a sleep surface with other adults and/or children. In 6 (75%) of these cases, toxicological analysis of the caregiver's blood revealed the presence of drugs and/or alcohol. In all 8 cases with arrests, the mother was charged with Unlawful Conduct Toward a Child. The table below outlines the sleep environment and caregiver toxicology results at the time of the infant death. *Note: Additional factors and probable cause related to the death are not listed.*

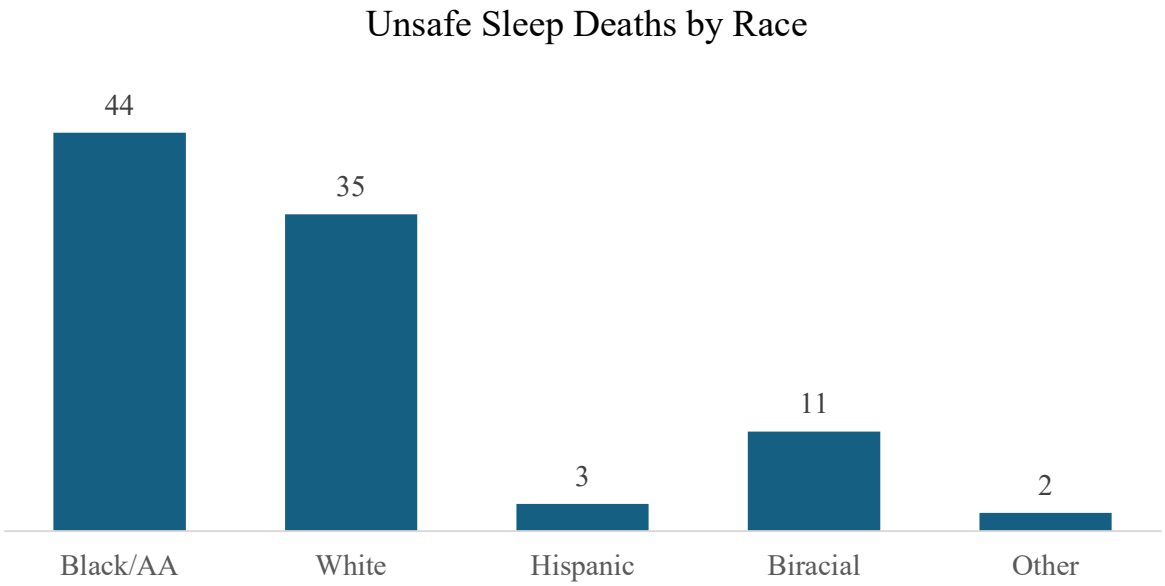
Sleep Environment and Caregiver Toxicology	Person Arrested and Charge(s)*
Bed-sharing with mother who was positive for THC	Mother – Unlawful Conduct Toward a Child
Bed-sharing with mother who was positive for ethanol	Mother – Unlawful Conduct Toward a Child
Sleeping on couch with siblings; mother was positive for amphetamine and methamphetamine	Mother – Unlawful Conduct Toward a Child
Sleeping on couch with another child; children left alone	Mother – Unlawful Conduct Toward a Child and Obstruction of Justice; Family Member – Obstruction of Justice
Placed prone on adult sized pillow in a basinet with blankets by mother	Mother – Unlawful Conduct Toward a Child
Bed-sharing with mother who was positive for Clonazepam metabolite	Mother – Unlawful Conduct Toward a Child
Bed-sharing with mother who was positive for THC	Mother – Unlawful Conduct Toward a Child
Bed-sharing with parents; mother was positive for methadone and methamphetamine	Mother – Unlawful Conduct Toward a Child

**Unlawful Conduct Toward a Child – S.C. Code Ann. § 63-5-70; Obstruction of Justice, Common Law*

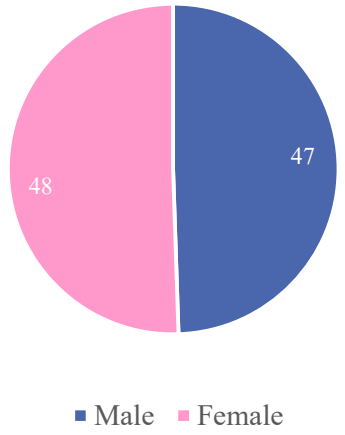
Unsafe Sleep Deaths By County




Unsafe Sleep Deaths by Age
53
14
21
5
1
1
0-30 Days
1-3 Months
4-6 Months
7-9 Months
10-12 Months
>1 Year

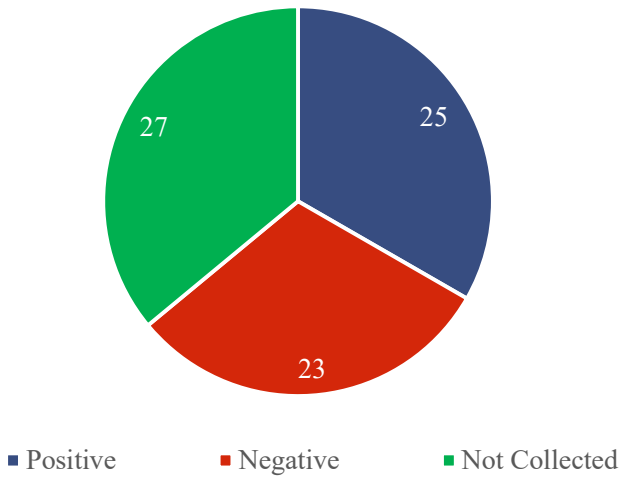

Unsafe Sleep Deaths by Race
44
35
3
11
2
Black/AA
White
Hispanic
Biracial
Other

Unsafe Sleep Deaths by Sex

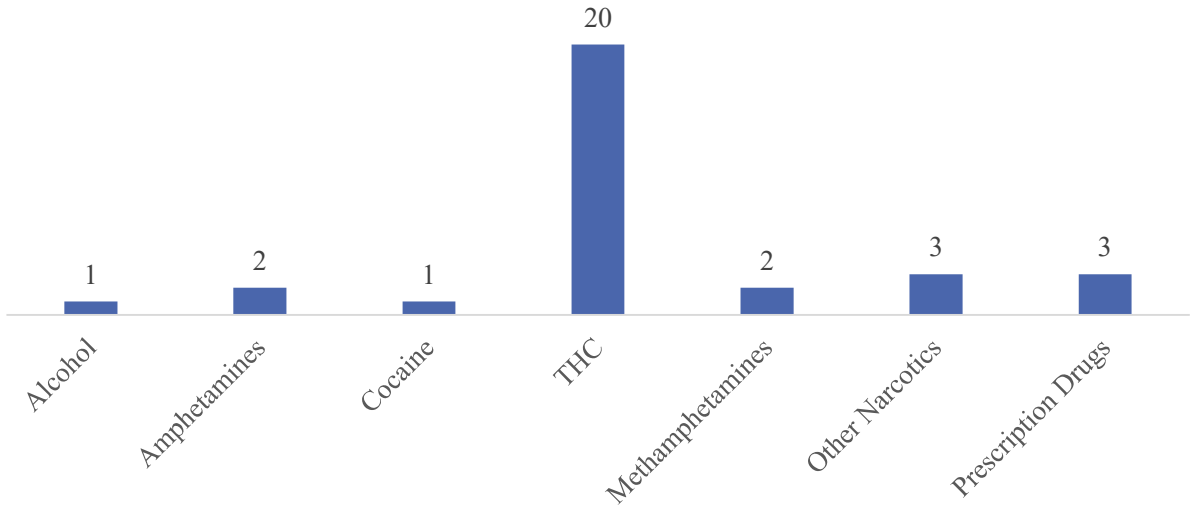


It is best practice for infant death investigations that caregiver(s) are offered or, depending on the circumstances, ordered to submit to toxicological analysis of their blood and/or urine. In the 75 cases of bed-sharing, caregivers submitted to toxicological analysis in 48 (64%) cases. There were 25 (33.3%) caregivers in those 75 bed-sharing deaths that tested positive for a drug or alcohol.

Toxicology on Caregivers (Bed-sharing Deaths)



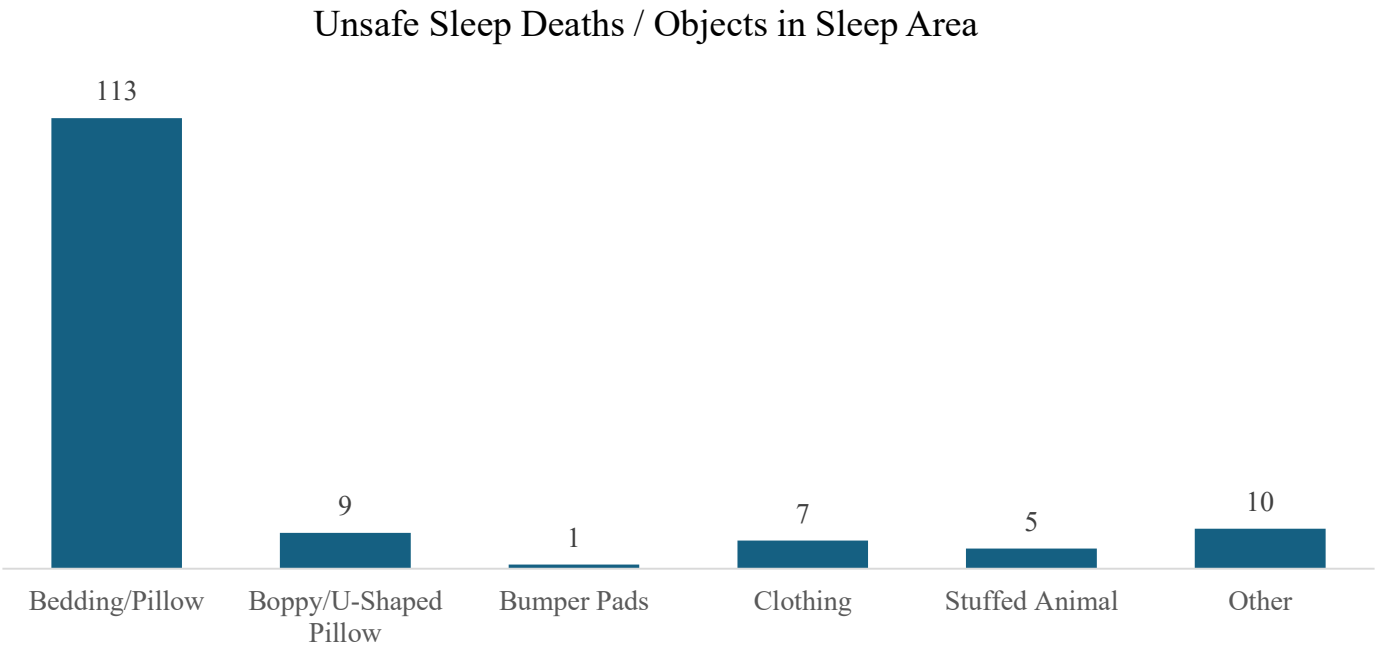
Positive Toxicology Results for Caregivers (Bed-sharing Deaths)



Of the 25 caregivers that tested positive for an illicit substance, 20 (80%) caregivers tested positive for THC. The remaining 5 (20%) caregivers were under the influence of either alcohol, amphetamines, cocaine, methamphetamines, or some other narcotic or prescription drug. Of the 25 caregivers that tested positive for an illicit substance, 7 were positive for multiple substances. The chart above illustrates the frequency that the substances were identified during analysis.

Best practice in infant death investigations also includes the use of a doll for caregivers to conduct a reenactment to show the position of how they placed the child to sleep, the position of the child the last time they were known alive, and the position they found the child when they were discovered unresponsive. This allows caregivers to show investigators the positioning of the infant in the sleep environment and to supplement their oral explanations. The reenactment is video-recorded, and the pathologist conducting the autopsy is provided a copy. Of the 95 unsafe sleep deaths, reenactments were conducted in 74 (77.9%) cases.

Of the 95 unsafe sleep deaths in 2024, 50 (52.6%) children were placed to sleep on their back by the caregiver(s), 18 (18.9%) were placed to sleep on their stomach, 9 (9.4%) were placed to sleep on their side, and in 18 (18.9%) deaths the sleep position was unknown. There were 32 (33.7%) children who were found unresponsive on their stomachs, 30 (31.6%) were found on their back, 19 (20%) were found on their side, and in 14 (14.7%) deaths the position in which the child was found was unknown.



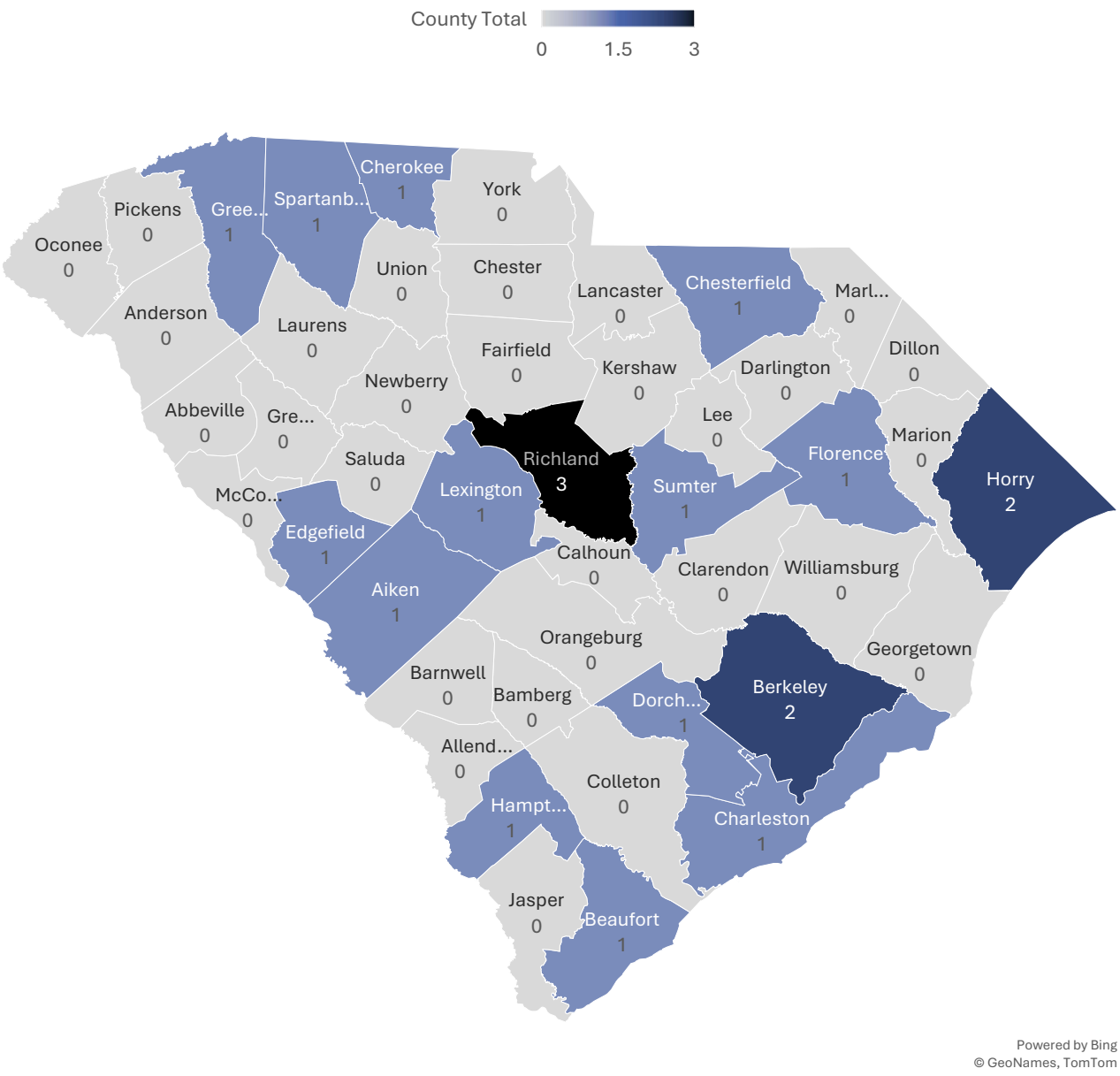
Of the 95 unsafe sleep deaths in 2024, 69 (72.6%) had an unsafe object in their sleep area. There were 17 (24.6%) deaths where multiple unsafe objects were in the child's sleep area. The chart above illustrates the frequency that the unsafe objects were found in a sleep area.

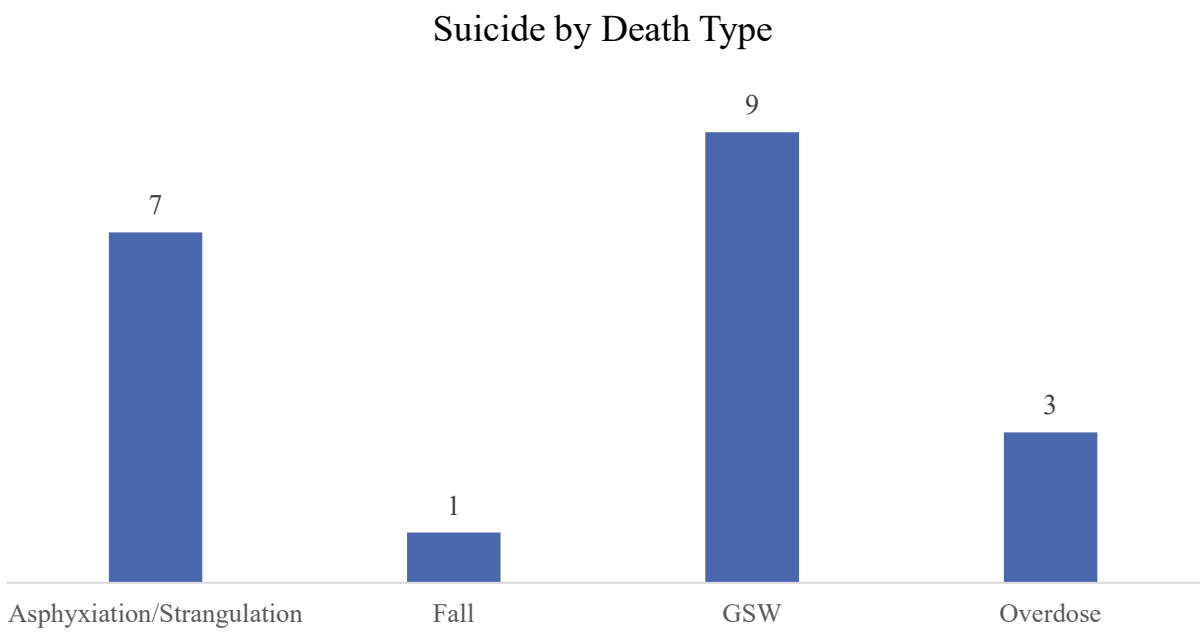
Of the 95 unsafe sleep deaths in 2024, 74 (77.9%) of children were in their usual sleeping environment (such as at their home), while 16 (16.8%) were in a different environment than usual (such as on vacation or at a relative's home). This information was unknown in 5 cases.

Suicide

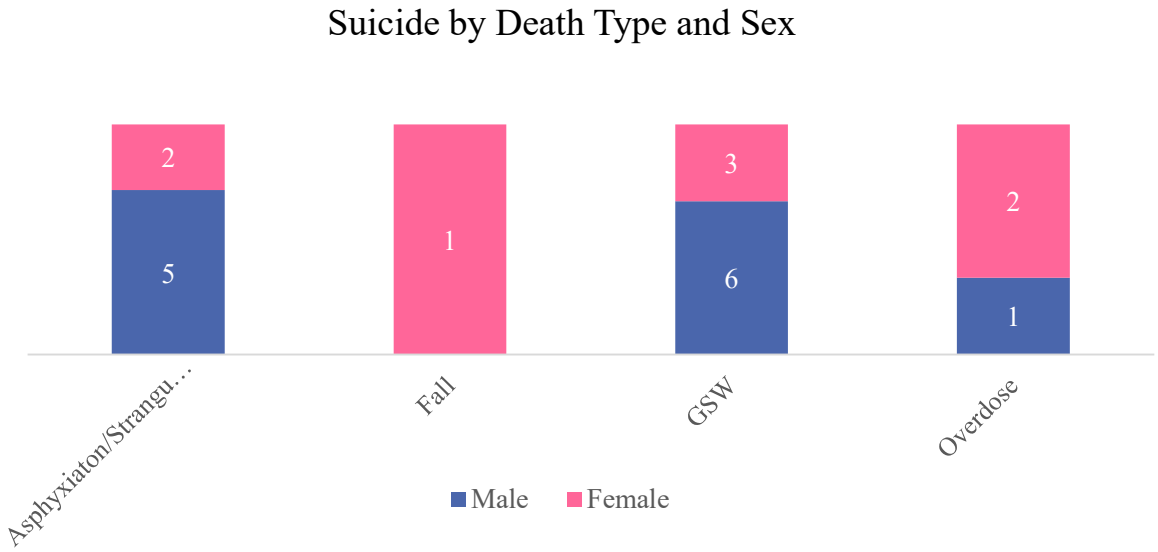
In 2024, 20 (6.35%) deaths had suicide listed as the manner of death. There were 3 of those deaths that occurred in Richland County, 2 each occurred in Berkeley County and Horry County, and 1 death occurred in Aiken, Beaufort, Charleston, Cherokee, Chesterfield, Dorchester, Edgefield, Florence, Greenville, Hampton, Lexington, Spartanburg, and Sumter counties.

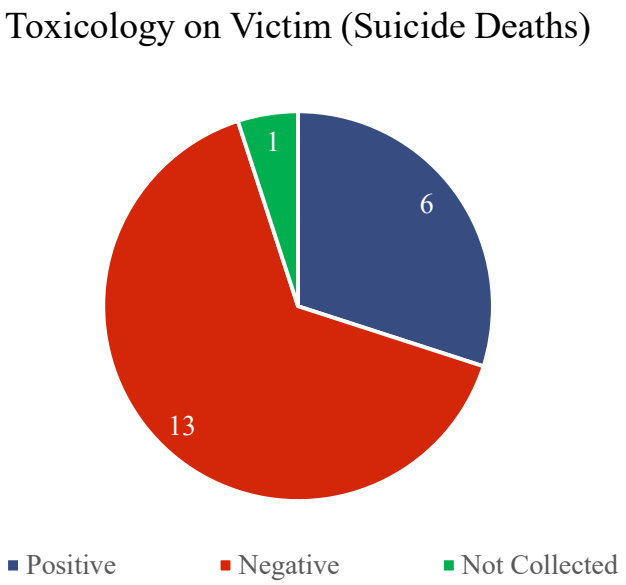
Suicide Deaths by County

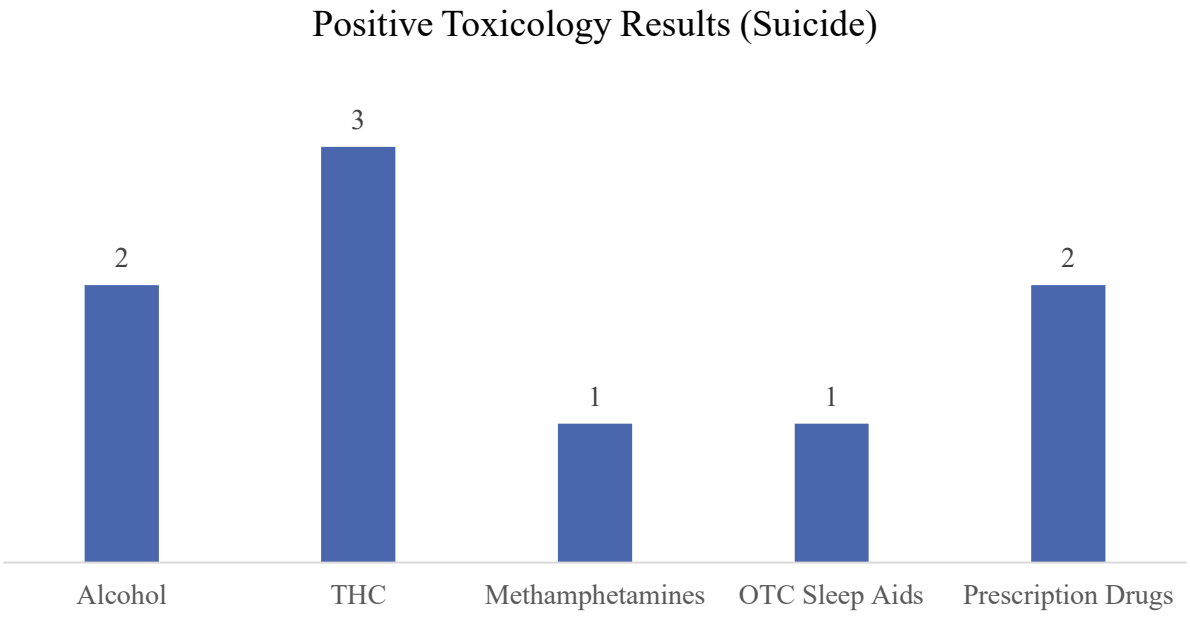




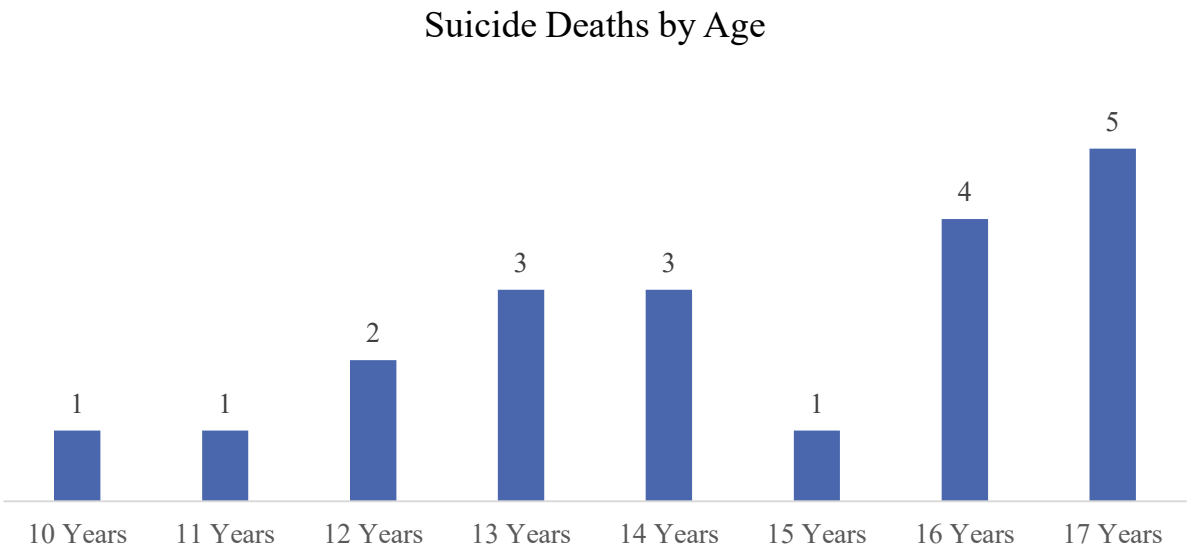
In 2024, 9 (45%) suicides were completed by GSWs, 7 (35%) were from asphyxiation or strangulation by hanging, 3 (15%) were from overdoses, and 1 (5%) was from a fall or jump. In 8 of the 9 suicides completed using a gun, a handgun was used. In 1 death, a shotgun was used. In 5 cases, the firearm was not stored properly by the owner. In the 3 suicide deaths from overdoses, 1 was due to diphenhydramine, and 2 were due to bupropion.

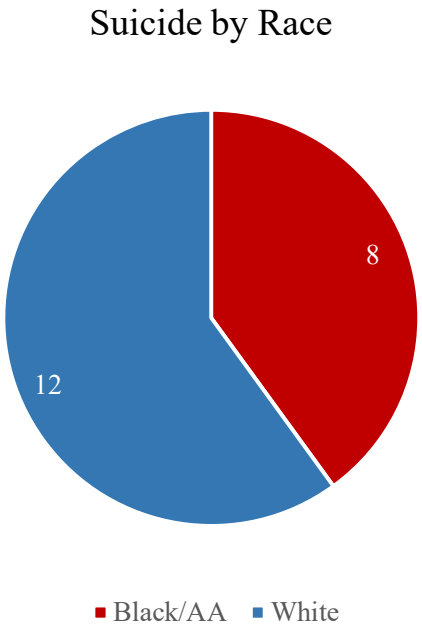


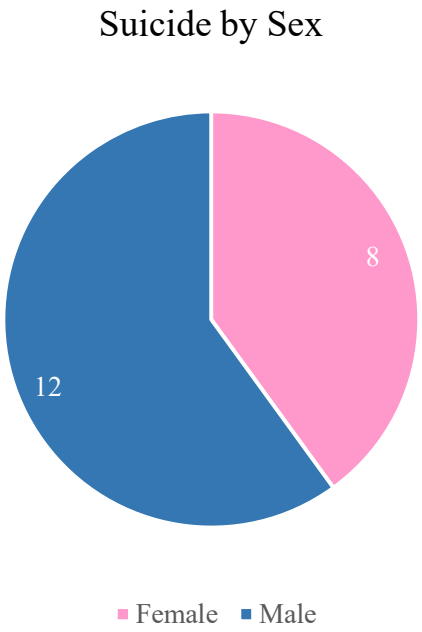




There were 6 (30%) children that had substances identified in their toxicological analyses at the time of the child's death. Of those 6 children, 3 were positive for multiple substances. The chart above illustrates the frequency that the substances were identified during analysis.







Of the 20 suicide deaths, 12 (60%) were White and 8 (40%) were Black/African American. Furthermore, 60% of suicide deaths were male and 40% were female.

In the 12 suicide deaths involving White children, 7 (58.4%) were male and 5 (41.6%) were female. In the 8 suicide deaths involving Black/African American children, 5 (62.5%) were male and 3 (37.5%) were female.

The most common circumstances for suicide deaths were an argument with a parent or caregiver and a breakup with a significant other. Each of those circumstances were identified in 6 (30%) suicide deaths in 2024. Other circumstances identified were parents' divorce or separation (4 deaths, or 20%), problems at school (4 deaths, or 20%), argument with a sibling (3 deaths, or 15%), known victim of bullying (2 deaths, or 10%), known victim of child abuse/neglect (2 deaths, or 10%), and known victim of sexual assault (2 deaths, or 10%). Many suicide deaths had multiple circumstances that precipitated the death. In 1 death, the circumstances that precipitated the suicide were unable to be determined.

There were 3 (15%) children who completed suicide that had a history of prior suicide threats, 4 (20%) had a history of prior suicide attempts, 7 (35%) had a history of mental health disorder(s), 4 (20%) were on medication for a mental health diagnosis, 4 (20%) had a history of substance abuse, and 2 (10%) had prior inpatient treatment for a mental health diagnosis.

There were 4 (20%) children that left a note prior to completing suicide.

There was 1 strangulation by hanging death that resulted in the mother being charged with 2 counts of Unlawful Conduct Toward a Child. The suicide occurred while the mother left 2 children unsupervised at home for several days without food.

Conclusion

The SLED Special Victims Unit remains firmly committed to ensuring that every child death in South Carolina is investigated with accuracy, completeness, and thoroughness. Additionally, families and caregivers are treated with the highest degree of respect and dignity throughout the process. The agents investigating these deaths are dedicated to the meticulous collection of all facts and evidence in each case in order to assist the coroner with the necessary information to determine the cause and manner of death. Furthermore, the agents remain vigilant in identifying any criminal elements that may have contributed to the child's death, thereby upholding the integrity of the investigative process and the pursuit of justice for the child who has lost his/her life. The agents do this while ensuring that each local law enforcement agency has the knowledge and assistance they need to adequately complete their investigation.

This report provides a summary of the data collected on the circumstances surrounding each child death SLED SVU investigated in 2024. Its purpose is to share these findings to raise awareness. It is the unit's hope that the information contained in this annual report will be utilized to influence positive changes for the well-being of all children in South Carolina.