Georgia Child Fatality Review Panel

Annual Report - Calendar Year 2018

Peggy Walker
Acting Panel Chairman

Brian Kemp
Governor

The Child Fatality Review Panel Members

Peggy Walker – Panel Acting Chair, Judge, Douglas County Juvenile Court

Vacant – Panel Vice-Chair,

Vic Reynolds – Director, Georgia Bureau of Investigation

Mandi Ballinger – Member, Georgia House of Representatives

Kathleen Bennett – Retired Mental Health Specialist

Judy Fitzgerald – Commissioner, Department of Behavioral Health and Developmental Disabilities

Gloria Butler – Member, Georgia State Senate

Kathleen E. Toomey – Commissioner, Department of Public Health

Robertiena Fletcher – Board Chair, Department of Human Services

Charles Fuller – Chair, Criminal Justice Coordinating Council

Tom Rawlings – Director, Division of Family and Children Services

Tiffany Sawyer – Prevention Director, Georgia Center for Child Advocacy

Richard Hawk – Coroner, Coweta County

Paula Sparks – Investigator, Georgia Peace Officer Standards and Training Council

Dr. Jonathan Eisenstat – Chief Medical Examiner, Georgia Bureau of Investigation

Rachel Davidson – Director, Office of the Child Advocate

Natalie Paine – District Attorney, Augusta Judicial Circuit

Amy Jacobs – Commissioner, Department of Early Care and Learning

Vacant – Member, State Board of Education

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Mission

The mission of the Georgia Child Fatality Review Panel is to provide the highest quality of child fatality data, training, technical assistance, investigative support services, and resources to any entity dedicated to the well-being and safety of children to prevent and reduce child abuse and fatality in the state. The mission is accomplished by promoting more accurate identification and reporting of child fatalities, evaluating the prevalence and circumstances of both child abuse and child fatalities, and developing and monitoring the statewide child injury prevention plan.

The Georgia Child Fatality Review Panel, each county-level review committee, their functions and membership requirements are established in Georgia statute (19-15-1 through -6).

Acknowledgments

The Georgia Child Fatality Review Panel acknowledges the following people and entities whose enormous commitment, dedication, and unwavering support to Child Fatality Review have made this report possible:

- All the members who serve on each of the County Child Fatality Review Committees
- John T. Carter, PH.D., M.P.H., Emeritus Assistant Professor, Rollins School of Public Health, Emory University

The report was developed and written by the staff members of the Child Fatality Review Unit within the Georgia Bureau of Investigation.

Letter from the CFR Panel Chair

Former Governor Nathan Deal and the Honorable Governor Brian Kemp and Members of the Georgia General Assembly:

We present the Annual Report of the Georgia Child Fatality Review Panel for data collected in the calendar year of 2018. This data has been reported to the Panel by the 159 county fatality review panels of the state pursuant to statutory requirements. This information is provided to you as part of our ongoing efforts to prevent and decrease child fatalities in Georgia. Thank you for the continuing partnership in this important effort.

This report is a transition in reporting format to use multi-year data to analyze specific topics related to Georgia's 1,435 child deaths in 2018. Many of these deaths do not meet criteria for review as these are deaths of infants on the first day of life and in the first month thereafter arising from medical complications related to prematurity and congenital defects. Certainly, this significant number of deaths points to Georgia's need to support access to medical care for pregnant women and maternal health.

There were 483 reviewable deaths for 2018 with 440 reviews completed. Child Fatality Review focuses upon unintentional deaths (30%) and intentional deaths (24%). Areas of concern include sleep related deaths of infants and toddlers; motor vehicle related accidents particularly among teens 15 to 17 years of age; suicide of children who are young, preteens and adolescents; and homicides of children.

We must educate and promote public awareness of our consistent messaging on the ABC's of safe sleep (Alone, on the Back, in a Crib) in every contact with families throughout our State. Our efforts to promote safe driving among our teens as well as use of child safety seats and booster seats, proper installation of child safety seats, and avoidance of distracted driving must continue. We must also engage communities on implementation of Georgia's suicide prevention plan to support our children who need additional support with stressors and the difficulties of social and emotional regulation. We also have an opportunity to plan prevention strategies by regions as the Division of Family and Children Services implements Georgia's new Prevention Plan.

The Georgia Bureau of Investigation and Director Victor Reynolds, his agents and staff continue to enhance support for this Panel's mission. Their contributions are vital to the important work of preventing child deaths throughout the State.

Thank you for your attention to this report and its findings. Together, we shall accomplish our mission to reduce and prevent child deaths in Georgia.

Sincerely,

Judge Peggy H. Walker
Acting Chair for Child Fatality Review Panel

Background and History

The child fatality review process was initiated in Georgia in 1990 as an amendment to an existing statute for child abuse protocol committees. The legislation provided that each county child abuse protocol committee establish a subcommittee to systematically in collaboratively review child deaths that were sudden, unexpected, and/or unexplained, among children younger than 18 years of age.

The Child Fatality Review committees became a state-wide, multidisciplinary, multi-agency effort to prevent child deaths. Georgia code section 19-15-1 through 6 has been amended over the years, adding even more structure, definition, and members to the process. Members now form a stand-alone committee instead of a subcommittee, which has added emphasis to the importance of the function. Through the State Panel and the work of the local committees, we have the opportunity to learn from tragedy, prevent deaths, and give a new generation hope. Agencies and organizations working together at the state and local level offer the greatest potential for effective prevention and intervention strategies.

The purpose of these reviews is to describe trends and patterns of child deaths in Georgia and to identify prevention strategies. As mandated in statute, this report identify specific policy recommendations to reduce child deaths in Georgia.

The members of the Georgia fatalities review panel are experts in the field of child abuse prevention, mental health, family law, death investigation, and injury prevention. The variety of disciplines involved, and the depth of expertise provided by the State Review Panel results in comprehensive prevention recommendations, allowing for a broad analysis of both contributory and preventative factors of child deaths.

Executive Summary

Each year, the Georgia Child Fatality Review Panel publishes an annual report chronicling preventable deaths of children in Georgia. These deaths are identified through death certificate data provided by the Office of Vital Records within the Division of Public Health.

Child deaths are often viewed as an indicator of the health of the community in which they occur. While child death data provide an overall picture of child deaths by number and cause, the meticulous review of each child's death is the best teacher on how to prevent future deaths.

Local Child Fatality Review (CFR) Committees examine child deaths that are sudden, unexpected or unexplained ("eligible") and complete a standardized form detailing the circumstances of the deaths. These child death data are useful in revealing recurring patterns, indicating prevention gaps and opportunities. We encourage all who are concerned about the welfare of Georgia's children to use these data to make life-saving decisions for our children.

The 2018 Annual Report represents a transition in the GA CFR reporting format. The National CDR data system is now a source for seven years of GA fatality review data. We are planning to use this multi-year data to conduct analyses on specific topics related to Georgia infant and child deaths. The topics may address specific causes of death (sleep-related, suicide, drowning) or cross-cutting subjects (maltreatment, supervision). Completed and documented analyses will be released and posted on the CFR website. The following sections of this 2018 CDR Report address two "cross-cutting" topics – prevention and maltreatment. Some cause-specific detail is included, but detailed analysis using multi-year data will follow later.

Reported Child Deaths in Georgia

In 2018, there were a total of 1,435 child deaths in Georgia. Of those 1,435 child deaths, 483 deaths met the eligibility criteria for county level Child Fatality Review. Of the 483 deaths that met the review criteria, 440 were reviewed (91.1%).

Any infant or child death is loss to society and a tragedy for the immediate family. The child fatality review (CFR) process was developed to provide a way to learn from these deaths so that future deaths could be prevented. A "learning process" can take place at three levels:

1

Community (county): A local CFR team reviews the individual deaths, enters data abstracted from the review into a GA (and National) database, and develops recommendations for action at the community level.

2

Georgia: The GA CFR Panel – through work by staff from the GA Child Fatality Review – reviews the analysis of the state-wide CFR data and prepares recommendations (legislation, education, and environmental) designed to reduce childhood injury and associated death.

3

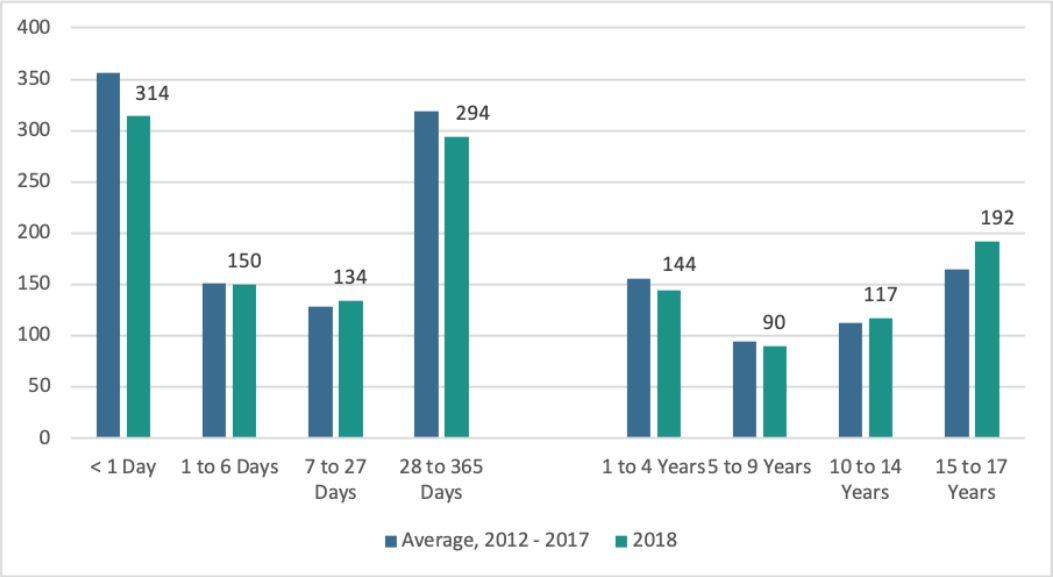
Nation: The National Center for the Review and Prevention of Child Deaths (NCFRP) maintains the national database and provides an opportunity for research on child deaths at the national level.

This annual CFR Report indicates trends in child deaths, summarizes the GA CFR 2018 activities, and provides a synthesis of the local CFR teams' prevention recommendations. The CFR Panel serves as one of the citizen review panels for the GA Child Abuse Prevention and Treatment Act (CAPTA), so one section explicitly addresses child maltreatment.

2018 Child Deaths:

There were 1,435 reported deaths of Georgia residents ages less than 18 in 2018. A majority of these were infant deaths (892, or 62%), and 314 of the infant deaths occurred in the 1st day of life (Figure 1). An additional 284 occur within the 1st month and these three age categories define "neonatal deaths". These neonatal deaths are generally associated with prematurity and congenital defects, and they are not usually a subject for CFR. The sleep-related infant deaths are the largest category of post-neonatal deaths, and they are reviewed.

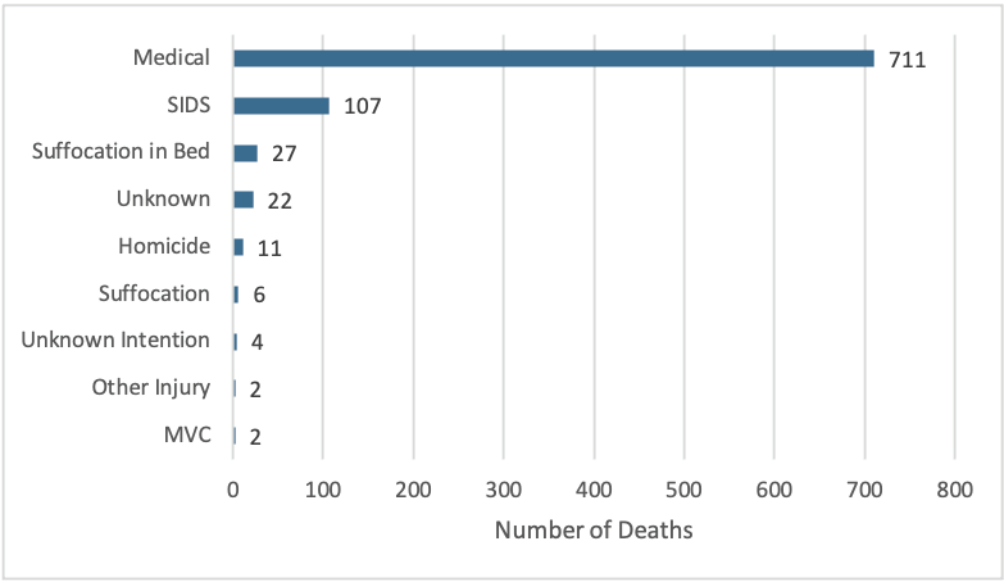
Figure 1. Number of Infant and Child Deaths by Age, Georgia



The 2018 Kids Count data showed a U.S. infant mortality rate of 5.7 per 1,000 and a GA rate of 7.0. The child and teen, ages 1 to 19, death rates were 25 per 100,000 for the U.S. and 28 for GA. Georgia's rate for both mortality measures is slightly higher than the National rate.

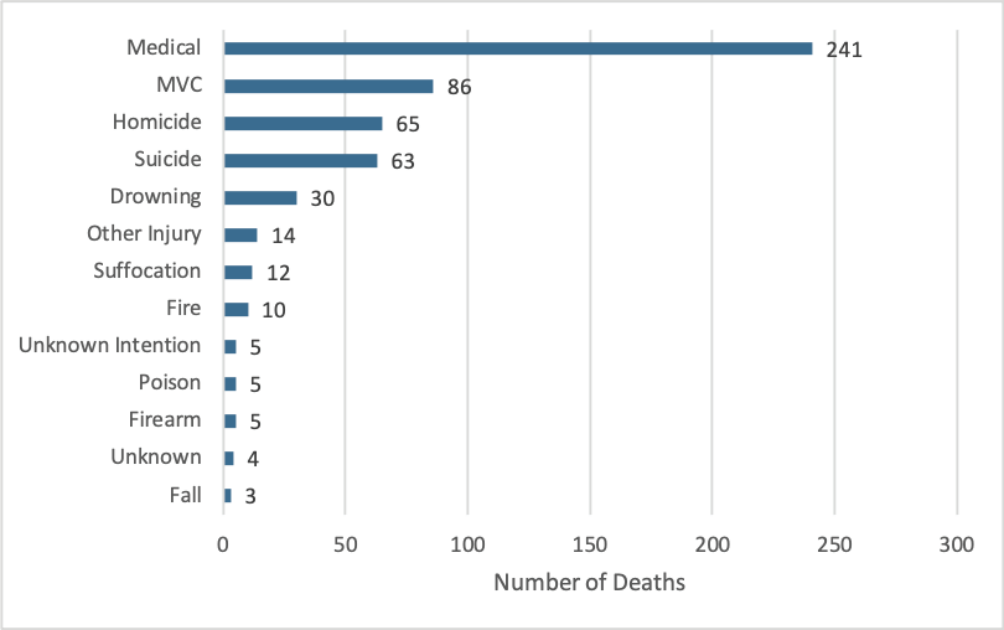
The 2018 infant deaths (Figure 2) are dominated by "medical" causes (80% of all infant deaths). The three next largest causes – SIDS, suffocation in bed, and unknown – comprise the combined category of "sleep-related" deaths and account for 17% of all infant deaths. However, these sleep-related deaths made up 47% of all post-neonatal infant deaths.

Figure 2. 2018 Georgia Infant Deaths, by Cause



The estimated population of children ages 1 through 17 in 2018 was 2,377,545, and there were 543 deaths in that population in 2018. Deaths are more common among toddlers and teens, and these age differences are associated with specific causes of death. Deaths attributed to medical causes continue to be the largest category of death for ages 1 through 17 years (44%), but Figure 3 shows the significant number of deaths from unintentional (30%) and intentional (24%) injuries.

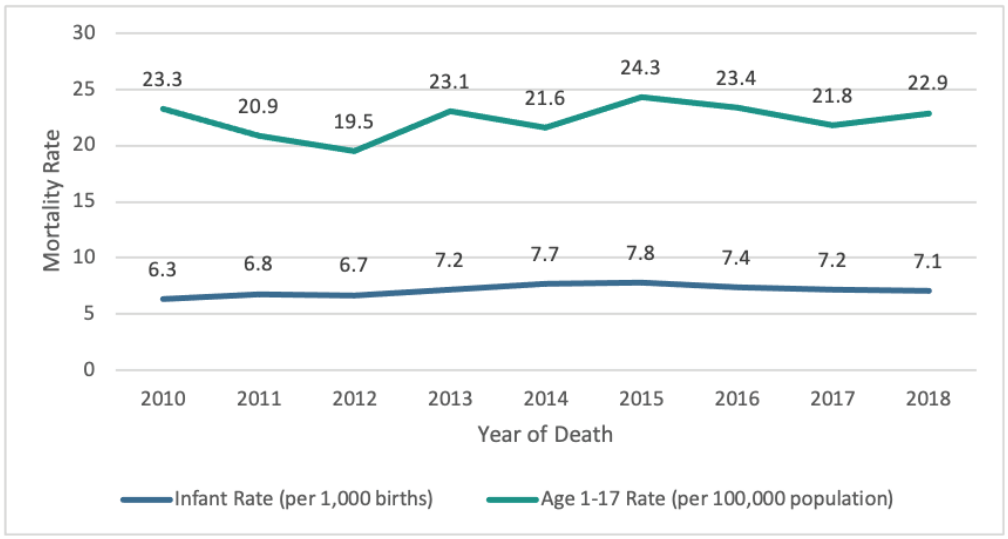
Figure 3. 2018 Georgia Deaths, Ages 1 - 17, by Cause



Trends in Georgia Infant and Child Deaths:

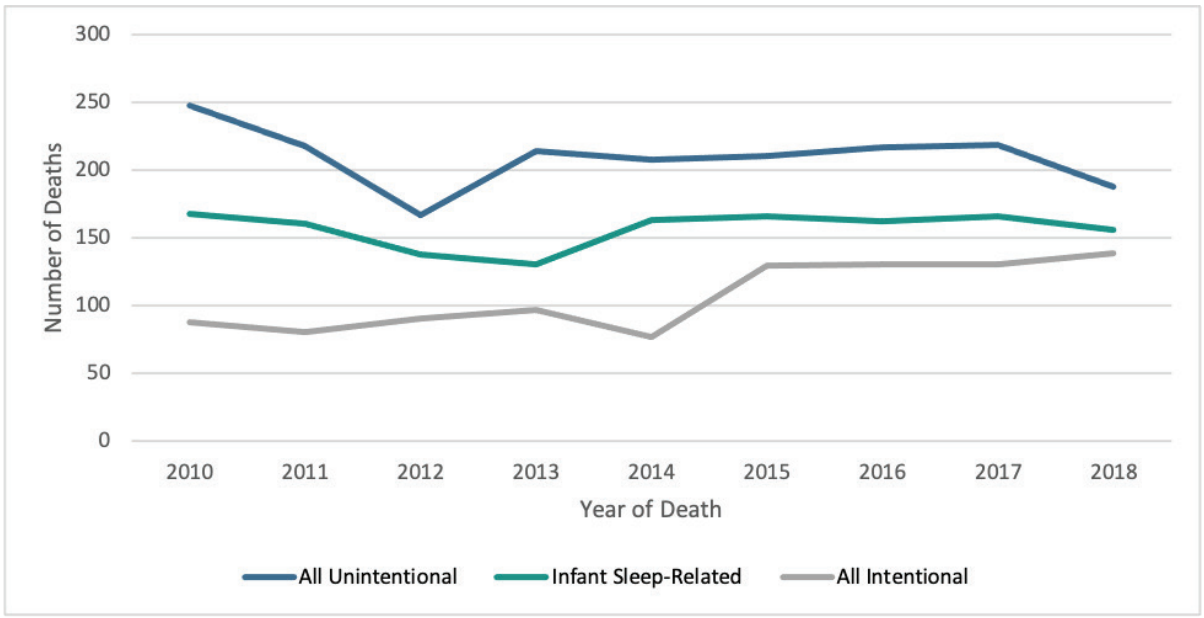
The total (all causes and ages) mortality rates obscure any of the age/cause differences, but they provide an overview of deaths for the past nine years (Figure 4). The infant rate shows an increase between 2010 and 2014/5 and then a decrease the last three years. The 1 – 17 rate appears to fluctuate more from year to year, but there is no obvious trend. The 2018 rate (22.9 per 100,000) is only slightly higher than the average rate (22.3) for the preceding eight years.

Figure 4. Georgia Infant and Child Death Rate Trends, 2010 - 2018



A cursory examination of cause of death numbers over time shows a significant increase in the intentional deaths in 2015 (Figure 5), and deaths remained at the higher level for the next three years. The increase occurred in both homicides and suicides and warrants additional study.

Figure 5. Count of Georgia Deaths, Ages 0 - 17, Selected Categories, 2010 - 2018



Child Deaths Reviewed

A child fatality review is required for deaths that are sudden, unexpected, unexplained, suspicious, or attributed to unusual circumstances, but the legislation does not provide a specific case definition for reviewable deaths. Historically, any non-medical cause death (defined by the ICD code for the underlying cause of death) has been defined as reviewable. Certain medical deaths (unexpected, decedent not under the care of a physician) are appropriately reviewed and are addressed in the annual report, however they are not included in either denominator or numerator when calculating the proportion of reviewable deaths reviewed. Using the "non-medical cause" criterium for reviewable death, there were 483 reviewable 2018 deaths.

The death certificate (DC) and Child Death Review (CDR) databases are linked (using dates of birth and death, decedent and parent names, and street address). The linked files are used to calculate the CDR performance metric – percent of "Reviewable Deaths" reviewed – and to provide data quality review.

The 2018 death certificate file identified 43 reviewable deaths for which there was no completed review. Some of these deaths have legitimate reasons for missing reviews:

- A death with an R99 (unknown) cause of death is considered reviewable; however, some infants die soon after birth and no known cause is identified. These deaths are included in the case definition of a "sleep-related" death, but that definition may not be appropriate.
- Thirteen of the 43 non-reviewed deaths occurred outside of Georgia. The team may not have known of the death or may not have had access to information required to conduct a review.
- A death may also occur in a different county than the resident county, and access to information may also be an issue.

Sixteen (16) of the 573 reviewed death records did not link with a DC. This list has been provided to GA Vital Records for follow-up. Seven of the remaining 557 records linked with a DC for a non-GA resident. Five hundred fifty (550) of the completed CFR records were linked with a death certificate for a GA resident.

These 550 records are used for the calculation of the proportion of reviewable deaths reviewed (Table 1). However, all 573 completed reviews are included in the analysis of reviewed deaths.

The GA CFR process has been in place and operating since 1991. Over these past 27 years the GA CFR and the county teams have worked diligently to complete reviews and enter the reviews into the state (now national) CDR database. The proportion of "reviewable deaths" reviewed has been as high as 95%; however, after decreasing for six years, the teams reviewed 91% of the reviewable 2018 deaths. That effort returns the reviewed proportion to the 2012 level. The extent of county team participation (in an unfunded mandate) after 27 years is very commendable, and it is important to acknowledge and encourage that local effort.

Table 1. Percent of 2018 GA Reviewable Deaths Reviewed

Cause of Death (DC)	All Deaths	Reviewed	% Reviewed
MVC	88	73	83.0
Drowning	30	25	83.3
Asphyxia	18	16	86.7
Other Injury	39	35	89.7
Unintentional Injury Total	**175**	**149**	**84.9**
Homicide	76	71	93.4
Suicide	63	60	95.2
Sleep-Related Total (Infants)	**156**	**147**	**94.2**
Unknown	4	4	100.0
Unknown Intent	9	9	100.0
Reviewable Total	**483**	**440**	**91.1**
Medical	952	110	11.6
All Deaths	**1,435**	**550**	**38.3**

A “reviewable” child death is (fortunately) a rare event. There was approximately one reviewable death for every 5,000 children in 2018 in GA. Seventy-six of GA’s 159 counties had a child population less than 5,000 in 2018, and 88 counties had fewer than two reviewable deaths in 2018 (48 with no deaths and 40 with one). Given these small numbers, the metric of reviewable deaths reviewed is not meaningful for a majority of the GA counties. However, the map in Appendix B displays counts by county for the number of reviewable deaths and the number of reviewable deaths reviewed. Eighty-two of the 159 GA counties reviewed all their reviewable deaths (Table 2). Some deaths were reviewed by a county other than the resident county on the death certificate, therefore county team counts of reviewed deaths may not match the numbers provided in the Appendix B map.

Table 2. Summary of 2018 Review Categories

Definition	Category	Counties	Reviewable Deaths	Reviewed
All reviewable deaths reviewed	4	82	274	274
One or more reviewable deaths not reviewed	3	18	193	166
Reviewable deaths, none reviewed	2	11	16	
No reviewable deaths	1	48		
Total			**483**	**440**

Maltreatment

The Role of Maltreatment in Reviewed Child Deaths

The World Health Organization defines child maltreatment as the abuse and neglect that occurs to children under 18 years of age. It includes all types of physical and/or emotional ill-treatment, sexual abuse, neglect, negligence and commercial or other exploitation, which results in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power. Exposure to intimate partner violence is also sometimes included as a form of child maltreatment.

2018 Reviewed Deaths with Maltreatment Reported

The purpose of this section is to document maltreatment as a reported cause of death and to describe deaths where there was a reported history of maltreatment. The National Child Death Review (NCDR) form captures maltreatment information (related specifically to the decedent) in various sections. Table 3 presents the maltreatment results (2018 reviewed deaths) from a derived summary variable which assigns an order to the maltreatment / contributing act categories. (The "de-duplication" works from the top down. For example, if abuse and neglect were both identified as causing the death, that death is reported as "Cause, Abuse". Thirty-nine deaths had neglect identified as a cause, but six of those deaths also had abuse identified. Those six deaths are not counted in the "Un-Duplicated" "Cause, Neglect" entry.)

Table 3. Maltreatment Reports and Other Adverse Acts

		All Reports	Un-Duplicated
Cause/Contribute	Abuse	33	33
	Neglect	39	33
History	Abuse	61	43
	Neglect	85	69
Poor Supervision		101	66
Exposure to Hazard(s)		226	142
	Totals		**386**

The sum of the un-duplicated counts for the four cause / history maltreatment categories (Table 3) is 178 (33+33+43+69). The "descriptive epidemiology" of these maltreatment-related deaths first addresses three basic variables – age, sex, and race-ethnicity. The purpose of the analysis is to determine whether the apparent proportion of reviewed deaths with reported maltreatment changes with these three variables. (i.e., Is a male decedent more likely than a female to have experienced maltreatment?)

Males are at greater risk than females for a "reviewable" death, with 61% in 2018. (Table 4) Males also had a higher proportion (33%) than females (28%) of deaths with maltreatment (in 2018), although the difference is not statistically significant. (p-value = .25) (A multi-year calculation shows females with an insignificantly higher proportion over a four-year period.)

Over half of the reviewed 2018 deaths were to Black / African American infants and children. However, their proportion of deaths with maltreatment (27%) was significantly lower (p-value = .044) than the White proportion (35.5%). (The multi-year calculation also has a higher proportion among White decedents.) The multi-race decedents comprise less than 5% of all reviewed deaths, but their maltreatment proportion is over 50% for the one-year and four-year calculations.

The age data (2018) shows lower proportions of infants and teens (15 to 17) with reported maltreatment. The other three age categories (including children 1 through 14) have about 38% of their deaths with maltreatment, while the infants and teens are < 30%.

Some of the observed age and race/ethnicity differences are associated with specific causes of death. Subsequent reports will use the four-year (2015 – 2018) data set to examine cause-specific associations with maltreatment, and multi-variate demographic associations.

Table 4. 2018 Reviewed Deaths with Maltreatment Reported (by Demographic Variables)

		Reviews with Maltreatment			
	All Reviewed	Percent	Count	Percent	%, '15 - '18
Sex					
Male	350	61.1	115	32.9	30.0
Female	223	38.9	63	28.3	31.0
Total	**573**		**178**	**31.1**	**30.4**
Race/Ethnicity					
Black	296	51.7	80	27.0	29.4
White	200	34.9	71	35.5	31.1
Hispanic	40	7.0	12	30.0	27.6
Multi-race	24	4.2	13	54.2	52.9
Other	12	2.1	1		
Unknown	1		1		
Age (Years)					
Infants	211	36.8	59	28.0	22.6
1 - 4	100	17.5	42	42.0	41.9
5 - 9	48	8.4	14	29.2	36.4
10 - 14	69	12.0	29	42.0	37.3
15 - 17	145	25.3	34	23.4	29.2

Table 5 shows all reviewed child deaths by cause of death with a cause or history of maltreatment. It reveals a disturbing number (31) of homicides with abuse as the cause. Over 50% of homicide related deaths has a history or reported maltreatment cause.

Table 5. Maltreatment Category by Cause of Death: GA, 2018 Reviewed Deaths
Maltreatment Category

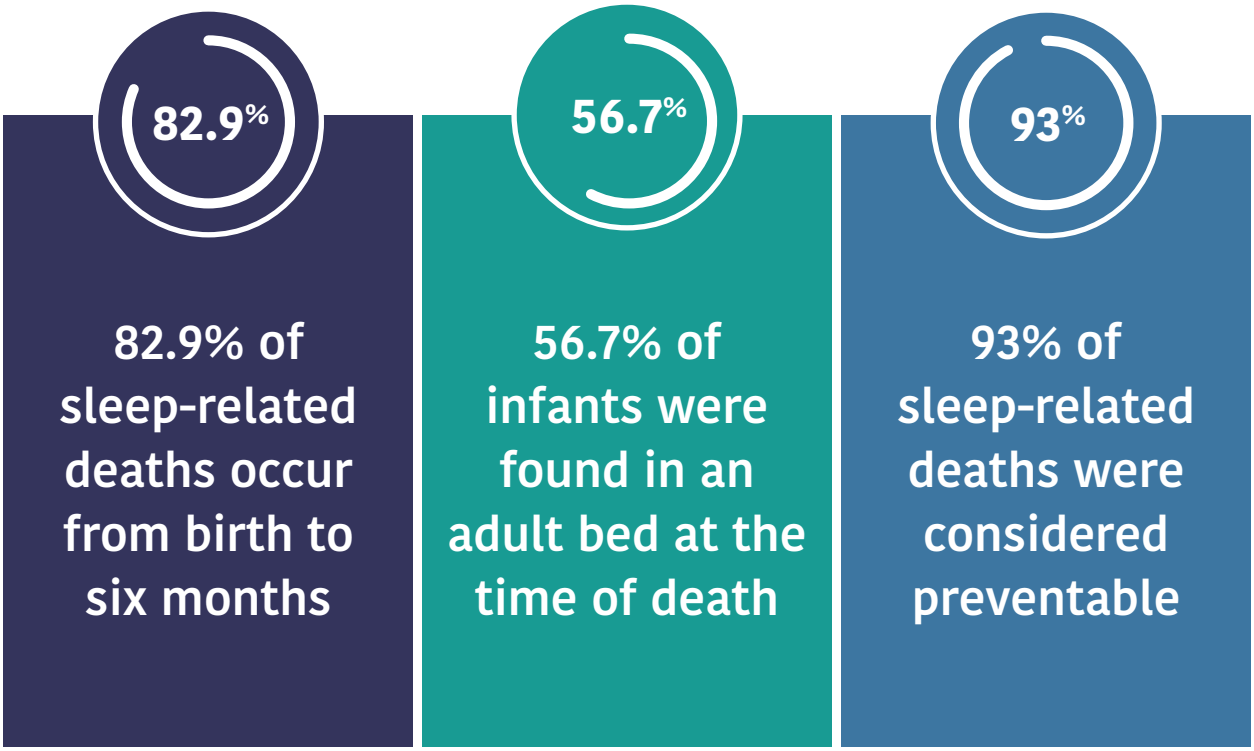
	Cause/Contribute		History				
Cause of Death	**Abuse**	**Neglect**	**Abuse**	**Neglect**	**No Malt.**	**Totals**	**% w/Malt**
MVC		1	6	9	61	77	20.8
Drowning		3	4	2	24	33	27.3
Other Unintentional		8	6	9	44	67	34.3
Homicide	31	3	3	6	34	77	55.8
Suicide	1	2	9	8	42	62	32.3
Sleep-Related	1	13	7	20	123	164	25.0
Medical		3	8	15	67	93	28.0
All Reviewed	33	33	43	69	395	573	31.1
Duplicated Counts	33	39	61	85			

Summary of Selected Causes

Sleep-related Infant Deaths

Sleep-related infant deaths continue to remain the largest number of preventable child deaths in Georgia. Georgia continues to average at least three infant deaths per week due to sleep-related causes, which are mostly preventable. In 2018, there were a total of 164 sleep-related deaths in Georgia.

There was a total of 164 sleep-related infant deaths in 2018. Key findings are:



Suicide

Suicide is the second leading cause of death for youth and adults ages 10-34 in the United States behind unintentional injuries (primary motor-vehicle crashes). Using CDC's categorizations for causes of death, in Georgia, suicide is the third leading cause of death for the 10-14 age group and the second leading cause of death for the 15-17 age group.

There was a total of 62 youth suicides reviewed in 2018. Key findings are:

- 43.5% of 2018 reviewed suicide deaths involved a firearm
- 46.7% of 2018 reviewed suicide deaths were by hanging
- Most reviewed suicide deaths involved decedents in the 15 to 17-year-old age category (59.6%)

Homicide

According to the CDC, homicide is the fourth leading cause of death for children ages 1-14 in the United States behind unintentional injuries and medical causes (cancer and congenital anomalies separately counted) and is the third leading cause of death for youth and adults ages 15-24 behind unintentional injuries and suicide.2

In 2018, the CFR Committees reviewed 77 homicide deaths. Key findings are:

- A firearm was involved in 38 of the 77 total homicides
- There were 13 infant homicides in 2018
- Since 2014, homicides have more than doubled for youth in the 15-17 age category

Motor Vehicle-Related Deaths

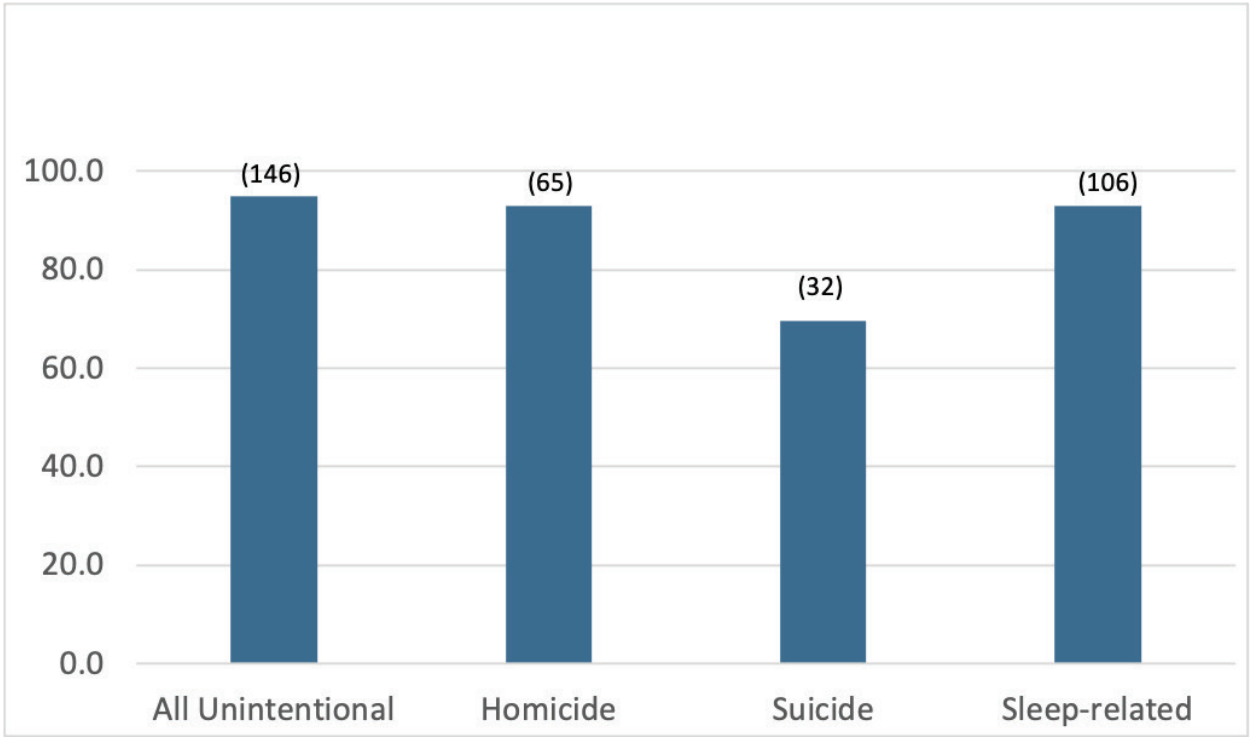
- In 2018, there were a total of 77 reviewed motor vehicle deaths in Georgia, a decrease from the 93 reviewed motor vehicle-related deaths in 2017. They are the number one leading cause of death for youth ages 15-17. Key findings are:
- The most impacted group was the 15 to 17-year-old age group, which encompassed 49.3% of the deaths
- The decedent was the driver or passenger in 55 of the 77 deaths (71.4%)

Preventability and Prevention Findings

There is strong consensus among the review teams that the non-medical (violent) deaths can be prevented. Ninety-one percent of non-medical deaths with a preventability determination (" No, probably not" or "Yes, probably") had "Yes, probably" reported. Almost 95% of deaths due to unintentional injuries, 93% of sleep-related deaths, 93% of homicide deaths, and 70% of suicide deaths were considered preventable (Figure 6).

The CDR process encourages local teams to consider possible interventions that could have prevented the death. The review form has a prevention section (L. Prevention Initiatives Resulting from the Review) designed to capture suggestions or implemented actions in the areas of agency policies and services, education, legal system changes, or environmental factors. Several "open-ended" questions provide opportunities for narrative on recommendations. These narratives are of significant value – when they are completed. Some of the CDR cases do have thoughtful recommendations regarding prevention steps; however, Section L comes close to the end of a long form, and detailed comments are the exception. The "prevention buck" does not stop with the local CFR team. The CFR staff is responsible for summarizing / synthesizing the prevention input from the teams and providing that data and / or draft recommendations to the CFR Panel. The Panel then develops the final recommendations for the Annual Report.

Figure 6. 2018 Reviewed Deaths, % Preventable (Number Preventable)



Preventability of Reviewed Deaths

Determining why a death occurred and utilizing the information to prevent future deaths is the focus of each CFR team. It is also important to review preventability of reviewed deaths. In 2018, over 90% of non-medical deaths — 360 of 444 reviewed — could have been prevented. As shown in Table 6, the CFR teams also determined that every cause of death category had a prevention percentage of over 80% except suicide where 69.6% of the deaths were determined to have been preventable.

Table 6: CDR Team Determination of Preventability: 2018 Reviewed Deaths

	Could the death have been prevented? (PRV prevented)				
Cause of Death	**Missing**	**No, probably not**	**Yes, Probably**	**Undetermined**	**% Prev***
Asphyxia		1	11	1	91.6
Drowning	1	3	24	5	88.9
MVC	1	1	66	9	98.5
Other, Unintentional	2	3	45	13	93.8
Homicide	1	5	65	6	92.9
Suicide	2	14	32	14	69.6
SUID_Asphyxia	1	4	46	6	92.0
SUID_Medical		1	1	4	50.0
SUID_Undetermined	1	3	59	29	95.2
Medical	1	49	11	32	18.3
Total	**10**	**84**	**360**	**119**	**81.1**
Non-Medical	**9**	**35**	**349**	**87**	**90.9**

Resources

Centers for Disease Control and Prevention, Injury Prevention and Control (www.cdc.gov)

US Department of Transportation, Federal Highway Administration (www.fhwa.dot.gov)

National Highway Traffic Safety Administration (www.nhtsa.gov)

Georgia Department of Driver Services (www.dds.ga.gov)

Georgia Governor's Office of Highway Safety (www.gohs.state.ga.us) American Red Cross (www.redcross.org)

Centers for Disease Control and Prevention (www.cdc.gov)

Children's Safety Network (www.childrensafetynetwork.org)

United States Consumer Product Safety Commission (www.cpsc.gov)
American Academy of Pediatrics (www.aap.org)

Centers for Disease Control and Prevention, Injury Prevention & Control: Division of Violence Prevention (www.cdc.gov/violenceprevention)

Georgia Department of Public Health, Youth Risk Behavior Surveillance System (www.dph.georgia.gov/YRBS)

Georgia General Assembly (www.legis.ga.gov)

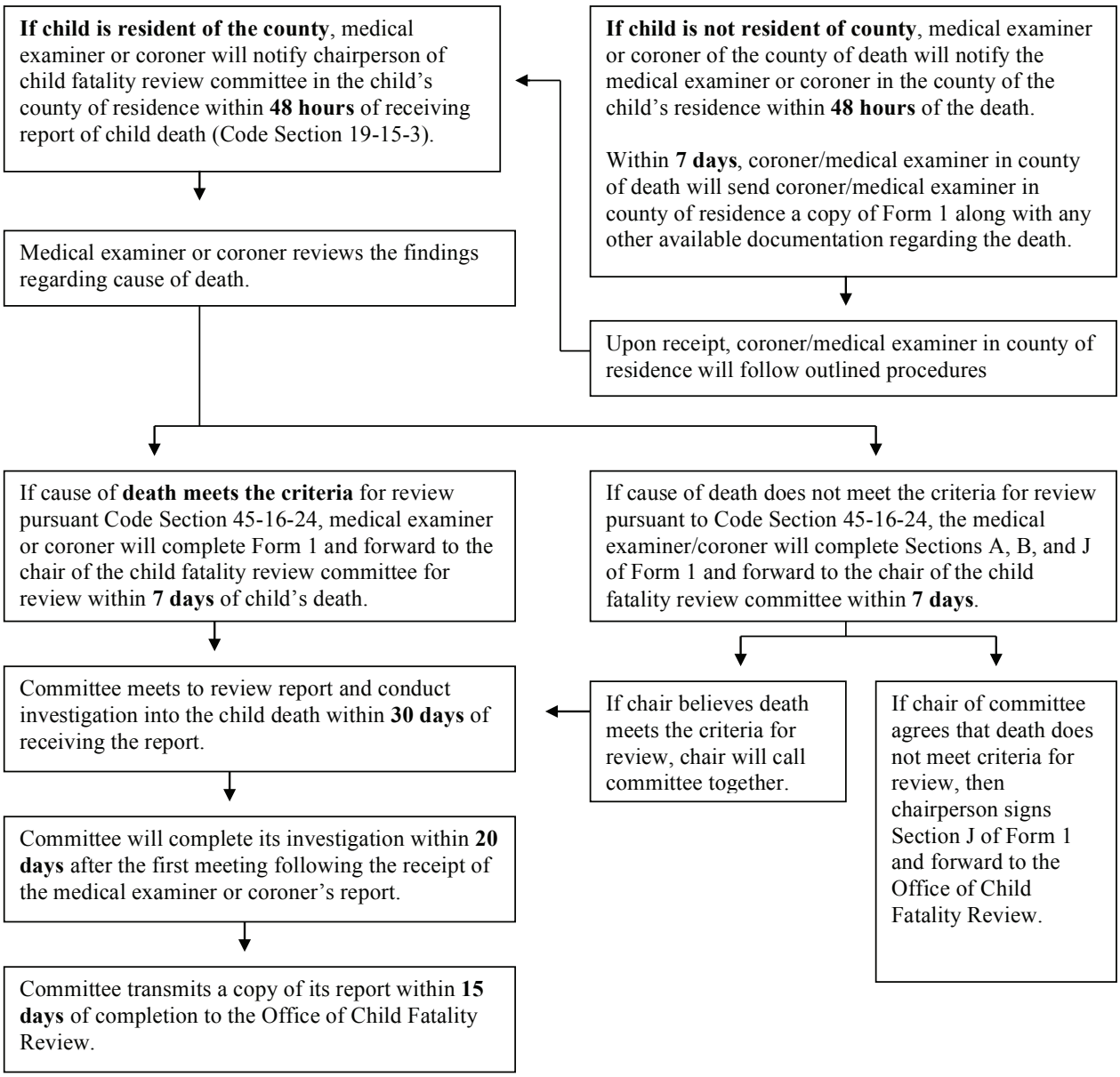
The Jason Foundation (www.jasonfoundation.com) Suicide Awareness Voices of Education (www.save.org)

Georgia General Assembly Legislation (www.legis.ga.gov)

Prevent Child Abuse America (www.preventchildabuse.org)

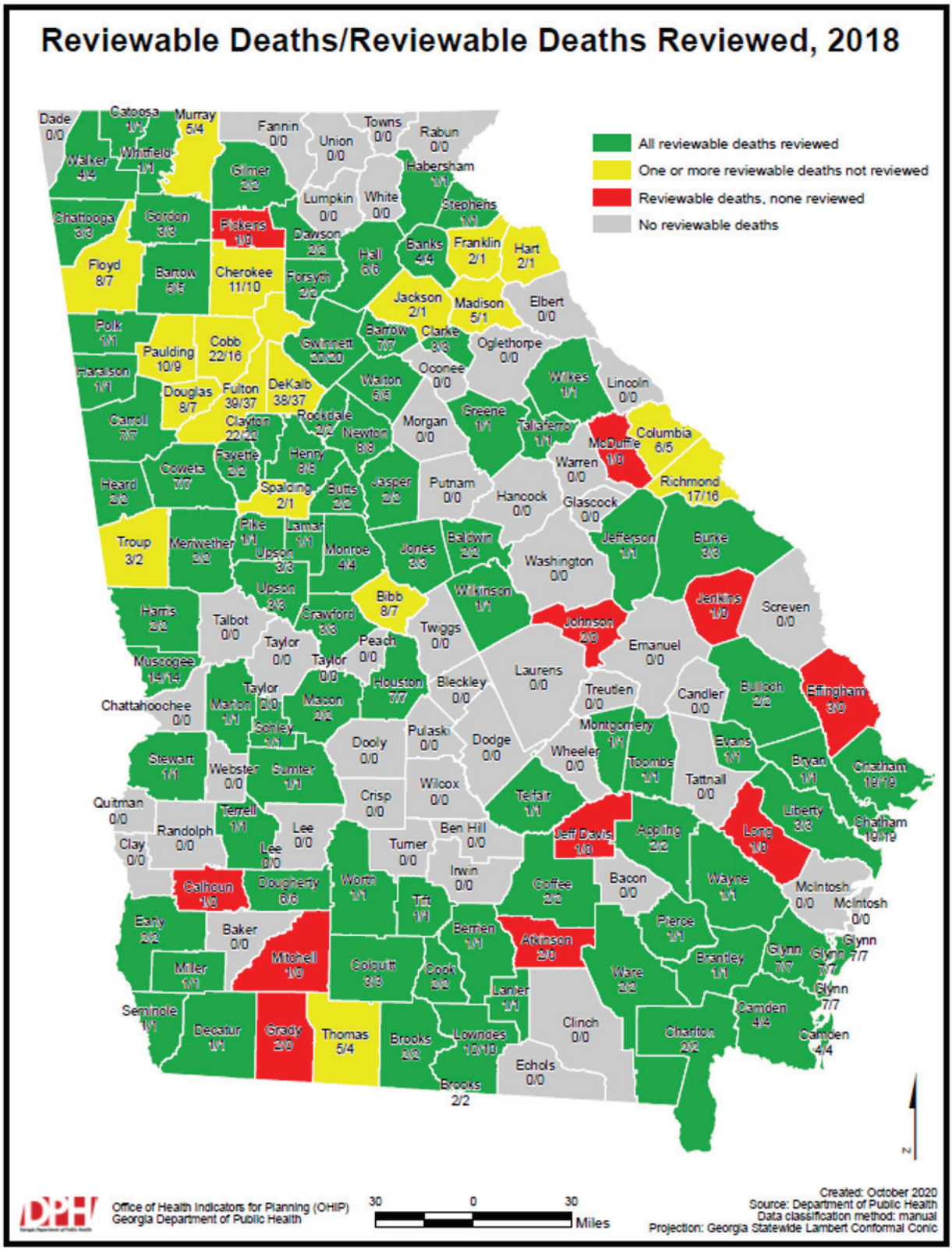
Appendix A

Child Fatality Review Committee Timeframes and Responsibilities



Send copy of the report within **15 days** to district attorney of the county in which the committee was created if the report concludes that the death was a result of: SIDS without confirmed autopsy report; accidental death when death could have been prevented through intervention or supervision; STD; medical cause which could have been prevented through intervention by agency involvement or by seeking medical treatment; suicide of a child under the custody of DHR or when suicide is suspicious; suspected or confirmed child abuse; trauma to the head or body; or homicide.

Appendix B - 2018 Compliance Map



Georgia Child Fatality Review Panel

Annual Report - Calendar Year 2018